

1956

Geraldine Huggins v. N. Frederick Hicken : Brief of Respondent

Utah Supreme Court

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STATE OF UTAH

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AUG 30 1956

GERALDINE HUGGINS,

Plaintiff and Appellant,

Clerk, Supreme Court, Utah

vs.

No. 8497

N. FREDERICK HICKEN,

Defendant and Respondent.

BRIEF OF RESPONDENT

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IN THE SUPREME COURT
of the
STATE OF UTAH

GERALDINE HUGGINS,
Plaintiff and Appellant,

vs.

N. FREDERICK HICKEN,
Defendant and Respondent.

No. 8497

BRIEF OF RESPONDENT

INTRODUCTORY STATEMENT

This was an action alleging medical malpractice.

The parties will be designated as they appeared in the trial court.

Plaintiff has appealed from a judgment of the District Court of Salt Lake County, Martin M. Larson, Judge. At the close of the evidence, defendant moved for a directed verdict, which motion was retained under advisement while the jury considered the case. A verdict in favor of plaintiff was returned in the amount of \$7,-

589.00, and the Court, without leaving the bench, set aside the verdict and dismissed the action (R. 363).

The rule asserted by plaintiff at the beginning of her brief, that facts should be viewed in the light most favorable to her, does not contemplate that the Court should be asked to ignore facts against plaintiff or to overlook a failure of proof. Since defendant believes both vices are present in plaintiff's brief, defendant has prepared a Statement of Fact.

Care should be exercised in reading the Transcript, since it is replete with typographical errors.

STATEMENT OF FACTS

Defendant is an experienced surgeon, whose proficiency in the surgical arts has been recognized by certification to membership in the International College of Surgeons, the American College of Surgeons, and the Southwestern Surgical Congress.

In July, 1954, plaintiff consulted defendant about a gall bladder condition. She was then 31 years of age, unmarried and an insurance agent by profession. Plaintiff's gall bladder was removed by the defendant August 2, 1954, at L.D.S. Hospital in Salt Lake City, Utah.

Plaintiff's complaint was in two counts. The second count alleged defendant, during the gall bladder operation, without permission, "... cut plaintiff's uterus free from an attachment to her abdominal cavity, causing

(her) menstrual cycle to increase and become abnormal . . .” (R. 1). The trial court dismissed this count for failure of proof at the end of plaintiff’s case (R. 275). Plaintiff has conceded the ruling was correct, and has not urged its reversal in this appeal.

The first count of the complaint alleged defendant did not properly attend plaintiff, thereby causing her right lung to collapse “subsequent” to the operation. (R. 1) It was admitted by plaintiff on trial that the operation was successful and that her claim of malpractice was confined to the post-operative period. She contended defendant failed to exercise proper skill and render proper care while she was still in the hospital and that he failed to care for her at all during the week she spent at her sister’s home in Granger, Utah, prior to her departure for Wyoming on August 20, 1954.

At a pre-trial hearing conducted by the court on January 6, 1956, three days before trial, counsel and the court agreed, for purposes of this trial, Dr. Hicken would be responsible for any breach of accepted medical standards committed by the doctors who comprised his surgical team in the treatment of plaintiff but that, in considering whether plaintiff was afforded proper care, in accordance with such standards, he would be entitled to the benefit of such professional services as were rendered plaintiff by these doctors. The surgical team which treated plaintiff at the hospital consisted of Doctors Hicken, McAllister, Call, Clayton and Buhler.

Exhibit 21 is a sheaf of hospital documents comprising the original hospital records on plaintiff's case. It consists of 29 pages, which are numbered, in ink, in the upper right hand corner of each page. Most of the pages, although numbered on the front side only, are written on both sides. A reference in this brief to a page of this exhibit may refer to both sides of the page. Pages 20-22 contain a graph, showing pulse rate in red ink, and temperature in blue ink.

The nurses' notes, temperature and respiration charts, and comments of attending physicians reveal that plaintiff's post-operative condition on the afternoon and evening of August 2, and through August 3, and most of August 4, was essentially satisfactory and apparently as to be expected following surgical removal of a gall bladder. Plaintiff was under heavy sedation for pain, was being feed intravenously and had a Levin tube, with continuous suction, running into her nostril and through her throat into her stomach. She was also catheterized, by insertion of a tube in the ureters, at periodic intervals. The operative wound was being drained by another tube. Plaintiff testified she has no coherent memory of anything that occurred for 2½ days following the operation and this same information was given to Dr. William Runel, chest specialist, when she consulted him in June, 1955 (R. 117).

At 4:00 p.m., August 4th, a nurse noted that plaintiff's temperature, respiration and pulse rate had risen

(Exhibit 21, p. 24). Her color was not good. Her breath sounds were abnormal. Remedial measures were commenced at once by Dr. Buhler. By 10:00 o'clock that evening, breath sounds in the lower right lung were more decreased and Dr. McAllister, accompanied by Dr. Clayton, examined her.

It was Dr. McAllister's clinical impression that plaintiff was experiencing the condition known as "atelectasis" (R. 301, Ex. 21, p. 17). This is a medical term meaning imperfect expansion of a lung. (Taber's "Cyclopedic Medical Dictionary" Revised 6th Edition, 1954). It may involve all, or only part of, the lung (R. 301). In plaintiff's case, it apparently involved only the lower portion of her right lung, since the four doctors who examined her in the evening of August 4, and the morning of August 5, all reported that the lower lung was "dull" and "flat" to percussion (Ex. 21, pp. 17-18), but breath sounds were present in the upper portion.

The prompt treatment, ordered by Dr. Buhler at 5:20 p.m. August 4th, and followed by Drs. McAllister, Clayton and Call, brought results and by 1:10 a.m. August 5th, Dr. Clayton found that plaintiff's pulse rate decreased 32 points in one hour (Ex. 21, p. 18).

On the morning of August 5, the anesthesiologist who participated in the operation, Dr. Edward Scott, examined plaintiff and determined that a mucous plug had apparently reduced her breath capacity in the right lung. He aspirated the bronchial tree, causing a cough which

freed the plug, and plaintiff's right lung began its return to normal expansion. (R. 122, 123).

Plaintiff's temperature and pulse rate began to recede to normal levels. Her temperature reached an approximate normal reading, by rectal measurement, in the late evening of August 5. Earlier that day, at a time about 18 hours after the trouble started, the examining physician found her so much improved that she was told to dangle her legs over the bed and to sit in a chair. (Ex. 21, p. 18). She was in a chair for 20 minutes at 10:00 a.m. August 5, 1954. (Ex. 21, p. 24).

