THE STATE OF SOUTH CAROLINA
In the Supreme Court

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S.C. SUPREME COURT

APPEAL FROM YORK COUNTY
Court of Common Pleas

R. Scott Sprouse, Circuit Court Judge

Appellate Case No. 2019-000838

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

V.

Carolina Cardiology Associates, PA and Naresh Mori, MD,...................Respondents.

PETITION FOR A WRIT OF CERTIORARI

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CERTIFICATE OF COUNSEL

Counsel for Petitioner certifies the petition for rehearing was made and ruled upon by the court of appeals on April 24, 2019. This Court then granted an extension.

QUESTIONS PRESENTED FOR REVIEW

I. Whether the court of appeals erred in affirming the trial court when the opinion failed to address the issue raised on appeal; and confused the doctrine of res ipsa loquitur and negative inference derived from circumstantial evidence.

II. Whether the Supreme Court should grant a writ of certiorari because clarifying the application and scope of circumstantial evidence is a question of significant importance to South Carolina courts and practitioners.

STATEMENT OF THE CASE

This writ of certiorari seeks a review of the court of appeal's decision to affirm, without oral argument and in an unpublished opinion, the trial court's decision to deny Petitioner's request to charge the jury with the control of the instrumentality charge pursuant to *Childers v. Gas Lines, Inc.*, 248 S.C. 316, 323–24, 149 S.E.2d 761, 764 (1966), on the basis that it was not the law in South Carolina. In support of its holding, the court of appeals summarily relied on the general proposition that res ipsa loquitur, pursuant to *Fletcher v. Medical University of South Carolina*, 390 S.C. 458, 463-64, 702 S.E.2d 372, 742 (Ct. App. 2010) , does not apply to medical malpractice cases—a fact undisputed by Petitioner. By failing to recognize the import of *Childers*, the court of appeals was unable to appreciate the distinction between the rejected doctrine of res ipsa loquitur and the allowed negative inference that may be drawn in medical malpractice cases, which includes the control of the instrumentality. Moreover, by failing to address the merits of this case, the court of appeals turned a blind eye to inconsistency and conflation of our jurisprudence in this area. Petitioner respectfully requests this Court grant certiorari.

STATEMENT OF FACTS

Mr. Dibernardo, a long-time patient of Respondent Carolina Cardiology Associates, was diagnosed around 2009 with a large pericardial effusion. (App.118). This occurs when there is a build-up of fluid between the heart and pericardium, an area commonly known as the heart sac. (App.117, 202, 207, 587-590). For Mr. Dibernardo, this build up occurred chronically, and was something his doctor, Dr. Shah, kept an eye on. (App.207, 587-90). If left unmonitored and untreated, extensive fluid build-up can compress the heart and prevent it from functioning normally. (App. 202). Thus, Mr. Dibernardo kept regular appointments to avoid an emergency or fatal situation. (App. 207).

In July 2013, Mr. Dibernardo began experiencing some swelling in his legs and shortness of breath when walking. (App. 118, 587-590). Dr. Shah admitted Mr. Dibernardo to Piedmont Medical Center to: (1) have the fluid around his heart drained by a surgeon within the practice group—Respondent Mori, and (2) have a heart catherization to confirm the overall health of the heart. (App. 62, 275, 284, 587-90, 585-96).

By way of background and for context, during a pericardiocentesis—which is the process of aspirating fluid from the pericardial space[1]—a hollow needle is inserted in the lower part of the sternum and is positioned towards the shoulder. (App. 208, 403, 467). The needle is directed to the fluid in the sac, not the heart itself. An echocardiogram and a fluoroscopy (a video x-ray) are used so the doctor can have a visual of where the fluid and the instrument are located within the patient's pericardial sac throughout the procedure. (App. 121, 210-12).

Prior to insertion of the needle, an EKG[2] clip (connected to an EKG machine[3]) is attached to the needle as a safeguard. The EKG creates a short circuit so that if the needle touches the heart it will alarm before any damage can be done to the heart.[4] (App. 122, 209, 211). The needle is then placed in the patient while a syringe, placed in the hollow portion of the needle, is used to extract the fluid—this act is known as aspiration. (App. 212-13). During this initial aspiration, the fluid color can appear clear, tan, yellow, or a pinkish color; however concern only arises if

[1] For visual purposes, the heart is covered by a sac—known as the pericardial sac. The sac is made up of two layers of tissue, the pericardium (outer and inner), and is surrounded by pericardial fluid that is used to cushion the heart as it expands and contracts. The pericardial space targeted in this procedure is comprised of the pericardium and pericardial sac. In Mr. Dibernardo's case too much fluid had gathered around the pericardium layers around the heart, which is why the fluid needed to be removed. (App. 147).

