2008-CA-01816-COART

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I. The Substantial Evidence Standard of Review

DRMC's brief (hereinafter referred to as "D.B.") states that the substantial evidence standard of review requires the Appellant to demonstrate the trial court was manifestly wrong, clearly erroneous or applied an erroneous legal standard. (D.B. at 23) However, there are two requirements for affirming a trial court under the substantial evidence standard. Reversal is warranted if the record fails to contain substantial evidence supporting the trial court's finding *or* if the trial court's findings are manifestly wrong, clearly erroneous or are based on application of an erroneous legal standard. A failure to satisfy any of these criteria will result in reversal. *Stanton v. DRMC*, 802 So. 2d 142, 145 (Miss. 2001), citing *Covington Cty. v G. W.*, 767 So. 2d 187, 189 (Miss. 2000).

> Substantial evidence ... means something more than a "mere scintilla" of evidence .... [I]t means such relevant evidence as reasonable minds might accept as adequate to support a conclusion. Substantial evidence means evidence that is substantial, that is, affording a substantial basis of fact from which the fact in issue can be reasonably inferred.

Delta CMI v. Speck, 586 So. 2d 768, 773 (Miss. 1991))

While a court "performs limited appellate review" under the substantial evidence standard, 'it is not relegated to wearing blinders.' *Public Emples. Retirement Sys. v. Marquez*, 774 So. 2d 421, ¶ 20 (Miss. 2000) A finding supported only by a trial judge's mistaken view of evidence which the appellate court is in as good a position to check as the trial judge is not supported by substantial evidence. See e.g., *Browder v. Williams*, 765 So. 2d 1281, ¶¶ 30-32 (Miss. 2000) Moreover,

> [w]hile [the reviewing court is] not obligated to go beyond the record or briefs of counsel, neither are we obligated to exclude from our consideration any scientific law, fact or truth which helps to explain, amplify or affect the validity of an expert

> opinion. Moreover, when a decision in a case rests upon technical, specialized or scientific knowledge, if we find the record does not make the subject matter sufficiently clear, we will not hesitate to conduct authoritative study on our own. This is not to find additional "facts," but to understand and intelligently evaluate the facts in evidence.

Samuels v. Mladineo, NO. 89-CA-0952, 1992 Miss. LEXIS 702 (Miss. 1992) at *11.

The Ervins do not ask this Court to go beyond the record or briefs of counsel or conduct a de novo review. (D.B. 24) They ask this Court to compare specific findings of the Trial Court to specific testimony and/or scientific literature in the record. Where the trial court's findings directly conflict with the clear meaning of the full context of the scientific literature or the clear testimony in the record, they are manifestly wrong, clearly erroneous and unsupported by substantial evidence. Findings in conflict with the medical literature in the record are not miraculously converted into being consistent with that literature, which this court can read for itself, merely because the defense counsel says they are and the Trial Court accepted defense counsel's argument and proposed findings. These are not credibility issues where the trial court is in a better position to make judgments than the reviewing court. These are issues of the type this Court regularly reviews when reviewing Daubert rulings and when reviewing findings on causation and other technical issues in scientific, technical and medical cases.

II. The Objective National Competence Based Standard of Care in a Physician's Specialty

DRMC seems to argue a Plaintiff's expert will not satisfy the burden of proof if he uses the word "community" in stating the standard of care and instead must explicitly state his opinion refers to a standard uniformly accepted nationwide by all physicians. DRMC then argues since the Ervins' expert, Dr. Miller, used the word "community" instead of the word "national," the Ervins did not meet their burden of proof. (D.B. at 24-27)

DRMC's position misstates both Dr. Miller's testimony and Mississippi law. When Dr. Miller's use of the word "community" is read in context, it is clear he was not using the word in the context of the specific hospital or geographic area where he personally practiced. The transcript on pages 132 and 177 (hereinafter referred to as "Tr.") make it clear that he used the word "community" to refer to the medical community or profession or to refer to a physician's area of specialty such as the community of OB/GYN physicians. (Tr. 132, 177) In response to further questioning, he specifically said:

> Q. Now, can you cite me any literature which finds affirmatively, where trials has [sic] been run and anyone has concluded that Ace bandages, TED hose, or SCDs affirmatively prevent the development of deep vein thombosis?
> A. It's the current opinion of ACOG. American College of OB-GYN has come out with a statement that says, this is the standard of care. ... I did not bring articles. But, obviously, that research, that data, has been collected; otherwise, that would not be the statement by the American College of OB-GYN.

(Tr. 184-185)

In *Delta Reg'l Med. Ctr. v. Venton*, 964 So. 2d 500, 504-505 (Miss 2007), this Court found testimony concerning the standard of care using the word "community" in the sense of the medical community or the community of physicians treating geriatric patients satisfied the Plaintiff's burden of proof on the standard of care. Mississippi courts have also used the term "community" in this same way long after *Hall v. Hilbun*, 466 So. 2d 856 (Miss. 1985) rejected the locality rule. See e.g., *Jones v. Baptist Mem'l Hospital-Golden Triangle, Inc.*, 735 So. 2d 993, 996 (Miss. 1999); *Clayton v. State*, 652 So. 2d 720, 725 (Miss. 1995); *Paepke v. North Miss. Med. Ctr.*, 744 So. 2d 809, 812 (Miss. App. 1999).

Furthermore, the reasoning and language used in *Hall v. Hilbun* demonstrates Dr. Miller's testimony applied the kind of objective standard of care based on a patient's objective health

related factors adopted in *Hall* while the testimony of Dr. Beckham and the defense experts used a subjective personalized standard of care based on their individualized personal definitions of risk levels and their personal customs and beliefs.

