STATE OF MINNESOTA
IN COURT OF APPEALS
A24-0797

Richard Nichols,
Appellant,

vs.

North Memorial Health Care,
Respondent.

Filed December 30, 2024
Affirmed
Worke, Judge

Hennepin County District Court
File No. 27-CV-21-8091

Wilbur W. Fluegel, Fluegel Law Office, Minneapolis, Minnesota; and

Joseph M. Crosby, Crosby Law Office, LLC, St. Paul, Minnesota (for appellant)

Patrick H. O'Neill, III, Mark A. Solheim, Kevin T. McCarthy, Larson • King, LLP, St. Paul, Minnesota (for respondent)

Considered and decided by Worke, Presiding Judge; Bentley, Judge; and Smith, John P., Judge.*

* Retired judge of the Minnesota Court of Appeals, serving by appointment pursuant to Minn. Const. art. VI, § 10.

NONPRECEDENTIAL OPINION

WORKE, Judge

Appellant challenges the judgment entered after the district court directed a verdict on his medical-malpractice claim in which he asserted that one of respondent's attending surgeons failed to supervise a procedure performed by a fellow.[1] Because the district court appropriately determined that appellant failed to present sufficient evidence of causation to support his claim, we affirm.

FACTS

In September 2018, appellant Richard Nichols was in a motorcycle accident and suffered several injuries, including a pneumothorax (which occurs when free air is trapped between the chest and lungs in patients with rib fractures). Nichols received medical treatment at respondent North Memorial Health Care.

Dr. Rachel Morris, a board-certified surgeon and critical-care fellow, consulted with Dr. Nick Davis, her attending physician, regarding Nichols's condition. Dr. Davis and Dr. Morris recommended that Nichols undergo the pigtail catheter procedure to address concerns with pneumothorax. Dr. Morris had previously performed the pigtail catheter procedure on other patients, and Dr. Davis had personally observed Dr. Morris perform the procedure on a patient. Dr. Davis spoke with Dr. Morris about her comfort level in performing the procedure, and Dr. Morris informed Dr. Davis that she was comfortable

[1] A medical fellow is a fully-qualified physician who has completed medical school and residency and is pursuing additional training in a medical subspecialty.

performing the procedure. Dr. Davis and Dr. Morris discussed consent with Nichols, and Nichols signed an informed-consent form for Dr. Morris to perform the procedure.

On September 15, 2018, Dr. Morris performed the pigtail catheter procedure on Nichols. During the procedure, a piece of the catheter punctured Nichols's left heart ventricle, requiring further medical treatment. Nichols sued North Memorial for negligence. Nichols alleged that, because Dr. Davis failed to supervise Dr. Morris, the catheter was negligently inserted, requiring emergency open-heart surgery.

Nichols's expert, Dr. Carl Warren Adams, a cardiovascular and thoracic surgeon, testified at a jury trial. Dr. Adams testified that Dr. Davis did not appropriately supervise Dr. Morris in the placement of the pigtail catheter. He testified that a "pigtail catheter never enters the heart," so this occurrence was a "never event."

Dr. Adams testified that during the procedure a V-tach machine[2] emanated an alert sound indicating an arrhythmia—Nichols's heart was beating fast. Dr. Adams stated that the alert signaled to the doctor that maybe "I've gone too far, I'm irritating the heart muscle, so stop." Dr. Adams stated that the V-tach was caused by a part of the catheter; possibly the needle going through the pericardium or the guide wire irritating the surface of the heart.

Dr. Adams testified that Dr. Morris deviated from the standard of care when she performed the procedure. And Dr. Adams testified that he was aware that Nichols had

[2] A V-tach machine is a device that detects a rapid heartbeat.

filed a medical-malpractice claim against Dr. Morris and that a settlement had been reached in that malpractice claim.

Dr. Adams testified that Dr. Davis should have been present to supervise Dr. Morris. On cross-examination, however, Dr. Adams testified that supervising physicians are given leeway in deciding when they need to be standing next to a fellow during a procedure. Dr. Adams testified that "guidelines allow a supervising physician, like Dr. Davis, to be available by phone to answer questions depending on the [fellow]'s experience and qualifications." Dr. Adams agreed that Dr. Davis, based on his experience working with Dr. Morris, had complied with the standard of care.

