IN THE COURT OF APPEALS OF THE STATE OF MISSISSIPPI

CIVIL CAUSE NO.: NO. 2008-TS-00987

PAULA LEE VAUGHN,
APPELLANT

VS.

MISSISSIPPI BAPTIST MEDICAL CENTER,
APPELLEE

APPELLANT'S BRIEF IN SUPPORT OF APPEAL

ORAL ARGUMENT REQUESTED

Bill Waller, Sr.
MSB No.: [redacted]
Waller & Waller, Attorneys
Post Office Box 4
220 South President Street
Jackson, Mississippi 39205
(601) 354-5252
Attorney for the Appellant

CERTIFICATE OF INTERESTED PARTIES

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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 this Court may evaluate possible disqualification or recusal.

Honorable Swan Yerger, Hinds County Circuit Court Judge
Paula Lee Vaughn, Appellant
Bill Waller, Sr., Attorney for Appellant
Mississippi Baptist Medical Center, Appellee
Eugene Naylor, Esq., Attorney for Appellee
Gaye Nell Currie, Esq., Attorney for Appellee

CERTIFIED, this the 18th day of December, 2008.

BILL WALLER, SR.

Attorney of Record for Appellant,
Paula Lee Vaughn

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2. It was Error for the Lower Court to Grant Summary Judgment in its Entirety as Keller is Qualified to Testify as to the Nursing Standard of Care and Breach Thereof.

3. It was error for the lower court to grant Mississippi Baptist Medical Center's Motion to Strike Crystal Bear Keller, R.N. as an expert witness and determine that she was not qualified to offer expert medical testimony regarding medical diagnosis and causation on the subject case. The claim is for damages arising from negligent "nursing care" and witness Keller is well qualified to present the "nursing standard of care."

4. It was error for the lower court to deny Paula Lee Vaughn's Motion to Amend Rulings of the Court.

II. STATEMENT OF THE CASE

This cause of action arose out of the negligence of the nursing staff at Mississippi Baptist Medical Center. When the original Complaint was filed, Paula Lee Vaughn filed suit against Mississippi Baptist Medical Center and Brandon Nursing and Rehabilitation Center for medical negligence in Hinds County Circuit Court. (R.5, R.E.30). Vaughn settled with Brandon Nursing and Rehabilitation Center and they were dismissed from the suit. (R. 143). The lower court granted Mississippi Baptist Medical Center's Motion for Summary Judgment and Motion to Strike the Affidavit of Crystal Bear Keller, R.N. on May 28, 2008, and thereby ruling that Plaintiff did not have an expert. The summary judgment was also based on testimony there was no infection in the Plaintiff's legs. (R. 719, 721, R.E. 8, 10). The lower court denied Vaughn's Motion to Amend Rulings of the Court on May 28, 2008. (R. 720, R.E. 9). The lower court entered a Final Judgment of Dismissal with Prejudice on May 28, 2008. (R. 722, R.E. 11). It is from these orders that the Plaintiff appeals. (R. 723).

III. STATEMENT OF FACTS

This is a case concerning nursing negligence and breach of the nursing standards of care.

Paula Vaughn was admitted to Mississippi Baptist Medical Center on October 24, 2005 for bypass surgery, mitral valve repair and tricuspid repair. While a patient at the Baptist Hospital she acquired a staph infection in her bilateral leg wounds as a result of nursing negligence which required multiple hospitalizations and additional expenses. Prior to her hospitalization in October 2005, Vaughn was a reasonably healthy female. She had diabetes and eye problems, but those conditions did not prevent Vaughn from living a normal life. Approximately six (6) months prior to her surgery in October 2005, she began to feel the symptoms of heart problems for which she was referred to the Baptist Hospital for surgery. Vaughn's adult children have all testified in their depositions that Vaughn led a normal and active lifestyle prior to her admission to Baptist Hospital on October 24, 2005 and that since that time, she has been forced to do only limited sedentary activities which caused her a substantial loss of quality of life. (R. 601, 602-603, 607, 630-631; R.E.148, 149-150, 154, 177-178).

Vaughn charges the Baptist Hospital with negligence in their nursing care and treatment of her. Specifically, the nursing staff at Baptist Hospital was negligent and did not follow the standard of care in their care and treatment of the Vaughn's surgical wounds on both legs. These wounds are on the inside groin area measuring a couple of inches in length. Her wounds were highly visible and she complained of extreme pain. The wounds were distended from the swelling, discolored in red and blue shades and discharging purulent material constantly.

Vaughn was admitted and discharged to and from the Defendant Hospital from October 24, 2005-November 2, 2005; November 7, 2005-November 21, 2005; and December 5, 2005-December

9, 2005, during which intervals Vaughn was totally dependent upon Baptist Hospital's nursing staff, employees and agents for all activities of daily living, including but not limited to, mobility, posturing, nutrition, medications and personal hygiene. It is contended that during the course of the Vaughn's hospital stay from October 24, 2005-November 2, 2005, she developed acute infection in her leg wounds from defecation and urination because she was unable to ambulate and get herself to the bathroom which forced the continued contamination of her wounds. This event caused her leg wound to become saturated with the waste material, and such contamination remained on her leg for approximately 3.5 hours before a nurse came to clean and sanitize the wounds. Shortly thereafter, these surgical wounds became acutely infected, becoming red in color, swollen, feverish and very painful. The negligence accounted for by her adult children was the failure of the nursing staff to take single hygienic steps to prevent the contamination and to cleanse the wounds once contaminated. (R. 185).

After Vaughn's leg drains and Foley catheter were discontinued she developed severe generalized edema with weeping. Vaughn also developed large amounts of serosanguinous drainage in her bilateral leg wounds which increased each time she got up out of bed saturating her dressings. Vaughn's leg wounds continued to discharge material, increased swelling, increased feverishness and increased blue and red discoloration. Vaughn's leg wounds continued to worsen developing creamy, yellow pus and discoloration. The nursing staff failed to notify a physician and a culture was not taken timely. The nursing care negligence was compounded repeatedly when Vaughn's leg wounds continued to worsen developing large amounts of drainage along with a hematoma to the back of her lower left thigh and neither supervising nor treating physicians were notified. Other regular treatment standards were violated such as having a consultant examine Vaughn and study

test results depicting the type and grade of infection so as to prescribe the appropriate antibiotic and other treatment modalities. Vaughn's leg wounds still continued to worsen with drainage to her inner thighs and her wounds were bleeding, bruised and yellow and a physician was still not notified. Documentation in the medical records reveals that the nursing staff failed to perform dressing changes as ordered on numerous occasions. She was discharged from the Baptist Hospital on November 2, 2005. (R. 188-189, R.E. 35-36).

The standard of care and the repeated violation of the standards was thoroughly and meticulously documented by Vaughn's well qualified expert witness who gave an affidavit which was of record when the summary judgment was granted. (R. 565, 662; R.E. 112, 207).

On November 7, 2005 Vaughn was readmitted to the Baptist Hospital, to be treated for symptoms of heart failure and renal failure, however, she was advised that she did not have heart failure, but that she did have acute and advanced infection in her legs and that the infection should be treated intensively. Vaughn underwent surgical debridement of the wounds which were noted to be very deep. Dressing changes were ordered every shift. However, documentation in the medical records reveals that the nursing staff failed to perform dressing changes as ordered on numerous occasions, preventing a timely cure and treatment of the infection. Vaughn was again discharged even though the condition of her wounds had not substantially improved with swelling and heavy draining continuing. The outward sign of the gross infection were unabated. (R. 189, R.E.36).

