THE STATE OF SOUTH CAROLINA
In the Court of Appeals

RECEIVED
MAY 16 2017
SC Court of Appeals

APPEAL FROM CHARLESTON COUNTY
The Court of Common Pleas for the Ninth Judicial Circuit

Hon. J. C. Nicholson, Jr., Circuit Court Judge

Appellate Case No. 2016-001986

Shon Turner, as Personal Representative of the Estate of Charles Mikell, deceased, ... Appellant

v.

The Medical University of South Carolina .... Respondent

INITIAL BRIEF OF APPELLANT SHON TURNER

Robert B. Ransom
LEVENTIS & RANSOM
Post Office Box 11067
Columbia, SC 29211
803-765-2383
bertcone@aol.com

Alex Apostolou
3443 Rivers Avenue
North Charleston, SC 29405
843-853-3637
alex@apostoloulaw.net

ATTORNEYS FOR THE
APPELLANT SHON TURNER

<u>Other Counsel of Record</u>:

M. Dawes Cooke, Jr.
Alissa D. Flemming
John W. Fletcher
BARNWELL, WHALEY,
PATTERSON & HELMS
Post Office Drawer H
Charleston, SC 29402
843-577-7700

ATTORNEYS FOR THE
RESPONDENT
MEDICAL UNIVERSITY OF
SOUTH CAROLINA

TABLE OF CONTENTS

Table of Authorities 4

Statement of Issues on Appeal 6

Statement of the Case 7

Facts 11

Argument 16

1. MUSC's motion for partial summary judgment 16

   a. Standard of review 16

   b. MUSC's argument 17

   c. Evidence of Dr. Nelson's malpractice 20

      i. Dr. Kofke's testimony 21

      ii. Dr. Nelson's testimony 25

      iii. The anesthesia record and audit trail 28

      iv. Nurse Embry's testimony 31

      v. Dr. Reeve's testimony 33

2. Dr. Zile's opinion testimony 35

3. MUSC's medical records document dump 38

4. The blank Mayday form 40

5. Failure to inform the jury of the court's ruling on the claim for physician malpractice. 43

Conclusion 44

TABLE OF AUTHORITIES

Cases

Baughman v. American Telephone and Telegraph Co. 16, 17
306 S.C. 101, 410 S.E.2d 537 (1991)

Cox v. Lund 28, 31
286 S.C. 410, 334 S.E.2d 116 (1985)

Gordon v. United States 42
344 U.S. 414, 73 S.Ct. 369 (1985)

Griggs v. Griggs 42
230 S.C. 97, 94 S.E.2d 225 (1956)

Hurst v. Sandy 9
329 S.C. 471, 494 S.E.2d 847 (Ct. App. 1997)

Jackson County Board of Health v. Fugett Construction, Inc. 42
270 Ga. 667, 514 S.E.2d 28 (1999)

Kershaw County DSS v. McCaskill 39
276 S.C. 360, 278 S.E.2d 771 (1981)

Madison ex rel Bryant v. Babcock Center 9, 18
371 S.C. 123, 638 S.E.2d 650 (2006)

Maybank v. BB&T Corp. 17
416 S.C. 541, 787 S.E.2d 498 (2016)

Norton v. Opening Break 9
319 S.C. 469, 462 S.E.2d 861 (1995)

State v. Council 39
335 S.C. 1, 515 S.E.2d 508 (1999)

State v. Johnson 43
418 S.C. 587, 795 S.E.2d 171 (2016)

State v. Jones 39
273 S.C. 723, 259 S.E.2d 129 (1979)

State v. Jones 43
343 S.C. 562, 541 S.E.2d 813 (2001)

Stokes v. Spartanburg Regional Medical Center 40, 42, 43
386 S.C. 515, 629 S.E.2d 675 (Ct. App. 2006)

Stokes-Craven Holding Corp. v. Robinson 17
416 S.C. 517, 787 S.E.2d 485 (2016)

Watson v. Ford Motor Co. 39
389 S.C. 434, 699 S.E.2d 169 (2010)

Statutes

S.C. CODE ANN. §15-78-120 (Code 1976, as amended) 7

S.C. CODE ANN. §15-78-70 (Code 1976, as amended) 7

S.C. CODE ANN. §40-33-20 (Code 1976, as amended) 8, 9, 34

Regulations

S.C. CODE OF REG. R. 61-16 §1212(A)(4) 8, 9, 34

Court Rules

Rule 50, SCRCP 16, 17

Rule 56, SCRCP 16, 17

Rule 401, SCRE 41

Rule 403, SCRE 38, 39

Rule 702, SCRE 39

Rule 803(6), SCRE 38

Rule 1002, SCRE 41, 42

STATEMENT OF ISSUES ON APPEAL

1. Did the lower court err in granting MUSC's motion for partial summary judgment on the Plaintiff's claim for physician negligence, when it had previously denied MUSC's two motions for directed verdict on all of the Plaintiff's claims?

2. Did the lower court err in ruling there was no jury issue presented, so that MUSC was entitled to judgment as a matter of law on the Plaintiff's claim for physician negligence?

3. Did the lower court err in ruling that the Plaintiff's claim for negligent supervision was not a medical malpractice claim, and that no claim for negligent supervision had been plead in the Second Amended Complaint?

4. Did the lower court err in failing to instruct the jury that the Plaintiff's claim for physician negligence had been removed from its consideration?

5. Did the lower court err in permitting MUSC to present undisclosed expert opinions from Dr. Zile, after ruling MUSC had not properly disclosed Dr. Zile as an expert witness prior to calling him to testify; and when his opinions lacked a proper foundation?

6. Did the lower court err in refusing to strike Dr. Zile's opinion testimony despite ruling it was inadmissible?

7. Did the lower court err in allowing MUSC to place in evidence a large volume of medical records, which included subjective opinions, without any finding that the records would assist the jury and not lead to confusion?

8. Did the lower court err in allowing MUSC to place a blank, specimen copy of a Mayday form into evidence, and in allowing a witness to provide testimony about the content of a missing Mayday record?

STATEMENT OF THE CASE

This medical malpractice case began when the Plaintiff filed a Summons and Complaint on November 6, 2012. Prior to service of the Complaint, an Amended Complaint was filed on January 31, 2013 and then served on February 12, 2013. MUSC served its Answer to the Amended Complaint on March 14, 2013. A Second Amended Complaint was filed on February 22, 2016. MUSC served an Answer to the Second Amended Complaint on March 9, 2016.

The Second Amended Complaint alleges causes of action for Medical Malpractice,[1] Survival,[2] and Wrongful Death[3] among others not at issue on appeal. The cause of action for Medical Malpractice specifically includes a specification of negligence for "failing to properly manage, supervise and direct the provision of anesthesia care" (emphasis added).[4]

The Plaintiff's claims arise out of the conduct of MUSC employees Donna Embry, CRNA and Eric Nelson, DO. Nurse Embry and Dr. Nelson were responsible for the anesthesia services provided to the decedent, Charles Mikell, during the colonoscopy procedure at issue in the case. Pursuant to the South Carolina Tort Claims Act, S.C. CODE ANN. §15-78-70(c) (Code 1976, as amended), the only proper defendant in the case is MUSC. MUSC contends that S.C. CODE ANN. §15-78-120(a) limits its liability for Nurse Embry's conduct to $600,000.00 and limits its liability for Dr. Nelson's conduct to $1,200,000.00.[5]

A series of five Consent Scheduling Orders were submitted, the last of which was entered by the lower court on August 5, 2015, setting deadlines for mediation (September 1, 2015) and the completion of discovery (October 2, 2015). The mediation was conducted on August 28, 2015 and resulted in an impasse. The case was set for a date certain jury trial which

---

[1] Second Amended Complaint at page 2, First Cause of Action.

[2] Second Amended Complaint at page 4, Second Cause of Action.

[3] Second Amended Complaint at page 4, Third Cause of Action.

[4] Second Amended Complaint at page 3, ¶6(g).

[5] Answer to Second Amended Complaint at page 6, Second Affirmative Defense.

commenced on April 18, 2016.

During trial, the Plaintiff's theory of the case was that Mr. Mikell's cardiac arrest had been caused by a combination of medical errors. First, the anesthesia care providers, Nurse Embry and Dr. Nelson, failed to check that the PICIS anesthesia software system was functioning properly before administering the anesthetic agent to Mr. Mikell. Second, a glitch in the PICIS software system was identified only after Mr. Mikell had been rendered unconscious with the anesthetic. Third, Nurse Embry was distracted by the effort to correct the PICIS software glitch when Mr. Mikell's medical condition began to deteriorate. Fourth, Dr. Nelson "popped in" to the colonoscopy procedure room for only a few brief minutes and then left even though Mr. Mikell's medical condition was not stable.

These errors were attributable to both Nurse Embry and Dr. Nelson because he had an obligation to critically observe and direct her administration of anesthetic drugs.[6] The combined result of these errors was that when Mr. Mikell's blood oxygen saturation levels precipitously declined, Nurse Embry was alone in the room without sufficient assistance to effectively respond before Mr. Mikell suffered a cardiac arrest.

During the presentation of evidence, the lower court allowed MUSC to present previously undisclosed expert opinion testimony from Michael Zile, MD, who was one of Mr. Mikell's treating physicians. The lower court also allowed MUSC to place in evidence a large volume of Mr. Mikell's medical records despite the lack of any proper foundation for the technical information they contained. The lower court further allowed MUSC to obliterate the best evidence rule, *see*, Rule 1002, SCRE, by placing in evidence a blank specimen copy of a Mayday record in order to support its contention that a lost Mayday record — the existence of which MUSC had repeatedly lied about — would not have contained any useful information.

At the close of the Plaintiff's case on Thursday April 21st, MUSC made a motion for

[6] *See*, S.C. CODE ANN. §§40-33-20(20) and (57); and S.C. CODE OF REG. R. 61-16 §1212(A)(4).

directed verdict[7] on the claims for medical malpractice, survival, and wrongful death, raising both breach of the standard of care[8] and proximate cause.[9] The lower court properly denied these motions.[10]

At the close of all the evidence on Friday April 22nd, MUSC made another motion for directed verdict based upon the alleged failure of proof on both breach of the standard of care and proximate cause.[11] In addition, MUSC made a "motion for partial summary judgment as to any negligence on the part of a licensed physician, . . ."[12] After hearing argument, the lower court properly denied the directed verdict motions[13] but took the partial summary judgment motion under advisement over the weekend.[14]

On Monday April 25th, counsel for the parties and the trial judge were discussing proposed jury instructions. The Plaintiff asked for the jury to be instructed on S.C. CODE ANN. §§40-33-20(20) and (57); and S.C. CODE REG. R.61-16 §1212(A)(4), all relating to a physician's duty to supervise a nurse anesthetist. The Plaintiff also sought an instruction that violation of the statute, the regulation, or MUSC's own Policies and Basic Standards of Anesthesia Care would support a finding of negligence *per se*. *See*, Norton v. Opening Break, 319 S.C. 469, 462 S.E.2d 861 (1995); and Madison ex rel Bryant v. Babcock Center, 371 S.C. 123, 638 S.E.2d 650 (2006). MUSC contended neither the statute nor the regulation create a duty of care owed to patients, citing Hurst v. Sandy, 329 S.C. 471, 494 S.E.2d 847 (Ct. App. 1997). The parties also submitted proposed verdict forms containing special interrogatories asking the jury about

---

[7] Trial Transcript beginning at page 765, line 20.

