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SC Court of Appeals

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM CHARLESTON COUNTY
Court of Common Pleas

Maite Murphy, Circuit Court Judge

Appellate Case No. 2023-000029
Circuit Court Case No. 2018-CP-10-02109

Rebecca Turisk,

Appellant,

v.

Dennis K. Schimpf, M.D. and
Sweetgrass Plastic Surgery, LLC,

Respondents.

FINAL BRIEF OF RESPONDENTS

Todd W. Smyth
Allie A. Maples
Smyth Whitley, LLC
126 Seven Farms Drive, Suite 260
Charleston, South Carolina 29492
Tel: (843) 606-5635
Fax: (843) 654-4095
tsmyth@smythwhitley.com
amaples@smythwhitley.com

Attorneys for Respondents

August 21, 2023

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COUNTER STATEMENT OF ISSUES ON APPEAL[1]

I. DID THE CIRCUIT COURT PROPERLY SUBMIT TO AND CHARGE THE JURY ON ASSUMPTION OF THE RISK WHERE (A) THE SUPREME COURT PREVIOUSLY HELD THAT IT WAS APPLICABLE TO MEDICAL MALPRACTICE CASES NEARLY IDENTICAL TO THIS ONE; AND (B) THERE WAS EVIDENCE THAT APPELLANT KNEW OF AND APPRECIATED THE KNOWN RISKS OF HER SURGICAL PROCEDURE AND THAT SHE NONETHELESS VOLUNTARILY EXPOSED HERSELF TO THEM BY CHOOSING TO UNDERGO THE ELECTIVE, COSMETIC PROCEDURE?

II. DID THE CIRCUIT COURT PROPERLY DENY APPELLANT'S POST TRIAL MOTIONS BECAUSE THE JURY'S VERDICT IN FAVOR OF RESPONDENTS WAS SUPPORTED BY THE GREATER WEIGHT OF THE EVIDENCE AND NOT INCONSISTENT?

STATEMENT OF THE CASE

This is a medical malpractice appeal arising from the unanimous defense verdict rendered at the conclusion of a four (4)-day jury trial held from November 14, 2022 to November 17, 2022. With this appeal, Appellant, who is simply dissatisfied with the jury's finding that she failed to meet her burden of proof with respect to proximate cause and their award of no damages, asks this Court to substitute its judgment for that of the jury by reversing South Carolina Supreme Court precedent on the application of informed consent to medical malpractice cases like this one and by generally relieving her of her burden to prove each and every element of her medical negligence cause of action. Appellant's arguments are without merit. As detailed further below, this Court should affirm the circuit court jury's verdict.

A. Factual Background

Respondent Dennis K. Schimpf ("Dr. Schimpf") is the owner of Respondent Sweetgrass Plastic Surgery, LLC (the "Practice") (collectively, "Respondents"). He is a board-certified plastic

[1] Respondents expressly do not consent to be bound by Appellant's Statement of the Issues, of the Case, and of the Standard of Review. Consequently, pursuant to Rule 208(b)(2), SCACR, Respondents submit their own Counter Statements and respectfully request that this Court adopt them.

surgeon with over fifteen (15) years of experience. (R. pp. 411-12). Appellant is a fifty-seven-year-old (57) woman with a significant medical history of chronic pain, adrenal fatigue, fibromyalgia, and multiple back surgeries. (R. pp. 253, 302-03, 316-17). Since 2012, she has been deemed disabled due to a back injury and the resulting treatment for it, including multiple fusion surgeries, a surgically implanted spinal cord stimulator, and chronic reliance on opioid pain prescriptions. (R. pp 302-03, 316).

On July 18, 2016, Appellant first presented to Respondents complaining of long-standing neck and upper back pain and that her breasts impeded her ability to perform physical activity. (R. p. 911). Accordingly, Dr. Schimpf assessed Appellant's medical history, discussed her surgical goals, and performed a physical examination, which Appellant acknowledges. (*Id.,* R. p. 303). Specifically, Dr. Schimpf examined Appellant's breasts, measured her nipple to clavicle length, and graded her ptosis (i.e., drooping), which revealed that Appellant's neck and back pain were directly related to her documented large, pendulous breasts. (R. p. 911). Consequently, Dr. Schimpf recommended that Appellant undergo a bilateral breast reduction, which included removing her prior breast implants, and discussed her surgical options with her. (*Id.,* R. p. 303). In doing so, Dr. Schimpf also *first* explained the risks associated with breast reduction to Appellant, to include wound healing, wound opening, draining, and infection, the need for revision surgery, and even death. (*Id.,* R pp. 303-04). As early as her first appointment, Appellant knew the risks described to her were real risks and she did not have any questions about them. (*Id.*). She confirmed that she was comfortable with proceeding with surgery knowing those risks were very real. (R. pp. 304, 911-12).

On October 27, 2016, Appellant returned to Respondents for a pre-operative appointment. (R. pp. 908-09). During this appointment, Respondents discussed the surgical risks with Appellant for

a second time as well as the alternatives to surgery. (*Id.*, R. p. 305). Their conversation was memorialized in writing and signed by Appellant. (*Id.*). More precisely, Respondents informed Appellant that the "**most likely material risks and complications**" associated with breast reduction included **asymmetry, bleeding, delayed healing, discoloration/swelling, discomfort, failure to improve symptoms, infection, skin, nipple and flag loss, wound separation, and unsatisfactory results**. (*Id.*). For a second time, Appellant represented to Respondents that she understood and accepted these risks and consented to the surgery. (*Id.*, R. p. 308). In fact, Appellant stated she was "over-the-moon excited to have the surgery despite **knowing that these were real risks**." (R. p. 310).

On November 1, 2016, Appellant presented to Respondents for her breast reduction surgery. (R. pp. 913-14)[2]. Prior to operating, Dr. Schimpf designed and physically pre-marked onto Appellate an inferior pedicle for use with the standard Wise pattern technique for this type of surgery, which consisted of creating a ten (10)-centimeter-wide inferior pedicle (i.e., wide segment of tissue under the nipple) to preserve blood flow to Appellant's nipple/areola complex. (*Id.*). Notably, it is undisputed that the inferior pedicle wise technique selected by Dr. Schimpf is considered the "gold-standard" technique for breast reduction. (R. pp. 354, 378-79, 407). Additionally, it is undisputed that Dr. Schimpf created a pedicle two (2) to four (4) centimeters wider than that required by the standard of care, which offered Appellant's nipple/areola complex greater and better blood supply. (R. pp. 425-26).

In addition to the above, prior to operating on November 1, 2016, Dr. Schimpf also discussed the details of the procedure with Appellant; discussed that he would be removing Appellant's

[2] Respondents' reference to Plaintiff's Exhibit 25, titled simply as "Operative Note" in the trial transcript and admitted at the end of the Defendants' case-in-chief, in their Initial Brief was a scrivener's error. Respondents intended to cite to the Defendants' Operative Note, which was designated in their matter to be included in the record on appeal.

implants and tissue and that he would be moving up the nipple/areola complex. (R. pp. 426, 913-14). Furthermore, he again reiterated the risks associated with breast reduction to Appellant – namely, that complications with **wound healing, need for revision surgery specific to breast and nipple loss, and painful scarring could result**. (R. pp. 913-14). In other words, contrary to Appellant's assertion, Dr. Schimpf informed Appellant on multiple occasions that there was a real risk that she would need a mastectomy or similar breast loss surgery if complications arose. (*Id.*). In response, Appellant again voiced her understanding and consented to the surgery. (*Id.*). Tellingly, Appellant did not have any criticisms of Respondents' informed consent process. (R. pp. 377-78, 533-34). Indeed, Appellant's own expert testified that a reasonable and prudent physician would discuss the risks that Respondents discussed with Appellant and that the informed consent form used by Respondents complied with the standard of care. (R. pp. 377-78).