An X-ray examination of plaintiff's chest was made August 6 by the hospital radiologists, Dr. Crowder and Dr. Frederick. Their report (Ex. 21, p. 8) revealed "no evidence of atelectasis" and the chest, except for slight hypo-aeration due to shallow respiration, was "normal."

The physicians' progress notes, reflecting their impressions of the plaintiff and their reports of her complaints and attitude, are found on both sides of pages 17 through 20, Exhibit 21. This source reveals that by the evening of August 6, which was 48 hours after plaintiff's difficulties began, Dr. Heaton, intern, noted that "she had no pain, no subjective complaints" and no shortness of breath. (Ex. 21, p. 18). The next day, the breath sounds in both lungs were equal and on August 8, Dr. Call noted that she "ambulates well and looks good." He also reported that plaintiff had "no complaints at present." (Ex. 21, p. 19).

Plaintiff testified on trial that she was in constant pain, of varying intensity, while she was hospitalized, but the nurses' notes, doctors' progress notes and doctors' orders, as found in Exhibit 21, reveal that her complaints gradually diminished, that some of her pain was apparently attributable to gas, since it was relieved by enema (for example, see p. 26, Ex. 21); that she asked for and received a shampoo on August 10, and according to a nurse's note on August 11, was up and about at will.

Plaintiff was discharged about noon August 13. She told the defendant she could not afford hospitalization and that she would convalesce at the home of her sister, a registered nurse, residing in Granger, Utah. She was instructed to report to Dr. Hicken's office in two days for further post-operative care (R. 166).

From the afternoon of August 13 until her departure with her parents for Wyoming on August 20, plaintiff was at the home of her sister, either in or on a bed or resting on a couch. She had what she described as "terrific pain," in her right shoulder and chest, just as she said she had had in the hospital. She was nauseated and could hold nothing on her stomach. She or her family talked either to Dr. Hicken or to one of his associates by telephone on Saturday, August 14, Sunday, August 15 and Monday, August 16. On each occasion, medication was requested, prescribed and received, together with suggestions to relieve the condition. The family also had advice from a doctor who was plaintiff's

brother-in-law, who "looked her over" at the family home, according to plaintiff's witness, James Harmon (R. 223).

Plaintiff's sister, Mrs. Harmon, testified she asked Dr. Hicken, on August 16, to come to the house, but he refused, stating it was too far (R. 242). This was categorically denied by Dr. Hicken, who stated he was sure he had not refused, that if he had, it "would have been the first time in my professional career that I have ever denied services to any patient." (R. 341).

On August 17, Dr. McAllister received a phone call from a drug store in the Granger area, reporting that Dr. Call had been asked to phone a prescription for plaintiff for pain and had not done so. Dr. McAllister inquired concerning the condition which required use of further drug, and when told plaintiff was vomiting and in pain, told the druggist that plaintiff "should be seen whether she desired it or whether she didn't" and that he would go to plaintiff, which he did. (R. 295).

Upon his arrival at the Harmon home, Dr. McAllister examined plaintiff, on a couch in the living room. Her bowel sounds were normal, and nothing was noted by palpation. Pulse and heart action were normal. Lungs were examined by stethoscope and by percussion, without abnormality being found, and the doctor was unable to explain either her pain or her nausea. (R. 296).

Dr. McAllister testified he wanted plaintiff to go back to the hospital, where she could get intravenous feeding, because he was afraid she would become dehydrated from vomiting. He recommended she return, whether she could afford it or not, and told her he was sure some "arrangement could be made" concerning the cost. (R. 298). Plaintiff finally admitted, on cross-examination, that Dr. McAllister had recommended that she go back to the hospital, but she did not go. (R. 169, 255).

Dr. McAllister, on the occasion of his visit, finally agreed to leave more pain medication, but told plaintiff and her sister they must either come to the office or to the hospital the next day — "otherwise, don't call me any more for pain medicine." (R. 298) His recommendation was not followed.

Plaintiff continued to have pain and nausea the next day, Wednesday, and on Thursday. On Friday, August 20, her parents arrived to take her to her home in Rawlins, Wyoming, and they drove her to the outpatient entrance to L.D.S. Hospital. Maude Huggins, plaintiff's mother, of Rawlins, Wyoming, testified that she and her husband prepared the back seat of the car in a comfortable fashion for plaintiff to make the ride to Wyoming, and before they started out on the trip, a call was made to the hospital to see if the doctor "could give her some pills or something to help her pain to see if we could get her home." (R. 231). Plaintiff's testimony was in accord. (R. 137, 138).

Dr. Hicken came to the out-patient department to see plaintiff. At his direction, the requested pain-killing drug was given her. He testified he told plaintiff and her parents that if "this thing was bothering her so much as she said, why didn't she come in and go to the hospital . . .?" (R. 342) This evidence was not contradicted by plaintiff, although it constituted the third recommendation by defendant or his associates, in the period following her discharge from the hospital, that she should be hospitalized. (R. 342, 136, 169, 255).

On direct examination, plaintiff testified that it was on August 20, 1954 that she no longer considered herself under Dr. Hicken's care. (R. 139).

Plaintiff produced testimony from Alta Huggins, from her mother and from herself to show she was hospitalized in Rawlins, Wyoming, the day after she arrived there and that she remained in the hospital 33 days. X-rays were taken in that hospital beginning August 23, and were introduced in evidence through the testimony of Henry Arnold, X-ray technician who was brought here to testify (R. 268, et seq.).

The Wyoming X-ray films, constituting exhibits 7 through 16, were never interpreted for the jury. On the afternoon of the first day of trial, counsel for plaintiff, while Dr. Rumel was under direct examination as plaintiff's third witness, informed the court he desired to ask the doctor certain questions in the absence of the jury (R. 97). The jury was thereupon excused for the

day and Dr. Rumel was questioned regarding standards of medical care, and was then asked to examine and explain the medical significance of X-ray exhibits 7 through 16 (R. 101, et seq.). Plaintiff did not recall Dr. Rumel for such testimony in the presence of the jury, nor did plaintiff ask to have his testimony read or stipulated, and the case went to the jury as if the testimony had never been given.

