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William T. Marsh v. Dr. Paul A. Pemberton : Brief of Respondent

Utah Supreme Court

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Skeen, Worsley, Snow & Christensen; John H. Snow; Attorneys for Defendant and Respondent;

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IN THE SUPREME COURT
of the

STATE OF UTAH

FILED

OCT 12 1959

WILLIAM T. MARSH,

Plaintiff and Appellant,

—VS.—

DR. PAUL A. PEMBERTON,

Defendant and Respondent.

Supreme Court, Utah

Case No. 9041

BRIEF OF RESPONDENT

SKEEN, WORSLEY, SNOW & CHRISTENSEN
and JOHN H. SNOW

Attorneys for Defendant and Respondent.

701 Continental Bank Building
Salt Lake City, Utah

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IN THE SUPREME COURT
of the
STATE OF UTAH

WILLIAM T. MARSH,
Plaintiff and Appellant,

—vs.—

DR. PAUL A. PEMBERTON,
Defendant and Respondent.

Case No. 9041.

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 an order of the District Court of Salt Lake County, Ray Van Cott, Jr., Judge, dismissing the action with prejudice at the close of plaintiff's case.

Plaintiff had alleged that the defendant surgeon who performed the operation known as a "triple arthrodesis" on plaintiff's left foot, had been negligent in the application of a cast after the incision was closed and in the postoperative care afforded the plaintiff.

The basis of the trial court's ruling was that casting procedures and postoperative care following this kind of orthopedic surgery require medical knowledge and judgment, that the standard of care required by the law in such cases must be established by the testimony of medical experts, that no such evidence of the standard had been produced, even if the evidence were viewed in the light most favorable to the plaintiff, and, therefore, there was no evidence on the issues of negligence or proximate cause to submit to the jury (R. 260-267).

Before the order of dismissal was actually made, but after the court had indicated its views on the subject, plaintiff moved to reopen his case in order to produce an "orthopedic surgeon to testify concerning this matter" (R. 260). The court commented that plaintiff had taken two days of trial but did not have an expert in court to

testify and, under such circumstances, the court was entitled to know the identity of the proposed witness and the substance of his testimony (R. 261).

Plaintiff's counsel declined to disclose the identity of the prospective witness and stated he "would abide by the court's ruling." However, the court pursued the matter by asking counsel to state the substance of the proposed testimony. Mr. White replied:

"Well, of course, your Honor, I can not pin him down as to whether he would be willing to testify as to certain things without talking with him further about it. . . ." (R. 262).

The court thereupon denied plaintiff's motion to reopen his case, granted defendant's motion and discharged the jury, after an explanation of the basis for his ruling (R. 262, et seq.).

Plaintiff did not file a motion for new trial. This appeal followed.

Plaintiff's brief contains 57 pages, of which 44 are devoted to his version of the facts. Despite this ostensibly thorough treatment of the case, defendant cannot accept plaintiff's Statement of Facts because examination reveals that it is based entirely upon the direct examination

of the witnesses called by plaintiff and has completely ignored, *in every instance*, the effect of defendant's cross-examination of those witnesses.

Further, that part of plaintiff's Statement of Facts which deals with Dr. Pemberton's testimony, either by quotation or summarization, is frequently misleading. Enlargement or elaboration of answers has been ignored. Questions are quoted as being asked directly following an answer, whereas in many instances, the answer was explained, or was more complete than quoted, or other subjects discussed before the printed question was asked, but no asterisk or other indication of the break in continuity or context has been utilized.

It is fundamental that "testimony of a witness on his direct examination is no stronger than as modified or left by his further examination or by his cross-examination. A particular part of his testimony may not be singled out to the exclusion of other parts of equal importance bearing on the subject." *Alvarado v. Tucker* (Utah, 1954), 268 P. 2d 986.

Since plaintiff claims (Brief, pp. 1, 2) defendant was negligent in three particulars—application of the cast, delaying to split the cast to relieve impairment of circulation and failure to take appropriate corrective measures thereafter — defendant will set forth the facts shown by

the record as applicable to each of these claims, after a brief discussion of the surgery performed, about which no complaint is made, and the complications which followed.

STATEMENT OF FACTS

Defendant is an experienced surgeon, with 29 years in the practice of medicine, of which 21 years have been devoted to the specialty of orthopedic surgery (R. 110, 111).

On December 20, 1954, defendant performed the operation known as "triple arthrodesis" upon the left foot of the plaintiff, who was then age 19 (Ex. 1). This kind of surgery as described by defendant, requires an incision on the upper surface of the foot, exposing the bones of three joints in the foot. The ends of the bones comprising the joints are exposed, cartilage is removed, bone surfaces are excised and then, with the foot in a new position, the bones are fitted together with the expectation that the surfaces will heal and fuse, making one solid joint (R. 113, Ex. 1).

