IN THE SUPREME COURT OF THE STATE OF MISSISSIPPI

NO. 2009-CA-00672

MANDA GRIFFIN, INDIVIDUALLY AND AS A WRONGFUL DEATH BENEFICIARY, AND ON BEHALF OF ALL OTHER WRONGFUL DEATH BENEFICIARIES OF GRACIE M. STEPHENS, DECEASED — **APPELLANT**

V. — **NO. 2009-CA-00672**

NORTH MISSISSIPPI MEDICAL CENTER, INC. — **APPELLEE**

APPEAL FROM THE CIRCUIT COURT OF LEE COUNTY, MISSISSIPPI

BRIEF OF APPELLEE

ORAL ARGUMENT NOT REQUESTED

JOHN G. WHEELER, MB[redacted]
MITCHELL, MCNUTT & SAMS, P.A.
105 SOUTH FRONT STREET
POST OFFICE BOX 7120
TUPELO, MS 38802-7120
(662) 842-3871
ATTORNEY FOR APPELLEE

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CERTIFICATE OF INTERESTED PERSONS

The undersigned counsel of record for appellee, North Mississippi Medical Center, Inc., 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 judges of the Court of Appeals may evaluate possible disqualification or recusal.

1. Manda Griffin, plaintiff/appellant;
2. Hiawatha Northington, II, attorney for plaintiff/appellant;
3. Felecia Perkins, attorney for plaintiff/appellant;
4. North Mississippi Medical Center, Inc., defendant/appellee;
5. John G. Wheeler, attorney for defendant/appellee;
6. Mitchell, McNutt, and Sams, P.A., attorneys for defendant/appellee;
7. Honorable Paul S. Funderburk, circuit judge.

JOHN G. WHEELER, M[redacted]

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Rules

STATEMENT OF ISSUES

1. Whether the plaintiff, in order to avoid a directed verdict, was required to present competent expert testimony that, but for the alleged negligence of the defendant hospital, the plaintiff's decedent more likely than not would have survived.

2. Whether the plaintiff's expert offered, in more than a conclusory form, the equivalent of an opinion that, but for the alleged negligence of the defendant hospital, the plaintiff's decedent more likely than not would have survived.

3. Whether a plaintiff's burden to present expert testimony that, but for the alleged negligence of the defendant hospital, the plaintiff's decedent more likely than not would have survived in a medical negligence case arises only when the defendant presents testimony negating proximate cause.

4. Whether the plaintiff's expert was qualified to offer the requisite opinion as to proximate cause.

STATEMENT OF THE CASE

Course of Proceedings and Disposition in the Court Below

On August 13, 2001, the plaintiff, Manda Griffin ("Griffin"), filed a wrongful death claim against Terry Pinson, M.D., as the sole defendant, alleging that her mother, Gracie Stephens, died as a result of the negligence of Dr. Pinson during surgery he performed on Ms. Stephens at North Mississippi Medical Center ("NMMC") on January 4, 2001. (R. 1:11-14.)[1] After Dr. Pinson filed a motion for summary judgment on the ground that Griffin had not proffered any expert testimony to support the allegations of the complaint (R. 1:40-44), Griffin filed an amended complaint on January 30, 2002, adding NMMC as a defendant, alleging that NMMC was vicariously liable because nurses employed by NMMC had failed adequately to assess Ms. Stephens following surgery. (R. 2:222-226.) The trial court subsequently granted Dr. Pinson's motion for summary judgment.[2] The cause against NMMC went to trial on March 23, 2009. After Griffin rested her case, the trial court granted NMMC's motion for directed verdict on the ground that Griffin had failed to offer expert testimony that, but for the alleged negligence of the defendant hospital, Ms. Stephens would have had a greater-than-fifty-percent chance of survival. (R.E. tab 3; R. 10:334-35.) Judgment was entered in favor of NMMC on May 26, 2009. (R.E. tab 2; R. 7:932.) Griffin then brought this appeal from the final judgment. (R. 7:934.)

Statement of Facts

Gracie Stephens, a 61-year-old woman suffering from end-stage kidney disease, underwent surgery on January 4, 2001, at NMMC for the removal of an abdominal peritoneal dialysis catheter and the placement of a hemodialysis ("Mahurkar") catheter in her jugular vein.

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[1] Matters of record are cited herein as follows: "R" refers to the ten volumes of the record, excluding trial exhibits, consisting of the court's papers (Vols. 1-7) and the trial transcript (Vols. 8-10), with citations in the form volume: page(s), "R.E." refers to the mandatory record excerpts, and "A.R.E." refers to the appellee's record excerpts.

[2] The summary judgment was affirmed on appeal. *See Griffin v. Pinson*, 952 So. 2d 963 (Miss. Ct. App. 2006), *cert. denied*, 951 So. 2d 563 (Miss. 2007).

(Deposition of Dr. Terry Pinson, 29:5-22; 30:2-16, A.R.E tab 1, Exhibits Vol. 10 (hereinafter "Pinson dep.").)[3] The abdominal surgery to remove the peritoneal catheter was uneventful, but during the surgery to place the Mahurkar catheter in the neck, the surgeon, Dr. Terry Pinson, inadvertently punctured the back wall of the jugular vein and the front wall of the adjacent carotid artery. Dr. Pinson attempted to repair the punctures and completed the placement of the catheter in the jugular vein. (Pinson dep. 50:18-22; 56:11-22.)

