

1979

# Ralph L. Conk v. Wallace L. Chambers, M.D., and Granger Medical Clinic, A Corporation : Appellant's Brief

Utah Supreme Court

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## Recommended Citation

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IN THE SUPREME COURT  
OF THE STATE OF UTAH

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RALPH L. CONK, :  
Plaintiff and Appellant, :  
vs. : No. 16227  
WALLACE L. CHAMBERS, M.D., :  
AND GRANGER MEDICAL CLINIC, :  
A Corporation, :  
Defendants and Respondents. :

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APPELLANT'S BRIEF

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APPEAL FROM THE JUDGMENT OF  
THIRD DISTRICT COURT FOR  
SALT LAKE COUNTY

HONORABLE STEWART M. HANSEN, JR., JUDGE

SNOW, CHRISTENSEN & MARTINEAU  
700 CONTINENTAL BANK BUILDING  
SALT LAKE CITY, UTAH 84101  
ATTORNEYS FOR RESPONDENTS

BLACK & MOORE  
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## STATEMENT OF THE KIND OF CASE

This is an action for personal injuries arising out of an alleged professional medical malpractice committed upon plaintiff, Ralph Conk by the defendant, Dr. Wallace Chambers, during the course of their professional relationship.

## DISPOSITION IN LOWER COURT

The case was tried to a jury. From a verdict and judgment for the defendant, and the trial court's failure to grant plaintiff's Motion for New Trial, plaintiff appeals.

## RELIEF SOUGHT ON APPEAL

Plaintiff seeks a reversal of the judgment and judgment in his favor as a matter of law as to defendant's negligence with the case remanded for a trial on the issues of causation and damages only, or that failing, a new trial on all issues.

## STATEMENT OF FACTS

Mr. Ralph Conk, plaintiff herein, was a patient of defendant Dr. Wallace Chambers, a board certified general surgeon at the Granger Medical Clinic. (R. 162-165) He had been treated by various doctors at the clinic over the years for various minor maladies, but primarily for high blood pressure and obesity. (See testimony of Drs. Laverne D. Poulsen and Jerry K. Poulsen. R. 1104-1141) Because of those continuing problems, plaintiff first went to Dr. Chambers on March 28, 1973, requesting surgical help and advice. The doctor recommended that Mr. Conk undergo an operative procedure wherein certain portions of his small intestine would be bypassed to decrease

its absorptive capabilities thereby effectuating substantial weight reduction. (R. 780-783) . That operation was performed on Mr. Conk at the Valley West Hospital on April 23, 1973. (R. 800)

According to the defendant, Mr. Conk "had an excellent operative and post-operative course" (R. 1173.) Also according to the doctor, up to February 17, 1975, they had achieved the "results contemplated or hoped for, at least, by the surgeon" (R. 1160)

However, again by the testimony of the defendant, by March 1975, a significant change in Mr. Conk's kidney function was noted. (R. 1169-1170) At that time Dr. Chambers patient was referred to other specialists who followed his condition. Ultimately his kidneys completely shut down. (R. 1171, 1010-1015)

Since the time of the total kidney failure in 1975, Mr. Conk has had one unsuccessful attempt at a kidney transplant. He has been put to the necessity of being attached to an artificial kidney machine three times per week for periods of five hours for each session. He has had many assorted physical difficulties directly associated with the loss of his kidneys. He can no longer be gainfully employed and is currently on a disability retirement from his job as a draftsman for the U.S. Government. (R. 1016-1026)

It was the position of plaintiff at trial that the medical treatment by Dr. Chambers was negligently administered.

More particularly, plaintiff alleged that the doctor was negligent in that he knew, or in the exercise of ordinary care he should have known that the performance of the ileal bypass involved extraordinary, unusual and medically unacceptable risks to his patient's health and well-being. Specifically, the doctor failed and neglected to advise plaintiff of the nature and seriousness of the risks associated with the operation, that the plaintiff had a pre-existing kidney condition that would contraindicate performance of the operation, and that the operation itself was experimental in nature. Therefore, the doctor did not obtain the requisite informed consent for the performance of the operation.

Plaintiff further asserted that the operation should never have been performed because Mr. Conk was not a proper candidate due to his prior kidney damage of which Mr. Conk had no knowledge. It was also alleged that the follow-up care and treatment administered by the defendant was substandard in that necessary tests were not conducted and adequate monitoring of plaintiff's condition, which was not done, would have revealed the deteriorating kidneys at a time when their function could have been saved or at least the damage minimized. (Citation of the facts and reference to the record concerning the above is made where appropriate in the Arguments that follow the Statement of Facts)

At the conclusion of the evidence, plaintiff made motions for directed verdict on the issues of the applicable statute of limitations and lack of informed consent. Both

of the motions were denied. (R. 1369-1374).

The trial court submitted the case to the jury by instructing them on the above two issues as well as "common standard of care." Following an adverse jury verdict and judgment, plaintiff filed his Motion For New Trial (R. 183-184) and Memorandum In Support Of Motion For New Trial (R. 196-220) which motion was denied.

This appeal is taken because the trial court committed prejudicial error in not granting plaintiff's motions for directed verdict, in erroneously instructing the jury, and in failing to grant plaintiff's Motion For New Trial.

## ARGUMENT

### POINT I

THE COURT ERRED IN PRESENTING ITS INSTRUCTIONS  
24 AND 25 TO THE JURY AS THEY DO NOT REFLECT THE PROPER  
STANDARD AS TO THE LIMITATION OF ACTIONS THAT APPLIES TO  
A MEDICAL MALPRACTICE CASE.

For the convenience of the Court we set forth  
hereunder the trial Court's Instructions 24 and 25 (R.163 and  
164).

#### INSTRUCTION NO. 24

As an affirmative defense, defendants contend this action is barred by the statute of limitations. Defendants have the burden of proving this defense by a preponderance of the evidence.

The statute of limitations requires that any action brought against a physician for an injury must be commenced within two years after the date of the injury or two years after the patient discovers, or through the exercise of reasonable diligence, should have discovered the injury, whichever occurs later. You must determine from the evidence when the plaintiff discovered or should have discovered his injury.

If the plaintiff became aware of facts that, under the circumstances, would have alerted an ordinary and prudent person to the possibility that some unexpected harm may have been caused by the surgery, then he is also deemed to have discovered the injury on that date. The plaintiff is charged with the responsibility of making inquiries upon learning of the possibility of harm and he is deemed to know everything that such an inquiry might have revealed concerning the injury and the cause of such injury.

#### INSTRUCTION NO. 25

For purposes of applying the statute of limitations, the plaintiff is deemed to have discovered his injury when he first became aware of any unexpected and harmful consequences that he knew, or upon reasonable inquiry should have known, were caused by the surgery Dr. Chambers performed. It is not required that the plaintiff was able to ascertain or comprehend the full extent or nature of his injury at that time, nor is it necessary that he knew, or could have known, that the injury was caused by negligence of Dr. Chambers

It is sufficient if plaintiff knew, or by the use of reasonable diligence could have learned, that the injury was the result of the surgery.

With these principles to guide you, if you find from a preponderance of the evidence that the plaintiff discovered or through the use of reasonable diligence should have discovered any injury before July 29, 1974, then you must return a verdict in favor of the defendants.

Plaintiff first made a motion for a directed verdict as to the statute of limitations at the conclusion of the evidence and then took exception to the legal standards expressed in the trial court's instructions at the appropriate time during the trial (R.1338 and 1339). Plaintiff further brought these matters to the attention of the trial court in his Motion for New Trial and in his Memorandum in Support of Motion for New Trial (R.200 202).

#### A. HISTORY OF LIMITATION OF ACTIONS STATUTES IN CASES OF MEDICAL MALPRACTICE.

Medical malpractice cases at common law were classified in the general category of negligence or tort actions. Therefore, until special legislation began being passed in various jurisdictions throughout the country, the general negligence limitation of action statutes applied. Utah's general statute found in Section 78-12-1 U.C.A., 1953, which is similar to most such sections throughout the country, states in pertinent part:

"Civil actions can be commenced only within periods prescribed in this chapter, after the cause of action shall have accrued, . . ."

The common law rule harshly interpreted the "accrual" date as being the moment of the defendant's neglect. Ballenger

v. Crowell, 247 S.E.2d 287 (N.C. 1978) at 293.

In the 1930's exceptions to the common law limitation began surfacing to ameliorate the inequities of such a harsh rule. The first exception that gained popular acceptance is known as the "continued course of treatment rule." The theory is basically that a Fiduciary relationship of trust exists between a patient and doctor which if broken could result in more serious consequences than the act of malpractice itself may cause. An illustrative case is that of Borgia v. City of New York, 187 N.E.2d 777 (N.Y. 1962). At 187 N.E.2d 779 the court explained the principle of continuing treatment tolling the statute of limitations by placing the theory in the context of the facts of the case that was before the court.

Little argument is needed to prove the proposition that the "continuous treatment" theory is the fairer one. It would be absurd to require a wronged patient to interrupt corrective efforts by serving a summons on the physician or hospital superintendent or by filing a notice of claim in the case of a city hospital. The case now under review will illustrate. This child by reason of the hospital personnel's negligence suffered permanent brain damage at the hospital on the night he was admitted and on three later occasions was a victim of neglect amounting to malpractice. Acceptance by us of the city's argument that the 90 days ran from the last malpractice would mean that, if the child had remained in the hospital a few days longer than he did, the 90-day period would have expired while he was still a patient receiving care and treatment related to the conditions produced by the earlier wrongful acts and omissions of defendant's employees.

We are warned of dire results from this holding. Patients, we are told, will use this decision to justify suits brought years later. But this assumes that, so long as a patient continues to consult the same physician for any kind of illness,

the time to sue as to any kind of malpractice will never start to run. We are creating no such situation. The "continuous treatment" we mean is treatment for the same or related illnesses or injuries, continuing after the alleged acts of malpractice, not mere continuity of a general physician-patient relationship.

The Utah Supreme Court very early in the trend toward liberalizing the severity of the common law rule adopted a continuing course of treatment rule. In the case of Peteler v. Robison, 17 P.2d 244 (Utah 1932), defendant was an eye, ear, nose, and throat specialist who allegedly performed an unnecessary tonsilectomy, and gave improper follow-up care and treatment which resulted in severe infection which spread to both ears requiring surgical care and treatment. The plaintiff was under the care and treatment of the doctor seeing him on a regular basis from January 16, 1919, to and including October 22, 1926. The defendant demurred with the trial court sustaining the demurrer on the ground that the cause of action was barred by the statute of limitations for failure to file within four years after the cause of action accrued. The action was filed January 24, 1927. Defendant took the position the cause accrued January 18, 1919 when the alleged misdiagnosis took place.