[3] An EKG machine operates the test that checks for problems with the electrical activity of the heart. An EKG shows the heart's electrical activity as line tracings on paper.
[4] Practically, this short circuit can be likened to the game Operation. (App. 122). The doctor will be alerted if the needle is misplaced. (App 122).

there is bright red blood in the syringe.[5] (App.213). Assuming blood is not detected, the surgeon removes the syringe from the needle and uses the needle to insert saline into the patient. (App. 123, 213). Saline is visible with the echocardiogram, and allows confirmation that the needle is correctly placed in the pericardial sac by the fluid. (App. 123, 213). After determining proper placement, a guide wire, known as a J wire, is inserted through the needle. (Flash drive—Picture of J-wire). The guide wire is essentially a soft, pliable spring that cannot hurt any tissue. (App. 213-15). This wire protects the pericardial space throughout the procedure to ensure nothing harms the heart. Once the wire is in, the needle is removed. (App.216).

Following the insertion of the wire, the doctor confirms the wire is placed deep enough into the pericardial space to adequately protect the heart from any other device that may be employed throughout the procedure. A dilator/introducer is then placed over the wire and it is slid down to the patient's pericardium. (App. 123, 214, 216, 219; Flash drive—Picture of dilator/introducer). The purpose of the dilator/introducer is to create the necessary space in the tissue to advance a catheter, sheath, or other tube that will be used in draining the fluid out of the pericardium sac. (App. 215, 2018). Unlike the wire, the dilator and the sheath (which may be inserted later on) are very sharp. (App. 216; Flash drive—Picture of dilator and sheath). The only way to protect the heart from being harmed by a dilator or sheath during the procedure is for the doctor to maintain a good wire position. (App. 216, 218, 223).

Once the dilator has created the space, it is removed so a catheter/sheath/other tube can be inserted over the wire. The wire is then removed and the chosen drainage device remains in the pericardium. The doctor verifies placement using a fluoroscopy. (App. 218-19). The doctor inserts a dye and confirms the device is properly placed within the pericardial sac by observing the

[5] If that were to occur, it would signify that the heart had been damaged. (App. 213).

dye circulating around the heart. (App. 124, 216, 219). Following that confirmation, the doctor begins draining the desired amount of fluid. (App. 124, 219, 469).

On July 22, 2013, Mr. Dibernardo was taken to the cardiac cath lab around 8:00 a.m. to begin heart monitoring and to receive sedation drugs for the procedure. (App.. 126, 278, 466, 634). Around 10:30 a.m., Respondent Mori arrived and was later joined by the echocardiogram technician, who operates the EKG equipment. (App 127, 600). At the time of the procedure, Mr. Dibernardo had about an inch and half of thick fluid around his heart. (App.121). The procedure went according to plan with the insertion of the needle, then the wire through the hollow needle, then the placement of the dilator, then the insertion of the catheter with confirmation of correct placement by inserting dye by 10:50 a.m. with a fluoroscopy (hereinafter "Fluro #1"). (App. 239, 246, 340, 404, 467; Flash drive- Fluro #1). Around 11:00 a.m., Respondent Mori began draining the fluid from Mr. Dibernardo's pericardium space. (App. 128, 601-02). Mr. Dibernardo's vital signs, including blood pressure, were stable and during the next fifteen minutes, a quarter of the fluid, more than a liter to be exact, was removed. (App. 128, 219-28, 640).

Respondent Mori then decided, with no stated reason in the medical records, to change the equipment in Mr. Dibernardo's heart and switch from the catheter to a sheath.[6] (App 128-29, 268-70, 640). As noted *supra* a catheter is a mechanism that drains the fluid and a sheath is a hard/sharp plastic tube. (App. 220). To make the switch from the catheter to the sheath, the J-wire had to be re-inserted to withdraw the catheter, leaving just the wire in the pericardial space. (App 223-24,

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[6] Respondent Mori's reasoning for removing the catheter was highly debated over the course of trial. At various points during litigation and trial Respondent Mori's reason ranged from the speed of the fluid, the coloring of the fluid, finding a clot, and arguable concerns about proper placement of the first catheter. For the purposes of the issue on appeal, Respondent Mori's reason is of no consequence.