[8] Trial Transcript beginning at page 766.

[9] Trial Transcript beginning at page 773.

[10] Trial Transcript at page 785, lines 10 - 14.

[11] Trial Transcript at page 1067, lines 13 -15.

[12] Trial Transcript at page 1067, lines 16 - 18.

[13] Trial Transcript at page 1082, lines 19 - 21.

[14] Trial Transcript at page 1082, lines 21 - 24.

negligence by a physician, so the court might apply the Tort Claims Act's limitation on damages to any verdict for the Plaintiff.

The trial judge declined the Plaintiff's proposed jury instructions, ruling the Plaintiff's claim that Dr. Nelson did not adequately supervise Nurse Embry was not a claim for medical malpractice, but rather sounded in ordinary negligence.[15] The trial judge further ruled that the Plaintiff's Second Amended Complaint only alleges claims for medical malpractice, not ordinary negligence, so that there was no negligent supervision claim properly before the jury.[16]

The lower court then returned to MUSC's motion for partial summary judgment. After hearing additional argument from counsel, the lower court granted the motion on the grounds that any "medical malpractice" — as opposed to "negligent supervision" — by Dr. Nelson had not proximately caused Mr. Mikell's cardiac arrest, wrongly believing there was no evidence Dr. Nelson's presence would have made any difference[17] had he been in the room when Mr. Mikell desaturated.[18]

As to the supposedly unplead negligent supervision claim, the lower court denied the Plaintiff's motion to amend the pleadings to conform to the proof.[19] The lower court further ruled the jury would not be informed of its decision on the claims involving Dr. Nelson's conduct.[20] Instead, Plaintiff's counsel was instructed to omit argument about those claims from his closing.

The jury returned a verdict for MUSC on Tuesday April 26, 2016. The lower court allowed the Plaintiff ten days to file any post-trial motions. The Plaintiff served a Motion for New

---

[15] *See*, Trial Transcript at page 1106, line 14 to page 1112, line 19.

[16] *See*, Trial Transcript at page 1111 - 1112.

[17] Trial Transcript at page 1100, lines 13 - 15.

[18] *See*, Trial Transcript at pages 1085 to 1102 for a protracted discussion of the issue of Dr. Nelson's malpractice, culminating in the lower's court's decision to grant MUSC's motion for partial summary judgment.

[19] *See*, Trial Transcript at pace 1107, line 6 to page 1108, line 3.

[20] *See*, Trial Transcript at page 1239, lines 20 - 22.

Trial on May 6, 2016. MUSC filed a Memorandum in Opposition on June 3, 2016. The Plaintiff served a Reply Memorandum on July 1, 2016. The lower court held a hearing on July 18, 2016 and denied the Plaintiff's motion via a Notice of Entry of Judgment/Order Pursuant to Rule 77, SCRCP entered on August 19 2016. Plaintiff's counsel received notice of the entry of the Judgment on August 25, 2016. The Plaintiff served a Notice of Appeal on September 20, 2016.

FACTS

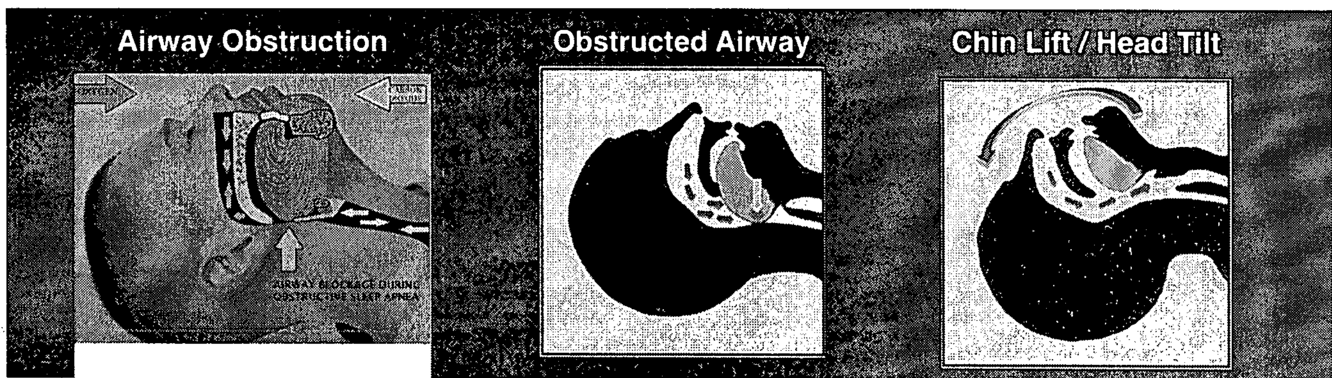
Charles Mikell was 49 years old when he suffered a life-altering cardiac arrest while undergoing a routine screening colonoscopy at MUSC on October 1, 2010. Nurse Donna Embry was the certified registered nurse anesthetist (CRNA) who provided anesthesia for the colonoscopy, under the direction and supervision of Dr. Eric Nelson, an anesthesiologist. Mr. Mikell was hospitalized at MUSC for six weeks. He spent part of that time in a coma on a ventilator in the intensive care unit. After being released from the hospital at Thanksgiving, Mr. Mikell continued to receive home health care through the end of the year. Mr. Mikell was found dead on his living room couch on January 2, 2011.

Mr. Mikell's medical history included obstructive sleep apnea and congestive heart failure, which together made him particularly susceptible to variations in the levels of oxygen and carbon dioxide in his blood. When a person with obstructive sleep apnea falls asleep, the muscles in the neck and throat that keep the airway open relax with the result that the airway sometimes becomes obstructed. The person may start snoring and in severe cases even stop breathing. This can result in lowered blood oxygen (inhaling) and increased blood carbon dioxide (exhaling). The brain will typically respond to these variations via a reflexive process that causes the person to arouse slightly and spontaneously clear the obstruction by coughing or repositioning.

The same process occurs when a patient with obstructive sleep apnea is rendered unconscious via the administration of anesthesia. However, the normal process of arousal is

blunted by the anesthesia, so the patient is unable to spontaneously clear the obstruction. When this occurs, there are a variety of airway management techniques available to an anesthesia provider to overcome the obstruction and prevent the patient's blood oxygen and carbon dioxide saturations from reaching dangerous levels that can be life threatening and lead to respiratory and cardiac arrest.

These basic principles were illustrated for the jury through reference to demonstrative exhibits used during the testimony of the Plaintiff's anesthesia expert, Dr. Kofke:[21]



Mr. Mikell was given the anesthetic agent Propofol in order to render him unconscious for the colonoscopy. During the procedure, biometric sensors attached to Mr. Mikell's body transmitted digital electronic data to a series of visual monitors and also into an anesthesia software program called PICIS. The PICIS software used an algorithm to generate visual waveforms of Mr. Mikell's vital signs for display on a monitor, including blood oxygen saturation, exhaled carbon dioxide, heart rate, respiratory rate, and other metrics. In addition to being displayed on visual monitors, this digital vital signs data was also captured and recorded by the PICIS software, thereby making an electronic anesthesia record which is part of the patient's chart for the colonoscopy procedure.

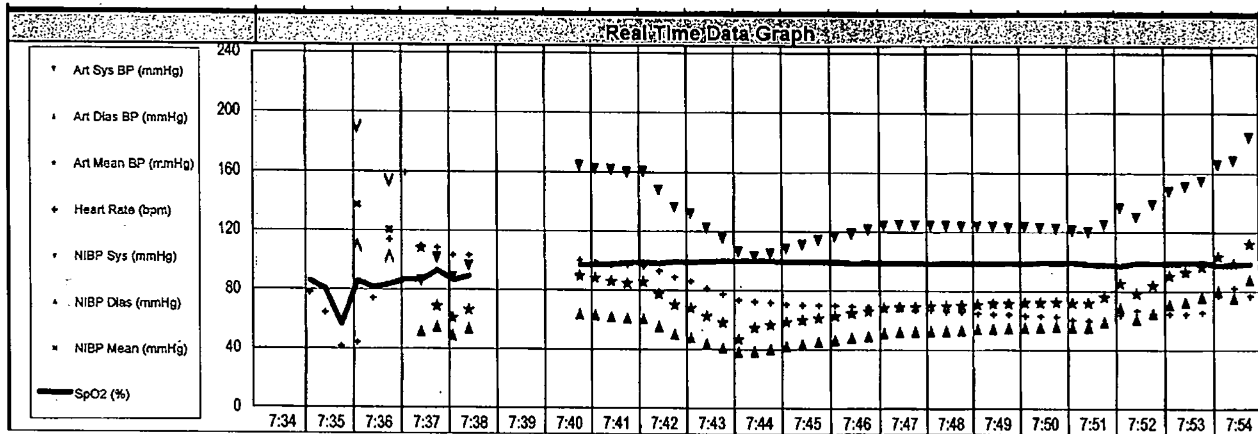
The anesthesia record consists of three separate sections: the real time variables; the real time data graph; and the narrative.

[21] Trial Transcript at page 346, line 4 to page 349, line 14.

