IN THE SUPREME COURT OF MISSISSIPPI

NO. 2010-CA-00654

THE ESTATE (THROUGH THE ADMINISTRATRIX IDA CAMPBELL) AND THE WRONGFUL DEATH AND SURVIVAL BENEFICIARIES OF JOHN EARL SYKES, IDA CAMPBELL, JEFFIE EZELL, DONNIE DRAINE, SAMMIE JOE SYKES, RICKY WAYNE SYKES, BRENDA FAY HARDWICK, TERRY SYKES, AND JAMES E. SYKES — APPELLANTS

V.

CALHOUN HEALTH SERVICES — APPELLEE

APPEAL FROM THE CIRCUIT COURT OF CALHOUN COUNTY, MISSISSIPPI

BRIEF OF APPELLEE

ORAL ARGUMENT NOT REQUESTED

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V.

CALHOUN HEALTH SERVICES **APPELLEE**

CERTIFICATE OF INTERESTED PERSONS

The undersigned counsel of record for appellee, Calhoun Health Services, 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 disqualification or recusal.

1. Ida Campbell, plaintiff/appellant;
2. Jeffie Ezell, plaintiff/appellant;
3. Donnie Draine, plaintiff/appellant;
4. Sammie Joe Sykes, plaintiff/appellant;
5. Ricky Wayne Sykes, plaintiff/appellant;
6. Brenda Fay Hardwick, plaintiff/appellant;
7. Terry Sykes, plaintiff/appellant;
8. James E. Sykes, plaintiff/appellant;
9. David A. Bowling, Esq., attorney for plaintiffs/appellants;

10. Susanna C. McKinney, Esq., attorney for plaintiffs/ appellants;

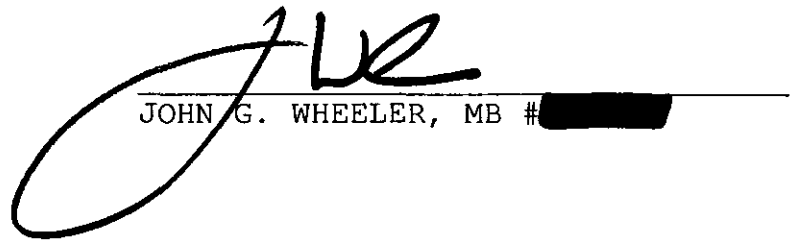
11. Wilson, Bowling & McKinney, attorneys for plaintiffs/ appellants;

12. Calhoun Health Services, defendant/appellee;

13. John G. Wheeler, Esq., attorney for defendant/appellee;

14. Mitchell, McNutt, and Sams, P.A., attorneys for defendant/appellee;

15. Honorable Andrew K. Howorth, circuit judge.



JOHN G. WHEELER, MB #[redacted]

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STATEMENT OF THE CASE

Course of Proceedings and Disposition in the Court Below

The estate of John Earl Sykes, through administratrix Ida Campbell, together with siblings of John Earl Sykes (collectively referred to herein as "Campbell") filed suit in the Circuit Court of Calhoun County against Calhoun Health Services ("CHS") under the Mississippi Tort Claims Act and the wrongful death statute, alleging that medical negligence on the part of one or more CHS employees was a proximate cause of the death of Mr. Sykes. Following a bench trial, the trial court rendered findings of fact and conclusions of law and entered a judgment in favor of CHS. (CP Vol. II, 248-59.)[1] Campbell appeals from that judgment.

Statement of Facts

CHS is a county-owned hospital in Calhoun County. In January, 2007, CHS had a 24-hour emergency department with four available patient beds. The department was usually staffed by one emergency medicine physician and one or two nurses depending on the time of day. The department did not have an available cardiologist on the medical staff at CHS for consultation, and CHS provided no specialized cardiology services, such as

[1] Citations to the record are as follows: "CP" denotes the court's papers; "Tr." denotes pages of the trial transcript; specific documents in the multi-document trial exhibit no. 1 are referenced by page number within the exhibit.

coronary catheterization, angioplasty, stenting, or bypass grafting. (Tr. 245.)

On January 1, 2007, John Earl Sykes ("Sykes") presented to the CHS emergency department at approximately 5:50 p.m. According to the CHS patient log, Mr. Sykes told the emergency department clerk that he was experiencing "heart racing." (Exhibit 1 pp. 46-47.) The emergency department was staffed by a single physician and two registered nurses. (Tr. 215-16.) When Sykes arrived, all medical personnel were busy providing care for multiple patients with potential life-threatening illnesses or injuries, including a patient with head trauma, a patient with diminished oxygen saturation levels, a patient with chest pain and shortness of breath, and a patient with acute abdominal pain. (Tr. 246-47.) At approximately 6:00 p.m., Toby Lafayette, an emergency medical technician who was assisting with the triage of waiting patients in the CHS emergency department, assessed Sykes. (Tr. 173, 247.) Lafayette took Sykes's vital signs and questioned him about his presenting complaint. Sykes told Lafayette that his chest was "sore" and that the soreness started the previous day. (Tr. 174.) Lafayette asked if Sykes felt pressure in his chest, whether the "soreness" was sharp or dull in nature, and whether he was experiencing radiating pain. Sykes responded that his chest was "just sore." (Tr. 163, 169.) Lafayette observed that Sykes was

not in acute distress, was not short of breath, and was not sweating. Sykes stated that he was not having trouble breathing. Lafayette asked Sykes if he was having any other symptoms, and Sykes said that he was not; he did not tell Lafayette of any history of nausea or vomiting, shortness of breath, or lightheadedness. (Tr. 163, 169, 173-78; Exhibit 1 p. 131.) Lafayette reported information gathered to the emergency department nursing staff. (Tr. 176.)