After providing the appropriate informed consent for a third time, Dr. Schimpf subsequently performed Appellant's breast reduction surgery and with special attention to the blood flow to Appellant's nipple/areola complex, as acknowledged by Appellant's expert, as well as his own: Dr. Todd Lefkowitz, a board-certified plastic surgeon that, unlike Appellant's expert, performs approximately 100 to 150 breast surgeries a year. (R. pp. 380-383, 525-26, 543-44). Specifically, Dr. Schimpf checked her nipple/areola complex's capillary refill to confirm that blood would fill the area when pressed and confirmed the continued viability of both nipples throughout the procedure and at the conclusion of surgery. (R. pp. 913-14)[3]. He also checked for congestion and ischemia and saw none. (*Id.*). Stated another way, during surgery and in the immediate post-operative period, Dr. Schimpf did not see any indication that the blood flow to Appellant's nipple/areola complex had been disrupted in any way despite properly looking for evidence of the

[3] Dr. Schimpf demonstrated for the jury how he checks for capillary refill using a video demonstrative during trial. (R. pp. 439-40).

same on multiple occasions throughout the procedure as well as post-operatively. Ultimately, Respondents discharged Appellant to the care of her friend, Ms. Mary Ackerman, on the same day and with aftercare instructions. (R. p. 907).

The day after her surgery, Appellant's caregivers contacted Respondents several times and informed Dr. Schimpf that Appellant was light-headed and dizzy but otherwise okay. (R. p. 941). They reported no problems with her surgical incisions or the appearance of her breasts. (*Id.*). The same day, Dr. Schimpf recommended that she continue to follow her post-operative instructions, encouraged increased fluid intake and invited her to come into in his office so she could be evaluated, but she declined to do so. (*Id.,* R. p. 311). Alternatively, he also told her that she could go to the emergency room, but she declined that option as well. (*Id.*). The next day, November 3, 2016, Dr. Schimpf learned from Appellant's caregivers that she had improved with additional fluids, was stable and ambulatory, and that she had taken her wound dressings down, which were clean, dry, and intact, and that she was sponge-bathing. (R. p. 942).

On November 7, 2016, one of Appellant's caregivers called Dr. Schimpf and reported that Appellant had dark red serosanguinous drainage and a reported fever. (R. p. 943). Accordingly, Respondents scheduled an appointment for Appellant the next day. (*Id.*). On November 8, 2016, Appellant presented to Respondents again. (R. p. 943). On this day, her incisions were documented as healing and draining appropriately and that there were no signs of erythema, warmth, redness, or seroma, indicating no infection was present. (*Id.*). It was also documented that her right nipple/areola complex was bruised. (*Id.*). Appellant returned to Respondents on November 15, 2016, where it was documented that she was "doing better daily" and that her right nipple/areola complex was very bruised and forming eschar. (R. p. 945). Subsequently, Appellant was scheduled for a two (2) week follow-up visit. (*Id.*).

However, prior to her follow up visit, on November 27, 2016, Appellant presented to an emergency room for breast-related complaints. (R. p. 946). There, it was discovered that, although Appellant had a normal white blood cell count and negative blood cultures, her wound swab from the breast incision grew out bacteria consistent with those found naturally on the skin and in the GI tract. (*Id.*). Dr. Schimpf consulted with the emergency room physician that evening and scheduled to see Appellant in-office the next day. (*Id.*). On November 28, 2016, Dr. Schimpf met with Appellant to discuss his concerns regarding the viability of her right nipple tissue and what could be done to address it later, and he sharply debrided some necrotic tissue around the area. (R. pp. 946-47). Her wound was open and draining appropriately. (*Id.*). Dr. Schimpf prescribed antibiotics prophylactically and asked her to return in forty-eight (48) hours. (R. pp. 947-50). Appellant never returned to Dr. Schimpf or Respondents after this appointment.

In the weeks that followed, Appellant was admitted to multiple hospitals, and she underwent a lengthy course of treatment with another plastic surgeon, Dr. Fernando Herrera. However, she ultimately developed fat necrosis (i.e., dead tissue), an infection, and lost her right nipple and volume in her right breast. Importantly, even at trial, Dr. Herrera did not attribute Appellant's nipple or volume loss to any action or negligence of Respondents.

> Q: [] [I]t's my understanding you are not here to tell this jury that Dr. Schimpf did anything that was below the standard of care or was medically negligent in any way, are you?
>
> A: I would agree with that statement.

(R. p. 726).

B. Procedural History

On April 23, 2018, Appellant initiated this lawsuit by filing a Complaint in the Court of Common Pleas for Charleston County (R. pp. 18-25). Contrary to Appellant's contention on

appeal, in her Complaint, Appellant not only alleged that Respondents were negligent in selecting the wrong approach to her breast implant removal and breast reduction, which allegedly disrupted the blood flow to her breasts, but also by "failing to timely diagnose and recognize" an infection in her breast and "failing to appropriately treat her" breast infection. (*Id.* at p. 24). On May 23, 2018, Respondents timely filed their Answer. In their Answer, Respondents properly asserted, among other defenses, that their conduct was in full compliance with the standard of care and that Appellant's claimed injuries were known complications of her surgical procedure for which she was properly informed yet voluntarily accepted (i.e., assumption of the risk). (R. p. 29, ¶¶ 2-4). Furthermore, they properly asserted that, in the exercise of ordinary care, Defendants could not have foreseen or anticipated that Appellant would, indeed, incur a known complication because, as detailed above, Respondents took more than one (1) reasonable measure to preserve blood flow to Appellant's nipple/areola complex and ensure that she healed properly in the post-operative period. (*Id.* at p. 29, ¶ 5).[4]

Between November 14, 2022 and November 17, 2022, the parties tried the case to a jury. Just as she did in her Complaint, starting with pre-trial motions and continuing through closing arguments, Appellant alleged that Respondents selected the wrong surgical technique **and** that Respondents' post-operative care violated the standard of care. (R. pp. 161-63, 188-89, 591-92). In fact, Appellant repeatedly showed the jury over a dozen photos of her breasts during the post operative period and testified about the "foul odor" allegedly emanating from her breasts during post-operative appointments with Respondents to suggest that Respondents must have somehow

[4] Appellant asks this Court to infer that Respondents were conceding assumption of the risk by pleading this defense, or at least contradicting it. (Appellant's Initial Brief, pp. 12, 25). As an initial matter, Respondents were permitted to plead defenses in the alternative without conceding any position. Second, Appellant plainly misconstrues this defense. (*Id.*). It does not undermine the assumption of the risk doctrine. Instead, it is complementary. It acknowledges that, while known surgical risks exist (and Appellant appreciated), there was no indication that Appellant would have developed one (1) or more of them due to Respondents' exercise of reasonable care.

missed an infection. (R. pp. 271-72, 880-98).

Moreover, Appellant's expert separated his opinions about Dr. Schimpf[5] in two (2) parts and testified that his second opinion was that Dr. Schimpf should have applied a topical antibiotic to Appellant's incision after November 6, 2016. (R. pp. 343, 356, 388-89). He did not, however, testify that Dr. Schimpf's alleged failure to timely administer antibiotics caused any of Appellant's claimed injuries or damages. As a result, **Appellant did not present any evidence of causation for her second distinct theory of liability**. Additionally, Respondents' infectious disease expert, Dr. Patrick Joseph, testified that an administration of a topical antibiotic would not have changed Appellant's outcome, which undermined it completely. (R. p. 517).

