IN THE SUPREME COURT OF THE STATE OF MISSISSIPPI

DOCKET NO. 2010-CA-00791

UNIVERSITY OF MISSISSIPPI MEDICAL CENTER,

Defendant/Appellant

VERSUS

DONNIE FOSTER AND SHIRLEY FOSTER, LEGAL GUARDIANS OF THE MINOR CHILD, MALIK R. CALDWELL, WRONGFUL DEATH BENEFICIARY, ON BEHALF OF ALL WRONGFUL DEATH BENEFICIARIES OF TAMIKA LYNETTE FOSTER

Plaintiffs/Appellees

APPEAL FROM THE CIRCUIT COURT OF THE FIRST JUDICIAL DISTRICT OF HINDS COUNTY, MISSISSIPPI

BRIEF OF APPELLANT UNIVERSITY OF MISSISSIPPI MEDICAL CENTER (ORAL ARGUMENT REQUESTED)

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IN THE SUPREME COURT OF THE STATE OF MISSISSIPPI

UNIVERSITY OF MISSISSIPPI MEDICAL CENTER — **DEFENDANT/APPELLANT**

V. — **DOCKET NO. 2010-CA-00791**

DONNIE FOSTER AND SHIRLEY FOSTER, LEGAL GUARDIANS OF THE MINOR CHILD, MALIK R. CALDWELL, WRONGFUL DEATH BENEFICIARY, ON BEHALF OF ALL WRONGFUL DEATH BENEFICIARIES OF TAMIKA LYNETTE FOSTER — **PLAINTIFFS/APPELLEES**

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.

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BY: 

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STATEMENT REGARDING ORAL ARGUMENT

University of Mississippi Medical Center requests oral argument for this appeal from a judgment entered for plaintiff in a Tort Claims Act wrongful death medical malpractice claim.

The bench ruling found that University of Mississippi Medical Center breached the standard of care because it did not diagnose and treat Ms. Tamika Foster for Thrombotic Thrombocytopenia Purpura (TTP) and that the failure to diagnose TTP and treat Ms. Foster for TTP was a proximate cause of Ms. Foster's death. The circuit court's Memorandum Opinion and Order exclusively relies on the autopsy report's finding that the cause of death was "myocardial ischema with arrhythmia, **secondary to ThromboticThrombocytopenia Purpura**."

The TTP causal finding in the autopsy report was based on a test called ADAMTS13. Postmortem blood was used for the test. Undisputed evidence at trial showed the test produces invalid findings when it is performed using postmortem blood.

This appeal raises the issue of whether an autopsy report can constitute substantial evidence when one of the report's findings is based on a test that was believed valid at the time of the autopsy but later was determined to be invalid.

This appears to be an out-of-the-ordinary factual context for the appeal issue and we believe oral argument would assist the parties' presentation and the Court's decision.

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STATEMENT OF THE ISSUES PRESENTED FOR REVIEW

The Circuit Court held that defendant University of Mississippi Medical Center (UMMC) was liable for the wrongful death of Ms. Tamika Foster because it breached the standard of care by failing to diagnose Thrombotic Thrombocytopenia Purpura (TTP) when Ms. Tamika Foster presented to UMMC's OB High Risk clinic in August, 2005. A Report of Autopsy is the only identifiable evidence cited in the Circuit Court's Memorandum Opinon and Order in support of its finding that Ms. Foster had TTP.

An ADAMTS13 test performed on postmortem blood is the foundation for the autopsy report's finding that Ms. Tamika Foster's cause of death was myocardial ischema with arrhythmia, **secondary to ThromboticThrombocytopenia Purpura**. During the trial, Defendant produced undisputed testimony that the ADAMTS13 test produces invalid results when the test is done with postmortem blood. UMMC raises two appeal issues:

1. Should the final judgment be reversed and rendered where the only "substantial" evidence supporting the circuit court's finding as to cause of death was based upon an autopsy report that relied upon an invalid test?
2. Did the circuit court err when it sustained Plaintiff's objection and refused to allow UMMC's expert and UMMC's treating physician to comment about the content of the autopsy report?

STATEMENT OF THE CASE

Introduction

These definitions and acronym explanations may help the Court understand the brief.

Thrombocytopenia is "a decrease in the number of platelets"[1]. This case centers around two causes of thrombocytopenia: (1) The HELLP Syndrome and (2) Thrombotic Thrombocytopenic Purpura (TTP).[2] Both are serious diseases in pregnant women and can be life-threatening. (Ex P-39, P-45).

The acronym "HELLP" describes the syndrome's clinical features. Those are: hemolysis (H), elevated liver enzymes (EL), and low platelets (LP). (Ex. D-23 at page 5; Ex. P-39 at page 1).

The pentad of findings for TTP are (1) microangiopathic hemolytic anemia, (2) thrombocytopenia, (3) neurologic abnormalities—confusion, headache, paresis, visual hallucinations, seizures, (4) fever, and (5) renal dysfunction. Obstetrics Normal and Problem Pregnancies Fourth Edition at 1172 (2002) edited by Stephen G. Gabbe, Jennifer R. Nibyl and Joe Leigh Simpson (Ex. P-46).