The Court explained its reversal of the trial court in the following language:

Had we a case where the only negligence alleged was the negligent and unskillful operation in removing the tonsils, and nothing more, let it be assumed that the cause of action accrued at the time of the commission and completion of such



operation, and, if an action based on such negligence alone was not commenced within four years thereafter, the bar of the statute would be complete, though the consequential damages or injuries resulting from such negligence were not ascertained or made manifest until after the statute had run. But that is not the alleged cause of action. Here the defendant undertook to treat the plaintiff for a throat affliction. From the time he undertook to treat the case until he ceased to treat it he, as alleged, did so in a negligent and unskillful manner. As alleged, the treatments were not separate and distinct acts, separate and distinct causes of action. They constituted an entire course of treatment of a case undertaken by defendant to be treated by him, and the whole thereof constituted but one cause of action. From the averments of the complaint, we think it should here be said, that the tort was a continuing one, and, where the tort is continuing, the right of action is also continuing. (17 P2d. at 249) (Citations Omitted).

In addition to the continuing tort theory the Court further discussed allegations of fraudulent concealment based upon representations of the defenant that his care and treatment would correct the problems in time and that she was suffering from the natural consequences of the operation. Defendant countered that such representations were mere expressions of opinion and not sufficient to show fraud. The Court implied that there is a different standard of fraud when the doctor patient relationship exists not entirely unlike the later decision in Ballenger, supra.

. . . (T)he case is not one of an alleged tort or breach where the parties stood on an equality and dealt with each other at arm's length, or where each had equal means of knowledge. The relation of the parties being that of physician and patient, the case is one of trust and confidence imposed in the defendant, and, as to what was to be done and what was being done and as to the manner of treatment, the plaintiff had the right to rely and did rely upon the superior knowledge of the defendant.

The necessity, purpose, and good faith of the continued treatments were facts peculiarly within the knowledge of the defendant. While the alleged assurances of the defendant, that the continued treatments would eventually clear up and cure the throat conditions, were in the nature of an opinion, and for that reason not subject as a basis of an action for failure to accomplish such results, still the promises and assurances were pertinent and relevant as bearing on the confidence and reliance placed in the defendant, on the acts and conduct of the plaintiff in submitting to the continued treatments and as to her delay of enforcing whatever right to a cause of action was possessed by her, for, if the defendant by his continued treatments was able to accomplish what he represented and assured he was able to do and the representations believed & relied on by plaintiff, the natural effect of such representations until the falsity of them was discovered was to cause delay in the enforcement of whatever right was possessed by the plaintiff...

17 P2d at 250 (Emphasis Added). (See Fowles v. Pennsylvania Ry, 264 F2d 399 (1959) putting the continuing tort theory in the context of a Federal Employers Liability Act case).

In the years that followed, many jurisdictions adopted the termination of treatment theory as the date of "accrual" of the cause of action. A relatively early California case faced the issue of whether or not the "termination of treatment" theory was to apply in a situation where a specific statute limited the cause of action. Myers v. Stevenson, 270 P2d. 885 (Cal. 1954). Therein, the Court was faced with an alleged malpractice by a physician committed on a minor during the course of the mother's labor. The suit was filed more than six years after the child's birth. The Court was asked to consider the applicability of California's six year statute governing torts committed upon children conceived, but not yet born. The statute specifically stated that there would be no tolling of the six year limitation during any period

disability mentioned in another section of the code that provided for tolling during periods of minority, insanity, and other disabilities. (It should be noted that this aspect is very similar to our current malpractice limitation of Section 78-14-4 U.C.A., 1953 as amended, infra.)

The Court found that there would be a tolling of the statute during the continuing treatment because the six year limitation was procedural in nature just as limitation of actions statutes are on any right that had its origin at common law as opposed to having its origin in legislative enactment and therefore:

If a statute specifies one exception to a general rule \* \* \* other exceptions \* \* \* are excluded."

Having expressly provided that the disabilities mentioned in Code Civ.Proc. § 352, i. e. infancy, insanity, etc., shall not extend the statute the legislature under this rule, as plainly indicated that other recognized legal grounds for extending the statute should be operative.

We conclude that the time limitation contained in section 29 was intended by the legislature as a procedural statute of limitations subject to being extended by any legal ground not specifically excluded in the section itself.

270 P2d. at 890 (Citations Omitted). (Emphasis Added).

That, of course is the status of the medical malpractice limitation that currently exists in Utah in that it has certain specifically excluded items leaving other legal grounds subject to court determination.

The Myers case also was an early decision further ameliorating the burden on plaintiffs by judicially invoking the rule "that the statute of limitation only starts to run from the date of discovery of, or the date when by the exercise

of reasonable diligence the plaintiff should have discovered the wrongful act." 270 P2d at 887. The Court used the "discovery rule" and the "termination of treatment rule" together in reversing the judgment of the lower court.

The Utah Supreme Court was again confronted with the definition of when a malpractice cause of action "accrues" in the case of Christiansen v. Rees, 436 P2d 435 (Utah 1968). Again, it should be recalled this case predated the passage of specific legislation limiting the period of time during which a malpractice claim could be filed. In the Christiansen case the evidence showed that a foreign object, to-wit: a surgical needle, had been left in the body of the Plaintiff after an operation; that Plaintiff had been ignorant of that fact for an ensuing period of time; that 10 years after the surgical procedure had been performed, but within four years after Plaintiff had discovered the existence of the surgical needle in his body, Plaintiff filed a malpractice action. The Trial Court granted Defendant's Motion for Summary Judgment. On appeal the question was whether Utah would adopt the so-called "discovery rule" or whether Utah would rule that regardless of the Plaintiff's lack of knowledge of the existence of the foreign object in his body, the Statute of Limitations commenced to run at the time of performance of the operation. In a four to one decision, Justice Callister made the following statement in support of the "discovery rule":

Case authority is divided as to the proper

rule in cases such as this. It would serve no useful purpose to discuss these divergent opinions. Suffice it to say, this court has read and analyzed them and has reached the conclusion that logic and reason support those authorities which have adopted the discovery rule. It seems somewhat incongruous that an injured person must commence a malpractice action prior to the time he knew, or reasonably should have known, of his injury and right of action. It seems apparent that adherence to the 'majority rule' would penalize the conscientious doctor, who would advise his patient of a mistake, and protect a practitioner, who would not reveal his mistake until the statute of limitations became a shield.

Therefore, we now hold that, regardless of prior pronouncements, where a foreign object is negligently left in the body of a patient during an operation and the patient is ignorant of the fact, and consequently of his right of action for malpractice, the cause of action does not accrue until the patient learned of the presence of such foreign object in his body. (Emphasis added)

The Court in arriving at its opinion cites with approval a number of cases, some of which are of particular importance.

The first of these cases is that of Berry v. Branner, 421 P.2d 966 (Ore. 1966). In the Berry case the Plaintiff brought a malpractice action against a physician. The Trial Court entered judgment adverse to the patient. The patient appealed and the Supreme Court in a five-two decision reversed, holding that the cause of action for malpractice action "accrues" within the meaning of the applicable two-year statute of limitations when the patient obtains ". . . knowledge, or reasonably should have obtained knowledge of a tort committed on the patient's

person by the physician." The facts of the case were that Defendant, in performing a hysterectomy upon the Plaintiff, had left a surgical needle in her abdomen and the existence of the surgical needle in her abdomen was not discovered until nine years later. The cause of action was filed within two years of the discovery. The relevant statute reads as follows:

"Actions at law shall only be commenced within the period prescribed in this chapter, after the cause of action shall have accrued, . . ."  
(Emphasis added)

The Court, after noting that the "present controversy revolves around the meaning of the word 'accrued', "had the following to say in support of its opinion:

"To say that a cause of action accrues to a person when she may maintain an action thereon and, at the same time, that it accrues before she has or can reasonably be expected to have knowledge of any wrong inflicted upon her is patently inconsistent and unrealistic. She cannot maintain an action before she knows she has one. To say to one who has been wronged, "you had a remedy, but before the wrong was ascertainable to you, the law stripped you of your remedy, makes a mockery of the law. In the absence of an expressed statutory direction to the effect, to ascribe to the legislature any such intention by their use of the word 'accrue' seems to us unreasonable."

And, again:

"We do not believe the legislature intended to limit patients asserting malpractice claims, who by the very nature of the treatment had no way of immediately ascertaining their injury, to

the same overall period of time that is allowed for bringing other tort actions that are normally immediately ascertainable upon commission of the wrong. The protection of the medical profession from stale claims does not require such a harsh rule."

And, finally, in support of its opinion, the Court states:

"It is the opinion of this court that the cause of action accrued at the time plaintiff obtained knowledge, or reasonably should have obtained knowledge of the tort committed upon her person by defendant. The case of Vaughn v. Langmack is overruled." (Citations Omitted)

Another case cited with approval by the Utah Court in the Christiansen case is Johnson v. St. Patrick's Hospital, et al. 417 P2d. 469 (Mont. 1966). In the Johnson case, Plaintiff brought an action against the doctor and hospital claiming he had recently discovered that a sponge had been left in his body in an operation performed ten years previously. The Trial Court granted summary judgment against the patient holding that the Statute of Limitations had run against his claim. The case was appealed and reversed. The applicable Statute of Limitations reads as follows:

"Within three years: . . ."

"3. An action upon an obligation or liability, not founded upon an instrument . . ."

