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S.C. SUPREME COURT

THE STATE OF SOUTH CAROLINA
In the Supreme Court

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

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

Appellate Case No. 2020-001231

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

vs.

Medical University of South Carolina . . . . . Petitioner

RESPONDENT SHON TURNER'S
RETURN TO
MEDICAL UNIVERSITY OF SOUTH CAROLINA'S
PETITION FOR WRIT OF CERTIORARI

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TABLE OF CONTENTS

TABLE OF AUTHORITIES ii

STATEMENT OF THE CASE 1

Discretionary Jurisdiction 1

Factual Background 1

Procedural History 2

ARGUMENT:

1. The Court of Appeals did not fail to properly apply the harmless error rule 3

2. The Court of Appeals did not err in reversing the trial court's directed verdict ruling 5

a. Dr. Kofke's testimony 5

b. Vital signs and anesthesia data 6

c. Hospital policy manual 7

d. State medical supervision law 8

e. Jury instructions 8

3. The Court of Appeals did not err in finding sufficient evidence on the issue of proximate cause 10

4. Physician negligence was raised and plead in a timely fashion 13

CONCLUSION 15

TABLE OF AUTHORITIES

Cases

Bultman v. Barber
277 S.C. 5, 281 S.E.2d 791 (1981) 5

Creech v. S.C. Wildlife and Marine Resources Dept.
328 S.C. 24, 491 S.E.2d 571 (1997) 5

Quesinberry v. Rouppasong
331 S.C. 589, 503 S.E.2d 717 (1998) 5

RFY Management Co., LLC v. Tinsley & Adams, LLP
399 S.C. 322, 732 S.E.2d 166 (2012) 4, 5

O'Neal v. Carolina Farm Supply of Johnston, Inc.
279 S.C. 490, 309 S.E.2d 776 (Ct. App. 1983) 4

Strange v.S.C. Dept.of Highways,
314 S.C. 427, 445 S.E.2d 439 (1994) 5

Statutes and Regulations

S.C. CODE ANN. §40-33-20(57) 8

S.C. CODE REGS. R.61-16 §1212(A)(4) 8

Court Rules

S.C.A.C.R. 242(b) 1

STATEMENT OF THE CASE

Discretionary Jurisdiction

S.C.A.C.R. 242(b) sets forth the "special and important" reasons why this Court will typically exercise its discretion to grant a petition for writ of *certiorari* to the Court of Appeals. The Medical University posits that a writ is appropriate in this case because "the decision of the Court of Appeals is in conflict with a prior decision of the Supreme Court." However, the Petition nowhere clearly identifies any specific, controlling case from this Court which the Court of Appeals allegedly failed to properly apply. The closest the Petition comes is to assert a misapplication of the harmless error doctrine, but even as to this assertion no controlling precedent mandating a different result is clearly identified by the Medical University. The Petition should therefore be denied.

Factual Background

Charles Mikell was 49 years old and experiencing chronic constipation so his primary care physician asked him to undergo a colonoscopy, performed at the Medical University on October 1, 2010. Although Mr. Mikell had a well-known history of sleep apnea and cardiac problems that made him especially sensitive to modest changes in the levels of oxygen and carbon dioxide in his blood, the anesthesia providers for his colonoscopy took no precautions whatsoever to either anticipate or manage the likelihood that Mr. Mikell would experience an upper airway obstruction leading to disaster.

Far from thinking ahead about risk mitigation for their patient, neither of the anesthesia providers bothered to check the electronic anesthesia machine to ensure all of its functions were working properly before Mr. Mikell was rendered unconscious. Not surprisingly, once Mr. Mikell's ability to consciously maintain his airway was chemically blunted by drugs, he experienced a correctable upper airway obstruction. Because of medical malpractice, Mr. Mikell desaturated, became hypercarbic, and went into an abnormal heart rhythm ending in cardiac arrest. Virtually all of this happened while the anesthesiologist was out of the room.

Instead of being alert to and on the lookout for foreseeable complications — which

quick intervention to manage Mr. Mikell's airway would likely prevent — the nurse anesthetist was distracted by a glitch with the anesthesia machine's software application. This software glitch required the nurse anesthetist to participate in a series of text messages, e-mails, and phone calls with an off-site technician. During this time, Mr. Mikell's upper airway began obstructing and his blood oxygen saturations became unstable.

