IN THE SUPREME COURT OF MISSISSIPPI
NO. 2006-TS-00639

UNIVERSITY OF MISSISSIPPI MEDICAL
CENTER AND JOHN DOES ONE THROUGH TEN — APPELLANT

VS.

EARQUELLA WARD — APPELLEE

CERTIFICATE OF INTERESTED PERSONS

The undersigned counsel of record certifies that the following listed persons have an interest in the outcome of this case. These representations are made in order that the justices of the Supreme Court and/or the judges of the Court of Appeals Court may evaluate possible disqualification or recusal.

1. Earquella Ward, appellee.

2. G. Joseph Diaz, Jr., Esq., Patrick K. Williams, Esq., Diaz Lewis & Williams, 115 South Congress Street, Suite 1218, P. O. Drawer 24268, Jackson, MS 39225-4268, attorneys for appellee.

3. Edward Blackmon, Jr., Esq., Blackmon & Blackmon, PLLC, 907 West Peace Street, P. O. Box 105, Canton, MS 39046, attorneys for appellee.

4. The University of Mississippi Medical Center, appellant.

5. Senith C. Tipton, Esquire and Melanie H. Morano, Esquire, Wilkins, Stephens and Tipton, P.A., P. O. Box 13429, Jackson, MS 39236-3429, attorneys for appellant.

SO CERTIFIED, this the 8th day of December, 2006.

BY: _____
Senith C. Tipton (MSB No. 8227)
Melanie H. Morano (MSB No. 100339)

Wilkins, Stephens & Tipton, P.A.
One LeFleur's Square, Suite 108
4735 Old Canton Road [39211]
P. O. Box 13429
Jackson, MS 39236-3429
Telephone: (601) 366-4343
Facsimile: (601) 981-7608 (fax)

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases Page

Statutes and Rules

Other Authorities

I. STATEMENT OF THE ISSUES

1. The trial court erred by relying upon non-existent and otherwise inadmissible testimony by treating physician Dr. Walter Wolfe.

2. The trial court erred by materially mischaracterizing the testimony of Dr. Thomas Austin.

3. The trial court erred in finding that Dr. Dave David was qualified as an expert witness in this case and that his testimony was relevant and reliable.

4. The trial court erred in finding that plaintiff's expert, Dr. Dave David, proved that UMMC breached the standard of care, proximately and foreseeably causing Ms. Ward's alleged severe infection and hysterectomy on or about April 5, 2004.

5. The trial court erred in any reliance upon the OB/GYN department's student practice guidelines as the standard of care in this case.

6. The trial court erred in denying UMMC's motion for directed verdict (involuntary dismissal).

II. STATEMENT OF THE CASE

A. Nature of the case, the course of the proceedings, and its disposition in the trial court.

Ms. Earquella Ward filed her lawsuit against the University of Mississippi Medical Center ("UMMC"), on December 31, 2002, alleging medical malpractice resulting in a hysterectomy. (C.P. 7.) The trial took place on October 24, 2005, with the trial judge sitting as the trier of fact pursuant to the Mississippi Tort Claims Act. At trial Ms. Ward offered the supportive testimony of her experts, Dr. Dave David (former practicing OB/GYN

physician who now derives most of his income through expert testimony) and Dr. Walter Wolfe (treating physician at Central Mississippi Medical Center ("CMMC") who performed the hysterectomy). UMMC offered the supportive testimony of its experts and physicians Dr. Carl Reddix (a local practicing OB/GYN physician), Dr. Stanley Chapman (director of the division of infectious diseases at UMMC), Dr. James Martin (attending physician and chief of the OB/GYN department at UMMC), and Dr. Thomas Austin, Dr. Ty Robinson, and Dr. Ben Hudson (former OB/GYN residents and licensed physicians).

Pursuant to the trial court's direction, the parties submitted post trial briefs. UMMC submitted its "Defendant's Proposed Findings of Fact and Conclusions of Law." (R.E. 5.) The plaintiff submitted her "Trial Brief of the Plaintiff." (C.P. 226; R.E.10.)

The trial judge's "Memorandum Opinion and Judgment" was signed on March 15, 2006, with a finding that UMMC breached the standard of care, proximately causing or contributing to Ms. Ward's injury, including her hysterectomy. (C.P. 243; R.E. 7.) Another judgment awarding damages was subsequently signed on April 25, 2006. (C.P. 253; R.E. 6.) From these judgments against UMMC, this appeal is taken.

B. Statement of the facts relevant to the issues presented for review.

Plaintiff Ms. Earquella Ward delivered her second child by repeat Caesarean section on March 14, 2002, at UMMC. She had a normal post-partal course until March 18, 2002, when she experienced a single temperature spike and a second elevated though declining temperature measurement. (T. 412-420, 529-530, 571-577; R.E. 2, pp. 13-14; T.E. D-1, 70.) Based upon her clinical examination, Ms. Ward was diagnosed with presumed endometritis ("EMM"), which is an inflammation or infection of the inner lining of the uterus and a

known complication of a Caesarean delivery, a diagnosis plaintiff maintains is correct. (T. 203, 218, 236, 258-259, 418-420, 537, 544-545, 601-602; R.E. 2, pp. 22-23; T.E., D-1, 44.)

Ms. Ward was treated for EMM with intravenous Unasyn, a broad spectrum penicillin antibiotic covering multiple bacterial pathogens which was one of the antibiotics recommended by the practice guidelines. (T. 202-203, 258, 418, 421-422, 457,459, 531-532, 541, 573-575; R.E. 11, p. 3.) Ms. Ward remained on Unasyn for 42 hours, approximately 48 hours after her elevated temperature showed a significant decline. (T. 211-212, 215-218, 418, 421-422, 531-532, 573-575, 577; T.E. D-1,110, 114.)

Several laboratory tests (complete blood count - "CBC", urinalysis, and blood cultures) were among those tests listed in the OB/GYN department's student practice guidelines and initially planned by resident physician Dr. Thomas Austin, but for unknown reasons they were not ordered, possibly because they were deemed unnecessary by the attending physician. (T. 218-220, 234, 535-536; R.E. 11, p. 2; R.E. 2, pp. 27-28; T.E. D-1, 44.) The guidelines were not a protocol, but were a summation of diagnostic and treatment considerations and a starting point for student learning created by the OB/GYN faculty. (T. 533-535, 602-603.)

During her hospitalization, Ms. Ward's incision showed no signs or symptoms of infection. (T. 228, 427-428, 435, 538, 578; R.E. 2, p. 23; T.E. D-1, 44-45,124.) Because her symptoms readily improved, no re-evaluation of her condition for resistant organisms such as MRSA was thus needed, as suggested by the guidelines if a patient's condition does not improve after initial antibiotic therapy. (R.E. 11, p. 3; R.E.2, p. 15; T. 212, 421, 532, 538, 575-578.) On March 20, 2002, she was discharged home with no evidence of infection.

(T. 212, 226, 426-427, 532, 538, 577-578; R.E. 2, pp. 17-18; T.E. D-1, 44,124.) Defendant's experts Dr. Reddix, Dr. Martin, and Dr. Chapman all testified that the care received on March 18-20 was within the standard of care and no laboratory testing was required. (T. 411, 423, 435, 453, 538-539, 570, 575, 593.)

One week later on March 27, 2002, a home nurse from the health department observed that Ms. Ward's temperature was elevated and pulled off the incision dressing, documenting redness, swelling and slightly brownish purulent drainage from a small nodule. (T. 50-51, 343-344; T.E. D-4, 31.) At her suggestion, Ms. Ward went to the UMMC OB Receiving clinic that same day for a wound evaluation. At UMMC, Dr. Ty Robinson observed fever and swelling but no redness at that point. (T. 120-121; R.E.3, p. 7-8; R.E. 4, p.69, 12, 22; T.E. D-1,190-191,195,198.) He opened, drained and cleaned the portion of Ms. Ward's incision displaying symptoms, finding only clear seroma fluid as the source of her inflammation, and no purulent drainage. (R.E. 3, pp.7-8; R.E. 4, pp. 6, 8- 9, 16, 20-21; T.E. D-1,190-191, 195,198.) Dr. Robinson found no signs indicative of EMM on March 27. (R.E. 4, p. 8-10,16-17.)

Given Ms. Ward's clinical presentation, no CBC or wound culture was needed on March 27. (T. 429-430, 434, 559-561, 579-580; R.E. 4, pp. 8, 12-14; R.E. 3, pp. 9-11,16.) There is disagreement between the experts as to whether Ms. Ward's incision was inflamed or infected on March 27, although plaintiff's expert Dr. David based his opinion that it was infected solely on an incorrect assumption that the wound interior contained purulent drainage. (T. 274-275, 429-434,546, 555, 578-581; R.E. 3, pp. 9-10; R.E. 4, pp. 8,10-12,17,21.) Nonetheless, Ms. Ward was provided treatment that would have been curative

of a wound infection even if one had been present. (T. 433-434, 579-580; R.E. 4, pp. 8, 12-14; R.E. 3, pp. 9-11,16.)

After Dr. Robinson opened, drained and cleaned Ms. Ward's incision, she was given wound care instructions to continue at home and she was prophylactically prescribed Keflex, a broad spectrum oral antibiotic used to treat soft tissue infections. (T. 432-433, 518, 558-559, 564, 578-580; R.E. 4, pp. 12,18-20, 22; R.E. 3, pp. 8-9,12-15; T.E. D-1, p. 191.) Over the next several days, Ms. Ward's fever abated, her drainage stopped, her incision closed, and she brought no further complaints to UMMC. (T. 347-348, 435, 581-583.) Defendant's experts Dr. Reddix, Dr. Martin, and Dr. Chapman testified that the care received on March 27 was within the standard of care and no laboratory testing was required. (T. 411, 433-435, 453, 563-564, 570, 579-581, 593.)

On April 5, 2002, Ms. Ward went to the emergency department at Central Mississippi Medical Center ("CMMC"), with complaints of brisk vaginal bleeding. (T. 136, 348-349, 436-437; T.E. D-2,385-387.) Ms. Ward's temperature was normal, her CBC showed a white blood count ("WBC") within the normal laboratory range, and her clinical presentation did not otherwise suggest a severe infection on admission. (T. 142-143, 437-439, 482-483, 506, 582-586, 597; T.E. D-2, 385-387, 427.) Ms. Ward was examined by the emergency department physician who made no mention of a potential infection. (T. 438-442; T.E. D-1, 385-387.) An ultrasound report indicated several possible evolving hematomas (blood clots), in Ms. Ward's uterus and abdomen, an occurrence not uncommon after a Cesarean delivery. (T. 273-274, 441-442, 499, 605-606; T.E. D-2, 442.)