On November 21, 2005, through referral by the Baptist Hospital, Vaughn was admitted and transferred to a health care facility located in Rankin County, Mississippi. The Baptist Hospital failed to adequately inform the transferring facility of proper treatment instructions regarding Vaughn's acute symptoms including her acute infection, including the existence of a staph infection, and the

to protect and treat her leg wounds, as well as problems related to her ambulation and her ability to take care of herself based upon her recovering from major surgery and as related to the disturbance of her bodily functions from the anesthetic and other drugs given her during the course of her surgery and recovery. It was gross and wanton negligence to prematurely discharge or transfer Vaughn from its' institution which proximately caused and contributed to the extent of the infection and directly and indirectly caused the Vaughn to suffer a serious and permanent injuries, including her to vital bodily functions. In addition to her physical injuries and related pain and suffering, Vaughn suffered emotional injuries, resulting in a severe stress disorder arising from the failure of Baptist Hospital to provide her reasonable and standard medical care. (R. 190, R.E. 37).

On December 5, 2005, Vaughn was readmitted to the Baptist Hospital, where additional diagnostic blood work established the fact that her kidney functions were normal, and that her blood count was very high, indicating severe infections. The wound vac instrument was re-established, and she was given two (2) units of blood due to her low blood count. (R. 186, R.E. 33).

She remained in the Baptist Hospital until December 9, 2005, when she was transferred to Restorative Care, remaining there until her discharge. While in Restorative Care she was placed back on an antibiotic for the staphylococcus infection in her wounds which infection originated while a patient in Baptist Hospital. Vaughn's leg wounds continued to require further treatment and continued to be infected because of improper care, by failing to report the infection, failing to document the infection, failing to document changes in her condition, failing to properly clean the leg wounds, failing to request consultation, failing to follow physician's orders, failing to conduct dressing changes and all other charges made in Vaughn's Complaint. Baptist Hospital had a duty to ensure that Vaughn's bilateral leg wounds were taken care of properly and that they had healed

prior to her discharge. Baptist Hospital discharged Vaughn on multiple occasions while her wounds were still saturated with infection, requiring a wound vac, and antibiotics. Vaughn should not have been discharged. Vaughn developed a duodenal ulcer, duodenitis, gastritis and stricture of the gastroesophageal junction. After her discharge from Baptist on December 29, 2005, she has continued to suffer diarrhea, nausea, vomiting and abdominal pain. Dr. Kessler is of the opinion that Vaughn's gastrointestinal complications resulted from the dosages of antibiotics used to treat Vaughn's staph and other infections while a patient at the Baptist Hospital. (R.415, R. 629, R.E. 66,176).

The nursing staff of Baptist Hospital is charged with other acts of negligence as are more fully outlined within the Argument of the Brief.

IV. SUMMARY OF THE ARGUMENT

The trial judge struck the expert witnesses testimony and used that ruling as a basis for granting summary judgment.

If an anatomical defect exists while a patient is hospitalized such as open and obvious infection in leg wounds which were not treated properly after repeated admissions, causation of the infected leg wounds yields to the negligence of the hospital in failing to determine the cause, however, the claim is about the cure and the evidence is overwhelming that the required treatment by the nursing staff was violated- - repeatedly.

Crystal Keller is qualified to testify not only to the deviations in the standard of care by the nursing staff of Baptist Hospital, but also to testify as to the infection and the lack of care and treatment of Vaughn's leg wounds.

The signs of the infection were open and obvious to laymen such as the Plaintiff's adult children. Additionally, the Plaintiff's adult children witnessed the deviations in the standard of care of the nursing staff of Baptist Hospital in their care and treatment of the Plaintiff generally. Where the negligence is within the common knowledge of a layperson, expert testimony is not needed to establish negligence. *Dailey v. Methodist Med. Ctr.*, 790 So.2d 903, 918 ¶ 23 (Miss. Ct. App. 2001).

Crystal Keller because she is qualified to give opinions regarding nursing standards of care from outset of infection forward and to nursing care generally. Keller should still be allowed to testify concerning the appropriate standard of nursing care and the deviations from that standard. The lower court was overly restrictive concerning Keller's testimony.

Crystal Keller is qualified as an expert witness to render testimony concerning the deviations

in the standard of nursing care and it was error for the lower court to strike her testimony.

Since the lower court struck Vaughn's expert and granted summary judgment because the court ruled that Vaughn's expert was not qualified to render expert testimony, then Vaughn should have been allowed time within which to offer the opinion from another expert witness.

Summary judgment was inappropriately granted and the Court should reverse the decision of the lower court.

V. STATEMENT REGARDING ORAL ARGUMENT

The main issue which will effect medical negligence practice in the future is the scope or limitation of the opinions of an expert witness nurse. To a large extent, a physician's care and diagnosis depends upon the record given him by the nursing staff which is in constant attendance whereas the physician's hands on attention is quite brief and intermittent. This points up the importance of proving nurses are meeting or not meeting the standard of "nursing care."

Oral argument will be helpful to the Court in fixing rules pertaining to the scope or limitations to be placed upon the opinions that may be given in the future by nurse experts.

VI. ARGUMENT

1. **It was error for the lower court to grant summary judgment and determine that there was no genuine issue of material fact with regard to the proximate cause of Paula Lee Vaughn's infection, including that there was no infection in Paula Lee Vaughn's legs proximately resulting from any acts or omissions of Mississippi Baptist Medical Center.**

Baptist filed a Motion for Summary Judgment on January 14, 2008 alleging that Vaughn had not presented expert medical testimony establishing the applicable standard of care, breach of that standard and that such breach proximately caused Plaintiff's alleged injuries. (R.479, 480; R.E.26, 27).

Vaughn designated Crystal Keller, R.N. to testify with regard to the nursing negligence at issue. (R. 406). Her qualifications are outlines herein below.

Baptist contended in its Motion for Summary Judgment that Crystal Keller was not qualified to testify regarding medical causation and she was not qualified to give testimony as to causal link between nursing care and infection. (R.480, R.E.27). However, the infection arose from intervention and Vaughn claims defective treatment of the infection.

Baptist further contended in its Motion for Summary Judgment that Vaughn provided no proof that the alleged negligence of the nursing staff at Mississippi Baptist Medical Center proximately caused Vaughn's legs wounds to become infected. (R.480, R.E.27).

Vaughn charged that the nursing staff at Baptist was negligent and did not follow the standard of care in their care and treatment of her as a whole and her surgical wounds on both legs. Crystal Keller has established the applicable standard of care for nurses and the breach of that standard by the nursing staff at Baptist. Summary judgment was inappropriately granted. Keller's testimony and the medical records along with the testimony of the Plaintiff and her adult children

create numerous genuine issues of material facts.

The standard of care and breach thereof goes far beyond the first admission to Baptist Hospital. She was admitted three times for treatment of her bilateral leg wounds. Baptist did not render the appropriate treatment in accordance with the standard of care for her wounds. Bedside attention from family members confirmed gross negligence in failing to cleanse and change the dressings on her wounds and bandages soaked with feces and urine.

Even if there was no infection during the first admission, which Vaughn contends is false, Baptist was obligated to administer care and treatment of the infected wounds on the second and third admissions so as to minimize and/or cure the infection and ensuing complications, all of which they failed to do.