The ADAMTS13 test is used to identify Thrombotic Thrombocytopenia Purpura. (Ex. P-44, P-45)

Nature of the Case

This is a Mississippi Tort Claims Act medical malpractice claim to recover damages from

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1 Dorland's Illustrated Medical Dictionary 29th Edition at 1836 (2000).

2 Obstetrics Normal and Problem Pregnancies Fourth Edition at 1170 (2002) edited by Stephen G. Gabbe, Jennifer R. Nibyl and Joe Leigh Simpson (Tr. 63; Ex. P-46).

the University of Mississippi Medical Center (UMMC) for the wrongful death of Tamika Lynette Foster.

Malik R. Caldwell, minor child of Tamika L. Foster, acting through his legal guardians, Donnie Foster and Shirley Foster (parents of Ms. Foster), filed a civil action on behalf of the wrongful death beneficiaries for the wrongful death of his mother, Tamika L. Foster, which occurred on August 20, 2005 while Ms. Foster was a patient at the UMMC hospital. The two wrongful death beneficiaries of Ms. Foster are her two minor children, Malik R. Caldwell, and Roy Bruce Day, Jr., (Ex. P-14). Plaintiff alleges UMMC was negligent in failing to diagnose and treat Ms. Foster for TTP and that said negligence was a proximate contributing cause of Ms. Foster's death. (R. 53-62).

Disposition in the Court Below

UMMC responded to the Complaint and denied all substantive allegations. (R. 67-73).

A three-day bench trial was held before Honorable Tomie T. Green. (Tr. 1). Plaintiff's witnesses included Dr. Robert Stern, OB-GYN expert witness, Dr. Charles Greenberg, hematologist expert witness, and UMMC treating physicians Dr. Tarrik Zaid, Dr. Meredith Kirk Griffin, and Dr. David Bofill. UMMC called Dr. Baha Sibai, OB expert witness, UMMC treating physician Dr. James Martin and hematologist Dr. Joel Lawrence Moake (by deposition). (Tr. 59, 199, 370, 395, 482, 613, 705).

During the trial, UMMC moved for a directed verdict which the circuit court denied. (Tr. 606-607,608; R. 139-147). UMMC renewed the motion at the close of the case. (Tr. 776). After the trial ended, UMMC moved to strike plaintiff's expert testimony because, *inter alia*, the experts relied on the invalid results of the ADAMTS13 test. (R. 129, 135).

The circuit court entered a Memorandum Opinion and Order and found UMMC breached

the standard of care because it did not diagnose TTP and treat Ms. Foster for TTP and held the breach of duty proximately caused Ms. Foster's death. Final Judgment was entered against UMMC in the amount of $500,000.00 (R. 242-253; RE 7-18).

UMMC moved for a judgment as a matter of law or for a new trial which the Circuit Court denied. (R. 254-256, 262). UMMC then filed its Notice of Appeal. (R. 263).

Statement of Facts

Brief Chronology of Ms. Foster's Treatment at UMMC

On January 25, 2005, Ms. Foster presented to OB Receiving at UMMC with complaints of blurred vision and headache, was prescribed medication and the blood test showed a platelet count of 386,000. (Ex. 1 at UMC0356-366). (The Circuit Court's Memorandum Opinion and Order mistakenly uses the date of February 25, 2005 for this visit. (R. 243; RE 10)).

On July 30, 2005, Ms. Foster saw Dr. Tarrik Zaid at OB Receiving. She presented with high blood pressure so he admitted her to monitor her for blood pressure, collection of urine and diabetic work-up. She was discharged on August 1, 2005, with a diagnosis of gestational diabetes. Her blood platelet count was 171,000. (Ex. 1 at UMC0394-435; Tr. 377-380).

On August 8, 2005, Ms. Foster was seen at the OB High Risk Clinic for her initial visit. (Ex. 1 at UMC436-447).

On August 12, 2005, Dr. Griffin saw Ms. Foster at the OB Receiving and she complained of blurred vision and numbness in her fingertips and toes. Dr. Griffin diagnosed gestational thrombocytopenia. Ms. Foster's blood count showed a platelet count of 91,000. (Ex. 1 at UMC449-465).

On August 18, 2005, at 11:30 a.m. Ms. Foster presented to OB Receiving with complaints of nausea, burning in the upper abdomen, vomiting, epigastric pain, intermittent

headache, some urinary urgency, denied dysuria or hematuria, good fetal movement, no vaginal bleeding and no loss of fluids. She was diagnosed with Class I HELLP, started on steriods and sent to labor and delivery at 7:15 p.m. where her child was delivered by c-section. She was taken to MICU. She received fluids, magnesium sulfate and dexamethasone. She was restful through the night and her pain, nausea and vomiting resolved. At 1:00 p.m. on August 19, 2005, Ms. Foster was returned to labor and delivery. Ms. Foster's condition worsened and at 3:15 a.m. on August 20, 2005, Ms. Foster went into respiratory arrest. She was coded and expired at 4:12 a.m. on August 20, 2005. (Ex. 1 at UMC468-691).