Real Time Variables

Real Time Variables																					
TIME	7:34	7:35	7:36	7:37	7:38	7:39	7:40	7:41	7:42	7:43	7:44	7:45	7:46	7:47	7:48	7:49	7:50	7:51	7:52	7:53	7:54
SpO2 (%)															96.7	75	69.2	90.1	80.7	88	73.3
Temperature (°C)																					
EKG Rhythm		SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR
SpO2 Heart Rate bpm															74	72	101	83	62	75	85
Spontaneous Resp Rate																			0	1	1
Resp Rate from pCO2 cart															0	0	0	11	14	17	0
Vent Resp Rate/min																			1	1	1
FiO2 (%)															99	35	26	29	24	26	29
EtCO2 (mmHg)															0	0.754	52.78	45.24	10.56	10.56	0.754
Des out (%)																					
Exp. Tidal volume (mL)																			41	32	
PIP (cmH2O)															0	0	0	0	0	1	0

Real Time Data Graph



Narrative

Dt/Tm Initials	EVENTS
10/01/2010 07:35 DBE	Transfer to:
10/01/2010 07:35 DBE	Patient in Room (PIR)
10/01/2010 07:46 ALT	Transfer # (EVTROUT-)
10/01/2010 07:47 DBE	Transfer to SCsNO
10/01/2010 07:48 EWN	Anesthesiologist assessed patient, reviewed chart and formulated anesthesia plan
10/01/2010 07:48 EWN	Anesthesiologist medically directing case and present for all critical portions.
10/01/2010 07:48 EWN	Anesthesiologist present for induction
10/01/2010 07:48 EWN	I (or another attending anesthesiologist) was immediately available throughout and present for all key/critical portions of case
10/01/2010 08:00 EWN	Memo Came into room. Pt. hypoxic with junctional rhythm and no palpable pulse. ACLS protocol initiated, Mayday team called.
10/01/2010 08:27 DBE	Central line placed by Attending Anesthesiologist
10/01/2010 08:27 DBE	Hand hygiene prior to donning gloves
10/01/2010 08:27 DBE	Maximum barrier precautions utilized for strict sterile technique including sterile body drape, hat, mask, and sterile gloves.
10/01/2010 08:27 DBE	Skin preparation with chlorohexadine
10/01/2010 08:27 DBE	Landmarks indentified
10/01/2010 08:27 DBE	Introducer needle inserted into vessel, free blood flow
10/01/2010 08:27 DBE	Triple lumen catheter Rt. femoral vein.
10/01/2010 08:27 DBE	Blood return through all lumens. Lumens flushed.
10/01/2010 08:27 DBE	Sterile transparent dressing placed over insertion site
10/01/2010 08:31 EWN	Anesthesiologist present for airway device placement
10/01/2010 08:31 EWN	Arrhythmia identified: v fib
10/01/2010 08:31 EWN	Non-palpable pulse
10/01/2010 08:31 EWN	Chest compressions initiated

Dt/Tm Initials	EVENTS
10/01/2010 08:31 EWN	Patient Oxygenated w/100% 02
10/01/2010 08:31 EWN	ETT in place
10/01/2010 08:31 EWN	Defibrillation - Joules: 200
10/01/2010 08:31 EWN	CPR stopped
10/01/2010 08:31 EWN	Patient stabilized
10/01/2010 08:31 EWN	Post resuscitation rhythm:
10/01/2010 08:37 DBE	To recovery area in stable condition
10/01/2010 08:37 DBE	Patient transported with O2
10/01/2010 08:37 DBE	Transported via stretcher/bed
10/01/2010 08:37 DBE	Patient Out of Room (POR)
10/01/2010 08:37 DBE	Transfer from SCsNO
10/01/2010 08:45 JGT	Phase I PACU admission
10/01/2010 08:45 JGT	Report received from: Donna Embry CRNA
10/01/2010 08:45 JGT	Side rails up
10/01/2010 08:45 JGT	Wheels locked
10/01/2010 08:45 JGT	Connected to monitors
10/01/2010 08:45 JGT	Arrival in PACU/ICU (APACU)
10/01/2010 08:54 DBE	Transfer to LCsAn
10/01/2010 08:58 DBE	Anesthesia machine checked, alarms on and functioning
10/01/2010 08:58 DBE	Integrity of Anesthesia circuit confirmed
10/01/2010 08:58 DBE	Standard monitors available, alarms on and functioning
10/01/2010 08:58 DBE	Suction available and functioning
10/01/2010 08:58 DBE	Airway equipment available and functioning
10/01/2010 08:58 DBE	Anesthesia and resuscitation drugs available
10/01/2010 08:58 DBE	NPO status verified
10/01/2010 08:58 DBE	Patient chart and preoperative assessment reviewed
10/01/2010 08:58 DBE	Patient identified by 2 methods
10/01/2010 08:58 DBE	Pre-op vital signs reviewed
10/01/2010 08:58 DBE	Surgical consent verified and appropriate
10/01/2010 08:58 DBE	Risks, benefits, and complications of anesthetic plan

The data in the real time variables section is automatically plotted in the real time data graph. The anesthesia narrative is created by individual anesthesia providers typing information into the anesthesia record using a keyboard attached to a PICIS workstation located near the patient during the procedure:

MUSC's electronic medical records system includes an audit trail function which shows a username, date, and time stamp every time someone accesses the anesthesia record to create, modify, or delete an entry.[22] There is also an audit trail which shows a username, date, and time stamp every time someone accesses the anesthesia record to print it in hard copy form.[23]

When functioning properly, the PICIS anesthesia software makes a contemporaneous record of all the biometric data captured during the procedure. The record can then be printed out to display the data in various time increments, including every 15 minutes, every one minute, every ten seconds, or every second.

---

[22] Plaintiff's Exhibit 10.

[23] Plaintiff's Exhibit 11.

However, the PICIS software does not always capture and record the patient's biometric data. MUSC refers to this as a "glitch." When this glitch occurs, the anesthesia provider sometimes needs to contact an information technology specialist for assistance. This contact sometimes takes the form of text messages and phone calls with a technician, located elsewhere in the hospital, using the PICIS workstation key board and a telephone attached to the wall in the colonoscopy procedure room. The technician can access the PICIS system remotely to fix the data capture glitch.

During Mr. Mikell's colonoscopy, the PICIS software did not capture and record the biometric data for several minutes at the beginning of the procedure. Nurse Embry engaged in a series of text messages and phone calls with a technician to overcome the problem. As the biometric data began to be captured and recorded by the PICIS software, it showed Mr. Mikell's blood oxygen starting to desaturate, then dropping to life threatening levels. As a consequence, Mr. Mikell's heart rate dropped (bradycardia), he stopped breathing (respiratory arrest), his heart began to flutter ineffectively (pulseless electrical activity or PEA), and he went into cardiac arrest.[24]

Very briefly stated, the Plaintiff's theory of the case at trial was that Nurse Embry and Dr. Nelson were in a hurry to begin their first of many colonoscopy procedures scheduled for October 1, 2010;[25] neglected to check whether the PICIS software system was fully and properly functioning before Mr. Mikell was rendered unconscious; and were then caught distracted by the PICIS software glitch and shorthanded when Dr. Nelson left the room while Mr. Mikell was unstable. The appropriate airway management techniques were not timely and effectively employed so that Mr. Mikell desaturated and descended into cardiac arrest.

---

[24] *See*, Plaintiff's Exhibit 19.

[25] *See*, Trial Transcript at page 923, lines 13 - 23; and page 959, line 19 to page 960, line 5.

ARGUMENT

1. MUSC's motion for partial summary judgment

Although the lower court denied all of MUSC's motions for directed verdict as to both standard of care and proximate cause, it nevertheless granted MUSC's motion for partial summary judgment "as to any negligence on the part of a licensed physician." As an initial matter, it is difficult to reconcile these rulings.

If a reasonable juror could find in the Plaintiff's favor on all of his claims — both at the close of the Plaintiff's case and at the close of all the evidence — so that MUSC's motions for directed verdict were properly denied, how then is it possible that there could be no genuine issue of material fact as to just one of the Plaintiff's claims, so that MUSC was entitled to judgment on that claim as a matter of law? Because if the evidence was sufficient to defeat MUSC's motions for directed verdict — which were not appealed and now constitute the law of the case — then that very same evidence is also sufficient to defeat MUSC's motion for partial summary judgment.

Simply stated, it was error for the lower court to grant a motion for partial summary judgment on a claim which had previously survived two prior motions for directed verdict.

a. Standard of review

On Friday April 22nd, at the close of all the evidence, defense counsel for MUSC made "a motion for partial summary judgment as to any negligence on the part of a licensed physician." The lower court took the motion under advisement over the weekend. The following Monday April 25th, the lower court construed the motion as one "for a partial directed verdict as to Dr. Nelson,"[26] and asked to hear from counsel for both parties again in regard to the issues.

As a practical matter, the standard applicable to a Rule 50, SCRCP, motion for directed verdict mirrors the standard for a Rule 56, SCRCP, motion for summary judgment. Baughman v.

[26] Trial Transcript at page 1085, lines 6 - 12.

American Telephone and Telegraph Co., 306 S.C. 101, 410 S.E.2d 537 (1991).

In reviewing a trial court's ruling on a Rule 50, SCRCP, motion for directed verdict, an appellate court must view the evidence and all reasonable inferences in the light most favorable to the non-moving party. Maybank v. BB&T Corp., 416 S.C. 541, 787 S.E.2d 498 (2016). The trial court must deny a motion for directed verdict if the evidence yields more than one reasonable inference or its inference is in doubt. *Ibid.* A motion for directed verdict may be granted only if no reasonable juror could reach a verdict for the non-moving party. *Id.* In deciding such motions, 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. *Id.*

Summary judgment is proper under Rule 56, SCRCP, only when there is no genuine issue of material fact and the moving party is entitled to judgment as a matter of law. Stokes-Craven Holding Corp. v. Robinson, 416 S.C. 517, 787 S.E.2d 485 (2016). On appeal from an order granting summary judgment, the appellate court must review all ambiguities, conclusions, and inferences arising in and from the evidence in a light most favorable to the non-moving party. *Ibid.*

b. MUSC's argument

During argument, defense counsel characterized the Plaintiff's theory of liability regarding Dr. Nelson's conduct: He was negligent because he was not in the room enough; and he was not there when the patient was in trouble, at a time when two sets of hands were needed to manage Mr. Mikell's airway.[27] Defense counsel then argued that even if this were established factually, it would not be a deviation from the standard of care.[28]

Defense counsel proceeded to recite MUSC's version of the vigorously disputed facts about when Dr. Nelson was in and out of the room and what Mr. Mikell's condition was during

[27] Trial Transcript at page 1085, lines 15 - 25.

[28] Trial Transcript at page 1086, lines 1 - 3.

those times. This included a discussion about the reliability of the data contained in various portions of the electronic anesthesia record, critical parts of which had been altered by Nurse Embry after the fact. At times, defense counsel referred to the "irrefutable chart," but a fair reading of all the evidence shows that virtually none of the information in the electronic anesthesia record was unchallenged, let alone irrefutable. The lower court itself was well aware of the disputed nature of the evidence and pointed this out to defense counsel.[29]

At one point, the lower court focused on the theory that Dr. Nelson's supervisory role required him to make sure the PICIS software system was recording data properly before Mr. Mikell was rendered unconscious.[30] The lower court recognized the Plaintiff's evidence supported a finding that Dr. Nelson had failed to follow MUSC's own Policies and Basic Standards of Anesthesia Care, which pursuant to Madison ex rel Bryant v. Babcock Center, 371 S.C. 123, 638 S.E.2d 650 (2006)(standard of care may be established by defendant's own policies and guidelines) was at least some evidence of negligence:

> THE COURT: . . . Why shouldn't he be responsible to make sure all the equipment is working properly before they start the procedure?
> MR. COOKE: Because that's not equipment. The — the —
> THE COURT: It is equipment. I disagree with that. I know you've tried to say that, but I think it is equipment.
> MR. COOKE: Well, they said that all the monitoring equipment was working appropriately —
> THE COURT: But it wasn't because there was a glitch, and I — that's where I disagree with you. I know you got the monitors and you got the computer, but I think the computer is there, and it should have been working. He should have made sure it was working.[31]

Defense counsel next argued Dr. Nelson's obligation to make sure the equipment was working properly before the anesthetic was administered was merely a "recordkeeping issue," unrelated to patient care. The lower court responded, "I just don't agree with that."[32] Defense

---

[29] *See*, Trial Transcript at page 1088, lines 1 - 12.