After the surgery was completed, Ms. Stephens was taken to the recovery room,[4] where Sherry Crenshaw, a registered nurse employed by NMMC, attended to her. In the recovery room, the patient began having recurring episodes of hypotension (low blood pressure) and was treated for this by numerous attending anesthesiologists who supervised all personnel in the recovery room. After several medical interventions by Dr. Fulton Thompson and other anesthesiologists to treat the recurring hypotension, Ms. Stephens, at around 5:50 p.m., began having difficulty breathing, became very restless and uncooperative, and had developed a small hematoma or bruise at the incision site on her neck. (R. 9:264.) Dr. Thompson notified Dr. Pinson of these observations about six minutes later. (R. 9:278-79.) Because of concerns that the hematoma might be causing Ms. Stephens's breathing problem by compressing the airway, Dr. Thompson inserted a breathing tube into Ms. Stephens's throat, and Dr. Pinson elected to take Ms. Stephens back to surgery to determine if the hematoma was interfering with her

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[3] At trial, the plaintiff offered in evidence certain portions of the deposition of Terry Pinson, M.D. The deposition of Dr. Pinson had been marked as an exhibit by both parties (Exhibits P-10 and D-6). The portions to be offered were highlighted on Exhibit D-6, and those portions were read to the jury. The court reporter did not transcribe the questions and answers as they were read to the jury; instead, the transcript states that highlighted portions of Exhibit D-6 were read to the jury. (R. 10:320.) When the circuit court clerk copied the record for transmittal to the supreme court, the copier did not pick up all the highlighting marks on D-6, and thus the appellate record does not accurately convey the portions of the deposition of Dr. Pinson that were read to the jury. The Appellee's Record Excerpts sets out the pages of Dr. Pinson's deposition containing the portions read to the jury, highlighted to conform to Exhibit D-6 as contained in the circuit court's file, as evidenced by the clerk's certificate.

[4] In the trial transcript, the recovery room is sometimes referred to as the "PACU" (Post-Anesthesia Recovery Unit).

breathing and to evacuate the hematoma in the event it was compressing the airway. (Pinson dep. 58:22-60:14; 64:11-22.) After Ms. Stephens was intubated, but before Dr. Pinson began the surgery, Ms. Stephens went into cardiac arrest and sustained hypoxic brain damage. (*Id.* 64:22-23; appellant's brief 3.) She died on January 11, 2001.

The plaintiff's theory at trial was that Ms. Stephens's death was the result of continuing internal bleeding from the carotid artery damaged by Dr. Pinson during the original surgical procedure (R. 9:229-30, 265), and that Nurse Crenshaw breached the standard of nursing care and contributed to Ms. Stephens's demise by failing to interpret the recurring drops in Ms. Stephens's blood pressure together with the results of her post-surgery hemoglobin/hematocrit blood test and her restlessness and agitation as indicative of internal bleeding and by failing to notify Dr. Pinson of these events, though she admittedly notified Dr. Thompson and several other anesthesiologists. (R: 9:264.) In support of the claim that Nurse Crenshaw failed to meet the standard of care expected of recovery-room nurses, the plaintiff offered the testimony of Patricia Ross, a registered nurse. The plaintiff also call Dr. Richard Truly, accepted by the court as an expert in family medicine and emergency medicine, who, over the objection of the defendant that he was not qualified to do so (R. 9:231-33, 235), expressed the opinion that Nurse Crenshaw's alleged deviation from the standard of care was a proximate cause of the death of Ms. Stephens. (R. 9:272.) Dr. Truly did not, however, expressly, or even impliedly, state the opinion that, had Nurse Crenshaw notified Dr. Pinson at the time at which Nurse Ross and Dr. Truly believed she should have, it was more likely than not that Dr. Pinson would have intervened and that such intervention would have likely prevented Ms. Stephens's cardiac arrest and subsequent death. Because of this deficiency in Dr. Truly's testimony, the trial court held that the plaintiff had failed to make out a *prima facie* case of medical negligence and that NMMC was thus entitled to a directed verdict. (R. 10:334-35.)

SUMMARY OF THE ARGUMENT

In a medical negligence case where the plaintiff alleges that negligence of a health care provider diminished or negated a patient's chance of recovery or survival (termed a "loss of chance of recovery" case), the plaintiff, to prove the element of proximate cause, must present expert testimony that proper medical treatment would have provided the patient with a greater-than-fifty-percent chance of a substantially better result than was, in fact, obtained. That burden applies whether or not the defendant offers expert testimony negating proximate cause or challenges the plaintiff's expert on cross-examination with respect to the patient's chances of survival in the absence of the alleged negligence. The instant action is such a "loss of chance of recovery" case, because Griffin does not allege that the attending nurse inflicted any injury on the patient, but rather that the nurse's failure to appreciate the gravity of the patient's symptoms and take appropriate action deprived the patient of a chance of recovery by permitting her internal bleeding to go undiagnosed and untreated.

Griffin failed to sustain her burden to create a jury issue as to proximate cause, because she failed to present expert testimony opining that, if the attending nurse had reported the patient's symptoms to the attending surgeon at an earlier time, there was a greater-than-fifty-percent chance that the surgeon could have intervened to prevent the patient's death. Therefore, the trial court was correct in holding that Griffin's evidence was not sufficient to create a *prima facie* case as to proximate cause and in granting NMMC's motion for a directed verdict.

In any event, the plaintiff's expert was not qualified to express an opinion as to proximate cause, because establishing the likelihood of a successful surgical intervention requires the testimony of an expert in general surgery, and the plaintiff's expert admittedly had no expertise in surgery, and therefore, was not qualified to state an opinion as to proximate cause. Consequently, the expert's opinion as to proximate cause was incompetent and insufficient to

sustain Griffin's burden of production and proof to create a *prima facie* case. Therefore, the trial court's grant of a directed verdict in favor of NMMC was correct, and the judgment in favor of the defendant should be affirmed.

