COURT OF APPEALS
DECISION
DATED AND FILED

January 7, 1999

Marilyn L. Graves
Clerk, Court of Appeals
of Wisconsin

No. 97-3701

STATE OF WISCONSIN **IN COURT OF APPEALS**
DISTRICT IV

WISCONSIN PATIENTS COMPENSATION FUND,

PLAINTIFF-RESPONDENT,

V.

PHYSICIANS INSURANCE COMPANY OF WISCONSIN, INC.,

DEFENDANT-APPELLANT.

APPEAL from a judgment of the circuit court for Dane County: RICHARD J. CALLAWAY, Judge. *Reversed and cause remanded with directions*.

Before Dykman, P.J., Eich and Deininger, JJ.

DEININGER, J. Physicians Insurance Company of Wisconsin, Inc., appeals a judgment ordering it to pay $399,263, plus costs, to the Wisconsin Patients Compensation Fund. Physicians contends the trial court erred when it set

aside a jury finding that its insured was only 5% causally negligent in the injury and death of a patient, and ordered a new trial on the apportionment of causal negligence. We agree, reverse the judgment based on the second verdict, and remand for entry of judgment on the initial jury verdict.

BACKGROUND

Marilyn Graupman elected to undergo a diagnostic radiological procedure which required her to receive an injection of a contrast dye. Unfortunately, she suffered a severe allergic, or anaphylactic, reaction to the injected dye. A "code" was called and Dr. Jules Marks, along with several hospital nurses and health care workers, responded to the "CT room," where Mrs. Graupman was located. Dr. Marks, an internist, supervised the code team in its efforts over the next several hours to reverse the effects of the severe allergic reaction. Those effects included difficulty in breathing and greatly reduced blood pressure.

Dr. Marks made three unsuccessful attempts at "intubation" of Mrs. Graupman—the insertion of a tube into the patient's trachea to assist with breathing. He therefore called for the assistance of an anesthesiologist to perform the procedure. Dr. Sidney Johnson, who was attending a patient during an operation elsewhere in the hospital, received permission from the surgeon performing the operation to respond to Marks's request. Johnson went to the CT room, performed the intubation on Mrs. Graupman, and quickly returned to the operating room to be with his surgical patient. After completing his treatment of the surgical patient in the recovery room, Johnson went to the intensive care unit (ICU) to check on Mrs. Graupman's status, although he was under no obligation to treat her at that time. About one hour had elapsed since he had performed the

intubation in the CT room, but Mrs. Graupman had not yet been transferred to the ICU, so he proceeded to the CT room.

Upon arriving at the CT room, Dr. Johnson discovered that Mrs. Graupman's condition had not improved. He assisted in transferring her to the ICU, and when there, ordered her placed on a ventilator, which did not result in any improvement in the patient's condition. In fact, she began to thrash about, endangering the placement of the endotracheal tube, so her wrists were then restrained and Dr. Marks ordered that she be given a sedative. Continuing to see no improvement, Dr. Johnson administered Tracrium, a muscle relaxer that has the effect of temporarily paralyzing a patient, the purpose of which was to relax Mrs. Graupman's chest wall muscles and thereby allow the artificial ventilator to function better in "breathing for the patient." Further and rapid deterioration followed the administration of this medication. Dr. Johnson then removed the endotracheal tube and replaced it with a new one. Moments later, it became apparent that the newly inserted tube was in the patient's esophagus, so Johnson removed it and again inserted a new tube. Mrs. Graupman's assisted breathing then improved, but she had suffered irreversible brain damage. She remained in a coma for seven months before dying in June 1989.

Mrs. Graupman's husband, individually and as personal representative of his wife's estate, commenced a medical malpractice action in 1990 against Dr. Marks, Dr. Johnson, their insurers, and the Fund. The matter was tried to a jury in Milwaukee County in 1992, but settled after two days of testimony. The plaintiffs accepted $400,000 from Marks and his insurance company and $500,000 from the Fund in exchange for a full and final release of all claims against all defendants. Physicians Insurance Company (Physicians), Dr. Johnson's insurer, refused to contribute to the settlement, maintaining that Dr.

