IN THE COURT OF APPEALS OF THE STATE OF MISSISSIPPI
NO. 2008-CA-01816

JANICE ERVIN, BY AND THROUGH HER HUSBAND AND NEXT FRIEND, CURTIS ERVIN, ON BEHALF OF THE WRONGFUL DEATH BENEFICIARIES AND AS ADMINISTRATOR OF THE ESTATE OF JANICE ERVIN — PLAINTIFFS/APPELLANTS

VS.

DELTA REGIONAL MEDICAL CENTER — DEFENDANT/APPELLEES

BRIEF OF APPELLEE

Appeal from the Circuit Court of Washington County, Mississippi
Cause No. CI2005-250

ORAL ARGUMENT REQUESTED

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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 Court of Appeals may evaluate possible disqualification or recusal.

1. Curtis Ervin, Plaintiff/Appellant
2. Cedric Jermaine Ervin/Wrongful Death Beneficiary
3. Jasmine Jonte Ervin/Wrongful Death Beneficiary
4. Jennifer Chonte Ervin/Wrongful Death Beneficiary
5. George F. Hollowell, Jr./Attorney for Plaintiffs
6. The Board of Trustees for Delta Regional Medical Center, Defendant/Appellee
7. L. Carl Hagwood/Attorney for Delta Regional Medical Center
8. Christopher W. Winter/Attorney for Delta Regional Medical Center
9. Mary Frances S. England/Attorney for Delta Regional Medical Center
10. Honorable Richard A. Smith, Circuit Court Judge

DELTA REGIONAL MEDICAL CENTER

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

STATUTES

STATEMENT OF THE ISSUES

I. The Plaintiffs failed to establish a nationally recognized standard of care. As a result, the trial court held that the Plaintiffs had failed to meet their burden of proof. As there is no evidence to the contrary, as a matter of law, the trial court's findings are manifestly correct.

II. Where the trial court hears a case under the Mississippi Tort Claims Act and issues findings of fact and conclusions of law, the trial court's findings will not be disturbed unless the trial court abused its discretion, was manifestly wrong, clearly erroneous, or an erroneous legal standard was applied. As the substantial evidence heard in this case supports the findings entered by the trial court, as a matter of law, the trial court's findings are manifestly correct.

III. The trial court found that no alleged breach caused or contributed to the decedent's death, and such findings are supported by the substantial, credible and reasonable evidence, and, as a matter of law, the trial court's findings are manifestly correct.

STATEMENT OF THE CASE

On October 15, 2004, Defendant/Appellee Dr. James Beckham performed an abdominal hysterectomy, without incident, on Plaintiff/Appellant Janice Ervin. (R.E. 5; D.E. 039, 103). Prior to surgery, Ms. Ervin had sought treatment from Dr. Beckham for pelvic pain and heavy bleeding due to uterine fibroids. (R.E. 5; D.E. 040). When conservative treatment with hormone therapy failed, Dr. Beckham suggested Ms. Ervin undergo a hysterectomy. (R.E. 5; D.E. 088). Ms. Ervin consented to the surgery and was prepared for a vaginal hysterectomy; however, upon examination in the operating room, Dr. Beckham determined an open abdominal hysterectomy would be required due to adhesions from prior surgeries. (R.E. 5 and 6; D.E. 039, 132, 040; Tr. 227, 229).

Upon completion of the abdominal hysterectomy, Ms. Ervin was transferred to her room. (R.E. 5; D.E. 050). Throughout the day, various friends and family visited with Ms. Ervin, and nurses attended to Ms. Ervin according to Dr. Beckham's orders, including turn, cough and deep breathing every two hours. (R.E. 5; D.E. 022, 050, 052).

On October 16, 2004, Dr. Beckham made his rounds shortly before 9:00 a.m. and ordered Ms. Ervin's Foley catheter be discontinued and ordered her to ambulate as tolerated. (R.E. 5; D.E. 023, 041). At approximately 10:00 a.m., Ms. Ervin was assisted to the bathroom by a nurse's assistant. (R.E. 5; D.E. 054). While in the bathroom, Ms. Ervin called for help. (R.E. 5 and 6; D.E. 054; Tr. 69). When her husband opened the door, Ms. Ervin collapsed. (R.E. 6; Tr. 069). Several other nurses, the nursing supervisor and Dr. Beckham were all summoned to Ms. Ervin's room, and oxygen was started. (R.E. 5; D.E. 042, 054). Upon examination, Dr. Beckham ordered Ms. Ervin transferred to the intensive care unit (ICU) to rule out a suspected pulmonary embolus. (R.E. 5; D.E. 042). Thereafter, Ms. Ervin was transferred to ICU on oxygen, and a code blue was initiated upon

arrival. (R.E. 5; D.E. 012, 091, 054, 055, 077) . Subsequently, Ms. Ervin was pronounced dead on October 18, 2004. (R.E. 5; D.E. 005).

On September 6, 2005, Plaintiffs filed suit against Delta Regional Medical Center (DRMC) and Dr. Beckham and other DRMC employees alleging negligence. (R.E. 1; R. 004-021).

On April 21-23, 2008, the case was tried in the Circuit Court of Washington County, Mississippi, before the Honorable Richard A. Smith. As DRMC is a community hospital entitled to the limitations, protections and immunities of the Mississippi Tort Claims Act, the trial was a bench trial. On October 14, 2008, the trial court entered Findings of Fact and Conclusions of Law and dismissed the Complaint with prejudice. Feeling aggrieved, Plaintiffs appealed to this Court.

SUMMARY OF THE ARGUMENT

The standard of review for factual determinations made in a bench trial is "the substantial evidence standard." *Stanton v. DRMC*, 802 So. 2d 142, 145 (Miss. 2001), *citing Covington Cty. v. G.W.*, 767 So. 2d 187, 189 (Miss. 2000). The trial judge's findings will not be disturbed unless the judge "abused his discretion, was manifestly wrong, clearly erroneous or an erroneous legal standard was applied." *Id.* "A circuit court judge sitting without a jury is accorded the same deference with regard to his findings as a chancellor, and his findings are safe on appeal where they are supported by substantial, credible, and reasonable evidence." *City of Jackson v. Spann*, 764 So. 2d 373, 376 (Miss. 2000), *citing Puckett v. Stuckey*, 633 So. 2d 978, 982 (Miss. 1993); *Sweet Home Water & Sewer Ass'n v. Lexington Estates, Ltd.*, 613 So. 2d 864, 872 (Miss. 1993); *Allied Steel Corp. v. Cooper*, 607 So. 2d 113, 119 (Miss. 1992). The findings of a trial court sitting without a jury will not be disturbed unless they are manifestly wrong, clearly erroneous or an erroneous legal standard was applied. *Id., citing Bell v. City of Bay St. Louis*, 467 So. 2d 657, 661 (Miss. 1985). The trial judge is given "the widest possible discretion" in his decision as to whether a witness is qualified to testify as an expert. *UMMC v. Pounders*, 970 So. 2d 141, 145 (Miss. 2007). Further, it is undisputed that a trial judge is charged with determining the credibility of witnesses when the judge sits as the finder of fact. *Yarbrough v. Camphor*, 645 So. 2d 867, 870 (Miss. 1994).

In his brief, Plaintiff attempts to argue his case de novo; however, the standard of review is the substantial evidence standard, not de novo. Plaintiff tried this case before the trial court, who determined the credibility, weight and admissibility of the evidence. The trial court then entered detailed Findings of Fact and Conclusions of Law addressing each issue and supporting each finding with substantial, credible and reasonable evidence.

The Plaintiffs' theory of the case is that the national standard of care required Dr. James Beckham, an employed obstetrician/gynecologist at Delta Regional Medical Center, to prescribe compression stocking devices post surgery and that, as a result of this failure, Janice Ervin threw a blood clot from her legs into her lungs, which resulted in her death. At trial, the Plaintiffs also alleged that following the development of the pulmonary embolus, when Ms. Ervin was being transferred to the ICU, that she was transported without supplemental oxygen and that this alleged failure to transport her with oxygen caused or contributed to her death. At trial, the Plaintiffs also alternatively sought to prove that a hospital nursing policy and procedure detailing how to apply compression devices to the legs, if such devices were ordered by a physician, required the nurses to instruct Dr. Beckham to order compression stockings. As a matter of law, and as specifically found by the trial court, the Plaintiffs failed to prove a nationally recognized standard of care that required an obstetrician/gynecologist performing this surgery on this classification of patient to apply compression hose post-surgery. The Plaintiffs' case further fails because the Plaintiffs failed to prove that Ms. Ervin was transported from the floor to ICU without supplemental oxygen and that this alleged failure caused or contributed to her death. Finally, the Plaintiffs failed to prove that a nursing policy and procedure required the nurses to override the decision of the physician not to prescribe compression stocking devices.

