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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

Deadra L. Jefferson, Circuit Court Judge

Appellate Case No. 2024-001698

Patricia P. McGougan and Edgar McGougan, …….. Appellants,

v.

Richard F. Frisch, M.D., Timothy E. West, M.D., The Southeastern Spine Institute, L.L.C., and Lowcountry Infectious Diseases, P.A. …… Respondents.

APPELLANTS' BRIEF

Daniel W. Luginbill
Julia M. Flumian
McGowan, Hood, Felder & Phillips, LLC
10 Shem Drive, Suite 300
Mt. Pleasant, SC 29464
dluginbill@mcgowanhood.com
jflumian@mcgowanhood.com

Jordan C. Calloway
McGowan, Hood, Felder & Phillips, LLC
1539 Health Care Drive
Rock Hill, SC 29732
(803) 327-7800
jcalloway@mcgowanhood.com

Attorneys for Appellants

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STATEMENT OF THE ISSUE ON APPEAL

1. Whether the circuit court erred in preventing the defendant infectious disease physician from reading on cross-examination treatment guidelines from a learned medical treatise the physician relied on during his direct examination and admitted was a reliable authority.

STATEMENT OF THE CASE

Appellants Patricia P. McGougan and Edgar McGougan initiated this medical malpractice litigation by filing a Notice of Intent to File Suit ("NOI") on June 13, 2018, with service completed by September 17, 2018. (R. p. 7). The NOI named as defendants Respondents Richard F. Frisch, M.D., Timothy E. West, M.D., The Southeastern Spine Institute, LLC ("Southeastern Spine"), and Lowcountry Infectious Diseases, P.A. ("Lowcountry"). Id. Since the pre-suit mediation ended in an impasse on October 18, 2018, the McGougans filed a Summons and Complaint on November 30, 2018, seeking damages for Ms. McGougan's personal injury and Mr. McGougan's loss of consortium. (R. pp. 11-12 ¶¶ 30-32). These claims arose out of a spinal surgery Dr. Frisch performed on Ms. McGougan at East Cooper Medical Center on August 2, 2016, as well as post-operative care for a surgical site infection. (R. pp. 9-12 ¶¶ 10-32). That care was provided by Dr. Frisch, mid-level providers at his practice (Southeastern Spine), and Dr. West, an infectious disease physician associated with Lowcountry. Respondents served their answers on January 2 and 11, 2019. (R. pp. 13-24).

The matter was tried by a jury and the Honorable Deadra L. Jefferson on September 9-16, 2024. On September 16, 2024, the jury returned a defense verdict, finding none of the Respondents violated the standard of care in treating Ms. McGougan. (R. pp. 1-3). The circuit court denied the McGougans' motion for a new trial under the thirteenth juror doctrine on September 26, 2024. (R. pp. 4-6). The McGougans filed and served a notice of appeal on October 9, 2024. (R. p. 1361).

STATEMENT OF THE FACTS

Patricia McGougan suffered a back injury on July 5, 2016. (R. pp. 395-96). After working a long overnight shift as a nurse supervisor at Loris Community Hospital, Ms. McGougan went out for breakfast and shopping with her husband. (R. p. 395). While reaching for an item in the

grocery line, Ms. McGougan experienced a loud pop and felt pain in her back and leg. Id. A chiropractor and Ms. McGougan's family physician were unable to address her injury and, following a MRI, Ms. McGougan was instructed to seek the assistance of a neurosurgeon. (R. p. 396). Ms. McGougan sought out Dr. Frisch, a neurosurgeon with Southeastern Spine, and he recommended she undergo a discectomy at L4-L5 and a left L4 hemi-laminectomy. (R. pp. 396-98; R. p. 9 ¶ 9).

Dr. Frisch performed the surgery at East Cooper Medical Center on August 2, 2016. (R. p. 9 ¶ 9). After an overnight hospital stay, Ms. McGougan was discharged home, fully expecting to return to work in 6-8 weeks. (R. p. 398). Dr. Frisch prescribed a seven-day course of doxycycline (14 doses) to address the risk of post-operative infection. (R. p. 9 ¶ 10). Ms. McGougan had her initial post-operative appointment at Southeastern Spine on August 16, 2016, during which she saw a physician assistant who noted no sign of infection. (R. p. 9 ¶ 11). Four days later, however, Ms. McGougan's wound reopened and she began to have substantial drainage. (R. pp. 399-400). Over the next several weeks—and through several visits with Southeastern Spine physician assistants—Ms. McGougan's drainage and pain worsened. (R. pp. 400-04). The Southeastern Spine providers failed to collect cultures from the wound drainage. (R. pp. 9-10 ¶¶ 12-15). Ms. McGougan finally saw Dr. Frisch on September 20, 2016. By this point, she was suffering from substantial pain and a fever. (R. p. 10 ¶ 16). Dr. Frisch noted Ms. McGougan had suffered wound dehiscence and admitted her to the hospital for an MRI and blood cultures. (R. p. 406).

