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Chester E. Farrow v. Health Services Corporation, A Corporation, Salt Lake Clinic, A Professional Corporation, Louis J. Schricker, M.D. And Louis J. Moench, M.D. : Brief of Appellant

Utah Supreme Court

IN THE SUPREME COURT OF THE STATE OF UTAH

CHESTER E. FARROW,

Plaintiff and Appellant,

vs

HEALTH SERVICES CORPORATION, a corporation, SALT LAKE CLINIC, a professional corporation, LOUIS J. SCHRICKER, M.D. and LOUIS J. MOENCH, M.D.

Defendants and Respondents.

No. 15458

BRIEF OF APPELLANT

Appeal from Judgment of Third District Court of Salt Lake County

Honorable Stewart M. Hanson, Jr., Judge

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IN THE SUPREME COURT OF THE STATE OF UTAH

CHESTER E. FARROW, :

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HEALTH SERVICES CORPORATION, :
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LOUIS J. SCHRICKER, M.D. and
LOUIS J. MOENCH, M.D. :

Defendants and Respondents.:

BRIEF OF APPELLANT

STATEMENT OF CASE

This is a malpractice action brought by Appellant, Chester E. Farrow, against Health Services Corporation (owner and operator of the LDS Hospital, Salt Lake City, Utah); Salt Lake Clinic, Louis J. Schricker, M.D. and Louis J. Moench, M.D.

Chester E. Farrow entered the LDS Hospital as a patient of Dr. Louis J. Schricker on the 12th day of August, 1974. His initial diagnosis was that of cervical spondylosis. He was operated on for this condition on August 15, 1974. The operation was, evidently, a success. However, on returning from the recovery

room and later while a patient on the neurosurgical floor of the hospital he became confused and disoriente and suffered from hallucinations at times. When the condition persisted, appellant requested phyciatric help from Dr. Schricker. Dr. Schricker arranged for a consultation by Dr. Louis J. Moench. Dr. Moench saw appellant on the evening of August 23, 1974. Subsequen to that visit and during the early morning hours of Aug 24, 1974, appellant broke the window of his room on the sixth floor of the hospital; jumped through the window and landed on a roof above the first floor entrance of the hospital on the west side. As a result of the fall and injuries sustained by appellant, he was rendered permanently paralized and is now quadriplegic.

Appellant claims that the hospital and attend physicians were negligent in his care, treatment and co trol post-operatively; and that his accident would not have happened had appropriate measures of surveilance a control been taken by those responsible.

Respondents deny any negligence on their part and allege further that appellant's fall and injuries were caused by a suicide attempt.

DISPOSITION IN LOWER COURT

The lower court granted summary judgment in favor of Dr. Schricker and Health Services Corporation. The issues against Dr. Moench were tried to a jury. From a verdict and judgment for Dr. Moench and from the summary judgments, plaintiff appeals.

RELIEF SOUGHT ON APPEAL

Plaintiff seeks reversal of the judgments in favor of defendants and asks for trial on the merits against all defendants.

STATEMENT OF FACTS

Chester E. Farrow, the plaintiff, was born December 28, 1924 and resided in Moab, Utah at the time of this accident. He received his education in geology from Okalahoma State University and was working as a consulting geologist in mineral exploration at the time of the accident. His training included work for the U.S.G.S., Bureau of Reclamation, Atomic Energy Commission, and Tidewater Oil Company. He has worked as a consulting geologist all over the western United States, Australia, South America, Central America, Canada and West Africa. Tr. 110-112.

His services were in demand and he earned a substantial income. Tr. 184.

In August, 1974, Farrow suffered an accident involving his 4-wheel drive vehicle. He was taking a sack of flour from the vehicle to his home when he struck his left arm against a mirror bracket on the car. This caused a series of spasms in his arm, through his shoulder and into his neck. This was on a Saturday in August, 1974. Tr. 115-116. He called the local doctor in Moab and received a prescription but the pain continued and on Monday he consulted his family doctor. Tr. 117. About Wednesday the following week he was hospitalized

in Moab, Utah for x-rays. It was suggested by his loca doctor that he would require additional treatment and would have to go to Salt Lake City for that purpose. About August 11, 1974, he came to Salt Lake City, staye overnight in a motel and was admitted to the LDS Hospit by Dr. Louis J. Schricker on August 12, 1974. (Tr. 11

Prior to any operative procedures being performed upon plaintiff he stated both to Dr. Schricker and the anesthesiologist that he had had a violent reaction to an anesthetic that was given to him in 1949 for an appendectomy. He advised them that as he was coming out of the anesthetic he became violent and it took several people to hold him down. (Tr. 119)

The first procedure performed upon him after he entered the hospital was a myelogram which confirmed the diagnosis of herniated disc at the C5-C6 level. (Page 36 of Hospital Records, Exhibit "D1")

On August 15, 1974, Dr. Schricker performed a laminectomy and discectomy on the cervical spine at the level indicated.

For a day or two following the operation, pla tiff had no knowledge of events that occurred to him or his surroundings. He did have a recollection, however, of a mental impression of bizarre events and happenings that occurred during this period of time that he typifi

as being hallucinations. He saw bright lights and people running as if an atomic blast had occurred. He experienced fear for the safety of his wife and daughter. He experienced sexual fantasies and had a mental picture of his home and office being burned down. (Tr. 124) After he became rational, he told Dr. Schricker about these episodes. (Tr. 125)

During the course of his post-operative progress, he first had visual hallucinations and later the hallucinations became auditory in nature. At times he was lucid and completely in control of his faculties and emotions. Then without apparent cause he would begin to hallucinate. He had no control of these matters, hallucinations would simply come and go. (Tr. 125-126)

As time progressed, the hallucinations were auditory rather than visual and consisted of voices in the room (he was in a private room at all times). The voices were accusatory and derogatory to him and he became very fearful about his own future. He did not have insight into what was happening to him. (Tr. 127)

On two occasions during lucid moments he asked Dr. Schricker to change his room. On one occasion he asked Mr. Kent Griffiths (a social worker employed by the hospital) to change his room. He was never moved. (Tr. 127)

The hallucinations continued. At times the sensation was very brief; at other times it would last most of the night. He had a mental impression that he was in a psychiatric observation ward and that the voic were talking about him. He detected that he was able t identify one of the voices, that of Dr. Schricker, the other voices were that of an older man and woman and a person with a Southern accent but he was unable to iden those voices. (Tr. 128-129)

He felt that during his hospital stay the hallucinations began to be less in frequency but a shor time before he jumped from the hospital room, the hallu cinations had definitely increased in intensity. (Tr.

Mr. Kent Griffiths has been mentioned before. He was assigned to visit with Mr. Farrow because of cer tain concerns expressed by plaintiff's wife over the fa that a gun that Mr. Farrow had at home had been misplac and she thought he had taken it with him to the hospita The fact is he did not have a gun. During his hospital stay Mr. Griffith became a confidant and the only perso in the hospital that plaintiff felt at ease with. (Tr. The afternoon before the night this terrible tragedy occurred, Mr. Griffiths had taken plaintiff to the outd patio of the hospital and it was one of the only times during his hospital stay that plaintiff had felt any pe (Tr. 139)

By August 23, plaintiff realized that he needed help. He asked Dr. Schricker to get him the best psychitrist in the City because he wanted someone to straighten him out and provide the proper care. (Tr. 1369)

To add to the confusion and fear that had occurred to this man, the hospital had lost or misplaced his money. Plaintiff customarily carried a fairly large amount of cash for use in his business of acquiring mineral options. When he entered the hospital he had between three and four thousand dollars cash on his person which he turned into the hospital on admittance. He became aware, after the operation, that the hospital could not produce his money and this fact greatly disturbed him. (Tr. 1369 - 1370) The money was eventually found, but not until after he had jumped from the window.

Returning to the events of this day, plaintiff returned to his room after his visit with Mr. Griffith on the hospital patio. On his return the hallucinations again commenced. He had a great deal of anxiety and called his wife at least twice before he was visited by the psychitrist, Mr. Moench. (Tr. 1374)

He was fearful and suspicious of everyone in the hospital. He did not contact the nurses about his condition because he felt they were spies for the voices that were accusing him and making derogatory remarks about

him. He had the mental impression that the people were going to put him in a mental institution.

