SC89762

IN THE MISSOURI SUPREME COURT

EDGAR T. EDGERTON,

Respondent,

vs.

FERRELL-DUNCAN CLINIC, INC.
AND
STEPHEN K. MORRISON, M.D.,

Appellants.

Appeal from the Circuit Court of Greene County, Missouri
The Honorable Thomas E. Mountjoy
Case No. 191CC2009

APPELLANTS' SUBSTITUTE BRIEF

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JURISDICTIONAL STATEMENT

Respondent Edgar T. Edgerton[1] ("respondent") brought this action for medical malpractice against several doctors and their employers, including Appellants Stephen K. Morrison, M.D. and Ferrell-Duncan Clinic, Inc. (collectively referred to as "Dr. Morrison" or "Appellants"). (LF 1, 26).[2] Following a two-week trial, the jury, on August 25, 2006, returned a verdict against Dr. Morrison and in favor of all other defendants. (LF 113; A25).

On August 31, 2006, the trial court entered judgment against Appellants. (LF 115; A19). Appellants filed a timely motion for judgment notwithstanding the verdict and, in the alternative, for a new trial on September 22, 2006. (LF 116-53). Those motions were denied on November 17, 2006. (LF 164; A20). Appellants filed a timely notice of appeal on November 27, 2006. (LF 165-166).

Because the appeal did not involve any issue within this Court's exclusive appellate jurisdiction, original appellate jurisdiction lay in the Missouri Court of

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[1] Judy A. Edgerton dismissed her claim without prejudice. LF 90.

[2] The legal file "LF" will be cited by page (*e.g.*, LF 115), and items in the appendix to this brief "A" will be cited parenthetically by page number, *e.g.*, (A1). The transcript "T" will be cited by volume 1 through 10 and page number,(*e.g.*, 1 T 188).

Appeals, Southern District, under Mo. Const. art. V, § 3 and Mo. Rev. Stat. § 477.060.

The Court of Appeals, Southern District, issued an opinion on October 16, 2008 (Burrell, P.J. with Lynch, C.J. and Rahmeyer, J. concurring). (A copy of the Court of Appeals' Opinion ("Op.") is included in the Appendix to this Brief.) The court reversed the jury's verdict in respondent's favor and remanded the case for a new trial. (Op. 9). This Court sustained respondent's Application for Transfer on December 16, 2008.

STATEMENT OF FACTS

Respondent suffered a heart attack in August 1989. (4 T 541). He was admitted to a Springfield, Missouri hospital where his condition was stabilized with care from a cardiologist. (2 T 188). The cardiologist referred respondent to Dr. Stephen Morrison, a cardio-thoracic surgeon, who performed coronary artery bypass graft surgery on August 9, 1989. (1 T 133, 2 T 188, 325). Despite respondent's numerous health issues, the grafts Dr. Morrison placed to bypass the blockages in respondent's coronary arteries were still functioning for respondent's benefit at the time of trial more than 17 years later.[3] (2 T 341-43).

[3] Respondent's health issues included: Obesity (2 T 264), regular smoking since the age of 5 (4 T 559-561), Chronic Obstructive Pulmonary Disease (4 T 562), Berger's Disease (4 T 561-62), high blood pressure (4 T 575), blood

As part of the bypass surgery, Dr. Morrison performed a ***sternotomy***[4] to gain access to respondent's heart and arteries. (2 T 248, 3 T 353). In a sternotomy, the surgeon divides the sternum in half in a vertical fashion with a saw. (2 T 248). The surgeon necessarily spreads the sternum apart to expose the heart for bypass surgery. (2 T 248). The bypass surgery circumvents the occluded artery, and reestablishes blood flow beyond the point of occlusion. (2 T 249). The internal mammary artery, which normally supplies blood to the sternal area, was sacrificed and used to supply blood to the heart. (3 T 357-58). After performing respondent's bypass surgery and restoring blood flow to respondent's heart, Dr. Morrison closed respondent's chest using sternal wires to tie respondent's sternum back together. (1 T 133, 165, 2 T 248-49). Respondent recovered from bypass surgery and was discharged on August 17, 1989. (4 T 541).

Although a divided sternum that has been tied with sternal wires generally heals back together, it may on occasion not heal and come apart. (2 T 249). When the sternum comes apart it is called a ***sternal dehiscence***. (2 T 282-83). A variety

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sugar problem that developed into diabetes (4 T 572), and possible stroke (4 T 576). Plaintiff's heart also required a second bypass surgery in 2005 involving arteries not bypassed in the 1989 operation. (4 T 563, 8 T 1163).

[4] For the Court's convenience, medical terms, when they first appear, will be bolded and italicized.

of factors can cause a sternal dehiscence, including sternal wires that break, bone tissue death, or an infection in the divided area of the sternum that prevents the sternum from healing back together. (2 T 249, 282-83). A sternal dehiscence is diagnosed by palpating the sternum, a procedure whereby the doctor pushes on each side of the sternum to determine if there is any movement. (2 T 270).

In some patients, the sternum does not heal, yet neither the patient nor the doctor are aware of it, or if diagnosed, it causes no problem for the patient. (5 T 645, 647). If diagnosed, the patient may be presented with options. If the dehiscence is caused by an infection, prompt treatment is important. (6 T 907, 8 T 1156). If the dehiscence is sterile, as in respondent's case, a patient may choose to leave it alone or may choose attempted rewiring of the sternum. (3 T 354-356, 5 T 648, 8 T 1157). Attempted rewiring was not available to respondent due to his sternal bone ***necrosis*** (death from lack of blood supply), coughing from smoking and his barrel-shaped chest. (2 T 300-302, 2 T 336, 6 T 902). A patient may also choose the ***pectoralis muscle flap procedure***. (2 T 312-313, 6 T 899). Other options, which are the subject of argument, are addressed later in the brief.

No claim was alleged or presented to the jury that Dr. Morrison was negligent in doing something, or failing to do something at the time of surgery, that caused or resulted in respondent's sternal dehiscence. (3 T 357-358, LF 107, A 5). The dehiscence was a consequence of two things: Respondent's

longstanding underlying disease processes, and respondent having his sternum divided which required arterial blood supply diversion from the sternum to the heart as part of the bypass operation. (3 T 357-358, 9 T 1215-1219, 8 T 1152).

A few days after his discharge, Dr. Morrison saw respondent on August 22, 1989. (4 T 542). Respondent's sternum was mechanically stable and Dr. Morrison found it to be so when he palpated it. (1 T 140-41, 4 T 542). Respondent also had two regular post-operative examinations. (4 T 542). The first was with Dr. Morrison on September 5, 1989. (4 T 542). The second was with respondent's cardiologist on September 7, 1989. (4 T 542).

On September 5, 1989, Dr. Morrison saw respondent. (2 T 288, 4 T 586). Two days before his visit to Dr. Morrison, respondent went to the emergency room after having one of his ribs "pop" and bulge out of his back. (2 T 287-288, 4 T 545). By the time respondent arrived at the emergency room, the rib had popped back into place. (4 T 545). Respondent told Dr. Morrison about the incident and about continued pain. (1 T 153, 4 T 587). Respondent's sternum was still mechanically stable at that time, due to the sternal wires, and respondent did not complain to Dr. Morrison of any movement or instability. (2 T 326, 4 T 587). Other than pain from his rib popping incident, Dr. Morrison noted that respondent was doing well. (8 T 1130).

At the conclusion of the September 5 visit, Dr. Morrison noted he would see respondent if there were any problems that required his [the surgeon's] attention. (8 T 1133-34). Respondent subsequently saw his cardiologist on September 7, 1989. (2 T 189-190). Dr. Morrison did not see respondent again until respondent called him on January 12, 1990. (1 T 157, 4 T 587). During this four month period, respondent never contacted Dr. Morrison, or in any way sought treatment from him. (4 T 587-89, 8 T 1134). While respondent was treated by several other doctors after September 5, there was no evidence that any of them referred respondent back to Dr. Morrison before January 12, 1990, nor were any of these doctors found negligent for failing to do so.

On January 12, 1990, a dermatologist, who was treating respondent for a chest rash that had developed in November of 1989, referred respondent back to Dr. Morrison. (3 T 400, 417-18). Respondent's rash had failed to heal and he also, for the first time, complained to the dermatologist about chest pain when he moved his left arm. (3 T 417-18). Dr. Morrison examined respondent's chest on that same day, January 12. (1 T 159-161, 4 T 598). After examining respondent and palpating his sternum, Dr. Morrison found respondent's sternum to be "well-healed." (1 T 162).