An autopsy was performed on August 20, 2005 at 2:00 p.m. On August 23, 2005 an ADAMTS13 test was performed using postmortem blood. The Report of Autopsy was signed on November 30, 2005, and stated the cause of death was "myocardial ischema with arrhythmia secondary to Thrombotic Thrombocytopenia Purpura." (Ex. 1 at UMC 632-635; Ex. P-4; RE 21-24).

SUMMARY OF ARGUMENT

The Circuit Court relies exclusively on the autopsy report to support its finding that Ms Foster had TTP. Based on that finding the Circuit Court then finds that UMMC breached the standard of care because it did not diagnose TTP and did not treat Ms. Foster for TTP. The Circuit Court also relies on the autopsy report to establish causation. It finds that as a proximate result of UMMC's breach of the standard of care, Ms. Foster dies from TTP.

The Circuit Court's finding that Ms. Foster had TTP is clearly erroneous. The undisputed facts show the autopsy report's finding is based on the ADAMTS13 test. The undisputed facts show the ADAMTS13 test is not reliable when postmortem blood is used. Therefore, the undisputed facts show there is no scientific or medical evidence to support the autopsy report's finding that Ms. Foster's death was secondary to TTP. The opinion in the autopsy report does not meet the reliability test of M.R.E 702 because it is "not based on sufficient facts"; more specifically, it is based on no facts; it is simply a conclusion.

Sans the autopsy report, the circuit court's opinion has no factual basis for the legal conclusion that UMMC breached the standard of care. Since the holding is not supported by any substantial credible evidence, UMMC asks the Court to reverse the verdict entered against it and to render a judgment of dismissal.

The circuit court also erred when it sustained plaintiff's objection to Dr. Sibai and Dr. Martin testifying about the content of the autopsy report based on their training and experience in treating patients with TTP and HELLP. Dr. Sibai and Dr. Martin did not seek to testify as pathologist. Instead, they sought to comment on some of the autopsy report's findings based on their own training and experience as physicians who treat patients with HELLP and TPP. If the Court does not reverse and render a verdict in favor of UMMC but instead reverses for a new

trial, then UMMC asks the Court to find that the testimony of Dr. Sibia and Dr. Martin about the autopsy report is admissible under M.R.E. 702.

ARGUMENT

Standard of Review

The circuit court's bench trial ruling is reviewed under the same deference afforded a chancellor.

> [A]fte reviewing the entire record, [this Court] will affirm if the judge's findings of fact are supported by substantial, credible evidence and are not manifestly wrong or clearly erroneous.

Young v. University of Mississippi Medical Center, 914 So.2d 1272, 1275 (¶ 10)(Miss. Ct. App. 2005).

The record is insufficient to support the verdict because (1) the autopsy report is based on an invalid application of a test, and (2) no other evidence in the record is sufficient to support the Circuit Court's finding that Ms. Foster had and died from TTP.

When evaluating the admissibility of expert opinion testimony, the Court applies an abuse of discretion standard and "will only reverse a trial judge's decision if it [is] 'arbitrary and clearly erroneous.'" *University Medical Center v. Martin*, 994 So.2d 740,745 (¶18)(Miss. 2008), *quoting*, *Poole v. Avara*, 908 So.2d 716, 721 (Miss. 2005).

The Circuit Court erred when it sustained Plaintiff's objection to testimony by UMMC's expert witness and treating physicians about the content of the autopsy report because the ruling violates M.R.E. 702.

The Circuit Court's Memorandum Opinion And Order

The Circuit Court held UMMC breached the standard of care by failing to diagnose TTP when Ms. Foster presented on August 12 and on August 18, 2005. (R. 245, 248,249; RE 12, 15, 16). All other findings flow from this finding.

The Circuit Court based its ruling on the autopsy report. (R. 245, 248; RE 12, 15). The

autopsy report cannot sufficiently support the Circuit Court's holding of failing to diagnose TTP because the autopsy report's finding is based on an invalid application of the ADAMTS13 test to postmortem blood.

The Circuit Court also states that its holding is based on "the testimony of the expert's [sic] comprehensively and collectively" but it doesn't identify the specific expert testimony upon which it relies. (R. 247; RE 14). UMMC has not found where any expert individually, or collectively with one or more of the other experts, opined that UMMC breached the standard of care by failing to diagnose that Ms. Foster had TTP. There is no way to comprehensively and collectively arrive at a standard of care based upon the Plaintiff's expert witness testimony and UMMC's expert witness testimony. This leads to the conclusion that the Circuit Court simply starts with the unreliable autopsy report and works backward to arrive at a breach of the standard of care. That is not permitted under M.R.E. 702. The rule contemplates that an expert will arrive at the standard of care by reviewing the medical records and the facts and circumstances surrounding the treatment and then announce a standard of care.

