THE STATE OF SOUTH CAROLINA
IN THE COURT OF APPEALS

Appeal from Berkeley County
Court of Common Pleas

Stephanie P. McDonald, Circuit Court Judge

Case No. 2009-CP-08-3237

Finley C. Evans,

Appellant,

v.

Roper Hospital, Inc. d/b/a Roper St. Francis Healthcare
and d/b/a Roper-St. Francis Home Health,

Respondent.

INITIAL BRIEF OF RESPONDENT

YOUNG CLEMENT RIVERS, LLP
Stephen L. Brown
Joseph J. Tierney, Jr.
Christine Kent Toporek
Russell G. Hines
25 Calhoun Street, Suite 400 (29401)
P.O. Box 993
Charleston, South Carolina 29402
(843) 720-5488
Attorneys for the Respondent

TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES

Page

Cases

Other Authorities

Rules

PROLOGUE

> "Negligence is not actionable unless it is a proximate cause of the injuries, and **it may be deemed a proximate cause only when without such negligence the injury would not have occurred or could have been avoided.**"[1]

INTRODUCTION

This is a case of alleged medical malpractice in the nursing context; specifically, in the home healthcare setting. This appeal arises out of the trial court's (correct) grant of a directed verdict in favor of the defendant because the plaintiff failed to present evidence sufficient to prove a causal link between the negligent conduct he alleged and his complained-of injuries.

At the time of the alleged malpractice, the Appellant, Finley C. Evans, had recently undergone surgery, and he was receiving in-home care for his surgical wounds from nurses employed by the Respondent, Roper Hospital, Inc. d/b/a Roper St. Francis Healthcare and d/b/a Roper-St. Francis Home Health ("Roper"). Mr. Evans complains of the following injuries that he claims to have been caused by negligent wound care attributable to Roper: pain and blood loss and associated medical conditions, including,

---

[1] Hanselmann v. McCardle, 275 S.C. 46, 48-49, 267 S.E.2d 531, 533 (1980) (quoting Hughes v. The Children's Clinic, P.A., 269 S.C. 389, 398, 237 S.E.2d 753, 757 (1977)) (emphasis added).

hypotension (low blood pressure[2]), bradycardia (slowness of the heartbeat[3]), loss of consciousness, and mental distress, as well as ambulance transport and hospitalization related thereto. To be clear, all of these injuries were temporary in nature; no permanent injury or impairment is alleged to have resulted from the incident in question.

The subject incident occurred on October 3, 2006, when, following a visit from one of Roper's nurses, Mr. Evans was taken to the hospital by ambulance on account of a bleeding episode. Upon arrival at the hospital, he was in stable condition. As a precautionary measure, he was admitted and stayed overnight for observation. He was discharged the following day.

At the time of the incident, Mr. Evans had open surgical wounds on areas of his body (his groin and scrotum) that were, in addition to being painful, especially difficult to heal (particularly, the groin wound); he was undergoing wound-vac therapy (ordered by his surgeon), which therapy promotes healing through stimulation of the body's production of granulation tissue, which tissue (while healthy) is highly vascular, necessarily presenting a potential for bleeding; and he was (and had for years been) taking blood-thinning medication, which hindered his ability to clot and increased the risk of bleeding.

---

[2] Langenscheidt's Pocket Merriam-Webster Medical Dictionary 312 (2002).

After the close of all evidence at trial, a directed verdict was correctly granted in Roper's favor because, in this medical malpractice case, Mr. Evans did not present any expert medical evidence to establish the requisite, non-speculative causal link between the alleged negligent conduct and his complained-of injuries. Critically, and notwithstanding expert testimony of (alleged) breaches of the standard of care, there was no expert testimony that, in the absence of, i.e., "but for," the (alleged) negligence, Mr. Evans's complained-of injuries would not have occurred or could have been avoided. And, under the circumstances of this case where there were a number of medically-significant, causative factors bearing upon the pain, blood loss, and related conditions Mr. Evans experienced, the jury's common knowledge could not be substituted for expert medical evidence of causation. Consequently, assuming, *arguendo*, that he proved negligent conduct attributable to Roper, Mr. Evans failed to prove **actionable** negligence against Roper, as the trial court duly recognized and ruled.

Moreover, as an additional sustaining ground, Mr. Evans's appeal is untimely as a consequence of him not making a timely motion for a new trial. Following the directed verdict on January 12, 2012, Mr. Evans did not immediately move for a new trial nor did he—as he must, if not making the

---

[3] Langenscheidt's, *supra*, 81.

motion immediately—ask for leave to do so within ten days. Accordingly, the post-trial motion he made on January 23, 2012 (incorrectly captioned as a motion to reconsider, alter and amend (under Rule 59(e), SCRCP), when it was a de facto motion for a new trial (under Rule 59(b)), i.e., the only relief that could have been granted to him under the circumstances) did not stay the time for appeal, and Mr. Evans's notice of appeal, not served until April 30, 2012, was untimely, preventing this Court's exercise of appellate jurisdiction over this matter.

Most respectfully, this Honorable Court should affirm the trial court's directed verdict and judgment in favor of Roper (or dismiss Mr. Evans's appeal for lack of appellate jurisdiction, leaving the directed verdict/judgment intact).

RESPONDENT'S STATEMENT OF THE ISSUES ON APPEAL

I. **Did the trial court err by directing a verdict in favor of Roper where Mr. Evans failed to present evidence sufficient to prove that Roper's alleged medical malpractice proximately caused his complained-of injuries?**

II. **Should Mr. Evans's appeal be dismissed for lack of appellate jurisdiction because he did not make a timely motion for a new trial following the trial court's grant of a directed verdict in favor of Roper and, therefore, the time for appeal was not stayed, making his notice of appeal (served more than three months after the directed verdict) untimely?**

RESPONDENT'S STATEMENT OF THE CASE

On April 30, 2010, Mr. Evans filed a summons and complaint in Berkeley County Circuit Court alleging medical malpractice relating to post-surgical wound care that he received from Roper; more specifically, care that he received from home healthcare nurses employed by Roper. (Summons and Complaint.)[4] Roper timely answered the complaint, denying its material allegations, and setting up a number of affirmative defenses. (Answer.)

After a period of discovery, the case was tried in Berkeley County before the Honorable Stephanie P. McDonald and a jury from January 9-12, 2012. (Trial Tr. p. 1.) At the close of Mr. Evans's case, Roper moved for a directed verdict, arguing, among other things, that Mr. Evans failed to present any evidence from which the jury could reasonably (and non-speculatively) conclude that Roper's alleged negligent conduct (even assuming it to have been proved) proximately caused Mr. Evans's complained-of injuries. At that time, the trial court did not grant Roper a

[4] Mr. Evans had filed a notice of intent to file suit against Roper on September 24, 2009, which was followed by an unsuccessful pre-suit mediation. The complaint filed thereafter, like the notice of intent to file suit before it, named Janelle Belk, R.N., and Brian G. Widenhouse, M.D., as defendants in addition to Roper. Unlike the notice of intent to file suit, the complaint also identified Mr. Evans's wife, Jane A. Evans, as a plaintiff. Ultimately, Mrs. Evans's claims were dismissed, as were all claims against Nurse Belk and Dr. Widenhouse. The only remaining parties to this case when it came on for trial were Mr. Evans and Roper; consequently, they are the only parties to this

directed verdict in full, but partially directed a verdict in favor of Roper as to Mr. Evans's claims for lost wages and medical expenses, ruling that Mr. Evans presented no evidence to support them. (Trial Tr. p. 507, line 1 - p. 523, line 9.) At the close of all evidence, the trial court granted Roper's renewed motion for a directed verdict as to the entirety of Mr. Evans's claims, ruling that Mr. Evans did not present sufficient evidence to prove proximate cause, an essential element of his medical malpractice case. (Trial Tr. p. 676, line 13 - p. 717, line 16.)[5] Following the directed verdict, Mr. Evans did not immediately move for a new trial, nor did he request leave to do so within ten days thereafter. (Trial Tr. p. 718.) The trial court entered judgment in favor of Roper that day, January 12, 2012. (Form 4 Order directing verdict in favor of Roper filed January 12, 2012.)

