SC No. 88887

IN THE MISSOURI SUPREME COURT

ROGER AND CARLA HICKMAN, Plaintiffs-Respondents

v.

BRANSON EAR, NOSE & THROAT, Defendant-Appellant

Appeal from the Circuit Court of Christian County, Missouri
38TH Judicial Circuit
The Honorable James Eiffert, Division 1

SUBSTITUTE BRIEF OF RESPONDENTS ROGER & CARLA HICKMAN

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JURISDICTIONAL STATEMENT

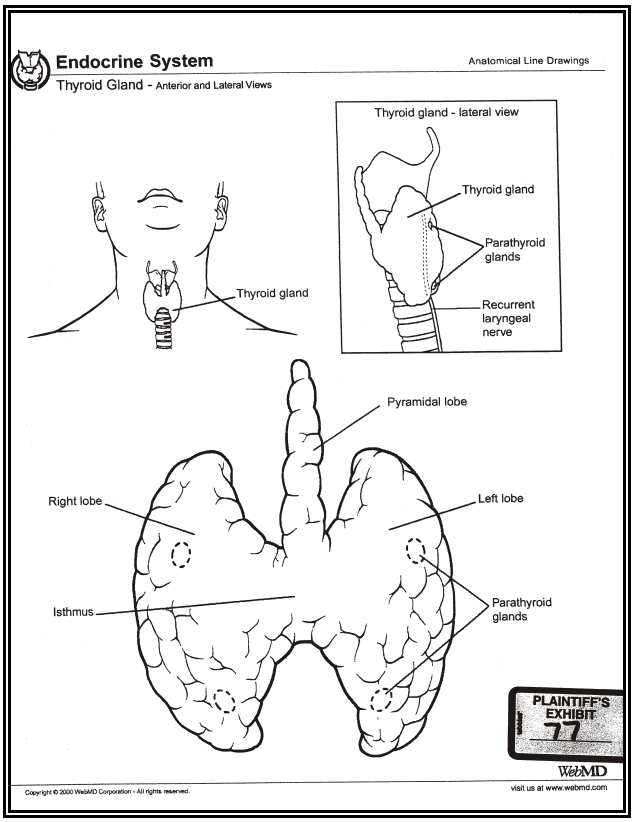
Respondents Roger and Carla Hickman adopt the jurisdictional statement set forth in Appellant's brief.

STATEMENT OF FACTS

Given the nature of Appellant's claims, Respondents feel a more detailed Statement of Facts is necessary. These facts follow:

A. Basic Anatomy of The Thyroid.

Exhibit 77 shows the general anatomy of the thyroid. (Tr. 139). The thyroid consists of two lobes, one on the right side and one on the left side. For an average male, the thyroid weighs between 17 and 20 grams. (Tr. 131). Each thyroid lobe weighs between 8.5 and 10 grams. (Tr. 131, 158, 188).



In April of 2001, Roger Hickman's general practitioner, Dr. Christopher Rittman, noticed that something was "going on" with Roger's thyroid. (Tr. 295). As a result, Dr. Rittman ordered ultrasounds and a CT scan. (Tr. 295-96). The ultrasound showed that there were nodules in both the left and right

thyroid lobes. (Tr. 296). In addition, the scans and CT showed a mass adjacent to or growing off of the lower pole of the right thyroid. (Exhibits 12a, 8a, 69a Tr. 136-37, 239-40, 386). The dimensions of the right thyroid lobe were measured at 4 centimeters in length and 1.5 centimeters in width. (Tr. 403). The tumor that was adjacent, or attached, to the right thyroid lobe measured 4 centimeters long by 3 centimeters wide. (Tr. 394). Thus, the tumor attached to the right thyroid lobe was essentially the same length and width as the thyroid lobe to which it was attached. (Tr. 239).

Subsequently, Dr. Rittman referred Roger to Dr. Michael Bays for further evaluation and surgical consult. (Tr. 296). Dr. Bays is an osteopathic physician who attended a general surgical residency. (Tr. 223-24). He dropped out of his two-year fellowship in general plastic and reconstructive surgery to open a practice in Branson. (Tr. 224-27, 229-31). Dr. Bays was and is the sole physician at Branson ENT, a clinic that he opened in 1996 and which he has continuously managed and operated from that time until present. (Tr. 36,108, 231).[1] As part of his evaluation of Roger, Dr. Bays performed a needle biopsy. (Tr. 297). The needle biopsy was indeterminate. (Tr. 297). Therefore, Dr. Bays recommended that Roger undergo surgery. (Tr. 297). Dr. Bays advised the Hickmans that his plan was to remove the entire right thyroid

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[1] As Dr. Bays, himself, testified, he had an otologist and "many ancillary personnel" working for him, and he had established skin care, hearing, and asthma clinics within Branson ENT so that his office staff would have something to do while he was performing surgeries. (Tr. 230-31).

lobe. (Tr. 242-43, 299). Dr. Bays explained that he would evaluate the tumor and thyroid lobe during surgery and, if either was cancerous, he would then remove the entire left thyroid lobe. (Tr. 299). Dr. Bays told them that if cancer was found, he would do a total thyroidectomy, which he explained was the complete removal of both thyroid lobes. (Tr. 243-46).

The surgical frozen section showed that the right-sided tumor was cancerous. (Tr. 142-43, 244). Dr. Bays therefore removed the left thyroid lobe as well. (Tr. 244). He dictated in his operative note that he performed a total thyroidectomy, told the Hickmans that he performed a total thyroidectomy, and he billed them for a total thyroidectomy. (Tr. 245, 247, 266).

Both Dr. Bays and Dr. Paul Nelson, the Hickmans' expert, testified that during a total thyroidectomy, all macroscopic or visible thyroid tissue is removed. (Tr. 172, 246). In other words, during a total thyroidectomy, both the left and right thyroid lobes are completely removed. (Tr. 246, 273). Dr. Bays and Dr. Nelson both testified that the accepted standard of care for treating a cancerous thyroid in an individual of Roger's age is to perform a total thyroidectomy. (Tr. 146-47, 155, 183, 245). Both doctors agreed that Roger required a total thyroidectomy because thyroid cancer is multi-focal, and a finding of cancer in the right lobe indicates that thyroid cancer may well exist in the left lobe. (Tr. 143-45, 242, 244-45). Furthermore, if thyroid cancer is not removed, it can spread or metastasize outside of the thyroid, in which case, it is much more difficult to treat. (Tr. 236). Other reasons which required a total thyroidectomy in this case included: (a) in men over 40, there is an increased

risk of recurrence of a more aggressive, fast-growing tumor, and (b) in order to perform appropriate follow-up blood tests to check for cancer recurrence, the entire thyroid needs to be removed. (Tr. 143-145). When not treated appropriately, thyroid cancer can be fatal; indeed, it kills between 1,200 and 1,500 people in the United States each year. (Tr. 237).

After a total thyroidectomy, the patient must undergo radioablation therapy. (Tr. 143-45, 155-56, 248). Radioablation is designed to kill any microscopic thyroid tissue that may be remaining so that any possible residual cancer is destroyed. (Tr. 143-145). If too much thyroid is left during surgery, radioactive iodine cannot properly kill the remaining tissue, and the patient faces the risk of residual cancer being left behind. (Tr. 156).

After Roger Hickman was released from the hospital, Dr. Bays referred him to Dr. Gregory Ledger, an endocrinologist at St. John's Hospital. (Tr. 264, 308). Following a total thyroidectomy, the patient's thyroid hormone levels should diminish or fade to nothing. (Tr. 147-48, 273). At the same time, the patient's thyroid stimulating hormone levels (TSH) should rise dramatically because the body recognizes a lack of thyroid, and produces excessive levels of the hormone that stimulates thyroid production. (Tr. 147-48, 272-73). When, however, Dr. Ledger performed blood tests on Roger, he found that Roger's thyroid levels were basically normal, as were his TSH levels. (Tr. 149). Dr. Ledger then ordered an ultrasound, which showed that the left thyroid lobe had been removed, but that the right thyroid lobe was still present. (Tr. 151, 418-20). The ultrasound showed the right thyroid lobe to be present in its entirety, although the mass was no longer attached to it. (Tr. 419-22). The ultrasound also showed that the nodules that existed in the right thyroid before Dr. Bays'

surgery were still present post-surgery. (Tr. 151). Dr. Leger felt that radioblation would be ineffective because so much thyroid tissue was left behind. (Tr. 420-22). Dr. Ledger referred Roger to Dr. Ashley, a thyroid surgeon in Springfield. (Tr. 310-11). Dr. Ashley reviewed the post-surgery ultrasounds and determined that Roger needed to undergo a second surgery to remove the right thyroid lobe that had been left during the first surgery. (Tr. 311). Dr. Ashley, however, refused to perform the second, redo surgery because it was a much more complicated and risky procedure. (Tr. 312). Instead, he referred the Hickmans to Dr. Moley, a surgeon in St. Louis. (Tr. 312).

Dr. Moley concurred with Dr. Ashley and advised Roger that he needed a second surgery to remove the right thyroid lobe that was left behind in the first surgery. (Tr. 312, 491-492). Roger needed the second surgery in order to remove the remaining cancer risk, and so that he could undergo post-surgical radioablation, which was needed to further reduce the risk of cancer recurrence. (Tr. 155-156, 159, 172). Given the fact that this was a re-do surgery in an area that had already been operated and in which scar tissue had developed, he advised that this second surgery was riskier than the first, and presented a significant risk of damaging Roger's vocal nerves. (Tr. 487, 492). During the second surgery, Dr. Moley found that the right thyroid lobe was intact, and he removed a right thyroid lobe weighing 8.2 grams – the size and weight of a normal right thyroid lobe. (Tr. 158, 251).