Johnson had not been negligent in Mrs. Graupman's care. The Fund then commenced the present litigation against Physicians, seeking contribution toward its payment in settlement of the Graupman claim.[1]

The case was tried over six days to a jury in Dane County, and jurors were asked: (1) whether Dr. Johnson was causally negligent; (2) whether Dr. Marks was causally negligent; (3) to apportion causal negligence, if necessary; and (4) to determine the amount of plaintiffs' damages caused by the medical malpractice of one or both doctors. After about four hours of deliberation, the jury sent a note to the trial judge, informing him as follows:

> Judge Callaway, we are split 6 to 6 on Questions 1 and 2 [inquiring if Dr. Johnson was negligent and, if so, whether his negligence was causal], with no one feeling that they can in good conscious [sic] change their mind. What should we do?

The trial court, without objection, summoned the jurors to the courtroom and read to them WIS J I—CIVIL 195, which urges jurors to reach a verdict if possible. After another hour or so, the jury returned its verdict finding both physicians causally negligent, assessing damages of $798,526, and apportioning causal negligence as follows: Dr. Johnson, 5%; Dr. Marks, 95%.

The Fund moved for and was granted a new trial in the interest of justice on the issue of apportionment of negligence. We denied Physicians'

[1] Health care providers are required under § 655.23(4), STATS., to maintain private professional liability insurance in the amount of $400,000 for each occurrence. The Fund is then responsible for paying medical malpractice liability claims that exceed that sum. *See* § 655.27(1), STATS. A person who claims damages arising out of the rendering of medical care or services may recover from the Fund by naming it as a party in a medical malpractice action against the person's health care provider. *See* § 655.27(5). The Fund may sue an insurer that refuses to contribute to the settlement of a claim against its insured. *See* ***Wisconsin Patients Compensation Fund v. Wisconsin Health Care Liab. Ins. Plan***, 200 Wis.2d 599, 618, 547 N.W.2d 578, 585 (1996).

petition for leave to appeal the nonfinal order for a new trial. The next trial was conducted in 1997, and the second jury apportioned causal negligence 50% to each of the physicians. Judgment was entered on the second verdict, ordering Physicians to pay the Fund $399,263, plus taxable costs. Physicians appeals the judgment, arguing that the trial court erred in setting aside the first verdict.[2]

ANALYSIS

We address at the outset Physicians' argument that the apportionment of negligence is a matter peculiarly within the province of the jury, and that, generally, a trial court should not invade that province to disturb a jury's answers to an apportionment question. *See* ***DeGroff v. Schmude***, 71 Wis.2d 554, 562, 238 N.W.2d 730, 734 (1976). It is beyond dispute, however, that a trial court may set a jury's apportionment aside and order a new trial for one or more of the reasons set forth in § 805.15(1), STATS., and this is true even when the jury's apportionment is supported by credible evidence. *See* ***DeGroff,*** 71 Wis.2d at 563, 238 N.W.2d at 735; ***Sievert v. American Family Mut. Ins. Co.***, 180 Wis.2d 426, 431, 509 N.W.2d 75, 78 (Ct. App. 1993), *aff'd*, 190 Wis.2d 623, 528 N.W.2d 413 (1995). Thus, the question before us is not whether the court had the power to order a new trial on the apportionment of negligence, but whether it properly did so on the present record.

Section 805.15(1), STATS., permits a trial court to set aside a jury verdict and order a new trial on several grounds:

> A party may move to set aside a verdict and for a new trial because of errors in the trial, or because the

[2] Physicians also claims error in certain trial court rulings during the second trial. Given our disposition reinstating the verdict from the first trial, we need not address these claims.

> verdict is contrary to law or to the weight of evidence, or because of excessive or inadequate damages, or because of newly-discovered evidence, or in the interest of justice.

When a trial court grants a motion for a new trial, it must specify the grounds upon which it relies: "No order granting a new trial shall be valid or effective unless the reasons that prompted the court to make such order are set forth on the record, or in the order or in a written decision." Section 805.15(2), STATS. The Fund's motion cited both "the interest of justice" and "that the allocation of fault is contrary to the weight of the evidence" as grounds for a new trial. In its oral ruling on the motion and in its subsequent written order, the trial court also refers to both grounds as the basis for its decision to grant a new trial on the apportionment of negligence.

