No. 66959

IN THE MISSOURI COURT OF APPEALS
WESTERN DISTRICT

Bernice L. Mitchell, *et al.*,
Appellants,

vs.

Joseph C. Evans, M.D., *et al.*,
Respondents.

Appeal from the Circuit Court of Jackson County,
Hon. Vernon E. Scoville, Judge Presiding
Circuit Court Nos. 02CV-222374 & 03CV-222184 (Consolidated)

APPELLANT'S BRIEF

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JURISDICTIONAL STATEMENT

This is an appeal from a judgment following a jury trial on the issue of whether medical negligence on the part of the Defendants against whom the case was tried caused or contributed to cause the death of a car accident victim. No circumstances exist which would give the Supreme Court initial or exclusive appellate jurisdiction, and the appeal is within the general appellate jurisdiction of this Court pursuant to Article V, Section 3 of the Missouri Constitution.

STATEMENT OF FACTS

Note: Line and page references throughout the Statement of Facts and the brief will be in the form page/line to line [12/1-15] or page/line to page/line [12/1-13/24]. The summary of expert witness testimony necessarily contains some paraphrasing. In the event of any discrepancy, obviously the transcript controls.

On August 13, 2002, suit was filed in this case. [LF Vol. I at 1.] The suit alleged medical negligence against Defendants Joseph C. Evans, M.D.; Surgical Care of Independence, Inc.; Sol H. Dubin, M.D.; Orthopedic Associates of Kansas City, Inc.; Robert L. Bowser, M.D., and Independence Anesthesia, Inc., and former Defendant Independence Regional Health Center ("IRHC"). *Id.*, at 1-27. On August 13, 2003, a separate wrongful death suit was filed against these Defendants, alleging in part that William Mitchell had died on August 13, 2000, and that the negligence of these Defendants caused or contributed to cause his death. *Id.*, at 128-155. A first Amended Petition was filed on August 21, 2003, in the second case. *Id.*, at 156-189.

William Mitchell was involved in a car chase in Independence which ultimately led to a collision that resulted in his having two broken femurs (as well as

other injuries), and he was transported from the scene to IRHC where he received medical treatment from Drs. Evans, Dubin and Bowser. Lyman Mitchell, William Mitchell's biological father, filed the two suits against these Defendants, and also filed two suits, one against the individuals involved in the car chase, and a separate one against the driver of the car which collided with William Mitchell's vehicle, and others. *See generally*, Defendants' Exhibits 325 and 326.

On November 14, 2003, Lyman Mitchell filed motions in both of these medical negligence cases, seeking to consolidate them with the multiple automobile cases arising out of the chase and collision which had been consolidated in Division 12 of the Circuit Court of Jackson County, before the Honorable Charles E. Atwell. [LF Vol. II at 254-285.] As these motions make clear, they were also filed in the corresponding automobile cases. *Id.* Defendants in these two medical negligence cases vigorously opposed the consolidation, filing their Suggestions in Opposition in the medical negligence cases and in the automobile cases. *Id.*, 286-307. Ultimately, Judge Atwell denied the motion to consolidate, and the trial judge here denied the motions as moot because of that decision. *Id.*, at 314-215.

On September 30, 2004, Suggestions of Death were filed regarding Lyman Mitchell. *Id.*, at 316-319. This was followed by a motion to substitute Mrs. Mitchell as plaintiff. *Id.*, at 320-327. On December 2 and December 14, 2004, the motions to substitute were granted. *Id.*, at 328-332. On September 20, 2005, Mrs.

Mitchell moved to consolidate the two medical negligence cases. *Id.*, at 333-363.

On October 25, 2005, Mrs. Mitchell dismissed with prejudice some of her claims against IRHC, in her capacity as personal representative of the Estate of William Mitchell. *Id.*, at 364-365. On October 28, 2005, the motion to consolidate the two medical negligence cases was granted. [LF Vol. III at 423-424.] On November 2, 2005, IRHC was dismissed from the case with prejudice. *Id.*, at 425-426. On November 28, 2005, Count I of the Second Amended Petition (loss of a chance claim by the Estate of William Mitchell) was dismissed. *Id*., at 427-428.

On November 29, 2005, a written Order was entered granting Plaintiffs leave to file a Second Amended Petition, although approval for doing so had been orally granted on November 23, 2005. *Id.*, at 430. As this Court's records reflect, when it came time to file the Record on Appeal, it was discovered that the Second Amended Petition, which had been marked by interlineation by the trial judge, and identified as "Court File Copy" on its face had disappeared from the files of the Circuit Clerk of Jackson County. After numerous attempts by everyone involved, including the trial judge, to locate the "Court File Copy" of the Second Amended Petition, a copy was discovered by one of defense counsel and provided to the parties. The parties then entered into a stipulation that the discovered "Court File Copy" was accurate, and both the "Court File Copy" and the stipulation were included in the Legal File. *Id.*, at 431-475. The Court is requested to take judicial

notice of its own files with reference to the discussion of the missing Second Amended Petition.

A summary of the testimony of Mrs. Mitchell's three experts appears below.

Testimony of Dale Dalenberg, M.D.

Dr. Dalenberg testified that hemodynamic instability has to do with "blood pressure, with the pulse remaining level, and if it is unstable then those things are not level. The blood pressure is down or the pulse is too high or those types of changes." [TR Vol. III at 1184/17-22.] He has personal knowledge of hemodynamic instability in a trauma setting, *id.*, 1184/23-1185/5. In a trauma setting patients come to the hospital having lost blood or sustained some internal injury, and a physician has to evaluate how stable the patient is, *e.g.*, whether blood pressure and pulse are appropriate, whether the patient is bleeding or has internal injuries. The body normally perfuses or supplies an adequate level of oxygenated blood to all organs through the circulatory system, and when trauma occurs to the circulatory system that means bleeding, which leads to hypovolemia (low blood volume) and to hemodynamic instability. *Id.*, 1185/8-1186/5.

Low blood volume can affect blood flow to the brain. *Id.*, 1186/6-7. Adequate oxygenation to the brain for a trauma patient going into surgery is necessary because "end-organ perfusion of the brain and all the other organs is what your heart is pumping for, what keeps you alive and if you don't have adequate perfu-

sion to the brain, you sustain a brain injury." *Id.*, 1186/16-24.

An individual's airway consists of the mouth, pharynx, trachea, and lungs; the way a person gets oxygen into the bloodstream.

Dr. Dalenberg has training, understanding and skill in reference to determining whether or not a patient's airway should be guarded before taking the patient to surgery. *Id.*, 1188/6-11. Patients who definitely need to have their airways guarded are those who are unconscious, or have an "altered sensorium;" patients with head injuries; those that are comatose or unconscious. And in a trauma setting a doctor assumes that the patient's stomach is full because that is the safest thing to do because of the risk of vomiting and aspirating stomach contents. *Id.*, 1188/14-1189/4. If a patient is unstable, *i.e.*, a trauma patient with a certain degree of low blood volume, the rule is that a physician protects the patient's airway from aspirating gastric contents. With no guarantee that the patient doesn't have something in his stomach, a physician has to assume the patient has a full stomach. *Id.*, 1189/5-18.

For an orthopedic surgeon taking a patient to surgery, the best way to guard the airway is to intubate the patient, which means to place a tube down the trachea. Any time an orthopedic surgeon is taking a patient to the operating room, he has a duty to oversee guarding the patient's airway. If an orthopedic surgeon has a patient with trauma and a long bone fracture going into surgery, the orthopedic

surgeon has a duty to oversee the overall management of the patient, which would include the patient's hemodynamic stability, heart, lungs, etc. *Id.*, 1189/19-1191/3.

Dr. Dalenberg is familiar with the standard of care for orthopedic surgeons across the country in 2000. He is familiar with the definition of "failure to use that degree of skill and learning ordinarily used in the same or similar circumstances by members of the respective defendants' professions." *Id.*, 1192/21-1193/11.

"Resuscitation" in the context of a patient with trauma who may have a history of losing blood, is what a physician does after the initial "ABC" assessment: airway, breathing, circulation. Resuscitation is what has to be done to get those things working, and with respect to blood loss, the word relates to fluid or blood replacement. Although replacing lost blood with blood is preferable, the fluid loss can also be replaced with colloids or with clear fluids call crystalloids. *Id.*, 1194/12-1195/2.

Dr. Dalenberg formed opinions based on a reasonable degree of medical certainty or probability that Dr. Dubin had breached the standard of care in this case. *Id.*, 1195/3-8.

Dr. Dalenberg's first opinion was that Dr. Dubin breached the standard of care by failing to oversee the anesthesia plan, as inadequate anesthesia was chosen and he did not modify that choice according to the orthopedic standard of care. William Mitchell was given a spinal anesthetic, despite the fact he had low blood

volume as manifested by tachycardia (rapid heart rate) and a little bit of low blood pressure before the surgery. It is well known among orthopedists and anesthetists that a spinal anesthetic will worsen those problems. The reason the spinal anesthetic does so is that it provides a sympathetic nervous system blockade, and the sympathetic nervous system is the part of a person's nervous system that supports blood pressure. When a spinal is given the patient becomes sympathectomized, which is common among patients with low blood volume. The blood pressure bottoms out right after the spinal goes in unless a trauma patient is properly resuscitated, or in an ordinary case, such as a dehydrated elderly person with a hip fracture, the patient is well hydrated before the surgery begins. *Id.*, 1195/9-1196/17.

Dropping blood pressure in a patient with low blood volume in a trauma setting further increases hemodynamic instability, and "the best way to think about why that's a problem is simply that you lose end-organ perfusion." If the patient can't support blood flow throughout the body there will be injuries to organs, to the brain, etc., so that is why low blood volume is a problem. If an anesthetic is chosen that only makes these manifestations worse, then it is a poor anesthetic plan. *Id.*, 1196/18-1197/4. In a trauma setting such as the one in this case, the spinal lowers blood pressure, increases the pulse, and decrease perfusion to the organs, including the brain. Insufficient blood to the brain, or insufficiently oxygenated blood can lead to neurological injuries, a stroke, and altered consciousness. It also

has an effect on the airway because altered consciousness affects a patient's ability to protect his own airway. The gag reflex is gone and it puts the patient more at risk for gastric aspiration. When a spinal is used, however, there is no tube or anything to protect the airway, just a face mask giving the patient oxygen. *Id.*, 11/97/5-1198/6.

What Dr. Dubin did wrong by not insisting on a general anesthetic was that the patient aspirated gastric contents, which was the proximate cause of death. The choice of the wrong anesthetic plan or poor oversight by Dr. Dubin directly contributed to William Mitchell's death. The medical records show that William Mitchell aspirated gastric contents about the time preparations began, in the middle of the operation, to change from a spinal anesthetic to a general anesthetic, a decision which was made because William Mitchell became unstable quite precipitously during the operation. It is Dr. Dalenberg's opinion based on a reasonable degree of medical certainty or probability that William Mitchell aspirated the gastric contents. *Id.*, 1198/7-1199/15.

Dr. Dalenberg testified Dr. Dubin fell below the standard of care relating to the stability or resuscitative capacity of William Mitchell by allowing him to go to surgery in an unstable condition. He had low blood volume, with a rather rapid heart rate of 140 when he went into surgery, and from the start of the surgery he was being given Neo-Synephrine to support his blood pressure. All of which goes

to prove he wasn't stable at the time the surgery was allowed to start. Dr. Dubin chose to start surgery on an unstable patient who had not been properly resuscitated. In keeping with the standard of care, Dr. Dubin should have allowed William Mitchell to be properly fluid resuscitated before the surgery started. *Id.*, 1199/16-1200/24.

Although there is a general tenet in orthopedic practice that femur fractures should be repaired within twenty-four hours of the injury, there is no standard of care requiring repair within six hours, which is when this surgery occurred. There is a general tenet that if repair isn't possible within the twenty-four hour time frame, the fractures should be stabilized, which would usually be by placing the patient in traction. Dr. Dubin could have conferred with his colleagues and told them he did not want to start the operation and make the patient more unstable at a time when the patient was requiring a lot of fluids, *e..g*, William Mitchell received 3500 cc of fluid in a very short time during the operation with a recorded blood loss of 100 cc. There is no question fluid resuscitation was ongoing when the operation began and continued during the operation. A reasonably prudent surgeon would have deferred the surgery on a patient who was clearly unstable, having tachycardia, requiring pressors, and still having fluids poured into him to resuscitate him at the time the incision began. *Id.*, 1200/25-1202/10.

In medicine, a physician doesn't do something wrong just because another

physician says to do so, such as starting the surgery on William Mitchell here because Dr. Dubin was told by another physician to go ahead. An orthopedic surgeon is obligated to abide by his own decision as to whether to follow the advice to go ahead. The standard of care for a reasonably prudent physician calls for making that decision himself. *Id.*, 1202/11-25.

Dr. Dalenberg then identified those portions of the data he reviewed which showed the vital signs he relied upon in reaching his conclusions concerning William Mitchell's physical condition, including low blood pressure for a young man; a rapid pulse of 110; no vomiting or nausea according to the emergency room physician; the presence of second-degree burns over five percent of his body, causing blisters which sequestered a lot of fluids. *Id.*, 1203/24-1207/3. The records indicated that in the emergency room he had no obstruction to his airway, and his lungs were not injured by the accident. *Id.*, 1210/4-1211/14. He had blood pressure of 86 (very low) and a pulse of 140 (rapid pulse), which were signs of low blood volume, and his pulse remained fast during his stay in the emergency room and during the surgery. *Id.*, 1211/15-1212/1. Dr. Dubin, in keeping with the standard of care, should have reviewed these records and should have known about the patient's vital signs before starting surgery. What was wrong with William Mitchell's vital signs was that he was largely hypotensive and tachycardic, with a rapid heart rate during his emergency room stay. The most likely reason for that

would be low blood volume, which requires fluid resuscitation, and even at the end of the emergency room stay that resuscitation had not occurred. *Id.*, 1212/2-1213/1. The initial chest x-ray showed his lungs were clear which means it was unlikely he had aspirated before the x-ray was taken. Aspiration pneumonia is a very aggressive process and signs would have shown up within a few hours. *Id.*, 1213/2-1215/5. The radiologist noted on the preoperative study that "The stomach is distended with a large amount of fluid," which simply underscored the fact that William Mitchell came to the hospital with a full stomach. *Id.*, 1218/1-1220/9.

Dr. Dalenberg supervises anesthetists in his work; he is generally familiar with using a spinal anesthetic and what it can do, as well as a general anesthetic. *Id.*, 1222/25-1223/6. Intubation is the process of putting a breathing tube down the trachea to breathe for the patient, which is frequently equated with a general anesthetic. It is possible to do that with a person who had a potential cervical fracture, as in this case. The general way to do that is to "protect the neck in a collar, not to remove the collar until the cervical fracture has been thoroughly evaluated, to keep the neck and head line for doing intubation. Classically, you'll extend the next for intubation, but you don't want to do that, so you'll have to intubate with a fiberoptic technique or with an awake nasal intubation...." *Id.*, 1223/7-1224/5.

The surgery began at 8:36 a.m., and ended at 9:36 a.m., with the general anesthetic initiated at 9:20. William Mitchell vomited prior to the tube being put in

his throat. The spinal was administered between 8:00 and 8:30 and the blood pressure plummeted; there was less volume going to the heart. *Id.*, 1226/8-1227/20. William Mitchell vomited right around 9:20 a.m. He had fat emboli in his lung in both the emergency room and at the time he was taken to the emergency room. Fat emboli are ubiquitous with long bone fractures, *i.e.*, they occur 95% of the time with long bone fractures or traumas. William Mitchell was asymptomatic for fat embolism prior to his surgery. *Id.*, 1228/16-1229/19. Based on a reasonable degree of medical certainty, William Mitchell developed aspiration pneumonitis/aspiration pneumonia after he vomited. Based on a reasonable degree of medical certainty: "Most fat emboli are non-fatal and this rapid progression into aspiration pneumonia is more often fatal and my opinion is that without the aspiration event and resultant aspiration pneumonia, that he would have survived." *Id.*, 1230/5-22.

Testimony of Angelito A. Ham, M.D.

Dr. Ham is a Board-certified anesthesiologist (1995) who has since that time uninterruptedly continued to practice medicine in the area of anesthesiology and in administering anesthesia to patients. [TR Vol. III at 1321/13-1322/13.]

With reference to fiberoptic anesthesia mechanisms, Dr. Ham testified:

> A fiberoptic is basically an instrument that an anesthesiologist would use to help secure an airway in a patient. Basically, it's an in-

> strument where one end is an optical piece where you can look through. The other end is a flexible hose with a light mini fiberoptic, and this fiberoptic or fiberscope allows an anesthesiologist to be able to look around corners by manipulating the instrument so you can basically look at 90 degrees up, down, whichever way you need to.

Id., 1322/14-24. It is possible to place an endotracheal tube in the trachea and blow up the cuff and add general anesthesia and keep vomitus from going down with a fiberoptic mechanism. "The fiberscope is used to facilitate putting a breathing tube into a patient, especially if that patient has a difficult airway where there are conditions that require it." One indication for its use would be where a patient has a cervical collar on because of a suspected cervical fracture. *Id.*, 1322/25-1323/10.

Dr. Ham has himself used that type of intubation many times on a patient with a suspected fracture, and has taught that procedure in a course given by Baylor College of Medicine between 1994 to 1997. Fiberoptic intubation is available across the country in hospitals that hold themselves out to be trauma centers. An anesthesiologist who is unable to utilize fiberoptic intubation does not comply with the standard of care, because part of the training anesthesiologists must undergo is how to use the fiberscope, particularly for patients with difficult airways. *Id.*, 1323/11-1324/7.

