THE STATE OF SOUTH CAROLINA
In the Supreme Court

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S.C. 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 BRIEF ON APPEAL

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STATEMENT OF THE CASE

1. Factual Background

In 2003, Charles Mikell experienced a diabetic crisis so that he came under the care of a team of cardiologists at MUSC. Over the next several years, Mr. Mikell and his physicians spent a great deal of time selecting and adjusting the dosage of his medications and managing his diet and activities so that by 2010, Mr. Mikell was able to enjoy a relatively normal lifestyle including working, walking, swimming, and spending quality time with his mother, children, and friends.[1]

In the summer of 2010, Mr. Mikell began experiencing constipation. His family doctor was unable to resolve this through conservative measures. So Mr. Mikell was asked to undergo a routine screening colonoscopy. During that colonoscopy — performed at MUSC on October 1, 2010 — Mr. Mikell suffered a cardiac arrest. The circumstances of that cardiac arrest formed the basis for the instant lawsuit alleging medical malpractice against MUSC.

Mr. Mikell's medical history presented two risks pertinent to the anesthesia he received during the colonoscopy.[2] First, he had obstructive sleep apnea which created the likelihood that once he was rendered unconscious his upper airway would obstruct to some degree, thereby interfering with his ability to move air in and out of his lungs, a biologic process known as ventilation. Inadequate ventilation could, in turn, both reduce his blood oxygen saturation level (through reduced inhalation of oxygen) and increase his blood carbon dioxide level (through reduced exhalation of carbon dioxide). Second, he had cardiomyopathy and atrial tachycardia so that Mr. Mikell's heart was especially susceptible to fluctuations in blood oxygen and carbon dioxide levels. This meant that inadequate ventilation could cause his heart to quickly reach a dangerous tipping point leading to cardiac arrest. Both of these risks were well-known to Mr. Mikell's anesthesia providers: Dr. Eric Nelson, an anesthesiologist, and Donna Embry, CRNA, a certified nurse anesthetist.[3]

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[1] *See generally*, the testimony of Dr. Van Bakel, App. at pages 1414 to 1416.

[2] *See, e.g.*, App. at pages 1567 to 1573.

[3] *Ibid.*

At 7:41 a.m. on October 1, 2010, in advance of the colonoscope being inserted, Mr. Mikell was given the intravenous anesthetic agent Propofol. Within minutes, Mr. Mikell became unconscious. In the fall of 2010, MUSC used an anesthesia software program known as PICIS to capture and record patient vital signs during anesthesia. Sometime during the anesthesia induction process, Nurse Embry noticed the PICIS anesthesia software was not working. One consequence is that Mr. Mikell's vital signs were not recorded during the first seven minutes of anesthesia. Another consequence was that Nurse Embry had to engage in a series of text messages, emails, and phone calls with an off-site technician in order to bring the PICIS software online while Mr. Mikell was unconscious.

The PICIS software came online at 7:48 a.m. and began capturing vital signs data which was contemporaneously plotted on a graph. Dr. Nelson and Nurse Embry say that prior to 7:48 a.m., Mr. Mikell's oxygen saturation level dropped, a nasal airway was placed, and the oxygen saturation level improved. It is undisputed that Dr. Nelson entered and left the room around the time of these events, but the exact timing is unclear. Shortly after Dr. Nelson left, tragedy struck as Mr. Mikell's oxygen saturation level plummeted and he went into cardiac arrest.

2. Discovery Abuse

When discovery in this case first commenced, Nurse Embry testified falsely about the PICIS software problem. Her false testimony was enabled by MUSC's failure to disclose its records of the text messages, emails, and phone calls she had made to correct the problem. This serious misconduct lead the trial court to impose substantial monetary sanctions for discovery abuse.[4] Although MUSC contends the texts, emails, and phone calls had no impact on Mr. Mikell's anesthesia care, if that were true why would all the evidence of those activities have been willfully obfuscated and purposely withheld? According to the ancient proverb, "Only the guilty flee when no one pursues."[5]

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[4] The trial court's Order for Sanctions was the subject of a separate appeal before the Court of Appeals, _Turner v. MUSC_, Appellate Case No. 2016-002326 The parties resolved this appeal by mutual agreement on the eve of oral argument, thereby making the trial court's sanctions order the law of the case.

[5] Paraphrasing Proverbs 28:1, New King James Version.

Two of the disputed issues at trial were the time at which Dr. Nelson left the room and whether Mr. Mikell's condition was stable when that occurred. An entry in the anesthesia narrative showed that Dr. Nelson left the room at 7:50 a.m., when Mr. Mikell's oxygen saturation level was a dangerously low 69.2%. MUSC was also sanctioned by the trial court for withholding an audit trail for the PICIS software which showed this entry had been changed by Nurse Embry to make it appear that Dr. Nelson did not leave the room until 7:51 a.m., when the oxygen saturation level was briefly 90.1%.

Another disputed issue at trial was the time at which Dr. Nelson returned to the room to assist with Mr. Mikell's desaturation and cardiac arrest. Dr. Nelson's own entry in the anesthesia narrative showed that he did not return until 8:00 a.m. But the PICIS audit trail showed that this entry had also been changed by Nurse Embry to make it appear as though Dr. Nelson returned at 7:56 a.m.

The times when Dr. Nelson left and returned to the room were further shrouded with intrigue by a controversy over a missing Mayday record. MUSC hospital policy[6] required that whenever a patient experienced an unexpected cardiac arrest, a Cardiopulmonary Resuscitation Event Form, or "Mayday record," was supposed to be completed and filed with the patient's medical chart. When MUSC produced Mr. Mikell's chart to Mr. Turner, no Mayday record was included. Nurse Embry and an MUSC Rule 30(b)(6) designee, Dr. Guldan, both provided false testimony about the existence of the Mayday record. Their subterfuge was revealed when a second Rule 30(b)(6) designee, Ms. Scarborough, testified that a Mayday record had been created but was later destroyed. When her alterations to the anesthesia chart were made evident by the PICIS audit trail, Nurse Embry then admitted the Mayday record had last been seen when she says she used it to change the entries in the anesthesia chart showing the times when Dr. Nelson had entered and left the room. The trial court imposed severe monetary sanctions on MUSC for its discovery abuse with the Mayday record.

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[6] Plaintiff's Exhibit 9, App. at pages 438 to 445.

