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SC Court of Appeals

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 IV

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

1 Q: Sure. I'm not asking --

2 A: And I'm not usually interested in talking about that
3 either.

4 Q: Fair enough. I'm not asking you to just chit chat. If
5 he has something to communicate to you, he can do it? He or
6 she can do it while they're doing the surgery; right?

7 A: Yes, sir.

8 Q: So it doesn't take three eyes in order to say to someone
9 go get the anesthesiologist, does it? As silly as that
10 question may be, just -- it may sound, you would not tell this
11 jury that the surgeon has to have three eyes in order to
12 request that the anesthesiologist come to the room, would you?

13 A: I would -- I would tell the surgeon that -- the jury that
14 if the surgeon has three eyes, he's either a really good
15 surgeon because he's got an extra eye, but it is very easy for
16 the surgeon to communicate with anesthesia, and that's
17 critical to good care of our patients.

18 Q: Right. It takes one mouth. Go get the -- go get the
19 anesthesiologist. I want to talk to him?

20 A: Yeah.

21 Q: Right? Okay. You wouldn't believe some of the stuff
22 we've heard. Doctor, do you -- you agree that a patient's
23 baseline blood pressure should be considered when making an
24 anesthesia plan and where to maintain the patient's blood
25 pressure during a surgical procedure; correct?

1 A: Yes.

2 Q: All right. A patient's baseline blood pressure should be
3 considered when making a plan about where to maintain the
4 patient's blood pressure during a surgical procedure; true
5 statement?

6 A: I think it's true.

7 Q: All right.

8 A: Did I say that?

9 Q: You did. You told me that a while back, and I just want
10 to make sure we still agree on this.

11 A: No. I agree on that.

12 Q: Okay.

13 A: I read through my deposition last night.

14 Q: Well, good. This may be real quick then.

15 A: Good.

16 Q: Nothing would please me and I think these twelve folks
17 more. So --

18 A: We'll see what we can do.

19 Q: You agree that a patient's intraoperative blood pressure
20 typically is kept within 20 percent of his or her baseline
21 blood pressure?

22 A: Typically.

23 Q: All right. A patient's intraoperative blood pressure
24 typically is kept within 20 percent of his or her baseline
25 blood pressure; true statement?

1 A: No question.

2 Q: All right.

3 A: Based on a very poorly based 20 percent rule.

4 Q: Okay.

5 A: But that's a good place to go.

6 Q: Okay. There's exceptions to every rule?

7 A: Correct.

8 Q: For instance, you agree that a patient with chronically
9 high blood pressure would typically be kept at a higher
10 intraoperative blood pressure than patients with the blood
11 pressure in a normal range?

12 A: I would agree with that, yes.

13 Q: All right. A patient with chronically high blood
14 pressure would typically be kept at a higher intraoperative
15 blood pressure than patients with a blood pressure in a normal
16 range?

17 A: Yes.

18 Q: All right. And you agree that this 20 percent guideline
19 or 20 percent rule of thumb, that that is widely recognized as
20 a rule of thumb in the field of anesthesia?

21 A: Yes.

22 Q: And you agree if a patient's preoperative baseline blood
23 pressure is high, it is to the benefit of the patient to try
24 to keep it within 20 percent of that baseline?

25 A: I don't believe I ever agreed to that.

1 Q: All right. Well, how about this? We'll rephrase that
2 slightly. It's a good goal to aim to try to keep your patient
3 within 20 percent of their baseline. How about that?

4 A: I think we said that before.

5 Q: Okay. And in your practice as an anesthesiologist, you
6 personally attempt to determine and understand what a
7 patient's baseline blood pressure is prior to starting the
8 surgery; right?

9 A: Yes.

10 Q: All right. You use a patient's preoperative baseline
11 blood pressure as a guide to try to keep them within this 20
12 percent range. That's what the 20 percent range is based off
13 of. That's the guide is their preoperative blood pressure?

14 A: Preoperative blood pressures. Usually, I have more than
15 one.

16 Q: You asked -- you got a copy of that?

17 A: I'm trying to help you here.

18 Q: Okay. So you don't just look at blood pressure -- blood
19 pressure, you try to look at multiple to get an idea of where
20 this person typically lives?

21 A: Yes.

22 Q: All right. And you agree that when looking to determine
23 that preoperative baseline blood pressure, it can be helpful
24 for a physician to simply ask the patient, do you regularly
25 check your blood pressure and, if so, where does it normally

1 run?

2 A: Yeah. I do that frequently, and I'm frequently
3 incredibly assisted in taking better care of my patients
4 because I did.

5 Q: Yep. Some of us are good about it and others of us less
6 so; right?

7 A: But it's definitely not required.

8 Q: Helpful to have those things. We got a Publix here in
9 Columbia. Publix has a blood pressure cuff right there at the
10 -- when you enter the store. I think Walmart has one when you
11 enter the store.

12 A: Well, I'm not crazy about -- about commercial blood
13 pressure cuffs like that, but it's a good start because they
14 kind of keep their algorithms as to how they determine the
15 pressure to themselves.

16 Q: All right. So it would be prudent to ask the patient do
17 you normally check your blood pressure at home, what does your
18 blood pressure typically run?

19 A: That's what I do.

20 Q: Good thing to ask; right?

21 A: That's a great thing to ask.

22 Q: All right. And you agree that for this patient, Crystal
23 Goodwin, she had a number of risk factors that needed to be
24 considered prior to beginning surgery by the anesthesia team
25 and the surgical team?

1 A: Yes, sir.

2 Q: All right. And you agree that her risk factors that
3 warranted consideration included chronic hypertension,
4 diabetes, obesity, and two prior spine surgeries?

5 A: Yes.

6 Q: All right. 2016, Crystal's risk factors that warranted
7 consideration included chronic hypertension, diabetes --
8 didn't have a comma there, need to fix that -- obesity, and
9 two prior spine surgeries?

10 A: Yes.

11 Q: All right. And then it would stand to reason in 2011
12 they would have been slightly different because in 2011 she
13 would have only had one prior spine surgery; right?

14 A: That would have been a difference, and there could have
15 been other differences. I didn't know -- I didn't look into
16 what medicine she was exactly on in 2011.

17 Q: You anticipated my next question. She was a different --
18 a somewhat different patient years earlier than she was in
19 2016?

20 A: Yes, she was.

21 Q: And by 2016, she had had more years of hypertension?

22 A: She had had more years of hypertension. You know, it
23 depends upon how -- how critical her hypertension was. I
24 would suggest that -- that a patient who is -- like, I'm on
25 hydrochlorothiazide and lisinopril. My hypertension is not --

1 is not significantly difficult to control.

2 So if -- if Ms. Goodwin was on lisinopril and
3 hydrochlorothiazide, like -- like I'm on, and that -- that
4 means her hypertension is present, but it's not -- it's not a
5 difficult hypertensive patient to treat. Plus, in '11, she
6 had a certain progression of her intrinsic spinal condition,
7 and that's progressed also.

8 Q: Okay. So just as a general concept though, Crystal
9 Goodwin in 2016 wasn't essentially the same patient she was in
10 '11 and wasn't essentially the same patient she had been back
11 in '09?

12 A: Yes, sir.

13 Q: And you agree -- I know you're not a surgeon, but you
14 went to med school. You did rotations through different --
15 different -- you went to --

16 A: Yes.

17 Q: -- an OB rotation, did a radiology rotation. You agree
18 that generally scar tissue can impact the perfusion of blood
19 flow?

20 A: I do.

21 Q: And that's true whether it's in the spine or whether it's
22 anywhere else in the body we might have scar tissue from prior
23 surgery?

24 A: Yeah. Even wisdom teeth.

25 Q: And you agree that chronic hypertension can change a

1 patient's vasculature, can change a patient's arteries; right?

2 A: It can.

3 Q: All right. And so this concept we talked about

4 throughout this trial, if a patient has high blood pressure

5 for a long time, the walls of the artery can get hardened and

6 less and less able to constrict and expand; right?

7 A: Actually, it goes -- it's not that simple.

8 Q: Okay.

9 A: It -- it -- the -- the concept of remodeling is poorly
10 studied in humans themselves, but the concept of remodeling is
11 affected by the blood pressure. It's affected by the chronic
12 hypertension, but how that works is through numerous chemicals
13 that are produced at the site of the hypertension, at the
14 tissue, in the nerve, in the brain, and it's also affected by
15 the chronic hypertension and the hormones that a variety of --
16 that the body makes, and of many local factors that are
17 occurring at the site of the arteriole or the capillary.

18 So it's -- it -- it is -- it's not something that goes
19 like -- like your pipe in your -- in your house, like a PVC
20 pipe. Somebody referred to that. It's just not that way.
21 This is a living organism. The -- the -- the artery has
22 muscles in it, cells, and all kinds of things are happening at
23 the same time.

24 So in 2011, there might have been a significant
25 narrowing, but by 2016, in some places it might be larger, in

1 other places it might be even smaller. But it's going to --
2 and it's going to respond. The -- the remodeling -- this is
3 what we think. I don't know this in humans. I know this in
4 animals. That the remodeling will occur in response to the
5 inflammatory process, and hypertension is part of that. In
6 Ms. Goodwin, her progressive spine disease was another big
7 part of that.

8 Q: There's lots of stuff going on; right?

9 A: Yes, sir. That's really my point.

10 Q: Okay. And -- and I don't mean to belabor it, but my
11 question essentially was just that vascular remodeling from,
12 as you mentioned, a number of things, not just high blood
13 pressure, it's real. We're not talking about a unicorn or a
14 leprechaun. This is a real concept in medicine that is
15 recognized that people have vascular remodeling under certain
16 conditions?

17 A: Yes. But I would just add to that that the picture
18 painted by the exhibits that Dr. Jones had is not a reflection
19 of how remodeling works.

20 Q: You disagree with the animation. I got you.

21 A: Well, just -- it just doesn't reflect what's really going
22 on. It's not a -- it's not a PVC pipe.

23 Q: Okay. But you don't disagree with the concept that it
24 happens?

25 A: No, sir.

1 Q: Okay. And you recognize that there's an area of the
2 spinal cord that's sometimes referred to as the watershed
3 region; right?

4 A: Yes.

5 Q: And you recognize that that area, the watershed region,
6 is in the thoracic spine; right?

7 A: Yes.

8 Q: And you recognize that this area, this watershed region,
9 is known to be more susceptible to low blood pressure?

10 A: Yes.

11 Q: It's essentially the last area of the spine to get blood;
12 right?

13 A: It's also a -- the place where one of the major arteries
14 to the spine goes also.

15 Q: And despite that --

16 A: So, again, it's a balance, but it's definitely an at-risk
17 -- a potentially at-risk portion of the spinal cord.

18 Q: And that is understood and recognized by physicians?

19 A: Yes.

20 Q: You learned it in med school?

21 A: Actually, you did. Yeah.

22 Q: Yeah.

23 A: I actually learned that in dental school, too.

24 Q: Really? That makes me feel better about going to the
25 dentist the other day. If you want to -- I won't comment on

1 my experience with the dentist.

2 You agree that when a surgeon is doing a third operation
3 on a patient's back, the arterial anatomy or perfusion is more
4 likely than not going to have been significantly disrupted?

5 A: Yes.

6 Q: Do you agree that Ms. Goodwin exhibited pretty
7 significant high blood pressure during her office visit with
8 Dr. Holbrook on June 20th, 2016?

9 A: June 20th?

10 Q: And I'd say that was the -- June 20th was the one that
11 was -- that was the first visit in 2016. It was 152 over 112.

12 A: Yeah, that's -- that is significant hypertension. Yes,
13 sir.

14 Q: All right. And you agree that she exhibited high blood
15 pressure during her pre-anesthesia evaluation on July 22nd,
16 2016; correct? That was 156 over 92.

17 A: Yes, sir.

18 Q: Okay. And you agree that she exhibited high blood
19 pressure during her evaluation on the morning of surgery 2000
20 -- excuse me -- July 28th, 2016? That was the 160 over 99.

21 A: Yes.

22 Q: And were you in the courtroom the other day? You've been
23 sitting back here for a couple of days now.

24 A: Just yesterday and today.

25 Q: Well, yeah.

1 A: It's been a great education.

2 Q: And were you in the courtroom when Ms. Goodwin was
3 talking about she would check her blood pressures when she'd
4 go into Walmart? And as a baker, she went often, as much as
5 every single day?

6 A: Yes. I was very impressed with Ms. Goodwin.

7 Q: And you heard her test -- testify that where she
8 typically -- to her recollection, where she typically ran in
9 2016, was in -- I think 150 at over 90, something like that?

10 A: Right.

11 Q: That would be --

12 A: I recall that.

13 Q: Sorry. Go ahead.

14 A: I recall that being -- being what she mentioned. I don't
15 recall the specifics.

16 Q: Okay. But it would be -- what she testified to was --
17 was -- was hypertension; right?

18 A: Well, 150s over 90s is hypertension. 160s over 100 is
19 getting into the dangerous range.

20 Q: Okay. Just -- just walking around like that is not
21 particularly safe?

22 A: Yes. Not 160 over 110 or 100.

23 Q: From the information available on the morning of July
24 28th, 2016, you agree it would be prudent for the healthcare
25 providers treating Crystal Goodwin to treat her as a patient

1 who had hypertension?

2 A: Yes, and I think they did.

3 Q: With the information that was available that morning, you
4 would be concerned about her hypertension and would be
5 thinking that you might need to keep her mean arterial
6 pressure during surgery a little bit higher, especially since
7 Dr. Holbrook was doing his third operation in the same area
8 and considering Ms. Goodwin's other medical problems?

9 A: Yes.

10 Q: In every back surgery in which you're involved, you make
11 sure that there is an understanding between the surgeon and
12 anesthesia about where the patient's intraoperative blood
13 pressure is going to be kept; correct?

14 A: Either spoken or unspoken. Yes, sir.

15 Q: Okay. And you talked about that a little bit. That if
16 -- if you work together lots and lots of times, you may not
17 need to have that conversation; right?

18 A: Right.

19 Q: All right. And you're talking -- there's some
20 relationships where the same surgeon is working with the same
21 anesthesiologist and the same CRNA -- CRNA every single day
22 almost, just day in and day out; right?

23 A: Yes, sir.

24 Q: And you heard the testimony from Mr. Starn that wasn't
25 the case in this situation. He just worked with whoever.

1 He'd just show up and whoever -- he might be assigned to a
2 different surgeon and a different anesthesiologist at any
3 given day; right?

4 A: Well, I heard Mr. Starn say that he worked with Dr.
5 Holbrook a lot.

6 Q: But it wasn't like he -- well, you understood he -- he
7 would be assigned to different -- different doctors and
8 different anesthesiologists any time he came in. I understand
9 he said he had worked with Dr. Holbrook before, but it wasn't
10 like he was Dr. Holbrook's CRNA. You understood that; right?

11 A: I've never worked at a hospital where any surgeon had
12 their anesthesiologist or CRNA, although that is not an
13 uncommon practice in Colorado.

14 Q: Okay. Well --

15 A: But not -- not -- not -- not that I'm aware of in North
16 Carolina or South Carolina.

17 Q: Okay. Fair enough. So in every back surgery in which
18 you have been involved, you made sure that there was an
19 understanding between the surgeon and the anesthesia -- and
20 anesthesia about where the patient's intraoperative blood
21 pressure was going to be kept?

22 A: Yes.

23 Q: All right. The anesthesia -- the anesthesiologist and
24 the surgeon almost always have a pre-operative conference or
25 powwow to discuss the surgical plan, especially when it's a

1 spine surgery; right?

2 A: That's my usual practice, yes.

3 Q: The standard of care requires that there be at least a
4 discussion of risk factors like prior surgeries, chronic
5 hypertension, diabetes, obesity, and the length of surgery,
6 unless there's already been an understanding between the nurse
7 anesthetist, anesthesiologist, and surgeon, what you were
8 talking about a minute ago, as to how blood pressures will be
9 managed; right?

10 A: Did I say that?

11 Q: I think so.

12 A: That makes sense.

13 Q: In other words, I think this is what you said. Yeah. I
14 think you and I agree on a lot of stuff.

15 A: Yes.

16 Q: Unless there's for some reason there's already an
17 understanding --

18 A: Which is --

19 Q: -- there needs to be --

20 A: Which is possible.

21 Q: There needs to -- regardless whether it happens with a
22 conversation or just day in and day out working with one
23 another, everybody needs to be on the same page about what's
24 going on with this patient and how the blood pressure is going
25 to be managed; fair?

1 A: Fair.

2 Q: All right. It's your testimony that the MAP for Crystal
3 should be kept above 80; isn't that correct?

4 A: I would think that would be a good place to keep her
5 blood pressure, yes.

6 Q: All right. So, in other words, if her ideal range -- a
7 good place to keep it for her is above 80, this is 70 down
8 here, you'd put it up here at 80; right?

9 A: I would say 80. I'm not sure.

10 Q: 80, not 70 for Crystal; fair?

11 A: Fair.

12 Q: All right. Now, earlier -- can I call you Dr. B because
13 --

14 A: You can call me Frank. You can call me anything. I'm
15 married.

16 Q: I got to tell you, I've been pronouncing your name wrong
17 in my head, and it's really hard to undo that now, and I'm
18 afraid I'm going to mess it up. So I'm just --

19 A: Yeah.

20 Q: Anyway, Dr. B.

21 A: Thank you.

22 Q: I'm not the only one to call you that I bet?

23 A: You are not.

24 Q: Okay. Earlier, you talked with Mr. Davis about trying to
25 determine where Crystal -- where she kept her blood pressure,

1 and you were looking at numbers, as I understood, in recovery
2 and in the days after the surgery; right?

3 A: Yes, sir.

4 Q: Okay. Did you realize that in the days after the
5 surgery, Crystal was on Percocet, Valium, Celebrex, and
6 Cymbalta?

7 A: Yes. And Lasix or -- and -- and the hydrochlorothiazide,
8 I believe.

9 Q: Okay. That Valium is going to, among other things, try
10 to keep her calmer; right?

11 A: Yes.

12 Q: Okay. Which would potentially have the effect of
13 lowering her blood pressure; right?

14 A: Usually Valium, if you're upset and it calms you down, it
15 may lower your blood pressure, but as a general rule, Valium
16 is not an antihypertensive medicine that would be treating
17 essential hypertension, which I believe is what Ms. Goodwin
18 has.

19 Q: And they had her on some blood pressure medicines in that
20 time period, too; right?

21 A: I think -- I looked. I was specifically looking for that,
22 and the only thing I found was the -- the HCTZ, the
23 hydrochlorothiazide, which was -- which was -- which is a very
24 initial starting point and a mild antihypertensive.

25 Q: But my point to it, I guess, is, Doctor, you agree that

1 in this post-surgical period, this two-week period where you
2 were looking at blood pressures, she's on all kinds of
3 different drugs than what she's normally on; fair? At least
4 some different drugs?

5 A: She's on -- yes, she's on different drugs for sure.

6 Q: All right. And you looked -- earlier, you were looking
7 at the chart. I need to pull it up. But you looked at the
8 little chart with the little carets and the little -- little
9 check marks, and you talked about where she began surgery;
10 right?

11 A: Yes.

12 Q: Her blood pressure at the beginning of surgery, but at
13 the beginning of surgery, she had already received propofol;
14 right?

15 A: I don't believe so, not when she got that first pressure.

16 Q: She didn't get it right around 7:25?

17 A: Yes, she did, but -- but you get -- usually, the
18 requirement is, is that before you go to sleep and get
19 propofol, you take a blood pressure. You don't -- you don't
20 bring a patient into the operating room, put them to sleep,
21 and then take their blood pressure. That is not good
22 practice.

23 Now, if that happened here -- but from my interpretation
24 of the record, what's more -- what's very likely happened --
25 and I mean, you can ask Dr. Root, and I think Mr. Starn said

1 that -- something to that effect yesterday. You don't go give
2 them 200 milligrams of propofol and put the patient to sleep
3 without taking their blood pressure first.

4 So -- and that's why it's important, especially in this
5 -- in this instance where the previous preoperative blood
6 pressure an hour or so ago was so high, to get a gauge as to
7 where you think the mean arterial pressure is, because causing
8 a patient to be hypertensive can be as harmful as hypotension.

9 Q: But deciding what her baseline blood pressure is isn't
10 just looking at one reading; right? We agree with that?

11 A: Yes.

12 Q: And you agree that had Dr. Holbrook's office sent over
13 the record of what Crystal's blood pressure had been in his
14 office in June and July, that would have been information that
15 the anesthesiologist should have considered; fair?

16 A: Absolutely should consider it.

17 Q: All right. But she doesn't know to consider it if it's
18 not sent to her; fair?

19 A: Yes.

20 Q: All right.

21 A: That's a clear deficit of the entire medical system in
22 the United States because I have a -- I work tirelessly. It's
23 part of the stress of my day is trying to find the right data
24 that you get from doctors' offices, other clinics, other
25 hospital systems. We just don't share it. We've made a

1 decision in our country to not make that easy, and that surely
2 is not a requirement for good care.

3 Q: It would be helpful though to have that more information
4 about -- have additional information about what her blood
5 pressures had been in the office; right?

6 A: Yes, sir.

7 Q: All right. Let's look at that. This is -- all right. I
8 think this is Exhibit Number 19 in the record. All right.
9 Exhibit Number 19.

10 A: Thank you.

11 Q: And this saves us from having to just pull out records
12 and calculators and all kinds of stuff. So June 20th, her
13 pre-op on June 20th in Dr. Holbrook's office. You reviewed
14 the record. You saw her blood pressure was 152 over 112;
15 right?

16 A: I did.

17 Q: And that equals a mean arterial pressure of 125. I think
18 it's actually 125.3, but we dropped off the -- rounded down to
19 the nearest number. July 28th, a little bit better there, 129
20 over 81, for a mean arterial pressure of 97. July 22nd,
21 that's the pre-op mean arterial pressure of 113, and the
22 morning of mean arterial pressure of 119; right?

23 A: Yes, sir.

24 Q: You agree to take all four of these numbers? And I did
25 put a decimal there because it was right in the middle. I

1 thought it prudent to both sides to put that.

2 A: Yeah.

3 Q: 113.5?

4 A: Yep. I totally agree with all those numbers.

5 Q: All right. That's -- that's the hypertensive -- hypo --
6 hyper -- that's elevated blood pressure?

7 A: That is definitely elevated blood pressure.

8 Q: All right. So -- nobody seems to have calculators
9 anymore. So 113.5 times 0.8, 90.8. That'd be the 20 percent
10 rule; right?

11 A: Yes, sir.

12 QL Keep her -- keep her no lower than --

13 A: No lower than 90, but that's not a baseline blood
14 pressure.

15 Q: All right.

16 A: Those are all -- those are all individual blood pressures
17 at distant times, and I would submit to you that that is -- if
18 they had all that data, that would bring -- that would really
19 be a -- a warning sign that maybe -- and if I had had that
20 data and I had a blood pressure of 166 over 99 in the pre-op
21 area just before I went to sleep, instead of the 140 over 70
22 or 80 or whatever that was, the first blood pressure before
23 going to sleep, then I -- with these numbers, I'd be -- I'd be
24 wondering about whether we should go forward with this kind of
25 surgery.

1 Q: That's a great question.

2 A: Yeah.

3 Q: These weren't -- these numbers warrant a discussion
4 between surgery and anesthesia, don't they?

5 A: If you had those numbers. Yes, sir.

6 Q: But in order to have those numbers, the surgeon's got to
7 send them over, doesn't he?

8 A: Yes. And that -- and that's the problem is that in the
9 -- in our country today --

10 Q: I agree with you.

11 A: -- I frequently am stuck with --

12 Q: That's the problem.

13 MR. DAVIS: Your Honor, would he quit making comments and
14 let the witness finish his answer?

15 THE COURT: I think it was the last -- the witness
16 finished. Go ahead.

17 THE WITNESS: Not -- not a problem.

18 BY MR. GOINGS:

19 Q: I'm -- it's just that -- that if -- I'm looking at what
20 -- what I think may possibly have happened, and -- and I would
21 suggest that -- that -- well, I'm not going to make any
22 suggestions, but what you're left to deal with is, in Ms.
23 Goodwin's case, a dilemma. I have a blood pressure. If I see
24 the 166 -- 160 over 99, I'm alarmed. Okay? If that were 160
25 over 110, I would definitely be saying to Ms. Goodwin, I don't

1 know that we should go through with this. We need to send you
2 to the emergency room. What have you been doing as far as
3 your medicine goes?

4 So my understanding is, is that Ms. Goodwin was on
5 hydrochlorothiazide, and that was all she was taking then.
6 But there was some mention in the record by Dr. Root that she
7 might have been on lisinopril. Now, I can say that I have to
8 make a judgment at that time. I can tell you that all of the
9 pressures in our system are to do the surgery today. She's
10 here. We're ready for it.

11 So I look at the 160 over 99 and I say did you just stop
12 taking your lisinopril three days ago? Four days ago? This
13 could be rebound hypertension from that. It could be a number
14 of things. So if -- if I've gotten the impression -- and then
15 if Ms. Goodwin told me, you know, my pressures usually run in
16 the 150s over 90s, I'm thinking, you know, she's definitely
17 got hypertension. I've got to treat her with that.

18 Then I would make that final decision when I went in the
19 O.R. and got her a little sedated before I put her to sleep,
20 and if my blood pressure there had been 160 over 99, I would
21 argue that that was a big mistake. They should have stopped
22 right then.

23 But what I -- what I will also say, which -- which I
24 think -- and again, I'm trying to == what really happened
25 here? What is Ms. Goodwin's usual baseline blood pressure?

1 Having the ability to see 40 or 50 blood pressures over ten
2 days gives you as good a measure as you're going to get for
3 baseline blood pressure, and that indicated that she needed to
4 --

5 Q: Those numbers were when she --

6 A: -- be kept above 85.

7 Q: And you're speaking of the numbers when she's taking
8 Percocet, Valium, Celebrex and Cymbalta?

9 A: Yes. Well, Ms. -- Ms. -- those -- if you're essentially
10 hypertensive, you can take a lot of medicines and you're still
11 hypertensive. That's a separate issue from -- if you're
12 hypertensive because of pain, then you take pain medicines and
13 your blood pressure comes down, but if you're hypertensive --

14 Q: How -- okay. I'm sorry.

15 A: -- because of essential hypertension, the fentanyl may
16 have no effect, the hydrocodone.

17 Q: Let's talk about signal loss approximately 10 o'clock.
18 You agree that attending anesthesiologist Dr. Root was not in
19 the operating room when the SSEP signal went out?

20 A: Yes, sir, I agree.

21 Q: All right. You agree that the loss of SSEP signal to the
22 patient's legs, lower extremities, is a significant change in
23 the patient's clinical condition; correct?

24 A: Yes, sir.

25 Q: And you agree that Dr. Root should have been immediately

1 notified about the loss of signal to the lower extremities?

2 A: I do.

3 Q: That was an error, wasn't it?

4 A: Yes, sir.

5 Q: And if, for whatever reason, Mr. Starn doesn't do it, do
6 you agree with me the surgeon in the operating room should
7 have said somebody go get the attending, I want to talk about
8 this with the attending anesthesiologist, I want to talk to
9 her about this?

10 A: Well, I'm not going to comment on what Dr. Holbrook
11 should or shouldn't have done. I can tell you that in my
12 experience, sudden loss of SSEP is a critical event and
13 demands a -- that it be addressed as soon as possible.

14 Q: It needs a powwow with those two physicians, doesn't it?

15 A: That would be my recommendation.

16 Q: If you had been the attending anesthesiologist in this
17 case, you later find out in recovery that your patient can't
18 move her legs, and you also find out that the signal -- there
19 was a signal loss at 10 o'clock, you'd go to the surgeon and
20 say why didn't somebody come get me, wouldn't you?

21 A: Oh, I would. I would have said a lot of things to a lot
22 of people. Yeah. I mean, not -- not being called is not a
23 good thing. Okay? I would have then looked at the record and
24 said thank God we kept her pressure where it was.

25 Q: You agree that this algorithm on how to address

1 Interoperative signal loss is a reasonable guideline,
2 excepting the wake-up test; right?

3 A: Well, first of all, this is from a -- from a non-peer --

4 Q: Well, it is -- I'll be happy to let you --

5 A: Let me -- let me --

6 Q: I'll let you explain your answer, but just can you answer
7 the question first? Do you agree, excepting the -- I know
8 you've got -- there's issues -- people disagree with this
9 wake-up test part, but do you agree that these other far --
10 other four are a reasonable guideline?

11 A: Actually, yes, I do agree.

12 Q: Okay. Now I'll let you explain the answer.

13 A: Well, it's just I have a criticism of this particular
14 paper for a couple of reasons. First of all, let's see here.
15 That is the --

16 Q: Before you -- before you -- and I promise you, I'll let
17 you explain. The algorithm on how to address interoperative
18 signal loss is a reasonable guideline?

19 A: Yeah. I mean, it's pretty difficult to argue with that,
20 but I will say to you that this is -- this is contemporary
21 spine surgery. This is not peer-reviewed. This is a -- this
22 is a -- this is a continuing medical education. I mean, it
23 has valuable information. It's from 2012 and -- and I agreed
24 with most of it. It also says although temperature and blood
25 pressure can affect SSEP results, physiologic temperature and

1 mean arterial pressure greater than 60 millimeters of mercury
2 are compatible with normal SSEPs.

3 So I happen to -- I happen to -- to disagree with that
4 because I think I would argue that -- that I would be aiming
5 closer to 70 millimeters of mercury minimum, because I have
6 good evidence that a mean arterial pressure of 60 can result
7 in hypoperfusion to many organs, and that 65 to 70 is a much
8 better goal.

9 Q: Well, after that sentence that you just read, all that's
10 saying it is -- okay. That sentence that you just read, I'm
11 familiar with it too.

12 A: Sure.

13 Q: It's saying that if the -- if the mean arterial pressure
14 drops below 60, the SSEPs just aren't going to work. It's not
15 saying that 60 is the range, it's just saying these things
16 won't even work at all if they get -- if the MAP gets below
17 60. Reread that sentence if you would.

18 A: I'm not sure that's what it says.

19 Q: All right.

20 A: Although temperature and blood pressure can affect SSEP
21 results, physiologic temperature and mean arterial pressure
22 greater than 60 are compatible with normal SSEPs. So if your
23 mean arterial pressure is above 60, your SSEPs are normal.

24 Q: Well --

25 A: I think that's a -- that's a -- that's a low number to

1 be aiming for when I'm doing -- doing major spine surgery
2 requiring SSEP, but that's what this article refers to. And
3 you know, if I -- I guarantee you that I can prove anything
4 you want if I'm allowed to cherry pick whatever I want from
5 the next 100 articles I print.

6 Q: Fair enough. Well, Doc, we -- we disagree on what that
7 sentence means, and I just want -- we've made it quite some
8 time before we disagreed about something. And that's -- I
9 think that that might be a record.

10 You agree that there is a latency, a delay from the time
11 something happens that's injurious to the spinal cord until
12 that shows up on the neuro -- the SSEP neuromonitoring; right?

13 A: I do.

14 Q: And you agree that that delay can range from one minute,
15 even as much as 30 minutes; right?

16 A: Yes.

17 Q: And so you would disagree with the idea that it would
18 only be 1 to 2 minutes; right? It could be as much as 30?

19 A: It can be, yes, 15 to -- 15 to 20 or 30 minutes. It's --
20 it's a -- it's a -- it's a -- it's a significant limitation of
21 the value of SSEP monitoring, which from my reading of the
22 literature is questionable whether it's helpful.

23 Q: And in your career as a physician -- and I think you and
24 Mr. Davis talked about this. You have had -- and I understand
25 it was a while ago. You have had one occasion where

1 neuromonitoring signal went out, the blood pressure was
2 raised, and signal came back. You've had an occasion where
3 that happened, haven't you?

4 A: I did.

5 Q: Doc, I want to talk very briefly about urine. Kind of a
6 funny statement. Things I never thought I'd say. You agree
7 that 80 milliliters of urine over a 4.5 hour period of time is
8 on the low side, don't you?

9 A: I do.

10 Q: All right. 80 milliliters of urine over 4 four point
11 [sic] hour period of time is, quote, on the low side?

12 A: I read my deposition last night.

13 Q: Doc, did you undertake to look at how much urine output
14 per kilogram per hour Crystal was producing in the 2016
15 surgery? Did you calculate that out?

16 A: No.

17 Q: Would it surprise you to learn that from the 2000 -- in
18 the 2009 surgery, she produced 1 milliliter of urine per
19 kilogram per hour? In the 2011 surgery, she produced 0.35
20 milliliters of urine per hour. But in the 2016 surgery, she
21 only produced 0.15 milliliters of urine per hour?

22 A: Doesn't surprise me. As that article said and as my
23 experience would lead me to believe, urine output from 0.1 to
24 about 0.5 is adequate urine output, and then the other part
25 about it is you -- kidney failure is not defined with 3 or 4

1 hours. It's defined over a couple of days at least. And so
2 there was definitely low urine output during this surgery.

3 Q: It was definitely low --

4 A: But it was not in --

5 Q: -- during the surgery? So --

6 A: But it was not below what is expected and is consistent
7 with good care.

8 Q: All right. But you agree there's definitely low urine
9 output during the surgery?

10 A: Yes.

11 Q: All right. What does the term oliguria mean?

12 A: Oliguria means not very much urine, but some.

13 Q: And you're familiar with the Merck manual?

14 A: Yeah. Now, that's 40 years ago.

15 Q: Well, they still exist.

16 A: I know. I don't go to the Merck Manual for most of my
17 sources.

18 Q: Do you agree that oliguria is often defined as producing
19 less than 0.5 milliliters per kilogram per hour?

20 A: In a normal patient.

21 MR. DAVIS: Your Honor --

22 A: This is not --

23 MR. DAVIS: You know you can't say those things.

24 THE WITNESS: Sorry.

25 MR. DAVIS: But he's obviously reading from an article he

1 mentioned. He has not laid the proper foundation as a learned
2 treatise. It's hearsay and I object under the rule.

3 MR. HINSON: The question is --

4 MR. DAVIS: Excuse me.

5 MR. HINSON: Sorry, I thought you were done, Mr. Davis.

6 MR. DAVIS: Under the exception of the hearsay rule,
7 Subsection 18, he has not laid a proper foundation.

8 THE COURT: Yes, sir, Mr. Hinson?

9 MR. HINSON: The question was simply do you agree that
10 urine output or oliguria is -- is often defined -- often
11 defined as 0.5 milliliters per kilogram per hour? That was
12 the question.

13 THE COURT: You handed him the article though; right?

14 MR. HINSON: I'd be happy to hand it to him if he --

15 THE COURT: No, no, no. No, no, no.

16 MR. HINSON: I wasn't asking him --

17 THE COURT: You were reading from that. Gotcha. The
18 objection is overruled.

19 BY MR. HINSON:

20 Q: Just do you agree, generally, Doctor, that oliguria is
21 often defined as less than 0.5 milliliters of urine per
22 kilogram per hour?

23 A: I'd have to go look at the definitions again, but please
24 keep in mind I believe that's the definition. I'd have to
25 look it up, and I'm sure you just did. If that's from a

1 recent Merck manual, it's probably consistent, but that does
2 not apply when a patient comes to the operating room. All
3 kinds of things can happen.

4 So imagine a woman who's having back surgery, she's lying
5 on her tummy. She's got a tube in her windpipe. The Foley
6 catheter goes into her bladder. There are numerous reasons --
7 I looked at the rest of the urine output during her stay, and
8 it was normal. So there are numerous reasons why you can only
9 have -- why you can have less urine for the four hours that
10 you're under surgery because the catheter can be kinked, it
11 can be tilted. It -- so you're lying on your tummy. You've
12 got a catheter going into your bladder. It comes around your
13 leg. There could be 40cc just in the tubing that you just
14 haven't seen yet.

15 So -- so it is not uncommon. There is nothing abnormal
16 about a urine output of 80 milliliters, except that it is low,
17 but it's in the low normal range during this surgery.

18 Q: Doc, you testified earlier -- I think you said you had
19 testified 25 to 35 -- 35 times for a plaintiff?

20 A: Probably about that many.

21 Q: Okay. Didn't you previously tell me you had only
22 testified 30 to 40 times, and most of them had been for the
23 defense?

24 A: I don't think I ever said that. I've probably testified
25 about half the time for defense and about half the time for

1 plaintiff.

2 Q: Doc, I thought we were going to make it through. You
3 gave a deposition in this case on August 25th, 2021?

4 A: Uh-huh.

5 Q: Almost. I had two more questions, Doc.

6 A: Oh, damn.

7 Q: This is a tough one. I like the paper better.

8 A: It's exciting watching you open that.

9 Q: I know; right? This is showmanship in the courtroom.
10 Just -- it's real quick. Just trying to understand. If you
11 would, turn to page 75. Well, 74. It starts on the very
12 bottom of the page, line 25.

13 I asked you: How many cases would you estimate you've
14 testified in? See that? Just let me know when you've got
15 there.

16 A: Great. How many times have you reviewed a case for a
17 plaintiff and found that the standard of care was not met?
18 That was only -- that's the question.

19 Q: All right. Let me just --

20 A: Okay.

21 Q: I asked you how many times have you testified, and you
22 said 30 to 40; right? Page 75, line 5.

23 A: Line 5. Yeah, 30 to 40.

24 Q: Yep, 30 to 40. And then you told me that the majority of
25 those 30 to 40 had been for the defense; right?

1 A: Yeah. Yes.

2 Q: Okay. And so if you've only testified 30 to 40 times and
3 the majority have been for the defense, it would seem -- I
4 have to pull out my calculator, but you couldn't have
5 testified 25 to 35 times for a plaintiff.

6 A: No. And you're absolutely right. I was including in the
7 times that I -- what you said, and I would reread your
8 question for you. How many times have you reviewed a case --
9 reviewed a case for a plaintiff and found that the standard of
10 care was not met and been willing to testify, been willing to
11 testify? I probably reviewed 20 -- you know, of those cases,
12 probably ten of them were cases where I reviewed the case for
13 the attorney and I said, you know -- which is just what your
14 question was. I tried to answer your question.

15 Q: I got you. And I think maybe we just misspoke, I think.

16 A: I think so.

17 Q: I retract my -- my attempt there. I think we just had a
18 complete misunderstanding.

19 A: I'm sorry if I was misleading.

20 Q: And I'm sorry if my question wasn't clear. That was not
21 my intention. You're being paid for your testimony; correct?

22 A: Yes, sir.

23 Q: You're paid for trial testimony \$5,000 a day?

24 A: Yes, sir.

25 Q: And you were sitting in the courtroom all day yesterday?

1 A: Great day.

2 Q: And -- yeah, that's a pretty good day. And -- and all
3 day today. So just the last two days, you -- you billed --
4 will have billed \$10,000 for your testimony --

5 A: Yes, sir.

6 Q: -- just on the last two days; right?

7 A: It's hard to believe.

8 Q: Okay.

9 MR. HINSON: Thank you, Doc. No further questions at
10 this time.

11 MR. DAVIS: Very briefly.

12 THE COURT: Yes, sir.

13 MR. DAVIS: Thank you, Your Honor.

14 REDIRECT EXAMINATION

15 BY MR. DAVIS:

16 Q: Dr. Balestrieri, he asked you about one time when you
17 were the anesthesiologist and signal was lost, blood pressure
18 was increased, and it came back. How low was that blood
19 pressure when it went out?

20 A: You know, I didn't want to mention that. I just -- I
21 don't recall. It was a time in Colorado where we tended to
22 keep the pressures up a little higher, but there was a period
23 when I was in the Navy and in Bowman Gray where we were
24 actually purposefully -- so -- so we didn't have
25 neuromonitoring, but -- and they didn't have -- the surgeons

1 didn't have the tech -- the instruments they have today.

2 And so one of the goals was to lower the blood pressure.
3 So we would purposefully keep blood pressure in the 50 to 60
4 range. And I've done that for, I don't know, probably 50 to
5 100 patients, and we never saw -- to my recollection, and
6 those are things to remember -- a patient who suffered from
7 hypotension. That doesn't mean that hypotension can't cause
8 damage.

9 Q: In this case, they were maintained in the 80s and 90s?

10 A: That's the key here. The blood pressures were maintained
11 in the 80s and 90s and sometimes in the low 100s, and it's my
12 opinion that if they had attempted to raise her mean arterial
13 pressure into the -- above 100, that there is a -- you know,
14 the reality is I don't know, but I am putting her at risk for
15 having congestive heart failure, rupture of a plaque or
16 rupture of an artery or a vessel. It could be in the spleen,
17 could be in the liver, could be in the brain, or a heart
18 attack.

19 So it's -- it's the -- I thought that the demonstration
20 that was presented here where the -- the danger zone on the
21 bottom was all red, just looking at that is kind of
22 frightening, but there should be a danger zone on the top that
23 was red also.

24 And so it is -- first of all, it is a matter of judgment
25 whether to proceed on that day with Ms. Goodwin, and I'm sure

1 that -- that -- that Ms. Goodwin wishes that that hadn't
2 happened that day. I wish it hadn't happened.

3 Q: The complication?

4 A: I wish the complication hadn't happened. I mean, she --
5 she -- she -- just from my sitting here yesterday, she -- she
6 appears to be an amazing woman to have dealt with this.

7 Q: We all agree on that. Doctor, you were asked about when
8 the signal was lost about Dr. Root being notified. Would you
9 expect your CRNA -- if you're the supervisor in the
10 anesthesia, would you expect your CRNA when something like
11 that happens to say -- to call you and let you know right
12 away?

13 A: Yes, sir.

14 Q: And that didn't happen, did it?

15 A: No.

16 Q: He asked you early in his examination of you about your
17 changing teams. Let me ask you this, Doc. Have you said
18 anything in this trial different in my questions to you and
19 your giving opinions to this jury that were any different than
20 the deposition you gave when Mr. Hinson was asking you
21 questions in August of '21? Did you give me any different
22 opinions?

23 A: No. No, sir.

24 Q: All right. And I believe some time ago -- and I don't
25 honestly remember when. You may remember. I called you after

1 other things happened, and I asked you would you -- would you
2 be willing to come and give that same testimony, that
3 deposition testimony, those opinions to this jury on behalf of
4 my client, Dr. Holbrook. Do you recall that?

5 A: I do.

6 Q: And you agreed to do that, didn't you?

7 A: Yes, sir.

8 Q: All right. And that's what you're here doing, isn't it?

9 A: Yes, sir.

10 Q: As a result of all the questions Mr. Hinson asked you,
11 all the discussion back and forth just now we've witnessed,
12 have you as a result of all that changed any of your opinions
13 about the adequacy of the blood pressure during the surgery?

14 A: No, sir.

15 Q: Or of the adequate urine output?

16 A: No. There was adequate urine output.

17 Q: Or of the adequate perfusion of her spinal cord during
18 the surgery, sir?

19 A: Well, I think there's no doubt that -- that Ms. Goodwin
20 suffered an injury --

21 Q: Yes, sir.

22 A: -- as a result of going forward with surgery. Whether it
23 was -- I just don't -- I don't know.

24 Q: No one knows.

25 A: I don't know why.

1 Q: Right.

2 A: I can tell you that -- that it is that blood pressure
3 where --

4 MR. HINSON: Objection. Your Honor, I think this is
5 moving into causation again.

6 THE WITNESS: Again --

7 THE COURT: I believe this is. The objection is
8 sustained.

9 BY MR. DAVIS:

10 Q: Wait, wait. Please don't make any comment about
11 causation. You can't do that.

12 A: I have -- I don't know why this happened.

13 Q: Okay.

14 A: I mean, but I can -- I can tell you that her -- that if
15 her blood -- let's just put it this way. If her blood
16 pressure --

17 MR. HINSON: We're still -- we're still talking about
18 causation. You're saying I don't know why this happened, but
19 it needs to stop.

20 THE WITNESS: I haven't said anything.

21 MR. HINSON: That's why I'm jumping up before you do,
22 Doc.

23 THE WITNESS: Great.

24 MR. DAVIS: Let me -- let me rephrase.

25 MR. HINSON: Thank you. Thank you, Mr. Davis.

DR. FRANCIS BALESTRIERI - REDIRECT BY MR. DAVIS

1 MR. DAVIS: Yeah. That's okay. Let me reboot this.

2 BY MR. DAVIS:

3 Q: This is my question.

4 A: Yes, sir.

5 Q: Okay. As a result of all of Mr. Hinson's questions of
6 you in front of this jury just a moment ago -- several moments
7 ago, has that changed any of your opinions that you gave
8 before he got up and questioned you?

9 A: No, sir.

10 MR. DAVIS: Nothing further. Thank you.

11 THE COURT: Anything further from this witness, Mr.
12 Hinson?

13 MR. HINSON: No, Your Honor.

14 THE COURT: All right. Thank you, sir. You may step
15 down.

16 MR. DAVIS: I'd ask the witness be excused.

17 THE WITNESS: Thank you, Your Honor.

18 THE COURT: Any objection to the witness being excused?

19 MR. HINSON: No, Your Honor.

20 MR. DAVIS: Thank you, Your Honor.

21 THE COURT: All right, sir. You are free to go.

22 Ladies and gentlemen, we're going to call it a day. I
23 have some things that I need to take care of in the morning.
24 So I'm going to ask you to be back in your jury room tomorrow
25 at 11 o'clock, 11 a.m. Please do not discuss the case. Don't

1 do any research about the case. Have a good night and be back
2 tomorrow at 11. Thank you.

3 THE COURT: I can't hear you. What's the question?

4 UNIDENTIFIED JUROR: Is it still going to look like
5 tomorrow, or should we try to push it back?

6 THE COURT: I'm not sure. I won't know that until
7 tomorrow, honestly.

8 UNIDENTIFIED JUROR: Okay. Thank you.

9 THE COURT: Sorry.

10 (WHEREUPON, the jury exited the courtroom at 5:37 p.m.)

11 THE COURT: That is my next question though. How many
12 more witnesses? I'm just curious.

13 MR. DAVIS: Your Honor, I think we've got two more
14 witnesses.

15 THE COURT: Okay. I'm not sure if we'll finish this
16 tomorrow. We may move into Thursday.

17 MR. DAVIS: I don't think there's any way that this case
18 will go to the jury tomorrow.

19 THE COURT: Yeah. I mean, I do have an appointment in
20 the morning. I could come before the appointment to discuss
21 jury charges, but it looks like we're not going to finish
22 tomorrow anyway, so maybe that's a matter that can wait until
23 tomorrow afternoon, since the jury won't get the case until
24 Thursday.

25 Does anyone disagree with that?

1 MR. GOINGS: That's fine.

2 MR. DAVIS: I think that sounds very reasonable.

3 THE COURT: Okay.

4 MR. DAVIS: What do you all think?

5 MR. GOINGS: We agree.

6 MR. DAVIS: Okay.

7 MR. GOINGS: Argue and charge on Thursday?

8 THE COURT: Thursday?

9 MR. GOINGS: Makes sense?

10 MR. DAVIS: Thursday morning.

11 THE COURT: That makes sense to me as well.

12 MR. DAVIS: That's fine.

13 THE COURT: Okay. So I'll see you all --

14 MR DAVIS: Maybe I'll get my voice back by then.

15 THE COURT: Right. So I'll see you all at 11 o'clock

16 also.

17 Did you have something, Mr. Goings?

18 MR. GOINGS: Yeah. I was just going to ask, Your Honor,

19 is it possible if you had, like, a standard charge that you --

20 because a little bit of the issue came up with what was going

21 to be redundant between what both sides were submitting, and

22 if you had your kind of standard charge that you like, it

23 would kind of help us figure out what was redundant and what

24 -- what we would propose to add.

25 THE COURT: Absolutely. I will have Bailey email it to

1 you, either this afternoon or in the morning, probably this
2 afternoon it looks like. It's not my final, final version,
3 but --

4 MR. DAVIS: Close enough. We'll take close enough.

5 THE COURT: Right.

6 MR. GOINGS: It's a good working draft.

7 THE COURT: Absolutely. It's a good place to start some
8 discussion. So -- okay. So I'll see y'all at 11 o'clock
9 tomorrow.

10 MR. GOINGS: Thank you, Your Honor. Have a good evening.

11 THE COURT: Thank you.

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

13

14 --- CONTINUED IN VOLUME VIII ---

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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 8 OF 9 - VOLUME VIII
	)	April 19, 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 19, 2023

2 (WHEREUPON, the proceedings resumed at 11:15 a.m.)

3 THE COURT: All right. Good morning. Late morning,
4 early afternoon. Are we ready for the jury? Okay.
5 Wonderful.

6 Bring the jury, please.

7 (WHEREUPON, the jury entered the courtroom at 11:18 a.m.)

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

9 THE COURT: Thank you.

10 Good morning. I'm getting a late start today, but that's
11 okay. As you know, we've ordered lunch for you or we're about
12 to order lunch for you. It should be here 1:30, 2 o'clock,
13 somewhere in that neighborhood. So we will take a lunch break
14 just because I don't know that -- whether y'all ate
15 immediately before coming here. I mean, I kind of want to
16 keep you on a good meal schedule, if that's what you need.
17 It'll probably be a little bit of a shorter lunch break.

18 As I told maybe two of the jurors yesterday afternoon,
19 after excusing you but then talking to the attorneys, it does
20 not look like we're going to finish this case today, even
21 though that was the goal. That was the estimate. It looks
22 like it will be tomorrow morning. So we should probably be
23 able to finish hearing from all of the witnesses today. Then
24 I need to hear -- I'll excuse you, and I need to hear some
25 legal arguments from the attorneys, but then we'll have

1 closing arguments and my charge to you on the law. The
2 closing arguments and the charge will probably happen tomorrow
3 morning. After that you will deliberate, and no one knows how
4 long you will deliberate. You will deliberate until you've
5 reached a verdict.

6 So I just always tell juries that part of it is, of
7 course, very unpredictable. I never know how long a jury will
8 deliberate, and you don't know until you start talking,
9 something you're not supposed to be doing yet. You're not
10 supposed to be discussing the case, but once you start
11 discussing, it could be five minutes, because maybe all of you
12 are on the same page already, but it could be five hours. It
13 could be longer than that, or somewhere in between. I have no
14 idea, and neither do you. So I just tell you all that for
15 your own scheduling purposes.

16 With that, we will return to the defendants' case, and
17 they will call their next witness.

18 MR. DAVIS: Thank you, Your Honor. I would like to call
19 Dr. David Goltra to the stand.

20 THE BAILIFF: Put your left hand on the Bible and raise
21 your right.

22 THE COURT: Do you solemnly swear or affirm the testimony
23 you give the Court to be the truth, the whole truth, and
24 nothing but the truth, so help you God?

25 THE WITNESS: Yes, I do.

DR. DAVID GOLTRA - DIRECT BY MR. DAVIS

1 THE COURT: All right. Would you have a seat in the
2 witness stand, please? And once you get situated, if you will
3 give us your full name.

4 THE WITNESS: My name is David -- David Goltra.

5 THE COURT: All right. Your witness, sir.

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

7 DR. DAVID GOLTRA, being first
8 duly sworn, testified as follows:

9 DIRECT EXAMINATION

10 BY MR. DAVIS:

11 Q: Would you introduce yourself to the jury, please?

12 A: Good morning.

13 Q: Dr. Goltra, I want to talk to you a little bit about your
14 background, your education, your training, and your experience
15 in the field of medicine.

16 A: Sure.

17 Q: Tell the jury just a little bit about your professional
18 training as a physician?

19 A: Well, let's see. I went to the University of Cincinnati.

20 THE COURT: Hold on. Having trouble hearing you, so you
21 need to pull the mic --

22 THE WITNESS: Okay.

23 THE COURT: -- up a little bit closer. You almost have
24 to get right on it.

25 THE WITNESS: Okay.

1 BY MR. DAVIS:

2 Q: I grew up in Cincinnati, Ohio. I joined the Navy, United
3 States Navy, immediately after high school and spent most of
4 my enlistment as a combat medic with the United States Marine
5 Corps. When I got out of the Navy, I enrolled at the
6 University of Cincinnati and finished my degree in biology and
7 attended the Ohio State University Medical School after that.

8 I graduated from both UC and Ohio State at the top of my
9 class. I went into -- I entered an emergency medicine
10 residency at the University of Cincinnati immediately after
11 medical school and trained in emergency medicine. UC was the
12 same place that they took Damar Hamlin when he was injured on
13 the football field. And in fact, the -- there were professors
14 from my training program on the field who participated in his
15 resuscitation.

16 So after -- well, in my last year of residency, I met my
17 wife, who is a pediatric dentist, and we got married, had our
18 first child in Cincinnati, and she's actually from here. So
19 after working there for a couple of years, I took a job in
20 Charleston, South Carolina, where I became the medical
21 director for a company that staffed and managed military
22 hospital emergency rooms, and I became the medical director
23 for the Charleston Navy Hospital emergency room.

24 And then after about a year with that company, I became
25 the medical director for the whole company. I did that for

1 four years. The contract ended because of changes in world
2 politics. They closed the Navy base in Charleston, and I
3 decided to do something different. I loved emergency
4 medicine. I think I was really good at it and -- but staying
5 up all night for half your life, it's pretty hard to do. It's
6 not good for your health. So I went back, and I did a
7 radiology residency.

8 Q: Dr. Goltra?

9 A: Excuse me.

10 Q: The court reporter, who's on the other side of that
11 glass, needs to hear your voice. So could you just make sure
12 you speak up?

13 A: Sure.

14 Q: Thank you.

15 A: Okay. I want to talk to the jury and the microphone at
16 the same time. So --

17 Q: Sure.

18 Q: Let's see. So I did my radiology residency at the
19 Medical University of South Carolina. Followed that with a
20 fellowship in neuroradiology at the Medical University of
21 South Carolina, and then took a job in Mount Pleasant, South
22 Carolina, in an imaging center.

23 After working there for about three years, I went out on
24 my own and started my own business, built a -- sort of a
25 teleradiology network. So I was connected with hospitals all

1 over the state that I could read MRIs for. I started working
2 with a multi-specialty, predominantly orthopedic group in
3 Aiken, South Carolina, that has two spine surgeons in it and
4 still work for them. I do all their radiology and did all
5 their interventional procedures until about 3 or 4 years ago.

6 I started my own imaging center in Mount Pleasant, South
7 Carolina, which we opened in 2005, and that's still open. So
8 right now I work there in Mount Pleasant at the imaging
9 center. I have another imaging center that I go to up in
10 Myrtle Beach one day a week. In Mount Pleasant, I
11 predominantly read images, read MRI images, and do
12 interventional spine procedures. So I also do a number of
13 other orthopedic procedures, but I do -- I treat mostly people
14 with pain, with spine pain, various types of spine pain, and
15 do interventional procedures.

16 And I've got three kids, two grandkids. They all live in
17 Charleston. They moved home after or during COVID and lived
18 with us and then were able to stay and bought their own houses
19 and live here. So COVID was good for me in that sense.

20 Q: Dr. Goltra, were you board certified in -- in emergency
21 medicine?

22 A: Yes.

23 Q: And how many years did you work as an emergency room
24 physician?

25 A: After my residency, 8 years.

1 Q: And did you have occasion as an emergency room physician
2 to treat patients with very low or even no blood pressure?

3 A: Yes. Many times.

4 Q: Are you board certified by the American Board of
5 Radiology?

6 A: Yes.

7 Q: Have you obtained or did you obtain a certificate of
8 special qualification for the practice of interventional
9 neuroradiology?

10 A: It's just neuroradiology.

11 Q: Okay. So where does the interventional part come in?
12 How do you -- how do you get that?

13 A: Well, there's no board for interventional neuroradiology.

14 Q: Okay.

15 A: There's just a board for neuroradiology.

16 Q: All right. So how -- did you do special training to
17 become an interventional neuroradiologist?

18 A: You can. My fellowship was very heavily interventional
19 weighted. My -- the chairman of our department was a very
20 famous neuroradiologist at the time named Joe Horton, and he
21 encouraged me to, you know, pursue the interests that I had in
22 interventional radiology.

23 I developed a procedure. Actually, I didn't develop it,
24 but there's a procedure called vertebroplasty that we use to
25 treat usually older people with osteoporotic compression

1 fractures. And I brought that procedure -- I did the first
2 vertebroplasty in basically the southeastern United States and
3 started a program doing vertebroplasties in Charleston and did
4 that for several years.

5 Q: Dr. Goltra, does your interventional neuroradiology
6 practice mostly deal with spine interventions?

7 A: Mostly, but not entirely.

8 Q: All right. In this case, what -- have you had occasion
9 -- well, let me just stop here.

10 MR. DAVIS: Your Honor, we'd offer Dr. Goltra as an
11 expert in neuroradiology and emergency medicine, hypotensive
12 blood pressure management.

13 MS. GOODING: Your Honor, I have some concerns about what
14 hypotensive blood pressure management means. No objection to
15 him being qualified as an expert neuroradiologist, which is
16 what he was disclosed to be. No objection with that
17 whatsoever. I'm not sure what the second half of that means.

18 THE COURT: Nor am I. Mr. Davis, if you would, inquire
19 of the witness.

20 MR. DAVIS: I'm sorry, I'm sorry. Yes, ma'am?

21 THE COURT: If you would inquire of the witness that
22 latter --

23 MR. DAVIS: Sure.

24 THE COURT: -- part where -- I think we're all clear on
25 neuroradiology, but let's talk about that second half.

1 MR. DAVIS: Sure.

2 BY MR. DAVIS:

3 Q: Dr. Goltra, as an emergency room physician, board
4 certified in emergency medicine, did you have occasion as an
5 emergency room physician to manage patients with low or no
6 blood pressure?

7 A: Yes, sir.

8 MR. DAVIS: I don't -- I don't know what else I need to
9 ask him, Judge. I would offer him as an expert in
10 neuroradiology, interventional neuroradiology, and with
11 expertise and experience in treating patients with no or low
12 blood pressure.

13 THE COURT: All right. He will be admitted as an expert
14 in the field of neuroradiology and emergency medicine, these
15 fields, plural, neuroradiology and emergency medicine.

16 I'm sorry. Any objection, Ms. Gooding, to emergency
17 medicine?

18 MS. GOODING: Well, I do have an objection to that, Your
19 Honor, because he wasn't disclosed as an expert in emergency
20 medicine. And when I inquired about his experience in this
21 area during his deposition, he indicated that his only
22 experience with blood pressures was in treating an acute low
23 blood pressure event in the emergency medicine context.

24 And so I'm concerned about how -- I don't think that
25 applies in this case, and so I would object to him being

1 identified as an expert in a -- in another -- in an additional
2 area that doesn't have application in this case.

3 MR. DAVIS: Mr. Davis?

4 MR. DAVIS: I'll leave it with the Court.

5 THE COURT: So the Court does find Dr. Goltra qualified
6 as an expert in the field of neuroradiology. I'm -- I don't
7 know whether hypotensive blood pressure management would fall
8 within that field of expertise. That may be part of it. I --
9 I do not know.

10 MR. DAVIS: Okay.

11 THE COURT: But at this point, he is qualified only as a
12 neuroradiology expert and, you know, of course, can talk about
13 neuroradiology and whatever attendant conditions he would deal
14 with within the field of neuroradiology.

15 MR. DAVIS: Thank you, Your Honor.

16 MS. GOODING: Thank you, Your Honor.

17 BY MR. DAVIS:

18 Q: Now, Dr. Goltra, tell the jury in this case sort of a
19 summary fashion what you've had the occasion to review that
20 helps to form the basis of any opinions you intend to give to
21 them today.

22 A: Yes, sir. I've reviewed all of the imaging studies that
23 have been provided to me, which I think is a pretty complete
24 collection of all the --

25 Q: You need -- you need to speak up.

1 A: -- of all of the MRI images that Ms. Goodwin has had that
2 are pertinent to this case. I've read the depositions of most
3 of the experts and read a good portion of the medical record.
4 It's been quite some time since I did that, and that's pretty
5 much it.

6 Q: Okay. Will you agree with me that any opinions that you
7 give the jury will be within a reasonable degree of medical
8 certainty unless you tell me otherwise?

9 A: Yes, sir.

10 Q: All right. Thank you. You prepared a PowerPoint to help
11 the jury understand some things that you have gone over in
12 your deposition. Do you remember that was taken? Do you
13 recall that?

14 A: Yes.

15 Q: I want to go to that PowerPoint, and I'm not going to go
16 through every slide, but I want to highlight a few of them and
17 let you explain them to the jury. Okay?

18 A: Yes, sir.

19 Q: All right.

20 MR. DAVIS: Will you pull the PowerPoint up?

21 I've got to get some technical assistance.

22 THE WITNESS: You might have to change the input on the
23 monitor to HDMI-1.

24 MR. DAVIS: Do you have the PowerPoint on your computer?

25 THE WITNESS: No, sir.

DR. DAVID GOLTRA - DIRECT BY MR. DAVIS

1 MR. DAVIS: Okay. Well, we'll see if it --

2 THE WITNESS: The remote is right in front of --

3 MR. DAVIS: I'm sorry?

4 THE WITNESS: The remote is right behind you right there.

5 MR. DAVIS: Okay. Thanks. All right, bear with me, Dr.
6 Goltra. I'm not technically proficient, but I've got some
7 help.

8 (WHEREUPON, there was a pause in the proceedings for
9 technical issues, after which the proceedings resumed as
10 follows.)

11 MR. DAVIS: Let's go to pull up Slide 3.

12 BY MR. DAVIS:

13 Q: What is -- explain to the jury what this slide is for and
14 why you prepared it?

15 A: So the issue that I'm going to try to help the jury
16 understand is the difference between a spinal cord infarction
17 --

18 Q: Dr. Goltra, excuse me. The court reporter behind you --
19 I know you can't see her.

20 A: Okay.

21 Q: She very much needs to hear what you have to say, as do I
22 and the jury.

23 A: Yes, sir.

24 Q: So try to keep that microphone close to you.

25 A: I sure will.

1 Q: Yes, sir. Thank you.

2 A: The -- the two disease entities that we're trying to
3 understand for this case are spinal cord infarction and
4 reperfusion injury. I think that's what it comes down to, and
5 I want to show by describing the different elements of each
6 one, both the cause, the location, and the MRI findings to
7 demonstrate that there's really very little overlap in those
8 two diseases and how they present.

9 Now, the consequences of both can be very similar. Both
10 can result in a severe neurologic injury, but the cause, the
11 location, and the MRI findings are different.

12 So I want to lead off with describing how we look at an
13 MRI of either the brain or the spinal cord following a stroke
14 or an ischemic event or an infarction, and we know a lot about
15 the time course of the different appearances of the MRI after
16 a stroke, because in medicine we see a lot of strokes,
17 particularly in the brain. So brain strokes are very common.
18 The spinal cord is just an extension of the brain, and the
19 appearance of the spine and the brain is very similar over
20 time after an infarction or a stroke.

21 And the reason it's important for us to understand this,
22 the reason that this topic is so heavily -- so heavily looked
23 at and researched is because we can intervene. So when an
24 individual has a stroke, if they come to the emergency room
25 soon enough, we can intervene with either drugs or we can do

1 interventions, endovascular treatments to remove a clot that
2 might be causing the stroke and actually restore the injured
3 brain tissue to normal symptoms.

4 So when a person has a stroke, there is a series of
5 events and we call them the early hyperacute phase, the late
6 hyperacute phase, and that's basically the first 24 hours, the
7 acute phase, the subacute phase, and then the chronic phase,
8 and there are different appearances on MRI that I will
9 demonstrate to you as best I can for all those different
10 phases.

11 Q: Okay.

12 MR. DAVIS: Go to Slide 7, please.

13 BY MR. DAVIS:

14 Q: What is -- what is this slide about, Doctor?

15 A: So the most important thing to understand about the
16 different phases is that early on following a stroke,
17 typically in the hyperacute phase, which is the first 24
18 hours, most of the time we don't see anything on conventional
19 imaging. And this goes back to my early days in emergency
20 medicine when MR was not widely available, and we had CAT
21 scans.

22 An individual would come in with a stroke and have, you
23 know, a very clear evidence of a stroke from a clinical
24 standpoint. We do a CAT scan and we wouldn't see anything,
25 but we knew that the individual had a stroke. It just hadn't

1 showed up yet, because the changes in the brain tissue that
2 had to take place after a stroke were just not happening.
3 When you think about it, when you have a stroke, the tissue
4 that is affected is suddenly deprived of blood. Do -- yes,
5 sir?

6 THE BAILIFF: You need to bring the screen closer. They
7 can't see it.

8 THE COURT: Okay.

9 THE WITNESS: All right.

10 MR. DAVIS: Is that better? That does? Okay. Thank
11 you.

12 Thank you, Your Honor.

13 BY MR. DAVIS:

14 Q: Go ahead, sir.

15 A: So if you can imagine the spinal cord, for instance,
16 suddenly being deprived of blood, so what is going to happen
17 is, it's not going to suddenly swell up and it's not going to
18 leak out fluid. It's going to just kind of remain like it was
19 for a period of time. So those changes that result in the
20 accumulation of fluid, which would allow us to see something
21 on MRI, take some time, usually after the first 24 hours.

22 That's why the most common scenario with a spinal cord
23 infarction immediately after it happens and during the first
24 24 hours is you don't see anything. The appearance is normal.
25 You don't see what we call high signal intensity.

1 And I'm going to try to educate you, and you've probably
2 heard some of this from other experts about what we mean by
3 high signal intensity or T2 signal intensity within the cord.
4 But basically, when we see brightness inside the spinal cord,
5 that's indicative of water or swelling inside the spinal cord,
6 and even before it swells, we will see bright signal intensity
7 within the cord.

8 In fact, the swelling is sort of another phase of
9 evolution of a stroke, and the same thing happens in the
10 brain. The first thing that we'll see is some brightness in
11 the gray matter and sometimes in the white matter, and only
12 after a period of time, usually a day or two, do we start to
13 see swelling in the brain. The spinal cord is the same way.

14 Q: And that's with a -- with an ischemic stroke?

15 A: Yes, sir. That's what --

16 Q: In the brain or the spinal cord?

17 A: In the brain or the spinal cord.

18 Q: All right, sir.

19 MR. DAVIS: Let's go to 8.

20 BY MR. DAVIS:

21 A: Back to that slide real quickly, that was an
22 observational study that looked at a group of patients that
23 came in who were ultimately diagnosed with spinal cord
24 infarction, and the vast majority of them had normal MRIs when
25 they came in.

1 And if you could go back to that slide for a second?

2 Q: The one prior?

3 A: The one prior, yes.

4 Q: Okay.

5 A: Okay. This was a single patient who came in, and it
6 wasn't until she was scanned at -- let's see. So at 24 hours,
7 the MRI did not exhibit T2 hyperintensities. And in fact, the
8 MRI changes were not detected after eight days.

9 And I'm going to show you a series of slides that
10 basically show you that same concept, that most of the time,
11 particularly when we know the history -- sometimes the history
12 is difficult to get accurately. You know, a patient can tell
13 us when their symptoms started, and we have this problem when
14 we treat strokes, too, because patients can have symptoms for
15 a while before they realize they are even having a stroke.

16 And that's really important to know, because if you give
17 a patient a thrombolytic drug, a drug that can dissolve the
18 blood clot too late, it can have very dangerous consequences.
19 They can bleed. And that's, you know, certainly something you
20 don't want.

21 Q: Okay. Go to the next slide now?

22 A: Yes.

23 MR. DAVIS: 8. Right. Thank you.

24 BY MR. DAVIS:

25 Q: And, Doctor, you prepared these slides; right?

1 A: Yes.

2 Q: This is what you prepared. All right, sir. And this is
3 what you discussed at some length in your deposition?

4 A: Yes.

5 Q: All right. Thank you.

6 A: This is just another example of a group of nine patients.
7 63 percent of their -- 63 percent of them had negative MRI
8 findings when they first presented. And my recollection is
9 that the other five patients did not have MRI findings in the
10 first 24 hours. So none of these patients had MRI findings in
11 the first 24 hours.

12 Q: When we see the initials SCI, what does that mean?

13 A: Spinal cord infarction.

14 Q: Okay. Are we done with this slide?

15 A: I want to make one more point.

16 Q: Sure.

17 A: You see it, the third from the bottom line, the -- the
18 mention of diffusion weighted imaging. I don't know if that's
19 been mentioned so far. So about 20 years ago, we -- we
20 figured out how to do something with the MRI imaging that has
21 great applications in the brain, and it's called diffusion
22 weighted imaging.

23 With diffusion weighted imaging, as soon as the stroke
24 happens, like within minutes, we can see it. And in the
25 brain, it's a very, very valuable technique. So somebody can

1 have symptoms, come into the emergency room. Within an hour,
2 we can do an MRI on them, and we can see the stroke right
3 away.

4 Diffusion imaging is very difficult, technically
5 difficult to do in the spinal cord, and we -- nobody really
6 does it consistently. There are a few medical centers with
7 high field strength magnets and protocols that may allow them
8 to do that, but routine diffusion weighted imaging in the
9 spine is really not done consistently around the country.

10 Q: All right. Are we done with this slide, sir?

11 A: Yes.

12 MR. DAVIS: Now, let's go to the next one, Number 10. I
13 lost count already. The next one is 9. All right. Thank
14 you.

15 BY MR. DAVIS:

16 Q: Slide 9. Tell the jury what significance, if any, is
17 this to you today, sir?

18 A: This is just another group of patients, and they showed
19 predominantly, I think, two out of 39 patients in this case,
20 only two of 39 had T2 weighted changes on their initial MRI in
21 the first 24 hours.

22 Q: Are you done with this one?

23 A: Yes.

24 Q: Okay.

25 MR. DAVIS: Go to Number 10, please. Thank you.

1 BY MR. DAVIS:

2 Q: Please tell the jury what -- why you put this slide
3 together?

4 A: Let's see.

5 Q: Can you see that okay?

6 A: Yeah. This showed similar findings. This was more of a
7 study looking at a radiologist's ability to interpret MRI
8 studies in the first 24 hours, and then they -- they found, as
9 you would expect, that as time went on, the radiologist's
10 ability to interpret the study became more accurate.

11 Q: Okay. Are we done with this one?

12 A: Yes.

13 MR. DAVIS: Go to Number 12, please.

14 BY MR. DAVIS:

15 Q: What is the significance of this one, sir? Are we still
16 talking about spinal cord infarction?

17 A: We're still talking about spinal cord infarction. And in
18 the second -- third sentence, T2 changes can develop over
19 hours to days. This -- this is accounting for the low
20 sensitivity in the hyperacute setting, which is the first 24
21 hours.

22 The whole point of all these slides is to just show you,
23 when you look at imaging of a spinal cord infarction, it's
24 very clear in the medical literature and amongst the common
25 clinical knowledge that -- that neurosurgeons, emergency

1 physicians have is that a spinal cord infarction is going to
2 be either negative or very equivocal and difficult to
3 interpret in the first 24 hours. The findings are very
4 subtle.

5 And the next phase, after you just see bright T2 signal,
6 is swelling of the cord. That is extraordinarily rare. In
7 fact, I think we -- in my deposition -- I put this
8 presentation together the night before the deposition. I
9 hadn't had a chance to read all the articles thoroughly.

10 There are one or two cases where we did find spinal cord
11 edema in the first 24 hours, and I went back and looked at
12 them. One of them was a patient who occluded his entire
13 aorta. So the biggest blood vessel in his body had completely
14 stopped, and he had spinal cord edema at 14 hours.

15 My theory about that case is that you really don't
16 suddenly occlude the biggest blood vessel in your body, and I
17 suspect that he had had symptoms for some period of time, but
18 they called -- they called the onset of symptoms for him when
19 he basically became paralyzed and couldn't walk.

20 The other patient actually was described as having had
21 edema and swelling at three hours. That patient was
22 undergoing surgery. The patient was undergoing what's called
23 endovascular surgery, where we put a catheter in the groin,
24 navigate it up into an aneurysm inside the brain, and deploy
25 through the catheter, through a tiny little micro catheter,

1 aneurysm coils to try to prevent the patient from needing open
2 brain surgery to clip an aneurysm. We're actually able to put
3 coils that can cause it to clot.

4 The spinal cord is supplied by the vertebral arteries in
5 the neck. They're little branches of the vertebral arteries
6 that supply the spinal cord in the neck. I can tell you from
7 personal experience that the vertebral artery is very, very
8 sensitive. There have been times when we've tried to do
9 interventional procedures by threading a catheter into the
10 vertebral artery, and the vertebral artery will shut down. It
11 will -- it will go into spasm, and we have to pull the
12 catheter out and inject some drugs to try to get it back in.

13 I remember a patient we tried to treat. We wanted to do
14 an angioplasty of his -- he had one blood vessel going to his
15 brain, and it was a single vertebral artery. And we put the
16 catheter in. There was just a little bit of flow going
17 through this high-grade blockage in his vertebral artery, and
18 the whole thing shut down. We backed out, injected a little
19 bit of drugs. It opened back up again.

20 But the point of this is that the vertebral artery is
21 very, very sensitive, and my interpretation of that patient
22 that had edema at three hours was that he had been under
23 anesthesia for several hours while they were doing that
24 procedure. And when they woke him up -- he actually didn't
25 wake up and he ultimately died, but his time course in reality

1 had been much longer than three hours because it probably
2 happened early on in the procedure.

3 Q: So are we finished with the -- that slide?

4 A: Yes.

5 MR. DAVIS: Go to 14.

6 THE WITNESS: That's -- I think we can move on. That's
7 pretty much what I just explained.

8 MR. DAVIS: Let's go to the next one.

9 BY MR. DAVIS:

10 Q: Now, is there -- are you shifting now in your PowerPoint
11 away from cord stroke to reperfusion?

12 A: Yes.

13 Q: All right. What does this slide indicate?

14 A: That's just a list of articles. You could probably go to
15 the next one, but I'll take this, if I can, to explain to the
16 jury what we see in a reperfusion injury. This is -- this is
17 really important to understand.

18 So a -- we see reperfusion injuries in the brain and the
19 heart. In fact, I've experienced that myself in taking care
20 of patients. They're very common in the brain and the heart.
21 They're --

22 MS. GOODING: Your Honor, I'm sorry to interrupt the
23 question. I don't believe a proper foundation has been laid
24 for these articles that you're showing, and we don't have
25 copies of the articles. They're being published to the jury

1 right now. I'm concerned about going through all of these
2 articles without that.

3 MR. DAVIS: Thank you.

4 THE COURT: Mr. Davis?

5 MR. DAVIS: Your Honor, I'm happy to lay the foundation.

6 THE COURT: Please.

7 MR. DAVIS: Thank you.

8 MS. GOODING: Do we have the articles here?

9 MR. DAVIS: I think we sent those cites to you after the
10 deposition.

11 MS. GOODING: I just need a copy of it. One thing, I
12 don't have subscriptions to these journals, so we don't have
13 copies of the articles.

14 THE COURT: If you'll turn the monitor off.

15 MR. DAVIS: I'll turn them off. Well, let me ask this
16 question to try to lay a foundation.

17 BY MR. DAVIS:

18 Q: The articles that you have cited in your PowerPoint, are
19 those articles that you consider to be reliable and
20 authoritative sources on this subject?

21 A: Yes.

22 THE COURT: Ms. Gooding?

23 MS. GOODING: Your Honor, my concern is that we don't
24 have a copy of the entire article and that -- or any of the
25 articles that he's referencing. And so we're just cherry

1 picking what's out of them, and we don't have an opportunity
2 to -- to look at the whole thing.

3 THE COURT: Mr. Davis, have you provided those articles?
4 Can you provide those articles to plaintiffs' counsel?

5 MR. DAVIS: Can I ask the witness questions since all
6 this is his?

7 THE COURT: Yes, sir.

8 BY MR. DAVIS:

9 Q: Dr. Goltra, at your deposition and after your deposition,
10 did you supply the citations or copies of any of these
11 articles to the plaintiffs' attorney as she requested them?

12 A: Yes, but I don't know whether -- I can't remember whether
13 I sent them directly to her or to your office first.

14 Q: You didn't send them to me.

15 A: Okay.

16 THE COURT: Were they citations or copies?

17 THE WITNESS: They were links to the articles. I did not
18 send physical copies.

19 THE COURT: Links to articles where a subscription is
20 required or --

21 THE WITNESS: No. No, ma'am.

22 MS. GOODING: Your Honor, my understanding from talking
23 to Dr. Goltra at his deposition was that he has a subscription
24 where he -- that he is able to utilize to read articles from a
25 lot of different sources, and I do not recall receiving any

1 links from him after that.

2 I did go over these articles with him in his deposition.
3 I did ask him for where they were from, but I don't have
4 copies of those articles, and that's the concern, Your Honor.

5 THE COURT: All right, ladies and gentlemen. Please
6 return to your jury room. Don't discuss the case.

7 (WHEREUPON, the jury exited the courtroom at 11:55 a.m.)

8 THE COURT: How many articles are there? Dr. Goltra, do
9 you recall how many articles?

10 THE WITNESS: From this point forward, Your Honor, I
11 believe there are just a few.

12 THE COURT: How many total?

13 THE WITNESS: Maybe four or five at the most.

14 THE COURT: Okay. Do you -- did you bring copies of
15 those? Do you have physical copies that could be photocopied?
16 Do you have the links?

17 THE WITNESS: I could probably dig them out of my email,
18 but honestly, I feel like I can explain to the jury the
19 reperfusion injury issues that they need without seeing the
20 articles. The articles just describe some cases of
21 reperfusion injury and what the findings were at those times,
22 and the whole point of the articles was just to demonstrate
23 consistency.

24 THE COURT: Yes, sir. Do you want to proceed without the
25 articles?

DR. DAVID GOLTRA - DIRECT BY MR. DAVIS

1 MR. DAVIS: Sure. I'm happy to do that.

2 THE COURT: Okay. Does that suit you, Ms. Gooding?

3 MS. GOODING: Yes, Your Honor. And just since we -- we
4 got along in it a little bit, I'd like to be able to ask him
5 about the things that he's already presented to the jury
6 without introducing anything new.

7 THE COURT: Absolutely. I think that's appropriate.

8 All right. Since the jury is out, let's just take ten
9 minutes.

10 MR. DAVIS: Thank you.

11 THE COURT: Thank you.

12 MR. DAVIS: Your Honor, would you instruct the witness?

13 THE COURT: Oh, yes. You can step down from the witness
14 stand. Do not discuss your testimony with anyone.

15 THE WITNESS: Yes, ma'am. Thank you.

16 THE COURT: Thank you.

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

19 THE COURT: Come on back up to the witness stand.

20 THE BAILIFF: All right. Just keep your microphone with
21 you.

22 THE WITNESS: Yes, ma'am. Hey, if I talk louder, it just
23 works.

24 THE COURT: Bring us the jury, please.

25 (WHEREUPON, the jury entered the courtroom at 12:17 p.m.)