After the bone ends have been fitted together in a manner described as similar to a "precision type of cabinet work" (R. 227), the foot is maintained tightly in its

new position so that the bone ends will remain in contact for healing. The incision is then closed with various types of sutures (R. 126).

With the foot in its corrected position, a long leg cast is applied, gripping the foot so the ends of the bones will not be allowed to move or shift even slightly from the proper position for healing. The toes are not covered. This is the only way the foot can be held properly (R. 241).

Defendant testified the operation on plaintiff's foot was "unsuccessful." It was a "poor result" because the cuboid bone did not unite with other bone ends. It dropped "nearly one-eighth of an inch" at the bottom of the foot, resulting in a bony protrusion on the sole of the foot (R. 228). The wound did not heal properly (Ex. 2).

Notwithstanding "the padding placed there, there was sufficient impairment of circulation" so that a blister formed at the site of the incision (R. 218). This was discovered when the cast was removed two weeks after surgery (Ex. 2).

While the impairment might have been sufficient to cause necrosis (death of tissue) deep within the wound this could not then be determined and nothing could then

have been done about it because it had probably occurred "within the first few hours after surgery" (R. 219, 220).

There is always some impairment of circulation in the foot as a result of the triple arthrodesis procedure, because blood vessels are cut, there is some destruction of soft tissues and there is always some swelling at the operative site following this procedure (R. 132). While circulation is always "impaired," the key question is whether it is still "adequate . . . to maintain a proper healing situation in the wound" (R. 178).

Before the cast is applied, cotton padding, of which Exhibit 4 is a sample, is wrapped around the leg and foot, with more padding being placed over the area where the surgery was performed, because this is where the "swelling usually occurs to the greatest degree." The padding provides a cushion for expansion. It "allows space for swelling to occur" (R. 118).

The amount of padding the surgeon uses depends upon his judgment (R. 116, 133) at the time the cast is applied. The defendant conceded that counsel was correct in stating that the judgment of a Salt Lake City orthopedic surgeon is "supposed to be interpreted and identified and limited and guided by his training and experience" and that an orthopedic surgeon "may use poor judgment or . . . good judgment . . ." in his practice (R. 133).

Defendant was never asked how much padding was indicated, in his judgment, by the appearance of plaintiff's foot after the sutures were applied and he was not asked, and it was not otherwise established, how much padding was actually used.

APPLICATION OF CAST:

Plaintiff contends defendant applied "the cast too tightly without making adequate provision for anticipated swelling causing impairment of circulation. . . ." (Brief, p. 1).

The only witness called by plaintiff who could have testified concerning the application of this cast was the defendant. Plaintiff did not, during the course of an extensive cross-examination, ask any questions concerning the technique and procedure utilized by the defendant in the application of the cast to the plaintiff's leg.

Instead, plaintiff asked defendant questions relating to triple arthrodesis operations generally and sought defendant's views concerning the padding utilized before the plaster cast is applied in such cases. From this testimony, it was shown that different areas of the foot and leg receive different amounts of padding depending upon whether the area contains a bony prominence and also depending upon the amount of swelling the doctor, in his

judgment, anticipates from the wound itself. Some swelling will always occur. Some doctors in this area use less padding than others but the defendant, who was the only medical expert utilized by plaintiff, stated he could not testify concerning the standard practiced in this community because he had not observed the technique of other surgeons and had not discussed it with them (R. 115-118).

Swelling is expected at or near the site of the operation but there is "no way of determining how much swelling will occur" (R. 257). Thus, that particular area receives padding which is believed to be sufficient to allow for swelling and which will prevent friction from the cast rubbing against the area but, at the same time, the surgeon tries not to put in so much padding that the purpose of the cast, which is to hold the foot firmly, is destroyed. It is a "matter of judgment between having too much padding and not enough fixation, or too little padding and not enough room for the swelling" (R. 115-119).

The defendant further testified, in part upon cross-examination, that the plaintiff's cast was not put on too tightly upon the day of the operation, but that the difficulty arose because tightness resulted in a change in the cast because of swelling which was greater than usual (R. 241, 242). If the cast had been put on too tightly at the outset there would have been almost immediate manifestations of difficulty, such as later occurred and an ex-

amination of the hospital chart did not reveal to the doctor any evidence that these manifestations, such as excessive swelling, discoloration of toes and increasing pain, were present in the few hours immediately after surgery (R. 241).

Plaintiff and his father testified (R. 47, 104) that, in a conversation seven months after surgery, the defendant was asked if "the original cast got put on too tight and he said it could have been." Of course, at that late date, in the light of what had occurred, it was obvious that there had been more swelling under the cast than the doctor expected as he viewed the foot on the day of surgery (R. 257).