Respondent sought a second opinion. (3 T 421). He was referred to a general surgeon who examined respondent on January 15, 1990, and who

diagnosed respondent's sternum as unstable and possibly infected. (3 T 421-23). Respondent's sternum was later proven to not be infected. (2 T 250, 295-96, 301). Respondent was subsequently referred to a thoracic surgeon, Dr. Rogers, for further examination that same day. (3 T 423-24, 9 T 1204). Dr. Rogers palpated respondent's sternum and felt the sternum to be unstable. (9 T 1204). The delay in diagnosis from January 12, 1990 (the date of Dr. Morrison's examination) until January 15, 1990 (the date of Dr. Rogers' examination) did not make any difference in respondent's outcome. (3 T 358).

Uncertain about the presence of infection, Dr. Rogers opened respondent's chest to directly examine the sternum on January 17, 1990, and found a sternal dehiscence. (9 T 1206, 1210). The dehiscence was caused by the fact that part of respondent's sternum [bone] had died. (9 T 1206-07, 1210). Dr. Rogers removed the dead portion of respondent's sternum and scraped the bone back until he found healthy bone tissue. (9 T 1207-08). Dr. Rogers remained concerned about a possible infection, so he kept respondent in the hospital with the surgical wound open but packed up, pending the lab results. (9 T 1206-10). The lab results came back negative. (9 T 1207).

Respondent's sternum was not infected. (2 T 250, 295-96, 301). His sternum had died and had been slowly deteriorating since the bypass surgery in August 1989 from a condition known as ***aseptic vascular necrosis***. (2 T 249-50,

340). Aseptic vascular necrosis occurs when there is not enough blood flow to the divided area to facilitate healing. (2 T 250). The lack of blood flow to respondent's sternum resulted from respondent's pre-existing health conditions, and the necessary use of the internal mammary artery for the bypass, not from wrong doing on Dr. Morrison's part. (2 T 40, 3 T 357-58). Due to lack of blood flow, bone tissue in the area died, and the sternum could not heal back together; therefore, the dead part of the sternum slowly deteriorated, gradually weakening and liquefying over a period of time. (2 T 250, 269-70). This portion of the sternum that died could not be saved because dead bone does not heal. (2 T 301-02).

Dr. Rogers called in the "go-to-guy" for sternal repair procedures, Dr. Rodney Geter, a plastic surgeon, who was to close up respondent's chest and repair the sternal non-union. (6 T 888, 890). Dr. Geter closed respondent's sternal non-union using the pectoralis muscle flap procedure, a procedure that closes the sternal area by dividing part of the pectoralis muscle and rotating that flap into the gap created by the death of sternal bone, thereby creating a muscle covering over the gap. (2 T 312-13, 6 T 899). The muscle flap procedure has the added benefit of restoring blood supply back to the sternal area, thus allowing treatment of any potential infection by antibiotics. (2 T 336). Dr. Geter uses the muscle flap procedure in closing sternal non-unions, regardless of whether the sternum is

infected and he would do so for respondent specifically, irrespective of infection. (6 T 901, 905). At the time of trial, 16 years later, the muscle flaps used by Dr. Geter were still providing coverage of the area for respondent. (2 T 318).

In 1991, respondent brought this medical malpractice action against Dr. Morrison and other physicians who provided the treatment respondent received following his coronary artery bypass surgery. (LF 26-27). Respondent did not bring suit against Dr. Geter or Dr. Rogers. (LF 26-27). Respondent claimed at trial that Dr. Morrison failed to diagnose the sternal dehiscence on or after September 5, 1989, causing respondent to undergo the muscle flap repair procedure instead of receiving, or having the option of receiving, one of two specific repair procedures (rib-transfer or methyl-methacrylate) that respondent claimed were preferable. (2 T 306-12, 3 T 384). None of the defendant doctors, other than Dr. Morrison, were found negligent. (LF 113; A25).

Although respondent was able to continue working at his job repairing appliances, respondent claimed that he was damaged in receiving the muscle flap repair in that it affected him in his daily activities and work. (4 T 556, 559). Respondent testified that he would experience pain in the sternal area when sleeping, laughing, and hiccupping. (4 T 556-58). He also stated that he was unable to play with his children like he used to, and was subject to a lifting

limitation of 10 to 20 pounds. (4 T 558). Respondent claimed that the muscle flap repair procedure "ruined" his life. (4 T 565).

Trial was held in August of 2006. (LF 23-24). Dr. Morrison moved for a directed verdict at the close of all the evidence, which included a specific request for a directed verdict on the issue of January 12th, but the trial court denied the motion. (9 T 1312, 1318; LF 96-98). The jury returned a negligence verdict against Dr. Morrison alone for money damages. (LF 113; A25-26). Dr. Morrison moved for a judgment notwithstanding the verdict and for a new trial but the court denied the motions. (LF 116-119, 120-123, 164; A20). He then filed an appeal with the Missouri Court of Appeals, Southern District. (LF 165).

On October 16, 2008, the Court of Appeals, Southern District issued an Opinion reversing the judgment entered in favor of respondent and remanding the case for new trial. (Op. 9). This Court sustained respondent's Application for Transfer on December 16, 2008.

POINTS RELIED ON

I. The trial court erred in denying Dr. Morrison's motion for directed verdict at the close of all evidence and for JNOV because respondent failed to make a submissible case on the causation-in-fact element of his medical malpractice claim in that respondent's evidence failed to show that "but for" Dr. Morrison's failure to diagnose respondent's sternal dehiscence, respondent would have undergone or had the

option of a surgical repair other than the pectoralis muscle flap procedure that he actually received.

Callahan v. Cardinal Glennon Hospital, 863 S.W.2d 852 (Mo. 1993)

Wicklund v. Handoyo, 181 S.W.3d 143 (Mo. App. 2005)

Lindquist v. Scott Radiological Group, Inc., 168 S.W.3d 635 (Mo. App. 2005)

Gulley v. Werth, 61 S.W.3d 293 (Mo. App. 2001)

II. The trial court erred in denying Dr. Morrison's motion for directed verdict at the close of all evidence and for JNOV with respect to Dr. Morrison's alleged failure to diagnose on January 12, 1990 because respondent failed to make a submissible case on the causation-in-fact element of his medical malpractice claim as to that date in that respondent's evidence failed to show that "but for" Dr. Morrison's conduct on January 12, respondent would have undergone or had the option of a surgical repair procedure other than the muscle flap procedure that he actually received.

Callahan v. Cardinal Glennon Hospital, 863 S.W.2d 852 (Mo. 1993)

Lindquist v. Scott Radiological Group, 168 S.W.3d 635 (Mo. App. 2005)

Gulley v. Werth, 61 S.W.3d 293 (Mo. App. 2001)

III. The trial court erred in submitting respondent's verdict director against Dr. Morrison (Instruction No. 11) because it failed to track respondent's theory of the case as established at trial and therefore constituted a prejudicial roving commission in that the jury was impermissibly allowed to make a finding of liability for failing to utilize "rigid fixation," an amorphous term that was not supported by evidence offered at trial, was not limited to procedures recommended by respondent's expert witness, and included a procedure that respondent's expert witness expressly testified would have been inappropriate for respondent.

Mast v. Surgical Serv. of Sedalia, L.L.C., 107 S.W.3d 360, 374 (Mo. App. 2003) (*overruled on other grounds by Marion v. Marcus*, 199 S.W.3d 887 (Mo. App. 2006))

Grindstaff v. Tygett, 655 S.W.2d 70 (Mo. App. 1983)

Stone v. Duffy Distribs., Inc., 785 S.W.2d 671, 678 (Mo. App. 1990)

Powderly v. South County Anesthesia Associates, 245 S.W.3d 267 (Mo. App. 2008)

IV. The trial court erred in submitting Instruction No. 15 on damages because it allowed the jury to award damages against one defendant for injury not caused by that defendant in that it stated the jury could

accumulate and award damages against one defendant for injuries caused by one or more other defendants.

Powderly v. South County Anesthesia Assoc., 245 S.W.3d 267 (Mo. App. 2008)

Grindstaff v. Tygett, 655 S.W.2d 70, 74 (Mo. App. 1983)

Mast v. Surgical Serv. of Sedalia, L.L.C., 107 S.W.3d 360, 374 (Mo. App. 2003)

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

V. The trial court erred in submitting the verdict form because the form failed to follow the directly applicable MAI 36.21 and instead improperly modified the verdict form in that one-sided references to respondent's verdict directors were inserted into the form, thereby emphasizing those instructions to the exclusion of all others.

