THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM HORRY COUNTY
Court of Common Pleas

The Honorable John C. Hayes, III

Case No. 2017-CP-26-1571
Appellate Case No. 2019-001665

David L. Scheer, as Personal Representative of the Estate of Matthew J. Scheer,.....Respondent,

v.

Southern Myrtle Inpatient Services, LLC, Nirlep A. Patel, M.D. and Rachel Ash-Bernal M.D. ..... Defendants,

Of which
Southern Myrtle Inpatients Services, LLC is.....Appellant.

INITIAL BRIEF OF APPELLANT

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STATEMENT OF THE CASE

This is an appeal from a jury verdict against Appellant Southern Myrtle Inpatient Services (SMIS) for the wrongful death of Matthew Scheer, an adult male (the Patient). It arises from the Patient's treatment at Grand Strand Regional Medical Center (the Hospital). The plaintiff is the Patient's father, acting as the personal representative of the Patient's estate (the Plaintiff or the Father). He sued SMIS, the Hospital, and defendant doctors Patel and Ash-Bernal. These doctors were employees of SMIS and placed by contract with the Hospital to serve as "hospitalists," *i.e.*, doctors that provide medical care to the Hospital's patients.

The Father alleged that Defendants Dr. Patel and Dr. Ash-Bernal were acting at all times as the agents of the Hospital and SMIS. (Amd. Cmplnt. ¶¶ 1-17). He further alleged that the Hospital and SMIS were liable for the defendant doctors' negligence in the medical care provided to the Patient. (Amd. Cmplnt. at ¶¶ 18-22). The Father's basic theory was the following: the Patient was mentally ill when he presented himself in the Hospital's emergency room and subsequently admitted to the Hospital; he was improperly allowed to leave the Hospital; and this lead to his death. (See Amd. Cmplnt. at R. ___-____, *passim*).

The Father settled with the Hospital for $600,000.00. (JNOV Order at 30). The jury rendered a defense verdict for the two defendant doctors, finding there was no negligence or medical malpractice by either of them. (Verdict Form; Tr. 808-812). The jury found that SMIS was 100% liable for $3,500,000.00 in actual damages and $250.00 in punitive damages. (Verdict Form; Supp'al. Verdict Form). The trial court set off the $600,000.00 settlement paid by the Hospital and entered a total judgment of $ 3,308,801.36 against SMIS and in favor of the Plaintiff. (JNOV Order at 32). SMIS timely appealed. The Plaintiff did not appeal the defense verdicts for Dr. Patel and Dr. Ash-Bernal, and they are not parties to this appeal.

INTRODUCTION & BACKGROUND

SMIS is a South Carolina corporation that employs South Carolina physicians and contracts with hospitals to provide those physicians to the hospital as "hospitalists" that provide medical care to hospital patients who do not have a private physician. As a matter of South Carolina law, SMIS cannot practice medicine in South Carolina, nor can it exercise any control over a physician's professional medical judgment. Defendants Dr. Patel and Dr. Ash-Bernard are internal medicine specialists and employees of SMIS. They are two of the "hospitalists" that treated the Patient at the Hospital.

Background Facts

The Patient presented himself at the Hospital's emergency room in the company of his Father. Dr. Battisti evaluated and treated the Patient in the emergency room, ordering lab work and imaging studies. These evaluations and studies revealed the following: high white blood cell count; elevated bilirubin levels; dehydration; malnourishment; and a history of epilepsy since childhood that had been treated by anti-seizure medication, which the Patient had recently discontinued due to his mistaken belief that his epilepsy had been cured (epilepsy is incurable). During Dr. Battisti's examination, the Patient presented visual, auditory, and tactile hallucinations that Dr. Battisti diagnosed as psychosis. Based on this diagnosis, and rather than admit the Patient due to his other diagnoses such as high white blood cell count and elevated bilirubin levels, Dr. Battisti referred the Patient to Lighthouse Behavioral Health Facility (Lighthouse, a psychiatric care facility) for an immediate psychiatric admission and evaluation. Notably, Dr. Battisti did not consider the Patient to be suicidal and did not order that the Patient be detained due to his psychosis. (Tr. 122 - 130).

As directed by Dr. Battisti, the Patient presented himself to Lighthouse with his Father. He continued to present the same delusions as presented at the Hospital's emergency room. The Patient was evaluated at Lighthouse but, despite a primary diagnosis of psychosis, Lighthouse did not admit the Patient. Lighthouse concluded that the Patient's high white blood cell count and elevated bilirubin level indicated a possible medical condition that could not be treated at Lighthouse. Therefore, Lighthouse instructed the Patient to return to the Hospital for medical clearance and evaluation. Notably, no one at Lighthouse considered the Patient to be suicidal and did not order that the Patient be detained due to his psychosis. (Tr. 131-132, 134-135).

The Patient returned to the Hospital's emergency room with this Father, and Dr. Battisti again treated the Patient at approximately 4:00 p.m. The Patient's condition remained unchanged – he remained psychotic. At the request of Dr. Battisti, Dr. Patel evaluated and admitted the Patient to the Hospital to address the underlying medical issues. Notably, neither Dr. Battisti or Dr. Patel considered the Patient to be suicidal, and neither of them ordered that the Patient be detained due to his psychosis. (Tr. 136, 138).

Dr. Patel ordered a psychiatric consultation for the Patient, but the psychiatrist never showed up to evaluate the Patient. Dr. Patel also ordered the administration of an anti-seizure medication for the Patient's epilepsy, but the Patient refused this medication due to his mistaken belief that his epilepsy had been cured. (Tr. 140-142). Dr. Patel did not order any treatment for the Patient's ongoing psychosis such as anti-psychotic medication. (Tr. 145; 261-262; 476). Dr. Patel's shift ended and he left the hospital at approximately 7:00 p.m. (Tr. 517). Dr. Patel did not conduct a face-to-face "handoff" of the Patient to the next on-duty

hospitalist (Dr. Ash-Bernal), *i.e.*, he did not discuss the Patient's history, diagnosis, treatment plan, etc. directly and personally with Dr. Ash-Bernal before leaving. (Tr. 262; 517-518).

