Michael D. Zimmerman (3604)
Troy L. Booher (9419)
Beth E. Kennedy (13771)
ZIMMERMAN JONES BOOHER
Felt Building, Fourth Floor
341 South Main Street
Salt Lake City, UT 84111
mzimmerman@zjbappeals.com
tbooher@zjbappeals.com
bkennedy@zjbappeals.com
(801) 924-0200

Terence L. Rooney (5789)
Bradley R. Blackham (8703)
SNOW, CHRISTENSEN & MARTINEAU
PO Box 45000
Salt Lake City, UT 84145
TR@scmlaw.com
brb@scmlaw.com
(801) 521-9000

Attorneys for Defendant

THIRD JUDICIAL DISTRICT COURT
SALT LAKE COUNTY, STATE OF UTAH

DAVID SCOTT and DEBRA SCOTT,

Plaintiffs,

v.

UNIVERSITY OF UTAH HOSPITAL AND MEDICAL CENTER,

Defendant.

MOTION FOR NEW TRIAL PURSUANT TO RULE 59

Case No. 110917738
The Honorable Su J. Chon

Oral Argument Requested

Table of Contents

Attachments

Table of Authorities

Pursuant to rule 59(a) of the Utah Rules of Civil Procedure, University of Utah Hospital and Medical Center (the "University") respectfully submits this motion for new trial.

Relief Requested and Grounds for Relief Requested

The University moves the court for an order granting a new trial under rule 59(a) of the Utah Rules of Civil Procedure. The court should grant the motion because the Scotts' counsel deliberately and repeatedly made improper comments that inflamed the passions and prejudices of the jury. Under rule 59(a)(1) and 59(a)(7), the court should order a new trial if the failure to order a mistrial affected a party's substantial rights and prevented the party from having a fair trial. Utah R. Civ. P. 59(a)(1), (7) (citing *id.* R. 61).

Counsel's comments violated Utah law and also this court's order in limine. The University filed its motion in limine because it was aware that the Scotts' counsel—Mr. Worel and Mr. Thronson—made similar improper comments in a recent trial. Remarkably, despite the University's efforts and in disregard of this court's order, Mr. Worel and Mr. Thronson made *the same* repeated improper comments in this case. Those comments, along with counsel's other improper and prejudicial comments, prevented the University from having a fair trial. The court should grant the University a new trial.

Relevant Procedural and Factual Background

In this medical malpractice case, the jury awarded more than $11 million in damages to David and Debra Scott for injuries Mr. Scott sustained in connection with brain surgery performed by Dr. Randy Jensen. (3/2/2015 Special Verdict at 3.) The jury was asked to decide whether Dr. Jensen breached the standard of care when he recommended surgery to biopsy what he believed was a brain tumor. Mr. Scott suffered a stroke during or shortly after the surgery.

(3/2/2015 Special Verdict at 2.) Mr. Scott is now permanently injured. (2/19/15 Trial Tr. at 211-17, 242-67; 2/20/15 Trial Tr. at 10-20.)

The Scotts argued that Dr. Jensen breached the standard of care by (i) failing to rule out infection before performing the surgery, (ii) failing to advise the Scotts that a viable option was to watch and wait for one to two months, and (iii) electing an unnecessary and dangerous surgical process, which caused the stroke.

1. The Evidence

In this motion, the University will demonstrate that the numerous improper comments made by the Scotts' counsel deprived the University of a fair trial. In what follows, the University briefly summarizes the evidence presented to the jury to show how the jury's decision was affected by counsel's misconduct. After hearing the evidence—and all of the improper comments—the jury found the University liable and awarded more than $11 million in damages.

In support of their argument that Dr. Jensen failed to rule out infection before performing the surgery, the Scotts presented evidence that Dr. Jensen should have included infection on his differential diagnosis and should have ordered testing to rule out an infection before proceeding with a surgical biopsy. (2/18/15 Trial Tr. at 43, 56-58, 69-72; 2/19/15 Trial Tr. at 29, 34-35.)

The University presented evidence that it was reasonable for Dr. Jensen to diagnose Mr. Scott as likely having a tumor, and also that the testing urged by the Scotts would not have revealed an infection. Dr. Jensen testified that he began with a broad differential diagnosis that included infection, and then narrowed it down to tumor as the most likely diagnosis as he spoke with and examined Mr. Scott. (2/26/15 Trial Tr. at 138-42, 146-58). And Dr. Jensen and four other experts—including a neurosurgeon who examined Mr. Scott before Dr. Jensen examined

him—testified that the clinical picture did not fit a diagnosis of infection. (2/26/15 Trial Tr. at 138-42, 146-158; 2/25/15 Trial Tr. at 39, 248; 3/2/15 a.m. Trial Tr. at 33-36; 2/24/15 Trial Tr. at 70-71.)

The University also presented evidence of extensive laboratory testing done after Mr. Scott's stroke that was negative for a brain infection. The University presented expert testimony from a brain infection specialist who said that even if the testing had been ordered by Dr. Jensen prior to the surgery, the result likely would have been negative for infection. (2/26/15 Trial Tr. at 58; 3/2/15 a.m. Trial Tr. at 48-57, 64-65.)

Next, in support of their argument that Dr. Jensen failed to advise the Scotts that a viable option was to watch and wait for one to two months, Mrs. Scott testified that Dr. Jensen did not inform them that it might be reasonable to wait and reevaluate with another MRI. (2/19/15 Trial Tr. at 226-28.) She also testified that, if given the option, Mr. Scott would not have undergone surgery immediately. (2/19/15 Trial Tr. at 227.)

But the University presented evidence that the option of observation was discussed extensively with the Scotts by not only Dr. Jensen but also by Dr. Peter Maughan, the neurosurgeon who initially consulted with the Scotts before they sought a second opinion from Dr. Jensen. (2/26/15 Trial Tr. at 165-67; 2/25/15 Trial Tr. at 233, 248.) While both Dr. Jensen and Dr. Maughan presented observation as an option—as reflected in records of their consultations with the Scotts—they independently shared their professional opinions with the Scotts that observation was not advisable because it posed a significant risk that the tumor would enlarge or cause neurologic symptoms, including seizures. (2/26/15 Trial Tr. at 165-67; 2/25/15

Trial Tr. at 233-34.) The University's neurosurgery expert agreed with Dr. Jensen and Dr. Maughan. (2/25/15 Trial Tr. at 48-49.)

Finally, in support of their argument that Dr. Jensen elected an unnecessary and unreasonably dangerous surgical process that caused a stroke, the Scotts presented evidence that Dr. Jensen breached the standard of care when he performed a "debulking" procedure instead of a needle biopsy or a more conservative open biopsy procedure. (2/20/15 Trial Tr. at 76-77, 80-90.) They also presented evidence that, during the surgery, Dr. Jensen cut the middle cerebral artery, which caused Mr. Scott's stroke. (2/20/15 Trial Tr. at 78-79; 2/18/15 Trial Tr. at 187-88; 2/25/15 Trial Tr. at 176.)

The University presented evidence that a needle biopsy would have been a "big mistake" because a needle biopsy both is not as diagnostically accurate and is a blind procedure that increases the risk of rupturing a blood vessel. (2/25/15 Trial Tr. at 71-91, 234; 2/26/15 Trial Tr. at 168-69.) The University also presented evidence that Dr. Jensen performed the biopsy procedure appropriately. (2/25/15 Trial Tr. at 81, 91-93; 2/26/16 Trial Tr. at 198-210.)

Finally, the University presented testimony that if Dr. Jensen had cut a major blood vessel during the procedure, there would have been significant bleeding and a change in Mr. Scott's blood pressure. (2/26/15 Trial Tr. at 207-09.) All of the neurosurgeons who testified about the surgery—including the Scotts' expert—agreed there is nothing in the surgical records to suggest a major artery was cut during the procedure. (2/26/15 Trial Tr. at 207-09; 2/25/15 Trial Tr. at 65-66; 2/20/15 Trial Tr. at 105-06, 122-23.)

2. The Motions & Orders in Limine

The parties made four motions in limine that are relevant to this motion. The University filed a "Motion in Limine Re: Reptile Theory," seeking to prevent the Scotts' counsel from suggesting, among other things, that the jury's goal should be to protect the community's safety, or that the jury should "send a message" about what is acceptable in this community. (1/12/15 Mem. in Supp. of Mot. in Limine.) The University was particularly worried about these types of improper comments because its counsel was aware that the Scotts' counsel, Mr. Worel and Mr. Thronson, made similar comments in a recent trial, *Friedli v. Grover*. (*Id.* at 1-3.) In the *Friedli* trial, the Scotts' counsel made the following statements that were improper because, in those comments, counsel asked the jury to "send a message," invoked a "community conscience," and invited a "call to action":

- "It's safety for our community, for our acquaintances, for our friends, for our families." (*Id.* at 2.)
- "The point is, you may have been under the mistaken impression that this case was just about that family, and it's not. It is not. This case and your decisions are much more than that." (*Id.* at 2.)
- "I think you understood in voir dire when I asked you, 'Do you guys agree in the concept that full justice in the right case can benefit all in the community because it can shape how things happen in the future?' Do you remember us discussing that? And you saying, 'Yeah, I get how that can be.'" (*Id.* at 2.)
- "This case, they are representatives of the community. This case affects so much more than the Friedli family." (*Id.* at 2.)
- "You have the right to change actions of how people will approach a similar situation in the future, be it this doctor or any doctor." (*Id.* at 3.)

The University's motion also asked the court to prevent the Scotts from making so-called "reptile" arguments—i.e., arguments that invite the jury to make their decision based on concerns for their own personal or community safety. (*Id.* at iv.)

While the court denied the motion on the reptile theory, importantly it imposed related restrictions on the types of comments the parties could make. (2/24/15 Order at 2.) Specifically, the court identified several types of improper prejudicial statements and ordered, in relevant part, that:

> (3) [T]he parties shall not make golden rule arguments;
>
> (4) the parties shall not argue or suggest that the jury serves as the conscience of the community in rendering a verdict;
>
> (5) the parties shall not argue or suggest to the jury that it send a message to medical providers through its verdict;
>
> (6) the parties shall not present arguments that appeal to or inflame passions or prejudice; and
>
> (7) the parties shall abide by Utah appellate court decisions relating to closing arguments.

(*Id.* at 2-3.)

The Scotts also worried that improper comments could prejudice the jury and filed two motions in limine to prevent similar improper statements. In one, the Scotts sought to prevent the University from referencing the so-called "McDonald's coffee case." (1/23/14 Mem. in Supp. of Mot. in Limine Re: *Liebeck v. McDonald's* at 2.) In the other, they sought to prevent the University from suggesting that the Scotts hoped to "win 'the jackpot' or "the lottery." (1/23/14 Mem. in Supp. of Mot. in Limine Re: "Jackpot" or "Lottery" at 2.) In both, the Scotts argued that the references could inflame and prejudice the jury by confusing the issues and suggesting that the jury base its decision on irrelevant material. (1/23/14 Mem. in Supp. of Mot. in Limine Re:

Liebeck v. McDonald's at 3; 1/23/14 Mem. in Supp. of Mot. in Limine Re: "Jackpot" or "Lottery" at 2.) Based on the parties' stipulations, the court granted both motions. (3/11/14 Order at 2.)

The Scotts also made an oral motion in limine to preclude the University from explaining why Dr. Jensen was at times absent from trial. (2/17/15 Trial Tr. at 175.) The University's counsel had noted that Dr. Jensen would be "in and out during the course of trial" to attend to his patient responsibilities. (*Id.* at 30.) The Scotts' counsel expressed concern that the University might use Dr. Jensen's absence to suggest that he was "saving lives" or "operating on people right now." (*Id.* at 177-78.) The court agreed and permitted the University to explain that Dr. Jensen has "responsibilities at the hospital," but noted that "[i]t shouldn't go any further than that." (*Id.* at 178.)

3. Counsel's Violations & the $11 Million Verdict

Despite these efforts to prevent improper and prejudicial comments—and the Scotts' concerns that counsel for the University not make the same types of comments—the Scotts' counsel made numerous comments that violated Utah law and the court's orders in limine. Counsel committed many of these violations while questioning witnesses at trial, but some of them when speaking directly to the jury.

First, while cross-examining Dr. Jensen, the Scotts' counsel insinuated that Dr. Jensen was at fault for being absent for portions of the trial:

- "Don't you think it would be valid for you to sit in this courtroom, since we are, and we're having to come every day, that you, since it's about you, and what you did, don't you think it's valid that you should be here to hear what these other doctors have to say about your care, so you might evaluate what they're going to—what they've said?" (2/26/15 Trial Tr. at 228.)

This question was particularly troubling because it was the *Scotts'* motion that prevented the University from explaining what Dr. Jensen was doing during the times he was absent from trial.

Second, the Scotts' counsel insinuated that the University had destroyed or withheld records. During discovery, the University provided to the Scotts the record of the meeting of the tumor board where the board discussed Mr. Scott's case before his surgery. (2/26/15 Trial Tr. at 1-2.) The tumor board then discussed Mr. Scott's case for a second time post-operatively, but the University explained to the Scotts—during discovery—that no record of that meeting existed. (2/26/15 Trial Tr. at 1-2.) Regardless, when Dr. Jensen testified that the tumor board discussed Mr. Scott's case after the operation, the Scotts' counsel repeatedly and insistently asked Dr. Jensen for the record of that meeting, suggesting improperly to the jury that the University had the record but had failed to provide it to the Scotts:

- "Show me the record of when . . . the doctors discussed what happened. . . . [W]e asked for all those records. . . . Where's the record of the second one . . . Where's my record to show us that it—you actually did take it to [the board], please? . . . Where is the record—you said [that you presented Mr. Scott's case to the tumor board post-operatively], too. . . . [W]here is the record that you actually did go and present to these people after the fact what you had found, and what was going on with your patient? Where is it, sir?" (2/19/15 Trial Tr. at 190-91.)

The Scotts' counsel then exacerbated the prejudice by repeating the insinuation during the cross-examination of Dr. Sloan. The Scotts' counsel asked whether Dr. Sloan had seen "any records about a post surgical tumor board meeting." (2/25/15 Trial Tr. at 170.) Dr. Sloan initially responded that he had. (*Id.*) The Scotts' counsel then stated that counsel had "asked that the hospital—for any record of a post surgical record," but had not received any. (*Id.* at 171.) In response—and consistent with the University's records—Dr. Sloan clarified that he was thinking of the record of the board meeting from *before* the surgery, not from after. (*Id.* at 171-72, 181-

84.) The Scotts' counsel then requested a spoliation instruction, confirming that it was counsel's intent to suggest to the jury that the University had destroyed the record. (*Id.* at 307-08.)

Third, the Scotts' counsel insinuated that the University had withheld other evidence from them. While re-cross-examining Dr. Chin about his memory of reviewing re-cut pathology slides of the biopsy of Mr. Scott's tumor, counsel stated:

- "I don't have those slides. Where'd you get those slides to be looking at, sir? . . . Where'd you get the slides?" (2/24/15 Trial Tr. at 203.)

The University's counsel established on the record that the University had provided the re-cuts to the Scotts' counsel, and provided the date that the Scotts' counsel picked them up and paid for them with a check. (2/26/15 Trial Tr. at 3.) The University requested a curative instruction because the Scotts' counsel had implied to the jury that the University had not provided the slides. (*Id.* at 3-11.) The court agreed that "there could be a reasonable perception that that might be the implication" and agreed to provide the instruction. (*Id.* at 3-8, 10.)

Most of the Scotts' counsel's improper comments occurred during closing argument. Counsel made several comments that violated the court's instructions that the parties shall not "suggest that the jury serves as the conscience of the community," "suggest to the jury that it send a message to medical providers," "inflame passions or prejudices," or violate "Utah appellate court decisions relating to closing argument. (2/24/15 Order at 2-3.) Specifically, in violation of the court's order, counsel stated as follows:

- "[Y]ou're going to be deciding a bigger issue, too, and that bigger issue you're going to be deciding is what do we as a population have the right to be informed of the medicine and our condition and do we have the right to have a say in what's done to our bodies? . . . When answering that question for Dave and Debra, you're answering that question globally for all of us. For my family, you're answering that question." (3/2/15 p.m. Trial Tr. at 23-24.)

- "It's going to take moral courage for you guys to come back with a verdict against the medical community. . . . [W]e don't want to think about that for my family, Charlie's family, for anybody's family . . . ." (*Id.* at 36-37.)

- "Debra . . . . took her husband on for better for worse, for richer for poorer, until death do they part. And she doesn't want to get paid for the fact that she's having to help her husband. She doesn't want . . . 'to be paid for it.' This thing here, care gratuitously rendered, that they said that's the cost of what she's given her husband. She doesn't want to be paid for it, but she does ask you, 'Take care of my husband.'" (*Id.* at 36.)

- "I have to say that I am flabbergasted by what you've just heard from defense counsel. . . . That Mr. Scott would have been better off dead is what he's basically saying." (*Id.* at 78.)

- "I was the one that took Dr. Jensen's deposition, and I remember coming back and talking to Mike, and I said, 'This guy seems pretty honest . . . . he's a pretty honest guy. And so, you know, . . . the jury will probably like him because he's been so honest.' I don't even recognize the person that took the stand that you heard when we put him on last Tuesday or Wednesday. That's 180 degrees from the individual I deposed." (*Id.* at 80-81.)

- "The final thing is if there was an award for spouse, caregiver, driver, confidante, supporter, advocate, Debra Scott would have won that award unanimously for the last five years. . . . [S]he said, 'You know, when I married him I love him and I accept that,' . . . . As Debra gets older, as tough as she is—she should have an 'S' on her chest—she's going to need more help." (*Id.* at 88-89.)

The University moved for a mistrial. (*Id.* at 38.) The court agreed that the Scotts' counsel violated the order in limine. (*Id.* at 38-39 ("I think it is [in violation] . . . [W]hat I heard seemed to cross that line . . . .."). The court provided a curative instruction, advising the jury that "[y]ou should not use this case[] as a form for correcting any perceived wrongs in other cases or in the broader society or as a means of expressing views about anything other than the right verdict in this case." (*Id.* at 92.)

The University renewed its motion after rebuttal. (*Id.* at 95.) The court denied the motion, ruling that the curative instruction "should have helped the situation." (*Id.* at 97-98.) The jury concluded that Dr. Jensen breached the standard of care and that he caused Mr. Scott's injury. (3/2/15 Special Verdict at 2.) The jury awarded $11,268,178.[1] (*Id.* at 3.)

Argument

During the trial, this court did not believe that any particular statement warranted a new trial. But when the improper comments are viewed cumulatively, it becomes clear that counsel's violations affected the University's substantial rights and deprived the University of a fair trial.

1. The Scotts' Counsel Made Numerous Comments that Violated Utah Law

The court should grant a new trial because the Scotts' counsel made numerous prejudicial comments in violation of Utah law.

1.1 Improper "Conscience of the Community" and "Send a Message" Statements

The Scotts' counsel made two comments that improperly suggested that the jury should act as the "conscience of the community" or that the jury should "send a message" with its verdict:

- "[Y]ou're going to be deciding a bigger issue, too, and that bigger issue you're going to be deciding is what do we as a population have the right to be informed of the medicine and our condition and do we have the right to have a say in what's done to our bodies? . . . When answering that question for Dave and Debra, you're answering that question globally for all of us. For my family, you're answering that question." (3/2/15 p.m. Trial Tr. at 23-24.)

[1] This court later reduced the award after applying the general damage cap and collateral source reductions provided in the Utah Healthcare Malpractice Act. (11/10/15 Mem. Dec. at 2.) The reduced amount has no bearing on whether counsel's comments were improper or prejudiced the jury, however.

- "It's going to take moral courage for you guys to come back with a verdict against the medical community. . . . [W]e don't want to think about that for my family, Charlie's family, for anybody's family . . . ." (*Id.* at 36-37.)

In other words, in violation of prior orders and obligations under Utah law, counsel told the jury that their verdict would impact the future medical care provided to other families, including their own.

It is well-settled that "conscience of the community" comments are improper because they ask the jury to "put themselves in the shoes" of the injured party, to "consider matters outside the evidence," and to base its decision on the future impact of their verdict. *State v. Campos*, 2013 UT App 213, ¶¶ 49, 51, 309 P.3d 1160. Indeed, "such statements divert the jury's attention from its legal duty to impartially apply the law to the facts." *State v. Akok*, 2015 UT App 89, ¶ 16, 348 P.3d 377. They are "an improper distraction from the jury's sworn duty to reach a fair, honest and just verdict according to the facts and evidence presented at trial." *Westbrook v. Gen. Tire & Rubber Co.*, 754 F.2d 1233, 1238 (5th Cir. 1985). In general,[2] improper comments in closing argument warrant reversal if, "absent the improper argument, there was a reasonable likelihood of an outcome more favorable to the complaining party." *Boyle v. Christensen*, 2011 UT 20, ¶ 23, 251 P.3d 810 (internal quotation marks omitted).

For example, in *State v. Akok*, the prosecutor told the jury, "[t]hey took advantage of a very vulnerable victim. Don't let them take advantage of it again." 2015 UT App 89, ¶ 16, 348 P.3d 377. The court reversed the conviction because the comment "appealed to the juror's emotions." *Id.* ¶ 30. Similarly, in *State v. Wright*, the prosecutor told the jury that they "have the

[2] As discussed below, a party need not show a "direct effect" on the jury's verdict if the improper comments were repeated violations of an order in limine. *Barrientos ex rel. Nelson v. Jones*, 2012 UT 33, ¶ 18-23. *See infra* part 2.1.

power to make [the abuse] stop." 2013 UT App 142, ¶ 41. The Utah Court of Appeals held that the comment was improper because it "appeal[ed] to the jurors' emotions by contending that the jury has a duty to protect the alleged victim—to become her partisan—which diverts their attention from their legal duty to impartially apply the law to the facts." *Id.*

The Utah appellate courts have not yet considered a "conscience of the community" or "send a message" statement outside of the criminal context, but cases from other jurisdictions confirm that the rule is the same in civil cases. Indeed, the United States Court of Appeals for the Eighth Circuit has held that "conscience of the community" statements are equally reprehensible in the civil context. *Gilster v. Primebank*, 747 F.3d 1007, 1011 (8th Cir. 2014).

Applying that rule, the United States Court of Appeals for the First Circuit vacated a judgment in a medical malpractice case because the plaintiff's counsel, in closing, told the jury to "decide this case with your heart" because "[y]ou are the conscience of the community." *Suarez Matos v. Ashford Presbyterian Cmty. Hosp., Inc.*, 4 F.3d 47, 51 (1st Cir. 1993). The court noted that "[i]t is difficult enough for a jury to decide a case involving serious suffering dispassionately upon the law and the evidence without being told that the community conscience calls to decide with the heart. The total argument was outrageous. We can only think that this experienced court, in permitting it, had a bad day." *Id.*

Similarly, in *Westbrook*, the plaintiff's counsel told the jury in closing that "[y]ou're going to be the conscience of the community with this verdict." 754 F.2d at 1238. The United States Court of Appeals for the Fifth Circuit reversed, holding that the comment "prejudiced the deliberations of the jury and affected the substantial rights of the parties. *Id.* at 1243. But the court noted that it is the message—not the precise words—that renders these statements

improper: "Our condemnation of a 'community conscience' argument is not limited to the use of those specific words; it extends to all impassioned and prejudicial pleas intended to evoke a sense of community loyalty, duty and expectation." *Id.* at 1238-39.

"Send a message" comments are similar and equally improper. "Send a message" comments "suggest to the jury that a significant verdict will send a message to stop such experiences from happening and will make others less likely to act irresponsibly." *R.J. Reynolds Tobacco Co. v. Gafney*, No. 4D13-4358, 2016 WL 1128480, at *3 (Fla. Dist. Ct. App. Mar. 23, 2016). They are "impermissibly calculated to inflame the passions of the jurors and divert[] the attention of the jurors from their duty to impartially apply the law to the facts of the case." *State v. Thompson*, 2014 UT App 14, ¶¶ 70, 91, 318 P.3d 1221 (reversing conviction after the prosecutor admonished the jury that they should "use its verdict to send a message" to the defendant). Because "send a message" comments suggest to the jury that "they may consider punishment or deterrence as an element of damages," they are impermissible in cases where punitive damages are not sought. *Smith v. Courter*, 531 S.W.2d 743, 748 (Mo. 1976), *overruled on other grounds by Tune v. Synergy Gas Corp.*, 883 S.W.2d 10 (Mo. 1994); *see also, e.g., R.J. Reynolds Tobacco Co.*, No. 4D13-4358, 2016 WL 1128480, at *3; 88 C.J.S. Trial § 291 (2016).

Cases from other jurisdictions are instructive. In *R.J. Reynolds Tobacco Co.*, the plaintiff's counsel told the jury in closing that its "verdict should speak loud and it should speak clear." No. 4D13-4358, 2016 WL 1128480, at *1. The court granted a new trial. *Id.* at *7. The court held that "send a message" and "conscience of the community" arguments are improper when discussing whether the plaintiff should be compensated, "due to the potential for the jury to punish through the compensatory award." *Id.* at *4.

Similarly, in *Maercks v. Birchansky*, a Florida appellate court reversed the judgment in a medical malpractice case after the plaintiff's counsel "three times asked the jury as the 'conscience of the community' to 'send a message with its verdict.'" 549 So. 2d 199, 199 (Fla. Dist. Ct. App. 1989) (per curiam). And in *Kloster Cruise Ltd. v. Grubbs*, the court granted a new trial because the plaintiff's counsel told the jury that it should "tell [the defendant] by your verdict in this case to do something about this." 762 So. 2d 552, 554-55 (Fla Dist. Ct. App. 2000). The court held that "such 'send a message' arguments are clearly improper" and that they denied the defendant a fair trial. *Id.* at 555.

Here, the Scotts' counsel's comments did numerous of these things in the same trial, suggesting to the jury that their verdict could impact the future medical care provided to other patients. The comments improperly asked the jury to "put themselves in the shoes" of Mr. Scott and future patients. *See Campos*, 2013 UT App 213, ¶¶ 49, 5. They also asked the jury to have the "moral courage" to send a message—not just to the University, but to the entire "medical community." The comments asked the jury to consider the future impact of their verdict, and thereby base its decision on *those* patients, not on Mr. Scott and the facts of this case. *See Akok*, 2015 UT App 89, ¶ 16; *Wright*, 2013 UT App 142, ¶ 41. The comments were improper and warrant a new trial.

1.2 Other Improper Statements that Inflame the Passions and Prejudices of the Jury

While the comments above are sufficient to warrant a new trial, the Scotts' counsel made six additional comments that served to inflame the passions and prejudices of the jury.

The first occurred when the Scotts' counsel insinuated that Dr. Jensen was at fault for being absent for portions of the trial:

- "Don't you think it would be valid for you to sit in this courtroom, since we are, and we're having to come every day, that you, since it's about you, and what you did, don't you think it's valid that you should be here to hear what these other doctors have to say about your care, so you might evaluate what they're going to—what they've said?" (2/26/15 Trial Tr. at 228.)

Counsel made the suggestion even though it was the *Scotts'* motion that prevented the University from explaining what Dr. Jensen was doing during the times he had to be absent from trial. (2/17/15 Trial Tr. at 175.)

The second occurred when counsel insinuated that the University had destroyed or withheld the record of a post-operative tumor board meeting, even though counsel was aware that no such record existed:

- "Show me the record of when . . . the doctors discussed what happened. . . . [W]e asked for all those records. . . . Where's the record of the second one . . . Where's my record to show us that it—you actually did take it to [the board], please? . . . Where is the record—you said [that you presented Mr. Scott's case to the tumor board post-operatively], too. . . . [W]here is the record that you actually did go and present to these people after the fact what you had found, and what was going on with your patient? Where is it, sir?" (2/19/15 Trial Tr. at 190-91.)

The Scotts' counsel then exacerbated the error by repeating the insinuation when he questioned Dr. Sloan about "any records about a post surgical tumor board meeting" and stated that counsel had "asked that the hospital—for any record of a post surgical record," but had not received any. (2/25/15 Trial Tr. at 170-71.) If there were any doubt that counsel intended to suggest to the jury that the University had destroyed the record, that doubt was removed when counsel requested a spoliation instruction. (*Id.* at 307-08.)

The third improper comment was similar and occurred when counsel insinuated that the University had withheld the re-cut slides, even though the University had provided them to the Scotts. While re-cross-examining Dr. Chin about the slides, counsel stated:

- "I don't have those slides. Where'd you get those slides to be looking at, sir?" . . . Where'd you get the slides?" (2/24/15 Trial Tr. at 203.)

The other three comments occurred in closing argument. Counsel twice suggested that Mrs. Scott—a plaintiff in this lawsuit, with a claim for loss of consortium—was merely a loving wife and a hero who did not want to "get paid":

- "Debra . . . . took her husband on for better for worse, for richer for poorer, until death do they part. And she doesn't want to get paid for the fact that she's having to help her husband. She doesn't want . . . 'to be paid for it.' This thing here, care gratuitously rendered, that they said that's the cost of what she's given her husband. She doesn't want to be paid for it, but she does ask you, 'Take care of my husband.'" (*Id.* at 36.)

- "The final thing is if there was an award for spouse, caregiver, driver, confidante, supporter, advocate, Debra Scott would have won that award unanimously for the last five years. . . . [S]he said, 'You know, when I married him I love him and I accept that,' . . . . As Debra gets older, as tough as she is—she should have an 'S' on her chest—she's going to need more help." (*Id.* at 88-89.)

Finally, and perhaps most outrageously, counsel suggested that the University's counsel had stated that Mr. Scott would have been "better off dead":

- "I have to say that I am flabbergasted by what you've just heard from defense counsel. . . . That Mr. Scott would have been better off dead is what he's basically saying." (*Id.* at 78.)

To the extent there was any doubt that the "conscience of the community" and "send a message" comments were prejudicial, these additional comments, viewed cumulatively, remove that doubt.

But these comments are also improper and prejudicial by themselves. They improperly appealed to the jury's passions and diverted the jury from its duty to render a decision based upon the facts of the case. *Boyle v. Christensen*, 2011 UT 20, ¶ 22, 251 P.3d 810; *State v. Akok*, 2015 UT App 89, ¶ 16, 348 P.3d 377. And like all the other improper comments, they were "impermissibly calculated to inflame the passions of the jurors and divert[] the attention of the jurors from their duty to impartially apply the law to the facts of the case." *State v. Thompson*, 2014 UT App 14, ¶ 70, 318 P.3d 1221. The Utah Supreme Court has been clear that "pleas plainly designed to elicit sympathy or to inspire passion or prejudice should not be allowed." *Donohue v. Intermountain Health Care, Inc.*, 748 P.2d 1067, 1068 (Utah 1987) (internal quotation marks omitted).

For example, in *Donohue*, the Utah Supreme Court held that a new trial was warranted in a medical malpractice case because counsel made three improper comments in closing argument. 748 P.2d at 1068. The plaintiff's counsel stated in closing that "[i]n our system, a small, but an injured party, is allowed, through the jury system, to take on the strong and the mighty," and that suing the hospital "is a little like suing Mother Nature in this community." *Id.* Counsel also insinuated that the hospital had been unwilling to resolve the case before trial. *Id.* The supreme court held that counsel's comments were improper because they "appear motivated by a desire to stir up the jury emotionally against [the hospital]" and that the comments "could have prejudiced the jurors against [the hospital] and caused them to render an inflated verdict." *Id.*

Similarly, in a more recent case, the Utah Supreme Court held that a single improper reference in closing argument can warrant a new trial. *Boyle*, 2011 UT 20, ¶¶ 22-24, 29. In *Boyle*, defense counsel referenced the iconic so-called "McDonald's coffee case" a single time in

closing argument. *Id.* ¶ 5. Importantly, counsel not only referenced it, but misrepresented that the case involved a per diem analysis. *Id.* ¶¶ 5, 24. The supreme court reversed the verdict and remanded for a new trial. *Id.* ¶ 29. The court noted that, "[g]iven the uniquely iconic nature of this case, the passion it has produced in the media, and the general misunderstanding of the totality of its facts and reasoning among the public, we find it hard to imagine a scenario where it would be proper for a party's counsel to refer to it before a jury." *Id.* ¶ 22.

The court held that there was a "reasonable likelihood" that the comment had caused actual prejudice for several reasons: (i) the comment referenced a case that aroused significant "passion and prejudice," (ii) the trial judge's handling of the objection allowed the jury to believe it was proper to consider the comments, (iii) the misrepresentation allowed the jury to believe the case they were deciding was similar to the McDonald's coffee case, and (iv) the size of the damages award "certainly could not have been the product of entirely rejecting" the improper reference. *Id.* ¶ 24.

The same is true here. Like the improper remarks in *Donohue*, the Scotts' counsel's statement that the University's counsel said "Mr. Scott would have been better off dead" and his comments about Mrs. Scott's selfless heroism "appear motivated by a desire to stir up the jury emotionally against [the hospital]." 748 P.2d at 1068. Indeed, the jury awarded Mr. Scott more than $9 million—a result that suggests the jury did not "reject[]" the improper comments. *Boyle*, 2011 UT 20, ¶ 24.

More important, all of the insinuations were false. The Scotts' counsel suggested that the University withheld the slides and the record of the tumor board meeting, even though counsel knew that the University had provided the re-cuts and that no record of the meeting existed.

Similarly, counsel accused the University's counsel of saying that "Mr. Scott would have been better off dead" even though he knew counsel made no such statement. And counsel insinuated that Mrs. Scott selflessly "doesn't want to be paid," even though Mrs. Scott had a pending claim for loss of consortium—for which the jury ultimately awarded her $2 million. Those misrepresentations, like the misrepresentation about the McDonald's coffee case, prejudiced the jury and warrant a new trial.

1.3 Improper Expression of Personal Belief

To compound the problems, in closing argument, the Scotts' counsel also improperly expressed his personal belief about Dr. Jensen's trustworthiness:

- "I was the one that took Dr. Jensen's deposition, and I remember coming back and talking to Mike, and I said, 'This guy seems pretty honest . . . . he's a pretty honest guy. And so, you know, . . . the jury will probably like him because he's been so honest.' I don't even recognize the person that took the stand that you heard when we put him on last Tuesday or Wednesday. That's 180 degrees from the individual I deposed." (3/2/15 p.m. Trial Tr. at 80-81.)

Like all the other improper comments, this comment violated Utah law. "[C]ounsel may not assert personal knowledge of the facts in issue or express a personal opinion, being a form of unsworn, unchecked testimony." *State v. Thompson*, 2014 UT App 14, ¶ 51, 318 P.3d 1221 (alterations and internal quotation marks omitted); *see also* Utah R. Prof'l Conduct 3.4 ("A lawyer shall not . . . assert personal knowledge of facts in issue" or "state a personal opinion as to . . . the credibility of a witness.").

The United States Supreme Court has been clear that the rule applies to both sides of the case: "Defense counsel, like the prosecutor, must refrain from interjecting personal beliefs into the presentation of his case." *United States v. Young*, 470 U.S. 1, 8-9 (1985). And the United

States Court of Appeals for the First Circuit has explained that the rule applies in both the civil and criminal context: "Courts have long recognized that statements of counsel's opinions or personal beliefs have no place in a closing argument of a criminal or civil trial." *Polansky v. CNA Ins. Co.*, 852 F.2d 626, 628 (1st Cir. 1988) (citing *Young*, 470 U.S. at 8-9). Indeed, in *Polansky*, the court granted a new trial because the plaintiff's counsel stated in closing argument that the defendant's testimony "wasn't convincing to me," that "I don't believe" the testimony of one witness, and that, with respect to another witness, "I would never ask her if she was coming in here to lie." *Id.* at 627-28.

Here, the Scotts' counsel told the jury that they should not trust Dr. Jensen, the most important witness in the case. And he did so in closing argument, just before the jury was tasked with deciding whether Dr. Jensen breached the standard of care—or in other words, whether to believe Dr. Jensen. The comment was improper, prejudicial, and warrants a new trial.

2. Counsel's Comments Warrant a New Trial Because the Comments Violated the Order in Limine and Prejudiced the Jury

As the court noted at trial, the Scotts' counsel violated this court's order in limine when they made repeated improper comments to the jury. Because the order in limine precluded comments that were already improper under Utah law, counsel's deliberate violations are alone enough to warrant a new trial. But even absent the order, the University would be entitled to a new trial because the comments prejudiced the jury and the curative instructions did not cure the error.

2.1 The Court Should Grant a New Trial Because Counsel Violated the Order Repeatedly and Deliberately

The Scotts might argue that their counsel's misconduct was harmless and that the University cannot show actual prejudice. But because their counsel deliberately and repeatedly violated the order in limine, the University need not show a "direct effect" on the jury. *Barrientos ex rel. Nelson v. Jones*, 2012 UT 33, ¶ 18-23, 282 P.3d 50.

Each of the Scotts' counsel's improper comments violated this court's order in limine, which stated that "the parties shall not argue or suggest that the jury serves as the conscience of the community in rendering a verdict," "the parties shall not argue or suggest to the jury that it send a message to medical providers through its verdict," "the parties shall not present arguments that appeal to or inflame passions or prejudices," and that "the parties shall abide by Utah appellate court decisions relating to closing arguments." (2/24/15 Order at 2-3.)

The Utah Supreme Court has explained that a new trial is warranted if counsel repeatedly violates an order in limine. *Wilson v. IHC Hosps., Inc.*, 2012 UT 43, ¶¶ 54-56, 289 P.3d 369; *Barrientos*, ¶¶ 13-23. In that context, improper comments are prejudicial for the reasons they were excluded in the first place—the court does not require the moving party to establish the "direct effect" the improper statements had on the jury or the verdict. *Barrientos*, 2012 UT 33, ¶¶ 18-23. And when counsel's comments violate both Utah law and an order in limine, any doubt about the effectiveness of a curative instruction should be resolved in favor of the disadvantaged party. *Wilson*, 2012 UT 43, ¶ 56.

For example, in *Barrientos*, the plaintiff obtained an order in limine to prevent the defendant from introducing evidence of the decedent's character because that evidence was unfairly prejudicial. 2012 UT 33, ¶ 11. Despite the order, defense counsel "repeatedly asked

questions regarding these forbidden topics." *Id.* ¶ 13. Defense counsel then argued that a new trial was not warranted because the plaintiff could not "meet her burden of establishing the questioning had a direct effect on the verdict." *Id.* ¶ 18.