Trauma is basically dealing with patients that come into an emergency room, involving such things as motor vehicle accidents to gunshot wounds. A trauma patient who has femur fractures (broken legs in the upper part of the leg) is in an evolving condition, not a static one, because they continue to have blood loss. In a closed fracture such as William Mitchell had there was continuing blood loss of his legs. Part of being an anesthesiologist is being able to assess and understand what goes on when there is a femur facture, which involves surveying the patient "in addition to looking at the conditions surrounding the patient and understanding what happens when you have a femur fracture." Two femur fractures (such as William Mitchell's) compound the injury, which means there is a potential for more blood loss. There is also a potential for blood emboli to occur. Greater loss of blood means the patient can rapidly become hypotensive, or have low blood pressure or decreased blood volume in the body. Decreased blood volume is called hypovolemia. *Id.*, 1325/17-1326/23.

A reduction in circulating blood or blood volume means that the patient might not be able to maintain an adequate blood pressure so that end organs, particularly the brain, heart and kidneys, can stay perfused. There are tests that can be performed to ascertain whether a patient has low blood volume besides taking blood pressure and checking the heart rate. For example, a physician could check to see if the patient was diaphoretic (cold, clammy, sweating), or check capillary

refill by squeezing down on the nail bed and seeing how long it takes for the color to come back. A physician can also look at the context of the patient's arrival, *i.e.*, being aware of the mechanism of the injury that brought the patient to the hospital. It is also possible to check vital signs such as blood pressure and heart rate over a period of time. There is also a tilt test, where blood pressure and heart rate are taken when the patient is on his back, and then again when he is tilted up. If there is a significant change, that can correspond to a 20% decrease in blood volume. *Id.*, 1327/2-1328/21. Fluids can be used to treat low blood volume, but depending on the type of low blood volume blood is sometimes required. *Id.*, 1328/22-1329/2.

One of the dangers of low blood volume is decreased blood flow to the brain, causing loss of consciousness, and with loss of consciousness the patient loses his protective airway reflex, which is the gag reflex. If that gag reflex is lost, the patient is susceptible to aspiration, "or swallowing of stomach contents or fluids into their lungs." *Id.*, 1329/6-13.

Spinal anesthesia is a regional anesthetic technique and every anesthesiologist should know that a spinal can cause a decrease in blood pressure. If the patient already has low blood volume, a spinal will lower the blood volume even more. That runs the risk of the patient losing consciousness and losing his protective airway reflexes, which in turn opens him up to the possibility of aspirating or swallowing some of his stomach contents. In a trauma setting there is a presumption

that there *are* stomach contents even if it is not known for certain by CT or otherwise. With any trauma patient there has to be a presumption of a stomach full of blood or food, because in a trauma setting gastric emptying is delayed by increased blood pressure, increased heart rate, and a release of catacholemines in the patient's stress response. Any assumption that because a patient responds to fluids with an increase in pressure and therefore there is no low blood volume, leaving it okay to give a spinal, would be premature. Adequate fluids have to be given to restore blood volume, so if the patient is in an evolving condition and losing blood, giving fluids and taking one blood pressure does not mean the patient is in fact normal and that it is safe to proceed with surgery. This has to be looked at in a continuum. *Id.*, 1329/25-1331/14.

Burns can definitely contribute to low blood volume. "The mechanism by which that occurs is that they have third spacing of fluids, meaning fluid is not in the intravascular space, meaning it's not in the blood vessels. In addition, they also have increased requirements for fluids." *Id.*, 1331/15-22.

Most people interpret general anesthesia as "going asleep" by means of medication through an IV that renders the patient unconscious so that the he is not aware of the endotracheal tube which goes into the windpipe in the patient's mouth. "We use a special instrument, typically what's called a laryngoscope, which is basically a handle with a blade that comes out of it that has a light at the

end of it. We insert that into the mouth and we expose the vocal cords. When we see the vocal cords, we put a breathing tube in there and we blow up a little balloon at the end of the tube and that secures your airway." *Id.*, 1332/1-16. "The cuff is the donut around the endotracheal tube and basically what that does is it seals off the airway, you imagine if you have a pipe and you stuck another tube through it and that tube had a little donut around it and you blow it up. You form a seal around the inside of that pipe so that basically you cannot have other substances, like liquid or gastric contests, go back into the windpipe. The windpipe should only be seeing air, not fluids." This process is called endotracheal intubation and it is a type of anesthesia typically called a general anesthetic. *Id.*, 1332/17-1333/6.

Dr. Ham testified that "securing the airway" means to put the breathing tube into the patient's windpipe and blow up the cuff or donut so that it is sealed against the windpipe and nothing can go in or out except through the endotracheal tube, which should only be oxygen or other gases. *Id.*, 1333/7-13.

Dr. Ham testified that when a patient has long bone fractures there is a high chance that fat emboli, *i.e.*, pieces of fat from when the bone breaks, can be carried into the bloodstream and lodged elsewhere. If a patient has long bone fractures like William Mitchell's broken femurs, "it would be high on your list to suspect fat emboli." If fat emboli are carried into the blood and lodge in the lungs they can cause a problem with oxygenation and thus ventilation, which could mean de-

creased perfusion to the patient's organs, and if that happened, then a loss of consciousness and the possibility of swallowing stomach contents. *Id.*, 1337/20-1339/2. Oxygenation is important because if a spinal is used and the blood pressure drops, and there isn't enough oxygen, the patient can lose consciousness and that in turn can cause or make the patient susceptible to swallowing stomach contents and fluids. *Id.*, 1339/11-25.

On April 18, 2004, Dr. Ham had an opinion to a reasonable degree of medical certainty, based on the information he had available at that time, that the cause of death was most likely consistent with fat embolism. Dr. Ham did not have the opinion of Dr. Sperry, a Board-certified pathologist and forensic pathologist at that time. Prior to preparing his final report he received the deposition of Dr. Sperry; additional information from Dr. Gill about the autopsy, and the deposition of Dr. Gulino. The latter was important because in conjunction with the information about the microscopic analysis of lung tissue slides containing food particles, because he needed to know whether the lung tissue samples represented the entire lung, and not just part. *Id.*, 1357/2-1359/23.

Dr. Ham testified that based on a reasonable degree of medical certainty the proximate cause of William Mitchell's death was that "because of a poor choice of anesthetic, inadequate preoperative evaluation, inadequate treatment of the hypotension and the hypovolemia, it caused the drop in blood pressure in Mr. Mitchell

which subsequently caused him to lose consciousness. He then vomited and then aspirated." Mr. Mitchell aspirated a significant amount of gastric fluid, which was enough to cause chemical pneumonitis or pneumonia, which contributed to William Mitchell's death. His opinion was that to a reasonable degree of medical certainty it was aspiration rather than fat emboli that caused the death. *Id.*, 1359/24-1361/16.

Dr. Ham's opinion was that Dr. Bowser definitely fell below the standard of care with reference to anesthetic for William Mitchell. Dr. Bowser deviated from the standard of care basically from the moment he first came in contact with the patient. Dr. Bowser failed to adequately assess William Mitchell before the operation to make sure that he could tolerate the anesthetic safely and not come to harm. Dr. Bowser failed to recognize that William Mitchell had low blood volume as evidence by low blood pressure and fast heart rate, not just based on one measurement of heart rate and blood pressure. William Mitchell was basically unstable. *Id.*, 1361/17-1363/10.

Dr. Bowser failed to look at William Mitchell's vital signs carefully enough and come to the conclusion that he had hemodynamic instability, with blood pressures that were generally very low, from the 80's to the 60's with the heart rates in the 110's to160's. That indicated William Mitchell had severely low blood volume. There was nothing in the records or in Dr. Bowser's deposition to indicate

that he performed any tests on William Mitchell for low blood volume. By taking a patient with low blood volume and low blood pressure and administering a spinal that would then cause lowered blood pressure he was putting the patient at greater risk. Dr. Bowser was negligent in failing to adequately assess William Mitchell's blood volume status. *Id.*, 1364/14-1365/7.

Dr. Bowser failed "to appreciate the nature of the injuries and consider the potential blood loss in the patient's legs. Again, the patient had long bone fractures and blood was accumulating in his legs, internal bleeding into the tissues." *Id.*, 1365/19-24. The anesthesia record signed by Dr. Bowser showed William Mitchell had an initial blood pressure of 140/30 when he came to the operating room, which was indicative of possible low blood volume. That was a very wide pulse pressure, which is the difference between the systolic blood pressure and the diastolic blood pressure. It is used to determine the mean arterial pressure, which reflects the perfusion of the organs, primarily the brain, heart and kidneys. Mean arterial pressure is usually calculated by a machine in the room, and is the systolic pressure added to two times the diastolic pressure with the result divided by three. At that point William Mitchell's vital signs were reflective of low blood volume. An ordinary prudent anesthesiologist in the same or similar circumstances would want William Mitchell's heart rate to be less than 100 instead of over 140, to make sure that his body was restored as close to normal status as possible. *Id.*, 1365/11-

1368/22.

William Mitchell had received three liters or three bags of fluid in the emergency room and he still had hemodynamic instability, meaning that his blood pressure was going up and down. That means the patient is not ready for surgery or anesthesia. *Id.*, 1368/25-1369/7. Dr. Ham then testified:

> Furthermore, Dr. Bowser elected to do a spinal anesthetic. Spinal anesthetic is basically a type of anesthesia where the patient stays awake and you put a needle in his back and make him numb from the waist down. When you do that, it's called a sympathectomy and that causes the blood pressure to drop.
>
> So a spinal anesthetic, you lower your blood pressure in a normal person. In the patient who is already low in fluids, that will drop it even more and that's shown here. You can clearly see what happened here.
>
> In addition, furthermore, Dr. Bowser used Neo-Synephrine. Neo-Synephrine is a vasopressor. It's a drug they use to increase blood pressure. So just to get him ready to do the spinal anesthetic, he had to give several does of Neo-Synephrine to boost his blood pressure up.
>
> ...

> To me, clearly that tells me that the patient is not ready, not hemodynamically stable to tolerate a spinal anesthetic. His actions clearly dictate. To me, what an ordinary prudent anesthesiologist would have known at this time was that this patient is definitely not ready for a spinal anesthetic, but Dr. Bowser continued to give Neo-Synephrine so that it would artificially elevate his blood pressure and then once he did the spinal, since there's no times in terms of—There's no times noted here as to when he did the spinal, but it is clear that it must have been around this time, which is around 8:00, 0815, 0820. The blood pressure drops approximately 65 to 25. That's extremely low blood pressure. Normal blood pressure is like 120/70.

Id., 1369/8-1370/16.

Dr. Ham testified that Dr. Bowser chose the spinal because of a concern about a possible cervical fracture, but the standard of care in this case would have been a general anesthetic, putting the patient to sleep and putting in a breathing tube to secure the airway. "Here he was worried about the neck, so he did a spinal knowing that full well it would cause a drop in blood pressure. It eventually made him lose consciousness, so that was a poor choice of anesthetic." *Id.*, 1371/9-24.

After the spinal was given, William Mitchell's blood pressure dropped precipitously, and once perfusion is lost to the brain, consciousness is lost immediate-

ly. William Mitchell then aspirated but in this instance it does not make any difference what time it occurred. *Id.*, 1371/25-1373/1.

The standard of care called for performing a general anesthetic "which would mean putting a breathing tube into the patient's windpipe and thus securing it for possible aspiration. Because of the cervical pathology, one method of intubating would be the fiberscope, which would allow the breathing tube to be put into the patient without worrying about the cervical fracture. Given all the existing signs and symptoms, Dr. Bowser should have concluded that William Mitchell was not ready for spinal anesthetic, but instead went ahead with it and the blood pressure dropped precipitously, to 60's over 20's. That is very low and correlates with the time frame where William Mitchell lost consciousness, vomited and then aspirated material. *Id.*, 1373/18-1376/20.

Testimony of Marvin Tile, M.D.

Dr. Tile testified that he was familiar with the standard of care in the United States in 2000. [Ex. 120A, at 15/20-16/11.]

In a polytrauma (multiple trauma) there are the "ABC's": airway, breathing and circulation. An airway is getting air from the environment into the lungs. These primary issues are life-threatening ones. Issues in secondary care, such as fractures, may be limb-threatening or ultimately life-threatening, but if a patient's airway is threatened then life is usually threatened within five minutes. *Id.*, at

16/12-17/12. The airway needs to be kept open because if the patient doesn't get enough oxygen from outside into his lungs then he cannot sustain life. *Id.*, at 18/16-22. "Breathing" is the mechanics of the lungs working. *Id.*, at 18/23-19/11.

With reference to circulation there are two ways to measure it, by heart rate and blood pressure. If you have low blood pressure you are not getting perfusion to the body, which means the blood has to get to all the vital organs of the body. *Id.*, at 21/13-22/2. If the lungs or kidneys do not get sufficient blood it can affect their ability to function, possibly total organ failure. *Id.*, at 22/3-15.

With fractures the main early problem with circulation is the loss of blood, and too much loss of blood can present problems for a person with multiple traumas. Everyone has a circulating blood volume. If a percentage is lost then the heart rate goes up to compensate, *i.e.*, beats faster. But if blood loss continues ultimately the blood pressure drops because there's not enough blood in circulation to keep going, which could cause the patient to go into hypovolemic shock, and kill the patient from loss of blood. *Id.*, at 22/16-23/25.

Where there is a break in both femurs there is generally going to be some bleeding or loss of blood. There are nutrient arteries which feed the bone, and depending on the size of the individual can be quite large. A broken femur in a high-energy injury often tears an artery, and femur fractures bleed a great deal. If there are two broken femurs, which are in pieces, that would indicate blood would be

present in and around the soft tissues of both legs. *Id.*, at 32/19-34/5. If the bones do not come out of the skin, the bleed will be internally in the deep part of the thigh. It is possible to get blood trickling right out to the skin, and if the sheath or fascial lining surrounding the muscles is intact, as the pressure of the blood rises the bleeding can't stop. *Id.*, at 34/9-24.

William Mitchell had two broken femurs that were broken in a couple of pieces, which is the trauma that sent him to the hospital. A "comminuted" fracture is one in which there are more than two fragments of bone and both fractures here were comminuted. *Id.*, at 34/25-35/16. There is fat inside the femur, which can be along the tube or it can be mixed in with the marrow. If there is a broken femur it is expected that fat will escape and get into the venous system, and to the right side of the heart. If the blood pumped through the right ventricle to the lungs for cleansing of CO_2 , if that blood has fat in it the little pieces of fat are called fat emboli. They can clog portions of the arterials that should pick up oxygen. *Id.*, at 36/23-38/2.

Fat emboli are expected to some degree in all long bone fractures. Depending on how much fat there could clogging of the little arterials in the lung which could lead to problems. The patient could still breathe but would have impaired oxygenation. If there is hypovolemia or lack of blood in the system that can impair the ability to breathe. Femur fractures usually produce fat globules going to the

lung. Doctors deal with the issue by "vigilance, and attention, and restoration of resuscitation." Resuscitation is keeping the circulation going. That in turn means that if you are looking at blood loss (hypovolemia) the blood needs to be replaced. If only a little is lost it can be replaced by giving crystallite fluids. Ultimately if the amount of blood loss is high enough, blood has to be given. Albumen and colloid solutions can also be given. *Id.*, at 38/6-41/7.

Fat emboli blocking some of the oxygen receptors doesn't automatically kill the patient. The mortality rate is very low for persons having two broken bones and interference with breathing due to fat emboli in the lungs. *Id.*, at 41/8-21.

If a patient has two broken femurs and has signs or symptoms of low blood volume (hypovolemia), the low blood volume can be addressed by replacing the circulating blood. *Id.*, at 41/27-42/8.

Dr. Tile briefly identified some of the materials he reviewed. *Id.*, at 42/10-45/17.

Dr. Tile is familiar with the standard of care as it relates to Dr. Tile. *Id.*, at 45/18-25. The standard of care for Dr. Evans, as the trauma team leader is to make all the decisions and be the final arbiter on what is to be done with the patient until he is handed over to another physician. Resuscitation in a multiple trauma setting means maintaining the state of the cardiopulmonary system and making accurate diagnoses of what is going on in the other systems. Hemodynamic instability is

another word for shock, which means the patient has signs of abnormal circulation, such as a fast heart rate, or low blood pressure, low urine volume. *Id.*, at 45/18-47/10.

A patient who has hypodynamic instability [from the general context it appears the intent was to say hemodynamic, rather than "hypodynamic"] is normally not taken to surgery unless the purpose of the surgery is to stop massive bleeding that might lead to the patient's death. While there may be circumstances to go to surgery with an unstable patient, if you're going to perform non-life-saving surgery then the situation would be unlikely, *i.e.*, unlikely the doctor would want to go to the operating room with an unstable patient. The reason is that when surgery is being perform, more blood will be lost and more things can happen. *Id.*, at 47/14-48/13.

In medical terms, "acute" means immediate, "sub-acute" means almost immediate, and "chronic" means long term. There is a difference between fat emboli syndrome and acute fat emboli ventilation disturbance. Fat emboli are little droplets of fat that come from a broken bone, and it is known that the fat is going to go to the lung and the right heart, but with most patients with a fractured femur there would be no effect; they would just be absorbed into the lung. The lung has a lot of capacity and can still ventilate with the outside air even though there is some fat clogging the tubes. Fat embolism syndrome usually involves the lung and the

brain. If a patient has a hole from the right to the left side of the heart the fat can come across, and the patients get confused, go unconscious, go into shock, and drop their hemoglobin. They can go into acute respiratory failure very quickly. *Id.*, at 53/14-56/17. According to the autopsy of William Mitchell, no fat was found in the brain nor was there any hole in the heart. Dr. Tile had an opinion to a reasonable degree of medical certainty or probability that William Mitchell did not have fat embolism syndrome, because he was conscious, there was nothing going on the brain; he was breathing on his own and there was nothing to suggest the presence of the syndrome. *Id.*, at 56/23-57/20.

Dr. Tile had opinions that Dr. Evans fell below the standard of care of what an ordinarily prudent physician would have done under the same or similar circumstances. *Id.*, at 57/21-58/5.

