IN THE SUPREME COURT OF MISSISSIPPI

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**
VERSUS	**NO.: 2010-CA-00654**
CALHOUN HEALTH SERVICES	**APPELLEE**

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 disqualification or recusal.

Appellants: 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, James E. Sykes and James Henry Sykes

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STATEMENT OF THE CASE AND OF THE FACTS

I. Statement of the Case

This is a medical malpractice suit asserted by The Estate (Through the Administratrix Ida Campbell) and The Wrongful Death and Survival Beneficiaries of John Earl Sykes against Calhoun Health Services (sometimes hereinafter referred to as "Calhoun") pursuant to the Mississippi Tort Claims Act, M.C.A. § 11-46-1 *et seq.*

The action contends that Mr. Sykes presented to the emergency department of Calhoun Health Services on January 1, 2007 with complaints of chest pain, nausea and vomiting. The suit asserts the substandard care on the part of Calhoun and its employees, for which it is vicariously liable. The suit asserts that Calhoun failed to perform a timely and proper assessment of a chest pain patient, failed to timely perform tests to determine whether the patient was suffering a cardiac event and failed to provide prompt and sufficient treatment to a patient suffering a cardiac event. It is alleged that as a result of this substandard care, John Earl Sykes expired. (Record, pp. 15-20).

The trial of this matter commenced on February 22, 2010 before the Honorable Andrew Howorth, and following post-trial briefing, a final judgment in favor of defendant was entered on March 24, 2010. (Tr. p. 248-259). Plaintiffs timely appealed the Trial Court's ruling and here seek reversal.

II. Statement of the Facts

The policies and procedures of Calhoun Health Services, which Nurse Joan Marshall admitted constituted the standard of care,[1] requires a triage to be conducted for every patient entering the Emergency Department by a registered nurse. (Record Ex. "E," p. 49). Although certain portions of the triage can be delegated to non-registered nursing personnel, "the targeted assessment of the chief complaint" must be performed by a registered nurse according to the policies and procedures of Calhoun Health Services. The registered nurse is also responsible for determining the patient's acuity level. (Record Ex. "E," p. 49). The triage is to be conducted using a triage form, which has checklists to make sure the right questions are asked. (Tr. p. 223, line 2-10). As admitted by the nurse who filled out the form in the case of Mr. Sykes, the form is to be filled out contemporaneously with the triage evaluation of the patient. (Tr. p. 217, line 4-18). This documented, prompt triage evaluation by a qualified registered nurse which must be done for any patient – even one with a non-serious condition – did not happen in the case of John Sykes, even though he came to Calhoun on New Years Day of 2007 for evaluation of cardiac discomfort, a life-threatening potential medical emergency.

Nurse Joan Marshall is the nurse who signed the triage form and was responsible to perform the triage on Mr. Sykes. (Tr. p. 217, line 4-18; Record Ex. "A," p. 5). Even though it is not apparent from the face of the document, Nurse Marshall did not fill the triage sheet out until after the patient was dead. On a "chest pain complaints" form, she documented vital

[1](Tr. p. 219, line 8-15).

signs of: a hypertensive blood pressure of 174/90, pulse of 77 and a pain level of 1 to 2 out of 5. She documented "chest sore - nausea and vomiting" and indicated that she believed that the patient vomited on one occasion. (Record Ex. "A" p. 5). As she admitted in her testimony, she never talked to the patient and never performed a triage of the patient, and she conceded that simply looking at the patient is not a triage or an assessment. (Tr. p. 225, line 26-29; Tr. p. 226, line 1-13). Thus, she initially classified the patient as non-urgent (and hence did not initiate ACLS protocol) without ever actually examining or questioning the patient herself. (Tr. p. 220, line 23-26).

Thus, there was thus no triage performed on John Sykes as contemplated by the Calhoun Health Services policies and procedures, even though he complained of a problem with his chest. Ms. Marshall made no documentation on the triage sheet that the emergency department had been too busy to perform the protocol of Advanced Cardiac Life Support for acute coronary syndromes (ACLS protocol) for the patient. (Record Ex. "A," p. 5). As stated above, she did not initiate ACLS protocol because she believed he was non-urgent, even though standard triage to confirm this non-urgency had not been performed.