> Nationally uniform standards are enforced in the case of certification of specialists. ... Medicine is a science, though its practice be an art (as distinguished from a business). Regarding the basic matter of the learning, skill and competence a physician may bring to bear in the treatment of a given patient, state lines are largely irrelevant. That a patient's temperature is 105 degrees means the same in New York as in Mississippi. Bones break and heal in Washington the same as in Florida, in Minnesota the same as in Texas. An abnormal blood sugar count should be interpreted in California as in Illinois as in Tennessee. A patient's physiological response to an exploratory laparotomy and needs regarding post-operative care following such surgery do not vary from Ohio to Mississippi. A pulse rate of 140 per minute provides a danger signal in Pascagoula, Mississippi, the same as it does in Cleveland, Ohio. Bacteria, physiology and the life process itself know little of geography and nothing of political boundaries. ...
>
> Each physician may with reason and fairness be expected to possess or have reasonable access to such medical knowledge as is commonly possessed or reasonably available to minimally competent physicians in the same specialty or general field of practice throughout the United States, to have a realistic understanding of the limitations on his or her knowledge or competence, and, in general, to exercise minimally adequate medical judgment. Beyond that, each physician has a duty to have a practical working knowledge of the facilities, equipment, resources (including personnel in health related fields and their general level of knowledge and competence), and options (including what specialized services or facilities may be available in larger communities, e.g., Memphis, Birmingham, Jackson, New Orleans, etc.) reasonably available to him or her as well as the practical limitations on same.
>
> In the care and treatment of each patient, each physician has a non-delegable duty to render professional services consistent with that objectively ascertained minimally acceptable level of competence he may be expected to apply given the qualifications and level of expertise he holds himself out as possessing and given the circumstances of the particular case. The professional services contemplated within this duty concern the entire caring process, including but not limited to examination, history, testing, diagnosis, course of treatment, medication, surgery, follow-up, after-care and the like. ...
>
> [A] qualified medical expert witness may without more express an opinion regarding the meaning and import of the duty of care articulated ... above, given the peculiar circumstances of the case. Based on the information reasonably available to the physician, i.e., symptoms, history, test results, results of the

> doctor's own physical examination, x-rays, vital signs, etc., a qualified medical expert may express an opinion regarding the conclusions (possible diagnoses or areas for further examination and testing) minimally knowledgeable and competent physicians in the same specialty or general field of practice would draw, or actions (not tied to the availability of specialized facilities or equipment not generally available) they would take.

466 So. 2d at 870-874.

The testimony in this case clearly shows terms like "low risk," "moderate risk," and "high risk," tended to vary in meaning according to the personal beliefs of the person using them. (Tr. 522-524, 616-618; see also discussion of testimony and references to the record at pages 2-7 of the Ervins' initial brief) However, the terms describing risk factors were objective. To put it as the *Hall* court did, Mrs. Ervin's age, weight to height ratio (in the obese range), use of hormone/ estrogen/birth control therapy, and the length of her surgery did not vary from one witness to another or in any other way. All the articles acknowledged each of these factors increased a patient's risk. These are the objective criteria. On the other hand, words like "low," "moderate," and "high" were words that lacked or varied in meaning unless they were defined in terms of the objective factors. The parts of each article using such words as a convenient way of referring to a list of objective factors must be read with the particular article's definition of these words for the conclusions and standards in the articles to make objective sense. Reading each article with each reader's subjective opinion as to what factor or combination of factors is equivalent to "low," "moderate," and "high" risk instead of with the article's own definition of "low", "moderate," and "high" risk, removes all the scientific objectivity and reliability of the conclusions and recommendations because the criteria changes with each reader causing what the article says to take on a fluid quality changing with every reader. Only defining of these terms using objective

risk factors results in each article expressing objective medical standards of care.

Thus, when Dr. Miller testified the standard of care required some prophylactic treatment to reduce Janice Ervin's risk of developing blood clots and dying because of her age, weight, use of hormone therapy and the length of her surgery, he was testifying to an objective standard of care for gynecologists. In refusing to use subjective terms and returning to these specific risk factors, he was making his testimony on the standard of care more objective, not less so. (Tr. 122-124, 129, 188-191) But when Dr. Beckham, Dr. Reddix, and Dr. Rigdon[1] testified the standard of care did not require the use of any prophylactic measures other than early ambulation because each personally believed Mrs. Ervin was a low risk patient according to his own personal beliefs on risk levels, they were testifying using subjective standards of care. (See e.g., Tr. 522-524, 616-618; see also discussion of testimony and references to the record at pages 2-7 of the Ervins' initial brief) Their interpretation of the recommendations and conclusions in the medical literature using their own subjective and differing definitions of these risk levels instead of the objective risk factors defined by each article did not show Dr. Beckman complied with the standard of care, that Dr. Miller's testimony failed to establish an objective standard of care, or that the medical literature demonstrated the standard of care for an ACOG certified gynecologist did not require the use of any prophylactic measures other than early ambulation for a patient in Janice Ervin's circumstances. It merely demonstrated their testimony was subjective and not supported by the gynecological standards of care or the medical literature.

Both the Trial Court's findings and DRMC's brief claim the medical literature establishes

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[1]Dr. Rigdon specifically stated he was testifying based on "my personal criteria" for what a patient's risk level was and what measures the patient needed. (Tr. 616-617)

a physician complies with the standard of care whether he uses prophylactic measures or not with patients such as Janice Ervin as long as he follows his own judgment. They incorrectly claim there are differing school of thought and the standard of care is met as "each individual patient must be treated according to the clinical judgment of the physician handling that particular patient." (D.B. at 27-33; R. 586; RE 13) However, such analysis is clearly in conflict with appropriate current legal standards applicable to Mississippi medical malpractice cases.

In *Bickham v. Grant*, 861 So. 2d 299 (Miss. 2003), an OB/GYN patient died from a blood clot which traveled to the lung becoming a pulmonary embolus.[2] The jury found for the Defendants after being given the following instruction.

