

2002

# Lori Haase v. Ashley Valley Medical Center, Columbia Ashley Valley Medical Center : Reply Brief

Utah Court of Appeals

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IN THE UTAH COURT OF APPEALS

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LORI HAASE,

Plaintiff/Appellant,

vs.

ASHLEY VALLEY MEDICAL CENTER  
AND COLUMBIA ASHLEY VALLEY  
MEDICAL CENTER, AND JOHN DOE  
DEFENDANTS 1 THROUGH 10,

Defendants/Appellees.

**REPLY BRIEF OF  
APPELLANT/CROSS APPELLEE  
LORI HAASE**

Case No. 2:0020524-CA

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Appeal from Amended Judgment on Verdict entered by the Eighth Judicial  
District Court, per the Honorable Douglas L. Cornaby, Senior Judge, on June 24,  
2002.

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Jefferies v. Stubbs, 970 P.2d 1234, 1243 (Utah 1998), cert denied, 119 S.Ct. 1803 (1999).

Dalley v. Utah Valley Regional Medical Center, 791 P.2d 193, 195 (Utah 1990).

Bishop v. Gen Tec, Inc., 48 P.3d at 227 (Utah 2002).

Harding v. Bell, 460 UAR 3, 5, fn. 4, 202 UT 108 (Utah 2002).



McCall v. Henry Medical Center, Inc., 551 S.E.2d 739, 739, 742-43 (Ga. App. 2001).

Greenwood v. Wierdsma, 741 P.2d 1079 (Wyo. 1987).

Benson ex rel v. IHC Hosps, 866 P.2d 537 (Utah 1993).

## **STATUTES**

UCA §15-1-1;

UCA §26-25-3;

UCA §78-27-44.

## **OTHER AUTHORITIES**

American Medical Association's Code of Ethics.

## **INTRODUCTORY STATEMENT**

This brief contains three sections. The first responds to the hospital's arguments that the trial court made reversibly erroneous evidentiary rulings in favor of Mrs. Haase. The second argues that the trial court made erroneous rulings prejudicial to Mrs. Haase. The third contains Mrs. Haase's reply arguments in support of her request for judgment in the amount of \$820,000, as supported by the jury's post-verdict affidavits and in-court declarations.

## **SECTION ONE**

### **THE TRIAL COURT COMMITTED NO REVERSIBLE ERROR FAVOR OF MRS. HAASE.**

#### **I**

#### **THE TRIAL COURT DID NOT ERR IN ADMITTING PORTIONS OF THE SURGEON'S PERSONAL MEDICAL RECORDS.**

- A. ... Because The Admitted Records Were the Best Evidence of What a Member of The Hospital's Medical Staff, Credentialing Committee, Medical Executive Committee and Governing Board Knew Concerning the Surgeon's Impairments and Drug Dependencies.**

A central issue in this case was what the hospital knew or should have known concerning the surgeon's physical limitations, emotional disorders and drug dependencies. The hospital's entire argument concerning Dr. Madsen's treatment records grandly ignores the fact that at the time the surgeon was

credentialed, Dr. Madsen was a member of the hospital's Medical Executive Committee, Credentialing Committee and Governing Board. (R. 227, 656, 660; 973-74; 1104-05). Throughout the entire time the surgeon operated at the hospital, Dr. Madsen was his primary care physician *and* a member of the hospital's medical staff. What Dr. Madsen knew was therefore chargeable to the hospital. Dr. Madsen himself acknowledged that: the confidential nature of physician/patient communications must yield when disclosure is necessary to protect the public interest or the welfare of an individual; a physician has an ethical obligation to report an impaired colleague to the hospital's chief of staff; and a physician involved in granting hospital privileges has an ethical duty to be guided primarily by concern for the safety of patients. (Tr. 1099-1103; See also AMA's Code of Ethics).

If the hospital didn't know what Dr. Madsen knew, it should have known. If it was ignorant, its ignorance was the fault of its own agent and medical staff member.

Dr. Madsen 's testimony and chart reveal that Dr. Madsen was aware of the impairments documented and quantified during the last few years of the surgeon's service as an orthopedic surgeon in the U.S. Army. <sup>1</sup> Dr. Madsen's

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<sup>1</sup> During the first office visit on May 4, 1993, Dr. Hawkes delivered to Dr. Madsen his medical records from the military. Dr. Madsen read those records. Although the court did not allow those records to be admitted, it did allow Dr. Madsen to be questioned concerning them. Dr. Madsen acknowledged, based on review of the military records, that in February of 1989, Dr. Hawkes was

testimony and chart also shed shockingly bright light on the surgeon's sad condition from early May of 1993 through the date he operated on Mrs. Haase in March of 1996.<sup>2</sup>

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receiving disability compensation from the military due to: limited motion in cervical spine; limited motion in lumbar spine; paralysis of upper radicular nerve group; shoulder condition, left upper; shoulder condition, right upper; limited motion of forearm, left upper; loss of motion of thumb, right upper. The records reflect residual vision problems due to "Horner's Syndrome" which "causes him difficulty driving at night due to depth discrepancies, and is more pronounced with fatigue, *causing some difficulty towards the end of an operation*". The records also state: "Dr. Hawkes is a pediatric orthopedic surgeon who is *definitely restricted in his medical activities because of his multiple service connected injuries*". The records state that due to subluxation and restriction of motion in his hand and fingers, "*both thumb and index finger are symptomatic and make problems when he's operating*". (Tr. 1106-1110).

<sup>2</sup> On May 4, 1993, Dr. Madsen learned that the surgeon:

suffered from significant chronic pain and the severe, recurrent migraine headaches "associated with nausea, vomiting and inability to concentrate";

experienced numbness and tingling in his right arm and chronic pain in both shoulders, low back, feet and knees;

had used "multiple pain medications" for his problems and was self-administering Demerol in addition to Fiorinal #3 and Restoril;

had promised his wife that he would no longer self-administer narcotics;

had been rated 90% disabled by the armed services; and

was taking hypertension medication.

In his own assessment of the surgeon, Dr. Madsen listed several maladies including: migraine headaches, chronic pain stemming mainly from cervical disk disease, multiple orthopedic related problems, a history of pulmonary injury, hepatic cysts . . . , rheumatoid arthritis, and hypertension.

Because Dr. Madsen's patient chart on the surgeon contained the best evidence of what he knew concerning the surgeon's condition and provided the only reliable means of testing the truthfulness of his testimony, it would have been reversible error for the trial court *not* to have allowed introduction of those treatment records.

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On his first visit, Dr. Madsen gave the surgeon a prescription for 60 Fiorinal #3 tablets with 2 refills. On July 1, 1993 - less than 60 days later, the surgeon requested another prescription of this opiate narcotic drug. He asked Dr. Madsen to prescribe Demerol vials but Dr. Madsen declined because he had been given those from other surgeons and was self-administering the medication. Nine days later, Dr. Madsen approved the administration of 100 mg of Demerol. Nine days after that - on May 24, he administered 150 mg of Demerol to the surgeon. Three days later he again administered 150 mg of Demerol. These administrations of Demerol continue on June 9 and June 10. Following the June 10 administration, Dr. Madsen made arrangements for the surgeon's son to drive him home because he "didn't want him operating the car under the influence of that injection". Seven days later, the surgeon requested and received another shot of Demerol as he did five days later. The surgeon received four injections of Demerol in June of 1993. He also received prescriptions for Fiorinal #3 with 2 refills. (120 doses in total). The Demerol administrations continued with great frequency.

The surgeon had high blood pressure at each visit. He was also put on anti depressant medication. His hypertension continued despite his being placed on Cardizem and, later, Procardia. The surgeon also received prescription sleeping medication (Ambien) which Dr. Madsen acknowledged could exacerbate and amplify the sedating properties of the narcotic pain medication he continued to take. (Plaintiff's Exhibit 12;Tr. 976-1106)

**B. The Hospital Failed to Object at the Time the Court Granted Mrs. Haase's Offer to Admit the Records And, Therefore, Waived Whatever Objection it Had.**

The relevant pages of Dr. Madsen's treatment records on the surgeon were first offered into evidence on the third day of trial, March 13. (Tr. 542-543). The trial court declined to receive the records at that time, indicating their having finally been produced did not make them admissible, without the accompanying testimony of the physician who created them. (Tr. 543). The court stated: ". . . I think the doctor's got to testify about them". At that time, the hospital's counsel stated: "Your Honor, you've expressed my objection brilliantly. Thank you." (Tr. 543). When Dr. Madsen took the stand to testify the following Monday, the relevant portions of his chart were again offered into evidence. (Tr. 592). The hospital again objected and the court indicated it would withhold a ruling until satisfied that sufficient foundation had been established through Dr. Madsen's testimony to warrant admission of the records. Dr. Madsen's testimony covers the next 145 pages of the trial transcript. At the conclusion of his testimony, the records were again offered into evidence. At this time, **the hospital made no objection.** (Tr. 1118). Apparently, the hospital was as convinced as the court that the necessary foundation for admission of the records had been established by Dr. Madsen's testimony. In any event, the hospital waived whatever objection it still may have had by failing to object at the time the court granted Mrs. Haase's offer to admit the records.

**C. The Hospital Knew What the Records Contained Nearly Three Years Before the Case Got to Trial and Their Late Production Prejudiced Mrs. Haase, Not the Hospital.**

The hospital contends the trial court erred in allowing reference at trial to the surgeon's personal medical records because "the defense had no opportunity to review the records or depose the physician who created them" (Brief of Appellee/Cross Appellant, p.7). It states:

The release of the records was so untimely as to create unfair prejudice. It allowed the Hospital no opportunity to depose Dr. Madsen regarding his records or even to discuss the records with him informally prior to his testimony.

(Brief of Appellee/Cross Appellant, p. 8). These assertions are meritless.<sup>3</sup>

The Hospital's representative, Risk Manager Debra Spafford, obtained access to and scrutinized Dr. Madsen's records on June 15, 1999 - some 13 months after this action was commenced and nearly 3 years before the case came to trial! (Transcript at 981). The hospital was fully aware that Dr. Madsen was the surgeon's treating physician from 1993 on. (Ron Perry depo at 43-44; trial transcript at 172). Mrs. Haase designated Dr. Ace Madsen as a possible

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<sup>3</sup> As is the hospital's suggestion that the production of Dr. Madsen's records was ordered only in "another case". (Brief of Appellee/Cross Appellant, p. 7). On March 12, 2002, the trial court signed an "Order on Dr. Madsen's Medical Records" in *this* case. That order directed the immediate production of Dr. Madsen's treatment records. The order was hand delivered to the hospital's counsel on the day it was signed. (R. 983-4).

trial witness in the formal Designation of Expert Witnesses her counsel sent to the hospital's counsel some 10 months before trial. (R. 496-500, Para.11 ).

The hospital could have deposed Dr. Madsen at any time and questioned him freely concerning his treatment of the surgeon and his knowledge of the surgeon's impairments and drug dependencies. It is disingenuous in the extreme for the hospital to claim "unfair prejudice" from the late release of Dr. Madsen's medical records. If anyone was unfairly prejudiced by the late release of those records, it was Mrs. Haase, not the hospital. The hospital was given access to those records nearly 3 years before she was.

**D. Reliance on the Records by Mrs. Haase's Credentialing Expert Was Only Incidental to His Opinions and Conclusions.**

Dr. Pasternak's review of and comment on the surgeon's treatment records was hardly a major factor in the trial. He had concluded the surgeon was dangerous and the hospital had breached its duty to Mrs. Haase long before he was allowed to review the surgeon's treatment records. (See Dr. Pasternak's 1-23-02 depo transcript). His additional comments, after reviewing those records, as to the red flags they raised were not particularly dispositive. A great quantity of strong and compelling evidence, aside from Dr. Pasternak's opinion, was presented that the surgeon was indeed impaired and dangerous. (See, e.g., the testimony of Dr. William Stryker at Tr. 1263-88). In any event, there was nothing preventing the hospital from trying to retain an expert to testify that Dr. Madsen's



illuminating treatment records do not reflect treatment of a dangerously impaired surgeon. Again, its Risk Manager knew what those records revealed nearly 3 full years before the case came to trial.

## II.

### **THE TRIAL COURT DID NOT ERR IN ALLOWING THE JURY TO HEAR SWORN DEPOSITION TESTIMONY GIVEN BY THE SURGEON IN MRS. HAASE'S CASE AGAINST HIM BECAUSE SUCH TESTIMONY WAS PROPERLY ADMISSIBLE UNDER SEVERAL EXCEPTIONS TO THE HEARSAY RULE.**

The hospital incorrectly characterizes the trial court's decision to allow the jury to hear the prior deposition testimony of the surgeon as a determination of law, reviewable for correctness with no deference to the trial court. The determination was in reality an evidentiary ruling which required the trial court to balance factors pertaining to admissibility. Stevenett v. Wal-Mart Stores, Inc., 977 P.2d 508, 511 (Utah App. 1999). A trial court is to be granted broad discretion in its decision to admit or exclude evidence and this court is to "presume that the discretion of the trial court was properly exercised unless the record clearly shows to the contrary." State v. Morgan, 813 P.2d 1207, 1210 n.4 (Utah App. 1991). In this instance, the trial court did not abuse its discretion.

The prior deposition testimony of the surgeon which the trial court allowed to be read to the jury consisted of statements by the surgeon that:

He had significant physical impairments and ongoing problems with chronic pain;

he had obtained a medical disability discharge from the Army while serving as an orthopedic surgeon during the Desert Storm conflict shortly before starting up his orthopedic surgery practice in Vernal;

he had received a 90% impairment rating from the Veterans Administration based on rheumatoid arthritis;

he was impaired by restricted range of motion in his right thumb, left ankle, neck and lumbar spine; his eyes "are not equal" which "drives me nuts";

he was diagnosed as having Post Traumatic Stress Disorder and was started on Serotonin uptake inhibitors;

following his medical disability discharge from the military in 1992, he attended a pain management clinic in Provo and another in Salt Lake;

he underwent neck surgery in Dallas, Texas in February of 1995;

he fell off a horse while trying to gain admission to a high school football game in September of 1995;

he spent four days at the Wasatch Canyons Day Spring Clinic in the Fall of 1995, where his treating physician was "the head addictionologist for the State";

while practicing orthopedic surgery in Vernal, he consumed various narcotic drugs on a regular basis including Methadone, Sublimaze patches, Zoloft, Deporal, Relafen, Lodine, Prilosec and Ultram.

(Trial transcript at pp. 444 - 446).

Rules 803 and 804 of the Utah Rules of Evidence contain exceptions to the hearsay rule. Those found in Rule 803 apply regardless of whether the declarant is available as a witness at trial. Those found in 804 apply when the declarant is

unavailable. The surgeon's prior deposition testimony is admissible under provisions of both rules.

**A. The Surgeon's Statements of His "Then Existing Physical Condition" Were Admissible Under Rule 803(3).**

Among statements not excluded by the hearsay rule are statements "of the declarant's then existing . . . physical condition (such as . . . pain, and bodily health)". Rule 803(3). Any statements made by the surgeon in depositions concerning his physical condition, pain or bodily health were expressly admissible under this recognized exception to the hearsay rule.

**B. The Surgeon's Statements Against Interest Were Admissible Under Rule 804(b)(3).**

When a declarant is unavailable because of death, any statement made by him is admissible if it was

at the time of its making so far contrary to the declarant's pecuniary or proprietary interest, or so far tended to subject the declarant to civil . . . liability . . . that a reasonable person in the declarant's position would not have made this statement unless believing it to be true.

Rule 804(b)(3). The statements Mrs. Haase sought to use in this case were all made by the surgeon in cases in which he was a defendant. There would have been no motive for the surgeon to have testified untruthfully about his having received a 90% disability rating from the VA or that he suffered from a wide variety of range of motion limitations and impairments. It was likewise against

his interest to reveal the identity of all the heavy prescription medications he was taking, to admit that he fell off his horse while attempting to gain access to a high school football game, and to acknowledge that shortly after that falling-off-the-horse-incident, he was admitted at the Day Spring Clinic in Salt Lake. Such statements by the surgeon were so far against his own interest that a reasonable person in his position would not have made them unless believing them to be true. The surgeon had no motive to prevaricate. His statements were therefore properly admitted.

**C. The Surgeon's Statements Were Admissible As Former Testimony Under Rule 804(b)(1).**

When a declarant is unavailable because of death, his prior deposition testimony is admissible when it was given:

in a deposition taken in compliance with the law in the course of the same or another proceeding, if the party against whom the testimony is now offered, or, in a civil action or proceeding, a predecessor in interest, had an opportunity and similar motive to develop the testimony by direct, cross, or re-direct examination.