There was testimony of questioning of the patient by Nurse Debbie Stroup-Russell, but as she admitted in her testimony, this occurred only shortly before the patient collapsed, and this information was not transmitted to Nurse Marshall, who had the responsibility to triage the patient. (Tr. p. 34, line 22-29; Tr. p. 345, line 1-4; Tr. p. 345, line 28-29; Tr. p. 346, line 1-5). Nurse Russell admitted that her questioning did not constitute a triage. (Tr. p. 345, line 23-25).

This erroneous classification of the patient's acuity was the product of what the testimony established occurred in lieu of a proper triage. The questioning of the patient by Toby Lafayette, who lacked proper qualifications as a non-ACLS certified Basic EMT, did not constitute a proper triage as he admitted in his testimony. (Tr. p. 158, line 5-28). He simply "overheard" a chest complaint, and for the first time in his career, decided to undertake to question the patient.[2]

As a result of the failure to perform a proper triage, there was considerable confusion as to the actual nature of the complaints made by the patient on presentation. Contrary to Nurse Marshall's testimony, Mr. Lafayette indicated that he told Nurse Marshall that the patient had chest soreness and not "heart racing." He testified that he was not attempting a triage and was simply trying to convey the chief complaint to her. (Tr. p. 158, line 5-28). Nurse Marshall recalled only that Mr. Lafayette gave her a "post-it note" with vital signs and a chief complaint of "heart racing." (Tr. p. 221, line 5–25). Ms. Marshall's original decision to triage the patient as a non-urgent patient, the lowest priority, was made on the basis of hearing on that the patient had "heart racing," which she believed conflicted with the vital signs. She was initially unaware that the patient had chest soreness. (Tr. p. 229, line 15-17). Thus, she made the critical decision not to initiate ACLS protocol on the basis of incomplete and inaccurate information which was the result of the failure to properly triage the patient.

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[2]Toby Lafayette testified that he was never trained in hospital triage, was not familiar with Calhoun's triage protocols and not authorized to document on triage forms. He had never evaluated a patient inside a hospital or even worked in a hospital setting at any time. (Tr. p. 150, line 2-29; Tr. p. 151, line 1-24).

As a result of the failure to properly perform a triage and the resulting miscommunications between Mr. Lafayette and Ms. Marshall, the ACLS protocol for workup and treatment for acute coronary syndrome did not occur.

There was abundant evidence that there was more than enough information suggestive of chest discomfort to initiate ACLS protocol. The autopsy records indicate in two separate sections that the patient had been complaining of "chest pain" at Calhoun Health Services. (See narrative prepared by Jerry Moore, Record Ex. "B," p. 37; see History of Steven Haynie, M.D., Record Ex. "B," p. 35). The testimony of the defense experts that the patient did not explicitly state that he had chest pain, tightness, squeezing or other indications of acute coronary syndrome is not meaningful, given that without a properly conducted triage, it cannot be reliably determined that Mr. Sykes would not have related those symptoms had he been properly triaged on January 1, 2007. The testimony of plaintiffs' expert, Dr. Neal Shadoff, a cardiologist, and Dr. Andrew Perron, an emergency medicine physician, established that for a 41 year old African American male, any kind of complaint of chest discomfort is sufficient to initiate ACLS protocol. (eg., testimony of Dr. Perron, Tr. p. 37, line 3-27).

The standard of care applicable to Calhoun Health Services, which was admitted by Nurse Joan Marshall to be a national standard of care which follow ACLS Guidelines, required an EKG to be performed within 10 minutes of the patient's arrival with the administration of morphine, oxygen, nitrates and aspirin. (Tr. p. 232, line 4-13; Tr. p. 240,

line 27-29; Tr. p. 241, line 1-5). None of these interventions, however, were performed in the case of John Sykes on January 1, 2007.

Dr. Frederick Carlton, a defense expert, admitted that under ordinary circumstances, the failure to initiate a proper triage of Mr. Sykes complaints was contrary to "standard practice." He indicated that he did not know about "standard of care." (Tr. p. 386, line 9-22). Dr. Carlton's testimony indicates that the only reason he could say that the overall circumstances of the case conformed to the standard of care was on the basis of a "mass casualty situation." (Tr. p. 387, line 9-20). As set forth previously, however, Nurse Marshall did not attribute the decision not to initiate ACLS protocol to the busyness of the Emergency Department.