Powderly v. South County Anesthesia Assoc., 245 S.W.3d 267 (Mo. App. 2008)

State ex rel. State Highway Comm'n v. Beaty, 505 S.W.2d 147, 154 (Mo. App. 1974)

Mo. R. Civ. P. 70.02(b)

MAI 36.21

ARGUMENT

I. The trial court erred in denying Dr. Morrison's motion for directed verdict at the close of all evidence and for JNOV because respondent failed to make a submissible case on the causation-in-fact element of his medical malpractice claim in that respondent's evidence failed to show that "but for" Dr. Morrison's failure to diagnose respondent's sternal dehiscence, respondent would have undergone or had the option of a surgical repair other than the pectoralis muscle flap procedure that he actually received.

Standard of Review

The standard of review for denial of a motion for JNOV and for a directed verdict is whether the plaintiff made a submissible case. *Scott v. Blue Springs Ford Sales, Inc.*, 215 S.W.3d 145, 184 (Mo. App. 2006). This determination is a matter of law, and the trial court's decision is reviewed de novo. *Envtl. Prot., Inspection, & Consulting, Inc. v. City of Kansas City*, 37 S.W.3d 360, 369 (Mo. App. 2000).

To make a submissible case, a plaintiff must present substantial evidence to support each element of the claim, and the evidence is viewed in the light most favorable to the party who obtained the verdict. *Coonrod v. Archer-Daniels-Midland Co.*, 984 S.W.2d 529, 532 (Mo. App. 1998). The court gives the plaintiff the benefit of all reasonable favorable inferences, disregarding defendant's

evidence except insofar as it may aid the plaintiff's case. *Id.* at 532-33. The court does not supply missing evidence or give plaintiff the benefit of unreasonable, speculative, or forced inferences. *Id.* at 533. Evidence and inferences therefrom must substantiate each element and not leave any issue to speculation. *Id.*

Argument

"[I]n order to make out a prima facie case of medical malpractice, the plaintiff must establish the following three elements: (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. 2005). To satisfy the causation element of the prima facie case, a plaintiff must establish that the defendant's conduct was both: (1) the cause-in-fact; and (2) the proximate, or legal, cause of the injury. *Id.* at 149.

In all but those rare cases where two independent forces concur to cause an injury, causation-in-fact is evaluated through the familiar "but for" test. *Callahan v. Cardinal Glennon Hospital*, 863 S.W.2d 852, 860-862 (Mo. 1993). In *Callahan*, a medical malpractice case, this Court confirmed the necessity of proving "but for" causation:

> 'But for' is an absolute minimum for causation because it is merely causation in fact. Any attempt to find liability absent actual causation is an

> attempt to connect the defendant with an injury or event that the defendant had nothing to do with. Mere logic and common sense dictate that there be some causal relationship between the defendant's conduct and the injury or event for which damages are sought.

Id. at 862. Missouri appellate courts consistently hold that a plaintiff who does not establish "but for" causation in a medical malpractice case fails to make a prima facie or submissible case. *See Lindquist v. Scott Radiological Group*, 168 S.W.3d 635 (Mo. App. 2005); *Gulley v. Werth*, 61 S.W.3d 293 (Mo. App. 2001); *Mueller v. Bauer*, 54 S.W.3d 652 (Mo. App. 2001); *Super v. White*, 18 S.W.3d 511 (Mo. App. 2000).

The "but for" causation test provides that a defendant's conduct is a cause of the event if the event would not have occurred "but for" that conduct. *Callahan*, 863 S.W.2d at 860-61. "More specifically, in failure-to-diagnose medical malpractice cases, causation is established through expert testimony 'that there is a reasonable degree of medical or scientific certainty' that defendant's negligence caused the harm." *Wicklund*, 181 S.W.3d at 149. "On the other hand, when an expert merely testifies that a defendant's action or inaction *might* or *could have* yielded a certain result, such testimony is 'devoid of evidentiary value' and fails to establish causation." *Id.* (emphasis in original).

Respondent herein was required to present substantial evidence that "but for" Dr. Morrison's failure to make an earlier diagnosis of sternal dehiscence ("defendant's conduct") respondent would not have received the muscle flap repair procedure, or he would have been presented with the option of either the rib-transfer or methyl-methacrylate procedures ("the injury"). Dr. Morrison challenged the submissibility of respondent's case on causation numerous times at trial. (*See* LF 93, 96, 116, 120; 5 T 614; 9 T 1312). Respondent did not establish the required causal connection for two primary reasons.

First, respondent relied solely on the expert testimony of Dr. William Flye to purportedly show the needed causal connection between the "injury" and the "defendant's conduct." However, Dr. Flye's testimony did not establish the required connection. Dr. Flye's testimony was inherently self-contradictory regarding the importance of the timing of the sternal dehiscence diagnosis. His testimony was also overly speculative regarding the allegedly available alternative repair procedures.

Second, even apart from Dr. Flye's deficient testimony, respondent did not establish the requisite causal connection because he did not show that Dr. Geter, the Springfield surgeon who performed the muscle flap procedure, would have performed – or even offered to perform – one of Dr. Flye's claimed alternative repair procedures "but for" Dr. Morrison's conduct. The only evidence presented

was that Dr. Geter, in his independent and non-negligent professional judgment, would have performed the same muscle flap procedure regardless of the date on which respondent was diagnosed with a sternal dehiscence. The muscle flap was the "state of the art" repair procedure in 1990, and remained so at the time of trial. (6 T 905).

A. Dr. Flye: Inherently Self-contradictory and Overly Speculative

1. Self-contradiction in timing

Dr. Flye's testimony is inherently self-contradictory regarding whether an earlier diagnosis by Dr. Morrison would have made any difference in the repair of respondent's sternum. It is well settled in Missouri that self-contradictory evidence does not constitute sufficient evidence of causation. *See Wicklund*, 181 S.W.3d at 150-51; *Yoos v. Jewish Hosp. of St. Louis*, 645 S.W.2d 177, 185 (Mo. App. 1982); *Griggs v. A.B. Chance Co.*, 503 S.W.2d 697, 703-04 (Mo. App. 1973); *ITT Commercial Finance Corp. v. Mid-America Marine Supply Corp.*, 854 S.W.2d 371, 382 (Mo. banc 1993) (self-contradictory evidence on a material fact is defective and fails to establish a prima facie case as a matter of law). The court must consider expert testimony as an integrated whole *unless* it is inherently self-contradictory. *Wicklund*, 181 S.W.3d at 151 (emphasis added); *see also Odum v. Cejas*, 510 S.W.2d 218, 223 (Mo. App. 1974).

Dr. Flye testified that the timing of a diagnosis and treatment of sternal dehiscence matters only when treating an infected sternum. (2 T 301-302). The earlier an infected sternum is diagnosed, the better the chance of saving a living sternum from the infection. (2 T 301). Respondent's sternum was not infected; it was necrotic, dying and liquefying. (2 T 301). The sternum began to die the moment of sternotomy as the blood supply was diverted to respondent's heart. Therefore, according to Dr. Flye's own testimony, the timing of the treatment did not matter:

> That part of the sternum was no longer there to be saved. And *even if you had operated early* dead bone doesn't heal, so you would have to debride away dead bone and then you're left with a defect, and then you have to fill it with something even if there's no infection.

(2 T 302) (emphasis added). When asked on direct examination about the timing of the treatment of respondent's necrotic sternum, Dr. Flye states that respondent's chest could have been repaired at "any time":

> Q. …. But again, just focusing on timing, if it is an avascular necrosis like [plaintiff] had, and stays sterile and there's no interruption with an infection coming down from the skin incision or anything, what about the timing? When, along this time frame, August [respondent's bypass surgery] to January [respondent's muscle flap repair procedure], could a reasonable

attempt to repair his chest – the sternum can't be saved, it's gone, but to repair his chest, when can that occur?

A. Well, *that can occur at any time during this spectrum*. The longer you wait, the longer he sort of goes through the uncertainty. And when you have dead tissue, then there's a nidus for possible infection. So you don't want to leave dead tissue around because that can create a problem.

(2 T 302-03) (emphasis added). Thus, Dr. Flye's testimony on direct examination was that the timing of the repair *did not matter* because it was necrotic, rather than infected. Therefore, repair could have been done at "any time" along the spectrum of August 1989 to January 1990 (when it was done). This testimony cuts *against* respondent's claim that an earlier diagnosis of sternal dehiscence by Dr. Morrison would have, in fact, made a difference in treatment and repair.[5]

On redirect examination, Dr. Flye contradicted his previous testimony about the effect of timing in diagnosing and repairing a necrotic sternum. In response to a question about his overall opinion of what happened to respondent over the course of his treatment by Dr. Morrison, Dr. Flye testified:

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[5] Also supporting this testimony that the timing of the repair *does not matter* when a sternum is not infected was the testimony of Dr. Rogers, the physician who diagnosed plaintiff's sternal dehiscence on January 15, 1990. (9 T 1214, 1217).