The MRI showed a collection of fluid at the surgical site for which the likely diagnosis included post-operative infection. The following day (September 21, 2016), culture results showed Ms. McGougan had heavy growth of the bacteria known as methicillin-resistant staphylococcus aureus ("MRSA"). Ms. McGougan was then by Dr. West, an infectious disease physician with

Lowcountry. Dr. West's initial plan was to delay ordering antibiotics to address the infection for the possibility of surgical exploration of the wound. Dr. Frisch performed a surgical procedure to drain the wound on September 22, 2016, and IV vancomycin was administered prior to the start of the surgery. (R. p. 406; R. p. 10 ¶ 20). Following the surgery, Dr. West prescribed a course of IV vancomycin administered every 12 hours from September 23, 2016, until Ms. McGougan was discharged home on September 26, 2016, for a total of seven (7) doses.

At the time of discharge, cultures from purulent fluid found in Ms. McGougan's surgical wound bed collected during the September drainage procedure showed moderate MRSA growth. Crucially, Dr. West chose to discontinue the IV vancomycin and send Ms. McGougan home with only an oral antibiotic (minocycline 100 mg) to be taken twice-a-day for two weeks. Dr. West was also vague in his instructions about if and when Ms. McGougan should reach out for a follow-up appointment. Ms. McGougan's condition declined substantially over the weeks that followed. By December 13, 2016, Ms. McGougan was suffering from such severe back and leg pain that she could barely get out of bed. An MRI showed granulation tissue at the site of her spinal surgery, and Ms. McGougan was readmitted to East Cooper Medical Center on December 19, 2016. Blood cultures showed continued MRSA growth, and a CT scan showed osteomyelitis (bone infection) at L4-L5. (R. p. 465). Since the infection had been allowed to fester and infiltrate the bone, Ms. McGougan's condition and prognosis worsened. Dr. West started Ms. McGougan on IV antibiotics via a PICC line to treat her worsening bone infection. Her condition was dire. Ms. McGougan remembers that "every day things got worse." Her doctors worried the infection could damage other vital organs, including her heart and kidneys. (R. p. 424). Things got so bad that Ms. McGougan thought she was going to die. Id.

After more than two weeks in the hospital, Ms. McGougan was finally sent home on January 3, 2017, but still had the PICC line and required 3 months of IV vancomycin to address the infection. Yet, Ms. McGougan's pain remained months later. After consulting with Dr. Peter Grossi at Duke Medical Center in Durham, North Carolina, Ms. McGougan learned the damage the bone infection had caused. Scans showed an almost complete collapse of the disc space at L4-L5. Along with the continuing pain and discomfort, the bone infection meant Ms. McGougan would not be able to return to work. (R. pp. 427-28).

The McGougans' suit alleges Respondents' medical malpractice proximately caused Ms. McGougan's damages and Mr. McGougan's loss of consortium. (R. p. 12 ¶¶ 31-32). Specifically, they allege Dr. Frisch and other Southeastern Spine providers breached the standard of care in failing to properly identify and respond to her infection following the original August 2016 spinal surgery. (R. p. 11 ¶ 30). They further allege Dr. West and Lowcountry breached the standard of care in the course of treatment Dr. West selected to address Ms. McGougan's infection during and following the September 2016 hospitalization. Only a short course of IV vancomycin was ordered during the hospitalization, and Dr. West chose to prescribe only oral minocycline when Ms. McGougan was discharged. Given Ms. McGougan's presentation and history, minocycline was not an appropriate medication to fight her complicated SSTI[1]. The standard of care required Dr. West to prescribe either continuation of IV vancomycin or a longer-lasting agent like IV Valvance (an antistaphylococcal agent) or Zyvox (an oral medication).