3. The Cardiac Arrest

During the two minute period from 7:48 a.m. to 7:50 a.m., Mr. Mikell's blood oxygen saturation level dropped from 96.4% (good) down to 69.2% (bad). By 7:57 a.m., Mr. Mikell's blood oxygen saturation level had further dropped to 41.2% (very bad). Indeed, by that point Mr. Mikell was in the throes of a life-threatening cardiac arrest. The resulting low cardiac output stunned Mr. Mikell's kidneys, rendering them incapable of handling the cardiac medications which his MUSC cardiologists had spent so many years carefully titrating. Those medications had to be stopped, directly contributing to Mr. Mikell's subsequent death.

4. Procedural Background

MUSC first challenged the evidence of physician negligence in a pre-trial motion for summary judgment, which the trial court properly denied. Next, at the close of Mr. Turner's evidence, MUSC made a motion for directed verdict, which the trial court correctly denied. At the close of all the evidence, MUSC made another motion for directed verdict, which the trial court also correctly denied. Finally, after the denial of its second directed verdict motion, MUSC made a motion for partial summary judgment on the issue of physician negligence. The trial court took this motion under advisement as the trial was adjourned for the weekend.

When the parties returned to court the following Monday, the trial court entertained a lengthy discussion about jury instructions. Following this charge conference, the trial court heard further argument on MUSC's motion for partial summary judgment and ultimately decided to grant it. The trial court then indicated it would not give several of Mr. Turner's requested jury instructions. Counsel for the parties thereupon gave their closing arguments, the trial court gave the jury its charge on the law, and the jury deliberated for a few hours before court was adjourned late Monday afternoon.

When the parties returned to court Tuesday morning, the trial court expressed concern over its decision to grant MUSC's motion for partial summary judgement. A discussion with counsel ensued as the trial court explored how its perceived error might be mitigated.[7] This

[7] App. at pages 1848 *et seq.*

created a Hobson's Choice for Mr. Turner, whose counsel came to believe it would be unwise to interfere in the jury's ongoing deliberations by altering the verdict form or giving additional jury instructions without an opportunity to make additional closing argument, to which defense counsel did not agree. Because counsel for the parties could not agree on a solution, the trial court determined to take no remedial action. The jury's deliberations proceeded until a verdict for MUSC was returned Tuesday around noon.

Mr. Turner filed a motion for new trial which the trial court denied. Mr. Turner then filed a notice of appeal. Following briefing and oral argument, the Court of Appeals reversed the granting of MUSC's motion for partial summary judgment and remanded the case for a new trial. MUSC filed a petition for rehearing which the Court of Appeals denied. MUSC then filed a petition for writ of certiorari which this Court granted.

ARGUMENT

1. Standard of Review

When considering a motion for directed verdict, the trial court must view the evidence and inferences that reasonably can be drawn therefrom in the light most favorable to the party opposing the motion and must deny the motion when either the evidence yields more than one inference or its inference is in doubt. Estate of Carr ex rel. Bolton v. Circle S Enters. Inc., 379 S.C. 31, 38, 664 S.E.2d 83, 86 (Ct. App. 2008). Neither the trial court nor the appellate court has authority to decide credibility issues or to resolve conflicts in the testimony or evidence. Erickson v. Jones St. Publishers, L.L.C., 368 S.C. 444, 463, 629 S.E.2d 653, 663 (2006).

Even where the evidence is uncontradicted, the jury may believe all, some, or none of the testimony, and where the credibility of the witness has been questioned, the matter is properly left to the jury to decide. Ross v. Paddy, 340 S.C. 428, 532 S.E.2d 612 (2000). The fact that evidence is not contradicted by direct evidence does not render it undisputed, as there still remains the question of its inherent probability and the credibility of the witnesses or their interest in the result. Terwilliger v. Marion, 222 S.C. 185, 72 S.E.2d 165 (1952). To justify a court in directing a verdict based on the truthfulness of evidence, there must be nothing in the circumstances or surroundings tending to impeach the witness or to throw discredit on her statements. If there is anything tending to create distrust in her truthfulness, the question must be left to the jury. *Ibid*.

2. Introduction

The Petitioner's Brief presents two fundamental contradictions which serve to undermine MUSC's argument. First, MUSC begins by suggesting that in October 2010 Mr. Mikell had a litany of medical problems so that he was essentially a "dead man walking."[8] Consistent with this narrative, at trial one of Mr. Mikell's cardiologists, Dr. Zile, testified that by the time of the colonoscopy, Mr. Mikell had already far exceeded his life expectancy.[9] At the

[8] Petitioner's Brief at page 2.

[9] App. at pages 1422 to 1427.

same time it highlights Mr. Mikell's frailties, MUSC denies there was any need for its anesthesia providers to pay close attention to Mr. Mikell during the colonoscopy. Instead, MUSC contends it was perfectly acceptable for Mr. Mikell to be rendered unconscious before the PICIS anesthesia software was working; and for Dr. Nelson to follow his customary habit of leaving the colonoscopy procedure room to attend to other patients despite Mr. Mikell's airway having already obstructed so that his blood oxygen saturation level hovered at an unsafe level.

Second, MUSC argues that the challenged ruling by the trial court did not prejudice Mr. Turner because Mr. Mikell was nevertheless allowed "to elicit and develop extensive lay and expert testimony about Dr. Nelson's alleged negligence"[10] and "to present significant evidence to convince the jury that Dr. Nelson breached a duty of care to Mr. Mikell."[11] But directly contrary to these very statements, MUSC vigorously disputes the existence of any evidence of physician negligence in this case. How could the trial court have allowed Mr. Turner to present such evidence if it does not exist?

Mr. Turner respectfully suggests that MUSC cannot both have its cake and eat it, too. If Mr. Mikell was a high risk patient living on borrowed time, then he needed to receive greater than routine attention from his anesthesiologist. And if Mr. Turner was allowed to introduce extensive evidence of physician negligence, then the trial court erred in removing the issue of physician negligence from the jury's consideration.

3. Harmless Error

MUSC claims the Court of Appeals' decision should be reversed because the trial court's error did not affect how Mr. Turner presented evidence at trial, making the error harmless.[12] MUSC further claims the trial court's error affected only the Tort Claims Act damage cap,[13] so it could not have impacted the jury's deliberations, again making the error

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[10] Petitioner's Brief at page 14.

[11] *Ibid.*

[12] Petitioner's Brief at pages 10 to 12.

[13] *See*, S.C. CODE ANN. §15-78-120(a)(Code 1976, as amended).

harmless.[14] Both of these arguments are misplaced and wrong.

