IN THE SUPREME COURT OF MISSISSIPPI

KEVIN BERRY — APPELLANT

v. — CASE NO. 2009-TS-01441

ORA L. PATTEN, as next friend of
BIANCA PATTEN,
SHADARRYLHARDNETT,
and MARIAH PATTEN — APPELLEE

APPEAL OF LAFAYETTE COUNTY CIRCUIT COURT CASE NO.LO2-138

BRIEF FOR APPELLEE

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ORAL ARGUMENT NOT REQUESTED

CERTIFICATE OF INTERESTED PERSONS

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

1. Ora L. Patten.....Plaintiff/Appellee
2. Bianca Patten.....Child of Sheila Patten
3. Shadarryl Hardnett.....Child of Sheila Patten
4. Mariah Patten.....Child of Sheila Patten
5. Sheila Patten.....Decedent
6. William C. Walker, Jr.....Attorney for Plaintiff/Appellee
7. L. Carl Hagwood.....Attorney for Defendant/Appellant
8. Christopher W. Winter.....Attorney for Defendant/Appellant
9. Mary Frances S. England.....Attorney for Defendant/Appellant
10. Duke Goza.....Attorney for Defendant/Appellant

This the 15th day of March, 2010.

Wm. C. Walker, Jr.

William C. Walker, Jr.
Attorney of record for Appellee

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v. **CASE NO. 2009-TS-01441**

ORA L. PATTEN, as next friend of BIANCA PATTEN, SHADARRYLHARDNETT, and MARIAH PATTEN **APPELLEE**

STATEMENT OF ISSUES

1. Whether Plaintiff proved her case by a preponderance of the credible evidence that Defendant breached an applicable standard of care which proximately caused Sheila Patten's aspiration and ultimate death?
2. Whether Jury Instruction P-6A was a proper instruction, especially when properly considered with all the jury instructions on standard of care and proximate cause which were given?
3. Whether the trial court followed clear and unquestioned Mississippi statutory and decisional law in refusing to fragment this wrongful death suit or otherwise complicate it procedurally?
4. Whether Dr. Mackey's deposition was properly read to the jury?
5. Whether Jury Instruction D-15 was properly refused?
6. Whether the trial judge abused his discretion in striking Juror #26, Bradley S. Knight, an employee of Duke Goza, one of Appellant's attorneys?

STATEMENT OF THE CASE

i. Course of Proceedings Below

The Complaint in this matter was filed on April 17, 2002. (R.Vol.1, pp.1-4) Although Baptist Memorial Hospital and James Robert Barnes were also sued as Defendants in the original Complaint, the suits against them were subsequently voluntarily dismissed by Plaintiff. Discovery was conducted. On March 5, 2009, a hearing was had on Defendants' Motion to Dismiss. That Motion was denied by Order of March 9, 2009. (R.Vol.2, p.230) The trial of this matter then commenced. On March 11, 2009, the jury found for Plaintiff against Defendant Kevin Berry only and awarded damages of $1,150,000.00. (R.Vol.2, p.282) Judgment was entered thereon on April 6, 2009. (R.Vol.2, p.283) Defendant Berry filed a Motion for Judgment notwithstanding the verdict, Motion for a New Trial or, alternatively, Motion for Remittitur on April 13, 2009. (R.Vol. 2, p.285) After Plaintiff filed a response and a hearing was had, an opinion denying the Motion was rendered on August 25, 2009. (R.Vol.3, pp.313-315) On September 1, 2009, Defendant/Appellant filed his Notice of Appeal. (R.Vol.3, p.316)

ii. Statement of Facts

This statement of facts complies with the standard of review applicable to motions for judgment notwithstanding the verdict and/or motions for directed verdict. The standard, with citation to authorities, is quoted on pp.21 and 22 in Appellant's Brief. Thus, the evidence viewed in the light most favorable to Appellee, giving Appellee the benefit of all favorable inferences that may be reasonably drawn from such evidence, will be presented.

It is undisputed that after having undergone gastric bypass surgery on April 17,

2000, the day after Sheila Patten was discharged, she returned to Baptist Memorial Hospital Emergency Room on April 26, 2000 and was admitted for a small bowel obstruction. Ms. Patten was scheduled to undergo an exploratory laparotomy. In connection with that procedure to be performed by a surgeon, Dr. Barnes, anesthesia was to be administered. The anesthesia care plan generated by Dr. Roller, a board certified anesthesiologist, provided for general anesthesia with "rapid sequence induction."[1] (D.E.7 at BMH 239; RE2; Appellant's Brief, p.6-8)

After Ms. Patten had been placed in the supine position on the operating table, and after a paralytic drug had been given to her, CRNA Kevin Berry (Appellant) noticed beige fluid coming from Ms. Patten's nose. He immediately put a tube down into her lungs. He then forced air through the tube into her lungs, causing the fecal matter which was coming up (being aspirated) to be forced deep down into her lungs. (R.Vol.9, pp.295-296) Although he has testified he placed her in Trendelenburg position after the placing of the tube and forcing of the air into her lungs, the medical record does not reflect that he ever placed her in Trendelenburg position, and Dr. Jones testified that when he came in the operating room, she was not in Trendelenburg position. (R.Vol.9, p.294) Dr. Jones admitted that the aspiration in question caused Ms. Patten to

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[1] Appellant's attorney maintained from opening statement throughout trial that "general anesthesia, rapid sequence induction," is the standard of care:

> When you are put to sleep and someone is given anesthesia, there are two aspects of it. They sedate you, and you go to sleep. Then they give you a paralytic drug that paralyzes you. It's then followed by what's called rapid sequence induction where a tube is immediately placed down into the lungs so they can immediately start breathing for you. That's called general anesthesia, rapid sequence induction; and that is the standard of care. (p.63 of Transcript)(R.Vol.8, p.63)(Emphasis added.)

subsequently die. (R.Vol.9, pp.256-257)

No anesthesiologist was in the operating room until after the aspiration had occurred. No nasogastric tube was attempted to be utilized. No awake intubation with fibro-optic technique was attempted.

Sheila Patten left three small children. These children were raised by their grandmother. Funeral expenses of $4,350.00 were incurred. (P.I.) The net cash value of decedent's life expectancy ($279,268.86) came in without objection as to its calculation. Medical records of Sheila Patten's stay both in the local hospital and after being moved to Tupelo where she ultimately died were introduced without objection. (R.Vol.8, pp.49-51) Sheila Patten's mother and three children each testified as to damages as follows: Ora Patten as to funeral expenses and as to her observations of Sheila Patten during her hospitalization prior to her death; the two older children testified as to their mother's condition when they saw her in the Tupelo hospital and as to loss of society and companionship; the youngest child was only two at the time of her mother's death and could not testify as to even seeing her at that time; rather, she testified as to her loss of society and companionship. There was no cross examination of any of these family members. (R.Vol.8, pp.72-81)

Testimony as to the general and specific standard of care applicable to the Defendants was provided by Plaintiff's expert, Dr. Futrell. Dr. Claude Brunson, Defendants' retained expert, also testified to the specific standard of care:

Dr. Futrell testified:

(1) Each physician or CRNA has a duty to use his or her knowledge and therewith treat through maximum medical recovery each patient with such

reasonable diligence, skill, competency, and prudence as are practiced by minimally competent physicans in the same or CRNAs in the same specialty or general field of practice throughout the United States who have available to them the same general facilities, services, equipment, and options. (R.Vol.8, pp.117-118)

(2) That the failure to utilize a nasogastric tube in an attempt to suction as much of the stomach contents obviously known to be present because of the bowel blockage constituted a deviation from accepted practice. (See, quotations infra.)

(3) That use of a fibro-optic technique in connection with the placement of the breathing tube would have required an awake intubation and would have solved asserted concerns by the Defendants and, in particular, by the surgeons of the insertion of a nasogastric tube damaging the sutures left by the gastric surgery and that since an NG tube had not been used, it was a breach of the standard of care not to attempt the awake fiberoptic procedure for inserting the breathing tube. (See, quotations infra.)

(4) That given the nature of the operation and the certainty of stomach contents, an anesthesiologist, not just a CRNA, should have been present in the OR at the time of the induction. (See, quotations infra.)

(5) That since an NG tube was not going to be used and was not used, Ms. Patten should have been placed in the Trendelenburg position (a tilted position where the head is lower than the stomach so contents cannot move from the stomach to the lungs) before induction. (See, quotations

infra.)

Dr. Brunson, Defendant's expert, testified that Ms. Patten should have been put in the Trendelenburg position after the beige fluid was seen by Kevin Berry and before intubation. (See, quotations infra.) Dr. Futrell and Dr. Bunsen both testified that suctioning should have occurred before ventilation (blowing air into Plaintiff's lungs). (See, quotations infra.)

