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. 2016-001986

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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FINAL REPLY BRIEF OF APPELLANT SHON TURNER

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ARGUMENT

Throughout its Brief, MUSC repeatedly claims there is "no evidence" to support any of the Appellant's arguments that jury issues were created during trial. But rarely if ever does MUSC respond directly to the very specific evidence outlined in Appellant's Brief. In the end, the best MUSC can do is to recite different evidence and to advocate alternative inferences, thereby tacitly conceding the Plaintiff's claims of physician negligence should have been submitted to the jury, because only the jury can weigh and resolve the conflicts in the evidence identified by MUSC's argument.

It is not possible within the constraints of time and space to reply to all of MUSC's many specious arguments. However, an effort is made below to address most of them in the general order in which they appear in the Respondent's Brief.

a. The anesthesia narrative

Replying upon altered entries in the anesthesia narrative, MUSC contends Dr. Nelson left the procedure room at 7:51 a.m., when Mr. Mikell's blood oxygen saturation level was at or above 90%.[1] MUSC ignores the audit trail[2] showing Nurse Embry originally entered 7:50 a.m. as the time when Dr. Nelson left the room (while Mr. Mikell's oxygen saturation level was 69.2%.) MUSC also ignores the substantial credibility issues faced by Nurse Embry.[3]

According to the standard of care established by both Nurse Embry and Dr. Nelson, it would be malpractice for Dr. Nelson to leave the room at 7:50 a.m. while his patient's blood oxygen saturation level was 69.2%. The conflicting evidence about Mr. Mikell's condition when Dr. Nelson actually left the room[4] was for the jury to decide.

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[1] Respondent's Brief at page 3

[2] Plaintiff's Exhibit 10, RA at page 252.

[3] Nurse Embry gave irreconcilably contradictory testimony about the Mayday record and the reason why the anesthesia record contained blank data boxes.

[4] Plaintiff's expert, Dr. Kofke, testified it was difficult to tell when Dr. Nelson was present in the room due to the inconsistent records and testimony on that issue. Trial Transcript at page 372, line 6 to page 374, line 2, RA at pages 776 - 778.

b. Peak inspiratory pressures

MUSC contends that the peak inspiratory pressure (PIP) values shown in the Real Time Variables section of the anesthesia record prove that Dr. Nelson re-entered the room at either 7:55 a.m. or 7:56 a.m.[5] But these automated PIP values were generated by the PICIS software, not a human being,[6] and therefore do not establish the presence of any particular person in the procedure room. The PIP values merely tend to show, if anything, that the oxygen mask attached to the anesthesia circuit was in use — but not by whom — at 7:55 a.m. or 7:56 a.m.[7]

Additionally, MUSC ignores Dr. Nelson's own entry in the anesthesia narrative showing he re-entered the room at 8:00 a.m. and ignores Nurse Embry's alteration of Dr. Nelson's entry. These discrepancies create factual issues for the jury to resolve.

As Plaintiff's counsel pointed out to the jury, if both Dr. Nelson and Nurse Embry were present and using the oxygen mask to ventilate Mr. Mikell at 7:55 a.m., then why did his blood oxygen saturation level continue to fall into the 40s?[8] One reasonable answer would be that events did not transpire as MUSC suggests. Just because PICIS recorded oxygen coming out of the mask at 7:55 a.m. or 7:56 a.m., that does not mean oxygen was going into Mr. Mikell's lungs, especially if Nurse Embry were alone in the room, struggling to adequately ventilate Mr. Mikell because of his obstructed airway.

c. Proximate cause of death

MUSC contends there is no competent evidence that Mr. Mikell suffered any lasting injury because of his cardiac arrest.[9] This is a fairly cavalier expression of Mr. Mikell's six week acute hospital stay — including a ventilator-dependent, medically-induced hypothermic coma; a

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[5] Respondent's Brief at page 4.

[6] Trial Transcript at page 448, lines 1 - 5, RA at page 852.

[7] Dr. Kofke testified about the Peak Inspiratory Pressures (PIP) and what they mean. See, Trial Transcript at page 447, line 10 to page 449, line 15, RA at pages 851 - 853.

[8] Trial Transcript at page 1124, lines 6 - 19, RA at page 1529.