The supreme court disagreed. Without requiring the plaintiff to show that the improper questions had a "direct effect" on the verdict, the court noted that the questions "could not have served any relevant purpose" and instead "served only to prejudice the jury." *Id.* ¶ 19. The court held that "[e]vidence is unfairly prejudicial in this context if it . . . appeals to the jury's sympathies, or . . . provokes its instinct to punish or otherwise causes a jury to base its decision on something other than the established propositions of the case." *Id.* (internal quotation marks omitted). The court concluded that the trial court erred when it declined to grant the plaintiff a new trial. *Id.* ¶ 23.

Similarly, in *Wilson*, the plaintiffs sought and received an order in limine "[t]o ensure enforcement of [the] well-established" common-law collateral source rule. 2012 UT 43, ¶ 2. But during trial, defense counsel "persistently and deliberately violated" the order. *Id.* In its discussion of the prejudice caused by defense counsel's statements, the supreme court did not draw a relationship between the comments and the verdict, but instead explained the long-standing rationale behind the collateral source rule and the reasons collateral source evidence should be excluded. *Id.* ¶¶ 47-52.

The court granted a new trial. *Id.* ¶ 78. The court also explained why the trial court's curative instruction was insufficient to cure the error: While the instructions "may have had some mitigating effect," defense counsel's violations of the order in limine were "neither isolated nor inadvertent." *Id.* ¶ 56. "When evidence with such recognized potential for prejudice permeates

the trial to the extent it did here, the possibility of prejudice remains high despite the trial court's efforts to reduce it." *Id.* And when the violations are part of a "deliberate strategy, in clear violation of [Utah law] and the court's orders, any substantial doubt about the effectiveness of curative instructions should be resolved in favor of the disadvantaged party in order to protect the integrity of the judicial process." *Id.*

Here, like in *Wilson*, the University sought and obtained the order in limine "[t]o ensure enforcement of [the] well-established" rules concerning prejudicial statements. And like in *Wilson*, counsel's violations were not only persistent, but deliberate.

First, counsel's history of improper statements as demonstrated in the *Friedli* trial show that his "conscience of the community" and "send a message" comments in this case were deliberate and a part of counsel's usual trial strategy. Indeed, the University filed its motion in limine because it was worried that the Scotts' counsel would make *this exact type of comment*, because Mr. Worel had done so in the recent *Friedli* trial. (1/12/15 Mem. in Supp. of Mot. in Limine.) And in violating this court's order, the Scotts' counsel made improper comments that were strikingly similar to the following comments he made in the *Friedli* trial:

- "It's safety for our community, for our acquaintances, for our friends, for our families." (1/12/15 Mem. in Supp. of Mot. in Limine. at 2.)
- "The point is, you may have been under the mistaken impression that this case was just about that family, and it's not. It is not. This case and your decisions are much more than that." (*Id.* at 2.)
- "This case, they are representatives of the community. This case affects so much more than the Friedli family." (*Id.* at 2.)
- "You have the right to change actions of how people will approach a similar situation in the future, be it this doctor or any doctor." (*Id.* at 3.)

Second, the motions in limine that the Scotts filed seeking to preclude *the University* from making prejudicial references show that the Scotts' counsel were well aware of the types of comments that could prejudice the jury, and that their decision to make improper comments themselves was deliberate. Indeed, the comments the Scotts' counsel made are improper for precisely the reasons the Scotts explained in their own motions in limine. (1/23/14 Mem. in Supp. of Mot. in Limine Re: *Liebeck v. McDonald's* at 2 (seeking to prevent the University from referencing the so-called "McDonald's coffee case"); 1/23/14 Mem. in Supp. of Mot. in Limine Re: "Jackpot" or "Lottery" at 2 (seeking to prevent the University from suggesting that the Scotts hoped to "win 'the jackpot' or "the lottery")). In those motions, the Scotts sought to prevent the University from doing what the Scotts did at trial—making comments that could inflame and prejudice the jury by confusing the issues and suggesting that the jury base its decision on irrelevant material. (1/23/14 Mem. in Supp. of Mot. in Limine Re: *Liebeck v. McDonald's* at 3; 1/23/14 Mem. in Supp. of Mot. in Limine Re: "Jackpot" or "Lottery" at 2.)

Counsel's comments violated both Utah law and the court's order in limine. To the extent there is any doubt that the comments prejudiced the jury, the court should resolve that doubt in favor of the University and grant a new trial. *Wilson*, 2012 UT 43, ¶ 56.

2.2 The Court Should Grant a New Trial Because Counsel's Comments Prejudiced the University and the Curative Instruction Did Not Cure the Error

Because the improper comments prejudiced the University, the comments would warrant a new trial even if counsel had not violated the order in limine.

The Scotts might argue that the court's curative instructions cured the prejudice caused by the improper comments. But the curative instructions were directed at only some of the

improper comments. And the instructions were ineffective to cure even the comments about which they were directed.

A curative instruction is ineffective if there is "an overwhelming probability that the jury was unable to follow the court's instructions, and a strong likelihood that the effect of the evidence was devastating to him." *State v. Mead*, 2001 UT 58, ¶ 50, 27 P.3d 1115 (alterations and internal quotation marks omitted). Curative instructions can be effective when they are "forceful" and given "immediately" after the improper comment is made. *State v. Harmon*, 956 P.2d 262-63, 271 (Utah 1998); *State v. Wright*, 2013 UT App 142, ¶ 42, 304 P.3d 887.

For example, a curative instruction can be sufficient to cure improper questioning when the court gives an instruction during the questioning—thus suspending the questioning before the witness could provide answers that would prejudice the jury—and then the court repeats the instruction at the close of evidence. *State v. Colwell*, 2000 UT 8, ¶¶ 36-38, 994 P.2d 177. Curative instructions are *not* effective when counsel has made repeated improper comments and the court "did not give the[] instructions to the jury until after closing arguments." *Wilson*, 2012 UT 43, ¶ 56.

And the Utah Supreme Court "ha[s] recognized that curative instructions are not a 'cure-all.'" *Id.* ¶ 54. Indeed, "[s]ome errors may be too prejudicial for curative instructions to mitigate their effect, and a new trial may be the only proper remedy." *Id.*

In *Wilson*, the court explained two circumstances in which a curative instruction is insufficient to cure the effect of improper statements at trial: "a curative instruction is insufficient if the complaining party can either show the verdict returned was adversely affected by the improper statements or counsel made persistent and studied attempts to bring the objectionable

matter before the jury." *Id.* (citation and internal quotation marks omitted); *see also Harmon*, 956 P.2d at 273 (curative instructions were effective because the improper comments were "arguably somewhat ambiguous and equivocal," and the comments were "inadvertent[]").

Here, the timing of the court's instructions shows that they were ineffective. The instructions were not "forceful," or given immediately after counsel's improper statements. The jury heard the instructions after closing arguments and more than an hour after the improper comment by counsel for which the instruction was given—counsel's second suggestion that the jury's verdict would impact the future medical care provided to other families, including their own. (3/2/15 p.m. Trial Tr. at 36-37, 92.) The instruction did not come at a time when it could effectively blunt the prejudicial effect of the improper comments. The length of time between counsel's misconduct and the curative instruction also made it difficult for the jury to understand which comments were improper and should be disregarded. Finally, counsel's statements were neither ambiguous nor inadvertent. The curative instructions did not cure the error.

But even if the instruction had been given forcefully and immediately after the improper comments, the instruction would still be insufficient to cure the error because both of the *Wilson* circumstances are present. First, as discussed above, the Scotts' counsel's violations of the order were "persistent and studied," and part of a deliberate trial strategy. That fact is alone sufficient to render the curative instruction ineffective.

And the second circumstance articulated in *Wilson* is also applicable here. The verdict was adversely affected by the improper statements. *Wilson*, 2012 UT 43, ¶ 54. The jury awarded the Scotts more than $11 million to the Scotts even though the University presented substantial evidence in its defense. The prejudicial effect of the Scotts' counsel's misconduct helps explain

why the jury disregarded the evidence showing that Dr. Jensen did not breach the standard of care.

First, the prejudicial effect of counsel's improper comments explains how the jury concluded that Dr. Jensen failed to properly assess and work up Mr. Scott's condition in the face of ample contradictory evidence. Every treating physician and all experts on both sides agreed that the large brain lesion seen on Mr. Scott's MRI could be a tumor, and that the only way to know for sure was to obtain a tissue biopsy and submit it to a pathologist for evaluation. (2/20/15 Trial Tr. at 93-94, 106, 2/25/15 Trial Tr. at 39-40, 223-24; 2/26/15 Trial Tr. at 146-157, 172-73, 176.) The University presented evidence that Dr. Jensen's decision to perform an open biopsy, as opposed to a needle biopsy, was an appropriate choice for obtaining tissue, and even the Scotts' expert agreed on cross-examination that an open biopsy as opposed to a needle biopsy was a reasonable option. (2/20 Trial Tr. at 88, 103; 2/25/15 Trial Tr. at 234, 2/26/15 Trial Tr. at 168-69.) Moreover, the University presented evidence that the open biopsy was performed appropriately by Dr. Jensen. (2/25/15 Trial Tr. at 81, 91-93; 2/26/15 Trial Tr. at 198-210.)

The Scotts argued that Dr. Jensen should have ruled out the possibility of infection with laboratory testing before proceeding with a tissue biopsy. But the jury heard evidence that extensive laboratory testing was performed post-operatively, that the results were negative for infection, and that had testing been done pre-operatively it likewise would have been negative. (2/26/15 Trial Tr. at 58; 3/2/15 a.m. Trial Tr. at 48-57, 64-65.) Indeed, the jury heard from only one physician who specializes in the diagnosis and treatment of brain infections. That expert, Dr. Karen Roos, reviewed the extensive laboratory testing that was done, explained the significance of the test results, explained that the testing was negative for infection and explained that,

contrary to the Scotts' argument, there is no such thing as a herpes simplex one virus that spontaneously resolves with no treatment. (3/2/15 a.m. Trial Tr. at 48-57, 64-65.)

The Scotts did not present any expert testimony to rebut Dr. Roos. Instead, the Scotts relied on a progress note from an infectious disease physician in training, who, after all testing came back negative for infection, expressly acknowledged in writing that infection could not be proven: "There is no identifiable diagnosis, but our feeling is that the most likely explanation is [herpes simplex virus 1] encephalitis that was spontaneously resolving at the time of surgery. This can't be proven, but it's the best explanation we have." (3/2/15 a.m. Trial Tr. at 64-65, 84.) Thus, as the University's counsel explained in closing argument, even if Dr. Jensen had thought infection was equally likely as a tumor and ordered testing, the negative results of that testing would have lead Mr. Scott right back to a biopsy to confirm or eliminate a suspected tumor. (3/2/15 p.m. Trial Tr. at 75-76.)

Significantly, the jury also heard evidence that another neurosurgeon, Dr. Peter Maughan, agreed with Dr. Jensen's handling of Mr. Scott's case. Dr. Maughan independently examined Mr. Scott, believed he had a brain tumor just as Dr. Jensen did, and recommended the same open biopsy procedure that Dr. Jensen recommended and performed. (2/25/15 Trial Tr. at 224-25.) Dr. Maughan testified that Mr. Scott's symptoms were not consistent with an infection, and that although he presented the Scotts with the option of "watching and waiting," he did not recommend that option. (2/25/15 Trial Tr. at 233, 248.) Dr. Maughan also testified that obtaining tissue specimens through a needle biopsy "would be a big mistake" because the surgeon has to put the needle into the brain somewhat blindly, which is less safe than an open biopsy procedure. (2/25/15 Trial Tr. at 222-34.)

In an attempt to explain how Dr. Jensen breached the standard of care even though his approach was consistent with Dr. Maughan's approach, the Scotts' counsel simplistically argued in closing that "two wrongs don't make a right"—without offering the jury any substantive explanation for how two qualified physicians working at different institutions could have independently examined and consulted with the Scotts, come to essentially the same diagnostic conclusions, given the Scotts the same treatment recommendations, and yet neither was acting reasonably under the circumstances. (3/2/15 p.m. Trial Tr. at 85.)

Second, the prejudicial effect of counsel's improper comments explains how the jury concluded that Dr. Jensen caused Mr. Scott's stroke in the face of evidence that no major artery was cut during the surgery. Every neurosurgeon who addressed the issue at trial—including the Scotts' neurosurgery expert, Dr. Stephen Bloomfield—agreed there was no excessive blood loss or drop in blood pressure during surgery, which would be expected if a major artery was severed. (2/26/15 Trial Tr. at 207-09; 2/25/15 Trial Tr. at 65-66; 2/20/15 Trial Tr. at 105-06, 122-23.) The jury heard evidence establishing that Mr. Scott's stroke did not occur in the area where Dr. Jensen was operating and that Mr. Scott's stroke was an unfortunate and unpreventable complication of any brain surgery, a risk that both Dr. Maughan and Dr. Jensen advised the Scotts about prior to surgery. (2/25/15 Trial Tr. at 238-41; 2/26/15 Trial Tr. at 173-75, 198-99, 213-16.)

The prejudicial effect of counsel's improper comments explains how, despite the evidence, the jury concluded that Dr. Jensen breached the standard of care.

Conclusion

The court should grant the motion because the Scotts' counsel deliberately and repeatedly made improper comments that inflamed the passions and prejudices of the jury and prevented the University from having a fair trial. Counsel's comments violated Utah law and also this court's order in limine. The court should grant the University a new trial.

DATED this 21st day of April, 2016.

ZIMMERMAN JONES BOOHER

/s/ Troy L. Booher
Michael D. Zimmerman
Troy L. Booher
Beth E. Kennedy

SNOW, CHRISTENSEN & MARTINEAU
Terence L. Rooney
Bradley R. Blackham

Attorneys for Defendant

Certificate of Service

I hereby certify that on the 21st day of April, 2016, I caused the foregoing to be electronically filed and served on the following via a court-approved e-filing service provider:

Charles H. Thronson
PARSONS BEHLE & LATIMER
201 South Main Street, Suite 1800
Salt Lake City, UT 84111

Michael A. Worel
DEWSNUP KING & OLSEN
36 South State Street, Suite 2400
Salt Lake City, UT 84111

Attorneys for Plaintiffs

/s/ Troy L. Booher

Excerpts from February 17, 2015 Trial Transcript

IN THE THIRD DISTRICT COURT - SALT LAKE

SALT LAKE COUNTY, STATE OF UTAH

DAVID SCOTT, et al.,	:	Case No. 110917738
Plaintiffs,	:	Volume I of X
v	:	
UNIVERSITY OF UTAH HOSPITAL, et al.,	:	
Defendants.	:	With Keyword Index

JURY TRIAL FEBRUARY **17**, 18, 19, 20, 23, 24, 25, 26, 27 and MARCH 2, 2015

BEFORE

THE HONORABLE SU CHON

CAROLYN ERICKSON, CSR
CERTIFIED COURT TRANSCRIBER
1775 East Ellen Way
Sandy, Utah 84092
801-523-1186

APPEARANCES

For the Plaintiffs: CHARLES H. THRONSON
MICHAEL A. WOREL
Attorneys at Law

For the Defendants: TERENCE L. ROONEY
BRADLEY R. BLACKHAM
Attorneys at Law

* * *

INDEX

THE COURT: All right.

MR. ROONEY: Thanks, Your Honor.

Terry Rooney, I'm with a law firm called Snow Christensen & Martineau. I have my partner Brad Blackham here who is with Snow Christensen & Martineau as well and then we've got Dr. Randy Jensen. Dr. Jensen is a neurosurgeon at the University of Utah and Hunstman Cancer Hospital. And then we have Louise Swenson. Louise is a member of the administration at the University of Utah Hospital.

Your Honor, just so the Court is aware, Dr. Jensen will be leading today and will be in and out during the course of the trial due to patient responsibilities but Louise Swenson will be her during the entire trial.

THE COURT: All right. Thank you. So, are plaintiffs ready to proceed counsel?

MR. THRONSON: Yes, Your Honor.

THE COURT: All right, and is the defendant ready to proceed?

MR. ROONEY: Yes, Your Honor, we are.

THE COURT: All right, thank you.

And ladies and gentlemen of the jury before we begin this morning, you must take the juror oath that will be given by the court clerk. The oath is your promise to give truthful and honest answers to questions posed to you. This

and that might be very distracting to the jury since they're sitting in there. So we'll just keep it closed. If you need access to it, the clerk will let you in before court and during, you know, during breaks and things like that. Okay? All right.

All right, thank you. We'll be in recess.

(Whereupon a noon recess was taken)

THE COURT: You may be seated counsel, sorry, you can remain seated anytime I come in. The only time you need to rise is for the jury but he can be excused from that and everybody else should do that. We understand.

Are you ready to proceed at this point, counsel?

MR. THRONSON: One thing I might ask, ummm, you know, I think Mr. Rooney has indicated that Dr. Jensen is going to be in and out. I think you may have said that as well. One request is that in opening when that, if there's any mention of that, that it be limited to he will be in and out as opposed to he will be at the hospital treating patients or he will be in surgery or he will be saving lives or something like that.

In addition, a lot of these doctors carry beepers and again, I would request that he turn the beeper off when he's testifying or when he's in the courtroom at least put it on silent. I've been in cases where certainly not Mr. Rooney, but where defense counsel has actually had people

it does the best that we can. And I'm sorry. counsel.

MR. WOREL: My opening statement, I need to come over here and use blowups and like that. I can't, I've never stood right here in opening statements. My voice I think will pick up really well.

THE COURT: That's fine. It's just the mike is the only mike we have for that area and so –

MR. WOREL: (Inaudible) I'll go like that.

THE COURT: That's fine, counsel. So, are we ready to proceed then and did you look at the jury instructions and did you see everything counsel?

MR. ?: It looks fine.

MR. ROONEY: Your Honor, can I ask about this issue, the beeper is not a problem but I'm not sure why I can't refer to why Dr. Jensen isn't here (inaudible). He's a surgeon and –

THE COURT: I guess if you don't say saving lives or anything like that, counsel. I think –

MR. ROONEY: I won't say saving lives, Your Honor.

MR. WOREL: Your Honor, the problem is it's his choice not to be here. You know, to just say he's not here is one thing, to say he's now taking care of his patients or he's in a surgery, that's – they could choose to do that so they can highlight he's still a surgeon operating on people right now. In fact right now he's in surgery operating on

somebody and it lends something to, that takes it out of what we're about, the trial or what happened with Scott.

THE COURT: Mr. Rooney?

MR. ROONEY: He's a neurosurgeon, Your Honor, the jury is going to hear all about the fact that he's a neurosurgeon and he is actually in the brain tumor clinic right now as we speak. We told them he would be in and out. He will be in and out, he's not the named party and I understand why that is (inaudible) care at issue. Why we can't say Dr. Jensen will be in and out during the trial because he has responsibilities at the hospital. I don't understand why we can't say that. I'm not sure the basis for excluding that.

MR. WOREL: I was planning on saying that our client will be in and out, period, not in and out because his leg hurts so bad right now and if he sits here and he does so-and-so, it's so bad and that's putting passion into a situation that isn't appropriate at this point.

MR. ROONEY: I have no problem if he says about why Mr. Scott is in and out.

MR. WOREL: I do have a problem with him -

THE COURT: Well, counsel, what I'm going to say is that I think how Mr. Rooney has addressed it, he has obli - responsibilities at the hospital and that he'll be in and out is adequate. It shouldn't go any further than that.

Excerpts from February 18, 2015 Trial Transcript

IN THE THIRD DISTRICT COURT - SALT LAKE

SALT LAKE COUNTY, STATE OF UTAH

DAVID SCOTT, et al.,	:	Case No. 110917738
Plaintiffs,	:	Volume II of X
v	:	
UNIVERSITY OF UTAH HOSPITAL, et al.,	:	
Defendants.	:	With Keyword Index

JURY TRIAL FEBRUARY 17, **18,** 19, 20, 23, 24, 25, 26, 27 and MARCH 2, 2015

BEFORE

THE HONORABLE SU CHON

CAROLYN ERICKSON, CSR
CERTIFIED COURT TRANSCRIBER
1775 East Ellen Way
Sandy, Utah 84092
801-523-1186

APPEARANCES

For the Plaintiffs:	CHARLES H. THRONSON MICHAEL A. WOREL Attorneys at Law
For the Defendants:	TERENCE L. ROONEY BRADLEY R. BLACKHAM Attorneys at Law

* * *

INDEX

sequences I can use on MRI. So, if you do a CAT scan, there's basically, you know, two things you can do. You can do a plain CAT scan, and then you can inject dye, and then look at it with dye.

With MRI, and you might've noticed, you've had one, there's multiple different sequences. So sometimes the brain looks black, sometimes it looks sort of gray. I can put the fluid inside the brain, sometimes it's white, sometimes it's black. I can give dye on an MRI scan as well. I can do certain sequences to look for blood more sensitively. So all of these different pulse sequences, I can - I use all of them to piece together the information about what's actually going on inside the brain.

So one of the more recent ones is called diffusion weighed imaging. DWI. And what that does, it's basically looking for how the protons sort of can diffuse through the tissue. So, it's another way of looking at tissue. And so that's actually very useful, for example, for telling an abscess in your brain, an infection versus a tumor. Certain types of tumors look like they're - have - contain water. Is that water or is it pus? So diffusion can help you that way, for example.

The dye that I mentioned, you can inject the dye. That can be helpful. When something enhances, that's usually bad. In order to show enhancements on a brain MRI, you have

here, on this side of the brain, there's nothing. Just - the gadolinium is in the vessels, so I can see the blood vessels. And there's certain - very few parts of the brain will enhance. Like, this is tissue inside the ventricle doesn't enhance, but most things intracranial - in the head don't, including the brain, doesn't enhance. And so I'm looking here, and you can see there's a region of enhancement here. Now, this is normal blood vessels, so that way I expect that. But this, as you can see, this is too bright. This is where there's abnormal enhancement.

Q So comparing the two films, does that help you in your differential diagnosis of what this could be?

A We need to see the other images. But what - if you looked at the other image, it'll show that same region that's triangular, in fact, you can see here, there's no enhancement here. So the region that was right - right here is not enhancing. The only part that's enhancing is this here. So most of this thing does not enhance.

Q So what's the significance of that from a radiological standpoint?

A Okay, so it's largely non-enhancing, which means - one thing - it's probably not that high grade. Whether it's a tumor - if it's a tumor it's not high grade. If it's kind of inflammation, non-enhancement like this is characteristic of like an encephalitis. And certain kinds of encephalitis,

having mostly non-enhancing with a little bit of enhancement at the outside - see, even though it's inside the brain, there's actually crevices and cavities in the brain. Like, where the blood vessels go, there's a little gap in the brain where the blood vessel has to go through. That's actually what's enhancing. So it's - the brain itself isn't really enhancing, but just the part around the blood vessels - see, there's a blood vessel going here, blood vessels here, it's really just enhancement of the blood vessel. And so, what's really enhancing is not the brain itself, but the tissue around the blood vessels and the coating of the brain. The brain is coated by something called meninges. And that's like - there's a cell layer, layers of cells, very thin layers around the brain. Around the outside of the brain, there's a thicker layer of enhancement. But it's all called meninges. So this is encephalo brain - well, meningoencephalitis, meninges being enhancing. The brain is inflamed, but not enhancing. So one thing you have to think of is a meningoencephalitis, such as a viral infection of the brain, would look like this. A low grade tumor possibly could, that can have a little bit of enhancement. A very high grade tumor probably should have more enhancement, an enhancement in the brain itself. So I'm thinking, if this is a tumor, it's maybe, you know, sort of a lowish grade tumor. But again, low grade tumors often don't have the enhancement

of the meninges. So I'm thinking this could be an infection or inflammation of the brain, with the brain itself not enhancing too much, but the meninges around it doing enhancement. So meningoencephalitis, or maybe a sort of unusual lower grade tumor.

MR. THRONSON: All right. Your Honor, we're going to now set up the TV screens.

THE COURT: Okay, why don't we take a break? It's 10:30 anyways. I promised the jury they could have a break at 10:30 to stretch their legs and to use the facilities, so why don't we take a brief recess at this time to enable that, all right?

(Whereupon the jury left the courtroom)

THE COURT: All right, thank you. You may be seated.

Mr. Worel – or Mr. Thronson, they seem to think – Kristen seems to think that when you move, there's something going on that's causing the mic to do static, so that the record –

MR. THRONSON: Could it be my tie?

CLERK: It's not you, it's actually Mr. Worel.

THE COURT: It is?

CLERK: Every time –

MR. WOREL: (Inaudible).

CLERK: Every time you move, I'm not sure if you

sparing the deep structures, the basal ganglia and the thalami. With a little bit of meningeal enhancement.

Q And does this image also show mass effect?

A Yes. And again, as we pointed out before, there's mass effect sort of compressing that left lateral ventricle right here.

Q All right. Now, I want to ask you your opinion. Based upon your background, training, and experience that you've described to the jury, are you able to form a differential after looking at all these images, of what the most likely explanation is for the imaging you're seeing?

A Yes.

Q And what is that opinion?

A Okay, so the differential diagnosis, there's too many things that this should be - or could be. The first thing it really looks like a meningoencephalitis. An infection of the brain with a little bit of enhancement of the meninges. That's the meningo part. Encephalitis, the inflammation of the brain and the meninges. So, meningoencephalitis, which could well be from a virus. And a common virus that does this in this location is herpes encephalitis. But it could be other kinds of meningoencephalitis, a viral infection of the brain. I think that's the most likely thing for this appearance, but it's also a thing that you really have to worry about. This is

the one that you really have to rule out.

Q Why is that?

A Because a viral infection in the brain can very rapidly cause severe damage in a matter of days, hours or days. That – you have to think of this, because this can be treatable.

Q How? I'm not asking you to go into the infectious disease part of it –

A Drugs – antibiotic. You can give an intravenous medication for this called acyclovir. So, if you think of herpes or some other meningoencephalitis of the brain, then you really want to immediately call the infectious disease people. And as soon as you call them and you say that, they're going to order up the acyclovir and put it in the vein immediately.

Q Does the – does – tell us what about this image – and perhaps it's just based upon years and years of studying this, but tell us what about this image suggests to you that the top of the differential is a – some kind of encephalitis or inflammation or infection of the brain?

A A large part is just what the picture looks like. The location in the temporal lobe is characteristic of a meningoencephalitis, in particular, herpes, but it could be other ones. The way it looks where there's some swelling of that brain in this location with very little enhancement

except for the meninges, that's - this is characteristic, it's something - and it's something that we are, as neuroradiologists, we're alerted to this because, like I said, an infection like this can proceed very rapidly to cause damage. So you want to think about this, and then get the appropriate physicians involved in the treatment.

Q As a professor of radiology and neuroradiology, do you have occasion to present this type of image to your students and your fellows and ask them to give an interpretation?

A Yes. Like I mentioned, we prepare the - our trainees, our residents and fellows, for - to pass the boards, but also to practice in real life. So, there's certain cases that we show them that you have to know what this is when you see this and this is one of those cases. When you see a lesion in the temporal lobe, often not enhancing, we train them to think, you have to put meningoencephalitis on top of the differential.

The other thing it could be is a low grade or medium grade brain tumor. That also must go in the differential. But there's - that goes second because, over a few days, a brain tumor, medium, or low grade, or even high grade, is not going to cause much change. But an infection of the brain can proceed very rapidly and very severely. So we have to think of that one first. And then secondly, it

could be a low grade brain tumor, or medium grade, but the urgency to act on that is less urgent than if it was a brain infection.

Q I want you to assume that the pathology slides indicate that it is an inflammation and a meningoencephalitis. Making that assumption, would that be consistent with the imaging that you've just shown to the jury here?

A Yes.

Q Are – based upon your background, training, and experience in doing imaging – or reviewing imaging like this, are there viral infections to the brain that are self limiting, that go away?

MR. ROONEY: Objection, Your Honor. Foundation.

THE COURT: Counsel, can you lay the foundation?

Q (BY MR. THRONSON) Have you had occasion, Dr. Lee, to study the progression of various viral infections of the brain, of patients that are not treated, and to see how those progress or regress? In terms of the imaging?

A Occasionally. But usually they're treated. Usually the most common one and the most lethal one is herpes encephalitis, which looks like this. There are other viral infections of the brain which come up less frequently, and which we image them less frequently.

Q All right. And, are – based upon your research in

Q - and discuss with you, and you said it was correct, you read it last night, it's correct. So the point was, he had said to you, the surgical manipulation of the head - I'm sure both of you probably were thinking brain right then.

A I think that's what he meant.

Q I would think that. So, let's just put that in there. Isn't it true, the reason he had the stroke was because of surgical manipulation to the brain?

Your answer was, that's what I would assume, but we don't know that, because you don't know exactly.

A Yes.

Q But, what I want to get to is from Dr. Jensen, the person that was there in the room, because I wasn't.

A Right.

Q The most likely explanation that they can take to the bank was that it was a surgical manipulation of the brain, and that's what you said yes to.

A Yes. I would agree with that. Yeah.

Q So, if your attorneys are going to come up at some point next week and have people talk about other causes of the stroke happening, the jury has the right to say, that - okay, I hear that. But the man that was there, and the man that was operating on this patient at the time says under oath, twice now, that the most likely explanation of why this

man had the stroke was my manipulation of the brain. That's fair.

A Without any other evidence, I think that's my best guess.

Q Well, it's not your best guess, you –

A Well, assume and guess to me are kind of the same sort of thing.

Q Okay. Just –

A I'm doing the best I can at figuring out what might have caused it.

Q The only point I'm trying to get to, do you know about who they have coming that's going to testify?

A I don't.

Q What they're going to say?

A I don't.

Q Okay, well, I just want to make the – you may not be here for me to put back the stand, and so I want to make sure that next week, that we know the man –

A I'll come back if you want me.

Q – that we know the man that was doing it –

A Sure.

Q – says, the most likely explanation is your manipulation of the brain at the time.

A Sure.

Q Right?

Excerpts from February 19, 2015 Trial Transcript

IN THE THIRD DISTRICT COURT - SALT LAKE

SALT LAKE COUNTY, STATE OF UTAH

DAVID SCOTT, et al.,	:	Case No. 110917738
Plaintiffs,	:	Volume III of X
v	:	
UNIVERSITY OF UTAH HOSPITAL, et al.,	:	
Defendants.	:	With Keyword Index

JURY TRIAL FEBRUARY 17, 18, **19**, 20, 23, 24, 25, 26, 27 and MARCH 2, 2015

BEFORE

THE HONORABLE SU CHON

CAROLYN ERICKSON, CSR
CERTIFIED COURT TRANSCRIBER
1775 East Ellen Way
Sandy, Utah 84092
801-523-1186

APPEARANCES

For the Plaintiffs: CHARLES H. THRONSON
MICHAEL A. WOREL
Attorneys at Law

For the Defendants: TERENCE L. ROONEY
BRADLEY R. BLACKHAM
Attorneys at Law

* * *

INDEX

tumor, and this - the - this more likely than not, if you were going to say what type of tumor it would be, most likely you'd say it's a glio - an astrocytoma. A low grade tumor that doesn't enhance, by definition, or almost by definition, and infection, can look identical. So that's why I would list those two things. The - and then the location of the temporal lobe is, you know, a location for more - more often than not, if you have an infection that is herpetic, it'll involve the temporal lobe. And so, if somebody said to me, Well, if it was a board exam and they said, well, okay, I'm going to tell you, this is an infection, and they said to me - now, but I want you to tell me what's your - give me a differential now on your list of infections, and I would put, you know, a herpes simplex virus infection as my first thing. So, it's just - that's what those two things look like.

Q All right. I want you to assume that Dr. Jensen never considered and never put on his differential, that this could be an infection or an inflammation, whether a herpetic, or (inaudible), I want you to assume that. Under that assumption, in your opinion, and based upon your background, training, and experience, would that be a breach of the standard of care?

A I believe if he did not think that that would - if you do not consider that as part of your differential, yes.

Q All right. Now, are there certain non-invasive or

a totally different appearance than this. And then you would want to look for other things like - we always check people - if we think somebody has an infection, we always check their dentition, we have a dentist come in -

Q Their what?

A Their teeth.

Q Oh.

A It's a common cause of a bacterial infection of the brain. It comes from infections of the gums. Depending on where the infection is, we may - you know, we'll check the ears, make sure there's not an extension from an ear infection that's gone to the brain. So those are all things that we would do to - because if we can find a peripheral - another source, another location, and make the diagnosis there, then we can try to treat the patient with medication to eliminate the infection or get it under control.

Q Are the things you just mentioned things that can be done before any decision made whether or not to cut into somebody's head?

A Yes.

Q All right. I want you to assume that, based upon this imaging, that Dr. Jensen never ordered or considered a C-reactive protein, a sedimentation rate, an EEG, cultures of urine, sputum, blood, dentition - calling in a dentist to look at teeth, ear exam, never preoperatively performed a

lumbar puncture, never did any of the things that you've said could be done to further elucidate whether or not this was an infection versus tumor. I want you to assume that. That none of these things were done. In your opinion, based upon your background, training, and experience, was that a breach of the standard of care?

A Yes.

MR. THRONSON: Nothing further.

THE COURT: All right. Mr. Rooney? And will you need the mic, counsel?

MR. ROONEY: (Inaudible).

THE COURT: All right. Mr. Thronson, if you could pass along the mic?

MR. ROONEY: Can I take this one?

THE COURT: If you'd like to, you can. You can just hand that to me, and I'll just keep track of it. Thank you very much, sir.

CROSS-EXAMINATION

BY MR. ROONEY:

Q Good morning, Dr. Horowitz.

A Good morning.

Q We didn't get a chance to meet yet. We did your deposition over a video conference, so nice to see you in person. You'll be interested to know we have a Baltimore Ravens fan on your jury pool, so if you're from Pittsburgh, I

be cancer.

A That's -

Q Even though it came back, and it's -

A I -

Q - an inflammation could be causing that.

A I was entertaining it by getting more tissue to entertain - to make a diagnosis.

Q "Did you consider that it might not be a tumor?

"No."

"Even though you got back the increased cellularity and gliosis, which can be the same with an inflammatory process, you wouldn't even consider that it wasn't a tumor."

That's what you said, isn't it?

A Right, because Dr. Chin couldn't tell me what it was.

Q You were working on an assumption when this was a tumor, and you weren't going to deviate from it, would you, sir?

A I would stop as soon as he gives me a diagnosis. But the patient's already been -

Q They don't always give you diagnosis. You've said that. With a frozen section, you don't always - in fact, you said, I most of the time don't get a diagnosis with a frozen section, didn't you?

A I don't get the final diagnosis, but they tell me

they have tissue that's adequate for making a diagnosis, and in this case, he did not have adequate tissue to make a diagnosis.

Q He said that to you?

A Yes.

Q You specifically remember?

A Yes.

Q So you re -

A That's why I came back.

Q No, sir. Because I ought to read his deposition and see what he says.

A Okay. Well -

Q Okay? Have you read his deposition?

A I have not read his deposition.

Q You know you can't tell me anything that was said preoperatively, but you're saying, I can specifically remember, he said that to me. Is that what you're saying?

A Well, yes, because I go personally to look at the pathology with him, and he sent me back for more tissue.

Q Oh, now you're saying Dr. Chin was controlling the operation and said, go back -

A No, no, no, I'm not -

Q - for more tissue, sir?

A No. I'm not saying that all. I'm - I'm in charge. I'm the guy -

or sometimes, like in this case, we do it both. And in this case, when I showed it postoperatively, it was to show, you know, the people who had participated, that the diagnosis - the pathological diagnosis didn't fit the radiological diagnosis.

Q Again, sir, if I asked you what time it is, don't give me how to make a clock - watch.

A Oh, I'm so sorry, I thought that's what you were asking me.

Q Okay.

A I'm sorry.

Q No, sir. I'd like to get it out, if I might.

A Uh-huh (affirmative).

Q And then I will get out of here -

A Okay.

Q - and you won't have to fool with me. Okay?

A Okay. Okay.

Q And that very simply is, you say to the jury there was both, and you bring this record, and all this record shows is that - the name of it to be presented on a day, right?

A Yes.

Q Show me the record of when it was the second time, and you presented it, and the doctors discussed what happened.

A I'm not sure. I mean, that's what you have. I -

Q Yeah, that's my point. Is we asked for - because you said, oh no, I also came back, and we had this conversation and everything, and we asked for all those records. And what we received was what you've just shown, and said, this shows the first one.

A Okay.

Q Where's the record of the second one where people would have been talking about, how did this happen? What happened? You said it there. Where's my record to show us that it - you actually did take it to them, please?

A I - you know, it's - once again, I didn't remember - I don't remember that specifically, so -

Q Where is the record - you said to them that you did it afterwards too. Then you said, I presented, and they were, okay, and - where is the record that you actually did go and present to these people after the fact what you had found, and what was going on with your patient? Where is it, sir?

A Oh, I don't know. I don't know where the record is.

Q There isn't a record, is there, sir?

A I - I'm not - that isn't something I looked for, and I don't know where - I don't know that. I'm not responsible for keeping that record, so I wouldn't know where

forward, please.

DEBRA REYNOLDS SCOTT

Having first been duly sworn, testified upon her oath as follows:

DIRECT EXAMINATION

BY MR. WOREL:

Q Do you need some water, Debra?

A Yeah, maybe.

THE COURT: There should be water in there. Let us know if there's not.

MR. WOREL: If not, I'll bring you some.

WITNESS: No, it's fine.

Q (BY MR. WOREL) You need to bring the microphone towards you a little bit. Okay, you good?

A I think so.

Q I understand. Would you state your name for the record to start us, please?

A Debra Reynolds Scott.

Q And Debra, how long have you been married to Dave?

A Thirty-one years.

Q Any children from your marriage?

A We have three daughters.

Q What's their ages, and what's their names? Names first; ages second, please.

A Abby's 30, Lily is 28, Isabelle is 23.

Q Tell us where they live.

A Abby lives in Moab. Lily lives in White Fish, Montana. Isabelle lives in Austin, Texas.

Q Okay. Now, you said you've been married 31 years, but – because I know you, how long have you been loving him?

A Oh, well, knew him on my 23rd birthday, so maybe as many as 37 years. Long time, long time.

Q All right, so where did you meet?

A We met at the University of Maine in Orono.

Q Okay, and what were you doing there?

A I was making a second run at my bachelor's, he was getting an MBA.

Q And how long did you date?

A Well, about six years.

Q Okay. And then you moved to Salt Lake about when?

A Oh. I moved to Salt Lake after about a year-and-a-half.

Q Okay. The – we're going to talk about Dave a lot, because this –

A Okay.

Q – specifically is a lot about his condition. But first we want to get to know you, just a little bit. When you first came to Salt Lake City, what was your – did you get a job?

A I did.

Q What job did you do?