Dr. Futrell and Dr. Jones agreed that the aspiration which occurred proximately resulted ultimately in Ms. Patten's death. Dr. Jones agreed that Ms. Patten would not have aspirated had she been placed in Trendelenburg. (See, quotations infra.)

There was no dispute that each of the individual "standards of care" alleged by Plaintiff were breached:

(1) No NG tube was used.

(2) No fiberoptic technique was used.

(3) No anesthesiologist was present in the OR at the time of induction.

(4) Trendelenburg was not used before induction.

(5) Trendelenburg was not used after the beige fluid was seen and before intubation.

(6) Ventilation was used before suctioning.

(See, quotations infra.)

SUMMARY OF ARGUMENT

Plaintiff proved her case by a preponderance of the credible evidence. Plaintiff proved the standards of care. She proved the *Hall v. Hilbun* general standard of care which was set forth in both Plaintiff's and Defendants' jury instructions. She also

proved the specific standards of care which were admittedly breached. Sheila Patten was to be operated upon for a bowel blockage following a Roux-en-Y gastric bypass. Plaintiff's expert testified that, under those facts, a nasogastric tube should have been inserted before Ms. Patten was paralyzed by the CRNA. He said that since there was concern by the CRNA for the surgeon's admonition never to use a nasogastric tube after a gastric bypass because of the danger of tearing or otherwise injuring the sutures, an awake intubation with the aid of fibro-optics should have been performed. Since that procedure was not done, in any case, the patient should have been placed in the Trendelenburg position before induction. Dr. Brunson, Defendants' expert, testified that a CRNA is taught to not place the patient in the Trendelenburg position unless and until contents from the stomach appear. The procedure sequence which is very important, according to Dr. Brunson, Defendants' expert, would be as follows: Once the brown fluid is seen coming from the patient's nose, immediately place her in the Trendelenburg position, then suction the patient, then intubate the patient, and only then provide ventilation. In the instant case, Kevin Berry testified via deposition used in connection with Dr. Brunson's testimony that he did not follow that procedure; rather, he stated that once he saw the brown fluid, he immediately intubated the patient and ventilated her (i.e., squeezed the bag that would push the fecal contents that was being aspirated deep down into her lungs); then he stated he put her in Trendelenburg position even though the medical records do not reflect he ever put her in Trendelenburg and Dr. Jones testified that she was not in Trendelenburg when he arrived. Both Plaintiff's expert and Defendants' expert agreed that the patient should be put in Trendelenburg (the only disagreement being that Plaintiff's expert thought that

should be done before induction and Defendants' expert thought that should be done immediately after the brown fluid was seen). Both agreed that before squeezing air into the lungs that the patient must be suctioned. Both agreed that as soon as possible after these steps, the patient should be intubated and only then be ventilated. Dr. Futrell further testified that an anesthesiologist should have been in the operating room at the time of induction not just a CRNA. Jury Instruction 6-A was supported by the above referenced facts and was not confusing except to the fact that fiberoptic "induction" was used. Once that fact was pointed out to the jury by Appellant's attorney (it was not pointed out in jury instruction arguments), Appellee's attorney readily admitted and cured the confusion that he was the idiot who put "induction" in that section when in fact "intubation" was the word that should have been used.

The trial court correctly allowed Dr. Mackey's deposition to be read to the jury since Defendants did not point out specific portions they believed were objectionable neither did Defendants follow up with the Court their objection to the form of the question.

Defendants' novel position, unheard of in Mississippi law, asking the Court to disregard the requirements of the wrongful death statute– there shall be but one action and all damages of every kind shall be recovered in that action– is not well taken. Therefore, the case was properly brought as next friend by the grandmother of Sheila Patten's three children.

Jury Instruction D-15 was properly refused because there was no basis to include an instruction relating to "loss of chance." Indeed, the other instructions, including especially D-4, properly instructed on causation and told the jury they could

not rely upon speculation and possibilities on the issue of causation. In addition to Dr. Futrell having testified in detail as to causation, Dr. Jones readily testified that the failure to use Trendelenburg probably caused the extent of the aspiration which resulted in aspirated matter getting into her lungs and resulting ultimately in her death.

The trial court did not abuse his discretion in discharging his absolute duty to make sure that the jury was fair and impartial by correctly taking corrective action to make sure that the jury that retired to decide the case was unbiased. Removing one of the Defense attorneys employees from the jury, who had been previously selected as an alternate and who had moved up because of a sickness of one of the original jurors, and substituting another juror who had absolutely no connection with any of the parties or any other reason to be unable to be impartial did not constitute an abuse of discretion.

ARGUMENT

I Plaintiff proved her case by a preponderance of the credible evidence that Defendant breached an applicable standard of care which proximately caused Sheila Patten's aspiration and ultimate death.

Appellant seems to limit his argument on this issue to the assertion that Dr. Futrell negated all proof by him, the medical records, and Defendant Jones on the issue of causation because a portion of an affidavit by Dr. Futrell and presented by Appellant's attorney used language of missed opportunity. Appellant, therefore, asserts that all of the proof of causation was a mere diminishment of a patient's chance to recover. Plaintiff will initially address the proof of the standard of care and its breach. That discussion includes proof of causation but will not address directly the argument

as to "loss of chance," which will be addressed in the next subpart.

A. Proof of standard of care and proximately resulting death.

Plaintiff agrees with the statement of law set forth by Appellant relating to proof necessary in a medical malpractice case. *See*, p.22 of Appellant's Brief. The following is evidence of the standard of care and proximate cause of aspiration and death:

(1) Dr. Futrell whose expertise and status as an expert was not challenged stated in pertinent part that the general standard of care when applied to the facts of this case resulted in several standards of care having been breached and that such breaches proximately caused Sheila Patten's death.

> Q. Doctor, please tell the jury what your opinion is concerning the duties of care of both defendants, recognizing that generally each physician or CRNA has a duty to use his or her knowledge and therewith treat through maximum medical recovery each patient with such reasonable diligence, skill, competency, and prudence as are practiced by mentally [sic][minimally] competent physicians in the same or CRNAs in the same specialty or general field of practice throughout the United States who have available to them the same general facilities, services, equipment, and options.
>
> A. After review of the documents relating to the care of this patient, it is my conclusion that there were significant breaches of the standard of care in the management of anesthesiology, both insofar as the supervision by the anesthesiologist, Dr. Jones, and by the nurse anesthetist, Mr. Berry, in the management of this patient in the preoperative evaluation of this patient, which resulted in the serious consequences leading to very adverse clinical consequences and ultimately the death of the patient.
>
> [Futrell Direct, p.117, line 12-p.118, line 1]
> (R.Vol.8, pp.117-118)

A. As a result of that lack of communication and as a result of the lack of preparation and as a result of the lack of supervision of this patient upon induction of anesthesia, there was a resulting release of gastric contents from the patient upon induction and paralysis due to the beginning of anesthesia that resulted in the contamination of this patient's lungs to a severe degree; and there were a number of clinical consequences over the next few days resulting in acute adult respiratory distress syndrome and the resulting complete respiratory collapse of the patient and her ultimate death.

[Futrell Direct, p.118, line 23-p.119, line 3]
(R.Vol.8, pp.118-119)

Q. Specifically, there's been mention made in opening statement by both sides for the need or lack of need for there to be an NG tube inserted in the patient. Do you have an opinion based on that?

. . .

A. However, the circumstance where the patient has a bowel obstruction where the patient has this large volume of undigested fluid and solids in the stomach when the paralytic drug is given, it completely relaxes the muscles that has been controlling the fluid; and it, therefore, releases. It goes reverse up the esophagus; and, depending upon the position of the patient, all of those fluids and those solids will pass from the esophagus into the trachea.

[Futrell Direct, p.119, lines 5-8, p.119, line 28-p.120, line 6]
(R.Vol.8, pp.119-120)

A. The use of the nasogastric tube, it is a tube that most commonly– it is a soft, plastic tube with a hollow opening. It can be attached to a suction device. We can pass it either by the mouth; or we can pass it through the nose; and that's why it's commonly called naso for the nose, gastric, meaning stomach; so it's a nose-to-stomach tube.

We pass the tube into the stomach and attach the end of the tube to suction; and we suck out all this fluid, this fluid that has been kept from passing along the regular bowel because of the obstruction.

When you are preparing a patient for general

anesthesia, you want to do this when you know that this is the situation so that when you have to give the paralytic drug, Anectine, so that you can put the tube into the lungs. You will have a much less risk associated with any fluids passing up the esophagus and into the trachea contaminating the lungs as I spoke about. That is the reason why the placement of a nasogastric tube in a patient where you know you have an obstruction is so important.
[Futrell Direct, p.120, line 21-p.121, line 10]
(R.Vol.8, pp.120-121)

Q. What, if anything, do you think forcing the fecal matter into the lungs, how did that meet or fall below the standard of care?