First, taken to its logical conclusion, MUSC's position leads to an absurd result: that despite the granting of the motion for partial summary judgment, the jury was nevertheless authorized to render a verdict based upon what MUSC claims was non-existent evidence of physician negligence — a verdict which MUSC would then have been entitled to have limited to the amount of the Tort Claims Act cap for non-physician negligence. Such a contradictory result — a verdict based on physician negligence but capped at the non-physician amount — could hardly be countenanced.

Second, a review of the trial record reveals defense counsel initially described the motion to the trial court as one "for partial summary judgment as to any negligence on the part of a licensed physician."[15] The motion was later described by defense counsel as "a motion for a partial directed verdict as to Dr. Nelson."[16] So the motion was not postured as a request to simply impose the non-physician cap on a verdict which the jury would nevertheless be allowed to render based upon supposedly non-existent evidence of physician negligence. Instead, the motion was presented to prevent the jury from returning a verdict based upon Dr. Nelson's conduct.

Third, the trial court did not view the motion for partial summary judgment in the narrow perspective suggested by MUSC on appeal:

> THE COURT: . . . **I just have a real difficulty in figuring out what Dr. Nelson did wrong** to be honest with you. I'm going to grant the motion. Thank you very much. **Now, that changes this charge somewhat, as far as a request for charge.**[17]

Fourth, with respect to prejudice, clearly the trial court's ruling affected the jury instructions. MUSC nevertheless contends those instructions did not prevent the jury from considering the allegations and evidence of physician negligence.[18] This argument is also

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14 Petitioner's Brief at pages 10 to 12.

15 App. at page 1676, lines 16 to 18.

16 App. at page 1694, lines 8 to10.

17 App. at page 1711, lines 9 to 11 (emphasis added).

18 Petitioner's Brief at page 12.

wrong and misplaced.

In the abstract, it is possible the jury could at least consider the allegations and evidence of physician negligence. But without the corresponding instructions, the jury lacked the legal framework necessary to properly analyze whether the evidence met the elements of physician negligence. The trial court's erroneous ruling on MUSC's motion for partial summary judgment lead it to also reject Mr. Turner's requested jury instructions on the issues of negligent supervision and negligent failure to comply with hospital policies.[19] So it is no surprise the jury returned a verdict for MUSC.

Where a request to charge is timely made and involves a controlling legal principle, a refusal by the trial judge to charge the request constitutes reversible error. Ross v. Paddy, 340 S.C. 428, 532 S.E.2d 612 (2000). Moreover, when general instructions to the jury are insufficient to enable the jury to fully understand the law of the case and the issues involved, a refusal to give a requested charge is reversible error. *Ibid. See also*, Cohen v. Atkins, 333 S.C. 345, 509 S.E.2d 286 (Ct. App. 1998); Brown v. Smalls, 325 S.C. 547, 481 S.E.2d 444 (Ct. App. 1997); Garraway v. Pee Dee Block, Inc., 275 S.C. 511, 273 S.E.2d 340 (1980); Waldrup v. Metropolitan Life Ins. Co., 274 S.C. 344, 263 S.E.2d 652 (1980); and Sanders v. Western Auto Supply Co., 256 S.C. 490, 183 S.E.2d 321 (1971).

MUSC's Policies and Basic Standards of Anesthesia Care were admitted into evidence[20] and discussed with several witnesses. These standards make the administration of anesthesia "the responsibility of the anesthesiologist . . . or his/her designate"[21] and state that

[19] Mr. Turner's requests to charge included S.C. CODE ANN. §40-33-20(20)(CRNA must practice under the supervision of a licensed physician); S.C. CODE OF REG., R 61-16 §1212(A)(4) (certified nurse anesthetist is under the supervision of an anesthesiologist); S.C. CODE ANN. §40-33-20(57)(supervision is the process of critically observing, directing, and evaluating another's performance); Norton v. Opening Break, 319 S.C. 469, 462 S.E.2d 861 (1995) (regulations have the force of law; violation of a 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*); Madison ex rel. Bryant v. Babcock Center, Inc., 371 S.C. 123, 638 S.E.2d 650 (2006) (the standard of care may be established and defined by the common law, statutes, administrative regulations, industry standards, or a defendant's own policies and guidelines).

[20] Plaintiff's Exhibit 8, App. at pages 429 to 437.

[21] App. at page 432.

the nurse anesthetist "will be under [the anesthesiologist's] direction and supervision."[22] Supervision, in this context, is defined by S.C. CODE ANN. §40-33-20(57) as "the process of critically observing, directing, and evaluating another's performance." Because of its erroneous ruling, the trial court refused to charge this statute or the corresponding regulation, S.C. CODE OF REG., R 61-16 §1212(A)(4). This omission allowed the jury to wrongly conclude that Dr. Nelson could be "supervising" Mr. Mikell's anesthesia care while somewhere down the hallway in another room with another patient. Can you critically observe conduct that you cannot see? Can you evaluate and direct someone's performance when you do not even know what they are doing? The jury could not even contemplate, let alone correctly resolve, such questions without being charged the applicable law.

The Policies and Basic Standards of Anesthesia Care further require that "Prior to administering anesthesia, the practitioner administering anesthesia will check and document the readiness, availability, cleanliness, sterility where indicated, working condition and the alarm systems of all equipment to be used" (emphasis in original).[23] The trial court itself observed that this policy obligated Dr. Nelson to make sure the PICIS software was properly functioning before Mr. Mikell was rendered unconscious:

> 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 computer, but I think the computer is there, and it should have been working. He should have made sure it was working.[24]

Defense counsel also argued that Dr. Nelson's obligation to make sure the equipment was working properly before the anesthesia was administered was merely a "record keeping

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[22] App. at page 433.

[23] App. at page 435.

