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S.C. SUPREME COURT

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 WRIT OF CERTIORARI

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CERTIFICATE PURSUANT TO RULE 242(d)(1)

Counsel for Petitioner certifies, pursuant to Rule 242(d)(1), S.C.R.A.P., that it filed a petition for rehearing in the South Carolina Court of Appeals in this matter. The South Carolina Court of Appeals finally ruled upon and denied that petition on August 13, 2020. As a result, MUSC has timely filed this Petition.

QUESTIONS PRESENTED

The questions presented for review in this Petition are as follows:

1. Did the Court of Appeals err in failing to consider, let alone apply, the harmless error rule when the trial court's grant of a partial directed verdict affected the outcome of the case?

2. Did the Court of Appeals err in reversing the trial court's partial directed verdict when all of the evidence showed that Dr. Nelson had acted within the generally accepted standard of care for an anesthesiologist supervising a nurse anesthetist?

3. Did the Court of Appeals err in reversing the trial court's partial directed verdict where Plaintiff presented no evidence showing that the alleged negligence of Dr. Nelson proximately caused any injury?

4. Did the Court of Appeals err in reversing the trial court's partial directed verdict where Plaintiff did not timely plead or raise Dr. Nelson's alleged negligence as a basis for recovery?

STATEMENT OF JURISDICTION

This Court has jurisdiction over the questions raised in Petitioner's Petition for Certiorari pursuant to Article V, § 5 of the South Carolina Constitution and S.C. Code §§ 14-3-310 & -330.

STATEMENT OF THE CASE[1]

A. Introduction and Factual Background

Plaintiff Shon Turner ("Plaintiff"), as Personal Representative of the Estate of Charles Mikell ("Mr. Mikell"), asserts 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.

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). Those 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 be reached if needed. (*See*

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[1] "In cases seeking review of a decision of the Court of Appeals, Rule 242, SCACR, requires the petitioner to file two copies of an Appendix. This requirement is suspended. Instead, the necessary documents to comprise the Appendix will be obtained from the electronic records of the case before the Court of Appeals." (*See* Order Re: Operation of the Appellate Courts During the Coronavirus Emergency (As Amended May 29, 2020) ¶ (e)). All citations herein shall be to the Record on Appeal filed with the South Carolina Court of Appeals in this matter.

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 own 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 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.

B. Procedural History

The case was tried in April, 2016, resulting in a jury verdict in favor of MUSC. Before the verdict, the trial judge granted MUSC a partial directed verdict as to claims that Dr. Nelson committed 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).

On May 6, 2020, the Court of Appeals filed a published Opinion ("Opinion") affirming in part and reversing in part.[2] *See Turner v. Medical Univ. of S.C.*, 846 S.E.2d 1 (S.C. Ct. App. 2020), reh'g denied (Aug. 13, 2020). Of relevance to this Petition, the Opinion reversed the partial directed verdict as to Plaintiff's claims of professional negligence by Dr. Nelson. Specifically, the court held that there was evidence that Dr. Nelson breached a duty of care because he "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 id.*, 846 S.E.2d at 9). Additionally, the Court of Appeals held that evidence supported that Dr. Nelson's negligence proximately caused Mr. Mikell's injuries. (*See id.* at 10-11).

MUSC filed a Petition for Rehearing. The Court of Appeals denied MUSC's Petition for Rehearing on August 13, 2020. For the following reasons, this Court should grant *certiorari* and review the Court of Appeals' Opinion. Upon reconsideration, the Court should reverse and

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[2] 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.

vacate the Court of Appeals and reinstate the trial judge's grant of partial directed verdict relating to Dr. Nelson's conduct.

ARGUMENTS

It is well-settled that this Court has considerable discretion in determining whether to grant a Petition for Writ of *Certiorari*:

> A writ of certiorari is not a matter of right, but of sound judicial discretion, and will be granted only where there are special and important reasons. The following, while neither controlling nor fully measuring the Supreme Court's discretion or power to grant review in general, indicate the character of reasons which will be considered:
>
> (1) Where there are novel questions of law.
>
> (2) Where there is a dissent in the decision of the Court of Appeals.
>
> (3) *Where the decision of the Court of Appeals is in conflict with a prior decision of the Supreme Court.*
>
> (4) Where substantial constitutional issues are directly involved.
>
> (5) Where a federal question is included and the decision of the Court of Appeals conflicts with a decision of the United States Supreme Court.

See S.C.R.A.P., Rule 242(b) (emphasis added). For the following reasons, the Court should exercise its discretion to grant *certiorari* in this matter.