That warning signs were missed and ignored, and proper studies were not performed in a timely fashion to pick this up in an early fashion so that you could diagnose a necrotic sternum that was not infected and therefore could be repaired to restore structural integrity of the skeleton, yes.

(3 T 384).

In yet another contradiction, Dr. Flye offered testimony that respondent still had the option of having a rib transfer or methyl- methacrylate procedure *at the time of trial*:

Q. You've educated us and shared with us the options that with earlier recognition by Dr. Morrison would have been available for Ed to obtain a solid repair. Does he have that option today?

A. For a solid repair?

Q. Yes.

A. He's gotten coverage of the wound now, and that's a major achievement. To establish structural integrity you'd have to now embark on a new operation to take bone and put it into the muscle flaps. *That could be done but, you know, it would have been much easier to do it initially*. And it means another invasion of somebody who has risk factors of being overweight, a breathing problem, previous heart disease, all those things, and that's a risk now, anesthesia from a major operation, and the morbidity;

that is the limitations from the taking the rib, doing the operation. So, you know, I would really, seriously, not consider doing that.

(2 T 318-19) (emphasis added). Dr. Flye's testimony that a rib transfer or methyl-methacrylate procedure could be done at the time of trial, over 17 years after the bypass surgery, highlights the utter absence of evidence of "but for" causation. Dr. Flye states that such a procedure would be a present risk based on respondent's health complications; but those health problems, which were not caused by Dr. Morrison's conduct or by the muscle flap procedure, were present 17 years ago. If it remains possible for respondent to have a rib transfer or methyl-methacrylate procedure 17 years later, subject to attendant risks that are unrelated to Dr. Morrison's conduct and which were equally present, a diagnosis between September 1989 and January 1990 could not have mattered.

It is inherently self-contradictory for Dr. Flye to state that timing only matters in diagnosing and treating an infected sternum but *not* a necrotic sternum, and then state that the timing of the diagnosis and treatment of respondent's necrotic sternum *did* somehow matter. It is also a contradiction to state that a surgical repair procedure could have happened at "any time" between August 1989 and January 1990 – even up to the time of trial, and then state that an "earlier" diagnosis was necessary to restore structural integrity of the skeleton. Because Dr. Flye offered inherently self-contradictory testimony regarding the

claimed difference that an earlier diagnosis may have made for respondent's repair procedure options, his testimony did not provide substantive evidence of causation-in-fact.

2. Speculation as to other repair procedures

Dr. Flye's testimony is far too speculative to provide substantial evidence of causation-in-fact under Missouri law. Dr. Flye testified that, in his opinion, there were two specific alternative repair procedures that would have been preferable to the muscle flap procedure, and that either of these could have been performed on respondent. The first alternative repair procedure Dr. Flye suggested was the "rib transfer" procedure: Removing a lower rib and using it to form a "strut" to reconnect the bone on either side of the sternum. (2 T 306-07). The second alternative repair procedure Dr. Flye suggested was the "methyl-methacrylate" procedure: Using a synthetic mesh material structure, "impregnated" with methyl-methacrylate, to close the sternum. (2 T 307, 3 T 368).

Respondent did not offer substantial evidence that the rib transfer or methyl-methacrylate procedures were widely used in similar cases for repair of sternal dehiscence. Viewing the testimony in the light most favorable to respondent, Dr. Flye claimed to have performed each of these procedures *once* in his career for repair of a sternal dehiscence following a sternotomy. (3 T 353-54,

368, 370-71). Dr. Flye did not identify any specific professional literature approving the use of the rib transfer or methyl-methacrylate procedures for the repair of sternal dehiscence. There was no evidence that other surgeons consider either one to be a standard, recognized procedure for the repair of sternal dehiscence. The testimony of the other doctors did not support the availability of alternative repair procedures; the other surgeons testified that the muscle flap procedure is the state of the art repair procedure. (5 T 663, 6 T 905). Similarly, no doctor, other than Dr. Flye, acknowledged any awareness of using the rib transfer or methyl-methacrylate procedures to repair a constantly moving bone such as the sternum. Nor was respondent's case aided by Dr. Geter, who testified that due to respondent's poor overall health and due to the nature of the sternum bone which needs to move during normal activities like breathing, that he would not have used the rib transfer or methyl-methacrylate procedures to treat respondent's sternal dehiscence because both procedures would have presented a dangerous risk of infection by introducing foreign objects into the body. (6 T 891-96).

In essence, Dr. Flye's testimony purports to supply evidence of causation by suggesting that had Dr. Morrison made an earlier diagnosis of sternal dehiscence, Dr. Morrison *might* have referred respondent to St. Louis to Dr. Flye for a procedure – either rib transfer or methyl-methacrylate – that Dr. Flye had

performed once, a procedure which no other surgeon recognized for use in the repair of sternal dehiscence. This constitutes little more than conjecture. No reasonable inference could be drawn from Dr. Flye's testimony that a patient with a sternal dehiscence (who went to any surgeon other than Dr. Flye [who himself had not performed cardiac surgery for 10 years prior to trial (3 T 351)]) would have been considered for a rib transfer or methyl-methacrylate procedure. There was no reasonable inference that respondent, who resided in Springfield, Missouri, would have been referred to Dr. Flye in St. Louis for such a procedure. Such unwarranted and unlikely inferences do not establish to a "reasonable degree of medical certainty" that Dr. Flye's alternative repair procedures would have been performed or offered "but for" Dr. Morrison's conduct.

The Court of Appeals noted additional speculation in Dr. Flye's testimony when they observed that "Dr. Flye did not explain how Dr. Morrison's having performed the original sternotomy on Edgerton would have given him the unique ability to more quickly (than any other doctor) determine weeks later that Edgerton's dehiscent sternum was not infected…" (Op. 4). Dr. Morrison did not see respondent between September 5, 1989 and January 12, 1990. Dr. Flye did not offer a shred of evidence to support his blanket assertion that Dr. Morrison would have been in a better position than any other physician to have known that respondent's sternum was not infected in January 1990 simply because he

operated on respondent in August 1989. Since there was no evidence offered, there can be no reasonable inference supposed to support this proposition. The law requires that each element of plaintiff's claim for negligence be supported by evidence or reasonable inferences therefrom and that plaintiff's evidence not leave an issue to speculation. *Coonrod*, 984 S.W.2d 529, 533 (Mo. App. 1998). The court does not, in evaluating causation, supply missing evidence or give plaintiff the benefit of speculative inferences. *Id*. Here, all that exists is speculation, unexplained, unsubstantiated and unsupported. Respondent attempts to saddle Dr. Morrison with liability simply by labeling him omniscient. More is required.

There was also no evidence to support Dr. Flye's assertion that Dr. Morrison, with his unexplained clairvoyant knowledge, would have performed, or referred respondent to a surgeon who would have performed, a rib-transfer or methyl-methacrylate procedure. The only evidence developed regarding this issue supports the opposite. Dr. Morrison has never had one of his patients receive a rib-transfer or methyl-methacrylate. (8 T 1157). He has never heard of anyone that has done either procedure, had it done to one of their patients, or knew of another surgeon that had had it done in a person in respondent's situation, i.e., a post coronary bypass patient. (8 T 1158). Dr. Morrison would advise against both of these procedures as they increase infection risk and do not

provide blood flow. (8 T 1158-59). Dr. Flye's opinion was not supported by any evidence; it was proven false by the evidence.

Each facet of Dr. Flye's testimony is appropriately characterized as unsupported speculation. His opinions were conclusively demonstrated to constitute inaccurate conjecture. Respondent failed to meet his burden of establishing that Dr. Morrison's conduct had any causal connection to respondent's outcome. The evidence at trial established it did not. Dr. Flye's testimony did not and cannot establish causation.

B. Dr. Geter: The Muscle Flap Procedure for Respondent Regardless

The events that unfolded after the diagnosis of respondent's sternal dehiscence on January 15, 1990 confirm that Dr. Flye offered utter speculation in lieu of a professional opinion to a reasonable degree of medical certainty. Upon diagnosis by Dr. Rogers, respondent was referred to Dr. Geter, the "go to" doctor in Springfield for repair of sternal non-unions. (6 T 890). Dr. Geter testified unequivocally that he would have used a muscle flap procedure *regardless* of whether Dr. Morrison had made an earlier diagnosis:

> Q. If someone were to say to you this would all have been different, boy, if Dr. Morrison had figured out Mr. Edgerton had a dehiscence in say October

or November or December, and sent the patient to you, you could then have used methyl-methacrylate or a rib, would that be accurate?