Autopsy Report Is Not Substantial Evidence that TTP Caused Ms. Foster's Death

A study published on February 27, 2009 concluded that "[P]ostmortem ADAMTS13 activity levels may not be valid in establishing a diagnosis of TTP, and high inhibitor levels in this setting may be related to elevated PFH. Caution must be used in the interpretation of ADAMTS13 testing in the presence of hemolysis." (Ex. D-28; RE 19).

After Ms. Foster's death , Dr. Martin decided to have blood drawn for an ADAMTS13 test because he was trying to find the cause of her death. He had never ordered the test in a postmortem context. Four years later, Dr. Martin learned "that [The ADAMTS13 test is] invalid if its drawn after the patient has died because of the normal body changes that occur it sort of

makes the value not accurate, but I did not know that until well after the time of [Ms Foster's] death." (Tr. 719).

Dr. Moake, a hematologist, testified the results are not reliable when postmortem blood is used:

> Q. Well, did you find in this case that the lab that did tests for the ADAM factor found that it was low?
> A. I did see that report.
> Q. And is that consistent with TTP?
> A. Well, the blood sample was drawn hours after her death and submitted. I've been running a lab for 20 years that assays ADAMTS 13 and **we don't accept postmortem samples because they're not reliable**.
>
> Q. And do you have studies that show a pattern of unreliability of postmortem blood?
> A. Studies, no
> Q. Is there-
> A. I've just run — **I've run a lab for 20 years and we don't accept those samples.**
> Q. Is there any literature out there that is peer tested that says -- that is consistent with your position on that?
> A. There is one relatively recent report. although I don't recall exactly where it was. I remember referencing it in a review I wrote some months back. It's either in Transfusion or Journal of Clinical Apheresis.

(Ex. D-34(b) at deposition pages 11-12)(emphasis added).

Dr. Meredith Griffin testified the ADAMTS13 test when conducted with postmortem blood cannot produce reliable information about TTP:

> Q. I know that her autopsy showed microthrombi, and I know that her ADAMTS13 level came back decreased. However, we know now from recent research that a low ADAMTS13 is not indicative if it's drawn postmortem.

(TR 429).

Dr. James Bofill explained the ADAMTS13 test is not valid when the blood is drawn after the patient dies:

A. The foundation of that paper was correct at the time that we wrote them. Since that time the science has evolved to demonstrate to us that that test was not valid in the circumstance in which it was used which was several hours after the patient had died.

(Tr. 495).

In a colloquoy with the Circuit Court, Dr. Bofill explained that the pathologist did not know that the ADAMTS13 test was invalid. (TR. 585).

Dr. Stern, plaintiff's expert, did not know the reliability of the test using postmortem blood:

Q. All right. Do you know the error rate of an ADAMTS13 test utilizing postmortem sample?
A. The err rate?
Q. Yes.
A. Meaning what. You mean if you took the same sample and tried to do serial values of that what would be like the coefficient and variation?
Q. Yes.
A. No, I haven't seen that published. I've worked a little bit with the enzyme just in a HELLP situation. There is some variability. So there can be a wide range of values. So I wouldn't be surprised if it would be high. But I don't know it. I haven't seen this.
Q. And you have not done any research on that and you've not published anything?
A. No, no, I have not.

(TR. 350)

Neither of Plaintiff's expert witnesses gave a specific clear opinion that Ms. Foster died from TTP. Where the experts link Ms. Foster's death to TTP, that linkage is grounded upon the autopsy report.

Dr. Stern, Plaintiff's OB-GYN expert, never diagnosed TTP in connection with Ms. Foster's August 12 visit and vaguely linked Ms. Foster's August 18 visit with TTP, but that linkage is grounded in the autopsy report. Dr. Stern testified:

> I think that the main point on August 12th was that she had symptoms. She had neurological symptoms. She had an unexplained low platelet count. The diagnosis was not clear at this

point. I'm not going to say it was HELLP syndrome. We can't say it was TTP, TTP. It was uncertain.

(TR. 90).

A. But it doesn't mean she's not developing pre-eclampsia. We don't know what was wrong with her on 8/12, but we know she's getting sick.

(Tr. 157).

Q. All right. Tell me are you calling it a diagnosis of HELLP on the 12th or not a diagnosis of HELLP on the 12th?
A. I'm not calling it. I'm calling it ... very suspicious on the 12th, but I will not call it HELLP syndrome.

(Tr. 161-162)

Q. Okay. What is the correct diagnosis on August the 12th, 2009; diagnosis?
A. We don It have a diagnosis for sure on August 12th. I never said we did.
Q. You don't have a diagnosis.
A. I said we have a sick patient. We do not have a diagnosis. We need a diagnosis.

(Tr. 169).

A. In my mind the cause of her numbness, I don't know. I'm not sure know what the cause is, but I don't believe its hypoglycemia. That's all I'm saying. I do not know what the cause is. She's having blurred vision and numbness in her fingers and toes. I don't know what's the cause.

(Tr. 178).

A. What I'm saying is that we have a patient with neurologic symptoms and thrombocytopenia. That's all I'm saying. I do not have a diagnosis here. I do not.