The Plaintiffs' case also fails as a matter of law because the Plaintiffs failed to establish a national standard of care (i.e., a duty to use compression devices in this classification of a patient) and, if such devices had been used, that this caused the death of the decedent. The Plaintiffs had one standard of care and causation witness, Dr. Harold Miller, who, when asked what the standard of care was, stated:

Q. And after reviewing those policies and procedures, as well as all other medical records, were you able to form opinions as to deviations from the standard of care as they apply to Dr. James Beckham?

A. Yes.

Q. All right, what about deviations as to the standard of care as they apply to the staff and nurses at Delta Regional Medical Center?

A. Yes.

Q. Okay. And would you tell us, if you would, based upon reasonable medical probability, what, if any, deviations there were as far as Dr. Beckham is concerned, and then I'll ask you to support them with whatever you feel necessary.

A. The deviation I found was the lack of utilizing anti-prophylaxis measures.

R.E. 6; Tr. 104.

* * *

Q. All right. Have you used SCDs in your practice or in your teaching?

A. Yes.

Q. And how often - I mean how long have you been doing so?

A. For over ten years.

Q. All right, before the SCDs, what did you use?

A. TED hose.

Q. All right, and before the TED hose, what did you use?

A. Ace bandages.

Q. Why did you change and use them in the order that you just – let me ask it this way. What order did you use them in?

A. The order was Ace bandages, to TED hoses, and to SCDs.

Q. Why?

A. As the technology improved then obviously we tried to maintain the standard that was practiced in the community, or at least using some devices. (Emphasis added.)

R.E. 6; Tr. 132.

* * *

Q. Okay. And when, in your opinion based upon reasonable medical probability, should anything have been placed on Mrs. Ervin, and you're going to have to tell the Court when, what, and how it was supposed to have been done?

A. We commonly use TED hoses or SCDs. After the patients are put to sleep, these devises are placed on a patient's legs before anything else is done. (Emphasis added.)

R.E. 6; Tr. 133.

* * *

Q. All right. Now, you based your opinion on what your - - what did you base all this opinion on which you've given here today?

A. The opinion is based upon fifty-four years of practicing medicine, my training, my experience, reading literature, attending meetings, talking to colleagues.

Q. All right, have you - -

A. And standard of care in the community. (Emphasis added.)

Q. Okay. Do you feel like Dr. Beckham did deviate from the standard of care?

A. Yes.

Q. All right. Do you feel like the nurses at Delta Regional Medical Center deviated from the standard of care?

A. Yes.

R.E. 6; Tr. 176-177.

* * *

Q. Now, if I understand what you testified to, the only criticism you have of Dr. Beckham and the nurses is that you believe that the standard of care requires the use of ACE bandages, or TED hose, or sequential compression devices applied at the time of surgery and kept on the patient thereafter until the patient starts ambulating?

A. Essentially, yes.

R.E. 6; Tr. 179.

* * *

When asked where this standard of care comes from, Dr. Harold Miller testified unequivocally:

> The opinion is based upon fifty-four years of practicing medicine, my training, my experience, reading literature, attending meetings, talking to colleagues.

R.E. 6; Tr. 176.

As will be developed in the brief, two other, younger, obstetricians testified at trial. The treating physician, Dr. James Beckham, is Board Certified in Obstetrics and Gynecology and was trained at the San Diego Naval Hospital in Obstetrics and Gynecology. (R.E. 6; Tr. 272-76). Dr. Beckham testified that, in his obstetrical/gynecological training, he was not trained to use Ace bandages, TED hose, sequential compression devices on patients in this classification. (R.E. 6; Tr. 272-76). Dr. Carl Reddix is Board Certified in Obstetrics and Gynecology and received his training at one of the premier medical training hospitals in the United States, The Johns Hopkins Hospital. (R.E. 6; Tr. 487). Dr. Reddix testified that, when he began his training, TED hose, sequential compression devices, were used but that, by the time he completed his training, his instructors at this premier medical hospital had abandoned the use of these devices. (R.E. 6; Tr. 491-93).

Thus, not only did the Plaintiffs not prove a "nationally recognized standard of care", the proof at trial at best was that there are two schools of thought, two standards of care, Dr. Miller's standard of care at his hospital, in the community in which he practices, which uses compression devices, and Drs. Beckham and Reddix's standard of care for the non-use of compression devices. Finally, one of the leading vascular surgeons in the South, Dr. Rigdon, testified that the logic behind using these devices at best is "fuzzy" and that taking the "literature" as a whole is up to the individual surgeon in this classification of patients to decide whether to use these devices or not. (R.E. 6; Tr. 617-19).

In medical malpractice cases, the Mississippi Supreme Court has stated:

> To present a prima facie case of medical malpractice, a plaintiff, (1) after establishing the doctor-patient relationship and its attendant duty, is generally required to present expert testimony (2) identifying

> and articulating the requisite standard of care; and (3) establishing that the defendant physician failed to conform to the standard of care. In addition, (4) the plaintiff must prove the physician's noncompliance with the standard of care caused the plaintiff's injury, as well as proving (5) the extent of the plaintiff's damages.

Cheeks v. Bio-Medical Applications, Inc., 908 So.2d 117 (Miss. 2005) (citing *McCaffrey v. Puckett*, 784 So.2d 197, 206 (Miss. 2001). As a general rule in medical malpractice actions, negligence cannot be established without medical testimony that the defendant failed to use ordinary skill and care. *Brooks v. Roberts*, 882 So.2d 229, 232 (Miss. 2004). The Mississippi Supreme Court set forth the standard of care for medical malpractice cases in *Hall v. Hilbun*, 466 So. 2d 856, 873 (Miss. 1985), stating:

> [G]iven the circumstances of each patient, each physician has a duty to use his or her knowledge and therewith treat through maximum reasonable medical recovery, each patient, with such reasonable diligence, skill, competence, and prudence as are practiced by minimally competent physicians in the same specialty or general field of practice throughout the United States, who have available to them the same general facilities, services, equipment and options. (Emphasis added.)

The burden is on the Plaintiffs to establish a national recognized standard of care, and the breach of that standard of care. *See, Phillips v. Hull*, 516 So.2d 488, 491 (Miss. 1987)(legal duty of surgeons in surgical procedures is to use reasonable and ordinary care as other surgeons in good standing would ordinarily exercise in like cases under **nationally recognized standards**....).

The trial court found that Plaintiffs failed to establish a nationally recognized standard of care, the breach of that standard and a causal relationship between the alleged breach and Ms. Ervin's death. Based on studies, literature, training and experience, all of the experts in this case, except Plaintiffs' expert, agreed that Dr. Beckham followed the standard of care as to the use or non-

use of prophylactic compression devices in Ms. Ervin's case. Plaintiffs' expert disagreed that Dr. Beckham followed the standard of care but offered no national standard of care, only his standard in his community, and offered no peer reviewed literature to support his position.

Also, the Plaintiffs wholly failed to demonstrate a breach of the standard of care by the nurses in this case. The Plaintiffs in this case clearly seized upon the erroneous deposition testimony of Natalie Reed and attempted to concoct a story that Ms. Ervin was transferred to ICU without supplemental oxygen. The Plaintiffs' attempt to focus on the alleged lack of oxygen was a red herring, as the records and testimony clearly reflect that Ms. Ervin was provided supplemental oxygen while being transferred to the ICU. (R.E. 5; D.E. 012, 054, 055, 077).