On January 23, 2012, Mr. Evans served and filed "Plaintiff's Motion

---

appeal.

[5] Taking nothing away from Roper's position that the trial court correctly granted a directed verdict in its favor as to the entirety of Mr. Evans's claims, out of an abundance of caution, Roper notes that Mr. Evans has not presented any argument on appeal as to the partial directed verdict in Roper's favor as to Mr. Evans's claims for lost wages and medical expenses. Accordingly, should the Court be inclined to reverse the trial court and remand this matter for a new trial, such new trial should not include any claim against Roper by Mr. Evans for lost wages or medical expenses. Judy v. Martin, 381 S.C. 455, 458, 674 S.E.2d 151, 153 (2009) ("Under the law-of-the-case doctrine, a party is precluded from relitigating, after an appeal, matters that were either not raised on appeal, but should have been, or raised on appeal, but expressly rejected by the appellate court."); Jinks v. Richland County, 355 S.C. 341, 344, 585 S.E.2d 281, 283, n. 3 (2003) (an issue which is not argued in the brief is deemed abandoned and precludes consideration on appeal); Cont'l Ins. Co. v. Shives, 328 S.C. 470, 474, 492 S.E.2d 808, 811, n. 2 (Ct. App. 1997) (an issue not raised in the appellant's principal brief may not be raised via a reply

to Reconsider, Alter and Amend Judgment," which the trial court denied by order filed March 29, 2012. (Plaintiff's Motion to Reconsider, Alter and Amend Judgment; Form 4 Order denying Mr. Evans's post-trial motion filed March 29, 2012.) Mr. Evans appealed by notice served on April 30, 2012. (Notice of Appeal.)

STATEMENT OF FACTS

Mr. Evans suffered from a skin disease called hidradenitis.[6] It is a form of infection in the sweat glands, and, in layman's terms, can be thought of as a severe form of acne. (Trial Tr. p. 364, lines 2-12; p. 368, line 22 - p. 369, line 4.) Mild cases can be treated with antibiotics, but surgical intervention is required in some severe cases. (Trial Tr. p. 364, lines 2-12.)

In Mr. Evans's case, in September of 2006, hidradenitis was present on his left groin and scrotum, and it required surgery. (Trial Tr. p. 368, line 22 - p. 370, line 12; p. 371, lines 14-23; Defendant's Exhibit 3 (Widenhouse 025); Defendant's Exhibit 5 (Widenhouse 098).)[7] Both of these areas are particularly sensitive places upon which to perform surgery, and the natural

---

brief).

[6] Throughout the transcript, this medical term is spelled "hydradenitis" or "hydrodenitis." It appears that the correct spelling of the condition is "hidradenitis." Langenscheidt's, *supra*, 289. In this brief, the spelling "hidradenitis" is used except where the term is contained within a quotation, in which case, the spelling of the quoted source is used.

[7] Dating back to 2000, Mr. Evans had dealt with severe hidradenitis. Then, it was present on his buttocks, requiring surgery (performed by Dr. Widenhouse) to remove the affected tissue and reconstruct the area with skin grafts. (Tr. p. 197, lines 10-13; p. 364, lines 13-

disease process of hidradenitis indeed lends itself to surgical complications that include post-operative bleeding from surgical wounds. (Trial Tr. p. 379, line 1 - p. 380, line 7.) The groin is an especially difficult place to heal. It is hard to keep a groin wound closed because of tension placed on the area by ordinary movements of the body required of daily living; getting out of bed or walking, for example. (Trial Tr. p. 370, line 13 - p. 371, line 13.)

On September 21, 2006, Dr. Widenhouse (a plastic surgeon, qualified as such in this case without objection) surgically excised the damaged tissue from Mr. Evans's groin and scrotum. (Trial Tr. p. 359, line 14 - p. 363, line 8; p. 368, line 22 - p. 370, line 9; p. 371, lines 14-23; Defendant's Exhibit 3 (Widenhouse 025).) Mr. Evans's post-operative course was complicated by suture-line dehiscence, i.e., his stitches came undone, and he was left with open surgical wounds. (Trial Tr. p. 372, line 17 - p. 374, line 13; p. 375, line 19 - p. 376, line 18; p. 385, lines 5-20; p. 388, lines 22-24; p. 402, line 23 - p. 404, line 20; Defendant's Exhibit 3 (Widenhouse 025); Defendant's Exhibit 5 (Widenhouse 098).)[8]

For treatment of the wounds, Dr. Widenhouse ordered wound-vac therapy—Mr. Evans had prior experience with wound-vac therapy on

---

25.)

[8] To be clear, there is no allegation of negligence as to Dr. Widenhouse. (Trial Tr. p. 407, line 1- p. 408, line 8.)

account of his 2000 hidradenitis surgery. (Trial Tr. p. p. 377, line 8 - p. 378, line 8; p. 643, lines 4-8; Defendant's Exhibit 7 (RSFH 0058).) The therapy was to be conducted in Mr. Evans's home, with intermittent visits from Roper's home healthcare nurses for wound assessment and dressing changes. (Trial Tr. p. 192, lines 10-16; p. 375, lines 8-18; p. 547, line 15 - p. 548, line 20; p. 550, lines 4-24; Plaintiff's Exhibit 2 at RSFH 0001-6 and 0069-71.)

A wound vac is a closed system that applies negative pressure to a wound. In laymen's terms, and as its name suggests, it operates like a vacuum. Through suction generated via a mechanized pump (which can be set at varying levels depending on the desired pressure), it removes excess drainage and bacteria and also pulls the edges of the wound together, promoting faster healing that than the body would be able to accomplish on its own. (Trial Tr. p. 130, line 21 - p. 131, line 22; p. 462, lines 11-17; p. 464, line 12 - p. 465, line 4; p. 643, line 9 - p. 644, line 11.) Use of a wound vac helps to prevent infection, keeping the wound environment moist and sealed, and only requiring dressing changes three times per week. (Trial Tr. p. 131, lines 1-4.) It also lessens healing time by promoting the body's production of granulation tissue (scar tissue). (Trial Tr. p. 139, lines 17-22; p. 643, line 9 - p. 644, line 11.) While ultimately healthy, and evidencing

the body's regeneration of tissue to heal the wound, granulation tissue is highly vascular, presenting the potential for bleeding. (Trial Tr. p. 366, line 18 - p. 368, line 14; p. 379, line 1 - p. 380, line 7.)