A. I want to be sure that I'm answering the question correctly. Am I to speak to the issue of the areas that were breaches of the standard in this regard?

Q. Yes. Thank you.

A. I mentioned the need for a nasogastric tube, and I mentioned the need to be sure that because of the prior surgery it was placed appropriately and carefully so as not to cause perforation and yet provide for the elimination of the dangerous fluids that were in the stomach.

That circumstance should be associated with an understanding of what happened and the position that the patient was in knowing that the nasogastric tube was not used and knowing that the stomach was full of fluids. Then the next appropriate thing that should have been done was that the patient should have been placed in the Trendelenburg position, which is a position where the patient, the bed, the operating table is moved and adjusted electrically such that the patient's head is lower than the patient's stomach.

In that circumstance, knowing that the patient has something in their stomach, and in an emergency situation without a nasogastric tube, knowing that you have to paralyze the patient, if those fluids, as they did, present themselves, water runs downhill and does not run uphill; and so since the head is a little lower than the stomach, even if that fluid presents itself during the period of time where the patient has to be paralyzed, that fluid will not run into the lungs;

and the anesthesiologist or the nurse anesthetist can get the breathing tube in without contaminating the lungs with this, which is essentially liquid bowel contents is what they are, into the lungs.

The next thing is that when– and we are talking about various conditions that existed in the actual case because in the actual case Mr. Berry relates that upon giving the paralytic drug he and the nurse noted that this mass of fluid and fecal contents were in the mouth and actually coming out of the patient's nose; and so in that circumstances now with the transfer of all this bad material up to the mouth, around the lungs, and in the nose, Mr. Berry has to suction the patient out and attempt to intubate the patient, putting the breathing tube correctly in through the vocal cord so he can now breath for the patient.

The statements in the depositions relating to the oxygenation of the patient had a low oxygen saturation, but not critical at that point. The first thing to do then, if you have time in such a circumstance where you now know that aspiration of content has occurred, is to attempt to suction some of that fluid out of lungs before you give the first breath because when you give the first breath, you are going to push air into the lungs; and you are going to push all of that fluid and contents deep into the lung fills where it cannot be suctioned where it can do all the bad things we already discussed.

That was not done; and so since that was not done, then the opportunity– and it's something that can be done in a few seconds; and if the oxygen saturation or oxygenation of the patient is too low, you may not have time to do it because you are about to lose the patient; but because of the testimony that the oxygenation was not that low, there was time to do it in my opinion; and it was not done; therefore, even as to the amount of fluid and bowel contents that were allowed to get into the lungs, there was an opportunity missed there to decrease that amount of fluid.

Q. All right, sir. Would you comment on whether or not starting this case with only a CRNA present is a deviation from accepted practice?

. . .

[Futrell Direct, p.123, line 20-p.125, line 29]
(R.Vol.8, pp.123-125)

Q. Is there anything else about not having an anesthesiologist present at the time of the induction? How would the presence of an anesthesiologist along with the CRNA make a difference?

A. It would make a difference in this circumstance because knowing the condition of the patient and knowing about the possibility of the gastric contents getting into the lungs as we have already discussed, it's important to have another set of hands, first of all, to be able to manage suction and intubation, putting the tube into the lungs at the same time.

This is a very messy, and you don't have a lot of time, and so in these circumstances where you can anticipate we commonly call another person in to help with the situation. It's not absolutely mandatory that we do so, but prudent anesthesiologists do that.

The other thing is that anesthesiologists, board certified anesthesiologists, know of and are regularly trained and have been so for 10 or 15 years about the technique of fiberoptic intubation. This is a situation where when you know that there are existing dangers to giving a patient a paralyzing drug so that you only have seconds in order to find the proper connection to the lungs rather than do that, rather than to paralyze the patient and run that risk, what we do is simply use anesthetic agents, spray anesthetic agents to numb the mouth and a little bit of a sedative medication to sedate the patient just a little bit; but the patient is breathing on her own and has all of her reflexes and has muscular control.

Under those circumstances using a fiberoptic light, which is a very thin device, much thinner than the wire to this microphone, that you can pass through and you actually move it and flex it, and you can pass this after anesthetizing the patient's nose and mouth into a breathing patient's mouth and pass it down into the breathing area into the trachea and slide the breathing tube over it and below [sic][blow] the cuff up and have complete airway control even though the

stomach is full.

This fiberoptic technique is well known. It has been well taught, and in circumstances like this it is part of the standard of care in those situations where to paralyze the patient would present the dangers that have now been presented.

[Futrell Direct, p.129, line 29-p.131, line 9]
(R.Vol.8, pp.129-131)

Q. If you would, Doctor, would you amplify your explanation that you've given generally that this aspiration event resulted in Ms. Patten's subsequent clinical course?

A. Yes, sir. First, again to summarize, the aspiration that we are talking about is the aspiration of a large amount of undigested food and fecal contents. That's continually referred to as yellow-colored, beige fluid. In fact, the truth of the matter is that what we are talking about is a liquid bowel movement that's been sitting there for days that has now backed up and been deposited during the induction of anesthesia into the lungs.

The syndrome of inflammation and pneumonia and compromise of the patient's lungs is well documented as a respiratory distress syndrome. It is associated with the onset over days and hours of increasingly difficult management of the patient's oxygenation because these chemicals and acids that are in this fluid are actually digesting the lung. That's what they do in the stomach. When they get in the lung, they do the same thing; and so the patient's clinical course then is gradually deteriorating.

Associated with this syndrome is renal failure. This patient had a chemical induction used to determine how well your kidneys work. It is what's called a creatinine; and the normal creatinine is 1, which is what this patient had prior to this operation; and in a few days this patient's creatinine was 11, the larger number indication worsening renal functioning.

That is why the patient had to be transferred from Baptist Memorial Hospital to the other hospital because there is where the dialysis treatment was. It

was decided to have the dialysis treatment at that location, and there are numerous reports from different consultants. Multiple consultants confirm this diagnosis of respiratory distress syndrome on confirming its ideology and location relative and its onset relative to the aspiration which took place.

This patient did not have this kind of problem prior to the surgery, and the pathology report shows in addition that this patient had complete consolidation of the lungs. That's what the autopsy report shows of the lung, and the autopsy was done immediately following her death. It shows she did not have a heart attack, and there were no other problems associated with her heart with all these consultants.

The pathological diagnosis, we know what the process was; and we know exactly when it began; and we've discussed already the circumstances that would have allowed us to prevent it.

[Futrell Direct, p.133, line 15-p.135, line 1]
(R.Vol.8, pp.133-135)

Q. [HAGWOOD] But, just so we are clear, the sum and substance of everything you've said here today about what you say are the breaches of the standard of care, these deviations caused a missed opportunity to prevent and limit the occurrence of the aspiration that followed. Sir?

A. Yes.

. . .

Q. [WALKER] Did you go on to say right where Mr. Hagwood stopped reading, This resulted in rapid respiratory compromise and the development of ARDS, adult respiratory distress syndrome, which Dr. Jones admits is a foreseeable consequence of aspiration, additional and progressive respiratory and renal tunnel complications occurred that are well recognized in this syndrome, and which resulted in the rapid demise and ultimate death of patient Patten?

Did you say that, Doctor?

A. I did.

[Futrell Redirect, p.167, lines 1-8, 18-27](R.Vol.9, p.167)
(Emphasis added to portions of all the quotations above.)

(2) Defendant's expert, Dr. Brunson, specifically testified that the duty of care required the patient be placed in Trendelenburg once the beige fluid was seen, followed by suctioning and followed by placing the breathing tube in next and, only after suctioning, ventilate (push air) into the patient's lungs:

> Q. You would be concerned about the size of the pouch of the stomach that's left there as far as running into it with a nasogastric tube, wouldn't you?
>
> A. Unfortunately, the human body is a little more complex than that. There are a number of things we are concerned about, and there are a number of things we train our doctors and our nurse anesthetist to deal with. That's why we don't let somebody come in for a one-year training program. It's very complex stuff that we do with human beings, different reflexes, different physiology. The human body is a very complex organism, and we train our folks very carefully over a number of years to be able to deal with these possibilities.
>
> Q. I don't think you answered my question, but I can't remember what it was, so we will go on.
>
> . . .
>
> But you do train them, if they see fluid coming, to put them in Trendelenburg after they see the fluid; is that correct?
>
> A. Yes, that's one of the things we tell them is put their heads down and suction the fluid out. What that does is whatever is around it gets into a particular place so we can suction it all out.
>
> Q. In this case the patient should have been put in Trendelenburg because everybody who notes in the record that this brown fluid comes out her nose, correct?
>
> A. Yeah. That would be something to think about is putting her in Trendelenburg. We would teach them in that circumstance put them in head down position, suction it out; and immediately as soon as you can intubate them. That's going to keep something from going on in the trachea. We need to get the

endotracheal tube and the cuff up.