DR. DAVID GOLTRA - DIRECT BY MR. DAVIS

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

2 THE COURT: All right. Thank you.

3 To the extent that there was an objection, I sustain the
4 objection. We're going to move on. Mr. Davis is going to
5 continue his questioning.

6 MR. DAVIS: Thank you, Your Honor.

7 THE COURT: Yes, sir.

8 BY MR. DAVIS:

9 Q: Dr. Goltra, did you have occasion to review MRI images in
10 this case?

11 A: Yes, sir.

12 Q: Would you tell the jury which imaging you referred to and
13 looked at?

14 A: I've looked at pretty much all of the MRI imaging, and
15 I'm happy to pull up the list if you want me to.

16 Q: We'll do the list. Can you -- well, let me just ask you
17 this way?

18 A: Okay.

19 Q: Did it include the 2009 imaging?

20 A: Yes.

21 Q: 2011?

22 A: Yes.

23 Q: 2016?

24 A: Yes.

25 Q: Have you formed an opinion whether or not the MRI imaging

1 that you reviewed of Crystal Goodwin prior to her surgery with
2 Dr. Holbrook on July 28th, 2016, revealed any evidence of
3 chronic ischemia in the area of the spinal cord?

4 A: Yes.

5 Q: What significance, if any, does that have to any of your
6 opinions that you want to give in the case?

7 A: Chronic ischemia in the spinal cord is a common and
8 consistent feature of reperfusion injury. So reperfusion
9 injury, also sometimes called white cord syndrome, is a
10 syndrome that takes place when a patient wakes up from
11 surgery, they have a severe neurologic deficit, and on MRI
12 imaging, they have bright signal and swelling in the spinal
13 cord at the location of a previously ischemic area.

14 So we can go back and look at the prior MRI imaging and
15 see that there was something going on in the spinal cord at
16 that location. Typically, that's the location that was
17 treated. So most of the time when we're doing this type of
18 surgery, we're doing a laminectomy. We're releasing -- we're
19 removing some of the bone that's resulting in compression of
20 that chronically ischemic spinal cord. When we do that, when
21 that pressure is released from that chronically ischemic
22 spinal cord, the reperfusion injury takes place.

23 So what happens is an area of tissue that's damaged, so
24 it's scarred, there's a reduced number of active, viable
25 nerves in that tissue. Typically, that segment of the spinal

1 cord is atrophied. So it's -- it's smaller. So when the
2 pressure is removed and blood flow to that area is suddenly
3 restored, the pressure of the blood flow, the in-wash of
4 chemicals, of toxic chemicals that have accumulated in that
5 tissue that's been deprived of blood, gets washed into that
6 area of previously ischemic tissue, and that causes even more
7 damage.

8 And because something that we talked -- we didn't talk
9 about before, what's called the blood brain barrier, which
10 normally protects the brain and the spinal cord. In the
11 setting of an infarction, for instance, because that has been
12 broken down by this chronic ischemia, this chronic atrophy in
13 the spinal cord, that segment of cord is susceptible to injury
14 when the -- when the compression is removed and blood flow
15 rushes in.

16 So it's -- it's got its own name. It's called white cord
17 syndrome. It's a -- it's a syndrome. It's a set of symptoms
18 that is commonly -- not commonly because it's pretty rare, but
19 it's known -- it's a known entity, particularly amongst spine
20 surgeons, most of whom are neurosurgeons.

21 When a patient wakes up from surgery, they have a
22 neurologic deficit, and they get an MRI that shows bright
23 signal and swelling in the spinal cord, which, if you remember
24 going back to the typical features of a spinal cord
25 infarction, there's no swelling early on. There's usually no

1 swelling for a day or two. It's rare for swelling to occur.

2 When a patient wakes up from surgery and there is swelling,

3 it's a reperfusion injury. It's white cord syndrome.

4 Q: Doctor, what is the significance, if any, about the -- I

5 hope I pronounce this right -- artery of Adamkiewicz. Am I

6 pronouncing that right?

7 A: Yes.

8 Q: Okay.

9 A: So --

10 Q: What's that about?

11 A: It's -- it's -- it's just an unusual artery, and then

12 there's -- I've got a picture of it in my slides, and it tends

13 to enter the spinal cord on the left side at T12. It has kind

14 of a hairpin configuration. So it will often go up and supply

15 blood to the area of the spinal cord all the way up to T9, or

16 sometimes even higher. I don't know that it really has great

17 significance in this case, but it might, and I'm happy to show

18 you the graphic at some point.

19 Q: Okay. Let's look at some of your imaging, Doctor. I

20 don't mean your imaging. Let's look at the imaging in this

21 case that you reviewed.

22 A: We need to go back to HDMI-2.

23 Q: Okay. I'm going to get my technical assistant. Tell me

24 when you're ready to begin.

25 A: Do we feel like the monitor is close enough to the jury?

1 Q: Okay. I think it is. Explain what you're seeing and why
2 you have these images.

3 A: Okay.

4 Q: And what -- what are we looking at?

5 A: So this panel in the middle where my mouse is right now
6 is what's called the sagittal T2 sequence from the MRI study
7 that was done June 24th, 2009, and this is sometime shortly
8 after the -- what I believe is the first surgery. I don't
9 have images prior to the surgery, but this is an -- this is a
10 set of images that was obtained after surgery. So I'm just
11 going to enlarge this a little bit.

12 Q: That little red T9, is that something you put on there?

13 A: I put that on there just to indicate where T9 is.

14 Q: Okay.

15 A: Okay. This back here looks different from everything
16 else. This is where the surgeon has removed a large segment
17 of the -- what's called the lamina and the spinous process
18 from the spinal canal.

19 Q: I'm sorry. Which -- what year date are we looking at
20 now?

21 A: So I'm still on June 24th, 2009.

22 Q: Okay.

23 A: I'm on the center panel on my screen right here.

24 Q: Thank you.

25 A: And this is a post-surgical image.

1 Q: So this is an image taken after Dr. Holbrook's surgery?

2 A: Image taken after Dr. Holbrook's surgery.

3 Q: All right, sir.

4 A: And just to show you a little bit what it might look like
5 if there had been no surgery, over here on the right is what's
6 called an axial sequence. So this reference line over on the
7 slice in the middle is where we would obtain that slice and
8 kind of hold it up. So now you're looking as if you're
9 looking from the patient's feet up to her head, and this is
10 the bone that has been removed when we slide up here.

11 So I'm going to slide up to the area where the surgery
12 is, and here is where the bone has been removed. So this is a
13 defect in the back of the spinal canal where bone has been
14 removed. And you can see that by removing this bone, this
15 space, this sort of triangular space with the spinal cord
16 right in the middle, it's more open.

17 So this is a decompression procedure. He's created more
18 space so the spinal cord can sort of move more freely in here.
19 Presumably -- and I don't have the preoperative images, but
20 presumably this was tight and there was pressure on the spinal
21 cord beforehand.

22 The other reason I think that it was tight is because
23 there is abnormal signal intensity. There's bright signal
24 intensity in the spinal cord right here. I'm over to the
25 center panel right now, right here opposite the T9-10 disk.

1 So these are the discs, these kind of bright wafer-like
2 structures. Those are the intervertebral discs. This is the
3 T9-10 disc, and this location is very important. As I'm going
4 to demonstrate further, this location is an area of chronic
5 ischemia, and this is where the reperfusion injury seven years
6 later took place.

7 I think we can move on if you want to.

8 Q: I'm happy for you to do that.

9 A: Okay. So I'm going to show you --

10 Q: Just orient us and tell us what we're -- what we're
11 seeing?

12 A: I will.

13 Q: Okay.

14 A: The next MRI that we have is from July 21st, 2011. So
15 this is roughly two years later, and we're going back up to
16 T9-10. And you'll remember that this space back here that was
17 wide open -- remember how wide open it was from the surgical
18 decompression -- is no longer wide open.

19 This is a really unusual phenomenon. She has regrown
20 some tissue back here that, if you look at it on this
21 sequence, you can see that this tissue is putting pressure on
22 the back of the spinal cord. She's got more compression up
23 here, but also right here at the T9-10 level. This, in my
24 experience, is unusual.

25 And we come up just a little bit and you can see how the

1 spinal cord is being compressed right here just slightly above
2 T9-10. This is causing chronic ischemia. So I think you've
3 seen graphics of the blood vessels that come into the spinal
4 cord. Most of them are very superficial. When you put
5 pressure on the spinal cord, it deprives those tissues of
6 blood. That's why she has bright signal in the spinal cord
7 right there. I'm not sure when that happened, but it probably
8 accumulated very slowly over time.

9 You have to realize that we see this all the time, and
10 this is the most common reason for spinal surgery, is to do a
11 laminectomy to open up the spinal canal, to either take
12 pressure off nerves or off the spinal cord in this case.

13 Okay. I think we can move on to the next MRI.

14 Q: All right, sir.

15 A: Okay. I'm going to leave the 2011 study on the screen
16 over here, and I'm bringing up a study from June 28th, 2016.
17 Our connection is a little bit slow, so it's just taking a
18 minute.

19 Q: So on the left side of the screen is 2011?

20 A: On the left side of the screen over here is the July
21 2011, and over on the right side of the screen over here is
22 June 2016.

23 Q: All right, sir.

24 A: So we're five years later.

25 Q: All right. What are you seeing here, Doc?

1 A: I'm going to tell you in just a second.

2 Q: Okay.

3 A: I'm going to get rid of that. Okay. Here we go. It's
4 just loading a little bit slowly. I tried to do this before
5 we started this morning, but it's -- the connection is not
6 great, but you can see -- it's a little bit harder to see, but
7 at T9-10 on this sequence over here, there's still a lot of
8 tissue that's back here behind the spinal cord. There's still
9 abnormal bright signal inside the spinal cord right here.

10 There's some stenosis of the canal, some narrowing of the
11 canal below this level now at the T10-11 level and the T11-12
12 level that was back here on the left side. It was pretty mild
13 back then. It's more severe now.

14 And another really interesting and unusual thing has
15 developed. Since this study, where before we had this
16 regrowth of tissue in the back, she has developed a very large
17 osteophyte or bone spur. This is it right here. This is on
18 the left side of the spinal canal, and it's compressing the
19 left side of the spinal cord. You can see it. It's like a --
20 it's like a spike pushing up. This is the spinal cord. This
21 is the bone spur pushing into the tissue of the spinal cord,
22 compressing it.

23 And you can see -- so let's go -- let's go up here. This
24 is what a normal spinal cord looks like up here. Look how
25 bright the spinal cord is right here at the level of

1 compression. This is chronic ischemia of the spinal cord from
2 compression at this point magnified by this large bone spur
3 that has developed, again right here at the T9-10 level.

4 Can I move on to the next?

5 Q: Yes, sir.

6 A: Okay. Now I'm pulling up the study that was done
7 immediately after surgery.

8 Q: That was July 28th?

9 A: Yes, sir.

10 Q: All right. And that would be the post-op MRI, sir?

11 A: Yes.

12 Q: All right, sir.

13 A: Okay. All right. It's just loading a little slowly.

14 Now, here we are again. So what has changed here is this
15 tissue in the back. The spinous processes in the lamina have
16 been removed by Dr. Holbrook's surgery. Okay? And by the
17 way, this is the immediate post-operative MRI that was -- that
18 was ordered emergently after she woke up and had symptoms.

19 Here we are at T9-10. You see this large area of
20 abnormal T2 hyperintensity brightness in the cord with
21 swelling of the cord. So not only is it bright, it's swollen,
22 it's enlarged, despite the fact that this bone has all been
23 removed. This is swollen, enlarged spinal cord.

24 Q: What significance, if any, does that swelling have for
25 your opinions?

1 A: So back to the difference between a spinal cord
2 infarction and a reperfusion injury. Spinal cord infarction,
3 blood flow stops, swelling and T2 signal changes don't start
4 until some point later on in, sometimes in the first 24 hours,
5 but usually even after that. Swelling is a late finding.

6 Q: In an ischemic cord stroke?

7 A: In an ischemic cord stroke, which is what is alleged in
8 this case, is that this was a spinal cord stroke from
9 transient low blood pressure.

10 I'd like to, if we could, at some point go back to the
11 slides just to describe to the jury what it would take for low
12 blood pressure to cause a spinal cord infarction. Just to let
13 you know, spinal cord infarctions are seen in people with
14 profound low blood pressure.

15 One of the studies I did, they only included patients in
16 that if they -- their blood pressure was below 50, an MAP of
17 50. It's patients who have had aortic aneurysm surgery. It's
18 patients that have had multiple trauma. And even in those
19 cases, spinal cord infarction is pretty rare because the brain
20 or the body protects. God put this mechanism in us to protect
21 our brain and our spinal cord from low blood pressure, from
22 high blood pressure. It's called autoregulation, which you've
23 heard about.

24 So, typically, the spinal cord is protected, but spinal
25 cord infarctions usually occur when there's prolonged,

1 dramatic, profound, low blood pressure.

2 Q: Yes, sir.

3 A: So I want to show the next study.

4 Q: Yes, sir.

5 A: And the reason I want to show the next study is because
6 you might look -- you might look at this large area of signal
7 abnormality in the spinal cord and say, well, where's the
8 injury? You know, it's -- it's T9-10, but it's also above T9-
9 10 and it's below T9-10, and the chronic ischemic changes were
10 right there at T9-10.

11 What happens when you have a stroke in the brain, a
12 stroke in the spinal cord is that you have -- just as you
13 would in any injury, you have a small area where the actual
14 injury occurred, and then you get swelling and changes in the
15 tissues around it. Like, for instance, in a stroke, there can
16 be a one tiny blockage in one tiny blood vessel and really
17 severe injury to the tissue that's immediately adjacent to
18 that blood vessel, but you get signal abnormality extending
19 out from that, and that area is called the penumbra, and we
20 know that that -- that tissue is at risk, but some of that
21 tissue can recover. Okay?

22 So the tissue right there in the center of that is
23 probably not going to recover. Some of the tissue in the
24 penumbra is going to recover, and it's going to be normal
25 again. Sometimes a patient can have almost complete --

1 complete recovery from what looks like a big stroke, because
2 the only part that was really damaged was that part right next
3 to the blood vessel. The penumbra tissue can recover.

4 Q: So -- so what's the date of the study we're looking at
5 now?

6 A: I haven't pulled it up yet.

7 Q: Oh, okay. I'm sorry. I didn't mean to get ahead of you.

8 A: That's okay. So this study is from November. Excuse me.
9 Hang on. That didn't work. It's just loading slowly. I
10 believe that if I reboot and refresh the connection. Are you
11 okay if I do that?

12 Q: Whatever it takes.

13 A: Okay. Please excuse me for -- this shouldn't take long.
14 Wait a second. Wait a second. I'm going to have to show you
15 all my passwords, so try to forget it when we're finished.
16 Oops. Okay. Almost there.

17 Q: To remind us, what's the date of these images, sir?

18 A: So this is the study that was performed November 29th,
19 2016, the November following the surgery. And what we see is
20 some changes have taken place in the spinal cord.

21 So the previous picture where we saw the swelling -- and
22 I'll pull that study. Let me pull it up. If you recall --
23 and I'll show you in just a second that large area of bright
24 signal intensity and swelling in the spinal cord is no longer
25 there. It's gone away. Right here, this bright spot, that's

1 that nidus, that focal area where the spinal cord was injured.
2 This is where we saw signal abnormality in the study all the
3 way back to 2009. This is embedded right in that previously
4 identified area of bright signal intensity.

5 And I'll show you in just a second. Here we go. This is
6 what we call cystic myelomalacia. So after a spinal cord
7 injury, we see this a lot in people that have had dramatic
8 spinal cord injuries. After everything heals, the part of the
9 spinal cord that is never coming back, the part where the most
10 severe injury took place is just a cyst within the spinal
11 cord, and that's what this bright high T2 signal intensity
12 spot in the spinal cord is.

13 You notice the spinal cord has gotten a lot smaller too,
14 but some of this previously identified bright tissue -- here
15 we go. So a lot of this swelling and edema in the spinal cord
16 is no longer present, but right here at T9-10, the spot where
17 I showed you at the very beginning in 2009, then again in
18 2011, and then in June prior to the surgery where most of the
19 chronic ischemia took place is where the cystic myelomalacia
20 is.

21 So that's ground zero for this event, which goes back to
22 the clinical scenario of a reperfusion injury that takes place
23 in an area of previously chronically ischemic tissue because
24 that tissue has been damaged over time, and it's susceptible
25 to the effects of rapid restoration of blood flow to that

1 tissue. That blood flow rushes in and damages the tissue.

2 That's right where it took place.

3 Now, where would a spinal cord infarction take place?

4 Spinal cord infarction is pretty much a random event. It's
5 going to usually take place more commonly in the thoracolumbar
6 spine or in the mid thoracic spine. Some studies have showed
7 that most spinal cord infarctions -- we're again talking about
8 infarctions again, not reperfusion injuries -- take place at
9 T2 or T4. They can take place anywhere.

10 In many of the articles that I showed you, spinal cord
11 infarctions took place in the cervical spine. So if that
12 event can occur pretty much anywhere -- and it's alleged that
13 a spinal cord infarction took place here. If it's not a
14 reperfusion injury, why did it happen right here? Why did it
15 happen right here at T9, in this area of where the spinal cord
16 was chronically ischemic from the very beginning?

17 Q: Doctor, I believe you took some measurements, some axial
18 measurements of the swelling. It was noted on the post-
19 operative MRI shortly after the surgery of July 28th, 2016.
20 Do you recall that?

21 A: I do.

22 Q: Can you pull those up?

23 A: Well, here's one right here.

24 Q: Okay. All right.

25 A: This one here. I think that their expert stipulated that

1 there is swelling in the spinal cord.

2 Q: Okay.

3 A: So I don't think we need to dwell on that a lot.

4 Q: All right. We'll move on. And you agree with that, that
5 there is swelling?

6 A: I do. There's no question about it. I mean, you can see
7 -- you can see how this part of the spinal cord is pushed out
8 against the dura. It's -- it's what we call a fusiform area
9 of swelling. There's no question that there's swelling there.

10 Q: All right. Doctor, in your opinion, can you absolutely
11 100 percent rule out spinal cord infarction, sir?

12 A: So when you say rule something out --

13 Q: With 100 percent, sir?

14 A: -- with 100 percent, there is nothing in this world that
15 is 100 percent certain.

16 Q: Okay.

17 A: But my job as a radiologist -- and radiologists are
18 usually left with figuring out what's going on. Now, after
19 all the other doctors have run tests and examined the patient
20 and talked to the patient, they send them to us to figure out
21 what's really going on. So my job is to come up with an
22 accurate diagnosis, and I've got to be right most of the time,
23 or I'll be sitting over at that table.

24 In my opinion, the overwhelming probability based on all
25 of the factors, the location, the swelling, the time course,

1 the chronic ischemia in the spinal cord is that this is a
2 reperfusion injury. And the probability that this is a spinal
3 cord infarction is probably less than 1 percent. I think in
4 my deposition I said 1 in a million, but it may be slightly
5 more than that.

6 But again, my job is to come up with the right diagnosis.
7 And I believe and I'm quite certain that I'm correct that that
8 is the right diagnosis.

9 Q: And your opinion is based on what, sir?

10 A: My opinion is based on all of the elements of this
11 syndrome that I've just described. We've got --

12 Q: And the images?

13 A: And the images.

14 Q: Okay. Did you see any owl's eyes on the spinal cord,
15 Doctor?

16 A: No, sir.

17 Q: What are owl's eyes?

18 A: Owl's eyes -- and I -- actually, I saved a picture of
19 owl's eyes, but I think it got wiped out in the reboot. So
20 owl's eyes is a manifestation of an anterior spinal cord
21 injury. So could we bring up the PowerPoint? Well, we don't
22 necessarily need to.

23 So the spinal cord has innervation from a single blood
24 vessel in the front and two blood vessels in the back. And
25 when you have a spinal cord infarction, there's a typical

1 pattern of T2 signal, not swelling, T2 signal that occurs
2 early on. And we see this a lot in patients that have chronic
3 ischemia to their spinal cord. But what you'll see is -- can
4 I draw on this?

5 Q: Yes, sir. Do you have a pen or pencil?

6 A: I don't.

7 Q: It's going to smell.

8 A: That's okay.

9 Q: Okay. It might wake you up. Oh, I am so sorry. Didn't
10 mean to insult you there.

11 A: All right. So owl's eyes look like this, except, of
12 course, in the spinal cord, they would be little bright spots.
13 And this, I know, kind of looks like an owl if you look at it.

14 So that's the axial sequence. If you look at it on the
15 sagittal, it looks like this. That's what owl's eyes look
16 like. And again, it's an early manifestation of the bright T2
17 signal that happens after a spinal cord infarction. You don't
18 really see it. Once there's edema, in this case, we just see
19 bright signal throughout the entire cord. You don't see the
20 owl's eyes.

21 Q: Dr. Mancuso demonstrated to the jury that he saw owl's
22 eyes. Did you look for owl's eyes?

23 A: I did. When I heard that, I went back and looked, and
24 I'm not sure what he was looking at, but I'll show you what I
25 think he might have been looking at.

1 So down here at the bottom of this large area of swelling
2 from the reperfusion injury, there's a little thin rim of what
3 might be some gray matter tissue surrounded by these large
4 areas of bright signal intensity. I'm guessing that may be
5 what he saw, but that's -- I don't know. I don't believe
6 there are owl's eyes on here.

7 Q: Okay. Doctor, you mentioned a little bit earlier about
8 three things that you focused on to help you kind of come to
9 your opinion and conclusion that these images reflect not
10 spinal cord infarction, but a reperfusion injury. What were
11 those three things again?

12 Q: The three things are the cause, the location, and the MRI
13 findings.

14 Q: So let's -- we're going to pull something up here in just
15 a second that we prepared at your suggestion. Well, that's
16 cool. I couldn't do this by myself, I promise. Okay. What
17 are we looking at here? We prepared this at your suggestion.

18 A: Well, I just wanted to prepare this so that we could
19 contrast the two different clinical entities in a way that
20 could be sort of easily remembered by the jury.

21 Q: All right.

22 A: Cause, location, MRI findings. The cause of a spinal
23 cord infarction, usually a vascular injury from surgery or
24 prolonged, profound, severe hypotension with an MAP less than
25 50.

1 Location. Again, a spinal cord infarction can be
2 anywhere. It's -- it's a random event. Unless the patient
3 has vascular disease in a particular location that might
4 predispose them to having a spinal cord infarction in their
5 cervical spine or their lower lumbar spine, it's going to be a
6 random event.

7 MRI findings. Initially negative the vast majority of
8 the time, and probably all the time in spinal cord injury or
9 spinal cord infarction.

10 Q: When you say hyperacute, what period of time is that
11 referring to again?

12 A: That's the first 24 hours.

13 Q: All right, sir. And we know that the MRI in this case
14 was taken about four hours after the injury?

15 A: According to the time stamp in my computer, it was three
16 hours and 15 minutes.

17 Q: All right, sir. Go ahead.

18 A: Again, the typical pattern of T2 signal when you see T2
19 changes initially are either the anterior posterior pattern,
20 the anterior pattern being the owl's eyes thing. Posterior
21 pattern because there are two blood vessels in the back,
22 usually you see signal changes on one side or the other in the
23 hyperacute phase after a spinal cord infarction.

24 Contrasting that with reperfusion injury, that takes
25 place in an area of the spinal cord that is chronically

1 ischemic, that has been damaged before, as I demonstrated
2 right here at the T9-10 level. All the way back on all the
3 MRIs, this is here.

4 MRI findings are this white cord syndrome. It's so
5 consistent when it happens that it's got its own name.
6 Patient wakes up. They've got white cord signal. Doctors
7 named it that because they never see that. First of all, you
8 really never see -- I've never seen in the 100,000 MRIs that
9 I've looked at an immediate post-operative spinal cord
10 infarction.

11 I've never seen that happen. And I believe that the two
12 surgical experts that were part of this case had not seen it
13 happen. I don't think any of the surgical experts that were
14 part of this case had not seen that happen. Turns out since
15 my deposition, I've seen another reperfusion injury.

16 But -- so this is just to contrast the two different
17 clinical entities, spinal cord infarction, reperfusion injury,
18 which is, I believe, what we have here.

19 Q: So the MRI findings on the spinal cord reperfusion
20 injury, you have edema and swelling in the spinal cord
21 immediately?

22 A: Yes, sir.

23 Q: And we've got it with less than four hours after the
24 signal went out at 10:03?

25 A: Yes, sir.

DR. DAVID GOLTRA - DIRECT BY MR. DAVIS

1 Q: All right. Overall, Dr. Goltra, in your opinion, have
2 you formed an opinion with any reasonable degree of medical
3 certainty whether this injury that Ms. Goodwin suffered was a
4 result of a reperfusion injury or a spinal cord infarction,
5 sir?

6 A: Yes.

7 Q: What is your opinion?

8 A: My opinion is that this is a reperfusion injury to the
9 spinal cord at the T9 level.

10 MR. DAVIS: Thank you, sir. Answer any questions that
11 the counsel have of you.

12 THE COURT: Ms. Gooding?

13 MS. GOODING: Thank you, Your Honor. May it please the
14 Court.

15 CROSS-EXAMINATION

16 BY MS. GOODING:

17 Q: Good afternoon, Dr. Goltra.

18 A: Good afternoon.

19 Q: I want to start by taking you back kind of where you
20 started with Mr. Davis. You were initially hired in this case
21 by a lawyer who is no longer involved; correct?

22 A: Yes.

23 Q: And then you told me in your deposition that last fall
24 you had a conversation with that lawyer who initially hired
25 you and Mr. Davis, and that, at that time, Mr. Davis then

1 retained you as an expert in this case involving Dr. Holbrook;
2 correct?

3 A: Yes.

4 Q: And you were disclosed as an expert in this case on
5 November 9th, 2022; is that right?

6 A: If you say so.

7 Q: I've got it right here.

8 A: Okay.

9 Q: Let me show it to you. I'm going to give you a copy of
10 the Defendants' Fourth Supplemental Answers to Plaintiffs'
11 Interrogatories.

12 A: Okay.

13 Q: And on page 4, it lists your name, Dr. David Goltra;
14 correct?

15 A: Yes.

16 Q: And it says Dr. Goltra is a neuroradiologist and an
17 interventional radiologist practicing in Charleston, South
18 Carolina. Dr. Goltra's CV has already been supplied, and then
19 it lists the materials that you've been given. Did I read
20 that correctly?

21 A: Yes.

22 Q: And if you turn to the very next page, it's signed by Mr.
23 Davis on November 9th, 2022; right?

24 A: Yes.

25 Q: And again, the jury has heard this several times already,

1 but as a retained expert in this case, you are being paid for
2 your time here; correct?

3 A: Yes.

4 Q: And what is your rate for the time that you reviewed the
5 medical records in this case?

6 A: It's \$400 an hour.

7 Q: And I took your deposition in this case. What was your
8 rate for that?

9 A: \$2,500.

10 Q: 2,500?

11 A: Yes.

12 Q: And then I think you told me that for trial, the rate was
13 \$7,500, plus travel time; is that right?

14 A: Yes. That's correct.

15 Q: And you were here yesterday as well; correct?

16 A: Yes.

17 Q: So two trial dates for this one?

18 A: Yes.

19 Q: Are those still your rates, Doctor?

20 A: Yes.

21 Q: Okay. And I believe you told me that you don't do a lot
22 of medical legal work, but that when you do that you have
23 typically testified for the defense; is that right?

24 A: Probably more often than not, but I have -- you know,
25 particularly in the -- the typical scenario is that an

1 attorney will ask -- call me and ask me if I'll look at, say,
2 an MRI, and the distribution is pretty random for plaintiffs
3 and defense. It's often a car wreck with a back injury.
4 Because of my expertise in MRI imaging, that's usually what
5 it's about. I actually did serve as an expert in a plaintiff
6 case, in a malpractice case, not too long ago, maybe three
7 years ago, and the plaintiff was awarded a substantial finding
8 from the jury.

9 Q: Okay. You began your career as an E.R. doctor; correct?

10 A: Yes.

11 Q: My understanding, if I did the math right from looking at
12 your CV, is that you've been a neuroradiologist for roughly
13 the last 23 years?

14 A: Yes.

15 Q: And for about the last 18 years or since 2005, you've
16 been working at Charleston Imaging, which is your imaging
17 center in Charleston; correct?

18 A: Yes.

19 Q: And you are also the CEO and president of Carolina
20 Imaging Specialists?

21 A: Yes.

22 Q: And your practice at Charleston Imaging is primarily
23 interventional. I think you told us that earlier; right?

24 A: Yes.

25 Q: Is this your website, Doctor?

1 A: Yes.

2 Q: I think we've got one with your picture on it, too. I
3 just wanted to kind of look at this real quickly. This
4 indicates the things that you do at Charleston Imaging Center.
5 MRIs, arthrograms, steroid injections, trigger point
6 injections, trial nerve stimulators, spino --

7 A: Spinocath.

8 Q: Spinocath?

9 A: Spinocath.

10 Q: And that is like a nasal injection; is that right?

11 A: Yeah.

12 Q: To put it simply?

13 A: To put it simply, yeah.

14 Q: Lumbar puncture and regenesis. You do all those things
15 at your imaging center?

16 A: I do.

17 Q: Okay. And you told me in your deposition that you
18 actually do quite a -- quite a lot of injections, including
19 stem cells, platelets, and steroids; right?

20 A: Yes.

21 Q: And you also do some biopsies and orthopedic procedures?

22 A: Yeah. Very few biopsies these days. We had a -- we
23 usually do biopsies with CT guidance, and RCT was moved over
24 to the hospital several years ago. So I'm not really called
25 upon to do those. I used to do all of the thyroid biopsies

1 for Charleston ENT, and I stopped doing that about three years
2 ago, too.

3 Q: Okay. And I think you told me that sometimes other
4 physicians will refer patients to you to have one of these
5 procedures done, but sometimes you actually see patients in
6 your office there at the imaging center. You're evaluating
7 that patient, you're recommending treatment for that patient,
8 and then, if it's appropriate, you actually are doing the
9 procedure on that patient; is that right?

10 A: Yes.

11 Q: It's fair to say then, Doctor, that your practice
12 includes a lot more than just interpreting MRIs.

13 A: Yes.

14 Q: Before we get into your opinions in this case -- again,
15 obviously, you've already shared them. I'd like to talk to
16 you just a little bit about the anatomy to make sure that
17 we're kind of on the same page and that I'm using the right
18 terminology. This jury has heard quite a few times about the
19 artery of Adamkiewicz or Adamkiewicz. Is that -- am I saying
20 that the two right ways?

21 A: Yeah.

22 Q: Okay. And you told me that that typically provides a
23 blood supply to the segment of the thoracic spine that goes
24 from about T8 to T12; is that right?

25 A: Yes.

1 Q: And we've got our trusty little model here, and that's
2 going to be at the bottom of this blue section of the spine;
3 correct?

4 A: Yes.

5 Q: Okay. And I believe you also told me that about 90
6 percent of the time, the artery of Adamkiewicz supplies at
7 least two levels of the lower thoracic spine, sometimes three;
8 right?

9 A: Yes.

10 Q: And in this case, Dr. Holbrook was operating on the lower
11 thoracic spine; correct?

12 A: Correct.

13 Q: You testified in your deposition that you reviewed
14 images, MRI images for Ms. Goodwin starting back in 2009, and
15 that between her surgery in 2011 and her surgery or -- I'm
16 sorry -- the MRI that she had in June of 2016, she developed
17 what I believe you referred to as a world-class bone spur?

18 A: Yes. I apologize for that terminology if it seems
19 inappropriate.

20 Q: No, that's okay, Doctor. I think your point was it was
21 large?

22 A: It was very large.

23 Q: And you showed me an axial image, and you showed to the
24 jury earlier an axial image at T9, where you could see that
25 bone spur compressing on and even displacing the spinal cord;

1 correct?

2 A: Yes.

3 Q: And I think that's also on this poster that y'all were
4 just looking at. Is this what we're talking about, Doctor?

5 A: Yes.

6 Q: Okay. And in looking at that image, that's going to be
7 kind of just beneath this T8-T9? Sorry?

8 A: I can't see what you're doing, Jess.

9 Q: Just beneath this disc; correct? This is kind of an
10 axial of this area?

11 A: It's actually just -- it's at -- at the other disk, right
12 where the spinal stenosis is pointing to. Yeah, that's T9-10.

13 Q: And I believe that you agree with me, Doctor, that Ms.
14 Goodwin suffered an injury in this case during her July 2016
15 surgery, and that that injury caused bowel incontinence,
16 bladder incontinence, and a loss of function in her lower
17 extremities; is that right?

18 A: I do.

19 Q: And you have given the opinion in this case that Ms.
20 Goodwin suffered a reperfusion injury and not an ischemic
21 injury or a spinal cord infarction; correct?

22 A: That's correct.

23 Q: And then you told me that it was not your opinion that
24 Ms. Goodwin had a stroke, and that you considered a stroke to
25 be synonymous with spinal cord infarction; correct?

1 A: Correct.

2 Q: And the difference being that an -- an ischemic injury or
3 an infarction occurs because of insufficient blood supply,
4 whereas a reperfusion injury occurs when the blood rushes
5 quickly to one area?

6 A: Correct.

7 Q: Okay. And you've talked a lot about the MRIs already,
8 Doctor, but one more terminology question that I just want to
9 clarify. When you talk about signal intensity or
10 hyperintensity, that's that bright white that you've been
11 pointing out to us; right?

12 A: Yes. Well, T2 hyperintensity is bright white in any
13 particular location. There are other things that can be
14 bright white, but when we were referring to T2 hyperintensity,
15 it's usually fluid or water. And so the answer to your
16 question is yes.

17 Q: Okay. And we're looking at T2 weighted images in this
18 case; correct?

19 A: For the most part.

20 Q: And the July 28th, 2016, injury is a T2 weighted image?

21 A: Yes. That -- well, there were a number of different
22 sequences in that study, but the ones I showed the jury were
23 T2 weighted.

24 Q: Okay. Thank you, Doctor. Thank you for that
25 clarification. That is what I meant.

1 A: Well, back to the first study that we looked at for some
2 reason didn't have any T2 weighted axial images. There was
3 just a T2 weighted sagittal image where I pointed out to the
4 jury that spot of high T2 signal in her spinal cord at T9-10.

5 Q: And your opinion today is really that that -- that MR
6 image, the July 28th, 2016, that was taken a few hours after
7 the injury that happened during the surgery in this case, that
8 that is the evidence of a reperfusion injury; correct?

9 A: Yes.

10 Q: It comes from that primarily. And you told me in looking
11 at that and you demonstrated it for us now that a spinal cord
12 infarction injury has a specific recognizable pattern or
13 character -- or has characteristics that, in the case of an
14 anterior spinal cord infarction, it's described as being long
15 or pencil-like on the sagittal image, which is that
16 lengthwise, up and down; correct?

17 A: Yes.

18 Q: And then it's owl's eyes on the axial image? That's the
19 slices?

20 A: That's correct.

21 Q: So if you saw owl's eyes, then you would be thinking
22 infarction; correct?

23 A: If I saw owl's eyes on the T2 weighted images at some
24 point beyond or in the late hyperacute state, I might think
25 that it was an ischemic thing.

1 Q: And you told me, contrary to that, that a reperfusion
2 injury is characterized by a sudden expansion of the cord
3 after reperfusion of a chronically ischemic area of the cord;
4 right?

5 A: That's correct.

6 Q: So you're going to have that high signal focal to that
7 area of reperfusion; right?

8 A: Yes. And swelling.

9 Q: Okay. And that tends to show up where the cord was
10 previously compressed or where we see on a preoperative MRI
11 that there was compression on the spinal cord?

12 A: Yes. And in this case, above and below as well.

13 Q: Okay. I asked you, Doctor, in your deposition if you had
14 any criticisms of the radiologist reading -- the radiologist
15 that -- that did the July 28th, 2016, post-surgical MRI
16 report, and you said that the finding he included in that
17 report -- and that's Exhibit 14. I'm happy to hand it to you
18 if you'd like to look at that.

19 A: Sure.

20 Q: You said that he used this phrase myelopathic changes?

21 A: Yes.

22 Q: Oh, you know what? I think I've got a copy right here.
23 And tell us what your criticism of that was, Doctor?

24 A: My main criticism was -- and it's -- you know, I'm not
25 feeling that this was evidence of a report that was below the

1 standard of care, but I think that myelopathic changes are a
2 little too general a term for the description of -- I'll wait
3 until I get your attention.

4 Q: Go ahead.

5 A: For the description of what was going on. So myelopathic
6 changes, it's a very general term. All it means is that
7 there's something going on in the spinal cord. It could be
8 chronic. It could be acute. It could be old. It could be
9 new. You know, it's just -- it's not helpful.

10 My main criticism of this report was that it didn't
11 really address the fact that there was a very dramatic,
12 emergent, or urgent finding, and it was kind of looked at out
13 of context with, as far as I could tell, everything else that
14 was going on. It didn't look like there was any attempt to
15 speak with the referring physician. It didn't look like there
16 were any comparisons made with prior studies. So that was my
17 main concern.

18 Q: And you told me, I believe, in your deposition, Doctor,
19 that you were concerned regarding what was included in the
20 history, the -- at the top there, and said that there was a
21 big difference on how to interpret a report when the history
22 says fall three days ago or bilateral leg weak -- and
23 bilateral leg weakness versus total paralysis after surgery;
24 correct?

25 A: That's correct.

1 Q: And, Doctor, did you realize that the -- the MRI order
2 that came in for this MRI indicated that the priority was
3 routine?

4 A: No, I did not.

5 Q: Now, in order to develop your opinions in this case,
6 Doctor, I think you told us that you ended up doing quite a
7 bit of research; is that true?

8 A: Sure.

9 Q: And based on the articles that you've reviewed, you
10 formed an opinion that disagreed with Dr. Mancuso, who has
11 already testified in this case and who is the chairman of the
12 Department of Radiology at the University of Florida School of
13 Medicine; is that right?

14 A: Yes.

15 Q: And some of what that research was on was case studies
16 that followed one patient; is that fair?

17 A: I think there was one case study that was one patient.
18 Most of them were small series of patients, observational
19 studies.

20 Q: Okay. And your conclusion from looking at those studies
21 was that a majority of spinal cord infarction injuries are not
22 seen on the first scan; right?

23 A: Yes.

24 Q: And you told me that it was common in reperfusion
25 injuries to see associated signal on preoperative MRIs where

1 the -- the later edema would be; correct?

2 A: Yes.

3 Q: And part of the reason that you decided that this was a
4 reperfusion injury is because you said that Ms. Goodwin had
5 chronic ischemia in her spinal cord prior to the July 26 --
6 2016 -- excuse me -- surgery; correct?

7 A: Yes.

8 Q: And when I asked you what MRI findings you relied on in
9 giving that opinion, you told me that her prior MRIs showed
10 cord compression at the T9-T10 level; correct?

11 A: Well, I showed -- the first MRI that we looked at, there
12 was no cord compression. That was the immediate post-
13 operative study at T9-10.

14 Q: The immediate post-operative study?

15 A: Well, it was -- it was a recent post-operative study, the
16 -- the study from -- I think it was June 2009. That study did
17 not show cord compression because there was a decompression
18 surgery that was still intact. And it wasn't until the
19 subsequent study, which was 2011, where she had redeveloped
20 some thickening and enlargement and probably some
21 calcification of ligamentous tissue or scar tissue or whatever
22 that was starting to compress the spinal cord.

23 Q: Okay. But you told me that in June of 2016, at the very
24 least, she had cord compression at the T9 or T9-10 level
25 because of that bone spur?

1 A: Yes.

2 Q: Now, just so that we're clear on this, by saying that she
3 had chronic ischemia, you are not saying that she had ischemia
4 that caused dead tissue, you're not saying that she had an
5 infarction, or you're not saying that that was something that
6 was causing significant neurological deficits prior to this
7 surgery; right?

8 A: I don't think that's accurate. So chronic ischemia can
9 certainly reduce blood supply. It can cause scar tissue, it
10 can kill nerve cells, and it can cause symptoms. As a
11 patient, based on Dr. Holbrook's testimony, she had
12 significant symptoms. So chronic ischemia can definitely
13 cause neurologic findings and pain.

14 Q: But in this case, Ms. Goodwin's last exam before she has
15 this surgery indicates that she ambulates satisfactorily and
16 has no gross focal motor deficits in her extremities; correct?

17 A: I don't know. I didn't see that.

18 Q: Plaintiffs' Exhibit Number 9, if you want to look at the
19 bottom of page 2, and this is part of the records that you
20 were provided, Doctor, according to the discovery response we
21 just looked at. I understand there are a lot of them, so I
22 don't blame you for looking at it again, but at the bottom of
23 page 2, it says she ambulates satisfactorily. There are --
24 there is no gross focal motor deficit in the lower
25 extremities; correct?

1 A: That's what it says.

2 Q: Okay. So any chronic ischemia that she had at this point
3 was not causing major neurological deficits; true?

4 A: Presumably. I don't know that everything is -- I mean, I
5 believe that I heard Dr. Holbrook testify that she had
6 significant symptoms just prior to the surgery. So I'm not
7 sure.

8 Q: This is Dr. Holbrook's record; right?

9 A: Yeah. I'm not sure how to interpret that, and it doesn't
10 necessarily mean that there's not chronic ischemic changes in
11 the --

12 Q: Sure.

13 A: -- spinal cord.

14 Q: I understand, but there was not a chronic ischemia that
15 was -- according to this record, that was causing significant
16 neurological deficits, and this is dated July 18th, 2016.

17 A: Well, so she had chronic ischemic changes in her spinal
18 cord because those don't go away. So those very rarely --
19 unless it's an acute injury, but the chronic changes that we
20 saw and we saw it on all the scans that we moved through,
21 those typically don't change. They can get worse, but they
22 don't get better.

23 So there can be chronic ischemic changes in the spinal
24 cord. There may be people in this room that have chronic
25 ischemic changes in their spinal cord and don't have

1 necessarily symptoms because they've accommodated or they've
2 gotten used to it or, you know, they may have had surgery to
3 decompress it, but the chronic ischemic changes are still
4 there.

5 Q: Okay. Can cause symptoms, doesn't always cause symptoms;
6 is that fair?

7 A: Sure.

8 Q: Okay. And you understand, Doctor, that the purpose of
9 this surgery was to -- to alleviate this issue; right? I
10 think you testified to that earlier. They wanted to remove
11 that bone spur in this surgery; correct?

12 A: Yes.

13 Q: Okay. So you have reviewed then the July 2016 MRI, and
14 based on that bright white signal shown on the MRI done on Ms.
15 Goodwin approximately four hours after the documented injury,
16 you determined that it is not an ischemic injury; correct?

17 A: Correct.

18 Q: And essentially, your belief is that if it was an
19 ischemic injury or an infarction, that that would not have
20 shown up so quickly; right?

21 A: Correct.

22 Q: You said that swelling after an infarction was rare?

23 A: In the immediate hyperacute timeframe, yes.

24 Q: And I think you also told me that you couldn't find
25 anything that said, well, we know we had an ischemic spinal

1 cord injury here and we saw it on the MRI within the first
2 four hours, and so you concluded that that most likely did not
3 happen here?

4 A: Could you repeat that question, please?

5 Q: Sure. So my understanding from your deposition testimony
6 is that you said, you know, I looked at a bunch of studies and
7 I wasn't able to find anything where they knew there was a
8 spinal cord infarction injury and they were also able to see
9 that injury within the first four hours. And since we're
10 about four-and-a-half hours post injury on this July 2016 MRI
11 and you've got that bright white intensity, I think that that
12 means this is not a spinal cord infarction?

13 A: The -- so we -- as we talked about in my direct
14 examination, we did find a case where there was bright T2
15 signal and swelling at three hours. At least that was what
16 was reported, but that was the patient that had probably been
17 under anesthesia for a prolonged period of time.

18 The main issue that I was trying to get to was that in
19 the majority of cases, the first MRI study -- and this is
20 borne out by all of the studies that I found, which was, as
21 far as I can tell, all the studies that are out there. I
22 didn't ignore any studies or fail to list any, as far as I can
23 tell.

24 It's very unusual. In the overwhelming majority of
25 cases, the first MRI study does not show T2 images or T2

1 hyperintensity and almost never shows swelling.

2 Q: Okay. Thank you, Doctor. I believe you also said on
3 direct examination that the possibility of a reperfusion
4 injury is a known thing to surgeons?

5 A: Yes.

6 Q: Did you read Dr. Holbrook's depositions from 2020 and
7 2021?

8 A: Yes.

9 Q: Did you see him suggest a reperfusion injury as even a
10 possible cause to what happened with Ms. Goodwin?

11 A: I don't recall that being in there.

12 Q: And you also told us earlier that cord compression, which
13 causes this chronic ischemia that you said was present in this
14 case, it's very common; right?

15 A: Yes.

16 Q: I think you told us that you see it all the time?

17 A: I see it all the time.

18 Q: But you told me in your deposition that you had never
19 seen a reperfusion injury; right?

20 A: Correct. At least never seen one that I knew about. So,
21 again, we often see -- in patients that have had spine
22 surgery, we usually don't see them right after surgery. It's
23 usually some point down the road they'll come back, and
24 they'll have an MRI scan. You know, most people or many
25 people at least that have spine surgery don't necessarily get

1 better. Everybody knows that back surgery is not -- it's not
2 a hundred percent cure for everybody. In fact, you know, if
3 you can avoid back surgery, it's probably a good idea.

4 But often patients will come back for another scan six
5 months, 12 months, 18 months later, and we'll see owl's eyes
6 or we'll see areas in the spinal cord that have atrophied,
7 have gotten smaller, and we'll see bright signal in the spinal
8 cord. That's not unusual to see.

9 You know, some reperfusion injuries can also be mild. So
10 not every reperfusion injury causes a severe, devastating
11 neurologic outcome like this. At least, I -- this is my
12 opinion. That there can be subtle reperfusion injuries that
13 can result in subtle damage to the spinal cord, and we can see
14 that on subsequent examinations.

15 So -- but since then, I have seen a definite reperfusion
16 injury in a patient who had an abscess related to a surgery
17 that was not discovered until approximately three months after
18 the surgery. The patient had some signs of a wound infection.
19 They gave the patient some antibiotics and sent him home. He
20 came back three months later with a big abscess.

21 So an abscess is an accumulation of fluid between or
22 inside the spinal canal, compressing the spinal cord. And in
23 this case, he was sent to the medical university, had surgery,
24 had all his hardware removed, and after the surgery he had big
25 bright signal. It wasn't immediately after, but he had some

1 weakness in his arm and some other symptoms after the surgery,
2 and there was an area of enlargement of the spinal cord
3 shortly after the operation.

4 Q: So in 22 years as a neuroradiologist and a decade or so
5 of experience in medicine before then, you had never seen a
6 reperfusion injury, and now in the last five months, you
7 believe you've seen two?

8 A: No, I've -- I believe I've seen one. And I believe that
9 a lot of times when I see signal abnormality in the spinal
10 cord in post-operative patients, it may be from a reperfusion
11 injury, but that's just my opinion. It's just kind of the way
12 I see the world.

13 Q: Okay. But you told me in your deposition that you had
14 never seen one before last --

15 A: I did.

16 Q: -- November; right?

17 A: Yes.

18 Q: And you also said that this type of injury is so
19 extraordinarily rare that surgeons don't even think about
20 them; isn't that right?

21 A: Yes.

22 Q: Okay. So you had -- had not seen one in 22 years as a
23 neuroradiologist. They're so extraordinarily rare that the
24 surgeons haven't even thought about them, even though chronic
25 ischemia is as common as it is, and Dr. Holbrook never had an

1 idea that this might be a reperfusion injury. But now, your
2 testimony today is that a reperfusion injury is a known
3 possibility to surgeons?

4 A: Did I say that?

5 Q: You just agreed with me on that a few minutes ago.

6 A: Well, I agree with you that it's a known possibility,
7 yes.

8 Q: Okay. You were in the courtroom all day yesterday;
9 correct, Doctor?

10 A: Yes.

11 Q: You had a chance to talk to defense counsel about what
12 their questions should be and what your testimony needs to be
13 in this case?

14 A: Yes.

15 Q: Okay. And were you even texting with defense counsel
16 during Mr. Goings' cross-examination of Dr. Holbrook
17 yesterday?

18 A: I don't recall whether I did or not. I don't think so.

19 Q: You're here today to tell this jury that we have Ms.
20 Goodwin, who we can all agree was injured during the course of
21 this surgery, who is completely incontinent of bowel,
22 completely incontinent of bladder, has very significant
23 neurological deficits in the lower extremities, suffers from
24 pain, muscle spasticity, and weakness in the lower
25 extremities, and that you just cannot fathom that an ischemic

1 injury of that severity would cause swelling that could be
2 seen on an MRI four hours after an injury; is that true?

3 A: So I have nothing but sympathy for Ms. Goodwin, and I --

4 Q: I appreciate that, Doctor. I ask that you answer my
5 question yes or no, and then I'll let you explain.

6 A: So I'm -- I'm here to tell the truth. I'm here to
7 evaluate the images and some of the clinical information and
8 apply known scientific reasoning and clinical studies, and
9 this is the outcome that seems overwhelmingly apparent. I
10 almost wish it wasn't so, but it is.

11 Q: Because the studies that you show that you found showed
12 that in most cases you can't see it in the hyperacute period?

13 A: That's part of the reasoning, yes. It's not all of it.

14 MS. GOODING: Thank you, Doctor.

15 THE WITNESS: That's part of it.

16 MS. GOODING: No further questions.

17 MR. DAVIS: Has he finished his response? I'm sorry, I
18 can't --

19 MS. GOODING: I'm sorry.

20 THE WITNESS: I think I did.

21 MR. DAVIS: Okay.

22 THE COURT: Any redirect?

23 MR. DAVIS: Very briefly, Your Honor.

24 REDIRECT EXAMINATION

25 BY MR. DAVIS:

1 Q: Reperfusion injury. Doctor, do you have an opinion
2 whether anybody really knows who's going to get this?

3 A: So my opinion is that you can look at an area that is
4 severely compressed where you see chronic signal changes in
5 the spinal cord. And even though it's rare -- and you have to
6 keep in mind, I'm not a surgeon, and you also have to keep in
7 mind that this is a very common surgical scenario where we're
8 looking at an area of the spinal cord, usually in the cervical
9 spine, that is compressed and there's signal abnormality in
10 the spinal cord.

11 But I think my opinion is that -- I mean, I am always
12 going to think about it every time I see it, and I'm probably
13 going to start mentioning it in my reports. And I've already
14 had conversations with the surgeons that I work with because
15 they've never seen it either, but, you know, are aware now
16 that there's a set of circumstances during which it can occur.

17 So I think it's incumbent as physicians that we think
18 about it. I mean, especially as radiologists, I mean, we
19 think of all the weird minutia that's out there in the world
20 that sometimes never happens, and you have to consider those
21 things because that's just part of our work.

22 Q: She asked you a lot of questions about what you said in
23 your deposition. Did you say in your deposition that you
24 can't really predict or prevent reperfusion injury?

25 A: Yes.

DR. DAVID GOLTRA - RECROSS BY MS. GOODING

1 MR. DAVIS: Nothing further. Thank you.

2 THE COURT: Anything further from this witness?

3 MS. GOODING: Briefly, Your Honor.

4 RECROSS-EXAMINATION

5 BY MS. GOODING:

6 Q: Doctor Goltra, do you agree with me that those owl eyes
7 indicate that there is a spinal cord infarction?

8 A: Yeah.

9 MR. DAVIS: Your Honor, I didn't ask anything about owl
10 eyes.

11 MS. GOODING: Your Honor, he asked about the -- the
12 cause, his opinion as to the cause of the injury based on the
13 MRI images.

14 THE COURT: Your objection is overruled.

15 MR. DAVIS: Okay. Thank you.

16 BY MS. GOODING:

17 A: Could you repeat the question?

18 Q: Do you agree with me that when you see owl eyes, that is
19 indicative of a spinal cord infarction?

20 A: It is consistent with the anterior spinal artery spinal
21 cord ischemic pattern, yes.

22 MS. GOODING: Thank you. No further questions.

23 THE COURT: All right. Thank you. You may step down.
24 Leave all those exhibits up there. Take what you came with,
25 but leave anything that you didn't bring.

1 MR. DAVIS: Your Honor, may we excuse Dr. Goltra?

2 THE COURT: Any objection?

3 MS. GOODING: No objection, Your Honor.

4 THE COURT: All right, sir. You are free to go.

5 MR. DAVIS: So we only have one other witness, and she's
6 not here right now. She'll be here right at lunch.

7 THE COURT: All right. It's about time for a lunch
8 break. So apparently Jimmy Johns could not accommodate us
9 today. So we were unable to place your sandwich orders, but
10 pizza has been ordered instead.

11 Ms. Gail is stepping out to determine whether it's here
12 and, if not, when it may be here.

13 Okay. So it'll be here in the next five minutes. So we
14 are going to take a lunch break until 2:30.

15 So, like Monday, you know, you can grab a slice of pizza
16 on a paper plate and go to your car if you want to. You can
17 sit in the jury room and eat it. You don't have to eat pizza
18 at all. If you want to run and grab something yourself and
19 come back, run errands, whatever you want to do, that's fine.
20 Just be back in your jury room at 2:30. And if you want to
21 wait for the pizza, like I said, it should be here in the next
22 five minutes or so.

23 (WHEREUPON, the jury exited the courtroom at 1:37 p.m.)

24 THE COURT: We'll be in recess until 2:30.

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

1 which the proceedings resumed as follows.)

2 THE COURT: Bring the jury, please.

3 THE BAILIFF: Yes, ma'am.

4 MR. HEITMAN: Your Honor?

5 THE COURT: Wait a minute, wait a minute.

6 MR. HEITMAN: Before we do that, we would like to move to

7 have our demonstrative exhibit submitted to evidence, and

8 these are just the charts that I showed you all earlier.

9 MR. GOINGS: Well, Your Honor, first of all, I think it's

10 proper to introduce exhibits through witnesses, not after the

11 fact. But for the good of the order, we will not object to

12 the charts, if there's any charts that he wants to --

13 THE COURT: Oh, hold on. That's fine.

14 MR. GOINGS: Okay.

15 MR. HEITMAN: Did you want to look at it?

16 THE COURT: Do you have an objection to part of it,

17 though, Mr. Goings?

18 MR. GOINGS: The -- these are charts that we talked about

19 earlier.

20 THE COURT: Okay. Is there more to it than that?

21 MR. HEITMAN: Yes, Your Honor. We would also like to

22 move to have this -- this is the chart that we showed to

23 Doctor Goltra when he testified. I believe there is no

24 objection to this.

25 THE COURT: So let me see the documents, the

1 objectionable one. Let's go ahead and bring the one to which
2 there is no objection. That will be Defendants' 5.

3 (WHEREUPON, Defendants' Exhibit Number 5, chart, was
4 admitted into evidence.)

5 (WHEREUPON, the jury entered the courtroom at 2:42 p.m.)

6 THE BAILIFF: And the jury is seated, Your Honor.

7 THE COURT: Thank you.

8 Sorry, folks. I jumped the gun in bringing you back in,
9 but I'll be with you in just a second.

10 MR. HEITMAN: No objection.

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

13 THE COURT: All right. So we've marked and admitted
14 Defendants' Exhibit 5 without objection, and we'll return to
15 the other documents later.

16 Welcome back from lunch. Hope you enjoyed the pizza,
17 even though it was Little Caesars. Nobody cleared that with
18 me. I wouldn't have chosen Little Caesars for that.

19 So I'm told we only have one more witness. So if this is
20 her, call your next witness so that we can get y'all out of
21 here for the day. As I said, we'll do closing arguments and
22 -- and the charge on the law and deliberation in the morning,
23 but let's get it going for the afternoon.

24 Mr. Davis, call your next witness.

25 MR. DAVIS: Your Honor, we'd like to call Dr. Root.

DR. JENNIFER ROOT - DIRECT BY MR. DAVIS

1 THE BAILIFF: Stand here. Put your left hand on the
2 Bible and raise your right to her.

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

7 THE WITNESS: Yes, ma'am.

8 THE CLERK: State your full name for the record, please.

9 THE WITNESS: Jennifer Root.

10 THE CLERK: You may have a seat.

11 THE WITNESS: Thank you.

12 THE BAILIFF: Ms. Root, if you would speak directly into
13 that microphone so everyone can hear you.

14 DR. JENNIFER ROOT, being first
15 duly sworn, testified as follows:

16 DIRECT EXAMINATION

17 BY MR. DAVIS:

18 Q: Let's -- let's give a check on that microphone, please.
19 Would you state your name, please?

20 A: Jennifer Root.

21 Q: Good. Okay. Thank you. Doctor, would you give the jury
22 just a bit of a thumbnail sketch of your education, your
23 training, and experience as a medical doctor?

24 A: Sure. I attended the University of Alabama School of
25 Medicine back in the late '80s, early '90s. I ended up at

DR. JENNIFER ROOT - DIRECT BY MR. DAVIS

1 Duke University to do my anesthesia residency from '93 to '97.
2 After residency, I ended up working in Orangeburg, coming to
3 South Carolina, until 2000 when I made the move to Columbia,
4 and I've been working in the Columbia area for the last 23
5 years.

6 Q: Being board certified?

7 A: Yes, sir.

8 Q: In anesthesia?

9 A: Yes, sir.

10 Q: Did you have to take an examination to become board
11 certified?

12 A: You have to take -- it's two parts in anesthesia. You
13 have to sit for a written exam, and then a year later, you
14 have to go through oral examination.

15 Q: And did you pass those exams the first time?

16 A: I passed the written exam the first time. It took me the
17 second time to pass my orals.

18 Q: And then you became board certified?

19 A: Yes.

20 Q: You can still practice if you're not board certified?

21 A: That is correct.

22 Q: All right. Dr. Root, do you have any independent
23 recollection of Crystal Goodwin from back in 2016?

24 A: I do not.

25 Q: Did you generate medical records for Crystal Goodwin on

1 July 28th, 2016?

2 A: Yes, sir, I did.

3 Q: What sort of medical records did you generate?

4 A: I would have generated my pre-anesthesia assessment.

5 It's your pre-anesthesia history and physical, and then I

6 would have generated the anesthesia record, which would have

7 been the record of the anesthetic that was given that day.

8 Q: Okay. Who is Erich Starn?

9 A: He is a certified registered nurse anesthetist that I

10 worked with that day at Baptist.

11 Q: Try to pull that microphone just a little bit closer to

12 you.

13 A: Okay.

14 Q: The court reporter needs to be sure that she understands

15 what you're saying. We can hear you, but she needs to

16 understand, too. Okay?

17 A: Okay.

18 Q: Thank you. Explain the role of a CRNA like Eric Starn

19 and your role as an M.D. anesthesia in an operation like Ms.

20 Goodwin had on July 28th, 2016.

21 A: Sure.

22 Q: How does that work?

23 A: So the role of the anesthesiologist is we're the ones who

24 actually evaluate the patient, number one, to make sure you're

25 ready to actually have the surgery, if there's nothing else

1 that needs to happen before we take you to the operating room.
2 We go over all your medications, your allergies, your past
3 medical history, concurrent diseases, just to make sure
4 everything looks good.

5 Then we're the ones that prescribe the anesthetic so that
6 if you have certain conditions, we might choose one drug over
7 another or one method of anesthesia over another. And so we
8 sort of prescribe the anesthetic, and then we work in a team
9 model with a nurse anesthetist who's the one that stays in the
10 room at all times during the procedure.

11 I am present when you're put off to sleep, I'm present
12 when you wake up, and then I come in intermittently during the
13 case to check how things are going. And if at any time
14 there's an issue or a concern, then I come into the room and I
15 address that issue with my nurse anesthetist.

16 Q: Very good. So it's not required that you be in the
17 operating room the entire time?

18 A: No, sir.

19 Q: All right. Let's look at -- if we can pull them up here
20 -- your pre-anesthesia assessment that you did on that
21 morning. Let's make it a little larger so we can maybe see
22 it. Can you see that okay?

23 A: Yes, sir.

24 Q: All right. Explain to the jury -- this is in evidence,
25 these documents. There you go. Thank you. Is this your

1 handwriting?

2 A: Yes, sir.

3 Q: Go through that with us and explain what you're doing and
4 what you're recording and -- and the process of doing a pre-
5 anesthesia evaluation the day of surgery?

6 A: Sure. So the first thing that I do when I arrive at the
7 -- at the patient's -- it's not really the bedside. We have
8 -- I have a little room, and outside the room is where the
9 records are. And the first thing I do is I go through all the
10 records, and I transcribe from the records important personal
11 things. Like, I put their vital signs, height, weight, make
12 sure they've got -- you know, if they've got allergies to
13 medications or not. At the very top, it'll tell you what kind
14 of procedure that was performed.

15 We go through each system to -- to check yes or no,
16 whether they've got any issues with that. As you can see
17 here, I circled high blood pressure. that she had had prior
18 back surgeries. I circled diabetes because she had reported
19 having prediabetes, and so diabetes is a spectrum. I just
20 consider it all diabetes. I don't document the severity or
21 anything. I just circle diabetes.

22 I come down. I do an airway exam just to check. We
23 place a breathing tube with a lot of procedures, and we like
24 to make sure that the -- there won't be any difficulty in
25 placing that breathing tube. And so I do an airway exam to

1 report whether there's any loose teeth or anything we need to
2 be cautious of when we place the breathing tube. I like to
3 make sure that the neck moves, because we have to extend the
4 head slightly in order to place the breathing tube. I also
5 probably filled in the medications just off the chart, and
6 then I filled in the laboratory work.

7 At that point, then I go into the room and have a
8 discussion one on one, and if she gives me any further
9 information that I need to add to that, then I'll add that. I
10 added there the airway exam when I did that off to the side.
11 Our forms didn't have a place for me to write my lung exam or
12 my cardiac exam, so we usually would just write it off to the
13 side.

14 Q: Is that this exam up here?

15 A: Yes. Uh-huh. Yep.

16 Q: CV? What's that stand for?

17 A: That means cardiovascular. Her heart was regular rate
18 and rhythm. I checked her lungs. There was no -- that means
19 no murmurs, rubs, or gallops. It's just a -- her cardiac exam
20 was perfectly normal. Her lungs were clear. And that's part
21 of the things that we document.

22 Q: All right.

23 A: And then as I began to speak with her, I asked her about
24 her -- the previous problems from anesthesia. She denied
25 having had prior issues with anesthesia medications. And then

1 she reported to me that while she was still taking the
2 metformin and the hydrochlorothiazide, she had stopped taking
3 the lisinopril, and that's why I wrote stop taking off to the
4 side.

5 Q: That's something that she would have related to you?

6 A: Correct. I would have asked her.

7 A: Okay.

8 A: And she would.

9 Q: Okay. This HCTZ, is that a blood pressure medicine?

10 A: It is.

11 Q: Or a medicine taken for blood pressure?

12 A: It's taken for a couple of reasons. It's a diuretic.

13 People call it a water pill, and we take it for blood pressure
14 or if you have problems with your legs swelling. That's
15 usually the two reasons.

16 Q: Okay. And pain score, what's -- what's that?

17 A: Right. So that was also something that when they check
18 in with the nurse, they ask what their pain is on a scale of 1
19 to 10, and she reported a pain scale of 4 out of 10 that
20 morning.

21 Q: What is SFB -- B -- SFBS, if I'm reading it correctly?

22 A: The fingerstick blood sugar, which is her blood glucose
23 the morning of surgery, and that's an absolutely normal
24 fasting sugar.

25 Q: Okay. What are these -- what are all these things down

1 here?

2 A: Sure. So those are her labs, the ones on the left. So
3 her hemoglobin was 12. Her hematocrit was 36. Her platelets
4 were 335,000. All of those are completely normal. Her
5 potassium was 3.7, which we like to look at because when
6 you're on a diuretic, you can lose potassium. Her potassium
7 was normal. Her creatinine of 0.7 indicated that she had
8 absolutely normal renal function. That's the --

9 Q: Kidneys?

10 A: Yes. Kidney function is --

11 Q: All right.

12 A: -- very good, 0.9. And then, again, you can see off to
13 the side the blood sugar of 91.

14 Q: Blood sugar of 91?

15 A: Yes.

16 Q: Which is also --

17 A: Right.

18 Q: -- good? Okay. And basic consent to plan of -- what
19 does that mean?

20 A: Yes. So -- so the first line it says ASA physical status
21 we use in anesthesia to try to determine the degree of
22 conditions that somebody has. For example, if you're an 18-
23 year-old person and you don't take any meds and you've never
24 had a problem in your life, you're what we call an ASA-1.
25 Right? And I've taken care of 60-year-old ASA-1s before who

1 were healthy and didn't take any medicines. Right? That one
2 just means kind of what kind of physical condition you're in.

3 As you start doing -- like, if you're a smoker, that
4 makes you an automatic 2. If you take medications for blood
5 pressure or you have mild diabetes, you move up to a 2. As
6 you start having more and more illness or chronic conditions,
7 it moves you up to a 3. ASA-4 means that you're -- you have
8 such severe conditions that you're in constant threat of life.
9 That would be somebody with a very bad heart that might have
10 had an implanted defibrillator or something that where they
11 are at risk of death. And then ASA-5 is what we consider our
12 organ donation patients. It means they have their own
13 category.

14 Q: And why did you rate her a 2?

15 A: She had very mild diabetes. She was on a single
16 medication with a normal fasting blood sugar, which is great,
17 and she was on single therapy for blood pressure.

18 Q: Okay. So underneath -- we'll take that down. Underneath
19 here, risk, benefits, and alternatives discussed with patient.
20 What -- what do you -- what are you doing there typically?

21 A: We -- so they typically have a consent form that goes
22 into all the gory details, so to speak, of all the bad things
23 that can happen. What I try to do is come in and discuss the
24 most likely issues. I usually talk about the possibility that
25 while we're putting in the breathing tube, we could injure

1 your teeth because we're going to put a piece of metal in your
2 mouth. I talk about the possibility of having a sore throat
3 afterwards. I talk about the possibility of having adverse
4 drug reactions from the -- you know, having allergic reactions
5 if you get a drug that you've never had before and we didn't
6 know you were allergic.

7 Those tend to be the top three things that I discuss with
8 patients. If I feel like there's additional risk that comes
9 from the anesthetic, like maybe it's somebody with a bad heart
10 --

11 Q: Uh-huh.

12 A: -- then I'll sit down and go over that risk with them
13 specifically. But -- but usually the morning of surgery, it's
14 very hard to have a conversation when you're about to take
15 somebody to an operating room in about an hour because they're
16 nervous and they're not often hearing. The main goal when I
17 sit down and have the risk, benefit, and discussion is really
18 more for them to ask questions of me so that I can make sure
19 that they understand what's about to happen and make sure they
20 don't have any further questions.

21 Q: Okay. The thing on the bottom left is that BMG 91. What
22 is that?

23 A: That actually is not my handwriting.

24 Q: Okay.

25 A: I believe the -- the pre-op nurse --

1 Q: What is -- do you know what that means?

2 A: Yeah. That's the glucose again.

3 Q: So --

4 A: So when she was at the bedside sticking the finger, she
5 just kind of hand wrote that at the corner. They just want to
6 make sure that we saw it. I usually look at their paperwork,
7 but she -- you know, sometimes they'll write it on ours.

8 Q: Okay. Is that the only page that the pre-anesthesia
9 sheet preserves?

10 A: Yes. Nope. It's a single page, pretty direct and to the
11 point.

12 Q: How long does that typically take to go through that with
13 a patient to gather that information, talk to them, and make a
14 note?

15 A: Variable. If you're a nice healthy patient and you don't
16 have a lot of questions and it's a fairly simple,
17 straightforward procedure, you know, sometimes just 5 minutes,
18 more of like an introduction so you can know who the person is
19 putting you to sleep, since that's usually the first time you
20 talk to them or met them.

21 The more medical conditions you may have that we need to
22 discuss risk or issues, the longer the conversation gets. The
23 patient has a lot of questions. Obviously, that can also lead
24 -- but a healthy patient, 5 minutes. Somebody a little more
25 complex, 15 to 20, depending on what we need to talk about.

1 Q: Okay. When you completed this document, did you sign it?

2 A: Yes.

3 Q: And at the bottom?

4 A: Yes.

5 Q: Is that -- is that your signature down there?

6 A: Yes, sir.

7 Q: What is GA? What does that stand for?

8 A: That's plans for general anesthetic.

9 Q: Explain to the jury, as an anesthesiologist, what is
10 general anesthetic? What is that?

11 A: Well, it's basically when we tell you we're going to put
12 you to sleep because we try to use words that people
13 understand, although I try not to use that with little
14 children, because then they get terrified at home because they
15 are worried about that.

16 But what that basically means is general anesthetic is
17 where we induce a chemical coma, so to speak, is we actually
18 use medications to put you -- to render you unconscious. We
19 put a breathing tube in, usually to help maintain your airway,
20 because the anesthesia drugs can interfere with your ability
21 to -- to breathe effectively. And we are giving you
22 anesthesia gases, which keep you asleep and unable to respond
23 to the surgery.

24 We don't all the time -- we don't all the time give
25 paralytic medications that paralyze you, only if it's needed

1 for the surgery. Sometimes, if they're doing things in the
2 abdomen, they need the muscles so relaxed so that they can get
3 into the abdomen, and we have to give drugs to them to help
4 cause muscle relaxation.

5 We give -- go ahead and we give pain medication because
6 even though you don't know that you're having pain, the body
7 will respond to pain. So we -- we work in pain medications.
8 We work in anti-nausea medications and other things that we
9 want to go ahead and get in your system to help with the
10 recovery period.

11 At the end of the procedure, we turn off the gas, we wake
12 the patient up, we get them through that period where we can
13 remove the breathing tube and have them breathing on their
14 own, and then we take them to the recovery area, and then
15 you're out of the general anesthetic. Does that answer your
16 question?

17 Q: Yes, ma'am.

18 A: Okay.

19 Q: Have you reviewed the anesthesia record in this case?

20 A: Yes, I have.

21 Q: I think it's two pages?

22 A: Yes, sir.

23 MR. DAVIS: Go to the first page.

24 BY MR. DAVIS:

25 Q: Is that the first page or is that the second?

1 A: That's the second.

2 MR. DAVIS: That's the second page. There we go. That's
3 the -- there you go. Thank you.

4 BY MR. DAVIS:

5 Q: Can you see that okay? And I can put the record in your
6 hand, but --

7 A: Yeah, I can see that, and it's very busy.

8 Q: It is. Tell us about that?

9 A: So at the top is usually the information. We make sure
10 that the surgeon is identified, the anesthesiologist. You can
11 see Erich's signature up there as well. He's identified as
12 the nurse of record. We put the diagnosis. He should have
13 written the procedure in, but he forgot to, the decompression
14 of the T9 to 12. Up at the top is just a reiteration of the
15 fact that she was an ASA-2, and that we were doing a general.

16 Our anesthesia records try to tell a little bit of a
17 story. So a lot of the stuff off to the right is just
18 documenting everything that was done. We have all the
19 monitors that we used were checked off. The -- when we place
20 the breathing tube, you can see under airway maintenance, we
21 used a 7.0 breathing tube. He wrote down the kind of blade
22 that he used, the little metal instrument that I mentioned.
23 He writes down that.

24 And a lot of that is not so helpful for that case, but
25 often if somebody comes behind us and said, oh, you put the

1 breathing tube in, you know, what did you use? You know, so
2 then you can look at it and say, oh, they used this last time.
3 That looks like that was prepped.

4 We write that we've secured the tube, that the -- at the
5 very bottom it says tube composition confirm and it says BS
6 equal B. That means your breath sounds are equal and
7 bilateral and that --

8 Q: Does that mean both lungs?

9 A: Yes.

10 Q: Okay.

11 A: And that the ET CO2 basically means that carbon dioxide
12 came out of the tube, which is what you would expect, and
13 you're just saying, yep, you're in the right place.

14 Q: Is that monitored with a -- with an end tidal CO2
15 monitoring?

16 A: Correct. Uh-huh.

17 Q: How does that work?

18 A: So it is a monitor that basically uses light
19 spectrophotometry, and --

20 Q: And what's that?

21 A: It's when you -- when you shine a certain wavelength of
22 light through different gases, some of it is absorbed before
23 it hits the receptor on the other side. Okay? And so when
24 carbon dioxide is detected by this machine, it'll come up and
25 tell us that not only was it detected, but it gives a number.

1 So generally speaking, if you're walking around and you
2 don't have lung disease, your entitled carbon dioxide
3 measurement would be 40. That's a standard kind of -- if I
4 walked up with a little thing and you breathed into it, it
5 would be 40. So that's -- when we place the breathing tube,
6 we like to -- we like to see that it's there, and we like to
7 see kind of where the patient is, because a lot of things can
8 change that number.

9 Q: Uh-huh.

10 A: Yeah.

11 Q: Just kidding. The monitors block. I want to ask you
12 about -- I think that this is -- these are the things that you
13 -- if you're flying the plane in the operating room or Erich,
14 if he's flying the plane, if I could use that very rough
15 analogy, these are the things that you as an anesthesiologist
16 or CRNA are looking at?

17 A: Correct.

18 Q: Okay. What -- EKG?

19 A: Right.

20 Q: I think we all know what that is?

21 A: Right. EKG. It monitors the heart rhythm and the heart
22 rate. We have a blood pressure cuff on to measure the blood
23 pressure.

24 Q: Where is that typically put?

25 A: He -- it looks like he did not circle right or left, but

1 it was placed on an arm.

2 Q: All right.

3 A: You can put the blood pressure cuff in a lot of different
4 places. We just like to designate where it was.

5 Q: All right. So it's on the -- it's on the arm?

6 A: Correct.

7 Q: Okay.

8 A: A pulse oximeter is a monitor that measures several
9 things as well. It can -- it directly measures the oxygen in
10 your bloodstream. It also gives you a heart rate, kind of
11 like the EKG does, because it's picking up on each heartbeat.
12 So it can give us a number.

13 And it also gives us a waveform so that when the blood
14 pressure or the blood flow is good, you see a nice waveform.
15 And when the blood flow or blood pressure goes down, it gives
16 you a very small waveform. Right? So it also picks up on the
17 amount of blood that's coming to that finger.

18 Q: Okay. ET CO2. Is that the entitled CO2 we talked about?

19 A: Correct.

20 Q: Temp SCR. What's that?

21 A: So we like to monitor temperature in the operating room.
22 One of the sites --

23 Q: Why is that?

24 A: One of the side effects of being put under a general
25 anaesthetic, your body cannot maintain your normal body

1 temperature anymore. We've actually put to sleep that part of
2 your brain that regulates temperature. So you become more
3 susceptible to, like, getting cold in the operating room,
4 because normally, if you were getting cold, you would shiver
5 or your brain would increase some metabolic rate to maintain
6 temperature. Well, you can't do that.

7 So we like to watch the temperature so that if you're
8 getting cold, we can put things on that would add heat back to
9 you. It's very important because a lot of bad things can
10 happen if you get cold.

11 Q: Okay. Oxygen, O2. So that's for oxygen analyzer. What
12 is that?

13 A: That's -- the O2 analyzer is actually something that is
14 built into the anesthesia ventilator machine.

15 Q: Uh-huh.

16 A: And it's more of just a safety feature so you can know
17 for sure how much oxygen you're giving the patient.

18 Q: Okay.

19 A: It's not a monitor on the patient. It's a monitor on our
20 machine.

21 Q: Measuring the amount of oxygen that goes into the
22 patient?

23 A: Correct.

24 Q: Okay. And PNF discon alarm. What's that?

25 A: That's also an anesthesia machine alarm. So that if it

1 -- there's a disconnect alarm. So if anything happened, like,
2 if the tube -- there's a lot of tubing involved and there's a
3 lot of different places where it could disconnect. It'll just
4 alert you if there's a disconnect, and it's just a basic
5 monitor.

6 Q: All right. How about PNS?

7 A: So PNS stands for peripheral nerve stimulator.

8 Q: What is that?

9 A: So as I mentioned, sometimes we give the para -- the
10 paralytic drugs, the drugs to help cause muscle relaxation.
11 We'll actually apply a monitor either at the wrist or on the
12 face, and it's called a peripheral nerve stimulator. And so
13 we normally hook it up. If I haven't given any paralysis, the
14 machine is set to give four twitches. So it'll go 1-2-3-4.
15 And then if I give a drug that paralyzes you, my goal is so
16 that when I click the monitor, I get no twitches.

17 Q: Uh-huh.

18 A: Right? That means that I've got good relaxation for the
19 surgical procedure. As the medication is wearing off, I can
20 watch. I'll test every 15 or 20 minutes, and first you'll
21 just see one twitch in response to the four signaling, and
22 then you'll see two twitches, and then you'll see three and
23 then four. And that lets you know where the patient is coming
24 back from the drug that's been given. So, yes, we had one of
25 those on as well.

1 Q: A train of four? Is that what you're talking about?

2 A: Correct.

3 Q: Four twitches? All right. Is that a yes?

4 A: Yes, sir. Sorry.

5 Q: That's all right. Foley? Foley catheter?

6 A: Foley catheter was placed. The eye care, we place tape
7 over people's eyes as well.

8 Q: Why do you do that?

9 A: Not everybody's eyes close completely. And so you're not
10 going to be blinking or creating tears or anything to help
11 keep the eyes moist. So we actually place tape across the
12 eyes, holding the eyelid down to protect the eye.

13 Q: Do you recall the position? There's been some testimony
14 about this position being prone and not supine. Can you
15 explain those two things?

16 A: Yeah. So prone position, obviously any time you're
17 working on the backside of the body, we have to lay you face
18 down so that the surgeon can get to the back. There's a
19 couple of things that we do very carefully.

20 We have a special pillow that the face sits in that has a
21 hole cut out so that the -- there's no pressure on the eyes or
22 the nose or the mouth or the breathing tube. We have special
23 padding that goes under the shoulders, under the hips and
24 knees, to keep -- you don't want the body completely flat
25 against the bed, because then it's hard to -- you know, it's

1 hard to breathe. There's too much pressure on the belly and
2 the chest, and it's hard to breathe in the prone position. So
3 we have special pads and all that to -- to correct the
4 position.

