IN THE SUPREME COURT OF MISSISSIPPI

NO. 2019-CA-00527-SCT

DR. ORHAN ILERCIL

v.

ANGELA WILLIAMS, INDIVIDUALLY AND ON BEHALF OF THE ESTATE OF JAMES R. WILLIAMS, AND ON BEHALF OF THE WRONGFUL DEATH BENEFICIARIES OF JAMES R. WILLIAMS

DATE OF JUDGMENT:	01/24/2019
TRIAL JUDGE:	HON. TOMIE T. GREEN
TRIAL COURT ATTORNEYS:	HEBER S. SIMMONS, III AUBREY BRYAN SMITH, III JOHN ERNEST WADE, JR. ROBERT LANE BOBO WHITMAN B. JOHNSON, III SENICA MANUEL TUBWELL
COURT FROM WHICH APPEALED:	HINDS COUNTY CIRCUIT COURT
ATTORNEYS FOR APPELLANT:	WHITMAN B. JOHNSON, III SENICA MANUEL TUBWELL
ATTORNEYS FOR APPELLEE:	HEBER S. SIMMONS, III AUBREY BRYAN SMITH, III JESSICA LEIGH DILMORE
NATURE OF THE CASE:	CIVIL - WRONGFUL DEATH
DISPOSITION:	REVERSED AND REMANDED - 11/19/2020
MOTION FOR REHEARING FILED:	
MANDATE ISSUED:	

EN BANC.

ISHEE, JUSTICE, FOR THE COURT:

¶1. James Williams suffered a severe brain injury from complications following cervical spine surgery. Suit was brought against the hospital and the surgeon for medical malpractice,

which included a claim for wrongful death after Williams died. Dr. Ilercil was ultimately found to be 15 percent responsible for Williams's injuries and death, which amounted to a judgment against him for $205,800. Dr. Ilercil appeals, contending among other things that the trial court erred by refusing to give an intervening/superseding-cause instruction. We agree, and we reverse and remand the case for a new trial.

FACTS

¶2. On September 4, 2015, Dr. Orhan Ilercil performed an anterior cervical discectomy and fusion and a posterior cervical discectomy and fusion on James Williams at St. Dominic-Jackson Memorial Hospital (St. Dominic). There were no complications during the surgery. In postoperative orders, Dr. Ilercil asked to be notified if Williams showed any signs of shortness of breath, difficulty swallowing, or excessive swelling. Some swelling was brought to Dr. Ilercil's attention shortly after the surgery, but he did not note anything out of the ordinary.

¶3. Several nurses monitored and cared for Williams on a rotation. During the evening of September 5, 2015, the day after the procedure, Nurse Rhonda Howard noticed that Williams's speech was muffled. She documented this change in Williams's condition but did not notify Dr. Ilercil. Williams also experienced trouble swallowing and difficulty breathing. Nurse Howard again documented the changes, but she did not did not notify Dr. Ilercil. Williams was later taken to the radiology department for a CT scan and then returned to his room. He coded shortly thereafter. It was later determined that Williams coded due to a large blood clot that had developed and had cut off his airway. His muffled speech and

difficulty swallowing and breathing were caused by the hematoma as it developed. Medical personnel were able to resuscitate Williams, but he suffered a brain injury that rendered him completely disabled. Dr. Ilercil was notified of Williams's condition after he coded.

¶4. Williams's wife and estate sued St. Dominic and Dr. Ilercil for medical malpractice. St. Dominic settled for $2.5 million, plus another $500,000 contingent on the outcome of the litigation against Dr. Ilercil. Williams died three years after the surgery while the litigation was pending.

¶5. The jury found Williams's damages to be $1.63 million for past pain, suffering, and mental anguish (reduced to $500,000 under the cap on noneconomic damages); $535,000 for medical bills and expenses; $334,000 for care and services; and $3,000 for funeral costs. The jury apportioned 15 percent fault to Dr. Ilercil, and a $205,800 judgment was entered against him.