A I worked for a company named EDP Corp, they put computer software programs in credit unions.

Q All right, and did - how long did you do it then?

A Well, I was there for about six years, and I dropped to part-time when I had my first baby, and then I was there another four years.

Q Okay. What do you do - do you work out of the home now?

A No. I do teach a little bit, but not from my home.

Q Right. The - prior to Dave's injury to his brain -

A Okay.

Q - were you working?

A Yes.

Q What were you doing then?

A I was teaching at Salt Lake Community College.

Q What were you teaching?

A I taught English, second language.

Q English as a second language?

A Uh-huh (affirmative).

Q All right, and how long did you do that?

A A few years, maybe three.

Q All right. I'm going to try to break my questions down. We're - I want to talk about prior to 2010.

A Okay.

Q Then we're going to talk about what happened going to the doctors.

A Okay.

Q Then we're going to talk about after his brain injury, what life's about. So I'm going to try to break it into that. So right now, I want to talk about - I want to talk about you for a second. Prior to 2010, what was your passions in life?

A Literacy.

Q Meaning what?

A Meaning, I was really involved with the downtown library, and they do this big used book sale, getting cheap books into the community. I volunteered at a - oh, a program that teaches adult people who can't read how to read.

Q Okay.

A That kind of stuff.

Q What did you and Dave like to do?

A We were pretty outdoorsy, we'd do cross country skiing, snow shoeing, kayaking -

Q How about during the summer?

A - kayaking, biking, hiking.

Q Was it pretty well, if the weather's good, you're outdoors?

A Yeah.

Q Did you both - prior to 2010, he was - let's say he

was 56 in 2010, does that sound right?

A Uh-huh (affirmative).

Q All right, so prior to 2010, you both being married for 20-something years at that point, did you have dreams for the future?

A Yeah.

Q Like what? Did I stump you on that one?

A Kind of. Yeah. I mean, you know, just -

Q What were you looking forward to doing as you guys grew older together?

A Traveling a lot. When he was in college, he - when he graduated from college, he went - you know, it's our age group. He went to Europe and bummed around for six months, and it's, you know, been a thing that he just always remembered, and we talked of kind of doing that in the adult version, where we actually had a place to sleep at night, you know.

Q Prior to 2010, what was Dave's passions?

A Outdoor sports.

Q Outdoors?

A Yeah.

Q Anything else?

A You know, his family, his children, his community, his - his job.

Q You had mentioned to me about reading the New York

Times a lot. Is that a -

A Oh, yeah. And actually, it was the Tribune that he reads cover to cover, and the -

Q Ah. Not the Times.

A - Times online.

Q Okay.

A Yeah.

Q So the Tribune cover to cover.

A Yeah.

Q Was a favorite of his.

A Yeah. Oh, yeah.

Q All right. Did he - was there anything specific he liked to do with the girls?

A Yeah. You know, again, the outdoor life. The camping and kayaking, downhill skiing with them.

Q Was he - was he partially their rock in terms of if something's up -

A Oh, yeah.

Q - they got to get to Dad?

A He's their dad. He's their dad. Yeah. I mean, he had a great - I mean, he still does have a great relationship with his daughters.

Q Sure.

A Yeah.

Q But, I mean, general conversations, that sort of

thing, was that more of a - was that a regular basis to be able to do that with his girls?

A Well, yeah. I mean, of course. He's their dad, and as I say, they - we've never had any bad times with the kids.

Q Didn't have the teenage years, huh?

A They worked out really well. Well, you know.

Q Very cool.

A We did okay.

Q What did he do for a living?

A He was the president of a construction equipment dealership.

Q How long had he been the president before 2010?

A I think since 1987.

Q '87? Okay.

A So...

Q He ran the company.

A Yeah. Yes.

Q Company - I heard something about family company?

A It was a family company started by his dad in about 1966, maybe.

Q Okay. And more than one location?

A Yes.

Q Okay.

A Yeah.

Q Mm-hmm (affirmative).

A And he showed us, you know, he showed us what he was thinking, and -

Q What did he tell you?

A About what?

Q About what he saw on the film?

A He said, this is a - I mean, he talked about Dr. - what Dr. Maughan saw, and Dr. Maughan - and he went over the four kinds of tumor, the one that is only for children, and the one that's benign, and the number three and the number four, and the - you know, they were progressively worse, and that Dr. Maughan said this is probably a four, but that he, Dr. Jensen, thought it looked maybe more like it could be a number three. And he showed us, you know, the places - you know, like the doctors have been doing here, that look abnormal.

Q Mm-hmm (affirmative).

A And he showed us on those slides what - I mean, I remember him referring to a little tag on the end of something, he said, this would be a good kind of thing to use for a - for a - you know, this'd be a good sample of what was there. Let me think. What else did he say?

Q I want to talk about some specific things with you.

A Okay.

Q First of all, at any time before the surgery, did

Dr. Jensen ever tell you and Dave that the abnormality could very well be something that's not cancer?

A No.

Q And all the times that you had discussions with him, was it Dr. Jensen's approach that you were dealing with cancer? Cancerous tumor?

A Yes.

Q Okay. Did he ever mention to you, at any time in that meeting, that this could, what he's seeing is the abnormality, that it could be an inflammation or an infection?

A No.

Q Did he ever - I want - there's a note - and you've seen, you were here, we - talking about that observation, so I want to be very specific. Do you specifically - did he ever tell you and Dave that a very reasonable approach to handling this circumstance would be to wait a month or two and do some diagnostic imaging, and watch to see if any symptoms change, and that that not only was reasonable, but it would not be in any way an injury to Dave to wait?

A No.

Q Are you sure about that, ma'am?

A I - I thought about that. But I think I'd have remembered that. I think we'd have jumped on that.

Q Why do you say you would have jumped on that?

A Well, because who wouldn't rather wait two months than go into brain surgery?

Q Would you have jumped on it even more especially if he had told you, listen, the differential diagnosis is it's 50/50 it may not even be a tumor at all?

A Of course.

Q It may not be cancerous.

A Of course.

Q And let me get the question all the way, okay?

A Okay. All right.

Q I've got to do that on the record. That it wouldn't be cancerous, that it might very well be an infection or an inflammation that might go away during those two months, what decision would you guys have made?

A We would've put it off.

Q And why would you do that?

A Because if it didn't make a material difference -

Q Right.

A - why would we not wait? Why would it - I mean, I think most people would not have surgery, especially on their brain, if they had the option of not having surgery on their brain.

Q He notes in his record that, not only did he not give you all that information, but that he discouraged you from having any observation. You remember - we've looked at

A Okay.

Q And we all could observe Dave, and we saw him, and it was something to watch him just try to gather his thoughts on the stand. But you tell us now, because physically, what is the difference in Dave since the brain injury?

A Well, he's - he is paralyzed on his right side. He can't feel that leg that he's walking on.

Q Okay, so you say he's paralyzed - I mean, if I can stop you just a second -

A Okay.

Q - because, you know, paralyzed - I saw that he couldn't use his right arm at all.

A Right.

Q Okay, can he use his right leg - obviously he walks, so he can use the right leg?

A I'm not sure how that works, but it does. I mean, he can't - if you tell him to, you know, swing his leg, he can't do that. But I - a physical therapist can explain this - I mean, a physical therapist did explain it to me.

Q Well, you tell me the best you can, so -

A I think that left leg primes the right leg.

Q Primes.

A I - yeah. It kind of gets it going, and then - I don't know. It - you were - Randy - not - Randy Carson, our first physical therapist told me, we were designed to walk.

That was his explanation of why people can be paralyzed and walk.

Q Okay, so can he do any movement whatever with his right hand? Any volitional –

A No, no.

Q – when they say, you try to get anything?

A No.

Q The right hand – the right arm just hangs. Is that – I don't know any other way to put that. Is that what we're talking about?

A That's – that's true.

Q All right, does he have feeling at all in his right arm?

A No. Not really. I mean, you know, it becomes a problem in that, like if he rubs on something, he doesn't feel it until it's – yeah.

Q So he can rub without meaning to and break down the skin, is what you're saying?

A Uh-huh (affirmative). Yeah.

Q All right, now, his right leg, can he feel anything in his leg?

A Very, very little.

Q Okay.

A Yeah.

Q All right, if we were – if he were sitting here,

and I asked him, move your right leg two inches to the right, can he do that?

A No. Only with his left arm moving.

Q Yeah.

A Yeah.

Q But he can't - you know, just like what I did here-

A You know, he has a little bit of control over his thigh muscles. So maybe.

Q All right, he -

A I mean, I guess I've never tried exactly that with him.

Q Does he have to wear any devices on his right side?

A He wears a brace on his leg all the time.

Q And what's -

A Well, it just - all the time he's awake.

Q Okay, all the time he's awake. So he doesn't sleep in the brace -

A That's right.

Q - but if he's up and about. And, I mean, what's the reason for the brace?

A I believe it's so that his foot won't drag, and then his - you know, if your toe drags -

Q Does he have foot drop? Where his foot -

A You know, I haven't heard that exact term, but that seems to be what his foot wants to do.

Q Is drop fully in the front.

A Yes. Yeah.

Q Okay. What else physically? I'm going to go mentally in a minute.

A Okay. Okay.

Q I'm talking about just actual physical manifestations. Does he have pain?

A He has a lot of pain in the middle of his back on the right side. I believe it's because he walks lopsided.

Q He didn't have that pain before.

A Correct.

Q All right, so since the brain injury, he now has pain on the right side.

A Uh-huh (affirmative).

Q All right, the - how does that affect him at night?

A You know, by the end of the day, he's in a lot of pain, probably - he can't sit in a regular chair, an hour-and-a-half and he's just very uncomfortable.

Q What kind of medications is he on for that?

A He takes a drug called tramadol.

Q Okay. Is he on any other medications?

A Yeah. He -

Q What else does he take?

A Let me think, he takes something called Ritalin for - some - it has methylphenidate -

Q Kind of a focus thing?

A - methylphenidate for focus.

Q Okay.

A Since the stroke, he's had a seizure or possibly two, and so he's on anti-seizure medication.

Q Okay.

A I'm sorry, I feel like there's a fourth -

Q Is that what comes to your mind?

A - (inaudible) -

Q Well, if it comes to your mind, you can tell us about it, but -

A Yeah.

Q - he's on med - he's on medications he has to take daily for this stuff.

A Uh-huh (affirmative).

Q All right, and then let's -

THE COURT: Counsel, make sure that your client says yes or no.

WITNESS: Oh. Sure.

THE COURT: Ms. Scott, when you say uh-huh (affirmative) -

WITNESS: Yeah.

THE COURT: - we can't tell what it is later on when we listen to it, so - and we're not recording your images, it's just your voice.

WITNESS: Okay.

THE COURT: Thank you.

MR. WOREL: I'll try to remind you, too.

Your Honor, I'm sorry I (inaudible).

THE COURT: It's okay, counsel. (Inaudible).

Q (BY MR. WOREL) The - physically we've talked about the right side. Going to the bathroom. Is there any manifestations for that with him?

A He's okay.

Q He's okay.

A He does that by himself, yeah.

Q All right. This one's a delicate question. I'm going to hit it, and I'm going to move on.

A Okay.

Q We're not going to stay there. Okay? And that is, is there a physical manifestation that comes into play on what I would call marital relationships?

A He has decreased feeling in his penis.

Q Okay. And I told you we're moving on. We can figure that out. Let's talk mentally. Cognitively, that's what the records talk about, cognitively and mentally. What do you see as manifestations of that?

A In many ways, he is the same person he was. He is an adult emotionally. He is - although he can't count to 40, he understands large numbers. And he sometimes skips a

little bit on short term memory, or in kind of executive function - I - what I call executive function, understand -

Q What do you mean by that?

A Well, oh, recently - a thing I noticed recently was we were in a house, and we went the awkward way from the front door to the living room, and it was obvious - it was a new house to us, and it was obvious it would be an easier way to go back.

Q Uh-huh (affirmative).

A But he didn't pick that up. He went the - I mean, he went the more awkward way when we left.

Q I see.

A He led us. That - that kind of - kind of subtle stuff, of sometimes skipping on - so I don't know.

Q Okay, I - we're going to show a film called The Day in the Life film.

A Uh-huh (affirmative).

Q It's just the legal term. Where it kind of - it - you've seen the film, right?

A Yeah.

Q And, is it representative of the activities that he does on some basis - on some regular basis?

A Absolutely.

Q All right. And one of the things I happened to notice, and we're going to talk about it afterwards, but he -

you have a reader, it looked like to me.

A Uh-huh (affirmative).

Q What - tell us about that. What is that, and why are you doing it?

A Although - let me think. I went out on the internet and found some things called Workbook for - aphasia is the name - he has also expressive aphasia. Which is -

Q And what is that?

A - which is what you saw up here. Expressive aphasia, there's receptive aphasia, that means you don't understand language coming in.

Q Uh-huh (affirmative).

A He doesn't have that very much, especially if you talk slow, he understands.

Q Well, when you say very much, does he have it some?

A Yes. You can - you - I - I can, you can talk too fast for him to follow. It's a lot - I mean, you can do that with anyone. But you could do it with him a lot easier than most adults.

Q Okay.

A So just by talking fast, you can get ahead of him.

Q So you have to -

A But if you - yeah.

Q - you have to be slower in your speech with him?

A Yeah. Yeah, but not - it's okay. You know, it's

not crazily slow. But what he has is expressive aphasia. He can – I don't know how it works. But, in his brain, he can't find the words to express what he wants to say. And when he – and he also has apraxia, so when he does find that word, the pronunciation isn't – isn't there for him sometimes.

Q Okay.

A So –

Q So with this expressive aphasia – and we're going to see it, but the book –

A Oh, so we got the workbooks. Yeah.

Q Yeah. What is that, why are you doing that?

A Well, it's – it's good mental exercise for him, it helps him, and when you see – on the day in the life video, I mean, he looks very slow, but compared to where he was five years ago, when it took him an hour to put on his T-shirt, he's actually – he's actually made a lot of progress. And –

Q He works hard at it, doesn't he?

A He does. And part of what he – anyway, so we get these books, and he also goes to a lot of professionals, but they're just books that ask him questions, kind of cognitive questions –

Q I see.

A – well, and you'll see them on the video, and –

Q Anything else –

A – they're good practice.

Q - that - from the brain side of things do you pick up on, that he has?

A There's the vision thing. We didn't talk about that.

Q Nope. Tell me about that.

A Okay. He has vision cuts in the right side of each eye. So, over time, he's kind of compensated. So basically, each of his eyes can see half.

Q Okay.

A Right, through the left side.

Q Same half, though?

A Yeah. So, it's actually worse than just having one eye.

Q I see that.

A So - because your brain can kind of compensate what's in the middle. But there's no - there's no - if he wants to see something on the right side, he turns.

Q Okay. So, he's - like here, the field of vision -

A So here, he couldn't see the jury very well. Right.

Q Not see. Now, about pain, you talked about the tramadol, does he also get injections for pain?

A He gets Botox injections that help some with the pain. They're also for spasticity.

Q Okay. So he has that. How often do you have to do

that?

A Every three months.

Q Okay, and where do you get those shots done?

A He has a physiatrist -

Q I see.

A - named Dr. Gooch.

Q All right. Tell us, if you will, with this condition that you - that you have - well, I'll tell you what we're going to do. Let's - you said you've seen the film.

A Uh-huh (affirmative).

Q And it represents a fair representation of some of the activities. One of the things - before we see it, one of the things is, he gets up, you're not in the room, and he puts on his clothes. Now, is that an everyday thing for him?

A No. Usually I'm available and I - you know, I come by - I don't do everything, like, I'll prime the shirt and then he finishes the shirt.

Q Uh-huh (affirmative).

A He buttons his own shirt.

Q Uh-huh (affirmative). But on some occasions -

A I - and I always have to put his - he can struggle into his brace, but he can't put his own shoes on. He - so I put his shoes on.

Q So - but sometimes, what we're going to see on the film, on occasion this is the way he's got to try to struggle

getting it on?

A A few times a month.

Q Okay.

A Yeah.

MR. WOREL: Why don't we now put this up...

(Inaudible conversation)

Q (BY MR. WOREL) Okay. Now, we're going to do this -

A Okay.

Q - and I kind of want to get you just - we're not going to talk while it's going on, but would you just kind of stand here and look, so that when I go, in the film, X happened you'll remember what we're talking about, okay?

THE COURT: So, counsel, is she going to need a mic? Because she doesn't -

MR. WOREL: No, she will not be testifying, I just want her to see it as it's played, was all, Your Honor.

(Whereupon a video was played from 3:34:55 to 3:36:37)

MR. WOREL: It's stuck.

THE COURT: I think it's frozen.

(Video resumed playing)

MR. WOREL: It's not loading.

Your Honor, the Gremlins are at it again in the courtroom.

THE COURT: If you're on public -

MR. WOREL: We're not going to start over again.

THE COURT: - if you're on public Wi-Fi, then that may be the reason. But if you have your own Wi-Fi, it should be...

MR. WOREL: Right there. There we go.

Your Honor, I think what might be best, if this is all right with the Court, since it's freezing right now, we'll work on it this evening and come back to it. There's some questions -

Have you got it?

MR. ?: Yes.

MR. WOREL: Oh, okay.

THE COURT: Okay.

(Continuation of video from 3:40)

MR. WOREL: Have to fix it? Okay.

Your Honor, we - this is a good time, there's some questions I can ask until we're finished for the day -

THE COURT: Okay.

MR. WOREL: - and then we can finish this tomorrow morning.

THE COURT: All right.

Then, Baker, turn up the lights, please.

Ms. Scott, if you'll come back on the stand, please.

MR. WOREL: Here we go.

Q (BY MR. WOREL) Debra, let's do some stuff that we

can do, and then we'll come back to this probably tomorrow morning, okay? The - tell us about a typical week for you guys now, after the injury.

A We have a woman who comes in and reads the newspaper to him, and works with him on rehab stuff.

Q Do you - let me ask you this. Do you have a difference between a Monday, Wednesday, and a Friday, and a Tuesday, Thursday?

A Monday, Wednesday, Friday look kind of similar. Tuesday, Thursday look kind of similar.

Q All right, so let's do the -

A Okay.

Q - let's do the Monday, Wednesday, Friday first.

A Okay.

Q Give the spiel.

A Sadie comes in from eight to 10 in the morning and works with him on - first she reads him the paper, and then they work on - kind of like the book that you'll see in the film, or he, you know, if he's been to physical rehab, a lot of times he'll have, do this exercise for homework. So they do that kind of stuff for -

Q What are you doing for the eight to 10?

A Well, I do this little volunteer thing, and then they work at school.

Q What do you do?

A Oh, it's almost too cute. I go pick up some ladies from the senior living center, and the three to five of us go over to the elementary school and read with the second and third graders, and it's pretty darn sweet.

Q Back on the literacy thing.

A Okay. Yeah, yeah, yeah.

Q I see.

A Okay.

Q All right, so while you're doing that, you have her come in, she helps him with his exercises, either mental exercises or physical.

A Uh-huh (affirmative).

Q Reads to him.

A Uh-huh (affirmative).

Q Does she read him the paper every day?

A Yes. That's how they start.

Q That's how they start. What else after that?

A Well, then he usually needs a nap. Brain injury - or anyway, our brain - Dave's brain injury makes him need to nap a time or two a day, and that, getting up, getting dressed, coming to breakfast, working with Sadie for two hours, wipes him out. So he typically naps, and then after that, in the afternoon, he has different physical and speech therapies that he goes to.

Q Okay, do you take him to those?

A I do.

Q All right, and then what?

A Then we come home at 5:00 and have dinner and watch PBS, and go to bed.

Q About what time does he go down now?

A To bed?

Q Yeah.

A He goes to bed about 9:30.

Q Okay. When you get back from your driving him around for the therapies and such -

A And (inaudible) -

Q - before dinner - what was that?

A He naps again.

Q He naps again.

A Yeah.

Q So, he has a nap in the morning, he gets up about what time?

A He gets up about seven.

Q Seven?

A Uh-huh (affirmative).

Q And so, he naps at about what time?

A Between - he starts at 9:30 or 10 and naps until 10:30 or 11. Like that.

Q Okay, so it's an hour - the length of the time of the nap is over an hour? Hour to two hours?

A An hour.

Q An hour.

A Twice a day. Yeah.

Q And then later in the afternoon, he's got to have another hour nap?

A Uh-huh (affirmative).

Q And you need to say yes or no.

A Oh, yes. Yeah. Yes.

Q Okay. And then after that, he's in bed by 9:30?

A Yes.

Q All right, how does - does he sleep through the night?

A No. He gets up a few times in the night for the bathroom.

Q Okay, and, you know, for some folks, and I'm in the older category, it's run to the bathroom, come back, go back to sleep.

A Well, you know -

Q What about with him?

A - of course it's more painstaking, because he doesn't have the brace on his foot, so he has to walk very carefully, and we did see the part where he has to stand up, so he stands up, and he walks along the end of our bed, and then the bathroom is not very far. But, you know, the bathroom's connected. But it's a 10-minute process, and his

cane has to be positioned in the right place, so when he comes back, I need to put the cane over to where it needs to be. That kind of –

Q So, it's a joint –

A – you know, it's disruptive. It's not like you or me going to the bathroom in the middle of the night.

Q – it's a joint project.

A Right.

Q All right. Let's talk about – and does pain get him up sometimes at night?

A Yes. In fact, most nights he takes a pill in the middle of the night for pain. Tramadol again.

Q Okay. That was the Monday, Wednesday, Friday. What's the Tuesday, Thursdays look like?

A Tuesday and Thursday mornings we really have off, but it's when we schedule any kind of doctor appointment, or dentist, haircut, that kind of stuff. And in the afternoon he goes to a group speech thing out at TOSH, the occupation – I don't know what it's called. It's a clinic out south. And his brother picks him up from there, and he and his brother have lunch together, and they go to – they go back to the office, where he works, and he sits at his desk and plays spider solitaire, and –

Q So he goes back to where he used to run the company.

A Yeah.

Q He does go to his office.

A Uh-huh (affirmative).

Q But when he's at the office, he plays spider solitaire?

A Yeah. Yeah.

Q About how long is he there?

A He's there - you know, Jeff picks him up at one, and then at 4:30 we actually meet at the acupuncturist's. So, Jeff brings him to the acupuncturist, I meet him there, we're there about an hour, and then it's, go home and have supper.

Q Okay. The - I want to ask from two different perspectives. I want - you know, one of the - we have to get an understanding of what this is like pre versus post to understand his condition. From your perspective, what do you miss the most of the days before versus the days after?

A I'm - you know, I miss Dave. I miss the - the kind of -

Q I'll make this easier on you.

A Okay. Kind of -

Q I asked you earlier to give me four things. And I'll help you out on this -

A Okay.

Q - because you wrote those down for me, and you can

explain how this means –

A Okay.

Q One was, you said, I miss his hugs.

A Oh, yeah. Yeah. You know, I was saying that typically – I mean, it was just – it was just a long time habit, where our house – the way our house is laid out, you walk through the kitchen almost to get a lot of different places in the house. And I spent a lot of time in the kitchen, and, you know, if we're standing, we just would hug, right? And, you know, longtime couples have a certain way that they fit together. I miss that, you know, that kind of body feeling. Okay? And I –

Q Do you miss the two-handed hugs?

A Yeah.

Q You said – this was interesting to me, and I'd like you to tell the jury about it. You said you miss his voice.

A I do miss his voice.

Q Explain what you mean about that.

A Well, I mean, he talks now, but his voice is not the same, so it's – I'm – you know, it's funny to hear my husband, you know, for the first 30 years that I knew him with one voice, and then the next day he has a different, hesitant voice. It was one of the things I – I mean, you know, very early on, found the most attractive about him, and it's not there at all.

Q You'd mentioned –

A So, I miss – I miss that.

Q You miss his problem solving. What did you mean by that?

A Well, I miss, you know – we had – we are – we're – we have different things that we do. We're not a couple who does a lot of things together, but a thing that we have about the same level, we're both the same amount of smart, and we're both the same amount of – with hiking, right? With a lot of sports, he skied so much better than me, I never skied with him. He – I run so much better than him, but we have some things in life that we were pretty equal on. And so there was always a little kind of – I don't know, you know, friendly competition. You know? Reading the Isaac Asimov quiz in the paper, you know, who could get the answer fastest, and –

Q The mental gymnastic –

A Yeah.

Q I get it.

A Yeah, I mean, that was – that really was a fun part of our relationship, and it's not fun to be able to win all the time. That's where we're at now.

Q You had mentioned handyman.

A What?

Q You mentioned you missed him as a handyman.

A Well, you know, he was the person who did that kind of stuff. Who actually just like saw that it could be done, like, by us, or not by us. So, you know, if - I don't know, if you can't open the door to the shed behind our house, which is pretty - which is too frequent, he would either once a year go out and, you know, muscle it all around, and make it work for another six months, and, you know, he misses that more than I do. That's actually, like, the most - well, no, it's not the most, but it's a very painful -

Q Well, that's - you're getting to where I was going to go next.

A - it's a very painful thing for him.

Q And -

A Okay.

Q - we've got a few more minutes. From you being with him, tell me the things that he laments, or he misses, or that come into his radar from his perspective.

A He misses, you know, what he said, he misses skiing, real skiing, you know, where he goes as fast as he can. He misses all of those sports things, he misses being able to hike off a totally - you know, off a surface like this. He misses, you know, being a dad, you know, our daughters can still come to him for advice, but it's really not the same. It -

Q Why do you say that?

A It's - well, because it seems more patronizing now. He misses being the boss. He misses being the boss at his work. He liked that. He liked how his life was. He misses - oh, he misses reading. He misses his friends. He just plain - you know, his friends are - he has a lot of friends, and they're very sweet, and very loyal, but they're not going to ask - they're also kind of jockish guys like he was, and so every Saturday - I mean, without them calling and saying, we're all going riding bikes up in Midway, he knows that's what they're doing. And he misses - I don't know. If - he misses -

Q Comradery?

A - the kind of handyman stuff. If there's furniture to be moved, you know, that kind of stuff, I purposely do it when he's not in the room because it's just - it's agonizing for him.

Q Well, the last thing I want to ask about today -

A Okay.

Q - with the time. Your interpersonal dynamic. That's the best way I know how to put it. The essence of you guys, and how you were versus how you are.

A Uh-huh (affirmative).

Q Can you give us a glimpse of that, please?

A Yeah, I mean, it's a different balance. We're -

Q What do you mean by that, balance?

A Well, there used to be, you know, emotional things that he did, and emotional things that I – you know, make decisions, you know, where one of us would lead or the other. I mean, he usually led on financial things. I insisted on leading on the child raising things. You know, and now I can do them all. I can convince him to do anything. And not because – not because he isn't emotionally an adult, but because he knows how dependent he is on me. And it's – it's tricky. You know –

Q Tricky in what way?

A Where – because I am the care giver, but I'm also his wife. And I want to keep that – you know, there are ways he still takes care of me. But, you know, in a longtime relationship, you take care of each other. It's more balanced.

Q Well, I'm curious. You – you okay?

A Yeah. I mean, this is my life.

Q I understand.

A I know it.

Q The – for Dave, it's been brought up that he's very – he's into being as self reliant as he possibly can be. The – how does he – with what we've seen with his condition and his limitations, how does he take care of you? What did you mean by that?

A I mean, when things get their worst, I go to him.

And he's still my emotional sounding board. I mean, he's - yeah. I mean, he's who I go to for comfort. So, in that way, I mean, we are still a marriage, we're just - we're just off balance. We're - you know, I've taken on some positions that are more - they're - well, they're care giver positions.

Q Well, I mean -

A So, it's -

Q - we can stop -

A Okay.

Q - I have one last question for you.

A Okay.

MR. WOREL: If that's appropriate time, Your Honor.

THE COURT: That's fine. I was just going to give you the five -

MR. WOREL: Yes, ma'am.

THE COURT: - sign. Say, five-minute warning.

WITNESS: Sorry.

THE COURT: No, no. You're fine, Ms. Scott.

MR. WOREL: If that's all right, we'll -

THE COURT: It's not - nothing to do with you -

WITNESS: Yeah.

THE COURT: - it's your attorney.

WITNESS: That's fine.

MR. WOREL: Yeah.

THE COURT: We're just giving him a five-minute

warning.

WITNESS: Yeah.

Q (BY MR. WOREL) Let me - I'm actually -

A Yeah.

Q - going to stop with just this question. All right?

A Okay.

Q The - you say, now you're the care giver and the wife. You ever wish you were just the wife?

A No. Of course I wish that. I wish that 24 hours a day. And so does he.

MR. WOREL: That's all the questions I have for right now. We'll finish - we'll come back and do the film and stuff, if it's all right with you, Your Honor. I'm not through with the witness or passing the witness, but -

THE COURT: I understand, counsel. And hopefully you can get your technological problems addressed in the meantime.

All right, members of the jury, thank you again for your attentive listening to today's evidence. Remember my - I'm supposed to give you this admonition, and periodically - I just assume that you remember it, but since I told you I would do it ad nauseam, please don't discuss this case with anyone until you're sent to deliberate. But thank you again for your patience, and we'll see you to0morrow at nine a.m.

Excerpts from February 20, 2015 Trial Transcript

IN THE THIRD DISTRICT COURT - SALT LAKE

SALT LAKE COUNTY, STATE OF UTAH

DAVID SCOTT, et al.,	:	Case No. 110917738
Plaintiffs,	:	Volume IV of X
v	:	
UNIVERSITY OF UTAH HOSPITAL, et al.,	:	
Defendants.	:	With Keyword Index

JURY TRIAL FEBRUARY 17, 18, 19, **20**, 23, 24, 25, 26, 27 and MARCH 2, 2015

BEFORE

THE HONORABLE SU CHON

CAROLYN ERICKSON, CSR
CERTIFIED COURT TRANSCRIBER
1775 East Ellen Way
Sandy, Utah 84092
801-523-1186

APPEARANCES

For the Plaintiffs:	CHARLES H. THRONSON MICHAEL A. WOREL Attorneys at Law
For the Defendants:	TERENCE L. ROONEY BRADLEY R. BLACKHAM Attorneys at Law

* * *

INDEX

MR. THRONSON: Hope springs eternal, Your Honor.

THE COURT: Okay.

MR. THRONSON: I - I went back to the 1990s.

THE COURT: Okay.

MR. THRONSON: And here we are. And we have Chris, who's here -

THE COURT: Okay. All right.

MR. ROONEY: I loved the '90s. I had hair and vision.

THE COURT: Well, at least he didn't refer to Betamax. Then, you know.

(Whereupon the jury entered the courtroom)

THE COURT: All right. Thank you, members of the jury for coming back again for another day.

We're back on the record in the matter of Scott versus University of Utah Medical Center, case number 110917738. The bailiff indicated that there were a couple jurors who wanted me to clarify the names of the attorneys. The gentleman standing up is Mr. Worel - or Worel, excuse me. And then next to him is his partner - Mr. Thronson, who is his co-counsel. Then we have Mr. Rooney and Mr. Blackham sitting at defense counsel's table. All right? So...

Counsel, how are we proceeding? Are we going with Ms. Scott first?

MR. WOREL: Yeah, we're still continuing with Ms.

Scott, we thought we'd go ahead and play the day in the life film –

THE COURT: Okay.

MR. WOREL: – (inaudible), Your Honor.

THE COURT: Oh. One second, counsel, before we start. We need to grab something for the jury. We had secured their papers last night, so...

BAILIFF: Sorry about that, Your Honor –

THE COURT: No, could you hit the wall switch, Baker?

BAILIFF: Sure can.

THE COURT: The one that says wall, because that'll take the sconces off. It does say wall on there.

BAILIFF: It says well.

THE COURT: Well. Whatever. Well, wall, it's the same. Same three letters.

MR. ?: Potato, po-tah-to, Your Honor.

THE COURT: It means –

BAILIFF: No, you were right. It says wall. I can't read.

THE COURT: Vindicated.

BAILIFF: (Inaudible).

MR. THRONSON: Mr. Baker, officer, I have another pair. These are probably a little stronger.

BAILIFF: I can see, I just can't read.

(Inaudible conversation)

THE COURT: All right, thank you. Are you ready to start now?

MR. WOREL: Yes, ma'am.

BAILIFF: I think we need a pen, Your Honor.

THE COURT: Another pen?

BAILIFF: We're short one.

THE COURT: Short one pen? We'll get one more pen.

(Inaudible conversation)

THE COURT: Do we still need an extra pen?

BAILIFF: I'm okay. I think we've got one.

THE COURT: Okay. They say they have enough pens. Okay.

All right, go ahead, counsel.

MR. WOREL: Ready to go?

THE COURT: And do you have the microphone?

MR. WOREL: I do have one on, yes, ma'am.

THE COURT: All right, Mr. Worel, if you'll just lift it up a little bit higher. We noticed that yesterday there were times when your jacket would muffle it a little bit.

MR. WOREL: Is that better, Your Honor?

THE COURT: Perfect. I think that should be fine.

MR. WOREL: It is not moving now. There you go.

(Whereupon a video was played from 9:15:59 to

9:37:40 - not transcribed per instructions)

MR. WOREL: You can get back on the stand, please. (Inaudible). There we go. Thank you.

DEBRA SCOTT

DIRECT EXAMINATION (resumed)

BY MR. WOREL:

Q Okay. I've got a couple questions based on what we watched right then. First of all, I was struck by the clothing that he was attempting to put on. Is that what he normally wears in the wintertime?

A Yeah. In the winter, he's cold, he wears two shirts.

Q All right. The, you know, the - no way around it, that dressing is a real struggle. Why don't you just dress him every day?

A Getting dressed is something he can do for himself.

Q You can pull it closer so you don't have to lean awkwardly.

A Oh, yeah. Okay.

Q There you go.

A Getting dressed is something he can do for himself. And there are many things that he can't do for himself. Everyone needs to be able to do things for themselves. But the truth is, I do help him most days, and typically I'll prime each piece of clothing.

Q Now – and the – the days where he really has to do – first of all, does he want to be independent? Does he want to–

A Oh, absolutely. And he wants to do –

Q He doesn't want you to dress him.

A – what he can do. No. Of course not.

Q Okay. And so, that struggle was meaningful to him when he accomplishes his task.

A Yeah. Yes.

Q Okay. All right. The – I saw he had a Utes shirt on. Is he a Utes fan?

A Yeah, he's a graduate. And it was game day, and I understand that it's good luck for the team when he does that.

Q When – let's say you are – we saw how long it took right then. But those days where you'll start the process, so to speak – so, I take it – I take it –

A This morning.

Q – you don't stand with him and dress him. You assist–

A Typically I'm dressing myself. I'm making the bed, I'm moving the laundry around.

Q Uh-huh (affirmative).

A I'm doing the upstairs stuff.

Q Okay.

A And – oh, I have to do all his socks and shoes.

Q Socks and shoes.

A And brace.

Q But like the –

A But, I'll start his shirt and – you know, the one arm, put his right arm on.

Q Uh-huh (affirmative).

A Start the left arm in, leave and make the bed, maybe, and he's buttoning up the shirt. He's a good buttoner.

Q Okay. The – how long does it take him to dress even with your assistance?

A We're one hour from out of bed, shower, out of the bedroom door. So with my assistance – I mean, he really was only 10 minutes. I mean –

Q Seemed like a lot longer.

A – you just have a different perspective on it than I do. Five years ago, it was a lot longer than that. So –

Q So (inaudible) –

A With my help, it's five minutes – half that time.

Q – if you don't mind, pause for a second.

A Okay.

Q You're saying what we saw right here, when you started with him after the injury, it took much longer than what we just saw?

A Yes. And the professionals start with him. Occupational therapists.

Q That's to teach him how to do that.

A Yes.

Q Okay. Okay. The - I'd like to focus on those - the cards that you were doing, and then the reader, but first the cards.

A Okay.

Q Where did you learn to do that with him?

A You know, I sat in on a lot of speech therapy sessions, and then I got out on - then I went on the internet a few years ago and, you know, Googled aphasia help, and they come up with aphasia workbooks, I mean, you could go to -

Q And what are we - what are you -

A - I mean, Amazon.

Q What are you attempting - the cards and saying, you know, pick up so-and-so after touching so-and-so. What's the purpose of that? What do - what are you doing with him?

A We're working with before and after. He pretty much knows all the shapes. I mean, he named them.

Q Uh-huh (affirmative).

A But aphasia, a kind of hallmark of it is getting up and down mixed up, getting yes and no mixed up, getting before and after. So that was that little lesson.

Q I see. The - is he getting better?

A Yeah. Day after the stroke he couldn't make any noises with his mouth. He's getting a lot better.

Q Good deal. The - then you went to the reader. What was the - what's the purpose of what you're doing there with him?

A Well, it's to try to pick up reading again. I mean, as you could see, he isn't really - he isn't reading phonetically. He's recognizing words, and then going through his head for what that word is. I mean, when he read about the bomb, destroyed. So that - it actually said the bomb exploded.

Q Uh-huh (affirmative).

A He saw exploded, he's got a picture in his head, but he can't remember the word exploded, but he can remember destroyed.

Q So, he's actually -

A So, it's a funny - it's not like regular reading.

Q That's what I was wondering.

A Yeah. It's different.

Q So instead of reading the words, he's getting to a word, and then he goes into his head, and he has a memory of what that word looked like, so to speak?

A Uh-huh (affirmative). Yeah.

Q And then tries to come out and read it.

A Right.

Q Rather –

A Right.

Q Rather than, like, if I'm looking here and I'm reading the words through. It's a memory exercise almost.

A Yeah.

Q Okay. Breakfast, lunch, dinner, that sort of thing. Can he make his own meals?

A He can make with about the same facility that he dresses himself. But all these things are exhausting, so typically I make the meals.

Q Difference, if making a sandwich used to be five minutes –

A Right. He could – then he could make a sandwich in 20 minutes.

Q Okay. So everything's just elongated, and it tires him out.

A Yeah. Yes.

Q Okay. Almost finished.

A That's okay.

Q All right. If you had to give the jury in one word, or a few words how you would summarize the change in your lives, I asked you about that.

A You did.

Q I asked you to think about that, didn't I?

A Uh-huh (affirmative).

Q I don't even know what you're going to say.

A I know.

Q I just asked you to think about it. What is that word or few words, to summarize the change in your lives now?

A Okay. Tiny backdrop, Dave and I, about seven years ago, drove through, on a road through woods, a place where there'd been a category two tornado, set down the day before, and here's what we called it, and here's what I call it. Devastation and cleanup. I'm cleanup. So -

Q Devastation and cleanup.

