THE STATE OF SOUTH CAROLINA
In the Court of Appeals

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

J.C. Nicholson, Jr., Circuit Court Judge

Appellate Case No. 2016-001986

Shon Turner, as Personal Representative of the Estate of Charles Mikell, Deceased.....Appellant

v.

The Medical University of South Carolina.....Respondent

RESPONDENT THE MEDICAL UNIVERSITY OF SOUTH CAROLINA'S PETITION FOR REHEARING

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PETITION FOR REHEARING

AND NOW COMES Respondent/Defendant The Medical University of South Carolina ("MUSC"), by and through its undersigned counsel, and files this Petition for Rehearing:

I. INTRODUCTION

This lawsuit involves claims by Plaintiff Shon Turner ("Plaintiff"), as Personal Representative of the Estate of Charles Mikell ("Mr. Mikell"), asserting survival and wrongful death claims against Defendant MUSC. On October 1, 2010, Mr. Mikell's primary care physician referred him for a colonoscopy. Mr. Mikell was overweight and had several preexisting conditions, including nonischemic dilated cardiomyopathy, atrial ventricular nodal reentry tachycardia, chronic kidney disease, hypertension, diabetes, G6PD deficiency, gallbladder disease, hyperlipidemia, and sleep apnea. (*See generally* R. pp. 275-404).

Board Certified Cardiac Anesthesiologist Dr. Eric Nelson ("Dr. Nelson") and Certified Registered Nurse Anesthetist ("CRNA") Donna Embrey ("Nurse Embrey") conducted the anesthesia aspect of the colonoscopy. Mr. Mikell was given Propofol at 7:41 a.m. (*See* R. p. 1340:14-18). At 7:48, Mr. Mikell's blood oxygen saturation level was 96.7%, a "very good" level. (*See* R. p. 1347:3-14). At 7:49, the level was recorded at 76% and at 7:50 the level was recorded at 69.2%. (*See* R. pp. 218-20). Dr. Nelson was definitely in the room at 7:49. (*See* R. pp. 1343:22-1344:4). Dr. Nelson and Nurse Embrey put in a nasal cannula, which increased and stabilized Mr. Mikell's blood oxygen saturation levels. (*See* R. p. 1348:8-12). Mr. Mikell's blood oxygen saturation levels increased to at least 90%, and Dr. Nelson left the procedure room at 7:51. (*See* R. p. 1348:8-17). Dr. Nelson testified that "[a]t the time I stepped out of the room, his vital signs were stable. He was in the hands of an experienced nurse anesthetist, and I was very close by." (*See* R. pp. 1361:25-1362:9). Dr. Nelson was across the hall, where he could easily be reached if needed. (*See* R. pp. 1350:4-1351:5). Nurse Embrey testified that she was comfortable and that Dr. Nelson was available "almost immediately." (*See* R. pp. 1051:15-1053:11). Plaintiff's expert testified that it is acceptable for an attending physician to be two minutes away from the operating room and that being across the hall would certainly be

acceptable. (*See* R. pp. 818:6-820:3). He also testified that he could handle up to four simultaneous procedures; Dr. Nelson and Nurse Embrey had only one patient other than Plaintiff. (*See* R. pp. 818:6-819:12).

After Dr. Nelson left the room, Mr. Mikell's blood oxygen saturation levels fell to 41.2 at 7:57 (six minutes after Dr. Nelson departed). (*See* R. pp. 218-20). Dr. Nelson testified:

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

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

Mr. Mikell went into cardiac arrest. (*See* R. p. 202). He was resuscitated and admitted to MUSC for further treatment. Subsequently, Mr. Mikell developed acute renal failure in addition to his pre-existing chronic kidney disease and underwent hemodialysis. He also had difficulty weaning from the ventilator and received a tracheostomy on October 12, 2010. Plaintiff presented no evidence that Mr. Mikell suffered an acute ischemic event or any injury to his heart because of the arrest.

On October 26, 2010, Mr. Mikell was transferred to Kindred Hospital. (*See* R. pp. 265-67). His tracheostomy was removed on November 11, 2010 and his respiratory failure was resolved. (*See* R. pp. 268-69). Dialysis was stopped on November 3, 2010, and Mr. Mikell was discharged home on November 19, 2010. (*See id.*). Plaintiff presented no competent evidence that Mr. Mikell suffered any lasting injury because of his arrest at MUSC. On January 2, 2011,

approximately six weeks after his discharge from Kindred, Mr. Mikell was found dead in his home.