Joan Marshall, R.N., one of the nurses on duty in the emergency department, initially received information concerning Mr. Sykes's complaint of "heart racing." That symptom did not put Sykes in the "emergency" category for assessment and treatment, particularly since his vital signs did not reveal a fast heart rate. (Tr. 221, 229, 238-39.) Nurse Marshall later became aware of Sykes's complaint of "chest soreness." She then asked Lafayette to question Sykes further as to whether he was complaining of chest pain indicative of potential heart problems, and was told that he was not. (Tr. 248.) She did not interpret the complaint of chest "soreness" as indicative of an acute heart condition and a consequent need for immediate evaluation and treatment; "soreness" is not one of the descriptors listed in the applicable protocols as indicative of a possible heart attack. (Tr. 317.) Because Sykes did not complain of chest pain and either did not display, expressly

denied, or did not report other symptoms which, when occurring in conjunction with chest pain, are indicators of a potential heart attack, such as profuse sweating, nausea, shortness of breath, and lightheadedness, Nurse Marshall considered Sykes as a non-urgent patient. (Tr. 240-41.) Nurse Marshall personally observed Mr. Sykes in the waiting area and noted that he appeared to be in no acute distress. (Tr. 248.) She continued to care for other acutely ill patients in the emergency department who appeared to be in more need of acute treatment than Sykes.

Debbie Stroup Russell, R.N. arrived at the CHS emergency department around 6:00 p.m. for her 7:00 p.m. to 7:00 a.m. shift. She found Nurse Marshall and the other medical personnel attending to the four critical patients. Some time thereafter, Nurse Russell reevaluated the waiting patients at the request of Nurse Marshall. (Tr. 327-29.) Sykes told Nurse Russell that he was experiencing "some chest soreness" but denied any active chest pain, shortness of breath, tightness in his arm, pressure, or any squeezing sensation in the chest. Nurse Russell observed that Sykes was in no acute distress and was interacting and laughing with others in the waiting area. He was not short of breath or sweating. (Tr. 331-32.) He did not report having nausea and vomiting. (Tr. 353.) Nurse Russell then attended to another patient who asked for immediate treatment and was

complaining of fever and severe pain. (Tr. 332.) After treating that patient, Nurse Russell again asked if any of the remaining patients needed immediate attention. Sykes, who still appeared to be in no distress, said nothing in response. (Tr. 333.)

At approximately 6:55 p.m., Sykes suddenly became unresponsive. Cardiac monitoring revealed that Sykes's heart was in ventricular fibrillation. The physician and nurses attempted to resuscitate Sykes through chest compressions, medications, and electronic defibrillation. The efforts were unsuccessful, and Sykes was pronounced dead at 7:32 p.m. (Tr. 333-34, 337.)

An autopsy revealed that Sykes had severe cardiomegaly, or enlargement of the heart, which can cause a fatal ventricular fibrillation in the absence of a heart attack. (Tr. 307-08; Exhibit 1 p. 28.) There was no autopsy evidence of any blockage of a coronary artery, scarring or death of heart muscle or other evidence that Sykes had suffered a heart attack or true myocardial infarction. (Tr. 306-07; Exhibit 1 p. 28.)

SUMMARY OF THE ARGUMENT

The factual finding of the trial court that CHS personnel were not negligent was supported by substantial evidence. CHS presented the testimony of two medical experts, each of whom stated the opinion that the treatment provided to Sykes satisfied the applicable standard of care. According to the precedents of this Court, such competent expert testimony constitutes sufficient evidence and certainly more than a scintilla of evidence to support the trial court's findings. The trial court, as trier of fact, is the sole judge of the credibility and weight of expert testimony, and it is not proper for the appellate court to substitute its judgment for that of the trial court in that regard. Campbell offered no authority to support her contention that the trial court's findings were not supported by substantial evidence, and thus, cannot prevail on that argument.

The trial court's finding that Sykes's presentation was atypical of a heart problem and did not give rise to a duty to institute immediate testing and treatment was not manifestly wrong. CHS's experts and Campbell's experts agreed that the presentation was atypical. Campbell's argument that typical cardiac symptoms were likely present but were not recognized by CHS personnel because of inadequate screening is based on

speculation and is refuted by the fact that observations made and questions asked by CHS personnel would have revealed the presence of such typical symptoms if they had been present and if Sykes had responded candidly.

