THE STATE OF SOUTH CAROLINA
In the Supreme Court

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S.C. SUPREME COURT

APPEAL FROM CHARLESTON COUNTY
Court of Common Pleas

Maite Murphy, Circuit Court Judge

Appellate Case No. 2026-000340

Rebecca Turisk,

Petitioner,

v.

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

Respondents.

**RESPONDENTS DENNIS K. SCHIMPF, M.D.
AND SWEETGRASS PLASTIC SURGERY, LLC'S RETURN**

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COUNTER QUESTIONS PRESENTED

I. WHETHER THE COURT OF APPEALS CORRECTLY HELD THAT THE CIRCUIT COURT'S INCLUSION OF AN ASSUMPTION OF RISK INSTRUCTION WAS NOT PREJUDICIAL WHERE THE JURY'S SPECIFIC FINDING OF A BREACH OF THE STANDARD OF CARE AFFIRMATIVELY DEMONSTRATED THAT THEY WERE NOT CONFUSED BY THE INSTRUCTION AND THEY DID NOT APPLY THE DOCTRINE?

II. WHETHER THE COURT OF APPEALS PROPERLY AFFIRMED THE DENIAL OF PETITIONER'S POST-TRIAL MOTIONS WHERE (A) THE RECORD CONTAINED EVIDENCE THAT THE SURGICAL TECHNIQUE AT ISSUE DID NOT PROXIMATELY CAUSE THE INJURY THAT ALL OF THE EXPERTS AGREED WAS A KNOWN COMPLICATION OF SURGERY; AND (B) THE JURY'S VERDICT WAS LOGICAL BASED ON THE DISTINCTION BETWEEN A BREACH IN TECHNIQUE SELECTION AND THE ACTUAL CAUSATION OF A KNOWN SURGICAL COMPLICATION?

COUNTER 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, Petitioner, who is simply dissatisfied with the jury's finding that she failed to meet her burden of proof with respect to proximate cause and the award of no damages, asks this Court to substitute its judgment for that of the jury by reversing South Carolina Supreme Court precedent and by generally relieving her of her burden to prove each and every element of her medical negligence cause of action. The Court of Appeals properly refused to do so and, respectfully, this Court should too by denying the Petition.

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 surgeon with over fifteen (15) years of experience. (R. pp. 411-12). Petitioner 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, Petitioner 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 Petitioner's medical history, discussed her surgical goals, and performed a physical examination, which Petitioner acknowledges. (*Id.,* R. p. 303). Specifically, Dr. Schimpf examined Petitioner's breasts, measured her nipple to clavicle length, and graded her ptosis (i.e., drooping), which revealed that Petitioner's neck and back pain were directly related to her documented large, pendulous breasts. (R. p. 911). Consequently, Dr. Schimpf recommended that Petitioner 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 Petitioner, 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, Petitioner knew the risks described to her were real risks and she did not have any questions about them. (*Id.*).

On October 27, 2016, Petitioner returned to Respondents for a pre-operative appointment. (R. pp. 908-09). During this appointment, Respondents discussed the surgical risks with Petitioner for a second time, as well as the alternatives to surgery. (*Id.*, R. p. 305). Their conversation was memorialized in writing and signed by Petitioner. (*Id.*).

On November 1, 2016, Petitioner presented to Respondents for her breast reduction surgery. (R. pp. 913-14). Prior to operating, Dr. Schimpf designed and physically pre-marked onto

Petitioner 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 Petitioner'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 Petitioner'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 Petitioner; discussed that he would be removing Petitioner's implants and tissue and that he would be moving up the nipple/areola complex. (R. pp. 426, 913-14). In response, Petitioner again voiced her understanding and consented to the surgery. (*Id.*).

After providing the appropriate informed consent for a third time, Dr. Schimpf subsequently performed Petitioner's breast reduction surgery and with special attention to the blood flow to Petitioner's nipple/areola complex, as acknowledged by Petitioner's expert, as well as his own: Dr. Todd Lefkowitz, a board-certified plastic surgeon that, unlike Petitioner'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)[1]. 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 Petitioner's

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

nipple/areola complex had been disrupted in any way despite properly looking for evidence of the same on multiple occasions throughout the procedure as well as post-operatively. Ultimately, Respondents discharged Petitioner to the care of her friend on the same day and with aftercare instructions. (R. p. 907).

The day after her surgery, Petitioner's caregivers contacted Respondents several times and informed Dr. Schimpf that Petitioner 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 Petitioner'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 Petitioner's caregivers called Dr. Schimpf and reported that Petitioner had dark red serosanguinous drainage and a reported fever. (R. p. 943). Accordingly, Respondents scheduled an appointment for Petitioner the next day. (*Id.*). On November 8, 2016, Petitioner 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.*). Petitioner 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, Petitioner was scheduled

for a two (2) week follow-up visit. (*Id.*).