The real time graphs in the anesthesia chart show that as the software application rebooted and came online, Mr. Mikell was already in trouble.[1] The anesthesiologist came in to check on Mr. Mikell but only for just a moment, making an entry in the chart and then leaving the room. A full-blown crisis then struck. The nurse anesthetist was left alone to manage Mr. Mikell by herself. Because Mr. Mikell was a very large man (weighing about 300 pounds) and the nurse anesthetist had no help, she was unable to quickly reposition him in order to effectively manage his airway. By the time the anesthesiologist returned to the room to assist, Mr. Mikell was already down for the count, without a pulse and in full cardiac arrest.

Procedural History

In August 2015, the Medical University moved for summary judgment on all of the Plaintiff's claims. The trial court held a hearing and denied the motion. The case was then tried to a Charleston County civil jury during two weeks in April 2016. At the close of the Plaintiff's case on Thursday of the first week, the Medical University moved for a directed verdict on all of the Plaintiff's clams. The motion was denied. At the close of all the evidence on Friday, the Medical University again moved for a directed verdict on all of the Plaintiff's claims. This motion was also denied.

The Medical University then made a motion for partial directed verdict on the Plaintiff's claims for physician negligence. The trial court took this motion under advisement over the weekend. On Monday morning, the trial court and parties had a lengthy charge conference in open court, none of which was preserved on the record by the court reporter. At the conclusion of the charge conference, the trial court decided to grant the motion for partial directed verdict.

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[1] *See, e.g.*, RA at pp. 193, 209, 218, 219, 224, 225, 227, 228, and 229.

Closing arguments ensued immediately afterward. The jury was then charged and received the case in the late afternoon on Monday, being dismissed for the evening after a few hours of deliberation.

On Tuesday morning, the trial court expressed regret about its decision to grant the motion for partial directed verdict. A discussion was had about how the ruling could be handled with the jury, for example by submitting a revised verdict form. The trial court made it clear that it would not do anything unless both parties agreed. Plaintiff's counsel was uncomfortable interfering with a deliberative process that had already been underway for several hours and saw no realistic opportunity to fully and fairly resurrect the jury's deliberations after closing arguments had already been made. The trial court thus determined to allow the jury to continue deliberating until, after several questions, a defense verdict was returned Tuesday afternoon.

The Plaintiff timely filed a motion for new trial, which was denied by the trial court. The Plaintiff thereafter timely filed a notice of appeal. In an opinion filed on May 6, 2020, the Court of Appeals agreed with the Plaintiff that the trial court had erred in granting the motion for partial directed verdict and reversed, granting a new trial. The Medical University filed a motion for reconsideration which the Court of Appeals denied on August 13, 2020. The Medical University then filed a petition for writ of *certiorari* on September 14, 2020.

ARGUMENT

1. The Court of Appeals did not fail to properly apply the harmless error rule

The Medical University asserts that it was harmless error for the trial court to grant a directed verdict ending Mr. Turner's claim for physician negligence, thereby also capping any potential recovery at $300,000.00 pursuant to the South Carolina Tort Claims Act. Importantly, if followed to its logical conclusion the Medical University's argument is that the jury was authorized to return a verdict based on physician negligence but any such verdict would nevertheless be subject to the non-physician cap. The absurdity of that result significantly undermines the plausibility of the Medical University's harmless error argument.

Moreover, it is difficult to conceive how ending claims on the merits can be considered harmless. Directing a verdict is quintessentially prejudicial to the non-moving party. Of the cases cited in the Petition, only two apply the concept of harmless error in the context of a decision to grant a directed verdict: RFY Management Co., LLC v. Tinsley & Adams, LLP, 399 S.C. 322, 732 S.E.2d 166 (2012) and O'Neal v. Carolina Farm Supply of Johnston, Inc., 279 S.C. 490, 309 S.E.2d 776 (Ct. App. 1983). Neither of those cases control the issue here.

The O'Neal case is not Supreme Court precedent. It also lacks meaningful bearing on the instant case, merely holding that an improper directed verdict on the issue of punitive damages is rendered harmless by a jury verdict finding no liability. Which is to say, since liability is a precondition to damages, an error in directing a verdict on an element of damages is harmless when the jury finds no liability. The instant case does not involve any such conjunction of issues. The trial court's directed verdict affected not only the damages recoverable under the Tort Claims Act but also the Medical University's liability for physician negligence.