5 Q: There's been a lot of discussion in this trial, just to
6 let you know, about what a baseline blood pressure is. I want
7 to ask you. What is your understanding as an
8 anesthesiologist? What is a baseline blood pressure?

9 A: So a baseline blood pressure is a patient's where they
10 live normal blood pressure.

11 Q: How do you determine that?

12 A: Well, it's very difficult to do so because a single point
13 of time blood pressure cannot give you a baseline. Usually
14 when you go into your primary care doctor and they see a
15 couple of high blood pressures when you've shown up to see
16 them, that will raise their suspicion that you may have a
17 blood pressure issue.

18 Q: Uh-huh.

19 A: But the problem is, is anywhere in studies that have
20 looked at this, anywhere from 5 percent to 65 percent of
21 people who show up with high blood pressure in their doctor's
22 office don't actually have high blood pressure. So the way to
23 correctly diagnose high blood pressure is you have the patient
24 get a blood pressure cuff and take it home, and you have them
25 keep a journal. You ask them to take their blood pressure

1 twice a day for about two weeks and write it down and then
2 bring it back.

3 And once you look at kind of what's happening in their --
4 you know, at their home when they're not at the doctor's
5 office, you can actually get a better determination of whether
6 they have hypertension or not. So how do you determine a
7 baseline blood pressure?

8 Q: How do you determine baseline blood pressure?

9 A: Well, I -- I usually can't because I don't have the
10 luxury of -- of having that log that a patient has made. We
11 try to look at any blood pressures that are previous to help
12 determine that, but the problem is blood pressure goes up and
13 down all the time.

14 If you're just sitting with your feet up, your blood
15 pressure is going to be lower. If you're upset or angry about
16 something, it's going to go higher. If you're nervous or
17 anxious, if you're in pain, these make the numbers go higher.
18 So it's really hard to just say, well, there's this random
19 blood pressure, you know, and it's elevated. They must live
20 here. That's not really true because everyone goes up and
21 down all day long depending on the circumstances.

22 Q: As an anesthesiologist, is it required of you to make
23 some determination of a patient's baseline blood pressure
24 before doing general anesthesia?

25 A: We do our best to make that determination, but we often

1 don't have that information present. We look through the
2 records that we have available at the morning of surgery, but
3 usually the way I've been trained is we maintain blood
4 pressures a systolic above 100 and a mean above 70, and that's
5 kind of been the area where we work to keep everybody, unless
6 we know that there's a specific reason to do it differently.

7 And we've gone that route because it is so hard to
8 determine a baseline blood pressure in a patient, nearly
9 impossible. So what we do is we've looked at studies and
10 found the blood pressures that correlate with the best
11 outcomes during surgery, and there's been a lot of data in the
12 last ten years that says that if you keep mean blood pressure
13 between 70 and 100 during surgery, that's where patients do
14 the best.

15 When the -- matter of fact, there's a guy out of
16 Cleveland Clinic that says we should be keeping blood
17 pressures between 65 and 85. He has data that shows blood
18 pressures below 65 mean, you have a high incidence of
19 problems, and that if your blood pressure starts going up from
20 85, then you start getting into other issues, such as bleeding
21 and swelling and edema. Right? So there's kind of a sweet
22 spot is what the -- what's been reported in our literature,
23 and everyone's aiming for 70 to 100 as kind of a general rule.

24 Q: Okay. I'm going to exit this and come back to it. Thank
25 you. I want you to assume, for the sake of my question, that

1 this is a graph indicating the calculated mean arterial
2 pressures in blue by Erich Starn for the surgery that we're
3 talking about today.

4 A: Uh-huh.

5 Q: From the beginning all the way to the end. We've got
6 this green box, and we labeled this ideal MAP range 70 to 100.
7 Is that what you were talking about?

8 A: Correct.

9 Q: All right. I want you to assume, just for the sake of
10 the question, that the neuromonitoring tech at 9:56:18
11 testified that she saw the blood pressure monitor registering
12 103 over 64. I'll ask you to assume that's a MAP of 77, and
13 that it would have happened sometime right about in here.

14 A: Yeah. I was very confused when I saw that on the
15 monitoring record.

16 Q: Yeah.

17 A: Because that was not the blood pressures that we reported
18 at that time.

19 Q: I see.

20 A: And where the monitoring person sits in the room is not
21 right next to where we are. They're across the room. So I'm
22 not convinced that that blood pressure that she documented on
23 her paperwork is actually correct because sometimes it's hard
24 to see our monitors on angle.

25 Q: Sure.

1 A: They're digital.

2 Q: These are the -- this is the official anesthesia MAP
3 record; correct?

4 A: Correct.

5 Q: All right.

6 MR. DAVIS: Go to the anesthesia record. Thank you.

7 BY MR. DAVIS:

8 Q: If -- if you can't determine a patient's baseline blood
9 pressure for whatever reason, do you use a guideline of the 70
10 to 100?

11 A: I do. And I'd like to explain that a little bit further.

12 Q: Sure.

13 A: So a lot of the current literature is now, like I said,
14 very clear that this is the range where we should be keeping
15 patients.

16 MR. HINSON: Objection, Your Honor. She hasn't
17 identified what literature she's talking about. We haven't
18 been provided this literature. Matter of fact, she hasn't
19 even been qualified as an expert. But just general
20 discussions about literature without citing specific articles
21 that the foundation has been laid, I would object.

22 THE COURT: The objection is sustained.

23 MR. DAVIS: Okay.

24 BY MR. DAVIS:

25 Q: Just don't talk about articles. Talk about your

1 experience. I can't remember what we were talking about.

2 A: Baseline blood pressure.

3 Q: Yeah. Baseline blood pressure. So go ahead.

4 A: Yes. So it's been my experience for 27 years, and these
5 are the -- this is how I've managed blood pressure my entire
6 career is I have maintained patient's blood pressure as a mean
7 higher than 70 and a systolic above 100. And that was what I
8 was taught and the way I practiced for thousands of patients.

9 Q: Well, Dr. Root, it begs a question. You have a patient
10 that comes in and on your pre-anesthesia record, she's got 160
11 over 92 or whatever it was. Don't you have to treat those
12 people a little different?

13 A: No.

14 Q: Why? Why not?

15 A: Because under anesthesia, everyone's blood pressure does
16 run lower. It's a side effect of the medication that we're
17 giving.

18 Q: I see.

19 A: But blood pressure and blood flow are not the same thing.

20 Q: Unpack that for us.

21 A: Okay. So blood pressure is simply a mathematical
22 measurement, and it is the force of the blood coming out of
23 the heart forward against the resistance of the arteries that
24 it's meeting. Okay? And so I can raise the blood pressure by
25 giving a drug that would squeeze the arteries down, that would

1 raise the resistance of the flow. Right? And it would shoot
2 the pressure up. It's like squeezing the hose when you're in
3 the garden. Right? But actually, it would reduce the blood
4 flow because you've squeezed the arteries down. Okay?

5 So you have a high blood pressure, but you've dropped the
6 blood flow. So blood flow and blood pressure are not the same
7 thing. Blood flow can affect the pressure. I can have a
8 heart that's failing. Right? That's not pumping blood very
9 well, but if that resistance -- if they're squeezed down, I
10 can get an artificially normal blood pressure, and they'd have
11 terrible blood flow.

12 So these numbers cannot be interchangeably used. Blood
13 pressure and blood flow are two separate things. They
14 influence one another, but they're separate.

15 Q: Okay. Let me ask you this. Hypothetically, if during a
16 surgery -- I hope this never has or will happen to you as an
17 anesthesiologist, but the blood pressure cuff just stops
18 working. Is there a way that you can determine the adequacy
19 of blood flow from other monitoring systems?

20 A: Absolutely. So all of our monitors actually kind of
21 cross cover. As I alluded to earlier, I have an EKG monitor
22 that measures the heart rate, but my pulse oximeter also
23 measures the heart rate.

24 And I have a CO2 monitor that measures the amount of
25 carbon dioxide coming out of the lungs. And when you have

1 conditions where the blood flow falls, the carbon dioxide
2 actually falls because carbon dioxide is produced when you get
3 oxygen. So your body takes in oxygen and makes carbon
4 dioxide. So if the blood flow drops, your carbon dioxide
5 drops because it's not getting the oxygen. So that monitor
6 could tell us that blood flow has dropped.

7 The pulse oximeter is also a good blood flow monitor in
8 some respects for two reasons. If blood flow goes down, then
9 your oxygenation in your finger can actually fall because
10 there's less blood traveling through your lungs picking up the
11 oxygen.

12 So sometimes one of my biggest first indicators that I
13 have a blood flow going down is my oxygen level is like at 98
14 percent, might drop to 95 percent, drop abruptly, and that
15 tells me, oh, something's affecting that. It's probably the
16 flow through the lungs. It's sort of an early indicator of
17 blood flow.

18 The other thing that it tells me is if I have good blood
19 flow all the way down to a fingertip, then my -- my pulse
20 oximeter wave is nice and pretty, nice and pretty. If my
21 blood flow drops, that pretty up and down waveform will
22 actually go like this. [*Indicating.*] Right? So even if my
23 blood pressure cuff stopped working, I have four other places
24 I can look to tell me that there's adequate blood flow.

25 Q: Looking at this chart that we prepared, I want you to

1 assume that these numbers were gleaned from the anesthesia
2 record itself. The end tidal CO2. Can you tell me whether
3 these are normal or abnormal?

4 A: Yes. So at the start of the case, generally what you'll
5 see is a drop. You'll see a drop in blood flow because as I
6 mentioned before, when you first put somebody to sleep, their
7 -- their arteries will dilate up. Right? So almost over the
8 course of a few minutes, if you have a three-gallon system
9 that has three gallons of fluid in it and you give a
10 vasodilator, so now I have a four-gallon system with three
11 liters of fluid in it. You have that immediate drop -- right?
12 -- in blood pressure and in blood flow.

13 And that's one of the reasons the first thing we do when
14 we put people to sleep is we actually open up our IV fluids,
15 and we give a liter pretty quickly in the first hour of the
16 case to make up for that difference, but what you'll see is
17 you'll notice that her blood -- her CO2 actually dropped.
18 Right?

19 Q: Right here?

20 A: Yep. But then it came right back up as -- as everything
21 stabilized?

22 Q: Okay. And it didn't -- didn't really change abruptly at
23 any time during the case.

24 Q: Okay.

25 A: Toward the end of the case, one of the things that

1 narcotics will do is it causes you to -- your brain to become
2 insensitive to the carbon dioxide levels. You know, when
3 people die of overdoses, they stop breathing. Right? So we
4 give narcotics during the anesthesia, and at the end of the
5 cases, we're trying to wake people up.

6 You can see her first carbon dioxide there was 40, which
7 was normal, but we had given her narcotics to help with pain
8 management for after surgery. So that's going to make your
9 CO2 go up. Right? So she was probably breathing there at the
10 very end. Right? But she was off of our ventilator, and
11 those numbers are her breathing on her own with a higher CO2,
12 which was predictable because of the narcotics on board.

13 Q: Okay. And the oxygen saturation. You spoke of these
14 numbers. Are they normal?

15 A: Stone cold. Yes.

16 Q: Stone cold normal? And I want you to look particularly
17 at this time that we've highlighted in yellow from 9:15 to
18 10:15. Okay? That hour. Are any of those numbers from the
19 entitled CO2 or the oxygen saturation abnormally low?

20 A: No, sir.

21 Q: What do those numbers tell you between that 9:15 and
22 10:15 about the blood flow?

23 A: It tells me it was very adequate to perfuse every organ
24 in our body.

25 Q: So after your initial assessment that you've discussed

1 with us, prior to surgery, before she goes to the hospital
2 room, did you have any concerns about Ms. Goodwin relative to
3 the anesthesia plan or anesthesia?

4 A: I'm sorry. After what? Can you repeat?

5 Q: After your pre-anesthesia evaluation --

6 A: Okay.

7 Q: -- prior to surgery.

8 A: So you're asking me what my main concerns were prior to
9 going back for surgery?

10 Q: Correct.

11 A: Probably my main concerns were airway. The first thing I
12 always have to think about is, can I get a breathing tube in?
13 Kind of the larger we are and the thicker our necks are, it
14 just adds a degree of difficulty. So I always like to --
15 that's number one is getting the breathing tube secured and
16 securing the airway.

17 The other thing that I'm concerned about is getting the
18 -- the tube out at the end. Some people are more prone to
19 difficulties getting the breathing tube out. People with a
20 history of sleep apnea, for example, and definitely people who
21 have thicker necks also tend to have more snoring and more
22 sleep apnea issues. They're also more sensitive to the
23 narcotics that we give them.

24 And so probably my main issue was securing the airway and
25 making sure we had a plan for getting that airway out at the

1 end, and then my second concern was probably the positioning,
2 because I wanted to make sure that we didn't cause any injury
3 in the process of placing her prone and having her there for a
4 few hours and then turning her back.

5 She had other medical conditions, but her blood sugars
6 were well controlled. I did not have any concern about her
7 diabetes. Having blood pressure at the age of 38 on single
8 medication, that's -- that's not a significant -- that's mild
9 hypertension. I didn't have any concerns about that.

10 All of our lab work showed normal kidney function. Her
11 oxygen saturation that they took on room air at the start of
12 the case, I believe, was 99 or 100 percent sitting out there.
13 So that told me there were no lung issues. There was no other
14 really issues that I had specifically for Mrs. Goodwin.

15 Q: All right. Did you form an opinion during your
16 assessment of Ms. Goodwin that her spinal cord would have a
17 heightened sensitivity to low blood pressure?

18 A: No, sir.

19 Q: Why not?

20 A: The spinal cord is like any other part of the body. I
21 did not have any concerns about blood flow to that area, any
22 more than I would have concerns about blood flow to her heart
23 or her lungs or anything else.

24 Q: Kidneys?

25 A: No.

DR. JENNIFER ROOT - DIRECT BY MR. DAVIS

1 Q: Okay. I'm checking all that stuff you've already talked
2 about so I don't have to repeat myself. Bear with me, please.

3 MR. DAVIS: Let's get the anesthesia record back up
4 again, please.

5 BY MR. DAVIS:

6 Q: This is a question that -- I'm not a doctor, but I'm just
7 compelled to ask out of curiosity. We've got a decompressive
8 laminectomy, four levels, that are planned for -- for this
9 patient. It's her third back surgery. You knew that; right?

10 A: Yes, sir.

11 Q: Did the standard of care require you to be there in the
12 operating room instead of Mr. Starn?

13 A: No, sir.

14 Q: Why not?

15 A: The team model of anesthesia is practiced all over this
16 country. It -- it's really kind of the way that -- the team
17 model is actually the way we practice and I would call more
18 the standard, but we don't really have a standard. As long as
19 a licensed professional anesthesia provider is present the
20 entire case.

21 Q: Mr. Starn?

22 A: Right. That's -- that's really the only requirement.

23 Q: Okay. Thank you. Would you consider Mr. Starn while he
24 was there -- and I think he was there the entire time except
25 for some period of time when he was relieved by somebody for a

1 short period of time. But the time he was there, is a CRNA
2 typically, whether it's Mr. Starn or John Doe or Sally Smith,
3 are they your eyes and ears when you're not there?

4 A: Absolutely.

5 Q: Okay. With a hypertensive patient, does the standard of
6 care require you to keep her MAP higher than between 70 and
7 100?

8 A: No, sir.

9 Q: Why not?

10 A: Because the blood flow at those mean pressures is very
11 adequate. And if for any reason with Ms. Goodwin or any
12 patient that we were not getting numbers off of our machines
13 that made us feel like the pressures we were running were
14 adequate, we would have changed it, but every bit of
15 information we had during the case showed that the blood flow
16 was just fine.

17 Q: Thank you. Is there a risk to a patient, a risk of
18 injury to the organs, generally, I mean the organs, your
19 heart, your kidney, your lungs, liver, brain, bowel? Is there
20 a risk of injury to those organs if the blood pressure and the
21 blood flow gets too low?

22 A: Correct.

23 Q: What do you consider to be too low in terms of MAP range?

24 A: I personally do not let the mean pressures fall below 65.

25 Q: 65?

1 A: I aim to keep it at 90, but keeping in mind that any time
2 you attempt to treat and push blood pressures up, you can
3 sometimes work against yourself because the drugs we give to
4 raise blood pressure are squeezing down the arteries. So it's
5 a bit of a Catch-22. You want the blood pressure high enough
6 to keep things flowing through the brain, which is sensitive
7 to blood pressure, and the kidneys, but you don't want to push
8 it so high with your drugs that you're actually having the
9 reverse effect of reducing blood flow peripherally.

10 Q: Uh-huh. Okay. If you had what you consider to be too
11 low of an MAP in a surgery below 60, 65, would it only affect
12 the spinal cord and nothing else?

13 A: No, not at all. It affects the entire body.

14 Q: Would it only affect the spinal cord and transiently the
15 kidneys?

16 A: No, it would affect the entire body at the same time.
17 It's all one single cardiovascular system.

18 Q: Okay. We've covered a lot of my questions so we can
19 speed this up. Bear with me.

20 How would you characterize the blood pressures recorded
21 by the anesthesiologist or anesthesia -- excuse me -- Mr.
22 Starn? Throughout this operation, how would you characterize
23 those?

24 A: Actually, these are very good blood pressures.

25 Q: Why do you say that?

1 A: Well, they're good because the systolic stayed above 100
2 the entire case. Even at the beginning, when I knew that
3 that's where we have to increase the amount of fluids abruptly
4 at the start, her blood pressure still really didn't fall that
5 dramatically.

6 And the other thing that I really like about it is you
7 don't see a lot of up and down. We call it train tracks
8 sometimes when we look across and we see almost a straight
9 line, and that's actually a very good thing. We're trying to
10 keep homeostasis in the operating room.

11 Having surgery can be a tremendous stress on the heart.
12 And sometimes in patients, their pressure runs up and we treat
13 it and it falls down and we treat it and it goes up and we
14 treat it, and it can be kind of chasing our tails the entire
15 length of the case.

16 I always prefer to see this because this is very smooth.
17 It's less stressful on the patient's physiology. It shows
18 that what we're doing is the -- is right. We've got the right
19 level of sedation or anesthesia. We've got the right level of
20 narcotics on board, and everything is homeostatic. I don't
21 want the heart rates racing up and down during the case. I
22 don't want the blood pressures racing up and down during the
23 case. I like them like that.

24 Q: You're there at the beginning of anesthesia?

25 A: Yes, sir. So between 7:15 and 7:30, that's my little

1 chicken scratch that I'll just squiggle in that just says,
2 hey, I'm here.

3 Q: Okay.

4 A: Just to document my presence.

5 Q: This right here?

6 A: Yep. Uh-huh.

7 Q: Okay. That's you?

8 A: That's me.

9 Q: Good to know. Doctor, is it your practice to come in
10 from time to time just to check and see how things are going?

11 A: Yeah. I mean, I -- I'm usually supervising multiple
12 rooms, trying to see the next round of patients, and trying to
13 cover the patients that are recovering. And so I'm kind of
14 making rounds through anywhere from 6 to 12 patients at any
15 given time.

16 But I always come through at least every hour if I don't
17 hear anything that's going on, because I just want to come in
18 and lay my own eyes on the situation and make sure things are
19 good. And certainly, if there's an issue, I carry a phone and
20 they call and I come right to the room. So --

21 Q: The times that you came to the room -- and we're going to
22 go through that in a little bit more detail in just a moment.
23 But every time you came into the room, for whatever reason,
24 would you have had the opportunity to look at these various
25 monitors we've been talking about?

1 A: Yes, sir.

2 Q: Is that what you do?

3 A: Yes.

4 Q: Did you, at any time that you came into the room, ever
5 see any issue with any of the monitors, particularly blood
6 pressure or anything to indicate low blood flow?

7 A: No, sir.

8 Q: And this -- there was something -- I think it was like
9 9:30. I'm not quite sure, but --

10 A: 9:15?

11 Q: Yeah. The tube kinking?

12 A: Kinking.

13 Q: Talk about that. What happened?

14 A: Sure. So this happens not infrequently when you have a
15 patient in the prone position. Normally when you're on your
16 back, the breathing tube comes straight up and it's hooked to
17 our ventilator. When you're prone, the breathing tube has to
18 come out of the mouth and make a sharp U-turn and come up to
19 where our anesthesia circuit is.

20 When we place a breathing tube, it's kind of room
21 temperature, which in an operating room is 68 to 70 degrees,
22 and the plastic is cold, but as it sits inside your mouth, it
23 actually warms up to body temperature and becomes a lot more
24 flexible. After the breathing tube goes in, we often take a
25 roll of gauze and put between the teeth to hold them apart,

1 but sometimes in the prone position, that can fall out since
2 they're facing downward, and the curve of that tube as it
3 softens can kink off right at the teeth.

4 And so it's -- it's not an uncommon occurrence in a prone
5 position case if the gauze does happen to fall out that --
6 that tube can become kinked.

7 Q: Did that happen here?

8 A: It did.

9 Q: And what -- what did you -- what did you know about that?

10 A: So when Erich called me to say that the tube was kinked
11 and he was unable to get it straightened, he called me.

12 Q: Uh-huh.

13 A: When I got to the room, her oxygen levels were fine. Her
14 carbon dioxide was fine. The ventilator machine was still
15 able to ventilate her. It just had a high-pressure alarm
16 because it was saying, hey, I'm meeting resistance, which we
17 knew from the kinked tube.

18 We both attempted to spread the teeth apart and
19 straighten the tube out and get the gauze back in, but when
20 you're on your face, there's a lot of pressure, and so we
21 didn't have muscle paralysis going during this case because we
22 try not to do that with spine cases, and she -- we just
23 couldn't get the teeth apart.

24 And so we asked Dr. Holbrook, hey, we -- we might need a
25 little relaxation here to relax her jaw so we can just get it

1 open enough to unkink the tube. Is that okay? Because I
2 never give a paralytic without checking with the surgeon to
3 make sure whatever he's doing at the time won't be affected,
4 and he said, no, go right ahead. So we did. We gave a very
5 small dose of muscle relaxant.

6 Q: Is that rocuronium?

7 A: Rocuronium.

8 Q: Okay.

9 A: And we gave, I believe, around 0.2 per kilo, which is
10 about just enough to give you 30 minutes of relaxation. If
11 you don't get enough, you won't get the muscle relaxation you
12 need. And if you give too much, then you're paralyzed for too
13 long. So we gave just enough, and that lasted between 30 and
14 45 minutes, and it allowed us to separate the teeth and to
15 slide the gauze back between and straighten out the kink.

16 Q: How do you know it only lasted 30 to 45 minutes?

17 A: Because I know the pharmacology of the drugs that I give.

18 Q: Okay. Well, she was -- she had neuromonitoring going on
19 at the time, as I think you were aware. She had motor nerves
20 monitored and the sensory nerves monitored, MEPs and SSEPs?

21 A: Yes, sir.

22 Q: When you gave the rocuronium to be able to secure that
23 airway, what happened to the MEPs?

24 A: Well, you can no longer check for the motor.

25 Q: Okay.

1 A: The -- the MEPs go away because we've given the muscle
2 relaxation, but it does not affect the sensory. So you're
3 able to still monitor the sensories until the motors come
4 back.

5 Q: Can you tell from this record if it's documented -- well,
6 I won't give the whole thing to you, but can you tell when it
7 was documented that she received the rocuronium? Where would
8 that be?

9 A: You'll have to go down to the bottom half.

10 Q: Okay.

11 A: There we go.

12 Q: Let me know when.

13 A: Right there is good.

14 Q: We'll make it bigger.

15 A: So I don't know. You see the oxygen there at the top of
16 the medication line?

17 Q: Right here?

18 A: Right. If you go to the fourth one, you see ROC.

19 Q: We'll call that out.

20 A: Right. That's rocuronium.

21 Q: Okay.

22 A: So at the very beginning of the case, we give muscle
23 relaxation for placing the breathing tube because we need you
24 relaxed for that.

25 Q: Uh-huh.

1 A: And then a small dose was given so that we could prone
2 position. We need the patient to be nice and relaxed.

3 Q: Uh-huh.

4 A: It's easier because sometimes patients can still move
5 even when they're under a general anesthetic, and we didn't
6 want her moving while we were trying to carefully position
7 her. So it's very common we give a small dose.

8 And then you can see farther over there, that's at around
9 9:15. The 25 milligrams was given there.

10 Q: Right here?

11 A: Uh-huh.

12 Q: All right. That was given at 9:15?

13 A: I'm pretty sure if you look up at the top.

14 MR. DAVIS: Take that down. All right. And go all the
15 way up to here, all the way to the top.

16 BY MR. DAVIS:

17 A: It's right under my signature. Yeah.

18 Q: Right here?

19 A: Yeah.

20 Q: What's blocking? I never can figure this out. Are these
21 five-minute blocks?

22 A: They are five-minute blocks.

23 Q: 0900. Which -- which -- which line is that supposed to
24 be?

25 A: So the little X line is -- we try to make it easy. So we

1 try to go with zero, 15, 30, zero.

2 Q: Okay.

3 A: Right? And so -- so you can see the first dark line all
4 the way to the left is 7:15, and it just goes from there.

5 Q: That -- that 7:15?

6 A: The next dark line.

7 Q: 7:45?

8 A: Right.

9 Q: And this every 30 minutes?

10 A: Right.

11 Q: Okay. All right. Thank you.

12 A: I believe there's also a little note that we placed in
13 the bottom right-hand box.

14 Q: Yeah.

15 MR. DAVIS: Get that. There we go.

16 BY MR. DAVIS:

17 A: Yeah.

18 Q: Yeah. All right. Here we go.

19 A: So Erich wrote --

20 Q: This right here?

21 A: Yeah. Erich wrote patient biting ETT, but that's not
22 really -- the patient's not awake, so they're not biting.

23 Q: Okay.

24 A: The gauze had fallen out and the teeth had clamped down,
25 kinking the tube, and so he just documented that the tube was

1 kinked. We gave the rocuronium. I'm not a hundred percent
2 sure what he says after that. Root M.D. to bedside.

3 Q: That's you?

4 A: Yeah.

5 Q: Because he called you in?

6 A: Yes, he called me in. We got the jaw loosened with
7 fingers. We got the oral airway placed, the gauze roll, as I
8 was saying, and -- and got her repositioned on the face. We
9 have a special foam pillow that their face is on, and he just
10 was documenting kind of what we said and that he double
11 checked that the eyes and everything was okay.

12 Q: Okay. All right. Thank you. You understand in this
13 case that the SSEPs, I'm going to say around 10 o'clock or
14 10:03, sometime in that timeframe, was announced by the
15 neuromonitoring tech that they had just -- just lost -- gone
16 out, stable before that and then just not there. You
17 understand that's what happened?

18 A: Yes, sir.

19 Q: When did Eric Starn call you to the operating room when
20 that happened?

21 A: I was not called when the SSEPs were lost. I came in
22 probably 20 to 25 minutes after that to check on anything.
23 Everything still looked good up at the anesthesia head of the
24 table. All the monitors looked great, but no one told me at
25 that time either.

1 Q: Erich didn't tell you?

2 A: It is my understanding that Dr. Holbrook determined that
3 it was an equipment issue, and he told Erich it was an
4 equipment issue, and I guess that's why he decided not to call
5 me, since it wasn't an anesthesia issue. But no, I was not
6 informed.

7 Q: Was it an anesthesia issue?

8 A: No, sir.

9 Q: How do you know that?

10 A: Because the main reason that you would have problems with
11 SSEP monitoring or MEP monitoring is hypotension, and she did
12 not ever have hypotension during the case. Her mean blood
13 pressures were in the 70s or higher the entire case. And as a
14 matter of fact, there is one more monitor that measures blood
15 flow, and that is the SSEPs and the MEPs. Actually, one of
16 the things that they look at during neuromonitoring is if
17 there's not adequate blood flow to the spine during the --

18 MR. HINSON: Objection, Your Honor. This witness has not
19 been -- not been qualified to talk about neuromonitoring.

20 THE COURT: Yes, sir. The objection is sustained.

21 MR. DAVIS: Could I lay the foundation?

22 THE COURT: You can attempt, yes.

23 MR. DAVIS: Okay. Thank you.

24 BY MR. DAVIS:

25 Q: Are you familiar with neuromonitoring?

DR. JENNIFER ROOT - DIRECT BY MR. DAVIS

1 A: I am familiar with what is in my textbooks and what I've
2 learned about neuromonitoring through anesthesia, yes.

3 Q: Do you know whether or not neuromonitoring can measure,
4 directly or indirectly, blood flow?

5 A: Yes.

6 Q: Did you look at the neuromonitoring in this case?

7 A: I did not, since it's not one of our anesthesia monitors.
8 No.

9 Q: Okay. So what time did you come into the operating room
10 to assist with waking the patient up?

11 A: I believe that's on the second page around 11 o'clock.

12 Q: All right. So you wouldn't have started doing that if
13 the surgeon is still doing stuff; right?

14 A: No, sir.

15 Q: You don't start to wake the patient up until the surgeon
16 is done with his suture closing and all that; correct?

17 A: Correct.

18 Q: So tell me again what time that was?

19 A: I signed in around 11 o'clock.

20 Q: Okay. So by 11 -- by around 11 o'clock, Dr. Holbrook was
21 done with his surgery?

22 A: Correct.

23 Q: What did you do then when you came in?

24 A: So I came into the operating room to wake Mrs. Goodwin,
25 and the surgeon had already left the room. Often, they leave

1 to go talk to the patient's family and to dictate their note
2 and those sorts of things.

3 And you have to keep a patient who's prone kind of deep.
4 You can't really lighten them up toward the end of the
5 procedure because, since they're prone, you don't want them
6 bucking or coughing while they're on that special table face
7 down.

8 So we keep patients kind of deep, which means after
9 you've turned them over to wake them up, it takes a little
10 longer, which, as you can see, we were there with her almost
11 30 minutes in the operating room waiting for her to wake up.

12 Q: Before taking her to the recovery room?

13 A: Correct.

14 Q: Okay. Well, Dr. Root, was it -- when you came in to help
15 wake the patient up around 11 o'clock, is that when Erich told
16 you they had lost SSEP signal?

17 A: He did. He -- he mentioned that they had had issues with
18 the -- with the monitoring during the case, and it was news to
19 me since I had not been told to this point.

20 Q: You looked at the entire anesthesia record. We've got it
21 here; correct?

22 A: Yes, sir.

23 Q: Had you been called at 10:03 based on the anesthesia
24 record, would you have done anything differently to raise the
25 blood pressure or do anything different?

1 A: No, sir.

2 Q: Why not?

3 A: Anything that's been written about loss of signaling as
4 relates to blood pressure --

5 MR. HINSON: Objection, Your Honor. Going into the
6 literature again.

7 THE COURT: Sustained.

8 BY MR. DAVIS:

9 A: In my -- in my clinical judgment and medical experience,
10 mean blood pressures of 70s to 80s is where you want the blood
11 pressure during these cases. If her blood pressure had been
12 lower than that, we would have raised it to that area with the
13 loss of signaling, but since she was already there, there was
14 nothing to raise it to.

15 As a matter of fact, raising blood pressures even higher
16 might have had a reverse effect of reducing blood flow, and it
17 could also increase the amount of bleeding and edema that was
18 happening in the spine. So it would not make sense to do that
19 at all.

20 Q: Okay. So you and Erich worked with Ms. Goodwin for about
21 half an hour in the operating room in the process of getting
22 her awake?

23 A: Yes, sir.

24 Q: Then did you take her to the recovery room?

25 A: She was not following commands still very well at that

1 point, which I thought may have been due to having some sleep
2 apnea and just still being too sleepy to -- to follow
3 commands. We did take her to the recovery room. We actually
4 left the breathing tube in because I did not feel like it was
5 safe to remove it yet. We took her with --

6 Q: Why not?

7 A: Because when a patient cannot protect their own airway or
8 if they obstruct after -- you've got a nice airway in, and
9 then once you pull it out, if they start to snore or their
10 airway collapses down, then you can't really do a whole lot
11 about it. So you really want to make sure they're good and
12 awake before you pull that breathing tube out.

13 Q: Okay.

14 A: And so I did not want to put her at risk for any sort of
15 airway compromise. So we took her to the recovery room with
16 the breathing tube still in, and I stayed at her bedside for
17 quite some time waiting for her to come around and -- and kind
18 of respond appropriately, which she did.

19 Q: And then what happened?

20 A: Well, we finally got her to respond to us and to move her
21 hands, but she would not move her feet. And after Erich had
22 told me that they had had trouble with the signaling during
23 the case, I immediately had Dr. Holbrook called to the bedside
24 in recovery because I was concerned that she wasn't moving her
25 legs, and he needed to address that.

1 Q: Did Dr. Holbrook, if you remember -- if you don't, just
2 tell the jury you don't remember. Did he at that time order
3 magnetic resonance imaging, an MRI?

4 A: Yes, sir. So I do remember that when I called him to the
5 bedside and he saw that she wasn't moving her legs, he
6 immediately had the MRI scan ordered.

7 Q: Okay. Were you involved in the second surgery?

8 A: No, sir, I was not.

9 Q: Do you know if Erich was?

10 A: Yeah, actually, I believe he was.

11 Q: Okay. Would you like to have been notified by Erich
12 Starn when those SSEP signals went out?

13 A: Yes, I would have.

14 Q: Did you ever discuss the possible causes from an
15 anesthesia perspective as to the injury that Crystal Goodwin
16 suffered? Do you ever remember having any discussion with him
17 about that?

18 A: With --

19 Q: Dr. Holbrook.

20 A: With the surgeon?

21 Q: Yeah.

22 A: I'll be honest, I don't remember having that discussion,
23 and there was never any anesthesia issue during the case to
24 have a discussion about. It was textbook perfect.

25 Q: And that would have been from your perspective. If

1 there's an anesthesia issue that you see, you're going to --
2 you're going to tell the surgeon about that?

3 A: Correct.

4 Q: Even looking back on it; right?

5 A: Correct.

6 Q: You didn't do that because that didn't happen, did it?

7 A: Correct.

8 Q: In the past, have you had occasion to work with Dr.
9 Holbrook in surgeries like this?

10 A: Yes, sir.

11 Q: Let's talk about the times that you were in the operating
12 room.

13 MR. DAVIS: Let's go to the first page, please. Let's do
14 the graph, the top part. Yeah.

15 BY MR. DAVIS:

16 Q: You were there in the 7:20 to 7:30 a.m. time for
17 induction; correct?

18 A: Correct.

19 Q: And you returned again around 8:30?

20 A: Correct.

21 Q: And what was the purpose of the 8:30 return?

22 A: Just to come check and see how everything was going.

23 Q: Okay. During both of those times at the induction and
24 the recheck at 8:30, were you able to review any of the
25 monitors of the blood pressure, end tidal CO2, oxygen

1 saturation, blood pressure, the waveforms? Were you able to
2 do that and did you do that?

3 A: Yes. So when I come into the room, I can see not only
4 what's real time being displayed, but I can also look down
5 because the anesthesia record is right there for me to look at
6 as well of what's been happening over the past hour.

7 Q: You can see in real time and you can look at the record
8 and see what's happened when you weren't there before you came
9 in?

10 A: Correct.

11 Q: And you did that?

12 A: Correct.

13 Q: When you come in like that, that little -- I think you
14 said hourly check in, typically, if you know, how long would
15 you typically be there?

16 A: Very quick, 3 to 5 minutes. How's everything going,
17 Erich? Everything looks good. How's this going? Look at the
18 chart. Walk out. Just very quick.

19 Q: Around 9:15 a.m., you came back because there was an
20 issue with the tube being kinked. We talked about that?

21 A: Correct.

22 Q: Were you able to review both the record and the monitors
23 in real time at that time?

24 A: Absolutely.

25 Q: Were there any issues that gave you concern for low blood

1 pressure at that time?

2 A: No, sir.

3 Q: Okay. When's the next time you came in? Was that around
4 11?

5 A: 10:30.

6 Q: 10:30?

7 A: 10:15, 10:30.

8 Q: Okay. And at that time, did you -- did you have the
9 opportunity to look at the monitors that would help you
10 determine what the blood flow was?

11 A: Everything still looked as it had been the entire case.

12 Q: Were you able to look back at the 10 o'clock time frame,
13 the 9:15 to 20, 30, 30, 40, 50 timeframe?

14 A: Yes, sir.

15 Q: Were there any issues in your opinion, Dr. Root, that
16 gave you any concern that there was low blood flow to
17 Crystal's spine?

18 A: None whatsoever.

19 Q: In looking at the entire anesthetic record, as we have
20 done and as you've done before today, as the M.D.
21 anesthesiologist responsible for anesthesia of the care team,
22 was there ever a concern on your part, Dr. Root, about the
23 blood pressures being too low during the entire operation?

24 A: No, sir.

25 Q: Would that include blood flow?

1 A: Yes, sir. No concerns.

2 Q: Would you have expected Mrs. Goodwin's blood pressures
3 and blood flow, as you were able to discern from the various
4 monitors in this case, to have been a cause of the SSEP signal
5 loss at around 10 o'clock?

6 A: I do not believe it had anything to do with that.

7 Q: Why would you not expect that to be the case?

8 MR. HINSON: Objection, Your Honor. She has not been
9 qualified in any sort of area of medicine that would allow her
10 to render this testimony.

11 THE COURT: Sustained.

12 MR. DAVIS: Thank you, Your Honor. I know I had one
13 other question. It went right out of my head, so it probably
14 wasn't very important.

15 Thank you, Dr. Root. Answer any questions these folks
16 may have.

17 THE COURT: Let's take a short break.

18 MR. HINSON: That's great.

19 THE COURT: Yes. Please return to your jury room. Don't
20 discuss the case.

21 (WHEREUPON, the jury exited the courtroom at 3:56 p.m.)

22 THE COURT: All right. We'll take a ten-minute break.

23 Doctor, you may step down from the witness stand. Don't
24 discuss your testimony.

25 We'll be at recess for 10 or 15 minutes.

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

3 MR. HINSON: We had one or two exhibits to -- to pre-mark
4 for time efficiency sake, which I understand are without
5 objection.

6 MR. DAVIS: That's correct.

7 MR. HINSON: All right. So what is our next numbers?

8 THE COURT REPORTER: 35 and 36.

9 MR. HINSON: 35 and 36. So 35 is the '09 and 36 is the
10 '11.

11 THE COURT REPORTER: So are these for ID or are these --

12 MR. HINSON: No. These are indexes.

13 THE COURT: And these are?

14 MR. HINSON: This is mine. It had a little comment on
15 this.

16 THE COURT: 35 and 36.

17 (WHEREUPON, Plaintiffs' Exhibit Number 35, 2009 blood
18 pressures index, and Plaintiff's Exhibit Number 36, 2011
19 blood pressures index, were admitted into evidence.)

20 MR. HINSON: Thank you, Ms. Harris.

21 THE COURT: All right. Are you ready?

22 MR. HINSON: Yes, Your Honor.

23 THE COURT: All right. Bring your jurors, please.

24 (WHEREUPON, the jury entered the courtroom at 4:17 p.m.)

25 THE BAILIFF: All right. All jurors are seated.

1 THE COURT: All right. Thank you.

2 It's now time for cross-examination.

3 Mr. Hinson?

4 MR. HINSON: Thank you, ma'am. Thank you, Your Honor.

5 May it please the Court.

6 THE COURT: Yes, sir.

7 CROSS-EXAMINATION

8 BY MR. HINSON:

9 Q: Good afternoon, Doctor.

10 A: Good afternoon.

11 Q: Did I understand your testimony correct a few minutes ago
12 when you said you try to keep a patient's blood pressures
13 between the mean arterial pressure -- intraoperative pressures
14 between 70 and 100?

15 A: Correct.

16 Q: All right. And so if that's the case here in this third
17 surgery -- excuse me. I'm sorry. The second, the 2011
18 surgery, should the blood pressure not have been kept this
19 high for this long above 100 if it had been Dr. Root
20 performing the anesthesia?

21 A: Well, since I wasn't participating in the case in 2011
22 and I don't know the circumstances, nor do I know where we
23 were in the surgery, you can't superimpose the times of the
24 surgery on top of one another.

25 Q: Well --

1 A: Because you don't know what parts of the procedure were
2 happening in different places. I don't know what was
3 happening at the time her blood pressure shot up or what they
4 did about them. No, I would not have allowed the blood
5 pressures to rise that high because it would increase bleeding
6 and swelling. However, I wasn't present, so I don't know what
7 the circumstances were around the time of the blood pressure
8 elevation.

9 Q: Okay. So with this -- this graph right here, as I
10 understand the defense graph, is just in time elapsed of the
11 surgery. So that's ten minutes into the surgery, and that's
12 260 minutes into the surgery. Is that your understanding of
13 this graph?

14 A: Correct.

15 Q: Okay. So you agree that per the -- per the data that's
16 in evidence, in the 2011 surgery her blood pressure was kept
17 pretty much above 100 for almost two hours?

18 A: I don't know. Again, I wasn't participating in that
19 surgery.

20 Q: Doctor, I didn't ask you --

21 A: I can't comment on it --

22 Q: Well --

23 A: -- except that I can see what you're putting on the
24 screen. And yes, it appears her mean pressures were around
25 100. They were awfully low in the first two hours, however.

1 Q: Okay. Well, my question simply is, do you agree from the
2 2011 chart, assuming this graph is correct, that for almost
3 two hours her mean arterial pressure was above 100, other than
4 a little tiny dip right there?

5 A: I would agree that the first two hours, her blood
6 pressures were quite low, and then for the second two hours,
7 her blood pressures were quite high, yes.

8 Q: Okay. You -- again, my question is, Doctor, is just
9 simply do you agree that for about two hours it was above 100?
10 That's -- that's my question.

11 A: That's what the graph shows.

12 Q: Okay. But your practice is to keep patients between 70
13 and 100?

14 A: Correct.

15 Q: All right. Doctor, you can only take action on the
16 information that's available to you; right?

17 A: Correct.

18 Q: And when you undertook to provide anesthesia to Ms.
19 Crystal Goodwin, did you undertake to determine her baseline
20 blood pressure?

21 A: There were only three blood pressures on the chart that I
22 saw the morning of surgery. The blood pressure that was taken
23 the morning of, which we all know is normally very high and
24 not related to the baseline. There was a blood pressure four
25 days earlier that was taken at the hospital, where she

1 reported a 4 out of 10 pain score. So I really can't see that
2 as a baseline pressure because she was in pain. And then on
3 the surgical history and physical that was on the chart, there
4 was a blood pressure of 129 over 82.

5 Q: The surgery history and physical?

6 A: Yes, sir.

7 Q: Where will we find that?

8 A: So a surgical history and physical is a DHEC requirement.
9 It has to be done within 30 days, and it's on the chart.
10 Usually, the last note from the physician's office that has
11 their assessment, history, and physical is sent in at the time
12 that they scheduled the surgery, and that acts as the surgical
13 history and physical. We are not allowed to proceed to the
14 operating room without a surgical history and physical on the
15 chart.

16 Q: Okay. Doctor, I'm going to show you Exhibit 33, and I'll
17 represent to you that these six pages that comprise Exhibit 33
18 are the six pages that Midlands sent over to the hospital
19 prior to Crystal's surgery. Are you familiar with these six
20 pages?

21 A: These appear to be simply the order to schedule the
22 surgery, yes.

23 Q: Okay. And so the surgery order asks for neuromonitoring;
24 correct?

25 A: Is that on the first page?

1 A: Yes, ma'am.

2 Q: Needs Midas rex retractor, fluoro spinal monitoring.

3 Correct.

4 Q: All right. Here it says instrument name company, Teresa
5 Adkins, Specialty Care Monitoring. Do you see that --

6 A: Right.

7 Q: -- right there? All right. Then I have to count three
8 pages in. It says summary care record for Crystal J.

9 Delbridge Goodwin. Do you see that?

10 A: Yes, sir.

11 Q: All right. And then it's got a table of contents going
12 from reason for referral, problems, allergies, so forth, so
13 forth. One of the things is -- is vitals; right?

14 A: Yes, sir.

15 Q: Okay. And so when you go to this document and the first
16 thing there's -- you flip the page and then there's the reason
17 for the referral, and it tells you what the reason for the
18 referral is. It says she needs a -- a thoracic laminectomy
19 for decompression at L9 through L12, and some more information
20 there goes on and talks about the need for neuromonitoring,
21 need for a McCullough retractor, and some other stuff. Do you
22 see that?

23 A: Yes, sir.

24 Q: All right. And then somebody's put down -- listed the
25 problems, that there's a spinal stenosis. Then there's

1 allergies. There's no allergies. Then it lists medications.
2 It lists her medications, goes to vaccines, then it goes to
3 vitals, and it says what there under vitals?

4 A: None recorded.

5 Q: None recorded?

6 A: Correct.

7 Q: All right. So would you agree that on -- at least on
8 this document, it doesn't appear that Midlands Orthopedics
9 ever gave you any information about the blood pressures that
10 were recorded in Dr. Holbrook's office; fair?

11 A: This document is not a pre-surgical history and physical,
12 and at least it's not what I saw on the chart the morning of
13 surgery.

14 Q: All right. That's a good point. Glad you brought that
15 up. So what you would have seen on the morning of surgery
16 would have been one blood pressure recorded on July 18th of
17 129 over 81; right?

18 A: 82, I believe. Yes. Is it 81? I'll stick with 81.

19 Q: But I'll be happy to show you if you want me to.

20 A: I don't have that.

21 Q: All right. And if there were other blood pressures in
22 Dr. Holbrook's chart, say from June 20th of 152 over 112, that
23 information wasn't provided to you, was it?

24 A: It was not.

25 Q: You weren't here the other day, but I represent to you

1 Crystal testified that at least in 2016, her blood pressure
2 typically ran about 150 over -- in the 150s over 90s. Would
3 that be information you would want to know?

4 A: I think it's information that I need to know. However,
5 point -- like I mentioned before, point of care blood
6 pressures are not a baseline. They're just -- and they're
7 very dependent on the situation that they're taken in. When
8 you come into a health care facility or a doctor's office,
9 often your blood pressure is elevated.

10 Q: Well, isn't -- if the patient is a patient who often
11 checks their blood pressure, say they go to Walmart almost
12 every day to buy baking goods, and they tend to pretty
13 frequently put their arm in one of those cuffs and look at
14 what their blood pressure is, and they are pretty
15 conscientious about it because they know they've got a
16 hypertension problem, isn't that information you would want to
17 know?

18 A: If she had shared that information, I would have listened
19 to it, but it really does not affect the blood pressure
20 management of the case.

21 Q: So I just want to make sure I understand your testimony.
22 You're saying if this patient ran in the 150s over 90s, that
23 would not have impacted your blood pressure management of this
24 surgical case?

25 A: Not in a 38-year-old on single therapy hypertension, no.

1 Q: Okay.

2 A: I would have still run her means between 70 and 100.

3 Q: What if the surgeon had said to you, Dr. Root, I'd like
4 to keep this patient a little bit higher? Would you -- would
5 that have impacted your anesthesia in the case?

6 A: When a surgeon believes that because of a surgical
7 requirement that a blood pressure needs to be kept at a
8 certain level, yes, we have a conversation and we discuss
9 that.

10 Q: Okay.

11 A: And I've certainly had that discussion with surgeons
12 through the years, usually specifically related to other types
13 of surgery, not this kind.

14 Q: Okay. So I want to make sure I understand your
15 testimony. If the surgeon, in this case Dr. Holbrook, had
16 said to you, Dr. Root, I'd like to keep this patient -- she's
17 had three prior surgeries right in the same -- excuse me --
18 two prior surgeries, this is going to be her third one right
19 in the same area. It's in the lower thoracic region. It's in
20 the watershed region. I'm concerned. She's got some chronic
21 hypertension now that's been going on for quite some number of
22 years at this point that's poorly, poorly controlled in the
23 last few years, I'd like to keep her a little higher, you
24 would have a conversation with him and assuming the surgeon
25 didn't change his opinion, would keep that -- that blood

1 pressure higher per his request?

2 A: I would have double checked and said are you sure you
3 want the increased bleeding and swelling? Sure, if that's
4 where you want it kept, we can work to do that.

5 Q: Okay. Did you have three blood pressure readings prior
6 to the surgery in order to -- to establish a baseline blood
7 pressure measurement?

8 A: You can't establish a baseline blood pressure measurement
9 off of three random blood pressures.

10 Q: Okay. But did you have three blood pressure readings
11 prior to surgery in order to establish a baseline blood
12 pressure?

13 A: I had a blood pressure the morning of surgery, which was
14 elevated. I had a blood pressure from four days prior that
15 was elevated, but was also -- had a reported pain score with
16 it. And then I had a reported blood pressure from an office
17 setting, 129 over 81.

18 Q: Okay. And --

19 A: If the 129 over 81 was too low for her, I would imagine
20 that she would have had symptoms, and nothing in the note
21 indicated that she had hypertension in the office.

22 Q: You agree that it's the policy of Prisma Health to have
23 at least three blood pressure readings prior to surgery in
24 order to provide baseline blood pressure measurement prior to
25 surgery?

1 A: Is this a document from Prisma Health? I'm unfamiliar
2 with it.

3 Q: It certainly is. You're not familiar with this document?

4 A: No, sir.

5 Q: All right. So, Dr. Root, you're the anesthesiologist
6 working at Prisma Health, formerly Palmetto Health, and you're
7 not familiar with the preoperative preparation of the patient
8 PGR?

9 A: I am unaware that three random blood pressures somehow
10 sets a baseline measurement. So I would actually disagree
11 with Prisma Health's statement there.

12 Q: Okay. My question, though, Doc, was you're not familiar
13 with Prisma Health's preoperative preparation of patient PGR.
14 That's the question.

15 A: Correct. That is for their nursing staff.

16 Q: How do you know? You just said you've never seen this
17 document.

18 A: Because they have a preoperative clinic, and it is run by
19 nursing staff, and it appears to be the -- the guidelines for
20 their nursing staff to use.

21 Q: Okay. So they have to do it, but you don't have to?

22 A: This is what Baptist Hospital at the time asked their
23 nurses to do.

24 Q: All right. These are Crystal's records from -- from
25 Baptist from this 2016 stay. Do you think you could find for

1 me where this -- this blood pressure, this 129 over 81 was --
2 was in there?

3 A: Yes.

4 Q: Okay. I --

5 A: Right here, sir.

6 Q: All right. Thank you. All right. So let's look at
7 that. I appreciate you finding that for me. All right. So
8 this is documentation. This information would necessarily
9 have had to come from one place; right? Midlands Orthopedics?

10 A: Yes, sir.

11 Q: Right. And so Midlands Orthopedics chose to send you
12 that blood pressure, the one -- the one blood pressure from
13 July 18th and not send you any information about the blood
14 pressure on July 20th -- or on June 20th; right?

15 A: Generally speaking, they send over something that's to be
16 -- it's usually the visit that happens within 30 days to meet
17 the state requirement for having the history and physical
18 within the last 30 days.

19 Q: Okay.

20 A: And that's usually what we receive from all physicians'
21 offices.

22 Q: Okay. And so prior to this surgery commencing, prior to
23 the beginning of the operation, did you ever discuss Crystal
24 Goodwin with Dr. Holbrook?

25 A: The morning of surgery?

DR. JENNIFER ROOT - CROSS BY MR. HINSON

1 Q: Did you ever discuss Crystal Goodwin with Dr. Holbrook
2 before the surgery began?

3 A: No, sir. I believe I saw her that morning before he had
4 arrived, and then by the time we went back to the operating
5 room, he had already come and gone.

6 Q: Okay. So is that a yes to my question?

7 A: That is yes.

8 Q: Okay. So Dr. Root says I never discussed the surgery
9 with Dr. Holbrook before it began. That's a fair statement?

10 A: Correct.

11 Q: Okay. Does Prisma Health have a policy that says that
12 there has to be a pre-procedural collaborative process between
13 the physician and the procedural team when a surgery is being
14 done?

15 A: I am unaware of what exactly that means and where that's
16 coming from, what that collaborative process.

17 Q: Okay. So you're unfamiliar with the policy at Prisma
18 Health --

19 A: We have a timeout --

20 Q: Okay.

21 A: -- that occurs in an operating room where the -- a
22 representative of the anesthesia team, the surgeon, and the
23 nursing staff all discuss the patient prior to the start.
24 It's called the safe surgery checklist. Yes.

25 Q: All right. And that should include the timeout and a

1 preoperative briefing. I mean, it's a -- it's a whole
2 conference; right?

3 A: The -- the concept of the preoperative briefing is
4 usually used when there's special cases to be discussed. If
5 there's not any sort of special case to discuss for the
6 patient, then we don't get together and talk. We actually
7 talk in the room.

8 Q: Okay. Okay. Does that say you don't have to do it if
9 there isn't anything special to discuss? Does this say if
10 there isn't anything special to discuss, you don't have to do
11 it?

12 A: I'm -- I can't tell you what the Palmetto Health Policy
13 states. I can just say that if -- if there's nothing that
14 needs to be discussed, we usually all talk about it once we're
15 back in the room together.

16 Q: Okay. You're part of the procedural team, aren't you?

17 A: I am. However, often we need just one person from the
18 anesthesia team to be present and to participate in this.

19 Q: Does this say that only one person from the anesthesia
20 team has to be there?

21 A: It does not, but that's in practice how it's been done.

22 Q: Okay. But you weren't familiar with this until I just
23 showed you, were you?

24 A: No. There's a lot of policies that Palmetto Health has.

25 Q: You are, though, familiar with the concept of having a

1 preoperative time out or conference or discussion with
2 yourself and the surgeon; right?

3 A: Correct.

4 Q: I mean, that's not just something I'm making up. The
5 American Society of Anesthesiologists recommends that, don't
6 they?

7 A: Correct.

8 Q: They have as part of their basic standards for pre-
9 anesthesia care, isn't it?

10 A: For us to all sit down together prior to going back to
11 the room?

12 Q: Well, to have -- I mean, for some patients, I imagine it
13 doesn't last very long, a minute or two. For other patients,
14 it might last longer; fair?

15 A: Correct.

16 Q: And you should discuss those aspects of the patient's
17 physical condition that might affect decisions regarding
18 perioperative, meaning during the surgery, risk and
19 management?

20 A: Correct.

21 Q: And you acknowledge that you never had a discussion with
22 Dr. Holbrook before this surgery began?

23 A: Correct.

24 Q: All right.

25 A: We have kind of a standard way that we take care of his

1 patients, and we usually operate the same way every time
2 unless he feels differently.

3 Q: Operate the same way every time?

4 A: Using the same parameters for care.

5 Q: Uh-huh. Using the same parameters for care, keeping
6 people between 70 and 100?

7 A: Correct.

8 Q: All right. What is the 20 percent rule, Doctor?

9 A: It is a -- it is a -- it's something that is taught that
10 really has never met scientific rigor, but it is a rule of
11 thumb about if you know the baseline on the patient, that you
12 should keep them within 20 percent.

13 Q: Do you follow the 20 percent rule?

14 A: The 20 percent rule has not found by anything to -- any
15 scientific study, if I can bring that up, to ever be
16 correlated with good outcome. Whereas the keeping the mean
17 pressures between 70 and 100 has much scientific evidence to
18 back it.

19 MR. HINSON: Your Honor, I'd ask if you'd instruct the
20 witness to please answer the question. I'm happy to let her
21 explain her answer, but I mean, that kind of -- actually, I
22 don't think I got an answer. My question was, do you follow
23 the 20 percent rule, and she just talked -- started talking
24 about what the literature shows. I'd like -- I think we can
25 move along quicker if the question will get answered.

DR. JENNIFER ROOT - CROSS BY MR. HINSON

1 THE COURT: Do I need to repeat that, Dr. Root?

2 THE WITNESS: No.

3 BY MR. HINSON:

4 A: No, I do not follow the 20 percent rule.

5 Q: You do not follow the 20 percent rule? Doctor, you gave
6 a deposition in this case, didn't you?

7 A: Yes, I did.

8 Q: All right.

9 A: And I reported that I followed the 20 percent rule when a
10 baseline blood pressure is known, but in the case of Mrs.
11 Goodwin, we did not have a known baseline blood pressure. And
12 so without the baseline blood pressure, you can't really use
13 the 20 percent rule.

14 Q: Okay. All right. So if you have a good baseline blood
15 pressure, then you follow the 20 percent rule?

16 A: That's usually going to put you between 70 and 100. Yes.

17 Q: All right. And one way you might find a patient's
18 baseline blood pressure would be to talk to the surgeon, say,
19 hey, I saw the chart, this patient had hypertension. Let's --
20 what do we need to do? Couldn't either -- either you or Dr.
21 Holbrook do that?

22 Well, hold on, let me retract that -- that question. So
23 you and Dr. Holbrook have -- you said have worked together
24 many times before?

25 A: Correct.

1 Q: So he would know then that it's just your standard to
2 keep people between 70 and 100?

3 A: Correct.

4 Q: So he would know then that unless he gives you
5 instruction, you're just going to keep the patient between 70
6 and 100?

7 A: Correct.

8 Q: All right. And then he would know then that you're not
9 going to apply the 20 percent rule unless he gives you some
10 more information, shouldn't he?

11 A: The supposition is the 20 percent rule is actually better
12 than the 70 to 100. It's really not. It's something that I
13 was taught as a resident that never actually had any
14 scientific basis for it. It was a rule of thumb. I really
15 tend to lean more towards the 70 to 100. If I know the
16 baseline pressure, then the 20 percent rule actually often
17 puts you right in that same ballpark. So --

18 Q: And Dr. Holbrook would know that it's your standard to do
19 70 to 100, and then you would expect that he would know,
20 unless he tells you otherwise, that's what you're going to do;
21 fair?

22 A: Correct. Just like he knows I'm going to put a breathing
23 tube in a patient because that's the standard.

24 Q: Doctor, you were -- well, I pulled out your deposition a
25 second ago. And at the time you were deposed, you were

1 actually a defendant in this case; right?

2 A: I'm sorry? I was what in this case?

3 Q: You were a party to this case; correct?

4 A: Yes, sir.

5 Q: All right. And those -- those matters have been resolved
6 at this point; right?

7 A: Correct.

8 Q: All right. And your attorney is sitting there in the
9 back of the room; right?

10 A: One of them, yes.

11 Q: One of them, one of several. We've seen, I think, three
12 in the back of the room in this case for you; right?

13 A: Yes, sir.

14 Q: Did I understand you -- what y'all call -- I just used
15 the word case, and I heard you use the word case.

16 Anesthesiologists and surgeons sometimes have used the word
17 case to mean a surgical case, a surgical procedure; right?

18 A: Correct.

19 Q: And did I hear you say earlier that you had no
20 recollection of this particular case?

21 A: No, that's not my --

22 Q: Okay.

23 A: I did not have any recollection of Mrs. Goodwin herself,
24 any conversations, any personal knowledge. I do actually have
25 recollections from this case.

1 Q: Okay. All right. Well, let's look real quick. I just
2 want to show you Exhibits 35 and 36. I'm happy to hand you
3 them, but they're getting ready to pop up on the screen here.
4 And I'd represent to you 35 is -- we took the -- took the
5 little carets from the anesthesia chart from the 2009 record
6 and put them on a -- on a board. In 2009, that blood pressure
7 stays between 70 and 100, right?

8 A: Yes, sir.

9 Q: And you agree with me that in 2009, Crystal in general
10 was a different patient than she was in 2011 and 2016; right?
11 By '16, she's got other -- other comorbidities, potentially
12 other issues.

13 A: I -- I can -- we can assume, but I have no personal
14 knowledge to confirm that statement.

15 Q: Okay. And do you know what her mean arterial pressure
16 was -- her mean arterial baseline pressure was in 2009?

17 A: No, sir.

18 Q: All right. And you hadn't undertaken to determine that;
19 fair?

20 A: Not for the case in 2009 that I wasn't involved with.

21 Q: All right. Well, I'll represent to you the other day
22 Crystal talked about and testified here in this courtroom
23 about where her blood pressures typically ran back then. I'm
24 looking. She testified -- what page are we on? Excuse me.
25 So I did the math on them, and now I can't find them, Doctor.

1 I'm sorry. It's okay. I got it. I got the data right here.
2 Oh, here's what I was looking for. She said in 2009 her blood
3 pressures ran 125 over 65. What mean arterial pressure would
4 that be?

5 A: 125 over 65, so 85, 87.

6 Q: 85. I think I did the math on it. Would you disagree
7 with that?

8 A: No. I mean, is there documentation of these blood
9 pressures?

10 Q: There is, and I'll show you. So she was in the hospital
11 in March of 2009. This was actually the hospital stay that
12 preceded her 2009 surgery, and I've taken the blood pressures
13 recorded from that hospital stay. We had 1, 2, 3, 4, 5, 6, 7,
14 8, 9, 10, 11, 12, 13, 14, 15 blood pressures there, and you're
15 welcome to look through it. I've pulled them. My copy is
16 highlighted. I'll be happy to hand you my copy if you'd
17 rather have it.

18 A: Do you have her preoperative blood pressure?

19 Q: We can find that. The preoperative blood pressure would
20 be here on Exhibit 3. Now, why are you interested in the
21 preoperative blood pressure?

22 A: I'm interested because I think it's great that here her
23 blood pressure means look good and do not look like a
24 hypertensive even.

25 Q: All right.

1 A: Do you have the numbers from inpatient as well here after
2 the 2016 case?

3 Q: So the first question though, Doc, is that's not a
4 hypertensive patient back in '09, is it?

5 A: No, sir.

6 Q: All right. And that would -- if it was Crystal's
7 testimony that she typically ran 125 over 65, that a mean
8 arterial pressure of 85, that would be similar or congruous to
9 what she testified to, wouldn't it?

10 A: Looks very similar, yes.

11 Q: All right. And even in 2009 -- this is her anesthesia
12 record -- her preoperative blood pressure then was -- was 130
13 over 89, a little bit elevated, but -- but nothing what it was
14 in '16, don't you agree?

15 A: Right. So her mean blood pressure was 90 plus -- yeah.
16 It's in the 110 region, yes.

17 Q: It's better, though, than it was in 2016, isn't it?

18 A: Correct, but it goes to the fact that blood pressures
19 preoperatively are elevated and unreliable and don't actually
20 reflect the baseline.

21 Q: So why do you even do them?

22 A: Why do -- why do a preoperative pressure?

23 Q: Yeah.

24 A: They don't do them in Great Britain. Their national
25 guidelines show that if you have a documented blood pressure

1 that's normal from your primary care not to even do a blood
2 pressure the morning of surgery because it's not really
3 reliable information.

4 Q: Do we practice in Great Britain or Columbia, South
5 Carolina?

6 A: No, sir. But we're all doing anesthesia, taking care of
7 patients.

8 Q: Okay. Doctor, let's look at Exhibit 36. This is her
9 blood pressures taken in the 2011 surgery, and we looked at
10 those a second ago on the -- on the other demonstrative that
11 has them all together.

12 A: Sure.

13 Q: These blood pressures -- I'll represent to you that
14 Crystal testified at 2011 her blood pressures typically ran
15 around 135 over 75. What mean arterial pressure would that
16 be?

17 A: 135 over 75 would be 18 -- so 94 or --

18 Q: 94 or 95; right? Yep. And I think I've got a mistake
19 there.

20 A: I didn't know I needed math.

21 Q: That's all right. I'm happy to get you a calculator if
22 we need to, but -- but I think actually we've got a mistake on
23 there. I want to correct it. I just did that in my head too.
24 We should put -- we should put 95.

25 MR. HINSON: Any objection to correcting that typo?

1 MR. DAVIS: No objection.

2 MR. HINSON: All right.

3 BY MR. HINSON:

4 Q: We -- can we change that 92 to 95, Doc? So she's
5 creeping up from -- from '09 to '11, going from 85 to 95. If
6 she was running at mean arterial pressure baseline, a baseline
7 MAP of around 95, those would be appropriate blood pressures
8 for the surgery? They never dropped below 70.

9 A: She was maintained between roughly 70 and 100 with that
10 one 20-minute period where she popped up and then probably
11 upon waking up, it jumped up because she had a breathing tube
12 down her throat. But yeah.

13 Q: But she wasn't too low, was she?

14 A: No, sir.

15 Q: Okay. But generally do you agree, Doctor, when planning
16 on how to manage a patient's blood pressure when the patient
17 is under anesthesia, a history of chronic hypertension may
18 impact your plan?

19 A: It may impact. It does not always.

20 Q: Do you agree that Crystal's risk factors for this surgery
21 included chronic hypertension and diabetes?

22 A: Mild hypertension. Mild diabetes.

23 Q: Is that a yes?

24 A: Yes.

25 Q: And so if other experts have testified that 152 over 112

1 is severe hypertension, you would classify it as mild
2 hypertension?

3 MR. DAVIS: Your Honor, that's pitting witnesses.

4 MR. HINSON: I'll retract the question.

5 MR. DAVIS: Thank you.

6 BY MR. HINSON:

7 A: Sir, again --

8 Q: It's your testimony this is mild hypertension?

9 A: Sir, I will say that a single point in time blood
10 pressure that you've taken without knowing the circumstances
11 -- I could have a blood pressure of 170 over 110 as a single
12 blood pressure if I was very angry yelling at my husband, but
13 that does not mean it's my baseline. It doesn't mean where I
14 live. It does not mean that my body cannot adapt and maintain
15 good blood flow with a mean pressure of 70 to 100.

16 Q: More readings is better, isn't it, Doctor?

17 A: More readings done on a consistent basis over a period of
18 time, same time every day for two weeks, is generally what in
19 the primary care world that you'll see.

20 Q: So if blood pressures over time are important and a
21 patient has chronic hypertension, diabetes, and two prior
22 surgeries at the same location, would it be prudent prior to
23 the surgery then to say, patient, I'd like you to check your
24 blood pressure every day and write them down for me and let me
25 know what they are? Would that be helpful to you?

1 A: It actually really would not because this -- well, I
2 can't mention the studies. Because the science as we
3 understand the blood flow during procedures is that actually
4 preoperative blood pressures don't really have that much of an
5 impact for intraoperative management because the conditions
6 are so radically different.

7 Q: Okay.

8 A: Blood flow and blood pressure are not the same thing.

9 Q: All right. So I want to make sure I understand. You
10 would like to have more information to establish a baseline
11 blood pressure; right? Yes or no?

12 A: There are two ways to go about this. You either
13 establish a baseline or you just work to keep the patient's
14 mean pressures between 70 and 100.

15 Q: Okay. So you either keep them between 70 or 100, keep
16 everybody the same, or you try to gather enough information to
17 figure out what their preoperative baseline is; fair?

18 A: That's a fair statement.

19 Q: Don't you agree that having more information and
20 tailoring it to the patient would be better than treating
21 everybody the same?

22 A: You're saying we're treating everyone the same, but we
23 actually don't treat everyone the same. But we're using the
24 -- the guidelines that we know are where patients have the
25 best outcomes from surgery.

1 Q: If you have the choice between having information about
2 what this patient's blood pressure has been running at home
3 over the last two weeks or so, or not having that information
4 and just sticking them between 70 and 80, which are you going
5 to choose?

6 A: That's an interesting question. I have never in my
7 career been handed the information from a patient about their
8 baseline blood pressure.

9 Q: Okay. But that's not my question though, Doctor. My
10 question is, if you had the choice between just putting a
11 patient between 70 and 100 or having the information over,
12 say, the last two weeks of where their blood pressure has been
13 running, which would you choose?

14 A: I think I would choose to go with where I know that blood
15 flow during surgery patients have the best outcomes, and
16 that's between 70 and 100.

17 Q: Okay.

18 A: That's what I would choose.

19 Q: You don't -- all right. All right. Did you look at the
20 urine output in this case?

21 A: Yes, I did.

22 Q: Do you agree it was low?

23 A: Yes, it was low.

24 Q: All right. Generally, what's the rule of thumb on how
25 much urine output you like to see during the course of a

1 multi-hour surgery?

2 A: Sure. So my rule of thumb is, generally, I'd like to see
3 a half a cc per kilo of lean body mass per hour.

4 Q: 0.5 milliliters per kilogram per hour?

5 A: Correct.

6 Q: And where did Crystal's fall?

7 A: Hers fell a little bit below that.

8 Q: A good bit below that, didn't it?

9 A: I believe she put out 80 to 100cc.

10 Q: I'd represent to you it was 80. I'm happy to show you if
11 you'd like to see it. Well --

12 A: No.

13 Q: -- it won't take a second. Let me show you.

14 A: You should put up -- I would have to look and see when
15 her last --

16 Q: Total? Total urine output?

17 A: Yes. The last urine measurement was approximately 10:30.

18 Q: And then no urine after that; right?

19 A: Well, none that was documented. Correct.

20 Q: Don't you want it to be documented if it's there?

21 A: Well, generally speaking, it has a container on the side
22 of it, and every time it -- you document it, you take the
23 little container, you measure, and you write down and you flip
24 it into the large bag. Toward the end of the case, when you
25 get busy, you don't often go down and do the hourly

1 measurement because you're more focused on waking the patient
2 up.

3 Q: So when you're on -- you aren't checking the urine
4 towards the end of the -- end of the case?

5 A: At the very end of the case, often you are distracted
6 taking care of the patient.

7 Q: All right. And the urine -- urine bags look like this;
8 right?

9 A: Correct.

10 Q: That's what y'all use at Prisma; right? More or less
11 looks like this; right?

12 A: That's generally what everyone uses.

13 Q: In fact, this is actually the brand y'all use, isn't it?

14 A: I couldn't tell you.

15 Q: You couldn't tell me? Okay. It's got the little hard
16 thing like this?

17 A: Uh-huh.

18 Q: And that's been around for a while, hasn't it?

19 A: Uh-huh.

20 Q: That was around -- it was around in 2016, wasn't it?

21 A: Yes, sir.

22 Q: Okay. That's what I thought. This is some hard -- hard
23 clear plastic isn't some brand new invention that just came
24 into the operating room a couple of years ago, is it?

25 A: No, sir.

DR. JENNIFER ROOT - CROSS BY MR. HINSON

1 Q: Okay. Doctor, when the SSEP signals went off -- went
2 out, no one let you know; isn't that true?

3 A: That's correct.

4 Q: And you would have liked to have known, wouldn't you?

5 A: I would have liked to have known. I like to know what's
6 going on in the room.

7 Q: And it was a significant event; right?

8 A: It was, to my knowledge, determined by the surgeon in the
9 room to be an equipment malfunction.

10 Q: Well, we now know that wasn't true, don't we?

11 A: Well, that's -- that's the pleasure of being able to look
12 backwards in time and not as you're living at real time.

13 Q: But you agree neuromonitoring signals going out is a
14 significant event; right?

15 A: It can be. Fifty percent of the time, apparently, it can
16 have no relation with outcome.

17 Q: But you don't know that at the moment, do you?

18 A: You don't.

19 Q: Okay.

20 MR. HINSON: No further questions at this time, Doctor.

21 THE COURT: Any redirect, Mr. Davis?

22 MR. DAVIS: One question, I think, Your Honor. May it
23 please the Court.

24 REDIRECT EXAMINATION

25 BY MR. DAVIS:

DR. JENNIFER ROOT - REDIRECT BY MR. DAVIS

1 Q: I want to start where Mr. Hinson left off about urine
2 output, and that -- that triggered in my mind that's what I
3 was going to try to ask you about that I forgot.

4 MR. DAVIS: So thank you, Mr. Hinson.

5 MR. HINSON: You're welcome.

6 BY MR. DAVIS:

7 Q: The -- the -- the urine output that was recorded, 80cc,
8 in your opinion, as the M.D. anesthesiologist who is in charge
9 of that anesthesiology team for that surgery, Dr. Root, in
10 your opinion, was her urine output proof or an indication that
11 she had low blood flow to her kidneys during her surgery?

12 A: Absolutely not.

13 MR. DAVIS: Nothing further. Thank you.

14 THE COURT: Mr. Hinson?

15 MR. HINSON: I think one question.

16 RE CROSS-EXAMINATION

17 BY MR. HINSON:

18 Q: Do you agree that low blood pressure can cause low urine
19 output?

20 A: It can.

21 MR. HINSON: Thank you. No further questions.

22 THE COURT: All right. Thank you. You may step down.
23 Leave all the exhibits up there.

24 MR. DAVIS: Your Honor, may she be excused?

25 THE COURT: Any objection, Mr. Hinson?

1 MR. HINSON: No, Your Honor.

2 THE COURT: All right. You are free to go, Dr. Root.

3 Any additional witnesses, Mr. Davis?

4 MR. DAVIS: Your Honor, I've been waiting a long time to
5 say this. The defense rests.

6 THE COURT: The defense rests.

7 All right, ladies and gentlemen. It's right at 5
8 o'clock. So, as I've told you a couple of times, all that
9 remains is the closing arguments of the attorneys and my
10 charge to you on the law. After that, you will begin to
11 deliberate and continue to deliberate until you reach the
12 verdict, and we'll do all that in the morning.

13 Please be back in your jury room at 10 o'clock tomorrow
14 morning. Don't discuss the case amongst yourselves. Have a
15 good night.

16 (WHEREUPON, the jury exited the courtroom at 4:59 p.m.)

17 THE COURT: I'd really like to discuss jury charges in
18 the morning. I just don't know if that's reasonable.

19 MR. DAVIS: Judge, that is your pleasure.

20 MR. GOINGS: My only suggestion, Your Honor, is obviously
21 in our closing we need to be able to, you know, explain
22 concepts of the law, what they're going to be charged on. I'd
23 hate -- and I don't actually want to say something in our
24 education in our closing that you're not going to charge and
25 so --

1 THE COURT: Oh, sure. So if we did them in the morning,
2 we would reconvene at 9 with the jury coming at 10. Would you
3 rather do it this afternoon?

4 MR. GOINGS: Well, it's just like a lot of times we have
5 to put something on -- on PowerPoint and everything, and just
6 -- I will do what you want to do, Judge. I would defer to
7 you.

8 THE COURT: I know. Let's do it.

9 MR. DAVIS: I don't think it's -- I don't think it's
10 going to take that long honestly, Judge, and I agree with my
11 friend. Preparing closing argument takes considerable effort
12 and time and thinking, and it's just so much more helpful if
13 you know you're not going to charge this or you are going to
14 charge that. So it does help frame how we prepare our
15 closing, but I think that's the only thing that Mr. Goings and
16 I are ever going to agree on.

17 MR. GOINGS: You know what? And where is it in the
18 trial?

19 THE COURT: Okay. So let's go through Plaintiffs'
20 Revised Amended Request to Charge to add to the Court's
21 working draft.

22 I have added vicarious liability to the charge. Any
23 objection to that?

24 MR. DAVIS: Your Honor, just if I can, I'm going to let
25 Andrew handle the rest of it, but just on vicarious liability,

1 in the past in cases like this, we never required an
2 instruction on vicarious liability. We will agree on the
3 record however we need to do it that if there is a verdict
4 against Dr. Holbrook that vicarious liability should apply and
5 that a judgment should be entered against both defendants.

6 So it just makes it cleaner. I mean, Midlands and Dr.
7 Holbrook are both defendants. I know if -- if a defendant
8 says or a plaintiff insists on vicarious liability, that's
9 fine, but I just -- I don't object. I'm just saying I don't
10 think it's necessary. We agree ahead of time that this is a
11 vicarious liability case. I stipulate to that.

12 THE COURT: Is it necessary, Mr. Goings?

13 MR. GOINGS: I think it is, Your Honor. I mean, the jury
14 needs to understand, you know -- you know, the relationship
15 that an employer is liable for the acts or omissions of his or
16 her employees. I've always seen it charged. I'll tell you,
17 I've never seen it not charged in a case of vicarious
18 liability.

19 MR. DAVIS: You haven't tried cases with me.

20 MR. GOINGS: And this is my first trial with Ashby.

21 THE COURT: Well, I have -- because to Mr. Davis's point,
22 if we're not separating one defendant from the other, then
23 does it really matter in this case? If they're -- they being
24 the jury, they are going to find either in favor of the
25 plaintiffs or the defendants collectively. Does it really

1 matter? I mean, I have a charge about a corporation as a
2 person and its acts through people.

3 MR. GOINGS: Well, Your Honor, I think there could be
4 some questions of the jury about, well, where does Midlands
5 fit in here? Is Midlands going to be responsible for Dr.
6 Holbrook, is responsible for -- I just think it's neater and
7 cleaner just to throw in these two paragraphs -- three
8 paragraphs about the short -- about vicarious liability and
9 the fact that an employer is liable for the acts and omissions
10 of their employees.

11 THE COURT: All right. I've already added it. I -- if
12 anything needs to come out, that may be it. And when I say
13 needs to come out, that's just because when the jury charges
14 are getting too long --

15 MR. GOINGS: Agreed.

16 THE COURT: -- you'll lose the jury. And so, it's --

17 MR. GOINGS: That is -- I am the least -- I care less
18 about that one than I do some other ones. I'll put it that
19 way.

20 THE COURT: Yes, sir.

21 MR. GOINGS: And I agree with you --

22 THE COURT: Okay.

23 MR. GOINGS: -- that if you need to cut one, that could
24 be a wise one.

25 THE COURT: Okay. Recklessness has been added.

1 Any objection to that, Mr. Heitman?

2 MR. HEITMAN: Yes, Your Honor. We don't believe that the
3 evidence in this case that's been presented supports a jury
4 charge for recklessness.

5 THE COURT: I'm sorry. You know what? Let's make you
6 talk directed verdict first.

7 MR. DAVIS: Thank you.

8 THE COURT: Pause here. Yes, sir, Mr. Davis?

9 MR. DAVIS: For the record, Your Honor, we'd renew our
10 motions for a directed verdict on the issue in their case in
11 chief and for failure to prove with evidence of
12 foreseeability, which is the touchstone of proximate cause.

13 Second, we would respectfully move for a directed verdict
14 on the issue of gross negligence. There has been no testimony
15 from any expert that Dr. Holbrook's conduct was grossly
16 negligent or even directly or indirectly impliedly can be seen
17 by a reasonable jury. So we would ask for that to be a
18 directed verdict on gross negligence.

19 MR. GOINGS: I'll reiterate my prior arguments,
20 incorporate them as fully stated, Your Honor.

21 THE COURT: Yes, sir. Motion for direct verdict is
22 respectfully denied.

23 Now, given that, subject to --

24 MR. DAVIS: Thank you.

25 THE COURT: -- the motion for a directed verdict, is

1 there any additional objection as to the charge of
2 recklessness?