II. PROCEDURAL HISTORY

The case was tried in April, 2016, resulting in a jury verdict in favor of MUSC. Prior to the verdict, the trial judge granted MUSC a partial directed verdict to the extent Plaintiff's claims alleged that Dr. Nelson engaged in professional negligence. On May 9, 2016, Plaintiff filed his Motion for a New Trial, arguing that the trial judge improperly granted a partial directed verdict and committed various trial errors. (*See generally* R. pp. 6-16). Plaintiff filed the instant appeal from the denial of his post-trial motions and the grant of the partial directed verdict. (*See* R. p. 3). The parties fully briefed and argued this appeal.

On May 6, 2020, the Court of Appeals filed its Opinion ("Opinion") affirming in part and reversing in part the trial court's orders.[1] Of relevance to this Petition, the Court's Opinion reverses the trial judge's grant of a partial directed verdict to MUSC to the extent Plaintiff's claims alleged professional negligence by Dr. Nelson. Specifically, this Court held that there was evidence that Dr. Nelson had breached a duty of care to Mr. Mikell "because Dr. Nelson failed to adequately attend to Mikell—a known tenuous patient—because he (1) only made a brief stop in Mikell's room and (2) left the room even though Mikell's saturation levels were consistently low." (*See* Opin., at 11). Additionally, this Court held that there was evidence supporting that Dr. Nelson's negligence was a proximate cause of Mr. Mikell's injuries. (*See id.* at 12).

For the reasons that follow, this Court erred in its reversal of the trial judge's grant of a partial directed verdict as to the claims relating to Dr. Nelson's conduct. Therefore, Defendant MUSC respectfully petitions this Court to rehear this matter and affirm the partial directed verdict entered against Plaintiff.

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1 Specifically, the Court affirmed, ruling in favor of MUSC, as to certain evidentiary and jury instruction issues. MUSC does not seek rehearing of this Court's affirmance of any of these rulings by the trial court.

ARGUMENT

A. Even if the Trial Judge Erred in Granting a Partial Directed Verdict, Such Error Was Harmless Insofar as the Jury Was Never Informed of the Directed Verdict.

In its Respondent's Brief, MUSC argued that — even if the trial judge erred in granting a partial directed verdict — such error was harmless and cannot support reversal. MUSC's only reason for moving for judgment as a matter of law on Dr. Nelson's professional negligence was to limit recovery to the lower non-physician limit under the South Carolina Tort Claims Act. The trial judge's ruling concerning Dr. Nelson did not change anything at trial. This ruling had no impact on the jury's verdict, as Plaintiff still presented evidence and made arguments relating to Dr. Nelson's conduct. Additionally, the trial judge never instructed the jury to disregard Dr. Nelson's negligence. However, this Court's Opinion did not address MUSC's argument that any error relating to the directed verdict was harmless. This was a separate ground for affirmance, which this Court should have considered.

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

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

See Judy v. Judy, 384 S.C. 634, 646, 682 S.E.2d 836, 842 (Ct. App. 2009). "[I]n order to conclude that the error did not contribute to the verdict, the Court must 'find that error unimportant in relation to everything else the jury considered on the issue in question, as revealed in the record.'" *Lowry v. State*, 376 S.C. 499, 508, 657 S.E.2d 760, 765 (2008) (*quoting Yates v. Evatt*, 500 U.S. 391, 403, 111 S.Ct. 1884, 114 L.Ed.2d 432 (1991)).

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

The trial judge's granting of a partial directed verdict did not affect how Plaintiff presented his case to the jury or the jury's final verdict. MUSC's oral motion was only relevant to a unique question under the South Carolina Tort Claims Act, under which caps on liability differ greatly depending upon whether the claim is one for a physician's professional negligence. For general negligence, the caps are $300,000 per person ($600,000 per occurrence); on the other hand, in an action "caused by the tort of any licensed physician or dentist, employed by a governmental entity and acting within the scope of his profession," the cap is $1,200,000. *See* S.C. Code § 15-78-120(a)(1)-(4) (emphasis added). The liability cap became moot when the jury returned a verdict for the Defendant.