RFY Management held that an improper directed verdict on a cause of action for unfair trade practices was rendered harmless when the jury returned a defense verdict on a remaining cause of action for legal malpractice. The Court reasoned that because both causes of action required the plaintiff to prove that a closing attorney committed acts of deception in connection with a real estate transaction, the defense verdict on the legal malpractice claim meant the jury found no deception, without which there could be no unfair trade practice. Again, the instant case does not involve any such conjunction of issues.

Importantly, RFY Management is an example of the harmless error rule being applied to different claims, not to different tortfeasors. The Court did not apply a directed verdict in favor of one employee to exonerate different conduct by a different employee, as the Medical University seeks to have done here. The instant case involves evidence of tortious conduct by not one but two Medical University employees, one of whom was obliged to supervise, direct, and critically observe the conduct of the other. When a defendant principal has multiple agents

each engaged in different tasks, a directed verdict finding no negligence by one agent does not foreclose the possibility of a jury verdict finding negligence by another agent.

By way of obvious example, the jury in this case could have exonerated the nurse anesthetist *because* the anesthesiologist failed to properly supervise her. Negligence does not necessarily consist in being unsupervised, but it does consist in failing to supervise when a duty to do so exists. In other words, the duty of supervision falls upon the superior, not the subordinate. So a lack of proper supervision could stand alone as a legitimate basis for imputing physician negligence to the Medical University.

In short, RFY Management is not controlling and the Court of Appeals did not fail to properly apply this Court's harmless error jurisprudence. As discussed further *infra*, the trial court's erroneous directed verdict ruling also meant that jury instructions relating to the anesthesiologist's conduct were not given, thereby further prejudicing the Plaintiff so that the error was not harmless. The Petition should therefore be denied.

2. The Court of Appeals did not err in reversing the trial court's directed verdict ruling.

The Medical University's directed verdict argument focuses on isolated snippets from the trial record to the exclusion of all conflicting and contrary evidence — in essence, presenting a completely one-sided version of the case. But in considering the propriety of a directed verdict, the standard is not whether the record can be plumbed for evidence to support the trial court's ruling. Instead, the standard is whether the evidence as a whole presents any material factual disputes, which only the jury can resolve.[2]

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[2] In ruling on a motion for directed verdict, the trial court must view the evidence and the inferences which reasonably can be drawn therefrom in the light most favorable to the party opposing the motion. The trial court must deny the motion when either the evidence yields more than one inference or its inference is in doubt. Strange v.S.C. Dept.of Highways, 314 S.C. 427, 445 S.E.2d 439 (1994). When considering directed verdict motions, neither the trial court nor the appellate court has authority to decide credibility issues or to resolve conflicts in the testimony or evidence. Creech v. S.C. Wildlife and Marine Resources Dept., 328 S.C. 24, 491 S.E.2d 571 (1997). The appellate court must determine whether a verdict for a party opposing the motion would be reasonably possible under the facts as liberally construed in his favor. Bultman v. Barber, 277 S.C. 5, 281 S.E.2d 791 (1981). If the evidence is susceptible to more than one reasonable inference, the case should be submitted to the jury. Quesinberry v. Rouppasong, 331 S.C. 589, 503 S.E.2d 717 (1998).

a. Dr. Kofke's testimony

For example, the Medical University repeatedly recites an isolated portion of the testimony of Dr. Kofke, the Plaintiff's anesthesia expert, in an effort to establish as a standard of care the proposition that an anesthesiologist is always allowed to leave a patient and supervise more than one nurse anesthetist at a time, regardless of the circumstances.[3] But the Medical University refuses to acknowledge — let alone address — Dr. Kofke's full testimony on this issue.

Dr. Kofke clearly testified that if the patient is unstable or in trouble, it is not okay for the anesthesiologist to leave the room to go do something else:

> 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. But in this case, the sats have been running in the 80s for most of the record. . . .[4]

Dr. Kofke testified that because Mr. Mikell's blood oxygen saturations were "running in the 80s for most of the record," it was not appropriate for the anesthesiologist to leave the room, even though under normal circumstances doing so might be okay.