A. No, I would do the same procedure that I did whatever the time line would be.

Q. If this patient is sent to you for repair, he's going to get the pectoralis flap?

A. Not necessarily. There are other flaps that can be used: Rectus muscle from the abdomen can be used, or omentum from around the bowel can be brought up and put between the edges of the sternum and the skin graft place, so there are other options. But the best is the pectoralis for him, and that's what I chose.

(6 T 896). And again:

Q. You're going to do this flap procedure either way, infected or not infected?

A. That's right.

(6 T 901).

The mere fact that injury follows negligence does not necessarily create liability. *Odum*, 510 S.W.2d at 222. A causal connection must be established between the negligence charged or submitted and the loss or injury sustained. *See id*. Respondent cannot establish the requisite causal connection in this case

because the event he suffered – receiving the muscle flap procedure without the option of a rib transfer or methyl-methacrylate procedure – would have happened whether Dr. Morrison had made an earlier diagnosis.

The instant case is similar to *Gulley v. Werth*, in which the court determined that the respondent's case failed to establish causation-in-fact when the injurious event would have occurred regardless of the doctor's putative negligence. *See* 61 S.W.3d 293 (Mo. App. 2001). In *Gulley*, the defendant psychiatrist wrote a letter in support of the involuntary commitment of the plaintiff, although he had not seen the plaintiff for three weeks. *Id.* at 295, 298. The plaintiff's husband used the psychiatrist's letter to have the plaintiff involuntarily committed following threats she made against her husband and herself. *Id.* at 295. The plaintiff was released from care a few days later when doctors at her facility determined she was inappropriately committed. *Id.* at 296. The plaintiff brought suit against the psychiatrist for medical malpractice. *Id.* at 294. The trial court directed a verdict for the defendant, stating that plaintiff had not made a submissible case. *Id.* at 294, 296.

The court affirmed the directed verdict against the plaintiff, noting the absence of sufficient evidence of causation. *Id.* at 298-99. The plaintiff argued that "but for" the psychiatrist's failure to meet with plaintiff before preparing the

letter for her husband, she would not have been involuntarily committed. *Id.* at 298. Rejecting her argument the court stated:

> There is little basis for an inference that [psychiatrist]'s opinion would have been different had he seen [plaintiff] face to face before writing his letter. He had been made aware by both the Sheriff or his deputies and [plaintiff's husband] that there had been an altercation the night previously. He had seen [plaintiff] less than a month earlier and had been treating [plaintiff] for over a year prior thereto. He was fully aware of her hostility toward [husband].

Id. at 299. The court denied that the plaintiff had substantial evidence that the psychiatrist's conduct, writing the letter without first seeing his patient, caused his patient's detention. *See id.*

As with the plaintiff in *Gulley*, respondent in the instant case does not have substantial evidence that "but for" Dr. Morrison's failure to diagnose his sternal dehiscence, respondent would not have received the muscle flap procedure from Dr. Geter. Viewing the testimony in the light most favorable to respondent, Dr. Flye purports to provide the substantial evidence of "but for" causation by offering his opinion that *if* Dr. Morrison had made an earlier diagnosis, *then* he, with his superior knowledge as the operating surgeon five months previously, would have known that respondent's sternum was not infected. (2 T 310-11).

With Dr. Morrison's knowledge that there was no infection, argues Dr. Flye, Dr. Morrison could have referred respondent to a colleague who could perform a rib transfer or methyl-methacrylate procedure. (2 T 306-10).

There is no reasonable inference that a rib transfer or methyl-methacrylate would have been performed or offered by Dr. Geter with this unexplained, extraordinary knowledge by Dr. Morrison that respondent's sternum was not infected. Again, no surgeon testified in support of Dr. Flye's alternative procedures for an uninfected sternum. Any suggestion that such a repair would have been offered or performed was controverted by the testimony of Dr. Geter. Dr. Geter testified unequivocally that he would not recommend Dr. Flye's alternative procedures and that he would have closed respondent's sternum using a muscle flap procedure *regardless* of when the diagnosis was made, and *regardless* of whether an infection was present. (6 T 896, 901). Dr. Geter testified that the repair procedures suggested by Dr. Flye would be contraindicated and "the wrong thing to do" as there would be a risk of infection associated with a foreign body material that would be dangerous to respondent's life. (6 T 892-893, 6 T 894-896). The selection of the muscle flap procedure to repair respondent's sternum was the result of Dr. Geter's own independent, professional judgment as to the proper surgical repair procedure – *a judgment that respondent did not allege to be negligent*.

Respondent failed to provide substantial evidence that Dr. Geter, or any other surgeon, would have performed or offered anything other than the muscle flap procedure but for Dr. Morrison's conduct. Furthermore, respondent's case was not aided by the testimony of Dr. Geter or any other doctor that testified. Thus, respondent failed to prove that Dr. Morrison's conduct, rather than Dr. Geter's independent, non-negligent, professional judgment, was the cause-in-fact of the muscle flap procedure repair that respondent received.

This error of law requires that the judgment be reversed and judgment be entered in favor of Dr. Morrison.

II. The trial court erred in denying Dr. Morrison's motion for directed verdict at the close of all evidence and for JNOV with respect to Dr. Morrison's alleged failure to diagnose on January 12, 1990 because respondent failed to make a submissible case on the causation-in-fact element of his medical malpractice claim as to that date in that respondent's evidence failed to show that "but for" Dr. Morrison's conduct on January 12, respondent would have undergone or had the option of a surgical repair procedure other than the muscle flap procedure that he actually received.

Standard of Review

The standard of review for the denial of a motion for JNOV and for a directed verdict is whether the plaintiff made a submissible case. *Scott v. Blue*

Springs Ford Sales, Inc., 215 S.W.3d 145, 184 (Mo. App. 2006). This determination is a matter of law, and the trial court's decision is reviewed de novo. *Envtl. Prot., Inspection, & Consulting, Inc. v. City of Kansas City*, 37 S.W.3d 360, 369 (Mo. App. 2000).

To make a submissible case, a plaintiff must present substantial evidence to support each element of the claim, and the evidence is viewed in the light most favorable to the party who obtained the verdict. *Coonrod v. Archer-Daniels-Midland Co.*, 984 S.W.2d 529, 532 (Mo. App. 1998). The court gives the plaintiff the benefit of all reasonable favorable inferences, disregarding defendant's evidence except insofar as it may aid the plaintiff's case. *Id.* at 532-33. The court does not supply missing evidence or give plaintiff the benefit of unreasonable, speculative, or forced inferences. *Id.* at 533. Evidence and inferences therefrom must substantiate each element and not leave any issue to speculation. *Id.*

Argument

Even assuming some portion of respondent's claim against Dr. Morrison was submissible on causation, the trial court erred by submitting any claim of negligence against Dr. Morrison for failure to diagnose on January 12, 1990. Dr. Morrison's failure to diagnose *on that date,* according to the testimony of respondent's own expert, was *not* the cause-in-fact of any outcome respondent experienced.

In all but those rare cases where two independent forces concur to cause an injury, causation-in-fact is evaluated through the familiar "but for" test. *Callahan v. Cardinal Glennon Hospital*, 863 S.W.2d 852, 860-862 (Mo. 1993). The "but for" causation test provides that the defendant's conduct is a cause of the event if the event would not have occurred "but for" that conduct. *Callahan*, 863 S.W.2d at 861-62. Missouri appellate courts consistently hold that a plaintiff who does not establish "but for" causation in a medical malpractice case fails to make a prima facie or submissible case. *See Lindquist v. Scott Radiological Group*, 168 S.W.3d 635 (Mo. App. 2005); *Gulley v. Werth*, 61 S.W.3d 293 (Mo. App. 2001); *Mueller v. Bauer*, 54 S.W.3d 652 (Mo. App. 2001); *Super v. White*, 18 S.W.3d 511 (Mo. App. 2000).

Regarding Dr. Morrison's failure to diagnose respondent's sternal dehiscence on the specific date of January 12, 1990, respondent failed to establish causation-in-fact at the most basic level. Dr. Morrison challenged the submissibility of respondent's case on this causation issue throughout the trial. (*See* LF 93, 96, 116, 120; 5 T 614, 9 T 1312).

Respondent relied solely on the expert testimony of Dr. Flye to establish a causal connection between Dr. Morrison's conduct on January 12, 1990 and the repair procedure used on respondent's sternum. That testimony failed to establish causation, and, indeed, affirmatively established and proved a lack of causation.