Baptist's experts are of the opinion that Vaughn's underlying health conditions were the proximate cause of the infections in the leg wounds and that there was no deviation from the standards of care by the nursing staff and other personnel at Baptist Hospital. However, this theory fails. Baptist's staff should have been aware of Vaughn's underlying health conditions and the associated risks therewith. By so knowing, Baptist was under a duty to watch Vaughn carefully for this type of infection injury, and yet Baptist did not attempt to prevent it. Regardless of other health conditions of Vaughn, Baptist was under a duty to prevent this type of infection injury to the Vaughn. Secondly, and thereafter, they were obligated to administer care and treatment of the infected wounds so as to minimize and/or cure the infection and ensuing complications, all of which they failed to do.

The problem as well as the cure was caused by negligent nursing care which was not observed by the nurses or reported to the physician. Plaintiff's expert opined as to the nurses duty

to record acute infection and to report such to the physician.

The circumstantial evidence in this case is overwhelming. If she did not have an infection or a condition that needed treatment, then why was she continuously being admitted to the hospital.

A. Standard of Review for Summary Judgment.

When reviewing a trial court's grant of summary judgment, the Court applies a de novo standard of review. *Busby v. Mazzeo*, 929 So.2d 369, 372 (¶8) (Miss. Ct. App. 2006). Summary judgment is proper where "the pleadings, depositions, answers to interrogatories and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." Miss.R.Civ.P. 56(c). The evidence must be viewed in the light most favorable to the party against whom the motion has been made. If, in this view, there is no genuine issue of material fact, and the moving party is entitled to judgment as a matter of law, summary judgment should be entered. Otherwise, it should be denied. *McMillan v. Rodriguez*, 823 So.2d 1173, 1176-77 (¶9) (Miss. 2002).

"Summary judgment is not a substitute for trial regarding disputed issues of fact." *Palmer v. Anderson Infirmary Benevolent Assoc.*, 656 So.2d 790, 795 (Miss. 1995).

B. Crystal Keller is qualified to render an opinion as to Infection and Causation of Infection.

The only evidence rebutting the competency of Plaintiff's expert was a medical doctor working with the Defendant who should not be relied upon in determining whether the nursing staff at Baptist Hospital followed the standard of care in their treatment and care of Vaughn. Clearly, a nursing expert is more qualified to testify as to the standards of nursing care. As pointed out, the doctor did not remove dressings to examine the wounds. Therefore, he cannot have knowledge of

the appearance or condition of the wounds.

Contrary to Baptist's experts assertions, Vaughn developed an infection in her leg wounds during her first hospitalization at Baptist Hospital from October 24, 2005 to November 2, 2005 as is obvious by Vaughn's medical records and the below cited testimony from lay witnesses and Vaughn's expert nurse.

Notwithstanding the causation factor, there was an infection and she had all of the signs of an infection regardless of Dr. McMullen's testimony. Defendant cited to Dr. McMullen's testimony that there was no sign of infection during Vaughn's first admission to Baptist. However, there is ample evidence to the contrary.

Sherry Blaine testified in her deposition that Dr. McMullen told her that her mother's leg wounds were infected. (R. 592, R.E. 139). Dr. McMullen testified that layman are accustomed to seeing pus as well as nurses. (R.666-667, R.E.211-212).

Nurses are to be the eyes and ears for physicians who are not continually around the patient. Physicians rely on nursing staff to report changes in patients' status and adequately note and document acute and/or recurring problems. A doctor only gives a fractional part of the picture, as the nurses are the primary care givers and are in constant contact with the patients. This entails performing ongoing reviews of patient's charts and consulting with other healthcare team members in reassessing, implementing and reevaluating the course of the patient's progress throughout their hospitalization. Nurses are more knowledgeable of hospital policies and inside events than doctors.

Nurses make up nurses' notes, which become an integral part of the official medical records and upon which the physicians rely. Records created by nurses and technical staff are by far the majority of all records. From this the Court must conclude that timely and complete notes are

required to inform and alert the treating physicians as to sudden changes in the obvious condition of these two massive open wounds.

The following facts are established by the Plaintiff's medical records and expert witness, Crystal Keller, which show that the nursing staff at the Baptist Hospital deviated from the standard of care and that Plaintiff had developed an infection during her first admission to the Baptist Hospital.

On October 26, 2005, Ms. Vaughn was noted to have severe 4+ generalized edema with weeping noted. Her bilateral leg wounds were noted to have moderate to large amounts of serosanguinous drainage, which increased each time she got up out of bed saturating her dressings. On October 28, 2005, Ms. Vaughn's leg wounds continued to weep and developed redness. Dr. McMullen ordered Levaquin 500 mg. by mouth every day prophylactically. Ms. Vaughn was also noted to be 25 pounds over her preoperative weight and Lasix was ordered.

On October 29, 2005, nurses' notes reveal redness and creamy, yellow pus was noted to Ms. Vaughn's left upper leg incision during dressing changes. The nurse failed to notify the physician and a culture of the drainage was not taken. On October 30, 2005, redness and edema were noted to her leg wounds bilaterally.

On October 31, 2005, her bilateral inner thighs had a large amount of drainage noted along with a hematoma to the back of her lower left thigh. There was no description of the drainage, including color, presence of odor, etc. In addition, a physician was not notified. Ms. Vaughn also developed an episode of atrial fibrillation for which she received Cardizem as per hospital protocol. She converted back to normal sinus rhythm without further incident.

On November 1, 2005, nurses' notes indicate a moderate amount of drainage to her inner

thighs and her wounds were noted to be bleeding, bruised and yellow in appearance. A physician was not notified. Due to Ms. Vaughn's weakness and slowness to mobilize, a swing bed consult was ordered.

On November 2, 2005, Ms. Vaughn was discharged to Montford Jones Memorial Hospital's swing bed for cardiac rehabilitation, wound care and assistance with all activities of daily living. It was noted that she had difficulty with her gait along with muscular posture fatigue and required the use of a walker for ambulation. Dr. Alford's admission summary reveals that her bilateral medial thigh graft donor sites were noted to be slightly indurated. Orders included dressing changes to bilateral upper inner thigh incisions prn, and Levaquin 500 mg. po daily until November 10, 2005.

In the case of *Richardson v. Methodist Hospital of Hattiesburg, Inc.*, 807 So.2d 1244, 1246 ¶ 8 (Miss. 2002) cited by Baptist regarding Vaughn's expert, Cystal Keller, the Court found as follows:

> We find the trial court's ruling was overly restrictive in not allowing Keller to testify concerning the appropriate standard of nursing care and the deviations from that standard. There is sufficient proffered evidence from Keller for a jury to consider whether the inadequate nursing care resulted in worsening Wheeless's physical pain and suffering.

Id. at 1246.

The Court went on further to state:

> The fact that Keller is not a physician does not bar her right to testify concerning the standard of care for the nursing staff, but more appropriately may affect the weight of her testimony, which is an issue for the trier of fact. Considering all of the evidence in the light most favorable to Richardson, we find there is a genuine issue of fact concerning whether Wheeless suffered more physically and incurred more expense from the failures of the nursing staff documented by Wheeless's expert and that the circuit court improperly granted summary judgment as to pain and suffering.

Id. at 1247 ¶ 11.

The Court in *Richardson* found that Keller could not testify regarding complex issues of medical causation. *Richardson* at 1248 ¶ 17. A stroke is considered to be a complex medical issue, however, an infection is something that is within a nurse's expertise as a nurse. Keller can testify as to the connection between the nursing negligence and the resultant infection in Vaughn's bilateral leg wounds. (R. 565, 662; R.E.112, 207)

The Court in *Sonford Prods. Corp. v. Freels*, 495 So.2d 468 (Miss. 1986), *overruled on other grounds, Bickham v. Department of Mental Health*, 592 So.2d 96, 98 (Miss. 1991) held that there need not be expert testimony from a medical doctor to establish causation.