There was substantial evidence to support the trial court's rejection of Campbell's theory that the mere complaint of chest soreness was sufficient to require CHS personnel to commence immediate monitoring and treatment. This theory was refuted by CHS's expert witnesses and was based on a strained and unreasonable interpretation of the guidelines relied on by Campbell's expert witnesses.

The trial court did not err in considering the available staffing resources of CHS at the time of Sykes's presentation in determining whether the care of Sykes met the applicable standard of care. It is well-established that the standard of care has a resources-based component. CHS offered expert testimony that it was reasonable for the registered nurse not to abandon the care of critical patients to personally interview and observe Sykes in light of his complaints that were not typical symptoms of a heart problem. Therefore, there was substantial evidence to support the trial court's conclusion.

There was substantial evidence to support the trial court's finding that the alleged negligence of CHS personnel was not a proximate cause of Sykes's death. Contrary to Campbell's

argument, the trial court did not overlook the contention that prompt monitoring of Sykes would have prevented the fatal arrhythmia. There was substantial evidence – the testimony of CHS's expert witnesses – that putting Sykes on a monitor shortly after his presentation probably would not have made a difference in the outcome because Sykes probably was not having a heart attack upon presentation, and it was not probable that an EKG would have given advance warning of the fatal arrhythmia in the absence of a heart attack, and thus, an EKG would not have resulted in any medical intervention that would have prevented the fatal arrhythmia from occurring.

ARGUMENT

I. THE TRIAL COURT'S FACTUAL FINDING THAT CHS DID NOT BREACH THE APPLICABLE STANDARD OF CARE WAS SUPPORTED BY SUBSTANTIAL EVIDENCE.

The standard of review of the trial court's findings of fact by this Court is very deferential. *Thompson v. Lee County School District*, 925 So. 2d 57, 62 (Miss. 2006) (court "must give great deference to the trial judge's findings"); *City of Jackson v. Lipsey*, 834 So. 2d 687, 691 (¶ 14) (Miss. 2003) (same). The appellate court must accept the findings of fact if they are supported by substantial evidence in the record. *City of Jackson v. Perry*, 764 So. 2d 373, 379 ¶ 29 (Miss. 2000); *Yarbrough v. Camphor*, 645 So. 2d 867, 869 (Miss. 1994). In determining whether the findings are supported by substantial

evidence, the appellate court must examine all the evidence in the light most favorable to the judgment and must accept as true the evidence and reasonable inferences that support or tend to support the trial court's findings of fact. *May v. Harrison County Dept. of Human Services*, 883 So. 2d 74, 77 (Miss. 2004); *Perry*, 764 So. 2d at 379; *Ezell v. Williams*, 724 So. 2d 396, 397 (Miss. 1998). The appellate court must disregard any evidence to the contrary. *Quitman County v. State of Mississippi*, 910 So. 2d 1032, 1045 (Miss. 2005); *Mississippi Department of Transportation v. Cargile*, 847 So. 2d 258, 263 (Miss. 2003); *Coleman v. Triplett*, 725 So. 2d 217, 219 (Miss. 1998); *Cotton v. McConnell*, 435 So. 2d 683, 686 (Miss. 1983). The trial court's legal conclusions are reviewed *de novo*, but are largely unchallenged by Campbell's appeal. *City of Jackson v. Internal Engine Parts Group, Inc.*, 903 So. 2d 60, 63 ¶ 7 (Miss. 2005).

The trial court found, as a matter of fact, that CHS personnel were not negligent in the care of Sykes. (R. Vol. II, p. 257.) That finding is supported by substantial evidence. CHS presented two expert witnesses: Dr. William Calhoun, a board-certified cardiologist who is also board-certified in internal medicine, and Dr. Frederick Carlton, a board-certified emergency medicine physician and professor emeritus at the University of Mississippi School of Medicine. (Tr. 291-92, 355-56.) Both Dr. Calhoun and Dr. Carlton stated opinions to a

reasonable degree of medical probability that CHS personnel did not deviate from the applicable standard of care, and thus, were not negligent in the salient care and treatment of Sykes. (Tr. 301-02, 360-61.)

"Substantial evidence" is "such relevant evidence as reasonable minds might accept as adequate to support a conclusion" or, more simply put, "more than a 'mere scintilla' of evidence." *Hall v. City of Ridgeland*, 37 So. 3d 25, 36 ¶ 33 (Miss. 2010)(quoting *Hooks v. George County*, 748 So. 2d 678, 680 ¶ 10 (Miss. 1999). The testimony of two board certified physicians unquestionably constitutes substantial evidence that CHS personnel did not breach the applicable standard of care; the testimony plainly is more than a scintilla of evidence and would be accepted by reasonable minds as adequate to support that finding. *See Hardaway Company v. Bradley*, 887 So. 2d 793, ¶ 14 (Miss. 2004)(court stated that "with the testimony of two physicians . . . the Commission's decision was supported by more than a scintilla of evidence.")