Rule 804(b)(1), Utah Rules of Evidence. Here, the depositions of the surgeon in the Gottfredson and Haase cases occurred in civil actions then pending against the surgeon. The surgeon and his counsel in those cases had a motive identical to the motive of the hospital in this case: to defeat liability by demonstrating the surgeon was fit and able. The surgeon and his counsel had opportunity to

develop his testimony by cross examination during those depositions. There is no basis for assuming that had the hospital's counsel been present, he would have done anything that the surgeon's own counsel didn't do to "develop the testimony by direct, cross, or re-direct examination". Rule 804(b)(1), U.R.E.

Courts which have considered the "predecessor in interest" requirement have held it does *not* require "privity or common property interest" but "rather, a shared interest in the material facts and outcome of the case will create such an interest." New Jersey Turnpike Authority v. PPG Industries, 197 F.3d 96, at \_\_\_, fn. 21 (3<sup>rd</sup> Cir. 1999); See also Lloyd v. American Export Lines, Inc., 580 F.2d 1179, 1185-87 (3<sup>rd</sup> Cir. 1978). In New England Mut. Life Ins. Co. v. Anderson, 888 F.2d 646 (10<sup>th</sup> Cir. 1989), the court found that if a "like motive" to develop the same material facts is present, the predecessor in interest requirement is met. The burden of establishing a lack of similar motive of witness examination is on the party against whom the former testimony is being offered. Supermarket of Marlinton v. Meadow Gold Dairies, 874 F. Supp. 721 (WDVa. 1994). The hospital has not met and cannot meet that burden.

The surgeon's sworn deposition statements were made in a civil action in which he was attempting to defeat liability by demonstrating he was a fit and able surgeon. His interest as a defendant was identical to the hospital's interest in this action. He was capably represented by counsel who had ample opportunity and an identical motive to "develop", rebut or clarify his testimony.

**D. The Surgeon's Statements were admissible under the Catch-all Exceptions of Rules 803 and 804 Because They Carried Circumstantial Guarantees of Trustworthiness.**

Hearsay statements are admissible under Rule 803(24) and 804(5) even when they do not qualify under any other recognized exception when they have "equivalent substantial guarantees of trustworthiness". The "catch all" exceptions set forth in these two rules are identical. They provide for the admission of

a statement not specifically covered by any of the foregoing exceptions but having equivalent substantial guarantees of trustworthiness, if the court determines that (A) the statement is offered as evidence of a material fact; (B) the statement is more probative on the point for which it is offered than any other evidence which the proponent can procure through reasonable efforts; and (C) the general purposes of these rules and the interests of justice will best be served by admission of the statement into evidence.

Rule 803(24); See also Rule 804(5). Here, the surgeon's sworn deposition statements were offered as evidence of material facts. They were more probative on the points for which they were offered than any other evidence Mrs. Haase could procure through reasonable efforts.<sup>4</sup> The general purposes of our rules of

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<sup>4</sup> Mrs. Haase attempted to obtain the surgeon's military discharge records but found they could not be obtained without the authorization of the surgeon's widow, who refused to authorize their release. The massive pleading file in this case reflects Mrs. Haase's dogged but fruitless attempts to obtain, prior to trial, records from the V.A. and from other providers of medical and psychological care to the surgeon. When she was finally able to obtain, the Day Spring records, the hospital refused to stipulate to their authenticity. Her counsel therefore had to take no fewer than 3 depositions to establish the truth of information contained in those records. Ultimately, the trial court refused to allow admission of any portion of the Day Spring records. (Tr. 1196).

evidence and the interests of justice were best served by the trial court's admission of the surgeon's statements into evidence. Because the statements carried substantial guarantees of trustworthiness, the trial court was correct in allowing them to be heard by the jury.

### III.

**THE TRIAL COURT DID NOT ERR IN ADMITTING  
THE RESULTS OF THE SURGEON'S FINGER  
DEXTERITY TESTS. THE FACT THAT THE TESTS  
WERE ADMINISTERED 14 MONTHS AFTER THE  
SURGERY ON MRS. HAASE GOES TO THE WEIGHT,  
NOT THE ADMISSIBILITY, OF THEIR RESULTS.**

Neither the dexterity tests administered to the surgeon during his May, 1997 deposition nor the test results constitute "hearsay". By stipulation, the testing was videotaped. The videotape was available for review by counsel and the court at any time. The tests were administered by a Utah Department of Work Services employee in Vernal who was subpoenaed to testify at trial and did in fact testify at trial. She was cross examined by the hospital's counsel in front of the jury concerning the tests she administered and the results of those tests.

Although the hospital was not present when the court in Vernal granted leave to administer the dexterity tests, the position it likely would have taken was strenuously and valiantly argued by the surgeon's own able counsel, Mr. David Epperson. The hospital's presumed objection to the *administration* of the

dexterity tests could not have been presented more forcefully or vehemently than presented by Mr. Epperson. The *admissibility* of the dexterity tests and test results was thoroughly briefed long before the trial occurred. (See, R.175-211 and 304-336). <sup>5</sup>

The fact that the tests were administered 14 months after the surgeon operated on Mrs. Haase does not render their results irrelevant or inadmissible. That fact goes only to weight, not to admissibility. The hospital's counsel very eloquently argued to the jury that they should assign little weight to the tests because of the time gap. (See Tr. 1498-99).

The trial court did not abuse its discretion in allowing the Utah Department of Work Services employee, Kathleen Williams, to testify at trial concerning her administration of the dexterity tests and the results of those tests.

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<sup>5</sup> In October of 2000, Mrs. Haase counsel presented written argument to the trial court stating Mrs. Haase's position: The test results are not hearsay because (a) the testing was videotaped and could be reliably confirmed by the videotape and (b) the tests were administered by a person who could appear in court and authenticate the test results. The hearsay rule is to prevent unreliable information from being used as evidence. The dexterity testing information was reliable. Its reliability was confirmable both by live testimony of the person administering the tests and by the videotaping of the testing itself.



#### IV.

**THERE WAS NO ERROR IN THE ADMISSION OF DR. LONNIE PAULOS' "UNEDITED"VIDEOTAPED TRIAL TESTIMONY BECAUSE THE HOSPITAL MADE ONLY FOUR OBJECTIONS DURING THE EXAMINATION, THE OBJECTIONS WERE EACH NON MATERIAL AND OVERRULEABLE, AND THERE WAS NOTHING OBJECTIONABLE TO DELETE. THE JURY HEARD NOTHING IT SHOULD NOT HAVE HEARD.**

The formal notice of Dr. Paulos' deposition expressly stated the deposition would be videotaped for use at trial in lieu of Dr. Paulos' personal appearance. It was clear when Dr. Paulos was deposed that Mrs. Haase intended to use his deposition at trial in lieu of his personal appearance. The hospital had notice that any objections it wished to make to his testimony should be made on the record during the deposition. (Tr. 142).

On page 17 of its brief, the hospital quotes a passage from the trial transcript which supposedly reflects the court's reservations about allowing the jury to hear Dr. Paulos' unedited videotape. The passage indicates the court would have sustained some objections made during the videotape. That passage, however, had nothing to do with Dr. Paulos' videotaped testimony. It concerned the videotaped testimony of Dr. Richard Jackson! (Tr. 509 - 511). The hospital has raised no objection to the use of Dr. Jackson's unedited videotaped testimony at trial. The quoted passage, therefore, is both inappropriate and misleading in a discussion of Dr. Paulos' videotaped testimony.

During the entire deposition of Dr. Paulos, the hospital made only four objections. Two simply complained that the question posed by counsel misstated the deposition testimony of the hospital's CEO, Ron Perry. After the first such objection was made, Mrs. Haase's counsel responded that "the transcript says whatever it says" and invited the hospital's counsel to correct whatever misstatement he felt had been made. The hospital's counsel declined that invitation. (Paulos depo at pp. 8-9)

The second such objection occurred on page 11 of the deposition:

Q. Now, I'm not going to try and misstate and I haven't so far tried to misstate Ron Perry's testimony, but I think he testified that during the recruiting process of Dr. Hawkes, Dr. Hawkes told him that he had had a falling out with his colleagues at Cottonwood Hospital, including you and Dr. Rosenberg, and he indicated to . . . Ron Perry that the reason for that falling out was of jealousy over his, Dr. Hawkes, having some preeminence in laser surgery.

A. Objection, misstates testimony.<sup>6</sup>

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<sup>6</sup> The hospital's counsel is correct that Mr. Perry had not used the word "jealousy". However, counsel's characterization is arguably fair. Mr. Perry said this concerning what the surgeon reported to him about his falling out with his orthopedic colleagues in Salt Lake:

Thomas Hawkes was in the forefront of laser shoulder surgery . . . and in orthopedic services, among surgeons, one upsmanship is good and bad. He was receiving recognition for his ability to perform this process called laser shoulder surgery, and Lonnie Paulos and Tom Rosenberg did not believe that this procedure was a good procedure and so they had a falling out.

(Ron Perry depo at 33).

This objection was also not material. Both sides had full opportunity to explore with Dr. Paulos whether there had been a falling out and, if so, the reasons for it. Dr. Paulos testified he was not even aware of any “falling out”. (Lonnie Paulos depo at 11).

Had the foregoing two objections been ruled on before trial, they would have resulted in no editing. There was simply nothing to delete. Moreover, the objections were to matters which were in no way material and could not have had any substantial impact on the jury’s deliberations of the real issues in the case.

A third objection was merely to foundation. It occurred when Dr. Paulos was asked when, if at all, he became aware of the surgeon having any sort of problems with drug use. This objection, like the others, proved entirely immaterial. Dr. Paulos responded that he was not aware of such problems until after the surgeon’s death. His reservations about the surgeon’s being a danger to patients was based entirely on his appraisal of the surgeon’s skills and judgment in performing surgeries, not upon any impairment related to drug use. (Paulos depo at 19, lines 16-20).

The only other objection was made when Dr. Paulos was asked this hypothetical question:

Q. . . . if you had been contacted . . . in early March of 1996 by anyone associated with the re-credentialing of Dr. Hawkes, what kind of response would you have given by then [as to whether Dr. Hawkes was a danger to patients]?

The hospital objected to this question on the grounds of “foundation, form of the question, relevance”. (Paulos depo at 16, lines 2-3). The objection to “form of the question” is patently meritless. The objection as to foundation is likewise meritless. Clearly, Dr. Paulos had the foundational knowledge to testify how he would have responded to such a question in March of 1996 or, if he didn’t, he could have said so. The only other ground offered by the hospital was “relevance”. Clearly, what was knowable by the hospital in early March of 1996 before this surgeon operated on Mrs. Haase was relevant to whether the hospital breached its duty to protect Mrs. Haase from a dangerously unfit surgeon.

The hospital’s own credentialing expert, Hugh Greeley, testified during the trial that the surgeon would have been due for re-credentialing in either 1995 or 1996. (R. 1170-71). Since Dr. Paulos had performed repair and revision surgeries on a number of Dr. Hawkes’ patients by that time, he would have been an appropriate person for the hospital to have contacted during the re-credentialing process.

Dr. Paulos was later asked how he would have responded if the hospital had made the same inquiry in 1995. Interestingly, the hospital raised no objection to that question. Dr. Paulos responded that he would have provided a “highly negative” response. (Paulos dep at 16, lines 5-6; page 19, line 9).

In summary, the failure to “edit” the Paulos deposition was immaterial. The jury heard nothing that it should not have heard. The hospital raised a total of

four objections during the testimony and all of them were inconsequential.<sup>7</sup>

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<sup>7</sup> The hospital made no objection to the “meat” of Dr. Paulos’ testimony, which was his authentication of his written response to a letter from Mrs. Haase’s counsel in January of 2002. The letter to Dr. Paulos began with the following question, typed in bold-faced letters:

**If the administrators or medical executive committee of Ashley Valley Hospital had asked you in early 1993 or at any time thereafter whether Dr. Thomas Hawkes was a danger to patients by reason of being an impaired or compromised provider or due to poor judgment or inadequate skill, what would your truthful response have been?**

(Exhibit 1 to Lonnie Paulos deposition; see also page 6 of Paulos deposition).

Dr. Paulos responded in writing to that letter as follows:

I have received your letter concerning Dr. Thomas Hawkes dated 1/24/02. My response to the question that you posed is that patients would have been in danger. . .

(Exhibit 2 to Lonnie Paulos deposition; see also pp. 6-7 of Paulos deposition).

Another critical feature of Dr. Paulos’ deposition testimony to which the hospital raised no objection was his recollection of having in 1993 verbally informed the hospital’s administrator, Ron Perry, of his serious reservations about Dr. Hawkes. When shown a copy of a questionnaire form allegedly sent to him by a secretary of the hospital’s credentialing committee, Dr. Paulos indicated he may in fact have received the questionnaire. The hospital had no record of any written response from him and he did not recall having made one. He did, however, recall having contacted Ron Perry by telephone to express his negative appraisal of the surgeon. (Lonnie Paulos depo at 14 -18).

Although Mr. Perry denied receiving such a call (Tr. 1165), he did admit learning in 1993 that Dr. Paulos held negative views about Dr. Hawkes’ operating skills and his safety to patients. (Tr. 1165, line 24 - 1166, line 2).

V.

**THE TRIAL COURT DID NOT ERR IN ALLOWING DR. MARGARET ENSIGN TO EXPRESS HER OPINION THAT THE SURGEON WAS IMPAIRED AT THE TIME OF THE HAASE SURGERY BECAUSE HER OPINION WAS SOLIDLY FOUNDED ON SEVERAL RELEVANT FACTORS WHICH SHE WAS COMPETENT TO CONSIDER.**

The hospital suggests that Dr. Ensign's "sole basis" for believing the surgeon was impaired "was her conclusion that the post-operative note written by the surgeon seemed confusing and inconsistent". (Brief of Appellee/Cross Appellant at p. 20). That is not correct.<sup>8</sup>

Dr. Ensign's opinion that the surgeon was impaired was based on several factors other than the surgeon's operative report being "anatomically inaccurate,

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<sup>8</sup> Dr. Ensign testified that she had reviewed both the pre-surgery and post surgery x-rays of Mrs. Haase's right knee, as well as x-rays of Mrs. Haase's uninjured left knee, for comparison purposes. She also studied, in addition to the surgeon's official report of his surgery on the right knee, the hospital chart and records reflecting Mrs. Haase's hospitalization before and after that surgery. In addition, she read the office notes, history and physical and operative report of Dr. Richard Jackson, the surgeon who undertook to repair the severe patellar baja created during the Vernal surgeon's operation. She studied Dr. Jackson's deposition testimony and the drawing Dr. Jackson made of what he found in the knee when he opened it up, which she compared with the drawing Dr. Hawkes had made to reflect what he claimed to have found during his surgery. (R. 1240). Her opinion was based on the pertinent x-rays, operative reports, deposition transcripts, the "nature, . . . angle, . . . location and . . . severity of the patellar tendon laceration . . . Dr. Jackson observed in his repair surgery" and on her scrutiny of the operative report the Vernal surgeon dictated on the day he performed his surgery. (R. 1246-47).

. . . unclear, confusing, [and] incomprehensible". (R. 1250). Those factors include the fact that what the surgeon described as his surgery "was totally different from what Dr. Jackson found at his surgery" (R. 1251, lines 19-21; 1250, lines 3-5). They also included Dr. Ensign's belief, as a trained physician, that an unimpaired physician would not prescribe vigorous physical therapy immediately post-op for a patient with patellar baja as bad as this patient had (R. 1253-54), would not prescribe a duragesic patch - which is a slow releasing narcotic medication - for treatment of acute pain in a patient following surgery (R. 1254), and would not fail to inform the patient that she had been left with severe patellar baja after the surgery. (R. 1254).

The hospital's suggestion that Dr. Ensign was unqualified to render the opinion she rendered is also without merit. Dr. Ensign testified that in addition to being a board certified radiologist with a sub specialty in musculoskeletal radiology, she took several courses during her medical training dealing with the effects of prescription pain medications, Class I, II and III narcotics, Demerol, Morphine, etc. She testified she had occasion to prescribe Demerol and other prescription pain medications during her career as a physician. She also testified that prior to becoming a physician, she worked as a high school teacher and athletic coach. She trained and worked with athletes who sustained broken bones in their lower extremities. (R. 1241-1242). An objective review of Dr. Ensign's entire testimony at trial reveals she was well qualified to render the

opinion she rendered. The trial court did not err in so finding.

The trial court's decision to allow Dr. Ensign to testify by telephone was not an abuse of discretion. The court heard evidence as to why it was virtually impossible for Dr. Ensign to appear in person at trial and, balancing all of the equities, concluded that she could testify by telephone. It is likely her testifying by telephone was more prejudicial to Mrs. Haase than to the hospital.

There is no basis for concluding that had Dr. Ensign not been allowed to testify, the outcome of the trial would have been any different. The evidence that the surgeon was in an unfit, dangerous condition at the time he operated on Mrs. Haase was overwhelming. Dr. Ensign was only one of some 20 witnesses to offer opinions and observations as to the surgeon's apparent impairment. More specifically, at least two other witnesses, orthopedic surgeon William Stryker and Richard Jackson, testified as she did that the surgeon's operative report was grossly "nonsensical". (Tr.1263-1283 and 474-554). Their testimony rendered her opinion as to the operative report merely cumulative.