Dr. Moench visited with him in his hospital room on the evening of the 23rd. (Tr. 1376)

The visit by Dr. Moench was a question and answer period wherein the plaintiff discussed the fact that he was having marital problems and that he was greatly concerned about the hallucinations that he was experiencing. Plaintiff has no recollection that Dr. Moench gave him any diagnosis of his problem or that he said anything about what plaintiff could expect in the future. He did try to reassure plaintiff. Dr. Moench frightened him by the manner of his questions and plaintiff became very anxious after Dr. Moench left. He called his wife and expressed that anxiety to her. (Tr. 1379)

At the time Dr. Moench left, plaintiff had the mental impression that Dr. Moench was talking to someone in the hall and that he had stated that they would have to transfer plaintiff to a mental institution. (Tr. 13 Whether this was a hallucination or fact plaintiff could not tell. At the time it occurred, he believed it was true and this created more fear and anxiety.

Some time after eight o'clock as indicated he called his wife. He told her to be sure to call him the next morning by nine-thirty because he felt that some-

thing was going to happen to him, that he might be moved and that he was very much afraid. (Tr. 1380)

The events occurring subsequent to Dr. Moench's visit can best be described by reference to the actual testimony of the plaintiff.

Q Then I want you to discuss with us and tell us in detal everything that happened to you from that point up until the time that you went out the window.

A Well, these audio hallucinations continued in intensity and frequency. I was very much afraid. I would get into bed; I would lie there a few minutes; I would get up, walk back and forth around the room, lie back in bed again trying to rest. I was very anxious. I'd get up and pace again.

There was a large chair in the corner of the room. I would sit in this for awhile. I thought that these people--I heard noises outside the room. The door was closed. I didn't know what was going on. I thought that these people were coming to get me, and I didn't have anything to defend myself with. I felt that I couldn't get out that door and get by them. There was a bathroom which--

Q At that point--

A Yes?

Q Had you reached a mental determination of action on your part?

A All I wanted to do at that point and ever since I had talked with Dr. Moench was to get out of th room. And I attempted to go through the bathroom, whic the other room adjoining me had a door which opened out and I went from my side of the bathroom into the other man's room. I heard people talking, heard somebody cough, and I--it scared me--and I came back in through the bathroom into the room which I was in. I made no further attempt to try to get out through the doorway. I didn't know what to do. I kept going back and forth to bed, getting up and walking around, sitting in the chair, very much afraid, trying to figure out what I could do.

These hallucinations were increasing. I had reached a point where I was not sure what I was doing.

Q Did you know where you were?

A Not all the time, I didn't. Part of the time I thought that I was back in the hospital in Moab.

Q How many stories does that hospital have?

A It's only one floor.

Q Continue.

A Anyway, this kept going on and on. And I

don't recall anyone coming into the room after Dr. Moench left. If they did, I have no recollection of it whatsoever.

Eventually, the whole thing just got the best of me. I took the chair and I broke out the left window of the room which I was in--it was a plate glass window--I broke it clean so that--

Q Where did you think you were then?

A I thought that I was on the ground floor and that I could just jump out of the window and run. And that's what I did. I took and broke the window clean so that I would not cut myself. There were no jagged edges, as I remember, and the only cut that I received from the glass was a small scar right there. That's the only place.

Q Pointing to your left hand?

A No, it's the right hand.

Q Excuse me, the right hand?

A It's right there. And that's the only cut that I received from the glass.

I stepped back from the window after I had broken it out, and I saw a place--and I would guess less than about 15 seconds, I stepped back from the window I would say about two paces, and I ran and jumped as if

were to be hurdling the windowsill. And it's possib to do that. I actually put my foot on the windowsill when I went down. And as soon as I went out the wind I knew that--what had happened.

Q As soon as you left the room, is that corr

A That's correct.

Q What did you think right at that moment?

A I just said, "Oh, my God."

MR. SNOW: Object to that as self-serving.

THE COURT: The objection is overruled.

A I said, "Oh, my God." And I was falling face down. And then I rolled over on my back, and I landed on my left shoulder and my head on the top of t covering of the--it's a walkway, I guess, to the entra of the hospital. (Tr. 1381, line 13 - 1383, line 28)

Exhibit 3P is a photograph of the west side of the LDS Hospital. At the time of the accident, Far was in a sixth-floor private room. He jumped from the window marked with a circle and landed on a roof cover the first floor entrance to the hospital. The positio of his body is marked with a circle and his name is written to the side. He did not lose consciousness as a result of the fall. He tried to move both his arms legs but realized immediately that he was paralyzed.

was in extreme pain. Dr. Schricker arrived and climbed onto the roof while Farrow lay there. He said "Chester, why in the hell did you do it?" Farrow replied that he did not know. (Tr. 1385-1386)

Eventually he was removed from the roof by fireman and taken inside the hospital for treatment. He remained in the hospital from his admittance in August to December 3, 1974. (Exhibit P1) As a result of the fall he sustained a fractured dislocation of cervical disc C-5, C-6 and C-7 resulting in severe damage to the spinal column, resulting in paralysis. He has had numerous operations and surgical procedures performed upon him, both at LDS Hospital and later at the VA Hospital in Long Beach, California. He is quadreplegic and his paralysis is permanent.

For a complete understanding of this case, and the reasons why this medical tragedy occurred and why it could have been prevented, one must carefully analyze Farrow's medical record at the LDS Hospital and the testimony of the doctors and nurses and other hospital personnel who had contact with the plaintiff. It is the interaction or rather the lack of interaction between these people that caused this accident. Each of those involved either

failed to carry out their duties or did so in a superficial and negligent manner.

The following factual survey will deal with the facts contained in the hospital record and the testimony of the personnel as these events unfold.

Examining the hospital records, the Court is asked to note that each sheet bears a penciled number usually in the lower right-hand corner. The hospital practice when a patient is discharged from the hospital is to send the hospital record to the records librarian. At that time a clerk numbers each page serially. The sheets in this record that are not numbered are "physic order sheets for August 15, 1974 through August 24, 197 involving three separate sheets. These are now located between numbered sheets 48 and 49. The unnumbered shee were missing from the first copies of hospital records obtained by plaintiff's attorneys but were later obtain from counsel for the hospital. No explanation has been offered as to why these sheets are unnumbered or why th were not with the other records for some period of time

The first indication given to the defendants in this case that there might be a potential problem wa when plaintiff entered the hospital and advised Dr. Schricker and the anesthesiologist of the bad reaction he had had years earlier from anesthetic given during

an appendectomy. This is noted on page 85 of the Record made by Dr. Lee Learned the anestheologist. The conversation was vaguely recalled by Dr. Schricker. (Tr. 1314) Clearly the doctors were put on notice of a potential problem.

After the operation a problem did develop. Plaintiff became confused, disoriented and depressed. This is reflected in the hospital records and particularly those notations made in the progress notes and the bedside clinical sheets signed by the nurses. We take this from the 16th of August, 1974 which was the day Farrow was taken from the intensive care unit to a private room on the neurosurgical floor.

AUGUST 16, 1974

PROGRESS NOTE	NURSES NOTE - BEDSIDE CLINICAL
Transfer out of ICU when bed is available. Doing well. Maybe sl. confusion (signed) Schricker.	8:30 p.m. Resting quietly 10:30 Resting quietly.

AUGUST 17, 1974

PROGRESS NOTE	BEDSIDE CLINICAL
Some confusion this evening. Neck is "good". Some fulness but not unexpected. Good spirits. (signed) Schricker.	12:00 a.m. Alert and oriented. Further note, has difficulty turning c/o discomfort in arms when on side. States wife and six-year old

BEDSIDE CLINICAL (Cont

daughter were here at
Refused breakfast at f
stated he was going to
(operating room) alert
oriented.

AUGUST 18, 1974

PROGRESS NOTE

Quite confused during the night and is not oriented fully. Wife told nurse during the night that this is not unusual for him that it had been going on for several months. Calmed down a bit at present. (signed) Schricker.

BEDSIDE CLINICAL

4:00 a.m. Resting qui
in bed.

7:00 to 3:00 Eating
agitated at times, rest
quietly at other times.

4:00 p.m. Walked in
and complains of left
being numb and tingly,
pain in shoulders, gri
Confused at times.

AUGUST 19, 1974

PROGRESS NOTE

Still remains moderately confused but less combative. Left arm feels good except for some numbness in left index finger. (signed) Schricker

BEDSIDE CLINICAL

12:00 a.m. Appears to
asleep.

4:00 to 6:00 Asleep
most of Noc.