MUSC made clear, and the trial court agreed, that its request for a directed verdict was concerned with its ultimate liability under the Tort Claims Act: "we would also, at this time, make a motion for partial summary judgment[2] [directed verdict] as to any negligence on the part

[2] Although the parties and the Court spoke in terms of summary judgment, the motion was one for partial directed verdict, since it was made at the close of the evidence.

of a licensed physician, and *that would – of course, I (sic) have consequences under the Tort Claims Act should there be a recovery.*" (*See* R. p. 1472:16-20). The trial judge agreed that the issue did not affect MUSC's liability, but only the caps on liability:

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

(*See* R. p. 1479:19-22 (emphasis added)). The trial judge also noted: "We were discussing at the bench the partial summary judgment [directed verdict] that the court granted to the defendant as to Dr. Nelson's liability. In the court's opinion, that would only affect the monetary terms if they get a verdict based on the Tort Claims Act." (*See* R. p. 1644:8-12). Consistent with this, the jury's verdict did not address the negligence of any particular individual, but decided the broader question of MUSC's alleged negligence. (*See* R. p. 1647:11-18). Neither Dr. Nelson nor Nurse Embrey were named as defendants.

The trial judge's jury instructions never named Dr. Nelson — and only mentioned Nurse Embrey once. (*See* R. pp. 1615:11-1636:10). The jury instructions did not preclude the jury from considering Dr. Nelson's alleged negligence. (*See id.*). In fact, the trial judge expressly denied a request for such an instruction. (*See* R. p. 1638:12-20). Plaintiff's counsel conceded at trial that the jury was not being told not to consider Dr. Nelson's negligence. (*See* R. p. 1644:14-24). In fact, the jury was expressly instructed that "the doctor and nurses were agents of the principle MUSC." (*See* R. p. 1632:13-14). Moreover, Plaintiff has not identified a jury instruction that was improperly denied as a result of the partial directed verdict. Plaintiff made no showing that the jury instructions prevented the jury from considering Dr. Nelson's negligence.

In fact, although MUSC requested it, the trial judge refused to instruct the jury that it could not consider Dr. Nelson's negligence:

> MR. COOKE: I'll mark them. And finally, Your Honor, we would just ask the court to direct the – the jury that they are to consider only Donna Embrey's

> alleged negligence, and not the negligence of anybody else consistent with the court's granting of a partial directed verdict.
>
> THE COURT: No, I'm not going to do that. Okay. Okay. . . .
>
> I had initially proposed bringing the jury back and telling them as a matter of law, that the only person -- the only agent that they should consider committing medical malpractice would be the nurse, not the doctor. But I understand the plaintiff does not want that, is that correct?
>
> MR. RANSOM: That's correct. . . .
>
> THE COURT: All right. I'm not going to do that.

(*See* R., at p. 1638:12-19, 1646:3-9 & 17-18).

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

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

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

(*See* R. p. 1613:19-22). In other words, even after the grant of a partial directed verdict, Plaintiff was allowed to argue that Dr. Nelson was to blame.

Plaintiff was permitted to elicit substantial expert and fact testimony at trial about Dr. Nelson. The trial judge did not prevent Plaintiff from presenting evidence regarding Dr. Nelson. In fact, Dr. Nelson's name was mentioned during testimony before the jury more than 150 times. Plaintiff presented evidence seeking to convince the jury that Dr. Nelson breached a duty of care to Mr. Mikell (though it was insufficient to justify submission to the jury). The trial court did not direct the verdict until *after* the close of *all* evidence. (*See* R. p. 1472:13-21). As a result, Plaintiff was never once hampered in his ability to present evidence concerning Dr. Nelson's alleged negligence.

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

B. <u>The Court Should Grant a Rehearing in This Matter, Because It Erred in Reversing the Entry of a Partial Directed Verdict in Favor of MUSC.</u>

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

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

See Brouwer v. Sisters of Charity Providence Hosps., 409 S.C. 514, 521, 763 S.E.2d 200, 203 (2014). "South Carolina does not recognize the doctrine of *res ipsa loquitur*," so Plaintiff must

prove how Dr. Nelson deviated from the standard of care. *See Fletcher v. Med. Univ. of S.C.*, 390 S.C. 458, 463, 702 S.E.2d 372, 374 (Ct. App. 2010). A physician is not an insurer or guarantor of a beneficial result. *Banks v. Medical Univ.*, 314 S.C. 376, 444 S.E.2d 519 (1994).