Throughout the foregoing evaluations and treatments by three doctors and numerous nurses, and despite the repeated preliminary diagnoses of psychosis with visual, auditory, and tactile hallucinations, no one considered the Patient to be a suicide risk, no one considered him to be homicidal, and no one ordered that he be detained.

The Patient's Father left the Hospital at 7:30 p.m. (Tr. 139-140; 320; 344). Several hours later, at 1:13 a.m., the Patient appeared at the nurses' station and demanded to be released from the Hospital. He refused the nurses' offer to call his Father. He was combative and no longer willing to undergo voluntary treatment. The nurses called Dr. Ash-Bernal to attend the situation. (Tr. 144-148).

Dr. Ash-Bernal had not discussed the Patient with Dr. Patel, and she had not seen the Patient before being contacted by the nurses at 1:13 a.m. She conferred with the nurses and reviewed the Patient's chart before seeing the Patient in his room. She unsuccessfully attempted to convince the Patient to stay in the Hospital. She was aware that psychosis was one of the earlier diagnoses for the Patient, but she concluded that the Patient was competent to make his own medical decisions. She therefore honored his decision to not call his Father and did not involuntarily commit him to the Hospital. Accordingly, she concluded at 1:27 a.m. that the Patient could leave the Hospital against medical advice and had him fill out a detailed "against medical advice form" before he left the Hospital. (Tr. 509-518-524, 528-531, 535, 538-542, 558, 563-564, 568-571, 574, 577-578, 583; Pl. Exh. 6 at p. 2).

The Patient left the Hospital at approximately 1:30 a.m. Sometime thereafter but before 2:30 a.m., someone matching the Patient's description was seen on the beach, where that person disrobed, went into the surf, and was never seen again. (Tr. 234-241).

The Plaintiffs' Experts: Dr. Patel and Dr. Ash-Bernal Violated the Standard of Care

The Plaintiff presented two experts on the medical standard of care applicable to Dr. Patel and Dr. Ash-Bernal. Dr. Robinson testified as an expert in internal medicine and the practice of hospital medicine. (Tr. 118). Dr. Malone testified as an expert in psychiatry and forensic psychiatry. (Tr. 248). Both experts based their opinions on their review of the medical records. (Tr. 120-121; 248). Both experts concluded that Dr. Ash-Bernal's treatment of the Patient fell below the applicable standard of care for the following reasons:

1. Failure to conduct an adequate psychiatric evaluation;

2. Failure to conclude that the Patient did not have the mental capacity to make his own decisions regarding his medical care and disclosure of his medical information;

3. Failure to call the Patient's Father when she could not convince him to stay in the Hospital and despite the Patient's decision that his Father not be called; and

4. Failure to detain the Patient involuntarily when he refused to stay voluntarily.

(Tr. 121, 148-150, 156-157, 168, 171; 248-249, 274, 277-280).[1] In short, the experts disagreed with Dr. Ash-Bernal's medical treatment and medical judgment.

[1] Dr Robinson also testified that Dr. Patel's treatment fell below the standard of care. The jury rejected all claims against Dr. Patel and rendered a defense verdict in his favor. Since Dr. Patel was not involved with the Patient's departure from the Hospital, his treatment is not relevant to the "training" issues asserted against SMIS, *i.e.*, that the Patient's Father should have been called before allowing the Patient to leave the Hospital and/or the Patient should have been involuntarily committed by Dr. Ash-Bernal. To the extent that Dr. Patel's conduct is relevant, the arguments made herein about Dr. Ash-Bernal apply with equal force to Dr. Patel.

The Plaintiff's experts agreed that physicians have an independent duty owed to their patients to understand when they can detain a patient against his will and when they can disclose healthcare information to third parties against his will or instructions. (Tr. 150, 155-156; 272-273). The Plaintiff's experts also agreed that if a physician determines the patient is competent, then the patient has the right to leave the hospital against medical advice and to control the disclosure of their healthcare information. (Tr. 192; 308-309, 311-312). This determination of competency or mental capacity is the linchpin for detaining a patient involuntarily and for overriding the patient's decisions on disclosing healthcare information, *e.g.*, calling the Patient's Father to advise him that the Patient was leaving the hospital despite the Patient's refusal of the offer to call his Father. The fundamental questions presented in this appeal are whether SMIS had a duty to train physicians on the involuntary detention of patients and the disclosure of a patient's healthcare information to third parties without the patient's consent, whether SMIS breached any such duty, and whether that breach caused the Patient's death.

Manifestly, the determination of whether a patient has the mental capacity to make his own healthcare decisions is a matter of medical judgment. There is no evidence or claim that SMIS had a duty to educate or otherwise control Dr. Ash-Bernal's exercise of her medical judgment on the question of the Patient's mental capacity.

It is undisputed that Dr. Ash-Bernal exercised her independent medical judgment to conclude Patient had the mental capacity to make his own decisions on whether to leave the Hospital and whether to call his Father. She specifically certified this in the "Against Medical Advice Form" at the time that the Patient left the Hospital – she certified that the Patient had "the mental capacity to understand the risks and benefits of . . . leaving [the hospital] against

medical advice . . .." (Pl. Exh. 6 at p. 2; see also Tr. 528-531, 534-538). Dr. Ash-Bernal noted in her treatment notes that the Patient understood her recommendations but refused them and that the Patient was able to weigh the information that she gave him regarding the benefits of treatment and the dangers of refusing treatment, including leaving the Hospital (Tr. 527-531, 535; see also Tr. 537-538; Pl. Exh. 1). In short, Dr. Ash-Bernal exercised her professional judgment and concluded that the Patient had the mental capacity to make his own medical decisions.