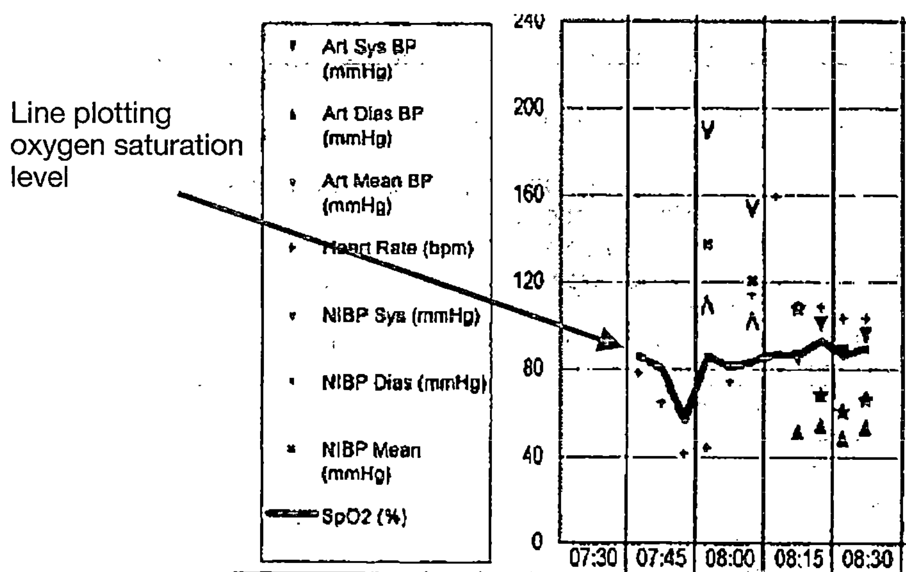
[24] App. at page 1700, lines 3 to 17.

issue," unrelated to patient care, but the trial court responded, "I just don't agree with that."[25]

If the trial court could reach these conclusions, so too could the jury. Yet the jury was not instructed that violation of the Policies and Basic Standards of Anesthesia Care would be evidence of negligence by Dr. Nelson. *See*, Madison ex rel. Bryant v. Babcock Center, Inc., 371 S.C. 123, 638 S.E.2d 650 (2006)(the standard of care may be established and defined by the common law, statutes, administrative regulations, industry standards, or a defendant's own policies and guidelines.) This failure was prejudicial to Mr. Turner and amounts to reversible error.

4. Evidence of Physician Negligence

For the first seven minutes of Mr. Mikell's colonoscopy, no blood oxygen saturation data was recorded by the PICIS anesthesia software. When the software finally came online at 7:48 a.m. and the data started plotting on the Real Time Graph, it showed the oxygen saturation level already rolling downhill towards a cliff:



The Real Time Graph was discussed during the cross-examination of Dr. Nelson:

Q Okay. You had said, when Mr. Cooke was asking you questions, he was asking you whether the administration of propofol was at about 7:41, you said that sounded about right to you?

[25] App. at page 1700, line 23 to page 1701, line 10.

A Yes. Well, I mean, that's what's charted, so.

Q You weren't in the room at the time that that happened, though, were you?

A I can't remember if I was or not.

Q And you also weren't in the room when Donna Embry was sending these text messages and taking these phone calls?

A. No.

Q. And so you really don't know anything about how, if at all, that may have interfered with her ability to manage Mr. Mikell, and you don't know anything really about what his condition was when all of that was taking place?

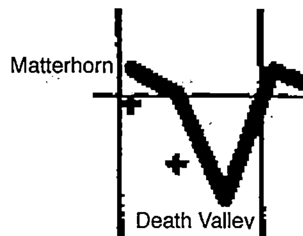
A. I can't speak to when I was not in the room. . . .

Q All I'm saying is, since you weren't there, you don't know?

A Correct.

Q. But what we do know is that — and I'm pointing to the real time graph — what we do know is, that after she does whatever it is that she's done to get this equipment to start working properly, **as soon as it starts plotting, Mr. Mikell's oxygen saturations, I mean, they are headed down the Matterhorn into Death Valley, aren't they?**

A. **It appears that way, yes.**



Q. And you can't tell us, because you weren't there and you don't know, what numbers go in any of these [empty data] boxes?

A. No, it wasn't coming across.

Q **All we know is that once it starts [coming across], it looks pretty bad?**

A **Yeah, I mean, it starts at 7:48, so.**[26]

So by Dr. Nelson's own account, as soon as the data starts being captured by the PICIS software at 7:48 a.m. "it looks pretty bad," meaning Mr. Mikell has <u>already</u> been in trouble since before the graph starts plotting data and that trouble is not abating. Instead, the oxygen saturation level steepens its descent into even worse trouble. Yet as this was taking place — as Mr. Mikell's oxygen saturations are headed "down the Matterhorn into Death Valley" — consistent with his routine practice to be present only at the beginning of anesthesia and again

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[26] App. at page 1588, line 21 to page 1590, line 9.

at the end, checking the patient every hour or so in between,[27] Dr. Nelson inexplicably leaves the room:

Q Okay. So what we see there is that Mr. Mikell takes a pretty steep descent on his O2 sats, pops back up a little bit, 90; it's not great, and you're gone?
A. Well at that point in time, we put the nasal airway in, and he was maintaining his airway and he was stable, so.
Q. **So 7:52, a minute after you go out the door, now he's back at 80?**
A. Right. But I mean this — this —
Q. **Three minutes after you've left, he's at 73. Four minutes after you've left, he's at 62. Now, you wouldn't try to tell this jury that an O2 sat of 62 is nothing to be worried about, would you?**
A. **No. That's bad.**
Q. Right.
A. And that's probably about when I cycled back into the room to check again.
Q. Well, unless we believe your entry in the record, which says that you don't come back into the room until 8:00.

10/01/2010 08:00 EWN	**Memo Came into room. Pt. hypoxic with junctional rhythm and no palpable pulse. ACLS protocol initiated, Mayday team called.**

And by the time you come back into the room, he's gone into this junctional rhythm. He's in pulseless electrical activity. And by that time, as far as Mr. Mikell is concerned, it's sort of ballgame over, isn't it? I mean, he's — he's done?
A. I came in the room, and we started coding him, yes.[28]

No reason was ever given for why Dr. Nelson needed to leave the room. No other patient requiring his immediate attention was ever identified.[29] MUSC nevertheless seeks to excuse Dr. Nelson's departure by claiming Dr. Kofke established the standard of care as allowing an anesthesiologist to supervise up to four patients at once, leaving the room as long as the anesthesiologist remains two minutes away in the event of an emergency.