Dr. David Rabin, the Hickmans' other expert witness, provided additional testimony concerning what was (and what was not) removed during Dr. Bays' surgery. Dr. Rabin is a medical doctor having practiced in the field of radiology for almost nineteen years. (Tr.

364). As a radiologist, he interprets over 1,000 thyroid ultrasounds per year and over 1,000 chest or neck CT scans per year. (Tr. 364-366). Dr. Rabin testified that the post-surgical CT taken at Skaggs on December 17, 2001, ten days after Dr. Bays' surgery, showed that the complete right thyroid lobe was still present. (Tr. 414-18). He further testified that the left lobe was removed by Dr. Bays, but that the only thing removed from the right side was the calcified mass which was attached posteriorly to the right thyroid lobe. (Tr. 414-18). Dr. Rabin testified that his reading of the post-surgical CT scan was further supported by: (1) the ultrasound report of February 12, 2002, which showed a normal-sized thyroid lobe still remaining after surgery, and (2) the fact that Dr. Moley removed an intact, normal-sized right thyroid lobe four months after Dr. Bays' surgery. (Tr. 418-425). Dr. Rabin testified that all of the films taken subsequent to the first surgery showed that Dr. Bays left the entire right thyroid lobe behind during his surgery. (Tr. 414-22).

Dr. Bays testified that if he had performed a total thyroidectomy, he would not expect any remaining thyroid tissue four months after his surgery (Tr. 249-50). He also testified that Dr. Moley's removal of 8.2 grams of thyroid tissue from the right side four months after Dr. Bays' surgery was consistent with his having not removed the right thyroid lobe. (Tr. 250-52).

B. Standard of Care Testimony.

Testimony concerning the standard of care came from two different witnesses, Dr. Paul W. Nelson and Dr. Bays. Dr. Nelson is a board-certified surgeon who performs approximately 50 thyroidectomies per year, and who has performed over 750

thyroidectomies in the past fifteen years. (Tr. 117, Exhibit 66). He has staff privileges at St. Luke's and Children's Mercy Hospitals in Kansas City and is the Chairman of the Surgery Department at St. Luke's. (Tr. 122-123). Dr. Nelson testified that he not only performs thyroid surgery, but that he has taught thyroid surgery to medical students for eighteen years as a full professor of surgery at the University of Missouri at Kansas City Medical School. (Tr. 123-26).

Dr. Nelson testified that given Roger's age and intraoperative finding of cancer, a total thyroidectomy was required. (Tr. 146-47, 155, 183). Dr. Bays agreed. (Tr. 245.) Dr. Nelson testified that, if a surgeon is required to perform a total thyroidectomy because of cancer, and they leave behind one-half of the thyroid, he has not met the standard of care for a surgeon performing a total thyroidectomy for treatment of cancer. (Tr. 146-47). Dr. Nelson further testified that, for eighteen years, he has taught his surgical students that you do not leave one entire lobe of the thyroid behind when you perform a total thyroidectomy. (Tr. 146-47). Dr. Nelson further testified that he was sure Dr. Bays left the entire right thyroid lobe because: (1) he could see the lobe in the December 17, 2001, post-surgical CT scan (Tr. 211); (2) Roger's thyroid hormone levels and TSH levels remained normal following surgery (Tr. 147-49); and (3) the February 2002, ultrasound taken two months after Dr. Bays' surgery showed a normal-sized right lobe with abnormal nodules still present. (Tr. 151). Furthermore, Dr. Moley's operative note described cutting the superior thyroid artery, which would not have been present had Dr. Bays performed a total thyroidectomy. (Tr. 153). Finally, Dr. Nelson noted that, in the second surgery, Dr. Moley removed 8.2 grams of normal thyroid tissue that

measured 4 x 2.5 x 2 centimeters, which is the size and weight of a normal thyroid lobe. (Tr. 158).

Dr. Nelson further testified that Dr. Bays' failure to perform a total thyroidectomy required a second re-do surgery that would not have been necessary had Dr. Bays performed a total thyroidectomy as required. (Tr. 155). The following testimony was elicited from Dr. Nelson on cross-examination:

> Q: Doctor, let's see if I can kind of paraphrase what your standard of care criticism is against Dr. Bays . . .
>
> A: Correct operation for a thyroid cancer of this type is to take out the whole thyroid gland. That wasn't done.

(Tr. 183).

Dr. Bays, Branson ENT's designated trial representative, also testified live at trial. (Tr. 20, 24). Branson ENT admitted that he was an employee who "was acting within the course and scope of his employment at all times during the care and treatment of Roger Hickman" in its first interrogatory responses, which were read into the trial record by Plaintiffs. (Tr. 108). Dr. Bays' standard of care testimony parroted the testimony given by Dr. Nelson. Dr. Bays testified that, when a patient Roger's age has thyroid cancer, the standard of care is to remove both lobes of the thyroid – in other words, to perform a total thyroidectomy by removing the entire thyroid. (Tr. 245). Further, Dr. Bays testified that a total thyroidectomy requires the entire removal of both thyroid lobes, leaving behind no visible tissue. (Tr. 246). Dr. Bays admitted that he told the Hickmans that he had performed

a total thyroidectomy and had removed all visible thyroid tissue. (Tr. 246). Dr. Bays testified that when you perform a total thyroidectomy, you "definitely" should not leave an entire thyroid lobe and that, if a surgeon told a patient he did a total thyroidectomy but left an entire lobe, he would be a "liar and a fraud". (Tr. 248). Dr. Bays testified that if he was attempting to perform a total thyroidectomy and mistakenly left one complete lobe of the thyroid, this would be a surgical mistake and something that would "definitely" be in violation of his duties as a surgeon. (Tr. 248-49).

Dr. Bays further testified that he had never seen, heard, or read of a thyroid lobe regrowing and, given the fact that he thought he performed a total thyroidectomy, he would not have expected Dr. Moley to remove any thyroid tissue during the second surgery. (Tr. 249-50). Dr. Bays agreed that, if he left the right thyroid lobe during the first surgery, and a right thyroid lobe was removed four months later by Dr. Moley, those two things would be consistent. (Tr. 251). He further agreed that Dr. Moley's removal of 8.2 grams of thyroid tissue during the second surgery would be consistent with the claim that he failed to remove an entire thyroid lobe and, thus, did not perform a total thyroidectomy. (Tr. 251).

Given the complete agreement between Dr. Nelson and Dr. Bays as to the standard of care required of a surgeon performing a total thyroidectomy, counsel for both plaintiffs and defendant told the jury (during both Opening Statements and Closing Arguments) that the sole liability issue in the case was the factual issue of whether Dr. Bays removed the right thyroid lobe on December 7, 2001. (Tr. 33-34, 63, 66, 564-68 589). Defendant's position throughout trial was that Dr. Bays completely removed the right thyroid lobe, but that it

regrew to normal size in the two months between surgery and the ultrasound ordered by Dr. Ledger. (Tr. 66, 94, 590-91).

C. Damages.

The evidence concerning the Hickmans' damages was this: Prior to treatment by Dr. Bays, Roger Hickman's life had been devoted to music. (Tr. 322, 459). He sang his first church solo when he was in the first grade, he focused on music throughout high school, and went to college on a musical scholarship where he received a degree in musical studies. (459, 461-62). Roger had spent his professional life in music ministry, writing commercial gospel music, and consistently performing as a gospel singer. (Tr. 459-69). Roger also recorded and sold gospel music that he sang both individually and with his family. (Tr. 463-67).

The Hickmans moved to Branson, Missouri in 1998, after purchasing an RV park. (Tr. 289-91). Shortly thereafter, Roger became a part-time music minister at Skyline Baptist Church and continued writing and recording gospel music. (Tr. 292-93, 473-75).

Following Dr. Bays' surgery on December 7, 2001, Roger experienced complications that sent him to ICU and almost caused his death. (Tr. 258-63, 303-04, 482). He was told that he had suffered a heart attack and sustained heart damage. (Tr. 482). When he was later told, by both Dr. Ashley and Dr. Moley, that he would need a second, riskier, surgery, Roger became depressed and withdrawn. (Tr. 315, 488-90). Ultimately, after learning that Roger would need a second surgery, the Hickman family sold their RV park because Roger could not perform the maintenance work needed to keep the place up. (Tr. 325-26, 490).

Between the first and second surgery, Roger and Carla were extremely afraid that

cancer had been left during the first surgery that would ultimately spread and kill Roger. (Tr. 482, 485-87, 490). Roger was also afraid and anxious because he recognized that the second surgery was riskier and posed a significant chance of injuring his voice (Tr. 486-87, 492). He also recognized that he faced the risk of having another heart attack following surgery, and possible death. (Tr. 487, 490). Ultimately, Roger decided that he would rather risk injuring his voice and possibly dying from a second heart attack than having cancer spread and kill him. (Tr. 487). After the second surgery, his voice was dramatically different. (Tr. 497, 512). In particular, Roger found that he had no endurance for singing, and that he had a significantly reduced range for singing. (Tr. 497). He could no longer sing commercially, record music, or work as a full-time music minister. (Tr. 497-501).

After selling the RV park, Roger wanted to return to full-time music ministry, but he was unable to do so due to the vocal damage he sustained. Instead, he owns and operates a small restaurant in Louisiana and, also works as a part-time music minister at a small church there. (Tr. 321-22, 457, 497-98). The Hickmans lost commercial recording income, income from writing gospel songs, and income that Roger could have made working in music ministry on a full-time, rather than a part-time, basis. (Tr. 498-99, 501-03). Roger has also suffered emotionally because he cannot actively pursue what had been his life-long passion: music. (Tr. 322, 324).