Campbell touts the testimony of her two expert witnesses opining that CHS personnel violated the standard of care. However, as noted above, any testimony of the plaintiff's expert witnesses that does not tend to support the defendant's case (and the trial court's corresponding factual findings and judgment) must be disregarded by this Court. *Quitman County v.*

State of Mississippi, 910 So. 2d 1032, 1045 (Miss. 2005); *Mississippi Department of Transportation v. Cargile*, 847 So. 2d 258, 263 (Miss. 2003). Where there are conflicting opinions by medical experts, the appellate court will not second-guess the trier of fact as to the preponderance of the evidence. *Hardaway Company v. Bradley*, 887 So. 2d 793, 796 (Miss. 2004); *Oswalt v. Abernathy & Clark*, 625 So. 2d 770, 772 (Miss. 1993); *Levy v. Mississippi Uniforms*, 909 So. 2d 1260, 1265 (Miss. App. 2005). In other words, "the trial court, sitting as the trier of fact, is the sole judge of the credibility of all witnesses, including experts." *University of Mississippi Medical Center v. Johnson*, 977 So. 2d 1145, 1152 ¶ 21 (Miss. App. 2007); *accord, Bryan v. Holzer*, 589 So. 2d 648, 659 (Miss. 1991). Thus, it is for the trial court alone to assess the credibility and persuasiveness of the expert witnesses and to decide what weight to give to conflicting opinions. *Mississippi State Hospital v. Wood*, 823 So. 2d 598, 601 (Miss. App. 2002). Consequently, "a trial court commits no error in finding one expert more persuasive than another." *Johnson*, 977 So. 2d at 1152 ¶ 21.

"Unless the testimony is so incredible as to be absolutely unworthy of belief, [the appellate court] will not re-weigh the evidence." *Johnson*, 977 So. 2d at 1152 ¶ 21. Campbell's brief offers nothing from which it could plausibly be argued that the opinions of Dr. Calhoun and Dr. Carlton are "so incredible as to

be absolutely unworthy of belief." Like the appellant in *Wood*, Campbell, "other than arguing for the credibility and persuasive power of [her] own witnesses, points to nothing of note in the record that would suggest that the trial court was manifestly in error in its decision to accept the view of [Dr. Calhoun and Dr. Carlton]." *Wood*, 823 So. 2d at 601 ¶ 8. Thus, there is no basis upon which this Court could properly reject the trial court's findings of fact.

Although Campbell argues, in effect, that the testimony of Dr. Carlton and Dr. Calhoun is not substantial evidence, she cites absolutely no case authority in which similar testimony was held not to constitute substantial evidence and to be insufficient to support a trial court's findings of fact. That omission alone causes Campbell's argument to fail. In *City of Jackson v. Internal Engine Parts Group, Inc.*, 903 So. 2d 60 (Miss. 2005), as in this case, the appellant argued that the findings of the trial court were contrary to the overwhelming weight of the evidence. Also as here, the appellant in *Internal Engine Parts Group* cited no authority for that proposition. This Court held that because the defendant failed to cite supporting legal authority, the argument was procedurally barred. *Id.* at 66 ¶ 18. Consequently, because Campbell cited no cases holding that similar evidence was insufficient to support a trial court's judgment, she has forfeited her argument

that there was no substantial evidence to support the trial court's findings in the instant case.

In any event, there is an abundance of cases demonstrating that the expert testimony of Dr. Calhoun and Dr. Carlton constitutes substantial evidence to support the trial court's findings and judgment. In *University of Mississippi Medical Center v. Johnson*, 977 So. 2d 1145 (Miss. App. 2007), the trial court found for the plaintiff based on the testimony of two medical experts. The court of appeals, noting that it was in the sole province of the trial court to assess the credibility of the experts, held that trial court's judgment was supported by substantial evidence, notwithstanding the fact that the defendant had offered the testimony of six medical experts contradicting the opinions of the plaintiff's experts. *See id.* at 1152 ¶ 22, 1154 ¶ 29.

Similarly, in *Mississippi State Hospital v. Wood*, 823 So. 2d 598 (Miss. App. 2002), the court of appeals held that the testimony of a single expert was sufficient to support the trial court's judgment in favor of the plaintiff even though his testimony was "sharply contradicted by competing opinion evidence" from "a number of witnesses" for the defendant. *Id.* at 601 ¶¶ 5, 7. The court held that there was "beyond question, substantial evidence...to support the trial court's factual determination." *Id.* at 602 ¶ 9.

In *Mississippi Association of Insurance Agents v. Dependents of Seay*, 218 So. 2d 413 (Miss. 1969), a workers' compensation appeal, the issue was whether the employee's heart attack was brought on by the stress of his job. The claimant presented two medical experts; the defendant presented four. This Court held that the finding for the claimant was supported by substantial evidence, stating that where there is a conflict in medical testimony, the decision of the fact-finder must be affirmed. *Id.* at 416, 417.

In *Cantrell v. Green*, 987 So. 2d 1002 (Miss. App. 2007), the critical issue was whether the plaintiff had sustained a muscle contracture as of the date of her last examination by the defendant surgeon. The court of appeals held that the testimony of a single physician, who had never examined the plaintiff, that the contracture existed on the critical date provided the substantial evidence necessary to avoid a directed verdict against the plaintiff in the face of contrary testimony by the surgeon and medical records showing that physical examinations by three other physicians, a physical therapist, and three nurses indicated that no contracture existed on the critical date or within two years thereafter. *Id.* at 1004-05 (majority opinion); *id.* at 1006-07 (Carlton, J., dissenting)(describing evidence).