Q. You teach them when you see the brown stuff coming out, put them in Trendelenburg and suction.

A. Yes.

Q. And then intubate?

A. You suction the fluid out and put the tube in immediately.

[Brunson Cross, p.290, line 23-p.291, line 29] (R.Vol.9, pp.290-291)

Q. This lady had two things that indicated she's going to have her stomach contents come out. She's heavy, and she's also got fecal matter everybody knows is down there because of the bowel blockage.

A. Which is why they use the rapid sequence induction.

Q. But they didn't do just a little extra. They wouldn't do a little extra like maybe put her in Trendelenburg?

A. Again, if you believe that she has, as you say, this extra risk now, you certainly don't want to put her in Trendelenburg.

Q. But you do once you see the fluid come out, right?

A. Yes, but you have to make sure you get the sequence correct.

[Brunson Cross, p.293, lines 16-28] (R.Vol.9, p.293)

Q. Trendelenburg is not in the hospital record, correct?

A. No, it's not in there; but in the deposition Mr. Berry stated that he used Trendelenburg.

Q. But Mr. Berry stated in his deposition that he put her in Trendelenburg; but the hospital records don't support that, do they?

A. Right. It is not written in the hospital record.

[Brunson Cross, p.294, lines 19-25] (R.Vol.9, p.294)

Q. Let's think back about Mr. Berry's deposition. He said that's when he put her in Trendelenburg, after he intubated her; isn't that what he said?

A. Again, I'm telling–

Q. Isn't that what he said in his deposition, he put her in Trendelenburg after he intubated her?

A. During the induction–

Q. Isn't that what he said in his deposition, Doctor?

A. Can you show me that?

Q. I certainly can.

. . .

Q. All right. Up at number 7, line 7, It was important to

put her in the Trendelenburg position, correct? Is that correct?

Mr. Berry says, Undoubtedly so. I remember doing it. Undoubtedly so.

And I say, Well, I'm not talking about whether you remember doing it or not. I'm talking about as a person who is a certified registered nurse anesthetist faced with the conditions you were faced with, with the beige fluid at the time you said you noticed it, appropriate care would be you were required to put her in Trendelenburg position, wouldn't it?

That's what you just told us was appropriate care, correct, Doctor?

A. Correct.

Q. Then he said, Well, no. The appropriate care would be to get the breathing tube in. That's the first thing, airway.

So he said he put the breathing tube in first rather than Trendelenburg; is that correct?

BY MR. WINTER: I object. That's not what he said. That's not what it says. He didn't say what he did. He's asking about what would be appropriate.

Q. Okay. After you put the breathing tube in and verified the physician [sic][position] that the appropriate care would be to put her in Trendelenburg position; is that correct?

I think it would be one of them.

He says on 52, Well, undoubtedly so because I put her in Trendelenburg. I specifically– well, I mean I specifically remember doing it.

BY MR. WINTER: Your Honor, he's not asking a question. He's just reading the deposition.

Q. What I was doing, Doctor, do you agree that Mr. Berry says he put her in Trendelenburg?

A. Yes, I agree to that.

[Brunson Cross, p.295, lines 5-14, p.295, line 22-p.296, line25] (R.Vol.9, pp.295-296)

Q. Didn't you just say the sequence to follow was to put her in Trendelenburg before you intubated her once

you see brown fluid. Didn't you say that, Doctor?

A. What I said to you when you were asking me the question about to put her in Trendelenburg starting out or not with the cricoid pressure, I said the appropriate sequence, if you are doing it that way, is to not start out in Trendelenburg because it would promote passive passage of fluid from the stomach. That's the question you asked, and that's the question I was answering.

Q. You went on to answer and say what you do is if you see the brown fluid, then you put her in Trendelenburg, and then you intubated her. You said that on this stand under oath, did you not, Doctor?

A. Yes. I said if you are going to use Trendelenburg, then that would be the time to use Trendelenburg, suction it out, and then you can intubate.

[Brunson Cross, p.297, line 27-p.298, line 14]
(R.Vol.9, pp.297-298) (Emphasis added on all quotations.)

(3) Defendant Dr. Jones testified that if Sheila Patten had been placed in Trendelenburg when she was induced by Mr. Berry, the fluid would not have come up and got then into the lungs and that the resulting aspiration caused her death.

Q. But this lady was not put in Trendelenburg position, was she?

A. At the time that I came into the room she was not. At the time Mr. Berry induced, I don't believe she was either.

Q. Thank you, sir. And if she had been probably, just a little bit probably, if she has been, it wouldn't have come up and got in her lungs, would it?

A. We don't know.

Q. Probably?

A. Possibly.

Q. Probably. How about making these difficult decisions you doctors make on risks and benefits. We are talking about what we lawyers talk about.

A. More likely than not because fluid runs downhill.

Q. More likely than not she would not have suffered the aspiration?

A. More likely than not she wouldn't have gotten as much content into her lungs, right.

Q. The less you get in there the better?
A. True.
Q. The more you get out with pulmonary lavage, the better.
A. If you can get it out with pulmonary– I know you all didn't like this term earlier today– is controversial, as Dr. Huggins indicated. Pulmonary lavage can be almost as damaging as it can be life saving. As he indicated also, he did it even though he didn't know if it did any good or ill.
Q. He wouldn't have to do it if we had her in Trendelenburg, would he?
A. We don't know that.
Q. Probably wouldn't have to do it?
A. Probably.
Q. Thank you, sir. Do you agree that her aspiration caused, ultimately caused her death?
A. It certainly caused her pulmonary complications, which I understand they are linking to the kidney failure and so forth, yes.
Q. You agree that the aspiration is what probably caused her death?
A. That set the chain of events in motion, yes.
[Jones Cross, p.256, line 7-p.257, line 17]
(R.Vol.9, pp.256-257)

B. The language of the affidavit, especially when compared to all the language relating to causation previously set forth, did not invoke a "loss of chance" interpretation and did not negate all the proof on causation, especially when the jury instructions given on causation are considered.

Defendant relies upon *Clayton v. Thompson*, 475 So.2d 439 (Miss.1985) as preventing recovery on the basis of "loss of chance" or "value of a chance." Plaintiff agrees that Mississippi rejected the "loss of chance" or "value of a chance" theory as inviting impermissible speculation and conjecture by the jury. Significantly, the Clayton case rejected the Clayton Plaintiff's theory of his right to recover based on a good

chance:

> Appellant contends that a peremptory instruction should have been granted because plaintiff's case rested entirely upon the theory that an earlier referral to an orthopedic surgeon would have resulted in a greater chance for more flexibility of the thumb. Appellant argues that a "chance" of a better result is not a sufficient causal connection to justify imposition of liability in a medical malpractice case. Since these last two assignments of error deal with the same substantive issue, they will be addressed jointly.
>
> 1. The instruction granted to the appellee covering his theory of the case is as follows:

The Court instructs the jury that if you find by a preponderance of the evidence that defendant Dr. R.S. Clayton made an incorrect finding on the July 9, 1979 x-ray film of Plaintiff Michael B. Thompson, and you further find from the preponderance of the evidence that such an incorrect finding, if any, by Defendant, Dr. R.S. Clayton was a result of negligence under all the circumstances of this case and that Dr. John Wood Boyd used reasonable care in relying upon Dr. R.S. Clayton's report did not refer the plaintiff to the immediate attention of an orthopedic surgeon and if you further find from the preponderance of the evidence that immediate attention by an orthopedic sureion [sic] would probably have given Michael B. Thompson a good chance to recover greater flexibility of his left thumb, then you must find for Plaintiff Michael B. Thompson.

The plaintiff's theory of his case was as follows:

. . .

(5) And that immediate medical attention by an orthopedic surgeon immediately following the x-ray examination by Dr. Clayton would "probably" have given the plaintiff a "good chance" to recover "greater flexibility of his left thumb."

This theory of recovery has been termed the "loss of a chance" or "value of a chance."

. . .

This Court concludes that the language of this instruction invited impermissible speculation and conjecture by the jury. The jury's deliberation should have been channeled to consider a substantial probability, rather than a "good chance," to recover substantially greater flexibility of his thumb.

This Court concludes, therefore, that Mississippi law does not permit recovery of damages because of mere diminishment of the "chance of recovery". Recovery is allowed only when the failure of the physician to render the required level of care results in the loss of a reasonable probability of substantial improvement of

the plaintiffs condition. This instruction, therefore, must fail for its failure to properly guide the jury.

