THE STATE OF SOUTH CAROLINA
In the Court of Appeals

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

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

RESPONDENT THE MEDICAL UNIVERSITY OF SOUTH CAROLINA'S FINAL RESPONDENT'S BRIEF

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COUNTERSTATEMENT OF ISSUES ON APPEAL

I. Did the trial court properly enter judgment as a matter of law as to Plaintiff's medical malpractice claim against Dr. Eric Nelson, where there was no evidence that: (a) Dr. Nelson left the room when Mr. Mikell's blood oxygen saturation levels were low or unstable; or (b) Dr. Nelson breached any duties regarding the operation of the PICIS system?

Suggested Answer: *Yes.*

II. Did the trial court properly enter judgment as a matter of law as to Plaintiff's medical malpractice claim against Dr. Eric Nelson, where there was no evidence that any alleged negligence by Dr. Nelson proximately caused any harm to Mr. Mikell?

Suggested Answer: *Yes.*

III. Even if the trial judge erred in entering judgment as a matter of law as to Plaintiff's medical malpractice claim against Dr. Eric Nelson, should this Court affirm where any such error had absolutely no impact upon trial or the jury's verdict?

Suggested Answer: *Yes.*

IV. Did the trial court properly allow Plaintiff's treating doctor, Dr. Michael Zile, to testify regarding Mr. Mikell's condition and likely future prognosis, where Plaintiff disclosed expert testimony regarding causation only a week prior to trial?

Suggested Answer: *Yes.*

V. Did the trial court properly admit medical records from Mr. Mikell's cardiology chart into evidence, where such records were indisputably authentic and relevant?

Suggested Answer: *Yes.*

VI. Did the trial court properly admit into evidence the blank "Mayday form," where MUSC sought to use that exhibit only to show the type of information contained on a "Mayday form"?

Suggested Answer: *Yes.*

VII. Did the trial court properly decline to inform the jury about its ruling on judgment as a matter of law as to the medical malpractice claim against Dr. Nelson, where that ruling had no impact on the jury's consideration of the case?

Suggested Answer: *Yes.*

COUNTERSTATEMENT OF THE CASE

I. FACTUAL BACKGROUND

A. Plaintiff's Procedure

This lawsuit involves claims by Plaintiff Shon Turner ("Plaintiff"), as Personal Representative of the Estate of Charles Mikell ("Mr. Mikell"), asserting survival and wrongful death claims against Defendant The Medical University of South Carolina ("MUSC").

Mr. Mikell (date of birth 1/25/1961) first came under the care of physicians at MUSC in 2003:

> He had had a very severe episode of low blood sugar, which we call hypoglycemia, and had a loss of consciousness, and I believe a cardiac arrest, was admitted to Roper Hospital. They felt that he had severe congestive heart failure, and they wanted to have the Medical University provide our expertise in the care of heart patients for Mr. Mikell. . . .
>
> I think he had ventricular tachycardia that was actually induced by the fact that he had this very, very, very low blood sugar. His blood sugar was in the 30s. Most of you have blood sugars sitting here in this room of about 100. So this would be two-thirds reduction. And I think that's why he lost consciousness and had irritability in his heart.
>
> When people have a very, very low blood sugar, they change a lot of things in their blood. They change the PH or acidity in their blood. They change the chemicals or electrolytes, potassium, for example. And it puts people at risk for these kind of events.

(*See* R. pp. 1219:8-14, 1220:10-21).

On October 1, 2010, Mr. Mikell's primary care physician, Dr. Jeffrey Akhtar, referred him to the Digestive Disease Center at MUSC for a colonoscopy because he was suffering from constipation, abdominal pain and bloating. In addition, Mr. Mikell was due for a colonoscopy to screen for colon cancer. Mr. Mikell was overweight and had several preexisting conditions, including nonischemic dilated cardiomyopathy, atrial ventricular nodal reentry tachycardia, chronic kidney disease, hypertension, diabetes, G6PD deficiency, gallbladder disease, hyperlipidemia, and sleep apnea. (*See generally* R. pp. 275-404).

Board Certified Cardiac Anesthesiologist Dr. Eric Nelson ("Dr. Nelson") and experienced Certified Registered Nurse Anesthetist ("CRNA") Donna Embrey ("Nurse Embrey") conducted the anesthesia aspect of Mr. Mikell's colonoscopy. Mr. Mikell was given Propofol at 7:41 on the morning of the incident at issue in this case. (*See* R. p. 1340:14-18). After the administration of Propofol, Mr. Mikell's blood oxygen saturation levels began to drop. At 7:48, Mr. Mikell's blood oxygen saturation level was 96.7%, a "very good" level. (*See* R. p. 1347:3-14). At 7:49, the level was recorded at 76% and at 7:50 the level was recorded at 69.2%. (*See* R. pp. 218-20). Dr. Nelson was definitely in the room at 7:49. (*See* R. pp. 1343:22-1344:4). When Mr. Mikell's blood oxygen saturation levels dropped, Dr. Nelson and Nurse Embrey put in a nasal airway (cannula), which increased and stabilized Mr. Mikell's blood oxygen saturation levels. (*See* R. p. 1348:8-12).

Following the placement of a nasal cannula, Dr. Nelson observed Mr. Mikell's blood oxygen saturation levels increase up to at least 90% and left the procedure room at 7:51. (*See* R. p. 1348:8-17). Dr. Nelson testified that "[a]t the time I stepped out of the room, his vital signs were stable. He was in the hands of an experienced nurse anesthetist, and I was very close by." (*See* R. pp. 1361:25-1362:9). When Dr. Nelson stepped out of the room, he was only across the hall and could easily be reached in the event of an emergency involving Mr. Mikell. (*See* R. pp. 1350:4-1351:5). The evidence further showed that this was proper supervision of Nurse Embrey in the treatment of Mr. Mikell. (*See* R. p. 1349:13-24). Nurse Embrey testified that she was comfortable with this arrangement and that Dr. Nelson was available "almost immediately" if she needed him. (*See* R. pp. 1051:15-1053:11). Dr. W. Andrew Kofke even testified that Dr. Nelson's availability to Nurse Embrey was appropriate; he even testified that it is acceptable for the attending physician to be as much as two minutes away from the operating room and that being directly across the hall would certainly be acceptable. (*See* R. pp. 818:6-820:3). Moreover, Dr. Kofke testified that he could handle up to *four* procedures simultaneously; Dr. Nelson and Nurse Embrey only had *two* procedures on the morning at issue (one patient other than Plaintiff). (*See* R. pp. 818:6-819:12).

After Dr. Nelson's departure, Mr. Mikell's blood oxygen saturation levels dropped, falling to 41.2 at 7:57 (six minutes after he left the room). (*See* R. pp. 218-20). Dr. Nelson testified regarding his return to the procedure room:

> I know it was -- when I came back in, it was when he -- his saturations were low. So I would – I don't remember the exact time, and if my time would actually match up with here, but it was probably between 7:55 and 7:58. Because I still remember, to this day, I walked back in the room and the monitor he was in -- what we call a junctional rhythm, which basically is kind of a squiggly line on the EKG instead of the nice QRS complex that you're used to seeing. And I felt his pulse, and I didn't feel a pulse.
>
> And so, at that point in time, I said we needed to start chest compressions. And these patients are propped up on a wedge on their side, and so we pull the wedge out. Dr. Payne took the scope out. And we started doing chest compressions because we realized that his heart, if it was beating or moving, was not pumping blood adequately enough to the rest of his body.

(*See* R. pp. 1351:11-1352:3). Dr. Nelson was back in the room by 7:55 or 7:56, in light of the measures of peak inspiratory pressure. (*See* R. pp. 1353:10-1354:23).

Mr. Mikell became hypoxic, bradycardic, developed a junctional heart rhythm, became pulseless, and had a cardiac arrest. (*See* R. p. 202). Mr. Mikell was fully resuscitated, a hypothermia protocol was instituted, and he was admitted to the ICU at MUSC for further evaluation and treatment.

Following the arrest, Mr. Mikell developed acute renal failure in addition to his pre-existing chronic kidney disease and underwent hemodialysis. He also had difficulty weaning from the ventilator and received a tracheostomy on October 12, 2010. A cardiac consult was performed on October 4, 2010 and his heart function was evaluated. Plaintiff presented no evidence that Mr. Mikell suffered an acute ischemic event or any injury to his heart because of the arrest.

On October 26, 2010, Mr. Mikell was transferred to Kindred Hospital, which is a long-term acute care hospital located in Charleston. (*See* R. pp. 265-67). His tracheostomy was removed on November 11, 2010 and his respiratory failure was resolved. (*See* R. pp. 268-69). Dialysis was stopped on November 3, 2010, and Mr. Mikell was discharged home from Kindred

on November 19, 2010. (*See id.*). Plaintiff presented no competent evidence that Mr. Mikell suffered any lasting injury because of his arrest at MUSC. On January 2, 2011, approximately six weeks after his discharge from Kindred Hospital, Mr. Mikell complained that he was feeling bad and was later found dead in his home. Plaintiff presented no competent evidence establishing that the arrest during the colonoscopy at MUSC caused Mr. Mikell's death.

B. <u>The PICIS System</u>

From 2007 through June 30, 2014, MUSC used "PICIS" as its electronic medical record software to document anesthesia and post-anesthesia care. (*See* R. p. 1292:10-13). Trial testimony described the PICIS system as follows:

> So PICIS is an application that was used by perioperative services, surgery and anesthesia, and that's what they used to document everything that happened during the surgery.
>
> It's comprised of two major pieces; there's a user application, which is what the nurses, the doctors, and the residents used. And it also has a back-end database, which is where all data is stored. Everything that is entered into PICIS, both from the users and from any machine linked into it, all information is stored on that database.

(*See* R. pp. 1292:25-1293:10). PICIS essentially captures and records data from monitors attached to the patient:

> Q. Now, while I've got this one up here, what of those -- how do those numbers get into that chart?
>
> A. So, there is a cable that -- as I understand it, my rudimentary understanding of it -- is that there is a cable that runs from the Phillips monitor and our anesthesia machine into the computer system. And it's captured by PICIS, our program, when we pull up that patient and that data on that machine in that room.
>
> Q. Now, which of those numbers up there are -- are entries -- are entered by a machine and which are entered by a human being?
>
> A. As I understand it, all of the -- all of the entries are the machine data that comes over.

(*See* R. pp. 996:20-997:7). When the captured PICIS data is printed out, it can be printed out at various time intervals. (*See* R. pp. 1001:22-1002:19).

For a very short time, the monitors attached to Mr. Mikell did not record data in the PICIS system because of a temporary communication problem between the physiological monitors and the PICIS system. (*See* R. p. 940:4-6 ("[T]he computer charting was not communicating with what I was seeing on the monitors.")). Plaintiff presented no evidence that this negatively affected Nurse Embrey's or Dr. Nelson's ability to see real-time data for Mr. Mikell.

As a result of this communication problem between the monitoring equipment and PICIS, Nurse Embrey sought support to remedy the situation. Specifically, Nurse Embrey testified that she sent two brief text messages to the support person and received one phone call. (*See* R. p. 907:15-21). MUSC's manager of Enterprise Application Development testified that the support person could often remotely transfer the patient to the operating room setting in PICIS. (*See* R. pp. 1301:22-1302:3). Specifically, Nurse Embrey sent the following short messages to MUSC's information technology person at 7:39:08 and 7:46:12, respectively:

- hey – call me re; NORA pt not in transfer bucket. TX!! Donna
- hey- can you call me abck. TX! donna

(*See* R. p. 256).

Nurse Embrey testified that she could monitor Mr. Mikell's condition while engaging in these efforts to connect the monitors to PICIS.