In light of the foregoing cases, in which the testimony of one or two expert witnesses was held to constitute substantial evidence even though such testimony was sharply contradicted by the testimony of the same or a greater number of expert witnesses, it is clear that the testimony of *either* Dr. Carlton or Dr. Calhoun, standing alone, would have been sufficient to provide substantial evidence to support the trial court's decision. Thus, the testimony of Dr. Carlton and Dr. Calhoun together unquestionably constitutes substantial evidence, particularly since the issues are addressed from the perspectives of both a cardiologist and an emergency medicine physician. Consequently, there is no basis upon which to set aside the trial court's decision. Accordingly, this Court should affirm the judgment below.

II. THE TRIAL COURT'S FACTUAL FINDING THAT THE APPLICABLE STANDARD OF CARE DID NOT REQUIRE THE INITIATION OF ACLS PROTCOL BECAUSE SYKES'S COMPLAINT WAS ATYPICAL WAS SUPPORTED BY SUBSTANTIAL EVIDENCE.

Campbell argues that it was manifestly wrong for the trial court to find that Sykes's complaint of chest "soreness" was not a typical indicator of a heart attack in progress and did not require CHS personnel to treat him as an emergency patient and institute a quicker medical evaluation or treatment. Both Dr. Calhoun and Dr. Carlton expressed that opinion (Tr. 302-03; 361-62), so, as noted above, the trial court's conclusion was

supported by substantial evidence and cannot be set aside on appeal.[2]

Campbell argues that such typical symptoms, as would have triggered the ACLS protocol, "were likely present" but were not appreciated because of the allegedly inadequate triage.[3] However, it is sheer speculation to assert that typical symptoms were likely present. In any event, the duty of medical care providers to provide treatment is based on what they can discern about the patient's condition. As Dr. Calhoun testified, this is largely based on the history, that is, the subjective information provided by the patient, which is the most important component of the evaluation. (Tr. 302.) If a patient does not report his symptoms, the medical care provider cannot reasonably be expected to treat them.

Campbell's theory is that the symptoms were there, but CHS personnel did not ask the right questions. However, there was ample evidence that, although not every possible specific

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[2] Indeed, one of Campbell's experts, Dr. Neil Shadoff, agreed that Sykes's presentation was atypical because he was not ill appearing, pale, or diaphoretic and did not have substernal pressure, radiating pain, fainting, or shortness of breath. (Tr. 129-131.) Campbell's other expert, Dr. Andrew Perron, also conceded that Sykes's symptoms were atypical. (Tr. 74.)

[3] Campbell asserts that the appearance of an atypical presentation was based on "after the fact documentation." However, although the responses and observations were written on the triage form afterward, the testimony of Nurse Marshall, Nurse Russell, and Toby Lafayette, which this Court must accept as true, was that the all the history and initial assessment facts were gathered prior to Sykes's collapse, except for the notation of nausea and vomiting, which was supplied by someone connected to Sykes after he collapsed. (Tr. 163, 169, 173-78, 226, 235-36.)

question suggested by CHS's triage form[4] was asked of Sykes, enough questions were asked that, if Sykes had been having typical symptoms of a heart attack and had answered candidly, CHS personnel could have deduced the presence of such typical symptoms and instituted immediate evaluation and treatment. For example, Lafayette specifically asked Sykes about the presence of typical symptoms of a heart attack that were on the triage form: if there was pressure, if the chest soreness was sharp or dull, or if there was radiation of pain into his arm. (Tr. 163, 169, 302-03; Exhibit 1 p. 5.) Sykes replied that his chest was "just sore." Other typical heart attack symptoms accompanying chest pain include nausea and vomiting, profuse sweating, shortness of breath, and dizziness or lightheadedness. (Tr. 302-03.) Lafayette specifically asked about, and Sykes denied, difficulty breathing, and Lafayette determined from observation that Sykes was not short of breath or sweaty. (Tr. 175.) Although Lafayette did not specifically ask Sykes if he had had lightheadedness or nausea and vomiting, he did ask if Sykes had experienced any other symptoms,[5] and Sykes did not report lightheadedness or nausea and vomiting in response.[6] (Tr. 163.)

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[4] This form, Exhibit 1, p. 5, is entitled "EMERGENCY NURSING RECORD/Chest Pain Complaints." It is also referred to in Campbell's brief as the "chest pain" form.

[5] Dr. Calhoun testified that such open-ended questions are consistent with the standard of care. (Tr. 302.)

[6] Although the triage form notes nausea and vomiting, the testimony of Nurse Marshall, which must be credited by the reviewing court, was that this information was provided by someone after Sykes went into

It is reasonable to assume that the average patient, if he had experienced nausea and vomiting, would disclose that complaint to the medical personnel when asked to report all symptoms. The same is true with respect to dizziness or lightheadedness. CHS personnel cannot be faulted for Sykes's failure to disclose those symptoms when given the opportunity, if indeed he had experienced them.[7] In short, Lafayette's interview and observations covered virtually all the points in the "chief complaint" section of the triage form, and would have detected any typical heart attack symptoms if they were present and if Sykes had responded openly and truthfully.