"[T]he general rule is that expert testimony is required in a malpractice case to show that the defendant failed to conform to the required standard, which is, such reasonable and ordinary knowledge, skill and diligence as physicians in similar neighborhoods and surroundings ordinarily use under like circumstances." *See Cox v. Lund*, 286 S.C. 410, 416, 334 S.E.2d 116, 120 (1985) (citation omitted). "The standard of care in a medical malpractice action concerns both the physician's skill and the physician's professional learning. . . . A physician is only bound to possess and exercise that degree of skill and learning that is ordinarily possessed and exercised by members of his profession in good standing acting in the same or similar circumstances." *See Durham v. Vinson*, 360 S.C. 639, 650–51, 602 S.E.2d 760, 765–66 (2004) (citation omitted).

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

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

Dr. Kofke, Plaintiff's expert, recognized that a physician could rely upon a CRNA and did not have to be in the room at all times. (*See* R. pp. 818:6-819:12). Dr. Kofke further testified that it is acceptable for the attending physician to be up to two minutes away from the operating room and that being directly across the hall was certainly appropriate. (*See* R. pp. 819:13-820:3).

Dr. Nelson testified that: "At the time I stepped out of the room, his vital signs were stable. He was in the hands of an experienced nurse anesthetist, and I was very close by." (*See* R. pp. 1361:25-1362:9). He further testified that he was easily reachable — either by pager or yelling for him across the hall in a small area, given the close proximity — in the event of an emergency. (*See* R. pp. 1350:4-1351:5 (emphasis added)). Dr. Nelson further testified that his supervisory role did not require that he be present in the room at all times. (*See* R. p. 1349:13-24). Dr. Nelson testified that his practice was to be with the patients at various times during their procedures, but not the entire time. (*See* R. pp. 1372:19-1373:10).

Nurse Embrey testified in detail at trial that she "[a]bsolutely" felt "comfortable" while Dr. Nelson was out of the room, that he was readily available and that he was there "almost immediately" when she called him for help. (*See* R. pp. 1051:15-1053:11 (emphasis added)). She further testified that Dr. Nelson created a plan for the treatment of Mr. Mikell, to which she agreed. (*See* R. p. 973:2-23). Nurse Embrey also testified that, even with 20/20 hindsight, she believes that the plan implemented for Mr. Mikell was appropriate. (*See* R. pp. 1058:2-1059:3). Dr. Nelson testified in detail about his treatment of Mr. Mikell and confirmed that he formulated a plan for Mr. Mikell's anesthesia, which he communicated to Mr. Mikell and Nurse Embrey. (*See* R. pp. 1328:17-1332:15). Plaintiff cannot direct the Court to any evidence that Dr. Nelson did not properly supervise this procedure.

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

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

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

See S.C. Reg. Code R. 61-16 § 1212(A)(4) (emphasis added). Under South Carolina Nurse Practices Act, Nurse Embrey was indisputably qualified as a CRNA and could work under Dr. Nelson's supervision. *See* S.C. Code § 40-33-20(20). Under the statute, supervision means "the process of critically observing, directing, and evaluating another's performance." *See* S.C. Code § 40-33-20(57).

In light of the foregoing, because it is undisputed that Dr. Nelson was immediately available to Nurse Embrey, he did not breach a standard of care by momentarily leaving Mr. Mikell's procedure room.

2. <u>This Court Erroneously Concluded That Plaintiff Had Created a Jury Question As to the Mr. Mikell's Blood Oxygen Saturation Levels When Dr. Nelson Left the Room.</u>

The Court's Opinion concludes that jury issues existed as to what Mr. Mikell's blood oxygen saturation levels were when Dr. Nelson left the procedure room:

> There is a question of fact regarding whether Dr. Nelson left the room at 7:50 A.M. — when the Picis Record showed Mikell's saturation level was 69.2 — or at 7:51 A.M. — when the Picis Record showed Mikell's saturation level was 90.1. There is also a question of fact regarding how long Dr. Nelson stayed out of the room despite Mikell's tenuous condition—one version of the Picis Record indicates Dr. Nelson returned to the room at 7:56 A.M. while another version indicates he returned at 8:00 A.M.

(*See* Opin., at 10). For the reasons that follow, this Court erred in reaching this decision. As a result, it should grant MUSC's Petition for Rehearing.