640). However, the J-wire was not inserted far enough into the pericardium, leaving it unable to perform its function of protecting the heart. (App. 227).

Respondent Mori fed a dilator/introducer down the wire into the pericardium space, and then added the sheath. App 228). Once those items were in place, Respondent Mori fed the same catheter into the sheath. (App. 224, 228). To confirm its placement, a visual was done using a fluoroscopy (hereinafter "Fluro #2"). (Flash drive-Fluro # 2; App. 640-41). During Fluro #2 it became apparent that there was an injury/abrasion to the heart. (App. 228). Specifically, as the dye was inserted for contrast purposes, the dye flowed towards the heart creating a stain, thereby demonstrating an injury had occurred. (App. 131, 227, 229-30; Flash drive-Fluro # 2). Fluro # 2 showed the catheter had become improperly "tethered" to the heart. (App 435). The injury was further indicated in a third fluoroscopy (hereinafter "Fluro#3"). (Fluro#3).

After Respondent Mori improperly inserted the sheath and injured Mr. Dibernardo's heart, his blood pressure dropped significantly, putting him at risk of brain damage. (App. 148, 222, 233, 341, 634-35). The heart injury damaged the surface of Mr. Dibernardo's heart, and caused it to bleed. (App. 116m 609). Respondent Mori accordingly called for a cardiac surgeon, but he was occupied with another patient. (App. 609, 640). However, the bleeding and potential health risks became so severe that Respondent Mori could not wait and initiated autotransfuses, in which Mr. Dibernardo's blood was taken from around his heart and placed back into him through a line placed in his groin while he waited for an emergency surgery. (App. 116, 147, 405, 471, 640-41).

During the surgery, the surgeon found the area in the heart that has been scraped by the sheath, and a clot was located and removed. (App. 136, 235-36, 609, 590, 641). When Mr. Dibernardo came out of surgery he was placed on a ventilator and admitted to the intensive care unit (ICU). (App. 137, 269, 634). Mr. Dibernardo was briefly removed from the ventilator, but

was placed back on because his body could not function or maintain requisite levels of stability without the assistance of the ventilator. (App. 269, 284, 626, 630). Ultimately, his family made the difficult decision to remove the ventilator and Mr. Dibernardo passed away. (App. 115, 271-73, 424, 634, 636).

Because of Mr. Dibernardo's injuries, Petitioner brought this lawsuit. (App. 39). Specifically, Petitioner alleged Respondents breached the standard of care by removing and replacing the catheter with a sheath; failing to document the repositioning of the catheter and replacement of the sheath; and improperly manipulating and repositioning the catheter resulting in the trauma to Mr. Dibernardo's heart. (App. 62).

At trial, no one disputed the fact that Mr. Dibernardo's heart was injured during the procedure conducted by Respondent Mori.[7] (App. 590-592). More importantly, it was undisputed that if the procedure had been performed correctly, this injury would not have occurred. (App. 224, 226-27, 230, 347-48, 354, 375, 376, 433). While the parties disagree on whether the sheath or the needle caused the injury during the pericardiocentesis, Respondent Mori, and both experts testified in accord that when the procedure is done properly no injury occurs. (App. 224, 226-27, 230, 347-48, 354, 375, 376, 433). Further during cross examination of Respondent Mori and his experts, Petitioner elicited there was no explanation for Mr. Dibernardo's injury, but for improper control of the procedure.

[7] Specifically, Respondent Mori; Dr. Shah; Petitioner's expert, Dr. Alan Schob; and Respondents' expert, Dr. Jim Story, all agreed an abrasion/injury to the heart occurred during the pericardiocentesis performed by Respondent Mori. (App.232, 238, 433). In fact, Dr. Shah testified that "but for the injury" to Mr. Dibernardo's heart during the pericardiocentesis, Mr. Dibernardo "would not have died when he did." (R. 165). The injury was further supported by the fluoroscopy recordings and echocardiogram images, along with the medical records. (App. 229-30; Fluro # 1, Fluro # 2, Fluro # 3).

Based on the testimony and evidence presented, Petitioner requested a jury charge regarding the control of an instrumentality pursuant to *Childers v. Gas Lines, Inc.*, 248 S.C. 316, 323–24, 149 S.E.2d 761, 764 (1966). The requested charge stated:

> 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.