Finally, the Plaintiffs have wholly failed to carry the burden of proof on causation. In a medical malpractice case, recovery is allowed only when the failure of the physician to render the required level of care results in the loss of a reasonable probability of substantial improvement in the patient's condition. *Clayton v. Thompson*, 475 So.2d 439, 445 (Miss. 1985). In other words, adequate proof in a medical malpractice case requires evidence that in the absence of the alleged malpractice, a better result was probable, or more likely than not. *Ladner v. Campbell*, 515 So. 2d 882, 889 (Miss. 1992), citing 54 A.L.R. 4th 10 § 4. Plaintiffs' expert, Dr. Miller, testified that he could not say definitively where Ms. Ervin's pulmonary embolus originated; *i.e.*, whether in the legs or in the pelvis. (R.E. 5 and 6; D.E. 409; Tr. 191-92). However, the Defendants' expert witnesses clearly opined and well supported their opinions that the pulmonary embolus in this case originated in the pelvis. All experts agree, mechanical devices on the legs would not have prevented the formation of blood clots in the pelvis. Therefore, even if Dr. Beckham had followed Dr. Miller's opinion of the community standard of care, applying a compression device to Ms. Ervin's legs would

not have prevented the embolus from forming in her pelvis and would not have prevented her ultimate death.

ARGUMENT

I. FACTS

Janice Ervin, a 40-year-old black female, had been suffering from uterine fibroids, which Dr. James Ray Beckham, an employee of DRMC, had treated since May, 2004.(R.E. 5; D.E. 039, 103). Following the failure of conservative treatment for Ms. Ervin's condition, Dr. Beckham suggested a hysterectomy and discussed the procedure, risks and benefits with Ms. Ervin. (R.E. 5; D.E. 088, 132). Ms. Ervin agreed that the procedure was reasonable and necessary and gave her informed consent allowing Dr. Beckham to proceed with the surgery. (R.E. 5; D.E. 088, 132).

Dr. Beckham initially planned for Ms. Ervin to undergo a vaginal hysterectomy, which would not require an abdominal incision. (R.E. 6; Tr. 227-29). However, upon examining Ms. Ervin under anesthesia, Dr. Beckham determined that the vaginal route was not the best means to proceed with Ms. Ervin's hysterectomy due to adhesions from prior surgeries; therefore, he changed the procedure to an open abdominal hysterectomy. (R.E. 6; Tr. 227-29). Dr. Beckham conducted the procedure successfully and without incident. (R.E. 5; D.E 039, 103). Ms. Ervin was returned to her room at approximately 1015 on the 15th of October, 2004. (R.E. 5; D.E. 050). Throughout the 15th, various individuals visited Ms. Ervin, and the nurses attended to Ms. Ervin according to the orders and directives of her physician, Dr. Beckham. (R.E. 5; D.E. 022, 050, 052). Dr. Beckham's orders included having Ms. Ervin turn, cough and deep breathe every two hours. (R.E. 5; D.E. 022). Dr. Beckham ordered Ms. Ervin on bed rest until the next morning. (R.E. 5; D.E. 022).

On the morning of October 16, 2004, Dr. Beckham rounded early and ordered that Ms.

Ervin's Foley catheter be discontinued and ordered her to ambulate as tolerated. (R.E. 5; D.E. 023, 041). Immediately following Dr. Beckham's orders, the Foley catheter was removed, and Ms. Ervin was assisted to the bathroom by a nurse's aid. (R.E. 5; D.E. 054). While in the bathroom, Ms. Ervin called out to her husband who opened the door to the bathroom. (R.E. 6; Tr. 69). When Mr. Ervin opened the door, Ms. Ervin collapsed in his arms. (R.E. 6; Tr. 69). The nurse's aid pulled the call light, and the nursing staff responded immediately. (R.E. 5; D.E. 042, 054). At that point, Ms. Ervin was noted to be cold, clammy and short of breath. (R.E. 5; D.E. 054). Ms. Ervin was placed in her bed whereupon it was noted that she had O_2 saturation of 68%, among other vital signs. (R.E. 5; D.E. 054). The nursing staff immediately placed a non-re-breather mask to deliver supplemental oxygen to Ms. Ervin with the oxygen flow set at 10L per minute. (R.E. 5; D.E. 054). The nursing staff immediately notified Dr. Beckham, who promptly returned to Ms. Ervin's room. (R.E. 5; D.E. 042, 054). Additionally, the floor nurses contacted the nursing supervisor, Josh Edwards, who also reported to Ms. Ervin's room. (R.E. 5; D.E. 054).

Upon arrival Dr. Beckham evaluated Ms. Ervin and ordered her transfer to the intensive care unit (ICU) to rule out a suspected pulmonary embolus. (R.E. 5; D.E. 042, 054). The nursing staff appropriately secured Ms. Ervin and, with supplemental oxygen via mobile oxygen bottle, transferred Ms. Ervin from the floor to the ICU. (R.E. 5; D.E. 042, 054, 055). Upon arrival at the ICU floor, Ms. Ervin's breathing deteriorated, and the nursing staff obtained a bag valve mask from the wall of the ICU hall and began assisted respirations via bag valve mask as Ms. Ervin was being rolled into the ICU. (R.E. 5; D.E. 042, 054, 055, 077, 012). Upon arrival in the doors of the ICU, a Code Blue was initiated. (R.E. 5; D.E. 012, 055). Ms. Ervin was given 100mg of Activase, which

is known to dissolve pulmonary emboli, in an attempt to restore Ms. Ervin's ability to breathe. (R.E. 5; D.E. 013). Despite the lifesaving efforts attempted by the physicians and staff at DRMC, Ms. Ervin expired on the morning of October 18, 2004, at approximately 9:00 a.m.

CURTIS ERVIN

The Plaintiffs called Mr. Curtis Ervin who testified that at the time of Ms. Ervin's surgery he had not slept for approximately eighteen (18) hours, as he worked nights at the Nissan manufacturing plant in Canton, Mississippi. (R.E. 6; Tr. 25-26, 53, 57). Mr. Ervin had worked the night before Ms. Ervin's procedure and after work proceeded directly to DRMC, with no sleep up to the time Ms. Ervin had her episode on the morning of October 16. (R.E. 6; Tr. 53). At the time of Ms. Ervin's collapse, Mr. Ervin had been awake for at least thirty-six (36) hours. Despite Mr. Ervin's testimony to the contrary, the medical records document that nursing staff properly treated Ms. Ervin by initiating turn, cough and deep breathe, and providing supplemental oxygen upon transfer from the floor to the ICU, among other treatment. (R.E. 5 and 6; D.E. 012, 054, 055, 077; Tr. 95-98).

NATALIE FRATESI REED

The Plaintiffs called to the stand Natalie Fratesi Reed, a registered nurse who worked the floor on the morning of October 16 when Ms. Ervin collapsed. Ms. Reed testified that, while she had previously testified by mistake that Ms. Ervin was not on oxygen between the floor and ICU, in fact, Ms. Ervin was on supplemental oxygen as the respiratory therapy notes, ICU notes and Code Blue flow sheet document. (R.E. 5 and 6; D.E. 012, 054, 055, 077; Tr. 413-15).

JOSH EDWARDS

The Plaintiffs next called Josh Edwards, RN, a nurse supervisor at DRMC. On the day in question, Mr. Edwards was the house supervisor and oversaw all nursing activities at DRMC. (R.E. 6; Tr. 444-45). Mr. Edwards testified that he was called to Ms. Ervin's room after her collapse, and that he supervised Ms. Ervin's transfer from the floor to the ICU. (R.E. 6; Tr. 446). Mr. Edwards testified with certainty that Ms. Ervin was on supplemental oxygen, which the nurses had obtained and installed prior to leaving Ms. Ervin's room. (R.E. 6; Tr. 455-56, 460-64). Mr. Edwards also explained that the nursing service policy and procedure 006, which makes reference to the use of sequential compression devices, would benefit the nurses if a sequential compression device was ordered by a physician. (R.E. 6; Tr. 472-76). The benefit would include reminding the nurses of the various reasons a physician may use these devices so that the nurses could educate the patients. *Id.* Additionally, the nursing policy and procedure directs and guides the nurses in the event that these devices are ordered so that the nurses may properly place them on patients. *Id.* Mr. Edwards also testified that the nursing staff did not have a duty to initiate steps to override a physician's judgment and have sequential compression devices placed on patients when a physician had not ordered these devices. (R.E. 6; Tr. 472-76, 479-80). Finally, the nursing policy specifically states that SCD devices must be ordered by a physician and can be used in patients who are "at moderate to high risk for deep vein thrombosis. . . ." (R.E. 4; P.E. 42-49).