Throughout his brief, plaintiff reiterates the phrase "impairment of circulation." The evidence shows, however, that the doctor was careful to point out that there is *always* impairment of circulation, from the moment the incision is made in this kind of surgery, and that the important fact is whether, despite the impairment, there is circulation "adequate . . . to maintain a proper healing situation in the wound" (R. 178). In the opinion of the defendant the available indications were that the circulation in this case was maintained at an adequate level, even though the circulation was impaired (R. 177, Ex. 1). As shown by the hospital record, Exhibit 1, circulation seem-

ed "good on the blanching sign" (pinching the flesh and noting if the blood promptly returns) two days after surgery.

No evidence was offered that defendant should not have used padding, or that the padding of the kind used was improper, or that the amount of padding the defendant used was not in accordance with standards or that some error was made in the application of the wet plaster itself.

FACTS CONCERNING THE ALLEGED DELAY IN SPLITTING THE CAST:

Plaintiff returned to his room from the recovery room following surgery at 11:50 a.m., December 20, 1954 (Ex. 1).

In the early morning of December 22, 1954, Dr. Lamb, Dr. Pemberton's partner, visited the patient at 6:30 a.m. and again shortly after the day shift nurse came on duty at 7:00 a.m. (Ex. 1). Dr. Pemberton arrived at the hospital shortly afterwards and the doctors, after weighing the factors involved, decided the cast should be split open to relieve the pressure within it. This was done at about 8:30 a.m., December 22, 1954, which was about 45 hours after surgery (R. 199, 200, Ex. 1).

Plaintiff contends that defendant should have split or removed the cast earlier than the morning of December 22, 1954, because there were symptoms of impairment of circulation which "began to manifest themselves on the day of the operation and continued to increase" (Brief, p. 45). The physical factors involved in the detection of these symptoms were described by the defendant:

"The amount of swelling, color, temperature, and subsequently the ability to move the toes and the sensation in the toes" (R. 136).

While each of these is "important", no one of them is "of supreme importance" (R. 205). "We bring them all together, weigh the information and then determine our course of action" (R. 206). Doctors are reluctant to split the cast applied following triple arthrodesis because, as the defendant explained:

"We put the cast on to hold the foot in a proper position and it is important that it be held in that position. . . . we fit the bones together, and then we have to hold them while the cast is there. If we have to loosen the cast or if it becomes loose for any reason, there is a risk of losing that position. So we try not to loosen it. When we do split the cast to spread it open it is adding to the risk of losing that position. . . . it is not that the act of splitting it is what concerns us. We can be very careful and know when we get it spread we have not disturbed it; but the first time the patient

turns over in bed we expect the foot to turn over with him, and if the cast was loose—we expect the bones to be in proper position, but if the cast was too loose and he turns over inside of the cast, you have lost the position” (R. 201, 202).

Nevertheless, if it appears to the surgeon that the impairment of circulation is of such degree that it would do harm, which determination is a matter of the doctor’s opinion, then the cast should be split because it will be of more danger to the patient to leave the circulation impaired, when it has reached such a degree, than it would be to split the cast and take the chance of losing position (R. 203).

In determining whether the cast should be split, the defendant surgeon testified he would reach his decision in the following manner:

“In such a situation I would consider all of the facts up to this time. When did this swelling occur—and give that a certain amount of weight. When did the blueness occur, and that would have a certain amount of weight. When did the numbness occur; when did the change in color occur, and to what degree is it continuing to change in color? And is that swelling increasing? All of those things would be weighed just as they are weighed today. When the time comes that it appears that this total decision is such that it appears to be to

split the cast on that day to relieve the pressure, whatever we have to do that day this time is given. Against that we weigh the risk of doing harm. In all this we stress the risk of doing harm so far beyond what we might justify on the basis of information that has accumulated. But if enough information accumulates in all of these five factors which I have enumerated so that it outweighs the risk of harm, we might do something about it." (R. 235, 236)

In addition to the five factors mentioned by the defendant, the element of pain must be considered by a surgeon in his postoperative care of a patient such as plaintiff. Severe pain is expected following the operation (R. 183). To control the pain expected to be suffered by the plaintiff, the defendant ordered the administration of 75 milligrams of demerol, to be given by the nurse approximately every three hours. In view of plaintiff's size, 6 feet 2 inches tall and 190 pounds, this was described as "the usual amount of analgesic" (R. 188).

If this drug had not given relief from pain, to the extent the surgeon had anticipated, he would have then been confronted with the problem of determining whether this patient was particularly susceptible to pain or whether there was in fact excessive pain developing which in itself might have indicated unexpected complications (R. 188, 189).

The defendant testified, therefore, that he examined the hospital chart maintained by the nurses and noted that the patient went to sleep after the administration of these hypos on December 20, and well into December 21 (R. 188). He then noted, on the record for December 21, the day after the operation, that the patient had not required a hypo to relieve his pain from 11:50 a.m. until 10:00 that night, or a period of slightly more than ten hours (Ex. 1, nurses notes of treatment and nursing care and clinical sheet, record of medications).