A. The Court of Appeals Did Not Properly Apply, or Even Consider, the Harmless Error Rule.

MUSC argued in this appeal that any alleged error by the trial judge was harmless and cannot support reversal. MUSC moved for partial directed verdict only to ensure that the court applied the proper cap on recovery under the Tort Claims Act if the jury returned a verdict for Plaintiff. The partial directed verdict did not change anything that occurred at trial or limit the jury's consideration of liability. It had no impact on the verdict itself, 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, the Court of Appeals' Opinion did not address MUSC's argument that any error was harmless. Irrespective of the

rulings on any other issues in this appeal, the Court of Appeals should have affirmed the entry of a partial directed verdict on this basis.

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).

The harmless error rule applies here. The trial judge's partial directed verdict did not affect how Plaintiff presented his case to the jury or the verdict itself. MUSC's oral motion was

only relevant to a unique question under the South Carolina Tort Claims Act. 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). MUSC made clear, and the trial court agreed, that its request for a directed verdict was concerned only with the Tort Claims Act caps: "we would also, at this time, make a motion for partial summary judgment[3] [sic] as to any negligence on the part 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 partial directed verdict "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). He further noted that the partial directed verdict "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 individual but decided the broad question of MUSC's liability for 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 that the jury was not told to disregard Dr. Nelson's alleged negligence. (*See* R. p. 1644:14-24). In fact, the jury was expressly instructed that "the doctor and nurses were agents of the principle (sic) MUSC." (*See* R. p. 1632:13-14). Moreover, Plaintiff has not argued that the trial judge refused to grant a particular jury instruction because of the partial directed verdict.

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[3] 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.

The jury instructions did not prevent the jury from considering Dr. Nelson's negligence. In fact, although MUSC requested it, the trial judge refused to tell the jury that it should 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 presented their cases. Plaintiff's opening statement (*see* R. pp. 508:25-524:5) did not name Dr. Nelson or Nurse Embrey. Plaintiff's opening statement did not state 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 focus on Dr. Nelson's alleged professional negligence in his opening.

The trial judge never prohibited Plaintiff from arguing to the jury that Dr. Nelson was negligent. Plaintiff's summation (R. pp. 1517:23-1552:9 and 1604:25-1615:10) references Dr. Nelson by name 23 times. Plaintiff's counsel specifically addressed 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 still argued 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. 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. The Court of Appeals' Opinion does not address this argument. To the contrary, the Court of Appeals presumed that the alleged error was harmless.

The harmless error rule is firmly established in South Carolina jurisprudence and is consistently applied in the decisions of this Court. The Court of Appeals did not even consider it even though it clearly applies in this case. This Court should grant *certiorari* to consider and address this controlling issue.

B. The Court Should Grant *Certiorari* Because the Court of Appeals Erred in Reversing the Partial Directed Verdict.

The Court of Appeals' Opinion also erroneously holds that that trial judge erred in granting a partial directed verdict to MUSC. The elements of a claim for medical malpractice are well-settled:

> 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).

The Court of Appeals' holding that there was sufficient evidence to submit Dr. Nelson's negligence to the jury runs directly counter to this Court's well-established professional liability jurisprudence. If allowed to stand, the Court of Appeals' decision will require almost every professional liability case to go to the jury. This Court has steadfastly required trial courts to serve an important gatekeeper function in professional liability cases, but the Court of Appeals' decision can be cited to allow any case to go to the jury based on even the most speculative evidence. And – of more concern to the medical profession than to the legal profession -- the Court of Appeals' decision might impair the normal and accepted way that anesthesiologists work with their nurse anesthetists, since juries will be permitted to find malpractice even when

an anesthesiologist has supervised the nurse anesthetists entirely within the accepted standard of care.

1. Dr. Nelson was Always Readily Available to Nurse Embrey.

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

Dr. Nelson testified: "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 he was easily reachable — either by pager or yelling for him across the hall in a small area, given the proximity — in the event of an emergency. (*See* R. pp. 1350:4-1351:5 (emphasis added)). Dr. Nelson further testified his supervisory role did not always require that he be present in the room. (*See* R. p. 1349:13-24). Dr. Nelson testified 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 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 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 she still believes that the plan 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). There is no evidence Dr. Nelson did not properly supervise Nurse Embrey.

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 testified was

acceptable. When he was out of the room, Dr. Nelson was only across the hall and within earshot of Nurse Embrey, who monitored their patient; he 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 the 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).