> You are instructed that you have heard from the expert witnesses who have testified in the case differing views as to what would be the proper procedures to be followed by Doctors Grant and Harris in their treatment of Tamara Bickham. If you find from these opinions that two or more alternative courses of action would be recognized by the profession as being proper and within the standard of care and that Doctors Grant and Harris, in the exercise of their best judgment, elected one of the proper alternatives you should find for Doctors Grant and Harris.

Id at ¶ 6. Our Appellate Court found this instruction to be reversible error, stating:

> A physician or a professional can always claim he was exercising his own judgment even though he was mistaken or negligent. ... This instruction provides a subjective standard of care by the doctor regarding his own misdiagnosis. This is clearly what our holding in Morrison forbids. To charge juries with the responsibility of assessing the mental state of treating physicians and to make a determination of liability is preposterous. Not to mention the negative effect such instructions will have on those injured. There is no conceivable way a jury weighing alternative treatments would possibly find physicians negligent for exercising their best judgment. ... Furthermore, a subjective jury instruction in a medical malpractice case is a misstatement of law ... .The appropriate standard of care in a medical malpractice case is objective and centers around exercising the

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[2]The Court of Appeals opinion found at *Bickham v. Grant*, 2001 Miss. App. LEXIS 223, 2001 WL 570018 (Miss. Ct. App. 2001) gives a more detailed description of the facts and testimony than the Supreme Court opinion.

> degree of care, diligence, and skill ordinarily possessed and exercised by a minimally competent and reasonably diligent, skillful, careful, and prudent physician in that field of practice. What the physician may have been thinking in "his best judgment" is irrelevant. What the physician did in treating the patient is the key factor. Patients expect their physician to always be exercising "their best judgment." However, it is clear that there are times where the physician's best judgment regarding treatment falls below the applicable standard of care. This is why instructions such as C-20 are misstatements of law as they hold the physician to his own personal standard of care and not the standard of care applicable to physicians in his area of practice.

Id at ¶¶ 11-114. Although the Ervins' case was decided by the Court instead of a jury, the reasoning is the same. Dr. Beckham was found not to be negligent based on the theory he applied his own clinical judgment and he personally believed in the exercise of that judgment that prophylactic measures were not needed to reduce the risk of pulmonary embolism for this particular patient. That finding embodies the application of an incorrect legal standard. *Id.*

III. The Fact that a Witness May Possess Qualifications that Would Have Satisfied MRE 702 Does Not Cure a Party's Failure to Designate the Witness as an Expert and Disclose His Expert Opinions Prior to Trial as Required by MRCP 26

Contrary to DRMC's arguments, the Ervins' objection to DRMC's questioning of Josh Edwards and tendering of his testimony as expert testimony is not an issue of qualification of an expert witness or an issue of the scope of cross examination. (D.B. at 35) The issue is non-compliance with our rules of civil procedure on pre-trial disclosure of expert opinions. M.R.C.P. 26; *Banks v. Hill*, 978 So. 2d 663 (Miss. 2008)

DRMC's deadline for designating its experts and disclosing their expert opinions in response to the Ervins' interrogatory on experts was December 14, 2007. (R. 49, 129, 202, 333) Four months before this deadline and eight months before trial, DRMC deposed the Ervins' nurse expert on August 16, 2007. In regard to her opinions as to the nursing standard of care and

breaches of that standard, she stated in her deposition:

Q. Do nurses order either mechanical or pharmacologic prophylaxis for DVT?
A. Do they write the order? No.
Q. Can they?
A. They can call the physician and request it and write the order as a phone order.

...

Q. Would that not be a physician call whether or not to use them immediately pre-op and post operatively?
A. No. I think that would be physician and nursing. As they work together that's part of the multidisciplinary team planning. And that's part of a care plan. And a care plan, a nursing care plan, should identify the risk for DVT and, therefore, the nursing care plan should address this. And there is a nursing care plan and it is not addressed. ...
Q. ... Is your criticism that because the nursing plan of care doesn't address it, there's a breach of the standard of care? Or because the mechanical prophylaxis wasn't used, there's a breach of the standard of care?
A. Both. ...
Q. So you think that DRMC needs to have ***a policy or procedure in place where a nurse*** can start to use mechanical prophylaxis without a physician's order?
A. You have to have a physician's order, but what I'm saying is most disciplinary teams, multidisciplinary teams get together ***a policy and procedure which is approved by the medical staff, that this can become a routine procedure***. ...
Q. Is it your opinion that the nurses should have insured that Mrs. Ervin received any form of heparin?
A. I believe ***the nurses should have insured that she had some form of thromboprophylaxis or DVT prophylaxis***, whether it was mechanical or pharmacologic. They should have documented where they asked the physician, that they showed that they had established some risks under their nursing assessment, and asked for orders from the physician. ... Saying I'm concerned because I have a post operative patient with abdominal surgery, who's obese, who's been on estrogen, et cetera, and I do not see any DVT prophylaxis, what would you prefer?
Q. *And when the physician comes back and says I don't want any, I don't want any mechanical prophylaxis?*
A. Then as a nurse I would document that and hopefully it would go through the peer review process, especially when something catastrophic occurs such as this.
Q. But in the end, you would agree with me that's a physician's call? In this

case, it was Dr. Beckham's call?