Had the patient been treated in accordance with the standard of care, it is likely that the dysrhythmia which became fatal would have been prevented by therapy to reduce ischemia, such as aspirin, oxygen and nitrates. Monitoring with a cardiac monitor would have provided an opportunity to correct rhythm disturbances before ventricular fibrillation developed, and would have allowed prompt defibrillation. (eg., testimony of Dr. Shadoff, Tr. p. 118, line14-29; Tr. p. 119, line 1-19). This is true regardless of whether the

dysrhythmia was due to ischemia and infarction, ischemia alone or any other cause.[3] There would not have been a delay between the patient's dysrhythmia and defibrillation (See Record Ex. "A," p. 12, indicating the patient collapsed at 1855 and was not defibrillated until 1900), but the patient likely would not have reached the point that defibrillation of a fatal arrhythmia was necessary if he had been given the ACLS protocol within 10 minutes of arriving at Calhoun as required by the standard of care. Thus, the deviations from the standard of care directly caused the patient's death.

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[3]As admitted by Dr. Carlton, the defense emergency medicine expert, the acute coronary syndrome includes unstable angina. Unstable angina is acute chest discomfort from ischemia which has not reached the level of infarction. The concept of acute coronary syndrome was originated in part in recognition that sudden cardiac death from a dysrhythmia can occur with mere coronary ischemia in the absence of infarction. One of the goals of ACLS protocol is to prevent sudden cardiac death from dysrhythmia which can result from an acute coronary syndrome, regardless of whether the subtype of the syndrome involves infarction (ST or non-ST elevated MI) or ischemia without infarction (unstable angina). (Tr. p. 378, line 20-29; Tr. p. 379, line 1-29; Tr. p. 380, line 1-25).

SUMMARY OF THE ARGUMENT

On January 1, 2007, John Earl Sykes presented to the emergency department of Calhoun Health Services with complaints of chest discomfort, nausea and vomiting. The patient's complaints were recorded on an Emergency Nursing Record "Chest Pain Complaints" form which indicated that the patient was triaged at 1750 and classified as a non-urgent case. In sharp deviation from the standard of care as well as Calhoun's policies and procedures, however, no such triage was actually performed. The documented triage was rather performed after the fact and after the patient had died. Even though a targeted assessment of any chief complaint – much less one with life threatening implications as in the case of chest discomfort – must be performed by a registered nurse, this did not occur with John Sykes.

Instead of the prompt, contemporaneously documented triage by a qualified registered nurse, what happened in the Calhoun Emergency Department on January 1, 2007 falls so far short of what should be expected from a provider of emergency services that the Trial Court's determination that the care was merely "imperfect" should not stand. An EMT Basic who "overheard" chest complaints undertook to ask questions of the patient. He passed her a "sticky note," an *ad hoc* process which resulted in Nurse Marshall not learning that the patient had chest "soreness," a form of discomfort for which ACLS protocol requires immediate action in a 41 year old African American male smoker. The result of this weak substitute for triage was that the staff was unable to appreciate more cardiac symptoms only about an hour before John Sykes' cardiac condition took his life. It was unreasonable for the

Trial Judge to find that his complaints were "atypical" given the lack of proper assessment before the patient was unresponsive. Without a proper triage assessment to get to the bottom of the true nature of the patient's complaints, there can be no substantial evidence that the complaints were in fact "atypical." This ruling which gives the defense the benefit of doubts directly created by a substantial deviation from the standard of care is manifestly wrong. Furthermore, ACLS protocol is not reserved for patients who definitely have "classic" symptoms of heart attack; a "wide net" must be cast to include in the workup those that merely have a reasonable chance of having this potentially devastating medical emergency. This is why the protocols use the term chest "discomfort" rather than "chest pain," and the "soreness" voiced by the patient rendered it completely improper to leave this man for more than an hour without any meaningful assessment.

