

2009

Midge Morgan v. Intermountain Health Care INC. : Brief of Appellant

Utah Court of Appeals

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IN THE UTAH COURT OF APPEALS

MIDGE MORGAN,	)	APPELLANT'S BRIEF
	)	
Plaintiff and Appellant,	)	
	)	
vs.	)	Appellate Case No. 20091044-CA
	)	Trial Court No. 050918581
INTERMOUNTAIN HEALTH	)	
CARE INC., IHC LDS HOSPITAL and	)	
JOHN AND JANE DOES I through X,	)	
	)	
Defendants and Appellees.	)	

INTERLOCUTORY APPEAL FROM THE THIRD JUDICIAL DISTRICT COURT
IN AND FOR SALT LAKE COUNTY, STATE OF UTAH
HONORABLE L.A. DEVER

Oral Argument Requested

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UTAH APPELLATE COURTS

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STATEMENT OF JURISDICTION

The Utah Supreme Court has jurisdiction over this appeal pursuant to Utah Code Ann. §78A-3-102-3(j) and has transferred this matter to the Utah Court of Appeals pursuant to Rule 42(a) of the Utah Rules of Appellate Procedure. The Utah Court of Appeals has jurisdiction over this appeal pursuant to Utah Code Ann. §78A-4-103(2)(j).

IDENTIFICATION OF THE PARTIES

Plaintiff/Appellant Midge Morgan, (“Midge” or “Morgan”), is an individual living in Draper, Utah. (Rec. 2, ¶ 4) Defendant/Appellee, Intermountain Health Care, Inc., (“IHC”) is a health care service corporation duly licensed under the laws of the State of Utah with its principal place of business and headquarters located at 36 South State Street, Salt Lake City, Utah 84111. (Rec. 3, ¶ 5) Co-Defendant/Appellee IHC LDS Hospital, (“LDS Hospital”), is a health care service corporation duly licensed under the laws of the State of Utah with its principal place of business and headquarters located at 8th Avenue and C Street, Salt Lake City, Utah 84111. (Rec. 3, ¶ 6) Rebecca Davis, R.N., (“Davis” or “Nurse Davis”), is a nurse duly licensed under the laws of the State of Utah and practicing nursing services either as an agent and/or employee of IHC. (Rec. 3, ¶ 7) IHC has assumed liability for any acts committed by Davis through the doctrine of respondeat superior thus Davis was not named as an individual Defendant in this action. (Rec. 14)

STATEMENT OF ISSUES FOR REVIEW

1. Whether the trial court erroneously determined, as a matter of law, that Plaintiff's medical malpractice claim failed because Plaintiff did not designate an expert or produce an expert witness report.
2. Whether the trial court erroneously determined, as a matter of law, that Plaintiff's negligence claim failed because Plaintiff did not designate an expert nor produce an expert witness report.
3. Whether the trial court erroneously determined that Plaintiff's malpractice and negligence claims did not fall within the "common knowledge" exception carved out by Utah law which provides that expert testimony is not required in every medical malpractice and negligence matter.

STANDARD OF APPELLATE REVIEW

For all issues presented herein the standard of appellate review is identical. Summary judgment should not be granted unless "the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law." Utah R. Civ. P. 56(c). An appellate court reviews a trial court's legal conclusions and ultimate granting of summary judgment for correctness. *Massey v. Griffiths*, 152 P.3d 312, ¶ 8 (Utah 2007) Because entitlement to summary judgment is a question of law, no deference is due the trial court's determination of the issues presented. *Higgins v. Salt Lake County*, 855 P.2d 231, 235 (Utah 1993). Additionally, an appellate court reviewing a grant of summary judgment views the facts

and all reasonable inferences drawn therefrom in the light most favorable to the nonmoving party. *Id.* at 233. Thus, “doubts about whether a nonmovant has established a genuine issue of material fact should be resolved in favor of permitting the party to go to trial.” *Butterfield v. Okubo*, 831 P.2d 97, 107 (Utah 1992) (citing *Rees v. Albertson’s Inc.*, 587 P.2d 130, 133 (Utah 1978)).

Lastly, “because negligence cases often require the drawing of inferences from the facts, which is properly done by juries rather than judges, ‘summary judgment is appropriate in negligence cases only in the clearest instances.’” *Matheson v. Marbec Investments*, 173 P.3d 199, 201, 590 Utah Adv. Rep. 21, 2007 UT App 363 (quoting *Trujillo v. Utah Dep’t of Transp.*, 1999 UT App 227, ¶12, 986 P.2d 752 (quoting *Nelson v. Salt Lake City*, 919 P.2d 568, 571 (Utah 1996) (quoting *Dwiggins v. Morgan Jewelers*, 811 P.2d 182, 183 (Utah 1991))

PRESERVATION FOR REVIEW

The interpretation of the allegations made by Morgan against IHC involving medical malpractice and negligence were raised in the trial court on IHC’s summary judgment motion filed on June 19, 2009; Morgan’s opposing memorandum filed on August 9, 2009; and IHC’s reply memorandum filed on (Rec. 195 – 236; 237 – 390; and 391 – 431, respectively.)

RULE OF CENTRAL IMPORTANCE

The rule whose interpretation is determinative of the appeal is Rule 56(c) of the Utah Rules of Civil Procedure which provides that:

The judgment sought shall be rendered if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law. A summary judgment, interlocutory in character, may be rendered on the issue of liability alone although there is a genuine issue as to the amount of damages.

STATEMENT OF THE CASE

Nature of the Case Course of the Proceedings and Disposition in Trial Court:

The lawsuit concerns a claim that Plaintiff/Appellant Midge Morgan, while recovering from a cervical fusion surgery performed at Defendant/Appellee LDS Hospital, sustained shoulder injuries not attributable to the surgery but instead due to the negligent actions of Nurse Davis. Midge Morgan, in her suit, claimed that, while recovering from neck surgery at LDS Hospital on February 27, 2003, Nurse Davis refused to heed Morgan's warnings that her legs were numb and she could not stand, making a trip to the bathroom impossible. Instead, Morgan claimed that Nurse Davis attempted to force Morgan out of the hospital bed by reaching under Morgan's arms and tried to "violently yanked" Morgan out of bed.

As background to the events leading up to Morgan's claims, on June 15, 1998, prior to Morgan's stay at LDS Hospital, Morgan was involved in an automobile accident in the employee parking lot at the Salt Lake City Airport when her car was struck by a delivery van that ran a stop sign. (Rec. 3, ¶ 9) As a result of the accident, Morgan

suffered injuries, including but not limited to her head, neck, upper and lower back as well as a mild traumatic brain injury. (Rec. 4, ¶ 10) Dr. Stephen J. Warner (“Dr. Warner”) treated Morgan for her pain and symptoms associated with her neck injuries sustained in the accident. (Rec. 4, ¶ 12) Dr. Warner recommended cervical spine surgery to Morgan. (Rec. 4, ¶ 13) Consequently, Morgan was admitted to LDS Hospital on February 26, 2003. (Rec. 4, ¶ 13) On February 26, 2003, Dr. Warner performed the following surgery on Morgan: a) anterior C5 – C6 discectomy, including removal of foraminal disk herniation; b) anterior C6 – C7 fusion using autogenous iliac crest bone graft; c) anterior cervical platin; c) C6 – C7, using ABC plate and d) harvesting, tricortical iliac strut graft through a separate skin and fascial incision. (Rec 4, ¶ 14).

As a result of the February 26, 2003 surgery, Midge had pumps connected to her leg and she could not feel or move her right leg. (Morgan Depo., 55:21-25, 89:25 – 90:4.) (Rec. 267) On the morning of February 27, 2003, Morgan needed to urinate and so requested a bedpan from both the nursing station and then from Nurse Davis. Midge testified as follows, regarding her request for a bed pan: “What I remember is that I asked for a bed pan, and no one was responding. And earlier in the morning ... [a bed pan] had be brought in and sat to the right of me on the table, and the table was quite a ways away. Because I had still the pumps on my legs and they had harvested the bone out of my right hip, I was not able to move in the bed, move that leg.” The nursing station was called and “brought my tray closer. Again, at that time I told them that I had asked for a bed pan.” (Morgan Depo., 55: 7 – 17) (Rec. 267)

Midge testified that she then requested Nurse Davis provide her with a bed pan because she was physically unable to get out of the bed but, ignoring her requests, [Nurse Davis] “walked through the door and came to the left side of me, the bed was on an incline. ... [Nurse Davis] said that I going to get up. And I told her that I couldn’t; that I still had the pumps on my legs and that the bone graft had been done on my right hip. I still could not feel – I wasn’t feeling and I couldn’t move it. And that I needed a bed pan.” (Morgan Depo., 55: 17 – 25, 56:1 – 25) (Rec. 267) Dr. Warner, Morgan’s treating physician corroborated Morgan’s need for a bed pan because the pain from the iliac crest bone graft could have prevented Midge from getting out of bed and going to the bathroom. (Warner Depo., 19:16-21.) (Rec. 286)

According to Midge, “[Nurse Davis] told me that LDS Hospital no longer had bed pans. ... “I told her that [] I had used the bed pan throughout the night, and if it was no longer in the bathroom, to please call another floor and get a bed pan. Because I did not feel like I could get up. [Nurse Davis] said “You are getting up.” (Morgan Depo., 56:1 – 7) (Rec. 267) There was a physical incident between Midge and Nurse Davis which forms the basis for Midge’s claims of medical malpractice and negligence. Midge has testified that Nurse Davis “proceeded to put her right arm across – underneath my left arm and across my chest and grabbed under my right armpit, and then she took her left hand on top and did not put down the railing and proceeded to try to pull me and jerk me forward and up and over the railing to put me on my feet.” (Morgan Depo., 56:8 – 12) (Rec. 267) Nurse Davis’ attempt to lift Midge, against her will, out of her hospital bed caused Midge to experience a “horrible pain.” (Morgan Depo., 56:13 – 14.) (Rec. 267)

Dr. Warner has testified that he found Midge in her room crying. Midge then told him that Ms. Davis “wanted her to get up to go to the bathroom, and according to Midge had grabbed her by the arms and jerked her up.” (Warner Depo., 19:4-15, 34:13 – 35:8.) (Rec. 286 and 290, respectively) It is Dr. Warner’s recollection that Midge was “extremely distraught” and “bawling” after the incident with Nurse Davis. (Warner Depo., 34:23 – 25; 2 – 8) (Rec. 290 and 287, respectively) Midge has testified that at that point she felt excruciating pain in both shoulders. She began screaming in pain, Ms. Davis dropped her, and she fell back on the bed. (Morgan Depo., 56:13, 63:25 – 64:9, 69:12 70:12, 71:14-16.) (Rec. 267, 269, and 270, respectively)

On or about October 20, 2005, Morgan filed her Complaint against IHC alleging Medical Malpractice, Negligence and Respondeat Superior. (Rec. 1 – 16). IHC filed its Answer on or about November 29, 2005. (Rec. 34 – 41) During the course of litigation, the following seven depositions were taken: plaintiff Midge Morgan (January 29, 2007); Dr. Stephen Warner, Ms. Morgan’s treating physician of several years and who performed the neck fusion surgery in February 2003 for which Morgan was hospitalized at the time her malpractice claims arose (May 29, 2007); Dr. Michael Metcalf, Ms. Morgan’s treating physician who performed her rotator cuff repairs in November of 2004 (May 29, 2007); Rebecca Davis, the nurse whose actions are directly at issue in this matter (June 12, 2007); George Smith a nurse and co-worker of Davis, on duty during Morgan’s February 2003 hospitalization (June 12, 2007); Terrence Spalding, an investigator for defendant (June 20, 2007); Somer Rignell Lasko and Debbie Mitchell, each nurses and co-workers of Davis, on duty during Morgan’s February 2003

hospitalization (both taken on May 19, 2008). Contrary to the insinuations of the trial court's November 9, 2009 Ruling, the parties, through their respective counsel, actively worked in a cooperative manner to further their respective sides and to move the case forward. (Rec. 440 – 445.) During the course of the litigation approximately two feet of medical records were produced. The scheduling of depositions in light of deponents and counsel's schedules was considered on multiple instances. Additionally, a mutual understanding existed between the parties that the deadlines in the case management order were not governing as discovery and the needs of the parties merited continued flexibility.

The briefing contained argument to challenge IHC's position that expert testimony was required given the nature and circumstances surrounding Morgan's claims. Moreover, there was direct and conflicting evidence, in the form of deposition testimony; affidavits and expert reports regarding 1) whether Nurse Davis was negligent in her actions; and 2) whether the shoulder injuries sustained by Morgan were caused from Nurse Davis' requiring Morgan to get out of bed on February 27, 2003.

On June 19, 2009, IHC filed its Motion for Summary Judgment requesting the trial court dismiss Morgan's claims based upon its conclusion that Morgan could not support her claims without expert testimony. Morgan's Memorandum in Opposition to IHC's summary judgment was filed on August 9, 2009; and IHC's reply memorandum was filed on August 31, 2009 (Rec. 195 – 236; 237 – 390; and 391 – 431, respectively) IHC filed its Request to Submit for Decision on September 11, 2009. (Rec. 432 – 434) Oral argument was requested by Morgan on September 14, 2009. (Rec. 435 – 437). The trial

court did not address Morgan's hearing request but instead, issued its Ruling on November 9, 2009, summarily dismissing Morgan's claims as a matter of law. (Rec. 440 – 445) (Ruling attached as Addendum 1 to this Brief)

The trial court concluded that, as a matter of law, Morgan's malpractice claims required that Morgan designate an expert witness and produce an expert report. Because Morgan did not designate an expert nor submit an expert report, the District Court determined that summary judgment, in favor of IHC, was appropriate. Specifically, the trial court ruled that "lay testimony is not sufficient to explain whether Plaintiff's shoulder injuries were the result of a previous injury and surgery or the act of a nurse." (Rec. 452) In support of its decision, the trial court cited to *Sanns v. Butterfield*, 2004 UT App 203, ¶ 6, 94 P.3d 301 (UT App. 2004) for its holding that "when a party fails to produce evidence sufficient to meet one of the elements of a claim, there can be not genuine issue as to any material fact, since a complete failure of proof concerning an essential element of the nonmoving party's case necessarily renders all other facts immaterial." (Rec. 452 – 453)

Based upon the granting of the summary judgment, the case was dismissed without further Order. (Rec. 453) On December 7, 2009, Morgan filed her Notice of Appeal pursuant to Rule 3(d), Fed. R. App. Pro., of the trial court's granting of summary judgment in favor of IHC. (Rec. 455 – 457). There were no transcripts made in this case. On December 30, 2009, the Utah Supreme Court notified the parties of its intent to transfer the matter to the Utah Court of Appeals. (Rec. 463) On January 25, 2010, the

parties were informed that the matter had been assigned to the Utah Court of Appeals.
(Rec. 466)

STATEMENT OF FACTS

1. Plaintiff/Appellant Midge Morgan, (“Morgan”), is an individual living in Draper, Utah. (Rec. 2, ¶ 4)

2. Defendant/Appellee, Intermountain Health Care, Inc., (“IHC”) is a health care service corporation duly licensed under the laws of the State of Utah with its principal place of business and headquarters located at 36 South State Street, Salt Lake City, Utah 84111. (Rec. 3, ¶ 5)

3. Co-Defendant/Appellee IHC LDS Hospital, (“LDS Hospital”), is a health care service corporation duly licensed under the laws of the State of Utah with its principal place of business and headquarters located at 8th Avenue and C Street, Salt Lake City, Utah 84111. (Rec. 3, ¶ 6)

4. Rebecca Davis, R.N., (“Davis” or “Nurse Davis”), is a nurse duly licensed under the laws of the State of Utah and practicing nursing services either as an agent and/or employee of IHC. (Rec. 3, ¶ 7)

5. IHC has assumed liability for any acts committed by Davis through the doctrine of respondeat superior thus Davis was not named as an individual Defendant in this action. (Rec. 14)

6. On June 15, 1998, Midge was involved in an automobile accident in the employee parking lot at the Salt Lake City International Airport when her car was struck by a delivery van that ran a stop sign. (Rec. 238, ¶ 1)

7. As a result of this accident, Midge suffered injuries, including but not limited to, her head, neck, upper and lower back. She also suffered a mild traumatic brain injury. (*Id.*, ¶ 10.) (Rec. 238, ¶ 2)

8. Midge has testified that she had surgery in 1970 to put a staple in her right shoulder when it was dislocated, and that the staple was removed approximately three or four months later. (Deposition of Midge Morgan, 32:15 – 33:15) (Rec. 261)

9. Midge has testified that she had no other shoulder problems between 1970 and 1998. (*Id.*, 33:16 – 19.) (Rec. 261)

10. Midge has testified that as a result of the automobile accident of June 15, 1998, she suffered pain in the upper part of her shoulders, where they connect to her neck. (*Id.*, 34:24 – 39:15.) (Rec. 262)

11. When Morgan's medical history was taken on August 27, 1998, shortly after her automobile accident, she did not report any shoulder problems. *See Addendum 3* at 000001 – 2. (Rec. 52 – 53)

12. Morgan's additional medical records, including those taken in close proximity to her February 2003 fusion surgery demonstrate a lack of injuries to her shoulders. *See Addendum 3* at 000003 – 40. (Rec. 52 – 53)

13. Midge came under the care and treatment of Dr. Stephen J. Warner ("Dr. Warner") for her pain and symptoms associated with her neck injuries sustained in the automobile accident of June 15, 1998. (Complaint, ¶ 12.) (Rec. 238, ¶ 6)

14. Dr. Warner has testified that he has cared for Morgan since May 4, 1999. (Warner Depo., 4:11 – 14) (Rec. 282)

15. Dr. Warner has testified that on January 30th, 2003, he examined Midge and determined that she had a C6-C7 Disk herniation, which resulted in arm and shoulder pain. (Warner Depo., 11:5 – 19, 12:3 – 9) (Rec. 284)

16. Dr. Warner testified that when he examined Midge on January 30, 2003 (approximately one month prior to her surgical procedure at LDS Hospital), she “demonstrates a reasonably good range of motion in both shoulders.” (Warner Depo., 13:11 – 12.) (Rec. 285)

17. Dr. Warner attributed the shoulder pain Midge was experiencing on January 30, 2003 to be actually originating from her injured neck and not from her shoulders. (Warner Depo., 13:14 – 18.) (Rec. 285)

18. Dr. Warner has testified that the pain and symptoms that Midge suffered prior to February 27, 2003 were consistent with the neck injuries that she had. (*Id.*, 35:18 – 36:1, 39:16 – 40:9.) (Rec. 239, ¶ 8)

19. Dr. Warner recommended Midge undergo surgery on her cervical spine so she was admitted to LDS Hospital from February 26 to 28, 2003. (Complaint, ¶ 13.) (Rec. 239, ¶ 9)

20. Dr. Warner performed the following surgery on February 26, 2003: a) anterior C5 – C6 discectomy including removal of foraminal disk herniation; b) anterior C6 – C7 fusion using autogenous iliac crest bone graft; c) anterior cervical plating, C6-C7, using ABC plate and d) harvesting, tricortical iliac strut graft through a separate skin and fascial incision. (*Id.*, ¶, 14.) (Rec. 239, ¶ 10)

21. Dr. Warner has testified that it is common for patients to have posterior neck pain after cervical spine surgery, and that this pain will often radiate in the distribution of the trapezius. (Warner Depo., 18:2-9.) (Rec. 286)

22. Midge has testified that on February 27, 2003, as a result of the surgery, she still had the pumps on her legs and that she could not feel or move her right leg. (Morgan Depo., 55:21-25, 89:25 – 90:4.) (Rec. 267)

23. Midge testified as follows, regarding her request for a bed pan: “What I remember is that I asked for a bed pan, and no one was responding. And earlier in the morning ... [a bed pan] had be brought in and sat to the right of me on the table, and the table was quite a ways away. Because I had still the pumps on my legs and they had harvested the bone out of my right hip, I was not able to move in the bed, move that leg.” The nursing station was called and “brought my tray closer. Again, at that time I told them that I had asked for a bed pan.” (Morgan Depo., 55: 7 – 17) (Rec. 267)

24. Midge testified that, on the morning of February 27, 2003 in response to her requests to be given a bed pan because she was physically unable to get out of bed, [Nurse Davis] “walked through the door and came to the left side of me, the bed was on an incline. ... And I had asked for a bed pan. And [Nurse Davis] said that I going to get up. And I told her that I couldn’t; that I still had the pumps on my legs and that the bone graft had been done on my right hip. I still could not feel – I wasn’t feeling and I couldn’t move it. And that I needed a bed pan.” (Morgan Depo., 55: 17 – 25, 56:1 – 25) (Rec. 267)

25. Dr. Warner has testified that the pain from the iliac crest bone graft could have prevented Midge from getting out of bed and going to the bathroom. (Warner Depo., 19:16-21.) (Rec. 286)

26. Midge has testified that on the morning of February 27, 2003, after requesting a bed pan, “[Nurse Davis] told me that LDS Hospital no longer had bed pans. ... “I told her that [] I had used the bed pan throughout the night, and if it was no longer in the bathroom, to please call another floor and get a bed pan. Because I did not feel like I could get up. [Nurse Davis] said “You are getting up.” (Morgan Depo., 56:1 – 7) (Rec. 267)

27. Midge has testified regarding the physical incident with Nurse Davis which Midge claims caused injuries to her shoulders that [Nurse Davis] “proceeded to put her right arm across – underneath my left arm and across my chest and grabbed under my right armpit, and then she took her left hand on top and did not put down the railing and proceeded to try to pull me and jerk me forward and up and over the railing to put me on my feet.” (Morgan Depo., 56:8 – 12) (Rec. 267)

28. Nurse Davis’ attempt to lift Midge, against her will, out of her hospital bed caused Midge to experience a “horrible pain.” (Morgan Depo., 56:13 – 14.) (Rec. 267)

29. Dr. Warner has testified that he found Midge in her room crying. Midge then told him that Ms. Davis “wanted her to get up to go to the bathroom, and according to Midge had grabbed her by the arms and jerked her up.” (Warner Depo., 19:4-15, 34:13 – 35:8.) (Rec. 286 and 290, respectively)

30. IHC's own Surgery Progress Notes, dated February 24 to February 27, 2003 reflect that Morgan was "very upset over confrontation [with] staff this [morning.]" *See Addendum 3* at 26. (Rec. 52 – 53)

31. It is Dr. Warner's recollection that Midge was "extremely distraught" and "bawling" after the incident with Nurse Davis. (Warner Depo., 34:23 – 25; 2 – 8) (Rec. 290 and 287, respectively)