DR. JAMES BECKHAM

Dr. James Ray Beckham was born in 1951, and completed his OB-GYN Residency in San Diego, California, at the Naval Medical Hospital and is Board Certified in Obstetrics and Gynecology. (R.E. 6; Tr. 272-76). Dr. Beckham testified that he graduated from the University of

Mississippi School of Medicine in 1980, and successfully completed an Obstetrics and Gynecology internship and residency at the U.S. Naval Hospital in San Diego, California, from 1980 to 1984. *Id.* Dr. Beckham became Board Certified in Obstetrics and Gynecology and was re-certified in that specialty in 1996. *Id.* Dr. Beckham testified that in his internship and residency, his professors did not train him to use compression hose on patients, such as Ms. Ervin, undergoing gynecological procedures. (R.E. 6; Tr. 272-76). Dr. Beckham testified that the procedure he performed on Ms. Ervin was reasonable and necessary, and Ms. Ervin had given her informed consent to the procedure, including acknowledging the potential risks of the procedure up to and including death. (R.E. 5 and 6; D.E. 039, 040, 132; Tr. 227-29). The risks of a pulmonary embolus were considered by Dr. Beckham in formulating his treatment plan for Ms. Ervin. (R.E. 6; Tr. 283). Dr. Beckham assessed Ms. Ervin as being a low risk for pulmonary embolism and acknowledged that he had not ordered any type of compression devices such as TED hose or sequential compression devices because according to his education, training and medical literature, those devices were not required for a low risk patient such as Ms. Ervin. (R.E. 6; Tr. 242-52, 283-84).

According to Dr. Beckham and the literature, Ms. Ervin was low risk because she was forty (40) years old, had no history of cancer or radiation therapy and had no history of clots. (R.E. 6; Tr. 242-252). Dr. Beckham opined that the standard of care in low risk patients does not require any type of prophylactic compression device prior to or after gynecological surgery, other than ambulation. (R.E. 6; Tr. 242-52, 283-84). Dr. Beckham also testified that, if a nurse had shown him the nursing policy and procedure 006 related to the use of sequential compression devices, the policy and procedure would not have changed his treatment of Janice Ervin. (R.E. 6; Tr. 294-95).

DR. HAROLD MILLER

Dr. Miller, Plaintiffs' expert, was born in 1936 and testified that he completed medical school in 1960 at the LSU School of Medicine and thereafter completed his internship and residency in Obstetrics and Gynecology at Charity Hospital in New Orleans, Louisiana, from 1960 to 1964. (R.E. 4; P.E. 029). Dr. Miller testified that he retired from private practice in 1995 and has since served as an Associate Professor in the Department of Obstetrics and Gynecology at the University of Texas, Houston, Texas. *Id.* Dr. Miller testified that in his internship and residency training he was taught originally to use ACE bandages to wrap the extremities of all gynecological surgical patients, regardless of classification of low, moderate or high risk, in an effort to reduce the risk of deep vein thrombosis, and thereafter that he has used compression stockings (TED hose) since they came on the market. (R.E. 5 and 6; D.E. 403; Tr. 132-33). At present, he uses sequential compression devices, when available, and testified that the use of ACE bandages, TED hose or sequential compression devices in all patients is the standard of care that he follows in his community. (R.E. 6; Tr. 131-34, 177, 181). He further testified that any one of the three, ACE bandage wrap, TED hose or sequential compression device, would meet the standard of care in his community. (R.E. 6; Tr. 129, 131-34, 177, 181). Not once in his testimony did Dr. Miller testify to the national standard of care.

Dr. Miller had no criticism of Ms. Ervin's need for surgery or the surgery itself. (R.E. 6; Tr. 088, 187, 105). His only criticism was that Dr. Beckham deviated from what Dr. Miller believes to be the community standard of care by not ordering some type of mechanical prophylactic device prior to, during and after surgery. (R.E. 6; Tr. 187-88). In addition, Dr. Miller attempted to modify the accepted treatment tables for patients with a risk of pulmonary embolism to meet his opinion that

Ms. Ervin was at a slightly higher risk than low risk, but he refused to categorize her as moderate or high risk. (R.E. 6; Tr. 123-28, 189-91). Nevertheless, Dr. Miller could not show the trial court any support in the literature or published studies to support his opinions. (R.E. 6; Tr. 184-86). In fact, the literature provided by the Plaintiffs, which allegedly supported their opinions, clearly stated that the studies pertaining to mechanical prophylactics for pulmonary embolism, such as TED hose or sequential compression devices, are suspect. (R.E. 2; R. 507). *CHEST* "Prevention of Venous Thromboembolism: The Seventh ACP Conference on Anti-Thrombic and Thrombolytic Therapy," at 343s. In discussing the use of sequential compression devices, the study concluded:

> There is insufficient evidence to assess whether IPC (intermittent pneumatic compression) prophylactics alone has any effect on symptomatic VTE (venous thrombo embolism) or mortality.

(R.E. 2; R. 510).

In regard to general surgery, the study concluded as follows:

> In low risk general surgery patients (Table 5) who are undergoing a minor procedure, or are less than 40 years of age, and have no additional risk factors, we recommend against the use of specific prophylactics other than early and consistent mobilization.

(R.E. 2; R. 510).

In discussing gynecological surgery, the study concluded:

> VTE is an important and potentially preventable complication of major gynecological surgery, with rates of DVT, PE, and fatal PE compatible to those seen after general surgical procedures. . . . As in other surgical patients, thrombi generally form during or shortly after the procedure. . . .
>
> * * *
>
> **Therefore, we recommend that a decision to provide prophylactics be individualized, considering a patient's comorbidity and procedure related risk factors.**

(R.E. 2; R. 512).

Further, the literature relied on by the Plaintiffs' expert clearly states that the studies are for reference purposes and that each individual patient must be treated according to the clinical judgment of the physician handling the case. (R.E. 2; Tr. 461). Another CHEST article submitted by the Plaintiffs contains the following information:

> Despite overwhelming evidence of the efficacy of an assortment of prophylactic modalities, surveys conducted in the United States, Canada, the United Kingdom, Sweden, Switzerland, Spain, and Australia/New Zealand document wide practice variations among physicians, with 28-100% of respondents indicating that they routinely use prophylactics. . . . However, a U.S. study of 2,000 patients, hospitalized at 16 acute care hospitals, showed that only one-third of these patients actually received prophylaxis despite the presence of multiple risk factors for VTE. Use of prophylactics was higher in teaching than in non-teaching hospitals.

"Prevention of Venous Thromboembolism," CHEST, 2001, 119:132S-175S. (R.E. 2; R. 457).

> **Specific caution should specifically be exercised in interpreting the risk reductions ascribed to mechanical methods of prophylactics for three reasons. Most trials have not been able to blind the mechanical devices, leading to the potential for diagnostic suspicious bias. If fibrinogen leg scanning was the DVT scanning method, the known 10-30% false positive rate of the FUT might have been reduced by the mechanical prophylactics but not by the alternate option. Finally, because a relatively poor compliance with all mechanical options, they may not well perform as well in routine clinical practice as in research studies when major efforts are made to optimize proper use.**

(R.E. 2; R. 461).

> The prophylaxis recommendations contained herein are made for groups of patients, for whom the benefits appear to outweigh the risks. **However, prophylaxis decisions for an individual patient are best made by combining knowledge of the literature (including the group recommendations provided herein and elsewhere) with clinical judgment (including detailed knowledge of that particular patient's unique risk for thrombosis, the potential for adverse consequences due to the prophylactics, and**

the availability of various prophylaxis options locally). The recommendations that are best for the group may not be best for the individual.

(R.E. 2; R. 461).

Notably, Dr. Miller could not testify definitively as to where Ms. Ervin's pulmonary embolus originated, though he thought it came from her legs. (R.E. 5 and 6; Tr. 191-92; D.E. 409). Finally, while Dr. Miller testified that the use of such devices was the standard of care, he would not criticize the professors of medicine at either Johns Hopkins, who taught Dr. Reddix, nor the professors at the Naval Hospital, who trained Dr. Beckham. (R.E. 6; Tr. 179-185). His failure to do so cast a cloud of credibility over his testimony as to what he believes to be the standard of care.