> Q. So if we were to pretend for a moment that this courtroom is set up the way that this room is set up, when you're using the keyboard, you're facing the screen just as you are right now. And the patient would be behind you, just like the TV monitor is?
>
> A. No. I understand this is -- this is the set up as you've photographed it, Rob, but when there's a patient there, you angle the machine and you angle -- or at least I do -- angle the computer screen and the keyboard, so that I can see everything going on. I might type ten seconds (indicating) then I'm looking at the monitor, and looking at him, making sure that everything is rolling along.

(*See* R. p. 946:8-20). MUSC's expert confirmed that Nurse Embrey's contacts with MUSC's information technology likely would not have distracted her from monitoring Mr. Mikell:

> Q. Do you have an opinion about whether Donna Embrey's pages to IT prevented her from adequately monitoring Mr. Mikell's status?
>
> A. I do have an opinion. And since monitoring is not just about looking -- certainly you can look away and do something for a minute, you're listening. You're watching. It's a -- it's a multisensory function. So I don't see how 10 seconds, clicking a couple of keys, is a -- is a significant distraction. We multitask a lot in our business. We're looking at this, looking at that, looking around; checking everything. It's kind of like a pilot flying an airplane. So, you know, it's just not realistic that that was a significant problem.

(*See* R. p. 1434:2-15). Plaintiff presented no evidence that Nurse Embrey was actually distracted from monitoring Mr. Mikell or that there was anything she specifically failed to detect.

II. PROCEDURAL HISTORY

The parties tried this case to a jury from April 18, 2016 to April 26, 2016, resulting in a verdict in favor of MUSC. Prior to the jury's verdict, the trial judge granted MUSC a partial directed verdict to the extent Plaintiff's claims alleged that Dr. Nelson engaged in professional negligence. On May 9, 2016, Plaintiff filed his Motion for a New Trial, arguing that the trial judge improperly granted a partial directed verdict and committed various errors during trial. (*See generally* R. pp. 6-16). Plaintiff files the instant appeal from the denial of its post-trial motions. (*See* R. p. 3). There is also a separate appeal from the imposition of discovery sanctions on MUSC that does not involve the trial of the merits of this matter and is not at issue in this Respondent's Brief.

ARGUMENT

I. THE TRIAL COURT DID NOT ERR IN GRANTING JUDGMENT AS A MATTER OF LAW AS TO PLAINTIFF'S MEDICAL MALPRACTICE CLAIM REGARDING ALLEGED NEGLIGENCE OF DR. ERIC NELSON

Plaintiff's main argument is that the trial judge improperly granted a partial directed verdict to MUSC with respect to Plaintiff's contentions that Dr. Eric Nelson committed medical malpractice. Plaintiff contends that Dr. Nelson committed professional negligence by momentarily leaving the procedure room. (*See* Pl.'s Init. Appellant's Br., at 20). Plaintiff also asserts that: "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 Embrey's administration of anesthesia." (*See id.*, at 21).

As an initial matter, Plaintiff states that it was improper for the trial judge to rule as to Dr. Nelson's alleged professional negligence, because it previously denied MUSC's motions for directed verdict as to the entire case: "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 . . . ?" (*See* Pl.'s Br., at 16). This position lacks merit.

First, Plaintiff does not cite any legal authority preventing the trial judge from ruling as to Dr. Nelson because of its ruling on MUSC's directed verdict motions as to the entire case. Such an unsupported argument, made with no legal citation or detailed analysis cannot possibly be a ground for reversal. Plaintiff did not make this argument to the trial judge and have it ruled upon; therefore, it was not preserved for appellate review. *See Tucker v. Doe*, 413 S.C. 389, 409, 776 S.E.2d 121, 132 (Ct. App. 2015), *cert. denied* (Oct. 20, 2016) ("[A]n issue cannot be raised for the first time on appeal, but must have been raised to and ruled upon by the trial judge to be preserved for appellate review.") (citation omitted).

Additionally, Plaintiff does not explain why the trial judge's rulings were inconsistent. MUSC's directed verdict motions raised proximate cause and standard of care as to the entire case, including Plaintiff's contention that Nurse Embrey was negligent. The trial judge determined that there was sufficient evidence to submit Plaintiff's claim that Nurse Embrey was negligent to a jury, warranting the denial of MUSC's motions for directed verdict as to the entire case. However, MUSC's motion for partial directed verdict as to Dr. Nelson was much more limited in scope and focused only on the claim that Dr. Nelson was professionally negligent. In ruling on that motion, the trial judge decided that there was *not* sufficient evidence of Dr. Nelson's alleged negligence. There is nothing improper or inconsistent in those rulings; rather, those rulings are logical and demonstrate that Plaintiff only presented evidence only warranting submission of *some* of his claims to the jury.

A. Standard of Review

"'In deciding whether to grant or deny a directed verdict motion, the trial court is concerned only with the existence or non-existence of evidence.'" *Corbett v. Weaver*, 380 S.C. 288, 292-93, 669 S.E.2d 615, 617 (Ct. App. 2008) (*quoting Sims v. Giles*, 343 S.C. 708, 714, 541 S.E.2d 857, 861 (Ct. App. 2001)).

> When reviewing a trial court's ruling on a directed verdict, this Court will reverse if no evidence supports the trial court's decision or the ruling is controlled by an error of law. *Law v. S.C. Dep't of Corr.*, 368 S.C. 424, 434-35, 629 S.E.2d 642, 648 (2006); *McMillan v. Oconee Mem'l Hosp., Inc.*, 367 S.C. 559, 564, 626 S.E.2d 884, 886 (2006). The appellate court must determine whether a verdict for the party opposing the motion would be reasonably possible under the facts as liberally construed in his or her favor. *Pye v. Estate of Fox*, 369 S.C. 555, 564, 633 S.E.2d 505, 509 (2006); *Erickson v. Jones St. Publishers, L.L.C.*, 368 S.C. 444, 463, 629 S.E.2d 653, 663 (2006). If the evidence as a whole is susceptible to more than one reasonable inference, a jury issue is created and the motion should be denied. *Proctor v. Dep't of Health & Envtl. Control*, 368 S.C. 279, 292, 628 S.E.2d 496, 503 (Ct. App. 2006). A motion for directed verdict goes to the entire case and may be granted only when the evidence raises no issue for the jury as to liability. *Huffines Co. v. Lockhart*, 365 S.C. 178, 187, 617 S.E.2d 125, 129 (Ct. App. 2005). When considering directed verdict motions, neither the trial court nor the appellate court has authority to decide credibility issues or to resolve conflicts in the testimony or evidence. *Wright v. Craft*, 372 S.C. 1, 19, 640 S.E.2d 486, 496 (Ct. App. 2006) (*citing Erickson*, 368 S.C. at 463, 629 S.E.2d at 663).

See Enos v. Doe, 380 S.C. 295, 300-01, 669 S.E.2d 619, 621 (Ct. App. 2008) (affirming entry of directed verdict). "'When the evidence yields only one inference, a directed verdict in favor of the moving party is proper.'" *Howard v. Roberson*, 376 S.C. 143, 150, 654 S.E.2d 877, 880 (Ct. App. 2007) (affirming directed verdict) (*quoting Swinton Creek Nursery v. Edisto Farm Credit, ACA*, 334 S.C. 469, 476-77, 514 S.E.2d 126, 130 (1999)).

B. Granting Plaintiff the Benefit of Every Doubt, There Is No Evidence That Dr. Nelson Breached a Duty of Care in His Supervision of Nurse Embrey

Contrary to Plaintiff's arguments, the evidence presented at trial does not support his contention that Dr. Nelson breached a duty of care to Mr. Mikell. As a result, this Court should affirm the trial judge's ruling regarding Dr. Nelson's alleged professional negligence.

1. There Is Not Sufficient Evidence to Create a Jury Issue as to Whether Dr. Nelson Breached a Duty of Care by Leaving the Room

The elements of a claim for medical malpractice are well-settled under South Carolina law:

> To establish a cause of action for medical malpractice, the plaintiff must prove the following facts by a preponderance of the evidence:(1) The presence of a doctor-patient relationship between the parties;(2) Recognized and generally accepted standards, practices, and procedures which are exercised by competent physicians in the same branch of medicine under similar circumstances;(3) The medical or health professional's negligence, deviating from generally accepted standards, practices, and procedures;(4) Such negligence being a proximate cause of the plaintiff's injury; and(5) An injury to the plaintiff.

See Brouwer v. Sisters of Charity Providence Hosps., 409 S.C. 514, 521, 763 S.E.2d 200, 203 (2014). "South Carolina does not recognize the doctrine of *res ipsa loquitur*," so Plaintiff must prove how Dr. Nelson deviated from the standard of care. *See Fletcher v. Med. Univ. of S.C.*, 390 S.C. 458, 463, 702 S.E.2d 372, 374 (Ct. App. 2010) (*Snow v. City of Columbia*, 305 S.C. 544, 555 n. 7, 409 S.E.2d 797, 803 n. 7 (Ct. App. 1991)). A physician is not an insurer or guarantor of a beneficial result. *Banks v. Medical Univ.*, 314 S.C. 376, 444 S.E.2d 519 (1994).

"[T]he general rule is that expert testimony is required in a malpractice case to show that the defendant failed to conform to the required standard, which is, such reasonable and ordinary

knowledge, skill and diligence as physicians in similar neighborhoods and surroundings ordinarily use under like circumstances." *See Cox v. Lund*, 286 S.C. 410, 416, 334 S.E.2d 116, 120 (1985) (citation omitted). "The standard of care in a medical malpractice action concerns both the physician's skill and the physician's professional learning. . . . A physician is only bound to possess and exercise that degree of skill and learning that is ordinarily possessed and exercised by members of his profession in good standing acting in the same or similar circumstances." *See Durham v. Vinson*, 360 S.C. 639, 650–51, 602 S.E.2d 760, 765–66 (2004) (citation omitted).

Contrary to Plaintiff's innuendo and speculation, there is no evidence that Dr. Nelson breached a duty of care to his patient because: (a) at all times he was supervising and readily available to Nurse Embrey, in full compliance with the standard of care described by Plaintiff's expert; (b) there is no evidence that Mr. Mikell's blood oxygen saturation levels were so low as to prevent Dr. Nelson from briefly stepping out of the room; and (c) there is no evidence of Dr. Nelson breached a duty of care with regard to the short period of time during which the PICIS system failed to record data generated and displayed by the physiological monitors.

a. The Evidence Shows That Dr. Nelson was Readily Available to Nurse Embrey at All Times

Plaintiff's contention that Dr. Nelson was negligent fail because it is undisputed that he complied with professional standards in his supervision of Nurse Embrey and was immediately available if needed in an emergency.

Dr. Kofke, Plaintiff's expert, offered his opinion that Dr. Nelson breached his standard of care by leaving the room:

> A. It's -- in a patient who he recognized was going to be very tricky, and that's why they used an unusual anesthesia technique -- he just popped in and then left. And -- and -- and he had to have heard about the sats in the 80s at the beginning of the case, but whenever he popped in, purportedly they were -- they were okay, but it's not seen anywhere in the record. And then -- then he left, you know, so that's his breach.

Q. Okay. And if both of the anesthesia care providers, Dr. Nelson and the nurse anesthetist had been present in the room and attending to the patient, do you have any conclusions as to whether or not they would have been able to prevent the cardiac arrest?

A. Oh, yes. I think that the two of them could have made sure that the airway was -- was patent. It's a word we use. And then he -- he could have managed the airway while she managed the electronic record.

(*See* R. pp. 779:23-780:22). However, Dr. Kofke recognized that a physician could rely upon a CRNA and did not have to be in the room at all times:

Q. Do you agree that you can trust a CRNA more in terms of being able to be a little bit further away or to do other things while they are managing the case?