Dr. Flye unequivocally verified that Dr. Morrison's conduct on January 12, 1990 had *no effect* on respondent's outcome:

> Q. Let's talk about a few timings. Let's take it to the end. January 12th, Dr. Morrison sees the patient, right?
>
> A. Yes.
>
> Q. At that point nothing's going to change at that point. That fact that he wasn't operated January 12th and he it was January 15th, a week or five days in January doesn't make a difference in the patient's outcome, fair?
>
> A. *Yes*, and absolutely amazed that Dr. Rogers could make that diagnosis at that point and several days before that Dr. Morrison couldn't, *but the outcome in that few days was not changed*.

(3 T 358) (emphasis added). Dr. Flye testified that Dr. Morrison's conduct on January 12, 1990 had *no effect* on the outcome; therefore, Dr. Morrison's conduct on that date could not have been the cause-in-fact of the injurious event. Even viewing this testimony in the light most favorable to respondent, Dr. Flye's testimony disproves "but for" causation. It actually demonstrates its absence.

Respondent failed to make a submissible case of medical malpractice against Dr. Morrison for his conduct on January 12, 1990. Because there was no basis on which to submit any claim of medical malpractice against Dr. Morrison

for his conduct on January 12, 1990, the trial court erred when it denied Dr. Morrison's motions for directed verdict and JNOV as to that specific date.

This error of law requires that the judgment be reversed and that any remaining submissible claim of negligence against Dr. Morrison be remanded for a new trial, free from the prejudicial effect of allegations of negligence in the case that had no causal connection to the respondent's outcome.

III. The trial court erred in submitting respondent's verdict director against Dr. Morrison (Instruction No. 11) because it failed to track respondent's theory of the case as established at trial and therefore constituted a prejudicial roving commission in that the jury was impermissibly allowed to make a finding of liability for failing to utilize "rigid fixation," an amorphous term that was not supported by evidence offered at trial, was not limited to procedures recommended by respondent's expert witness, and included a procedure that respondent's expert witness expressly testified would have been inappropriate for respondent.

Standard of Review

This Court reviews claims of instructional error de novo. *Powderly v. South County Anesthesia Assoc.*, 245 S.W.3d 267 (Mo. App. 2008). A reviewing court evaluates whether, in the light most favorable to the party submitting the instruction, the instruction was supported by both the evidence and the law. *Id.*

To reverse on grounds of instructional error, the party challenging the instruction must show that it misdirected, misled or confused the jury, and that prejudice resulted. *Id.*

"When an erroneous instruction is given and the trial results in favor of the party at whose instance it was given, the presumption is that the error was prejudicial." *Grindstaff v. Tygett,* 655 S.W.2d 70, 74 (Mo. App. 1983) (citing *Moloney v. Boatmen's Bank,* 288 Mo. 435, 232 S.W. 133, 140 (1921)). Prejudice must exist and be overwhelming to a degree of confusing or misleading the jury. *Mast v. Surgical Serv. of Sedalia, L.L.C.,* 107 S.W.3d 360, 374 (Mo. App. 2003), (*overruled on other grounds, Marion v. Marcus,* 199 S.W.3d 887 (Mo. App. 2006)). When a verdict director does not follow substantive law, it misdirects the jury and reversal is proper. *See Durley v. Board of Police Com'rs ex rel. City of St. Louis*, 238 S.W.3d 685 (Mo. App. 2007). When it materially affects the outcome, prejudice exists and reversal is effected. *See Ploch v. Hamai,* 213 S.W.3d 135 (Mo. App. 2006).

Argument

Respondent tendered and the trial court gave the following verdict director:

INSTRUCTION NUMBER 11

Your verdict must be for plaintiff Ed Edgerton and against Stephen Morrison, M.D. and Ferrell-Duncan Clinic, Inc. if you believe:

First, defendant Stephen Morrison, M.D. failed to diagnose and treat Ed Edgerton's unhealed sternum with rigid fixation on or after September 5, 1989, and

Second, defendant Stephen Morrison, M.D. was thereby negligent, and

Third, such negligence directly caused or directly contributed to cause damage to plaintiff Ed Edgerton.

(LF 107; A23). At the instruction conference, (10 T 7-8), and again in the motion for new trial (LF 121, 144-146), Dr. Morrison objected to this instruction on the basis that it constituted a roving commission, allowing the jury to find him negligent on a basis other than that supported by the evidence. The term "rigid fixation" encompasses a repair (sternal rewiring) that was discussed at trial, but rejected by respondent's expert as available to respondent, and also encompasses any repair that the jury could divine to constitute "rigidity," as the word is commonly understood. The resulting prejudice to Dr. Morrison was overwhelming, and was exploited by respondent's counsel in closing argument.

In medical malpractice cases, verdict directors must track plaintiff's expert's testimony developed at trial. Because jurors lack a common understanding of medicine, the law requires plaintiffs to prove negligence through expert witnesses who explain unequivocally and specifically how the doctor fell

below the standard of care. *See Mast*, 107 S.W.3d at 367. Verdict directors that follow expert testimony are proper as they do not permit the jury to find for plaintiffs on facts different than those proved at trial. *Id.* at 368. Verdicts entered in cases on a verdict director allowing the jury to find liability against a physician for reasons not recommended by a plaintiff's expert or established by the expert at trial are improper and routinely reversed. *See, e.g.*, *Mast*, 107 S.W.3d 360; *Grindstaff*, 655 S.W.2d 70.

In *Mast*, the court held the trial court did not err in refusing to submit verdict directors that failed to track plaintiff's expert's testimony developed at trial because the proffered instruction would have allowed the jury to find liability against the physician for failing to prescribe a treatment that plaintiff's own expert witness did not recommend. *Mast*, 107 S.W.3d at 370. The court approved the submitted jury instruction that tracked the specific testimony of plaintiff's expert witness because the instruction ensured that the jury did not have a roving commission to find the doctor liable for failing to prescribe treatments that were not recommended by plaintiff's expert witness.

The *Mast* case involved treating malnutrition. Plaintiff's expert witness ultimately concluded that "the only proper treatment was a very specific type, known as hyperalimentation or 'TPN.'" *Id.* Plaintiff's proffered jury instruction, which the appellate court held to be a roving commission, stated that

"Dr. Braverman should be found liable if he failed '*to treat the malnutrition of Shirley Mast.*'" *Id.* Plaintiff's expert witness testified about other means of supplying nutrition to Mrs. Mast, but the evidence was that he *recommended* one type of treatment. The court held that because plaintiff's case only supported a finding that Dr. Braverman was negligent in "*failing to treat Mrs. Mast with TPN*," the trial court did not err in refusing to submit an instruction that was not limited to that specific treatment. *Id.* at 370. It reasoned that in submitting the instruction plaintiff proposed, it would have allowed a finding of liability against Dr. Braverman for failing to prescribe a treatment that plaintiff's own expert witness did not recommend being used to treat plaintiff.

Grindstaff is also apposite. The court held a verdict director constituted a roving commission and reversed and remanded for a new trial. 655 S.W.2d 70. The verdict director stated that defendant had performed a mid forceps rotation delivery when such procedure was "not medically proper." *Id.* at 72. Defendant alleged that the instruction failed to provide facts that made the mid forceps rotation delivery "not medically proper," thus failing to provide the jury with a factual guideline to determine negligence, constituting a roving commission. *Id.* Expert testimony was established at trial that revealed the conditions under which a procedure may be proper or improper, but those specifics were absent in the verdict director. The court concluded that limiting the verdict director to use of

the terms "not medically proper" was susceptible to many interpretations, including those testified to be proper and improper, and allowed the jury to independently determine why and in what manner the mid forceps rotation procedure was "not medically proper." The court held the verdict director constituted a roving commission, was erroneously misleading, and reversed and remanded based on that error. *Id*. at 74.

The circumstances in both *Mast* and *Grindstaff* are strikingly similar to the instant case. There was testimony throughout the trial that one solution to treat certain sternal non-unions is to re-wire the sternum. (2 T 300-302, 5 T 644, 8 T 1114, 8 T 1155). Re-wiring the sternum does provide a solid or "rigid fixation" because the procedure provides mechanical stability to the bone to knit itself back together, thereby resulting in a solid union. (5 T 684). Dr. Morrison wired respondent's sternum after his cardiac by-pass procedure. This wiring, failed through no fault of Dr. Morrison, to result in a solid union for respondent because his sternal bone died, and therefore, could not hold the wires.