When a wound-vac system is used, the wound is dressed in the following basic layered fashion. A porous sponge (also referred to in the record as foam) is cut to fit the shape of the wound and serves as packing, which is in direct contact with the wound bed. A transparent adhesive dressing (resembling plastic wrap) is applied atop the sponge and the surrounding area, holding the sponge in place and creating an air-tight environment underneath. (Trial Tr. p. 133, lines 14-21; p. 135, line 17 - p. 136, line 8; p. 139, lines 7-22; p. 178, lines 7-23; p. 462, line 6 - p. 464, line 14; 645, line 2 - p. 646, line 21.) A hole is cut into the adhesive dressing allowing a tube (running from the wound-vac machine and through which pressure will be applied) to be affixed to the dressing above the sponge. (Trial Tr. p. 139 lines 7-14; p. 646, line 22 - p. 647, line 7.) Drainage drawn from the wound is collected in a canister. (Trial Tr. p. 568, lines 15-21.)

The wound vac was delivered to Mr. Evans's home on Friday, September 29, 2006. On that date, one of Roper's nurses visited Mr. Evans for an initial assessment and placement of the wound vac, whereupon the wound vac was placed without incident. (Trial Tr. p. 189, line 24 - p. 192,

line 1; p. 192, lines 17-20; p. 239, line 22 - p. 240, line 5; p. 290, lines 11-25; Plaintiff's Exhibit 2 at RSFH 0007-26.)

The would-vac dressing was to be changed three times per week (Monday, Wednesday, and Friday). (Trial Tr. p.131, lines 2-3; Plaintiff's Exhibit 2 at RSFH 0003; Defendant's Exhibit 7 (RSFH 0058).) Accordingly, Mr. Evans was next seen by a Roper nurse on Monday, October 2, 2006, when Nurse Belk visited for his scheduled dressing change. (Trial Tr. p. 192, lines 2-9; 549, line 19 - p. 550, line 10; p. 553, line 17 – p. 555, line 14; Plaintiff's Exhibit 2 at RSFH 0029-31.).

Dressing changes are known to be painful. (Trial Tr. p. 133, lines 8-9; p. 138, lines 23-24; p. 292, line 17 - p. 293, line 2.) Indeed, if the wound vac is performing its function of promoting granulation tissue, the tissue can grow up into the pores of the sponge, making removal of the sponge for a dressing change particularly painful. (Trial Tr. p. 647, line 18 - p. 649, line 13.)

Mr. Evans reported discomfort with the dressing change. (Trial Tr. p. 198, lines 6-19; p. 243, lines 3-5; p. 555, lines 19-25.) Later that day, after Nurse Belk left, Mr. Evans claims that the pain increased, leading him to call Roper complaining of the pain. (Trial Tr. p. 243, line 12 - p. 244, line 10; 293, line 3 - p. 294, line 4.) A special visit (known as a "PRN" visit or "as

needed visit) was arranged for the next day. (Trial Tr. p. 141, line 2-19; p. 245, line 23 - p. 246, line 2; p. 293, lines 12-14; 557, line 11 - p. 559, line 10; 651, lines 15-20.)

Nurse Belk returned to Mr. Evans's home on the morning of October 3, 2006 for the PRN visit. She removed the wound vac, stopping the application of pressure to Mr. Evans's wounds. (Trial Tr. p. 202, line 11 - p. 203, line 7; p. 558, line 18 - p. 566, line 22; Plaintiff's Exhibit 2 at RSFH 0035.) She found bleeding at the site upon removal of the dressing, which she described as "slow trickle-like but continuous," likening it to the type of bleed that might be found following a venipuncture[9] for a blood draw, requiring the application of slight pressure. (Trial Tr. p. 199, lines 8-9; p. 566, line 15 - p. 568, line 14; Plaintiff's Exhibit 2 at RSFH 0036.)[10]

For a number of years, Mr. Evans had been (and was at the time) taking the drug warfarin (commonly known under the brand name Coumadin), which is a blood thinner, and hinders a person's ability to form blood clots, increasing the risk of bleeding. (Trial Tr. p. 241, line 17 - p. 242, line 6; p. 372, line 8-12; p. 376, line 19 - p. 377, line 7; p. 404, lines 21-

[9] In the transcript, this medical term is spelled "vena puncture." It appears that the correct spelling is "venipuncture." Langenscheidt's, *supra*, at 740.

[10] As explained above, when a wound-vac system is used, drainage (which would include any draining blood) from the wound is deposited into a canister. When full, the wound vac's drainage canister sounds an alarm. There is no evidence in the record that the alarm sounded. (Trial Tr. p. 568, line 15 - p. 570, line 2.)

14, p. 410, lines 3-17.) Upon encountering the bleeding, Nurse Belk was concerned about Mr. Evans's plan of care vis-à-vis continuing with wound-vac therapy while he was on blood-thinning medication. She contacted Dr. Widenhouse, advised him of Mr. Evans's condition, and obtained a lab order for a test called a PT/INR, which is used to determine the clotting tendency of blood (i.e., the time it takes to clot). (Trial Tr. p. 170, lines 7-15; p. 173, lines 5-19; p. 202, line 11 - p. 203, line 14; p. 380, line 8 - p. 383, line 24; p. 399, line 21 - p. 400, line 11; p. 566, line 25 - p. 567, line 3; p. 574, line 8 - p. 577, line 22; p. 584, line 16 - p. 585, line 12; p. 657, lines 3-23; 660, lines 9-25; Plaintiff's Exhibit 2 at RSFH 0036; Defendant's Exhibit 6 (RSFH 0064).) After drawing blood for the PT/INR, Nurse Belk left Mr. Evans's home to deliver the sample to the lab. (Trial Tr. p. 577, line 23 - p. 579, line 22.)

Standard procedure required that blood drawn for a PT/INR be delivered to the lab for analysis within two hours of being drawn. (Trial Tr. p. 577, line 23 - p. 579, line 22.) Nurse Belk had planned to return to Mr. Evans's home upon receipt of the lab results for reassessment of the wounds and to change the dressing. (Trial Tr. 474, lines 4-6; p. 584, line 25 - p. 587, line 18.) According to Nurse Belk, when she left the home, the bleeding was under control, her having been able to stop the bleeding by the application of

pressure, and the outer gauze pressure dressing that she applied to Mr. Evans being dry without blood. (Trial Tr. p. 147, lines 8-11; p. 172, lines 8-12; p. 206, line 14 - p. 207, line 2; p. 297, line 7 - p. 298, line 4; p. 472, line 22 - p. 473, line 21; p. 474, lines 4-6; p. 486, lines 15-24; p. 566, lines 15-24; 570, line 18 - p. 572, line 3; p. 573, lines 8-11; p. 573, line 19 - p. 574, line 7; p. 579, line 18 - p. 580, line 4; p. 659, lines 1-20; Plaintiff's Exhibit 2 at RSFH 0035.) The only evidence in the record is that, at the time Nurse Belk left the Evans's home, Mr. Evans's vital signs were stable, with no distress noted. (Trial Tr. p. 570, line 18 - p. 573, line 4; Plaintiff's Exhibit 2 at RSFH 0035.)

