THE STATE OF SOUTH CAROLINA
IN THE COURT OF APPEALS

APPEAL FROM YORK COUNTY
COURT OF COMMON PLEAS
THE HONORABLE R. SCOTT SPROUSE
CIRCUIT COURT JUDGE

APPELLATE CASE NO. 2016-002008
CIVIL ACTION NO. 2015-CP-46-00882

Lorrie Dibernardo, individually and as the Personal Representative of the Estate of Anthony Dibernardo, deceased,

APPELLANT,

versus

Carolina Cardiology Associates, PA and Naresh Mori, MD,

RESPONDENTS.

FINAL BRIEF OF RESPONDENTS

George C. Beighley
Carmen V. Ganjehsani
RICHARDSON, PLOWDEN & ROBINSON, PA
1900 Barnwell Street (29201)
Post Office Drawer 7788
Columbia, South Carolina 29202
(803) 771-4400
ATTORNEYS FOR RESPONDENTS CAROLINA CARDIOLOGY ASSOCIATES, PA AND NARESH MORI, MD

TABLE OF CONTENTS

PAGE

TABLE OF AUTHORITIES

CASES **PAGE**

COUNTERSTATEMENT OF ISSUE ON APPEAL

The Trial Court correctly refused to give the jury Appellant's requested charge which would have invited the jury to find negligence or malpractice of the physician based solely upon the occurrence of an adverse result during a medical procedure because such a charge is contrary to a plaintiff's burden of proof in a medical malpractice action and because furthermore, the evidence at trial, in which it was repeatedly shown that the procedure performed on Appellant's decedent carried with it a number of known potential complications, did not support Appellant's requested jury charge.

COUNTERSTATEMENT OF THE CASE

This case arises out of a medical malpractice action filed by Appellant Lorrie Dibernardo, individually and as the Personal Representative of the Estate of Anthony Dibernardo ("Mr. Dibernardo"), against Respondents Carolina Cardiology Associates, PA ("Carolina Cardiology") and Naresh Mori, MD ("Dr. Mori").

On March 23, 2015, Appellant filed her Complaint against Respondents in the York County Court of Common Pleas, alleging Mr. Dibernardo suffered a fatal injury during a pericardiocentesis. [R.pp. 29-49; Compl.] Respondents answered on April 29, 2015, denying the material allegations of the Complaint and further asserting that "any injuries or damages as alleged in the Complaint were due to and caused by [Mr. Dibernardo's] underlying medical condition, and complications arising therefrom . . . ." [R.pp. 50-53; Answer.]

The case proceeded to trial before The Honorable R. Scott Sprouse and a jury on September 12, 2016. [R.p. 54; Tr. p.1.] On September 15, 2016, the jury returned a verdict in favor of Respondents, finding Dr. Mori did not violate generally accepted standards of medical care in his treatment of Mr. Dibernardo. [R.pp. 544, l. 15 – 545, l. 14; 1-3; Tr. pp. 491, l. 16 – 492, l. 14; Verdict.]

Appellant filed and served her notice of appeal on or about September 26, 2016.

COUNTERSTATEMENT OF THE FACTS

Mr. Dibernardo was a patient of Carolina Cardiology from approximately 2005 until his passing in 2013 and was primarily seen by Dr. Jay K. Shah, a cardiologist with Carolina Cardiology. [R.pp. 128, l. 1-129, l. 9; Tr. pp. 75, l. 1 – 76, l. 9.]

Mr. Dibernardo was born with Noonan's syndrome, a genetic disorder which caused him to have a larger than normal heart, as well as other physical abnormalities. As a result, Mr. Dibernardo had a longstanding history of heart problems. He had a history of congestive heart failure, and the left and right atria of his heart had dilated massively and already failed as a consequence of his genetic condition. Mr. Dibernardo had a pathologic over-thickening of the heart muscle which led to his condition of progressive heart failure for which he dealt with for many years. Over the years, he also developed significant edema, or swelling of the lower extremities. Mr. Dibernardo also suffered from ascites which is fluid buildup inside the abdomen. His heart had failed to such an extent that the fluid had built up in both the legs and the abdomen. In addition, Mr. Dibernardo had a condition known as atrial fibrillation for which he was on blood thinner medication. Because of Mr. Dibernardo's numerous heart conditions, it became increasingly hard for him to breathe with any amount of effort whatsoever and his lifestyle was severely limited. [R.pp. 111, ll. 13-25; 130, ll. 2-8; 131, ll. 10-19; 259, l. 19 – 260, l. 21; 363, l. 24 – 365, l. 17; 366, ll. 1-15; 428, l. 18 – 429, l. 7; 548; 550-552; Id. at pp. 58, ll. 13-25; 77, ll. 2-8; 78, ll. 10-19; 206, l. 19 – 207, l. 21; 310, l. 24 - 312, l. 17; 313, ll. 1-15; 375, l. 18 – 376, l. 7; P. Ex. 1, p.1; P. Ex. 2.]

Dr. Shah eventually diagnosed Mr. Dibernardo with a large pericardial effusion. [R.pp. 173, ll. 21-22; 549; Tr. p. 120, ll. 21-22; P. Ex. 1, p. 2.] A pericardial effusion

occurs when there is a build-up of fluid in the sac surrounding the heart. [R.pp. 130, ll. 9-15; 173, ll. 10-14; 366, ll. 12-15; Tr. pp. 77, ll. 9-15; 120, ll. 10-14; 313, ll. 12-15.] Mr. Dibernardo had a massive pericardial effusion which was causing high pressures within his heart chambers and in turn causing the size of the heart to be increased preventing the heart from functioning normally which resulted in the shortness of breath experienced by Mr. Dibernardo. [R.pp. 169, ll. 7-12; 261, ll. 10-17; Id. at pp. 116, ll. 7-12; 208, ll. 10-17.]

Mr. Dibernardo's symptoms markedly worsened in the months preceding July 2013. [R.pp. 143, ll. 23-25; 429, ll. 8-14; Id. at pp. 90, ll. 23-25; 376, ll. 8-14.] On June 14, 2013, Dr. Shah saw Mr. Dibernardo and noted that Mr. Dibernardo complained of increasing difficulty breathing, ankle swelling, and the inability to walk in his house without difficulty breathing. [R.p. 143, ll. 9-22; Id. at p. 90, ll. 9-22.]

Dr. Shah again saw Mr. Dibernardo on July 19, 2013. Mr. Dibernardo informed Dr. Shah that he could no longer walk in his house without losing the ability to breathe. [R.p. 142, ll. 10-12; Id. at p. 89, ll. 10-12.] Dr. James Story, a cardiologist admitted at trial as an expert in the field of cardiology and invasive cardiology, opined that Mr. Dibernardo was suffering from class four heart failure at this time – meaning the heart is failing to do its job as a pump such that a patient has signs and/or symptoms of heart failure at rest and has difficulty conducting minimal activities - and "was a very sick man." [R.pp. 361, ll. 2-10; 362, ll. 17-19; 365, ll. 7-16; 366, ll. 10-20; 386, ll. 2-10; 429, ll. 18-23; Id. at pp. 308, ll. 2-10; 309, ll. 17-19; 312, ll. 7-16; 313, ll. 10-20; 333, ll. 2-10; 376, ll. 18-23.] Dr. Michael Foster, an interventional cardiologist also admitted at trial as an expert in the field of cardiology and invasive cardiology, concurred that Mr.

Dibernardo was having class four congestive heart failure when he was seen by Dr. Shah on July 19, 2013. [R.pp. 425, l. 22-426, l. 4; 427, ll. 22-24; 429, ll. 8-25; Id. at pp. 372, l. 22 – 373, l. 4; 374, ll. 22-24; 376, ll. 8-25.] The five-year survival rate for heart failure is only twenty percent. [R.p. 366, ll. 21-22; Id. at p. 313, ll. 21-22.]

Dr. Shah convinced Mr. Dibernardo to be seen in the hospital to try to alleviate the large amount of fluid around his heart which was contributing to Mr. Dibernardo's decline, and Mr. Dibernardo ultimately agreed. [R.pp. 142, ll. 8-15; 429, ll. 8-14; Id. at pp. 89, ll. 8-15; 376, ll. 8-14.] Mr. Dibernardo was admitted to Piedmont Medical Center by Dr. Shah on July 19, 2013. [R.pp. 259, ll. 5-8; 548-549; 550-552; Id. at pp. 206, ll. 5-8; P. Ex 1; P. Ex. 2.]