The significance of this fact, coupled with the notes by the nurses that the patient had had "no special complaint" throughout that day or evening, the first full day following surgery, was that the patient was experiencing "the usual rate of improvement" and that the "severity of pain" was indicated by the record as having lessened because demerol was not required on the three-hour basis of the previous day (R. 238, 239).

When, on the morning of December 22, 1954, the defendant noted from the hospital chart that it had been necessary again to resume administration of demerol every three hours, this indicated a need for action, when coupled with the other factors previously described (R. 239). As has been outlined, the cast was split that morning and the plaintiff testified that he had obtained relief following the splitting of the cast. The swelling in the

toes "had begun to go down after they cut the cast," the "blue color receded" so that the toes became "normal color . . . a skin color" (R. 70, 71, 72).

Specific testimony was elicited from the defendant concerning the significance of each of the five physical factors mentioned by him as of assistance in detecting the patient's condition. He stated that the factors he first would consider, in determining whether the patient was progressing properly, were those of swelling, color of toes and temperature. "Subsequently," he would consider "the ability to move the toes and the sensation in the toes" (R. 136).

In addition to the defendant's testimony on the significance of these factors, repeated reference was made to the hospital chart and to the comments of the nurses as reflected in the notes made by them during the course of their treatment and care of the plaintiff.

To assist the court in its examination of the hospital chart, Exhibit 1, it should be pointed out that the notes concerning the patient's progress may be found in the nurses' notes and in the doctor's "progress notes" on the grey sheets located as the third and fourth documents in the chart. The other matters of significance which may be found in the chart are noted in the doctor's order sheet and in the clinical sheet which shows the temperature and pulse record of the patient, together with the

medications administered. The temperature is recorded in blue ink upon the clinical sheet and the pulse rate recorded on the graph in red.

The last three pages of the Exhibit comprise the nurses' notes commencing with the patient's admission into the hospital and ending with his discharge. Those notes in red ink reflect comments of the nurses on the evening and night shifts beginning at 6:00 p.m. and ending at 7:00 a.m. the following morning while those in blue colored ink are the notes made by the nurses on the day shift from 7:00 a.m. until 6:00 p.m.

An examination of the chart notations relating to the physical factors of swelling, color and temperature clearly reveals no unusual or untoward development on December 20, the day of the surgery. As to December 21, the nurses noted that the patient had spent a "fairly good day with no special complaints" and the first indication of difficulty is found the evening of December 21, at 9:00 p.m. when Nurse Ingersoll noted that the patient's toes "seemed quite red and somewhat swollen."

She also noted that the edges of the cast were snipped slightly to relieve pressure and her next note, at 10:00 p.m., reflects that the color of the toes was improved and that the patient had had a good evening.

The following morning, December 22, 1954, the morning upon which the cast was split, the nurses' record reveals that Dr. Lamb visited the patient at 6:30 a.m., as shown by the note in red ink under that date. The day shift nurse, writing in blue ink, at sometime after 7:00 a.m., then noted that Dr. Lamb was again present and examined the patient's toes. At this time they were "quite swollen" and the patient stated that he had "no sense of feeling" in the toes. The nurse, however, commented that circulation "seems good on blanching sign."

As has previously been outlined, Dr. Pemberton conferred with Dr. Lamb, his orthopedic partner, between the time of Dr. Lamb's second visit and the time the cast was split and it was then decided that in view of all factors, the cast should be split to relieve pressure.

Plaintiff and his father each testified on direct examination that his toes were "bluish in color" on December 21, 1954, and upon this basis, plaintiff urges that defendant should have acted sooner to relieve the pressure within the cast (R. 31, 82, 99, Brief pp. 48, 49).

However, upon cross-examination of plaintiff and his father, they were forced to concede, as they had done upon deposition prior to trial, that the first time either had noticed that the toes had turned a darker shade was De-

ember 22, 1954, which is the time when the defendant took steps to relieve the situation which had developed (R. 59, 61, 108).

Concerning temperature, the doctor testified that the temperature chart maintained by the nurses never revealed a temperature of more than 100 degrees and this is classed as an "increased elevation," rather than as a "fever" and is expected following a surgical procedure such as triple arthrodesis (R. 211). Further, on this point the defendant stated:

"If he is developing infection or spreading infection in the wound, he is going to get a fever. There is an unusual amount of redness and heat, local heat. That is, especially if it becomes hot we consider spreading infection and we know that something is going wrong in the wound because that is where it spreads from" (R. 200).

There was never a fever, nor was there local heat nor an unusual amount of redness. The potential factor of temperature, therefore, indicated no unexpected complication.

Plaintiff testified, upon cross-examination, the nurses visited him regularly, about every two hours or so, and that interns were coming in also. He conceded also that Dr. Pemberton or Dr. Lamb, one or both, saw him daily

in the hospital and when they came in, they felt and wiggled his toes, made some sort of examination, and inquired of his condition (R. 59, 66, 67).