Mrs. Evans, who was at home with her husband at the time, testified that she did not notice active bleeding when Nurse Belk left the house. (Trial Tr. p. 269, lines 17-22.) Mr. Evans testified that he did not feel bleeding in the area until after Nurse Belk left, albeit soon thereafter. (Trial Tr. p. 300, lines 2-14.)[11]

As highlighted in Mr. Evans's brief to this Court, Mr. Evans's nursing expert, Lauren Cauwels, R.N., testified that, "to [her] [Mr. Evans] was unstable " when Nurse Belk left the home, because "[w]e don't know if that

[11] Mr. Evans readily admitted that he contradicted his prior deposition testimony in this regard. When he was deposed, he testified that he did not feel any blood until he was eating lunch. (Trial Tr. p. 300, lines 5-8.)

bleeding actually had stopped . . . ." (Trial Tr. p. 147, lines 19-22.) She also "believe[d]" that Mr. Evans had an "active bleed" when Nurse Belk left, but nonetheless thereafter affirmatively testified that "the bleed happened after the nurse left." (Trial Tr. p. 170, lines 21-24; p. 171, lines 13-17.) Although, ultimately, Roper does not believe Nurse Cauwels' testimony in this regard is material to the outcome of this appeal, Roper would note that it is clear from the record that Nurse Cauwels could not definitively testify that Mr. Evans was bleeding when Nurse Belk left the home.

There is no dispute that the PT/INR was run on Mr. Evans's blood sample at 12:36 p.m. Consequently, there can be no dispute that Nurse Belk left Mr. Evans's home prior to this time—Nurse Belk's chart indicates that her time of departure was 12:18 p.m., after having drawn the blood at 11:45 a.m. (Trial Tr. p. 165, line 16 - p. 167, line 8; p. 581, line 15 - p. 582, line 24; p. 584, line 12 - p. 585, line 12; Plaintiff's Exhibit 2 at RSFH 0035-38; Defendant's Exhibit 1 (RSFH 0073); Defendant's Exhibit 2 (RSFH 0072).)

After Nurse Belk left the home, Mr. Evans ate lunch. According to trial testimony, during this time, he stated to Mrs. Evans that he felt something tickling or trickling in the area of his wounds. Although Mrs. Evans had not noticed any bleeding when Nurse Belk left the home, after Mr. Evans finished lunch, she lifted a towel that was covering his wounded

area and saw blood, which she (and Mr. Evans) claimed to be profuse, describing it at different times as "spurting," "shoot[ing]," and "spraying up." (Trial Tr. p. 149, lines 2-19; p. 209, line 19 - 211, line 21; p. 261, line 14 - p. 265, line 13; p. 267, lines 4-16; p. 269, lines 17-22; p. 300, line 2 - p. 301, line 2.) Mrs. Evans called Nurse Belk to report the bleeding, and Nurse Belk instructed her to call 911. (Trail Tr. 209, line 19 - p. 211, line 21; p. 589, lines 9-23.)

Mrs. Evans testified that she called Nurse Belk as soon as she noticed the bleeding, which, according to other testimony from Mrs. Evans (and Mr. Evans), was not long after Nurse Belk left. (Trial Tr. p. 209, line 19 - p. 210, line 12.) Records conclusively show, however, that Mrs. Evans called 911 at 1:40 p.m. (without question, more than an hour after Nurse Belk left the Evans's home), and that EMS arrived on the scene at 1:47 p.m. to transport Mr. Evans to the hospital. (Trial Tr. p. 150, lines 7-11; p. 165, lines 16-20; p. 167, lines 6-8; Plaintiff's Exhibit 3 (DHEC/EMS Run Sheet).)[12]

Records describe Mr. Evans's condition when EMS arrived on the

[12] Nurse Belk had not returned to Mr. Evans's home prior to the time that he was taken to the hospital by EMS. The results of the PT/INR did not become available to Nurse Belk until 1:48 p.m., i.e., one minute after EMS had already arrived at the Evans's home. During the interim between the time that she left the home and the time that the PT/INR results became available Nurse Belk saw another patient. (Trial Tr. p. 182, lines 3-22; p. 586, line 5 - p. 597, line 16.)

scene as urgent, and estimate that he lost approximately one liter of blood or more. Mr. Evans lost consciousness (i.e., he "passed out") before arrival at the hospital and he was revived by the administration of intravenous fluids. By the time that he was delivered to the emergency room, Mr. Evans was hemodynamically stable. (Trial Tr. p. 150, line 3 - p. 151, line 10; p. 165, line 16 - p. 167, line 8; p. 385, line 20 - p. 386, line 1; p. 390, line 25 - p. 392, line 12; Plaintiff's Exhibit 3 (DHEC/EMS Run Sheet); Defendant's Exhibit 3 (Widenhouse 025).) This means that his vital signs were stable and that his heart rate and blood pressure were within normal limits. (Trial Tr. p. 386, lines 4-10.)

Dr. Widenhouse consulted with the emergency room doctor who attended Mr. Evans and was advised that there was no bleeding at the time of that doctor's assessment. (Trial Tr. p. 386, line 25 - p. 387, line 12.)[13] Mr. Evans's condition was such that he could have been discharged home directly from the emergency room, but Dr. Widenhouse admitted him to the hospital for overnight observation as a precautionary measure. (Trial Tr. p. 385, line 4 - p. 386, line 1; p. 387, lines 4-6; p. 390, lines 14-24; Defendant's Exhibit 3 (Widenhouse 025).)[14] When Dr. Widenhouse saw Mr. Evans in

[13] Nurse Belk had called Dr. Widenhouse to advise that Mr. Evans's was en route to the hospital. (Trial Tr. p. 591, line 25 - p. 592, line 18.)

[14] Roper is compelled to note that Dr. Widenhouse's express testimony that Mr. Evans

the hospital, Mr. Evans was alert, oriented, and lying comfortably in his hospital bed. (Trial Tr. p. 389, lines 9-12.) Upon examination, he found Mr. Evans's wounds to be clean, with no evidence of infection or active bleeding. (Trial Tr. p. 388, line 4 - p. 389, line 12; Defendant's Exhibit 3 (Widenhouse 025).) Mr. Evans was discharged home from the hospital the following day. (Trial Tr. p. 228, lines 1-13; p. 392, line 13 - p. 396, line 8; Defendant's Exhibit 4 (Widenhouse 050).)

While, as noted above, there is evidence in the record that Mr. Evans lost blood, again, the only evidence in the record is that Mr. Evans was hemodynamically stable upon arrival at the emergency room, and that he did not require a blood transfusion, just saline IV fluids. (Trial Tr. p. 175, lines 12-23; p. 386, lines 15-19; p. 389, line 1 - p. 390, line 13; Defendant's Exhibit 3 (Widenhouse 025).) The only evidence in the record (including testimony from Mr. Evans's expert, Dr. Murat Gezen, whose deposition excerpts were read into the record) is that Mr. Evans did not experience hemorrhagic shock (i.e., a drop in blood pressure or a change in hemodynamic stability based on blood loss). (Trial Tr. p. 386, lines 11-14; p. 454, lines 1-23.) Rather, Mr. Evans was diagnosed by the emergency

---

could have been discharged home directly from the emergency room without being admitted to the hospital is contradictory to Mr. Evans's assertion in his brief that, "[d]ue to the amount of blood [he] lost, he was admitted to the hospital . . . ." (App. Br. p. 2);

room physician as having lost consciousness because of a vasovagal event or syncopal episode (i.e., he "passed out"), which is a nervous system response that may occur in response to number of triggers unrelated to blood loss; panic, for example. (Trial Tr. p. 390, line 25 - p. 392, line 12; p. 402, lines 11-16; p. 454, lines 1-23.)