Dr. Shah believed Mr. Dibernardo needed a surgical evaluation for his worsening of fluid around the heart. Mr. Dibernardo had a difficult effusion and for that reason he was referred to surgery. For a complicated pericardial effusion, surgery is the preferred option for treating the effusion. Mr. Dibernardo, however, refused to undergo any surgical procedure to open the pericardium to drain the fluid. [R.pp. 141, l. 23 – 142, l. 4; 244, ll. 7-9; 260, l. 22 – 261, l. 5; 318, ll. 11-15; 321, ll. 21-23; 367, ll. 9-14; 431, ll. 4-17; Tr. pp. 88, l. 23 – 89, l. 4; 191, ll. 7-9; 207, l. 22 – 208, l. 5; 265, ll. 11-15; 268, ll. 21-23; 314, ll. 9-14; 378, ll. 4-17.]

In the hospital, after declining direct surgical intervention, Mr. Dibernardo met with Dr. Mori, an interventional cardiologist with Carolina Cardiology. [R.pp. 257, ll. 2-16; 259, ll. 3-18; Id. at pp. 204, ll. 2-16; 206, ll. 3-18.] Because Mr. Dibernardo had declined surgery, Dr. Mori felt it was reasonable to offer to perform a procedure called a pericardiocentesis to remove the fluid. [R.p. 261, ll. 6-13; Id. at p. 208, ll. 6-13.]

A pericardiocentesis is a procedure whereby fluid is drained and removed from the space around the heart usually through a tube or catheter. [R.p. 169, ll. 4-25; Id. at p. 116, ll. 4-25.] If surgery is eliminated as an option, a pericardiocentesis is the next best option to provide relief for a patient suffering from a pericardial effusion. All experts at trial, including Appellant's expert, agreed it was appropriate for Dr. Mori to recommend Mr. Dibernardo undergo a pericardiocentesis to remove the fluid from around his heart in light of Mr. Dibernardo's refusal to undergo surgery. [R.pp. 213, ll. 22-25; 220, ll. 6-10; 367, ll. 1-18; 431, ll. 4-20; Id. at pp. 160, ll. 22-25; 167, ll. 6-10; 314, ll. 1-18; 378, ll. 4-20.]

Dr. Mori believed that Mr. Dibernardo's initial presenting symptoms – the shortness of breath, swelling of the legs, and swelling of the abdomen – were symptoms of heart failure and would have become progressively worse without this treatment. [R.p. 292, ll. 8-20; Id. at p. 239, ll. 8-20.] Appellant's expert, Dr. Alan Schob, agreed that if left untreated, Mr. Dibernardo's heart condition would have continued on a downhill progression. [R.p. 221, ll. 9-14; Id. at p. 168, ll. 9-14.]

As with all cardiac procedures, there are risks associated with even a properly performed pericardiocentesis. Because a pericardiocentesis involves the insertion of a needle and catheter or other tube into the space surrounding the heart containing the fluid, there is a risk of striking veins, vessels, or the heart muscle itself. Therefore, the most common and prominent complication from a pericardiocentesis is bleeding from injury to the heart or one of the vessels close to the heart. Other complications include arrhythmia and risk of infection. [R.pp. 131, l. 22-132, l. 7; 142, ll. 16-23; 261, l. 18 – 262, l. 5; 367, l. 19-368, l. 16; 431, l. 21 – 432, l. 15; Id. at pp. 78, l. 22 - 79, l. 7; 89, ll. 16-23; 208, l. 18

– 209, l. 5; 314, l. 19 – 315, l. 16; 378, l. 21 – 379, l. 15.] Compounding the risk of complications arising from the procedure was Mr. Dibernardo's multiple underlying medical issues and physical conditions, including a deformed chest cavity. [R.pp. 142, l. 25; 260, ll. 17-21; 264, ll. 20-23; 512, ll. 15-16; Id. at pp. 89, l. 25; 207, ll. 17-21; 211, ll. 20-23; 459, ll. 15-16.]

Mr. Dibernardo was advised of the risks of a pericardiocentesis and informed of the complications which could occur during the procedure, including bleeding. [R.pp. 142, ll. 16-23; 262, ll. 6-11; Id. at pp. 89, ll. 16-23; 209, ll. 6-11.] Mr. Dibernardo understood all risks and complications of the procedure, continued to decline surgery, and opted to undergo a pericardiocentesis to try to improve his symptoms. He signed an informed consent indicating that he understood the risks of the procedure. [R.pp. 262, l. 12 – 263, l. 7; Id. at pp. 209, l. 12 – 210, l. 7.]

Mr. Dibernardo was taking a blood thinner and therefore, when he was admitted to the hospital on July 19, 2013, his blood was very thin. Due to this, the procedure was delayed until July 22, 2013 to allow the blood thinner to be eliminated from his system in order for the blood to begin clotting normally. [R.pp. 143, ll. 1-7; 433, l. 5-21; Id. at pp. 90, ll. 1-7; 380, ll. 5-21.]

At trial, Dr. Mori described the pericardiocentesis performed on Mr. Dibernardo on the morning of July 22, 2013. Dr. Mori's description of the procedure illustrated the numerous risks and complications he encountered due to not only the normal risks of a pericardiocentesis, but from Mr. Dibernardo's underlying medical conditions and physical anatomy.

The procedure began with the placement of a local anesthetic and a small incision in the chest area, and the subsequent insertion of a hollow needle with a syringe attached into the pericardial space through what is called the subxiphoid process, meaning the needle is inserted under the sternum, or breast bone, toward the heart at a 45-degree angle. [R.pp. 264, ll. 1-5; 266, ll. 19-23; 369, l. 20 – 370, l. 3; 434, ll. 3-21; Id. at pp. 211, ll. 1-5; 213, ll. 19-23; 316, l. 20 – 317, l. 3; 381, ll. 3-21.] The subxiphoid approach is the safest and most commonly used approach for a pericardiocentesis. [R.pp. 212, ll. 18-20; 317, ll. 9-10; 318, ll. 20-22; 319, ll. 20-22; Id. at pp. 159, ll. 18-20; 264, ll. 9-10; 265, ll. 20-22; 266, ll. 20-22.] A syringe is attached to the needle, aspirating as the needle is inserted so the physician will know when he has reached the pericardial space because fluid will be withdrawn. [R.p. 434, ll. 19-21; Id. at p. 381, ll. 19-21.]

Dr. Mori explained that while an injury to the heart or a vessel should not occur, there is nevertheless always a risk of injury and bleeding because the physician is entering the space with a sharp object. Because the physician is inserting a sharp needle into the space surrounding the heart, there is a risk of injury by entering the blood vessels, either a vein or artery, or even the heart muscle itself. In Mr. Dibernardo's case, the risk was magnified because of his enlarged heart. The enlarged heart was very close to the space in which the needle had to be inserted, significantly increasing the risk of injury and bleeding because of the limited space for the needle insertion without touching the heart. Dr. Mori testified that Mr. Dibernardo's heart condition increased the risk of potential complications from the pericardiocentesis. [R.pp. 264, ll. 1-19; 266, ll. 19-23; 274, ll. 5-8; Id. at pp. 211, ll. 1-19; 213, ll. 19-23; 221, ll. 5-8.]

In addition, Mr. Dibernardo had an abnormal anatomy. He had a deformity in the chest area called ectis exoskeleton in which the chest bone is not flat as in most humans but rather caved in, and the deformity in Mr. Dibernardo's chest area made it more difficult for Dr. Mori to access the area with the needle. [R.pp. 260, ll. 17-21; 264, ll. 20-23; 512, ll. 15-16; Id. at pp. 207, ll. 17-21; 211, ll. 20-23; 459, ll. 15-16.]

Furthering complicating a pericardiocentesis procedure is that the needle is to be inserted into the space surrounding the heart – a fibrous membrane – in which fluid has accumulated. The fluid, however, is not evenly distributed around the heart. The width of fluid is different from one area to the next. If the fluid was evenly distributed, insertion of the needle without injury would be more possible because the physician would be aware of the exact space for needle insertion available before hitting the heart muscle or a vessel. But because the fluid is not distributed evenly, it is much more difficult for the physician to determine the amount of space available for the needle insertion. In addition, in Mr. Dibernardo's case, there was not as much fluid around the right ventricle of his heart and most of the fluid was located behind the left ventricle. Therefore, there was not much fluid for access around the right ventricle where the needle was to be inserted which increased the risk of injury by hitting a vessel or the heart muscle itself. Dr. Mori discussed this complication with Mr. Dibernardo prior to the procedure. [R.pp. 265, ll. 1-19; 273, l. 13 – 274, l. 5; 274, l. 16 – 275, l. 8; 276, ll. 9-11; 315, ll. 20-25; Id. at pp. 212, ll. 1-19; 220, l. 13 – 221, l. 5; 221, l. 16 – 222, l. 8; 223, ll. 9-11; 262, ll. 20-25.]