DISCUSSION

¶6. Dr. Ilercil raises several issues on appeal, but we find one to be dispositive: the trial court refused to allow the jury to consider an instruction on Dr. Ilercil's theory of his case. Instructions for intervening and/or superseding causes have been approved by this Court for so long that a citation is unnecessary. Whenever a defendant offers evidence of acts or failures to act of another that cause a plaintiff's injuries, that defendant is entitled to an intervening/superseding-cause instruction.

¶7. In today's case, Dr. Ilercil presented evidence to the jury that the acts or failures to act of the staff of St. Dominic caused Williams's injuries and subsequent death. A plethora of

evidence was presented to the jury that the registered nurse, charged with the responsibility to attend Williams, made an ill-advised, conscious decision not to follow the surgeon's written orders. It is without dispute that Dr. Ilercil was not notified of Williams's deteriorating condition until after Williams coded, depriving Dr. Ilercil of an opportunity to prevent this tragedy. An intervening/superseding-cause instruction was supported by the evidence. Because the trial court committed reversible error by denying Dr. Ilercil's requested jury instruction, we reverse the judgment of the circuit court and remand this case for a new trial.

¶8. Dr. Ilercil performed an anterior and posterior cervical discectomy and fusion on Williams. It is undisputed that there were no complications during the surgery. After the surgery, Dr. Ilercil issued written orders instructing the hospital staff of St. Dominic to inform him if Williams developed "any shortness of breath, difficulty swallowing, or excessive swelling." Dr. Ilercil testified that his routine orders also required that he be notified if Williams experienced difficulty speaking.

¶9. Williams had a history of hypertension and diabetes. Because Williams had these preexisting conditions, Dr. Ilercil sent Williams to the ICU as a precaution. After an uneventful stay in the ICU, Williams was moved to a bed on the neurosurgical floor. During a postsurgery examination, a nurse noticed minimal swelling at Williams's surgical site and informed Dr. Ilercil. Dr. Ilercil responded and examined Williams. Dr. Ilercil noted that the swelling was superficial, a common finding after this particular surgery. Dr. Ilercil noted in the records that Williams was not having any difficulty breathing or swallowing.

¶10. Williams was attended by several nurses who did not observe any remarkable changes in Williams's condition. For example, a nurse had noted in his chart that his speech was clear only a few hours before Williams's condition began deteriorating.

¶11. The first notation of a change in his condition was made by Nurse Rhonda Howard, a staff nurse on the neurological floor for nineteen and a half years who had experience in dealing with postoperative neurosurgical patients. Howard testified that she understood that Dr. Ilercil has to rely on the nursing staff to call him about any changes in a patient's condition. Nurse Howard also testified that, although she was fully aware of Dr. Ilercil's orders, she did not call Dr. Ilercil or any other physician.

¶12. Shortly after Nurse Howard's shift began, she noted in Williams's chart that he was having "muffled speech." Howard failed to inform Dr. Ilercil of this change in Williams's condition. During Howard's initial rounds, she also noted in Williams's chart that he had "significant swelling" all around his surgical site. The medical records introduced at trial indicated that, before Nurse Howard's shift, the other nursing personnel had only noted swelling on the left side. Howard also failed to inform Dr. Ilercil of this change in Williams's condition, despite Dr. Ilercil's orders.

¶13. Later that evening, when Nurse Howard attempted to give Williams his medication, she noted that he was having difficulty swallowing. Howard noted her observations on Williams's chart, but she again failed to inform Dr. Ilercil of the change.

¶14. Not until telemetry contacted Nurse Howard and informed her that Williams's heart rate was 180 and not until Williams's wife called the nursing station because Williams was

having difficulty breathing did Nurse Howard finally notify a physician of Williams's worsening condition. Nurse Howard did not call Williams's attending surgeon, Dr. Ilercil, who had left specific instructions with the nursing staff to be informed of any changes in Williams's condition. Instead, she elected to call Dr. Shekoni, who had been called in to consult Dr. Ilercil regarding Williams's hypertension. Dr. Shekoni ordered a CT scan to be performed immediately.