A. Yes. Yes, I do.

Q. In your practice, if you had CRNAs under you, you would be able to supervise up to four at one time; correct?

A. Yes, that's a lot in my hospital.

Q. Do you know how many Dr. Nelson was supervising the day that he was taking care of Mr. Mikell?

A. I seem to recall one other, but I'm not sure.

Q. So that would be a pretty good attending to CRNA ratio, wouldn't it?

A. Yes, yes.

Q. It would be about twice as good as four to one, wouldn't it?

A. It would be better than four to one. Now, if you want to say -- yeah, yes.

Q. So almost by definition, if you're supervising four CRNAs, you are going to be in each room an average of a quarter of the time; right?

A. I would -- I would think so, yeah.

Q. Because you would be circulating among those rooms?

A. Yes.

Q. So if you had only two CRNAs going at a time, you would be splitting the time between those two; correct?

A. Right.

Q. And that's better; right?

A. Right. You should be more available.

(*See* R. pp. 818:6-819:12). Dr. Kofke further testified that, in his practice, it is acceptable for the attending physician to be up to two minutes away from the operating room and that being directly across the hall was certainly appropriate. (*See* R. pp. 819:13-820:3).

Dr. Nelson testified that: "At the time I stepped out of the room, his vital signs were stable. He was in the hands of an experienced nurse anesthetist, and I was very close by." (*See* R. pp. 1361:25-1362:9). He further testified that he was easily reachable — either by pager or yelling for him, given the close proximity — in the event of an emergency:

A. I mean, maybe from me to you, *it's a rather small area.* The rooms that we work in, there's four rooms, and it's kind two across -- literally across the hall from each other. And so the room I went to, I kind of popped across the hall. Then I circled back pretty quickly just because I knew we already had to intervene once, and put the nasal airway in. And so sicker patients, I tend to do more frequent rounds and check in more frequently, just to make sure everything is okay.

Q. And how can you be reached if somebody does need you?

A. *It's most commonly by pager. And so you can send a page, either through the operator or through the computer.*

Q. Could somebody just yell out the door if they needed you?

A. Yeah. *I was close enough that if somebody yelled through the door, I would hear them,* which has it, it happens kind of frequently down there, because everything is so close together. So if somebody needs help, usually the quickest thing to do is they stick their head out the door, and just say we need help in here, so.

(*See* R. pp. 1350:4-1351:5 (emphasis added)). Dr. Nelson further testified that his supervisory role did not require that he be present in the room at all times:

Q. What's the -- what's the interaction between you and Donna Embrey in that situation?

A. In this situation, we -- from the beginning, we kind of discussed the case, say this is what's going on. These are what his medical issues are. This is how I think we should do it. We agreed. She says okay.

I'm in a supervisory role, and so I go there for kind of the key parts. So at the beginning of the case, the end of the case, I come in throughout the case to make sure everything is okay. If there's any issues, Donna would page me and let me know.

(*See* R. p. 1349:13-24). Dr. Nelson testified that his practice was to be with the patients at various times during their procedures, but not the entire time:

Q. You said that you were sort of in at the beginning and out at the end, that's what -- that's what your role is in these cases?

A. In there for induction during the -- with all the big parts and checking in. And then at the end as well, yes.

Q. But generally speaking, it's at the beginning when the patient is put to sleep?

A. Yes.

Q. And then you come in at the end when it's time to wake him back up?

A. Yes.

Q. All right. And so you wouldn't normally plan on being present in the room during the middle of the procedure?

A. No. I'm usually present -- check in every hour or so.

(*See* R. pp. 1372:19-1373:10).

Nurse Embrey testified in detail at trial that she "[a]bsolutely" felt "comfortable" while Dr. Nelson was out of the room, that he was readily available and that he was there "almost immediately" when she called him for help:

Q. Did you feel comfortable allowing him to leave the room under the circumstances?

A. *Oh, absolutely. Absolutely, I would have told him, listen, I need some help. I put the nasal airway in and I'm not getting good results, or I'm -- I'm not feeling -- or I would absolutely immediately let him know if I -- if there was something that I felt like I needed him to stay for or to help me with at the moment.*

Q. Did you know where he was going to be?

A. So not specifically and exactly, but I know that he's within -- he's within quick access to me should I page him or need him for any reason. Yes, usually within the department, because he's supervising, you know, depending on what's going on, at least one CRNA. *So he's kind of on a short leash for the procedures.*

Q. Tell us what happened after he left the room?

A. So, after he left the room, the Propofol continued to infuse. And Mr. Mikell desaturated a little more than I could make better as far as with the nasal airway and the cannula.

Q. And so what did that mean to you?

A. So at I believe it was 55, I said to Mark Payne, first, I said I'm having trouble keeping his saturations up. I feel like I need to turn him over supine where I can -- on his back and manage his airway a little more -- a little more tightly than I can with him in the lateral position. So I'm going to do that now. I'm going to turn the Propofol off. And I believe I said to the RN, will you call Eric Nelson in, to come assist me and see what it is we need to do. Can we give him a couple of bags. He's a little bit better. And then he can support his own airway with or without a nasal airway enough for us to finish the procedure, so.

Q. And did you -- I think, according to the chart, you turned the Propofol off at 7:53?

A. Correct, yes, uh-huh. Yeah. That was the point at which I felt like there was an issue, and we might have to -- number one, take a break from the Propofol. And, number two, you know, manage his airway concurrently, just to get him back to an acceptable saturation level.

Q. *And how quickly did Dr. Nelson arrive after you determined that you needed help?*

A. *Like almost immediately, almost immediately.*

(*See* R. pp. 1051:15-1053:11 (emphasis added)).

Nurse Embrey testified that Dr. Nelson created a plan for the treatment of Mr. Mikell, to which she agreed:

Q. And medically directing the case is important because you, as a nurse anesthetist, under state law are not allowed to administer drugs like Propofol unless you're acting under the supervision of a medical doctor?

A. Correct, yes.

Q. And now when Dr. Nelson says that he's medically directing the case, I mean, that's true; right?

A. Absolutely. We made a -- we made a plan and agreed upon what we would do with Mr. Mikell.

Q. He was directing your care and he was supervising what you were doing?

A. Yes. Yes.

Q. And that's why he's making this entry right here, attesting that he was present to direct and supervising what you were doing?

A. Yes, but they are not necessarily present during the entire case. The plan is made, and he may step in, like he did, and check on things. If all is well, then they will, you know, a lot of times they will step in and out.

(*See* R. p. 973:2-23). Nurse Embrey further testified that, even with 20/20 hindsight, she believes that the plan implemented for Mr. Mikell was appropriate:

> I kind of like to think that -- that I set the bar very high for myself as far as the anesthesia that I deliver, and my job that I do every day. And I like to think that my judgment on an anesthetic plan, especially when it's in collaboration, obviously, with an anesthesiologist or whoever I'm working with that day, is the absolute best plan, and the safest plan for our patient or, you know, whoever we're -- we're undertaking to get their procedure done with the anesthesia.
>
> I've looked back on it. I've gone over my conversation with Eric [Nelson], and I -- I -- I truly believe that we had a good anesthetic plan for Mr. Mikell. I think that he became unstable, and we did -- we did a lot of things for him very quickly and very efficiently. But I look back on the plan, and I – I would do it all the same again, as far as the anesthetic plan. I really do not see anything differently that I would do as far as the anesthetic that we had planned for him.
>
> I also look back on how we responded to him becoming unstable. And during that period, and the procedural room, I'm -- I'm -- I'm very pleased with what we did for him, and how we reacted to him becoming unstable. But I -- I wouldn't change anything about my plan of Versed or the Propofol infusion; I can say that without reservation.

(*See* R. pp. 1058:2-1059:3). Dr. Nelson testified in great detail about his treatment of Mr. Mikell and confirmed that he formulated a plan for Mr. Mikell's anesthesia, which he communicated

both to Mr. Mikell and Nurse Embrey. (*See* R. pp. 1328:17-1332:15). Plaintiff cannot direct the Court to any evidence that Dr. Nelson did not properly supervise this procedure.

Based on the undisputed testimony, Dr. Nelson fully complied with his standard of care. Dr. Nelson was only supervising two patients, a number that Plaintiff's expert, Dr. Kofke, found to be acceptable. Moreover, when he was out of the room, Dr. Nelson was only across the hall and within earshot of Nurse Embrey, who monitored Mr. Mikell. In the event of an emergency, Dr. Nelson was immediately available to assist Nurse Embrey. Dr. Kofke testified that this was acceptable; in fact, he testified that, in his practice, it would be proper to be as much as two minutes away from the operating room.

Under South Carolina law, a CRNA, such as Nurse Embrey, is permitted to administer anesthesia with appropriate supervision:

> Anesthesia shall be administered according to the South Carolina Code of Laws and the South Carolina Code of State Regulations by . . . [a] certified registered nurse anesthetist (CRNA), as defined in S.C. Code Ann. Section 40-33-20(20), [who] is *under the supervision* of the operating practitioner or of an anesthesiologist who is *immediately available* if needed;

See S.C. Reg. Code R. 61-16 § 1212(A)(4) (emphasis added). Under South Carolina Nurse Practices Act, Nurse Embrey was indisputably qualified as a CRNA and could work under Dr. Nelson's supervision:

> "Certified Registered Nurse Anesthetist" or " CRNA" means an advanced practice registered nurse who:
>
> (a) has successfully completed an advanced, organized formal CRNA education program at the master's level accredited by the national accrediting organization of this specialty area and that is recognized by the board;
>
> (b) is certified by a board-approved national certifying organization; and
>
> (c) demonstrates advanced knowledge and skill in the delivery of anesthesia services.
>
> A CRNA must practice in accordance with approved written guidelines developed under supervision of a licensed physician or dentist or approved by the medical staff within the facility where practice privileges have been granted.

See S.C. Code § 40-33-20(20). Under the statute, supervision means "the process of critically observing, directing, and evaluating another's performance." *See* S.C. Code § 40-33-20(57).

In light of the foregoing, because it is undisputed that Dr. Nelson was immediately available at all times to Nurse Embrey, he did not breach a standard of care by momentarily leaving Mr. Mikell's procedure room. He was, at all times, immediately available to Nurse Embrey in the event she needed him. He indisputably supervised Nurse Embrey in accordance with his standard of care. As a result, the trial judge properly granted partial directed verdict to MUSC.

b. The Evidence Shows That Mr. Mikell's Saturation Levels Were Acceptable At the Time Dr. Nelson Left the Room

i. There Is No Evidence That Mr. Mikell's Blood Saturation Levels Were So Low That Dr. Nelson Could Not Leave the Procedure Room

Plaintiff further argues that the trial judge erred in his ruling concerning Dr. Nelson because Dr. Nelson breached his professional standard of care "by exiting the procedure room when Mr. Mikell's condition was unstable, thereby leaving Nurse Embrey without assistance in managing Mr. Mikell's airway." (*See* Pl.'s Br., at 20). This contention is not supported by any evidence.

Mr. Mikell's PICIS anesthesia records reflect the following blood oxygen saturation levels at various times during the morning of his colonoscopy:

Time	SpO2 (%)
7:48	96.7
7:49	76
7:50	69.2
7:51	90.1
7:52	80.7
7:53	88.0
7:54	73.3

7:55	62.1
7:56	75.0
7:57	41.2
7:58	47.5
8:00	67.6
8:01	88.1
8:02	88.4
8:03	96.4
8:04	88.3
8:05	19.9

(*See* R. pp. 218-20). As discussed in detail below, there are several minutes for which data, including blood oxygen saturation, was not recorded because the PICIS software was not recording that data. (*See* R. p. 920:5-9). However, this does not mean that the data was not being displayed and monitored to Nurse Embrey and/or Dr. Nelson in real time.