(Tr. 179).

Q. ... . You don't disagree with the diagnosis of HELLP on August the 18th, '05 when she presented, do you?
A. No, I don't.

(Tr. 186)

A. The final autopsy report revealed TTP, thrombotic thrombocytopenic purpura.

(TR. 91).

Dr. Greenberg, Plaintiff's hematologist expert, does link TTP to Ms. Foster's death but that linkage is grounded only on the autopsy report. Otherwise, he gives no specific clear opinion independent of the autopsy that Ms. Foster died from TTP.

Dr. Greenberg admitted it was impossible to diagnose HELLP or TTP on August 12, 2005.

> Q. It's not possible based on these lab values to make a diagnosis of HELLP or TTP, is it?
> A. No, no, I would not -- absolutely not a diagnosis of HELLP or TTP at this point.

(Tr. 312).

On August 18, Dr. Greenberg said the diagnosis was either HELLP or TTP:

> Q. So you agree that as of August 18th, HELLP and TTP are the differential diagnosis?
> A. Yes, sir, in the differential, yes.

(Tr. 313)

Dr. Greenberg says that TTP killed her and he bases that statement on the autopsy. (Tr. 229-231).

> Q. (By Mr. Baladi) Your opinion that she died of TTP as you just said was based on the lab test deficiency in ADAMTS13; is that correct?
> A. Both a deficiency in the activity and the presence of an inhibitory antibody activity.

(Tr. 277).

On the other hand, UMMC's expert, Dr. Sibai, gave clear specific opinions that were grounded in the medical records that Ms. Foster was correctly diagnosed with Gestational Thrombocytopenia on August 12 and correctly diagnosed with HELLP on August 18 and did not have TTP.

Dr. Sibai's testimony that Ms. Foster was properly diagnosed with Gestational Thrombocytopenia on August 12 is amply supported by citations to the medical record and his

explanation of the meaning of those records based upon his experience and education.

A. She came with blurred vision and then had one episode of numbness and tingling in the fingers. And they checked her blood sugars and there were blood pressures and were blood tests obtained. And, ultimately, based on the findings, a diagnosis of gestational thrombocytopenia and she was diagnosed with gestational diabetes already.

Q All right. And do you agree with that diagnosis of gestational

A. Yes, absolutely. No doubt in my mind.

Q. And what do you base that on?

A. I base my opinion on the following. obtained a blood test and the blood test revealed that the patient had a normal hematocrit, and she had a platelet count that was 91,000.

...

Okay. Because of the complaints that she had they had some concern, so the blood test was obtained. The blood test revealed the presence of blood platelets, which is really what we call a moderate thrombocytopenia. Blood pressures were measured consistently, which were normal. This in essence ruled out the possibility of preeclampsia. Her urine was tested. And this is very important in this case. If you really look at the urine, the urine specially commented on the absence of bilirubin and the absence of blood. So we know hundred percent during that visit this patient did not have any evidence consistent with any microangiopathy or HELLP syndrome or TTP or any condition. The bilirubin was normal, the blood was normal. In contrast, when she came on the 18th, if you look at her urine, there was bilirubin there and there is blood. So we know that when she was admitted she was having evidence of hemolysis during this admission.

The second important thing is that when you have platelet count in this range, during pregnancy in the third trimester, the most common cause for it is gestational thrombocytopenia, which his really about 75 percent of the cases. The next most common cause would be preeclampsia and HELLP syndrome, which would make probably I would say about 20 percent of those.

The third one is going to be ITP, which would make about probably four to five percent, and then there are what we call the very rare conditions, which all of them together are less than one percent, and this will include drugs that could cause thrombocytopenia, it could be HIV or AIDS, it could be autoimmune diseases like lupus or there could be TTP

or hemolytic uremic syndrome. So one of the most important things during this visit, the physicians actually investigated for all of those. If you see when this blood test came there were two runs. The first run reported on the hematocrit and the platelet count. So all of them this test realized since the platelets are normal, I need to look for something else. So you can see they went back and made a smear and they evaluated the smear. And this smear, in essence, should rule out all other potential causes. And this is why there is no doubt in my mind she had gestational thrombocytopenia. Because by definition gestational thrombocytopenia has the platelet count and then she had as the most common finding, you have to rule out other conditions.

By looking at this very first smear, whoever ran that smear looked first to see are there any abnormal cells. And the fact that the cells were reported to be normal, in essence ruled, out that this could be TTP, it ruled out HELLP Syndrome as being hemolysis, it ruled out leukemia or some of these bone marrow diseases. So this really the second run. So they did it twice. First they got the platelet count being 91, so they went and screened.

The third important thing, some woman with HELLP Syndrome might present with a normal blood pressure. So the obstetrician at the University were aware of that. They went and did tests to rule out the presence of preeclampsia. So they ordered a test called uric acid, which was perfectly normal. Again, this is very important. If you follow her uric acid you are going to see how these changes. Uric acid is one of these tests that obstetricians use to confirm the diagnosis of preeclampsia, which was normal.