¶15. When the transporter, Eddrique Body, arrived to take Williams to the radiology department, Body refused to take Williams because he felt that Williams was too unstable to make the trip. Body that testified when he unhooked Williams's oxygen from the wall, Williams began gasping for breath. Body then suctioned Williams's airways. He expressed his concerns to Nurse Howard, who was in the room with him at the time, and told her that he would not take Williams unless she went with him. Nurse Howard refused, once again interfering with another doctor's order that the CT scan be performed immediately. Body left Williams's room without transporting Williams to radiology for a CT scan.

¶16. Body was called again to Williams's room for transport. Williams's condition had not improved. He testified that Howard belittled him for not taking Williams. Body once again requested Nurse Howard to come with him due to Williams's severe condition. Howard refused, allowing Williams's condition to continue to worsen while waiting on a CT scan. Howard admitted that Williams was "in significant respiratory distress the whole time." The medical records reveal that Williams's blood pressure was a stroke level, registering 229 over

114. While Williams's condition worsened, Howard's actions delayed Williams's receiving a CT scan and being seen by a physician.

¶17. After Nurse Howard finally elected to accompany Williams, he was taken to get a CT scan. But Williams coded shortly after he returned to his room. During this tragic sequence of events, Dr. Ilercil was never called and was never given the opportunity to assess or treat his patient.

¶18. Nurse Howard testified multiple times that she was aware that Dr. Ilercil instructed her to call if she noticed any changes with breathing, swallowing, or speaking. Nurse Howard testified that she failed to call Dr. Ilercil when she observed these changes in Williams's condition.

¶19. Dr. Moses Jones, Williams's neurosurgery expert, testified that Dr. Ilercil's written orders were "necessary but not sufficient. And certainly you would not disregard this order. . . . Clearly that order needs to be there." Dr. Jones testified that Dr. Ilercil's orders required the nurses to call if any one of the changes in his condition occurred. The orders did not require all three to occur. "So any one of those [conditions] is, hey, call me . . . ." Dr. Jones testified that he was not critical of Dr. Ilercil's orders; he simply opined that Dr. Ilercil should have informed the nursing staff of Williams's heightened or increased risks.

¶20. During the discovery phase, Dr. Jones had provided opinions not only as to Dr. Ilercil but also as to the nursing staff of St. Dominic:

Q. All right. And you also had been designated to give opinions regarding the negligence of the nursing staff at St. Dominic, particularly, Rhonda Howard, correct?

A. Yes, that's correct.

Q. Okay. And, in fact, in that designation you acknowledged that you believe she was guilty of negligence in the care of Mr. Williams, correct?

A. That's correct.

. . . .

Q. You believe she had committed negligence in her care of Mr. Williams.

A. Yes.

Q. Okay. And, in fact, you believe that negligence was such that it rose to a level of gross negligence and a reckless disregard to his safety?

A. I don't know if that was my word. Somebody may have asked the question that way. I don't know.

Q. Well, can I show you the designation that we got?

A. If that's what it says, that's fine. I'm not disputing that, yes. What she did was grossly negligent.

¶21. Dr. Jones specifically testified that Howard was grossly negligent by failing to inform Dr. Ilercil of Williams's deteriorating condition:

Q. But would you agree with me that significant changes in conditions ought to be called to the attending physician?

A. Yes.

Q. All right. And would you consider shortness or significant shortness of breath[] to be a significant change of condition?

A. That is a very significan[t] change of condition.

Q. And Mr. Williams suffered that at roughly 11 to 11:15 p.m. that day, correct?

A. I don't know. We'd have to look at the chart. I don't know that it was specifically 11 p.m. Was that the time? I thought it actually started a little bit before that but I may be wrong.

Q. Okay. Well, all right. It started before then. Whenever it started that he begin having significant shortness of breath, she should have picked up the phone and called Dr. Ilercil?

A. That's correct.

¶22. Dr. Jones testified that Howard's failure to inform Dr. Ilercil of Williams's condition deprived Dr. Ilercil of the opportunity to prevent the code from occurring:

Q. Had she done so at that time knowing what we know about the time that it took him to have his code, could Dr. Ilercil have addressed the situation and avoided this?