Moreover, Nurse Debbie Stroup Russell followed up on Lafayette's assessment of Sykes. She observed that he appeared to be in no distress and was not short of breath or sweating. In response to her questions, although reporting "some chest

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cardiac arrest and was not known to her at the time the triage was performed or at any time prior to the time Sykes collapsed. (Tr. 235-36.)

[7] The only competent evidence that Sykes had nausea and vomiting before going to the hospital was the testimony of Creasy Gunn, Sykes's girlfriend, who allegedly went with him to the emergency department. Her testimony was impeached by testimony that Sykes's sister had promised to give her money if the family was successful in the lawsuit, and by evidence that she had changed her testimony since giving a recorded statement to defense counsel. (Tr. 185:25-186:8, 193:11-21, 197:7-198:23.) In any event, as noted above, Gunn's testimony about alleged nausea and vomiting must be disregarded for purposes of this appeal. Although, after Sykes collapsed, someone reported a prior episode of nausea and vomiting, and this was recorded on the "Emergency Nursing Record" form (Tr. 235-36; Exhibit 1 p. 5), Gunn did not testify that this information came from her. Since the source of that information is unknown, and thus, it cannot be determined that the source had personal knowledge of the episode, that evidence is not competent to prove that Sykes in fact had nausea and vomiting prior to going to the emergency department.

soreness," he denied any pressure or squeezing pain, radiation to the arm, or shortness of breath, and reported no nausea or vomiting. (Tr. 331-32, 353.) Nurse Russell also testified that Sykes was laughing and talking to other people in the waiting area. (Tr. 332.) Dr. Carlton testified that this was not the behavior of a person experiencing a heart attack. (Tr. 304.)

Based on the foregoing, there is substantial evidence that the fact that CHS personnel did not discern typical heart attack symptoms in Sykes was because he had no such symptoms, not because of any deficiency in the triage assessment, and there is no support for any suggestion that the typical symptoms were present but undetected by CHS personnel. Therefore, Campbell's argument is without merit.

Campbell also argues that the evidence is overwhelming that the symptoms Sykes did report, typical or not, were by themselves serious enough to require CHS personnel to initiate the ACLS protocol. This argument appears to be two-fold. First, Campbell notes that the "chest pain" form (Exhibit 1 p. 5) notes a pain severity of 2 of 5 and lists "aching" as a symptom to be inquired about. Campbell argues that "aching" is synonymous with "soreness," and that therefore Sykes's complaint of that magnitude of "soreness" should have triggered the ACLS protocol. However, the primary meaning of "sore" is painful to the touch or upon movement, while "ache" means a dull, steady

pain. *American Heritage Dictionary* (2d College ed. 1985). Thus, the two terms are not synonymous. This position was refuted by the testimony of CHS' two experts (and factually rejected by the trial court), and Campbell's own experts did not make this assertion as a basis for their opinions, although Dr. Andrew Perron, in response to a leading question on re-direct examination, agreed with Campbell's attorney that the terms were synonymous. Neither did they testify that the pain level recorded on the form was significant.

Campbell's second argument is that any chest discomfort of any type, no matter how described, in a man of Sykes's age and race requires initiation of the ACLS protocol regardless of whether there are any accompanying symptoms. For this argument, Campbell cites the testimony of her expert witness, Dr. Shadoff. Once again, however, Campbell's argument runs afoul of the principle that evidence contrary to the trial court's factual findings must be disregarded on appeal, and that resolving conflicts in expert testimony is for the trial court alone. Thus, the testimony of Campbell's expert cannot be used to overturn the judgment, particularly since CHS's expert, Dr. Calhoun, offered a contrary opinion. Dr. Calhoun testified that the standard of care did not require CHS personnel to institute the ACLS protocol based merely on Sykes's complaint of chest soreness. (Tr. 312-13.)

Campbell argues that Dr. Shadoff's testimony is confirmed by the ACC/AHA guidelines. Campbell relies on the statement in the guidelines that a heart attack protocol should be commenced on all patients "with chest discomfort or other symptoms suggestive of STEMI[8] or unstable angina." Campbell argues that the use of the word "or" means that "chest discomfort" (of any kind) standing alone would require initiation of the protocol. In other words, Campbell contends that the adjective phrase "suggestive of STEMI or unstable angina" modifies only "other symptoms." However, Dr. Calhoun, a cardiologist who is board-certified by the same organization that promulgated the guidelines (Tr. 316), testified that Campbell's interpretation of the guidelines is incorrect, and the guidelines do not require that a complaint of chest discomfort alone be met with initiation of the ACLS protocol. Dr. Calhoun testified that "suggestive of STEMI or unstable angina" modifies "chest discomfort" as well as "other symptoms." (Tr. 315-16.) Thus, there is chest discomfort that is suggestive of heart attack, such as crushing pain, substernal pressure, and pain that radiates into the arm, and there is chest discomfort that is not suggestive of heart attack, such as Sykes's vague complaint of "chest soreness." Only the types of chest discomfort that are suggestive of STEMI require initiation of the protocol. (Tr.