ARGUMENT

I. STANDARDS OF REVIEW AND PROOF

A. Standard of Review

Appellate courts review a trial court's grant of a directed verdict *de novo*, applying the same standards applicable in the trial court. *Troupe v. McAuley*, 955 So. 2d 848, 858 (Miss. 2007); *Alfa Mut. Ins. Co. v. Cascio*, 909 So. 2d 174, 177-78 (Miss. Ct. App. 2005). "In conducting such a review, [the court] 'must decide whether the facts presented, together with any reasonable inferences, considered in the light most favorable to the nonmoving party, point so overwhelmingly in favor of the movant that reasonable jurors could not have returned a verdict for the plaintiff.'" *Troupe*, 955 So. 2d at 858 *(quoting Robley v. Blue Cross/Blue Shield*, 935 So. 2d 990, 996 (Miss. 2006)). The court is to consider the evidence that is favorable to the nonmoving party, as well as any uncontradicted evidence that is not favorable to the nonmoving party. *Walker v. Reed*, 773 So. 2d 374, 376 (Miss. App. 2000). A trial court may grant a defendant's motion for directed verdict, "if, in the opinion of the court, the plaintiff has failed to present credible evidence to establish their necessary elements of his right to recover." *Cascio*, 909 So. 2d at 178.

B. Burden of Production and Proof

It is well-settled under Mississippi law that a plaintiff seeking to prevail in a suit based upon allegations of medical negligence against a hospital or health care provider must establish that (1) the defendant had a duty to act in accordance with an applicable standard of care, (2) the defendant failed to conform to the applicable standard of care in a causally significant fashion, and (3) the plaintiff suffered cognizable damages as a proximate result of the alleged breach of duty. *Hubbard v. Wansley*, 954 So. 2d 951, 956-57 (Miss. 2007); *Maxwell v. Baptist Mem'l Hosp. – Desoto, Inc.*, 15 So. 3d 427, 434 (Miss. Ct. App. 2008); *Lyons v. Biloxi H.M.A., Inc.*, 925

So. 2d 151, 154 (Miss. Ct. App. 2006). To establish a *prima facie* case of medical negligence against a defendant hospital or physician, a plaintiff must present competent expert testimony as to the applicable standard of care, breach thereof, and proximate causation. *Hubbard*, 954 So. 2d at 957.

In a case where it is not alleged that the defendant actively inflicted the injury but rather that that the defendant, by omission, allowed an injury or disease process to go untreated or be improperly treated—a "loss of chance of recovery" case—the plaintiff, in order to prove a causal connection between the alleged negligence and a patient's injury, must prove something beyond the mere loss of a chance of a better result. *Harris v. Shields*, 568 So. 2d 269, 273-74 (Miss. 1990); *Clayton v. Thompson*, 475 So. 2d 439, 445 (Miss. 1985) ("Mississippi law does not permit recovery of damages because of a mere diminishment of the 'chance of recovery'"). In such a case, "[r]ecovery is allowed only when the failure of the [health care provider] to render the required level of care results in the loss of a reasonable probability of substantial improvement of the [patient's] condition," *Clayton*, 475 So. 2d at 445 (*quoted in Ladner v. Campbell*, 515 So. 2d 882, 888 (Miss. 1987)), and the plaintiff must establish proximate causation by presenting expert testimony that "proper treatment would have provided the patient 'with a greater than fifty (50) percent chance of a better result than was in fact obtained.'" *Hubbard v. Wansley,* 954 So. 2d 951, 964 ¶ 42 (Miss. 2007)(*quoting Ladner*, 515 So. 2d at 889).

II. THE PLAINTIFF FAILED TO ESTABLISH A *PRIMA FACIE* CASE OF MEDICAL NEGLIGENCE BY FAILING TO PRESENT COMPETENT EXPERT TESTIMONY AS TO PROXIMATE CAUSATION, AND THUS, THE TRIAL COURT CORRECTLY GRANTED A DIRECTED VERDICT TO NORTH MISSISSIPPI MEDICAL CENTER.

A. This is a "loss of chance of recovery" case; therefore the plaintiff, in order to avoid a directed verdict, was required to present competent expert evidence that, but for the alleged negligence of the defendant hospital, the plaintiff's decedent more likely than not would have survived.

Griffin asserts that this case is not a "loss of chance of recovery" case because she did not plead it as such, and thus she was not required to offer expert testimony regarding "loss of chance." (Appellant's Brief 13). This argument is without merit.

A medical negligence action is considered a "loss of chance of recovery" case in circumstances where a health care provider's negligence "does not cause a patient's injury or death, but arguably hindered the patient from achieving reasonably probable and substantial recovery from injury." *Causey v. Sanders*, 998 So. 2d 393, 410 (Miss. 2008). In *Causey*, the plaintiff's mother was given palliative care for terminable pancreatic cancer, receiving hydromorphone for pain in increasing increments. *Id.* at 396. An autopsy revealed that the patient did not have pancreatic cancer and that she died of a massive dose of hydromorphone. *Id.* The plaintiff sued for wrongful death, and the jury found for the plaintiff. *Id.* at 398. On appeal, the defendant argued that the trial court erred by refusing to instruct the jury as to "chance of recovery." *Id.* at 399. In finding no error, this court noted that the defendant allegedly caused the death of the patient through his active negligence (i.e., ordering high doses of hydromorphone), rather than through inaction that merely hindered her recovery, and thus the "loss of chance of recovery" analysis was inapplicable. *Id.* at 410.