STANDARD OF REVIEW

In reviewing a directed verdict, the appellate court must view the evidence and all reasonable inferences that can be drawn therefrom in the light most favorable to the party that opposed the directed verdict motion below, i.e., the appellant. In essence, the appellate court must determine whether a verdict for the appellant would have been reasonably possible under the facts as liberally construed in the appellant's favor. Bultman v. Barber, 277 S.C. 5, 7, 281 S.E.2d 791, 792 (1981). Importantly, however, in order to properly conduct such a review, the appellate court "must determine the elements of the action alleged and whether any evidence existed on each element." First State Sav. & Loan v. Phelps, 299 S.C. 441, 446, 385 S.E.2d 821, 824 (1989).

---

see also (App. Br. p. 10) ("Mr. Evans lost so much blood that doctors required him to remain in the hospital overnight.")

ARGUMENT

I. The trial court correctly directed a verdict in favor of Roper because Mr. Evans failed to present evidence sufficient to prove that Roper's alleged medical malpractice proximately caused his complained-of injuries.[15]

Mr. Evans argues that, in directing a verdict in favor of Roper, the trial court erred in three ways: "(1) misconstruing the evidence before the court; (2) misapplying established proximate cause principles; and (3) failing to apply the common knowledge exception to the expert witness requirement." (App. Br. p. 4.) Respectfully, Mr. Evans is mistaken, and his appellate challenge to the directed verdict is without merit.

The only cause of action at issue is for medical malpractice. (Trial Tr. p. 74, lines 12-24; p. 87, lines 23-24.)[16] "[M]edical malpractice lawsuits," of course, "have specific requirements that must be satisfied in order for a genuine factual issue to exist." David v. McLeod Reg'l Med. Ctr., 367 S.C. 242, 247, 626 S.E.2d 1, 3 (2006).

Specifically, a plaintiff alleging medical malpractice must provide evidence, through expert testimony, showing (1) the generally recognized

---

[15] In his brief, Mr. Evans separately sets forth three subsections of argument (identified as A, B, and C) with respect to the issue he raises in this appeal. Though not broken into subsections, the argument/analysis presented herein is intended to respond to the entirety of Mr. Evans's argument.

[16] To be clear, South Carolina does not recognize medical abandonment as a separate tort from medical malpractice; rather, our courts have held that claims for medical abandonment are properly analyzed under the traditional medical malpractice framework.

and accepted practices and procedures that would be followed by average, competent practitioners in the defendant's field of medicine under the same or similar circumstances, and (2) that the defendant departed from the recognized and generally accepted standards. Melton, 389 S.C. at 655, 698 S.E.2d at 893 (citing David, 367 S.C. at 247, 626 S.E.2d at 4.) "Additionally, the plaintiff must show that the defendant's departure from such generally recognized practices and procedures was the proximate cause of his alleged injuries and damages." Id. (citing David, 367 S.C. at 248, 626 S.E.2d at 4.); *see also* Carver v. Med. Soc. of S.C., 286 S.C. 347, 350, 334 S.E.2d 125, 127 (Ct. App. 1985) ("In addition to proving the defendant negligent, the plaintiff must also prove that the defendant's negligence was a proximate cause of the plaintiff's injury."). "'**Negligence is not actionable unless it is a proximate cause of the injuries, and it may be deemed a proximate cause only when without such negligence injury would not have occurred or could have been avoided.**'" Hanselmann, 275 S.C. at 48-49, 267 S.E.2d at 533 (1980) (quoting Hughes, 269 S.C. at 398, 237 S.E.2d at 757) (emphasis added); *see also* Grier v. AMISUB of S.C., Inc., 397 S.C. 532, 537-38, 725 S.E.2d 693, 696-97 (2012) ("[T]the term 'negligent act or omission' consistently has been used to refer only to breach

---

Melton v. Medtronic, Inc., 389 S.C. 641, 650, 698 S.E.2d 886, 890 (Ct. App. 2010).

and never to causation. Furthermore, proximate cause requires proof beyond just the act or omission in question and concerns whether it is the 'but for' cause of the plaintiff's injuries and whether the harm was foreseeable.") (internal citations omitted).

"Proof of proximate cause must also be established by expert testimony where either the origin of the injury is obscure and not readily apparent to a layperson or where there are several equally probable causes of the condition." Carver, 286 S.C. at 350, 334 S.E.2d at 127 (citing Welch v. Whitaker, 282 S.C. 251, 317 S.E.2d 758 (Ct.App.1984)); *see also* Watson v. Ford Motor Co., 389 S.C. 434, 445, 699 S.E.2d 169, 175 (2010) ("Expert evidence is required where a factual issue must be resolved with scientific, technical, or any other specialized knowledge."). Even in a case where expert testimony is not required (which is not the case here), "[w]hen expert testimony is not relied upon to establish proximate cause, the plaintiff must offer evidence that "'rises above mere speculation or conjecture.'" Id. (quoting Armstrong v. Weiland, 267 S.C. 12, 16, 225 S.E.2d 851, 853 (1976)); *see also* Hanahan v. Simpson, 326 S.C. 140, 149, 485 S.E.2d 903, 908 (1997) ("We have repeatedly recognized that when only one reasonable inference can be deduced from the evidence, the question becomes one of law for the court. A corollary of this rule is that **verdicts may not be**

permitted to rest upon surmise, conjecture or speculation.") (emphasis added) (internal citation omitted).

Here, the trial court correctly applied South Carolina law regarding proximate cause, recognizing the fatal insufficiency of Mr. Evans's evidence with respect to this essential element. Respectfully, much of the argument Mr. Evans presents in his brief is misplaced, devoted not to identifying evidence of causation, but to identifying evidence of (alleged) breaches of the standard of care.[17] Even assuming, *arguendo*, that all of these breaches were proved, Mr. Evans still failed to prove his case.

To prevail in this medical malpractice action, it was incumbent upon Mr. Evans to present competent evidence to support a reasonable, non-speculative finding by the jury that any breach(es) of the standard of care were causally-related to his complained-of injuries, i.e., that his complained-of injures would not have occurred or could have been avoided in the absence of the breach(es). *See e.g.*, Dumont v. U.S., 80 F.Supp.2d 576, 581 (D.S.C. 2000) ("[T]he plaintiff's case fails in that there is no evidence that the failure to have the proper equipment to remove the staples or leaving the broken staple in place was the proximate cause of any injury suffered by the plaintiff. **Proof of a causal connection must be something more than**

[17] To be clear, Roper denies any breach of the standard of care.

evidence consistent with the plaintiff's theory of how the claimed injury was caused; proof of causation cannot rest on conjecture, and the mere possibility of such causation is not enough to sustain the plaintiff's burden of proof.") (emphasis added). Under the circumstances presented here, Mr. Evans needed expert medical evidence that he did not present.