Ms. Ward was later examined by Dr. Walter Wolfe, an on-call OB/GYN physician, who performed immediate exploratory surgery for infection with possible necrotizing fasciitis (a rare but life-threatening infection of the abdominal wall) which was ruled out during surgery. (T. 172, 444-445; T.E. D-2, 265-267.) At trial Dr. Wolfe testified that he removed Ms. Ward's uterus "for the best post operative outcome," and "the absolute best benefit" although her ovaries were left intact. (T.152, 154, 183-184.) No blood culture was performed at CMMC, as Dr. Wolfe did not think Ms. Ward had infection in her bloodstream. (T. 142-143, 518, 584-585.) There was disagreement among the experts as to whether or not Ms. Ward had a severe infection prior to her surgery on April 5, 2006, but Dr. Wolfe's notes indicate that Ms. Ward was in stable condition following the surgical procedure. (T. 277-279, 436-442, 582-583; T.E. D-2, 368-369.) The first time Ms. Ward began to exhibit clear symptoms of infection was post-operatively the following day when she developed a continuous fever and an elevated white blood count that rose to more than twice the normal range. (T. 451, 452, 515-516, 585-586; T.E. D-2, 416, 418, 424, 427.)

Dr. Wolfe documented that Ms. Ward stated before surgery that she did not want any more children, and she did not have a problem with a hysterectomy, if necessary, on this basis. (T. 145-147, 172-174, T.E. D-2, 366.) After the surgery, Dr. Waddell, the physician who made rounds on Ms. Ward, documented that he told her about the hysterectomy and that she would not be able to have additional children, whereupon she responded that this was okay with her. (T. 174-176, T.E. D-2, 415.)

The culture taken of the surface of Ms. Ward's suture line during surgery returned a delayed growth three days later of "few" methicillin resistant staphylococcus bacteria

("MRSA"), of the outpatient or community-acquired variety. (T. 160, 448-451, 586-589, 591, 596; T.E. D-2, 436.) MRSA is a strain of staph aureas bacteria which is normally found on the skin surface and is resistant to many commonly used antibiotics.(T. 263-266, 448-450, 586-589, 591.) The "few" number of colonies indicated a small amount of bacteria and the delayed three-day growth indicated the MRSA was not a major organism in any infection. (T. 449-451, 586-589, 591.) An MRSA infection has an incubation period of a few hours to a day or two, and was believed by Dr. Reddix and Dr. Chapman to be a contamination of the wound surface rather than the cause of an infection. (T. 448-451, 586-589, 591-592, 604.) Dr. Chapman testified that it is very common to have staph bacteria (including MRSA) on a person's skin as normal flora. (T. 591.)

A culture taken from the deeper incision site grew high numbers of group B streptococcus, a bacteria normally found in the GI tract, the vagina, and the skin of the perineal area, which Dr. Chapman thought to be the cause of Ms. Ward's infection subsequent to her admission to CMMC. (T. 450-451 589-591, 596-597; T.E. D-2, p. 435.) Group B Strep is sensitive to penicillins, such as Unasyn. (T. 162,421; T.E. D-2, p. 435, R.E. 11, pp. 1, 3.) The typical rapid progression of a Group B strep infection made it unlikely that Ms. Ward had the Group B strep infection found at CMMC more than a couple of hours to a couple of days before its discovery. (T. 592, 604, 608-609.) The culture taken from the abdominal drainage tube several days after surgery revealed no growth of bacteria, thus no bacteria was documented in the deeper abdominal area. (T. 451-452, 590-591; T.E. D-2, 434.)

Dr. Wolfe's original operative note written on the day of the surgery explained the procedure simply as an exploratory laparotomy with lysis of adhesions, evacuation of a massive abdominal wall hematoma, total abdominal hysterectomy and wound debridement. (T. 175; T.E. D-2, 415.) When the uterus was examined by the pathologist after surgery, his findings were consistent with the pre-surgical ultrasound report, and he found no necrosis, purulent infection, or missing portions. (T. 445-448, 494-496, 607-608; T.E. D-2, 421-422.) However, Dr. Wolfe's later operative note, dictated on April 8, 2004, (by which time Ms. Ward had developed a serious post-operative infection) stated that he had removed Ms. Ward's uterus because it was infected and necrotic with portions missing. (T. 149, 152-153; T.E. D-2, 368-369.) Dr. Wolfe initially prescribed several antibiotics (including Unasyn) for Ms. Ward, but changed her antibiotics as indicated in the cultures when her condition did not improve. (T. 158-159; T.E. D-2, 379-380, 407.) The pathology report did indicate the presence of chronic endometritis ("EMM"), which was more likely than not an inflammatory response to the normal process of Ms. Ward's uterus shrinking back to pre-pregnancy size and may have been the cause of Ms. Ward's vaginal bleeding on April 5. (T. 447-448, 600-601.)

Ms. Ward did not take all of her antibiotics after leaving CMMC as instructed, and developed a small pus pocket on her abdomen near the incision. (T. 181-182; T.E. D-14.) Ms. Ward informed Dr. Wolfe that unless he had done something wrong she should not have an infection. (T. 182.) Dr. Wolfe chastised Ms. Ward for not taking her antibiotics and for wearing extremely tight jeans, which could have negatively affected the healing process and trapped infectious material in her incision. (T. 180-183.)

III. SUMMARY OF THE ARGUMENT

Ms. Ward believes that she had an EMM infection on March 18 and a wound infection on March 27, although her expert, Dr. David, did not fully acknowledge the fact that UMMC had diagnosed her as possibly having these conditions and had actually treated her for them. Although plaintiff counsel attempted to guide the questioning to imply that Ms. Ward had an MRSA infection on March 18 and/or on March 27 based on the finding of the few MRSA bacteria on the surface of her incision on April 5, Dr. David did not express this opinion. (T. 263-265, 282-284.)

In the course of his testimony, Dr. David discussed multiple diagnostic tests, treatments, conditions and problems. The language he used was often so nonspecific that it was unclear which test, treatment, condition or problem he was referring to. His opinion was based upon multiple factual inaccuracies and he failed to explain the basis of his illogical opinion that the several alleged breaches of the standard of care proximately caused Ms. Ward's later hysterectomy. The sum of his testimony essentially alleged a failure to cure, and was so nonspecific and unsupported by the facts as to be unreliable and unconvincing as authority.

UMMC maintains that Ms. Ward was properly diagnosed and treated for presumed EMM within the standard of care on March 18, after which her symptoms readily responded. UMMC further maintains that Ms. Ward was examined for a possible wound infection on March 27 and treated with wound cleaning, antibiotics and continued home wound care meeting the standard of care, and her symptoms likewise responded quickly. As UMMC and

Dr. David based their diagnoses on Ms. Ward's clinical presentation, the performance of laboratory testing was not required.

UMMC asserts that no breach of care or lack of care provided by UMMC proximately and foreseeably caused Ms. Ward's hysterectomy at CMMC. UMMC maintains that the short incubation period of MRSA and Group B strep precluded a likelihood that these infections were present on March 18 and 27, and the few MRSA bacteria cultured from the surface of her incision during surgery on April 5 was most likely a community-acquired contaminant rather than an infection. UMMC notes that because the few MRSA bacteria cultured were found only on the incision surface and no MRSA bacteria was found on or near Ms. Ward's uterus area at any time, plaintiff failed to explain how treating this alleged MRSA infection on the skin surface would have spared Ms. Ward's uterus. It is clear that Ms. Ward presented with symptoms of a severe post-operative infection on April 6. It is clear that Ms. Ward did not present with symptoms of a severe infection at all until after her hysterectomy, and there is disagreement between UMMC's experts and plaintiff's experts as to whether or not Ms. Ward had a severe uterine infection prior to her surgery.

In this appeal, UMMC challenges the trial court's findings and reliance upon nonexistent and otherwise inadmissible testimony by treating physician Dr. Walter Wolfe that UMMC breached the standard of care, proximately causing Ms. Ward's hysterectomy. UMMC likewise requests a review of the trial court's material mischaracterizations of the testimony of Dr. Thomas Austin, the physician who treated Ms. Ward for her presumed EMM on March 18.

UMMC maintains that the trial court erred in finding that plaintiff's expert, Dr. Dave David, was qualified as an expert, and maintains that his testimony was irrelevant and unreliable. Dr. David's qualifications were outdated, his knowledge of the facts incomplete, his veracity suspect and his testimony confounding, highly speculative and based on incorrect factual evidence. UMMC maintains that the trial court erred in finding that Dr. David proved that UMMC breached the standard of care on March 18-20 and March 27, proximately and foreseeably causing or contributing to Ms. Ward's alleged severe uterine infection and hysterectomy on April 5, 2002. UMMC also challenges any reliance upon the OB/GYN student practice guidelines as the standard of care, where individualization of this teaching tool is expected, and challenges the position that the guidelines cannot be modified even by their creators. Finally, UMMC maintains that the trial court should have granted its motion for directed verdict or involuntary dismissal under *Miss. R. Civ. P.* 41(b), as the plaintiff failed to prove that Dr. David, an unqualified and unreliable expert, had established the standard of care and proven proximate cause. To this end, UMMC specifically challenges the trial court's opinion that finding a question as to an alleged breach of duty alone created a *prima facie* case of negligence, wholly negating the required element of proximate cause.

IV. ARGUMENT

A. Standard of Review.

"Where - as here - a trial judge sits without a jury, this court will not disturb his factual determinations where there may be found in the records substantial supporting evidence." *Rice Researchers, Inc. v. Hiter*, 512 So. 2d 1259, 1264 (Miss. 1987). "A circuit court judge sitting without a jury is accorded the same deference with regards to his findings

as a chancellor, and his findings will not be reversed on appeal where they are supported by substantial, credible, and reasonable evidence." *Donaldson v. Covington County,* 846 So. 2d 219, 222 (Miss. 2003); see also *Mississippi Department of Transportation v. Trosclair*, 851 So. 2d 408, 413 (Miss Ct. App.2003). If it appears that a trial judge has adopted verbatim the proposed findings of fact and conclusions of law submitted by one of the parties, the appeals court will stray from the usual practice of deferential treatment of the trial judge's findings of fact and will apply a heightened scrutiny or *de novo* review. *City of Greenville v. Jones*, 925 So. 2d 106, ¶ 21(Miss. 2006). Where a trial court misperceives the correct legal standard to be applied, the appeals court will review questions of law *de novo*. *Estate of Grubbs v. Woods*, 753 So. 2d 1043, 1047 (Miss. 2000).