The Plaintiffs' experts disagreed with Dr. Ash-Bernal's professional judgment, opining that she could have and should have involuntarily detained the Patient and/or called his Father. In particular, both experts concluded that the Patient did not have the mental capacity to make his own decisions, that his lack of capacity made him a danger to himself, that Dr. Ash-Bernal should have reached these same conclusions and either detained him or called his father, and that her failures to do so caused the Patient's death. The jury disagreed with the Plaintiff's experts and found that Dr. Ash-Bernal did not render any negligent treatment to the Patient, *i.e.*, her failure to detain the Patient or call his Father was not wrongful and did not cause any injury to the Patient.

ARGUMENT

I. This Court should reverse and remand for the entry of judgment in favor of SMIS.

The questions of detaining a patient and permissively disclosing his healthcare information to a third party are governed by statute and regulation. To detain a person and force care upon him against his wishes, the physician must certify that she "has examined the person and is of the opinion that the person is *mentally ill* and because of this condition is *likely to cause harm to himself* through neglect, inability to care for himself, or personal

injury, or otherwise, or to others if not immediately hospitalized." S.C. Code Ann. § 44-17-410(2) (Rev. 2018) (emphasis added). In like manner, absent the patient's express permission, the "trigger" for disclosure of a patient's healthcare information (PHI) under HIPPA[2] is a medical judgment and good faith belief that disclosure is "necessary to prevent or lessen a *serious* and *imminent* threat to the health or safety of" the patient. 45 C.F.R. § 164.512(j)(1)(i)(A).[3] The Hospital's policy echoed this HIPPA standard, allowing disclosure "to prevent or lessen a *serious* threat to health or safety" of the patient. (Pl. Exh. 5) (emphasis added). In short, involuntary detention and permissive disclosures share a common "trigger," *i.e.*, the treating physician's medical judgment that the patient is unable to make healthcare or other decisions for themselves and thereby presents a likely or serious and imminent threat to their own health or safety. Unless and until a physician makes these medical determinations in the exercise of her independent professional judgment, the questions of detaining a patient or disclosing his healthcare information to third parties never arise and are irrelevant.

It is against the foregoing legal background that the training duty advocated by the Plaintiff must be measured and ultimately rejected because: (A) SMIS did not and could not have the alleged duty to train; (B) assuming there ever could be such a duty, the Plaintiff failed to prove the existence of the duty or any breach of that duty with the requisite expert testimony; and (C) assuming the existence and breach of a duty to train, it was not the proximate cause of the Patient's injury.

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[2] HIPPA is the Health Insurance Portability and Accountability Act.

[3] See generally, 45 C.F.R. §§ 164.502, 164.508, 164.510. See also Pl. Exh. 7, Letter from HHS regarding HIPPA disclosures (doctor may disclose when she "believe[s] the patient represents a *serious* danger to himself . . . [and] believes in good faith that [disclosure] is necessary to prevent or lessen a *serious* and *imminent* threat to the health or safety of the patient . . ..") (all emphasis added).

A. Standard of Review

The question of whether any evidence supports the judgment is a question of law, and the appellate court applies the same standard as the trial court, to-wit: viewing the evidence in favor of the non-moving party, does the evidence support the jury's verdict? See *Shupe v. Settle*, 445 S.E.2d 651, 654 (S.C. App. 1994). The question of whether a duty exists that a defendant owes to a plaintiff is a question of law for the court. *Washington v. Lexington County Jail*, 523 S.E.2d 204, 206 (S.C. App. 1999). The appellate court reviews all questions of law *de novo* and gives no deference to the trial court. *Menezes v. WL Ross & Co., LLC*, 744 S.E.2d 178, 182 (S.C. 2013).

B. SMIS did not owe a duty to the Patient nor did it breach any applicable standard of care.

South Carolina law mandates that a physician may disclose information pertaining to a patient's medical treatment or discharge *only if* the patient is unable to consent. *See generally* S.C. Code Ann. §§ 44-66-10 to -80 (Rev. 2018 & Supp. 2019). The process for deeming a patient incapable of consent requires certification by two physicians, based on their examination of the patient and their medical judgment, that the patient cannot make a "reasoned decision" about his healthcare. The certification must include the physicians' medical opinion regarding the cause and nature of the inability to consent. *See generally id.*; see also S.C. Code Ann. § 44-66-20(8) (Rev. 2018 & Supp. 2019) (certification by two physicians).

SMIS is a limited liability company that is prohibited from engaging in the practice of medicine[4], which is defined as any decision that affects the diagnosis and treatment of a

[4] The right to practice medicine in South Carolina is governed by the Board of Medical Examiners (the Board) under the administration of the Department of Labor, Licensing, and Regulation. See S.C. Code Ann. § 40-1-40 (Rev. 2011) and § 40-47-10 (Supp. 2019). Only a "person" licensed by the Board may

patient. See, *e.g.*, S.C. Code Ann. § 40-47-20(36) (Supp. 2019) (defining the practice of medicine). SMIS therefore cannot train its employee physicians on the exercise of their medical judgment in providing medical care – physicians are obligated under their licensure and privileges to determine medical care independently. See, *e.g.*, S.C. Code Ann. § 40-47-110(B)(5), (B)(7), (B)(12) (Rev. 2011). Plaintiff claims that SMIS had a duty to train physicians on medical statutes and regulations, but these laws specifically require a licensed physician to exercise her independent medical judgment, *i.e.,* to determine whether the patient has the mental capacity to make his own healthcare decisions and whether he presents a serious and imminent threat to himself or others. See, *e.g.*, S.C. Code Ann. § 44-17-410(2) (Rev. 2018); 45 C.F.R. § 164.512(j)(1)(i)(A). Imposing the duty advocated by the Plaintiff would require SMIS and its employee doctors to violate the foregoing provisions of law, because the advocated training would dictate or influence the doctor's practice of medicine and the exercise of her independent medical judgment. Manifestly, there can be no legal duty for a corporate entity to violate the law or force its employed physicians to violate the law.