The second important thing, with the very remote possibility this could be HELLP Syndrome, they went and ordered liver enzymes, and the liver enzymes were normal. So, in essence, you have a woman who has a low platelet count in the third trimester where your most common diagnosis is gestational thrombocytopenia, the second most common cause is preeclampsia HELLP, which was ruled out in this case, then you have got the rare condition which also was ruled out. So they ruled out every condition that had caused this, so what's left was gestational thrombocytopenia.

(Tr. 625-629).

Dr. Sibai opined that on August 18, 2005, Ms. Foster had the symptoms for HELLP and not for TTP and that opinion is amply supported with citations to the medical record and explanations for his opinions.

Q. How would you define a classic presentation of HELLP syndrome generally.

A Is a patient who presents in the third trimester coming with nausea and vomiting. Some of them will come with headache or blurred vision and upper gastric pain. This is really the classic presentation.

Q. Okay. And then what do you find on laboratory values generally for that classic presentation?

A. The most important says many of the manifestations reflect liver involvement. You need to find elevated liver enzymes. The second important thing says part of the HELLP Syndrome is to have low platelets, so you expect to have low platelet. And the most important thing which is the HES, that stands for hemolysis, you have to have evidence of hemolysis. So these are the three requirements.

Q. On August 18, what was Ms. Foster's presentation to the University of Mississippi Medical Center?

A. I would say it was the classic most average case we teach everybody on daily basis. This is a woman with HELLP Syndrome presents. She had almost everything that a woman with HELLP syndrome is expected to have. Had symptoms, had liver validity findings, everything.

Q, Do you have any doubt about Ms. Foster's presentation of HELLP Syndrome on August 18th?

A. No.

Q. Is there any signs or symptoms that you would say are more consistent with TTP than HELLP on August 18th?

A. I would say on August 18th she didn't have neurological findings which are really more consistent with TTP, because for TTP there are five findings, but three of them we call the major and you need the three following diagnosis. This include the low platelets, the hemolysis or microangiopathy and the neurologic findings. Then you have got the two minor, which are the renal involvement and the fever. So in her presentation on the 18th she had the low platelet that was hemolysis, but she didn't have the neurologic findings.

... .

Q. Did Ms. Foster's postpartum course resemble what you would expect in HELLP syndrome?

A. I would say a hundred percent of what I would expect to see, and it's inconsistent with somebody who has TTP. And this is really very important in this case.

First, if we ask you, the patient presented on the 18th with an acute onset of TTP, then I would have seen, again, based on my experience, that the effects of this could have resulted in major platelet aggregation affecting the blood vessels in the placenta and the fetus or the baby would have had changes in the fetal heart rate. So this couldn't be that this woman has this acute TTP at that point in time. The fact that this baby

> was born with a good APGOR score, more important, this baby wasn't small for gestation; actually, it was large, we cannot say this woman was having a chronic onset of TTP, because this would have affected the blood flow from the maternal site to the placenta, and this baby's growth wouldn't have been normal. So, first, this would rule out at all that this is a TTP that has been going on for a long time, and she started on the 12th or before. The second important thing, if this is really TTP, during the acute manifestation, I would have expected to see changes in the fetal heart rate, which we didn't have. So we know that this couldn't have happened if it is an acute TTP. It didn't happen on the 18th considering the fetal heart rate was not affected and the baby's APGOR score.
>
> Then if we look at HELLP sequence course, we know that she was having changes in her lactic dehydrogenase. She was having changes in her AST. But, very important, the most important marker for hemolysis is the unconjugated or indirect bilirubin.
>
> ... .

(TR. 634, 635, 636, 646, 647).

The Circuit Court viewed the autopsy report as containing opinion testimony just like the opinion testimony offered by Dr. Sibai and the other experts. Addressing UMMC's attorney, the Circuit Court stated:

> This is an opinion as an autopsy report that she had TTP. The death certificate says HELLP. I recognize there are two strings of thought, and you now have a witness [Dr. Sibai] who has testified that the patient had HELLP. My ruling is that those opinions are out there. This Court must decide I only will have two people who said HELLP and a pathology report that said TTP. Now I have to make that resolution.

(TR. at 662).

The Circuit Court's Memorandum Opinion and Order could not be clearer on the Circuit Court's resolution.

> Tamika Foster's autopsy report by Defendant UMMC's own pathologist concluded that the cause of death was myocardial ischema with arrhythmia, **secondary to ThromboticThrombocytopenia Purpura (TTP)** ... .TTP was never diagnosed prior to Tamika's death. ... .

... .

> The Court finds the autopsy report of Defendant UMMC's pathologist's [sic] to be credible and reliable. Despite Defendant's challenge of the methods and tests used by the UMMC pathologists, the pathologists have stood firm regarding their objective finding of TTP as the cause of Tamika's death rather than HELLP. Thus, the autopsy findings lean heavily in favor of Plaintiff's claim that Defendant UMMC's physicians failed to timely diagnose TTP and that said failure proximately cause Tamika's untimely death.