In making this argument, MUSC simply mischaracterizes Dr. Kofke's testimony. There

[27] App. at page 1574, line 19 to page 1575, line 10.
[28] App. at page 1586, line 6 to page 1587, line 6.
[29] App. at page 1575, lines 11 to 25.

was more to Dr. Kofke's testimony than what MUSC discusses:

> Q: In your practice, if you had CRNAs under you, you would be able to supervise up to four at one time; correct?
>
> A: Yes, that's a lot in my hospital.[30]
>
> * * *
>
> Q: So being directly across the hall from — from the room would be acceptable generally?
>
> A: Oh, oh, yes.[31]
>
> * * *
>
> 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.** . . .[32]

So the entirety of Dr. Kofke's testimony falls short of establishing the standards advanced by MUSC. First, Dr. Kofke did not say that a 4:1 ratio was the standard of care at his hospital in Philadelphia, nor at MUSC. Instead, he said supervising four CRNAs at one time was "a lot." Nowhere did Dr. Kofke say being "across the hall" was acceptable in Mr. Mikell's case. To the contrary, he rejected that very proposition when it was suggested by defense counsel. According to Dr. Kofke, the 4:1 supervision ratio does not apply to Mr. Mikell because his oxygen saturation levels "have been running in the 80s for most of the record."

Dr. Nelson himself testified he should remain in the room with Mr. Mikell unless his oxygen saturations were consistently in the 90s.[33] MUSC insists there is no evidence the oxygen saturations were not consistently in the 90s, but Dr. Kofke testified they were "in the 80s for most of the record." Dr. Nelson testified that something more than a nasal airway was needed if the saturations were below 90.[34] Nurse Embry essentially agreed.[35] MUSC does not

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[30] App. at page 1018, lines 10 to 13.

[31] App. at page 1020, lines 1 to 3.

[32] App. at page 1042, lines 13 to 22 (emphasis added).

[33] App. at page 1596, lines 7 to 11.

[34] App. at page 1550, line 23 to page 1551, line 2.

[35] App. at page 1264, line 17 to page 1265, line 18.

deny the oxygen saturation level went below 90. But prior to the cardiac arrest, nothing was done except the placing of a nasal airway.

In sum, the testimony and evidence simply do not compel acceptance of MUSC's position on the standard of care issues as a matter of law. Taken in the light most favorable to Mr. Turner, there are disputed factual issues for the jury to determine.

Furthermore, whatever happened during the seven minutes that no oxygen saturation data was being recorded, it indisputably predisposed Mr. Mikell to a desaturation and cardiac arrest which the interim placement of a nasal airway did not prevent. Like a snowball gaining mass as it rolls downhill, Mr. Mikell's airway obstruction sent his cardio-pulmonary system careening towards a precipice. As this tragic series of events was unfolding, Dr. Nelson was typing on a keyboard and then leaving the room to go do something else. By the time he returned, Mr. Mikell had already passed the point of no return.

Whether Mr. Mikell's vital signs were stable when Dr. Nelson left the room was one of the most bitterly contested issues during the trial. The proof on this issue included an altered anesthesia chart that Dr. Kofke at times described as "goofy"[36] and unreliable.[37] MUSC consistently claims that isolated data points in the anesthesia chart are indisputable proof and MUSC repeatedly refers to vague testimony about unrecorded data displayed in real time on a monitor, arguing there is no evidence Mr. Michael's vital signs were ever unstable. Yet consider the testimony of Nurse Embry:

Q Now you had said, I think, Mr. Cooke had pointed out with respect to the audit trail, which is Plaintiff's Exhibit 11, that **Dr. Nelson was over here actually at the [PICIS] terminal keying in information at 7:48 — I'm sorry — at 7:49. And what he was putting into the system at that time were these entries as to what he was doing at 7:48?**

A **All right, sir.**

Q And that was what — that's what you and Mr. Cooke talked about; right? So what I wanted to confirm with you then, is if **he's actually on the**

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36 App. at page 1045, line 12.

37 App. at page 1309, line 4 to page 1041, line 2.

terminal at 7:49, we see that Mr. Mikell's oxygen saturation is 75. All right. Now you had testified that when the patient's oxygen saturation is less than 90, you need to be doing something about it? Okay.

A **Yes, sir.**

Q **Would standing at the terminal, entering entries at 7:49 be the thing to be doing when your patient's saturations are 75?**

A **No, sir,** but may I explain? There - there could have been some artifact on the O2 sat, because **if I had noticed that it was that low, or [Dr. Nelson] had noticed that it was that low, we would have done something very differently** than just leaving it at the nasal airway in and the nasal cannula flowing at what it was, so.

Q Well, I just want to make sure I understand this because I'm gathering your defense team is basing your defense on the numbers up here [in the real time variables section]. Okay. And I want to know, can we rely on those numbers as being accurate? Because if they're accurate for your defense, they're accurate for my client, too. And it's the same thing over here with this audit trail, **if Dr. Nelson is on the computer terminal at 7:49 –**

A **Yes.**

Q **— when Mr. Mikell's sats are at 7 — 75, that's malpractice, isn't it?**

A **I don't recall them being that low** when — you know, until he started kind of becoming unstable a little bit later and closer to the Mayday being called.[38]

Oddly, Nurse Embry did not deny that Mr. Mikell's oxygen saturation level was in the 70s while Dr. Nelson was typing. She simply said that she and Dr. Nelson did not notice it at the time and she did not recall it being that low. Of course, Nurse Embry's powers of recollection were severely undermined by her false testimony about the Mayday record and her surreptitious alterations to the anesthesia narrative, her false testimony about the PICIS software problem, and her false testimony about the texts, emails, and phone calls to fix it. She had at various times denied or claimed to not recall any of those things, either. So her feigned inability to recall Mr. Mikell's oxygen saturations being in the 70s as Dr. Nelson made entries in the chart and then left the room was hardly binding upon the jury.

As MUSC itself points out through the testimony of Nurse Embry which it recites,[39] once the nasal airway was placed and Dr. Nelson left the room, Mr. Mikell continued to desaturate, his oxygen saturation level fell to 55% (worse than bad), his airway needed to be

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[38] App. at page 1264, line 4 to page 1265, line 18 (emphasis added).

[39] Petitioner's Brief at page 20.

managed, and she needed help. According to Nurse Embry, this downward spiral initiated at 7:50 a.m. — when the original, unaltered anesthesia record showed Dr. Nelson leaving the room — and it steepened at 7:53 a.m., when Nurse Emery claims she turned off the Propofol infusion in recognition that the situation had gotten away from her and she needed assistance. Although Nurse Embry testified that Dr. Nelson returned to assist her "almost immediately," Dr. Nelson's own unaltered entry in the anesthesia chart showed that he did not in fact return to the room until 8:00 a.m., at which point Mr. Mikell was already in full cardiac arrest.