[9] Respondent's Brief at page 5.

tracheostomy; and kidney hemodialysis — which one of MUSC's own cardiologists, Dr. Van Bakel, described as "quite an astounding adventure in the hospital"[10] and "an incredible journey that he went through following this cardiac arrest."[11]

MUSC further contends there is no competent evidence establishing that the cardiac arrest caused Mr. Mikell's death.[12] This contention ignores the unbroken chain of natural and continuous events leading from airway obstruction, desaturation, cardiac arrest, ICU hospitalization, rehab hospitalization, cardiac medication changes, debilitation, and fatigue to home health care, feeling poorly, inactivity, persistent coughing, and sudden cardiac death. It also ignores Dr. Kofke's testimony:

> Q So as a result of the hospitalization there at MUSC and Kindred, can you say to a reasonable degree of medical certainty whether or not the cardiac arrest and the injuries, and the hospitalization, and the treatment and the changes to his medications, most probably caused his death?
>
> * * *
>
> A I think that clearly . . . the two events, his death in early January and his cardiac arrest on October 1st, are inextricably linked.
>
> * * *
>
> Q So, let me ask again, can you say to a reasonable degree of medical certainty, that Mr. Mikell's death was most probably caused by the cardiac arrest on October 1st?
>
> * * *
>
> A. The two — the phrase you used was "medical certainty." I mean, to me, it's obvious. That's what I want to say. It's obvious that they're linked. . . . To a reasonable degree of medical certainty they are linked. . . . Obviously . . .[13]

MUSC contends Dr. Kofke's testimony is not "competent evidence,"[14] but Dr. Kofke is board certified in critical care,[15] his testimony was heard by the jury, it is contained in the record below, and its admission in evidence has not been appealed. So it is competent evidence that

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[10] Plaintiff's Exhibit 40, page 175 of 2115.

[11] Trial Transcript at page 805, line 25 to page 806, line 12, RA at pages 1209 - 1210.

[12] Respondent's Brief at page 5

[13] Trial Transcript at page 405, line 15 to page 406, line 6, RA at pages 809 - 810; page 406, lines 23 - 25, RA at page 810; page 407, lines 4 - 7, RA at page 811.

[14] Respondent's Brief at page 5.

[15] Trial Transcript at page 342, lines 4 - 25, RA at page 746.

the cardiac arrest contributed to cause Mr. Mikell's death.

As the trial court correctly charged the jury (without objection from MUSC), "Proximate cause does not mean the only cause. The defendant's act can be the proximate cause of plaintiff's injury if it was at least one of the direct concurring causes of the injury."[16]

d. Distraction by the PICIS glitch

MUSC contends there is no evidence that Nurse Embry was actually distracted from monitoring Mr. Mikell's condition.[17] This contention ignores the text messages and phone calls Nurse Embry sent and received while correcting the PICIS software glitch. How could Nurse Embry be typing and reading text messages, and talking on the phone, at the same time she was monitoring Mr. Mikel"s condition and managing his airway? Could her hands be on a keyboard and a telephone at the same time they were manipulating Mr. Mikell's jaw, or holding an oxygen mask against his face? If Nurse Embry's attention was solely focused on Mr. Mikell, then why did an obstructed airway cause him to desaturate into cardiac arrest?

The PICIS software glitch obviously distracted Nurse Embry from her at-risk patient, whose blood oxygen saturation level was fluctuating up and down from the beginning of the procedure. It was for the jury to decide what role the distraction precipitated by the software glitch played in bringing about Mr. Mikell's crisis. Given Nurse Embry's myriad credibility problems, the jury certainly was not obliged to accept her explanation *carte blanche*.

e. Inconsistent directed verdict rulings

MUSC contends that Mr. Mikell did not raise the inconsistent nature of the trial court's directed verdict rulings to the trial court so that this issue is not preserved for review.[18] This contention ignores the following language from the Plaintiff's Motion for New Trial:

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[16] Trial Transcript at page 1219, lines 20 -23, RA at page 1624; *see also*, Trial Transcript at page 1222, lines 9 - 12, RA at page 1627.

[17] Respondent's Brief at page 7.

[18] Respondent's Brief at page 8.