A. In theory, yes.

Q. In theory?

A. Yes. Because, as we said, sometimes when you take these folks to surgery or try to address the condition, they can progress right in front of your eyes. So that's why I say in theory that can happen.

Q. Well, let's say this. To a reasonable degree of medical probability—had he been contacted before 11:00, notified of the shortness of breath—to a reasonable degree of medical probability, wouldn't he have been able to address the situation and avoid this?

A. I would say in all probability, yes.

¶23. Dr. Jones testified that even if there had been no specific written orders from Dr. Ilercil, which there were, Nurse Howard was still required to call Dr. Ilercil at the first sight of Howard's observing either that Williams had trouble swallowing, had trouble speaking, or had shortness of breath. "The nurse should have notified Dr. Ilercil for sure once he started having trouble breathing." Dr. Jones testified that, once Williams began exhibiting all of the changes in condition that Dr. Ilercil had ordered the nursing staff to watch for and inform him of, Howard's failure to inform Dr. Ilercil caused Williams's condition to progress to a point of no return:

> Q. . . . At 7:30 he's got muffled speak [sic]. Do you think that's an early sign of the hematoma affecting the trachea?
>
> A. I think it's now probably a pretty late sign.
>
> Q. All right. And then we got a difficulty swallowing at 9:07?
>
> A. Yes.
>
> Q. Do you think that's a sign of the hematoma's affect?
>
> A. Yes. The whole picture is progressing toward disaster.
>
> Q. Okay. And a disaster that could have been avoided to a reasonable degree of medical probability had Nurse Howard picked up the phone and called Dr. Ilercil?
>
> A. Quite likely, yes.

¶24. Dr. Ilercil testified the his actions did not cause or contribute to the injuries or death of Williams because he was never notified by the nurses of Williams's change in condition.

The record supports that, due to the nursing staff's intervening and/or superseding negligence, Dr. Ilercil was never given an opportunity to prevent the code.

¶25. The trial judge refused Dr. Ilercil's jury instruction D-8, which read:

> You are instructed that a superseding cause is an independent and unforeseen act by a third person which follows the defendant's actions and which is the substantial fact in causing the plaintiff's injuries. A superseding cause becomes the proximate cause for the plaintiff's injuries and any actions on the part of the defendant become a remote cause for which he is not liable. Therefore, if you find from a preponderance of the evidence in this case that the failure of Nurse Howard to contact Dr. Ilercil when Mr. Williams had swallowing problems and then trouble breathing was a substantial factor in causing Mr. Williams's respiratory arrest, injuries, and subsequent death so as to constitute a superseding cause, then Dr. Ilercil cannot be liable for Mr. Williams's injuries and death proximately resulting from Nurse Howard's negligence and it is your sworn duty to return a verdict in his favor, even if you believe Dr. Ilercil was negligent.

¶26. The jury instructions, when read without the refused Instruction D-8, did not properly instruct the jury as to Dr. Ilercil's theory of his case. The evidence presented at trial supported such an instruction, and the trial court erred by refusing the instruction.

¶27. In a factually similar case, ***Eckman v. Moore***, 876 So. 2d 975 (Miss. 2004), this Court held that the trial court committed reversible error by denying Dr. Eckman a jury instruction on his theory of the case. Dr. Eckman argued that the failure of the nursing staff to follow his orders was a superseding cause of Moore's injuries and death. ***Id.*** at 980. Dr. Eckman ordered the hospital's nursing personnel to perform neurological checks every two hours on Moore. ***Id.*** Experts for both parties agreed Dr. Eckman's orders were appropriate. ***Id.*** Furthermore, Moore's wife and wrongful death beneficiaries "put on proof that the nursing

personnel at [the hospital] failed to perform appropriately those neurological checks on [Moore] as ordered by Dr. Eckman." ***Id.***

¶28. Similar to today's case, the last time Dr. Eckman was contacted about Moore, Dr. Eckman was informed that Moore's neurological status was normal. ***Id.*** Seven and a half hours later, Moore went into cardiac arrest. ***Id.*** at 979. "During that seven and one-half hour time lapse, the nursing personnel, upon orders by Dr. Eckman, should have performed at least four other neurological checks on [Moore], but, according to the testimony of [the plaintiffs'] own expert witnesses, they failed to do so." ***Id.*** at 981.