7:40 Alert, awake

8:30 c/o pain TL noti
10:00 Resting
11:30 Resting TL notif
patients request for mu
relaxant
1:00 Resting, having
pain, talking on phone

BEDSIDE CLINICAL (Continued)

4:00 Chilly - asked for pain med.

6:00 Nauseated
6:45 Up to BR
8:00 Asked for milk
9:00 Cooperative
10:00 Had a carton of milk
No special problems

AUGUST 20, 1974

PROGRESS NOTE

Much more oriented today and wondering what has gone on the past few days. Is concerned about his wife. Neck is soft and pliable. Good progress. (signed) Schricker

BEDSIDE CLINICAL

12:00 to 1:00 a.m. Appears to be asleep

2:00 Awake c/o that he can't sleep

4:00 Appears to be asleep

6:00 A fairly restful night frequently stiring.

8:00 Complaint of losing watch. Would like to get envelope from downstairs. c/o bad headache. Seems to be feeling better. Visiting.

4:00 p.m. Appears depressed.

AUGUST 21, 1974

PROGRESS NOTE

Doing better today. Daughter and wife are here and he is very happy today. (signed) Schricker

BEDSIDE CLINICAL

12:00 a.m. Appears to be asleep.

4:00 Appears to be asleep.
7:00 Resting
10:00 Family in to visit.

PROGRESS NOTE (Continued)	BEDSIDE CLINICAL (Conti
Dr. Schricker! Can we consider a psych consult on this pt? (signed) Kent Griffith Yes! (writing of Dr. Schricker)	12:00 p.m. Appears com table. Sleeping. 8:00 Up ad lib. Seem oriented and quiet. No plaints.

AUGUST 22, 1974

PROGRESS NOTE	BEDSIDE CLINICAL
Much clearer! Doing well ambulating. (signed) Schricker	12:00 a.m. Asleep at lo intervals during noc. 7:00 - 8:00 Awake, no complaints. Awaiting wi and friend. 12:00 p.m. Patient very cooperative. 3:00 A quiet day. 4:00 Up ad lib. in ro and in hall. No complai 8:00 Made ready for th night.

AUGUST 23, 1974

PROGRESS NOTE	BEDSIDE CLINICAL
Has asked for psychiatric help today for the first time. Neurologically he is doing quite well. (signed) Schricker	12:00 a.m. Appears to be asleep. 4:00 - 6:00 Asleep most 8:00 Patient claims tha does not feel well.

PROGRESS NOTE (Continued)

Dr. Moench contacted and will see patient this evening. He is clear and well oriented, seems happier today. (signed) Schricker.

BEDSIDE CLINICAL (Continued)

2:00 p.m. Patient feels very tired. No pain at the moment. Good day.

4:00 Up ad lib. No complaints

6:00 Dr. Moench here
8:00 Resting quietly.
10:00 Backrub given, made ready for the night.

AUGUST 24, 1974

BEDSIDE CLINICAL

12:00 a.m. Spoke to patient states he is o.k. Offers no complaint. Instructed to call nurse if he should need anything.

1:30 Checked patient. Seemed asleep.

2:40 Upon hearing loud crash while in 611 I entered 607 patient was not in bed, I turned on light and was that window was broken. Upon looking out window was what appeared to be Mr. Farrow lying on 2nd floor roof. Nursing supervisor (F. Blood) notified administrator of nursing and nursing administration notified Dr. Schricker and Moench notified.

The Progress Note and nurses notes have been set forth in detail here for several days following the operation until the moment he jumped from the window. Significantly, we find that the psychiatric social worker Mr. Griffith, felt concerned enough about this patient to put a note in the chart requesting a psychiatric consult. He emphasized his request with exclamation points. Dr. Schricker responded by placing an exclamation point after the word "yes". Note also, the following day where Dr. Schricker places an exclamation point after the words "Much clearer!" (There appears to be a little bit of professional pride involved here.)

Dr. Moench saw Farrow on the evening of the 7th at about 6:00 p.m. He completed his examination and report at 8:00 p.m. The report is on pages 68 and 69 of the hospital record. It is reproduced here.

Age 49.

> Patient is a geologist from Moab who had a recent injury and operation for cerv - disc. Following, he has had marked and repid swings in mood, in contact with with reality, has fluctuated between cooperation and compliance and combative, suspicious hostility.
>
> At present he is very tense, says he hears voices of 2 to 4 persons - in hall and ceiling, talking about (not to) him,

keeping him under surveilance, accusing him of being a sex fiend, etc. etc.

Tells of prolonged marital problems, of lack of problem-solving skills (bilateral), of periods of tension over finances, and esp. recently when his work pressures are high. Had 2 counselling sessions but felt that he was cast as the villain, so he didn't continue. Has enjoyed and appreciated his visits (with) Mr. Griffith. Was esp. appreciative of a visit off the ward, where the surveilance doesn't follow.

Imp = 1. Long term marital maladjust
2. Present episode is either a dissociative reaction or a paranoid schizophrenic reaction. His tension is very high; his anxiety level very high; his distortion of reality may lead to acts of poor judgment.

Suggest: 1. A phenothiazine med. in fairly large doses promptly (I'll take the liberty of ordering).
2. Avoid barbiturates, if possible.
3. Repeated reassurance by direct nurse contact (nurse entering room, standing by bed, while talking).
4. If aud. hallucinations don't subside promptly, may have to move to 3 North (psychiatric ward) for safety. *
5. Continue marital counseling (with) Mr. Griffiths.

Thanks

L. G. Moench
23 Aug 74
20:00 hours

* The words "psychiatric ward" added for clarity.

The foregoing factual summary protrays this medical tragedy. First, from the mental impressions plaintiff and then from the record as set forth by th attending psysician, the psychiatrist and the nurses. From this impression, it is apparent that Mr. Farrow a very sick and very disturbed person.

As the points of argument unfold the testim of other witnesses in the case will be discussed in d tail as it pertains directly to the elements of liabi

POINT I: THE COURT ERRED IN GRANTING SUMMARY JUDGMEN TO DEFENDANT LOUIS J. SCHRICKER, M.D. AND HEALTH SERVICES CORPORATION (LDS HOSPITAL)

On August 29, 1977, the day before this tri was to begin, motions for summary judgment were argue by Health Services Corporation and Louis J. Schricker Cross-motions by plaintiff against the defendants wer filed and argued by the plaintiff. To the astonishme of practically everyone involved in this case, the co granted summary judgment to Louis J. Schricker, MD an Health Services Corporation.

The evidence before the court at the time simply did not warrant summary judgment. Considered it must be, in a light most favorable to the losing p (plaintiff), the evidence clearly shows a genuine iss

of fact for determination by the jury.

The lower court either chose to ignore or completely failed to understand the testimony of the witnesses.

The court had before it at the time of the motion the deposition of Dr. Sydney Walker, a psychiatrist practicing in La Jolla, California. The deposition was taken by the attorneys representing the defendants. The testimony of Dr. Walker is as follows:

Transcript 765:

Q. That is a generalized statement. I would like you to now tell me precisely, based on your review of this record, what the nursing staff of the LDS Hospital failed to do in the treatment of this patient.

A. I feel they failed to recognize the emotional problem, in terms of this man's acute toxic psychosis, number one, and then to exercise the care of watching him prior to, during and after the time of the psychiatric evaluation.

Transcript 767:

Q. Is it your statement that their failure to require the doctors, after they have called this situation to the doctors' attention, is a failure on their part to meet an accepted medical standard?

A. Yes, it is.

The testimony following has to do with the fact that the hospital social worker (an employee of the hospital) noted the psychiatric condition of Farrow and brought it to the attention of Dr. Schricker. However, it was two

days later that Dr. Schricker acted and it was not u

later that night that the psychiatrist finally appea

The testimony concerning this event is found at Tr.

Q. All right. He called this to the atte of the doctor on the 21st. On the 23rd the doctor, treating physician, does call in a psychiatrist for psychiatric evaluation. Is it your position that th social worker or the supervising nurses should have these doctors react more swiftly than they did?

A. Yes.

Q. And they have the authority and contro of that?

A. They certainly do.

Q. So they are supposed to diagnose the ac ness of this patient and then tell the doctor what t

A. I am not asking for them to make a diag They are responsible for taking immediate action.

If this man should come into the emergency without an airway open and one doctor doesn't open th airway, it is necessary for the staff to get a doctor that will open the airway.

Q. Let's stay with the facts. We have got a patient that is disoriented and it appears to the e ees of the hospital maybe he needs a psychiatric exam tion. It is your position, your professional positio now as an expert in the case, that the failure of the hospital to insist that Dr. Schricker act more swiftl than he did is a failure of the hospital to sustain a cepted medical practice?