As a result of the failure to properly perform triage, the patient's medical emergency went unrecognized, and he was not given standard treatment which was well within the capabilities of Calhoun Health Services. The patient was not provided the immediate care, physician evaluation and treatment which his condition required. He was not given any care at all for the condition he sought care for, and at 1859 on January 1, 2007, the patient collapsed in the waiting room. This was more than an hour after John Sykes arrived complaining of chest discomfort. The patient was then moved to a room and a "Code Blue" was called. The initial findings at the time the code was called included no respirations, a weak pulse and ventricular fibrillation. Resuscitative efforts were initiated. Since Mr. Sykes was not on any kind of monitor/defibrillator which he would have been on if standard triage

and chest discomfort protocol had been initiated, there was approximately a five minute delay in defibrillation. Resuscitative efforts were unsuccessful and the patient's death was called at 1932.

Due to the substandard care of Calhoun Health Services and its employees, for which it is vicariously liable, in failing to perform a timely and proper assessment of a chest pain patient, in failing to timely perform tests to determine whether the patient was suffering a cardiac event and in failing to provide prompt and sufficient treatment to a patient suffering a cardiac event, John Earl Sykes expired.

The Trial Court committed clear error additionally by finding no medical causation on the basis of the mere possibility that the patient may not have been having a frank myocardial infarction. In addition to applying the incorrect burden of proof, the entire concept of an acute coronary syndrome is testament to the fact that the ACLS protocol can successfully treat and prevent death in cardiac conditions other than the full myocardial infarction envisioned by the Trial Court. Whether or not the patient was infarcting simply does not fully or directly answer the question as to whether proper care would have been lifesaving. Moreover, the Trial Court improperly considered the key causation issue as one involving the question of whether or not quicker defibrillation at the time the patient suffered ventricular fibrillation would have altered the outcome, as opposed to addressing the proper caustion question presented. The Court did not address the question of whether or not the immediate institution of ACLS protocol, which includes not only cardiac monitoring but also

the administration of morphine, oxygen, nitrates, aspirin would have been life-saving if started well before the ventricular fibrillation developed.

In sum, the ruling that there were no deviations from the standard of care which caused the death of John Earl Sykes was clearly wrong, manifestly erroneous and lacking in substantial evidentiary support.

ARGUMENT

I. THE DEFERENTIAL STANDARD OF REVIEW FOR THE TRIAL JUDGE'S FINDINGS IS NOT GROUNDS TO AFFIRM THE RULING THAT THERE WERE NO DEVIATIONS FROM THE STANDARD OF CARE WHERE DEVIATIONS ARE ESTABLISHED BY SIMPLY COMPARING THE CARE DOCUMENTED BY THE HOSPITAL TO THE ADMITTED STANDARDS FOR THAT CARE

The standard of appellate review applicable to a ruling from a circuit court judge sitting without a jury pursuant to the Mississippi Tort Claims Act has often been stated by this Court. See, eg, *City of Jackson v. Internal Engine Parts Group, Inc.*, 903 So.2d 60, (Miss. 2005). This Court has stated that "a circuit court judge sitting without a jury is accorded the same deference with regard to his findings as a chancellor, and his findings are safe on appeal where they are supported by substantial, credible and reasonable evidence (citations omitted). This Court will not disturb those findings unless they are "manifestly wrong, clearly erroneous or an erroneous legal standard was applied." *City of Jackson v. Perry*, 764 So.2d 373 (Miss. 2000). Although the general standard of review is one of significant and perhaps even great deference to the trial judge, Mississippi law nevertheless embraces true appellate review of factual determinations.

This is a medical malpractice case in which there was little debate in defining the standards of care. According to the nurse who was supposed to be performing the triage, the standard of care requires compliance with the Calhoun policies and procedures. It simply cannot be questioned that there was no triage which occurred in this case in conformance with the policies and procedures and the standard of care. Comparing the agreed upon

standards of care or "practice" to the factual events which are admitted to have happened involves no credibility determinations. When a trial judge renders a judgment which is inescapably wrong and which simply overlooks substantial deviations from the applicable standard of care, it is this Court's duty to reverse.