[30] Trial Transcript at pages 1090 - 1091.

[31] Trial Transcript at page 1091, lines 3 - 17.

[32] Trial Transcript at page 1091, line 23 to page 1092, line 10.

counsel then continued reciting MUSC's version of the contested facts about when Dr. Nelson was in and out of the room and what Mr. Mikell's condition was during those times, concluding with the inaccurate claim, "Everything was fine [with Mr. Mikell] by the time [Dr. Nelson] left the room."[33]

Plaintiff's counsel responded with the Plaintiff's version of the disputed facts and the reasonable inferences deducible from them. The lower court focused on the testimony of the Plaintiff's anesthesia expert, Dr. Kofke,[34] but there was significant additional evidence relating to Dr. Nelson's negligence beyond just Dr. Kofke's testimony.[35]

The lower court acknowledged the evidence showing that Mr. Mikell's condition "was deteriorating"[36] when Dr. Nelson left the room, but expressed concern about "what the doctor would have done different" had he been present.[37] Mr. Ransom attempted to answer this concern, and the lower court seemed on the verge of understanding about chin-lift maneuvers:

> THE COURT: Well, what did he — what did [Dr. Kofke] say she did wrong at this point in time? She reduced the Propofol. She put in a breathing tube. What else could she have done to him **other than adjust the jaw?**
> MR. RANSOM: Have two hands on — on her patient in order to be able to manipulate the airway, to prevent this obstruction from sending his sats down the cliff. That was what his testimony was. . . .
> THE COURT: Well, I understand all that. But assuming the doctor was there the whole time is what —
> MR. RANSOM: Yeah.
> THE COURT: The point I'm trying to make is — **assuming [Dr. Nelson] was there, what could he have done differently?**
> MR. RANSOM: Well, again, with —
> THE COURT: **Other than manipulate the jaw** with the breathing tube, I think he said if they work, and then you put in a breathing tube. Well, she put a breathing tube in.
> MR. RANSOM: Right, but not until 8:00.
> THE COURT: So what difference does it make? She didn't manipulate the jaw,

---

[33] Trial Transcript at page 1094, lines 1 - 2.

[34] Trial Transcript at page 1096, lines 9 - 10.

[35] *See*, testimony of Dr. Nelson, Dr. Reeves, and Nurse Embry, *infra*.

[36] Trial Transcript at page 1098, line 1.

[37] Trial Transcript at page 1098, line 11 to page 1099, line 1.

she put the breathing tube in.[38]

In the end the lower court failed to fully grasp the crucial point: if Dr. Nelson had been present in the room throughout the time when Mr. Mikell was in trouble, there would have been two sets of trained hands to reposition him, manipulate his jaw, clear the airway obstruction, apply bag mask ventilation, and thereby avoid the desaturation altogether. Dr. Kofke testified that had this been done, Mr. Mikell most probably would not have suffered a cardiac arrest requiring extended hospitalization.

The lower court never got to this point, instead concluding the exchange with Plaintiff's counsel, "I just have a real difficulty in figuring out what Dr. Nelson did wrong to be honest with you. I'm going to grant the motion."[39] But the correct standard was not whether the lower court could figure it out. The correct standard was whether there was any evidence in the record from which a reasonable juror could render a verdict for the Plaintiff.

d. Evidence of Dr. Nelson's negligence

During the trial, evidence of malpractice by Dr. Nelson was introduced through a variety of witnesses and documents. (1) The Plaintiff's anesthesiology expert, Dr. Kofke, testified that Dr. Nelson breached the standard of care by exiting the procedure room when Mr. Mikell's condition was unstable, thereby leaving Nurse Embry without assistance in managing Mr. Mikell's airway. (2) Dr. Nelson himself acknowledged that he should not have left the room if Mr. Mikell's oxygen saturation levels were not consistently in the 90s. Yet extent vital signs data in the anesthesia record showed that Mr. Mikell's oxygen saturations were never consistently in the 90s. (3) There was powerful documentary evidence that the anesthesia narrative had been deliberately altered to make it look as though Dr. Nelson left the room during the one brief moment when Mr. Mikell's oxygen saturation was above 90.

---

[38] Trial Transcript at page 1099, line 22 to page 100, line 24.

[39] Trial Transcript at page 1102, lines 6 - 9.

Other evidence showed that Mr. Mikell got into trouble at a time when Nurse Embry was distracted by text messages and phone calls undertaken to correct a problem with the PICIS anesthesia software. MUSC hospital policy made Dr. Nelson ultimately responsible for ensuring that all of the anesthesia equipment was functioning properly before the anesthetic was administered. Dr. Nelson was also legally responsible for directing and supervising Nurse Embry's administration of anesthesia.

i. Dr. Kofke's testimony

Dr. Kofke is a physician board certified in both anesthesiology and critical care. He testified that minutes and seconds are important in responding to a patient who stops breathing, or who suffers a cardiac arrest.[40] In the context of a patient like Mr. Mikell, who has obstructive sleep apnea, Dr. Kofke testified the standard of care when breathing becomes obstructed is to employ "chin lift" maneuvers,[41] which he demonstrated to the jury through a video filmed using a mannequin at an anesthesia simulation center.[42] Dr. Kofke testified these maneuvers should have been used <u>before</u> Mr. Mikell's blood oxygen saturation began to fall to dangerous levels; and that if this had been done in a timely and effective manner, Mr. Mikell would not have desaturated to the point where his heart slowed (bradycardia), went into pulseless electrical activity,[43] (fluttering but not effectively pumping blood), and stopped (cardiac arrest).

One of the problems Dr. Kofke encountered in his analysis of Mr. Mikell's anesthesia care was the missing vital signs data occasioned by the PICIS anesthesia software glitch. Nevertheless, a reliable entry in the medical chart showed the colonoscope was inserted at 7:42 a.m. Using this data point, Dr. Kofke reasoned that the anesthetic agent (Propofol) must have been started 10 or 15 minutes prior to that time because it was being administered at a dose of

[40] Trial Transcript at page 344, lines 8 - 16.

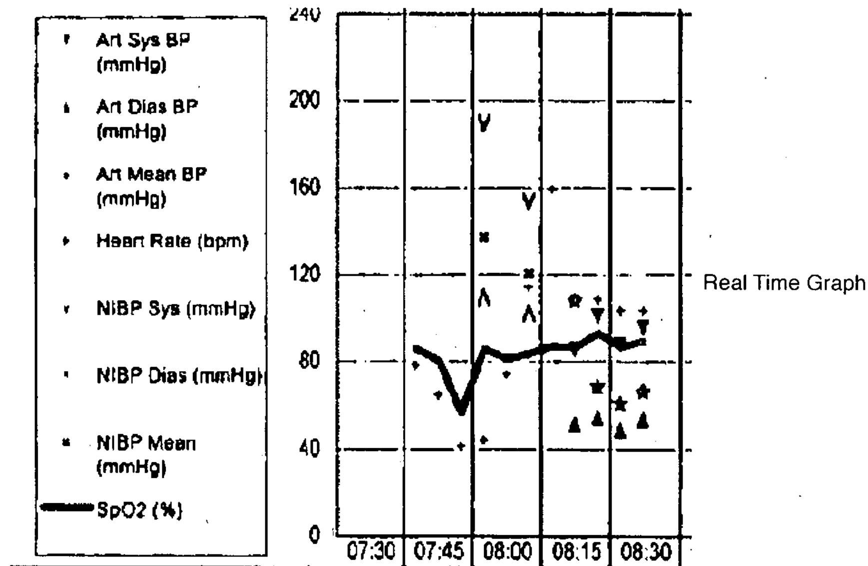
[41] Trial Transcript at page 348, line 9 to page 349, line 1.

[42] Trial Transcript at page 349, line 15 to page 350, line 6.

[43] Trial Transcript at page 355, line 13 to page 356, line 24.

75 micrograms per minute and it would take several minutes at that dose and rate to render Mr. Mikell suitably unconscious to begin the colonoscopy.

The real time graph in the anesthesia chart showed Mr. Mikell's oxygen saturation levels making a precipitous drop into the 40s:



The primary factual contests during the trial resulted from the parties' efforts to identify the time at which this drop began; which anesthesia providers were present when it occurred; and whether they responded to it appropriately. Dr. Kofke offered the following testimony about the blood oxygen saturations:

> **[B]efore the big desaturation**, their - **the sats were already in the 80s**, . . . so at that point, even to prevent that drop in the 40s, **there should be these maneuvers that I discussed** which entail the various things you do in the airway, you know, a chin lift, opening the mouth. You know the various things to support — get the tongue — get the tongue off. . . .[44]

According to Dr. Kofke, when the PICIS anesthesia software first began plotting the blood oxygen saturation data on the real time graph at 7:48, "the sats were already in the 80s," which indicated to him that "even before they had the life threatening drop" into the 40s, "they

[44] Trial Transcript at page 353, line 20 to page 354, line 14 (emphasis added).

were in trouble."[45] The jury was entitled to credit this testimony.

Dr. Kofke further testified that if at that time — when the sats first dropped into the 80s — the anesthesia providers had been "supporting the airway"[46] and "focusing on the patient,"[47] Mr. Mikell's oxygen saturations would not have continued to fall,[48] his heart would not have gone into pulseless electrical activity,[49] and he would not have ended up a critical care patient in the hospital.[50] The jury was entitled to credit this testimony as well.