A. Yes.

The doctor testified that the hospital fail to move the patient to the psychiatric ward, Tr. 80 that the hospital had responsibility in regard to the medication given, Tr. 801 - 802; and on the assumptio

that the nursing care given after the visit by Dr. Moench was merely normal and routine, the hospital would be guilty of negligence.

Q. Assume, doctor, after he (Moench) visited the patient that the nurses only made routine and normal checks and did nothing else. Would you consider that to be an act of negligence on the part of the hospital?

A. Yes.

His testimony is best summed up in a letter to counsel which is contained in the transcript at page 846:

"In conclusion, it would appear that Mr. Farrow's acute psychotic reaction when unidentified by the hospital personnel or attending physicians who, if they had taken appropriate measures for diagnosis and correction of the situation, would have avoided the patient's catastrophic actions."

The deposition of Dr. Walker must be considered by the Court in its entirety so that the full panoply of medical thought will be evident. The negligence of the doctor and hospital is apparent from this testimony alone and precludes the granting of summary judgment. There is much additional evidence.

Frances Funk, R.N.

Frances Funk was an expert witness for the plaintiff. Her deposition was taken by the hospital and was before the Court for the motion for summary judgment. Mrs. Funk had been a long-time employee of the LDS Hospital

and was retired at the time. She was at the hospital during the week that the accident to Farrow occurred was aware that he had been a problem patient. (Depos Page 43.) Significant portions of her testimony foll Page 29.

Q. So the psychiatric problem was noted, w known, and was called to the attention of the doctor; isn't that right?

A. That's right and that is why it seems t me that the nurses should have certainly been aware t this patient needed closer observation and needed mor help.

Page 32.

A. I think they were aware of this patient problem from the time he was admitted.

Page 51.

Q. In your opinion there was nothing given this man other than routine care; is that correct?

A. Routine custodial care.

Q. Given the circumstances of Dr. Moench's visit, would appropriate nursing care in this case ha dictated that this man be restrained?

A. Yes, and not being a psychiatric nurse, would-- (objections)

The Witness: Let me finish. I would want t be very careful how I observe that patient.

Q. If I have that correctly, then, without being a psychiatric nurse, but being an RN.

A. Right.

Page 53.

Q. And does this record indicate to you, th nurse's record, that this man was given the surveilla

and observation that Dr. Moench recommended?

A No.

NOTE

A most significant element relating to the liability of the hospital is the medication ordered by Dr. Moench. Had it been given when ordered and in the correct dosages this tragedy could have been prevented. Dr. Moench ordered 100 milligrams of Mellaril "stat" (meaning "right now") at eight o'clock p.m. The medication was not actually given until ten o'clock p.m. (See medical record.)

On this very important note, Mrs. Funk testified as follows:

Deposition Page 45.

Q When a doctor given an order stat, what does that mean to a nurse? What is the meaning of that? What must they do?

A It means it is supposed to be done immediately.

Q Now, if an order is issued at 8:00 stat for 100 milligrmas of Mellaril and it is given at 10:00 p.m., is that compliance with the doctor's order?

A No.

Deposition Page 46.

Q. Should prescriptions have been given immediately?

A. Yes, it should have.

Q. And is that also one of your areas of c
cern here concerning this man's care?

A. Yes.

Mary E. Vaughn, RN

Mary E. Vaughn's deposition was before the Court on motion for summary judgment. Mrs. Vaughn ha been an RN since 1942 and for 24 years, to 1974, she was night supervisor at the LDS Hospital. Although n a supervisor at the time, she was on duty at the hosp the night Mr. Farrow jumped from the window. After t accident Mrs. Vaughn talked to Diane Karren (the nurs duty at the time of the accident). This was Diane Ka first night on duty after coming off of vacation. Sh not read the chart or the consultation note of Dr. Mc before this tragic event. From the deposition at pag 20:

"...Oh, by the way, that night Diane Karren told me that this patient had been restrained previou to this night that he went out the window and he had up in the halls walking around but this is while she was on vacation, she told me."

Deposition Page 11.

Q. Do you have an opinion as to whether th nurses performed and did the things that they were su posed to do that evening or didn't do what they were supposed to?

A. Yes.

Q. You have that opinion?

A. I have my own opinion

Q. It is a personal opinion?

A. It is my own opinion.

Q. What areas do you have in mind with reference to that opinion?

A. Well, after being supervisor that many years, I was always concerned about the safety of the hospital.

Q. What do you mean by the safety of the hospital?

A. Well, you are always thinking for the safety of the patient and the safety of the hospital.

Q. But do you have an area where you think that the nurses may not have done everything they were supposed to have done that evening?

A. Well, with a patient like Mr. Farrow, I would have said that he should have been posied or had a restraint on, especially after Dr. Moench had been in at eight o'clock that evening. That was quite a late time to be going in to see a patient on consultation.

Q. Okay. Define for the record what you mean by posied.

A. It is a belt that goes around them and ties them and they have locked ones and they have ones that do not lock around their waist.

Her further testimony was to the effect that the nurse on duty had not read the consultation report of Dr. Moench and that she stated to Mrs. Vaughn that had she read it she would have taken other changes (measures?), Page 42. Farrow was awake at midnight and should have been asleep if he had had 100 milligrams of Mellaril, Page 42. While she did not expect the nurse to be con-

stantly in Farrow's room, she did expect that the nu
would do more than just open the door and look in.
nurse on duty should have assured herself that Farr
was sleeping and not merely open the door and look
Tr. 74.

Again, nurse Vaughn also stated that when
doctor makes an order "stat" it means immediately.
67.

The Court is again directed to the matter
medication. On the 10th day of September, 1975, bo
the deposition of Craig Jackson, a pharmisist at th
Hospital, and Karen Pool, the nurse on duty when Dr
Moench visited, were taken. Mr. Jackson was asked
give the particulars as to how the prescription for
Mellaril would have been filled. The doctor ordere
100 milligrams stat and then 50 milligrams every fo
hours and as needed. Mellaril comes in several amo
from 15 milligrams to 200 milligrams and the tablet
are different colors for different amounts. Tr. 97
Customarily, with a prescription such as was given
Farrow, the pharmicist would put twelve 50 milligra
tablets to fill the 100 milligram prescription and
thereafter would give one tablet to fill the 50 mil
gram prescription. Tr. 969.

Nurse Karen Pool who gave the medication testified as follows: Tr. 1029.

Q. How many pills did you give him?

A. One.

Q. One?

A. Yes.

Q. Did he take that pill?

A. Yes.

Q. Are you sure?

A. Yes.

A very curious thing occurred after this deposition was taken. At the time this deposition was signed by Miss Pool, almost one year later, on the 23rd day of August, 1976, she changed her testimony, gave no reasons therefor and it now reads as follows:

Q. How Many pills did you give him?

A. One or two, depending on the dosage sent up by the pharmacy. KP

Q. One?

A. Yes.

Q. Did he take that pill?

A. Yes, if a 100 mg pill was sent up. KP

This young, inexperienced nurse (at most three months out of nursing school, and not yet an RN) gave Farrow only one-half the Mellaril dosage prescribed

By Dr. Moench. Negligence on the part of the hospit is proven and corroborated by nurse Vaughn in her de sition when she states that Farrow should have been asleep at midnight (he was not) if he had been given milligrams of Mellaril at 10:00 p.m. (Mellaril is a major tranquilizer.)

A mistake in medication had been made and t hospital knew it as soon as the two depositions were taken. The result-- the nurse changed her testimony gave no reasons therefor.

This is so patently offensive that the lowe court should have ignored the testimony change on the motion for summary judgment.

Further on the matter of medication. The August 23, medication order of Dr. Moench is as follo

> "Mellaril 100 mg stat. 50 mg qid and prn Dalmane 30 mg hs prn. D/C Nembutal."

Dr. Moench finished his work and left the hospital at 8:00 p.m. He talked to nurse Pool before he left. W find, however, that nurse Pool did not acknowledge th prescription order until 8:50 p.m., almost one hour l Referring to the medication chart, we find that she d not give the Mellaril to Farrow until 10:00 p.m. The is no explanation for this delay. Simply stated, whe a doctor gives an order "stat" meaning that it should

carried out immediately, there is absolutely no excuse for a two hour delay. Had the medication been given timely the tragic accident to Farrow would have been avoided.