II. THE TRIAL COURT WAS MANIFESTLY WRONG AND CLEARLY ERRONEOUS IN FINDING THAT THERE WAS NO VIOLATION OF THE REQUIREMENT THAT A BASIC TRIAGE BE PERFORMED FOR EVERY PATIENT

This is a case in which John Sykes, a 41-year-old African American male with a history of smoking, developed symptoms of discomfort in his chest and sought evaluation and treatment at Calhoun Health Services' Emergency Department. He remained in the Emergency Department's waiting room, without receiving the standard Calhoun Health Services triage within a reasonable period of time. An hour and nine minutes after arriving at Calhoun, he fell out and then died from what the Trial Court found to be a cardiac event.

Notwithstanding the glaring nature of Calhoun's failure to comply with its own protocols for performing a basic triage for any patient – and not just those presenting with cardiac complaints which by their nature could be life-threatening – the Trial Judge committed clear error by failing to find that there was a deviation from the standard of care in performing the basic triage function to which John Earl Sykes was entitled.

The policies and procedures[4] require that a targeted assessment of the chief complaint be performed in a reasonable time. Nurse Marshall admitted that the approximate hour and 10 minutes as was the case for John Sykes was not a reasonable amount of time. (Tr. p. 231, line 25-29). The triage must be contemporaneously documented, rather than having the triage form filled in after the fact as occurred in this case. As Nurse Marshall testified

> Q. I understand, but the way it's supposed to work is that the triage form is supposed to be filled out contemporaneously with the time you are doing the triage, correct?
>
> A. Yes.
>
> Q. It's not supposed to be filled out after the fact, is a question
>
> A. No, it's not supposed to be. When things happen like they did that night, it was after the fact. (Tr. p. 217, line 12-20).

Even the defendant's own emergency medicine expert, Dr. Frederick Carlton, indicated that Calhoun failed to comply with its policies and procedures and "standard of practice," if not standard of care:

> Q. And in the context of a guy walking through the emergency department, and you have read the policies and procedures of this facility, haven't you?

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[4]Joan Marshall testified as follows:

> Q. . . . you will agree with me that the policy and procedure enbodies the standard of care, doesn't it?
>
> A. Yes. (Tr. p.19, line 9-12).

A. Yes, sir.

Q. There has to be a targeted assessment of the chief complaint, the reason he comes in there by a registered nurse; correct?

A. Correct.

Q. And that is the standard of care; right, at your hospital, everywhere in Mississippi, everywhere in the country; correct

A. Yeah. I guess the only thing I'm hesitating on is it the standard of care. I mean, that is what is done. It certainly standard of practice . . ." (Tr. p. 386, line 9-22).

. . .

A. As I told you it didn't conform to the standard of practice whether conform to the standard of care, I don't know that that is really part of the standard of care . . . (Tr. p. 387, line 13- 16).

As will be seen, it was this basic failure to perform triage which caused John Sykes' chest complaints to go ignored. The Trial Court jumped to the question of whether there were sufficient cardiac symptoms present without first determining whether the absence of additional cardiac symptoms was the product of the failure of basic triage. That there was a failure of basic triage could not reasonably be questioned, and the Trial Court's failure to note this and rather rely on the absence of information a proper triage likely would have yielded entirely undermines the Final Judgment.

III. THE TRIAL COURT'S FINDING THAT THE PRESENTATION OF JOHN SYKES WAS SO ATYPICAL THAT THE FAILURE TO INITIATE ACLS PROTOCOL CAN BE EXCUSED WAS MANIFESTLY WRONG AND LACKED SUBSTANTIAL EVIDENTIARY SUPPORT