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

<u>Time</u>	<u>SpO2 (%)</u>
7:48	96.7
7:49	76

7:50	69.2
7:51	90.1
7:52	80.7
7:53	88.0
7:54	73.3
7:55	62.1
7:56	75.0
7:57	41.2
7:58	47.5
8:00	67.6
8:01	88.1
8:02	88.4
8:03	96.4
8:04	88.3
8:05	19.9

(*See* R. pp. 218-20). There are several minutes for which data was not recorded. (*See* R. p. 920:5-9). However, data was displayed to in constant real time.

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

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

(*See* R. pp. 1393:19-1394:11 (emphasis added); *accord* R. pp. 1347:3-1348:22). This is consistent with Nurse Embrey's testimony that Mr. Mikell's saturation levels were acceptable

when Dr. Nelson briefly left the room at 7:51. (*See* R. pp. 1066:13-1067:11 (testifying that Mr. Mikell's sat levels had "absolutely" "improved to 90.1 percent" before Dr. Nelson left room)).

Plaintiff argues that the audit trail for the anesthesia records shows that the entry for when Dr. Nelson left the room "was originally created by Nurse Embrey to show the time as 7:50, but she later changed it to 7:51." (*See* Pl.'s Br., at 29). Plaintiff argues that this is important because Mr. Mikell's blood oxygen saturation level was only 69.2% in the 7:50 PICIS one-minute interval entry. From this, Plaintiff infers that Dr. Nelson left the room while Mr. Mikell's blood oxygen saturation levels were too low. However, the record does not support Plaintiff's argument.

First, irrespective of whether Nurse Embrey corrected entries, there is no evidence that she did so incorrectly or that Dr. Nelson actually left the room at 7:50 rather than 7:51. There is no evidence disputing that, at the time Dr. Nelson left the room, Mr. Mikell's blood oxygen saturation levels were at 90% or higher. Plaintiff speculates, without support, that Dr. Nelson left the room when Mr. Mikell's blood oxygen saturation levels were below 70%, presuming that he left at precisely the same time as the interval recording for 7:50. There is nothing to support such conjecture.

Aside from what is stated in the actual PICIS record, other incontrovertible evidence shows that Dr. Nelson was in the room at key junctures of the procedure. The evidence established without dispute that Dr. Nelson was in the room at 7:49, because he made an entry then in the record that was listed on the audit trail. (*See* R. p. 249). The timestamp for this entry was created automatically, and thus was not subject to human error or interpretation. Moreover, Dr. Nelson's presence in the room at 7:51 is corroborated by the fact that the dosage of Propofol was reduced at that time, while Dr. Nelson was assisting to place a nasal airway:

> Q. And so what does that record show with regard to the administration of Propofol?

A. It shows that the Propofol was started at 7:41. And at 7:51, the dose was decreased from 75 to 50.

Q. All right. In your opinion, was that appropriate to reduce the dose based on what was happening at that time?

A. Yes, it was. Because that would be right around the time that *we* put the nasal airway in, and it seemed like he was having a little trouble breathing.

(*See* R. p. 1361:10-20 (emphasis added)). Dr. Nelson returned to the room by 7:56, based upon Mr. Mikell's peak inspiratory pressure numbers, which increased because Dr. Nelson "bagged" him. (*See* R. pp. 1352:4-1354:23). Plaintiff presented no evidence that Dr. Nelson left the room before 7:51 (or that he did not return by 7:56). Plaintiff presents no evidence that any change to the record was inaccurate; to the contrary, Nurse Embrey testified that she only changed the record to ensure it was accurate. (*See* R. pp. 1015:19-1016:1).

Even if Plaintiff proffered evidence that Dr. Nelson left the room at 7:50 when Mr. Mikell's saturation levels were below 70%, it is undisputed that at 7:51 the level increased to 90.1% and was in the 80s in the following minutes. In other words, even if Dr. Nelson left when the blood oxygen saturation levels were low, the following minute they had increased to an acceptable level. So, had Dr. Nelson stayed in the room, he would have been justified in leaving the room at 7:51.

For the foregoing reasons, Plaintiff did not present any evidence disputing that when Dr. Nelson left Mr. Mikell's procedure room his blood oxygen saturation levels were appropriate and stable. Therefore, the trial judge properly entered a partial directed verdict.