Mr. Evans presented testimony from two experts: Nurse Cauwels and Dr. Gezen. Nurse Cauwels offered no testimony as to causation. (Trial Tr. p. 107, line 24 - p. 183, line 6.) Indeed, the trial court disallowed testimony from Nurse Cauwels on the issue of causation. (Trial Tr. p. 125, lines 17-24; p. 126, lines 17-25; p. 160, lines 19-25.) Mr. Evans even acknowledges this in his brief, explaining: "The issue of Nurse Cauwels' qualification to provide causation testimony was discussed by counsel and the court at a sidebar conference referenced at p. 127 of the trial transcript but not transcribed. At the conclusion of that conference, the Court sustained Roper's objection and explicitly told Mr. Evans' counsel to 'Move on.'" (App. Br. p. 11, n. 1.)[18] Likewise, a review of Dr. Gezen's testimony

[18] Of course, Roper maintains that the trial court properly disallowed testimony from Nurse Cauwels on the issue of caution. Moreover, Mr. Evans has not raised any issue on appeal with regard to the trial court's disallowance of Nurse Cauwels' testimony as to causation, and any issue in this regard cannot now be revived. Judy, 381 S.C. at 458, 674 S.E.2d at 153; Jinks, 355 S.C. at 344, 585 S.E.2d at 283, n. 3; Shives, 328 S.C. at 474, 492 S.E.2d at 811, n. 2. Further still, Roper notes that Mr. Evans did not make a proffer of any testimony from Nurse Cauwels in this regard. Greenville Mem'l Auditorium v. Martin, 301 S.C. 242, 244, 391 S.E.2d 546, 547 (1990) ("An alleged erroneous exclusion

(which, again, was presented via deposition excerpts read into the record) reveals that he offered no evidence as to the proximate cause of Mr. Evans's complained-of injuries. (Trial Tr. p. 452, line 4 - p. 460, line 3.) He expressly confirmed that had no opinion to offer as to the cause of the bleeding episode that took place on October 3, 2006. (Trial Tr. p. 454, lines 1-5.) While he did testify that the bleeding episode Mr. Evans experienced "led to a vasovagal event, which caused him to be hypotensive, bradycardic and presented to the emergency room the way that he did,"[19] **he never testified that this would not have occurred but for the alleged negligence**. In short, neither Nurse Cauwels nor Dr. Gezen provided any expert medical evidence on the critical issue of whether, without (i.e., but for) the alleged negligence, Mr. Evans's complained-of injuries would not have occurred or could have been avoided.

Having presented no expert medical evidence touching upon this critical issue in this medical malpractice case, Mr. Evans must argue for

---

of evidence is not a basis for establishing prejudice on appeal in absence of an adequate proffer of evidence in the court below.") Lastly, as Mr. Evans alludes to in his brief (where he refers to this matter being addressed via a sidebar conference), no contemporaneous argument was placed on the record in opposition to the trial court's disallowance of Nurse Cauwel's testimony on the issue of causation. Elam v. S.C. Dept. of Transp., 361 S.C. 9, 23-24, 602 S.E.2d 772, 779-80 (2004) ("Issues and arguments are preserved for appellate review only when they are raised to and ruled on by the lower court."); Washington v. Whitaker, 317 S.C. 108, 114, 451 S.E.2d 894, 898 (1994) ("Unlike the federal courts, this Court does not recognize a 'plain error' rule. Rather, it is well settled that a contemporaneous objection must be made to preserve an argument for appellate review.").

application of the common knowledge exception to the general rule that expert testimony is required. Simply put, this is not one of those exceptional medical malpractice cases where the jury's common knowledge is a reliable substitute for expert medical evidence linking the alleged negligence to Mr. Evans's complained-of injuries. This is a case where expert testimony on this issue is **required**, because, in light of the medically-significant, causative factors involved, the complained-of injuries are obscure and not readily apparent to a layperson and there are several equally probable. Carver, 286 S.C. at 350, 334 S.E.2d at 127 (citing Welch, 282 S.C. 251, 317 S.E.2d 758); *see also* Watson, 389 S.C. at 445, 699 S.E.2d at 175 (2010).

In his brief, Mr. Evans attempts to downplay (or simply ignore) the medically-significant, causative factors bearing upon his complained-of injuries, contending that the common knowledge exception is applicable here because "the fact finder was only required to find a causal relationship between bleeding and blood loss." (App. Br. p. 12.)[20] Respectfully, this is not so.

As an initial matter, a faulty premise for this argument is Mr. Evans's

---

[19] (Trial Tr. p. 454, lines 5-8.)

[20] Upon review of the record, Roper is unable to find where this particular argument (regarding the causal relationship between bleeding and blood loss) was raised to and ruled on by the trial court. To the extent that this argument was not raised to and ruled on by the trial court, it is not preserved for appellate review. Elam, 361 S.C. at 23-24, 602 S.E.2d at 779-80.

erroneous assertion that he "presented evidence that Nurse Belk caused bleeding when she changed his wound dressing" on October 3, 2006. (App. Br. p. 11.) As noted above, neither of Mr. Evans's experts were able to provide any testimony that Nurse Belk caused bleeding when she removed Mr. Evans's wound dressing—Nurse Cauwels was disallowed from testifying on this subject (which is now the law of the case) and Dr. Gezen expressly testified that he was not offering any opinion on this subject. This alone supports the trial court's ruling that, under the circumstances, the issue of causation was not a matter within the ambit of the jury's common knowledge.

Mr. Evans argues that "Nurse Belk's documentation from October 3rd also shows that the dressing change caused bleeding." (App. Br. p. 11.) This statement reflects a patently unacceptable and unreasonable reading of the relevant documentation,[21] which plainly states that Nurse Belk encountered bleeding upon removal of Mr. Evans's wound dressing, not that she caused the bleeding that she encountered. Indeed, Mr. Evans's own statement of the case is worded—consistent with the plain language of the

[21] At trial, Mr. Evans pointed to two records supposedly showing that Nurse Belk's dressing change "caused" bleeding on October 3, 2006. The first, from Nurse Belk's visit note, provided, "[w]ith removal of the sponge bleeding noted." (Plaintiff's Exhibit 2 at RSFH 0036.) The other, the lab order for the PT/INR, authorized Nurse Belk to draw blood for the PT/INR "due to bleeding with dressing change." (Plaintiff's Exhibit 2 at RSFH 0064.)

records—that "[d]uring the October 3rd visit, Nurse Belk **noted** bleeding after she peeled off the dressing." (App. Br. p. 1) (emphasis added.) Mr. Evans is bound by his statement of the case and may not elsewhere in his brief contradict the recitation set forth therein by arguing that the bleeding Nurse Belk "noted" was actually "caused" by her actions. Rule 208(b)(1)(C), SCACR ("Any matters stated or alleged in appellant's statement shall be binding on appellant.").

In any event, the critical relationship to be examined with respect to the issue of causation presented here is not, as Mr. Evans's urges, the relationship between bleeding and blood loss, but, again, the relationship between the alleged negligence attributable to Roper and the injuries of which Mr. Evans complains. Under the circumstances here, this relationship is complicated by a number of considerations relating to the natural disease process of hidradenitis, the nature of wound healing via wound-vac therapy (which, as noted above, is intended to promote the growth of highly vascular tissue), and Mr. Evans's ongoing Coumadin therapy. It must be remembered that, at the time of the incident, Mr. Evans was in the midst of recovery from hidradenitis-excision surgery on particularly sensitive areas of his body, which were also particularly difficult to heal. Under the circumstances, bleeding of his open surgical wounds was a known and

unavoidable risk, which risk was compounded by his blood-thinning medication. Indeed, Nurse Cauwels testified that Mr. Evans was taking other medication, in addition to Coumadin, which, in combination, made Mr. Evans "even more at-risk for bleeding." (Trial Tr. p. 128, lines 16-21.)