In the preceding section of this brief, Plaintiffs have cited the rather undisputable evidence that the information gathering process was not performed in accordance with standard triage protocol. It is highly implausible that the chest complaints voiced by Mr. Sykes were simply coincidental to the fact that he fell out a little more than an hour after arriving at Calhoun Health Services for evaluation and treatment of those complaints. Even Dr. Carlton did not believe that the complaints of the patient seeking treatment for chest discomfort and the fact that he suffered a cardiac death a little more than an hour later are only linked by coincidence. (Tr. p. 381, line 22-29). Typical symptoms were likely present but simply uncovered due to inadequate triage, and yet the Trial Court found that Mr. Sykes' presentation was "atypical." (Record p. 257-258). To the extent the after the fact documentation indeed paints an "atypical" picture of an acute coronary syndrome, it is manifestly wrong to simply assume that this atypicality was the result of the actual condition of the patient on presentation rather than the result of the failure to get the true picture through proper triage assessment. The information on the symptoms was being gathered by an inexperienced EMT basic who had never performed a chest complaint assessment in an emergency department setting in his life prior to that time, and has never done it since, rather than a qualified questioner. Thus, the Trial Court had no evidentiary support to find it unnecessary for ACLS protocol to be initiated to at least confirm whether the patient was

having an acute coronary syndrome. It is entirely implausible to assume that had proper triage been performed rather than the "post-it note" passing which happened in the case of John Sykes, more typical cardiac symptoms would not have been found an hour before he died from his heart condition. The Trial Court had no basis on which to simply assume that the findings as documented in the various pieces of paper that were put together in the defendant's after-the-fact reconstruction of the event was the same as what would have been learned had the patient been appropriately and contemporaneously triaged and placed through the ACLS protocol. One rarely finds what is not properly searched for.

In any event, the evidence of chest discomfort sufficient to require ACLS protocol is overwhelming even without a properly documented triage. The patient's complaints were recorded on a "Chest Pain" form. Additionally, the patient's "PAIN LEVEL" was documented on the triage form as a level 2 out of 5. (Record Ex. "A," p. 5). On that same Chest Pain form, "aching," which is synonymous with "soreness," is listed as a possible descriptor of chest pain.

At a minimum, John Sykes presented to the emergency department at Calhoun Health Services on January 1, 2007 with complaints of chest soreness, nausea, vomiting and vital signs displaying hypertension. These symptoms alone are sufficient to require the immediate initiation of ACLS acute coronary syndrome protocol pursuant to minimum standards of care.

As established by the testimony of Plaintiffs' experts, any sign of chest discomfort in a 41 year old African-American male, without other obvious explanation of a non-cardiac etiology, requires the acute coronary syndrome protocol to be initiated immediately. (eg.,

testimony of Dr. Shadoff, Tr. p. 107, line 20-29; Tr. p. 108, line 1-15). The opinions of Plaintiffs' experts are consistent with the ACC/AHA Guidelines relied upon by both parties. These Guidelines provide that chest discomfort or some other sign of an acute coronary syndrome require the ACLS protocol to be launched. (emphasis added). These Guidelines do not support the defense position that their must be an explicit statement of "pain," or chest discomfort plus some other symptom. The Guidelines state:

> *Regardless of the approach used, all patients presenting to the ED with chest discomfort or other symptoms suggestive of STEMI or unstable angina should be considered high-priority triage cases and should be evaluated and treated on the basis of a predetermined, institution-specific chest pain protocol. The protocol should include several diagnostic possibilities (Figure 9) (4). The patient should be placed on a cardiac monitor immediately, with emergency resuscitation equipment, including a defibrilator, nearby. An ECG should be performed and shown to an experienced emergency medicine physician within 10 minutes of ED arrival.*[5]

The Guidelines further state:

> *A 12-lead ECG should be performed and shown to an experienced emergency physician within 10 minutes of ED arrival on all patients with chest discomfort (or anginal equivalent) or other symptoms suggestive of STEMI.*

(Tr. p. 312, line 13-29; Tr. p. 313, line 1-29; Tr. 314, line 1-29; Tr. 315, line 1-28).

Nurse Marshall also indicated that the protocol should have been initiated if the patient used the word "pain" instead of "soreness." (Tr. p. 140, line 27-29; Tr. p. 241, line 1-11). The difference between "sore" and "pain" is not a valid or sufficient distinction, and

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[5] ACC/AHA 2004 Guidelines for the Management of Patients with ST-Elevation Myocardial Infarction - A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (Committee to Revise the 1999 Guidelines for the Management of Patients with Acute Myocardial Infarction), by the American College of Cardiology Foundation and the American Heart Association, Inc.

minimum standards of care required the acute coronary syndrome protocol to be initiated for a patient such as Mr. Sykes regardless of the discomfort descriptor voiced by the patient.