The alleged duty to train on permissive disclosures or detention cannot be separated from the underlying medical care and professional judgment that is rendered by a physician. SMIS provided training on several federal statutes including the general mandates on non-disclosure provided under HIPAA, but these non-disclosure provisions do not hinge on any medical judgment. The permissive disclosures under HIPPA, however, require and rest upon the exercise of medical judgment in the practice of medicine. Thus, the law cannot impose a

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practice medicine in South Carolina. § 40-47-30(A) (Rev. 2011). For purposes of the Board's actions and functions, a "person" is defined as "a natural person, male or female." § 40-47-20(33) (Supp. 2019). Thus, a corporation cannot practice medicine in South Carolina. See also *Baird v. Charleston County*, 511 S.E.2d 69, 78 (S.C. 1999) ("South Carolina has a common law prohibition against the corporate practice of medicine."); *Wadsworth v. McRae Drug Co.*, 28 S.E.2d 417, 419 (S.C. 1943) ("a corporation may not engage in the practice of medicine even through licensed employees.").

corporate duty to train on permissive disclosures, because doing so would require the corporation to engage in the unlawful practice of medicine by a corporation. See n. 4 and accompanying text, *infra*. The same would be true of any training on detaining a patient against his will, because that decision also hinges upon the exercise of medical judgment in the practice of medicine. Indeed, it would be illegal for a physician to abide by any such training, because a physician is bound by law to exercise her medical judgment independently of any corporate mandates. Moreover, requiring physicians to attend or accept such corporate training would force them to violate their obligations to not assist anyone in the unlawful practice of medicine. See S.C. Code Ann. § 40-47-110(B)(5), (B)(7), (B)(12) (Rev. 2011).

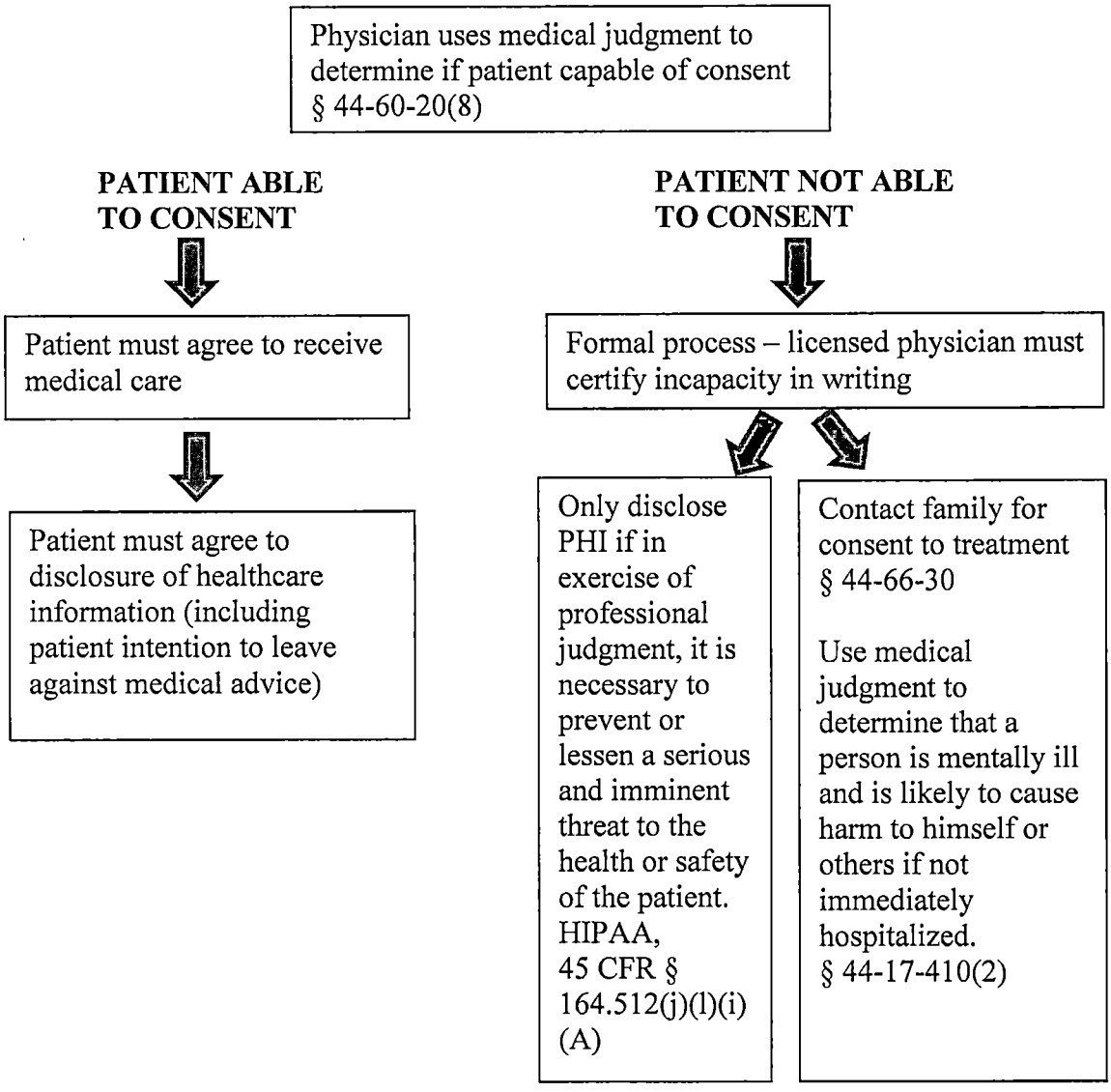
C. Assuming there can ever be a corporate duty to train on detention or permissive disclosures, the Plaintiff failed to establish the duty or any breach of that duty by the requisite expert testimony.