To establish a standard of medical treatment, to which plaintiff claimed defendant did not conform, plaintiff relied principally upon the testimony of defendant, who was called as an adverse party (R. 38, et seq.), and the testimony of Alta Huggins, plaintiff's cousin, who was a nurse in training in August, 1954, and a registered nurse at time of trial (R. 181). Alta's testimony concerning medical and nursing practice and procedure begins at page 203 in the record.

By these witnesses, it was shown that the prevailing practice in this community in August, 1954, required, among other things, that a patient who had undergone gall bladder surgery, was encouraged to cough, to take deep breaths, and was turned, all at intervals of two hours. The purpose of such treatment was to prevent, if possible, the "onset of atelectasis" (R. 39). Dr. Hicken said that there were "standing rules" at L.D.S. Hospital for such treatment (R. 39). Alta Huggins agreed, stating, when asked if such treatment was "common, routine and proper," "I know it is." (R. 216). She stated that nurses, of course, did not treat patients without orders

from the doctor (R. 220), but that when the doctor ordered coughing, turning, deep breathing and other expected post-operative care, the nurses were trained to give these and other treatments at two-hour intervals, and sometimes more often (R. 205).

She admitted that such orders were given by Dr. Hicken in this case (R. 216). This, of course, was undisputed, since the orders are found in Exhibit 21, p. 9.

Alta Huggins spent a great deal of time by plaintiff's bedside. It was she who first noticed that plaintiff's condition had deteriorated on the afternoon of August 4, which was 48 hours after surgery, and she at once reported this fact to the nurse on duty (R. 188). Dr. Buhler came and commenced the remedial measures with the results previously described.

Concerning the standard of care of a patient in the hospital in post-operative days, after the first orders are given, evidence was received from Alta Huggins and Dr. Hicken, who agreed, in substance, that if the patient appears to be progressing satisfactorily, the doctor's orders would not be changed (R. 126). However, should her temperature and pulse rate rise "above their expected limits," the treatment then to be followed would depend upon the nature or extent of the increase in temperature and pulse rate (R. 49).

Plaintiff's pulse rate rose sharply in the 36-hour period after the operation, and then decreased. Her

temperature rose also, but not as much, comparatively, as did her pulse (Ex. 21, p. 20). Her temperature, in that period, rose to 101.6 degrees by rectum which would be 100.6 degrees orally, since rectal temperatures are one degree higher than oral (R. 312). Forty hours after surgery, her temperature had returned to normal.

During this period, the original orders for the immediate post-operative care of the patient were supplemented by additional orders from four different doctors (Ex. 21, p. 9, 10). There was no evidence that these supplemental orders were medically improper or insufficient under the prevailing standards of care.

Whether the rises in temperature and pulse were higher than was to have been expected in gall bladder surgery was never shown by any testimony. The inference to be drawn from the hospital records, however, is that the increases apparently were not unexpected, since Exhibit 21 reveals that plaintiff's progress in this period was observed and noted in the record by Doctors Hicken, McAllister, Call, Clayton and Buhler, and by Nurses Briggs, Bromfield, Cordey, Thompson, Christensen, Hansen, Paulsen and Webb, none of whom made any entry on any record indicating alarm or dissatisfaction with plaintiff's recovery.

With reference to plaintiff's contention that defendant was negligent in the care of plaintiff following her trouble on August 4th and 5th, in that he did not order additional X-ray of her chest, it will be recalled that an

X-ray of the chest was ordered on the morning of August 6. The chest was normal. Plaintiff contends that additional X-rays should have been obtained during the next week, although there was no evidence that good practice required additional X-rays or that plaintiff's subjective or objective symptoms were of such a nature that further use of X-ray was indicated by good medical practice.

With regard to plaintiff's final claim of negligence, which was to the effect that defendant "failed to give the proper care and attention" (Brief, p. 21) which plaintiff's condition required while she was at her sister's home, the record concededly contains no evidence of what care and attention would have been proper. The record reveals that there were telephone consultations with one or more of the doctors on each day for the 6-day period, and that Dr. McAllister visited and examined plaintiff on the evening of the 4th day. There was no evidence that this was insufficient or that plaintiff suffered injury or damage she would not have experienced otherwise.

At the close of plaintiff's evidence and again at the close of all the evidence, defendant moved the court for a directed verdict. The motions were considered by the court while the jury deliberated. Following return of a verdict in favor of the plaintiff, the trial court reported that he had carefully reviewed the record while the jury was deliberating. From that examination he concluded that he could "... find no evidence in the record from

which the jury could find that the plaintiff's pain in her chest and troubles, had any relationship to any act, or lack of action on the part of Dr. Hicken . . ."

The court thereupon set aside the jury's verdict, granted the motions by the defendant and dismissed the action. Plaintiff did not file a motion for new trial, but appealed directly to this Court.

STATEMENT OF POINTS

POINT I.

THE TRIAL COURT CORRECTLY GRANTED DEFENDANT'S MOTION FOR DIRECTED VERDICT AND SET ASIDE THE VERDICT, BECAUSE THE EVIDENCE WAS INSUFFICIENT TO SHOW EITHER NEGLIGENCE, THE NATURE OF PLAINTIFF'S AILMENT, OR ANY CAUSAL RELATIONSHIP BETWEEN THEM.

ARGUMENT

POINT I.

THE TRIAL COURT CORRECTLY GRANTED DEFENDANT'S MOTION FOR DIRECTED VERDICT AND SET ASIDE THE VERDICT, BECAUSE THE EVIDENCE WAS INSUFFICIENT TO SHOW EITHER NEGLIGENCE, THE NATURE OF PLAINTIFF'S AILMENT, OR ANY CAUSAL RELATIONSHIP BETWEEN THEM.

Since plaintiff's claim of negligence has been divided by her in her brief into two periods, the first consisting of the period from the time of surgery until hospital

discharge, and the second from hospital discharge until her departure from Utah seven days later, her claim will be discussed in the same division, and in the same order.

HOSPITALIZATION FOLLOWING SURGERY:

This period of time extends from the conclusion of surgery at 3:25 p.m. August 2, 1954 to plaintiff's discharge at noon, August 13, 1954. Plaintiff first contends that during the period immediately following surgery, the standard of medical care prevailing in this community and the routine procedure at L.D.S. Hospital required that the plaintiff be coughed, turned and encouraged to breathe deeply at two hour intervals. Plaintiff next contends, through the testimony of her cousin, Alta Huggins, and by reference to the hospital chart, that plaintiff did not receive this treatment.