That is not all the evidence of negligence relating to medication. The only medication given Farrow after the visit of Dr. Moench was the half dosage of Mellaril. That was given at 10:00 p.m. He was to have 50 milligrams at least every four hours and even more if it was needed. He jumped out of the window at 2:40 a.m. Obviously, the nurses should have given him more Mellaril by at least 2:00 a.m. Additionally, Dr. Moench ordered 30 milligrams of Dalmane (a sleeping pill) at bedtime and as needed. The sleeping pill was never given. Mr. Farrow was awake at midnight according to the note made by the LPN (hospital record, page 208). Dr. Moench obviously wanted Mr. Farrow tranquilized and asleep for that night. Had the nurses carried out his orders (which they did not do) this tragedy would have been avoided.

In addition to the medication ordered by Dr. Moench, he made a further directive to the hospital staff. On page 69 of the hospital records, he states:

> " ③ Repeated reassurance by direct nurse contact (nurse entering room, standing by bed while talking)."

Nurse Pool was familiar with this order at the time it was written by Dr. Moench. Tr. 1027. Nurse

Pool testified that she gave Farrow a pill at 10:00 p
This was noted in the hospital chart. She testified
she saw him again at 11:00 p.m. as she was going off
duty. In a three-hour period she visited his room t
This is hardly the frequent contact ordered by Dr. M
The LPN on duty at the time visited Farrow's room at
10:00 and said she saw him on another occasion. How
the only visit that is charted is the 10:00 p.m. vis

At 11:00 p.m. a shift change occurred at t
hospital. Nurse Pool and LPN Callahan turned the fl
over to nurse Diane Karren and LPN Judy Hall. The de
of Diane Karren was before the court at the time of t
motion for summary judgment. She worked three days
a week for the hospital and this was her first shift
a two-week vacation. Tr. 1052. Her only knowledge
Mr. Farrow was gained from nurse Karen Pool who prec
her on duty. She was told that Dr. Moench had been i
and that he had requested that Mr. Farrow be watched.
Tr. 1057. According to Diane Karren, the number of n
on a ward depended upon the type of patient on the fl
Nurse Karren and LPN Hall were the only two on duty a
11:00 p.m. (Except for the personnel in the intensiv
care unit, and they were not involved with the patien
on the floor.) At times, there were three people on
duty on the neuro floor depending upon the nature of

patients. When asked about this, nurse Karren responded that a third person would be needed if someone had to be watched extra closely, that you could not trust. Farrow was such a person and this was apparent from the consultation note of Dr. Moench: Tr. 1056-57

> "His tension is very high; his anxiety level very high; his distortion of reality may lead to acts of poor judgment."

It was usually the responsibility of the afternoon shift to request additional help. Tr. 1057. The night shift could demand extra help but sometimes they would get it and sometimes not. Tr. 1057. Furthermore, this was a busy night on that floor. There is space for 22 patients and the floor was virtually full on that evening. Tr. 1048 - 1050 - 1063. A need for extra help existed but help was never requested.

During the very critical period of time when something could have been done for Mr. Farrow, nursing care completely failed. From 11:00 p.m. until 2:40 a.m., a period of about four hours, Farrow was visited only once and that was by the LPN and not by the registered nurse. At 1:30 a.m. nurse Karren did open the door to Farrow's room and look in, but she did not know whether he was asleep. Tr. 1061-62. This hardly complies with the "direct nurse contact ordered by Dr. Moench. Tr. 1273.

> "I suggested also that their checking on him included them going into his room and not

just looking through the door, to go to hi bedside, to identify themselves, and to ask how he was, and to ask if he needed anything."

The subject of medication also came up in deposition of nurse Karren. She testified as follow Tr. 1062.

Q. Do you recall if he had any medication take that night?

A. That I had to give him?

Q. Yes.

A. No. No.

Q. You say he did not, or you don't recal

A. No, I didn't have any.

Q. No order for medication?

A. No.

As pointed out in detail above, both Mella and Dalmane had been ordered for Farrow and should h been giver to him by nurse Karren. Yet, she denies any medication order existed. Unbelievable!

From the record it must be concluded that Schricker and the hospital are liable. At the very an issue of liability is present. Dr. Schricker, th attending physician, failed to heed the fact that Fa told him that he had had a bad reaction to a prior m

cation (anesthesia); failed to move Farrow from the room he was in, although it had been requested; failed to recognize that Farrow had become psychotic after the operation; and failed to secure the assistance of a specialist until too late. (The record will show that Dr. Schricker took no action on the matter until it was demanded by a social worker and then a specialist was not summoned until over two days later.) Had he responded promptly as he should have, this tragedy would have been avoided.

The negligence of the hospital results from an impressive catalog of failures and omissions:

1. When the hospital personnel knew that Mr. Farrow needed psychiatric help they were obligated to step in and do something about it when the attending physician failed to act. Darling v Charleston Community Memorial Hospital, 33 Ill 2d 326, 211 NE2d 253, 14 ALR 3d 860;

2. Failure to change his room when he requested to be moved;

3. Provided only routine custodial care when much more care was indicated;

4. Failure to provide surveillance or restraint and direct nurse contact when indicated and ordered by Dr. Moench;

5. Failure to take reasonable steps to pro
Farrow from "acts of poor judgment";

6. Failed to provide extra personnel when
nurses knew that Farrow was a patient that needed to
watched;

7. Delayed two hours in giving Farrow medi
tion that had been ordered "stat" and then --

8. Gave only one-half the prescribed dosag
and then --

9. Failed to give the sleeping medication
ordered; and

10. Totally ignored the medication order af
10:00 p.m.

A case of striking resemblance to this one
the Kentucky case of Lexington Hospital, Inc. vs Whit
245 SW2d 927. In that case the plaintiff suffered fr
epilepsy. After an epileptic seizure he would have
paranoid delusions imagining he was in a German pris
with spies all around and without warning would run
and hide. The hospital knew of his anxiety symptoms
paranoid delusions when he was admitted. After he w
admitted, he did in fact escape one time. (It will
recalled that the hospital records and nurse Pool's

mony reflect the fact that Farrow was found wondering and confused in the hall of the LDS Hospital.) On the day following the escape, the attendants left the plaintiff unattended and unwatched. He went into a bathroom, smashed the window and fell to a sidewalk two stories below. The Court held that:

> "In the present case the defendant had recognized in its written contract the need of restraint of the patient. It had been expressly advised of his sudden and intermittent fits of aboration and of his trait to flee in his delirium. It had let the patient get away a few days before, so received adequate warning from its own experience. This emphasized the need of special care and protection to prevent a recurrence. Despite all this, the patient had been left alone without surveillance long enough to enter another room, break out the window and fall to the ground."

Verdict for the plaintiff was affirmed.

Another case in close parallel is that of E. W. Misfeldt v Hospital Authority of the City of Marietta, 115 SE2d 244 (Ga.) Plaintiff's wife was admitted to the hospital with the diagosis of paranoid schizophrenia. From the opinion:

> "The case, construed in favor of the plaintiff, thus presents us with the tragic results of divided responsibility. The physician in charge felt he had made plain to the hospital authorities that the patient was mentally disturbed, and, being on the hospital staff, he undoubtedly supposed that such a patient would at no time be left to her own devices contrary to hospital regulations.

The admissions clerk felt she had represented the case to the superintendent of admissions if anything too strongly, because she received a rebuke from that source at her specific indication of the "psycho room." The superintendent contended she was not told the patient might become violent, that her appearance was normal, and that she accordingly awaited further instructions from the director of nurses. The director never entered the picture. The floor nurse relied upon any lack of special instructions to herself to guard the patient, and, as to the medicine, she contended that the words on the prescription "Q.I.D." instead of "stat" indicated to her that there was no reason for prompt medication, but only that the medicines, after they were obtained, would be administered in routine fashion.

[4] From the above there can be no doubt but that there was some evidence, at least, to sustain the allegations of negligence. The hospital did have notice of the patient's mentally distrubed condition, and it cannot be said as a matter of law that they were freed from responsibility because this notice was not in writing contained in the specific instructions brought to them by the patient's husband at the physician's request. There was enough evidence as to the patient's appearance on arrival to make a jury issue as to whether trained staff members should not then have recognized her irresponsible condition. They did not, rightly or wrongly, keep constant watch over her, and they did allow her to wander away by herself. The particular tranquilizer on which the physician undoubtedly relied should have been given at the regular 4 p.m. administration of medicine. Whether had it been sent for in time, it would have been available for that purpose, and whether the delay in sending for it constituted negligence, were also jury questions.

