

2003

Lucy Johnson v. Gary Watts MD, and Douglas Kohler MD : Brief of Appellant

Utah Court of Appeals

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IN THE COURT OF APPEALS
STATE OF UTAH

LUCY JOHNSON aka LUCY
MACLEOD
Appellant and Plaintiff,

v.

GARY WATTS MD,
Appellee and Defendant

and

DOUGLAS KOHLER MD,
Defendant.

BRIEF OF APPELLANT

Appellate Case No. 20031019-CA

APPEAL OF ORDER OF
SUMMARY JUDGMENT
DISMISSING DEFENDANT GARY
WATTS MD

Fourth District Court No. 010400391
Judge Steven L. Hansen

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Lucy Johnson aka Lucy MacLeod Plaintiff and Appellant

Gary Watts MD Defendant and Appellee

Douglas Kohler MD Defendant

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STATEMENT OF JURISDICTION

This Court has jurisdiction over this Appeal pursuant to Utah Code Ann. 78-2-2(3)(j).

ISSUES PRESENTED FOR REVIEW

Issue I: Is there a genuine issue of material fact regarding whether Dr. Watts' failure to consult the primary care physician was a proximate cause of the injury she suffered from the surgery performed by Dr. Kohler?

Supporting Authority: Rule 56(c) of the Utah Rules of Civil

Procedure

Kilpatrick v. Wiley, Rein & Fielding, 909 P. 2d 1283 (Utah 1996)

Blue Cross and Blue Shield of Utah v. State, 779 P. 2d 634 (Utah 1989)

Ron Case Roofing and Asphalt Paving, Inc. v. Gerald V. Blomquist, 773 P. 2d 1382 (Utah 1989)

Payne v. Garth G. Myers, M.D. 743 P. 2d 186, 187 (Utah 1987)

Standard of Review: A grant of summary judgment is appropriate only when no genuine issue of material fact exists and the moving party is entitled to judgment as a matter of law. In considering an appeal from a grant of summary judgment, the appellate court views the facts in a light most favorable to the losing party below. In determining whether those facts require, as a matter of law, the entry of judgment for the prevailing party below, the Appellate court gives no deference to the trial court's conclusions of law; those conclusions are reviewed for correctness. Blue Cross and Blue Shield of Utah v. State, 779 P. 2d 634, 636 (Utah 1989).

Issue II: Is there a genuine issue of material fact regarding whether Dr. Watts' delay in appropriate treatment of Ms. Johnson between Nov. 6, 1998 and Nov. 9, 1998 was a reasonably foreseeable cause of injury?

Supporting Authority: The supporting authority is the same as for the first issue.

Standard of Review: The standard of review is the same as for the first issue.

Both issues are preserved for review pursuant to the trial court's Order Certifying Judgment as Final under Rule 54(b), Utah Rules of Civil Procedure, dated November 7, 2003. (R. 857)

DETERMINATIVE PROVISIONS ON APPEAL

This appeal turns upon the application of Rule 56(c) of the Utah Rules of Civil Procedure. This section provides:

The judgment sought shall be rendered if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law.

STATEMENT OF THE CASE

Ms. Johnson sued Gary Watts, M.D. on December 19, 2001 asserting two negligence claims against Dr. Watts. First, Dr. Watts, a radiologist and the nephew of Mrs. Johnson, was negligent when he failed to consult Ms.

Johnson's primary care physician, Dr. Salisbury, at Mrs. Johnson's first visit in late October 1998. She had consulted Dr. Watts about chronic abdominal pain which Dr. Salisbury had previously investigated. Dr. Watts referred Mrs. Johnson to a surgeon, Dr. Kohler, who performed surgery on November 3, 1998, during which surgery Mrs. Johnson suffered an unrecognized bowel perforation.

Second, Dr. Watts was negligent when he re-admitted Mrs. Johnson to the hospital and assumed care of Ms. Johnson between Nov. 6 and Nov. 9, 1998 in the absence of Dr. Kohler. Mrs. Johnson claims that Dr. Watts should have consulted a surgeon immediately and this failure to do so caused additional damage to her.

Dr. Watts moved for summary judgment on Jan. 29, 2003, claiming that Ms. Johnson failed to establish a prima facie case by failure to establish a causal link between any action of Watts and the injuries alleged. Plaintiff served her Memorandum in Opposition to the Motion together with the Affidavit of Darwood Hance, M.D. on Feb. 12, 2003. Dr. Watts filed his reply to Plaintiff's Opposition to Motion for Summary Judgment on Feb 21, 2003. After hearing oral argument on June 16, 2003, the trial court granted summary judgment to Dr. Watts on July 22, 2003. The Order Certifying

Judgment as Final was entered Nov. 10, 2003. The Notice of Appeal was filed December 3, 2003.