C. <u>The Court's Opinion Incorrectly Finds a Jury Issue as to Proximate Cause.</u>

In its Opinion, the Court concluded that there was sufficient record evidence to support a jury's finding of proximate cause as to Dr. Nelson's alleged negligence:

> [Plaintiff's expert Dr. Kofke testified] that when Mikell's saturation levels began to drop into the eighties, if Nurse Embrey and Dr. Nelson would have (1) been in the room attending to Mikell and (2) begun supporting Mikell's airway, Mikell likely would not have gone into cardiac arrest or ended up in critical care. Dr. Kofke indicated Mikell was a large man and it would have been difficult for Nurse Embrey to support his airway by herself. Although a breathing tube was

> ultimately inserted, Dr. Kofke opined that minutes or seconds are important in responding to a patient that stops breathing or whose heart stops functioning properly.

(*See* Pl.'s Opin., at 12). For the reasons that follow, the Court should grant rehearing on this issue and affirm the trial judge's grant of a partial directed verdict.

"As in any negligence action, the plaintiff in a medical malpractice action must establish proximate cause." *Bramlette v. Charter-Med.-Columbia*, 302 S.C. 68, 72, 393 S.E.2d 914, 916 (1990). "A negligent act or omission is a proximate cause of injury if, in a natural and continuous sequence of events, it produces the injury, and without it, the injury would not have occurred." *See Hurd v. Williamsburg County*, 353 S.C. 596, 579 S.E.2d 136, 144 (Ct. App. 2003). Proximate cause requires that the harm be foreseeable at the time of the alleged breach. *See Parks v. Characters Night Club*, 345 S.C. 484, 491, 548 S.E.2d 605, 609 (Ct. App. 2001) (emphasis added). "'When one relies solely upon the opinion of medical experts to establish a causal connection between the alleged negligence and the injury, the experts must, with reasonable certainty, state that in their professional opinion, the injuries complained of most probably resulted from the defendant's negligence.'" *Jamison v. Hilton*, 413 S.C. 133, 141, 775 S.E.2d 58, 62 (Ct. App. 2015) (citations omitted).

"[E]xpert testimony as to proximate cause must provide a significant causal link between the alleged negligence and the injuries suffered, rather than a tenuous and hypothetical connection." *Martasin v. Hilton Head Health Sys., L.P.*, 364 S.C. 430, 438, 613 S.E.2d 795, 800 (Ct. App. 2005). It is not enough "for the expert to testify merely that the ailment might or could have resulted from the alleged cause." *See id.* Speculation or conjecture is insufficient. *See Harris Teeter, Inc. v. Moore & VanAllen, P.C.*, 390 S.C. 275, 289-90, 701 S.E.2d 742, 749 (2010). "[A] medical malpractice plaintiff who relies upon expert testimony must introduce evidence that the defendant's negligence *most probably* resulted in the injuries alleged." *Sherer v. James*, 290 S.C. 404, 407, 351 S.E.2d 148, 150 (1986).

Dr. Kofke's only testimony about causation relating to Dr. Nelson was that "I think that the two of them could have made sure that the airway was -- was patent. It's a word we use.

And then he -- he could have managed the airway while she managed the electronic record." (*See* R. p. 780:14-22). However, there is no evidence that Nurse Embrey was ever physically unable to establish a patent airway. Plaintiff did not present any evidence that Dr. Nelson's absence from the room prevented a proper response to Mr. Mikell's condition. Dr. Kofke did not provide any testimony of proximate cause beyond this "tenuous and hypothetical connection." Dr. Kofke simply assumes that, had a physician been present in the room, Plaintiff's result would have changed. Beyond Dr. Kofke's *ipse dixit* there is no evidence supporting such a conclusion.

There is no evidence that Nurse Embrey was unqualified or unable to respond to Mr. Mikell's problems in the room. There is no evidence that she was physically incapable of providing proper care to Mr. Mikell. There is no evidence that Nurse Embrey did not know how to respond to Mr. Mikell's problems. There is no evidence that Nurse Embrey failed in an effort to respond to Mr. Mikell's arrest because Dr. Nelson was not in the room. There is no evidence that Dr. Nelson was unavailable to assist Nurse Embrey should she encounter any problems. There is no evidence that, had Dr. Nelson been in the room (rather than right across the hall within earshot) the result would have been any different. Plaintiff's claims of causation are mere conjecture and speculation, without any specific supporting evidence. Without evidence specifically showing that Dr. Nelson's presence in the room would have actually most probably made a difference, Plaintiff's claims must fail. *See Melton v. Medtronic, Inc.*, 389 S.C. 641, 659-60, 698 S.E.2d 886, 895-96 (Ct. App. 2010) ("Melton failed to present evidence showing that, had Dr. Feldman employed different selection criteria, either (1) it would have led her to choose a different ICD, or (2) that a different ICD would not have caused him the same or similar problems."). Plaintiff's causation argument is mere speculation.