B. Conclusions of Law.

"As in all claims for negligence, in order to establish a prima facie case for medical malpractice, the following elements must be proven: (1) The existence of a duty on the part of the defendant to conform to a specific standard of conduct for the protection of others against an unreasonable risk of injury; (2) A failure to conform to such standard required of the defendant; (3) The breach of such duty by the defendant was a proximate cause of the plaintiff's injury; (4) Injury resulting to the plaintiff's person." *Burnham v. Tabb*, 508 So. 2d 1072, 1074 (Miss. 1987); (citing W. Keeton, Prosser & Keeton on Torts, § 41 (5th Ed. 1984). Ms. Ward must also show that her injury was a foreseeable consequence of the allegedly negligent care provided and that the injury was not superceded by an independent, efficient intervening cause. *Gulledge v. Shaw*, 880 So. 2d 288, 292-293 (Miss. 2004).

Under Mississippi law, the plaintiff must prove through qualified expert support that the alleged negligent care proximately caused the alleged injury. *Palmer v. Anderson Infirmary Benevolent Association,* 656 So. 2d 790, 795 (Miss. 1995). An expert's self proclaimed opinion is an insufficient measure of reliability, but rather, the expert must explain the basis of his opinion and link his conclusions to the facts. *Mississippi Transportation Commission v. McLemore*, 863 So. 2d 31, 37 ¶13 (Miss. 2003). "The plaintiff bears the burden of presenting significant probative evidence" of proximate cause in a negligence action. *Mississippi Department of Transportation v. Cargile*, 847 So. 2d 258, 262 ¶ 11 (Miss. 2003); see also *Foster v. United States*, 214 F. Supp. 181, 183 (S.D. Miss. 1963.) If a plaintiff seeks to prove causal connection with circumstantial evidence the proof must be sufficient to make the plaintiff's asserted theory more probable than any other theory, not merely possible. *Mississippi Department of Transportation* at ¶ 12; and *Mississippi Valley Gas Co. v. Walker*, 725 So. 2d 139, 145 ¶ 21 (Miss. 1998) (Overruled on other grounds). No causal connection exists where the plaintiff alleges a failure to perform a test designed to discover a condition from which the plaintiff did not suffer. *Austin v. Wells*, 919 So. 2d 961, 9117 (Miss. 2006).

The standard of care for medical treatment in Mississippi is "that degree of care, skill, and diligence which would have been provided by a reasonably prudent, minimally competent physician" under the same or similar circumstances. *McCarty v. Mladineo*, 636 So. 2d 377, 381 (Miss. 1994). "Certainly no court has ever held that a physician is a warrantor of cures." *Hawkins v. Ozborn*, 383 F. Supp. 1389, 1396 (N.D. Miss. 1974). "It is settled law in Mississippi that negligence on the part of a physician is not to be presumed

solely because of untoward results." *Hawkins* at 1395. "As other courts have frequently pointed out, if the failure to cure is to be taken as evidence of negligence on the part of a physician or surgeon in causing bad results, few would be bold enough to engage in the practice of medicine at the risk of having to pay damages to any patient who had less than a complete recovery." *Hawkins* at 1396. "Simply because one act precedes another does not make the first act cause the second." *Cuevas v. DuPont De Nemours and Company*, 956 F. Supp. 1306, 1311 (S. D. Miss. 1997).

C. Conclusions of Fact.

1. The trial court erred by relying upon non-existent and otherwise inadmissible testimony by treating physician Dr. Walter Wolfe.

Dr. Walter Wolfe was one of Ms. Ward's treating physicians at CMMC and was the physician who performed her hysterectomy. In the trial judge's Memorandum Opinion and Judgment, the first portion of the paragraph detailing the court's findings on the testimony of Dr. Wolfe was very similar to the corresponding portion of Ms. Ward's "Trial Brief of the Plaintiff," offering the same essential findings and conclusions regarding the care and treatment he personally rendered. (C.P. 243; R.E. 7, pp. 3-5); (C.P. 226; R.E. 10, p.9).

Both plaintiff and the trial court asserted that Dr. Wolfe offered the medical opinion that "a hysterectomy was needed in order to save Ms. Ward's life." (C.P. 226; R.E. 10, p. 9, C.P. 243; R.E. 7, p. 4.) This finding was not supported by Dr. Wolfe's trial testimony, where he stated that he removed Ms. Ward's uterus "for the best post-operative outcome" and "the absolute best benefit," and at no time offered an opinion that a hysterectomy was needed to save Ms. Ward's life. (T. 152-154, 172-174, 183-184, 126-189.)

Then the court added the following finding of its own not reflecting that in plaintiff's trial brief:

> Finally, Dr. Wolfe opined that Ms. Ward's UMMC physicians had not maintained the requisite standard of care in treating Ms. Ward's condition when she experienced problems that delayed her initial March 18, 2002 discharge, nor on March 27, 2002 when Ms. Ward returned to UMMC with wound incision problems. Specifically, Dr. Wolfe sited UMMC's failure to perform the needed lab work (i.e. blood count, blood and urine analysis, wound culture), as ordered by Dr. Austin on March 18, 2002 and the failure to choose the appropriate antibiotic for the necessary time period, in light of Ms. Ward's EMM. Additionally, Dr. Wolfe sites UMMC's failure to perform needed lab work that would have properly diagnosed Ms. Ward's infection and appropriate antibiotic treatment. In his opinion, these failures lead to Ms. Ward's life threatening infection and subsequent hysterectomy at CMMC on April 5, 2002.

(C. P. 243; R.E.7, p. 4)

A review of the trial transcript reveals that Dr. Wolfe's actual testimony at trial was limited to Ms. Ward's alleged condition at the time of his evaluation and treatment on and after April 5, 2006. (T. 126-189) Dr. Wolfe did not address the care provided by UMMC, either positively or negatively. (T. 126-189.) He did not offer opinion on the standard of care applicable to UMMC nor the treatment required by that standard of care. (T. 126-189.) Further, Dr. Wolfe offered no opinion that the care provided by UMMC proximately caused injury to Ms. Ward. Thus, contrary to the trial court's finding, Dr. Wolfe did not testify that UMMC breached the standard of care, proximately causing plaintiff's injury. The trial court's statement in her findings of fact to the contrary was completely unsupported by any evidence and constitutes manifest error.

Even had Dr. Wolfe so testified (which he did not), such testimony would have been inadmissible at trial as an opinion far beyond the limited scope of his expert designation. (R.E. 8, ¶ 2; R.E. 9, ¶ 2.) "An expert should not be allowed to testify concerning a subject matter which is not included in the response to the interrogatory." *Buskirk v. Elliott*, 856 So. 2d 255, 264 (Miss. 2003). To allow expert testimony not revealed in discovery constitutes "trial by ambush" and is not allowed under Mississippi law. *Coltharp v. Carnesale*, 733 So. 2d 780, 783-785 (Miss. 1999).

Dr. Wolfe's brief expert designation was limited to the care he previously provided and did not include an opinion of the care rendered by UMMC. (R.E. 8, ¶ 2; R.E. 9, ¶ 2.) The trial court would have erred in admitting and relying on an opinion by Dr. Wolfe as to the care provided by UMMC (if it had been offered) as "trial by ambush" which is disallowed under Mississippi law. Finally, the alleged testimony, if it had taken place, would have been without basis and should have been excluded, as no evidence was offered that Dr. Wolfe had even reviewed the UMMC medical records, much less reviewed the important depositions of the UMMC treating physicians and other relevant witnesses to provide a basis for said alleged opinion.

A review of the trial court's egregiously mistaken finding of fact concerning the opinion of Dr. Wolfe and mistake of law in the alleged admission of said testimony (if it had occurred) justifies a *de novo* review of this issue. The trial court's reliance upon this non-existent and inadmissible "opinion" of Dr. Wolfe in finding UMMC liable was clearly misplaced and manifestly in error.

2. The trial court erred by materially mischaracterizing the testimony of Dr. Thomas Austin.

Dr. Thomas Austin was the resident physician who performed Ms. Ward's Caesarean section and examined her following her temperature spike on March 18. Based on his finding of moderate tenderness in her uterus and her temperature spike, he concluded that she had EMM, a diagnosis Ms. Ward maintains was correct. (R.E. 2, pp. 22- 23.) His exam note states a plan to check a CBC, urinalysis, and blood culture, but for unknown reasons these lab tests were not ordered.(R.E. 2, pp. 16, 27- 29; T.E. D-1, p. 44; T. 535-539.) Dr. Martin, Dr. Austin's attending physician on March 18, did not recall this event but testified that he would not have considered the CBC, blood cultures, and urinalysis to be needed under the circumstances and suggested perhaps Dr. Austin had been advised as such by one of his supervising physicians. (T. 536.) Nonetheless, Dr. Austin prescribed the IV antibiotic Unasyn in treatment for presumed EMM and delayed Ms. Ward's discharge.

Dr. Austin has since moved to another state and testified by deposition at trial. The trial court's findings of fact regarding the testimony of Dr. Austin closely reflected the plaintiff's opinion in her Trial Brief of the Plaintiff. Both the plaintiff and the trial court found that Dr. Austin planned to order a CBC, urinalysis, and blood cultures, and <u>both</u> concluded with the following statement:

> It is clear from Dr. Austin's testimony that he diagnosed Ms. Ward with EMM, a uterine infection on March 18, 2002. It is also clear from the testimony that Dr. Austin failed to perform the tests that he deemed necessary to confirm his diagnosis and ensure that Ms. Ward would have received the proper antibiotic therapy and follow-up treatment.

(C. P. 243; R.E. 7, p. 5.); (C. P. 226; R.E.10, p. 5.)

Contrary to the trial court's opinion that Dr. Austin deemed the tests "necessary to confirm his diagnosis" of EMM, when Dr. Austin was asked whether he deemed the tests medically necessary in deposition, the question was interrupted and not answered. Another question was then offered as to why he ordered the tests (which were actually never ordered), to which he answered "I thought, at the time, that they would be helpful." (R.E. 2, pp.15-16, T. 535.) As "helpful" and "necessary" are clearly not synonymous, the trial court mischaracterized this testimony. As plaintiff agrees that Dr. Austin was correct in diagnosing EMM and treating her for EMM, this issue is also moot.