> At the close of the Plaintiff's case on Thursday, the court denied the Medical University's motion for directed verdict. Implicit in this ruling was a determination that there was evidence in the record sufficient to require submission of all the Plaintiff's claims to the jury, including the claims arising out of Dr. Nelson's conduct.[19]

This issue was further raised to the trial court in the Plaintiff's Reply Memorandum on Motion for New Trial.[20] Plaintiff's counsel also specifically raised the issue at the July 18, 2016 hearing on the Motion for New Trial.[21]

Mr. Mikell's position is simple and requires no recitation of legal authority to support or explain. At the close of the Plaintiff's case, MUSC moved for a directed verdict on all of the Plaintiff's claims — both wrongful death and survival — disputing the sufficiency of the evidence on both standard of care and causation.[22] The trial court found sufficient evidence had been presented to require submission of all the Plaintiff's claims — both wrongful death and survival — to the jury, on both standard of care and causation.[23] These claims included all of the various specifications of negligence alleged against MUSC's employees.[24]

Then at the close of all the evidence, MUSC moved for partial summary judgment as to the claims for physician negligence only.[25] Mr. Cooke actually made some of the same arguments which the trial court had previously rejected at the close of the Plaintiff's case.[26]

The evidence which supported denial of MUSC's first motion did not simply disappear from the record by the time of MUSC's second motion.[27] If there were sufficient evidence to require submission of all the Plaintiff's claims to the jury at the close of Plaintiff's case, then it

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[19] Plaintiff's Motion for New Trial at page 3, RA at page 8.

[20] Plaintiff's Reply Memorandum at pages 1 - 2, RA at page 36 - 37.

[21] July 18, 2016 Hearing Transcript at page 5, lines 3 - 12, RA at page 1655.

[22] Trial Transcript at page 765, lines 20 - 24, RA at page 1169.

[23] Trial Transcript at page 785, lines 11 - 14, RA at page 1189.

[24] *See*, Second Amended Complaint at ¶6, RA at pages 54 - 55.

[25] Trial Transcript at page 1067 *et seq.*, RA at page 1472.

[26] Trial Transcript at page 1069 and 1070, RA at pages 1474 - 1475.

[27] *See*, Trial Transcript at page 1074, lines 2 - 3, RA at page 1479.

necessarily follows that there was sufficient evidence to require submission of all the Plaintiff's claims to the jury at the close of the evidence. It is in this very logical sense that the trial court's rulings were hopelessly inconsistent.

In its Brief, MUSC seems to contend it did not move for a directed verdict on the claims for physician negligence at the close of the Plaintiff's case.[28] That is certainly an opportunistic characterization of the record, completely unsupported by the trial transcript. In point of fact, Mr. Cooke specifically raised the claims against Dr. Nelson in urging the trial court to grant the first directed verdict motion:

> And so — and so as to Dr. Nelson, the criticism of him was — I don't know when he was in the room, but it wasn't enough, whatever it was. That testimony is almost exactly like the testimony that was given — may have been on that very witness [sic] in Fletcher v. MUSC. . . .[29]

Which is to say, on the first motion MUSC argued that the evidence of physician negligence was insufficient under the case of Fletcher v. Medical University of South Carolina, 390 S.C. 458, 702 S.E.2d 372 (Ct. App. 2010). In responding to MUSC's first motion, Mr. Ransom specifically discussed the claims of physician negligence by Dr. Nelson:

> So it's a dispute that Mr. Cooke wants to argue to the jury, you shouldn't believe that evidence. But I think the evidence has certainly come in through Dr. Kofke, through Nurse Embry, through Dr. Reeves, and all of the evidence that we've had from these records and so forth, that the jury would certainly be entitled to reach the conclusion that both Dr. Nelson and Nurse Embry breached the standard of care. . . .[30]

In light of this exchange, it is clear that MUSC's first motion sought to end the Plaintiff's claims for physician negligence based upon Dr. Nelson's conduct. The trial court properly denied the motion.[31] That ruling cannot be reconciled with the trial court's subsequent decision to grant MUSC's second motion, finding insufficient evidence to support the very same claims

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[28] Respondent's Brief at pages 9 and 10.

[29] Trial Transcript at page 772, line 10 and continuing, RA at page 1176 and continuing.

[30] Trial Transcript at page 777, lines 4 - 11, RA at page 1181.