Causey thus illustrates the case where "loss of chance" does not apply and where expert testimony concerning the loss of a reasonable probability of recovery is not required. In contrast, in *Harris v. Shields*, 568 So. 2d 269 (Miss. 1990), it was the defendant's failure to act—the failure to take the patient's blood pressure—that allegedly failed to prevent a cerebral hemorrhage from occurring. *Id.* at 273.[5] Similarly, in *Hubbard v. Wansley*, 954 So. 2d 951 (Miss. 2007), the allegation was that the defendant did not summon a neurosurgeon soon enough,

[5] The court in *Harris* also noted that, as in this case, "No one suggests [the defendant] did anything which directly caused Judith's death," observing that, for instance, there was no allegation that the patient had an adverse reaction to the anesthetic. *Id.* at 271.

resulting in the patient's brain hemorrhage not being treated in time to avoid brain damage. *Id.* at 959-60. In both cases, the court applied the "loss of chance of recovery" analysis and held that the plaintiff was required to present specific expert opinion that, but for the alleged negligence, the patient would have had a greater-than-fifty-percent chance for a substantially better outcome. *See Hubbard*, 954 So. 2d at 963-64; *Harris*, 568 So. 2d at 274, 276-77. Similarly, in the instant case, it is alleged that the attending nurse's failure to act allowed internal bleeding to go undiagnosed and untreated. It is obvious that this case falls into the category of *Harris* and *Hubbard* rather than that of *Causey*. Indeed, the situation in *Hubbard* is, for all practical purposes, identical to this case—the defendant allegedly failed to notify a surgeon in time, purportedly resulting in brain damage caused by internal bleeding. Unlike the defendant in *Causey,* who ordered the overdoses of pain medication that killed the patient, NMMC is not alleged to have inflicted any injury on Ms. Stephens or performed any act that caused Ms. Stephens's alleged internal bleeding; Nurse Crenshaw did not perform surgery on Ms. Stephens—that was Dr. Pinson (a non-employee of NMMC), who was initially sued by Griffin, but was dismissed on summary judgment due to Griffin's failure to produce expert evidence to support her claim against him. The purported internal bleeding occurred as a result of complications from surgery performed by Dr. Pinson. As in *Harris* and *Hubbard*, the purported cause of Ms. Stephens's death, as it related to NMMC's case, was the failure to take action to intervene and prevent an untoward result that was in the process of occurring.

In sum, this is "a loss of chance of recovery" case, because the plaintiff's theory is that Nurse Crenshaw's alleged inaction prevented Dr. Pinson from performing some intervention which would have altered Ms. Stephens's outcome. Neither the framing of the plaintiff's pleadings nor the nature of the language used by the plaintiff's expert can alter the fundamental nature of the claim and relieve the plaintiff of her burden to offer expert testimony as to the loss

of chance of recovery. For the reasons set forth above, it cannot plausibly be argued that this is not a "loss of chance of recovery" case. Consequently, Griffin was required to present expert opinion that, had Nurse Crenshaw acted sooner to notify Dr. Pinson of Ms. Stephens's symptoms, Dr. Pinson could have and would have taken action that, more likely than not, would have prevented Ms. Stephens's death.

B. The plaintiff failed to present expert testimony that it was reasonably probable that Ms. Stephens would have survived in the absence of Nurse Crenshaw's alleged negligence, and thus, the trial court correctly granted a directed verdict in favor of NMMC.

Because the instant case is a "loss of chance of recovery case", Griffin was required to establish proximate cause by putting on expert evidence that a different outcome was reasonably probable but for Nurse Crenshaw's alleged negligence. *Hubbard v. Wansley,* 954 So. 2d 951, 964 (Miss. 2007); *Harris v. Shields*, 568 So. 2d 269, 274 (Miss. 1990). Specifically, Griffin was required to prove proximate causation by presenting expert testimony establishing that "proper treatment would have provided the patient 'with a greater than fifty (50) percent chance of a better result than was in fact obtained.'" *Ladner v. Campbell*, 515 So. 2d 882, 889 (Miss. 1987)(internal citations omitted). Therefore, in this case, since the patient died, the plaintiff's burden was to prove through expert testimony that if Nurse Crenshaw had met the standard of care as opined by the plaintiff's expert, Ms. Stephens likely would not have died.

In *Harris*, this court affirmed the grant of a directed verdict in favor of the defendant, a dentist, finding that the plaintiff failed to provide any proof regarding the probabilities that the death of the plaintiff's decedent would have been avoided had the defendant performed as the plaintiff's expert believed he should have. *Harris*, 568 So. 2d at 276. In *Harris*, the plaintiff's wife died from a cerebral hemorrhage, which occurred during the course of a dental procedure. The plaintiff's theory was that had the defendant checked the patient's blood pressure prior to administering an anesthetic for her dental procedure, he would have learned that she was

hypertensive and thus in danger of suffering a cerebral hemorrhage. In affirming the trial court's grant of a directed verdict, this court stated,

> We find nothing offered by [the plaintiff's expert]—or anyone else—of the chances of sparing [the patient's] life, had Dr. Shields behaved as [the plaintiff's expert] thinks he should have. No proof before us affords a basis for seeing those chances in the 90 percent range, or 98 percent, for that matter, or as low as ten percent or even two percent. . . . Seen in this view, plaintiff's proof—and his proffer through [his expert]—legally fail.

Id. at 276.

Griffin attempts to distinguish *Harris* by arguing that, in *Harris*, "the discussion of the need for testimony regarding a fifty percent or greater chance of recovery was made in the context of discussion of proper jury instructions – after a matter has been submitted to the jury at the close of the evidence." (Appellant's brief 13-14.) Griffin, however, misreads that case; *Harris*, in fact, involved the same issue presented here—whether the plaintiff had presented sufficient evidence of causation to avoid a directed verdict—not whether the jury was properly instructed. *See Harris*, 568 So. 2d at 276-77.

Like the plaintiff in *Harris,* the plaintiff in the present case failed to make out a *prima facie* case of medical negligence against NMMC because her medical expert, Dr. Richard Truly, did not offer any opinion as to the chances of sparing the life of Ms. Stephens had Nurse Crenshaw's care of Ms. Stephens been exactly as it allegedly should have been. Importantly, Dr. Truly did not offer any testimony that, had Nurse Crenshaw timely and personally notified Dr. Pinson of Ms. Stephens's condition, she would have had a reasonably probable chance (greater than fifty percent) of survival. Dr. Truly testified as follows:

> Q: Dr. Truly, do you have an opinion as to whether or not failures or omissions of North Mississippi Medical Center caused or contributed to Ms. Stephens' death?
>
> A: Yes.