A. It was up to Dr. Beckham to write the order for it. I think nursing can certainly pursue it if he – if any nurse sees a physician going against a standard of practice, I think *nurses have a responsibility to address it and to bring it to the appropriate, through the appropriate avenue of* ***chain of command*** *to have it addressed.*

(DSR Ex. 11 at deposition pages 77-85; RE. 290-293). Thus, DRMC's claim that it tendered Edwards as an expert on policies and procedures issues not disclosed prior to trial is clearly incorrect. (D.B. at 35) The claim it tendered Edwards on the oxygen issue not disclosed prior to trial is likewise incorrect. *Id.* The transcript demonstrates DRMC tendered him as an expert in the field of nursing (Tr. at 468), and did not ask him any questions at all concerning oxygen. DRMC tendered Edwards as an expert and questioned him in areas clearly put in issue by the Ervins' nurse expert's opinions four months before DRMC's expert disclosure deadline and eight months before trial. (Tr. at 466-477)

Although DRMC does not use the word "rebuttal" in its arguments that Edwards' expert opinion should be admissible, it is making essentially the same type argument rejected in *Harris v. General Host Corporation*, 503 So. 2d 795 (Miss. 1986) and *Banks v. Hill*, 978 So. 2d 663 (Miss. 2008). It attempts to recast its argument to slip through a narrow opening which *Banks* acknowledges by alleging that it offered Edwards' expert testimony on issues the Ervins did not disclose prior to trial. However, as the quoted deposition testimony from the Ervins' nurse expert clearly demonstrates, this was clearly not a "circumstance where the party had no reasonable means of anticipating in advance of trial the need for calling the witness."

DRMC knew the Ervins had a nursing expert who would testify it should have nursing policies on circumstances where the standard of care required the use of prophylaxis for DVT. It

knew the Ervins' nursing expert would testify its nurses had a duty to assess Mrs. Ervin's risk factors for DVT, to recognize she had enough risk factors that there should be an order for prophylactic treatment, to recognize the absence of such an order by Dr. Beckham needed to be addressed, to bring the absence of such an order to Dr. Beckham's attention and ask him for an appropriate order, and to go up the chain of nursing command advocating for such treatment if Dr. Beckham refused to authorize an order for prophylaxis. It also had a copy of its own policy.

Thus, DRMC had reasonable means of anticipating in advance of trial the need to call a nursing expert to testify on these issues. Nevertheless, it did not designate Josh Edward to testify on these points at any point in the eight months between this deposition and trial or disclose his opinions even though it knew he was the nursing supervisor present during the response to Mrs. Ervins' pulmonary embolism and even though it did designate as experts and disclose the opinions of other witnesses it expected to also call as experts such as Dr. Beckham. Thus, *Banks* and *Harris* are controlling and requires the Trial Court's admission of Edward's expert testimony to be reversed and stricken.

IV. Fallacies in DRMC's Standard of Care Arguments

DRMC argues the Ervins' theory of the case was the national standard of care required Dr. James Beckham to prescribe compression stocking devices post surgery and therefore the Ervins' case must fail unless they can definitively prove the embolus causing her death originated in her leg and would have been prevented by the use of compression stockings. (D.B. at 5) First, this argument misstates both the Ervins' theory of the case and Dr. Miller's opinions and the evidence. The Ervin's theory of the case, and Dr. Miller's testimony, was the standard of care required the use of prophylactic measures, not a specific prophylactic treatment. Dr. Miller

testified at a minimum the standard of care required "mechanical prophylaxis" but that other prophylactic measures were available as well. "Mechanical prophylaxis" is much broader than compressions stockings as it also includes automatic compression devices. Furthermore, while Dr. Miller would not have personally used pharmacologic prophylaxis, he did testify that it was an option within the standard of care. The breach of the standard of care was not the failure to use compression stockings, but the failure to use any type of prophylactic treatment. (Tr. 129)

Second, contrary to DRMC's arguments, it was not necessary for the Ervins to prove the standard of care and its breach according to DRMC's very narrow factual interpretations of what was necessary to prove negligence. DRMC is in this case as the party responsible for the actions of three categories of tortfeasors. It is here as the party responsible for the standard of care applicable to its employee Dr. Beckman. Second, it is here as the party responsible for the standard of care applicable to its employees the nurses. Third, it is here as the party responsible for standard of care applicable to the hospital. Doctors, nurses, and hospitals all owe a duty to the patient to comply with their own standards of care. The Ervins could succeed in this case by showing a breach of any one of these standards of care. Moreover, contrary to DRMC's brief, the Ervins did not have only one expert who testified on the standards of care applicable to DRMC. (D.B. at 5) They had two – Dr. Miller and nurse Debra Baggett-Woodward.

DRMC claims the Ervins sought to prove the nurses violated the standard of care because a hospital policy required the nurses to instruct Dr. Beckham to order compression stockings. (D.B. at 5) This argument conflates several separate duties, standards of care and the applicable evidence. The policy was offered not to show the nurses had a duty to instruct Dr. Beckman to order compression stockings, but to show the hospital recognized and acknowledged the standard

of care applicable to hospitals required the use of prophylactic treatments in a patient with Mrs. Ervins' risk factors. Using a party's own documents acknowledging applicable standards is a valid means of proving duty and the standard of care. See e.g., *Heritage Cablevision v. New Albany Elec. Power Sys.*, 646 So. 2d 1305, 1311 (Miss. 1994) It happened to be a nursing policy of the hospital which contained the language showing that the hospital recognized and acknowledged that prophylactic measures were needed for a abdominal gynecological surgery patient with the risk factors Mrs. Ervin had. But that does not mean the Ervins had to prove the policy was directly applicable to Dr. Beckman or that it required the nurses to instruct Dr. Beckman to order prophylactic measures. Regardless of what it said about Dr. Beckman and the nurses duties, the policy showed DRMC recognized as a hospital the standard of care applicable to it called for prophylactic measures in a patient with Mrs. Ervins' risk factors.

On the point of the standard of care in regard to the nurses duty to assess Mrs. Ervin's risk factors, to check for a prophylactic treatment order, to contact Dr. Beckham and request such an order, and to go up the chain of command if he refused to issue such an order, the Ervins did not rest their case on DRMC's nursing policy. Their primary evidence in regard to the nursing standard of care came from the testimony of their nursing expert, Debra Baggett-Woodward.