However, it is undisputed that following surgery, seven post-operative orders were issued for the treatment of this patient, including the order to "turn, cough and encourage deep breathing and leg exercises." (Exhibit 21, p. 9). Alta Huggins conceded that such orders were given and were proper. It is therefore clear that this standard of medical care was followed by defendant and his responsibility to issue proper orders was fully discharged.

If plaintiff did not receive the treatment contemplated by the standard and by the rules of the hospital,

such failure was the responsibility of hospital personnel, and could not be attributable to the defendant, unless and until some fact occurred which, in the exercise of proper professional practice, should have put him on notice that his orders were not being followed, and he thereafter failed to remedy the situation.

Plaintiff has admitted that this is the law. The court so instructed the jury, by its instruction No. 19. Plaintiff did not except to this instruction and, under familiar doctrine, the principle is the law of this case. It is also the law generally. The rule is well stated by the United States Circuit Court of Appeals for the District of Columbia, in *Hohenthal vs. Smith* (1940), 114 Fed. 2nd, 494, where it is said:

“ . . . where employees of the hospital are negligent in carrying out the surgeon's instructions as to treatment after the operation, the overwhelming weight of authority holds that the surgeon is not liable in the absence of a showing that he was negligent in giving the instructions or selecting the persons to carry them out, that he was present and could have avoided the injury by exercising due care, or that his special contract relative to the negligent employee was such as to make the doctrine of respondent superior applicable. . . . Part of the service furnished to the patient and charged for by the hospital is the assistance of nurses, interns and attendants in caring for the patient after the operation pursuant to instructions given by the operating surgeon. They perform the duty of their employer (the hospital) to the patient when they carry out the instructions of the doctor. . . . ”

Plaintiff, however, asserts that if defendant had conformed to accepted medical standards, he would have observed facts which would have put him on notice that his orders were not being followed by hospital personnel. In support of this contention, it is claimed that plaintiff's temperature and pulse rate increased during the night following surgery, and on the next day, to such an extent that defendant ought to have known, as a competent surgeon, that his orders were not being followed, or that his orders were insufficient.

The difficulty with this contention, however, is that there was no evidence that the increase in temperature and pulse was more than was to have been medically expected in the first hours following surgical treatment of cholecystitis, which is the medical term for plaintiff's illness.

Moreover, plaintiff's repeated assertion that plaintiff was not "turned," because that word appears infrequently upon the nurses' notes, which she asserts should have put the doctor on notice that his orders were being ignored, is completely refuted by other portions of the hospital record and the record of this trial. It is undisputed plaintiff was receiving repeated injections for pain, which were of the type that are given in the buttocks, which requires turning on one side or the other (R. 328). Further, it was not disputed, and, in fact, it is known by any person who has ever been hospitalized, that when a patient is "made comfortable," or given

“routine care,” or given a “bed bath,” that the patient is moved so that soothing lotions may be rubbed on the back, that bed linen is smoothed or changed or that bed clothes are changed (R. 217, 328).

It is further within common knowledge, and certainly within the knowledge of the doctors on a case, that when a patient is in pain, she will not remain absolutely still, as plaintiff seems to imply, but will turn and change her position of her own volition. Dr. Hicken so testified (R. 43).

Plaintiff asserts in her brief, page 20, that she was “turned” only four times in 43 hours, but the record shows that she was either turned, given a bed bath, given medication for pain, made comfortable, given routine care, catheterized, or received a rectal tube, on 18 occasions in that period, or an average of more than once each $2\frac{1}{2}$ hours, not including examination by doctors (Ex. 21, pp. 23, 24).

It is, therefore, clear that plaintiff’s claim that she was “turned” only when that word appeared on the hospital record, constitutes an unreasonable, improbable and improper inference from the facts in this record. The trial judge noted this defect in plaintiff’s case at the time of his decision. (R. 363).

On the morning of August 3rd, the first post-operative day, Dr. McAllister noted she was “doing well.” The next morning, her temperature was normal. Dr. Hicken

testified he was of the opinion that his orders were being carried out. No doctor ever testified that conformance to medical standards would have required Dr. Hicken to reach a different conclusion, under these circumstances.

There is, therefore, no showing that a competent doctor, conforming to medically accepted standards of treatment in post-operative gall bladder cases, would have been placed on notice that his orders were being ignored, or that such a doctor would have done more than the defendant did.

Beyond this, however, is the fact that there is absolutely no basis to be found in this record for the assertion by plaintiff, in her brief at page 20, paragraph numbered 2, that defendant failed to observe the elevation of pulse and temperature, or having noted them, failed to take remedial measures. The record shows, in Exhibit 21, pages 9 and 10, that the original doctor's orders were supplemented during this period by eight additional orders, entered in writing by four separate doctors. These new orders directed the administration of certain fluids, drugs and chemical compounds, together with the use of such apparatus as was required to facilitate their application. Plaintiff has not only failed to mention these orders, but failed to show, on trial, that they were improper or insufficient under prevailing medical standards of treatment for such conditions.

On this phase of the case, therefore, plaintiff did not uphold her burden of proof, which required her, under

long-established doctrine, to produce facts tending "affirmatively to show that the defendant . . . did not exercise such reasonable care, skill and diligence as ordinarily is exercised . . ." by skilled surgeons in Salt Lake City in the treatment of such cases. *Baxter vs. Snow*, 78 Utah 217, 2 P. 2nd 257.

Plaintiff has apparently now abandoned any claim that defendant or the hospital were negligent in the treatment of her extraordinary complications which appeared on the afternoon of August 4th. Her reason is clear, for the hospital chart (Exhibit 21) reveals that during the course of this treatment, and extending through the morning of August 6th, there were recorded 52 visits by nurses, and examinations or treatments by 8 separate doctors.

The next assertion of negligence relates to the period from August 6th to the date of discharge on August 13th. Plaintiff contends that, during that week, her symptoms of pain in the chest, rise and fall in temperature, and continued requirements of heavy sedation for pain, all indicated the need for further X-ray examination. Again, however, no evidence was offered or received that such symptoms as plaintiff displayed in this period would have required, under prevalent medical standards, that a competent physician undertake additional X-ray examination. Plaintiff impliedly recognizes this defect in her case by asserting in her brief that X-ray is such an accepted method of diagnosis that the need for its use

need not be established by expert evidence. The cases cited in support of this proposition contain correct principles of law in view of the facts in such cases. However, no case comparable to the present case has been cited in plaintiff's brief. While X-ray is of obvious assistance in many cases, such as in detecting the nature and extent of fractures, or the presence of foreign objects and tumorous masses, it cannot be said to be a matter of common knowledge or judicial notice that good medical practice requires a surgeon to use X-ray because his patient complains of pains after major surgery.