The question again was clearly presented as to whether the Statute of Limitations commenced to run at the time of the negligent incident or at the time plaintiff discovered the negligent incident. The Court in a very erudite opinion covers various theories different jurisdictions have promulgated to obviate the harshness of the so-called general



rule that Statutes of Limitation run from commission of the negligent act. The Court discussed the "continuing negligence theory," the "contract theory," and the "fraudulent concealment theory" and then the Court in summary had the following to say:

"All of these exceptions to the so-called 'general rule' which respondents want this court to follow illustrate that in reality the 'general rule' has little to recommend it. Courts out of necessity have tried to make exceptions in order to do justice. We confronted with the problem presented by the facts of this case had adopted the best reasoned rule, which we adopt and will follow. It is: 'Where a foreign object is negligently left in a patient's body by a surgeon and the patient is in ignorance of the fact, and consequently of his right of action for malpractice, the cause of action does not accrue until the patient learns of, or in exercise of reasonable care and diligence should have learned of the presence of such foreign object in his body.' (Citations Omitted)

Another case cited by the Utah Court in Christiansen to which we call the Court's attention is Billings v. Sisters of Mercy of Idaho, et al., 389 P.2d. 224 (Idaho 1964). In the Billings case, Plaintiff brought an action for malpractice alleging that a gauze sponge had been left in her body during an operation performed in 1948, which was not discovered until an exploratory operation was performed in 1961. The case was filed within five years of discovery of the sponge. The applicable Statute of Limitations reads as follows:

"Civil actions can only be commenced within the periods prescribed in this chapter after the cause of action shall have accrued, . . ."

The Trial Court dismissed the Complaint on the ground



that the cause of action was barred by the Statute of Limitations. The case was appealed and reversed by the Idaho Supreme Court. Defendant claimed that the cause of action accrued at the time the sponge was left in her body. Once again we have a Court covering the entire Statute of Limitations problem as it pertains to the "discovery" rule. Discussing once again the "contract rule," the "continuing negligence rule," the "fraudulent concealment rule" and so on, the Court states:

"Of course, when a plaintiff is run down by an automobile, it is clear that his cause of action will accrue on that date. This is not only because he has a right to sue, but also because he can use judicial process to secure enforcement of that right. Where a surgeon negligently leaves a sponge in the body of a plaintiff, while the plaintiff might possess some potential right to sue, he has no means of developing that right, or acting upon it until he is able to discover the negligence of the surgeon. It is more logical to follow the reasoning stated in Note, Developments in the Law: Statutes of Limitations, 63 Har.L.Rev. 1177 at 1205 (1950), as follows, '\* \* \* the "cause of action" which commences the limitations period should not refer to the "technical" breach of duty which determines whether the plaintiff has any legal right, but to the existence of a practical remedy.'" (Emphasis added)

And, again, the Court states:

"Indeed, it appears that most jurisdictions, when faced with the set of facts we have presented herein would, on one theory or another, allow appellants to come into court and present their claims."

And in conclusion, the Court makes the statement which is quoted with approval in Christiansen:

"In reality, the 'general rule' has little to commend it. It is neither the position of a majority of the jurisdictions nor is it firmly based on considerations of reason or justice."

We will, therefore, adhere to the following rule" where a foreign object is negligently left in a patient's body by a surgeon and the patient is in ignorance of the fact, and consequently of his right of action for malpractice, the cause of action does not accrue until the patient learns of, or in the exercise of reasonable care and diligence should have learned of the presence of such foreign object in his body. (Citations Omitte

Some argued the proposition that the "discovered, or should by the exercise of reasonable care have discovered" rule applied only to cases where foreign objects are left in the bodies of persons during operative procedures and does not extend to other cases. Such a contention was not supportable by the Christiansen case, by simple logic, or by authorities from other states. Again, we refer to the Christiansen langua

"It seems somewhat incongruous that an injured person must commence a malpractice action prior to the time he knew, or reasonably should have known, of his injury and right of action."  
(Emphasis Added)

And then in a footnote, the Court quotes from the case of Rose v. Senger, (1944) 149 P.2d 372:

"It is . . . an ancient maxim of the common law that 'Where there is a right there is a remedy.' What a mockery to say to one, grievously wronged, 'Certainly you had a remedy, but while your debtor concealed from you the fact that you had a right, the law stripped you of your remedy.'"

A case directly in point demonstrates "foreign body" is only one aspect of the "discovery" doctrine. That case dealt with a misdiagnosis. In the case of Yoshizaki v. Hilo Hospital, 433 P2d. 220 (Hawaii 1967) plaintiff filed a medical malpractice action. The question was whether the "discovery doctrine" should be applied or whether the harsh

doctrine that the Statute of Limitations began to run at the time of the negligent act should be applied. Plaintiff had alleged that Defendant hospital, through one of its doctors, negligently diagnosed the plaintiff's neck ailment as cancer. The doctor recommended radiation treatment of the "cancer". The plaintiff was treated at another hospital where, as a result of negligence by an employee of the other hospital, the plaintiff received radiation burns. The narrow question upon which the case turned, as stated by the Court, was as follows:

"When does the statute of limitation begin to run against a malpractice claim where the plaintiff did not know, nor acting reasonably could have been expected to know, that the defendant had negligently diagnosed an ailment?"

The claim was made in Yoshizaki that the "discovery" rule should be limited to foreign object cases and should not apply to a broader range of cases. The Court stated:

"We conclude that the statute does not begin to run until the plaintiff knew or should have known of the defendant's negligence. This conclusion is consistent with the legislative prescription to avoid constructions which would lead to absurd results. The injustice of barring the plaintiff's action before she could reasonably have been aware that she had a claim is patent. A basic reason underlying statutes of limitation is nonexistent; the plaintiff has not delayed voluntarily in asserting her claim. We realize that added burdens are placed on defendants by forcing them to defend claims with evidence that may be stale. We should not overlook the fact that the plaintiff must produce evidence sufficient to establish a prima facie case before the defendant is obliged to produce any evidence. A few courts appear to have limited the discovery doctrine to cases in which the defendant has left a foreign object inside the plaintiff in order to reduce the possibility that the

plaintiff is asserting a completely fraudulent claim. (cases cited) We reject the distinction. In some cases, especially those involving an allegedly negligent diagnosis, a physical object is not involved proof becomes more difficult. This does not necessarily mean that a fraudulent claim may be more easily asserted. As in the instant case, treatment generally follows diagnosis. The treatment is an objective fact which may be proved or disproved by people other than the plaintiff. The fact that the treatment is the kind normally administered for the ailment the doctor allegedly improperly diagnosed is strong evidence of the diagnosis.

We concluded that the conflicting policies are best reconciled by permitting the plaintiff the opportunity to prove that she neither knew nor could reasonably have been expected to know of the defendant's alleged negligence until the date alleged in her complaint. If the legislature deems our reconcilliation of these conflicting policies incorrect or wishes to place an outside limit on the time for bringing a malpractice action, it is free to do so. Until that time, however, we will not deny a plaintiff access to our courts for failure to assert such a claim if he asserts it within two years after he actually or constructively discovered it."

A later Idaho case applied the rule of law expressed in Billings, supra, to a misdiagnosis case. We cite Renner v. Edwards, 475 P2d. 530, (Ida. 1979). The Renner case involved a misdiagnosis which resulted in Colostomy surgery being performed on March 21, 1961. For three years thereafter Plaintiff suffered other problems including pain and inability to control normal body functions. On July 15, 1964, corrective surgery was performed revealing the misdiagnosis and a suit was filed within two years of the discovery of said misdiagnosis. The Court ruled in favor of Plaintiff and stated:

"It would, in our opinion, be manifestly unjust to bar the enforcement of injury claims brought by a plaintiff who was not, nor could not have known that he was, the victim of tortious conduct because the consequent harm was unknowable

within two years of the negligent act. In this age of enlightened medicine and highly sophisticated curative treatment, it is very likely that the maturation of injury resulting from negligent treatment would not evidence itself for well after the two years provided for in the statute of limitations. This thought becomes particularly disturbing when one realizes that the latent injuries arising from medical malpractice would very likely go undetected by the victim as only trained and skillful practitioners of medicine could ascertain whether a patient has been mistreated. Even the physical symptoms which might herald future inquiry may well be beyond the comprehension or perception of the average layman."

Later, on the same page, the Court continues:

"To require a man to seek a remedy before he knows of his rights is probably unjust. Under such circumstances, in order for a patient to secure and protect his legal rights against doctors for malpractice, the patient would be required to submit himself to complete examinations by a series of independent physicians after every operation or treatment he received from the physician of his first choice. The unreasonableness of such a result is self-evident."  
(Emphasis added)

See also for a 9th Circuit Court of Appeals interpretation of Idaho law supporting the "Discovery" rule in a negligent diagnosis situation the case of Owens v. White, et al. (9 CCA 1965) 342 F2d. 817.

Another negligent diagnosis case is Hungerford v. U.S. (9 CCA 1962) 307 F2d. 99. The Hungerford case is a Federal Tort Claims Act case. A soldier wounded in July, 1950, in Korea was misdiagnosed as having a psychosomatic condition, when, in fact, he was suffering from organic brain damage which was correctable by surgery. The organic brain damage was not discovered until ten years later. The action was thereafter filed against the Government. The Government claimed the Statute of Limitation had run. The Court state

". . . The Government had not only the duty to communicate to Hungerford a correct diagnosis of his condition, but also to render proper care for the treatment of the physical condition from which he was actually suffering. Under the allegations of the Complaint there was a failure to perform this latter duty because of the negligent manner in which the examination and diagnostic tests were made, or because of the failure to make tests, which in the exercise of proper care should have been made.

With regard to the "discovery rule", see also:

Tomlinson v. Siehl, 459 S.W.2d 166 (Ky. 1970); Hackworth v. Hart, 474 S.W.2d 377 (Ky. 1971); Layton v. Allen, 246 A.2d 794 (Del. 1968); Hundley v. St. Francis Hospital, 161 Cal. App. 800, 327 P.2d 131 (1958); Johnson v. Caldwell, 371 Mich. 368, 123 N.W.2d 785 (1963); Edwards v. Ford, 279 So.2d 851 (Fla. 1973); Hays v. Hall, 488 S.W.2d 412 (Tex. 1972); Mayer v. Good Samaritan Hospital, 14 Ariz.App. 248, 482 P.2d 497 (1971); Owens v. Brochner, 172 Colo. 525, 474 P.2d 603 (1970); Lipsey v. Michael Reese Hospital, 46 Ill.2d 32, 262 N.E.2d 450 (1970); Ruth v. Dight, 183 Neb. 866, 165 N.W.2d 74 (1969); Wilkinson v. Harrington, 104 R.I.224, 243 A.2d 745 (1968); Iverson v. Lancaster, 158 N.W.2d 507 (N.D. 1968); Springer v. Aetna Casualty and Surety Co., 169 So.2d 171 (La.App. 1964); Seitz v. Jones, 370 P.2d 300 (Okla. 1962); Nowell v. Hamilton, 249 N.C. 523, 107 S.E.2d 112 (1959); Lopez v. Swyer, 62 N.J. 267, 300 A.2d 563 (1973); Frohs v. Greene, 253 Or. 1452 P.2d 564 (1969); Waldman v. Rohrbaugh, 241 Md. 137, 215 A.2d 825 (1966); Flanagan v. Mount Eden General Hospital, 24 N.Y.2d 427, 248 N.E.2d 871 (1969); Hungerford, supra; Toal v. United States, 438 F.2d 222 (2d Cir. 1971); Johnson v.