In the case of *Mellies v. National Heritage, Inc.*, 636 P.2d 215, (Kan.App.1981), the Kansas Court of Appeals ruled regarding a nursing expert being able to testify as to causation of injuries involving breach of the nursing standard of care. In so doing, they considered cases regarding expert testimony being necessary to support the conclusion as to causation. The Court went on further to state that those same cases recognized that if causation is within the common knowledge of the jury, medical testimony is not necessary. The Court cited *James v. Grigsby*, 114 Kan. 627, 632, 220 P.2d 267 (1923), wherein it was stated: "And where negligence in the treatment is shown by medical witnesses and the evidence shows a bad result, it is the province of the jury to say whether the result was caused by the negligence." *Id.* The issue in the case was whether decubitus ulcers were contracted or made worse by the nursing center, or by the hospital from which the plaintiff was transferred. The Court concluded that the testimony and evidence about when each decubitus ulcer appeared on the nursing records, the question could be resolved by a jury without the testimony of a medical expert. The Court also stated: "**We conclude that as to the areas concerning which the**

nurses were allowed to testify, they were qualified to state the standard of care. Since this case deals with *nursing* negligence, it would seem that the jury had competent evidence from which it could determine the standard of nursing care for patients for the prevention and treatment of decubitus ulcers." *Mellies v. National Heritage, Inc.*, 636 P.2d 215, (Kan.App.1981)(emphasis added). The Court went on further to state: **"Since this case involves primarily a nursing problem, we feel that nurses are experts under the facts of this case and that there was sufficient evidence as to all three negligence elements, even without a doctor's testimony, to establish a jury question as to whether there was negligence in this case."** *Mellies v. National Heritage, Inc.*, 636 P.2d 215, (Kan.App.1981)(emphasis added).

In the case of *Sacks v. Necaise*, 991 So.2d 615 (Miss. App. 2007), the trial judge allowed an expert nurse to testify on causation based on her designation and the *Daubert* hearing. The appellants argued that the expert nurse should not have been allowed to testify as to causation because such issues are outside a nurse's expertise and should be determined by a medical doctor. The Court of Appeals found that the expert nurse did not testify outside of the areas of her expertise and found the issue to be without merit.

Keller's testimony as to the infection would have included that Ms. Vaughn has signs and symptoms of infection in her leg wounds during her first hospital admission which was on October 24, 2005. That Vaughn developed staph infection during the first admission as a result of the negligence of Baptist Hospital's nursing staff and continued to require further treatment because her leg wounds continued to be infected because of improper care. The leg wounds developed as a result of the negligence of Baptist Hospital's nursing staff and progressed into a smoldering infection, Acinetobacter baumannii and Klebsiella pneumoniae. Vaughn continued to require further treatment

and continued to be infected because of improper care, failure to report the infection, failure to document the infection, failure to document changes in her condition, failure to properly clean the leg wounds, failure to request consultation until the infection had set in, failure to follow physician's orders, failure to conduct dressing changes and all other charges made in Vaughn's Complaint. Baptist Hospital had a duty to ensure that Vaughn's bilateral leg wounds were taken care of properly and that they had healed prior to her discharge. Baptist discharged Vaughn, twice, while her wounds were still saturated with infection, while they still required a wound vac, and antibiotics. Vaughn should not have been discharged on November 2, 2005 until after her leg wounds had healed. Vaughn developed a duodenal ulcer, duodenitis, gastritis and stricture of the gastroesophageal junction. After her discharge from Baptist on December 29, 2005, she continued to suffer diarrhea, nausea, vomiting and abdominal pain. Vaughn has suffered permanent gastrointestinal problems as a result of the antibiotics from the infections. (R. 640-643; R.E. 187-190). Paula Vaughn's treating physician, Dr. Victor Kessler, would have testified, had he been called, that Vaughn has suffered permanent gastrointestinal problems as a result of the antibiotics from the infections.

There are genuine issues of fact concerning Vaughn's pain, suffering and injuries, established through the expert testimony of Vaughn's expert witnesses, as well as the lay testimony of Vaughn's witnesses.

It is the function of the jury as the traditional factfinder to weigh conflicting evidence and inferences and determine credibility of witnesses, not the court. *Clark v. Illinois Central R. Co.*, 794 So.2d 191 (Miss. 2001).

Summary judgment was inappropriately granted and the Court should reverse the lower court's grant of summary judgment.

C. Laymen's Knowledge.

Where a layman can observe and understand the negligence as a matter of common sense and practical experience, an expert is not needed. *Gatlin v. Methodist Medical Center*, 772 So.2d 1023 (Miss. 2000)(citing *Coleman v. Rice*, 706 So.2d 696, 698 (Miss. 1997)).

Where the negligence is within the common knowledge of a layperson, expert testimony is not needed to establish negligence. *Dailey v. Methodist Med. Ctr.*, 790 So.2d 903, 918 ¶ 23 (Miss. Ct. App. 2001).

The facts revealed by Vaughn and her children have explicitly explained the gross appearance of the wounds resulting from contamination of the wounds from urine and feces, among other things, allowed by inadequate nursing care and resulting in gross changes in the appearance of the wounds, including discoloration, swelling, discharge and odorous material. Rising above that which a nursing staff member should have known and responded to is the testimony of the Plaintiff and her daughter, who was attending her bedside, that they repeatedly requested attention to the contaminated wounds and failed to receive treatment.

Additionally, the Plaintiff's adult children witnessed the deviations in the standard of care of the nursing staff of Baptist Hospital in their care and treatment of the Plaintiff generally.

In fact, Dr. McMullen testified that layman are accustomed to seeing pus as well as nurses. (R.666-667; R.E.211-212).

Sherry Blaine testified in her deposition that Dr. McMullen told her that her mother's leg wounds were infected. (R. 592, R.E. 139).

Susan Vaughn Rone testified that the lack of care was the nursing staff not taking care of Vaughn, not cleaning her, not bathing her, not keeping her room clean, not keeping it clean enough

to where she would not develop staph infection and that development of staph infection is common knowledge. Uncleanliness leads to infection. (R. 630-631, R.E. 177-178).

An infection is a medical issue that is common to a layperson and within a layperson's knowledge. Signs of infections are swelling, inflammation, discharge, pain and discoloration, all of which are common to a layperson. It does not take an expert or doctor to diagnose an infection. In fact, Plaintiff's children were aware that her leg wounds had become infected as shown by their deposition testimony. (R.568-603; R.E.115-150); (R.607, 610; R.E. 154, 157); (R.630-631; R.E.177-178). Sherry Blaine testified that Dr. McMullen told her that her mother's leg wounds were infected. (R. 592, R.E. 139). Sherry Blaine also testified that her mother's leg wounds appeared swollen and red and had stuff coming out of it like pus. (R. 588-589, R.E. 135-136). Sherry Blaine testified that her mother's leg wounds began to get red after she urinated on herself the third day and that one of the nurses said that they were red. (R. 594, R.E.141). Sherry Blaine testified that the morning she was discharged to Brandon, she looked at the leg wounds and they were much worse than they had been before. (R. 596, R.E. 143).

The Court has ruled that in a medical malpractice action a layman may give testimony regarding purely factually matters thus avoiding summary judgment, notwithstanding the physician's factual testimony to the contrary. *Kelley v. Frederic*, 573 So.2d 1385 (Miss. 1990).