Clayton v. Thompson, 475 So.2d 439 (Miss.1985).

In the instant case, Plaintiff did not seek a jury instruction nor have as a theory of this case "good chance" to recover. Rather, Defendant's entire argument is based upon, ignoring all of the evidence of proof of damage and death set forth in the previous subsection and injecting into the case a portion of an affidavit previously given by Plaintiff's expert, and, indeed, doesn't even read the second paragraph to the jury. The following was quoted in Appellant's Brief:

> As to causation, Plaintiff's expert, Dr. Futrell, re-affirmed his affidavit which stated:
>
> > All of the above deviations...are accepted practice caused the patient to suffer complications associated with aspiration or (sic) fecal matter and fluids into her lungs after institution of anesthesia with paralytic drugs given by Mr. Berry in the absence of Dr. Jones' assistance and supervision...
> >
> > These deviations caused a missed opportunity to prevent and limit the occurrence of the aspiration that followed...
>
> (Tr. at 166-67; R.E. 3.) Defense counsel summed up Dr. Futrell's testimony and asked:
>
> Defense Counsel: But just so we are clear, the sum and substance of everything you've said here today about what you say are the breaches of the standard of care, these deviations caused a missed opportunity to prevent and limit the occurrence of the aspiration that followed. Sir?
> Dr. Futrell: Yes.
>
> *Id.* Because Plaintiff's expert failed to establish causation, and the jury's verdict is against the overwhelming weight of the evidence, the verdict should be reversed.
> (Appellant's Brief, p.23)

The record at trial reads as follows:

> Q. Did you go on to say right where Mr. Hagwood stopped reading, This resulted in rapid respiratory compromise and the development of ARDS, adult respiratory distress syndrome, which Dr. Jones admits is a foreseeable consequence of aspiration, additional and progressive respiratory and renal tunnel complications occurred that are well recognized in this syndrome, and which resulted in the rapid demise and ultimate death of patient Patten?
>
> Did you say that, Doctor?
> A. I did.
> [Futrell Redirect, p.167, lines 1-8, 18-27](R.Vol.9, p.167)

Since Defendant's complaint as to the refusal of its Jury Instruction #15 is based exclusively upon the argument made by Defendant herein. This section of Appellee's argument will be referenced and relied upon in response to the argument relating to Jury Instruction D-15, and the causation jury instructions given at trial will also be relied upon in response to Defendant's argument on failure to grant Jury Instruction D-15.

II Jury Instruction P-6A was a proper instruction, especially when properly considered with all the jury instructions on standard of care and proximate cause which were given.

The law regarding jury instructions is set forth below:

> The Circuit Court enjoys considerable discretion regarding the form and substance of jury instructions. Our overarching concern is that the jury was fairly instructed and that each party's proof-grounded theory of the case was placed before it. *Rester v. Lott*, 566 So.2d 1266, 1269 (Miss.1990). We read the jury instructions as a whole, our focus upon what the jury heard and not on what was kept from it. We see how full the glass, not how empty. Defects or inadequacies in particular instructions do not trouble us, so long as the aggregate of the instructions, taken as a whole, fairly, though not necessarily perfectly, express the applicable primary rules of law. *See, e.g., Payne v. Rain Forest Nurseries, Inc.*, 540 So.2d 35, 40-41 (Miss. 1989); *Detroit Marine Engineering v. McRee*, 510 So.2d 462, 465 (Miss. 1987); *Tippit v. Hunter*, 205 So.2d 267, 271 (Miss.1967); *Walker v. Polles*, 248 Miss.887, 896, 162 So.2d 631, 634 (1964).(fn2)

Splain v. Hines, 609 So.2d 1234, 1239 (Miss.1992)(Emphasis added.)

Defendant's argument boils down to its unsupported assertion that no part of Jury Instruction P-6A is supported by any evidence. The evidence as to each of the subparts of Jury Instruction P-6A has already been provided in the lengthy quotations from the record of Dr. Futrell, Dr. Brunson, and Dr. Jones.

The circumstances under which P-6A was produced are set forth below:

> JURY INSTRUCTION NO. D-17
>
> BY MR. WALKER: Your Honor, I object to this one. This indicates that there's only one potential breach of standard of care, and that has to do with NG tube, and we have at least five alleged breaches of the standard of care.
>
> BY THE COURT: The Court's of the opinion that the instruction should be refused, and it is refused under the testimony. All right.
>
> BY MR. HAGWOOD: Yes, sir. The question I then pose to the Court, Mr. Walker has no instruction setting forth what he says the duty is, and so I would ask the Court to hold this, and I think that at some point we're going to have to reach an agreement about an instruction of this nature. I thought I framed it correctly; but if there [is] something else that needs to be added to it, then I would be amenable to that; but I don't think Mr. Walker has anything that sets forth what the duty is.
>
> BY MR. WALKER: I have the Hall vs. Hilbun instruction as to duty, and they don't get to the specific duty, but I think in most of these cases we don't get to any specific duty, but I'll be happy to work with something.
>
> (Obj. To Instructions, p.310, line 19-p.311, line 13)(R.Vol.10, p.310)
>
> . . .
>
> BY MR. WALKER: I doubt if Carl agrees with this. We couldn't agree before lunch.
>
> BY THE COURT: Let me hear your objection.
>
> BY MR. HAGWOOD: First of all, the itemization of the list is contradictory.
>
> The utilization of an NG tube could be with or without fiber optic intubation. If it's fiber optic intubation, the patient is upright, not supine. The use of Trendelenburg position before induction depends on which one of these induction techniques are you using.
>
> If it's a fiber optic intubation, then you are sitting up. That's the

problem with the plaintiff's case is that the plaintiff's case is absolutely in contradiction throughout their entire presentation.

That's the reason that I was trying to simple it down; but with this list, this demonstrates the contradictory medical position that the plaintiff has placed the defendants in because it's either utilization of an NG tube under their theory– I assume with Trendelenburg position before induction, but I'm not sure that that's the proof.

But the fiber optic intubation would entail the following: First, the insertion of an NG tube in an upright position while awake. Then a fiber optic induction with patient upright and awake, and then intubation.

I mean that's that technique, so this instruction is faulty.

BY MR. WALKER: Your Honor, excuse me. My attempt was to provide specific examples of the standard of care so that I would have more precise breaches of duty.

We allege and attempted to prove all of these each as a separate breach of the standard of care. We may or may not have proved any of these. I obviously don't think so; but if the jury finds we've proved that that proximately resulted in aspiration or death, then they have to find for us.

I'm just trying to make the instructions better. My general instructions, general Hilbun duty, they didn't object to; so I guess we could put those on and not have a complaint later for failure to more specifically state the standard of care; but that's why I got these.

(Obj. to Instructions, p.318, line 25-p.320, line 12)(R.Vol.10, pp.318-320)

Defendant's argument as to each of the items listed in P-6A is based upon his ignoring the proof which has been set forth in Dr. Futrell's testimony quoted previously in this brief:

(1) An NG tube should have been used in this case and it was not.

(2) Fiberoptic intubation[2]– In the instant case since an NG tube was not

---

[2] Plaintiff's attorney utilized the term induction. And although Defendant's attorney used the same fiberoptic induction language during jury instruction arguments, Plaintiff's attorney readily admitted to the jury that he was the idiot who misused the term and the term should have been intubation. (Mr. Hagwood's assertion that I confused intubation and induction in connection with subpart 6 of the Instruction is in error. The term I used was the term I intended to use and the correct term– after one

inserted, apparently because of concern of the surgeons for the sutures in a gastric bypass, the standard of practice would require under those circumstances the use of fibro-optic technique in intubating. That procedure was not done.

(3) An anesthesiologist should have been in the OR at the time of induction because of the complexities of the case with the bowel blockage; had he been there, he could have assisted in intubation even in the presence of fluids and he could have inserted the breathing tube, utilizing the fibro-optic technique which a doctor would know and would have been trained in; Dr. Jones testified that he knew it very well and had been trained in it.

(4) Dr. Futrell said the Trendelenburg position should have been utilized before induction in this case because none of the previous steps were taken. Dr. Jones admits that use of the trendelenburg position would probably have prevented the aspiration and resulting death. Trendelenburg was not used according to Mr. Berry, himself, prior to induction.

(5) Dr. Brunson, Defendant's expert, disagreed that Trendelenburg should have been used before induction but absolutely insisted and forcefully stated that he taught CRNAs to put the patient in Trendelenburg immediately upon seeing the beige fluid and before intubation.

(6) Both Dr. Futrell and Dr. Brunson (Defendant's expert) testified that

---

intubates the patient, one does not immediately blow air into the patient's lungs when one knows the patient has aspirated. Dr. Brunson agreed.)

suctioning should occur before ventilation.