Regarding Appellant's other theory of liability, that Respondents allegedly selected the wrong surgical technique, Appellant merely offered the testimony of her expert, who does not routinely perform this procedure and who instead focuses his practice on the treatment of burns, to opine that Dr. Schimpf's choice of technique was contraindicated by the scars on Appellant's areolas from her prior implant surgery and that *the technique caused* the disruption in Appellant's blood flow and, in turn, her injuries and damages. (R. pp. 337-38, 353-55, 371, 376-77). However, this unsupported theory was thoroughly rebutted by the testimony of Dr. Lefkowitz, who actually and regularly performs breast reduction surgery, and who testified that Dr. Schimpf selected the proper technique for Appellant's surgery, that "[the] scar [was] not, in any way, an issue for Dr. Schimpf to choose an inferior pedicle technique[,]" and that blood can and does flow through scars in a variety of plastic surgeries, such as facial reconstruction after skin cancer, which has less

[5] Appellant did not present any expert testimony that the practice or any of its employees violated the standard of care at any time. Therefore, Respondents argued that the practice was entitled to a direct verdict and maintain that position. (R. p. 386 (During the cross examination of Appellant's expert: "Q: And you're not offering any opinions that any of the employees of the practice, any of the nurses, physician assistants, anyone else that worked for the practice, did anything that was negligent or below the standard of care in this case? A: No.")).

vascularity than a breast. (R. pp. 540-43). He also testified that disruptions in blood flow are a known surgical complication that can and do occur in the absence of negligence and that Appellant unfortunately developed known complications after surgery through no fault of Dr. Schimpf. (R. pp. 534-35, 546). Most importantly, he testified that Respondents met the standard of care in every aspect of their care of Appellant, including their obligations to obtain Appellant's informed consent prior to operating. (R. pp. 530, 533-34, 545-46, 548, 572).

Dr. Schimpf likewise testified that he met the standard of care, that the inferior pedicle technique was appropriate for Appellant and was not at all contraindicated by the scars from her prior breast surgery, and that her known complications were not the result of the technique that he chose. (R. pp. 421-23, 428, 438-39, 467-69). Contrary to Appellant's repeated assertion, Dr. Schimpf did not testify that Appellant was "high risk." Instead, he explained to the jury why the technique suggested by Appellant's expert (i.e., the superior pedicle technique) would not have been appropriate and would have, in fact, been riskier for Appellant given the size, weight, and drooping of her breasts. (R. pp. 438-39).

Dr. Schimpf also offered an explanation for the **cause of Appellant's post-operative issues** that was **unrelated to his surgical technique**: venous congestion, which is when blood that enters tissue cannot leave or becomes clogged in the vein and causes tissue death. (R. p. 451). Without casting blame on Appellant, Dr. Schimpf explained that venous congestion can occur when there is too much external compression on vulnerable tissue and that it can happen when a patient goes home and sleeps in a way that causes a bra or bandage to twist and tighten across vulnerable tissue. (R. pp. 447-48). He further explained that there is a limited window to act to relieve the congestion and if he is not made aware of symptoms consistent with the condition and able to see the patient, such as the case with Appellant who did not report massive swelling or

other issues and refused to be seen in the forty-eight (48)-hour post-operative period, the tissue death is inevitable. (R. pp. 448-49, 451). He clarified that there was no evidence that Appellant was likely to develop venous congestion when she was discharged after surgery, but he could not rule out that she could have developed the condition at her home before he saw her again post-operatively given the lack of evidence of blood flow disruption during surgery. (R. p. 447). Thus, not everyone agreed that the blood supply to Appellant's breasts was disrupted as a result of Dr. Schimpf's surgical technique as Appellant now posits.

Dr. Joseph provided an explanation for how infection can develop and spread once tissue dies (e.g., fat necrosis). However, importantly, he did not attribute Appellant's development of fat necrosis or infection to the conduct of Respondents. (R. p. 520). In sum, before resting, Respondents presented ample evidence at trial of informed consent, that Respondents met the standard of care with respect to Appellant's surgery and post-operative care, and that neither Appellant's claimed damages nor outcome were caused by medical negligence. Consequently, the circuit court properly submitted the issue of assumption of the risk to the jury and denied Appellant's motions for directed verdict on it.

Contrary to Appellant's suggestion, the circuit court did not submit assumption of the risk as a total bar to recovery. Instead, consistent with South Carolina law, it instructed the jury that assumption of the risk goes to the jury's initial determination of negligence. (R. pp. 626-27). The jury had a copy of the instructions and did not submit any questions related to assumption of the risk. The lone question posed by the jury concerned causation. (R. pp. 634-35).

Moreover, assumption of the risk was not included on the verdict form. Instead, in typical fashion, the form asked, (1) "Did the plaintiff prove by the greater weight, or preponderance of the evidence, that the defendant deviated from the standard of care[;]" and (2) "Did the plaintiff prove

by a greater weight, or preponderance of the evidence, that the defendant deviating (sic) from the standard of care was the proximate cause of the plaintiff's injuries?" (R. pp. 638-39). In other words, the verdict form asked whether Appellant proved both negligence and causation. If the jury answered yes to the first two (2) questions, then and only then, the form asked the jury to consider damages. After deliberating for only a few hours, the jury returned a unanimous decision in Respondents' favor. (*Id.*). As is their right, they determined that Appellant proved that there was deviation in the standard of care (i.e., negligence), but that she did not likewise prove causation by a preponderance of the evidence. (*Id.,* R. p. 10-17). The circuit court's poll of the jurors confirmed the unanimous verdict, foreclosing any concern that the jurors were unsure of their decision or had been misrepresented on the verdict form. (R. pp. 639-641).

On November 28, 2022, Appellant sought a new trial as to proximate cause and damages only, or, in the alternative for judgment notwithstanding the verdict, or, alternatively, for a new trial absolute. (R. pp. 130-37). The crux of Appellant's post-trial motion was that the jury was somehow confused because they did not award Appellant any damages despite evidence of her poor surgical outcome and that the verdict was inconsistent and against the greater weight of the evidence. Appellant did not make any arguments about assumption of the risk.

Similar to her Initial Brief, in her post-trial motion, Appellant disregarded that she pursued a distinct theory of liability based on Respondent's post-operative care that could have resulted in the jury's finding that Respondents breached the standard of care with respect to Appellant's after care (versus the choice in surgical technique) but that the asserted breach did not cause Appellant's injuries and damages. Appellant's position also ignores the well-establish law of South Carolina that liability may not be inferred from a bad result alone. *See Dumont v. United States*, 80 F. Supp. 2d 576, 581 (D.S.C. 2000) (holding that a bad result is not by itself sufficient to raise an inference

or presumption of negligence); *Ward v. Epting*, 290 S.C. 547, 561, 351 S.E.2d 867, 875 (S.C. App. 1986) (same). Accordingly, the circuit court's order denying Appellant's post-trial motion was proper, was consistent with the evidence, and should not be reversed. (R. pp. 1-9).

STANDARD OF REVIEW

A. Jury Instructions

An appellate court will not reverse the circuit court's decision regarding jury instructions unless the circuit court abused its discretion. *Clark v. Cantrell*, 339 S.C. 369, 389, 529 S.E.2d 528, 539 (2000) (internal citations omitted). There is no abuse of discretion where the circuit court's ruling is based on South Carolina law, or, where grounded in factual conclusions, there is evidentiary support. *See id.* (internal citations omitted). Even if the charge is confusing, which it was not in this case, that alone is insufficient to warrant reversal. *Keaton v. Greenville Hosp. Sys*., 334 S.C. 488, 498, 514 S.E.2d 570, 575 (1999). Moreover, even if the circuit court erred in giving a particular instruction, the requesting party must also show that the error was prejudicial to warrant reversal on appeal. *Id.* at 390, at 539.