During the September 2024 trial of this action, Dr. West took the witness stand in his own defense. He testified not only as a fact witness recounting his treatment of Ms. McGougan but also

[1] The IDSA guidelines define complicated skin and soft tissue infection ("SSTI") as "patients with deeper soft-tissue infections, surgical/traumatic wound infection, major abscesses, cellulitis, and infected ulcers and burns."

offered a broad array of opinion testimony about how various antibiotic medications function (R. p. 888) and about matters ranging from his personal research on rheumatology (R. pp. 896-97; 901-02) to treatments for exotic diseases like the bubonic plague and rocky mountain spotted fever (R. p. 899). He also sought to defend his choice of oral minocycline to address Ms. McGougan's infection in September 2016. During direct examination, Dr. West touted guidelines from a medical journal published by the Infectious Diseases Society of America ("IDSA"). (R. p. 890). These were guidelines Dr. West claims he "had in mind" and was "following" when choosing how to address Ms. McGougan's post-operative infection. (R. pp. 889-90). Dr. West then began to quote from the IDSA guidelines to suggest minocycline was an appropriate medication to prescribe for Ms. McGougan and to assert that she had received an ample amount of antibiotics to address her infection. (R. p. 890).

The McGougans' attorney attempted to return to this point on cross-examination. Dr. West again claimed the IDSA guideline "helped formulate [his] decision-making" for Ms. McGougan's care. (R. pp. 931-32). To support that proposition, he then read a portion of Paragraph 5 from the guidelines. (R. p. 932). Then, the McGougans' attorney challenged Dr. West by asking him to read from Paragraph 7 of the same guideline—which appeared on the same page from which Dr. West had just read. (R. pp. 932-33). Dr. West's counsel objected, arguing the very document from which his client had just quoted (and about which counsel had asked during the direct examination) was inadmissible hearsay. (R. pp. 933). The circuit court sustained the objection and stated on the record that Dr. West could not be asked to read from Paragraph 7 of the IDSA guidelines. (R. p. 933).[2]

[2] Dr. West's attorney also objected to a similar attempt to present the IDSA guideline during cross-examination of Dr. West's infectious disease expert. (R. pp. 964-65).

When the trial was over, the jury found no breach in the standard of care by Dr. Frisch and Southeastern Spine or Dr. West and Lowcountry. (R. pp. 1-3). This appeal followed.

STANDARD OF REVIEW

A circuit court's rulings on evidence admissibility issues are reviewed for an abuse of discretion. State v. Blake, 442 S.C. 295, 308, 898 S.E.2d 184, 191 (Ct. App. 2024). An abuse of discretion occurs when the circuit court's ruling was either controlled by an error of law or based on unsupported factual conclusions. State v. Douglas, 369 S.C. 424, 429-30, 632 S.E.2d 845, 848 (2009). A circuit court abuses its discretion by excluding evidence that is "highly probative on the issue of defining [the defendant's] duty of care." Elledge v. Richland/Lexington Sch. Dist. Five, 352 S.C. 179, 188-89, 573 S.E.2d 789, 794 (2002). An evidence admissibility error may lead to reversal and a new trial where the appellant was prejudiced by the error. State v. Garris, 394 S.C. 336, 350, 714 S.E.2d 888, 896 (Ct. App. 2011).

ARGUMENT

The circuit court erred in barring the McGougans' attorney from asking Dr. West to read into evidence a portion of the IDSA guidelines for treating MRSA infections. The guidelines fall squarely within the learned treatise hearsay exception designed to allow a party to challenge their opponent's testimony with scientific literature, especially where even the opponent admits the guidelines are authoritative. Moreover, the court should not overlook the fact that Dr. West himself is the reason IDSA guidelines were brought into this trial. He used them in his direct examination to tell jurors he followed the rules. Fairness dictates he should have to read to jurors other portions of those rules (from the same page) suggesting he deviated from the standard of care. In the end, the circuit court's error left the jury with an incomplete, misleading view of the guidelines. Dr.

West got to claim he met their requirements and complied with the standard of care, but the McGougans were denied the chance to show otherwise. A new trial is needed to correct this error.

1. **The IDSA guideline section the circuit court excluded was admissible under the learned treatise hearsay exception.**

The circuit court abused its discretion in excluding from evidence a paragraph from the IDSA guidelines for treating MRSA infections because the foundation questions asked by the McGougans' attorney and Dr. West's own testimony during his direct examination provided all the prerequisites for applying the learned treatise hearsay exception.