DEBORAH WOODARD

Plaintiffs' expert and nurse, Deborah Woodard, testified that DRMC failed to have Ms. Ervin turn, cough and deep breathe. (R.E. 6; Tr. 368-69). On cross examination, Nurse Woodard acknowledged that she was incorrect when shown the DRMC records clearly indicating that Ms. Ervin had turned, coughed and deep breathed appropriately. (R.E. 6; Tr. 383-88). Ms. Woodard also testified that the nurses should have brought the nursing service policy and procedure 006 related to the use of sequential compression devices to Dr. Beckham's attention. (R.E. 6; Tr. 351-63). She testified that failure to bring this to Dr. Beckham's attention was a breach of the standard of care. *Id.* However, Dr. Beckham had testified that, even if he had known of this policy and procedure, he would not have altered his treatment of the patient. (R.E. 6; Tr. 294-95). Nurse Woodard also testified that transferring Ms. Ervin from the floor to the ICU without supplemental oxygen was a breach of the standard of care but would withdraw her opinion if the medical records reflected that Ms. Ervin was on oxygen, which they did. (R.E. 5 and 6; Tr. 367, 382-84; D.E. 12, 54, 55, 77).

DR. CARL REDDIX

Defense expert and Board Certified OB/GYN, Dr. Carl Reddix was born in 1958. Dr. Reddix received his medical training at Tufts University School of Medicine where he graduated in 1985. (R.E. 6; Tr. 487). He attended the Harvard University School of Public Health where he received a Masters Degree in Health Policy and Management and thereafter successfully completed a residency and internship in Gynecology and Obstetrics from the Johns Hopkins Hospital between 1985 and 1989. *Id.* He thereafter became Board Certified in Obstetrics and Gynecology and has been re-certified. *Id.* Dr. Reddix testified that during his internship and residency training at Johns Hopkins Hospital he was trained initially to use compression stockings (TED hose), but that by the time he completed his residency training, the professors at Johns Hopkins Hospital concluded that there was no benefit from the use of these devices and had discontinued using such devices. (R.E. 6; Tr. 491-93). Dr. Reddix opined that the standard of care in low risk patients does not require any type of prophylactic compression devices prior to or after gynecological surgery, other than ambulation. (R.E. 6; Tr. 497, 531). Dr. Reddix testified that Dr. Beckham complied with the applicable standard of care and that, in fact, Ms. Ervin's case showed no indication for the use of prophylactic mechanical devices such as ACE bandages, TED hose or sequential compression devices. (R.E. 6; Tr. 497).

In his brief, Plaintiff states that Dr. Reddix admitted Ms. Ervin did not qualify as a low risk patient under the ACOG guidelines. However, in reading Dr. Reddix's testimony, he admits that as to that particular classification system, she would not be considered low risk, but in his expert opinion, she is low risk. (R.E. 6; Tr. 497, 523, 531).

Dr. Reddix also testified that Ms. Ervin's pulmonary embolus originated in her pelvic area, where the open surgical procedure was conducted. (R.E. 6; Tr. 499). Dr. Reddix opined that the open procedure hysterectomy would, more likely than not, cause a pulmonary embolus to originate in the pelvic area rather than the lower legs. (R.E. 6; Tr. 499-500). In support of his opinion, he cited the gynecological textbook entitled Comprehensive Gynecology, Fourth Edition, which states, "[M]ost pulmonary emboli in gynecologic patients originate from thrombi in the pelvic and femoral veins." Stenchever, M.D., Morton A, *et al.*, COMPREHENSIVE GYNECOLOGY, 788 (4th ed.). (R.E. 6; Tr. 499-500). Importantly, Dr. Reddix noted that with a pelvic origin the use of sequential compression devices on the lower legs or TED hose on the legs would not prevent the formation of a pulmonary embolus. *Id.*

LISA HAYNIE

Defense expert and nurse, Lisa Haynie, testified that the DRMC nursing staff complied with the standard of care for nurses and acted appropriately in all regards. (R.E. 6; Tr. 557). In support of her opinion, Ms. Haynie showed that Ms. Ervin was indeed documented to have been turned, coughed and deep breathed appropriately. (R.E. 6; Tr. 557-58). Additionally, the testimony of Josh Edwards, along with the documentation in the chart, supports the proposition that Ms. Ervin was on oxygen upon transfer from the floor to ICU. (R.E. 6; Tr. 573-74). Finally, Ms. Haynie testified that the nurses did not have an obligation to inform Dr. Beckham of the nursing policy and procedure pertaining to the use of sequential compression devices, and they certainly did not have an obligation to "go up the chain of command" to force Dr. Beckham to use sequential compression devices on Ms. Ervin. (R.E. 6; Tr. 574-76).

DR. EDWARD RIGDON

Finally, the Defendants called Dr. Edward Rigdon, who was born in 1953, and completed his General Surgery Residency at the University of Mississippi School of Medicine in the early 1980's and Vascular Surgery Fellowship at The Ohio State University in the early 1990's and is Board Certified in both General and Vascular Surgery. (R.E. 6; Tr. 578-80). Dr. Rigdon regularly treats patients suffering from deep vein thrombosis and pulmonary embolus. (R.E. 6; Tr. 585-87). Dr. Rigdon carefully and in great detail explained the mechanism for the formation of deep vein thrombosis and pulmonary embolism. (R.E. 6; Tr. 588-90). Dr. Rigdon went on to explain the treatment methods once a deep vein thrombosis or pulmonary embolus is identified. (R.E. 6; Tr. 596-98).

Dr. Rigdon also explained the theory behind the use of intermittent pneumatic compression devices and TED hose. (R.E. 6; Tr. 598). Dr. Rigdon cited learned treatises and scientific literature, which refutes the Plaintiffs' position that such devices are the standard of care and that they are also effective. (R.E. 6; Tr. 598-600). Dr. Rigdon also opined that the standard of care in low risk patients, such as Ms. Ervin, does not require any type of prophylaxis prior to or after gynecological surgery, other than ambulation. (R.E. 6; Tr. 596-97). Dr. Rigdon further testified concerning the lack of efficacy of sequential compression devices and TED hose. (R.E. 6; Tr. 598). Further, Dr. Rigdon explained the shortcomings in the literature supporting the use of sequential compression devices and TED hose. (R.E. 6; Tr. 598-600, 616-20). Dr. Rigdon clearly explained the reason that nurses should not determine whether or not patients should have sequential compression devices and the damage allowing nurses to make such determinations could have on patients. (R.E. 6; Tr. 603-04).

In his brief, Plaintiff states that Dr. Rigdon admitted Ms. Ervin did not qualify as a low risk patient under the ACOG guidelines. However, Dr. Rigdon explained that according to the specific article, Ms. Ervin would not be low risk but that the science is "fuzzy," and he would look at the individual, and in his opinion, Ms. Ervin was low risk. *Id.* (R.E. 6; Tr. 617-19).

Additionally, Dr. Rigdon testified that the pulmonary embolus in Ms. Ervin's case developed in the pelvic area. (R.E. 6; Tr. 590-95, 598). Dr. Rigdon explained the mechanism of the surgical procedure that could cause a pulmonary embolus to form in the pelvic area. (R.E. 6; Tr. 590-95). Dr. Rigdon agreed with the textbook, COMPREHENSIVE GYNECOLOGY, citing the pelvic area as the primary source of pulmonary embolus in gynecologic patients. (R.E. 6; Tr. 593-95).

II. CASE LAW

A. STANDARD OF REVIEW

The standard of review for factual determinations made in a bench trial is "the substantial evidence standard." *Stanton v. DRMC*, 802 So. 2d 142, 145 (Miss. 2001), *citing Covington Cty. v. G.W.*, 767 So. 2d 187, 189 (Miss. 2000). The trial judge's findings will not be disturbed unless the judge "abused his discretion, was manifestly wrong, clearly erroneous or an erroneous legal standard was applied." *Id.* "A circuit court judge sitting without a jury is accorded the same deference with regard to his findings as a chancellor, and his findings are safe on appeal where they are supported by substantial, credible, and reasonable evidence." *City of Jackson v. Spann*, 764 So. 2d 373, 376 (Miss. 2000), *citing Puckett v. Stuckey*, 633 So. 2d 978, 982 (Miss. 1993); *Sweet Home Water & Sewer Ass'n v. Lexington Estates, Ltd.*, 613 So. 2d 864, 872 (Miss. 1993); *Allied Steel Corp. v. Cooper*, 607 So. 2d 113, 119 (Miss. 1992). The trial judge is given "the widest possible discretion" in his decision as to whether a witness is qualified to testify as an expert. *UMMC v. Pounders*, 970

So. 2d 141, 145 (Miss. 2007). Further, it is undisputed that a trial judge is charged with determining the credibility of witnesses when the judge sits as the finder of fact. *Yarbrough v. Camphor*, 645 So. 2d 867, 870 (Miss. 1994).