A - I think of his head, when he's look - searching for words, as looking like those trees must've looked when they were flying around, and I - you know, it obviously devastated our, you know, our regular lives. It didn't help our financial situation any. And cleanup is what they do - we actually - it's only about a mile from my mother's place in Maine, and we see it every year, and you know, the grass has grown back, the loggers came and cut the logs up and - so you can get through the road. Anyway, so...

Q Gotcha'.

A That was a - anyway, yeah.

Q Do you feel that you and Dave had the right to know that there was a 50/50 opportunity that what they had seen on the MRI was not cancerous at all?

A Yes, I do.

Q Do you feel that you and Dave had the right to know that a very valid, reasonable option of watchful waiting to go a couple months, and that it wouldn't hurt Dave to wait, that should've been something you should've known?

A Absolutely. Yes.

Q And if you had done the watchful waiting, had you known about it and chose it - I guess I should ask you, would you have chosen that? I think you said yes before, and we don't have to do that.

A Yeah. We -

Q And if you had chosen it, you had a doctor that told you within even the first month, not the second -

A That's right.

Q - the first month, that whatever was on that MRI had gone away, didn't he?

A Yes. I mean, you're telling me something I think of all the time.

MR. WOREL: But you didn't. I think that's all the questions I have.

WITNESS: Okay.

MR. WOREL: They may have some for you, ma'am.

WITNESS: Okay.

THE COURT: All right.

Mr. Rooney?

MR. ROONEY: Thank you, Your Honor.

however, this biopsy shows hypothetically that it was a glioma, which did not happen in Mr. Scott's case, because we know that the biopsy showed that he had (audio skips from 11:24:29 to11:24:36) a meningoencephalitis that was found to be going away on subsequent scans. But if, hypothetically, this was a glioma, the biopsy can identify successfully the tumor, give a relatively accurate grade to the tumor, and then help direct the proper radiation therapy and chemotherapy that the patient would need to treat this tumor.

With that in mind, any thought for surgical approach to this type of tumor, because of its location in the dominant hemisphere and the majority, if not at least half of the tumor, being in a no-fly zone where you cannot safely resect, then a biopsy would be the only appropriate treatment, and in my opinion the standard of care would be violated if somebody is going to subject the patient to removing a third of this tumor in order to be able to de-bulk it without any significant benefits of de-bulking.

Q Is a stereotactic needle biopsy less invasive?

A Much less invasive, and much less risk.

Q Why is that?

A Because you could define a safe target and a safe trajectory, and that safe target and safe trajectory, like in here, will avoid the major blood vessels that could be at risk in performing the operation that would be necessary to

de-bulk this portion of the tumor, as Dr. Jensen performed.

Q What other benefits besides high accuracy of diagnosis, less invasive, less risky? Are there other benefits - is it less healing - shorter healing time?

A Much shorter healing time, and you get to go home either the same day or the next day.

Q Oh, really? Okay. Less chance of infection, because it's a smaller -

A Much less chance of infection also. And much less chance of medical complications, because the operation is a much shorter procedure.

Q All right. Is it - are you prepared to talk about the other option of biopsy, which is an open craniotomy?

A Yes. There are times when a physician might say, I'm going to put a needle into this target, and if the pathologist does not give me an abnormal tissue response to the frozen section, because there's not enough tissue, then one option is to take this needle and follow it down with a small open resection, following it to the target and removing more tissue in this area, and sparing the surrounding brain around it.

So, for instance, it would be relatively reasonable if the biopsy in this area on Mr. Scott came back non-diagnostic on frozen section, and the surgeon might consider, okay, there is a chance I might be able to improve the

diagnostic accuracy hypothetically by taking more tissue out. He has the choice of taking more tissue out with the biopsy needle, getting a second or third biopsy, or he has the opportunity to make a small resection in the surface of the brain here that's normal brain, and follow it down through a small corridor, down to the area of abnormality, and take more tissue with an open surgical biopsy approach. And that would relatively spare the surrounding brain around it, and give more tissue from here in a safe area that's still about a half an inch to an inch away from the major blood vessel.

Q Now, neither of those things Dr. Jensen did. Correct?

A That's correct.

Q He didn't do a stereotactic needle biopsy, and he didn't also, correspondingly, go back in on the same trajectory, making a slightly larger hole, and taking some additional tissue. He didn't do either of those things, did he?

A No, what he did was he took this normal brain tissue away, sent it to pathology for a frozen section, and then took another hunk of tissue away. Both specimens were approximately an inch in diameter. And then - and the second specimen he did not send for frozen section. He then went into this area here and saw an area that seemed a little bit more abnormal, and took out a piece of tissue that was about

a half an inch in diameter, with a part of that piece of tissue, one of the blood – wall of a blood vessel. And that wall of the blood vessel, we don't know exactly which blood vessel that was, but it has to be a portion of the middle cerebral artery, and more likely than not, it's a portion of the middle cerebral artery in this area right about here, where we see the middle cerebral artery coming in both sides. Here's the middle cerebral artery on the right side, here's the middle cerebral artery on the left side, and it stops right here, right at the edge of Dr. Jensen's resection margin. And we notice on the angiogram – interesting. Okay, we notice on the angiogram it's not going – wait, next. Well, we'll notice on the angiogram that this blood vessel, the middle cerebral artery, is cut off right there. So let's see if I could get to show Mr. David Scott's angiogram. Yes. Here's his angiogram, where the middle cerebral artery is – should be filling with multiple branches here, it's no longer filling, and it stops right there, right at the location at the medial margin of the resection margin that Dr. Jensen performed. So this is where his third biopsy came out of, where a piece of the blood vessel was seen by the pathologist.

Q You've used the term – you've used the term – we've used the term biopsy. You use the term, when you talk about what Dr. Jensen did, resection.

A Yes.

Q There's a difference.

A Yes. Dr. Jensen resected the anterior three centimeters of the temporal lobe.

Q Are you saying that this wasn't just a biopsy?

A This was a temporal lobectomy. We see post-op scans showing that there was a resection of three centimeters. And he even, in his operative report, describes the resection, which included the normal brain peripherally, as well as the abnormal brain in the center of the temporal lobe.

Q In doing - so, this - he actually did a - as I understand it, did - he cut out more than just he needed for biopsy. He took out a piece of his brain.

A Right. I'll show you again on Mr. Scott's preoperative scan, his goal was to remove some of the tissue here for pathological analysis, biopsy of this area. He removed this normal tissue here and here to get to this area. And his postoperative scan right here shows that from here back to here is about three centimeters, and it shows that the resection came from the superficial area where the superficial normal cortex was included, which was the abnormal central portion of the temporal lobe that we saw in the scans, and unfortunately caused the occlusion of the middle cerebral artery right there.

Q Did the cutting of the middle cerebral artery cause extensive damage to that side of his head?

A Yes. The middle cerebral artery – this is another projection. The middle cerebral artery caused a blockage of flow to the brain, which then without tissue started to die. And because the middle cerebral artery was injured very close to its root, not only did you lose the tissue here, but you would lose the deep nuclear tissue and the temporal lobe tissue. And here's a picture of where the middle cerebral artery was cut off, and here's a picture of Mr. Scott's brain where the dark area represents dead tissue –

Q I wonder –

A – from the stroke that he developed after the middle cerebral artery was occluded. And –

Q I wonder if you could take the image –

A – occluded right there.

Q – I wonder if you could take the image off the board that I have here, and bring it up in front of the jury, so that they can have a better idea of Mr. Scott's – the level of damage that wound up occurring to Mr. Scott after this –

A Well, you can see on the picture on the screen, the dark area, and here's an MRI scan which shows the area of damage as being white for the middle cerebral artery. It's a very large portion of the brain – this is the left side of

his brain - because of the middle cerebral artery being occluded at the time of the surgery.

Q Is this part of his brain essentially - looks like almost half his brain dead now?

A It's not half the brain, but it's about two-thirds of the left side of his brain. And that is an area that not only controls the motor function for his right arm and face, a little bit for his right leg, but also the speech and language functions. And also in the left temporal lobe, there's a significant processing of day to day memory, syntactic memory, like what you had for breakfast, what you were talking about five minutes ago with the person that you're with, why you went to the kitchen, or whether or not you are picking up the phone to call someone, who you wanted to call, will slip away from you.

Q We - have you loaded a video of an open craniotomy?

A I can try to see if I could pull that up. Not sure where you have that. Is this it here?

MR. THRONSON: Before we click on that, I think we should - let's stop for a minute.

MR. ROONEY: Your Honor, can we explain to the jury this is our video?

MR. THRONSON: Yeah, I - that's -

THE COURT: Okay. Go ahead, Mr. Thronson, if will explain - make the explanation.

MR. THRONSON: No – would you like me to do it, or would –

THE COURT: Or Mr. Rooney, would you like to do it?

MR. ROONEY: Sure. Thank you, Your Honor.

So, this is a video that Dr. Jensen put together to show the jury (inaudible) basically what he did during the procedure. It's not Mr. Scott's case, but it's a similar type of case, another biopsy, craniotomy, and it will be representative and demonstrative of what he will describe to you that he did during Mr. Scott's case, and we've allowed counsel to –

MR. THRONSON: Yeah, Mr. Rooney's been kind of enough to – because we're talking about stereotactic, now we're going to see what an open craniotomy looks like.

MR. ROONEY: Thank you, Your Honor.

THE COURT: You're welcome.

(Whereupon a video was played from 11:37:54 to 11:38:13 unintelligible for transcription.)

THE WITNESS: I would like to make one comment about what you've seen so far, which is that, with neuro navigation that's used during craniotomies, you also have an idea of the three-dimensional anatomy of the target, the location, and where the best entry site should be, so that the surgeon is doing the same thing as a stereotactic biopsy, but using open techniques.

Also aware of where the important blood vessels are, so that you're constantly aware of no-fly zones, where dangerous blood vessels might be, as well as where the tumor and the target is, and deciding upon an approach. So, this is a neuro navigation study, just like the operation Dr. Jensen performed on Mr. Scott, that has those techniques and resources available with the computers in the operating room.

Q (BY MR. THRONSON) And you're saying this is something that a neurosurgeon should have available and should do.

A And Dr. Jensen did use this technology during Mr. Scott's operation.

Q Okay.

A At least, used this technology during most of the surgery, though unfortunately it did not enable him to identify where that blood vessel was when he took the third biopsy. And that was, in my opinion, a mistake on Dr. Jensen's part.

MR. THRONSON: Let's go ahead and show the rest of this.

(Video resumed from 11:39:36 to 11:39:54)

THE WITNESS: So, in addition to knowing the target-

MR. ROONEY: Your Honor -

MR. THRONSON: Yeah, I just - I think we should just

play the video.

WITNESS: Okay.

THE COURT: Okay.

(Video resumed from 11:39:56 to 11:44:04 unintelligible for translation)

MR. THRONSON: Okay, thank you.

Q (BY MR. THRONSON) Has it finished playing?

A Yes.

Q Okay. In your review of this case, and focusing on the issue of the biopsy, did you formulate opinions as to whether or not Dr. Jensen breached certain applicable medical standards of care?

A Yes, sir.

Q I'd like you to tell the jury what those opinions are.

A Well, I believe the first was that a biopsy surgery was premature, as we discussed before. And even if you could justify the biopsy surgery, the technique for the biopsy that was chosen, and multiple choices and judgments that Dr. Jensen used during his operation, sequentially added extra harm and risk to the operation that Mr. David Scott went through. The first was that he performed a de-bulking procedure on a lesion that had no benefit to be de-bulked, even if it was a glioma, as he has presumed it would be, because he could not take out 70 percent or more of the

lesion. In fact, he could not even take out 30 to 50 percent of the lesion safely.

The next was that he decided to remove normal brain outside of the lesion, which would place Mr. Jensen's memory at risk even if he did not injure the middle cerebral artery.

Next, he continued to remove tissue without further frozen sections, when the pathologist told him that he had unfrozen section, abnormal tissue, with hypercellularity, which very likely could've made the diagnosis.

And then lastly, his third biopsy was performed in a location that his neuro navigation system and his knowledge of anatomy would tell him was very close to the middle cerebral artery. And it was performed in a way that placed the middle cerebral artery at an unfair risk, where there were other techniques that could have enabled him to perform that biopsy more safely, had he been more aware of the dangerous closeness of that middle cerebral artery.

Q Do you believe that the breaches of the standard of care that you've identified led to the damage that David Scott suffered?

A Absolutely. We have primarily the damage that was subsequent to the injury to the middle cerebral artery, and we also have memory problems that are due to a combination of the middle cerebral artery damage as well as the removal of parts of the brain that communicate with the memory centers

in the hippocampus, which is an area of the temporal lobe that is very important for short-term memory.

Q Do you believe that if these breaches in the standard - these errors, breaches of the standard of care made by Dr. Jensen had not occurred, that David Scott would be neurologically, more probably than not, neurologically intact today?

A Yes, sir. The only risk that he had was the risk of his meningoencephalitis progressing, and as we see on the subsequent scans and the reports of the infectious disease expert, that the meningoencephalitis was going away, and going away at such as relative significant rate, that they did not even feel it was necessary to use the antiviral agents.

The other risk that would've been present to him would've been the risk of a biopsy of that area that was safe, and that risk of a biopsy, keeping it to the abnormal area, would have been very low risk, as long as you didn't go close to the middle cerebral artery, and as long as you didn't remove the normal temporal lobe surrounding the abnormality in the temporal lobe.

Q Do you believe it was a breach of the standard of care for Dr. Jensen not to have encouraged a stereotactic biopsy of this patient?

A I would say it was a breach in the standard of care

not to discuss at length the pros and cons of a stereotactic biopsy versus the open biopsy. However, even an open biopsy could be performed with techniques that would've significantly reduced the risks of a complication to the middle cerebral artery and to memory complications.

Q What are those techniques?

A The technique would be to either perform an open biopsy or a needle biopsy just of the abnormality in a safe area of the temporal lobe that I pointed out on the imaging. Or, if compelled to biopsy the area next to the middle cerebral artery, the technique to do so would be to expose the middle cerebral artery safely prior to taking a biopsy, and not to take a biopsy blindly, not seeing the middle cerebral artery, like he did in his third biopsy. By exposing the middle cerebral artery, by careful dissection, we can then identify on the navigation systems, the abnormality next to the middle cerebral artery, and then avoid injuring the middle cerebral artery at the time of taking tissue for samples for pathology.

Q In his neurosurgery clinic note, Dr. Jensen states, stereo - well, he says, I discussed in detail the three options of observation, which I discouraged; versus frameless stereotactic biopsy, which I thought probably was not the best way to go about this given the potential sampling error. Was that a - assuming a stereotactic biopsy was properly

performed, was a concern about a potential sampling error reasonable?

A Not in the sense that he had a large target, and the area of the target would have a high risk – I'm sorry, not a high risk, but a high rate of success in obtaining a diagnosis. Sampling error is an issue with gliomas whereby a glioma may have a heterogenous type of pattern, where some areas of the glioma are low grade, and some of the areas of the glioma are higher grade. In that kind of setting, if you take a needle biopsy, you can biopsy an area that might be a lower grade next to a higher grade, and miss the higher grade and that is a potential concern. But that, in my opinion, is such a minor concern, if you make the diagnosis of a glioma, almost certainly you'll be able to have the diagnosis of the grade more accurately in mind within a short period of time, even if you under grade it to begin with.

Q What are the additional risks of an open craniotomy, like we have just seen on this video, versus a – the stereotactic needle biopsy?

A Yes, an open craniotomy is a longer operation with more risks, because you're disturbing more tissue. And you have a longer anesthesia, so you have more risks for medical complications and infection. You're also taking out more tissue, which is potentially functional tissue.

That said, there are times when it's very

appropriate to perform that if you're going to de-bulk the tumor, like that video was a de-bulking of the tumor, and has a benefit if you can de-bulk over 70 to 80 percent of the tumor if it's a glioma. That said, the alternative of an open brain biopsy, to stay in a safe area, could have been relatively safer than the operation chosen to remove the anterior temporal tip. So, an open brain biopsy with a smaller - a little bit bigger than a needle biopsy, but smaller than a resection, would've been a reasonable alternative. And that would've enabled more tissue to be removed to avoid any sampling errors, and been removed in an area safe, far away, at least a half an inch away from the middle cerebral artery.

Q So, it - but that's not what was done here.

A No. What was performed was a de-bulking surgery similar to what you saw on the video, where a fairly large amount of tissue was removed. And, in fact, the amount of tissue removed at the time of Mr. Scott's surgery was greater than what you saw on this video.

Q How much more accurate - you said a stereotactic biopsy is 98 percent accurate in terms of getting a tissue diagnosis, correct?

A Yes.

Q Up to 98 percent? How much more accurate is an open craniotomy, statistically, in getting tissue?

THE COURT: ... shortly, so if Dr. Howoritz would like to join us back on the stand, we'll get it all set up. I mean, Dr. Bloomfield. I'm sorry, I've got that name stuck, I heard somebody say that this morning, and that's probably why it's stuck in my brain. And that is why our brains are complicated things. We don't understand how the - everything works and why things misfire.

(Whereupon the jury returned to the courtroom)

THE COURT: All right, thank you. I think we are still - the plaintiff finished his questioning of Dr. Bloomfield, and Mr. Rooney, I believe it's your turn now.

MR. ROONEY: Thank you, Your Honor.

CROSS EXAMINATION

BY MR. ROONEY:

Q Good afternoon, Dr. Bloomfield.

A Good afternoon.

Q I'm - I've got a bunch of notes here, so I apologize, it might be a little hectic and jumping around. We'll try to get some order (inaudible). So, Doctor, you've had an opportunity to review the medical records in this case, correct?

A Yes, sir.

Q And you had an opportunity to review the X-rays as well, correct?

A That's correct.

Q And you thought this was a glioma, that was your first choice, wasn't it?

A Yes, there were a number of things in the differential diagnosis, and glioma was one of the more common considerations.

Q Glioma was your top choice, wasn't it?

A Yes, sir.

Q And with a suspected glioma, your recommendation would be to get a tissue biopsy, correct?

A With a low grade glioma, tissue biopsy, or to wait and watch with another scan.

Q And that's a good point. You actually mentioned in your deposition, and in effect, that kind of happened, didn't it?

A There was a scan two weeks after the first scan, which was the neuro navigation scan.

Q Right. And you mentioned in your deposition, in a way, that was like getting another scan, a serial scan, correct?

A Yes, but not long enough time to see if there was any change.

Q Well, and you said there was no change. You looked at those scans, you said there was no change, correct?

A That's correct.

Q So you didn't see a change between the image that

tissue, correct, Doctor?

A Yes, sir.

Q And in fact, that's what you said in this case in your report, wasn't it? That one of the options, because of your diagnosis of glioma, which you would consider to be a reasonable option, would've been for Dr. Jensen to get tissue. I know you disagree on how he got it. But you would agree that if he had - if he'd done this with a stereotactic needle biopsy, you wouldn't have any criticisms, would you?

A That's correct. And we wouldn't be here.

Q In fact, if he'd done it with an open biopsy, as how you defined open, you wouldn't have any criticisms.

A That's correct.

Q In fact, the size of the opening isn't really what creates the risk, is it, Doctor? Whether it's -

A It's the -

Q - this big, or this big, or in - somewhere in the middle, isn't going to change the risk profile, is it?

A It's the - no, it's the amount of tissue you remove, and what tissue you do remove to obtain the biopsy.

Q And let's talk a little bit about the needle biopsy. You've testified many, many times, probably about the issue of needle biopsy many times, correct?

A Yes, sir.

Q And you've lectured on needle biopsy?

patients will have a hemorrhage that could cause a problem.

Q And one of those problems could be, they could die from it, correct?

A That's very rare. But that's possible.

Q And one of the reasons they could is because when you bleed, and the skull is not open, then you have to do an emergency craniotomy, open them up while they're in the surgical suite, correct?

A Yes. And in 750 patients I have biopsied, I've had to do that on two occasions.

Q And there's other –

A So that's very rare.

Q Fair enough. There's other literature, including out at MD Anderson, that thinks that the risk is higher with stereotactics, isn't it?

A Well, it depends on what you define as a hemorrhage. About four to five percent of patients will have a small little hemorrhage at the biopsy site that is inconsequential, but one percent will have a hemorrhage that can be very significant.

Q And when the brain is bleeding and it's closed, blood pressure rises – it rises even when the brain is open, correct? Or it could lower, right?

A Yes.

Q When you have bleeding in the brain, you're going

to have changes in the patient's vital signs during surgery that require responses of the surgeon and the anesthesia team, correct?

A Yes, sir.

Q And fair enough, the only definitive way to find out what was in Mr. Scott's brain was tissue - tissue biopsy.

A Yes. Or a spinal tap.

Q Yeah, we'll talk about -

A In Mr. Scott's case.

Q - we'll talk about that a little later. So, you're familiar with the results of the spinal tap in this case, then?

A Yes.

Q Okay, and those were negative, correct?

A They were abnormal, but they did not have a definitive diagnosis.

Q There was no diagnosis made, was there? From the spinal tap.

A Yes, that's correct.

Q In fact, there's a long laundry list of viruses and other things that were checked with both the spinal tap and the PCR, correct?

A Yes.

Q Let me hand you -

MR. THRONSON: Your Honor, may we approach?

A That's correct.

Q In fact, the neuro navigation systems that you guys use make it very clear where that is located, and where you need to go.

A That's correct.

Q In fact, if somebody injured the middle cerebral artery, this large artery that we talked about, you'd expect there to be a significant amount of bleeding, wouldn't you?

A That's possible. However, an injury could be a partial injury that could cause an occlusion without hemorrhage.

Q But you said, I believe, earlier, that you believed it was cut. It was taken out.

A We have a piece of artery in the pathology specimen.

Q And you've never looked at the pathology, have you?

A No, I have not.

Q Will you turn to page 324?

A Yes, sir.

Q Do you see under the estimated blood loss of the procedure? This is the operative report of Dr. Jensen?

A Yes, sir.

Q Says 250 milliliters, correct?

A That's correct.

Q Completely normal (inaudible).

A That's a reasonable amount.

Q In fact, and there's no reference during his operative report anywhere of there being a concern about a large bleeder that they had to cauterize, is there?

A That's correct.

Q And if you had hit the middle cerebral artery during the surgery, you wouldn't know it, would you, Doctor?

A That's correct.

Q In fact, there's nothing in the anesthesia record suggesting any changes in vital signs suggestive of an injury to a major artery, is there?

A That's correct.

Q And you looked at that, didn't you?

A Yes, sir.

Q In fact, you told me earlier when there's bleeding in the brain, you're going to have changes in vital signs, correct?

A Possible. Yes.

Q There was no change in vital signs, and there was a normal amount of blood loss. No description of any major bleeder in the operating room, correct?

A That's correct.

Q What's a vasospasm, Doctor?

A A blood vessel of that size has a tendency to be able to constrict and dilate, and it has muscles in the wall

Excerpts from February 24, 2015 Trial Transcript

IN THE THIRD DISTRICT COURT - SALT LAKE

SALT LAKE COUNTY, STATE OF UTAH

DAVID SCOTT, et al.,	:	Case No. 110917738
Plaintiffs,	:	Volume VI of X
v	:	
UNIVERSITY OF UTAH HOSPITAL, et al.,	:	
Defendants.	:	With Keyword Index

JURY TRIAL FEBRUARY 17, 18, 19, 20, 23, **24**, 25, 26, 27 and MARCH 2, 2015

BEFORE

THE HONORABLE SU CHON

CAROLYN ERICKSON, CSR
CERTIFIED COURT TRANSCRIBER
1775 East Ellen Way
Sandy, Utah 84092
801-523-1186

APPEARANCES

For the Plaintiffs: CHARLES H. THRONSON
MICHAEL A. WOREL
Attorneys at Law

For the Defendants: TERENCE L. ROONEY
BRADLEY R. BLACKHAM
Attorneys at Law

* * *

INDEX

use this as - let me help, it's in upside-down - some context later, Doctor. But you've got that model in your hand that sort of looks like the one we have over here that's got - we've heard a lot about temporal lobe and frontal lobe. Can you just show the jury on that model what the - where the temporal lobe is?

A Right, so the - in a way, the brain looks kind of like a glove, and so the temporal lobe would be the thumb. So it's this part that sticks out here. This is all the temporal lobe.

Q Okay, and I - I know I assume there's different sizes of brains, but how does this compare to a normal brain size? Is this 10 percent smaller, 50 percent smaller, or -

A I would say it's maybe 50 percent smaller.

Q Okay.

A Yeah.

Q Okay, so if you had my brain in your hand, it would be twice that size?

A Possibly.

Q Thank you. You know, I figured it was going to come from these guys.

(Inaudible conversation)

MR. ROONEY: The silence was deafening over there. The crickets behind me.

THE WITNESS: This would be the size of a child's

a little muffled, that's all. Okay.

Q (BY MR. ROONEY) The characteristics on this scan, if you're just looking at the images, are they consistent with some type of brain infection or inflammation?

A Well, I think that they do have similarities to infection, and if it was an infection, it would be a herpes infection, because that's where a herpes infection likes to affect the brain. So then I would want to get clinical history and see if the patient clinically appeared to have herpes infection, and kind of fit those pieces of the puzzle together.

Q And if you had information about Mr. Scott's clinical history that did not reflect a history of infection, where would you place that in the differential, or in the list?

A Right, so if he didn't have a fever, if he didn't have a white count, then my suspicion that that's an infection would go way down the list.

Q Okay.

A And brain tumor would be number one on the list.

Q Why is it - why would that information change your prioritizing?

A Because people that have herpes encephalitis are very sick. And so, the clinical history helps you. When we do radiology, we try and come up with a list of

possibilities. And then we try and rank those according to what we think is most probable to what's less probable. And getting that additional information helps you kind of sort through the list. And so, in this case, if you are concerned about infection, but the patient doesn't appear to be infected, then naturally that – the chance is going – that they're infected is going to go way down the list. And I think that's what you have here.

Q And I know you indicated earlier as a radiologist, sometimes you don't have any information about the history.

A That's right. Sometimes you have none whatsoever.

Q And sometimes you do have information about the (inaudible) –

A Sometimes we do.

Q And when you have that information, do you take that into account in sort of forming your impressions about what you're seeing?

A Absolutely. This – the information can help us provide a better list, is what it comes down to. It makes us better radiologists.

Q Okay. Doctor, let me see if we can pull up the images that were done. There was some testimony about comparing images. And we can't pull them up side by side, but if we can pull up the scan that was done on, I think it was the 3rd – yes. March 3rd. I think it's this one – I

THE COURT: I think the jury could probably use a break at this point.

MR. ROONEY: Okay.

THE COURT: So why don't we give them a break, and then we'll continue with this witness after the break.

MR. ROONEY: Okay. Thank you, Your Honor.

THE COURT: All right? Go ahead.

(Whereupon the jury left the courtroom)

THE COURT: All right, thank you. You may be seated. Counsel, if you'd like to take a break, too, as well to –

MR. ROONEY: Thank you, Your Honor.

THE COURT: – use the facilities. We'll break for about 10 to 15 minutes depending on how much time you need to be ready before the next. All right? Okay, we'll be in recess.

(Whereupon a recess was taken)

THE COURT: Mr. Rooney, do we have enough room for the jurors to get by that stand? I don't want them to break it.

MR. ROONEY: Thank you, Your Honor. (Inaudible).

THE COURT: Okay.

(Whereupon the jury returned to the courtroom)

THE COURT: All right, thank you.

Would you like to bring Dr. Pope back up? And –

A I see.

Q - if I might.

A Sure.

Q Okay? And so - because we're here about a neurosurgeon, I want to make sure we understand, you're not the one that meets with the family, goes over and makes a physical examination, discusses different options with them, discusses treatments, that sort of thing. That's not yours.

A That's right. I mean, sometimes we do talk to the patients, but not typically.

Q No, sir. You're not here to comment in any wise about that. You haven't even looked into that, have you? As to what was said, whether it was appropriate, any of those things.

A Correct.

Q That's what I thought. All right. You did say you went into radiology because you liked making a diagnosis. And you said, I wrote down, I thought you said that's the most interesting part of medicine to you. Do you remember saying that?

A I do.

Q You said, I like fitting pieces of the puzzles together to make a story.

A Yes.

Q All right. If you - when I think about a puzzle,

and I think about all those pieces laid out, if they're all laid out and I just pick up one piece and I focus on one piece, I might not get the full picture, mightn't I?

A That's correct. Yes.

Q When you say putting the pieces, it's assembling, more than focusing on one piece, bringing in all the pieces, putting them together, and trying to come up with a picture; is that fair?

A Right. We try and take all the information that's available to us, and see if it all fits together, and come up with the most likely –

Q And part of fitting pieces together is forming what's called a differential diagnosis, isn't it?

A Well, that's one thing that you – that happens, sure.

Q Sure. That's – when you were saying, you know, I'm not focusing on one little piece, and trying to get the story from a piece, a differential diagnosis comes into play – you learned about that all the way back in medical school, didn't you?

A Yes. That's right.

Q Okay, let me ask you something about a differential diagnosis. This is a definition that we've asked people about, in terms of what you learned even back in medical school before focusing on yours. A differential diagnosis is

what's on - what's - what the vessels look like microscopically.

Q I don't have those slides. Where'd you get those slides to be looking at, sir?

MR. ROONEY: Your Honor, they were given the slides. That's not -

Q (BY MR. WOREL) Where'd you get the slides?

THE COURT: Counsel -

THE WITNESS: I have not reviewed the original slides as we discussed at the deposition. I reviewed the scanned images of the original slides-

Q (BY MR. WOREL) Yes.

A - as well as the re-cuts.

Q Have you looked at the originals?

A Not recently.

Q Okay. Thank you, sir.

A But the scanned images are accurate representations of the original slides.

MR. WOREL: Thank you, sir.

MR. ROONEY: Nothing further, Your Honor.

THE COURT: All right.

All right, then, Dr. Chin, thank you for your testimony, and you may be excused from the courthouse. All right? Thank you.

All right.

Excerpts from February 25, 2015 Trial Transcript

IN THE THIRD DISTRICT COURT - SALT LAKE

SALT LAKE COUNTY, STATE OF UTAH

DAVID SCOTT, et al.,	:	Case No. 110917738
Plaintiffs,	:	Volume VII of X
v	:	
UNIVERSITY OF UTAH HOSPITAL, et al.,	:	
Defendants.	:	With Keyword Index

JURY TRIAL FEBRUARY 17, 18, 19, 20, 23, 24, **25,** 26, 27 and MARCH 2, 2015

BEFORE

THE HONORABLE SU CHON

CAROLYN ERICKSON, CSR
CERTIFIED COURT TRANSCRIBER
1775 East Ellen Way
Sandy, Utah 84092
801-523-1186

APPEARANCES

For the Plaintiffs: CHARLES H. THRONSON
MICHAEL A. WOREL
Attorneys at Law

For the Defendants: TERENCE L. ROONEY
BRADLEY R. BLACKHAM
Attorneys at Law

* * *

INDEX

Q Correct.

A Well, Mr. Scott presented with a headache of a number of weeks' duration. He had no fever, he had no chills, he had no cognitive issues, he had no decreases in his level of consciousness, he had no – I think seizures, I said, no psychiatric changes, he had no joint pain, he had no neck stiffness or meningismus, as we say, he had no photophobia, he had none of the things that we think of as being suggestive of infectious or encephalopathic pictures.

So, that – even though the MRI, you know, would include infectious and inflammatory, that led me to think tumor was the – probably more likely based on the history, and also – can I – you know, his labs, his white count was normal. He did not have what we call a left shift, which is suggestive of inflammation. There were no inflammatory markers. And so, I felt, because of – you know, once I put all that together, I felt that, you know, tumor was the most likely diagnosis.

Q And how common are tumors versus sort of brain infectious or inflammatory processes at your institution?

A Well, I mean, tumors are far more common than inflammatory processes and infections.

Q So after considering the presentation of Mr. Scott, and knowing Dr. Jensen's assessment that he thought this was a grade three anaplastic astrocytoma, do you believe it was

appropriate for him to move forward with that as his number one priority?

A Tumor?

Q Correct.

A Yes.

Q And do you believe his decision to recommend a biopsy to Mr. Scott based on that – based on that suspicion, that this was a grade three glioblastoma or glioma – I don't want to use the wrong terminology – do you believe that was appropriate within the standard of care?

A Yes.

Q Why is that?

A Well, because he – he looked at the evidence, and he looked at the MRI, and he came to the same conclusion that I did, that it was a tumor, and by the way, the radiologist – I'm forgetting the name – as well as the other neurosurgeon, Dr. Jensen, as I recall, was the second opinion – Dr. Maughan was the first neurosurgeon – also thought that this was most likely a tumor. And so, I think – in fact, I don't – reading through the records, I didn't find anyone who, before the surgery, thought it was anything – who didn't think tumor was the number one thing on the diagnostics list.

Q Let me ask you. The jury's seen a lot of the X-rays, and we've had a number of people talk about the characteristics in them. Why don't you summarize for me,

you get the whole tumor out, and you don't hurt the patient, that, you know, patient's probably not going to get better. He might get a little bit better because the swelling goes away, and he might tolerate the radiation and chemotherapy better, but you're not - if he can't speak, he's probably not going to - if he can't speak pre-op, he's not going to speak post-op. If he can't understand language pre-op, he's not going to understand language post-op, almost always. And there are very few exceptions, and again, there's - exceptions are when, you know, the deficit is due to the inflammatory process around the tumor, not due to the tumor itself. These tumors basically eat up the normal neurons and glia and synapses, so those things that are responsible for complex behaviors that make humans different from virtually every other animal, are gone and at least at this stage, we have no way to fix that.

Q Let me ask you, Doctor, I think you've sort of walked into one of the issues that we've talked about during the course of the trial, this concept of watchful waiting. Do you believe it was - watchful waiting should've been recommended? Meaning, go home, come back in and we'll take images of your brain and follow you, and see if any symptoms come on?

A No.

Q Why not?

A Well, so I said my top two differential, one is tumor, malignant brain tumor, malignant glioma. The other is inflammatory or infectious. You know, infectious disease can also – is often highly malignant, highly – I shouldn't use the word malignant. Highly fatal. Very high rate of fatality. You also want to be able to – you know, if someone has an encephalitis and it's treatable, and not all of them are treatable, but if they are, you'd really want to know that early on. And so you would want to get a piece of that and treat – whether it's tumor or infection, you'd want to treat it. And the only way to do that is to have some sort of specimen.

Q And –

A And here, since we're thinking that tumor is the number one priority, and since we already said that he's seven weeks into something that historically untreated might have survival as low as three months, he's already used up two-thirds of that time. You bring him back in a month, you know, he could be dead, or he could not speak, or not – he may be paralyzed, he may be, you know, any one of a number of things could happen, and you can't take that back.

Q Do you believe Dr. Jensen's recommend that – recommendation to proceed forward with a biopsy was appropriate and within the standard of care based on the patient's presentation, imaging, and scenario?

A Can I hand you that?

MR. ROONEY: Your Honor, I've got sort of one other area to go into. Does the Court want to break now, or go - keep going? I actually have another area I can go into that's brief.

THE COURT: All right.

MR. ROONEY: Whatever -

THE COURT: Let's ask the members of the jury how they're feeling.

Do you want to break now, or could you sit for a few more minutes? Okay, good.

Then go ahead, counsel.

Q (BY MR. ROONEY) Doctor, before we sort of talk about the surgical issue, let me ask you, one of the other claims in this case is that Dr. Jensen either cut into the middle cerebral artery or some other artery near it, causing Mr. Scott's stroke. And you commented on this briefly. In your review of the operative record, including the anesthesia record and the operative report, do you see any indication in those records that there was an injury to a major blood vessel during the surgery?

A No. There's nothing in the operative report to suggest any hemodynamic instability -

Q What's hemodynamic instability?

A So if you cut into a major blood vessel like the

MCA-

Q And that's the middle cerebral artery?

A Middle cerebral artery, thank you. Sorry about that. That - you know, the - 20 percent of the blood volume in your body goes to your brain. So if you cut into the MCA, there's a lot of bleeding very quickly. And usually you lose a lot of blood, and sometimes, you know, the blood pressure will go down because of that, and the heart rate will pick up. And when I looked at the anesthesia record, and when I looked at his op record, I didn't see, you know, the blood pressure seemed to be pretty flat, as did the - and the blood loss was pretty minimal, about 250 cc, which is, you know, pretty typical for -250, 350 cc is pretty typical for this kind of case.

Q Do you believe, based on that information and those records, that there was an injury to a major vessel during the surgery?

A There's no indication that there was injury to a major vessel.

Q Okay. Doctor, the last area I want to get into pertains to the choice of biopsy procedure. And maybe we'll talk about it generally for a few minutes, and then we'll describe for the jury after the break how you perform this. But let me ask you, you perform biopsies presumably for suspected gliomas as part of your neurosurgical practice?

Q Let me stop you real quick.

A Yeah.

Q Deep, meaning deep in the brain?

A So, for example, this is an area called the thalamus. And it's very hard to get to - to get to the thalamus, I have to go through a lot of the brain -

Q You mean -

A - the normal brain -

Q - opening up and going in through an open procedure.

A Right.

Q Okay.

A So, if I do this open, I can do it open, but I have to - and sometimes I do have to do it, but if I'm just looking for a diagnosis, and it's not supervascular, I can stick a needle in there, and that's probably what I generally do. And-

Q And you said focalized. If it was focalized.

A I said localized.

Q Localized. I'm sorry.

A I said localized. Sorry. I'll try to enunciate.

Q No, you did. I -

A Sometimes there'll be a very well circumscribed lesion that's fairly superficial, and I can stick a needle in that, and that's not an unreasonable thing to do either. But

in an area here that's right near a vessel, where the part that's abnormal is right around the vessel, I would not - I do not do needle biopsies on that, because I think it's very - you know, do you want me to demonstrate? Do you have -

Q No, we'll do that after the break.

A Okay.

Q The thing I want -

A I think there's - there's a high risk with sticking a needle in there. Because remember, you're sticking a needle in there, you're not - you don't really see with your eyes. You're using a computer, and there's a certain amount of precision, but it's not - it's not perfect. And if you're off by as much as a millimeter, which frankly is unfortunately not that unusual once you get in, you know, five or six centimeters deep, you know, if you're off half a degree, you're probably off a millimeter once you go six centimeters deep in the brain, you could be taking a biopsy of that blood vessel and not a biopsy of that - whatever that process is.

Q Let me ask you this, and then we'll - if it's okay with the Court and the jury, maybe we'll take a break. We saw a video of an open craniotomy - an example of one that Dr. Jensen did where a piece of the skull is taken off.