## VI.

**THE TRIAL COURT DID NOT ERR IN ALLOWING  
REFERENCE TO THE SURGEON'S TREATMENT AT  
DAY SPRING BECAUSE HIS TREATMENT THERE  
WAS HIGHLY RELEVANT TO WHETHER THE  
HOSPITAL WAS NEGLIGENT IN FAILING TO  
PROTECT MRS. HAASE FROM A DANGEROUSLY  
IMPAIRED SURGEON.**

The hospital has not identified any particular passage from the trial record containing a reversibly erroneous reference to the surgeon's treatment at Day Spring. Such failure should itself defeat the hospital's claim.

In his pretrial deposition, the hospital's CEO testified he had not been aware the surgeon had been treated at Day Spring.<sup>9</sup> In his trial testimony, he initially claimed to have first learned of the surgeon's in-patient treatment at Day Spring during his deposition in this case. (Tr. 196). However, he eventually admitted he had learned of the surgeon's Day Spring stay before the surgeon operated on Mrs. Haase 6 months later and that this was contrary to his deposition testimony. (See Tr. 197). Reference to the Day Spring treatment was necessary to impeach the hospital's CEO. Reference to the surgeon's treatment at Day Spring was appropriate. In fact, admission of the Day Spring treatment records themselves would have been appropriate. See Section II, Argument I, infra.

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<sup>9</sup>The records themselves suggest in no fewer than 5 places that the surgeon had been sent to Day Spring for treatment by the hospital! See fn. 11, infra.

## SECTION ONE

### THE TRIAL COURT MADE REVERSIBLY ERRONEOUS RULINGS IN FAVOR OF THE HOSPITAL.

#### I.

**THE TRIAL COURT ERRED IN REFUSING TO ALLOW THE JURY TO CONSIDER AUTHENTICATED RECORDS OF THE DECEASED SURGEON'S TREATMENT AT DAY SPRING WHEN THOSE RECORDS WERE OFFERED A) TO SHOW WHAT THE HOSPITAL COULD AND SHOULD HAVE KNOWN; AND B) TO REBUT THE HOSPITAL'S CLAIM IT HAD NEITHER REQUESTED NOR REQUIRED HIM TO SUBMIT TO TREATMENT AT DAY SPRING.**

Rulings on the admissibility of evidence are generally reviewable under an abuse-of-discretion standard. State v. Alonzo, 932 P.2d 606, 613 (Utah App. 1997), *aff'd*, 983 P.d 975 (Utah 1998). Mrs. Haase submits the trial court acted beyond the bounds of reasonability in refusing admission of the surgeon's Day Spring treatment records.

The trial court's refusal to admit selected portions of the surgeon's treatment records in the Day Spring program was based on lack of evidence that the hospital knew what those records contained before the surgeon operated on Mrs. Haase. (Tr. 1196). The key question, however, isn't solely what the hospital knew, but what it *should have known* about the surgeon's treatment at Day Spring. The records themselves indicate in numerous places that the

surgeon had been sent to Day Spring by hospital representatives.<sup>10</sup> It is strongly inferable from the Day Spring records that the hospital should have learned both of the specifics and of the outcome of the surgeon's in-patient treatment there. Having sent him, the hospital had an obligation to find out if the treatment was successful and, if the care providers at Day Spring recommended further treatment, whether he was submitting to the following up care he needed. Jurors could well have found the records highly useful in determining whether the hospital met its duty to monitor and follow up on the treatment it recommended.

The hospital could have discovered the contents of the Day Spring records

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<sup>10</sup> Day Spring chart entries include these:

"The medical staff at his hospital have requested an evaluation concerning his possible drinking and substance abuse."

"The hospital medical staff has requested this evaluation."

"Here now per referral from 1° [primary care ] M.D."

"Admits that hospital he works at requested a CD [chemical dependency] evaluation."

"13. Have you ever gotten into trouble at work because of your drinking or drug use?      ✓ [Yes]."

(See Plaintiff's Trial Exhibit 18 and Addendum 2, attached, at pp. 6, 10, 24, 46, 107).

under the authorization the surgeon signed in his credentialing application.<sup>11</sup>

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<sup>11</sup> Although the hospital was unable to provide or authenticate a complete copy of its entire credentialing file on the surgeon, it did produce, through various witnesses, portions of the credentialing file. One document produced as part of the surgeon's credentialing file is entitled "**Specific Consent to Information Exchange and Conditions of Consideration in Connection with . . . Appointment/Re-appointment.**" (Emphasis added) This document, apparently signed by the surgeon on 8-15-94, provides in pertinent part:

I understand that it is necessary . . . to obtain detailed information about me in order to complete the Process. I understand that such information may be private, sensitive, privileged, and otherwise confidential. It is my request, and I hereby give my consent, that such information be disclosed.

**. . . I intend that this consent include all information that reflects on my ability to safely, competently, and professionally perform the professional activities . . . and/or . . . participation I have requested .**  
. . .

I intend that this consent extend to all persons, institutions, and entities that have such information about me, including: . . . hospitals, . . . and to persons or committees associated with any of these. In connection with the Process, I also give my consent for all such persons, institutions, and entities to express their opinion(s) about me and to make recommendations about my professional skills, conduct, and ability to perform the clinical privileges . . . I have applied for. I also give my consent for [Ashley Valley Medical Center] and [its] medical staffs, officers, agents, committees, and employees involved in the Process to receive and act upon all such information, opinions, and recommendations in connection with the Process.

(See Addendum 3, attached).

One of Mrs. Haase's principal reasons for offering the Day Spring chart was to rebut the hospital's assertion that it was unaware the surgeon had received in-patient treatment at Day Spring. Dr. Ace Madsen was both the surgeon's primary care physician and a member of the hospital's medical staff. At the time the surgeon was credentialed, he was a member of the Credentialing Committee, the Medical Executive Committee and the hospital's Governing Board. (Tr. 227, 660, 973-74, 1104-05). Dr. Madsen claimed at trial to have been unaware that the surgeon had sought and obtained treatment at Day Spring and he denied having referred the surgeon to the Day Spring program. (Tr. 1072). The Day Spring records rebut that testimony. (See fn. 10, supra). Mrs. Haase should have been allowed to confront him with the Day Spring entries indicating the surgeon had been sent to the Day Spring program by his primary care physician.

## II.

### **THE TRIAL COURT ERRED IN REFUSING TO ALLOW THE JURY TO HEAR THE TESTIMONY OF DR. RAYMOND MIDDLETON, WHO TREATED THE SURGEON AT DAY SPRING AND COULD AUTHENTICATE THE SURGEON'S PERTINENT DAY SPRING TREATMENT RECORDS.**

In his February 1, 2002 deposition, Dr. Middleton authenticated the written memorialization of the history and physical he took of the surgeon in September of 1995. He acknowledged having learned the medical staff at the hospital had requested an evaluation concerning the surgeon's drinking and substance abuse. (Middleton depo at 6). He also acknowledged he had learned the surgeon suffered from frequent chronic migraine headaches. He determined the surgeon's "recent memory was impaired" and "his judgment has probably been poor". (Middleton depo at 9,10). His treatment plan for the surgeon included attendance at AA [Alcoholics Anonymous] and NA [Narcotics Anonymous] meetings and he expected the surgeon to attend such meetings after his in-patient stay at Day Spring. (Middleton depo at 12). Dr. Middleton confirmed there were indication throughout the record that people at the hospital had referred the surgeon to Day Spring. (Middleton depo at 19). He also confirmed the surgeon had acknowledged needing a career change and indicating he needed "at least 8 more months working as an orthopedic surgeon to avoid an

extreme catastrophe with the IRS, family and other issues”.<sup>12</sup> (Middleton depo at 21).

Dr. Middleton confirmed the surgeon had admitted having a chemical dependency problem as a result of long term use of opiates. (Middleton depo at 23). Dr. Middleton prescribed ongoing psychiatric treatment with Dr. Collins, following the surgeon’s discharge. (Middleton depo at 27-29).

Dr. Middleton’s deposition testimony shed considerable light on the surgeon’s condition 6 months prior to his undertaking surgery on Mrs. Haase and was therefore relevant. The jury reasonably could have found information he possessed concerning the surgeon’s condition included information the hospital should have obtained, if it did not. In addition, his testimony rebutted the hospital’s assertion it had not requested or demanded the surgeon go to Day Spring. (See p. 27, *supra*, and fn. 10, *supra*).

The jury should have been allowed to hear Dr. Middleton’s testimony.

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<sup>12</sup>The surgeon operated on Mrs. Haase within that 8 month period following his acknowledgment that he needed a career change.

III.

**THE JURY SHOULD HAVE BEEN ALLOWED TO  
CONSIDER AN ASSESSMENT OF PUNITIVE  
DAMAGES AGAINST THE HOSPITAL.**

Mrs. Haase's complaint specifically requests punitive damages. (R. 6, 4).

Mrs. Haase's Proposed Special Verdict Form included a question and a space for punitive damages. (R. 857-859). Mrs. Haase's Proposed Jury Instructions included an instruction on punitive damages. (Exhibit 13 to appellant's opening brief). The trial court, however, declined to allow the jury to consider punitive damages. In doing so, it erred.

The trial court's refusal to allow the jury to consider punitive damages was tantamount to a directed verdict on Mrs. Haase's punitive damage claim. In reviewing such a decision, the evidence must be examined in a light most favorable to the adverse party and if there is a reasonable basis in the evidence or the inferences to be drawn therefrom which would support a finding in favor of the adverse party, the directed verdict can not be sustained. Management Comm. of Graystone Pine Home Owners Association Ex Rel Owners of Condominiums v. Graystone Pines, Inc., 652 P.2d 896 (Utah 1982). A directed verdict is only appropriate when the court is able to conclude, as a matter of law, that reasonable minds could not differ on the facts to be determined from the evidence presented. *Id.* This issue, then, presents a question of law to be reviewed for correctness only.



By statute, punitive damages may be considered and awarded when there is clear and convincing evidence that a party's acts or omissions manifest a knowing and reckless indifference toward, and a disregard of, the rights of others. UCA §78-18-1(1)(a). During the nine day trial, clear and convincing evidence was presented in rich abundance that the hospital was fully aware that Dr. Hawkes was a dangerously impaired surgeon who suffered from a host of physical, emotional and financial problems, regularly consumed a dangerously high volume of narcotic pain medication and was so impaired that the hospital's CEO arranged for hospitalization and referred him to the Division of Professional Licensing's Impaired Physician Program one year before he operated on Mrs. Haase. The hospital began administering drug screen tests on Dr. Hawkes as early as 1993 and continued such testing past the surgeon's operation on Mrs. Haase but failed to retain (or at least produce) the results of those tests.

Dr. Hawkes' surgeries brought to the hospital a revenue of one million dollars per year. (Tr. 253). There is strong evidence that the hospital placed profits before patients and put its own financial welfare ahead of the welfare of both Dr. Hawkes and his patients.<sup>13</sup>

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<sup>13</sup> In closing argument, the jurors were asked: "Which is better: An impaired surgeon or no surgeon?" The evidence clearly and convincingly showed the answer in this instance to be: "It depends on whether you are the patient or the hospital". Perversely, the more impaired the surgeon, the more revenue that flowed to the hospital. In the case of Mrs. Haase, her error-filled surgery required her to remain in the hospital several days. If the surgeon's judgment and skills had not been impaired, Mrs. Haase either would not have had

Several witnesses confirmed the existence of numerous red flag indicators of a dangerously impaired surgeon. The trial court allowed 15 of those “red flags” to be admitted into evidence. (Plaintiff’s Exhibit 9; See Addendum 1, attached).

The hospital allowed Dr. Hawkes to perform surgeries at the hospital before he had even submitted his application for privileges! (Tr. 1410). The hospital’s own credentialing expert, Hugh Greeley, admitted that it would be reckless for a hospital to permit a physician to perform surgery before it had verified that the physician was competent to perform surgery. (Tr. 1436-37; See also 1411).

Although Mr. Greeley claimed he lacked expertise to opine on whether it would also be reckless for a hospital to permit a surgeon who regularly used opiates to operate on patients (Tr. 1437), other witnesses testified that a surgeon on opiate pain medications was extremely dangerous and the combination of such medication with prescription sleeping medication (which the surgeon was consuming) was “dynamite”. (Tr. 1282).

There was ample evidence to support a jury award of punitive damages. The trial court erred as a matter of law in refusing to allow the jury to consider a punitive damage assessment.

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the surgery or would have been fit to leave the hospital immediately following the surgery.

#### IV.

**THE TRIAL COURT ERRED IN CONCLUDING THAT A STATUTORY PEER-REVIEW PRIVILEGE PRECLUDED MRS. HAASE'S INTRODUCTION OF EVIDENCE AND TESTIMONY AGAINST THE HOSPITAL WHEN A) THE INFORMATION CONCERNED THE SURGEON'S FITNESS, NOT HIS PERFORMANCE, AND B) THE "PEER" UNDER REVIEW WAS DECEASED AT THE TIME OF TRIAL.**

Utah's medical peer-review statute protects certain information from disclosure on the theory and policy ground that health care providers will be better able to improve medical care if their peer-review studies and discussions are kept secret. UCA §26-25-3. The peer-review privilege, however, is to be narrowly construed. Benson ex rel v. IHC Hosps, 866 P.2d 537 (Utah 1993). Our Supreme Court has held that the privilege protects only documents prepared specifically for peer-review purposes, not documents that might or could be used in the peer-review process. *Id.* See also McCall v. Henry Medical Center, Inc., 551 S.E.2d 739, 739, 742-43 (Ga. App. 2001) and Greenwood v. Wierdsma, 741 P.2d 1079 (Wyo. 1987).

A critical distinction exists between peer-review and credentialing. Peer-review measures a provider's performance. Credentialing inquires about a provider's fitness. Even the hospital's credentialing expert admitted the distinction between credentialing and peer-review. (Tr. 1365). He further admitted that the credentialing and reappointing process includes assessments

“as to whether or not a physician’s health status would compromise their ability to provide safe patient care.” (Tr. 1366). He acknowledged that hospitals are expected to make such assessments as part of the credentialing/reappointment process. (Tr. 1366).

Throughout the trial, the hospital was allowed to hide behind the cloak of peer-review secrecy in dodging pertinent questions and withholding critical information as to what it knew concerning the surgeon’s physical impairments, drug dependencies and emotional and financial difficulties.<sup>14</sup> Its CEO and

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<sup>14</sup> Mr. Perry gave two-word, “peer-review” stonewalling responses to questions including these:

“As chief executive officer of the hospital did you personally become aware that Dr. Hawkes between ‘93 and March 12 of ‘96 had sought treatment from Ace Madsen?” (Tr. 1172).

“Did you ever contact Dr. Hawkes’ physician, Dr. Ace Madsen or anybody else, to determine whether he may have had a drug problem during the critical time period we’re talking about [1993 through April 15, 1996]?” (Tr. 261).

“Can you tell us whether you passed on to the board the fruits of your investigation of the high school falling off the horse incident?” (Tr. 267).

Did you ever report to the governing board about Dr. Hawkes having gone to rehabilitation for physical, emotional or drug problems? (Tr. 237)

“Did you report to the credentialing committee what Dr. Hawkes had told you about his falling out with his orthopedic colleagues in Salt Lake?” (Tr. 1175)

“Did you ever tell anyone on the credentialing committee or the MEC

attorney claimed the peer-review privilege on no fewer than 21 occasions during the trial. (Tr. 171, 189, 196, 204, 206, 207, 237, 265, 267, 273, 1164, 1172, 1173, 1175). The trial court routinely sustained the peer-review privilege assertions. (See, e.g., Tr. 207, 235, 261, 262, 266, 267, 275).

The peer-review privilege is to protect the care provider whose performance is under review by his peers. In this instance, the care provider died several years before the case came to trial. A major purpose of the peer-review privilege evaporates when the person under review is no longer living.

If this case is to be retried, the trial court should be given clear direction that no information concerning the surgeon's qualifications and fitness to perform invasive surgeries on patients at the hospital are to be protected on the ground of peer-review privilege. Queries pertaining to a surgeon's fitness fall under credentialing/reappointment matters, unlike queries concerning a surgeon's infection and morbidity rates, which may well be peer-review matters.

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about your awareness that Dr. Hawkes had some serious emotional problems?" (Tr. 1173).

## SECTION THREE

### **THE JURY'S CLEAR INTENT THAT MRS. HAASE RECEIVE ITS FULL \$820,000 DAMAGE AWARD SHOULD BE HONORED.**

#### **I.**

#### **THE TRIAL COURT INCORRECTLY INTERPRETED THE UTAH SUPREME COURT'S DECISION IN BISHOP V. GEN TEC, INC.**

Whether a trial court properly interpreted the effect of a prior judicial decision is a question of law which is to be reviewed for correctness with no deference given to the trial court's determination. Billings v. Union Bankers Ins. Co., 918 P.2d 461, 464 (Utah 1996).