[31] Trial Transcript at page 785, lines 11 - 14, RA at page 1189.

later in the proceeding.

f. *Res ipse loquitur*

MUSC points out that South Carolina does not recognize the burden-shifting doctrine of *res ipse loquitur*.[32] But medical malpractice can nevertheless be proven by circumstantial evidence. *See, e.g.*, Green v. Lilliewood, 272 S.C. 186, 249 S.E.2d 910 (1978); Cox v. Lund, 286 S.C. 410, 334 S.E.2d 116 (1985). Focusing exclusively on the testimony of Plaintiff's expert, Dr. Kofke, MUSC contends there is no evidence Dr. Nelson breached any standard of care.[33]

This contention not only glosses over Dr. Kofke's testimony — he explicitly said Dr. Nelson breached the standard of care[34] — but it also ignores the evidence recited in Appellant's Brief highlighting the testimony of Dr. Nelson,[35] Nurse Embry,[36] and Dr. Reeves,[37] along with various items of documentary evidence, all of which tend to show physician negligence by Dr. Nelson.

g. Supervising multiple patients

MUSC points out the standard of care allowed Dr. Nelson to supervise up to four (4) patients and/or CRNAs at one time — subject to Dr. Nelson's own qualification that Mr. Mikell be stable with blood oxygen saturations consistently in the 90s. MUSC thus contends that it could never be a breach of the standard of care for Dr. Nelson to leave to attend other patients while Mr. Mikell was under anesthesia.[38] This contention ignores the evidence that Mr. Mikell was in a tenuous and unstable condition, with his blood oxygen saturation level already having dipped

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[32] Respondent's Brief at page 10.

[33] Respondent's Brief at page 11 *et seq*.

[34] Trial Transcript at pages 375, line 24 to page 377, page 11, RA at pages 779 - 781.

[35] Appellant's Brief at pages 26 - 28.

[36] Appellant's Brief at pages 32 - 33.

[37] Appellant's Brief at pages 33 - 35.

[38] Respondent's Brief at pages 12 - 13.

into the 60s, when Dr. Nelson left the room for as many as ten (10) minutes.[39]

Whether it was Dr. Nelson's practice to be with patients only at certain times during a procedure is immaterial when by his own testimony it would violate the standard of care to leave a patient whose blood oxygen saturation level was not "consistently in the 90s." Likewise, whether Nurse Embry "felt comfortable" about Mr. Mikell's condition is immaterial when by her own testimony the standard of care required that something be done if a patient's blood oxygen saturation level dips below 90.

Nurse Embry's self-congratulatory assessment of her own performance — "I'm very, very pleased with what we did for him, and how we reacted to him becoming unstable"[40] — was certainly not binding on the jury. If "all is well," Dr. Nelson might be permitted to leave the room, but there was evidence in the record that everything was not well: there was a glitch with the PICIS software, Mr. Mikell's airway was obstructing, and his blood oxygen saturation level was unstable.

h. Stopping the Propofol

MUSC contends Nurse Embry stopped giving the Propofol anesthetic agent to Mr. Mikell at 7:53 a.m. and Dr. Nelson returned to the procedure room "almost immediately" thereafter.[41] This contention assumes, with little evidentiary support, that the time when the Propofol was stopped was the same time when Dr. Nelson returned. One must rely exclusively on the testimony of Nurse Embry to reach this conclusion.

MUSC's contention also ignores Dr. Nelson's own entry in the anesthesia narrative, which times his return to the room at 8:00 a.m. A seven (7) minute delay — from 7:53 a.m. to 8:00 a.m. — would permit a reasonable juror to conclude that Dr. Nelson did not return to the

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[39] *See, e.g*, Dr. Nelson's own testimony at Trial Transcript page 976, RA at page 1381.

[40] Respondent's Brief at page 16. If Nurse Embry is "very, very pleased" with a level of care that left her patient in a coma, it is hard to imagine what it would take to disappoint her.

[41] Respondent's Brief at page 15.

room "immediately." This is especially significant in the context of MUSC's acknowledgment that the Propofol was stopped because Mr. Mikell was already in trouble. If Mr. Mikell were already in trouble by 7:53 a.m., then why does the PIP data not show the oxygen mask in use until 7:55 a.m. or 7:56 a.m.? Why did Dr. Nelson wait until 8:00 a.m. before returning to the room? If Nurse Embry had the situation under control, why did Mr. Mikell end up in a coma?

i. Lack of supervision

MUSC contends there is no evidence Dr. Nelson failed to properly supervise Mr. Mikell's anesthesia care and the testimony of Dr. Nelson's compliance with the standard of care was "undisputed."[42] These contentions ignore the standard of care testimony from Dr. Kofke, Nurse Embry, Dr. Reeves, and Dr. Nelson himself.