William Mitchell had a rapid heart from the beginning, which indicates hypovolemia until proven otherwise; he had fracture femurs; a very large flank hematoma; injuries to his right hip; a fracture in the femoral head; and an evulsion fracture. There was bleeding in the flank, in the back and from the twofemurs. From a hemodynamic standpoint, his burns meant a loss of fluid, which is all part of circulating blood volume. He had tachycardia, and in a young person that is the first thing that happens. The heart races to make up for the lack of circulating blood. *Id.*, at 58/18-60/9.

Dr. Evans fell below the standard of care because there should have been more resuscitation with respect to replacing fluid. There were a lot of indications of tachycardia in a very young person, with the potential of great deal of blood loss from many areas, and the blood was not replaced. Dr. Evans should have monitored more closely; been more worried about cardiopulmonary failure and replaced more fluid. *Id.*, at 60/10-61/15.

When a doctor knows that fat emboli from femur fractures will be going to the lungs, the doctor needs to do cardiopulmonary resuscitation; needs to keep the circulation going, and needs to keep the blood volume up to get the heart rate down. You do that mainly be giving fluids and if necessary, blood. *Id.*, at 62/22-63/23.

Dr. Tile reviewed some of the materials supporting his opinion and in the course of doing so said that at the scene his blood pressure was low and the pulse was high. He never got below the tachycardic rate, *i.e.*, pulse over 100. After Dr. Evans arrived, William Mitchell had normal breath sounds, which would not indicate any difficulty with ventilation. It is also possible to have clear lungs according to an x-ray and normal breath sounds, but have less-than-adequate oxygen in the blood. *Id.*, at 63/24-69/17. At 3:00 a.m. William Mitchell's airway was open, and the medical records did not indicate he had vomited at the scene or in the emergency room. *Id.*, at 69/20-72/6.

The standard of care would require Dr. Evans to look at all x-rays that had been taken after he arrived at 2:20 a.m. Dr. Evans testified in his deposition that he had looked at all the x-rays. *Id.*, at 76/13-77/5. Before Dr. Evans arrived various x-rays were taken, including one which showed that the lungs were clear. *Id.*, at 72/24-73/25. A CT scan ordered by Dr. Evans showed the stomach was distended with a large amount of fluid. In a trauma setting it is very important to know what is in the stomach, especially if the patient is going to the operating room, because one of the problems during surgery is aspiration of stomach material into the lungs, and if food and stomach acid is in the lungs the patient can produce pneumonitis and a real lung problem. This is due to the hydrochloric acid in the lungs, which is corrosive and can cause an inflammation in the wrong place. Vomit can go down the airway if the airway is not protected, which is something a physician wants to avoid in a multiple trauma situation. *Id.*, at 82/18-85/17.

There was evidence that during a three-hour period prior to the surgery William Mitchell had a very fast pulse rate for a young person, bouncing as high as 162, as low as 126, but well up in the 140's and 150's. That indicates he was hypovolemic until proven otherwise, and as that condition relates to surgery it means he was in a shock state. Taking a person to surgery in a shock state is justified if the surgery is for life-saving reasons, for example, to stop a major hemorrhage. It's unlikely to be justified for if the operation is for any other reason. *Id.*, at

91/13-93/21. In Dr. Tile's opinion Dr. Evans allowed William Mitchell to go to surgery while he was in a hypovolemic state. *Id.*, at 94/24-95/7. William Mitchell's small urine output in the time frame he was in the emergency room supports his being in hypovolemic shock. *Id.*, at 95/9-24.

William Mitchell's tachycardia, low urine output and low PO2 are indicative of hemodynamic instability or hypovolemic shock. *Id.*, at 103/23-104/13.

William Mitchell was in the operating room from 7:49 a.m. on, and at 7:50 was being given oxygen via a mask. An endotracheal tube is placed down the windpipe through the nose or mouth to deliver oxygen and if it's put right down can protect the airway from vomitus getting in. William Mitchell did not have an endotracheal tube before 9:20 a.m. The first principle in a trauma setting is to protect the airway, and once he was in the operating room that duty fell to the anesthetist or anesthesiologist. *Id.*, at 106/18-108/4.

Dr. Tile testified to a reasonable degree of medical certainty that Dr. Bowser fell below the standard of care toward William Mitchell because he did not protect the airway, in that the patient "had a fluid level in his stomach, he had lots of stomach content, he had two fractured femurs, was going to have a fairly lengthy anesthetic, he had a spinal anesthetic which further drops blood pressure, almost—almost always, and he had a mask. So there was no protection of the airway." *Id.*, at 108/6-109/2. Dr. Tile's opinion was that Dr. Bowser fell below the standard of

care in choosing a spinal anesthetic because in William Mitchell's case, with all the signs, including tachycardia, low output, and low POS, a general anesthetic with an endotracheal tube and a proper monitor would have been the standard of care. *Id.*, at 109/7-22.

General anesthesia began at 9:20 a.m. The original operation was under a spinal anesthetic; general anesthesia was in response to the patient crashing. Based on a reasonable degree of medical certainty, Dr. Tile opined that William Mitchell was generally unprepared for surgery, not well controlled during the operation, and the vomiting was the precipitating event to the crash. Dr. Tile said he did have an opinion to a reasonable degree of medical certainty as to the crash. William Mitchell was in hypovolemic shock. The surgery would have caused him to lose more blood. The aspiration of the food into the lungs was the precipitating moment of the crash. He opined that the vomit occurred around 9:05 a.m. and aspiration would have occurred after that. *Id.*, at 115/21-118/9. Vomiting that goes into the lungs can bring about cardiac arrest even though fat emboli were already present in the lungs. *Id.*, at 119/25-120/14.

Dr. Tile's opinion, based on a reasonable degree of medical certainty was that the post-surgery x-ray ordered by Dr. Evans showed a pulmonary contusion or the result of aspiration. Prior to the surgery there were no signs of aspiration or consolidation in the right lower lobe of the lung. Although the radiologist said

"pulmonary condition or aspiration," Dr. Tile testified the former was unlikely. It was therefore aspiration of flood and fluid from the stomach into the lungs. *Id.*, at 120/20-122/20.

Dr. Tile opined that but for the vomitus William Mitchell would have lived, other things being equal. *Id.*, at 127/1-15.

William Mitchell's death certificate said he died of complications of blood trauma. The microscopic addendum contained the diagnoses "patchy areas of bronchopneumonia, organizing pneumonia with rare aspirated food particulate." This played in role in Dr. Tile's opinion that William Mitchell aspirated because "you don't see food in the lung." The addendum also said that there were multiple fat emboli in small blood vessels of [the] lung. It was Dr. Tile's opinion that it was expected to be found in a person who went through surgery for bilateral femoral fractures. *Id.*, at 129/15-103/20. But for the vomit he aspirated William Mitchell would be alive even if he had fat emboli in his lungs. *Id.*, at 1313/9-16.

The Remaining Chronology

Following a trial of more than three weeks, there was an off-the-record conference between the trial court and counsel on the subject of instructions, and then an instruction conference was held on December 21, 2005. [TR Vol. VII at 3352-3371.] Instructions 1 through 6 were mandatory instructions and no one objected to their being given. [LF Vol. III at 554-561; Appendix at A-30 to 37.]

Instruction No. 7, the verdict director for Dr. Evans was not tendered by any of the parties. [LF Vol. III at 562; Appendix at A-38.] There was a matching converse instruction (No. 8). [LF Vol. III at 563; Appendix at A-39.] Mr. Pickett argued that his proposed verdict director was a fair and appropriate statement of ultimate fact, as opposed to the detailed facts in the version provided by the trial judge; Mrs. Mitchell's verdict director was refused. [TR. Vol. VII, at 3354/22-3355/5-8. Counsel for Dr. Evans argued at greater length in opposition to the verdict director drafted by the trial judge, including but not limited to arguing that the trial court's verdict director was vague and general and constituted a roving commission. *Id.*, at 3355/14-3357/13. Mr. Pickett objected to the converse instruction on the ground that it didn't conform to MAI 33.03, but also pointed out that he did not propose converses to his own instructions. There were no objections by defense counsel. *Id.*, 3357/17-3358/6.

The verdict director for Dr. Dubin was submitted by the trial court as No. 9. [LF Vol. III at 564; Appendix at A-40.] Mr. Pickett objected on the grounds that the trial court's version calls for a specific finding of a spinal anesthetic and then a finding that the spinal anesthetic was improper, which was misleading, internally argumentative, called for speculation and conjecture and did not make any sense. [TR Vol. VII at 3358/7-3359/5.] Counsel for Dr. Dubin offered their own verdict director, and argued against the trial court's version, in part on the basis that it was

overly broad and a roving commission. *Id.*, at 3559/9-3560/17. Over objection, the trial court's converse (No. 10) was to be submitted. [LF Vol. III at 565, Appendix at A-41.] *Id.*, at 3360/18-3361/9.

The trial court's verdict director for Dr. Bowser was No. 11. [LF Vol. III at 566; Appendix at A-42.] The court formally rejected Mrs. Mitchell's verdict for both Dr. Dubin and Dr. Bowser that Plaintiff's version was a fair and non-confusing statement, and the trial court's change to include too much evidentiary detail would be confusing and misleading to the jury. Dr. Bowser objected to the trial court's verdict director in part of the grounds that it was vague and ambiguous, and allowed for a roving commission. Dr. Bowser's proposed verdict director was rejected. And the trial court's corresponding converse as to Dr. Bowser was also approved over the objections of Mrs. Mitchell's counsel. [LF Vol. III at 567; Appendix at A-43.] [TR. Vol. VI at 3361/10-3363/13.] The remainder of the instructions were approved, some over objection. *Id.*, at 3363/14-3368/3.

The package of instructions, including the trial court-drafted Nos. 7-12, were given on December 22, 2005. [LF. Vol. III at 590.] Later that day the jury asked five questions, which the court answered. [LF Vol. III at 579-583; Appendix at A-38 to 43.] That same day the jury reached a verdict in favor of all Defendants. [LF Vol. III at 593-594.]

On January 1, 2006, the trial court entered judgment. *Id.*, at 584; Appendix

at 1. On January 11, 2006, the trial entered an amended judgment, *sua sponte*. *Id.*, at 595; Appendix at 12. A motion for an order *nunc pro tunc* was filed on January 19, 2006, LF Vol. IV at 604, and on February 6, 2006, a second amended judgment was entered. *Id.* at 608; Appendix at 21.

Mrs. Mitchell's motion for new trial was filed on February 6, 2006, *id.*, at 618, with suggestions in opposition, *id.*, at 637. Defendants' joint suggestions in opposition to the motion for new trial were filed on April 24, 2006. *Id.*, at 681. The motion was overruled on May 9, 2006, *id.*, at 773, and the Notice of Appeal was filed on May 15, 2006. *Id.*, at 775.

POINTS RELIED ON

POINT I

The trial court erred in rejecting Plaintiff's proffered Instructions corresponding to given instructions 7, 9 and 11, and instead giving Instructions 7, 9 and 11, with matching converse instructions 8, 10, and 12, all of which were drafted by the court and not by any party, because as a matter of law Plaintiff was entitled to have her proffered instructions submitted to the jury in that:

a. Mo. R. Civ. P. 70.02(a) does not give a trial court discretion to reject a plaintiff's proffered instructions so long as the instruction is in the proper form and supported by substantial evidence;

b. Plaintiff's proffered and rejected instructions were in the proper form and supported by substantial evidence;

c. There is no legal authority for a trial judge to reject a Plaintiff's proffered instructions and, *sua sponte*, draft both verdict directors and converse instructions on his own;

d. Plaintiff and Defendants Drs. Evans, Dubin and Bowser all objected to the trial court's self-drafted instructions, and

e. There was no substantial evidence to support any of the court-drafted instructions;

f. The court-drafted instructions were vague, confusing and misleading;

g. The court-drafted instructions significantly prejudiced Mrs. Mitchell by depriving her of the right to go to the jury with her theories of recovery, instead of being compelled to argue theories she did not believe in, had not chosen and which were not supported by substantial evidence.

Marion v. Marcus, 199 S.W.3d 887 (W.D. Mo. App. 2006)

Ploch v. Hamai, 213 S.W.3d 135 (E.D. Mo. App. 2006)

Mo. R. Civ. P. 70.02

POINT II.

The trial court erred in failing to declare a mistrial as sought by Plaintiff during voir dire because the trial court thereby abused its discretion, in that a mistrial was the only appropriate remedy when:

a. Defendants violated the letter and spirit of the pretrial order to refrain from mentioning any settlement by asking a question in voir dire about the former Defendant, Inde-

pendence Regional Health Center ("IRHC"), thereby necessarily implying to the jury that IRHC had settled with Plaintiff and that was the reason it was no longer a part of the case;

b. Defendants brought up the subject of IRHC during voir dire without approaching the bench first, as counsel had promised to do;

c. Defendants admitted there was no legitimate basis for identifying IRHC as a prior Defendant, as they had no reasonable expectation that there would be any question of comparative fault on the verdict director, and as a matter of law there could be no issue of set-off since the allegations were that IRHC and the Defendants against whom the case was tried were joint tortfeasors, and in any event, any issue of set-off would have purely been a question of law for the trial court and not a question of fact for the jury;

d. The fact that IRHC was a former defendant in the case was completely irrelevant to any issue to be proved in the case against the Defendants against whom the case was

tried, and

e. Allowing Defendants to mention IRHC as a former Defendant tainted the entire proceeding by injecting a false and misleading issue into the minds of the jury, *i.e.*, that Plaintiff was being greedy by having (implicitly) settled with IRHC and then proceeding to trial against the remaining Defendants.

Boyer v. Sinclair & Rush, Inc., 67 S.W.3d 627 (E.D. Mo. App. 2002)

Othman v. Wal-Mart Stores, Inc., 91 S.W.3d 684 (E.D. Mo. App. 2002)

State v. Burch, 939 S.W.2d 525 (W.D. Mo. App. 1997)

POINT III.

The trial court erred in failing to exclude evidence of the prior cases brought by Plaintiff against those involved in the car chase and the collision which resulted in William R. Mitchell being taken to IRHC and being treated by the Defendants against whom the case was tried, because the trial court thereby abused its discretion, in that exclusion was the only proper ruling when:

a. The sole reason for raising the issue was to create the appearance for the jury that Plaintiff was overly litigious and greedy by filing other suits and that by doing so she had

admitted that it was the conduct of the defendants in the car chase/crash cases which actually caused the death of William R. Mitchell, and not any conduct on the part of the Defendants against whom the case was tried;

b. The fact of the prior litigation and the allegations made had no relevance to the proceedings against the medical malpractice Defendants due in part to the legal principle of downstream liability, *i.e.*, the tortfeasors who caused the vehicle crash which led to the injuries to William R. Mitchell at the scene which in turn led to him being at IRHC and treated by these Defendants were responsible for the totality of his injuries and/or death, while the medical malpractice Defendants were liable only for their share of responsibility;

c. Defendants used the argument to the Court that one reason the mention of the chase/crash cases was that Plaintiff could have filed a single suit but chose not to do so, despite the fact that the record shows that Plaintiff attempted to consolidate the medical malpractice case with the automobile cases; these Defendants vigorously and successfully

opposed that consolidation, and then used the lack of consolidation/lack of a single case as a reason for introducing evidence about the chase/crash cases;

d. The pleadings in the automobile cases were not abandoned pleadings;

e. The pleadings in the automobile cases were not binding judicial admissions;

f. The pleadings in the automobile cases were valid alternative pleadings which could not properly be used against Mrs. Mitchell in the instant case, and

g. The prejudicial effect of the evidence relating to the automobile cases far outweighed whatever probative value the evidence might have.

Boyer v. Sinclair & Rush, Inc., 67 S.W.3d 627 (E.D. Mo. App. 2002)

POINT IV.

The trial court erred in permitting improper closing argument by all defense counsel because in doing so he abused his discretion in that he allowed appeals to regional prejudices; personalization; appeals for sympathy, and misleading statements (as more fully detailed in the Argument below), all of which are impermissible in

closing arguments as a matter of law, thereby confusing and misleading the jury, and depriving Mrs. Mitchell of a fair trial because of the resulting prejudice.

Carlyle v. Lai, 783 S.W.2d 925 (W.D. 1989)

Gibson v. Zeibig, 24 Mo. App. 65, 1887 WL 1742 (E.D. 1887)

May v. May, 294 S.W.2d 627 (E.D. Mo. App. 1956)

State ex rel. Bitting v. Adolf, 704 S.W.2d 671 (Mo. 1986) (en banc)

POINT V.

The cumulative effect of the errors of the trial court as identified in the preceding Points Relied on warrants granting of a new trial, even if the errors considered individually do not warrant granting a new trial.

Faught v. Washam, 329 S.W.2d 588 (Mo. 1959)

Reed v. Spencer, 758 S.W.2d 736 (W.D. Mo. App. 1988)

Wiedower v. ACF Industries, Inc., 763 S.W.2d 333 (E.D. Mo. App. 1988)

Crawford v. Shop 'n Save Warehouse Foods, Inc., 91 S.W.3d 646 (E.D. Mo. App. 2002).

ARGUMENT

POINT I

The trial court erred in rejecting Plaintiff's proffered Instructions corresponding to given instructions 7, 9 and 11, and instead giving Instructions 7, 9 and 11, with matching converse instructions 8, 10, and 12, all of which were drafted by the court and not by any party, because as a matter of law Plaintiff was entitled to have her proffered instructions submitted to the jury in that:

a. Mo. R. Civ. P. 70.02(a) does not give a trial court discretion to reject a plaintiff's proffered instructions so long as the instruction is in the proper form and supported by substantial evidence;

b. Plaintiff's proffered and rejected instructions were in the proper form and supported by substantial evidence;

c. There is no legal authority for a trial judge to reject a Plaintiff's proffered instructions and, *sua sponte*, draft both verdict directors and converse instructions on his own;

d. Plaintiff and Defendants Drs. Evans, Dubin and Bowser all objected to the trial court's self-drafted instructions, and

e. There was no substantial evidence to support any of the court-drafted instructions;

f. The court-drafted instructions were vague, confusing and misleading;

g. The court-drafted instructions significantly prejudiced Mrs. Mitchell by depriving her of the right to go to the jury with her theories of recovery, instead of being compelled to argue theories she did not believe in, had not chosen and which were not supported by substantial evidence.