32. Midge has testified that at that point she felt excruciating pain in both shoulders. She began screaming in pain, Ms. Davis dropped her, and she fell back on the bed. (Morgan Depo., 56:13, 63:25 – 64:9, 69:12 70:12, 71:14-16.) (Rec. 267, 269, and 270, respectively)

33. Midge has testified that shortly after this, Dr. Warner came into the room and told Ms. Davis that his orders were that Midge was not supposed to be moved until she felt able to be moved. (Morgan Depo., 57:1-4, 64:19 – 66:2.) (Rec. 268, 269 and 270, respectively)

34. Dr. Warner has testified that it is his opinion that if someone grabbed Midge's arms and jerked upward, it could cause rotator cuff tears. (Warner Depo., 28:2 – 29:16.) (Rec. 241, ¶ 19)

35. Dr. Warner has testified that "[o]n the next day [after the incident with Nurse Davis] [Midge was] complaining of bilateral shoulder pain." (Warner Depo., 23:17 – 22) (Rec. 287)

36. Dr. Warner has testified that on the day of Midge's release from LDS Hospital "she was complaining of both of her shoulders hurting over the anterior shoulder." (Warner Depo., 25:9 – 14) (Rec. 288)

37. Dr. Warner ordered an MRI scan for Midge on May 10, 2003, approximately 3 months after her surgery at LDS Hospital. (Warner Dep., 26:9 – 11) (Rec. 288)

38. Dr. Warner "order[s] MRI imaging when [he] thinks [injuries] might be rotator cuff pathology." (Warner Depo., 30:24 – 25) (Rec. 289)

39. Dr. Warner has testified that, based on the May 10, 2003 MRI Report stating "Focal 5x6 millimeter area of abnormal increased signal intensity within the anterior supraspinatus" could "certainly be an acute [rotator cuff] tear." (Warner Depo., 27:9 – 13) (Rec. 288)

40. Dr. Warner testified in his deposition and was prepared to testify at trial that Morgan's rotator cuff injuries could be related to the incident with Nurse Davis. (Warner Depo., 28:2 – 25) (Rec. 288)

41. Dr. Warner testified that, if the incident with Nurse Davis happened as Morgan described, this single event could have torn Morgan's rotator cuffs. (Warner Depo., 32:8 – 16) (Rec. 289)

42. Specifically, Dr. Warner testified in his deposition and was prepared to testify at trial that "[A]s described to me by Ms. Morgan, the even as she described it to me, if indeed her arms were grabbed and jerked, could it cause rotator cuff tears? Yes, it

could. I mean, that's my honest opinion. And if you ask me that at trial, that's how I would answer it." (Warner Depo., 29:11 – 16) (Rec. 289)

43. On May 10, 2003, approximately two and one-half months after performing the cervical fusion on Ms. Morgan, several Dr. Warner diagnosed Midge as suffering from torn rotator cuffs and other damage to both shoulders. He advised Midge that she needed to have both shoulders surgically repaired. (Complaint, ¶ 22.) (Warner Depo., 26:9 – 25 and 31:3 – 10) (Rec. 241, ¶ 20; and 288 – 289)

44. When Defendants' counsel asked Dr. Warner his opinion as whether it is "often true that rotator cuff tears often develop secondary to neck problems in adults" Dr. Warner disagreed. (Warner Depo., 13:20 – 23.) (Rec. 285)

45. Dr. Warner further testified that he "would say that rotator cuff problems are associated with the shoulder" and that he is "not aware of any article that describes neck problems as a cause of rotator cuff tears." (Warner Depo., 14:13 – 16.) (Rec. 285)

46. Prior to the February 2003 surgery, Midge "wasn't having a lot of pain that [he] would attribute to her shoulders" as testified to by Dr. Warner. (Warner Depo., 39 – 40:16 – 25, 1 - 9) (Rec. 288)

47. Midge testified during her deposition that, prior to the February 2003 surgery, the pain she was experiencing from the car accident was located "in [the] upper part [of her body] where [her shoulders] connect[] into [her] neck." (Morgan Depo., 34 - 35:24 – 25, 1 – 2) (Rec. 262)

48. In describing the location of her "shoulder" pain after the incident with Nurse Davis, Midge testified during her deposition that the pain was "right on the ends of

the upper arm ... where the shoulder and upper arm meet.” (Morgan Depo., 91:17 – 24) (Rec. 276)

49. When asked to describe the difference in pain in her shoulders prior to the incident with Nurse Davis and afterwards, Midge testified that prior to the incident the pain felt “like lightning going down my arms and numbness ... like holding onto [an] electric fence ... a shocking-type feeling.” This pain was “totally different than when the rotator cuff is hurting. It’s a constant pain, and it’s a more of a burning sensation.” (Morgan Depo., 91:4 – 16) (Rec. 276)

50. Midge testified that she does not recall any doctor telling her that she had preexisting or degenerative shoulder injuries. (Morgan Depo., 61:2 – 15) (Rec. 269)

51. Midge came under the care and treatment of Dr. Michael Metcalf (“Dr. Metcalf”), who confirmed Dr. Warner’s diagnosis of torn rotator cuffs and recommended surgical repair of both shoulders. (Complaint, ¶ 23; Deposition of Dr. Michael Metcalf, 44:4 – 20) (Rec. 241, ¶ 21 and 306, respectively.)

52. Midge testified during her deposition regarding the difference between limitations she attributed to the car accident versus those she associates with being yanked out of bed by Nurse Davis as follows:

“After the torn rotator cuff, it’s a limitation of where ... you can’t lift heavy above [] your head or, you know, you can’t have the weight in your hand and then try to lift it up. [Also] there’s certain motions to the side that [] if you do it, then you pay the consequences of the pain. ... [I]t’s a different

kind of pain that you feel. And that kind of pain, I didn't feel after the [car accident.] (Morgan Depo., 95:1 – 21) (Rec. 277)

SUMMARY OF ARGUMENT

The trial court erred in granting IHC's Motion for Summary Judgment on Morgan's medical malpractice and negligence claim on the grounds that, as a matter of law, Morgan's claims required an expert witness in order to establish the applicable standard of care and violation of the applicable standard of care. Utah courts have determined that, in certain circumstances, expert testimony is not required to demonstrate malpractice occurred. Instead, if the facts surrounding the claims are within the "common knowledge" of a lay person, Utah Courts permit the determination of negligence to be made by the jury.

The conclusions of law made by the trial court are also erroneous because, Morgan's complaint also raised allegations of negligence which Utah courts have clearly indicated that expert testimony in matters of negligence. Based upon the nature of Morgan's injuries and Davis' conduct, a jury is qualified to make a determination as to whether malpractice and common law negligence occurred. Moreover, the "issue of negligence, or breach of a legal duty is normally a question of fact for the jury." *Kitchen v. Cal Gas Co., Inc.*, 821 P.2d 458, 461 (Utah App. 1991) (citing to *Harris v. Utah Transit Auth.*, 671 P.2d 217, 220 (Utah 1983)). For this reason, "summary judgment is generally improper on the issue of negligence and only in clear-cut cases, with the exercise of great caution, should a court take the issue of negligence from the province of

the jury. *Kitchen*, at 461. See e.g. *Williams v. Melby*, 699 P.3d 723, 725, (Utah 1985); *Bowen v. Riverton City*, 656 P.2d 434, 436 (Utah 1982).

The trial court further erred in ruling, as a matter of law, that summary judgment was appropriate because there are disputed material facts which, under Rule 56(c) , Utah R. Civ. Pro. preclude a granting of summary judgment. As of the filing of IHC's summary judgment motion, the parties disagree as to what transpired on February 27, 2003 between Ms. Morgan and Nurse Davis. Moreover, the deposition testimony of Morgan and Dr. Warner, her treating physician directly conflicts with IHC's reports, affidavits and deposition testimony. Because there are genuine issues of material fact, summary judgment is an inappropriate remedy at law.

ARGUMENT

I. A reasonable finder of fact could conclude, without expert testimony, that Davis was negligent in the post-surgical treatment of Morgan which caused Morgan's shoulder injuries therefore, summary judgment was erroneously granted.

a) Utah law provides an exception for requiring an expert witness in medical malpractice cases.

The trial court erroneously concluded, as a matter of law, that Morgan required expert testimony in order to demonstrate that her shoulder injuries were the result of Nurse Davis' actions and not due to a previous injury and surgery. (Rec. 452) Because Morgan failed to designate an expert witness and did not submit an expert report, the trial court found that Morgan's claims failed as a matter of law. In its opinion, the trial court determined that "lay testimony is not sufficient to explain whether Plaintiff's shoulder

injuries were the result of a previous injury and surgery or the act of a nurse.” (Rec. 452) For this reason, the trial court ruled that “Plaintiff’s claims fail as a matter of law” citing to *Sanns v. Butterfield*, 2004 UT App 203, ¶ 6, 94 P.3d 301 for its holding that “when a party fails to produce evidence sufficient to meet one of the elements of a claim, there can be not genuine issue as to any material fact, since a complete failure of proof concerning an essential element of the nonmoving party’s case necessarily renders all other facts immaterial.” (Rec. 452 – 453)

A plaintiff claiming medical malpractice must demonstrate 1) the standard of care by which a health care provider’s conduct is to be measured; 2) that the standard of care was breached; and 3) that the injury was proximately caused by that breach. *See Dalley v. Utah Valley Regional Medical Center*, 791 P.2d 193, 195 (Utah 1990). Morgan concedes that, in general, a plaintiff must usually provide expert testimony establishing that the health care provider’s negligence proximately caused the plaintiff’s injury because of the complex issues involved in the determination of negligence in most medical malpractice claims. *See e.g. Kent v. Pioneer Valley Hosp.*, 930 P.2d 904, 906 (Utah Ct. App.); *cert. denied*, 939 P.2d 683 (Utah 1997) ; *see also, e.g. Chadwick v. Nielsen*, 763 P.2d 817, 921 (Utah Ct. App. 1988) However, Morgan contends that the circumstances surrounding her shoulder injury – namely the physical interaction with Nurse Davis – fall within an exception to this general principal.

Recently, the Utah State Supreme Court in *Bowman v. Kalm*, examined the issue of whether or not a plaintiff was required to present expert testimony to support medical malpractice claims made against a psychiatrist regarding the proscribing of medication

that was alleged to have caused a patient's death. 179 P.3d 754, 597 Utah Adv. Rep. 3, 2007 UT 9. The facts of *Bowman* are as follows. Dr. Kalm, a psychiatrist, prescribed sleeping pills to Ms. Menlove, a patient he was treating for anorexia, depression and anxiety. The patient died from asphyxiation when she became pinned under a bedroom dresser. At the time of her death, Ms. Menlove had sleeping pills in her systems and there was evidence to suggest she was taking the medication at a higher-than-prescribed dosage. *Bowman* at p. 755. Kim Bowman, Menlove's husband, filed a medical malpractice case against Dr. Kalm and provided limited expert witness testimony regarding the standard of care. However, Bowman's expert did not provide any testimony regarding whether the alleged acts of malpractice were the proximate cause of Menlove's death. *Id.*

In *Bowman*, the Utah State Supreme Court acknowledged that medical malpractices cases generally require expert testimony, but that there is a limited "common knowledge" exception. *Id.* at 756. "This exception applied when the causal link between the negligence and the injury would be clear to a lay juror who has no medical training – i.e., when the causal connection is readily apparent using only "common knowledge." *Id.* Citing to *Kent v. Pioneer Valley Hosp.*, 930 P.2d 904, 906 & n. 3 (Utah Ct.App.1997) (stating that "the plaintiff must provide expert testimony establishing that the health care provider's negligence proximately caused plaintiff's injury," but also noting that "there are certain limited situations where expert testimony ... is not needed"); *Chadwick v. Nielsen*, 763 P.2d 817, 821 (Utah Ct.App.1988) ("[E]xpert medical testimony must be presented at trial in order to establish the standard of care and

proximate cause – except in unusual circumstances.”). The Utah State Supreme Court in *Bowman* explained that “where the causal connection between the alleged negligence and injury is “so common” [] or is non-medical in nature, expert testimony is not required to prove proximate cause. *Id.* at 756 (citing references omitted)

- b) Case law from other jurisdictions supports a finding that exceptions exist from the expert witness requirement of medical malpractice cases.

While not binding authority, the legal position outlined by Utah courts which allows for a finder of fact to rely upon their own experiences and common knowledge in lieu of expert testimony, has been followed in a host of other jurisdictions. *See e.g. Ewing v. Northridge Hospital Medical Center*, 120 Cal.App .4th 1289, 1302 (Cal. App. 2003); *Carney v. Tranfaglia*, 57 Mass. App. Ct. 664, 666-667, 785 N.E. 2d 421, 423 (Mass App. Ct. 2003); *review denied*, 439 Mass. 1109, 793 N.E.2d 375 (Mass. 2003); *Fontinas v. Westchester Cty. Med. Ctr.*, 300 AD.2d. 437, 752 N.Y.S.2d 90, 2002 N.Y. Slip Op. 09399; *Guevara v. Ferrer*, 247 S.W.3d 662, 665 (Tex. 2007); and *Wade v. Castillo*, 658 F.Supp.2d 906 (W.D. Wis. 2009) (citing *Carney-Hayes v. Nw. Wis. Home Care, Inc.*, 2005 WI 118 ¶ 35, 284 Wis.2d 56, 699 N.W.2d 524 (Wis. 2005)).

Perhaps the closest parallel has been drawn by the Appellate Court of Illinois’ opinion in *Prairie v. Univ. Chicago Hosp.*, which involves not only very similar legal standards, but also possesses extremely similar facts, therefore Morgan draws this Court’s attention to this matter. 298 Ill. App. 3d 316, 698, N.E.2d 611, 232 Ill.Dec. 520 (App. Ill. 1998). For the convenience of the Court, a copy of this opinion appears as Addendum 2.

Illinois requires that medical malpractice plaintiffs establish “1) the proper standard of care, 2) a deviation from that standard and 3) an injury proximately caused by that deviation.” *Id.* at p. 321 (citing references omitted). This standard is virtually identical to that of Utah Courts, as outlined in the trial court’s Ruling which cites to *Chadwick v. Nielsen, supra.*, at 821. (Rec. 450 – 451) Moreover, Illinois has a similar “common knowledge” exception which removes the expert testimony requirement for “those cases where the conduct is so grossly negligent or the treatment so common that a layman may understand the conduct without the necessity of expert testimony to establish the standard of care and its breach. *Prairie* at 321 (citing *Walski v. Tiesenga*, 72 Ill.2d 249, 21 Ill.Dec.201, 381 N.E. 2d 279 (1978)). Lastly, the facts of *Prairie* are so analogous to those presented in Morgan’s claims as to support Morgan’s position that her case, like *Prairie* does not require the input of expert testimony.

In *Prairie*, Robin Prairie, the plaintiff, underwent back surgery at the University of Chicago Hospital. Ms. Prairie testified during her deposition that

On August 5, 1990, she was ... jarred awake when [a nurse] ... told plaintiff that she had to get up and also that [the nurse] had to make the bed. ... Plaintiff informed [the nurse] that she had not gotten any sleep, that she was in a lot of pain and that she wanted to rest. A dialogue ensued between the two during which time plaintiff continued her pleas to stay in bed. [The nurse] told the plaintiff she was sorry, but she had to make the bed.

... [The nurse] proceeded to pull the plaintiff up by her arm, whereupon plaintiff again pleaded with her to leave her alone because she wanted to sleep. She also told her that it hurt to have her arm pulled the way [the nurse] was doing. [The nurse] let go of plaintiff’s arm and plaintiff lay back down on the bed. [The nurse] next pulled plaintiff’s feet so that they were hanging off the edge of the bed.

... [A]ccording to the plaintiff, her pain was excruciating. She testified that she started to yell, to plead with [the nurse] not to do what she was doing and told her that it hurt. [The nurse], insisting that plaintiff had to get up and that [the nurse] had to make the bed, forced plaintiff into a standing position, whereupon plaintiff, still in a lot of pain, informed [the nurse] that she was going to throw up or faint. [The nurse] then shoved plaintiff into a straight back chair using her hands to press down hard on plaintiff's shoulders. Plaintiff's pain was excruciating and she again pleaded with [the nurse] and informed her that she was going to faint. [The nurse] then took plaintiff's head and forced it between her knees, at least down to her lap. At that point, plaintiff felt excruciating pain in the middle of her back.

Id. at 230.

The court in *Prairie* held that summary judgment in favor of the defendant hospital was not appropriate given that “the alleged negligence here was so grossly apparent that a breach of duty could be determined without the use of expert testimony.

Id. at 329.

- c) The facts of Morgan’s claims fall within the “common knowledge” exception therefore expert testimony is not required.

As applied to Morgan’s situation, the reasoning in both *Bowman* and *Prairie* strongly suggests that the trial court erred in concluding that Morgan required expert testimony. Morgan claims that, while recovering at LDS Hospital from a surgical procedure, she sustained painful rotator cuff tears as a result of Nurse Davis’ physically attempting to lift Morgan out of her hospital bed against Morgan’s protest. Morgan has been admitted to LDS Hospital on February 26, 2003, to undergo a cervical fusion procedure, involving a bone graft for neck injuries sustained in an automobile accident on June 15, 1998. (Rec. 238, ¶¶ 1 & 6) The surgery was performed by Morgan’s treating physician, Dr. Stephen J. Warner. (Rec. 239, ¶ 10)

Morgan testified that, on February 27, 2003, as a result of the surgery, she still had the pumps on her legs and that she could not feel or move her right leg. (Morgan Depo.,55:21-25, 89:25 – 90:4.) (Rec. 267) Given her inability to move her leg and because the surgical procedure involved a bone graft taken from Morgan’s own hip, Morgan requested a bed pan, first from the nursing station, then from Nurse Davis but her requests were denied. (Morgan Depo.,55: 7 – 17) (Rec. 267) Even after telling Nurse Davis that Morgan was physically unable to get out of bed Nurse Davis “walked through the door and came to the left side of me, the bed was on an incline. ... And I had asked for a bed pan. And [Nurse Davis] said that I going to get up. And I told her that I couldn’t; that I still had the pumps on my legs and that the bone graft had been done on my right hip. I still could not feel – I wasn’t feeling and I couldn’t move it. And that I needed a bed pan.” (Morgan Depo., 55: 17 – 25, 56:1 – 25) (Rec. 267)

Midge next testified that Nurse Davis “proceeded to put her right arm across – underneath my left arm and across my chest and grabbed under my right armpit, and then she took her left hand on top and did not put down the railing and proceeded to try to pull me and jerk me forward and up and over the railing to put me on my feet.” (Morgan Depo., 56:8 – 12) (Rec. 267) Morgan contends that Nurse Davis’ attempt to lift Morgan, against her will, out of her hospital bed caused Midge to experience a “horrible pain.” (Morgan Depo., 56:13 – 14.) (Rec. 267) Dr. Warner has testified that he found Midge in her room crying. Midge then told him that Davis “wanted her to get up to go to the bathroom, and according to Midge had grabbed her by the arms and jerked her up.” (Warner Depo., 19:4-15, 34:13 – 35:8.) (Rec. 286 and 290, respectively)

Based upon the findings in *Bowman*, Morgan contends that it is within the common knowledge of a lay person to determine whether 1) refusing to provide a patient with a bed pan; 2) forcibly lifting someone out of bed; 3) lifting a person against their verbal protests and 4) doing so less than 24 hours after surgery involving a bone graft, constitutes medical malpractice. Namely, can a jury determine, without expert testimony that the standard of care owed to Morgan by Nurse Davis would be to listen to her patient's concerns that she was unable to physically get out of bed and to, instead, bring the patient a bed pan so that she could urinate. Morgan contends that common sense is sufficient for a lay person to make this finding. The trial court should not have required expert testimony to determine the nurse's standard of care. A reasonable jury could determine that Nurse Davis clearly violated a standard of care owed to Midge when, she chose to ignore Midge's request for a bedpan and ignored Midge's vehement statements that, due to the pain and numbness in her recently operated leg, Midge could not physically get out of bed. Moreover, as this incident occurred in the hospital setting, clearly Nurse Davis had access to Dr. Warner and could have sought his input and guidance regarding whether or not it was safe to force Midge out of bed.

Next, a reasonable jury could make a determination that Nurse Davis breached her duty of care based upon the testimony of Ms. Morgan, coupled with the testimony of Dr. Warner, Morgan's treating physician, who found Morgan "extremely distraught" and "bawling" after the incident with Nurse Davis. (Warner Depo., 34:23 – 25; 2 – 8) (Rec. 290 and 287, respectively) The final prong of the analysis rests with determining causation. As with the other two prongs, Morgan contends that a jury could determine

for itself that Nurse Davis' conduct caused Morgan's shoulder injuries. In fact, the "common knowledge exception outlined by the Utah State Supreme Court in *Bowman*, appears to be tailored to the very facts at issue as the "exception applie[s] when the causal link between the negligence and the injury would be clear to a lay juror who has no medical training – i.e., when the causal connection is readily apparent using only "common knowledge." *Id.* (citing to *Kent v. Pioneer Valley Hosp.*, 930 P.2d 904, 906 & n. 3 (Utah Ct.App.1997))

In Morgan's case, medical training is not required to make the link between the alleged conduct and claimed injuries. In determining malpractice, a lay person would possess testimony from Morgan that Davis' actions caused her to experience a "horrible pain." (Morgan Depo., 56:13 – 14.) (Rec. 267) Prior to the February 2003 surgery, Morgan "wasn't having a lot of pain that [Dr. Warner] would attribute to her shoulders." (Warner Depo., 39 – 40:16 – 25, 1 - 9) (Rec. 288) Morgan herself does not recall any doctor telling her that she had preexisting or degenerative shoulder injuries. (Morgan Depo., 61:2 – 15) (Rec. 269) Morgan's claims that she could not get out of bed are supported by Dr. Warner's testimony that the pain from the iliac crest bone graft could have prevented her from getting out of bed and going to the bathroom. (Warner Depo., 19:16-21.) (Rec. 286) The very next day following the incident with Nurse Davis, the record reflects that Morgan was complaining to Dr. Warner of "bilateral shoulder pain." (Warner Depo., 23:17 – 22) (Rec. 287) Additionally, the jury would have been presented with the testimony of Dr. Warner that, if someone grabbed Morgan's arms and jerked

upward, as she describes, it could cause rotator cuff tears. (Warner Depo., 28:2 – 29:16.) (Rec. 241, ¶ 19)

Lastly, Dr. Warner was prepared to testify at trial that Morgan's rotator cuff injuries could be related to the incident with Nurse Davis and that, if the incident with Nurse Davis happened as Morgan described, this single event could have torn Morgan's rotator cuffs. (Warner Depo., 28:2 – 25 and 32:8 – 16) (Rec. 288 and 289) A reasonable jury could find that the shoulder injuries sustained by Morgan were proximately caused by Nurse Davis' mishandling of Morgan without requiring testimony of a medical expert.