To prove actionable negligence in this medical malpractice case, Mr. Evans was required to show that, but for the negligence he alleged on the part of Roper, he would not have suffered his complained-of injuries. He offered no expert medical evidence to prove this element of his claim and, in the absence of such guidance, under the circumstances here, the jury could only speculate whether Mr. Evans, in his condition, would have experienced pain, bleeding, and complications related thereto notwithstanding the negligence alleged against Roper. Indeed, the main thrust of Nurse Cauwels' testimony was to criticize Nurse Belk for leaving the Evans's home and not seeing that Mr. Evans was transported to the hospital for emergency medical attention. (Trial Tr. p. 144, lines 1-9; p. 147, line 19 – p. 148, line 2; p. 161, lines 18-22.) The record unquestionably shows, however, that Mrs. Evans (according to her own testimony) called Nurse Belk and immediately thereafter called 911 once she noticed the bleeding, and applied pressure to the bleeding while waiting for EMS to arrive (Trial Tr. p. 209, line 19 – p. 213, line 23.) Again, EMS arrived to transport Mr.

Evans to the hospital within seven minutes of Mrs. Evans's call. (Trial Tr. p. 150, lines 7-11; p. 165, lines 16-20; p. 167, lines 6-8; Plaintiff's Exhibit 3 (DHEC/EMS Run Sheet).) Based upon the evidence in the record (which does not include any expert medical testimony), there is simply no non-speculative way to meaningfully connect Mr. Evans's complained-of injuries with the negligence he alleges or, for that matter, to quantify those injuries.[22] Because a jury's verdict cannot stand upon such a shaky (speculative) foundation, the trial court correctly directed a verdict in favor of Roper.

Mr. Evans argues that the trial court misconstrued the evidence presented, pointing to selected remarks from the trial court regarding the stability of his condition at the time Nurse Belk left the home, whether he was "actively bleeding" at that time, and whether the incident involved one continuous bleed (with Nurse Belk not stopping the bleeding before leaving) or two bleeds (with Nurse Belk stopping the bleeding before leaving but it reoccurring after her departure). (App. Br. pp. 4-7.) Respectfully, Mr. Evans does not adequately explain or place the trial court's remarks in context—of course, regardless of these remarks, the trial court's ultimate conclusion that Mr. Evans failed to prove his case because of the lack of

[22] During argument, Mr. Evans's counsel even appeared to concede that there was no evidence allowing the rate of any blood loss to be quantified. (Trial Tr. p. 633, lines 9-11.)

evidence of proximate cause in this medical malpractice case is readily apparent from the face of the record. The trial court was addressing (and rejecting) Mr. Evans's position that the common knowledge exception to the expert requirement applied in this case to excuse his failure to introduce expert medical evidence of causation, explaining as follows:

> [A]s I am sure your attorney has told you, in South Carolina -- really in any state where you have a medical malpractice case, there are very specific requirements that must be met in order for the jury to ever get to consider a medical malpractice case.
>
> Without a doubt in my mind, although I never know what that they are going to do in Columbia, they certainly correct those of us on the trial level when we make a mistake, or mistakes; which does happen.
>
> **If** Jannelle Belk had come and changed that wound dressing on what sounds like a very painful wound vac in a very painful area and it had spurting blood, Ms. Evans, as you described it when you lifted the blanket and the towel and saw it, and if she had just left right then when she saw that objectively, no question about it -- in my mind -- **that would've fallen within the common knowledge exception and could have been held to have proximately caused what you went through**.
>
> ***
>
> The situation here is that no one -- not Ms. Cauwels, not any of the doctors, can testify as to what caused the bleeding event that led to the calling of EMS. No question about it that when she changed the dressing on that wound and took the wound vac off, as all the experts have said, and

as I think anybody in their common knowledge can figure out, it's painful when you take off a wound vac. It's painful when you change a dressing on just a skinned knee on a child, much less a groin area hydrodenitis wound that has had a skin graph. That was painful and it caused bleeding. But when she left that day to go get the blood checked at the lab, because of the Coumadin, the testimony in the record is that the outer dressing was dry, that Mr. Evans was stable and the bleeding was controlled if not completely stopped. The rice was there. Even Dr. Gezen admits in his deposition, in what I read, that those salt bags that are used in cath labs are a standard of care that is followed. We also heard from the expert this morning that the bag of rice was an extra precaution.

No doubt about it, if Ms. Belk had left when there was an active spurting bleed, or even if the outer dressing had shown blood, I think that you could get to the jury. But I don't have any evidence to show that anything that Ms. Belk did, no matter how many times she may have violated the standard of care -- she might have been the rudest nurse that y'all have ever dealt with, but unless that caused the second bleed, the later bleed that led to the vasovagal event, that is not proof of proximate cause that allows me to let the case go to the jury.

So under Melton v. Medtronic and more specifically under Watson v. Ford Motor Company, I do believe that the defendant is entitled to a directed verdict in this matter.

Dr. Gezen specifically testified that there was no hemorraghic event, that it was a vasovagal event. Dr. Widenhouse testified that even panic can trigger a vasovagal event and a transient drop in blood pressure. Which, I know that was horrifying but that's what we had here -- a vasovagal event with a transient drop in blood pressure.

> Nobody, except, laywitnesses, otherwise, can testify to -- at all, much less "more probably than not" what caused the second bleed, that caused the vasovagal event.
>
> No question about that removing the wound vac caused the first bleed. That's what happens when you dress a wound. But right here in this case we are dealing with the treatment of hydradenitis, which causes very difficult wound healing problems. The groin area, which Dr. Widenhouse testified does not heal easily, and which is very easily disturbed -- I think the example that he used was ambulation. Any kind of strange movement could have dislodged that granulation tissue and cause it to bleed again.
>
> Wound vacs cause granulation tissue. That's what they want them to do. Unfortunately, granulation tissue is subject to bleeding. That's one of the complications. In fact, complications from a bleed are known to occur just from the hydradenitis surgery later. Dr. Widenhouse testified to that.
>
> So under the *Medtronic* decision, *Melton v. Medtronic*, and the other line of cases in South Carolina, there is no proximate cause that allows me to send this to the jury.

(Trial Tr. 706, line 13 - p. 711, line 15) (emphasis added.)

In making these remarks, the trial court was not weighing evidence or otherwise invading the province of the jury; rather, the trial court was explaining that this was not a case where the common knowledge exception could be properly applied—such cases being, of course, the exception, not the rule. The trial court correctly noted that the only evidence in the record is that the scene at the Evans's house at the time Nurse Belk left was not

sufficiently exceptional as to allow the jury—equipped with only common knowledge—to reasonably pass upon the medically-driven issue of causation without resorting to speculation. In his brief, Mr. Evans makes the point that "[t]here is voluminous evidence [he] was profusely bleeding shortly **after** Nurse Belk's exit . . . ." (App. Br. p. 6) (emphasis added). The point that the trial court was making was that there is no evidence of profuse bleeding **at** the time of Nurse Belk's exit. The only evidence in the record is that no one saw bleeding at the time that Nurse Belk left. And, indeed, the record leaves no doubt that Mrs. Evans did not call 911 until more than one hour after Nurse Belk left.