POINT RELIED ON

I. THE TRIAL COURT DID NOT ERR IN DENYING BRANSON EAR NOSE & THROAT'S MOTIONS FOR DIRECTED VERDICT AND JUDGMENT NOTWITHSTANDING THE VERDICT BECAUSE THE HICKMANS MADE A SUBMISSIBLE CASE IN THAT (A) THEY ELICITED EVIDENCE FROM BOTH DR. PAUL W. NELSON, THEIR EXPERT WITNESS, AND DR. MICHAEL BAYS, WHO WAS DEFENDANT'S DESIGNATED TRIAL REPRESENTATIVE AND WHOSE CONDUCT WAS AT ISSUE, THAT THE STANDARD OF CARE IN THIS CASE REQUIRED DR. BAYS TO PERFORM A TOTAL THYROIDECTOMY, DEFINED AS THE REMOVAL OF ALL MACROSCOPIC THYROID TISSUE; AND (B) BOTH PARTIES INFORMED THE JURY, FROM OPENING STATEMENTS THROUGH CLOSING ARGUMENTS, THAT THE ISSUE TO BE DETERMINED WAS THE FACTUAL ISSUE OF WHETHER DR. BAYS DID, INDEED, REMOVE ALL OF ROGER HICKMAN'S MACROSCOPIC THYROID TISSUE.

LaRose v. Washington Univ., 154 S.W.3d 365 (Mo. App. E.D. 2005).

Pettet v. Bieterman, 718 S.W.2d 188 (Mo. App. S.D. 1986).

Redel v. Capital Region Med. Ctr., 165 S.W.3d 168 (Mo. App. E.D. 2005).

Sheffler v. Arana, 950 S.W.2d 259 (Mo. App. W.D. 1997).

ARGUMENT

I. THE TRIAL COURT DID NOT ERR IN DENYING BRANSON EAR NOSE & THROAT'S MOTIONS FOR DIRECTED VERDICT AND JUDGMENT NOTWITHSTANDING THE VERDICT BECAUSE THE HICKMANS MADE A SUBMISSIBLE CASE IN THAT (A) THEY ELICITED EVIDENCE FROM BOTH DR. PAUL W. NELSON, THEIR EXPERT WITNESS, AND DR. MICHAEL BAYS, WHO WAS DEFENDANT'S DESIGNATED TRIAL REPRESENTATIVE AND WHOSE CONDUCT WAS AT ISSUE, THAT THE STANDARD OF CARE IN THIS CASE REQUIRED DR. BAYS TO PERFORM A TOTAL THYROIDECTOMY, DEFINED AS THE REMOVAL OF ALL MACROSCOPIC THYROID TISSUE; AND (B) BOTH PARTIES INFORMED THE JURY, FROM OPENING STATEMENTS THROUGH CLOSING ARGUMENTS, THAT THE ISSUE TO BE DETERMINED WAS THE FACTUAL ISSUE OF WHETHER DR. BAYS DID, INDEED, REMOVE ALL OF ROGER HICKMAN'S MACROSCOPIC THYROID TISSUE.

A. Introduction.

Appellant's sole claim on appeal is that the Hickmans failed to present sufficient standard of care evidence to make a submissible case. Given the fact that such testimony was elicited not only from the Hickmans' expert, Dr. Paul W. Nelson, but also from Dr. Michael Bays, Branson ENT's designated trial representative and the physician whose conduct was at issue, this argument is without legal or logical merit.

Both Dr. Nelson and Dr. Bays testified about the standard of care for a surgeon treating a patient with thyroid cancer. Both doctors agreed that when thyroid cancer is found in a man Roger Hickman's age, the standard of care requires that the patient undergo a total thyroidectomy. Both doctors further agreed that during a total thyroidectomy, it is the surgeon's job to remove all of the patient's macroscopic, or visible, thyroid tissue. In fact, Dr. Bays went so far as to testify that if he failed to remove Roger's right thyroid lobe during surgery, he committed a surgical mistake that constituted malpractice bordering on fraud.

Throughout the course of the trial, there was never any dispute as to: (a) the type of treatment (i.e., a total thyroidectomy) that was required by the standard of care; or (b) that leaving one lobe of the thyroid while attempting a total thyroidectomy violated the standard of care for a surgeon. Instead, as counsel for Branson ENT told the jury during both opening statement and closing argument, this was a simple case with a single factual issue: whether Dr. Bays mistakenly failed to remove Roger's right thyroid lobe, or whether he removed the entire thyroid and it regrew following surgery. Thus, the standard of care was an admitted issue. The jury was entrusted only with the **factual** issue of whether or not Dr. Bays correctly performed a total thyroidectomy by removing both lobes of Roger's thyroid.

Inasmuch as Dr. Nelson and Dr. Bays both testified in lockstep that the standard of care required Dr. Bays to remove all visible tissue from both thyroid lobes, and to "definitely" not leave an entire thyroid lobe behind, there was more than sufficient evidence of the standard of care to submit the case to the jury. As a result, the trial court properly denied Branson ENT's motions for directed verdict and judgment notwithstanding the

verdict, and the trial court's judgment should be affirmed.

B. Standard of Review.

The standard of review as to the denial of a motion for judgment notwithstanding the verdict ("JNOV") is essentially the same as that for the denial of a motion for directed verdict. *Scott v. Blue Springs Ford Sales, Inc.*, 215 S.W.3d 145, 184 (Mo. App. W.D. 2006)(citing *Cohen v. Express Fin. Servs., Inc.*, 145 S.W.3d 857, 865 (Mo. App. W.D. 2004)); *see also Rush v. Senior Citizens Nursing Home Dist.*, 212 S.W.3d 155, 157-58 (Mo. App. W.D. 2006)(citing *Dhyne v. State Farm Fire & Cas. Co.*, 188 S.W.3d 454, 456 (Mo. banc 2006)). A trial court should sustain a motion for directed verdict or a motion for JNOV "only when all of the evidence and the reasonable inferences to be drawn therefrom are so strong against the plaintiff's case that there is no room for reasonable minds to differ." *Williams v. Daus*, 114 S.W.3d 351, 358 (Mo. App. S.D. banc 2003)(quoting *Poloski v. Wal-Mart Stores, Inc.*, 68 S.W.3d 445, 458 (Mo. App. W.D. 2001)). This is because both the directed verdict and the judgment notwithstanding the verdict are "drastic actions" that should only be granted on the rare occasion when reasonable minds could not differ with respect to the correct disposition of the case. *Id.* at 359 (quoting *Butts v. Express Pers. Servs.*, 73 S.W.3d 825, 835 (Mo. App. S.D. 2002))(stating a JNOV is a "drastic action"); *see also Thong v. My River Home Harbour, Inc.*, 3 S.W.3d 373, 377 (Mo. App. E.D. 1999)(citing *Schumacher v. Barker*, 948 S.W.2d 166, 168 (Mo. App. E.D. 1997))("Directing a verdict is a drastic measure.").

Consequently, a trial court's denial of a motion for directed verdict or JNOV must be

affirmed so long as the plaintiff made a submissible case. *Scott,* 215 S.W.3d at 184 (citing *Cohen,* 145 S.W.3d at 865). To make a submissible case, the plaintiff must present "substantial evidence" that establishes each and every element of his claim. *Id.* (citing *Payne v. City of St. Joseph,* 135 S.W.3d 444, 450 (Mo. App. W.D. 2004)). "Substantial evidence is that which, if true, has probative force upon the issues, and from which the trier of facts can reasonably decide a case." *Coonrod v. Archer-Daniels-Midland Co.,* 984 S.W.2d 529, 534 (Mo. App. E.D. 1998)(quoting *Hurlock v. Park Lane Med. Ctr., Inc.,* 709 S.W.2d 872, 880 (Mo. App. W.D. 1985)). In determining whether the plaintiff made a submissible case below, the reviewing court must view the evidence in the light most favorable to the plaintiff, giving the plaintiff the benefit of all reasonable inferences that can be drawn from the evidence, while disregarding all unfavorable evidence and inferences. *Peters v. Gen. Motors Corp.,* 200 S.W.3d 1, 16 (Mo. App. W.D. 2006)(citing *Seitz v. Lemay Bank & Trust Co.,* 959 S.W.2d 458, 461 (Mo. banc 1998)); *Coonrod,* 984 S.W.2d at 534 (citing *Cohen,* 145 S.W.3d at 865).

The appellate court must therefore "presume the plaintiff's evidence is true and disregard any of defendant's evidence which does not support the verdict." *Hogate v. American Golf Corp.,* 97 S.W.3d 44, 46 (Mo. App. E.D. 2003); *Ryan v. Maddox,* 112 S.W.3d 476, 480 (Mo. App. W.D. 2003)(citing *Erdman v. Condaire, Inc.,* 97 S.W.3d 85, 88 (Mo. App. E.D. 2002)). A jury verdict may be reversed for insufficient evidence only if there is a "complete absence of probative fact" to support the verdict. *Rush,* 212 S.W.3d at 158 (quoting *Dhyne,* 188 S.W.3d at 457); *Gill Constr. v. 18th & Vine Auth.,* 157 S.W.3d 699, 712

(Mo. App. W.D. 2004)(quoting *Seitz*, 959 S.W.2d at 461). On the other hand, there is a presumption in favor of reversing a directed verdict or a judgment notwithstanding the verdict. *Blue v. Harrah's North Kansas City, LLC*, 170 S.W.3d 466, 472 (Mo. App. W.D. 2005)(citing *Brockman v. Regency Fin. Corp.*, 124 S.W.3d 43, 46 (Mo. App. W.D. 2004))(presumption in favor of reversing JNOV); *Thong*, 3 S.W.3d at 377 (citing *Schumacher*, 948 S.W.2d at 168)(presumption in favor of reversing directed verdict).