The three tests initially planned by Dr. Austin were a CBC, urinalysis and blood culture. Dr. Austin testified that the CBC would only have given "additional information that can help to support a diagnosis of an [unspecified] infection," but not that it could confirm a diagnosis of EMM (R.E. 2, p. 14.) There is no question that a urinalysis would have diagnosed a urinary tract infection, but that condition was not at issue in this case. (T. 319, 537.) Although Ms. Ward responded well to the antibiotic Dr. Austin prescribed, and there was no issue of the antibiotics not working, Dr. Austin testified that "sometimes if the antibiotics are not working, you can look at the blood culture and try to get more information" (R.E. 2, p. 15.) He did not testify that blood cultures would have confirmed EMM, nor that this confirmation was required. Directly opposite of the trial court's characterization of his testimony when asked whether the lab tests would have been all the information he needed to diagnose the alleged infection, Dr. Austin responded that, "Actually, the clinical picture is actually more important than the laboratory data." (R.E. 2, p. 15.)

Finally, the plaintiff and the trial court both erroneously stated that Dr. Austin believed the lab tests would have provided information that would "ensure that Ms. Ward would have received the proper antibiotic therapy and follow up treatment." Contrary to this assertion, Dr. Austin actually testified that performing the lab tests "would have just given us additional information to support our diagnosis of infection. But I don't think they changed – having them or not having them changed her management at all." (R.E. 2, p. 28.) (Emphasis added.) Dr. Austin also testified that the IV Unasyn is usually given until the patient is without fever for 12 to 24 hours (although in this case she received them for 42 hours), and the decision to stop the Unasyn was a clinical judgment decision. (R.E. 2, pp. 16-17, 23-24.)

Dr. Austin never testified that he deemed the laboratory tests "necessary to confirm his diagnosis of EMM" and insure that Ms. Ward would have received the proper antibiotic therapy and follow up treatment." (C.P. 243; R.E. 7, p. 5); (C.P. 226, R.E. 10, p. 5.) In summary of his actual opinion (rather than the mischaracterized opinion asserted by plaintiff and the trial court.) Dr. Austin testified as follows:

> Q. Okay. Would those tests have been helpful in the diagnosis of Ms. Ward?
>
> A. It could have added a little bit more information, but we basically had the diagnosis from the clinical picture. They did not change her management at all.

(R.E. 2, p. 16.) As Dr. Austin further noted, Ms. Ward's signs and symptoms disappeared and she was discharged home several days later. (R. E. 2, p. 13,17- 18.)

Therefore, the trial court's reliance on Dr. Austin's initial plan to perform laboratory tests is illusory, as Dr. Austin clearly testified that the CBC, urinalysis, and blood cultures

were not necessary to confirm his diagnosis of EMM, a diagnosis that the plaintiff maintains is correct. Dr. Austin further testified that the treatment given to Ms. Ward was correct and would not have changed if the tests had been performed. The trial court's finding that he believed otherwise is completely unsupported and opposite to his specifically stated opinion, and therefore a *de novo* review of this issue is appropriate. The trial court's reliance upon this inaccurate and mischaracterized reading of Dr. Austin's clear testimony in finding UMMC liable was misplaced and clearly erroneous.

3. The trial court erred in finding that Dr. Dave David was qualified as an expert in this case and that his testimony was relevant and reliable.

(a) The trial court's findings of fact regarding Dr. David's testimony were substantially verbatim to that found in the plaintiff's trial brief.

Of the utmost importance, the trial court's entire finding of fact regarding the testimony and opinion of Dr. David, the plaintiff expert, was almost verbatim to that found in Ms. Ward's trial brief. (C.P. 243; R.E. 7, p. 6.); (C.P. 226; R.E. 10, p. 10.) Under Mississippi law, an appellate review of *de novo* or heightened scrutiny of this opinion is thus appropriate. See *City of Greenville v. Jones*, 925 So. 2d 106, ¶ 21 (Miss. 2006); *Estate of Grubbs v. Woods*, 753 So. 2d 1043, 1046-1047 (Miss. 2000); *Rice Researchers, Inc. v. Hiter*, 512 So. 2d 1259, 1264-1266 (Miss. 1987).

(b) Dr. David was not qualified to testify as an expert in this case.

At trial, UMMC challenged the qualifications of plaintiff's expert, Dr. Dave David. The trial judge did not allow or consider much of UMMC's evidence, which was then submitted by proffer. (T. 241-256, 289-313.) Relying on the fact that Dr. David had renewed his ten year certification in OB/GYN in 1996 (although he had not practiced as a

board certified OB/GYN since at least that time), the trial court found him competent to testify in this case in 2005. (T. 239, 249, 255-256.)

In *Mississippi Transportation Commission v. McLemore*, 863 So. 2d 31 (Miss. 2003), the Mississippi Supreme Court adopted a modified *Daubert* standard for admission of expert testimony based upon the requirements of *Miss. R. Evid.* 702. Under *Mississippi Transportation Commission*, an expert's testimony must be both relevant and reliable to be admissible in court. *Mississippi Transportation Commission* at 39; see also *Stanton v. Delta Regional Medical Center*, 802 So. 2d 142 (Miss. Ct. App. 2001). First, the witness must be qualified by virtue of his or knowledge, skill, experience or education. Second, the witness' scientific, technical or other specialized knowledge must assist the trier of fact in understanding or deciding a fact in issue. In addition, Rule 702 does not relax the traditional standards for determining that the witness is indeed qualified to speak an opinion on a matter within a purported field of knowledge. *Mississippi Transportation Commission* at 36. "Further, we have stated that the facts upon which the expert bases his opinion or conclusion must permit reasonably accurate conclusions as distinguished from mere guess or conjecture." *Mississippi Transportation Commission* at 35; *citing Hickox v. Holleman*, 502 So. 2d 626, 638 (Miss. 1987).

Dr. David lacked the requisite knowledge, skill, experience and/or education to offer opinion as to the standard of care in this action. Dr. David admitted that he had not managed post-Cesarean complications in or near the year 2002, when the events at issue occurred, and the trial court declined to consider evidence that the guidelines for the American College of Obstetricians and Gynecologists ("ACOG") required that testifying obstetricians and

gynecologists have practice experience at the time of the occurrence and in the specific area in question. (T. 251-253, 289-294; T.E. D-20.)

Dr. David testified that he practiced as a board certified OB/GYN for seven years between 1986 and 1993, did not practice OB/GYN between 1996 and 1998, and did not practice medicine at all after that (except for a brief period outside the United States). (T. 242-244, 250-251.) At trial he claimed to have earned $250,000 per year practicing OB/GYN medicine during the years 1993-1995; however, a proffered statement of financial affairs from the United States Bankruptcy Court for the Eastern District of Massachusetts, signed by Dr. David in declaration of its truthfulness on June 7, 1998, declared he had zero income in the years 1993-1995 from all sources. (T. 245-249; T.E. D-19.) Dr. David's veracity was thus called into question.

Nonetheless, it is clear he had not practiced OB/GYN for six to nine years prior to the events in 2002, and for nine to twelve years prior to trial. (T. 242-251; R.E. 1; T.E. D-19.) Dr. David relied upon his previous experience to inform him of the standard of care in 2002 and offered only his "general reading" and unspecified continuing education to update his knowledge. (T. 253-254.) When asked at trial if he would not agree that the treatment provided by UMMC was the predominant way that obstetricians handled post-Cesarean temperature spikes in the year 2002, Dr. David side- stepped the question and responded vaguely, "I hope not." (T. 319.) The alleged qualifications of Dr. David to speak as an expert in the treatment of post-Cesarean complications in the year 2002 were outdated and his veracity suspect; thus his opinion lacked authority.

Between 1996 and 1998, Dr. David focused his practice on health fitness and weight management. He made film and media appearances, such as infomercial advertising of Voluptus (a breast enhancement cream for women), and the California Contour System (a cream and mechanical applicator represented to reduce cellulite) with celebrity Joan Rivers. (T. 240-244, 294-298.) At the time of the trial in 2005, Dr. David reported he taught human physiology and anatomy at a local university, but was receiving approximately 70 percent of his income (or roughly $200,000 per year) from testifying as a legal expert, with about 90 percent of this testimony on behalf of plaintiffs. (T. 240-241, 300-303, 313.) He advertised his expert services on various internet sites and in plaintiff's magazines, claiming in the ads to be very jury friendly because of his superior skills in communication as an educator. (T. 303.) Thus, Dr. David's purchased opinion was suspect as biased, since providing expert opinions for plaintiffs essentially constituted his livelihood at the time of trial.

When setting forth the standard of care for UMMC, Dr. David dutifully required the performance of laboratory tests in keeping with plaintiff's argument. However, Dr. David's testimony as to his personal practice made it clear that he relied mostly upon a patient's clinical presentation to diagnose their ailments, as was done with Ms. Ward in this instance. (T. 314-317, 320-321.) This testimony also suggested a lack of veracity. Considering these factors, Dr. David did not qualify as a truthful, unbiased, current expert in this case, and the trial court erred in finding otherwise.

(c) Dr. David's testimony against UMMC was neither relevant nor reliable.

Dr. David's opinion was based upon multiple contradictions and mistaken facts crucial to a meaningful understanding of the care Ms. Ward received at UMMC, and thus

under *Miss. R. Evid.* 702 and *Mississippi Transportation Commission v. McLemore,* 863 So. 2d 31(Miss. 2003), his opinion was unreliable and unhelpful to the trier of fact. "In order to be admissible, expert testimony must be based upon sufficient facts or data and be the product of reliable principles and methods. *Miss. R. Evid.* 702. Also, the expert must apply the principles and methods reliably to the facts of the case." *Brooks v. Stone Architecture,* 934 So. 2d 350, 354 ¶ 13 (Miss. Ct. App. 2006). Dr. David's testimony was often led by plaintiff counsel to an implied but unspoken conclusion, and as a result he at times expressed two or more opinions on the same question. He often blurred the dates of treatment to which he was referring, and spoke vaguely of "cultures", "tests", "treatments", "problems", and "conditions", unclear as to which of several cultures, tests, treatments, problems, or conditions he was referring.

Dr. David testified that he reviewed the UMMC and CMMC records and at least the home nurse's note for March 27; however, there is no testimony that he reviewed the key depositions of Dr. Austin and Dr. Robinson or the depositions of any other physician or witnesses. (T. 256, 270, 272-277.) Nonetheless, Dr. David's opinion lacked awareness of numerous basic facts found in the medical records themselves.

The following are incorrect facts upon which Dr. David's opinion was based:

1. Dr. David did not know that Ms. Ward was given Unasyn for 42 hours on March 18-20, mistakenly believing that she received only 24 hours of the Unasyn therapy. (T. 288-289; T.E. D-1, pp. 110, 114.)

2. Dr. David confused Ms. Ward's clinical presentation on March 18-20 with her presentation on March 27, mistakenly believing that Ms. Ward had signs of a possible infection in her incision on March 18-20. (T. 285-287; T.E. D-1, pp. 44, 124.)