So according to the testimony which MUSC itself recites, Nurse Embry was alone with Mr. Mikell for 5 to 10 minutes in the midst of a crisis requiring help to reposition Mr. Mikell (who weighed over 300 pounds) in order to manage his obstructed airway. Dr. Nelson simply was not there. Although MUSC contends the standard of care allowed Dr. Nelson to be two minutes away, clearly he was gone for longer than that. This is true even if MUSC's assertion that Dr. Nelson left the room at 7:51 a.m. and returned at 7:56 a.m is accepted as true. Did Dr. Nelson have something more important to do than attend to Mr. Mikell, whose fragile medical history and tenuous reaction to the induction of anesthesia had already put him in jeopardy?

Although there may be evidence that the administration of Propofol was reduced at some point, Dr. Kofke testified the anesthesia chart did not clearly identify when this occurred.[40] Moreover, evidence of a mere reduction in the flow of Propofol is not proof as a matter of law that Dr. Nelson was present in the room at any specific time. If the argument is that the Propofol was reduced, therefore Dr. Nelson must have been in the room, it is a glaring *non sequitur* rather than a necessary inference.

MUSC cleverly seeks refuge in the peak inspiratory pressures (PIP) sprinkled in the anesthesia chart, contending this data is incontrovertible evidence that Dr. Nelson was in the room at 7:55 a.m. or 7:56 a.m.[41] These PIP values reflect the use of a bag valve mask to provide oxygen to Mr. Mikell. The PIP values were discussed during Dr. Kofke's cross-

[40] App. at page 1037, line 13 to page 1039, line 19.

[41] Petitioner's Brief at page 27.

examination.[42]

Dr. Kofke noted MUSC's PIP theory is inconsistent with the corresponding Fi02 values[43] which show the oxygen flow rate through the bag valve mask: "Why would you be giving someone in this situation 25 percent oxygen?"[44] Dr. Kofke believed the PIP values represented inadequate ventilation,[45] thereby supporting the theory that Nurse Embry faced a crisis she could not manage by herself: She could not turn Mr Mikell onto his back and hold the bag valve mask to his face, turning up the oxygen flow and executing needed chin lift and jaw thrust maneuvers all by herself. If the argument is that the PIP values mean it must have been Dr. Nelson who was using the bag valve mask to inadequately ventilate Mr. Mikell with only 25% oxygen, that too is a *non sequitur* rather than a necessary inference.

In short, the Propofol and PIP issues are not conclusive evidence establishing as a matter of law that Dr. Nelson was in the room at some specifically identifiable moment earlier than the 8:00 a.m. time which Dr. Nelson himself documented. MUSC can dispute that entry all it wants, but Dr. Nelson himself testified he intended it to be accurate when he made it.[46] Disputed evidence has to be weighed and decided by the jury.

MUSC suggests that all of the evidence of physician negligence is somehow neutralized by the anesthesia providers' self-serving claims that they nevertheless felt comfortable with what they were doing. This is akin to the Captain of *The Titanic* feeling comfortable sailing in the icy North Atlantic. History is filled with incidents of misplaced confidence, proving the truth of the ancient proverb, "Pride goes before destruction, and a haughty spirit before a fall."[47] A false sense of assurance was the last thing Mr. Mikell needed from his anesthesia providers. Dr.

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[42] App. at page 1051, line 10 *et seq.*

[43] The Fi02 value is the fraction of inspired oxygen, representing the concentration of oxygen in the gas mixture flowing through the bag valve mask. The gas mixture at room air has a fraction of inspired oxygen of 21%, meaning that the concentration of oxygen at room air is 21%. In an emergency, the FiO2 should be 100%.

[44] App. at page 1053, lines 10 to 11.

[45] App. at page 1053, lines 19 to 23.

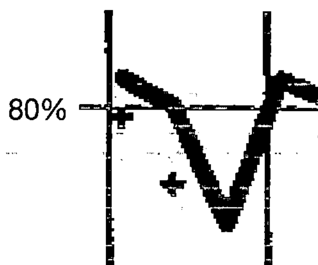
[46] App. at page 1576, line 5 to page 1578, line 10.

[47] Proverbs 16:18, New King James Version.

Nelson may have felt it was safe to leave a fragile, tenuous patient but Mr. Mikell paid a high price for that misjudgment, which Dr. Kofke criticized as a breach the standard of care.

The same is true of Nurse Embry's self-congratulatory self-assessment that she and Dr. Nelson had the "absolute best plan and the safest plan for our patient. . . I'm very pleased with what we did for him, and how we reacted to him becoming unstable."[48] If the absolute best and safest plan results in your patient spending the next six weeks in the ICU recovering from a cardiac arrest, what would the outcome of a bad plan look like? And while Nurse Embry may have been pleased with how the anesthesia care was managed, Dr. Kofke and Mr. Mikell's family most assuredly were not. Simply stated, these sorts of gratuitous comments have no place in an objective analysis of the standard of care or the evidence.

MUSC contends there is no evidence disputing its assertion that when Dr. Nelson left the room Mr. Mikell's blood oxygen saturation level was 90% or higher.[49] MUSC also contends that Mr. Turner has somehow succeeded in duping the Court of Appeals into misapprehending and placing undeserved weight on the vital signs data recorded by the PICIS anesthesia software.[50] These arguments are refuted by the testimony of Dr. Nelson and Nurse Embry recited and discussed above. But beyond even that, these arguments are likewise defeated simply by looking again at the Real Time Graph:



It cannot credibly be argued that this graph shows an "appropriate and stable" blood oxygen saturation level.[51] To the contrary, it shows that level dropping off a cliff. Anyone who is

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48 Petitioner's Brief at page 21.

49 Petitioner's Brief at pages 23 to 27.

50 Petitioner's Brief at pages 28 to 30.

51 Petitioner's Brief at page 28.

not blind can clearly see and appreciate this. It is not an electronic artifact or clever evidentiary mirage. It is an accurate, computer-generated, graphic representation of cold, hard fact. This graph literally shows a man headed to his death.

This graph — which is certainly not the only evidence of physician negligence — supports several reasonable inferences: (1) Mr. Mikell's airway was not being adequately managed; (2) his oxygen saturation level was never consistently in the 90s; and (3) it was not safe for Dr. Nelson to leave the room to go do something else. These inferences do not evaporate, and the evidentiary weight of this graph is not suspended, by claims that Mr. Mikell's vitals signs were being instantaneously displayed with every heartbeat so that the graph and the oxygen saturation data it plots somehow give a false perspective of the situation Dr. Nelson and Nurse Embry were facing. MUSC is free to dispute the evidence and inferences, but the jury is the rightful arbiter of all such disputes.