3 MR. HEITMAN: Nothing additional that wasn't presented in
4 the motion for a directed verdict.

5 THE COURT: Okay. We'll keep recklessness.

6 Elements of actual damages. I had an actual damages
7 charge that didn't list these things. I think I probably
8 should have. So --

9 MR. GOINGS: And that's why I added it. This is out of
10 the charge book.

11 THE COURT: Yes, sir.

12 MR. GOINGS: You had a condensed, shorter version, and I
13 just threw in that last paragraph.

14 THE COURT: Yeah. We're working from an older charge
15 that I made, and I forget what case that was that maybe didn't
16 require all of this, but I think this is appropriate.

17 Any objection, Mr. Heitman?

18 MR. HEITMAN: Yes, Your Honor. I'm -- I'm sorry. I made
19 all my notes off of their original proposed jury charges, so
20 I'm trying to get through here and find it, but I believe it
21 should say the language in it on that paragraph where it says
22 in determining the amount of compensation for injury suffered
23 by the plaintiffs as a result of this negligence.

24 I don't believe that language is proper because they
25 haven't determined at that point that the defendants are

1 negligent. I think that it should say, you know, if you
2 determine that the defendants are negligent by a preponderance
3 of the evidence and if you determine that the injuries were
4 the proximate result of the defendant's negligence.

5 THE COURT: All right. This is directly from Ralph King
6 Anderson's book. I'm going to charge it as it is in the book.
7 It's not the entire charge in Ralph King Anderson's book
8 because there are certain elements of damages that need not be
9 enumerated here.

10 Also, the list is very long, and I have separate charges
11 on some of these things, such as -- I don't know. I mean,
12 depression is listed, for example, as a separate element. I'm
13 sure the plaintiffs are going to argue that that is part of
14 the damages. It's not in this enumerated list, but I think
15 that's -- that goes to mental anguish, loss of enjoyment of
16 life, et cetera. It's subsumed within that. So I will charge
17 elements of actual damages.

18 MR. GOINGS: And, Your Honor, you picked up on something
19 that some of these are your charges that you already did with
20 just a little bit of additional information per the charge
21 book. So you will see a lot of this is actually redundant to
22 what you already have, maybe adding a paragraph or taking out
23 a claim that's not relevant to this case.

24 THE COURT: Yes, sir.

25 MR. GOINGS: So --

1 THE COURT: Value of medical and health care expenses.
2 Let me hear from you, Mr. Goings.

3 MR. GOINGS: This was out of the charge book as well, and
4 there's actually a separate one for health care expenses, so I
5 included this one. I did not -- I did not craft this on my
6 own.

7 THE COURT: Why -- but the charge already includes --

8 MR. GOINGS: You're right. It does. It includes some
9 sentences about it. This is one, Judge, that I'm not -- I
10 have -- I don't have strong feelings about this one.

11 THE COURT: Okay. So I'm not going to add that. I think
12 it's an appropriate charge, and we'll double check to make
13 sure that what I have already encompasses what is suggested.

14 MR. GOINGS: I'm mindful of the length of charge, and I
15 -- and I hear you on that. So --

16 THE COURT: Okay. Yes, sir.

17 Loss of enjoyment of life. I know that my charge, which
18 I can't put my hand on right now, is relatively short.

19 MR. GOINGS: It is. And so I just say we put this whole
20 one in there, which just is another sentence that talks about
21 pursuits of her talents, recreational interests, hobbies,
22 applications. There was direct testimony about that. And
23 again, that's straight out of the charge book.

24 THE COURT: I think the charge is appropriate. Any
25 objection, Mr. Heitman?

1 MR. HEITMAN: Your Honor, if it's -- if it's directly out
2 of the charge book, word for word, then no. However, there
3 was no citation on it. It's a little bit different than what
4 the plaintiffs had submitted to the Court in their original
5 proposed jury charges, which -- which also did not have a
6 citation. So to the extent it's the exact same as what's in
7 your charge, we would have no objection. However, if it -- if
8 it is, then I would object to whatever is different.

9 THE COURT: It seems to mirror the charge book. I won't
10 include that more lengthy version from the charge book.

11 Mental anguish. Mr. Goings?

12 MR. GOINGS: I thought this charge was important. You
13 already have mental anguish, but it omitted the -- the -- the
14 text about differentiating -- differentiating -- I can't say
15 that word. Yes. Between physical pain and suffering and the
16 emotional effect or the emotional harm of the physical pain
17 can result in mental anguish, the mental reaction to the pain
18 and the possible consequences of the injury.

19 I mean, this is right out of the charge book too. You
20 can take that last sentence out if you want to. The amount of
21 mental suffering cannot be exactly measured, but will be left
22 to the judgment of you, the jury, because you say that earlier
23 when you talk about just non-economic damages. You know,
24 there's not a --

25 THE COURT: What say you, Mr. Heitmann?

1 MR. HEITMAN: Your Honor, I would object to the extent
2 that it is duplicative with what your charge already
3 concludes. And, your Honor, I don't -- I didn't see a
4 citation on this charge either, and so I would object for
5 those reasons.

6 MR. GOINGS: And, Your Honor, the reason I didn't put
7 cites is because the charge book didn't have a cite. I
8 literally copied and pasted it in here from the book. So I'm
9 sorry I don't have a cite.

10 THE COURT: All right. We'll include the longer charge
11 on mental anguish or mental suffering.

12 All right. The duty to provide patient diligent care.
13 Mr. Goings?

14 MR. GOINGS: I think this is an appropriate charge. I --
15 you know, when you look at some of the charges that -- that
16 you're going to charge, they read in a way that seems -- not
17 that it is, but seems to be more defense friendly.

18 This one right here is the duty to provide patient
19 diligent care. That is the law, and it is not inconsistent
20 with anything that you -- that you previously have, but what I
21 think is this charge balances the scales a bit on the overall
22 malpractice charge that I've seen previously, and we've used
23 it in other cases, you know, without any problems. So we've
24 put it in here.

25 THE COURT: Mr. Heitman?

1 MR. HEITMAN: Your Honor, we would object. I believe the
2 first line is inappropriate. That's -- that's asking the
3 Court to comment on the facts. It -- it's uncontested that
4 physician-patient relationship exists between Crystal Goodwin
5 and defendants Dr. Holbrook and Midlands Orthopedics and
6 Neurosurgery. Well, while that may be true, I don't think
7 that's proper in a jury charge.

8 Also, in this case, there's no allegation for the failure
9 to treat Ms. Goodwin. Everyone agrees that Dr. Holbrook
10 performed the 2016 surgery and that it was indicated. So we
11 don't believe that charge to be relevant in this case.

12 THE COURT: It's not about diligence and methods of
13 discovering the nature of the ailment?

14 MR. GOINGS: That's our whole case. And the first
15 sentence I don't think is -- I mean, I think we all know this
16 is a patient-doctor relationship. There's no -- that is
17 uncontested, but if he's got a problem with an uncontested
18 fact, please take it out. I don't -- I don't want -- I don't
19 want that to throw anybody.

20 MR. HINSON: Well, their answer says they admit it.

21 MR. GOINGS: Oh, they do answer. They admitted it in the
22 answer.

23 Quote, answer on -- answer in paragraph 15. To quote,
24 these defendants admit a doctor-patient relationship existed
25 between Dr. Holbrook and Crystal Goodwin during all times

1 indicated in the medical records of Crystal Goodwin.

2 Just read it, the answer of the defense.

3 MR. HEITMAN: Well, we don't -- we don't contest it. I'm
4 not saying we contest it, but I don't think it's appropriate
5 for the Court to comment on the facts of the case.

6 THE COURT: Well, the Court very often comments on
7 uncontested facts or legal conclusions. For example, if this
8 were an ordinary negligence case and the defense admitted
9 liability and the jury need only determine damages, I would
10 tell the jury that the defendant admits duty breached and that
11 some damages were proximately caused by that breach of duty,
12 and you need only determine the extent of the damages.

13 I don't think that's uncommon or inappropriate where it's
14 uncontested. It's essentially telling the jury that this is
15 an element of this claim that they need not determine. That's
16 already been determined because everyone agrees it's
17 uncontested.

18 If it were contested, then I'm with you, but uncontested,
19 I think, is harmless. It just saves the jury a step and --
20 and sort of corrects on the front end for a potentially
21 inconsistent verdict for them to find, for example, I mean,
22 hypothetically, that no physician-patient relationship existed
23 would be inconsistent with the allegations of the complaint,
24 the answer. I mean, it would really kind of nullify their
25 verdict because it would be wholly inconsistent with what

1 we're doing here. So that takes that possibility -- take that
2 out of the realm of possibility.

3 MR. HEITMAN: I understand, Your Honor, and we would
4 still object based on the fact that there's no allegation of
5 failure to treat patient.

6 THE COURT: Well, there is. The whole case is failure to
7 appropriately diagnose and treat when the signals went out and
8 -- and but for Dr. Holbrook continuing the surgery and not
9 stopping to address the concern, then Crystal wouldn't be in a
10 wheelchair. That -- that's the case.

11 MR. HEITMAN: I -- I guess I read that as a failure to
12 perform -- perform the surgery and treat her for her spinal
13 stenosis. I think, to me, it seems -- well, that was my
14 interpretation of it.

15 THE COURT: And I see where you get that, and I think
16 that's -- that maybe needs to be cleared up in argument, but
17 to the extent that it's an accurate statement of the law, that
18 does potentially -- that applies to the allegations in this
19 case, at least I will charge that. I will include that, do
20 you provide patient diligent care, on page 5.

21 MR. GOINGS: The next, loss of earning capacity, that's
22 straight out of the -- the book.

23 THE COURT: We've included that.

24 MR. GOINGS: The next one, more technically --

25 THE COURT: Hold on.

1 MR. GOINGS: Oh, I'm sorry. I didn't mean to talk over
2 you. Sorry.

3 THE COURT: Any objection to loss of earning capacity,
4 Mr. Heitman?

5 MR. HEITMAN: Yes, Your Honor. We would object to the
6 physical pain and suffering, Number 4. That -- that sentence,
7 we would object to that.

8 THE COURT: Why? On what basis?

9 MR. HEITMAN: Well, I don't -- I don't believe that was
10 included in the -- in the case citations I looked at.

11 THE COURT: Is it an incorrect statement of the law, sir?

12 MR. HEITMAN: I believe on loss of earning capacity, it
13 is.

14 THE COURT: Based on what?

15 MR. HEITMAN: I think physical pain and suffering goes
16 towards non-economic damages and -- and loss of earning
17 capacity goes towards economic damages.

18 THE COURT: Do you have a case citation, statute,
19 something?

20 MR. HEITMAN: Well, I don't have a case on that, no.

21 THE COURT: Yeah, it's a correct statement of the law. I
22 find that it is, and I'm going to base that on Ralph King
23 Anderson's research and all of his citations to cases where
24 that was found to be a correct statement of the law. So
25 that's what I'm relying on. We will charge loss of earning

1 capacity as I've already included that.

2 Mortality table.

3 MR. GOINGS: Yours is fine. The only reason I put this
4 one in here, Judge, is so you can see that there's actually
5 James Goodwin's mortality table as well. It needs to be
6 included because of his loss of consortium -- consortium for
7 his lifetime. If I'm wrong on this, just say, Robert, you're
8 wrong. I don't care. I mean, I don't care about this one,
9 really, but I care about James Goodwin.

10 THE COURT: So what say you, Mr. Heitman?

11 MR. HEITMAN: We would object to that as duplicative, as
12 well as I'm not exactly sure of a case that states that loss
13 of consortium should -- there should be a mortality table for
14 a loss of consortium claim.

15 MR. HINSON: Your Honor, if I might, could I speak on
16 this?

17 THE COURT: Yes, sir.

18 MR. HINSON: Thank you. If James, for instance, was a
19 lot older than Crystal, which he isn't, and let's just say he
20 only had five more years on his mortality table, which thank
21 goodness he doesn't, then the jury would only consider his
22 loss of consortium would last for five more years.

23 But in this case, they have almost the exact same
24 statutory life expectancy. So the presumption under the law
25 of South Carolina is that James will lose the companionship

1 and society of his wife that he otherwise would have pretty
2 much for the remainder of his life, and I think that's what
3 the jury should -- when they hear those mortality tables, they
4 can understand that. I think James -- and James and Crystal
5 and I are all three the same age, and it's kind of -- I have
6 to say, it's harrowing to realize what the law of South
7 Carolina says my life expectancy is.

8 But the point being, he will spend the rest of his life
9 taking care of his wife, according to the statutory life
10 expectancy tables, and that's what I think is important that
11 his life expectancy also be mentioned.

12 THE COURT: What say you, Mr. Heitman?

13 MR. HEITMAN: Your Honor, I don't really have anything to
14 add other than what I -- what I've already mentioned my
15 objections are.

16 THE COURT: That's what I'm unsure about. Certainly, for
17 argument, that's fair game. He is as old as he is, and -- and
18 life expectancy is what it is according to the life expectancy
19 table, and I think that's appropriate for argument.

20 Whether I will include James's life expectancy in the
21 charge, I'm unsure about. I actually need to look that up and
22 ask around, because I'm accustomed to that being associated
23 with physical -- permanent physical injury, and so I'm not
24 saying that this is incorrect. I just don't know the answer
25 to that yet. But for purposes of your argument --

1 MR. GOINGS: Thank you, Your Honor. Yeah, I guess I'm
2 trying to draw the situation if he were a lot older than
3 Crystal and his life expectancy was shorter, they'd say we
4 wanted to include that, that he's only got seven more years of
5 life anyway, but I think my point has been made. Thank you,
6 Your Honor, for considering it.

7 THE COURT: Yes, sir.

8 Physical evaluation. Mr. Goings?

9 MR. GOINGS: Your Honor, that's right out of *Jernigan v.*
10 *King*, and so -- and it -- and it has -- some of this language,
11 Your Honor, quite frankly, can be added to your -- just to
12 make sure your other malpractice charge has this -- this
13 language. It might. I need to look about the fact that that
14 evaluation should be made with diligence and methods of
15 diagnosis that are usually approved.

16 And this goes -- this evaluation goes to the blood
17 pressure, and the diligent care you should undertake as a
18 physician once you know somebody's blood pressure, especially
19 going into surgery.

20 MR. HEITMAN: *Jernigan v. King*?

21 MR. GOINGS: Yeah. And that is also in the charge book.
22 It's in -- it's in -- this is actually in the charge book.
23 Yeah, on page -- right above substitution of doctors in the
24 charge book.

25 MR. DAVIS: Your Honor, may I be excused? I don't want

1 to leave if you need me.

2 THE COURT: Yes, sir.

3 MR. DAVIS: Thank you.

4 MR. GOINGS: Every time we say Ralph King Anderson here,
5 it makes Mr. Hinson very, very happy because he is the former
6 law clerk of the Honorable Ralph King Anderson, Jr.

7 THE COURT: Oh.

8 MR. GOINGS: Which kind of explains some things, perhaps,
9 like the big words and stuff. That's why you had an omnibus
10 motion from the plaintiffs, Your Honor.

11 THE COURT: I wondered.

12 MR. GOINGS: That's what I told him. I said what does
13 that mean? What's an omnibus?

14 And my wife, Rebecca, who is a clerk in the Court of
15 Appeals, she said that sounds like a Ralph King Anderson word
16 to me.

17 THE COURT: Yeah, it definitely does.

18 MR. GOINGS: And his legend -- he lives on; right?

19 THE COURT: Absolutely.

20 MR. HINSON: Nothing would make him happier than to know
21 right now that we were discussing him and his big words. That
22 would -- that would please him to no end.

23 THE COURT: Goodness.

24 Mr. Heitman, let me hear from you.

25 MR. HEITMAN: We -- we would object to this jury charge

1 as well. I -- I read that case, Your Honor. I -- I really
2 have no idea where they got the language from, because I could
3 not find that in that case at all.

4 The case they cited was about a child that was
5 temporarily under the care of a doctor who was filling in for
6 his -- a senior physician, and the doctor ordered a CT, but
7 did not read it because the CT didn't result until the --
8 until his care ended. And so the case was about, you know,
9 what the -- what the doctor's duty of care was to the child,
10 and I really don't -- didn't see anywhere where it talked
11 about evaluation.

12 THE COURT: Okay. Where did you tell me it was, Mr.
13 Goings, in the book?

14 MR. GOINGS: *Jernigan v.* -- where was it or where is it?

15 THE COURT: Where is it in the -- the charge of what
16 we're calling it.

17 MR. GOINGS: It's above -- it's above -- it's the charge
18 right above substitution of doctors. I have the electronic
19 version of it. I can show you that, and it's a direct quote.
20 And they in a footnote cite the *Jernigan v. King* case. It
21 shows this on page 49 of the charge book. That's --

22 THE COURT: This is probably an older version. It's not
23 49 in mine.

24 MR. GOINGS: So here's the civil charges for judges, June
25 of 2006. And then --

1 THE COURT: Oh, I'm sorry. I meant the Ralph King
2 Anderson book.

3 MR. GOINGS: Okay. Well, this is the one that the -- that
4 the Supreme Court did.

5 THE COURT: The Bench Book. Gotcha.

6 MR. GOINGS: Bench Book. Okay. So I'm calling it the
7 wrong one.

8 And then under the medical malpractice, there is failure
9 to diagnose and treat, which you just charged. Right under
10 that is evaluation. Page 49. And then 49, direct quote. If
11 you want me to, I can email you what we have here. Just --

12 THE COURT: So I haven't read the *Jernigan* case. I just
13 did a keyword search, but I would tell you that Mr. Goings did
14 get it from the judge's Bench Book, and that in the Bench Book
15 there is a citation to *Jernigan*. So clearly whoever composed
16 the Bench Book thought that that's the proper position to be
17 taken from *Jernigan*.

18 I don't know if that's right or wrong, because I've not
19 read *Jernigan* as I sit here, but it -- it is a charge that's
20 suggested in the Bench Book. So the question would be whether
21 it is appropriate to charge in this case under these facts.

22 Do you have any comment on that, Mr. Heitman?

23 MR. HEITMAN: I -- Your Honor, I would -- I would just
24 object. I would -- my objection -- my objection is this is
25 being charged as just based on that -- on that case not being

1 a pro map [ph] case.

2 THE COURT: Okay.

3 MR. GOINGS: All right.

4 MR. HEITMAN: So --

5 THE COURT: I'll review the case, but if it is
6 appropriate -- an appropriate statement of the law, then I
7 will charge it. I'll do that this evening.

8 Moving on to pre-existing condition, I have included
9 that. I've just sort of talked about that on the front end.

10 Any objection, Mr. Heitman?

11 MR. HEITMAN: Objections to including the defense charge,
12 I'd object as duplicative, as well as, I believe, about
13 halfway down where it says -- it says the defendant is
14 responsible for all ill effects, which considering the
15 plaintiff's condition of health when the plaintiff was injured
16 naturally and necessarily flowed from the injury.

17 I think that there should be some kind of statement in
18 there. You know, if you find liable to plaintiffs on the
19 evidence that the defendant was negligent and the defendants'
20 negligence was the proximate cause of the plaintiffs'
21 injuries.

22 THE COURT: Okay. I don't find it to be duplicative. I
23 mean, I'll double check and make sure that this isn't stated
24 elsewhere, but to the extent that it's not, I will charge it
25 as written on pre-existing conditions or eggshell plaintiffs.

1 It's a correct statement of law, and the suggested charge
2 really doesn't include that preponderance of the evidence if
3 you find, you know, all of these other things because you
4 don't get to damages unless you have found all of these other
5 things.

6 MR. HEITMAN: My concern was just with it says -- it says
7 that the defendants are or the defendant is responsible for
8 all ill effects.

9 THE COURT: Again turning to Ralph King Anderson's book
10 as our authority on this, it is the law of the state that one
11 who negligently inflicts a personal injury on another is
12 responsible for all ill effects, which considering the
13 condition of health in which the plaintiff was in when
14 received the injury naturally and necessarily follows such
15 injury.

16 I think the only difference is we've changed the person
17 causing the injury to defendant. So I will charge pre-
18 existing conditions over defense objection.

19 Fraud and misrepresentation. Mr. Goings?

20 MR. GOINGS: Yes, Your Honor. If you look at -- and I've
21 put the case law with the statute. If you look at the statute
22 15-32-220(e), this deals with the exceptions to the cap.
23 There are three exceptions to the cap.

24 And, quote, first one, quote, if the jury or the Court
25 determines that the defendant was grossly negligent, willful,

1 wanton, or reckless, and such conduct was the proximate cause
2 of the claimant's economic damages. Well, you know, you've
3 already put in the definition of gross negligence and
4 reckless. We've gone there.

5 The second one is, quote, if the defendant has engaged in
6 fraud or misrepresentation related to the claim. Okay? And
7 that is the section that we're talking about. The third one
8 is inapplicable, and we don't ask for a charge on that. That
9 deals with destroying medical records.

10 But there is significant evidence in this case to support
11 that the defendant engaged in fraud or what we would argue as
12 it relates to misrepresentation related to the claim. And
13 that misrepresentation, quite frankly, Your Honor, goes back
14 to the issue of neuromonitoring.

15 The biggest thing that could happen in this type of
16 surgery is the neuromonitoring goes off, and it's not anywhere
17 in an operative report. There is no medical record in the 600
18 pages. These 600 pages of records, there's not one reference
19 anywhere that the signal went out or the signal was lost. The
20 discharge that talks about what happened, not one mention of
21 neuromonitoring ever.

22 And we only found out about the neuromonitoring, Judge,
23 in discovery in this case because there is no neuromonitoring
24 records anywhere, and we ended up having to bring in Dr. Erich
25 Starn as an additional party outside of the statute of

1 limitations, because neuromonitoring failure was omitted from
2 anything, and it was only first discovered in discovery in
3 this case.

4 So -- and if you -- if you look at the radiology report
5 as to why they needed to do the MRI -- you can take that back
6 -- why they needed to do the MRI, it wasn't because the
7 signals went out or she's not feeling her legs because the
8 signals went out. There's no mention of anything related to
9 signals. Dr. Holbrook wrote and it said MRI because she fell
10 three days ago.

11 And so here's the thing. Nobody -- my -- our position is
12 Dr. Holbrook didn't want anybody to know about the signals
13 going out. That's why this last witness just told the truth
14 when she said -- wait for it -- nobody was called from
15 anesthesia because Dr. Holbrook said that the -- that the --
16 that the -- the equipment just broke and he was just going to
17 go on with it without it, and that is -- that was a major
18 mistake, and he -- he lived and died by that mistake, and he
19 did not put anything anywhere about it.

20 And that is a blatant, bold misrepresentation from the
21 start of this problem, and we're now talking about it nearly
22 seven years later. That is only one of the misrepresentations
23 that we have.

24 And if you see, it's engaged in fraud or
25 misrepresentation related to the claim. Our request to charge

1 is just that -- just defining fraud and defining
2 misrepresentation, and those definitions are out of the charge
3 book.

4 Because if you look at our verdict form, the jury needs
5 to be able to check yes or no for gross negligence and check
6 yes or no for -- for misrepresentation. So that's the basis
7 of our charge for it. Thank you.

8 MR. DAVIS: Are we talking about verdict form now. I'm
9 just -- I'm just --

10 MR. GOINGS: No. We're just --

11 MR. DAVIS: Thank you.

12 THE COURT: Mr. Heitman?

13 MR. HEITMAN: Your Honor, we would object to including
14 this charge on fraud and misrepresentations. We don't believe
15 there's any evidence of fraud or misrepresentation in this
16 case. There's been no testimony to it. It's not relevant.
17 There's no evidence of a cover up. So we don't believe that
18 it should be charged.

19 THE COURT: Okay. I'll charge fraud and
20 misrepresentation,, these definitions over the defendants'
21 objection.

22 Violation of policy. Mr. Goings?

23 MR. GOINGS: So this is based on the case law that says
24 that there are various ways to establish duty of care, and one
25 of those ways to establish duty of care is policies and

1 procedures. And this just charges that a duty of care can be
2 violated based on a violation of a policy and procedure. And
3 we have -- we've talked every day about policies and
4 procedures of the hospital where this surgery was taking
5 place, where doctor has privileges.

6 THE COURT: Mr. Heitman?

7 MR. HEITMAN: Your Honor, we would object to this one as
8 well.

9 THE COURT: Shop it.

10 MR. HEITMAN: The -- the *Evanston* case suggests that
11 there was a Prisma Health policy that was violated, and these
12 cases that -- where this charge is from all discuss internal
13 or self-imposed policies. This was not an internal or self-
14 imposed policy. Dr. Holbrook is not an employee of Prisma.
15 He did not adopt or self-impose these policies on himself.

16 THE COURT: Is the allegation of violation of Prisma's
17 policies or of Midlands Orthopedics' policies?

18 MR. GOINGS: Well, the -- if you're doing surgery at the
19 hospital and you have privileges, you abide by the hospital --
20 in order to have privileges, you abide by their policies and
21 procedures. And --

22 THE COURT: So the answer to my question is the violation
23 of Prisma's policies?

24 MR. GOINGS: Prisma's policies. Absolutely. I'm sorry,
25 I thought I answered. Yes, ma'am. Prisma's policies.

1 THE COURT: Now you're doing like some of these
2 witnesses.

3 MR. GOINGS: I know. I was -- I was having a bit of
4 amnesia.

5 THE COURT: Ms. Penn was going to get on you.

6 MR. GOINGS: I was thinking the same thing when you said
7 that, Your Honor.

8 THE COURT: My gosh. Just say yes, yes or no, and then
9 explain.

10 MR. GOINGS: And I'm usually good at answering your
11 questions, aren't I? I --

12 THE COURT: Usually. Aye, yai, yai.

13 I will charge violation of policy over the defendants'
14 objection.

15 Duty to create complete and accurate medical records.

16 MR. GOINGS: We cited S.C. Code 40-47-110, Subsection
17 (b)(17) and (24), and also the South Carolina regs. And there
18 is an actual legal duty to create complete and accurate
19 medical records per South Carolina law, and charging the jury
20 on statutes or regulations is -- is common in tort cases.

21 I mean, how many times have you charged the motor vehicle
22 statute? So this would be just kind of akin to that, Your
23 Honor.

24 THE COURT: Yes, sir.

25 MR. GOINGS: And it's short. It literally is your

1 shortest charge.

2 THE COURT: Yes, sir.

3 MR. HEITMAN: Your Honor, we object to this charge as
4 well. The law doesn't actually say that a doctor has to have
5 complete and accurate medical records. This -- this statute
6 that's cited is actually a statute that deals with what
7 defines a misconduct for purposes of a disciplinary action.
8 And actually, the Code section actually empowers the board to
9 take disciplinary actions, if it deems appropriate.

10 MR. HINSON: Your Honor, if I might?

11 THE COURT: Yes, sir.

12 MR. HINSON: I think it's -- I mean, to use a Ralph King
13 Anderson word for a second, I think it's axiomatic that there
14 is an -- there's an obligation to create truthful and accurate
15 medical records, but -- and I put this together actually in
16 another case. I dug it out last night.

17 All the different ways the law requires the doctor to
18 create truthful, complete, and accurate medical records from
19 the South Carolina law that says it's misconduct not to.
20 South Carolina Code of Regulations for Hospitals and,
21 obviously, this is a hospital record we're talking about, as
22 well as the Federal Code Regulations.

23 I'm happy to hand it to you, but it's just -- there's
24 numerous ways that the law says a physician has to create
25 truthful, complete, and accurate medical records. It's all

1 over the law, and that's why we just kept it simple. There's
2 an obligation to do so.

3 THE COURT: Yeah. Let me see what you have actually,
4 because this suggests that it's like the law requiring you to
5 not exceed the speed limit or -- or yield the right of way.

6 MR. HINSON: Sure.

7 THE COURT: This statute concerns misconduct, and you can
8 be guilty of misconduct in a lot of ways, but I wouldn't
9 necessarily call violations of the law, for example, driving
10 while drunk above 0.08 is illegal, per se illegal, but
11 drinking in general, if I were sitting here drunk today -- I
12 am not, but I wish I were. I don't know, but I don't know
13 that that's a violation of the law. It may be misconduct in
14 my office.

15 MR. HINSON: And, Your Honor, that -- you make a
16 fantastic point, and it possibly could just be worded
17 something along the lines of physicians have an obligation to
18 create complete and accurate medical records.

19 I mean, the Code of Federal Regulation also has different
20 provisions that require this. I mean, it's just all -- and
21 again, I think it's just -- all patient record entries must be
22 legible, complete, dated, timed, and authenticated. And
23 that's -- let's see. That's from the Federal Code of
24 Regulations 42, Section 482.24. I mean, it's just -- again --

25 THE COURT: That's right. And then when the doctor

1 scribbles their notes, as they are prone to do, they're not
2 disciplined. It's not -- I mean, you may call it a violation
3 of the law, but --

4 MR. HINSON: But it could be.

5 THE COURT: I don't know. I think this one goes a bit
6 far. I'm not going to charge this duty to create complete and
7 accurate medical records. The reality is you can get to where
8 you're trying to go on this fraud and misrepresentation
9 anyway, if that's your argument, if the jury believes that.
10 So yeah, the defense objection to that one is the same.

11 MR. HINSON: Thank you for consideration, Your Honor.

12 THE COURT: Yes, sir.

13 Previously resolved claims. I don't really want to
14 charge on that or collateral source, which is the next one.

15 MR. GOINGS: And -- right. So we put this here just to
16 have the discussion to see kind of what we needed to do here
17 because there is a strong possibility, more -- more likely
18 than not, that a -- that a juror is going to ask and bring a
19 question about I've heard of other claims, other parties. Are
20 we supposed to consider that?

21 I thought -- and if -- you can disregard what we put
22 here. We thought this was neutral. If you have any other
23 type of commentary or charge to address this -- this issue and
24 -- and maybe that's something you can think on. I don't know.
25 I -- we put this here for really discussion sake. We think

1 this is -- this is our proposal how to handle the issue, and I
2 just think it will resolve a lot of questions on the front end
3 for the jury.

4 THE COURT: I don't know. I find that with insurance,
5 for example, I have a charge on insurance mentioned during
6 trial for regular negligence cases. I sort of keep it in my
7 back pocket in case there's a question for the jury, because
8 even though it may be mentioned in passing, I think that
9 giving the charge highlights it and makes them think about it
10 when they may not otherwise be considering it.

11 They've heard about resolved claims, but the point is
12 they're here to determine Dr. Holbrook's liability, if any,
13 and the liability of Midlands Orthopedics and Neurology or
14 Neurology and Orthopedics.

15 MR. DAVIS: Just Midlands.

16 THE COURT: Midlands, if any. Right? I don't really
17 want to focus them on any other parties, former parties, non-
18 parties, unless there's a question.

19 MR. GOINGS: Then something like this can be appropriate
20 if there's a question.

21 THE COURT: Yes.

22 MR. GOINGS: I get you. That's fine.

23 THE COURT: Okay.

24 MR. GOINGS: And if it becomes an issue, this is kind of,
25 I think, a good neutral response.

1 THE COURT: And I feel the same about collateral source.

2 MR. GOINGS: I agree.

3 THE COURT: Does that suit you, Mr. Heitman? You're
4 about to object to both of these anyway.

5 MR. HEITMAN: Yes, Your Honor.

6 THE COURT: Exactly. Go. That resolves that on the
7 front end. We'll revisit the language of it if it comes up,
8 if there's a jury question, if those need to be charged.

9 MR. GOINGS: Fair enough.

10 THE COURT: Purpose of tort law. You're killing me here.

11 MR. GOINGS: I know, I know. Judge, so I used this
12 charge in a case in the upstate, and the well-known and well-
13 respected judge was the trial judge for that case. He liked
14 it so much, I understand he uses it in all of his court cases
15 now because it -- because it discusses, you know, the purpose
16 of -- and this is kind of towards the beginning of your
17 charges.

18 And so it -- and this is exactly what he wrote, and I
19 found it to be helpful because it kind of explains the purpose
20 of the law for this -- for this type of negligence case.
21 Because what you do is in your normal charge, you just, like,
22 jump into negligence -- not you, but like the charge literally
23 just, like, dives headfirst into negligence.

24 And by the time you're finished talking about negligence,
25 people are like, well, what are we doing here? Negligence.

1 And I think this is a good segue in your general charge to the
2 jury, and so I'm obliged to -- to provide it and strongly
3 suggest that -- that -- that Your Honor consider it. Thank
4 you.

5 THE COURT: I think it could be appropriate in some
6 cases. I don't know that it's necessary in this case. I
7 don't think that any juror is sitting over there wondering why
8 are we here. Maybe if it were Gwyneth Paltrow asking for a
9 dollar in damages, this might be necessary. Like, excuse me,
10 what are we doing?

11 MR. GOINGS: That's right.

12 THE COURT: But I think in this case, it's clear why
13 we're here. She walked into or ran into a surgery and came
14 out in a wheelchair. I don't think there's any question. The
15 question is, is Dr. Holbrook responsible for that, but I don't
16 think anyone's wondering what is this case about, why are we
17 here, why would we award damages.

18 MR. GOINGS: This is not one that we have overly strong
19 feelings on, like a couple of others, so I respect that.

20 THE COURT: Okay.

21 MR. GOINGS: Thank you.

22 THE COURT: Okay. Mr. Heitman was going to object
23 anyway.

24 MR. HEITMAN: I was.

25 THE COURT: All right. Does the defense -- we sort of --

1 are there any specific charges from the defense that we've not
2 discussed?

3 MR. HEITMAN: Yes, Your Honor. And so we -- I believe in
4 your -- in your standard charge for gross negligence, I think
5 -- I think that's a good charge, and I don't have an objection
6 to that, but I do think that it needs to add the standard or
7 the burden of proof for gross negligence is clear and
8 convincing evidence, and I think a jury charge on clear and
9 convincing evidence would be appropriate.

10 MR. GOINGS: Judge?

11 THE COURT: Yes, sir?

12 MR. GOINGS: The standard for clear and convincing
13 evidence is only in the second phase of your -- of the trial.
14 Okay? Clear and convincing evidence is for punitive damages.
15 Okay? But the cap for gross negligence is -- is under the
16 preponderance of the evidence. Okay?

17 So you don't charge them on clear and convincing in the
18 first level because under the statute, for purposes of the
19 cap, it doesn't say by clear and convincing evidence that you
20 have to prove gross negligence or recklessness. You only
21 prove clear and convincing -- by clear and convincing for
22 purposes of punitive damages.

23 So -- and that kind of goes to a jury charge -- a verdict
24 form issue as well. So there is no -- there is only one
25 burden in phase one of the case. There is another burden in

1 phase two of the case. The burden does not increase. The
2 burden of proof does not increase to avoid a cap though.

3 THE COURT: Mr. Heitman?

4 MR. HEITMAN: Well, gross negligence is different than,
5 you know, just standard negligence or simple negligence.

6 THE COURT: Uh-huh. It is.

7 MR. HEITMAN: It has -- it has a different burden of
8 proof, which is clear and convincing.

9 THE COURT: Do you have a citation for that?

10 MR. HEITMAN: Your Honor, can I provide you one in the
11 morning?

12 THE COURT: Sure.

13 MR. HEITMAN: Okay.

14 THE COURT: But I think Mr. Goings is correct. You've
15 got an uphill battle, but yeah, we'll revisit that in the
16 morning.

17 MR. HEITMAN: I appreciate that.

18 THE COURT: Okay. What else did you want?

19 MR. HEITMAN: I think -- I think most of ours were pretty
20 much identical to your standard charges. I'm just scrolling
21 back through. Yeah, I think -- I think the rest of them are
22 pretty much identical to what you have.

23 THE COURT: Okay.

24 MR. HEITMAN: I think for -- so for our Request Number 2,
25 negligence, I can't -- I don't recall if you had that last

1 sentence that we have on there. This is not necessarily the
2 best level of treatment or the ideal level of treatment, but
3 rather it is a standard of care which is ordinarily possessed
4 and exercised on members of defendants' medical specialty in
5 good standing. I can't remember if you have it or not. If
6 you do, then -- then I'm fine with it, but if you don't, we
7 would request that be added.

8 THE COURT: Some version of that is in there.

9 MR. HEITMAN: Okay. Also, I don't -- I don't believe you
10 had a jury charge for our Number 15, negligence not presumed.
11 I believe plaintiffs' objection to that was to the extent that
12 it was duplicative. And the same --

13 THE COURT: It is in there.

14 MR. HEITMAN: Okay.

15 THE COURT: Negligence on part of a good physician is not
16 presumed, but must be affirmatively presented. Yeah.

17 MR. HEITMAN: Okay. And then the same with 16 was -- was
18 on ours. And those are the -- those are the only ones I --

19 THE COURT: That's included as well.

20 MR. HEITMAN: Okay. Thank you, Your Honor.

21 THE COURT: Okay. Verdict form.

22 MR. DAVIS: Your Honor, I hope you got what I did this
23 morning on my computer.

24 THE COURT: Yes, sir, I do.

25 MR. DAVIS: I'm a little out of -- out of my office, you

1 know. So it's kind of --

2 THE COURT: I understand.

3 MR. DAVIS: -- hard to get it. That's the best I could
4 do. I apologize for all the errors in the transcription and
5 all that.

6 THE COURT: It's quite all right.

7 MR. DAVIS: Thank you.

8 THE COURT: I generally don't separate negligence and
9 proximate cause. I mean, you've both done that.

10 MR. GOINGS: We didn't.

11 THE COURT: You're right. You did not. It's a separate
12 clause in there. You're right, you're right.

13 I generally just ask were the defendants negligent
14 because people have different views of this. We use
15 negligence in a different way than it means legally. Legally,
16 negligence is all four elements, and that's what I'm telling
17 the jury, that you've got to have a duty, breach, causation,
18 and damages. That is negligence. So to separate out
19 causation seems unnecessary in this case.

20 MR. DAVIS: Your Honor, in this case, there are two
21 theories of causation. One is low blood pressure. The other
22 is a reperfusion injury.

23 The jury could find from this evidence that Dr. Holbrook
24 was negligent in some capacity, but that his negligence did
25 not cause or contribute to this injury, and I think that's a

1 relevant separate charge, and it should be on the verdict
2 form.

3 THE COURT: Well, no, because to find negligence, they
4 have to find that his breach of duty proximately caused some
5 injury. That's part of the definition of negligence.

6 MR. DAVIS: Well, I understand that. I don't -- I'm not
7 arguing against that legal principle. I'm just saying for a
8 verdict form in this case where there are two -- at least two
9 alternative causes of action -- causes of injury, at least
10 two. There may be others.

11 For the -- for the jury not to be required in the verdict
12 form to say, yes, he was negligent, yes, his negligence
13 proximately caused the injury, because they could very well
14 say he was negligent in some manner, but that negligence did
15 not cause this injury, was not a proximate cause.

16 THE COURT: I know. Then he would not be negligent.

17 MR. DAVIS: Well, Your Honor --

18 THE COURT: As a matter of law.

19 MR. DAVIS: I'm just --

20 THE COURT: But I --

21 MR. DAVIS: I'm going to stand by my request and respect
22 your ruling.

23 THE COURT: We'll go with -- I'm going to -- unless you
24 have something else on that issue, the phrasing of plaintiffs'
25 Question 1 on their proposed verdict form, is that suitable,

1 Mr. Davis? Because that includes it. It makes it one
2 question.

3 MR. DAVIS: Yes.

4 THE COURT: But it does separate out causation so that
5 they know they've got to find both things.

6 MR. DAVIS: But I respect and maintain my request that
7 the negligence be one question, the proximate cause would be a
8 separate question. So with that, I'd respectfully object to
9 the other form.

10 MR. GOINGS: Your Honor, I'm fine how you normally do it
11 for negligence. Okay? Actually, that's how I normally do it,
12 quite frankly, but Judge Hinson wrote this one.

13 I was trying to be accommodating to -- to Mr. Davis and
14 make mention of it, because I knew he wanted just two separate
15 questions. To me, putting it as an "and" was kind of the
16 split in the baby, so to speak.

17 THE COURT: That's what I was thinking. Okay. I'll show
18 y'all something in the morning. Let's go on to --

19 MR. DAVIS: Can we explain this verdict form?

20 THE COURT: Yes, sir.

21 MR. DAVIS: Okay.

22 THE COURT: What about Number 2 on the plaintiffs'
23 verdict form? It's their --

24 MR. DAVIS: Your Honor, I request additional language.
25 Do you find the defendant grossly negligent, reckless,

1 careless, and without any slight care.

2 THE COURT: But it's -- gross negligence is the failure
3 to exercise slight care. Then why do I need to ask about
4 that? I'm defining it for them.

5 MR. DAVIS: But is it not the correct proposition of law
6 that gross negligence is the absence of even slight care?

7 THE COURT: Yes.

8 MR. DAVIS: Then why could that not be on the verdict
9 form?

10 THE COURT: It can be. It seems unnecessary.

11 MR. DAVIS: Okay. Will that be a part of your charge?

12 THE COURT: Gross negligence is the failure to exercise a
13 slight degree of care.

14 MR. DAVIS: Is that what you're going to charge the jury?

15 THE COURT: Yes, sir.

16 MR. DAVIS: Okay. Thank you. That's fine. Appreciate
17 that.

18 THE COURT: All right. Number 3, any additional
19 objection or any objection to that being a question on the
20 verdict form?

21 MR. DAVIS: I object to that question totally on the
22 verdict form.

23 THE COURT: Well, how else is -- would there be a
24 determination? But tell me the basis of your objection.

25 MR. DAVIS: The basis of my objection goes to the

1 allegation that has never been outlined in this complaint,
2 that Dr. Holbrook was somehow fraudulent or somehow
3 misrepresented something about the plaintiffs' claims. That's
4 -- that's never been a part of her complaint.

5 THE COURT: Right. But you understand that that is not a
6 separate cause of action for fraud and/or misrepresentation,
7 but an effort to determine whether the statutory cap applies
8 or damages?

9 MR. DAVIS: I know that's what they wanted. I understand
10 that.

11 THE COURT: Well, how else is there to be a
12 determination?

13 MR. DAVIS: Well, I submit, respectfully, there's not
14 enough evidence. There is no evidence to submit to the jury
15 from testimony in this case that would support either the
16 charge which you've already accepted to and/or that question
17 on the verdict form.

18 THE COURT: Okay. So subject to previous objections, I
19 will include that question.

20 What about Number 4, Mr. Davis?

21 MR. DAVIS: Your Honor, I think it's a -- I like verdict
22 forms to be simple, and these days it's never simple.

23 THE COURT: Clearly.

24 MR. DAVIS: I mean, I think we all take notes on that,
25 but I really prefer when I submit it to the Court as far as

1 damages, it includes everything that needs to be included
2 without a lot of explanatory language that has already been
3 covered in the Court's charge.

4 I'm quite confident of that about the issue of damages,
5 so I prefer my Number 4, please state the total amount of
6 damages, subparagraph A, as to Crystal Goodwin, dollar sign,
7 economic damages. As to Crystal Goodwin, dollar sign, non-
8 economic damages. As to James Goodman, dollar sign, non-
9 economic damage.

10 I prefer the simplicity. It includes everything they
11 need to know. If they get to Question 4, which, of course, we
12 hope they never do, but if they get to Question 4, that's the
13 simplest way. They can fill in those blanks. I object to all
14 the extra language that they've included in their subparagraph
15 A, B, and C.

16 THE COURT: Just because you think it's unnecessary or
17 because you think it's incorrect?

18 MR. DAVIS: No. It's totally unnecessary, Your Honor,
19 because you will have charged the jury, I'm confident of this,
20 of what consists of economic damages, what consists of non-
21 economic damages, what consists of pain and suffering, what
22 consists of actual damages. All that's going to be a charge.
23 I believe I saw that in your charge. And if I didn't, I
24 misread it.

25 THE COURT: Well, what I do charge on is the definition

1 of pain and suffering, mental and emotional anguish, loss of
2 enjoyment of life, et cetera, but never do I identify which
3 category of damages those fall within, whether they're
4 economic damages or non-economic damages. So this would
5 actually be the only place for them to determine what goes in
6 what category or have any guidance as to what non-economic or
7 economic damages are.

8 MR. DAVIS: Your Honor, I've never seen this on any
9 verdict form I've ever tried in over a hundred malpractice
10 cases, and I object to it. I think it's -- I think it's
11 unnecessary. I think it draws attention to the wrong things.

12 You know, this -- your charge is going to be more than
13 adequate to tell the jury what economic and non-economic
14 damages are, and they've presented an economic economist who
15 talked all about and put in evidence of what the economic
16 damages were. They put in a summary of all the economic
17 damages as far as the hospital bills are concerned.

18 That's evidence, and in closing, they are free to talk
19 about any and all of that. I expect they will. I certainly
20 do, and I will ask them to open in full.

21 THE COURT: I will include it as written on plaintiffs'
22 proposed verdict form over the defendants' objection.

23 MR. DAVIS: Thank you, Your Honor.

24 THE COURT: But I'll tell you, my least favorite
25 objection in the world is I've never seen this done because

1 that -- that -- that doesn't give me any legal basis for
2 making an independent determination, and I operate
3 independently of anything anyone's ever done. I don't care if
4 it's been done for a thousand years. It could have been done
5 wrong for a thousand years. Or just because you've never seen
6 it doesn't mean that it wasn't appropriate to do. That's just
7 my least favorite objection in the world.

8 MR. DAVIS: Noted, Your Honor, and I'm not a thousand
9 years old. I look old, but I have taken note.

10 THE COURT: Yes, sir.

11 MR. DAVIS: And I appreciate your comments, and I will
12 never say that to you again.

13 THE COURT: That's just a note for everyone.

14 MR. DAVIS: Thank you, Your Honor.

15 THE COURT: It means little to me. I don't know. People
16 do things wrong all the time too.

17 Anything else?

18 MR. GOINGS: No, Your Honor. We'll see you in the
19 morning.

20 THE COURT: I'll see you all at 9:30 tomorrow.

21 MR. DAVIS: Okay.

22 THE COURT: We'll get you a jury form hopefully at some
23 point this evening, maybe tomorrow morning. And just in case
24 there's any last minute anything before the jury gets here at
25 10.

1 MR. GOINGS: Ms. Goodwin had a childcare issue that came
2 up, and I told her I would tell you that she just didn't run
3 out for no reason.

4 THE COURT: Understood.

5 MR. GOINGS: Yes, Your Honor.

6 THE COURT: Okay.

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

8

9 --- CONTINUED IN VOLUME IX ---

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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 9 OF 9 - VOLUME IX
	)	April 20, 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 20, 2023

2 (WHEREUPON, the proceedings resumed at 9:46 a.m.)

3 THE COURT: All right. Good morning. Bailey is about
4 to bring out copies of the jury charge. One thing that I
5 neglected to ask yesterday -- or ask or tell you, I don't know
6 -- is that I plan to give a copy of the charge to the jury.

7 Is there any objection to that from the plaintiff?

8 MR. GOINGS: Your Honor, that -- we would object to that.
9 And I would -- if later they ask for it, I -- I'd -- we could
10 revisit it. My suggestion is we would revisit it then, if
11 they request it later, but just to start out with that would
12 be -- that would -- we would object to that.

13 THE COURT: On what basis?

14 MR. GOINGS: I know what I -- I know what I should not
15 say.

16 THE COURT: But that's what you're thinking. It's not
17 what I've typically done. Right.

18 MR. GOINGS: Your Honor, I just think they get back
19 there, they start analyzing every word and picking apart and
20 trying to become judges and lawyers and just --

21 THE COURT: Aren't they judges? Judges of the facts.

22 MR. GOINGS: That is true. Your Honor, if you're
23 inclined to do it, I -- I'm not strongly opposed. It just
24 would be my request and we would object, the request being if
25 they ask for it later, possibly give it at that point, but not

1 -- not just off -- off the -- off the bat, so to speak.

2 THE COURT: Right. They won't know to ask for it
3 necessarily. What they ask is can we hear the law again, and
4 then I've just got to reread it. But I mean, that is what it
5 is.

6 Let me hear from the defense.

7 MR. DAVIS: Your Honor, I have no objection at all to
8 that, but at least in my experience, I've found that to be
9 helpful in the deliberations. It kind of reduces the need --
10 Judge, can you charge us again on this? And even when you do
11 that, sometimes they'll still do it, and I know the Court will
12 do that, but I just think it's a -- it's a great deliberation
13 time saver, in my opinion, in my experience. I have no
14 objection.

15 THE COURT: Yeah, I think it is too. And considering the
16 length of the charge, that's why I plan to give it to them.
17 If this were an ordinary negligence case, I mean, I've almost
18 never or maybe actually never done it in an ordinary
19 negligence case. It's just when the charge gets kind of long
20 and complicated and there are lots of topics, I find that it's
21 helpful to the jury.

22 And I also don't want to discount the fact that some
23 people absorb information better audibly and some by reading
24 it, and I just -- I'm one of those people that does better
25 when I read a document rather than having it read to me.

1 People object all the time, and I asked the basis of your
2 objection, one, because we're in court and I need a legal
3 basis, but also, I'm just curious as to why people oppose it.
4 I don't know. I'll decide in the next few moments.

5 You now have copies of jury charges and verdict form.
6 Any objection to the verdict form from the plaintiff?

7 MR. GOINGS: Yes, Your Honor. Just with this first
8 question, I really -- this is something far more than anything
9 else we've talked about the plaintiffs care deeply about, and
10 I really -- you know, yesterday you said you just typically
11 put negligence. Do you find the defendant or defendants were
12 negligent? It just is one question. It's all encapsulated.

13 And we really thought that splitting -- splitting the
14 baby, so to speak, of putting causation in the first question
15 -- that our proposed verdict form said, do you find that the
16 defendants were negligence -- were negligent, and that any
17 negligence proximately caused injury to Crystal Goodwin was --
18 it made sure to mention proximate cause, and it made sure it
19 had the word "and" in it.

20 And, Your Honor, I mean, if you're inclined to -- to
21 consider it, maybe even underline the word "and" but not to
22 split them up in two separate questions. That's not the
23 verdict form that said, you know, do you find for the
24 plaintiff or do you find for the defense. We're not asking
25 for something like that, but if we could -- again, do you find

1 the defendant -- the defendants were negligent and --
2 underline it. That's fine. Underline it, bold it, make it --
3 make it 24 point font, but not two separate questions.

4 THE COURT: Yes, sir. That was me sort of trying to
5 throw Mr. Davis a bone because I really was satisfied with it
6 the way plaintiff suggested it. I do think that's the better
7 approach, and that's why I asked about the objection.

8 MR. GOINGS: We don't break down and say do you find
9 there was a duty, do you find there was a -- you don't --

10 THE COURT: Exactly.

11 MR. GOINGS: -- do all that. So --

12 THE COURT: Exactly. I agree.

13 MR. GOINGS: Thank you, Your Honor.

14 THE COURT: So I am going to revert back to the
15 plaintiffs' suggested language as to that first question that
16 combines Questions 1 and 2 on this proposed verdict form. We
17 will underline the word "and" so that they are crystal clear
18 that they have to make both findings, although I still believe
19 that the proximate cause is subsumed within the definition of
20 negligence, just as a matter of law that that is a fact.

21 But to satisfy the defendants and to highlight that there
22 has to be causation, we'll combine the question, but
23 underlying the word "and."

24 MR. GOINGS: Thank you, Your Honor.

25 THE COURT: The remainder of the verdict form, any

1 additional objections from defense, maybe anything I didn't
2 hear yesterday?

3 MR. DAVIS: I think we pretty much stated anything
4 yesterday.

5 THE COURT: Okay.

6 MR. DAVIS: Apart from the verdict form and the charges,
7 there is another question that we have, two housekeeping
8 things.

9 One is yesterday -- I can't remember when -- that Mr.
10 Heitman sort of mentioned. Y'all were talking with plaintiff
11 counsel about marking exhibits.

12 THE COURT: Yes.

13 MR. DAVIS: And -- and that got -- that got interrupted
14 and it was to be taken up at a later time. This is
15 housekeeping we'd like to do this morning.

16 THE COURT: Yes, sir. We'll --

17 MR. DAVIS: And I think Mr. Heitman may have led the
18 charge on the request of charge regarding misrepresentation
19 and fraud.

20 MR. HEITMAN: Yes. Yes, Your Honor. When we left off
21 yesterday, you told me that I could do some research on gross
22 negligence and clear and convincing evidence.

23 THE COURT: Yes, sir.

24 MR. HEITMAN: You told me that I had an uphill battle,
25 and you were right. I could not find anything on gross

1 negligence and clear and convincing evidence. However, I did
2 find clear and convincing evidence for fraud and
3 misrepresentation, and I emailed the Court and plaintiffs'
4 counsel a proposed charge on that, you know, subject to our
5 original objection, that we don't believe it should be
6 charged, but if it is going to be charged, we believe that a
7 summary should be included in the Court's charge.

8 THE COURT: So I do see your proposed charge, and it --
9 it is, you know, textbook definition of a cause of action for
10 fraud and misrepresentation. In this case, we don't have a
11 cause of action for fraud and misrepresentation. The question
12 is, was the conduct fraudulent or -- or subject to some
13 misrepresentation, which falls short of all nine elements of a
14 claim or a cause of action for fraud and misrepresentation.

15 MR. HEITMAN: Yes, Your Honor. I understand their claim
16 for fraudulent misrepresentation. However, since the Court is
17 asking or charging the jury on fraud and misrepresentation,
18 the plaintiffs' counsel has asked that the jury find in their
19 jury verdicts for fraud, misrepresentation in order to, you
20 know, bust the non-economic damages cap. We believe that it's
21 kind of -- we don't want that to be a backdoor way to -- to
22 say there's fraud and misrepresentation without proving clear
23 and convincing evidence of it.

24 THE COURT: Well, is it a back-door way or -- I'm just
25 giving them the definitions of fraud and misrepresentation.

1 MR. HEITMAN: Well, I think -- I think in order to -- to
2 bust that non-economic -- non-economic damages cap for fraud
3 and misrepresentation, I think that should be shown by clear
4 and convincing evidence.

5 THE COURT: Mr. Hinson?

6 MR. HINSON: Yes, Your Honor. I -- we're not -- I think
7 you've kind of barking up the same tree we are. S.C. Code
8 15-32-220(e) is the way -- essentially the cap buster section.

9 And it says if we -- if we prove that the defendants were
10 negligent, grossly negligent, willful, wanton, or reckless, or
11 if we prove that the defendant has engaged in fraud and
12 misrepresentation related to the claim. Nowhere in that
13 section does it say that the burden of proof for that is clear
14 and convincing evidence.

15 We're not bringing a fraud claim. We're just alleging
16 that there was fraud related to the claim, which is, as the
17 legislature has set forth, a way around the cap. And if the
18 -- if the legislature thought the way around the cap had to be
19 proven by clear and convincing evidence, that's what they
20 would have stated in 15-32-220(e).

21 THE COURT: I think he's right. I think that the burden
22 of proof in civil matters in general is the preponderance of
23 the evidence, unless stated otherwise, and there is no
24 exception in this statute that indicates it must be by clear
25 and convincing evidence. So I decline to charge that as

1 requested by the defense.

2 Returning to yesterday's conversation or keeping with
3 yesterday's conversation, I was going to look at the mortality
4 table. With respect to James Goodwin, the Court will not
5 charge life expectancy. That is for personal injury, and a
6 loss of consortium claim isn't personal injury. So we will
7 not charge that with respect to James Goodwin.

8 Physician evaluation? Yes. Okay. I will charge that
9 physician evaluation portion that's requested. I did read
10 through *Jernigan v. King*. I don't know why that's cited with
11 respect to this law. I don't know how anyone gleaned all of
12 this from *Jernigan*. It is, however, a correct statement of
13 the law.

14 So it's a poor citation, in my opinion, because that was
15 about summary judgment. The *Jernigan* case was about the grant
16 of summary judgment where there's no genuine issue of material
17 fact because the opposing party has not put forth any
18 evidence. In fact, the defendant who was granted summary
19 judgment provided affidavits, and plaintiff's claim was really
20 consistent with the affidavits provided by defendants. So I
21 just don't know why *Jernigan* was cited with respect to this
22 law, but it's a correct statement of law.

23 MR. HINSON: Your Honor, that's probably my fault. I
24 helped Judge Ralph King Anderson with his charge book, and I
25 probably made that -- I probably cited the wrong case, so I'll

1 actually take responsibility for that.

2 THE COURT: All righty. I thought I was talking about
3 some nebulous, you know, whoever anonymous person, but that is
4 now included in the charge.

5 I know you've just been handed the final-ish charge. So
6 I'll give you a moment to look it over just to make sure there
7 are no additional last-minute objections while we wait for the
8 arrival of the last few jurors.

9 And we're going to fix this verdict form and then start
10 with closing arguments. So I'll see y'all in just a few
11 moments after that.

12 MR. HEITMAN: We had the issue with these exhibits that
13 we wanted to get admitted.

14 THE COURT: Oh, right. The exhibits, yes.

15 MR. HEITMAN: I know -- I know there's an objection to
16 them. I'm not sure exactly what.

17 THE COURT: Yeah. Oh, I need to see them to determine
18 whether they are objectionable.

19 Y'all brought half the Richland County Bar to observe.

20 MR. HINSON: I didn't bring anybody. I don't know.

21 THE COURT: It's a big deal, big case.

22 All right. There's a chart with some times and some
23 measurements. Thoracic laminectomy, July 28th, 2016.

24 MR. HEITMAN: That's --

25 THE COURT: What's the objection to this, Mr. Goings.

1 MR. GOINGS: I do, Your Honor, for the reasons we've
2 already talked about. This chart was never shown to a
3 witness. A witness never identified this document that you
4 have in your hand. I've never seen it until yesterday.

5 I will say that we agreed to the actual chart that is in
6 evidence. I don't know what these numbers correspond to, if
7 anything. I will say that if the visual chart is already into
8 evidence, there's no reason to also put those numbers in as
9 well.

10 MR. HEITMAN: I -- so I -- I think Dr. Balestrieri --
11 that was shown to Dr. Balestrieri, our expert, and also I read
12 out every single one of those numbers to Erich Starn, and he
13 looked at his anesthesia chart and confirmed them. That's
14 just the data that is on -- that's from our chart that's
15 already in evidence. That's the data from it, the same as
16 their chart that's in evidence has those blood pressures or
17 MAPs on it.

18 THE COURT: I'm guessing you have a similar objection to
19 this document, Mr. Goings?

20 MR. GOINGS: Yes, Your Honor.

21 MR. HEITMAN: And I -- I believe there was no objection
22 to the graphs going into evidence, and that's essentially what
23 that is, just not in graph form. It's the data, just the data
24 points of what a graph would be.

25 THE COURT: I know. The difficulty for me though, for

1 the Court, in situations like this is that when it's not done
2 contemporaneously with the witness testifying, and I can't see
3 what you're showing the witness, I can't even see what's on
4 that monitor. I don't know that the witness discussed this,
5 identified this.

6 You know, had that happened, it would have been moved
7 into evidence at that time or should have been. Without going
8 back through the record -- and I don't even know that the
9 record would help because it wasn't offered then or even
10 marked then.

11 And so with an objection and this not being part of the
12 medical record, something created by counsel or someone else,
13 I don't know.

14 MR. HEITMAN: It's -- it's part of the anesthesia record,
15 Your Honor.

16 THE COURT: This is a page from the anesthesia record?

17 MR. HEITMAN: No, it's not. It's taken from the
18 anesthesia record.

19 THE COURT: Exactly. It's data taken from the record but
20 put in a different format. So this isn't from the medical
21 records. I get that the information is.

22 MR. HEITMAN: Yes.

23 THE COURT: But the document itself is not. So I will
24 not admit these two documents into evidence. I'm happy for
25 you to mark them for ID.

1 MR. HEITMAN: That would be great. Thank you, Your
2 Honor.

3 THE COURT: Yeah. Let's go ahead and do that right now.
4 I do have -- don't go anywhere.

5 MR. HEITMAN: Just mark those as Court's exhibit?

6 THE COURT: What about these photographs, Mr. Goings?

7 MR. GOINGS: They were never moved into evidence by a
8 witness. No one identified these documents as -- as a true
9 and accurate depiction of the surgery, and it wasn't offered
10 through a witness.

11 It's now offered -- trying to be offered after the fact.
12 So I think that's just improper. We -- we agreed to the
13 graphs as the only demonstrative type exhibits to go to the
14 jury, not this. If it was important enough to make an
15 exhibit, it should have been important enough to actually move
16 in with a witness at the proper time during the evidence, not
17 right before closing arguments after the evidence has been
18 closed.

19 THE COURT: Well, to be fair, there was an attempt made
20 before the -- finishing the last witness, not to move them in
21 through that witness, but at some point before defense rested.
22 We just postponed it and then kind of forgot about it until
23 this morning.

24 MR. GOINGS: That's right.

25 THE COURT: So -- so they didn't wait until the close of

1 evidence.

2 MR. GOINGS: Well, their -- the witness that they were
3 going to put this in through had already left the courtroom.

4 MR. HEITMAN: Well, actually, Dr. Holbrook testified to
5 that, to -- to that first one and said that it was an accurate
6 depiction of the surgery that he does.

7 THE COURT: You need to speak up too.

8 MR. HEITMAN: I'm sorry.

9 THE COURT: Aye yai yai yai. You have the same objection
10 to all of them, Mr. Goings?

11 MR. GOINGS: Yes, Your Honor.

12 MR. HINSON: Your Honor, is it Mancuso -- not Dr.
13 Mancuso. Is it the Goltra summary?

14 MR. GOINGS: I'm about -- I'm about to get there.

15 MR. HINSON: Okay.

16 MR. GOINGS: So this document is just a summary of the
17 witness's testimony, which is -- absolutely should not be
18 allowed into evidence. I mean, it's cumulative as to his --
19 his oral testimony, but to actually have a document that goes
20 back to the jury that says what a witness says is just
21 improper. That's not demonstrative of anything. It's just a
22 summary of somebody's oral testimony.

23 MR. HEITMAN: I believe -- I believe the *Cantrell* case
24 that you all cited earlier when y'all were trying to move the
25 demonstrative exhibits in allows for that.

1 MR. GOINGS: That's not demonstrative. That is textual
2 that talks about what a witness testified about, and that's my
3 objection.

4 THE COURT: Yes, sir. So none of these additional
5 documents will be admitted as evidence. The last one that --
6 let's see. The photographs, I will -- you can mark
7 collectively as one exhibit.

8 The one that we spoke about last that has the text, the
9 summary of the witness's testimony, I haven't stapled that.
10 That can be a separate exhibit, just so that it's clear for
11 the record what we're talking about.

12 So if you'll have all those marked for identification as
13 defense exhibits, but they are not admitted into evidence.

14 MR. HEITMAN: Thank you, Your Honor.

15 MR. GOINGS: Thank you, Your Honor.

16 THE COURT: Anything else?

17 MS. GOODING: Your Honor, we had noticed that some of
18 these -- some of the plaintiff and defense exhibits were
19 duplicative. I was just wondering --

20 MR. GOINGS: If that's okay to hear that this morning,
21 there was only one, and it appeared that Mr. Davis's had some
22 stuff attached to it, and it was not -- it was going to work
23 out just fine.

24 THE COURT: Okay. That's that.

25 MS. GOODING: I'm sorry.

1 THE COURT: All good?

2 MR. GOINGS: We're good.

3 THE COURT: Alrighty then. All right. I'm going to step
4 out just for a moment, five minutes or so. Assuming we have
5 all the jurors, I don't know, but we'll be back in just a few
6 minutes.

7 (WHEREUPON, the proposed defense exhibits were marked as
8 Defendant's Exhibits 6 through 9 for identification
9 only.)

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

12 THE COURT: All right. We have all the jurors.

13 I will not send a copy of the charge to the jury because
14 there's an objection.

15 MR. DAVIS: Thank you.

16 THE COURT: As much as I hate that, but I think Justice
17 Pleicones said if there's any objection, you shouldn't do it,
18 I think. Anyway. All right.

19 MR. GOINGS: And again, Your Honor, if the jury asks for
20 it, we're happy to revisit it, but thank you.

21 THE COURT: Yes, sir. I just -- based on my experience
22 that this could be a different trial, but based on my
23 experience, they don't know to ask for it. They know that I
24 was reading from something, and they'll ask what the law was.
25 Can you remind us of what that was? But in those situations,

1 I bring them back into the courtroom and read it to them
2 again. That's fine.

3 All right. Are we all in position and ready and got all
4 your props?

5 MR. GOINGS: I just need to back this up to memory first.

6 THE COURT: Yes, sir.

7 Ready to go?

8 MR. GOINGS: Yes, Your Honor. Thank you.

9 THE COURT: All right. Bring the jury, please.

10 (WHEREUPON, the jury entered the courtroom at 10:18 a.m.)

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

12 THE COURT: Thank you.

13 Good morning, folks. It's now time for closing
14 arguments. I don't know how long they'll go, but just give
15 them your full attention. After the closing arguments, I will
16 charge you on the law that applies to the case, but Mr. Goings
17 is ready to talk to you.

18 Mr. Goings?

19 MR. GOINGS: Thank you, Your Honor. May it please the
20 Court.

21 THE COURT: Yes, sir.

22 CLOSING ARGUMENT ON BEHALF OF THE PLAINTIFFS

23 MR. GOINGS: Good morning. Two weeks. Wow. Ain't that
24 right? Y'all have really been an amazing jury, understanding
25 the process, each one of y'all hearing with compassion, and I

1 know the reason why. Because you know that your decision in
2 this case will have a tremendous effect on the quality of life
3 of Crystal Goodwin, a really profound effect on the quality of
4 her life.

5 When we started this case, ladies and gentlemen, we
6 offered you three questions. The first question: Should
7 doctors treat their patients as individuals? Should doctors
8 respond to medical alarms and red flags? And should doctors
9 create truthful, accurate, and complete medical records?

10 And now, ladies and gentlemen, after hearing the
11 evidence, you know that if doctors don't treat patients as
12 individuals, devastating consequences can result. You now
13 know that if doctors don't respond to alarms and red flags,
14 devastating results will follow. And that if these medical
15 records are not complete, not accurate, omit very important
16 details or done sloppily, that that affects quality patient
17 care.

18 The failure to do those things, ladies and gentlemen, has
19 an effect on our lives. Failure to do those things has an
20 effect on our families. And the failure to do those things
21 creates lifelong consequences.

22 Just think, what if Dr. Holbrook would have spent just
23 one minute, just one minute doing what he was supposed to do?
24 One minute, ladies and gentlemen, just one minute treating
25 Crystal as an individual. One minute. Just one minute

1 responding to the medical alarms and the red flags that he saw
2 in the surgery room that he knew about before the surgery.
3 Just one minute.

4 The truth came out with that last voice, and I saw the
5 reaction on your face when Dr. Root said the reason she wasn't
6 called was because Dr. Holbrook made the decision in the
7 surgery suite that the equipment just malfunctioned. He
8 disregarded the equipment. He had disregarded the medical
9 alarms that went off. He disregarded the neuromonitoring tech
10 that in the records told Dr. Holbrook at least five times the
11 signal is lost. There's nothing wrong with the equipment.
12 The signal is lost. There's nothing wrong with the equipment.
13 The signal is lost. There's nothing wrong with the equipment.
14 Five times.

15 But he, head of the surgery in charge of the operating
16 room, disregarded what Teresa Adkins told him and proceeded
17 with the surgery. And you heard testimony from Dr. Holbrook
18 that what he did was he tried his best to complete that
19 surgery as fast as he could and go check on the patient in the
20 recovery room to see if she can move her legs. That's what he
21 told you he did.

22 But did you hear what Dr. Root said? Dr. Holbrook had
23 already gone on to something else that day. The person who
24 determined that her legs did not move and that she was
25 motionless from the waist down was Dr. Root, who then inquired

1 why isn't her legs moving? And then for the first time Erich
2 Starn, the CRNA, said, well, you know what? We did lose
3 signals during the procedure.

4 Then she called Dr. Holbrook to come, and then he
5 recognized again that the legs were not moving. He made it
6 sound like he tried to emergently and quickly get an MRI.
7 That didn't happen either. It took four-and-a-half hours from
8 the signal going out for the MRI to even be completed. It was
9 done routine. The reason? She fell a couple days ago. Not
10 we need an emergency MRI because we lost motor function and
11 sensory function to someone's legs.

12 Ladies and gentlemen, the burden of proof in this case is
13 referred to by law as the greater weight of the evidence. The
14 greater weight of the evidence. This is not a case about
15 criminal charges. This is not a case about licensing. This
16 is not a case about deciding if Dr. Holbrook is a good doctor
17 or not. The burden of proof for this case, a civil case, is
18 the lowest standard in the law, absolute lowest standard.

19 You've heard and we've seen trials lately here in South
20 Carolina that's been televised, and the standard is you have
21 to prove it beyond a reasonable doubt. It's the highest
22 standard in the law, beyond a reasonable doubt.

23 The standard in this case is you can actually have
24 reasonable doubt and find for the plaintiff. Judge Newman
25 will tell you when she gives you the charge and tells you what

1 the law is, that if the scales tip even slightly, even
2 slightly in favor of the plaintiff, then the plaintiff has met
3 the burden.

4 Now, in the deliberation room when you're talking, if
5 someone says, well, you know, I just can't be certain, fair
6 enough. Well, that's not the standard. You don't have to be
7 certain. If someone back in deliberation says I just can't be
8 sure, then one of you needs to say, well, that's not the
9 standard. You don't have to be sure.

10 If someone says, I'm just not convinced, the law doesn't
11 say you have to be convinced. The law only says that it must
12 be slightly more likely than not that -- that we're correct.
13 Slightly more likely than not.

14 What's the law in this case? The judge is going to
15 instruct you on the law, but I'm going to explain generally
16 what the law is. And this is the law to protect us, the law
17 to protect patients first, and this is all common sense. This
18 is something that you came into this courtroom before you were
19 ever asked to be a juror that you agreed to, common sense.

20 Doctors have a duty to provide diligent medical care. We
21 can all agree to that. Doctors have a duty to provide a
22 thorough and careful examination or thorough and careful
23 treatment. Doctors have a duty to comply with generally
24 recognized practices. Doctors have a duty to be careful and
25 prudent, and doctors have a duty to fully evaluate and

1 investigate. If a red flag or an alarm is going off, not to
2 ignore it, but to investigate it. This is the law in South
3 Carolina, ladies and gentlemen, to protect patients.

4 One of the things that you're going to hear is
5 negligence. What is negligence? It's a legal word, and it's
6 not intentional, that he intended to harm. Okay? We know
7 that he did not intend to put Crystal in a wheelchair. The
8 standard is was it an error that was unacceptable, that we, as
9 the conscience of our community, think is unacceptable.

10 We have said, ladies and gentlemen, that Crystal is in a
11 wheelchair today because of a lack of blood pressure and
12 inadequate blood pressure during the surgery. Now, we say
13 that her blood pressure for this four-and-a-half-hour surgery
14 was too low for too long. We say that the pressure wasn't
15 right during the surgery.

16 You know what? You don't have to be a neurosurgeon.
17 You don't have to be a neuroradiologist. You don't have to be
18 a neuroscientist to understand this simple concept of
19 pressure. So you've heard this somewhat explained by the
20 jury, and I want to do it here today.

21 Imagine this is long. It's round because we now know
22 that the spinal cord is circular. When the pressure is set
23 right for the long -- and you have two sprinklers, because we
24 know that the spinal cord gets blood from the anterior portion
25 and then the posterior, both sides. So you have a sprinkler

1 here, posterior. You have a sprinkler here, anterior. And
2 when the pressure is set right for this area, you have a
3 watershed.

4 What is a watershed? You can see this. You see this red
5 symbolizes the pressure and also the blood, and it overlaps on
6 this side and it overlaps on this side. The area in between,
7 ladies and gentlemen, the center of the spinal cord is the
8 watershed, a very important area, the area that controls your
9 ability to walk, the area that controls your ability to feel,
10 the center of the cord.

11 And the center of the cord gets good blood when your
12 pressure is set right, but when your pressure is set for too
13 low for too long, turning it down, what happens, ladies and
14 gentlemen, is that the pressure is cut down. And when the
15 pressure is cut down, the flow decreases. And when the flow
16 decreases, you're left with this, ladies and gentlemen, the
17 watershed area, the area of the spine that controls motor
18 function, that controls the ability to feel, the ability to
19 walk, and the ability to stand, gets no blood.

20 And when this area gets lack of perfusion for too long,
21 the watershed area, the area in between, begins to suffer, a
22 word that we've heard, ischemic. It becomes ischemic.

23 The grass, ladies and gentlemen, starts to brown. Well,
24 what do we do when the grass gets brown in our yard? You
25 water it; right? Water it for -- water it for some time and

1 it comes back, but if you don't water it and the pressure is
2 not set right, you're left just like this, ladies and
3 gentlemen. You're left with the watershed, the center of the
4 spinal cord, the center of the turf, that dies because you
5 didn't get the proper blood, and it was set too low for too
6 long.

7 We heard what you do when the pressure is low, how you
8 get the grass back growing. I see y'all nodding. You know
9 you increase the pressure. You don't have to be a
10 neurosurgeon. You don't have to charge \$15,000 a day to sit
11 over there to take this stand and tell you that I was first in
12 my class, I was top of the class.

13 How many times did we hear doctors tell us that they were
14 top of the class? Well, folks, let me tell you what. You
15 know where I was in the class? I was in the bottom of the
16 class, and I understand this. It's real simple.

17 Paralyzed due to blood pressure being low. Here's the
18 danger zone. We see essentially the entire surgery from this
19 point at 7:50 all the way to when Dr. Holbrook decided to go
20 on and continue his schedule, she was in the danger zone.

21 Now, the defense wanted to bring up the fact that she had
22 surgery in 2009, and she wasn't paralyzed. She had surgery in
23 2011, and she wasn't paralyzed. We know why she wasn't
24 paralyzed with those two surgeries, because in 2009, her mean
25 arterial pressure was different. Remember, you treat the

1 individual, not a generic person.

2 Her blood pressure, mean arterial pressure, was where it
3 needed to be. It was out of the danger zone. 2011, she was
4 not in the danger zone. That's why she didn't have these
5 problems in the first surgery and in the second surgery
6 because she wasn't suffering from the full extent of chronic
7 hypertension, chronic high blood pressure in those two years.

8 This is what Dr. Jones had to say.

9 (WHEREUPON, a portion of Dr. Jones' video deposition was
10 played as follows.)

11 Q: Do you have an opinion to a reasonable degree of
12 medical certainty as to whether sustained low blood
13 pressure during the surgery on July 28th, 2016, caused
14 Crystal Goodwin's neurologic injury?

15 A: Yes, I do.

16 Q: And what is that opinion?

17 A: It did. Her blood pressure was too low for too
18 long, and that's what caused the injury.

19 Q: And if it had been -- if her blood pressure had
20 timely been raised in the face of or in response to this
21 neuromonitoring signal loss to her lower extremities, do
22 you have a belief as to whether her permanent neurologic
23 injury could have been avoided?

24 A: Yes, I do. And I think it could have been avoided.
25 That's also one of the reasons for my criticism is that

1 going in, we had low MAPs. You had that one spike that
2 was good, but I don't know why it's there. And then it
3 drops back down. It's allowed to remain down. That
4 gives me some cause for concern too, because, you know,
5 we -- the hypotension is what led to the signal loss, and
6 that was due to the poor perfusion.

7 Then even after that, you know, something occurred.
8 I don't know what it was. It got it up, but then it was
9 allowed to drift down again. For all I know, she may
10 have been salvageable. The cord may have been
11 salvageable at that point if the right things had been
12 done, but they weren't.

13 Pressors, fluids, lightening the anesthetic, any of
14 those things could have been done. And yet, after that
15 one episode, it goes down as low as it was before, in
16 some cases even lower. That was -- that gave me serious
17 reasons for concern. And that, combined with the low
18 urine output, it was a perfusion issue without a doubt in
19 my mind.

20 (WHEREUPON, the video was stopped, and the proceedings
21 resumed as follows.)

22 MR. GOINGS: So why was this a blood pressure issue?
23 Number one, she was kept in the danger zone the entire
24 surgery. Too low for too long. The -- another reason why we
25 know it's a blood pressure issue is because she had very low

1 urine output, 80cc. 80cc, yet she received this much during
2 the surgery in fluid.

3 Mr. Hinson, I haven't seen much evaporation in that bowl
4 that you showed the jury last week.

5 80. Who agrees that this was low urine output? Dr.
6 Lustgarten. Now, that was way back beginning of last week,
7 the first expert that took the stand, Dr. Lustgarten.

8 Who else agrees that there was low urine output? Dr.
9 Jones. We just played his clip.

10 Who else agrees that this is low urine output? Three of
11 these experts that took the stand for the defense. Don't take
12 our word for it. Take their paid experts. Dr. Poletti. Dr.
13 Balestrieri. He says it's on the low side. There's the
14 chart. There's the graph. This is -- this 480 is what the
15 minimum -- minimum urine output should have been. Look, she's
16 down at 80. Another chart comparing all the surgeries.

17 Next, why do we know that this is a perfusion blood
18 pressure issue? Because the injury occurred to the most
19 susceptible part of the body to perfusion. Now, this is the
20 watershed region.

21 Now, Dr. Sampson -- you may remember he said people don't
22 have watershed regions. Dr. Holbrook says he's never heard of
23 a watershed region, but Dr. Lustgarten, Dr. Mancuso, Dr.
24 Jones, Dr. Poletti, here from Southeastern Spine, said, yes,
25 this is the watershed region. This is the area most prone to

1 a low perfusion injury. Dr. Balestrieri said it as well.

2 Dr. Poletti testified. He referred to this area. This
3 is his testimony in this trial that the court reporter gave us
4 on Friday. He referred to this area as the watershed region
5 and agreed that it's the area most susceptible to injury.
6 Right, right, at that T10-L1 level, the lower thoracic spine.

7 How do we further know that this is a lack of blood flow
8 perfusion injury? The MRI. Dr. Holbrook can change his
9 testimony and lie, but the MRI don't lie. Let me show you.
10 See this? Look at that. Remember that witness yesterday who
11 took the stand, and he said if you see owl eyes, yeah, that's
12 an injury caused by lack of perfusion. Yesterday, Dr. Goltra
13 told you that. Remember that?

14 And remember last week, Dr. Mancuso, the -- the guy that
15 comes once a year to the Newberry Opera House to perform with
16 his family in The Nutcracker, the ballerina? Remember he was
17 talking to you about snake eyes and owl eyes? Now, Dr.
18 Mancuso is not somebody that, like, does injections on people
19 and Botox and -- and sinus fillers and whatever. He is the
20 chief radiologist for the University of Florida School of
21 Medicine, and he's been the chief for 25 years. There's
22 nobody higher than him in the entire state of Florida about
23 radiology. He brought the MRI to the state of Florida. He
24 talked about these -- this -- this effect that you see.