Dr. Kofke's point is hardly controversial. As Dr. Nelson himself testified, "I would have had to see consistently his saturations in the 90s before I would have stepped out of the room."[5] Yet rather than struggle to integrate all of the testimony into its argument, the Medical University simply ignores the parts that are clearly incompatible with its position.

b. Vital signs and anesthesia data

As another example, the Medical University ignores the dispute over the vital signs and other data contained in the anesthesia records, treating potentially helpful entries in those records as irrefragable, carved-in-stone fact. Yet Dr. Kofke — a very experienced anesthesia

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[3] Petition at pp. 11-12.

[4] RA at p. 842, lines 13-22.

[5] RA at 1394, line 7 -11.

provider — described the anesthesia record as so fundamentally unreliable he was at pains to make sense of it:

> [N]one of their records agree with each other, even though they're electronic. . . .[6] I just don't believe the times on this record. . . .[7] I don't trust — I just don't know what to make of the — any of the times. . . .[8] I'm telling you, these numbers are goofy.[9]

Moreover, the Medical University scarcely mentions: (1) critical vital signs data missing from the anesthesia record due to the software glitch; (2) narrative entries in the anesthesia record that were substantially altered by the nurse anesthetist, without the anesthesiologist's permission, after-the-fact and with knowledge of a pending hospital investigation; or (3) demonstrably false testimony about a missing Mayday record which the nurse anesthetist claimed to have used to "correct" and "complete" entries in the anesthesia record.[10]

The point simply being, virtually all of the evidence recited in the Petition was controverted or tainted by demonstrably false testimony, obviously altered records, and unexplained missing documents. Because the vast majority of the "facts" set forth in the Petition were disputed at trial, the Court of Appeals correctly reversed the partial directed verdict ruling by the trial court.

c. Hospital policy manual

The Medical University has a hospital policy manual entitled, "Policies and Basic Standards of Anesthesia Care."[11] In this policy manual, the Medical University mandates that the provision of anesthesia by nurse anesthetists must be performed under the "direction and supervision" of an attending anesthesiologist. The policy manual also states that an anesthesia

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[6] RA at p. 838, lines 17-18.

[7] RA at p. 839, lines 6-7.

[8] RA at p. 840, lines 15-16.

[9] RA at p. 845, line 12.

[10] These extremely significant evidentiary issues lead the trial court to impose almost $90,000.00 in monetary sanctions against the Medical University. This Court can take judicial notice of the Medical University's appeal from the trial court's Order for Sanctions, S.C. Court of Appeals, Appellate Case No. 2016-002326, which the Medical University withdrew on the eve of oral argument, agreeing to pay the full amount of the trial court's award.

[11] Plaintiff's Exhibit 8, RA at pp. 231-239.

patient's medical condition "will be the responsibility of a qualified physician member of the medical staff."[12] The manual further states, "Prior to administering anesthesia the practitioner administering anesthesia will check and document the readiness [and] working condition . . . of all equipment to be used"[13] (emphasis in original.)

The policy manual was entered into evidence[14] and discussed at length during the testimony of Dr. Reeves, the Chairman of the Medical University's Department of Anesthesia.[15] Dr. Reeves testified, *inter alia,* that the policy manual was developed in order for the Medical University to comply with the physician supervision requirements of State law.[16] Dr. Reeves also testified the policy manual requires all equipment to be checked for proper functioning before a patient is given an anesthetic.[17]

d. State medical supervision law

The State law requirements adverted to during Dr. Reeves' testimony are found in S.C. CODE REGS. R.61-16 §1212(A)(4), which says that a nurse anesthetist must act "under the supervision of . . . an anesthesiologist . . . ;" and S.C. CODE ANN. §40-33-20(57), which defines "supervision" in this context as "the process of critically observing, directing, and evaluating another's performance." In its Petition, the Medical University acknowledges these are controlling provisions of law in this case.[18] Despite the Plaintiff's request, none of these provisions were charged to the jury.

e. Jury instructions

As a consequence of its erroneous directed verdict ruling, the trial court also declined to charge several of Mr. Turner's other requested jury instructions relating to how a duty of care can arise from a statute, regulation, or internal policy manual:

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[12] RA at p. 235.

[13] RA at p. 237, ¶2.