> A. It is part of the nurse's practice to do assessments, evaluation, and a plan of care. This includes identification of risks to the patient ... . If a nurse knows in her scope of practice and in her assessment that there is an issue that needs to be dealt with, then it is the nurses responsibility to collaborate with the team, which includes the physician, to communicate if there is an issue and that it needs to be taken care of, and to request an order for such device.
> Q. All right. In Janice Ervin's case, what do you think?
> A. That the nurse upon receiving the patient needed to know that a post-operative patient did not have TED hose on, sequential compression devices, and no order for them, and had no prophylaxis at all. And this is not a medical diagnosis. This is a nursing assessment, and during that assessment, then the

nurse would contact the physician and say, this patient is at risk; can we have an order for elastic stockings, sequential compressions device, et cetera.
Q. That's what you consider to be the deviation, is that correct?
A. Yes.
Q. ... and are there any specific reference that you used to form that opinion?
A. The – uh – well, one reference apparently is the Mississippi reference, but the national standard of care is that nurses perform an assessment, evaluation, plan, and follow up. ... That is the national standards and in policy and procedures that there is an assessment, and referrals are made based on that assessment.
Q. I want you to assume that after the doctor received this ... notice of the nurse's assessment ... the doctor did not so order – refused to order, what, if anything should the nurses - what is the standard that the nurses should follow if something of that nature occurred?
A. ... then the nurse goes to the chain of command ... to follow that chain of command. And the nurse would then - uh - go to her - uh - nurse manager or nurse supervisor. From there to Director of Nurses. From there to the Hospital Administrator, and hopefully the medical staff would be contacted and - uh - there would be something done for the patient.
Q. Have you had any experience with that?
A. Yes, sir.

(Tr. 343-345) Nurse Woodward's testimony on this aspect of the national nursing standard of care is neither novel nor at variance to recognized national standards of nursing care. Courts from other jurisdictions have similarly found or accepted testimony from experts that nurses have a duty to go up the chain of command if a treating physician refuses to address a risk noted by a nurse assessment and refuses orders addressing the patient's risk. See e.g. *Poor Sisters of St. Francis Seraph of Perpetual Adoration, Inc. v. Catron*, 435 N.E.2d 305 (Ind. Ct. App. 1982)[3]; *Gladney v. Sneed*, 742 So. 2d 642, 646 (La. App. 1999) (finding nurse testimony that hospital's failure to have a policy and nurses failure to intervene and go up "chain of command" to get a

[3]"[I]f a nurse or other hospital employee fails to report changes in a patient's condition and/or to question a doctor's orders when they are not in accord with standard medical practice and the omission results in injury to the patient, the hospital will be liable for its employee's negligence. ... Another nurse in ICU testified it is the duty of a nurse to report any critical condition to the doctor in charge and, if he did nothing, then to report the condition to her supervisor." 435 N.E.2d at 308.

transfer to a better hospital when doctor failed to do so supported assessment of partial fault to hospital); *Columbia Med. Ctr. of Las Colinas v. Bush*, 122 S.W.3d 835 (Tex. App. 2003); *Livingston v. Montgomery*, 279 S.W.3d 868 (Tex. App. 2009)[4]; *Ramos v. Kuzas*, 1992 Ohio App. LEXIS 680, *11 (Ohio Ct. App., Cuyahoga County Feb. 13, 1992). The presence of language in DRMC's nursing policies instructing nurses to implement specific treatment when ordered by a physician and setting out factors indicating when the treatment order should be present is not an indication that nurses have no duty to assess the patient's risk, no duty to request an order for the treatment for a patient at risk when they do not receive such an order, and no duty to report up the absence of such an order in a patient at risk. It is at least evidence the hospital acknowledges the existence of risk factors and the existence of appropriate means of avoiding an avoidable risk . Such a policy coupled with a nurse expert's testimony that nurses have such additional duties which were not carried out is sufficient to support the hospital's liability. See *Clark v. St. Dominic-Jackson Memorial Hosp.*, 660 So. 2d 970, 972-973 (Miss. 1995) (hospital must take measures to reduce or eliminate if possible a known risk in a patient at risk); *Univ. of Miss. Med. Ctr. v. Pounders*, 970 So. 2d 141, 148 (Miss. 2007) (same).

V. Conflicts Between the Record and DRMC's Arguments of Substantial Evidence

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[4]Breach of the nursing standard of care established by expert opinion that although a nurse is not the treating physician, he or she is an integral part of the "team" effort necessary to render the standard of such combined care. He or she has an obligation to act as his or her patient's advocate. The standard of care ... called for nurses to recognize the [danger presented by the ordered treatment], institute resuscitative measures, and discontinue [the medication ordered by the physician]. They have the added obligation to notify the nursing chain of command when such danger ... continues without being effectively addressed, i.e., discontinuing the augmentation orders contraindicated by the above conditions, or without effective remedy, i.e., Cesarean rescue.

279 S.W.3d at 872, n1.

Supporting Challenged Factual Findings

There are numerous factual allegations in DRMC's brief which are either unsupported by citations to the record or where the portions of the record DRMC cites fail to rise to the level affording a substantial basis of fact which reasonable minds might accept as adequate to support the fact in issue. Frequently, DRMC relies on drawing inferences from similarly sounding words without paying careful attention to the specific words being used and their medical or anatomical meanings. The length limitations on a reply brief do not permit the quotation of testimony on all such points here. In addition to the points discussed here, Ervin respectfully requests this Court to review the record excerpts and to compare the pages cited to both the factual statements in Ervin's briefs and DRMC's brief before making judgments as to whether the challenged findings are supported by substantial evidence in the record.