This care and attention is corroborated by the entries in the hospital chart which shows, even though all such visitations are not noted by the charting nurse (R. 245, 246), that in the period between plaintiff's arrival in his room from surgery, and the time the cast was split some 45 hours later, the patient received recorded attention or visits at least 27 times (Ex. 1).

No evidence was offered that the standard of care of an orthopedic specialist required any different professional care from that afforded, or that the factors present required, under such a standard, that the defendant act more quickly than he did in splitting the cast. Neither was any evidence offered that, if defendant had done differently, a different result would have occurred.

ALLEGED FAILURE TO TAKE ADDITIONAL CORRECTIVE MEASURES DURING POSTOPERATIVE CARE:

Although plaintiff's brief does not define too clearly his contentions on this phase of the case, apparently the claim is that, after the cast was split December 22, 1954, some other or additional remedy should have been followed or that the defendant should have seen the plaintiff in his office more quickly than was the case following

the plaintiff's discharge or that in any event some unspecified measures should have been taken either to correct the improper position of the bones in the foot or to cause the wound, which was not healing, to heal over.

After the cast was split, the hospital chart reveals, and the defendant testified, that evidence of the impairment of the circulation was still present and this apparently was not unusual nor unexpected, because the defendant commented that he had already taken measures to correct the impairment of circulation and that "it takes time for this impairment to disappear" (R. 209, 210).

Although the left foot was still swollen and dark in appearance on the day following the splitting of the cast, it was defendant's apparent opinion that the patient's condition was improving because on December 23 the defendant made a note in the hospital chart that the motor function was good, the circulation was adequate but that the plaintiff still had no sensation in the toes. He was to get up on crutches (Ex. 1).

Prior to that time the plaintiff had been required to remain in bed with his foot elevated, which was an aid to circulation. The fact that he was allowed to get up and was measured for crutches on December 23 indicates that the circulation had improved because, as the defendant testified, "... we wanted to keep the foot elevated in order

that it might improve the circulation. When it improved we could let it down and he was allowed to be on crutches" (R. 237, 238).

It was agreed that if the bones in the foot had lost position after the splitting of the cast, this condition could be corrected or adjusted, by surgery under anesthetic, with reasonable opportunity for success, if the attempt was made within a two or three week period following the operation (R. 213, 214).

Therefore, plaintiff was seen in defendant's office 14 days after surgery, but the bones had not lost position by that time nor by the time of the second visit to the office January 19 (R. 220, 221, 244). Loss of position occurred some time after that, in the succeeding 60 days, but, as will be seen, the wound was not healing, so corrective surgery was not then possible. On the first office visit, January 3, 1955, the cast was removed and there was a bleb formation or blister found on the top of the forefoot just back of the toes (Ex. 2, R. 218). Additionally, the doctor noted "there is considerable hemorrhage into the skin along the wound and there will possibly be some breaking down of the wound edges but this is not definitely evident today. . . ." (Ex. 2).

The patient returned January 19 and when the cast was removed it was apparent the wound had "broken

down considerably" (Ex. 2) and there was odor in the cast.

The "tissue was dead. It had no circulation whatsoever. It was dark in color and had become infected . . . and had fallen apart so that the wound was lying open. . . ." There was "dead tissue underneath . . . with dead tissues on both sides of it and considerable discharge from it. . . ." (R. 224).

From this time forward, it was obvious no corrective surgery could be performed and, in fact, as late as July 20, 1955, the doctor, recognizing the need for correction, noted in the chart that the procedure would be delayed until "at least two months because I think we should wait until it is well healed before anything is done" (Ex. 2).

No evidence was offered or received that the standard of orthopedic care required different treatment of the wound or that defendant should have attempted corrective surgery despite the necrotic wound. Neither was evidence offered that if defendant had taken other or different steps, the result would have been different.

Defendant testified that necrosis could have been in process, inside the wound, as early as when the incision was being sutured and that it could have continued, all without the surgeon "being able to notice it" (R. 201).

When the cast was opened, the possibility of the wound breaking down was noted, and the defendant said that necrosis deep within the wound could be present, but that there was nothing that could then be done about it, nor could anything have been done about it if the cast had been split or removed earlier than December 22. Instead, the time when something might have been done was "the first few hours after surgery" (R. 219, 220).

No evidence was offered that these conclusions and opinions were improper or that the defendant, in the practice of his specialty, should have been able to determine, in the first hours following the surgery, that trouble was occurring.

The only other doctor called to the stand by plaintiff was Dr. A. M. Okelberry, a qualified orthopedist, who saw the patient in July, 1955, and who performed minor surgery upon the foot. He was never even asked a question bearing upon the issues in this case even though he is completely familiar with the prevailing practices in this area.