South Carolina law generally excludes from evidence an out-of-court declarant's statement offered for the truth of the matter asserted. Rule 801(c), SCRE (defining "hearsay"); Rule 802, SCRE (generally excluding hearsay from evidence). Dr. West invoked Rule 801 in his objection to Dr. West reading a paragraph from the IDSA guidelines for treating a MRSA infection. (R. p. 933, lines 7-11). The circuit court cited the hearsay rule as its basis for sustaining the objection and instructing the jury to disregard lines from the disputed section Dr. West had already read aloud. (R. p. 933, lines 19-24). That ruling was in error for two reasons.

First, the disputed section of the guidelines did not qualify as "hearsay" because it was not offered for its truth. Instead, the McGougans were using the guidelines to impeach. In response to questions from his own attorney, Dr. West told jurors he "had in mind" the IDSA guidelines when choosing an antibiotic for Ms. McGougan in September 2016 and that he "followed" and "exceeded" the requirements stated in Paragraph 7 of those guidelines in the course of treatment he chose for her. (R. p. 889, line 20 – p. 890, line 19). Dr. West reiterated on cross-examination that he considered IDSA guidelines to "formulate [his] decision-making" in Ms. McGougan's

case. (R. p. 931, line 24 – p. 932, line 2)[3]. He then read Paragraph 5 of the IDSA guideline section titled "What is the management of skin and soft-tissue infections (SSTIs) in the era of the community-associated MRSA (CA-MRSA)?" to support the contention that he had considered the guidelines before choosing an antibiotic to treat Ms. McGougan's MRSA infection. (R. p. 932, lines 20-24). Paragraph 5 of this section addresses "empirical coverage of CA-MRSA in outpatients with SSTI." In response, the McGougans' attorney pursued a line of questioning about Paragraph 7 of this same IDSA section ("Paragraph 7") addressing hospitalized patients like Ms. McGougan with complicated surgical-site infections (C-SSTI). (R. p. 932, line 25 – p. 933, line 6).

The aim was to challenge the credibility of Dr. West's testimony. Dr. West told jurors under oath he used the IDSA guidelines to formulate his treatment plan, but he plainly had not considered the implications of Paragraph 7. Thus, apart from the truth of Paragraph 7's contents, it was properly cited in cross-examination to challenge Dr. West's claimed method for reaching his ultimate prescribing decision. See Baker v. Port City Steel Erectors, Inc., 261 S.C. 469, 474, 200 S.E.2d 681, 682-83 (1973) (holding that a scientific textbook can be used for the purpose of impeaching an expert witness and "testing the reliability of one of the factors used by [the expert] in analyzing the" issue in question). As New York's top court has ruled, clinical practice guidelines like the IDSA guidelines at issue here are admissible as non-hearsay statements when offered during a treating physician's cross-examination "as demonstrative evidence of the steps he had followed" in treating the plaintiff. Hinlicky v. Dreyfuss, 848 N.E.2d 1285, 1289 (N.Y. 2006).

[3] IDSA guidelines are organized by section. "Each section of the guidelines begins with a specific clinical question and is followed by numbered recommendations and a summary of the most relevant evidence in support of the recommendations."

Second, even if the IDSA guidelines were hearsay, the circuit court erred in refusing to allow them to be published to the jury them pursuant to the learned treatise hearsay exception. The general rule against admission of hearsay statements does not apply:

> To the extent called to the attention of an expert witness upon cross-examination or relied upon by the expert witness in direct examination, statements contained in published treatises, periodicals, or pamphlets on a subject of history, medicine, or other science or art, established as a reliable authority by the testimony or admission of the witness or by other expert testimony or by judicial notice. If admitted, the statements may be read into evidence but may not be received as exhibits. This rule is in addition to any statutory provisions on this subject.

Rule 803(18), SCRE.

All requirements for applying this exception were met before Dr. West was asked about Paragraph 7 of the IDSA guidelines. The IDSA guidelines fall within the category of "published treatises, periodicals, or pamphlets on a subject of history, medicine, or other science or art." These guidelines appear in *Clinical Infectious Diseases*, a peer-reviewed medical journal IDSA publishes. Torrey v. Infectious Diseases Soc. of Am., 86 F.4th 701, 702-03 (5th Cir. 2023). The IDSA guidelines specifically, and clinical practice guidelines more broadly, have been recognized as appropriate writings for applying the learned treatise hearsay exception. Emers v. Lyons, Case No. A-4704-13T3, 2015 WL 10434723, at * 4 (N.J. Super. App. Div. Mar. 8, 2016) (finding IDSA guidelines qualified as learned treatise and were properly used during cross-examination of expert witness in medical malpractice trial); Guthrie v. Ball, No. 1:11-cv-333-SKL, 2014 WL 5471531, at * 6 (E.D. Tenn. Oct. 17, 2014) (finding pain management guidelines covered by federal rule 803(18)).