25 You remember yesterday Dr. Goltra? He said -- I don't

1 know what he was looking at, but this is what it looks like,
2 and if you see this, you know it's a lack of perfusion, and I
3 saw y'all. A couple of y'all were smiling because you know
4 you saw those owl eyes last week when he wasn't here.

5 Let me show you. See that? That's the center of her
6 cord. Those -- those white dots. Remember he said you're
7 going to have high signal. He drew it in black on a marker,
8 but these are supposed to be white, high signal in the cord.
9 That. That. That. That. He didn't show you that yesterday.
10 That's the same appearance, the white dots in the cord.

11 Do you remember when he said on the sagittal view, which
12 is when you cut the banana in half, you should see a little
13 line on either side? He drew it on this side, which
14 represents -- there's the line. There's the line.

15 Another reason why the MRI shows that this was the blood
16 pressure and not a reperfusion is because you heard the
17 testimony if it's reperfusion, it would happen at the level
18 where the osteophyte is taken off. That's T9-T10, which is
19 only right here, but the owl eyes, the spinal cord death,
20 measures 6.2 centimeters. That long.

21 That is a blood pressure lack of perfusion because the
22 testimony was clear that if you have a reperfusion injury, it
23 only reperfuses at the area where you took the osteophyte off.
24 So from here to here, you have that phenomenon.

25 Why is it not a reperfusion injury? Dr. Mancuso

1 explained. He said you would have -- would have caused
2 complete cord injury. The periphery was spared. It would not
3 have extended more than a level above or a level below. It
4 would be where the bone spur was removed.

5 Dr. Goltra, who testified yesterday, said that a
6 reperfusion injury is extraordinarily rare. That was the
7 words he used, even if you have ischemia in a chronic nature
8 in your cord. Dr. Goltra also agreed that reperfusion would
9 show focal signal intensity.

10 Why is it not reperfusion? This is what Dr. Fred Jones
11 said.

12 (WHEREUPON, the video deposition of Dr. Fred Jones was
13 played as follows.)

14 Q: Do the clinical picture and the evidence in this
15 case fit with a reperfusion injury?

16 A: No, for a couple reasons. One, if perfusion is
17 adequate up to that point, then there is no reperfusion
18 injury. In other words, reperfusion injury occurs in
19 tissue that has not been perfused and you suddenly
20 restore perfusion.

21 Looking at those records, the perfusion wasn't
22 adequate -- was -- you know, if it had been adequate to
23 begin with, there would not have been any occurrence of
24 reperfusion injury.

25 Also, reperfusion injury does not occur at an

1 instant in time. Even Dr. Holcomb [sic], in his
2 deposition, said the signal drop off was dramatic. It
3 was like almost instantaneous, like flipping a switch.
4 That's not the way reperfusion injury typically occurs.
5 It manifests over a period of time. So, no, I don't
6 think reperfusion injury occurred here.

7 Q: And if there were -- if it were -- I understand your
8 position is you don't believe it was a reperfusion
9 injury, but if it were a reperfusion injury, would doing
10 the things you mentioned earlier in response, giving
11 fluids, lowering the anesthetic levels, raising blood
12 pressure, would they help to lessen or alleviate blood
13 pressure, would they help to lessen or alleviate a
14 reperfusion --

15 MR. HEITMAN: Same objection.

16 BY MR. HINSON:

17 Q: You can answer.

18 A: Okay. With reperfusion, yes. You'd be doing the
19 same thing. You'd want to restore pressure, provide
20 supportive therapy, keep the pressure up, keep the
21 patient well oxygenated and ventilated. And that's about
22 all you would -- would do. So if the same things had
23 been done that should have been done as soon as the
24 signal was lost, then if this was due to a reperfusion
25 injury, it should have resolved.

1 Q: And -- but in order to do that, those things that
2 you just described, the anesthesiologist would have to
3 what?

4 A: They would have to have been notified.

5 (WHEREUPON, the video was stopped, and the proceedings
6 resumed as follows.)

7 MR. GOINGS: So even if it was reperfusion, which now
8 they're wanting to claim, all you do is increase perfusion and
9 fix the problem.

10 Another reason why we know it's not reperfusion is
11 because other areas of the spine were affected. Now, the
12 signals also showed problems in the cervical spine, the upper.
13 That's what caused blood supply, blood flow, blood perfusion
14 was not making it up to the upper part of the back. If it's a
15 reperfusion, remember the only injury is where the bone spur
16 was. You would have the same phenomenon, the same effect on
17 the neuromonitoring in the cervical spine.

18 Now, when we say that it was an issue with blood
19 pressure, issue with improper perfusion, that is the same
20 thing as an ischemic injury. That is the same thing as an
21 infarction. Remember early on the doctors talked about
22 infarction and ischemia, infarction and ischemia.

23 The truth is Dr. Holbrook, this gentleman sitting over
24 here, Dr. Holbrook knows that this is not a reperfusion
25 injury, and here's why. He told Crystal in the hospital on

1 August 1st, 2016, that the cause of injury was something
2 during surgery that restricted blood flow to that area of the
3 spine, restricted blood flow to that area of the cord.

4 (WHEREUPON, the video deposition of Dr. Holbrook was
5 played as follows.)

6 A: It was something during the course of the surgery
7 that irritated one of those blood vessels, and that's
8 what maybe caused it to occlude and restrict the blood
9 flow to that area of the spinal cord.

10 (WHEREUPON, the video was stopped, and the proceedings
11 resumed as follows.)

12 MR. GOINGS: Remember when I said lack of blood flow,
13 lack of perfusion is the same thing as an ischemic problem?
14 Look at what Dr. Holbrook's own medical records say. The
15 referral to physical therapy that he signed, he called it an
16 ischemic disorder of the spinal cord. He called it an
17 infarction. His own medical records agree with us.

18 And it doesn't stop there. Look at Exhibit 11. This is
19 the Midlands records. He calls it an ischemic disorder of the
20 spinal cord. He doesn't call it a reperfusion of the spinal
21 cord. He calls it an ischemic disorder. Ischemic disorder is
22 a lack of blood flow.

23 She had an -- quote, she had an ischemic event to her
24 spinal cord during surgery. This was -- he wrote a month -- a
25 little more than a month after the surgery. That's Exhibit 10

1 in the records.

2 And another reason why Dr. Holbrook, in fact, the most
3 important reason why Dr. Holbrook doesn't believe it's an --
4 it's a reperfusion injury is because when he put his hand on
5 the Bible and took the solemn oath to tell the truth in 2020,
6 he said he didn't know the cause. To be sure, when he put his
7 hand on the Bible a year later in 2021, he said I can't tell
8 you the cause. I don't know the cause.

9 Yet when he put his hand on the Bible in front of you for
10 the first time, he calls it a reperfusion injury. She's been
11 paralyzed for nearly seven years, and the first time he knows
12 the cause is when he has to face you. So think about how
13 credible their excuse is.

14 And the last reason why we know that it's not a
15 reperfusion injury is because Dr. Goltra took the stand and
16 said if you see white dots on the spinal cord, you know it's
17 from a lack of blood supply. Quote, if you see white dots in
18 the spinal cord, you know it's from a lack of blood supply.
19 White dots, the owl's eye appearance that he actually drew on
20 that board.

21 Now, another concept that you need to understand for
22 purposes of your deliberations is what is the standard of
23 care? What is the standard of care of a doctor? Earlier on,
24 I told you what the law was about what a doctor should do.

25 Well, the standard of care is really the law, that they

1 provide diligent medical care, that they provide a thorough
2 and careful examination, that they comply with generally
3 recognized and accepted principles, that they are careful and
4 prudent, and that they fully evaluate and investigate.

5 So the standard of care, the first standard of care that
6 we submit that was breached, broken, violated was the standard
7 of care to determine the baseline blood pressure. The
8 baseline blood pressure.

9 Who -- what testimony did you hear that you need to
10 determine a baseline blood pressure? Dr. Lustgarten, the
11 first witness. Dr. Jones, who you saw on video. Erich Starn,
12 the CNRA [sic]. Dr. Poletti from Southeastern Spine. And Dr.
13 Balestrieri. Three defense experts, paid experts, all agree
14 that you need and you're supposed to and the standard of care
15 requires to determine the baseline blood pressure before you
16 start the operation, before you administer anesthesia.

17 Dr. Balestrieri, Dr. B, who testified just recently, he
18 said, quote, a patient's baseline blood pressure should be
19 considered when making a plan about where to maintain the
20 patient's blood pressure during a surgical procedure. That's
21 what he said, the defense's expert.

22 And the determination of keeping the blood pressure where
23 it needs to be is based on the 20 percent rule. Dr. Jones
24 uses the 20 percent rule of thumb. Dr. Balestrieri, the
25 defense witness, uses the 20 percent rule of thumb.

1 Dr. Lustgarten, the first witness, says, now, listen, 20
2 percent is always the right answer if you're healthy, but if I
3 know somebody has chronic high blood pressure like she does,
4 I'm not going to flirt with the 20 percent. I'm going to try
5 to keep it as close as possible to the baseline.

6 And guess what? Guess what Erich Starn said when he took
7 the stand? Erich Starn is the CRNA that was in the room. He
8 said, quote, he likes to keep a patient within 10 to 15
9 percent of their baseline blood pressure because if the
10 patient is not adequately perfused, that can result in injury.

11 Dr. Lustgarten, the first witness, he said that mean
12 arterial pressure must be kept higher for patients with
13 chronic hypertension. Due to her risk factors, she should be
14 kept close to her baseline.

15 Erich Starn testified -- this is the defense witness --
16 the standard of care requires anesthesia to consider a
17 patient's history of hypertension when determining where to
18 keep a patient's blood pressure. And he said anesthesia must
19 keep the blood pressure for a hypertensive patient higher
20 because you want to make sure the patient is properly
21 perfused. Directly from the defense's own witness.

22 But what does Dr. Holbrook say about establishing
23 baseline blood pressure? He says two different things in both
24 depositions. He flip flopped. The first deposition, I want
25 to show you what he said. Then once he realized that they

1 didn't consider the baseline blood pressure, you're going to
2 see how it changed his testimony.

3 (WHEREUPON, Dr. Holbrook's video deposition was played as
4 follows.)

5 Q: Despite surgery under anesthesia, a patient's
6 intraoperative blood pressure should be kept within a
7 certain range of his or her baseline blood pressure?

8 A: It should be kept at a reasonable level.

9 Q: And what's a reasonable level for one patient may
10 differ to another patient; is that fair?

11 A: The point at which they may have symptoms from an
12 abnormality may be different in different patients.

13 Q: One should consider the patient's baseline blood
14 pressure when determining what blood pressure to keep the
15 patient during a surgery?

16 A: We look at the baseline blood pressure.

17 Q: So a patient who has been historically hypertensive
18 might need a higher blood pressure maintained during
19 surgery than another patient who had normal blood
20 pressure historically?

21 MR. TODD: Object to form.

22 A: You mean is that ever possible? On any situation,
23 could it ever happen? Yes. It's possible.

24 Q: Do you agree that when determining where to keep a
25 patient's blood pressure during anesthesia, the patient's

1 historical baseline blood pressure should be considered?

2 MR. TODD: Object to form.

3 A: It is considered.

4 Q: It is considered, and it should be considered?

5 A: It is considered.

6 Q: It is considered?

7 A: That's just a normal part of the process.

8 Q: A normal part of the process?

9 A: Every patient's baseline blood pressure is observed

10 before the surgery.

11 Q: How far would one go back to look at baseline blood

12 pressure?

13 A: I don't know.

14 Q: Whose job is that?

15 A: Is to look at the blood pressure?

16 Q: To determine the baseline blood pressure?

17 A: To determine the baseline blood pressure? I think

18 that's something that everybody -- everybody knows what

19 the baseline blood pressure is.

20 Q: Is that something you consider prior to a surgery?

21 A: Yes.

22 (WHEREUPON, the video was stopped, and the proceedings

23 resumed as follows.)

24 MR. GOINGS: Everybody knows baseline blood pressure, and

25 he considers it prior to surgery. What does he say a year

1 later?

2 (WHEREUPON, the video deposition of Dr. Holbrook was
3 played as follows.)

4 Q: Determining baseline blood pressure is something
5 that has to be considered prior to surgery; right?

6 A: It could be. Not necessarily.

7 (WHEREUPON, the video was stopped and then started
8 again.)

9 Q: What was Crystal Goodwin's baseline blood pressure?

10 A: We don't have one.

11 (WHEREUPON, the video was stopped, and the proceedings
12 resumed as follows.)

13 MR. GOINGS: He considers it. It's something everybody
14 considers. He considers it, but he put her under anesthesia
15 without a baseline blood pressure.

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

18 Q: Obtain blood pressure based off a patient?

19 A: We use the patient's history. Yes, sir.

20 (WHEREUPON, the video was stopped, and the proceedings
21 resumed as follows.)

22 MR. GOINGS: They use the patient's history. This is
23 what he said first.

24 (WHEREUPON, the video deposition of Dr. Holbrook was
25 played as follows.)

1 Q: Preparing to perform a spine surgery, what would you
2 look at to determine the patient's pre-operative blood
3 pressure?
4 A: The numbers of the blood pressure.
5 Q: You look at patient's chart; correct?
6 A: Yes.
7 Q: And you look at the recordings of blood pressure at
8 previous appointments and visits; correct?
9 A: We record the blood pressure at our business, yes.
10 Q: And you would look at that prior to performing the
11 surgery?
12 A: Yes. We look at blood pressure before the surgery.
13 Q: And you would look at the patient's blood pressure
14 in prior visits before performing the surgery?
15 A: I wouldn't look at every blood pressure with every
16 visit that she's had with every doctor. No. No, that's
17 not customary.
18 Q: So how far back would you go?
19 A: I would look at her existing blood pressure, her
20 history of hypertension and, based on her history, try to
21 determine if there were any issues with that that needed
22 to be dealt with preoperatively.
23 (WHEREUPON, the video was stopped and then started again
24 as follows.)
25 Q: Or doubt that Crystal Goodwin's baseline blood

1 pressure is in the realm of someone who suffers from
2 hypertension?

3 A: I think she has hypertension.

4 Q: Okay. If she has hypertension, do you agree that
5 her blood pressure should be kept during a surgery or
6 operation at a level that's consistent with her baseline
7 hypertensive state?

8 A: I believe we determined an accurate baseline blood
9 pressure.

10 Q: Her baseline blood pressure was what?

11 A: That was not determined.

12 Q: It was not determined by who?

13 A: Anyone.

14 Q: Why wasn't it determined?

15 A: It's not necessary.

16 Q: Why wasn't it necessary?

17 A: Well, why are you saying it was?

18 (WHEREUPON, the video was stopped, and the proceedings
19 resumed as follows.)

20 MR. GOINGS: When you deliberate and you enter a verdict,
21 will you answer that question for Dr. Holbrook? Will you
22 answer why it was necessary? The standard of care.

23 Erich Starn testified. Now, this is a CNRA. Once we
24 showed him the blood pressures, he admitted on the stand that
25 the blood pressures were not adequately -- adequately

1 maintained.

2 We said looking at the preoperative assessment today,
3 that she had a mean arterial pressure of 113 on 7/22. Would
4 you agree that Ms. Goodwin's intraoperative blood pressure on
5 the morning of the surgery should have been kept higher than
6 it was?

7 And he said if that blood pressure is accurate, yes, it
8 should have been kept higher.

9 What did Dr. Jones say about the blood pressures?

10 (WHEREUPON, the video deposition of Dr. Jones was played
11 as follows.)

12 Q: Do you believe to a reasonable degree of medical
13 certainty as to whether sustained low blood pressure during
14 the surgery on July 28th, 2016, caused Crystal Goodwin's
15 neurologic injury?

16 A: Yes, I do.

17 Q: And what is that belief?

18 A: It did. The blood pressure was too low for too
19 long, and that's what caused the injury.

20 Q: And if it had been -- different blood pressure had
21 timely 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 injury could have
24 been avoided?

25 A: Yes, I do. I think it could have been avoided.

1 (WHEREUPON, the video was stopped, and the proceedings
2 resumed as follows.)

3 MR. GOINGS: So we've explained that the blood pressures
4 were not adequately kept for purposes of establishing a
5 baseline blood pressure, which is the standard of care.

6 The second standard of care that was violated is the
7 failure to perform a required preoperative timeout. What
8 witnesses agree that you're required to do a timeout? Dr.
9 Lustgarten, Dr. Jones. The doctor from Southeastern Spine,
10 Dr. Poletti, he says you have to do a timeout. That's the
11 standard of care. Dr. Balestrieri, who was here, the defense
12 witness, also says that you were supposed to do a preoperative
13 timeout. And if you don't want to believe any of those, the
14 hospital policy says you're required to do a timeout.

15 Dr. Poletti. This is what he said. Quote, a
16 preoperative timeout is required for every surgery. He said
17 the standard of care -- now, this is the defense's paid
18 expert. The standard of care requires a conversation with
19 anesthesia to discuss comorbidities.

20 Well, blood pressure, hypertension is a comorbidity or
21 pre-existing condition, blood pressure, hypertension, that
22 might have an impact on surgery, the surgical history and any
23 condition that a patient may have that should be considered by
24 the whole surgery team.

25 Here's the policy required by Palmetto Health. It's the

1 universal protocol to perform an invasive procedure, which is
2 a surgery. It says must be led by the physician, Dr.
3 Holbrook, and it must include all members, to include the
4 preoperative briefing, timeout, and debriefing.

5 And why do we have a timeout? Their policy tells you why
6 you're supposed to do a timeout. This is applicable to any
7 invasive procedure or surgery performed at Palmetto Health to
8 enhance communication and reduce complications. To enhance
9 communication and reduce complications. That's why he was
10 required to do a timeout so the whole team could communicate
11 so we wouldn't have problems like we have today.

12 This lady, Sunny Jumper, the surgical tech, she said that
13 she's been in about 15 to 20 surgeries with Dr. Holbrook, and
14 he never does a timeout. He always skips that step.

15 Erich Starn. He said there was never a meeting with
16 anesthesia. There was never a discussion with anesthesia.
17 They never talked.

18 Dr. Root said they never discussed this case, they never
19 discussed anesthesia, and what she was doing was what Holbrook
20 always likes to do. Treat them like a generic patient. Keep
21 them in the range of a normal person, not in the range of an
22 individual.

23 And you know what? Who else agrees that a timeout wasn't
24 performed? Dr. Holbrook himself. He said it in 2020 under
25 oath. He said it in 2021 under oath. And you know what he

1 told you, thinking that he could fool you? That he did one.
2 He -- he testified to you that he did do a timeout, and then
3 he said it's a hospital policy. Of course, I did a timeout.
4 He says, well, it's in the medical records.

5 Go back and look at these medical records and see if you
6 see any reference to a timeout. It wasn't done. It's not
7 documented in the medical records.

8 You know what I find to be absolutely amazing is that the
9 neuromonitoring records -- you know, anesthesiology never
10 talked to surgery, but the neuromonitoring records that Teresa
11 Adkins took and kept that said, warning, warning,
12 neuromonitoring is lost, she subscribes everything that
13 occurs. And she has on this page that -- because you have to
14 check a box for timeout, and it has a time that the timeout
15 occurs, and then you have to check a box and put the time when
16 the surgery started. She checked the box for timeout, and she
17 checked the box for surgery started, and there's a four second
18 difference between the two. Four seconds. That means it
19 wasn't done. It wasn't done.

20 Erich Starn. There was no preoperative timeout or
21 conversations. That's his direct quote. There was no
22 preoperative conversation with Dr. Holbrook regarding blood
23 pressure or history of chronic hypertension. He said that.
24 He said it again that anesthesia was not provided any prior
25 medical records or recorded blood pressures.

1 We showed what Midlands sent. Vitals unrecorded. Dr.
2 Holbrook had said, well, they could have asked for it. If
3 they wanted it, they could ask. How do you know to ask for it
4 if you send it over and it says vitals not recorded?

5 Because you know his defense now? It was -- it was Dr.
6 Root's fault. That's his -- that's his -- that's his sole
7 defense that he wants y'all now to -- now to believe.

8 The last standard of care that was violated? So we've
9 gone through that the baseline blood pressure was not
10 calculated. They never did the required pre-timeout
11 discussion to talk about blood pressure.

12 And the last standard of care that was violated is that
13 there was no response to medical alarms and red flags. There
14 is a protocol for what to do when this happens. A protocol on
15 what to do when this happens, and it's right here. This is
16 directly out of the journal assignments. It tells us what to
17 do when the signals go out.

18 You know what? He knows that this is what you do when
19 the signals go out. You know why? Because he did step one,
20 and he stopped. He made the decision. Despite Teresa Adkins
21 saying that it's nothing wrong with the equipment, he made the
22 unilateral decision that it was an equipment failure. That I
23 can't believe what that neurotech, that little tech over
24 there, was telling me. I'm the neurosurgeon. It must -- she
25 must be wrong.

1 He should have said we need to check the anesthetics. He
2 should have said we need to improve perfusion. But he didn't
3 go to step two. He didn't go to step three because he never
4 got off of check the equipment because he didn't believe what
5 he was told. He ignored the medical alarms and the red flags.

6 Now, this chart of what to do, Dr. Lustgarten agrees with
7 it. Dr. Jones agrees with it. Dr. Poletti, their own expert,
8 agrees with it. They keep talking about why would you ever
9 wake somebody up during surgery? Well, look, the truth of the
10 matter is, you don't ever have to get to this if you do the
11 anesthetics and improve perfusion because 99 percent of the
12 time, the grass comes back.

13 Dr. Poletti. Neuromonitoring is absolutely the standard
14 of care. The reason and the purpose for neuromonitoring is so
15 the surgery team can be aware of a dysfunction right away, and
16 the surgery team can address it. He said there's a checklist
17 that you go through when the signal is out. Now, this is
18 their expert that they pay that agreed that this is -- number
19 one is check the equipment, and he said, quote, you have to
20 have a conversation with anesthesia to -- to assess for
21 anesthetic changes.

22 This is what Dr. Jones says when the signals go off.

23 (WHEREUPON, the video deposition of Dr. Jones was played
24 as follows.)

25 A: The critical portion of the case when the signal was

1 lost, which is what stands out most in my mind, he and
2 the anesthesiology team were informed at the same time.
3 So I don't think there was a breakdown in communication
4 between them, other than the fact that, you know, if he
5 had been more adamant about get your attending in here,
6 in other words, Dr. Root, or exploring or, you know,
7 mentioning to the CRNA perhaps what is the pressure?
8 These are all things that in the spine cases I've been in
9 that have started to have problems with the signal that
10 has occurred.

11 And so I would have a criticism of that. I don't
12 think he communicated with them enough once he was told
13 that the signal dropped off. Bells and whistles should
14 go off when that occurs.

15 (WHEREUPON, the video was stopped, and the proceedings
16 resumed as follows.)

17 MR. GOINGS: We know why he didn't go to the steps of
18 letting anesthesia because Dr. Root testified the reason she
19 wasn't called was because Dr. Holbrook unilaterally made the
20 decision himself that it was an equipment issue.

21 (WHEREUPON, the video deposition of Dr. Jones was played
22 as follows.)

23 Q: What should have occurred? The whole surgical team,
24 what should -- just generally speaking, what should have
25 been done?

1 A: An emphasis should have been placed right away on
2 getting the pressure back up, on getting the pressure
3 higher. And if they thought it was in normal range, then
4 you get it even higher than that because sometimes that's
5 what it takes.

6 Q: And you -- and have you in your career had occasion
7 where signal went out because of inadequate perfusion?

8 A: Yes. Oh, yes.

9 Q: And in your experience, what was done in the face of
10 inadequate perfusion?

11 A: The very things I mentioned. Lighten the anesthesia
12 if you can. Sometimes lightening the anesthetic is not
13 an option because you don't want the patient to wake up.
14 But fluids is a big one, particularly in a patient who
15 really is running dry based on how much she was getting
16 versus how much she was -- urine output she had.

17 And then pressor agents. Pressor agents are
18 probably the most common. And like I said, vasopressin,
19 phenylephrine, ephedrine, all of those medications we
20 regularly give in these cases of things.

21 Q: And in every occasion where you had that occur,
22 where there was a signal loss and there was a reaction
23 with pressors, fluids, and lightening anesthetic, was the
24 patient's neurologic function able to be salvaged in
25 return?

1 A: Yes. Thank God they were.

2 Q: And you believe that could have happened in this

3 case?

4 A: I do.

5 Q: Do you believe it would have happened in this case

6 had the standard of care been followed?

7 A: I do.

8 (WHEREUPON, the video was stopped, and restarted as

9 follows during cross-examination.)

10 Q: Have you yourself ever been involved in a case where

11 the signal was temporarily lost but then returned?

12 A: Yes.

13 Q: How many cases?

14 A: Over a period of 20-some years, I wouldn't say

15 probably about more than 10 or 15, but I've had to deal

16 with that. That's a reality of a spine surgery.

17 Q: And in those situations, was signal loss due to poor

18 perfusion?

19 A: Well, obviously, we will go through the diagnostic.

20 In some cases, it was perfusion issues, in which case you

21 raise the pressure. In others, it was mechanical, and

22 surgeons had to make adjustments.

23 I don't recall if I've been anywhere where the

24 signal was -- was thrown off due to -- from the monitor

25 error, but I know some stand out in my mind of perfusion

1 issues and the -- the surgeon manipulating
2 instrumentation.

3 Q: About how many would you say were due to poor
4 perfusion?

5 A: Maybe as many as a half.

6 Q: And in those situations, did you raise the patient's
7 blood pressure?

8 A: Yes. That's how -- that's largely how we determined
9 that it was a perfusion issue. You run into a
10 differential diagnosis when you lose the signal. Okay?
11 First of all, you have to assume is it, you know, the
12 monitor, but the monitoring tech is usually going to be
13 working on that.

14 On our side, we're looking at the pressures. And
15 sometimes those pressures on the screen may appear what
16 we would consider textbook normal. Okay. It's 120 over
17 80. Why are we having this? But you raise the pressure
18 because if it turns out that raising the pressure doesn't
19 do it, then you rule that out as a cause of it. In which
20 case then you say, you know, surgeon, hey, I brought the
21 pressure up. I've got a mean now, you know, well over,
22 you know, the 20 percent range. And we still don't have
23 return of signal. We know it's not a perfusion issue.
24 Check again.

25 In some cases, the surgeon will check and say, oh --

1 in many cases, it is something. It is compression. If
2 they're applying screws or whatever, they let off on it,
3 all of a sudden the signal comes back.

4 But it's a differential thing, and that's where the
5 communication is crucial because we don't always know,
6 but you've got to try everything until you get that
7 signal back.

8 If the -- if the equipment's working, we know it's
9 not the equipment. The surgeon says, hey, I haven't
10 touched it, fine. It's not you. It must be at the head
11 of the table, as we say, which is anesthesia. Lighten
12 the anesthetic, give a fluid, give pressors, see if you
13 get the signal back. Thank God I've never had one that
14 didn't get back. So that's how we roll through that.

15 Q: So in those cases that you mentioned, when you raise
16 the blood pressure, the signal returned?

17 A: Correct. In those cases where it was a matter of
18 perfusion. In some cases, we raised the blood pressure
19 and it didn't. The surgeons in those cases typically
20 would make a manipulation and would get return of signal.

21 Q: And in your experience in thousands of cases, you've
22 never been involved in a -- in a case where the signal
23 was lost or remained lost; is that correct?

24 A: Correct.

25 Q: The signals always come back in your experience with

1 low perfusion cases because you raise the blood pressure?

2 A: On the cases that I myself have performed, yes,

3 that's correct.

4 (WHEREUPON, the video was stopped, and the proceedings

5 resumed as follows.)

6 MR. GOINGS: Now, you don't have to be a medical doctor,

7 a neurosurgeon, or an anesthesiologist to know these steps.

8 Did you hear the testimony of Sunny Jumper, the surgical tech?

9 She said that everybody looked around in the room, like, what

10 the hell, when the doctor said it was an equipment issue, and

11 Teresa Adkins, the neuromonitoring physiologist, said nothing

12 is wrong with the equipment.

13 And did you also hear the testimony of Teresa Adkins, the

14 neuro tech that was being disregarded? She said there's a

15 step for what to do. Check the equipment. It's not the

16 equipment, then you increase pressure. She knows what the

17 steps are. She said -- Sunny Jumper said all he had to do was

18 follow generally recognized principles, and that's all.

19 Could it be that maybe Dr. Holbrook is not very

20 approachable? Could it be that maybe somebody in the surgery

21 room didn't want to challenge him? Could it be that maybe Dr.

22 Holbrook, you know, considers himself the neurosurgeon, and

23 what I say is right? Obviously, a lack of communication. It

24 goes deeper. You saw that.

25 Ladies and gentlemen, you will be given a verdict form,

1 and it's two pages. And this is the verdict form that you
2 will get. And the first question on the verdict form is do
3 you find that the defendants were negligent, and the
4 negligence proximately caused injury? Yes or no?

5 Remember I told you there are three ways we know that the
6 standard of care was violated? If you find just one of those
7 three ways happened, the answer is yes. You don't have to
8 find that he violated the standard of care every three times
9 -- every time. You've just got to find out and determine one
10 time did he deviate from the standard of care?

11 We would say, ladies and gentlemen, respectfully, the
12 answer is yes based on the preponderance, the greater weight,
13 more likely than not, of the evidence. And that's simple
14 negligence. It's just simple negligence. Again, not that he
15 meant to, not that it was intentional, but that he departed
16 from the standard.

17 There's a second question. Do you find that the
18 defendants were grossly negligent or reckless? Let me tell
19 you what grossly negligent means, because that's a word that
20 has a legal context. And the judge, Judge Newman, is going to
21 tell you what gross negligence means.

22 Let me tell you what she's going to tell you it means.
23 The reason I know it is because she has provided the lawyers
24 with the charge that she's going to provide to y'all. This is
25 what gross negligence means. Again, not that it's

1 intentional, but the failure to exercise a slight degree of
2 care at every step or just acting indifferent about the
3 consequences. Like, acting indifferent about the medical
4 alarm that went off. Acting indifferent about her blood
5 pressure.

6 Here are some examples in this case of gross negligence,
7 and if you find any one of these, we believe it's gross
8 negligence.

9 Not following a policy. If you find evidence that there
10 was a policy that was not followed, that is a -- that is gross
11 negligence.

12 If you skip steps, steps that are required, disregarded
13 steps, disregarded what someone told you, like Teresa Adkins,
14 ignored medical alarms and red flags, that, ladies and
15 gentlemen, is evidence of gross negligence. We submit the
16 answer is yes to that.

17 It says gross negligence and/or recklessness. In the
18 law, gross negligence and recklessness mean the same thing.
19 They're synonymous. But let me tell you what the legal
20 definition of reckless is. Reckless means carelessness, lack
21 of concern of safety.

22 Was there a lack of concern of Crystal Goodwin's blood
23 pressure? Was there a lack of concern of what to do when the
24 alarms went off? If you find that that occurred and you saw
25 evidence of it, then, ladies and gentlemen, again, not

1 following policy, skipping steps, disregarding what somebody
2 tells you, ignoring medical alarms, then the answer is yes to
3 that question.

4 Now, there's a third question, and there's a third
5 question that's also very critically important. Here it is.
6 Do you find that the defendants engaged in fraud or made one
7 or more misrepresentations related to the claims?

8 Misrepresentations. You've seen the misrepresentations,
9 the misrepresentations to you. If you find that Dr. Holbrook
10 misrepresented anything to you, you should check yes. I'm
11 just going to -- there's a lot of misrepresentations, but I'm
12 going to just point out a couple.

13 First, misrepresentation started in the operative report.
14 Identifiable causes found. Blanks. There is no mention of
15 signals going out in the operative report. The most critical
16 part of the surgery, there could be a problem, the signals are
17 out, it's not even mentioned in his operative report.

18 The MRI that he says I did emergent. He put in there
19 since a fall three days ago. He told you that it was
20 emergent, and we know it's not emergent. He ordered it just a
21 routine MRI, and that explains why it took four-and-a-half
22 hours for it to be performed.

23 The discharge summary. The discharge summary. Ladies
24 and gentlemen, the document that describes everything that
25 happened and all critical events, not once mentions -- not

1 once mentions the signals went out.

2 He says patient was admitted to the hospital same day of
3 surgery. She underwent a procedure and was transferred to the
4 recovery room. In the recovery room, she was unable to move
5 her legs with good strength and was taken back in the
6 operating room for re-exploration.

7 If you read this, the medical records, you would have no
8 idea that the alarms and the bells are going off. You would
9 have no idea that Dr. Holbrook disregarded what everybody was
10 saying, that it wasn't an equipment problem. That's because
11 if he put that in the records, that he was told that there was
12 a problem in the surgery, then that would look bad and that
13 would be bad for him. So he omitted it. He omitted it.

14 And this is the entire set of medical records for
15 Crystal's stay for two weeks, front and back. It consists of
16 nearly a thousand pages. In a thousand pages, two weeks,
17 would it surprise you to know that there's not one mention by
18 Dr. Holbrook that the neuromonitoring went out? There's not
19 one mention in the medical records that he was told that the
20 neuromonitoring went out. There's not one mention in the
21 records that there was an equipment failure, or I believe
22 there was an equipment failure. That's because he did not
23 want to have a paper trail of it.

24 Has he made a misrepresentation? I think the most
25 damning misrepresentations that he's made is the bold-faced

1 lies that he's told you, that he did a preoperative timeout,
2 despite putting a hand on the Bible twice and saying he
3 didn't. That he checked the baseline blood pressure, when he
4 finally admitted he didn't. When he said he had that meeting
5 with anesthesiology before the surgery. He told y'all that,
6 and everybody who is a party to that alleged conversation said
7 that didn't happen. And you know what? The first and second
8 times he answered those questions, he said he never talked to
9 anesthesia. If you believe that Dr. Holbrook took the stand
10 to try to misrepresent, then you need to check yes.

11 Now, a lot of people testified and a lot of people have
12 talked. Weird is Midlands Orthopedics. Dr. Holbrook is not a
13 part of Midlands Orthopedics. He's retired. He retired in
14 2020.

15 Not one person from Midlands Orthopedics has sat at this
16 table. Not one person from Midlands Orthopedics has taken the
17 stand. Where is Midlands Orthopedics? The group that has 20-
18 something highly skilled surgeons, multiple places all around,
19 where are they in this courtroom? They're the ones that
20 profited from all of this. Where are they?

21 Well, when I asked them admit that, Midlands Orthopedics,
22 you didn't do any investigation into why Crystal Goodwin was
23 in a wheelchair, they said Midlands Orthopedics did not
24 undertake any sort of review or investigation to determine any
25 cause of her neurologic injury, nor were they required to do

1 so. Nor were they required to do so.

2 A lady, wheelchair bound for the rest of her life. They
3 wouldn't even look into why. And not once in two weeks have
4 they graced the doors of this courthouse. Do you think
5 there's any misrepresentations? Ladies and gentlemen, the
6 answer is yes.

7 So I have spent a lot of time, more time than I actually
8 wanted, talking about the violations of the standard of care
9 and the evidence, trying my best to summarize two weeks of
10 complicated testimony from doctors who all told us how smart
11 they were. I want to talk to you now about what this case
12 really is about.

13 I'm sure over the last week you thought to yourself that
14 Crystal Goodwin is an amazing woman. I'm sure you've thought
15 to yourself that what happened to Crystal Goodwin was
16 preventable, and none of us should have had to have that kind
17 of care throughout this time of life.

18 And so when you ask what are the damages, what are the
19 harms that were caused, the best place to start is to ask Dr.
20 Holbrook. Admit, Dr. Holbrook, that her injury is permanent.
21 This is his answer under oath in something called a Request to
22 Admit that the judge explained to you that you have to answer
23 under oath specific questions. He denies that she has a
24 permanent injury.

25 So when he tells you everything that he told you and put

1 these witnesses up, think about this. If he can't tell the
2 truth about her having a permanent injury, is he telling the
3 truth about what happened in the surgery room?

4 Dr. Holbrook also says that --

5 (WHEREUPON, the video deposition of Dr. Holbrook was
6 played as follows.)

7 Q: Does Midlands Orthopedics take any responsibility
8 whatsoever for Crystal Goodwin being paralyzed today?

9 A: Crystal Goodwin is not paralyzed today.

10 Q: Do you understand why Crystal Goodwin believes she's
11 paralyzed today?

12 A: Did you tell her that?

13 Q: Do you understand why she believes she's paralyzed
14 today?

15 A: Did you tell her that she was?

16 Q: I'm asking you. Do you understand why Crystal
17 Goodwin believes she's paralyzed?

18 A: It might be best to ask her that question.

19 (WHEREUPON, the video was stopped, and the proceedings
20 resumed as follows.)

21 MR. GOINGS: Every doctor has told her she's paralyzed.
22 They also said there's two types of paralysis, complete and
23 incomplete. Complete is there's no feeling at all.
24 Incomplete is you still suffer pain. You still suffer nerve
25 damage. You suffer these spastic twitches that you witnessed

1 in this courtroom. Maybe this attitude is why they never
2 spoke in the surgery room once he said there's nothing wrong
3 with the signals.

4 Now, the law -- even though the defendants claim she
5 could walk, remember they cross-examined a doctor -- a doctor
6 who said the medical records say she can walk, and there's a
7 video where she's bragging to her family about being able to
8 walk, and then we actually showed you the video. See, they
9 thought that you were thinking in your mind, well, maybe she
10 can walk. So I'm glad we got to show you.

11 But the law says, ladies and gentlemen, that Crystal
12 Goodwin is required to be made completely whole. Completely
13 whole, as if this didn't happen. And the law says that this
14 includes all past medical expenses. This includes all future
15 medical expenses. To be made whole includes past pain and
16 suffering. It includes future pain and suffering. It
17 includes every single day that she's in a wheelchair, and to
18 be fully put back in the position that she was in before this
19 happened. And the law says that you can only recover once and
20 you can't come back a year later or five years later. You
21 have to recover once in your lifetime.

22 So how to calculate damages? The judge is going to talk
23 to you about the damages in this case. There's something you
24 can remember about what we said in opening so far is in this
25 chart.

1 The first thing is how to calculate damages. What are
2 the past medical and therapy expenses? We have that in
3 evidence. It's \$389,000. It's an exhibit in the courtroom.
4 You'll take it back with you. That is her past medical
5 expenses.

6 Now, this does not include -- this is a -- this is the
7 floor. This doesn't include all the enemas. This doesn't
8 include a cast. This doesn't include the travel three times a
9 week to therapy. This includes the actual medical bills and
10 expenses. So this is the lowest number it could be.

11 Future medical expenses. You've heard testimony about
12 the future medical expenses in this case, and Dr. Alford wrote
13 down the range of future medical expenses. You'll take this
14 back. You don't have to remember these numbers. He said that
15 this number represents her getting all the medical treatment
16 that the conservative life care plan says she needs, and this
17 low number is if she gets the very least medical care that the
18 life care plan shows.

19 Now, this is important to understand. These numbers are
20 based on an understanding that there is very low inflation and
21 very low interest rates, and we all know the reality of our
22 world is that we cannot predict interest rates and we cannot
23 predict inflation. Sitting here today, we know the effects of
24 interest rate and inflation. So this is the floor based on
25 considering a 2 percent rate of interest and a very low rate

1 of inflation, \$2.6 million.

2 Loss of earning capacity. Crystal explained her loss of
3 earning capacity. Don't you love that she still finds the
4 pleasure in baking cakes? That she still does that? Before
5 this, thriving, five to six cakes a day, and she has to work
6 on Saturdays, too. If you do the math of that, that's about
7 800 to \$1,000 a week to support the family.

8 Now, what she could do in one day, which is five or six
9 cakes or baked items, she can do maybe one or two. If you
10 take that and extrapolate it based on her loss of earning
11 capacity going forward, meaning she could never work outside
12 the house -- her dream was to own a bakery. We conservatively
13 estimate that number at about \$500,000 for the rest of her
14 life. For the rest of her life, from the date of the spinal
15 cord injury to the rest of her life.

16 The economic damages are three -- a little over. This is
17 the low end. You can go higher. It's \$3.5 million. The
18 reason this says economic damages is because on page 2 of the
19 verdict form, there's a line that says what are Crystal
20 Goodwin's economic damages? And it says, such as past and
21 future medical expenses, past and future therapy, past -- past
22 and future health care expenses. At least \$3.5 million just
23 in economic damages.

24 These are the witnesses that testified as to her future
25 medical needs, and there is no evidence to contradict the life

1 care plan and the values. The nurse case manager was not even
2 cross-examined. They don't have a competing nurse case
3 manager. Dr. Alford was only cross-examined to say, yes,
4 Doctor, I hired you too, by the defense, and you're a nice --
5 you're a nice gentleman basically. The economic damages for
6 the future medical needs are not contested in this case.

7 Now, how to calculate damages based on something else,
8 that's the second line in the verdict form. It says non-
9 economic damages. What are the non-economic damages? You may
10 be saying what do you mean by non-economic damages?

11 Non-economic damages are damages that compensate for
12 things that we cannot put an actual price tag on. We can't
13 value pain and suffering. How do you value, how do you put a
14 price tag on pain and suffering? Ladies and gentlemen, that
15 is what you are going to be asked to do in this case is to put
16 a price tag on past pain and suffering.

17 And you can see, ladies and gentlemen, that the non-
18 economic damages, the components of non-economic damages are
19 far more than medical bills and future medical bills. It's
20 pain and suffering, mental anguish, loss of enjoyment of life,
21 future loss of enjoyment of life, and then permanent
22 impairment.

23 And when you add all those up, ladies and gentlemen, that
24 comes to the total non-economic damages. So the line on the
25 second page, the second line on the second page is what is the

1 total non-economic. That is the largest number in the case
2 because that includes things that a lot of us are probably
3 thinking is priceless.

4 So how do you put a price tag on what Crystal is going
5 through? Now, this is -- this is hard for me to talk about
6 because I think you heard that Crystal was not just a client
7 of mine. She's a personal friend, and she's been a personal
8 friend for a long time. And we know and the judge is going to
9 instruct you on the life expectancy tables.

10 That Crystal has never stood on her own for over 2,457
11 days. How do you put a price tag on that? Based on South
12 Carolina law, she's got another 13,620 days to live like this,
13 and when you take the days that she's been paralyzed with her
14 life expectancy, she will spend 16,007 -- 16,077 days
15 paralyzed. How do you put a price tag on that?

16 How do you put a price tag on that? There's various ways
17 to do that. One way to do it is this. What's the price of a
18 step? That's what she's not able to do. She's not able to
19 take a step. How do you value a step?

20 Statistics show that we all, on average, take 7,500 steps
21 a day, on average. Now, when you get your Fitbit or Apple
22 Watch, your goal a lot of times is preset at 10,000.
23 Sometimes it's 12,000, but that's the average steps you take.

24 What if, ladies and gentlemen, you had to put a value on
25 what each step is, how to value that step, because you see, we

1 take steps for granted. She doesn't. It's not what we value
2 a step. It's what the only person in this courtroom values a
3 step.

4 So when you walk down the sidewalk and you see a penny,
5 do we all stop for a penny? Admittedly, I do, because a lot
6 of people walk past a penny. So how do you put a value on a
7 step? Is it worth a penny? Is it worth something that a lot
8 of people don't recognize or pick up? The value of a step has
9 to be a meaningful value to us.

10 So what's a step worth? Is it worth a quarter? Is a
11 step worth a quarter? Do most people pick up a quarter? If
12 you do the math, 7,500 steps a day by a quarter comes out to
13 \$1,875 a day. When you multiply that by the days that she's
14 not able to take steps, that number is 30,144,375, and that's
15 a quarter.

16 What if you say, you know, a step is not worth a quarter?
17 A lot of people don't pick up a dime, but let's use a dime.
18 7,500 steps a day time's a dime is \$750 per day. When you
19 multiply that by the number of days, \$12 million for the rest
20 of her life for every step that she can't take, every step
21 that she can't take.

22 Now, you may be saying those are big numbers. That's a
23 lot per day. That's a lot per day, but you've had testimony
24 in this case, because the judge is going to tell you you apply
25 the testimony in this case. You have testimony in this case

1 as to what people value a day for. There's testimony in this
2 case about what people value their day.

3 So \$750 a day, \$1,800 a day. Let me show you the
4 evidence in this case of the value of the day.

5 Dr. Balestrieri. He values a day at \$5,000. If you
6 remember, he said, yeah, it's been a rough day, and then we
7 said, well, you're making \$5,000. Yeah, yeah, yeah, I'm
8 making \$5,000 sitting over here. That's his value of the day.

9 Dr. Goltra. He values a day at \$7,500. Dr. Sampson.
10 He's -- his value today is \$16,000 per day. So when you value
11 money, value money based on how they value money, not how we
12 value money.

13 So let's take this. If we said, all right, I'm going to
14 value the day -- every day that Crystal goes paralyzed based
15 on the amount of their cheapest expert. That's \$5,000.
16 That's over \$80 million, and that's on the cheapest expert.
17 All right?

18 Now, how do you value a day? Let's say you cut that in
19 half. So that's ridiculous, \$2,500. That's 40 million. So
20 that's why when you just apply a quarter, it's reasonable.

21 You know what this number represents? Do you know what
22 that number represents? 96,462. That number represents the
23 number of times the Crystal will have to catheter herself in
24 her lifetime. All these people that came up at 5,000 a day,
25 \$7,500 a day, none of them cath themselves. That's what she

1 lives through every day of her life.

2 Do you know what this number represents? 8,039, the
3 number of times in her life that she has to put her fingers in
4 her rectum to stimulate her bowels and to dig out stool. Is
5 that worth something?

6 Let me tell you what else she lives with, ladies and
7 gentlemen. Not only does she cath herself six times a day,
8 she has to digitally penetrate herself to use the bathroom.
9 The only time in the last seven years that she was intimate
10 with her husband, she voided on him.

11 She lives with uncontrollable muscle pain, uncontrollable
12 nerve pain. She lives with real depression, thoughts of
13 killing herself because the burden is too big. When you value
14 her day, put that in consideration. The first year and a half
15 after this spinal surgery, she slept in the den in a medical
16 bed. Value that when you value her day.

17 Value the fact that when she goes out in public, people
18 talk about her, people stare at her, look at her, marginalize
19 her. You hear me? They marginalize her. You must be
20 somebody, Crystal, that got beat by her husband. That's what
21 they tell you. Why? Because he's got dreads?

22 Value, ladies and gentlemen, the non-economic damages of
23 something that we take for granted, which is the independence
24 of living, the independence of driving, the independence of
25 going to work, the independence of taking a bath, the

1 independence of going to the bathroom. Only one person in
2 here took a bath in a kiddie pool. Only one person in here
3 for lunch went home to cath. The independence that we enjoy
4 every day has been taken from her, and the law says that she's
5 required to be made whole.

6 James, his case briefly. I think we can all learn from
7 James, a man that works seven days a week for the City of
8 Columbia picking up trash. Saturday nights, he's cleaning up
9 the Vista. He's cleaning up Five Points and Main Street to
10 provide for his family.

11 The intimacy of the woman that he met, the girl that he
12 met in second grade, is gone. When he gets off from work
13 three days a week, he takes his wife to physical therapy.
14 It's forever changed the marriage relations. She loved going
15 on walks on the beach with him. Forever changed their life.

16 So, ladies and gentlemen, we started with three questions
17 at the beginning of this case, and I want to end with one.
18 Why are you here? We know why Crystal is here. We know why
19 Dr. Holbrook is here. But there is a question that each of
20 you has been asking yourself since the judge said you were
21 selected as a juror in this case, and that's why me? Why me?

22 We all have families to be there for, work to be there
23 for, obligations to be there for. And you were stripped of
24 that without your choice. Why you? We all thought we had
25 somebody or somewhere else we needed to be, and I hope you've

1 seen that in the course of this two-week trial, that there is
2 no place you could have been in the last two weeks where your
3 voice can be heard loud and your presence, sir, ma'am, can be
4 more felt.

5 They say that jurors are the conscience of the community,
6 that you bring into this courtroom fairness, common sense, and
7 the ability to make sure people do right by one another. And
8 collectively, ladies and gentlemen, that is what you're doing
9 as jurors. You bring to this courtroom the sense of fairness
10 and respect and to make sure that folks do right by others.

11 Being friends with Crystal in this case has been a burden
12 for me because I know that if I say something wrong, do
13 something wrong, Crystal Goodwin is affected. But I know that
14 the ultimate burden is on you to do the right thing.

15 In your hands when you deliberate is all of her medical
16 bills. In your hands when you deliberate is every single pain
17 and suffering that's she had. In your hands is every time she
18 has to cath herself. Ultimately, that's a burden of you
19 twelve collectively.

20 On behalf of Crystal and on behalf of James, I thank you
21 for helping this family.

22 THE COURT: Ladies and gentlemen, let's take a short
23 break. Please return to your jury room, but do not begin to
24 discuss the case.

25 (WHEREUPON, the jury exited the courtroom at 11:55 a.m.)

1 THE COURT: We'll take a 15-minute recess.

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

3 which the proceedings resumed as follows.)

4 THE COURT: All righty. Again, Mr. Goings claims not to

5 have had that crowd here, but miraculously, they're mostly

6 gone now that you're done speaking. I don't know. Whatever.

7 Just coincidence.

8 All right. Bring the jury, please.

9 THE BAILIFF: Okay.

10 (WHEREUPON, the jury entered the courtroom at 12:22 p.m.)

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

12 THE COURT: Thank you.

13 It's now time for the defense's closing argument.

14 Mr. Davis?

15 MR. DAVIS: Thank you, Your Honor. May it please the

16 Court.

17 THE COURT: Yes, sir.

18 CLOSING ARGUMENT ON BEHALF OF THE DEFENDANTS

19 MR. DAVIS: Well, now it's good afternoon. I want to

20 thank you for your attentiveness to all the parties, all the

21 lawyers, all the witnesses the last two weeks. We all

22 appreciate it.

23 We work hard to try to get you the evidence that you can

24 make your decision on, get you the witnesses and present them,

25 let you hear them, and let you determine who you're going to

1 believe and who you're not going to believe, and how you are
2 going to base your verdict on the evidence. I just want to
3 mention a couple of things before I jump into some of my more
4 prepared remarks.

5 I want to talk about this concept of timeout. Dr.
6 Holbrook testified unequivocally, without any hesitation, that
7 prior to every surgery, it's required for the anesthesiologist
8 or the anesthesia team, the scrub techs, the neuromonitoring
9 tech, if there's one, the surgeon, other people in the
10 operating room, how many people there, before he starts to
11 make that first cut, that incision, before that starts,
12 everything is ready.

13 The patient is already anesthetized. She's asleep. I
14 think the testimony was the anesthesia person says timeout.
15 Everybody just stops whatever they're doing, including the
16 surgeon who is present, and they say is this Crystal Goodwin?
17 We're doing a decompressive laminectomy from T9 to T12, and
18 they confirm all that essential information with everybody
19 there. Yes, yes, yes.

20 Now, it doesn't take very long. I don't know how many
21 seconds that takes. There was a timeout in this case, and Dr.
22 Holbrook was there. This notion that he skips timeouts is
23 ridiculous. Just you make that -- make of that what you wish.

24 And interestingly enough, Teresa Adkins, one of their
25 witnesses, not mine, verified in her report that you have in

1 evidence as Exhibit 15 that there was a timeout. What do you
2 mean it wasn't documented? It's even documented. The
3 neuromonitoring tech.

4 There is a notion made to you earlier that somehow Dr.
5 Holbrook is hiding the fact from all the world that the
6 neuromonitoring signals went out. You heard him testify in
7 his deposition in 2020, when he was first under oath and asked
8 by Mr. Hinson questions about this case. He said fill in
9 those blanks. He said, oh, well, that blank is the
10 neuromonitoring signal blank, and he filled it in in May of
11 2020. He should have done it when he signed it. I get that.
12 Shame on him for not doing that.

13 But here's another curious thing. Not 2020, but 2016,
14 days -- days after the operation. I may remember this
15 incorrectly and, if I do, you correct me in the jury room.

16 That video that was taken by Jazmine of Dr. Holbrook
17 standing in the room next to his patient with family members
18 there that Jazmine recorded on her phone, which was a good
19 reason, you know, maybe mom won't remember and maybe we won't
20 understand it. That's fine.

21 I'm glad she did that because you heard Dr. Holbrook say,
22 if I remember correctly, I think he even said the signal just
23 [*snaps fingers*] -- I can't do that -- went out. It just went
24 out. Days after the operation, he didn't hide it from Crystal
25 or the family. There's -- there's no -- there's no -- there's

1 no intent to misrepresent anything or hide the ball.

2 Another thing that you might think about along those
3 lines about this misrepresentation, this fraud they claim, the
4 neuromonitoring log, your Exhibit 15, all the things that were
5 recorded from the neuromonitoring tech, the discussions back
6 and forth between Teresa Adkins and Dr. Gregg, wherever he was
7 offsite, all the wavelengths, everything. It's a part of the
8 medical record. There's -- there's no hiding that.

9 Then there was some discussion about a request for
10 admission that the lawyers do when they say request that you
11 admit this, that, or the other. We can, as attorneys, say --
12 if we deny it -- if we say we deny it, they have to prove it.
13 That's all it means.

14 This is what Dr. Holbrook denied. Was Crystal Goodwin
15 paralyzed? That has a medical meaning. Even Dr. Shaufele,
16 their expert, who was a fine expert, said, well, she's not
17 really paralyzed. She's functionally paralyzed. We don't --
18 we don't dispute that, but he said she wasn't paralyzed. So
19 for Dr. Holbrook to say, no, technically she's not paralyzed,
20 she's got paraparesis, she's got weakness, bilateral weakness,
21 and he has never to this day denied that she has permanent
22 injury.

23 Well, this is my copy of Exhibit 15. This is the
24 neuromonitoring log. It's part of the hospital record.
25 There's no fraud or misrepresentation. They weren't hiding

1 anything.

2 Ladies and gentlemen, your duty as jurors in this case,
3 in any case, a civil case like this, your duty is to make your
4 decision, to reach a verdict, a unanimous verdict. All twelve
5 of you must agree on your verdict, and when the -- the judge
6 will tell you that it must be based on the evidence.

7 So what's evidence? Evidence is exhibits that both sides
8 have put in. You can consider that as you wish. Also,
9 evidence is -- are people that took this witness stand or were
10 played on the video like Dr. Jones. Those are witnesses who
11 testify under oath and give their testimony in a case. That's
12 evidence that you can consider. You don't have to, but you
13 can, and that's evidence.

14 So let's talk about -- since this is a lawsuit, let's
15 talk about evidence. I'd like to first review the plaintiffs'
16 evidence, not all of it because we don't really, frankly, have
17 a lot of dispute with a lot of it, but those we do I'm going
18 to talk about.

19 Let's talk about Dr. Lustgarten, the neurosurgeon from
20 Florida, who averages between 40 and 60 cases a year as an
21 expert until about 10 or 12 years ago. Now he averages 12 to
22 14 cases a year. With 40 to 60 cases, that's over 43 years.
23 I mean, he has made a lot of money being an expert witness.
24 He said somewhere in the 500 depositions he's given in medical
25 malpractice cases as an expert, he's reviewed three or four

1 cases for this law firm, one since this lawsuit came up.

2 At his deposition, which was in March of 2021, he said he
3 had spent about 24 hours looking at this case. It's been
4 about 10 or 15 more hours between then and trial. At \$600 an
5 hour, that's over \$20,000. I forgot to ask him about what he
6 got paid to be here at trial. Maybe he told you. Consider
7 that for what it's worth.

8 How many decompressive laminectomies have you performed?
9 4- or 5,000. Dr. Lustgarten told you that the surgery in this
10 case, which is the subject of this litigation, was indicated,
11 medically indicated. It was necessary. This is their expert.
12 Dr. Holbrook had all the indications to do a posterior
13 decompressive laminectomy.

14 He told you that specific to spine surgery, he agrees
15 that there's always a risk to the surgery: infection, spinal
16 fluid leaks, nerve root and/or spinal cord injury and damage,
17 which could lead to a worsening of the patient's neurologic
18 conditions that they did not have prior to that surgery.
19 That's a risk. All of those things he told you can happen,
20 all of those things can happen in spite of good and
21 appropriate care.

22 So those bad, terrible things can happen, and we don't
23 want that to happen to us or our family or friends, not in a
24 hundred years. But when they happen, it doesn't mean that
25 somebody was negligent, and that's what Dr. Lustgarten told

1 you.

2 He said the critical blood pressures in this case, in his
3 opinion, were between 9:20 a.m. and 9:55 a.m.

4 Can you blow that up? Is that the chart? So can you
5 blow this up a little bit? Thank you.

6 So this is Dr. Lustgarten's testimony. This is a
7 critical time. And at 10:03, there's a reported loss of
8 signal. And it's -- is it 10:01, 10:02, 10:03? There may be
9 some variable in that, but 10:03 is what the record seems to
10 indicate the signal loss was announced.

11 These were the MAPs, the mean arterial pressures in the
12 critical time that Dr. Lustgarten said you've got to watch.
13 They were above 80 and they were below 100, not just 70 or 60,
14 but above 80. That's by recorded documentation, part of the
15 medical records by the anesthesiology team, in this case Mr.
16 Starn.

17 Thank you.

18 Dr. Lustgarten said when a neurosurgeon creates the --
19 operates within the standard of care and exercises the
20 appropriate clinical judgment, complications can still occur
21 that can cause a result -- that caused a result of the same
22 condition that Ms. Goodwin is in today.

23 He said it was appropriate for Dr. Holbrook to have
24 paused his surgery when Teresa Adkins said I've lost signal.
25 And that loss of signal unequivocally, according to her record

1 and testimony, like Dr. Holbrook said, just went out. It was
2 just, like, we didn't see this coming. It didn't drift down,
3 you know, saying, oh, we've got -- we've got some neurological
4 problems. This thing's kind of getting bad here. Maybe we've
5 got -- maybe we need to fix something. It was fine, and then
6 just it was gone.

7 He said that it was appropriate for Dr. Holbrook to pause
8 his surgery, inspect his wound site to see if there was
9 anything that he was doing that may have caused or contributed
10 to the loss of signal. What did he do? That's exactly what
11 he did. Acknowledge signal loss. Okay, I hear that. Check
12 your equipment because I'm not seeing -- where did it go out?
13 T9. Well, I'm south of there. I've already gone up there.
14 I'm not -- I'm not there anymore. I'm down here, but please
15 check your equipment.

16 And Teresa wasn't offended by that. That's what her
17 protocol demands that she do. She's got to check her
18 equipment and make sure that it's working and properly
19 functioning. She's got to check the leads. She's got to
20 check the equipment. All the things her little checklist and
21 what she does is going to take some time, and she said it took
22 some time. I can't remember, 10, 15 minutes, whatever it
23 took. And every time she checked, she verified the signal is
24 still out. The machine is working appropriately.

25 So Dr. Holbrook knew that, and what was he doing at that

1 time? He was looking in his operative site to say is there
2 anything I can see with my naked eye in this operative field?
3 I'm the only one who can see. Teresa Adkins can't see in
4 there. Anesthesiology can't see in there. Sunny Jumper can't
5 see in the -- in the wound site.

6 Only the operator, the surgeon is over that wound site.
7 He looks in and says is there anything I'm -- I'm doing or
8 have done? Is there a bleeding problem going on? Is there a
9 hematoma forming that could cause that signal to go out? So
10 he's investigating while she's checking her machine.

11 And Dr. Lustgarten said that's appropriate to do. He
12 said that he should check in with the neuromonitoring tech and
13 check with anesthesia to see if any of the vital signs that
14 anesthesia was monitoring were somehow not in order that may
15 be causing a loss of signal.

16 And Dr. Holbrook did that too. He checked with Erich
17 Starn, who was monitoring a number of things. We've gone over
18 those things. I'll mention them a little bit later. He said
19 are there any anesthesia issues? No, no anesthesia issues.

20 We can't make Dr. Holbrook an anesthesiologist or even a
21 certified registered nurse anesthetist. That's not what he
22 does. His role on the team in the operating room is to
23 perform the surgery. Nobody else can do that. Nobody else
24 can do what the anesthesiology team does either.

25 And so he checks with the neuromonitoring tech. Check

1 your equipment, please. Checks with anesthesia. Any issues
2 with anesthesia? No.

3 What does that mean to a neurosurgeon? Blood pressure is
4 normal, MAPs are normal, end tidal CO2 is normal, oxygen
5 saturation waveforms are normal, urine output is normal. All
6 the things, entitled CO2, all those things that they check
7 around at the head of the table. That's within anesthesia's
8 purview. And he checked with them and said any issues? No.

9 Dr. Lustgarten said the best way to get a patient -- to
10 get the best diagnostic test when something like this happens.
11 Find out what's going on, particularly once you find out
12 there's bilateral leg weakness, which they could not have
13 known right then and there. It's to get her to the recovery
14 room and get an MRI, and that's exactly what he did. He had
15 to make a decision.

16 [Coughs.] Excuse me. I'm going to get rid of this one
17 day, not today.

18 He had to make a clinical decision as the operating
19 surgeon in the operating room with this patient that he'd
20 operated on two times before. This -- this was not unfamiliar
21 territory to him. He had to make a decision.

22 Well, Teresa says that the machines are working okay,
23 that it's not the machinery. I really wonder, but, hey,
24 that's fine. It's nothing I'm doing. There's nothing I can
25 do to reverse this. I checked with my anesthesia person in

1 the room, and my anesthesia team person says there are no
2 issues. Blood pressure is okay, MAPs okay. Everything's
3 okay. What do I do?

4 The plaintiff maintains that the standard of care
5 required him to tell the anesthesiologist to increase his
6 blood pressure and/or decrease the anesthesia and wake her up
7 with this big incision in her back and she's lying there prone
8 so we can check to see if her legs move. It took anesthesia
9 in this case 30 to 45 minutes, according to Dr. Root, to wake
10 that patient up when they started doing it.

11 And if they'd have woken her up in 30 to 45 minutes on
12 the operating table, which the standard of care does not
13 require him to do so, and she couldn't move her legs, what do
14 they do then? Well, we can't take her to the recovery room
15 with a six-inch incision open in her back. We've got to close
16 the wound. That takes time, 30 minutes, 40 minutes, I don't
17 know. It's going to take whatever it's going to take.

18 And then they get to the recovery room, and she's now got
19 to be woken up again. She's got to be totally woken up
20 because you can't close a wound with a patient not under
21 anesthesia. You can't do that. That would be malpractice,
22 egregious malpractice.

23 So he makes a decision. I need to find out if this is
24 for real or something serious. I've got to -- I've got to
25 know. I'm going to go ahead and finish this operation. We're

1 almost done. I'm going to close her up. It's going to take a
2 while to get her awake anyway, and we're going to find out as
3 soon as she gets awake from anesthesia, 30, 45 minutes,
4 however long that took.

5 And then when he finds out her legs don't move, he orders
6 an MRI. He looks at the results of the MRI. MRIs are -- if
7 you've ever had one, they aren't quick. You don't just go in
8 and out like a plain X-ray or chest X-ray. It takes time.
9 Then it's got to be interpreted, and film has got to be
10 produced. Images electronically have to be produced.

11 And once he saw those images on the post-operative MRI --
12 and we've seen those films before today. He said I don't see
13 anything that causes that. Maybe it's that scar tissue up top
14 at T9-T10. I'm going to take her back into surgery. I'm
15 going to try to take more of that down. Maybe that's causing
16 some compression.

17 Nobody criticized him, not even Dr. Lustgarten, for doing
18 that. In fact, he said it's appropriate for Dr. Holbrook once
19 they got her to the recovery room, got her awake, and he could
20 examine her, based on his findings of leg weakness to order an
21 MRI and then take her back to surgery. He said that was
22 appropriate. No criticisms of him doing that.

23 In his opinion -- and he looked at these images, too. In
24 Dr. Lustgarten's opinion, the post-operative MRI did not
25 demonstrate a cause for what he maintains is ischemia, no

1 cause. That's what Dr. Holbrook has been saying from day 1 or
2 2. He couldn't demonstrate a cause. We don't -- I don't see
3 a cause for ischemia. That's what he thought it was. I don't
4 see a reason for it.

5 Dr. Lustgarten said, look, Dr. Holbrook didn't do
6 anything like dropping an instrument on the spinal cord or
7 anything mechanically, what they do during the operation, that
8 would have caused that loss of signal.

9 He -- I asked him about this big word called -- called
10 iatrogenic, iatrogenic, and what that is basically is
11 something that happens during surgery. It doesn't mean
12 negligence. It could be, but it's something that happens
13 during surgery. And Dr. Lustgarten said that nothing that Dr.
14 Holbrook did -- excuse me. One can have an iatrogenic injury
15 that may be quite serious and devastating to the patient even
16 though the surgeon was operating appropriately, reasonably,
17 and within accepted standard of care.

18 And then, you know, there's been a lot of discussion
19 about the blanks on his operative note. He's filled them in.
20 He filled them in in his deposition in 2020. There's no
21 dispute about that.

22 So I asked Dr. Lustgarten about that, and he said I agree
23 that those blanks in his operative note didn't cause or
24 contribute to any injury because it had nothing to do with
25 this case. This is their expert now. Still theirs.

1 Now, I asked him, and he said had Crystal Goodwin, for
2 whatever reason, decided I'm not going to have the surgery,
3 just assume that. If she had made that decision -- and we're
4 not faulting her for having surgery. But Dr. Lustgarten said
5 had she elected not to have the surgery performed by Dr.
6 Holbrook on July 28th, 2016, she would most probably have had
7 a progressive symptomatic myelopathy. And I said, well,
8 what's myelopathy? And he explained that.

9 He said I agree that progressive symptomatic myelopathy
10 means, in her case, spinal cord dysfunction. And he agreed
11 that spinal cord dysfunction -- this is his testimony -- can
12 result in bilateral leg weakness, sensory changes, bowel and
13 bladder problems, and disturbance in mobility.

14 And he agreed that the unfortunate complication -- and it
15 is most unfortunate -- that occurred in this case can happen
16 in the absence of any negligence by the operating surgeon.
17 That was their single standard of care expert.

18 So what else did they do? Well, they brought in Dr.
19 Mancuso. He is a radiologist. Let's remind ourselves, if I
20 could remind you, of some of the things that he said.

21 In his deposition, he showed us a list of his experience
22 as an expert. I think he listed 109 medical malpractice cases
23 where he's given a deposition. He said that the percentage of
24 his income from doing expert witness work since 1997 varies
25 from as much as 35 to 40 percent to maybe less than 25

1 percent. That's a big chunk of his income.

2 I think he was a nice guy. I do. I liked him, enjoyed
3 hearing what he had to say, but what he said was, he agreed
4 that it's reasonable to assume that Crystal had symptoms, and
5 that they were likely symptoms related to what was going on at
6 the left side of her T9 prior to surgery. That's what he
7 said. I assume there were symptoms. I would expect that.

8 He agreed that the displacement of the sac of the spinal
9 cord itself by that osteophyte was a new finding since 2011.
10 Right here. It was a largely new and much more advanced form
11 of the disease than was present in 2011.

12 He reviewed the report of the radiologist of the post-
13 operative MRI that was ordered by Dr. Holbrook. He went over
14 the report in some detail in his deposition. I didn't want to
15 bore you with all that at trial, so I kind of cut to the
16 chase.

17 He said if he were generating that report based on those
18 images, he would suggest that there is acute edema that is
19 explaining the weakness that Crystal Goodwin has experienced
20 post-operatively in the lower legs. His impression would have
21 said something about there is edema rather than cord increased
22 signal. He would have just interpreted that as, quote --
23 these are his words -- cord edema in that segment of the cord
24 that explains the lower leg bilateral weakness that she was
25 experiencing in the recovery room. He would also say the cord

1 is swollen and explains the leg weakness, and it's not due to
2 compression, so it must be due to something else.

3 Now, Dr. Mancuso is not an anesthesiologist. He is a
4 radiologist. I asked him if he'd heard about a reperfusion
5 injury. He had, and he agreed that a reperfusion injury can
6 be shown on an MRI that was done post-operatively. He agreed
7 that a reperfusion injury would look like edema of the cord on
8 an MRI. He agreed that an edema pattern in the cord shown on
9 an MRI without contrast -- that's what was done -- could be
10 seen as a result of reperfusion injury. He said that means
11 that you had to have ischemia, a lower blood flow, to begin
12 with.

13 Let's go back to that image. This osteophyte pressing
14 against and pushing the spinal cord to the other side is going
15 to cause ischemia in that spinal cord for a very long time.
16 We don't know how long that thing has been there, but it
17 started and it grew and it grew, and it got to the point where
18 it's pushing the whole spinal cord, not just the canal. This
19 is the canal. This is the cord. It's pushing the cord off to
20 the side. It is going to compress vessels inside the spine,
21 and that's going to cause chronic, long-standing ischemia,
22 lowered blood flow. He said that ischemia can be either
23 acute, something happened fairly recently, or chronic,
24 something happened more over a longer period of time.

25 And then I asked him, Dr. Mancuso, looking at those MRI

1 images after she was found to not be able to move her legs,
2 you cannot rule out a reperfusion injury. Now, when he gave
3 an explanation of why he didn't think it was -- and that's --
4 he's entitled to his opinion.

5 Teresa Adkins, next witness I want to talk about. For
6 her, step one when the signal goes out is notify the surgeon.
7 Let him know that they lost signal and that you're going to
8 check your equipment. That's what she did. And then she
9 checks with anesthesia, checks positioning and all. Those are
10 the first things that she said she does when you lose a
11 signal, like in this case. So not only is Dr. Holbrook asking
12 Erich Starn, are there any anesthesia issues, no, Teresa is
13 asking Erich, do we have any anesthesia issues? No.

14 He told -- she told Dr. Holbrook, I've got to go check
15 positioning and check my electrodes. I've got to do my
16 checklist. He said that's fine. You do that. I'm checking
17 in the operating field. She did document in Exhibit 15 her
18 record. This is not controversial, I don't think, or
19 contested.

20 She documented that Dr. Holbrook told her I was not
21 around the spinal cord when those lower signals were recorded
22 to be lost. Totally consistent with what Dr. Holbrook has
23 testified to you and throughout this case, because we're
24 focused, I think, it seems to be, on what did he do and when
25 did he do it? What did he know and when did he know it? And

1 was it reasonable and was it appropriate or not at that moment
2 in time in this operation?

3 She said I agree that it's the CRNA's job, Erich Starn,
4 to communicate with the M.D. anesthesia, Dr. Root. That's
5 what she said. This was their witness, not mine.

6 I asked her, did you form an opinion or impression of
7 your communication, your looking at Dr. Holbrook, listening to
8 what he was saying and what he was doing? Was he concerned?
9 Yes, he was concerned.

10 And she reported and she testified that there was no
11 warning about those signals drifting. In fact, when she
12 recorded that blood pressure of 103 over 62 or whatever it
13 was, MAP of 77, which was right before -- moments before the
14 signal went out, it's not a part of the anesthesia record, but
15 that's fine. If she says she saw that on Erich's monitor, she
16 saw it on Erich's monitor. That's not the point. The point
17 is, she documents in her record at that time when it was 77,
18 signals are stable.

19 And minutes -- excuse me. Seconds later, Dr. Gregg,
20 who's seeing everything she's seeing on the monitors on the
21 neuromonitoring, he records in the chat agree, stable. And
22 then the next thing, it's like -- and you see it in the
23 exhibit. The signals just went out. Just lost signal. Don't
24 know why.

25 I asked her if Dr. Gregg made any recommendations to Dr.

1 Holbrook or anyone else because he had the ability, the
2 authority, and the capability of doing so. He did not. I'm
3 not critical of Dr. Gregg, but you've got to ask yourself, why
4 didn't he intervene? Why didn't he say something? Well, let
5 me talk to the neurosurgeon. You know, let me talk to
6 anesthesia.

7 Dr. Jones. I don't have his video, but I've got his
8 testimony. I just want to highlight a couple of things to
9 refresh your memory of some other things that Dr. Jones said
10 in his sworn testimony.

11 Question: If they're allowed to fall too low for too long
12 for a period of time, talking about blood pressures, what sort
13 of things can -- could happen to the patient?

14 Well, a number of things, but -- excuse me. A number of
15 organ systems can be affected by the pressure falling too
16 level, a number of organ systems, not just one. You can have
17 cerebral infarction, stroke in the brain. In other words, a
18 stroke. You can have a heart attack, you can have renal
19 failure, and you can have poor perfusion. Really all of the
20 organs, but the ones that stand out the most are usually going
21 to be the central nervous system and spinal cord. The kidneys
22 certainly are one, and heart is a very obvious one too, but
23 all of the organs can suffer. You can even have muscle damage
24 to low blood pressure for too long.

25 There isn't evidence of any damage of any other organ

1 system in this case. And there was -- if it was, as he
2 maintains and he opines -- he has a right to his opinion -- it
3 was too low for too long, we'd see all kinds of things wrong
4 with Crystal Goodwin. I mean, right after the surgery and
5 probably today, and thank God we don't.

6 I asked -- he was asked, when is pre-anesthesia
7 evaluation performed?

8 Most of the time it's immediately before surgery. That's
9 when Dr. Root did her pre-anesthesia evaluation. He said that
10 most of the pre-anesthetic evaluations are right before
11 surgery. That's what Dr. Root did.

12 He was asked, you've never seen any studies or reports
13 where someone undergoing spine surgery had a permanent nerve
14 injury where the MAP stayed above 80; is that right?

15 I've never seen any studies of that, no. He also said if
16 the equipment's working, we know it's not the equipment, the
17 surgeon says, hey, I haven't touched it, fine. It's not you.
18 Surgeon, it's not you. It must be at the head of the table,
19 as we say, which is anesthesia. But this is their expert.
20 I'm not making this up. Lighten the anesthetic, give a fluid,
21 give pressors. See if you get a signal back, anesthesia, head
22 of the table.

23 During the procedure that Crystal had on July 28th, 2016,
24 he was asked is the anesthesia care team responsible to
25 appropriately monitor the patient's blood pressure?

1 Certainly, yes. Not just blood pressure, but all the
2 vital signs.

3 And it's the anesthesiologist's and the CRNA's job to
4 monitor urine output; is that right?

5 Correct. Correct.

6 Well, that's the plaintiffs' case. You know, we're not
7 going to dive into Dr. Alford and Dr. Shaufele and the life
8 care planner, the physical therapist. She's a hero. So is
9 this lady and her husband.

10 We're not here to contest or dispute the injuries that
11 Crystal has and that she has suffered and will suffer, and all
12 the awfulness that she and her family and her husband have
13 been through. That is not what we're here to dispute. So I
14 didn't -- we didn't ask a lot of questions of those people.
15 We don't have an issue with that.

16 We want to focus on what they're focusing on. What did
17 Dr. Holbrook do in surgery when the signal went out, and was
18 it reasonable under the circumstances? Not perfect. The
19 standard of care in medical malpractice is not perfection.
20 Look, if you're under the knife or your family member is under
21 the knife on that operating table, we want perfection. I
22 mean, let's be honest. We want everything to go really well.
23 We don't want complications, and we want that doctor to be
24 perfect.

25 The law does not require a physician to be even at his

1 best all the time, and it certainly does not require -- it's
2 not the standard of care that he be perfect in everything he
3 does and every judgment he makes. What they do require is
4 that he be reasonable under the circumstances, and that's the
5 issue in this case. Is what Dr. Holbrook did in those minutes
6 in the surgery -- was it reasonable under the circumstances?
7 Not perfect. Was it reasonable?

8 So let's talk about Dr. Holbrook just a little bit. Dr.
9 Holbrook has been deposed under oath for eight hours in this
10 case prior to trial, eight hours, and they played some video
11 clips. I don't know, half an hour, 45 minutes of eight hours
12 for the deposition testimony that they thought were important.
13 That's fine. They can do that. Eight hours of testimony.
14 They don't want you to talk about or think about anything
15 except the 30 or 40 minutes a day cherry picked.

16 So we put him on the witness stand and kind of went
17 through everything with him. How many decompressive
18 laminectomies do you think you've performed in your career?
19 About 5,000. Dr. Lustgarten doesn't have any complaint about
20 Dr. Holbrook's qualifications, training, or experience as a
21 neurosurgeon. That's not really an issue.

22 I asked Dr. Holbrook, what is a timeout, and he explained
23 it. I mentioned to you earlier is that -- was there one at
24 the beginning of this surgery before you started operating?

25 Yes.

1 Were you there?

2 Absolutely.

3 Are you always present for that?

4 Every time.

5 I don't know Sunny Jumper. You take her testimony, her
6 demeanor, and her friendship -- Facebook friendship with Mr.
7 Hinson, play all that out however you want to, but she ain't a
8 neurosurgeon. Maybe she's got some issues with Dr. Holbrook.
9 I don't know. But for her to say he never comes to a timeout
10 when he was standing right there in the room with her, I don't
11 understand that kind of testimony. You make of it whatever
12 you wish.

13 Dr. Holbrook, how would you characterize that sudden loss
14 of signal?

15 It's like a light switch. It was like on, and then it
16 was off, just like bang. And that's exactly what Teresa
17 Adkins documented and testified to.

18 He stopped his operation at that point. He immediately
19 stopped. Check your equipment. Teresa is already doing that.
20 He didn't have to ask her to do that, but that's fine. Check
21 with anesthesia. Any issues? No issues. He's looking around
22 the operative site while Teresa is doing what she's doing.

23 Dr. Holbrook, where do you understand the signal had been
24 lost? At what level?

25 Teresa told me at T9. Well, we'll come back to that.

1 Did you check with anesthesia?

2 Yes.

3 Any concerns?

4 No.

5 After it was confirmed to you the equipment was not

6 malfunctioning, what did you do?

7 I decided I needed to finish the surgery. It's almost

8 done. Close her up. Get her to recovery. Get her awake and

9 check out and see if she has any problems. And if she does,

10 we'll go from there. That's exactly what he did.

11 Did you see anything in the surgical site that could

12 maybe answer the question why signal went out?

13 Nothing.

14 Why did you continue the surgery, Dr. Holbrook?

15 Because we were all stunned, and I wanted to get her

16 closed up and get her to recovery so if there's some problem,

17 I could get her to an MRI scan. I can't do that in the

18 operating room.

19 I asked him, in his opinion as a neurosurgeon, did the

20 standard of care require him to wake up Crystal Goodwin and

21 check it out right in the operating room?