There no longer can be any question that the controlling law in Utah now dictates that the jury's intent, above all else, is to be honored. Whenever necessary, a **"jury's verdict should be amended to reflect the true intent of the jury."** Bishop v. Gen Tec, Inc., 48 P.3d at 227 (Utah 2002).

The hospital asks this court to disregard the actual holding and precise ruling of our Supreme Court in Bishop and instead focus on New York case law. (Hospital's brief, p. 28). The hospital also asks this court to distinguish clerical error from judicial error in a manner inconsistent with the express distinction made by our Supreme Court. Unequivocally and unreservedly our Supreme Court has stated that "accurately recording the intent of the jury in its calculations

of the damage award constitutes a correction of a clerical error, not a judicial error”. Bishop at 227. **Here, 6 of the 7 jurors** who returned to court 6 weeks after the trial at the trial court’s direction **declared**, after learning the court had interpreted their special verdict in a way which gave Mrs. Haase only \$246,000 of their damage award, **that they had not accurately recorded their actual intent on the special verdict form.** (Tr. 1358 at pp. 24-25). Those same 6 jurors responded “**No**” to the specific query: “**was it your intent to award Mrs. Haase only \$246,000 for the damages she sustained as a result of the hospital’s negligence?**” (R. 1358, p. 19, lines 1-18, 22-25).

## **II.**

### **JUROR MISUNDERSTANDING WAS LIMITED SOLELY TO MATTERS FLOWING FROM THE INTRODUCTION OF FAULT ASSESSMENT AGAINST THE SURGEON (AFTER THE JURY HAD BEEN TOLD REPEATEDLY THE CASE WAS *NOT* ABOUT THE SURGEON’S NEGLIGENCE).**

The hospital mistakes Mrs. Haase’s purpose in explaining the likely cause of juror misunderstanding over its assessment of fault against the surgeon and the effect of that assessment on its damage award. Mrs. Haase does not seek to assign error with respect to the adequacy or inadequacy of jury instructions and special verdict forms. Her purpose has been merely to explain why the trial court and the jury did not share the same understanding of the jury’s damage award.

The trial was not about the surgeon's negligence. (Tr. 2) The hospital asked the court to remove the surgeon's negligence from consideration at trial. The court granted the hospital's request. (Tr. 1198, lines 16-17, 21, 1200, 1212-13).

Our Supreme Court recently declared:

A comparative negligence analysis necessarily involves an assessment of the relative degree of negligence of both parties. Indeed, in order to *compare* negligence, the trier of fact must assess both parties' conduct.

Harding v. Bell, 460 UAR 3, 5, fn. 4, 202 UT 108 (Utah 2002). Here, the jury had no basis for comparing the negligence of the hospital with the surgeon because the surgeon's negligence was not before it.<sup>15</sup> It is clearly understandable that the jury intended for Mrs. Haase to receive its full \$820,000 damage award, as that damage award reflected the damages flowing from the only negligence it had been given opportunity to consider.

It may be significant that although the jury had no knowledge of the amount of money the surgeon's representatives had paid Mrs. Haase in settlement three years prior to this trial, that sum, when added to the jury's \$820,000 award produces a total recovery just \$3,100 off the economist's projection of Mrs.

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<sup>15</sup> It was the hospital who asked the court to remove the surgeon's negligence from the jury's consideration. The court granted that request without regard to Mrs. Haase's position. Mrs. Haase should not be punished by having to endure another trial when she did nothing to contribute to the misunderstanding.



Haase's actual *special* damages.<sup>16</sup> It is apparent, therefore, that the jury was conservatively wise beyond its knowledge in awarding Mrs. Haase \$820,000 for the hospital's negligence.

## CONCLUSION

Under controlling Utah case law, the jury's true intent governs as to the damages Mrs. Haase is to receive for the hospital's negligence. The jury's intent to award Mrs. Haase \$820,000 for the hospital's negligence is overwhelmingly clear from the jurors' post-trial declarations.

The trial court committed no reversible errors in favor of Mrs. Haase during the trial. All of the evidence the jury was allowed to hear against the hospital was both relevant and reliable. Much of the evidence the hospital claims should not have been admitted was largely cumulative and did not likely impact the result.

The trial court did make reversibly erroneous rulings in favor of the hospital during the trial in: refusing to allow the jury to consider authenticated records of the deceased surgeon's Day Spring treatment records; refusing to allow the jury to hear the testimony of Dr. Raymond Middleton, who treated the surgeon at Day Spring; concluding Utah's statutory peer-review privilege justified the hospital's dodging numerous pertinent questions about its awareness of the surgeon's

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<sup>16</sup> See fn 5 on p. 8 of Mrs. Haase's brief in chief. Counsel reveals this fact as an officer of this Court in full awareness of both the penalty of perjury and the risk of violating a confidentiality term.

unfitness; and refusing to allow the jury to consider an assessment of punitive damages against the hospital.

Although errors which favored the hospital may well justify a new trial, Mrs. Haase does not seek a new trial. On the contrary, she submits requiring the out-of-town judge, attorneys, expert witnesses and fact witnesses to return to Vernal for a two week trial would entail colossal expense, inconvenience and trauma. By this point, just impaneling a Uintah County jury without knowledge or bias concerning this case would be tremendously time-consuming and expensive, if not impossible.

Neither Mrs. Haase nor the jury did anything wrong. Mrs. Haase should not be punished with having to endure a new trial. Ordering a new trial would punish Mrs. Haase for mistakes she did not make and for a misunderstanding she did not create. By the clear weight of evidence, the jurors' post-trial declarations resolve any doubt concerning their true intent. That intent should be honored.

## **RELIEF REQUEST**

Mrs. Haase requests the relief she be granted include:

1. An order substituting the jury verdict component of the judgment from \$246,000 to \$820,000;
2. An order awarding her all costs incurred by her in this appeal, in addition to the \$4,570.19 in taxable costs awarded by the trial court;
3. Interest on the total judgment amount at the pre-judgment legal interest rate of 10% per annum or at the judgment interest rate, whichever the court deems more appropriate, pursuant to UCA §78-24-44 and 15-1-1.

## **ADDENDUM TO REPLY BRIEF**

### **MRS. HAASE'S RESPONSE TO THE HOSPITAL'S OPPOSITION TO MRS. HAASE'S OVERLENGTH BRIEF AND THE ALLEGED RAISING OF "NEW" ISSUES.**

The hospital cannot seriously contend surprise by Mrs. Haase's evidence issues (Section Two, *supra*). On pages 2 and 3 of her initial brief, Mrs. Haase identified nine issues she wished to preserve. Each of the four issues raised in Section II of this brief are identified as trial court errors on those pages of her opening brief. Because the hospital is allowed to file the last brief, it will not be prejudiced by responding to those issues in that brief.

After stating her opposition to remand for retrial and identifying the specific unfavorable evidentiary rulings she contests, Mrs. Haase stated her intent to defer briefing of her evidence issues to the submission she would file in response to the hospital's cross-appeal (see appellant's opening brief, p.3). The hospital's cross-appeal, unlike Mrs. Haase's opening brief, deals with trial evidence issues. Mrs. Haase's opening brief was less than 37 pages in length - nearly 14 pages shorter than it could have been. The combined length of Mrs. Haase's two briefs (excluding this addendum) exceeds the total page limits normally allowed under Rule 24(g), URAP by only 4 pages.

The hospital's opening brief was nearly 7 pages shorter than allowed. Mrs. Haase has no objection to this Court's receiving from the hospital a final brief of

up to 37 pages in length. If it does so, each party will have had equal opportunity and space to brief the issues properly before this Court.

The hospital should have adequate time and space to respond to the issues identified but not briefed in Mrs. Haase's opening brief. Mrs. Haase will not oppose a motion from the hospital for leave to file a final brief longer than 25 pages. Under the circumstances, such a motion should be granted. Each side should have equal opportunity adequately to address the issues raised by the other.

Respectfully submitted this 15 day of January, 2003.



Douglas G. Mortensen

**Matheson, Mortensen, Olsen & Jeppson, P.C.**  
Attorneys for Plaintiff/Appellant

#### **CERTIFICATE OF SERVICE**

On the 16 day of January, 2003, I caused to be delivered via the following method two copies of the foregoing to the following:

Robert R. Harrison  
Snow, Christensen & Martineau  
10 Exchange Place, 11<sup>th</sup> Floor  
P.O. Box 45000  
Salt Lake City, Utah 84145

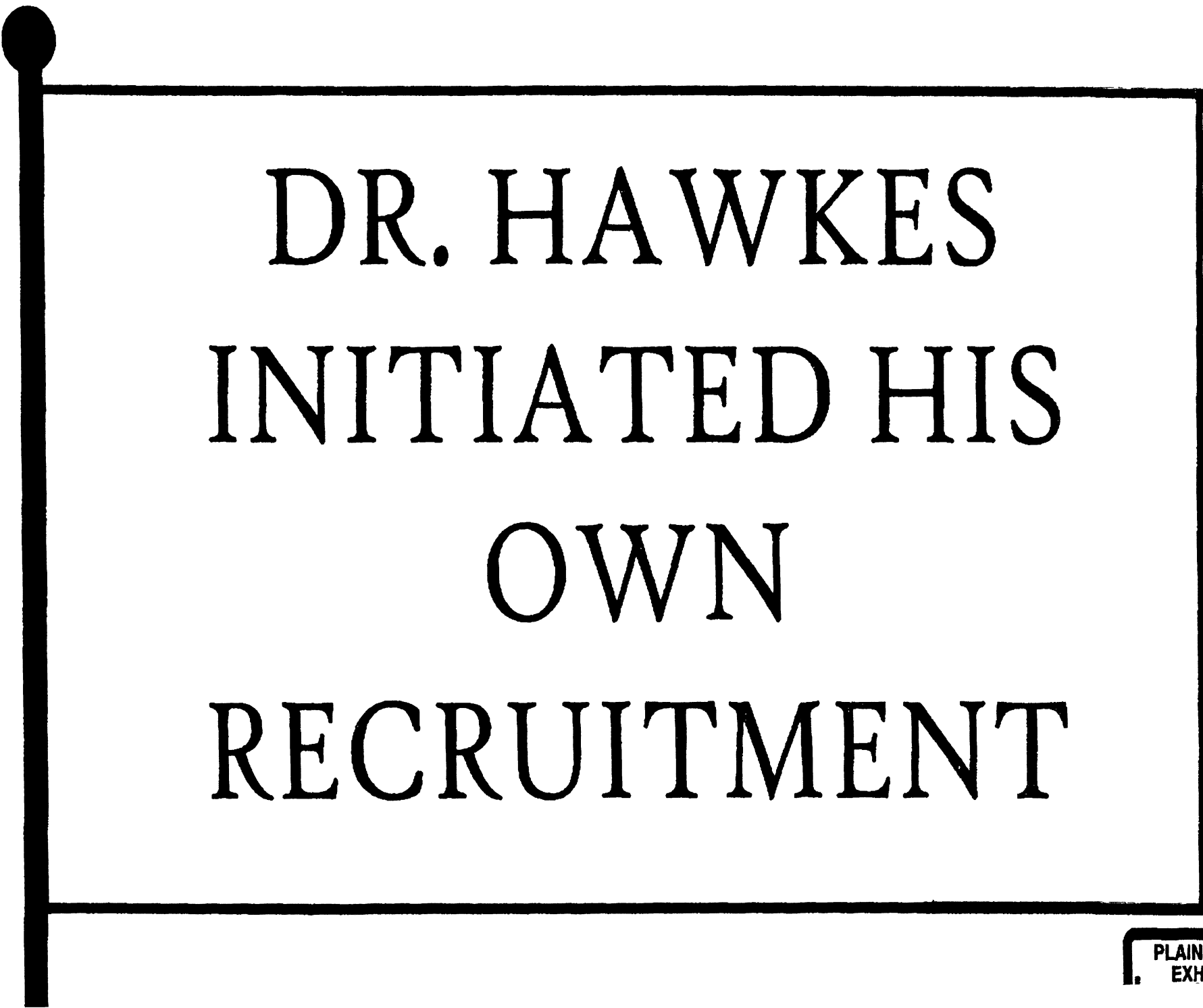
<input checked="" type="checkbox"/>	U.S. Mail
<input type="checkbox"/>	Facsimile -363-0400
<input checked="" type="checkbox"/>	Hand-Delivered
<input type="checkbox"/>	Federal Express



## **ADDENDUM EXHIBITS**

- 1. PLAINTIFF'S EXHIBIT 9 (RED FLAG INDICATORS OF AN IMPAIRED SURGEON)**
- 2. SELECTED PAGES OF PLAINTIFF'S PROPOSED EXHIBIT 18 (THE SURGEON'S DAY SPRING TREATMENT RECORDS)**
- 3. CONSENT TO RELEASE OF INFORMATION FOUND IN THE HOSPITAL'S INCOMPLETE CREDENTIALING FILE ON THE SURGEON**