Dr. Flye acknowledged the repair option of treating a sternal non-union by re-wiring the sternum; however, he testified that *re-wiring was not an option for respondent.* (2 T 300-302). To the contrary, Dr. Flye, respondent's only expert to testify against Dr. Morrison, was explicit that, in his opinion, there were only two advisable treatment options available to respondent: 1) rib transfer, or 2) methyl-

methacrylate. (2 T 306-307, 3 T 368). These two options are far narrower than the general, undefined, but all encompassing phrase "rigid fixation" which was submitted to the jury. Because the verdict director did not include any limitation to these two specific treatments, the verdict director constitutes an impermissible roving commission that misdirected the jury requiring the case be remanded for new trial.

The verdict director failed to provide the jury with a factual guideline to determine negligence because it did not track the facts developed at trial. "Rigid fixation" was never defined in the evidence. Dr. Flye, respondent's only expert to testify as to negligence, never spoke the phrase. As the Court of Appeals recognized, "the term "rigid fixation" was never uttered during Edgerton's case-in-chief." Op. 5. The verdict director did not track respondent's expert testimony developed at trial, as required by law, as it did not provide the jury with the opportunity to find for respondent on facts consistent with those proven by respondent's expert testimony; conversely, it instructed them to find against Dr. Morrison based on facts that were never included in the testimony of respondent's expert. It contained a phrase never mentioned in respondent's evidence and instructed the jury to find Dr. Morrison liable for an act that, pursuant to respondent's evidence, was not negligent.

The inclusion of the term "rigid fixation" allowed the jury to find Dr. Morrison liable for not re-wiring respondent's sternum, a proposition that respondent's expert testified, as elicited by respondent's counsel, was not recommended for respondent nor would support liability against Dr. Morrison. The term also is susceptible to numerous interpretations and would include any repair option the jurors could divine to provide a "rigid" sternum, as that word is commonly understood. The verdict director allowed the jurors to determine in what manner "rigid fixation" could have been achieved, thus allowing them to speculate as to how a verdict could be returned. It was respondent's counsel's own discussion with his expert, Dr. Flye, that created this problem. In discussing how to reconstruct the sternum, Dr. Flye responded to respondent's counsel saying "So once you make that diagnosis, you want to cut away all the dead tissue and then reconstruct the integrity of the skeleton. And so '*that can be done in several different ways*'". (2 T 303). To encourage jury's minds to wander and decide for themselves what they were, respondent never clarified what those *several different ways* encompassed. He left it up to the jury to decide the meaning.

The prejudice to Dr. Morrison resulting from the verdict director submitted against him is evident. After listening to testimony about an option that was not recommended for respondent, the jury was then instructed to find Dr. Morrison liable for not exercising that option. At a minimum, appellants should not be

subjected to a finding of liability on a basis that no witness, let alone respondent's expert, testified was negligent. The law does not support that. Non-negligent conduct is not actionable under Missouri law. The verdict director violated substantive law by allowing the jury to find Dr. Morrison liable for a reason not supported by the evidence at trial and actually established to be not negligent. When such a violation occurs, the jury is misdirected, prejudice exists, and reversal is proper. *See Durley*, 238 S.W.3d 685.

Leaving the jury to decipher what "rigid fixation" means in the face of testimony discussing several choices, some of which are available to respondent and some not, results in confusion and misdirection. As *Grindstaff* teaches, when a verdict director includes a term that is not defined, thus giving the jury a roving commission, the instruction is "misleading and confusing and, therefore, prejudicial." 655 S.W.2d at 74.

The prejudice to Dr. Morrison was compounded by respondent's attorney. MAI contemplates that the jury will be properly advised by argument of counsel regarding the factual details needed to understand the instructions. *See Mast*, 107 S.W.3d at 375; *Stone v. Duffy Distribs., Inc.*, 785 S.W.2d 671, 678 (Mo. App. 1990). Respondent's attorney made no attempt to provide those contextual facts to the jury that are necessary for their understanding of the verdict director. Rather than directing the jury in closing argument to the necessary details the jury

must find to support liability, respondent's attorney took refuge in the broad term "rigid fixation." In closing, he argued for a finding of liability on a basis he knew was established to be not negligent, as it included a repair that was not recommended. Instead, he stated specifically that respondent's problem was "he does not have a rigid chest." (10 T 35). By such argument, respondent's attorney compounded the prejudice to Dr. Morrison caused by the erroneous verdict director.

Respondent's verdict director is a classic roving commission. Applying established Missouri law, the Court of Appeals properly characterized it as such and reversed the judgment, remanding the case for a new trial. This case should be retransferred to the Court of Appeals for reinstatement of its Opinion in that regard, or, in the alternative, this Court should reverse the judgment of the trial court and remand the case for a new trial.

IV. The trial court erred in submitting Instruction No. 15 on damages because it allowed the jury to award damages against one defendant for injury not caused by that defendant in that it stated the jury could accumulate and award damages against one defendant for injuries caused by one or more other defendants.

Standard of Review

This Court reviews claims of instructional error de novo. *Powderly v. South County Anesthesia Assoc.*, 245 S.W.3d 267 (Mo. App. 2008). A reviewing

court evaluates whether, in the light most favorable to the party submitting the instruction, the instruction was supported by both the evidence and the law. *Id.* To reverse on grounds of instructional error, the party challenging the instruction must show that it misdirected, misled or confused the jury, and that prejudice resulted. *Id*.

"When an erroneous instruction is given and the trial results in favor of the party at whose instance it was given, the presumption is that the error was prejudicial." *Grindstaff v. Tygett*, 655 S.W.2d 70, 74 (Mo. App. 1983) (citing *Moloney v. Boatmen's Bank*, 288 Mo. 435, 232 S.W. 133, 140 (1921)). Prejudice must exist and be overwhelming to a degree of confusing or misleading the jury. *Mast v. Surgical Serv. of Sedalia, L.L.C.*, 107 S.W.3d 360, 374 (Mo. App. 2003), (*overruled on other grounds*, *Marion v. Marcus*, 199 S.W.3d 887 (Mo. App. 2006)). When a verdict director does not follow substantive law, it misdirects the jury and reversal is proper. *See Durley v. Board of Police Com'rs ex rel. City of St. Louis*, 238 S.W.3d 685 (Mo. App. 2007). When it materially affects the outcome, prejudice exists and reversal is effected. *See Ploch v. Hamai,* 213 S.W.3d 135 (Mo. App. 2006).

Argument

Respondent tendered and the trial court gave the following damage instruction:

INSTRUCTION NUMBER 15

If you find in favor of plaintiff Ed Edgerton, then you must award plaintiff Ed Edgerton such sum as you believe will fairly and justly compensate plaintiff Ed Edgerton for any damages you believe he sustained and is reasonably certain to sustain in the future that the conduct of one or more of the defendants as submitted in Instruction Numbers 7, 9, 11 and 13 directly caused or contributed to cause.

Any damages you award must be itemized by the categories set forth in the verdict form.

(LF 111, A24). At the instruction conference (10 T 11-12) and again in the motion for new trial (LF 121, 147-49), Dr. Morrison objected that the instruction erroneously permitted the jury to assess damages against one defendant for the conduct of another defendant.

Instruction No. 15 was misleading and prejudicially erroneous. It authorized and invited the jury to award against any one defendant damages not caused by that defendant, namely any damage arising from the conduct of one or more other defendants. As if to encourage this result, the instruction cross-referenced all four verdict directors against four different doctors to define the universe of injurious conduct for which damages could be awarded against "one or more of the defendants." Further confirmation that the instruction permitted the

accumulation of damages against one defendant is found in the verdict form, which called for the specification of damages by category but not by defendant. (*See* LF 114).

The substantive law requires: "(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*, 181 S.W.3d at 148-9. The damages instruction violated substantive law by eliminating an essential element required to sustain a verdict. It removed causation from consideration and instructed the jury to find Dr. Morrison liable for his mere association with respondent. It did not require that Dr. Morrison have *caused* damage in order to be liable to respondent; it just required a finding that respondent suffered damage.

The jury was instructed that they "must award plaintiff...such sum as…will fairly and justly compensate plaintiff…for any damages…that the conduct of one or more of the defendants…directly caused or contributed to cause." The error is evident: The jury could have determined that Dr. Morrison did not cause respondent any damage, but perhaps another defendant did. They then were instructed by the court to hold Dr. Morrison liable for it. It is beyond contestation that a physician's conduct and a plaintiff's injury must be causally connected to

support a verdict against a physician in a medical malpractice case. The jury was instructed otherwise, and as such, the judgment must be reversed.

The jury heard evidence of respondent's consultation with various physicians over a period of several months, all of whom the jury exonerated except for Dr. Morrison. Nevertheless, the damage instruction left the jury free to shift any damages associated with the acts of those defendants into Dr. Morrison's column. Given the outcome in the case, there is a substantial likelihood that the jury did precisely that, as the instruction compelled them to do. The prejudice suffered by Dr. Morrison is clear: the universe of conduct for which he could be held liable was expanded beyond that permitted by law.