[8] "STEMI" is an acronym for ST-elevation myocardial infarction, a type of heart attack.

315-17.) Under those guidelines, chest "soreness," standing alone, does not trigger the protocol. (Tr. 312-13, 315-16.) The unreasonableness of Campbell's interpretation is evident when one considers that, under that interpretation, a person presenting to an emergency department complaining only of dizziness, nausea and vomiting but no chest pain whatsoever, would have to be given an EKG within ten minutes.

In the final analysis, of course, the question of whether Sykes's complaint of chest soreness imposed a duty on CHS personnel to initiate the ACLS protocol is a matter beyond the competency of lay persons and requires expert testimony to resolve. CHS offered the testimony of two competent experts that CHS personnel had no such duty under the circumstances. It was in the trial court's sole province whether to accept or reject those opinions. The trial court's decision to accept the opinions of CHS's experts and find in favor of CHS on that basis is not subject to second-guessing on appeal. Consequently, there is no merit to this assignment of error by Campbell.

III. THE TRIAL COURT WAS CORRECT IN CONSIDERING AVAILABLE RESOURCES AND OPTIONS OF THE CHS EMERGENCY DEPARTMENT IN DETERMINING WHETHER CHS PERSONNEL BREACHED THE APPLICABLE STANDARD OF CARE.

Campbell argues that the trial court erred in considering the fact that the CHS emergency department staff was extremely busy with multiple acutely ill patients at the time Sykes

arrived. The argument that this fact has no bearing on whether CHS complied with the standard of care is simply incorrect. This Court has recognized that the standard of care has a "resources-based component." *Hall v. Hilbun*, 466 So. 2d 856, 873 (Miss. 1985). Thus, the duty of care requires that the medical care provider treat the patient "with such reasonable diligence, skill, competence, and prudence as are practiced by minimally competent physicians . . . who have available to them the same general *facilities*, services, equipment and *options*." *Id.* (emphasis added); *see also Ortman v. Cain*, 811 So. 2d 457, 462-63 (Miss. App. 2002)(quoting *Hall*).

Campbell points out that it was admitted that the stress on the resources would not have prevented the commencement of the ACLS protocol. However, that was not the issue with regard to the demands on the staff, and that was not what the trial court was addressing in that part of its ruling. Campbell's criticism of the triage, through Dr. Perron, was that Nurse Marshall classified Sykes as non-urgent based on the assessment done by Lafayette rather than asking the questions herself. (Tr. 41.) Under *Hall*, the trial court properly considered the fact that, because Nurse Marshall was busy caring for patients who unquestionably were in emergency situations, it was appropriate for her to have Lafayette obtain from Sykes the information she used to determine if he needed emergency treatment. Given the

number of patients in critical need, CHS did not have the option available to dispatch a registered nurse to question Sykes. It was not a viable option for Nurse Marshall to leave a patient with a serious head injury to interview a patient whose complaint of "heart racing" was not corroborated by his pulse rate and whose complaint that his chest was "sore" was not a typical indicator of a heart attack.

Campbell argued that the CHS policy embodied the standard of care. As Nurse Marshall testified, that policy permitted her to delegate parts of the triage process to others. (Tr. 218; Exhibit 1 p. 49.) CHS's experts were aware of the entire situation confronting Nurse Marshall, and they testified that the treatment of Sykes did not violate the applicable standard of care. The trial court accepted the opinions of those experts. As set forth above, it would not be proper for this Court to second-guess the trial court's findings or substitute its judgment as to the credibility or persuasiveness of CHS's expert witnesses. Those experts' opinions are substantial evidence supporting the trial court's findings and judgment. Therefore, Campbell's argument is without merit.

IV. THE TRIAL COURT'S FACTUAL FINDING THAT CAMPBELL FAILED TO PROVE THAT THE ALLEGED FAILURE TO EVALUATE SYKES WAS A PROXIMATE CAUSE OF HIS DEATH WAS SUPPORTED BY SUBSTANTIAL EVIDENCE.

The trial court factually determined that, even if Campbell had proved that CHS personnel were negligent in the evaluation of Sykes, she did not meet her burden of proving, in addition, that such negligence was a proximate cause of Sykes's death. (Final Judgment ¶ 7, CP 258.) Contrary to Campbell's argument, there is substantial evidence supporting this factual finding.

Campbell's contention was that CHS personnel should have put Sykes on a heart monitor or EKG, and that if they had, he probably would not have died. The trial court found that Campbell had not met her burden of proof that, even if Sykes had been monitored at the time of the fatal arrhythmia, it was more likely than not that he could have been resuscitated. The evidence supporting this trial court finding was the testimony of CHS expert, Dr. Carlton, that, even in cases where defibrillation and other resuscitative efforts are instituted immediately, there is at best a 30 percent survival rate from fatal arrhythmia. (Tr. 391.) In order to prove that quicker commencement of resuscitation efforts would have made a difference, Campbell would have had to prove that the success rate of immediate defibrillation was more than 50 percent. Thus, the finding of the trial court was supported by

substantial evidence. Indeed, Campbell's brief does not seem seriously to dispute this point.