We accord great deference to a trial court's decision to grant a new trial. *See* ***Sievert***, 180 Wis.2d at 431, 509 N.W.2d at 78. It is a discretionary order and the trial court is in the best position to observe and evaluate the evidence. *See* ***id***. A reviewing court will, however, reverse a trial court's order for a new trial if (1) the trial court fails to provide a reasonable basis for its determination that a verdict is contrary to the great weight and clear preponderance of the evidence, or (2) the trial court bases its decision on a mistaken view of the evidence or the law. *See* ***Krolikowski v. Chicago & N.W. Transp. Co.***, 89 Wis.2d 573, 581, 278 N.W.2d 865, 868 (1979). We conclude that the trial court committed the first of these errors.

If a trial court decides to order a new trial in the interest of justice, it must "set forth in detail the reasons in the order or in a memorandum decision"—a "mere statement that a jury's finding is against the great weight and clear preponderance of the evidence, without more, is … insufficient to support such a decision." ***DeGroff***, 71 Wis.2d at 564, 238 N.W.2d at 735. Rather, where a

verdict is deemed contrary to the great weight and clear preponderance of the evidence, "the order should recite or the incorporated opinion should contain the subsidiary reasons and basis for the general statement." ***Loomans v. Milwaukee Mut. Ins. Co.***, 38 Wis.2d 656, 661, 158 N.W.2d 318, 320 (1968). Finally, in determining whether to grant a new trial, a trial court may not substitute its judgment for that of the jury, nor may it order a new trial simply because a different jury might reach a different result. *See* ***Burch v. American Family Mut. Ins. Co.***, 198 Wis.2d 465, 477, 543 N.W.2d 277, 282 (1996).

With these principles in mind, we review the reasons cited by the trial court for granting a new trial on the issue of the apportionment of the doctors' negligence. Given the statutory requirement that a trial court articulate specific grounds for a new trial order, and the common law emphasis on the necessity for a statement by the court of the reasons why it deems a verdict to be contrary to the weight and preponderance of the evidence, our review is limited to the reasons specified in the trial court's order. *See* ***Krolikowski***, 89 Wis.2d at 580, 278 N.W.2d at 868. In conducting our review, we do not seek to sustain the jury's apportionment of negligence, since our role is to look for reasons to sustain the trial court's findings and order. *See* ***id***.; ***Sievert***, 180 Wis.2d at 431, 509 N.W.2d at 78.

In its oral ruling on the Fund's motion for a new trial, the trial court referred to a "smell test"—"that if it didn't smell right, the verdict, that you took it away from the jury"—and to the comment of a former circuit judge who counseled that "if the verdict came back and your first thought was, 'Jesus Christ,' that in his mind, that was sufficient for him to take it away from the jury." The court went on to say that it was "quite shocked when the verdict came back at 95/5 per cent," which the court concluded was a compromise following the jury's initial

deadlock on the question of Dr. Johnson's negligence, a result which the court concluded "doesn't make sense." It found the jury's damage award puzzling as well, since it "gave the exact damage award as requested." Finally, it concluded that the jury's answer on the apportionment question was "contrary to the great weight and clear preponderance of the evidence" commenting as follows on the evidence at trial:

> I think that at least the greater weight and clear preponderance of the evidence would seem to indicate that the damage that occurred to Marilyn Graupman, where she was massively brain damaged, took—occurred to her in the—in the ICU unit, and from the substantial weight of the evidence, that—that it was two factors; one was the giving of the Tracrium, which is a paralyzing agent, and also by giving that paralyzing agent, then took away the ability of Mrs. Graupman to successfully take in oxygen—necessary oxygen, with the intubation, which we know, during that time period was not correct, because when the intubation was correctly done, a massive change occurred in her medical standing, except for the brain.