3. Dr. David confused Ms. Ward's clinical presentation on March 18 with the clinical presentation she developed while at CMMC, believing in error that she had abdominal pain, distension, and an ileus while at UMMC. (although at no time was her abdomen distended.) (T. 286-287, 313-314; T.E. D-1, pp. 44-45; T.E. D-2, pp. 366, 368.)

4. Dr. David did not acknowledge Dr. Robinson's examination, findings, and treatment on March 27, basing his entire opinion on the home nurse's preliminary notes. (T. 270-277; T.E. D-1, pp. 191.)

5. Dr. David did not know that Dr. Robinson had opened, drained and cleaned the wound on March 27, and faulted him for not doing so. (T. 274-277, 281; T.E. D-1, pp. 191.)

6. Dr. David believed incorrectly that the wound pocket contained purulent drainage on March 27. (T. 270-271, 275-276; T.E. D-1, p. 191.)

7. Dr. David did not know that Ms. Ward's WBC on April 5 was within the normal laboratory range. (T. 322-325; T.E. D-2, pp. 427.)

8. Dr. David did not know that Ms. Ward was free of fever on April 5. (T. 325; T.E. D-2; pp. 385-387.)

The following are material inconsistencies and contradictions in Dr. David's testimony:

1. Confusing Ms. Ward's clinical presentation, Dr. David testified at various times that on March 18, Dr. Austin should have taken blood cultures (T. 262-263, 266-267), an endometrial or cervical culture (T. 287, 315-316), and a wound culture on that date. (T. 285-286.)

2. Dr. David testified that Unasyn was the appropriate antibiotic for Ms. Ward on March 18. (T. 283, 285, 288-289, 317-318.) Covering his bases, he also testified that Unasyn was not the appropriate antibiotic. (T. 269-270, 282.)

3. Dr. David offered his opinion that Unasyn would treat MRSA, but when plaintiff counsel immediately asked him again he reversed his testimony, saying that Unasyn would not treat MRSA. (T. 283.)

4. Dr. David noted that Dr. Austin diagnosed Ms. Ward with EMM on March 18. (T. 258.) In contradiction, he also opined that Dr. Austin did not diagnose Ms. Ward with EMM on March 18, but should have. (T. 284-288.)

5. Dr. David testified that a urinalysis was required by the standard of care on March 18. (T. 258, 262-263, 266-267, 269-270, 319.) However, he explained that the urinalysis would not diagnose EMM, but was to rule out a urinary tract infection and was just for "completeness", as a urinary tract infection was not at issue. (T. 261, 319.)

6. Dr. David testified that a CBC was required by the standard of care and the lack of CBC proximately caused Ms. Ward's hysterectomy. (T. 258, 261-263, 266-267, 270, 282.) However, he also testified that the CBC was only "a baseline in case its – to see if she's getting better or worse." (T. 277.)

7. Dr. David was clear that the portion of the CBC potentially indicative of an infection is an elevated white blood count (WBC). (T. 260-261, 316-317, 323.) He also admitted that you can get an elevated WBC "in everything." (T. 317.) However, when informed that Ms. Ward's WBC was within the normal range on April 5, he promptly changed his opinion, testifying that it is the platelet count that you look at in a CBC to indicate infection. (T. 324-325.)

8. Dr. David testified that blood cultures are critical and required. (T. 262-263, 266-267, 270, 314-315.) In contradiction, he later testified that blood cultures indicate bacteria in the blood and won't diagnose an infection in the uterus, except suggestively if the bacteria involved is one of the usual culprits for uterine infections. (T. 314-315.) He also testified that MRSA is usually found on the skin, not in the uterus. (T. 264-266.)

9. Dr. David testified that a fever was defined as a temperature of 100.4 or above and that when Ms. Ward had a temperature spike on March 18, she was "running a fever". (T. 257, 267, 318.) Although he testified that after the temperature spike he was not clear what her temperature was, he nevertheless implied that she had a continued fever, stating that it didn't come all the way down the next day. (T. 267, 318.)

10. Dr. David testified that various cultures were required by the standard of care and were needed in case the initial therapy hadn't worked and the patient continued to get sicker. (T. 261-262, 268-269.) Ms. Ward's signs and symptoms improved and she did not get sicker, a fact that Dr. David ignored.

11. Dr. David testified that the antibiotic Keflex, prescribed to Ms. Ward on March 27, both would and would not treat MRSA. (T. 284.)

12. Although plaintiff counsel implied (without specifically stating) that Ms. Ward had an MRSA infection on March 18 and/or 27, Dr. David did not express this opinion. (T. 263-266, 282-284.)

13. Dr. David appeared to rely on the OB/GYN student practice guidelines as the standard of care. (T.266-267, 270.) However, he only generally followed the guidelines of the American College of Obstetricians and Gynecologists, testifying that they were "guidelines, not regulations, but they're guidelines." (T. 293.)

The sum of the above factual mistakes, contradictions and inconsistencies is that Dr. David's opinion is unreliable and therefore unhelpful to the trier of fact. Importantly, when not relaying plaintiff's trial position on the laboratory tests, Dr. David spoke freely of his own practice, where he relied mostly on the patient's clinical presentation, as did the physicians at UMMC in this case.

Dr. David testified regarding the laboratory tests:

Q. All right. And what are the common tests run to rule out endometritis or any kind of infection post cesarean?
A. Well, I think any time you make any kind of diagnosis in medicine, most of the diagnoses are made just on the basis of history. If you ask the right questions and find out symptoms that the patient is having, then you go to physical exam; touching the patient, you know, using all your senses as a physician in examining the patient. And then from there you'll go past physical exam to any ancillary studies that we have available to us; laboratory, x-ray, cultures, blood work; things like that.

(T. 260.)

Dr. David's belief that Ms. Ward had EMM on March 18 was based on her clinical December 6, 2006presentation:

Q. You know she was infected [on March 18]?
A. Yes.
Q. Based on the temperature spike?
A. The temperature spike and her clinical presentation.

(T. 314.)

Dr. David also testified regarding the WBC:

Q. Wouldn't you agree with me that infection is not the only cause of an elevated white blood count?

A. I agree. You can get elevated white blood counts in everything. But, you know, you don't just take one blood test. The whole idea is you look at your patient, you talk to your patient, you feel your patient's belly. You look at everything else, and you come up with a diagnosis.

(T. 316-317.)

Dr. David testified regarding blood cultures:

Q. Is it possible that the infection could have originated in some place other than the uterus?
A. Yes, it is. But the blood cultures isn't the only thing you go with, you have to examine the patient.

(T. 315.)

Dr. David further testified regarding clinical judgment:

Q. And would you agree that it's appropriate for treating physicians to exercise their clinical judgment based upon the signs and symptoms as they perceive them with their own patient?
A. Well, they can't perceive symptoms. Only the patient herself can perceive a symptom.
Q. As reported by the patient?
A. As reported by the patient?
Q. Yes.
A. Yes. They have to ask the right questions, though. You can't expect a patient to go over everything. A good 97 percent of all diagnoses are made from the history alone. And being a good clinician, you know which questions to ask your patient. 97 percent of diagnoses can be made over the telephone by asking the patient the correct questions. The rest is done by physical exam, and a very small amount by lab and imaging studies . . . .

(T. 320-321.)

Dr. David's testimony above is in direct contradiction to his testimony that laboratory tests are required to make a diagnosis. Dr. David was not qualified to render a knowledgeable, unbiased and well-considered opinion in this case and his unqualified testimony was both irrelevant and unreliable. Thus, the trial court erred in admitting,

considering, and relying on Dr. David's testimony, and dismissal of this action was appropriate.

4. The trial court erred in finding that plaintiff's expert, Dr. Dave David, proved that UMMC breached the standard of care, proximately and foreseeably causing Ms. Ward's hysterectomy on April 5, 2004.

Dr. David testified that the two most common causes of post-Cesarean fever are EMM and a wound infection.(T. 287.) The physicians at UMMC evaluated Ms. Ward's symptoms, finding that she likely had EMM on March 18 and that she may have had a wound infection on March 27. She was treated for EMM on March 18, and although after evaluation a wound infection was ruled out on March 27, she was given treatment curative of a wound infection nonetheless.

(a) Dr. David did not establish that the physicians at UMMC breached the standard of care on March 18-20, 2004, and March 27, 2004.

Plaintiff's trial brief set forth several ways in which Dr. David allegedly asserted that UMMC breached the standard of care on March 18-20 and 27, which were adopted verbatim by the trial court; thus a *de novo* or heightened scrutiny review is appropriate. (C.P. 243; R.E.7, p. 6); (C.P. 226; R.E.10, p.10.) The trial court's "findings" relative to the testimony of Dr. David reflected opinions he did not offer in several instances. In other instances, the court's "findings" reflected only one of his several contradictory opinions on the topic. At yet other times, the trial court adopted an opinion of Dr. David which was based on only portions of the relevant medical record, ignoring documented findings contrary to his opinion. In sum, the trial court's finds of liability were unsupported by a fair interpretation

of the testimony offered, the medical records, and the facts of this case and should be subjected to a *de novo* or heightened scrutiny review.

The trial court found that Dr. David believed UMMC breached the standard of care as follows:

> (1) **"By not properly evaluating, diagnosing, and treating her post-op infection."** (C.P. 243; R.E.7,p. 6); (C.P. 226; R.E.10, p.10.)

This "finding" appears to be a general summation of the specific allegations of breach of duty as detailed below.

> (2) **"By not performing a CBC, blood culture, and wound culture on Ms. Ward after her fever on March 18, 2002, and on the March 27, 2002, visit to the OB Receiving unit at Wiser Hospital."** (C.P. 243; R.E.7, p. 6); (C.P. 226; R.E.10, p10.)

Dr. Hudson testified that recent medical literature for the past 15 years did not support a lot of diagnostic laboratory tests in a situation such as this. (T. 230.) Dr. Martin testified, "We don't do lab tests when a diagnosis is apparent. We do lab tests when we think they may help us because a diagnosis is not apparent, or if it may be more extensive than what we are doing." (T. 564.) A CBC, blood culture and wound culture were otherwise not required by the standard of care on March 18 and March 27 as follows:

CBC: Dr. David testified that a CBC was required by the standard of care and the failure to perform a CBC proximately caused Ms. Ward's later "condition". (T. 269-270, 281-282.) Dr. Chapman, Dr. Martin, Dr. Reddix, Dr. Hudson, Dr. Austin, and Dr. Robinson each testified that a CBC is not required by the standard of care in this case, nor would its performance have changed the care rendered. (T.199-200, 218-219, 230, 423-424, 466, 489, 536-537, 561-562, 575-577, 579-580, 593, 602; R.E. 2, pp.14-16; R. E. 4, pp. 22-23; R.E.3,

p. 16.) Dr. Martin, Chief of OB/GYN Department at UMMC, testified that CBC's are not usually done soon after delivery, although they are listed in the guidelines, but may be considered if the patient is not responding to antibiotics (unlike here where Ms. Ward responded well.) (T. 536-537.) Dr. Martin stated, "It's really rather foolish to do them this close to delivery because we expect that the white count is going to be elevated. So that's something should be eliminated from the guidelines of even being considered." (T. 536.)