A Right.

Q And then we saw some pictures - we didn't see a

video, we saw some pictures of a needle biopsy.

A Right.

Q And you see a big piece of bone come off, and you see blood, and then you see a needle sliding in, one on the surface for laypeople looks scarier than the other one. Explain why open isn't scarier than a needle. In fact, it could be the reverse.

A Well, I mean, every case is different. So - and I think - I don't want to say, in a generic sense, that one is safer than the other. But with an open craniotomy, yes, it's bigger. First of all, let me take - so there's a big trend in all of surgery to do what we call minimally invasive surgeries. And generally the reason for that is, the smaller the incision, the less pain, the faster the patient recovers, pretty common sense. Makes a lot of sense, right? The brain is a little unique, in that the brain has no pain receptors. So the skin has pain receptors, but we can numb up the skin, and typically the skin from a craniotomy is numb. The brain has no pain receptors. So, patients who have pain after surgery don't have pain because of the brain. So a smaller incision in the brain has no more and no less pain than a bigger incision in the brain. So there's no - pain is not really an issue, recovery is not really the issue. The issue, which has to be decided on an individual basis is, what's the best way to make a diagnosis, and what's the

safest way to make the diagnosis, and what's the risks?

So, a craniotomy is bigger, and you may lose a little bit more blood, but when you do a craniotomy, you can see a – you bring in a surgical microscope, you not only have stereotaxis, because we use stereotaxis too, so we know in general where these, you know, these abnormalities, and where the blood vessels are, and we have a pretty good idea. But remember, there's – the patient's not in exactly the same position when you're doing the surgery, and the anesthesiologist is breathing for the patient rather than having the patient breathing on his own, and that can shrink or make the brain swell, plus the brain – you know, blood is going through these big vessels here. And the brain is pulsating just like the vessels are pulsating. So the vessels move. And so, if I'm doing a biopsy near a vessel, I want to actually see that vessel, so whatever I take in my biopsy forceps, I actually can see. Now if I get a piece of vessel, you know, I can actually – you know, if I see a vessel, I can actually avoid getting that vessel, if I think it's an important vessel. Whereas, you know, obviously you always get some vessels when you're operating on the brain, because the brain is full of vessels. But you could see the major ones, you know where they are, you avoid them. When you stick a needle in, you're basically going on this two-dimensional structure, and you already know that you're

probably going to be about millimeter off. Plus, you know, you're - the brain is moving, you have no perception of what the moving is, you don't know exactly, you think you know where your needle is, but the truth is, you're operating on the MRI that was done the day before that's done with a patient like this, and then you're operating with the patient like this, with the anesthesiologist breathing for the patient, with a whole bunch of things that add a little bit of uncertainty. And in cases where you're near major vessels like this, I think that adds risk. Plus, remember, when you're taking -

Q Doctor, we'll - we'll -

A Okay.

Q - go into the details of the procedure after we're done. Fair to say that blood that you can see, to a neurosurgeon, is better than blood you can't see?

A Well, a blood vessel - it's safer to be - if you're going to be near a blood vessel, it's safer to see it.

Q (Inaudible).

A The other thing is - let me just add one more thing. One - I said earlier that the risk of any operation, whether the brain or anywhere else, is always bleeding and infection. If you're operating openly, and you cause bleeding, well, you're there, you're seeing it under the microscope, you see it, you can figure out where it's coming

from and stop it relatively quickly. And Dr. Jensen sort of eluded that in his op report, he caused a little bleeding after his first biopsy, and he – during the process of coagulating that bleeding, getting hemostasis, as we call it, he saw that second area where he got the third biopsy specimen from.

If you're sticking a needle in there, you know, there could be bleeding – sometimes there's bleeding that comes out the needle. But sometimes the bleeding goes deeper into the brain. It could go somewhere else. Blood is fluid. It goes along the path of least resistance. So sometimes, you do a needle biopsy, you think it went great, and there's a blood – there's a – you know, a big blood clot in the brain. And how do you figure that out? Well, you take the – you wake the patient up, that takes 30, 40, 50 minutes, then you take them to the recovery room, and first you think, well, he's not waking up, but maybe his anesthesia hasn't worn off, so you wait another 20, 30 minutes, and then you – still not waking up, and he's not looking normal, then you get a CT, well, maybe someone's in the CT, maybe it takes – you know, the CT is not in your recovery room, so maybe depending on where it is, takes 30 to 60 more minutes to get a CT. Suddenly on CT you see a big blood clot, and suddenly you have a surgical emergency, because it's a life threatening blood clot. Then you have to rush the patient

back to surgery and take the blood clot off, and, you know, sometimes you get there, hopefully, most of the time you get there, but sometimes you might not. If you're – so if you're open, and you're near a blood vessel, you know you're near a blood vessel, it's nice to see that blood vessel, so that if you cause bleeding by accident you can stop that bleeding. If you've got a needle there, you don't necessarily know that you've – whether you've caused bleeding or not.

MR. ROONEY: Thank you, Doctor.

Would now be a good time, Your Honor?

THE COURT: That'll be fine, counsel.

All right, then, members of the jury, we'll give you a brief recess. And please remember not to talk – discuss about – discuss this case with each other. All right, thank you.

(Whereupon the jury left the courtroom)

THE COURT: All right, thank you. You may be seated.

Dr. Sloan, if you'd like to take off the microphone–

WITNESS: Oh, sure.

THE COURT: – and you can take a brief recess too, and turn it off.

And counsel, I'll expect that we'll need about 10, 15 minutes, is that correct? All right, thank you. We'll be

in recess, then.

(Whereupon a recess was taken)

THE COURT: All right, we're back on the record.

TJ - no, don't bring them in yet, I just need to make a brief - okay.

Counsel, you know, I - I think we are moving a little bit slowly at this point. If you don't mind me talking to Dr. Sloan for just a second.

Dr. Sloan, if we could try and stay on task. No, you're welcome to stay there.

MR. SLOAN: Oh, sorry.

THE COURT: I'm - I just - let's keep on task, and if you can just stick to the salient points so we can keep it moving, we would appreciate it.

MR. SLOAN: I will do my best to do that.

THE COURT: I know. And I appreciate that you're here, and thank you for your testimony. We just need things to keep moving. So if you can limit the extraneous things that are not relevant to this case, we would - it would be appreciated. All right? Thank you.

All right, now we're ready to go.

(Whereupon the jury returned to the courtroom)

THE COURT: All right, thank you. Why don't we make sure everybody's microphones are turned on, and let's continue with the examination of Dr. Sloan.

MR. ROONEY: Thank you, Your Honor.

Q (BY MR. ROONEY) Dr. Sloan, I put a copy up, which I've shown counsel, of a - I apologize for the low technology on this. This was an angiogram that the jury saw yesterday that I just printed off real quickly. And I've got a copy up there in front of you. Doctor, you recognize this as an angiogram that was done after Mr. Scott's stroke?

A Yes, sir.

Q And can you show the jury if you can from there, or walk up in front of them if it's easier, where the occlusion is in the stroke, and -

A Sure.

Q I know they saw this yesterday with Dr. Pope, so -

A So this is what's called an internal carotid artery injection. The radiologist sticks a little micro catheter into this vessel, through the neck, up into the brain - sometimes in the neck, sometimes in the brain, goes into the internal carotid artery here, goes up and around, it's obviously not straight, and then it breaks - branches into two different portions. This part is called the anterior cerebral artery, and this is a normal looking anterior cerebral artery distribution, and then it branches into what's called the MCA, or middle cerebral artery. And the first branch of the MCA, we call it M1, and M1 typically goes out - typically I'd expect it to go about halfway between the

branch point and the surface of the brain. Here it goes – you know, it only goes a short distance. So it's cut off abruptly, and that's really where the vessel is cut off. And that's most likely what caused the stroke.

Q Doctor, show the jury where the location of the surgery that Dr. Jensen performed was.

A Sure.

Q The area.

A Can I hold – can I ask you to hold this –

Q Sure. Sure.

A – while I hold that? So, if you look here, this is what we call M1. And so this is before surgery, M1 is intact here, and we – we didn't see in the angiogram, but we see it on the various other films. I don't think that's really in contention. M1 is intact. And around here, it splits in M2. The process that he was trying to biopsy is pretty close – halfway between the branch point between M1, the first branch of the MCA, and M2, the second branch of the MCA, about halfway between that branch point, which is about here, and the surface of the brain, which is here. So, he's operating here, which relatively speaking would be, you know, somewhere around here.

Q Doctor –

A So that's where he's operating.

Q Do you believe, based on the location of his

operation, that the occlusion was caused by something he did in the surgical field?

A I – you know, I can't see anything on the op report that leads me to believe that it was something that he did at surgery.

Q Okay. Doctor, let me ask you about the one – last thing I want to talk about is, Dr. Jensen obviously made the decision and recommended an open biopsy in this case, correct?

A Yes, sir.

Q Do you believe his recommendation for an open biopsy was within the standard of care?

A Yes, sir.

Q And you believe his decision to choose that over a needle biopsy was within the standard of care?

A Yes, sir.

Q And the last thing I want you to do is explain to the jury why you believe a needle biopsy – well, let me ask you, do you believe a needle biopsy would have subjected Mr. Scott to more risk in this case?

A Yes, I do.

Q And I want you to explain that to the jury.

A Sure.

Q I think we have a needle. Here's a biopsy needle. And I'll – maybe we can put this up in front of the jury.

A Sure.

Q And that way you can have it on the board, and don't have to hold it.

A So -

Q Wait for a second, Doctor.

A Well, let me just -

Q Let me get over there, Doctor. I'll just put it up.

A Okay. So, I said already that this is what we call M1 -

Q Can I wait - let's wait until we get this up.

A Okay.

Q So that way you don't have to hold it. So Doctor, let me ask you before we get into that, and I'm really low tech today, this is a pipe cleaner that I think you're going to use to replicate an artery -

A Right.

Q - so to speak, just to give the jury some context and demonstrate what you're trying to explain to them. What do you have in your hand? Describe for the jury what that is you're holding.

A This is a commercial tool that we use to perform a needle biopsy. And what I want to show you is that, you know, most people - as I said earlier, we think about - we plan this as if it's a point, and that's how most people

would generally think about it because it seems logical, but actually, it's not a point. The way this works is –

Q Let me ask you real quick, Doctor, interrupt. This comes out of a package like this in the operating room, out of a sterile package –

A Yeah, it's sterile. In the OR it's sterile. This is not sterile because obviously –

Q Right.

A – we're not in a sterile environment.

Q National biopsy needle, disposable, is that just a brand name of a biopsy needle?

A This is the one that we use, and most commonly people use, I don't know exactly what Dr. Jensen used, but this is –

Q We got this from Dr. Jensen's –

A Okay. So, I guess this is, from what I understand, what he uses as well.

Q Okay.

A But this is what most people use. It's – and there are other brands, but they all have more or less the same principle. There's an outer cannula here, and an inner cannula here, and what happens is, you put it in, in a closed position – well, let me show what the outer cannula is. The outer cannula has a blunt tip. It's straight, it's rigid, it's pretty rigid, you can bend it a little bit, but it's

pretty rigid.

Q So, the tip of it's not open, it's closed.

A Right, the tip is closed and it's blunt. And I can pass it to them if you want me to.

Q Sure.

A And then it's got an opening in it, which is where the biopsy is performed. But the way the biopsy is performed is - so the inner cannula has two things. It has a little channel in it that I put a syringe on, and I actually suck tissue into the inner cannula, and there's a little opening in the inner cannula that matches up with the outer cannula -

Q (Inaudible) - maybe you can -

A I'll - sorry.

Q Yeah.

A I'll pass it around. Because I think it's -

Q Warn them that this inner cannula apparently has a-

A Yeah, this is sharp. You don't want to cut your finger off.

Q (Inaudible) part there.

A But this is actually a little - like a small razor blade. So the way it works is - so, there's a blade here on the inner cannula. The way you use this is - and it's got little indicators on the outside, so when you put it in, you put it in closed. So you're not going to catch - hopefully you don't want to catch a vessel as you're putting it into

the brain, right? You want to not get anything – and then, once it's in the location you want it to be, you then rotate it 180 degrees until these two things line up. And you'll see – I think you can see – the opening is now open. Right? So then I stick a syringe there. It's now open, I put a syringe there, and I actually suck a little bit out. It pulls some tissue into that. And then, very quickly, I turn it back 180 degrees. So whatever's cut – whatever's sucked in is cut off by the inner cannula. And then, the outer cannula stays there, I take the inner cannula, and I deliver this to my circulating nurse, and that's where the biopsy comes from. It's basically a cylinder about this size. That's what the biopsy is.

So, then let's talk about the safety. You know, if you're talking about something that's well circumscribed, and not near any vessels, it's a safe thing to do. Sure. But, we already talked about the M1 vessel being around here, and then the M2 is here, and this area of enhancement, the area that's the most abnormal here, the area that we need – if we're going to get a diagnosis – the surgeon's responsibility to get the diagnosis means that he probably wants to get a sample of this area. But you'll notice – I think that you can see, if you look closely, this bright white – there's sort of hazy white around here, you know, sort of a blob, irregular shape, but right in the middle of it, more or less,

is this bright white. And that represents the M2 vessel. The blood vessel's running right between the part here and the part here that's abnormal. And it's not straight, either. It's curved. All right?

Can I borrow the pipe cleaner?

Now, the other thing we realize is this is an MRI, you're seeing one plane, and the patient is lying on his back and not moving. And he's breathing at whatever way he normally breathes.

But now, we're going to go in the OR. And so, first of all, we realize that this is not a two-dimensional structure like you see it here, it's got three dimensions. So, this represents the internal carotid, this represents M1, this represents this curve at M2. And, you know, I don't know exactly the shape, but this is - I'm trying to more or less model generic - you know, in a reasonable fashion, that curve. But also, it's not in one plane. It also curves up, the vessel typically comes up, not quite this high. I probably should've cut this pipe cleaner off. But I'm going to be focusing here.

So, I want you to remember a couple things. Number one, here he's lying flat on his back and he's breathing on his own. When we do surgery, we've rotated him like this, so remember, all these spaces in the brain, this is called the sylvian fissure, that's a space, that's a space, it's filled

with fluid, but gravity works on the brain. The skull stays the same, and my reference point for this stereotaxis, this computer – fancy computer stuff that I'm doing, is the surface of the skull. The surface of the skin, really. But, when you turn the head, the brain shifts a little bit. And then, patient's asleep, so the anesthesiologist is breathing for him. And if he breathes a little faster, if he artificially makes the patient breathe a little faster than the patient normally breathes, the brain – the patient basically blows off carbon dioxide, and the brain shrinks a little bit. On the other hand, if he breathes a little less rapidly, the brain expands a little bit. Now, you know – and you don't see – the anesthesiologist is closely monitoring oxygen. But within a fairly wide range, the oxygen really won't change. You can hyperventilate or hypoventilate to a fairly significant extent, and cause the brain to shrink or expand, without changing the oxygen. And then lastly, you know, the brain is not static there. It's pulsating.

Q Why is it pulsating?

A Well, because the heart pulsates, we always know, we can feel our heart pound. If you feel your carotid artery in your neck, that's the beginning of the internal carotid. When you're taking your pulse, what you're actually feeling is that pulsation in the artery. That's a natural process. We all have that. All right? And the brain has that – that

artery goes directly into the head. And that's pulsating. And it's moving in two or three dimensions. Plus, you stick your needle - you open the brain - I'm sorry, you open the skin, you open the bone, you open the dura, some CSF is leaking out. So suddenly, the position here, even though you can be extremely precise with respect to your reference mark on the skin and the skull, the brain is not necessarily in that exact position. All right? So, keep that in mind. Let's just do this to remind us of that.

Can I ask you to hold this? Because I need four hands for this.

Q Sure. Where do you want me to -

A So I want you to - can you stand here? And hold it just like that. So, I - let's say I'm going to try to do a needle biopsy of this area that's probably four or five millimeters on each side of this vessel. I'm going to come in, I'm going to come in closed, and I'm going to put my needle right there. Right? And then I'm going to open it. Sorry, we have a holder that keeps more still than I am here. We're going to open it, and we're going to suck. So I'm a little bit worried that I'm going to suck that vessel in. But then realize that there's a little shift, and his heart is beating. So this vessel is doing this.

Can you do that for me?

So I'm going to open this, and I'm going to be

right here, because that's where the abnormal enhancement is. And you're going to ask me to suck in and take a specimen. You know, I might do it, and I might do it safely. But there's a much higher risk than normal. We normally think of the risk of bleeding from a stereotactic biopsy is about five percent, roughly. But in this context, it's much higher than that. And in my, you know, in my experience, and in how I teach my residents, I don't think it's worth the risk when you're, you know, less than a centimeter away from a major vessel like the M2 vessel like this.

Q Why is it –

A You – sorry.

Q – why is it a lower risk to go in through an open incision?

A Because, instead of doing this blindly, you still have shift –

Q Still have movement.

A – you still have movement. But you're seeing with a microscope that magnifies things somewhere between 10 and 40 times, depending on how you set it. And you can see the movement. And you can precisely time your biopsy to – so that you don't – you know, you don't grab this blood vessel. And you could still take the tissue you want. And, by the way, you can see what you're doing as you do it. So even if you don't grab this vessel – by the way, so I didn't mention

this, there are all sorts of little vessels. You see a hint there, there's a little blush there. There are a whole bunch of little vessels as part of the M1 and M2 called the lenticulostriate vessels. And I don't want to get too much into minutia, but those are the vessels – even though they're teeny vessels, you don't – they're so small, you don't really see the vessel. But even though they're very small, if you nip off – if you take one of those vessels, the patient will be paralyzed, even though there's not a big stroke, there's a small stroke in a key area, and the patient will very likely be paralyzed on the left side like this, in the dominant hemisphere. There's a good chance he's going to either lose receptive speech, that is the ability to understand language, motor speech, which is the ability to speak, because – you know, to speak is a very complicated function. There are all sorts of muscles in the face and the tongue, you have to coordinate all of those. And – or both. And so, it's just – and plus, you're suctioning – with this diagnostic – with this technology, you're – you don't see those small vessels. You can't even aim to miss them. You don't know where they are. You can see them if you're open under the scope. With the needle, you have no idea where they are, and you could just be unlucky and suck one of those into your needle and take them. And even if it doesn't cause a massive bleed, the patient's going to have a stroke. And there's – it's just

not worth the risk, in my opinion. When you're this close to a vessel.

Q Let me ask you, Doctor –

A And you can see here, these are one centimeter marks. So that's about five millimeters, or half a centimeter, about this much – about that far from the vessel. Let me show you something. This opening is about a centimeter. So the distance between the blood vessel and the distant part of that part that enhances, is half that distance. So, if you think you're not precise, and I've explained to you why I think you can't be super precise in this sort of context, I don't think it's safe to do that.

Q Why not just stick the needle into one of the parts of the lesion somewhere else?

A Well, because, you know, this is what we call Sutton's law. So – Willie Sutton was a bank robber, and someone said to him, Well, Mr. Sutton, why do you rob banks? And he said, well, because that's where the money is. The surgeon's job here, Dr. Jensen, all he said – his job is not – he wasn't going to try to take out the tumor. He was going to try to get a diagnosis. And if you're going to get the diagnosis safely, you want to go – you want to get an accurate diagnosis, you know, and you want to go where the most abnormal tissue is. And, you know, I would be – you know, it's hard to – I can't really say, but the first two

specimens may – my guess is, the first two specimens may have been there, and that's why they're abnormal, but not diagnostic. I mean, it showed gliosis. It's not normal, but not diagnostic. So, that's why, you know, I think if you – that's why he needed to get a third specimen, because it wasn't diagnostic. And the closer you get to that vessel, the more the abnormal – the more the tissue is abnormal.

Q Last thing I want to ask you about this, Doctor.

A Sure.

Q There was some testimony that the accuracy of getting a piece of tissue that you can get a diagnosis from is 98 percent. Is that consistent with your experience and your understanding of the literature in this area?

A No, I saw a quote from someone. I've looked in the literature. I do not know a single piece of literature in the peer review journals, in any of the peer review journals that I've seen, that says accuracy and precision is 98 or 99 percent. You know, we live in a free country, you can say whatever you want, but I'd really like to see – I'd like to see anyone produce that. I'd be very interested. Let me tell you, this is – for example, there's a recent paper –

Q Doctor, I think that –

A Thank you.

Q – that's enough. Thank you. I think you can return, Doctor. Thank you.

A Thank you.

Q Doctor, I think we've covered each of the issues that have been raised. My last question to you is, assuming we haven't addressed them, is there - in your review of the records, in your review of the materials, do you believe Dr. Jensen's care in its entirety was appropriate and consistent with the standard of care for a neurosurgeon performing the procedure and doing the evaluation on the patient that he did?

A Yes.

MR. ROONEY: Thank you, Doctor.

THE COURT: Thank you.

Mr. Worel?

MR. WOREL: Yes, ma'am.

(Inaudible conversation)

MR. WOREL: We just need to be able to plug it in when it's time, if you don't mind. Okay?

CROSS EXAMINATION

BY MR. WOREL:

Q Good morning, sir.

A Good morning.

Q I'm Mike Worel. We've never met.

May I approach?

THE COURT: Yes, you may.

Q (BY MR. WOREL) Just to kind of get you - there may

chills, and – to make it reverse, she's got a right, and he's got a right to know that on the differential, when they're deciding the options, infectious process, inflammation are a very real part of the differential. They had a right to know that. Didn't they?

A Yes.

Q Did you see – Dr. Jensen was asked specifically if the – Ms. Scott has testified that they were never told they had a month or two months that this could be observed, are you in a position to dispute that? And he says no. Or confirm. Do you remember seeing that?

A I believe I did.

Q Okay. Dr. Jensen has said something about, there was a post surgical tumor board meeting. Do you see any records about any post surgical tumor board meeting?

A I did.

Q Post surgical tumor board meeting?

A Yes.

Q Really?

A There was a – it didn't say much, but it was a list – it was after surgery, and it listed who was there, and Dr. Jensen was one of the people that was there.

Q Did you – I don't think you looked at the date. It's already come up, it's been before the jury. That was before the operation. Did you happen to look at the date?

A I guess I could be wrong but –

Q Okay.

A – why don't you show that to me?

Q Dr. Jensen has testified, and I asked him, because we asked that the hospital –

A Okay.

Q – for any record of a post surgical record.

A Okay.

Q And there isn't.

A Okay. Well, I saw a tumor board, and if the date was wrong, I didn't catch that.

Q Yeah, because that's important. I understand that there may have been one before, but sometimes the tumor board meets where somebody has to say, I thought this, but it turned out to be that. Right?

A Correct.

Q And the whole purpose of that is so maybe it won't happen again and learn from it.

A Well, the point of tumor board is therapy. We –

Q Well, after the fact it's not therapy. After the fact is, this is what we thought, this is what we found. That's part of what happens in the tumor board, isn't it?

A Different tumor boards run different ways, but –

Q Okay, well, that's what they said.

A Okay. Fair enough.

Q All right. So, assume that. The whole purpose of having it after the fact is so somebody can learn from it, and maybe not have it happen again. That's part of it, isn't it?

A Okay.

Q Okay. Nobody's given you any records of them actually doing that at the University of Utah, have they?

A Well, like I said, I saw a tumor board that had his name on it –

Q Okay.

A – and the patient – I did perhaps miss the date.

Q That's fine. And let's talk a minute about here what caused the stroke. You know, you went through the angiogram and all that.

A Right.

Q I was listening real close about what you thought. You certainly agree that it could be just the surgical manipulation that caused the stroke, don't you?

A It's possible.

Q Well, let's see what – Dr. Jensen – you know he says the most likely explanation, not possible, the most likely explanation is that it was surgical manipulation, don't you?

A Yes.

Q Okay. And when you were asked that, you said, you

and over, but I wonder if it could be this inflammatory process –

Q Does that mean you – it's a simple answer. Is it yes or no, will you defer to him, or not? That's all I got to get from you.

A I – he might be right, he might be wrong. I don't know if he's right or wrong. I don't know why this patient had a stroke.

Q Okay.

A Could he be right? Yes.

Q Next thing I want to ask you about, you did look at the imaging – and this is going to come up with another expert that's coming in on Monday, so I want to ask you (inaudible).

A Sure.

Q I'd asked Dr. Chin about a thing called leukodystrophy.

A Yeah.

Q You're familiar with that (inaudible)?

A Yes.

Q Don't you?

A Yes.

Q Okay, let me find it. And Dr. Chin, you know, is the pathologist.

A Yes.

Q And you wouldn't - there could be something behind it, you just can't see it.

A Yeah. You can't see any - the abnormality that we saw pre-op, you don't see post-op.

Q While we're on page 32, stay there for a second.

A Sure.

Q I want to ask you a question. There's been some statements about a tumor board. And I'll reference to you that there's a log that just shows a list of people that attended a tumor board before Mr. Scott's procedure.

A I apologize, I got the date wrong, but I -

Q Mr. -

A - I did look at that log.

Q And that's fine. What I'm asking you, there's other processes where neurosurgeons and other doctors talk about cases, particularly unusual cases, isn't there?

A Correct.

Q It's called a morbidity and mortality conference?

A Correct.

Q And that's when you talk informally as a group and say, hey, I had this unusual case, and you try to learn from it, right?

A Yes, sir.

Q And there's been a suggestion here that Dr. Jensen said, I remember talking about this case afterwards - I'll

reference that to you that during his testimony he said, I remember talking about the case afterward, and he said he thought it was a tumor board. Another option for talking about a case would be a morbidity and mortality conference, correct?

A Actually, that's - when we talk about mistakes, generally that's what - when we're talking about it. When things don't go right, when you have a problem that you didn't expect, it's the QA, morbidity, mortality report, that - in my personal experience, that's where we discuss those things. Tumor board, we discuss tumors. This patient has such and such, what are the treatment options, here's what we do. You know, I - and so, I don't know what is and is not discussed at tumor boards at University of Utah, but - that's why I was a little confused by the - your opposing attorney's testimony, because I - generally we don't talk about what went wrong at tumor board. That's a very - we cover 30 or 40 patients quickly. What do we do, what are the options, should he see a radiation oncologist, should he see a medical oncologist, should he see social work, does it - what other things does he need? Tumor board is for tumor related treatment. This patient -

Q Let me ask you -

A Yeah.

Q - morbidity and mortality.

A Right.

Q Morbidity stands for what? Or denotes what?

A Any complication.

Q Any complication.

A Something that - yeah.

Q And mortality means someone that passes away.

A When someone dies. Yes.

Q So, the conference is to discuss complications and-

A And deaths.

Q - unfortunately deaths?

A Right.

Q Which sometimes you conclude was a result of a mistake.

A Correct.

Q Sometimes you conclude is just a complication?

A Correct.

Q And it's a process to try to learn from unusual presentations in cases; is that fair?

A Fair.

Q Let me turn you to that page there on page 32. If you look about - under the progress note section, about two-thirds of the way down there's a sentence there that says, "We had discussed his case," referring to Mr. Scott - and this is from - let me give you some context here. This is January 4th of 2011. So, this is Dr. Jensen's office note

after the surgery, where Mr. and Ms. Scott – presumably Mr. and Ms. Scott, are in for a return visit. And he's discussing with them Mr. Scott's situation. And it says, "We have discussed this case in our morbidity and mortality conference, and everyone was quite perplexed by this unusual but severe complication." Does that suggest there was a discussion about Mr. Scott's case after the surgery?

A Yes, it does.

Q And that they were perplexed by an unusual but severe complication?

A Correct.

Q And then it says, "Even more complicating is the fact that the specimen removed did not show any neoplastic tissue, and in fact, was a chronic inflammatory infiltrate and gliosis reaction, and was felt to be an acute and chronic meningoencephalitis. The patient had an extensive postoperative work up by the ID team," that's infectious disease?

A Yes, sir.

Q "And they felt that most likely was a burnout herpes type encephalitis, but I do not know that we ever 100 percent were confident in what this lesion really was." So, this is in his note of his meeting with the family. Does it suggest that Dr. Jensen passed this information on to the family? I know you weren't there, but the fact that it's in

A I don't remember for sure.

Q Doctor, we've got the note up in front of the jury, and it looks like Mr. Scott was referred to you by Dr. Lisa Kuwahara for evaluation and treatment advice regarding MRI showing an enhancing mass around the middle cerebral artery. Do you have an independent memory of either speaking with Dr. Kuwahara or any communication with her about the referral of Mr. Scott over to you?

A No.

Q Is Dr. Kuwahara someone that has referred other patients to you?

A Yes.

Q Do you have an independent memory – in this case, it looks like Mr. Scott had had MRI of his brain done on February 19th and interpreted by Dr. Peter Schloesser, who was here yesterday testifying. Do you have any memory of speaking with Dr. Schloesser about his evaluation of the imaging?

A No.

Q Is that something you do on occasion? When there's already been an interpretation by a radiologist?

A To talk to the radiologist?

Q Correct.

A Sometimes, but not usually.

Q What is your routine when a patient comes to you

with films that have already been done, and wants your opinion about what you think is going on? What's the routine that you employ?

A I usually look at the films myself and see what I think, and then look at what the radiologist thinks after.

Q And have you had an opportunity to review the films in order to just refresh your memory for testifying today?

A Not since the deposition but –

Q Okay. And I think that was quite a while ago, I believe.

A A while. Yeah.

Q February of 2013. Doctor, I'll give you – we've been using some of the images just sort of as illustrative of the issues that have been discussed in the case, and some of the characteristics. I will put these in front of you and let you look at them just to refresh your memory. Try to limit the ones that are somewhat similar. Doctor, we've got some imaging tests that were done by – read initially by Dr. Schloesser, I'll let you glance at these just to briefly to refresh your memory.

A Okay.

Q Thank you, Doctor. I don't know if – you said you had some memory of the meetings with the Scotts –

A Yeah, I –

Q – I don't know if looking at the films, you know,

refreshes your memory, or - does the image - do these images look consistent with what you can recall seeing when he came to you?

A Yes.

Q And Doctor, without going into detail, obviously you made a diagnosis at that point in time. What was your diagnosis based on the imaging you saw and your evaluation of Mr. Scott?

A So I would say that a little differently. I mean-

Q Right.

A - diagnosis is made with tissue, generally, so I think we have a differential diagnosis, right? Things we think this might be, but I wouldn't say I made a diagnosis.

Q Great, and I stand corrected on that -

A Is that fair?

Q - I think you're right.

A Okay, sorry.

Q No, no. I think that's an accurate correction.

A So my - I guess here, assessment and plan was that this was a mass most consistent with a tumor, and I recommended getting a tissue diagnosis so we had a diagnosis. And the way I planned to do that was with a craniotomy and open surgery to sample the tissue.

Q And we've seen - let me pull this out. This is probably a rough description of a craniotomy, but I think we

had a picture of one over here. Doctor, does this represent, even roughly, what it is you were planning on doing to access the tissue in this case?

A Yes.

Q And that's sort of a general description of a craniotomy.

A Yes.

Q What is the definition of a craniotomy?

A The definition of a craniotomy is taking out a piece of skull, opening the skull, essentially, so the skin's cut, the - and retracted, the bone is - a piece of bone is cut out, and then the covering of the brain is opened, and then you have access to the brain tissue.

Q Okay. In looking at your note, Doctor, it looks like Mr. Scott presents with the chief complaint that we've referenced, and then there's a history of present illness, and that history, I assume, is taking from the patient?

A Yes.

Q And then underneath that there's some other - past history and social history, etcetera, that you typically see in a record, and then there's a physical exam and musculoskeletal and neurological testing, and then musculoskeletal - further musculoskeletal and neurological testing on the second page, as well as testing his strength, etcetera. With the physical exam and the history and the

testing, what is it - why are you doing that, given his presentation?

A Well, that's part of any evaluation. The history is important to - if you have a history of colon cancer, then the differential changes some. The exam is important to see if, and to what extent, there might be neurologic deficits or symptoms or signs related to the - signs related to the presentation.

Q Were there any abnormalities in his presentation or neurological evaluation that you can tell from the records, Doctor?

A There were not.

Q And do you rely, at least in some part, on your history and your physical examination of the patient, in trying to decide what's going on in his brain?

A Yes.

Q And in this case, you also, I presume - it looks like you referenced that the findings were most suspicious for glioblastoma versus lymphoma. Was that your original interpretation, or are you referring to Dr. Schloesser's original interpretation, if you can remember?

A I don't remember specifically, that's what Dr. Schloesser thought and I agreed with his thoughts.

Q Okay. I assume part of your evaluation would've been to review the films as well.

A Yes.

Q And would you – what's your routine and practice – unless you specifically remember with Mr. Scott, do you sit down with the patient and pull them up on a computer screen and show them, are they up on a light board, or what's the practice–

A They're both – for an MRI, generally it's on a computer that's in the exam room.

Q Do you –

A And we look at them together.

Q Do you have a specific memory of looking at the films with Mr. Scott?

A No.

Q Do you have any reason to believe you wouldn't have followed your normal practice?

A I do not.

Q With a situation like this, where your diagnosis was glioblastoma, obviously very serious diagnosis, would that affect the meeting you had with the patient? In other words, you know, would there be specific time spent, or more time spent to discuss that diagnosis?

A Yes.

Q And why is that?

A It's a – well, a glioblastoma is a pretty devastating diagnosis. The average survival is between 12

and 18 months, and so –

Q Is that with treatment, Doctor?

A That's with treatment.

Q What's the survival rate without treatment?

A About three months.

Q And the survival with treatment, what is the treatment? Is it surgery or chemotherapy or radiation, or all of the above?

A Yeah, the treatment – all three. Surgery has a – sort of a dual role. The first important part of surgery is getting a diagnosis. The radiation or chemotherapy can't happen unless you know what you're treating. Surgery is also important some of the time as far as resection of tumor. So, if there's a tumor that can be safely resected, patients do better and have better survival if you can resect the entire tumor. That's a little bit of a false statement, in that you can never resect the whole tumor, it's never cured by surgery. But if you take out all the visible tumor, survival is better. In this situation with the location of this lesion on the MRI, surgical resection was never – complete surgical resection was never a goal or a consideration at all.

Q And we've seen, I think, reference, and we've had some testimony about the location of it in the brain being in the eloquent center of the brain, so you couldn't remove the

whole tumor without doing too much damage, is that –

A Yes.

Q – roughly the – and when you say you can – even when you can remove the tumor, you don't get rid of it, is that because there's tumor cells that are left behind that you can't see and take out?

A Yes.

Q So even when you're getting what you think is all of the visible tumor, the belief is that that patient still has cancer.

A Yes.

Q Doctor, you made the reference to, when I used the term diagnosis, you said, well, it's really – you can't make a diagnosis until you get tissue. Are there times when you go looking for cancer and you don't find it?

A Yes.

Q And if I've mis – if I phrased that wrong –

A Yeah, so –

Q – feel free to correct me.

A I would say, there are times when you are look – you have an abnormality, and you biopsy the abnormality, you may suspect that it was cancer and it turns out to not be, or vice versa. So generally, I think we're looking for what it is, rather than (inaudible) cancer.

Q Better put than the way I put it.

A But we're looking for a diagnosis. And there is also a list of non-diagnostic biopsies. So possibly you get tissue and you don't have a clear answer what something is.

Q So non-diagnostic meaning, we think it's something, we're going to go in the brain and get tissue, and the tissue doesn't tell us what it is. It's something, but we don't know what.

A That is a risk of biopsy.

Q Okay. And are you saying it's a risk that the tissue doesn't tell you what it is, or maybe they just don't even have anything, or it's hard to even determine what they have?

A Yeah, it's hard to determine - you get tissue, you give it to the pathologist, and they can't tell you what it is.

Q Okay. Doctor, let's turn to your note. We'll turn to the second page of it, Doctor. When we talked a little bit, Doctor, about this musculoskeletal and neurological exam, and there's a muscle strength testing, so you're actually moving the patient's arms and legs, and evaluating whether there's any deficits or not?

A Yes.

Q Can deficits be related to some type of process in the brain?

A Yes.

Q And I think you said earlier there was no abnormalities or no symptoms other than – well, maybe you didn't say that. What was the symptom that he presented with?

A Just headache.

Q Is that unusual to have just headache in a tumor?

A I think there usually – I guess more commonly there are other symptoms, but it's – often people just have headache.

Q Okay. So, Doctor, it sounds like Mr. Scott comes in, there's imaging that you can access through the computer, because it's in the IMC system, because Dr. Schloesser worked at the same facility and it's in the computer, comes in for an office visit, and you do a physical exam and evaluation, take a history and look at the films with him. And then I assume after looking at the films, sit down with him and convey to him what you think is going on?

A Yes.

Q Doctor, let me ask, would you have looked at the films before his visit, or do you look at them in the room with him?

A Both, but always before.

Q Okay. So, you look at them before and have a sense before he walks in the door about what you think is going on, and then you do your exam, and then talk to him about it?

A Yes.

Q The bottom of your note is your assessment and plan. Tell the jury what - what are you trying to convey in that portion of your note?

A I think the title is good, the assessment is the overall - what I think is going on, and the plan is what we're going to do next, or alternatives of what we might do next.

Q It looks like you describe what you see on the imaging, left-sided enhancing mass around the middle cerebral artery with surrounding vasogenic edema with some local mass effect. Those are the things you're seeing on the X-rays?

A Yes.

Q And then you say, I would recommend a left - you're going to pronounce that one for me.

A Pterional.

Q Pterional craniotomy for surgical exploration and biopsy for tissue diagnosis. Pterional, is that a type of craniotomy, or a location?

A It's a location.

Q Okay.

A It's right here.

Q The image we saw here, is that pterional?

A No.

Q Okay. Describe for the jury, you've been using

your own skull, where a pterional would be.

A Pterional craniotomy is a - the skin incision is made from the front of the ear behind the hairline, that skin is pulled down, and then the craniotomy is about the size of your ear, located right here.

Q Okay. And you recommended that. Were there any other recommendations for procedures to evaluate what's going on in his brain?

A Not procedures. I discussed the alternative of serial imaging, meaning, not doing surgery, and just getting another MRI, so that was not my first choice.

Q I think you said that, I did discuss what the probable radiographic diagnosis of glioblastoma and lymphoma - oh, now wait. There - I discuss alternatives of surgery, which would be following the lesion radiographically and symptomatically. I do not think this is the best course of action. Why is it you did not think that was the best course of action?

A With the differential diagnosis, particularly of glioblastoma, with an untreated survival of three months, I didn't think waiting three months to get another MRI would be the best way to treat him or care for him.

Q Now, you make reference in here of lymphoma. Is that - that's considered a tumor as well, correct?