(App. 639). The trial court declined to give the charge, finding it did not reflect the medical malpractice burden of proof. (App. 578). Petitioner's counsel noted his objection for the record and the requested charge was marked as a court's exhibit. (App. 578-79, 639). The jury subsequently returned a verdict in favor of Respondents.

Petitioner appealed to the court of appeals arguing she was prejudiced by the trial court's error in declining to the give the requested charge and was entitled to a new trial. After briefing and without oral argument, the court of appeals affirmed the trial court. Specifically, the court of appeals in string cite stated the following:

> *Snow v. City of Columbia*, 305 S.C. 544, 555 n.7, 409 S.E.2d 797, 803 n.7 (Ct. App. 1991) ("South Carolina does not recognize the rule of res ipsa loquitur."); *id.* at 555, 409 S.E.2d at 803 ("[The] 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."); *Fletcher v. Med. Univ. of S.C.*, 390 S.C. 458, 463-64, 702 S.E.2d 372, 374 (Ct. App. 2010) (rejecting the application of res ipsa loquitur in a medical malpractice action, and stating South Carolina courts were "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").

Petitioner filed a petition for rehearing, which was denied.

ARGUMENTS

I. The court of appeals confused res ipsa loquitur and negative inference, and thereby ignored South Carolina's jurisprudence allowing for the control of the instrumentality charge in medical malpractice cases.

Res ipsa loquitur speaks for itself. The doctrine arises in a context in which "there is *no evidence, circumstantial or otherwise*, at least none of sufficient probative value, to show negligence, apart from the postulate, which rests on common experience and not on specific circumstances of the instant case . . . ." *O'Leary-Payne v. R.R. Hilton Head, II*, 371 S.C. 340, 348, 638 S.E.2d 96, 100 (Ct. App. 2006). (emphasis added).

In contrast to res ipsa loquitur, our courts allow circumstantial evidence to support an inference as a means of satisfying the burden of proof requirements. *See e.g., Snow,* 305 S.C. at 553-55, 409 S.E.2d at 803-04. The distinction between res ipsa loquitur and circumstantial evidence that allows an inference of negligence is significant. The two theories are distinguished by whether the factual circumstances point merely to an occurrence "without any tendency to indicate the responsible human agency" or if there is some indication of "fault of omission or commission upon the part of the defendant." *Eickhoff*, 199 S.C. ____, 20 S.E.2d at 155. The first scenario cannot prove negligence without invoking res ipsa loquitur while, in the second circumstance, "a fact may be established prima facie by circumstantial evidence . . . without invoking the distinctive doctrine of res ipsa loquitur." *Id.* Since *Eickhoff*, South Carolina courts have continually invoked a flexible case-by-case approach in the use of circumstantial evidence to warrant the inference of negligence. *Chaney v. Burgess*, 246 S.C. 261, 266, 143 S.E.2d 521, 523 (1965) (explaining when circumstantial evidence is relied upon to meet the burden of proof, "the plaintiff must show such circumstances as would justify the inference that his injuries were due to the negligent act of the defendant, and not leave the question to mere conjecture or speculation").

Consistent with this approach, our courts have acknowledged an inference of negligence, as set forth in Petitioner's requested charge, is appropriate for control of an instrumentality. In *Childers v. Gas Lines, Inc.*, the Court explained a reasonable inference can be drawn when an injury occurs from an instrumentality under the known management of the defendant, and an accident of such nature does not occur if the instrument had been managed with proper care, in the absence of explanation. 248 S.C. 316, 323–24, 149 S.E.2d 761, 764 ("negligence may be inferred from all of the facts and attendant circumstances in the case, and where the circumstances are such as to take the case out of the realm of conjecture and into the realm of legitimate inferences from established facts, a prima facie case is made"). Res ipsa loquitur was not invoked in *Childers*, because there was a known "responsible human agency" to indicate fault and coupled with specific factual circumstances—established by testimony—warranted an inference of negligence. *Eickhoff*, 199 S.C. ____, 20 S.E.2d at 155; *See e.g., Childers*, *Sheperd v. United States Fidelity & Guaranty Company*, 233 S.C. 536, 106 S.E.2d 381 (1958) (explaining a prima facie inference of negligence is sufficient to satisfy the burden of proof for proximate cause); *see also Bramlette v. Charter-Med.-Columbia,* 302 S.C. 68, 72, 393 S.E.2d 914, 916 (1990) (citing *Childers*) (relying on facts of instrumentality of control, the Court found in a medical malpractice action that a defendant "may be held liable for anything which appears to have been a natural and probable consequence of his negligence").