As evidenced by the Patient Teaching record (R.567, R.E.114), the nurses teach their patients the signs and symptoms of infection, therefore a doctor is not needed to establish an infection. The patients are to notify or come back to the hospital if they develop these signs and symptoms. (R.567, R.E.114) Patient Teaching, October 27, 2005 #10 "Incision care: Report redness, swelling, small amount of dark or clear drainage normal; report any infected drainage or temp over 101° to MD."

This is evidence that if a nurse is teaching a patient about infection, and a patient is supposed to know all the signs and symptoms of infection, then obviously a nurse knows what an infection is. This record shows that this is Baptist's teaching standard. Therefore, it is obvious that a layman will be able to understand the signs and symptoms of an infection and expert testimony is not needed to establish infection. It is clear from Vaughn's medical records which should have been presented into evidence before a jury.

The lay witnesses testimony, coupled with that of Vaughn's treating physicians and experts overcomes summary judgment. There are genuine issues of material fact that must be decided by a jury. Further, the credibility of witnesses is for the jury to determine and summary judgment was erroneously granted.

2. It was Error for the Lower Court to Grant Summary Judgment in its Entirety as Keller is Qualified to Testify as to the Nursing Standard of Care and Breach Thereof.

Even if the Court is persuaded that Crystal Keller's testimony should exclude causation, it was error for the lower court to grant summary judgment in its entirety as to Crystal Keller because she is qualified to give opinions regarding nursing standards of care from outset of infection forward and to nursing care generally. Baptist does not dispute this in their Reply to Response to Motion for Summary Judgment. (R.674, R.E.219). There are genuine issues of material fact to be presented to a jury concerning the nursing standard of care and whether or not Baptist nurses fell below the applicable standard.

This point is specifically made by the Court in *Richardson v. Methodist Hospital of Hattiesburg, Inc.*, 807 So.2d 1244 (Miss. 2002) as cited above. Keller should still be allowed to testify concerning the appropriate standard of nursing care and the deviations from that standard.

The Court should find that the lower court herein was overly restrictive in not allowing Keller to testify as there is sufficient proffered evidence from Keller for a jury to consider whether the inadequate nursing care resulted in worsening Vaughn's physical pain and suffering. *Richardson* at 1247.

The Court in *Richardson* also reiterated its standard for expert witnesses in medical malpractice cases set in *Hall v. Hilbun*, 466 So.2d 856 (Miss. 1985), wherein the Court stated that "expert opinion testimony should be allowed where the witness is qualified and independent, and the testimony will assist the trier of fact." *Richardson at* 1246.

Specific facts of negligence include, but are not limited to the following which are established by the medical records, expert witnesses and lay witnesses:

Paula Vaughn had bilateral leg wounds as a result of her surgery. The nursing staff did not properly clean the wounds. The nursing staff did not change the dressings as ordered by the physicians. The nursing staff did not properly document the change in the wounds, the progression. The nursing staff did not inform the doctors of the change in the wounds. A wound consult was not ordered until days after the infection had set in. Premature discharge before wounds were healed.

On the third day after surgery- Vaughn called for help to use the bathroom, and the nurses did not come. Vaughn waited an hour, nobody came, nobody helped her to the bathroom. Vaughn used the bathroom on herself. Vaughn called for someone to clean up the urine that had gotten on her. It was four hours before someone came to clean it up. A nurse that came in there after four hours around 5:00 p.m. to change her dressings said that they were short staffed. (R. 581, R.E.128). There were several times Vaughn and her children called the nurse to come help her to the bathroom and the nursing staff did not come for an hour or two so her children took it upon themselves to help

her to the bathroom. (R. 571, 572, 573, 574, 576, 578-579, 580, 582, 583-584, 585, 586, 587, 635, 636; R.E. 118, 119, 120, 121, 123, 125-126, 127, 129, 130-131, 132, 133, 134, 182, 183).

On October 28th, Vaughn's daughter Sherry called the nurse about 9:00 a.m. to help her to the bathroom. The nurse did not come. Sherry helped Vaughn and about 2-3 hours later she had an accident- feces. They called the nurses station. It was almost an hour before a nurses assistant came down and cleaned her up. The nurses' aid said they were short staffed when Sherry complained about the amount of time it took for someone to get down there. (R. 586-587, 593-594; R.E.133-134,140-141). The children's testimony reveals the bathroom incidents occurred just about every day. The children had a hard time getting the nurses to come to Vaughn's room to take care of her, clean her and bathe her. The children had to take care of her and bathe her. (R. 618, 619, 620, 621, 622, 635, 636; R.E.165, 166, 167, 168, 169, 182, 183). The nursing staff did not bathe her, they just sponged her off with a rag. (R. 599-600, R.E. 146-147).The nurses did not change the bandages as ordered. (R. 582, 623, 626, 635, 636; R.E. 129, 170, 173,182, 183). The bandages had fecal matter and urine on them. (R. 585-586, 625-626, R.E. 132-133, 172-173). On one occasion, the nursing staff through a rag with feces on it in the bathroom and left it there for three days during the first visit. (R. 599-600, R.E. 146-147). (R. 571, 572, 573, 574, 578-579, 580, 583-584; R.E. 118, 119, 120, 121, 125-126, 127, 130-131) The children complained to the staff about the treatment their mother was receiving. (R. 586-587, 593-594, 608, 611, 612, 627, 638, 639 ; R.E.133-134, 140-141, 155, 158, 159, 174, 185, 186).

The deposition testimony of Paula Vaughn's adult children shows that the nursing staff at Baptist Hospital was negligent. (R. 542-553, 568-639; R.E. 89-100,115-186).

Additionally, it is the responsibility of nurses to be sure that she has the prescriptions and that

she is discharged with the amount of medications and to be sure to notify the physician that she was not discharged with medications. It is a nursing responsibility to bring things to the attention of physicians since the physicians are hardly with their patients.

A timeline of breaches in the applicable standard of might be helpful to the Court in understanding the significance of Crystal Keller's testimony. It is broken down into categories by the three admission dates. (R. 555-561; R. E. 102-108).

October 24, 2005 – November 2, 2005 admission:

1). Failure to adequately assess and reassess-

October 26, 2005 0800 – Joyce Thomas, RN. Nsg. Notes indicate Ms. Vaughn's respiratory status included gasping, grunting, stridor, wet, wheezes, decreased expiratory, intermittent scattered crackles, rales, and severe rhonchi. Nurse Thomas failed to reassess Ms. Vaughn's respiratory status. Nurse Thomas also documented a small amount of drainage noted to her lower extremity incisions, but failed to assess and describe the type of drainage, color, presence or absence of odor, etc.

1600 – Joyce Thomas, RN – Documents a moderate amount of drainage to lower extremity incisions, but once again, failed to assess the drainage for type, color, odor, etc.

October 27, 2005 0300 – Eva Davis, RN. Documents that Ms. Vaughn's bilateral leg dressings were saturated with a large amount of serosanguinous drainage. Dressings were changed. Nurse Davis failed to assess the incisions for any redness, swelling, or odor.

1541- Joyce Thomas, RN. Respirations congested, gasping, stridor, wet, wheezes, decreased expiratory, intermittent scattered slight moist coarse rales. Nurse Thomas failed to reassess her respiratory status. In addition, Nurse Thomas documents a large amount of drainage to her bilateral lower extremity incisions, but failed to assess the drainage for type, color, odor, etc.

October 28, 2005 – 0015- Francis Grant, LPN. Nurse Grant failed to assess Ms. Vaughn's bilateral leg wounds. There is no mention of her leg wounds in her assessment.