The existence, scope, and operation of a corporate duty to train physician employees on detention or permissive disclosures under HIPPA, and the breach thereof, is not and cannot be a matter of common knowledge and lay experience. For example, as noted earlier, the statutes and regulations on these matters specifically require the exercise of medical judgment on medical issues and care, which manifestly is not and cannot be a matter of common knowledge and lay experience. Thus, expert testimony was required on the existence and breach of any such corporate duty to train because, as this Court has repeatedly held, expert testimony is required whenever the "matter [is] outside the common knowledge and experience of most lay persons." *E.g., Spartanburg Reg'l Med. Ctr. v. Bulsa*, 417 S.E.2d 648 (S.C. App. 1992) (expert testimony required for medical related issues even though case not pursued as a medical malpractice action).

Here, there is no expert testimony on the duty or the breach of that duty. The trial court specifically ruled that the Plaintiff's expert, Dr. Robinson, was not an expert on the corporate duty to train. (Tr. 165-166). The Plaintiff did not present any other witnesses as experts on the claimed corporate duty to train. Therefore, even if one assumes that the law would ever impose any "training" duty on a corporation, the Plaintiff failed to prove its existence, scope, or breach by the requisite expert testimony.

D. Assuming SMIS had a duty to train, and assuming SMIS breached that duty, this did not and could not proximately cause the Patient's injuries.

Prior to rendering medical care or disclosure of any medical information on the care, a physician must first determine whether the patient has the ability to consent to treatment. *E.g.*, S.C. Code Ann. § 44-66-20(8) (Rev. 2018). This determination can only be made by a licensed physician who has examined the patient. *Id.* The chart below shows the legally required decision-making process by physicians.



1. Dr. Ash-Bernal was aware of the permissive HIPAA disclosure exceptions and the ability to detain patients and, therefore, any assumed breach of any assumed duty to train by SMIS was not and could not be a proximate cause of the Patient's injury.

Dr. Ash-Bernal has an impressive medical education and training history, including an internship and residency at Johns Hopkins, and she is or has in the past been licensed to practice medicine in seven (7) states. (*E.g.*, Tr. 499-503). By the time she treated the Patient,

she had been credentialed in numerous (9 to 12) hospitals, and she received training on the do's and don'ts under HIPPA at each of these hospitals, including the Hospital where she treated the Patient. (Tr. 505-507). She also testified without objection and without contradiction that she had been trained in and was aware of a physician's ability to detain patients. (Tr. 520-521). She also testified that there were numerous persons at the Hospital to consult with on detention and permissive disclosure issues if she had any questions on what to do in a particular case. (Tr. 520-521, 561-562). None of this is surprising because, as established by both of the Plaintiff's experts, physicians have an independent duty to know the regulations on patient confidentiality and patient consent to treatment. (Tr. 155-156; 272-273). Against this backdrop of prior training and knowledge, there is no reasonable basis to conclude that Dr. Ash-Bernal would have treated the patient differently had SMIS also provided training on these matters. Therefore, any assumed breach of any assumed SMIS duty to train, did not and could not proximately cause the patient's death. See *David v. McLeod Reg'l Med. Ctr.*, 626 S.E.2d 1, 4-5 (S.C. 2006) (speculative to rest causation on a failure to communicate information, *i.e.*, that providing the information would have caused doctor to treat the patient differently and in a manner that would have prevented the claimed injury).

2. Dr. Ash-Bernal's medical and professional judgment about the Patient's condition demonstrates that any assumed breach of any assumed training duty by SMIS was not the proximate cause of the Patient's injury.

The linchpin for any provision of medical treatment against a patient's wishes or any disclosure of healthcare information is the medical judgment by a physician that the patient does not have the mental capacity to make his own decisions. To detain a person, the physician must certify that she "has examined the person and is of the opinion that the person is *mentally ill* and because of this condition is *likely to cause harm to himself* through

neglect, inability to care for himself, or personal injury, or otherwise, or to others if not immediately hospitalized." S.C. Code Ann. § 44-17-410(2) (Rev. 2018) (emphasis added). In like manner, absent the patient's express permission, the "trigger" for disclosure of a patient's healthcare information (PHI) under HIPPA[5] is a medical judgment and good faith belief that disclosure is "necessary to prevent or lessen a *serious* and *imminent* threat to the health or safety of" the patient. 45 C.F.R. § 164.512(j)(1)(i)(A).[6] The Hospital's policy echoed this HIPPA standard, allowing disclosure "to prevent or lessen a *serious* threat to health or safety" of the patient. (Pl. Exh. 5) (emphasis added). In short, involuntary detention and permissive disclosures share a common "trigger," *i.e.*, the treating physician's medical judgment that the patient is unable to make healthcare or other decisions for themselves and thereby presents a likely or serious threat to their own health or safety.