Dr. David testified as follows:

Q. And you talked earlier about whether a CBC test should have been ordered on the 18th. Is one of the things you're looking for with a CBC test whether there is an elevated white blood count?
A. That's correct.
Q. Wouldn't you agree with me that infection is not the only cause of an elevated white blood count?
A. I agree. You can get elevated white blood counts in everything. But, you know, you don't just take on blood test. The whole idea is you look at your patient, you talk to your patient, you feel your patient's belly. You look at everything else, and you come up with a diagnosis.

(T. 316-317.) (Emphasis added)

A CBC is a blood test in which an elevated white blood count ("WBC") can generally indicate a possible infection or inflammation somewhere in the body (though there are numerous other reasons a WBC can be elevated) and is useful as "baseline" information according to Dr. David. (T. 133-134, 200-201, 218-219, 260-261, 316-317, 438, 586.) Both Dr. Wolfe (plaintiff's treating physician at CMMC) and Dr. David agreed with defendant's experts that the specific test in a CBC relevant to a possible infection is the WBC. (T. 133-134, 260-261.) Confusingly, when Dr. David was informed during questioning that Ms. Ward's WBC was within the normal laboratory range on April 5, he abruptly changed his earlier position, asserting that an elevated platelet count in a CBC is indicative of an

infection, a position strongly contested by UMMC's experts. (T. 323-325.) Dr. Reddix explained that Ms. Ward's platelet count elevation indicated her body's normal response to blood loss, and was clear that "the platelet count has absolutely nothing to do with signaling infection." (T. 438, 483-485, 505.) Dr. Chapman, Director of the Division of Infectious Diseases at UMMC, also disagreed with Dr. David's new opinion regarding a platelet count, testifying that Ms. Ward's elevated platelet count was secondary to acute blood loss, and that platelet counts usually fall, not rise, with serious infection. (T. 583-584.)

Ms. Ward's WBC on April 5 at CMMC was within the normal laboratory range, and any inference that Ms. Ward's WBC would have been abnormal on March 18 and 27 was pure conjecture. (T. 142-143, 437-439, 482-483, 582-586; T.E. D-2, p. 427.) Even if a CBC had been performed at UMMC which indicated a possible infection on March 18 and March 27, this would have weighed to confirm, not change UMMC's diagnoses of possible infection or inflammation, and the outcome would have been unchanged. Thus, the trial court's "finding" that a CBC was required to diagnose Ms. Ward's symptoms and that the lack of a CBC proximately caused Ms. Ward's hysterectomy is medically unfounded and against the weight of the evidence.

Blood cultures: Blood cultures identify bacteria found in a patient's bloodstream, the source of which can be infections somewhere else in the body. (T. 424-425, 202, 313-315, 325.) Dr. Ben Hudson, treating physician, testified that blood cultures had fallen out of favor in the medical literature in the past 10-15 years and have continuously been proven not to be a very helpful clinical tool in most instances. (T. 218-219.) UMMC's other experts testified that blood cultures were not required and would not have changed the treatment

results on March 18 and 27. (T. 424-425, 518-519, 538-539, 575-576, 562, 593; R.E. 2, pp. 14-16, R.E. 3, pp. 9-10; R.E. 4, pp. 9-10.)

Dr. David clearly testified that "cultures" were important, but alternately described these as blood cultures, wound cultures, and endometrial /cervical cultures, often blurring the type culture and date to which he was referring. (T. 263, 268-269, 275-277, 281-282, 285-287, 313-318.) Notably, Dr. Wolfe did not order blood cultures at CMMC, testifying that he did not think Ms. Ward had infection in her blood stream. (T. 142-143, 584-585.)

Dr. David never speculated what blood cultures at UMMC would have shown if they had been taken. He testified that:

> Q. It's your testimony that a blood culture will tell you that the infection is in the uterus?
> A. No. I just said it's beyond the uterus. That wherever the infection emanated from, it had now disseminated into the bloodstream which is how you get a positive blood culture.
> Q. Isn't it possible that the infection could have originated in some place other than the uterus?
> A. Yes it is. But the blood cultures isn't the only thing you go with. You have to examine the patient.

(T. 314-315.)

The trial court's finding that blood cultures were required by the standard of care to diagnose EMM and a wound infection is clearly erroneous, as blood cultures could only definitively diagnose bacteria in the bloodstream, not in a uterus or wound site. Thus plaintiff failed to prove that blood cultures were required to diagnose any condition relevant to this lawsuit, nor that they were required by the standard of care given the facts of this case.

Wound culture: Confusing the events of the case, Dr. David erroneously stated that a wound culture was needed on March 18, despite the reality that Ms. Ward had no wound

symptoms on March 18-20 and no wound drainage to culture at that time. (T. 285-286, 427-428, 435, 578; R.E. D-1, pp. 44-45, 124, 128, 132.) Dr. David's opinion that wound cultures were required on March 27 was likewise unfounded. Based entirely on the home nurse's preliminary note, Dr. David mistakenly presumed that purulent drainage would be present in the wound site if it were opened and drained (not realizing that it was opened and drained at UMMC on that date with no such finding. (T. 270-275, T.E. P-2, p. 31.) He based his opinion that the wound was infected on his incorrect presumption that the wound contained purulent drainage. (T. 274-275.) He then based his opinion that a wound culture was needed on his unfounded opinion that the wound was infected. (T. 275-277.)

The home nurse documented a finding that the wound incision had a nodule with "slightly brownish purulent drainage." (T. 50-51, T.E. P-2, p. 31.) Dr. Reddix explained that just because a drainage may appear purulent on the surface of a wound, it does not mean that the fluid inside the wound is purulent. (T. 432-433.) Dr. Robinson testified that upon opening and draining the contents of the incision, he found clear seroma (a straw-colored plasma-like fluid more indicative of inflamation, not infection), with no finding of purulent drainage inside. (R.E. 3, p. 7-8, 9-10, 14; R.E. 4, 16, 20, 21; T. 550, 555-556.)

Dr. Robinson testified that "with no purulence, there's no reason for a wound culture," (R.E., 4, p. 13.) He further testified that, even if purulent drainage is found, a wound culture is often not warranted because typically, even if there is evidence of infection, the wound culture results are polymicrobial and you don't know if the results are from the wound or a contaminant. (R. E. 3, p. 16; R.E. 4, pp. 13, 23.) Considering both the home nurse's notes and Dr. Robinson's findings, UMMC's experts testified that no wound

cultures were required, nor would they have altered the course of treatment. (T. 510-511, 562, 570, 579-581, 593.)

Dr. David testified that culturing the wound was essential to determine the type of bacteria infecting the wound, so no time is wasted giving a patient the wrong antibiotic while she continues to get sicker. (T. 261-262, 268-269.) Dr. Chapman testified that "even if infection was present, the standard treatment of a wound infection is incision and drainage [which was done in this case] and does not require antibiotic therapy," and therefore wound cultures were not required. (T. 580.) Dr. David agreed that incision and drainage was curative treatment for an infection, and antibiotics were needed if that did not work. (T. 276-277.) Even if wound cultures had been taken on March 27, by the time they would have returned a result 1-3 days later, Ms. Ward's condition had already improved after the opening, draining, and cleaning of her wound, continued wound care, and antibiotic therapy, after which she sought no further care at UMMC. (T. 435, 581-583.)

Dr. David offered no opinion that wound cultures were needed on March 27 taking into consideration Dr. Robinson's findings and treatment or the fact that her condition improved. Since Dr. David's opinion that wound cultures were required was based upon the false assumption that purulent drainage was present inside the wound, his opinion was unreliable. *Brooks v. Stone Architecture*, 934 So. 2d 350, 355 ¶¶ 13-14. (Miss. Ct. App. 2006.) Dr. Robinson based his opinion that no wound cultures were needed after personally opening, draining, and cleaning the wound, and Dr. David ignored or never reviewed the medical records and deposition testimony documenting Dr. Robinson's treatment and findings. Dr. Reddix and Dr. Chapman offered opinions that wound cultures were not

required on March 27, taking into consideration both the home nurse's notes and Dr. Robinson's findings. (T. 429, 432-434, 579-581.) The trial court's reliance on Dr. David's opinion that wound cultures were required on March 18 and March 27 based on incorrect factual evidence was thus in error.

(3) **"By not leaving Ms. Ward on the IV antibiotics until she was free of symptoms for 48 hours, following her fever on March 18, 2002."** (C.P. 243; R.E.7, p. 6); (C.P. 226; R.E. 11. p10.)

Dr. David testified that Ms. Ward should remain on the IV Unasyn for 48 hours, mistakenly believing she had received it for only 24 hours. (T. 288-289.) Dr. David did not testify that Ms. Ward should remain on the IV antibiotics "until she was free of symptoms" for 48 hours. This addition to his opinion was made by the plaintiff in the plaintiff's trial brief and adopted by the trial court and did not reflect Dr. David's testimony at trial.

Ms. Ward continued the IV Unasyn on March 18 -20 for 42 hours (as is clearly documented in the medical records), which was approximately 48 hours after her temperature significantly declined (as her fever had abated before her first dose of Unasyn.) (T. 212, 426, 573-577; T.E. D-1, pp. 110, 114.) Dr. David testified that he really didn't know at what point Ms. Ward became symptom free. (T. 267.) Though the UMMC physicians and experts testified that for EMM, 24-48 hours of antibiotics was standard at that time, even the student guidelines (although non-authoritative) suggested only "approximately" 48 hours of antibiotic therapy after the patient was symptom free for most patients, which was done in this case. (T. 426, 573-577; R.E. 2, pp. 23-24, R.E. 11, p. 3.)

Plaintiff counsel (not Dr. David) implied that Ms. Ward had an MRSA infection while at UMMC. (T. 263-265; 282-284.) Assuming, *arguendo*, that an MRSA infection

was present at UMMC (for which there is no evidence), Unasyn would not have cured this MRSA infection no matter how long it was given, since according to Dr. Wolfe and Dr. David, Unasyn is not effective against MRSA. (T. 162, 283.) Thus plaintiff's assertion that more Unasyn was required to cure Ms. Ward's alleged infection at UMMC was nonsensical if she likewise maintains her infection was caused by MRSA.