Section 1. Standard of Review

The standard of review on a claim of improper rejection of a plaintiff's proffered instructions is *de novo*.

This Court held in *Marion v. Marcus*, 199 S.W.3d 887, 892-893 (W.D. Mo. App. 2006):

> ...Rule 70.02(a)...declares that jury instructions "shall be given or refused by the court according to the law and the evidence in the case." The imperative "shall" in Rule 70.02(a) does not admit discretion on the part of the trial judge if the proffered instruction is supported by the evidence and the law and is in proper form. Rule 70.02(a), rewritten in 1993, conforms to the Missouri Supreme Court's

holding that "a party is entitled to an instruction upon any theory supported by the evidence." *Vandergriff v. Mo. Pac. R.R.*, 769 S.W.2d 99, 104 (Mo. banc 1989) (emphasis added); *Mast v. Surgical Serv. of Sedalia, L.L.C.*, 107 S.W.3d 360, 380 (Mo. App. W.D.2003) (Hollinger, J., dissenting) (citing Vandergriff). The refusal to give a verdict director supported by the law and the evidence is not a matter for the trial court's discretion. Rule 70.02(c) indicates the proper standard of review: "The giving of an instruction in violation of the provisions of this Rule 70.02 shall constitute error, its prejudicial effect to be judicially determined[.]" Rule 70.02(c) (emphasis added). Our Supreme Court has confirmed the standard under Rule 70.02(c). *Shutt v. Chris Kaye Plastics Corp.*, 962 S.W.2d 887, 890 (Mo. banc 1998); *State v. Richardson*, 923 S.W.2d 301, 318-19 (Mo. banc 1996); *Graham v. Goodman*, 850 S.W.2d 351, 355 (Mo. banc 1993).

And at 893-894:

We review the trial court's refusal to give Ms. Marion's proffered instructions *de novo*, evaluating whether the instructions were supported by the evidence and the law. Rule 70.02(a). Nevertheless, we reverse only if we determine that error resulted in prejudice, Rule 70.02(c), and the error "materially affect[ed] the merits of the action,"

Rule 84.13(b).

See also, *Ploch v. Hamai*, 213 S.W.3d 135, 139 (E.D. 2006), which held:

> Following the analysis in *Marion*, we review the court's refusal to give a proffered verdict director de novo, evaluating whether the instruction was supported by the evidence and the law. [Citation omitted.] We will reverse only if the error resulted in prejudice and materially affected the merits of the action. [Citation omitted.] We review the evidence in the light most favorable to submission of the instruction. [Citation omitted.]

Section 2. Argument

There are only three issues for the Court to consider under this Point:

1. Were Mrs. Mitchell's instructions in the proper form?
2. Were Mrs. Mitchell's instructions supported by substantial evidence?
3. Was Mrs. Mitchell prejudiced by the refusal to give the instructions she had proffered?

The answer to all three questions is "Yes."

Mo. Rule Civ. P. 70.02(a) says in pertinent part: All instructions shall be submitted in writing and shall be given or refused by the court according to the law and the evidence in the case. Mo. Rule Civ. P. 70.02(c) says: "The giving of an instruction in violations of the provisions of this Rule 70.02 shall constitute er-

ror, its prejudicial effect to be judicially determined, provided that objection has been timely made pursuant to Rule 70.03." Mo. R. Civ. P. 70.03 states:

> Counsel shall make specific objections to instructions considered erroneous. No party may assign as error the giving or failure to give instructions unless that party objects thereto before the jury retires to consider its verdict, stating distinctly the subject matter objected to and the grounds of the objection. Counsel need not repeat objections already made on the record prior to delivery of the instructions. The objections must also be raised in the motion for new trial in accordance with Rule 78.07.

With reference to the issue of a plaintiff's absolute right to use of his or her proffered instructions, both *Marion* and *Ploch* make it crystal clear that a plaintiff is entitled to submit his or her theory, so long as the standards of form and evidentiary support are met, thereby leaving the trial court with no discretion whatsoever. And most especially not the discretion to override the decisions of Mrs. Mitchell's counsel and instead decide for Mrs. Mitchell that there was a "better" way to submit her case, and that that way was for the trial court to draft its own instructions.

There can certainly be no claim made that the instructions at issue, *i.e.*, Mrs. Mitchell's proposed verdict directors as to Drs. Evans, Dubin and Bowers, were not in proper form. As can be seen by a review of the instruction conference in its

entirety [TR Vol. VII at 3352-3371], there were no objections that the form of the proffered instructions was improper.

As a review of the instructions conference discloses, and as detailed in the Statement of Facts above, there can hardly be any question that Mrs. Mitchell's counsel made timely objections to the trial court's decision to reject her proffered instructions. [TR. Vol. III at 572-574; Appendix at 48-50.] The objection to the refusal to give Mrs. Mitchell's proffered instructions was renewed in the Motion for New Trial. [LF Vol. IV at 619-624], and argued in her Suggestions in Support of her motion for new trial, *id.* at 638-664.

The second issue here is substantial evidentiary support for the proffered instructions. As pointed out in *Ploch, supra*, at 139-140:

> An instruction must be given where there is substantial evidence to support the issue submitted. *Romeo v. Jones*, 144 S.W.3d 324, 330 (Mo. App. E.D. 2004). Substantial evidence is that which, if true, is probative of the issues and from which the jury can decide the case. *Id.* A party is entitled to an instruction on any theory supported by the evidence. *Id.* In the case of a disjunctive instruction, each submission must be supported by substantial evidence. *Berra v. Union Electric Co.*, 803 S.W.2d 188, 190 (Mo. App. E.D. 1991). There are three elements of a prima facie medical malpractice claim:

"(1) proof that the defendant's act or omission failed to meet the requisite standard of care; (2) proof that the act or omission was performed negligently; and (3) proof of a causal connection between the act or omission and the injury sustained by the plaintiff." *Wicklund v. Handoyo*, 181 S.W.3d 143, 148-49 (Mo. App. E.D. 2005). Taking these standards under consideration, we review the record for substantial evidence of the "essential facts" of the rejected verdict director.... *See Banther v. Drew*, 171 S.W.3d 119, 124 (Mo. App. S.D. 2005).

Plaintiff's expert Dr. Tile was designated to speak as to Dr. Evans; Dr. Dalenberg was designated to speak as to Dr. Dubin and Dr. Ham was designated to speak as to Dr. Bowser. For the convenience of the Court, although the instructions at issue (Mrs. Mitchell's proffered instruction and the trial court's self-drafted instructions) appear in both the Legal File and the Appendix, as cited above, they are provided below for ease of review.

INSTRUCTION 7 AS GIVEN AS TO DR. EVANS AND SCI

Your verdict must be for the plaintiff Bernice Mitchell if you believe:

First, defendant Joseph C. Evans, M.D. and Surgical Associates of Independence, Inc. permitted William Mitchell while in an unstable hypovolemic condition to be transferred to surgery, and

Second, defendant Joseph C. Evans, M.D. and Surgical Care of Independence, Inc. were thereby negligent, and

Third, such negligence either directly caused the death of William Mitchell or combined with the injuries from the motor vehicle accident to directly cause the death of William Mitchell.

CONVERSE INSTRUCTION 8 AS GIVEN AS TO DR. EVANS AND SCI

Your verdict must be for defendant Joseph Evans, M.D. and Surgical Associates of Independence, Inc. unless you believe that Joseph Evans, M.D. and Surgical Associates, Inc.:

Permitted William Mitchell while in an unstable hypovolemic condition to be transferred to surgery;

And were thereby negligent;

And such negligence either directly caused the death of William Mitchell or combined with the injuries from the motor vehicle accident to directly cause the death of William Mitchell.

REJECTED INSTRUCTION (7) AS TO DR. EVANS AND SCI

Your verdict must be for the plaintiff Bernice Mitchell if you believe:

First, defendant Joseph C. Evans, M.D. and Surgical Associates of Independence, Inc. failed to establish adequate hemodynamic stability

by proper restoration of fluid volume before allowing surgery by Dr. Dubin, and

Second, defendant Joseph C. Evans, M.D. and Surgical Care of Independence, Inc. was negligent, and

Third, such negligence either directly caused the death of William Mitchell or combined with the injuries from the motor vehicle accident to directly cause the death of William Mitchell.

INSTRUCTION 9 AS GIVEN AS TO DR. DUBIN AND OAKC

Your verdict must be for the plaintiff Bernice Mitchell if you believe:

First,

Defendants Sol Dubin, M.D. and Orthopedic Associates of Kansas City, Inc. took William Mitchell to surgery in an unstable, hypovolemic condition to be transferred to surgery; or

Defendants Sol Dubin, M.D. and Orthopedic Associates of Kansas City, Inc. failed to object to Robert Bowser, M.D.'s decision to perform a spinal anesthetic rather than a general anesthetic if such spinal anesthetic was improper; and

Second, defendants Sol Dubin, M.D. and Orthopedic Associates of Kansas City, Inc. were thereby negligent, and

Third, such negligence either directly caused the death of William Mitchell or combined with the injuries from the motor vehicle accident to directly cause the death of William Mitchell.

CONVERSE INSTRUCTION 10 AS GIVEN AS TO DR. DUBIN AND OAKC

Your verdict must be for defendant Sol Dubin, M.D. and Orthopedic Associates of Kansas City, Inc. unless you believe that Sol Dubin, M.D. and Orthopedic Associates of Kansas City, Inc.:

Took William Mitchell to surgery in an unstable, hypovolemic condition; or

Failed to object to Robert Bowser, M.D.'s decision to perform a spinal anesthetic rather than a general anesthetic if such spinal anesthetic was improper;

And were thereby negligent;

And such negligence either directly caused the death of William Mitchell or combined with the injuries from the motor vehicle accident to directly cause the death of William Mitchell.

REJECTED INSTRUCTION (9) AS TO DR. DUBIN AND OAKC

Your verdict must be for the plaintiff Bernice Mitchell if you believe:

First, either

Defendant Sol Dubin, M.D. and Orthopedic Associates of Kansas City, Inc. failed to establish adequate hemodynamic stability by proper restoration of fluid volume before his surgery, or

Defendant Sol Dubin, M.D. and Orthopedic Associates of Kansas City, Inc. failed to assure that an endotracheal tube with an inflated cuff around it was placed for use with general anesthesia before his surgery, and

Second, defendant Sol Dubin, M.D. and Orthopedic Associates of Kansas City, Inc. in any one or more of the respects submitted in paragraph First, was thereby negligent, and

Third, such negligence either directly caused the death of William Mitchell or combined with the injuries from the motor vehicle accident to directly cause the death of William Mitchell.

INSTRUCTION 11 AS GIVEN AS TO DR. BOWSER AND IA

Your verdict must be for the plaintiff Bernice Mitchell if you believe:

First, defendant Robert Bowser, M.D. and Independence Anesthesia, Inc. either:

Failed to recognize that William Mitchell was in an unstable hypovolemic condition prior to anesthesia, or

Failed to perform a general anesthetic rather than a spinal anesthetic if such spinal anesthetic was improper; and

Second, defendant Robert Bowser, M.D. and Independence Anesthesia, Inc. were thereby negligent, and

Third, such negligence either directly caused the death of William Mitchell or combined with the injuries from the motor vehicle accident to directly cause the death of William Mitchell.

CONVERSE INSTRUCTION 12 AS GIVEN AS TO DR. BOWSER AND IA

Your verdict must be for defendant Robert Bowser, M.D. and Independence Anesthesia, Inc. unless you believe that Robert Bowser, M.D. and Independence Anesthesia, Inc.:

Failed to recognize that William Mitchell was in an unstable hypovolemic condition prior to anesthesia, or

Failed to perform a general anesthetic rather than a spinal anesthetic if such spinal anesthetic was improper; and

Second, defendant Robert Bowser, M.D. and Independence Anesthesia, Inc. were thereby negligent, and

Third, such negligence either directly caused the death of William Mitchell or combined with the injuries from the motor vehicle accident to directly cause the death of William Mitchell.

REJECTED INSTRUCTION (11) AS TO DR. BOWSER AND IA

Your verdict must be for the plaintiff Bernice Mitchell if you believe:

First, either

Defendant Robert L. Bowser, M.D. and Independence Anesthesia, Inc. failed to establish adequate hemodynamic stability by proper restoration of fluid volume before surgery by Dr. Dubin, or

Defendant Robert L. Bowser, M.D. and Independence Anesthesia, Inc. failed to assure that an endotracheal tube with an inflated cuff around it was placed for use with general anesthesia before surgery by Dr. Dubin, and

Second, defendant Robert L. Bowser, M.D. and Independence Anesthesia, Inc. were negligent in any one or more of the respects submitted in paragraph First and was thereby negligent, and

Third, such negligence either directly caused the death of William Mitchell or combined with the injuries from the motor vehicle accident to directly cause the death of William Mitchell.

The detailed evidence which provides substantial support for the use of Mrs. Mitchell's proffered instructions can be seen in the Statement of Facts. A brief review of some of the highlights of that evidence, regarding hemodynamic instabili-

ty; the use of an endotracheal tube and general anesthesia, and aspiration as the cause of death follow.

Hemodynamic Stability

Dr. Dalenberg pointed out that the body normally perfuses or supplies an adequate level of oxygenated blood to all organs through the circulatory system, and when trauma occurs to the circulatory system that means bleeding, which leads to hypovolemia (low blood volume) and to hemodynamic instability. *Id.*, 1185/8-1186/5.

An individual's gag reflex normally prevents something from getting into the airway, but if you lose consciousness, the gag reflex is lost. A person can become unconscious due to inadequate blood flow to the brain. *Id.*, 1187/4-20.

If an orthopedic surgeon has a patient with trauma and a long bone fracture going into surgery, the orthopedic surgeon has a duty to oversee the overall management of the patient, which would include the patient's hemodynamic stability, heart, lungs, etc. *Id.*, 1189/19-1191/3.

"Resuscitation" in the context of a patient with trauma who may have a history of losing blood, is what a physician does after the initial "ABC" assessment: airway, breathing, circulation. Resuscitation is what has to be done to get those things working, and with respect to blood loss, the word relates to fluid or blood replacement. Although replacing lost blood with blood is preferable, the fluid loss

can also be replaced with colloids or with clear fluids call crystalloids. *Id.*, 1194/12-1195/2.

Dr. Dalenberg opined that Dr. Dubin breached the standard of care by allowing a spinal anesthetic which has the effect of dropping blood pressure, which is common among patients with low blood volume. The blood pressure bottoms out right after the spinal goes in unless a trauma patient is properly resuscitated, or in an ordinary case, such as a dehydrated elderly person with a hip fracture, the patient is well hydrated before the surgery begins. *Id.*, 1195/9-1196/17.

Dr. Dalenberg testified Dr. Dubin fell below the standard of care relating to the stability or resuscitative capacity of William Mitchell by allowing him to go to surgery in an unstable condition. He had low blood volume, with a rather rapid heart rate of 140 when he went into surgery, and from the start of the surgery he was being given Neo-Synephrine to support his blood pressure. All of which goes to prove he wasn't stable at the time the surgery was allowed to start. Dr. Dubin chose to start surgery on an unstable patient who had not been properly resuscitated. In keeping with the standard of care, Dr. Dubin should have allowed William Mitchell to be properly fluid resuscitated before the surgery started. *Id.*, 1199/16-1200/24.

There is no question fluid resuscitation was ongoing when the operation began and continued during the operation. A reasonably prudent surgeon would have

deferred the surgery on a patient who was clearly unstable, having tachycardia, requiring pressors, and still having fluids poured into him to resuscitate him at the time the incision began. *Id.*, 1200/25-1202/10.

Dr. Dalenberg then identified those portions of the data he reviewed which showed the vital signs he relied upon in reaching his conclusions concerning William Mitchell's physical condition, including low blood pressure for a young man; a rapid pulse of 110; no vomiting or nausea according to the emergency room physician; the presence of second-degree burns over five percent of his body, causing blisters which sequestered a lot of fluids. *Id.*, 1203/24-1207/3. The records indicated that in the emergency room he had no obstruction to his airway, and his lungs were not injured by the accident. *Id.*, 1210/4-1211/14. He had blood pressure of 86 (very low) and a pulse of 140 (rapid pulse), which were signs of low blood volume, and his pulse remained fast during his stay in the emergency room and during the surgery. *Id.*, 1211/15-1212/1. Even at the end of the stay in the emergency room, resuscitation had not occurred. *Id.*, 1212/2-1213/1.

Dr. Ham testified that with two femur fractures (such as William Mitchell's) the injury is compounded, which means there is a potential for more blood loss. There is also a potential for blood emboli to occur. Greater loss of blood means the patient can rapidly become hypotensive, or have low blood pressure or decreased blood volume in the body. Decreased blood volume is called hypovole-

mia. *Id.*, 1325/17-1326/23.

Dr. Ham testified Dr. Bowser failed to recognize that William Mitchell had low blood volume as evidence by low blood pressure and fast heart rate, not just based on one measurement of heart rate and blood pressure. William Mitchell was basically unstable. *Id.*, 1361/17-1363/10.

Dr. Bowser also failed to look at William Mitchell's vital signs carefully enough and come to the conclusion that he had hemodynamic instability, with blood pressures that were generally very low, from the 80's to the 60's with the heart rates in the 110's to 160's. That indicated William Mitchell had severely low blood volume. There was nothing in the records or in Dr. Bowser's deposition to indicate that he performed any tests on William Mitchell for low blood volume. By taking a patient with low blood volume and low blood pressure and administering a spinal that would then cause lowered blood pressure he was putting the patient at greater risk. Dr. Bowser was negligent in failing to adequately assess William Mitchell's blood volume status. *Id.*, 1364/14-1365/7.