The record reflects that Dr. Nelson was present in Mr. Mikell's procedure room at 7:48 and left at 7:51. (*See* R. p. 204). After Dr. Nelson's departure, Mr. Mikell's blood oxygen saturation levels dropped, falling to 41.2 at 7:57. (*See* R. pp. 218-20). Dr. Nelson testified in detail about when he left the procedure room and Mr. Mikell's saturation levels:

> Q. Okay. I'm just going to pull this down so we can kind of look at both at the same time if necessary. And I want to try to correlate what was going on according to the notes, with what was going on, on the record here. So going to 7:48, you got your note here that says that "anesthesia, present for induction", Nelson -- "memo, Nelson MD in, nasal airway in, 02 sat up to 94 percent, patient remains lateral". And indeed at 7:48, the first reading -- you see that as 96.7?
>
> A. Yes.
>
> Q. Now, is that a good number?
>
> A. Yes, it's very good.
>
> Q. All right. And then it says at 7:51, you were out?

A. Uh-huh.

Q. Is that correct to your knowledge?

A. I believe so. And so I know -- we put the nasal airway in. I kind of stuck around to make sure it was working, that his saturations came up. You can see at 7:49 and 7:50, it dipped a little bit, which really isn't that uncommon. Sometimes there's a little bit of a delay between you starting to breathe a little bit better and your sats coming up. And so that could be what happened here.

And then 7:51, the saturation of 90.1. I saw that his saturation had come up and so I stepped out of the room to go to another room. At the time, I was covering two rooms down there. And so I think I went out and checked on the other colonoscopy site at that time.

Q. Were you comfortable -- well, I don't want to put words in your mouth. Describe for the jury, if you would, what your judgment was at the time that you -- that you decided it was all right to step out of the room at 7:51?

A. As I said, I thought he was doing okay. We put the nasal cannula -- nasal airway in. His saturations had come up. Dr. Payne had started the procedure and everything seemed to be stable and kind of going as expected, so.

Q. And that -- that 90.1, is that -- is that an acceptable --

A. Yes.

Q. -- saturation level?

A. Yes.

(*See* R. pp. 1347:3-1348:22). Dr. Nelson testified that, when he momentarily left the room, Mr. Mikell's oxygen saturation was stable and acceptable:

> At 90 percent. And I believe that Donna had documented also, that when I left they were 94 percent. So these are one minute intervals. *And we actually see your oxygen saturation with every heart beat.* So his heart rate was in the 80s, *we'll see 80 different numbers every minute*, so. We had seen -- I mean, like I said, this was six years ago, but I wouldn't have left the room if I thought he was teetering on the edge. I would have had to see consistently his saturations were in the 90s before I would have stepped out of the room.

(*See* R. pp. 1393:19-1394:11 (emphasis added)).

This is consistent with Nurse Embrey's testimony that Mr. Mikell's saturation levels were acceptable when Dr. Nelson briefly left the room at 7:51:

> Q. Going back to the one minute. Mr. Ransom circled these numbers here, and I don't know whether you can see it from where you are. But your record -- your narrative record reflects that Dr. Nelson left the room at 7:51; correct?
>
> A. Yes. Yes.
>
> Q. And can you see what the oxygen saturation is up to at 7:51?
>
> A. The number appears to be 90.1.
>
> Q. And so is that what you're referring to when you said that you recall it having increased dramatically from the lower numbers before you inserted the nasal airway?
>
> A. Yes. Yes. *Eric wouldn't have stepped out and I wouldn't have let him if what I had done at 48 was not effective* -- an effective intervention for Mr. Mikell. If it wasn't working then -- then I would have had him stay or give me a hand or, you know.
>
> Q. So at the time that he left, did it appear that he had improved to 90.1 percent, and that that was as a result of the insertion of the nasal airway?
>
> A. Absolutely.

(*See* R. pp. 1066:13-1067:11 (emphasis added)).

For the foregoing reasons, Plaintiff cannot dispute that Dr. Nelson only left Mr. Mikell's procedure room when his blood oxygen saturation levels were appropriate and stable.

ii. <u>Plaintiff's Reliance on the PICIS Record is Misplaced</u>

Plaintiff takes the position that Dr. Nelson "should not have left the room if Mr. Mikell's oxygen saturation levels were not consistently in the 90s." (*See* Pl.'s Br., at 20). Plaintiff focuses on the term "consistently" and relies on the one-minute blood oxygen saturation levels set forth above. Plaintiff argues that the PICIS one-minute record showed a blood oxygen saturation level of 69.2% at 7:50 and 90.1% at 7:51. From this, Plaintiff posits that there was only a single reading of 90% or higher before Dr. Nelson left the room. This contention is without merit and misapprehends the nature of the information available to Dr. Nelson.

From 2007 through June 30, 2014, MUSC used "PICIS" as its electronic medical record software to document anesthesia and post-anesthesia care. (*See* R. p. 1292:10-13 ("PICIS went dormant on July -- July 1, 2014, when the University switched over to Epic."). The PICIS system was described at trial as follows:

> So PICIS is an application that was used by perioperative services, surgery and anesthesia, and that's what they used to document everything that happened during the surgery.
>
> It's comprised of two major pieces; there's a user application, which is what the nurses, the doctors, and the residents used. And it also has a back-end database, which is where all data is stored. Everything that is entered into PICIS, both from the users and from any machine linked into it, all information is stored on that database.

(*See* R. pp. 1292:25-1293:10). PICIS essentially captures and records data from the Phillips monitors attached to the patient:

> Q. Now, while I've got this one up here, what of those -- how do those numbers get into that chart?
>
> A. So, there is a cable that -- as I understand it, my rudimentary understanding of it -- is that there is a cable that runs from the Phillips monitor and our anesthesia machine into the computer system. And it's captured by PICIS, our program, when we pull up that patient and that data on that machine in that room.
>
> Q. Now, which of those numbers up there are -- are entries -- are entered by a machine and which are entered by a human being?
>
> A. As I understand it, all of the -- all of the entries are the machine data that comes over.

(*See* R. pp. 996:20-997:7). When the captured PICIS data is printed out, it can be printed out at various time intervals, including fifteen-minute and one-minute:

> Q. And which version of that -- of this chart do you normally print for the record, is it the 15 minute version or the one minute version, or some other version?
>
> A. I'm -- I'm not sure. It may -- it may have to do with whoever is printing the chart, and what their -- what their default settings are. You know, when we are monitoring and looking at it, you know, when we were using PICIS, we could opt to look at a one minute, a five minute, a 15 minute

chart in numerical values and everything is -- we could kind of decide what our default was, that we were looking at, as the case was going on.

When it gets printed, I'm not certain. Because when PICIS was in its infancy, like the first year or two, it would print out a lot of pages that didn't need to be, like 200, and some of them were blank. So I believe they eventually tried to kind of pare it down, if they could to to the -- to the 15 minute version was my understanding from other people just in general.

Q. But in your experience, by the time it's printed out, you're done; right?

A. Oh, absolutely, yes.

(*See* R. pp. 1001:22-1002:19).

However, the information available to Dr. Nelson and Nurse Embrey in the procedure room was *not* limited to the one-minute readings in the PICIS printout. The monitors in the room do not only display blood oxygen saturation on a one-minute or fifteen-minute interval. Instead, Dr. Nelson testified that the monitors in the room displayed Mr. Mikell's blood oxygen saturation levels on a *continuous* basis, literally with every heartbeat:

> At 90 percent. And I believe that Donna had documented also, that when I left they were 94 percent. So these are one minute intervals. *And we actually see your oxygen saturation with every heart beat.* So his heart rate was in the 80s, *we'll see 80 different numbers every minute*, so. We had seen -- I mean, like I said, this was six years ago, but I wouldn't have left the room if I thought he was teetering on the edge. I would have had to see consistently his saturations were in the 90s before I would have stepped out of the room.

(*See* R. pp. 1393:19-1394:11 (emphasis added)). Nurse Embrey confirmed that she *continuously* monitored Mr. Mikell's blood oxygen saturation levels:

Q. What things are actually hooked up to the patient -- or what things were actually hooked up to Mr. Mikell?

A. Okay. So, you'll see on some things coming off here, and the three things that we monitor continuously are the O2 sat, which is a probe that goes on your finger. It's either a probe that clips on, or a peel-on that attaches to a cable that stays on the anesthesia monitor; a blood pressure cuff, and then EKG leads. And, again, we monitor two NV (ph) for everybody, that Phillips falls to it, and we monitor two NV for everyone. So you have a -- you have a two lead perspective.

(*See* R. p. 1039:5-17). Nurse Embrey further testified:

Q. We are sitting here looking at this chart as it records these numbers every 15 minutes.

A. Correct.

Q. *But I think you testified that you're actually monitoring it on a continuous basis?*

A. *Oh, yes. Oh, yes, like beat to beat.*

Q. All right.

A. And you have the pulse -- you have the pulse tone, obviously, on your O2 stat. That's an ASA standard. So it defaults, and it comes on at a pretty good volume level so everybody can hear it.

(*See* R. p. 999:3-13 (emphasis added)).

Thus, it is undisputed that Dr. Nelson and Nurse Embrey had continuous access to ongoing blood oxygen saturation levels, not merely the one-minute recordings, which only take a snapshot of a particular instant in time. Dr. Nelson could, therefore, see in real-time how Mr. Mikell's levels were stabilizing and whether they were consistently in the nineties. With this information, as discussed above, Dr. Nelson made a determination that Plaintiff had consistently reached an acceptable blood oxygen saturation level before he left the procedure room. Plaintiff has not presented any evidence to the contrary.

Therefore, the trial judge did not err in granting partial directed verdict to MUSC.

iii. Plaintiff's Challenge to the Time Dr. Nelson Left the Procedure Room is Meritless

Plaintiff further argues that he should have been permitted to proceed to a jury as to Dr. Nelson's negligence because there was an issue of fact as to the time Dr. Nelson briefly left the procedure room. In particular, Plaintiff argues that the audit trail for the anesthesia records shows that the entry for when Dr. Nelson left the room "was originally created by Nurse Embrey to show the time as 7:50, but she later changed it to 7:51." (*See* Pl.'s Br., at 29). Plaintiff argues that this is important because Mr. Mikell's blood oxygen saturation level was only 69.2% in the 7:50 PICIS one-minute interval entry. From this, Plaintiff infers that Dr. Nelson left the room

while Mr. Mikell's blood oxygen saturation levels were too low. However, Plaintiff's contention does not support his position in this appeal.

First, irrespective of the fact that Nurse Embrey corrected the entries in the medical records, there is no evidence to support that she did so incorrectly or that Dr. Nelson actually left the room at 7:50 rather than 7:51. Moreover, there is no evidence to refute that, at the time Dr. Nelson left the room, Mr. Mikell's blood oxygen saturation levels were at 90% or higher for a sufficient time to lead Dr. Nelson to conclude that his condition was stabilized. Plaintiff speculates, with no evidentiary support, that Dr. Nelson left the room when Mr. Mikell's blood oxygen saturation levels were below 70%, presuming that he left at precisely the same time as the one-minute interval recording for 7:50. There is nothing to support such conjecture. To the contrary, the only evidence is that Dr. Nelson actually left the room at 7:51.

Aside from what is stated in the actual PICIS record, other evidence shows that Dr. Nelson was in the room at key junctures of the procedure. The evidence established without dispute that Dr. Nelson was in the room at 7:49, because he made an entry then in the record that was listed on the audit trail. (*See* R. p. 249). Moreover, Dr. Nelson's presence in the room at 7:51 is corroborated by the fact that the dosage of Propofol was reduced at that time, while Dr. Nelson was assisting to place a nasal airway:

> Q. And so what does that record show with regard to the administration of Propofol?
>
> A. It shows that the Propofol was started at 7:41. And at 7:51, the dose was decreased from 75 to 50.
>
> Q. All right. In your opinion, was that appropriate to reduce the dose based on what was happening at that time?
>
> A. Yes, it was. Because that would be right around the time that *we* put the nasal airway in, and it seemed like he was having a little trouble breathing.