[14] Plaintiff's Exhibit 8, RA at p. 231-239.

[15] RA at pp. 1133 *et seq*.

[16] RA at p. 1136-1137.

[17] RA at pp. 1137-1138.

[18] Petition at p. 12.

Negligence Per Se

Where there is a duty arising from a statute or regulation and the Plaintiff shows the Defendant violated the statute or regulation, the violation is negligence per se. That is, negligence in and of itself, as a matter of law.

Negligence per se simply means you, the jury, need not decide if the Defendant acted as a reasonable medical care provider under the circumstances. The statute and regulation fix the standard of care required of the Defendant, leaving you merely to decide whether the Defendant breached the statute. If the Defendant did, then his or her failure to take due care is established as a matter of law. The only issue then left for you to determine is whether the Defendant's conduct proximately caused damage or harm to the Plaintiff.

Accordingly, proof of violation of a statute or regulation is, in fact, proof of negligence so that your only concern then would be whether such violation of the statute or regulation so shown was the proximate cause of the injury and harm.

Ralph King Anderson, Jr., South Carolina Requests to Charge - Civil, 2002, §20-6

Norton v. Opening Break, 319 S.C. 469, 462 S.E.2d 861 (1995) (regulations have the force of law; violation of regulation constitutes negligence per se);

Green v. Sparks, 232 S.C. 414, 102 S.E.2d 435 (1958)(violation of an applicable statute is negligence per se)[19]

Standards of Care

The fact finder may consider relevant standards of care from various sources in determining whether a defendant breached a duty owed to an injured person in a negligence case. The standard of care in a given case may be established and defined by the common law, statutes, administrative regulations, industry standards, or a defendant's own policies and guidelines.

Madison ex rel Bryant v. Babcock Center, Inc., 371 S.C. 123, 638 S.E.2d 650 (1985).[20]

The trial record contains evidence that Dr. Nelson was responsible for supervising and critically overseeing the administration of anesthesia. The jury received evidence that Dr. Nelson was nevertheless barely present during the events leading up to Mr. Mikell's cardiac

[19] RA at p. 108.

[20] RA at p. 109.

arrest. The jury also heard evidence that Dr. Nelson left the room when the patient was unstable. Yet during the charge process, the jury was never instructed on any of the law that would allow it to use that evidence as a basis for a verdict in favor of the Plaintiff.

Having no guidepost against which to measure the conduct of the person whom the evidence showed was supposed to be in charge, is it any wonder the jury did not find the Medical University at fault? Having heard evidence that the administration of anesthesia was ultimately the anesthesiologist's responsibility, is it any wonder that in the absence of the Plaintiff's requested instructions the jury returned a verdict in favor of the Medical University?

3. The Court of Appeals did not err in finding sufficient evidence on the issue of proximate case

The Medical University attacks Dr. Kofke's testimony about proximate cause, characterizing it as tenuous, hypothetical, speculative, conjectural, and an *ipse dixit* about what proper care most probably would have achieved.[21] Here is what Dr. Kofke had to say:

> Q . . . [L]et's turn our attention to Dr. Nelson for a moment. Have you reached any conclusions as to whether Dr. Nelson's conduct met or breached he standard of care?
> A Yes.
> Q All right. And what are those conclusions?
> A It's — in a patient who he recognized was going to be very tricky, and that's why they used an unusual anesthesia technique — he just popped in and then left. And — and — and he had to have heard about the sats in the 80s at the beginning of the case but whenever he popped in, purportedly they were — they were okay, but it's not seen anywhere in the record. And then — then he left, you know, so that's his breach.
> Q Okay. And if both of the anesthesia care providers, Dr. Nelson and the nurse anesthetist, had been present in the room and attending to the patient, do you have any conclusions as to whether or not they would have been able to prevent the cardiac arrest?
> A Oh, yes. I think that the two of them could have made sure that the airway was — was patent. It's a word we use. And then he — he could have managed the airway while she managed the electronic record.
> Q All right. Now, have you — have you reached both of those conclusions as to the standard of care to a reasonable degree of medical certainty?
> A Yes.
> Q Okay. And beyond that, are you confident? Are you sure?
> A Yeah, I'm sure.

[21] Petition at p. 17.