MUSC further contends it is undisputed that Dr. Nelson was immediately available at all times.[43] This contention ignores the evidence that Dr. Nelson never entered the room until 7:48 a.m., several minutes after the Propofol had been administered; so that he was not present to assist with managing Mr. Mikell's airway while Nurse Embry was attending to the PICIS software glitch. This contention also ignores the evidence that Dr. Nelson left the room as early as 7:50 a.m. — when Mr. Mikell's blood oxygen saturation level was 69.2% — and that he did not return to the room until 8:00 a.m. — when Mr. Mikell's heart was already in pulseless electrical activity.

A reasonable jury could conclude that Dr. Nelson should not have been gone from the room for over ten (10) minutes when Mr. Mikell was unstable, desaturating, and going into cardiac arrest while Nurse Embry attended to text messages and phone calls. Although Dr. Nelson testified that Mr. Mikell was stable when he left the room, there was contrary evidence which the jury was entitled to credit if it chose to do so.

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[42] Respondent's Brief at page 17.

[43] Respondent's Brief at pages 18 - 20.

j. Continuous data display

MUSC contends that because the vital signs monitors display a continuous readout of the patient's blood oxygen saturation level,[44] the jury was obliged to reject the dangerous levels actually recorded in the one-minute version of the Real Time Variables section of Mr. Mikell's anesthesia record (*e.g.*, 76.0 at 7:49 a.m.; 69.2 at 7:50 a.m.) and instead accept Nurse Embry's testimony, that other "unrecorded" vital signs data was perfectly normal; and that despite the values actually recorded, the levels were "consistently in the 90s" when Dr. Nelson left the room at 7:50 a.m. or 7:51 a.m.

This contention is simply ridiculous. Given Nurse Embry's immense credibility problems, the jury was not obliged to accept anything she said about unrecorded data, especially when a perfectly normal blood oxygen saturation level cannot explain a cardiac arrest caused by an obstructed airway.

k. Changed and altered records

MUSC contends there is no evidence Nurse Embry did anything but "correct" the entries in the anesthesia narrative[45] to accurately reflect when Dr. Nelson first left the procedure room (was it at 7:50 a.m. or 7:51 a.m.?) and later returned (was it at 7:55 a.m. or 8:00 a.m.?). This, too, is simply ridiculous, as it conveniently ignores Nurse Embry's immense credibility problems and the huge scandal about the missing Mayday record, which Nurse Embry said she relied upon in making all of her "corrections" to the anesthesia narrative.

The audit trails show Nurse Embry — who knew there would be a peer review investigation into Mr. Mikell's case — spent several hours over a two day period of time creating, modifying, and reorganizing virtually every entry in the anesthesia narrative;[46] printing

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[44] Respondent's Brief at pages 21 - 24.

[45] Respondent's Brief at pages 25 - 26.

[46] Plaintiff's Exhibit 10, RA at pages 249 - 252.

the narrative;[47] throwing away the printout; making more modifications, etc., until she had finally succeeded in creating a record which shows Mr. Mikell receiving near textbook perfect medical care.[48] Dr. Kofke was so unimpressed by this effort that he called the anesthesia record "goofy."[49]

The missing Mayday record throws all of this effort into doubt. Without the ability to compare Nurse Embry's final masterpiece with the Mayday record she allegedly used to "correct" it, one simply cannot know whether Nurse Embry "corrected" the anesthesia narrative or instead fabricated a *magnum opus* of deceit. If the former, why would Nurse Embry and MUSC's Rule 30(b)(6) designee, Dr. Guldan, both have lied under oath about the existence of the Mayday record in the first place? MUSC's position simply does not add up.

I. MUSC's hospital anesthesia policy

MUSC contends that because its anesthesia policy[50] was created in 2009, it does not apply to electronic records and thus cannot be understood to require Dr. Nelson — or anyone else for that matter — to check the PICIS software system to make sure it was working properly before Mr. Mikell was rendered unconscious.[51] This contention is perhaps best rebutted by the conclusion of the trial court itself:

> THE COURT: . . . Why shouldn't he be responsible to make sure all the equipment is working properly before they start the procedure?
> MR. COOKE: Because **that's not equipment**. The — the —
> THE COURT: **It is equipment. I disagree with that. I know you've tried to say that, but I think it is equipment.**
> MR. COOKE: Well, they said that all the monitoring equipment was working appropriately —
> THE COURT: But it wasn't because **there was a glitch**, and I — that's where I disagree with you. I know you got the monitors and you got the

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[47] Plaintiff's Exhibit 11, RA at pages 253 - 255.