October 29, 2005 – 0000 – Amanda Bell, RN. Small amount of drainage to bilateral leg wounds. She failed to assess drainage for type, color, odor, etc.

0800 – James Russ Taylor, RN. Small amount of drainage to bilateral lower extremities. He failed to assess drainage for type, color, odor, etc.

1600 – James Russ Taylor, RN. Upper left leg incision reddened. Small amount of creamy, yellow pus noted. He failed to assess drainage for odor.

October 30, 2005 – 0030 – Lillian Hawthorne, RN. Upper left incision reddened and small amount of creamy, yellow pus noted. She failed to assess drainage for odor.

0800 – Karla Holmes, RN. Failed to assess bilateral leg wounds for redness or swelling. Popliteal pulses were documented as diminished earlier. Nurse Holmes failed to reassess popliteal pulses. She documents pedal pulses palpable, but failed to document regarding whether the pulses were strong, diminished, etc.

1300 – Karla Holmes, RN. Redresses bilateral leg wounds. She failed to assess the incisions for redness, swelling, drainage, odor, etc.

1600 – Karla Holmes, RN. Redresses bilateral leg wounds again, but documents no drainage and wound yellow. Failed to assess wounds for odor.

October 31, 2005 – 0800 – Zina Allen, RN. Documents diminished pedal pulses. Failed to reassess pulses. Also failed to assess/reassess popliteal pulses which were diminished earlier.

1604 – Glenn Brogan, RN. Hematoma to back of left thigh, edges marked. Failed to measure hematoma. Small amount of drainage noted. Failed to assess drainage for type, color, odor, etc.

1815 – Glenn Brogan, RN. Large amount of drainage noted. Dressing changed. Failed to assess drainage for type, color, odor, etc. Failed to assess hematoma for measurements, increase in size, etc.

November 1, 2005 – 0004 – Glenn Brogan, RN. Hematoma noted. Failed to assess measurements, increase in size, etc. Small amount of drainage. Failed to assess drainage for type, color, odor, etc.

0800 – Denise Schimmel, RN. Moderate amount of drainage noted. Failed to assess drainage for type, color, odor, etc.

1730 – Denise Schimmel, RN. Dressing changed. Failed to assess for type of drainage, color, odor, etc.

2000 – Denise Schimmel, RN. Documents no bleeding to incision, but also documents the incision is bloody, yellow with moderate serosanguinous drainage. Failed to adequately assess.

November 2, 2005 – 0001 – Eva Davis, RN. Bilateral lower extremity dressings saturated with serous drainage. Changes dressings and documents no drainage. Inadequate assessment. Also failed to assess pulses.

0800 and 0853 – Denise Schimmel, RN. Moderate amount of drainage. Failed to assess drainage for type, color, odor, etc.

2). <u>Failure to notify physician of change in patient's status –</u>

October 25, 2005 – Stephanie Powell, RN and Anna Brooks, RN. Decreased urinary output during their shifts. Both nurses failed to notify the physician of this change.

October 26, 2005 – 0800 - Joyce Thomas, RN. Failed to inform the physician of the change in patient's respiratory status (see above).

October 27, 2005 – 1541 – Joyce Thomas, RN. Failed to inform the physician of the change in patient's respiratory status (see above).

October 29, 2005 – 1600 – James Russ Taylor, RN. Upper left leg incision reddened and small amount of creamy, yellow pus at incision. Also diminished popliteal pulses to bilateral lower extremities. He failed to notify the physician of these changes in patient's status. He also failed to obtain an order to culture wound drainage.

October 30, 2005 – 0030 – Lillian Hawthorne, RN. Upper left leg incision reddened with small amount creamy, yellow pus at incision. Failed to notify physician of this change in patient's status. Failed to obtain order to culture wound drainage.

0632 – Lillian Hawthorne, RN. Bilateral lower extremity wounds with erythema, edema, pale and diminished pulses. Failed to notify physician.

October 31, 2005 – 0800 – Zina Allen, RN. Diminished pedal pulses. Failed to notify physician. Pt. already had diminished popliteal pulses along with infectious drainage.

1604 – Glenn Brogan, RN. Hematoma to back of left lower thigh. Failed to notify physician of this change.

1815 – Glenn Brogan, RN. Hematoma. Same as above.

November 1, 2005 – 0004 – Glenn Brogan, RN. Hematoma. Same as above.

0800 – Denise Schimmel, RN. Hematoma. Same as above.

1730 – Denise Schimmel, RN. Bilateral lower extremity bleeding, bruised, yellow with

moderate amount of drainage. Failed to notify physician.

3). Failure to follow physician's orders –

October 30, 2005 – 0800 – Karla Holmes, RN. Foot of bed flat throughout her shift. MD order was for foot of bed elevated at all times.

November 1, 2005 – 0800 – Denise Schimmel, RN. Foot of bed flat during her shift. MD order was for foot of bed elevated at all times.

November 2, 2005 – 0001 – Eva Davis, RN. Foot of bed flat during her shift. MD order was for foot of bed elevated at all times.

4). Failure to provide adequate nursing care - This encompasses all of the deviations listed since adequate nursing care is to follow the Standard of Care.

5). Failure to adequately monitor - The nurses listed failed to monitor Ms. Vaughn's wounds for types of drainage, color, odor, etc., which include signs and symptoms of infection. Some nurses didn't even mention the bilateral leg wounds at all. The nurses also failed to monitor her status for decreased circulation to her lower extremities as evidenced by diminished pulses. Some nurses didn't even check her pulses which were documented as being diminished earlier.

6). Failure to adequately document – The nurses failed to adequately document the incisions, drainage, pulses, measurements of the hematoma, etc. They failed to adequately document assessments and reassessments.

7). Failure to follow facility's own policies and procedures- The nurses listed above failed to follow the policies regarding assessment, reassessment, notifying physician for changes in the patient's status, including signs and symptoms of infection, documentation and following physician's orders.

November 7, 2002 – November 21, 2005 admission:

1). Failure to adequately assess and reassess –

November 9, 2005 – day shift – Jamie Hill, RN. Failed to assess wounds, stage of wounds, drainage, odor, surrounding tissue, etc. Failed to assess right upper leg wound.

Night shift – Thomas Burns, RN. Failed to assess bilateral leg wounds at all.

November 10, 2005 – day shift – Mary McInnis, LPN. Failed to assess bilateral leg wounds or dressings.

Evening shift – Mary McInnis, LPN. Failed to assess bilateral leg wounds.

Night shift – Vicki Williamson, RN. Failed to assess bilateral leg wounds or dressings.

November 11, 2005 – day shift – Thomas Burns, RN. Failed to assess bilateral leg wounds or dressings.

November 12, 2005 – Evening shift – Jamie Hill, RN. Failed to assess bilateral leg wounds.

November 13, 2005 – day shift – Thomas Burns, RN. Failed to assess bilateral leg wounds.

Evening shift – Thomas Burns, RN. Failed to assess bilateral leg wounds.

Night shift – Jacqueline Boyd, RN. Failed to assess bilateral leg wounds.

November 14, 2005 – day shift – Jamie Hill, RN. Failed to assess bilateral leg wounds.

Evening shift – Jamie Hill, RN. Failed to assess bilateral leg wounds.

November 15, 2005 – day shift. Failed to assess bilateral leg wounds.

Night shift – Margie Slade, RN. Failed to assess bilateral leg wounds.

November 18, 2005 – Evening shift – Kimberly Ball, RN. Failed to assess bilateral leg wounds.

Night shift – Kimberly Ball, RN. Failed to assess bilateral leg wounds.