22 He said no.

23 Could he have?

24 Yes, but he elected not to.

25 Why?

1 Because I wanted to close her up. I've got to get the
2 surgical wound closed, get her to the recovery room where the
3 anesthesia people can wake her up and get her to recovery.
4 We'll find out what's going on there. If something's going on
5 there, I'm going to get an MRI.

6 That's exactly what they did. Was that reasonable? We
7 submit that it was. If it was reasonable, it was not a
8 violation of the standard of care.

9 Who is responsible to monitor the vital signs during
10 surgery? Dr. Jones and Dr. Holbrook agreed it was anesthesia.

11 Do you rely on the anesthesia team to monitor the vital
12 signs minute to minute?

13 Yes.

14 What was included in the vital signs?

15 Blood pressure.

16 If there are abnormalities in -- in the vital signs,
17 would you expect the anesthesiology team, whoever it is,
18 whether it's Dr. Root or whether it's Erich Starn, would you
19 expect them to let you know?

20 Absolutely. They always do.

21 Did they do it in this case?

22 No.

23 Did anybody in the anesthesia team during the entire
24 surgery, whether it was Dr. Root or Erich Starn, because she
25 was in and out several times, ever advise you that there was

1 some problem or issue with her blood pressure being too low at
2 any point?

3 No, sir.

4 I asked him, in his opinion, did Crystal Goodwin have any
5 hypotension, low blood pressure, for too long and too low
6 during her surgery, and he said based on the anesthesia record
7 that I looked at, in my opinion, no.

8 In all of his decompressive laminectomy surgeries, have
9 you ever seen or known of blood pressure in the ranges that
10 existed in Crystal's case, that you looked at and you've all
11 seen, cause or result in a stroke in the spinal cord?

12 No.

13 Who manages the urine output, Dr. Holbrook?

14 That would be anesthesia. He's kind of busy operating on
15 her spine.

16 Do you have an opinion about the relative blood supply in
17 the T9 area where all the damage was?

18 I think his testimony was something like it's a -- it's a
19 good blood supply. It's robust.

20 Dr. Holbrook, this is your patient. This is the third
21 time you've operated on her. Did her spinal stenosis put her
22 at greater risk for a spinal cord injury?

23 It did. That's consistent with Dr. Lustgarten's
24 testimony as well.

25 And he talked about a diagnosis of exclusion. That's

1 what a reperfusion injury is. Well, if it's nothing I did
2 mechanically, everybody agrees that that box is checked. No,
3 we didn't do anything. Nothing mechanically in the operation.
4 That didn't cause this. And if it wasn't low blood pressure
5 for too long, too low for too long, is there anything left?
6 Well, reperfusion injury.

7 Well, what's that based on? A review of Dr. Goltra and
8 the research that he did. He was deposed in November of 2022,
9 I believe.

10 Well, can you see a reperfusion injury happen?

11 No.

12 Can you predict it?

13 No.

14 Can you foresee it's going to happen?

15 No.

16 What about Dr. John Sampson? We put him up Friday. And
17 I -- and I appreciate counsel allowing us to do that because
18 they could not be here, either Dr. Sampson or Dr. Poletti this
19 week. They had other things planned. That's all we can do.
20 So I appreciate very much plaintiffs letting me put them up on
21 Friday.

22 So we put Dr. Sampson up first. Dr. Sampson is the chief
23 of neurosurgery at Duke University. Enough said. He has
24 performed thousands of decompressive laminectomy surgeries
25 himself. He characterizes the suddenness of the loss of

1 signal as almost instant, consistent with Teresa Adkins.

2 Do you have an opinion whether or not at the time Dr.
3 Holbrook was made aware of the loss of signal, the standard of
4 care required him to notify the M.D. anesthesia doctor?

5 It did not. That would be anesthesia. If Erich Starn
6 had an anesthesia issue or when a signal goes out even if
7 there were no anesthesia issues, it would be his
8 responsibility to bring Dr. Root in. We're going to get to
9 that in a minute.

10 I asked him about 80cc of urine that were documented in
11 this case. Is that an accurate and reliable measure of total
12 urine output during that surgery?

13 No. Evaporation, spacing, fluid goes everywhere, faces
14 get puffy. No, it's not an accurate -- accurate measurement.

15 Was it adequate? In your opinion was this adequate for
16 this surgery, this patient?

17 Yes.

18 I asked him what his opinion was as to the cause of this
19 awful complication. He said, in my opinion, it was a
20 reperfusion injury. It is not predictable. It is not
21 foreseeable. And when it happens, there's nothing you can do
22 to reverse it. And you can't see it happen. You can only see
23 it later.

24 It's like that dry sponge I think he was trying to
25 explain to you. And when you -- you get a glass of water or a

1 pitcher of water and you've got that dry sponge and you start
2 pouring that water on it, we all know what it does. It just
3 gets bigger. He said that's sort of what a reperfusion injury
4 is.

5 Let's pull that up. [Coughs.] Excuse me. Thank you so
6 much.

7 The mechanism of a reperfusion injury to the spinal cord,
8 you've got ischemia caused by this osteophyte. That's not
9 Crystal's fault. It just happened. And then when you take
10 that thing off, that dry sponge all of a sudden gets very
11 flooded with blood and it swells.

12 Go to the next one, please.

13 And as a result, it goes from something like this to
14 something like this. That's the cord swelling you see on the
15 MRI. Mancuso says it's there. Goltra says it's there.
16 Nobody contests that. Why did it swell?

17 Dr. Sampson's opinion and Dr. Poletti's opinion is it was
18 a reperfusion injury where the blood just rushes in to that
19 previously ischemic area, and that sponge fills up with blood,
20 if you will, water, and that causes damage, permanent damage
21 in a matter of minutes to this spinal cord and the nerves, and
22 you can't reverse it.

23 Is that predictable? Is it foreseeable?

24 No.

25 Is it treatable if it happens?

1 No.

2 Was a reperfusion injury, Dr. Sampson, in this case
3 related to any change in her blood pressure during the
4 surgery?

5 No. Those blood pressures were adequate. No evidence of
6 mechanical injury, but there was some evidence that even after
7 this awful complication that helped him understand and believe
8 and affirm that it was a reperfusion injury. Because if it's
9 a paralysis, that cord is like somebody would cut it. It is
10 not going to work again.

11 But if it's a reperfusion injury that stuns the nerves,
12 in time there can be some improvement, and Dr. Shaufele, their
13 expert, talked about that improvement. It's not great by any
14 means. It doesn't mean she's not injured. Not at all. But
15 Dr. Shaufele said, well, she -- she got a little bit of motion
16 back. Not a lot. She got a little bit of sensation back.

17 But Dr. Sampson, as a neurosurgeon, he said that's what
18 happens when there's a reperfusion injury. Dr. Poletti said
19 the same thing. If it's a total loss from a paralysis, you
20 don't recover anything. But that -- that helps them both
21 believe that it was a reperfusion injury.

22 In his opinion and that of Dr. Poletti, the reperfusion
23 injury -- excuse me. The blood pressures or MAPs throughout
24 the surgery were normal and were not the cause of the
25 neurologic injury.

1 We asked him, because Dr. Jones had said, oh, the MAPs
2 have to be between 100 and 105 minimum. You've got to keep it
3 at that level. That's his opinion. So we asked Dr. Sampson
4 about that and Dr. Poletti and Dr. Root and Dr. Starn and Dr.
5 Balestrieri. Do you agree with that? No. Why not? If you
6 keep it between 70 and 100, you're okay. Balestrieri, to his
7 credit, said I would have kept her about in the 80s, and
8 that's where she was almost throughout this entire surgery.

9 Do you have an opinion, Dr. Sampson, whether any of Mrs.
10 Goodwin's blood pressures during this surgery were severe?

11 No.

12 Were they adequate?

13 Yes.

14 Was Dr. Holbrook required by the standard of care to do a
15 wake-up test in that situation?

16 No, it did not. Could he have? I guess if he elected to
17 do it and there was a complication to that, we'd probably be
18 here for a different reason, but he elected not to, and
19 standard of care didn't require him to do that.

20 He said what he did when the signal went out was he
21 stopped the surgery, checked with neuromonitoring, checked
22 with anesthesia, examined the wound site. And when it was
23 confirmed the machine was working, he continued his operation
24 because he needed to get her to the recovery room. That's
25 what he did and that takes time. It's not just, oh, I'm

1 finished, just roll her out there, and we'll see if she can
2 move her legs. It took Erich Starn and Dr. Root about 45
3 minutes to wake her up from that surgery. It's not a quick,
4 quick thing.

5 Well, Dr. Sampson, have you had patients suffer
6 reperfusion injuries yourself?

7 I have.

8 Well, were they predictable?

9 They were not.

10 Dr. Poletti -- and I just want to start with Dr. Poletti.
11 I don't know if anybody's done more back surgeries than Dr.
12 Poletti in South Carolina. Maybe there are some. He didn't
13 think so. Maybe he's right, maybe he's not.

14 They want to talk about don't believe Dr. Poletti. When
15 Robert Goings hires Dr. Poletti, believe him, but when we hire
16 Dr. Poletti --

17 MR. GOINGS: Your Honor, I object. That is not his
18 testimony. That's not into evidence. I've never hired him
19 before. That's not what that doctor said.

20 THE COURT: The objection is overruled. The jury can
21 rely on their collective recollections.

22 MR. GOINGS: Thank you.

23 MR. DAVIS: Thank you, Your Honor.

24 Have you testified as an expert in plaintiffs' cases?

25 Yes.

1 Including for Mr. Goings?

2 Yes. That's what he said.

3 And let me just say this, and I probably should have said
4 it earlier. I'm just one person. I took a lot of notes. I
5 paid attention the best I could, just like you did. It's hard
6 for two weeks. If I say something reflecting on testimony and
7 you remember it differently, go with what you remember, not
8 what I'm saying. That's your job, but that's what I wrote
9 down and I recall him saying.

10 He talked about congenital spinal stenosis, which, very
11 unfortunately, Ms. Goodwin had, and that's not in controversy.
12 It will require multiple surgeries over the years, and it has
13 for her over the years. We hate it. Hate it for her, hate it
14 for her family. She even had one in 2021 after the 2016
15 surgery. It's a progressive problem.

16 That's what a reperfusion injury was. He explained it.
17 I asked him if it was predictable or foreseeable. No, it was
18 not foreseeable.

19 Does it have -- does a reperfusion injury have the
20 potential to cause permanent neurologic damage?

21 It absolutely does.

22 Can it be seen by the surgeon when it happens?

23 No.

24 Is there anything you can do to prevent it?

25 No.

1 Anything you can do to reverse it when it happens?

2 No.

3 If a patient has a reperfusion injury during a surgery
4 like Dr. Holbrook was doing, such that there is swelling of
5 the spinal cord, can that begin suddenly or immediately?

6 Yes, it can.

7 When the signal is lost, he said that the surgeons go
8 through a checklist, which includes making sure there's no
9 external compression against the spinal cord. He did that.
10 Make sure there's no hematoma underneath the spinal cord. He
11 did that. Check with the neuromonitoring equipment. He did
12 that. Check to see if any changes in anesthesia. He did
13 that. We'll get all those things done, close up the surgery
14 wound, and assess the patient's neurological status in the
15 recovery room. And he did that.

16 And in your opinion, Dr. Poletti, having performed
17 multiple thousands of these operations, in this particular
18 surgery that you're reviewing that Dr. Holbrook performed that
19 day, did the standard of care require him to wake Crystal
20 Goodwin up?

21 No, not before getting her to the recovery room.

22 We're going to look at low blood pressure as a theory of
23 injury. Dr. Poletti, do you have an opinion whether or not
24 low blood pressure caused the injury to Crystal?

25 It did not.

1 Do you determine a patient's baseline blood pressure?

2 No. That's anesthesia's job.

3 Have you in your entire career ever seen any hypotensive
4 intraoperative issue cause permanent neurological deficit?

5 I think he's up in the 15,000 range of surgeries, and his
6 answer was no. Dr. Sampson has never seen it. Dr. Lustgarten
7 has never seen it. Dr. Poletti has never seen it. That's a
8 lot of years of experience in multiple thousands of
9 operations. Nobody's ever seen this happen.

10 And Dr. Poletti -- I think one of his comments was why
11 this case? Why this case? These blood pressures are normal.
12 Why this case? He leaves it up to the anesthesia team in
13 their judgment to keep somebody normal intensive during the
14 surgery.

15 Did the standard of care, Dr. Poletti, require Dr.
16 Holbrook to request that Dr. Root come to the operating room?

17 It did not. If he had wanted to, he could have. Erich
18 Starn could have if there was an anesthesia issue, but there
19 wasn't.

20 In your opinion, Dr. Poletti, did Dr. Holbrook do or fail
21 to do anything to cause this terrible injury to Crystal
22 Goodwin?

23 No, sir.

24 And Erich Starn. You know, Erich Starn was not a paid
25 expert. He was subpoenaed, just like Dr. Root was, to come

1 here and testify. What did Erich tell you? His role, he
2 assessed the patients and records with the M.D. anesthesia.
3 We come up with a plan of anesthesia. We individualize the
4 plan for each patient, not Dr. Holbrook. This is Dr. Root and
5 Erich Starn. We tailor anesthesia for each patient. It is
6 anesthesia's role to determine the baseline blood pressure. I
7 was monitoring Crystal's blood pressure during surgery. She
8 had MAPs in the 80s, which is what Dr. Balestrieri said I
9 would have kept her in that range.

10 According to the chart, all her blood pressures were
11 consistent with perfusion. We tried to explain this through
12 as many experts as we possibly could. Blood pressure does not
13 equate to and mean the same thing as blood flow. It's just
14 not the same.

15 Sounds simple. Turn the spigot, turn the pressure. The
16 human body, thank God, is not like a garden hose. We are
17 fearfully and wonderfully made. And the complexities --
18 that's why it takes an M.D. anesthesiologist and a
19 neurosurgeon and trained and skilled people in an operating
20 room, all working together to try to take care of the patient
21 in various areas of their responsibility. It's not like --
22 like sprinkling the yard. It's just not like that.

23 He said that I recall when the SSEPs went out, and I
24 heard Dr. Holbrook say I wasn't anywhere near the spine at the
25 time. What did you do, Erich? Well, the blood pressures were

1 still good. They were fine at that time. My job is to
2 increase or decrease blood pressure in case -- in the case,
3 even without the M.D. anesthesia telling me to. I don't need
4 her to come and say, hey, Erich, you need to bump up the
5 pressure. You need to lower it. I can do that myself. I'm
6 trained and experienced to do that. That's my job.

7 He manages all the vital signs, blood pressure, end tidal
8 CO2, oxygen saturation, level of anesthesia, fluid in and out,
9 any fluid loss, blood loss, urine output. He said we want to
10 keep our patients above 70, and they did. All of her blood
11 pressures were above 70. Most were above 80, and they were.

12 We talked about oxygen saturation, heart rate, end tidal
13 CO2. All were normal. All of them. And he said that's a
14 good indication of perfusion, blood flow to the organs,
15 including the spinal cord. He said the heart rate will go up
16 if you're not perfusing.

17 Well, what was the heart rate in this case? Stone cold
18 normal I think is the way Dr. Root characterized it. Her
19 heart rate tells me she was well perfused. All of them were
20 in the 90s and 80s heart rate. It's my job -- it's my job to
21 notify M.D. anesthesia. My job.

22 Any MAP over 70, he said is good. All her MAPs were over
23 70. It was good.

24 I won't talk a lot about Dr. Balestrieri because most of
25 what I wanted to highlight was already highlighted by

1 plaintiffs' counsel. There were a couple of things that you
2 might not be surprised that I want to point to, but I know
3 it's getting long and I'm getting hungry and tired, just like
4 you. So bear with me. I'll try to wrap this up. You've been
5 so patient and kind. Thank you.

6 I asked him to estimate the breakdown between plaintiff
7 work and defendants' work, 40 percent for plaintiffs, he's an
8 expert for the plaintiff. About 60 percent he's an expert for
9 the defendant, like in this case.

10 How many times have you reviewed a case for a plaintiff
11 and found that the standard of care was not met and be willing
12 to testify against the doctor?

13 20 to 25 times. He's trying to call balls and strikes
14 here. That's what we all want with an expert.

15 What sort of MAP range to Mrs. Goodwin's case would you
16 believe would be within the standard of care?

17 Then he calculated all the MAPs and he had sheets of 530
18 pages of records he went through from her hospital stay. He
19 got all those blood pressures and did a lot of math. Tough
20 luck, man. I couldn't have done it. I just couldn't have
21 done it.

22 But he did it, and he said, you know, looking at
23 everything, I'd keep her in the 80s.

24 Pull that up again, please.

25 Here's 80. Here's 90. I'd have kept her in the 80s.

1 He said the best evidence that he's found in the area of
2 anesthesia, where he is an expert, says you should keep a
3 mean arterial pressure above 60 or 65 at a minimum to maintain
4 perfusion. Well, they say, well, let's -- let's move it up to
5 70. Well, let's -- let's move her up to 80s. It's good, good
6 perfusion. Not a lack of perfusion. Not too low too long.

7 This is how you, you know, color your lines with red and
8 call it a danger zone. Y'all have to figure that out, not me.
9 A lot of different experts said a lot of different opinions.

10 In your opinion, do you believe the goal of maintaining
11 her mean arterial pressure above 80 would have been within the
12 standard of care?

13 Yes.

14 Please understand we're not here criticizing Erich Starn
15 or Dr. Root. We think they did the right thing. We think
16 they kept her blood pressure they were supposed to, but it was
17 their responsibility. That's the difference. We're not
18 blaming them.

19 Does the standard of care, Dr. Balestrieri, as an
20 anesthesiologist who testifies for plaintiffs and defendants
21 in these kind of cases, does the standard of care require a
22 preoperative meeting, not a timeout, a preoperative meeting
23 with the CRNA, M.D. anesthesia, and surgeon?

24 No, sir. It does not.

25 Okay. What about that urine output? In Ms. Goodman's

1 case, you would like to see 20 to 30 milliliters per hour of
2 urine output?

3 Yes, sir.

4 Well, she had 80cc in four hours.

5 In your opinion, was that adequate?

6 Yes, it was in this case.

7 And that's what they do. I mean, they monitor all that
8 stuff, including the urine. The surgeon is not monitoring
9 that.

10 We talked about the various monitors. We won't go over
11 that again. The end tidal CO2.

12 Can you pull that up? There you go. Thank you, sir.

13 And Dr. Root talked about this a bit, as did Dr.
14 Balestrieri. This is Dr. Lustgarten's critical time right
15 here. These are all normal. You can't get better than 100
16 percent oxygen saturation. You just can't. These are all
17 normal. What Dr. Root explained and what Dr. Balestrieri
18 explained and what Dr. -- excuse me. Not doctor, Mr. Starn
19 explained, these anesthesiology folks, when you have those
20 kind of numbers running, in addition to the MAPs and the -- in
21 this case, but when you've got this, even if you don't have a
22 blood pressure cuff, if it's broken, when you've got these
23 numbers on these categories, you can be assured as an
24 anesthesia care team she's getting good blood flow to her
25 organs, including the spinal cord. And he told you, in his

1 opinion, these are all normal, as did Dr. Root, as did Erich
2 Starn.

3 What was her pulse rate throughout the surgery?

4 Normal.

5 Dr. Goltra -- I'm almost done. Great. I'm not going to
6 be the lawyer who says I just have one more thing to say.
7 That's what the lawyer says. This is an important case for my
8 client. So I appreciate your attention.

9 Dr. Goltra. He's a board-certified neuroradiologist,
10 same credentials as Dr. Mancuso has.

11 Do you have an opinion what the cause of her injury was?

12 Well, looking at the -- at the images -- I'll pull up the
13 pre-op. When I see this, I'm seeing a cause for chronic
14 ischemia that has to pre-exist a reperfusion injury, making
15 the sponge dry. That's what I'm seeing here.

16 That's the spinal cord. This is before the operation, a
17 month before, where you've got all kind of things pushing in
18 and pressing against the spinal cord that's supposed to look
19 like this, and here it doesn't. That's ground zero. That's
20 where Dr. Holbrook operated to get this stuff out -- thank you
21 -- to try to get this stuff out during the surgery to stop the
22 compression on her spinal cord that was causing and would
23 continue to cause in the future real problems. There's my
24 cause for chronic ischemia, he said, as well as down here.
25 It's not just here. It's down here, too.

1 Okay. Take that down. Thank you. Well, let's do the
2 post-operative MRI.

3 What do you think it was, Doc?

4 Well, I think it was a reperfusion injury.

5 What's that based on?

6 This is where he operated. This is where the damaged
7 cord is. It's exactly the same thing as Dr. Mancuso said.
8 Yeah, this is the damage here. That's where the injury is,
9 but ground zero is at this T9 area, that in November on the
10 MRI is this bright white spot. Everything is sort of settled
11 down. That was -- that was the one that said, well, that's --
12 that's where everything happened. And it makes sense.

13 Let's go to the reperfusion. Okay.

14 So he said when -- when you take this out surgically,
15 that sponge -- now that these blood vessels are free to get
16 fluid and blood into them and that sponge fills up over here.

17 Go to the next one, please.

18 And when that happens, it damages permanently and very,
19 very quickly the spinal cord, which it comes in, all the
20 awfulness that this lovely couple had suffered and will
21 continue to suffer.

22 Thank you.

23 And he showed you on the images -- I don't need to show
24 them to you again. You saw them. He was here. It wasn't
25 that long ago, although it does seem like a long time ago.

1 Everything does right now.

2 Did you form an opinion whether or not the MRI, the
3 images of Crystal Goodwin prior to her surgery, revealed
4 evidence of chronic ischemia?

5 Yes.

6 What significance is that?

7 Well, you have chronic ischemia before you have a
8 reperfusion injury, and even Dr. Mancuso agreed with that.
9 You've got to have ischemia before you can have reperfusion,
10 exactly what the images show.

11 They talked about white cord syndrome. I'm not going to
12 go back over that. It's kind of confusing to me, quite
13 frankly. But I asked him if he had an opinion whether or not
14 the findings of the post-operative MRI --

15 Let's pull that up, please. Yeah, that -- that'll work.
16 And let's go -- yeah, that's fine.

17 Do you have an opinion whether the findings four hours
18 after the surgery -- actually four hours after the injury like
19 this, it shows swelling of the spinal cord is consistent with
20 and indicative of reperfusion injury?

21 Yes.

22 Nobody in this case, no radiologist, not Dr. Mancuso --
23 Will you take it down, please?

24 Nor Dr. Goltra have disputed that there is spinal cord
25 edema. Dr. Goltra's point, I believe, was -- and you may

1 remember it differently. That's fine. When you see spinal
2 cord edema 4 or 5 hours after the injury, 6 hours after the
3 injury, any time shorter than 12, 14, 24 hours after the
4 injury, when you see spinal cord swelling like that, it's not
5 from ischemia. It's not from a cord stroke. It's from
6 reperfusion. That's the only time you see it.

7 The post-operative images -- and we went over all those
8 -- are those images that you see -- and you've gone over with
9 this jury, are they consistent with or indicative of ischemia
10 or a stroke of the spinal cord?

11 No, but they are consistent with reperfusion injury.

12 And I asked him, well, Doctor, what -- Dr. Goltra, can
13 you 100 percent rule out an ischemic injury from low blood
14 pressure?

15 He said I can't 100 percent rule it out, but if we're
16 going to go with odds, I think he started with 1 in 1,000,000,
17 and I think he backed it down to something less than that.

18 The odds are incredibly against this being from low blood
19 pressure, given the MAPs in this surgery. If you've got 40s
20 and 50s MAPs running for a long time, we'd have a different
21 discussion about the causation of this injury, but that wasn't
22 the case here.

23 He said -- he said the telltale sign -- there's a
24 document here we talked a lot about.

25 Well, Doctor, did you see any owl's eyes?

1 You know, Mr. Davis, I heard that Dr. Mancuso talked
2 about that. So I went back through all my images, axial
3 images, and I looked and I didn't find any owl's eyes.

4 It's a curious thing to me. You know, the plaintiffs can
5 do whatever they want pretty much. I try to do whatever I can
6 do, pretty much within the bounds of Rules of Evidence, but it
7 was curious to me. I sort of expected that they were going to
8 say, well, hey, flip up on their screen for cross-examination,
9 well, Dr. Goltra, here's owl's eyes right here. Here. You
10 see it? Mancuso sees it. It's right here. What do you say
11 about that?

12 You know what? We'll never know because they chose not
13 to do that. You've got to ask yourself, why didn't they do
14 that? Were they afraid of what he was going to say? Maybe.

15 And Dr. Jennifer Root. Like the caboose on a big train,
16 she was subpoenaed to be here. She'd been up here 2 or 3 days
17 waiting to testify. She was under subpoena. They subpoenaed
18 her. We subpoenaed her. I mean, they wanted her to testify.
19 She couldn't come when it was their case. That's fine. I
20 said, well, listen, I'll call her. You can cross-examine her.
21 It's okay. She's under subpoena. I want to hear what she has
22 to say.

23 Where do you try to keep a patient's blood pressure
24 during anesthesia in an operation like this, Dr. Root? You're
25 the M.D. anesthesiologist in this case.

1 Between 70 and 100.

2 Is blood pressure of a patient the same as blood flow?

3 No.

4 And I won't go back over all that again. We showed her
5 the end tidal CO2s and oxygen saturation and pulse rates, all
6 that. Were those consistent with good perfusion to the spinal
7 cord and all the other organs? It's not like one artery goes
8 just to the spinal cord and then blood doesn't go everywhere
9 else in the body. I mean, it goes everywhere to all our
10 organs, the brain, the heart, the liver, the kidneys, the
11 bowels, all the organs. Blood is continuously running through
12 the system.

13 And she explained that that's all the evidence that we
14 look at, all those monitors. It tells me that that's good
15 perfusion.

16 Corey, let's put that one up.

17 COREY: Okay.

18 MR. DAVIS: You got your little pen ready? Okay.

19 Dr. Root was in there several times, and I just want to
20 kind of wrap up with this. I'm close to the end anyway.

21 I think the first time was 7:20. We'll look at that
22 here, 7:20 to 7:30 a.m. She was there at the very beginning.
23 All right? And everything was fine. Blood pressure. All the
24 monitors are working. Everything is good.

25 She said she came back around 8:30 and was there for

1 maybe 5, 10 minutes, whatever she did. And here's the thing.
2 And she said, you know, everything is looking fine here, too,
3 but she had the ability to look at the record that's already
4 been generated and could look back and say everything from
5 here to here looked good. I'm not just looking at this point
6 in time. I'm looking all the way back here. Everything's
7 fine. Good perfusion. No problems.

8 The next time she said she came in was around 9:15 when
9 the tube kinked, and she and Erich had to do some things to
10 make sure that Crystal's airway was secure because a patient
11 has got to breathe. So I think it's -- I think it's a little
12 bit longer than this, but that's okay. She was at this
13 timeframe. That's right. Probably around 9:15 to -- I think
14 they said around 9:30 when we finally got things tied up.
15 That's -- that's fine, in this time frame.

16 So when that was happening, she could see everything
17 going on then, not just the blood pressure, but all the other
18 monitors, and everything was fine, good perfusion. And she
19 could look back from here to when she was last there and say,
20 yeah, everything was fine there, too. And that's what she
21 testified to.

22 The next time she came in -- I'll find this here. When
23 she came in to start getting ready to wake the patient up, she
24 said around 10:30 to 11, in that time frame, and she continued
25 with the patient all the way until the recovery room. So

1 that's all the way out here.

2 It took a while to get her awake, as any patient, it's
3 not just Crystal. It takes a while to turn that anesthetic
4 down, monitor the patient's vital signs, making sure the plane
5 is going to land fine. Keep that airway tube in there so she
6 doesn't stop breathing. And she was here and said everything
7 was fine here, and I'm looking back to when I was last here,
8 and everything is fine as well.

9 She had in real time a review of everything going on with
10 the anesthesia records that told her, as an M.D.
11 anesthesiologist in charge of this patient with the anesthesia
12 part, everything in this chart tells me -- everything I looked
13 at tells me that she had good perfusion, good blood flow going
14 to her spinal cord. It's not the same as blood pressure.

15 At any time, Dr. Root, when you were in the operating
16 room in real time and looking back at the records from the
17 last time you were in, was there ever an issue ever with low
18 blood pressure where you needed to raise the blood pressure?

19 No. Erich said the same thing, and we don't disagree
20 with them, ladies and gentlemen.

21 Were the blood pressures acceptable every time you came
22 in?

23 They were.

24 Looking at the entire record, was there ever a concern on
25 your part about the blood pressure being too low for too long

1 during this operation?

2 No, sir.

3 In your opinion, were the blood pressures in a normal
4 range during the entire surgery?

5 They were.

6 Was the blood flow normal throughout her entire
7 operation?

8 They were.

9 In your opinion, did she ever suffer a low blood pressure
10 for too long during her -- during any part of her surgery that
11 day?

12 No, sir.

13 She was not a paid expert. Ladies and gentlemen, I
14 suggest to you they have experts, they pay them. You know, we
15 have experts, we pay them. Dr. Root is your expert. She
16 wasn't paid. She came in under oath and told you the truth.

17 If you want to know what the blood pressures were and the
18 perfusion and was it adequate and was it normal and was it a
19 problem or not, you can take it from your expert, Dr. Root.
20 Forget Dr. Balestrieri, forget Dr. Jones, throw them off the
21 bus if you want to. I mean, you can do that as you evaluate
22 the evidence. She's your expert.

23 Well, I've heard preachers do this and I hate it. In
24 closing -- and I hate -- I hate saying that, but I'm kind of
25 dehydrated. I'm sorry. Well, it's okay with nasty cold. I'm

1 glad you got that Plexiglass up there. I don't want anybody
2 getting this.

3 What is the standard of care? Standard of care is that
4 which is a reasonably prudent, in this case, neurosurgeon
5 would do or would not do in the same or similar circumstances.

6 The ground zero of the plaintiffs' case, if you will, is
7 what happened when Teresa Adkins said the signals went out.
8 Their claim centers on those minutes. That's it.

9 We would ask you to consider that what he did was
10 reasonable, not perfect. Could somebody else have done it
11 better? Probably. After this lawsuit, maybe you could have
12 done better. I don't know. But it's not the standard of
13 care.

14 Is what he -- is what he did and how he responded and his
15 plan at that time in real time, without the benefit of
16 hindsight, without the benefit of a crystal ball to look into
17 the future, in real time, was his judgment okay? Was it
18 reasonable? Was it appropriate? If it was, then he's met the
19 standard of care in spite of the injuries, in spite of that.

20 The judge is likely to tell you something along the lines
21 of when you come to judge Dr. Holbrook -- and that's what you
22 have to do. You judge his actions, his care. You have to
23 determine what was in front of him at the time, the
24 circumstances at the time, not in light of what hindsight
25 reveals, at the moment.

1 We're all Monday morning quarterbacks, not just sports
2 but in our life. I wish I hadn't done that. I've got way too
3 many of those in my life. My kids and my grandkids, they're
4 building a whole life of I wish I hadn't have done that, but
5 we can't live our life in reverse. We have to make our
6 decisions with what's in front of us as best we can.

7 And that's what Dr. Holbrook did as a neurosurgeon
8 responsible for his patient in this third back surgery he
9 performed on his patient. That's the standard of care.

10 I want to talk a little about gross negligence, that
11 question that the verdict form is going to have for you to
12 answer. Do you find that the defendants were negligent and
13 that their negligence proximately caused the injuries? That's
14 question number one.

15 If you say yes to that, question number two is do you
16 find the defendants' negligence -- excuse me. Do you find
17 that the defendants were grossly negligent and/or reckless?
18 Let's talk a bit about that.

19 Gross negligence is a failure to exercise any slight
20 degree of care. Slight degree of care, not a lot, just a
21 slight. If he failed to exercise a slight degree of care, and
22 you find that from this evidence and you find that he was so
23 indifferent to the consequences of his conduct as not to give
24 a slight care or concern of what he was doing, that would be
25 gross negligence. Folks, that's going to be up to you. I'm

1 going to ask you, based on the evidence in this case or the
2 lack of evidence, if you -- if and when you get to that
3 question, just say no.

4 Recklessness. The knowing -- the knowing failure to
5 exercise reasonable care under all the surrounding
6 circumstances. An act both reckless -- an act of reckless is
7 it -- is if it is committed in a manner and under
8 circumstances which a person of ordinary reason and prudence
9 knows would invade the rights of the injured person. A
10 reckless act is a lack of concern for the rights and safety of
11 others.

12 I submit to you that what he did and what he decided to
13 do when the signals went out was reasonable under the
14 circumstances, and it just defies recklessness and gross
15 negligence as the law defines it. If you get to that
16 question, I would ask you to consider, based on the evidence,
17 the answer is no.

18 Fraud? Misrepresentation? Fraud means bad faith,
19 dishonesty as opposed to mistake or negligence. Deceit means
20 a fraudulent misrepresentation by which one person deceives
21 another. Misrepresentation may be orally or in writing or by
22 acts or conduct or by acts meant to deceive. It's not
23 necessary for the defendants to have made their presentation
24 directly. A false impression made by words or acts may
25 constitute -- may constitute fraud.

1 Ladies and gentlemen, that's a stretch. That's just a
2 stretch. And they want you in that question -- do you find
3 the defendants engaged in fraud or made one or more
4 misrepresentations related to the plaintiffs' claims? When
5 you get -- if you get to that question, your answer based on
6 the evidence should be no.

7 Days after this operation -- we're not sure when that
8 video that Jazmine did was made. Some days after this
9 complication with mom in the room. We all have seen it. You
10 saw the video. Glad she did that because now we know what Dr.
11 Holbrook said days after this complication was evident.

12 Do you remember what he said? I'm going to paraphrase it
13 because I didn't quote it. I didn't write it down. Your
14 memory is probably better than mine. Something like he
15 snapped his fingers, and I can't do it with my right hand for
16 some reason. I'm left-handed.

17 He snapped his fingers and said the signal just went out.
18 We don't know what happened, and we looked for a cause and
19 couldn't find a cause, even with the MRI. And they were
20 asking questions, good questions, questions that you'd ask,
21 questions that I would be asking. What caused this? This is
22 terrible. How did this happen? Man, those are good
23 questions.

24 Sometimes good questions that needed to be asked cannot
25 be answered very well. Medical science doesn't have answers

1 to every question you can ask. That doesn't mean they don't
2 deserve an answer if there can be an answer found. That
3 doesn't mean they shouldn't be asking the questions. Ask them
4 and keep asking them.

5 He didn't misrepresent anything to them. He said the
6 signal just went out, just like Teresa Adkins said. He was
7 concerned, just like Teresa Adkins said he was. He was
8 concerned. That's fraud and misrepresentation? Ladies and
9 gentlemen, use your common sense when you answer that
10 question.

11 Sympathy. I've thought about this a lot in the last
12 several days, last week, because I knew I was going to get to
13 this point. The judge is going to tell you something, and
14 this is not just my cold. The judge is going to tell you
15 something in her charge on the law about sympathy. It sounds
16 something like this, but you take it from how she does it.

17 You can't let sympathy ruin your decision. Your decision
18 has to be based on the evidence in the case, not on sympathy
19 for one side or the other, or even for both. That sounds
20 stone cold hard. And I would submit to you that that's
21 impossible for you and me and everybody in this courtroom. We
22 cannot set sympathy aside, and that's not what she's asking
23 you to do. That's not a requirement.

24 When we heard James testify Friday, last Friday
25 afternoon, I was stunned. Absolutely stunned what this man

1 said to his wife when she was waking up with her legs not
2 moving, and he laid his head on her chest, this big man, and
3 said I'm never going to leave you.

4 Ladies and gentlemen, that's a testimony of a hero, of a
5 husband, without question, and how he has quietly suffered as
6 his wife has through these seven years. Admiration has no
7 limit to how I could possibly try to describe that.
8 Absolutely amazing man.

9 Crystal Goodwin. And she testified in her wheelchair
10 before you. If you didn't have sympathy for this woman,
11 there's something wrong with you. And I don't think there is,
12 but the law simply says -- and it's hard in a case like this.
13 The law says -- it doesn't say you can't have sympathy. Lord
14 have mercy, have all the sympathy. Weep with sympathy if you
15 wish. I have. I will for this amazing couple, what they've
16 been through, what they're going through, what they will go
17 through. It's stunning.

18 They should be poster children for courage and
19 perseverance and endurance and faith, and I'd be the first one
20 to sign that poster. So have sympathy, absolutely have it.
21 Have deep feelings for this couple and what they've been
22 through, what they're going through, but the law just says you
23 can't let that be the basis of your decision. It's got to be
24 based on the evidence.

25 So somehow, I don't know how you can do it. I don't know

1 how I can do it. You've got to blend all that together and
2 make a decision, a verdict that speaks the truth. Verdict is
3 a Latin word. It's two words, *vera dicta*. Verdict. *Vera*
4 means to speak. *Dicta* means the truth.

5 So in a sense, your verdict based on the evidence should
6 speak the truth based on the evidence as you see it. You are
7 judges of the facts, but the judge is the judge of the law,
8 and she's going to give it to you in a minute.

9 But you're judges of the facts. You determine what the
10 facts are in this case, all twelve of you working together.
11 And when you reach a verdict, all twelve must be in agreement,
12 unanimous, one way or the other, that speaks the truth based
13 on the evidence.

14 The scales of justice -- and I'll end with this. I
15 promise I'll end with this. It's not a preacher's closing
16 now. Okay? I'm not saying that.

17 These scales of justice, if you can imagine again these
18 old market scales. When this case begins, when it began three
19 years ago, those scales were perfectly balanced because
20 there's no evidence on them. Plaintiff presents her case, and
21 you may be persuaded, well, sort of kind of tipping a little
22 bit in their favor. And then when we put up some of our
23 witnesses and some of our evidence and opinion testimony, and
24 maybe they kind of not tipped our way, but if they do, that's
25 up to you.

1 But there's three -- there's three possibilities. When
2 you finish your deliberations, you're kind of mentally
3 weighing the evidence together as a group. And there's three
4 possibilities as I see it.

5 One is you started out even, you go back and forth, and
6 they tip ever so slightly in favor of the plaintiffs, then
7 you've reached a verdict for the plaintiffs and you award
8 damages that you feel is appropriate under the circumstances.

9 Another possibility -- and this is up to you. As you
10 weigh the evidence back and forth, you may decide, well, they
11 tipped a little bit ever so slightly in Dr. Holbrook's favor.
12 That's up to you. If that's the case, then it would be a
13 verdict for the defendant.

14 Then there's a third possibility. You started off even.
15 You go back and forth, and at the end of your deliberations,
16 whenever that is -- and we'll wait for you -- they're even
17 again. What do you do now? The plaintiff has failed to prove
18 her case. The law says you should enter a verdict for the
19 defense.

20 Our Lady of Justice, who you have seen statues, maybe
21 pictures of her, I want to talk about her. She holds those
22 scales in one hand, and in the other hand she holds a sword to
23 execute the justice, but the thing that's most important about
24 that statue of Our Lady of Justice is she has a blindfold
25 around her head and their eyes. Why? What does -- what does

1 that mean?

2 When Our Lady of Justice was holding the scales that --
3 that you must use to weigh the evidence and you execute
4 justice, however you determine that to be, you must also put
5 those blindfolds on to the extent that you don't pay attention
6 who the plaintiff is, who the defendant is, what their
7 socioeconomic background is, or anything else. That you're
8 just going to look at the evidence and you're going to weigh
9 it as best you can, given the common sense that y'all are born
10 with and the evidence in this case. And you weigh those
11 scales, and then then when you come to a verdict, justice is
12 blind. It doesn't favor one party or another based on
13 anything other than evidence.

14 Ladies and gentlemen, when I was a prosecuting attorney
15 for many years up in Greenville, I prosecuted a good number of
16 murder cases and other high crime cases. I enjoyed the job.
17 The part I enjoyed most was that closing argument. I get to
18 open, and then the defense attorney would get up like I'm
19 doing now and give his closing argument, and then he'd sit
20 down. He can't get back up again, but I can. As a
21 prosecutor, I get to get back up and have the last word with
22 the jury. Why is that? Because as a criminal prosecutor, I
23 had the burden of proof.

24 Because they have the burden of proof, we don't, that's
25 going to kill some of you, but they've got the opportunity to

1 come back up here and rebut any and everything I had to say.
2 They can do whatever they want to. I can't, and I'm going to
3 want to -- no, I got -- but I'm done. This is it. You're
4 probably glad. I'm glad.

5 It's been a long day. So I'm going to sit down, and I'm
6 going to turn it over to you. If they have something they
7 want to say, give them the courtesy of listening to whatever
8 they want to say, and then pay very, very careful attention to
9 the law that the judge gives you, because that's what you have
10 to apply to the facts that you, the judges of the facts, find
11 in this case. Thank you.

12 THE COURT: All right, ladies and gentlemen. I think we
13 should take a break before we hear the final closing argument
14 from the plaintiffs. It's going to be about 20, 25 minutes.
15 Lunch is here. I'm probably going to interrupt your eating of
16 your lunch to bring you back in here for the final closing
17 argument and my charge to you on the law, but at least you'll
18 be able to take a bite or two before you have to come back
19 into the courtroom.

20 So please return to your jury room. Do not begin to
21 discuss the case. Thank you.

22 (WHEREUPON, the jury exited the courtroom at 2:16 p.m.)

23 THE COURT: We'll be at recess for about 20 minutes. I'm
24 sure Ms. Goodwin needs a bit of a break. I do, too.

25 We're all going to grab two bites of our sandwiches. I'm

1 sorry that you all will probably starve, but that's -- unless
2 you have a runner or somebody bring you something, but we're
3 not going to take a full lunch break, just about 20 minutes.

4 MR. HINSON: Thank you, Judge.

5 MR. GOINGS: Thank you.

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

8 MR. GOINGS: I was just going to say, Your Honor, for
9 your planning --

10 THE COURT: Okay.

11 MR. GOINGS: For your planning purposes, my reply is not
12 going to be very -- very limited.

13 MR. DAVIS: Two hours?

14 MR. GOINGS: So I know you're about to do your jury
15 charges. I was just letting you know for your planning
16 purposes.

17 THE COURT: Thank you. Do we want to wait on Dr.
18 Holbrook? Yes? No? Do you want to wait for your client?

19 MR. DAVIS: Yes, probably. I don't know where he is.

20 MR. HEITMAN: I'm going to try to find him.

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

23 THE COURT: All righty. We've got Dr. Holbrook back.
24 Yeah. Bring the jury.

25 (WHEREUPON, the jury entered the courtroom at 2:40 p.m.)

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

2 THE COURT: Thank you.

3 Sorry to interrupt lunch, folks, but we're going to get
4 this case finished or close to, and you're going to hear from
5 Mr. Goings one more time before I charge you on the law.

6 MR. GOINGS: Thank you, Your Honor. May it please the
7 Court.

8 THE COURT: Yes, sir.

9 REPLY CLOSING ARGUMENT ON BEHALF OF THE PLAINTIFFS

10 MR. GOINGS: Ladies and gentlemen, as Mr. Davis
11 explained, you all are the judges, the judges of the facts of
12 this case. And when the judge enters the courtroom, you stand
13 because she's the judge of the law. And we're taught that
14 when the judges of the facts enter the courtroom, you stand.
15 You may have wondered.

16 It's because what you're about to do is reach a verdict.
17 Verdict in Latin means to speak the truth. And when I stand
18 up in court, it's important that what I say be true.

19 Mr. Davis said these neuromonitoring records that you're
20 going to see -- they're Exhibit 15, remember that. These
21 neuromonitoring records that you see that says the word
22 timeout, he says they're there in the Palmetto Health Hospital
23 records. Well, they're not. Neuromonitoring records are not
24 a part of the hospital records. You'll see on Exhibit 15, it
25 says Specialty Care. They're from Specialty Care because

1 Specialty Care, Inc., was the neuromonitoring company.

2 In the binder is the medical records. The
3 neuromonitoring records of Ms. Adkins that have the charts and
4 the charts, that reference the signals going out, are not in
5 the records from Prisma Health Baptist in the file. Now, this
6 binder of all the records, the defense did not move into
7 evidence because there's nothing in these records that help
8 them.

9 So first off, when I stand up and say something, it
10 better be the truth. There is no reference to neuromonitoring
11 signals going out in the hospital records. You have to send a
12 subpoena to Tennessee to get the records, and you'll see that
13 on the records.

14 Now, the only reference whatsoever of a timeout is in the
15 neuromonitoring records, but it doesn't involve the surgeon.
16 It doesn't involve the anesthesia. And look at the time.
17 8:08:49, timeout. Incision, when the cut occurred, 8:08:53.
18 Four seconds. Four seconds. There was not a timeout. Dr.
19 Root said she did not talk to Dr. Holbrook about the
20 anesthesia or ever discuss or talk to him whatsoever before
21 the procedure.

22 You also heard -- you also heard that Dr. Sampson was the
23 chief of neurosurgery at Duke. He didn't say he was the chief
24 of neurosurgery at Duke. He is one of hundreds of
25 neurosurgeons at Duke. His name is not Chief Dr. Gerald

1 Grant. That's the chief.

2 Dr. Poletti. He says I've hired Dr. Poletti, but you
3 heard what Dr. Poletti said. Apparently, he says Dr. Poletti
4 does a lot of surgeries. One of my former clients had a
5 surgery performed by Dr. Poletti. I have never hired Dr.
6 Poletti. Okay? Let's get that straight.

7 Change in testimony. The question that they denied was
8 admit that she suffered a neurologic impairment. Remember, we
9 don't -- we know she had a neurologic impairment. We -- we've
10 been saying all along she has a neurological impairment. Then
11 why are you denying that she's got a neurological impairment?

12 Truth. Dr. Root. Mr. Davis said Dr. Root is not paid.
13 You can believe everything she says. She's not here today as
14 a defendant, but she's been a party in this case. She has
15 more self-interest and bias to say things that protect her
16 than any other witness, except for Dr. Holbrook.

17 Loss of signal. Erich Starn specifically said he did not
18 ask any questions of Dr. Holbrook about neuromonitoring. Dr.
19 Root said that the determination of loss of monitoring signals
20 was an equipment failure determined by Dr. Holbrook.
21 Determined by Dr. Holbrook.

22 And so when the defense said gross negligence, gross
23 negligence, that means not using any care. We're not saying
24 that he didn't use care when he made the incision. We're
25 saying that he didn't use any care or he didn't use the

1 requisite slight care when the alarms were going off. The
2 alarm for Crystal Goodwin to be able to walk again was going
3 off. The alarm for her to walk again was going off. The
4 neuromonitoring tech said at least five times in the records
5 it's not an equipment issue. The alarm was going off for her
6 to be able to walk again.

7 Because you see, Dr. Holbrook gets to walk out of the
8 operating room. It doesn't affect him. The alarm was going
9 off for somebody else to be able to walk again, and he
10 disregarded what he was being told. At the very least, that
11 is a disregard of slight care.

12 Now, the defense said, well, it cannot be possibly a
13 perfusion issue because there was no effect of other organs.
14 Well, of course, there was an effect of other organs. The
15 effect of the other organs was demonstrated in the 80cc.
16 Dr. Holbrook could have easily performed lab work.

17 How many times do we get lab work done when we get our
18 physical? You don't have to wait very long for them to get
19 your labs. By the way, she already still had the IV cord in.
20 They could have easily drawn blood. If he really cared, he
21 would have drawn blood to see if there was anything with the
22 other metabolic panel readings, which would have shown, of
23 course, other functions of the organs being affected, but we
24 clearly have -- with the only thing that we can measure, we
25 clearly have it with the urine.

1 So was there a breach caused by the injury? If basic
2 blood pressure information had been shared with anesthesia,
3 basic blood pressure information had been shared with
4 anesthesia, a baseline blood pressure would have been
5 established, but instead Midlands Orthopedics and Dr. Holbrook
6 did not send the blood pressure readings.

7 They sent a surgery order, and they sent a document that
8 said vitals, none recorded. If baseline blood pressure had
9 been established, the blood pressure could have been kept
10 higher. And if Dr. Holbrook would have followed generally
11 accepted principles when the signal was lost, her spinal cord
12 could have been saved. You don't even have to get to the
13 alarms going off if the blood pressure was set and consistent.

14 Now, we said all along that you treat a patient as an
15 individual, not some generic person. Can you imagine if you
16 went to the doctor and they just treated you as a generic
17 person and not the patient that you are? I was so blown away
18 by Dr. Root yesterday, sticking to her guns, that she sets
19 blood pressure on a generic basis, not based on an individual.

20 And I remarked to myself, if I was going to have to have
21 surgery, would I want Dr. Root to set my blood pressure as a
22 generic person or would I want Dr. Jones to set my blood
23 pressure based to my baseline blood pressure?

24 We have had many doctors come in here and tell us about
25 their combined experience in medicine. We've had a lot of

1 doctors come and tell us about their combined years in
2 medicine, but your combined years of common sense far exceeds
3 their years in medicine. The youngest person on this jury is
4 27 years old. The oldest person on this jury is 70. And if
5 I'm wrong, the clerk's office is doing us wrong on the math,
6 but when you add that together, that's a total of 529 years of
7 common sense. Common sense.

8 A verdict is the truth. A verdict is built on common
9 sense. A verdict is what we asked you to render.

10 The defense has no objection as to what we say the value
11 of her life is for each step. They never once said a quarter
12 a step is unreasonable. If they thought it was unreasonable,
13 they would have spent the last two hours at least mentioning
14 it. Because we know that they value a day in the thousands,
15 value money the way they value money so it will make a
16 difference.

17 One minute. All it took was the trouble of one minute to
18 send the blood pressure readings. One minute. All it took
19 was the trouble of one minute to talk to anesthesia during the
20 surgery. One minute. One minute to stop and say, well, since
21 you're telling me the equipment is working just fine, we need
22 to check again. One minute. One minute would have kept
23 Crystal Goodwin out of a wheelchair. One minute has cost
24 nearly 17,000 days of the life she used to have.

25 Is it too hard to ask for one minute to do the right

1 thing? That one minute is no longer in his hands. That one
2 minute is in your hands now. With your verdict, tell us the
3 truth. Tell us what should have happened in that one minute.

4 Thank you, Your Honor.

5 THE COURT: Can you move this monitor, please?

6 MR. GOINGS: Yes, ma'am. Would you like me to put that
7 here or just scoot it back?

8 THE COURT: Just scoot it. It doesn't matter. Just so
9 that I can see the jury or they can see me. Okay. If you go
10 six more inches, you'll be fine.

11 MR. GOINGS: I'm going to get it all out of the way for
12 you, Judge.

13 THE COURT: Okay.

14 MR. GOINGS: Thank you.

15 CHARGE ON THE LAW

16 THE COURT: All right, folks. It's now time for me to
17 charge you on the law that applies to this case.

18 I remind you that during this trial, you and I have
19 certain duties to perform. As the trial judge, it is my
20 responsibility to preside over the trial of this case, and I
21 also have the duty to rule on the admissibility of the
22 evidence offered during this trial.

23 You are to consider only the evidence before you. If
24 there was any testimony ordered stricken from the record
25 during this trial, you must disregard that testimony. You are

1 to consider only the testimony which has been presented from
2 this witness stand, any exhibits which have been made a part
3 of the record in this case, and any stipulations of counsel.

4 I have the additional duty to charge you the law
5 applicable to this case. It is your duty as jurors to accept
6 and apply the law as I now state it to you. If you think you
7 have any idea as to what the law is or what the law ought to
8 be, and it does not agree with what I tell you the law is, you
9 must forget that idea because you are sworn to accept the law
10 and apply the law exactly as I state it to you.

11 In every case tried in this court before a jury, the jury
12 becomes the sole and exclusive judge of the facts. A trial
13 judge cannot comment on or make any statement about the facts
14 in a case. Since you are the sole judges of the facts, do not
15 think by anything that I have said during the trial that I
16 have any opinion about the facts in this case. The law does
17 not allow me to have an opinion about the facts.

18 The burden of proof in this case is by the preponderance
19 of the evidence. A preponderance of the evidence simply means
20 the greater weight of the evidence. It is evidence which as a
21 whole shows that the fact sought to be proved is more likely
22 true than not true.

23 This can be illustrated by imagining a traditional set of
24 scales. When the case begins, the scales are even. After all
25 of the evidence has been presented, if the scales remain

1 evenly balanced or if they tip even slightly in favor of the
2 defendants, then the plaintiffs have failed to meet the burden
3 of proof, and you would return a verdict for the defendants.
4 If, on the other hand, the scales tip even slightly in favor
5 of the plaintiffs, the plaintiffs will have met the burden of
6 proof, and you should return a verdict for the plaintiffs.

7 The preponderance of the evidence is not determined by
8 the number of witnesses. Instead, it must be determined by
9 the greater weight of all of the evidence.

10 There are two types of evidence which are generally
11 presented during a trial: direct evidence and circumstantial
12 evidence.

13 Direct evidence is the testimony of a person who claims
14 to have actual knowledge of a fact, such as an eyewitness. It
15 is evidence which immediately establishes the main fact to be
16 proved.

17 Circumstantial evidence is proof of a chain of facts and
18 circumstances indicating the existence of a fact. It is
19 evidence which immediately establishes collateral facts from
20 which the main fact may be inferred. Circumstantial evidence
21 is based on inference and not on personal knowledge or
22 observations. It is proof that does not actually establish
23 the fact in question, but that asserts or describes something
24 else from which you may either reasonably infer the truth of
25 the fact, or at least reasonably infer an increase in the

1 probability that the fact is true.

2 For circumstantial evidence to be sufficient to warrant
3 the finding of a fact, the circumstances must lead to that
4 fact with reasonable certainty. The facts and circumstances
5 should be considered in light of ordinary experience and
6 common sense. The existence of a fact cannot be based on
7 speculation, surmise, or conjecture.

8 The law makes absolutely no distinction between the
9 weight or value to be given to either direct or circumstantial
10 evidence, nor is a greater degree of certainty required of
11 circumstantial evidence than of direct evidence.

12 Necessarily, you must determine the credibility of the
13 witnesses who have testified in this case. Credibility simply
14 means believability. It becomes your duty as jurors to
15 evaluate the evidence and determine which evidence convinces
16 you it is true.

17 In determining the believability of witnesses who have
18 testified in this case, you may believe one witness over
19 several witnesses or several witnesses over one witness. You
20 may believe a part of the testimony of a witness and reject
21 the remaining part of the testimony of that same witness. You
22 may believe the testimony of a witness in its entirety or
23 reject the testimony of a witness in its entirety.

24 You may consider whether the witness has an interest in
25 the result of the trial, whether the witness is prejudiced

1 toward either the plaintiffs or the defendants, the
2 opportunity for the witness to have seen the matters and
3 things about which the witness may testify, and the way the
4 witness acts on the witness stand.

5 The rules of evidence ordinarily do not permit witnesses
6 to testify to opinions or conclusions. An exception to this
7 rule exists for witnesses we call expert witnesses. A witness
8 who, by education and experience, has become expert in some
9 art, science, or profession may give an opinion as to the
10 subject the witness claims to be an expert in and may also
11 give the reasons for the opinion.

12 You should consider any expert opinion given by a witness
13 and, like any other evidence, give it the weight you think it
14 deserves. If you decide that an expert's opinion is not based
15 on sufficient education or -- and experience, or if you decide
16 that the reasons given in support of the opinion are not
17 sound, or that the opinion is outweighed by other evidence,
18 you may disregard the opinion entirely. An expert witness's
19 testimony is to be given no greater weight than that of other
20 witnesses simply because the witness is an expert, and you do
21 not have to accept an expert's opinion, even though it is
22 uncontradicted.

23 To resolve any conflict in the testimony of expert
24 witnesses, you should weigh the opinion of one expert against
25 the others as you would of any other witnesses. You should

1 consider the qualifications and credibility of the expert
2 witnesses, the reasons for each opinion, and the facts upon
3 which the opinions rely.

4 During the trial of this case, we have had testimony by
5 way of depositions of witnesses taken outside of the
6 courtroom. Although these witnesses did not appear before
7 you, the depositions were taken in the manner prescribed by
8 law.

9 You must consider the testimony from those depositions
10 just as if the witnesses were here upon the stand testifying.
11 You are to take this deposition testimony in connection with
12 all of the other testimony and assess the credibility of those
13 witnesses from anything that is in the record that will aid
14 you in doing so.

15 You are to consider that deposition testimony -- I'm
16 sorry -- that deposition evidence, along with the testimony of
17 the witnesses who have appeared in person. You must determine
18 from all of the evidence in this case, whether by witnesses
19 present or by depositions or whether by exhibits in the case,
20 what the truth of this controversy is, according to the facts,
21 as you find them to be, and then apply the law as it is given
22 to you.

23 In our courts, no distinction is made between
24 corporations and individuals. A corporation is a person in
25 the eyes of the law. A corporation is entitled to the same

1 fair and impartial consideration and to justice by the same
2 legal standards as an individual.

3 In this case, it is uncontested that Dr. Holbrook was an
4 employee of defendant Midlands Orthopedics and Neurosurgery
5 while he provided treatment to plaintiff Crystal Goodwin. An
6 employer is liable for the negligent acts or omissions of
7 employees which are within the scope of their employment and
8 which proximately cause injury to another person.

9 A medical practice as an entity cannot practice medicine,
10 diagnose an illness, or establish a course of treatment.
11 However, the practice may be held vicariously liable for the
12 negligence of its employees.

13 The plaintiff, Crystal Goodwin, claims that the
14 defendants committed medical malpractice, which is a form of
15 carelessness or negligence. More specifically, medical
16 malpractice is a form of negligence that consists of not
17 applying the degree of skill and care which is ordinarily
18 employed by those in the medical profession under similar
19 conditions and in like surrounding circumstances.

20 In order to recover from medical malpractice, the
21 plaintiff must prove by a preponderance or greater weight of
22 the evidence four things: the standard of care, a breach of
23 the standard of care, proximate cause, and damages.

24 Negligence on the part of a -- negligence on the part of
25 a physician is not presumed, but must be affirmatively proven.

1 The burden of proof is on the plaintiff to prove each element
2 of her claim by the preponderance or greater weight of the
3 evidence. In other words, to prevail in a medical malpractice
4 action, the plaintiff must prove that generally recognized and
5 accepted practices and procedures which would be used by
6 average competent practitioners in the defendant's field of
7 medicine under the same or similar circumstances.

8 The plaintiff must also prove by a preponderance of the
9 evidence that the defendants departed from those generally
10 recognized and accepted practices and procedures in the manner
11 alleged by the plaintiff, and that as a result thereof that
12 the plaintiff suffered injury or damage.

13 It is uncontested that a physician-patient relationship
14 existed between Crystal Goodwin and defendants Dr. Holbrook
15 and Midlands Orthopedics and Neurosurgery. During the
16 existence of the physician-patient relationship, a physician
17 is under a duty to give the patient all necessary care, as
18 long as the case requires attention. A lack of diligence in
19 attending to the patient after assumption of the case renders
20 the physician liable for negligence or malpractice.

21 A patient who is treated by a physician is entitled to a
22 thorough and careful examination, as permitted by the
23 circumstances, with such diligence and methods for discovering
24 the nature of the ailment as are usually approved and
25 practiced by physicians of ordinary or average training,

1 judgment, and skill in that field of practice.

2 Negligent failure to attend and to treat -- and to treat
3 a patient at a time when the need of treatment is known to the
4 physician amounts to negligent treatment and medical
5 malpractice. The physician is answerable for such failure.
6 To recover for the lack of diligence of a physician in
7 attending a patient, the plaintiff must show that such lack of
8 diligence was a proximate cause of the injury for which
9 redress is sought.

10 A physician who is -- I'm sorry.

11 A patient who is treated by a doctor is entitled to a
12 careful evaluation. The evaluation should be made with the
13 diligence and methods of diagnosis that are usually approved
14 in practice by doctors of ordinary learning, judgment, and
15 skill, acting under the same or similar circumstances.

16 In order to prove that the defendants were negligent, the
17 plaintiffs must prove that the patient's physical condition
18 required a careful doctor to investigate further before
19 continuing a course of treatment or care. That the defendant
20 did not make this investigation, and that as a direct and
21 proximate result of the defendant's failure to investigate,
22 the patient received improper treatment or care from which the
23 plaintiff or the patient later suffered injury or death.

24 The plaintiff must also prove that the defendants
25 negligently departed from the standard of care in treating

1 her. Negligence is the failure to do what an ordinary,
2 careful, and prudent doctor in the defendant's field of
3 medicine would have done under the same or similar
4 circumstances, or the doing of something that an ordinary,
5 careful, and prudent doctor would not have done under the same
6 or similar circumstances.

7 A doctor is not an insurer of a cure, a perfect result,
8 or even a positive result. Therefore, the mere fact that a
9 treatment does not benefit the patient or that it even harms
10 the patient -- patient does not, in and of itself, mean that
11 the defendants were negligent.

12 A bad result, injury, or failure to cure is not by itself
13 enough to show that the defendants were negligent, and
14 negligence may not be inferred by a poor result. In fact, a
15 doctor is not responsible for the lack of success of a
16 particular treatment, unless that lack of success results from
17 his failure to exercise ordinary skill and care in the
18 treatment of the patient.

19 On the other hand, a doctor is not relieved from
20 liability simply because the result is as good as is usually
21 obtained in similar cases. Similarly, a doctor's mistake or
22 error in making a decision does not alone constitute
23 negligence where, according to standard medical practice, the
24 diagnosis and course of treatment involved are matters to be
25 subjected to the judgment of the doctor, the doctor must be

1 allowed to exercise that judgment, and cannot be held liable
2 if, in the exercise of that judgment, he has made a mistake as
3 to the course of treatment to be taken.

4 If, however, a doctor fails to gather information
5 reasonably available, which a reasonable doctor would have
6 gathered before making a decision, then the doctor has failed
7 to comply with the record -- recognized standard of medical
8 care which would be exercised by a similar doctor under
9 similar circumstances.

10 The difficulties and uncertainties in the practice of
11 medicine and the unpredictable variations in the response to
12 treatment are such that no doctor can guarantee results.
13 Where there is more than one recognized diagnosis or
14 treatment, and no one of them is used exclusively and
15 uniformly by all doctors in good standing, it is not
16 negligence for a doctor in making a decision to choose one of
17 the approved methods, even when the choice later turns out to
18 be a wrong selection.

19 Qualified doctors and experts may differ as to what
20 constitutes the best course of treatment, and these
21 differences do not amount to malpractice. Where doctors in
22 good standing disagree, or when medical authorities are
23 divided with regard to a specific course of treatment or care,
24 then the doctor is bound only to exercise his best judgment in
25 determining which course on the whole is best for the patient.

1 Just because another doctor might have used a different
2 course of treatment does not make the defendants negligent.
3 Where there is more than one recognized method of treatment,
4 the doctor is at liberty to follow any such recognized
5 treatment.

6 The plaintiff must show by the preponderance or greater
7 weight of the evidence that the physician did not possess the
8 degree of skill common to doctors in the defendant's field of
9 medicine, or that he failed or was negligent in exercising
10 such skills in the treatment of the patient. There must be a
11 failure to do that which an ordinary, careful, and prudent
12 doctor in the defendant's field of medicine would do under the
13 same or similar circumstances shown by the evidence to have
14 existed at the time of the events in question, or it was the
15 doing of that which an ordinary, careful, and prudent doctor
16 in the -- in the defendant's field of medicine would not have
17 done under the same or similar circumstances shown to have
18 existed at the time of the events in question.

19 However, if a doctor does not have the degree of learning
20 and skill required, or if the doctor does not use the care
21 required, it is no defense to a charge of negligence that the
22 doctor did the best that he could. In considering whether the
23 defendants made a reasonable decision, you must consider the
24 decision in relation to the facts as they existed at the time,
25 and not in light of what hindsight may reveal.

1 The plaintiffs have alleged that the defendants violated
2 one or more company or hospital policies. You may consider
3 these policies as evidence of the applicable standard of care.

4 The standard of care in a given case may be established
5 and defined by the common law, statutes, administrative
6 regulations, industry standards, or a defendant's own policies
7 and guidelines. When a defendant adopts internal policies or
8 is required to follow policies from another source and
9 thereafter violates those policies or rules, the jury may
10 consider such violations as evidence of negligence if they
11 proximately caused the plaintiffs' damages.

12 Finally, the plaintiff must prove by a preponderance or
13 greater weight of the evidence that the defendant's negligence
14 proximately caused the plaintiffs' injuries. If the plaintiff
15 fails to demonstrate a proximate cause, she has failed to
16 prove her cause of action.

17 Proximate cause is something that produces a natural
18 chain of events which in the end brings about the injury. It
19 is the direct cause of the injury.

20 To prove that the defendants' negligence proximately
21 caused the plaintiffs' injury, the plaintiff must first prove
22 causation in fact. This is proven by showing that the injury
23 would not have occurred but for the defendants' negligence.

24 The plaintiff must also prove legal cause. Legal cause
25 is proven by showing that the injury was foreseeable. This

1 means that the injury occurred as a natural and probable
2 consequence of the defendants' negligence. The plaintiff must
3 prove that some injury from the defendants' negligence was
4 foreseeable but does not have to prove that the particular
5 injury that occurred was foreseeable. However, the defendants
6 cannot be held responsible for something which could not be
7 expected to happen.

8 Proximate cause does not mean the only cause. There may
9 -- there may be more than one proximate cause. The
10 defendants' acts can be a proximate cause of the plaintiff's
11 injury if they were at least one of the direct concurring
12 causes of the injury.

13 The plaintiff does not have to prove that the defendants'
14 negligence was the sole proximate cause of the injury. The
15 plaintiff must prove only that the defendants' negligence was
16 a proximate cause, among any number of causes. However, the
17 plaintiff may not rely on the theory that the -- that the mere
18 fact of injury warrants recovery.

19 There is evidence in this case that plaintiff Crystal
20 Goodwin had a -- had pre-existing health conditions, which may
21 have increased the likelihood of her injury, how susceptible
22 she was to injury, or the degree of injury that she suffered.

23 It is a basic principle in the law that the defendants
24 take the plaintiff as they find her, whether she is in perfect
25 health, in poor health, or somewhere in between. Often called

1 the eggshell plaintiff rules, this principle states that a
2 defendant is responsible for injuries greater than normal if
3 the plaintiff is more sensitive or more prone to injury due to
4 a pre-existing condition.

5 The defendants are responsible for all ill effects,
6 which, considering the plaintiff's condition of health when
7 the plaintiff was injured, naturally and necessarily follow
8 the injury. A defendant's liability is in no way lessened or
9 affected because of the fact that the injury would not have
10 resulted or would not have been as serious or severe had the
11 plaintiff been in good health. In other words, if the
12 presence of a pre-existing injury or condition contributes to
13 the severity of the injury and increases the damages, the
14 plaintiff should be compensated for those additional damages.

15 Gross negligence is the failure to exercise a slight
16 degree of care. A person who is so indifferent to the
17 consequences of his conduct as to not give slight care as to
18 what he is doing acts with gross negligence.

19 Recklessness is the knowing failure to exercise
20 reasonable care under all of the surrounding circumstances.
21 An act is reckless if it is committed in a manner and under
22 circumstances which a person of ordinary reason and prudence
23 knows would invade the rights of the injured person. A
24 reckless act is a lack of concern for the rights and safety of
25 others.

1 Fraud means bad faith and dishonesty, as opposed to
2 mistake, neglect, or negligence.

3 Deceit means a fraudulent misrepresentation by which one
4 person deceives another. Misrepresentations may be made
5 orally, in writing, by acts and conduct, or by acts meant to
6 deceive. It is not necessary for the defendants to have made
7 the representation directly. A false impression made by words
8 or acts may constitute fraud.

9 The plaintiff, James Goodwin, is claiming a loss of
10 consortium. This is a claim for the loss of services,
11 society, and companionship of a spouse. Loss of consortium
12 arises out of the special relationship between a husband and
13 wife. Consortium refers to the conjugal relationship and
14 conjugal fellowship of husband and wife and the right of each
15 to the company, society, co-operation, affection, and aid of
16 the other in every conjugal relation.

17 Loss of consortium includes several elements: support and
18 services provided by the other spouse, love, companionship,
19 affection, society, sexual relations, comfort, solace, and
20 guidance.

21 In order to prevail in an action for loss of consortium,
22 the plaintiff, James Goodwin, must prove that the defendant --
23 I'm sorry -- must prove the defendants' liability for his
24 spouse's injuries, as well as damages to the plaintiff
25 resulting from the spouse's injury. So he must prove Crystal

1 Goodwin's injury, as well as his resulting damages as a result
2 of Crystal's injuries. A spouse's loss of consortium, of
3 which he is deprived by a negligent injury to his spouse, is a
4 right which entitles him to damages for such loss.

5 In determining the amount of damages for loss of
6 consortium, you may consider the nature and extent of the
7 wife's services and society prior to the incident, including:
8 her disposition, temperament, and character, the interest she
9 had in caring for her home, the social life of her family, and
10 in the comfort, happiness, education, and general welfare of
11 the members of her family, the services she rendered in
12 tending to the household and training the children, her acts
13 of affection, love, and sexual intercourse performed, and the
14 extent to which the injuries she sustained in the incident
15 incapacitated her from performing such services and providing
16 such society after the incident.

17 If you find the defendants' conduct resulted in the
18 plaintiff's loss of consortium, that is James's loss of
19 consortium, you are to determine the value of such loss from
20 the evidence in the case and your own observations,
21 experience, and knowledge, conscientiously applied to the
22 facts and circumstances of this case.

23 The defendants have answered the plaintiffs' complaint
24 with a denial that they were negligent, and a denial that the
25 plaintiffs' injuries were caused by a deviation from the

1 standard of care. Because of this denial, the plaintiffs have
2 the burden of proving each and every element of their alleged
3 claims.

4 Actual damages are to -- are to compensate the plaintiffs
5 for the plaintiffs' injuries or loss, and to put the
6 plaintiffs as near as possible in the same position that they
7 were in before the incident occurred. In other words, actual
8 damages will be the actual losses and expenses which the
9 plaintiffs have suffered because of the defendants'
10 negligence. When a person is injured by the negligent acts of
11 another, the injured person is entitled to be fully
12 compensated for all injuries directly or proximately resulting
13 from any negligent acts or omissions by the defendants.

14 In determining the amount of compensation for injuries
15 suffered by the plaintiffs as a result as a result of the
16 defendants' negligence, it is proper for you to consider and
17 award past, present, and future damages for medical expenses,
18 including physicians, hospital, medicines, physical therapy
19 expenses, rehabilitation experience -- expenses, and
20 transportation expenses connected with medical treatment, lost
21 wages, loss or impairment of earning capacity, out-of-pocket
22 expenses, loss of family services, pain and suffering, mental
23 anguish, impairment of health or physical condition, and loss
24 of enjoyment of life. The plaintiffs bear the burden of
25 proving each of these elements of their damages by the

1 preponderance or greater weight of the evidence.

2 The loss or impairment of earning capacity resulting from
3 injuries to plaintiff Crystal Goodwin is a proper element of
4 damages. In determining the amount of damages due to the
5 plaintiff for the loss or impairment of earning capacity, you
6 should consider the following.

7 The loss of future earning power. This requires you to
8 consider all matters that relate to the issue of any
9 impairment, the effect which the impairment will have on the
10 plaintiff's capacity to work, the extent to which the
11 impairment will impair the plaintiff's earning capacity, the
12 value of all losses due to the plaintiff's impaired earning
13 power, and the physical pain and suffering as is reasonably
14 certain to result in the future from the injuries to the
15 plaintiff, and the evidence of what the plaintiff had
16 previously earned when employed in the past, which is a factor
17 on which to base any loss or impairment of earning capacity.

18 In awarding damages for loss or impairment to earning
19 capacity, the plaintiff may recover for the loss or decrease
20 of earning capacity during her entire life expectancy. In
21 determining the loss of earning capacity which may result in
22 the future, the fact that the plaintiff is making the same or
23 more earnings since the injury is only one factor to consider.
24 If you determine that plaintiff Crystal Goodwin is entitled to
25 damages for impairment of earning capacity, then you must

1 decide the amount of damages using the life expectancy table
2 as a guide.

3 Pain and suffering compensates the plaintiffs for
4 physical discomfort, and we're really talking about Crystal
5 Goodwin here. Pain and suffering will compensate Crystal
6 Goodwin for physical discomfort and emotional response to this
7 sensation of pain caused by the injury itself.

8 There is no definite standard by which to compensate the
9 plaintiff for pain and suffering. You, the jury, have the
10 authority to determine the amount, if any, to be allowed for
11 pain and suffering, using calm and reasonable judgment to
12 ensure that the damages are just and reasonable in light of
13 the testimony and evidence presented in this case.

14 Any future damages for pain and suffering must be
15 reasonably calculated to have resulted from the alleged injury
16 or damages sustained in this case. Future damages must be
17 reduced to their present cash value.

18 The loss of capacity to enjoy life or a diminishing of
19 that capacity is also a proper element of damages, provided
20 you find it results from the defendants' negligence. Loss of
21 enjoyment of life compensates a plaintiff for limitations on a
22 plaintiff's ability to participate in and derive pleasure from
23 the normal activities of daily life, or for the plaintiff's
24 inability to pursue her talents, recreational interests,
25 hobbies, or vocations. This includes damages for the

1 subjective knowledge that she can no longer enjoy all of
2 life's pursuits, but also for the objective loss of the
3 ability to engage in these activities.

4 The plaintiff must prove that expenses caused by the
5 injury were both necessary and reasonable. Actual damages for
6 a plaintiff who has been physically injured include pain and
7 suffering, both past and future, as well as mental anguish and
8 impairment of health or physical condition.

9 In determining the amount of compensation for personal
10 injuries, it is proper to consider past, present, and future
11 aspects of the injury. This would include physical and mental
12 pain and suffering, expenses incurred for necessary medical
13 treatment, the loss of enjoyment of life suffered as a result
14 of the injury, and any other losses which are reflected by the
15 character of the injury.

16 Very closely associated with pain and suffering is mental
17 anguish. Mental anguish includes mental suffering,
18 apprehension, shock, fright, emotional upset, stress,
19 humiliation, and anxiety, and can properly be considered as an
20 element of damages.

21 When connected with a physical injury, the term mental
22 anguish includes both the resulting mental sensation of pain
23 and also the accompanying feelings of distress, fright, and
24 anxiety. That is, mental anguish covers not only the pain
25 associated with the injury, but also the mental reaction to

1 that pain and to the possible consequences of the injury.

2 The amount of damages for mental suffering cannot be
3 exactly measured, but must be left to the judgment of you, the
4 jury. If you find that the plaintiff Crystal Goodwin was
5 permanently injured as a result of the defendants' actions,
6 you must then decide how, if at all, that injury will affect
7 the rest of her life.

8 A person's life expectancy is determined by a life
9 expectancy table, which is a part of the laws of this state.
10 The life expectancy table is only an estimate of the probable
11 average remaining length of the life of all persons in our
12 state of a given age.

13 The plaintiff Crystal Goodwin is a 45-year-old female
14 with a life expectancy, according to the life expectancy
15 table, of 37.29 years. This fact is to be considered by you,
16 along with any other facts and circumstances in evidence
17 bearing on the plaintiff's life expectancy, including
18 occupation, habits, and health at the time of injury in
19 deciding the amount of damages to be awarded to the plaintiff.

20 A plaintiff is never entitled to recover conjectural or
21 speculative damages, but if you find that either or both of
22 the plaintiffs is entitled to a verdict for actual damages,
23 your verdict should include an amount to cover any past,
24 present, and future damages which were proximately caused by
25 the defendants. Actual damages need not be proven to a

1 mathematical certainty or be based on evidence of the precise
2 amount of damages the plaintiffs have suffered. Instead, the
3 evidence must allow you to determine what amount of damages is
4 fair, just, and reasonable.

5 All twelve of you must agree on the verdict. Your
6 verdict cannot be based on sympathy, passion, prejudice,
7 emotion, or any other consideration not in evidence in this
8 case.

9 Madam Foreperson is going to be this juror in the corner
10 right here on the front row. Give me your juror number. Yes,
11 you looking around.

12 JUROR NUMBER 269: 269.

13 THE COURT: 269. That is the foreperson.

14 So Juror 269, you will preside over the jury's
15 deliberations in the jury room. When the jury agrees on a
16 verdict, you will complete the verdict form, sign your name on
17 the second page as foreperson of the jury, and then knock on
18 the door and advise the bailiff that you have a verdict, and
19 we'll receive you back into the courtroom.

20 I couldn't see, but I believe at least one of the
21 attorneys went over this verdict form with you. The short,
22 short version -- there are instructions on it, but the short,
23 short version is that you answer yes or no to Question Number
24 1 about defendants' negligence. And depending on what your
25 answer is, if you answer no, you're actually finished with the

1 verdict form if your answer to Number 1 is no. If the answer
2 is yes to Number 1, then you go on to some other questions.

3 But as I said, there are instructions on here. They're
4 written in italics. So you shouldn't have any questions about
5 it.

6 So I'm now going to ask you to return to your jury room.
7 This is the last time I'll ask you not to discuss the case,
8 and that is only because you can't begin to discuss it until
9 you've received this verdict form and all of the evidence in
10 the case. The bailiff is going to bring that to you. Once he
11 knocks on the door and gives you the evidence and the verdict
12 form, that's your signal to begin deliberating, and you'll
13 continue deliberating until you've reached a verdict.

14 Please return to your jury room, except the alternates.
15 Alternates can stay here.

16 A JUROR: Judge?

17 THE COURT: Yes.

18 A JUROR: I just need -- will we be getting the -- the
19 reading of the law that you just read as well?

20 THE COURT: That's not my plan, but let's see. Let me
21 ask the lawyers. Okay?

22 (WHEREUPON, the jury exited the courtroom at 3:30 p.m.)

23 THE COURT: And I called it wrong, which there's a
24 question already. So now what's the objection? I told you,
25 it was so much.

1 Any objection from the plaintiffs to sending the written
2 charge back to the jury room?

3 MR. GOINGS: No objection.

4 THE COURT: Okay. So then I will send the charge back to
5 the jury room.

6 Any objections to the jury charge as read from the
7 plaintiffs?

8 MR. GOINGS: None from the plaintiffs.

9 THE COURT: From the defense? I mean, I know there were
10 previous objections to the contents, but --

11 MR. HEITMAN: Your Honor, we would renew our previous
12 objections.

13 THE COURT: Okay. Those objections are overruled.

14 Gentlemen, our alternates.

15 Y'all come forward and start making sure all the evidence
16 is there.

17 You are two backup jurors. I hate that after two weeks
18 you can't deliberate on the trial, but, I mean, it is what it
19 is. You are our backups in case we lost a juror somehow. You
20 know, people have medical emergencies, car accidents, things
21 like that. That didn't happen to anyone. So -- thankfully,
22 so you will not be permitted to deliberate, and your jury
23 service is complete.