In reviewing jury charges for error, the appellate court must consider the circuit court's jury instruction as a whole in light of the evidence and issues presented at trial. *Hennes v. Shaw*, 397 S.C. 391, 402, 725 S.E.2d 501, 507 (Ct. App. 2012) (internal citation omitted). If the instructions are reasonably free from error, isolated portions that might be misleading do not constitute reversible error. *Id.* (citing *Keaton*, 334 S.C. at 497, 514 S.E.2d at 575).

B. New Trial

Whether to grant a new trial is a matter within the discretion of the circuit court, and the decision will not be disturbed on appeal unless it is unsupported by the evidence or is controlled by an error of law. *Daves v. Cleary*, 355 S.C. 216, 231, 584 S.E.2d 423, 430 (Ct. App. 2003) (citing *Stevens v. Allen*, 336 S.C. 439, 446, 520 S.E.2d 625, 628-29 (Ct. App. 1999)). Stated another way,

a jury's verdict is entitled to "substantial deference." *Mills v. S.C. State Ports Auth.,* 435 S.C. 213, 227, 865 S.E.2d 910, 917 (Ct. App. 2021). "A new trial absolute should be granted only if the verdict is so grossly excessive that it shocks the conscience of the court and clearly indicates the amount of the verdict was the result of caprice, passion, prejudice, partiality, corruption, or other improper motive." *Id.* at 226 (internal citation omitted). A so-called inconsistent verdict is not an automatic ground for a new trial. *Austin v. Stokes-Craven Holding Corp.*, 387 S.C. 22, 49-50, 691 S.E.2d 135, 149 (2010) (internal citation omitted). To the contrary, where there is a logical reason for reconciling an inconsistent verdict, it is the duty of the court to sustain it. *Id.*; *see also Longshore v. Saber Sec. Servs*., 365 S.C. 554, 561, 619 S.E.2d 5, 9 (Ct. App. 2005) (affirming the trial court's decision to not overturn a jury verdict in favor of the defendants on an assault and battery claim where the jury found liability for negligent hiring because the verdict could be "harmonized."); *Johnson v. Hoechst Celanese Corp*., 317 S.C. 415, 422, 453 S.E.2d 908, 912 (Ct. App. 1995) (affirming denial of plaintiffs' motion for new trial where the jury returned a verdict for two other plaintiffs because the moving plaintiffs did not prove each element of their causes of action).

Equally important to medical malpractice cases like this one, the plaintiff must show, through expert testimony that, "in their professional opinion, the injuries complained of most probably resulted from the defendant's negligence . . . [and] when it is the only evidence of proximate cause relied upon, it must provide a significant causal link between the alleged negligence and the plaintiff's injuries, rather than a tenuous and hypothetical connection." *Daves*, 355 S.C. at 230, 584 S.E.2d at 430 (*quoting James v. Lister*, 331 S.C. 277, 286, 500 S.E.2d 198, 203 (Ct. App. 1998)). In other words, the plaintiff has the burden of proving both a deviation from the standard of care **and** proximate cause through expert testimony. *Id.; see also Richardson's*

Rests. v. Nat'l Bank of S.C., 304 S.C. 289, 295, 403 S.E.2d 669, 672 (Ct. App. 1991) (internal citation omitted) ("In order to prevail on a claim of negligence, the plaintiff must show (1) a duty of care owed by the defendant to the plaintiff; (2) a breach of that duty by a negligent act or omission; and (3) damage proximately resulting from the breach. If he fails to establish any one of these elements, his cause of action fails."). Where a jury finds that she did not do so and it is supported by the evidence, the decision of the jury should not be disturbed through a new trial. *See Stevens,* 342 S.C. at 53, 536 S.E.2d at 666 ("[I]f a jury finds the plaintiff has failed to prove damages proximately caused by the defendant's negligence, then its verdict should be for the defendant."); *Dropkin v. Beachwalk Villas Condo. Ass'n,* 373 S.C. 360, 365, 644 S.E.2d 808, 810 (Ct. App. 2007) (affirming denial of the plaintiff's motion for a new trial in a traditional negligence case where plaintiff did not prove proximate cause).

C. Judgment Notwithstanding the Verdict (JNOV)

In reviewing the denial of motions for directed verdict and JNOV, the evidence and the reasonable inferences that can be drawn therefrom must be viewed in the light most favorable to the non-moving party, which, at this juncture, is Respondents. *Daves*, 355 S.C. at 229, 584 S.E.2d at 429 (citing *Brady Dev. Co. v. Town of Hilton Head Island*, 312 S.C. 73, 78, 439 S.E.2d 266, 269 (1993)). The motion should not be granted where the "evidence yields more than one inference[,] or its inference is in doubt." *Id.* (internal citation omitted). As with considering a motion for a new trial, a jury's verdict should be given substantial deference when contemplating a JNOV. *See Mills,* 435 S.C. at 227, 865 S.E.2d at 917.

ARGUMENT

I. THE CIRCUIT COURT DID NOT ERR IN DENYING APPELLANT'S MOTIONS AND INSTRUCTING THE JURY AS TO ASSUMPTION OF THE RISK.

A. The South Carolina Supreme Court Held That Assumption Of The Risk Applies In Medical Malpractice Cases Like This One.

The circuit court did not err in denying Appellant's motions and instructing the jury as to assumption of the risk because the South Carolina Supreme Court previously held in *Faile v. Bycura* that assumption of the risk can apply in medical malpractice cases like this one; where the plaintiff is not seeking damages for lack of informed consent. 289 S.C. 398, 346 S.E.2d 528 (1986). Importantly, in the same case, it held that assumption of the risk ***should*** be submitted to the jury under facts nearly identical to this one.

In *Faile*, the plaintiff alleged that her surgeon selected the wrong procedure for relief of her heel pain. *Id.* at 399, at 529. She did not allege that the surgery was performed incorrectly – just that it was the wrong choice. *Id.* She also did not allege that there was a lack of informed consent. *Id.* The defendant-surgeon defended that the procedure was appropriate and raised the defense of assumption of the risk because, prior to both surgeries, the plaintiff signed a consent form in which she acknowledged that the surgery would probably result in a complication (i.e., stiff toes), that it may not work, and that she may need additional procedures in the future. *Id.* Additionally, the plaintiff signed a form acknowledging that other treatment options existed but that she was nonetheless electing the surgery. *Id.* Despite this, at trial, the circuit court struck assumption of the risk from the defendant-surgeon's answer. *Id.* The Supreme Court reversed the decision of the circuit court and held that assumption of the risk should have been submitted to the jury. *Id.* at 399-400, at 530.

The present case is strikingly similar to *Faile*. Appellant alleges that Respondents chose the incorrect technique for her breast reduction surgery: the inferior pedicle/Wise pattern

technique. Like the plaintiff in *Faile*, she does not allege that Respondents performed her surgery incorrectly or that they lacked consent – just that the surgery was the wrong choice for her. Appellant's informed consent to the surgery also mirrors that of the plaintiff's in *Faile*. Specifically, Appellant signed a consent form stating that the "**most likely** material risks and complications" associated with her surgery included asymmetry, bleeding, delayed healing, discoloration/swelling, discomfort, failure to improve symptoms, infection, skin, nipple and flag loss, wound separation, and unsatisfactory results." (R. p. 908-09). She signed a consent form acknowledging the likelihood of the same injuries that she would later claim in her lawsuit. (R. p. 328). In the same form, she also acknowledged that other treatment options existed and that future surgeries may be required, but that she nonetheless elected to undergo the procedure. (*Id.*). Moreover, Dr. Schimpf personally discussed the risk of Appellant's surgery with her during multiple pre-operative appointments. (R. p. 911-12). Therefore, it follows that, under South Carolina law, assumption of the risk is applicable to the present case and the circuit court properly denied Appellant's motions to exclude and motions for directed verdict related to the same.