It is also evident from the record the IDSA guidelines had been "relied upon by [Dr. West] in direct examination." His own attorney asked Dr. West about the IDSA guideline section specific to the management of skin and soft tissue infections in the era of community-associated MRSA,

and Dr. West confidently claimed to have "followed" and "exceeded" its requirements. (R. p. 890, lines 17-18). Moreover, the IDSA guidelines were "established as a reliable authority" when Dr. West testified the guidelines are used in an infectious disease physician's process for recommending antibiotics for patients. (R. p. 889, line 22 – p. 890, line 2). Dr. West vouched for the IDSA guidelines' authority as an IDSA member. (R. p. 890, lines 3-6). This point cannot be seriously questioned as other courts have recognized how important the IDSA guidelines are in the field of infectious disease medicine. See e.g. Va. Bd. of Med. v. Zackrison, 796 S.E.2d 866, 869-70 (Va. App. 2017) (describing IDSA as "a private organization of health care professionals often cited by the federal Centers for Disease Control and Prevention" that offers "peer-reviewed guidelines").

Additionally, the learned treatise hearsay exception applied here because Dr. West was testifying as an "expert witness." While Dr. West is a named defendant in this litigation, that does not prevent him from testifying as an expert witness at trial. Ward v. Epting, 290 S.C. 547, 555-56, 351 S.E.2d 867, 872 (Ct. App. 1986). Defense counsel claiming a defendant physician is solely a fact witness does not make it so. Id. What matters is the type of testimony counsel elicits or the physician chooses to provide. Ward held that a treating physician steps into the role of an expert witness when (1) his qualifications were discussed during direct examination; (2) he testified as to the routine practice for addressing a condition like that suffered by the plaintiff in addition to the physician's specific conduct in treating the plaintiff; or (3) he gave an opinion as to the cause of certain medical conditions suffered by the plaintiff. Id.

Dr. West's testimony did all of these things and more. The first few pages of Dr. West's direct examination testimony are nothing but a recitation of his educational background and other professional credentials. (R. pp. 860-61). Dr. West then went on to describe in detail his work with

an AIDS clinic in New York in the 1980s that, while laudable, bears no connection to the specific facts of Ms. McGougan's MRSA infection and the proper course of treatment. (R. pp. 861-62). Throughout his direct exam, Dr. West went well beyond Ms. McGougan's care to discuss broader infectious disease medicine and even to dabble in other medical specialties. He did not limit his testimony to his treatment of Ms. McGougan or even MRSA in general, as he discussed the proper antibiotics for treating exotic diseases ranging from rocky mountain spotted fever to bubonic plague. (R. p. 899) ("Has minocycline been used to treat things like the plague?"). At one point, Dr. West began offering comments on the proper practice for rheumatologists. (R. p. 896) ("I looked at the guidelines . . . from the rheumatology societies . . ."). Dr. West then admitted to a quintessentially expert witness activity—consulting medical literature on an unfamiliar subject in order to offer an in-court opinion. (R. pp. 903-04) (discussing his research on studies related to various rheumatoid arthritis medications). Dr. West concluded his direct examination with a standard of care opinion. (R. p. 905). Ward is consistent with rulings from many other jurisdictions finding this type of testimony transforms a treating physician into an expert witness. See e.g. Rowland v. Novartis Pharm. Corp., 9 F. Supp. 3d 553, 556 (W.D. Pa. 2014) ("treating physicians' opinions on prognosis and causation are inherently expert testimony"); Montoya v. Sheldon, 286 F.R.D. 602, 613-14 (D.N.M. 2012) ("treating physician's opinions regarding diagnosis of a medical condition is almost always expert testimony"); Langston v. Kidder, 670 So.2d 1, 4 (Miss. 1995) (defendant treating physician is offering expert opinion if he "testif[ies] to industry standards and whether the defendant met those standards").