A Yes.

Q And would you – if you thought it was – lymphoma was your top diagnosis, would you have also gotten a tissue biopsy?

A Yes.

Q And would you have recommended the same –

A Yes.

Q – pterional craniotomy?

A Yes.

Q Why is it that you didn't make reference to a needle biopsy?

A I think that would be a big mistake.

Q Why is that?

A I think the most important tissue to sample in Mr. Scott's case was the enhancing tissue that's around the middle cerebral artery. It's a very big artery that has to be handled carefully. When you put a needle in, you're doing it with image guidance, so you have a GPS system, but you're not seeing the actual tissue, you're just somewhat blindly putting a needle into the brain. And so, I think it's much safer to do it in an open way. My – can I say an analogy?

Q Sure.

A My analogy is if you wanted to take a knife out of a knife drawer, you would open the drawer all the way and pick out the knife. You wouldn't barely open the drawer and stick your hand in and feel around and pick the knife.

like your discussion here about what you recommended, and the alternatives. You also talk here about the probable radiographic diagnosis of glioblastoma and lymphoma, that either of these would likely require additional treatment in the form of radiation and/or chemotherapy. So are you basically saying, if it turns out to be this with tissue, this is how we'll probably have to treat it?

A Yes.

Q And the treatment for lymphoma and glioblastoma, there's going to be some treatment, but it will be somewhat different?

A Yes.

Q Is it –

A The treatments are very different. I mean, the (inaudible) lymphoma you'd use chemotherapy, it's a completely different chemotherapy than you'd use for glioblastoma. And glioblastoma would also get radiation.

Q Is that one of the reasons that you needed the tissue to sort of –

A Yes.

Q – obviously figure out what you had, and then also how to treat it?

A Yes.

Q Okay. And then there's a discussion here, Doctor, about risks and benefits of surgery. I suspect you've

already covered the benefits, which would be, you know, getting a diagnosis. It says, risks include, but are not limited to, death, coma, paralysis, infection, bleeding - is that - should there be a comma after bleeding?

A Should be a comma there. Yeah.

Q Bleeding, comma, spinal fluid leak, worsened neurologic injury, specifically to language function or right-sided motor function, and then medical complications, such as heart attack, deep vein thrombosis, or pulmonary embolism. Are these risks of the procedure that you, as a surgeon, know can happen regardless of how the surgery goes?

A Yes.

Q And how is it that you've learned or become aware that these are risks of this type of procedure?

A I guess by seeing all those things happen.

Q I think a lot of these we all know about, I assume - is the death and coma, is that anesthesia related, or could that be surgical related also?

A It could be both.

Q And that's just simply because you're operating in the brain?

A Yeah, you know, death is not generally a complication of the surgery, but there are other complications - you have a heart attack, it's a complication of surgery if it happens because of surgery, but it's not

from the brain operation (inaudible)

Q Fair enough. Fair enough.

A - directly.

Q And then paralysis, is that something that you're thinking about depending on - because of the location in the brain you're operating?

A Yes.

Q Infection I think is the obvious one. Bleeding, simply because you're doing surgery and there's a risk of bleeding. When you're saying bleeding, what are you talking about there?

A I think there are two risks of bleeding. There's a risk of bleeding in surgery, everyone bleeds during surgery. That's usually easily controlled. There's also a risk of bleeding after surgery. So before we - when operate on someone, make sure that all the bleeding has stopped and then close things up. And occasionally people will bleed after surgery. And that is a risk - that can cause additional injury to the brain, and so that is a risk.

Q What kind of additional injuries are you referring to?

A Well, if there's bleeding in tissue, and the tissue's disrupted, that can cause a deficit specific to that tissue, meaning, bleed in the motor strip, you get weak or paralyzed. If you bleed in the language area, you can't talk

or understand. If you bleed in a visual area, you're blind. That doesn't always happen, sometimes people bleed and they look sick, and you get a scan and see the bleed, and you take them back to surgery and take out the blood, and they do fine, so it's not a certainty, but that's a risk. Doesn't happen much, but it happens sometimes.

Q Okay. And then spinal fluid leak, I think, worsened neurological injury specifically to language, function, or right-sided motor function. Why is that specific - why is that one in there specifically?

A I listed those because of the location. The left frontal and temporal areas are involved in the language function, and so with the lesion in those areas, and the approach through those areas, they are at risk. I listed the right-sided motor function, specifically because of the location around the vessel. The middle cerebral artery supplies the - much of the motor function to the - sorry. Much of the blood supply to the motor area of the right - of the left side of the brain, which controls the right side of the body.

Q Okay. And then sort of mentions some of the obvious risks of any surgery. It looks like Mr. Scott said he wanted to talk about it with his wife and would call to schedule surgery. And we already referenced the conversation with Ms. Scott, I believe. Do you recall whether it was Mr.

last question actually in your deposition, do you see that?

A Yeah.

Q And maybe I misunderstood what you said. The question was "Have you had an occasion to diagnose or review what's been diagnosed as encephalitis in an adult patient?

"Answer: I was going to say in kids. I have not in an adult. I don't recall one in an adult."

Did I read that right, sir?

A Yeah, this is as we were walking out the door. Was the last question. I think the - let me look at the above here. I think my experience with encephalitis and infection, and why I didn't consider them high on the differential, is that when people have encephalitis, they look incredibly sick. They - they're terribly obtunded, they don't wake up, and a brain infection, which we see rarely, fortunately, at the time people look very, very sick.

Q Okay, but that wasn't my question, and I'm sorry. I mean, I just - I think what you were asked -

A Uh-huh (affirmative). Go ahead.

Q - have you ever had an occasion to diagnose or review what's been diagnosed as encephalitis in an adult patient? And you tell me if I read this right. You were going to - you said, "I was going to say in kids. I have not in adults. I don't recall one in an adult." Did I read that right, sir?

that? With respect to the tumor board?

MR. ROONEY: Your Honor, we asked for this in discovery, and we looked for it. This is Dr. Jensen's memory. We gave them the tumor board records that have Mr. Scott's name on it. Dr. Jensen had a memory, he mentioned (inaudible).

THE COURT: Yeah, counsel, I'm not - I didn't ask for you -

Go ahead, Mr. Thronson.

MR. THRONSON: All right. We asked for all the records. We've asked specifically over a year ago for these tumor board records, actually at the time of the deposition. I was going to interject. By making this motion, I'm in no way stating that Mr. Rooney and Mr. Blackham have had anything - that there was anything that they did.

There's an important reality here. Any type of personal injury case, the most common case in which there's been some spoliation of records - and by that I mean records are altered or disappear, are medical malpractice cases. There's actually been a study in this - on this subject, and they - and the (inaudible) Corporation found that in 30 percent of all medical malpractice cases, there is evidence of spoliation. The records have been altered or disappear.

My personal experience is, that's about the right percentage in the cases I do. It's unfortunate, but it

happens. And it is clear, since the pre-op tumor board records were in file, is - and since Dr. Jensen testified specifically that he knows a post-op tumor board was held, that these records should be in existence. You will see when you look at the contested jury instructions, one of the instructions that we'll be contested, is the instruction that is in MUJI about spoliation of records, and what the jury can take away from that in terms of significance.

THE COURT: But the Court hasn't made any findings regarding spoliation, counsel.

MR. THRONSON: I know. I know, but Your Honor, you're - you'll - you will need to at some point when you consider the jury instructions.

Now, the - okay, that gets us -

THE COURT: Well, I don't know about that, counsel, because it seems to me that whenever spoliation comes up, it comes up during discovery, and that there's some proof regarding spoliation of evidence. And I know this because I've had this come up in my cases. Not in med mal, but in other cases and this is where it's come up. So, I mean, the question is, you know, just because there's a memory of it doesn't - if there's no documents, and you have no proof that there was something spoliated, then how can you prove it? I mean, you're trying to prove a negative by saying, well, because they testified to it, it doesn't exist.

Excerpts from February 26, 2015 Trial Transcript

IN THE THIRD DISTRICT COURT - SALT LAKE

SALT LAKE COUNTY, STATE OF UTAH

DAVID SCOTT, et al.,	:	Case No. 110917738
Plaintiffs,	:	Volume VIII of X
v	:	
UNIVERSITY OF UTAH HOSPITAL, et al.,	:	
Defendants.	:	With Keyword Index

JURY TRIAL FEBRUARY 17, 18, 19, 20, 23, 24, 25, **26**, 27 and MARCH 2, 2015

BEFORE

THE HONORABLE SU CHON

CAROLYN ERICKSON, CSR
CERTIFIED COURT TRANSCRIBER
1775 East Ellen Way
Sandy, Utah 84092
801-523-1186

APPEARANCES

For the Plaintiffs: CHARLES H. THRONSON
MICHAEL A. WOREL
Attorneys at Law

For the Defendants: TERENCE L. ROONEY
BRADLEY R. BLACKHAM
Attorneys at Law

* * *

INDEX

SALT LAKE CITY, UTAH - FEBRUARY 26, 2015

JUDGE SU CHON PRESIDING

(Transcriber's note: speaker identification may not be accurate with audio recordings.)

P R O C E E D I N G S

THE COURT: Counsel, I understand that you wanted to talk really briefly.

MR. ROONEY: We do, Your Honor.

THE COURT: And let me just put this on the record so it's there. We're here on the matter of the Scott versus University of Utah Hospital and Medical Center, case number 110917738.

What's the issue, counsel?

MR. ROONEY: Two things, Your Honor. One is just sort of just follow up to notify the Court, following up on what happened at the end of the day yesterday. Obviously it was after five, and we weren't able to get the answer, and we don't have it, but we are looking for it. But I did go back - so we're looking for the M and M records to provide to the Court, assuming there are any. That's being looked into as we speak.

Two things, Your Honor. One, I went back, given that this came up yesterday, and maybe tomorrow is the time to argue this if we're going to ask for an instruction on this. But just to make sure it's clear to the Court, there

were two separate requests for production of documents pertaining to tumor board materials. We responded to the first one, which was defendant's – excuse me, plaintiff's first request for a production of documents, which we produced the tumor board records, two pages that the Court's aware of from March 3rd, 2010, and those were produced, and then following Dr. Jensen's deposition several years ago, when he referenced his memory of discussing this after the fact, counsel requested any other tumor board records pertaining to anything that was discussed after the fact, and we've reviewed that with our clients and responded that there were no documents, and so respondent – pursuant to the rules, and our client's checked, and Mr. Scott's name did not show up on any subsequent tumor board records after that, Your Honor. So I'd just notify the Court of that, (inaudible) have those with me yesterday. We're actually going to be asking for an instruction to the jury that they be told there's absolutely no evidence of any destruction of records, because that's been implied or suggested to the record several times.

The second issue, Your Honor, which is more temporal, what's going to happen, Dr. Andrew Bollen is going to be our witness. Dr. Bollen is a pathologist. This doesn't pertain to what he's going to say, but when Dr. Chin was on the stand, Mr. Worel stood up and made a clear

indication in front of the jury that we had not provided slides to the other side, suggesting clearly that we were hiding something. And so I went back and confirmed what I said in open court, and have correspondence to counsel where we provided them with pathology slides on October 12 of 2012, and then they followed up later in January of 2013 saying, we can't find the slides. Our office checked, and that they – we found evidence they'd been picked up by plaintiff's counsel's office on October 12, 2012, they had paid us with a check that was cashed on November 9, 2012 for copies of the pathology slides, and then when counsel sent me the letter, I sent him an email saying, I think we gave these to you already, and we got an email back from his assistant saying, I took a look – another look in our files, and we do have the pathology slides. Please disregard Charlie's previous request.

Your Honor, there was clearly a suggestion made in front of the jury that we were somehow hiding these slides. Dr. Bollen is going to talk about – you know, he was obviously given re-cuts of the slides, that's how it works, it's like a copy in the medical record, (inaudible) made a copy (inaudible) thin slices (inaudible) standard practice. And so, I want the jury to be instructed this morning that there was no evidence that the University did not provide the slides to counsel. In fact, the evidence is that they did

provide the slides to counsel, and they should disregard any inference or suggestion otherwise.

THE COURT: All right.

MR. ROONEY: I can provide Your Honor with copies of these correspondence if the Court would like. I've made extra copies.

THE COURT: I don't think I need them at this time, counsel, but let's hear from the plaintiffs.

MR. WOREL: Well, what we were talk - what I was talking about was that he said there was re-cuts of the slides. I have not seen any re-cuts that he said that he had done. The slides themselves were re-cuts. He said that they had taken and sliced it again and looked at it. And that's what we were talking about.

MR. ROONEY: Your Honor, the way I remember it was, we were not given those, were we?

MR. WOREL: The re-cuts.

MR. ROONEY: Where are those slides?

MR. WOREL: No, the re-cuts.

MR. ROONEY: The suggestion was clearly made to the jury that somehow we were withholding that.

THE COURT: Well, my memory of this seems to be that it's ambiguous as to what they were referring to. So perhaps there should be an instruction indicating that the original copies were sent, that there is - that plaintiffs did not

receive the re-cuts. Would that be appropriate?

MR. ROONEY: Your Honor, if I could approach?

THE COURT: Go ahead.

MR. ROONEY: Just so the Court's aware, it's highly unusual for a pathology department to release the originals for obvious reasons, because they can't be reproduced, so the practice is to send the re-cuts. As indicated in this letter, "Pursuant to your request, please find enclosed five pathology slides, which are re-cuts from Mr. Scott's surgery of March 11, 2010." So to me, that seems to directly address the causation.

MR. WOREL: It doesn't direct what I was talking about. He said he had another set of re-cuts that they had done, that the doctor himself had had another set of re-cuts that were done. These are different slices. And I was talking about, I haven't seen the slice you did, is the thing. And that's what I was talking about, was the slices. I know they sent what they sent. But he said that, I had done another step. And I have never seen that other step. And that's what I was talking about.

THE COURT: Well, again, I think the testimony was ambiguous, counsel, as to what you were referring to.

MR. WOREL: It may have been.

THE COURT: And so, I think that it would be appropriate to have some sort of instruction indicating that-

MR. WOREL: I'm fine with your instruction, Your Honor. I'm fine with what you just suggested.

MR. ROONEY: Your Honor, just so it's clear. Originals don't get sent around, for obvious reasons. And its practice is to - the cuts they make of these are essentially the thickness of a piece of paper. And that's the only way people can look at them. That's when people do studies and research. They're not looking at the original slides. Otherwise, there'd be chain of custody issues. And if counsel wanted pictures of the re-cuts we sent to someone else to look at, Dr. Bollen got re-cuts, I assume it's going to come up again, we didn't see your re-cuts. Nobody's saying they're seeing anything different on these slides. So if there's some question about whether the re-cuts represent something different than mentioned in the request earlier, it was a clear implication that we were withholding something. That's exactly what it was. Just like with the tumor board records.

THE COURT: Well, we'll deal with that - okay, who has a phone on that's near a microphone or something? We -

MR. ?: Not me.

MR. ?: Not me, Your Honor.

CLERK: It did that without anything this morning, too.

THE COURT: Okay. Okay. Just making sure. Make

sure everybody, even witnesses, do not bring cell phones up to the witness stand, because we have that issue. We're not quite sure what it is, but we're trying to keep the record clean.

Counsel, well, what I would suggest is, I think there's some ambiguity - there's some ambiguity with respect to what they are referring to. What would be the best language to address that issue because I'm not sure that I have the best language. I was just going to say that there may have been - there may have been some misunderstanding regarding the questioning, and that - I'm not sure what to say, so that's why I'm just asking. Because obviously -

MR. ROONEY: Your Honor, (inaudible) -

THE COURT: - the original pathology slides cannot be given. Cannot be released.

MR. ROONEY: I'm fine with, original pathology slides do not leave custody of the pathology department. Plaintiff's counsel have been and were supplied with re-cuts of the slides in 2012.

MR. WOREL: And I don't think it goes far enough. The issue was the re-cuts that he did that I had not seen. So he's now trying to create an impression through an order that I had somehow done something improper, and I have not, Your Honor. And so if you want to say that the cuts stay in the thing, then I'm perfectly fine with that. But he's - by

the way he's offering this, it is like the Court is saying I did something inappropriate and I did not.

MR. ROONEY: I still think the jury was - it was the clear suggestion that we weren't providing something to them that we should have.

THE COURT: Well, then, I think what the proper thing is, is that the original pathology slides are never released once they're cut. However, the parties have been given diff - have been given re-cuts, and everybody's been given a separate re-cut to observe and I'll leave it at that.

MR. ROONEY: Thank you, Your Honor.

THE COURT: Because your re-cut's going to be different, counsel. It's not saying that you are hiding anything, and I don't think that that's what we're trying to intend.

MR. WOREL: I - whatever you want to do.

THE COURT: I mean, I'm just trying to figure out the best way to say it without -

MR. WOREL: I understand.

THE COURT: - you know, however, the specimens have been re-cut, and the various re-cuts have been sent to the experts and the other side. So that means - I don't think that implies that they're the same.

MR. ROONEY: I'm fine with that, Your Honor.

MR. WOREL: I think we're nitpicking on that, but

whatever you want to do.

THE COURT: I think, counsel, you're still entitled to ask about the re-cuts if you want. I'm not saying that I'm barring you from that. I'm just say - I'm going to say that, because of the way - you can't -

MR. WOREL: This could've been -

THE COURT: - because you can't duplicate it -

MR. WOREL: This could've been taken care of if he had chosen with the witness, and just said to the witness, instead of having the Court having to enter some kind of a thing. All he had to do is - clearly he could've said, I - we sent you those things. We keep them, don't we? Yes, we do. You know, he's waiting until the next day to then make an implication that I have done something in error, and getting the Court to get involved, when a very simple question to the witness would've taken care of that all the way.

THE COURT: But I recall him asking that question again. So -

MR. WOREL: But if he did, then there's no reason for the Court to get involved. It's been cleared up through his questioning.

MR. ROONEY: No, I think the issue that I was concerned about, not about re-cuts and what Dr. Chin saw, was the suggestion by counsel that we weren't providing something

that they asked for, or we should've provided. And I think that was clearly (inaudible).

MR. WOREL: No.

THE COURT: Well, I think that there could be a reasonable perception that that might be the implication. We're just going to advise the jury that the original slides are never released, once they've been examined, and that all - that the various experts and all the sides have received some version of re-cuts of those specimens.

MR. ROONEY: And just so we're clear, Your Honor, I've had cases where we've allowed their people to come to the institution if they wanted to look at originals, so we'll have access to look at them if they want to.

THE COURT: Well, I'm not -

MR. ROONEY: Not to confuse the jury with that, but I don't want to suggest to the Court that there isn't a circumstance where someone can't get their eyes on the original. For obvious reasons, the chain of custody (inaudible) evidence (inaudible).

THE COURT: Well, we're not going to add that into it-

MR. ROONEY: And I'm fine with that, Your Honor.

THE COURT: - we're just going to let them know that there may have been some confusion regarding - and just that - we're just going to let them know that the originals are

never released once they're examined, and they remain in the custody and control of the University Hospital, but the various experts and all the parties have received some version of re-cuts.

MR. ROONEY: Thank you, Your Honor.

THE COURT: Mr. Thronson?

MR. THRONSON: Terry, are you done with your -

MR. ROONEY: I am.

MR. THRONSON: Okay. Mr. Rooney and I had a chance to discuss this, I don't know if it was yesterday or the day before. Dr. Bollen is here, and he's a pathologist, and we had a motion in limine last year about Dr. Bollen's opinions. And he has a - just a one-and-a-half page opinion letter. The Court - my concern at the time was that Dr. Bollen in his opinion letter talks about - well, he says, neuroimaging for evaluation of a persistent headache has demonstrated a left frontotemporal mass concerning for malignant neoplasm. The report by Dr. Schloesser indicated the findings are suspicious for glioblastoma versus lymphoma. You ruled - we objected, you ruled in our favor that he is not to testify about what the neuroimaging said in this case.

THE COURT: Well, I said - I think the order says that he shall not offer independent interpretations of radiology studies. So I think he can certainly say what he read in the record, counsel, as part of his review. I don't

couldn't find any evidence of a herpes virus, correct?

A That's correct.

Q You did find evidence of a meningoencephalitis and inflammatory process, correct?

A Right.

Q But - and that could very well be some kind of a viral infectious process that you just were not able to identify; isn't that right?

A It could be. The reason I think it's unlikely is that, in addition to the slides, I've reviewed all of the ancillary testing that was done, which probably - which covered probably the most - the 10 most frequent viruses that we see, a number of other rare entities, but you're absolutely right that there are some very uncommon viruses, some viruses we don't even know how to test for. So I can't look at this and say, they've absolutely been excluded. But based on looking at the slides and all of the accompanying additional studies, which were very extensive, I don't see evidence, you know, for viral meningoencephalitis.

Q You know, you talk about the other studies. You know, there are viruses that show up with - in a patient, and the only symptom they have is headache. Isn't that right?

A That's right. I believe what you're referring to is what clinicians would refer to as an aseptic meningitis.

Q All right. But that can happen. You can have

probably triple that.

Q Okay. And a craniotomy is a standard way to access the brain, not just for a biopsy, but for other reason?

A Oh, yeah, for anything. Blood vessel problems, stroke, tumor, yeah.

Q Doctor, I want you to talk to the jury about – obviously we're here because of Mr. Scott coming in to see you as a new patient, as a second opinion, obviously, but a new patient to you. I want you to explain to the jury sort of the process involved – not with him specifically, but just in general, in evaluating a new patient who comes in to you.

A Okay.

Q And why don't we focus it on a new patient – well, let's make it somewhat specific, in that Mr. Scott came to you on a second opinion with what was already thought to be a tumor. So why don't you explain to the jury that process, and what you go through?

A Okay. Well, I mean, the brain tumor clinic would be the classic example, because everybody that comes there has some abnormality on their MRI, but they're not all tumors, but there's some abnormality on the MRI. And so, you know, the way medicine is done, and the way you're – we teach residents, and the way that I was taught is, you know, you walk into a room, and you look at the patient, and maybe their family that they're all there interacting together.

And, you know, you start to size them up the minute you walk in the room, and kind of figure out maybe what's going on.

Q Can I - I'm sorry, you said something, I meant to ask you, I apologize for interrupting. You said, if they come into the brain tumor clinic, they've already had something diagnosed?

A Well, they've had - they have an abnormal MRI.

Q Okay (inaudible).

A There's very few people that would be sent to that clinic without something funny on the MRI scan.

Q And what I'm getting at is, if I have headaches, I can't just go up and show up into the brain tumor clinic. There needs to be a referral from someone.

A No, there has to be a referral.

Q Okay. For a suspicion of a problem.

A Yes.

Q Okay.

A But none of these are - yeah, everybody's referred from their primary care physician or whoever happened to do the workup first.

Q Okay, I butted in. I'm sorry.

A No, that's -

Q You were talking about when you first walk into the room.

A So, you know, you kind of see how everybody's

doing, and then you start to ask questions. So, you know, most patients, if you give them a chance, they'll tell you what's wrong with them because the history really is very revealing. And, you know, if you see somebody who's struggling to talk, or that they obviously are weak on one side, it's giving you clues about what might be going on.

And I never look at the MRIs before I go in, because I feel like that - I'm going to get that - I don't want to be biased about the information the patient's going to give me. So I have a list, when I'm walking into the room, in my head, that's - this checklist. You know, is it inflammation? Is it infection? Is it multiple sclerosis? Is it - have they had a stroke? Have they had an - have they fallen and hit their head and have an old trauma? Do they have a tumor? And I've kind of got this in my head, but as I listen to their story, you know, you're kind of going through, and these things are marking off in your head, because you know that it doesn't fit the story.

So, you - after they've told you your story, and you kind of feel like you know what's going on, then you do a physical examination and you examine the patients to find out, you know, what kind of physical limitations there are, or what kind of - we call them deficits, but you know, things that are wrong with the wiring of the way we're put together.

And then when you've seen those two things, and

you've kind of got an idea in your head, then you look at the imaging. And I like to do that together with the patient. You know, we sit around a computer screen and we look at it, and then we go over that. And what they really want to know is, you know, what do I think that is? And that's where we have a discussion about what that image represents in light of what they've told me.

And then we have to have a discussion about, well, what are we going to do about it? And that's when we discuss options and kind of give the pros and cons of what those options are. And then, you know, somebody's going for a second opinion, I might at that point find out what the other physician said, and I might either agree or disagree or whatever, maybe help them with - help them understand what that other opinion meant, and then we, you know, if they've just come for a second opinion, sometimes people will just leave at that point, sometimes people will ask me to help them with that, and then I think that's pretty much the process.

Q So this process begins when you walk in the room and observe the patient. And then, this physical exam, is this - and we all go into our primary care docs, and they tap our knees and -

A Right.

Q - with the stethoscope - whoops - we don't have

that on usually - put the stethoscope on your heart, and do the depressor in the throat. Is that what a neurosurgeon does, or is your exam directed at trying to pick up some neurological process?

A No, it's directed - you know, I don't usually listen to somebody's heart, and those sorts of things, because people have been to their primary care physician for that. I'm usually really focused on the neurological exam. You know, do they have a pupil that's a little bigger, I'm going to look in their eyes, I'm going to do all those things that are sort of based - neurologically-based exam.

Q And as you do that exam, are you ruling in and ruling out things in that basket of things you have -

A Yes. Oh, yes. Definitely.

Q And is that your process that you employ, basically, and have employed during the course of your career?

A It is.

Q Doctor, obviously Mr. Scott came to see you in February of 2010. You had a clinic with - a clinic visit with him at that point in time. I think I've got the record there in front of you, Doctor. Let me put up for the jury the record - the jury's seen it multiple times during the course of the case, but I'll put it up so they can follow along with us.

Q I'm going to put up from the first page, Doctor, so the jury can follow along. And I want to talk – we'll talk generally about – talk generally about how you do your evaluation, Dr. Jensen.

And I believe, Your Honor, for the Court's reference, and counsel's, it's in the exhibit book, page 13, 14, and 15.

Dr. Jensen, I want to talk to you specifically about your first clinic visit with Mr. Scott. Let me ask you generally, based on your review of the record and your habit in practice, do you believe you followed the same routine with Mr. Scott that you've described to the jury?

A Yes.

Q And why do you feel that way?

A Well, you can see from my note, that's how I do it, but that's how I do it on every patient.

Q And when you saw Mr. Scott that day, did you enter the room in the same fashion you've described, with the broad differential in your head?

A Yes.

Q Okay. And review with the jury what about his presentation and your examination that allowed you to narrow down that differential into the one that you concluded on?

A Well, you know, as has been mentioned before, he really didn't have any deficits. So he didn't – he was

having some headache, but it was pretty mild. So I knew already that this wasn't stroke, there wasn't a recent history of any head trauma to make me think that. You know, I've never seen a patient that could walk into a clinic, have an encephalitis. The only time I've ever taken care of patients with encephalitis, they're in a hospital sick in a bed, and I get consulted in sort of dire circumstances, so that didn't really rise very high on my - on the list of things I had in my head. You know, he'd - he hadn't had multiple episodes of neurological deficits like you'd have with multiple sclerosis. So the story just didn't really fit with anything but with the tumor.

Q So you start with the history they gave you, which is basically at the top of that note, and then you go through the past medical history. What are you looking for in their past medical history? A history of cancer or something like that?

A Yeah, you know, if he'd had history of cancer, maybe I would think this was cancer from the lung that had spread to the brain or something like that, or, you know, does he have a history of some sort of autoimmune disease, or has he had some strokes? I mean, the past medical history is really important for, you know, helping make that determination.

Q And what about his history led you one way or

another, if anything?

A Well, I think most of his history discouraged things on - you know, helped me rule those things out. There was nothing there that really pointed at any specific thing.

Q Okay. And then, the next section down is review of systems. Generally describe what that is for the jury.

A Well, that's a - that's just a quick way of just making sure that people haven't had things that are unrelated to - you know, he's here for neurological consultation, but, you know, it'd be important to know if somebody was having fever or chills, or they had lost 25 pounds in the last couple of years, or - so, that review of systems is a way to look at things that maybe people wouldn't think of naturally as being part of what they're there to see you for that might give me a clue about what's going on.

Q Okay. And then the next page gets into your physical examination. Doctor, while we're here, this - the length of this note, about three pages, I think - yeah, about two-and-a-half pages. Is that consistent with your practice? More, less, where does that fit in?

A No, that would be a usual new patient consultation.

Q And you follow sort of a format?

A Yes.

Q Okay. And so let's talk about the physical examination. You went through a physical examination and did

specific evaluations of Mr. Scott's?

A Yes.

Q And anything about the physical examination that steered you one way or another towards what was going on?

A No, it was – neurologically everything was the way it was supposed to be.

Q And what does that suggest to you, if the neurological exam is normal, what are some of the obvious things that that would rule out?

A Well, like I say, encephalitis is one of those things that would not fit with that picture. You know, stroke, having a blood clot in the brain, all of those things wouldn't fit with that. It would have to be some process that's – that hasn't had a chance to cause a neurological deficit.

Q Okay, and part of that exam are cranial nerve exam, facial sensation, motor testing, deep tendon reflexes. What are those things designed to elicit or find out?

A Well, you're just really trying to look at all of the wiring of the brain, so you kind of start at the top, and it's just a matter of, you know, how do people think, speak, interact, understand? And then you look at the – the cranial nerves are, you know, how do things like – do the eyes move properly, can you see, can you hear, is your face symmetrical, is it – sensation normal? Those are the cranial

nerves. And there's a lot of clues that can be in the cranial nerves.

Q So if somebody's eye doesn't move up, or their smile doesn't move up, that could suggest some type of nerve problem in the head?

A That's right. And it can localize you where to really pinpoint your – especially when you're going to look at the MRI, it can pinpoint exactly where you should be looking carefully.

And then you examine the physical, you know, how strong is somebody, is it symmetrical, are they weak on one side, not as strong, and then you look at the reflexes, and I just had this conversation with the patient yesterday in clinic that – about the reflexes, and they wondered, you know, why we do that. And we're not really looking for a reflex, we're just looking for an abnormal reflex, where the brain's control of the reflexes in the spinal cord has been disinhibited by some sort of an interruption of the wiring. And that can give you a clue that maybe, you know, something in their spinal cord or the lower part of their brain stem.

And then you look at the sensory examination, are they numb or weak – or numb or have tingling, or loss of spatial sensation of where they're at, and then walking, and that pretty much – oh, and the cerebellum to see what their coordination is like.

Q So you review all of those things. Were any of them abnormal in your examination?

A No, they were not.

Q And does that physical examination allow you to rule – thin out that basket in your head about what's going on?

A It does.

Q Next item on here is radiographic studies. So, we're talking about the imaging that has been done of the brain, specifically the MRI, correct?

A Yes.

Q And I assume if a patient had a CT scan or something else, it would be under that same category.

A Yes.

Q And I – is it fair to say that, in trying to figure out an abnormality in the brain, almost every patient's eventually going to have an MRI if there's a suspicion about a brain abnormality?

A I mean, that's one of the oddities of this brain tumor clinic, is that everybody there pretty much has an MRI. It'd be hard to come into that unless they had a reason they couldn't do an MRI, and then maybe they'd have a CT scan done with contrast.

Q Meaning they had some metal or something that wouldn't react to the magnets?

A Yeah, or they have a pacemaker or –

Q Okay.

A – or something that precludes MRI.

Q So, a CAT scanner is an X-ray, uses – I'm not even–

A Radiation.

Q Yeah, I was close.

A Yeah.

Q Whereas, an MRI is using magnets and –

A Yes.

Q – pulse waves, and what have you.

A Right.

Q So, and if you've got metal in you, you can't go in an MRI.

A That's correct.

Q Okay, so let's talk about the radiographic studies. The jury has seen them, we've reviewed them a lot, so why don't we just talk about them? What were the findings or characteristics in the MRI studies that were most significant to you, trying to evaluate what was going on with Mr. Scott?

A Well, as I think – you know, had some radiologists here that have explained that there's these images, the FLAIR and the T2, are both ways of looking at extra water in the brain and abnormalities in the brain, and there were signal abnormalities in the temporal lobe, also involved a little bit of the frontal lobe, with – on the T2 and FLAIR signal.

And then there was some enhancement that was found in the temporal lobe as well. I think that's probably what got most of us the most concerned, is the transition from a more slow growing tumor to a more –

Q I'm getting better at picking this up, I think. This is what you're referring to here, Doctor?

A Yes. Yeah.

Q This white line that we've been hearing all about?

A Yeah, enhancement usually means that it's a higher grade tumor, meaning, you know, that it's grade three or grade four, and – matter of fact, I think that some of the others that had seen the patient or done the MRI thought maybe this was a grade four because of that enhancement. So it was a tumor that had sort of some mixed character – or there was a mass that had some mixed characteristics.

Q And we've heard a lot of testimony about what characteristics mean what, and what don't. Is – with gliomas, is there a typical pattern that shows up?

A Not necessarily. It can come in a lot of different varieties, and there's some that don't take up any dye, and they're still higher grade, and there's some that are lower grade that take up the dye, and, you know, throw us off and make us think that they're more aggressive.

Q Now, Ms. Scott recalled bringing actually the – not a disk, but the old-fashioned – old-fashioned, it's probably

not that long ago, but –

A Yeah.

Q – when they used to just throw up the films on a light board. Do you have a memory one way or another about that?

A I don't, but we loved that when people did that, because it used to be a lot easier, but now the computers are good, so...

Q I see. And you can throw them up on a light board rather than have to scroll through images and –

A Right.

Q – okay, I see what you're saying. So – and presumably there's still light boards – or there were light boards at least in 2010 –

A Still – yep, still have them. Every once in a while somebody has – anyway.

Q And so, what would have been your practice and routine with examining films with a patient such as Mr. and Ms. Scott?

A Well, we'd put them all up, and we'd all stand around and look at them.

Q And the things we've been looking at, obviously in a different size, they would – you would be pointing them out to them?

A Yes.

Q And based on this imaging, and based on the examination - so this - your notes kind of go in sequence. You take a history and then you do the physical exam and then you get to the X-rays.

A Yes.

Q Is this sort of thinning out that -

A Yes.

Q - basket in your mind as you go through each one of those things?

A Yes. That's how medicine should always - I mean, should be done in that manner. Like I say, most patients can tell you what's wrong with them, if you can get the story from them.

Q And so when you get to the radiology study point of this, what's your leading diagnosis about what you think's going on with Mr. Scott?

A I really thought this was a grade two, and possibly a grade three astrocytoma.

Q In fact, I think you, in your note, referenced it as a likely - most likely a grade three from my interpretation, I think that's on the assessment and plan. And so, getting to that point, thinking it's a grade three, or a grade two, do a lot of - is there a lot of difference between the two of those? I mean, radiographically, can you be - can one look like another and -

A Oh, yes. Many times that – you can't tell that ahead of time – and even a grade four, for that matter.

Q Okay. So in February of 2010, it looks like you – when you're looking at these, you're thinking it's most likely a grade three.

A That was – that's what I thought it was.

Q And then after you get that diagnosis, you've got your assessment and plan there. Before we go on, you make reference to the fact that it had been read at Intermountain Medical Center by Dr. – it says Schloessinger, I think it was Schloesser, and reference his thought it was glioblastoma versus lymphoma. You say it certainly could be a higher grade, but for the most part it does not enhance. When you said for the most part, you're meaning there was that one sort of piece of enhancement.

A Yes.

Q Are there times when there's a lot of enhancement in them?

A Yes.

Q Okay.

A Like the one that they showed the other day where that – there was a big thing with lots of enhancement, that can happen as well.

Q Okay. So you've got this picture, and you've got the exam, and you've got the family there, what's the next

step in sort of sitting down with them and explaining where you're going to go?

A We'll talk about options and what we should do next to sort this out.

Q By the time you got through this, why was it that you were believing this was most likely a grade three astrocytoma?

A Well, the story that they had told me, the fact that Mr. Scott was relatively healthy, I mean, was a healthy man without any signs or symptoms neurologically, and imaging study with this, you know, large abnormality in the temporal lobe, and with the enhancement, part of it made me think this was - I mean, the most likely thing was a glioma that was in transition, maybe going from a three to a four, or a two to a three because of the enhancement.

Q There's been a lot of discussion in this case about whether this should've been called an infection, or encephalitis, or an inflammation. There's been a variety of terms thrown out. Taking that as a group, why is it you didn't believe that it fit into that category?

A I'd just never seen anybody, nor have I since that time seen anybody that had an encephalitis that wasn't hospital bound or deathly ill. Somebody who could walk in under their own steam into the - you know, into my clinic, and be able to tell me his story, and have relatively few

symptoms.

Q Okay. Let's turn to the last page, Doctor. So, Doctor, this is the last page where you discuss the conversations you had with Mr. and Ms. Scott, and basically your review of - with them of what your recommendation was, and what you thought was the most likely and top priority; is that fair?

A Yes.

Q And you start at the top of talking about the time. It says you spent an hour with them, 45 minutes of which was spent in counseling. And so, is that within the normal time for a -

A Yes.

Q - initial consultation?

A Uh-huh (affirmative).

Q And I assume a lot of the counseling is explaining what you see, and what you might think it is, and -

A Right.

Q - reviewing the X-rays?

A Right.

Q Talk about that process. I mean, it's - I assume it's an extremely difficult process to sit down with the family and convey information that dire. Review that with the jury, what that scenario's like.

A Well, you know, I mean, it's a little bit different

Q Okay. Okay. I think you can go back, Doctor, and we'll talk about the rest of your note, and then we'll get up and have you describe the procedures. So in the second paragraph, it looks like you have your discussion about the three options. And there was a lot of testimony back and forth about the first one there, observation. So let's talk about that. Your note says, "I discussed in detail the three options of observation, which I discouraged." Let's talk about that, Doctor. You made this note on the very day you had that visit, correct?

A Yes.

Q Does it suggest and reflect to you that you had a conversation with the family about watching the tumor?

A Yes.

Q And your note says you discouraged it. I think you said earlier that's not what you would normally do, but let me ask you this -

A Yeah.

Q - did you think that was a good idea?

A No.

Q Why not?

A Well, this tumor had some enhancing areas, it was quite large, and I felt that we needed to know what was going on there before this turned into something much bigger.

Q What's the risk of watching and not doing anything?

A The tumor keeps growing, gets big.

Q And if it gets bigger –

A Maybe is – gives neurological deficits, causes a problem, causes seizures, causes things that can't be reversed, like, you know, speech loss and paralysis, those sorts of things.

Q We've heard reference to the term watching and waiting, and I think the implication was watching and waiting without getting any biopsy. Is that something you felt was within the standard of care to recommend in this case?