Q: Please share that opinion with the jury.

A: My opinion is that the – that the negligence on behalf of the hospital contributed and proximately caused her death by the mere fact that there was – one, there was a failure to recognize the significance of a failing blood pressure, couple with a falling hematocrit, couple with a patient who is uncooperative and restless, coupled with the change in her status, coupled with air hunger.

So there was a failure of the hospital to respond to these changes of a falling blood pressure and a falling hematocrit or hemoglobin.

(R. 9:272). The plaintiff asserts that, through this testimony, she met her burden of proving proximate causation, because experts are not required to use "magical language"—in this case the "greater-than-fifty-percent chance" formulation—as long as the testimony has the same import,[6] and Dr. Truly's opinion that Nurse Crenshaw's alleged negligence was a proximate cause of Ms. Stephens's death is sufficient. However, for the reasons set forth below, this argument is without merit.

First, the import of what Dr. Truly actually said is not clearly to the same effect as a statement that Ms. Stephens would have had a greater-than-fifty-percent chance of survival if Nurse Crenshaw had notified Dr. Pinson personally and sooner. Dr. Truly said that proximate cause followed "merely from the fact" that Nurse Crenshaw did not recognize the symptoms of internal bleeding. In other words, what Dr. Truly said was that there was proximate cause merely from the facts that (allegedly) Ms. Stephens was bleeding internally, Nurse Crenshaw failed to recognize the symptoms (and inform Dr. Pinson) and Ms. Stephens died from the internal bleeding. Dr. Truly's opinion, as stated, completely ignores the issue of whether

[6] Plaintiff asserts that "none of the cases cited in *Harris* mentioned an expert having to specifically quantify in testimony a particular percentage greater than fifty percent of a better outcome." (Appellant's brief 14.) However, the defendant has not argued, the trial court did not hold, and *Harris* did not hold, that an expert has to state a specific percentage greater than fifty, but only that that the expert must state that the **probability** of a substantially better outcome (in this case, survival) was greater than fifty percent, or more likely than not. Therefore, the plaintiff's assertion, while correct, is beside the point.

surgical intervention after the critical point—the time when Ms. Stephens's symptoms reached the level that the obligation to summon Dr. Pinson arose—would have, to a reasonable degree of probability, saved her life.

Second, even if Dr. Pinson's testimony were deemed to have the same import as the "magical words," those "magical words" are, without more, insufficient to sustain the plaintiff's burden. In *Hubbard*, the plaintiff's expert, Dr. Stringer, used the "magical words," submitting an affidavit stating that "had Ruby Hubbard been treated properly by Dr. Wansley, or if Dr. Wansley had notified appropriate personnel, it is my opinion that Ruby Hubbard would have had a greater than fifty percent chance of reduced neurological injury." 954 So. 2d at 965 ¶ 47. This court, however, held that the expert's opinion, despite the "magical language," was insufficient to create a *prima facie* case, because, the court said,

> The language of Dr. Stringer's affidavit is almost wholly conclusory on the issue of causation and gives very little in the way of specific facts and medical analysis to substantiate the claim that Hubbard had a greater than fifty percent chance of substantial recovery if she had received the 'optimal care' of which Dr. Stringer spoke.

Id. at 965-66 ¶ 48. Thus, an expert's opinion as to "loss of chance," to be sufficient to satisfy the plaintiff's burden to avoid a directed verdict, must set forth "specific facts and medical analysis" explaining why the patient would have had a greater-than-fifty-percent chance of recovery but for the alleged negligence of the defendant.

The above-referenced testimony from Dr. Truly as to proximate causation is "wholly conclusory" and "given with no real facts to back it up." *Id.* As such, it is insufficient to create a genuine issue of material fact as to causation under the standard of *Hubbard*. The only facts given by Dr. Truly to back up his opinion that the alleged negligence of Nurse Crenshaw was the proximate cause of Ms. Stephens's death were the alleged breaches of the standard of care themselves. At no point did Dr. Truly give any supportive medical analysis or explanation to

show that, had Nurse Crenshaw reported the critical symptoms to Dr. Pinson, his surgical intervention would have altered Ms. Stephens's outcome and prevented her death.

According to Griffin's evidence, the obligation to suspect internal bleeding and summon the surgeon came well into the course of Ms. Stephens's stay in the recovery room. Dr. Truly testified as follows:

> When you go back and look at the record, she is calm, she has good strength, but around about 17:50, which is 5:50, she is uncooperative. She is pulling off her oxygen. She is pulling off her blood pressure cuff. She is flailing around in the bed. She falls back. She is restless. In the presence of a falling blood pressure and in the presence of a falling hematocrit, when patients become restless and uncooperative, and there is a change in their status and they develop this kind of – kind of air hunger, that means that they are bleeding. There is a change in her status. So *at this particular time* something needs to be done.

(R. 9:264 (emphasis added).)[7] Dr. Truly admitted that Dr. Pinson was notified about six minutes after these events began. (R. 9:278-79.)[8] Dr. Truly also testified that Ms. Stephens suffered cardiac arrest about 26 minutes after these events. (R. 9:264.) Thus, to be sufficient to establish to a reasonable degree of medical probability that the alleged delay in notifying Dr. Pinson prevented Ms. Stephens from surviving, Dr. Truly's testimony would have to explain, with specific facts and medical analysis, how and why surgical intervention by Dr. Pinson to stop the alleged internal bleeding would have been successful and saved the patient's life if undertaken at

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[7] There was testimony by Patricia Ross and Dr. Truly that Nurse Crenshaw should have notified Dr. Pinson of Ms. Stephens's status at an earlier time (4:57 p.m.), when Nurse Crenshaw observed edema or swelling at the incision site on the neck. However, Dr. Truly's opinion concerning proximate cause set forth above does not causally link that event to Ms. Stephens's death. In any event, it would be the plaintiff's burden to support an alleged causal connection with a non-conclusory expert opinion sufficient to meet the *Hubbard* standard. To meet that standard, Dr. Truly would have to explain, *inter alia*, why notification at that earlier time would have made a difference in light of the fact that Dr. Pinson testified without controversion that he was notified by Dr. Thompson, the anesthesiologist, of Ms. Stephens's status at 4:57 p.m. and yet Dr. Pinson did not decide that surgical intervention was needed at that time. (Pinson dep. 57: 21-24, A.R.E. tab 1.) Dr. Truly offered no such analysis.