C. Respondents' Expert, Dr. Paul Nelson, Properly Testified as to the Applicable Standard of Care for Treatment of a Patient with Cancerous Thyroid Tissue.

1. <u>The substance of Dr. Nelson's testimony.</u>

The Hickmans called Dr. Paul Nelson, a board-certified surgeon, to testify regarding the standard of care. As noted previously, Dr. Nelson is the Chairman of the Surgery Department at St. Luke's Hospital in Kansas City, and has performed more than 750 thyroidectomies over the course of the last fifteen years. (Tr. 117, 122-26). In addition, he is a full professor of surgery at the University of Missouri at Kansas City Medical School, where, for the last eighteen years, he has taught medical students how to perform thyroid surgery. (Tr. 122-26). Quite simply, Dr. Nelson testified that Dr. Bays violated the standard of care <u>for a surgeon performing a total thyroidectomy for the purpose of treating cancer</u> because he failed to remove Roger's potentially cancerous right thyroid lobe. (Tr. 119, 146-47). Standing alone, his testimony constituted substantial evidence of the applicable standard of care, such that the Hickmans made a submissible case at trial.

Essentially, Appellant asks this Court to disregard Dr. Nelson's testimony because he

did not regurgitate form language from MAI 11.06 to the jury. This argument fails for two reasons. First, as will follow, Dr. Nelson did in fact testify in accordance with MAI 11.06. Second, Missouri courts have long held that the plaintiff is not required to establish the standard of care in a "particular manner" or in "ritualistic fashion". *See Blevens v. Holcomb,* 469 F.3d 692, 695 (8th Cir. 2006); *Redel v. Capital Region Med. Ctr.,* 165 S.W.3d 168, 175 (Mo. App. E.D. 2005); *Ladish v. Gordon,* 879 S.W.2d 623, 634 (Mo. App. W.D. 1994). Under Missouri law, there is no "talismanic" language that must be used so as to transform the expert's testimony into substantial evidence. *See Bynote v. Nat'l Super Markets, Inc.,* 891 S.W.2d 117, 125 (Mo. banc 1995). Instead, the expert's testimony need only show that the expert is using the objective standard of care subscribed to by the medical profession at large. *Boehm v. Pernoud*, 24 S.W.3d 759, 762 (Mo. App. E.D. 2000)(citing *Dine v. Williams*, 830 S.W.2d 453, 457 (Mo. App. W.D. 1992)); *Ladish,* 879 S.W.2d at 634. A review of Dr. Nelson's testimony makes clear that he met this standard of objectivity.

Dr. Nelson testified that when an individual of Roger's age has cancerous thyroid tissue, the standard of care requires that he undergo a total thyroidectomy. (Tr. 146-47, 155, 183). He explained that a total thyroidectomy is a surgical procedure whereby all macroscopic, or visible, thyroid tissue is removed, with only microscopic tissue remnants left behind. (Tr. 172). He also set forth several reasons as to why Roger needed a total thyroidectomy, including (a) the multi-focal nature of thyroid cancer; (b) the risk of the cancer returning if the entire thyroid is not removed; and (c) the need for radioablation treatment after surgery, which cannot be performed unless all macroscopic thyroid tissue has

been removed. (Tr. 143-45, 155-56). At various points throughout his testimony, he explained that, under Roger's circumstances it is "standard procedure" to remove the entire thyroid. (Tr. 143, 155). More specifically, Dr. Nelson testified as follows:

Q. All right. Let me ask you, sir, do you have an opinion about whether Roger Hickman given his clinical history and findings needed to have a total thyroidectomy?

A. Yes. Total thyroidectomy is **the proper** procedure for what Mr. Hickman's diagnosis was.

Q. Do you have an opinion about whether or not Dr. Bays performed a total thyroidectomy December 7, 2001?

A. He did not.

Q. Do you have an opinion, sir, whether given that failure, the subsequent surgery that was undertaken by Dr. Moley in St. Louis was needed and necessary?

A. Yes, it was necessary.

(Tr. 119) (emphasis added).

Q. All right. Now, do you have an opinion about whether there was a total thyroidectomy that was actually done? You indicated the records indicate that that's what was intended. Was it done?

A. No. The patient had most of this right side still left in after the surgery.

Q. And why do you say that?

A. Oh, well, there are several scans that are done in the time between the two operations that show it still there; and then at the second surgery that was done in St. Louis, it was still there.

(Tr. 145).

Q. Now, Doctor, if you are required to do a total thyroidectomy, based upon the findings of cancer like you've described, and you leave one lobe of the thyroid, does that meet the standard of care for a surgeon?

A. No.

Q. Why does it not?

A. Well, if you – if you go to take out a whole thing and you leave half the thing in, that's not what you are supposed to do.

Q. Um, as you teach these students on how to do these surgeries, have you ever taught them that it is appropriate to leave half a lobe or half of a thyroid when you do

A. No.

(Tr. 146-47).

When viewed in light of the language from MAI 11.06, it is clear that Dr. Nelson's testimony provided substantial, objective evidence of the standard of care as required by Missouri law. According to MAI 11.06, in the context of a medical malpractice case, negligence refers to "the failure to use that degree of skill and learning ordinarily used under the same or similar circumstances by the members of defendant's profession." Rather than generically define "standard of care" by reciting this legal definition, Dr. Nelson explained

exactly what type of treatment (i.e., a total thyroidectomy) the medical community recognizes as the standard, accepted way of treating thyroid cancer in a patient in Roger's circumstances. Dr. Nelson not only explained that a total thyroidectomy is the "proper" and "standard" procedure, he also explained that medical students have been taught for more than eighteen years that it is the procedure for patients such as Roger. Likewise, Dr. Nelson discussed the standard of care for a surgeon doing a total thyroidectomy to treat thyroid cancer. He thus testified about what the standard of care required of someone in Dr. Bays' exact profession who was performing the exact surgery that Dr. Bays attempted, for the exact reasons that Dr. Bays indicated. In a malpractice case based upon the negligent performance of a surgery, it is difficult to imagine what more could be said. When viewed side-by-side, it is clear that Dr. Nelson's testimony encompasses every element of MAI 11.06.

MAI 11.06	**Testimony of Dr. Nelson**
1. failure to use that degree of skill and learning	1. failure to perform a total thyroidectomy, defined as the failure to remove all macroscopic thyroid tissue (Tr. 72)
2. used under the same or similar circumstances	2. in treating a patient Roger's age with thyroid cancer (Tr. 146-47, 155, 183)

3. by members of defendant's profession	3. by a surgeon (Tr. 146-47)
4. violates the standard of care	4. violates the standard of care (Tr. 146-47)

Dr. Nelson's testimony shows that he testified on a case-specific basis about each requirement of MAI 11.06. It would be odd if the law were to favor generic, rote, definitional incantations versus case-specific, understandable inquiry about the standard of care applicable to the exact profession doing the exact surgery for the exact reason at issue. Missouri law simply does not require an expert to recite the exact, generic language from MAI 11.06 when opining as to the applicable standard of care.

2. <u>Missouri law does not exalt form over substance, but instead requires only that a plaintiff present objective standard of care evidence.</u>

A review of Missouri case law makes clear that Missouri courts have never adopted a "form over substance" approach to standard of care testimony. For example, in *Pettet v. Bieterman*, 718 S.W.2d 188 (Mo. App. S.D. 1986), the defendant argued that plaintiffs had failed to make a submissible case because they "never specifically inquired of their expert, 'whether or not defendant did or did not use that degree of skill and learning ordinarily used under the same or similar circumstances.'" *Id*. at 190. In rejecting this argument, this Court first considered the background of plaintiffs' expert, noting that he was both a board certified gynecologist and a clinical instructor to medical students. *Id.* The Court then reviewed the expert's testimony in regard to the operation performed, and held that testimony which used

such phrases as the "standard," "accepted," and "prescribed" medical practice was evidence of an objective standard, rather than evidence of the expert's own personal practice and opinion. *Id.* The Court, therefore, outright rejected any argument requiring "the intonation of the phrase in question [as] a required element of plaintiffs' prima facie case." *Id.* Under the *Pettet* analysis, Dr. Nelson's testimony that a total thyroidectomy is the "recommended," "proper," and "standard" procedure surely evinces his use of an objective, profession-wide standard of care. Likewise, as to his testimony that a surgeon who leaves one-half of a potentially cancer-laden thyroid when trying to remove the whole thing violates the standard of care applicable to surgeons.

In a similar case, *Redel v. Capital Region Medical Center*, 165 S.W.3d 168 (Mo. App. E.D. 2005), the defendant claimed that the plaintiffs failed to make a submissible case because their expert witness did not set forth an "objective" standard of care. *Id.* at 172. *Redel* was a case involving alleged negligence on the part of a nurse who failed to follow a doctor's orders to (a) administer continuous passive motion ("CPM") therapy to only one of the patient's legs at a time; and (b) to monitor the patient closely due to his disorientation. *Id.* at 171-73. Citing precedent, the Eastern District noted that, because the claim of negligence was predicated on a nurse's failure to follow physician orders, no expert testimony as to standard of care was necessary. *Id.* at 173. Nevertheless, the Court specifically analyzed the expert testimony that the defendant claimed to be deficient, and found that it was sufficient to show that the expert was applying an "objective, profession-wide standard of care". *Id.* at 174.