It must also be kept in mind that an X-ray was taken by a competent specialist in radiology on August 6, 1954, and had been interpreted by him as essentially normal. The record further shows without contradiction that the X-ray films were examined by Drs. Hicken and McAllister and that they concurred in the interpretation of the radiologist, Dr. Frederick.

Plaintiff's contention seems to be that one X-ray was not enough, and that defendant ought to be liable because he did not obtain more than one. A similar contention, in a fracture case in Idaho, was rejected by the Ninth Circuit Court of Appeals in the case of *Moore vs. Tremelling* (1935) 78 Fed. 2nd 821, where, as here, no evidence was produced by plaintiff that local medical standards required more than one X-ray. Without such evidence, the Court said, there is ". . . no proof that the appellant did not exercise such professional skill and

care as were reasonably to be expected in that locality.”

In *Boyce vs. Brown* (Arizona, 1938), 77 Pac. 2nd 455, plaintiff urged that it was negligence to fail to take an X-ray of an ankle, many years after the defendant had reduced a fracture by surgical open reduction. Plaintiff said such failure was “such obvious negligence that even a layman knows it to be a departure from a proper standard.” The Arizona Supreme Court did not agree, stating:

“It is true that most laymen know that the X-ray usually offers the best method of diagnosing physical changes of the interior organs of the body, and particularly of the skeleton, short of an actual opening of the body for ocular examination, but laymen cannot say that in all cases where there is some trouble with the internal organs that it is a departure from standard medical practice to fail to take an X-ray.”

Since plaintiff did not produce evidence from a competent medical practitioner that additional X-ray was required in order to conform to accepted practice, the jury should not have been allowed to speculate and should not have been allowed to substitute, in retrospect, its untrained and lay judgment for the training and experience of a qualified doctor, familiar with medical standards of care in this community.

CONVALESCENT PERIOD AFTER HOSPITAL DISCHARGE:

Plaintiff's final contention is that in the six day period following her discharge, while she was in con-

valescence at the home of her sister in Granger, Utah, Dr. Hicken failed "to apprise himself of or discover the seriousness of" plaintiff's "lung complications." Plaintiff in effect alleges a form of abandonment of his patient by the defendant. Plaintiff's proof, however, fails to support this charge in that there was no proof to show what defendant should have done that he did not do, except that plaintiff contends he should have visited her on August 16, 1954, when her sister requested him to come.

Plaintiff failed to establish by any medical evidence whatsoever that the daily telephone consultations with the defendant, or with one or more of his associates, and Dr. McAllister's visit and examination on August 17th, were insufficient for the defendant to apprise himself of plaintiff's condition.

The United States Court of Appeals for the District of Columbia, in a leading case decided in 1948, was confronted with the same plea by a plaintiff who alleged that the defendant doctor had failed to inform himself as to the condition of his patient, and had failed to call upon her when asked to do so. Justice Stephens, speaking for the Court, ruled:

"... it is not shown that such daily examination was required in the exercise of proper professional care. Nor is it shown that Dr. Lawson could not properly, in view of the nature of the ailment, inform himself, as he did . . . through

frequent telephoned reports of Mrs. Rodgers' condition after she returned home . . ."

The Court held that the case, which involved care of a postnatal breast condition, involved

" . . . a question of the merits of a diagnosis and scientific treatment. This cannot be determined by a lay jury without the aid of expert opinion . . ."

Finally the Court rejected the argument, which is also made in the case at bar by plaintiff, that the presence of pain required the doctor to act. Proof of pain for an extended period, without more, does not evidence neglect, according to the Court, and there was no evidence that due professional care required the administration of sedatives. *Rodgers vs. Lawson* (1948) D. C., 170 Fed. 2nd 157.

Further, plaintiff has completely failed to show, as we believe is required in a case of alleged abandonment, that the results which the plaintiff encountered were otherwise than would have been the case if the alleged abandonment had not occurred. This principle was recently affirmed by this Court in stating the proof which should have been made by a plaintiff in a case of alleged abandonment. *Spendlove vs. Georges*, 4 Utah 2nd 393, 295 P. 2nd 336.

Beyond this, however, is another glaring weakness in plaintiff's case—a weakness recognized by the trial

court when he dismissed the action (R. 361). Even if there had been competent evidence of the medical standards which defendant is alleged to have breached, there was no evidence upon which a jury could properly find a causal relationship between the breach and plaintiff's ultimate physical condition.

A jury should not be allowed to speculate that an unidentified physical ailment proximately resulted from the doctor not having done more than he did in his treatment. This principle has been recognized by this Court repeatedly.

In *Anderson vs. Nixon* (1943), 104 Utah 262, 139 P. (2d) 216, the patient had developed osteomyelitis and he alleged that the defendant doctor negligently failed to recognize that condition and negligently failed to treat him for it properly, in that he should have ordered blood transfusions. Under the evidence this Court held that there was sufficient evidence for a jury to consider on the question of whether or not the defendant was negligent in failing to apprise himself of the plaintiff's condition by the use of available blood tests.

However, on the question of the causal relationship between this failure and the end result, the Court stated:

“There was no expert evidence in this case that if defendant had done these things at that time the condition which caused the eventual amputation of plaintiff's leg could have been avoided. Osteomyelitis being a disease the cause

and cure of which is peculiarly within the knowledge of medical men and not a matter of common knowledge, it is necessary to have expert testimony on the effect of the negligence of a doctor on the end result. . . . In the absence of such expert testimony there is nothing upon which a jury can base its finding on the proximate cause of the injury. A jury may not conjecture or speculate, but must have substantial evidence upon which to base a verdict."

To the same effect are both earlier and later Utah cases. *Edwards vs. Clark* (1938), 96 Utah 121, 83 P. (2d) 1021; *Jackson vs. Colston* (1949), 116 Utah 295, 209 P. (2d) 566.

The principle announced in these cases should be even more forcefully applied where, as in the present case, plaintiff has not only failed to show causation, but has failed to establish or define, except by vague generalities, the injury which allegedly resulted.