Dr. Ham pointed out that William Mitchell had received three liters or three bags of fluid in the emergency room and he still had hemodynamic instability, meaning that his blood pressure was going up and down. That means the patient is not ready for surgery or anesthesia. *Id.*, 1368/25-1369/7. *See also, id.*, 1369/8-1370/16.

Dr. Tile testified that fat emboli are expected to some degree in all long bone fractures. Depending on how much fat there could clogging of the little arterials in the lung which could lead to problems. The patient could still breathe but would have impaired oxygenation. If there is hypovolemia or lack of blood in the system that can impair the ability to breathe. Femur fractures usually produce fat globules going to the lung. Doctors deal with the issue by "vigilance, and attention, and restoration of resuscitation." Resuscitation is keeping the circulation going. That in turn means that if you are looking at blood loss (hypovolemia) the blood needs to be replaced. If only a little is lost it can be replaced by giving crystallite fluids. Ultimately if the amount of blood loss is high enough, blood has to be given. Albumen and colloid solutions can also be given. *Id.*, at 38/6-41/7.

Hemodynamic instability is another word for shock, which means the patient has signs of abnormal circulation, such as a fast heart rate, or low blood pressure, low urine volume. *Id.*, at 45/18-47/10.

A patient who has hypodynamic instability [from the general context it appears the intent was to say hemodynamic, rather than "hypodynamic"] is normally not taken to surgery unless the purpose of the surgery is to stop massive bleeding that might lead to the patient's death. While there may be circumstances to go to surgery with an unstable patient, if you're going to perform non-life-saving surgery then the situation would be unlikely, *i.e.*, unlikely the doctor would want to go to

the operating room with an unstable patient. The reason is that when surgery is being perform, more blood will be lost and more things can happen. *Id.*, at 47/14-48/13. *See also, id.*, at 58/18-60/9; 60/10-61/15, and 62/22-63/23.

In Dr. Tile's opinion Dr. Evans allowed William Mitchell to go to surgery while he was in a hypovolemic state. *Id.*, at 94/24-95/7. William Mitchell's small urine output in the time frame he was in the emergency room supports his being in hypovolemic shock. *Id.*, at 95/9-24.

William Mitchell's tachycardia, low urine output and low PO2 are indicative of hemodynamic instability or hypovolemic shock. *Id.*, at 103/23-104/13.

Aspiration

Dr. Dalenberg testified that based on a reasonable degree of medical certainty, William Mitchell developed aspiration pneumonitis/aspiration pneumonia after he vomited. Based on a reasonable degree of medical certainty: "Most fat emboli are non-fatal and this rapid progression into aspiration pneumonia is more often fatal and my opinion is that without the aspiration event and resultant aspiration pneumonia, that he would have survived." *Id.*, 1230/5-22.

Dr. Ham testified that one of the dangers of low blood volume is decreased blood flow to the brain, causing loss of consciousness, and with loss of consciousness the patient loses his protective airway reflex, which is the gag reflex. If that gag reflex is lost, the patient is susceptible to aspiration, "or swallowing of sto-

mach contents or fluids into their lungs." *Id.*, 1329/6-13.

Adequate fluids have to be given to restore blood volume, so if the patient is in an evolving condition and losing blood, giving fluids and taking one blood pressure does not mean the patient is in fact normal and that it is safe to proceed with surgery. This has to be looked at in a continuum. *Id.*, 1329/25-1331/14.

Dr. Ham testified that "securing the airway" means to put the breathing tube into the patient's windpipe and blow up the cuff or donut so that it is sealed against the windpipe and nothing can go in or out except through the endotracheal tube, which should only be oxygen or other gases. *Id.*, 1333/7-13.

Dr. Ham testified that based on a reasonable degree of medical certainty the proximate cause of William Mitchell's death was that "because of a poor choice of anesthetic, inadequate preoperative evaluation, inadequate treatment of the hypotension and the hypovolemia, it caused the drop in blood pressure in Mr. Mitchell which subsequently caused him to lose consciousness. He then vomited and then aspirated." Mr. Mitchell aspirated a significant amount of gastric fluid, which was enough to cause chemical pneumonitis or pneumonia, which contributed to William Mitchell's death. His opinion was that to a reasonable degree of medical certainty it was aspiration rather than fat emboli that caused the death. *Id.*, 1359/24-1361/16.

Dr. Tile opined that but for the vomitus William Mitchell would have lived,

other things being equal. *Id.*, at 127/1-15. *See also, id.*, at 1313/9-16.

Endotracheal Tube

Dr. Ham testified it is possible to place an endotracheal tube in the trachea and blow up the cuff and add general anesthesia and keep vomitus from going down with a fiberoptic mechanism. "The fiberscope is used to facilitate putting a breathing tube into a patient, especially if that patient has a difficult airway where there are conditions that require it." One indication for its use would be where a patient has a cervical collar on because of a suspected cervical fracture. *Id.*, 1322/25-1323/10.

Dr. Ham has himself used that type of intubation many times on a patient with a suspected fracture, and has taught that procedure in a course given by Baylor College of Medicine between 1994 to 1997. Fiberoptic intubation is available across the country in hospitals that hold themselves out to be trauma centers. An anesthesiologist who is unable to utilize fiberoptic intubation does not comply with the standard of care, because part of the training anesthesiologists must undergo is how to use the fiberscope, particularly for patients with difficult airways. *Id.*, 1323/11-1324/7.

All three experts talked about hemodynamic instability; all three experts said a doctor does not take an unstable patient to surgery; all three said William Mitchell was unstable in part due to low blood volume; all three said that blood vo-

lume and therefore hemodynamic stability would be restored by replacing the lost fluids (or "resuscitating" him by doing so) prior to surgery.

Words chosen by Mrs. Mitchell's counsel state the first theory of recovery against Drs. Evans, Dubin and Bowser, and therefore their respective corporations, in a fair, neutral, accurate and uniform fashion. While the theory is uniform as to all three physicians (you sent a man with an unstable blood/circulatory system to surgery instead of first making sure he was stable by replacing the blood and fluids he lost), the phrasing was properly uniform as well, rather than trying to quote specific bits and pieces from the separate experts, and risk confusing the jury by the variations in phraseology.

Mrs. Mitchell's alternative theory of negligence against Drs. Dubin and Bowser was that they were negligent in not using a general anesthetic accompanied by an endotracheal tube with an inflatable cuff. All three experts spoke of the need for general anesthesia and the endotracheal tube, the primary purpose for which was to prevent vomiting and aspiration of stomach contents into the lungs. Again, the theory of recovery was uniformly expressed as to both doctors in a fair, neutral, non-argumentative fashion.

Whether the literal words were precisely the same as used by Mrs. Mitchell's counsel in the proffered instructions or not, the substance was the same. All three experts agreed that William Mitchell was unstable before surgery; that

spinal anesthetic causes further hemodynamic instability by dropping already low blood pressure even further, thereby decreasing blood volume, and thus the use of the spinal anesthesia increased the risk of aspiration and death.

With reference to the court-drafted Instruction No. 7 there is no question that hypovolemia (low blood volume) was used by Mrs. Mitchell's experts in varying ways in talking about his condition heading into surgery. There is no question that he was unstable when he went into surgery. With all due respect, so what? As the record clearly demonstrates, the theories of recovery selected by Mrs. Mitchell and her counsel are more than amply supported by the evidence. Thus Mrs. Mitchell had an absolute right to use her own version of No. 7.

The trial judge apparently followed the lead of Mrs. Mitchell's counsel in structuring his instructions, if nothing else. The first allegation of negligence drafted by the trial judge is essentially the same as to all three defendants.

The alternative theory or negligence forced on Mrs. Mitchell with reference to Drs. Dubin and Bowser required that the jury potentially make two findings: first, that a spinal anesthetic and if it was—and only if it was—then a second finding as to whether Dr. Dubin failed to object to using a spinal. Logic says the findings have to be made in that sequence, but they are illogically reversed in the trial court's instructions.

It is important to note that there is no substantial evidence that any expert

ever said that Dr. Dubin's duty was to merely object to Dr. Bowser's anesthesia choice. That would have resulted in the following colloquy: Dr. Dubin: "I object." Dr. Bowser: "I insist." Dr. Dubin: "Well, if you insist…okay." The testimony was that Dr. Dubin's error was not a failure to object, but a failure to *act*—a failure to control all aspects of the surgery he was performing and insist on the use of general anesthesia with an endotracheal tube.

There is also the problem of the misplaced comma. In two of the three verdict directors drafted by the trial court (Dr. Evans, No. 7, and Dr. Bowser, No. 11), and the corresponding converse instructions (Nos. 8 and 12), the phrase "unstable hypovolemic condition" was used. In the trial court's instruction as to Dr. Bowser (No. 9, converse No. 10), the phrase was "unstable, hypovolemic condition." There is a significant difference between the two phrases simply because of the addition of the comma. The first phrase describes a single state: an unstable (hypovolemic condition). The second phrase describes multiple conditions: an unstable condition and a hypovolemic condition. To put it another way, the first phrase has a single modifier for "condition": unstable hypovolemic. The second phrase has two modifiers: unstable *and* hypovolemic.

That a comma can cause a significant alteration in the meaning of a phrase is perhaps best explained by the 2004 book, "Eats, Shoots and Leaves: The Zero Tolerance Approach to Punctuation," by Lynne Truss. The title of the book comes

from a real sentence in which the writer said that a panda "eats, shoots and leaves." The comma creates multiple conditions: the panda first eats, then shoots, and then departs (leaves). Without the comma, the phrase describes how a panda receives nourishment: eating "shoots and leaves."

Here, in two of the three instructions, the jurors were asked to determine whether there was an unstable hypovolemic condition present; in the third instruction they were asked to determine whether William Mitchell was both hypovolemic *and* in an unstable condition, whether for that reason (hypovolemia) or some other reason. It appears that the trial court intended to use the same phrase across the board in the instructions the court drafted, but the intent differed from the result. Whether the jurors might be able to articulate the difference between the two phrases if asked as a "pop quiz" is immaterial. When the two phrases are read aloud in a normal, unpremeditated fashion (normal fashion and unpremeditated fashion) there is no pause in reading "unstable hypovolemic condition" but in the alternate phrase, there is a pause after the comma, and a discernible if shorter pause after "hypovolemic" and before "condition."

The only reasonable conclusion to be reached is that this inconsistent phraseology contributed to the jury's confusion.

That the instructions confused the jury is also clear from the questions they asked. At 3:21 they asked what they could do if they couldn't reach a 9-3 verdict

and were told to continue deliberations. [LF Vol. III at 581.] At 3:47 the jury said: "We need more clarification in the last two sentences in the instructions regarding negligence. Also, what is considered unstable for surgery!?? in a trauma setting!" They were told the trial court could not provide any further clarification and to look at all the instructions for "further guidelines." *Id.* at 582. The last question at 3:55 was to be provided with a dictionary, which was denied. *Id.* at 583.

Rule 70.02, per *Marion* and *Ploch*, allows the trial court no discretion, and no power to reject Mrs. Mitchell's proposed verdict directors so long as they were supported by substantial evidence. Considering Mrs. Mitchell's evidence as a whole, and disregarding all evidence that conflicts, it is clear the proffered verdict directors were supported by substantial evidence. That being so, Rule 70.02 mandates a finding by this Court that the decision to use court-drafted verdict directors and corresponding converses was error.

Prejudice must then be determined by this Court.

The issue of a judge rejecting all verdict directors and/or converse instructions proposed by the parties, drafting his own, and forcing them down the parties' throats by judicial fiat, appears to be one of first impression. Although Mrs. Mitchell recognize that holding something to be automatically reversible error is extremely rare, that is precisely what this Court should hold. The decision of a judge to draft his own instructions and use them without the consent of the parties should

be reversible error *per se*. To hold otherwise is to take a cataclysmic step backwards from *Marion*.

Marion unequivocally rejected any discretionary power in a trial judge to reject proposed instructions supported by substantial evidence. What is drafting your own instructions but the exercise of discretion? And what mechanism is there for holding a judge accountable for the quality and accuracy of his drafting?

None.

If the parties draft instructions and then are displeased with the choices made by the trial court, the parties are "accountable" on appeal because they are required to show, from the record, how the instructions at issue were wrong or unsupported by substantial evidence. A trial judge is inherently immune from the necessity to justify himself. He is immune from the need to prove that his choice of words is backed up by substantial evidence. His immunity lies in the fact that as a judge he has no duty to justify or explain himself. Thus, anyone wishing to support the use of court-drafted instructions on appeal can only do so through speculation and conjecture.

Here, Mrs. Mitchell's counsel drafted her proposed instructions. He had personal knowledge of the evidence when he did so; he knew his thought processes, and he can apply that knowledge to the record in a case such as this, and say, "This, this and this support my instructions." But no one knows a trial judge's

thought processes. No one can definitively say, or definitively argue from the record, that the judge relied on X or Y or Z, or some or all, as the basis for drafting his instructions. Without the trial court's presence as a participant on appeal, an obvious impossibility, no one can actually know the rationale for his decision. They can only comb through the record and essentially say, albeit without the necessary qualifiers, "he probably relied on this," or "perhaps he relied on that" as substantial evidence.

A trial judge drafting his own instructions and forcing their use over objections should be automatic reversible error.

If there is no automatic reversible error, then the question of prejudice arises. In the context of the evidence here, the court-drafted instructions are confusing and misleading. They inject false issues into the proceedings, *e.g.*, requiring a finding that Dr. Dubin was negligence not because of his conduct but because of his silence.

There can be nothing more prejudicial than forcing a plaintiff to accept going to the jury with theories of recovery she vehemently opposes, and then forcing her counsel to act as if those theories were his idea, as if those theories were somehow supported by substantial error, and then try, somehow, some way, to persuade the jury to agree to something Mrs. Mitchell's counsel does not and cannot believe in.

Without conceding that the other errors by the trial court identified in this brief do not, individually or collectively, warrant reversal and remand for a new trial, the trial court's error in abrogating to itself Mrs. Mitchell's absolute right to choose her own destiny and decide for herself what theory of recovery she wants to submit to the jury, mandates reversal and remand here for a new trial.

POINT II.

The trial court erred in failing to declare a mistrial as sought by Plaintiff during voir dire because the trial court thereby abused its discretion, in that a mistrial was the only appropriate remedy when:

a. Defendants violated the letter and spirit of the pretrial order to refrain from mentioning any settlement by asking a question in voir dire about the former Defendant, Independence Regional Health Center ("IRHC"), thereby necessarily implying to the jury that IRHC had settled with Plaintiff and that was the reason it was no longer a part of the case;

b. Defendants brought up the subject of IRHC during voir dire without approaching the bench first, as counsel had promised to do;

c. Defendants admitted there was no legitimate basis for identifying IRHC as a prior Defendant, as they had no reasonable expectation that there would be any question of comparative fault on the verdict director, and as a matter of law there could be no issue of set-off since the allegations were that IRHC and the Defendants against whom the case was tried were joint tortfeasors, and in any event, any issue of set-off would have purely been a question of law for the trial court and not a question of fact for the jury;

d. The fact that IRHC was a former defendant in the case was completely irrelevant to any issue to be proved in the case against the Defendants against whom the case was tried, and

e. Allowing Defendants to mention IRHC as a former Defendant tainted the entire proceeding by injecting a false and misleading issue into the minds of the jury, *i.e.*, that Plaintiff was being greedy by having (implicitly) settled with IRHC and then proceeding to trial against the remaining Defendants.

Section 1. Standard of Review

The standard of review for the failure to grant a mistrial is abuse of discretion. The Eastern District said in *Othman v. Wal-Mart Stores, Inc.*, 91 S.W.3d 684, 686 (E.D. Mo. App. 2002):

> The decision to grant a mistrial lies within the sound discretion of the trial court and an appellate court will not disturb the trial court's decision absent abuse of discretion. *Howe v. ALD Services, Inc.*, 941 S.W.2d 645, 653 (Mo. App. E.D.1997).

See also, State v. Burch, 939 S.W.2d 525, 528 (W.D. Mo. App. 1997):

> The standard of review where the trial court denies a request for a mistrial is abuse of discretion. *State v. Schneider*, 736 S.W.2d 392, 400 (Mo. banc 1987). Mistrial is a drastic remedy appropriate in the most extraordinary circumstances where there is no other way to remove unfair prejudice. *State v. Sidebottom*, 753 S.W.2d 915, 919 (Mo. banc 1988).

According to the Eastern District, the definition of what constitutes an abuse of discretion has been held to be:

> ...when the court's judgment is clearly against the logic of the circumstances and is so arbitrary and unreasonable as to shock one's sense of justice and indicates a lack of careful consideration. [Citation

omitted.]

Boyer v. Sinclair & Rush, Inc., 67 S.W.3d 627, 634 (E.D. Mo. App. 2002).

Section 2. Argument

In *Burch*, *supra*, a criminal case, a police officer volunteered inadmissible information during his testimony. Defense counsel sought a mistrial. This Court said at 528-529:

> When a witness unexpectedly volunteers inadmissible information, the action called for rests in the trial court's discretion. [Citations omitted.] The prejudicial effect of a statement can be removed by striking the statement and instructing the jury to disregard it. [Citations omitted.] This court finds no abuse of discretion in the trial court's decision to overrule the motion for a mistrial and instead to instruct the jury to disregard the statement. Further, there is no contention nor evidence the prosecutor orchestrated the officer's volunteering the stress test testimony.

What is present in this case is not inadvertent disclosure of inadmissible evidence during a witness' testimony, but instead *deliberate* disclosure of inadmissible and highly prejudicial information by defense counsel during voir dire.

Before the trial began, a discussion was held out of the presence of the jury, on a variety of issues. One of the issues was how to address the issue of the car

chase, subsequent collision and multiple injuries. [Generally, TR Vol. I at 2-4.] Mr. Pickett suggested that a little snippet of factual background might refresh any recollections the venirepersons might have about the events of August 13, 2000. *Id.*, at 4/20-25. There was a brief discussion about how "graphic" to be about the events, followed by Mr. Pickett's reference to "And then he was taken to the hospital," to which the trial court agreed. *Id.*, 5/2-16.