Appellant tries to distance herself from *Faile* by misconstruing its holding and the evidence on the record. Contrary to Appellant's assertion, under *Faile* and other South Carolina law, Respondents were not required to use any magic words or phrases in obtaining Appellant's informed consent, such as "high-risk," "most probably," or "mastectomies," to submit the doctrine to the jury. *See Faile*, 289 S.C. at 399, 346 S.E.2d at 529 (submitting assumption of the risk to the jury without noting that the plaintiff was specifically informed that her heel pain, in addition to stiff toes, would most probably persist); *see also Baxley v. Rosenblum*, 303 S.C. 340, 347, 400 S.E.2d 502, 507 (Ct. App. 1991) ("The defense of assumption of the risk ordinarily presents a question of fact for the jury."). Instead, Respondents were only required to produce evidence of

assumption of the risk that was "susceptible of more than one reasonable inference." *Carter v. A. C. Tuxbury Lumber*, 173 S.C. 58, 60, 174 S.E. 754 (1934) (holding that assumption of the risk should have been submitted to the jury where the testimony adduced at trial was susceptible to "more than one reasonable inference" as to whether the plaintiff assumed the risk of his work injury). As explained in greater detail below, Respondents produced more than enough evidence that (i) Appellant was informed of the "most likely" risks of her surgery, which included those that she later experienced, on at least three (3) occasions, (ii) that she understood those risks and appreciated that they were real, and (iii) that she ultimately elected to pursue her surgery with full knowledge of and in spite of those risks. **The best evidence of this is the fact that Appellant did not bring a cause of action in her Complaint against Respondents for want of informed consent despite trying to intimate the same in her Initial Brief**. (*See generally*, R. pp. 18-25).

Furthermore, Dr. Schimpf never testified that Appellant was a "high-risk" patient. Thus, it makes sense that there were no references to the alleged "high-risk" status of Appellant in Respondents' medical records. Appellant cannot convert Dr. Schimpf's statement that Appellant had "large, pendulous breasts, and it was definitely not just a straightforward garden variety" to create an issue where one does not exist. (*Compare* Appellant's Initial Brief, pp. 11-12 *with* R. pp. 422-23). Accordingly, any argument premised on Respondents' alleged obligations to so-called high-risk patients is misdirected and should be disregarded.

Appellant also tries to circumvent *Faile* by making a blanket assertion that the doctrine has no "legitimate application in the medical malpractice context" because a "patient that undergoes surgery does not assume the risk that the physician will deviate from the standard of care." However, this assertion is both nonsensical and ignores the plain text of *Faile*, which addresses the relevance of assumption of the risk to medical malpractice cases like this one. First, the

assertion is nonsensical because no one ever asked Plaintiff to assume a risk of potential medical negligence in this case, nor would they. Appellant would seek to conflate the very real medical risks of the procedure that are being assumed with a completely hypothetical legal one that could never be assumed. As the Supreme Court explained: "[w]hen a patient seeks treatment by a particular type of practitioner, he may be held to have assumed the risk of the method of treatment of the particular school of thought chosen." *Faile*, 289 S.C. at 399, 346 S.E.2d at 529-300. Appellant's position also ignores the well-established purpose of assumption of the risk in South Carolina tort law. *See Baxley*, 303 S.C. at 347, 400 S.E.2d at 507 ("The doctrine of assumption of the risk embodies the principle that one should not be permitted knowingly and voluntarily to incur an obvious risk of harm and then hold another person responsible for his injury."). Thus, there is both a legitimate and purposeful application of assumption of the risk to medical malpractice cases, including this one.

Appellant's assertion that there is no "legitimate application" of the doctrine is without any other support under South Carolina law. Appellant claims that *Cole v. Raut* is "instructive on this issue." (Appellant's Initial Brief, p. 19). However, *Cole* does not stand for Appellant's proposition at all and is inapplicable to the present case. In *Cole*, the plaintiff plainly did not sign a consent form for a C-section delivery, which was the basis of the plaintiffs' medical malpractice claim. 378 S.C. 398, 411, 663 S.E.2d 30, 36 (2008). Instead, she signed a consent form for an entirely separate procedure (i.e., a VBAC). *Id.* As a result, the South Carolina Supreme Court held that the plaintiffs could not be held to assume the risk of a C-section. *Id.* Here, Appellant admittedly signed a consent form for the surgery at issue, which explained the known complications of the surgery. Furthermore, she was also instructed on these potential risks during multiple other encounters with Respondents, so assumption of the risk is directly relevant to this case and applicable. Neither *Cole*

nor the out-of-jurisdiction case law cited by Appellant changes this.

Moreover, Appellant's assertion is, at best, a red herring. Respondents never argued that Appellant consented to negligence. Indeed, the record is replete with testimony that a patient cannot consent to negligence, so this is a non-issue. (R. pp. 329, 565, 595). The same is true with Appellant's references to comparative negligence, which Appellant conflates with assumption of the risk. (Appellant's Initial Brief, pp. 20-21). Respondents never pursued, and the circuit court did not submit assumption of the risk as a complete bar to Appellant's recovery. Instead, the circuit court correctly instructed the jury that assumption of the risk goes the initial determination of negligence. *See Davenport v. Cotton Hope Plantation Horizontal Prop. Regime*, 333 S.C. 71, 81, 508 S.E.2d 565, 570 (1998) (holding that "primary implied assumption of risk is simply a part of the initial negligence analysis[.]"); *see also Hurst v. E. Coast Hockey League, Inc.*, 371 S.C. 33, 38, 637 S.E.2d 560, 562 (2006) (noting that South Carolina's adoption of comparative negligence does not affect the doctrine of assumption of the risk). In short, none of Appellant's arguments alter the fact that *Faile* controls and unequivocally supports the circuit court's decisions as to assumption of the risk.

B. Respondents Presented More Than Sufficient Evidence That Appellant Assumed The Risks Of Her Surgical Procedure To Create A Question For The Jury.

The circuit court did not err in denying Appellant's motions and instructing the jury on assumption of the risk because, as detailed above, the doctrine is available in all medical malpractice cases under South Carolina law, and Respondents presented more than sufficient evidence of it to create a question for the jury of its application to the present case. Assumption of the risk is the deliberate and voluntary choice to assume a known risk. *Baxley*, 303 S.C. at 347, 400 S.E.2d at 507. It may be implied by a plaintiff's conduct. *Davenport*, 333 S.C. at 78-79, 508 S.E.2d at 569 (internal citations omitted) (providing the elements). It is ordinarily a question for

the jury. *Id.* Assumption of the risk presents a question of fact for the jury where the defendant produces evidence that is susceptible of more than one reasonable inference that the plaintiff (i) had knowledge of a dangerous condition, (ii) appreciated the dangerous condition, and (iii) voluntarily exposed herself to it. *Baxley*, 303 S.C. at 347, 400 S.E.2d at 507; *see also Carter*, 173 S.C. at 60, 174 S.E. at 754 (cited *supra*).