24 You are no longer eligible to serve on a jury in circuit
25 court for the remainder of 2023. If you're summoned for jury

1 duty in 2024 or 2025, you'll have to show up that Monday
2 morning, but tell that judge that you served on a jury this
3 week, and they'll let you go home. You won't have to serve.
4 You have the option. You can exercise the exemption.

5 You're now free to discuss the case with whoever you want
6 to discuss it with. I'm sure these attorneys would like some
7 feedback, but that's your call.

8 When I excuse you in two seconds, you're going to go back
9 there because I'm sure you need cell phones and maybe the rest
10 of your lunch, or -- I don't know, whatever your belongings
11 are back there.

12 If you don't want to talk to anybody, just go out the way
13 you've been coming in, and that bypasses this whole thing.
14 If you don't mind chatting with these lawyers, they're going
15 to be sitting around waiting for this jury to deliberate. So
16 you can come on back in the courtroom and chat with them if
17 you want.

18 Y'all are free to go. Thank you so much.

19 (WHEREUPON, the alternate jurors were released and exited
20 the courtroom.)

21 (WHEREUPON, there was a pause in the proceedings to check
22 the exhibits.)

23 (WHEREUPON, jury deliberations began at 3:35 p.m., and
24 there was a break in the proceedings, after which the
25 proceedings resumed as follows.)

1 THE COURT: All right. Everyone is present. I
2 understand that the jury has reached a verdict.
3 Will you please bring the jury, Madam Bailiff?
4 (WHEREUPON, the jury entered the courtroom at 6:32 p.m.)
5 THE BAILIFF: All jurors are seated, Your Honor.
6 THE COURT: Thank you.
7 Madam Foreperson, has the jury reached a verdict?
8 THE FOREPERSON: Yes, Your Honor.
9 THE COURT: Is it unanimous?
10 THE FOREPERSON: Yes.
11 THE COURT: Are you sure?
12 THE FOREPERSON: Yes.
13 THE COURT: If you would, hand the verdict form to
14 bailiff, please. Thank you.
15 Madam Clerk, will you publish the verdict?
16 VERDICT
17 THE CLERK: The State of South Carolina, County of
18 Richland. Crystal Goodwin and James Goodwin versus Thomas J.
19 Holbrook, Jr., M.D., and Midlands Orthopedic and Neurosurgery,
20 Case Number 2019-CP-40-04185.
21 Do you find the defendants were negligent and that they
22 were negligent proximately caused injury to Crystal Goodwin?
23 The answer is no.
24 THE COURT: Signed by the foreperson today?
25 THE CLERK: Signed by -- I'm sorry -- Gabrielle Ross,

1 Juror Number 269.

2 Is this your verdict?

3 THE FOREPERSON: Yes, ma'am.

4 THE COURT: And the verdict of the entirety?

5 THE CLERK: Verdict of the entire jury?

6 THE FOREPERSON: Yes, ma'am.

7 THE COURT: Okay. Anything from the jury before they're

8 dismissed?

9 MR. GOINGS: I'd like to poll the jury, Your Honor.

10 Thank you.

11 THE COURT: Madam Clerk, would you poll the jury, please?

12 THE CLERK: Gabrielle Ross, Juror Number 269, is this

13 your verdict?

14 THE FOREPERSON: Yes, ma'am.

15 THE CLERK: Is this still your verdict?

16 THE FOREPERSON: Yes, ma'am.

17 THE CLERK: Karen --

18 THE COURT: I need you to speak very loudly, like you're

19 talking to me. So it's going to feel like you're shouting.

20 JUROR NUMBER 349: Yes, ma'am.

21 THE CLERK: Karen L. Withrow, Juror Number 349, is this

22 your verdict?

23 JUROR NUMBER 349: Yes, ma'am.

24 THE CLERK: Is this still your verdict?

25 JUROR NUMBER 349: Yes, ma'am.

1 THE CLERK: Austin P. Ford, Juror Number 103, is this
2 your verdict?
3 JUROR NUMBER 103: Yes, ma'am.
4 THE CLERK: Is this still your verdict?
5 JUROR NUMBER 103: Yes, ma'am.
6 THE CLERK: Michael L. Casto, Juror Number 54, is this
7 your verdict?
8 JUROR NUMBER 54: Yes, ma'am.
9 THE CLERK: Is this still your verdict?
10 JUROR NUMBER 54: Yes, ma'am.
11 THE CLERK: Robert M. Andreo, Juror Number 9, is this
12 your verdict?
13 JUROR NUMBER 9: Yes, ma'am.
14 THE CLERK: Is this still your verdict?
15 JUROR NUMBER 9: Yes, ma'am.
16 THE CLERK: Timothy R. Shealy, Juror Number 288, is this
17 your verdict?
18 JUROR NUMBER 288: Yes, ma'am.
19 THE CLERK: Is this still your verdict?
20 JUROR NUMBER 288: Yes, ma'am.
21 THE CLERK: Roxann G. Lewis, Juror Number 195, is this
22 your verdict?
23 JUROR NUMBER 195: Yes, ma'am.
24 THE CLERK: Is this still your verdict?
25 JUROR NUMBER 195: Yes, ma'am.

1 THE CLERK: Michael Mitchell, Juror Number 219, is this
2 your verdict?
3 JUROR NUMBER 219: Yes, ma'am.
4 THE CLERK: Is it still your verdict?
5 JUROR NUMBER 219: Yes, ma'am.
6 THE CLERK: Stephanie Creek-Cribb, Juror Number 68, is
7 this your verdict?
8 JUROR NUMBER 68: Yes, ma'am.
9 THE CLERK: Is this still your verdict?
10 JUROR NUMBER 68: Yes, ma'am.
11 THE CLERK: Tameka M. Harvey, Juror Number 146, is this
12 your verdict?
13 JUROR NUMBER 146: Yes, ma'am.
14 THE CLERK: Is this still your verdict?
15 JUROR NUMBER 146: Yes, ma'am.
16 THE CLERK: Jaekwon A. Robinson, Juror Number 263, is
17 this your verdict?
18 JUROR NUMBER 263: Yes, ma'am.
19 THE CLERK: Is this still your verdict?
20 JUROR NUMBER 263: Yes, ma'am.
21 THE CLERK: Charles A. Jenkins II, Juror Number 171 --
22 JUROR NUMBER 171: Yes.
23 THE CLERK: Is this your verdict?
24 JUROR NUMBER 171: Yes.
25 THE CLERK: Is this still your verdict?

1 JUROR NUMBER 171: Yes.

2 THE CLERK: The jury has been polled, Your Honor.

3 THE COURT: All right. Ladies and gentlemen of the jury,
4 thank you very much for your service. Your jury service is
5 now complete. Thanks for hanging in there for two weeks.
6 This is a little bit of a long trial, the longest one I've
7 ever had. Some go longer certainly. There's been at least
8 one more prominent case this year that went for six weeks, but
9 typically ours are reserved to one week. So I very much
10 appreciate you being prompt and attentive and hanging in there
11 with us for the nearly two weeks.

12 You are no longer eligible to serve on a jury in Circuit
13 Court during the remainder of 2023. If you are summoned for
14 jury duty in 2024 or 2025, you'll have to report for jury
15 duty, but you can exercise an exemption. If you choose not to
16 serve, you'll just let the judge know that you served on a
17 jury here in Richland County this week, and they will excuse
18 you, provided that they have enough jurors, of course.

19 You're now free to discuss the case with whoever you want
20 to discuss it with. That includes the lawyers, parties,
21 anyone in the world. You can post it on Facebook, shout it
22 from the rooftops, whatever you want to do.

23 The lawyers may or may not want some feedback from you.
24 They're going to be in here sort of packing up and getting
25 ready to leave. If you don't want to talk to them, you'll

1 just go out the way you've been coming in down this back
2 hallway, the door at the end of the hallway. In fact, that's
3 probably the best way just in general.

4 If you do want to talk to them, though, you can pop your
5 head back in here, either through this door that you've been
6 entering through, or once you get out to the main hallway,
7 this door at the back of the room, and they may be in the
8 hallway. I don't know.

9 But work excuses will be brought to you in the jury room
10 as you're collecting your belongings, and I'm going to ask you
11 to stay and hang out in the jury room just for a second. I
12 just want to come back there and chat with you before you
13 leave, but you are dismissed from the courtroom at this time.

14 (WHEREUPON, the jury exited the courtroom at 6:38 p.m.)

15 THE COURT: Counsel, I anticipate that you intend to file
16 post-trial or make post-trial motions. I'll give you 10 days
17 to do that in writing. I think that's probably the best way,
18 if you choose to do it. If I don't hear from you in 10 days,
19 so be it, and I will just, you know, have the verdict entered,
20 but I think probably a written motion may be easiest because
21 the trial has been so long. There's so much testimony and
22 evidence.

23 If there is a written motion that I receive, then, of
24 course, I will give the defense the opportunity to respond in
25 writing. We can communicate all of it via email. It's

1 important that you not only file a motion, but make sure that
2 I have a copy of the motion, because otherwise I won't know
3 that the motion has been filed.

4 So thank you all.

5 MR. GOINGS: Thank you, Your Honor.

6 MR. DAVIS: Thank you, Your Honor.

7 THE COURT: Thank you, thank you. We are adjourned for
8 the week.

9 (WHEREUPON, the proceedings ended.)

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11 --- END REQUESTED TRANSCRIPT ---

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I, the undersigned, Krystal J. Smith, Official Court Reporter for the Twelfth Judicial Circuit of the State of South Carolina, do hereby certify that the foregoing pages, numbered 1 through 1822, constitute a true, accurate, and complete Transcript of Record of all the proceedings had and evidence introduced in the hearing of the above captioned case, relative to appeal, in the Court of General Sessions for Richland County, South Carolina, on the 10th through 20th days of April, 2023, to the best of my ability based upon the audio and notes provided.

I do further certify that I am neither of kin, counsel,
nor interest to any party hereto.

S / Krystal J. Smith

Court Reporter

Florence, South Carolina

April 24, 2025

STATE OF SOUTH CAROLINA) IN THE COURT OF COMMON PLEAS

COUNTY OF RICHLAND) 2019-CP-40-04185

Crystal Goodwin and)
James Goodwin,)

Plaintiff,) **Transcript of Record**

vs.)

June 1, 2023

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

Defendants.)

B E F O R E:

Honorable Jocelyn Newman
Richland County Courthouse
Columbia, South Carolina

A P P E A R A N C E S:

Robert F. Goings, Esquire
Francis M. Hinson, IV, Esquire
Attorneys for Plaintiff

Andrew Heitman, Esquire
Attorney for Defendants

Sallie Beth Todd
Official Court Reporter

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I N D E X

<u>WITNESS</u>	<u>DIRECT</u>	<u>CROSS</u>	<u>REDIRECT</u>	<u>RECROSS</u>

Gabrielle Ross	23			
Karen Withrow	33			
Austin Ford	38			
Michael Casto	42			
Robert Andreo	48			
Timothy Shealy	55			
Roxanne Lewis	62			
Michael Mitchell	69			
Tameka Harvey	74			
Jaekwon Robinson	78			
Charles Jenkins	86			
Stephanie Cribb-Creek	92			

Certificate of Court Reporter.....	123

E X H I B I T S

<u>NO.</u>	<u>DESCRIPTION</u>	<u>ID</u>	<u>EV</u>	<u>PAGE</u>

(There were no exhibits marked during this hearing.)

1 **THE COURT:** Okay. We are on the record in 2019-CP-40-
2 04185, Crystal Goodwin versus Midlands Orthopedics and
3 Neurosurgery. This hearing is on post-trial motions filed by
4 the plaintiff. I have -- the Court has subpoenaed all 12
5 jurors who deliberated on this case. I see not all 12 are
6 here necessarily, but Madam Clerk if you would call the roll
7 just to see who we do have.

8 **THE CLERK:** Yes, Your Honor.
9 Good morning. Gabrielle Ross; Karen Withrow.

10 **MS. WITHROW:** Here.

11 **THE CLERK:** Austin Ford.

12 **MR. FORD:** Here.

13 **THE CLERK:** Michael Casto.

14 **MR. CASCO:** Here.

15 **THE CLERK:** Robert Andreo.

16 **MR. ANDRIO:** Here.

17 **THE CLERK:** Timothy Shealy; Roxanne Lewis.

18 **MS. LEWIS:** Here.

19 **THE CLERK:** Michael Mitchell.

20 **MR. MITCHELL:** Here.

21 **THE CLERK:** Stephanie Cribb-Creek.

22 **MS. CREEK:** Here.

23 **THE CLERK:** Tameka Harvey.

24 **MS. HARVEY:** Here.

25 **THE CLERK:** Jaekwon Robinson; Charles Jenkins.

1 **MR. JENKINS:** Here.

2 **THE CLERK:** Okay. Your Honor, that completes the roll.

3 **THE COURT:** Okay. Thank you. Okay. So I'll take that
4 back from you.

5 **THE CLERK:** Yes, ma'am.

6 **THE COURT:** Thank you.

7 So, ladies and gentlemen, I don't hope to take up too
8 much of your time, but I need to talk to each of you about
9 this trial. I'm going to ask you certain questions. The
10 attorneys may or may not have questions for you concerning
11 this trial and deliberations and what occurred in the jury
12 room. What I would like to do is everyone except Ms.
13 Stephanie Cribb-Creek, I will excuse you to the jury room. I
14 will bring you back in one by one to talk to you individually.

15 Ms. Cribb-Creek, I'm going to have you actually step out
16 to another jury room. This is Ms. Sutton in the white shirt
17 here. She's going to go to the jury room down there with Mr.
18 Tolbert. The others will go to the jury room behind this
19 courtroom. Okay. And I will bring you back shortly. You can
20 follow Ms. Sutton.

21 All right. I've also invited the public defender's
22 office, Ms. Eigenbrot, is here from the Richland County Public
23 Defender's Office. I have called down to their office, and
24 I'll explain to you, Ms. Eigenbrot, this is a civil case, a
25 medical malpractice case that was tried over a two week period

1 approximately to verdict. But there were subsequent
2 allegations of juror misconduct. In particular, that
3 Stephanie Cribb-Creek, who I've separated from the other
4 jurors, may have made some statements, done some things,
5 failed to disclose some things that would have been material
6 to jury selection. We're here today to flush out those
7 allegations, but I've invited the public defender's office
8 here in the event that all of it turns out to be true, all of
9 the allegations turn out to be true and there needs to be a
10 contempt hearing at some point. We're not at that point yet,
11 but I thought it might be prudent to have counsel on the front
12 end, rather than trying to pay catch up after the fact if we
13 were to get to that point. So of course I'm happy for you to
14 stay in the courtroom. I've separated her from the others
15 because I have some indication that she may know why she's
16 here and I don't want her influencing the other jurors because
17 she's made phone calls, or at least a phone call, to
18 plaintiff's counsel asking questions, she's called my office
19 at least twice about whether she should appear and she didn't
20 do anything wrong, etcetera, etcetera. So I believe that she
21 may have some inkling as to why she's here and I don't want
22 her to persuade the other jurors to give inaccurate
23 information. I've excused the other ten who showed up from
24 the courtroom just because I don't want them influenced by
25 what each other says. I'll bring them in one by one, almost

1 like sequestering witnesses, or it is sequestering witnesses
2 because they're witnesses in this proceeding. I'll bring them
3 in to question them and of course they can stay in the
4 courtroom after that questioning. I think Ms. Cribb-Creek
5 will be the final juror called into the courtroom.

6 So let's get on the record from Mr. Goings, yeah, Mr.
7 Goings why we're here and some background before we get into
8 the witnesses.

9 **MR. GOINGS:** Yes, Your Honor. I know we had -- the Court
10 had reached out about trying to schedule a status conference
11 with Your Honor beforehand. I know there were some scheduling
12 issues by the defense. So I just wanted to kind of maybe put
13 on the record what I would have told you at that status
14 conference just to kind of bring this issue kind of full
15 circle to let you know kind of where we've been, where we've
16 come, and our position based on the communication that our
17 office received from Ms. Stephanie Cribb-Creek.

18 So after the verdict the foreperson actually approached
19 Ms. Gooding and I on the sidewalk after we had packed up our -
20 - were in the process of packing up our vehicle with a bunch
21 of boxes, she came up rather tearful and it was right there on
22 the corner of Main Street and I think Blanding. She
23 approached us rather tearful and she said I wanted to stand up
24 and say that was not my verdict, but I didn't know if I could
25 or not. And then she got more emotional and talked about a

1 nurse that she said took over the jury room and talked about
2 her personal experiences as a nurse, and the policies and
3 procedures as a nurse. And that in particular, hospital
4 procedures about blood pressure and they talked about who was
5 the captain of the ship and whose not the captain of the ship,
6 and actually used the phrase captain of the ship when she
7 talked to me, which I found to be troubling and odd and I can
8 get to that a little later because the parties never discussed
9 captain of the ship and the only mention of captain of the
10 ship would be in arguments to you, Your Honor, as it relates
11 to the motion in limine filed by the defense using the phrase
12 captain of the ship. We never talked about that in front of
13 the jury. And she talked about the policies and procedures
14 that the nurse went into and her personal experiences related
15 to blood pressure and what she does, what the hospital does.
16 And she said and this nurse she worked at the hospital there
17 and that's when Ms. Gooding asked, wait, she said she worked
18 at the hospital? She said, yeah, I'm pretty sure she said she
19 works at the hospital there. I'm not sure if she works there
20 now or used to work there, but she really took over the jury
21 room and kind of became the jury expert as to these medical
22 issues and we all ultimately kind of deferred to her.

23 And so then I said, well, ma'am, if it seems that we need
24 to get an affidavit from you, would you provide your phone
25 number and would you provide an affidavit. She said, yes,

1 because everything I'm telling you is true. I said, yes,
2 ma'am. We might need to get an affidavit and we exchanged
3 phone numbers there, okay, on the sidewalk.

4 And then we get back and I tell my two paralegals, I
5 said, you're not going to believe what this juror said. She
6 said there was this nurse Ms. Cribb and that she worked at the
7 hospital and they -- now this was at night, now. They're at
8 my office and they're research on Stephanie Cribb-Creek and it
9 keeps coming up as Prisma. LinkedIn comes up as Prisma. Then
10 they do a public record index search, and it comes up that she
11 -- that Stephanie Cribb worked at Prisma and was actually sued
12 for malpractice at Prisma. Then -- that was that night.

13 Then the next morning I contacted Ms., I forgot her name,
14 Gabrielle Ross. I contacted Ms. Ross and said, would you be
15 willing to provide a statement. Mr. Hinson had come to my
16 office at that time and we talked to her on the phone and what
17 she said we put down in a statement and made it an affidavit
18 form and we read it over to her. She said absolutely, that's
19 100 percent correct. She then gave us her address. Mr.
20 Hinson drove out to her apartment, kind off of Percival Road,
21 and she read it again. I told her we wanted to make sure it
22 was very clear and correct, that was very important to us, I
23 said because the Court may have questions about it. And she
24 said, well everything in this is true. I said, okay, thank
25 you for signing it.

1 Then we filed that motion the day after the verdict
2 because we thought that it was an important matter that Your
3 Honor needed to look into and all of the parties needed to
4 look into, okay.

5 And then opposing counsel filed their response and then
6 it was not until last Wednesday when I was at the -- Wednesday
7 morning, that I was -- actually like 6 o'clock in the morning,
8 I was cooking a barbeque pig ---

9 **THE COURT:** Let me interrupt you. Is this Mr. Robinson,
10 Jaekwon Robinson?

11 **MR. ROBINSON:** Yes, ma'am.

12 **THE COURT:** Come on forward. So as I explained to the
13 other people who served on this jury, this is the Crystal
14 Goodwin case, the medical malpractice case on which you sat as
15 a juror. I'm going to have some questions of all 12 of the
16 jurors in just a little while. But until we get to that
17 point, I'm going to have you go back to the jury room and
18 we'll bring you in in just a little while, okay.

19 **MR. ROBINSON:** Okay.

20 **THE COURT:** Thank you, sir.

21 Go ahead, Mr. Goings.

22 **MR. GOINGS:** Thank you, Your Honor. And I'm providing
23 this kind of chronological understanding from the plaintiff's
24 standpoint because I do want you to understand that candor to
25 the Court is very important from our standpoint, so that's why

1 I'm telling you this.

2 So Wednesday morning apparently we find out, I'm at the
3 law school cooking for the law school barbeque, and I think
4 Tuesday night she called our office and left a voicemail with
5 our answering service saying that you've got the wrong
6 Stephanie Cribb, wrong person, I have documentation to prove
7 it. Then Ms. Gooding called me while I was literally cooking
8 the barbeque pig at the very beginning of it, like 6:30, 7
9 o'clock in the morning. I said well we've got to send the
10 voicemail and message that we received directly to the Judge
11 via email to let her know of this discovery, and we let
12 opposing counsel know, and that's what we did. And we have
13 not filed our email to the Court and our voicemail that we
14 submitted to you, but we have supplied that to the Court.

15 Our position from the plaintiff's standpoint is we have
16 no reason to believe that she is misrepresenting to us that
17 it's the wrong Stephanie Cribb, okay. We've done some
18 additional further research and it's still inconclusive
19 because when we did a skip trace, the Stephanie Cribb-Creek
20 and Stephanie Austin Cribb, they are found on the same
21 background searches. So I think the background search
22 overlaps the two names. But we have no reason to believe that
23 she is misrepresenting to us or eventually the Court that it's
24 the wrong Stephanie Cribb. If that is the case that it's the
25 wrong Stephanie Cribb or another Stephanie Cribb, then we

1 would obviously withdraw those particular arguments to our
2 motion for juror misconduct, but there's still some bigger
3 issues and other issues in that motion for juror misconduct.

4 I tell you that because we would withdraw those
5 allegations, but I do want Your Honor to know that when we
6 filed the motion the day after the jury verdict, those were
7 obviously filed in good faith because we thought that was
8 something immediately the Court needed to know. That's why we
9 didn't waste any time, we filed it based on the information we
10 had. And then when we got updated information from the jurors
11 themselves, Your Honor, we supplied that. So I just wanted
12 you to know from the plaintiff's standpoint that, and not that
13 you would believe otherwise, but that the candor to the Court
14 as it relates to our position is important. And we've told
15 defense counsel as well that our intention is to withdraw
16 those particular allegations in the motion alleging juror
17 misconduct, assuming that Ms. -- this is not the Cribb-Creek
18 that worked for Prisma, okay.

19 **THE COURT:** Right.

20 **MR. GOINGS:** And we're happy to answer any questions that
21 Your Honor may have about our communication with the forelady
22 and getting the affidavit. But it was just like when the
23 forelady was telling us in a tearful manner, you know, that
24 she's a nurse. She said she worked there, but I don't know if
25 she works there now. I mean I think the foreperson was

1 confused about her involvement in what hospital, but I don't
2 think the foreperson was trying to mislead us either.

3 **THE COURT:** Right.

4 **MR. GOINGS:** So ---

5 **THE COURT:** Okay.

6 **MR. GOINGS:** But to the extent that we need to file our
7 email to Your Honor with the voicemail that we received from
8 Ms. Cribb-Creek, we're happy to do that. I just want to make
9 sure that the record is complete on that.

10 **THE COURT:** Absolutely.

11 **MR. GOINGS:** Thank you.

12 **THE COURT:** Thank you for that.

13 And so the Court's intention is to bring each juror in,
14 as I said, one by one, ask them about their recollections of
15 deliberations and whether Ms. Cribb-Creek said any of the
16 things that she is alleged to have said. I plan to question
17 each juror. I don't know if counsel has questions prepared
18 for jurors, that's actually back to the status conference that
19 I was going to have yesterday, a little planning meeting sort
20 of, yesterday or the day before I don't remember. But the
21 plan there was to just discuss how today's hearing would go
22 because this is sort of an unconventional procedure, maybe not
23 unconventional but rarely used procedure.

24 So does counsel intend to ask questions of jurors, Mr.
25 Goings?

1 **MR. GOINGS:** Well in candor, we didn't know that all of
2 the jurors were coming. I knew that the foreperson was
3 subpoenaed because she contacted our office and said that she
4 got a subpoena from our office to come to court, and we told
5 her we didn't sent that subpoena and it was based on the
6 motion that we filed based on her affidavit. We also knew Ms.
7 Cribb-Creek was coming because she contacted our office and
8 again said that we subpoenaed her as well. We explained that
9 we didn't subpoena her, but we would pass on her sentiments to
10 Your Honor, which we did.

11 So I can discuss with my co-counsel if we plan on asking
12 any questions. We may have several that we can hand up to
13 Your Honor if you want to be the one to ask them.

14 **THE COURT:** Yeah, that's probably the best course of
15 action, and that goes for defense counsel too. I will ask
16 questions and I guess what I need help with is determining
17 whether I've left anything out or glossed over anything, and
18 that's from both parties. It'd probably be better for me to
19 ask the questions because I don't want them to feel that
20 they're being cross examined or that they're in some trouble
21 or, you know, that they're in the hot seat now.

22 Mr. Hinson.

23 **MR. HINSON:** Yes, Your Honor. Kind of in the same spirit
24 of candor with the Court, or to the Court, I wanted to mention
25 the two jurors that approached me or that I was otherwise able

1 to speak with included Roxanne Lewis and Charles Jenkins. And
2 from them I gleamed a very similar discussion in the jury
3 deliberations, which was regardless of whether or not Ms.
4 Stephanie Creek-Cribb or Cribb-Creek worked for Prisma,
5 essentially what I gleamed was that they became -- she became
6 an expert in the deliberation room. And so to the extent that
7 our motion for juror misconduct, should it be withdrawn, you
8 know, and should she under oath say we've got the wrong
9 person, with all respect to her, we believe some unintentional
10 misconduct took place in that there was basically an expert
11 sitting back there in the deliberations which every one cowed
12 down to. So again, I just wanted to mention the two that I
13 had spoken to at the conclusion of the trial.

14 **THE COURT:** Absolutely. And I'll also put on the record
15 that after receiving the verdict I did go back to the jury
16 room to talk with the jurors. I was curious, as I often am,
17 as to how they reached their verdict and we talked for five or
18 ten minutes. The foreperson was visibly upset by the verdict.
19 She did not tell me that it was not her verdict, but she was
20 visibly upset, sort of -- she was not crying but seemed on the
21 verge of crying. I don't know which juror mentioned captain
22 of the ship, if they had heard that Doctor Holbrook was
23 captain of the ship or something along those lines their
24 verdict might have been different. I was actually taken
25 aback, but in my mind I chalked it up to maybe at some point

1 someone objected, counsel objected based on captain of the
2 ship, maybe, maybe not. I was trying to figure out where
3 those words came from.

4 They also talked about policies and procedures and not
5 have received sufficient testimony about policies and
6 procedures that may have changed the way they viewed things.
7 So you know of course I didn't know we would end up here, and
8 so I didn't -- I don't remember it exactly, but I do remember
9 the topics of policies and procedures and captain of the ship
10 came up in my conversations with the jurors which raised my
11 eyebrows, but I probably would have paid a little closer
12 attention or made mental notes had I known that we would end
13 up here.

14 Yes, sir, Mr. Heitman.

15 **MR. HEITMAN:** Your Honor, I believe Ashby objected at one
16 point and did mention captain of the ship. And at some point,
17 you know, I would like to make an objection to this juror
18 affidavit, as well as juror testimony being admissible in this
19 proceeding. I don't know if you'd like to hear that now?

20 **THE COURT:** Sure.

21 **MR. HEITMAN:** Okay.

22 **COURT STAFF:** What's your name?

23 **MR. HEITMAN:** Sir?

24 **COURT STAFF:** What's your name?

25 **MR. HEITMAN:** Andrew Heitman, H-E-I-T-M-A-N.

1 **THE COURT:** What's your objection, sir?

2 **MR. HEITMAN:** Well, Your Honor, juror testimony is only
3 admissible if there are allegations of external juror
4 misconduct or if the allegations of internal juror misconduct
5 rise to the level of violating a parties' due process rights.
6 State v Zeigler, which is 610 S.E. 2d 859, the Court of
7 Appeals in 2005 said as a general rule juror testimony is
8 inadmissible to impeach a jury verdict. They continued to say
9 that if the alleged misconduct is internal, the courts are
10 more strict.

11 In State v Hunter our Supreme Court said that juror
12 testimony is only competent in cases involving internal
13 misconduct where necessary to insure due process. An example
14 of internal misconduct that deprives a party of due process is
15 racial prejudice playing a roll in determining the verdict,
16 and that's been mentioned in a verdict -- an opinion by the
17 Court. Here we allegations of juror misconduct that took
18 place inside the jury room stemming from Stephanie Cribb-
19 Creek's opinions. There's no allegation of an external
20 manipulation or external forces swaying the jury. There's no
21 allegation of racial prejudice or other egregious event
22 triggering constitutional fundamental fairness concerns which
23 impend on due process.

24 Some examples of cases that have external misconduct
25 would be **State v Harris**. In that case the Court held that

1 jurors misconduct in consulting a legal dictionary for
2 definitions of malice aforethought and manslaughter did not
3 entitle the defendant to a new trial. In State v Kelly the
4 Court held that a juror's misconduct in sharing a pro death
5 penalty pamphlet with other jurors during the penalty phase
6 did not violate defendant's right to a fair trial. In State v
7 Lawson the Court ruled that the fact the two jurors read a
8 newspaper article discussing alleged extraneous crimes by the
9 defendant and summarizing testimony did not entitle defendant
10 to a mistrial. In Stone v City of Florence the Court said
11 that an action against the city for injuries sustained by
12 stepping into an unprotected drain hole, some of the jurors
13 visited the scene of the accident and stepped from the curb
14 into the hole. The plaintiff was not entitled to a new trial
15 on those grounds.

16 **THE COURT:** Would y'all like to respond?

17 **MR. GOINGS:** Well on Page 8 of our motion for a new trial
18 based on juror misconduct we site the Ethier versus Fairfield
19 Memorial Hospital case. It's a 2020 opinion from South
20 Carolina Supreme Court. The South Carolina Supreme Court held
21 that an affidavit of a juror is permissible for purposes of
22 showing that juror misconduct affected the fundamental
23 fairness of trial in the deliberation phase. And so you know
24 it reasons that if the Court can consider an affidavit, which
25 is sworn testimony, then the Court can examine the jurors

1 under oath as well. So with respect to his motion, we would
2 show that the clear case law as of 2020 says that testimony
3 from jurors as an acceptable form of testimony or evidence in
4 this type of case involving allegations of juror misconduct.

5 **MR. HEITMAN:** Your Honor, the Ethier case cites -- that
6 Mr. Giongs cites, that case deals with premature juror
7 deliberations which is internal misconduct that violated the
8 other party's due process rights. As I mentioned earlier in
9 my argument, we don't have a situation in that case.

10 **THE COURT:** Is that all that Ethier was about?

11 **MR. HEITMAN:** It was about premature juror deliberations.
12 Yes, Your Honor.

13 **THE COURT:** Internal juror concealment of matters that
14 affected the fundamental fairness of the trial was also a
15 subject of the Ethier decision.

16 **MR. HEITMAN:** I'm sorry, was that concealment during the
17 jury selection process, because I believe that they've
18 withdrawn that argument.

19 **THE COURT:** They haven't, I don't believe, withdrawn any
20 argument yet. They're willing to withdraw the argument based
21 on the testimony of the jurors. What I heard is if they were
22 wrong in those allegations, they are happy to withdraw those
23 arguments. They were trying to act quickly and based on the
24 information that they had at the time. If that turns out to
25 be inaccurate information, then pursuant really to ethical

1 rules, Rule 11 and everything else, then they would withdraw
2 that argument.

3 **MR. GOINGS:** That's correct.

4 **MR. HEITMAN:** Your Honor, in plaintiff's email to the
5 Court that we were copied on, I believe it said that they
6 wanted to go forward only on the allegations of internal -- of
7 jury misconduct as well as the 13th juror.

8 **THE COURT:** I've not read any of those emails and that's
9 not what's been presented to me today. So the Court is going
10 to enquire, take testimony, of the jurors and we'll do that
11 right now.

12 Mr. Bowen, if you'll go back to the jury room and bring -
13 --

14 **MR. GOINGS:** Your Honor, to answer your question that no
15 one answered if we have a question --- you're going to ask
16 questions to the juror, we're going to listen, if there's
17 anything that's left out, that we need to supplement then Your
18 Honor we're going to come and approach; is that correct?
19 Write it down? How do you want to do it?

20 **MR. HINSON:** Could I ask, Your Honor, could we take just
21 maybe four or five minutes to talk amongst ourselves to
22 potentially submit at least questions or topics that we might
23 ask you -- we might not have any, but I would like to talk to
24 my co-counsel and potentially suggest some topics.

25 **THE COURT:** Sure. Let's do that. Take just a few

1 minutes.

2 **MR. HINSON:** Thank you, Your Honor.

3 **(COURT IS IN RECESS)**

4 **THE COURT:** Yes, sir, Mr. Goings.

5 **MR. GOINGS:** I'm going to read for the record some
6 general topics and then I can hand it up to you. First, did
7 the nurse on the jury, when we say the nurse on the jury we're
8 talking about Ms. Creek, speak to her personal experience of
9 working in hospitals. Did any particular -- as it relates to
10 the jurors, did the jurors refer to the nurse on issues
11 regarding hospital policies and procedures generally and what
12 they would also be regarding blood pressures or the roll of a
13 surgeon or the roll of an anesthesiologist? Did the jurors
14 refer to the nurse on personal experiences as to the way
15 things are done in a hospital? Defer to the nurse as to her
16 medical opinions, medical expertise, and her understanding of
17 the job of a surgeon versus the job of an anesthesiologist?
18 Did they defer to the nurse as to this whole captain of the
19 ship that was discussed in deliberation?

20 And I'll say this, that multiple jurors that we did speak
21 to say that we were not able to prove that he was the captain
22 of the ship, they used the phrase captain of the ship, you
23 know, that's not the law in South Carolina. Captain of the
24 ship is not a legal doctrine that is even the correct standard
25 of law. Also, did they defer to the nurse on the jury

1 regarding on how to determine a baseline blood pressure, how
2 she determines baseline blood pressure?

3 And so, Your Honor, these are just kind of general
4 topics, but I'm sure you have some as well.

5 **THE COURT:** All right. Mr. Heitman.

6 **MR. GOINGS:** And then as it relates to ---

7 **THE COURT:** Oh, I'm sorry. Go ahead, Mr. Goings.

8 **MR. GOINGS:** Specifically to Ms. Cribb-Creek, how did she
9 discover that plaintiff's motion -- I will say that we didn't
10 contact her about the motion. The defense didn't contact her
11 about the motion. She contacted us about the motion and told
12 us that the statements in that motion were incorrect. So how
13 she got the motion, also to the issues of how were they
14 talking about captain of the ship? The only writings of
15 captain of the ship were also filed on the public index. Did
16 she ever look at the public index, and in particular did she
17 discuss plaintiff's motion with anyone else here, any of the
18 other jurors. And her contact and communication with any
19 other jurors post-verdict. Thank you, Your Honor.

20 **THE COURT:** Do you have that written down or can you?

21 **MR. GOINGS:** I have it generally speaking.

22 **THE COURT:** Okay. Mr. Heitman.

23 **MR. HEITMAN:** I have a few questions that I would like to
24 be asked as well. The first is, did the jury take a vote
25 right away, and if so how many were for the defense or

1 plaintiff? The second question is did you refer to the
2 Judge's printed instructions during deliberations? How often
3 or approximately how many times? And then also, was everyone
4 in agreement at the end of deliberations on the verdict?

5 **THE COURT:** If you'll -- those are written down? Can you
6 give me ---

7 **MR. HEITMAN:** I'm trying to finish transcribing them.

8 **THE COURT:** Okay. All right. Mr. Bowen, would you bring
9 in -- just go knock on the jury room door and get Gabrielle
10 Ross.

11 **BAILIFF:** Gabrielle Ross.

12 **THE COURT:** The rest can stay back there.

13 I'm going to have her in the middle seat on the front
14 row.

15 If you'll come on forward and sit in that middle seat.
16 Okay. We're going to make sure that microphone can get you.

17 **MS. ROSS:** I know y'all are all about that microphone.

18 **THE COURT:** This courtroom is a little bit better than
19 that one, but still it's weird.

20 Madam Clerk, would you place Ms. Ross under oath after
21 you hand me that piece of paper?

22 **THE CLERK:** Yes, Your Honor.

23 **THE COURT:** Thank you.

24 **GABRIELLE ROSS, HAVING BEEN DULY SWORN TESTIFIES**

25 **AS FOLLOWS:**

1 **MS. ROSS QUESTIONED BY THE COURT:**

2 **THE COURT:** All right. You can have a seat. And let me
3 just tell you, you're not in any trouble at the outset. I
4 just need some information about deliberations.

5 You, after deliberations, completed and signed an
6 affidavit that you gave to Mr. Goings or his associates; is
7 that right?

8 **MS. ROSS:** Yes.

9 **THE COURT:** Okay. And I'm just going to ask you about
10 the things in the affidavit. Starting with you were the
11 foreperson of the jury, right?

12 **MS. ROSS:** Yes, the one with the giggles.

13 **THE COURT:** Yes, the one with the giggles, exactly.
14 Do you remember a nurse being on the jury?

15 **MS. ROSS:** Yes. I don't recall her name, but yes.

16 **THE COURT:** Okay. We'll just refer to her as the nurse
17 then. Did that nurse talk about working at a hospital?

18 **MS. ROSS:** Yes. From my understanding, what I remembered
19 her saying, she worked currently at the VA, but she had
20 experience -- I don't want to lie, if my memory serves me
21 correctly, but I believe Prisma. She had either done work
22 there or worked there. I don't want to quote it because it's
23 fuzzy.

24 **THE COURT:** Okay. And is that something that she
25 mentioned just in y'all having chitchat? And I say this

1 because I know I tell y'all don't discuss the case until it's
2 time to deliberate, right. So was it chitchat like you're
3 talking about the weather and where everybody works, or did
4 that come up when you were discussing the case, deliberating
5 about the case?

6 **MS. ROSS:** I remember it coming up during deliberation.
7 She was the first one to speak and she -- we were basically
8 trying to figure out what we were going to talk about that
9 would determine what the verdict was going to be, and she ---
10 we could not let go of the baseline blood pressure, we heard
11 it so much during trial. So she basically went on to explain
12 how when she was working how they would determine their
13 baseline blood pressure and how you know basically it wasn't
14 a, not quoting, but pretty much a relevant factor in how they
15 made decisions.

16 **THE COURT:** Okay. So she did speak about her personal
17 experience in working at a hospital?

18 **MS. ROSS:** Yes, ma'am.

19 **THE COURT:** Did she talk about hospital policies and
20 procedures at all?

21 **MS. ROSS:** I -- it's been a while. I vaguely remember.
22 I don't want to lie and say she didn't because that one is
23 kind of fuzzy.

24 **THE COURT:** Okay. So let's do it this way, you did
25 complete the affidavit and it looks like that was done on

1 April 21st, so more than a month ago. Would your recollection
2 have been better then when you did the affidavit? So if it
3 says in the affidavit that the nurse did talk about hospital
4 policies and procedures, would that be accurate?

5 **MS. ROSS:** Yes, I was about to say -- because I
6 personally came to the lawyers to give feedback, so my memory
7 was much better then.

8 **THE COURT:** Okay. Did she talk about, I guess I've asked
9 about policies and procedures, but did she talk about just the
10 way things are normally done in a hospital?

11 **MS. ROSS:** Yes. I definitely remember her saying how
12 they did things when she was working.

13 **THE COURT:** Okay. Did she talk about what the surgeon's
14 job is versus the anesthesiologist's responsibilities or
15 anything like that?

16 **MS. ROSS:** In a way. So we're talking about basically
17 how -- I brought up the fact that as the surgeon, Doctor
18 Holbrook is in turn essentially responsible for picking up the
19 pieces wherever someone is lacking because you know doctors
20 say this is my OR, this is my OR, and you ask a surgeon even
21 though you're directly responsible for just what you're doing
22 at the moment -- and I had my personal opinions because I've
23 had plenty of surgeries. And I personally thought to myself
24 whenever I had a surgery, my doctor, the only one that has
25 done surgery on me, he goes by my history because you know

1 that's what it is.

2 I'm trying to remember her exact comment. She said
3 something about yes, but does -- something about the
4 anesthesiologist and the surgeon being like co-heads. That it
5 wasn't necessarily anyone's OR, something to that nature. I
6 can't exactly remember.

7 **THE COURT:** Okay. Did -- have you heard the term captain
8 of the ship?

9 **MS. ROSS:** Yes. It was brought up several times in the
10 jury room.

11 **THE COURT:** And who brought it up? Do you remember
12 whether it was the nurse or someone else?

13 **MS. ROSS:** I think TJ brought that I up, Charles, I think
14 his name was.

15 **THE COURT:** Okay.

16 **MS. ROSS:** But I do remember us talking about it. I'm
17 kind of fuzzy about who exactly brought it up.

18 **THE COURT:** Okay. Did the nurse ever talk about that
19 topic, captain of the ship?

20 **MS. ROSS:** Yes, it was definitely. The main ones when we
21 were discussing that portion of the discussion was me, he
22 called himself TJ, and the nurse, I can't remember her name,
23 the one I guess in discussion. We were basically talking
24 about -- I think chain of command was the exact term that was
25 used, and we were trying to differentiate exactly who would be

1 the top of that chain of command. And she said something
2 along the lines of, well in the operating room it's not
3 necessarily one person that's the head of everybody.
4 Everybody has their specific jobs, and it's not the
5 responsibility of just one person to dictate what's done in
6 the OR, in so many words, I'm not quoting.

7 **THE COURT:** Okay. And you said the term captain of the
8 ship was brought up. Had you heard it before that time? Had
9 you heard that phrase before that you can think of?

10 **MS. ROSS:** Not that I can think of.

11 **THE COURT:** Did you know what that meant before that day?

12 **MS. ROSS:** It's pretty obvious, but ---

13 **THE COURT:** Right. Okay. So just it was self-
14 explanatory?

15 **MS. ROSS:** Yes.

16 **THE COURT:** But did you have any greater knowledge about
17 that phrase beyond it just being self-explanatory? I mean you
18 can kind of figure out what it means, but prior to
19 deliberations did you know anything about that phrase?

20 **MS. ROSS:** No, ma'am.

21 **THE COURT:** Before you came here today, did anybody tell
22 you why you were coming today?

23 **MS. ROSS:** Yes, because I had personally -- when I
24 received the subpoena, I had a little -- I expected when I
25 first approached the defense about my personal feelings,

1 because I'm going to be honest, when I left the courtroom I
2 was kind of uneasy about my decision. And my original
3 thoughts and feelings when I explained my case, not my case,
4 but how I was feeling it seemed like there was always a
5 rebuttal, the majority of the time from Stephanie. So at that
6 moment in time it was just like we was at the point where it
7 was like some people felt like it was his decision. It was a
8 few people that brought up, you know, kind of felt like I
9 felt. And then as the deliberation went on we all just came
10 to a standstill, like no one -- well some people actually had
11 their feelings but it was like -- at that moment it was like,
12 okay, since we can't make a decision, not necessarily knowing
13 -- I feel like we didn't take into account the instructions
14 that you gave us. It wasn't off of what was presented. We
15 were going through the different evidence that was presented
16 and trying to basically figure out the case and that wasn't
17 what we were supposed to do. So when I recollected that and I
18 thought back on it, I was like that wasn't done right. So
19 that's what originally made me say something about it, because
20 I don't feel like we deliberated, or not deliberated, made the
21 decision according to the instructions that were given to us.
22 And me, as the foreperson, I was supposed to do that and I
23 didn't.

24 **THE COURT:** Do you fell like you were in charge of the
25 deliberations or was Stephanie?

1 **MS. ROSS:** Kind of sort of. I don't -- really, I'm going
2 to be honest, I didn't want to do it so I kind of like fell
3 back. I tried to keep everybody in line, keep everybody from
4 talking over each other, but I kind of like faded away as
5 things progressed.

6 **THE COURT:** Do you think that the jury was influenced, or
7 I'll ask about you personally, whether your verdict would have
8 been different if the nurse Stephanie had not made the
9 comments that she made?

10 **MS. ROSS:** Oh, I definitely do because I went in, you
11 know we had a lot of time to process a lot of information and
12 not being able to talk about it throughout, it was kind of
13 hard to digest. It was a lot of things being thrown at us and
14 I feel like some of the things that should have been -- would
15 have been helpful for us weren't admitted into evidence for us
16 to look at. So basically all we were going off of was pretty
17 much personal knowledge or what was in front of us. And since
18 all of us are sitting here like we have all of these papers
19 and we really don't know what they mean and we have someone
20 like, you know, that's basically done like this in this field
21 and you have people -- because there were some who had their
22 personal opinions, they felt like he wasn't -- but I felt like
23 a few of the people that were really passionate, like they
24 were saying it's his OR, he's negligent. As time went by they
25 just stopped talking and then next thing you know the

1 conversation was in that direction. I honestly feel like
2 everybody was just ready to -- we didn't really know what we
3 were doing so we were like, okay, this is what it's going to
4 be.

5 **THE COURT:** Okay. Right. So I asked you about talking
6 to or knowing why you were here today. How did you find out?
7 Did you call Mr. Goings office or who did you talk to about
8 why you were here today? Or did you just know it because you
9 had given them an affidavit?

10 **MS. ROSS:** Well once I was given the subpoena, I reached
11 out to Mr. Goings because I thought I was in trouble.

12 **THE COURT:** Right. That's fair. I should have sent a
13 cover letter with it saying you are not in any trouble.

14 **MS. ROSS:** But our conversation was very vague. He was
15 like, you know, it's not because you're in trouble. He did
16 let me know that he thought that all of the jurors were being
17 called back and that was the end of the conversation. Once I
18 found that out I was like okay. I kind of put it together and
19 found out that was ---

20 **THE COURT:** Okay. Anything else from the plaintiff?

21 **MR. GOINGS:** No, Your Honor.

22 **THE COURT:** Mr. Heitman, I'll tell you that I've reviewed
23 the questions that you've submitted. I have touched on the
24 ones that I find appropriate. Is there any additional
25 questions that are not on this page, though, let's talk about

1 that.

2 **MR. HEITMAN:** Yes, Your Honor. Do you want me to pass
3 them up?

4 **THE COURT:** Yes, please. Thank you.

5 Right. Did you discuss why you're here today with any of
6 the other jurors?

7 **MS. ROSS:** Earlier when we were in the courtroom, but I
8 don't know any of them personally. I just, I'm not trying to
9 add on anything, but just me personally, like I said, I'm not
10 trying to throw anybody under the bus. I do not think that
11 she was malicious. I just felt like, you know, if you were
12 having a conversation with someone and the conversation was
13 law related, sometimes eventually it will come as habit. So
14 honestly I don't feel like she was malicious in her intent, I
15 just felt like maybe it would have come as trying to guide us
16 because we were all confused as to exactly what we need to be
17 discussing, so I just wanted to make that known.

18 **THE COURT:** Thank you. I appreciate that. So do -- in
19 your deliberations did the experts testimony come up or were
20 you guided by Stephanie's expertise?

21 **MS. ROSS:** We did talk briefly about experts, there were
22 so many. That definitely was a big topic of the conversation.
23 There were so many contradicting statements, and from what I
24 recall, I don't remember us talking about who was more
25 credible. I just remember us having a conversation about how

1 the experts they all had contradicting statements, both on
2 defense and plaintiff's side. So we spent some time talking
3 about the experts and their testimony, but not a whole lot.

4 **THE COURT:** Do you feel like what Stephanie was talking
5 about was part of her expertise in the operating room or in
6 the field?

7 **MS. ROSS:** Definitely. That was one of her first
8 statements, as I was saying earlier, was what her personal
9 experience is. And if I misspoke about her, because I did
10 mention I thought she said something about working at Prisma,
11 so if that was me false accusing I do apologize for that.
12 That was just something I thought I heard her say.

13 **THE COURT:** Absolutely. And that's why we're here, to
14 figure out what's actually going on. She's here to. All
15 right. Well, thank you. Thank you for coming. You were
16 under subpoena, so you didn't have much of a choice, but ---

17 **MS. ROSS:** I knew it was coming. I knew what I was doing
18 when I came up, and when I see something I have to go with my
19 spirit. When I came back to the courtroom after deliberation
20 if didn't feel right, so I had to say something.

21 **THE COURT:** All right. Thank you. And that's important
22 to speak up and say something. So you are now free to go.
23 You can stay if you want and see what the other jurors have to
24 say or you can go to home, work, TJMaxx, wherever you want to
25 go, but you're free to go.

1 **MS. ROSS:** Thank you.

2 **THE COURT:** Thank you. And you can come out this, yeah.
3 Mr. Bowen, would you go get Karen Withrow.

4 **BAILIFF:** Karen Withrow.

5 Madam Clerk, would you swear the juror, please.

6 **THE CLERK:** Yes, Your Honor.

7 **KAREN WITHROW, HAVING BEEN DULY SWORN TESTIFIES**

8 **AS FOLLOWS:**

9 **MS. WITHROW QUESTIONED BY THE COURT:**

10 **THE COURT:** All right. Ms. Withrow was juror number 349.
11 Do you know why you're here today?

12 **MS. WITHROW:** Bits and pieces.

13 **THE COURT:** Okay. How did you come to learn why you're
14 here today? Obviously you got a subpoena, obviously it's in
15 reference to this trial. Did you talk to anybody before today
16 about why you were coming today?

17 **MS. WITHROW:** No, just today outside.

18 **THE COURT:** Okay. Good enough.

19 **MS. WITHROW:** Yes.

20 **THE COURT:** So you were a juror for the trial of Ms.
21 Crystal Goodwin's case. And I'll tell you, you're not in any
22 trouble. I just have some questions about the deliberations.

23 **MS. WITHROW:** All right.

24 **THE COURT:** Do you remember there being a nurse on the
25 jury?

1 **MS. WITHROW:** Yes.

2 **THE COURT:** Do you remember who the nurse was or her
3 name?

4 **MS. WITHROW:** Stephanie.

5 **THE COURT:** Stephanie.

6 **MS. WITHROW:** I don't know her last name.

7 **THE COURT:** Okay. Did Stephanie talk about working at a
8 hospital ever during the deliberations?

9 **MS. WITHROW:** Just the VA hospital.

10 **THE COURT:** Okay. Do you know how long she's worked at
11 the VA?

12 **MS. WITHROW:** I don't remember her saying.

13 **THE COURT:** Okay. And did she talk about working at any
14 other hospitals besides the VA?

15 **MS. WITHROW:** No.

16 **THE COURT:** Okay. Have you heard the term captain of the
17 ship?

18 **MS. WITHROW:** Yes.

19 **THE COURT:** And when for the first time had you heard
20 that term? Was it in context with this case or before that?

21 **MS. WITHROW:** Before that.

22 **THE COURT:** Okay. Do you know what that term means?

23 **MS. WITHROW:** The one in charge is the captain.

24 **THE COURT:** Right. Did it come up in this case in the
25 jury's deliberations?

1 **MS. WITHROW:** Not that I remember, no.

2 **THE COURT:** Okay. Did Stephanie ever talk about her
3 personal experience working in the hospital that you recall?

4 **MS. WITHROW:** In the VA, just their dermatology. I know
5 she was talking about dermatology.

6 **THE COURT:** Okay.

7 **MS. WITHROW:** I have a skin condition, so we were talking
8 about that.

9 **THE COURT:** That's fair. Did she ever talk about
10 hospital policies and procedures that you recall?

11 **MS. WITHROW:** No, not that I recall.

12 **THE COURT:** Do you remember her talking about what a
13 surgeon's responsibility is versus the anesthesiologist's
14 responsibility?

15 **MS. WITHROW:** No, not off the top of my head. I'm sorry.

16 **THE COURT:** No, that's fine. Do you remember her talking
17 about how to determine baseline blood pressure, a term which
18 came up a lot during the trial, baseline blood pressure?

19 **MS. WITHROW:** When we were deliberating she may have
20 mentioned something, but I don't -- I don't remember if it was
21 anything substantial.

22 **THE COURT:** Okay.

23 **MS. WITHROW:** I think we all discussed it. I mean it
24 wasn't just specifically her, it was everyone was saying it.

25 **THE COURT:** Okay.

1 **MS. WITHROW:** I mean there were a couple people with
2 medical backgrounds, wasn't there, if I remember right. So we
3 all kind of ---

4 **THE COURT:** Could be. I don't know.

5 **MS. WITHROW:** I thought so, but ---

6 **THE COURT:** Okay. Do you think that the jury's
7 deliberations were guided by the Court's instructions on the
8 law and the testimony, or do you think that there were some
9 outside factors of any kind, or someone bringing their own
10 expertise to the deliberations, or a combination?

11 **MS. WITHROW:** I think we tried to really focus on what
12 happened and not the external stuff, like the emotional side
13 of things, which you know that's hard to do.

14 **THE COURT:** Absolutely.

15 **MS. WITHROW:** But that's what we were focusing on.

16 **THE COURT:** Okay. Any additional questions from
17 plaintiff?

18 **MR. GOINGS:** May we approach?

19 **THE COURT:** Yes.

20 **REPORTER'S NOTE:** (Whereby bench conference was held.)

21 **THE COURT:** Do you remember when Stephanie said that she
22 worked at the VA? Was that during deliberations or when y'all
23 were sitting back there during any of those breaks when you
24 weren't supposed to deliberate?

25 **MS. WITHROW:** Right. No, I think we talked about it

1 before deliberation.

2 **THE COURT:** Okay. Did you talk about it during
3 deliberation?

4 **MS. WITHROW:** I'm not sure whether she mentioned the VA
5 during deliberation, but we knew that prior to that so ---

6 **THE COURT:** Right. Did you talk about -- have you talked
7 about Stephanie's employment or anything outside of this
8 courtroom today?

9 **MS. WITHROW:** No.

10 **THE COURT:** And you don't recall her mentioning any other
11 hospital that she worked at?

12 **MS. WITHROW:** No.

13 **THE COURT:** Okay. Anything additional from the defense?

14 **MR. HEITMAN:** No, Your Honor.

15 **THE COURT:** From the plaintiff?

16 **MR. GOINGS:** No, Your Honor.

17 **THE COURT:** Okay. Thank you so much for being here. You
18 are free to go. That's all I've got for you. You can go.

19 **MS. WITHROW:** Thanks.

20 **THE COURT:** Thank you. Thank you. You can go out this
21 back door.

22 Mr. Bowen, would you now go grab Austin Ford.

23 She can go that way, it's the long way, but you can go
24 that way.

25 **MR. HEITMAN:** I'm sorry, Your Honor. Who was the next

1 juror?

2 **THE COURT:** Austin Ford.

3 In front of that microphone. Stand up first because
4 she's going to put you under oath.

5 **AUSTIN FORD, HAVING BEEN DULY SWORN TESTIFIES**

6 **AS FOLLOWS:**

7 **MR. FORD QUESTIONED BY THE COURT:**

8 **THE COURT:** All right. Mr. Ford was juror number 103 on
9 this case. Mr. Ford, before today did anybody tell you why
10 you were coming here?

11 **MR. FORD:** Oh, no, no, ma'am.

12 **THE COURT:** Okay. Have you since found out why you are
13 here?

14 **MR. FORD:** No, ma'am.

15 **THE COURT:** Okay. Good enough. All right. Well I will
16 tell you you're here because I just have some questions about
17 how the deliberations went and the information discussed in
18 the jury room during the trial that you sat on, Crystal
19 Goodwin's case.

20 **MR. FORD:** Okay.

21 **THE COURT:** Do you remember there being a nurse on the
22 jury?

23 **MR. FORD:** Yeah, I think there was a nurse. Yes.

24 **THE COURT:** Okay. Did she ever talk about where she
25 worked?

1 **MR. FORD:** I don't remember exactly where she worked.

2 **THE COURT:** Okay.

3 **MR. FORD:** I wasn't paying attention I should say.

4 **THE COURT:** Okay. Okay. Do you remember her talking
5 about hospital policies and procedures or the way things go in
6 a hospital?

7 **MR. FORD:** I do.

8 **THE COURT:** Okay. What kind of stuff was she talking
9 about?

10 **MR. FORD:** I just remember -- I remember her talking
11 about how they do it at the place that she works, but I don't
12 remember where she works.

13 **THE COURT:** Where she works, right. Okay. Did she talk
14 about things like how to determine baseline blood pressure?
15 I'm sure you remember that term from the trial.

16 **MR. FORD:** Yeah, I remember. I remember, but I don't
17 remember what she was talking about. I remember what they
18 were talking about.

19 **THE COURT:** Okay. Good. But do you remember her
20 talking about it?

21 **MR. FORD:** About how to calculate them?

22 **THE COURT:** Yeah.

23 **MR. FORD:** Oh, no, no, no. I don't remember.

24 **THE COURT:** Do you remember her talking about what the
25 surgeon's job is versus what the anesthesiologist's job is in

1 an operating room?

2 **MR. FORD:** No, not from her. I remember us talking about
3 the case but not from her perspective.

4 **THE COURT:** Okay. So then did you talk about, in your
5 deliberations, the expert's testimony about, you know, there
6 were a lot of expert witnesses, right.

7 **MR. FORD:** Yeah.

8 **THE COURT:** Did you discuss that or refer to that when
9 y'all were deliberating?

10 **MR. FORD:** Yeah. That's pretty much the only thing we
11 referred to.

12 **THE COURT:** Okay. Have you heard the term captain of the
13 ship?

14 **MR. FORD:** Yes.

15 **THE COURT:** And had you heard it before this case?

16 **MR. FORD:** Yeah, I have.

17 **THE COURT:** Okay. Did you hear that term in connection
18 with this case?

19 **MR. FORD:** Yes.

20 **THE COURT:** Like in the deliberation room?

21 **MR. FORD:** Yeah.

22 **THE COURT:** Do you remember who talked about captain of
23 the ship in the jury room?

24 **MR. FORD:** I mean we all talked about it. I don't
25 remember who brought it up, but we all talked about it.

1 **THE COURT:** Okay. Did anybody back there explain what
2 captain of the ship means or did y'all all kind of know?

3 **MR. FORD:** I think we all kind of knew. We didn't really
4 like go over it in detail.

5 **THE COURT:** Okay. Who do you think was in charge of the
6 deliberations? Was it the foreperson or somebody else?

7 **MR. FORD:** In charge of the deliberation? We chose a
8 Gabrielle, yeah, we chose her.

9 **THE COURT:** Okay. And you felt like she kind of -- I
10 mean I know you all talk about it, but you felt like she
11 remained sort of in charge?

12 **MR. FORD:** As far as she was the person writing down the
13 decisions, but as far as her being the final decision, no.
14 She wasn't like the final decision. It was more of like a
15 joint effort.

16 **THE COURT:** Okay. Do you remember the nurse doing
17 anything that you thought was weird during the deliberations
18 or saying anything that you thought ---

19 **MR. FORD:** No. She -- she did a lot of talking from, you
20 know, from like her perspective and what her job does, but as
21 far as -- but that had to do with like the standards and
22 procedures, but not really like the actual case, just like
23 what her job does and how she understands. But other than
24 that, no.

25 **THE COURT:** Okay. Do you remember any juror saying that

1 they worked at Prisma Health?

2 **MR. FORD:** No. No.

3 **THE COURT:** All right. Any additional questions from the
4 plaintiff?

5 **MR. GOINGS:** No, Your Honor.

6 **THE COURT:** From the defense?

7 **MR. HEITMAN:** No, Your Honor.

8 **THE COURT:** All right. Well thank you for being here.
9 I'm sorry to take you away from your life, but you're free to
10 go. You can go out this back door the way you came in. I
11 appreciate it.

12 All right. We're going to take five minutes, a five-
13 minute break before we bring in the next juror. Five-minute
14 break.

15 **(COURT IS IN RECESS)**

16 **THE COURT:** Okay. Ms. Sutton, would you bring me Michael
17 Casto?

18 **BAILIFF:** Yes, ma'am.

19 **THE COURT:** In that middle seat.

20 **MICHAEL CASTO, HAVING BEEN DULY SWORN TESTIFIES**

21 **AS FOLLOWS:**

22 **MR. CASTO QUESTIONED BY THE COURT:**

23 **THE COURT:** All right. Mr. Casto was juror number 54 on
24 Crystal Goodwin's trial.

25 Mr. Casto, you're not in any trouble.

1 **MR. CASTO:** Good.

2 **THE COURT:** I just have some questions to ask you. The
3 first being, did you know before today why you were coming
4 here?

5 **MR. CASTO:** No.

6 **THE COURT:** Okay. Have you discussed today with anyone
7 why you're here, the other jurors or anyone?

8 **MR. CASTO:** Well I mean the other jurors have all had
9 discussions. Yes, ma'am.

10 **THE COURT:** Okay. Does anyone know why you're here?

11 **MR. CASTO:** I think there's speculation.

12 **THE COURT:** Of course. I just want to ask you some
13 questions about deliberations on this case.

14 **MR. CASTO:** Yes, ma'am.

15 **THE COURT:** As I said, you're not in any trouble. I just
16 need to sus some things out. Do you remember there being a
17 nurse on the jury?

18 **MR. CASTO:** Yes, ma'am.

19 **THE COURT:** Do you remember her name? It's okay if you
20 don't.

21 **MR. CASTO:** No, other than it came up this morning, but I
22 really don't. I know she worked at the VA hospital.

23 **THE COURT:** Okay. Did that come up this morning that she
24 worked at the VA?

25 **MR. CASTO:** No, ma'am.

1 **THE COURT:** So you remember that back from deliberations?

2 **MR. CASTO:** That's correct. Yes, ma'am.

3 **THE COURT:** Did she talk about working at any other
4 hospital?

5 **MR. CASTO:** Not to my knowledge or recollection.

6 **THE COURT:** Okay. Do you remember what she does at the
7 VA?

8 **MR. CASTO:** No, ma'am. I just assumed that she was a
9 registered nurse. My ex-wife was a nurse, that was a little
10 connection there.

11 **THE COURT:** Okay. Now, during the deliberations did the
12 nurse Stephanie talk about hospital policies and procedures or
13 the way things are done in a hospital or anything like that
14 that you recall?

15 **MR. CASTO:** I recall because it was brought forth in the
16 trial, something about the SOPs from the hospital. But I
17 don't particularly recall that she directed any conversation
18 about that.

19 **THE COURT:** Okay. Do you remember her talking at all
20 about the role of a surgeon in the operating room versus the
21 role of an anesthesiologist?

22 **MR. CASTO:** I think we all had that discussion, all of
23 the jurors had that discussion.

24 **THE COURT:** Okay. Did anybody have any input about that
25 from their own experience based on something that wasn't

1 discussed in the courtroom that you recall?

2 **MR. CASTO:** Not to my knowledge.

3 **THE COURT:** Okay. Have you ever heard the term captain
4 of the ship?

5 **MR. CASTO:** Yes.

6 **THE COURT:** Have you heard that before this trial or
7 during this trial or after this trial?

8 **MR. CASTO:** Before, during, after, now.

9 **THE COURT:** Okay. Was captain of the ship, that concept,
10 discussed in the jury room?

11 **MR. CASTO:** I believe so. Yes, ma'am.

12 **THE COURT:** Do you remember who broached the subject?

13 **MR. CASTO:** I believe that I specifically mentioned
14 something about it because I was taken back by the SOP at the
15 hospital that was brought forth as evidence and it didn't
16 really define the surgeon as the captain of the ship.

17 **THE COURT:** Okay. All right. Do you remember anyone
18 during deliberations deferring to the nurse for her knowledge
19 or expertise on any particular subject?

20 **MR. CASTO:** I do not recall that.

21 **THE COURT:** Any additional questions from the plaintiff?

22 **MR. GOINGS:** Yes, Your Honor.

23 **REPORTER'S NOTE:** (Whereby bench conference was held.)

24 **THE COURT:** So we're curious, why -- what is the
25 speculation as to why y'all are here? What do the other

1 jurors think is going on?

2 **MR. CASTO:** Well initially I was like what did I do
3 wrong, and the second thing is I questioned why I was even on
4 the jury. The reason I say that was during the trial, Mr.
5 Hinson and I are next door neighbors currently.

6 **THE COURT:** Okay.

7 **MR. CASTO:** I didn't recognize that until -- we have
8 probably talked two or three times. It's more or less
9 neighborly, hey, welcome to the neighborhood or whatever. And
10 my wife and I were driving out of the cul-de-sac, and I said
11 he's the plaintiff's attorney. So I was like is there a
12 conflict of interest and I brought that to the bailiff's
13 attention, I think it was Monday morning. I said we don't
14 have any social interaction, but I didn't know if that was an
15 issue or not, so I was concerned about that.

16 But I think to address your question, was prior to being
17 called in or coming into the courtroom today, Stephanie
18 mentioned that her name may have been mistaken for someone
19 involved in a previous case.

20 **THE COURT:** Okay. Did she talk about her work experience
21 at all in connection with that speculation?

22 **MR. CASTO:** I believe she did say she'd never worked at
23 Prisma Health.

24 **THE COURT:** Okay. Did you, prior to her making that
25 comment, think that she had worked at Prisma Health?

1 **MR. CASTO:** I had no knowledge. I always -- all I knew
2 is that she worked at the VA hospital because that's where I
3 live is back behind it.

4 **THE COURT:** Okay.

5 **MR. CASTO:** And I'm retired from federal service too.

6 **THE COURT:** Okay. Any additional questions from the
7 plaintiff?

8 **MR. GOINGS:** (Inaudible) We moved to a new house in
9 January when a pipe burst in our old house and it flooded, we
10 had to move to a rental house. I feel like a terrible
11 neighbor for not making the connection until right now.

12 **MR. CASTO:** Well I'm guilty of the same thing. Like how
13 attentive am I. We live this close to each other. You have a
14 face I can't remember, I guess.

15 **THE COURT:** I think a lot of people feel that way.

16 **MR. CASTO:** That's funny.

17 **THE COURT:** Any additional questions from the defense?

18 **MR. HEITMAN:** No, Your Honor.

19 **THE COURT:** All right. Well thank you for being here.
20 You are free to go. You can go on out, come around and walk
21 out the door.

22 **MR. CASTO:** Thank you.

23 **THE COURT:** Thank you so much.

24 All right. Robert Andreo is the next juror.

25 **BAILIFF:** Robert Andreo.

1 **ROBERT ANDREO, HAVING BEEN DULY SWORN TESTIFIES AS**
2 **FOLLOWS:**

3 **MR. ANDREO QUESTIONED BY THE COURT:**

4 **THE COURT:** All right. Mr. Andreo was juror number 9 on
5 the Crystal Goodwin trial.

6 You're not in any trouble. I just have some questions
7 about jury deliberations and the things that happened in the
8 jury room. The first question is do you know, or have any
9 idea, about why you're here today?

10 **MR. ANDREO:** I do.

11 **THE COURT:** Okay. And why do you think you're here
12 today?

13 **MR. ANDREO:** Because a juror gave an affidavit about a
14 juror at trial.

15 **THE COURT:** And how did you come to learn that? Was that
16 this morning or before today?

17 **MR. ANDREO:** That was before today, yeah.

18 **THE COURT:** And how did that come up?

19 **MR. ANDREO:** I searched it online.

20 **THE COURT:** You searched, oh, this case?

21 **MR. ANDREO:** This case, yeah, online through the public
22 records, yeah.

23 **THE COURT:** Okay. So you've read the jurors affidavit?

24 **MR. ANDREO:** Yes, and all of the evidence and stuff like
25 that as well.

1 **THE COURT:** Okay.

2 **MR. ANDREO:** Is that allowed? I didn't think I was in
3 trouble for that, but is that allowed?

4 **THE COURT:** No, not at all.

5 **MR. ANDREO:** I do my research, so I was ---

6 **THE COURT:** Right. Okay. Okay. Well so then I'm going
7 to sort of go through the affidavit with you then. Do you
8 remember Stephanie, the nurse, on the jury?

9 **MR. ANDREO:** Uh-huh. (Affirmative response.) I do.

10 **THE COURT:** Do you remember her talking about being a
11 nurse or where she worked?

12 **MR. ANDREO:** Uh-huh. (Affirmative response.) Yeah.

13 **THE COURT:** Where did she say she worked?

14 **MR. ANDREO:** The VA.

15 **THE COURT:** Do you remember her talking about working at
16 Prisma Health?

17 **MR. ANDREO:** No.

18 **THE COURT:** Not at all?

19 **MR. ANDREO:** No.

20 **THE COURT:** So if the affidavit says that Stephanie told
21 the other -- all of the jury that she had been a nurse at
22 Prisma Health for many years, you don't remember that?

23 **MR. ANDREO:** She didn't say that.

24 **THE COURT:** Okay. Did she talk about hospital policies
25 and procedures that you recall?

1 **MR. ANDREO:** Kind of. I mean not like what Prisma did or
2 anything like that, just in general what they kind of mean
3 basically.

4 **THE COURT:** Okay. And okay. Do you remember her talking
5 about how to determine baseline blood pressure?

6 **MR. ANDREO:** Not really, no.

7 **THE COURT:** Do you know Stephanie outside of this case?

8 **MR. ANDREO:** No.

9 **THE COURT:** Have you spoken with her since the trial?

10 **MR. ANDREO:** No.

11 **THE COURT:** Did you speak to her this morning at all?

12 **MR. ANDREO:** No. I made a joke about her keeping the
13 other juror awake, but I don't think she really acknowledged
14 me.

15 **THE COURT:** Okay. Do you remember in the deliberation
16 room talking about the phrase captain of the ship?

17 **MR. ANDREO:** Sort of, yeah.

18 **THE COURT:** Do you remember who brought up that topic or
19 broached that subject?

20 **MR. ANDREO:** I mean we all kind of talked about how --
21 about that subject and how it wasn't really like -- we kind of
22 felt like it was kept from us, I guess you could say, that we
23 weren't really supposed to use that as a way to determine, you
24 know, our verdict, I guess, or in our deliberations, basically
25 not to pay attention to it in our deliberations and stuff.

1 **THE COURT:** Do you remember how it even came up in the
2 jury room though, who mentioned it?

3 **MR. ANDREO:** No. I don't know who mentioned it or not,
4 not.

5 **THE COURT:** And do you think that the jury considered
6 captain of the ship? I mean you just said you felt like it
7 was kept from you and maybe you shouldn't use it. Do you feel
8 like it was used at all or affected the verdict?

9 **MR. ANDREO:** No. I mean we all kind of understood from
10 the evidence and testimony that it's more of a team thing,
11 more so like the whole operation is a team, it's not one
12 person has say over everything else. So that was just kind of
13 (inaudible), I guess.

14 **THE COURT:** And do you think you got that -- came to that
15 conclusion or got that idea from the testimony in the case or
16 just based on people's life experience and knowledge?

17 **MR. ANDREO:** Just from the testimony in the case, yeah,
18 the different doctors and stuff like that.

19 **THE COURT:** Okay. So did you all discuss the expert
20 testimony that was given during trial? Was that part of
21 deliberation?

22 **MR. ANDREO:** Yeah, some of them. Yeah.

23 **THE COURT:** All right. Did you discuss the affidavit
24 that you read and the motion and all of that stuff with any of
25 the other jurors?

1 **MR. ANDREO:** I just said that that's why we're here
2 basically.

3 **THE COURT:** Okay. And that was this morning or before
4 today?

5 **MR. ANDREO:** This morning, yeah.

6 **THE COURT:** Have you talked to any of the jurors since
7 the trial, between the trial and today?

8 **MR. ANDREO:** No. I've seen a few of them. I've seen one
9 juror and a lawyer in public basically.

10 **THE COURT:** Okay. Just like out in the world?

11 **MR. ANDREO:** Yeah.

12 **THE COURT:** Okay. Do you think that the jury relied on
13 the law, the legal instructions that I gave you, in coming up
14 with the verdict or do you think that the verdict was based on
15 something else?

16 **MR. ANDREO:** No. I think we definitely followed the law,
17 tried to.

18 **THE COURT:** Okay.

19 **MR. ANDREO:** That was a very -- we made it a point to
20 follow the law.

21 **THE COURT:** Okay. Any additional questions from the
22 plaintiff?

23 **MR. GOINGS:** May we approach?

24 **THE COURT:** Yes.

25 **REPORTER'S NOTE:** (Whereby bench conference is held.)

1 **THE COURT:** Mr. Andreo, so you were able to look on the
2 internet and find the affidavit, correct? Is that what you
3 said?

4 **MR. ANDREO:** Yes. Multiple affidavits.

5 **THE COURT:** Okay. Right, multiple affidavits. Prior to
6 -- did you do that prior to or after receiving the subpoena in
7 this case?

8 **MR. ANDREO:** After.

9 **THE COURT:** Okay. Did you at any time prior to receiving
10 the subpoena, look at any online documents related to this
11 case?

12 **MR. ANDREO:** No. Not through the public records or
13 anything like that.

14 **THE COURT:** Okay. Have you ever read the complaint in
15 this case or any motions, outside of the one that we're here
16 about today?

17 **MR. ANDREO:** Before the subpoena or after the subpoena?

18 **THE COURT:** Before?

19 **MR. ANDREO:** No. The only ---

20 **THE COURT:** Go ahead.

21 **MR. ANDREO:** The only thing I looked up was just about
22 the lawyers and stuff after the case, Instagram, stuff like
23 that.

24 **THE COURT:** How did you know how to find this case or the
25 affidavits online?

1 **MR. ANDREO:** Public knowledge that you can search court
2 stuff, so I looked it up basically. I honestly thought I was
3 in trouble for something because I got a subpoena, so I was
4 like what's going on.

5 **THE COURT:** Okay. Do you remember when I came back to
6 the jury room after the case was over?

7 **MR. ANDREO:** I do, yes.

8 **THE COURT:** Do you remember what I discussed with you
9 all?

10 **MR. ANDREO:** Kind of, a little bit, yeah, a little bit.

11 **THE COURT:** Generally what do you recall?

12 **MR. ANDREO:** You were interested in like how we kind of -
13 - like our thought process on how we came to our conclusion,
14 our verdict. So yeah.

15 **THE COURT:** Do you remember anything that y'all said to
16 me during that time, during that conversation?

17 **MR. ANDREO:** No. No. I was a little upset you didn't
18 hit the gavel.

19 **THE COURT:** That's right. And still don't have it today.
20 I'm sorry.

21 **MR. ANDREO:** No. I think we asked some general questions
22 and just talked about, I don't really remember exactly what we
23 talked about but nothing serious or anything like that.

24 **THE COURT:** Okay. Any additional questions from the
25 plaintiff?

1 **MR. GOINGS:** No, Your Honor.

2 **THE COURT:** From the defense?

3 **MR. HEITMAN:** No, Your Honor.

4 **THE COURT:** Okay. Thank you for being here. You are
5 free to go.

6 **MR. ANDREO:** Okay.

7 **THE COURT:** You can come down and walk back out that way.

8 **MR. ANDREO:** All right.

9 **THE COURT:** Thank you. Thank you.
10 All right. Let's have Timothy Shealy.

11 **BAILIFF:** Shealy.

12 **TIMOTHY SHEALY, HAVING BEEN DULY SWORN TESTIFIES AS**
13 **FOLLOWS:**

14 **MR. SHEALY QUESTIONED BY THE COURT:**

15 **THE COURT:** All right. Mr. Shealy was juror number 288
16 on the Crystal Goodwin trial.

17 Mr. Shealy, do you know why you're here today?

18 **MR. SHEALY:** I'm sure it has something to do with the
19 case, we're all talking in the back about why we're here, so I
20 have some idea.

21 **THE COURT:** What's the talk back there?

22 **MR. SHEALY:** It wasn't talk. It was I guess someone
23 believed that Stephanie, which I didn't know her name until
24 today, was coercing people in the jury. That's what Stephanie
25 told me this morning when we got here.

1 **THE COURT:** Okay. Do you agree with that or disagree
2 with that?

3 **MR. SHEALY:** I do not agree with that.

4 **THE COURT:** Okay. And she told you that this morning?

5 **MR. SHEALY:** Yes.

6 **THE COURT:** Have you had any conversations with her
7 between the end of the case and this morning?

8 **MR. SHEALY:** No, I've never, no.

9 **THE COURT:** Okay. Have you talked to ---

10 **MR. SHEALY:** I didn't know anybody's name until we got
11 here today.

12 **THE COURT:** Okay. Good enough. All right. Did you know
13 that Stephanie was a nurse?

14 **MR. SHEALY:** Yeah.

15 **THE COURT:** Did you know that before today?

16 **MR. SHEALY:** Yeah. I knew that she was at the VA. I
17 know she does something at the VA.

18 **THE COURT:** Okay. And how did that come up? Was that
19 just during breaks like getting to know each other, or did it
20 come up during deliberations?

21 **MR. SHEALY:** The only reason it stood out to me was
22 because Mike, the grey-haired guy, worked at -- he was a golf
23 pro at I guess the Veteran's Golf Course or something like
24 that and that's why I made the connection between he and her.
25 They both worked at the veteran's organization in my brain.

1 **THE COURT:** Okay. Did she talk about being a nurse
2 during deliberations that you recall?

3 **MR. SHEALY:** Uh-huh. (Affirmative response.)

4 **THE COURT:** Do you know -- you said she works where, I'm
5 sorry?

6 **MR. SHEALY:** I think she works at the VA, right?

7 **THE COURT:** I think so. I haven't talked to her yet.
8 Do you know, did she talk about any other hospitals that
9 she worked at?

10 **MR. SHEALY:** No.

11 **THE COURT:** Did anybody in the jury room talk about
12 working at Prisma Health?

13 **MR. SHEALY:** No.

14 **THE COURT:** Okay.

15 **MR. SHEALY:** Now Stephanie and I talked outside, and she
16 said she didn't work at Prisma Health.

17 **THE COURT:** Before she said that, did you think that she
18 had worked at Prisma Health?

19 **MR. SHEALY:** No, I didn't. She just told me what
20 happened outside and she was like, yeah, because I was kidding
21 when I walked up and I said are you the reason why we're here.
22 I was just joking or whatever, but she said, yeah, I might be
23 the reason why we're here.

24 **THE COURT:** Okay.

25 **MR. SHEALY:** In jest.