¶29. The jury found the hospital to be negligent and 40 percent at fault. ***Id.*** at 978. The ***Eckman*** Court found that it was "clear that the jury found that the nursing personnel negligently performed their duties, such as conducting proper neurological checks as ordered by Dr. Eckman . . . ." ***Id.*** This Court held that

> [b]oth Dr. Eckman and plaintiff presented evidence that the negligence of the nursing personnel of NMMC contributed to the death of Taylor Moore. The jury must be instructed on all material issues presented in evidence. Therefore, the trial court erred in refusing Dr. Eckman's superseding cause instruction and, thus, denied Dr. Eckman his right to have his theory of the case properly presented to the jury.

Id. at 982.

¶30. Unquestionably, Williams's expert established that the nursing personnel of St. Dominic failed to perform the written orders of Dr. Ilercil. Ultimately, Nurse Howard admitted that she failed to heed Dr. Ilercil's written orders. The jury found St. Dominic to be 85 percent at fault. Like the jury in ***Eckman***, this jury found that St. Dominic's nursing

personnel negligently performed their duties, such as contacting Dr. Ilercil when they first noticed signs that Williams's condition was deteriorating, i.e., that he was having muffled speech, difficulty breathing, and respiratory distress.

¶31. Both Dr. Ilercil and Williams presented evidence that Nurse Howard was negligent by failing to contact Dr. Ilercil after she observed Williams's rapidly declining condition, the signs of which Dr. Ilercil had specifically instructed the nursing staff to notify him. The jury must be instructed on all material issues presented in evidence. We therefore conclude that the trial court erred by refusing Dr. Ilercil's intervening/superseding-cause instruction and, thus, denied Dr. Ilercil his right to have his theory of the case properly presented to the jury. We reverse the judgment of the circuit court and remand the case for a new trial.

¶32. **REVERSED AND REMANDED.**

RANDOLPH, C.J., COLEMAN, MAXWELL, BEAM AND CHAMBERLIN, JJ., CONCUR. GRIFFIS, J., CONCURS IN PART AND DISSENTS IN PART WITHOUT SEPARATE WRITTEN OPINION. KITCHENS, P.J., DISSENTS WITH SEPARATE WRITTEN OPINION JOINED BY KING, P.J.

KITCHENS, PRESIDING JUSTICE, DISSENTING:

¶33. I respectfully dissent. From the outset, Dr. Ilercil's postoperative order was insufficient to inform the nursing staff of Williams's heightened risk of complications, and Dr. Ilercil cannot be absolved of liability because later the hospital's nursing staff failed to follow his insufficient order in every respect. Thus, I would affirm the trial court's refusal of Dr. Ilercil's intervening- and superseding-cause jury instruction and would affirm that court's judgment against Dr. Ilercil.

¶34. Dr. Ilercil contends he was entitled to a jury instruction that would have allowed the jury to find that the negligence of Nurse Howard was an intervening and superseding cause of Williams's injuries and death. The majority finds that "[a]n intervening/superseding-cause instruction was supported by the evidence[]" and that the trial court erred by refusing Dr. Ilercil's proposed jury instruction. Maj. Op. ¶ 7. The majority relies on "a factually similar case, ***Eckman v. Moore***, 876 So. 2d 975 (Miss. 2004)[.]" Maj. Op. ¶ 27. But there is a major distinction between ***Eckman*** and this case. In ***Eckman***, the "[e]xperts for both parties agreed Dr. Eckman's orders were appropriate." Maj. Op. ¶ 27 (citing ***Eckman***, 876 So. 2d at 980). In this case, Williams's expert, Dr. Moses Jones, testified that Dr. Ilercil's order was "not sufficient." Unlike the ***Eckman*** case, a question remains about the sufficiency of Dr. Ilercil's postoperative order. The sufficiency of his order goes to the heart of this case because part of Nurse Howard's negligence was a direct result of Dr. Ilercil's negligence, i.e., his failure to inform the nursing staff of Williams's heightened risk of complications.