The Court ruled that the lower court did not commit error in failing to direct a verdict for the defendant.

Accidents such as occurred to the plaintiff in this case are not that rare and unusual. Many similar cases are reported on 70 ALR 2d 347. A good summary of law is stated on page 348 of that annotation.

> "The ordinary rule that the duty of a hospital toward its patients is to exercise such reasonable care for their safety as their known mental and physical condition may require, and that in a proper case this duty may extend to affording reasonable protection against self-inflicted injury, has frequently been recognized in actions for injury or death to a patient alleged to have resulted from his escape or attempt to escape."

See also, Kent v Whitaker, 364 P2d 556, (Wash.); Vistica v Presbyterian Hospital and Medical Center, 432 P2d 193 (Cal. App.); Wood v Samaritan Institution, Inc., 161 P2d 556 (Cal.); Hunt v King County, 481 P2d 593 (Wash.); Meier v Ross General Hospital, 445 P2d 519 (Cal.) (Approving the doctrine of res ispa loquitur in similar cases.)

The evidence before the court on motion for summary judgment was that the hospital knew that Mr. Farrow was suffering from hallucinations; that he was confused; had wandered in the hall; and that a psychiatric consultation was needed. Then when the psychiatrist finally arrived the nurse read his note while he was making it and would know that "his tension was very high; his anxiety level was very high; his distortion of reality

may lead to acts of poor judgment" and "if aud. hall cinations don't subside promptly, may have to move t 3 North (psychiatric ward) for safety."

The failure to provide restraint, surveill and medication for the plaintiff is detailed above. Additionally, the testimony of the experts convict t hospital of negligence. At the very least, the liab of the hospital was a question to be submitted to th jury.

The summary judgment is not, and should no a favorite of the law. It deprives a litigant of hi right to a trial before a court or jury. It should granted only with great reluctance and only then if clearly appears that the party against whom the judg would be granted cannot possibly establish a right t recover. Rule 56 has given rise to more litigation and appellate practice than any of the other rules o civil procedure. A recent statement of the court re tive to summary judgment is set forth in the case of vs McGovern, 551 P2d 1266:

> "However, inasmuch as the party moved against is being defeated without the privilege of a trial, the court should

> carefully scrutinize the 'submissions' and contensions he makes thereon to see if his contensions and proposals as to proof of material facts, resolved in his favor, would entitle him to prevail; and if it so appears, the motion for summary judgment should be denied and the trial should be had for the purpose of resolving the disputed issues of fact and determine the rights of the parties."

For other statements of the Rule see Brandt vs Springville Bank & Company, 10 Utah 2d 350 353 P2d 460; Tanner vs Utah Poultry & Farmers Co-op, 11 Utah 2d 353 359 P2d 18.

POINT II: THE JUDGMENT FOR DEFENDANTS UPON THE VERD MUST BE REVERSED BECAUSE PLAINTIFF'S INJU WAS FORESEEABLE AND DEFENDANTS HAD A DUTY TO PROTECT HIM FROM THAT RISK.

The LDS Hospital Progress Notes (Defendant Exhibit 1) on the plaintiff reveal a marked pattern mental instability. Dr. Schricker noted on August 1 and 19 the plaintiff was confused. On the 20th, Kent Griffiths, M.S.W., noted that a long discussion with plaintiff revealed an "extensive history of personal and marital difficulties..." and that, "his confusio seems to revolve around the lack of any consistent me to the significant relationships in his life." On Au 21, Mr. Griffiths asked Dr. Schricker to consider a consult" on the plaintiff. To this request, Dr. Schr answered, "Yes!" On August 22, Mr. Griffiths wrote i the notes that there were definitely problems that "n psychiatric, if not other forms of counseling." On A 23, the plaintiff himself asked for psychiatric help. That evening the plaintiff was visited by Dr. Moench. LDS Hospital "Report of Consultation" signed by Dr. M at 8:00 p.m., August 23, stated that:

> "At present he (the plaintiff) is very tens says he hears voices of 2 to 4 persons -- i hall + ceiling, talking about (not to) him, keeping him under surveillance, accusing hi of being a sex fiend, etc., etc.,"

Dr. Moench then entered his impressions, "2.

Present eppisode is either a dissociative Reaction or a Paranoid schizophrenic reaction. His tension is very high; his distortion of reality may lead to acts of poor judgment."; and suggestions "4. If aud. Hallucinations don't subside promptly may have to move to 3 North for safety." 3 North is the psychiatric ward of LDS Hospital. Six hours later, Chester E. Farrow went out the window of his room on the sixth floor of LDS Hospital.

At the trial the court read the following instruction to the jury:

> "If you find from a preponderance of the evidence that the plaintiff intentionally jumped from the window in an attempt to commit suicide, he is not entitled to recover from defendants, and you must find against him, and for the defendants, no cause of action." Trial 483.

The thrust of this instruction is that a psychiatrist who has undertaken to care for a patient with notice that he has severe psychiatric problems that may lead to acts of poor judgment, has no duty to protect that person from those acts of poor judgment.

This is not the law in other states and should not be the law in Utah. "Those charged with the care and treatment of a patient, who know of facts from which it might reasonably be concluded that a patient would be likely to harm himself in the absence of preclusive measures, must use reasonable care to prevent such harm." Meier vs. Ross General Hospital, 71 Cal. Rptr. 903, 445

P2d 519, 525. (1968). Also see Fleming v Prince George's County, 277 Md. 655, 358 A2d 892 (1976).

The trial court's instruction would have been proper had the defendant been a layman. "Generally, courts are reluctant to impose civil liabili for another's act of suicide. This is partly due to the following paradox. 'If suicide is a deliberate i tentional act by an individual how can one person be civilly liable for causing the suicide of another?'" Note, the Liability of Psychiatrists for Malpractice, University of Pittsburg Law Review, 108, page 110. I the defendant is not a layman--he is a doctor holdin himself out as a specialist in the disorders of the mind. His patients rely on his specialized skill an training and he holds a position of trust regarding their well-being. "In the psychiatrist-patient rela ship, there is an affirmative duty to prevent suicid ibid at page 110. Plaintiff's expert witness, Dr. S Walker, III, testified at his deposition that "You a obliged to take the steps to prevent suicide, yes, y are." Tr. 746.

The scope of the duty "is to exercise pers ally or by means of orders and instructions to hospi personnel, reasonable restraint and observation." M Tort Liability of the Psychiatrist, 16 Buffalo Law R 649, 666. Of course, what is reasonable in each cas

depends on the psychiatric condition of the patient. ibid. In other words, the psychiatrist must at least partially base his determination as to the course of treatment the patient will receive on the foreseeability that the patient will in some manner harm himself. D. Dawidoff, The Malpractice of Psychiatrists (1973). Plaintiff's expert witness, Dr. C. H. Hardin Branch, testified at his deposition on August 4, 1977, that Mr. Farrow's psychiatric condition was such that it justified more protection than he was given in this situation. Trial 867. Plus, defendant Louis G. Moench, as reflected in his Consultation Report, recognized that plaintiff was a hazard to himself. Clearly, there was at least a jury question on whether or not Dr. Moench fulfilled his duty to the plaintiff based on Mr. Farrow's psychiatric state. However, that question was never considered by the jury because the effect of instruction No. 19 was to grant the defendants a directed verdict if the jury found that the plaintiff "intentionally jumped from the window in an attempt to commit suicide." The instruction was thus erroneous because the jury was told that an irrational act by the plaintiff, with no qualifying instructions as to foreseeability of that act and as to Dr. Moench's duty to protect the plaintiff from that act, will relieve the defendant of any liability. The law is that a physi-

cian has a duty to safeguard his patients against dan due to mental incapacity by exercising personally, or means of orders and instructions to hospital personne reasonable restraint and observation and the jury sho have been instructed to that effect.

The impact and effect of the intentional ac instruction is magnified by instruction 20 relating t proximate cause. (This instruction is not a good sta ment of proximate cause and unduly emphasizes the con There is an earlier instruction covering the subject. Here the jury is told that even if they find Dr. Moen negligent, nonetheless, he would not be liable is his negligence did not cause the event when the jury considered these two instructions together, they could w have found Dr. Moench negligent; but have further fou that plaintiff intentionally jumped from the window; therefore, plaintiff could not recover. The theory s forth by the court in the two instructions is erroneo Even further, the wording of the two instructions is couched in such manner that the jury had no choice an thus, the court, in essence, directed a verdict again plaintiff.