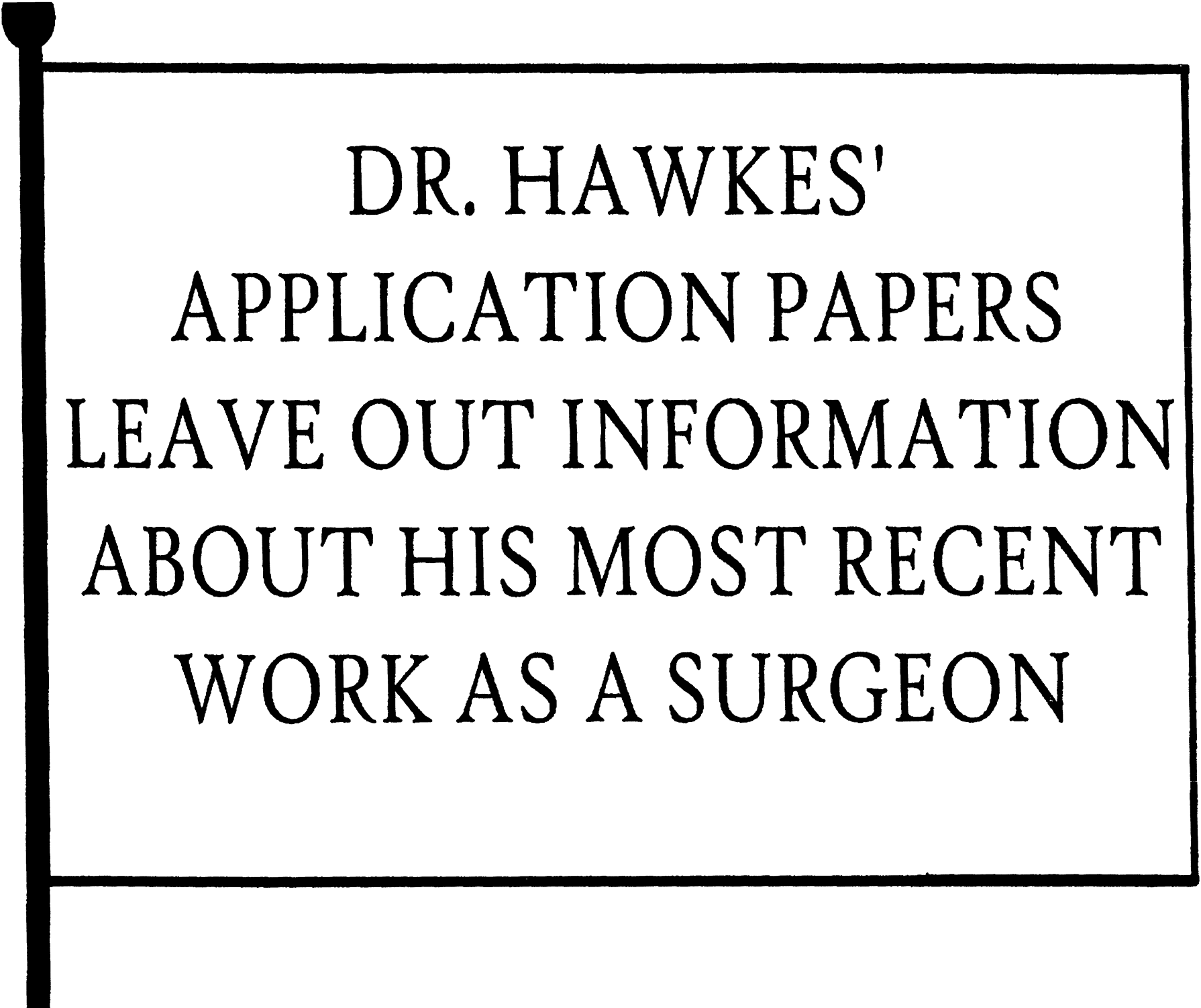
Tab 1



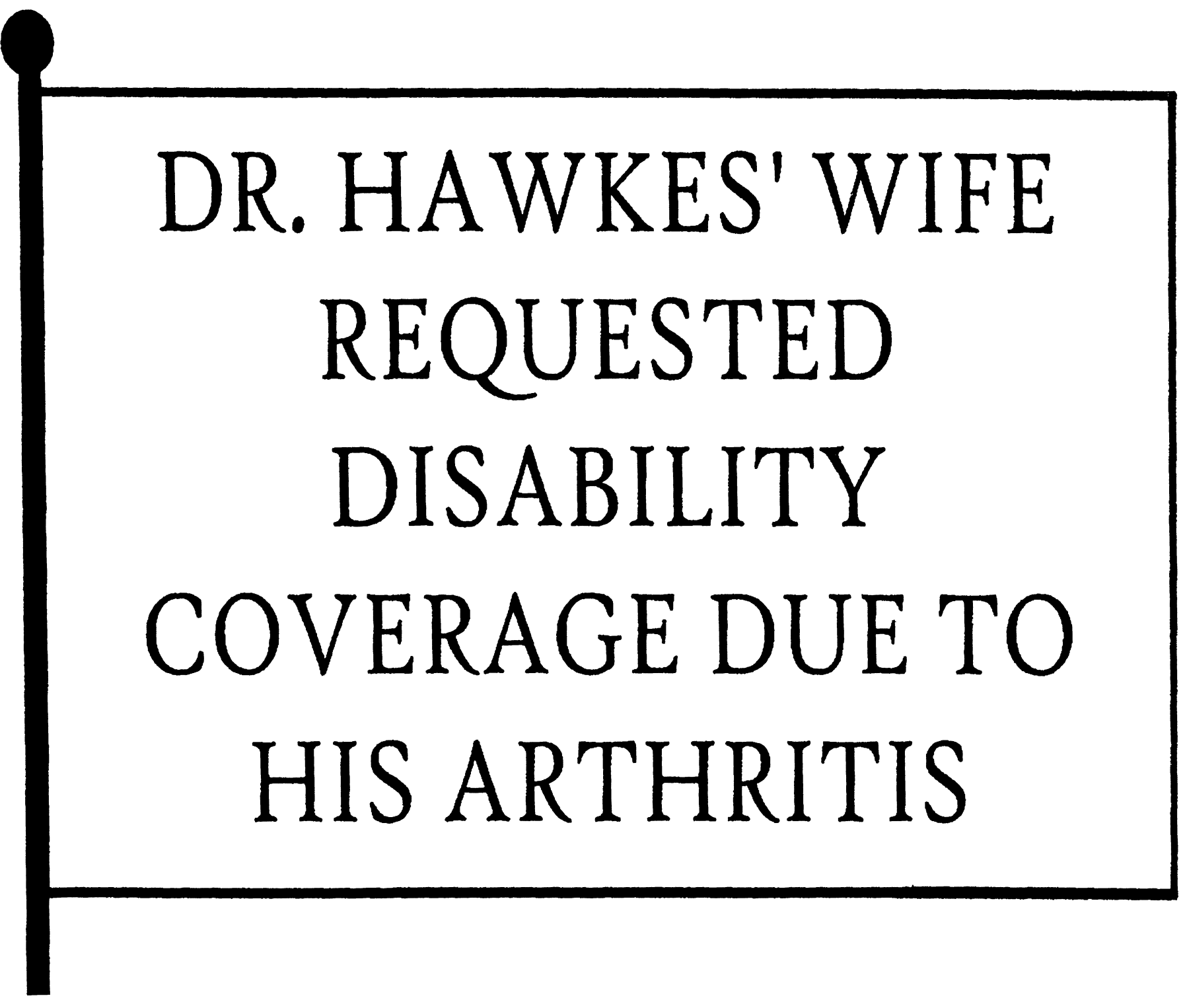
DR. HAWKES  
INITIATED HIS  
OWN  
RECRUITMENT

PLAINTIFF'S  
EXHIBIT

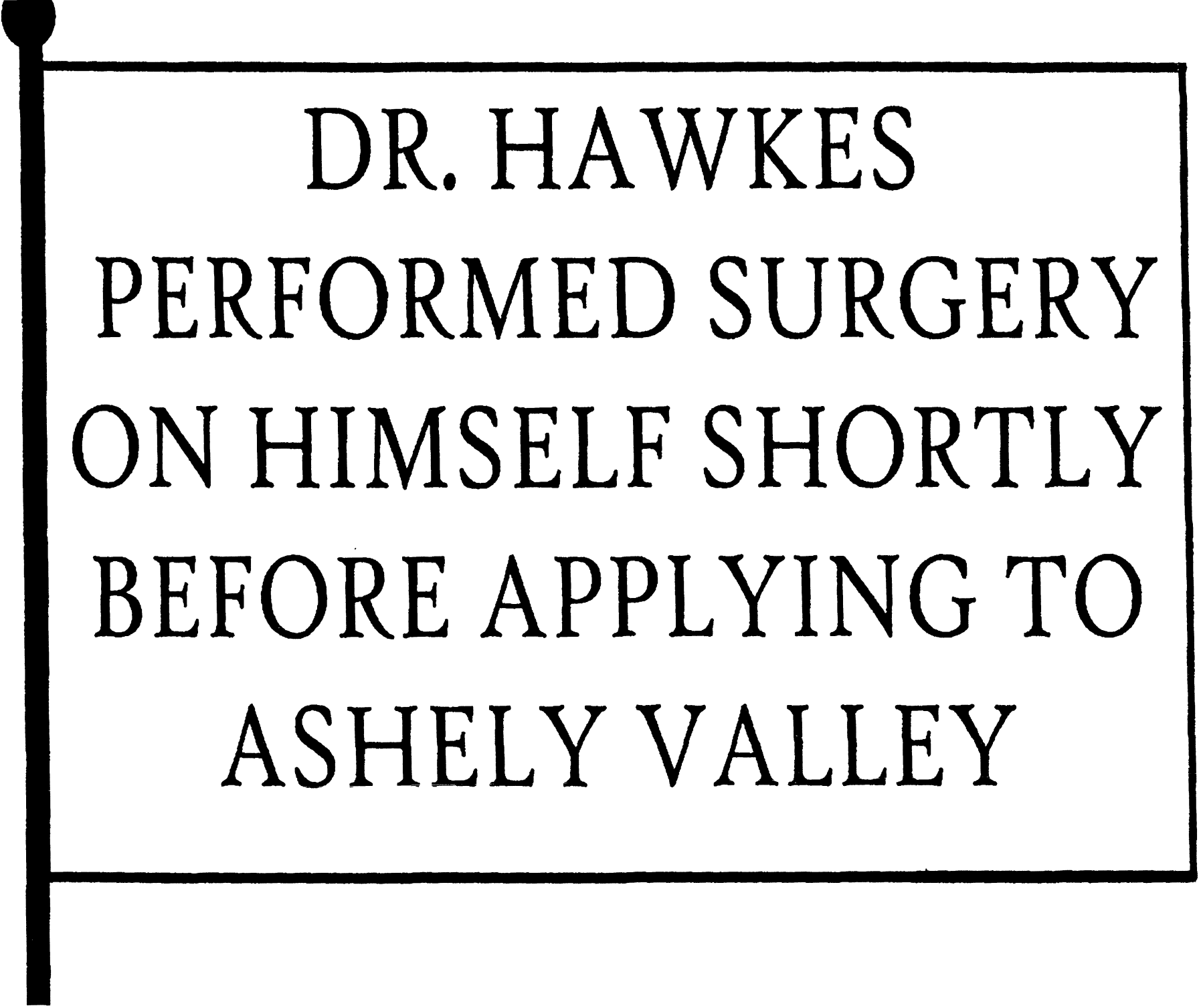




DR. HAWKES'  
APPLICATION PAPERS  
LEAVE OUT INFORMATION  
ABOUT HIS MOST RECENT  
WORK AS A SURGEON



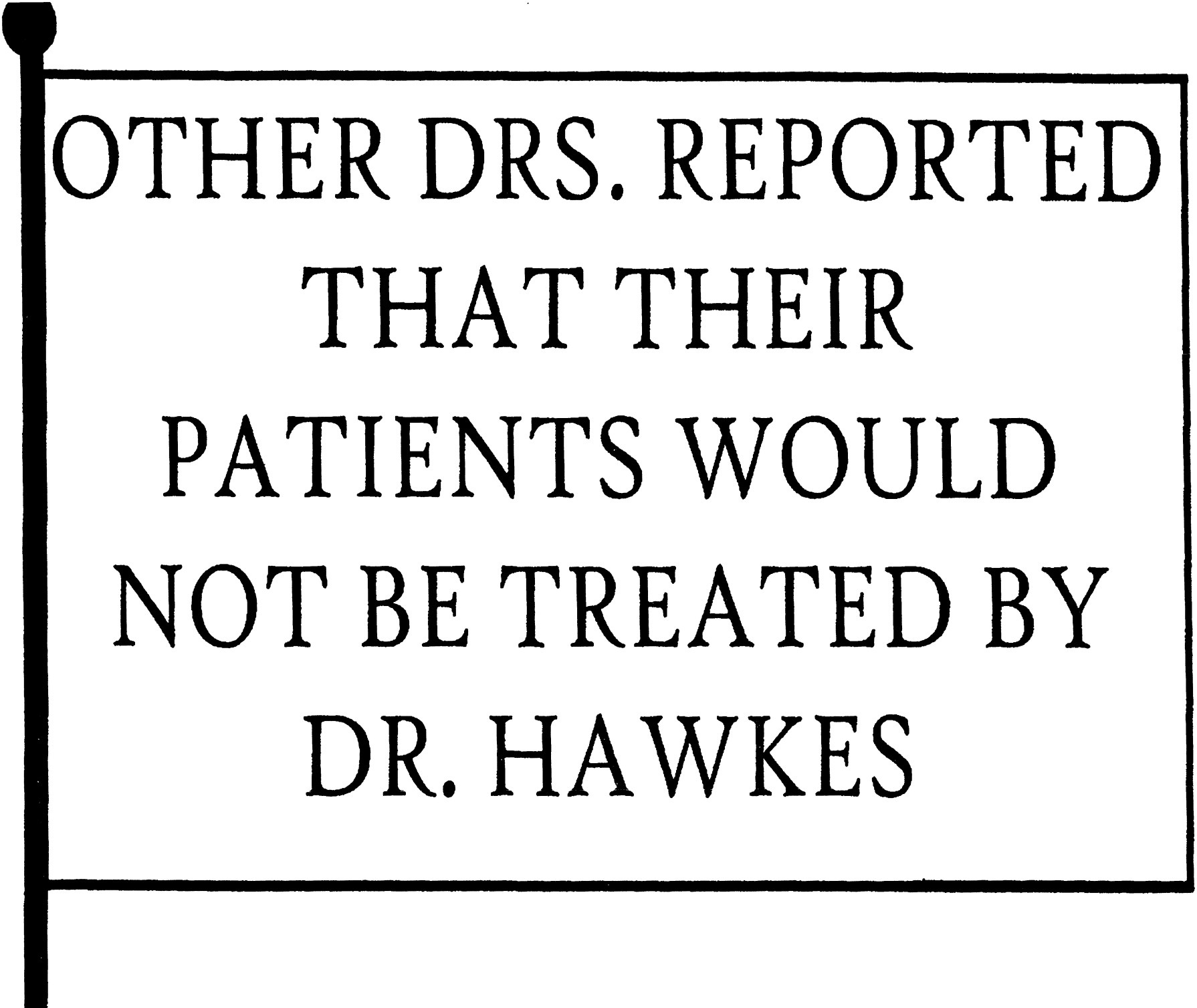
DR. HAWKES' WIFE  
REQUESTED  
DISABILITY  
COVERAGE DUE TO  
HIS ARTHRITIS



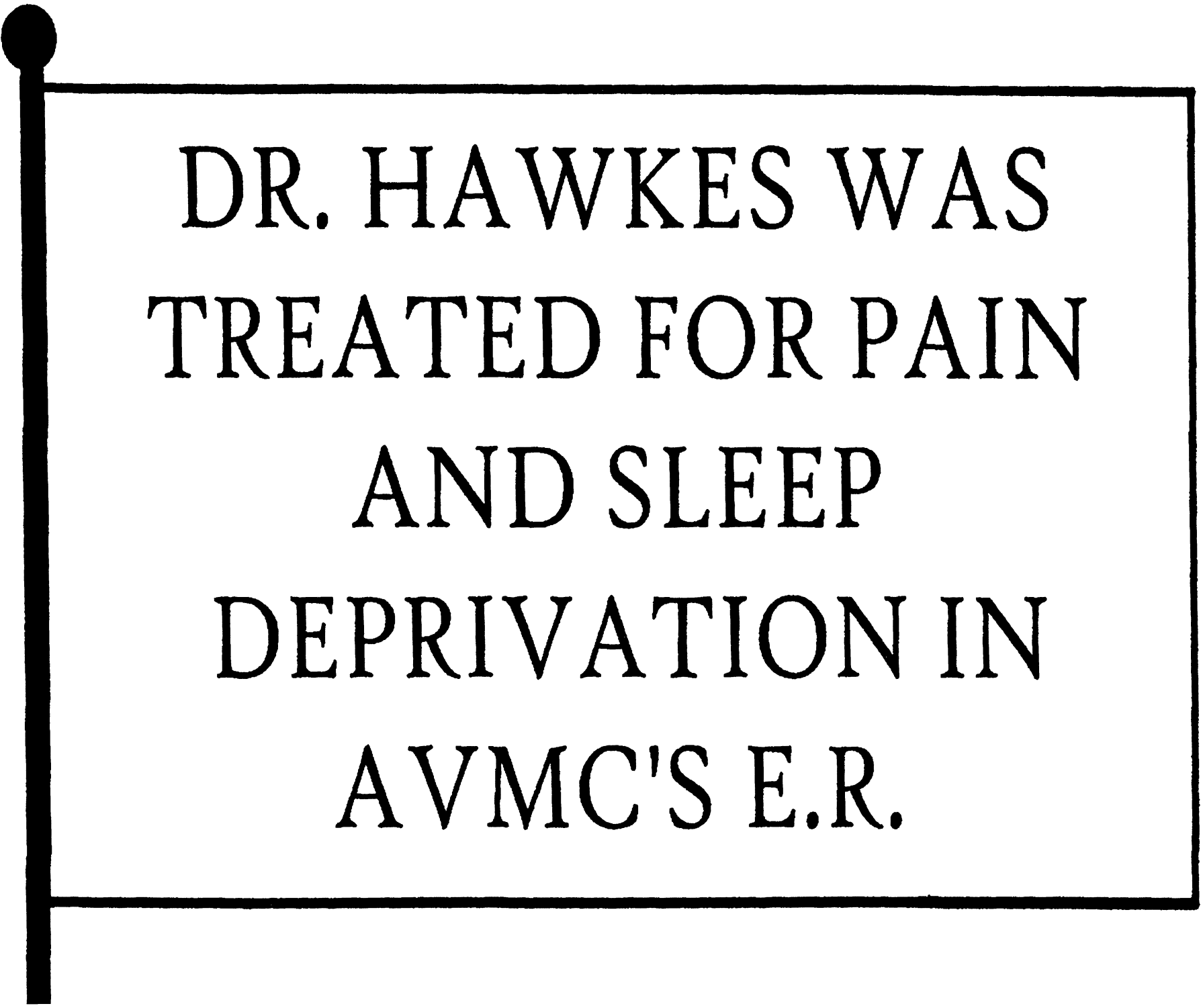
DR. HAWKES  
PERFORMED SURGERY  
ON HIMSELF SHORTLY  
BEFORE APPLYING TO  
ASHELY VALLEY