STATEMENT OF POINTS

POINT I

THE TRIAL COURT CORRECTLY GRANTED DEFENDANT'S MOTION FOR INVOLUNTARY DISMISSAL WITH PREJUDICE BECAUSE THE EVIDENCE FAILED TO SHOW EITHER NEGLIGENCE OR PROXIMATE CAUSE.

ARGUMENT

POINT I

THE TRIAL COURT CORRECTLY GRANTED DEFENDANT'S MOTION FOR INVOLUNTARY DISMISSAL WITH PREJUDICE BECAUSE THE EVIDENCE FAILED TO SHOW EITHER NEGLIGENCE OR PROXIMATE CAUSE.

The purpose of the triple arthrodesis operation was to form a solid joint in the foot and to do this, it was necessary not only to cut and form the ends of the bones but to fit them together with such precision that they would, if held in the same position and if expected healing occurred, fuse together in solid bony union.

This then is a delicate orthopedic surgical problem and the placement and maintenance of the foot in "one exact position" (R. 117), requires orthopedic knowledge and skill in the application of the protective padding and the wet plaster itself.

Because of his experience, the surgeon knows that there will be some swelling at the site of the operation. How much swelling is going to occur he can only estimate, because "it varies in different patients" (R. 135). How much padding, therefore, will be required can only be estimated and the undisputed evidence is that such estimates are made by the exercise of the judgment and the opinion of the surgeon in the light of the circumstances

of the case, the condition of the patient, the appearance of the operative site and all of the other medical and surgical factors which his training and perception disclose.

It is obvious, therefore, that whether a casting technique was properly performed in accordance with accepted orthopedic standards cannot be determined by laymen without the assistance of qualified medical experts. No expert was produced in this case concerning the technique of application of a plaster cast and not only that, the defendant was not even questioned concerning the amount of padding he used, the reasons for his decision to use this amount or the amount or method of application of the plaster material.

Plaintiff, therefore, is reduced, on this phase of the case, to attempting to prove negligence in the application of the cast by asserting that subsequent developments prove that the cast must have been applied too tightly.

The law has never presumed to judge a surgeon upon the basis of his result except in those cases so elemental in nature that a knowledge of medical science is not required to reach a decision. As stated in *Ewing v. Goode* (C.C.) 78 Fed. 442, which is one of the leading cases in medical-legal jurisprudence and which has been often quoted by this and other courts:

"The naked facts that defendant performed operations upon her eye, and that pain followed, and that subsequently the eye was in such a bad condition that it had to be extracted, established neither the neglect and unskillfulness of the treatment; nor the causal connection between it and the unfortunate event. A physician is not a warrantor of cures. If . . . a failure to cure were held to be evidence, however slight, of negligence on the part of the . . . surgeon causing the bad result, few would be courageous enough to practice the healing art, for they would have to assume financial liability for nearly all the 'ills that flesh is heir to'".

To the same effect is the decision of this Court in the case of *Baxter v. Snow*, 78 Utah 217, 2 P. 2d 257. In that case, the plaintiff claimed that he had hearing in his ear when he got in the doctor's chair, but when an instrument was inserted and then removed he felt a change in his hearing. Thereafter he could not hear through that ear and this, the plaintiff contended, showed prima facie negligence and called upon the defendant to go forward and establish his freedom from neglect.

This Court rejected such an argument, quoting with approval numerous cases from other jurisdictions.

Neither the jury, the trial court, nor this Court, is competent to say how much padding should be used by a

surgeon in the application of a cast following triple arthrodesis procedure. Even if, however, the courts were trained in such matters, plaintiff has not established any basis for a determination that the amount of padding used was insufficient for the simple reason that plaintiff totally failed to establish how much padding was used.

Additional evidence is found in the record which tends to show that the cast was not applied improperly. This evidence consists of the testimony of the defendant that if the cast had been applied too tightly at the outset, there would have been, very quickly, manifestations of difficulty and these would have occurred in the hours immediately following surgery. The defendant examined the hospital chart on the witness stand, and testified that he could find no indication that any such manifestations had been present.

No other medical expert was produced to examine the chart and to reach a different conclusion or to testify that the standard of care among orthopedic surgeons in this community required a different conclusion from the hospital chart.

We submit, therefore, that the evidence totally fails to establish any basis for a finding of negligence on the part of the defendant in the application of the plaster cast.

Plaintiff next contends that the defendant was negligent in delaying to split the cast although again, no medical expert was produced to testify, either upon the basis of hypothetical questions, the hospital chart or otherwise, that the circumstances that existed between the surgery and the morning of December 22, 1954, required a surgeon, in the exercise of accepted standards of care, to split the cast or to take other steps sooner than the defendant did.