Indeed, the published protocols such as ACLS use the word "chest discomfort" rather than "chest pain" in recognition of the fact that different people use different descriptors to describe chest discomfort. (Tr. p. 110, line 4-25).

IV. THE TRIAL COURT'S FAILURE TO FIND THAT THE "IMPERFECT" CARE WAS NOT SUBSTANDARD BECAUSE THE EMERGENCY DEPARTMENT WAS BUSY WAS MANIFESTLY WRONG AND LACKS SUBSTANTIAL EVIDENTIARY SUPPORT

The defense contention that the Emergency Department was busy does not excuse a violation of the standard of care. Indeed, there were only eight patients who were present in the Emergency Department for any of the time that John Sykes was in the Emergency Department prior to his death. The Emergency Department Register shows that the head injury patient discussed in Ms. Marshall's testimony was discharged/transferred at 1835, 20 minutes prior to the time Mr. Sykes collapsed. (Record Ex. "C," pp. 46-47). Two patients who came in before Mr. Sykes were admitted to the medical floor of Calhoun Health Services, and the other patients were able to be discharged home, while one left against medical advice. (Record Ex. "C," pp. 46-47). There was no documentation or other evidence of a "mass casualty" situation.

As Nurse Stroup-Russell testified, she would have come earlier if called and told that extra help was needed. She was never called. (Tr. p. 346, line 27-29; Tr. p. 347, line 1-3). The triage form does not indicate that there was a failure to initiate ACLS protocol because

the Emergency Department was busy. The reason that there was nothing done according to the Triage Form was the "non-urgent" classification of the patient. (Record Ex. "A," p. 5). This was confirmed by the nursing testimony. The trial transcript may contain a few asides about the busyness of the Emergency Department on January 1, 2007, but the nurses did not testify that this was the reason that John Sykes did not receive ACLS protocol. As Nurse Marshall[6] testified:

> Q. So the reason that he did not get an EKG and the protocol was because he was non-urgent in your opinion and did not have anything to do with how busy the emergency department, correct?
>
> A. Based on the information that I had, he was stable. He didn't complain of chest pain . . . (Tr. p. 240, line 14-19).
>
> . . .
>
> A. He didn't get it [ACLS protocol] because he was not in distress. He didn't complain of chest pain, and he didn't have any of the symptoms that you are talking about for an acute coronary syndrome. He was stable.
>
> Q. But that's the reason he was non-urgent, not because you were too busy to do an EKG, fair statement?
>
> A. I suppose. (Tr. p. 241, line 8-14).

A fair reading of the totality of the testimony of Dr. Carlton is that he was only willing to testify that the care rendered was not below minimum standards because he excused them on the basis of a "mass casualty." (Tr. p. 363, line 9-29; Tr. p. 364, line 1-25). And yet the

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[6]Similarly, Nurse Stroup-Russell testified that she could have immediately performed an EKG on Mr. Sykes after she arrived, regardless of what else was going on in the Emergency Department. (Tr. p. 347, line 4-25).

recognition that ischemic events falling short of myocardial infarction are in need of urgent treatment to prevent death or severe heart injury. This concept was thoroughly described by plaintiffs' experts and was embraced by Dr. Carlton, one of the defense experts. (Tr. p. 378, line 20-29; Tr. p. 379, line 1-29; Tr. p. 380, line 1-25). Thus, even if the Trial Court actually found that there was no "myocardial infarction" notwithstanding the elevated enzyme levels, on the basis of the absence of scarring on gross pathology examination,[7] this does not justify a finding that Mr. Sykes probably did not die due to being neglected in the Calhoun emergency department for more than an hour.