Respondents produced evidence that Appellant knew of and appreciated the dangers associated with her surgery beginning with her very first encounter with Respondents. During her cross examination, Appellant testified that, at her first preoperative appointment with Respondents, Dr. Schimpf explained the surgical options available to her and the risks that were associated with those surgical options. (R. p. 303). Specifically, she testified that he discussed that she may not be satisfied with the outcome, that she could develop an infection, that there might be a problem with asymmetry, and that there was a risk of death, in addition to a general list of things that could happen with any surgery. (R. pp. 303-04). She also testified that she did not have any questions related to these risks and that she knew that they were "very real." (R. p. 304). In fact, she told the jury that she had even been researching the risks on her own and that she was comfortable proceeding with the surgery knowing that the dangerous risks were real. (*Id.*).

She further testified that the risks were reiterated to her during a second encounter with Respondents – just days before her surgery – and that her understanding of the risks was memorialized yet again in a signed consent form. (R. 304-05). Consequently, Respondents entered Appellant's signed consent form into the record <u>without objection by Appellant</u> and confirmed that she initialed that the most likely risks of surgery were explained to her in terms that she understood and that those included, among others, asymmetry, bleeding, delayed healing, different size than expected, discoloration and swelling, discomfort, pain, sensitivity, failure to improve

symptoms, infection, nipple loss, wound separation, and unsatisfactory terms. (R. pp. 305-98, 908-09). Appellant agreed that Respondents covered with her all of the complications that she later developed before she chose to move forward with the surgery. (R. p. 328). Appellant further agreed that she was "over-the-moon excited" to have the surgery despite knowing that above-referenced risks were real risks. (R. p. 310).

Through Dr. Schimpf's testimony, Respondents elicited uncontradicted testimony that he explained the surgical risks, such as delayed wound healing, need for revision surgery specific to breast and nipple loss, and painful scarring, to Appellant for a third time immediately prior to operating. (R. p. 443, 911-12). Additionally, with full knowledge of the potential risks, she voluntarily chose to undergo the procedure anyway. The surgical experts, including Appellant's, were unified that Respondents' explanation of the risks to Appellant met the standard of care. (R. pp. 377-78, 533-34). Appellant's subsequent treating physician also agreed that the risks that Respondents informed Appellant of for the surgery in question were the same as those that he tells his patients. (R. pp. 728-29).

The foregoing demonstrates that, before resting, Respondents produced more than enough evidence that would enable a reasonable juror to conclude that Appellant was properly informed of the complications for which she later sought damages (e.g., nipple and volume loss, asymmetry, infection, pain, need for revisional surgery, and an unsatisfactory outcome) and that she fully appreciated the potential for these complications yet still voluntarily chose to subject herself to them by electing the surgery. The fact that Dr. Schimpf did not have any indication that Appellant would ultimately develop one (1) or more complication after his exercise of reasonable care does not negate that he provided Appellant with the information that she needed to make an informed decision about surgery and that she did, in fact, make an informed decision of her own free will.

Furthermore, as mentioned above, Respondents did not have to use specific language, such as "mastectomies," to trigger the doctrine as Appellant argues – though the evidence on the record supports that Respondents properly informed Appellant that there was risk that she would have to undergo subsequent surgeries for nipple and volume loss. (R. pp. 913-14). This evidence, along with the Supreme Court's opinion in *Faile*, was available to and considered by the circuit court in ruling on Appellant's motions. (R. pp. 165-68). Therefore, the circuit court's submission of assumption of the risk to the jury was appropriate and not arbitrary.

C. The Circuit Court's Instruction On Assumption Of Risk Was Not Confusing And Did Not Affect The Outcome Of The Trial.

The circuit court correctly instructed the jury on assumption of the risk under South Carolina law. In fact, the circuit court's instruction contained the very same language used by the Supreme Court in *Davenport* in articulating assumption of the risk, including implied assumption of the risk, which was proper for the circuit court to include. *See* 333 S.C. at 79-81, 508 S.E.2d at 569-70. Despite Appellant's contention, primary implied assumption of the risk's application is not limited to spectator sports, and it does capture Appellant's conduct in this case. *See e.g., Conrad-Hutsell v. Colturi*, 2002-Ohio-2632, ¶ 29 (Ct. App.) (holding that implied assumption of the risk may be submitted to a jury in a medical malpractice case); *Gray v. Gonzalez*, 290 A.D.2d 292, 293, 735 N.Y.S.2d 776 (App. Div. 2002) (same).

In South Carolina, there are only three (3) variations of assumption of the risk: (1) express, (2) primary implied and (3) secondary implied. *See Davenport*, 333 S.C. at 78-82, 508 S.E.2d at 570-71. "Express assumption of risk applies when the parties expressly agree in advance, either in writing or orally, that the plaintiff will relieve the defendant of his or her legal duty toward the plaintiff." *Id.* at 79, at 569. Primary implied assumption of risk arises when the plaintiff impliedly assumes those risks that are inherent in a particular activity. *Id.* at 81, at 570. Primary implied

assumption of risk is not a true affirmative defense, but instead "is simply a part of the initial **negligence analysis**." *Id.* Stated another way, it is a part of determining whether there was an exercise of reasonable care. *See Cole v. S.C. Elec. & Gas, Inc.*, 362 S.C. 445, 453, 608 S.E.2d 859, 863 (2005) (holding that primary implied assumption of the risk was submitted to the jury despite finding a duty existed because there was still of question of fact as to whether the defendant met the standard of care). "Secondary implied assumption of risk, on the other hand, arises when the plaintiff knowingly encounters a risk created by the defendant's negligence. It is a true defense because it is asserted only after the plaintiff establishes a prima facie case of negligence against the defendant." *Id.* at 71, at 571.

The evidence presented at trial supports that Appellant impliedly assumed the risks of her surgical procedure by executing her consent form wherein she acknowledged and accepted the risks inherent to her surgery and by choosing to undergo it. Thus, it was appropriate for the jury to be instructed on primary implied assumption of the risk versus the other variations. The fact that Respondents have a statutory duty of care does not render primary implied assumption of the risk inapposite because the jury was still tasked with assessing whether Respondents exercised reasonable care; breached their statutory duty. *See Cole*, 362 S.C. at 453, 608 S.E.2d at 863 (cited *supra*). This was explained to the jury in the circuit court's instruction. (R. pp. 626-27) ("Primary implied assumption of the risk is not a trial affirmative defense, but instead goes to the initial determination of whether the defendant's legal duty encompasses the risk encountered by the plaintiff. In other words, **it is simply part of the initial negligence analysis**."))[6] (emphasis added). So, Appellant's claim that the circuit court's instruction was confusing is wholly without merit and

[6] Although not required under South Carolina law, this is arguably the "redemptive" or "clarifying" language that Appellant claims the circuit court's instruction lacked as it specifies that assumption of the risk is not a complete bar to Appellant's recovery.

unsupported by the record. Even so, the limited portion of the circuit court's instruction on primary implied assumption of the risk is not sufficient on its own to overturn the jury's verdict. *See Hennes*, 397 S.C. at 402, 725 S.E.2d at 507 (holding that, even assuming isolated portions of an instruction are "misleading," the instruction does not constitute reversible error if the remainder of the instruction is reasonably free from error).

Markedly, there is no evidence that the jury was at all confused by the court's instruction on this issue. The jury did not submit any questions related to assumption of the risk or otherwise intimate confusion during the circuit court's polling. The mere fact that it was offered as part of the larger instruction is not sufficient to overturn the circuit court because, as discussed in detail above, assumption of the risk was both relevant and applicable. Additionally, Appellant's incorrect perception that causation was undisputed likewise does not justify a new trial because assumption of the risk does not bear on causation; it is only relevant for assessing negligence.