Plaintiff describes her ultimate condition as "lung complications." That this term may encompass any one or more of a vast number of ailments of the human breathing apparatus is so obvious as to require no citation of authority, either medical or legal. That such ailments may result from a multitude of causes, either singly or in combination, is equally clear.

The only evidence offered to aid the jury in determining what had occurred after plaintiff left Utah consisted of testimony from plaintiff and her family of

her pain, her nausea, and her hospitalization in Wyoming, together with X-ray films which were introduced in evidence by the testimony of the technician who operated the X-ray machine in the Wyoming hospital and who was brought here to testify. Although plaintiff said she was treated by two physicians in Wyoming, neither was brought here to testify nor was there any attempt to obtain the testimony of these, or any other doctors, either by oral deposition or written interrogatories.

The X-ray films from Wyoming, although in court during most of the trial, were never interpreted for the jury, even though at one time or another five physicians were present in court, subject to call. Thus the jury was allowed to interpret X-rays and to base a verdict, in part, upon its untrained observation of X-ray films, when it is a matter of common knowledge that even medical men often have difficulty in interpreting such films despite their training and experience.

An example of this difficulty is found in that portion of Dr. Rumel's testimony which was presented to the jury. He was shown two X-ray films of plaintiff's spinal area. But, despite his obvious ability to interpret X-rays, he declined to comment upon the films handed him, stating:

“I'm supposed to know about chests. These are spine tones. . . . “I'm not supposed to know about that. . . . I don't pretend to know that.”
(R. 90, 91).

The only "aid" afforded the jury in understanding the X-rays was upon final argument of plaintiff's counsel, who placed some of the films in the view box and attempted to interpret them to the jury. He claimed that they showed damage and deterioration of the lung, and that the condition obviously resulted from defendant's lack of care.

Counsel, of course, did not go so far as to claim that his argument constituted evidence or that he was a medical expert on lung conditions or their causes. However, since there was no proof, his statement of cause and effect may have impressed the jury of laymen as being at least logically correct.

Members of the jury, it will be recalled, were not permitted to hear Dr. Rumel's testimony that the lung condition portrayed in the Wyoming X-rays can result in "an hour or two," from a number of different causes, of which an embolus, or blood clot, would be "statistically the most common" (R. 112, 113).

From what has been said regarding proof of events following plaintiff's discharge from L.D.S. Hospital, it is clear she did not prove a medical standard or a departure therefrom, did not prove the nature of the injury she allegedly suffered and did not prove that any other result would have been reached had the defendant done more, or other, than he did.

CONCLUSION

Defendant believes it clear that no judge, and particularly a judge with long experience on the bench and at the bar, lightly sets aside a substantial verdict which has been awarded to plaintiff only moments earlier. When such a verdict is reversed, it is because the trial court finds that his duty compelled the act.

We earnestly contend that upon the written record only in this case, a record which reveals neither negligence nor proximate cause, the trial court was required to dismiss this action as a matter of law.

His judgment, based not only upon the written record, but upon his personal observation of the witnesses and all other factors in the trial, factors which are never discernible on the printed page, was sound, both in principle and in precedent and such judgment ought to be affirmed by this court.



Should the Supreme Court reject the foregoing argument and find it necessary to reverse the order of the trial court, defendant urges that the verdict ought not to be reinstated and judgment entered thereon, because defendant believes he is entitled in such event, as a matter of law, to a new trial, and in support of such contention, defendant relies upon the following additional Statement of Points, which he asks that the Supreme Court consider if, and only if, the Court finds it necessary to reverse the order of the trial court.

ADDITIONAL STATEMENT OF POINTS

POINT I.

THE TRIAL COURT COMMITTED ERROR, SUBSTANTIALLY PREJUDICIAL TO THE DEFENDANT, IN ITS INSTRUCTIONS TO THE JURY NUMBERED 6, 7, 10, 11, 14, 17 AND 18.

POINT II.

THE TRIAL COURT COMMITTED ERROR, SUBSTANTIALLY PREJUDICIAL TO THE DEFENDANT, IN REFUSING TO INSTRUCT THE JURY IN ACCORDANCE WITH DEFENDANT'S REQUESTS NUMBERED 1, 3, 8, 15, 17 and 19.

POINT III.

THE TRIAL COURT COMMITTED ERROR SUBSTANTIALLY PREJUDICIAL TO THE DEFENDANT, IN RECEIVING EVIDENCE REGARDING PLAINTIFF'S PHYSICAL CONDITION, AND MEDICAL TREATMENT AFFORDED HER IN THE STATE OF WYOMING FOLLOWING AUGUST 20, 1954, AND RELATING TO HER PHYSICAL CONDITION SINCE HER RETURN FROM WYOMING, BECAUSE NONE OF SUCH EVIDENCE WAS PRECEDED BY A PROPER FOUNDATION SHOWING A CAUSAL RELATION WITH ANY ACT OR OMISSION CHARGED AGAINST DEFENDANT.

ADDITIONAL ARGUMENT

POINT I.

THE TRIAL COURT COMMITTED ERROR, SUBSTANTIALLY PREJUDICIAL TO THE DEFENDANT, IN

ITS INSTRUCTIONS TO THE JURY NUMBERED 6, 7, 10, 11, 14, 17 AND 18.

The instructions given the jury by the trial court were inadvertently omitted by the clerk of the lower court at the time the record was transmitted to the Supreme Court, and were forwarded under separate certificate dated August 7, 1956. The instructions are therefore not serially numbered with the remainder of the record, and must be examined by number.

Instruction 6 is a "stock" instruction relating to the terms "negligence," "ordinary care" and "proximate cause." It is believed to be objectionable in a case of alleged medical malpractice, which is essentially a specialized branch of the law of negligence. It allowed the jury to consider the standard of the "reasonably prudent person," and stated:

"The duty is dictated and measured by the exigencies of the occasion."

Instruction 7 carried this same thought forward, and applied it to this case stating that the jury could find the defendant liable if it determined:

"... that he was careless or negligent in caring for the plaintiff. . . ."

This is not the test in medical negligence cases. The true measure is whether there was exercised "that degree of care and skill considered proper by correct

and accepted standards of the profession. . . ." *Forrest vs. Eason* (Utah, 1953), 261 P. (2d) 178.