There is sufficient evidence to support a finding that Morgan's shoulders were not injured before February 27, 2003; that the incident with Nurse Davis happened as described by Morgan and that the incident left Morgan with shoulder injuries as described by herself and her doctor of several years. Even in the unlikely event that the jury was to determine that Midge could have gotten out of bed, the jury could still find that Nurse Davis was negligent in the forceful manner in which she yanked Midge up under her arms in order to accomplish Nurse Davis' goal in getting Midge to the restroom.

The strong factual similarity found in *Prairie* presents a compelling argument in favor of finding that a Utah jury, without the benefit of expert testimony, is capable of determining whether Nurse Davis was negligent in her treatment of Morgan. In both this instant case and in *Prairie*, nurses forced patients to at least attempt to get out of bed, against the patient's verbal protests that they could not get up and in light of recently undergoing serious surgical procedures. In this matter, Midge had just had surgery on her

neck less than 24 hours earlier and, in *Prairie*, the patient had had back surgery approximately 48 hours earlier. There is sufficient evidence to support Morgan's position that, as in *Prairie*, not only is the cause of her injuries within the lay person's field of knowledge, it is also non-medical in nature. Arguably, Nurse Davis was not attempting to administer medical treatment to Morgan but was instead performing a non-medical function – "helping" her out of bed in order to use the bathroom. Not only do both matters involve a nurse's decision to force a patient out of bed against that patient's will, the legal standards established under Illinois case law are almost identical to Utah law.

For the reasons stated herein, the trial court erroneously concluded that Morgan was required by Utah law to present expert witness testimony in order to prove that her shoulder injuries were sustained by the actions of Nurse Davis.

II. Alternatively, a reasonable finder of fact could conclude that Davis was negligent in moving Morgan out of her hospital bed which, under Utah law, does not require expert testimony therefore summary judgment was erroneously granted.

a) Under Utah law, expert testimony is not required to prove Negligence, therefore summary judgment was erroneously granted.

As argued in Section I of this Brief, it is Morgan's position that her situation satisfies the criteria outlined by Utah case law which provides that not every medical malpractice case requires the use of expert testimony. However, as Morgan's Complaint also asserted that Defendants were negligent, there are additional grounds to determine that the trial court committed an error of law in ruling that Morgan's claims failed for lack of expert testimony. (Rec. 2, Section I. and Section II. ¶ 1)

The elements of a negligence claim are: “(1) that the defendant owed plaintiff a duty, (2) that the defendant breached that duty, (3) that the breach of duty was the proximate cause of the plaintiff’s injury, and (4) that the plaintiff in fact suffered injuries or damages.” *Thurston v. Workers Comp. Fund of Utah*, 2003 UT App 438, ¶ 12, 83 P.3d 391 (internal quotation marks omitted.) *See also Webb v. University of Utah*, 2005 UT 80, ¶ 9, 125 P.3d 906 quoting *Hunsaker v. State*, 870 P.2d 893, 897 (Utah 1993).

Proximate cause is “that cause which, in the natural and continuous sequence [], produces the injury and without which the result would not have occurred. It is the efficient cause – the one that necessarily sets in operation the factors that accomplish the injury.” *Mahmood v. Ross*, 1999 UT 104, ¶ 22, 990 P.2d 933 (quoting *Harline v. Barker*, 912 P.2d 433, 439 (Utah 1996) (citations omitted). Moreover, a cause need not be the sole cause of a patient’s injuries. *See e.g. George v. LDS Hosp.*, 797 P.2d 1117, 1122 (Utah Ct. App. 1990), *cert denied*, 830 P.2d 1383 (Utah 1991). Instead, a defendant’s negligence need only be a substantial factor in bringing about the injury. *Id.* at 1121 – 22. In *George*, the Court concluded that a jury could have reasonably concluded that a nurse’s failure to notify a patient’s physician of change in that patient’s condition was a proximate cause of the patient’s ultimate death.

On the facts as presented herein, a reasonable jury could find that Davis’ attempts to physically move Morgan from her hospital bed to the bathroom, given that Morgan’s leg had been operated on less than 24 hours previously and that Morgan verbally protested, was a substantial factor in the rotator cuff injuries sustained by Morgan. *See e.g. Alder v. Bayer Corp., AGFA Div.*, 2002 UT 115, ¶ 87, 61 P.3d 1068, 1090 (where a

negligent act was deemed wrongful because the act increases the chance that a particular type of accident would occur, and a mishap of that very sort did happen, this is enough to support a finding by the trier of fact that the negligent behavior caused the harm. Emphasis in original) (quoting *Zuchowicz v. United States*, 140 F.3d 381, 390 (2d Cir. 1998)). Additionally, a reasonable jury could concur with the testimony of Dr. Warner, Midge's treating physician, that the pain from the iliac crest bone graft could have prevented Midge from getting out of bed and going to the bathroom. (Warner Depo., 19:16-21.) (Rec. 286) Similarly, a reasonable jury could conclude that Dr. Warner's testimony regarding his finding Midge in her room crying, extremely distraught and bawling, supports Midge's claims that she was injured by the actions of Nurse Davis. Lastly, the testimony Dr. Warner gave during his deposition and was prepared to give at trial, that, in his opinion, if someone grabbed Midge's arms and jerked upward, it could cause rotator cuff tears could have persuaded a jury to believe Midge's accounts of the altercation with Nurse Davis and that this was the cause of her rotator cuff tears. (Warner Depo., 28:2 – 29:16.) (Rec. 241, ¶ 19)

III. In the event that this Court finds that expert testimony is not required to sustain Morgan's claims, there are sufficient issues of material fact to preclude summary judgment.

Assuming *arguendo*, that this Court determines that the trial court erroneously determined that Morgan was required to obtain expert testimony, there were genuine issues of material fact presented to the trial court to preclude a granting of summary judgment.

A moving party is entitled to summary judgment only “if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law. Utah Rules of Civil Procedure, Rule 56(c). Summary judgment determinations should be limited to matters where “the record shows that there is no genuine issue of material fact and that the moving party is entitled to a judgment as a matter of law.” *Yazd v. Woodside Homes Corp.*, 109 P.3d 393, 395 (Utah Ct. App. 2005) (citations omitted). This Court has previously held that, “[t]o withstand summary judgment, plaintiff must at least create a material issue of fact as to whether the allegedly negligent [conduct] was the proximate cause of [plaintiff’s injury...” *Kent*, 930 P.2d at 907.

The record, including the deposition testimony of Morgan, and Drs. Warner and Metcalf and the pleadings filed by Defendants is replete with disputes as to material facts. There can be no doubt, for example, that the parties do not agree as to what transpired on February 27, 2003 in Ms. Morgan’s room at LDS Hospital. Despite lengthy litigation, conducting discovery and taking multiple depositions, at the time Defendants filed their summary judgment motion, the circumstances surrounding the February 27, 2003 incident between Ms. Morgan and Nurse Davis remained in dispute.

CONCLUSION

The District Court erroneously granted summary judgment against Plaintiff and Appellant Midge Morgan. First, the type of claims raised by Morgan fall within the exceptions outlined by Utah courts in which medical malpractice claims do not require

expert testimony. Alternatively, Morgan's claim of negligence does not require expert testimony. Given that Morgan's claims for medical malpractice and negligence present genuine issues of material fact that preclude summary judgment and require resolution by a finder of fact. Morgan respectfully requests this court to reverse the trial court's decision granting summary judgment to IHC on all claims alleged against it by Plaintiff and Appellant Morgan.

DATED this 4th day of June 2010.

DUNN & DUNN, P.C.

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TIM DALTON DUNN
SUSAN BLACK DUNN
CHRYSTAL MANCUSO-SMITH
Attorneys for Plaintiff Midge Morgan

CERTIFICATE OF SERVICE

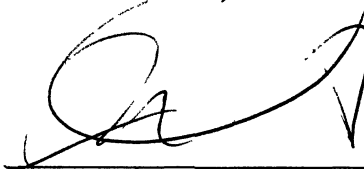
Pursuant to UTAH R. APP. 21(b), the undersigned hereby certifies that on the date indicated below I caused to be served a true copy of the foregoing **BRIEF OF PLAINTIFF AND APPELLANT MIDGE MORGAN**, by the method indicated below, to the following:

JoAnn E. Bott
Manning, Curtis, Bradshaw and Bednar
170 South Main, Suite 900
Salt Lake City, Utah 84101

( ) U.S. Mail, Postage Prepaid
(X) Hand Delivered
( ) Overnight Mail
( ) Facsimile

DATED this 41 day of June 2010.

DUNN & DUNN, P.C.



Legal Assistant

ADDENDA

- Addendum 1 – November 9, 2009 Trial Court Ruling granting Defendants' Motion for Summary Judgment (Rec. 440 – 445)
- Addendum 2 – *Prairie v. Univ. Chicago Hosp.*, 298 Ill. App. 3d 316, 698, N.E.2d 611, 232 Ill.Dec. 520 (App. Ill. 1998)
- Addendum 3 – Medical Records of Midge Morgan provided as part of Plaintiff's Initial Disclosures, bates labeled 000001 - 41 (Rec. 52 – 53)

ADDENDUM 1

IN THE THIRD JUDICIAL DISTRICT, SALT LAKE COUNTY
STATE OF UTAH

MIDGE MORGAN,

Plaintiff,

vs.

INTERMOUNTAIN HEALTHCARE INC.,
IHC LDS HOSPITAL, and JOHN AND
JANE DOES I-X,

Defendants.

RULING

Case No. 050918581

Judge: L.A. DEVER

The above entitled matter is before the Court on Plaintiff's Request to Submit for Decision on Defendant's Intermountain Healthcare Inc.'s dba LDS Hospital, Motion for Summary Judgment, filed September 11, 2009. Having reviewed Defendant's Motion and Plaintiff's Opposition thereto, the Court makes the following Ruling.

By way of relevant background, Plaintiff filed her Complaint on October 20, 2005. Plaintiff alleges that on February 27, 2003, she sustained injuries to her shoulders when a nurse "violently tried to yank" Plaintiff out of her hospital bed. (Compl. No.18). Plaintiff further calims that prior to February 26, 2003, she did not suffer any injuries to either of her shoulders in previous motor vehicle accidents nor, did she have any previous injuries, damages or defects to either of her shoulders. Id. at no. 11.

On January 29, 2008, a Stipulated Amended Scheduling Order was filed with the

Court. As provided, all fact discovery was to be completed no later than March 3, 2008. Plaintiff was to designate expert witnesses by April 1, 2008, and any rebuttal experts were to be designated by July 1, 2008. Expert discovery was to be completed by August 1, 2008. Defendants filed their Preliminary Designation of Expert Witnesses on July 15, 2008. Although this was after the stipulated deadline of June 3, 2008, for Defendants' designation, Plaintiff did not file an objection or any other motion noting the untimeliness of Defendants' designation. Plaintiff did not designate any expert or rebuttal witnesses. Neither party took any dispositive action in moving the case forward until Defendant filed its Motion for Summary Judgment on June 19, 2009.

Defendant claims that it is entitled to summary judgment because although Plaintiff claims that she did not have any previous shoulder injury or damage, Plaintiff (1) did have shoulder surgery when her right shoulder was previously dislocated, (2) complained of pain in her right shoulder in 2001, and (3) complained of pain in her shoulders following the automobile accident that led to her back surgery. (Def.'s Mem. In Supp. pp. 2-3, nos. 5-12).

Utah courts have held, "In order to sustain a medical malpractice prima facie case, a plaintiff must establish the following elements: (1) the standard of care by which the [medical provider's] conduct is to be measured, (2) breach of that standard by the [medical provider], and (3) injury proximately caused by the [medical provider's]

negligence.” Chadwick v. Nielsen, 763 P.2d 817, 821 (Utah Ct. App. 1988)(citing Schmidt v. Intermountain Health Care, Inc., 635 P.2d 99, 101 (Utah 1981)). Therefore, “[d]ue to the technical and complex nature of a medical [provider’s] services, *expert medical testimony must be presented* at trial in order to establish the standard of care and proximate cause--*except in unusual circumstances*.” Id. (citation omitted) (emphasis added).

Plaintiff maintains that expert testimony is unnecessary because the standard of care and any breach thereof, is “within the common knowledge and experience of the layman.” Chadwick, 763 P.2d at 821. However, Plaintiff does not account for nor dispute her prior injury and complaints regarding her shoulders in light of the cited case law.

Plaintiff’s case is similar to that in Fox v. Brigham Young University, Inc., 2007 UT App 406, 176 P.3d 446.

Fox’s injuries were the result of a fall down a single stair. Id. at ¶12. After falling, Fox was unable to stand or use her right leg. Id. EMTs observed that Fox’s right knee was obviously swollen and that there was deformity on both sides of her leg. Id. at ¶14. They also noted that there was no external trauma to her leg or knee, such as scrapes or scuff marks, and that Fox’s pants were not ripped or torn. Id. More importantly, Fox told the EMTs that she had been previously diagnosed with osteoarthritis in her right knee, and that there was some missing cartilage in that knee. Id. at ¶15.

Fox did not present any expert testimony at the bench trial. Id. at ¶19. Fox

asserted that lay testimony was sufficient to establish her prima facie case because the injury and damages experienced by Fox were within the realm of common experience.

Id.

The Fox court concluded:

Mrs. Fox's slip-and-fall negligence suit is not a case that is excepted from the requirement that a plaintiff use expert testimony to establish a causal link between the defendant's negligent act and her injury. At the scene of Mrs. Fox's fall, she first attributed the cause of her fall to the fact that her knee "gave out." She admitted to the EMTs that she had been diagnosed with a pre-existing condition, osteoarthritis, in that same knee. Thus, *by her own initial explanation of the cause of her fall and her admission of an osteoarthritic condition, Mrs. Fox tied the cause of her fall to medical factors sufficiently complicated to be beyond the ordinary senses and common experience of a layperson.* Mrs. Fox's lay testimony would not have been sufficient to determine whether the need for her medical treatment, the surgery and attachment of the fixator, was caused by BYU's allegedly defective stairs or the failure of her own arthritic knee. Although Mrs. Fox could testify that she descended the stairway, fell, and experienced pain, she needed expert testimony to establish her prima facie case of causation and to prevent the fact-finder from resorting to speculation. Absent this expert testimony, the trial court correctly ruled that Mrs. Fox had failed to prove the element of causation and her negligence claim failed as a matter of law.

Id. at ¶23 (emphasis added).

Similarly, this Court concludes that lay testimony is not sufficient to explain whether Plaintiff's shoulder injuries were the result of a previous injury and surgery or the act of a nurse.

Based upon the foregoing, Plaintiff's claims fail as a matter of law. See Sanns v. Butterfield Ford, 2004 UT App 203, ¶6, 94 P.3d 301 ("[W]hen a party fails to produce evidence sufficient to meet one of the elements of a claim, there can be no genuine

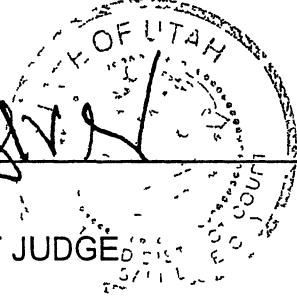
issue as to any material fact, since a complete failure of proof concerning an essential element of the nonmoving party's case necessarily renders all other facts immaterial." (citations and quotation omitted)). Therefore, the Court GRANTS Defendant's Motion.

This Ruling stands as the Order of the Court. No further order is required.

Dated 7th day of November, 2009.

BY THE COURT:


_____
L.A. DEVER
DISTRICT COURT JUDGE



CERTIFICATE OF MAILING

I certify that I mailed a true and correct copy of the foregoing Ruling dated this 9 day of November, 2009, postage prepaid, to the following:

JoAnn E. Bott
David C. Castleberry
Manning, Curtis, Bradshaw & Bednar
170 South Main Street, Suite 900
Salt Lake City, UT 84101

Tim Dalton Dunn
Susan Black Dunn
Dunn & Dunn
505 East 200 South, 2nd Floor
Salt Lake City, UT 84102


_____
CLERK OF COURT

ADDENDUM 2

 [West Reporter Image \(PDF\)](#)

298 Ill.App.3d 316, 698 N.E.2d 611, 232 Ill.Dec. 520

[Briefs and Other Related Documents](#)
[Judges and Attorneys](#)

Appellate Court of Illinois,
 First District, First Division.
 Robin PRAIRIE, Plaintiff-Appellant,
 v.
 UNIVERSITY OF CHICAGO HOSPITALS, Defendant-Appellee.

No. 1-97-2146.
 July 27, 1998.

Patient who had undergone back surgery at university hospital sued hospital for medical malpractice, based on actions of nurse who allegedly removed patient from her bed while patient was recovering. The Circuit Court, Cook County, James F. Smith, J., granted summary judgment to hospital, and patient appealed. The Appellate Court, Gallagher, J., held that: (1) alleged negligence of nurse in taking patient out of her bed against patient's wishes, and despite orders in patient's chart prohibiting such behavior, was so grossly apparent that existence of breach of duty could be determined without expert testimony, and (2) fact issues regarding breach of duty precluded summary judgment.

Reversed and remanded.

West Headnotes

[1]  [KeyCite Citing References for this Headnote](#)

30 Appeal and Error
30XVI Review
30XVI(F) Trial De Novo
30k892 Trial De Novo
30k893 Cases Triable in Appellate Court
30k893(1) k. In General. Most Cited Cases

Appellate review of order granting summary judgment is de novo.

[2]  [KeyCite Citing References for this Headnote](#)

198H Health
198HV Malpractice, Negligence, or Breach of Duty
198HV(B) Duties and Liabilities in General
198Hk611 k. Elements of Malpractice or Negligence in General. Most Cited Cases
 (Formerly 299k18.12 Physicians and Surgeons)

To recover damages in medical malpractice action, plaintiff must establish (1) proper standard of care, (2) deviation from that standard, and (3) injury proximately caused by that deviation.

[3]  [KeyCite Citing References for this Headnote](#)

198H Health
198HV Malpractice, Negligence, or Breach of Duty
198HV(G) Actions and Proceedings
198Hk815 Evidence
198Hk821 Necessity of Expert Testimony

198Hk821(2) k. Standard of Practice and Departure Therefrom. Most Cited Cases
(Formerly 299k18.80(9) Physicians and Surgeons)

General rule is that expert testimony is required to establish essential elements of medical malpractice action when assessment of alleged negligence requires knowledge, skill, or training in a technical area outside comprehension of laypersons.

[4]  KeyCite Citing References for this Headnote

198H Health

198HV Malpractice, Negligence, or Breach of Duty

198HV(G) Actions and Proceedings

198Hk815 Evidence

198Hk821 Necessity of Expert Testimony

198Hk821(4) k. Gross or Obvious Negligence and Matters of Common Knowledge. Most Cited

Cases

(Formerly 299k18.80(9) Physicians and Surgeons)

Exception to general rule that expert testimony is required to establish essential elements of medical malpractice action is where conduct is so grossly negligent, or treatment so common, that layperson may understand the conduct without necessity of expert testimony to establish standard of care and its breach.

[5]  KeyCite Citing References for this Headnote

198H Health

198HV Malpractice, Negligence, or Breach of Duty

198HV(G) Actions and Proceedings

198Hk815 Evidence

198Hk821 Necessity of Expert Testimony

198Hk821(5) k. Particular Procedures. Most Cited Cases

(Formerly 204k8 Hospitals)

Alleged negligence of hospital nurse in taking patient who had undergone back surgery out of her bed, against patient's wishes and despite orders in patient's chart prohibiting such behavior, and maneuvering patient into chair and leaving patient tied there while nurse made bed, was so grossly apparent that breach of duty could be established without aid of expert testimony; handling of patient while making bed was not implicit part of assisting patient to increase his or her activity, and nurse's directions in that regard were to increase pain "as tolerated," which was matter within lay comprehension.

[6]  KeyCite Citing References for this Headnote

198H Health

198HV Malpractice, Negligence, or Breach of Duty

198HV(G) Actions and Proceedings

198Hk815 Evidence

198Hk821 Necessity of Expert Testimony

198Hk821(4) k. Gross or Obvious Negligence and Matters of Common Knowledge. Most Cited

Cases

(Formerly 299k18.80(8) Physicians and Surgeons)

Even where medical malpractice action involves a complicated procedure, expert testimony may not be required to establish essential elements of claim when act alleged to be negligent is not an implicit part of procedure.

[7]  KeyCite Citing References for this Headnote

228 Judgment

228V On Motion or Summary Proceeding

228k181 Grounds for Summary Judgment228k181(15) Particular Cases228k181(33) k. Tort Cases in General. Most Cited Cases

Genuine issue of material fact as to whether hospital nurse deviated from applicable standard of care, as result of gross negligence, when she removed patient who was recovering from back surgery from bed, against patient's wishes, in order to make bed, precluded summary judgment in medical malpractice action against hospital.

[8] KeyCite Citing References for this Headnote198H Health198HV Malpractice, Negligence, or Breach of Duty198HV(G) Actions and Proceedings198Hk815 Evidence198Hk821 Necessity of Expert Testimony198Hk821(2) k. Standard of Practice and Departure Therefrom. Most Cited Cases
(Formerly 299k18.80(8) Physicians and Surgeons)

Where medical malpractice plaintiff fails to obtain her own expert witness to testify as to standard of care, testimony of defendant practitioner may be sufficient to establish applicable standard of care.

[9] KeyCite Citing References for this Headnote228 Judgment228V On Motion or Summary Proceeding228k181 Grounds for Summary Judgment228k181(15) Particular Cases228k181(33) k. Tort Cases in General. Most Cited Cases

Genuine issue of material fact as to whether hospital nurse mistreated or abused patient, as would breach applicable standard of care, when she removed patient from bed in order to make bed, precluded summary judgment in medical malpractice action against hospital.

[10] KeyCite Citing References for this Headnote198H Health198HVI Consent of Patient and Substituted Judgment198Hk913 Terminal Illness; Removal of Life Support198Hk916 k. Competent Patients; Living Wills and Other Prior Indications. Most Cited Cases
(Formerly 299k45 Physicians and Surgeons)

Competent person has common law and statutory right to refuse all types of medical treatment of any kind, including life-saving or life-sustaining procedures; right is rooted in sacred right to personal inviolability. S.H.A. 755 ILCS 40/5.