Following Dr. Adams's expert testimony, North Memorial moved for a directed verdict, claiming that Nichols "did not prove to a reasonable degree of medical certainty that [Dr. Davis's] supervision would have changed anything about the way the procedure was performed . . . and the heart injury being avoided." North Memorial argued that Dr. Adams could not identify what caused the heart irritation, and he did not say what Dr. Davis could have observed, if in the room, to prevent either the needle, the guide wire, or the catheter from puncturing the heart. The district court granted North Memorial's motion, determining that Nichols failed to offer "sufficient expert evidence that Dr. Davis'[s] presence in the room could have prevented this . . . never-heard-of event." Judgment was entered and this appeal followed.

DECISION

Directed verdict/judgment as a matter of law (JMOL) may be granted when "a party has been fully heard on an issue and there is no legally sufficient evidentiary basis for a

reasonable jury to find for that party on that issue." Minn. R. Civ. P. 50.01(a). "JMOL is inappropriate if jurors could differ on the conclusions to be drawn from the record." *Daly v. McFarland*, 812 N.W.2d 113, 119 (Minn. 2012) (quotation omitted). When considering a JMOL motion, a district court "must view the evidence in the light most favorable to the nonmoving party." *Longbehn v. Schoenrock*, 727 N.W.2d 153, 159 (Minn. App. 2007) (quotation omitted). This court reviews a district court's decision on a JMOL motion de novo. *Navarre v. S. Washington Cnty. Schs.*, 652 N.W.2d 9, 21 (Minn. 2002).

The district court granted JMOL after Nichols presented his medical-malpractice claim and the district court determined that Nichols failed to establish an essential element of that claim. The elements of a medical-malpractice claim are (1) a standard of care recognized by medical practitioners in the community as applicable to the defendant's conduct; (2) a breach of the standard of care; and (3) direct causation of the patient's injuries by the breach. *MacRae v. Grp. Health Plan, Inc.*, 753 N.W.2d 711, 717 (Minn. 2008). The district court determined that Nichols failed to establish the causation element.

"Causation, by definition, is something producing a certain effect or result." *Leubner v. Sterner*, 493 N.W.2d 119, 121 (Minn. 1992). In a medical-malpractice case, the plaintiff must establish "that it is more probable than not that his . . . injury was a result of the . . . health care provider's negligence." *Id.* "Failure to present such proof (normally in the form of expert testimony) mandates either summary judgment or a directed verdict for the defendant." *Id.*

Here, the district court determined that North Memorial was entitled to JMOL because Nichols failed to present expert testimony that would permit the jury to find that

Dr. Davis would have prevented Nichols's injury if he had provided more supervision over Dr. Morris when she performed the procedure. In other words, Nichols failed to present sufficient evidence that Dr. Davis's failure to supervise produced the injury. We agree with the district court.

An expert witness should illustrate with specificity "how" and "why" the alleged malpractice caused the injury. *Teffeteller v. Univ. of Minn.*, 645 N.W.2d 420, 429 n.4 (Minn. 2002). Dr. Adams did not show how and why Dr. Davis's absence from the room caused the injury. Nichols argues that the V-tach indicated an abnormal heart rhythm at some point during the procedure. He claims that if Dr. Davis had been in the room, he would have heard the monitor alert and could have stopped Dr. Morris from continuing the procedure. But Dr. Adams's testimony did not explain the timing of the V-tach alert, rendering it insufficient to show when the damage occurred. Dr. Adams could not state which component of the catheter irritated Nichols's heart—it could have been the needle or the guide wire. It is unknown whether the harm was done simultaneous to the V-tach alert or after. Because the evidence does not show when the damage occurred, it is insufficient to establish what Dr. Davis could have done when the V-tach alerted or whether any specific action would have prevented the injury.

Dr. Adams's expert testimony was insufficient to establish that if Dr. Davis provided more supervision over Dr. Morris the event would not have occurred. As the district court determined, "without knowing the cause of the injury, there was no reasonable basis for . . . the jury to determine that Dr. Davis'[s] presence in the room would have

prevented the injury." The district court appropriately granted North Memorial's motion for a directed verdict.

Affirmed.