Here, it is undisputed that Dr. Ash-Bernal concluded that the patient had the mental capacity to make his own decisions and was not a serious or imminent threat to himself. Thus, she could not detain the patient or disclose his information under the standards advocated by the Plaintiff. There is no claim that SMIS had any duty to train Dr. Ash-Bernal on how to evaluate a patient's mental capacity to make their own decisions about treatment or disclosure. There is no evidence that the training advocated by the Plaintiff would have or could have changed Dr. Ash-Bernal's medical judgment on the Patient's mental capacity to make his own decisions or protect himself from harm. Therefore, any assumed breach of any assumed duty by SMIS to train as advocated by the Plaintiff did not and could not proximately cause the

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[5] HIPPA is the Health Insurance Portability and Accountability Act.

[6] See generally, 45 C.F.R. §§ 164.502, 164.508, 164.510. See also Pl. Exh. 7, Letter from HHS regarding HIPPA disclosures (doctor may disclose when she "believe[s] the patient represents a *serious* danger to himself . . . [and] believes in good faith that [disclosure] is necessary to prevent or lessen a *serious* and *imminent* threat to the health or safety of the patient . . .") (all emphasis added).

patient's injuries, because Dr. Ash-Bernal concluded in her medical judgment that the "triggers" for detention or disclosure had not "pulled."[7]

3. The jury exonerated the medical care rendered by SMIS' employees and thus there can be no causal connection linking any presumed breach to the Patient's suicide.

Assuming a breach of duty by SMIS, its presumed breach could not be a proximate cause of the Patient's injuries, because the jury completely exonerated Dr. Ash-Bernal (and Dr. Patel). There is no South Carolina law on this specific issue, but this Court has noted without deciding that proving a tort by the negligently trained employee may be a proximate cause requirement for imposing liability on the employer. *Longshore v. Saber Sec. Servs.*, 619 S.E.2d 5, 9 (S.C. App. 2005).[8] Such an approach makes sense. If the "negligently trained" employee does not commit a tort, there cannot be any proximate cause resulting from the employer's negligent training of the employee.[9] This is particularly true in the present case,

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[7] Dr. Robinson, one of the Plaintiff's experts, opined that SMIS's power-point slideshow on the need to protect patient information should have included a slide on when HIPPA permitted disclosure. There is no evidence that including this slide in the presentation would have or could have changed Dr. Ash-Bernal's treatment of the Patient, particularly her medical judgment that the Patient had the mental capacity to make healthcare decisions for himself and that he was not a danger to himself or others. Having reached these medical judgments, Dr. Ash-Bernal could not detain the Patient or disclose his medical information without his consent. Thus, the absence of a slide on permissive disclosures without patient consent did not and could not proximately cause the Patient's injury.

[8] This Court stated: "Neither current statutory law nor jurisprudence in this state has specifically required a plaintiff, in an action against an employer for negligent hiring, training, and supervision, to prove the employee committed an actionable tort. However, there is authority to support the proposition. *See Sabb v. South Carolina State Univ.*, 567 S.E.2d 231, 238-39 (S.C. 2002) (Pleicones, J., dissenting). In this case, we are not required to address the issue because, as previously noted, the action for negligent hiring, training, and supervision against Saber also included allegations of negligence by Shafer, and the verdict form required the jury to determine whether the 'defendants' were negligent." 619 S.E.2d at 9. Here, the jury assessed the defendants' culpability separately.

[9] See *Hays v. Patton–Tully Transp. Co.*, 844 F.Supp. 1221 (W.D.Tenn.1993) (negligent supervision claim will lie only where supported by viable claim of tortious conduct by offending employee); *Mulhern v. City of Scottsdale*, 799 P.2d 15 (Ariz. App.1990) (in order for employer to be liable for negligent hiring, retention, or supervision, the employee must have committed an actionable tort); *Schoff v. Combined Ins. Co. of America*, 604 N.W.2d 43 (Iowa 1999) (the torts of negligent hiring, supervision, or training must include as an element an underlying tort or wrongful act committed by the employee); *Hogan v. Forsyth Country Club Co.*, 340 S.E.2d 116 (N.C. App. 1986) (before employer can be held liable for negligently hiring or retaining an employee, plaintiff must prove that the offending employee committed a tortious act resulting in injury to plaintiff); *Gonzales v. Willis*, 995 S.W.2d 729 (Tex. App.1999) (plaintiff-employee's negligent hiring, retention, and supervision

where the doctors had an independent and professional medical duty to know and follow the rules and regulations on detention and disclosure.

The Plaintiff attempts to separate Dr. Ash-Bernal's medical judgment in rendering medical care from the causal link, but this is an impossibility. Without Dr. Ash-Bernal's medical decision that the patient was competent and was not a danger to himself or others, she would not have allowed the patient to leave the Hospital. (See generally, Tr. 528-542). Thus, any assumed failure to train by SMIS did not cause the Patient to be discharged from the Hospital and did not cause the failure to contact the Patient's Father. Rather, the Patient was discharged and his Father was not contacted because Dr. Ash-Bernal concluded, in her professional and medical judgment, that the Patient had the mental capacity to make his own decisions and that he was not a danger to himself or others. Thus, even if one assumes that SMIS had a duty to train and breached it, this breach of duty was not and could be the cause of the Patient's injury.

4. There is no evidence to support a jury determination that the alleged failure to train was the cause in fact of the Patient's suicide or death.

While South Carolina does not recognize a general rule that suicide is an intervening act that always break the chain of causation in a wrongful death case, plaintiffs have a difficult burden in claims for wrongful suicide to prove that 'but for' the defendant's negligence, the patient would not have died. See *Wickersham v. Ford Motor Co.*, Op. No. 27904, 2019 LEXIS 68 (filed July 24, 2019).[10] To prove causation in a wrongful suicide case, the inquiry is

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claims against employer failed where plaintiff-employee failed to show actions of offending employee amounted to an actionable tort); *Haverly v. Kaytec, Inc.*, 738 A.2d 86 (Vt. 1999) (the tort of negligent supervision must include as an element an underlying tort or wrongful act committed by the employee).