[48] Compare Plaintiff's Exhibit 2 at page 611 of 2115, RA at page 202, with Plaintiff's Exhibit 3 at page 494 of 2115, RA at page 204.

[49] *See, e.g.*, Trial Transcript at pages 441 - 442, RA at pages 845- 846.

[50] Plaintiff's Exhibit 8, RA at pages 231 - 239.

[51] Respondent's Brief at pages 26 - 28.

computer, but **I think the computer is there, and it should have been working. He should have made sure it was working.**

MR. COOKE: All right. I'll say what I'm going to say, then I'm going to go to the next argument —

THE COURT: Okay.

MR. COOKE: Because you don't agree with me.

THE COURT: All right.[52]

If the trial judge was able to reach this conclusion from the evidence, then the jury was entitled to do so, too. There was no evidence Dr. Nelson did anything to check the PICIS software to see if it was working properly before Mr. Mikell's procedure started.

m. Proximate cause of the cardiac arrest

Relying upon language in Harris Teeter v. Moore & Van Allen, P.C., 390 S.C. 275, 289-90, 701 S.E.2d 742, 749 (2010), MUSC contends Dr. Kofke failed to sufficiently elaborate how Dr. Nelson's lack of supervision caused Mr. Mikell's cardiac arrest.[53] Specifically, MUSC contends "there is no evidence that Nurse Embry was ever physically unable to establish a patent airway."[54] This contention ignores Dr. Nelson's own testimony that Mr. Mikell's airway became obstructed[55] — the opposite of being patent — and Nurse Embry's own testimony about her ability to respond to the obstruction:

Q Ms. Embry, can you be putting a nasal airway in your patient when you're on the telephone?

A No, sir.

Q Can you be doing a chin lift to clear an obstruction if you're on the telephone?

A No, sir, absolutely not.[56]

The fact that Mr. Mikell's obstruction lead to desaturation and cardiac arrest is itself circumstantial evidence that Nurse Embry was unable to establish a patent airway.

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[52] Trial Transcript at page 1091, lines 3 - 22 (emphasis added), RA at page 1496.

[53] Respondent's Brief at page 30.

[54] Respondent's Brief at page 31.

[55] Trial Transcript at page 934, lines 20 - 25, RA at page1339; page 973, line 12 to page 975, line 18, RA at pages 1378 - 1380.

[56] Trial Transcript at page 662, lines 2 - 7, RA at page 1066.

Unlike the Harris Teeter case, Dr. Kofke did not "hedge" his testimony about causation, saying anything even remotely like, "You never know because it's conjecture."[57] The entirety of Dr. Kofke's testimony conveyed his conclusion, expressed to a reasonable degree of medical certainty, that Mr. Mikell's desaturation and cardiac arrest came about because the anesthesia providers did not timely employ the standard airway management maneuvers which would most probably have prevented him from descending "down the Matterhorn into Death Valley."[58]

If Nurse Embry and Dr. Nelson never had any trouble maintaining a patent airway, then why were they unable to adequately ventilate Mr. Mikell with the result that his blood oxygen saturation level fell into the 40s? Why did his heart go into a junctional rhythm followed by pulseless electrical activity? By way of analogy, if a medical care provider never has any trouble stopping a wound from bleeding, then how can the patient bleed to death?

n. The jury was allowed to consider Dr. Nelson's negligence

MUSC seems to contend that the trial court's jury instructions were sufficient to permit the jury to find physician negligence, or malpractice by Dr. Nelson, despite the trial court's directed verdict ruling removing the physician negligence claims from the case.[59] But the trial court did not charge the jury any of the Plaintiff's requested instructions on a physician's duty to supervise a CRNA's provision of anesthesia care.[60] It is hard to envision how the jury would have found physician fault in the absence of receiving instructions about the pertinent law.