DR. HAWKES  
HAD PAIN  
PROBLEMS

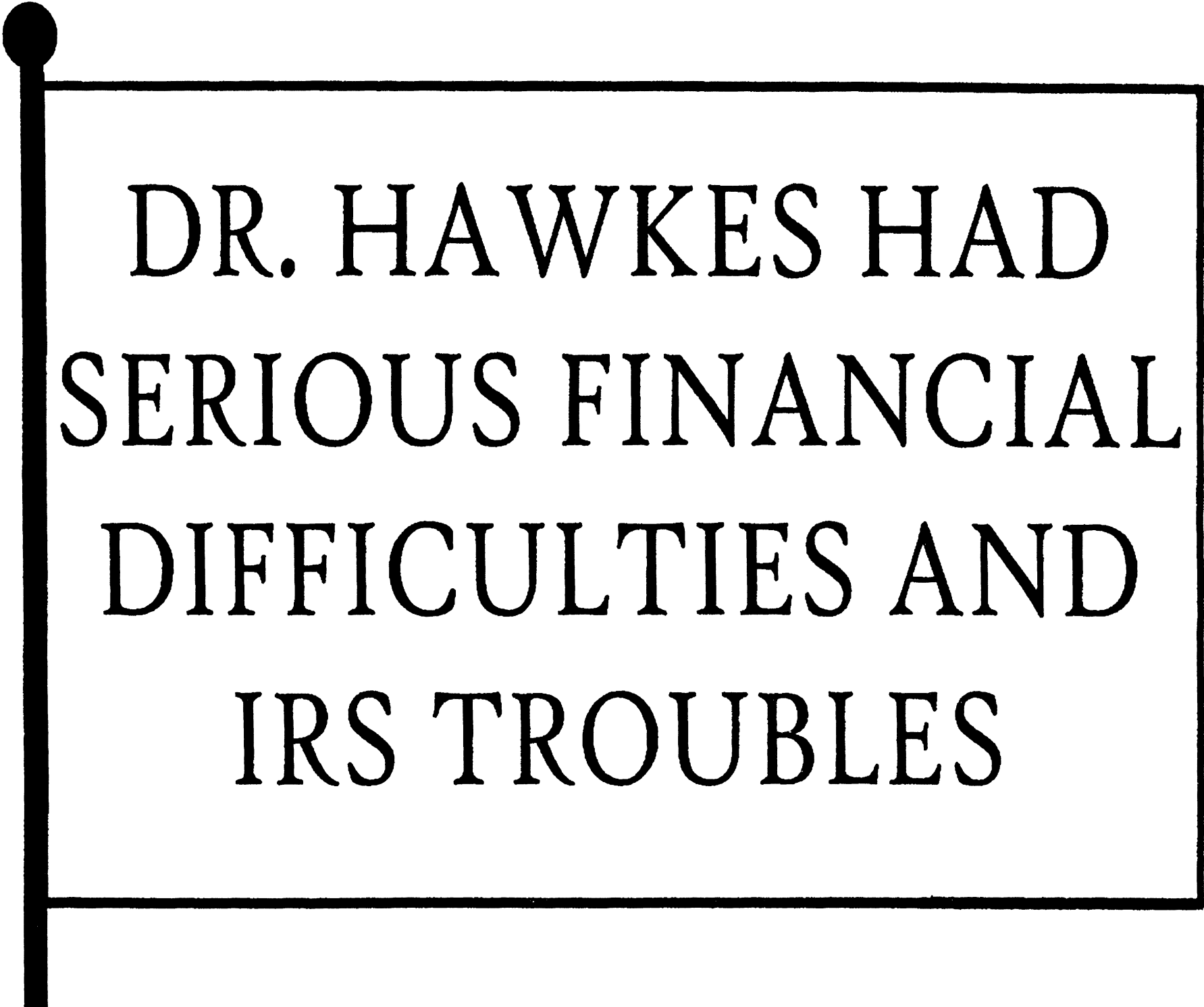


OTHER DRS. REPORTED  
THAT THEIR  
PATIENTS WOULD  
NOT BE TREATED BY  
DR. HAWKES



DR. HAWKES WAS  
TREATED FOR PAIN  
AND SLEEP  
DEPRIVATION IN  
AVMC'S E.R.

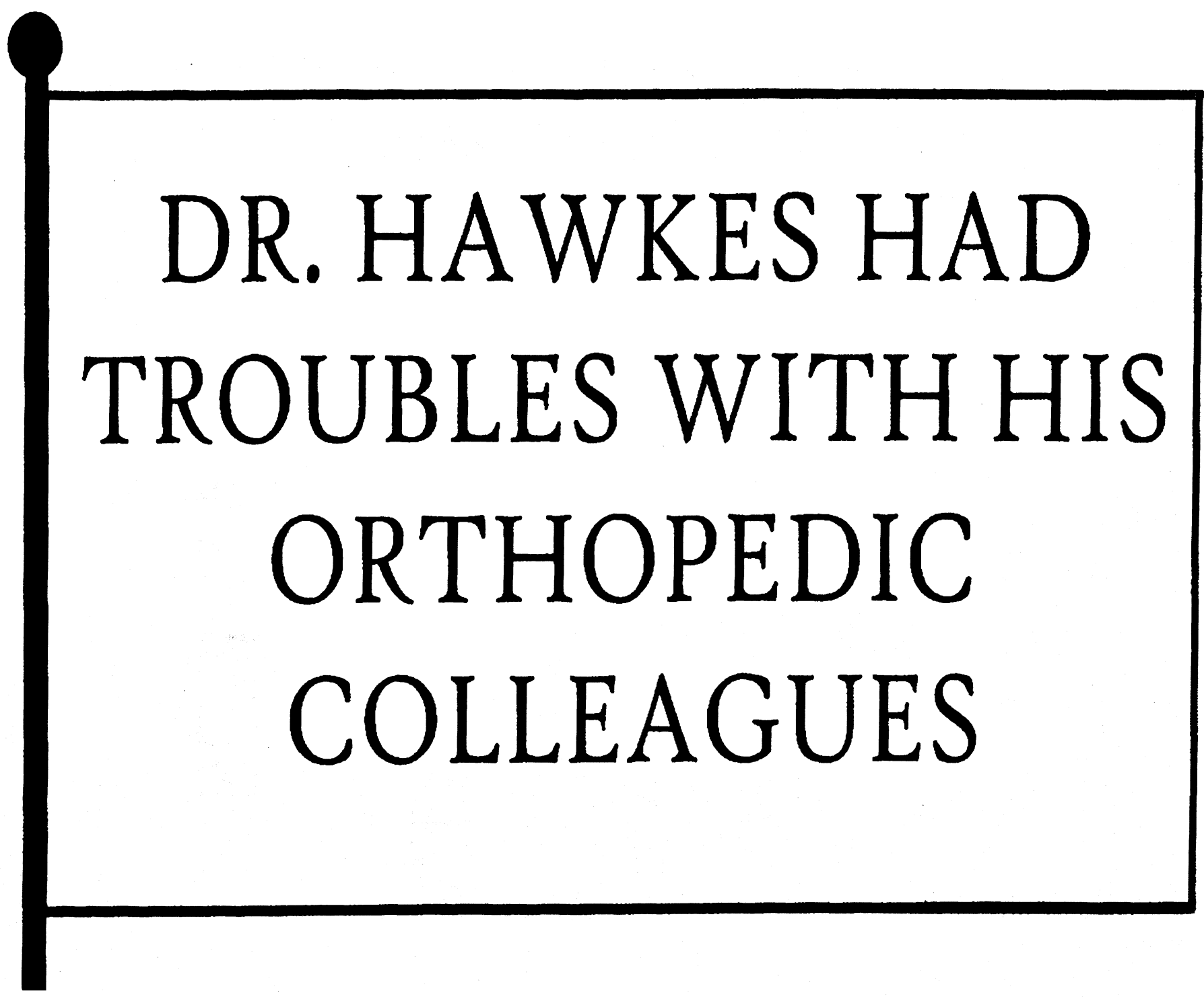
DR. HAWKES  
SUBMITTED TO  
DRUG TESTS AT  
AVMC



DR. HAWKES HAD  
SERIOUS FINANCIAL  
DIFFICULTIES AND  
IRS TROUBLES

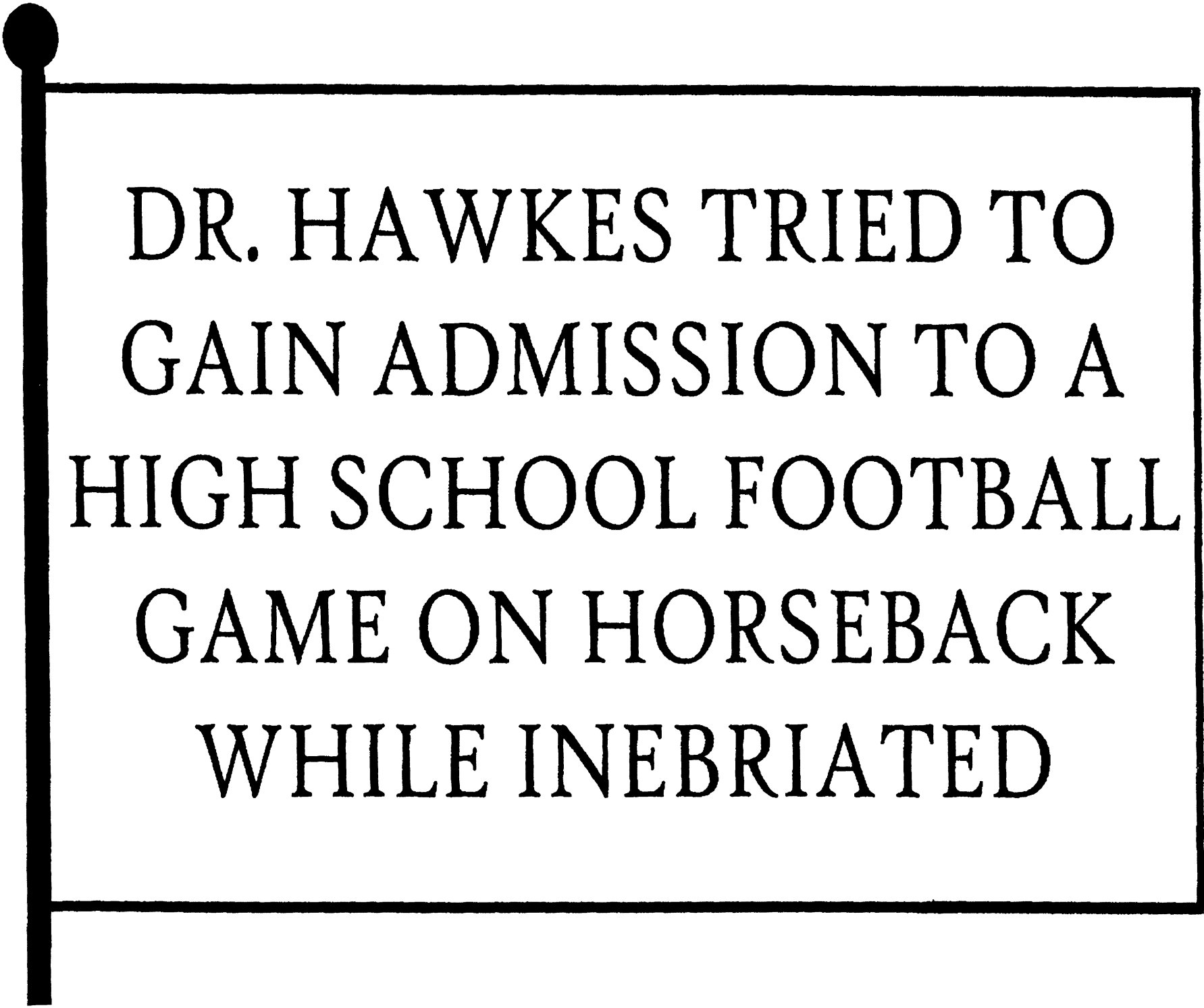


DR. HAWKES'  
ORTHOPEDIC  
COLLEAGUES  
HAD NEGATIVE  
VIEWS OF HIS  
ABILITIES AS A  
SURGEON



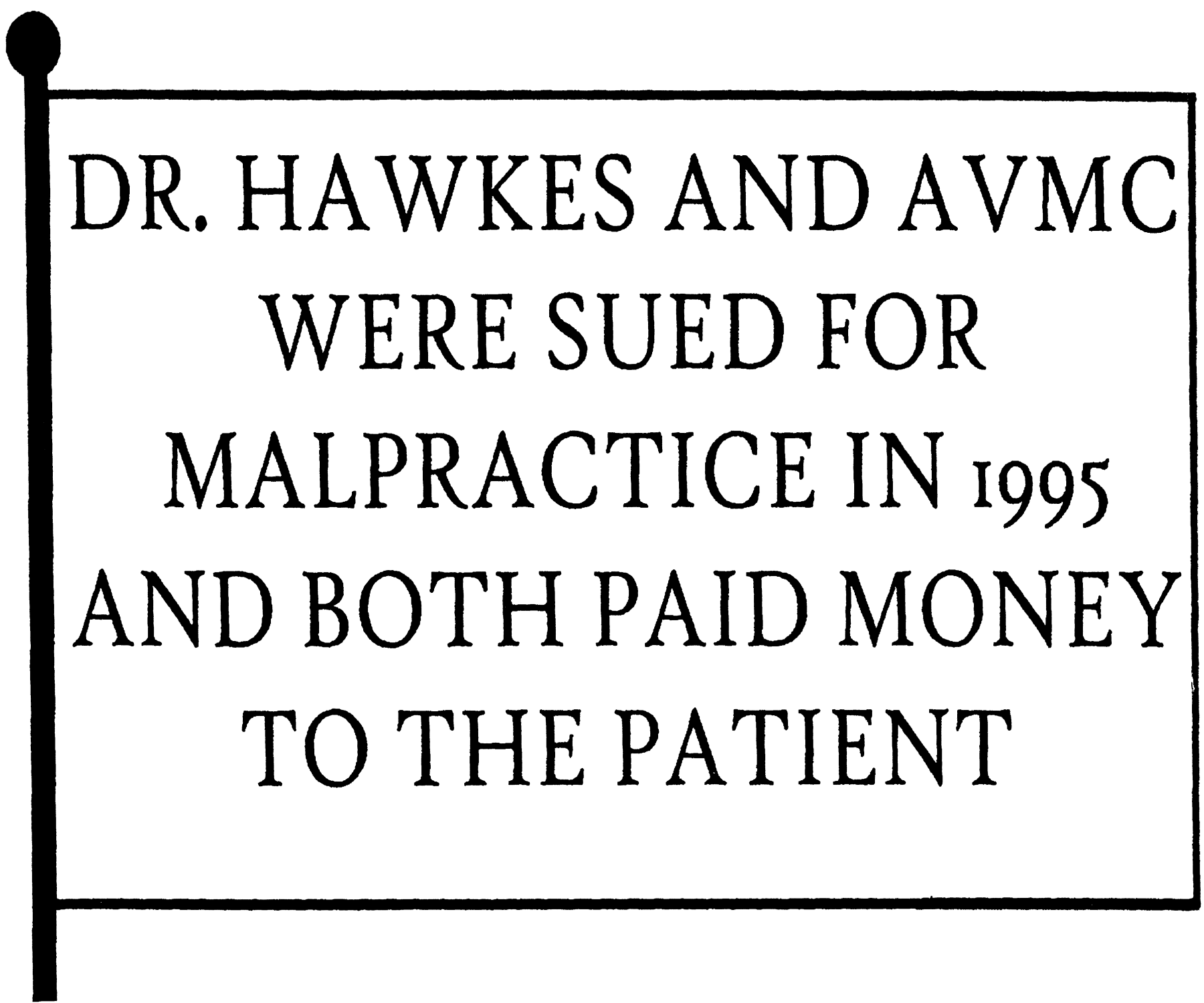
DR. HAWKES HAD  
TROUBLES WITH HIS  
ORTHOPEDIC  
COLLEAGUES

DR. HAWKES  
HAD  
DISABLING PAIN  
IN 1995 FOR  
WHICH HE WAS  
HOSPITALIZED  
AND AVMC  
KNEW IT



DR. HAWKES TRIED TO  
GAIN ADMISSION TO A  
HIGH SCHOOL FOOTBALL  
GAME ON HORSEBACK  
WHILE INEBRIATED

DR. HAWKES  
UNDERWENT  
INPATIENT  
TREATMENT AT  
DAYSPRING  
IN SEPT. 1995



DR. HAWKES AND AVMC  
WERE SUED FOR  
MALPRACTICE IN 1995  
AND BOTH PAID MONEY  
TO THE PATIENT

Tab 2

**Selected Portions of Day Spring Treatment Records**

**Offered into Evidence as Plaintiffs Exhibit 18**





**WASATCH CANYONS HOSPITAL**

*A Service of Intermountain Health Care*

5770 South 1500 West, Taylorsville, Utah 84123

NAME: HAWKES, THOMAS

ADMITTED: 09-07-95

RAY MIDDLETON, MD

## HISTORY & PHYSICAL

### MEDICAL HISTORY

**PRESENTING COMPLAINT:** "I'm very depressed and I need to control my pain."

**PATIENT PROFILE:** Thomas is a 50-year-old orthopedic surgeon who was born in Brigham City, and has been living in Vernal for the last two and a half years. He is LDS by religious profession, and claims that he is very active in his faith. He is admitted to hospital for evaluation concerning the possible abuse of pain medications, particularly benzodiazepines and various narcotic preparations. He was a helicopter pilot in Vietnam, and was shot down and severely injured. The crash apparently killed all the other occupants of the helicopter. He continues to have ongoing problems, having fractured his left ankle, ruptured his liver, chest injuries, severe cervical spine injuries, and has developed arthritis as a result of all these problems. He has been under the influence of benzodiazepines on a couple of occasions when it was felt by the people in his town that he might have been drinking. In fact, he denies this. The medical staff at his hospital have requested an evaluation concerning his possible drinking and substance abuse.