Accordingly, this case must be remanded for new trial.

POINT III: THE JUDGMENTS IN FAVOR OF THE DEFENDANTS MUST BE REVERSED BECAUSE THE LOCALITY RULE, UNDER WHICH THE OPINIONS OF PLAINTIFF'S EXPERT WITNESS WERE NOT ALLOWED INTO EVIDENCE AND WHICH WAS THE BASIS OF THE STANDARD OF CARE INSTRUCTION GIVEN THE JURY, IS A LEGAL ANACHRONISM AND MUST BE REJECTED AS THE RULE OF LAW IN UTAH.

On Tuesday, July 27, 1976, defendants deposed plaintiff's expert witness, Sydney Walker, III, M.D., a specialist in neuropsychiatry. Prior to the deposition, Dr. Walker had personally examined the plaintiff, reviewed the LDS Hospital records that pertained to the plaintiff, examined plaintiff's records from the San Diego Veterans Administration Hospital, and reviewed the depositions of Karen Pool, Dr. Louis G. Moench, Craig Jackson, Betty Farrow, John K. Griffiths, Julie Ann Hanson, Dr. Louis J. Schricker, Diane Karren, and of the plaintiff, Chester Farrow. (Pages 17 and 18, deposition of Sydney Walker, III.) At this deposition, Dr. Walker testified that in his opinion defendant Health Services Corporation, defendant Louis G. Moench, M.D., and defendant Louis J. Schricker, M.D. failed to properly care for the plaintiff, according to accepted standards of medical care and that this failure to care for the plaintiff resulted in his injuries. The trial judge refused to allow the opinions of Dr. Walker, as stated in

his deposition, to be admitted into evidence because had never practiced medicine in Utah, and thus, the reasoning went, was incompetent to testify as to the medical standard of care in this state.

The 11th instruction the court read to the ju stated:

> "You are instructed that if you find that the defendant Dr. Moench, in prescribing the drug Mellaril to treat the plaintiff's psychosis and the drug Dalmane for sleeping and instructing the nurse to repeatedly reassure the plaintiff by direct contact consisting of entering his room and standing by his bed while talking to him, complied with accepted standards of psychiatric care in this community, you should return a verdict in favor of the defendant."

Instruction 11, insofar as it makes the applicable standard of care against which Dr. Moench's conduct was to be judged, that of accepted standards psychiatric care "in this community" (emphasis added), correctly states the Utah position regarding the "locality rule". That position is this:

> "In malpractice cases, whether a physician or surgeon is negligent in the treatment of a patient depends upon whether he has used or failed to use the ordinary care and skill required of doctors in the community which he serves." Anderson v Nixon, 104 Utah 262, 139 P2d 216, 218.

As a rule of law, the locality rule is out of touch wi medical reality.

The root of the locality rule goes back to th 19th Century and is found in cases such as Small v. H

128 Mass. 131, 35 Am Rep. 363 (1880). (Overruled by Brune v. Belinkoff, 235 NE2d 703 (1968).) At that time, long before the advent of the automobile, the airplane, radio or television, persons were admitted to medical school if they had a high school diploma or its equivalent. Upon gradutaion, the practitioner was given an M.D. Degree and turned loose upon the world, in most cases never again to see the inside of a medical school classroom or be brought up to date on the latest developments of medical care. Obtaining a license to practice medicine was a formality. Wiggins v. Piver, 276 NC 134, 171 SE2d 393 (1970). Transportation and communication systems were primitive. "Then, except for a few stops on the railroads, the quickest mode of travel was by 'coach and four'. Forty miles between sunup and sundown was a full days travel--less than fifty minutes will suffice today." 171 SE2d at 396-397.

With this state of affairs the courts quite rightly felt that it was unjust to apply the same standard of care to city doctors and to their country cousins.

Circumstances, to coin a phrase, have changed. Travel times that used to be measured in days and weeks are now calculated in terms of hours. A doctor can pick up a telephone in Salt Lake City and speak with a colleague in Boston at a cost of a few dollars. "New

techniques and discoveries are available to all doctor within a short period of time through medical journals closed circuit television presentations, special radio networks for doctors, tape recorded digests of medical literature, and current correspondence courses." Note An Evaluation of Changes in the Medical Standard of Care, 23 Vanderbilt Law Review 729, 732. There have b great improvements in the quality of medical schools a those accepted for admittance thereto. In addition, t states have toughened up their licensing requirements for doctors. Note - Negligence - Medical Malpractice The Locality Rule, 18 De Paul Law Review 328. The Sta of Utah now requires all physicians and surgeons to ha a degree from a medical school approved by the Depart of Business Regulation, to have successfully completed twelve months of hospital internship training, and to pass an examination in anatomy, histology, bacteriolo biochemistry, pathology and physiology. (Section 58-31 and Section 58-27-6 Utah Code Ann.)

The reason for the foregoing historical bac ground is to show that the conditions that led to a di ference in the standard of medical care from one place another no longer exist. In fact, at least within med specialties, the standard of medical care is uniform throughout the country.

In 1962 the Stanford Law Review conducted a survey of the practice of medicine by specialists practicing within their specialities. Its conclusion: The practice of medicine by physicians within their medical specialities is similar throughout the nation. Medical Specialities and the Locality Rule, 14 Stanford Law Review 884.

The locality rule has several very real and practical difficulties which serve to wreak manifest injustice upon those unfortunate enough to be injured by a doctor's or hospital's negligence:

First, professional people are reluctant to testify against their colleagues in the community, Pederson v. Dumochel, 431 P2d 973, Wash. (1967). In point of fact, plaintiff's attorney in this case contacted a number of doctors in Utah to solicit (1) their opinion regarding possible liability on the part of the defendants and (2) testimony in line with their opinions. They believed that there was liability but refused to testify. Tr. 155.

Second, "the possibility of a small group who, by their laxness or carelessness could establish a local standard of care that was below that which the law requires." 431 P2d at 977;

Third, since the locality rule dictates that the standard of care be that of other doctors in the

community, the plaintiff is barred from bringing in expert witnesses from outside the community because, reasoning goes, not being familiar with the situation in the community, he is not competent to testify as t the standard of medical care. This is in total disre gard of the fact that, at least as far as specialists there is no difference in the standard of medical car from community to community and in disregard of the f that the defendant may be an acknowledged expert in h field who has access to the latest developments in th field of medicine. Such is the case here.

Defendant Louis G. Schricker has a bachelor degree, an M.D. degree and spent almost six and one-h years as an intern/resident before being certified by American Board of Neurological surgery. For almost f years Dr. Schricker was Chief of Neurologic Surgery a Fitzsimmons Army Hospital in Denver, Colorado. Tr. 1 Since 1957 he has been an associate professor of neur logic surgery at the University of Utah College of Me cine. (Deposition of Dr. Louis J. Schricker, page 5. Defendant Louis G. Moench is a Phi Beta Kappa and a graduate of the University of Chicago Medical School, diplomate of the American Board of Internal Medicine for a period of six years a preceptor under the vice

chairman of the American Board of Internal Medicine. Dr. Moench received post-graduate training in psychiatry in McLain Hospital, the University of California at San Francisco and the Utah State Hospital in Provo. Tr. 1856. He currently is an associate clinical professor at the University of Utah School of Medicine, (Deposition of Louis G. Moench, page 3.) having been associated with the medical school since 1945 in the departments of Medicine and Psychiatry. Tr. 1857.

In addition, at Dr. Schricker's deposition he stated that there are several excellent medical libraries in Salt Lake City, including one at the LDS Hospital and one at the University of Utah. (Deposition of Louis J. Schricker, page 9.)

Defendant Health Services Corporation, formerly known as LDS Hospital, is affiliated with the University of Utah Medical School as a teaching hospital.

The outstanding credentials of the defendants in this case highlight the unreasonableness of refusing the testimony of specialists from outside Salt Lake City because of a rule which was designed to protect the poorly trained, poorly equipped practitioner of the healing arts who did not have access to the latest advancements in medical care.

The argument against the Utah locality rule is now complete. Its origins are in the days when Utah had not even

achieved statehood. In the time between then and now there have been vast improvements in the quality of me cal education, medical students, post-graduate traini and continuing education. In the interim has come the automobile, the airplane, radio, television, and tele phone. The states now rigorously test physicians bef allowing them to practice within their boundaries. W the locality rule is the law, unless the plaintiff is able to convince the trial judge that res ipsa loquit should apply, the injured party is effectively cut of from seeking redress of his grievances in the courts to an inability to produce a "qualified" expert witne to testify as to the standard of medical care in the community.