A I thought a discussion of that was worthwhile, but I didn't think it made sense for this particular patient. It makes sense for some patients, but not this particular patient.

Q Okay. And I assume that that applies to a lot of the evaluations you're doing, in that you have to assess the patient's particular problem and make a judgment about what makes sense and what doesn't.

A Yes.

Q It doesn't – the same thing doesn't fit for every patient.

A No.

Q And I think you've identified why you thought it wasn't a good choice in this case, and when someone comes to you in this clinic, is it your assumption or belief that

they're asking you for your opinion based on your training and experience?

A Yes.

Q And based on your training and experience, did you think that it was a good idea for them to watch and do nothing about the tumor –

A No.

Q – at that point in time? The next one you reference is, versus frameless stereotactic biopsy. Now, we saw some pictures earlier about a biopsy with a frame on it. Something like this.

A Uh-huh (affirmative).

Q That was described by Dr. Bloomfield, I believe. So this is a frame – the frame base?

A Yeah, frame base. Yeah, that's a –

Q Frame base.

A – Lexel frame.

Q Okay. And you were not recommending a frame – or you were not even discussing a frame base, were you?

A No, that's physically hard to do in the temporal lobe, and it also, with the modern technology, with the computer based biopsy systems that we have, you don't need all of that frame. I don't use that frame any more.

Q Okay. And he wasn't using this one, this is just a – you know, an example of one.

A An example, yes.

Q I can't remember which one Dr. Bloomfield had up, but it had a cage - I'm going to call it cage around it.

A Yeah.

Q And so your discussion here pertains to a frameless stereotactic biopsy.

A Yes.

Q And I'm going to have you sort of describe for the jury what you were talking about in a moment, but just give us the quick version of what you're referring to there.

A Well, you know, it - there's a computer system in the operating room that's like a GPS system, it allows you to precisely go from point A to point B. And when you do a frameless stereotactic biopsy, you drill a hole in the skull, you use that navigation system to plan how you're going to pass a needle down that hole and into whatever the target is you want to biopsy.

Q Why is it that - I think ultimately you said you didn't recommend that. And we'll get into the specifics of that. But why generally did you not recommend a frameless stereotactic biopsy?

A Well -

Q You actually say there, which I thought was probably not the best way to go about this given the potential sampling error.

A Yes. Well, whenever possible, whenever you can reach a lesion without doing it, that's generally my practice, and the practice of all the people I know that do tumors, because with the stereotactic biopsy it's a blind technique. I don't know where that needle's going, and I could cause a life threatening hemorrhage as I'm passing it down there, and not know that I've done that. But I think the bigger issue in this situation is that I don't know what the - that tumor's made up of. I've already got a picture here that shows part of it taking up dye, part of it not taking up dye, you know, what do I sample, and what will give the most accurate diagnosis of what this tumor is?

Also, you know, a lot of what we do is based on doing molecular biology studies of these tumors, and trying to figure out, you know, personalized treatment for the patient and to do that, you know, these needle biopsies make a piece of - get a piece of tissue that's about half the size of a rice grain. So the pathologists just really don't like these biopsies, because it's hard for them to make a diagnosis. I don't exactly know where it's been sampled, because I can't see where the end of that needle is, and the - and I don't know that if I'm sampling over here, that's the same as, you know, the front of the tumor or the other side of the tumor, and am I giving an accurate diagnosis to that patient about the tumor? So I try not to do stereotactic

an inch or so. But it lets you see those, and if you stir one of those up, and you can't see it, and you can't coagulate it, you get some bleeding, and you can cause a blood clot for a patient.

But I think the big thing that - you know, that's all for safety, but the thing that really is helpful is that I know exactly where that tissue came from, and I can take a piece that's a substantial piece to give to the pathologist, that they can do the kind of studies to make a diagnosis.

Q So when you say you're using a microscope, you're not wearing those loops that you see -

A Some people do that, but I like the microscope.

Q Okay. You're not wearing your -

A No, these are my readers. That's -

Q Okay.

A Yeah.

Q You've literally got your - is the thing attached to your head, or are you looking in it -

A No, it's a stand, it's a - matter of fact, on the video there was a - the microscope was there, I think, I can't remember, but it's a stand, and it's - two people can stand and look through the visual oculars and see what's going on down below.

Q Doctor, there's been a lot of discussion about differential diagnosis.

A Uh-huh (affirmative).

Q And that infection or inflammation should've been included. Why did you rule that out in this case?

A I just didn't feel like the clinical picture fit the diagnosis of anything but tumor.

Q Have you seen cases of herpes encephalitis or brain infections, other types of infections?

A Yes.

Q And what do they present like?

A Well, I usually get called when somebody's in the hospital, they're deathly ill, and they've asked - they're asking me to do a biopsy or be involved somehow in the care of that patient who's very sick.

Q Doctor, you - the rest of your note talks about the discussion about the risks of the procedure, the first of which - I think you say the major risk is of speech deficit, and I think you described that earlier. Is that because the area of the brain that you're working in?

A Well, yes and no. So, it - thankfully, if you stay within the first four centimeters of that temporal tip, you really don't run a lot of speech deficit risk. But an MCA stroke or a stroke of the brain can get the frontal lobe, which is - you know, is remote from that. So, here's the temporal lobe. But the frontal lobe is over here. That's where you get the kind of speech deficit that Mr. Scott has.

And so, you know, any injury while doing this surgery can lead to that kind of speech deficit. I wasn't necessarily thinking about the speech deficit - although, I guess that's included as well if we went too far back or we got into something there.

Q And then you talk about sort of the other risks of surgery, which presumably are always present. Hemorrhage, that's bleeding?

A Yes.

Q And infection, DVT, pulmonary embolism, urinary tract infection, and pneumonia. And then we've seen - and we'll look at it again later when we get to it, but there was also another discussion and form the day of surgery that reviewed additional risks of the procedure, including stroke.

A Yes.

Q Is that a known risk or complication when you're doing surgery in the brain?

A It is.

Q Is it a risk or complication of doing a needle biopsy as well?

A Oh, yes.

Q And then you say, the patient's questions were answered. I told them that I thought Dr. Maughan would be very capable of performing this surgery. He told me that Dr. Maughan's discussion was similar to the one we had today. So

you were basically conveying to them that, I think you'd be in good hands going back to Dr. Maughan?

A Yes.

Q You're welcome to come to me, but it's your choice.

A Yes.

Q And it sounds like you're conveying that they told you the discussions you had with them were very consistent with what Dr. Maughan had told him.

A Yes.

Q Let me ask you while we're here, Dr. Maughan testified yesterday, and his note and his testimony was that he was recommending an open craniotomy for tissue biopsy as well. And then we've had some other testimony from people saying you should have done a needle biopsy. Is this concept of an open craniotomy for tissue biopsy, is that a Utah thing?

A No. No. That's a - I think it's the default for anybody that does any neurosurgery. Any chance you could get to do something where you can see what you're doing, we take that opportunity. I mean anything that's done blind is - I mean, that's just a neurosurgical maxim, you want to see what you're doing while you're doing it. You don't want to be, you know, pulling something from somewhere you can't see, you don't want to be coagulating something you can't see. I mean, you want to be looking at it and dealing with the

problem directly.

Q And based on your training and experience, did you feel an open biopsy was a safer option than a tissue –

A Yes.

Q – than a needle biopsy?

A Yes. And a higher yield.

Q Higher yield meaning, more likely –

A Make the diagnosis.

Q – that you'd get an answer.

A Yes.

Q And then you talked about the long term prognosis, which were the – with a – an anaplastic astrocytoma, grade three, what's the long-term prognosis for that?

A Three to five years of survival.

Q With treatment.

A With treatment.

Q What's the prognosis without treatment?

A Much shorter than that, maybe a year.

Q And then with a grade four, what's the prognosis for a grade four, glioblastoma, without treatment?

A Year, year-and-a-half. Oh, without treatment?

Q Yeah, without it.

A Oh, without treatment, three months.

Q Okay. And then with treatment, it's about 12 to 18 months?

It's only as good as the MRI pictures that you have in it.

Q Okay. Very good. I want you – we'll flip that and describe for the jury this open procedure and how it happens.

A Okay.

Q That –

A The temporal lobe –

Q Correct.

A – procedure?

Q Yes.

A Okay. So, we knew that there was an abnormality, you know, in the temporal lobe, bigger than that, but temporal lobe, and so we used our navigation system to localize that and to make an incision in the skin over this area, and then remove a bone opening, remove some bone, this is kind of larger than scale, but it's – kind of shows schematically, something like that. So remove enough bone that you can see that temporal tip, and you can see the various lobes of the temporal lobe. It's a very –

Q So literally coming in through the side of the brain?

A Coming from the side. So it's coming in right here. And if you can imagine the incision is just – is like this. A line like this, and then this piece of bone is temporarily removed so that we can look in there and see – first the covering of the brain, and we open the cover into

the brain, and I think you saw that in the video, and then underneath that you can see the brain. And then you can use that navigation system and come in here and – first of all, you can find this tip, because it's – there's bone right here. So you can literally –

Q So, is that a boundary of sorts?

A It's a boundary. So you know that that's the end of the temporal lobe, and you can measure back from that to find this safe zone to work in. You can also use the computer to find that safe zone, and we're looking at it. So we have all those visual cues to know that –

Q I think your operative report describes measuring out 4.5 centimeters –

A Yeah.

Q – actually specifically, and then do you go inside that boundary, or outside, or –

A No, no, we don't want to go behind it. So when we draw that boundary, we know that – you know, that everything from here forward is in that safety zone, and everything behind that is fraught with getting language deficits or memory deficits.

Q Okay. And this sylvian fissure area, what's located in here?

A Well, unfortunately I've used my red marker, but that's where the middle cerebral artery is.

Q You can use orange, I guess.

A Yeah, orange. And the middle cerebral artery's actually clear up in here, but those branches that come out and split are kind of out in these –

Q Okay. So this was the procedure that you recommended for Mr. Scott to access the lesion in this brain to get tissue.

A It is.

Q Okay. Why don't you describe for the jury, either with this drawing or another one, if you need, how you accessed the tissue that ultimately was sent to pathology.

A Okay. Okay. So you can imagine now that we've opened this area up, it's exposed, we've measured it out, and so, you know, the computer's saying that this is abnormal stuff there, so we started with –

Q Do you need –

A I just need to pick another color, like purple or something, green. Our first biopsy piece was right here, and it was about the size of a grape, large grape – or a medium grape, you know, it's – the measurement's – I can't remember, like two centimeters by a centimeters, like an inch by a half an inch, I think is what we – I'd have to look at the exact thing.

Q I think you're about right. Yeah. I could give you the report, but I think you're in the area. Yeah.

A Okay. So we took that piece and that's the piece I walked over and looked at with Dr. Chin and –

Q We'll talk about that, but why don't you –

A Okay.

Q – draw the other pieces –

A Okay.

Q – that were taken out?

A So then when he was unable to make a diagnosis, I came back and I just took the same piece, kind of like that – it's actually a little bit farther forward, I haven't drawn this exactly to scale, but it was a piece about the same size, I think the measurements are exactly the same size.

Q Let me ask you something. The operative report says that there was two pieces taken at 10:19, and then a third piece at 10:35. Is that more reflective likely of when these pieces would've been taken, or, you know, what do you think is the best –

A You know –

Q – memory of that?

A – I'm not sure, because there's – you know, we put that in the computer kind of when the nurse gets it, so that doesn't necessarily mean that's when it comes off the field. So I don't know that for sure.

Q Okay, fair enough. Fair enough.

A I don't think I paid attention – I'm not sure what

that meant. But these were – these were sequential pieces.

Q Okay. Okay. And –

A Matter of fact, if you see Dr. Chin's note, this first piece, he actually cut it in half and used part of it to save just in case he needed it for later, and then he used part of that for his diagnosis.

Q And he describes that those two pieces are very similar terms, so –

A Yes.

Q – they were taken from roughly the same area.

A Yes, they were.

Q Okay. Okay. And then there was a third specimen that was sent –

A Yeah, so – so you know, when we're taking these out, you know, we're looking through the microscope, and we're removing those, and once they're out, then I took the second piece and I put it – gave it to the nurse, and I'm looking through the scope, and I'm just making sure there's no bleeding. There's little blood vessels we coagulate and make sure it's clean. And as I'm looking there, I notice that there's something that doesn't look the same as this piece. And that third piece, it's about the size of a pea, kind of came from that area.

Q And that's the one that you labeled suspected higher grade?

A Yeah, because it looked different to me. It looked different to me.

Q Can you see with the microscope sometimes the tissue looks different when it's got a problem?

A Yeah, although, you know, the trouble with these – the trouble with these brain tumors is, most of them look like the brain. They don't look like something completely different. I – you know, we see these (inaudible) books, and everything's purple and green and color coated, and unfortunately, you know, it's not that way. This all looks the same, and –

Q So it doesn't necessarily look like this either, I guess.

A No. No, I –

Q Right.

A – that – it's a little less defined than that is.

Q We're – orient us a little bit, here. So, are you on the outside, or do you have to go in –

A I'm outside going forward, so that first piece is kind of this area, second piece is this area, and the third is here towards the end of the temporal lobe.

Q Okay. Let's talk about the first piece that was taken to pathology.

A Okay. Can I take this pen –

Q This frozen – whatever you need.

A Okay.

Q That's this frozen section piece that we've had discussion about. Talk to the jury about how that process works.

A Okay. Well, you know, that's one that I physically walked up for him to see, and they - what the pathologists do, there's two ways they can - you know, to look at a - and Dr. Chin may have explained this, so stop me if I go - but they need to be able to pass light through the tissue to be able to examine it, so there's two ways to do that. One is to freeze it, and the other is to put it in wax. And when they freeze it, it's quick and dirty, but it puts some artifact in there. So we do the frozen section as like a quick way in the operating room to make a diagnosis, just to make sure you're roughly in the right place. The rest of it gets submitted as a permanent - they call it permanent section, and that's in wax. And that doesn't come out for many days later. I think in this case, it was three or four - two or three days, or four days later. The piece that we - that I walked up to Dr. Chin, he froze half of it. The other half, he submitted for permanent section. And that's the piece that we sliced real thin, he puts it on a glass slide, and we look at it under a - another mic - a different kind of microscope, not the operating room microscope, but a pathologist microscope. And we're - he and I are sitting

across from each other, we're both looking through and looking at the tissue, and we're looking at how - you know, it's basically - I don't know if he showed pictures, but it's-

Q No, we didn't see pictures, I don't -

A - blue and red and -

Q - I think it would all look the same to us.

A I mean, you have to be a pathologist - well, and even to a neurosurgeon, quite frankly, unless it's something that's pretty obvious, but, you know, I have - I know the story, so I like to go there and help him, but I need his expertise to make the diagnosis.

Q I think the way he's recorded the frozen section is, increased cellularity with gliosis.

A Yeah.

Q So when you get that back from the pathologist, walk the jury through your mind set. Why don't you stop - it's abnormal, so why don't you stop, close the patient up, and send that (inaudible) -

A Well, it's abnormal, but it's not a diagnosis. It means that we're on the edge of something. Matter of fact, the number one reason for increased cellularity and gliosis is to be on the edge of a glioma. That - so - I mean, that happens all the time. Dr. Chin and I - we're waiting for the people to cut the sections - we've had this conversation over

and over again, when he was here, and now our new neuropathologist, about how hard it is to make the diagnosis on these things unless it's just completely obvious. So, you know, he was not able to tell me, yes, you're in the tumor, or no, you're in the tumor, or what the lesion was. He just said, there's more cells than there should be, and that there's inflammation. Those are signs of being on the edge of it.

Q And what was your goal of the biopsy at that point in time?

A To make a diagnosis.

Q And do you believe that stopping at that point in time would've been a reasonable thing to do?

A No. I think at that point I - we'd taken all the risk, but had no benefits to show.

Q Okay. The pieces that you took - the size of these pieces, are they consistent with similar biopsies you've done in other cases?

A Yes. Yes. This would be my way of doing this operation.

Q Okay. So the way you describe this is very similar to how you've done it on other occasions.

A Yes.

Q Okay. So he gives you this description of what you've got, and you go back and get additional tissue -

A Yes.

Q - and then you send it to the lab, and they - it's processed for permanent section.

A Yes.

Q And then, do you close he patient up at that point in time?

A Yes.

Q Let me ask you -

A Make sure there's no bleeding, look around, get - you know, hemostasis means no bleeding, so we make sure that that's all good, and we lay down some little materials that help so there's not bleeding later, and just make sure that it's a clean field.

Q Little materials. You mean, inside the wound somewhere -

A Yeah.

Q - like a kind of -

A Yeah.

Q - mesh, or something like that?

A Well, it's absorbable stuff that helps with controlling bleeding in case, while a patient's waking up from anesthesia, they cough or they strain, so that they don't stir up bleeding.

Q If you had hit a vessel, a large size vessel during the procedure, particularly the middle cerebral artery,

what's going to happen?

A Well, there'd be a lot of bleeding. Because it's magnified. So you know when you get into a vessel there's no - you know, especially something that's - the middle cerebral artery's - you know, it's the size of a straw. I mean, it's a pretty big vessel, whereas, you know, some of the vessels you were looking at on that video are, you know, the size of a couple of hairs. So -

Q Okay. The operative report references a blood loss I think of 215, what's the measurement you guys use?

A cc.

Q cc.

A Cubic centimeters.

Q Somewhere in that neighborhood. Is that within a normal -

A Yeah.

Q - amount of blood loss? If you hit the middle cerebral artery, how much blood do you use?

A Well, it could be a lot. I mean, you could lose a liter of blood.

Q Was there any indication -

A Which is a thousand - sorry.

Q Yeah.

A - it's - again, I -

Q You guys live in a different world than I -

A That's a thousand cc, where the other are 250, so it'd be like four times that much.

Q Okay. Was there any indication from the operative report or the anesthesia record that you hit any vessel that caused –

A No.

Q – bleeding to any significant point?

A No.

Q All right, there's always bleeding during a surgery, obviously.

A Yes.

Q And you're seeing it, and you're stopping it with your little –

A Right.

Q – cautery devices?

A Right.

Q Bipolar?

A Bipolar. Yeah.

Q Is it electricity that –

A Yeah, it puts a little current between two little pinchers, they're like little tweezers, and you can put them on the vessels and let a little current go through, and that coagulates them.

Q Okay. So, Doctor, the surgery that you've described, is that the surgery you performed on Mr. Scott?

A Yes.

Q Okay, and you believe you performed that in the same manner that you were trained to do it?

A Yes.

Q And the same manner you train your residents and fellows?

A Yes.

Q And in the same manner that you are still doing it?

A Yes.

Q Okay. Is this a procedure you still do?

A Yes.

Q Frequently?

A Very frequently.

Q I think that's all we need to draw, Doctor, I'll let you go back to the stand.

Doctor, there was some - we talked to the jury a little bit about this MRI that was ordered I think on February 26th and put into the computer to allow you to see what's going on during the surgery.

A Yes.

Q Or at least to map what's going on - I'm probably using the wrong words. There was some testimony, in fact, I think you were here for it, about comparing the original MRI from IMC on February 19th to the one on March 3rd -

A Right.

and you certainly wouldn't expect that they wouldn't have - have a speech deficit. So we knew that something was wrong and did a CT scan immediately.

Q There was some testimony from Ms. Scott that she, I think was called into a room, and you were there, and some other physicians were there, and they were recommending a procedure be done to try and open that artery.

A Yes. So, what we - when we got the CT scan, we could see that the distribution of that middle cerebral artery wasn't getting adequate blood flow. We did a perfusion MRI, which is another technique to look at that. And so, we were hopeful that maybe we'd be able to put some dye in the artery and see where there was some blockage, maybe get it opened up again. I believe it was Steve Stevens that was the radiologist that was with me when we discussed that with Ms. Scott.

Q And I think Ms. Scott said she'd turned to you because you were the only doctor she knew in the room and said, what do you think, and you said, I think it needs to be done.

A Yeah, it was my idea, so I - I was wholeheartedly behind it. I thought that was the right thing to do.

Q And this is one of the pictures the jury's seen something of. And maybe you can - I'm sorry, I don't mean to bounce you back and forth, but maybe you can sort of

reference what we've got with what this is showing and where the location of your surgery was.

A Okay. Well, so this is a cerebral angiogram where the patient's groin vessels are accessed and a small wire is put up through the vessels and up into the carotid artery, and this is the carotid artery on the left side, the major blood supply to the front part of the brain. And it comes up, and it splits into two branches. One's called the anterior cerebral artery, which feeds the middle part of the brain, and the other that feeds the middle cerebral artery out here and that feeds the outside and middle part of the brain. But what we could see here is that this blood vessel is not having - letting any dye out right at the point where it takes off of the carotid artery. To me, that was surprising, because, you know, our biopsy is out here. Should've been nowhere near this artery in any way. So we weren't sure why - what had happened to block that artery off at that point. Dr. Stevens put a catheter up there, but he wasn't able to get that to open back up, and he quite frankly was concerned about it, because it was a fresh post-op, he wasn't sure if maybe what he wouldn't do is start a big hemorrhage. So I think he was - we appreciate him trying to do it, but he wasn't able to do very much.

Q You mean, they'll try and stick a wire into the -

A Yeah, really thin little wire and open it.

Q - and open whatever's blocking it, and hopefully the blood can flow back out -

A Yeah.

Q - but it wasn't able to do it in this case, and -

A No.

Q - what you're saying, you're worried after a surgery, there's a concern about more bleeding?

A Yeah, because it's a fresh post - fresh craniotomy. We don't know - we've coagulated little blood vessels out in here, we're not sure about opening that back up and getting, you know, high flow blood out there.

Q Have you seen angiograms like this before in people that have had stroke?

A Oh, yeah.

Q Do they often look similar to what this one is, or is it a variety -

A Well, by definition, a lot of strokes are middle cerebral artery, and they can happen anywhere along that trunk, that's a common place to have a stroke.

Q Okay. And is one of the - is it one of the places of stroke that when you're explaining the risks and benefits to a patient, what you're referring to is they could have an MCA stroke? Or could it be anywhere in the brain?

A Anywhere in the brain.

Q Okay.

A Yeah.

Q Can – let me ask you this. Can you be operating in one area of the brain and a stroke occur on the other area of the brain?

A Yeah.

Q Why is that?

A Well, sometimes we don't know. I've had people develop, you know, operating the front of their brain and have one develop in the back, we don't know if it's a – like a blood flow during the case that their blood pressure drops, or blood flow, I mean – but a lot of times you never find out why that happens.

Q Okay. Doctor, let me ask you a couple – you can return to the stand now. I think I won't make you come back down. Couple of questions. There's some testimony about tumor board, and I think it's been explained to the jury that's a process where different physicians get together and talk about cases, both before and after, and there were some records of lists of people that showed up for a tumor before Mr. Scott's case.

A Yes.

Q Describe for the jury how that process works.

A Well, it's a formal meeting that we hold every Wednesday. Anybody in our tumor group can bring a patient there. It's attended by all the different specialties

A I don't know that to be true.

MR. ROONEY: Your Honor, (inaudible) misstates the evidence.

Q (BY MR. WOREL) Did you know that –

THE COURT: Mr. Worel, there is an objection.

MR. WOREL: Oh, I'm sorry.

THE COURT: Said that it misstates the evidence.

MR. WOREL: It doesn't. I mean, it absolutely doesn't. I'll just say hypothetically. We'll do that so I can move on and we can be finished.

Q (BY MR. WOREL) Because Dr. Sloan did criticize your care. We heard it yesterday, and I can show you where we wrote it. But anyway, have you heard that before coming here today?

A No.

Q Don't you think it would be valid for you to sit in this courtroom, since we are, and we're having to come every day, that you, since it's about you, and what you did, don't you think it's valid that you should be here to hear what these other doctors have to say about your care, so you might evaluate what they're going to – what they've said?

MR. ROONEY: Your Honor, can we approach?

THE COURT: Yes, you may.

Do not answer the question.

(Whereupon a sidebar was held as follows:

Excerpts from March 2, 2015 A.M. Trial Transcript

IN THE THIRD DISTRICT COURT - SALT LAKE

SALT LAKE COUNTY, STATE OF UTAH

DAVID SCOTT, et al.,	:	Case No. 110917738
Plaintiffs,	:	Volume X of X - Partial Transcript
v	:	
UNIVERSITY OF UTAH HOSPITAL, et al.,	:	
Defendants.	:	With Keyword Index

JURY TRIAL FEBRUARY 17, 18, 19, 20, 23, 24, 25, 26, 27 and MARCH **2**, 2015

BEFORE

THE HONORABLE SU CHON

CAROLYN ERICKSON, CSR
CERTIFIED COURT TRANSCRIBER
1775 East Ellen Way
Sandy, Utah 84092
801-523-1186

APPEARANCES

For the Plaintiffs: CHARLES H. THRONSON
MICHAEL A. WOREL
Attorneys at Law

For the Defendants: TERENCE L. ROONEY
BRADLEY R. BLACKHAM
Attorneys at Law

* * *

INDEX

A Yes, and this is – this is very, very important. So, let me first start with herpes simplex virus type two, and then we'll talk about herpes simplex virus type one.

So herpes virus type two is a sexually transmitted infection and it causes meningitis. So, it – when you get a herpes virus – first of all, for the jury, you have a number of herpes viruses that are asleep or latent in your brain. And those are – and we'll come back to this again, herpes simplex virus type one, Epstein-Barr virus, varicella zoster virus, human herpes virus six, there's other viruses as well, and you get them throughout your lifetime.

But herpes simplex virus type two you only get through sexual transmission and that causes a sexually transmitted disease with lesions, and you get meningitis. It's what we call self-limited. And when doctors use that term, that means that you get better without therapy. You get better with time.

Now, herpes simplex virus type one, we all have that as – we all have that one. So again, herpes simplex virus type two, we don't. That's sexually transmitted. Herpes simplex virus type one, we all have. Now, when did you get this? You got this when you were a little kid. And you either had no symptoms or you had these little lesions that formed on the back of your throat, and your mom took you to the pediatrician, and the pediatrician said, not to worry,

it's a virus, it'll get better. But what the pediatrician didn't tell your mom is that this virus is going to travel along a distribution of the trigeminal nerve, and it's going to establish latent infection. Now, what I mean by that is, it's going to become dormant in something called your trigeminal or Gasserian ganglion. So all of us in our fifth nerve ganglion, our trigeminal ganglion –

Q Can I ask you where that is? Where's the trigeminal nerve or this ganglion you're referring to?

A Okay. So it's right by the temporal lobe. It's right next to your temporal lobe. And you have one on both sides. And so it's going to – it goes there, the virus, and it becomes latent. And then for some, you know, for many different reasons, I see a lot of college kids when this reactivates because they're just stressed out by school and things, but anyway, when the virus reactivates or wakes up, it then moves from neuron to neuron and it infects the temporal lobe. When this virus infects the temporal lobe, you get a fever. That's the most common symptom. So you get an acute illness with fever and you get a headache. Now, when you have the fever and headache, that can go on – the headache will be on the one side, the virus will – when it woke up, or reactivated in the ganglion, and infected the temporal lobe, it'll be on that side of your brain, you'll have a headache and a fever. This can go on for a couple of

days to two weeks before you start having trouble finding words, you start having behavioral abnormalities, doing things that are very strange, and then eventually you'll have seizures. If this goes untreated, this infection, it continues to move from neuron to neuron in your brain, and takes over the machinery of the neuron. It actually is - it's really scary. It causes swelling and bleeding and that gets progressively worse, and if you are not treated with acyclovir, you will die.

Q Acyclovir - and what is acyclovir?

A Acyclovir is an antiviral agent that works really only for herpes viruses. So the other big category of herpes viruses that the jury is aware of is the zoster virus. The shingles virus. That virus, as you know, is sleeping in the sensory ganglia along your spinal cord. So when that wakes up, it causes shingles. So different herpes viruses like different parts of the central nervous system, they tend to be what we call - the term doctors use is neurotropic, meaning they want to be in a certain area. But this herpes simplex virus type one is in that ganglia right next to your temporal lobe. So that's why it gets the temporal lobe.

Q Doctor, how many patients have you seen during the course of your career with herpes simplex type one infection of the brain?

A Oh, I - probably a couple hundred.

Q Have you ever seen one with the clinical presentation over time that only included headache?

A No, and I want to emphasize this to the jury. So, one of the things that is really important is, how does a doctor make a diagnosis? So the first thing is how you present to the doctor. What are your symptoms when you come to the doctor? That's where the doctor first starts thinking about what's wrong with you. And then, if at that point – there's, of course, a broad number of things. But also as importantly is the clinical course. So there is the clinical presentation, and then the clinical course, how it evolves. So with herpes, you present with headache, fever, and then evolve to having word finding trouble, behavioral abnormalities, seizures, and eventually coma if you're not treated.

Q Doctor, when you suspect a herpes infection of the brain, what tests do you run, or how do you try to diagnose it?

A Okay. So when you suspect herpes simplex virus type one infection of the brain – this is what you think is causing your patient's trouble – the first thing you're going to order is an MRI. And it's very important you want to order a FLAIR – well, nowadays we just do this automatically, so I guess you don't have to order it, it – we automatically get a FLAIR and a diffusion-weighted imaging, because we know

Definitely.

Q Anything in this –

A You'll see it –

Q Go ahead.

A Go ahead – it comes down again, but it just is following the stress of the surgery. Yes.

Q Anything about these lab values done before surgery that would make – that would suggest any infectious process going on at that point in time?

A No.

Q Doctor, the next note I want to refer to, I think you refer to this in some of the testing, we can look at page 384, which is sort of a laundry list of all the things that were – some of the things that were tested for, I think there was actually even some others. And maybe if we can enlarge the column under 3/9/2010. So, Doctor, this is the cerebrospinal fluid tests that were done on March 9th, 2010, and then March 11th.

And I don't know, Cynthia, if you're able to scroll down as we go through.

Doctor, there's a laundry list of things on this that were checked for, some of which I'm not even going to try to pronounce, but it sort of starts with the appearance, and then it says asperjillus, or aspergillus, and it goes down into a bunch of different encephalitis' and different

items I can't pronounce. Can you maybe summarize for the jury what this represents and what the results were?

A Sure. So now, this now is a spinal tap that was done five days after the biopsy was done. And so, let's talk about the numbers that are abnormal. That might be the easiest way to go about this for the jury. So, what you want to do is look down on this, and you'll see that the appearance is hazy, and then you'll see two days later on the 11th that it was clear. We'll talk about that in a minute.

Then if you look down, look for where you see H for high. So, at the bottom, there's a - you know, something that tells you what the different symbols stand for. And H means the number of highs. So there's a couple of high numbers. So the total protein is 82, and normally in your spinal fluid your protein goes as high as about 45. But he'd had surgery, so that's not unexpected. There's 13 white blood cells, and as I said earlier, normally you have five white blood cells or less. But again, this is a post surgery spinal fluid analysis.

Q And so, let me give the -

A Those are the -

Q Let me give the jury a little -

A Those are the -

Q I'm sorry, Doctor. I didn't mean to interrupt. I apologize. Go ahead.

A Okay. So those are the two tests that – right where you see here, on (inaudible) abnormal, then there's a number of other things that they sent here. And then if you look at 311, the white blood cells now have completely gone away, because again, this was just some inflammation post surgery in the spinal fluid that went away.

Q I'll start at the –

A (Inaudible) –

Q – I'll start at the top, Doctor. So, the fluid that was hazy is now clear, and then down at the bottom, the white blood cells that were 13 are now 1.

A Right. And the protein is simply – that number means there's been a breakdown in the blood brain barrier. So what that means for the jury is, any time there's any disruption to the blood – you have this really tremendous – you know, blood vessels don't let a lot of stuff get in your brain, but if you've had a surgical procedure, you're going to have a breakdown in that. And so he's had a breakdown in his blood brain barrier, so his protein's a little high, and that's all that that means.

Q Doctor, let me give the jury a little context. So, these tests were run – the first one was run on March 9th, 2010, and then two days later they ran it again. This is the test of the cerebrospinal fluid from a lumbar puncture; is that correct?

A That's correct. Yes.

Q And then, these were done I believe at the time that the final pathology report came back, then they began to work the patient up for an infectious process. Based on these two cerebrospinal fluid tests, do you see evidence that Mr. Scott had an infection in his brain?

A No.

Q Doctor, if these tests had been run before surgery, do you believe they would've shown an infection of the brain?

A No. They would not – he did not have infection of his brain. They would not have shown infection of his brain. No.

Q Why do you say that?

A Because he never had an infection in his brain. So there – the tests are normal now, on the 9th, and they would have been normal on the 3rd.

Q Doctor, I want to pull up another one of the labs. It's going to be page 419, which shows the PCR that we've been talking about.

A Okay.

Q And Cynthia's going to blow that up for the jury. Do you have that one in front of you, Doctor? It's Bate number 419?

A I sure do. Yeah, yeah.

Q Okay. And so, the top of that, it's got – there's

like three references, I believe, to PCR in this test. This is on March 9th of 2010. And at the very top, there's EBV by PCR not detected. What's EBV? Is that Epstein-Barr virus?

A That - for the jury, that's yet another herpes virus, yes. That's the Epstein-Barr virus. It is the mono virus. And believe it or not, that one also is latent or dormant, asleep, in your central nervous system. Now, that'll only cause trouble if you need like a bone marrow transplant or something, then that can cause trouble. But other than that, it's - it just goes there and stays there with all your other herpes viruses.

Q And that's the - that's the bug that causes mononucleosis? Mono?

A Yes.

Q Okay. And then in the middle here, we've got herpes simplex virus by PCR, not detected.

A Correct.

Q And that's the one we've talked about. And then, at the bottom we've got, varicella zoster by PCR, not detected. That again was the chickenpox shingles virus?

A Yes.

Q Based on this PCR test at this point in time, does that give you any further information about whether Mr. Scott had herpes infection of his brain?

A He did not have herpes simplex virus type one

infection of his brain. No.

Q I want to turn to page 421 now, Doctor, which is a very similar thing, but was done the next day – or excuse me, two days later. So this test was run on March 11 – March 11, 2010. So two days later, and I believe we've got sort of the same things. We've got herpes simplex by PCR not detected, varicella zoster not detected. Let me ask you, why is it this was run two days in a row? And I know they did two spinal taps, but why would they run the PCR test two days in a row? Or not – excuse me –two separate times within a couple of day period.

A We often do that nowadays. So we have what we call a routine CSF studies that we send on all our patients, so we send cell counts, we send glucose and protein, we send gram stain and culture, and we send PCR. So that we tend to just repeat these, you know, more than once. We're doing another spinal tap, we have more spinal fluid, we just want to make sure. We'll redo a test.

Q Based on the labs that we've looked at so far, and the tests that have been run on the spinal fluid, and the PCR tests, do you believe there's any evidence in these tests that Mr. Scott had an infection in his brain?

A No. He did not have an infection in his brain.

Q And do you believe if these tests had been run before he had his procedure on March 4th, the results

would've been essentially the same?

A That's exactly right, because he never had an infection in his brain. This was not a brain infection.

Q Doctor, I want to ask you about something that was brought up I think on Thursday before we broke for the weekend with the jury. And we'll turn back real quickly to page 384, which was that sort of laundry list of tests that were run that we looked at, I think - yeah, very good. If we can go to the second on HSV and highlight that.

A Okay.

MR. ROONEY: About the middle, Cynthia, right - this sort of section here.

THE WITNESS: Right.

MR. ROONEY: Great. Thanks, Cynthia.

Q (BY MR. ROONEY) So, there's number there that don't have a high or a low on them. Let's talk about the HSV1 number of 2.11, and then underneath it, 2.06. What is that checking for?

A Well, again, they're - what they're looking for is, this is an IgG. So we all have - if they do a blood tests, if today we took blood from everybody in the courtroom, we would find HSV IgG in just about everybody's blood. That I'm sure of. So here, there just - the IgG just actually goes into the - in and out of the spinal fluid as well. It just is able to cross over and go back and forth. So there,

they're just looking for, you know, they ran an HSV, they ran it for measles, mumps, all the viruses that you've had since childhood and those also have titers.

Q Okay.

A And that's expected. You remain seropositive, as we say, for life.

Q So if you've been exposed to any of those things, you'll have some number there.

A Yep.

Q So the 2.11 and the 2.06, all those HSV1 and HSV1 and 2 numbers, are those abnormal numbers, per se?

A No. If they were, the lab would have marked them. And as you see, they don't get marked. Therefore, they're not abnormal.

Q I want to turn to page 388, Doctor. It's one of these - a lot of these lab tests have sort of these reference intervals, and then they have some description underneath them?

A Yes.

Q And it seems like there's some for almost everything that was run here. There was a section - so we're at page 388, there's a section here that's got some reference intervals about what they mean.

Cynthia, can you get - yeah, perfect. Thank you.

We've got sort of negative, no level, equivocal,

and then we've got 1.1 IV or greater, positive IgG antibody to HSV detected, which may indicate a current or past HSV infection. Explain that to the jury and what that means.

A Sure, absolutely. So again, we're going back to when you were a child, and you got HSV type one. Remember what I told you? You either had no symptoms, or you had these little white lesions in the back of your throat, and this virus is now asleep or latent in the trigeminal ganglion next to your temporal lobe. So what this means is that, this is what we have. This is the reality of who we all are. We live with all these herpes viruses in our brain. And we – and they can reactivate, but this just simply means, as indicated by this lab sheet, that as a child, or a young adult, Mr. Scott had herpes simplex virus type one, and it is latent in his trigeminal ganglion.

Q Doctor, if you've got a number that's over one, how do you determine whether or not this was from this childhood issue that you were talking about versus a brain infection?

A Oh, absolutely. So if you want to know, is it a current infection, is it something that I need to worry about, what you have to do is what we call the serum – the CSF ratio. And you're looking for a number of less than 20 to one. So when I do a spinal tap in a patient, and I'm concerned they're beyond the window of the HSV PCR giving me the diagnosis, I grab both spinal fluid and blood at the same

time, and then the lab runs an antibody index for me. And the antibody index tells me if I have active infection and then it comes out that way on the lab sheet.

Q Is there any indication in any of the labs run on Mr. Scott that he had active infection?

A No.

Q Doctor, it looks like there was also – I don't need to put these up, but it looks like there was also tests run for hepatitis. Is that also something that you would check in this panel? I don't believe I have that in front of me, but I saw it in the –

A We check hepatitis for everything nowadays.

Q Okay. Okay. Doctor, I want to put up some of the progress notes that were written in this case, and see if we can apply your 30 years of training and practice in infectious disease of the brain to some of the records and we'll go through them real quickly.