The expert at issue testified that it was "unacceptable" to simultaneously use two CPM range of motion devices on a patient, which is precisely what the nurse had done. *Id.* at 171. The Eastern District specifically determined that the expert's testimony sufficiently set forth an objective standard of care because (a) it was not merely based on what the expert would have done differently; and (b) it did not merely suggest that another type of treatment would have been "more appropriate." *Id.* at 174. As a result, the Court concluded that "while [the expert] did not recite the legal definition of the standard of care, we find that her explanation of the standard of care is sufficiently objective." *Id.* In reaching this conclusion, the Court noted that Missouri law does not

> require that a plaintiff establish the standard of care in a particular manner, only that the plaintiff must adequately inform the jury as to the appropriate standard of care. We find that [the expert's] testimony adequately describes the standard of care applicable to the use of CPM machines regardless of whether she was responding to question of Plaintiff[s] or of [Defendant]. Consequently, when viewed in the light most favorable to Plaintiffs, Plaintiffs' evidence adequately established the appropriate standard of care.

Id. at 175 (internal citation omitted)(emphasis added).

In a recent case similar to the one at bar, *LaRose v. Washington Univ.*, 154 S.W.3d 365 (Mo. App. E.D. 2005), the Court confirmed that the focus of this inquiry is the *substance* of the expert's testimony, as opposed to the *form* in which it is offered. In *LaRose,* plaintiff's expert testified that the defendant doctor deviated from the standard of care by failing to

order a specific test for decedent, and thereby failing to timely discover that she had ovarian cancer. *Id.* at 368-69. Rather than quote MAI 11.06 verbatim, the expert testified that when a bone scan shows a potential blockage of one of patient's ureters, as in decedent's case, the standard of care requires an internal medicine physician, such as defendant, to follow up by ordering an ultrasound. *Id.* at 369. In other words, instead of simply reading MAI 11.06, the expert went a step further, and applied the standard of care for an internal medicine physician to the facts of the case. *Id.* Thus, in substance, the expert's testimony was based on MAI 11.06, and constituted substantial evidence of an objective standard of care. For that reason, the Court rejected the defendant's argument that the plaintiff had presented insufficient evidence as to standard of care. *Id.* at 370. The Court further noted that any argument about what standard of care the expert was applying went to the "weight and credibility of [the expert's] testimony, which is a question for the jury." *Id.*

Appellant, however, gives short shrift to the aforementioned cases and instead relies heavily on the cases of *Swope v. Printz*, 468 S.W.2d 34 (Mo. 1971), *Ladish v. Gordon*, 879 S.W.2d 623 (Mo. App. W.D. 1994), and *Boehm v. Pernoud,* 24 S.W.3d 759 (Mo. App. E.D. 2000). Such reliance is problematic, however, because Appellant seeks to rely on the holdings of these cases in a vacuum, after divorcing them from their factual underpinnings.

The case of *Swope*, for example, hinges on the application of the "locality rule," which has since been abandoned by Missouri law. It is true that the expert witness was asked whether the procedure at issue "was up to acceptable medical standards as you know them," to which he replied that the procedure "was not up to acceptable medical standards."*Swope,*

468 S.W.2d at 40. The Court did not, however, analyze this exchange in isolation in determining that the expert was impermissibly testifying as to a subjective standard of care. Instead, the Court emphasized that the expert (1) had received his medical training in England and Scotland; (2) had limited experience in the branch of medicine at issue; (3) had never performed a thryroidectomy or other major surgery; (4) had not followed the literature related to thyroid surgery since 1956; and (5) practiced primarily in the area of psychiatry and mental health. *Id.*

In light of the expert's background and experiences, the Court reasonably questioned his ability to testify as to the standard of care that applied to a thyroid surgeon practicing in Kansas City. *Id.* Specifically, the Court noted:

> There was no showing that [the expert] knew or was acquainted with the standards of learning, skill and proficiency commonly exercised by ordinarily careful, skillful and prudent surgeons in good standing performing thyroidectomies in Kansas City and similar localities; no showing that he was acquainted with community standards of proficiency under the requirements of [the then applicable version] of MAI No. 11.06.

Id. In light of his testimony as to his training and experience, there was no basis from which to believe that the expert was testifying as to the objective Kansas City standard of care for thyroid surgery, as opposed to his own subjective standard of care. *Id.* In other words, there was simply no factual basis for believing that "acceptable medical standards" in the mind of the expert were the same as "acceptable medical standards" for Kansas City thyroid

surgeons. *Id.* For this reason, the Court found that plaintiff failed to make a submissible case. *Id.*

The testimony offered by Dr. Nelson stands in stark contrast to that offered by the expert in *Swope*. As stated in his testimony, Dr. Nelson has performed over 750 thyroidectomies in the last fifteen years alone, and has taught medical students how – and when – to perform this procedure for more than eighteen years. (Tr. 117, 122-26.) In addition, Dr. Nelson testified that he is the Chairman of the Department of Surgery at St. Luke's hospital, where he also serves on the credentialing committee. (Tr. 122-26). In this capacity, he is responsible for determining whether new doctors who are applying for staff appointments are capable of practicing within the standard of care. (Tr. 126). Thus, unlike the *Swope* expert, Dr. Nelson's experience as both a surgeon and a medical school instructor demonstrate that he is intimately familiar with the objective, profession-wide standard of care for thyroid surgeons. As a result, the *Swope* case is wholly inapposite to the matter at hand, even if one ignores the fact that *Swope* was decided using the now abandoned locality standard.

Appellant also looks to *Ladish* for support for its argument that the Hickmans failed to make a submissible case at trial. The testimony at issue in *Ladish*, however, is likewise distinguishable from the testimony given by Dr. Nelson. In *Ladish*, the expert never testified that the defendant's conduct was a deviation from the standard of care or a departure from accepted medical standards; instead, he only opined that "it would have been more appropriate" to do something else, and that the defendant "exhibited rather poor judgment"

in taking certain actions. *Ladish*, 879 S.W.2d at 634. Not surprisingly, after reviewing this testimony, the Western District found that this expert testimony was insufficient because, while it was critical of the defendant, it did not include an objective expert opinion that the defendant actually violated the standard of care. *Id.* The distinction between the two is crucial, as a physician is not liable for malpractice if he fails to provide the best possible care, but only if his actions fall below the standard of care baseline. Throughout his testimony, Dr. Nelson never testified that a total thyroidectomy would have "been more appropriate," or that Dr. Bays exercised "poor judgment". Instead, he consistently and repeatedly testified that the standard of care dictated a total thyroidectomy, and that Dr. Bays deviated from that standard when he failed to perform a total thyroidectomy by leaving Roger's entire right thyroid lobe during surgery. For this reason, the *Ladish* case does not and cannot give credence to Appellant's argument.[2]

Appellant also drafts the case of *Boehm v. Pernoud*, 24 S.W.3d 759 (Mo. App. E.D. 2000) in support of its argument that Dr. Nelson's testimony was insufficient. There, plaintiff's malpractice action was predicated on the defendant's alleged negligent failure to timely diagnose a retinal hole in plaintiff's eye. *Id.* at 760-61. Plaintiff's expert testified as

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[2] For a discussion of the ultimate holding of *Ladish* – i.e., that a submissible case was made via the defendant doctor's testimony regarding the standard of care – see *infra* § E2. This holding supports the second prong of the Hickmans' argument, that the standard of care was admitted through the testimony of Dr. Bays.

to two possible methods the defendant could have used which likely would have led to the timely diagnosis of the retinal hole. *Id.* at 762. Specifically, the expert opined that the defendant could have (1) performed a second examination after allowing plaintiff to rest; or (2) referred plaintiff to a retinal specialist. *Id.* He further testified that both methods were "consistent" with the standard of care, and that, in his practice, he always referred patients to retinal specialists. *Id.*

The Court emphasized, however, that the expert never testified that the defendant's failure to employ one of those two methods constituted a standard of care violation; rather, he merely testified that his proposals were "consistent" with the standard of care. In particular, the Court noted:

> Just because a course of action is consistent with the standard of care . . . does not necessarily mean that not following that course of action constitutes a deviation from the standard of care. A particular course of action may surpass the standard of care of a profession, yet it would still be consistent with that standard.

Id. Thus, because the expert's testimony could reasonably be construed as requiring more than what was required by the standard of care, the Court found that plaintiff had failed to introduce substantial evidence as to the standard of care element. *Id.* As a result, the Court reversed for failure to make a submissible case. *Id.*

Again, the testimony offered by the *Boehm* expert is simply not analogous to the testimony offered by Dr. Nelson. Dr. Nelson did not testify on the basis of his private

practice, nor did he opine that a total thyroidectomy was merely "consistent" with the standard of care. To the contrary, he testified that Dr. Bays' failure to perform a total thyroidectomy (as evidenced by the fact that Roger's right thyroid lobe had to be removed four months after Dr. Bays' procedure) constituted a violation of the standard of care for a surgeon performing this exact surgery under the exact same circumstances. (Tr. 146-47).

Two other cases cited by Appellant – *Mills v. Redington* and *Hurlock v. Park Lane Medical Center* – are likewise distinguishable. In *Mills v. Redington,* 736 S.W.2d 522 (Mo. App. E.D. 1987), the plaintiff alleged that her defendant doctor had committed malpractice in misdiagnosing (and, consequently, mistreating) a recurrence of bone cancer as osteoporosis. *Id.* at 523. The trial court, however, entered directed verdict in favor of the defendant because plaintiff failed to offer objective evidence of the relevant standard of care. *Id.* at 524. On appeal, the Missouri Court of Appeals affirmed the trial court's judgment, noting that the expert's testimony only recited "what *his* individual custom or practice was, under comparable circumstances," rather than testifying about the prevailing standard of care in the medical profession at large. *Id.*

The expert testimony in *Hurlock v. Park Lane Medical Center,* 709 S.W.2d 872 (Mo. App. W.D. 1985), suffered the same fatal short-comings. There, plaintiff's contention was that while she was in the hospital for treatment of a leg fracture, she developed bed sores as a result of her doctor's negligence, and these bed sores worsened to the point that she had to undergo amputation of her right leg. *Id.* at 875-76. At trial, plaintiff offered "the testimony of several doctors as to what their individual custom or practice was under comparable

circumstances". *Id.* at 883. Rejecting this evidence, and affirming the trial court's determination that plaintiff failed to make a submissible case, the Western District stated:

> Mere evidence that the conduct of a physician or surgeon did not measure up to the standards of an individual member of the profession, as opposed to the standards of the profession at large, does not constitute substantial evidence of probative force to support a submission of negligence in a medical malpractice case as individual standards may be higher or lower than the standards of the profession as a whole.