As to MUSC's suggestion this was harmless error,[61] the jury could easily have decided not to hold a subordinate member of the anesthesia team liable for care that was supposed to

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[57] Dr. Kofke's testimony directly answering the issue of causation is at Trial Transcript pages 375 - 377, RA at pages 779 - 781.

[58] Trial Transcript at page 982, line 20 to page 983, line 2, RA at pages 1387 - 1388.

[59] Respondent's Brief at pages 34 - 36.

[60] S.C. CODE ANN. §40-33-20 (Code 1976, as amended); S.C. CODE. REG. 61-16 §1212(A)(4); Norton v. Opening Break of Aiken, Inc., 319 S.C. 469, 462 S.E.2d 861 (1995).

[61] Respondent's Brief at page 34.

have been directed and supervised by a licensed physician. It is entirely plausible the jury believed Dr. Nelson's lack of adequate involvement was the root of the problem and Nurse Embry was essentially caught out by the absence of Dr. Nelson's needed direction, supervision, and assistance.

There are good reasons why both South Carolina law and MUSC policy require a licensed physician to supervise and direct the administration of anesthesia. Which is to say, the jury may simply have declined to blame the tearfully remorseful Nurse Embry for mistakes which the evidence suggested were Dr. Nelson's ultimate obligation to manage.

o. Plaintiff's references to Dr. Nelson during closing argument

MUSC makes the odd assertion that since Plaintiff's counsel mentioned Dr. Nelson's name 23 times during his closing argument, it necessarily follows that Dr. Nelson's negligence was being urged upon the jury.[62] If defense counsel mentioned Dr. Nelson's name 33 times during his closing argument, does that mean he, too, was urging the jury to find Dr. Nelson at fault?[63]

MUSC's assertion ignores the truth, that (1) Nurse Embry's alteration of Dr. Nelson's entries in the anesthesia record; (2) the times at which Dr. Nelson came in and left the room; and (3) Dr. Nelson's admission that Mr. Mikell's airway became obstructed, account for 22 of the 23 times Plaintiff's counsel mentioned Dr. Nelson's name during closing argument.[64] By arguing that Dr. Nelson's presence in the room would have changed the outcome,[65] Plaintiff's counsel was seeking to impose liability on Nurse Embry for not summoning help sooner.

Contrary to MUSC assertion,[66] Plaintiff's counsel did not persist in arguing to the jury

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[62] Respondent's Brief at page 36.

[63] Trial Transcript at pages 1147 - 1198, RA at page 1552 - 1603.

[64] Trial Transcript page 1118 to 1131, RA at page 1523 - 1536.

[65] Respondent's Brief at page 37.

[66] Respondent's Brief at page 37.

that Dr. Nelson was to blame for Mr. Mikell's injuries.

p. Untimely assertion of physician negligence

One of MUSC's most bizarre arguments is that the trial court properly directed a verdict on the Plaintiff's claims for physician negligence because the Plaintiff did not allege physician negligence until the Second Amended Complaint was filed and served on February 22, 2016, about two months before trial.[67] This argument is baseless and hardly merits any response — except to say the trial court was keenly aware of the manner in which MUSC's own discovery abuse had interfered with the Plaintiff's ability to develop his case so the Plaintiff was allowed to present expert opinion testimony based upon information MUSC was severely sanctioned for not producing in a timely fashion.[68]

q. Dr. Zile's testimony

MUSC contends the trial court's allowance of Dr. Zile's improper opinion testimony was justified because MUSC was not informed until the "eve of trial" that Dr. Kofke was going to offer opinions about the cause of Mr. Mikell's death.[69] This contention reflects MUSC's persistent determination to ignore Dr. Kofke's deposition testimony, given in March 2015 (more than a year before the case was tried): "I can't help but conclude that the cardiac arrest contributed to this [Mr. Mikell's death]. . . . The only way that I would think that it didn't, that the cardiac arrest didn't contribute to it, is if he went on to totally recover and get hit by a car or something."[70] Regardless of how many times MUSC repeats it, the argument that Dr. Kofke did not express an opinion about cause of death until "the eve of trial" is pure fiction.

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[67] Respondent's Brief at page 38.

[68] *See*, Trial Transcript at page 97, line 3 to page 99, line 23, RA at pages 501 - 503.

[69] Respondent's Brief at page 40.