In the written order which followed, the court stated its conclusion that "[t]he apportionment of negligence of 95/5 in favor of Dr. Sidney Johnson is shocking, unbelievable and contrary to the greater weight and preponderance of the evidence." The order also specified the following "grounds" for retrying the apportionment issue:

> 1. The massive brain damage to Marilyn Graupman occurred in the Intensive Care Unit, when she was being treated by Dr. Jules Marks and Dr. Sidney Johnson;
>
> 2. The massive brain damage was caused by two factors: administration of the Tracrium, a paralyzing drug, which deprived Mrs. Graupman of the ability to breathe on her own and the intubation of the endotracheal tube into her esophagus instead of the trachea;
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> 3. Dr. Sidney Johnson administered the Tracrium to Marilyn Graupman;
>
> 4. Dr. Sidney Johnson inserted the endotracheal tube into the esophagus as opposed to the trachea.

We have reviewed the portions of the trial transcript relied upon by the Fund to support the preceding four statements, as well as the evidence cited by Physicians to the contrary. It is undisputed that Dr. Johnson first suggested, and then administered, Tracrium to Mrs. Graupman after her arrival in the ICU, and that his first attempt to re-insert the endotracheal tube in the ICU was unsuccessful because it entered the patient's esophagus instead of her trachea. There was ample testimony, however, that neither of these acts were negligent: Paralyzing agents may properly be administered to overcome a patient's resistance to efforts to artificially assist with breathing,[3] and esophageal tube insertions are not uncommon, even by experienced practitioners, especially when intubation is attempted under difficult circumstances.[4]

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[3] Dr. Savarese, an anesthesiologist with extensive knowledge of and experience in the administration of Tracrium, testified for Physicians that the choice, dosage and purpose for administration of the Tracrium were all appropriate, and that there was no negligence involved in the administering of the drug by Dr. Johnson. One of the Fund's experts, Dr. Jeffries, agreed, testifying that "anesthesiologists use drugs like Tracrium all the time" and that "there was nothing wrong with the use of the Tracrium, per se." Dr. Jeffries opined that Johnson was negligent, however, for "paralyzing her and then failing to recognize that the tube was not in the right place, when she was paralyzed."

[4] One of the Fund's own experts acknowledged that "putting the tube into the esophagus is not a deviation," but testified that a failure to recognize that fact and correct it is a "deviation from the accepted standard of care." We cannot tell from the trial court's remarks whether its conclusion that Dr. Johnson "inserted the endotracheal tube into the esophagus as opposed to the trachea" referred to Johnson's initial intubation in the CT room or to his first re-insertion of the tube in the ICU.

Whether the initial, CT-room intubation was properly made into the trachea or improperly into the esophagus was a matter of considerable dispute in the testimony at trial. The Fund maintains that it was into the esophagus, and argues that Dr. Johnson should have recognized and corrected the problem before leaving to return to surgery. However, even if the initial, CT-room intubation was improper, we agree with Physicians that the evidence supports a conclusion that Dr. Marks bears some responsibility as well, since he remained with the patient for the next hour and apparently took no action to verify or replace the initial breathing tube. There is no dispute that the first re-insertion of the endotracheal tube in the ICU was esophageal, but it also appears that the fact was quite quickly recognized and corrected. The exact time lapse between the first and second ICU intubation was in dispute, however, as was its potential impact on the patient.

Although the Funds' experts testified that Dr. Johnson's treatment of Mrs. Graupman fell short of the appropriate standard of care, Physicians' three experts each testified that Johnson was not negligent in any of the treatment he rendered. Physicians' experts concluded that it was Dr. Marks's inadequate and improper response to the patient's initial anaphylactic reaction that ultimately caused her brain damage and ensuing death.[5] They described Dr. Johnson as having "walked into an ongoing catastrophe that was at its final moments" and taking appropriate actions in his attempts to restore Mrs. Graupman's breathing. They opined that some brain damage had undoubtedly occurred while she was still in the CT room, and cited numerous indications tending to show that Dr. Johnson's initial intubation in the CT room was proper, and not into the patient's esophagus as the Fund's experts concluded. Finally, the defense presented expert testimony that, even before Dr. Johnson took any actions in the ICU, Mrs. Graupman was "in big trouble," was "dying … in front of everybody's eyes," and was "in extremis."