[11] KeyCite Citing References for this Headnote198H Health198HVI Consent of Patient and Substituted Judgment198Hk913 Terminal Illness; Removal of Life Support198Hk915 k. Substituted Judgment; Role of Courts, Physicians, Guardians, Family or Others. Most Cited Cases
(Formerly 299k44 Physicians and Surgeons)

Lacking consent, physician or nonphysician health care professional cannot force medical care upon patient, even in life-threatening situations. S.H.A. 755 ILCS 40/5.

[12] KeyCite Citing References for this Headnote

198H Health

198HVI Consent of Patient and Substituted Judgment

198Hk904 Consent of Patient

198Hk907 k. What Constitutes Medical Battery in General. Most Cited Cases
(Formerly 299k41 Physicians and Surgeons)

Mentally competent patient has not only the capacity, but the right, to make reasoned decision regarding his or her need for medical treatment, and knowing interference with this right to refuse medical treatment is a battery.

[13] KeyCite Citing References for this Headnote

30 Appeal and Error

30XII Briefs

30k755 k. Necessity. Most Cited Cases

Purpose of appellate briefs is to aid reviewing court in arriving at a proper determination of issues by providing legal support for one's arguments.

**613 *318 ***522 Mark E. Wohlberg, Chicago, for Plaintiff-Appellant.

Stamos & Trucco, Chicago (Michael T. Trucco, Scott S. Fintzen, of counsel), for Defendant-Appellee.

Justice GALLAGHER delivered the opinion of the court:

This is a medical malpractice action brought to recover damages caused by the alleged negligence of a nurse who cared for the plaintiff while she was a patient at the University of Chicago Hospitals, the defendant in this case. This appeal arises out of an order entered by the circuit court granting summary judgment in favor of defendant. The trial court's decision was based upon plaintiff's failure to obtain expert testimony regarding the applicable standard of care and whether it was breached by the defendant. Plaintiff contends that the alleged negligence was so obvious as to be determinable by lay persons, so that expert testimony is not required to establish the standard of care. For the reasons stated below, we reverse and remand this case to the circuit court for further proceedings.

[1]  Before discussing the facts of the instant case, we set forth the standard for our review of the trial court's grant of summary judgment. "Since the entry of a summary judgment is not a matter committed to the discretion of the trial court, a reviewing court must independently examine the evidence presented in support of and in opposition to a motion for summary judgment." Groce v. South Chicago Community Hospital, 282 Ill.App.3d 1004, 1006, 218 Ill.Dec. 453, 669 N.E.2d 596, 598 (1996). Thus, appellate review of an order granting summary ***319** judgment is *de novo*. Berlin v. Sarah Bush Lincoln Health Center, 179 Ill.2d 1, 7, 227 Ill.Dec. 769, 688 N.E.2d 106, 108 (1997); In re Estate of Hoover, 155 Ill.2d 402, 185 Ill.Dec. 866, 615 N.E.2d 736 (1993).

Our supreme court has provided us with additional guidance with respect to summary judgment proceedings:

"Although the use of a summary judgment procedure is encouraged as an aid in expeditious disposition of a lawsuit, it is a drastic means of disposing of litigation and should only be allowed when the right of the moving party is clear and free from doubt. * * *

Furthermore, it is well established that in deciding a motion for summary judgment, the court may draw inferences from the undisputed facts. However, where reasonable persons could draw divergent inferences from the undisputed facts, the issue should be decided by the trier of fact and the motion should be denied." Loyola Academy v. S & S Roof Maintenance, Inc., 146 Ill.2d 263, 271-72, 166 Ill.Dec. 882, 586 N.E.2d 1211, 1215 (1992).

"Summary judgment is proper when the pleadings, depositions and affidavits on file, construed in the light most favorable to the nonmoving party, establish that there is no genuine issue of material fact and that the

moving party is entitled to a judgment as a matter of law." Lajato v. AT & T, Inc., 283 Ill.App.3d 126, 135, 218 Ill.Dec. 502, 669 N.E.2d 645, 651 (1996). With these principles in mind, we have examined the pleadings, depositions and affidavits in this case in the light most favorable to the plaintiff. We conclude that summary judgment should be denied based upon the following pertinent facts.

On August 2, 1990, plaintiff, Robin Prairie underwent back surgery at the University of Chicago Hospitals, defendant in this appeal. Plaintiff remained hospitalized until August 17, 1990. From August 2, 1990 through August 4, 1990, the attending physician ordered complete bed rest for the plaintiff. On August 4, 1990, the physician's order was changed to "increase activity, up as tolerated with assist." On the same day, Nurse Sandra Pullings, contrary to the physician's orders, changed plaintiff's pain pump from 2.0 to .2 or .02. As a result, the pump did not ****614 ***523** deliver a sufficient dosage of pain medication and plaintiff had a very uncomfortable night. In fact, she did not fall asleep until 6 a.m. the following morning. The pain pump was reset to the proper dosage sometime between 8 a.m. and 9:40 a.m., at which time plaintiff was finally able to fall into a deep sleep.

During her deposition, plaintiff testified as follows. On August 5, 1990, she was awakened from her sleep at approximately 11 a.m. According to plaintiff's testimony, she was jarred awake when Nurse Pullings bumped into plaintiff's bed. Nurse Pullings told plaintiff that she had to get up and also that Nurse Pullings had to make the bed. ***320** Plaintiff explained to Nurse Pullings what had happened the previous night with her pain pump. She also informed Nurse Pullings that she had not gotten any sleep, that she was in a lot of pain and that she wanted to rest. A dialogue ensued between the two during which time plaintiff continued her pleas to stay in bed. Nurse Pullings told the plaintiff she was sorry, but she had to make the bed.

At that point, Nurse Pullings proceeded to pull the plaintiff up by her arm, whereupon plaintiff again pleaded with her to leave her alone because she wanted to sleep. She also told her that it hurt to have her arm pulled the way Nurse Pullings was doing. Nurse Pullings let go of plaintiff's arm and plaintiff lay back down on the bed. Nurse Pullings next pulled plaintiff's feet so that they were hanging off the edge of the bed. At that point, according to the plaintiff, her pain was excruciating. She testified that she started to yell, to plead with Nurse Pullings not to do what she was doing and told her that it hurt. Nurse Pullings, insisting that plaintiff had to get up and that Nurse Pullings had to make the bed, forced plaintiff into a standing position, whereupon plaintiff, still in a lot of pain, informed Nurse Pullings that she was going to throw up or faint. Nurse Pullings then shoved plaintiff into a straight back chair using her hands to press down hard on plaintiff's shoulders. Plaintiff's pain was excruciating and she again pleaded with Nurse Pullings and informed her that she was going to faint. Nurse Pullings then took plaintiff's head and forced it between her knees, at least down to her lap. At that point, plaintiff felt excruciating pain in the middle of her back. Nurse Pullings then raised the plaintiff back up. Plaintiff's pain was excruciating. She wanted to try to get up, but could not. She continued to plead with Nurse Pullings to put her back in bed.

Nurse Pullings again informed plaintiff that she had to make the bed. She ripped the sheet off the bed and used it to tie plaintiff in the chair with a knot towards the back. Throughout this event, plaintiff was under the assumption that Nurse Pullings was a nurse's aid and not a nurse, based upon the fact that she was not wearing a name tag, while all of the other nurses were. Plaintiff tried to reach forward to push the nurse's call button, whereupon Nurse Pullings kicked and pushed the table out at the same time, away and out of the plaintiff's grasp. Plaintiff informed Nurse Pullings that she wanted to call the nurse. At this point, Nurse Pullings stated that she had to get some sheets and she left the room for 10 minutes. She came back and made the bed with a laboratory technician. Plaintiff believed that the laboratory technician was Nurse Pullings' friend because she had previously observed Nurse Pullings complaining to the laboratory technician about her work schedule. When the laboratory technician and ***321** Nurse Pullings finished making plaintiff's bed, Nurse Pullings put the plaintiff back in bed. Plaintiff was crying.

Nurse Pullings' note in plaintiff's medical chart concerning the incident in question, while not as detailed, is corroborative of plaintiff's testimony. Nurse Pullings noted that plaintiff stated she was uncomfortable, stated she did not want to sit up in the chair, and stated that she wanted to return to bed. The note also states that the plaintiff was screaming at her and the laboratory technician, was uncooperative and informed the service that she wanted a different nurse.

[2] ☒ [3] ☒ To recover damages in a medical malpractice action, a plaintiff must establish the following three elements: (1) the proper standard of care, (2) a deviation from that standard, and (3) an injury proximately caused by that deviation. ****615** Purtill v. Hess, 111 Ill.2d 229, 95 Ill.Dec. 305, 489 N.E.2d 867 (1986). *****524** The general rule is that expert testimony is required to establish these elements when the

assessment of the alleged negligence requires knowledge, skill, or training in a technical area outside the comprehension of lay persons. Schindel v. Albany Medical Corp., 252 Ill.App.3d 389, 395-96, 192 Ill.Dec. 154, 625 N.E.2d 114 (1993). This appeal is limited to the issue of whether expert testimony is required here to establish the first two elements-the standard of care and a breach of that standard-since plaintiff has procured expert testimony regarding the third element of proximate cause. The rationale for the requirement of expert testimony is that "jurors are not skilled in the practice of medicine and would find it difficult without the help of medical evidence to determine any lack of necessary scientific skill on the part of the physician [or any other health care provider]." Walski v. Tiesenga, 72 Ill.2d 249, 256, 21 Ill.Dec. 201, 381 N.E.2d 279, 282 (1978). "In other words, the subject matter is so complicated that laypersons are not in an adequate position to assess whether a breach of duty has occurred." Schindel v. Albany Medical Corp., 252 Ill.App.3d 389, 395, 192 Ill.Dec. 154, 625 N.E.2d 114, 119 (1993).

[4]  An exception to the general rule that expert testimony is required in a medical malpractice case has been recognized in those cases where the conduct is so grossly negligent or the treatment so common that a layman may understand the conduct without the necessity of expert testimony to establish the standard of care and its breach. Walski v. Tiesenga, 72 Ill.2d 249, 21 Ill.Dec. 201, 381 N.E.2d 279 (1978). Plaintiff contends that Nurse Pullings' conduct here constituted grossly apparent negligence warranting the application of this "gross *322 negligence" or "common knowledge" exception.^{FN1} Defendant counters with the argument that Nurse Pullings' conduct in the instant case involved the exercise of professional judgment necessitating expert testimony to establish whether she deviated from the standard of care. Plaintiff has failed to procure expert testimony to establish the standard of care and its breach as to the defendant hospital. Thus, the sole issue before this court is whether the alleged negligence on the part of the hospital nurse was so grossly apparent or within the common knowledge of the lay person that a breach of duty can be determined without the aid of expert testimony.

FN1. Our review of the case law shows that this exception is sometimes referred to in the singular, while other times is described as two different exceptions, i.e. "gross negligence" or "common knowledge" exceptions. Semantics aside, the inquiry is whether a lay person can readily appraise the alleged negligence using his or her everyday knowledge.

[5]  In order to determine whether this exception applies in the instant case, we must ascertain what conduct on defendant's part is alleged to constitute gross negligence. We begin our analysis by considering those issues framed by the plaintiff's amended complaint. Count II of plaintiff's amended complaint alleged that the defendant hospital was negligent by and through the actions of its agents, specifically, a nurse later determined to be Nurse Sandra Pullings, who took the plaintiff out of her hospital bed against her wishes despite orders in the chart prohibiting such behavior. The complaint further contained specific allegations that the nurse "insisted that the plaintiff get out of bed against her wishes and then abruptly pulled, pushed, and maneuvered the plaintiff out of bed, forcing her into a straight-back chair, and left her tied up for some period of time in said chair." We also consider those evidentiary materials that were before the trial court in support of and in opposition to the motion for summary judgment. In passing upon the motion for summary judgment, the trial court had before it the pleadings, the deposition testimony of plaintiff's causation expert, the affidavit and deposition testimony of Nurse Pullings, Nurse Pullings' note in plaintiff's medical chart pertaining to the incident in question, and the deposition testimony of plaintiff which described her version of the facts, particularly the conduct alleged to constitute gross negligence. The court also had before it materials relevant to the codefendant physician who was subsequently dismissed from the case, including court documents evidencing the numerous continuances granted to plaintiff in her unceasing and ultimately fruitless effort to obtain an expert **616 ***525 witness to support her allegations against the codefendant physician; those materials are irrelevant to this appeal.

*323 The cases that discuss the "gross negligence" or "common knowledge" exception generally, but not always, involve physicians. Most cases involve complicated procedures performed by a physician or other health care provider. As a result, expert testimony is usually required because the procedure is so complicated that lay persons, unskilled in the practice of medicine, cannot assess whether a breach of duty has occurred.

[6]  A plaintiff typically seeks to recover for "an unfortunate result which occurred as a result of an act that was an *implicit* part of the accepted procedure." (Emphasis added.) Newman v. Spellberg, 91 Ill.App.2d 310, 320, 234 N.E.2d 152, 157 (1968). Nevertheless, as explained in the Newman decision, even where a

case involves a complicated procedure, expert testimony may not be required when the act alleged to be negligent is not an implicit part of the procedure. Newman, 91 Ill.App.2d 310, 234 N.E.2d 152. Although the *Newman* case involved a physician and a complicated procedure performed by the physician, namely a gastroscopic examination, the court nevertheless applied the gross negligence exception where the physician lifted the patient during the procedure for a purpose unrelated to the procedure itself. The court determined that the plaintiff had presented evidence of the proper standard of care by the defendant doctor's testimony regarding the standard procedure for the performance of the gastroscopic examination. Plaintiff, however, furnished additional evidence of an extraneous act. This extraneous act was that of lifting the patient's body, presumably done for the purpose of demonstrating the process of the gastroscopic examination to an intern. The court described this additional evidence of the extraneous act, *which had been provided by the plaintiff's testimony*, "as if it were evidence that the doctor had blinded the patient by sticking his finger in his eye during the course of a gastroscopic examination." Newman v. Spellberg, 91 Ill.App.2d 310, 320, 234 N.E.2d 152, 157 (1968). This extraneous act of lifting the patient's body for the purpose of educating an intern on the procedure, which was foreign to the standard procedure of performing a gastroscopic examination, constituted a deviation from the standard of care.

We believe that the situation presented here is comparable to that present in the *Newman* case. We note certain distinctions with respect to the three elements of a medical malpractice case, standard of care, deviation from that standard and proximate cause, discussed above. In *Newman*, the first element, the standard of care, was established by the expert testimony of the defendant doctor, while the second and third elements, a deviation from that standard and proximate cause, were established under the gross negligence exception. In the instant ***324** case, expert testimony with respect to the third element, proximate cause, is present, but not with respect to the first two elements. These distinctions, however, are not critical.

Nurse Pullings' actions here involved carrying out a physician's order to increase the plaintiff's activity as tolerated with assistance. Nonetheless, plaintiff provided testimony that Nurse Pullings' actions may have been done for the purpose of making the plaintiff's bed, which can properly be characterized as an act extraneous to the procedure of carrying out the physician's order in question. Plaintiff provided testimony regarding how she was handled by Nurse Pullings, including the fact that she was pulled, the fact that she was forced, the fact that she was shoved and the fact that she was tied up. Throughout all of this, it is undisputed that Nurse Pullings was also engaged in the act of bedmaking. Thus, any acts that were done for the purpose of bedmaking are analogous to the physician's act in *Newman* of lifting the patient's body for the purpose of educating an intern. Educating an intern may constitute a legitimate activity on the part of the physician, but acts done in furtherance of that activity cannot be said to constitute an implicit part of a gastroscopic examination. Similarly, making a patient's bed may constitute a legitimate activity on the part of a nurse, but acts done in furtherance of that activity also cannot be said to constitute an implicit part of assisting a post-operative patient****617 ***526** to increase his or her activity as tolerated. Plaintiff's testimony here established a breach of duty, just as the plaintiff's testimony in *Newman* established causation. At the very least, it created a genuine issue of material fact as to whether the nurse was carrying out the physician's order in the first place or merely engaged in her bedmaking duties.

Even assuming that bedmaking was not the sole reason for Nurse Pullings actions, and that she was implementing the physician's order to increase plaintiff's activity, we emphasize that the order contained the explicit admonition that the plaintiff's activity was to be increased "as tolerated." The physician intended no activity other than that which the plaintiff tolerated. Common sense tells us that whether an individual tolerates something is always subjective in part. Assuming a patient is otherwise mentally competent, as was the case here, the determination of whether an activity is tolerated by a patient will always depend in part on the patient's judgment. This is no less true merely because the assessment of patient tolerance may require additional professional judgment, for example, an objective evaluation of the patient's vital signs.

While we certainly recognize that in those instances where a patient may be subjectively tolerating something, the assessment of ***325** the patient's objective tolerance, such as the evaluation of the patient's vital signs, might be beyond the skill of the average lay person and would require knowledge, skill or training in a technical area outside the comprehension of lay persons, that is not the situation which was present in the instant case. The conduct of Nurse Pullings here in which she compelled the plaintiff to get out of bed against her wishes and then forced her to sit up in a chair, despite the fact that the patient was uncooperative, screaming, and crying out in pain, is not such that a nursing degree is required to evaluate its inappropriateness. Under the particular circumstances of this case, where there was no immediate emergency situation or other exigent circumstances, the negligence alleged, if true, is grossly apparent to a lay person. Even a lay person could determine that the plaintiff was not "tolerating" the activity.

We also find unpersuasive the defendant's contentions that a jury would be unable to assess whether Nurse Pullings' actions were negligent unless they understood (1) why increasing activity was important for post-operative patients, (2) what a *nurse* should consider tolerable for a post-laminectomy patient, (3) the medical benefits of getting a patient up after surgery to prevent potential complications, such as pneumonia, which might arise when a patient lies on her back for an extended period of time and (4) the medical benefits of getting a patient up after surgery to speed recovery. We point out that plaintiff is not challenging the appropriateness of the physician's order to increase plaintiff's activity as tolerated or even a nurse's decision to implement the order. Likewise, a plaintiff who sues when a physician leaves a sponge in him during an operation is not necessarily challenging the importance of the surgery. Rather, here, it is the gross negligence exhibited on the part of the health care provider while performing these duties that is challenged.

The essence of plaintiff's argument is that under the particular circumstances here, Nurse Pullings' *conduct* constituted gross negligence. The essence of defendant's argument apparently is that a patient's subjective evaluations of whether he or she can tolerate something should never be considered. While concerns about potential complications that might arise if a patient refuses to cooperate in his or her treatment might require communication and encouragement on the part of a nurse, even a lay person can understand that such concerns do not justify the forcible removal of a patient from her bed against her wishes. More importantly, nothing in the record indicates that these potential complications were imminent or that plaintiff was in immediate danger or at risk of developing any complications if her request to be let alone at that moment had been respected. Even if a patient were at risk for future complications, this does not give a ***326** health care provider a license to force medical treatment and ignore a patient's exercise of the right to refuse medical treatment, as will be discussed later in this opinion.

**618 ***527 We also take note of the fact that the order in question stated that the plaintiff's activity was to be increased, not only "as tolerated," but also "with assist." "With assist" clearly means that the patient was to get up of her own volition. At most, it allows the nurse to assist a patient who is in the process of trying to increase his or her activity. It is impossible to characterize Nurse Pullings' coercive actions, as described by the plaintiff, as "assistance."

We are not saying that every physician's order that includes the "as tolerated" caveat will always be such that its implementation will not require professional judgment and possibly expert testimony to determine whether the appropriate standard of care was met. We hold, however, that under the particular circumstances of this case, the alleged negligence is so grossly apparent that a lay person can readily appraise it using his or her everyday knowledge.

[7]  Defendant submits that the only evidence as to the standard of care that existed in this case comes from Nurse Pullings, who testified in the affidavit in support of her motion that she is familiar with the standard of care and that she complied with it. Although Nurse Pullings opined in her affidavit that she did not deviate from the applicable nursing standard of care in her care of plaintiff, she also denied that she "mistreated, abused, or manhandled" plaintiff. Due to this latter statement, rather than establishing that her treatment complied with the applicable standard of care, Nurse Pullings' affidavit, when considered in concert with plaintiff's deposition testimony, creates triable issues of material fact as to whether Nurse Pullings deviated from the applicable standard of care as a result of gross negligence. Plaintiff clearly showed that a contrary version of events exists than that stated by Nurse Pullings that she did not mistreat or abuse plaintiff. Plaintiff's version unequivocally described Nurse Pullings' actions as mistreatment and abuse. The existence of this factual controversy alone would preclude summary judgment, since it is not the duty of a court to resolve disputed factual matters or make credibility determinations. See Winston & Strawn v. Nosal, 279 Ill.App.3d 231, 215 Ill.Dec. 842, 664 N.E.2d 239 (1996).

Assuming that defendant does not dispute the facts as presented by plaintiff in her deposition, we conclude that defendant was not entitled to summary judgment as a matter of law. At the preliminary stage of a summary judgment proceeding, the nonmoving party is not required to prove his case, but must simply present some factual basis that would support his or her claim. See, e.g., Taliaferro v. One Grand Place Venture, 256 Ill.App.3d 429, 432, 195 Ill.Dec. 351, 628 N.E.2d 815, 818 (1993). ***327** Plaintiff has done so here. "All reasonable inferences must be drawn in favor of the party opposing the summary judgment motion. [Citation.]" Taliaferro v. One Grand Place Venture, 256 Ill.App.3d 429, 433, 195 Ill.Dec. 351, 628 N.E.2d 815, 818 (1993). Here, the alleged conduct on the part of Nurse Pullings was sufficiently blatant such that lay persons, relying on their common knowledge, could legitimately infer negligence.

[8] ☒ [9] ☒ Though not necessary to our determination of this case, which has been decided upon other grounds, and although not raised by the plaintiff, our independent review of the record has disclosed the existence of another genuine issue of material fact. Interestingly, Nurse Pullings testified in her deposition, when asked the meaning of the physician's order in question, that if a patient would complain of a lot of pain, she would not get that patient out of bed if the patient were having a problem. Yet that is precisely what plaintiff testified Nurse Pullings did. It is unclear from the phraseology of the question and answer whether plaintiff's counsel was attempting to establish what Nurse Pullings did on the day in question or whether he was attempting to establish the standard of care. Under the first scenario, a fact question was created. Under the second scenario, plaintiff arguably obtained expert testimony on the standard of care. Where a plaintiff fails to obtain her own expert witness to testify as to the standard of care, the testimony of the defendant practitioner may be sufficient to establish the applicable standard of care. ****619 ***528** Novey v. Kishwaukee Community Health Services Center, 176 Ill.App.3d 674, 679, 126 Ill.Dec. 132, 531 N.E.2d 427, 430 (1988), citing Walski v. Tiesenga, 72 Ill.2d 249, 21 Ill.Dec. 201, 381 N.E.2d 279 (1978). Plaintiff, however, failed to use this testimony as expert testimony. Nevertheless, this failure does not defeat plaintiff's action because we have already determined that expert testimony is not required here to establish either the standard of care or the deviation from that standard of care in view of the gross negligence exhibited by Nurse Pullings.