Despite a repetitive and meticulous examination of the defendant as an adverse witness, plaintiff failed to overcome the fundamental theme of defendant's testimony that the surgeon should look for the physical factors of pain, excessive swelling, changes in color, increases in temperature, and subsequently, impairment of sensation and motor function. These factors, according to the undisputed testimony, must each be weighed carefully, having in mind when and to what extent they first appeared and how they progressed following their appearance. When, after such careful weighing, the total decision is that there is danger to the patient from an unusual impairment of circulation, then the surgeon must further utilize his judgment by weighing the danger of circulation impairment against the potential danger of destroying the position which he has so meticulously obtained through the original operative procedure.

No medical expert was produced to establish that there are other or additional factors to be considered, or that the defendant's use or interpretation of these factors was not in accordance with standards, or that the circumstances which existed were such that orthopedic practice required other or different measures from those utilized by the defendant.

Thus, a jury would have been required to speculate as to when the defendant should have split or removed the cast or to speculate whether some different, unmentioned or unspecified treatment should have been followed.

We submit that the postoperative care of a patient who has undergone orthopedic surgery of the kind here described "... depends upon complex scientific knowledge and cannot be ascertained by common lay knowledge ..."; and to submit a case to a jury upon such a record would have allowed "the jury to indulge in that type of speculation unpermitted by this or other courts generally." *Huggins v. Hicken* (Utah, 1957), 310 P. 2d 523; *Forrest v. Eason* (Utah, 1953), 261 P. 2d 178.

An analysis of the argument contained in the last few pages of plaintiff's brief shows it is bottomed on the repeated assertion that impairment of circulation results in necrosis, or tissue death, beginning after three hours, from which it is argued defendant, having knowledge of

such facts, was negligent in doing what he did or in failing to do what he should have done.

This assertion is typically stated in plaintiff's brief on pages 46 and 47, where it is said: "The defendant admitted that when the initial impairment (of circulation) occurs because of excessive swelling or inadequate padding, the impairment would have a tendency to become worse (R. 121). That after three hours of impairment the tissue death begins to occur (R. 122)." (Parenthesis added.)

This constitutes a spurious and unwarranted interpretation of the defendant's testimony found in the record beginning at the bottom of page 118. When read in its entirety, and when excerpts are not read out of context, it plainly and conclusively shows that defendant never conveyed any such meaning, conclusion or opinion as has been attributed to him by plaintiff in his brief.

Specifically, the Court's attention is directed to the fact that this portion of the defendant's testimony began with counsel asking the defendant to assume a fact which was never proved, i.e., that there was "an inadequate amount of padding" within a cast (R. 118). The defendant was then asked what would be the result if swelling occurred in such a situation.

The defendant replied: "Excessive pressure on the soft tissues within the cast, which would result in impairment of circulation, impairment of nutrition and increased pain."

The defendant then went on to say that as the swelling presses against "an immovable layer we will call the plaster, it gets tighter, and that tightness *eventually* will reach a point where it compresses the blood vessels and compression of the blood vessels, of course, has the result of impairment of circulation." (Emphasis added) (R. 118, 119).

Thus it is seen that the defendant testified that *if* a cast has inadequate padding and *if* the swelling is allowed to continue to a point where the tightness "*eventually*" compresses the blood vessels, there will be an impairment of circulation. This is far removed from the interpretation assigned to this testimony by the plaintiff. Plaintiff derives no aid from this testimony, even when it is correctly stated, because plaintiff never proved the padding was inadequate.

Further, in the next portion of the testimony relating to impairment of circulation, which the plaintiff has again quoted out of context at pages 14 and 15 of his brief, the defendant described what might occur in a hypothetical situation where the pressure "is built up to a definite point between the pressure which is in the veins,

which are the vessels returning the blood, and the pressure in the arteries . . .” When that point is reached the defendant said that if the pressure is adequate the venous return of blood will be stopped but the arterial blood will still be going into the tissues (R. 119).

Then, although this fact is omitted from defendant’s answer quoted on page 14 of plaintiff’s brief, the defendant compared the hypothetical situation he had been describing to that which results from the use of a tourniquet and from the use of a variable pressure tourniquet (R. 120). There then ensued a discussion of how long tissue can live when circulation is impaired to the point where there is no return of blood through the veins and from this to an explanation of how long various types of tissue may be expected to live if they are deprived of nutrition (R. 121).

The defendant expressed the opinion that a tourniquet which is pressed so tightly as to shut off the blood supply completely can be left on a lower extremity for a period of two to three hours without impairment of the life of the tissue (R. 121, 122).

For plaintiff to claim, on the basis of this testimony, that the defendant testified that the impairment of circulation within the plaintiff’s cast would begin to destroy tissue after three hours, serves only to demonstrate incontestably that the argument is deceptive and fallacious

and is completely without foundation when the record is read in full and in context.