United States, 271 F.Supp. 205 (W.D. Ark. 1967); and Quinton v. United States, 304 F.2d 234 (5th Cir. 1962).

In 1971 the Utah Statute of limitations was amended by adding thereto Section 78-12-28 Utah Code Annotated, 1953 (1975 Pocket Supplement). This section, for the first time in Utah codified the "discovery" rule. For convenience of the Court we refer to the old general statute, and the subsequent amendments to it. The key language reads as follows:

"78-12-1. Time for commencement of actions generally.--Civil actions can be commenced only within the periods prescribed in this chapter, after the cause of action shall have accrued, . . . (Emphasis added)

The 1971 statute reads in pertinent part:

78-12-28. Within two years: . . .  
(3) An action against a physician and surgeon, . . . or a licensed hospital . . . for professional negligence . . . two years after the date of injury or two years after the plaintiff discovers, or thought the use of reasonable diligence, should have discovered the injury, whichever occurs later, . . . " (Emphasis added)

The 1976 Legislature made additional changes in the limitation of action section of the "Health Care Malpractice Act". Section 78-14-1 et. seq, Utah Code Annotated, 1953.

Again, in pertinent part that section states:

78-14-4. Statute of limitations--Exceptions--Application.--(1) No malpractice action against a health care provider may be brought unless it is commenced within two years after the plaintiff or patient discovers, or through the use of reasonable diligence should have discovered the injury, whichever first occurs, but not to exceed four years after the date of the alleged act, omission, neglect or occurrence, . . .

It can readily be seen from that language that the "discovery" rule pronounced so clearly in Christiansen has been reaffirmed by the new statutes. The difference between the 1971 and the 1976 statutes is minimal. The key language of "discovery . . . of the injury" is the same.

B. THE TRIAL COURT COMMITTED PREJUDICIAL ERROR IN INSTRUCTING THE JURY IN INSTRUCTION 25 ". . . NOR IS IT NECESSARY THAT HE KNEW OR SHOULD HAVE KNOWN THAT THE INJURY WAS CAUSED BY NEGLIGENCE OF DR. CHAMBERS . . ."

With the history of statute of limitations in medical malpractice actions in mind, it is now appropriate to go to the specifics of the case at bar. The court's instruction 25 (R.164) misstates the law. The standard the Trial Court presented the jury would require an injured patient to file his cause of action before he has a reasonable opportunity to discover the necessary elements of a prima facie cause of action. The elements of a prima facie cause of action are physical injury plus some act of neglect proximately causing physical injury. Instruction 25 would require an individual to file a cause of action every time an operation or any medical treatment didn't result in a complete recovery whether due to the neglect of his physician or not. This would result in a great multiplicity of meritless lawsuits which is contrary to public policy.

It is advisable that the definition of "injury" be examined. It is axiomatic that in determining legislative



intent the words in a statute must be interpreted in the light of their common meaning. "Injury" is defined in the College Edition, Webster's New World Dictionary of the American Language, World Publishing Company, Cleveland and New York, 1960, as follows:

"1. physical harm or damage to a person, property, etc. 2. unjust treatment; violation or rights; offense." (Emphasis added)

An amplification of that definition as it applies to the law of torts is contained in the Restatement of Torts II:

"§ 7. Injury and Harm

"(1) The word 'injury' is used throughout the Restatement of this Subject to denote the invasion of any legally protected interest of another.

(2) The word 'harm' is used throughout the Restatement of this Subject to denote the existence of loss or detriment in fact of any kind to a person resulting from any cause.

(3) The words 'physical harm' are used throughout the Restatement of this Subject to denote the physical impairment of the human body, or of land or chattels." (emphasis added)

It is clear that in defining the term "injury" as used in the Utah Code, there must be an invasion of a legally protected interest. Furthermore, had the legislature intended to say that the statute would commence to run from the time of physical harm as that term is defined in the Restatement of Torts, it would have used the term "physical harm."

The legally protected interest in this case is not the actual physical damage standing alone. Rather, it is the emergence of a cause of action sounding in tort at the time when Plaintiff discovered or in the exercise of ordinary care should have discovered, that his treating physician had breached his legal duty to Mr. Konk.

The better reasoned case authority supports the above proposition. The case of Hunter v. Knight, 571 P2d. 212 (Wash. 1977) involved the alleged malpractice of an accounting firm. The Washington Supreme Court held that the statute begins to run only when all of the elements necessary to the maintenance of a lawsuit are present. The Court said that the "critical point of inquiry" is the later event the absence of which makes suit impossible or improbable.

In a California case that stood among other things for the proposition that the "patient is entitled to rely upon the physician's professional skill and judgment while under his care, and has little choice but to do so . . .", the Court also made it clear that "Since . . . (1963), it had been clear that the limitations period did not commence until the plaintiff either (1) actually discovered his injury and its negligent cause or (2) could have discovered injury and cause through the exercise of reasonable diligence." Sanchez v. South Hoover Hospital, 553 P.2d 1129 (Cal. 1976) at 1132. (omitted) (Emphasis added). The Court went on to analyze the recent California statute which is very similar to the current Utah limitation in malpractice cases by stating what "injury" means.

The legislative history to which we previously have alluded gives no indication that the drafters of section 340.5 either intended to modify the common law "discovery" rule in the foregoing fashion or to effect such a change by focusing on the term "injury." In fact, the word "injury" had come to be used in the cases to denote both a person's physical condition and its "negligent cause." We think that the Legislature in enacting section 340.5 intended no more than to adopt the prior "discovery"

rule, and that the word "injury" retained, in the context used, the broad meaning the courts had previously given to it. 553 P.2d at 1133. (Citations omitted) (Emphasis added)

The Sanchez court affirmed the trial court's granting of summary judgment because the plaintiff had discovered her physical injury and the negligent cause therefore more than the limitation period prior to filing.

Frohs v. Greene, 452 P.2d 564 (Or. 1969) similarly stated the gross inequity that would exist if "injury" was to be defined in the narrow terms of the trial court in the present case before the Court.

. . . It is manifestly unrealistic and unfair to bar a negligently injured party's cause of action before he has had an opportunity to discover that it exists. This is true whether the malpractice consists of leaving a foreign object in the body or whether it consists of faulty diagnosis or treatment. The following language used in Berry v. Branner, supra, at page 312, 421 P.2d at page 998, when construing the Oregon statute, is equally applicable to all kinds of malpractice:

"\* \* \* To say that a cause of action accrues to a person when she may maintain an action thereon and, at the same time, that it accrues before she has or can reasonably be expected to have knowledge of any wrong inflicted upon her is patently inconsistent and unrealistic. She cannot maintain an action before she knows she has one. To say to one who has been wronged, 'You had a remedy, but before the wrong was ascertainable to you, the law stripped you of your remedy,' makes a mockery of the law. \* \* \*."

We do not believe that the danger of spurious claims is so great as to necessitate the infliction of injustice on persons having legitimate claims which were undiscoverable by the exercise of ordinary care prior to the lapse of two years from the time of the act inflicting the injury. Nor do we believe the legislature intended such a result. 452 P.2d at 565. (Emphasis added) See also Billings v. Sister of Mercy Hospital, supra. and Renner v. Edwards, supra.

Just decisions as those noted above are not limited to the Western United States. In 1978 the North Carolina Supreme Court, in Ballenger v. Crowell, supra in applying its variation of the "course of treatment" rule limited by the "discovery rule" in a malpractice action against a physician who allegedly caused a patient's narcotic addiction, adopted the following language from two other jurisdictions:

"(THE) limitation period starts to run when the patient discovers . . . the negligent act which caused his injury." Jones v. Sugar, 305 A.2d at 223 (Md.)

"(T)he injury may be readily apparent, but the fact of wrong may lay hidden until after the prescribed time has passed." Also see Lopez v. Swyer supra 300 A.2d at 567.

New Hampshire likewise has the rule that a physically injured individual must "discover" both the physical injury as well as wrongful conduct or negligence. Brown v. Memorial Hospital, 378 A.2d 1138 (N.H. 1977).

Justice Maughan writing the opinion for the court in the case of Vincent v. S. L. County, 583 P.2d 105 (Utah 1978) considered an analogous situation. There, a homeowner suffered damage to his home from water undermining his foundation. He didn't know from where the water was coming until after the notice period for the county had run. Ultimately the plaintiff found that the county had negligently caused the water to run which damaged his home. The court approvingly adopted the language from its previous decision on malpractice limitations in the Christiansen case supra:

"It seems somewhat incongruous that an injured

person must commence a malpractice action prior to the time he knew or reasonably could have known of his injury and right of action." (Emphasis added)

It would seem more than "somewhat" incongruous to interpret the legislature's intent in any way other than that "injury" equals "physical harm" plus a "legally invaded right." To rule otherwise would create a great social evil. This court should not say to Ralph Conk, "You had a remedy but before the wrong was ascertainable to you, the law stripped you of your remedy." Frohs v. Greene, supra.

C. THE COURT COMMITTED PREJUDICIAL ERROR IN ITS INSTRUCTION 24 WHEREIN IT INSTRUCTED THE JURY THAT "IF THE PLAINTIFF BECAME AWARE OF FACTS THAT UNDER THE CIRCUMSTANCES, WOULD HAVE ALERTED AN ORDINARY AND PRUDENT PERSON TO THE POSSIBILITY THAT SOME UNEXPECTED HARM MAY HAVE BEEN CAUSED BY THE SURGEON, THEN HE IS ALSO DEEMED TO HAVE DISCOVERED THE INJURY ON THAT DATE."