Mr. Moeller (counsel for Dr. Evans) raised the question of how to address the issue of whether any member of the panel knew the others who were injured in the accident. The judge instructed that questions on that topic be limited to the statement that there were others involved that day, and then provide the names and ask if anyone knows each person. *Id.*, 5/22-6/5. Mr. Pickett commented that they fact they were brought to the same hospital did not need to be mentioned, and the Court and Mr. Moeller agreed. *Id.*, 6/7-10. The judge said "Just, 'Do you know these folks?'" to which Mr. Moeller responded:

> I don't anticipate getting into that in voir dire. I would approach before that was addressed. During the trial is all I'm saying, if I thought that was appropriate. We talked about that at pretrial.

Id., 7/11-16. The Court also stated that there was no need for anyone, *i.e.*, the attorneys or the court, saying that a particular person died, or that he was taken to the same hospital as William Mitchell. *Id.*, 7/17-23.

Before trial the court had ruled that there would be no mention of settlements. The above-referenced discussion made it clear that Independence Regional Health Center ("IRHC") wasn't going to be tied to the accident, and thus, necessarily, to the case being tried, except to the extent that it would be mentioned as the hospital to which William Mitchell was taken.

During Mr. Pickett's questioning of the panel, there were five references to IRHC. Mr. Pickett briefly described the chase, the collision and mentioned that William Mitchell was taken to IRHC. *Id.*, 22/11-23. On two occasions, in response to separate questions, venireperson Flowers stated that her husband was a pharmacist employed at IRHC. *Id.*, 27/19-22 and 46/16-18. Mr. Pickett asked if anyone was familiar with the trauma manual at IRHC. *Id.*, 67/11-13. The final reference was when Mr. Pickett asked if anyone knew Dr. David Lisbon, who had formerly been employed by IRHC. *Id.*, 8-/21-23. Up to that point, therefore, the only thing the jury panel knew about IRHC vis-à-vis the case being tried against Drs. Evans, Dubin and Bowser and their respective corporations, was that IRHC was simply the hospital to which William Mitchell had been taken.

That all changed when Mr. Moeller began questioning the panel. At first he adhered to the principle of mentioning IRHC solely as the hospital where William Mitchell was treated or by a neutral reference to it, by mentioning that Dr. Evans had his office by IRHC. *Id.*, 110/21-22. That all changed when he said to the jury:

"There were some questions asked about trauma and I want to ask this. First of all, Independence Regional Hospital or Health Center was previously a defendant in this lawsuit." *Id.*, 125/5-8.

Mr. Pickett asked for a bench conference and said that to his recollection the trial court had ruled that there would be no mention of other defendants and no mention of settlements. Mr. Moeller agreed that there was to have been no reference to settlements, but said that there had never been a reference to mentioning "other entities, because that's under the Missouri comparative fault." The following colloquy then occurred:

> MR. MOELLER: If there's evidence that defendant Independence Regional will be on the verdict form, I'm entitled to say "Independence Regional." I believe, respectfully, I'm entitled to say, "Independence Regional was previously a defendant and if there's evidence presented that they did something wrong, would anybody have a problem assessing fault against them?
>
> THE COURT: Do you anticipate them being on the verdict form?
>
> MR. MOELLER: No.

Id., 125/20-126/5. Mr. Moeller then raised the issue of a set-off, followed by Mr. Pickett's motion for a mistrial. *Id.*, 126/6-127/24.

The trial judge pointed out that it had been an "air shock" when Mr. Moeller asked the question, *i.e.*, mentioned that IRHC had previously been a defendant in the case. *Id.*, 128/2-3. Mr. Moeller asked and was granted leave to explain that part of the reason for mentioning IRHC as a defendant was because of an alleged dispute about a credit or set-off issue vis-à-vis the pretrial settlement with IRHC. He argued that because no one knew what the evidence was going to be it was appropriate to mention IRHC. *Id.*, 128/10-24. The judge denied the motion for mistrial. *Id.*, 129/18/19. Mr. Picket also pointed out that there had never been a set-off issue with reference to IRHC since IRHC was a joint tortfeasor, but rather that the argument had been about whether there could be a credit for settlements with the parties involved in the separate accident litigation. *Id.*, 129/25-130/8.

Mr. Pickett thereafter asked for a limiting instruction informing the jury "that any inquiry about any other party that may have been present in this case is irrelevant and immaterial to any issues in this case before the jury." *Id.*, 130/15-23. Defense counsel objected and ultimately the judge denied the request for the limiting instruction sought by Mr. Pickett in favor of an instruction to the effect that "what lawyers say is not evidence in this case and you're reminded of that." The motion for mistrial was renewed and again denied. *Id.*, 131/20-133/22.

The purported rationales for identifying IRHC as a former defendant in the case were specious. Mr. Moeller admitted that he had no reason to believe that

IRHC would be on the verdict form, yet he still introduced the issue of IRHC's status as something other than the hospital at which William Mitchell received medical care. The alternate "rationale" about a purported argument over a set-off relating to the hospital's settlement that somehow would have necessitated cross-examination of witnesses is equally specious. As a matter of law the settlement with IRHC, as a joint tortfeasor, would have resulted in a credit or set-off had the jury awarded damages to Mrs. Mitchell in an amount in excess of the settlement amount with IRHC. There was, therefore, no legitimate basis for using a non-existent set-off dispute to identify IRHC as a former defendant.

Jurors know nothing about the verdict forms or verdict directors in the case until they receive them, along with the trial judge's instructions, after closing arguments. Jurors are not going to be asked to decide whether a settlement amount with any former defendant should be credited toward the amount they awarded against the defendants against whom the case was actually tried. Jurors have no idea what reasons there might be for a party to be a defendant one day and out of the case the next. What jurors *do* know however, given the pervasiveness of legal and trial themes in television and motion pictures, is that when someone is a defendant in a case, and then after a while is no longer a defendant, the high probability is that that defendant has reached a settlement with the plaintiff.

That one statement by Mr. Moeller was enough to taint the entire trial, be-

cause the single most reasonable inference to be drawn by the jurors from that statement was that Mrs. Mitchell had already received a settlement from IRHC. It isn't a vast leap from that to a conclusion by the jurors that Mrs. Mitchell had already been amply compensated by that settlement and was merely being greedy in going after the three physicians.

Mrs. Mitchell recognizes that a mistrial is a drastic remedy and one that should be reserved for situations in which it is the only possible recourse. With all due respect to the trial court, that was true here. For all practical purposes, defense counsel had introduced into the record, and into the minds of the jurors, the fact that there had been a settlement with IRHC, despite counsel having admitted to knowledge that mentioning of settlements was prohibited. An attorney should not be able to do indirectly what he cannot do directly. What defense counsel really said was: "First of all, Independence Regional Hospital or Health Center was previously a defendant in this lawsuit, *but entered into a settlement with plaintiff and was dismissed*." Granted, the italicized phrase was unspoken, but the words were as much present as if they had been said aloud.

After the denial of the motion for mistrial, Mr. Pickett went so far as to seek a limiting instruction on the issue of any former defendants, without mentioning the word settlement. Clearly, if Mrs. Mitchell could not have a mistrial, she would have been satisfied with the proposed language, as it didn't highlight any issue of

settlements. Even that relief was denied her.

In *Burch, supra*, this Court found no abuse of discretion in the denial of a mistrial after inadvertent introduction of inadmissible evidence during the course of the trial because the trial court had taken the curative step of instructing the jury to disregard the statement. Mr. Pickett's request for curative relief as an alternative to a mistrial was also denied. What the trial judge actually said to the jury panel was:

> Ladies and gentlemen of the jury, I would like to remind you that any statement of counsel in the voir dire, the opening statement, or the closing argument is not evidence. The jury will determine the facts based on only the evidence that they receive in this case when the case begins after the conclusion of picking this jury.

Id., 133/24-134/5.

A mid-voir dire instruction that what lawyers say is not evidence has no relationship whatsoever to, and no curative capability about, a statement that IRHC was a former defendant in the case. If—and that is a major "if"—the jury was in some manner able to connect the "IRHC used to be a defendant" statement with the admonition, then it is remotely conceivable they might have thought that maybe IRHC wasn't actually a defendant in the case. But the admonition also included references to deciding the case based solely on the evidence heard after the trial ac-

tually began. The jury was never going to be called on to decide whether or not, based on evidence at the trial, IRHC had ever been a defendant in the case and if so, why the hospital was no longer a defendant. The admonition in no way clearly and unequivocally made sure the jury understood that the fact that IRHC or any other defendant was no longer a case was irrelevant and had no bearing on any issue the jury would be called upon to decide.

Mrs. Mitchell sought the appropriate relief of a mistrial following the intentional, unjustified introduction of the fact that IRHC had previously been a defendant, as the only thing required would be a new jury panel since the event giving rise to the need for a mistrial occurred early in the trial process, as opposed to significantly later when a great deal of time, judicial resources, and expense had been incurred by the introduction of evidence. When that was denied, she sought alternative curative relief in the form of a limiting instruction to the jury that directly addressed the issue of IRHC being a former defendant without accentuating that fact. That relief was denied as well. The refusal to grant either form of curative relief was against the logic of the circumstances and constituted an abuse of discretion.

A new trial should be granted.

POINT III.

The trial court erred in failing to exclude evidence of the prior

cases brought by Plaintiff against those involved in the car chase and the collision which resulted in William R. Mitchell being taken to IRHC and being treated by the Defendants against whom the case was tried, because the trial court thereby abused its discretion, in that exclusion was the only proper ruling when:

a. The sole reason for raising the issue was to create the appearance for the jury that Plaintiff was overly litigious and greedy by filing other suits and that by doing so she had admitted that it was the conduct of the defendants in the car chase/crash cases which actually caused the death of William R. Mitchell, and not any conduct on the part of the Defendants against whom the case was tried;

b. The fact of the prior litigation and the allegations made had no relevance to the proceedings against the medical malpractice Defendants due in part to the legal principle of downstream liability, *i.e.*, the tortfeasors who caused the vehicle crash which led to the injuries to William R. Mitchell at the scene which in turn led to him being at IRHC and treated by these Defendants were responsible for the totality of his injuries and/or death, while the medical

malpractice Defendants were liable only for their share of responsibility;

c. Defendants used the argument to the Court that one reason the mention of the chase/crash cases was that Plaintiff could have filed a single suit but chose not to do so, despite the fact that the record shows that Plaintiff attempted to consolidate the medical malpractice case with the automobile cases; these Defendants vigorously and successfully opposed that consolidation, and then used the lack of consolidation/lack of a single case as a reason for introducing evidence about the chase/crash cases;

d. The pleadings in the automobile cases were not abandoned pleadings;

e. The pleadings in the automobile cases were not binding judicial admissions;

f. The pleadings in the automobile cases were valid alternative pleadings which could not properly be used against Mrs. Mitchell in the instant case, and

g. The prejudicial effect of the evidence relating to the automobile cases far outweighed whatever probative value the

evidence might have.

Section 1. Standard of Review

The standard of review for admission or exclusion of evidence is whether there has been an abuse of discretion. The Eastern District has said of this standard:

> The admission or exclusion of evidence is a matter of trial court discretion. [Citation omitted.] Our review is limited to an abuse of discretion standard. [Citation omitted.] A ruling within the trial court's discretion is presumed correct and the appellant bears the burden of showing the trial court abused its discretion and that they have been prejudiced by the abuse. [Citation omitted.] Judicial discretion is abused when the court's judgment is clearly against the logic of the circumstances and is so arbitrary and unreasonable as to shock one's sense of justice and indicates a lack of careful consideration. [Citation omitted.]

Boyer v. Sinclair & Rush, Inc., 67 S.W.3d 627, 634 (E.D. Mo. App. 2002).

Section 2. Argument

A. The Factual Background

Out of the hearing of the jury and before opening statements, counsel for Dr. Evans raised the issue of Mrs. Mitchell's objection to his proposed use of the peti-

tions in the two automobile cases previously filed by Lyman Mitchell, the father of William Mitchell, for whom Mrs. Mitchell was substituted as plaintiff following Lyman Mitchell's death. [Generally, TR. Vol. I, 357/17-373/7.]

During the course of the discussion between the trial court and counsel, Mrs. Mitchell's counsel objected not only to the use of the petitions in opening but to any mention of the prior automobile cases on the following grounds: (1) the petitions do not constitute binding, judicial admissions, *id.*, 358/7-16; (2) there was no differentiation proposed by Defendants as to what allegations of fact they proposed to use, *id.*, 358/16-22; (3) the allegations in the other petitions were made in good faith and based on genuine doubt, and therefore as alternative allegations to the ones in the petition being tried in this case, *id.*, 358/19-359/6; (4) lack of relevance, *id.*, 359/11-12, 368/14-16; (5) the automobile petitions did not constitute abandoned pleadings, *id.*, 366/10-367/2; (6) the automobile defendants were upstream tortfeasors liable for anything done by downstream tortfeasors, *id.*, 368/4-6, and (7) there was no probative value to the issues of negligence, causation or damages, *id.*, 369/10-12.

Defendants' arguments for both the use of the petitions and bringing the prior lawsuits into evidence in this case were: (1) the allegations in the automobile petitions were admissible as abandoned pleadings because they alleged that someone other than Defendants caused the death, and were admissions against interest,

id., 359/188-360/4, 360/25-361/15; (2) the allegations in the automobile petitions were inconsistent arguments as to who caused William Mitchell's death, *id.*, 360/25-361/15; (3) the alternative pleading argument was not valid because these were separate cases and not a single case, and the decision to file separate cases was made by Mrs. Mitchell's counsel, *id.*, 361/17-23, 362/15-21, 364/4-12; (4) the automobile petition allegations were admissible because Defendants were going to argue that the car chase was the sole cause of William Mitchell's death, and not any negligence on the part of Defendants, *id.*, 369/9-370/22.

Throughout the course of this argument the trial court expressed concerns about confusing the jury, and about bringing in new issues that would amount to relitigating the automobile cases. It is clear, however, that what finally persuaded the trial judge to allow the use of the automobile petitions and to allow introduction of evidence was that the prior petitions alleged that the automobile defendants had caused or contributed to cause, or directly caused or directly contributed to cause, the death of William Mitchell. *See generally*, TR. Vol. I, 357/17-373/7, and in particular, *id.*, 369/9-370/25.

As a result of that ruling, Mrs. Mitchell's counsel had no choice except to mention the existence of the prior lawsuits in his opening statement. He said, *id.*, 392/11-16:

> So at a subsequent time, a good period of time after the loss, I

was contacted. An investigation is what one does professionally. Lawsuits were filed against the other people who directly caused or contributed to cause the end result, the final death, but the injuries were visible there at the scene.

Mr. Moeller stated in his opening argument:

> The evidence will establish, ladies and gentlemen, that Mrs. Mitchell has filed proceedings against many of the individuals involved in this accident as well as the Sonic Drive-In as well as two police officers who were sitting right outside the Sonic at the time that this altercation occurred and this pursuit took place, and it's claimed at various points in the papers filed in the proceedings that these individuals either directly caused or contributed to cause the death or her son, or caused or contributed to cause the death of her son.

Id., 451/16-452/1.

The issue of the prior lawsuits was apparently not further raised until the cross-examination of Mrs. Mitchell. She was asked by defense counsel whether she had filed lawsuits against "other individuals and companies who were involved with the car chase that ended up with your son's automobile wreck," to which she answered, "Yes." [TR Vol. IV at 1934/25-1935/4.] At a bench conference requested by Mrs. Mitchell's counsel, Mr. Pickett pointed out that the other lawsuits

had no probative value and no relevance to this case; that Mr. Romano was not a joint tortfeasor but an upstream tortfeasor who had liability for all downstream consequences including the death of William Mitchell; that the automobile petitions were not abandoned pleadings; that the language proposed to be used constituted conclusions and not statements of fact and would be misleading. *Id.*, 1935/7-1937/17.

Defense counsel argued that they were always free to argue sole cause; that Mrs. Mitchell had previously filed lawsuits against others, making the claim they had directly caused or contributed to cause the death of her son, and arguing that it was permissible to discuss both lawsuits because Mrs. Mitchell's counsel had opened the door via his opening statement. *Id.*, 1937/18-1938/13. Mrs. Mitchell again objected on the grounds of relevancy and lack of probative value, again pointing out that all the petitions really showed was that Mr. Romano created an injury that eventually led to death as a result of a downstream tortfeasor's negligence.

When cross-examination resumed, Mrs. Mitchell acknowledged that in the suit against the four individuals involved in the chase that she claimed they had directly caused or contributed to cause her son's death, and indirectly acknowledged the same thing with reference to the suit against Mr. Romano, Sonic Drive-In and others. The two automobile petitions, Defendants' Exhibits 325 and 326 were ad-

mitted into evidence over objection. *Id.*, 1941/6-1943/3.

B. Abandoned Pleadings

Before the trial Defendants cited *Brandt v. Csaki*, 937 S.W.2d 268 (W.D. Mo. App. 1996), and *Lewis v. Wahl*, 842 S.W.2d 82 (Mo. 1992) (en banc), to support their claim of entitlement to use the petitions in the prior automobile cases against Mrs. Mitchell in this medical malpractice case. Mr. Moeller said that both *Csaki* and *Lewis* stood for the proposition that:

> Statements from abandoned pleadings alleging that actions of a physician other than the defendant physician caused patient's injuries were admissible as admissions against interest and there are, of course, statements in here. These are wrongful death actions, Your Honor, and there are statements in here, allegations that these individuals directly caused to the death of Mr. Mitchell.

[TR Vol. I at 359/21-360/4.]

There are multiple flaws in that claim.

First, in *Csaki* the plaintiff objected on appeal to having been cross-examined about a prior petition *in that same suit*, in which she alleged that another physician had caused her injuries. This Court said at 274:

> Missouri courts have consistently held that abandoned pleadings containing statements of fact are admissible as admissions

> against interest against the party who originally filed the pleading. [Citations omitted.] Only allegations of fact are admissible; conclusions of law are not admissible to impeach the witness. [Citation omitted.] "It has been held that extra judicial admissions are competent evidence even though in the form of conclusions as to the ultimate fact at issue." [Citation omitted.]