[8] When confronted with the evidence that Dr. Pinson had been notified by Dr. Thompson at the purported critical juncture by an attending anesthesiologist, Patricia Ross maintained that Nurse Crenshaw should have notified Dr. Pinson also. However, the plaintiff presented no evidence that Dr. Pinson would have acted differently had he been notified by Nurse Crenshaw herself, instead of Dr. Thompson, about Ms. Stephens's condition.

that time or, stated another way, how notification of, and intervention by, Dr. Pinson six minutes sooner would have made any difference. In particular, Dr. Truly had to explain how an earlier notification of Dr. Pinson would have made a difference with respect to timely arresting the alleged internal bleeding, when it is uncontroverted that Dr. Pinson, when notified, did not elect to explore possible massive blood loss from the carotid artery, but rather decided to investigate whether a hematoma at the external wound site was interfering with Ms. Stephens's breathing and to evacuate the hematoma if it was impinging on the airway. (Pinson dep. 58:22—60:14; 64:11-22, A.R.E. tab 1.) The conclusory opinion of Dr. Truly is completely devoid of any medical analysis with respect to these matters. Therefore, it is not sufficient under the *Hubbard* standard to sustain the Griffin's burden to avoid a directed verdict.

Nevertheless, Griffin asserts that "it reasonably can be inferred from the testimony presented by Dr. Truly that the loss of blood that caused Ms. Stephens's death would have been averted with surgical intervention." In support of her argument, Griffin cites *Hammond v. Grissom*, 470 So. 2d 1049 (Miss. 1985), in which the court reversed a directed verdict for the defendant despite the absence of any mention in the opinion of explicit expert testimony concerning "loss of chance." However, for the following reasons, *Hammond* is inapposite and non-instructive.

First, it does not appear from the opinion in *Hammond* that the defendant raised, or that the court considered, the issue of the sufficiency of evidence as to proximate cause. Rather, the sole issue addressed by the court in *Hammond* was whether there was sufficient evidence of negligence to avoid a directed verdict despite the absence of expert testimony for the plaintiffs as to negligence.[9] The court found that, in light of the egregious neglect of the patient by the

[9] The trial court had erroneously excluded the plaintiffs' proffered expert. Although the court stated that it could not properly reverse *solely* on that basis because the plaintiffs had not made an offer of proof of the expert's testimony, the court cited the error as a factor in reversal. *Hammond*, 470 So. 2d at 1052-53, 1054.

healthcare defendant, which the court characterized as the complete absence of care, the case was one of the rare cases where the expert testimony of a physician was not necessary to make out a *prima facie* case of negligence. *Id.* at 1054-55. Consequently, since *Hammond* addressed only the quantum of evidence necessary to establish medical negligence, the case is not authoritative as to the evidentiary standards for proving proximate cause in a "loss of chance" case.

Second, in any event, *Hammond* was decided prior to *Harris v. Shields*, which unequivocally established the requisites for expert opinion in a "loss of chance case." Thus, even if the "greater-than-fifty-percent chance" formulation was not clearly the law, or was not uniformly applied by the courts, at the time *Hammond* was decided, it is unquestionably the standard today, under the authority of *Hubbard* and *Harris*. In short, *Hammond* does not support Griffin's position.

For the foregoing reasons, the plaintiff failed to meet her burden as to proximate cause. Accordingly, the trial court was correct in granting a directed verdict in favor of NMMC.

C. The plaintiff, not NMMC, had the burden of production and proof as to proximate cause.

The plaintiff argues that the burden to offer expert testimony establishing that proper treatment would have provided the patient with a greater-than-fifty-percent chance of survival does not arise until the defendant first submits sworn expert evidence *negating* proximate cause. (Appellant's brief 16-17.) Griffin also asserts that NMMC had the burden to "challenge Dr. Truly" on cross-examination by questioning him as to whether "Ms. Stephens would have died regardless of the nurses' actions or inactions." (Appellant's brief 15.) In other words, the plaintiff's contention is that a plaintiff's expert need say nothing about "loss of chance" on direct examination, and the defendant must either put the "loss of chance" question to the expert on cross-examination and get an admission of no causal connection, or present its own witness negating proximate cause, in order to be in a position to obtain a directed verdict. Of course, the

plaintiff cites no authority stating that novel proposition, because that simply is not the law in Mississippi.

As set forth above, under Mississippi law, a plaintiff has the burden to present expert evidence in her case in chief sufficient to create a jury issue that (1) the defendant had a duty to act in accordance with an applicable standard of care, (2) the defendant failed to conform to the applicable standard of care in a causally significant fashion, and (3) the plaintiff suffered damages as a proximate result of the breach of duty. *See Hubbard v. Wansley*, 954 So. 2d 951, 956-577 (Miss. 2007); *Travis v. Stewart*, 680 So. 2d 214, 218-19 (Miss. 1996); *Maxwell v. Baptist Mem'l Hosp. – Desoto, Inc.*, 15 So. 3d 427, 434 (Miss. App. 2008). In a "loss of chance" case, the burden to offer expert testimony demonstrating proximate cause includes the burden to offer a non-conclusory expert opinion that, but for the defendant's negligence the patient, more likely than not, would have had a substantially better outcome. *Hubbard*, 954 So. 2d at 965-66; *Harris v. Shields*, 568 So. 2d 269, 274 (Miss. 1990). It is well settled under Mississippi law that a plaintiff has the burden of production as well as the burden of proof as to proximate causation. The plaintiff's argument attempts to flip the burden of production as to proximate cause. While Griffin is correct that a plaintiff has no burden to "prove matters beyond what the elements of a cause of action require," that statement overlooks the point that, in a "loss of chance" case, "the elements of a cause of action" include proof that the patient more likely than not would have survived but for the defendant's negligence.