Finally, the cross-examination of Dr. West regarding Paragraph 7 from the IDSA guideline section regarding the management of skin and soft-tissue infections in the era of community-associated MRSA remained within the substantive limitations for learned treatise testimony. Rule

803(18), SCRE (providing that these statements "may be read into evidence but may not be received as exhibits"); Mizell v. Glover, 351 S.C. 392, 403-04, 570 S.E.2d 176, 182 (2002) (finding circuit court properly applied Rule 803(18), SCRE in permitting questioning about medical article and allowing article to be read during questioning). Dr. West was in the process of reading Paragraph 7 when defense counsel lodged his objection, and the circuit court incorrectly sustained the objection after instructing the jury to disregard what Dr. West had begun reading. (R. p. 933, line 5-24).

In sum, the circuit court abused its discretion by excluding Paragraph 7 of the IDSA guidelines. Since this material was offered to impeach rather than for its truth, it did not meet the definition of a hearsay statement. Moreover, the circuit court's ruling is contradicted by the plain language of Rule 803(18), which permits the publication of material from a learned treatise under the circumstances presented during Dr. West's cross-examination.

2. Permitting Dr. West to introduce one portion of the IDSA guidelines and to prevent admission of an adjacent portion is fundamentally unfair and deprived the jury of essential context.

This appeal is not just about a straightforward application of the learned treatise hearsay exception. It is also about whether the parties were treated fairly in their use of the same proposed evidence and whether the jury was afforded adequate context for applying that evidence to the complex medical questions they were asked to weigh in their deliberations. As such, the circuit court abused its discretion in excluding Paragraph 7 from the IDSA guidelines for a second reason: Dr. West had offered a different paragraph from the same section of the guidelines into evidence to support his defense, and the circuit court's ruling meant the McGougans were denied the opportunity to show jurors an adjacent paragraph calling Dr. West's position into question.

When Dr. West brought the IDSA guidelines into this trial by citing, touting, and seeking protection within them (R. p. 889, line 20 – p. 890, line 19), he implicated the long-standing evidentiary principle commonly known as the "rule of completeness" which is now codified in the South Carolina Rules of Evidence as follows:

> When a writing, or recorded statement or part thereof is introduced by a party, an adverse party may require the introduction at that time of any other part or any other writing or recorded statement which ought in fairness to be considered contemporaneously with it.

Rule 106, SCRE. The note accompanying Rule 106 states, "the party seeking to bring out the remainder must do so during cross-examination or during that party's case."

This fundamental evidentiary principle arises from two common sense ideas. First, if a party presents the defense-friendly parts of a document to the jury, it is only fair to permit that party's opponent to show the jury plaintiff-friendly parts of the same document. State v. Tennant, 394 S.C. 5, 15, 714 S.E.2d 297, 302 (2011) ("The standard here is "fairness"). Second, since a trial is a search for truth and the burden of determining truth falls to the jury, jurors ought to be provided adequate context for the documentary evidence they are asked to consider. State v. Oglesby, 384 S.C. 289, 294, 681 S.E.2d 620, 622 (Ct. App. 2009) (holding that the rule's purpose is to "avoid the unfairness inherent in the misleading impression created by taking a conversation out of context").

Thus, while Dr. West and his attorneys had the choice of whether he would read part of the IDSA guideline section into the record in an attempt to justify his decision to prescribe a hospitalized patient with a complicated SSTI only a short course of an oral antibiotic, that choice had consequences. At the very least, doing so opened the door for the McGougans to ask Dr. West on cross-examination to read to jurors an adjacent provision of the same guideline section that rejected the clinical course he chose. In other words, if jurors were going to be asked to consider

an IDSA guideline section in reaching their verdict[4], they ought to have at least received a full picture of precisely what the relevant guideline section says.

In the end, when Dr. West's counsel stood up to object as Dr. West read Paragraph 7 and the circuit court sustained that objection, the effective result was that the jury got only part of the relevant information. To provide the necessary context and to ensure fairness to all parties, Rule 106 required the circuit court to permit Dr. West to read Paragraph 7 into the record during cross-examination. By preventing Dr. West from doing so and instructing jurors to ignore the portion of Paragraph 7 already read, the circuit court violated Rule 106 and abused its discretion.

3. The wrongfully excluded evidence had unique probative value and its exclusion prejudiced the McGougans' case.

Finally, the Court should reject any attempt by Respondents to argue the improperly excluded portion of the IDSA guidelines caused the McGougans no harm. Excluding this important evidence was prejudicial because, as Dr. West's own testimony and his attorney's arguments to the jury show, the guidelines were a crucial issue in the case. Additionally, the unique probative value of industry-standard evidence has a unique probative value for which there was no effective substitute.