Finally, the heart is not static. Dr. Mori explained it moves around in the pericardial fluid. Therefore, the heart is not a fixed target. Because the heart is moving

and not staying still, there is a risk of injury from the insertion of the needle because the needle could stick the moving heart. Dr. Mori described this as a known complication from the procedure. [R.pp. 274, ll. 9-15; 315, l. 20 – 316, l. 4; 368, l. 17 – 369, l. 1; Id. at pp. 221, ll. 9-15; 262, l. 20 – 263, l. 4; 315, l. 17 – 316, l. 1.]

In summary, the pericardiocentesis on Mr. Dibernardo began with Dr. Mori's insertion of the needle at about a forty-five (45) degree angle into the pericardial space of Mr. Dibernardo under an echo (ultrasound) and fluoroscopy (similar to an x-ray movie) and under telemetry monitoring called electrocardiographic ("ECG") guidance[1]. These aids were to assist Dr. Mori in determining whether the needle was being inserted properly without injuring the heart or any vessel. [R.pp. 265, l. 22 – 266, l. 2; 267, ll. 4-6; 311, ll. 2-5; 312, ll. 1-18; 314, ll. 2-15; Id. at pp. 212, l. 22 – 213, l. 2; 214, ll. 4-6; 258, ll. 2-5; 259, ll. 1-18; 261, ll. 2-15.]

Dr. Mori testified that at some point the procedure and insertion of the needle does become blind as the needle is entering the pericardial space. The physician is unable to see where the needle is going even with the use of x-ray technology because the x-ray is a two-dimensional imaging technique yet the heart is three-dimensional. As such, at some point, the x-ray imaging becomes of no value in providing guidance. [R.pp.

[1] While the Appellant asserts Dr. Mori used EKG, or an alligator clip guidance, Dr. Mori used telemetry electrocariographic guidance. [R.pp. 311, ll. 4-5; 312, ll. 12-18; 314, ll. 2-15; Id. at pp. 258, ll. 4-5; 259, ll. 12-18; 261, ll. 2-15.] There was no evidence at trial that Dr. Mori's use of telemetry electrocariographic guidance violated any standard of care. This is one reason why an alarm would not sound if Dr. Mori had hit the heart because of his use of different monitoring. [R.p. 176, ll. 1-6; Id. at p. 123, ll. 1-6.] In addition, no alarm would sound if a vessel not near the heart was hit by the needle, which could have occurred in this case to cause Mr. Dibernardo's bleeding. [R.pp. 176, ll. 1-6; 178, ll. 10-13; 414, l. 16 – 415, l. 8; Id. at pp. 123, ll. 1-6; 125, ll. 10-13 (explaining only arteries or veins hit near the heart would signal an alarm); 361, l. 16 – 362, l. 8.] Further, under ECG guidance, the physician instead monitors for premature beats that might signify that the physician is in contact with the ventricle. [R.p. 312, ll. 1-8; Id. at p. 259, ll. 1-8.]

266, ll. 3-5; 435, ll. 6-10; Id. at pp. 213, ll. 3-5; 382, ll. 6-10.] As noted above, the blind approach, coupled with the size and swinging motion of Mr. Dibernardo's heart, as well as the lower amount of fluid around the right ventricle where the needle is inserted, all leads to a risk of bleeding. [R.p. 275, ll. 17-25; Id. at p. 222, ll. 17-25.]

Dr. Mori inserted the needle using the xipoid approach as described above. Because of Mr. Dibernardo's difficult anatomy, it took Dr. Mori more than one attempt to insert the needle. [R.p. 281, ll. 2-6; Id. at p. 228, ll. 2-6.]

According to Dr. Mori, once the physician feels fluid coming back, it is confirmed that the needle has entered the pericardial space. [R.pp. 266, ll. 6-11; 267, ll. 5-10; 435, ll. 11-15; Id. at pp. 213, ll. 6-11; 214, ll. 5-10; 382, ll. 11-15.] A flexible guide wire is passed through the center of the needle. This is a thin wire which serves as a guide for the catheter intended to be placed in the pericardium. A pigtail catheter, which is a relatively small catheter with a little loop on the end and a series of very small, tiny holes, is then inserted. The catheter is designed to allow fluid to filter into the catheter and be aspirated out through that catheter. Once it is determined on the fluoroscopy that the catheter is in place, the guide wire is removed. [R.pp. 267, ll. 16-25; 435, l. 16 – 436, l. 6; Id. at pp. 214, ll. 16-25; 382, l. 16 – 383, l. 6.]

Dr. Mori was able to confirm proper placement of the pigtail catheter around 10:40 a.m. [R.pp. 268, ll. 3-18; 269, ll. 12-17; 276, ll. 12-17; Id. at pp. 215, ll. 3-18; 216, ll. 12-17; 223, ll. 12-17.] Dr. Mori began drawing the fluid from Mr. Dibernardo's pericardial space but what started out as pinkish fluid became "frank bloody." It took a few minutes for the color to change from pink to bloody. The fluid coming out became increasingly bloody, and Dr. Mori began having difficulty getting any fluid out at all.

[R.pp. 269, ll. 18-23; 281, l. 7 – 282, l. 2; 307, l. 4 – 308, l. 6; 371, ll. 2-9; 436, ll. 11-25; Id. at pp. 216, ll. 18-23; 228, l. 7 - 229, l. 2; 254, l. 4 – 255, l. 6; 318, ll. 2-9; 383, ll. 11-25.] The bleeding was concerning to Dr. Mori, and he believed if Mr. Dibernardo kept bleeding, he would develop a fatal condition known as cardiac tamponade. With cardiac tamponade, blood will eventually fill the pericardial space, the heart chambers become compressed, and the patient has a drop in blood pressure and ultimately suffers cardiac arrest. [R.pp. 269, l. 5 – 270, l. 21; 271, l. 8 – 272, l. 10; 282, ll. 14-18; Id. at pp. 216, l. 5 - 217, l. 21; 218, l. 8 – 219, l. 10; 229, ll. 14-18.]

Dr. Mori further testified that the echocardiogram showed the first signs of a blood clot around 10:53 a.m. which confirmed the existence of bleeding. The appearance of the blood clot on the echocardiogram was confirmed by Respondents' cardiology experts. [R.pp. 276, l. 24 – 277, l. 17; 282, ll. 9-11; 302, ll. 4-9; 383, l. 24 – 384, l. 8; 424, ll. 11-17; 445, ll. 17-25; Id. at pp. 223, l. 24 – 224, l. 17; 229, ll. 9 -11; 249, ll. 4-9; 330, l. 24 – 331, l. 8; 371, ll. 11-17; 392, ll. 17-25.] The timing of the blood clot indicated that the bleeding occurred as a result of a needle injury, of which, as Dr. Mori had previously explained, was a known risk and complication of the procedure compounded by the size of Mr. Dibernardo's heart, the anatomy of his chest, and the movement of the heart. [R.pp. 277, ll. 5-23; 343, ll. 5-12; Id. at pp. 224, ll. 5-23; 290, ll. 5-12.]

Dr. Mori initially removed the pigtail catheter to flush it out in order to try to remove any clot or debris out of the little holes and then reinserted it. [R.pp. 371, ll. 14-17; 437, ll. 1-11; Id. at pp. 318, ll. 14-17; 384, ll. 1-11.] Due to the hemorrhagic conversion from a pinkish fluid to bloody fluid and Dr. Mori's concerns about the

bleeding and the overall condition of Mr. Dibernardo, Dr. Mori then made a decision to remove the catheter and change to a sheath. [R.pp. 272, ll. 11-15; 302, ll. 4-9; Id. at pp. 219, ll. 11-15; 249, ll. 4-9.] The sheath is made of soft plastic with a single large hole at the end of the sheath larger than the holes on the pigtail catheter. [R.pp. 371, ll. 18-24; 437, ll. 13-15, ll. 23-25; Id. at pp. 318, ll. 18-24; 384, ll. 13-15, ll. 23-25.] The sheath, according to Dr. Mori, was inserted around 10:59 a.m. The sheath was only inserted after Dr. Mori observed bleeding which occurred as a result of the needle injury. [R.p. 277, ll. 8-23; Id. at p. at 224, ll. 8-23.] Dr. Mori recognized the needle injury early in the procedure and stated he had a definite change in color from the fluid being drained from initial pink to frank blood towards the end. [R.p. 277, ll. 18-23; Id. at p. 224, ll. 18-23.]