Id. at 884 (internal citations omitted).

When Dr. Nelson's testimony is viewed through the lens of the foregoing case law, it is plain that the standard of care criticisms that he offered were not based on his individual custom or practice, but on an objective, profession-wide standard of care. He also set forth the specific reasons why the profession-wide standard of care exists. As a result, and even ignoring Dr. Bays' own admissions, the Hickmans did, indeed, present substantial evidence of the standard of care, such that the trial court's judgment should be affirmed.

3. <u>Appellant's failure to cross-examine Dr. Nelson regarding his standard of care opinions underscores the sufficiency of his testimony.</u>

The sufficiency of Dr. Nelson's testimony is further bolstered by the fact that the Appellant completely and utterly failed to cross-examine him regarding his standard of care opinions. During cross-examination, Appellant's trial counsel asked Dr. Nelson to paraphrase his standard of care criticism pertaining to Dr. Bays, to which Dr. Nelson responded:

"Correct operation for a thyroid cancer of this type is to take out the whole thyroid gland. That wasn't done. He left most of the right side still in." (Tr. 183)

At no time did Appellant's trial counsel cross-examine Dr. Nelson as to whether he was applying a personal, subjective standard of care as opposed to an objective, profession-wide standard of care. In fact, trial counsel effectively *endorsed* Dr. Nelson's standard of care criticism during the course of the following exchange:

> Q. Would you agree that Mr. Hickman could have been treated, talking about the time frame he was cared for by Dr. Moley, he could have been treated in an alternative manner to surgery, but the general practice in recent years in your experience with regard to this type of problem is to perform a total thyroidectomy; would that be a fair statement?
>
> A. That's correct. The standard treatment is a total thyroidectomy for this.

(Tr. 170-71). As the above exchange demonstrates, Appellant's trial counsel knew that Dr. Nelson was testifying about the standard of care for surgeons performing a total thyroidectomy for treatment of cancer. There was no uncertainty in trial counsel's mind because Dr. Nelson's testimony left no room for any uncertainty.

Under similar circumstances, the defendant in *Sheffler v. Arana*, 950 S.W.2d 259 (Mo. App. W.D. 1997) moved for a judgment notwithstanding the verdict on the grounds that plaintiff's expert had not defined what he meant by the phrase "standard of care". *Id.* at 267. The Court held this argument was "without merit," as the plaintiff's expert had applied the

standard of care to the specific facts of the case by testifying as to (1) who the standard applied to (i.e., a surgeon); (2) the circumstances at issue (i.e., a surgeon performing bowel surgery); and (3) what that standard required under that specific fact pattern. *Id.* Having set forth this testimony, the expert then opined that the defendant had not abided by this standard of care when doing the surgery in question. *Id.* The Court held that, by setting forth the specific profession and factual circumstances at issue, the expert had properly established the applicable standard of care. *Id*. at 268.

Moreover, the Court emphasized the fact that defendant had failed to cross-examine the expert with respect to what he meant by the phrase "standard of care":

> If [defendant] believed that [plaintiff's expert] failed to answer the questions asked or that the range of acceptable conduct was more inclusive than that testified to by [expert], [defendant] could have explored those issues on cross examination of [expert]. Declining to inquire of [expert] on cross examination about the required standard of care because of the belief that [expert] failed to state what the standard requires assumes some risk, when, as is determined here, [expert] asserted the procedure required to satisfy the standard of care under the facts of this case.

Id. (emphasis added); *see also Daus,* 114 S.W.3d at 363 (holding no precise language need be used by an expert witness, and finding waiver of the argument expert failed to use proper standard in testifying where no attempt was made to cross-examine expert regarding this issue); *Wright v. Barr*, 62 S.W.3d 509, 526-28 (Mo. App. W.D. 2002)(finding that

defendant's argument that plaintiff's expert was applying a subjective, rather than objective, standard of care was waived where defendant failed to preserve this issue at trial by objecting).

In light of the foregoing cases, if Appellant truly believed that there was a question as to whether or not Dr. Nelson was offering an objective standard of care criticism, it should have explored this issue on cross-examination and/or objected to the testimony. Appellant's failure to do either of these things underscores (1) the fact that there was no question that Dr. Nelson was testifying as to the objective, profession-wide standard of care; and (2) the reality that there was never any disagreement between the parties as to the appropriate standard of care in this case. Because Dr. Nelson's testimony was substantial evidence of an objective standard of care criticism, Appellant's basis for appeal is without merit. Therefore, Appellant's point on appeal should be denied.

D. Dr. Bays' Testimony, Standing Alone, Established the Standard of Care and Admitted Violation of the Standard of Care Applicable to Him as Roger's Surgeon, Should the Jury Find He Left the Right Thyroid Lobe Behind.

1. <u>Dr. Bays' testimony was binding on Branson ENT.</u>

Respondents agree with Appellant's contention that Dr. Bays' ability to bind Branson ENT was never, at any time, raised by Branson ENT, but was instead raised *sua sponte* by the Missouri Court of Appeals for the Southern District.[3] Specifically, in its opinion, the

[3] *See* Appellant's Substitute Brief, pg. 28 n. 1.

intermediate court noted that "Plaintiffs do not cite authority for their implicit contention that Dr. Bays' testimony, under these circumstances was binding on Defendant or could be considered 'its' evidence." *Hickman v. Branson Ear, Nose & Throat, Inc.*, No. 27648, 2007 WL 2429928, at *8 (Mo. App. S.D., Aug. 29, 2007).[4] While Missouri law makes clear that the appellate courts are to consider only those issues which were actually raised on appeal, *see Tri-State Motor Transit Co. v. Holt,* 921 S.W.2d 652, 656 (Mo. App. S.D. 1996); *Tice v. Tice*, 872 S.W.2d 148, 149 (Mo. App. S.D. 1994), out of an abundance of caution, Respondents will nevertheless address this criticism raised by the Southern District.

Simply put, there was reason why Branson ENT never contested Dr. Bays' ability to bind it. Both the factual record and Missouri precedent make clear that Branson ENT was bound by the testimony of Dr. Bays – including his admissions as to the standard of care. In the first place, Dr. Bays was the designated corporate representative chosen by Branson ENT to represent it and speak on its behalf at trial. (Tr. 20, 24). As the corporate representative, Dr. Bays' statements were binding against Branson ENT as a matter of law.[5] This rule

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[4] *See also id.* at *9 (stating, in response to Respondents' Motion for Rehearing/Application for Transfer that "it was Plaintiffs' obligation to cite in their brief to portions of the record establishing a factual basis . . . and legal authority supporting it").

[5] *See Payne v. Cornhusker Motor Lines, Inc.*, 177 S.W.3d 820, 826, 838-39 (Mo. App. E.D. 2005)(holding that railroad was bound by the deposition testimony of its

reflects the fact that, once an employee has been designated as a corporate representative, he testifies not as an individual but as an extension of the corporation itself. *Annin v. Bi-State Dev. Agency,* 657 S.W.2d 382, 386 (Mo. App. E.D. 1983). Thus, inasmuch as Dr. Bays was clearly and unequivocally designated as Branson ENT's corporate representative for trial, his admissions regarding the standard of care are binding as to Branson ENT.

Secondly, in addition to being Branson ENT's designated trial representative, Dr. Bays was also an employee of Branson ENT whose conduct was at issue, and who was admittedly acting within the course and scope of his authority while providing medical care to Roger Hickman. (Tr. 108). In reality, Dr. Bays is not only the sole physician at Branson ENT, but he actually opened the clinic and continues to operate and manage it to this day. There was never any question – before, after, or during trial – that, when he testified, Dr.

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employee, who was a company clerk, where the railroad had designated the clerk as its corporate representative); *Annin v. Bi-State Dev. Agency,* 657 S.W.2d 382, 386 (Mo. App. E.D. 1983)(holding that defendant corporation was bound by the deposition testimony of its employee bus driver who had been designated as its corporate representative); *see also Central Missouri Elec. Coop. v. Wayne,* 18 S.W.3d 46, 49 (Mo. App. W.D. 2000)(discussing the testimony of employer's corporate representative in the context of admissions of the employer); *Tuterri's, Inc. v. Hartford Steam Boiler Inspection & Ins. Co.,* 894 S.W.2d 266, 269 (Mo. App. W.D. 1995)(using the testimony of the defendant's corporate representative as admissions against the defendant).

Bays was speaking not just for himself, but on behalf of Branson ENT as well.

Under Missouri law, statements by employees regarding acts within the course and scope of their employment are binding on the employer. *See Bynote v. Nat'l Super Market, Inc.,* 891 S.W.2d 117, 124 (Mo. banc 1995); *Skay v. St. Louis Parking Co.,* 130 S.W.3d 22, 27 (Mo. App. E.D. 2004); *Henson v. Bd. of Educ. of the Washington Sch. Dist.,* 948 S.W.2d 202, 209 (Mo. App. E.D. 1997); *Brawley & Flowers, Inc. v. Gunter,* 934 S.W.2d 557, 562 (Mo. App. S.D. 1996). Thus, in a slip-and-fall case against a grocery store, statements made by a grocery store checker to the effect that she had told a bagger to clean up the puddle of liquid at issue were admissible against her employer because notifying baggers about spills that needed to be mopped up fell within the checker's job duties. *Bynote,* 891 S.W.2d at 124.