In his brief, Plaintiff attempts to argue his case de novo; however, the standard of review is the substantial evidence standard, not de novo. Plaintiff tried this case before the trial court, who determined the credibility, weight and admissibility of the evidence. The trial court then entered a detailed Findings of Fact and Conclusions of Law addressing each issue and supporting each finding with substantial, credible and reasonable evidence.

B. ANALYSIS

THE TRIAL COURT'S FINDINGS OF FACT AND CONCLUSIONS OF LAW ARE SUPPORTED BY SUBSTANTIAL, CREDIBLE AND REASONABLE EVIDENCE:

1. The trial court found that:

> **The Plaintiff has failed to establish a nationally recognized standard of care as to the use of sequential compression devices. Based on the studies, literature and experience, all the experts, except Plaintiff's expert, agree that Dr. Beckham followed the standard of care as to the use or non-use of prophylactic compression devices." (R.E. 3; R. 586).**

The trial court correctly noted the law and found that the Plaintiff failed to establish a nationally recognized standard of care. Regarding medical malpractice cases, the Mississippi Supreme Court has stated:

> To present a prima facie case of medical malpractice, a plaintiff, (1) after establishing the doctor-patient relationship and its attendant duty, is generally required to present expert testimony (2) identifying and articulating the requisite standard of care; and (3) establishing that the defendant physician failed to conform to the standard of care.

> In addition, (4) the plaintiff must prove the physician's noncompliance with the standard of care caused the plaintiff's injury, as well as proving (5) the extent of the plaintiff's damages.

Cheeks v. Bio-Medical Applications, Inc., 908 So.2d 117 (Miss. 2005) (citing *McCaffrey v. Puckett*, 784 So.2d 197, 206 (Miss. 2001). As a general rule in medical malpractice actions, negligence cannot be established without medical testimony that the defendant failed to use ordinary skill and care. *Brooks v. Roberts*, 882 So.2d 229, 232 (Miss. 2004). The Mississippi Supreme Court set forth the standard of care for medical malpractice cases in *Hall v. Hilbun*, 466 So. 2d 856, 873 (Miss. 1985), stating:

> [G]iven the circumstances of each patient, each physician has a duty to use his or her knowledge and therewith treat through maximum reasonable medical recovery, each patient, with such reasonable diligence, skill, competence, and prudence as are practiced by minimally competent physicians in the same specialty or general field of practice throughout the United States, who have available to them the same general facilities, services, equipment and options. (Emphasis added.)

The burden is on the Plaintiffs to establish a national recognized standard of care, and the breach of that standard of care. *See, Phillips v. Hull*, 516 So.2d 488, 491 (Miss. 1987)(the legal duty of surgeons in surgical procedures is to use reasonable and ordinary care as other surgeons in good standing would ordinarily exercise in like cases under **nationally recognized standards**....).

In a recent Mississippi Supreme Court case addressing whether summary judgment was appropriate in a medical malpractice case, the Court stated, "the first bridge that must be crossed is establishing duty, which is a legal question." *Estate of Northrop v. Memorial Hosp. at Gulfport*, 9 So. 3d 381, 382 (Miss. 2009). The Court went on to say that "[t]he standard [of care] articulated must be objective, not subjective. This Court stated in *Hall*, '[e]mphasis is given the proposition that

physicians incur civil liability only when the quality of care they render falls below objectively ascertained minimally acceptable levels.'" *Id.* at 384, *citing Hall v. Hilbun*, 466 So. 2d 856, 871 (Miss. 1985). Subsequently, the Court found that Plaintiffs' expert's personal, subjective preference did not establish a national standard of care, and therefore, summary judgment was appropriate. *Id.*

In the case *sub judice*, Plaintiffs had the burden to establish a nationally recognized standard of care, the breach of that standard and a causal relationship between breach and damages. Based on the evidence before the trial court, the trial court found that the Plaintiffs failed to establish the standard of care.

In his testimony, Dr. Miller stated that he used either ACE bandages, TED hose or SCD's because, "[a]s the technology improved then obviously we tried to maintain the standard that was practiced in the community, or at least using some devices." (R.E. 6; Tr. 132). (Emphasis added.) In addition, Dr. Miller testified that "[w]e commonly use TED hoses or SCDs." (R.E. 6; Tr. 133). When asked what his opinion was based on, Dr. Miller replied among other things, the "standard of care in the community." (R.E. 6; Tr. 177). (Emphasis added.)

Not once did Dr. Miller state the nationally recognized standard of care. According to *Hall v. Hilbun*, 466 So. 2d 856, 873 (Miss. 1985) and its progeny, Plaintiff has not met his initial burden, and the remainder of his case fails.

Dr. Beckham, who trained at the Naval Medical Hospital in San Diego, California, in the 1980's, opined that the standard of care in low risk patients does not require any type of prophylactic compression device prior to or after gynecological surgery, other than ambulation. (R.E. 6, Tr. 272-76, 242-52, 283-84). Dr. Reddix, who trained at The Johns Hopkins Hospital in the 1980's, opined that the standard of care in low risk patients does not require any type of prophylactic compression

device prior to or after gynecological surgery, other than ambulation. (R.E. 6, Tr. 487, 497). Dr. Rigdon, a vascular surgeon who trained at University Medical Center in Jackson, Mississippi, and The Ohio State University in the 1990's, also opined that the standard of care in low risk patients does not require any type of prophylactic compression device prior to or after gynecological surgery, other than ambulation. (R.E. 6, Tr. 578-80, 596-97). Dr. Miller, Plaintiffs' expert who trained at Charity Hospital in New Orleans, Louisiana, in the 1960's, twenty years before the other experts trained, opined that the standard of care in low risk patients required prophylactic measures, either ACE bandages, TED hose or sequential compression devices, prior to and after gynecological surgery. (R.E. 4 and 6, P.E. 029, Tr. 187-88). In fact, the literature provided by the Plaintiffs, which allegedly supported their opinions, clearly stated that the studies pertaining to mechanical prophylactics for pulmonary embolism, such as TED hose or sequential compression devices, are suspect. See "Prevention of Venous Thromboembolism," CHEST, 2001, 119:132S-175S. (R.E. 2, R. 507). Further, the literature designated by the Plaintiffs clearly states that the studies are for reference purposes and that each individual patient must be treated according to the clinical judgment of the physician handling the case. *Id.* Therefore, Dr. Beckham and DRMC, vicariously, did not breach the standard of care when Dr. Beckham followed the acceptable standard of care for a low risk patient undergoing gynecological surgery. The trial court's finding is supported by substantial, credible and reasonable evidence and should therefore be affirmed.

2. The trial court found:

> **While Plaintiff's expert, Dr. Miller, opined Dr. Beckham did not follow the standard of care in low risk patients, Miller offered no peer review literature to support his position; he offered no literature or published studies to support his**

> **position that his opinion is the nationally recognized standard. The literature stated that such use is suspect and that each individual patient must be treated according to the clinical judgment of the physician handling that particular patient. (R.E. 3; R. 586).**

In addition to Dr. Miller testifying as to his community standard of care and not the national standard of care, he could not show the trial court any support in the literature or published studies to support his opinion regarding his standard of care. (R.E. 6; Tr. 184-86). In fact, the literature provided by the Plaintiffs, which allegedly supported their opinions, clearly stated that the studies pertaining to mechanical prophylactics, such as TED hose or sequential compression devices, are suspect. (R.E. 2; R. 507). *CHEST* "Prevention of Venous Thromboembolism: The Seventh ACP Conference on Anti-Thrombic and Thrombolytic Therapy," at 343s.In discussing the use of sequential compression devices, the study concluded:

> There is insufficient evidence to assess whether IPC (intermittent pneumatic compression) prophylactics alone has any effect on symptomatic VTE (venous thrombo embolism) or mortality.

(R.E. 2; R. 510).

In regard to general surgery, the study concluded as follows:

> In low risk general surgery patients (Table 5) who are undergoing a minor procedure, or are less than 40 years of age, and have no additional risk factors, we recommend against the use of specific prophylactics other than early and consistent mobilization.