November 19, 2005 – Night shift – Brenda Tipton, RN. Failed to assess bilateral leg wounds.

November 20, 2005 – Day shift – Thomas Burns, RN. Failed to assess bilateral leg wounds.

2). <u>Failure to follow physician's orders –</u>

November 9, 2005 – Night shift – Thomas Burns, RN. Failed to perform dressing change.

November 15, 2005 – day shift – Ropondia Buckley, RN. Failed to perform dressing change.

November 18, 2005 – Evening shift – Kimberly Ball, RN. Failed to perform dressing change.

November 19, 2005 – Night shift – Brenda Tipton, RN. Failed to perform dressing change.

November 20, 2005 – Day shift – Thomas Burns, RN. Failed to perform dressing change.

3). Failure to provide adequate nursing care – This encompasses all of the deviations listed since adequate nursing care is to follow the Standards of Care.

4). Failure to adequately monitor – The nurses failed to adequately monitor Ms. Vaughn's wounds for size, Stage, color, drainage, odor, etc. They failed to monitor the progression of her wounds.

5). Failure to adequately document – The nurses failed to document bilateral leg wounds including size, Stage, color, drainage, odor, etc. The nurses failed to document the progression of her wounds. The nurses failed to document bilateral leg wounds even when they performed dressing changes.

6). Failure to follow own facility's policies and procedures – same as #7 above.

December 5, 2005 through December 28, 2005 admission:

1). Failure to adequately assess and reassess-

December 15, 2005 – Day shift – Christy Mertz, RN. Failure to adequately assess leg wounds, Wound Vac or dressings.

Night shift – Doris Johns, LPN. Failure to adequately assess right thigh wound.

December 17, 2005 – Night shift – Marilyn Simmons, RN. Failure to assess bilateral leg wounds.

December 18, 2005 – Night shift – Marilyn Simmons, RN. Failure to assess bilateral leg wounds.

2). Failure to provide adequate nursing care – same as prior admissions.

3). Failure to adequately monitor – The nurses failed to adequately monitor Ms. Vaughn's wounds and their progression.

4). Failure to adequately document – same as above admission.

5). Failure to follow own facility's policies and procedures – same as above admission.

Baptist Hospital's nursing staff failed to exercise that degree of skill, care, competence, and prudence, and was, therefore, negligent in the following respects and deviated from the standard of

care as follows: (1) failure to adequately assess and reassess; (2) failure to notify the physician of the change in the patient's status; (3) failure to properly document the changes/progression of the wounds; (4) failure to recognize signs and symptoms of infection; (5) failure to follow physician's orders; (6) failure to change dressings as ordered; (7) failure to properly clean wounds; (8) failure to prevent contamination of wounds; (9) failure to provide adequate nursing care; (10) failure to provide adequate wound care; (11) failure to timely request wound care evaluation and consultations; (12) failure to follow facility's own policies and procedures; (13) failure to adequate document; (14) failure to follow the nursing process; all of which will be confirmed by the testimony of Crystal Keller.

It was error for the lower court to grant summary judgment in its entirety as to Crystal Keller's testimony concerning the standard of care and breach of those standards by the nursing staff of Baptist Hospital. There are genuine issues of material facts which must be considered by the jury and not dismissed on summary judgment. Summary judgment was inappropriately granted and the Court should reverse and remand this case for a trial on the merits.

3. It was error for the lower court to grant Mississippi Baptist Medical Center's Motion to Strike Crystal Bear Keller, R.N. as an expert witness and determine that she was not qualified to offer expert medical testimony regarding medical diagnosis and causation on the subject case. The claim is for damages arising from negligent "nursing care" and witness Keller is well qualified to present the "nursing standard of care."

In Baptist's Motion to Strike, Baptist contends that Crystal Keller's opinions exceed the bounds of nursing practice under Mississippi law and that she is prohibited from diagnosing an infection. Baptist contends that at best Crystal Keller's affidavit establishes nothing more than her opinions regarding alleged breaches of the standard of care.

Crystal Keller has been a registered nurse since 1986 in Louisiana, since 1987 in Virginia and since 1999 in Mississippi. She was employed as a nurse by various hospitals from 1986 through 1997. She cared for a variety of medical-surgical patients including neurosurgical, general surgery, gastrointestinal, pulmonary and infectious disease. She also cared for surgical intensive care unit patients who were thoracic/cardiovascular, major trauma, neurosurgical and general surgery patients. She also worked in intensive care, coronary care, and emergency rooms. Her experience and training gives her an in-depth understanding of the nursing standard of care required for patients having surgical wounds as described herein. From 1993 to present she has served as director of Medical Legal Consulting Services, an organization she founded to provide expert nursing opinions in expectation of litigation. Keller has also received a *Certification of Distinction for Outstanding Clinical Performance-Charity Hospital School of Nursing*; *Who's Who Society of American Nursing*; and *Strathmore's Who's Who*. She has completed extensive critical care course, involved in *Neurosurgical Study for Vasospasms*, involved in pilot program for patient classification system. She is a member of the American Nursing Association, American Association of Legal Nurse Consultants, and American Association of Critical Care Nurses. She also has various publications and participates in continuing education. (R. 524-526; R.E. 71-73). Keller is clearly qualified to testify in this case.

Baptist Hospital cited a portion of Miss. Code Ann. § 73-15-5(2) (1972) as its basis for its assertion that Crystal Keller's Affidavit exceeds the bounds of nursing practice. However, the first portion of the statute was not cited and this section is extremely important as it shows that Crystal Keller's testimony is within the realm of her practice and expertise and that she is qualified to testify.

The 'practice of nursing' by a registered nurse means the performance for

> compensation of services which require substantial knowledge of the biological, physical, behavioral, psychological and sociological sciences and of nursing theory as the basis for assessment, diagnosis, planning, intervention and evaluation in the promotion and maintenance of health; management of individual's responses to illness, injury or infirmity; the restoration of optimum function; or the achievement of a dignified death...

Id.

In paragraph 5 of Crystal Keller's Affidavit she explains that "Nurses have the autonomy to assess, monitor, identify, and evaluate for signs and symptoms of infection independently of a physician. Nurses have the autonomy to provide interventions to assist in the prevention of infection, including maintaining a clean wound environment, prevention of wound contamination, providing dressing changes to the wounds, assessing the wound for redness, swelling, increased drainage, change in drainage color and/or odor, monitoring the patient's vital signs and laboratory results, and notifying the physician timely of these changes in the patient's status." (R. 565, 662; R.E. 112, 207).

Keller is of the opinion that "The deviations in the Nursing Standard of Care by the nursing staff at Baptist Hospital led to the development of signs and symptoms of infection in her bilateral leg wounds during her October 24-November 2, 2005 admission to Baptist Hospital." (R. 565, 662; R.E. 112, 207).

There is nothing more than a disagreement between Baptist Hospital's experts and Vaughn's experts and treating physicians. It is in the province of the jury to weigh the evidence, including competing evidence presented from medical experts. The Motion to Strike should not have been granted and summary judgment should have been denied.

The facts revealed by Vaughn and her children have explicitly explained the gross appearance of the wounds resulting from contamination of the wounds from urine and feces, among other things, allowed by inadequate nursing care and resulting in gross changes in the appearance of the wounds,

including discoloration, swelling, discharge and odorous material.

The testimony of the lay witnesses who were present at the hospital with Vaughn is very compelling. They were very much aware of the change in the Vaughn's leg wounds, including the redness, swelling, inflammation and infection. Although, Dr. McMullen testified that antibiotics were given to Vaughn as a precautionary matter, he also testified that the reason for giving the Levaquin was to hopefully create a situation where there was less opportunity for organisms to proliferate. (R.668, R.E. 213). Thus, slowing the infection process down.