[10] ☒ [11] ☒ Our decision in this case also comports with an important public policy of this state. In Illinois, a competent person has a common law right to refuse all types of medical treatment of any kind, including life-saving or life-sustaining procedures. In re Estate of Longeway, 133 Ill.2d 33, 44-45, 139 Ill.Dec. 780, 549 N.E.2d 292, 297 (1989). This common law right is rooted in the "sacred" right to "personal inviolability." Longeway, 133 Ill.2d at 44, 139 Ill.Dec. 780, 549 N.E.2d at 297. This right has also been statutorily recognized. 755 ILCS 40/5 (West 1996); see also In re Brown, 294 Ill.App.3d 159, 228 Ill.Dec. 525, 689 N.E.2d 397, 403 (1997). Our supreme court has stated that "[l]acking consent, a physician cannot ***328** force medical care upon a patient, even in life-threatening situations." Longeway, 133 Ill.2d at 45, 139 Ill.Dec. 780, 549 N.E.2d at 297. This same principle holds true for nonphysician health care professionals.

[12] ☒ We acknowledge that the cases discussing this right to refuse medical treatment typically arise in the context of the State seeking to impose medical treatment upon a patient, often involve terminally ill patients or patients who lack decisional capacity, and generally involve more invasive "treatment" than that in the present case, e.g., blood transfusions, electroconvulsive shock treatment, or insertion of a feeding tube. Thus, the present case presents entirely different issues from those found in these cases. Nevertheless, the underlying principle of a patient's dignity is no less germane to the instant case. A mentally competent patient, such as the plaintiff here, has not only the capacity, but the right, to make a reasoned decision regarding his or her need for medical treatment.

Knowing interference with this right to refuse medical treatment is a battery. Cohen v. Smith, 269 Ill.App.3d 1087, 1095, 207 Ill.Dec. 873, 648 N.E.2d 329, 335 (1995). Certainly, it appears that plaintiff could have brought an action for battery, but did not do so. Defendant asserts that plaintiff here sought to recast her theory of liability from negligence to an intentional tort only after summary judgment was entered. This assertion is incorrect. Plaintiff's theory of liability remains one of negligence. She alleges that Nurse Pullings' conduct, which arguably rises to the level of a battery, also constitutes gross negligence recognizable by a lay person. Furthermore, an action premised on a theory of battery was merely an alternative theory plaintiff could have pursued and not her only theory. See, e.g., Ramos v. Pyati, 179 Ill.App.3d 214, 227, 128 Ill.Dec. 290, 534 N.E.2d 472, 479 (1989); cf. Wegman v. Pratt, 219 Ill.App.3d 883, 162 Ill.Dec. 221, 579 N.E.2d 1035 (1991) (intentional act of shooting could also constitute negligence in determining proper amount of force to use in self-defense).

[13] ☒ We believe that it is incumbent upon us to note that defendant has raised numerous contentions in its response brief which we do not believe plaintiff has addressed in her reply brief. This court's independent research, rather than plaintiff's reply brief, has assisted it in deciding which of defendant's contentions are meritorious and which are incorrect. Plaintiff's reply brief, on the other hand, reads more like a closing argument replete with rhetorical questions pertaining to "humanity," "common sense" and plaintiff's right to "her day in court." While these are valid policy concerns, this court needs no admonitions as to how it should perform its duties. The purpose of briefs is to aid this court in arriving at a proper determination of the issues by providing legal support for one's arguments. This reviewing ***329** court is "entitled to have the issues clearly defined, to be cited pertinent authorities and [is] not a depository in which an appellant is to dump the entire matter of pleadings, court action, argument and research as it were upon the court.

[Citation.]” ****620 ***529** *Thanopoulos v. Pickens*, 87 Ill.App.3d 906, 909, 42 Ill.Dec. 862, 409 N.E.2d 477, 479 (1980).

We conclude that summary judgment was improperly entered in favor of defendant because reasonable minds could draw different inferences from the undisputed facts as to whether defendant deviated from the applicable standard of care. The alleged negligence here was so grossly apparent that a breach of duty could be determined without the use of expert testimony. Additionally, we conclude that genuine issues of material fact exist as to whether Nurse Pullings mistreated or abused the plaintiff. The issue of defendant's negligence should be determined by the trier of fact.

Reversed and remanded.

SHEILA M. O'BRIEN and FROSSARD, JJ., concur.

Ill.App. 1 Dist., 1998.

Prairie v. University of Chicago Hospitals

298 Ill.App.3d 316, 698 N.E.2d 611, 232 Ill.Dec. 520

Briefs and Other Related Documents ([Back to top](#))

- [1998 WL 34297170](#) (Appellate Brief) Reply Brief and Argument of Plaintiff-Appellant, Robin Prairie (Feb. 03, 1998) [Original Image of this Document \(PDF\)](#)
  - [1998 WL 34297169](#) (Appellate Brief) Brief and Argument of Defendant-Appellee, University of Chicago Hospitals (Jan. 06, 1998) [Original Image of this Document \(PDF\)](#)
-

Judges and Attorneys ([Back to top](#))

[Judges](#) | [Attorneys](#)

Judges

- **Frossard, Hon. Margaret O'Mara**

State of Illinois Appellate Court, 1st District

Illinois

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- **Gallagher, Hon. Michael J.**

State of Illinois Appellate Court, 1st District

Illinois

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- **O'Brien, Hon. Sheila M.**

State of Illinois Appellate Court, 1st District

Illinois

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- **Smith, Hon. James Fitzgerald**

State of Illinois Appellate Court, 1st District

Illinois

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ADDENDUM 3

PERSONAL HISTORY

(all information will be held in strict confidence)

Patient's Name Midge Morgan M or (F) Today's Date 8/27/98
 Age 51 Date of Birth 1-16-47 Married or Single (Single) Spouse's Name N/A
 Home Address 79 W. Goldenbar West Rd. Phone 801-572-8822
 Street Drapeer, UT City 84020 Zip Code Home Business
 If Minor, Father's Name N/A Mother's Name _____
 Person Financially Responsible _____ Relation _____
 Driver's License # _____ Social Security # _____
 Address _____ Phone _____
 Street _____ City _____ Zip Code _____
 Responsible Party's Employer _____
 Name _____ Address _____
 Business Phones _____
 Father (if minor) _____ Mother (if minor) _____ Spouse _____
 Nearest Relative Not Living With You _____ Relation _____
 Address _____ Phone _____
 Street _____ City _____ Zip Code _____

INSURANCE INFORMATION

Att No: Marcia Daybell Accident: 6-15-98
 Primary Insurance Company Name: State Farm Insurance Claim # 14-1047-190
 Address P.O. Box 30463 SLC, UT, 84130-0463 Phone _____
 Street _____ City _____ Zip Code _____
 Subscriber Name Midge Morgan Birthdate 1-16-47 Social Security # 528-68-0283
 Secondary Insurance Company Name: Self Select Med Group # 013000
 Address P.O. Box 11670 SLC, UT, 84147-0670 Plan # DDA3
 Street _____ City _____ Zip Code _____ Phone # 442-5038
 Subscriber Name Self Delta Air Lines Birthdate 1-16-47 Social Security # _____

If accident, give date and details 6-15-98 (Car totaled in emp parking lot of Delta Air Lines. Heavily damaged. I wanted to upstate his attention but couldn't. Failed to stop and
 Referred by Sarah Solis (friend) Dentist Dr. Myles Prible

MEDICAL-DENTAL HISTORY

Physician Rodney Hughes, M.D.
 Have you had a physical in the last 6 months? yes
 Are you under a physician's care now? yes
 For what? the auto accident

Orthodontist _____

What drugs or medicines are you taking? Migale, relaxer, med for head pain, (Liquorice licorice) etc.

What drugs, medicines or other things are you allergic to? just hayfever to my knowledge

Any unusual reactions to types of drugs or anesthetics? no

What major operations have you had? Appendix, gall bladder, tubal ligation etc.

Height 5'2" Weight 120 lbs
 Have you had radiation treatments? ... ☒ YES ☐ NO ☐ DO NOT KNOW
 Have you had prolonged bleeding? ... ☒ YES ☐ NO ☐ DO NOT KNOW
 Do you have a heart pacer? ... ☒ YES ☐ NO ☐ DO NOT KNOW
 Do you wear contact lenses? ... ☒ YES ☐ NO ☐ DO NOT KNOW
 Women patients, are you pregnant? ... ☒ YES ☐ NO ☐ DO NOT KNOW
 Have you had any of the following?
 Diabetes ... ☒ YES ☐ NO ☐ DO NOT KNOW
 Heart disease ... ☒ YES ☐ NO ☐ DO NOT KNOW
 Lung disease ... ☒ YES ☐ NO ☐ DO NOT KNOW

	YES	NO	DO NOT KNOW
Kidney disease		☒	
Liver disease		☒	
High blood pressure		☒	
Low blood pressure		☒	
Blood diseases		☒	
Emphysema		☒	
Shortness of breath		☒	
Chest pain		☒	
Epilepsy		☒	
Tuberculosis		☒	
Anemia		☒	
Rheumatic Fever		☒	
Hepatitis		☒	
Asthma		☒	
Fainting or dizziness		☒	
Heart murmur		☒	
Frequent cough		☒	
Aids/HIV		☒	
Have you ever had alcohol or substance abuse problems?		☒	

6/15
Sincerely
G/E

Midge Morgan 8/27/98
 Signature of Patient Date

HISTORY

1. Describe your problem:
  2. Which side hurts? Right Left *by the end of the night*
  3. For how long? *Went out* Is the pain constant or intermittent?
  4. Is the pain worse in morning, afternoon, evening? *after talking, eating etc.*
  5. Does it hurt to move your jaw? yes to chew? yes
  6. On the figures to the right, outline where your pain is.
  7. Does your jaw make noise? Clicking Grinding
Pops out
Other *When? laughing, smiling, talking* For how long? *Since 6/15 accident*
  8. Has your jaw ever locked open? yes closed?
When? *the time* How often? *all now*
  9. If your jaw does not make noise or lock now, has it ever in the past? Describe:
  10. Do you have: a. Headaches b. Neckaches *humming*
c. Shoulder pain d. Ear pain e. Ringing in the ears
f. Dizziness *fuzzy* g. Change in hearing
  11. Do you grind or clench your teeth? NO
At night During the day
  12. Do you have sore or sensitive teeth? *by the end of the night, now they are tired.*
  13. Do you have trouble getting to sleep? yes Do you sleep well? NO
  14. Do you consider yourself to be under a lot of stress? NO *Since the accident* Are you nervous or anxious about anything? yes *everything since the accident*
  15. Have you ever had nervous stomach, ulcers or skin disease? yes *Since the accident 6/15*
tummy hurts a turns alot - test done -
  16. Do you have or ever had arthritis? NO
  17. Does your pain keep you from doing anything? yes If yes, what? *It's a Numbing of the pain is there all the time and it consumes energy -*
  18. Can you remember any injury to your jaw? yes If yes, describe: *my head, neck, shoulders, back, buttocks, legs - etc - auto accident 6/15/98*
  19. Do you take medications for the pain? muscle relaxers If yes, what?
  20. Do you take medications for relaxation? yes If yes, what? *Now since accident 9/15/98*
  21. Have you had any treatments for your problem? NO *right after a surgery for broken jaw - etc.*
one time the physical massage therapy
- a. Bite splint   b. Medication   c. Physical therapy   d. Counseling
e. Occlusal adjustment   f. Orthodontics   g. Surgery   h. Other
0 0 1 - +1 - - lter : it has been 2000..



May 4, 1999
Midge Morgan - 22110

History of Present Illness: The patient is seen today with complaints of neck pain, headaches, blurred vision, bilateral arm pain and numbness, and the sensation of her left arm feeling cold and her right arm feeling hot. Her symptoms are fairly constant. The biggest problem has been neck pain and headaches along with the bilateral arm pain.

The patient states the problem started on June 16, 1998. The patient is very emotional when describing the accident. She states she was on her way to work for Delta Airlines, parking her car in the lot. A large truck struck her stopped vehicle on the right front quarter panel. The patient was the seat belted driver of a VW Fox. The accident totalled her car.

The patient states she went to work that day, but was "in lots of pain everywhere". This included her neck, jaw, arms, legs, and back, essentially everywhere. The patient states she saw her primary care physician, Dr. Rodier, who started her on physical therapy.

She was not improving and she was subsequently referred to Dr. Goldstein, who continued physical therapy including massage and speech therapy. The patient states she was stuttering and having problems with her speech due to a closed head injury. She states the therapist noted that her jaw was locking and she was subsequently referred to Dr. Austin, who performed an arthrogram and later did reconstructive surgery of her TMJ.

The patient states that after this she had a second surgical procedure by a plastic surgeon to repair nerves in her facial area. It was felt that this surgery was going to alleviate her symptoms.

She has also been followed by Dr. Goldstein, a neurologist at St. Mark's. She continues to have neck pain, headaches, and numbness into her arms. She also describes blurred vision. She has not had any electrodiagnostic studies.

The patient was referred to Dr. Sawchuk, who tried an epidural injection. The patient states she developed paleness, nausea, and vomiting and that the epidural was of no benefit. Again, she has not had any electrodiagnostic studies.

The patient states she has been off work from Delta Airlines since July 3, 1998. The patient could not tell me what made her symptoms worse. She states they are better if she lays down flat with her head in a neutral position, hot showers, and pain medication.

Physical Examination: The patient is a pleasant female who is very emotional throughout the interviewing and examination process. Examination of the cervical spine demonstrates full flexion, complaining of pain in the back of her neck. She demonstrates 20 degrees of extension, complaining of neck pain. She demonstrates 80 to 90 degrees of both right and left rotation. She demonstrates 30 degrees of side bending to each side.

May 4, 1999 (cont)
Midge Morgan - 22110

The patient demonstrates break away strength throughout both upper extremities, including biceps, triceps, wrist flexion, wrist extension, finger extension, and grip strength. Overall, I would rate her strength as 4+/5 throughout with break away strength. Deep tendon reflexes are 1 to 2+ and bilaterally symmetrical. She has intact sensation to light touch throughout both upper extremities. Her radial pulses are 2+ and bilaterally symmetrical.

Deep tendon reflexes in the lower extremities are 2+ and bilaterally symmetrical. There is no clonus on examination. She has downgoing toes with Babinski reflex testing.

The patient's gait is normal and she is able to heel and toe walk without difficulty. There is no evidence of any balance abnormalities. Her neurological examination is essentially normal with no gross neurological deficits noted.

Review of X-rays: The patient has an MRI scan of the cervical spine from July of 1998 present today for my review. The patient has complete disc space collapse at the C5-C6 level. This does cause mild to moderate bilateral foraminal stenosis at the C5-C6 level. The remainder of the MRI scan looks normal. There is no significant canal compromise. There is no spinal cord impingement. I see no evidence of any significant soft disc herniation. She does have bony osteophyte formation from the degenerative changes at the C5-C6 level.

The patient had five views of the cervical spine, including a flexion and extension lateral film obtained today in the office. The AP film appears normal except for the disc space collapse and uncovertebral spurring at C5-C6.

On the lateral film, the patient has complete disc space collapse at the C5-C6 level with posterior osteophytes seen.

The oblique film shows some foraminal narrowing bilaterally at C5-C6. However, there is good opening on both sides. It is somewhat narrower on the right side than on the left side. This confirms the findings on the MRI scan.

Impression: Neck pain, headaches, bilateral arm numbness, and blurred vision.

I cannot explain all the patient's symptoms based on the findings of the MRI scan and plain films. I explained to her that the C5-C6 disc space collapse and osteophyte formation was clearly seen on the MRI scan done in July of 1998, only one month following the patient's car accident. These degenerative changes were there prior to the accident. It is entirely possible that the motor vehicle accident aggravated the degenerative changes.

I explained to her that it would be extremely unlikely for surgery to alleviate her symptoms. She also complains of bilateral arm numbness without a good dermatomal pattern. I think it

May 4, 1999 (cont)
Midge Morgan - 22110

would be reasonable to have her see Dr. Goldstein to perform electrodiagnostic studies of her upper extremities, looking for any evidence of a C6 radiculopathy. Again, there were no gross neurological changes on examination.

At this point, I cannot recommend surgical intervention to alleviate the patient's symptoms. My recommendation would be to have the patient evaluated by Dr. Goldstein for electrodiagnostic studies of her upper extremities, looking for any evidence of radiculopathy.

I would be happy to see the patient after that study has been obtained to review the findings.

Stephen J. Warner, M.D.
SJW/la

cc: Michael L. Goldstein, M.D.
Terry C. Sawchuk, M.D.
Hugo E. Rodier, M.D.

ADDENDUM:

I called IHC Select Med (442-5054) and spoke with Hanna Gay. She said no pre-authorization was required for an EMG.

EMG bilateral upper extremities - R/O cervical radiculopathy

This will be done by Dr. Robert Satovick at LDS Hospital on Wednesday May 12th at 9:00 am. She will follow-up with Dr. Warner on Tuesday June 1st at 9:30 am.

Stephen J. Warner, M.D.
SJW:ar

-4-

June 29, 1999
Midge Morgan - 22110

History of Present Illness: The patient is a 52-year-old female seen today for follow-up with the electrodiagnostic studies performed by Dr. Satovick. The EMG was normal in both upper extremities. This included nerve conduction studies on the left side, including the median nerve and ulnar nerve. There are no abnormalities seen.

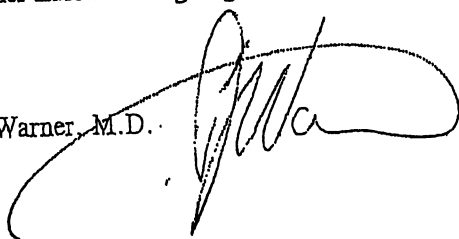
The patient still is complaining of neck pain, headaches, and bilateral arm numbness. I see no abnormalities on electrodiagnostic studies. I did not have her MRI scan to review again today.

The patient has complete disc space collapse at the C5-C6 level on her plain films with osteophytes in the C5-6 foramen. This could account for her symptoms. There is no electrodiagnostic evidence of radiculopathy.

I reviewed the plain films with the patient and her husband. We talked about options, including surgery and what it would involve. Because there are no electrodiagnostic abnormalities, it is difficult for me to quote a definitive success rate, but I would expect it to be in the range of 60% or 70%. I talked to them at length about this. The patient states that the MRI scan is approximately one year old. It may be reasonable to repeat it to make sure there is no significant change.

At this point the patient and her husband are going to consider their options. I spent one-half hour with them discussing the x-rays, the EMG study, and possible treatment options. The patient and her husband are going to consider these and will let me know what they would like to do.

Stephen J. Warner, M.D.
SJW/la



HISTORY AND PHYSICAL EXAMINATION

SS19
Med. Rec #: - - 0
Visit #: 31620651

DATE OF BIRTH: 1/16/47

ADMITTING DIAGNOSIS: C5-C6 spondylosis with bilateral arm numbness associated with foraminal stenosis.

HISTORY OF PRESENT ILLNESS: The patient is a pleasant 52-year-old female who was referred to my office with complaints of neck pain, headaches, bilateral arm pain and numbness, and the sensation of her left arm feeling cold and her right arm feeling hot. The primary problem is neck pain and headaches along with bilateral arm pain and numbness. The patient's problem started on 6/16/98. The patient was involved in a motor vehicle accident in which a large truck struck Volkswagen Fox. The accident totalled her car.

The patient had multiple problems of pain in many locations. The patient subsequently underwent reconstructive surgery on her temporomandibular joints, but continued to have problems with neck pain. She also states that she had a second surgical procedure by a plastic surgeon to repair nerves in her facial area. The patient continued to have neck pain, headaches and numbness into her arms. An MRI scan was subsequently obtained which demonstrated disk space collapse at the C5-6 level associated with foraminal stenosis. An epidural injection was tried in the cervical region which did not provide her with any long-term benefit. The patient states that her symptoms are better if she lies down flat in bed with her head in a neutral position. Hot showers also improve her symptoms.

The x-rays and MRI scans were reviewed with the patient and her significant other. She has complete disk space collapse at the C5-C6 level with foraminal stenosis bilaterally, left greater than right. I talked to the patient about surgery as an option. We talked about doing an anterior cervical discectomy, distraction arthrodesis at the C5-C6 level using a bone graft plug, and plating.

We talked about the risks and complications of surgery including bleeding, infection, failure of surgery to alleviate her symptoms, symptoms that are worse following surgery than before surgery, failure of fusion, failure of instrumentation, tracheal/esophageal injury, recurrent laryngeal nerve injury with voice hoarseness, vertebral or carotid artery injury with resultant stroke, and long-term implications of spinal surgery. The patient's questions have been answered and she wishes to proceed with surgical intervention.

PAST MEDICAL HISTORY: (1) Hysterectomy; (2) Appendectomy; (3) Cholecystectomy; (4) History of skin cancer removal.

CURRENT MEDICATIONS: Prozac, hormonal replacement, imipramine, Imitrex, ibuprofen.
Neurontin

ALLERGIES: An antibiotic that causes a skin sun reaction.

PHYSICAL EXAMINATION:

GENERAL: A pleasant female in no marked distress.
HEENT: Shows some mild scarring but no other major abnormalities noted. Pupils equal, round and reactive to light and

MORGAN, MIDGE M

WARNER, STEPHEN J.

11/18/1999

HISTORY AND PHYSICAL EXAMINATION

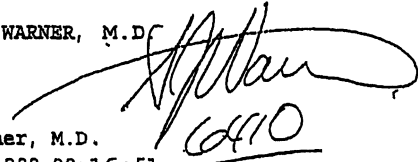
SS19
Med. Rec #: - - 0
Visit #: 31620651

accommodation.
RESPIRATORY: Lungs clear to auscultation with equal bowel sounds bilaterally.
CARDIOVASCULAR: Regular rate and rhythm without gallops or murmurs. There is no jugular venous distention noted on examination.
ABDOMEN: Soft, nontender. Bowel sounds are intact.
NEUROLOGIC: Upper and lower extremities intact neurologically. She demonstrates good strength with some breakaway strength in the upper extremities. Deep tendon reflexes are 1+ to 2+ and bilaterally symmetrical. She has intact light touch sensation throughout both upper extremities.