(*See* R. p. 1361:10-20 (emphasis added)). Dr. Nelson returned to the room by 7:56, based upon Mr. Mikell's peak inspiratory pressure numbers, which increased because he was "bagged" by Dr. Nelson. (*See* R. pp. 1352:4-1354:23). Plaintiff has presented no evidence to dispute that

Dr. Nelson did not leave the room until 7:51 (returning at 7:55 or 7:56). Plaintiff presents no evidence that any change to the record was inaccurate; to the contrary, Nurse Embrey testified that she only changed the record to ensure it was accurate:

> I'm very -- I'm very meticulous and take a lot of pride in what I do in the -- in my anesthesia work area, and what I do for patients in the OR and in the procedural areas. So if there has been a lot going on, I try to -- even if it's noncontemporaneous, as in not at the time of the occurrence, I try to make sure that everything is accurately reflected that we gave and did for a patient.

(*See* R. pp. 1015:19-1016:1).

Moreover, even if Plaintiff could proffer any evidence that Dr. Nelson left the room at 7:50 when Mr. Mikell's saturation levels were below 70%, it is undisputed that at 7:51 the level had increased to 90.1% and that it was at least in the 80s in the following minutes. In other words, even if Dr. Nelson left when the blood oxygen saturation levels were low, the following minute they had increased to an acceptable level.

2. The Evidence Conclusively Shows That Dr. Nelson Did Not Breach His Duty of Care Regarding the Functioning of PICIS

Plaintiff suggests that Dr. Nelson breached a duty of care in failing to ensure that the PICIS system was working properly before anesthesia was administered. Plaintiff bases his argument upon MUSC's Anesthesia and Perioperative Medicine Policies and Basic Standards of Anesthesia Care Manual, which states in part:

> 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. The availability of the equipment necessary to conduct the anesthetic procedure includes, but is not limited to, a functioning laryngoscope, endotracheal tubes, airways and mask, functioning suction, and a means of artificial ventilation will be determined.

(*See* R. p. 237). This policy was created in 2009, before MUSC had electronic records systems such as PICIS. (*See* R. p. 1139:12-15 ("This particular guideline that you're talking about was signed in 2009, which is before we had electronic record systems.")).

Plaintiff presented no evidence to support his contention that Dr. Nelson violated the MUSC policy. Dr. Nelson testified at trial that his standard of care did not require him to ensure that the PICIS system was properly capturing data from the monitors before starting the procedure:

> Q. So this was your responsibility to make sure that this was all working correctly?
>
> A. I don't believe so, no. This is a computer and it's a computer system. It doesn't fall under the attending anesthesiologist. I could have gone back and taken a paper chart, and hit the vitals trend, and looked at all the vital signs that were recorded on the vitals. Because it records them, and just charted that way, and it would have been accurate.

(*See* R. p. 1392:15-23). He additionally testified that PICIS was simply not part of the equipment he was required to check before beginning the procedure:

> [T]he PICIS and the anesthetic record is not part of our anesthesia equipment quote/unquote that we check beforehand. The equipment we check includes the monitors that monitor vital signs, the machine -- things that we actually use to keep the patient safe. The anesthetic record is totally separate and it's not under the purview of something we check in the morning to make sure it's working. Because, like I said, if the computer doesn't work, we just go to a paper chart and chart by hand.

(*See* R. p. 1391:18-987:2).

Nurse Embrey disagreed that the alleged temporary PICIS issue was a failure of equipment to work properly under the MUSC policy:

> No. The equipment working properly would be me seeing an appropriate oxygen sat. Once I've got Mr. Mikell on monitors, nasal cannula oxygen is in, and I have an appropriate 02 sat that is working versus changing it to another finger, or an ear, or a nose where it can pick up a little bit better. So that's the focus in number one.

(*See* R. p. 939:11-17). Nurse Embrey further testified that she "did not have a problem, but the computer charting was not communicating with what I was seeing on the monitors." (*See* R. p. 940:4-6).

Dr. Scott Reeves — Chairman of the Department of Anesthesia and Perioperative Medicine and signatory to the MUSC policy — testified that "[t]he PICIS monitor does not have

a pre-way to know that it's actually functioning until it's hooked up to somebody." (*See* R. pp. 1138:13-1139:4). Dr. Reeves further testified that:

> That's -- there's really no way to know whether or not it's going to be functional until it's actually hooked up to a patient. . . . There's not a precertification type checklist for that monitor -- or it's a recording system. It's not a monitor like there is with an anesthesia machine or the Phillips monitors.

(*See* R. p. 1140:12-20). Additionally, he testified that it would not be a breach of the standard of care to administer anesthesia to a patient if there is a problem with the PICIS system. (*See* R. p. 1141:2-17). Dr. Reeves also confirmed that, even if the PICIS system was not linked, Mr. Mikell's vital information was being monitored at all times:

> But the patient was being completely monitored. I think we need to be very clear about that in the way -- the way the electronic system works, is that in front of -- the patient is on a stretcher in front of us. There's two monitors with his vital signs being recorded continuously on a monitor called the Phillips monitor. His blood pressure, his saturation, his heart rate are all on those monitors working properly. The anesthesia machine is to -- to Ms. Embrey's right. That's where oxygen is being delivered, and the saturation monitor.
>
> And behind is the electronic record that's designed to capture data coming from the monitors that we are see in front of us. So all -- from -- everything that's in the -- so the monitors that we use to actually take care of the patient are functioning.

(*See* R. p. 1144:2:17).

In the face of this evidence that Dr. Nelson did not violate MUSC's policy, Plaintiff has not presented any evidence to support his contention that Dr. Nelson failed to satisfy that policy. To the contrary, there is no evidence that the PICIS system was part of the equipment that the policy governed. There is no evidence that Dr. Nelson even could have checked the PICIS system before Mr. Mikell was being monitored. Moreover, there is no evidence that PICIS was a necessary part of Mr. Mikell's procedure or had anything to do with Mr. Mikell's arrest.

C. Even If Plaintiff Could Present Evidence That Dr. Nelson Breached a Duty of Care, There is No Competent Evidence That Such Negligence Was a Proximate Cause of Plaintiff's Alleged Injuries

Even if Plaintiff could show that Dr. Nelson breached a duty of care to Mr. Mikell, he still could not succeed upon his claims stemming from Dr. Nelson's alleged negligence. Specifically, Plaintiff has not presented evidence establishing that the alleged negligence of Dr. Nelson — not being in the room at certain times — was a proximate cause of Plaintiff's injuries.

"As in any negligence action, the plaintiff in a medical malpractice action must establish proximate cause." *Bramlette v. Charter-Med.-Columbia*, 302 S.C. 68, 72, 393 S.E.2d 914, 916 (1990); *accord Guffey v. Columbia/Colleton Reg'l Hosp., Inc.*, 364 S.C. 158, 163, 612 S.E.2d 695, 697 (2005) ("In a medical malpractice action, the plaintiff must establish proximate cause as well as the negligence of the physician."). Under South Carolina law, "[a] negligent act or omission is a proximate cause of injury if, in a natural and continuous sequence of events, it produces the injury, and without it, the injury would not have occurred." *See Hurd v. Williamsburg County,* 353 S.C. 596, 579 S.E.2d 136, 144 (Ct. App. 2003).

Proximate cause requires that the ultimate harm be foreseeable at the time of the alleged negligence:

> It is apodictic that a plaintiff may only recover for injuries proximately caused by the defendant's negligence. *Olson v. Faculty House*, 344 S.C. 194, 544 S.E.2d 38 (Ct. App. 2001).
>
> To prove causation, a plaintiff must demonstrate both causation in fact and legal cause. *Id.* Causation in fact is proved by establishing the plaintiff's injury would not have occurred "but for" the defendant's negligence. *Id.* Legal cause turns on the issue of foreseeability. *Id.* An injury is foreseeable if it is the natural and probable consequence of a breach of duty. *Id. Foreseeability is not determined from hindsight, but rather from the defendant's perspective at the time of the alleged breach. Id.*

See Parks v. Characters Night Club, 345 S.C. 484, 491, 548 S.E.2d 605, 609 (Ct. App. 2001) (emphasis added).

"'When one relies solely upon the opinion of medical experts to establish a causal connection between the alleged negligence and the injury, the experts must, with reasonable certainty, state that in their professional opinion, the injuries complained of most probably resulted from the defendant's negligence.'" *Jamison v. Hilton*, 413 S.C. 133, 141, 775 S.E.2d 58, 62 (Ct. App. 2015) (*quoting Hoard ex rel. Hoard v. Roper Hosp., Inc.*, 387 S.C. 539, 546, 694 S.E.2d 1, 5 (2010); *Ellis v. Oliver*, 323 S.C. 121, 125, 473 S.E.2d 793, 795 (1996)). "[T]he expert testimony as to proximate cause must provide a significant causal link between the alleged negligence and the injuries suffered, rather than a tenuous and hypothetical connection." *Martasin v. Hilton Head Health Sys., L.P.*, 364 S.C. 430, 438, 613 S.E.2d 795, 800 (Ct. App. 2005). It is not enough "for the expert to testify merely that the ailment might or could have resulted from the alleged cause." *See id.*

"[P]roof of causation cannot rest on conjecture, and the mere possibility of such causation is not enough to sustain plaintiff's burden of proof." *See Todd v. United States*, 570 F. Supp. 670, 677-78 (D.S.C. 1983) (*citing Walstead v. University of Minn. Hosps.*, 442 F.2d 634 (8th Cir. 1971)). In this respect, speculation or conjecture is insufficient to show factual cause:

> When asked if the case would have produced a different outcome had the Respondents not breached their standard of care, Scarminach hedged: "you never know because it's conjecture." Instead of stating that the Respondents' conduct most probably caused the outcome, Scarminach said, "had [Respondents] done these things, the percentage of success would have been greater." Thus, Scarminach's deposition did not establish that the Respondents' actions were the "but for" cause of Harris Teeter's loss.

See Harris Teeter, Inc. v. Moore & VanAllen, P.C., 390 S.C. 275, 289-90, 701 S.E.2d 742, 749 (2010).

The South Carolina Supreme Court in *Sherer v. James*, 290 S.C. 404, 351 S.E.2d 148 (1986), refused to follow *Hamil v. Bashline*, 307 A.2d 57 (Pa. Super. Ct. 1973) or *Clark v. Ross*, 284 S.C. 543, 328 S.E.2d 91 (Ct. App. 1985). The *Hamil* case reduced the proximate cause standard to allow the issue of causation to reach the jury upon evidence that the defendant's negligence merely *increased the risk* of harm. In *Sherer*, the plaintiff sued a pediatrician,

alleging a delay in diagnosing his son's testicular torsion. At trial, plaintiff's expert opined that had the child's condition been diagnosed sooner, there would have been better than fifty percent chance of saving his testicle. The Supreme Court held that Section 323(a) of the Restatement applies *only* to the duty of care and *not* proximate cause and confirmed that "a medical malpractice plaintiff who relies upon expert testimony must introduce evidence that the defendant's negligence *most probably* resulted in the injuries alleged." *See Sherer*, 290 S.C. at 407, 351 S.E.2d at 150.