(TR. 245, 248; RE 12, 15)(footnote omitted)

The pathologist did not testify. The record contains absolutely no testimony to support the statement that UMMC or its physicians challenged the pathologists, much less to support the statement that the pathologists stood firm.[3]

M.R.E. 702 is the evidentiary rule that applies to the admission of expert witness testimony. The rule reads:

> If scientific, technical or other specialized knowledge would assist the trier of fact to understand or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training or education may testify thereto if the form of an opinion or otherwise if (1) the testimony is based upon sufficient facts or data, (2) the testimony is the product of reliable principles and methods, and (3) the witness has applied the principles and methods reliably to the facts of the case.

M.R.E. 702.

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[3] In footnote number 5, the Circuit Court states that one of UMMC's physicians met with the pathologist and suggested that their findings were flawed and that "[t]he pathologists were not convinced by [the physician's] arguments and the autopsy results remained unchanged." The Circuit Court does not identify the UMMC physician. The pathologist invited Dr. Martin to attend the autopsy conference. After describing the conference, Dr. Martin concluded his testimony as follows:

> I had nothing to do with how they finished their final report, but we finished the conference with the possibility that because of the findings that they had in the ADAMTS13 that she might have had TTP. That's really what initiated the report I wrote later that year.

(Tr. 734).

The Circuit Court's Memorandum Opinion and Order gives no reason for its acceptance of the autopsy report other than the fact that it was performed by UMMC pathologists. The Opinion never acknowledges UMMC's claim that the ADAMTS13 test is invalid when postmortem blood is used and never discusses UMMC's undisputed evidence. The Court simply rejects that evidence without any reason.

In *Mississippi Transportation Commission v. McLemore,* 863 So.2d 31 (Miss. 2003), the Court made this statement about the sufficiency of such unsupported expert opinion testimony:

> Furthermore, neither *Daubert* nor the Federal Rules of Evidence requires that a court 'admit opinion evidence that is connected to existing data only by the *ipse dixit* of the expert,' as self-proclaimed accuracy by an expert [is] an insufficient measure of reliability.

863 So.2d at 37 (¶ 13).[4]

The Circuit Court accepted the autopsy report's cause of death finding simply because the pathologist said it.

The undisputed evidence in the record shows the ADAMTS13 test is invalid if postmortem blood is used. The autopsy report's finding that TTP was secondary to Ms. Foster's death is based only on the ADAMTS13 test. There is no other evidence in the autopsy report. Since there is no scientific evidence to support the autopsy report's finding, the autopsy report is rendered conclusory as far as its linking TTP to Ms. Foster's death. "'A conclusion for which there is no underlying medical support was not vindicated by the use of general methodology in the medical field.'" 863 So.2d at 39 (¶ 19) *quoting Black v. Food Lion, Inc.*, 171 F.3d 308, 314 (5th Cir. 1999). The Circuit Court clearly erred when it adopted the autopsy report's finding that

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[4] *Ipse dixit* means "[h]e himself said it; a bare assertion resting on the authority of an individual." Black's Law Dictionary Revised Fourth Edition at 961 (1968).

that TTP was secondary to Ms. Foster's death because it was only a conclusion without any scientific foundation.

The Circuit Court relied exclusively on the autopsy report to support its finding that UMMC breached the standard of care by failing to diagnose TTP and by failing to treat Ms. Foster for TTP. Without that autopsy report, there is no evidence to support the Circuit Court's finding. Lacking any evidence, the Plaintiff has failed to meet its burden of proof.

> To prove a medical malpractice claim, a plaintiff must show: (1) the existence of a duty on the part of the physician to conform to a specific standard of conduct; (2) the specific standard of conduct; (3) that the physician's breach of duty was the proximate cause of the plaintiff's injury, and (4) that damages resulted.

Young v. University of Medical Center, 914 So. 2d 1272, 1276 (¶ 15)(Miss. Ct. App. 2005)

Without a diagnosis of TTP, Plaintiff cannot establish a duty. Without a diagnosis of TTP, Plaintiff cannot prove that UMMC failed to conform to a specific standard for treating TTP. Without a diagnosis of TTP, Plaintiff cannot establish proximate cause by showing that she died as a result of UMMC's failure to treat her for TTP. E.g., Id. at 1276 (¶ 15)(medical malpractice claim is dismissed where plaintiff established duty and breach of duty but failed to establish proximate cause).

Since Plaintiff failed to prove a claim of medical negligence, UMMC asks the Court to reverse the verdict entered against it and to render a judgment of dismissal in its favor.

The Court erred when it excluded testimony by Dr. Sibai and Dr. Martin.

Plaintiff objected to Dr. Sibai testifying about the autopsy report because "the autopsy and the findings of the autopsy are outside of his expertise. He is not a pathologist." (Tr. 658).

The Circuit Court sustained the objection and addressing UMMC's arguments stated:

> It means you [Dr. Sibai] can't testify to the pathology report as to physicians who are a pathologist, and that's outside your area of

expertise.