**DRUG AND ALCOHOL EFFECTS:** Following his rehabilitation from the injuries in Vietnam, he went into medical school and on into orthopedics. He has practiced in several areas and on a couple of occasions has been accused of being a drug addict, and either quit or was removed from medical staff. He apparently is a very hardworking and very adequate surgeon. He has been married for 28 years. He has ten children. His wife is very concerned about the allegations of substance abuse and possible alcoholism in her husband. He has never had any legal problems around the substance abuse, but is in some serious problems with the IRS and with finances in general. He currently is living in his own home. There have been several problems with his health, as noted above. He performs well sexually. He has severe problems with sleep. His appetite has been poor. His main hobby currently is raising and breaking horses. With regard to chronic illnesses, he does have chronic arthritis, chronic pain from the injuries noted above.

**PAST HEALTH:** He has been diagnosed with attention deficit disorder, which apparently still bothers him. He has a long family history and personal history of depression. He has been on various antidepressants. He has had the usual childhood diseases. He had a very traumatic childhood, being raised by an alcoholic father and a mother who was not always available to him, either.

**SURGERIES:** He has had multiple surgeries as a result of his injuries.

**ALLERGIES:** He complains of season allergies. He may be allergic to morphine and to some of the dyes that are used in radiological investigations.

**FAMILY HISTORY:** Father died at 80 of alcoholism. Mother died at 52 of a lymphoma. He has two half sisters, one of whom is a recovering alcoholic and substance abuser. The other, he is not sure of her state of health. He has one full sister who lives out of state. She is a substance abuser and a lesbian. He states there is a good deal of alcoholism on the paternal side of the family, in that all of his paternal uncles and several of his paternal cousins are dead from alcoholism.

### REVIEW OF SYSTEMS

1. **SKIN:** No rash, itching, moles, sores, hives, cancer, hair, pigmentation.
2. **EYES:** He wears corrective lenses. No pain, diplopia, scotoma, itch, dryness, infection or redness.
3. **EARS:** No hearing loss, infection, pain, tinnitus, vertigo.
4. **NOSE:** No dryness. No bleeding, pain, discharge. No obstruction. Smell normal. No sneezing.
5. **MOUTH:** No soreness, pain, infection, ulcers, hoarseness, dryness. Gums are clean and healthy, as are tongue and teeth. Swallowing normal.
6. **BREASTS:** No discharge, lump, pain, bleeding or infection.

**DISCHARGE SUMMARY**

**PATIENT NAME:** HAWKES, THOMAS  
**MEDICAL RECORD NO:** 00-46-50  
**UNIT PROGRAM:** Dayspring Inpatient  
**DATE OF ADMISSION:** 09/07/95  
**DATE OF DISCHARGE:** 09/12/95  
**ATTENDING PHYSICIAN:** Ray Middleton, M.D.

**ADMISSION DIAGNOSES**

*Axis I* Major Depression, Recurrent, Moderate  
Post-Traumatic Stress Disorder  
Opiate-Derivative Analgesic Abuse/Dependence  
*Axis II* Depressive Personality Disorder with Compulsive and Histrionic Features  
*Axis III* Status post multiple injuries with resultant surgeries

**DISCHARGE DIAGNOSES**

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Post-Traumatic Stress Disorder  
Opiate-Derivative Analgesic Abuse/Dependence  
*Axis II* Depressive Personality Disorder with Compulsive and Histrionic Features  
*Axis III* Status post multiple injuries with resultant surgeries

**CONDITION ON DISCHARGE**

Improved physically and mentally over admission status.

**HISTORY**

Tom is a 50-year-old orthopedic surgeon who has been living in Vernal for the last 2 1/2 years, where he practices orthopedics. He has been admitted for evaluation concerning the possible abuse of pain and benzodiazepine-type medications. He was seriously injured when a helicopter he was piloting was shot down in Vietnam, and he continues to have ongoing problems with arthritis, his abdomen, and his cervical spine particularly. The hospital medical staff has requested this evaluation.

He has been married for 28 years and has 10 children. His wife is very concerned about the allegations of substance abuse and possible abuse of alcohol and drugs by her husband. He complains of serious financial problems. He has difficulty with sleep, and his appetite has been poor.

He has been diagnosed in the past with attention-deficit disorder, and stated that he is deeply depressed at this time. His family history is positive for alcoholism, in that he had an alcoholic father. One of his half-sisters is a recovering alcoholic and substance abuser, as is another sister who lives out of state. He



## DISCHARGE SUMMARY

stated that there is a good deal of alcoholism on the paternal side of the family, in that all of his paternal uncles and several of his paternal cousins have died from alcoholism.

### PHYSICAL EXAMINATION

Essentially within normal limits. He did have some difficulty with full range of movement in his head and neck because of his previous injuries. There is scarring around his ankle fracture and surgery, as well as abdominal scarring from the surgery on his ruptured liver sustained in the helicopter crash.

### LABORATORY DATA

Urine toxicology was positive for benzodiazepines and caffeine. SMAC profile showed elevations of cholesterol and LDH, as well as triglycerides and VLDL cholesterol. RPR was nonreactive. Routine urinalysis was normal.

### HOSPITAL COURSE (Medical)

Medical problems encountered during the course of the patient's hospital stay included:

1. He did not appear to be under the influence, and required little in the way of detox medications.
2. Various aches and pains from arthritis and old injuries, for which he has taken enteric-coated Naprosyn in the past. When taking this kind of medication, he also needs to take Zantac and Carafate.
3. Seasonal allergies, which normally respond to Claritin, and appeared to do so at this time.
4. Depression. He was seen in consultation by a psychologist and a psychiatrist, and trazodone and Zoloft were ordered for him. These medications will be followed by Dr. Ed Collins.

### DAYSRING TREATMENT COURSE

Following a full-scale evaluation, the patient was discharged from treatment on 09/12/95. Following an in-depth meeting with his wife, his physician (Dr. Middleton), and myself, (Rick Garrett, clinical counselor), the decision was reached that the patient would be returned to his hometown with his wife, where he will continue his medical practice. He has been referred to the Diversion Committee, and in fact met with the Diversion Committee while here on the Dayspring Unit. An initial interview has been set up with them, and they will likely be following this case. The patient has also been referred for one-to-one therapy with Dr. Edgar Collins, and an initial therapy session with Dr. Collins has been scheduled for Friday, September 22, 1995, at 3 p.m. at the Professional Office Building here at Wasatch Canyons Hospital.

Because of financial reasons that necessitate the patient returning to work as quickly as possible, it was felt that the structure that will be provided by the Diversion Committee in association with the one-to-one therapy would be a reasonable treatment plan for this patient. He is a surgeon in the Vernal, Utah, area. Having cleared the chemical dependency evaluation here at Dayspring, he is being allowed to return to work now.



WASATCH CANYONS HOSPITAL  
5770 South 1500 West  
Taylorsville, Utah 84123

NAME: HAWKES, THOMAS

## CONSULTATION

### REASON FOR CONSULTATION

Psychiatry was asked to see this 50-year-old, married, white, male orthopedic surgeon, father of ten, and Vietnam veteran, who had been admitted to Wasatch Canyons Hospital Dayspring Program on 09-07-95 as arranged per Dr. Ray Middleton for evaluation in regards to the patient's use of analgesics. He uses for control of headaches and orthopedic injuries suffered in a helicopter crash during service in Vietnam.

Because the patient also has a history of depression and has been on various antidepressant medications, psychiatry was asked to make an evaluation, along with recommendations for treatment.

### HISTORY OF THE PRESENT ILLNESS

Approximately three and a half hours were spent obtaining the following information, which will be abbreviated in this report.

In 1968 the patient was serving as a helicopter pilot in Vietnam. He and a small crew aboard his helicopter were asked to rescue a small band of men stranded on a hillside in the thick of battle. The rescue took place under fire. Nine injured men were loaded aboard the helicopter under extremely difficult circumstances. The helicopter was extensively damaged by enemy gunfire. Despite the patient's best efforts as pilot, the helicopter crashed. He was the lone survivor, but suffered extensive injuries including burns, fractures of his neck, back, ankle, and ribs. He was rescued and treated. He spent approximately a year convalescing.

Despite his injuries and associated pain, he was able to complete medical school, residency training in orthopedic surgery, and sub-specialty in pediatric orthopedics.

Opiate derivative analgesics were utilized for control of episodic pain and after procedures and surgeries of his neck, back and ankle in attempts to improve function and decrease pain. These were not completely successful and he describes one surgery to his neck as resulting in complications including Horner's syndrome and vagotomy.

He continues to complain of headaches, which were worsened recently when he bumped his head while working on his car. Recent episodes of misuse of medications resulting in excessive sedation and inappropriate behaviors in public, i.e., falling asleep in a theater requiring his 17-year-old son to help him up out of the theater and home. Also recently falling off his horse while riding over to see a high school football game. Patient admits to having taken medications prior to both these episodes, but is vague as to which medications and the amounts.

Most of the patient's medical career has been in the Service. After retirement he worked for awhile in Salt Lake City, then opening a practice in Vernal, Utah. He describes doing well, but was recalled into the Service during the Gulf War. He states that this became a financial burden in that there was a marked change in income. He now describes significant financial problems, including problems with the IRS.

According to the patient he has been diagnosed with major depression, along with post traumatic stress disorder in the past. He has been treated at various times by psychologists for therapy and a psychiatrist for medications during the patient's career in the military. His most recent psychotropic medications have included Zoloft and trazodone.



## PSYCHOLOGICAL EVALUATION

### PERSONALITY ASSESSMENT RESULTS

**MCMI-III:** The profile appears to be valid. Patient does have a very high score, however, on the Desirability Scale, indicating that his answers may have been influenced by a desire to be liked or present a positive image. Among Axis I Scales, the patient demonstrated elevations on post traumatic stress disorder and somatoform disorder scales.

Among Axis II diagnoses, the patient demonstrated a depressive personality disorder with histrionic and compulsive features.

**Suicide Probability Scale:** The SPS is significant for very high levels of hostility. The patient is a mild risk for suicide according to this instrument.

**Beck Depression Inventory:** The BDI indicates a mild mood disturbance. Somatic symptoms (problems sleeping, with fatigue, decreased appetite, health problems) are prominent.

**Alcohol Readiness for Change Inventory:** This scale indicates that the patient is currently in an action oriented mode, indicating that he at least is reporting that he is ready to take steps towards treating his current problem.

### CLINICAL INTERVIEW

The patient indicates that he has come to treatment because he believes he "recognizes signs" that he is an addict, and does not want this to precipitate problems in his marriage and life. There is no history of early problems with learning or attention deficit disorder. Family history is positive for alcoholism and depression. Patient reports that he was involved in at least two serious accidents. The first occurred when he was about 18 years old. He was in the back of a pickup truck which hit a tree. Patient reports that he was the only survivor from among five passengers. In the second case, the patient was flying a helicopter in 1968 in Vietnam and was shot down. He received back and leg injuries when the helicopter crashed, and suffered severe burns when the helicopter exploded. He was, however, thrown free and again was the only survivor from among about 13 other passengers and patients. Patient reports long history of feeling lonely and depressed. He indicates that he has always considered "suicide as an option," but does not believe he has ever been a danger to himself. He denies that he is a danger to himself at this time. Patient appears to have post traumatic stress disorder secondary to his experiences in Vietnam. He has repetitive recurring nightmares times two (seeing a young girl die from a grenade explosion and seeing a village massacre in which the Viet Cong apparently came into the village and eviscerated 30+ children). He has been treated for post traumatic stress disorder, and has had a number of treatment trials of antidepressants. He indicates that when he has been on trazodone that it is a very effective antidepressant for him.

### SEVERITY / JUSTIFICATION

The patient's substance abuse has caused significant occupational, family, psychological, and interpersonal problems. These problems have been severe enough to require treatment in a structured inpatient or outpatient rehabilitation program at this time. The patient is a mild risk to himself according to the Suicide Probability Scale.



## PSYCHOLOGICAL EVALUATION

### DIAGNOSTIC IMPRESSION

AXIS I      Opiate Abuse and Dependence  
              Post Traumatic Stress Disorder, Moderate, Continuous  
AXIS II      Depressive Personality Disorder With Compulsive and Histrionic Features  
AXIS III     See Medical History and Physical: Multiple Physical Problems Secondary to his Injury in  
              Vietnam  
AXIS IV     Problems: Psychological, Family, Occupational, Substance Abuse, Financial  
AXIS V      GAF: 55-60

### TREATMENT RECOMMENDATIONS

1. A structured inpatient program would appear to be most beneficial for the patient at this time. During his treatment the patient should participate in individual therapy, group therapy, and didactic lectures to address the issues surrounding substance abuse and to gain an education in addiction. Family therapy would also be an important part of treatment. Treatments geared towards improved self-esteem, improved coping and problem solving abilities, stress management, appropriate anger management, assertiveness, and improved communication skills may be helpful for this patient. Supportive relationships with AA and/or NA should be established.
2. The patient has moderate, continuous post traumatic stress disorder. He should consider counseling for this problem. Sometimes patients with depressive symptoms secondary to post traumatic stress disorder respond to older antidepressants which tend to be more sedating since sleep disturbance secondary to nightmares is often a significant problem. Patient reports that he has done well on trazodone in the past, and this medication, or possibly nortriptyline, may be considered. Individual counseling for post traumatic stress disorder may also be worth considering.
3. Patient has extensive experience with various pain programs. He does appear to do well when actively enrolled, and referral to Pain Clinic or concurrent treatment, might be considered.
4. By patient's report he has not engaged in aggressive, active program of physical therapy. Participation in programs such as the Spine Clinic at Cottonwood Hospital may also be considered.

CHARLES Y. KONDO, PhD  
Licensed Psychologist

D: 09-11-95  
T: 09-12-95  
CYK/mp

000022

# PROGRESS NOTES

DATE	TIME	PROBLEM NUMBER	CODE	
9/7/95			MD	<p>PSYCHIATRIC CONSULT</p> <p>50 y/o M<sup>r</sup> orthopedic @ of 10 from Vernal UT          @ 1<sup>st</sup> admission to WCH.</p> <p>Hx of Depression Tx @ various SSRIs, TCAs &amp;          tricyclics - most recently on Zolift 50mg qd          &amp; Trazodone up to ~ 150mg qhs.</p> <p>Hx of PTSD from experience as a helicopter pilot          in Vietnam - therapy &amp; tx in various forms per          psychologist &amp; psychiatrist during career in military.          Now @ occasional flashbacks &amp; mood &amp; behavior swing</p> <p>Long Hx of analgesic use/abuse/dependence 2<sup>nd</sup>          &amp; orthopedic injuries from helicopter crash in Vietnam          in his early 20's and subsequent surgeries &amp; procedures.</p> <p>Here now per referral from 1<sup>st</sup> care MD &amp; arrangement          per Dr R. Miller for evaluations</p> <p><u>Dx</u> Major Depression, recurrent, moderate          PTSD          Analgesic abuse</p> <p><u>Recommendations</u> ① Zolift 50mg po qd with 1<sup>st</sup> of 25mg q          &amp; a titrated to level dose of 150mg ② Trazodone 50-          100 qhs ③ Psych testing i.e. MMPI-II ④ Visit while          hospitalized ⑤ Follow up out patient care</p> <p>Full Consent to be Dictated</p>

## PROGRESS NOTES



WASATCH CANYONS HOSPITAL

A Service of Intermountain Health Care

1070 REV 4/95

PATIENT STAMP  
 HAWKES, THOMAS A  
 7127144 50Y M 9/7/95  
 -46-50 5217

# PROGRESS NOTES

TIME	PROBLEM NUMBER	CODE	
	Cont. Nsc.		COMPLETED Y TESTING AND WAS INSTRUCTED HOW TWO "IS HARMFUL" HE STATES THAT THE MORE HE TALKS & INTERACTS C STAFF, THE MORE INSIDE HE IS GAINING AROUND HIS SITUATION THOUGH HE STILL RATIONALIZES ALL OF HIS "CHEMICAL USE"
			M) PAIN CLINIC WAS NOTIFIED FOR CONSULT <i>Thompson</i>
5:50pm	Dietary		A Dietary Consult has been ordered for the patient Kathy S. Sathith <i>Dietary</i>
5:1735 +2			
5:1630 5:1935	1, 2, 3	PAIN CLINIC	PT. WAS SEEN FOR A PAIN CLINIC CONSULTATION FOR HIS CHRONIC PAIN AND POSSIBLE ADMISSION TO THE L.D.S. HOSPITAL PAIN CLINIC. PT. AFFECT WAS NEUTRAL WITH A PLEASANT BUT TALKATIVE MOOD. PT. WAS DRESSED IN HOSPITAL GOWNS AND PANTS. PT DID SHOW CHARACTERISTICS OF DEPRESSION AND POSSIBLE WITHDRAWAL IE TEARY EYED, RUNNING NOISE, TANGENTIAL WANDERING IN IDEAS, IRRITABILITY AND SOME FRUSTRATION WITH REGARDS TO PRESENT SITUATION. PT. DID ADMIT TO INTERMITTENT USE AND ABUSE OF OPATES FROM 1991 TO PRESENT. HE ALSO ACKNOWLEDGE DYSFUNCTIONAL BEHAVIOR SINCE HIS MOST RECENT SURGERY FEB. OF 1995. PT. ALSO REPORTED SIGNIFICANT CHEMICAL ABUSE FROM 1976 TO THE "LATE 80S" PT. ALSO REPORTED HAVING UNDERGONE SOME 38