When asked why all of these bad things nevertheless occurred, Dr. Kofke explained there were "multiple reasons." First, the nurse anesthetist "was basically in the room by — by herself."[51] Second, "there was a lot of distractions going on related to the electronic record,"[52] meaning the efforts to fix the PICIS software glitch via text message and telephone call.[53] As Dr. Kofke explained:

> So while he's desaturating, there's two phone calls — two texts, two phone calls, two instructions to fix the problem, six distractions going on either before or during the desaturation episode. So you ask what — one of the things that are going on that undoubtedly contributed to this, is — this, I think, was a large contributor.[54]

Dr. Kofke amplified this testimony by noting that the phone calls and text messages would require the CRNA to face away from the patient "while the sats are in 80s to 40s. So that — that's what I think is — I think your question was the cause."[55] Dr. Kofke likened this to

---

45 Trial Transcript at page 356, lines 4 - 7.

46 Trial Transcript at page 356, line 10.

47 Trial Transcript at page 356, line 11.

48 Trial Transcript at page 356, lines 13 - 15.

49 Trial Transcript at page 356, lines 16 - 19.

50 Trial Transcript at page 356, lines 20 - 24.

51 Trial Transcript at page 357, lines 3- 4.

52 Trial Transcript at page 357, lines 7 - 9.

53 Trial Transcript at page 357, line 16 to page 361, line 13.

54 Trial Transcript at page 359, lines 12 - 18.

55 Trial Transcript at page 360, lines 5 - 7.

"texting and driving, texting and doing anesthesia. Not on a phone, you know, it's the same sort of thing,"[56] because it would have prevented the CRNA from giving her full attention to the patient and kept her from timely executing the appropriate airway management maneuvers.[57]

In regard to the issue of how Dr. Nelson's presence in the room would have changed the outcome, Dr. Kofke testified that due to Mr. Mikell's size — "He's a large man, 300 pounds or so" — it would have been very difficult for the CRNA all by herself to reposition the patient, apply an oxygen mask, and perform the necessary airway maneuvers, especially if those actions were disrupted by typing texts and making phone calls.[58] In that regard, Dr. Kofke also testified there was evidence that the precipitous desaturation began right about the time the last text message was being sent.[59]

Because of uncertainty about the exact timing of events caused by the empty data boxes in the anesthesia record — which he at one point described as "goofy" — Dr. Kofke presented a three part analysis of the breaches of the standard of care.[60] First, if the text messages and phone calls occurred before the desaturation, then a lack of attention to the patient contributed to the descent into the 40s, in breach the standard of care. Second, if text messages or phone calls occurred during the time when the sats were in the 40s, this was a breach of the standard of care because attention should have been focused on the patient. Third, if the text messages and phone calls occurred after the sats went into the 40s, this would mean appropriate airway management maneuvers had not been employed, also a breach of the standard of care. In summary, "if the text messages didn't interfere, then they should have been able to manage

[56] Trial Transcript at page 360, lines 20 - 22.

[57] Trial Transcript at page 361, lines 2 - 13.

[58] Trial Transcript at page 363 - 364.

[59] Trial Transcript at page 477, lines 14 - 22.

[60] Trial Transcript at page 368, line 13 to page 370, line 1.

it."[61]

Dr. Kofke specifically addressed Dr. Nelson's conduct, testifying the standard of care was breached when Dr. Nelson "just popped in and then left" the procedure room despite the sats being "in the 80s at the beginning of the case."[62] Dr. Kofke testified that if both Dr. Nelson and the CRNA had been in the room together "the two of them could have made sure that the airway was — was patent."[63] There was "no question"[64] in Dr. Kofke's mind that Dr. Nelson breached the standard of care: "[Dr. Nelson] had a patient who — who he knew was tenuous, and he didn't pay that much attention to, making only a brief stop in the room — as documented, anyway — before the — before the [cardiac] arrest arose. So he wasn't around for the sats in the 80s or any of that stuff" because he was going in and out.[65]

By way of defense, MUSC elicited testimony from Dr. Kofke that the standard of care would normally allow an anesthesiologist to be out of the procedure room and supervising CRNAs managing as many as four patients at one time.[66] However, Mr. Mikell's crisis did not present the normal circumstance,[67] as Dr. Nelson himself acknowledged when he testified — in response to questions asked by defense counsel — that he should have remained in the procedure room if Mr. Mikell's oxygen saturation levels were not consistently in the 90s. The whole tenor of Dr. Kofke's testimony was that the oxygen levels were <u>never</u> consistently in the 90s, so Dr. Nelson should not have left the room.

ii. Dr. Nelson's testimony

Dr. Nelson testified that when he came into the room around 7:48 or 7:49, Mr. Mikell was

---

[61] Trial Transcript at page 369, lines 21 - 23.

[62] Trial Transcript at page 375, line 24 to page 376, line 13.

[63] Trial Transcript at page 376, lines 14 -22.

[64] Trial Transcript at page 377, lines 5 - 10.

[65] Trial Transcript at page 397, line 16 to page 398, line 4.

[66] Trial Transcript at Page 414, line 14 to page 416, line 3.

[67] Trial Transcript at page 438, lines 13 - 22.

having trouble related to his obstructive sleep apnea:

> I went into the room. It seemed like his oxygen saturations were down a little bit. Because of his sleep apnea, we initially attributed it that maybe he was obstructing, so he wasn't able to get air pass [sic] his soft tissues. They were kind of collapsing his airway . . .[68]

Dr. Nelson testified he was "absolutely positive" he was "in the room at 7:48 or 7:49,"[69] but not before then. Which is to say, Dr. Nelson was absolutely certain that when he first came into the room, Mr. Mikell's airway was already "kind of collapsing" and "his oxygen saturations were down a little bit." This is a patient who's heart is particularly susceptible to variations in blood oxygen and carbon dioxide levels,[70] requiring greater as opposed to lesser attention and care[71] – and he was already in trouble when Dr. Nelson first entered the room. According to Dr. Kofke, this was because Nurse Embry was alone and distracted by the text messages and phone calls trying to fix the PICIS software problem.

The following exchange took place during Dr. Nelson's cross-examination relative to Mr. Mikell's condition:

> Q Okay. You had said, when Mr. Cooke was asking you questions, he was asking you whether the administration of propofol was at about 7:41, you said that sounded about right to you?
> A Yes. Well, I mean, that's what's charted, so.
> Q You weren't in the room at the time that that happened, though, were you?
> A I can't remember if I was or not.
> Q And you also weren't in the room when Donna Embry was sending these text messages and taking these phone calls?
> A. No.
> Q. And so you really don't know anything about how, if at all, that may have interfered with her ability to manage Mr. Mikell, and you don't know anything really about what his condition was when all of that was taking place?
> A. I can't speak to when I was not in the room. . . .
> Q All I'm saying is, since you weren't there, you don't know?

---

[68] Trial Transcript at page 934, line 21 to page 935, line 1.

[69] Trial Transcript at page 938, lines 22 - 25.

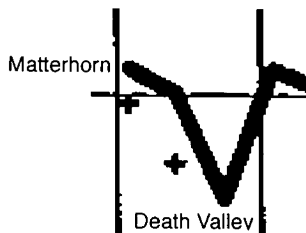
[70] Trial Transcript at page 965, line 12 to page 966, line 4.

[71] Trial Transcript at page 966 lines 5 - 10.

A	Correct.

Q.	But what we do know is that — and I'm pointing to the real time graph — what we do know is, that after she does whatever it is that she's done to get this equipment to start working properly, **as soon as it starts plotting, Mr. Mikell's oxygen saturations, I mean, they are headed down the Matterhorn into Death Valley, aren't they?**

A.	**It appears that way, yes.**



Q.	And you can't tell us, because you weren't there and you don't know, what numbers go in any of these [empty data] boxes?

A.	No, it wasn't coming across.

Q	**All we know is that once it starts [coming across], it looks pretty bad?**

A	**Yeah, I mean, it starts at 7:48, so.**[72]

So by Dr. Nelson's own admission, as soon as the data starts being captured by the PICIS software at 7:48, Mr. Mikell is <u>already</u> in trouble and desaturating into even worse trouble. Yet as all of this is taking place — as Mr. Mikell's oxygen saturations are headed "down the Matterhorn into Death Valley" — consistent with his general practice to be present at the beginning of anesthesia and again at the end, checking the patient every hour or so in between,[73] Dr. Nelson left the room:

Q	Okay. So what we see there is that Mr. Mikell takes a pretty steep descent on his O2 sats, pops back up a little bit, 90; it's not great, and you're gone?

A.	Well at that point in time, we put the nasal airway in, and he was maintaining his airway and he was stable, so.

Q.	**So 7:52, a minute after you go out the door, now he's back at 80**?

A.	Right. But I mean this — this —

Q.	**Three minutes after you've left, he's at 73. Four minutes after you've left, he's at 62. Now, you wouldn't try to tell this jury that an O2 sat of 62 is nothing to be worried about, would you?**

A.	**No. That's bad.**

---

[72] Trial Transcript at page 981, line 21 to page 983, line 9.

[73] Trial Transcript at page 967, line 19 to page 968, line 10.

Q.	Right.
A.	And that's probably about when I cycled back into the room to check again.
Q.	Well, unless we believe your entry in the record, which says that you don't come back into the room until 8:00. And by the time you come back into the room, he's gone into this junctional rhythm. He's in pulseless electrical activity. And by that time, as far as Mr. Mikell is concerned, it's sort of ballgame over, isn't it? I mean, he's — he's done?
A.	I came in the room, and we started coding him, yes.[74]

So when Dr. Nelson first comes into the room, Mr. Mikell is already in trouble. As soon as Dr. Nelson leaves the room, Mr. Mikell desaturates into cardiac arrest.

In regard to the standard of care — what a reasonable medical care provider would or would not do under the same or similar circumstances — Dr. Nelson testified, "I would have had to see consistently his saturations were in the 90s before I would have stepped out of the room" (emphasis added).[75] This testimony establishes a standard of care applicable to Dr. Nelson. Cox v. Lund, 286 S.C. 410, 334 S.E.2d 116 (1985). And there was powerful evidence before the jury that Dr. Nelson breached this standard of care — by leaving the room while Mr. Mikell's oxygen saturations were not "consistently in the 90s."

iii. The anesthesia record and the audit trail

The original, unaltered anesthesia record[76] shows entries made under Dr. Nelson's initials ("EWN"): one at 7:48 ("Anesthesiologist present for induction"); and another at 8:00 ("Memo Came into room.")[77]

10/01/2010 07:48 EWN	Anesthesiologist present for induction
10/01/2010 07:48 EWN	I (or another attending anesthesiologist) was immediately available throughout and present for all key/critical portions of case
10/01/2010 08:00 EWN	Memo Came into room. Pt. hypoxic with junctional rhythm and no palpable pulse. ACLS protocol initiated, Mayday team called.

[74] Trial Transcript at page 979, line 6 to page 980, line 6.

[75] Trial Transcript at page 989, lines 7 - 11.

[76] Plaintiff's Exhibit 2, printed at 13:38 on October 1, 2010.

[77] Plaintiff's Exhibit 2 at page 611 of 2115.

It was Dr. Nelson himself who, intending to be accurate, noted his return to the room at 8:00.[78] These entries are thus evidence that Dr. Nelson was present in the room at the designated times[79] — 7:48 and 8:00 — but not necessarily present in the room at other times.

Two other versions of the anesthesia record[80] include the entry, "Memo Nelson out," both timed at 7:51:

10/01 07:51 DBE Memo Nelson out.

Importantly, the audit trail for the electronic anesthesia record shows that this "Memo Nelson out" entry (indicating when Dr. Nelson left the room) was originally created by Nurse Embry to show the time as 7:50, but she later changed it to 7:51.[81] So from this evidence the jury could reasonably conclude that Dr. Nelson first came into the room at 7:48 and then left as soon as two minutes later at 7:50. The jury could also conclude, from Nurse Embry's conduct in creating and altering these entries, that the time when Dr. Nelson left the room was important to what happened. In other words, that his presence or absence made a difference.