In alleged cases of medical malpractice, in the interests of justice, the need for competent proof of causation is particularly compelling. It is not enough for a plaintiff to bring forth an expert to offer after-the-fact criticism of the defendant's conduct; the plaintiff must show that such criticism is material in reference to the plaintiff's complained-of injuries. Here, while recovering from recent hidradenitis-excision surgery and surgical wounds related thereto on particularly sensitive parts of his body, and while also on wound-vac therapy and taking blood-thinning medication, Mr. Evans experienced, pain, bleeding, and complications related thereto, and needed to go to the hospital. And he did go to the hospital. While there is evidence in

that Nurse Belk should have acted differently that day, there is no evidence in the record that the outcome would have been different had she done so. No expert testified that Mr. Evans would not have experienced the injuries at issue or could have avoided them but for the alleged negligence, and analysis of the causal nexus between the alleged negligence and complained-of injuries is fraught with medical considerations outside the ambit of a jury's common knowledge and experience. The trial court correctly prevented the jury from engaging in speculation and directed a verdict with judgment thereon in favor of Roper.

II. Mr. Evans's appeal should be dismissed for lack of appellate jurisdiction because he did not make a timely motion for a new trial following the trial court's grant of a directed verdict in favor of Roper and, therefore, the time for appeal was not stayed, making his notice of appeal (served more than three months after the directed verdict) untimely.

Notice of appeal of an order or judgment must be timely served. Rule 203(b), SCACR. There are no exceptions to this requirement. Rule 263(b), SCACR (the time prescribed for serving the notice of appeal under Rule 203 may not by extended); Mears v. Mears, 287 S.C. 168, 169, 337 S.E.2d 206, 207 (1985) ("Service of the notice of intent to appeal is a jurisdictional requirement, and this Court has no authority to extend or expand the time in which the notice of intent to appeal must be served."). If the notice of appeal is not timely served, the appellate court does not have jurisdiction and

the appeal should be dismissed. Southbridge Props., Inc. v. Jones, 292 S.C. 198, 355 S.E.2d 535 (1987); Mears, 287 S.C. 168, 337 S.E.2d 206.

Rule 203(b)(1) requires a notice of appeal from the Court of Common Pleas to be served on all respondents within 30 days after receipt of written notice of entry of the order or judgment to be appealed. If a timely motion is made under Rule 59, however, the time for appeal is stayed and runs from receipt of written notice of entry of the order granting or denying the motion.

Rule 59 addresses both new trials and amendment of judgments, two distinct requests as evidenced by the plain language of the rule. Although captioned "Plaintiff's Motion to Reconsider, Alter and Amend Judgment," Mr. Evans's post-trial motion (served/filed January 23, 2012) can only be properly viewed as a Rule 59(b) motion for a new trial—not a motion to alter or amend under Rule 59(e)—because there is simply no other relief that the trial court could have then granted besides a new trial. Mickle v. Blackmon, 255 S.C. 136, 140, 177 S.E.2d 548, 549 (1970) (treating motion based on its substance and effect as opposed to how it was captioned by party); Richland County v. Kaiser, 351 S.C. 89, 94, 567 S.E.2d 260, 262 (Ct. App. 2002) (illustrating that when court is able to discern the relief requested, "[i]t is the substance of the requested relief that matters regardless of the form in which the request for relief was framed"). To rule otherwise,

would elevate form over substance, unduly blurring the distinction between motions under Rule 59(b) and (e) and nullifying the plain language in Rule 59(b), which our Supreme Court has expressly recognized as requiring that "a party must make a motion for a new trial promptly after the jury is discharged or request ten days within which to make the motion." Boone v. Goodwin, 314 S.C. 374, 376, 444 S.E.2d 524, 525 (1994) (reversing the trial court's grant of a new trial where new trial had been granted by the trial court in response to a motion that was untimely because additional time to make the motion had not been requested). Untimely movants would simply seek the grant of a new trial indirectly, avoiding the plain-language requirement of Rule 59(b), by labeling their motion seeking such relief as a motion "to alter or amend the judgment" as opposed to a motion "for a new trial."

Lastly, some treatment of our Supreme Court's decision in Fields v. Regional Medical Center Orangeburg, 363 S.C. 19, 609 S.E.2d 506 (2005), is relevant here. In Fields, the defendant-respondent moved to dismiss the appellant's appeal arguing that it was not timely noticed because the plaintiff-appellant had previously made an improper successive new-trial motion that did not stay the time for appeal. Following an adverse jury verdict, the plaintiff had requested ten days to move for a new trial, but the

trial court denied the request, preferring to hear the motion immediately. The plaintiff then made an immediate oral motion for a new trial grounded upon a brief argument that the trial court's evidentiary rulings constituted reversible error. Within ten days thereafter, the plaintiff then filed a written motion for a new trial. The defendant argued that this was an improper successive motion, which did not stay the time for appeal, and that the plaintiff's later appeal was untimely. The Supreme Court disagreed.

The Fields Court found that the written motion, although captioned as a motion for a new trial, "is properly viewed as a motion for reconsideration under Rule 59(e), SCRCP **to the extent it addressed the trial court's evidentiary rulings which Plaintiff challenged in her briefly stated oral motion at the end of the trial**." 363 S.C. at 27, 609 S.E.2d at 510 (emphasis added). In other words, the Court found that the written new trial motion was properly viewed as a motion to alter or amend the Court's ruling to deny the prior oral motion for a new trial.

The circumstance here is different than in Fields. In Fields, the ruling on the prior oral new trial motion gave rise to a ruling that the trial court could reconsider. Here, there was no such prior oral or written motion. Moreover, the only evidentiary ruling challenged in Mr. Evans's post-trial motion related to the admission of Nurse Cauwels' testimony on causation,

which as noted above, is no longer a viable issue because it was not challenged via Mr. Evans's appellate brief, no testimony was proffered, and any contemporaneous argument that Mr. Evans presented on the issue was not of record.

Ultimately, Roper contends that the only motion available to Mr. Evans in light of the trial court's directed verdict was a motion for a new trial (because the grant of a new trial was the only relief then possible to be obtained) and that such a motion was not timely made and, therefore, did not stay the time for appeal. Mr. Evans's post-trial motion was served/filed on January 23, 2012; thereby, establishing his notice of entry of the judgment in favor of Roper by that time. His notice of appeal was not served within 30 days thereafter—it was served on April 30, 2012. Consequently, Mr. Evans did not timely notice his appeal and, most respectfully, this Court is without jurisdiction to upset the trial court's directed verdict and judgment in favor of Roper.

CONCLUSION

For the foregoing reasons, and any other reason that may be apparent from the record, Roper asks that this Honorable Court affirm the circuit court's directed verdict and judgment in its favor (or dismiss Mr. Evans's appeal for lack of appellant jurisdiction, leaving the directed

verdict/judgment intact).

Respectfully submitted,

YOUNG CLEMENT RIVERS, LLP

By: 

Stephen L. Brown
Joseph J. Tierney, Jr.
Christine Kent Toporek
Russell G. Hines
25 Calhoun Street, Suite 400 (29401)
P.O. Box 993
Charleston, South Carolina 29402
(843) 720-5488
Attorneys for the Respondent

Charleston, South Carolina

Dated: 2/4/13