IMPRESSION AND PLAN:

C5-C6 spondylosis with foraminal stenosis. The patient understands the planned surgical procedure of an anterior C5-C6 discectomy and interbody distraction fusion. She understands that there is a chance that surgery will not help her. I have given her a success rate in the range of 60% to 70%. She understands that there is a 30% to 40% chance that surgery will not help her and that she could have symptoms that are worse following surgery than before the surgery. The patient understands the risks and complications of surgery. Her questions have been answered and she has given informed consent to proceed.

STEPHEN J. WARNER, M.D.



PAT: MORGAN, MIDGE

DIC: Stephen J. Warner, M.D.

EVD: 11/18/1999 D: 11/18/1999.09:14 TD: 11/18/1999.09:16:51

C: 0000000 6410 7 - H0AQ1P10L7

TYPIST: 544 JOB # 40828

BATCH: 27610

MORGAN, MIDGE M

WARNER, STEPHEN J.

11/18/1999



Intermountain Health Care
IDX Clinics

Clinical Notes

Patient:	MORGAN, MIDGE M	Home Phone:	(801) 572-5822	DOB:	01/16/1947
Address:	79 W GOLDEN HARVEST RD	Work Phone:		Sex:	F
	DRAPER, UT 84020	MMI:	540720398		
		MRN:	1830488		

General Surgery Report

Date:	11/23/1999	Clinician:	
Status:	Preliminary	Encounter:	#31620651-LDS Hospital
		POC:	

SURGEON: Stephen J. Warner, M.D.

PREOPERATIVE DIAGNOSIS: Cervical five, cervical six spondylosis with bilateral arm numbness.

POSTOPERATIVE DIAGNOSIS: Same as above.

OPERATIONS PERFORMED:

1. Anterior cervical five-six discectomy.
2. Harvesting, tricortical iliac strut graft from the left hip through a separate skin and fascial incision.
3. Anterior cervical fusion, cervical five-six using tricortical iliac strut graft.

INDICATIONS AND CONSENT FOR PROCEDURE: The patient is a 52-year-old female who was referred to my office with neck pain, headaches and bilateral arm numbness. The patient has had symptoms since being involved in a motor vehicle accident several months earlier. The patient's MRI scan showed spondylosis at the C5-C6 level, associated with bilateral foraminal stenosis.

The diagnosis was discussed at length with the patient. The treatment options were discussed at length with the patient as well. The patient understands the planned surgical procedure consisting of an anterior cervical discectomy and fusion. I reviewed the planned surgical procedure on models with the patient. We also talked about the risks and complications of surgery including bleeding, infection, failure of surgery to alleviate her symptoms, failure of fusion, possible need for anterior cervical plating, failure of instrumentation, failure of fusion, tracheoesophageal injury necessitating further surgery, recurrent laryngeal nerve injury with voice hoarseness, spinal cord or nerve root injury, failure of surgery to alleviate her symptoms, and long term implications of anterior cervical discectomy and fusion. The patient's questions have been answered and she has given informed consent to proceed with surgery.

DESCRIPTION OF OPERATION: The patient was brought to the Operating Room where she was administered a general anesthetic via an endotracheal tube. After satisfactory anesthesia, the patient was positioned on the operating table in the supine position with her arms tucked at the sides, wrapped in blue foam. Care was taken to make sure that there was no undue pressure placed on any of the peripheral nerves or in the axilla. Gentle extension of the neck was obtained, using a thyroid pillow. Care was taken to make sure that the neck was in the neutral position. The patient did receive prophylactic antibiotics in the preoperative period.

6

-11-

April 3, 2000
Midge Morgan

The patient is seen today after having tripped and fallen about one week ago. She is not exactly certain how she tripped or how she fell. She thinks she may have lost consciousness for a brief period of time. The patient states she saw her primary care physician with complaints of severe right-sided chest pain just underneath her right breast, worse with deep breathing or coughing. With either of these activities, the patient gets severe pain.

In addition, the patient is complaining of some right forearm pain over the ulna. She has a large area of ecchymoses present over the right forearm in a small step-off felt on palpation. She is also complaining of some irritation medially over the right elbow, which was present before the fall with radiation into the small and ring finger. This would be most consistent with cubital tunnel syndrome. Oddly, she states that she has not had any increased neck pain and, in fact, since the fall, she feels that her neck pain actually may be better.

PHYSICAL EXAMINATION: She demonstrates 60 to 70 degrees of both right and left rotation of the cervical spine. She has good strength in both upper extremities. She has a large area of bruising over the right forearm with what appears to feel like a step-off over the ulna. This area is quite tender to palpation. She also has a positive Tinel sign over the ulnar nerve in the cubital groove.

REVIEW OF X-RAYS: A single lateral view of the cervical spine was obtained today in the office. The x-rays show the cervical spine in excellent alignment and it appears to have solidly fused at the level of the fusion. I see no problem with the cervical spine.

I also obtained an AP and a lateral of the right forearm. I do not see any fracture of the ulna. I do not see any evidence of a nightstick fracture or other abnormality. The x-ray looks normal.

IMPRESSION:

1. Cervical spine fusion.

This looks good. At this point I am not going to resume any physical therapy. I think that the patient will increase her motion as tolerated. I would like to see her back in five to six weeks for a repeat exam.

2. Right forearm ecchymoses and tenderness.

This most likely represents a soft tissue injury. I did not see any fracture on the x-rays and her strength is normal in the right arm. I would follow this symptomatically.

April 3, 2000 (cont)
Midge Morgan

3. Right chest wall pain.

This most likely represents rib fractures. The patient does not have any symptoms of a pneumothorax, such as shortness of breath. She has pain when she coughs. At this point, the treatment is symptomatic.

4. Right arm numbness.

The symptoms are consistent with cubital tunnel syndrome with entrapment of the ulnar nerve at the elbow. If her symptoms persist, I think the patient's symptoms warrant electrodiagnostic studies.

Stephen J. Warner, M.D.
SJW/la

cc: Hugo E. Rodier, M.D.

-16-

April 24, 2001
Midge Morgan - 22110

The patient is seen today for follow up for her anterior cervical discectomy and fusion. She has several complaints. Her biggest complaint is regarding persistent numbness in both arms. She is somewhat vague in describing the numbness. She has been seen by a neurologist in the past who did some testing of the nerve.

At this point, the patient would like to have some repeat testing to make sure that there is no nerve damage in her upper extremities. Again, she describes numbness in both of her arms. She also describes some right shoulder pain. She had previous surgery on her right shoulder many years ago.

She also reports some posterior neck pain. I explained to her that posterior neck pain is not uncommon following cervical surgery and that this is not unusual.

We are going to try and set up electrodiagnostic studies of both of her arms to see if there is any ongoing cervical radiculopathy or peripheral nerve compression that would explain the symptoms in her arms. We will try and set this up with Dr. Miska or Dr. Alderson. I will see her back after the testing is completed.

Stephen J. Warner, M.D.
SJW/ha

Addendum: The patient has an appt w/ Dr. Miska at UCS Hospital on 5-3-01 at 11:00 am for EMG studies. She will follow-up w/ Dr. Warner on 5-24-01 at 11:30 am. Her records will be faxed prior to her appt. ~~~~~ AR

SALT LAKE CLINIC
Gary R. Hunter, M.D.

8

Name MIDDLE MORGAN M/F Age 46-47 Date 5-31-02
Phone No. 572-5822 History No. 1830488
Referring Person DR. JESSA Insurance HCC MC-B
Reason BCC RIGHT SIDE NDS E

When did the problem start? BY 5/9/02 DR. JOSEPH JESSA

Other physicians you have consulted about this problem and any recommendations or treatment given _____

Any family history of serious illness (list) FA. SKIN CA
2 SISTERS

What work do you do? DELTA AIRLINES
Do you smoke? Yes ☐ No ☒ Do you drink? Yes ☒ No ☐
List any medicine you are allergic to: NONE

List any allergies: HAY FEVER

List all operations you have had and date: MULTI. SKIN CA RESECTION
JAW SURGERY HYSTER. BLADDER REPAIR APPEN. GB

List all medications you are taking: (R) SHOULDER REPAIR X2
ANTIDEPRESSANT MITREY VENTILATOR BAND CA ON LEFT 4TH DL.

Do you have any history of: (If yes, explain below)

Heart trouble	Yes ☐ No ☒	Kidney disease	Yes ☐ No ☒
High blood pressure	Yes ☐ No ☒	Liver/Hepatitis	Yes ☐ No ☒
Diabetes	Yes ☐ No ☒	Stomach ulcers	Yes ☐ No ☒
Cancer <u>BODY SKIN</u>	Yes ☒ No ☐	Bleeding disorders	Yes ☐ No ☒
Asthma	Yes ☒ No ☐	Bruise easily	Yes ☐ No ☒
Lupus	Yes ☐ No ☒	Bowel change	Yes ☐ No ☒
Keloid	Yes ☐ No ☒	Other <u>PT</u>	

B.P. _____ Ht. 5'11" Wt. 125#
LABS: _____ MEDS: _____ MISC: _____
CBC _____ OxyContin 10 mg _____ Fees PAID
U/A / HCG _____ Lortab 5.0/7.5 mg _____ Photos PAID
Percocet 5mg _____ Consents PAID
Cefzil 250 mg _____ Insurance forms PAID

SSYOW ok in good luck
Amis around u
H2O from 300 - H2O uniting, feeling
x ground up -
EXCEL -

Low, 2000
implantation
normal.

1.1cm indented tumor
@ base.
Plan - exc. 300 @ base of fib

January 30, 2003
Midge Morgan - 22110

HISTORY OF PRESENT ILLNESS: The patient is a 56 year old female who I have taken care of in the past for problems with her cervical spine. I last saw her in May of 2002 with some complaints of increased neck pain. The patient states that in December, she developed increased neck pain followed by pain and numbness radiating into her left upper extremity. The patient states that it radiates towards the index and long finger with possibly involvement in her left thumb. Associated with this, the patient has been losing strength in her left upper extremity. She has difficulty lifting and holding on to objects. She gets pain that radiates into the peri-scapular region as well as towards her left axilla.

When the symptoms started, she saw her primary care physician, Dr. Rada. He obtained electrodiagnostic studies as well as an MRI scan. The electrodiagnostic studies performed by Dr. Walter Reichert showed findings compatible with a left cervical radiculopathy localized to the C7 nerve root with abnormalities in the cervical paraspinal muscles as well. The remainder of the examination was within normal limits with no evidence of a peripheral nerve compression syndrome (carpal tunnel syndrome/cubital tunnel syndrome).

The patient had an MRI scan done on January 4, 2003. This showed a small central disc protrusion at C4-5. It showed a C6-C7 disc herniation as well with extension towards the left neuroforamen.

The patient feels that her symptoms are getting progressively worse. The numbness in the left arm is constant. She gets intermittent electrical shocks down the left arm especially with certain movements of the neck. She has had physical therapy which did not help. Again, she states that it is not getting better and is starting to interfere with activities of daily living because she feels like she is losing strength in the left upper extremity.

Past medical history, past surgical history, review of systems, and family and social history were completed by the patient and are present on the 2 page medical information sheet.

CURRENT MEDICATIONS:

1. Xanax prn.
2. Flexeril.
3. Ambien.
4. Vioxx.
5. LAP.
6. Dexadrine.
7. HRT.

PHYSICAL EXAMINATION: Pleasant female in mild distress. Overall, the patient demonstrates a good range of motion of the cervical spine with full flexion, 70-80

January 30, 2003
Midge Morgan - 22110

degrees of both right and left rotation, and 10-20 degrees of extension which does precipitate shoulder and arm pain.

The patient demonstrates a reasonably good range of motion of both shoulders. There was mild pain in the shoulders with range of motion but no marked impingement sign was noted.

Manual motor strength testing in the right upper extremity is normal throughout. I could not break her strength anywhere on exam.

Manual motor strength testing in the left upper extremity shows weakness of the left triceps which was rated as 4/5. Left wrist flexion and extension were also weak on exam rated as 4/5 as well. Again, strength in the right upper extremity was normal.

Deep tendon reflexes were 2+ at both biceps, 2+ at both brachial radialis, 1-2+ at the right triceps, and absent at the left triceps.

The patient has loss of the triceps reflex along with weakness in a C7 nerve root distribution.

REVIEW OF X-RAYS: The patient has an MRI scan of the cervical spine present today for my review dated January 2003 from Cottonwood Hospital. The patient's fusion at C5-C6 is solid. At C4-C5, she has mild disc desiccation and narrowing. No significant disc herniation is noted. At C6-7, the patient has disc space narrowing with a small posterior disc bulge. This does appear to be left sided. On the axial images, I don't see any marked compromise of the foramen. There is a subtle disc herniation at C6-C7. As noted above, the patient has electrodiagnostic evidence of a C7 radiculopathy.

IMPRESSION: C6-C7 disc herniation with radiculopathy. The patient has loss of the triceps reflex as well as weakness in a C7 nerve root distribution. The differential diagnosis might include carpal tunnel syndrome, however according to the electrodiagnostic studies by Dr. Reichert, the patient does not have evidence of a carpal tunnel syndrome.

I had a long discussion with Midge regarding her treatment options. We talked about a selective nerve root block. We also talked about further conservative management. The patient states that her symptoms are not improving and that her left arm feels progressively weak. She does have weakness again fitting a C7 nerve root distribution.

We again talked about other options such as an anterior cervical discectomy and fusion procedure at the C6-C7 level. We again talked about exactly what this would involve. She has a previous anterior cervical fusion so she is well versed in what it entails. We



DIAGNOSIS SUMMARY RECORD

CODE 1

PRINCIPAL DIAGNOSIS		SECONDARY DIAGNOSIS		COMPLICATIONS/COMORBIDITIES/INFECTIONS		OPERATIONS/PROCEDURES		CHECKLIST	
								ASSEMBLY ANALYSIS DATA ENTRY CODING ABSTRACT COMPLETE	
								This is a Signed Original Legal Document. Do not Remove It from This Medical Record.	
I CERTIFY THAT THE NARRATIVE DESCRIPTIONS OF THE PRINCIPAL AND SECONDARY DIAGNOSIS AND THE MAJOR PROCEDURES PERFORMED ARE ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.									
ATTENDING PHYSICIAN SIGNATURE									
PATIENT ACCOUNT NUMBER		PATIENT TYPE		BILLING TYPE		UNIT RECORD NUMBER		MEDICAL RECORD NUMBER	
45207842		N01		A00		000540720398		76-84-52	
PATIENT NAME		ROOM		CLERK		CLG		PARKS	
MORGAN, MIDGE M		SS26		F		NO		NO	
ADDRESS 79 W GOLDEN HARVEST RD		W		DATE 06/26/02		UNDER		NAME	
CITY DRAPER, UT 84020		M		D		HOSPITAL		WARRANTY	
DATE 02/26/03 05:30		BIRTH 1/16/1947		AGE 56Y		DATE 2-28-03		CODE	
PHONE (801)572-5822		RELIGION		LATTER-DAY SAINTS		FAX		DELTA AIRLINES	
S.S. 528-68-0283		ADDRESS		150 W 500 S		OCCUP.		SENIOR CSA	
NAME WARNER, STEPHEN J.		CODE 6410		STATE SLC, UT 84101		EMP.		9/PHONE (404) 715-26	
NAME RADA, MARK A.		CODE 27830		STATE SLC, UT 84101		OCCUP.		SENIOR CSA	
NAME WARNER, STEPHEN J.		CODE 6410		STATE SLC, UT 84101		EMP.		9/PHONE (801) 532-71	
NAME MARCROFT, PATRICK W.		CODE 7373		STATE SLC, UT 84101		EMP.		9/PHONE (801) 532-71	
NAME PALLOTTA, CRAIG MICHAEL		FRIEND		NAME MCDERMAID, TROY CLARK		SON		SON	
ADDRESS 79 W GOLDEN HARVEST RD		NAME		SELF		EMPL.		DELTA AIRLINES	
CITY DRAPER, UT 84020		PHONE (801)572-5822		NAME		150 W 500 S		OCCUP.	
NAME MORGAN, MIDGE M		PHONE (801)572-5822		NAME		SLC, UT 84101		SENIOR CSA	
CITY DRAPER, UT 84020		S.S. 528-68-0283		NAME		SLC, UT 84101		SENIOR CSA	
NAME HNP		NAME		NECK, BACK, HEAD		DATE 07/16/98 13:3		TRANSPORT	
NAME C6-7 ANT DISC/FUSION/ABC PLATE		NAME		RUN OVER BY VAN		NAME		DELTA EMPL PARKING	
NAME NPO		NAME		2		NAME		07570	
NAME IHC HEALTH PLANS		NAME		191201		NAME		MEDICARE O P R	
NAME PO BOX 30192		NAME		30269		NAME		PO BOX 30269	
NAME SALT LAKE CITY, UT 84130-0192		NAME		84130-0192		NAME		SALT LAKE CITY, UT 84130-0192	
NAME DELTA AIRLINES		NAME		SELECTME		NAME		DELTA AIRLINES	
NAME MORGAN, MIDGE M		NAME		528680283		NAME		MORGAN, MIDGE M	
NAME P		NAME		01/16/1947		NAME		P	
NAME		NAME		(800) 538-5054		NAME		(800) 538-5054	

CONSENT FOR OPERATION, ANESTHETICS, AND OTHER MEDICAL SERVICES

I request Dr. Warner and associates of his/her
choice to perform the following procedure[s] C6-7 anterior discectomy / fusion (ABC plate)
upon myself

My physician[s] has explained to me my condition, the nature and purpose of the proposed procedure[s], the anesthesia necessary for the procedure[s], including the giving of appropriate anesthetic agents and blood products, and also explained any alternative treatment[s]. My questions about the procedure[s] and the risks have been answered in a satisfactory manner. I accept the risk of substantial and serious harm, if any, in hopes of obtaining the desired benefits from the procedure[s].

I also understand that the procedure[s] may result in complications (which have been known to occur after the procedure[s] to which I am consenting), even though the utmost care, judgment, and skill are used. I understand that all anesthetics involve risks and that serious injury or death have been known to occur. No guarantees have been promised to me from this procedure[s].

I recognize that, during the procedure[s], unforeseen conditions may require additional or different procedures than those explained. I request that my physician[s] and associated perform those procedures as, in their professional judgment, are desirable, including administration of anesthesia and blood or blood products.

Any tissues that are removed from my body may be examined and then disposed of by the hospital personnel.

I agree to observation and photography in the operating room during my procedure in order to advance medical education.

I HAVE READ AND UNDERSTAND THIS DOCUMENT AND IN ADDITION HAVE REVIEWED THE INFORMATION ON THE BACK OF THIS FORM AND REQUEST THE PROPOSED CARE IN SPITE OF THE RISKS INVOLVED.

Midge M. Morgan
PATIENT NAME (PLEASE PRINT)

Midge M. Morgan
PATIENT SIGNATURE

PATIENT'S AGENT / REPRESENTATIVE NAME (PLEASE PRINT)

PATIENT'S AGENT / REPRESENTATIVE SIGNATURE

2/26/03
DATE SIGNED

0630
YEAR TIME

Holler
WITNESS TO SIGNATURE

Reason(s) Patient is unable to sign: _____

PATIENT'S ADDRESS-O-GRAPH

HCMPR-906/9-00



INTERMOUNTAIN HEALTH CARE

CONSENT FOR OPERATION, ANESTHETICS, AND OTHER MEDICAL SERVICES

MORGAN, MIDGE M
45307842 M - 23. STEPHEN
01/11/43 - 03/19/2003
MD - 24-52 02/26/03
LO - 100017

TODAY'S DATE

PATIENT NAME	Midge Morgan	JM	PREFERRED NAME	Midge	PHONE	801-572-5822	AGE/DOB	56/1-16-
REASON FOR ADMISSION	Neck Fusion/plate	PROCEDURE	DATE	2-26-03	SURGEON/DOCTOR	Dr. S. D. Davis	PRIMARY CARE PHYSICIAN	Dr. R. Rad

ALLERGIES/REACTION	LIST	NONE	MEDICATIONS	FOODS	LATEX	TAPE	OTHER	HT	WT
	Hay Fever								

PREVIOUS HOSPITALIZATION(S) OR OPERATIONS (INDICATE APPROXIMATE YEAR)	CURRENT AND RECENT MEDICATIONS & HERBAL REMEDIES (INCLUDE PRESCRIPTIONS, EYE DROPS, OVER THE COUNTER MEDS/HERBS, ASPIRIN, IBUPROFEN, DIET AIDES & DOSA)
2002 - Sinus graft nose cancer	Pain meds - Demand, Percocet, Flexal
2001 - Shoulder repair, etc	Hormone replacement VIOXX, Fospholine
2000 - Saw surgery / tms	Codeine, Robaxin, Saw, etc.
2000 - Neck fusion	Verelan, Zolof
2000 - Saw surgery / tms	