In short, on the evidence presented at trial, the jury could have reached the same conclusions regarding the causes of Mrs. Graupman's brain damage as did the trial court in its oral and written rulings, but the evidence was far from one-sided or uncontroverted. The trial court concluded that Mrs. Graupman's massive brain damage was "caused by … administration of the Tracrium … which deprived Mrs. Graupman of the ability to breathe on her own and the intubation of the endotracheal tube into her esophagus instead of the trachea." Neither the court's order nor its oral decision on the Fund's motion,

[5] The Fund's experts also testified that Dr. Marks was negligent, and the Fund conceded as much in its closing argument.

however, give any reasons for arriving at this conclusion, which, in our view, is a critical failing. That is, the fatal deficiency in the trial court's ruling stems from the fact that it cites as "grounds" for a new trial on apportionment two actions by Dr. Johnson that were all but conceded to be not negligent in themselves, but neither the court's written order nor its oral decision explains why, despite this, the jury's allocation of minimal negligence to Johnson was contrary to the weight of the evidence produced during the trial. (*See* notes 3 & 4, above.)

In medical malpractice actions, Wisconsin law generally requires the plaintiff to introduce expert testimony as to the standard of care and the defendant's departure from it, and thus, the claims of negligence involved in the present case are distinguishable from those which are within the realm of the ordinary experience of mankind, which do not require special learning, study, or experience. *See* ***Olfe v. Gordon***, 93 Wis.2d 173, 180-81, 286 N.W.2d 573, 576 (1980) (citations omitted). Although our role is to look for reasons to support the trial court's findings, we have difficulty doing so here because the court has given us no justification for discounting the extensive testimony of Physicians' experts that Dr. Johnson was not negligent at all in the treatment he administered to Mrs. Graupman, and that the primary, if not sole, cause of her brain damage and death was Dr. Marks's inadequate response to her anaphylactic reaction during the two hours preceding her transfer to the ICU.

The present apportionment of negligence issue is thus quite different from the one presented in ***DeGroff***. There, the supreme court upheld the trial court's order for a new trial, noting that the trial court's "decision to grant a new trial was based upon a thorough review of the evidence." ***DeGroff***, 71 Wis.2d at 564, 238 N.W.2d at 735. The jury had attributed equal negligence to a Mr. Schultz, whose vehicle had struck the rear end of a stalled vehicle, and to Orville

Schmude, the owner of the stalled vehicle. *See* ***id***. at 562, 238 N.W.2d at 734. The trial court set aside the verdict and ordered a new trial in the interest of justice because the jury's apportionment was contrary to the great weight and clear preponderance of the evidence, giving the following reasons for concluding that Schultz's negligence exceed Schmude's:

> (1) Schultz' operation of his automobile without glasses contrary to the restriction on his driver's license; (2) his consumption of alcohol before the accident; (3) his admission to traveling 30 miles per hour in a 25 mile per hour zone on a snowpacked highway; (4) his failure to alter the speed of his automobile upon first noticing the lights of the vehicles ahead; (5) his failure to pump his brakes or safely pass the Schmude vehicle in the face of evidence that there was room to pass and that other vehicles had safely done so earlier; (6) his admitted misjudgment as to the situation presented by the lights on the roadway ahead; and (7) his failure to observe the vehicles until he was within 144 feet of them in contrast to testimony that they were visible earlier.

Id. at 565, 238 N.W.2d at 736; s*ee also* ***Loomans***, 38 Wis.2d 656, 158 N.W.2d 318 (1968) (holding that trial court properly granted a new trial in the interest of justice on the apportionment issue where jury had allocated 60% of negligence to the plaintiff whose vehicle was struck by a following vehicle).

Unlike traffic accident cases, where safety statutes and lay knowledge and experience can assist a trial court in assessing whether a jury's apportionment of causal negligence is contrary to the weight of the evidence, the present case required the trial court to assess whether the jury's apportionment contravened the great weight and clear preponderance of evidence that was largely in the form of expert testimony. We cannot sustain its order because it provides no reasons to support the court's choice of the Funds' experts' opinions over those of Physicians' experts.