In this case, as admitted by Branson ENT, Dr. Bays was acting within the course and scope of his employment at all times while providing care to Roger Hickman. Thus, in speaking about what type of treatment was mandated by the standard of care, Dr. Bays was speaking about the essence of his job duties as the lone physician employed by Branson ENT. Under *Bynote*, and its progeny cases, the standard of care admissions by Dr. Bays were binding on Branson ENT. Indeed, as the only physician employed by the clinic, Dr. Bays was the only employee who could bind Branson ENT with his statements regarding the standard of care. *See State ex rel. Pitts v. Roberts,* 857 S.W.2d 200, 202 (Mo. banc 1993)(noting that an organization can only act and speak through its employees).

It is a well-accepted tenet of the law that corporations are fictitious persons who speak and act only through their agents and employees. *Pitts v. Roberts,* 857 S.W.2d at 202.

Inasmuch as Branson ENT was the sole remaining defendant in the case, any speaking in the case was necessarily about that sole defendant and the actions it took or failed to take through its employees and agents. In light of both the record and Missouri precedent, there can be no doubt that Branson ENT was bound by Dr. Bays' admissions regarding the standard of care. This, of course, is why Appellant has always conceded this issue.

2. Standing alone, Dr. Bays' testimony constituted substantial evidence of the standard of care.

As discussed above, Dr. Nelson's testimony constituted substantial evidence of the standard of care, such that the Hickmans made a submissible case at trial. Dr. Nelson was not, however, the only trial witness who established the applicable standard of care for treatment of Roger's thyroid cancer. Dr. Bays, whose conduct was the basis for the malpractice action, also took the stand and testified (consistently with Dr. Nelson) that the standard of care required that he perform a total thyroidectomy, defined as the removal of all macroscopic thyroid tissue. (Tr. 245-46). Dr. Bays likewise agreed that leaving behind half of the thyroid when performing a total thyroidectomy was a "definite" violation of his surgical duties, and constituted medical fraud. (Tr. 248-49).

Accordingly, it was never disputed at trial that a total thyroidectomy was required by the standard of care and that leaving one potentially cancer-ridden lobe of the thyroid while attempting a total thyroidectomy was a violation of the standard of care. Rather, the only issue for the jury was the factual issue of whether Dr. Bays actually performed a total thyroidectomy, or whether he mistakenly failed to remove Roger's right thyroid lobe. For this

reason, the Hickmans would have made a submissible case even without the testimony of Dr. Nelson.

Missouri law only requires a plaintiff to prove those issues that are actually in dispute. Once an issue is admitted by the defendant, there is no longer any need for the plaintiff to submit evidence proving that issue. This is true even in the context of medical malpractice cases, where Missouri courts have held that "[e]xpert testimony is not required . . . if the defendant's own testimony establishes the standard of care." *Redel*, 165 S.W.3d at 172-73 (citing *Delisi v. St. Luke's*, 701 S.W.2d 170, 173 (Mo. App. E.D. 1985)). Moreover, a party is bound by the uncontradicted testimony of the party's own witness, even if that testimony was elicited on cross-examination. *Erdman v. Condaire, Inc.*, 97 S.W.2d at 88 (citing *Simpson v. Johnson's Amoco Food Shop, Inc.*, 36 S.W.3d 775, 776 (Mo. App. E.D. 2001)).

In *Redel*, the case in which the propriety of a nurse's administration of CPM therapy was at issue, the plaintiffs called several employees of the defendant hospital and asked them questions pertaining to the standard of care. 165 S.W.3d at 173. For example, one employee was asked, "Well, a nurse shouldn't put two CPMs on one person, period, right?," to which the employee responded, "Correct. We never do that." *Id.* Similarly, another employee testified that it was never appropriate to put a patient on two CPM machines at the same time, while an employee-doctor testified that she never ordered bilateral CPMs to be done. *Id.* In reviewing this testimony, the Eastern District found that it was "sufficient to establish the standard of care without additional expert testimony." *Id.* at 174.

A similar result was reached in *Delisi*. There, the defendant argued that plaintiff failed

to make a submissible case because he offered absolutely no expert testimony, including any testimony pertaining to the standard of care. 701 S.W.2d at 173. The Court disagreed, however, noting that the defendant's own testimony established the standard of care. *Id.* The underlying issue at trial was whether the defendant should have administered a prophylactic antibiotic when treating plaintiff's puncture wound, which occurred when plaintiff accidentally cut himself with an old, rusty knife. *Id.* The parties disagreed as to whether plaintiff had informed the defendant doctor that the puncture was caused by a rusty knife; however, the defendant agreed that a puncture caused by a rusty knife would be considered a "dirty wound". *Id.* at 173-74. The defendant was then questioned about the circumstances in which an antibiotic should be given, and was asked to identify circumstances in which it would be inappropriate to give an antibiotic to a wound patient. *Id.* at 174. The defendant testified that antibiotics should be given to a wound patient unless (1) the patient is allergic to antibiotics, or (2) the wound is "clean," as opposed to dirty. Then the following exchange took place:

> Q. Are there any other reasons that you would not administer an antibiotic?
>
> A. I can't say offhand. Those are the primary.
>
> Q. Those are the only ones you can think of; is that correct?
>
> A. Right.

Id.

Based on this testimony, the Eastern District determined that the defendant had

"established the standard of care." *Id.* The defendant argued that his testimony "pertained only to his own personal standard of care, and did not establish any general standard applicable to the community at large." *Id.* at 175. The Court, however, summarily rejected this argument, holding that "when viewed in a light most favorable to plaintiff, [the testimony] establishes a general standard of care." *Id.* Specifically, the Court found that the admitted standard of care required a physician to administer prophylactic antibiotics if the physician knew that the patient had a dirty wound. *Id.* at 174-75. Thus, the only remaining issue was the factual issue of whether the defendant knew that the puncture was a dirty wound. *Id.* at 174. Just as in *Delisi*, the Hickman jury was presented with the simple, factual issue of whether Dr. Bays attempted a total thyroidectomy, but mistakenly left half the thyroid behind.

The Court likewise found that defendant's own testimony established the standard of care in *Pinky v. Winer,* 674 S.W.2d 158 (Mo. App. E.D. 1984). At trial, plaintiff presented no expert testimony, and the trial court entered a directed verdict in favor of the defendant on the grounds that plaintiff had not made a submissible case. *Id.* at 159. The Eastern District, however, disagreed in light of the following testimony given by the defendant:

> Q. Now, Doctor, in the post-operative care of a patient such as [plaintiff], is it important for the operating physician to insure that the little finger is so bandaged as to not interfere with the circulation of that portion of the body following surgery?
>
> A. Are you asking me specifically related to putting the dressing on this

patient or in a general question?

Q. I'm asking generally.

A. In a general question, dressings are put on in a manner to avoid any compromise to the circulation.

Q. Why, sir?

A. Because persistent compromise to the circulation can lead to permanent damage to the muscles, nerves and possibly even the loss of an extremity or finger.

Id. at 160. In light of this testimony, the Court reversed the trial court's judgment, finding that defendant's own testimony "established that the standard of care required is to put dressings on 'in a manner to avoid any compromise to the circulation.'" *Id.* Having established the standard of care, the only issue remaining was the factual issue of whether the defendant doctor did, indeed, put the dressings on in a way that avoided compromising the circulation. In the same way, because Dr. Bays agreed that the standard of care required that he perform a total thyroidectomy on Roger, and agreed that leaving one-half of the thyroid violated the standard of care. The only remaining issue was the factual issue of whether he failed to perform a total thryoidectomy. As to this issue, Dr. Bays agreed that Dr. Moley's removal of 8.2 grams of thryoid four months after the original surgery was consistent with Dr. Bays' having left one-half of the thyroid behind.

In *Richeson v. Roebber*, 159 S.W.2d 658 (Mo. 1942), the Missouri Supreme Court reiterated that a plaintiff need not introduce expert evidence as to the standard of care when

the defendant, himself, admits the issue. *Id.* at 659-60. At issue in *Richeson* was whether the defendant properly advised the plaintiff that he would need surgery to properly align and repair his broken leg. *Id.* at 658-59. Plaintiff introduced no expert evidence at trial, and the trial court directed a verdict in favor of the defendant. *Id.* at 658-59.

On appeal, the Supreme Court noted that the defendant, himself, testified that the standard treatment for plaintiff's leg fracture was surgical realignment, although plaintiff did not receive such treatment. *Id.* at 659. As summarized by the Court, the defendant testified that "he used a method which he knew was not practical under the circumstances and would not accomplish a satisfactory result." *Id.* As the Court noted, "[a] dozen expert witness [sic] could not have added much to that." *Id.* There was no dispute as to the treatment required under the standard of care; instead, the sticking point at trial was the factual issue of whether defendant failed to advise plaintiff that he needed to undergo surgery, or whether plaintiff refused to undergo surgery after having been properly advised of the necessity of surgery by the defendant. *Id.* The Court reversed the trial court's judgment because this factual issue did not go to the submissibility of the case, but was instead a credibility issue to be determined by the jury. *Id.* at 660.