Of equal stature are the cases cited by plaintiff in support of his argument that this case should have been submitted to the jury. An examination of them reveals no case with facts even remotely similar to those in the case at bar. In some there was expert medical testimony to support the claim of negligence. In others there was indisputable proof that a cast was too tight almost from the time it was in place and dry. In others, because of injury resulting in fractures and destruction of arterial blood vessels, there were additional elements not present in this case.

Typical is plaintiff's reference to the case decided by the Supreme Court of Washington, *Prather v. Downs*, 2 P. 2d 709. In that case the patient had suffered a fracture of the right femur at about the middle third. Other and less serious injuries were suffered at other parts of the right leg. An incision was made in the right thigh, a severed artery was located and the broken ends of the bones were fastened together with metal bands. A cast was placed from the chest to the base of the toes on November 28, 1927. Although "infection developed soon afterwards," nothing was done until December 5, 1927, when a window was cut over that portion of the cast covering the incision. The cast was never split or loosened. A large quantity of pus was seen discharging from the wound. Infection

continued to develop and the following spring the lower right leg was amputated to save the patient's life.

Upon trial, expert witnesses testified concerning the standards of practice and since obvious differences developed about the true condition of plaintiff's leg and since the opinions of the experts were somewhat at variance, the court held it was proper to submit the case to the jury.

Additionally, the evidence showed that the patient's toes extending from the cast became purplish and puffy three or four days after the cast was applied and that the patient developed a fever but despite these manifestations of trouble the defendant surgeon did nothing.

No argument is required to demonstrate the absurdity of plaintiff's contention that his claim is supported by this decision.

Much of plaintiff's argument is devoted to the claim that defendant should have split or removed the cast sooner than he did, or that he should have seen the patient in his office earlier than January 3, 1955, or that he should have taken X-rays or rendered other unspecified treatment in the weeks and months that followed.

No evidence was adduced to show that the standard of orthopedic practice in this area required defendant

to have done anything other than what he did. But, even if such evidence had been produced, there is an additional omission of proof which is fatal to plaintiff's case. There was no proof of proximate cause.

It seems inescapable that medical knowledge, and particularly knowledge of the specialty of orthopedic surgery, is necessary in order to evaluate correctly the progress of a patient following the delicate procedure of triple arthrodesis. Such knowledge and training is also necessary in determining whether the physical factors present show an unexpected or serious complication is developing. If such complications do occur, surely no layman without such knowledge and training, can determine from his own experience when and how and to what extent a cast should be split in order to give relief from the complication and, at the same time, to maintain the exact position of the bones upon which the surgery has been performed.

Neither is lay knowledge and experience sufficient to determine after a cast has been split, whether the physical factors then discernible show that the complication is sufficiently relieved or whether other additional treatment is required. Further, a layman cannot determine from his limited knowledge and experience, what, if any, treatment is required where the edges of a wound break down and an area of necrosis becomes apparent.

Therefore, since the postoperative care and treatment of a patient who has undergone triple arthrodesis involve matters not within common knowledge but within the knowledge of medical men, it follows that there must be some evidence, from medical experts, to enable the jury to determine not only negligence, but what, if any, effect the claimed negligence had upon the end result.

In *Anderson v. Nixon* (1943), 104 Utah 262, 139 P. 2d 216, this Court, in a case involving osteomyelitis, stated:

“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 this case there was no evidence that anything Dr. Nixon did or failed to do after osteomyelitis developed caused 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. . . .”

This principle has repeatedly been affirmed by this Court. See *Huggins v. Hicken*, 310 P. 2d 523, and cases therein cited.

Plaintiff never availed himself of the opportunity to supply this defect in his case by asking the available medical experts what, if any, effect the claimed conduct of the defendant had upon the end result in this case. Although Dr. Pemberton was asked a number of questions relating generally to some of the problems present in triple arthrodesis surgery, and its postoperative care, he was never asked specific questions based upon the facts of the case as revealed by the testimony previously adduced. Equally significant is the fact that, although Dr. Okelberry was called by plaintiff as a witness, he was not asked even one question concerning the claim of negligence or its relation to the end result.

As previously related, when the trial court gave counsel the opportunity to state in substance what testimony he might produce from an unidentified surgeon, the question was evaded and the opportunity impliedly extended by the trial court to reopen the case in order to produce the indicated testimony was never accepted.

CONCLUSION

The trial judge dismissed this action when, after observing all of the witnesses and considering their testimony in the light most favorable to the plaintiff, he could not find, by any standard, anything that the doctor did that he should not have done or anything that he failed

to do that he should have done. (Unnumbered page following record 265.)

The judgment of the trial court, based not only upon the written record, but upon his personal observation of the witnesses and all other factors in the trial, and supported by the precedent of decisions of this Court, none of which have been either cited or discussed by plaintiff, was correct and proper and should be affirmed.

Respectfully submitted,

**SKEEN, WORSLEY, SNOW & CHRISTENSEN
and JOHN H. SNOW**

Attorneys for Defendant and Respondent.