We agree with Physicians that it appears the trial court may have deemed the 95/5 apportionment to be an improper "compromise verdict." It commented in its oral ruling that "the jury had to compromise somewhere between their deadlock and arrive at a 5 and 95—95 and 5 percent, which, in effect, doesn't make sense," and later that "I think because of that deadlock and the jury instruction—the Court's instruction to the jury—and I recall they weren't out very long after we answered that question." But not all compromises by jurors on contested issues are necessarily improper. *Cf.* ***Carlson & Erickson Builders, Inc. v. Lampert Yards, Inc.***, 190 Wis.2d 650, 674-75 & n.34, 529 N.W.2d 905, 914 (1995) (holding that where evidence on damages is in conflict, "jury [may] accept[] and reject[] parts of each party's evidence" and its verdict "may reflect a compromise"); ***Tetzlaff v. Pilot Press, Inc.***, 270 Wis. 214, 217, 70 N.W.2d 678, 679-80 (1955) (holding that trial court erred in granting new trial because of perceived "compromise … on the part of the jury" where "exact mathematical computation" is not possible and jury "was required to use its best judgment").

We do not know, of course, how the jury arrived at its answer to the apportionment question. We do know that after some four hours of deliberations, six jurors felt Dr. Johnson was not causally negligent at all. And, although we also know that the remaining six jurors concluded that Dr. Johnson was negligent and at least partially responsible for Mrs. Graupman's brain damage and subsequent death, we do not know if they were ready to ascribe a significant portion or only a small portion of the causal negligence to him. After the jurors were told that "in most cases absolute certainty cannot be expected" and that they should "examine the questions submitted … with candor and frankness and with proper deference to and regard for the opinions of each other," *see* WIS J I—CIVIL 195, they arrived at

their verdict allocating 95% of the causal negligence to Dr. Marks and only 5% to Dr. Johnson.[6]

In this regard, we note also that Physicians argued that the jury should find its insured not negligent at all, while the Fund, having conceded Dr. Marks's negligence, did not argue for any specific apportionment of negligence between the physicians. Rather its counsel told the jury:

> It's a difficult question. I don't know if it's 50/50 on each physician, or what it should be, but that is something you will have to decide, after reviewing your notes and discussing this case.

The Fund was understandably disappointed in the jury's response to the apportionment question, and the trial court was apparently surprised by the jury's determination. Nonetheless, the trial court has not told us why the jury should have rejected the evidence presented by Physicians, nor why its apportionment was an improper compromise, and we conclude therefore that it erred in ordering a new trial. *See* ***Burch v. American Family Mut. Ins. Co.***, 198 Wis.2d 465, 477, 543 N.W.2d 277, 282 (1996) (holding that a trial court may not assume that a jury did not follow its instructions and base its order for a new trial purely on speculation as to basis for the jury verdict).

Finally, the Fund suggests that the trial court may have "had credibility concerns" regarding Dr. Johnson's testimony concerning his efforts to verify the proper placement of the initial endotracheal tube before he left the CT room to return to surgery. If so, we can only speculate as much, because the court

[6] Two jurors dissented from the answer to the apportionment question. Again, however, we cannot be sure whether the two dissenters believed Dr. Johnson should be held more or less responsible for Mrs. Graupman's brain damage and death than the verdict agreed to by the remaining ten jurors.

makes no comment on Johnson's credibility, or that of any other witness, in its oral decision and written order. Moreover, when issues are tried to a jury, credibility determinations are absolutely within the province of the jury, not the court. *See* ***Meurer v. ITT Gen. Controls***, 90 Wis.2d 438, 450, 280 N.W.2d 156, 162 (1979). Thus, the court's "credibility concerns," if it had them, would be an improper basis on which to set the jury's verdict aside. Only if "human testimony is in direct conflict with established physical facts and common knowledge" may a court deem it incredible and incapable of supporting a jury's verdict. *See* ***Strnad v. Co-Operative Ins. Mut.***, 256 Wis. 261, 271, 40 N.W.2d 552, 559 (1949). Neither the trial court in its ruling, nor the Fund on this appeal, claim that the testimony of any of Physicians' witnesses at the first trial was incredible as a matter of law.

CONCLUSION

For the reasons discussed above, we reverse the appealed judgment and remand with directions to enter judgment on the jury's verdict of June 12, 1995.

By the Court.—Judgment reversed and cause remanded with directions.

Not recommended for publication in the official reports.