The trial court, of course, recognized this rule, and informed the jury, in its Instruction 17, that it was required to consider what the medical standard was when it determined "whether the defendant and the other doctors associated with him properly fulfilled the duties imposed upon them. . . ." This, however, was near the end of the instructions, and long after the jury had been told they could find defendant liable if he disregarded ordinary prudence. Further, this instruction contained the first reference to "other doctors associated with" defendant, and the jury may well have considered this not to be a modification of the earlier instructions which related to the defendant alone.

Instruction 17 further did not cure the error in the earlier instructions, because it did not properly tell the jury how the medical standard of care should have been proven. It allowed the jury to determine the standard "through evidence presented in this trial as to such standards and practices." Nowhere was the jury told that the evidence must have been presented by medical experts and since plaintiff relied heavily upon the testimony of her cousin, Alta Huggins, a student nurse at L.D.S. Hospital, to discuss hospital and medical practice, it seems clear that the jury was allowed to consider other than medical evidence in determining the medical standard.

This constituted prejudicial error. This was a case involving the determination of the care which ought to be given, post-operatively, to a person with the disease of cholecystitis. As such, the general rule announced by this Court in *Fredrickson vs. Maw* (1951), 227 P. (2d) 772, should govern. The Court said:

“... in those cases which depend upon knowledge of the scientific effect of medicine, the results of surgery ... whether the attending physician exercised the ordinary care, skill and knowledge required of doctors in the community which he serves, must ordinarily be established by the testimony of physicians. There is, however, another well-recognized rule holding that when facts may be ascertained by the ordinary use of the senses of lay witnesses, it is not necessary that expert testimony be produced and relied upon.”

This is obviously not a case where “facts may be ascertained by ordinary use of the senses of lay witnesses.” As the Court stated, such cases are usually the so-called “sponge” cases, where an object, foreign to the body, is left within it. We have found no case, and plaintiff has cited none, where the “sponge case rule” has been extended to embrace facts such as were before the Court in this case.

It is no answer to the foregoing to say that the trial court corrected its errors regarding the medical standard by its Instruction 18, which further explained the test to be applied by the jury. The test, said the court, was whether the plaintiff “was treated with the same

methods, skill and care ordinarily used in like cases by surgeons in hospitals in the neighborhood, *and* given the attention and treatment usually and ordinarily given to such patient *by nurses and attendants.*" (Italics supplied).

This instruction not only did not mention the requirement that the evidence of the standard must come from medical testimony, but allowed the jury to believe that the defendant was responsible for the care given by nurses and attendants, which, as has been pointed out earlier in this brief, is not the law generally, nor the law of this case, and was directly contradictory with the court's instruction 19.

Under Instruction 18, since there were two tests given the jury to consider, and since they were stated conjunctively, the jury could find that unless the plaintiff was treated with the same methods, skill and care ordinarily used in like cases by surgeons in this vicinity and also received care from nurses and attendants ordinarily given such patients, the defendant would be liable. Thus, if the jury found that either test was not met, it was told defendant would be liable, yet the responsibility of hospital care was clearly not his if he gave proper orders, which he did, and if nothing occurred to put him on notice they were not being followed.

Defendant contends Instructions 10 and 11 were improper in a number of particulars. Instruction 10 purports to inform the jury of the plaintiff's claim of negli-

gence, and submits, for jury consideration, elements of the claim which were not supported by any substantial evidence. Instruction 11 informed the jury what its verdict should be if the elements in No. 10 were proved.

Since Instruction 10 is divided into paragraphs designated (a) through (e) the objectionable portions will be discussed under similar headings.

10(a): This paragraph advised the jury of the claim that “defendant failed and neglected to visit plaintiff and examine her condition as frequently as was the standard . . .” of surgeons in Salt Lake City in similar cases. From what has been said in the earlier portions of this brief, it is clear that there was no evidence of any kind as to such standard. Defendant, when called as an adverse witness for the purpose of establishing a medical standard, was never even asked about the “frequency of visits or examinations,” nor was any other doctor.

In addition, this portion of the instruction was limited to the defendant alone, although it was clear that defendant’s associate doctors should have been mentioned, as they were later, in Instruction 17.

10(b): Here, the jury was told of the claim that defendant had failed to issue proper orders and directions to the nurses. This should not have been submitted to the jury, in view of the undisputed evidence that such orders were, in fact, given immediately following surgery and in view of the further fact that there was never any

evidence that the additional orders, in the days that followed, were improper or insufficient under the prevailing standard of care, or that the orders which were given were improper.

10(c): This stated that plaintiff claimed that defendant “did not see that the nurses and attendants obeyed and fulfilled his orders.” He was not required to take such action, unless and until some fact occurred which put him on notice that his orders were not being obeyed or fulfilled. The jury should have been so told, in this instruction, because, in Instruction 11, the court stated that if plaintiff had proved the matters set forth in the sub-paragraphs of Instruction 10, they should find for plaintiff. Hence, it is natural they would look only to No. 10 and not feel required to search through the entire set of twenty-five instructions to see if the formula given them in Instructions 10 and 11 was modified.

10(d) and (e): By these paragraphs, the jury was advised that plaintiff claimed she developed and suffered a collapsed lung as a result of neglect of the defendant, and that she endured physical and mental pain and suffering and was impaired in body, as a result of the collapsed lung. As has been pointed out repeatedly in this brief, there was no substantial evidence to this effect, and it is fundamental that a question should not be submitted for jury consideration unless it is supported by such evidence.

Finally, defendant asserts that while the instructions, as a whole, contain many correct statements of the principles of law involved, the jury could not have applied them as the court intended them to be applied, in view of the flat statement by the Court, in Instruction 11, that if the elements set forth in the sub-paragraphs of Instruction 10 were proved, the jury's verdict "should be in favor of plaintiff . . . , and you must assess plaintiff's damage."

It is unlikely that any jury, regardless of the merits of the instructions as a whole, would overlook the opportunity presented by such a peremptory formula for decision.

POINT II.

THE TRIAL COURT COMMITTED ERROR, SUBSTANTIALLY PREJUDICIAL TO THE DEFENDANT, IN REFUSING TO INSTRUCT THE JURY IN ACCORDANCE WITH DEFENDANT'S REQUESTS NUMBERED 1, 3, 8, 15, 17 and 19.

Defendant has already stated, in the main argument in this brief, his reasons why he believes the court should have instructed the jury in accordance with defendant's Request No. 1, which was a request for directed verdict.