Unlike *Csaki*, in this case Drs. Evans, Dubin and Bowser had no prior petitions which contained claims against a separate defendant that were "abandoned" by the filing of an amended petition. *Csaki* is not on point and does not support the claims made for it.

Second, *Lewis* involved the issue of using the pleadings of an active claim in the same case against the plaintiff. The Supreme Court said at 86:

> In considering the admissibility of pleadings as an inconsistent statement, we have generally distinguished between abandoned pleadings and pleadings from other cases on the one hand, and pleadings which are live and active in the present lawsuit on the other. Because the cross-claim used by plaintiff to impeach defendant Dulaney was not abandoned and was a live, active pleading at the time it was used for impeachment, *we need not consider whether and to what extent the rules for the use of pleadings may differ with respect to abandoned*

pleadings or pleadings from other cases. [Emphasis added, both underscore and italics.]

The Supreme Court thus expressly excluded its opinion from having any relation to either abandoned pleadings or to pleadings from other cases. It should also be noted that the Supreme Court made a clear distinction between "abandoned pleadings" and "pleadings from another case." It is obvious that a pleading is "abandoned" if it is a prior pleading in the same case which has been superseded by a later pleading, *e.g.*, an original petition which names six defendants as having caused the injury and a final amended petition just before trial which names only two. If a pleading is in another case, whether that case is live and active, or whether that case is over, by reason of judgment, settlement or other dismissal, those other-case pleadings have not been and could not possibly be said to have been "abandoned" with reference to the separate case in which those pleadings are sought to be used.

Thus, neither *Csaki* nor *Lewis* support the argument Defendants made below that the pleadings in the two automobile cases constituted abandoned pleadings.

Third, there is the case of *Dean Machinery Company v. Union Bank*, 106 S.W.3d 510 (W.D. Mo. App. 2003), in which this Court said at 518:

In addition to the evidence that a sale occurred, Dean Machinery's original and first amended pleadings were admitted at trial as an

admission against the interest of the pleader. "[A]n abandoned pleading is generally not admissible in evidence except for use as an admission against the interest of the pleader." [Citations omitted.] "Even under these circumstances, an admission in an abandoned pleading is not conclusive as to the fact alleged, and does not constitute a judicial admission." [Citations omitted.]

Defendants based their "abandoned pleading" arguments solely on their Exhibits 325 and 326, the petitions in the two automobile cases, and those two petitions clearly do not fall within the definition of an abandoned pleading. No argument was made that there were abandoned pleadings in *this* case. The automobile petitions, therefore, could not legitimately supply any foundation for the abandoned pleading theory of admissibility of the petitions, testimony about the automobile cases, or argument about the automobile cases.

C. Binding Admissions and Downstream Liability

In *May v. May*, 294 S.W.2d 627 (E.D. Mo. App. 1956), several months before the Missouri trial for divorce based on the husband's counterclaim, the husband had filed a divorce petition in New Mexico, in which he alleged he was a resident of that New Mexico. Missouri law at the time required residence in Missouri for a year before a divorce could be obtained. On appeal, the wife argued that the trial court did not have jurisdiction over the divorce because the husband had made

a binding admission that he was not a resident of Missouri. The Eastern District, after pointing out the confusion in the cases over what constituted an admission, said at 634:

> A true judicial admission is an admission made in court or preparatory to trial, by a party or his attorney, which concedes for the purposes of that particular trial the truth of some alleged fact so that one party need offer no evidence to prove it, and the other party ordinarily is not allowed to disprove it. It removes the proposition in question from the field of disputed issues in the particular case wherein it is made. It is a substitute for evidence in the sense that it does away with the need for evidence on that subject in that cause. [Citations omitted.] The true judicial admission is sharply distinguished from the ordinary or quasi admission, which is usually some form of self-contradiction and which is merely an item of evidence, available against the party on the same theory any self-contradiction is available against a witness. The person whose act or utterance it is may nonetheless proceed with his proof in denial of its correctness. It is merely an inconsistency which discredits, in greater or lesser degree, his present claim and his other evidence. It is to be considered along with the other evidence and circumstances of the case. Thus, the moment

one seeks to use admissions made in other litigation, even though between the same parties, he must resort to them merely as ordinary or quasi admissions—i.e., ordinary statements or acts which now appear to tell against the party who made them or did them. [Citation omitted.] Assuming, but not deciding, that we will take judicial notice of the appropriate statute of the State of New Mexico concerning that state's residential requirements in divorce proceedings, nonetheless defendant's testimony that he filed a petition for divorce in New Mexico some seven or eight months after he filed his cross bill in Missouri is not a judicial admission that he was a resident of the State of New Mexico on April 2, 1954, the date he filed his cross bill. Nor is it a judicial admission that he had not been a resident of the State of Missouri for the lawfully required time. It was at most an ordinary or quasi admission to be implied from his stated conduct of filing a petition for divorce in New Mexico. Whatever probative value it may have, as being possibly inconsistent with his other testimony concerning his Missouri residence, was before the trial judge, who have [sic] heard it, must be presumed to have weighed it in with the other testimony and evidence on the subject. The question of whether or not defendant met the necessary residential requirements, as required by our statute

> in divorce actions, is a question of fact to be determined in the first instance by the trial Court. Under the particular facts and circumstances of this case, we believe the trial Court reached the correct conclusion on this question and we, therefore, would not be justified in disturbing his findings thereon. [Citation omitted.]

Any allegation in the automobile petitions that those defendants caused or contributed to cause the death of William Mitchell was not a binding admission. At most it was what the Eastern District referred to as a quasi-admission, or a self-contradiction, which still allowed the party to go forward and to offer evidence to explain away the seeming contradiction. Apparently, Mr. May's testimony about his place of residence prior to filing his cross bill for divorce in Missouri was sufficient to persuade the trial court that the jurisdictional requirement had been met so that the Missouri divorce trial could go forward.

Unlike Mr. May, who was dealing with a specific fact about which he had direct personal knowledge (where he lived at various times in the nearly thirty years of marriage that were ending in divorce), and who could therefore refute or explain away the inconsistency of the New Mexico pleading, Mrs. Mitchell had no way to explain the inconsistency here by her own testimony or otherwise. This is so because the automobile cases, in relation to the medical negligence case here, were based on the theory of downstream liability.

The Supreme Court said in *State ex rel. Bitting v. Adolf*, 704 S.W.2d 671 (Mo. 1986) (en banc), at 672-673:

> By familiar law, a person who negligently causes an accident is liable for all damages caused by the accident, including malpractice damages for negligent treatment of the resulting injuries. The medical defendants, however, are liable only for that portion of the total damages which is caused by their malpractice. The two sets of defendants, then, may be liable jointly and severally for a portion of the plaintiff's damages.

Thus, the theory was that the defendants in the two automobile petitions were upstream tortfeasors whose aggregate negligence led to the collision that fractured William Mitchell's legs and sent him to the hospital where he was treated by Drs. Bowser, Dubin and Evans. That in turn made them liable for the downstream negligence of Drs. Bowser, Dubin and Evans. And there was no possible way for that application of the legal principle of downstream liability to be provided to the jury to show that there was in fact, no inconsistency, and in fact no admission that the automobile defendants were the sole cause of the death of William Mitchell.

It can hardly be questioned that Mrs. Mitchell is a lay person. Even so, the allegations of a petition drafted by a plaintiff's attorney become the plaintiff's allegations. Here, however, there was no factual discrepancy between the automobile

petitions and the petition in this case about which Mrs. Mitchell had personal knowledge and could testify. It would take a lawyer to offer expert testimony on the meaning of the theory of downstream liability, and to explain its application in this case vis-à-vis the automobile petitions. Mrs. Mitchell's counsel was certainly barred by the Rules of Professional Conduct from taking the stand to explain the distinction so that the jury could consider the caused/contributed to cause conclusions in the automobile petitions in the proper context.

Just as William Mitchell was boxed in by four vehicles for a period of time during the car chase that led to the collision and the injuries that sent him to the hospital, Mrs. Mitchell's counsel was boxed in here, with no way out. He could not engage in re-direct examination of Mrs. Mitchell on the subject of the downstream liability of the automobile defendants. Neither Mr. Pickett nor any attorney in his firm could testify about the concept of downstream liability, and it would have been an exercise in futility to have suggested a new expert witness be added on behalf of Mrs. Mitchell mid-trial.

In the ordinary case, a quasi-admission or inconsistency such as the one in *May* is susceptible of testimony to show the lack of *actual* inconsistency. The trier of fact would thus have both the apparent inconsistency *and* an explanation to consider in making a decision. Given the impossibility of offering testimony on the subject of downstream liability, the jury here had only one side of the story, com-

bined with silence as far as explaining the inconsistency. In such circumstances, silence could only leave the jury with the conclusion that the defense wanted it to reach: Mrs. Mitchell had made a binding admission that someone other than these medical defendants caused her son's death. Under the particular facts and circumstances here, the automobile petitions did not properly serve as a foundation for the admission of evidence about those cases.

D. Alternative Pleading

In *Silver Dollar City, Inc. v. Kitsmiller Construction Company*, 931 S.W.2d 909 (S.D. Mo. App. 1996), the Southern District said at 917:

> We recognize the rule that alternative fact allegations made in good faith and based on genuine doubt are not considered admissions (sometimes referred to as admissions against interest) against the pleader. *Rauch Lumber Co. v. Medallion Dev. Corp.*, 808 S.W.2d 10, 12 (Mo. App.1991). Alternative fact allegations not based on genuine doubt may be considered as admissions against interest. *Id.* "Such a holding is consistent with Rule 55.03 which states that an attorney, by signing a pleading certifies that 'to the best of his knowledge, information and belief,' the pleadings are 'well grounded in fact' and not interposed 'to cause unnecessary delay or needless increase in the cost of litigation.' " *Id.* at 13.

The automobile petitions served two functions. The first is that in relation to this case they were pleadings of downstream liability. The second function is that they served as alternative and inconsistent theories of recovery, expressly authorized by Mo. R. Civ. P. 55.10.

Had this been a single case in which all the automobile defendants and all the medical negligence defendants were parties, the issue of downstream liability would in all likelihood never have arisen as a direct issue or an issue made necessary by implication. If, for example, this hypothetical single case had gone to trial against all defendants, the verdict form would have asked the jurors to assess a percentage of fault to each automobile defendant and each medical negligence defendant, thus making the medical negligence defendants liable only for their proportionate share of the damages arising from the death of William Mitchell. That this was not, ultimately, a single suit is at least in part the responsibility of these Defendants.

Counsel for Dr. Dubin argued:

> The case law is directly on point and there is case law that says when you file different pleadings like this in different cases and you make the same allegation of harm in both of those, those petitions are admissible in the opposite cases.
>
> That was Mr. Pickett's election. He could have chosen to sue

> us all in the same action and chose not to. He elected instead to file different lawsuits. He chose to do that and those other petitions which allege the exact same injury as Mr. Pickett is alleging in this case are admissible for that reason.

[TR Vol. I at 362/10-21.] Defense counsel also argued with reference to the automobile petitions and the allegations of upstream liability (though defense counsel never mentioned that aspect of the automobile pleadings):

> This proof just happens to be a specific type of proof that I think is powerful. I agree with that. I think it's powerful and I think it could raise a concern, but we didn't create the situation. As counsel points out, separate lawsuits were filed. That's a strategy decision. Under the law we are entitled, I believe, with all due respect, Your Honor, to use these and they are admissible.

Id., 364/4-12.

What defense counsel never mentioned to the trial court was that Defendants were responsible for there not being a single case. In the automobile cases and in this case, Mrs. Mitchell filed a motion to consolidate, seeking to have a single lawsuit in which all of the issues relating to the death of her son, from the collision through the medical negligence, would be heard by a single trier of fact. [LF Vol. II at 254 and 270.] Defendants opposed the motion to consolidate. [LF Vol. II at

286, 293, 300, and 307.] They were successful and the motion to consolidate was denied. [LF Vol. II at 314.] Defendants have in essence profited from their successful efforts to prevent consolidation because they were then able to argue that it was the lack of consolidation which made evidence about the automobile cases admissible. Defendants should not be allowed to profit from stopping consolidation by rewarding them with permission to introduce evidence and make arguments that would not have been allowed in a consolidated case.

Under the facts and circumstances of this case, the allegations of the automobile petitions were simply permissible alternative theories of recovery. In light of Defendants preventing the consolidation of the automobile cases with this medical negligence case, the automobile petitions and any evidence or argument arising from or based on them, should have been excluded.

E. Logical and Legal Relevance

In *Carlyle v. Lai*, 783 S.W.2d 925 (W.D. 1989), this Court defined relevant evidence at 928:

> The test for relevancy applied in Missouri is whether an offered fact tends to prove or disprove a fact in issue or corroborates other relevant evidence. *Lawson v. Schumacher & Blum Chevrolet, Inc.*, 687 S.W.2d 947, 951 (Mo.App.1985). The amount of proof required to meet the relevancy threshold is attained when the truth of the

> offered fact makes probable the existence of the fact in issue. *Id.* Because of the obvious subjective nature of such a determination, the trial court is granted broad discretion which will be disturbed by this court only for an abuse of that discretion. *Id.*

In *Gurley v. Montgomery First National Bank, N.A.*, 160 S.W.3d 863 (S.D. Mo. App. 2005), the Southern District said at 870-871:

> To be admissible, evidence must be relevant, both logically and legally. *Shelton v. City of Springfield*, 130 S.W.3d 30, 37[7] (Mo. App. 2004). Evidence is logically relevant if it tends to prove or disprove a fact in issue or corroborate other evidence. *Guess v. Escobar*, 26 S.W.3d 235, 242[14] (Mo. App. 2000). Evidence is legally relevant when its probative value (usefulness) outweighs its prejudicial effect, such as unfair prejudice, confusion of the issues, misleading of the jury, undue delay, or waste of time. *Id.* at 242[16].

Or as stated in Fed. R. Evid. 403: "Although relevant, evidence may be excluded if its probative value is substantially outweighed by the danger of unfair prejudice, confusion of the issues, or misleading the jury, or by considerations of undue delay, waste of time, or needless presentation of cumulative evidence."

Evidence relating to the automobile cases, particularly the mere fact that the petitions contained a conclusion that based on the specific acts of negligence pled,

the defendants caused/directly caused or contributed/directly contributed to cause the death of William Mitchell, was neither logically nor legally relevant under the facts and circumstances of this case.

For all the reasons previously stated, the conclusions in the two automobile petitions were not binding legal admissions which eliminated the need for the Defendants to prove that the automobile defendants were the sole cause of William Mitchell's death, or in essence to prove, that no matter what the medical defendants here did or failed to do for William Mitchell once he got into their hands, he was going to die anyway. As those conclusions were not binding admissions, they did not constitute proof of sole causation by the automobile defendants. Those conclusions did not tend to prove or disprove that any medical defendant negligently breached the standard of care, nor did they tend to prove or disprove that there was a causal relationship between negligent breach of the applicable standard of care and William Mitchell's death. Nor did they corroborate any other evidence in the case. There was, therefore, no logical relevance to this evidence, whether by admission of the automobile petitions as exhibits or by other evidence.

The automobile case evidence was not legally relevant, either. Although Mrs. Mitchell vigorously disputes that such evidence had any probative value in this trial, even if it did, that scintilla of probative value was vastly outweighed by the unfair prejudice, by misleading the jury and confusing the issues.

The unfair prejudice occurred because the admission of the automobile case evidence created the appearance, despite the legal reality otherwise, that Mrs. Mitchell had admitted that someone else caused her son's death, and the mechanism for that "admission" was the introduction of evidence that would have required expert testimony to refute—testimony which could not be provided. The testimony misled the jury into believing that because Mrs. Mitchell said nothing to explain away the inconsistency between the automobile petitions and all the weeks of testimony in this trial, that there was nothing she could say, and thus the false and confusing impression of a binding admission was continued.

The lack of logical and legal relevancy should have resulted in the exclusion rather than the admission of the automobile case evidence.

F. Conclusion

Under the particular, and perhaps unusual facts and circumstances of this case, the trial judge abused his discretion, because his decision to admit the automobile case evidence was "clearly against the logic of the circumstances," and in this factual context, was "so arbitrary and unreasonable as to shock one's sense of justice and indicates a lack of careful consideration." *Boyer*, *supra*.

POINT IV.

The trial court erred in permitting improper closing argument by all defense counsel because in doing so he abused his discretion in

that he allowed appeals to regional prejudices; personalization; appeals for sympathy, and misleading statements (as more fully detailed in the Argument below), all of which are impermissible in closing arguments as a matter of law, thereby confusing and misleading the jury, and depriving Mrs. Mitchell of a fair trial because of the resulting prejudice.

Section 1. Standard of Review

The standard of review for whether a trial court properly controlled closing arguments is abuse of discretion. *Duncan v. American Commercial Barge Line, LLC*, 166 S.W.3d 78, 87 (E.D. Mo. App. 2004)

Section 2. The Inappropriate Closing Arguments

The closing arguments by defense counsel in this case can be essentially divided into four categories: (1) appeals to regional prejudice; (2) appeals for sympathy; (3) personalization and (4) misleading statements.

Regional Prejudice

There were multiple appeals to regional prejudice with reference to the experts in this case. The most egregious of them were tied to Dr. Tile who is from Canada. Defense counsel referred to him as "this Canadian person," *id.*, at 3434/2-3. Counsel was permitted to say the following about Dr. Tile:

Every single witness with the exception of Dr. Tile from Canada, and

> counsel wants to make it seem [sic] like it's not a big deal we go to Canada. I've never seen an expert from outside the United States...testify. ... Credibility is an issue for you to decide and it is somewhat telling, ladies and gentlemen of the jury, that counsel couldn't find any...trauma expert.... Counsel couldn't find any expert in the United States, trauma, to testify against my client. He had to go to Canada, ladies and gentlemen of the jury, and get a retired trauma surgeon...