In short, ample proof of breach of "standard of care" occurred as to each of the listed items since none of the listed items had in fact occurred. The purpose of this jury instruction was to give the jury an opportunity to decide what it believed based upon the expert testimony was the specific standard of care, the general standard of care having also been included in the instructions. In other words, the jury had to find as fact what the standard of care was. This instruction lists what Plaintiff alleges were the standards of care under her theory of the case.

Appellant's attorney makes much of the difference between the term "induction" and the term "intubation." Of course, there is a difference. However, in Appellant's attorney's opening argument and throughout the case, induction being limited to providing the paralytic agent is not apparent. The sequence given in Appellant's attorney's statement is as follows:

> When you are put to sleep and someone is given anesthesia, there are two aspects of it. They sedate you, and you go to sleep. Then they give you a paralytic drug that paralyzes you. It's then followed by what's called rapid sequence induction where a tube is immediately placed down into the lungs so they can immediately start breathing for you. That's called general anesthesia, rapid sequence induction; and that is the standard of care.
>
> (Transcript, p.63)(Vol.8, p.63)

The most directly relevant additional instructions relating to the standard of care as well as causation which were given are set forth below (R.Vol.2, pp.259-273):

> The Court instructs the jury that a certified registered nurse anaesthetist has a non-delegable duty of care to use his or her knowledge and therewith treat through maximum reasonable medical recovery, each patient, with such reasonable diligence, skill, competence, and prudence as are practiced by a

minimally competent certified registered nurse anaesthetist in the same specialty or general field of practice throughout the United States, who have available to them the same general facilities, services, equipment, and options.

Therefore, if you find from a preponderance of the evidence, if any, that the Defendant, Kevin Berry, breached his duty of care and that such breach, if any, proximately caused Sheila Patten's injury and death, then you must find for Plaintiff and against Defendant, Kevin Berry.

(Jury Instruction P-1)

You are instructed that the word "negligence" or "malpractice" as used in these instructions means that given the circumstances of each patient, a physician has a duty to use his or her knowledge and therewith treat through maximum reasonable medical recovery, each patient with such reasonable diligence, patience, skill, confidence, and prudence as are practiced by minimally competent practitioner in the same specialty who have available to them the same general facilities, services, equipment, and options.

(Jury Instruction D-13)

The Court instructs the jury that if you believe from a preponderance of the evidence that Kevin Berry, CRNA, at the time of his treatment of Sheila Patten followed acceptable procedures and exercised reasonable care and skill commensurate with that exercised by other physicians practicing in the field of anesthesiology under like and similar circumstances, then Kevin Berry, CRNA, was not negligent, and it is your sworn duty to return a verdict for Kevin Berry, CRNA.

(Jury Instruction D-6)

The Court instructs the jury that the applicable standards of care alleged by Plaintiff are as follows:

(1) Utilization of an NG tube;

(2) Fiberoptic induction;

(3) Presence of an anaesthesiologist in the OR at the time of induction;

(4) Use of the Trendelenburg position before induction;

(5) Use of the Trendelenburg position after the beige fluid was seen and before intubation;

(6) Suctioning immediately after intubation rather than beginning ventilation.

Therefore, if you find the standard of care to be any of the above and you further find that such standard of care, if any, was breached and that such breach proximately caused Sheila Patten's death, then you must find for Plaintiff and against any Defendant who you find breached the standard of care.

(Jury Instruction P-6A)

The Court instructs the jury that in order to be a proximate cause a Defendant's breach of duty must be a substantial factor in producing Plaintiff's injury. In other words, if Sheila Patten would have died even if both Defendants had not breached their duty, such breach of duty is not a substantial factor and is not a proximate cause. On the other hand, a breach of duty is a proximate cause if it contributes to the Plaintiff's injuries. In other words, it is not necessary that the breach of duty by Defendants, if any, be the sole cause of the death to be the proximate cause, only that such breach of duty, if any, be a contributing cause of the death in question.

Therefore, if you find from a preponderance of the evidence, if any, that either or both Defendant(s) breached their duty toward Plaintiff, as set forth in the Court's other instructions, which breach, if any, proximately caused Sheila Patten's death, then you must find for Plaintiff and against one or both of the Defendant(s).

(Jury Instruction P-2)

The Court instructs the jury that you may not return a verdict founded on speculation or possibilities. In order for Plaintiffs to recover monetary damages against Dr. Frederick D. Jones or Kevin Berry, CRNA, on their claim of medical malpractice, they must prove to a reasonable degree of medical probability that the death of Sheila Patten was the result of medical malpractice or negligence on the part of Dr. Frederick D. Jones or Kevin Berry, CRNA. Speculations and possibilities are to be disregarded.

(Jury Instruction D-4)

The Court instructs the jury that the burden of proof rests upon the Plaintiffs. You are further instructed that a physician may not be held liable for every untold result which may occur in the practice of medicine. A physician is not the warranter of his or her cues not is he or she a guarantor of good health. In order to recover from Dr. Frederick D. Jones and Kevin Berry, CRNA, the Plaintiffs must prove by a preponderance of the evidence that Dr. Jones and Kevin Berry were negligent, and Dr. Jones' and Kevin Berry's alleged negligence was the proximate contributing cause of the death of Sheila Patten. Because Sheila Patten died does not mean that the Plaintiffs have proven their case or met their required burden of proof. In order to recover from Dr. Jones and Kevin Berry, Plaintiffs must prove by a preponderance of the credible evidence that such act or failure to act on behalf of Dr. Jones and Kevin Berry was the sole proximate contributing cause of the death of Sheila Patten. If the Plaintiffs have not proven this by the credible evidence, then it is your sworn duty to return a verdict for Dr. Jones and Kevin Berry.

(Jury Instruction D-7)

III The trial court followed clear and unquestioned Mississippi statutory and decisional law in refusing to fragment this wrongful death suit, or otherwise complicate it procedurally.

The wrongful death statute provides in pertinent part as follows:

> The action for such damages may be brought in the name of a child for the death of a parent...there shall be but one (1) suit for the same death which shall ensue for the benefit of all parties concerned...in such action, the party or party suing shall recover such damages allowed by law as the jury may determine to be just, taking into consideration all the damages of every kind to the decedent and all the damages of every kind to any all parties interested in the suit...in an action brought pursuant to the provisions of this section by the...child,...such party or parties may recover as damages property damages and funeral, medical or other related expenses incurred by or for the deceased as a result of the wrongful or negligent act...whether an estate has been opened or not. Any amount, but only such an amount, as may be recovered for property damage, funeral, medical or other related expenses shall be subject only to the payment of the debts or liabilities of the deceased for property damages, funeral, medical or other related expenses. All other damages recovered under the provisions of this section shall not be subject to the payment of the debts or liabilities of the deceased, except as hereinafter provided, and such damages shall be distributed as follows:...if the deceased has no husband or wife, the damages shall be equally distributed to the children...
>
> (MISS. CODE ANN. §11-7-13)(Emphasis added.)

This controlling statutory law has not in any way been modified to include the requirements asked for but not ever previously, even asked for, much less given. Indeed, cases relied upon by Defendant involve resolutions when multiple lawsuits and conflicting Plaintiffs rather than a single lawsuit for all the wrongful death beneficiaries and for damages of every kind.

The decision purportedly and erroneously relied upon actually makes various

very specific holdings, none of which require dismissal of the instant lawsuit.

> In this wrongful death case, we are called upon to address issues which ought to have been settled long ago. Two law firms representing different wrongful death heirs filed separate wrongful death suits in the same circuit court:... [W]e hold that where the provisions of this opinion conflict with the Statute, the provisions herein shall control... Thus, we hold that the first court to properly take jurisdiction of a wrongful death action in our state courts shall, so long as that action is pending, have exclusive jurisdiction, and any other subsequently filed action for the same death shall be of no effect... We hold that, in wrongful death litigation, all claims shall be joined in one suit. There is no general requirement under the law that the personal representative obtain chancery approval to pursue the claims of the estate in the litigation nor is there a general requirement that counsel representing the personal representative and the estate in the litigation obtain prior chancery court approval of such representation or the agreement for compensation of counsel... Frequently, wrongful death litigation will involve a minor, either as an heir of the estate, a wrongful death beneficiary, or both. In such cases, the representation of the minor's interests, and any agreement for the payment of attorney's fees from the minor's share of proceeds, must be approved by a chancellor, as in other cases. [Note there is no requirement of any prior approval; clearly whatever court in Michigan with authority over minors will have to approve any settlement and/or the disbursement of any award and approval of any attorney's fees.]... Although our statutes mandate no specific procedure for the identification of wrongful death beneficiaries, a chancery court may make such determinations. [Notice that the chancery court need not make a determination especially when no determination is needed, there being absolutely no conflict in a single case with all issues brought by all the wrongful death beneficiaries and statutory heirs.] *Long v. McKinney*, 897 So.2d 160, 162, 164, 173, 174, 176 (Miss.2004)(Emphasis added.)