Q No question in your mind —
A No.
Q — that they both breached the standard —
A No.
Q — of care?
A No.[22]

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Q Okay. And do you have any opinion, to a reasonable degree of medical certainty, as to whether or not the anesthesiologist, Dr. Nelson, also breached the standard of care?
A Yes.
Q All right. And what is that?
A And that is that he had a patient who — who he knew was tenuous, and he didn't pay that much attention to, making only a brief stop in the room — as documented anyway —before the — before the arrest arose. So he wasn't around for the sats in the 80s or any of that stuff.
Q Okay. Because he was going in and out?
A Yes. I'm not sure how many — once or twice, but I don't see documentation for more than that.
Q Okay. Now, do you also have — been able to reach any conclusion, to a reasonable degree of medical certainty, as to whether or not Mr. Mikell would have suffered the cardiac arrest and ended up in the hospital if the nurse anesthetist and the anesthesiologist had met the standard of care?
A I think that this would not have happened if either one of them had met the standard of care. It didn't require both.
Q Okay.
A But both would have been clearly better.[23]

This testimony should and must, of course, be taken in the context of Dr. Kofke's earlier discussion — accompanied by videos, photos, and diagrams — about the various jaw and chin maneuvers used by anesthesia providers to prevent an upper airway obstruction from developing into an emergency.[24] That discussion included the following commentary:

Q Now, what should Mr. Mikell's anesthesia care providers have done when this desaturation that's depicted on that graph started to occur?
A Well, before the big desaturation there — the sats were already in the 80s, so that — I don't remember offhand, but I expect that they were — his sats were okay beforehand. Otherwise, I don't think that they would have started the case. But by okay, I mean over 90 — 90 percent — are the prep areas. So the first sat that we have here is in the 80s, so at that point, even to prevent that drop in the 40s, there should be these maneuvers — there should be these maneuvers that I discussed which entail the various things to do in the airway, you

[22] RA at pp. 779-781.

[23] RA at pp. 801-802.

[24] *See*, RA at pp. 751-755.

know, a chin lift; opening the mouth. You know, various things to support — get the tongue — get the tongue off. And if it's due to anesthesia, you know, these folks are known to be sensitive to anesthesia, then you've got to turn the anesthesia down or off.[25]

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Q Now, the oxygen saturations that are represented on that graph there, you said that they were already in the 80s?
A Right.
Q So what does that indicate to you?
A That even before they had the life threatening drop, they were in trouble. I mean the 80s is a warning, but the — but the 47 is a life — is an alarm.
Q And what should the anesthesia providers have been doing?
A They should have been supporting the airway — focusing on the patient, supporting the airway, and you know, getting up — getting the sats back up.
Q Now, if they had done those things, would his sats have continued to have fallen?
A I don't think so.
Q All right. If they had done those things, would his heart have gone into pulseless electrical activity?
A No.
Q Okay. And if they had done those things, do you believe Mr. Mikell would have ended up a critical care patient in the hospital?
A If they had done those things, that would not have happened.[26]

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A . . . it's a fairly straight forward technique to keep the airway open.[27]

Simply stated, if the nurse anesthetist had not been distracted by the software glitch and the texts, e-mails, and phone calls, Mr. Mikell's condition would have received her undivided attention so that the upper airway obstruction could have been safely managed before Mr. Mikell got into trouble. If the anesthesiologist had not been absent from the room, there would have been two sets of hands immediately available to manage Mr. Mikell's airway before the obstruction resulted in desaturation and cardiac arrest. Dr. Kofke, with his many years of clinical experience, was certainly competent to testify that if both anesthesia providers had been present, the outcome most likely would have been different.

The Medical University's argument seems to be that because Dr. Kofke described the airway management techniques that should have been used before Mr. Mikell desaturated as "fairly straight forward," his testimony somehow fails as mere speculation and conjecture. But

[25] RA at pp. 757-758.

[26] RA at pp. 759-760.

[27] RA at p. 773.

Dr. Kofke testified that these maneuvers are effective in alleviating upper airway obstructions. Because his experience is that these maneuvers are effective, Dr. Kofke concluded that Mr. Mikell's anesthesia providers either must not have used them properly or waited until it was too late.[28] It was for the jury to determine whether that conclusion is reasonable inference as opposed to speculation and conjecture.