But let's start with page 125, 0125, which is a progress note for March 13 of 2010. And I'll reference to the jury, it's written by a Dr. Elaine Skalabrin, who was a stroke neurologist that was following Mr. Scott after his procedure. This is March 13th. So this is after the two spinal fluid tests were run, and after the two PCRs were run, which were the 9th and the 11th. If we'll go to the middle of the page, Dr. Skalabrin has a description here where she

MR. ROONEY: (Inaudible) the note. That's fine.

THE COURT: Okay. All right. Then the objection will be sustained.

MR. WOREL: Yes, ma'am.

THE COURT: All right.

(End of sidebar)

THE COURT: The objection is sustained.

All right, Dr. Roos, we have you back on the line -

WITNESS: Okey-doke.

THE COURT: Mr. Rooney's going to ask you a different question.

Q (BY MR. ROONEY) Doctor, I'm going to go through this go through this note and ask you about some of the things in here. The first sentence is, Mr. Scott has had an extensive - I believe it says ID, meaning infectious disease evaluation for etiologies of right temporal lobe lesion. Would you - do you believe that Mr. Scott had an extensive infectious disease evaluation to determine what was - what that lesion represented?

A Oh, absolutely. I mean, everything from imaging to spinal fluid analysis times two, to brain biopsy. Yes.

Q And then I believe the next sentence says, there is no...

A Identifiable.

Q - identifiable diagnosis, but our feeling is that

he – that the most likely explanation is HSV1 encephalitis that was spontaneously resolving at the time of surgery. Let me ask you first, would – did you find any identifiable diagnosis for Mr. Scott's lesion based on the tests that were run?

A There is no infectious etiology identified for Mr. Scott's lesion, based on any of the tests that were run. None whatsoever.

Q Do you believe that the most likely explanation of his lesion was HSV1 encephalitis that was spontaneously resolving?

A HSV1 encephalitis does not spontaneously resolve. That does not happen. Again, I think the confusion is with HSV2 meningitis, which is self limited. But HSV encephalitis does not spontaneously resolve.

Q And then the resident – or the fellow goes on and says, this cannot be proven. Would you agree with that?

A Well, what can be proven is that this isn't HSV.

Q And then he has a note here – he says it's the best explanation, HSV PCR can turn negative within two weeks of encephalitis, and there's a reference to a 1995 journal. First of all, explain this HSV PCR and whether it can turn negative within two weeks of encephalitis.

A Right. So there's always been this discussion about, does – can the HSV PCR become negative? For different

Q Okay.

A I've never seen anything written by him at all in brain infections anywhere.

Q I didn't ask you that question, ma'am. So please stay with me. The reason why I bring that up with you is, there was some other notes in the record concerning the infectious disease party that they didn't read earlier this morning. And I'm sure you've looked at it. You said you've really looked extensively at everything, didn't you?

A Yes.

Q Okay. The fellow's note - I want to read in its full context, if I might. Because you guys stopped and started, and everything, I want to get the full context. And we've already heard, you think he's a rookie, and you don't have to say it again. But what you - what the staff note is, says, it's the infectious disease fellow brief note of 3/30/10. "Mr. Scott had an extensive ID evaluation for etiologies of the right temporal lesion. There is no definite diagnosis, but our feeling is that the most likely explanation is HSV1 encephalitis that was spontaneously resolving at the time of surgery. This can't be proven, but it's the best explanation we have. HSV PCR can turn negative within two weeks of encephalitis" - and they cite an article. "This very high serum IgG and indeterminate serum IgM are consistent with recent infection reactivation, as is the

Excerpts from March 2, 2015 P.M. Trial Transcript

IN THE THIRD JUDICIAL DISTRICT COURT

SALT LAKE COUNTY, STATE OF UTAH

-O-

DAVID SCOTT and DEBRA SCOTT, Plaintiffs, vs. UNIVERSITY OF UTAH HOSPITAL MEDICAL CENTER, Defendant.	No. 110917738 CLOSING ARGUMENTS, BENCH CONFERENCE, MOTION FOR MISTRIAL

* * *

Recorded Proceeding Excerpt Date: March 2, 2015

Recorded Proceeding Excerpt Times: 13:46 to 15:56

* * *

Transcribed by Letitia L. Meredith
-Registered Professional Reporter-
Certified Shorthand Reporter CA

I N D E X

clinically, he was essentially neurologically intact clinically and there's no evidence whatever this was in his brain had progressed, what would you have done in the circumstances?

"Probably given a similar options.

"All right.

"Another observation could be.

"So say you go another two months and it hasn't progressed. He's intact neurologically. You look at the films there's no change in the films. What will your option then be? Continue to observe?

"Could be."

That's what this is. If the conditions worsening, urgent. No change in condition, observation. Key factor, Dr. Sloan said, "Family, in order to meet the standard of care, this family needed to be told that that observation was available." It was valid, that he wouldn't be injured by it, and he could make a decision for his own life. That's what the standard of care is, and that's what's morally right. It just is.

You're going be deciding a case about Dave, and you're going to be deciding a case about Debra, but you're going to be deciding a bigger issue too, and that bigger issue you're going to be deciding is

do we as a population have the right to be informed of the medicine and our condition and do we have the right to have a say in what's done to our bodies?

And the standard of care is yes, we do. When answering that question for Dave and Debra, you're answering that question globally for all of us. For my family, you're answering that question.

Now, I have been trying to figure out why this institution is throwing their own doctors under the bus to try to convince you something's different, that the last person they brought is a doctor to say their own employees are incompetent.

I've not seen that before, and I've been sitting there going why is that happening? Because we do know there's no question I didn't write these records. They did. I wasn't in the radiology department, the neurosurgery department, the infectious disease department that came up with this conclusion. They did.

I didn't inject herpes infection into this. They did. I didn't say for sure it was an infection. He did. All I was doing is bringing you the records that we were supposed to be able to rely on, and when we look at the records that we're supposed to rely on, there's no definitive diagnosis but feeling the

the thing, it will talk to you about that. I'm going to tell you something right here. Debra has asked me to tell you she doesn't want it. She took her husband on for better for worse, for richer for poorer, until death do they part.

And she doesn't want to get paid for the fact that she's having to help her husband. She doesn't want it, and she's authorized me -- actually told me, not authorized me -- told me to tell you, "Take care of my husband. I don't need to be paid for it."

This thing here, care gratuitously rendered, that they said that's the cost of what she's given her husband. She doesn't want it. She gave it to her husband because she loves him. She doesn't want to be paid for it, but she does ask you "Take care of my husband."

It's going to take moral courage for you guys to come back with a verdict against the medical community. It is. Because that whole thing, we don't want to think about it. We don't want to think about that for my family, Charlie's family, for anybody's family.

Winston Churchill once said, "For anything truly significant to happen in life, two things have

to be present. One is there has to be an opportunity, and the second is that people" -- "an opportunity to do right, and the second is there has to be people with moral courage to do it, and then something significant can happen."

You have the chance and the opportunity, and I submit, the obligation, to do something significant for Dave and Debra. I feel like I'm nowhere near conveying what I really feel about them to you and what their life is. Hopefully, you've heard it and even though I don't say it right you have heard it, and you will do something significant to try to make some good come out of this tragedy.

Thanks, you-all.

MR. ROONEY: (Unintelligible).

THE COURT: All right. That's fine. Counsel, please approach, and if you'll have Ms. Ross take these thing down, that will be great.

MR. WOREL: Sherry, do you mind trying to get our stuff down, please.

(The following proceedings were held at the bench, out of the hearing of the jury.)

MR. ROONEY: Your Honor, I am doing this to preserve this. I can make a motion now or I can make it after (unintelligible). (Unintelligible) our

motion in limine that would say to the jury that the standard of care (unintelligible). (Unintelligible). This is directly what we talked about in our motion in limine (unintelligible). I am going to object (unintelligible) make a motion for mistrial. (Unintelligible).

THE COURT: Counsel, I did hear you say that "this is for the community" and things like that.

MR. WOREL: I didn't say (unintelligible) community. I said that it's a bigger issue than just one, but that is not in violation, Your Honor.

THE COURT: But I think it is.

MR. WOREL: If you decide that, you have to decide do we have the right to -- to be told. That's the issue (unintelligible) this case. I haven't gone past (unintelligible).

THE COURT: There's not an informed consent issue in this case.

MR. WOREL: It's standard of care. They spoke to the standard of care. (Unintelligible). If you don't remember, you go back (unintelligible). We took out the common law and informed consent, but he even stipulated that as to the standard of care, we have the right to speak to whether he's supposed to tell the people or not. That's absolutely part of

the stipulation we gave at the beginning.

MR. ROONEY: My concern goes to the motion in limine about all this reptile stuff. We had a ruling that's very specific on that, and counsel violated --

MR. WOREL: (Unintelligible).

MR. ROONEY: -- (unintelligible) what he said, and I can make a motion now. I need a record.

THE COURT: We're on the record. I'm going to deny your motion, Counsel. What I'm going to do is I (unintelligible) instruction of some sort just to remind the jury that they are not to think about the community, you know, doing this for the community but that they --

MR. ROONEY: My concern is that just violates (unintelligible).

THE COURT: (Unintelligible).

MR. ROONEY: My motion in limine was supposed to be curative (unintelligible).

MR. WOREL: Very careful not to violate it.

THE COURT: (Unintelligible) what I heard to go do that (unintelligible). I'm sorry I'm whispering. I said what I heard seemed to cross that line because I said we are not to talk about community standard or anything like that and you said "community issue" and it was said twice, and so I think --

Dr. Rouse.

Without going through every single one, you saw these up in front of you. None of these gave anyone an answer, none of them, and she explained sort of the complex way of sorting all this out. I would think, quite frankly, they would want to explain what was in his brain. Yet they didn't bring anyone who tried -- they didn't send it to anyone to even try to sort that out. We're the ones that tried to sort that out.

So you can criticize Dr. Rouse for having an opinion about it, but she's the only one that's really tried to look at this like a scientist and say "What was this" because nobody knows. Even the pathologist says, "Sometimes we get these descriptions on pathology and we can't figure out what they are."

And I think most importantly, you know, what Dr. Rouse said, "Here's the PCR test that we looked at." Those are on March 9th. These are on March 11, and here's the hepatitis panel that I couldn't find that also looked at HIV and hepatitis. They looked at everything from A to Z and not one of these tests says, "This is what he has."

So their claim all along has been, "Oh, you

should have ruled out infection." Well, they ruled out infection -- tried to rule out infection after all this happened with all the tests they had to do it. Yet they still don't have an answer for it. So what would have happened is they run all these tests, as Dr. Horowitz says, send him to a dentist and had his ears checked, is he would have ended up back in Dr. Jensen's office with a big lesion in his brain with no explanation for it which would have it made even more likely to think it was tumor.

He would have come back and he would have had this, and all these tests would have been negative, and they wouldn't give any explanation. You know, it's a bit of the elephant in the room, but I can't imagine it would have been a better result if Mr. Scott did have cancer. Clearly that wouldn't have been a good thing.

Unfortunately, in trying to figure out what this was in following the standard of care, going in and getting tissue and putting it under a microscope, Mr. Scott suffered one of those complications, and nobody wants that to happen. He's a very nice man, and they are very nice people, but as I indicated, these things don't discriminate. They don't just happen to people we don't like. They happen to nice

had to change your lives around, but we really appreciate -- both sides appreciate it and especially representing Mr. Scott.

I have to say that I am flabbergasted by what you've just heard from defense counsel. I may have written this down wrong, but I heard him say that perhaps it would have been better if Mr. Scott did have -- better result if Mr. Scott did have cancer. Honestly? That Mr. Scott would have been better off dead is what he's basically saying, because any kind of cancer that they identified him having would have been a grade-three astrocytoma which is one to three years or a grade-four glioblastoma which is three months to a year.

You know, they are saying, you know, "Honestly, jury, he would have been better off dead than being here today." Now, I've heard some interesting defense arguments, but that's a first for me that the Plaintiff really should have just died and --

MR. ROONEY: Your Honor, that's not what I said.

THE COURT: Counsel (unintelligible) objection. Approach, please.

(The following proceedings were held at the bench, out of the hearing of the jury:)

the first place there wouldn't have been any injury because what he had had gone away.

Now, this case as for my partner, Mike, has been a series of firsts. I've never been in a case before where the defendants chief neurosurgical witness was a pal of the 5,000 neurosurgeons around or 4,000 whatever the number is they pick him. And I've never been in a case where the chief neurosurgical -- or chief liability expert identifies on three separate occasions that Dr. Jensen has breached the standard of care. That's another first for me.

And so Dr. Jensen -- Dr. Sloan agrees with Dr. Horowitz. He agrees with Dr. Bloomfield. This is also the first case I've had where a physician whose care has been called into question has run so far from his own medical records and his own sworn deposition testimony.

And I will tell you something -- I was the one that took Dr. Jensen's deposition, and I remember coming back and talking to Mike, and I said, "This guy seems pretty honest. I mean he admitted he made a mistake. He admitted that the Scotts could have watched and waited. He admitted that could have waited for a month or two. He admitted that he

doesn't know why he would have said to them you can't wait."

I said, "You know, he's a pretty honest guy. And so, you know, you need to -- when they put him on the stand you need to -- you know, the jury will probably like him because he's been so honest."

I don't even recognize the person that took the stand that you heard when we put him on last Tuesday or Wednesday. That's 180 degrees from the individual I deposed. He couldn't answer a simple question like "What does 'needless' mean? Or "What does 'resolved' mean?"

He fought with Mr. Worel about "Well, you know, you can wait but really you can't really wait in a case like this," and Mike had get up and say, "You said right here in this case you can wait. You don't have to go in. It's not" -- "Well, I'm not sure" -- I mean it was painful to watch this, and frankly it was disappointing because I had taken his deposition and he had sworn to tell the truth.

Dr. Jensen said himself it would have been perfectly reasonable to wait and see what happens with this abnormality that everybody sees, and instead he raced to cut Mr. Scott's head open. You saw the video where they used a saw to cut his head

record where he says, "It appears to have resolved," so whatever it was was gone.

The other people he's hiding behind are -- after throwing essentially the entire staff at the University of Utah under the bus, he's now hiding behind Drs. Mahan and Schlosser. Dr. Schlosser spent ten minutes reading the film, never saw the patient, knows nothing about the patient and never talked to Dr. Jensen about it, never spoke to Dr. Jensen.

Dr. Mahan met with the patient, kind of a newer guy who does 5 percent of his work in brain tumors. He never talked to Dr. Jensen either about it. Dr. Jensen was supposed to be the guy on tumors, and he said, "I make my own decisions. I read my own films. I make my own decisions." They went to him for a second opinion. They did not go to him for rubber stamp.

And I will tell you I have never seen a case where if two previous physicians have made a mistake it lets the third physician off the hook. There's a saying two wrongs don't make a right, you know. These two previous physicians by everyone's testimony made a mistake about what this was, even Dr. Jensen admits that.

THE COURT: Ten minutes.

technology we have today.

One of Davis Scott's great joys was reading. He was a voracious reader, and he talked about reading the New York Times. Only the intensive therapy recommended -- you'll have this when you retire to deliberate -- only that kind of therapy is going to provide him the greatest ability that he will ever have to be able to read again and comprehend again.

It's this apraxia and aphasia type therapy. She's given him zero for that, and Helen Woodard said, as you may remember, "If you don't provide this therapy he'll regress," and that's what will happen.

The greatest development in the last million years in terms of human development I think is the ability of speech. They say that the eyes are the window to the soul, probably you've heard that. Well, speech is the ability to express that soul. And David has struggled, as you saw.

You saw the day in the life and him on the stand -- struggled to speak, and she has given him one intensive speech therapy thing, one time, for the rest of his 20.6 statistical life expectancy years, and that I think is outrageous.

The final thing is if there was an award

for spouse, caregiver, driver, confidante, supporter, advocate, Debra Scott would have won that award unanimously for the last five years.

Now, as Mike said, she said, "You know, when I married him I love him and I accept that," but it's not justice when somebody else causes this level of damage. That is not justice. That's not something that someone has to accept.

Who has to accept it -- just under the law and under the way we operate, who has to accept it is the person and institution that caused that damage. That's who has to accept it, and the fact is as David gets older, he's going have more care needs. As Debra gets older, as tough as she is -- she should have an "S" on her chest -- she's going to need more help.

And you are, as Mike said, uniquely qualified in the world. This jury right here is uniquely qualified in the world to provide that care. Nobody else. There's no one else in the world that can do this other than you.

So it has been our privilege to have represented the Scotts in this case over the last three years, and it is now your privilege and opportunity to provide them a full measure of

the evidence presented to you.

You may take the following things with you when you go to the jury room to deliberate on this case: All exhibits admitted into evidence; your notes, if any; your copy of the jury instructions; verdict form that will be given to you.

The first thing you should do in the jury room is select a foreperson. The foreperson's duties are to keep order and allow everyone a chance to speak, to represent the jury in any communication you make, to sign your verdict and bring it back to court.

And in deciding what your verdict should be, all jurors are equal. The foreperson has no more power than any other jury. Your duty is to decide this case and this case alone. You should not use this case's as a forum for correcting any perceived wrongs in other cases or in the broader society or as a means of expressing views about anything other than the right verdict in this case.

Your verdict should reflect the law that's been given to you in these instructions, apply to the facts you find supported by the evidence. Your decision should not be distorted by any outside factors and objectives.

their duty is was violated in this case, Your Honor.

There was reference to the jury's decision being for the entire (unintelligible). There was reference to it being for Mr. Worel's family, for Mr. Thronson's family, that they had a moral obligation, that this was -- they needed to have the moral courage to find against the medical community.

All these things are things that we've dealt with before trial, Your Honor, that they were specifically instructed not to do, and they did it in front of the jury, and so as much as I don't want to do this, Your Honor. I don't feel like I have any choice in representing my client zealously, but I need to move for a mistrial based on violation of the court's motion in limine.

We have case law in this state, both in civil and criminal context, that have overturned cases with the exact same thing that were done during closing, Your Honor. That's why we tried to address this beforehand. So I would regret this, Your Honor, but I have to move for mistrial.

THE COURT: Do you have the cases, Counsel?

MR. ROONEY: There were cases that we referred to in our briefing, Your Honor. There was two criminal cases. I can't remember the names off the

What I said is perfectly appropriate. Those cases that he just cited are not applicable to this closing argument at all. They just aren't. And so, you know, for him to say, "Did so," I completely disagree, and it was not so, and did not violate any order regardless of what he said.

THE COURT: Mr. Rooney, do you want to respond?

MR. ROONEY: Nothing further, Your Honor. Submit on that. I didn't know if we had a record we were (unintelligible).

THE COURT: You did. You had a record, and I offered a curative instruction. Counsel, you said that you did not want it. That was what was on the record, and, you know, the alternatives to a mistrial, I have to determine that no reasonable alternative exists, and I think that by offering a curative instruction of some sort should have helped that situation.

And I think also based on my instructions to them that they have -- that they are not to express views about anything other than the right verdict in this case; they are not to collectively perceive wrongs or something in broader society.

Hopefully, that instruction would have fixed that as well, so given that I see that there

was some alternatives, I don't think that it is appropriate to grant the mistrial at this time.

MR. ROONEY: Thank you, Your Honor.

THE COURT: Thank you.

(Recorded Proceeding Excerpt End Time: 15:56)

* * * *

R.J. Reynolds Tobacco Co. v. Gafney,
No. 4D13-4358, 2016 WL 1128480 (Fla. Dist. Ct. App. Mar. 23, 2016)

2016 WL 1128480
Only the Westlaw citation is currently available.
District Court of Appeal of Florida,
Fourth District.

R.J. REYNOLDS TOBACCO COMPANY,
as successor by merger to Lorillard
Tobacco Company, Appellant,
v.
Kathleen GAFNEY, as Personal Representative
of the Estate of Frank Eugene Gafney, Appellee.

No. 4D13–4358.
|
March 23, 2016.

Synopsis

Background: Personal representative of smoker's estate brought action against cigarette manufacturers. Following a jury trial, the Circuit Court of the 15th Judicial Circuit, Peter D. Blanc, J., entered judgment for plaintiff in the amount of $1,914,000.00. Manufacturers appealed.

Holdings: The District Court of Appeal, Klingensmith, J., held that:

[1] exhorting jury with a "call to action" to use its verdict to "speak loud and speak clear" via a compensatory damage award in favor of smoker's estate was improper due to the potential for the jury to punish cigarette manufacturers through the compensatory award;

[2] even when both compensatory and punitive damages claims are at issue, a plaintiff may not utilize "send a message" and conscience of the community arguments when discussing whether the plaintiff should be compensated, abrogating *Ocwen Financial Corp. v. Kidder*, 950 So.2d 480; and

[3] comments by smoker's estate's counsel during closing argument, that referenced "the defense in these cases," was clearly directed toward cigarette manufacturer's attorneys, and thus constituted an improper ad hominem attack on opposing counsel.

Reversed and remanded.

Appeal and cross-appeal from the Circuit Court for the Fifteenth Judicial Circuit, Palm Beach County; Peter D. Blanc, Judge; L.T. Case No. 502007CA020540XX.

Attorneys and Law Firms

Chad A. Peterson, W. Randall Bassett and William L. Durham II of King & Spalding LLP, Atlanta, GA; Jeffrey S. Bucholtz of King & Spalding LLP, Washington, D.C., for appellant/cross-appellee.

David J. Sales of David J. Sales, P.A., Jupiter; James W. Gustafson, Jr., and Darryl L. Lewis of Searcy Denney Scarola Barnhart & Shipley, P.A., Tallahassee, for appellee/cross-appellant.

Opinion

KLINGENSMITH, J.

***1** R.J. Reynolds Tobacco Company and Lorillard Tobacco Company ("appellants") [1] appeal from an adverse jury verdict in favor of Kathleen Gafney, as Personal Representative of the Estate of Frank Eugene Gafney ("appellee"). The jury found that the decedent's death was the result of diseases and medical conditions caused by addiction to cigarettes manufactured and distributed by appellants. We reverse due to improper comments made to the jury during appellee's counsel's closing argument. Specifically, statements requesting the jury to send a message through a compensatory damage award, and insinuating that appellants' attorneys were involved in a conspiracy to conceal the addictive nature of smoking. Because we reverse this case for a new trial, we decline to address the issues raised in appellee's cross-appeal.

During closing argument, different attorneys handled various aspects of the issues to be presented. On the issue of compensatory damages, one of appellee's attorneys began his remarks by stating:

> Now, for the next few minutes, I want to discuss with you what I humbly believe is probably the most important part of the case. And in your verdict —"verdict" means to speak the truth. *Your verdict must speak loud and it must speak clear.* And the truth your compensation verdict must speak is

> the amount of money it will take to compensate and equalize, balance the harm that has been done in this case.

Shortly thereafter, appellee's counsel continued with the same theme:

> Now, what I like to refer to this is, members of the Jury, it's your call to action. *When you see that compensation part of this verdict, it's your call to action.*
>
> And the question was asked by Mr. Gustafson, what are you going to do about it? What are you going to do about it? *This is your call to action.*
>
> ....
>
> Now, the truth your verdict must speak, it must make these cigarette companies meet its full responsibility also....
>
> ....
>
> And, members of the jury, for her to begin the healing process, they got to give full account. They got to give full account.

Although the defense's objection to these comments was overruled, another objection was later sustained when counsel followed up with this argument on the compensatory damage award:

> It's not $11 million, it's not $9 million. The right figure in this case for this loss is $10 million.
>
> And I say that very clearly and very humbly, understanding what your role is as jurors, but there has been enough devaluing of the full worth of human companionship and of human worth and all the agony caused and contributed to by all that these companies did, members of the Jury. There has been enough of that. *And I say to you enough is enough. And your verdict should speak loud and it should speak clear.*

Later in the closing argument, while discussing the verdict form and the question of whether the decedent was addicted to cigarettes containing nicotine, another of appellee's attorneys remarked:

> ***2** And this is an addiction case. It's not a choice case. The word “choice” isn't in those jury instructions and it may be—the word “choice” isn't in those jury instructions. The word “control” isn't in those jury instructions. What's in those jury instructions are things about what addiction does and doesn't do, and whether or not it makes a difference in the 20th Century, in the life of somebody like Frank Gafney.
>
> And, you know, it's important for other reasons, not just to understand an answer to that first question on the verdict form, but it's important also because it sets up, if you will, the real dispute of the case, and if you wanted to have a window when the defendants, through the Tobacco Institute, were speaking privately, secretly among themselves, high-ranking officials of the Tobacco Institute, *and want to know why the defense in these cases consistently tries to recast the jury instructions and the questions on the verdict form, you have information that helps you from one of their co-conspirators,* and that's the Tobacco Institute, and here it is.

Appellants' counsel immediately objected and moved for a mistrial, arguing that appellee's counsel was attempting to link the defense attorneys to a scheme to conceal the truth about the harmful effects of smoking, which amounted to an attack on appellants' conduct of their defense in the suit. The court reserved on the motion for mistrial, but indicated that whether intentional or not, counsel's remark sounded like an improper reference to the defendants' attorneys being involved in a conspiracy. In response, appellee's counsel tried to explain his remarks:

> I am seeking to draw a legitimate comparison between an admission of a co-conspirator as to what the issue is when someone is asked a question as to whether or not it's addiction or choice, and the arguments that were made here, I'm asking the jury to contrast evidence, matters in evidence with the positions taken by the parties. I will not suggest that [appellants' attorneys are] co-conspirator[s] or that they are actively seeking to perpetuate any fraud on the public. That's not part of my argument.

After the trial judge informed appellee's counsel that comment on the evidence was fair while comment on the attorneys was not, appellee's counsel continued with his closing argument by stating to the jury that he “want[ed] to make it completely clear that it is not the position of [appellant or her attorneys] that these lawyers are participants

in any conspiracy. There's no suggestion offered that way whatsoever."

At the conclusion of the case, the jury found that the decedent was addicted to cigarettes containing nicotine, which was a legal cause of his lung cancer and death, and that smoking cigarettes manufactured by appellants was a legal cause of decedent's lung cancer and death. The jury awarded $5.8 million in compensatory damages for appellee's loss of companionship and protection, and for her pain and suffering, apportioning 33% of the fault to appellant R .J. Reynolds, 33% of the fault to appellant Lorillard, and 34% of the fault to the decedent. The trial court denied all of appellants' post-verdict motions. This appeal followed.

I. "Send a Message" Arguments

***3** **[1]** **[2]** **[3]** "A trial court's denial of a motion for mistrial and a motion for new trial based on improper closing arguments are reviewed for abuse of discretion." *Whitney v. Milien*, 125 So.3d 817, 818 (Fla. 4th DCA 2013). "If the issue of an opponent's improper argument has been properly preserved by objection and motion for mistrial, the trial court should grant a new trial if the argument was 'so highly prejudicial and inflammatory that it denied the opposing party its right to a fair trial.' " *Engle v. Liggett Grp., Inc.*, 945 So.2d 1246, 1271 (Fla.2006) (quoting *Tanner v. Beck*, 907 So.2d 1190, 1196 (Fla. 3d DCA 2005)).

[4] "Send a message" arguments have been defined as those that ask a jury to "award money not based on the proof supporting the proper recoverable damages allowed in a wrongful death action, but to remedy wrongful, intentional, as opposed to negligent, conduct," and those that "suggest[ ] to the jury that a significant verdict will send a message to stop [such] experiences from happening and will make others less likely to act irresponsibly." *City of Orlando v. Pineiro*, 66 So.3d 1064, 1070–71 (Fla. 5th DCA 2011) (footnote omitted). The overwhelming weight of Florida jurisprudence informs us that "send a message" arguments are clearly inappropriate when utilized in a way that links the "sending of the message" to a compensatory damage award, and not to the entitlement to, or amount of, punitive damages.

In *Ocwen Financial Corp. v. Kidder*, 950 So.2d 480, 481 (Fla. 4th DCA 2007), this court found that an attorney presented a "send a message" argument when, "[d]uring closing argument, the plaintiffs[' attorney] suggested to the jury that it should send a message 'loud and clear from this courtroom that you are not going to permit these corporations to treat these people this way.' " However, the court concluded that the comment was not improper, because claims for both compensatory damages and punitive damages were submitted to the jury at the time the comments were made: "Ocwen's argument that this type of argument cannot be used in a punitive damage case ignores that '[p]unishment and deterrence are the policies underlying punitive damages.' " *Id.* at 482 (alteration in original) (quoting *W.R. Grace & Co.—Conn v. Waters*, 638 So.2d 502, 504 (Fla.1994)); *see also Westbrook v. Gen. Tire & Rubber Co.*, 754 F.2d 1233, 1238–39 (5th Cir.1985) (stating that "[o]ur condemnation of a 'community conscience' argument is not limited to the use of those specific words; it extends to all impassioned and prejudicial pleas intended to evoke a sense of community loyalty, duty and expectation"); *Maercks v. Birchansky*, 549 So.2d 199, 199 (Fla. 3d DCA 1989) (stating that in "suit for compensatory damages in which there was no claim for punitive damages" court would "not condone such arguments as were made in closing where counsel for plaintiff three times asked the jury as the 'conscience of the community' to 'send a message with its verdict' "); *Erie Ins. Co. v. Bushy*, 394 So.2d 228, 229 (Fla. 5th DCA 1981) (reversing because plaintiff's counsel's "send a message" argument during closing created the possibility that part of the damages awarded may have been punitive when "there was no basis for" punitive damages before the jury).

***4** **[5]** The purpose of punitive damages is to punish for outrageous conduct done in reckless disregard of another's rights to deter similar conduct. *See, e.g.*, *W.R. Grace & Co.—Conn.*, 638 So.2d at 504 ("Punishment and deterrence are the policies underlying punitive damages."). Compensatory damages, on the other hand, are intended only to make a plaintiff whole. *See, e.g.*, *Engle*, 945 So.2d at 1262 (noting that compensatory damages "are intended to redress the concrete loss that the plaintiff has suffered by reason of the defendant's wrongful conduct." (quoting *Cooper Indus., Inc. v. Leatherman Tool Grp., Inc.*, 532 U.S. 424, 432, 121 S.Ct. 1678, 149 L.Ed.2d 674 (2001))). Here, the proceedings were bifurcated so that the jury would first decide the issues of entitlement to and amount of compensatory damages, and entitlement to punitive damages. Next, if necessary, the jury would determine the amount of punitive damages. Because appellee's counsel's arguments related specifically to the compensatory award when describing the verdict as the jury's "call to action" and imploring it to "speak loud and speak clear," this was an obvious and direct plea to include a punitive element in the jury's compensatory damages award.

Appellee's counsel's comments are similar to those that were at issue in *Kloster Cruise Ltd. v. Grubbs*, 762 So.2d 552, 554 (Fla. 3d DCA 2000), where, during closing argument, the plaintiff's counsel argued that a cruise ship was unsafe and that "the jury should 'tell [the defendant] by your verdict in this case to do something about this.... Tell them by the verdict that it is significant.' " Even though counsel did not specifically use the phrase "send a message," the Third District nonetheless categorized the statements as "send a message" arguments, and held that the trial court's denial of a motion for mistrial was error because the comments were "clearly improper." *Id.* at 555.

[6] Exhorting a jury with a "call to action" to use its verdict to "speak loud and speak clear" via a compensatory damage award, as was done repeatedly here, is improper. In *Ocwen*, we held that such arguments are permissible where claims for both compensatory and punitive damages are before the jury. *See* 950 So.2d at 482. However, today we clarify that even when both claims are at issue, a plaintiff may not utilize "send a message" and conscience of the community arguments when discussing whether the plaintiff should be compensated, due to the potential for the jury to punish through the compensatory award. Appellee's counsel's comments in this case served only to divert the jurors' attention from the proper consideration.

II. Attacks on Opposing Counsel

[7] **[8]** Comments by counsel must be directed to the strength of the evidence, and not amount to an *ad hominem* attack on opposing counsel for being part of a purported scheme to mislead. *See United States v. Sanchez*, 176 F.3d 1214, 1224–25 (9th Cir.1999) (finding misconduct and holding that prosecutor's comments were a denigration of the defense where prosecutor stated "the defense in this case read the records and then told a story to match the records. And, ladies and gentlemen, I'm going to ask you not to credit that scam that has been perpetrated on you here"); *see also Coleman v. State*, 126 So.3d 1199, 1203 (Fla. 4th DCA 2012) (Ciklin, J., concurring) (stating that "*ad hominem* attacks on one's opposing counsel are anathema to the profession of lawyering").

***5** Appellee's counsel's reference to "the defense in these cases" was clearly directed toward appellants' attorneys. He could not have been merely referring to either of the litigants, particularly when describing the "recasting" of jury instructions and verdict forms in other litigation—extraneous matters not in evidence during the trial. Further compounding this *ad hominem* attack, appellee's counsel expressly linked appellants' attorneys to alleged wrongdoing by identifying the Tobacco Institute as "one of their co-conspirators."

There is no question that appellee's counsel went outside the broad parameters of permissible closing argument when he turned his commentary on opposing counsel. These statements were totally irrelevant to the issue of appellants' liability. The insinuation that appellants' attorneys were engaged in a conspiracy with either the defendants or third parties to mislead, conceal, or manipulate as part of an on-going scheme did not merely push the envelope, but instead went wholly beyond the pale.

Consistent with our standards for proper argument, we distinguish reasoned analysis of the evidence and the credibility of testimony, which is appropriate, and disparagement through attacks on a party or opposing counsel's character or morals. Such tactics are decidedly improper and can cause prejudicial misdirection of the jurors' attention when those character traits are not in issue. *See, e.g.*, *Hosang v. State*, 984 So.2d 671, 672 (Fla. 4th DCA 2008) ("[A]ttorneys must 'confine their argument to the facts and evidence presented to the jury and all logical deductions from the facts and evidence.' " (quoting *Knoizen v. Bruegger*, 713 So.2d 1071, 1072 (Fla. 5th DCA 1998))). In emphasizing this distinction in trial strategy, we endorse the former approach, and decry the latter.

The comments at issue regarding defense counsel did not involve evidence, or deductions and conclusions therefrom. Whether these comments are viewed as an unsubstantiated accusation, an unflattering characterization, or as a mere inadvertent or unintended flourish, they were neither reasonable nor permissible inferences to be drawn from the evidence adduced at trial. Comments accusing an opposing party's attorney of wanting the jury to evaluate the evidence unfairly, of trying to deceive the jury, of deliberately distorting the evidence, or of participating in a concerted scheme to do so, have no place in our legal system.

We have previously held that "[r]esorting to personal attacks on defense counsel is an improper trial tactic which can poison the mind of the jury." *Wicklow v. State*, 43 So.3d 85, 87–88 (Fla. 4th DCA 2010). Accusations of wrongdoing by opposing counsel, such as those made in this case, would likely be improper even if made solely to a judge. Here, the comments achieved no other purpose than to discredit appellants' attorneys in the eyes of the jury, planting in the

juror's minds the thought that the attorneys themselves were engaged in nefarious behind-the-scenes acts in "the defense of *these* [tobacco] *cases.*"

***6** After the court reserved on the motion for mistrial, appellants' counsel accurately explained to the court why the comments were so harmful:

> MR. BASSETT: The argument that Mr. Sales is articulating is an inference to the very violation that we have been seeking to prevent all along. I mean, what he's exactly arguing is, maybe not directly, that we, in this courtroom, have participated in [a] conspiracy, but that indirectly we are by presenting the defense we're presenting. So we're defending the case in a way that he's going to argue by inference is consistent with the conspiracy that's been ongoing for the last 40 years.
>
> THE COURT: I understand your concern and the record will speak for itself. Comment on the evidence is fair; comment on the attorneys is not. So let's go on.

Appellee's counsel tried to explain he was not suggesting that the defense attorneys were participants in any conspiracy. We are not persuaded that this attempt at clarification served to unring the bell; rather, it appears to us that these comments were reasonably likely to prejudice the jury and fatally impair the fairness of the proceedings. *See Henry v. Beacon Ambulance Serv., Inc.*, 424 So.2d 914, 915–16 (Fla. 4th DCA 1982) (holding that trial court's curative instruction that jury disregard inappropriate closing argument concerning a pre-suit settlement with another defendant was "insufficient to counteract the effect of appellees' improper argument"). We believe that the trial judge's interpretation of appellee's counsel's comment was correct when he noted at sidebar:

> I'm not sure exactly what I heard, but it sounds like you made reference to these attorneys seeking to modify the instructions and the questions on the verdict form, and then you talked about co-conspirators .... it sounds like, whether it was intentional or not, you were making reference to the attorneys being involved in a conspiracy. That, as you know, is prohibited.... I'm going to ask the court reporter to note your comments so that if we need to go back to them, we can. But I just got to tell you it jumped right out at me, and maybe I missed it and didn't hear it in proper context, but you may want to clarify. And I'm reserving on the motion.

Considering that this comment, in the words of the trial judge, "jumped right out at [him]," it is highly probable that it influenced the jury as well. A subsequent curative instruction by the court aimed at rectifying this error would in all likelihood have been insufficient to remedy the damage. Further, appellee's counsel's attempt to mitigate the consequences of his statements by explaining his intentions was also wholly ineffective.

As the Third District recently noted, the tactic of maligning opposing counsel during closing argument has unfortunately become a persistent problem:

> [C]omments on the credibility of counsel, such as those at issue in this case, are recurring in closing arguments at an alarming rate. We caution counsel ... to uphold their professional and ethical obligations and to be mindful of the line clearly established by the courts of this State. *See, e.g., Jackson v. State*, 421 So.2d 15 (Fla. 3d DCA 1982); *Del Rio v. State*, 732 So.2d 1100 (Fla. 3d DCA 1999).

***7** *Fagins v. State*, 116 So.3d 569, 569 (Fla. 3d DCA 2013).

[9] This court has previously held that comments "impugn[ing] the integrity or credibility of opposing counsel" in the context of a criminal trial were egregious enough to constitute fundamental error. *Wicklow*, 43 So.3d at 88. In order for an error to be considered harmless in civil cases, "the beneficiary of the error must prove that there is no reasonable possibility that the error complained of contributed to the verdict." *Special v. W. Boca Med. Ctr.*, 160 So.3d 1251, 1253 (Fla.2014). Because there is no reasonable possibility that the errors discussed above were harmless, we reverse the judgment and remand for new trial.

Reversed and Remanded.

CIKLIN, C.J., and CONNER, J., concur.

1 Post-trial, R.J. Reynolds was substituted in place of Lorillard when the two companies merged, and Lorillard ceased to exist as a result of the merger.

All Citations

--- So.3d ----, 2016 WL 1128480