Id., 3442/18-3443/25.

Defense counsel made a point of identify defense expert Dr. Freeman as being "at Washington University here in St. Louis, across the state in St. Louis, a level I trauma center." *Id.*, 3454/5-10.

Sympathy

There were numerous arguments designed to make the jury more sympathetic to the defendants. They were told that Dr. Evans was taking care of patients; that he wasn't thinking about a lawsuit being filed; that he was doing a job. *Id.*, 3436/20-23. The jurors were told that if Dr. Evans had done something other than what he did to William Mitchell, he still would have been sitting in the courtroom, *i.e.*, no matter what he did or did not do, the greedy plaintiff was going to sue him. *Id.*, 3452/14-3453/1; 3453/8-24.

The jury was told that Dr. Dubin took "a lot of pride in taking care of patients, in taking care of patients to the best of his ability. He cares about his patients and he always tries to do the right thing...." *Id.*, 3463/8-11. The jury was told about Dr. Dubin getting a telephone call in the middle of the night and getting him to come to the hospital, *id.*, 3465/15-16, as if he did so only as a good Samaritan, rather than being on call and being paid for taking such calls and coming into the hospital on such occasions. This theme of getting up in the middle of the night and coming right in was then repeated. *Id.*, 3487/3-6. Another effort to elicit sympathy for the defendants came when counsel said, "It's not easy for the family. I'm sure it's hard for Mrs. Mitchell. But you know what? It's also hard for the guys sitting at this table. It's not easy for them, either." *Id.*, 3489/20-24.

Counsel for Dr. Bowser argued that the issues in the case were ones with which none of the defense lawyers had any previous experience, and they had five years to learn it, and the jury only four weeks. *Id.*, 3491/17-20. He argued that Dr. Bowser took great pride in his work and what he had done for patients in Independence (also an appeal to regional prejudices), and hoped that the jury would not hold it against Dr. Bowser or his lawyer that Dr. Bowser zealously defended himself, because it was important that he continue to provide and that they continue to defend himself. *Id.*, 3491/25-3492/8.

There was more commentary about the doctors responding when people like

William Mitchell needed their help, but now found themselves being second-guessed for the care they provided, somewhat like Monday morning quarterbacking. *Id.*, 3495/13-16.

Personalization

Personalizing a closing argument essentially occurs in two ways. Either the argument explicitly or implicitly asks the jury to put themselves in the shoes of a party or a witness, or the attorney offers his personal opinions or comments. Both occurred in this case.

In speaking about Dr. Evans being "raked over the coals" about an issue not in dispute, counsel commented, "I don't get it." *Id.*, 3437/8-14. In discussing an issue related to blood gases, counsel said "You know, I have a little bit of trouble with that concept and I came up with...[t]he concept of what's indicated or not indicated for a patient is sometimes a difficult concept...." *Id.*, 3439/25-3440/9.

Defense counsel talked to the jury about the three and a half week trial being at a "horrible time of the year" (the verdict was rendered only a few days before Christmas), and thanking the jurors. Counsel went on to say, "I mean I don't know about you guys but I don't have any holiday presents bought yet and so I appreciate all your time, Dr. Dubin certainly does, and we thank you for your efforts and for your attendance every day for a long trial." *Id.*, 3462/9-3463/2. Clearly this was also some attempt to garner sympathy from the jurors for Dr. Dubin, in ex-

change for Dr. Dubin's expression of sympathy (through his counsel) to the jury for what they were going through in the weeks up to the Christmas holiday season.

In commenting about Dr. Dalenberg's testimony, defense counsel said in reference to a statement by Dr. Dalenberg: "That is exactly what he told you and I'm going to show it to you because I couldn't believe it." *Id.*, 3468/3-4. Later, counsel said, "That's Dr. Dalenberg. Now you guys decide credibility, but I certainly have my own opinions about that." *Id.*, 3469/3-10.

After discussing the expert testimony that said Dr. Dubin should have overridden Dr. Bowser and used a general anesthetic, counsel said: "Now, folks, you know I've been struggling with what to say about these claims because, frankly, I can't believe that somebody stands here in front of you with a straight face and says..." The objection of personalization and the need to argue the evidence was not ruled upon, but the trial court merely told the jury that the statements of counsel are not evidence and "are merely designed to assist you in the interpretation of the evidence." *Id.*, 3474/19-3475/17.

Later, as part of an argument that Dr. Dubin couldn't be monitoring vital signs during complicated surgery, defense counsel said: "He's got his own job to do. And you know what? I want him to do it. If it's my legs, I don't want my orthopedic surgeon looking up every now and then to see what else is going on. I want him doing what he's supposed to be doing. There's other people doing the

other jobs." *Id.*, 3484/19-25.

In speaking about the use of a fiberoptic tube for intubation, defense counsel said: "Dr. Ham acknowledged that when you put a fiber-optic tube down a patient's throat, they're awake and people don't like things being stuck down their throat while they're awake. You can imagine what it would feel like." *Id.*, 3508/18-25.

Misleading Statements

Counsel argued that Dr. Tile was the only standard of care expert to say that Dr. Evans was negligent. *Id.*, 3444/24-3425/1. Essentially this was an argument that the number of experts a party presents is somehow determinative of whether the party should prevail, and also conveniently overlooked the fact that the parties were allowed to designate only one expert per defendant.

One of the most misleading arguments made was the use by Dr. Dubin's counsel to the jury that Dr. Tile had no opinions that Dr. Dubin violated the standard of care. *Id.*, 3485/17-3486/22. What defense counsel deliberately ignored was that the parties were limited to one expert per defendant. Dr. Tile spoke only as to Dr. Evans, as he was designated to do. While it may be a common practice for defense attorneys to ask, during the deposition of an expert opining about Defendant X, whether the witness had any opinions about Defendant Y, the proper function of such questioning is to raise the argument of surprise if the expert takes

the stand and suddenly starts offering opinions about Defendant Y. Here, however, Dr. Tile's statement that he had no opinions about Dr. Dubin was used by counsel to obtain indirectly what could not be obtained directly: testimony from a second expert (one retained by Dr. Dubin, one retained by Mrs. Mitchell) that Dr. Dubin had done nothing wrong.

Section 3. Lack of Judicial Control

For all practical purposes the trial court did nothing to control Defendants' closing arguments. In response to an objection of personalization, the trial court implicitly overruled it and said that the jury would remember the evidence. *Id.*, 3439/25-3440/9. Another objection that it was the evidence which should be argued, not what the attorneys experienced, was disposed of with a similar statement that what attorneys said was not evidence and the jury's decisions "will be guided by the evidence." *Id.*, 3442/18-3443/25.

When argument was made that no matter what the defendants did or did not do in providing care to William Mitchell they would still have been sued, and counsel objected that this was outside the evidence, the judge once again merely repeated that the "jury shall remember that the statement of counsel is not evidence and is merely closing argument of counsel." *Id.*, 3453/8-24. The court expressly overruled this objection, thereby leaving the jury to assume that it was appropriate for the defense to argue matters extrinsic to the evidence presented. Another per-

sonalization objection met with the same fate. *Id.*, 3469/3-10. Another personalization objection led to the judge saying: "The jury will remember the statements of counsel are not evidence and are merely designed to assist you in the interpretation thereof and is [sic] not evidence." *Id.*, 3474/19-3475/17.

A careful reading of the entirety of the defense closing arguments discloses that the judge exercised no control over what was being said, but for all practical purposes allowed the defense to say whatever they chose, telling the jury only the rubric that they would remember the evidence. More objections would have been an exercise in futility.

Section 4. Argument

For at least one hundred twenty years, the appellate courts have held that improper closing argument can be grounds for a new trial, or for reversal on appeal and remand for a new trial. That is precisely what occurred in *Gibson v. Zeibig*, 24 Mo. App. 65, 1887 WL 1742 (E.D. 1887). The plaintiffs were merchants doing business in Chicago; the defendant was a Saint Louis merchant. In closing, defense counsel said, "I take it, gentlemen, that all this matter amounts to is a little difference between St. Louis and Chicago; and I think you will decide (or find) that in this case (or this time), we of St. Louis rather got the best of Chicago." *Id.*, at 2. This argument, appealing to the local prejudice of Saint Louis jurors against Chicagoans, was sufficient for a reversal and a new trial.

The Eastern District went on to say at 3:

We have not regarded it as ground for reversing a judgment that counsel for the successful party have indulged in extravagant flights of oratory, or have drawn inferences from the testimony which might be deemed unwarranted and unfair. We have regarded it as important and counsel should not feel themselves trammeled in the forcible and zealous advocacy of their client's cause, by being beset at every step of their argument by the fear that they might let slip something which, in case of their client's success, would entitle the other party to a new trial. But there is a clear line of demarkation between matters which pertain to the case on trial and matters which are wholly extrinsic; and where counsel have attempted to make a case in their argument to the jury which the law would not allow them to make in their tenders of evidence, our courts have always held that such conduct, if objected to at the time and allowed to pass unrebuked, is ground for a new trial. *Miller v. Dunlap*, 22 Mo. App. 97; *Marble v. Walters*, 19 Mo. App. 134; *Roeder v. Studt*, 12 Mo. App. 566; *Brown v. Railroad*, 66 Mo. 588, 590; *The State v. Lee*, 66 Mo. 165, 168; *The State v. Barham*, 82 Mo. 67. Because the counsel for the defendant saw fit to indulge in these unwarranted remarks, and because the court, notwithstanding

the objection of the plaintiff's counsel, failed to rebuke this impropriety in the presence of the jury, but overruled the plaintiff's objection thereto, we reverse the judgment and remand the cause, and for no other reason.

A motion for rehearing was filed and considered by the Eastern District, resulting in a reaffirmation of the decision to reverse and remand. The court said at 5:

> But when, after objection, the court declined to check counsel or to admonish the jury not to regard such considerations, the effect was produced of the court putting its seal of approbation upon the language used. Counsel, of course, may be pardoned for errors of this kind, where not deliberately planned and persisted in after objection or after admonition from the bench; but after the attention of the court is called to a prejudicial expression of this nature used by counsel, the duty of the court is plain to rebuke the expression and admonish the jury to disregard it, and a refusal to perform this duty is ground of exception and error.
>
> Entertaining these views, believing that they are well supported by authority both in and out of this state and founded upon the highest considerations of public policy, that of preserving in its integr-

> ity the system of jury trial, already the subject of much public dissatisfaction, we must adhere to our former ruling in the case, that the judgment be reversed and the cause remanded for a new trial.

Two years later, in *Fathman v. Tumility*, 34 Mo. App. 236, 1889 WL 1536 (E.D. 1889), the Eastern District reversed and remanded for a new trial because of prejudicial closing argument by plaintiff's counsel, including appeals to local prejudices (ethnicity or nationality) and personalization. Counsel told the jury that the plaintiff was a Dutchman and the defendant was an Irishman, and the case was nothing but an attempt by an Irishman to beat a Dutchman out of an honest debt. *Id.* at 2.

The case was in part about the value of the services provided, and plaintiff's counsel said "I have been hiring men all my life and know what the wages are. I never gave a man less than fifteen dollars per month." *Id.* The Eastern District said:

> If plaintiff's attorney thought that his own testimony was necessary to make out his client's case, he should have been sworn as a witness and submitted to a cross-examination. It was the duty of the court to rebuke the attorney for making such a statement, and in such a way as to leave no doubt in the minds of the jurors, as to the impropriety of his conduct. The plaintiff's attorney may be, and doubtless is,

> a man of high standing among his fellow citizens, and such a statement by him, would, with the ordinary juror, have as much weight as if delivered from the witness stand. For this reason, it is the duty of lawyers, and especially lawyers of good standing to confine their arguments to the evidence in the case. Gibson v. Zeibig, 24 Mo. App. 65; Holliday v. Jackson, 21 Mo. App. 669, 670.

Id.

In *Snell v. Overfelt*, 307 S.W.2d 716 (E.D. Mo. App. 1957), a new trial was granted because of prejudicial closing arguments by plaintiff's counsel. *Id.* at 720. Plaintiff's counsel kept comparing his client, "a human being," "a country boy," to the defendant "big Railway Express Company, a corporation in the State of Delaware." He described the defense attorneys as "the largest array of lawyers ever gathered in Marion County." *Id.*, at 718. The plaintiff's lawyer said he was glad that a Marion County jury would "try the case of this Monroe County country boy." *Id.*, at 719. What the attorney was doing was impermissibly asking the jury to decide the case based on extraneous, immaterial, prejudicial grounds. *Id.*, at 718. In *Snell*, the plaintiff's lawyer was appealing to local prejudice, and trying to create a "David and Goliath" type of sympathy for his client.

In *Welch v. Sheley*, 443 S.W.2d 110, 116-117 (Mo. 1969), argument to rouse prejudice against the plaintiff because of his wealth was reversible error.

In *Delaporte v. Robey*, 812 S.W.2d 526, 537 (E.D. Mo. App. 1991), although the case was reversed on other grounds, the Eastern District condemned the personalized argument and appeal to local prejudice (references to "Saint Louis attorneys").

In *Yingling v. Hartwig*, 925 S.W.2d 952, 958 (W.D. Mo. App. 1996), this Court said:

> We reiterate the instruction and warning of the Missouri Supreme Court that arguments designed to appeal to local prejudices will not be tolerated. *Moore v. Missouri Pac. R. Co.*, 825 S.W.2d 839, 845 (Mo. banc 1992).
>
> > Trials before juries ought to be conducted with dignity and in such manner as to bring about a verdict based solely on the law and the facts. Hence reckless assertions unwarranted by the proof and intended to arouse hatred or prejudice against a litigant or the witnesses are condemned as tending to cause a miscarriage of justice.... Due administration of justice demands that the jury in passing on such grave questions should not be allowed to have injected in a case, either by evidence, remarks of counsel, or even by the conduct of the judge,

> any extrinsic matter that tends to create bias or prejudice. The evil effect of such matters is not always cured by the ruling of the court withdrawing them from consideration or even by rebuking counsel. The red hot iron of prejudice has been thrust into the case; merely withdrawing it still leaves a festering wound. When there is no evidence to justify it is always improper for counsel to indulge in argument to the jury which tends towards the prejudice of one party or to the undue sympathy for the other.

Calloway v. Fogel, 358 Mo. 47, 213 S.W.2d 405, 409 (1948) (citations omitted).

What these cases collectively teach is that a trial judge has a duty to control the scope of closing arguments, and to rein in arguments outside the scope of the evidence. All of the comments made by opposing counsel fall within the parameters of impermissible argument, and whether they were objected to, or should be considered here on the ground of plain error, in the aggregate the effect was to turn the jury away from the facts and to base their decision in whole or in part on prejudices against going outside the United States or outside of Missouri for an expert, on sympathy for the doctors who had to get up in the middle of the night on er-

rands of mercy, on the personal opinions and prejudices of defense counsel, or on statements designed to mislead them.

The law is plain. Each and every one of these arguments was legally impermissible. A new trial should be granted.

POINT V.

The cumulative effect of the errors of the trial court as identified in the preceding Points Relied on warrants granting of a new trial, even if the errors considered individually do not warrant granting a new trial.

Section 1. Standard of Review

The standard of review in determining cumulative error is the same standard of review for each of the "cumulative" errors as the standards cited in the preceding Points Relied On, with the additional consideration of whether, in the aggregate, the errors warrant granting a new trial, even if the errors, considered individually, do not.

Section

Obtaining a reversal and remand for a new trial on the basis of cumulative error is clearly something that many appellants seek, but few find. Two cases clearly establish the policy that errors which, standing alone, are not enough to justify reversal and remand, may in the aggregate do so.

> Without undertaking to determine whether any single matter...standing alone, would constitute reversible error [citations omitted], we are firmly of the opinion that, in their totality, they do.

Faught v. Washam, 329 S.W.2d 588, 604 (Mo. 1959). And in *Reed v. Spencer*, 758 S.W.2d 736, 741 (W.D. Mo. App. 1988):

> ...an appellate court is not to reverse a judgment for error unless some injury has been worked upon the complainant. [Citation omitted.]

See also, *Wiedower v. ACF Industries, Inc.*, 763 S.W.2d 333, 336-337 (E.D. Mo. App. 1988). A more recent holding recognizing this principle can be found in *Crawford v. Shop 'n Save Warehouse Foods, Inc.*, 91 S.W.3d 646, 652 (E.D. Mo. App. 2002).

As demonstrated out in the preceding Points, there are significant prejudicial errors in the record, including the trial court rejecting Mrs. Mitchell's proposed instructions and substituting, over universal objection, ones he drafted himself; failure to grant a mistrial or other appropriate relief given the then-existing circumstances; failing to exclude evidence of the automobile cases, and having no control over defense closing argument so that defense counsel had free rein to engage in repeated inappropriate conduct.

There is clear and patent injury to Mrs. Mitchell.

While Mrs. Mitchell strongly believes that the errors identified in the pre-

ceding Points Relied On are sufficient in and of themselves to require a new trial on apportionment, even if this Court disagrees, the aggregate impact of the errors and the prejudice to Mrs. Mitchell do merit a new trial.

CONCLUSION

The case should be reversed and remanded to the trial court for a new trial.

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CERTIFICATE OF COMPLIANCE

I hereby certify the following:

1. This brief is in compliance with the requirements of Mo. R. Civ. P. 55.03.

2. This brief complies with the limitations contained in Mo. R. Civ. P. 84.06(b).

3. This brief contains 28531 words, exclusive of the cover, signature block, certificate of service, and certificate of compliance. This brief was prepared using Microsoft Word 2007, and the word count was calculated by Word 2007.

4. The file containing this brief, and the respective diskettes filed with the Court and/or served on the parties were scanned for viruses on 24 May 2007, using McAfee VirusScan 10, with virus definitions updated through 24 May 2007, the most recent date for which virus definitions were available, and the file and diskettes have been found to be virus-free.

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