STATEMENT OF FACTS

1. Ms. Lucy Johnson was formerly Ms. Lucy MacLeod. For the purposes of this appellate brief, she will be named as Ms. Johnson. (R. 414).
2. In late October 1998, Ms. Johnson contacted her nephew Dr. Watts, and requested assistance in securing diagnosis and treatment for her complaints of stomach pain. (R.280).
3. Dr. Watts is Board certified in radiology and provided medical services in radiology at Utah Valley Regional Medical Center ("UVRMC") and elsewhere. (R. 280).
4. On October 27, 1998, Dr. Watts arranged a surgical consultation for Ms. Johnson with Dr. Douglas Kohler, ("Dr. Kohler") a general surgeon. Dr. Kohler determined that Mrs. Johnson needed to have surgery to remove her gallbladder. (R. 279).
5. Dr. Kohler performed the surgery to remove her gall bladder on November 3, 1998, resulting in a perforation to her bowel. (R. 279).
6. Mrs. Johnson was discharged from UVRMC on November 4, 1998. (R. 35)

- 7 Ms. Johnson continued to experience abdominal pain in the days following the surgery. (R.245).
- 8 She was subsequently readmitted to UVRMC by Dr. Watts on November 6, 1998. (R. 279).
- 9 After Ms. Johnson was readmitted to the hospital, Dr. Watts provided all her medical care until Dr. Kohler, who was out of town, returned to UVRMC on November 9, 1998. (R. 279).
- 10 Dr. Kohler found Ms. Johnson to have extensive abdominal wall cellulitis for which he re-operated, finding a perforation in her bowel. (R. 238).
- 11 After the second surgery, Ms. Johnson remained in the hospital until November 24, 1998. (R. 279).
- 12 The affidavit of Darwood Hance, M.D. ("Dr. Hance") was attached to plaintiff's Opposition Memorandum. Dr. Hance is a radiology expert and is board certified in radiology and nuclear medicine. (R. 236).
- 13 In his affidavit, Dr. Hance stated that Dr. Watts breached the standard of care when he failed to consult plaintiff's primary care physician, Dr. Salisbury, and undertook to diagnose and refer plaintiff for treatment of abdominal pain. (R. 322).

14 In his affidavit, Dr. Hance stated that Dr. Watts' failure to consult Ms. Johnson's primary care physician, Dr. Salisbury, was negligent and resulted in a referral to a surgeon that would not have been made if plaintiff's primary care physician had been consulted. (R. 322).

15 Dr. Hance stated in affidavit that Dr. Watts should have consulted a surgeon to report that Ms. Johnson was having abdominal pain when Dr. Watts readmitted her to the hospital on November 6, 1998. (R.321).

16 Dr. Hance's affidavit stated that Dr. Watts' failure to consult a surgeon resulted in prolongation of Ms. Johnson's pain, increasing infection, additional complications and additional hospitalization. (R. 321).

17 Deposition of Richard G. Barton, M.D. that was attached to the Opposition Memorandum of Plaintiff was taken in Salt Lake City, Utah on February 3, 2003. (R. 320). Dr. Barton is a board-certified surgeon and was the expert for the other defendant in this case, Dr. Kohler.

18 Dr. Barton stated that the appropriate treatment upon recognition of an intra-abdominal infection due to perforated bowel in plaintiff's circumstances is prompt surgical treatment. (R. 317).

19 Dr. Barton stated that delaying surgery in Mrs. Johnson's case increased the severity of the infection. (R. 315)

SUMMARY OF ARGUMENT

Summary judgment is appropriate only when there is no genuine issue as to any material fact and the movant is entitled to judgment as a matter of law. The party opposing a summary judgment motion is entitled to have the court survey the evidence and all reasonable inferences fairly drawn therefrom in the light most favorable to him.

The trial court improperly granted defendant Dr. Watts' summary judgment on plaintiff Ms. Johnson's two claims. First, Ms. Johnson claimed that Dr. Watts' negligent failure to consult the plaintiff's primary care physician at her first visit was a proximate cause of her initial injury. Dr. Hance's affidavit stated that it was negligent for Dr. Watts to fail to consult Dr. Salisbury, Mrs. Johnson's primary care physician. Further, Dr. Hance stated that if Dr. Watts had consulted Dr. Salisbury, there would have been no need for surgery, which would have made referral to Dr. Kohler or any other surgeon unnecessary. Because it is reasonable to infer that Ms. Johnson would never have had a bowel perforation if she had not had surgery, there is evidence by which a jury could decide that Dr. Watts'

negligent failure to contact Dr. Salisbury was a proximate cause of Ms. Johnson's injury.

Second, Ms. Johnson claimed that Dr. Watts' delay in consulting a surgeon on and after Nov. 6 caused her additional injury. Dr. Hance's affidavit stated that Ms. Johnson's intra-abdominal infection continued and worsened after she first complained of abdominal pain to Dr. Watts on Nov. 5, 1998. Dr. Hance further stated that Dr. Watts was negligent in failing to consult a surgeon when he re-admitted Ms. Johnson to the hospital on Nov. 6, 1998. Moreover, Dr. Hance stated that because of this failure to consult a surgeon, Ms. Johnson suffered pain, increasing infection, additional complications and additional hospitalization, and incurred additional medical bills.