(R.E. 2; R. 510).

In discussing gynecological surgery, the study concluded:

> VTE is an important and potentially preventable complication of major gynecological surgery, with rates of DVT, PE, and fatal PE compatible to those seen after general surgical procedures. . . . As in

> other surgical patients, thrombi generally form during or shortly after the procedure. . . .
>
> * * *
>
> **Therefore, we recommend that a decision to provide prophylactics be individualized, considering a patient's comorbidity and procedure related risk factors.**

(R.E. 2; R. 512).

Further, the literature relied on by the Plaintiffs' expert clearly states that the studies are for reference purposes and that each individual patient must be treated according to the clinical judgment of the physician handling the case. (R.E. 2; R. 461). Another CHEST article submitted by the Plaintiffs contains the following information:

> Despite overwhelming evidence of the efficacy of an assortment of prophylactic modalities, surveys conducted in the United States, Canada, the United Kingdom, Sweden, Switzerland, Spain, and Australia/New Zealand document wide practice variations among physicians, with 28-100% of respondents indicating that they routinely use prophylactics. . . . However, a U.S. study of 2,000 patients, hospitalized at 16 acute care hospitals, showed that only one-third of these patients actually received prophylaxis despite the presence of multiple risk factors for VTE. Use of prophylactics was higher in teaching than in non-teaching hospitals.

"Prevention of Venous Thromboembolism," CHEST, 2001, 119:132S-175S. (R.E. 2; R. 457).

> **Specific caution should specifically be exercised in interpreting the risk reductions ascribed to mechanical methods of prophylactics for three reasons. Most trials have not been able to blind the mechanical devices, leading to the potential for diagnostic suspicious bias. If fibrinogen leg scanning was the DVT scanning method, the known 10-30% false positive rate of the FUT might have been reduced by the mechanical prophylactics but not by the alternate option. Finally, because a relatively poor compliance with all mechanical options, they may not well perform as well in routine clinical practice as in research studies when major efforts are made to optimize proper use.**

(R.E. 2; R. 461).

> The prophylaxis recommendations contained herein are made for groups of patients, for whom the benefits appear to outweigh the risks. **However, prophylaxis decisions for an individual patient are best made by combining knowledge of the literature (including the group recommendations provided herein and elsewhere) with clinical judgment (including detailed knowledge of that particular patient's unique risk for thrombosis, the potential for adverse consequences due to the prophylactics, and the availability of various prophylaxis options locally). The recommendations that are best for the group may not be best for the individual.**

(R.E. 2; R. 461). Therefore, the trial court's finding is supported by substantial, credible and reasonable evidence and should be affirmed.

The Plaintiffs argue extensively in their brief the "literature" that was produced and introduced into evidence at trial as "learned treatises". The Plaintiffs either do not understand the literature, or they are trying to confuse the issue. At page 24 of the Plaintiffs' brief, the Plaintiffs correctly cite a table from the Chest article which recognized "two generally accepted approaches to making decisions about when and what type of prophylaxis therapy to use with a particular patient." (Emphasis added) (R.E. 2; R. 505). This is an excellent example of why the Plaintiffs failed to prove a national standard of care that was breached in this case. Table 5 from the Chest article, quoted at page 24 of the Plaintiffs' brief, categorizes levels of risk (low, moderate, high, and highest), and the prophylaxis therapy referred to is limited to "LDUH/LMWH-drugs, Heparin and low molecular weight Heparin, etc." *Id.* For "low risk patients", the Chest article specifies, "No specific prophylaxis; early and 'aggressive' mobilization". *Id.*

The Plaintiffs then go on to discuss "the second approach divides patients into more specific target groups based upon the type of surgery plus age and additional risk factors . . .". (Plaintiffs' Brief 24) Cited on page 25 of the Plaintiffs' Brief, the article states, "The implementation of

evidence-based and thoughtful prophylaxis strategies provides benefits to patients **and should also protect their caregivers and hospitals providing care from legal liability**." (Page 25 of Plaintiffs' Brief, R.E. 2; R. 505).

3. **The trial court found:**

> **At most Plaintiff showed two schools of thought as to whether to use prophylactic measures prior to and after gynecological surgery when dealing with a low risk patient. Dr. Miller refused to criticize the training of Dr. Reddix who was trained not to use these devices. While Dr. Miller gave basically his opinion as to how he would treat a patient, this did not establish a nationally recognized standard of care for a minimally competent physician practicing under like and similar circumstances which is the standard of care that Plaintiff must establish before the Court can find a breach. (R.E. 3; R. 586).**

Clearly, the experts in this case underwent specialty training at different times and at different medical facilities. Dr. Beckham, Dr. Reddix and Dr. Rigdon, who trained in the 1980's and 1990's, all opined that because Ms. Ervin was a low risk patient, she did not require any type of prophylactic compression device in an attempt to prevent a pulmonary embolism. They all agreed that ambulation after surgery was the standard of care for low risk gynecological patients, such as Ms. Ervin, and Dr. Beckham followed the standard of care. On the other hand, Dr. Miller, who underwent his training in the 1960's, opined that his "community" standard of care in low risk patients requires prophylactic measures, either ACE bandages, TED hose or sequential compression devices, depending on availability, prior to and after gynecological surgery. (R.E. 6, Tr. 129, 131-34). Dr. Miller testified that he used either ACE bandages, TED hose or SCD's because, "[a]s the technology improved then obviously we tried to maintain the standard that was practiced in the community, or at least using

some devices." (R.E. 6; Tr. 132). In addition, Dr. Miller testified that "[w]e commonly use TED hoses or SCDs." (R.E. 6; Tr. 133). When asked what his opinion was based on, Dr. Miller replied among other things, the "standard of care in the community." (R.E. 6; Tr. 177). Therefore, Dr. Beckham and DRMC, vicariously, did not breach the standard of care when two acceptable methods of treatment exist, and Dr. Beckham followed one of those acceptable methods.

The burden was on the Plaintiffs to establish the national standard of care that Dr. Beckham allegedly breached. Dr. Miller testified that in his opinion the standard of care required the use of ACE bandages, TED hose, or sequential compression devices, but when asked if he would criticize the professors of obstetrics and gynecology that taught Dr. Reddix who was trained at The Johns Hopkins or Dr. Beckham who was trained at the Naval Hospital in San Diego who were trained not to use these devices, Dr. Miller declined. (R.E. 6, Tr. 179-185). Thus, how Dr. Miller practices is obviously not the nationally recognized standard of care for a minimally competent physician practicing under like and similar circumstances, which is the standard of care that must be established before the trial court can find a breach. *See* e.g. *Hall v. Hilbun*, 466 So. 2d 856 (Miss. 1985); *Palmer v. Biloxi Reg. Med. Ctr. Inc.*, 564 So. 2d 1366, 1354 (Miss. 1990); *Phillips v. Hall*, 516 So. 2d 488, 491 (Miss. 1987).

In his brief, Plaintiff attempts to manipulate the evidence to show that Ms. Ervin was not a low risk patient. However, as the trial transcript demonstrates, Plaintiff's expert, Dr. Miller, tried to manipulate the treatment tables to meet his opinion that Ms. Ervin was at a slightly higher risk than low risk, but refused to categorize Mrs. Ervin as moderate or high risk. (R.E. 6; Tr. 123-28, 189-91). It is well-established that the trial judge determines the credibility of witnesses when the judge sits as the trier of fact, and the trial court in this case found that Dr. Miller's opinion did not establish

a national standard of care and was not supported by the literature. The trial court's finding is supported by substantial, credible and reasonable evidence and should be affirmed. *See, e.g., Yarbrough v. Camphon*, 645 So. 2d 867, 870 (Miss. 1994).