... He [Dr. Sibai] may be able to read them [autopsy reports], but he doesn't know what he's reading if he's not expert in pathology. ...

... .

But he [Dr. Sibai] can't do that if he's not an expert, only a pathology can. ... . If you want to bring the pathologist in and let him testify to his own report and what he has found in the cases of HELLP and TTP, then you can do that. But this witness is limited only as to the cases that he has had with live patients in his research. This is a pathologist who is also a physician who has some credential. And right now I am looking at the report and I am taking judicial notice of the pathology report and the persons who provided it. But I am not going to let him [Dr. Sibai] give opinions about it. I'll let him, if you want to let him look and see what's here and what has been written, but I'm not going to let him give testimony as to the pathologist's work.

(Tr. 658-659).

The Court applied this same ruling to Dr. Martin and held that he could not testify about the autopsy report. (Tr. 733).

Dr. Sibai was not being offered as a pathologist expert nor to second guess the pathologist who performed the autopsy report. As Dr. Sibai explained:

> I'm not talking about the pathology. I'm talking about what I see at the time of caesarean section in women who have HELLP Syndrome and TTP when I look at their liver. That's what I'm commenting on. So I have looked at the liver of these patients when I operate on them.

(Tr. 660).

The Court rejected Dr. Sibai's contention because the persons were alive. (Tr. 660).

"The scope of the [expert] witness's knowledge and experience and not any artificial classification, governs the questions of admissibility." *University of Mississippi Medical Center v. Pounders*, 970 2d 141, 146 (ps 19)(Miss. 2007). The multi-page curriculum vitaes of Dr. Sibai (D-35) and Dr. Martin (D-37) demonstrate without a doubt that they are qualified by training, education and experience to testify about TTP and HELLP Syndrome and how those conditions

education and experience to testify about TTP and HELLP Syndrome and how those conditions affect a patient. That is all UMMC sought to do. Dr. Sibai was asked a question about petechia hemorrhages and about thrombi in the small blood vessels, both of which are mentioned in the autopsy report, when the objection was made. UMMC did not ask Dr. Sibai to comment about the autopsy.[5]

Dr. Sibai and Dr. Martin should have been permitted to testify about the conditions recorded in the autopsy report as it relates to their experience in treating patients with HELLP and TTP. The Circuit Court's ruling was clearly erroneous because it conflicts with the legal standards established under M.R.E. 702 for determining the admissibility of expert opinion testimony. If the Court does not reverse and render the judgment, as UMMC requests, then upon a new trial, Dr. Sibai and Dr. Martin should be permitted to comment about the specific conditions described in the autopsy report as they relate to their experience and observation in patients they have treated who have HELLP or TTP.

For the foregoing reasons, UMMC asks this Court to find that the Circuit Court abused its discretion when it excluded Dr. Sibai and Dr. Martin from testifying about the contents of the autopsy report as it related to their experience in treating patients with HELLP and TTP.

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5 UMMC's questions and Dr. Sibai's response do not directly or impliedly attack the autopsy report. The transcript pages containing the questions and Dr. Sibai's response to which Plaintiff objected and upon which the Court based its ruling are in the record excerpts at RE 25-26.

CONCLUSION

In *Hall v. Hilbun*, 466 So. 2d 856 (Miss. 1985), the Court emphasized the objective character of the standard of care that each physician has by virtue of his position.

> The content of the duty of care must be objectively determined by reference to the availability of medical and practical knowledge which would be brought to bear in the treatment of like or similar patients under like or similar circumstances by minimally competent physicians in the same field, given the facilities, resources and options available.

466 So.2d at 872.

The standard of care announced in the Circuit Court's Memorandum Opinion and Order does not meet this objective requirement. It is not determined by reference to any medical and practical knowledge. It is determined by its linkage to an autopsy report that is fundamentally flawed. Its flaw lies in the fact that it is based upon the use of the ADAMTS13 test with postmortem blood. Under those circumstances, the test is not reliable and is certainly not the foundation upon which a standard of care can be based.

Since the standard of care does not satisfy the test in *Hall v. Hilbun*, it follows that it cannot be used to support a ruling that UMMC breached its duty and that this alleged breach was a proximate cause of Ms. Foster's death. In summary, there is no foundation upon which to base the Circuit Court's ruling that Plaintiff established a medical negligence claim by a preponderance of the evidence under this Court's applicable standards. For that reason, UMMC asks the Court to reverse the verdict and render a judgment in its favor.

If in the alternative, the Court determines that the case should be reversed and remanded for new trial, then UMMC asks the Court to find that the Circuit Court erred when it excluded the testimony by Dr. Sibai and Dr. Martin about their observations and comments on the contents of the autopsy report based upon their personal experience, education and training in treating

CERTIFICATE OF MAILING

I, Robert H. Pedersen, do hereby certify that I have this day hand-delivered to the Clerk an original and three copies (3) copies of the Brief of Appellant, University of Mississippi Medical Center, in Docket No. 2010-CA-00791, on the 24th day of February, 2011.

DATED this the 24th day of February, 2011.

ROBERT H. PEDERSEN