¶35. "The question of whether an act of negligence is a foreseeable superseding cause requires an examination of the sequence of events leading to the injury." ***Lift-All Co., Inc. v. Warner***, 943 So. 2d 12, 17 (Miss. 2006) (citing ***Eckman***, 876 So. 2d at 982). Additionally, this Court has said:

> Although one may be negligent, yet if another, acting independently and voluntarily, puts in motion another and intervening cause which efficiently thence leads in unbroken sequence to the injury, the latter is the proximate cause and the original negligence is relegated to the position of a remote and, therefore, a non-actionable cause. Negligence which merely furnishes the condition or occasion upon which injuries are received, but does not put in

> motion the agency by or through which the injuries are inflicted, is not the proximate cause thereof. The question is, did the facts constitute a succession of events so linked together as to make a natural whole, or was there some new and independent cause intervening between the alleged wrong and the injury?

Eckman, 876 So. 2d at 982 (quoting ***Miss. City Lines v. Bullock***, 194 Miss. 630, 13 So. 2d 34, 36 (1943)). "[I]f an *antecedent negligent act puts in motion* an agency which continues in operation until an injury occurs it would appear to be more like a second proximate cause than a remote and unactionable cause." ***Id.*** at 981 (quoting ***Blackmon v. Payne***, 510 So. 2d 483, 487 (Miss. 1987)). Simplified, if a doctor's order were insufficient to inform a nurse adequately at the beginning, then the nurse's actions or inactions would not be a "new and independent cause" but rather an integral part of a continuous "succession of events" that led to improper medical care. ***Id.*** at 982 (quoting ***Bullock***, 13 So. 2d at 36). Here, Nurse Howard's negligence was not independent of Dr. Ilercil's negligence because her negligence, at least in part, was the product of Dr. Ilercil's negligent failure at the outset to provide a sufficient order that informed and instructed the nursing staff fully of the seriousness of Williams's condition. Thus, Nurse Howard's negligence was not a intervening and superseding cause.

¶36. This Court has held that "[j]ury instructions are within the discretion of the trial court and the settled standard of review is abuse of discretion." ***Jackson HMA, LLC v. Morales***, 130 So. 3d 493, 501 (Miss. 2013) (internal quotation marks omitted) (quoting ***Watkins v. State***, 101 So. 3d 628, 635 (Miss. 2012)). "[A] court may refuse a jury instruction which 'incorrectly states the law, is fairly covered elsewhere in the instructions, or is without

foundation in the evidence.'" ***Eckman***, 876 So. 2d at 979 (quoting ***Coho Res., Inc. v. McCarthy***, 829 So. 2d 1, 23 (Miss. 2002)). "In reviewing jury instructions, the instructions must be read as a whole." ***Bay Point Props., Inc. v. Miss. Transp. Comm'n***, 201 So. 3d 1046, 1054 (Miss. 2016) (citing ***N. Biloxi Dev. Co., LLC v. Miss. Transp. Comm'n***, 912 So. 2d 1118, 1123 (Miss. Ct. App. 2005)). Reading the jury instructions as a whole, it is clear that the jury in this case was tasked with determining whether Dr. Ilercil's order was sufficient. If so, the nursing staff's negligence, if any, would have become the proximate cause of Williams's death. If not, Dr. Ilercil's negligence would have become the proximate cause, or a proximate contributing cause. The jury found Dr. Ilercil to be 15 percent at fault, which suggests that the jury determined Dr. Ilercil's order to have been insufficient in some causative way. While I agree that Nurse Howard's actions were negligent, her negligent conduct was not an intervening and superseding cause of Williams's injuries and death. Rather, the nurse's negligence was generated by Dr. Ilercil's insufficient postoperative order. Thus, the trial court did not abuse its discretion by refusing Dr. Ilercil's proposed jury instruction, and I would affirm the trial court's judgment.

KING, P.J., JOINS THIS OPINION.