Since there is absolutely no dispute that the suit is being brought on behalf of minors who are the sole heirs and wrongful death beneficiaries, all the proceeds which may be recoverable will be equally split among these minors. Defendants' argument as to splitting up portions for estate recovery, etc. does not require that an estate ever be

opened nor that heirs ever be determined. Rather, counsel for all the heirs and wrongful death beneficiaries will be required to look out for their interests and to have a Court protect their interest in Michigan– as to the distribution of any sums awarded for the wrongful death of their mother.

Defendants reference to a footnote in the *Willing v. Estate of Benz*, 958 So.2d 1240, 1257 n.16 (Miss.2007) does not quote the entire footnote nor does it set forth the analysis in *Willing*, which also involved a dispute as to different parties being represented by different attorneys. The footnote states in full:

> The court in *Long* held that chancery approval of representation and of the fee agreement is prudent, but not required, prior to initiating suit on behalf of the estate and other beneficiaries. Chancery court approval is necessary for representation of a minor's interest, for attorney's fees awards from a minor's proceeds, for fees awarded from proceeds of an estate, and for determination of wrongful death beneficiaries.

The analysis of the *Long v. McKinney* opinion in *Willing* makes clear that the submission to Chancery Court of any matter is not necessary prior to the bringing of suit, especially when there is no conflict of interest as to the parties– i.e., all wrongful death beneficiaries and heirs at law are parties to the same lawsuit with the same attorney:

> A wrongful death beneficiary may bring suit with or without the knowledge and agreement of the remaining beneficiaries or estate representative... Naturally, in doing so, the beneficiary has authority to retain counsel to prosecute the suit on behalf of all interested parties. However, the representative beneficiary has an affirmative duty to "provide reasonable notice (i) to all wrongful death beneficiaries, (ii) to the personal representative of the decedent if one has been appointed..." Additionally, "full disclosure is required of any agreement or arrangement for the payment of costs or attorney's fees from the portion of recovery attributable to those receiving such notice."... The personal representatives

> and/or one or more of the beneficiaries may join the litigation represented by separate counsel... In this event,...the trial judge has discretion, upon petition by the personal representative or any beneficiary, to "equitably adjust and allocate fees among the attorneys based on the quantitative and qualitative contribution of each to the case..." *Willing v. Estate of Benz*, 958 So.2d 1240, 1256 (Miss.2007) citing *Long v. McKinney*, 897 So.2d 160 (Miss.2004) (citations omitted from the above quotation)(Emphasis added.)

In accordance with the mandate in *Long v. McKinney*, when all the persons who have an interest in the wrongful death are joined in the same action and, as in the instant case, the only persons who would be entitled to recover anything are one and the same– the three children who are both beneficiaries and heirs at law– all of the money for the different elements may be recovered: "We hold that in wrongful death litigation, all claims shall be joined in one suit." *Long v. McKinney*, supra.

The traditional use of "as next friend of" is ignored in Defendants' argument on appeal, not surprisingly, since Defendants could not get the trial court to overlook the fact that this case is brought in the name of a non-minor as next friend as authorized in Rule 17(c) of the Mississippi Rules of Civil Procedure: "If an infant...does not have a duly appointed representative he may sue by his next friend." In this case, the minor children sued for are undisputedly the only heirs at law or wrongful death beneficiaries of Sheila K. Patten, the decedent.

IV Dr. Mackey's deposition was properly read to the jury.

Appellant complains that Dr. Mackey was not an expert and that yet he was asked to provide expert opinion. As the record makes clear, Dr. Mackey's deposition was taken because one of Appellant's attorneys advised that Dr. Mackey and others

might be called at trial to testify that the anesthesiologist and CRNAs did not use a nasogastric tube in cases where a gastric bypass a.k.a. Roux-en-Y procedure had been performed. Appellee's attorney, therefore, took Dr. Mackey's deposition. (R.Vol.1 of 2, Exhibit P-2, p.652) The examination by Appellee's attorney covered Dr. Mackey's background, asked Dr. Mackey if he had any direct involvement with Sheila Patten or know anything about this case, and was advised that Dr. Mackey did not. The question to Dr. Mackey was always by Plaintiff limited to "in your practice and in the practice of your group." (*Id.*, p.654) The response was that the procedure followed was what was called rapid sequence induction, which procedure was explained as well as the need for it to avoid aspiration. (*Id.*, p.655) Dr. Mackey was then asked Do you use a nasogastric or any other kind of tube to go in and suction the stomach contents, again referring to what Dr. Mackey did in such a procedure. (*Id.*, p.656) He responded it was on a case by case basis. (*Id.*) He stated that if they knew the stomach was full they would go ahead and suction it out. (*Id.*) That would be compliant with the standard of care for an anesthesiologist or CRNA in Oxford. (*Id.*, p.657 with no objection)

Mr. Winter, Appellant's attorney, moved from broad questions to the particular facts of the case. (*Id.*, p.658) He gave the details of this lady having had Roux-en-Y gastric bypass eight days before and the small bowel obstruction. He was then asked about Dr. Barnes rule concerning not using an NG suction on a post-gastric bypass small bowel obstruction, and was advised that Dr. Barnes did have such a rule. (*Id.*, pp.658-659) Dr. Mackey called the rule a standard. (*Id.*, pp.659-650) On redirect, Mr. Walker questioned whether Dr. Mackey gave up his right as an anesthesiologist to make an individual and informed decision. Dr. Mackey said that he did not and that if

necessary conversation with the surgeon would occur. (*Id.*, pp.661-663) On p.665 of the record, which is p.16 of Mr. Mackey's deposition, Mr. Walker asked the following question:

> Q. In a situation such as this one, which included a small bowel blockage in the gastric surgery previously, shouldn't you have an anesthesiologist actually in the operating room when you are going in there to try to give her anesthesia and make decisions about whether you're going to run a tube in her or not?
>
> BY MR. WINTER: Object to the form. Go ahead.
>
> Q. You can answer.
>
> A. I can answer?
>
> BY MR. WINTER: I'm not going to ever tell you you can't answer but I am going to say, "Object to the form." So go right ahead.
>
> A. Alright. For a situation like that I would say probably yes.
>
> Q. Because you need an anesthesiologist because of all the difficulties you are facing?
>
> A. Right.
>
> (*Id.*, p.665)

Significantly, at trial, Appellant's attorneys did not follow up and seek to enforce the objection to the form of that question. While the question might not have been objectionable since it was asking specifically about "you" Dr. Mackey, nevertheless, it is the only thing that might be construed as seeking an opinion. The failure to follow up on that objection renders the argument against allowing Dr. Mackey's deposition to be read in its entirety inappropriate. All Defendant's attorney had to do was to go to the specific questions that arguably called for an opinion and determine whether he objected as to the form. (I didn't remember him objecting to any, but he obviously did to this one.) If he did object, obviously he should have taken that objection up with the judge at that time. The judge then could have been in a position to take out anything

even arguably objectionable. Rather than taking that approach, once the judge said he was going to allow the deposition to be read to the jury, (note that no specific objections had been made then nor had additional time been asked to be allowed to make those objections and although Defendant's attorney had indicated that we might be able to work some of this out if we went through the deposition.) Defendants' attorneys failed to inform the Court precisely as to what they were objecting to. (R.Vol.8, pp.84-96) Defendants' attorney then required Plaintiff's attorney to read not only the questions he asked but to read the questions that they asked.

Of course, the Court's ruling was absolutely correct, having briefly reviewed the deposition and concluding that Mr. Walker's questions appear to be touching upon the general standard of care for a person that presents with this lady's problem. If defense counsel believed that not to be the case, especially since prior to trial Defendants' attorneys' knowing that they were going to object to this deposition, a review of the deposition and an item by item and line by line objection could have been presented to the Court at that very point and that one arguably opinion-type statement could have been addressed.

Finally, it should be noted that Defendant only objects to giving opinions about incomplete factual scenarios. (p.87) The incomplete factual scenario existed, if at all, based upon the representation of the facts made by defense counsel himself. Even assuming error occurred, it clearly was harmless since all that was testified to was also testified to by Dr. Huggins and Dr. Jones.

V Jury Instruction D-15 was properly refused.

