THE STATE OF SOUTH CAROLINA
In the Court of Appeals

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

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

Appellate Case No. 2016-002326

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

v.

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

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APPELLANT'S RETURN TO RESPONDENT'S PETITION FOR REHEARING

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Petitions for rehearing are governed by Rule 221, SCACR: "A petition for rehearing shall . . . state with particularity the points supposed to have been overlooked or misapprehended by the court." The general approach of MUSC's petition is to re-raise every disputed fact not directly addressed in the court's opinion and re-make every argument not explicitly rejected by the court's opinion.

1. Harmless Error

The Appellant addressed MUSC's argument concerning harmless error in the Appellant's Final Reply Brief at pages 15 and 16.

On the whole, MUSC's harmless error argument is illogical. If the relief sought by MUSC's serial motions for directed verdict and partial summary judgment made no difference to the outcome of the trial, why was so much time and energy expended in repeatedly moving the trial court to end the Appellant's claims of physician negligence?

The trial court's error in granting MUSC's motion for partial summary judgment at the close of the evidence was not harmless. The petition claims "[t]he trial judge never said or did anything to prohibit Plaintiff from arguing to the jury that Dr. Nelson was himself negligent." Petition at page 7. This is inaccurate.

First, by virtue of its granting MUSC's motion, the trial court refused the Appellant's requested jury instructions about Dr. Nelson's obligation to supervise the anesthesia provided to Mr. Mikell:

> THE COURT: . . . I just have a real difficulty in figuring out what Dr. Nelson did wrong to be honest with you. I'm going to grant the motion. Thank you very much. Now, **that changes this [jury] charge somewhat**, as far as a request for charge. . . .

RA, p. 1507, lines 6-11 (emphasis added). The trial court's erroneous ruling left the jury without the guidance of important standards to which Dr. Nelson's conduct was to be compared. A trial court is required to charge the current and correct law. Ross v. Paddy, 340 S.C. 428, 532 S.E.2d

612 (2000). Ordinarily, the trial court has a duty to give requested instructions that correctly state the law applicable to the issues and evidence. Id. Where a request to charge is timely made and involves a controlling legal principle, a refusal by the trial judge to charge the request constitutes reversible error. Id. Moreover, when general instructions to the jury are insufficient to enable the jury to understand fully the law of the case and issues involved, a refusal to give a requested charge is reversible error. Id.

Second, the Appellant's closing argument to the jury was affected. *See*, RA, p. 1508, lines 10-19. This should not be considered harmless. *See, e.g.*, State v. Mouzon, 326 S.C. 199, 485 S.E.2d 918 (1997). MUSC seems to suggest the Plaintiff was free to argue physician negligence to the jury because the trial court's ruling ostensibly did nothing more than limit any verdict to the amount of the non-physician cap. While it may be true Plaintiff's counsel was free from fear of contempt and could argue whatever he liked to the jury, why would trial counsel spend time arguing physician liability to the jury when the trial court had ruled no such liability exists? Counting the number of times counsel uttered Dr. Nelson's name is not the answer.

A review of the record below reveals defense counsel first described the motion to the trial court as one "for partial summary judgment as to any negligence on the part of a licensed physician," RA, p. 1472, lines 16-18. The motion was later described by defense counsel as "a motion for a partial directed verdict as to Dr. Nelson." RA, p. 1490, lines 8-10. The motion was not postured to impose a non-physician cap on a potential verdict against Nurse Embry. Followed to its logical conclusion, MUSC's argument leads to an absurd result: the jury was authorized to render a verdict based upon Dr. Nelson's conduct, but MUSC was entitled to have the verdict limited to the amount of the non-physician cap.

2. Evidence of Physician Negligence

The Appellant addressed the evidence of physician negligence in the Appellant's Final Brief at pp. 20-35.

MUSC focuses (as did the trial court) on Dr. Kofke's testimony in isolation, to the exclusion of other evidence bearing upon the standard of care. In reversing the trial court, this Court properly considered all of the evidence. *See*, Opinion at pages 3 and 4. Nothing was overlooked or misapprehended.

a. supervision of multiple CRNAs

MUSC continues to stress Dr. Kofke's testimony about the level of CRNA supervision at his hospital in Philadelphia:

> Q: In your practice, if you had CRNAs under you, you would be able to supervise up to four at one time; correct?
>
> A: Yes, that's a lot in my hospital.

RA, p. 818, lines 10-13.

> Q: So being directly across the hall from — from the room would be acceptable generally?
>
> A: Oh, oh, yes.

RA, p. 820, lines 1- 3. It is important to note, however, that Dr. Kofke testified more on this subject later during his cross-examination:

> Q: Now, didn't you say a little while ago that — that exactly what you would expect for the attending anesthesiologist to do would be to be in the room, and then that when the sats are up to an acceptable level in the 90s, that it's okay for him to leave the room and rely on the CRNA to monitor the patient and to call him if he's needed?
>
> A: As a general concept, yes. <u>But in this case</u>, the sats have been running in the 80s for most of the record. . . .