4. The trial court held:

> **As to the nurses standard of care and breach thereof, much was said and argued regarding Nurse Natalie Reed's deposition testimony, the errata sheet correcting an error in her deposition testimony, when this was learned by the plaintiff and whether such may be allowed. Addressing all these problems is not necessary. Even if Plaintiff were given the benefit of her testimony from the deposition, that is, that Ervin was transferred without supplemental oxygen, the remaining testimony and evidence to a preponderance of the evidence still showed and proved the contrary. The remaining testimony and the records (respiratory therapy notes, ICU notes and Code Blue flow sheet) clearly reflected that Ervin was provided supplemental oxygen while being transferred to the ICU. Mr. Ervin's testimony to the contrary is highly suspect given his lack of sleep and the highly emotional events in question. (R.E. 3, R. 586-87).**

The Plaintiffs wholly failed to demonstrate a breach of the standard of care by the nurses in this case. The Plaintiffs in this case clearly seized upon the erroneous deposition testimony of Natalie Reed and attempted to concoct a story that Ms. Ervin was transferred without supplemental oxygen. The nursing staff appropriately secured Ms. Ervin and, with supplemental oxygen via mobile oxygen bottle, transferred Ms. Ervin from the floor to the ICU. (R.E. 5; D.E. 042, 054, 055). Upon arrival at the ICU floor, Ms. Ervin's breathing deteriorated, and the nursing staff obtained a bag valve mask from the wall of the ICU hall and began assisted respirations via bag valve mask as

Ms. Ervin was being rolled into the ICU. (R.E. 5; D.E. 042, 054, 055, 077, 012). Nursing supervisor, Josh Edwards, testified that he was called to Ms. Ervin's room after her collapse, and that he supervised Ms. Ervin's transfer from the floor to the ICU. (R.E. 6; Tr. 446). Mr. Edwards testified with certainty that Ms. Ervin was on supplemental oxygen, which the nurses had obtained and installed prior to leaving Ms. Ervin's room. (R.E. 6; Tr. 455-56, 460-64). Nurse Woodard, Plaintiff's nursing expert, also testified that transferring Ms. Ervin from the floor to the ICU without supplemental oxygen was a breach of the standard of care but would withdraw her opinion if the medical records reflected that Ms. Ervin was on oxygen, which they did. (R.E. 5 and 6; Tr. 367, 382-84; D.E. 12, 54, 55, 77). Mr. Curtis Ervin testified that at the time of Ms. Ervin's surgery he had not slept for approximately eighteen (18) hours, as he worked nights at the Nissan manufacturing plant in Canton, Mississippi. (R.E. 6; Tr. 25-26, 53, 57). Mr. Ervin had worked the night before Ms. Ervin's procedure and after work proceeded directly to DRMC, with no sleep up to the time Ms. Ervin had her episode on the morning of October 16. (R.E. 6; Tr. 53). At the time of Ms. Ervin's collapse, Mr. Ervin had been awake for at least thirty-six (36) hours. The Plaintiffs' attempt to focus on the alleged lack of oxygen was a red herring, as the records and testimony clearly reflect that Ms. Ervin was provided supplemental oxygen while being transferred to the ICU.

In Plaintiff's brief, he again argues in the fact section that the standard of care required Ms. Ervin to be transported with oxygen, but he never addressed causation. The transcript demonstrates the Defendants' objection to Dr. Miller testifying about whether Ms. Ervin should have been transferred with oxygen was sustained because that opinion had never been disclosed by Plaintiff's prior to trial. (R.E. 6, Tr. 139). When asked whether Ms. Ervin could have been revived when she arrived at ICU, Dr. Miller stated, "At that particular point, I could not say that she is not at a point

where she cannot survive." (R.E. 6, Tr. 145). Plaintiff's expert, Dr. Miller could not testify as to causation concerning any alleged oxygen deprivation.

Also in Plaintiff's brief, he describes the trial court's acceptance of Josh Edward's as an expert and the trial court's reliance on Mr. Edward's testimony trial by ambush. However, Plaintiff called Mr. Edwards, and Defendant's scope of cross-examination in Mississippi is broad and within the discretion of the trial court. *Ekornes-Duncan v. Rankin Medical Center*, 808 So. 2d 955, 961 (Miss. 2002). In addition, Defendants' tendered Mr. Edwards as an expert to testify to the oxygen issue and the policy and procedure issue, both of which had not been disclosed by Plaintiff prior to trial. (R.E. 6, Tr. 139, 146, 173). Again, the trial judge is given "the widest possible discretion" in his decision as to whether a witness is qualified to testify as an expert. *UMMC v. Pounders*, 970 So. 2d 141, 145 (Miss. 2007).

In addition, the Plaintiff argues in the fact section of his brief that the nursing policy and procedure required the nurses to report a doctor to his superior if he refused to order prophylactic measures in a patient at risk. However, Defendant's objection to the evidence was sustained because Plaintiff never supplemented Dr. Miller's opinion, and that is not what the nursing policy states. (R.E. 6, Tr. 146, 173). The trial court's finding regarding the nursing standard of care is supported by substantial, credible and reasonable evidence and should therefore be affirmed.

5. The trial court found:

> **Plaintiffs have wholly failed to meet its burden of proof as to causation, that is, Plaintiff has failed to establish that any such breach of that standard of care caused the death of Janice Ervin. Plaintiff's expert, Dr. Harold Miller, could not say definitively where Ervin's pulmonary embolus originated; it could have been either in the legs or**

in the pelvis. This Court finds that this was an essential element in the Plaintiff's causation proof and this proof is missing. (R.E. 3; R. 587).

The Plaintiffs have wholly failed to carry the burden of proof on causation. In a medical malpractice case, recovery is allowed only when the failure of the physician to render the required level of care results in the loss of a reasonable probability of substantial improvement in the patient's condition. *Clayton v. Thompson*, 475 So.2d 439, 445 (Miss. 1985). In other words, adequate proof in a medical malpractice case requires evidence that in the absence of the alleged malpractice, a better result was probable, or more likely than not. *Ladner v. Campbell*, 515 So. 2d 882, 889 (Miss. 1992), citing 54 A.L.R. 4th 10 § 4. Plaintiffs' expert, Dr. Miller, testified that he could not say definitively where Ms. Ervin's pulmonary embolus originated; *i.e.,* whether in the legs or in the pelvis. (R.E. 6, Tr. 191-92, D.E. 409). However, the Defendants' expert witnesses clearly opined and well supported their opinions that the pulmonary embolus in this case originated in the pelvis. (R.E. 6, Tr. 499-500, 590-98). All experts agree, mechanical devices on the legs would not have prevented the formation of blood clots in the pelvis. *Id.* Drs. Rigdon and Reddix explained and offered literature to support the fact that most pulmonary emboli in gynecological patients, including Ms. Ervin, originate in the pelvic or femoral veins. *Id.* Further, Dr. Rigdon, Dr. Reddix, and Dr. Beckham established that the use of a prophylactic compression device on the legs would not have prevented a deep vein thrombosis from forming in the pelvis, where Ms. Ervin's originated. *Id.* Therefore, even if Dr. Beckham had followed Dr. Miller's opinion of the standard of care, applying a compression device to Ms. Ervin's legs would not have prevented the embolus from forming in her pelvis and her ultimate death. The opinions of Dr. Rigdon, Dr. Reddix and Dr. Beckham and the literature was substantial, credible and reasonable evidence for the trial court to find in the

Defendants' favor.

Because each of the trial court's findings in its very thorough and thoughtful Findings of Facts and Conclusions of Law is supported by substantial, credible and reasonable evidence, the trial court's decision must be affirmed.

CONCLUSION

For the above and foregoing reasons, the Court affirms the trial court's findings that the staff at Delta Regional Medical Center and Dr. James Beckham complied with the applicable standards of care in the care and treatment of Janice Ervin and that the cause of Ms. Ervin's death was not related to the alleged breaches of the standard of care submitted by the Plaintiffs.

RESPECTFULLY SUBMITTED, this 14 day of September, 2009.

DELTA REGIONAL MEDICAL CENTER

BY: _____

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CERTIFICATE OF SERVICE

I, Mary Frances S. England, one of the attorneys of record for Defendant DRMC herein, certify that I have this day mailed, postage prepaid, a true and correct copy of the foregoing document to:

George F. Hollowell, Jr., Esq.
Hollowell Law Firm
P. O. Box 1407
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Honorable Richard A. Smith
Circuit Court Judge
P. O. Box 1953
Greenwood, MS 38935-1953

THIS, 14 day of September, 2009.

Mary Frances S. England
MARY FRANCES S. ENGLAND

CERTIFICATE OF FILING

I, Mary Frances S. England, certify that I have this day delivered via Federal Express, the original and three copies of, and a floppy disc containing, Brief of Appellee on September 14, 2009, to Ms. Kathy Gillis, Clerk, Supreme Court of Mississippi, P.O. Box 117, Jackson, Mississippi 39205.

Mary Frances S. England
MARY FRANCES S. ENGLAND