Additionally, South Carolina appellate courts have held an admission by the defendant doctor along with circumstantial evidence is sufficient to infer proximate cause in medical malpractices cases. *Green v. Lilliewood*, 272 S.C. 186, 191, 249 S.E.2d 910, 912 (1978). Thereby, demonstrating that an inference based on evidence, as well as an admission at times, is distinguishable from res ipsa loquitur because the evidence far exceeds res ipsa loquitur's no

evidence standard.[8] Accordingly, the court of appeals' decision to affirm this matter on the basis of res ipsa loquitur, pursuant to *Fletcher*, circumvented the actual issue raised on appeal—whether South Carolina law allows an inference of negligence when the factors for control of the instrumentality are satisfied. Petitioner respectfully requests this Court grant certiorari to not only distinguish the two doctrines, but also to allow Petitioner to demonstrate the error and resulting prejudice that warrants a new trial.

II. The Supreme Court should grant certiorari to clarify *Fletcher v. Medical University of South Carolina*, and to squarely address use of circumstantial evidence to allow a negative inference in medical malpractice cases.

Pursuant to Rule 242, SCACR, this Court has discretion to grant a writ of certiorari for "special and important reasons." The court of appeals' conclusory reliance on *Fletcher v. Medical University of South Carolina*, only furthers the disparity in our jurisprudence on this issue and invites inconsistent application of the law throughout trial and appellate courts. As discussed herein, the *Fletcher* court haphazardly relied on piecemeal case law to support its holding. In so

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[8] Because of this misconception, the court of appeals also misconstrued the burden of proof. As this court is aware, a plaintiff has two distinct burdens of proof in tort law: the burden of going forward with evidence and the burden of persuading the jury on an issue. *See, e.g.*, Rule 301, SCRE ("a presumption imposes on the party against whom it is directed the burden of going forward with evidence to rebut or meet the presumption, but does not shift to such party the burden of proof in the sense of the risk of non-persuasion, which remains throughout the trial upon the party on whom it was originally cast."); *Pike v. S.C. Dep't of Transp.*, 343 S.C. 224, 230-231, 540 S.E.2d 87, 90-91 (2000); *King v. J.C. Penny Co.*, 238 S.C. 336, 340, 120 S.E.2d 229, 230 (1961). A plaintiff can meet the burdens of proof through direct evidence as well as circumstantial evidence, which allows a reasonable inference of negligence. *See e.g., Snow v. City of Columbia*, 305 S.C. 544, 553–55, 409 S.E.2d 797, 803–04 (Ct. App. 1991). Moreover, an inference of negligence or reference to the lack of a defendant's explanation of events does not mean that the burden of proof has shifted to a defendant; rather it indicates the plaintiff has satisfied the burden of going forward with the evidence, and a jury with proper instruction on the law will determine if the plaintiff has satisfied the second burden of persuading the jury. *See, e.g.* Rule 301, SCRE; *Tucker v. Reynolds*, 268 S.C. 330, 336, 233 S.E.2d 402, 406 (1977); *Brock v. Carolina Scenic Stages*, 219 S.C. 360, 366, 65 S.E.2d 468, 470 (1951).

doing, *Fletcher* characterizes res ipsa loquitur too broadly and suggests an impractical standard to warrant an inference in medical negligence cases. The holding in *Fletcher*, as now relied on by the court of appeals, is at odds with *Bowie by Bowie v. Hearn*, 294 S.C. 344, 364 S.E.2d 469 (1988) (*Bowie II*) and *Childers*. For these reasons, Petitioner requests this Court clarify *Fletcher* and recognize the use of circumstantial evidence to allow a negative inference in medical malpractice cases, including control of an instrumentality.

At the outset, Petitioner takes issue with the court of appeal's reliance on *Fletcher*'s legal reasoning because it ignores this Court's later holding in *Bowie II*. While the distinction was of little significance to the precise issue that before the court at that time, the broad interpretation offered by *Fletcher* is inconsistent with the case law and results in an error of law. As such, Petitioner turns to *Fletcher*'s interpretation to explain res ipsa loquitur and thereby illuminate the distinction with circumstantial evidence and the allowed negative inference.