Plaintiff's position regarding proximate causation is that "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." (*See* Pl.'s Br., at 20). Dr. Kofke's only testimony about causation relating to Dr. Nelson was that "I think that the two of them could have made sure that the airway was -- was patent. It's a word we use. And then he -- he could have managed the airway while she managed the electronic record." (*See* R. p. 780:14-22). Yet, there is no evidence whatsoever that Nurse Embrey was ever physically unable to establish a patent airway. Dr. Kofke did not provide any testimony of proximate cause beyond this "tenuous and hypothetical connection." Dr. Kofke simply assumes that, had a physician been present in the room, Plaintiff's result would have changed. Beyond Dr. Kofke's *ipse dixit* there is no evidence supporting such a conclusion.

Plaintiff did not present sufficient evidence to the trial judge of proximate cause relating to Dr. Nelson's alleged negligence. There is no evidence that Nurse Embrey was unqualified or unable to respond to Mr. Mikell's problems in the room. There is no evidence that she was physically incapable of providing proper care to Mr. Mikell. There is no evidence that Nurse Embrey did not know how to respond to Mr. Mikell's problems. There is no evidence that Nurse Embrey failed in an effort to respond to Mr. Mikell's arrest because Dr. Nelson was not in the room. There is no evidence that Dr. Nelson was unavailable to assist Nurse Embrey should she encounter any problems. There is no evidence that, had Dr. Nelson been in the room (rather than

right across the hall within earshot) the result would have been any different. There is no evidence that Nurse Embrey's efforts to rectify the situation with PICIS impacted patient care in any way. Plaintiff's claims of causation are mere conjecture and speculation, without any specific supporting evidence.

Without evidence specifically showing that Dr. Nelson's presence in the room would have actually most probably made a difference, Plaintiff's claims must fail:

> [W]e need not decide whether the expert testimony establishes the standard of care or breach because Melton presented no evidence showing that Dr. Feldman's selection criteria was the proximate cause of his injuries. . . . Specifically, Melton failed to present evidence showing that, had Dr. Feldman employed different selection criteria, either (1) it would have led her to choose a different ICD, or (2) that a different ICD would not have caused him the same or similar problems.

See Melton v. Medtronic, Inc., 389 S.C. 641, 659–60, 698 S.E.2d 886, 895–96 (Ct. App. 2010). Plaintiff's causation argument amounts to nothing more than rank speculation and conjecture.

For the foregoing reasons, the trial judge properly entered judgment as to Plaintiff's claims relating to Dr. Nelson's alleged negligence because there was no evidence of proximate causation. Therefore, this Court should affirm the decision of the trial judge.

D. Assuming *Arguendo* That the Trial Judge Did Err in Granting Judgment As to Plaintiff's Claims Relating to Dr. Nelson's Negligence, Such Error Was Harmless

As MUSC discussed above, the record does not support, in any way, Plaintiff's claims regarding Dr. Nelson's alleged negligence. As a result, the trial judge properly granted a partial directed verdict as to such contentions. However, even assuming *arguendo* that the trial judge erred, any error was harmless and would not support reversal. The trial judge's ruling regarding Dr. Nelson's alleged negligence could have had no impact on the jury's verdict for MUSC. Plaintiff's counsel presented evidence and made arguments relating to Dr. Nelson's alleged negligence, and the trial judge never told the jury not to consider Dr. Nelson's negligence. MUSC's only reason for moving for judgment as a matter of law on Dr. Nelson's professional negligence was to limit recovery, in the event Plaintiff obtained a verdict, to the lower limit

under the South Carolina Tort Claims Act applicable to non-physicians. Simply put, the ruling concerning Dr. Nelson's alleged negligence did not change anything in the trial of this matter. Rather, the issue of Dr. Nelson's negligence would only become an issue if the jury awarded a substantial verdict to Plaintiff.

1. General Legal Standards Governing Harmless Errors

It is well-settled in South Carolina that a harmless error is not a proper ground for the reversal of a trial court:

> Whether an error is harmless depends on the circumstances of the particular case. *In re Harvey,* 355 S.C. 53, 63, 584 S.E.2d 893, 897 (2003). "No definite rule of law governs this finding; rather, the materiality and prejudicial character of the error must be determined from its relationship to the entire case." *State v. Mitchell*, 286 S.C. 572, 573, 336 S.E.2d 150, 151 (1985). Error is harmless where it could not reasonably have affected the result of the trial. *Harvey*, 355 S.C. at 63, 584 S.E.2d at 897. Generally, appellate courts will not set aside judgments due to insubstantial errors not affecting the result. *State v. Sherard*, 303 S.C. 172, 176, 399 S.E.2d 595, 597 (1991).

See Judy v. Judy, 384 S.C. 634, 646, 682 S.E.2d 836, 842 (Ct. App. 2009).

Where a claimed error would not have changed a jury's verdict, it is not a proper basis for reversal on appeal. *See RFT Mgmt. Co. v. Tinsley & Adams L.L.P.*, 399 S.C. 322, 340, 732 S.E.2d 166, 175 (2012) ("Because RFT alleged the same facts for its UTPA claim as in the legal malpractice claim, i.e., the deceptive acts of Law Firm, which the jury has already rejected, RFT has not shown it could have established all of the necessary elements of this claim."); *O'Neal v. Carolina Farm Supply of Johnston, Inc.*, 279 S.C. 490, 497, 309 S.E.2d 776, 780 (Ct. App. 1983) ("As the jury returned a verdict for Carolina Supply in this case, any issue as to punitive damages is now moot. Counsel conceded as much in oral argument. If granting a directed verdict was error (a point we do not decide), it was harmless error in light of the jury verdict."); *Smith v. Ridgeway Chemicals*, 302 S.C. 303, 395 S.E.2d 742 (Ct. App. 1990) (not reversible error to direct verdict for defendant on plaintiff's breach of implied warranty claim, when the jury found for defendant on strict liability claim, and not reversible error not to submit the loss of consortium claim to jury because jury found for defendant on spouse's claim).

2. The Trial Judge's Alleged Error Did Not Impact the Verdict

The trial judge's granting MUSC's motion for partial directed verdict did not affect how Plaintiff presented his case to the jury or the verdict. MUSC's oral motion was only relevant to a unique question under the South Carolina Tort Claims Act. Under that Act, the limits on liability differ greatly depending upon whether there is a claim for a physician's professional negligence:

> (1) Except as provided in Section 15-78-120(a)(3), no person shall recover in any action or claim brought hereunder a sum exceeding three hundred thousand dollars because of loss arising from a single occurrence regardless of the number of agencies or political subdivisions involved.
>
> (2) Except as provided in Section 15-78-120(a)(4), the total sum recovered hereunder arising out of a single occurrence shall not exceed six hundred thousand dollars regardless of the number of agencies or political subdivisions or claims or actions involved.
>
> (3) No person may recover in any action or claim brought hereunder against any governmental entity and caused by the tort of *any licensed physician or dentist, employed by a governmental entity and acting within the scope of his profession, a sum exceeding one million two hundred thousand dollars* because of loss arising from a single occurrence regardless of the number of agencies or political subdivisions involved.
>
> (4) The total sum recovered hereunder arising out of a single occurrence of liability of any governmental entity for *any tort caused by any licensed physician or dentist, employed by a governmental entity and acting within the scope of his profession, may not exceed one million two hundred thousand dollars* regardless of the number of agencies or political subdivisions or claims or actions involved.

See S.C. Code § 15-78-120(a)(1)-(4) (emphasis added). Therefore, if MUSC was held liable for the professional negligence of a physician — as opposed to the negligence of a non-physician employee — Plaintiff's potential recovery would be much greater.

MUSC made clear that its motion only concerned the ultimate potential liability of MUSC under the Tort Claims Act: "we would also, at this time, make a motion for partial summary judgment[1] [directed verdict] as to any negligence on the part of a licensed physician, and *that would – of course, I (sic) have consequences under the Tort Claims Act should there be*

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[1] Although the parties and the Court spoke in terms of summary judgment, the motion should properly be considered one for partial directed verdict because it was made at the close of the evidence.

a recovery." (*See* R. p. 1472:16-20). The trial judge observed that the resolution of the issue would not affect MUSC's liability in the first instance, but rather was relevant to the limits on liability under the South Carolina Tort Claims Act:

> I'd like to hear you on the partial summary judgment [directed verdict] concerning Dr. Nelson, *which basically won't affect your liability on MUSC, but it would affect the caps under the state Tort Claim Act.*

(*See* R. p. 1479:19-22 (emphasis added)). The trial judge also noted: "We were discussing at the bench the partial summary judgment [directed verdict] that the court granted to the defendant as to Dr. Nelson's liability. In the court's opinion, that would only affect the monetary terms if they get a verdict based on the Tort Claims Act." (*See* R. p. 1644:8-12).

In light of this, it is not surprising that the trial court's ruling had no effect on the actual trial of this matter. To the contrary, at all times, Plaintiff presented evidence of Dr. Nelson's alleged negligence and contended that Dr. Nelson breached a duty of care. The jury's verdict did not specifically address the negligence of any particular individual, but only decided whether "defendant" — *i.e.,* MUSC — was negligent:

> In case number 2012-CP-10-7275, Shon Turner, as Personal Representative of the Estate of Charles Mikell, deceased, Plaintiff, vs. Medical University of South Carolina, Defendant: "As to the professional negligence cause of action, do you unanimously find by the preponderance of the evidence that the defendant was negligent in his care of Mr. Mikell?" Answer "No."

(*See* R. p. 1647:11-18). Notably, neither Dr. Nelson nor Nurse Embrey were ever parties to this lawsuit.

The trial judge's instructions to the jury never mentioned Dr. Nelson by name — and only mentioned Nurse Embrey once. (*See* R. pp. 1615:11-1636:10). Nothing in the jury instruction indicated that the jury could *not* consider Dr. Nelson's alleged negligence. (*See id.*). In fact, the trial judge expressly denied MUSC's request for such an instruction:

> And finally, Your Honor, we would just ask the court to direct the – the jury that they are to consider only Donna Embrey's alleged negligence, and not the negligence of anybody else consistent with the court's granting of a partial directed verdict.

THE COURT: No, I'm not going to do that.

(*See* R. p. 1638:12-20). Plaintiff's counsel stated on the record that the jury was not being told not to consider Dr. Nelson's negligence:

> Yes. Judge, the plaintiff's position is that the motion that was actually made was for partial summary judgment on behalf of Dr. Nelson. The dilemma that we face is the granting of a motion of that nature, in favor of the Medical University employee, who is not actually named as a defendant in the case, and the jury not having been informed that they shouldn't consider any of Dr. Nelson's conduct during its deliberations, the plaintiff's position is that the manner in which that dilemma is best resolved is by awaiting the jury's determination.

(*See* R. p. 1644:14-24). In other words, the instructions to the jury did not prevent the jury from considering the negligence of Dr. Nelson.

Additionally, the ruling as to Dr. Nelson's alleged professional negligence did not change how the parties argued their respective cases to the jury. Plaintiff's opening statement (*see* R. pp. 508:25-524:5) did not mention either Dr. Nelson or Nurse Embrey by name. Notably, Plaintiff's opening statement did not even mention claims that Dr. Nelson improperly supervised Nurse Embrey or that he left the room at an inappropriate juncture. Obviously, at that time, the Judge had not yet ruled on claims relating to Dr. Nelson's professional negligence. Nonetheless, Plaintiff chose not to specifically argue Dr. Nelson's professional negligence in his opening.

The trial judge never said or did anything to prohibit Plaintiff from arguing to the jury that Dr. Nelson was himself negligent. To the contrary, Plaintiff's summation to the jury (R. pp. 1517:23-1552:9 and 1604:25-1615:10) makes specific reference to Dr. Nelson by name 23 times. Plaintiff's counsel specifically addresses Dr. Nelson leaving the room: "Dr. Nelson said that before he left, he would want to see sats consistently in the 90s. I don't see any sats that are consistently in the 90s either." (*See* R. p. 1532:9-12). Plaintiff's counsel even argued to the jury that the expert testimony showed that the inattentiveness of *both* Dr. Nelson *and* Nurse Embrey caused Mr. Mikell's death:

> Now, you'll remember Dr. Kofke, he testified to a reasonable degree of medical certainty, that if both Dr. Nelson and Nurse Embrey had been attendant to their patient, there would have been no cardiac arrest.