[70] Plaintiff's Response to Defendant's Motion for Partial Summary Judgment at page 10, RA at page 93.

r. The blank Mayday form

MUSC reveals in its Brief that the blank Mayday form was presented in evidence in order to show "the type of information ordinarily contained in the Mayday Record,"[71] "the purpose of the Mayday Record,"[72] "the information that is ordinarily recorded in the [Mayday] record,"[73] and the information a Mayday record "normally contains."[74] MUSC also concedes the blank Mayday form was placed into evidence "to rebut the adverse inference instruction" given by the trial court as a consequence of MUSC's unexplained loss/destruction of the original Mayday record.[75]

In other words, MUSC plainly admits the goal of the blank form was indeed to show the jury that the lost Mayday record "did not contain" harmful information.[76] This is precisely what the best evidence rule[77] prohibits: proving the contents of a document through secondary evidence other than the document itself. Any effort to prove what a document does or does not contain, other than marking the document as an exhibit and offering it into evidence, is a violation of the best evidence rule.

In Griggs v. Driggers, 230 S.C. 97, 104, 94 S.E.2d 225, 228 (1956), the issue was whether a patient had a pre-existing condition of varicose veins. The patient's medical records were not available to place into evidence. However, a witness testified that he had reviewed the medical records and "nowhere in any of the clinical records is there any mention of varicose veins." The court unequivocally ruled, "This testimony was clearly a violation of the best evidence rule . . ." The situation is identical here: MUSC never stopped trying to convince the

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[71] Respondent's Brief at page 44.

[72] *Ibid.*

[73] *Id.*

[74] *Id.*

[75] Respondent's Brief at page 45.

[76] Respondent's Brief at page 46.

[77] SCRE 1002.

jury that the missing Mayday record did not contain anything untoward. The blank form was the centerpiece of that improper effort. The trial court erred in allowing the Mayday form into evidence.

MUSC contends the blank form is nevertheless admissible as "other evidence" of the contents of the Mayday record pursuant to Rule 1004, SCRE. However, there was no evidence before the trial court of any effort to diligently search for the original Mayday record; or that MUSC had "in good faith exhausted, in a reasonable degree, all the sources of information and means of discovery which the nature of the case would naturally suggest, which were available" to find the missing document. Uzzell v. Horn, 71 S.C. 426, 51 S.E. 253, 254 (1905)(setting forth preliminary requirements for admission of secondary evidence of a document's contents).

Indeed, MUSC's own custodian of records never testified; and no explanation whatsoever was given for MUSC's failure to produce the original Mayday record. *Compare*, Windham v. Lloyd, 253 S.C. 568, 172 S.E.2d 117 (1970)(holding it was not an abuse of discretion to exclude secondary evidence of a deed's contents where the loss, destruction or unavailability of the original was not sufficiently shown.) To put the matter bluntly, MUSC cannot be permitted to destroy a record containing vitally important, potentially incriminating information and then present the testimony of a witness, and produce a blank form, in order to convince the jury the original document was completely innocuous.

CONCLUSION

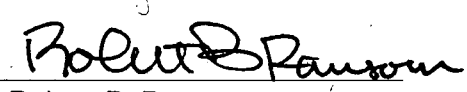
The trial court committed reversible error by removing the Plaintiff's claims for physician negligence from the jury's consideration despite evidence that Dr. Nelson breached the standard of care by leaving the procedure room at a time when Mr. Mikell's blood oxygen saturation level was tenuous and unstable. This breach of the standard of care caused harm to Mr. Mikell by leading to a catastrophic desaturation, cardiac arrest, lengthy hospitalization, and death. The trial court also committed reversible error by ruling the Plaintiff's claims for negligent

supervision were not viable.

The trial court further committed reversible error in its evidentiary rulings on the admissibility of Dr. Zile's opinion testimony, the large volume of Mr. Mikell's unexplained cardiology records, and the blank Mayday form.

The trial court's granting of MUSC's motion as to physician negligence should be reversed. Its decision on the supervision claims should be reversed. And the jury verdict in favor of MUSC should be reversed. This case should be remanded for a new trial on all of the Plaintiff's claims.

Respectfully submitted

By: 

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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. 2016-001986

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

v.

The Medical University of South Carolina . . . . . Appellant

CERTIFICATE OF COUNSEL

The undersigned certifies that this Final Brief complies with Rule 211(b), SCACR.

September 5, 2017

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