[10] At the time of this initial brief, the *Wickersham* opinion was not yet final and, therefore, citation is to the "LEXIS" citation for the convenience of the Court.

whether the injury is a natural and probable consequence of the wrongful act and should have been foreseen in light of the attendant circumstances. *Id.* at ___, *quoting Scott v. Greenville Pharmacy*, 48 S.E.2d 324, 328 (S.C. 1948).

South Carolina courts have repeatedly found that the alleged breach of the standard of care was too attenuated to find that it was the proximate cause of the suicide. See, *e.g.*, *Wickersham,* ___ at ___-___, *citing Scott, supra* (the unlawful sale of barbiturate capsules that brought about a condition of suicidal mania was not a natural and probable consequence of the sale was not reasonably foreseeable) and *Home v. Beason*, 331 S.E.2d 342, 344-345 (S.C. App. 1985) (defendant could not be expected to foresee that a 17 year old would hang himself by tying his bathrobe belt to overhead bars in his jail cell, because a bathrobe belt is not a dangerous instrumentality). The specific set of circumstances must be evaluated in each case. *Wickersham,* ___ at ___.

If a patient is a known suicide risk, then the healthcare provider may be liable for the suicide under the particular circumstances of the case. *Bramlette v. Charter Medical-Columbia*, 393 S.E.2d 914 (S.C. 1990) (jury question created by the particular facts of the case given that defendants treating the patient knew he was or had recently been a suicide risk through expressed suicidal ideation). Here, SMIS did not render medical care to the Patient nor could it have done so, because a corporation like SMIS cannot practice medicine in South Carolina. Moreover, it is undisputed that multiple healthcare professionals found the Patient did not have any suicidal ideation, and there is no evidence that he was a known suicide risk. The Patient was believed to be suffering from psychosis, *i.e.*, he was delusional, but this did not establish *a priori* that he was suicidal or a danger to himself. More importantly, Dr. Ash-Bernal exercised her independent professional and medical judgment to conclude the Patient's

condition did not meet the requirements for involuntary commitment, involuntary treatment, or involuntary disclosure of his decision to leave the Hospital against medical advice. Thus, any assumed breach of any assumed duty to train was not and could not be the cause of the Patient's suicide.

The Patient's suicide had to be the natural and probable consequence of SMIS's acts or omissions, *i.e.*, the alleged failure to train. As argued earlier, there was no such duty and any assumed breach of any such duty was not and could not be a proximate cause of the Patient's suicide. Thus, SMIS cannot be liable. In any event, there is no reasonable basis to conclude that SMIS should have reasonably foreseen that any failure to train Dr. Ash-Bernal on these matters would result in a patient's suicide or death.

There is no liability if the injury is not reasonably foreseeable as judged from the perspective of the defendant at the time of the negligent act rather than after the injury has occurred. *Crolley v. Hutchins*, 387 S.E.2d 716, 717 (S.C. App. 1989) (attempted suicide not reasonably foreseeable). Here, the following would have to be reasonably foreseeable to SMIS at the time of its training: (1) the doctor would not know the standards for detention and permissive disclosure, even though the doctor has an independent duty to know these things; (2) the doctor would mistakenly conclude that the patient had the mental capacity to make his own decisions; (3) the doctor would mistakenly conclude that the patient was not a serious and imminent danger to himself; (4) the doctor would therefore mistakenly allow the patient to leave the hospital, and would mistakenly fail to call the patient's family member to advise that the patient was leaving the hospital against medical advice; and (5) the patient would then commit suicide after leaving the hospital, despite the absence of any suicidal ideations being noted by any of the any healthcare professionals that attended to the patient during his stay at

the hospital. As in *Scott* and *Crolley*, "it would be going entirely too far" to hold that the foregoing sequence of events was reasonably foreseeable to SMIS at the time of the training. *Crolley*, 387 S.E.2d at 717-718, *quoting Scott*, 48 S.E.2d at 328. Moreover, this sequence of events did not in fact occur, because the jury found that Dr. Ash-Bernal did not mistakenly allow the Patient to leave the Hospital and did not mistakenly fail to call the Patient's Father.

The analysis and result is the same, even if one considers the Patient's presumed death to have been accidental rather than suicidal. As the Supreme Court held in *Wickersham, supra*, South Carolina applies traditional principles of proximate cause to suicide cases. ___ at ___. The sequence of events noted in the preceding paragraph remain unforeseeable, even if the Patient died as the result of an accident rather than suicide. And again, this sequence of events did not in fact occur, because the jury found that Dr. Ash-Bernal did not mistakenly allow the Patient to leave the Hospital and did not mistakenly fail to call the Patient's Father.

II. This Court should reverse and remand for a new trial.

A. Standard of Review

The admission of evidence is an issue that resides in the discretion of the trial court and will not be disturbed absent an abuse of that discretion. *R & G Constr., Inc. v. Lowcountry Reg'l Transp. Auth.*, 540 S.E.2d 113, 121 (S.C. App. 2000). Reversal based on the erroneous admission of evidence requires a showing of error and resulting prejudice, *i.e.*, "that there is a reasonable probability the jury's verdict was influenced by the challenged evidence." *Fields v. Reg'l Med. Ctr. Orangeburg*, 609 S.E.2d 506, 509 (S.C. 2005). The erroneous admission of evidence "having some probative value upon a material issue of fact in the case is ordinarily presumed to be prejudicial." *Mali v. Odom*, 367 S.E.2d 166, 170 (S.C. App. 1988).

B. The trial court erred in admitting any evidence on the claim of failure to train on the permissive disclosures of healthcare information under HIPPA, because the Plaintiff did not plead this claim in his Amended Complaint.