In line with the above reasoning, seven sta in the last eleven years have rejected the locality r as the statement of the standard of care in medical malpractice cases: Iowa;[1] Kentucky;[2] Maryland;[3] Mass chusetts;[4] North Carolina;[5] Washington[6] and Wisconsi

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[1] Speed v. State, 249 NW2d 901, (1976); [2] Blair v. Et 461 SW2d 370, (1970); [3] Shilkret v Anapolis Hospital Association, 276 Md., 349 Atlantic 2d 245 (1975); [4] B v. Belinkoff, 235 NE2d 793 (1968); [5] Wiggins v. Pive N.C. 134, 171 SE2d 393 (1970); [6] Pederson v. Dumochel P2d 973 (1967); [7] Shier v. Freeman, 58 Wis. 2d 269, 166 (1973).

Three states have rejected the locality rule as the statement of the standard of care a specialist owes his patient: Arizona;[8] Michigan;[9] and Minnesota.[10]

Three states have rejected the locality rule as the statement of the standard of care for hospitals: Iowa;[11] Washington;[12] and Maryland.[13]

Although the Restatement Second of Torts, Section 299 A reflects a modified locality rule in that it would require a professional to exercise "the skill and knowledge normally possessed by members of the profession or trade in good standing in similar communities", "Comment d. Special Representation.", states that if an actor holds himself out as a specialist he should be held to possess the skill and knowledge of other specialists in that trade. The comment specifically includes physicians and states, "Thus a physician who holds himself out as a specialist in certain types of practice is required to have the skill and knowledge common to other specialists."

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[8] Kronkee v Danielson, 108 Ariz. 400, 499 P2d 156 (1972); [9] Christy v Saliterman, 179 NW2d 288 (1970); [10] Naccarato v Grob, 348 Mich. 248, 180 NW2d 788 (1970); [11] Dickinson v Mailliard, 175 NW2d 588, 36 ALR 3d 425 (1970); [12] Pederson v Dumochel, Supra; [13] Shilkret v Anapolis Hospital Association, Supra.

The sole issue remaining is what should be standard of care once the locality rule has been abro Plaintiff favors the formulation of the Supreme Court of Wisconsin-- "The jury should be told in substance a qualified medical (or dental) practitioner, be he a general practitioner or a specialist, should be subje to liability in an action for negligence if he fails exercise that degree of care and skill which is exerc by the average practitioner in the class to which he longs, acting in the same or similar circumstances. graphical area and its attendent lack of facilities a circumstances that can be considered if appropriate." Shier v Freedman, 58 Wis. 2d 269, 266 NW2d 166, 174 This statement of the standard accurately reflects th realities of medical care in the United States today. eliminates the injustice that is part and parcel of t locality rule yet allows consideration of the defenda inability to keep up with advances in medical care in rare case where that may be a factor.

Accordingly, the only conceivable course f this Court to follow is to overrule the locality rule in Utah, adopt the standard that most accurately reflects the realities of medical practice in the Unite States today, and remand this case to the trial court for a new trial.

POINT IV: THE SUMMARY JUDGMENT AND JURY VERDICT FOR DR. MOENCH MUST BE REVERSED AND ON THE RE-TRIAL OF THIS ACTION, THE LOWER COURT MUST BE DIRECTED TO SUBMIT THE ISSUE OF LIABILITY AGAINST THE DEFENDANTS JOINTLY.

One of the basic principles of the medical community in this day and age is the concept of "team care". No one medical person provides for all the medical needs of the patient. Each team or group interacts with the other and all share credit for the medical success. However, when a failure occurs the team breaks apart and each stands separate and points to the other or others as being the weak link in the medical care chain.

That has occurred in this case. The attending surgeon says the operation was a success and that his responsibility for the patient terminated after he turned the patient over to the psychiatrist. (Albeit two and one-half days after the problem was brought to his attention by the psychiatric social worker.) Dr. Moench, on the other hand, says that Farrow was not his patient and that he was merely called in for a consultation. (He did, however, order immediate medication and a doctor can only do that if a doctor/patient relationship exists.)

The hospital then says that Dr. Moench was not precise in his orders and directions, e.g. "how many times an hour is direct nurse contact" and "repeated

reassurance."

Dr. Moench then says that he ordered somet beyond the routine custodial care that was afforded Farrow and testified that such care was available in the hospital. Tr. 1271, 1280. The hospital replies through Dr. Charles R. Smart who is an employee of t hospital and Chief of Surgery. Initially, Dr. Smart filed an affidavit in this case in support of the hos pital's motion for summary judgment. Tr. 231. Para 6 of the affidavit states:

> "6. In the setting of a hospital giving general nursing care, as was the situation in this case, it would be unreasonable for the medical staff to request or expect more frequent contacts than were afforded the plaintiff Farrow on the evening of August 2 and early morning of August 24, 1974. It is my opinion that the frequency and content of the nursing contacts afforded to Chester E. Farrow on the evening of August 23 and early morning of August 24, 1974, were in compliance with reasonably prudent nursing care on a neurosurgical ward in the Salt Lake City, Utah, vicinity."

Dr. Smart was called as a witness for the plaintiff during the course of trial for the purpose of developing that statement he made in his deposition At this point, the hospital was out of the case and h tried every way to back away from that statement until finally the court allowed counsel to confront him with paragraph 6 of his affidavit. Dr. Moench ordered mor

than general care; the hospital did not provide it; and Dr. Smart testified that it would be unreasonable for Dr. Moench to expect it. Tr. 1273, Tr. 1583. Exhibit D-1.

The hospital, through its affidavits, etc., says that it reasonably complied with the medication orders of Dr. Moench. Dr. Moench, through counsel's closing argument replied: Tr. 1994.

> "...Now, the hospital isn't here to defend itself; it isn't sued in this case, but I suggest to you when the doctor orders Mellaril stat and even if you allow a one-half hour leeway, it surely means that it ought to be done before 10:00, it ought to be done by 8:30... Now, if it had been given at 8:30 and the peak at 12:30 had not produced any results, if the fellow was still having the same kind of problems as evidenced earlier, the nurse would then have had the opportunity to give him 50 more, if in her judgment he needed it... and if that had been done around 12:30, quarter to one, that also would have begun to take effect, because it begins in a half an hour. So by 2:40 there would have been the cumulative effect of all that medicine. I suggest to you that if that had been done, we would not be here..." (Mr. Snow)

Everyone who has ever defended a tort lawsuit knows that the most successful defense is to place blame on an absent, third party. That is precisely what has happened to the plaintiff at the first trial.

It is imperative that the summary judgment be reversed, the jury verdict be reversed and that the entire matter be remanded for new trial so that further injustice to the plaintiff will be prevented.

CONCLUSION

The trial court erroneously granted summar judgment in favor of Dr. Schricker and the LDS Hospi Dr. Schricker failed in his responsibilities to Farr by not timely recognizing that Farrow had become psy tic; taking immediate steps to protect him; change h environment; and secure the services of a specialist. His negligence was a question for the jury.

The extensive fingers of the hospital will be cataloged again. It will suffice here to say tha the hospital knew early in the confinement that help needed and failed to secure that help. Then when he finally arrived, Mr. Farrow was not watched as the ps chiatrist ordered and not medicated. It does not ta an expert to know that negligence is present on the p of the hospital and that it must be submitted to a ju

The jury verdict in favor of Dr. Moench mus be reversed. He clearly failed to carry out the duty imposed upon a psychiatrist and in particular:

1. The locality rule must be revised so that the opinion of Dr. Walker can be admitted in evi

2. The instructions to the jury relating t intentional acts is an incorrect statement of the dut imposed upon a psychiatrist and was tantamount to a

directed verdict in his favor. (A psychiatrist and hospital have a duty to take reasonable measures to prevent intentional acts.)

It must be apparent to the Court that the medical community enjoys tremendous advantages in malpractice cases. First of all, local doctors will not testify against their colleagues and when out of state help is brought into the case, they are frequently prevented from testifying by reason of the locality rule. It is a statistical fact that with one or two exceptions the medical community has never lost a malpractice case in the courts of this state. Our courts should stop accepting the subtle and pervasive propaganda put out by the medical community and send this case back with new guidelines so that simple and evenhanded justice will be restored between litigants in this case and in whole field of malpractice.

Respectfully Submitted,

Edward M. Garrett

Brigham E. Roberts