The McGougans bear the burden to show both legal error and prejudice arising from the error. Matter of Daily, 443 S.C. 557, 567, 905 S.E.2d 310, 315 (Ct. App. 2024). A legal error is considered harmless when circumstances show, beyond a reasonable doubt, the error did not contribute to the verdict. Id. The South Carolina Supreme Court has set forth factors for evaluating whether improperly excluded evidence prejudiced its proponent. Those factors include (1) whether

[4] Jurors were asked to make this consideration. Dr. West's attorney claimed during his closing argument that Dr. West and Ms. McGougan's other providers "knew what they were doing. They ***knew the guidelines***." (R. p. 1117, lines 11-12) (emphasis added).

equivalent or cumulative evidence or testimony was offered; (2) whether the aggrieved party still managed to accomplish its primary objective; (3) whether the jury's verdict rendered the wrongly excluded evidence moot because it concerned an issue the jury did not have to reach; (4) whether the aggrieved party would still fail to establish her claim considering both the admitted and wrongfully excluded evidence; and (5) whether the wrongfully excluded evidence involved a generally known fact. Fields v. Reg'l Med. Ctr. Orangeburg, 363 S.C. 19, 32-33, 609 S.E.2d 506, 512-13 (2005). These factors show there was prejudice in this case.

For the first factor, the South Carolina Supreme Court has recognized there is simply no equivalent or substitute for the type of evidence the circuit court wrongfully excluded here. Elledge v. Richland/Lexington Sch. Dist. Five, 352 S.C. 179, 188-89, 573 S.E.2d 789 (2002). The analysis starts by recognizing the important role a document like the IDSA guidelines can have in evaluating the performance of a professional like Dr. West. Courts have long recognized industry safety standards are important evidence to establish the standard of care in a negligence claim. Elledge, 352 S.C. at 186, 573 S.E.2d at 793 (collecting cases); see also Jolly v. Gen. Elec. Co., 435 S.C. 607, 652, 869 S.E.2d 819, 843 (Ct. App. 2021). Industry standards are important indicators of "safety practices or rules generally prevailing in the industry" from which they arise. Elledge, 352 S.C. at 186, 573 S.E.2d at 793 (quoting McComish v. DeSoi, 200 A.2d 116, 121 (N.J. 1964)).

This general rule applies with even greater force when it comes to the IDSA guidelines. Courts from around the country recognize the IDSA guidelines not just as relevant to the standard of care for medical providers but as fully stating the standard of care for addressing a patient's infection. Carley v. Aranas, 103 F.4th 653, 656 (9th Cir. 2024) (citing expert testimony describing IDSA recommendations as "the standard of care for [Hepatitis C] treatment"); Atkins v. Parker, 972 F.3d 734, 741 (6th Cir. 2020) (recognizing IDSA as one of the "organizations responsible for

setting the standard of care for hepatitis C"); Barfield v. Semple, No. 3:18-cv-1198, 2019 WL 3680331, at * 2 (D. Conn. Aug. 6, 2019) (holding that IDSA guidelines "set forth the medical standard of care for the treatment" of Hepatitis C). Even the federal government recognizes these guidelines as the governing standard for infectious disease specialists. Abu-Jamal v. Wetzel, No. 3:16-cv-2000, 2017 WL 34700, at * 4 (M.D. Pa. Jan. 3, 2017) (noting U.S. Center for Disease Control and Prevention points to IDSA guidelines as the standard of care for the treatment of hepatitis C).

Elledge is also crucial precedent to show why Paragraph 7 of the IDSA guidelines was irreplaceable. There, the South Carolina Supreme Court held wrongfully excluded industry standard evidence was not rendered cumulative by the standard of care testimony of the plaintiff's expert. 352 S.C. at 188-89, 573 S.E.2d at 794. A retained expert offering his/her opinion on the standard of care is probative evidence, but it is no substitute for the rhetorical and persuasive power of an objective industry standard compelling a course of conduct. In fact, this sort of evidence is often used in conjunction with an expert's testimony for the specific purpose of fortifying the expert's opinion. Id. at 188, 573 S.E.2d at 794 (quoting Brown v. Clark Equip. Co., 618 P.2d 267, 276 (Haw. 1980) (finding industry safety code evidence "admissible as an alternative to *or* utilized *to buttress* expert testimony") (emphasis added)).