The Trial Court therefore held plaintiffs to the burden of proving beyond contrary possibility that a myocardial infarction sufficient to yield autopsy results occurred, when the question of whether or not the patient had a myocardial infarction was not really the true issue before the Court. The Court compounded this error by finding that "even if John Earl

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[7]In addition to being somewhat beside the point, the Trial Court's finding was manifestly wrong. The Plaintiffs' experts, consisting of an emergency medicine physician who has extensively published on the topic of acute coronary syndromes and a cardiologist with training and experience in cardiac pathology, explained that it is highly likely that the patient was having a myocardial infarction when he entered the hospital. The absence of autopsy evidence of infarction is explained by the fact that scar tissue cannot be formed after death. Evidence of infarction on gross pathological description lags significantly behind the evidence of infarction on CPK/MB and Troponin lab studies. Both of plaintiffs' experts indicated that although Troponin's and CPK/MB can become slightly elevated by chest compression/defribrilation attempts, this cannot explain the extremely high levels – an over 300% high Troponin level as described by Dr. Neal Shadoff – on the lab studies drawn only a few minutes after the patient collapsed. (eg., testimony of Dr. Perron, Tr. p. 86, line 19 - p. 88, line 29; testimony of Dr. Shadoff, Tr. p. 144, line 9 - p. 118, line 4).

The section of the autopsy pertaining to the heart does not indicate that microscopic examination of heart tissue was performed, nor does it indicate that staining of the cells was performed. (Record Ex. "B," p. 28).

Sykes was being monitored on a cardiac monitor at the time of his fatal dysrhythmia as suggested by the plaintiffs and their trial experts, it cannot be concluded to a reasonable degree of medical probability that any efforts at defibrillation by CHS personnel at the time of the fatal dysrhythmic event would have saved Mr. Sykes's life." (Record p. 258). This conclusion is manifestly wrong, but even if correct, it does not justify the judgment in favor of the defense. It does not address the point of the testimony and other proof establishing that had all components of the ACLS protocol been initiated, this almost certainly would have saved John Sykes' life. (eg., testimony of Dr. Shadoff, Tr. p. 118, line 14-29; Tr. p. 119, line 1-16). Although it is true that one of the questions on which the plaintiffs' and defense experts disagreed was whether quicker defibrillation, after the patient went into ventricular fibrillation and fell out[8], would have successfully resuscitated Mr. Sykes, rejecting the entirety of plaintiffs' causation case simply because the Trial Court resolved this one issue in defendant's favor was unwarranted. This case involves much more than just the care which should have been rendered "at the time of his fatal arrythmia." (Tr. p. 258). Obviously, John Sykes was not having that fatal arrhythmia for the hour long period of time that he was sitting in the waiting room, appearing in no distress to the nurses who looked at

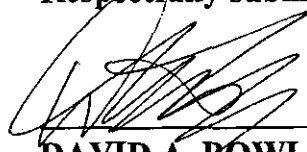
[8]At various points in his testimony, Dr. Carlton cited a 30% survival rate. (e.g., Tr. p. 391, line 10-23). Although plaintiffs believe that this is clear from the overall context of his testimony, in one passage he makes it very plain that this 30% survival rate is his estimate of the chances of successfully resuscitating someone once they are unresponsive and in ventricular fibrillation. (Tr. p. 377, line 16 - 29; Tr. p. 378, line 1-3). This testimony in no way supports the notion that Drs. Shadoff and Perron were wrong when they testified that it is more probable than not that had ACLS protocol been initiated as required by the standard of care 10 minutes after the patient entered the door of the hospital, he would not have died approximately an hour thereafter.

but did not assess him. There was abundant evidence that placing a patient on a cardiac monitor can allow rhythm disturbances to be addressed before they degenerate into fatal arrhythmias (e.g., testimony of Dr. Perron, Tr. p. 53, line 9-29; Tr. p. 54, line 1-13). Moreover, therapies such as morphine, oxygen, aspirin and nitrates relieve ischemia and hence can prevent fatal dysrhythmias from developing in the first place. (e.g., testimony of Dr. Perron, Tr. p. 52, line 10-28). The Trial Court committed clear error by only focusing on the chances of resuscitating the patient after he collapsed. It is the likely lost opportunity to save him during the hour plus period of time he was waiting for assessment and care before he became unresponsive which is the issue in this case. Accordingly, the Trial Court's ruling that plaintiffs did not establish causation is not supported by substantial evidence, is clearly erroneous and is manifestly wrong.

VI. CONCLUSION

Considering the foregoing, it is respectfully submitted that the ruling of the Trial Court be reversed.

Respectfully submitted,



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