(*See* R. p. 1613:19-22). Moreover, Plaintiff's summation also addressed his baseless argument that Dr. Nelson was somehow to blame for not checking to make sure the PICIS system worked before anything began:

> And it's unfortunate in this case because it could have been so very, very simple for Nurse Embr[e]y or Dr. Nelson, or somebody there, to discharge their obligation under these policies to just check things out before they get started, to make sure that everything is working.

(*See* R. pp. 1534:24-1535:4). In other words, even in Plaintiff's summation, *after the grant of a partial directed verdict regarding Dr. Nelson's alleged negligence*, Plaintiff persisted in arguing to the jury that Dr. Nelson was to blame for Plaintiff's injuries.

As discussed herein (and as set forth in detail in Plaintiff's Appellant's Brief), Plaintiff was permitted to elicit substantial testimony — both expert and factual — relating to Dr. Nelsons' alleged negligence. The trial judge did not prevent Plaintiff from presenting evidence regarding Dr. Nelson. In fact, the transcript of the trial references Dr. Nelson's name during testimony before the jury more than 150 times. As detailed in his Appellant's Brief, Plaintiff, presented significant testimony and evidence seeking to convince the jury that Dr. Nelson breached a duty of care to Mr. Mikell (though, as discussed below, it was insufficient to justify submission to a jury). MUSC did not move for a partial directed verdict until *after* the close of all evidence. (*See* R. p. 1472:13-21).

Simply put, Plaintiff has made no showing that the trial judge's grant of partial directed verdict relating to Dr. Nelson's negligence — even if incorrect — was a reversible, prejudicial error. To the contrary, Plaintiff tried this case as if the jury could consider Dr. Nelson's negligence, and the jury was never told not to consider Dr. Nelson's negligence. Therefore, this Court should affirm the trial judge's grant of partial directed verdict to Defendant MUSC regarding the alleged professional negligence of Dr. Nelson.

E. Plaintiff Did Not Timely Assert Dr. Nelson's Negligence as a Basis for Recovery in This Matter

In any event, the trial judge properly entered judgment against Plaintiff as to his claims regarding Dr. Nelson's alleged negligence because Plaintiff and his experts did not assert any such negligence until the eve of trial. As a result, the trial judge should have prevented Plaintiff from presenting any evidence of Dr. Nelson's alleged professional negligence.

Neither Plaintiff's original Complaint (filed on November 6, 2012) nor his Amended Complaint (filed on January 31, 2013) allege negligence in the form of any person, let alone Dr. Nelson, being absent from the room at critical times. (*See* R. pp. 72-83). Moreover, Dr. Kofke's January 17, 2013 Affidavit does not allege any negligence with regard to Dr. Nelson not being in the room at any particular time. (*See* R. pp. 77-78). Plaintiff's Second Amended Complaint (filed less than two months before trial) does not specifically reference Dr. Nelson, but does finally make allegations that unidentified agents of MUSC were negligent "in leaving the colonoscopy procedure room to attend to other patients at a time when Mr. Mikell's condition was unstable." (*See* R. p. 55 ¶ 6(i)). MUSC denied such allegations. (*See* R. pp. 63-71).

As a result, the Plaintiff did not properly raise the professional negligence of Dr. Nelson as a basis for recovery in a timely manner. Therefore, the trial judge did not err in granting partial directed verdict to MUSC.

II. THE TRIAL COURT DID NOT ERR IN PERMITTING DR. ZILE'S TESTIMONY

Plaintiff next contends that the trial court erred in allowing Mr. Mikell's treating cardiologist, Dr. Michael Zile, to testify about Mr. Mikell's prognosis. Specifically, Plaintiff complains that MUSC "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." (*See* Pl.'s App. Br., at 36). Specifically, Plaintiff complains about the following testimony from Dr. Zile:

Q. What was his prognosis when you first met him in 2003?

A. So, Mr. Mikell had chronic heart failure. And his -- if I recall his ejection fraction was between 40 and 50, in that range. 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. So his prognosis, from the point of view of what his survival expectation would be, and what his expectation of recurrent hospitalizations would be, are the numbers that I just gave you. It's easy to remember 50 percent in five years, and 50 percent for hospitalizations in six months.

And that doesn't include -- when you say prognosis, we also talk about how the patient actually feels. And as Dr. Van Bakel's already testified, he had symptoms of chronic heart failure. And the disability that people have with chronic heart failure is profound. There is -- as you've heard probably testimony about Mr. Mikell, he had difficulty with activities of daily living and -- and activities outside, he had difficulties in daily living.

(*See* R. pp. 1220:22-1221:22). Plaintiff also complains that Dr. Zile was permitted to testify about whether Mr. Mikell's heart medications were properly indicated following his cardiac arrest. Plaintiff contends that, as a result of this testimony, MUSC "successfully undermined Dr. Kofke's testimony linking Mr. Mikell's death to the cardiac arrest." (*See* Pl.'s Br., at 38). This argument fails for several reasons.

First, there is no evidence that would support a conclusion that Dr. Zile's testimony had any bearing on the jury's verdict. The jury returned a verdict answering the following question in the negative, "[a]s to the professional negligence cause of action, do you unanimously find by the preponderance of the evidence that the defendant was negligent in his care of Mr. Mikell?" (*See* R. p. 1647:14-18). In reaching this conclusion regarding whether there was any negligence, the jury was not required to make any determination about the cause of Mr. Mikell's death or his future prognosis. In other words, the jury never determined whether there was a causal link between MUSC's alleged negligence and Mr. Mikell's death because it never reached that issue. As a result, even if the trial judge admitted Dr. Zile's testimony in error, such error was harmless.

Moreover, Plaintiff does not set forth any legal basis for the exclusion of Dr. Zile's testimony. To the contrary, this section of Plaintiff's Appellant's Brief is devoid of any case citations. As a result, Plaintiff has not properly preserved and presented this issue for appellate review. *See Bennett v. Investors Title Ins. Co.*, 370 S.C. 578, 599, 635 S.E.2d 649, 660 (Ct. App. 2006) (when appellant fails to cite supporting authority and makes conclusory arguments, appellant abandons issue on appeal); *State v. Crocker*, 366 S.C. 394, 399 n. 1, 621 S.E.2d 890, 893 n. 1 (Ct. App. 2005) (holding conclusory statements unaccompanied by argument and legal citation are insufficient to preserve issue for review and constitute abandonment); *State v. Colf*, 332 S.C. 313, 332, 504 S.E.2d 360, 364 (Ct. App. 1998) (conclusory, two-paragraph argument citing no authority other than evidentiary rule abandoned issue for appeal).

Additionally, the trial judge properly permitted Dr. Zile to testify about Mr. Mikell's prognosis to rebut Plaintiff's expert, who was permitted to testify about a causal link between the cardiac arrest and Mr. Mikell's death — even though he did not give that testimony in his deposition and his opinion on this issue was disclosed only the week before trial. (*See generally* R. pp. 113-177). In fact, Plaintiff's counsel first disclosed Dr. Kofke's testimony regarding proximate cause of Mr. Mikell's death on April 11, 2016, shortly before trial:

> Following his debilitating hospitalization, Mr. Mikell never returned to his pre-event baseline. Several medications which had been used to keep him stable were changed while he was in the hospital. This made him more susceptible to the type of heart dysfunction described as being the likely cause of his death. So the cardiac arrest, physical injuries, hospitalization, debilitation, medical management, etc. all contributed to his death.

(*See id.*, R. pp. 175-77). It would have been highly unfair to permit Plaintiff, on the eve of trial, to offer for the first time expert testimony of a causal link between Mr. Mikell's arrest and his death, without permitting Mr. Mikell's own treating physician to opine on the same subject. Therefore, to the extent MUSC allegedly disclosed Dr. Zile's testimony late, this was the result of Plaintiff's late disclosure of Dr. Kofke's new testimony.

In addition, Plaintiff cannot dispute that Dr. Zile was more than qualified testify as he did. Dr. Zile was a treating physician of Mr. Mikell and testified that he had numerous conversations with Mr. Mikell regarding his long-term prognosis and medication regimen. He further testified that Mr. Mikell's long-term prognosis was relevant to his treatment of Mr. Mikell's heart failure. Dr. Zile's testimony fell well within the realm of testimony that a treating physician would be competent and qualified to give. Indeed, it is difficult to conceive who would be more qualified to testify as to Mr. Mikell's cardiac health and future prognosis than his treating cardiologist following MUSC's alleged negligence.

Therefore, the trial judge did not abuse his discretion in permitting Mr. Mikell's treating cardiologist, Dr. Zile, to testify regarding his prognosis at the relevant time.

III. THE TRIAL COURT DID NOT COMMIT REVERSIBLE ERROR IN ADMITTING MR. MIKELL'S MEDICAL RECORDS

Plaintiff next argues that the trial court erred in that "[o]ver Plaintiff's objection, MUSC was permitted to place into evidence 131 pages of medical records from Mr. Mikell's cardiology chart at MUSC." (*See* Pl.'s Br., at 38). Specifically, Plaintiff objects to the admission of Defendant MUSC's Exhibit 8. (*See* R. pp. 275-404). Plaintiff does not argue that Defendant's Exhibit 8 was inadmissible for reasons of relevance, hearsay, foundation or other substantive reasons. Rather, Plaintiff contends that the "dump" of those medical records into evidence was erroneous because the jury was incapable of properly evaluating or understanding those records and because the records contain "subjective opinions."

Under South Carolina Rule of Evidence 403, relevant "evidence *may* be excluded if its probative value is substantially outweighed by the danger of unfair prejudice, confusion of the issues, or misleading the jury . . . ." (Emphasis added). "'This [c]ourt reviews 403 rulings pursuant to the abuse of discretion standard, and gives great deference to the trial judge's decision.'" *State v. McGee*, 408 S.C. 278, 288, 758 S.E.2d 730, 736 (Ct. App. 2014) (*quoting State v. Myers*, 359 S.C. 40, 48, 596 S.E.2d 488, 492 (2004)); *accord State v. Lee*, 399 S.C. 521, 527, 732 S.E.2d 225, 228 (Ct. App. 2012) ("A trial court has particularly wide discretion in

ruling on Rule 403 objections."). "A trial judge's decision regarding the comparative probative value and prejudicial effect of evidence should be reversed only in *exceptional circumstances*." *State v. Adams*, 354 S.C. 361, 378, 580 S.E.2d 785, 794 (Ct. App. 2003) (emphasis added).

> "Unfair prejudice does not mean the damage to a defendant's case that results from the legitimate probative force of the evidence; rather it refers to evidence which tends to suggest decision on an improper basis." *State v. Gilchrist*, 329 S.C. 621, 630, 496 S.E.2d 424, 429 (Ct. App. 1998) (quotation marks and citations omitted). "All evidence is meant to be prejudicial; it is only unfair prejudice which must be [scrutinized under Rule 403]." *State v. Lee*, 399 S.C. 521, at 529, 732 S.E.2d 225, at 229 (2012) (alteration and emphasis in original; quotation marks and citations omitted).

See State v. Dennis, 402 S.C. 627, 636, 742 S.E.2d 21, 26 (Ct. App. 2013).