For the same reasons that the Court committed error in Instruction 25, Instruction 24 is erroneous. This instruction assumes that "injury" only relates to physical harm. The case authority previously cited demonstrates incongruities and missapplication of legislative intent of such a standard. The standard is not when the ordinary and prudent person would have been alerted that some unexpected harm was caused by the surgery, but rather when the plaintiff discovered or by reasonable diligence he should have discovered his physical harm and

the negligent cause of his physical injuries. No further case authority need be cited for this position.

Further, presenting two such instructions to the jury with their improper standard only stands to emphasize and enlarge their import to a jury thereby aggravating their prejudicial effect. See Devine v. Cook, 279 P.2d 1073 (Utah 1954).

D. THE TRIAL COURT COMMITTED PREJUDICIAL ERROR IN NOT GRANTING PLAINTIFF'S MOTION FOR DIRECTED VERDICT AND IN NOT GRANTING HIS MOTION FOR NEW TRIAL ON THE ISSUE OF THE STATUTE OF LIMITATIONS.

It is now appropriate to put the legal standards in the context of the facts at issue before the court. At the conclusion of the evidence, plaintiff made a Motion for a Directed Verdict on the issue of the statute of limitations. That issue was renewed with the plaintiff's Motion for New Trial. Both motions were denied by the trial court. It is plaintiff's position that the evidence taken in its entirety does not support submission of this issue to the jury either under the erroneous instructions given to the jury or the correct standard discussed earlier.

This cause of action was filed on July 29, 1976. (R. 790) Mr. Conk first consulted with the defendant doctor on March 28, 1973 (R. 790). The ileal bypass surgery was performed at the Valley West Hospital on April 23, 1973. (R. 800) Therefore, for purposes of the tolling the statute of limitations we are primarily concerned about Mr. Conk's discovering his "injury" (as that term has been defined herein) prior to July 29, 1974.

To begin with, there is absolutely no evidence that:

1. Prior to July 29, 1974, Mr. Conk became aware of any preexisting kidney problems that would have contraindicated surgery;

2. Mr. Conk was aware of any kidney problems possibly associated with his bypass surgery at any time prior to the difficulties that demonstrated themselves beginning in January, 1975;

3. Mr. Conk was ever aware of the experimental nature of the operation prior to his last treatment by the defendant in 1975;

4. Dr. Chambers ever informed the patient that any of the conditions he was experiencing were in any way out of the ordinary for a postoperative bypass patient prior to the kidney problems that were diagnosed in the early months of 1975;

5. Mr. Conk should not have relied on the assurances given to him by the defendant that his condition would stabilize, nor that he didn't rely on those assurances.

During the entire period of time prior to the first of 1975, Mr. Conk testified that Dr. Chambers told him that his condition would stabilize, that his condition would smooth out, that it would improve, that what he was experiencing was to be expected in the type of surgery he had and that he would be alright (R. 997, 1000, 1004, 1006, 1064, 1068).

Mr. Conk further testified that he had confidence in

the doctor, that he was the professional, that he was of the opinion that the doctor knew what he was talking about, that he had no complaints about the doctor's care, and that the doctor was doing his best (R. 999, 1004, 1007).

It is of more than passing interest to note again that Dr. Chambers did not refute giving Mr. Conk the assurances noted.

A study of Dr. Chambers direct testimony demonstrates clearly what was being told his patient on various postoperative examinations:

September 28, 1973--

Q Will you tell us what was written by you and what was written by the nurse, please?

A "Post-operative check five months." My note says, "No complaints, some malaise. Happy about operation. (R. 115)

December 24, 1973--

Q Tell us what is noted, please?

A 79 pound weight loss, blood pressure 150 over 110. My entry, "no symptoms, doing very well on blood pressure medicine." (R. 1151)

May 10, 1974--

Q Give us the notes and what you found and what you wrote

A "post-operative check 13 months. Blood pressure 160 over 110. Weight loss 92 pounds. Plateau of weight. Has been eating heavily and working hard. Color good. Patient looks almost good enough, but could lose some more weight (R. 1153)

Laboratory test June 14, 1974--

Q All right. Now, can you look in your laboratory



reports and tell us the results of the chemistry survey?  
I can call your attention to the date of about June 14th,  
12th to 14th would be the last sheet that you would be looking for.

A The laboratory test is dated June 14, 1974.

\* \* \* \* \*

Q Did you find any abnormal reading in any of those  
chemistries of the blood?

A No, sir.

Q Any of the electrolytes that were abnormal or lower than  
normal?

A No, sir, they are all normal. (R. 1154-1155)

August 1, 1974--

Q What does that say?

A That says "15 months post-operative, 99 pounds weight  
loss, blood pressure 150 over 100. Charleyhorse in both legs."

Q This is what the nurse wrote about the patient?

A Yes, this is the nurse's note of his complaint,  
charleyhorse in both legs. My note says, "Post-operative  
shunt very good. Vitamin B<sub>12</sub> given."

Q Now, at that point when you say very good, that's  
compared to what? What you would expect or what the normal  
is, or what?

A I would say very good for the course of the post-  
operative intestinal shunt patient. (R. 1155)

December 30, 1974--

Q All right. Now, we go into December 30th of '74, or  
31st, whichever it is. Tell us what she wrote and what the  
readings were and what you found and what you noted?

the fiduciary and confidential patient-doctor relationship. As the Supreme Court of California (which has a statute similar to that of Utah) has put it:

"... the patient is fully entitled to rely upon the physician's professional skill and judgment while under his care, and has little choice but to do so. It follows, accordingly, that during the continuance of his professional relationship, which is fiduciary in nature, the degree of diligence required of a patient in ferreting out and learning the negligent causes of his condition is diminished..." Sanchez v. South Hoover, supra. 553 P.2d at 1135.

Because the statute of limitations is an affirmative defense, defendant has the burden to show by a preponderance of the evidence that Mr. Conk discovered or should have discovered his "injury" on or before July 29, 1974. There being no evidence of actual discovery of the injury by the plaintiff, defendant must affirmatively show that through the use of reasonable diligence Mr. Conk should have discovered the injury prior to that date. That reasonable diligence would, arguendo, require Mr. Conk to inquire of Dr. Chambers into what the status of his condition was; was it caused by the operation; and was his condition any different than would have been normal given the nature of the procedure.

In order for the defendant to prevail on that issue, he must present substantive evidence that Mr. Conk's inquiries would reasonably have led him to discover that the effects of the operation were adverse to his health and contrary to what was normal for a postoperative ileal bypass patient. Such an inquiry to Dr. Chambers would have revealed the facts previously stated to the effect that all was well. The doctor himself had no idea by his own testimony of any untoward, unanticipated

negative turn to the physical condition of his patient postoperatively.

The defendant simply failed to produce any evidence support that affirmative burden. It is patently ridiculous to place the burden on Ralph Conk to diagnose kidney problems when his own doctor could not do so himself.

The above argument is based solely on discovery of physical harm. It becomes more persuasive if the correct definition of "injury" as being physical harm plus invasion of legally protected right is added to the equation. No evidence was presented by defendant to demonstrate that such inquiry would have been fruitful at any relevant time. Mr. Conk's reliance on his fiduciary is by substantive evidence unassailed and uncontroverted. As to its reasonableness, no triggering event took place to shake that relationship until the first evidence of kidney damage occurred in the first part of 1975.

The statute of limitations should not have been submitted to the jury as an issue for its consideration.

## POINT II

THE COURT BELOW ERRED IN FAILING TO GRANT APPELLANT'S MOTION FOR DIRECTED VERDICT FOR NEGLIGENT FAILURE TO OBTAIN INFORMED CONSENT PRIOR TO SURGERY, AND IN IMPROPERLY INSTRUCTING THE JURY ON THAT ISSUE.

It has become universally recognized that prior to performing a surgical procedure a physician owes his patient a duty to inform him of the treatment options available and the risks attendant with each to allow the patient a meaningful opportunity to grant or withhold his knowing and informed consent to the treatment contemplated by the physician. See, e.g.,

Dunham v. Wright, 423 F.2d 920, 943-46 (3rd Cir. 1970) (applying

Pennsylvania law); Campbell v. Oliva, 424 F.2d 1244, 1250-51 (6th Cir. 1970) (applying Tennessee law); Woods v. Brumlop, 71 N.M. 221, 337 P.2d 520, 524-25 (1962); Mason v. Ellsworth, 3 Wash. App. 298, 474 P.2d 909, 918-19 (1970).

In the instant case, the appellant alleged, among others, that Dr. Chambers failed to advise him of two material facts pertaining to the intestinal bypass operation: 1) that the operation was still experimental in nature and without sufficient history to have all of its side effects known; and 2) that it would result in increased stress being placed upon the patient's kidneys, making any kidney disease a contraindication to the performance of the operation.

The respondent testified unequivocally at trial that the intestinal bypass he performed on Mr. Conk was an experimental operation and that it was important that the patient be advised of this fact:

Q (By Mr. Black) Now, Doctor, during the time that you proceeded through these 25 operations, this particular intestinal bypass operation was experimental, was it not?

A Yes, sir.

Q And it was important, and is important in the medical profession, that in the event a doctor undertakes to perform an experimental operation with the results of such operation being unknown to the profession and the consequent risks that are involved in unknown results, to tell the patient forthright that the operation was, in fact, an experimental kind of operation?

A Yes, sir.

Q And as a matter of fact, in the other hearing in the

matter, your other patient in 1972, you advised that patient that the operation was experimental, and you stated in a deposition in that case that you advised the patient that it was experimental because you thought the patient ought to know that fact; isn't that true?

A Yes, sir.

(R. 787-88).

Mr. Conk testified that he was never informed that the operation was experimental. (R. 435-36). Dr. Chambers indicated at his deposition that he did not think he advised Mr. Conk of the experimental nature of the operation, but at trial he gave a different version:

Q And as a matter of fact, when we come down to April of 1973 when you first saw Mr. Conk, when you talked to him about this particular operation, you did not advise Mr. Conk that the operation was experimental, did you?

A I don't believe that's correct, sir.

Q You don't believe that you didn't advise him?

A I believe I did.

Q Well now, Doctor, you will recall that I took your deposition in this case on the 1st day of June, 1977, at my office?

A Yes, sir.

Q And Mr. Snow was present, who is your counsel?

A Yes, sir.

Q You were again placed under oath?

A Yes, sir.

Q And I will ask you to state--

THE COURT: What page?

MR. BLACK: Again at page 17, line 19.