However, prior to her follow up visit, on November 27, 2016, Petitioner presented to an emergency room for breast-related complaints. (R. p. 946). There, it was discovered that, although Petitioner 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 Petitioner in-office the next day. (*Id.*). On November 28, 2016, Dr. Schimpf met with Petitioner 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). Petitioner never returned to Dr. Schimpf or Respondents after this appointment.

In the weeks that followed, Petitioner 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 Petitioner'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, Petitioner initiated this lawsuit by filing a Complaint in the Court of

Common Pleas for Charleston County (R. pp. 18-25). Contrary to Petitioner's contention on appeal, in her Complaint, Petitioner 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 in the exercise of ordinary care, Defendants could not have foreseen or anticipated that Petitioner would, indeed, incur a known complication because, as detailed above, Respondents took more than one (1) reasonable measure to preserve blood flow to Petitioner's nipple/areola complex and ensure that she healed properly in the post-operative period. (*Id.* at p. 29, ¶ 5).

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

Moreover, Petitioner's expert separated his opinions about Dr. Schimpf in two (2) parts and testified that his second opinion was that Dr. Schimpf should have applied a topical antibiotic to Petitioner'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 Petitioner's

claimed injuries or damages. As a result, Petitioner did not present any evidence of causation for her second distinct theory of liability.[2] Additionally, Respondents' infectious disease expert, Dr. Patrick Joseph, testified that an administration of a topical antibiotic would not have changed Petitioner's outcome, which undermined it completely. (R. p. 517).

Regarding Petitioner's other theory of liability, that Respondents allegedly selected the wrong surgical technique, Petitioner 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. (R. pp. 337-38, 353-55, 371, 376-77). Even with his criticisms of Dr. Schimpf, Petitioner's expert agreed that "the fact that a patient's blood flow may be affected in some ways postoperatively doesn't necessarily mean the surgery was performed the wrong way" and that Dr. Schimpf did not injure Petitioner's blood vessels. (R. p. 237).

Respondents' expert, Dr. Lefkowitz, testified similarly and thoroughly rebutted Petitioner's criticisms of Dr. Schimpf's technique. Specifically, Dr. Lefkowitz testified that Dr. Schimpf selected the proper technique for Petitioner'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 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 Petitioner unfortunately developed known complications after surgery through no fault of Dr. Schimpf, especially since he created a wider pedicle to mitigate potential blood flow issues**. (R. pp. 534-35, 546).

Dr. Schimpf likewise testified that he met the standard of care, that the inferior pedicle

[2] While not mentioned in the Court of Appeals' Opinion, Respondents maintain that Petitioner's failure to meet to her burden with respect to her second theory of liability also supports the jury's verdict.

technique was appropriate for Petitioner 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 Petitioner's repeated assertion, Dr. Schimpf did not testify that Petitioner was "high risk." Instead, he explained to the jury why the technique suggested by Petitioner's expert (i.e., the superior pedicle technique) would not have been appropriate and would have, in fact, been riskier for Petitioner given the size, weight, and drooping of her breasts. (R. pp. 438-39).

Dr. Schimpf also explained another potential cause of Petitioner'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 Petitioner, 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 Petitioner 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 Petitioner 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, contrary to Petitioner's sole position on appeal, not everyone agreed that the blood supply to Petitioner's breasts was disrupted as a result of Dr. Schimpf's surgical technique as Petitioner now tries to assert. In fact, the evidence

presented to the jury demonstrated that Dr. Schimpf was aware of the potential issue and planned his surgical approach in a way that would mitigate against such a problem, and that she developed a complication unrelated to the surgical approach. (R. pp. 301-303, 389-399),

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 Petitioner'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 that Respondents met the standard of care with respect to Petitioner's surgery and post-operative care, and that neither Petitioner's claimed damages nor outcome were caused by medical negligence. While Respondents also presented evidence of informed consent, they did not state that it was a central tenant of their defense *to the jury* – only to the Circuit Court during Motions in Limine. (R. p. 22).

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 Petitioner 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 Petitioner 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, Petitioner 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 Petitioner's post-trial motion was that the jury was somehow confused because they did not award Petitioner any damages despite evidence of her poor surgical outcome and that the verdict was inconsistent and against the greater weight of the evidence. Petitioner did not make any arguments about assumption of the risk.