Rather, Campbell argues that the proximate causation issue involves more that the question of whether being on a monitor would have made a difference once the arrhythmia occurred. Campbell contends that, had Sykes been on a monitor, his heart attack would have been detected and could have been treated so that the arrhythmia would not have happened in the first place. Campbell's argument regarding proximate cause is faulty, for at least two reasons.

First, Campbell is incorrect in arguing that the trial court overlooked this issue and "only focus[ed] on the chances of resuscitating the patient after he collapsed." The trial court addressed the issue in finding that Campbell failed to prove that Sykes, in fact, was suffering a heart attack at the time he presented to CHS. (Final Judgment ¶ 5, CP 258.) That question is central to the causation issue, because Campbell's "prevention" theory depends on the existence of a heart attack. Campbell contended that, if CHS personnel had put Sykes on a monitor, and thus discovered that he was having a heart attack, they would have administered medications that might have stemmed the attack and prevented it from reaching the point where it caused the fatal ventricular fibrillation. In order to prove that it was more likely than not that immediately placing Sykes

on a monitor would have prevented the arrhythmia from occurring, Campbell had to prove that the EKG would have revealed a heart attack in progress; otherwise, there would have been no reason for the administration of the medications that might have arrested the heart attack and prevented the arrhythmia. Obviously, the EKG would not have shown an ongoing heart attack if one was not in fact occurring; thus, to prove her case Campbell had to prove that Sykes was indeed having a heart attack on presentation to the emergency department. Therefore, in addressing the issue of whether Sykes had a heart attack, the trial court was addressing the "preventative" portion of the proximate cause theory that Campbell says the trial court disregarded.

Second, there is no basis for Campbell's argument that the trial court was manifestly wrong in finding that Sykes was not having a heart attack on presentation. For that argument, Campbell relies on the opinions of her expert witnesses to that effect. However, as noted above, in determining whether the trial court's conclusions were supported by substantial evidence, this Court must disregard evidence that does not support the judgment. Thus, since Campbell's argument relies on the testimony of her expert witnesses, it is without merit.

Moreover, CHS's cardiology expert, Dr. Calhoun, expressed the opinion that Sykes probably was not having a heart attack at

the time of his presentation to the emergency department. (Tr. 304.) Dr. Calhoun based this opinion in part on the absence of evidence on autopsy of any damage to the heart muscle, which should have been present had Sykes been having a heart attack, and on the fact that the autopsy revealed severe cardiomegaly, which could have caused the fatal arrhythmia in the absence of a heart attack. (Tr. 306-09.) Dr. Carlton, CHS's other expert, testified similarly. (Tr. 367-70.)

Dr. Carlton also testified that there was "absolutely no way" one could say that, in the absence of a heart attack, an EKG would have given advance warning of dysrhythmia caused solely by the cardiomegaly so that the fatal ventricular fibrillation could have been medically prevented. (Tr. 376-77.) Thus, there was substantial evidence to support rejection of Campbell's secondary theory that placing Sykes on a heart monitor could have allowed rhythm disturbances to be addressed before they degenerated into a fatal arrhythmia.

Because the expert testimony is in conflict concerning whether Sykes actually had a heart attack, in particular as to whether he was having a heart attack at the time of presentation to the emergency department, and whether monitoring would have given warning of the potential for a fatal arrhythmia in the absence of a heart attack, the trial court cannot have been manifestly wrong in the conclusion that Campbell did not meet

the burden of proof on the causation issue. The expert testimony of Dr. Calhoun and Dr. Carlton described above constitutes substantial evidence supporting the trial court's factual finding.

CONCLUSION

At the conclusion of the evidence in this bench trial, the parties elected to forego closing arguments. Apparently, Campbell elected to advance her factual argument on appeal instead. Campbell's brief is essentially an argument that the trial court should have believed her expert witnesses instead of the expert witnesses offered by CHS. However, that is not a proper or cognizable argument on appeal, and it is not a valid basis upon which to reverse a trial court's judgment. Because the trial court's findings are unquestionably supported by substantial evidence according to all precedents of this Court and clearly based on more than a scintilla of proof, Campbell's assignments of error are not valid. Accordingly this Court should affirm the judgment of the circuit court.

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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 appellants 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:

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This the 3rd day of November, 2010.

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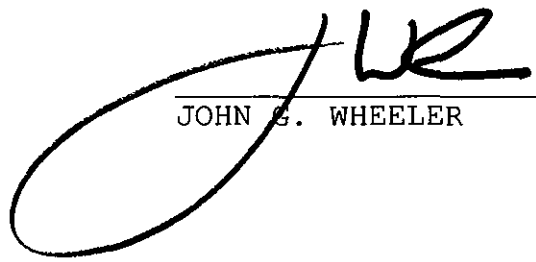
CERTIFICATE OF FILING

The undersigned, an employee of Mitchell, McNutt & Sams, P.A., certifies that on November 3, 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.



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