This error of law requires that the judgment be reversed and the case against Dr. Morrison be remanded for new trial.

V. The trial court erred in submitting the verdict form because the form failed to follow the directly applicable MAI 36.21 and instead improperly modified the verdict form in that one-sided references to respondent's verdict directors were inserted into the form, thereby emphasizing those instructions to the exclusion of all others.

Standard of Review

This Court reviews claims of instructional error de novo. *Powderly v. South County Anesthesia Assoc*, 245 S.W.3d 267 (Mo. App. 2008). A reviewing court evaluates whether, in the light most favorable to the party submitting the

instruction, the instruction was supported by both the evidence and the law. *Id*. To reverse on grounds of instructional error, the party challenging the instruction must show that it misdirected, misled or confused the jury, and that prejudice resulted. *Id*.

"Whenever Missouri Approved Instructions contains an instruction applicable in a particular case that the appropriate party requests or the court decides to submit, such instruction shall be given to the exclusion of any other instructions on the same subject." Rule 70.02(b) (A21); *accord State ex rel. State Highway Comm'n v. Beaty*, 505 S.W.2d 147, 154 (Mo. App. 1974). Given the mandatory nature of the Missouri Approved Instructions, prejudicial error will be presumed when the trial court fails to use an applicable MAI. *Id.*, 505 S.W.2d at 154. The proponent of that instruction has the burden of proving its nonprejudice on appeal. *Id*.

"Where an MAI must be modified to fairly submit the issues in a particular case . . ., then such modifications . . . shall be simple, brief, impartial, free from argument, and shall not submit to the jury or require findings of detailed evidentiary facts." Rule 70.02(b) (A21). MAI contains Notes on Use that are instructive on appropriate and permissible modifications. These must be followed, and the failure to do so may be, and almost invariably is, reversible error. *Beers v. Western Auto Supply Co.*, 646 S.W.2d 812, 814 (Mo. App. 1982); *Wadlow v.*

Lindner Homes, Inc., 722 S.W.2d 621, 629 (Mo. App. 1986). Such a violation is "presumed to be prejudicially erroneous 'unless it is made perfectly clear that no prejudice has resulted.'" *Beers*, 646 S.W.2d at 815.

Argument

The verdict form offered by respondent, and given by the court, was generally patterned after MAI 36.21. However, the verdict form contained a not in MAI addition. The portion of the verdict form relevant to Dr. Morrison is set forth below, with the offending additional language highlighted in bold:

> On the claim of plaintiff Ed Edgerton for personal injuries against Defendants Stephen Morrison, M.D., and Ferrell-Duncan Clinic, Inc., **as submitted in Instruction No. 11**, we, the undersigned jurors, find in favor of:
>
> _____
>
> (Plaintiff Ed Edgerton) or (Defendants Stephen Morrison, M.D., and Ferrell-Duncan Clinic, Inc.)

(LF 113, A25) (emphasis added). Defendants objected to this verdict form at the instruction conference (10 T 13-14) and again in their motion for new trial (LF 121, 149-51).

MAI 36.21 (1988 New) (A27) provided a verdict form directly on point to the instant case. The form of verdict states that it is for use in actions against healthcare providers, where there is a single plaintiff versus multiple defendants, and where there is no apportionment of fault among defendants and no comparative fault. Those criteria for use are precisely on point with this case. Therefore, Rule 70.02(b) mandates that it "shall be given to the exclusion of any other instructions on the same subject." This departure from MAI was erroneous and presumptively prejudicial, so the judgment should be reversed. *See State ex rel. State*, 505 S.W.2d 147.

Even assuming there had been some basis for a modification departing from MAI, the result should be the same. Respondent's inclusion of the phrase "as submitted in Instruction No. 11" highlights for the jurors a single instruction – the respondent's verdict director – among the packet of 16 for their consideration *at the very moment the verdict form is in hand and they are considering their decision*. The verdict form highlights only one specific instruction, to the exclusion of others, on which a verdict may be found *against* Dr. Morrison. This modification failed the test of Rule 70.02(b) that any modification be "impartial" and "free from argument."

The inclusion of the not in MAI phrase converted the verdict form into an instruction of the court, and a de facto mandate to the jury, either to disregard

other instructions or at least to regard Instruction Number 11 as more important. By contrast, the jury was not directed back to Instruction Number 12, which was a true converse instruction that advised the jury of the findings on which they must render a verdict for Dr. Morrison and his employer. Appellants' Instruction No. 12 was not given the benefit of highlight in the verdict form as was Respondent's Instruction No. 11. This modification also would have been improper, just as it was improper to reference respondent's verdict director in the verdict form, but is mentioned to address prejudice. Moreover, the jury was directed away from Instruction Number 6, which defined negligence and is crucial to the jury's understanding of all the instructions. It was erroneous and not "impartial" for the court to have steered the jury away from these other instructions in the verdict form, contrary to the neutral approach mandated by Rule 70.02(b).

In an effort to justify this deviation from an MAI verdict form expressly drafted for and applicable in this action against healthcare providers, respondent could only argue by analogy to instructions in criminal cases. (10 T 6-7). Any suggestion that a criminal instruction, approved or otherwise, should somehow control in a civil action alleging medical malpractice is a non sequitur. (Criminal case instructions have other issues to consider, such as lesser included offenses, etc., that are not applicable in civil case instructions.) Rule 70.02(b) is explicit:

"Whenever Missouri Approved Instructions contain an instruction applicable *in a particular case* that the appropriate party requests or the court decides to submit, such instructions *shall* be given to the exclusion of *any other instruction*s on the same subject." Rule 70.02(b) (emphasis added). This rule does not contemplate or permit the departure from MAI proposed by respondent and accepted by the trial court. MAI and Rule 70.02 establish bright-line rules that are to be followed for the sake of uniformity and predictability in the submission of cases to civil juries. The Committee Comment to the 1996 revision of MAI should have been heeded here:

> You may have the ability to improve an instruction in MAI but you do not have the authority to do it. Do not do it. The use of a provided MAI is mandatory. If you think the change of a word or phrase will make it a better instruction, do not do it. You are falling into error if you do.

Missouri Approved Jury Instructions, Committee Comment (1996 revision), at XLIX (6th Ed. 2002). The trial court here fell into error.

While Dr. Morrison has demonstrated the actual prejudice he suffered as a result of the modification, respondent, as the proponent of this erroneous verdict form, cannot carry his burden to prove nonprejudice. To the contrary, the trial court's error in instructing the jury in the verdict form to focus on a single instruction rather than the instructions as a whole was plainly prejudicial. When a

single instruction purports to be the only instruction on which a verdict may be rendered against a defendant, the prejudice is evident. *See Brown v. St. Louis Public Serv. Co.*, 421 S.W.2d 255 (Mo. banc 1967) (holding that prejudicial error will be presumed when the trial court fails to use an applicable Missouri approved instruction.); *Tillman v. Supreme Exp. & Transfer, Inc.*, 920 S.W.2d 552, 554 (Mo. App. 1996) (trial court committed reversible error by giving a non-Missouri approved instruction when a MAI instruction is available and applicable.); *Epps v. Ragsdale*, 429 S.W.2d 798 (Mo. App. 1968) (plaintiff failed to meet burden of establishing that trial court's failure to give applicable Missouri approved instruction was not prejudicial).

This error of law requires that the judgment be reversed and the case against Dr. Morrison be remanded for new trial.

CONCLUSION

Appellants Stephen K. Morrison, M.D., and Ferrell-Duncan Clinic, Inc. request relief as follows:

With respect to Point I, Appellants request that the judgment be reversed, and that judgment be entered in favor of Appellants.

With respect to Point II, Appellants request that the judgment be reversed, that judgment be entered in Appellants' favor with respect to any act or omission by Appellants occurring on January 12, 1990, and that any remaining claims be remanded for a new trial.

With respect to Points III, IV, and V, and each of them, Appellants request that the judgment be reversed and the case be remanded for a new trial.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

I certify that:

The brief includes the information required by Rule 55.03;

The brief complies with the limitations contained in Rule 84.06(b);

According to the word count function of counsel's word processing software (Microsoft® Word 2002), the brief contains 12,252 words; and

The disk submitted herewith containing a copy of this brief has been scanned for viruses and is virus-free.

_____
Darynne L. O'Neal

CERTIFICATE OF SERVICE

On this 20th day of January 2009, I hereby certify that two copies of the above and foregoing together with a copy of this brief on disk were served by hand-delivery, addressed to:

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_____
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APPENDIX