What did the evidence show Mr. Mikell's condition was during those few minutes when Nurse Embry felt it was important to show that Dr. Nelson was present? The one-minute anesthesia record[82] shows the oxygen saturation levels over the 12 minute period from 7:48 to 8:00:

7:48	7:49	7:50	7:51	7:52	7:53	7:54	7:55	7:56	7:57	7:58	7:59	8:00
96.7	75	69.2	90.1	80.7	88	73.3	62.1	75	41.2	47.5		67.6

Consider the oxygen saturation values over the three minute period from 7:48 until 7:50 inclusive:

---

[78] Trial Transcript at page 950, lines 2 - 16; and at page 969, line 1 to page 971, line 13.

[79] These were the only entries showing when Dr. Nelson was in the room prior to Nurse Embry's alteration of the anesthesia chart. *See*, Trial Transcript at page 507, line 4 to page 508, line 15.

[80] Plaintiff's Exhibit 3 at page MUSC 494 of 2115; Plaintiff's Exhibit 6 at page MUSC 2116;

[81] Plaintiff's Exhibit 10 at page BWPH 4951.

[82] Plaintiff's Exhibit 5 at pages MUSC 2151 and 2153.

7:48	96.7
7:49	75.0
7:50	69.2

Two of these three values are not in the 90s. The average of these values is 80.3. The range is 27 points, a variation of 28%. If Nurse Embry's original "Memo Nelson out" entry is accurate, Dr. Nelson left the room at 7:50 — when the oxygen saturation level was 69.2, which Dr. Nelson himself described as "bad."

Why wouldn't this evidence allow a reasonable juror to conclude that the oxygen saturation levels were not "consistently . . . in the 90s," so that it was not alright for Dr. Nelson to leave the room at 7:50? Dr. Kofke testified that at this point, Mr. Mikell was already in trouble.

And of course at 7:52 — just a minute (or two) after Dr. Nelson leaves the room — the oxygen saturations have dropped 10 points in one minute, beginning an erratic but decidedly downward trending pattern that finally bottoms out at 41.2 — Death Valley. According to Dr. Nelson's own entry in the original, unaltered anesthesia narrative, another three minutes elapses before he returns to the room at 8:00 ("Memo came into room, pt. hypoxic with junctional rhythm and no palpable pulse.") Dr. Kofke testified that Nurse Embry could have used help during this time to reposition Mr. Mikell and ventilate him with a mask.

By his own testimony, Dr. Nelson admitted that "you want to intervene"[83] when the oxygen saturations are in the 70s. Yet according to the original, unaltered anesthesia narrative, Dr. Nelson had "stepped out of the room to go to another room,"[84] to check on another patient, while this very situation — oxygen saturations in the 70s or lower — was occurring and getting worse by the minute. Dr. Nelson was gone for about 10 minutes during a time when "you want to intervene," not go check on another patient. According to Dr. Kofke, Nurse Embry needed help during this time.

[83] Trial Transcript at page 943, line 25 to page 944, line 2.

[84] Trial Transcript at page 943, lines 2 - 7.

Dr. Nelson also testified that when he left the room — presumably at 7:50 or 7:51, according to the record — he knew he needed to return "pretty quickly," because Mr. Mikell was a "sicker patient" with whom they "already had to intervene once."[85] Yet his own entry in the original, unaltered anesthesia narrative showed that he did not return for another ten minutes. A reasonable jury could find that under the circumstances, ten minutes was not "pretty quick."

By his own testimony, when Dr. Nelson returned to the room, Mr. Mikell's "saturations were low," he was in "what we call a junctional rhythm," and "I didn't feel a pulse."[86] According to Dr. Nelson, when he entered the room, Nurse Embry had not begun using a face mask to assist Mr. Mikell in breathing.[87] Had he been present, Dr. Nelson could already have been doing so.

All of this evidence certainly supports Dr. Kofke's thesis: Dr. Nelson popped into the room for a few brief minutes; then left at a time when Mr. Mikell was not doing well, leaving Nurse Embry alone to manage the obstructed airway of a 300 pound desaturating patient.

iv. Nurse Embry's testimony

During a discussion about oxygen saturation values, defense counsel asked Nurse Embry, "[I]s there a general number that is considered not compatible with life?"[88] Her response was, "Well, less than — less than 90 — less than 90, you become concerned and try to do something differently."[89] This testimony established the standard of care. *See*, Cox v. Lund, *supra*. Defense counsel tried to soften the blow of this testimony, but Nurse Embry doubled down on it: "If it's trending downward and not getting better immediately, then you need — you need to do something different, . . ."[90]

---

85 Trial Transcript at page 945, lines 10 - 16.
86 Trial Transcript at page 946, lines 9 - 20.
87 Trial Transcript at page 947, lines 4 - 6.
88 Trial Transcript at page 588, lines 20 -21.
89 Trial Transcript at page 588, lines 22- 24.
90 Trial Transcript at page 589, lines 4 - 12.

Consider whether there is any evidence that Mr. Mikell's oxygen saturation level was ever "less than 90" or "trending downward" or "not getting better immediately" and, if so, what Dr. Nelson was doing about it.

Perhaps the most pernicious testimony during the whole trial came from Nurse Embry on re-direct by Plaintiff's counsel:

> Q Now you had said, I think, Mr. Cooke had pointed out with respect to the audit trail, which is Plaintiff's Exhibit 11, that **Dr. Nelson was over here actually at the [PICIS] terminal keying in information at 7:48 — I'm sorry — at 7:49. And what he was putting into the system at that time were these entries as to what he was doing at 7:48?**
>
> A **All right, sir.**
>
> Q And that was what — that's what you and Mr. Cooke talked about; right? So what I wanted to confirm with you then, is if **he's actually on the terminal at 7:49, we see that Mr. Mikell's oxygen saturation is 75.** All right. Now you had testified that when the patient's oxygen saturation is less than 90, you need to be doing something about it? Okay.
>
> A **Yes, sir.**
>
> Q **Would standing at the terminal, entering entries at 7:49 be the thing to be doing when your patient's saturations are 75?**
>
> A **No, sir,** but may I explain? There - there could have been some artifact on the O2 sat, because **if I had noticed that it was that low, or [Dr. Nelson] had noticed that it was that low, we would have done something very differently** than just leaving it at the nasal airway in and the nasal cannula flowing at what it was, so.
>
> Q Well, I just want to make sure I understand this because I'm gathering your defense team is basing your defense on the numbers up here [in the real time variables section]. Okay. And I want to know, can we rely on those numbers as being accurate? Because if they're accurate for your defense, they're accurate for my client, too. And it's the same thing over here with this audit trail, **if Dr. Nelson is on the computer terminal at 7:49 —**
>
> A **Yes.**
>
> Q **— when Mr. Mikell's sats are at 7 — 75, that's malpractice, isn't it?**
>
> A **I don't recall them being that low** when — you know, until he started kind of becoming unstable a little bit later and closer to the Mayday being called.[91]

In short, if Nurse Embry and Dr. Nelson had noticed how low Mr. Mikell's oxygen saturation level was at 7:49 — it was 75 — they would have been doing "something very differently" than what they actually were doing. According to Dr. Kofke, they would have been

[91] Trial Transcript at page 658, line 13 to page 659, line 18 (emphasis added).

repositioning Mr. Mikell, applying airway management maneuvers, and using a mask to ventilate him. According to Dr. Kofke, if these things had been done, the cardiac arrest would have been prevented. And according to both MUSC hospital policy and South Carolina law, Dr. Nelson was responsible for making sure these things happened. Instead, he left the room.

Nurse Embry's only response, when confronted with this irrefragable reality, was to plaintively cry, "But I don't remember it happening that way." As Plaintiff's counsel pointed out, unless the numbers defense counsel himself chose to establish are lying, that is what happened, whether Nurse Embry says she remembers it or not.

The failure of Nurse Embry and Dr. Nelson to notice the oxygen saturations in the 70s, and their failure to respond in the fashion Dr. Kofke described, is evidence from which a reasonable juror could find Dr. Nelson committed malpractice. Period. This testimony alone was all the Plaintiff needed for his claims of malpractice by a physician to go to the jury.

Nurse Embry's extremely damaging testimony lays bare the basic truth of the Plaintiff's entire theory of the case: Dr. Nelson's attestation entries in the narrative section of the anesthesia record — the ones that Nurse Embry could not alter after the fact — show that just like Emperor Nero was fiddling as Rome burned, Nurse Embry and Dr. Nelson were neither paying attention nor reacting appropriately while Mr. Mikell was desaturating and getting into irreversible trouble.[92] His underlying medical conditions meant there was no time to fool around as his blood oxygen levels decreased and his carbon dioxide levels increased.

v. Dr. Reeves' testimony

Scott Reeves, MD is an anesthesiologist and Chairman of MUSC's Department of Anesthesia.[93] He testified that the anesthesia services provided to Mr. Mikell were controlled by

---

[92] Trial Transcript at page 564, lines 7 - 10.

[93] Trial Transcript at page 729, lines 16 - 25.

MUSC's Policies and Basic Standards of Anesthesia Care, which provide:[94]

> During the elective surgical schedule, **all anesthetics administered** in the Operating Room **will be the responsibility of the anesthesiologist** assigned to the specific case or his/her designate. **The certified nurse anesthetist** and house staff **will be under his/her direction and supervision.**
>
> * * *
>
> These standards apply for any administration of anesthesia involving the Department of Anesthesia personnel and are specifically referable to . . . DDC locations.
>
> * * *
>
> Anesthesia care will be provided by the Attending Anesthesiologist. Certified Registered Nurse Anesthetist and House Staff may perform anesthesia **under supervision of an Attending Anesthesiologist**.
>
> * * *
>
> 2. Prior to administering anesthesia, **the practitioner administering anesthesia will check and document the readiness**, availability, cleanliness, sterility where indicated, **working condition** and the alarm systems **of all equipment to be used.**
>
> * * *
>
> 5. Continuous monitoring: During every administration of general anesthesia, the anesthesia provider shall employ methods, which continuously monitor the patient's ventilation and circulation. . . Pulse oximetry is mandatory on all patients. . . .
>
> * * *
>
> 9. **All information is to be accurately recorded on the anesthetic record.** This shall at least include monitoring data, . . . and any unusual occurrence during the course of the anesthetic.

Dr. Reeves further testified that under South Carolina law,[95] a nurse anesthetist like Nurse Embry is not allowed to administer anesthetic agents like Propofol unless she is being supervised and directed by a medical doctor.[96] In this context, "supervision" means "the process of critically observing, directing, and evaluating another's performance."[97]

According to Dr. Reeves, it would be a breach of the standard of care to administer an anesthetic agent to a patient without first checking to make sure all of the equipment was

---

[94] Plaintiff's Exhibit 8 (bolded emphasis added); Trial Transcript at page 730, line 1 to page 732, line 5.

[95] *See*, S.C. CODE REG. R.61-16 §1212(A)(4).

[96] Trial Transcript at page 732, line 22 to page 733, line 2.