Considering 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 stepping out of Mr. Mikell's procedure room. The evidence cannot possibly support a claim against MUSC for Dr. Nelson's alleged absence from the 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 of Appeals' Opinion also 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 Mikell*, 846 S.E.2d at 9). For the following reasons, the Court of Appeals erred in this regard.

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

Time	**SpO2 (%)**
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 constantly displayed in real time.

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:

> 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 was corroborated by 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 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 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 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 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 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 Dr. Nelson left the room when Mr. Mikell's blood oxygen saturation levels were below 70%, assuming he left at precisely the same time as the interval recording for 7:50. There is no evidence supporting this conjecture.

Aside from the PICIS record, other incontrovertible evidence shows Dr. Nelson was in the room at key junctures. The evidence established that Dr. Nelson was in the room at 7:49, because he made an entry that was listed on the audit trail. (*See* R. p. 249). The timestamp for this entry was created automatically and was not subject to human interference. 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 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, the only evidence is Nurse Embrey's testimony that she only changed the record to ensure its accuracy. (*See* R. pp. 1015:19-1016:1).

Moreover, 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.

On the surface the foregoing analysis might appear to be specific to the unique facts of this case. To the contrary, this case presents an important legal issue because the Court of Appeals improperly curtailed the trial court's gatekeeping responsibilities in professional liability

cases by requiring submission to the jury based upon the most speculative evidence of negligence.

C. The Court of Appeals' Opinion Incorrectly Finds a Jury Issue as to Proximate Cause.

"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).

The Court of Appeals concluded that there was sufficient evidence to support proximate cause:

> [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 Mikell*, 846 S.E.2d at 10).

Dr. Kofke's only causation testimony relating to Dr. Nelson was: "I think that the two of them [Dr. Nelson and Nurse Embrey] 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, Dr. Kofke did not testify to causation beyond a "tenuous and hypothetical connection." Dr. Kofke speculates that, had a physician been present in the room, the result would have been different. Beyond his *ipse dixit* there is no evidence supporting that conclusion.

Plaintiff presented no evidence Dr. Nelson's absence from the room prevented a proper response to Mr. Mikell's condition. Plaintiff presented no evidence Nurse Embrey was unqualified or unable to respond to Mr. Mikell's issues. There is no evidence she was physically incapable of providing proper care to Mr. Mikell. There is no evidence Nurse Embrey did not know how to respond to Mr. Mikell's issues. There is no evidence Nurse Embrey failed to respond to Mr. Mikell's arrest because Dr. Nelson was not in the room. Indeed, the jury found Nurse Embry had acted within the accepted standard of care. 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 outcome would have been different. Plaintiff's claims of causation are mere conjecture and speculation. Without evidence specifically showing that Dr. Nelson's presence in the room would have most probably made an actual 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.

The Court of Appeals' decision effectively removes proximate causation as a material element of a plaintiff's proof in professional liability cases. Contrary to the searching inquiry that this Court has required in these cases, the Court of Appeals now allows a plaintiff to satisfy this important element merely by having his expert intone, without explanation, that the result would have been different if the defendant had met the required standard of care.

D. <u>This Court Should Grant *Certiorari* Because the Court of Appeals Failed to Address Plaintiff's Failure to 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 against him were an afterthought that the trial court could (and should) 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 procedure room at critical times. (*See* R. pp. 72-83). Dr. Kofke's expert 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)). Plaintiff did not timely allege or raise the professional negligence of Dr. Nelson as a separate basis for recovery. The Court of Appeals should have affirmed the grant of a partial directed verdict to MUSC. This is an important issue because this Court long ago established procedures for pleading, discovering, and trying civil cases so as to abolish trial by ambush. This is especially important in

professional liability cases because of the complexity of developing and rebutting expert testimony. In partially directing a verdict as to Dr. Nelson's personal negligence, the trial court effectively mitigated the unfairly prejudicial effects of interjecting a new theory of liability at the eleventh hour.

CONCLUSION

For the foregoing reasons, the Court should grant MUSC's Petition for Writ of *Certiorari* in this matter and agree to review the Court of Appeals' reversal of the grant of a partial directed verdict to MUSC as to claims of Dr. Nelson's alleged professional negligence. This case warrants review by this Court because the Court of Appeals' decision seriously undermines this Court's precedents requiring a plaintiff to prove deviation from generally accepted standards of care and proximate cause in professional liability cases, because the Court of Appeals disregarded the important harmless error rule, and because the jury should never have been allowed to consider Plaintiff's eleventh-hour claim that Dr. Nelson was negligent.

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