The lower court based its ruling that Crystal Keller cannot give testimony concerning medical causation based on *Richardson v. Methodist Hospital of Hattiesburg, Inc.*, 807 So.2d 1244 (Miss. 2002). Vaughn points out that the Court in *Richardson* found that Keller could not testify regarding complex issues of medical causation. A stroke, which was the diagnosis in *Richardson*, is considered to be a complex medical issue, however, a leg wound infection is something that is within a nurse's expertise as a nurse. Therefore, the granting of Baptist Hospital's Motion to Strike was error. Keller can testify as to the connection between the nursing negligence and the resultant infection in Vaughn's bilateral leg wounds. This is an area that is within her expertise as a nurse and as set forth by Miss. Code Ann. § 73-15-5(2) (1972).

The Court in *Richardson* also reiterated its standard for expert witnesses in medical malpractice cases set in *Hall v. Hilbun*, 466 So.2d 856 (Miss. 1985), wherein the Court stated that "expert opinion testimony should be allowed where the witness is qualified and independent, and the testimony will assist the trier of fact." *Richardson at* 1246.

Very important is the fact that Crystal Keller is of the opinion that the nursing staff failed to assess and reassess the leg wounds. The failure has been clearly outlined by Crystal Keller in that

the nursing staff failed to failed to monitor Vaughn's wounds for types of drainage, color, odor, etc., which include signs and symptoms of infection. Some nurses did not even mention the bilateral leg wounds at all. The nurses also failed to monitor her status for decreased circulation to her lower extremities as evidenced by diminished pulses. Some nurses did not even check her pulses which were documented as being diminished earlier.

On October 29, 2005, James Russ Taylor, RN noted the upper left leg incision was reddened and small amount of creamy, yellow pus at incision. On October 30, 2005, Lillian Hawthorne, R.N. noted yellow, creamy pus in the left leg wound. On that same date Karla Holmes notes yellow in the wound. However, they failed to notify a physician of the change in the patient's status. Dr. McMullen testified that if the leg wounds were covered up he did not uncover them to look at them. (R. 664, R.E. 209).

Dr. McMullen also testified that a diabetic is more prone to infection, thus alerting the physicians and nurses to be more careful with a wound. (R. 665, R.E. 210). Therefore, the nursing staff should have been more aware and taken more precautions to prevent an infection in Vaughn's leg wounds. The failure of the nursing staff to adequately care and treat Vaughn encompasses far more than the infection in her bilateral leg wounds as outlined in the Appellant's Brief herein above.

Vaughn directs the Court's attention back to the Kansas cases cited in Issue 1 regarding a nursing expert being able to testify as to causation of injuries involving breach of the nursing standard of care. *Mellies v. National Heritage, Inc.*, 636 P.2d 215, (Kan.App.1981). The Court cited *James v. Grigsby*, 114 Kan. 627, 632, 220 P.2d 267 (1923), wherein it was stated: "And where negligence in the treatment is shown by medical witnesses and the evidence shows a bad result, it is the province of the jury to say whether the result was caused by the negligence." *Id.* The issue in

the case was whether decubitus ulcers were contracted or made worse by the nursing center, or by the hospital from which the plaintiff was transferred. The Court concluded that the testimony and evidence about when each decubitus ulcer appeared on the nursing records, the question could be resolved by a jury without the testimony of a medical expert. The Court also stated: "**We conclude that as to the areas concerning which the nurses were allowed to testify, they were qualified to state the standard of care. Since this case deals with *nursing* negligence, it would seem that the jury had competent evidence from which it could determine the standard of nursing care for patients for the prevention and treatment of decubitus ulcers.**" *Mellies v. National Heritage, Inc.*, 636 P.2d 215, (Kan.App.1981)(emphasis added). The Court went on further to state: **"Since this case involves primarily a nursing problem, we feel that nurses are experts under the facts of this case and that there was sufficient evidence as to all three negligence elements, even without a doctor's testimony, to establish a jury question as to whether there was negligence in this case."** *Mellies v. National Heritage, Inc.*, 636 P.2d 215, (Kan.App.1981)(emphasis added).

Additionally, Vaughn draws the Court's attention back to the case of *Sacks v. Necaise*, 991 So.2d 615 (Miss. App. 2007) cited above in Issue 1 wherein the trial judge allowed an expert nurse to testify on causation based on her designation and the *Daubert* hearing.

Crystal Keller is an expert witness who is well qualified to testify regarding the nursing standard of care and the leg wounds infections as a result of the negligence of the nursing staff at Baptist Hospital.

There are genuine issues of material fact which must be presented to the jury at the trial of this case. The jury is responsible for judging the credibility of witnesses and the weight that should be attached to their testimony.

It was error for the lower court to grant Baptist Hospital's Motion to Strike and error for the lower court to grant summary judgment.

4. **Whether or not it was error for the lower court to deny Paula Lee Vaughn's Motion to Amend Rulings of the Court.**

Since the lower court struck Vaughn's expert and granted summary judgment because the court ruled that Vaughn's expert was not qualified to render expert testimony, then Vaughn should have been allowed time within which to offer the opinion from another expert witness. Since Miss. Code Ann. § 11-1-58(1)(a) requires that an expert be employed prior to filing suit and since Crystal Keller was employed prior to filing suit, but the lower court will not allow her opinion, instead of dismissing the case in its entirety, Vaughn should have been allowed to obtain an opinion from another expert witness.

VII. CONCLUSION

Crystal Keller is an expert witness who is well qualified to testify regarding the nursing standard of care and the leg wounds infections as a result of the negligence of the nursing staff at Baptist Hospital.

The only evidence offered by Defendant to support its Motion for Summary Judgment was that of the treating physician, who is not a nurse and whose post surgical care and/or observation of the Plaintiff was very sparse, probably 1% compared with 99% by the nursing staff. Even taking his testimony verbatim favoring Defendant, there remains significant issues of material facts for the jury to decide. The jury is responsible for judging the credibility of witnesses and the weight that should be attached to their testimony. Therefore, summary judgment is not appropriate.

RESPECTFULLY SUBMITTED, this the 18th day of December, 2008.

PAULA LEE VAUGHN, APPELLANT

BY: 
BILL WALLER, SR. (MSB [redacted]

OF COUNSEL:

WALLER & WALLER, ATTORNEYS AT LAW
220 South President Street (39201)
Post Office Box 4
Jackson, Mississippi 39205-0004
Telephone: (601) 354-5252
Facsimile: (601) 354-2681

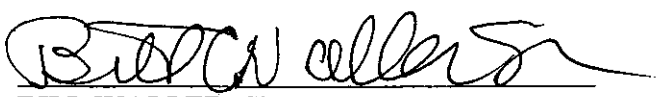
CERTIFICATE OF SERVICE

I, Bill Waller, Sr., the undersigned attorney of record for the Appellant, Paula Vaughn, do hereby certify that I have this day mailed a true and correct copy of the above and foregoing document via United States mail, postage prepaid, to the following counsel of record:

Honorable Swan Yerger
Hinds County Circuit Court
Post Office Box 327
Jackson, Mississippi 39205

Eugene R. Naylor, Esq.
Gaye Nell Currie, Esq.
Wise, Carter, Child & Caraway
Post Office Box 651
Jackson, Mississippi 39205

So Certified this 18th of December, 2008.


BILL WALLER, SR.