Furthermore, as Appellant recognizes in her own Initial Brief, the instruction must affect the outcome of trial. *See Cole*, 378 S.C. at 404, 663 S.E.2d at 33. There is simply no evidence that the instruction affected the outcome of the trial. **In fact, the jury found for Appellant on the issue of negligence – which is the only element of the verdict that could possibly be affected by assumption of the risk**. Therefore, even assuming *arguendo* that the instruction had the potential to confuse jurors, Appellant cannot prove that she was prejudiced by it and, therefore, the jury's unanimous verdict should not be disturbed.

D. Assuming The Circuit Court Erred In Denying Appellant's Motions And Instructing The Jury As To Assumption Of The Risk, Such Error Was Harmless And There Are Other Reasons For Sustaining The Verdict.

The circuit court's denial of Appellant's motions and instructions as to assumption of the risk are consistent with South Carolina law. However, assuming *arguendo* that the circuit court erred in submitting assumption of the risk to the jury, any error that resulted was harmless and

would not support reversal. In South Carolina, harmless error is not a proper ground for reversal of a circuit court. *Judy v. Judy*, 384 S.C. 634, 646, 682 S.E.2d 836, 842 (Ct. App. 2009). Whether an error is harmless depends on the circumstances of the particular case. *In re Harvey*, 355 S.C. 53, 63, 584 S.E.2d 893, 897 (2003). "No definite rule of law governs this finding; rather, the materiality and prejudicial character of the error must be determined from its relationship to the entire case." *State v. Mitchell*, 286 S.C. 572, 573,336 S.E.2d 150, 151 (1985). Error is harmless where it could not reasonably have affected the result of the trial. *Harvey*, 355 S.C. at 63, 584 S.E.2d at 897. Similarly, "[u]nder the present rules, a respondent - the 'winner' in the lower court - may raise on appeal any additional reasons the appellate court should affirm the lower court's ruling, regardless of whether those reasons have been presented to or ruled on by the lower court." *I'On, L.L.C. v. Town of Mt. Pleasant*, 338 S.C. 406, 419, 526 S.E.2d 716, 723 (2000).

First, Appellant can point to no improper prejudice that the submission of assumption of the risk or the circuit court's instruction on it had on her case, especially when, as observed in the prior section, the jury found for Appellant on the issue of negligence. Second, the record is clear that Appellate had a full and fair opportunity to rebut testimony about her informed consent. However, she admitted under oath that she knew and understood the very real risks of her procedure, but that she was nonetheless "over the moon" to proceed. Moreover, she did not object to the admission of her consent form.

Third, while there was a wealth of evidence that Respondents properly obtained Appellant's informed consent prior to operating, assumption of the risk was not a central tenant of Respondents' case. Instead, Respondents principally defended the case based on the evidence that Respondents chose the correct and "gold standard" surgical technique and provided Appellant with proper post-operative care and that Appellant's injuries were known complications that can occur

in the absence of negligence. In other words, Respondents defended that negligence did not cause Appellant's injuries and damages. The jury's verdict is entirely consistent with this and should not be disturbed.

Contrary to Appellant's contention, it was not conclusively established that Dr. Schimpf disrupted the blood flow to Appellant's breasts during surgery. In fact, the evidence shows that this issue did not develop in the immediate post-operative period, but later on during the healing process. Moreover, Dr. Schimpf offered venous congestion as an alternative explanation for the Appellant's issues with blood flow. Furthermore, Dr. Lefkowitz did not testify that any alleged disruption in blood flow during surgery ***was the result of negligence; the choice in surgical technique***. (R. pp. 554, 568-69). In fact, he testified that a disruption in blood flow and Appellant's resulting complications is known to occur in the absence of negligence and did so in this case. In sum, he did not testify that Respondents caused Appellant's injuries or damages. Additionally, Appellant's treating physician plainly refused to be critical of Respondents' conduct and, as a result, did not lend support to Appellant's theory of causation. (R. pp. 725-26).

It is well settled law in medical malpractice cases that neither the court nor jury may infer liability based on evidence of a bad result alone. *See Dumont*, 80 F. Supp. 2d at 581 (requiring evidence of a deviation of the standard of care and not merely a bad result); *Ward,* 290 S.C. at 561 S.E.2d at 875 (same). Additionally, neither the judge or jury were required to accept the testimony of Appellant's expert that the choice in surgical technique caused Appellant's disruption in blood flow and resulting injuries because, under South Carolina law, there can be more than one (1) acceptable surgical approach. *McCourt v. Abernathy*, 318 S.C. 301, 307, 457 S.E.2d 603, 607 (1995) ("The mere fact that the plaintiff's expert may use a different approach is not considered a deviation from the recognized standard of medical care. Nor is the standard violated because the

expert disagrees with a defendant as to what is the best or better approach in treating a patient. Medicine is an inexact science, and generally qualified physicians may differ as to what constitutes a preferable course of treatment."). Also, the jury was permitted to be critical of and not accept all or part of Appellant's expert's opinions due to his admitted lack of experience with breast reduction surgeries relative to Dr. Schimpf and Dr. Lefkowitz. (R. p. 339) (Appellant's expert testifying that he does not "frequent[ly] perform Appellant's operations"); *Bonaparte v. Floyd*, 291 S.C. 427, 439, 354 S.E.2d 40, 48 (S.C. App. 1987) (holding that the fact that a witness is not a specialist in the particular branch involved affects the weight of the witness's testimony and may afford a basis for completely rejecting it). Thus, Appellant did not automatically meet her burden of proof as to the required element of causation simply because she offered the opinion of an expert and that she experienced post-operative complications.

Also, regardless of her attempts to now distance herself from her claims related to her post-operative care, the fact remains that she made those allegations a part of her Complaint, elicited an opinion from her expert on antibiotics, suggested through her own testimony that she had developed an infection prior to receiving antibiotics from Respondents by repeatedly showing graphic images of her breasts and discussing its foul odor, and otherwise made her post-operative care an issue for the jury. However, she did not present **any evidence** that Respondents' alleged post-operative care proximately caused her injuries and damages. In fact, Respondents confirmed that these same complaints are more consistent with the fat necrosis process that can occur following this surgery, than with an alleged infection. (R. p. 516). Therefore, it is quite possible that the jury could have taken issue with Respondents' aftercare but concluded that it did not cause her injuries and damages, which is an acceptable ground for sustaining their verdict.

II. THE TRIAL COURT DID NOT ERR IN DENYING APPELLANT'S POST-TRIAL MOTIONS FOR A NEW TRIAL, OR, IN THE ALTERNATIVE, FOR JUDGMENT NOTWITHSTANDING THE VERDICT, OR, ALTERNATIVELY, FOR A NEW TRIAL ABSOLUTE.

A. The Jury's Unanimous Verdict As To Proximate Cause Was Supported By The Greater Weight Of The Evidence.

The circuit court did not err in denying Appellant's post-trial motions because the jury received overwhelming evidence that neither Respondents' choice in surgical technique nor their post-operative care proximately caused Appellant's injuries and damages. Appellant misstates the record to try to overcome the jury's unanimous verdict. As a threshold matter, Respondents never conceded causation in any manner as Appellant repeatedly suggests. In fact, as previously discussed, they offered the testimony of Dr. Schimpf and Dr. Lefkowitz to fully rebut the testimony of Appellant's expert on both negligence and causation. Both surgeons testified that Dr. Schimpf complied with the applicable standard of care and that Appellant's injuries were known complications that can be caused by physicians exercising reasonable care; in the absence of negligence. This was supported by the testimony of Appellant's own expert who testified that the complications that Appellant developed can arise even when the right surgical approach is taken, and, in fact, has occurred to his own patients. (R. pp. 377-79). Appellant's treating physician testified similarly. (R. pp. 729, 737). Thus, Appellant's claims that "[t]here was never any doubt at trial that Defendants caused Plaintiffs' injuries" and "there was no controversy as to whether Defendants caused Plaintiff's injuries" are gravely inaccurate and Appellant was not relieved of her burden to prove each and every element of her cause of action. Appellant's claims as to the lack of controversy about causation are also contradicted by the verdict form, which required the jury to assess both negligence and causation.