[97] S.C. CODE ANN. §40-33-20(57).

functioning correctly.[98] This would include anything that might prevent some piece of equipment from functioning as properly intended.[99] If an anesthesia provider knew the PICIS software was not functioning properly, they should fix that before the patient is rendered unconscious.[100] This standard of care applies to both nurse anesthetists and anesthesiologists.[101]

During her testimony, Nurse Embry repeatedly acknowledged that she had started giving Mr. Mikell Propofol after discovering the PICIS software was not recording Mr. Mikell's vital signs data in the electronic anesthesia record but before this glitch was fixed.[102] Pursuant to Dr. Reeve's testimony, this was a breach of the standard of care. Pursuant to the Policies and Basic Standards of Anesthesia Care, Dr. Nelson was responsible for this breach because he was "medically directing the case" and "in charge."[103]

Dr. Reeves also testified, with respect to the real time graph section of the anesthesia record, that the downward sloping trend begins at 7:48,[104] while Dr. Nelson was in the room and just before he left.

2. Dr. Zile's opinion testimony

In 2003, Michael Zile, MD became one of Mr. Mikell's treating cardiologists at MUSC. In pretrial discovery, his medical chart for Mr. Mikell was produced; and Dr. Zile's deposition was taken by Plaintiff's counsel on October 7, 2014. However, MUSC never identified Dr. Zile as a

---

[98] Trial Transcript at page 733, lines 13 - 19.

[99] Trial Transcript at page 734, lines 2 - 12.

[100] Trial Transcript at page 735, lines 5 - 10; at page 738, lines 12 - 21; and at page 739, line 18 to page 740, line 2.

[101] Trial Transcript at page 733, lines 13 - 19.

[102] Trial Transcript at page 504, line 22 to page 505, line 12; page 538, lines 5 - 14; page 637, lines 12- 24.

[103] Trial Transcript at page 547, lines 14 - 16.

[104] Trial Transcript at page 758, lines 3 - 8; and at page 759, lines 11 - 15.

fact witness;[105] nor did MUSC ever identify Dr. Zile as an expert witness,[106] or disclose to Plaintiff's counsel any opinions held by Dr. Zile outside the contents of his medical chart.

MUSC called Dr. Zile as a witness at trial and — under the guise of questions about Mr. Mikell's "prognosis" — propounded expert opinion testimony about Mr. Mikell's life expectancy, to the effect that Mr. Mikell's heart problems put him at risk of dropping dead at any minute because Mr. Mikell had already well outlived his life-expectancy by the time of the colonoscopy in October 2010:

> [In 2003] his five year mortality, the chance of him dying within five years, was 50 percent or greater. The chance of him being hospitalized for recurrent heart failure within six — any six month period of time was 50 percent. His eight year mortality — I'm sorry — the chances of him dying within eight years exceeded 80 percent.[107]

In addition to this highly prejudicial surprise opinion testimony, Dr. Zile also rendered an opinion about the effect the October 2010 cardiac arrest had on Mr. Mikell's mortality and morbidity,[108] even though Dr. Zile had not seen Mr. Mikell for six months before the cardiac arrest; and had not seen him a single time after the cardiac arrest.

The Plaintiff objected to this opinion testimony[109] and asked the lower court to strike it[110] on three grounds: (1) that no notice had been given to the Plaintiff that Dr. Zile would present opinions about life expectancy;[111] (2) that his opinions were not scientifically reliable because not rendered to a reasonable degree of medical certainty;[112] and (3) there was no proper

---

105 MUSC's Answers to Plaintiff's First Discovery Request.

106 MUSC's Supplemental Answers to Plaintiff's First Discovery Request.

107 Trial Transcript at page 816, line 22 to page 817, line 8; and at page 852, lines 10 - 13.

108 Trial Transcript page 818, lines 1 - 7.

109 Trial Transcript at page 819, lines 2 - 3; at page 822, lines 2 - 7; and at page 852, lines 15 - 21.

110 Trial Transcript at page 823, lines 15 - 16; page 838 at lines 16 - 17; and at page 884, lines 5 - 11.

111 Trial Transcript at page 824, line 12 to page 825 line 1.

112 Trial Transcript at page 825, lines 2 - 15.

foundation for Dr. Zile to render opinions on the effect of an October 1, 2010 cardiac arrest when he had not seen Mr. Mikell since April 30, 2010, at which time Dr. Zile had described Mr. Mikell in his medical chart as "doing exceedingly well."[113]

The lower court correctly ruled that MUSC should not be allowed to present expert opinion testimony of which the Plaintiff had been given no prior notice:

> My problem is you never told the other side, hey, he's going to be an expert witness. I'm going to qualify him. He's going to give some opinions, and give him a synopsis of those opinions. I think that's what the rule requires. That has not been done.[114] * * * I'm not going to allow it at this point in time in the trial.[115]

However, despite this ruling the lower court nevertheless inexplicably refused to strike Dr. Zile's life expectancy opinion.[116]

The lower court also allowed Dr. Zile to testify, over Plaintiff's objection and motion to strike,[117] about whether certain of Mr. Mikell's heart medications were properly indicated (meaning, whether his condition merited continuing to take them) following the cardiac arrest.[118] This opinion testimony was important because Dr. Kofke had testified, in regard to cause of death, that Mr. Mikell's cardiac arrest lead to some of his heart medicines being changed; and those medication changes substantially contributed to Mr. Mikell's death.[119] Dr. Zile had not seen Mr. Mikell since April 30, 2010, so he had no proper foundation for rendering opinions about medication changes he was not even aware of. Additionally, as with Dr. Zile's other opinions, MUSC had not given the Plaintiff any notice that Dr. Zile would offer these opinions at

---

[113] Trial Transcript at page 831, lines 8 - 18.

[114] Trial Transcript at page 828, lines 4 - 9.

[115] Trial Transcript at page 836, lines 14 - 15.

[116] Trial Transcript at page 838, line 18; and at page 884, lines 17 - 18.

[117] Trial Transcript at page 841, lines 8 - 9.

[118] Trial Transcript at page 835, line 6 to page 836, line 4; at page 845, lines 6 - 16; and at page 856, line 6 to page 857, line 10.

[119] Trial Transcript at pages 378, line 12 to page 395, line 13; at page 398, line 17 to page 407, line 12; and at page 480, line 19 to page 481, line 14.

trial.

Through these errors by the lower court, MUSC succeeded in placing before the jury an alternative explanation for Mr. Mikell's death: he was a dead man walking, ready to drop at any moment because he had outlived his life-expectancy regardless of his medications. MUSC thereby successfully undermined Dr. Kofke's testimony linking Mr. Mikell's death to the cardiac arrest.

3. MUSC's medical record document dump

Over Plaintiff's objection,[120] MUSC was permitted to place into evidence[121] 131 pages of medical records from Mr. Mikell's cardiology chart at MUSC.[122] Most of this material involved highly technical information, including echocardiography reports, laboratory test results, radiology reports, and innumerable diagnoses, assessments, and other subjective medical opinions,[123] none of which lay jurors could reasonably be expected to properly evaluate or understand in the absence of some guidance from a properly qualified witness. For example, how could lay jurors be expected to understand the significance of multiple lab tests showing the levels of sodium, potassium, chloride, calcium, and magnesium in Mr. Mikell's blood? There was not one iota of testimony from anyone about what these blood values mean.

While the lower court initially ruled that subjective opinions in these medical records would need to be redacted,[124] it later changed its mind, erroneously allowing the subjective opinions to go into evidence as well.[125]

---

[120] Trial Transcript at page 867, line 18 to page 882, line 8.

[121] Trial Transcript at page 1234, lines 16 - 20.

[122] Defendant's Exhibit 8.

[123] *See*, Rule 803(6), SCRE, which excludes subjective opinions from the hearsay exception for business records.

[124] Trial Transcript at page 878, lines 23 - 25; at page 879, lines 3 - 5; and at page 881, line 13 to page 882, line 8.

[125] Trial Transcript at page 1234, lines 16 - 20.

Placing this large volume of technical information into the jury deliberation room created a high likelihood of confusion. *See*, SCRE 403 (although relevant, evidence may be excluded if its probative value is substantially outweighed by the danger of confusion of the issues or misleading the jury).

An intelligent evaluation of complex facts and information is often difficult or impossible without application of some scientific, technical, or other specialized knowledge. The medical records at issue are of a character that untrained laymen are simply not qualified to determine intelligently what the proper import of their contents might be. When admitting this type of scientific or technical evidence, the lower court must first find that it will assist rather than confuse the jury. *See*, State v. Council, 335 S.C. 1, 515 S.E.2d 508 (1999)(explaining proper analysis for admissibility of scientific or technical evidence); *see also*, State v. Jones, 273 S.C. 723, 259 S.E.2d 129 (1979)(setting forth factors for trial court to consider in determining admissibility of scientific evidence).

The lower court undertook no inquiry whatsoever to satisfy itself that the medical records met the Council requirements under Rules 702 and 403, SCRE, that: (1) they will assist the trier of fact in determining some fact in issue; and (2) their probative value is not outweighed by their prejudicial effect in confusing the jury. As the South Carolina Supreme Court said in Watson v. Ford Motor Co., 389 S.C. 434, 456, 699 S.E.2d 169, 180 (2010):

> The trial court serves as the gatekeeper in the admission of all evidence presented at trial, and in making admissibility determinations, the trial court is required to make certain preliminary findings regarding admissibility requirements, such as qualification of experts, reliability of the substance of the testimony, and substantial similarity of alleged similar incidents, before a jury may hear evidence. If these preliminary requirements are not met, as a matter of law, the trial court may not permit the jury to consider the evidence.

Because the threshold admissibility requirements of assistance and lack of confusion were not met, it was error for the lower court to admit these medical records into evidence despite their status as business records. *See*, Kershaw County DSS v. McCaskill, 276 S.C. 360,

362, 278 S.E.2d 771, 773 (1981)("Not everything contained in a 'business record' is automatically admissible.") This improper evidence further undermined the Plaintiff's case because it gave the jury the opportunity to find for itself, somewhere in these records, an explanation for Mr. Mikell's cardiac arrest other than the anesthesia providers' malpractice.

4. The blank Mayday form

No issue in the case was more contentious than that of the missing Mayday record from Mr. Mikell's cardiac arrest — an issue central to the Plaintiff's Motion for Discovery Sanctions which is the subject of a separate appeal. MUSC hospital policy[126] required the creation of a Mayday record which was supposed to be made a part of Mr. Mikell's chart. MUSC ultimately was forced to concede that the Mayday record had been lost and/or destroyed. The Plaintiff directly attacked the credibility of two MUSC witnesses, Nurse Embry and Dr. Guldan, over their testimony about the missing Mayday record. The Plaintiff also sought, and the lower court granted, an adverse inference jury instruction pursuant to Stokes v. Spartanburg Regional Medical Center, 386 S.C. 515, 629 S.E.2d 675 (Ct. App. 2006).