Q And I will ask you to read along with me. Did you or did you not make the following answers to the following question:

"Question: Did you tell him that this was an experimental operation?

"Answer: No, I don't think so."

Did you or did you not make that answer to that question on that occasion?

A I did.

Q But you will concede before this Court and jury at this time that if an operation which is proposed is, in fact, experimental, the patient ought to know; is that not true?

A Yes, sir.

Q But this patient wasn't told that, was he?

A I said "I think" in that one; I say "I think" now. I believe I did.

Q Well, if you did, then you testified falsely on this occasion, is that right?

A I said "I think" in there, and I say it again today. (R. 788-89).

Appellant submits that on the basis of this testimony it would be error to make any finding that Dr. Chambers informed Mr. Conk of the experimental nature of the operation. Pitted against the patient's unambiguous denial that he ever received any warning that the operation was an experiment, the physician's inconsistent responses that at one time he felt he didn't inform and later felt he did inform Mr. Conk of the nature of

the procedure are insufficient to present a jury question on the issue. Where a witness' testimony is as internally inconsistent as to refute itself, it is insufficient to support a finding on an ultimate issue. See, e.g., State v. Pratt, 25 Utah 2d 76, 475 P.2d 1013 (1970); Alvardo v. Tucker, 2 Utah 2d 16, 268 P.2d 986 (1954).

Moreover, on the issue of the hazzard presented by the increased stress placed on the patient's kidneys due to the operation, there is no dispute that the appellant was not informed of such increased stress or of the fact that he, in the opinion of Dr. Chambers, had damaged kidneys before the operation was performed. Dr. Chambers testified that he never informed Mr. Conk that an added burden would be placed on his kidneys after the operation (R. 793), and responded as follows to further questions on the subject:

Q Now, it would be very important for you as a treating physician to know, if it be a fact, that a patient had a kidney problem prior to such an operation; isn't that true?

A I don't know what "kidney problem" means.

Q Well, I think the word "problem" is a word that we all understand. If a person had a problem with his kidneys, it would be important that you know that before you perform this operation, wouldn't it?

A Yes, sir.

Q And why would it be important?

A Well, the obviously continuing the function of the kidneys through the operative period and the post-operative period.

Q And that would be a matter you would take under advis-  
and into consideration in determining whether a patient was a  
proper candidate for a bypass operation?

A Yes, sir. (R. 793-94)

\* \* \* \* \*

Q And if he had a significant problem you would abort the  
operation, wouldn't you?

A That is correct, sir.

Q And if he had a significant problem, you would at least  
tell him so and tell him how that was involved in the decision-  
making with regard to the performance of this operation?

A That is correct, sir.

Q And as a matter of fact, Dr. Chambers, the Granger  
Medical Clinic records reveal that Mr. Conk, in fact, had a  
kidney problem at the time that you made the determination to  
perform this operation?

Well, I'm waiting for your answer.

A I wasn't asked for an answer, sir.

MR. BLACK: Would you read the question?

(The question was read by the reporter.)

A I don't agree with that statement. You didn't ask  
me a question, but I don't agree with it.

Q You don't think he had any kidney problem at all?

A Yes, I think he had a problem related to his hypertensi-  
the kidney problem that goes with hypertension.

Q That isn't the way you answered the question when I took  
your deposition, is it, Dr. Chambers?



And I will ask you to read with me the following question and the following answer.

THE COURT: What page?

Q And this in on line 8, page 19:

"Question: And in this connection, did you become aware of the fact, if it be a fact, that he'd had some kidney problems before this time?

"Answer: No."

Did you answer that question in that manner?

A Yes, sir. (R. 794-96)

\* \* \* \* \*

Q Although you never told Mr. Conk anything about his kidneys in discussing this operation with him, at the time you discussed it with him you knew that he was suffering from kidney damage; isn't that true?

A Not necessarily kidney damage at the time I operated, sir.

Q Well, Dr. Chambers, down the road a ways on November 18, 1975, you wrote a letter "To Whom It May Concern" regarding Mr. Ralph Conk, and signed your name to it. It's marked Plaintiff's Exhibit 13-P, and I will ask you to examine that letter and state to this Court and jury whether you, in fact, wrote the letter and affixed your signature to it?

A I did write this letter as of November 18th, 1975, and this is my signature.

Q And the subject matter of that letter is Mr. Conk's kidneys, is it not?

A Yes, sir.

Q And that letter, or a copy of it, is located in the Granger Medical Clinic records, is it not?

A Yes, sir.

Q And it's a part of Mr. Conk's records that you brought court here with you today?

A Yes, sir.

MR. BLACK: We offer the exhibit, your Honor.

MR. SNOW: No objection.

THE COURT: Exhibit 13-P is received.

(Plaintiff's Exhibit No. 13 was received into evidence.)

MR. BLACK: We ask permission to read the exhibit to the jury, your Honor.

THE COURT: Any objection?

MR. SNOW: No.

THE COURT: You may

MR. BLACK: On Granger Medical Clinic stationer dated November 18, 1975.

"To Whom It May Concern:

"Re: Mr. Ralph Conk

"Mr. Ralph Conk was referred to me by Dr. Lavere Poulsen on March 28, 1973. At that time he had severe obesity that had not responded to the usual measures of treatment. He also had severe hypertension.

"On April 23, 1975, I performed an intestinal shunt procedure because of the obesity and the hypertension. His immediate post-operative course went very well.

"At the time I first saw Mr. Conk prior to his

intestinal shunt procedure, he had severe hypertension which, of course, meant that he had kidney damage which occurred with it. Kidney function tests as early as March, 1972, showed some elevation of urea nitrogen.

"It is my impression that there was kidney damage related to the hypertension prior to his intestinal shunt procedure.

"Signed Wallace L. Chambers, M.D."

Q Is that a correct recitation of that letter?

A One mistake there, and it's in there, too.

Q Did I correctly read the letter, Doctor?

A You correctly read the letter, and there is a mistake. The operation was April 23, 1973. It does say "75 there.

Q Thank you. And that is an incorrect recitation of the date.

And at the time that you decided on this operation, number one, you didn't tell him about the information contained in this letter, did you?

A I told him about his hypertension, and this letter states that the kidney damage is related to his hypertension. And I talked about his hypertension. I did not talk about kidney damage. (R. 798-800)

Mr. Conk also confirmed the fact that he wasn't informed about the possible alteration of the function of the kidneys or the fact of his already existing kidney damage.

Q Mr. Conk, what, if anything, did Dr. Chambers tell you concerning what the Granger Medical Clinic records showed as of April 1973 concerning kidney damage as a result of a long-

standing high blood pressure condition?

A He told me nothing.

Q What, if anything, did Dr. Chambers tell you concerning what the effects of this operation might have on your kidneys?

A He didn't tell me anything about my kidneys.

Q What change in the course of your conduct would you have done had you been told that this bypass procedure was, because of its very nature, a dehydrating procedure and could cause further damage to your kidneys?

A I would never have had it.

Q What, if anything, did the doctor tell you about the possibility of kidney stones occurring as a result of this surgery?

A He didn't tell me anything about the kidneys.

The kidneys were never mentioned.

Q What, if anything, did he tell you concerning whether or not, in order to be a candidate for this procedure, an individual should have either--well, strike that. Let me restate the question, Mr. Conk.

What, if anything, did Dr. Chambers tell you concerning the advisability of having this operation should an individual have a pre-existing renal or kidney disease?

A He didn't tell me anything about the kidney disease. If he had told me anything about the kidney disease, I would never have the operation. Kidney disease, I was very, very frightened of. I watched my favorite uncle pass away with kidney disease and if anything at any time would have showed me that it would

have affected my kidneys, I would have stayed within miles of it. There would be no way I would have had the operation.  
(R. 1038-39)

The significance of a physician's failure to inform his patient of the risks inherent in a particular surgical procedure is that it deprives an individual of the right to make his own determination, on the basis of adequate facts, of what is to be done with his own body.

When initially confronted with the problem of determining the scope of a physician's duty of disclosure, courts tended to view the disclosure requirement as an aspect of medical practice which should be judged by the same rules applicable to performance of surgery, forming a diagnosis, or prescribing medication: did the physician's practice meet the standard of care of a reasonably competent medical practitioner performing in the same or similar circumstances? The duty of disclosure was viewed in reference to a medical standard, and the standard was set by physicians practicing under like circumstances. As a result, expert testimony was required to establish the appropriate standard before any breach of that standard could be found.

More recently, however, the law has come to recognize that in disclosure cases the proper focus should be upon the needs of the patient and not the practice of the profession. The patient's right of self-determination is the overriding concern and medical considerations only become relevant when disclosure itself would have a dramatically adverse effect on the patient's health. Under this formulation of the standard, a

physician is negligent if he fails to inform his patient of all material risks involved in the proposed procedure, and he is liable in damages if the patient suffered harm as a result of such procedures being performed without his informed consent.

In Canterbury v. Spence, 464 F.2d 772 (D.C. Cir. 1972), the court called into question the practice of judging of a physician's duty of disclosure in terms of its compliance with the practice prevailing in the medical community. The court noted that, in reality, there is serious doubt as to whether any discernible custom exists among doctors evidencing a professional consensus on what is proper communication of risk information to patients. As the court noted, there is a

. . . danger that what in fact is no custom at all may be taken as an affirmative custom to maintain silence, and that physician-witnesses to the so-called custom may state merely their personal opinions as to what they or others would do under given conditions. We cannot gloss over the inconsistency between reliance on a general practice respecting divulgence and, on the other hand, realization that the myriad of variables among patients makes each case so different that its omission can rationally be justified only by the effect of its individual circumstances. Nor can we ignore the fact that to bind the disclosure obligation to medical usage is to abrogate the decision on revelation to the physician alone. Respect for the patient's right of self-determination on particular therapy demands a standard set by law for physicians rather than one which physicians may or may not impose upon themselves. 464 F.2d at 783-84 (footnotes omitted).

The court held that expert testimony is not essential to establish a doctor's duty to disclose risks of a proposed treatment. The court stated that lay witness testimony can competently establish a physician's failure to disclose

particular risk information, the materiality of a risk to the patient's decision on whether to undergo the proposed treatment, or to the effect reasonably expectable if the disclosure had been made. While the court noted that expert testimony would be needed to identify and elucidate for the factfinder the risks of the proposed treatment, the standard of care required of the physician in making disclosure about such risks was expressly held not to be dependent upon the practice of physicians in the community.