Dr. Mori made the decision to insert the sheath in an attempt to save Mr. Dibernardo's life. [R.pp. 277, l. 24 – 278, l. 1; Id. at pp. 224, l. 24 – 225, l. 1.] Dr. Mori was not getting enough fluid though the catheter which he suspected had clogged up. The decision to change to the sheath was to treat the bleeding. [R.pp. 278, ll. 3-8; 334, l. 17 – 335, l. 14; Id. at pp. 225, ll. 3-8; 281, l. 17 – 282, l. 14.] Dr. Mori chose a larger and longer sheath over a smaller sheath because of the size of Mr. Dibernardo's heart. [R.p. ___; Id. at p. 226, ll. 19-25.] He further confirmed that he had inserted enough guide wire to properly exchange the catheter for a sheath. [R.pp. 279, l. 19 – 280, l. 10; Id. at pp. 226, l. 19 – 227, l. 10.]

Due to the evidence of bleeding and Mr. Dibernardo's risk of developing cardiac tamponade and ultimately cardiac arrest, Dr. Mori testified that it would not have been appropriate to have simply left the original pigtail catheter in for fluid to drain and to have sent Mr. Dibernardo to the intensive care unit. [R.pp. 282, l. 3 – 283, l. 1; Id. at pp.

229, l. 3 – 230, l. 1.] Respondents' cardiology experts, Dr. Story and Dr. Foster, agreed that leaving the original pigtail catheter in, attaching it to a drain, and sending the patient to the recovery room would not have been appropriate. [R.pp. 385, ll. 10-22; 450. ll. 2-9; Id. at pp. 332, ll. 10-22; 397, ll. 2-9.]

In response to the significant bleeding, Dr. Mori immediately called for the surgeon. Because of the degree of bleeding, Dr. Mori was worried about injury to the heart and called for the surgeon to find the source of the bleeding and take further measures to treat the source. [R.p. 283, ll. 2-10; Id. at p. 230, ll. 2-10.] The surgeon was not immediately available, however, and therefore, Dr. Mori began the process of an autotransfusion whereby blood from the source of the bleeding, here the pericardium, is withdrawn and given back to the patient through a sheath placed in the femoral vein – the vein in the leg. These efforts were undertaken to halt the drop in blood pressure. Dr. Mori's efforts to autotranfuse Mr. Dibernardo were successful in stabilizing him until the surgeon was available. Mr. Dibernardo's blood pressure improved due to the autotransfusion. Mr. Dibernardo was alert and talking following the autotranfusion and never lost consciousness or became unresponsive. [R.pp. 217, ll. 13-23; 283, l. 11 – 284, l. 8; 285, l. 18 – 286, l. 5; 372, ll. 5-12; 438, ll. 8-25; Id. at pp. 164, ll. 13-23; 230, l. 11 – 231, l. 8; 232, l. 18 – 233, l. 5; 319, ll. 5-12; 385, ll. 8-25.]

After Mr. Dibernardo was stabilized, the surgeon was able to see him and agreed Mr. Dibernardo needed surgery because of the significant bleeding. [R.p. 286, ll. 6-9; Id. at p. 233, ll. 6-9.] During surgery upon Mr. Dibernardo, the surgeon removed a large blood clot and found an abrasion across the right ventricle possibly from the sheath. The surgeon found no significant ongoing bleeding from this abrasion and placed a piece of

SurgiSeal, a type of gel, on the abrasion "just in case." No stitches were required to repair the heart. [R.pp. 288, l. 3 – 290, l. 2; 315, ll. 5-7; 375, ll. 2-22; 572; Id. at pp. 235, l. 3 – 237, l. 2; 262, ll. 5-7; 322, ll. 2-22; P. Ex. 5, p. 2.]

The sheath did not penetrate the heart. The surgeon found no hole in the heart. There was no damage to the heart requiring stitches. While the sheath came into contact with the right ventricle of the heart, such contact was a known potential risk of using the sheath but the use of the sheath was necessary to control the bleeding. [R.pp. 287, l. 7 – 288, l. 2; 375, ll. 2-25; 376, ll. 1-4; Tr. pp. 234, l. 7 – 235, l. 2; 322, ll. 2-25; 323, ll. 1-4.]

Dr. Mori testified that the sheath's contact with the heart wall was not sufficient to account for all the blood he had to pull out of Mr. Dibernardo. The significant bleeding and the blood clot were present before the sheath placement occurred. Dr. Story opined that the needle possibly struck a small artery or vessel, some which can be half a millimeter in diameter that the surgeon would not have seen during the operation. By exchanging the catheter for a sheath, Dr. Mori managed a known complication – injury to the heart or vessel by the initial needle insertion – in accordance with the generally accepted standards of care. [R.pp. 290, l. 7 – 291, l. 3; 310, ll. 18-22; 376, ll. 5-8; 385, ll. 2-9; 414, l. 16 – 415, l. 8; 419, l. 16 – 420, l. 1; 424, ll. 11-17; Id. at pp. 237, l. 7 – 238, l. 3; 257, ll. 18-22; 323, ll. 5-8; 332, ll. 2-9; 361, l. 16 – 362, l. 8; 366, l. 16 – 367, l. 1; 371, ll. 11-17.]

Respondents' cardiology expert, Dr. Story, agreed that the injury to the heart was caused by the initial needle insertion based on the amount of bleeding and the timing of the blood clot and that Dr. Mori appropriately managed the bleeding complication that occurred during the procedure. [R.pp. 385, ll. 2-5; 408, ll. 6-16; Id. at pp. 332, ll. 2-5;

355, ll. 6-16.] Dr. Story concurred that the sheath's contact with the heart wall could not have produced all the bleeding Dr. Mori encountered, further indicating that the bleeding was due to an injury caused by the initial needle insertion. [R.pp. 376, ll. 1-8; 408, ll. 6-16; Id. at pp. 323, ll. 1-8; 355, ll. 6-16.]

Mr. Dibernardo survived the heart surgery and was placed on a ventilator. [R.p. 291, ll. 4-11; Id. at p. 238, ll. 4-11.] Due to the surgery and Mr. Dibernardo's underlying medical conditions, Mr. Dibernardo was not successful in coming off the ventilator, and Mr. Dibernardo's family, specifically his wife, ultimately elected to terminate the ventilation. [R.pp. 251, ll. 9-12; 293, ll. 13-17; pp. 198, ll. 9-12; 240, ll. 13-17.] Mr. Dibernardo died on July 24, 2013. [R.p. 599; P. Ex. 10.] Following Mr. Dibernardo's death, Appellant brought this lawsuit alleging that Respondents Carolina Cardiology and Dr. Mori failed to perform an appropriate pericardiocentesis. [R.pp. 29-49; Compl.]

At trial, Dr. Mori explained that even if the physician does everything properly during a pericardiocentesis and all precautions are taken, complications can still occur as did in Mr. Dibernardo's case. [R.pp. 315, ll. 12-18; 316, ll. 1-4, 10-20; Tr. pp. 262, ll. 12-18; 263, ll. 1-4, 10-20.] He further testified that a pericardiocentesis is never 100 percent fool proof and that even if the procedure is performed with all appropriate steps taken, an injury can still occur. [R.pp. 344, ll. 7-17; 347, ll. 1-4; Id. at pp. 291, ll. 7-17; 294, ll. 1-4.] The fact that an injury occurs is not indicative of a physician's departure from the standard of care and even if the standard of care is met, a patient can still have a complication. [R.p. 347, ll. 5-15; Id. at p. 294, ll. 5-15.]