Griffin erroneously contends that *Harris v. Shields* implicitly supports her position that the defendant has the burden to offer evidence negating causation, and attempts to distinguish *Harris* from the present case, because the defendant in *Harris* offered the testimony of an expert who opined that the patient's cerebral hemorrhage would have happened even if the defendant had detected high blood pressure and terminated the procedure. However, the court expressly

stated that defendant's directed verdict "does not hang upon any acceptance of [the defense expert's] coincidence theory, but rather on whether the plaintiff presented a credible case that the [defendant's negligence] was a substantial contributing cause of [the decedent's] death." *Id.* at 275. In *Harris*, the plaintiff's case foundered because the expert's opinion that the patient's blood pressure was dangerously high when the procedure was commenced was based on speculation, and his opinion that high blood pressure and the continuation of the anesthesia caused the cerebral hemorrhage was "conclusory." *Id.* at 275, 276. Nothing in the court's opinion suggests that the plaintiff would not have had to offer evidence as to the probability of the patient's survival if the defendant had not offered expert testimony to the contrary. The court in *Harris* specifically held that the plaintiff had to prove proximate causation by presenting credible evidence that showed that, had the defendant not breached the standard of care, the plaintiff's decedent "probably would not have lost her life." *Id.* at 275.

Griffin also asserts that *Hubbard v. Wansley*, 954 So. 2d 951 (Miss. 2007) "should be viewed with skepticism when applied to this case" because the plaintiff's expert in *Hubbard* admitted in his deposition that the plaintiff's injury could have resulted despite the alleged negligence of the defendant healthcare provider. (Appellant's brief 16.) That fact, however, does not render *Hubbard* inapposite. First, the admission that the plaintiff's permanent neurological injuries *could* have happened even with proper treatment was not a concession that there was no proximate cause. In any case in which the chance of a better outcome is greater than fifty percent but less than 100 percent, the untoward result *could* have happened anyway; the plaintiff's burden in not to show a better outcome was *certain*, only greater than fifty percent. Thus, the expert's deposition testimony was not an admission that there was no "loss of chance." In fact, the expert testified that the patient had suffered consequences as a result of the improper medical treatment and that, while such adverse consequence could happen even with proper

treatment, the risk of such consequences would be reduced with proper treatment. *Id.* at 965. That testimony, however, was insufficient because it failed to say that the risk would have been reduced enough to make a substantially better outcome more likely than not. Second, the expert in *Hubbard* subsequently submitted an affidavit explicitly opining that, if the plaintiff had received proper treatment, she would have had a greater-than-fifty-percent chance of a substantially better outcome. *Id.* The case turned on the fact that the opinion in the affidavit was "almost wholly conclusory," lacking "specific facts and medical analysis." *Id.* at 965-66 ¶ 48. *Hubbard* cannot plausibly be construed as holding that a defendant has a duty to cross-examine the plaintiff's expert as to whether the injury sustained by the plaintiff would have occurred anyway. Therefore, contrary to Griffin's assertion, NMMC did not have the burden of suggesting on cross-examination of Dr. Truly that "Ms. Stephens' death was inevitable" and would have occurred anyway, nor did it have the burden to "ask Dr. Truly to quantify the chance of an alternative outcome." Because the plaintiff failed to present any expert evidence at all regarding Ms. Stephens's chances of recovery had Nurse Crenshaw performed as Dr. Truly and Nurse Ross believe she should have, the plaintiff failed to meet her burden of proof or production as to proximate cause. Thus, the trial court's grant of a directed verdict in favor of NMMC was correct.

III. DR. TRULY WAS NOT QUALIFIED TO GIVE AN OPINION AS TO THE PROBABILITY OF MS. STEPHENS'S CHANCE OF RECOVERY OR SURVIVAL.

Even if Dr. Truly's testimony were to be construed as sufficiently opining as to the "loss of chance," such testimony is incompetent, because Dr. Truly does not possess the necessary expertise to be able competently to state an opinion that Ms. Stephens probably would have survived but for the defendant's alleged negligence. Dr. Truly, whom the trial court accepted as an expert only in family medicine and emergency medicine (R. 9:227), is not a surgeon and is admittedly not an expert in the field of surgery. (R. 9:223.) Accordingly, as NMMC asserted at

trial (R. 9:231-35), he was not qualified to opine as to the causal connection between the alleged fault of Nurse Crenshaw and Ms. Stephens's death.

As noted above, Dr. Truly testified as follows:

> When you go back and look at the record, she is calm, she has good strength, but around about 17:50, which is 5:50, she is uncooperative. She is pulling off her oxygen. She is pulling off her blood pressure cuff. She is flailing around in the bed. She falls back. She is restless. In the presence of a falling blood pressure and in the presence of a falling hematocrit, when patients become restless and uncooperative, and there is a change in their status and they develop this kind of – kind of air hunger, that means that they are bleeding. There is a change in her status. So *at this particular time* something needs to be done.