Causation

The Trial Court's factual finding on lack of proof of causation and DRMC's claim that it is supported by substantial evidence in the record rests on five premises: 1) Dr. Miller testified at trial that he could not say definitively where Ervin's pulmonary embolus originated; it could have been either in the legs or in the pelvis; 2) DRMC's expert witnesses testified unequivocally at trial Mrs. Ervin's pulmonary embolus originated in the pelvis, 3) the medical literature supports DRMC's expert's claim that Mrs. Ervin's pulmonary embolus originated from thrombi in the pelvis; 4) DRMC's expert witnesses testified unequivocally at trial Janice Ervin's death could not have been prevented by mechanical prophylaxis because they only prevent DVT in the legs and are of no use in preventing pulmonary emboli of the type Mrs. Ervin died from; and 5) the medical literature supports the claims of DRMC's expert witnesses that mechanical prophylaxis

would have been of no use in preventing the pulmonary emboli originating from Mrs. Ervin's pelvis. DRMC relies solely on pages 499-500 and 590-98 of the transcript to support this argument. However, when this testimony is compared to the scientific literature said to support it, the other scientific literature in the record, and in light of the other testimony of the same witnesses on other pages of the transcript, and without drawing unsupportable inferences from similarly sounding words which do not mean the same thing or a lack of understanding of anatomy and medical terms[5], it is clear the literature supports Dr. Miller's opinion that Mrs. Ervin more probably than not died from a pulmonary embolus that developed out of clotting activity in her legs that progressed into thrombi which broke off and moved on to her lungs. Any of the prophylactic measures would have helped her.

Dr. Miller testified in person at trial. His complete testimony appears at pages 100-201 of the trial transcript. He is never asked about and never even mentions the possibility the blood clot which became the pulmonary embolus that killed Mrs. Ervin might have originated in her pelvis. DRMC's counsel's memory of what he thinks Dr. Miller testified to at trial is simply inaccurate. Dr. Miller testified unequivocally it was his opinion the pulmonary embolus started out as a DVT in her leg, saying

> Q. ... as I understood it, you believe she had deep vein thrombosis. A blood clot formed in her leg and traveled up stream to her heart and lungs?
> A. That's my belief.
> Q. Yes, sir, that's your opinion. So, your opinion necessarily is that there was – as I understand it and appreciate it – there was a significant blood clot in her leg that traveled up stream, and that's what caused this?
> A. Yes.

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[5]The phrases "pelvic vein," "pelvic vessel," and "pelvic and femoral veins" may sound somewhat similar to the term "pelvis" but they are not synonymous. In particular, the femoral veins are located in the leg, not the pelvis.

Q. So, we have a large blood clot that went up stream, deep vein thrombosis, and that's what caused this pulmonary embolus to occur?
A. Yes.

(Tr. 191-192) There is no basis in this testimony (and DRMC cites no other) to support DRMC's argument and the Trial Court's finding that "Dr. Harold Miller, could not say definitely where Ervin's pulmonary embolus originated; it could have been either in the legs or in the pelvis."

DRMC cites only pages 499-500 of Dr. Reddix testimony where he states:

Q. ... Would TED hose or sequential compression devices have made in [sic] difference in the outcome of Janice Ervin?
A. Absolutely not, not in my opinion.
Q. And why is that?
A. Because I believe that this clot originated in her – in her pelvis. ...
Q. Okay, Doctor, the highlighted portion here, would you read that, please, sir?
A. Most pulmonary emboli and gynecological patients originate thrombi in the pelvic and femoral range. Predisposing factors find majority of women with pulmonary embolus coagulation is also dangerous, so the associated risk of Heparin treatment is a false positive diagnosis made. Heparin is the leading cause of drug-related deaths in hospitalized patients.[6]

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[6]This answer does not make grammatical sense. Upon reviewing the transcript, it is obvious the material was either transcribed or read incorrectly from the text leaving some words out. A copy of the document DRMC's counsel handed to Dr. Reddix to read from was not included in the record. However, at the time this reply brief was written, an unpaginated copy of Vern L. Katz, COMPREHENSIVE GYNECOLOGY, 5th ed. *Chapter 25 – Postoperative Counseling and Management : Fever, Respiratory, Cardiovascular, Thromboembolic, Urinary Tract, Gastrointestinal, Wound, Operative Site, Neurologic Injury, Psychological Sequelae* was available commercially online. The following quotation is provided for the court's assistance in understanding and intelligently evaluating the technical and scientific facts in evidence. *Samuels v. Mladineo*, NO. 89-CA-0952, 1992 Miss. LEXIS 702 (Miss. 1992)

KEY POINTS

...

• Thrombophlebitis most often begins in the deep veins of the calf. Approximately 75% of pulmonary emboli originate from a thrombus that begins in the leg veins and extends to the femoral veins.

Q. Do you agree with that statement, Doctor?
A. I have no reason to disagree. ...

(Tr. at 499-500) Dr. Reddix said a great deal more on the subject of causation which demonstrates his pelvis origination theory is sheer conjecture not supported by medical literature and that a reliable inference cannot be drawn from his testimony that Mrs. Ervin's clotting, which developed into the pulmonary emboli that killed her, did not start in her legs where mechanical prophylaxis would have helped.

Q. Doctor, are you aware that Dr. Miller, the Plaintiff's expert, testified that he believes the origin of the pulmonary embolus in this case was the legs?
A. Yes.
Q. Do you agree with that?
A. I disagree.
Q. All right, why is that?
A. Just that both of us are using conjecture, but I think statistically - uh - even when it's a gynecological patient or a surgery patient, most fatal emboli

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... Venous thrombosis and PE are the direct causes of approximately 40% of deaths in gynecologic cases. ... Because women often die within a few hours of the appearance of initial symptoms, emphasis must be placed on prevention rather than treatment of this complication. ... The process of thrombosis most often begins in the deep veins of the calf. It is estimated that 75% of pulmonary emboli originate from a thrombus that began in the leg veins. ... In approximately 1 in 20 cases the process extends centrally to the veins of the upper leg and pelvis. ... The site of initial formation of the thrombus is most often near the base of a valve cusp in the calf of the leg (Fig. 25-6). The thrombus propagates and grows by repetitive layers of platelet aggregation and deposition of fibrin from fibrinogen. The most recently formed portion of the propagating thrombi are free floating (not attached to the vein) and are most likely to become pulmonary emboli.