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

D. <u>This Court Should Grant a Rehearing Because Plaintiff Did Not Timely Assert Dr. Nelson's Negligence as a Basis for Recovery.</u>

The Court of Appeals' reversal of the trial court's direction of a verdict as to Dr. Nelson's alleged negligence is ironic because Plaintiff's claims as to him were purely an afterthought that the trial court could have excluded as untimely. MUSC has argued that the trial judge properly entered judgment on Plaintiff's claims relating to Dr. Nelson's conduct because Plaintiff and his expert waited too long to assert such negligence. Neither Plaintiff's original Complaint nor his Amended Complaint alleged negligence by any particular person, let alone that Dr. Nelson was negligent because of his absence from the room at critical times. (*See* R. pp. 72-83). Dr. Kofke's January 17, 2013 Affidavit does not allege any negligence by Dr. Nelson. (*See* R. pp. 77-78). Plaintiff's Second Amended Complaint (filed *less than two months before trial*) still does not specifically reference Dr. Nelson, though it does make general allegations of negligence "in leaving the colonoscopy procedure room to attend to other patients at a time when Mr. Mikell's condition was unstable." (*See* R. p. 55 ¶ 6(i)). As a result, the Plaintiff did not timely allege or raise the professional negligence of Dr. Nelson as a basis for recovery. Therefore, the trial judge did not err in granting partial directed verdict to MUSC.

CONCLUSION

For the foregoing reasons, the Court should grant partial rehearing in this matter, limited to its reversal of the grant of a directed verdict to MUSC as to claims of professional negligence by Dr. Nelson. In all other respects, the Opinion should remain in full force and effect.

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May 20, 2020

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

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

J.C. Nicholson, Jr., Circuit Court Judge

Appellate Case No. 2016-001986

Shon Turner, as Personal Representative of the Estate of Charles Mikell, Deceased.....Appellant

v.

The Medical University of South Carolina.....Respondent

PROOF OF SERVICE

I certify that I have served the Respondent The Medical University of South Carolina's Petition for Rehearing on the above-referenced Appellant by depositing a copy of it in the United States Mail, postage prepaid, on May 20, 2020, addressed to his attorneys of record:

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REPLY TO SOUTH CAROLINA OFFICE

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May 20, 2020

VIA FEDERAL EXPRESS
Honorable Jenny Abbott Kitchings
S.C. Court of Appeals
P.O. Box 11629
Columbia, SC 29211

RE: Shon Turner v. MUSC
Appellate Case No.: 2016-001986

Dear Ms. Kitchings:

Please find enclosed for filing Respondent The Medical University of South Carolina's Petition for Rehearing along with a check for $50.00 for the filing fee. Pursuant to the March 20, 2020 Order of the South Carolina Supreme Court, we are sending only one unbound original to the Court for filing.

As indicated in the enclosed Proof of Service, we are also serving a copy of the Petition for Rehearing on counsel for the Respondent.

Very truly yours,

John W. Fletcher

JWF/jgc
Enclosures

cc: Rob Ransom, Esquire
Alex Apostolou, Esquire

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FAX

REPLY TO SOUTH CAROLINA OFFICE

John W. Fletcher, Esq.
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TO:	THE HONORABLE JENNY ABBOTT KITCHINGS, CLERK OF COURT
FAX NUMBER:	1-803-734-1839
FROM:	**JOHN W. FLETCHER, ESQUIRE**
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DATE:	MAY 20, 2020
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Message to Addressee:

Enclosed for filing, please find Respondent's Petition for Rehearing and Proof of Service in the above-referenced matter. The original documents, along with our firm check in the amount of $50.00, is also being sent to the Court via FedEx overnight delivery.

If you had a problem receiving this FAX transmission, please call the sender at 843.577.7700.