Similar to her Final Brief to the Court of Appeals, in her post-trial motion, Petitioner 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 Petitioner's after care (versus the choice in surgical technique) but that the asserted breach did not cause Petitioner's injuries and damages. Petitioner'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, just as the Court of Appeals found, the circuit court's order denying Petitioner'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 a seemingly 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." *Davis*, 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 through expert testimony both a deviation from the standard of care and that ***the deviation proximately caused harm*** 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. *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 COURT OF APPEALS DID NOT ERR IN HOLDING THAT THE ASSUMPTION OF THE RISK JURY INSTRUCTION WAS NOT PREJUDICIAL BECAUSE THE INSTRUCTION WAS NOT CONFUSING AND THE JURY DID NOT APPLY ASSUMPTION OF THE RISK ANYWAY, SO THE INSTRUCTION COULD NOT HAVE AFFECTED THE OUTCOME OF THE TRIAL.

Petitioner neglects that her cause of action has multiple elements so she naturally does not understand that assumption of the risk can only affect one element (i.e., the duty component of negligence) in her effort to assign error. However, while relying on the same sound precedent of this Court, both the circuit court and the Court of Appeals correctly characterized the application of assumption of the risk in South Carolina. *See Cole v. S.C. Elec. & Gas, Inc.*, 362 S.C. 445, 453, 608 S.E.2d 859, 863 (2005) ("Primary implied assumption of the risk arises when the plaintiff impliedly assumes risks inherent in a particular activity. It is not a true affirmative defense but is

another way of stating there is no duty to the plaintiff.") (internal citation omitted); *Davenport v. Cotton Hope Plantation Horizontal Prop. Regime*, 333 S.C. 71, 81, 508 S.E.2d 565, 570 (1998) ("Primary implied assumption of risk is not a true affirmative defense[] but instead goes to the initial determination of whether the defendant's legal duty encompasses the risk encountered by the plaintiff."). Specifically, the Court of Appeals held that "assumption of risk contemplates whether a defendant's duty encompasses a particular risk." This was echoed in the instruction at issue. *Compare* Opinion, p. 8 *with* (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.").[3] Thus, the instruction merely stated the letter of the law and cannot be said to be confusing.

Plus, there is no evidence that the jury was at all confused by the circuit 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. Petitioner relies heavily on the jury's note regarding "ramifications," but this only demonstrates that the jury was carefully distinguishing between deviation from the standard of care and causation, which is exactly what the law required them to do.

Further, the mere fact that assumption of the risk was offered as part of the larger instruction is not sufficient to overturn the circuit court because it simply could not have affected the outcome of the trial. *See Cole*, 378 S.C. at 404, 663 S.E.2d at 33. As discussed above, the jury found for Petitioner on deviation or breach – which contains the only element of the verdict that could possibly be affected by assumption of the risk (i.e., duty). In other words, the jury necessarily

[3] Although not required under South Carolina law, this is arguably the "redemptive" or "clarifying" language that Petitioner claims the circuit court's instruction lacked and distinguishes it from *Cole*.

found that Respondents owed a duty and were not relieved of it by the Petitioner's "assumption of risk." This is the curative factual finding that renders any error in the instruction moot.

The Court of Appeals reached the same, correct conclusion: "The jury may only reach proximate cause once the existence of a duty, the standard of care, and a breach of that standard have already been established. By reaching proximate cause, the jury rejected the theory that Turisk assumed the risk of her injuries." Therefore, even assuming *arguendo* that the instruction had the potential to confuse jurors, Petitioner cannot prove that she was prejudiced by it. Indeed, the jury's verdict and the Court of Appeals' Opinion indicates that she refuted it.[4]

Furthermore, while there was a wealth of evidence that Respondents properly obtained Petitioner's informed consent prior to operating, assumption of the risk was not as significant at the trial as Petitioner insists. Instead, Respondents principally defended the case based on the evidence that Respondents chose the correct and "gold standard" surgical technique, Respondents provided Petitioner with proper post-operative care, and that Petitioner's injuries were known complications that can occur in the absence of negligence. In other words, Respondents defended that negligence did not cause Petitioner's injuries and damages. The jury's verdict is entirely consistent with this and should not be disturbed.

[4] "There is no testimony or indication that Turisk was aware of the different techniques Dr. Schimpf could have used to perform the surgery, nor is there any evidence that she consented to a particular technique. Moreover, even if she had consented to Dr. Schimpf's use of the inferior pedicle technique, there is no evidence that she fully understood and appreciated the risks of this technique compared to any other." Opinion, p. 7.

II. THE COURT OF APPEALS DID NOT ERR IN HOLDING DENYING PETITIONER'S POST-TRIAL MOTIONS BECAUSE THE RECORD FACTUALLY SUPPORTS AND EXPLAINS THE JURY'S VERDICT.