Pulmonary Embolus

Most pulmonary emboli in gynecologic patients originate from thrombi in the pelvic and femoral veins. Predisposing risk factors are found in the majority of women with PE. Anticoagulation therapy is also dangerous, as heparin is one of the leading causes of drug-related deaths in hospitalized patients.

originate in the pelvis, whether it's a male or female.[7] ...

Q. Doctor, to a reasonable degree of medical certainty - medical scientific certainty, where did the emboli come from that Mrs. Ervin experienced?

A. The pelvis. I believe the *femoral or the iliac vessels specifically.* ... The literature supports that.[8] ... I think clearly most blood clots - most deep vein thromboses are in the lower leg. So, statistically, the - uh - legs has the most number of clots. But when you're talking about – that's why I was very specific – fatal emboli ... . I said most deep vein thromboses are in the leg – in the lower leg. ... But most vein emboli originate in the pelvis. ... Well, the pelvis isn't a deep vein thrombosis. We're just talking about where it occurred. It occurred in the pelvis, and that's just a statistical probability. I can't – it's just conjecture on my part. I can't physically tell where the thrombus originated. It could have originated in the right heart.

(Tr. 502-507) Shortly after this testimony, Dr. Reddix read and agreed with the following statement from the American College of Gynecologists Practice Bulletin "Prevention of Deep Vein Thrombosis and Pulmonary Embolism:

> In the United States venous thrombus embolism remains the leading cause of death and morbidity among hospitalized patients. Over 60,000 deaths per year are contributed [sic - attributed] to venous thrombus embolism and the subsequently [sic] complications including post-traumatic [sic - postthrombitic] syndrome, venous insufficiency, pulmonary hypertension, and pulmonary dysfunction. Venous thrombus embolism often has no symptoms, and pulmonary embolism is not suspected clinically in 78% of patients and detected postmortem.

(Tr. 520; R. 481a; RE 22) Dr. Reddix went on to state he agreed with that statement and also that in reference to this statement from the ACOG Bulletin he had testified and was repeating "the most likely and most common place for a venous thrombosis embolism is in the lower leg." (Tr.

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[7]See previous footnote clearly demonstrating this statement is not true.

[8]The scientific literature demonstrates the femoral and iliac veins are common origination sites but they are in the leg, not the pelvis. (R. 492; RE. 29 - Dino W. Ramzi and Kenneth V. Leeper, *DVT and Pulmonary Embolism: Part I. Diagnosis*, 69#12 American Family Physician 2829-2836 (June 14, 2004)); see also footnote 3 demonstrating the activity starts in the lower leg and grows up toward the pelvis with the most recent parts at the top breaking off to form pulmonary emboli if DVT are not prevented from starting lower down and progressing up.

521) A few pages on, Dr. Reddix declined to answer questions related to the matters involving breathing and the lungs saying "I'm not qualified to - uh - offer an opinion ... .All my knowledge is below the pelvis." (Tr. 525-526) He simply doesn't have the expertise on this issue. The only thing that is clear here is that his testimony does nothing to assist the trier of fact in understanding the evidence or the scientific literature.

Dr. Rigdon was presented with the same excerpt from Katz's COMPREHENSIVE GYNECOLOGY which DRMC's attorney had asked Dr. Reddix to read. Unlike Reddix, he did not attempt to read it into the record. Instead he read it silently and when asked if it supported his opinion that Mrs. Ervin died from an embolism that started in her pelvis, he said

> And in most gynecological surgery, and certainly a hysterectomy, that surgery comes within the pelvis, the pelvic vein. The reference of the *femoral vein in the leg, of course, we know that they are another source of clots and emboli.* All the people who are having pelvic surgery is *less common in the pelvic veins*, but its more common in some other types of surgery. The remainder of that highlighted part - uh - I'm not sure what the question about that part is.

(Tr. 594) He did not refer to any other literature to support his testimony that Mrs. Ervin's pulmonary embolus was likely to have originated from the trauma of surgery in her pelvic area.

Most importantly, the trial court's findings on causation, which are crucial to his decision, were clearly based on the perception that Dr. Miller testified he could not say definitely where Ervin's pulmonary embolus originated in the legs or in the pelvis. (R. 587, RE 14) The transcript clearly demonstrates this is a mistaken view of Dr. Miller's testimony which has no basis in the actual evidence but developed solely from DRMC's counsel's misstatement of Dr. Miller's testimony in his closing arguments. Dr. Miller was never even asked if it was possible that Mrs. Ervin's pulmonary embolism originated in her pelvis and his testimony that it did originate in her

legs was not in any way equivocal. Moreover, his unequivocal testimony that it originated in her legs is clearly supported by the medical science and the literature in the record. There is simply no literature which says that it is more probable than not or that the majority of pulmonary emboli in gynecological patients originate in the pelvis. That conclusion can only be drawn from the literature if one reads out the words referring to the femoral and iliac veins of the leg.

DRMC also claims there was no evidence that a failure to provide oxygen to Mrs. Ervin during transport from her regular room to ICU contributed to her death because the trial court excluded such testimony by Dr. Miller as not being previously disclosed in his opinions. DRMC did attempt to keep out such evidence, but the trial court did allow hypothetical questions which do provide the necessary causation evidence. (Tr. 140-145) Moreover, as pointed out in the argument on that objection, this point was not raised in Dr. Miller's earlier disclosures because the testimony it relates to was not discovered until the discovery deposition of Nurse Natalie Fratizi Reed was taken shortly before trial. (Tr. 139-140) In such circumstances, *Banks v. Hill*, 978 So. 2d 663 (Miss. 2008) allows such testimony even though it was not in the earlier disclosures of expert opinion.