Cardiology experts at trial, Dr. Story and Dr. Foster, concurred that Dr. Mori complied with the generally accepted standards of medical care in performing the

pericardiocentesis and conducted the procedure appropriately. [R.pp. 363, ll. 4-23; 370, ll. 17-19; 421, ll. 13-22; 451, ll. 9-17; Id. at pp. 310, ll. 4-23; 317, ll. 17-19; 368, ll. 13-22; 398, ll. 9-17.] Dr. Story confirmed that a pericardiocentesis is a difficult procedure given the insertion of a needle in a tight space with a beating, moving heart. [R.pp. 368, l. 10 – 369, l. 1; Id. at pp. 315, l.10 - 316, l. 1.] He further explained that even if safeguards are used during the procedure, injuries can still occur and the fact that an injury or bleeding occurs during the procedure does not mean that the physician has done anything wrong. [R.pp. 369, ll. 2-15; 413, ll. 23-24; 417, l. 23 – 418, l. 4; 420, ll. 12-15; Id. at pp. 316, ll. 2-15; 360, ll. 23-24; 364, l. 23 – 365, l. 4; 367, ll. 12-15.] In a procedure involving the placement of a sharp needle near a beating heart, even if a physician performs all appropriate steps, an injury can occur and the existence of an injury is not evidence of malpractice. [R.p. 421, ll. 4-12; Id. at p. 368, ll. 4-12.] According to Dr. Story, complications can occur even if all normal and standard procedures are followed for either the initial needle insertion or the insertion of the sheath. [R.pp. 375, ll. 2-10; 417, l. 23 – 418, l. 4; Id. at pp. 322, ll. 2-10; 364, l. 23 – 365, l. 4.]

Dr. Foster likewise agreed that complications can occur even when a physician properly performs a pericardiocentesis and that evidence of bleeding during the procedure is not by itself evidence that the physician committed malpractice. A physician can perform the procedure with the highest standard of care and still have a bleeding complication. [R.pp. 431, l. 21 – 432, l. 25; Id. at pp. 378, l. 21 – 379, l. 25.] Dr. Foster agreed with Dr. Story that complications can occur even if all proper

techniques are followed for either the initial needle insertion or sheath insertion. [R.pp. 465, ll. 5-14; Id. at pp. 412, ll. 5-14.]

In Dr. Foster's opinion, the bleeding that occurred during the procedure on Mr. Dibernardo occurred because of the needle stick. The needle insertion is the most common reason why bleeding occurs during a pericardiocentesis. The needle is the only sharp instrument utilized during the procedure. [R.pp. 439, l. 23 – 440, l. 5; Id. at pp. 386, l. 23 – 387, l. 5.] Because the insertion of the needle is essentially a "blind stick," there are all sorts of structures in the body that can get in the way and can be injured, including organs grossly enlarged because of a patient's condition. [R.p. 440, ll. 6-13; Id. at p. 387, ll. 6-13.] Dr. Foster also testified that it was not surprising that Dr. Mori did not initially draw back blood after the needle insertion because fluid will clear out of the needle first before blood is drawn back. [R.pp. 440, l. 21 – 442, l. 2; Id. at pp. 387, l. 21 – 389, l. 2.]

In addition, while Appellant argued before the jury at trial that Mr. Dibernardo's blood pressure did not drop until after the sheath was inserted, which Appellant believed showed that the injury was caused by the alleged improper insertion of the sheath and not the needle, Dr. Foster explained that even for grave injuries, blood pressure does not begin to drop until usually thirty minutes after the injury. [R.pp. 442, l. 8 – 444, l. 6; Id. at pp. 389, l. 8 – 391, l. 6.]

Dr. Foster also confirmed that the blood clot was visible on the echocardiogram prior to the insertion of the sheath and had to have occurred prior to the sheath's insertion. Given the blood that Dr. Mori was drawing out, the presence of the blood clot, and the timing of the blood pressure drop, Dr. Foster opined that the injury to Mr.

Dibernardo occurred prior to the insertion of the sheath.[2] [R.pp. 445, ll. 9-25; 467, l. 5 – 468, l. 7; Id. at pp. 392, ll. 9-25; 414, l. 5 – 415, l. 7.]

Appellant's expert, Dr. Schob, agreed that performing a pericardiocentesis on a patient has a number of risks associated with it, including the risk of bleeding. [R.pp. 212, l. 21 – 213, l. 2; Id. at pp. 159, l. 21 – 160, l. 2.] He further agreed that bleeding can occur even when the procedure is performed within the standard of care. [R.p. 213, ll. 3-6; Id. at p. 160, ll. 3-6.] Dr. Schob acknowledged that the occurrence of a bleeding complication does not by itself mean that the physician committed malpractice. [R.pp. 213, ll. 7-10; 224, ll. 4-10; Id. at pp. 160, ll. 7-10; 171, ll. 4-10.] He also conceded that the riskiest time of a pericardiocentesis is during the insertion of the needle. [R.p. 177, ll. 20-23; Id. at p. 124, ll. 20-23.] Dr. Schob further agreed that the needle was the sharpest instrument utilized during Mr. Dibernardo's pericardiocentesis – sharper than the sheath or catheter. [R.p. 213, ll. 3-16; Id. at p. 163, ll. 3 – 16.]

At trial, Respondents Carolina Cardiology and Dr. Mori argued to the jury that a known, potential complication occurred during the pericardiocentesis performed by Dr. Mori on Mr. Dibernardo, a patient who had a massive heart and a large effusion along with a difficult anatomy, which Dr. Mori managed appropriately by exchanging the catheter for a sheath and by conducting an autotransfusion to stabilize Mr. Dibernardo. Despite the longstanding principle that an adverse result does not equal malpractice, Appellant requested the following jury charge:

[2] There was some dispute at trial about the timing of the blood clot and whether timing on the images from the cath lab were off. Appellant tried to argue at trial the clot appeared after the sheath was inserted but Dr. Foster confirmed at trial that it would have been impossible for a blood clot to form only a minute and a half after the sheath was inserted even if Appellant's timing was assumed. [R.pp. 467, l. 5 – 468, l. 7; Tr. pp. 414, l. 5 – 415, l. 7.]

> When a thing which causes injury is shown to be under the management of the defendant, and the accident is such as in the ordinary course of things does not happen if those who have management use proper care, it affords a reasonable evidence, in the absence of explanation by the defendant, that the accident arose from a want of care.

[R.pp. 540, l. 8 – 541, l. 11; 602; Id. at pp. 487, l. 8 – 488, l. 11; Court's Ex. 3.]

The Trial Court declined to give Appellant's requested charge, ruling that such a charge "establishes a different standard, a different burden of proof that is not in accordance with our medical malpractice burden of proof that the plaintiff has." [R.p. 541, ll. 5-11; Tr. p. 488, ll. 5-11.]

The jury returned a verdict in favor of Respondents Carolina Cardiology and Dr. Mori, finding that Dr. Mori did not violate generally accepted standards of medical care in his treatment of Mr. Dibernardo. [R.pp. 1-3; 544, l. 16 – 545, l. 14; Verdict; Tr. pp. 491, l. 16 – 492, l. 14.] Appellant's appeal followed, challenging the Trial Court's ruling declining to give the above-requested charge regarding control of the instrumentality.

ARGUMENT

The Trial Court correctly refused to give the jury Appellant's requested charge which would have invited the jury to find negligence or malpractice of the physician based solely upon the occurrence of an adverse result during a medical procedure because such a charge is contrary to a plaintiff's burden of proof in a medical malpractice action and because furthermore, the evidence at trial, in which it was repeatedly shown that the procedure performed on Appellant's decedent carried with it a number of known potential complications, did not support Appellant's requested jury charge.

The jury in this case heard the evidence from both parties and resolved the issues of fact in favor of Respondents Carolina Cardiology and Dr. Mori, specifically finding that Dr. Mori did not violate generally accepted standards of medical care in performing the pericardiocentesis on Mr. Dibernardo. [R.pp. 1-3; 544, l. 16 – 545, l. 14; Verdict; Tr. pp. 491, l. 16 – 492, l. 14.] Appellant seeks a new trial solely on the basis of the Trial Court's refusal to give the following instruction to the jury:

> When a thing which causes injury is shown to be under the management of the defendant, and the accident is such as in the ordinary course of things does not happen if those who have management use proper care, it affords a reasonable evidence, in the absence of explanation by the defendant, that the accident arose from a want of care.

[R.pp. 540, l. 8 – 541, l. 11; 602; Tr. pp. 487, l. 8 – 488, l. 11; Court's Ex. 3.]

The Trial Court properly refused to charge the jury with Appellant's requested instruction because not only does it not accurately state the law and the burden of proof for a medical malpractice case in South Carolina, the charge was incongruous with the evidence presented at trial – that known complications can occur during a properly performed pericardiocentesis.