A. The jury's proximate cause decision was a factual determination based on conflicting expert testimony.

Petitioner conflates complication with causation. However, the Court of Appeals properly recognized that known surgical complications exist and that the jurors were presented with a factual choice as to whether (i) the technique – right or wrong – caused Petitioner's disruption in blood flow and the resulting necrosis or (ii) Petitioner experienced a known surgical complication. As the Court of Appeals noted, every expert at trial recognized that inadequate blood flow and necrosis can occur as a natural consequence of Petitioner's surgery, regardless of the technique used. In fact, Petitioner's own expert admitted that his own patients have suffered from complications even when he has chosen the right surgical approach. (R. pp. 377-79). While Petitioner's expert then opined that Petitioner's complication was due to negligent technique selection, Dr. Schimpf and his experts disagreed.

Moreover, although he was under no obligation to do so as a defendant without a burden of proof, Dr. Schimpf did offer an alternate explanation for what occurred within a reasonable degree of medical certainty. He testified that, in retrospect, Petitioner likely developed venous congestion post-operatively in her home which would explain Petitioner'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 Petitioner'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 Petitioner that was several inches larger than what is standard, which promoted greater blood flow to Petitioner's nipple/areola complex and made it less likely that the surgical technique would cause a disruption. (R. pp. 430-31, 571-72).

Consequently, the only evidence before the jury in support of Petitioner's theory that Dr. Schimpf's choice in surgical technique caused her injuries was the limited testimony of Petitioner's expert, Dr. Hultman, which, the jury was not required to accept above all else, particularly in light of his admitted relative inexperience with this surgery. The existence of choice is controlling because it keeps proximate cause within the providence of the jury. *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).

To try to overcome this, Petitioner argues that the Court of Appeals made a credibility determination by using the word "credible" in the Opinion. This is a red herring. First, the Court of Appeals specified in the Opinion that "neither the trial court nor the appellate court has the authority to decide credibility issues or to resolve conflicts in the testimony or the evidence." Second, the Court of Appeals did not disregard Petitioner's expert for Dr. Schimpf or anyone else. If anything, they only reinforced Petitioner's expert's opinion on Dr. Schimpf's surgical technique since they did not take into consideration the post-operative care issues in the case. However, the Court of Appeals nonetheless had to respect the jury's determination that Dr. Schimpf and/or his experts were more credible when it came to causation because the jury was also specifically presented with conflicting expert testimony on this element.

Petitioner also contends that the Court of Appeals created a heightened proximate cause standard. However, this, too, is wholly without merit. Like the circuit court, the Court of Appeals held that since surgery already carries a risk of disruptions to blood flow, Petitioner had to prove that her complication was not inherent to the breast surgery but ***because of*** the technique selected. This is the law of South Carolina though. South Carolina requires plaintiffs to prove a causal link between the alleged negligence and their outcome. Petitioner's position, on the other hand, would

require the Court to reverse years of precedent and infer causation based on negligence alone. *See Dumont*, 80 F. Supp. 2d at 581 (cited *supra*); *Ward*, 290 S.C. at 561, 351 S.E.2d at 875. Petitioner's position would negate their burden of proof as to an essential element to her cause of action.

It would also require the Court to engage in the type of credibility consideration that Petitioner wants to avoid. The Court would have to ignore Dr. Lefkowitz's testimony that if "not a drop of blood got through the scar," due to Dr. Schimpf's choice of technique, Dr. Schimpf mitigated any ***increased*** risk of blood flow disruption by cutting a larger-than-standard pedicle. This is not the standard of review and does not justify the Petition.

B. The jury's verdict was not inconsistent.

The jury's verdict is both possible and permissible. *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). As the experts testified and is discussed above, complications are not usually, and certainly not always, caused by negligence. This is precisely why plaintiffs are required to prove the element of causation in medical malpractice. Petitioner attempted to do so through her expert but was met with competing expert testimony from Dr. Leftkowitz (and Dr. Schimpf). The record indicates that the jury considered both sides and, based on their verdict, decided that Dr. Lefkowitz's testimony that the larger pedicle mitigated the increased risk of disruptions to blood flow meant the technique did not cause Petitioner's injuries. Accordingly, any concerns that the jury was confused as to proximate cause (in addition to assumption of the risk) are entirely speculative, wholly without support, and likewise does not justify Petitioner's post-trial motions or this Petition.

CONCLUSION

None of the issues presented by Petitioner warrant reconsideration, let alone a new trial. The rulings of the circuit court challenged here did not prejudice Petitioner, who was able to present her entire case and overcome any possible influence of assumption of the risk. 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 and deny the Petition.

Respectfully submitted,

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April 8, 2026

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S.C. SUPREME COURT

THE STATE OF SOUTH CAROLINA
In the Supreme Court

APPEAL FROM CHARLESTON COUNTY
Court of Common Pleas

The Honorable Maite Murphy, Circuit Court Judge

Appellate Case No. 2026-00034

Rebecca Turisk,

Petitioner,

v.

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

Respondents.

CERTIFICATE OF COMPLIANCE

The undersigned certifies that this Return to Petition of Respondents complies with Rule 211(b), SCACR.

Respectfully submitted,

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