Similarly, in Cobbs v. Grant, 8 Cal. 3d 229, 502 P.2d 1 (1972), the court held that expert testimony is not required to establish a doctor's duty to disclose risks of a proposed treatment. Stressing that the rule of many courts, relating the reasonableness of a physician's disclosure to the custom of physicians in the community, was needlessly overbroad, the court reasoned that even if there can be said to be a medical community standard as to the disclosure requirement for any prescribed treatment, it appears so nebulous that doctors become, in effect, vested with virtual absolute discretion. To bind the disclosure obligation to medical usage, the court declared, is to leave the decision on disclosure to the physician alone. It was pointed out that unlimited discretion in the physician is irreconcilable with the basic right of the patient to make the ultimate informed decision regarding the course of treatment to which he knowingly consents. The court stated that a medical doctor, being the expert, appreciates the risks inherent in the procedure

he is prescribing, the risks of a decision not to undergo the treatment, and the probability of a successful outcome of the treatment. However, the court explained that once this information has been disclosed, the doctor's expert function has been performed, the weighing of these risks against the subjective fears and hopes of the patient not being an expert skill. It was emphasized that such an evaluation and decision is a nonmedical judgment reserved to the patient alone. Stressing that the scope of the disclosure required of physicians defies simple definition, the court stated that the scope of the required disclosure must be measured by the patient's need, and that this need is for whatever information is material to the decision whether to undergo the proposed treatment.

In Cooper v. Roberts, 220 Pa. Super. 260, 286 A.2d 647 (1971), where the plaintiff patient alleged that she should have been warned of the risk of perforation of her stomach from a gastroscopic examination, the court, reversing a judgment for the two defendant doctors, rejected a requirement of expert testimony to establish a doctor's duty to disclose a given risk of a proposed treatment as unacceptable since such a requirement failed to produce equitable results and demeaned the concept of physical integrity of the individual. While stating that it had high regard for the professionalism of the medical community, the court noted that the standard of disclosure within the medical community bears no inherent relationship to the amount of knowledge that any particular patient might require in order to make an informed choice. Further justification



its conclusion that expert testimony was not necessary in a disclosure of risk case, the court stated that any physician testifying on the issue of the duty of disclosure would be testifying as to either what he would have done under similar circumstances, or as to what he thinks another practitioner should have done under such circumstances, neither of which supplies an adequate definition of the "community standard." It was also noted that the plaintiff's difficulty in finding a physician to testify against another physician had to be considered. The court stated that an equitable test in disclosure of risk cases would be whether the physician disclosed all those facts, risks, and alternatives that a reasonable man, in the situation which the physician knew or should have known to be the plaintiff's, would deem significant in making a decision to under go the recommended treatment. In addition, calling attention to the rule that generally in medical malpractice suits expert testimony is required, the court stated that there is a basic distinction between the normal malpractice suit, where the issue is whether the physician failed to conform to accepted medical practice, and informed consent cases, where the salient question is whether the patient made an effective assent to treatment and where the determination of whether there was any dereliction of professional duty on the part of the physician is only one factor in the resolution of the ultimate issue.

This view of the applicable standard in disclosure cases is clearly the modern trend among courts which have considered the question in recent years. See, e.g., Hamilton v. Hardy, 549 P.2d 1099 (Colo. App. 1976); Zelevnik v. Jewish

Chronic Disease Hosp., 47 App. Div. 2d 199, 366 N.Y.S.2d 163 (1973); Congrove v. Holmes, 37 Ohio Misc. 95, 308 N.E. 2d 765 (1975); Small v. Gifford Memorial Hosp, 349 A.2d 703 (Vt. 1974); Holt v. Nelson, 523 P.2d 211 (Wash. App. 1974); Miller v. Kennedy, 522 P.2d 852 (Wash. App. 1974), aff'd 85 Wash. 2d 151, 530 P.2d 334 (1975); Getchell v. Mansfield, 260 Or. 174, 489 P.2d 953 (1971).

The fundamental principles set forth in these cases are that a patient has the right to be informed about: 1) Alternative treatments to that proposed by the physician; 2) all reasonably foreseeable material risks involved in each alternative including that proposed by the physician; and 3) the risks involved in no treatment at all. The courts have frequently emphasized that "materiality" is not a clear cut, self-defining term, but:

[t]he factors contributing significance to the dangerousness of a medical technique are, of course, the incidence of injury and the degree of the harm threatened. A very small chance of death may well be significant; a potential disability which dramatically outweighs the potential benefit of the therapy or the detriments of the existing malady may summon discussion with the patient. Canterbury v. Spence, supra, 464 F.2d at 788.

If the evidence shows that a physician failed to disclose material risks, then expert testimony can be offered to show that such a failure was justified as proper medical practice to protect the patient. However, as the court noted in Canterbury v. Spence, supra:

[t]he physician's privilege to withhold information for therapeutic reasons must be carefully circumscribed, . . . for otherwise it might devour the disclosure rule itself. The privilege does not accept the paternalistic notion that the physician may remain silent

simply because divulgence might prompt the patient to forego therapy the physician feels the patient really needs. That attitude presumes instability or perversity for even the normal patient, and runs counter to the foundation principle that the patient should and ordinarily can make the choice for himself. 464 F.2d 789.

The sole purpose for the expert testimony on the standard of disclosure in the medical profession would be to show a specific justification that could be considered by the trier of fact, but only as it effects the legal duty imposed upon physicians to reveal all material risks. It is in the nature of a defense to the prima facie breach of the duty imposed by law, not a yardstick of the duty itself, and even as a defense it would only justify non-disclosure when such disclosure would have demonstrably adverse effect on the patient. See Hamilton v. Hardy, supra.

In summary, courts are now recognizing that a physician's duty of disclosure to his patient is not defined in terms of medical practice, but rather by the needs of the patient and his right of self-determination.

In the instant case, Dr. Chambers admittedly did not inform the appellant of the risks posed to the continued function of his kidneys and wasn't certain whether or not he even advised Mr. Conk of many other ill effects which might be seen to flow from the operation which, due to its experimental nature, were as yet unknown.

This type of information is precisely what a patient deserves to know prior to consenting to an operation, and particularly an elective surgery such as that presented in this matter.

The normal test, whether a physician informed his

patient of all foreseeable material risks inherent in the operation cannot be used to determine the duty to disclose the experimental nature of an operation because, by definition, many of what will later be found to be material risks are totally unknown because the procedure is new. It would be absurd to allow a physician to have no dialogue at all about the risk factor of a surgery simply because it is so novel that the risks are unknown. When such is the case, the doctor should, as a matter of law, inform the patient that many of the potential dangers of the surgery are as yet unknown and allow the patient to weigh for himself his desire for treatment against the fear of the unknown. This subjective decision of whether to proceed when much is not known is one for the patient, not the physician.

While this issue appears to be novel, appellant submits that it is also irrefutable that a doctor owes as great a duty to disclose what he admittedly does not and cannot be expected to know as that which he does know. Appellant respectfully requests this Court to hold that as a matter of law a physician breaches his duty to obtain a patient's informed consent when he does not disclose that a surgical procedure is experimental and that this duty was breached in the instant action.

Alternatively, appellant submits that Dr. Chambers' failure to disclose to Mr. Conk the condition of his kidneys prior to the surgery and the adverse effect the surgery could have on damaged kidneys constituted a breach of the duty owed by all physicians to inform their patients of all material risks involved in their treatment. Clearly, Dr. Chambers felt the condition of Mr. Conk's kidneys prior to surgery was significant or he would not have noted it for the record after the surgery.

and the onset of Mr. Conk's more pronounced kidney disease. As it was significant, Mr. Conk should have been so advised prior to surgery.

The court below erred by failing to direct the jury that Dr. Chambers had breached his duty of disclosure to Mr. Conk and focusing their inquiry on whether such breach caused the appellant any damage. This error demands that the matter be reversed and remanded for consideration of the question of damage.

Even assuming the court was correct in allowing the issue of informed consent to go to the jury, the instructions given by the court, and excepted to by appellant, improperly stated the law and were internally inconsistent, thereby requiring reversal of the judgment entered below.

In instruction number 15 the court charged the jury that Dr. Chambers owed Mr. Conk the duty to advise him of "any risks or uncertainties involved in the operation" of which he was aware or should have been aware, including the fact that the operation was experimental. (R. 154) In the next instruction, number 16, the court informed the jury that the physician's duty was to inform Mr. Conk of those "reasonably anticipated risks and complications as would have been disclosed as part of the accepted practice" of doctors practicing in accord with the professional standard of care. The court further indicated that

To prevail on this issue, plaintiff must prove each of the following propositions:

1. That in discussing the operation with him Dr. Chambers failed to conform to the standard of disclosure which was required by accepted medical practice among surgeons practicing at that time, and

2. That a reasonably prudent person who had been considering an intestinal by-pass operation for weight reduction would have refused the operation if such disclosure had been made by the defendant. In determining what a reasonably prudent person in the patient's position would do under the circumstances, you must use the viewpoint of the patient before the surgery was performed and before the occurrence of any complications or harmful results alleged to have resulted from the surgery.

These two instructions are inconsistent with each other, as the first imposes a duty to inform concerning subjects which the physician knows or has reason to know present risks or uncertainties, while the latter instruction limits this duty by excusing failure to inform of known risks or uncertainties if the "accepted medical practice" would have been to withhold such information. As demonstrated in the above, defining the disclosure duty in terms of medical practice is error because it is inconsistent with the overriding interest of the patient in having as complete knowledge as possible when choosing what course to follow. The medical standard of care defines what the physician should know, but the legal duty to reveal that information should not be restricted or modified by any prevailing practice among physicians of not disclosing risks, or uncertainties, of which they are required to be aware.

Had the court not modified instruction 15 with the improper standard set forth in the next instruction, the jury would have been free to determine that Dr. Chambers breached his duty to the appellant by failing to inform him of the experimental nature of the operation or the hazards posed to kidneys. However, instruction 16 adds an additional element necessary to establish a breach of duty, namely that such fa-





tion 15. As such, the giving of the challenged instruction is reversible error which requires that the case be remanded for submission to the jury on the basis of a proper statement of the law.