A trial court must only charge the current and correct law. In re Estate of Pallister, 363 S.C. 437, 451, 611 S.E.2d 250, 258 (2005). The law to be charged to the jury is determined by the evidence at trial, and in reviewing jury charges for error,

appellate courts must consider the charge as a whole in light of the evidence and issues presented at trial. Id.; Keaton ex rel. Foster v. Greenville Hosp. Sys., 334 S.C. 488, 497, 514 S.E.2d 570, 575 (1999). A jury charge is correct if, when read as a whole, it contains the correct definitions and adequately covers the law. Pallister, 363 S.C. at 451, 611 S.E.2d at 258.

An appellate court will not reverse a trial court's decision regarding jury instructions unless the trial court abused its discretion. State v. Lemire, 406 S.C. 558, 565, 753 S.E.2d 247, 251 (Ct. App. 2013). An abuse of discretion occurs when the trial court's ruling is based on an error of law or, when grounded in factual conclusions, is without evidentiary support. Id. To warrant reversal, a trial court's refusal to give a requested jury charge must be both erroneous and prejudicial to the requesting party. State v. Mattison, 388 S.C. 469, 479, 697 S.E.2d 578, 583 (2010).

To prevail in a medical malpractice action, a plaintiff must present (1) evidence of the generally recognized practices and procedures that would be exercised by competent practitioners in a defendant's field of medicine under the same or similar circumstances, (2) evidence that the defendant departed from the recognized and generally accepted standards, practices, and procedures in the manner alleged by the plaintiff, and (3) evidence that the defendant's departure from the generally accepted standards and practices was the proximate cause of the plaintiff's injuries and damages. Hoard ex rel. Hoard v. Roper Hosp., Inc., 387 S.C. 539, 546, 694 S.E.2d 1, 4–5 (2010).

Critically, a plaintiff in a medical malpractice action must prove that the physician was negligent by departing from the recognized and generally accepted practices for the procedure performed. A plaintiff can prove a physician's negligence by direct or

circumstantial evidence, Cox. v. Lund, 286 S.C. 410, 334 S.E.2d 116 (1985); however, a plaintiff must prove each element of negligence, including the physician's lack of due care. Snow v. City of Columbia, 305 S.C. 544, 555, 409 S.E.2d 797, 803 (Ct. App. 1991).

Notably, South Carolina does not recognize the doctrine of *res ipsa loquitur*. See, e.g., Legette v. Smith, 265 S.C. 573, 578, 220 S.E.2d 429, 430 (1975); Snow, 305 S.C. at 555 n.7, 409 S.E.2d at 803 n.7. Therefore, "[t]he plaintiff's burden of proof cannot be met by relying on the theory that the thing speaks for itself or that the very fact of injury indicates a failure to exercise reasonable care." Reiland v. Southland Equip. Serv., Inc., 330 S.C. 617, 634-35, 500 S.E.2d 145, 154 (Ct. App. 1998); see also Bellamy v. Hardee, 242 S.C. 71, 77, 129 S.E.2d 905, 908 (1963) ("The doctrine of *res ipsa loquitur* does not apply in this state and the mere failure of the [equipment] in this case, without more, does not give rise to a presumption of negligence on the part of anyone."); King v. J.C. Penney Co., 238 S.C. 336, 338-40, 120 S.E.2d 229, 230 (1961).

Instead, as this Court has recognized, "[i]n an action for negligence, the plaintiff must prove by direct or circumstantial evidence that the defendant did not exercise reasonable care. South Carolina's rejection of *res ipsa loquitur* is consistent with its general adherence to fault based liability in tort. It also comports with the normal rules of proof, which require the plaintiff to prove affirmatively each element of his cause of action." Snow, 305 S.C. at 555 n.7, 409 S.E.2d at 803 n.7.

The rejection of *res ipsa loquitur* has been equally applied by the courts of this State in medical malpractice actions. For example, in Fletcher v. Med. Univ. of South Carolina, 390 S.C. 458, 702 S.E.2d 372 (Ct. App. 2010), the patient filed suit against a university hospital for medical malpractice after the patient suffered complications

following subclavian bypass surgery. Id. at 461-62, 702 S.E.2d at 373-74. The plaintiff's expert, while testifying that he believed the hospital's physicians deviated from the standard of care, also testified that he did not find any evidence in the medical records which indicated the hospital's physicians used any improper techniques during the operation. Accordingly, the trial court directed a verdict in favor of the hospital on the medical malpractice claim where the plaintiff presented no evidence of negligence in the performance of the procedure. Id. at 462-63, 702 S.E.2d at 374.

The patient appealed the directed verdict in favor of the hospital to this Court. Id. at 462, 702 S.E.2d at 374. In affirming the directed verdict based upon the patient's failure to present any evidence of how the physicians deviated from the standard of care, this Court observed that the patient was in essence asking the Court "to conclude that the occurrence of a complication [was] itself evidence of negligence." Id. at 463-65, 702 S.E.2d at 374-75. Noting South Carolina's rejection of *res ipsa loquitur*, the Court stated it was "not permitted to speculate that misfortune was the result of negligence in the absence of any evidence as to how the physicians deviated from the standard of care." Id. at 464, 702 S.E.2d at 374.

In stressing the requirement that a plaintiff cannot rely on the fact of injury to establish a physician's negligence or departure from the standard of care in a medical

malpractice case, the Fletcher court relied upon Bowie v. Hearn, 292 S.C. 223, 355 S.E.2d 550 (Ct. App. 1987) (Bowie I)[3] which also addressed this very principle.

In Bowie I, the plaintiff sued the physician who delivered him via cesarean section because he was cut on the cheek during the procedure, resulting in a scar. Id. at 224–25, 355 S.E.2d at 551. The plaintiff's expert testified the standard of care required the physician not to cut the baby. Id. at 226, 355 S.E.2d at 552. In analyzing the sufficiency of this testimony, the court referenced another oft-cited medical malpractice case and stated:

> Under the plaintiff's reasoning in this case [Bowie I] the doctors in [Cox v. Lund, 286 S.C. 410, 334 S.E.2d 116 (1985)[4]] could simply have testified that normally colons are not perforated during colonoscopies, the standard of care, therefore, is a doctor should not perforate the colon, and to do so violates the standard of care. Such reasoning would, in effect, make a doctor an insurer of perfect result in every surgical procedure. *A doctor is not an insurer of health and negligence may not be inferred.*

Bowie I, 292 S.C. at 227, 355 S.E.2d at 552 (emphasis added).

Therefore, based upon South Carolina's rejection of *res ipsa loquitur* and the principles espoused by this Court, it is well-established that the mere fact that an injury or

---

[3] This case was reversed by the Supreme Court in Bowie v. Hearn, 294 S.C. 344, 364 S.E.2d 469 (1988) (Bowie II) on the particular facts presented in that case, namely that the plaintiff had presented evidence at trial that the physician deviated from the standard of care for a caesarean procedure by making three or four swipes with a scalpel in order to incise the uterine wall. Nevertheless, the reasoning employed by this Court in Bowie I remains instructive.

[4] In Cox, the patient died because his colon was perforated during a colonoscopy, performed by the defendant-doctor. The decedent's administratrix, who brought the action, produced expert testimony detailing the appropriate measures in preparing the colon for the procedure and in conducting the procedure. The expert witnesses also detailed exactly how the defendant-doctor deviated from the standard of care; namely in not properly preparing the colon and in persisting with the procedure when he knew or should have known to stop.

adverse result occurs during a medical procedure does not indicate that a physician was negligent or committed malpractice.

Despite this long-standing requirement in medical malpractices actions, Appellant argues the Trial Court erred in refusing her requested charge to the jury:

> When a thing which causes injury is shown to be under the management of the defendant, and the accident is such as in the ordinary course of things does not happen if those who have management use proper care, it affords a reasonable evidence, in the absence of explanation by the defendant, that the accident arose from a want of care.

[R.pp. 540, l. 8 – 541, l. 11; 602; Tr. pp. 487, l. 8 – 488, l. 11; Court's Ex. 3.]

The requested charge directly contradicts the very requirement in medical malpractice actions that a plaintiff prove a physician departed from the recognized and generally accepted standards, practices, and procedures. The requested charge also invokes the doctrine of *res ipsa loquitur* which the South Carolina courts have expressly rejected. In requesting this particular charge, Appellant asks this Court to conclude that the adverse result which occurred during the pericardiocentesis performed on Mr. Dibernardo is alone and sufficient enough for a jury to find malpractice and negligence on the part of Carolina Cardiology and Dr. Mori. Such is not the law of medical malpractice in South Carolina and had the Trial Court given this charge to the jury, it would have constituted reversible error had the jury rendered a verdict in favor of Appellant.