MUSC's argument that no jury issue was created about the stability of Mr. Mikell's oxygen saturation level is further put paid by the undeniable fact that Mr. Mikell went into cardiac arrest as the result of an upper airway obstruction.[52] Whatever comfort Dr. Nelson and Nurse Embry may claim to have had based upon whatever so-called irrefutable or incontrovertible evidence MUSC may wish to recite, the undeniable truth remains that they were 100% wrong. Mr. Mikell's oxygen saturation level was <u>not</u> stable, he was <u>not</u> okay, and it was <u>not</u> safe to go do something else down the hall.[53] However great a plan the anesthesia care providers might now wish to claim they had, it lead to total disaster.

MUSC contends there was no evidence Dr. Nelson breached a duty of care in failing to ensure the PICIS software was working properly before Mr. Mikell was rendered unconscious.[54] The analogy here is that a truck driver has no duty to check his tires before leaving the parking

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[52] Dr. Nelson himself admitted the cardiac arrest was the result of an obstructed airway. App. at page 1580, line 12 to page 1581, line 18.

[53] While South Carolina does not recognize the burden-shifting doctrine of *res ipsa loquitur*, this does not mean that negligence — even medical negligence — cannot be proved using circumstantial evidence. <u>Eickhoff v. Beard-Laney, Inc.</u>, 199 S.C. 500, 20 S.E.2d 153 (1942); <u>Cox v. Lund</u>, 286 S.C. 410, 334 S.E.2d 116 (1985).

[54] Petitioner's Brief at pages 31 to 33.

lot with a loaded trailer. This issue requires an analysis of both MUSC's Policies and Basic Standards of Anesthesia Care and the statutes imposing a duty of supervision.

Scott Reeves, MD was the Chairman of the Department of Anesthesia at MUSC. He was called to testify about MUSC's Policies and Basic Standards of Anesthesia Care. The following testimony was developed:

> Q . . . Under South Carolina State law, a nurse anesthetist isn't actually allowed to administer anesthetic agents like Propofol, for example, unless she's being supervised by a medical doctor; right?
> A That's correct.
> Q And that's why we see that provision, that standard, is in these policies and guidelines several different times because it's so important?
> A That's correct.
> Q Now, if we turn to page 4 of 6, one of the important responsibilities that the anesthesiologist and the nurse anesthetist has is to make sure that all of the equipment is working properly before they start the procedure; correct?
> A Correct.[55]

Which is to say, Dr. Reeves agreed that the responsibility to make sure all of the equipment is working properly falls upon <u>both</u> Dr. Nelson and Nurse Embry. Dr. Reeves continued:

> Q And would you agree with me that if a nurse anesthetist or an anesthesiologist, as the case may be, administered an anesthetic agent to render a patient unconscious when they hadn't checked to make sure all of the equipment was functioning properly, that would be a breach of these standards of care?
> A **Yeah.** This — this particular thing is talking specifically about monitoring equipment, but that's correct.
> Q Okay. So — and we can agree that with respect to these standards that are set forth in Exhibit 8, if they aren't followed that's — that's — that's a breach of the standard of care?
> A It's our policy, **correct.**
> Q Okay. And it indicates up here that "The practitioner administering the anesthesia will check and document the readiness, availability, cleanliness, sterility, when indicated, working condition and alarm system of all equipment to be used"; that's right, isn't it?
> A **Correct.**
> Q Okay. And the working condition would be anything that might prevent some piece of equipment from functioning as properly intended; right?
> A **Correct.**
>
> * * *
>
> Q . . . if an anesthesia provider knew that the PICIS — what do we want to call it — the PICIS system was not functioning properly, should they fix that before or after they knock the patient out?
> A **They should fix it before.**

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[55] App. at page 1338, line 22 to page 1339, line 12.

Q Okay.

A I would like to make one more comment. This particular guideline that you're talking about was signed in 2009, which is before we had electronic record systems.

Q All right. Well, do these standards apply, though, to new systems that are implemented in the hospital?

A **Yeah**. . . .[56]

This last testimony addresses MUSC's argument that the Policies and Basic Standards of Anesthesia Care were somehow superseded by the time of Mr. Mikell's colonoscopy. According to Dr. Reeves, they were not.

Dr. Reeves further testified that if Nurse Embry knew the PICIS software was not working properly, it would be a violation of the Policies and Basic Standards of Anesthesia Care for her to put Mr. Mikell to sleep.[57] He then went on to begrudgingly admit that during the time when she was trying to fix the PICIS software problem, Nurse Embry did in fact administer Propofol to Mr. Mikell, thereby putting him to sleep.[58]

So here is testimony from the Department Chairman that Nurse Embry violated MUSC's Policies and Basic Standards of Anesthesia Care by undertaking a regulated activity — the administration of Propofol — without direct physician supervision and without first making sure the PICIS system was working properly.

This goes to the very heart of Mr. Turner's allegations and evidence of physician negligence: Because Dr. Nelson was not properly supervising Nurse Embry, she acted in violation of both South Carolina state law and MUSC's Policies and Basic Standards of Anesthesia Care by rendering Mr. Mikell unconscious without first making sure all of the equipment was working properly. Prevention of such improper, unsafe conduct is the very reason why the physician has a duty of supervision in the first place: the doctor is supposed to make sure anesthesia is not administered in an unsafe manner. It was Dr. Nelson's obligation to prevent Nurse Embry from knocking Mr. Mikell out before the PICIS system was working

56 App. at page 1339, line 13 to page 1341, line 19 (emphasis added).

57 App. at page 1342, line 21 to page 1343, line 1; and page 1344, lines 12 to 21.

58 App. at page 1345, line 18 to page 1346, line 2.

properly.[59] If Dr. Nelson had done that,[60] the snowball of airway obstruction would not have rolled off the cliff of desaturation into the valley of cardiac arrest.

Dr. Kofke's first criticism was that despite Mr. Mikell's fragile medical history and unstable oxygen saturations in the 80s, Dr. Nelson simply "popped in and out." There is certainly evidence in the record to support that position. MUSC has gamely tried to counter that evidence, but it exists in the trial record nevertheless, thus creating a factual dispute which only the jury can resolve.

Dr. Kofke's second criticism was that because Dr. Nelson was not in the room, Nurse Embry did not have anyone to help her reposition Mr. Mikell and manage his airway, a circumstance which she herself described in testimony which MUSC itself recites.[61] As Dr. Kofke succinctly stated, "I think that the two of them could have made sure that the airway was patent."[62]

As to the issue of proximate cause, Dr. Kofke testified as follows:

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 the 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.[63] And then he — he could

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[59] As explained at page 10, *supra*, the trial court fully understood and accepted the logic of this reasoning.