CHECK IF YOU HAVE HAD A BAD REACTION TO ANESTHESIA?	YES	NO
HAS A BLOOD RELATIVE HAD A BAD REACTION TO ANESTHESIA?	YES	NO

HEALTH HISTORY	YES	NO	HAVE YOU HAD:	YES	NO	DO YOU CURRENTLY USE OR HAVE A HISTORY OF USING TOBACCO?
						NO OF YRS USED PACKS/DAY DATE QUIT
			DIABETES			DO YOU DRINK ALCOHOLIC BEVERAGES?
			HYPOGLYCEMIA (Low Blood Sugar)			HOW OFTEN HOW MUCH
			THYROID PROBLEMS			DO YOU HAVE A HISTORY OF SUBSTANCE ABUSE OR ADDICTION?
			HEART PROBLEMS (Rheumatic Fever, Murmur, Chest Pain, Heart Attack, Irregular Heartbeat, Angina, Ankle Swelling, Valve Replacement, etc.)			
			BLOOD CLOTS, TRANSFUSION PROBLEMS, OR BLEEDING TENDENCY (Hemophilia, Anemia, etc.)			DO YOU HAVE ANY OF THE FOLLOWING?
			HIGH BLOOD PRESSURE			False Teeth Chipped Teeth Braces Bridges
			STROKE (Weakness/Numbness on one side, Difficulty Speaking, Loss of Vision, etc.)			Loose Teeth Caps/Crowns Retainers Body Piercing
			SEIZURES (Epilepsy, Convulsions, Blackouts, etc.)			DO YOU WEAR CONTACT LENSES?
			NEUROLOGICAL PROBLEMS (Loss of Sensation, Numbness, Tingling, etc.)			ARE YOU RECEIVING TREATMENT FOR GLAUCOMA?
			SEVERE HEADACHES			DO YOU HAVE ANY SPECIAL COMMUNICATION NEEDS?
			LUNG PROBLEMS (Asthma, Chronic Cough, Pneumonia, Wheezing, Shortness of Breath, Emphysema, Abnormal Chest X-ray, etc.)			Hearing Language Speech
			TUBERCULOSIS / TB			DO YOU HAVE ANY PHYSICAL LIMITATIONS?
			SLEEP APNEA (Breathing Interruption During Sleep, etc.)			DO YOU HAVE ANY ENVIRONMENTAL CONCERNS?
			LIVER PROBLEMS (Jaundice, Hepatitis, etc.)			(Room Temperature, Lighting, etc.)
			KIDNEY, BLADDER OR PROSTATE PROBLEMS (Infections, etc.)			DO YOU HAVE ANY SPECIAL REQUESTS?
			STOMACH PROBLEMS (Ulcer, Hiatal Hernia, Reflux, Heartburn, Nausea/Vomiting, etc.)			DO YOU CURRENTLY NEED ASSISTANCE TO GET AROUND THE HOUSE?
			BOWEL PROBLEMS (Irritable Bowel, Diverticulosis, Diarrhea, etc.)			DO ERRANDS, AND TAKE CARE OF YOUR PERSONAL NEEDS?
			BACK TROUBLE (Strain, Disc Problems, Numbness/Tingling of Hands or Feet, etc.)			WOULD YOU LIKE TO DISCUSS ANY CONCERNS OR FEARS REGARDING THIS PROCEDURE?
		BROKEN BONES OF HEAD, NECK OR SPINE, OR RESTRICTIONS IN MOVEMENT			WOMEN, IS THERE A POSSIBILITY YOU ARE PREGNANT?	
		DIFFICULTY OPENING MOUTH (TMJ, etc.)			LAST MENSTRUAL PERIOD	
		ARTHRITIS			age 26	
		MUSCLE DISORDERS (MD, Myasthenia Gravis, etc.)			WOMEN: ARE YOU BREASTFEEDING?	
		CANCER			IF THE PATIENT IS A CHILD:	
		MENTAL HEALTH / PHOBIAS (Anxiety, Depression, Psychosis, etc.)			WAS THE CHILD PREMATURE?	
		MENTAL DISABILITY (Confusion, Memory Loss, Downs Syndrome, etc.)			ANY BIRTH DEFECTS OR DEVELOPMENTAL PROBLEMS?	
		SKIN PROBLEMS (Eczema, Fragile Skin Breakdown, etc.)			ANY IMMUNIZATION PROBLEMS OR DELAYS?	
		PAIN IN THE PAST SEVERAL WEEKS			ANY HISTORY OF BREATH HOLDING, BREATHING PROBLEMS OR CROUP?	
		PAIN THAT LIMITS DAILY ACTIVITIES				
		OTHER MEDICAL PROBLEMS/ COMMENTS				

PATIENT'S OR SIGNIFICANT OTHERS SIGNATURE	RELATIONSHIP	DATE
Midge Morgan	Self	2/26/03

ANY ILLNESS, COLD, COUGH OR FEVER WITHIN THE LAST WEEK?	FOR HOSPITAL STAFF USE
RECENT EXPOSURE TO ANY COMMUNICABLE DISEASES?	COMMENTS
INFLUENZA VACCINE (LAST 12 MO)	
PNEUMOVAX VACCINE	

IF YOU MARK YES FOR ANY OF THE FOLLOWING, A COPY MUST BE PROVIDED FOR US TO HONOR YOUR WISHES	

DO YOU HAVE A LIVING WILL?	Copy Requested
WOULD YOU LIKE MORE INFORMATION?	Info Given
DO YOU HAVE A DURABLE SPECIAL POWER OF ATTORNEY?	Copy Requested
WOULD YOU LIKE MORE INFORMATION?	Info Given
DO YOU HAVE A MEDICAL TREATMENT PLAN?	Copy Requested
WOULD YOU LIKE MORE INFORMATION?	Info Given

PATIENT HISTORY	24F2

IHC NS-040 / 3-02

1. Place a (✓) in the column below that best describes your current ability to do each of the items below.

	Self Care	Require Equipment	Require Assistance, Supervision	Require Assist. Supervision & Equip. Device	Assistive Devices (please specify)
Eating	✓				
Bathing	✓				
Toileting	✓				
Getting in & out of bed	✓				
Dressing	✓				
Grooming	✓				
Medication Administration	✓				
General Mobility	✓				Cane, Crutches, Walker, W/C
Stairs	✓				
Housekeeping	✓				
Shopping	✓				
Cooking	✓				

2. Who will provide your care after discharge?
 Caregiver: Celia Pallotta
 Relationship: Husband
 Phone: Work 572 2758 Home 572 5822

3. Describe your living arrangements prior to hospitalization:
☒ Home / apartment with spouse / relative / friend
☐ Home / apartment alone ☐ Extended care facility
☐ Other: _____

4. Will your living arrangements change after discharge?
 Explain: _____

5a. Is there anyone dependent on you for day-to-day needs: ☐ Spouse ☐ Children ☐ Parent ☐ Significant Other ☐ Sibling ☒ Pet ☐ Other: _____

5b. Will meeting their needs be a problem?
 Explain: _____

6. Do you have a history of falling down?
☒ Yes ☐ No

7. Have you used or do you currently use any of the following services? (Indicate providers name)
☐ Homemaker services _____
☐ Meals on Wheels _____
☐ Transportation _____
☐ Medical supplies / Oxygen _____
☐ Nursing services _____
☐ Other: _____

8. Are you concerned that you will not have the support (meal preparation, daily assistance) you may need after leaving the hospital?
☒ Yes ☐ No

9. Have you been injured, house bound, or hospitalized due to a violent situation with someone close to you?
☒ Yes ☐ No

10. Would you like to discuss any financial concerns regarding:
☐ Cost of this hospitalization
☐ Questions about insurance / medicare coverage
☐ Cost of ongoing treatment / medications & supplies

11. Nutritional Care Needs (questions 11-14)
 Have you had an unexplained weight loss of 10 or more pounds over the last 6 months?
☒ Yes ☐ No
 Explain: _____

12. Have you: ☐ Been unable to eat for the last 3 days
☐ Had a poor appetite ☐ Been on clear liquids only
 Explain: _____

13. Do you have any problems with chewing, swallowing or with digestion? Explain: _____

14. Are you on a special diet or is there anything you cannot eat? Explain: _____

15. Do you have any problems or complaints regarding your bowel movements? ☐ Constipation
☐ Diarrhea ☐ Black / bloody stools
☐ Other: _____

16. Do you use anything to maintain your usual bowel pattern? ☐ Enemas ☐ Laxatives
☐ Special diet ☐ Fiber supplements
☐ Stool softeners ☐ Other: _____

17. Do you have any problems sleeping?
☐ Insomnia ☐ Pain ☒ Breathing difficulties
☐ Up at night to use bathroom
☐ Other: _____

18. Do you use something to help you get to sleep? Explain: _____

19. Would you like to discuss any concerns about the impact of your condition on your sexuality?
 Explain: _____

Spiritual Care Needs (No spiritual leader will be contacted without your permission)

20. Do you have a religious/spiritual preference?
 If yes, please list: LDS

21. Do you wish to have a spiritual leader/representative or chaplain (if available) called?
 Person to be contacted: _____

22. I would like the following religious/spiritual ministrations or support provided: (Blessing, sacrament of the sick, prayer, scriptures, literature, etc.) _____

23. Are there any religious / spiritual / cultural issues that are important for us to know about?
 _____

24. Is there anything else you want to ask about or tell us that will help you deal with your condition?
 _____

25. Who will be the key contact person for you during this hospitalization?
 Name: Celia Pallotta
 Relationship: Husband
 Phone: Work _____ Home 572 5822

THIS FACILITY WILL NOT BE RESPONSIBLE FOR PERSONAL BELONGINGS AND VALUABLES. AS MANY BELONGINGS AND VALUABLES AS POSSIBLE SHOULD BE TAKEN HOME BY FAMILY MEMBERS.

PATIENT'S OR SIGNIFICANT OTHER'S SIGNATURE: X Celia Pallotta RELATIONSHIP: Husband DATE: 2/6/03

REVIEWED BY: X H. Murray LON DATE: 2/28/03 R.N.

MORGAN, KIDGE H
 45207842 WARNER, STEPHEN
 01/16/47 F 56Y U54072039A
 HR76-84-52

DATE 2/26/03	TIME	GENERIC EQUIVALENT MAY BE SUBSTITUTED UNLESS BOX IS CHECKED	☐ WT	HT
ALLERGIES:				
① Admit to W3, SSExt, Dr. Warner				
② Dx: ACDE				
③ End: Good				
④ All: Tape				
⑤ Vitals: q 4 ^o				
⑥ Activity: Ad lib				
⑦ Straight Cath q 6 ^o prn				
DATE	TIME	GENERIC EQUIVALENT MAY BE SUBSTITUTED UNLESS BOX IS CHECKED	☐	
⑧ ADAT to Regular				
⑨ IV: LR @ 100cc/hr. Hepwell C				
good PO				
⑩ Ancel 1gm IV q 8 ^o x 2				
⑪ MSOx 2-6mg IV q 1 ^o prn				
⑫ Percolone or Lortab				
10-20 mg PO q 4 ^o prn				
⑬ Zofran 4-8mg IV q 6 ^o prn				
DATE	TIME	GENERIC EQUIVALENT MAY BE SUBSTITUTED UNLESS BOX IS CHECKED	☐	
⑭ Xanax 0.5mg PO q 8 ^o prn anxiety				
⑮ Flexeril 10mg PO q 8 ^o prn				
⑯ Ambien 10mg PO hs prn				
⑰ Valium 20loft 100mg PO q 4 ^o				
⑱ Amitrex 25-50mg PO q 6 ^o prn				
MORGAN, RIDGE H 45207942 WARNER, STEPHEN 01/15/47 F 56Y U540720398 HR76-84-52 NOI 02/26/03 LDS HOSPITAL				
W327				
DATE 2/26/03	TIME 12:00	GENERIC EQUIVALENT MAY BE SUBSTITUTED UNLESS BOX IS CHECKED	☐	
① K = pad to ② shoulder				
Throat Lozenges per sore throat				
② Demerol 25-100mg IV q 1 ^o prn				
③ Phenergan 25mg IV q 4 ^o prn NIV				
MORGAN, RIDGE H 45207942 WARNER, STEPHEN 01/15/47 F 56Y U540720398 HR76-84-52 NOI 02/26/03 LDS HOSPITAL				
240/2 King RN 2/27/03 013				

PATIENT ORDERS

A hand-drawn sketch on lined paper. The sketch consists of a single, continuous, curved line that starts near the top left, curves downwards and to the right, and then continues as a nearly horizontal line towards the right edge of the page. The line is drawn with a dark pen or marker. The background shows horizontal ruling lines. At the very top of the page, there is a header area with some faint, partially visible text and a small square box.

5207842 WARNER. - 150H
01/16/47 F 54Y US407-03
576-84-52 HQ1 02/21/03
HOSPITAL

LDS HOSPITAL
COMMENTS REPORT
SHIFT: 02/26/03 00:01 - 02/27/03 00:00

03/16/05 14:47

name: MORGAN, MIDGE M sex: F age: 56 No: 45207842 M.R.#: 760452
Dr. WARNER, STEPHEN J. Ht: 158 cm Admit Wt: 63.00 kg Current Wt: 63.00 kg
Rm: DSCH
Caregiver/Provider: CHAN, ANISSA K, RN 02/26/03 12:00 - 02/26/03 19:00 Admit date: 02/26/03 05:43
PEARL, NICOLE, RN 02/26/03 19:01 - 02/26/03 23:00
KING, DARLENE, RN 02/26/03 23:00 - 02/27/03 00:00

1200 Admit/Discharge/Transfer	Admitted: admitted to W3, Transferred: Transferred from PACU, Admission action: Routine: Pt/SO oriented to the unit (OPT);, Safety: Siderails up, Call light within reach, Transport info: Method of transport: Bed, Accompanied by: Orderly, Oxygen;
1247 Severity	Pain severity: Pain reported as 10, on a 0 to 10 pain scale,
1248 Supplemental Oxygen/Measurements	Route: Cannula, Amount: Liters/min 4.00, SpO2 (finger): 97,
1248 Vital Signs/Measurements	Weight 63.00 KG, Height 157.5 CM, Body Surface Area(BSA) 1.67 SQM, Weights: Estimated/stated, Admission weight,
1250 Location	Pain location, Neck, Shoulder, Left, Right,
1250 Location	Pain location, Hip, Right,
1250 Exacerbation	Pain exacerbation: Exacerbation during rest,
1251 Oral Fluids	Tolerated: Well, Dist: Comment: crackers,
1251 GU Out	Status voiding unknown amt., NET URINE OUT (GU OUT - GU IN): = 0
1500 GU Out	Voided urine 450 ml, NET URINE OUT (GU OUT - GU IN): = 450
1500 Hygiene	Partial bath, Other linen change, Gown changed, Peri-care, Routine skin care,
1516 Supplemental Oxygen/Measurements	Route: Cannula, Amount: Liters/min 4.00, SpO2 (finger): 97,
1530 Severity	Pain severity: Pain reported as 8, on a 0 to 10 pain scale,
1612 Severity	Pain severity: Pain reported as 8, on a 0 to 10 pain scale,
1613 Orientation,Loc	Level of Consciousness: Alert and oriented to person, place, time. Short term memory intact.,
1613 Pupils	Pupils: Pupils equal, round, and reactive to light (PERRL).,
1613 Verbalization	Verbalization clear and understandable for age,
1613 Peripheral Pulses	Site: All peripheral pulses 3+,
1613 Peripheral Edema	Peripheral edema: No edema present,
1613 Extremity Temp. And Color	Extremity temp. & color: Warm, Dry, Natural color, Site: All extremities,
1613 Capillary Refill	Capillary refill: Capillary refill time <= 3 seconds, all extremities,
1613 Rhythm	Rhythm. Regular pulse/rhythm,
1613 Heart sounds	Heart Sounds: Normal heart sounds,
1613 GU Out	Voided urine 300 ml, NET URINE OUT (GU OUT - GU IN): = 750
1615 Respiratory Pattern/Effort	Pattern/Character: Regular, Even, Effort: Without effort,
1615 Breath Sounds	Clear, Bilateral, All lung fields,
1615 Cough/Secretions	Cough. No abnormal cough,

MORGAN, MIDGE M # 45207842 Rm: DSCH COMMENTS REPORT Print time: 03/16/05.14:47 S#: 02/26-02/27.00:00

Demonstrates understanding: Verbalizes understanding,
 Persons taught: Patient,
 Teaching Assessment: No barriers:has desire to learn,
 Routine: Vented feelings, Discussed hospitalization, Discussed treatment,
 Emotional support - patient,
 2108 Emotional Support
 Movement: Purposeful movement, Upper bilateral extremities,
 2214 Movement
 Movement: Movement (PT): moves toes slightly in right leg, Right foot,
 2214 Movement
 Movement: Movement (PT): wiggles toes and leg, Movement (PT): wiggles toes and
 left leg,
 2214 Movement
 Left foot, Left leg,
 Movement/Grips/Sensation/Strength: Numbness, Right leg,
 2214 Sensation
 Movement/Grips/Sensation/Strength: Sensation (PT): pt. is able to detect pain in
 right hip and pressure in lower leg, but states she is unable to move leg,
 Right leg,
 Movement/Grips/Sensation/Strength: Sensation intact, Left leg,
 2214 Sensation
 Skeletal assessment: Normal skeletal alignment and structure,
 2214 Skeletal
 Pain severity: Pain reported as 9, on a 0 to 10 pain scale,
 2216 Severity
 Routine: Teaching (PT): talked to pt. about physiologics of pain and explained
 the pain scale along with meds of controlling it,
 2230 Teaching
 Method used: Explanation,
 Demonstrates understanding: Verbalizes understanding,
 Persons taught: Patient,
 Teaching Assessment: No barriers:has desire to learn,
 Pain characteristic: Pain characteristic (PT): "deep bone pain",
 2232 Characteristic
 Pain onset: Progressive onset,
 2232 Onset
 Pain location: Hip, Right,
 2232 Location
 Pain duration: Duration (PT): since surgery,
 2232 Duration
 Pain relief: What relieves the pain? (PT): demerol iv,
 2232 Relief
 Oral intake 360 ml,
 2233 Oral Fluids
 Diet: Select/Regular,
 Tolerated: Well, Ate 50-75% of diet,
 2247 Oral Fluids
 Water 850 ml,
 Diet: Comment: Fresh ice water given,
 2354 Supplemental Oxygen/Measurements
 Route: Cannula,
 Amount: Liters/min 4.00,
 SpO2 (finger): 97,
 0000 Orientation,Loc
 Orientation: Oriented x 3,
 Responsive: Arouses with difficulty,
 0000 Peripheral Pulses
 Site: All peripheral pulses 3+,
 0000 Extremity Temp. And Color
 Extremity temp. & color: Warm, Dry, Natural color,
 Site: All extremities,
 0000 Capillary Refill
 Capillary refill: Capillary refill time <= 3 seconds, all extremities,
 0000 Rhythm
 Rhythm: Regular pulse/rhythm,
 0000 Heart Sounds
 Heart Sounds: Normal heart sounds,
 0000 Treatments
 Type: Cough and deep breathe,
 Tolerated: Well,
 0000 Respiratory Pattern/Effort
 Pattern/Character: Regular, Even,
 Effort: Without effort,
 0000 Breath Sounds
 Clear, Bilateral, All lung fields,
 0000 Cough/Secretions
 Cough: No abnormal cough,
 0000 Bowel Sounds
 Bowel sounds: Present, normal, All Quadrants,
 0000 Abdominal Exam Findings
 Abdominal exam findings: Soft, No tenderness on palpation, All Quadrants,
 0000 Abdominal Discomfort
 Abdominal discomfort: No nausea and/or vomiting, No c/o abdominal discomfort,
 0000 Voiding/Bladder
 Voiding/bladder: Continent, Voiding without discomfort, No bladder distention,
 0000 GU Out
 Voided urine 800 ml,

03/16/05 14:47

0030	Hygiene	Hygiene (PT): bedpan,
0200	Orientation,Loc	Level of Consciousness: Alert and oriented to person, place, time. Short term memory intact.,
0200	Verbalisation	Verbalisation clear and understandable for age,
0400	Treatments	Type: Cough and deep breathe,
		Toleration:: Well,
0400	Activity	Type: Repositioned,
		Assist by 2 persons,
0406	Supplemental Oxygen/Measurements	Route: Cannula,
		Amount: Liters/min 4.00,
		SpO2 (finger): 97,
0455	GU Out	Voided urine 600 ml,
		NET URINE OUT (GU OUT - GU IN): = 600
0456	Hygiene	Hygiene (PT): bedpan,
0550	Oral Fluids	Water 150 ml,
0805	Severity	Pain severity: Pain reported as 9, on a 0 to 10 pain scale,
0814	Supplemental Oxygen/Measurements	Route: Cannula,
		Amount: Liters/min 2.00,
		SpO2 (finger): 96,
0936	GU Out	Voided urine 400 ml,
		NET URINE (GU OUT - GU IN): = 1000
0945	Orientation,Loc	Level of Consciousness: Alert and oriented to person, place, time. Short term memory intact.,
0945	Pupils	Pupils: Pupils (PT): pupils equal and round,
0945	Grip	Grips: Grip strong, Bilateral,
0945	Verbalization	Verbalization clear and understandable for age,
0945	Peripheral Pulses	Site: Bilat. dorsalis pedal 3+, Bilat. radial 3+,
0945	Peripheral Edema	Peripheral edema: Bilateral LE 3 +,
0945	Extremity Temp. And Color	Extremity temp. & color: Warm, Dry, Natural color,
		Site: All extremities,
0945	Capillary Refill	Capillary refill: Capillary refill time <= 3 seconds, all extremities,
0945	Rhythm	Rhythm: Regular pulse/rhythm,
0945	Heartsounds	Heart Sounds: Normal heart sounds,
0945	Respiratory Pattern/Effort	Pattern/Character: Regular, Even,
		Effort: Without effort,
0945	Breath Sounds	Clear, Right, Anterior, Left, Anterior,
0945	Cough/Secretions	Cough: No abnormal cough,
0945	Bowel Sounds	Bowel sounds: Present, normal, All Quadrants,
0945	Abdominal Exam Findings	Abdominal exam findings: Soft, No tenderness on palpation, All Quadrants,
0945	Abdominal Discomfort	Abdominal discomfort: Nausea,
0945	Voiding/Bladder	Voiding/bladder: Voiding without discomfort, Patient reported,
0945	Urine color	Character: Clear, Dilute, Characteristic odor,
0945	General Skin Character	General skin character: Skin warm, dry, intact, and color within patient norm,
		Nail beds normal color,
0945	Oral Cavity	Mouth assessment: Mucous membranes moist,

0945	Wound Assess/Care/Dressing	Wound type: Surgical wound, Site: Neck, Site location: Anterior, Drainage character: None, Wound character: Sutures/strips/staples intact, Nursing assessment (wound): comparison to previous: Unable to determine,
0945	Wound Assess/Care/Dressing	Wound type: Surgical wound, Site: Hip, Site location: Right, Dressing dry and intact,
0945	Braden Scale	Screening questions Braden Scale: Patient is not immobile, Patient does not have pressure ulcer, ,
0945	Muscle Strength	Muscle Strength/Weakness: Active movement with decreased strength, All Extremities,
0945	ADL Ability	ADL Ability: Activity (FT): up c pt this am,
0945	Movement	Movement: Purposeful movement, Voluntary movement, Movement (FT): pt able to wiggle toes - does not dorsiflex/plantarflex well on rle, Lower bilateral extremities,
0945	Movement	Movement: Purposeful movement, Voluntary movement, Upper bilateral extremities,
0945	Sensation	Movement/Grips/Sensation/Strength: Numbness, Right foot, Right leg,
0945	Sensation	Movement/Grips/Sensation/Strength: Sensation (FT): pt does feel some pressure, Right foot, Right leg,
0945	Sensation	Movement/Grips/Sensation/Strength: Sensation intact, Upper bilateral extremities,
0945	Skeletal	Skeletal assessment: Skeletal (FT): ricbg, c5-6 anterior disectomy,
0945	Characteristic	Pain characteristic: Sharp stabbing pain, Dull aching pain,
0945	Location	Pain location, Hip, Right,
0945	Location	Pain location, Shoulder, Right,
0945	Location	Pain location, Neck, Anterior,
0945	Exacerbation	Pain exacerbation: Exacerbation during activity,
0945	Radiation	Pain radiation: Radiates (FT): denies,
0945	Relief	Pain relief: What relieves the pain? (FT): demerol iv,
0945	Severity	Pain severity: Pain reported as 10, on a 0 to 10 pain scale,
0945	Appearance	Characteristics of appearance, and communication appropriate to situation and age. ,
0945	Behavior	Appropriate, Calm, Cooperative, Crying, Anxious, Mild anxiety,
0945	Safety	Safety: Safety needs managed per Basic Care Protocol, Bed in low position, Siderails up, Right upper, Left upper,
0945	Falls Risk Assessment	Falls Risk Assessment: Medication (1), Sensory deficit (3), Falls Risk Assessment Score: 4,
0945	Emotional Support	Routine: Vented feelings, Discussed hospitalization, Discussed treatment, Emotional support - patient,
0945	Special Equipment	Type: Cervical collar, Management: In place,
1030	GU Out	Voided urine 600 ml, NET URINE OUT (GU OUT - GU IN): = 1600
1134	Severity	Pain severity: Pain reported as 9, on a 0 to 10 pain scale,
1135	Supplemental Oxygen/Measurements	Route: Cannula, Amount: Liters/min 2.00, SpO2 (finger): 94,
1315	Severity	Pain severity: Pain reported as 7, on a 0 to 10 pain scale,
1515	Special Equipment	Type: Sequential lower limb wrap (OPT), Management: In place, Turned on,
1630	Severity	Pain severity: Pain reported as 7, on a 0 to 10 pain scale,

-----

SURGERY PROGRESS NOTE   POD # 1
 02/24/03.08:04 - 02/27/03.08:04
 PAT #: 45207842   AGE: 56 Y   DOB: 01/16/47   SEX: F   ROOM: W327
 ADMIT DATE: 02/26/03.05:43   ADMIT WEIGHT: 63.00 kg   HEIGHT: 157.5 cm   BSA: 1.67 sqm
 ADMIT DIAG: RNP
 MEDICATION ALLERGIES: DR: WARNER, STEPHEN J.