The *Fletcher* Court began its analysis with citation to *Cox v. Lund*, 286 S.C. 410, 334 S.E.2d 116 (1985), which sets forth the well-known burden of proof for a plaintiff in a medical malpractice case. Specifically, the burden requires the plaintiff provide: (1) evidence of the generally recognized practices and procedures which would be exercised by a competent practitioner in similar circumstances and (2) evidence that the defendant doctor departed from the practices and procedures. The *Cox* Court found that the burden was established by plaintiff's expert who opined —based on a review of relevant medical charts and x-rays—that a doctor breached the standard of care for a colonoscopy when the evidence demonstrated the decedent's colon was unprepared for the procedure and offered the opinion that no colonoscopy should have been performed. 286 S.C. at 414–15, 334 S.E.2d at 119. Thus, the general proposition is derived

from *Cox* that a plaintiff must satisfy the medical malpractice burden, which can be achieved through expert testimony that is formed through the review of relevant medical charts and x-rays.

The *Fletcher* Court then turned to *Bowie by Bowie v. Hearn*, 292 S.C. 223, 355 S.E.2d 550 (Ct. App. 1987) (*Bowie I*) for the following proposition that it deemed as "precisely on point":

> Under the plaintiff's reasoning in this case [*Bowie I*] the doctors in *Cox* 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.

390 S.C. at 464, 702 S.E.2d at 374–75. The *Fletcher* Court explained because *Bowie I*'s reasoning was on point it ended all discussion. *Id.* *Fletcher*'s reliance on *Bowie I* for that proposition is misplaced. By making that assertion, the *Fletcher* Court incorrectly expanded the doctrine of res ipsa loquitur.

To appreciate that expansion, it's necessary to review both *Bowie* cases. In *Bowie I*, plaintiff "sued the physician who delivered him via caesarean section because he was cut on the cheek during the procedure, resulting in a scar." *Fletcher,* 390 S.C. at 464, 702 S.E.2d at 374–75. Plaintiff's expert testified the proper standard of care would have been for defendant doctor not to cut the baby. *Bowie I*, 292 S.C. at 226, 355 S.E.2d at 552. The *Bowie I* Court found the expert's opinion to be "conclusory" and insufficient to satisfy the statutory requirements previously enunciated by the Supreme Court in *Cox*. 292 S.C. at 227, 355 S.E.2d at 552. Finding this reasoning legally unsound, the *Bowie I* Court found plaintiff failed to meet the burden of proof. 292 S.C. at 227, 355 S.E.2d at 552.

The Supreme Court reversed *Bowie I* in a per curium opinion. 294 S.C. 344, 364 S.E.2d 469 (1988) (*Bowie II*). The Supreme Court found the expert's testimony that "the use of [the] standard technique will not result in injury to the baby" was sufficient. 294 S.C. at 345, 364 S.E.2d

at 469. The Court noted that defendant doctor testified that he made "swipes" with a scalpel, instead of the standard tiny incision, and this admission coupled with expert testimony was evidence that defendant doctor deviated from the standard of care. *Id.* at 346, 364 S.E.2d at 469. In sum, the Supreme Court found an expert stating the standard technique does not cause an injury, coupled with evidence or admission by defendant doctor, is sufficient to meet the burden of proof, i.e. is not res ipsa loquitur.

Despite the reversal, the *Fletcher* Court relied on *Bowie I*'s misperception of *Cox* to find res ipsa loquitur and for the proposition that "negligence cannot be inferred." 390 S.C. at 464–65, 702 S.E.2d at 375 ("[t]he analysis in *Bowie I* is precisely on point with this case, and we discern no factual basis that would cause the reasoning in that case to be inapplicable to the facts presented here.") Appellant respectfully submits the reasoning of *Bowie I*, as interpreted by the *Fletcher* Court as res ipsa loquitur, was rejected by the Supreme Court in *Bowie II*—relying on the expert's testimony to the effect that if the procedure had been done properly, the injury would not have occurred when coupled with other evidence. This is seemingly acknowledged by the *Fletcher* Court in footnote 3 in which it states, "No self-incriminating testimony from [the defendant doctors] in this case suggests a deviation in the standard of care," however this is merely dicta and fails to set forth, and arguably ignores, the standard as outlined by *Cox* and *Bowie II*. 390 S.C. at 464 n. 3, 702 S.E.2d at 375 n. 3. Further, the suggestion that there is a requirement of self-incrimination to overcome an implication of res ipsa loquitur has never been the standard. Instead, South Carolina courts have readily relied on medical records and x-rays as the basis of circumstantial evidence in medical malpractice, as discussed *supra*. As it stands, *Fletcher* characterizes res ipsa loquitur too broadly and suggests an impractical standard to warrant an inference in medical negligence cases.