While Plaintiff argues that the admission of Defendant's Exhibit 8 created a "high likelihood of confusion," he does not dispute the accuracy or authenticity of those medical records. He does not specifically identify anything in those documents that he believes misled the jury or confused the issues at trial. He does not specifically identify anything in the records that is inadmissible or that he contends is an impermissible opinion. Instead, Plaintiff speculates that something in Defendant's Exhibit 8 *might have* somehow improperly affected the jury. Simply put, Plaintiff makes no showing that the introduction of Mr. Mikell's medical records was an abuse of discretion that misled the jury or somehow confused the issues in this case. Instead, Plaintiff simply speculates that the jury was confused without any factual predicate.

The cases that Plaintiff cites are inapposite. For example, in *State v. Council*, 335 S.C. 1, 24, 515 S.E.2d 508, 520 (1999), the Court determined that the challenged polygraph evidence because of the unreliability of the test. *See id.* ("Unless the jury is allowed to speculate, the fact that Douglas' exam showed deception does not prove that Douglas was lying or that Douglas committed the crimes against Mrs. Gatti."). Similarly, in *State v. Jones*, 273 S.C. 723, 732, 259 S.E.2d 120, 125 (1979), the Court considered the scientific reliability of testimony regarding bite marks, which Plaintiff has not challenged in this appeal. *See id.* ("There was no showing that the techniques and theories employed were other than accepted by the photographic and dental

communities."). In the cited cases, courts addressed the admissibility of scientific/expert evidence of questionable reliability. Here, there is no evidence or legitimate argument that any specific portion of Defendant's Exhibit 8 was inherently unreliable or involved questionable methodology.

Therefore, for the foregoing reasons, the trial judge did not abuse his discretion in admitting Defendant's Exhibit 8, comprised of Mr. Mikell's authentic medical records.

IV. THE TRIAL COURT DID NOT ERR IN ADMITTING A BLANK "MAYDAY FORM" INTO EVIDENCE

Plaintiff objects to the trial court's admission into evidence of a blank Cardiopulmonary Resuscitation Event Form ("Mayday Form") and testimony regarding same. (*See* R. p. 274). Plaintiff argues that the trial judge erred in admitting the blank "Mayday Form" into evidence "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." (*See* Pl.'s Br., at 42). For the reasons that follow, Plaintiff's argument lacks merit.

South Carolina Rule of Evidence 1002 provides that "[t]o prove the content of a writing, recording, or photograph, the original writing, recording, or photograph is required, except as otherwise provided in these rules or by statute." (Emphasis added). Rule 1004 states that "[t]he original is not required, and other evidence of the contents of a writing, recording, or photograph is admissible if — [] [a]ll originals are lost or have been destroyed, unless the proponent lost or destroyed them in bad faith." "[T]he question of whether to admit evidence under the 'best evidence rule' is [] addressed to the discretion of the trial court." *State v. Halcomb*, 382 S.C. 432, 443, 676 S.E.2d 149, 154 (Ct. App. 2009).

The trial judge properly admitted the blank Mayday Record as a business record under South Carolina Rule of Evidence Rule 803(6). Moreover, the blank Mayday Record did not, in any way, violate the best evidence rule. Importantly, MUSC did not introduce Defendant's Exhibit 2 to show the *actual* "content of" Mr. Mikell's Mayday Record so as to trigger the best evidence rule. To the contrary, MUSC used Defendant's Exhibit 2 to show *the type* of

information ordinarily recorded in the Mayday Record. Plaintiff argued that the "lost" Mayday Record likely contained harmful information suggesting that MUSC's negligence caused Mr. Mikell's arrest. MUSC's purpose in introducing the blank form was to demonstrate that, to the contrary, the form is intended to record information beginning with the resuscitation by the Mayday team, not information from events prior to the resuscitation. In other words, contrary to the inference that the Plaintiff argued, if the Mayday Record ever did exist, it did not – and was not intended to – reflect information pertinent to the cause of the patient's cardiac arrest. This was evident from the blanks on the form that were to be filled in.

Sheila Scarbrough, RN, MSN, testified that she created the blank Mayday Record form and that it was the form in use at the time of Mr. Mikell's arrest. (*See* R. p. 656:2-11). She further testified regarding the Mayday Policy and the application of the Mayday Record in clinical practice which includes the information that is ordinarily recorded in the record pertaining to resuscitation. For example, Nurse Scarborough testified regarding the purpose of the Mayday Record:

> 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.
>
> Q. And you said that you helped to create this form; why did -- why did MUSC create this form that's called the Cardiopulmonary Resuscitation Event --
>
> A. There's a couple of reasons. First and foremost, from the quality standpoint, we wanted to make sure that at the time of resuscitation, when people are busy saving lives, they don't think a lot of the data points that we want to capture to put in the database, so this helps to remind them to write these things down.

(*See* R. pp. 656:15-657:4). Nurse Scarborough further testified that Mayday Records normally only contain information occurring after the mayday is called:

> Q. Ms. Scarbrough, I'm going to put a copy of this form up so the jury can see it. Now, Ms. Scarbrough, what information is -- is documented in the

resuscitation form? And when I say that, I'm really referring to -- is it information that's -- 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? . . .

A. No. It's actually about the resuscitation, but it's what the patient's condition was at the time that he went into cardiac arrest. Like there's a question about was it witnessed or not. So when he went into cardiac arrest, was someone there. Because sometimes we have patients that we find, you know, in the bed that has cardiac arrest that we didn't know about. Those sort of things.

Yeah, it's all about at the time of cardiac pulmonary arrest on -- until the patient is resuscitated or not, that's what the information is in the form is all about.

(*See* R. pp. 658:9-659:13). This is consistent with the labels on the blank Mayday Record, which primarily seek information about how the mayday was addressed. (*See* R. p. 274).

The blank Mayday Record was plainly admissible to rebut the adverse inference instruction. Plaintiff moved for an adverse inference instruction in accordance with *Stokes v. Spartanburg Regional Medical Center*, 368 S.C. 515, 629 S.E.2d 675 (Ct. App. 2006) based on the spoliation of evidence. The trial judge gave an adverse inference charge regarding the "missing" Mayday Record:

> I charge you that when a party fails to preserve material evidence for a trial, it is for you to determine whether the party has offered a satisfactory explanation for the failure. If you find the explanation is unsatisfactory, you are permitted, but not required, to draw the inference that the evidence would have been unfavorable to the party's claim.

(*See* R. p. 1622:2-9). Under that instruction, Plaintiff was permitted to, and did, argue that the jury should infer that the Mayday Record contained relevant information that was adverse to MUSC. (*See* R. p. 1521:4-7 ("[M]ost importantly, they didn't even want us to know that there was a Mayday record, let alone tell us what that Mayday record would have shown.").

While Plaintiff was permitted to argue that the jury could draw an adverse inference from the alleged absence of a Mayday Record, such an adverse inference is rebuttable. *See Stokes v. Spartanburg Regional Medical Center*, 368 S.C. at 679, 629 S.E.2d at 521. Therefore, MUSC was entitled to introduce evidence that tended to demonstrate that the Mayday Record likely did *not* contain any information about what occurred prior to the mayday and, as a result, did not contain any relevant adverse evidence.

Thus, for these reasons, the trial judge did not abuse his discretion in concluding that the introduction of MUSC's Exhibit 2 did not violate the best evidence rule.

V. THE TRIAL COURT DID NOT ERR IN DECLINING TO INFORM THE JURY ABOUT THE ENTRY OF JUDGMENT AS TO PLAINTIFF'S LEGAL MALPRACTICE CLAIM REGARDING DR. NELSON'S CONDUCT

Plaintiff next argues that the trial judge erred in not informing the jury that it had granted a partial directed verdict to MUSC concerning Dr. Nelson's alleged professional malpractice. Plaintiff posits that this somehow diminished the credibility of Plaintiff's counsel before the jury because "claims which had occupied a significant amount of time during the presentation of evidence were left inexplicably absent from any discussion during closing arguments. (*See* Pl.'s Br., at 43). This argument is wholly without merit.

First, Plaintiff did not ask the trial judge to inform the jury about the grant of partial directed verdict. Plaintiff did not argue to the trial judge that the trial judge's alleged failure to advise the jury of the grant of partial directed verdict prejudiced him. As a result, this issue has not been properly preserved for appellate review. "'[A]n issue cannot be raised for the first time on appeal, but must have been raised to and ruled upon by the trial judge to be preserved for appellate review.'" *Tucker v. Doe*, 413 S.C. 389, 409, 776 S.E.2d 121, 132 (Ct. App. 2015), *cert. denied* (Oct. 20, 2016) (*quoting South Carolina Dep't of Transp. v. First Carolina Corp. of S.C.*, 372 S.C. 295, 301, 641 S.E.2d 903, 907 (2007)). Therefore, Plaintiff has not properly preserved this issue for appellate review.

Moreover, as set forth *supra*, contrary to his present argument, Plaintiff discussed Dr. Nelson by name numerous times throughout his summation. Plaintiff argued to the jury that Dr. Nelson's absence from the room at critical times constituted negligence and blamed Dr. Nelson for Mr. Mikell's arrest. Contrary to Plaintiff's argument on appeal, he did not materially "refrain from discussing the physician negligence claims during closing arguments." (*See* Pl.'s Br., at 43). Ironically, the one time during trial that Plaintiff did *not* mention Dr. Nelson by name was during his *opening* statement. As a result, he never made any promises to the jury that he would be presenting evidence or asking for a verdict stemming from Dr. Nelson's alleged negligence. Simply put, Plaintiff could not have lost any credibility in the eyes of the jury as he claims, since he did not refrain from mentioning Dr. Nelson in his summation. Additionally, Plaintiff has not presented any evidence to support his conjecture that the trial judge's action had any effect at all on the jury or affected the ultimate verdict in any way.

Moreover, Plaintiff cannot show that the trial judge abused his discretion in not informing the jury about the grant of partial directed verdict regarding Dr. Nelson's alleged negligence. Dr. Nelson was not even a party to this lawsuit. His name, therefore, did not appear in the caption. None of the Complaints reference him by name. The trial judge was not obligated to tell the jury that Plaintiff's claims against MUSC were without merit as to Dr. Nelson's alleged negligence.

The cases that Plaintiff cites in his brief do not support his contention. For example, in *Johnson*, the trial court erred in telling the defendant it would not charge on the "hand of one is the hand of all" rule, permitting the defendant to give his closing in reliance on that representation, then changing its mind *after the defendant's closing*:

> We agree with Appellant's contention that to reargue his closing would have required him to "shift theories" because during his closing argument, he contended he was not at the scene, and after the additional jury charge, he would have had to argue he was merely present. We further agree with Appellant that this shifting of theories could have potentially diminished his credibility with the jury.

State v. Johnson, 418 S.C. 587, 594, 795 S.E.2d 171, 175 (Ct. App. 2016), reh'g denied (Jan. 6, 2017). Similarly, in the other case Plaintiff cited, the Court held that the trial judge's "after the fact decision to excise the hesitate to act language from his charge was to diminish appellant's attorney's credibility in the eyes of the jury." *See State v. Jones*, 343 S.C. 562, 578, 541 S.E.2d 813, 821 (2001). In other words, these cases suggest only that a change to a jury instruction, made after summation, could be reversible error since the appellant's counsel would be making arguments to a jury based on a different understanding of the law that would ultimate be charged to the jury. The instant case presents no such scenario.

Therefore, the trial judge did not abuse his discretion in not informing the jury of his grant of partial directed verdict to MUSC.

CONCLUSION

For the foregoing reasons, the Court should affirm the trial judge's denial of Plaintiff's Motion for New Trial and should affirm the jury's well-supported verdict in this matter.

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August 31, 2017

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

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

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

RULE 211 CERTIFICATE

I hereby certify that this Final Respondent's Brief complies with Rule 211(b), S.C.A.C.R.

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