[60] Dr. Nelson himself acknowledged that he was responsible for the decisions that were made in providing Mr. Mikell's anesthesia care. App. at page 1574, lines 10 to 18.

[61] Brief of Petitioner at page 20.

[62] App. at page 980, lines 19 to 20.

[63] A patent airway is the opposite of an obstructed airway.

have managed the fairway while she managed the electronic record.[64]

Dr. Kokfe had offered additional commentary about proximate cause earlier in his testimony:

Q Okay. 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, their — 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 pre-op 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 know, a chin lift, opening the mouth. You know, various things to support — get the tongue — get the tongue off. And if its 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.[65]

* * *

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 — the 47 is a life — is an alarm.

Q And so what should the anesthesia providers have been doing?

A **They should have been supporting his airway** — focusing on the patient, supporting the airway, and you know — getting the sats back up.

Q Now, if they had done those things, would his sats 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.**[66]

The maneuvers Dr. Kofke was referring to had been explained to the jury using a series of anatomical diagrams and a video simulation.[67] He described these maneuvers as "a fairly straight forward technique to keep the airway open."[68] Dr. Kofke clearly expressed the

[64] App. at page 979, line 24 to page 980, line 22.

[65] App. at page 957, line 20 to page 958, line 14 (emphasis added).

[66] App. at page 959, line 24 to page 960, line 24 (emphasis added).

[67] *See, e.g.*, App. at page 950, lines 4 to 6; and page 954, line 2.

[68] App. at page 773, lines 13 to 21.

conclusion that if both Dr. Nelson and Nurse Embry had been in the room working together in tandem, it would have been a simple matter for them to manage Mr. Mikell's airway using these straight forward maneuvers so that Mr. Mikell would not have desaturated into cardiac arrest. This testimony, coming from a pre-eminently qualified anesthesiologist who has served on the faculty at several elite academic medical centers, should have been sufficient to get Mr. Turner's claims of physician negligence to the jury. The Court of Appeals agreed.

MUSC nevertheless contends there is no evidence that Nurse Embry was unable to establish a patent airway by herself.[69] This argument denies reality. The fact that Mr. Mikell desaturated into cardiac arrest is irrefragable proof that Nurse Embry was indeed unable to establish a patent airway by herself.[70] If there were nothing preventing her from establishing a patent airway, then why did she fail to do so? After all, Mr. Mikell's life depended upon it.

It bears mentioning that the causation testimony in this case bears no resemblance to Harris Teeter, Inc. v. Moore & VanAllen, P.C., 390 S.C. 275, 701 S.E.2d 724 (2010).[71] When testifying about causation, Dr. Kofke never said anything even remotely like, "You never know because it's conjecture." Likewise, the evidence here goes beyond mere proof of an increased risk of harm, so that Sherer v. James, 290 S.C. 404, 351 S.E.2d 148 (1986)[72] is not controlling, either.

Lastly, MUSC contends that because Mr. Turner did not timely allege claims of physician negligence, nor disclose Dr. Kofke's opinions about physician negligence, Mr. Turner was not prejudiced by the trial court's erroneous ruling.[73] Not only are the premises of this argument completely false — physician negligence was alleged and Dr. Kofke's opinions were disclosed — but even if the premises were true, the conclusion does not follow. The trial court correctly rejected these arguments and MUSC did not appeal its rulings. An unappealled trial

[69] Petitioner's Brief at pages 35 to 36.

[70] Dr. Kofke testified that the cardiac arrest was caused by hypoxia, which is a lack of sufficient oxygen to support normal heart function. App. at page 969, lines 11 to 13.

[71] Cited at page 34 of the Petitioner's Brief.

[72] Cited at page 35 of the Petitioner's Brief.

[73] Petitioner's Brief at pages 36 to 37.

court ruling cannot serve as the basis for this Court to reverse the decision of the Court of Appeals. The illogic of MUSC's argument is once again manifest: How could it be error for the trial court to admit undisclosed evidence of unalleged physician negligence if, as MUSC claims, no such evidence exists?

CONCLUSION

Mr. Mikell's cardiac arrest came about through the confluence of several factors. First, as a result of Mr. Mikell's well-known, pre-existing obstructive sleep apnea, when he was rendered unconscious by the Propofol his upper airway obstructed so that Mr. Mikell's oxygen saturation level dropped early during the colonoscopy. Mr. Mikell's fragile heart was adversely affected by the resulting changes in blood oxygen and carbon dioxide levels and his cardiac function took a blow from which it never recovered. Second, Nurse Embry and Dr. Nelson were not paying proper attention when the administration of Propofol began so that a problem with the PICIS software was not corrected until the anesthesia was already underway. This blunder allowed Mr. Mikell's airway obstruction to go unnoticed and unmanaged until it was already headed toward a cliff. The placement of a nasal airway was simply not enough to stop the desaturation-to-arrest pathway once it had been triggered. Third, Dr. Nelson just "popped in and out" of the room so that Nurse Embry was alone to wrestle the desaturation and cardiac arrest which inexorably followed from the ineffectively managed initial airway obstruction. These multiple failures by the anesthesia team combined to lead to cardiac arrest and disaster for Mr. Mikell. The evidence at trial fully supports each part of this narrative. MUSC is free to dispute this evidence, but it is in the record nonetheless and Mr. Turner was entitled to have the jury weigh and determine it.

South Carolina law and MUSC hospital policy both make Dr. Nelson responsible for: (1) the proper functioning of the PCIS software; (2) the safe administration of anesthesia; and (3) the direct supervision of Nurse Embry. Yet Dr. Nelson was barely present in the room despite knowing Mr. Mikell was a tenuous patient who had already encountered an airway obstruction. Dr. Kofke testified that Dr. Nelson breached the standard of care and that the cardiac arrest

would not have occurred without his breach.

Given all of this evidence, the Court of Appeals correctly determined that the trial court erred in granting MUSC's motion for partial summary judgment. As the Court of Appeals correctly observed, there was sufficient evidence to support a verdict for physician negligence. The trial court's erroneous ruling on MUSC's motion for partial summary judgment lead it to refuse Mr. Turner's requested jury instructions on important aspects of his physician negligence claims. This error was not harmless and merits reversal for a new trial.

Respectfully submitted,

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