Appellant's claims that the experts agreed that it was Dr. Schimpf that disrupted the blood supply to Appellant's breasts are equally unfounded. First, Appellant's treating physician did not

offer any testimony as to causation. (R. pp. 725-26). Second, Dr. Lefkowitz did not testify that Dr. Schimpf's **surgical technique** caused the disruption in Appellant's blood flow. The fact that he opined that her blood flow had been disrupted at some point during the surgery is not dispositive on causation or liability because he did not link it to any particular decision of Respondents, including Dr. Schimpf's decision to use the "gold standard" surgical technique and to go above and beyond in order to preserve blood flow by utilizing a larger pedicle. This was fatal to Appellant's first theory of liability because she did not contend that the surgery was performed incorrectly.

More generally, Dr. Lewkowicz's testimony on the disruption is not dispositive because Dr. Schimpf testified within a reasonable degree of medical certainty that, in retrospect, Appellant likely developed venous congestion post-operatively in her home which would explain Appellant's complications as opposed to any surgical cause. (R. pp. 447-51). He also explained that he saw no indication that there was any disruption in Appellant's blood flow during surgery despite extensively looking for evidence of it by checking her capillary refill. (*Id.*). Moreover, both he and Dr. Lefkowitz testified that Dr. Schimpf created a pedicle for Appellant that was several inches larger than what is standard, which promoted greater blood flow to Appellant's nipple/areola complex and made it less likely that the surgical technique would cause a disruption. (R. pp. 430-31, 571-72).

Dr. Joseph likewise did not testify that any action of Dr. Schimpf caused Appellant's fat necrosis and subsequent infection. (R. pp. 509, 520). Consequently, the only evidence before the jury in support of Appellant's theory that Dr. Schimpf's choice in surgical technique caused her injuries and damages was the limited testimony of Appellant's expert, Dr. Hultman, which, again, neither the jury nor circuit court was required to accept above all else, particularly in light of his

admitted relative inexperience with this surgery. Appellant presented no evidence supporting that Respondents' post-operative care caused her any injury despite affirmatively pursuing it as a separate theory of liability. Accordingly, the greater weight of the evidence supports that Respondents did not proximately cause Appellant's injuries and damages and, in turn, the jury's verdict and the circuit court's decision to deny Appellant's post-trial motions. *See McKnight v. S.C. Dept. of Corrections*, 385 S.C. 380, 387, 684 S.E.2d 566, 569 (Ct. App. 2009) (holding that proximate cause is only a matter for the court where the evidence does not support more than one inference).

B. The Jury's Verdict Was Not Inconsistent And In No Way Demonstrated That The Jury Was Confused.

The circuit court also did not err in denying Appellant's post-trial motions because the jury's verdict was not inconsistent. *See e.g., Stevens*, 342 S.C. at 51, 53, 536 S.E.2d at 661, 666 (holding a verdict that found the defendant liable for ***proximately causing*** the plaintiff's injuries yet awarding zero dollars in damages was facially inconsistent); *Herring v. Home Depot, Inc*., 350 S.C. 373, 381, n.16, 565 S.E.2d 773, 777, n.16 (Ct. App. 2002) (internal citation omitted) (illustrating that a verdict in favor of a plaintiff for both revocation of acceptance and breach of warranty would be inconsistent due to their contradictory elements). Instead, it was a verdict indicative that Appellant failed to prove at least one (1) element of her medical malpractice cause of action: proximate cause. This kind of verdict is entirely permissible and appropriate under South Carolina law. *See Dropkin,* 373 S.C. at 365, 644 S.E.2d at 810 (cited above); *see also Vinson v. Hartley*, 324 S.C. 389, 411-12, 477 S.E.2d 715, 727 (Ct. App. 1996) (denying the plaintiff's motion for a new trial where the jury found for the defendant on proximate cause although the defendant admitted negligence). Otherwise, a plaintiff would be relieved of its burden to prove each and every element of its cause of action which is most certainly not the law.

Regardless, even assuming *arguendo* the verdict was inconsistent, it was not irreconcilably inconsistent because in her Complaint and at trial, Appellant argued that Respondents' surgical technique and aftercare violated the standard of care. *Austin*, 387 S.C. at 49, 691 S.E.2d at 149 (internal citation omitted) (holding that verdicts must be irreconcilably inconsistent to warrant a new trial). Appellant's expert never retracted his opinion that Respondents were negligent in not applying topical ointment to Appellant's breast wounds. Moreover, her attorneys included Appellant's criticisms of Respondents' aftercare in their statements to the jury. (R. pp. 590-92). Therefore, it stands to reason that the jury could have found that Respondents' aftercare breached the standard of care, but that their surgical technique did not. Moreover, unlike the verdict in *Stevens*, the verdict reflects that Appellant **did not prove** that her damages were proximately caused by Respondents' alleged deviations. Thus, an award of zero damages is entirely consistent with South Carolina law and does merit reversing the circuit court.

Further, the mere fact that the jury did not find proximate cause does not mean that the jury was confused on the issue. Indeed, the record supports that the opposite was true. The jury was verbally instructed on Appellant's burden of proof as to proximate cause and was also provided with a copy of the instructions. Additionally, the jury was polled after the verdict was read and each juror affirmed that the verdict was, in fact, the one that they had reached. Accordingly, any concerns that the jury was confused as to proximate cause (in addition to assumption of the risk) is entirely speculative, is wholly without support in the record and likewise does not justify Appellant's post-trial motions.

CONCLUSION

At base, this Court is left with a straightforward decision. None of the issues presented by Appellant warrant the reversal of the circuit court, which exercised its discretion and made proper, well-considered decisions to submit assumption of the risk to the jury and deny Appellant's

motions related to the same, as well as to deny Appellant's post-trial motions. The rulings of the circuit court challenged here did not prejudice Appellant, who was able to present her entire case. The jury spent nearly a week hearing the evidence and promptly returned a verdict for Respondents, which is supported by the factual record detailed above. Because there is no indication in this record that the circuit court abused its discretion in any way, this Court should affirm the jury's unanimous verdict in favor of Respondents.

Respectfully submitted,

s/Todd W. Smyth
Todd W. Smyth
Allie A. Maples
Smyth Whitley, LLC
126 Seven Farms Drive, Suite 260
Charleston, South Carolina 29492
Tel: (843) 606-5635
Fax: (843) 654-4095
tsmyth@smythwhitley.com
amaples@smythwhitley.com

Attorneys for Respondents

August 21, 2023

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SC Court of Appeals

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM CHARLESTON COUNTY
Court of Common Pleas

Maite Murphy, Circuit Court Judge

Appellate Case No. 2023-000029
Circuit Court Case No. 2018-CP-10-02109

Rebecca Turisk,

Appellant,

v.

Dennis K. Schimpf, M.D. and
Sweetgrass Plastic Surgery, LLC,

Respondents.

CERTIFICATE OF COMPLIANCE

The undersigned certifies that this Final Brief of Respondents complies with Rule 211(b), SCACR.

Respectfully submitted,

s/Todd W. Smyth
Todd W. Smyth
Allie A. Maples
Smyth Whitley, LLC
126 Seven Farms Drive, Suite 260
Charleston, South Carolina 29492
Tel: (843) 606-5635
tsmyth@smythwhitley.com
amaples@smythwhitley.com
Attorneys for Respondents