It is indisputable that the failure to train on permissive disclosures under HIPPA was the overriding issue in the Plaintiff's "failure to train" evidence and claim. Thus, if the trial court erred in admitting this evidence, it manifestly requires a new trial under *Fields* and *Mali*, both *supra*.

The Plaintiff's Amended Complaint included only one "training" allegation, and it related solely to an alleged failure "to educate and otherwise train physicians and staff as to the ability, means, and mechanisms to *detain a mentally ill patient against his/her will*." (Amd. Cmplnt. at p. 7, ¶ 50(e)) (emphasis added). In the next paragraph of the Amended Complaint, the Plaintiff repeated this claim in a summary of the claims made but only against the Hospital: "Additionally, Defendant GSRMC [Hospital] failed to educate and otherwise train its physicians and staff as to the ability, means, and mechanisms to *detain a mentally ill patient against his/her will*." (Amd. Cmplnt. at p. 8, ¶ 51) (emphasis added). The failure to train on permissive disclosures allowed by HIPPA is not alleged anywhere in the Amended Complaint despite being the centerpiece of the Plaintiff's "failure to train" claim at trial. (See Amd. Cmplnt. at R. __-___, *passim*).

A party cannot pursue a claim at trial that it did not plead in its complaint, unless the issue was tried by express or implied consent. See *Hynes Family Trust v. Spitz*, 682 S.E.2d 831, 834 (S.C. App. 2009) (party cannot be granted relief not sought in pleadings); *Woods v. Rabon*, 368 S.E.2d 471, 473-474 (S.C. 1988) (failure to plead an issue is forgiven if tried by express or implied consent). Here, there was no trial by implied or express consent, because SMIS objected to the HIPPA training claim and evidence, but the trial court overruled the

objection. (Tr. 20-25; 157-163; 416). After the verdict, SMIS renewed its objection to this evidence and sought a new trial. (JNOV Motion at 13, 14).

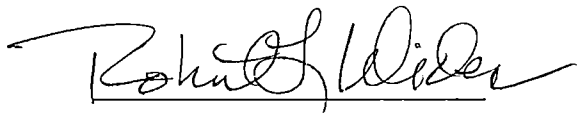
The trial court denied the motion, reasoning that the defendants had raised the HIPPA privacy rules as a defense to any claim based on calling the Patient's Father. (JNOV Order at 9, 23). SMIS, however, did not plead any such defense. (SMIS Answ. to Amd. Cmplnt. at R. ___-___, *passim*). Moreover, the "HIPPA failure to train" claim made at trial was made against SMIS only. Therefore, SMIS is entitled to a new trial.

The trial court also reasoned that SMIS's production of a slideshow on HIPPA training somehow put it on notice that the Plaintiff was going to make a "failure to train" on HIPPA claim against SMIS at trial. (JNOV Order at 9, 23). It is axiomatic that the "relevancy" test for discovery, unlike the issue of "relevancy" at trial, is extremely broad and "relevancy" objections to discovery requests seldom succeed. See Rule 26(b)(1), SCRCP. Thus, responding to discovery is not and cannot be notice that a claim will be made at trial, particularly when (as here) the evidence could be relevant to other claims pleaded by or against other parties. Rather, it was incumbent upon the Plaintiff to amend his complaint or otherwise give timely notice that a "HIPPA failure to train" claim would be made against SMIS at trial. Since the Plaintiff failed to do so, it was manifest error for the trial court to admit evidence on this matter at trial, because the "HIPPA failure to train" claim was made only against SMIS. Therefore, this Court should reverse and remand for a new trial on the claims against SMIS.

CONCLUSION

For all of the foregoing reasons, it is respectfully submitted that this Court should reverse and remand for entry of judgment in favor of SMIS or, in the alternative, for a new trial on the claims against SMIS.

Respectfully Submitted,



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February 20, 2020
Columbia, SC

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM HORRY COUNTY
Court of Common Pleas

The Honorable John C. Hayes, III

Case No. 2017-CP-26-1571
Appellate Case No. 2019-001665

David L. Scheer, as Personal Representative of the Estate of Matthew J. Scheer,.....Respondent,

v.

Southern Myrtle Inpatient Services, LLC, Nirlep A. Patel, M.D. and Rachel Ash-Bernal M.D. ..... Defendants,

Of which
Southern Myrtle Inpatients Services, LLC is.....Appellant.

CERTIFICATE OF SERVICE

I, Ann Shuler, an employee of Burr & Forman, LLP, hereby certify that true and correct copies of the **Appellant's Initial Brief** and **Appellant's Designation of Matter to be Included in Record on Appeal** were served upon counsel for the Respondent in the above-captioned matter, by causing a copy of same to be deposited in the United States Mail, first class postage prepaid, this 24th day of February, 2020, addressed as follows:

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February 20, 2020

Honorable Jenny Abbott Kitchings
Clerk of Court
S.C. Court of Appeals
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Re: David Scheer -v- Southern Myrtle Inpatient Services, LLC
Appellate Case No. 2019-001665

Dear Ms. Kitchings:

Please find enclosed for filing the original and one copy each of Appellant's Initial Brief and Appellant's Designation of Matter to be Included on Appeal, along with the original and one copy of the Certificate of Service. Please file the brief and designation in your office, and return the file stamped copies to me in the return envelope provided.

By copy of this letter, we are serving counsel for the Respondent with copies of the same.

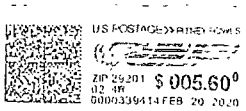
Thank you for your assistance in this matter.

Sincerely,

Burr Forman McNair

Robert L. Widener
Partner

RLW/as
Enclosures
cc: Francis M. Hinson IV
Nicholas D. Mermiges



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