Even *Ladish* – the lynchpin of Appellant's appeal – is supportive of the Hickmans' position. Admittedly, the Western District found that testimony by the plaintiff's expert that "it would have been more appropriate" for the defendant to have done something else and that the defendant "exhibited rather poor judgment"was insufficient to establish the objective standard of care. *Ladish,* 879 S.W.2d at 634. The Court then went on, however, to reverse

the trial court's entry of JNOV in favor of the defendant, finding that a submissible case was made through the testimony of the defendant doctor, who admitted the standard of care. *Id.* at 633, 635. Specifically, the Court held that

> because [defendant's] *own evidence* acknowledged the importance of advising the patient about frequent separation of the labial lips . . . we hold that plaintiff established that there was a duty to advise plaintiff concerning the need for frequent separation of the labial lips. Even though [plaintiff's expert's] testimony was not in itself sufficient to establish defendant's duty, we will not find that plaintiff failed to establish defendant's duty, where defendant's evidence also acknowledges the existence of the duty.

Id. at 635 (emphasis in original). Thus, the actual holding of *Ladish* is that when a doctor agrees with the plaintiff as to what duties he owed her, his testimony *alone* is sufficient evidence of the standard of care, such that the case can properly be submitted to a jury.

When Dr. Bays' testimony is examined in light of the above case law, Appellant's argument is unsupportable, to put it politely. At trial, he testified as follows:

> Q. And when a patient comes to you, you know that they're relying upon your skill, your education, your training?
>
> A. I'm aware of that.
>
> Q. And you recognize, don't you, Doctor, that you owe that individual certain duties of care?
>
> A. I definitely recognize that.

Q. And if they are going under your knife, you recognize that you owe them duties to do the operation properly, correct?

A. I do.

Q. And if you don't do the operation properly, then it's your responsibility, correct?

A. That's correct.

Q. No disagreement with any of that?

A. No.

(Tr. 233). Dr. Bays then testified that "there was no question" that he intended to perform a total thyroidectomy on Roger, as this was the type of treatment required by the standard of care. (Tr. 243, 245). He further testified that he told the Hickmans that he had performed a total thyroidectomy, and billed them for a total thyroidectomy procedure. (Tr. 245-47). Dr. Bays subsequently reiterated that the standard of care mandated a total thyroidectomy:

Q. [T]hat's the standard of care when you have thyroid cancer is to remove the entire thyroid, to do a total thyroidectomy, correct?

A. You're correct . . . .

. . .

Q. And a total thyroidectomy is removal of the macroscopic tissue, correct?

A. That's what I learned from literature search[6] that that's what they define it as, removal of macroscopic tissue.

Q. All right. Now, macroscopic tissue versus microscopic. Macroscopic is tissue you can see, right?

A. Tissue that you can see.

(Tr. 245-46). Clearly, this testimony alone establishes the standard of care in this case, and demonstrates that there was never any dispute between the parties as to the standard of care. Even so, Dr. Bays provided additional testimony regarding the standard of care:

Q. [W]hen you do a total thyroidectomy you don't leave the entire thyroid lobe, correct?

A. You definitely don't do that.

Q. You don't do that. And if you do that then you haven't done the right operation, and that would be a mess up, correct?

A. If you did that and said that you did that, then you would be a liar and a fraud.

Q. And so if you leave entire thyroid lobe and you feel you have done a total thyroidectomy, that is a surgical mistake, true? We can agree on

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[6] *See Redel*, 165 S.W.3d at 174 (noting that the fact that the witness indicates his testimony is based on a review of medical literature is sufficient to establish the standard of care).

that.

A. Um, it may not be a surgical mistake, but it would be an out-and-out lie.

Q. Well, all right. We'll get into the distinction a little bit. If you think you removed the thyroid but you left it, uh, that's a mistake; isn't it?

A. If you think you did, but you left it, yeah, that would be a mistake.

Q. All right. That would be a mistake. That would be a surgical error. That would be something that would be in violation of your duties as a surgeon, true?

A. Definitely.

(Tr. 248-49)(emphasis added). It is of course axiomatic that the standard of care states the duty – that is its purpose. *Ostrander v. O'Banion*, 152 S.W.3d 333, 338 (Mo. App. W.D. 2004)("Breach of duty refers to the commission or omission of an act that the actor should or should not have done in accordance with the relevant standard of care."). Dr. Bays further conceded that the thyroid tissue that was removed by Dr. Moley during the second surgery was consistent with the Hickmans' claim that he failed to properly perform a total thyroidectomy by leaving one-half of the thyroid. (Tr. 251-52).

Ultimately, Dr. Bays admitted each of the following facts at trial:

1. Roger needed a total thyroidectomy;
2. It was his intention to perform a total thyroidectomy;
3. He told the Hickmans that he had performed a total thyroidectomy and charged them for that procedure;

4. He owed Roger the duty to perform a proper total thyroidectomy;

5. A surgeon's duty in performing a total thyroidectomy is to remove both lobes of the thyroid;

6. According to medical literature, a total thyroidectomy requires the removal of all macroscopic tissue;

7. When performing a total thyroidectomy, a surgeon "definitely" does not leave a thyroid lobe in the patient's body;

8. If a surgeon fails to remove a thyroid lobe while purporting to perform a total thyroidectomy, he has made a surgical error bordering on fraud;

9. Failing to remove a thyroid lobe while performing a total thyroidectomy would "definitely" be in violation of Dr. Bays' duties as a surgeon; and

10. The thyroid tissue removed during the second surgery was consistent with Dr. Bays' failure to perform a proper total thyroidectomy during the first surgery.

In light of this testimony, it is difficult to imagine what more Dr. Bays or anyone else could have offered with respect to the applicable standard of care. Indeed, as this Court found in *Richeson*, "a dozen expert witness[es] could not have added much to that." 159 S.W.2d at 659.

Dr. Bays' testimony clearly goes above and beyond the testimony that was deemed sufficient in the *Redel, Delisi, Pinky, Richeson,* and *Ladish* cases. There can be no question

that Dr. Bays' testimony established that the standard of care required him to remove Roger's entire thyroid gland. It is inconceivable that Appellant would argue otherwise, especially considering that, during both opening statements and closing arguments, Appellant's trial counsel informed the jury that the sole liability issue in the case was the factual issue of whether Dr. Bays removed the right thyroid lobe during his December 7, 2001 surgery. (Tr. 63, 66, 589).

Throughout the course of trial, it was never Appellant's position that the standard of care mandated some form of treatment other than a total thyroidectomy, nor was it Appellant's position that Dr. Bays could leave behind half of the thyroid and meet the standard of care. Instead, Appellant steadfastly maintained that Dr. Bays performed the appropriate procedure, a total thyroidectomy, and that Roger's right thyroid lobe subsequently regrew. The issue, then, was always whether Dr. Bays performed a total thryoidectomy, and never the question of what the standard of care required. This was a factual issue that fell squarely within the province of the jury as fact-finder because Plaintiffs' standard of care evidence was admitted. As a result, the case was properly submitted to the jury, and the trial court's judgment should be affirmed.

CONCLUSION

Despite Appellant's assertions to the contrary, there has never, at any time, been any question regarding the applicable standard of care in this case. As early as opening statements, Appellant's trial counsel explained that this case hinged on the factual question of whether or not Dr. Bays performed a total thyroidectomy by removing all of Roger

Hickman's thyroid gland. The Hickmans' expert, Dr. Nelson testified that the standard of care required a total thyroidectomy, defined as the removal of all macroscopic tissue. Dr. Nelson testified as to the objective, profession-wide standard of care applicable to a surgeon doing this exact operation for the exact reasons it was done. His testimony fully satisfied Plaintiffs' burden. When it was Dr. Bays' turn to take the stand, he unequivocally (and repeatedly) concurred with Dr. Nelson's assessment of the standard of care. This testimony by Dr. Bays, in which he admitted the standard of care, was, as a matter of law, binding on Defendant Branson ENT. At the conclusion of the case, during closing arguments, Appellant's trial counsel again reiterated that the controlling issue was whether Dr. Bays' failed to remove Roger's right thyroid lobe, or whether the right thyroid lobe regrew after he performed a total thyroidectomy.

A motion for directed verdict or JNOV is to be denied unless the plaintiffs fail to make a submissible case at trial. A submissible case is made so long as the plaintiffs introduce "substantial evidence" for each element of their claim. When the evidence is viewed in the light most favorable to the Hickmans, it is clear that they not only presented substantial evidence as to the standard of care, but that they presented standard of care evidence that was overwhelmingly conclusive because it was admitted by the doctor whose care was at issue. Appellant's argument to the contrary is baseless, and is supported by neither the testimony adduced at trial, controlling Missouri precedent, nor basic common sense. As such, the judgment of the trial court should be affirmed.

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CERTIFICATE OF COMPLIANCE WITH RULE 84.06

AND CERTIFICATE OF SERVICE

STATE OF MISSOURI)
) ss
COUNTY OF GREENE)

Pursuant to Rule 84.06(c) and Local Rule 16, counsel for Respondents certifies that this substitute brief complies with the limitations contained therein. Excluding the cover page and this certification, there are 13,936 words in this brief. Counsel for Respondents relied on the word count of their word processing system in making this certification.

Pursuant to said Rules, counsel for Respondents certifies that the CD-ROM filed herewith contains an electronic version of the brief in Word Perfect v. 11, and that said CD has been scanned for viruses and is virus-free.

Further, counsel for Respondents state that Respondents' substitute brief was served by hand-delivery, in the following stated number of copies, addressed to the following, on the ___day of December, 2007:

One (1) original and nine (9) copies of Respondents' brief, and one (1) CD-ROM containing same:

Thomas F. Simon, Clerk
Missouri Supreme Court
207 W. High Street
Jefferson City, MO 65101
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The following was also served by United States Mail on the ___ day of December, 2007:

Two (2) copies of Respondents' brief and one (1) CD-ROM containing same:

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Subscribed and sworn to before me this ___ day of December, 2007.

_____

Notary Public

My Commission Expires:

INDEX OF APPENDIX