Other Issues With DRMC's Citations to the Record

DRMC repeated cites to "R.E. 5" or "R.E. 6," often but not always followed by references to "D.E.", in support of specific facts. Page 5 of the record excerpts is a citation to the first page of the Trial Court's Findings of Fact and Conclusions of Law. That page contains nothing more than a statement of who are the parties and some of the witnesses. It does nothing to support any specific fact or to show that any finding of the Trial Court is supported by substantial evidence in the record. Page 6 of the record excerpts continues listing the witness, including the experts and

sets out undisputed medical history prior to October 15, 2004. The last part of that page does begin to discuss the events of October 15, 2004, but again it does nothing to support or to show that any of the disputed findings of the Trial Court are supported by substantial evidence in the record. DRMC does not specify what the abbreviation "D.E." refers to and it does not correspond to any abbreviation used in the record excerpts or the record itself. The Ervins assume it is a reference to the Defendant's Trial Exhibits. It is also unclear which set of numbering DRMC is using, but the Ervins assume DRMC is referring to the numbers used by the Trial Court Clerk in sequentially numbering the pages of the defense exhibits.

At least the following statements in DRMC's brief suffer from such problems with their references to the record.

- DRMC's statement at D.B. at 12 that immediately after Mrs. Ervin's collapse in her room, the nurses put a non-rebreather mask on her to deliver supplemental oxygen at 10L per minute citing R.E. 5 and D.E. 054. D.E. 054 is the nursing notes for the time of collapse. It refers to providing oxygen at 10 liters but does not mention a non-rebreather mask.
- DRMC's statement at D.B. 12 and 33 that after Dr. Beckham ordered Mrs. Ervin's transfer to ICU, the nursing staff appropriately secured her and transferred her, with supplemental oxygen via mobile oxygen bottle, from the floor to the ICU citing R.E. 5 and D.E. 042, 054, and 055. None of these pages mention the staff appropriately securing Mrs. Ervin or a mobile oxygen bottle. They do not document the actual transfer. D.E. 042 is Dr. Beckman's exam note from the room and his decision to transfer. It says nothing about the nurses or the actual transport. D.E. 054 are the nurses notes in the

room concerning collapse ending with administration of Levenox and the call to ICU to secure a room. It says nothing about transport. D.E. 055 is the ICU narrative which does not start until Mrs. Ervin's arrival in ICU and the ICU staff began using an ambubag to manually breathe for her. All it says about transport is she arrived on a stretcher with three nurses and she was unresponsive is no breath or heart sounds on arrival.

- DRMC's statement at D.B. at 14 and 33 that Josh 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 citing R.E. 6 and Tr. 455-56, 460-64. At page 455 when asked if they had oxygen when the transfer began, Edwards said the oxygen was coming out of the wall in the room. On 456 he said he did not remember if portable oxygen was available on the floor or not or who went and got portable oxygen. He had no recollection of where they put the bottle, stating only where it was usually placed during transport of most patients. Pages 460-464 are a description of the deterioration of Mrs. Ervin's breathing and the retrieval of a manual bag and mask to try to restart her breathing as they got off the elevator at ICU and moved the final few feet into ICU. It says nothing about portable oxygen prior to her arrival on that floor.
- DRMC's statement at D.B. 16 that Dr. Miller 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 and that any one of the three would meet the standard of care in his community citing R.E. 6; Tr. 129, 131-34, 177, 181. Dr. Miller testified to what the standard of care had been in the OB-GYN community over a period of decades and how it had progressed over that period of time. He testified that the standard of care requiring

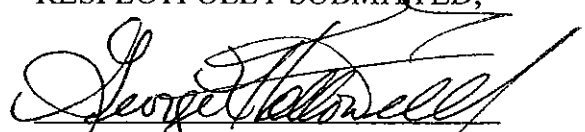
the use of some devices had existed over his entire career but the specific devices changed over time as technology improved and that ACE bandage are no longer used because better technology was developed and the standard of care kept up with the technology. (T. 129, 132)

These items along with other points presented in the Ervins' initial brief show the need to carefully evaluate whether the evidence does or does not rise to level of providing substantial evidence to support the Trial Court's Findings of Fact and Conclusions of Law which were based heavily on DRMC's Proposed Findings of Fact and Conclusions of Law.

CONCLUSION

The decision here rests upon technical, specialized or scientific knowledge and evidence. The subject matter is often not clearly understandable from short sound bites and snippets. This Court cannot determine whether there is substantial evidence to support the Trial Court's finding unless it considers enough of the medical science in context to understand and intelligently evaluate the facts in evidence. A careful examination of the science, the record and the briefs demonstrates the Trial Court findings are supported only by its mistaken view of the evidence and erroneous legal standards. Accordingly, the Judgment of the Trial Court should be reversed.

RESPECTFULLY SUBMITTED,



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CERTIFICATE OF SERVICE

Pursuant to M.R.A.P. Rule 25(a), I hereby certify that I have mailed the original and three (3) true and correct copies of the above and foregoing Brief of Appellant via First Class U.S. Mail to:

Hon. Betty W. Sephton
Clerk, Supreme Court of Mississippi
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Jackson, Mississippi 39205-0249

I further certify that I have mailed a true and correct copy of the above and foregoing Brief of Appellant via First Class U.S. Mail to:

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I further certify that pursuant to M.R.A.P. 28(m), that I have also mailed an electronic copy of the above and foregoing on an electronic disk and state that this brief was written in Wordperfect format.

This the 21st day of October, 2009.

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