The second factor also favors the McGougans as there was no alternative means to meet their primary objective in offering Paragraph 7 into evidence. The McGougans' primary objective with Paragraph 7 was to provide jurors a fuller picture of what the IDSA guidelines actually said and to address the misleading image of these guidelines left by Dr. West's reference to them in his direct examination. That objective could not be met in the absence of the wrongfully excluded evidence. In fact, this case goes beyond even the typical application of Elledge because the

McGougans were denied the chance to directly confront Dr. West with text from the IDSA guidelines at odds with his attempt to use the guidelines to his advantage. There is simply no substitute or viable equivalent to the side-by-side of Dr. West's claim regarding the IDSA guidelines and the provisions of Paragraph 7 that the circuit court halted from entering the record.

There is also no indication of mootness, the sign of harmlessness considered in Fields' third factor. The wrongfully excluded evidence concerned the proper course of antibiotics for a hospitalized patient with a complex surgical site infection (R. p. 933, lines 3-6). That evidence was directly related to the standard of care Dr. West was required to meet in his role as Ms. McGougan's infectious disease physician. Dr. West's compliance with the standard care was an issue the jury was required to reach. It was the very first Dr. West-specific question on the verdict form, and the jury could not complete its task without addressing the matter. (R. p. 1).

Fields' fourth factor considers the relative importance of the wrongfully excluded evidence by asking whether its inclusion likely would have made a difference in the outcome of the case. This factor also favors the McGougans. As discussed above, the IDSA guidelines are a crucial factor in defining an infectious disease physician's standard of care, and Paragraph 7's contents were directly on point for this case. They were specifically targeted at hospitalized patients with surgical site infections—the precise situation Ms. McGougan faced when Dr. West chose to send her home with only a short course of an oral antibiotic. The relative importance of the IDSA guidelines is also evident from just how often the issue came up in closing arguments. The McGougans (R. pp. 1047, 1049, 1131) and Dr. West (R. pp. 1113-14, 1117) presented arguments to the jury on the guidelines. Notably, Dr. West's counsel did not just reference the guidelines in the abstract. He argued Dr. West "knew the guidelines" and "knew exactly what they required." (R. p. 1114, lines 3-4). With the aid of the circuit court's erroneous ruling, Dr. West succeeded in

presenting his view of the guidelines during his direct examination, preventing essential context from entering the record on cross, and then telling the jury the guidelines' "exact[]" language supported his prescription decision. This progression of events underscores the prejudice the wrongfully excluded evidence caused in this case.[5]

In sum, the wrongful exclusion of Paragraph 7 of the IDSA guidelines from evidence was a prejudicial error because it concerns Dr. West's standard of care, a crucial issue in the case. Plus, there could be no equivalent to the unique probative value of the IDSA guidelines' precise language, and, pursuant to Elledge, this form of industry-standard evidence supports rather than duplicates expert testimony on the standard of care. Under the prejudice analysis established in Fields, the evidence excluded here was crucial, its exclusion was prejudicial, and the proper remedy is a new trial.

CONCLUSION

Based on the arguments stated above, the McGougans respectfully request the Court reverse the circuit court's ruling preventing the admission of critical language from the IDSA guidelines. This text was a proper matter to impeach Dr. West, and even if it was hearsay, it fell well within the reach of Rule 803(18), SCRE's learned treatise hearsay exception. Moreover, since Dr. West is the one who brought the guidelines into this trial and read a portion of them to jurors to exculpate himself, Rule 106, SCRE's "rule of completion" shows that it was only fair that the McGougans be allowed to compel Dr. West to read the adjacent text from Paragraph 7. By ruling otherwise, the circuit court abused its discretion by disregarding multiple rules of evidence. Since

[5] Factor five also plainly favors the McGougans as the IDSA guidelines' contents and the proper course of treatment for a hospitalized patient with a post-operative infection are not generally known facts. Each side presented documentary evidence and expert testimony on these questions precisely because they go beyond the realm of common knowledge.

this error concerned evidence on a key issue for which there was no comparable alternative, the error was prejudicial and a new trial should be ordered.

Respectfully submitted.

s/s Jordan C. Calloway
Daniel W. Luginbill
Julia M. Flumian
McGowan, Hood, Felder & Phillips, LLC
10 Shem Drive, Suite 300
Mt. Pleasant, SC 29464
dluginbill@mcgowanhood.com
jflumian@mcgowanhood.com

Jordan C. Calloway
McGowan, Hood, Felder & Phillips, LLC
1539 Health Care Drive
Rock Hill, SC 29732
(803) 327-7800
jcalloway@mcgowanhood.com

Attorneys for Appellants

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