RA, p. 842, lines 13-22 (emphasis added).

First, Dr. Kofke's whole testimony falls short of establishing the rule being advanced by MUSC. Dr. Kofke did <u>not</u> say that a 4:1 ratio was the standard of care at his hospital, nor at MUSC; instead, he said it was "a lot." Nowhere did Dr. Kofke say being "across the hall" was acceptable in Mr. Mikell's case. To the contrary, he rejected that very proposition when it was

suggested by defense counsel. According to Dr. Kofke, the 4:1 ratio does not apply to a patient whose oxygen saturation levels "have been running in the 80s for most of the record."

Second, Dr. Nelson himself testified he should remain in the room with Mr. Mikell unless his oxygen saturations were consistently in the 90s, RA, p. 1394, lines 7-11; and that something more than a nasal airway was needed if the saturations were below 90, RA, p. 1348, line 8 to p. 1349, line 2. Nurse Embry testified to that effect as well, RA, p. 1062, line 17 to p. 1063, line 18. So none of the testimony supports MUSC's position on the ratio-of-supervision issue.

b. Dr. Nelson's availability

MUSC contends the only reasonable inference from all of the evidence is that Dr. Nelson was immediately available at all times, thereby fully discharging his only duty of care as a matter of law. The truth of the matter is that Dr. Nelson was absent when his presence was most needed. The original, unaltered entries in the anesthesia record show that Mr. Mikell's condition became perilous at 7:49 a.m. but Dr. Nelson left the room and did not return until 8:00 a.m., at which point Mr. Mikell's fate had already been sealed. The alleged facts recited in the petition are anything but uncontroverted. This Court did not misapprehend anything in its assessment of the record.

MUSC points to Nurse Embry's self-serving testimony about feeling comfortable in a needlessly unsafe situation. The Crocodile Hunter felt safe swimming in open water with a giant stingray — right up until the moment the stingray's tail spike stabbed him in the chest and killed him. Deliberately anesthetizing a patient with Mr. Mikell's co-morbidities while simultaneously dealing with text messages and phone calls to fix an entirely avoidable computer glitch was a bad idea whether Nurse Embry felt safe doing it or not. That conduct started Mr. Mikell on his way down the Matterhorn. Dr. Nelson then left the room for no good reason — why did he need to go check on another patient? — as Mr. Mikell descended into Death Valley.

MUSC's reliance on Nurse Embry's comfort also overlooks her very serious credibility

problems. She altered Dr. Nelson's entries in the anesthesia chart without his knowledge and gave 100% false testimony about the Mayday record and the PICIS software glitch. The jury was entitled to give her testimony about her comfort with Dr. Nelson's whereabouts and conduct no weight whatsoever.

The jury was entitled to find Dr. Nelson failed to properly discharge his duty of supervision when he allowed Mr. Mikell's case to commence in the face of risks (PICIS not checked-out, CRNA distracted by glitch) that were both completely avoidable and part of his responsibility:

> A. Uh-huh. I'm ultimately responsible for the — making sure the equipment works, yes.
> Q. Your — this is your responsibility?
> A Yes.
> Q. And part of your responsibility in making sure that the equipment works is — is making sure that all of the information is being accurately recorded in the record?
> A. Yes.

RA, p. 1390, lines 6-14. Imagine if Dr. Nelson had said, "Don't knock Mr. Mikell out until everything is ready to go." Delegating authority is not the same as abdicating responsibility. The jury was also entitled to find Dr. Nelson failed to follow his own patient safety rules when he left the room while Mr. Mikell was unstable.

None of these issues were overlooked or misapprehended by the court in reversing the trial court's ruling.

c. the anesthesia record

First, MUSC relies upon entries in the anesthesia record that were altered by Nurse Embry without Dr. Nelson's knowledge or approval. RA, p. 1376, line 3 to p. 1378, line 11. The Appellant was entitled to have the jury assess the weight of those entries in light of the circumstances of their creation. Second, the oxygen saturation values set forth in the petition are nowhere consistently in the 90s. The extent anesthesia data simply does not compel one to

conclude that Mr. Mikell was stable as a matter of law. Third, Dr. Kofke offered several observations about the overall accuracy of the anesthesia chart including, "[N]one of their records agree with each other, even though they're electronic," RA, p. 838, lines 17-18; "I just don't believe the times on this record." RA, p. 839, lines 6-7; and "I don't trust — I just don't know what to make of the — any of the times." RA, p.840, lines 15-16. The reason, of course, is because the times were reverse engineered by Nurse Embry after-the-fact.