Appellant's requested charge would have further directly contravened the Trial Court's instruction to the jury, to which Appellant did not object, that a physician cannot insure a positive result and is not negligent simply because an adverse result in fact occurred during a procedure:

> A doctor is not an insurer of a cure or even of a positive result; therefore, the mere fact that a treatment does not benefit the patient or that it even harms the patient does not in and of itself mean that the defendant was negligent. A bad result, injury, death or failure to cure is not by itself enough to show that the defendant was negligent.

[R.p. 525, ll. 15-22; Tr. p. 472, ll. 15-22.]

Appellant bases her requested charge on the case of Childers v. Gas Lines, Inc., 248 S.C. 316, 323-24, 149 S.E.2d 761, 764 (1966). In Childers, the plaintiff brought an action for personal injuries sustained when his motorcycle collided with debris from traffic signs left at a construction site by a gas company. 248 S.C. at 319, 149 S.E.2d at 762. The gas company had denied that it left the sign in the street, but the court noted "[t]he position of the sign at the time the injury was sustained in this case is strong circumstantial evidence that [the gas company's] witnesses were mistaken in denying that the sign was left on the asphalt portion of the street." Id. at 324, 149 S.E.2d at 765.

The Childers court, observing the principle that "[p]roof of negligence may rest entirely on circumstances, and circumstantial evidence alone may authorize a finding of negligence," found that the above referenced evidence was sufficient to require submission of the gas company's negligence to the jury. Id. at 322, 149 S.E.2d at 763-64. In its holding that sufficient circumstantial evidence existed to warrant submission of the gas company's negligence to the jury, the Childers court referred to the case of Shepherd v. U.S. Fid. & Guar. Co., 233 S.C. 536, 541-42, 106 S.E.2d 381, 383 (1958) which originally cited the language of the charge requested by Appellant.

In Shepherd, the plaintiff brought an action after his automobile collided with the defendant's runaway automobile which had been parked by the defendant in her driveway. 233 S.C. at 539-40, 106 S.E.2d at 382. The defendant testified that she knew

she had set the brakes before leaving the vehicle because that was her fixed habit. Id. After the collision with the plaintiff's automobile, the runaway automobile was found not to have had its brakes set and to be in neutral gear. Id. The court, in dismissing the contention of the defendant that this evidence was insufficient to submit to the jury on the issue of her negligence, held that the unexpected presence on the highway of the automobile without a driver raised a prima facie inference of negligence on the part of the owner. Id. at 540-41, 106 S.E.2d at 383-84. Like Childers, this was a case in which there was strong circumstantial evidence that the defendant's denial of the facts was wrong.

In both Childers and Shepherd, the courts merely cited the language of Appellant's requested charge to illustrate the circumstantial nature of the facts of the two cases and to explain the appropriateness of the submission of such circumstantial cases of negligence to a jury. In fact, the Shepherd court explicitly recognized that the doctrine of *res ipsa loquitur* was not accepted in South Carolina and that its opinion should not relieve a plaintiff of the burden of proof, even where the plaintiff faces a difficulty of proof. Shepherd, 233 S.C. at 542, 106 S.E.2d at 383.

The facts of Childers and Shepherd further did not arise in the medical malpractice context and there has never been an opinion in this State in a medical malpractice action where the language used in Childers and Shepherd was approved to ease a plaintiff's burden of proof in such an action. Appellant nevertheless seeks to use the language of Childers and Shepherd to in essence charge the jury that because an injury occurred during Mr. Dibernardo's pericardiocentesis, Carolina Cardiology and Dr. Mori violated the standard of care.

At most, under the reasoning of the Childers and Shepherd cases, the Trial Court was only required to have instructed the jury on the use of circumstantial evidence, which the Trial Court did:

> Circumstantial evidence is proof of a chain of facts and circumstances indicating the existence of a fact. It is evidence which immediately establishes collateral facts from which the main fact may be inferred. Circumstantial evidence is based on inference and not on personal knowledge or observation. It is proof that does not actually establish the fact in question but that asserts or describes something else from which you may either reasonably infer the truth about the fact or at least reasonably infer an increase in the probability that the fact is true.
>
> For circumstantial evidence to be sufficient to warrant the finding of a fact the circumstances must lead to that fact with reasonable certainty. The facts and circumstances should be considered in light of ordinary experience and common sense.
>
> . . .
>
> The law makes absolutely no distinction between the weight or value to be given to either direct or circumstantial evidence, nor is a greater degree of certainty required of circumstantial evidence than of direct evidence.

[R.pp. 521, ll. 9-25; 522, ll. 3-7; Tr. pp. 468, ll. 9-25; 469, ll. 3-7.]

Therefore, if Appellant's argument is that she was merely asking the Trial Court to charge the language of Childers and Shepherd to illustrate the circumstantial nature of the case, the Trial Court adequately did so. See also Green v. Lilliewood, 272 S.C. 186, 249 S.E.2d 910 (1978), cited by Appellant in support of her requested charge, but which merely recognizes that a medical malpractice recovery may be based on circumstantial evidence and which opinion supports the circumstantial evidence charge given by the Trial Court in this case. It is not error for the trial judge to refuse a specific request to charge when the substance of the request is included in the general instructions. Varnadore v. Nationwide Mut. Ins. Co., 289 S.C. 155, 160, 345 S.E.2d 711, 715 (1986).

In addition, the Trial Court did not err in refusing to give the specific charge requested by Appellant because the elements of the charge were not supported by the evidence presented at trial. Appellant's requested charge required Appellant to show at trial (1) that the thing which caused injury was shown to be under the management of the defendant; (2) the accident was such as in the ordinary course of things does not happen if proper care is used; and (3) there was no other explanation by defendant of how the injury could have occurred. A failure of Appellant to meet even one of these elements defeats the charge.

The trial focused on the known complications which can occur during an even properly performed pericardiocentesis, which in this case was compounded by Mr. Dibernardo's physical condition. Dr. Mori and Respondents' cardiology experts described in detail how Mr. Dibernardo's injury could have occurred even under the proper standard of care.

The evidence presented established that the most common and prominent complication from a pericardiocentesis is bleeding. [R.pp. 131, l. 22 – 132, l. 7; 142, ll. 16-23; 261, l. 18 – 262, l. 5; 367, l. 19 – 368, l. 16; 431, l. 21 – 432, l. 15; Tr. pp. 78, l. 22-79, l. 7; 89, ll. 16-23; 208, l. 18 – 209, l. 5; 314, l. 19 – 315, l. 16; 378, l. 21 – 379, l. 15.] As explained by Dr. Mori and Respondents' cardiology experts, Dr. Story and Dr. Foster, even if a physician properly performs a pericardiocentesis and all precautions are taken, complications can still occur. A pericardiocentesis is never 100 percent fool proof and injury can occur to a patient despite a physician following all appropriate steps and procedures. A complication can occur even if a physician meets the standard of care, and injury is not indicative of a physician's departure from the standard of care. [R.pp.

315, ll. 12-18; 316, ll. 10-20; 344, ll. 7-17; 347, ll. 1-15; 369, ll. 2-15; 413, ll. 23-24; 417, l. 23 – 418, l. 4; 420, ll. 12-15; 431, l. 21 – 432, l. 25; 465, ll. 5-14; Id. at pp. 262, ll. 12-18; 263, ll. 10-20; 291, ll. 7-17; 294, ll. 1-15; 316, ll. 2-15; 360, ll. 23-24; 364, l. 23 – 365, l. 4; 367, ll. 12-15; 378, l. 21 - 379, l. 25; 412, ll. 5-14.]

While there was a dispute between Appellant and Respondents at trial as to whether Mr. Dibernardo's injury occurred from the initial needle insertion or insertion of the sheath, in either procedure both Dr. Mori and Dr. Story testified that possible injury from insertion of the sheath was a known complication which also would not indicate a physician's departure from the standard of care. [R.pp. 287, l. 17 – 288, l. 2; 375, ll., 2-10; 417, l. 23 – 418, l. 4; Id. at pp. 234, l. 17 – 235, l. 2; 322, ll. 2-10; 364, l. 23 – 365, l. 4.]