Dr. David's opinion of this alleged breach of the standard of care was based on his mistaken belief that Ms. Ward only received 24 hours of IV antibiotics, and this opinion was therefore irrelevant and unreliable. He offered no testimony that 42 hours of IV Unasyn therapy (received until approximately 48 hours past the decline of Ms. Ward's fever) was beneath the standard of care and would have proximately caused plaintiff's injury. The trial court was mistaken in finding that Dr. David believed that UMMC erred by not leaving Ms. Ward on the IV antibiotics until she was "free of symptoms for 48 hours" on March 18-20, as this "finding" was not found in his trial testimony. Further, UMMC did leave Ms. Ward on the IV antibiotics until she had been free of symptoms for approximately 48 hours, even though this was beyond the standard of care. (T. 426.)

(4) **"By not admitting Ms. Ward to the hospital on March 27, 2002, for IV antibiotic therapy."** (C.P. 243; R.E.7, p. 6); (C.P. 226; R.E. 11, p. 10.)

Dr. David never testified that the standard of care required that Ms. Ward be admitted to the hospital on March 27, and the plaintiff's and trial court's assertion that he so testified was mistaken. (T. 271-277, 283-284.) However, he did testify that she should have been given an unspecified intramuscular or IV antibiotic on March 27, again based entirely on his

unreliable opinion that the wound was infected, which was based on his mistaken assumption that there was purulent drainage inside the wound. (T. 271-277, 283-284.)

After opening and draining the wound, Dr. Robinson assessed that Ms. Ward had an inflammatory wound seroma, and not a wound infection, and that a culture of the seroma drainage was not warranted. (R.E. 4, p. 8,10,12-13, 15,17,21-23.) UMMC's experts testified that the proper curative treatment for a wound seroma and/or a wound infection was opening and draining the wound, treatment which was curative by itself even without antibiotics. (T. 433-434, 578-581; R.E.3, p.11.) Dr. Wolfe similarly drained and irrigated the affected area during surgery at CMMC, testifying "You can't really treat an abscess. You have to drain it." (T. 155-156.) Dr. David testified that "one way to get rid of infection is to mechanically let it drain out just like we talked about opening up the wound and letting the pus drain out." (T. 281.) When asked whether he thought cultures, opening and irrigating the wound, IV antibiotics, and getting a baseline CBC would have arrested the infection on March 27, Dr. David replied, "Well, certainly cleaning it out. If it didn't completely arrest it, you may need the help of good antibiotics with that at that point." (T. 276-277.)

UMMC went beyond curative opening, draining and cleaning the wound, also instructing Ms. Ward on home wound care and prescribing prophylactic antibiotics. Although this was documented in the medical records, Dr. David did not seem to be aware that any of this was done. UMMC's experts testified that, based on both the home nurse's notes and Dr. Robinson's finding on March 27, Ms. Ward's care and treatment at UMMC was appropriate, and even more than needed. (T. 433-435, 578-581.) The trial court erred in relying on Dr. David's mistaken belief that purulent drainage and a wound infection was

present on March 27, and also Dr. David's unreliable derivative opinion that Ms. Ward's alleged wound infection should have been treated with unspecified intramuscular or IV antibiotics. The trial court's finding that UMMC erred by not admitting Ms. Ward to the hospital on March 27, 2002, for IV antibiotic therapy is thus unsupported by trial testimony and the documented facts of this case.

(b) Dr. David did not establish that any of the alleged breaches by UMMC proximately and foreseeably caused Ms. Ward's hysterectomy on April 5, 2004.

Proximate cause must be proven to a reasonable probability. "To prove no more than that it was a possibility is not a sufficient foundation for the support of a verdict or judgment." *Berryhill v. Nichols*, 158 So. 470, 471 (Miss. 1935). In this case, Ms. Ward must prove to a reasonable probability that the alleged lack of laboratory testing and the treatment actually provided at UMMC on March 18 and 27 proximately and foreseeably caused or contributed to her hysterectomy on April 5. *Toche v. Killebrew*, 734 So. 2d 276 ¶ 12 (Miss. Ct. App. 1999.) Ms. Ward's proof must not consist of a simple inference that UMMC failed to cure her on March 18 and March 27. *Hawkins v. Ozborne*, 383 F. Supp. 1389,1396 (N.D. Miss. 1974.) She must show the basis of this opinion and link her conclusion to the actual facts in evidence, not a mischaracterized, partial version of the facts.

Dr. David's limited testimony as to proximate cause was fraught with ambiguity and medical impossibility and was compromised by his lack of factual understanding of the case, constituting fatal defects in his opinion. As to foreseeability, he testified only that if you don't treat an infection or EMM, several complications can occur. (T. 279-280.) He did not

testify that the treatment actually provided was inadequate and a hysterectomy could foreseeably result.

Dr. David's testimony as to proximate cause consisted primarily of the following two statements:

1. Q. When Ms. Ward was at the University Medical Center if they had performed a CBC and a wound culture and started her on the [unnamed] right antibiotic, would it have avoided and cured this [unspecified] condition that she later suffered with?
   A. More likely than not it would have.
   Q. And is that your opinion based on a reasonable degree of medical probability?
   A. Yes, it is.

(T. 280-282.)

2. Q. Do you have an opinion whether or not Ms. Ward's [unspecified] condition was–subsequent treatment was proximately caused by the negligence of the University Medical Center?
   (Objection and objection overruled)
   Q. And what is your opinion?
   A. Well, if you insert the words "lack of treatment", my answer is yes, I do have an opinion and that the opinion – or the opinion is that the [unspecified] treatment or lack thereof fell below the standard of care, and that this– a deficiency below the standard of care was a direct and proximate cause of the [unspecified] problems suffered by Ms. Ward including that need for the hysterectomy.

(T. 327.)

In statement 1. Dr. David agreed with plaintiff counsel's ambiguous statement, but it is not at all clear which date or alleged infection he was referring to, nor which antibiotic he believed would cure the unspecified later "condition." This vague and conclusory agreement hardly qualifies as well-considered and reliable proof that the care rendered by UMMC proximately caused or contributed to plaintiff's later hysterectomy.

In statement 2. Dr. David himself used garbled and imprecise language to attempt to prove proximate cause without actually stating a specific opinion. It is not clear what treatment Dr. David found lacking, particularly as he was unaware of the treatment Ms. Ward actually received at UMMC as documented in the medical records, nor how this alleged "lack of treatment" proximately caused Ms. Ward's later hysterectomy. Again, this conclusory statement does not establish, to a reasonable probability, that the lack of a specific treatment at UMMC proximately and foreseeably caused Ms. Ward's later hysterectomy.

It is clear from the sum of the testimony of all of the experts that a urinalysis, CBC, blood culture, or wound culture would not have given information directly relative to a uterine infection. Dr. David opined broadly that these tests were required by the standard of care; however, he offered no opinion to a reasonable probability what the results of these tests would have shown if they had been taken on March 18 and 27, what treatment changes would have followed, and how this would have led to a different result. Thus he has failed to establish the element of proximate cause. *Brooks v. Stone Architecture*, 934 So. 2d 350, 355 ¶ 14 (Miss. Ct. App. 2006).

Although plaintiff counsel implied (without specifically stating) that a wound culture would have shown the presence of MRSA if taken on March 27, based on the likely contaminant presence of community-acquired MRSA on the incision surface on April 5, Dr. David never offered or stated agreement with this opinion. (T. 283-284.) Even if, *arguendo*, a wound culture had been taken on March 27 which showed an MRSA infection (although there is no evidence such a culture would have revealed an MRSA infection if taken), plaintiff failed to show to a reasonable probability that treating this alleged MRSA wound

infection would have cured Ms. Ward's allegedly infected uterus, as there was never evidence of MRSA in or near the uterus documented in the medical records.

UMMC's experts testified that, even if a CBC, blood culture, urinalysis, or wound culture had been performed at UMMC, the treatment would not have changed. (T. 423-426, 433-435, 453, 570, 572-580.) Dr. David's vague opinion as to proximate cause is plagued by his lack of knowledge of the full records and facts of this case, and is thus unhelpful to the trier of fact and unreliable. Beyond vague assertions of failure to cure, he has wholly failed to prove, to a reasonable probability, that the performance of the laboratory tests would have yielded specific results which would have led to different treatment, which in turn would have led to a different outcome.

The trial court's conclusion that the alleged lack of a urinalysis and blood cultures to rule out a urinary tract infection or bacteria in the bloodstream, proximately caused or contributed to Ms. Ward's hysterectomy was factually without merit because neither condition was at issue in the case. The trial court's conclusion that the lack of a CBC, which was not diagnostic of any condition relevant to this action but useful only as supportive baseline information, proximately caused or contributed to Ms. Ward's hysterectomy is likewise without medical merit. Similarly, a wound culture would potentially diagnose an infection in the wound where the culture was taken, not in a woman's uterus. The trial court's asserted conclusion that a wound culture was required on March 27 that would have somehow diagnosed and cured Ms. Ward's alleged uterine infection is thus without medical merit. Plaintiff has failed to prove that the alleged lack of a urinalysis, blood cultures, a CBC, and a wound culture proximately caused Ms. Ward's later alleged uterine infection

and hysterectomy. As plaintiff cannot sustain her claim of negligence without proof of the element of proximate cause, dismissal is appropriate.

5. The trial court erred in any reliance upon the OB/GYN department's student practice guidelines as the standard of care in this case.

Throughout the prosecution of this case, the plaintiff and trial court relied upon the OB/GYN practice guidelines to allegedly require a CBC, blood cultures, and a urinalysis on March 18, 2002, and to mandate the length of time for Unasyn therapy in EMM. (The practice guidelines were specifically for EMM and not applicable to the performance of a wound culture or Ms. Ward's incision signs and symptoms on March 27, 2002.) (R.E. 4, pp. 8-10,16-17.) The court's position was an errant attempt to oust clinical judgment and reduce the complex and highly individualized decision-making process of a physician to a pre-determined checklist.

The trial court apparently relied on the guidelines to fill in where Dr. David's expertise was lacking. (T. 376-377, R.E. 10, p. 2.) Dr. David essentially adopted the student guidelines as the standard of care rather than speaking from his own outdated expertise, testifying:

Q. All right. And would that [referring to the OB/GYN practice guidelines] have been a good course of treatment to make a determination of what Ms. Earquella Ward's problems were?
A. Yes. I think that's what you'd want to do at that point.
Q. And I believe you told me earlier that you looked at her records and none of these were performed?
A. Not that I could see, that's correct.
Q. Are you critical of the physicians not following these guidelines?
A. In this case?
Q. Yes.
A. Oh, yes. Oh, yes.