SUBJECTIVE:

② Arm pain gone. Pt very upset over confrontation c staff this am. C/O severe ② Hip pain

MEDICATIONS:

MEPERIDINE (DEMEROL), CA	200.00	CYCLOBENZAPRINE (FLEXERIL)	10.00	SERTRALINE (ZOLOFT), TAB	100.00
MORPHINE, TUBEX	8.00	ONDANSETRON (ZOPRAN), V	8.00	SUMATRIPTAN (IMITREX), T	50.00
CEFAZOLIN (KEFZOL), VIAL	2000.00	PROMETHAZINE (PHENERGAN)	50.00		

VITAL SIGNS													
DATE	TIME	SP / DP	MP	HR	RR	TEMP	WEIGHT	PIO2	SVO2	STO2	GLUCO	GUAIC	PAIN
02/27/03	04:06	121/ 73		80	20	36.7		4.0 L		97			
02/26/03	23:55	97/ 66		74	20	36.6		4.0 L		97			
02/26/03	22:16												9
02/26/03	19:13	137/ 89		83	14	34.8		4.0 L		98			
02/26/03	18:42												8
02/26/03	17:41												2
02/26/03	16:12												8
02/26/03	15:30							4.0 L		97			8
02/26/03	15:14	140/ 80		66	12	34.5							
02/26/03	12:48	128/ 86		72	16	35.3	63.00	4.0 L		97			10

24 HOUR TOTALS

	FEB 24	FEB 25	FEB 26
INTAKE			
Oral Input	0	0	1360
Non-Blood IV	0	0	1702
TOTAL INTAKE	0	0	3062
OUTPUT			
Voided urine	0	0	3050
Stool voiding unkno	0	0	0
Insensible loss	0	0	421
TOTAL OUTPUT	0	0	3471
Net Urine Output			3050
NET BALANCE	0	0	-409
Estimated volume from running infusions, 02/27.06:00-02/27.08:04: 207 ml. This is in addition to the intake volume reported under CURRENT TOTALS.			
WEIGHTS (kg)			63.00
MAX TEMP			36.7

PHYSICAL EXAM:

Neck wound is clean, dry;
 overall good strength in UES.

LABORATORY DATA

CBC & DIFFERENTIAL COUNT

DATE	TIME	WBC	RBC	HGB	HCT	MCV	MCH	MCHC	RDW	PLTS	MPV	NRBC
		10 ³ /UL	10 ⁶ /UL	G/DL	%	FL	PG	G/DL	%	10 ³ /UL	FL	/100WBC
26FEB	06:40			15.0	44.0							

HCT: Test(s) performed on ISTAT analyzer

DATE	TIME	MYELO	BAND	SEG	LYMPH	MONO	EOS	BSO	NEUT	LYMPH	MONO	EOS	BSO
		%	%	%	%	%	%	%	10 ³ /UL	10 ³ /UL	10 ³ /UL	10 ³ /UL	10 ³ /UL

MAJOR CHEMISTRY PANEL

Signature: Stephen J. Warner Date: 02/27/2003

NAME: MORGAN, MIDGE M NO: 45207842 ROOM: W327 SHIFT: FEB 24 08:04 - FEB 27 08:04

DATE	TIME	NA MMOL/L	K MMOL/L	CL MMOL/L	CO2 MMOL/L	GLUC MG/DL	BUN MG/DL	CREA MG/DL	CA MG/DL	TPRT GM/DL	ALB GM/DL	PHOS MG/DL	CHOL MG/DL
26FEB	06:40	137	3.5										
		K: Test(s) performed on ISTAT analyzer											
		NA: Test(s) performed on ISTAT analyzer											

DATE	TIME	TRIG MG/DL	URAC MG/DL	TBIL MG/DL	CBIL MG/DL	UBIL MG/DL	ALKP U/L	AST U/L	ALT U/L	LDR U/L	GGTP U/L	MG MG/DL	AMY U/L
----- STOOL -----													
No Stool data available													
-No PT data available----- PHYSICAL THERAPY NOTES - LAST 24 HOURS -----													

ASSESSMENT/PLAN:

D/C PUBLISHING - CHART REVIEWED. Will
 Follow & Assist if D/C needs arise.
 TRAMER USW

2/28/03

DC - plan home w/ discharge needs
 RW. Smother

Signature:  Date: 02/27/2003

//

June 3, 2003
Midge Morgan - 22110

The patient is seen today for follow-up for her neck and her shoulder. She does report symptoms of neck pain bilaterally in the paraspinal muscles. She is not taking a muscle relaxer or pain medication. The injection into her left shoulder did help significantly but the pain has returned. I had the actual MRI scan for review today. The patient does have a rather significant degeneration of the left acromioclavicular joint with some signal abnormality in the rotator cuff tendon consistent with a rotator cuff tendonitis. This was reviewed directly with the patient. The findings are most consistent with rotator cuff tendonitis and a partial thickness tear. No evidence of a complete thickness tear was noted.

A

REVIEW OF X-RAYS: A flexion and an extension lateral x-ray of the cervical spine were obtained today in the office. I see no motion of flexion and extension. The graft has incorporated quite nicely. The x-rays look very good. From the standpoint of her cervical spine, the patient can be active as tolerated.

IMPRESSION:

revis.
res 3x/day

1. Anterior cervical discectomy and fusion. The x-rays look quite good. I did give her samples of Skelaxin 400 mg po bid to see if we can alleviate some of the paraspinal muscle symptoms that she is having. She also reports this clicking sensation but I think that is some persistent arthritis in the rest of her cervical spine and there is not much I can do about that.
2. Rotator cuff impingement syndrome the patient's left shoulder area was prepared using Alcohol and Betadine. A subacromial injection using Lidocaine, Marcaine and Kenalog was then performed into the subacromial bursa. I am going to initiate a physical therapy program for both her neck and her shoulder. I am going to reevaluate her in 6 weeks. If she continues to have significant symptoms, I am going to have the patient see one of the shoulder specialists such as Dr. Hugh West, Dr. Charles Beck or even Dr. Mike Holmstrom.

Stephen J. Warner, M.D.
SJW: dr

clo ① Hip pain
clo Neck pain & spasms
③ shoulder pain.

Better: Lifting head / massage.

MEDS
1) Promethazine
2) VioX -

July 22, 2003
Midge Morgan - 22110

The patient is seen today for follow up for her shoulder as well as her neck. She complains of spasms in the paraspinal cervical muscle. It involves the muscle primarily near the insertion on the cranium. If she lifts her head up on both sides, it tends to relieve it. Massage helps too. The last time I saw her I prescribed Skelaxin, which helps as well. She has taken Vioxx in the past, but does not take it on a regular basis.

She still has the significant problems with her shoulder, left greater than right. We did do the MRI scan, which shows hypertrophy of the acromioclavicular joint on the left side with a chronic rotator cuff tendinitis.

PHYSICAL EXAMINATION: The patient demonstrates 40-50 degrees of both right and left rotation. She demonstrates 20-30 degrees of flexion and 20 degrees of extension. She still demonstrates a positive impingement sign of both shoulders. Overall, the patient has good strength on examination throughout both upper extremities. I cannot break her strength anywhere on exam including shoulder abduction, external rotation, internal rotation, biceps, triceps, wrist flexion, wrist extension, and pinch strength.

REVIEW OF X-RAYS: A single lateral x-ray of the cervical spine was obtained today in the office. The x-ray looks good. I do not see any change. She has solidly fused.

PROCEDURE: The patient's left area was prepared using Alcohol and Betadine. A subacromial injection was then performed using Lidocaine, Marcaine, and Kenalog into the left acromial space.

IMPRESSION: 1. Neck pain. At this point, the treatment is symptomatic. I am happy to prescribe her the Skelaxin 2-3 per day. I also suggested that she try going on the Vioxx for a continuous period of time to see if it helps. I will continue to follow her along symptomatically.

2. Chronic impingement syndrome, left shoulder. I did another injection into the shoulder today, however if she continues to have significant symptoms she will need to consider subacromial decompression. This can be done arthroscopically. There are several physicians that perform this and I would refer her to one of those for consideration of arthroscopic decompression.

Stephen J. Warner, M.D.
SJW/ha

9/30/03
③ Side neck ache
④ P.S. Tendin
⑥ Facet 7/1

MORGAN, MIDGE
176140
02/11/04
991
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HISTORY OF PRESENT ILLNESS: This is a new patient evaluation of a 57-year-old female regrading bilateral shoulder difficulties, her right worse than her left. She has had pain on and off for several years. She has a history of cervical spine problems for which she has been followed by Dr. Warner. She has had two neck fusions, the first in 2000 and subsequently in February of 2003. During her neck workup, she has had problems with her shoulders, weakness treated initially with injections. Subsequently, an MRI scan was performed which revealed full thickness cuff tear involving the right shoulder and a partial thickness tear involving the left shoulder.

PAST MEDICAL HISTORY: Hypoglycemia, a prior history of skin cancer, nerve impairment, severe headaches, and depression. Please see the orthopedic intake sheet for complete details of the past medical history.

MEDICATIONS: She currently takes Vioxx, Imitrex, Dexedrine, MSM, vitamin E, hormone replacements, calcium, and multivitamins.

ALLERGIES: None to medicines. She does have hay fever.

PHYSICAL EXAMINATION: The patient rates her pain as 9½/10 and severe. She is not able to do any of the 12 simple shoulder test questions. Physical examination of her left shoulder reveals forward elevation active is 95, passive 170. External rotation in abduction is 80, external rotation at the side 60. Internal rotation of the back is to L2. Cross-body adduction is to 10 cm on the right side. On the right side, she has forward elevation active to 95, passive to 160. External rotation in abduction is 95, at the side 85. Internal rotation of the back is to T12. Cross-body adduction is 10 cm. She has mild tenderness over the AC joint, but minimal over the acromion, tuberosities, or biceps. Load and shift is grade I throughout. She has positive Neer and Hawkins on both sides, as well as isolation and stress tests on both sides. Whipple is also positive, as is Speed. Yergason is negative. Lift-off and horn blower are both negative. She has significant periscapular tenderness and tenderness up into her cervical spine posteriorly and periscapular musculature.

RADIOGRAPHS: Her radiographs reveal grade I changes within the glenohumeral joint, grade II changes within the AC joint and type II acromion bilaterally, including four views of each shoulder.

DIAGNOSIS:

1. Right shoulder full thickness cuff tear.
2. Left shoulder partial thickness cuff tear.
3. Bilateral shoulder impingement.
4. Longstanding cervical radiculopathy and degenerative disc disease.

MORGAN, MIDGE
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PLAN: I discussed with the patient her symptoms. She certainly has a significant amount of pain on a daily basis. She has been able to be off narcotics, however. Her MRI scan does reveal a full thickness tear. I am unclear whether or not all the pain is generated is solely from the rotator cuff. She has been followed very closely by Dr. Warner for her cervical spine. She states that he feels they maximize the cervical spine and I have encouraged her to have her shoulders addressed. Given the fact that she does have a documented full thickness tear on the right side, I would approach this one first. This would be an arthroscopic technique including rotator cuff repair, decompression, and careful evaluation of the AC joint. We discussed the risks of surgery including infection, bleeding, numbness, tingling, reactions to the anesthetic, nonhealing of the cuff, recurrence of her symptoms postoperatively. She will follow up with me at the time of surgery.

Michael H. Metcalf, M.D.

MM/dmc

D: 02/13/04 T: 02/16/04 dir: o:\cervantes\04feb\0213c
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Attn: DR. WARNER, STEPHEN J.

DEPARTMENT OF RADIOLOGY
COTTONWOOD HOSPITAL MEDICAL CENTER
5770 South 300 East
Murray, Utah 84107
(801) 314-2370

UTAH RADIOLOGY ASSOCIATES P.C.

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Ordering MD: WARNER, STEPHEN J. Pt Phn: (801) 572-5822
PCP MD: RADA, MARK A. Pt Adr: 79 W GOLDEN HARVEST RD
Admit Dx: MRI LT SHOULDER PAIN POSS TEAR DRAPER, UT 84020
Room #: MRI DOB: 01/16/47.

NAME: MORGAN, MIDGE M STATUS: *** FINALIZED REPORT ***
EXAM: LT MRI Upst Joint WU CNT DATE: 05/10/2003.0059
RSN1: LT SHOULDER PAIN POSS TEAR
RSN2: Unavailable

MORGAN, MIDGE M 10.059

EXAMINATION: LEFT SHOULDER MRI 05/10/03

INDICATION: Injured shoulder February 2003 with shoulder pain and limited motion.

TECHNICAL FACTORS: The following sequences were obtained with dedicated shoulder coil:

- 1) Axial T1-weighted images.
- 2) Axial proton-density images with fat suppression.
- 3) Coronal oblique T1-weighted images through the rotator cuff.
- 4) Coronal oblique fat-suppressed T2-weighted images through the rotator cuff.
- 5) Oblique sagittal T2-weighted images perpendicular to the long axis of the supraspinatus tendon.

FINDINGS

OSSEOUS STRUCTURES/PERIARTICULAR SOFT TISSUES: Motion artifact moderately degrades image quality on multiple sequences. There is extensive increased signal intensity within the acromioclavicular joint and adjacent bones associated with moderate acromioclavicular hypertrophy. The findings suggest active arthropathy as well as hypertrophy. The anterior acromion demonstrates a type II slope. These features moderately narrow the supraspinatus outlet. There is moderate inflammatory change or fluid present in the subacromial subdeltoid bursa.

ROTATOR CUFF: Evaluation of the rotator cuff is somewhat limited by motion artifact. There does appear to be some increased signal intensity within the supraspinatus tendon along its anterior insertion on the greater tuberosity. This may reflect a small, partial, incomplete articular surface tear versus more focal inflammatory change. No complete full-thickness tear is seen. The size of the signal abnormality is about 5 x 6 mm. No muscular atrophy is associated. The subscapularis, teres minor, and infraspinatus tendons appear intact. The long head of the biceps tendon is normally located and within the intratrabecular sulcus.

LABRUM: Evaluation of the glenoid labrum is limited by motion artifact but no

discrete abnormality is apparent.

IMPRESSION

1. Focal, 5 x 6 mm area of abnormal increased signal intensity within the anterior supraspinatus tendon along its articular surface at the attachment on the greater tuberosity which may reflect a small, partial, incomplete articular surface tear.
2. Changes of subacromial subdeltoid bursitis and active acromioclavicular arthropathy and arthritis, moderate narrowing of the supraspinatus outlet by the type II anterior acromion is seen and acromioclavicular hypertrophy is noted.

RADIOLOGIST: Stephen M. Shultz, M.D.

D: 1030 hrs 05/12/03

Attending Radiologist:	SHULTZ, STEPHEN M.	RAD #:	126573
Authenticating MD:	SHULTZ, STEPHEN M.	MR #:	53-91-
Transcriber:	AM	ENC #:	58293903
Date Transcribed:	05/12/03 15:53	UR #:	540720398
Patient Name:	MORGAN, MIDGE M	LOG #:	05/10/2003.0059

Attn: DR. WARNER, ST IL J.

DEPARTMENT OF RADIOLOGY
COTTONWOOD HOSPITAL MEDICAL CENTER
5770 South 300 East
Murray, Utah 84107

UTAH RADIOLOGY ASSOCIATES P.C.

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Ordering MD: WARNER, STEPHEN J.
PCP MD: RADA, MARK A.
Admit Dx:
Room #: MRI

Pt Phn: (801) 572-5822
Pt Adr: 79 W GOLDEN HARVEST RD
DRAPER, UT 84020
DOB: 01/16/1947

NAME: MORGAN, MIDGE M
EXAM: RT MRI Upr Joint WO CNT
RSN1: NECK PAIN DUE TO INJURY AFTER SURGE
RSN2: Unavailable

STATUS: *** FINALIZED REPORT ***
DATE: 11/28/2003.0243

MORGAN, MIDGE M 28.243

EXAMINATION: MRI RIGHT SHOULDER WITHOUT CONTRAST: 11/28/03

CLINICAL HISTORY: Right shoulder pain. Limited range of motion.

TECHNICAL FACTORS: The following sequences were obtained with dedicated shoulder coil:

1. Axial T1 weighted images.
2. Axial proton density images with fat suppression.
3. Coronal oblique T1 weighted images through the rotator cuff.
4. Coronal oblique fat suppressed T2 weighted images through the rotator cuff.
5. Oblique sagittal T2 weighted images perpendicular to the long axis of the supraspinatus tendon.

FINDINGS: Mild degenerative change is present AC joint. Acromion is Type II in configuration. Glenohumeral articulation demonstrates suggestion of minor degenerative change. No focal osteochondral defects are present. Motion artifact, however, somewhat degrades fine detail evaluation of the glenohumeral joint. Rotator cuff demonstrates full thickness tear distal anterolateral margin supraspinatus. Estimated transverse width is 1 cm and length approximately 1 cm. There is no muscular atrophy. Remainder of the rotator cuff appears intact.

Glenoid labrum as visualized is unremarkable. Longhead of the biceps tendon is grossly unremarkable although somewhat limited in evaluation due to motion artifact.

IMPRESSION:

1. Mild degenerative change AC joint as noted above.
2. Full thickness tear distal anterolateral supraspinatus with an estimated gap of approximately 1 cm. No significant muscular atrophy.

RADIOLOGIST: John N. Henrie, M.D.

D: 0907 12/01/03

Attending Radiologist: HENRIE, JOHN N. RAD #: 126573
Authenticating MD: HENRIE, JOHN N. MR #: 00-53-91
Transcriber: JS ENC #: 59985200
Date Transcribed: 12/01/03 09.48 UR #: 540720398
Patient Name: MORGAN, MIDGE M LOG #: 11/28/2003 0243

MORGAN, MIDGE
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02/11/04
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Michael H. Metcalf, M.D.

MM/dmc

D: 02/13/04 T: 02/16/04 dir: o:\cervantes\04feb\0213c
*

PREOPERATIVE DIAGNOSIS: 1. Left shoulder rotator cuff tear.
2. Left shoulder impingement.

POSTOPERATIVE DIAGNOSIS: 1. Left shoulder rotator cuff tear.
2. Left shoulder impingement.

OPERATION PERFORMED: 1. Left shoulder rotator cuff repair.
2. Left shoulder subacromial decompression.
3. Insertion of Marcaine pain pump.

SURGEON: MICHAEL METCALF, M.D.

ASSISTANT: STEVE PEARMAIN, P.A.

COMPLICATIONS: None apparent.

IDENTIFY INFORMATION:

This is a 57-year-old female who had an injury of both shoulders in February of 2003, at that point she was recovering from a cervical spine procedure and had lack of use of her lower legs and injured her shoulders with an attempt to be transferred out of bed. This occurred on February 27, 2003 while in the hospital. She has struggled with bilateral shoulder pain and a massive tear on her right side. She has developed a smaller tear on her left side. She presents at this time for repair of her left shoulder. The risks and benefits have been previously outlined.

DESCRIPTION OF PROCEDURE:

General anesthetic and IV antibiotics were administered by the anesthesia team with the patient in the lateral position. The left upper extremity was prepped and draped in a sterile fashion and suspended via 10 pounds of traction.

The posterior portal was created. Diagnostic arthroscopy of the glenohumeral joint revealed a full thickness tear involving her supraspinatus tendon insertion. The subscapularis was intact. The biceps tendon was intact. There was no evidence of a loose body. The anterior portal was created to allow debridement of the undersurface of the rotator cuff, including the footprint.

**HEBER VALLEY
MEDICAL CENTER**

1485 South Highway 40
Heber City, UT 84032

PATIENT: MORGAN, MIDGE M
MRN: 019735 ENC: 10584027
DOB: 01/16/1947
ROOM: DSCH
PHYSICIAN: MICHAEL METCALF, M.D.
DATE OF SERVICE: 11/18/2004

OPERATIVE REPORT

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The arthroscope was switched to the subacromial space. A lateral portal was established. A complete bursectomy was performed with a motorized shaver and a décompression completed with acromioplasty.

Two accessory portals were created to allow placement of two Mitek Panalok loops, RC suture anchors. Previously, the tuberosity was prepared with decortication. The sutures were passed and tied via arthroscopic knot tying techniques. A Marcaine pain pump was placed in the subacromial space. The area was injected. Portals were approximated with nylon suture.

The postoperative plan will be range of motion; passive only for the first six weeks, then began an active range of motion program.

MICHAEL METCALF, M.D.

MM/mke/cb/mo/kr DD: 11/18/2004 13:21:30 DT: 11/18/2004 13:50:51 VJ:
2069622/2161998/2181021/2183424 DOC: 1402388

HEBER VALLEY
MEDICAL CENTER

1485 South Highway 40
Heber City, UT 84032

PATIENT: MORGAN, MIDGE M

MRN: 019735 ENC: 10584027

DOB: 01/16/1947

ROOM: DSCH

PHYSICIAN: MICHAEL METCALF, M.D.

DATE OF SERVICE: 11/18/2004

OPERATIVE REPORT

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