Defendant's request No. 3 was given in part by the Court in its Instruction 19, but the court omitted the most important part of the request, which was to the effect that evidence of medical standards ought to have

been received from a doctor or doctors called as expert medical witnesses. This has already been discussed by defendant in the argument under the preceding point wherein the general rule set forth in the case of *Fredrickson vs. Maw* was discussed.

Defendants Request No. 8, although marked by the trial court as “covered” was not given, even in part. This Request, in substance, would have instructed the jury that the plaintiff, to sustain her burden of proof, was required to show by a preponderance of the evidence that the injury allegedly suffered by her would not have occurred without neglect by the defendant, and that plaintiff would not satisfy that burden of proof unless she showed that the result would probably have been different had the defendant acted with due care.

Failure to give this Request deprived defendant of one of the theories of his defense. The theory was based upon the rule to be drawn from the previously discussed case of *Anderson vs. Nixon*, 139 P. (2d) at page 220. It will be recalled that that case involved osteomyelitis and the effect of blood transfusions on the progress of that disease. There was no evidence that if the defendant doctor had given blood transfusions the end result would have been avoided. This constituted a fatal defect in the case, according to the opinion of this Court.

Defendant's Request No. 15 set forth the defendant's theory that he could not be held responsible for any in-

jury of plaintiff which resulted from the failure of due care of hospital personnel, unless and until some fact occurred by which he knew, or should have known, that the orders he had given were not being followed and that he thereafter failed to take corrective measures and that as a result of such failure plaintiff was injured.

The trial court marked upon this Request the words in ink "substance covered."

Later while the jury was in deliberation there was written by the court, in pencil, the words "should probably have been given". We submit the reason for the latter comment was that the court's instruction No. 19, which attempted to cover the matters contained in this Request, failed to apply the principal of proximate causation to this theory of defense, and thus failed to present completely one of the theories upon which defendant had relied.

Although defendant's answer was amended by leave of court, asked and obtained at pre-trial, to include the defense of contributory negligence, the court refused to give defendant's Request No. 17, which set forth another theory of defense. Although there had been considerable emphasis placed by defendant upon the plaintiff's failure to follow the recommendations of Dr. McAllister and Dr. Hicken on August 17, 19 and 20, 1954, which recommendations were to the effect that plaintiff ought to return to the hospital, the court re-

fused this request with the comment "outside issues". This was an apparent inadvertence on the part of the trial court since defendant's answer contains, upon the margin of the first page, this notation by the trial judge: "Deft. permitted to amend to include contributory".

It will be noted that the Request concerning contributory negligence sought merely to mitigate damages to the extent that if the jury found that plaintiff had failed to follow her doctor's recommendation, she would not be entitled to any sum for damages suffered from that time forward.

Defendant's Request No. 19 was tendered for the purpose of informing the jury that it should not consider Dr. Hicken's conduct alone on this case, but should consider the conduct of his associate doctors, and if such doctors failed in their duty toward plaintiff, such failure would be chargeable to the defendant, but if they assisted in the performance of such duty, such assistance would be to the benefit of the defendant and could be considered by the jury as if defendant himself had performed such acts.

This theory was in accord with the understanding reached by the court and counsel upon the pre-trial hearing and was the theory upon which the case was tried to the jury, even though plaintiff continually emphasized the alleged failure of Dr. Hicken personally to visit or treat plaintiff.

The theory was mentioned by the court in its Instruction 17, wherein the jury was instructed concerning the method of determining a proper standard of medical care. The court began that Instruction by stating “In determining whether the defendant *and the other doctors associated with him properly fulfilled the duties imposed upon them.*”

Plaintiff did not except to this Instruction and it was noted that throughout the trial plaintiff was perfectly willing to follow this theory of “doctors in association” whenever it best suited her purpose.

Failure to give this instruction constituted prejudicial error, which was specifically recognized by the trial court in his decision at the end of the case (R. 362).

POINT III.

THE TRIAL COURT COMMITTED ERROR SUBSTANTIALLY PREJUDICIAL TO THE DEFENDANT, IN RECEIVING EVIDENCE REGARDING PLAINTIFF'S PHYSICAL CONDITION, AND MEDICAL TREATMENT AFFORDED HER IN THE STATE OF WYOMING FOLLOWING AUGUST 20, 1954, AND RELATING TO HER PHYSICAL CONDITION SINCE HER RETURN FROM WYOMING, BECAUSE NONE OF SUCH EVIDENCE WAS PRECEDED BY A PROPER FOUNDATION SHOWING A CAUSAL RELATION WITH ANY ACT OR OMISSION CHARGED AGAINST DEFENDANT.

The evidence to which defendant objects and which was received erroneously consisted of exhibits relating

to charges for medical care and hospitalization claimed by plaintiff to have been incurred in Rawlins, Wyoming, following her departure from Salt Lake City. There was no proper foundation for this evidence.

There was no showing of the nature of plaintiff's ailment which required treatment or hospitalization and no evidence that the expenses were attributable to any act or omission upon the part of the defendant.

The evidence was also improperly received because it was not submitted by any testimony that the charges made by the Wyoming doctors and hospital were reasonable or reasonably necessary.

Further, the court erroneously received evidence concerning alleged loss of earnings and earning power on the part of the plaintiff during a seventeen month period following her departure from Salt Lake City. The jury was instructed concerning these claims in the court's Instructions 22 and 23, but there was no evidence of any kind from which a jury would properly have found that plaintiff had had an impairment of earning power or loss of earnings caused by or resulting from any act or omission on the part of the defendant.

Defendant believes that the reception of such evidence by the court was prejudicial. The trial court agreed, stating: “. . . reception of that evidence in the record was error—very prejudicial in its nature—because

it left the way open to inferences, presumption of fact and conclusions without any proper basis therefor, and there is no evidence that the expenses incurred were incurred in connection with, or as a result of anything involved in the action which was on trial here in court." (R. 361, 362).

SUMMARY OF ADDITIONAL ARGUMENT

We believe, as did the trial judge, that plaintiff failed to establish actionable negligence. Should the Supreme Court disagree, we submit that the Court should not reinstate the jury verdict and direct entry of judgment, for the effect of the errors described in the foregoing Additional Argument was to deprive the defendant of his fundamental right to a fair and impartial trial, and, under such circumstances, defendant is entitled, as a matter of law, to a new trial, where such errors, clearly recognized by the trial court, would not be likely to recur.

Respectfully submitted,

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