### POINT III

IN FAILING TO GIVE PLAINTIFF'S REQUESTED INSTRUCTIONS 9, 10, and 13 DEFINING "SAME OR SIMILAR COMMUNITIES" THE TRIAL COURT COMMITTED PREJUDICIAL ERROR, PARTICULARLY IN ALL OF THE INSTRUCTIONS WHEREIN "SAME OR SIMILAR COMMUNITIES" IS USED DESCRIBING THE STANDARD OF CARE REQUIRED OF NATIONALLY BOARD CERTIFIED SURGEONS PERFORMING INTESTINAL SHUNTING PROCEDURES FOR THE PURPOSE OF WEIGHT REDUCTION.

For the convenience of the court we cite herein Plaintiff's Requested Instructions 9, 10 and 13:

#### INSTRUCTION NO. 9

On the subject of standard of care of physicians and/or board certified surgeons in discharging the duties of their respective professions, this Court has from time to time made reference to the terms "community" and "similar Communities" and to physicians and/or board certified surgeons practicing within a "community" or "similar communities". You are instructed that the term "similar communities" for the purpose of this case, means any area of the United States where physicians and/or board certified surgeons practice and where operative procedures are performed, which are similar in nature to the operative procedure here involved. (R. 101)

#### INSTRUCTION NO. 10

You are further instructed that where the evidence shows a national standard of care to exist with respect to a particular surgical procedure then board certified surgeons throughout the nation are required to perform said procedure in accordance with said national standard. (R. 102)

#### INSTRUCTION NO. 13

Plaintiff sufficiently meets the burden of proof required of him by showing by a preponderance of the evidence that the defendant physician, in his treatment of the plaintiff, either did something that a board certified surgeon of ordinary skill, care and diligence would not have done under like or similar circumstances, or that said defendant physician failed



or omitted to do something that a board certified surgeon of ordinary skill, care and diligence would have done under like or similar circumstances or conditions in the same or similar communities. The expression "board certified surgeons of ordinary skill, care and diligence" as used in this instruction, means board certified surgeons possessing that reasonable degree of professional learning and skill generally possessed by board certified surgeons of good standing in the same or in similar communities nationwide.  
(R. 107)

The trial court refused to give the above instructions, leaving to the jury the determination not only of what the standard was and whether the defendant breached that standard of care required, but also whether that standard was a national standard or merely a local standard. Plaintiff asserts that that is error of a very grave nature. If the jury was to determine that the standard was merely a local standard, or that plaintiff's experts did not practice in communities similar to Salt Lake City, then no evidence presented by plaintiff's experts as to the neglectful performance of the operation and the negligence in follow-up care would be considered. The two primary experts for the plaintiff were from San Diego and New York City.

There can be little doubt of the prejudicial and improper nature of the refusal to give the above instructions to the jury in light of the recent case of Swan v. Lamb, et al., 584 P.2d 814 (Utah 1978).

Justice Ellett succinctly stated for the majority of the court what law should apply to this type of case concerning what the appropriate standard of care should be in our modern and advanced technical age:

It thus appears that in the past, this court has stated that the doctor in treating a patient

cannot be held to be negligent unless it is shown that he did not comply with the standards used and approved by other doctors in the same vicinity. Those holdings were proper at the times when they were made; however, there is no reason to hold that doctors in Salt Lake City who profess to be experts in a field of surgery or medicine should not be held to the standard of care exercised by experts in the same field in cities of comparable size and throughout the medical profession.

Our quality of medical care in Utah rates with the best in the nation. Our hospitals are among the finest with the most recent technology, and the medical college at the University of Utah enjoys an outstanding reputation. In addition, doctors practicing their profession here come from various medical colleges throughout the nation. Medical journals are available nationally as are seminars and workshops. There is need for doctors here to have a lower standard of care than that of other doctors who are practicing in similar localities. Indeed, it is doubtful that any physician in the State of Utah would be willing to admit that his skill and knowledge is not equal to any other physician trained in his field, or that his ability is less than that of doctors trained and practicing in other cities.

True it may be that doctors practicing in small rural communities cannot be expected to have the facilities or the equipment to perform equally as well as can physicians in Salt Lake City; however, they have the same quality of training and should know enough to refuse to undertake operations or to treat patients if they are not in a position to successfully administer the needed treatment--save perhaps in emergency cases.

If surgeons throughout the nation consider it improper to allow foreign substances that have been injected into the spinal canal to remain there after completing a myelogram, it beggars the imagination to think a doctor in Salt Lake City could escape responsibility for harm done to his patient by failing to remove the substance in the canal so that it will be absorbed by the body. If this procedure is generally regarded to be unsatisfactory or dangerous, no doctor should escape responsibility merely because the local practice has not yet adopted it." (Emphasis added)

Without the proffered instruction, there is a serious likelihood that the jury misunderstood the "similar locality rule" as it is applied in Utah. As Justice Wilkins

noted in his concurring opinion in Swan,

"in determining similarity the courts will not now look to such socio-economic facts as population, type of economy, and income level, but to factors more directly relating to the practice of medicine."

And, Justice Crockett noted that for purposes of this rule, Los Angeles and Salt Lake City are similar communities, a conclusion no jury would reach without an adequate definition of the standard such as the plaintiff offered in this case.

Without the excluded instructions, the jury was left without proper guidelines as to the standard of care, making the trial court's Instructions, 12, 14, 15 and 18 and any other instructions wherein the same or similar community standard is set forth misleading, improper and prejudicial. (R. 145, 150, 153, 154, 157.)

It is recognized that certain of the above instructions are those submitted to the court by plaintiff, however, they were submitted with Instructions 9, 10, and 13, defining their meaning. Absent 9, 10, and 13, the other instructions erroneously and prejudicially set forth the law.

#### CONCLUSION

It is claimed by plaintiff herein that the trial court prejudicially erred in several particulars. The first two errors concern the trial Court's Instruction Numbers 24 and 25 that in essence state that the statute of limitations begins to run before the plaintiff has a reasonable opportunity to know that whatever physical harm he suffered was caused by the negligence of the defendant doctor. That type of instruction is patently contrary to justice,

legislative intent, the better reasoned trend of authority cited in points I B and C herein, and common sense.

Such instructions as the court gave tell an injured patient that he had a physical injury or harm but before he had a reasonable opportunity to know that his treating physician had negligently caused that physical injury or harm, his right to recourse had expired. This Court should not burden this plaintiff and future plaintiffs so heavily.

This matter should be reversed and remanded for a new trial on that issue alone. However, the trial court committed further error in not granting plaintiff's Motion for Directed Verdict on the issue of the applicable limitation of actions section of the Utah Code Ann. i.e. § 78-4-14 (supp. The evidence cited previously in Point I D clearly demonstrates the defendant did not provide substantive evidence that plaintiff knew or should have known more than two years prior to filing his complaint that: he had suffered any physical injury to his kidneys; the defendant doctor had not informed him of the experimental nature of the operation; the doctor had not informed him of the pre-existing kidney damage that was a contraindication for the bypass surgery; the plaintiff didn't have the right to rely on the assurances of his treating physician that he was progressing well and any problems he may have been having were the natural anticipated after effects of such surgery that would stabilize; or the defendant doctor had invaded any legally protected right of plaintiff. Defendant's own testimony as cited hereinbefore unassailably

supports simply that he failed in his burden on the affirmative defense of the statute of limitations. On remand that issue should not be presented to the jury.

Other compelling reasons, as shown by the record cited hereinbefore, demand that this case be remanded for a new trial on the issues of medical causation and damages only. The defendant's testimony without reasonable qualification is that the operation performed on plaintiff was experimental in nature and that he never told plaintiff of that fact. Defendant also did not tell the plaintiff that he had a pre-existing kidney condition that would be important to consider in this type of operation and would or could complicate his post-operative care. No evidence was provided to refute plaintiff's testimony that he wouldn't have agreed to the operation if he had known the detail of his pre-existing kidney problems and/or that the operation itself was experimental. Those issues should not have been presented to the jury.

Though the informed consent issues should not have been presented to the jury, the trial court further compounded its error by improperly and incorrectly instructing the jury. The standard the trial court used was incorrect. The instructions were also inconsistent. (R. 154, 155) The first such instruction imposes a duty to inform concerning subjects which the physician knows or has reason to know present risks or uncertainties, while the second limits that duty by excusing failure to inform of known risks or uncertainties if the "accepted medical practice"

would have been to withhold such information. The medical standard of care defines what the physician should know, but the legal duty to reveal that information, especially in an elective procedure, should not be restricted or modified by any prevailing practice of not disclosing risks, or uncertainty of which they are required to be aware. The patient is entitled to all such information and the decision to proceed is his and his alone, not that of the doctor who does not give a full disclosure and thereby makes that decision for his patient.

It is a case of first impression before this court and few courts have been confronted with informed consent in an experimental procedure. The proper standard in such circumstances should be that the doctor, in failing to advise the procedure and the incumbent uncertain results, should be liable for whatever physical injury results that was unknown at the time of the operation due to its experimental nature. Such is the case at bar regarding the plaintiff's kidney failure.

Finally, the trial court committed prejudicial error in failing to submit to the jury Plaintiff's Instruction 9, 10, and 13 defining "same or similar communities" standard as national in scope. The evidence in this case was that board certified surgeons such as defendant are governed by national boards and standards. Therefore, the trial court was incorrect in leaving to the jury a determination of whether the standard was national in scope as well as what

the standard was and whether or not the defendant breached that standard. In so doing, the court improperly allowed the jury to disregard the testimony of plaintiff's two main medical authorities simply on the basis that one of them came from New York City and the other from San Diego, California. That is patently contrary to the purport of the Swan case supra.

This case should be reversed and remanded for a new trial with the issues of the statute of limitations and/or negligent failure to obtain informed consent resolved in plaintiff's favor as a matter of law. In the alternative, this matter should be remanded for a new trial with the jury to be properly instructed on the issues.

RESPECTFULLY SUBMITTED this 2 day of July, 1979.

BLACK & MOORE

BY:

Wayne L. Black  
WAYNE L. BLACK

BY:

James R. Black  
JAMES R. BLACK

BY:

M. David Eckersley  
M. DAVID ECKERSLEY

MAILING CERTIFICATE

On this 2nd day of July, 1979, I mailed two copies of the foregoing Brief to John Snow and Elliot Williams, counsel for defendants, 700 Continental Bank Building, Salt Lake City, Utah 84101.

Lois Stubs  
Secretary