In order to counter this adverse inference and to bolster the credibility of its witnesses, MUSC sought to prove to the jury that the lost Mayday record did not contain any important information. In other words, MUSC sought to prove the contents of the missing Mayday record. Central to this effort was Defendant's Exhibit 2, a blank Mayday form which served as the predicate for asking MUSC witness Sheila Scarborough a series of improper questions:

> Q. What information should or would be documented in an actual Mayday record code sheet?[127]
>
> Q. [S]o did the labels on the [blank] document and each of the various sections describe accurately the data that is recorded during a Mayday or code?[128]

---

[126] Plaintiff's Exhibit 9.

[127] Trial Transcript at page 245, lines 23 - 25.

[128] Trial Transcript at page 246, lines 17 - 19.

Q. Do those sections represent the information that is supposed to be recorded in the form during a code or a Mayday resuscitation?[129]

These questions had no purpose other than to fill in the blanks on the missing Mayday record so that the Stokes adverse inference could be counter-balanced if not entirely defeated. Despite the fact that a blank form does not tend to make the existence of any fact of consequence to the determination of the action more or less probable than it would without the blank form, *see*, Rule 401, SCRE, the lower court allowed it into evidence over the Plaintiff's objection.[130]

Once the form was in evidence, a full scale assault on the best evidence rule, Rule 1002, SCRE, began:

Q. And the information on the form — there are various places to record information; correct?
A. That's correct.
Q. Okay. Is this representative of the information that was documented in the form during resuscitation after a Mayday was called?
A. Yes. This is the type of information that is documented for Maydays.[131]

The next series of questions were designed to convince the jury that the contents of the missing Mayday form for Mr. Mikell's cardiac arrest were of no consequence:

Q. Now Ms. Scarborough, what information is — is documented in the resuscitation form? And when I say that, I'm really referring to — is it information that occurs after a Mayday is called?
A. After the Mayday is called, yes. After it's determined that the patient is in cardiopulmonary arrest.
Q. Does — is anything that occurs, generally speaking, prior to the time of the Mayday, recorded in this document?

Once again, Plaintiff's counsel objected and was overruled.[132] Defense counsel and the witness continued the effort to fill in the contents of the missing Mayday record:

---

[129] Trial Transcript at page 246, line 24 to page 247, line 1.

[130] Trial Transcript at page 253, lines 14 to page 254, line 7.

[131] Trial Transcript at page 252, lines 12 - 19.

[132] Trial Transcript at page 254, lines 21 - 25.

A. It's actually about the resuscitation, but it's what the patient's condition was at the time that he went into cardiac arrest. . . . It's all about at the time of cardiac [sic] pulmonary arrest on — until the patient is resuscitated or not, that's what the information in the form is all about.[133]

The whole point of this exchange was to convince the jury that the contents of the missing Mayday record would not include any information about events prior to the effort to resuscitate Mr. Mikell — meaning, it would not include any information about his unstable condition leading up to and including the desaturation. This point was crucial to MUSC because Stokes permitted the jury to conclude the Mayday record had been "lost" because it contained evidence of malpractice.

The reason this whole effort was objectionable is because the best evidence of the contents of Mr. Mikell's Mayday record is the Mayday record itself, not some blank form filled in from the witness stand by the testimony of Ms. Scarborough. The best evidence rule — codified at Rule 1002, SCRE — simply says that the best evidence of the contents of a document is the document itself: "To prove the content of a writing, . . . the original writing . . . is required." In the absence of the Mayday record itself, MUSC was not permitted to place the supposed contents of the Mayday record into evidence, either through the use of a blank form or through the testimony of a witness.

The elementary wisdom of the best evidence rule rests upon the fact that the document is a more reliable, complete, and accurate source of information as to its contents and meaning than anyone's description. Gordon v. United States, 344 U.S. 414, 73 S.Ct. 369 (1985). The best evidence rule thus prohibits questioning a witness about the contents of a document which is not itself in evidence. Jackson County Board of Health v. Fugett Construction, Inc., 270 Ga. 667, 514 S.E.2d 28 (1999). In South Carolina, the best evidence rule specifically prohibits testimony about the contents of a medical record when the record itself is not in evidence.

[133] Trial Transcript at page 255, lines 2 - 13.

Griggs v. Griggs, 230 S.C. 97, 94 S.E.2d 225 (1956).

It was error for the lower court to allow MUSC to introduce improper secondary evidence of the contents of Mr. Mikell's Mayday record. This included both the blank Mayday form admitted into evidence as Defendant's Exhibit 2; and the testimony of Ms. Scarborough describing the contents of Mr. Mikell's Mayday record. Through this improperly admitted evidence, MUSC was able to counter the Plaintiff's attack on its witnesses' credibility and counter the adverse inference permitted under Stokes.

5. Failing to inform the jury of the court's ruling on the claim for physician malpractice.

Throughout the trial, the Plaintiff took pains to develop before the jury the theory that Dr. Nelson was at fault for failing to check the PICIS system before the colonoscopy began; for failing to properly supervise Nurse Embry; and for leaving the room when Mr. Mikell's condition was unstable. When it granted MUSC's motion for partial summary judgment, the lower court removed the Plaintiff's carefully crafted physician negligence claims from the jury's consideration. Instead of informing the jury of its ruling, however, the lower court simply instructed Plaintiff's counsel to refrain from discussing the physician negligence claims during closing arguments.

The result was that claims which had occupied a significant amount of time during the presentation of evidence were left inexplicably absent from any discussion during closing arguments. The ability of Plaintiff's counsel to effectively represent his client was thus impaired because the situation gave the jury the impression that Plaintiff's counsel did not think enough of his own position to even merit mentioning it to the jury, let alone urging the jury to adopt it.

This rhetorical vacuum diminished the credibility of Plaintiff's counsel in the eyes of the jury, thereby rendering the trial fundamentally unfair. It was reversible error for the lower court to force Plaintiff' counsel to involuntarily shift his theory of the case in such a significant fashion

without any explanation being given to the jury for why this dramatic change was occurring. *See*, State v. Johnson, 418 S.C. 587, 795 S.E.2d 171 (2016)(when a trial court's erroneous ruling impairs counsel's credibility with the jury, the trial is rendered fundamentally unfair); State v. Jones, 343 S.C. 562, 541 S.E.2d 813 (2001)(trial court commits reversible error when it's conduct diminishes counsel's credibility in the eyes of the jury).

CONCLUSION

The lower court erred in granting MUSC's motion for partial summary judgment as to the Plaintiff's claim for physician negligence. First, the lower court improperly found that Dr. Nelson's failure to adequately supervise Nurse Embry was not medical malpractice but rather an unplead type of ordinary negligence. Second, the lower court improperly found no evidence that Dr. Nelson's presence in the room would have made any difference to Mr. Mikell's outcome. Third, there was an abundance of evidence that Dr. Nelson left the room when Mr. Mikell's condition was unstable and required the attention of both he and Nurse Embry to reposition him, clear his airway obstruction, and administer oxygen via face mask. Fourth, the Plaintiff's expert, Dr. Kofke, testified that had these things been done, Mr. Mikell's cardiac arrest would have been prevented. Finally, there was testimony from Dr. Kofke, Dr. Nelson, Nurse Embry, and Dr. Reeves — together with evidence in the anesthesia record and audit trail — from which a reasonable juror could have concluded that Dr. Nelson was at fault in causing Mr. Mikell's cardiac arrest. These errors, individually and in combination, deprived the Plaintiff of his rightful opportunity to receive a verdict from the jury on his claim for physician malpractice.

The lower court also erred in allowing Dr. Zile to present previously undisclosed opinion testimony which was not within a reasonable degree of medical certainty and which lacked an adequate factual foundation. The lower court further erred in allowing MUSC to dump a large volume of medical records into evidence without any testimony or other guidance about the

meaning or import of the technical information those records contained. The lower court erred in allowing MUSC to violate the best evidence rule by placing a blank Mayday form into evidence. And the lower court erred by not informing the jury of its decision to remove the physician negligence claim from its consideration, thereby improperly undercutting the credibility of Plaintiff's counsel. These errors infected the jury's decision to return a verdict in favor of MUSC on the claim for nursing malpractice.

As a result of these errors, the decision of the lower court to grant partial summary judgment on the claim for physician negligence should be reversed. Likewise, the jury's verdict in favor of MUSC on the claim for nursing malpractice should be reversed. This case should be remanded for a new trial on the Plaintiff's causes of action for Medical Malpractice, Survival, and Wrongful Death.

Respectfully submitted

By:

Robert B. Ransom
LEVENTIS & RANSOM
Post Office Box 11067
Columbia, SC 29211
803-765-2383
bertcone@aol.com

Alex Apostolou
3443 Rivers Avenue
North Charleston, SC 29405
843-853-3637
alex@apostoloulaw.net

ATTORNEYS FOR THE
APPELLANT SHON TURNER

IN THE STATE OF SOUTH CAROLINA
In the Court of Appeals

RECEIVED
MAY 16 2017
SC Court of Appeals

APPEAL FROM CHARLESTON COUNTY
Court of Common Pleas

J. C. Nicholson, Circuit Court Judge

Appellate Case No. 2016-001986

Shon Turner as Personal Representative
of the Estate of Charles Mikell, deceased,. . . . . Appellant

v.

The Medical University of South Carolina . . . . Respondent

PROOF OF SERVICE

I certify that I have served the Initial Brief of Appellant Shon Turner on The Medical University of South Carolina by depositing a copy of it in the United States Mail, postage prepaid, on April 21, 2017, addressed to its attorney of record, M. Dawes Cooke, Jr.,

May 16, 2017

By: [signature]

Robert B. Ransom
Leventis & Ransom
Post Office Box 11067
Columbia, SC 29211
(803) 765-2383
Attorney for the Appellant

LEVENTIS & RANSOM

ATTORNEYS AT LAW

Post Office Box 11067
Columbia, South Carolina 29211

1913 Bull Street
Columbia, South Carolina 29201

Telephone (803) 765-2383
Facsimile (803) 799-1612 (fax)

James J. Leventis
jjleventis@aol.com

Robert B. Ransom
bertcone@aol.com

May 16, 2017

Jenny Abbott Kitchings
South Carolina Court of Appeals
Calhoun Building, 1220 Senate Street
Columbia, SC 29211

RECEIVED
MAY 16 2017
SC Court of Appeals

Re: Shon Turner v. MUSC
Appellate Case No. 2016-001986

Dear Ms. Kitchings:

Enclosed please find one copy of the Initial Brief of Appellant Shon Turner along with a Proof of Service.

Also enclosed please find one copy of the Appellant Shon Turner's Designation of Matter to Be Included in the Record on Appeal along with a Proof of Service.

Thank you for your attention to this matter. Please call me if you have any questions or comments.

Very truly yours,

Robert B. Ransom

c: M. Dawes Cooke, Jr., Esq.
Alex Apostolou, Esq.