(T. 266-267.)

The Mississippi Supreme Court has already disapproved the use of guidelines in place of professional judgment. In refusing to adopt road sign guidelines created and adopted by the State of Mississippi as conclusively establishing the standard of care, the Supreme Court in *Donaldson v. Covington County*, 846 So. 2d 219 (Miss. 2003), found that "to rule as *Donaldson* urges would substitute the MUTCD [guidelines] for engineering judgment." *Donaldson* at ¶ 22, p. 224. The OB/GYN student practice guidelines were far less authoritative than the guidelines rejected in *Donaldson*. The plaintiff's attempt to remove judgment and discretion from the professional practice of medicine at UMMC is thus misplaced, as physicians are bound by the hypocratic oath "to exercise their judgment without interference from others." *Corey v. Skelton*, 834 So. 2d 681, ¶ 13 (Miss. 2003).

Further, UMMC is a teaching and learning hospital and serves an important public function to "make sure the state of Mississippi has a ready pool of competent physicians." *Mozingo v. Scharf*, 828 So. 2d 1246, ¶ 11 (Miss. 2002). The UMMC practice guidelines were created by the OB/GYN faculty as a teaching aid for the UMMC students, resident, and nurses and were intended for conference discussion and as an outline reference a physician would consider in possible diagnostic and treatment options, not to establish the standard of care. (T. 203-206, 533-536, 593-595, 602.) The trial court's misplaced reliance upon this teaching tool as a legal weapon against UMMC in a court of law is counter to its educational purpose. (T. 533-536.) Dr. James Martin, chief of obstetric services at UMMC, testified clearly that the guidelines were not a protocol, that modification was expected (as is printed on the guidelines themselves), and that clinical judgment is expected to take precedence over the guidelines. (R. E. 11, p. 4; T. 533-536.) The guidelines are modified narratively by the

faculty and some modification always occurs to fit the individual circumstances. (T. 533-536.) Plaintiff's position that the student practice guidelines, created by the faculty, could not be modified by said faculty in their supervision of the students and residents is far fetched indeed, as though once the guidelines were created they somehow become law even to their creators. Dr. Chapman testified that the tests listed in the guidelines "could have been performed. But in this case they wouldn't have changed the decision that was made on the length of antibiotic therapy or discharge." (T. 602).

Even if the UMMC student practice guidelines established the standard of care (which they did not), they were substantially followed by the treating physicians on March 18-20. The guidelines did not indicate that the list of laboratory tests was a list of required procedures. (R.E. 11, p. 2.) A diagnosis of EMM was made, which plaintiff herself urges was correct. Unasyn was recommended by the guidelines in treatment for EMM and was discontinued approximately 48 hours after Ms. Ward's single temperature spike showed significant decline, also as recommended by the guidelines. (R.E. 11, p.3.) Finally, Ms. Ward and the trial court ignored that the guidelines suggest the practitioner re-evaluate for resistant microorganisms (such as MRSA) if the patient is unresponsive to the antibiotics given, a scenario that did not occur in this case where Ms. Ward responded quite well to the treatment provided. (T. 536-537, R.E. 11, p.3.) Thus, even if the guidelines represented the standard of care (which they did not), the allegedly correct diagnosis was made, the treatment suggestions were followed, and no re-evaluation was necessary because Ms. Ward's symptoms readily responded. (T. 537.)

The trial court thus erred in relying upon the OB/GYN practice guidelines to mandate diagnostic tests and treatment for EMM in this case. Nonetheless plaintiff agrees with the diagnosis of EMM and the treatment provided substantially followed the guidelines. As the trial court applied an incorrect legal standard by relying upon the OB/GYN student practice guidelines to establish the standard of care, a *de novo* review of this issue is appropriate.

6. The trial court erred in denying UMMC's motion for directed verdict (involuntary dismissal).

At the close of plaintiff's case UMMC moved for a directed verdict, arguing that Dr. David was not qualified to offer a reliable opinion as to the applicable standard of care and that plaintiff failed to prove the required element of proximate cause. (T. 372-377.) This motion was then renewed at the conclusion of the trial. (T. 611.) UMMC notes that the proper motion in a bench trial was not one for directed verdict, but one for involuntary dismissal under *Miss. R. Civ. P.* 41(b). *Partlow v. McDonald*, 877 So. 2d 414, 416 ¶ 7 (Miss. Ct. App. 2003). "In considering a motion for involuntary dismissal under Rule 41(b), the trial court should consider the evidence fairly, as distinguished from the light most favorable to the plaintiff, and the judge should dismiss the case if it would find for the defendant." *Partlow* at 416-417 ¶ 7 (emphasis added).

Neither plaintiff counsel nor the trial court addressed the challenge to the qualifications of Dr. David in response to defendant's motions for directed verdict. Instead, the trial court's ruling denying the motion expressly found that the laboratory tests listed in the OB/GYN practice guidelines were not performed and there may have been an antibiotic resistant infection, with no mention of the element of proximate cause. (T. 372-377, 611.) The trial court expressed the standard she was following as "at this point, the burden is to

determine whether there is genuine issue, material fact to be determined by the fact finder as to whether the standard of care was breached by the University Hospital, meaning the doctors that saw the plaintiff, Earquella Ward." (T. 376.) In denying defendant's motions for directed verdict (involuntary dismissal), the trial court concluded:

> There has been raised an issue of the breach of standard of care with reference to the treatment of Ms. Earquella Ward. And the Court finds that the plaintiffs have met their burden and have proved a prima facie case. And the burden now is for the defendant to bring forth its proof in order for the fact finder to make its determination.

(T. 377.)

The trial court thus denied UMMC's motion for directed verdict (involuntary dismissal), requiring only that the plaintiff raise an issue as to the element of breach of duty to establish a *prima facie* case of negligence, which is a clear error of law. *McCaffrey v. Puckett*, 784 So. 2d 197, ¶ 33 (Miss. 2001); *Burnham v. Tabb*, 508 So. 2d 1072, 1074 (Miss. 1987.) The trial judge made no finding that the plaintiff had proven the element of proximate cause. As plaintiff had failed to establish the applicable standard of care through its unqualified and unreliable expert Dr. David, and/or failed to prove to a reasonable probability the element of proximate cause, the trial court erred in denying UMMC's motions for directed verdict (involuntary dismissal), and a *de novo* review is appropriate.

V. CONCLUSION

On March 18-20 and 27, 2002, Ms. Ward was provided treatment at UMMC for post-Cesarean complications (presumed EMM and a possible wound infection), after which her symptoms disappeared and she sought no further care at UMMC. Plaintiff claims that a lack of care by UMMC on those dates caused her later hysterectomy. The court mistakenly found

plaintiff's expert, Dr. David, to be qualified to offer expert testimony as to the standard of care in 2002, and mistakenly construed his testimony to be relevant and reliable. In denying UMMC's motions for directed verdict (involuntary dismissal), the trial court mistakenly required only a showing of an issue as to a breach of the standard of care to create a *prima facie* case of negligence, relieving plaintiff of the requirement of proving proximate cause, a clear error of law.

In finding UMMC liable in her memorandum and judgment after trial, the court relied upon testimony she attributed to treating physician Dr. Wolfe that did not take place and does not appear in the record, as well as upon a mischaracterization of the testimony of treating physician Dr. Austin. The trial court's several testimonial creations and enhancements suggested a possible bias in favor of the plaintiff, despite the court's duty to "faithfully and impartially execute and perform" its duties. *Mississippi United Methodist Conference v. Brown*, 929 So. 2d 907, ¶ 6, (Miss. 2006); *In Re Blake*, 912 So. 2d 907, 917 ¶ 33, (Miss. 2005.)

The trial court also mistakenly relied upon a UMMC teaching tool to establish the standard of care, indicating that the faculty who created the tool could not interpret the tool or modify it to fit the individual patient situation. Finally, the trial court adopted the plaintiff's proposed version of Dr. David's opinion, including a "finding" that Dr. David held several opinions which were never offered at trial. In relying on Dr. David's opinion to prove the elements of negligence, the trial court ignored that his opinion was based on upon incorrect facts and partial information on the key issues.

Taking into consideration the accurate factual evidence and the whole of the information available, UMMC's experts testified that UMMC did not breach the standard of care and did not proximately cause the plaintiff's hysterectomy. It was an abuse of discretion and against factual evidence for the trial court to find in favor of the plaintiff in this case, and UMMC thus requests the Mississippi Supreme Court to reverse the trial court's erroneous findings of breach of duty and/or proximate cause of Ms. Ward's hysterectomy, and to dismiss this action, with prejudice.

WHEREFORE, PREMISES CONSIDERED, UMMC requests this Honorable Court to reverse the ruling of the trial court on UMMC's motions for directed verdict and/or on the final verdict at trial, and to finally dismiss UMMC from plaintiff's claim, with prejudice.

Dated this the 8th day of December, 2006.

Respectfully submitted,

UNIVERSITY OF MISSISSIPPI MEDICAL CENTER

WILKINS, STEPHENS & TIPTON, P.A.

BY: Senith C. Tipton

Senith C. Tipton (MSB No. [redacted])
Melanie H. Morano (MSB No. [redacted])

WILKINS, STEPHENS & TIPTON, P.A.
One LeFleur's Square
P. O. Box 13429
Jackson, MS 39236-3429
(601) 366-4343
Fax: (601) 718-0156

CERTIFICATE OF SERVICE

I do hereby certify that I have this day caused to be hand delivered a true and correct copy of the above and foregoing **Brief of Appellant** to the following:

Hon. Tomie T. Green
Circuit Judge
Hinds County Courthouse
P. O. Box 327
Jackson, MS 39205

G. Joseph Diaz, Jr., Esq.
Patrick K. Williams, Esq.
Diaz Lewis & Williams
115 South Congress Street, Suite 1218
P. O. Drawer 24268
Jackson, MS 39225-4268

(Via United States mail, postage prepaid)
Edward Blackmon, Jr., Esq.
Blackmon & Blackmon, PLLC
907 West Peace Street
P. O. Box 105
Canton, MS 39046
Attorneys for Plaintiffs

This the 8th day of December, 2006.

Senith C. Tipton (MSB No. [redacted]
Melanie H. Morano (MSB No. [redacted])

M:\ybrowning\SCT1- pldg\Ward-Earquella.BriefforAppellant.wpd