Moreover, reliance on the proposition that "negligence may not be inferred" is an incorrect statement of law. 292 S.C. at 227, 355 S.E.2d at 552. It is well settled in South Carolina that negligence can be inferred. *The Winthrop Univ. Trustees for the State v. Pickens Roofing & Sheet Metals, Inc.*, 418 S.C. 142, 162, 791 S.E.2d 152, 163 (Ct. App. 2016) ("where circumstantial evidence is relied upon to establish liability, plaintiff must show such circumstances as would justify the inference that his injuries were due to the negligent act of the defendant, and not leave the question to mere conjecture or speculation") (internal citation omitted).[9] Both of these inconsistencies should be clarified by this Court.

In sum, the doctrine of res ipsa loquitur is inapplicable when expert testimony and other evidence, which can include admissions, demonstrate that if the procedure was done correctly the injury would not have occurred. Therefore, Petitioner respectfully requests this Court grant certiorari to address the necessary distinction and address whether Appellant was entitled to the requested charge based on Respondent Mori's admission, along with other circumstantial evidence presented at trial. Moreover, if the Court agrees, then Petitioner respectfully requests this Court determine whether Petitioner was prejudiced by the trial court's failure to provide her requested charge to the jury.

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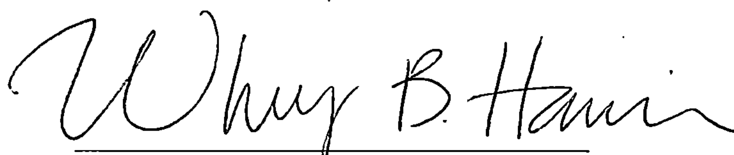
[9] *See e.g., McQuillen v. Dobbs,* 262 S.C. 386, 392, 204 S.E.2d 732, 735 (1974) (affirming the denial of a directed verdict when plaintiff established a reasonable inference that defendant's negligent inspection of furnace led to fire; based partially on testimony regarding recommended procedures for the proper inspection and maintenance of furnace that defendant's failed to follow); *McCready v. Atl. Coast Line R. Co.*, 212 S.C. 449, 455, 48 S.E.2d 193, 196 (1948); *Graham v. Town of Latta, S.C.*, 417 S.C. 164, 187, 789 S.E.2d 71, 83 (Ct. App. 2016); *Tucker v. Doe*, 413 S.C. 389, 401, 776 S.E.2d 121, 128 (Ct. App. 2015); *Gastineau v. Murphy,* 323 S.C. 168, 178–79, 473 S.E.2d 819, 826 (Ct.App.1996) (quoting 29 Am.Jur.2d *Evidence* § 313 (1994)), *rev'd on other grounds,* 331 S.C. 565, 503 S.E.2d 712 (1998).

CONCLUSION

For the reasons set forth herein, Petitioner respectfully asks this Court to grant this writ of certiorari and review the court of appeals' decision to affirm this matter.

Respectfully submitted,



June 10, 2019

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THE STATE OF SOUTH CAROLINA

In the Supreme Court

RECEIVED
JUN 10 2019
S.C. SUPREME COURT

APPEAL FROM YORK COUNTY
Court of Common Pleas

R. Scott Sprouse, Circuit Court Judge

Appellate Case No. 2019-000838

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

v.

Carolina Cardiology Associates, PA and Naresh Mori, MD.................Respondents,

PROOF OF SERVICE

The undersigned hereby certifies that on June 10, 2019, she served counsel for Respondents with the *Petition for Certiorari and Appendix* in this matter by mailing a copy of the same by United States Mail with first class postage prepaid to the following addresses:

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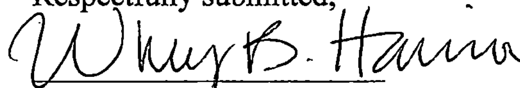
Columbia, SC

Respectfully submitted,



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