Below is the complete discussion concerning D-15. As is made clear in the previous subsection I-B, this instruction should not have been given because there was no potential for recovery based on loss of chance as is made clear by the previous proof itself and by the other jury instructions on causation previously quoted, especially D-4:

> BY MR. HAGWOOD: 15 was requested, if the Court please, because the affidavit given by Dr. Futrell; and I think because of that– I understand the Court denied my motion for directed verdict; but I do think that in light of the affidavit he gave my cross examination that there's no basis for D-15.
>
> BY MR. WALKER: Except for the fact that Dr. Jones admitted that aspiration is what caused her suffering and death.
>
> (Obj. to Instructions, p.310, lines 5-130)(R.Vol.10, p.310)

VI The Trial Court did not abuse his discretion in striking juror 26, Bradley S. Knight, an employee of Duke Goza, one of Appellant's attorneys.

The law is set forth below:

> The circuit judge has an absolute duty, however, to see that the jury selected to try any case is fair, impartial and competent. Miss. Const. art. 3, § 26; *King v. State,* 421 So. 2d 1009, 1016 (Miss.1982). "[T]rial judges must scrupulously guard the impartiality of the jury and take corrective measures to insure an unbiased jury." *Hudson v. Taleff,* 546 So.2d 359, 363 (1989); *Miss. Power Co. v. Stribling,* 191 Miss.832, 845, 3 So.2d 807, 810 (1941).
>
> To the extent that any juror, because of his relationship to one of the parties, his occupation, his past experience, or whatever, would normally lean in favor of one of the parties, or be biased against the other, or one's claim or the other's defense in the lawsuit, to this extent, of course, his ability to be fair and impartial is impaired. It should also be borne in mind that jurors take their oaths and responsibilities seriously, and when a prospective juror assures the court that, despite the circumstance that raises some question as to his qualification, this will not affect his verdict, this promise is entitled to considerable deference. *Harding v. Estate of Harding,* 185 So.2d 452, 456 (Miss.1966); *Howell v. State,* 107 Miss.568, 573, 65 So.641, 642 (1914).

> These varied imponderables make selection of jurors a judgment call peculiarly within the province of the circuit judge, and one we will not on appeal second guess in the absence of a record showing a clear abuse of discretion.
>
> . . .
>
> We have consistently held that the trial court may not be put in error for refusal to excuse jurors challenged for cause when the complaining party chooses not to exhaust his peremptory challenges.
>
> . . .
>
> A party may not remain silent when an opportunity is presented to challenge a prospective juror for cause, opting instead to simply exercise a peremptory challenge on this juror, and then complain because the court refused to excuse another juror for cause upon whom he did exercise a peremptory challenge. Such a tactic would enable counsel to enlarge the number of peremptory challenges allotted him. There is no ground for reversal in this assignment.
>
> *Scott v. Ball*, 595 So.2d 848, 849-50 (Miss.1992)(Emphasis added.)

Mr. Knight spoke in terms of "I don't think so...I believe...I think I could set aside the fact that I'm being compensated from one of the lawyers that's going to get compensated maybe." He never actually stated that he could be fair and impartial. (See, quotation in Appellant's Brief, p.35)

Nevertheless, Plaintiff's attorney, although intending to challenge for cause this juror, forgot, but then believed he could use a peremptory challenge. This juror did not come up during the phase of the trial when all the jurors were selected. Plaintiff's use of his fourth peremptory challenge on this juror was, therefore, unavailable. In chambers, Plaintiff's attorney advised that he had planned to use that fourth challenge in addition to the one challenge which was to be given to him for the alternate. The Court advised that that procedure was not available. Plaintiff's attorney was, therefore, in a position to be unable to exercise a peremptory on Mr. Knight and advised the Court

that he had intended to use a for cause challenge. Plaintiff's attorney never technically "accepted" Mr. Knight. However, it was Plaintiff's attorney's error that resulted in this scenario in question. Fortunately, the trial court did what the trial court was duty bound to do: "the Circuit Court has an absolute duty, however, to see that the jury selected to try any case is fair, impartial, and competent...and must scrupulously guard the impartiality of the jury and take corrective measures to insure an unbiased jury." *Id.*

The Trial Court did give considerable deference to Mr. Knight's having stated that he thought and believed he could present a rational judgment and thought he could set aside the fact of Duke being his employer.

This action by the Trial Court under these circumstances was not "a clear abuse of discretion." This case does not involve a party choosing not to exhaust peremptory challenges when an opportunity is presented in an attempt to enlarge the number of his peremptory challenges:

> BY MR. WALKER: Even on the– I thought we had three and then one on the alternates.
>
> BY THE COURT: No. I'll give you an extra one on the alternates. I'll give you an extra one on the alternates.
>
> (p.38, lines 25-29)(R.Vol.8, p.38)
>
> . . .
>
> BY THE COURT: All right. I'll give you one challenge for an alternate. We're going to choose two.
>
> BY MR. WALKER: Can I also use one of my challenges I saved for an alternate.
>
> BY THE COURT: No, sir.
>
> BY MR. WALKER: Well, I challenge 25.
>
> BY THE COURT: That's going to be P-1A. All right.
>
> BY MR. WINTER: Who's the last juror?

BY THE COURT: That gets us down to Bradley Knight and Sheila Tyson as alternates.

BY MR. WALKER: Bradley Knight is the one I should have challenged and forgot. He worked for Duke.

BY MR. GOZA: You rehabilitated him.

(p.40, line 16-p.41, line 2)(*Id.*, p.40)

. . .

BY THE COURT: . . .

There's one other thing. This might be reversible, but it will be one of the fewer reversible errors that I have committed during this trial.

I have been concerned about juror number 13, Bradley Knight, working for Mr. Goza; and since we had a juror that is ill, Court's of the opinion that I should have spoken out and I should have dismissed Mr. Knight because of his employment. I think it's just more than we could be asking of this young man to be fair and impartial in this.

We have another juror, Sheila Tyson; and, you know, it's my duty– and this is no criticism on either of the attorneys. I want that clearly understood– but it's the trial Court's responsibility to guard against even the appearance of impropriety or unfairness and to instill public confidence in the fairness of our jury system, and that is essential to our legal system, and I have been worried about this, so I'm going to move Mr. Tyson up. I mean Mrs. Tyson up as the 13th juror.

I know that's unusual. It may be unwarranted. I hope not, but I want you to know that's what's going to occur.

Please dictate into the record without offense to me, I want you to know, your objections.

BY MR. HAGWOOD: If the Court please, we do object. He expressed that he could be fair and independent, and there was no peremptory challenge made to him by the plaintiff. Plaintiff accepted him, and we do not believe there's a sufficient basis for the Court's ruling.

BY MR. WALKER: Your Honor, I would like to apologize to the Court for not raising him as a challenge for cause, which would have prompted this perhaps; and I also apologize for me being confused and thinking that I could use my fourth challenge on him and would be limited. Both of those were my fault, and I apologize to the Court for having put it in the position of even having to deal with this matter this way. I certainly think you are doing right, of course.

BY THE COURT: We'll see what happens.

BY MR. HAGWOOD: Judge, just for the record, I don't think that the plaintiff used all four of their peremptory challenges.

BY THE COURT: No, they didn't.

BY MR. HAGWOOD: So he had him for cause and for peremptory; so , therefore...

BY MR. WALKER: I did not use it, Your Honor, as you will recall, because I thought I could use it as to the alternates. That's why I was holding it for that man. Then I found out to my shame and chagrin that that wasn't the appropriate procedure.

(p.315, line 18-p.317, line13)(R.Vol.10, pp.315-317)

CONCLUSION

Plaintiff proved her case by a preponderance of the credible evidence. Plaintiff proved the standards of care. Plaintiff proved causation. The jury was properly instructed. Jury Instruction P-6A was correctly granted, and Jury Instruction D-15 was properly refused. The trial court correctly followed clear and unquestioned Mississippi statutory and decisional law in refusing to fragment this wrongful death suit. The trial court correctly allowed Dr. Mackey's deposition to be read to the jury, especially in light of Defendants' failure to make specific objections as to portions it deemed inadmissible. The trial court did not abuse his discretion in striking a juror who was an employee of one of Appellant's attorneys. In short, no error was committed by the trial court which supports Appellant's appeal. Therefore, it is respectfully requested that the judgment below be affirmed.

RESPECTFULLY SUBMITTED, this the 15th day of March, 2010.

ORA L. PATTEN, as next friend of
BIANCA PATTEN,
SHADARRYLHARDNETT,
and MARIAH PATTEN
Appellee

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CERTIFICATE OF SERVICE

I, WILLIAM C. WALKER, JR. , do hereby certify that I have this date mailed, postage prepaid, a true and correct copy of the above and foregoing to the following counsel of record and to the Trial Judge:

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Honorable Henry L. Lackey
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This the 15th day of March, 2010.

Wm. C. Walker

WILLIAM C. WALKER, JR.