1 **THE COURT:** Right. Of course. I'm losing my papers.
2 Have you heard the phrase captain of the ship?

3 **MR. SHEALY:** Yes.

4 **THE COURT:** Before this trial, during this trial, or
5 since this trial?

6 **MR. SHEALY:** I think I heard the phrase captain of the
7 ship it was either in the courtroom or it was by you after the
8 verdict, but I can't remember at what point. And I used the
9 phrase when I was talking to these guys out on the street
10 because someone -- I know the term came up, but I can't
11 remember when the term came up.

12 **THE COURT:** Okay.

13 **MR. SHEALY:** I'm blaming it on you.

14 **THE COURT:** That's fine. I'll take it.

15 Well I'll tell you, and I don't want to influence you,
16 but my recollection is when I came back to the jury room to
17 talk to you all after the verdict, that someone else, another
18 juror mentioned the phrase captain of the ship. Does that
19 sound right or wrong?

20 **MR. SHEALY:** That's an extreme possibility because of the
21 way the deliberation was going, I mean, the discussion was
22 Doctor Holcombe the main guy in the operating room which was
23 something that everybody had discussed in court. And we
24 believe that it was a corroboration, that everybody kind of
25 worked together in unison. That he wasn't necessarily the

1 captain of the ship, we didn't view it that way. We came
2 together collectively and did not view it that way.

3 **THE COURT:** Okay. Do you remember who broached that
4 subject in the jury room, the captain of the ship?

5 **MR. SHEALY:** No. I didn't -- no, no, I don't remember
6 that at all.

7 **THE COURT:** But you did discuss the concept of captain of
8 the ship during deliberation?

9 **MR. SHEALY:** I believe, I believe we did, but I could be
10 completely wrong. That's a little ---

11 **THE COURT:** Okay.

12 **MR. SHEALY:** I mean I remember the term and I remember
13 that being an issue and I don't remember why it was an issue.
14 But I don't remember.

15 **THE COURT:** Do you think that that concept influenced
16 your verdict at all?

17 **MR. SHEALY:** Not really. I didn't believe him to be the
18 captain of the ship, so regardless of the terminology I didn't
19 believe -- I believe the whole thing was a group working
20 together in unison and everybody had their own expertise,
21 their own responsibilities. So I never would have -- I never,
22 I mean if you want to say he was the captain of the ship I
23 would have said no, I wouldn't have thought he was the captain
24 of the ship.

25 **THE COURT:** Okay.

1 **MR. SHEALY:** Regardless of that phrase being used or not.

2 **THE COURT:** Okay. Do you think that the jury at any
3 point deferred to Stephanie for her expertise since she is a
4 nurse?

5 **MR. SHEALY:** I mean I think maybe she had some ideas on
6 policies or whatever, but I don't think it was anymore, you
7 know, obviously when you go in there -- I've never been there
8 before, but after the case we're all talking about our ideas
9 and we made a specific purpose to go around the room before we
10 even discussed it really to see where everybody stood. There
11 was no sense in discussing it if we're all on the same page,
12 so we did that. And then we had a group conversation, and
13 then you know some people were leaning one way, some people
14 were leaning the other way and we just kept discussing, you
15 know, the issues that were causing them to lean that way or
16 each of us to lean that way.

17 **THE COURT:** Okay.

18 **MR. SHEALY:** I thought, I mean, she was -- I mean she
19 seems bright and intelligent. You know I think she did
20 exactly what she was supposed to do, as the rest of us did.

21 **THE COURT:** Okay. Do you remember anybody, or do you
22 remember Stephanie talking about how to determine baseline
23 blood pressure?

24 **MR. SHEALY:** No. We talked about that --- that was
25 discussed so much in the courtroom, I don't know if that was -

1 - I don't recall her saying anything about it.

2 **THE COURT:** Okay. And do you believe that the jury based
3 its decision on the law as given by the Court, the
4 instructions that I gave you, or do you think that there were
5 outside influences or other factors that played into your
6 verdict?

7 **MR. SHEALY:** I think it was based on the guidelines you
8 gave us. I think we came to a good decision.

9 **THE COURT:** Okay. And additional questions from the
10 plaintiff?

11 **MR. GOINGS:** Yes, Your Honor.

12 **THE COURT:** And, Mr. Heitman, if you have anything I'll
13 take that too.

14 **REPORTER'S NOTE:** (Whereby bench conference is held.)

15 **THE COURT:** Mr. Shealy, returning to the captain of the
16 ship concept, do you believe that your decision was guided by
17 your understanding of that concept? In other words, did it
18 have any impact? I mean did you understand that Doctor
19 Holbrook need not be captain of the ship to be found liable?
20 Did you believe that he had to be captain of the ship to be
21 found liable? Did that play into your decision?

22 **MR. SHEALY:** No. I don't believe he would have had to be
23 the captain of the ship one way or that other.

24 **THE COURT:** Okay. Okay. Good enough.
25 Anything else from the plaintiff?

1 **MR. GOINGS:** No, Your Honor.

2 **THE COURT:** From the defense?

3 **MR. HEITMAN:** No, Your Honor.

4 **THE COURT:** All right. Well thank you for being here.
5 You are free to go. I hope I didn't take up too much of your
6 time. And you can go on out this back door of the courtroom.
7 Thank you so much.

8 **MR. SHEALY:** Thank you.

9 **THE COURT:** Let's bring Roxanne Lewis.

10 **ROXANNE LEWIS, HAVING BEEN DULY SWORN TESTIFIES AS**

11 **FOLLOWS:**

12 **MS. LEWIS QUESTIONED BY THE COURT:**

13 **THE COURT:** All right. Ms. Lewis was juror number 195.

14 **MS. LEWIS:** Hello.

15 **THE COURT:** Thank you for being here. Do you know why
16 you're here?

17 **MS. LEWIS:** I presume that you weren't happy with the
18 jury decision.

19 **THE COURT:** Not exactly. Not exactly. Unfortunately it
20 doesn't work that way, I kind of wish it did. Then I could
21 just decide that you were wrong.

22 But have there been any discussion back in the jury room
23 or in the hallway today about why you are all here?

24 **MS. LEWIS:** Yes.

25 **THE COURT:** Okay. And what were those discussions?

1 **MS. LEWIS:** Why we're all here.

2 **THE COURT:** Yes.

3 **MS. LEWIS:** It was just, gosh ---

4 **THE COURT:** Was there speculation as to why?

5 **MS. LEWIS:** Not particularly. Well why in what regard,
6 why we're here and there were a lot of different ideas and
7 speculations.

8 **THE COURT:** Okay. Tell me about some of them.

9 **MS. LEWIS:** The decision, the defense side and the
10 plaintiff side.

11 **THE COURT:** Okay. Do you remember there being a nurse on
12 the jury?

13 **MS. LEWIS:** Oh, yeah.

14 **THE COURT:** Stephanie, is that right?

15 **MS. LEWIS:** Well we never knew each other's names, so I
16 didn't know who Stephanie was. But today, yes, I now know.

17 **THE COURT:** Okay. Did you talk to Stephanie today?

18 **MS. LEWIS:** Yes.

19 **THE COURT:** Did you talk about why you're here today with
20 Stephanie?

21 **MS. LEWIS:** Yes.

22 **THE COURT:** And what did Stephanie say? What was that
23 conversation about?

24 **MS. LEWIS:** She was concerned about the confusion of the
25 name and her title, whatever their title was. She said there

1 was a question about that.

2 **THE COURT:** Okay. Do you know where Stephanie works?

3 **MS. LEWIS:** No.

4 **THE COURT:** Did it not come up in the jury room at all?

5 **MS. LEWIS:** No. I don't recall that, no.

6 **THE COURT:** Okay.

7 **MS. LEWIS:** We didn't discuss about personal lives.

8 **THE COURT:** Did anybody ever say in the jury room that
9 they worked for Prisma Health at any point?

10 **MS. LEWIS:** Your Honor, I don't recall.

11 **THE COURT:** Okay. That's fair. Do you remember anybody
12 in the jury room giving you sort of additional information
13 more than what you learned in court about hospital policies
14 and procedures?

15 **MS. LEWIS:** It may have been Stephanie because she was a
16 nurse. She seemed to be the most medical person that we
17 turned to. It was not a great discussion except for what was
18 happening here.

19 **THE COURT:** Did she talk about determining baseline blood
20 pressure at all?

21 **MS. LEWIS:** I don't recall that.

22 **THE COURT:** Okay. Did she talk about the surgeon's role
23 versus what the anesthesiologist's role is?

24 **MS. LEWIS:** I do recall that, yes.

25 **THE COURT:** Okay. And do you remember generally what she

1 said, or no?

2 **MS. LEWIS:** That -- she did say -- we were saying that
3 what Doctor Holbrook did, that was his job. And the
4 anesthesiologist, we were saying well it should have been all
5 together, and she disagreed. She said, no, they're skilled
6 people and they go to school, they're doctors so everybody had
7 their professional jobs.

8 **THE COURT:** Did you get the impression that that was
9 generally her personal opinion or based on her certain
10 expertise in the medical field?

11 **MS. LEWIS:** Expertise.

12 **THE COURT:** Okay. Did she sort of emerge as a bit of an
13 expert in the jury room, a medical expert?

14 **MS. LEWIS:** No.

15 **THE COURT:** Okay. Did you discuss with the other jurors
16 during deliberation the expert testimony given in court?

17 **MS. LEWIS:** Yes. The expert witnesses?

18 **THE COURT:** Yes.

19 **MS. LEWIS:** Yes.

20 **THE COURT:** Okay. Do you feel like the jury relied on
21 the expert testimony or was anyone influenced by anything that
22 Stephanie may have said?

23 **MS. LEWIS:** Oh, no.

24 **THE COURT:** Have you heard the phrase captain of the ship
25 before?

1 **MS. LEWIS:** Yes.

2 **THE COURT:** Had you heard it before this trial?

3 **MS. LEWIS:** Oh, yes.

4 **THE COURT:** Okay. Did you talk about it during this
5 trial in the jury room?

6 **MS. LEWIS:** When we were deliberating.

7 **THE COURT:** Okay. Do you remember who broached that
8 subject?

9 **MS. LEWIS:** Me.

10 **THE COURT:** Really? Okay. And what's the -- how did it
11 come up? Tell me generally about the captain of the ship
12 discussion.

13 **MS. LEWIS:** Well we were deliberating and trying to
14 siphon all of the evidence and such. I did bring up the point
15 that whether it was viable to have a title in the medical ship
16 as the captain of the ship, as a coach is in charge of his
17 team, etcetera, etcetera, and that was about the discussion of
18 it.

19 **THE COURT:** Do you think that the concept of the captain
20 of the ship, whatever your view on it is, impacted your
21 decision or your verdict in this case?

22 **MS. LEWIS:** No. Once I really reviewed it personally,
23 hours and hours, and sleepless evenings.

24 **THE COURT:** Okay. Hours and hours, when did that occur,
25 after the trial or before?

1 **MS. LEWIS:** Yes.

2 **THE COURT:** Wait, which one?

3 **MS. LEWIS:** Both.

4 **THE COURT:** Both. Okay. Do you have a medical
5 background at all?

6 **MS. LEWIS:** Oh, no.

7 **THE COURT:** Okay. So you just know generally the concept
8 of captain of the ship. What kind of reading or research did
9 you do before the trial?

10 **MS. LEWIS:** I have no -- this is my first time in any
11 kind of adjudication process, so I did a lot of reading on
12 what the juror's responsibility is and I mean copious readings
13 and Googling and searched on many subjects.

14 **THE COURT:** Okay.

15 **MS. LEWIS:** In regards to the legal system.

16 **THE COURT:** Did any of that include any specific topics
17 raised in this case?

18 **MS. LEWIS:** No.

19 **THE COURT:** Okay. Did you ever read any of the documents
20 that were filed, like in the public record, with respect to
21 this case?

22 **MS. LEWIS:** No, no.

23 **THE COURT:** Okay. And to this day you still have not; is
24 that right?

25 **MS. LEWIS:** I have not.

1 **THE COURT:** All right. Any additional questions from the
2 plaintiff?

3 **MR. GOINGS:** No, Your Honor.

4 **THE COURT:** From the defense?

5 **MR. HEITMAN:** Yes, Your Honor. One of the questions I
6 submitted earlier about after the deliberations had taken
7 place.

8 **THE COURT:** No. I think that's all of the questions that
9 I have for you. Thank you for being here.

10 **MS. LEWIS:** You are welcome.

11 **THE COURT:** And you are free to go.

12 **MS. LEWIS:** All right.

13 **THE COURT:** You can go out this back door back here.

14 **MS. LEWIS:** Okay. All right.

15 **THE COURT:** The next juror is Michael Mitchell.

16 **MR. HEITMAN:** Your Honor, can I get that question on the
17 record that you declined to ask?

18 **THE COURT:** Absolutely. So the question was after the
19 verdict when the Judge came back to the deliberation room,
20 what did the Judge say to the jurors and what did the jurors
21 say to the Judge. I have not asked Ms. Lewis that question.
22 I did not think it was necessary. I asked it of one other
23 juror because we were really trying to get at sort of the, at
24 least in my mind, trying to get at the captain of the ship
25 concept and the policies and procedures because those are my

1 recollections of the important topics that came up.

2 You can go ahead and bring the other juror.

3 The important topics that came up in our discussions
4 after the verdict in the jury room. But because Ms. Lewis
5 said she broached the subject, she knows about captain of the
6 ship, and that there was talk of policies and procedures, I
7 didn't find it necessary to ask that question of her.

8 **MICHAEL MITCHELL, HAVING BEEN DULY SWORN TESTIFIES AS**

9 **FOLLOWS:**

10 **MR. MITCHELL QUESTIONED BY THE COURT:**

11 **THE COURT:** All right. Mr. Mitchell was juror number 219
12 on Crystal Goodwin's trial.

13 How are you today?

14 **MR. MITCHELL:** Okay.

15 **THE COURT:** You're not in any trouble. I just have some
16 questions for you.

17 **MR. MITCHELL:** Oh, yes, ma'am. Yes, ma'am.

18 **THE COURT:** So I hope that makes you feel a little bit
19 better, right? Maybe?

20 **MR. MITCHELL:** Yes, ma'am.

21 **THE COURT:** Okay. Do you know why you're here today?
22 Have you talked with the other jurors about why you're here
23 today?

24 **MR. MITCHELL:** Not other than the subpoena.

25 **THE COURT:** Yeah, but has anybody, any other juror told

1 you about why they think they're here today?

2 **MR. MITCHELL:** Other than maybe got coerced or something,
3 that's the word I heard, but that's it.

4 **THE COURT:** Okay. And who do they think is accused of
5 coercing?

6 **MR. MITCHELL:** A Sarah, not Sarah, it starts with an S.

7 **THE COURT:** Stephanie?

8 **MR. MITCHELL:** Stephanie, there you go. I'm sorry.

9 **THE COURT:** Did you talk with Stephanie this morning?

10 **MR. MITCHELL:** No, ma'am.

11 **THE COURT:** Okay. So that's the other jurors thinking,
12 speculating that ---

13 **MR. MITCHELL:** Yes.

14 **THE COURT:** --- it had something to do with Stephanie?

15 **MR. MITCHELL:** Yeah, yeah, yeah.

16 **THE COURT:** Do you think that Stephanie coerced anyone
17 during the jury deliberations?

18 **MR. MITCHELL:** No, ma'am.

19 **THE COURT:** Do you remember what Stephanie does for a
20 living?

21 **MR. MITCHELL:** I think VA nursing or something like that.

22 **THE COURT:** Okay. And how did you -- where does that
23 come from? Did somebody tell you that today?

24 **MR. MITCHELL:** No. That's from ---

25 **THE COURT:** The trial?

1 **MR. MITCHELL:** Yes, ma'am.

2 **THE COURT:** Did Stephanie talk about working at any other
3 hospital?

4 **MR. MITCHELL:** Not that I know of. No, ma'am.

5 **THE COURT:** Okay. Was Stephanie sort of an expert juror?
6 Did she talk about her knowledge in the medical field?

7 **MR. MITCHELL:** Not, not from that standpoint. No, ma'am.

8 **THE COURT:** Okay. Do you remember Stephanie talking
9 about things like how to determine baseline blood pressure or
10 anything like that?

11 **MR. MITCHELL:** No, ma'am.

12 **THE COURT:** Okay. Do you remember her talking about
13 hospital policies and procedures at all?

14 **MR. MITCHELL:** No, ma'am. Not outside of what we had for
15 the case. No, ma'am.

16 **THE COURT:** Have you ever heard the phrase captain of the
17 ship?

18 **MR. MITCHELL:** Yes, ma'am.

19 **THE COURT:** Had you heard it before this trial?

20 **MR. MITCHELL:** Yes, ma'am.

21 **THE COURT:** Did it come up during this trial?

22 **MR. MITCHELL:** As in like during the case?

23 **THE COURT:** During deliberations in the jury room?

24 **MR. MITCHELL:** Yes.

25 **THE COURT:** All right. Do you remember who brought up

1 that topic, who broached that subject?

2 **MR. MITCHELL:** No, ma'am, because it came from multiple
3 people. Yes, ma'am.

4 **THE COURT:** Did that concept factor into the jury's
5 deliberations?

6 **MR. MITCHELL:** No, ma'am. Not necessarily. No, ma'am,
7 not from my standpoint.

8 **THE COURT:** Okay. Who do you think sort of was in charge
9 of the deliberations in the room? Was it the foreperson or
10 somebody else?

11 **MR. MITCHELL:** It was the foreperson, but how she
12 presented it, it was more of a group thing, but she kept it in
13 line.

14 **THE COURT:** Good. Was there discussion in the jury room
15 about the expert witnesses that testified in the case?

16 **MR. MITCHELL:** During the deliberation?

17 **THE COURT:** Yes.

18 **MR. MITCHELL:** Yes, ma'am.

19 **THE COURT:** Do you think that you based your verdict on
20 the expert testimony or some other discussions that happened
21 in the jury room?

22 **MR. MITCHELL:** Everything, a little bit of everything.

23 **THE COURT:** Do you think that the jury followed the
24 Court's instructions on the law or were there outside
25 influences?

1 **MR. MITCHELL:** No outside, so yes, we followed the law.
2 Yes, ma'am.

3 **THE COURT:** Okay. Do you remember Stephanie, the nurse,
4 talking about what the surgeon's role is versus what an
5 anesthesiologist's role is?

6 **MR. MITCHELL:** No, ma'am.

7 **THE COURT:** Do you not remember or you're saying she
8 didn't talk about that?

9 **MR. MITCHELL:** I don't remember at all because like I
10 said that's one of those things that came up from everybody
11 discussing it.

12 **THE COURT:** Right. Okay. Do you remember Stephanie
13 talking about her personal experiences as a nurse in a
14 hospital?

15 **MR. MITCHELL:** I do not remember. No, ma'am.

16 **THE COURT:** Okay. Any other questions from the
17 plaintiffs?

18 **MR. GOINGS:** No, Your Honor.

19 **THE COURT:** From the defense?

20 **MR. HEITMAN:** No, Your Honor.

21 **THE COURT:** All right. Thank you for being here. Sorry
22 for keeping you as long as I have. You can get back to your
23 life and be done with this case.

24 **MR. MITCHELL:** Yes, ma'am. Thank you.

25 **THE COURT:** You are free to go. You can go out of this

1 back door back here.

2 All right. Tameka Harvey is next.

3 **TAMEKA HARVEY, HAVING BEEN DULY SWORN TESTIFIES AS**
4 **FOLLOWS:**

5 **MS. HARVEY QUESTIONED BY THE COURT:**

6 **THE COURT:** Tameka Harvey was juror number 146 on the
7 trial of Crystal Goodwin's case.

8 Do you know why you're here today, Ms. Harvey?

9 **MS. HARVEY:** Not really.

10 **THE COURT:** Okay. What do the other jurors think about
11 why they're here today?

12 **MS. HARVEY:** Something about the first lady, Stephanie.
13 That she was doing something or worked somewhere at Prisma or
14 was trying to coerce the jury.

15 **THE COURT:** Okay. Do you remember Stephanie working at
16 Prisma or talking about working at Prisma?

17 **MS. HARVEY:** No, I don't.

18 **THE COURT:** Do you think that she coerced the jury during
19 deliberations?

20 **MS. HARVEY:** I do not.

21 **THE COURT:** Okay. Do you remember where she does work?

22 **MS. HARVEY:** The VA.

23 **THE COURT:** And do you remember that -- did you talk
24 about that like just getting to know each other in the jury
25 room, or did you find that out today, or somewhere in between?

1 **MS. HARVEY:** She talked about it before.

2 **THE COURT:** During deliberations or otherwise?

3 **MS. HARVEY:** No, just in general conversations.

4 **THE COURT:** Did she talk about ever working at any other
5 hospitals?

6 **MS. HARVEY:** I don't recall that.

7 **THE COURT:** Did she give sort of her expertise on sort of
8 hospital policies and procedures or anything like that?

9 **MS. HARVEY:** I don't remember her doing that.

10 **THE COURT:** Do you remember her talking about how -- the
11 proper way to determine baseline blood pressure, a subject
12 which came up a lot during the trial?

13 **MS. HARVEY:** She did mention something about blood
14 pressure, but I can't remember specifically what she said.

15 **THE COURT:** Okay. Do you remember her at all being like
16 an expert on that topic within the jury room or anything?

17 **MS. HARVEY:** I don't feel as though she was, no.

18 **THE COURT:** Do you feel like she emerged as an expert on
19 any medical topic in the jury room?

20 **MS. HARVEY:** Not for me, no.

21 **THE COURT:** Okay. Have you heard the phrase captain of
22 the ship?

23 **MS. HARVEY:** Yes.

24 **THE COURT:** Had you heard it before this trial?

25 **MS. HARVEY:** Yes.

1 **THE COURT:** Did you discuss it in the jury room?

2 **MS. HARVEY:** We did not, not in those terms, we did not.

3 **THE COURT:** Okay. Was it referred to by other terms or
4 was the concept discussed?

5 **MS. HARVEY:** Just I guess the principle of who's actually
6 in charge, who's responsible, who led the team if there was
7 anybody to lead the team.

8 **THE COURT:** Okay. Do you think that the concept, captain
9 of the ship, influenced your verdict at all?

10 **MS. HARVEY:** I think the lack of knowing or identifying
11 captain of the ship definitely did.

12 **THE COURT:** Okay. And do you think if that phrase or
13 that terminology had been defined for you during the trial
14 that your verdict may have been different?

15 **MS. HARVEY:** In hearing conversations, yes, I believe so.

16 **THE COURT:** Okay. So your verdict was in fact influenced
17 by the captain of the ship concept?

18 **MS. HARVEY:** Yes.

19 **THE COURT:** Or lack thereof?

20 **MS. HARVEY:** Lack thereof.

21 **THE COURT:** Or lack of explanation of it.

22 **MS. HARVEY:** Yes, or identifying.

23 **THE COURT:** Okay. And I don't recall whether I asked
24 you, do you remember who broached that subject, captain of the
25 ship, who brought that up in the jury room?

1 **MS. HARVEY:** Again, the phrase captain of the ship was
2 not mentioned.

3 **THE COURT:** That's right.

4 **MS. HARVEY:** However, everybody was just questioning well
5 who was in charge. Nobody said who was in charge, so we don't
6 know who was supposed to be doing what. We don't know who
7 played what role. That was the question that just kind of
8 kept going around and around.

9 **THE COURT:** Okay. Do you remember Stephanie talking
10 about hospital policies and procedures? I think I may have
11 asked you that.

12 **MS. HARVEY:** Not specifically, I do not.

13 **THE COURT:** Do you remember her talking about the role of
14 a surgeon versus the role of the anesthesiologist?

15 **MS. HARVEY:** No, not specifically.

16 **THE COURT:** Do you think that the jury adhered to the
17 Court's instructions, or do you think that there were other
18 ideas outside of the law that I told you that influenced the
19 verdict?

20 **MS. HARVEY:** I don't think so. I think everybody was
21 trying to listen to the instructions that we were given and
22 make the decision with what we were presented with.

23 **THE COURT:** Okay. Any additional questions from the
24 plaintiff?

25 **MR. GOINGS:** No, Your Honor.

1 **THE COURT:** From the defense?

2 **MR. HEITMAN:** No, Your Honor.

3 **THE COURT:** Well thank you for being here. I'm sorry for
4 keeping you so long. You are free to go.

5 **MS. HARVEY:** Okay. Thank you.

6 **THE COURT:** Thank you. Thank you.

7 Next is Jaekwon Robinson.

8 Ms. Eigenbrot, I know you didn't sign up for this, but I
9 appreciate you being here.

10 **MS. EIGENBROT:** Yes, ma'am.

11 **THE COURT:** Out of an abundance of caution.

12 **JAEKWON ROBINSON, HAVING BEEN DULY SWORN TESTIFIES AS**
13 **FOLLOWS:**

14 **MR. ROBINSON QUESTIONED BY THE COURT:**

15 **THE COURT:** All right. Mr. Robinson was juror 263 on
16 Crystal Goodwin's trial.

17 Mr. Robinson, do you know why you're here today?

18 **MR. ROBINSON:** Yes.

19 **THE COURT:** Okay. Tell me why.

20 **MR. ROBINSON:** Because somebody apparently coerced us
21 into changing our votes.

22 **THE COURT:** Do you think that that's correct, that you
23 were coerced?

24 **MR. ROBINSON:** No. No, ma'am.

25 **THE COURT:** Why allegedly coerced you? Do you know?

1 **MR. ROBINSON:** Stephanie.

2 **THE COURT:** All right. Do you remember who Stephanie is?
3 Do you remember she is a nurse?

4 **MR. ROBINSON:** Yeah. Yes, ma'am. She works at the VA.

5 **THE COURT:** Okay. Do you know her outside of just being
6 a fellow juror?

7 **MR. ROBINSON:** No, ma'am.

8 **THE COURT:** And how do you know she works at the VA?

9 **MR. ROBINSON:** She told us.

10 **THE COURT:** When did she tell y'all, in the jury room or
11 today?

12 **MR. ROBINSON:** In the jury room.

13 **THE COURT:** Okay. So like during the trial?

14 **MR. ROBINSON:** Yes, ma'am.

15 **THE COURT:** Did she ever mention working at any other
16 hospital?

17 **MR. ROBINSON:** No, ma'am.

18 **THE COURT:** Have you talked to Stephanie today?

19 **MR. ROBINSON:** No, ma'am.

20 **THE COURT:** Oh, right. You were the last one to come in.

21 **MR. ROBINSON:** Yeah, I didn't see her.

22 **THE COURT:** Okay. You didn't get to see her. So you
23 don't remember her talking about working at any other
24 hospitals?

25 **MR. ROBINSON:** No, ma'am.

1 **THE COURT:** Do you remember her talking about how things
2 are done policy and procedure wise like at the VA, this is how
3 it works in a hospital?

4 **MR. ROBINSON:** No. No, ma'am, not really.

5 **THE COURT:** Do you remember her talking about the role of
6 an anesthesiologist versus the role of the surgeon in the
7 operating room?

8 **MR. ROBINSON:** No, ma'am.

9 **THE COURT:** Do you know the phrase captain of the ship?

10 **MR. ROBINSON:** I remember hearing it during the trial.

11 **THE COURT:** During the trial, like in the courtroom or in
12 the jury room?

13 **MR. ROBINSON:** Well like in the trial, like in the trial
14 itself.

15 **THE COURT:** Okay. Did y'all discuss that concept in the
16 jury room?

17 **MR. ROBINSON:** No, ma'am.

18 **THE COURT:** You don't remember any discussions about
19 captain of the ship or who's in charge of the operating room
20 or anything like that?

21 **MR. ROBINSON:** Yeah. All we said was because they
22 couldn't tell us that, that's why we couldn't really talk
23 about it.

24 **THE COURT:** Okay. Because they couldn't tell us that?

25 **MR. ROBINSON:** Because they never argued it, so because

1 we didn't get told who exactly runs the operating room, we
2 didn't know who would actually be responsible.

3 **THE COURT:** And that was the conversation back in the
4 jury room?

5 **MR. ROBINSON:** Yes, ma'am. Yeah, during deliberation.

6 **THE COURT:** Okay. Do you remember who said that, who
7 brought that up?

8 **MR. ROBINSON:** We all did actually.

9 **THE COURT:** Okay. All right. Do you think that the
10 jury's verdict was based on the law as I told you the law was,
11 the instructions that I gave you, or do you think that it was
12 based on something else that someone said during
13 deliberations?

14 **MR. ROBINSON:** Based off the law you gave us.

15 **THE COURT:** Okay. Any additional questions from the
16 plaintiff?

17 **MR. GOINGS:** I may need a clarification of an answer.

18 **THE COURT:** Sure.

19 **REPORTER'S NOTE:** (Whereby bench conference is held.)

20 **THE COURT:** So just for clarification, you said that you
21 didn't -- let's see, I forget exactly how you said it, but
22 y'all didn't know who ran the operating room or who was in
23 charge of the operating room or something.

24 **MR. ROBINSON:** Yes, ma'am.

25 **THE COURT:** Remind me what you said.

1 **MR. ROBINSON:** We didn't know because it wasn't argued
2 who was the lead person in the operating room so we couldn't
3 solely based everything on the surgeon if it was everybody on
4 the trial then maybe it would have went a little differently,
5 but you can't solely base him responsible if he wasn't -- you
6 know if it wasn't argued to us like the surgeon is the one in
7 charge of the operating room when they're performing.

8 **THE COURT:** Okay. And that's the discussion that the
9 jury had?

10 **MR. ROBINSON:** Yes, ma'am, in the deliberating room,
11 yeah.

12 **THE COURT:** So did you -- did you think that that was
13 like a lack of evidence, like maybe a witness should have told
14 you who was in charge in the operating room or was it more
15 like ---

16 **MR. ROBINSON:** They just didn't. It wasn't like a lack
17 of evidence or anything like that, it was just because that
18 wasn't argued, how can we solely blame this one person.

19 **THE COURT:** Okay.

20 **MR. ROBINSON:** And then with the law that we understood
21 it as, we couldn't give a guilty verdict solely on him.

22 **THE COURT:** Okay. And that was the conversation in the
23 deliberation room?

24 **MR. ROBINSON:** Yes, ma'am.

25 **THE COURT:** Did that help clarify?

1 **MR. GOINGS:** Yeah, that clarified what I understood him
2 to say. That's correct. Yes, Your Honor.

3 **THE COURT:** Mr. Heitman?

4 **MR. HEITMAN:** I guess I'll approach.

5 **THE COURT:** Go ahead from there.

6 **MR. HEITMAN:** Your Honor, I guess my question is are you
7 saying -- is he saying that because that wasn't argued in the
8 courtroom, that they couldn't consider that as evidence?

9 **THE COURT:** Right. And that's sort of what I was trying
10 to get at.

11 Did you consider the fact that no one told you that the
12 doctor is in charge, like if they had only said that this
13 would have been different, they had to have told us that?

14 **MR. ROBINSON:** I think it would have had to been like
15 argued between the two, you know, but because it wasn't how
16 can we even consider that in the room? That was never even an
17 argument during the trial. That would just be like an
18 assumption we made, I guess.

19 **MR. HEITMAN:** Is that because the evidence wasn't
20 presented?

21 **THE COURT:** Right. Is that because ---

22 **MR. ROBINSON:** Yeah. Yes, ma'am.

23 **THE COURT:** --- no witness testified to that and nobody
24 made that argument.

25 **MR. ROBINSON:** Yeah.

1 **THE COURT:** But if they had made that argument, would
2 your decision have been different?

3 **MR. ROBINSON:** It could have. I don't -- I mean it could
4 have been.

5 **THE COURT:** Okay. Are we good folks?

6 **MR. HEITMAN:** Yes, Your Honor.

7 **THE COURT:** Mr. Goings?

8 **MR. GOINGS:** Yes, Your Honor. I understood the testimony
9 from this juror was that because there was no evidence that
10 Doctor Holbrook was in charge of the operating room, because
11 there was no evidence that he was actually in charge of the
12 room, therefore Doctor Holbrook could not be found, in his
13 words, solely negligent because he was not solely in charge of
14 the operating room. I think that's what the juror was trying
15 to say. He can clarify though.

16 **THE COURT:** Well hold on, let me let him respond to that.

17 **MR. ROBINSON:** So, yeah, yeah, that's pretty much it.

18 **MR. GOINGS:** Thank you. It sounds to me like what he's
19 trying to say is because the concept of captain of the ship
20 wasn't argued in the courtroom, there was no evidence
21 presented towards captain of the ship, they decided that they
22 couldn't consider that during their deliberations.

23 **MR. ROBINSON:** Correct.

24 **THE COURT:** That's correct too. Okay.

25 And this has nothing to do with this proceeding, but I'm

1 curious. If you had known that -- that other people have also
2 been sued, it wasn't just Doctor Holbrook, like that you would
3 be finding him solely negligent, would that have made a
4 difference?

5 **MR. ROBINSON:** Yeah, I think for me personally. If it
6 was all of the people that was in that operating room, all of
7 them were sitting on trial, yeah, I definitely would have
8 voted differently.

9 **THE COURT:** Okay. I was just curious. That doesn't
10 really have anything to do with what we're talking about
11 today, but I was curious.

12 **MR. ROBINSON:** Yeah. Yeah, but if it was all of them,
13 then, yeah, I would have definitely voted differently.

14 **THE COURT:** Okay. So if I were to tell you now that the
15 anesthesiologist was sued, the hospital was sued, I forget who
16 else, a bunch of other folks, nurses, and that some of them
17 had already resolved their parts of the case, does that make a
18 difference to you as you sit here?

19 **MR. ROBINSON:** No, cause they just resolved it. They
20 didn't take it to trial. So because they settled that kind of
21 took them out of the picture.

22 **THE COURT:** Okay. All right. Now, we're getting into
23 some real philosophical discussion. That doesn't really have
24 anything to do with what I'm trying to get at today. All
25 right. Those are all of the questions that I have. Thank you

1 for being here and you are free to go.

2 **MR. ROBINSON:** You're welcome. Thank you.

3 **THE COURT:** Thank you. Thank you. And you can go out
4 the way you came in back here.

5 **MR. ROBINSON:** Okay.

6 **THE COURT:** All right. Charles Jenkins should be the
7 last one in that room.

8 **CHARLES JENKINS, HAVING BEEN DULY SWORN TESTIFIES AS**

9 **FOLLOWS:**

10 **MR. JENKINS QUESTIONED BY THE COURT:**

11 **THE COURT:** All right. Mr. Jenkins was juror number 171.
12 Do you know why you're here today?

13 **MR. JENKINS:** Yes, I have an idea.

14 **THE COURT:** Okay. Tell me what you think. What y'all
15 discussed.

16 **MR. JENKINS:** The verdict of the case.

17 **THE COURT:** Okay. What about the verdict?

18 **MR. JENKINS:** I guess if it was the correct verdict or I
19 guess fair verdict given the evidence that we had.

20 **THE COURT:** Okay. Do you remember the nurse on the jury,
21 Stephanie?

22 **MR. JENKINS:** Yes.

23 **THE COURT:** Have you talked to Stephanie today?

24 **MR. JENKINS:** No.

25 **THE COURT:** Have you talked with Stephanie at all since

1 the deliberations ended?

2 **MR. JENKINS:** No.

3 **THE COURT:** And did you know before I just told you that
4 she was a nurse?

5 **MR. JENKINS:** Correct.

6 **THE COURT:** Did she say that in the jury room?

7 **MR. JENKINS:** I believe so, yes.

8 **THE COURT:** Did she tell you where she worked?

9 **MR. JENKINS:** I think she works at the VA.

10 **THE COURT:** Okay. Did she ever talk about working at any
11 other hospital?

12 **MR. JENKINS:** Not that I can recall.

13 **THE COURT:** Did anybody in the jury room ever talk about
14 working at Prisma Health?

15 **MR. JENKINS:** No, ma'am. Not that I can recall.

16 **THE COURT:** All right. Did Stephanie tell you about sort
17 of her expertise in nursing during the deliberations?

18 **MR. JENKINS:** Yeah. It was just more of, you know, as an
19 RN, you know, what her thoughts of how, I guess, that workflow
20 is.

21 **THE COURT:** Did she talk about the surgeon's
22 responsibility in the operating room versus the
23 anesthesiologist or anything like that?

24 **MR. JENKINS:** Kind of.

25 **THE COURT:** And did she give you information on that from

1 her own knowledge, something that you didn't get from the
2 trial?

3 **MR. JENKINS:** Just that, you know, they both hold MDs,
4 but one doesn't, you know, succeed the other.

5 **THE COURT:** And that was based on her experience, is that
6 what you understood?

7 **MR. JENKINS:** Yes.

8 **THE COURT:** Okay. Did she talk about any other hospital
9 policies and procedures that you remember?

10 **MR. JENKINS:** Not that I can recall.

11 **THE COURT:** Did she talk about how to determine baseline
12 blood pressure that you remember?

13 **MR. JENKINS:** I don't recall that.

14 **THE COURT:** Have you ever heard the phrase captain of the
15 ship?

16 **MR. JENKINS:** Yes.

17 **THE COURT:** Had you heard that before this trial?

18 **MR. JENKINS:** Yes.

19 **THE COURT:** Did you talk about it during this trial in
20 the deliberation room?

21 **MR. JENKINS:** Yes.

22 **THE COURT:** Do you remember who broached that subject?

23 **MR. JENKINS:** I mean I think we all kind of discussed it,
24 but I think, you know, we all kind of said our thoughts about
25 it and then I feel like, you know, as the only licensed

1 practicing medical professional, that her thoughts, you know,
2 carried some weight compared to everyone else.

3 **THE COURT:** Okay. Do you think that the jury deferred to
4 her on that topic, or did you defer to her?

5 **MR. JENKINS:** I wouldn't use the word deferred. I would
6 say that I felt like it kind of carried some value given that
7 we, you know, I think that was one of the main questions that
8 we had, that we didn't have any, you know, literature or
9 documentation or evidence to say otherwise. I thought that it
10 carried some weight just to reaffirm things.

11 **THE COURT:** Okay. Do you think that the discussions of
12 the concept of captain of the ship ultimately influenced the
13 jury's verdict?

14 **MR. JENKINS:** Yeah, I wouldn't use the word influence. I
15 would say kind of reaffirmed the direction, you know, that
16 everyone was starting to go.

17 **THE COURT:** Okay. Okay. Were there any topics that you
18 discussed that you relied on Stephanie's expertise and not on
19 the expert testimony given during the trial?

20 **MR. JENKINS:** No.

21 **THE COURT:** No, did you say no?

22 **MR. JENKINS:** Oh, no.

23 **THE COURT:** I'm sorry. I heard the Uh, but I missed the
24 -- sorry, I was waiting for you. Is there anything that
25 you've heard about or talked about since the end of the trial

1 that would make your verdict any different than it was?

2 **MR. JENKINS:** No.

3 **THE COURT:** Any additional questions from the plaintiff?

4 **MR. GOINGS:** None, Your Honor.

5 **THE COURT:** From the defense?

6 **MR. HEITMAN:** Your Honor, I just asked the question about
7 if their decision was based on the law, or did you ask that?

8 **THE COURT:** Do you believe that your decision was based
9 on the law as I gave it to you, or were there other
10 influences?

11 **MR. JENKINS:** It was based off the law, but you know the
12 thoughts of others were considered in tandem with what we had
13 based off the law.

14 **THE COURT:** Other's thoughts on what kinds of things?

15 **MR. JENKINS:** So, you know, I think in the beginning I
16 think it's the plaintiff's job to prove the case. If they
17 didn't tip the scale in that direction, you go towards the
18 defense. So given that, I think one of the major questions
19 that we had as a jury was, you know, who is responsible as
20 captain of the ship. But I feel that, you know, with
21 Stephanie being an RN and actively practicing, that kind of
22 helped reaffirm like okay.

23 **THE COURT:** Okay. Any additional questions from the
24 plaintiff?

25 **MR. GOINGS:** None from the plaintiff, Your Honor.

1 Nothing else.

2 **THE COURT:** How did you figure out that Stephanie was
3 licensed, a licensed nurse?

4 **MR. JENKINS:** Well, okay, so I don't know if she's
5 licensed, but she is a registered nurse. I'll say that.

6 **THE COURT:** Okay. So she did talk about being a
7 registered nurse?

8 **MR. JENKINS:** Yes, yes. It was known that she was a
9 registered nurse.

10 **THE COURT:** Okay.

11 **MR. JENKINS:** So actively licensed, I don't know.

12 **THE COURT:** Right.

13 **MR. JENKINS:** But a registered nurse.

14 **THE COURT:** Okay. Okay. That's what you meant. And I
15 wasn't trying to suggest that her license isn't valid or it's
16 expired or anything like that. That's not what I meant. But
17 it was mentioned that she was a registered nurse?

18 **MR. JENKINS:** Yes.

19 **THE COURT:** So you assumed that she's licensed?

20 **MR. JENKINS:** Yes.

21 **THE COURT:** I got it. Okay. All right. Well thank you
22 for coming. I'm sorry for taking up so much of your time, but
23 you are free to go. You can go out that way, the way y'all
24 came in.

25 All right. We're going to take just another quick five

1 minutes because the last juror is Stephanie Cribb-Creek. So
2 we're going to take a short break and then I'll bring her in.

3 **(COURT IS IN RECESS)**

4 **THE COURT:** All right. We now have Stephanie Cribb-Creek
5 who was juror number 68. Let's place Ms. Cribb-Creek under
6 oath.

7 **STEPHANIE CRIBB CREEK, HAVING BEEN DULY SWORN TESTIFIES**

8 **AS FOLLOWS:**

9 **MS. CRIBB-CREEK QUESTIONED BY THE COURT:**

10 **THE COURT:** All right. Ms. Cribb-Creek, is Cribb-Creek
11 hyphenated?

12 **MS. CREEK:** No.

13 **THE COURT:** Okay. How should I address you?

14 **MS. CREEK:** Stephanie Creek.

15 **THE COURT:** Okay. Is Cribb your maiden name?

16 **MS. CREEK:** Yes.

17 **THE COURT:** Creek is your married name?

18 **MS. CREEK:** Yes.

19 **THE COURT:** Okay. What's your middle name?

20 **MS. CREEK:** I was born Stephanie Suzanne Cribb.

21 **THE COURT:** Has any part of your name ever been Austin?

22 **MS. CREEK:** No.

23 **THE COURT:** Okay. Are you a registered nurse?

24 **MS. CREEK:** Yes.

25 **THE COURT:** Do you hold any other licenses?

1 **MS. CREEK:** I was an LPN prior to being a registered
2 nurse.

3 **THE COURT:** And what about any respiratory care or
4 therapy?

5 **MS. CREEK:** No.

6 **THE COURT:** Okay. Where do you currently work?

7 **MS. CREEK:** Dorn VA.

8 **THE COURT:** Okay. How long have you worked there?

9 **MS. CREEK:** With my service computation date, I've been
10 there almost 26 years.

11 **THE COURT:** Okay.

12 **MS. CREEK:** There was a break. I had a break in service
13 there for a couple of years. I worked at McLeod Regional
14 Medical Center in Florence.

15 **THE COURT:** What years did you work at McLeod?

16 **MS. CREEK:** September of '99 to April of '01. I stayed
17 on part-time after I moved back to Columbia. I'm not quite
18 sure how long I did that. It wasn't very long.

19 **THE COURT:** Okay. And then when did you go back to the
20 VA?

21 **MS. CREEK:** I went back to the VA in -- I started there
22 originally in December of '95, left September of '99, went
23 back to the VA in April of '01.

24 **THE COURT:** And you're still there?

25 **MS. CREEK:** Yes.

1 **THE COURT:** Have you ever worked at Prisma Health?

2 **MS. CREEK:** No.

3 **THE COURT:** Never done anything with respiratory care
4 therapy?

5 **MS. CREEK:** No.

6 **THE COURT:** What area of specialty, if you have one, do
7 you practice in?

8 **MS. CREEK:** Originally when I was an LPN and for my first
9 two years as an RN I worked in the long-term care nursing
10 home. And then I worked in the Medical Intensive Care Unit at
11 McLeod. Then when I came back to the VA I worked in the
12 Medical Intensive Care Unit, Coronary Care Unit, PCU area at
13 the VA. And currently I'm in the outpatient clinic in the
14 dermatology clinic.

15 **THE COURT:** And how long have you done that?

16 **MS. CREEK:** Dermatology?

17 **THE COURT:** Yes.

18 **MS. CREEK:** Since January of '07.

19 **THE COURT:** Did you tell the other jurors that you were a
20 nurse?

21 **MS. CREEK:** I believe some of them knew I was a nurse,
22 yes.

23 **THE COURT:** Okay. Did you discuss dermatology with any
24 of the jurors that you recall?

25 **MS. CREEK:** I talked, one juror he was an alternate, we

1 discussed it as we were walking out one night.

2 **THE COURT:** Okay. No advice to other jurors about
3 dermatology care or anything?

4 **MS. CREEK:** Not that I recall.

5 **THE COURT:** Okay. Have you ever, in your career, had to
6 determine baseline blood pressure?

7 **MS. CREEK:** To determine baseline blood pressure, no.

8 **THE COURT:** Okay. But you've taken blood pressures?

9 **MS. CREEK:** I've taken blood pressures, yes.

10 **THE COURT:** Were you familiar with the term baseline
11 blood pressure prior to this trial?

12 **MS. CREEK:** Yes.

13 **THE COURT:** From your work or ---

14 **MS. CREEK:** From school. My dad takes his blood pressure
15 twice a day every day to establish his baseline -- to have his
16 baseline blood pressure.

17 **THE COURT:** Okay. Why do you think anyone on the jury
18 would believe that you worked at Prisma Health?

19 **MS. CREEK:** I do not know.

20 **THE COURT:** Do you remember any juror working at Prisma
21 Health or talking about having worked in the past at Prisma
22 Health?

23 **MS. CREEK:** No, I don't.

24 **THE COURT:** Do you remember discussing Prisma Health in
25 the jury room with the jurors at all?

1 **MS. CREEK:** Besides looking at the evidence and talking,
2 I know we discussed the one policy that was brought up about
3 the baseline, about the three -- to get a baseline for the
4 three blood pressures. I know we discussed that, but I don't
5 -- I know that when I was discussing a few items I told them I
6 had never worked at Prisma and I was not familiar with their
7 policies, I had been at the VA. But as far as discussing
8 Prisma other than that, I don't recall that.

9 **THE COURT:** Do you remember discussing the VA's policies?

10 **MS. CREEK:** I do. We talked about, I had brought up
11 about the time out and that in dermatology we do do a time out
12 before every procedure that we do and that is our policy, and
13 that's what I stated to that effect.

14 **THE COURT:** Okay. And why did that come up, if you
15 recall?

16 **MS. CREEK:** Because at the beginning of the deliberation
17 we had discussed, not we had discussed, in the trial it had
18 been brought up many times about time out and a pre-procedure
19 conference, and it had been back and forth during the trial
20 from what I remember, and I had stated that a time out was not
21 the same thing as a conference. And I stated that at the VA
22 when we do a time out, this is what we do, this is why we do
23 it, and this is when we do it. So we did discuss that issue.

24 **THE COURT:** Okay. What about the phrase captain of the
25 ship; are you familiar with that prase?

1 **MS. CREEK:** I remember it was said originally during, I
2 believe, the questioning of the jury maybe something was
3 brought up, I don't remember. And then there was a break, we
4 were called out. We briefly discussed captain of the ship,
5 but I think we had discussed it in the reference of that
6 everybody had their job and that maybe the surgeon was, maybe
7 some people thought of him as the captain of the ship. But I
8 don't remember a long drawn-out conversation about that, I
9 remember us talking about that after the verdict had already
10 been read. I don't recall any long conversation about captain
11 of the ship during deliberations.

12 **THE COURT:** And when you say you recall it coming up
13 after the verdict was read, are you referring to when you
14 returned to the jury room or when I stepped into the jury
15 room?

16 **MS. CREEK:** When you stepped into the jury room somebody
17 had brought that up and I don't recall everything that said.
18 It seems like they were not supposed to be talking about that,
19 that that was something that they were supposed to stay -- I'm
20 not sure with all of that. That's kind of -- but I don't
21 remember any long discussion of captain of the ship during
22 deliberations. It was mentioned, but it was not discussed and
23 it was not discussed in length regarding that.

24 **THE COURT:** Do you remember who broached that subject?

25 **MS. CREEK:** I don't.

1 **THE COURT:** So it was not you?

2 **MS. CREEK:** I don't think it was. I don't know. We
3 talked about -- I felt like my knowledge base for certain
4 things, not that -- I didn't know more than other people in
5 the jury room. There were several people in there that seemed
6 to have some sort of medical knowledge. There was a nursing
7 student in the room. Another juror, I'm not sure what she
8 did, but she seemed to have a grasp on some of the medical
9 stuff. You know, I know that I mentioned that whenever I
10 worked with other physicians or providers, whether it's a mid-
11 level or not, that it's a team basis and that there isn't a
12 captain of the ship per se. But who brought it up originally,
13 I don't know.

14 **THE COURT:** Do you think that at any point the jurors
15 looked to you for your knowledge or expertise as a medical
16 professional?

17 **MS. CREEK:** I don't think so. I mean there was, I know
18 there was one time that I was actually going back and looking
19 at something in the evidence and then we said well we've
20 already -- somebody said we've already looked at that, and I
21 was like okay. I was just trying to clarify some stuff in my
22 mind regarding that. I don't think that they looked to me as
23 an expert. I don't think they -- I mean most of them knew I
24 worked at the VA. They knew I was not a surgical nurse, I had
25 never been a surgical nurse. I don't think they were looking

1 to me as an expert. I didn't feel that way. I felt like the
2 whole deliberation was a conversation with everybody.
3 Everybody had an idea; everybody had an opinion. And I don't
4 feel like it was just me.

5 **THE COURT:** Have you ever been sued before?

6 **MS. CREEK:** No.

7 **THE COURT:** Okay. Never in any kind of case, not a car
8 accident, not anything?

9 **MS. CREEK:** No. I was -- I had to give a deposition in a
10 tort claim with the VA, but that was -- my name happened to be
11 in the chart, so I had to give a deposition in that. But as
12 far as being named in a case, no.

13 **THE COURT:** Okay. When did you become a licensed
14 registered nurse?

15 **MS. CREEK:** I graduated from the program, I think it was
16 August of '97, so maybe I took my boards like sometime in
17 October, and I think I took my next position as an RN at the
18 VA in December of '97, I think.

19 **THE COURT:** If I told you November of '97, would that
20 sound right? November 12, 1997?

21 **MS. CREEK:** Yeah.

22 **THE COURT:** Do you know your license number?

23 **MS. CREEK:** 73159.

24 **THE COURT:** Yeah. So November 12th, 1997, at least
25 according to these records. And your license expires next

1 year?

2 **MS. CREEK:** I think so. It's April, I think so.

3 **THE COURT:** Okay. Have you ever held, you said you were
4 an LPN.

5 **MS. CREEK:** I was.

6 **THE COURT:** What year would that have been?

7 **MS. CREEK:** '95.

8 **THE COURT:** License number 26573; does that sound right?

9 **MS. CREEK:** Maybe. I have the paperwork, but I have no
10 idea what that number was.

11 **THE COURT:** But if it was issued September 23rd, 1995;
12 does that sound right?

13 **MS. CREEK:** That sounds about right.

14 **THE COURT:** And you've not maintained that license; is
15 that right?

16 **MS. CREEK:** No.

17 **THE COURT:** Do you have social media accounts?

18 **MS. CREEK:** I do.

19 **THE COURT:** Do you have a LinkedIn account?

20 **MS. CREEK:** I do.

21 **THE COURT:** And what is your name on your LinkedIn
22 account, if you know?

23 **MS. CREEK:** Stephanie Creek, and I have a copy of that as
24 well.

25 **THE COURT:** Okay. Do you ever go by Stephanie Cribb?

1 **MS. CREEK:** No. That's my maiden name. That's on my
2 Facebook account because it is my maiden name.

3 **THE COURT:** Okay. Did you legally change your name after
4 getting married to Creek?

5 **MS. CREEK:** Yes.

6 **THE COURT:** And when was that? When did you get married?

7 **MS. CREEK:** February of '01.

8 **THE COURT:** And so since about that time you've been
9 known as Stephanie Creek?

10 **MS. CREEK:** Cribb Creek, yes.

11 **THE COURT:** Cribb Creek?

12 **MS. CREEK:** Yes. Just for simplicity purposes I kept my
13 maiden name instead of my middle name, and that way all of the
14 documents, the driver's license, all of that stuff would still
15 be ---

16 **THE COURT:** Okay. Do you know anything about
17 neuromonitoring, other than what you learned in the trial?

18 **MS. CREEK:** No.

19 **THE COURT:** So you would not have discussed
20 neuromonitoring or medical alarms or anything in the jury
21 room, when I say discuss I don't mean discussing the evidence,
22 I mean of your own knowledge?

23 **MS. CREEK:** No. I had no knowledge of neuromonitoring.

24 **THE COURT:** Okay. You learned about that from the trial;
25 is that correct?

1 **MS. CREEK:** Yes.

2 **THE COURT:** How did you determine why you were coming
3 here today?

4 **MS. CREEK:** Because I was supposed to be out of town, and
5 I called and then I -- my husband was trying to figure out a
6 way I could get out of this because I was supposed to be out
7 of town. He spoke with another lawyer and they --- and he
8 essentially led us to the online records to where when I
9 pulled all of the online records up, I saw exactly why I was
10 going to be here today.

11 **THE COURT:** So that was of course after you received the
12 subpoena, correct?

13 **MS. CREEK:** After I received the subpoena, yes.

14 **THE COURT:** Okay. And did you read that plaintiff's
15 motion for a new trial?

16 **MS. CREEK:** I did.

17 **THE COURT:** And the affidavits attached to it?

18 **MS. CREEK:** I did.

19 **THE COURT:** Did you discuss those documents with anyone
20 other than your husband or immediate family? Did you discuss
21 with other jurors?

22 **MS. CREEK:** With other jurors?

23 **THE COURT:** Yes.

24 **MS. CREEK:** This morning we talked about it a little bit
25 as we came in. Some of them didn't understand why we were

1 here and I didn't give all of the information. There was
2 another juror who said that she had received an affidavit and
3 she talked about that, that she had received some information.
4 And we kind of discussed the 13th Juror Doctrine and the
5 misconduct. So, yes.

6 **THE COURT:** Okay. But that all happened this morning
7 when you arrived?

8 **MS. CREEK:** That happened this morning. I mean my
9 coworkers know about it; my family knows about it. I called
10 several of the attorneys to try to fix this situation and so,
11 yeah. I mean I discussed it, but that was it.

12 **THE COURT:** Do you believe that the jury adhered to the
13 Court's legal instructions as to how to come up with their
14 verdict?

15 **MS. CREEK:** I do.

16 **THE COURT:** Do you believe that your own personal
17 knowledge from the medical field impacted your decision, or
18 was it based on the evidence at trial?

19 **MS. CREEK:** I think it was based on the evidence because
20 I'll be honest, when we went in there to deliberate I didn't
21 know either. We discussed it, we talked about it. I felt
22 like I had a little bit more knowledge base because of the
23 definitions that were thrown around and the gray areas of time
24 out, pre-procedure conference, baseline blood pressure, all of
25 that information my knowledge helped with that, I believe.

1 But as far as knowing what was going to happen when I went
2 into that deliberation room, I didn't know.

3 **THE COURT:** Did you do any research about this case at
4 all before deliberations?

5 **MS. CREEK:** No.

6 **THE COURT:** Counsel, any additional questions?

7 **MR. GOINGS:** May we approach?

8 **THE COURT:** Yes.

9 **REPORTER'S NOTE:** (Whereby bench conference is held.)

10 **THE COURT:** Ms. Creek, you testified just a moment ago
11 about giving a deposition in a case involving the VA, a tort
12 claim, correct?

13 **MS. CREEK:** A tort claim, yes.

14 **THE COURT:** Was the VA a defendant, the hospital?

15 **MS. CREEK:** Yes.

16 **THE COURT:** Okay. Why did you -- well what was that case
17 about, if you know?

18 **MS. CREEK:** That case was about a male veteran who had a
19 consult to the dermatology clinic to have a lesion looked at.
20 My name was on it because I had received the consult for
21 dermatology. We attempted to schedule him, he continued to
22 cancel, and ended up with melanoma and had to have a lot of
23 treatment with that. He ended up seeing somebody privately.
24 So I'm not sure what all happened with that. I think he
25 settled. I just had to give a deposition as to the consult

1 and the receiving process on dermatology's end as far as
2 trying to get him in to be seen.

3 **THE COURT:** Were you accused of doing anything wrong in
4 that case?

5 **MS. CREEK:** No. No.

6 **THE COURT:** Do you remember the veteran's name by chance?

7 **MS. CREEK:** Whittgen is the last name, W-I-T-T-G-E-N,
8 Jeffrey maybe, J-E-F-F-E-R-Y, I think.

9 **THE COURT:** Okay. And so how long did your deposition
10 last, if you remember? Was it like all day ---

11 **MS. CREEK:** No.

12 **THE COURT:** --- or just an hour or two?

13 **MS. CREEK:** Yeah, it was just maybe about an hour. I
14 went to a different room and it was via phone.

15 **THE COURT:** Okay. How long ago did you give the
16 deposition?

17 **MS. CREEK:** I get the years mixed up but maybe it was in
18 '22, maybe it was in September of '22.

19 **THE COURT:** Okay. Give me one moment. I am missing
20 something that I am looking for.

21 **MR. GOINGS:** The name of the lawyer that deposed her, and
22 any lawyers that were involved in that case. I just -- with
23 the information that was provided this far I can't decipher
24 even the name of the veteran.

25 **MS. CREEK:** I do not know any of the lawyers that were

1 involved in that case. That came -- I got my information from
2 the -- I can't remember what it's called, but the people that
3 handle the legal stuff at the VA. I don't -- I don't know any
4 of the lawyers. I was not in touch with any of them.

5 **THE COURT:** And you said the deposition was by phone or
6 like Zoom or how was it done? Or did you go to a lawyer's
7 office?

8 **MS. CREEK:** No. It was done -- I went to another
9 conference room at the VA. I don't remember a face, so I
10 don't think it was through Zoom. I think it was via phone.
11 And I want to say it was in September of '22, it may have been
12 September of '21. It seemed like it was somewhere around
13 there, and his name was Jeffery Wittgen, and Jeffery was
14 spelled I think J-E-F-F-E-R-Y Wittgen W-I-T-T-G-E-N.

15 **THE COURT:** Anything else, Mr. Goings?

16 **MR. GOINGS:** No, Your Honor.

17 **THE COURT:** Mr. Heitman?

18 **MR. HEITMAN:** No, Your Honor.

19 **THE COURT:** Okay. Thank you for being here. Is there
20 any reason to keep Ms. Creek at this time?

21 **MR. GOINGS:** Not from the plaintiff, Your Honor.

22 **THE COURT:** From the defense?

23 **MR. HEITMAN:** No, Your Honor.

24 **THE COURT:** Thank you so much for being here and you are
25 free to go.

1 As are you, Ms. Eigenbrot.

2 **MS. EIGENBROT:** Thank you, ma'am.

3 **THE COURT:** All right. Counsel, Mr. Goings, talk to me.

4 **MR. GOINGS:** Yes, Your Honor. As it relates to the
5 arguments in our motion related to juror misconduct that
6 Stephanie Cribb Creek worked at Prisma Health and was involved
7 in the medical malpractice case that we presented in our
8 motion, we would respectfully withdraw those arguments, Your
9 Honor.

10 And I will put on the record that as the foreperson
11 testified to you under oath, she did in fact tell plaintiff's
12 counsel that she understood Ms. Cribb-Creek to work at Prisma
13 Health, okay, and she put that in her affidavit. She also put
14 in her affidavit that she didn't know if she currently worked
15 there or had recently worked there, she didn't know all of the
16 specifics, but she understood Prisma was involved.

17 The jury list that we received from the court, and Your
18 Honor may have it, actually lists Stephanie Cribb Creek as
19 Stephanie Cribb-Creek, okay, so what we received was Cribb-
20 Creek even though Ms. Creek testified today that she doesn't
21 go by Cribb. And when you -- she said she had a LinkedIn
22 page, her LinkedIn page says Prisma Health on it, the one that
23 we were about to find, we were not able to find another Cribb
24 Creek. And, you know, the coincidence that a foreperson would
25 tell us about Prisma and this juror and the internet research

1 would link it up to corroborate what she told us, I don't know
2 how, you know, how many times -- the odds of that happening
3 are very, very, very slim, thus the reason why we made our
4 motion. And the Court system, and I would say, did what it
5 was supposed to do to get to the truth of good faith
6 allegations, which we made. And, Your Honor, based on what
7 the witness, Ms. Cribb Creek, testified to, we would withdraw
8 those grounds.

9 But we do believe that there was issues related to juror
10 misconduct that we can go into right now if you would like to.

11 **THE COURT:** Yes, sir.

12 **MR. GOINGS:** Well first off, and this is the first time
13 I'm hearing that she was deposed merely months before this
14 case in a medical malpractice case involving the VA. Her
15 involvement in it, I still would like to get some better
16 understanding of that, and maybe finding her deposition after
17 this proceeding would be helpful because, you know, she did
18 not disclose that she was involved in a medical malpractice
19 case. I know she said that she was not individually named or
20 allegations against her, but she wouldn't really know if there
21 were allegations against her, but she was a part of the care
22 team that treated someone on a claim involving failure to
23 diagnose cancer, skin cancer. She was the one that did the
24 intake on the patient for the alleged diagnosis.

25 Now, captain of the ship is something that I will say

1 most of the jurors talked about and was candid to you in
2 discussing that they talked about captain of the ship. And it
3 was some confusion about captain of the ship, and I think
4 there's some confusion of the issues. One or two jurors
5 discussed the fact that since there was not evidence that he
6 was captain of the ship and it was a team approach then Doctor
7 Holbrook could not be found liable because he was a part of a
8 team instead of the captain of the ship. And Stephanie Cribb
9 Creek testified that they talked about captain of the ship.
10 She kind of watered it down from what other people said, you
11 know why? Because she actually read the pleadings, read what
12 we filed in the court record.

13 The fact that Doctor Holbrook was or was not captain of
14 the ship, we were not allowed to even get that into evidence
15 one way or another in the case of this trial. But the law is
16 that if Doctor Holbrook committed an act of negligence that
17 was one of the concurrent causes of Crystal Goodwin's damages,
18 that he can be held liable. But it's clear that the jury
19 thought that we had to prove that he was in fact captain of
20 the ship, and Stephanie Cribb Creek talked about her own
21 personal experiences in -- at the VA hospital.

22 And one of the issues in the case was pre-procedure
23 conference versus a time out. And there was a lot of
24 testimony about pre-procedure conferences and a time out. We
25 say that a pre-procedure and a time out is one in the same and

1 there is policies and procedures that say a pre-procedure
2 conference and time out is one in the same. Stephanie Cribb
3 Creek talked about, and told the jury about, the policies at
4 the VA that she's aware of and she's aware that they're two
5 different things. So at the VA they're two different things,
6 i.e pre-procedure conference and time out. You may recall
7 that we had four grounds of negligence of Doctor Holbrook.
8 The first being that he did not have the required time out,
9 and the testimony was clear that he did not have the time out.
10 The evidence in the record showed there was not a time out.
11 Doctor Holbrook testified in his deposition, not once but
12 twice, that there wasn't a time out or pre-procedure
13 conference. But for the first time on the stand, he then says
14 he did a time out, okay, despite prior testimony, despite all
15 of the other testimony of the witnesses. But Cribb Creek
16 introduces and interjects her own professional understanding
17 as a nurse at the VA and tells the jury what the policies are
18 at the VA, and we think that's very important.

19 She did discuss VA policies, as set forth by her own
20 testimony today and as corroborated by multiple juror's
21 testimony. And she actually said her knowledge base helped
22 with "the grey areas" regarding time out, baseline blood
23 pressure, and all of that is what she said.

24 Now, I find it -- I don't know if Your Honor and the
25 Bench picked up on this, but I felt like that these jurors

1 knew that they had to come in here and take up for Stephanie
2 and say that they were not coerced. Everyone of them used the
3 word coerced, every single one of them used the word coerced.
4 And it was almost like it was repeated. Y'all we all know
5 Stephanie didn't coerce us, now go in there and tell the Judge
6 that our verdict and our verdict. We all know that's exactly
7 what happened back there before they walked out and discussed
8 this matter in front of you. Some were more candid than
9 others, some were absolutely more candid than others.

10 You know the captain of the ship was clearly discussed in
11 the jury deliberation room. The gentleman with the long
12 beard, Tim, we spoke with him before -- right after the jury
13 and he talked to us about captain of the ship and that, you
14 know, since the doctor was not the captain of the ship he
15 can't be solely responsible for what happened, and that's just
16 not the law is in this state, and certainly is not the law
17 that you gave them. Yet, in here today he kind of watered
18 down the captain of the ship and watered down what he
19 previously told us.

20 The fact that this juror introduced and interjected
21 hospital policies and her own expertise played a significant
22 role in this jury's decision. And unfortunately this juror
23 got to the jury and let them know why they were here because
24 they were all kind of locked step in saying well she didn't
25 coerce us, and saying things like oh, she wasn't a defacto

1 expert in the jury room. She didn't give her expertise. Well
2 that's because those are the arguments, the exact arguments we
3 made in our motion. It's almost like she knew what she needed
4 to say for her verdict to stick.

5 So as it relates to our motion related to juror
6 misconduct, as it relates to that, we do believe that she
7 introduced and interjected her own personal medical
8 understanding. She interjected the VA policies and
9 procedures. The jury clearly talked about captain of the
10 ship, and you know that because they personally told you that
11 after the verdict went down.

12 And that segways, Your Honor, into the motion that we
13 have for 13th juror. And one of the grounds, the most
14 important ground, for a 13th juror decision is that it says,
15 this is the case law, When a Judge believes that justice has
16 not been done in a case, or if there is confusion amongst the
17 jury, or the verdict is contrary to the fair preponderance of
18 the evidence the Circuit Court has the "authority and
19 responsibility to grant a new trial." And I think it's clear
20 from the discussions with the jury here today that they were
21 confused as to a threshold issue in this case, and that is was
22 Doctor Holbrook responsible for the OR or not. If he was
23 responsible for the OR or not has no bearing whatsoever in his
24 liability. He doesn't have to be responsible for the OR ---

25 **THE COURT:** I meant to ask earlier, I just kind of

1 forgot.

2 **MR. GOINGS:** Your Honor, unless you have anything for Ms.
3 Goodwin, can she be excused from today's proceedings.

4 **THE COURT:** Absolutely. Absolutely.

5 **MS. GOODWIN:** (Inaudible)

6 **THE COURT:** Okay. Take care.

7 **MR. GOINGS:** Ms. Goodwin, we'll be in touch.

8 **MS. GOODWIN:** All right. Thank you.

9 **MR. GOINGS:** Thank you, ma'am.

10 **THE COURT:** Yes, sir.

11 **MR. GOINGS:** So the point in the 13th Juror Doctrine that
12 if there is confusion amongst the jury is manifested very well
13 with this whole captain of the ship doctrine. First off,
14 that's not the law in South Carolina, number one. And number
15 two, the finding of responsibility on Doctor Holbrook is
16 irrespective of him being in charge of the OR. And it's clear
17 that every single juror was confused about that and about his
18 role and his responsibility. Ang guess what? Stephanie Cribb
19 Creek told them, hey, listen this is how it's done at the VA,
20 she said that. She talked about the responsibility of one
21 doctor and you had jurors say, yeah, she explained to us that
22 one doctor is not above the other doctor, so they're both MDs
23 and because they're both MDs he wasn't captain of the ship.
24 And since he wasn't captain of the ship, then he can't be held
25 solely responsible. And the jury charge that you gave them

1 was not that he had to be solely responsible. There's nothing
2 in your jury charges that tells this jury that they have to
3 find him to be solely responsible or that he was the doctor
4 that was in charge of the operating room. The law is what you
5 gave them, that his alleged acts or omissions had to be at
6 least one of the proximate causes, not the proximate cause,
7 but a proximate cause and that's straight out of your jury
8 charges.

9 The jury did not apply the law. They thought that in
10 order to find for the plaintiff they would have to find that
11 Doctor Holbrook was of course the captain of the ship. And
12 that goes to the 13th Juror Doctrine is if there is confusion
13 amongst the jury ---

14 **THE COURT:** Sorry, I was just told that jelly roll is out
15 there.

16 **MR. GOINGS:** Yeah, she is cute.

17 If there is confusion amongst the jury, that's when the
18 13th Juror Doctrine comes into play. And the case law says
19 that, Your Honor, you don't even have to give a reason under
20 the 13th Juror Doctrine. It is affirmed if that is your
21 opinion that justice was not done in this case and it could be
22 if there were confusion amongst the jury, it could be if it
23 was contrary to the fair preponderance of the evidence.
24 You're not prejudicing anyone, other than the fact that we
25 have to do another trial, they still get their day in trial,

1 you're just giving the parties an opportunity to present their
2 case in front of another jury. And, Your Honor, that's
3 exactly what we're asking here today is that Ms. Goodwin have
4 the opportunity to present her case in front of another jury.

5 You know, in this case we presented expert after expert
6 that defined the standard of care, that not only defined the
7 standard of care, but set forth the violations of the standard
8 of care. The defense experts, most of them conceded, conceded
9 our points as to the violations of the standard of care. The
10 CNRA admitted on the stand that if he would have been given
11 the baseline blood pressures from Doctor Holbrook's office in
12 Midlands Orthopedics, if he would have been given those then
13 Crystal Goodwin's blood pressure would have been maintained at
14 the right level. He admitted that the blood pressure was not
15 properly maintained and it fell well below the 20 percent rule
16 of thumb. Everyone agrees to the 20 percent rule of thumb,
17 and everyone agreed that the baseline blood pressure fell
18 below the 20 percent.

19 And so expert after expert, witness after witness, you
20 know, Ms. Goodwin is, of all the clients I've ever had, Your
21 Honor, is truly the most deserving. And it would be an error
22 of justice for us not to ask this Court to invoke her
23 responsibility under the 13th Juror Doctrine.

24 I apologize to the Court for filing the motion, the first
25 motion that we filed the day after the proceedings based on

1 evidence that we understood and believed to be true based on
2 what we were told and what we found in the public index, Your
3 Honor, and we're being extremely candid to Your Honor about
4 that. And I hope you understand that the last thing, Your
5 Honor, that we wanted you to do was to take up your precious
6 time, the juror's precious time based on something we believe
7 to be untrue. That certainly was not the case. But there is
8 a lot of merit in that motion as it relates to the juror
9 misconduct, and it may not be malicious, as Mr. Ross said, I
10 don't believe that she was being malicious. And you don't
11 have to find that the juror was being malicious. But, Your
12 Honor, I think it's clear that she interjected, she as in Ms.
13 Stephanie Cribb Creek, interjected her own professional
14 knowledge as a nurse, she interjected her understanding of
15 policies and procedures in a hospital into that deliberation
16 and that is evidence that is -- that this jury should never
17 consider, never considered at all, but the jury did consider
18 it. And she, being the medical expert in the room, carried
19 the day. And that's exactly what happened in this case. And
20 I understand these jurors were reluctant to say maybe perhaps
21 what they told us off the record, but suffice it to say that
22 the 13th Juror Doctrine as it relates to if this Court
23 believes that justice was not done in this case, if this Court
24 believes that there may have been confusion amongst the jury,
25 if this Court believes that the verdict is contrary to the

1 fair preponderance of the evidence, Your Honor can invoke the
2 13th Juror Doctrine. You don't have to give any explanation,
3 didactic opinion, you don't have to actually give an order
4 that weighs and considers the evidence. The fact that you
5 believe, Your Honor, that simply justice may not have been
6 done in the trial of this case, would open the door to Ms.
7 Goodwin having her day in court with 12 other jurors.

8 If I could answer, Your Honor, any questions that you may
9 have, and I do on behalf of Ms. Goodwin and the other
10 plaintiff counsel here, appreciate the seriousness in which
11 you've handled this motion. In particular the motion of the
12 juror misconduct because I think the Court and the parties
13 were able to get down to what we now know to be the truth as
14 it relates to Ms. Stephanie Cribb Creek. Thank you, Your
15 Honor.

16 **THE COURT:** Mr. Heitman?

17 **MR. HEITMAN:** Your Honor, since there has been no
18 evidence of concealment after questioning the jury, I would
19 like to renew my objection to the admissibility of both the
20 juror affidavit, as well as any of this juror testimony at
21 this time based on my previous arguments.

22 **THE COURT:** Plaintiff's counsel, let me hear from you on
23 that because that was sort of a threshold issue in even taking
24 the testimony, or is it sufficient that there was an
25 allegation ---

1 **MR. GOINGS:** That's what I was going to say, it's
2 sufficient that there was an allegation for Your Honor to take
3 testimony. And not only an allegation, but a good faith
4 allegation for Your Honor to take testimony. And quite
5 frankly I think the proper protocol was done by you bringing
6 the jury in here and asking them questions under oath. How
7 else would you ever determine the truth other than what you
8 did? I didn't have that luxury before I filed the motion so -
9 --

10 **THE COURT:** Mr. Heitman?

11 **MR. HEITMAN:** Your Honor, I don't believe any of the
12 cases say anything about if there is an allegation of
13 concealment that it's proper to admit all of the evidence that
14 we've heard today. I believe the Court is very clear when it
15 says in State v Ziller that as a general rule juror testimony
16 is inadmissible to impeach a jury verdict, and then if the
17 allegation or alleged misconduct is internal the Courts are
18 more strict. Here we have an instance of internal misconduct,
19 we don't have all of these external extraneous factors coming
20 in, people trying to sway the jury one way or the other. And
21 we don't have any allegation of racial prejudice playing a
22 role in determining the verdict, or any other factor that
23 would violate Ms. Goodwin's due process rights.

24 Here we have juror misconduct, alleged juror misconduct,
25 that took place inside the jury room, that is not external

1 misconduct and the Court's are very clear that evidence of
2 internal jury misconduct by way of juror testimony and juror
3 affidavits is not admissible.

4 **THE COURT:** All right. Talk to me about the 13th Juror
5 Doctrine which need not rely on juror testimony.

6 **MR. HEITMAN:** Yes, Your Honor.

7 Well first of all, it's not the trial court's job to look
8 at the greater weight of the evidence. Dixon v Grand Fire and
9 Marine Insurance Company stated that the courts cannot pass
10 upon the credibility of witnesses or the weight of the
11 testimony, these are matters for the jury.

12 Similarly, in Bass v South Carolina Department of Social
13 Services it says neither an Appellate Court or the trial court
14 has the authority to decide credibility issues or resolve
15 conflicts in the testimony or evidence.

16 In Richie v Ingle that opinion said resolving disputes
17 over the conflicting versions of the facts and the correct
18 inferences to draw from those facts fall squarely within the
19 jury's role as finder of the facts. Now, however, it is the
20 trial court's job to step in only when the facts of the case
21 do not support the verdict.

22 **THE COURT:** Is that not their argument?

23 **MR. HEITMAN:** No, Your Honor. They're asking you to give
24 credence to the weight of the evidence that had been submitted
25 in this case. Folkens v Hunt says the 13th Juror Doctrine is a

1 vehicle by which the trial court may grant a new trial
2 absolute when it finds that the evidence does not justify the
3 verdict. Here in this case, there was proper evidence
4 introduced by the defendants at trial to support the jury
5 verdict. We introduced evidence that showed that Crystal
6 Goodwin's injury was not caused by blood pressure and low
7 blood perfusion, but was instead caused by a reperfusion
8 injury. We also introduced evidence that a reperfusion injury
9 is unpredictable, unforeseeable, and unpreventable, once it
10 occurs the injury is not treatable.

11 We further introduced evidence that Doctor Holbrook
12 appropriately responded to the nerve monitoring tech in the OR
13 when it was announced that the signals went out, and Doctor
14 Holbrook stopped the surgery, asked the tech to check the
15 equipment to see if it was functioning, and asked anesthesia
16 if there were any issues, and inspected the surgical site.
17 All of that evidence supports the jury verdict in this case,
18 and it would be improper to give them, as if they submitted
19 greater weight than the evidence we submitted.

20 **THE COURT:** Anything else?

21 **MR. GOINGS:** He's just incorrect about the standard, Your
22 Honor, with the cases it's absolutely clear and on point. And
23 it's your discretion based on the facts, evidence, witnesses,
24 and trial circumstances as the Judge views them is what the
25 case says. And the trial judge has the authority -- quoting

1 from Adams v Duffy "The trial judge has the authority and
2 responsibility to grant a new trial when in her judgement the
3 verdict of the jury is contrary to the fair preponderance of
4 the evidence." And there was a case in this case, Your Honor,
5 the Court affirmed the 13th juror and from the 13th juror
6 decision of the trial judge when the trial judge said "They're
7 not satisfied that justice of this case was done and feels
8 like it should be tried before another jury." Simply saying
9 that, the Supreme Court said that in and of itself is enough.
10 And you don't really have to give a reason whatsoever other
11 than the fact that the standard is stating that if the Judge
12 believes the verdict is either unsupported by the evidence, or
13 is inconsistent, or is based on jury confusion, any and all of
14 these in the Judge's sole discretion constitutes a "hanging of
15 the jury" and grants the parties a new trial for justice to
16 prevail.

17 **MR. HEITMAN:** Your Honor, every juror who was questioned
18 and earlier testified that their decision was based on the law
19 and on expert testimony in this case.

20 The confusion that Mr. Goings is talking about regarding
21 the Captain of the Ship Doctrine, Mr. Robinson said that the
22 Captain of the Ship Doctrine was not discussed during the
23 trial of this case, it was not evidence, so they decided they
24 couldn't discuss or consider it during the jury deliberations.
25 And every single juror who was questioned whether that had a

1 weight on their verdict said that -- said that their verdict
2 was based on the law as you charged it and that it was also
3 based on expert testimony within the case.

4 **THE COURT:** Okay. Anything else from anyone else?

5 **MR. GOINGS:** No, Your Honor. Thank you.

6 **MR. HEITMAN:** No, Your Honor. Unless I guess you haven't
7 ruled on my objection.

8 **THE COURT:** Right. I will get you a decision in writing.

9 **MR. HEITMAN:** Okay. Thank you.

10 **THE COURT:** Okay. Thank you all. Thank you. Thank you
11 for being here.

12 **(COURT IS ADJOURNED)**