(R. 9:264 (emphasis added).) According to Dr. Truly, the above-described combination of symptoms, occurring at 5:50 p.m., necessitated the summoning of the surgeon, Dr. Pinson. Dr. Truly testified that Ms. Stephens suffered cardiac arrest about 26 minutes later, at 6:16 p.m., and he admitted that Dr. Pinson was notified about 5:56 p.m. (R. 9:264, 278-79.) Consequently, the issues for proximate cause, under the plaintiff's theory of cause of death, are whether surgical intervention by Dr. Pinson to stop the alleged internal bleeding would have been successful if undertaken as soon as possible after 5:50 p.m., when the symptoms reached critical mass and Nurse Crenshaw purportedly should have notified Dr. Pinson, or whether Ms. Stephens was too far gone from blood loss by that time for surgery to have saved her, and whether the six minutes between 5:50 p.m. and 5:56 p.m., when Dr. Pinson was called, would have made a difference in the outcome. Since Dr. Truly is not an expert in surgery, he is not competent to state an opinion on any of those issues.

The admission of expert testimony is governed by Rule 702 of the Mississippi Rules of Evidence, which provides:

> If scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education, may testify thereto in the form of an opinion or otherwise, if (1) the testimony is based upon

> sufficient facts or data, (2) the testimony is the product of reliable principles and methods, and 3) the witness has applied the principles and methods reliably to the facts of the case.

Miss. R. Evid. 703. Accordingly, a witness will qualify as an expert on a particular topic only if he or she "possesses scientific, technical or specialized knowledge" on that topic. *Thompson v. Carter,* 518 So. 2d 609, 615 (Miss. 1987).

In *Hubbard v. Wansley,* 954 So. 2d 951 (Miss. 2007), this court stated that it was "illogical to allow a proposed expert to testify as to the standard of care of a specialty with which he has demonstrated no familiarity." *Id.* at 958 ¶ 17. In that case, the plaintiff proffered a neurosurgeon to give an opinion on the standard of care of an internal medicine physician. The trial court found that the proffered expert "did not consider himself to be an expert in the field of internal medicine," "had never practiced primary care medicine," "had never held medical staff privileges that would entitle him to do so," and had testified that he had not "recently read the internal medicine treatises" with which the plaintiff claimed he was familiar. *Id.* at 957-58 ¶16. The trial court did not allow the testimony, and this court affirmed that decision. *Id.* at 958.

Similar to the situation in *Hubbard*, Dr. Truly does not consider himself to be an expert in the field of general surgery, has never practiced as a general surgeon, and has never held medical staff privileges that would entitle him to practice as a general surgeon. (R. 9:223-24.) The plaintiff presented no evidence that Dr. Truly had any familiarity with the standard of care that would be required of a surgeon in treating a patient's blood loss after the puncture of her jugular vein and carotid artery during surgery. Therefore, applying the same standard as in *Hubbard*, Dr. Truly is not qualified to testify as to what a surgeon could or would have done when confronted with Ms. Stephens's symptoms, and, in particular, whether anything could have been done to save Ms. Stephens after the time when notification of Dr. Pinson was allegedly necessary. Accordingly, any opinion by Dr. Truly related to proximate cause is incompetent and

thus insufficient to sustain the plaintiff's burden of production to avoid a directed verdict. Consequently, regardless of the sufficiency of the form and content of Dr. Truly's testimony, Griffin failed to make out a *prima facie* case of medical negligence, and NMMC was entitled to a directed verdict.

CONCLUSION

For the reasons set forth above, the trial court was eminently correct in granting a directed verdict in favor of NMMC based on its holding that Griffin failed to establish a *prima facie* case of medical negligence because Dr. Truly did not state the opinion that, but for the alleged negligence of NMMC's nurse employee, the plaintiff's decedent would have had a greater-than-fifty-percent chance of surviving. Even if the expert testimony offered by Griffin was sufficient in content to support a *prima facie* case, the granting of a directed verdict for NMMC was still correct, because the plaintiff's expert was not qualified to offer the opinion necessary to establish proximate cause. Accordingly, the judgment of the trial court should be affirmed.

JOHN G. WHEELER, MB [redacted]
MITCHELL, MCNUTT & SAMS, P.A.
105 SOUTH FRONT STREET
POST OFFICE BOX 7120
TUPELO, MS 38802-7120
(662) 842-3871
ATTORNEY FOR APPELLEE, NORTH
MISSISSIPPI MEDICAL CENTER, INC.

CERTIFICATE OF SERVICE

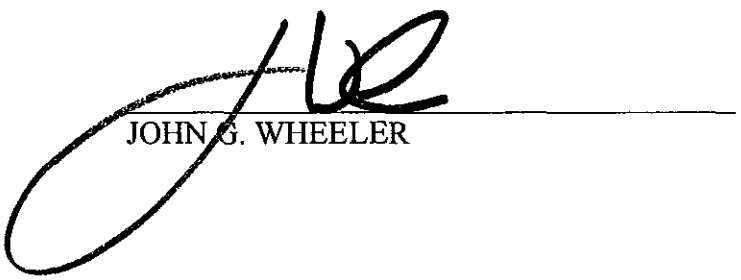
I certify that I have this day served a true and correct copy of the above and foregoing Brief of Appellee on the attorneys for appellant and the trial court judge, by placing said copy in the United States Mail, postage prepaid, addressed to them at their usual addresses as follows:

Hiawatha Northington, II
Smith & Fawer, LLC
774 Avery Boulevard North
Ridgeland, Mississippi 39157

Felecia Perkins
Law Offices of Felecia Perkins, P.A.
Post Office Box 21
Jackson, Mississippi 39205

Honorable Paul S. Funderburk
Circuit Court Judge
Post Office Box 1100
Tupelo, Mississippi 38802-1100

This the 12th day of April, 2010.



JOHN G. WHEELER

CERTIFICATE OF FILING

The undersigned, an employee of Mitchell, McNutt & Sams, P.A., certifies that on April 12, 2010, he/she deposited in Federal Express overnight delivery, addressed to the clerk of the Mississippi Supreme Court, the original and three copies of the Brief of Appellee.

JOHN G. WHEELER