4. Physician negligence was raised and plead in a timely fashion

Seeking to capture the high ground of irony, the Medical University complains about alleged late, unfair notice of the Plaintiff's claims against Dr. Nelson.[29] Yet the Petition fails to mention several salient points about the pre-trial development of this case.

First, in September 2015, the Chairman of the Department of Anesthesia, Dr. Reeves, was deposed. His testimony covered the hospital policy manual and the duties of physician supervision and direction which it describes. His testimony thus gave defense counsel clear and unmistakable notice that physician supervision was squarely in play.

It was during Dr. Reeves' testimony that the Plaintiff first learned of the anesthesia software glitch and the text messages, e-mails, and phone calls needed to correct it, all while Mr. Mikell was under anesthesia and while Dr. Nelson was out of the room.

Second, in February 2016, the Plaintiff learned for the first time that the nurse anesthetist had obtained a paper "Mayday" record from Mr. Mikell's bedside hospital chart and used it to reorganize and reverse engineer the critical chronology of events recorded in the narrative portion of the anesthesia chart. Included in her revisions were entries indicating the times at which Dr. Nelson had entered and left the room.[30]

The point to this very brief recitation is that while the Medical University uses its Petition to claim protection from "trial by ambush,"[31] it was in fact the Medical University that was

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[28] RA at pp. 772-774.

[29] Petition at p. 18.

[30] Following the nurse anesthetist's use of the mayday record, it has never been seen again. The nurse anesthetist provided false testimony about the mayday record at her August 2014 deposition. In November 2014, the Medical University produced a Rule 30(b)(6) designee whose testimony about the mayday record was also absolutely false.

[31] Petition at p. 18.

sanctioned almost $90,000.00 by the trial court for altering evidence, withholding evidence, destroying evidence, and repeatedly lying about it under oath. The major consequence of that sanctionable misconduct was that the Plaintiff's efforts to learn the full truth about what really happened during Mr. Mikell's colonoscopy were significantly thwarted for almost three years.

Third, it was because of the Medical University's initially successful efforts to obfuscate the truth that the Second Amended Complaint was not filed until February 22, 2016,[32] alleging causes of action for medical malpractice along with unfair trade practices, constructive fraud, and civil conspiracy. As to medical malpractice, Paragraph 16(f) of the Second Amended Complaint alleges negligence "in failing to properly manage, supervise and direct the provision of anesthesia care to Mr. Mikell."[33] Paragraph 16(i) alleges negligence "in leaving the colonoscopy procedure room to attend to other patients at a time when Mr. Mikell's condition was unstable."[34] By late February 2016, it should have been no great secret to the Medical University that both of those specific delicts were attributable to Dr. Nelson — only he had supervisory responsibility and only he left the room.

Fourth, one consequence of the Medical University's serious discovery abuse was that Dr. Kofke was unable to finalize his opinions in the case until shortly before trial. Written notice of Dr. Kofke's opinions was nevertheless provided as soon as Dr. Kofke was able to integrate into his analysis all of the information the Medical University's sanctionable misconduct had successfully obscured. The Medical University repeatedly sought to have Dr. Kofke's opinions excluded and stricken at trial.[35] The trial court's refusal to do so[36] has not been appealed.

The case was then tried to the jury in April 2016. Throughout discovery and trial, the Plaintiff first developed and then presented evidence that the hospital policy manual and State law made Dr. Nelson responsible for supervising and directing the safe provision of anesthesia

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[32] RA at pp. 53-62.

[33] RA at p. 55.

[34] RA at p. 55.

[35] RA at pp. 781-799; and at pp. 887-905.

[36] RA at p. 905.

via machines and systems that were checked and fully operational before the patient was rendered unconscious. It was the Medical University's own sanctionable misconduct that created the timing about which it now complains.

CONCLUSION

The Court of Appeals did not fail to properly apply controlling precedent from this Court on the harmless error doctrine. Nor did the Court of Appeals err in deciding to reverse the trial court's granting of a partial directed verdict on the issue of physician negligence. The trial record contains sufficient evidence of physician negligence and proximate cause to require submission of those issues to the jury. Nor was the Medical University unfairly ambushed at trial by the Plaintiff's physician negligence claims.

In summary, the Medical University's position is manifestly without merit. The Petition should therefore be denied.

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