Even Appellant's expert, Dr. Schob, agreed that a pericardiocentesis involves a number of risks and complications and that an occurrence of an injury during the procedure, whether from the use of needles or equipment, is not indicative of a physician's negligence or malpractice:

Q: Performing a pericardiocentesis on a patient has a number of risks associated it with it; is that true?

A: That's true.

Q: And bleeding is one of those risks; is that true?

A: Yes.

Q: And bleeding can occur even when the procedure is performed within the standard of care, can it not?

A: Yes, sir.

Q: And the fact that bleeding – a bleeding complication occurred by itself doesn't mean the physician did something wrong, does it?

A: In general, no.

. . .

Q: Needle injuries, equipment injuries, any kind of an injury will cause bleeding with this procedure; is that true?

A: In general, yes,

Q: And just because there's bleeding that doesn't mean somebody's committed a malpractice?

A: In general, that's correct.

[R.pp. 212, l. 21 – 213, l. 10; 224, ll. 4-10; Id. at pp. 159, l. 21 – 160, l. 10; 171, ll. 4-10.]

The charge requested by Appellant would require the evidence at trial to at a minimum establish that the accident was the type that would not occur if proper care was used which Dr. Mori and all experts at trial, including Appellant's expert, refuted.

Further, the requested jury charge would only be applicable if the defendant could not explain why the injury or accident occurred. The testimony of Dr. Mori and cardiology experts Dr. Story and Dr. Foster thoroughly disclosed how Mr. Dibernardo's injury could have occurred even with proper care. Mr. Dibernardo's massively enlarged, moving, and beating heart increased the difficulty of inserting a needle into a tight space with little room available for the insertion of the needle. [R.pp. 264, ll. 1-19; 266, ll. 19-23; 274, ll. 5-15; 315, l. 20 – 316, l. 4; 368, l. 10 – 369, l. 1; Id. at pp. 211, ll. 1-19; 213, ll. 19-23; 221, ll. 5-15; 262, l. 20-263, l. 4; 315, l. 10 – 316, l. 1.] The fluid into which the needle was to be inserted was not evenly distributed and most of the fluid was located behind the left ventricle, not around the right ventricle near where the needle was to be inserted. The narrow amount of fluid located at the needle insertion site left little room for the needle insertion with no risk of injury. [R.pp. 265, ll. 1-19; 273, l. 13 –

274, l. 5; 274, l. 16 – 275, l. 8; 315, ll. 20-25; Id. at pp. 212, ll. 1-19; 220, l. 13 – 221, l. 5; 221, l. 16 – 222, l. 8; 262, ll. 20-25.]

Mr. Dibernardo's abnormal anatomy and deformity in his chest area causing it to cave in also made access to his heart area difficult. [R.pp. 260, ll. 17-21; 264, ll. 20-23; 512, ll. 15-16; Id. at pp. 207, ll. 17-21; 211, ll. 20-23; 459, ll. 15-16.] At some point the insertion of the needle is blind, even with aids used for guidance, and there are all sorts of structures in the body, from tiny vessels to organs, that can be stuck and injured. [R.pp. 266, ll. 3-5; 414, l. 18415, l. 8; 435, ll. 6-10; 440, ll. 6-13; Id. at pp. 213, ll. 3-5; 361, l. 18 – 362, l. 8; 382, ll. 6-10; 387, ll. 6-13.]

The trial was replete with evidence by Respondents explaining the very reasons why Mr. Dibernardo's injury occurred during the pericardiocentesis despite Dr. Mori's compliance with the standard of care. For this additional reason, the Trial Court properly denied Appellant's requested jury instruction.

Furthermore, the requested jury charge requires "the thing" which causes injury to be under the management of the defendant. In any procedure involving a patient such as Mr. Dibernardo, who has numerous pre-existing conditions complicating a physician's performance of the procedure, a physician does not have full control and management over the conditions of the patient's physical anatomy which contributes to the injury.

Appellant attempts to argue that Dr. Mori and Dr. Story testified at trial that Mr. Dibernardo's injury would not have occurred if the procedure had been performed properly. Appellant erringly takes their testimony out of context. While Dr. Mori testified that the goal of a pericardiocentesis is that injury should not occur if the procedure is done properly, this testimony should be construed against the backdrop of

Dr. Mori's repeated explanation of the known complications which can occur during a properly performed pericardiocentesis. [R.pp. 314, l. 16 – 316, l. 20; 341, l. 15 – 345, l. 22; Id. at pp. 261, l. 16 – 263, l. 20; 288, l. 15 – 292, l. 22.]

Appellant also misconstrues Dr. Story's testimony. Dr. Story explained that the intent of a proper pericardiocentesis is not to cause an injury to the patient, including the patient's heart, but that even with the best standard of care and techniques used, complications and injuries can occur. [R.pp. 412, l. 4 – 413, l. 24; Id. at pp. 359, l. 4 – 360, l. 24.]

The evidence presented at trial highlighted the number of risks and complications which can occur from a pericardiocentesis, especially on a patient such as Mr. Dibernardo who suffered from a massively enlarged heart and a large pericardial effusion and who had a deformity in his chest area. A difficult procedure was made more difficult by Mr. Dibernardo's condition. Any instruction to the jury which would have permitted the jury to find negligence and malpractice against Carolina Cardiology and Dr. Mori based upon the occurrence of the injury to Mr. Dibernardo would have been in error.

As a final point, the Trial Court's refusal to give Appellant's requested charge to the jury, a charge which in itself would have been improper, was in any event not prejudicial to Appellant. A trial court's refusal to give a requested jury charge must be both erroneous and prejudicial to the requesting party before an appellate court will reverse a trial court's decision to not give the requested charge. State v. Mattison, 388 S.C. 469, 479, 697 S.E.2d 578, 583 (2010).

No prejudiced resulted to Appellant from the Trial Court's refusal to give the requested charge. In the closing statement to the jury, Appellant's counsel repeatedly argued to the jury that if the physician had followed the standard of care, injury to Mr. Dibernardo would not have occurred and that his injury was indicative of a violation of the standard of care. [R.pp. 478, ll. 19-25; 480, ll. 8-16; 484, ll. 12-13; 487, ll. 20-25; 517, ll. 21-22; Tr. pp. 425, ll. 19-25; 427, ll. 8 – 16; 431, ll. 12-13; 434, ll. 20-25; 464, ll. 21-22.] The jury heard this argument and rejected it. Any alleged error by the Trial Court in refusing Appellant's requested jury instruction was therefore harmless.

The requested charge sought by Appellant would have permitted a jury to find negligence and malpractice by Carolina Cardiology and Dr. Mori based upon the fact of Mr. Dibernardo's injury alone. The requested charge not only would have invoked the inapplicable doctrine of *res ipsa loquitur* into a medical malpractice action and relieved the plaintiff from its burden of proof in such an action, but was also not supported by the evidence presented at trial. Dr. Mori and cardiology experts, Dr. Story and Dr. Foster, testified that bleeding was a known complication during the performance of a pericardiocentesis and the risks from the procedure were heightened by Mr. Dibernardo's difficult anatomy, massively enlarged heart, and large pericardial effusion with uneven fluid distribution. While any injury to a patient during a medical procedure is unfortunate and undesired, the fact of an injury does not indicate malpractice by the physician. The Trial Court therefore properly declined to give Appellant's requested jury charge on the control of the instrumentality.

CONCLUSION

For the reasons set forth herein, Respondents Carolina Cardiology Associates, PA and Naresh Mori, MD respectfully request this Court to affirm the jury verdict finding that Dr. Mori did not violate the generally accepted standards of medical care in his treatment of Mr. Dibernardo and to further deny Appellant's appeal for a new trial.

Respectfully submitted,

George C. Beighley
Carmen V. Ganjehsani
RICHARDSON, PLOWDEN & ROBINSON, PA
1900 Barnwell Street (29201)
Post Office Drawer 7788
Columbia, South Carolina 29202
(803) 771-4400
ATTORNEYS FOR RESPONDENTS CAROLINA CARDIOLOGY ASSOCIATES, PA AND NARESH MORI, MD

September 18, 2017.

CERTIFICATE OF COMPLIANCE

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

Respectfully submitted,

George C. Beighley
Carmen V. Ganjehsani
RICHARDSON, PLOWDEN & ROBINSON, PA
1900 Barnwell Street (29201)
Post Office Drawer 7788
Columbia, South Carolina 29202
(803) 771-4400
ATTORNEYS FOR RESPONDENTS CAROLINA CARDIOLOGY ASSOCIATES, PA AND NARESH MORI, MD

September 18, 2017.