# PROGRESS NOTES

DATE	TIME	PROBLEM NUMBER	CODE	
AS 2030		1,23	CNT	<p>BIOFEEDBACK, ECT. PT. ALSO APPEARED TO BE WILLING TO ADMIT TO HIS CHEMICAL DEPENDENCY PROBLEM. HOWEVER, HE DID RELATE THAT THE REASON HE WAS A "SELF-ADMIT" TO THE DAY SPRINGS PROGRAM WAS TO PROVE TO THE VERNAL COMMUNITY THAT HE WASN'T A "DRUG-ADDICT." PT. ALSO SEEMED TO BE CONCERNED THAT HE MIGHT BE FACING A "PHYSICIAN-DISABILITY". PT. ALSO REPORTED SEVERAL INCIDENTS WHERE HE WAS THE "PHYSICIAN TREATING THE PHYSICIAN" (HIMSELF). IN EACH OF THESE INCIDENTS HE DIAGNOSED, PRESCRIBED AND TREATED THE ILLNESSES SEVERE MIGRAINE HEADACHES, INSOMNIA, INTRACTABLE NEUROMUSCULAR PAIN AND STRESS. PT. ALSO REPORTED SOME SUCCESS TREATING HIS CHEMICAL DEPENDENCY IN THE PAST. BUT, HE OPENLY ADMITS NEEDING PROFESSIONAL HELP AT THIS TIME WITH BOTH HIS CHRONIC PAIN AND HIS CHEMICAL DEPENDENCY PROBLEMS. PT. SHOULD BE REFERRED TO THE PAIN CLINIC'S MEDICAL DIRECTOR FOR A MEDICAL EVALUATION AND DETERMINATION OF HIS APPROPRIATENESS TO BE ADMITTED TO THE PAIN CLINIC. PATIENT DOES NEED TO CONTINUE WITH A</p>

# PROGRESS NOTES

E	TIME	PROBLEM NUMBER	CODE	
5	1740	1,2,3	CNT	<p>WAS VERY FOCUSED. PT. WAS ABLE TO ADMIT HIS PROBLEM WITH USING OPATES FOR MANAGEMENT OF HIS CHRONIC PAIN. PT. WAS ALSO VERY CLEAR ON HIS NEED FOR AND A PAIN MANAGEMENT PROGRAM WITHOUT THE USE OF OPATES. PT ALSO COMMUNICATED A VERY SINCERE AND HIGHLY MOTIVATED NEED TO DO A SUCCESSFUL SELF-MANAGEMENT CHRONIC PAIN PROGRAM. PT. ALSO RECOGNIZES THAT THIS PROGRAM MAY NECESSITATE A CAREER CHANGE. THIS REALIZATION WAS AND CONTINUES TO BRING A TREMENDOUS AMOUNT OF STRESS TO PATIENT IE, INTIMATE, FINANCIAL, SOCIAL, FAMILY, LEGAL CHURCH/SPIRITUAL (LDS) AND OCCUPATIONAL. PT. DOES REFER TO "NEEDOWN" AT LEAST EIGHT (8) MORE MONTHS... WORKING AS AN ORTHOPEDIC SURGEON TO AVOID AN EXTREME CATASTROPHE WITH THE IRS, FAMILY AND OTHER LEGAL ISSUES. PT WAS ADVISED TO "GET OFF" AND STAY OFF OPATES. THAT IT WAS HIS PHYSICAL DEMANDS OF HIS CHOSEN PROFESSION IE AS AN ORTHOPEDIC SURGEON, THAT HAS CAUSED HIS EXCELLENT RELAXATION SKILLS TO FAIL AND TO START THE WHOLE CYCLE OF SURGERIES,</p>



# DAYSPRING

DATE 9-8-95

SUBSTANTIATED DIAGNOSES 504 w/ w/m i)

Claims to use alcohol and xanax 5mg x3 on 9/1/95 only. of Eth. use reported.  
Admits using fentanyl, codeine. Has tried "marijuana" + "heroin".  
**MEDICAL MANAGEMENT ISSUES** Reports allergy to cornstarch - 1/2 depression, SI  
and chronic pain Migraines, HBP, broken neck in 3 places. Demographic survey.  
Pt born April '68. Current residence in Brown Hts.

**EMOTIONAL / BEHAVIORAL COMPLICATIONS** pts + anger, mood swings, "suicidal"  
behaviors, tendency to isolate. ACOA. 1/2 current, want change. Extensive SI reported  
numerous places. Reports abuse x3 in past. Voluntary admission to Vietnam  
1/2 very violent childhood. For "serious" personal problems. Claims ADD.  
**ATTITUDE** wants to find the reasons for his case both medical &  
psychological. Wants pain control. Uncomfortable in groups + people.  
Wants that hospital to work on request in CD evaluation.

**RECOVERY ENVIRONMENT** Wants to include psychiatry in care, Pain Clinic  
& C.A.T. Manual 28g 10 children. Father deceased Alcohol. Reports extensive  
abuse in past by father 4th. Past 12 steps appearance of father. Pt is M.D.  
strong suspect drug addiction. Pt denied.

**STRENGTHS** "intentional + bright, very caring & loving, self-sacrificing"  
intelligent

**WEAKNESSES** "Lack emotional control, fear rejection, anger problems +  
tension/tension, & don't tolerate mistakes in self + others.

**IDENTIFIED PROBLEMS** CD - denies chronic abuse. ACOA - father deceased Eth. i.  
Extensive past by Soc/Guilt - few friends always a loner. Father - Anger, violent, severe  
perfectionist? Past - depressed, disorganized & self. past case well at life situations.  
Employ - Hsp. requests CD eval. Abuse - x3 in childhood. DC - med pen + refusal.

**DISCHARGE CRITERIA** Pt to complete detox program. Complete psych test +  
interview. Psych consult scheduled in Pain Clinic consult. Evaluation of  
psych eval + case

[Signature] MD  
[Signature] PC

[Signature] PhD  
[Signature] RT

[Signature] RN  
[Signature] RD  
[Signature] ED  
139  
(ADOLESCENTS ONLY)

**INTEGRATED SUMMARY  
MULTIDISCIPLINARY  
TREATMENT PLAN**

425312 Patient Name AS A  
717144 504 # 9/7/95  
-46-50 5217

**DAYSRING QUESTIONNAIRE ABOUT DRINKING & DRUG USE**

- |   | YES                                 | NO   |
|---|-------------------------------------|--|
| 1. Do you feel you are a normal drinker, or that your use of drugs is normal?   | <input checked="" type="checkbox"/> | <input type="checkbox"/>                               |
| 2. Have you awakened the morning after some drinking or drug use the night before and found that you could not remember a part of the evening before? | <input checked="" type="checkbox"/> | <input type="checkbox"/> <i>once when taking in...</i> |
| 3. Does your spouse (or parents) ever worry or complain about your drinking or drug use?  | <input checked="" type="checkbox"/> | <input type="checkbox"/>                               |
| 4. Can you stop drinking or using drugs without a struggle?   | <input checked="" type="checkbox"/> | <input type="checkbox"/>                               |
| 5. Do you ever feel bad about your drinking or drug use?  | <input checked="" type="checkbox"/> | <input type="checkbox"/> <i>guilt over necessity</i>   |
| 6. Do friends or relatives think you are a normal drinker or that your use of drugs is normal?  | <input type="checkbox"/>            | <input type="checkbox"/> <i>?</i>                      |
| 7. Are you always able to stop drinking or using drugs when you want to?  | <input checked="" type="checkbox"/> | <input type="checkbox"/>                               |
| 8. Have you ever attended a meeting of Alcoholics Anonymous (AA) or Narcotics Anonymous?  | <input checked="" type="checkbox"/> | <input type="checkbox"/>                               |
| 9. Have you ever gotten into fights while drinking or using drugs?  | <input type="checkbox"/>            | <input checked="" type="checkbox"/>                    |
| 10. Has your drinking or drug use ever caused problems with you and your spouse?  | <input checked="" type="checkbox"/> | <input type="checkbox"/>                               |
| 11. Has your spouse (or any other family member) ever gone for help about your drinking or drug use?  | <input checked="" type="checkbox"/> | <input type="checkbox"/>                               |
| 12. Have you ever lost friends or girlfriends/boyfriends because of your drinking or drug use?  | <input type="checkbox"/>            | <input checked="" type="checkbox"/>                    |
| 13. Have you ever gotten into trouble at work because of your drinking or drug use?   | <input checked="" type="checkbox"/> | <input type="checkbox"/>                               |
| 14. Have you ever lost a job because of your drinking or drug use?  | <input type="checkbox"/>            | <input checked="" type="checkbox"/>                    |
| 15. Have you ever neglected your obligations, your family, or your work for two or more days in a row because of your drinking or drug use?           | <input type="checkbox"/>            | <input checked="" type="checkbox"/>                    |
| 16. Do you drink or use drugs before noon fairly often?   | <input type="checkbox"/>            | <input checked="" type="checkbox"/>                    |
| 17. Have you ever been told that you have liver trouble or cirrhosis?   | <input type="checkbox"/>            | <input checked="" type="checkbox"/>                    |
| 18. Have you ever had delirium tremens (DT's), severe shaking, heard voices, or seen things that weren't there after drinking or drug use?            | <input type="checkbox"/>            | <input checked="" type="checkbox"/>                    |
| 19. Have you ever gone to anyone for help about your drinking or drug use?  | <input type="checkbox"/>            | <input type="checkbox"/>                               |
| 20. Have you ever been in a hospital because of your drinking or drug use?  | <input type="checkbox"/>            | <input checked="" type="checkbox"/>                    |
- Prin Clinic  
evaluation*

DATE: 4-17-70

To ensure that issues important to my treatment do not go untreated, Wasatch Canyons Hospital is providing me with a referral to: Appt. Fri 9/22/95 @ 3pm use south entrance to Pk3.

Name: Dr. Edgar Collins  
Agency: Wasatch Canyons Hospital Center for Counseling  
Address: 5770 So. 1500 West SLC, UT. 84123  
Phone: 265-3109

I am being referred for treatment of: depression, PTSD

I hereby grant permission to Wasatch Canyons Hospital to contact the individual or agency listed above to determine whether client contact occurred as planned and whether referral was appropriate.

Signed: [Signature]  
Witness: Rich Smith

### ACCEPTING INDIVIDUAL OR AGENCY

Name: Dr. Edgar Collins  
Agency: Wasatch Canyons Hospital Center for Counseling  
Address: 5770 So. 1500 West SLC, UT. 84123  
Phone: 265-3109

On 9/12/95, Thomas Hawkes was referred to you for treatment of: depression, PTSD

In order to maintain an adequate record of our client's continuing treatment, we request the following information

1. Did client contact you and make an appointment? ☐ Yes ☐ No
2. If so, did client keep his/her appointment? ☐ Yes ☐ No
3. Was it appropriate that this client was referred to you for treatment? ☐ Yes ☐ No

Why or why not? \_\_\_\_\_

4. Was your agency able to meet the client's need for assistance? ☐ Yes ☐ No

Why or why not? \_\_\_\_\_

Thank you for your timely response.

Rich Smith  
WASATCH CANYONS HOSPITAL STAFF MEMBER

134 B



WASATCH CANYONS HOSPITAL  
REFERRAL / FOLLOW-UP  
FORM

HAWKES, THOMAS A  
425200  
7107144 50Y M 9/7/95  
-46-50 5217

Tab 3

**Specific Consent to Information Exchange and Conditions of Consideration  
in Connection with  
IHC Appointment/Reappointment, Employment, and/or Participation.**

I am applying or reapplying for medical staff membership, clinical privileges, employment, or panel participation at one or more IHC facilities, entities, operations, or services. The scope of such application or reapplication is determined by other documents. Such application(s) or reapplication(s) involve an IHC hospital, some other facility or operation of IHC Health Services, Inc., the IHC Physician Division, and/or IHC Health Plans and its affiliated companies. Such IHC facilities, entities, operations, and services, together with their medical staff(s) or equivalent provider organizations, and their governing boards, officers, administrators, and employees, are referred to in this document as "IHC entities" or singly as an "IHC entity." I understand that IHC entities are required to compile information so that they can make a fully informed decision about me and my relationship or potential relationship with them. This document is intended to facilitate that process. For convenience in this document, I refer to the processes of obtaining verification of my credentials, checking my background, and of considering me for initial or continuing medical staff membership, clinical privileges, employment, or panel participation (as appropriate) as the "Process." I intend that this document apply to the Process in each IHC entity to which I am applying or reapplying. I understand that the Process may involve IHC Medical Staff Services providing assistance to the IHC entities to which I have applied or reapplied.

1. I have received or have had the opportunity to request, and I have had the opportunity to read, the medical staff and hospital bylaws, fair hearing plan, rules and regulations, and/or the other employment or participation documents for each IHC entity to which I am applying. I acknowledge that such documents apply to me both in connection with the Process and in connection with my medical staff membership, clinical privileges, employment, or panel participation, if granted, for each IHC entity involved.
2. On all application(s) to IHC entities, I have provided true, complete, and accurate information in connection with the Process. I represent to each IHC entity that such information provides an accurate, fair, and complete picture of my professional background, training, and experience for all the periods of time specified on the forms I have filled out. I acknowledge that any material omission or misstatement of information on such documents may be grounds for terminating my relationship with an IHC entity.
3. If granted or extended medical staff membership, clinical privileges, employment, and/or panel participation, I agree to abide by the bylaws, requirements, rules, and regulations of each IHC entity with which I am involved. I understand that my professional practice is subject to state and federal laws and regulations, and that persons, institutions, and entities involved in the Process may be protected by state and federal laws designed to encourage and protect good faith peer review and quality assurance activities.
4. I understand that it is necessary for each IHC entity to obtain detailed information about me in order to complete the Process. I understand that such information may be private, sensitive, privileged, and otherwise confidential. It is my request, and I hereby give my consent, that such information be disclosed to IHC entities and received by them in the manner described in this document.

The information that may be disclosed shall include information about me that bears upon any of the following: my education, post-graduate specialty training, board certification, experience, competence, professional conduct, ethics, ability to work with others, quality assurance data and information, hospital and other affiliation(s) (such as other professional practice settings or participation with other health plans), utilization data, clinical privileges, disciplinary actions, malpractice coverage, claims history, judgements and settlements paid, litigation experience, state licensure, and controlled substance licensure. I intend that this consent include all information that reflects on my ability to safely, competently, and professionally perform the professional activities, employment, and/or panel participation I have requested with each IHC entity.

I intend that this consent extend to all persons, institutions, and entities that have such information about me, including: colleges, universities, professional societies, hospitals, specialty boards, practice groups, clinics, insurance companies, partnerships, professional corporations, and employers, and to persons and committees associated with any of these. In connection with the Process, I also give my consent for all such persons, institutions, and entities to express their opinion(s) about me and to make recommendations about my professional skills, conduct, and ability to perform the clinical privileges, or job I have applied for. I also give my consent for the IHC entities and their medical staffs, officers, agents, committees, and employees involved in the Process to receive and act upon all such information, opinions, and recommendations in connection with the Process.

6. I recognize that the free exchange of the types of information, opinions, and recommendations identified in this document is a necessary part of each facility(s) credentialing, recredentialing, privileging, and peer review processes. I realize, however, that the threat of litigation and liability tends, as a practical matter, to discourage the exchange of these types of information. As a result, it is my purpose and intention to induce and encourage others to do the things identified in this document by removing the threat of litigation and liability as a result of their good faith actions to provide information to the Process on my behalf. To that end, I intend that the persons, institutions, and entities identified above will rely on this document as my consent to their action(s) and as my release from liability and promise not to subject them to legal claims and lawsuits as a result of their good faith efforts to do the things described in this document, which I acknowledge to be for my benefit to facilitate the Process. I intend that this paragraph will apply both to persons, institutions, and entities supplying information, opinions, and recommendations to the facility(s), medical staff(s) and to all persons, committees, and entities involved in the Process for the facility(s), medical staff(s) and IHC Health Plans.
7. I understand that signing this document is an important part of the Process and that any change in this document as provided to me will cause my application or request to be incomplete and will delay the Process.
8. I intend that a copy of this document may be relied upon as if it were the original.

Date:

8-15-94

Signature

Printed Name

Address

Thomas A. Hawkes M.D.  
Pediatric & Adult Orthopedic Surgery  
175 North 100 West #204  
Vernal, Utah 84078