During the time Dr. Nelson documented himself being out of the room (7:50 a.m. to 8:00 a.m.), only one of the ten recorded oxygen saturation values was in the 90s. Under a directed verdict standard, this evidence withstands all efforts by Nurse Embry and Dr. Nelson to dispute it. A conflict in the evidence requires submitting the case to the jury.

MUSC contends there is no evidence Nurse Embry's alteration of the anesthesia record did anything except make it more accurate. That argument simply ignores Dr. Kofke's testimony, the missing Mayday record, and the false testimony from both Nurse Embry and Dr. Gulden that there never was any Mayday record in the first place, even though Nurse Embry later claimed to have used the Mayday record to reconstruct what she alone says really happened. Given these credibility problems, coupled with Nurse Embry's inconsistent testimony about the computer glitch, the jury could refuse to credit Nurse Embry's claim that her unauthorized alterations to the anesthesia chart simply made it more accurate. According to Dr. Kofke, her remanufactured chart was "goofy," not accurate. RA, p. 845, line 12.

Although there may be evidence that the administration of propofol was reduced at some point, Dr. Kofke testified the anesthesia chart did not clearly identify when this occurred. RA, p. 837, line 13 to p. 839, line 19. The petition does not recount any testimony that the propofol was adjusted by Dr. Nelson. So evidence of a reduction in the flow of propofol is not evidence that Dr. Nelson was present in the room at any specific time. If the argument is that the propofol was reduced, therefore Dr. Nelson must have been in the room, it is a complete *non sequitur*.

MUSC points to the peak inspiratory pressures (PIP) recorded in the anesthesia chart, contending this data is incontrovertible evidence that Dr. Nelson was in the room at 7:55 or 7:56 a.m. The PIP values were discussed at length during Dr. Kofke's cross-examination (RA, p. 851, line 10 *et seq*.) He noted the PIP values are inconsistent with the oxygen flow rate (FI02) values — "Why would you be giving someone in this situation 25 percent oxygen?" (RA, p. 853, lines 10-11) — and on the whole Dr. Kofke believed the PIP values represented inadequate ventilation, RA, p. 853, lines 19-23, thereby supporting the Appellant's theory of the case. If the argument is that the PIP values mean Dr. Nelson was in the room ventilating Mr. Mikell, that too is a *non sequitu*r.

In short, the propofol and PIP issues by themselves are not conclusive evidence that Dr. Nelson was in the room or that the bag valve mask was being used to adequately ventilate Mr. Mikell at some specifically identifiable moment. The jury would certainly not have been required to reach only those conclusions. The court did not misapprehend this issue.

3. Proximate Cause

MUSC claims there is "no evidence that Nurse Embry was ever physically unable to establish a patent airway." Petition at page 16. Although the evidence for this is largely circumstantial, the conclusion that Nurse Embry was unable to establish a patent airway springs from undeniable facts: her patient went into cardiac arrest as the result of a failed airway. If she were able to manage Mr. Mikell's airway all by herself, then why didn't she? Why did Mr. Mikell's airway obstruct? Why wasn't the obstruction cleared using the chin-and-jaw maneuvers described by Dr. Kofke? Why did Mr. Mikell continue to desaturate after the nasal airway was placed? Why did Mr. Mikell become hypoxic and go into cardiac arrest? Why was it necessary for Dr. Nelson to come back into the room before Mr. Mikell was resuscitated and intubated? None of these questions would have any meaning unless Nurse Embry had been unable to establish a patent airway by herself.

4. Alleged Failure to Timely Assert Dr. Nelson's Negligence.

The pleadings (RA, pp. 72-75 and 80-81) allege a variety of delicts by the "actual and apparent agents, servants, and employees" of MUSC which, under the Tort Claims Act, was the only proper party to the case. There was never any secret that several of the alleged negligent acts were attributable to Dr. Nelson. MUSC seems to argue that it never had proper notice the case involved claims arising out of Dr. Nelson's conduct. That is completely false, but even if it were true, MUSC has no one to blame but itself.

Respectfully submitted

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PROOF OF SERVICE

The undersigned certifies that the Appellant's Return to Respondent's Petition for Rehearing has been served upon counsel for the Respondent by emailing a copy of it to John William Fletcher, Esq. at jfletcher@barnwell-whaley.com on June 1, 2020.

June 1, 2020

By: S Robert B. Ransom

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Subject: **Turner v MUSC -- Appellant's Return to Respondent's Petition for Rehearing**
Date: 6/1/2020 12:41:16 PM Eastern Standard Time
From: bertcone@aol.com
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John,

Attached is my letter to the Court of Appeals along with the Appellant's Return to respondent's Petition for Rehearing, which are being served by email pursuant to Paragraph (g)(3) of the South Carolina Supreme Court's May 29, 2020 Amended Order Re: Operation of the Appellate Courts During the Coronavirus Emergency.

Best regards,

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