Adding to Dr. Hance's testimony, Dr. Barton, a surgeon, stated that the appropriate treatment upon recognition of a bowel perforation in plaintiff's circumstances is prompt surgical treatment. It is reasonable to infer from Hance's and Barton's evidence that Ms. Johnson would have had prompt surgery for the perforated bowel and intra-abdominal infection if Dr. Watts had contacted a surgeon on November 6, as he should have done. Going further, such an inference leads to the conclusion that delaying the surgery from November 6 to November 9, when Dr. Kohler returned,

resulted in increasing infection, additional abdominal pain, a larger abscess, additional hospital bills, increased risk of complications and everything attendant upon a longer hospital stay. These additional damages were stated by Dr. Hance in his affidavit. Dr. Barton also stated that the delay in performing surgery resulted in increasing infection and increased risk of complications. Thus, there is evidence by which jury could reasonably decide that Dr. Watts' failure to consult a surgeon was a proximate cause of Ms. Johnson's additional injury.

Evidence presented by plaintiff's expert and reasonable inferences drawn therefrom created a genuine dispute of material facts regarding Dr. Watts' negligence enough to defeat summary judgment motion. Yet, the trial court not only failed to recognize the genuine dispute but also failed to fairly draw reasonable inferences from all the evidences in Ms. Johnson's favor. Accordingly, this court should correct the error and reverse the decision of the court below.

ARGUMENT

A. The Facts and Inferences from the Facts Create a Genuine Issue of Material Fact Which Precludes Summary Judgment on the Issue of Causation

Utah law mandates that "[i]n determining whether the trial court correctly found that there was no genuine issue of material fact, we review

the facts and inferences to be drawn therefrom in the light most favorable to the losing party.” Ron Case Roofing and Asphalt Paving, Inc. v. Gerald V. Blomquist, 773 P. 2d 1382, 1385 (Utah 1989)(citing Geneva Pipe Co. v. S & H Insurance Co., 714 P. 2d 648, 649 (Utah 1986); Atlas Corp. v. Clovis National Bank, 737 P. 2d 225, 229 (Utah 1987); Beck v. Farmers Ins. Exch., 701 P. 2d 795, 802 (Utah 1985); Harmon City, Inc. v. Nielsen & Senior, 907 P. 2d 1162, 1164 (Utah 1995); Higgins v. Salt Lake County, 855 P.2d 231, 233 (Utah 1993). In determining whether those facts require, as a matter of law, the entry of judgment for the prevailing party below, the appellate court gives no deference to the trial court’s conclusions of law: those conclusions are reviewed for correctness. Blue Cross and Blue Shield of Utah v. State, 779 P.2d 634, 636 (Utah 1989); Atlas Corp., 737 P.2d at 229; Kimball v. Campbell, 699 P. 2d 714, 716 (Utah 1985); see also Scharf v. BMG Corp., 700 P. 2d 1068, 1070 (Utah 1985).

Negligence cases, such as the medical malpractice case at issue here, are particularly unfit for summary judgment. Utah law provides that “[o]rdinarily, the question of negligence is a question of fact for the jury. Thus, summary judgment is appropriate in negligence cases only in the most clear instances.” Baczuk v. Salt Lake Regional Medical Center, 8 P.3d

1037, 1039 (Utah 2000)(citing Hunt v. Hurst, 785 P. 2d 414, 415 (Utah 1990)).

When the issue to be determined is that of causation, the requirements of summary judgment are perhaps even more restricted. Utah law has it that “[p]roximate cause is an issue of fact. Thus, only if there is no evidence upon which a reasonable jury could infer causation, is summary judgment appropriate.” Kilpatrick v. Wiley, Rein & Fielding, 909 P. 2d 1283, 1292 (Utah 1996).

The quantum of evidence to establish a dispute and preclude summary judgment is small. “It only takes one sworn statement under oath to dispute the averments on the other side of the controversy and create an issue of fact.” *Id.*(citing Harline v. Barker, 854 P.2d 1356 (Utah 1993)). In this negligence case, there is much more than one sworn statement to establish a dispute on the issue of causation.

B. There Is Evidence That Dr. Watts’ Negligent Failure To Consult Ms. Johnson’s Primary Care Physician Foreseeably Caused Her Injury.

Mrs. Johnson claims that Dr. Watts failed to consult her primary care physician. If he had done so, she claims, Dr. Watts would not have referred her to Dr. Kohler or to any other surgeon. She would not have undergone surgery and would not have suffered the bowel perforation that occurred during surgery. Because there is evidence by which a jury could reasonably

infer that Dr. Watts' failure to consult Dr. Salisbury resulted in a surgery that otherwise would not have been performed, the grant of summary judgment was erroneous.

The trial court granted summary judgment because it found that "[b]ecause Dr. Watts' involvement with Ms. Johnson' care ended with his referral to an experienced surgeon, Dr. Kohler, there is no causal connection between any harm Ms. Johnson suffered from surgery and Dr. Watts' referral." (R.809). However, viewing the evidence in that manner turns the analysis logically inside out. The issue is not who decided to perform the surgery. The issue is whether Mrs. Johnson should have been referred to a surgeon in the first place. It is clearly foreseeable that once referral to a surgeon has been made, surgery may ensue.

Although it may be that Dr. Watts did not make a decision to perform the surgery (R.328), this statement is only part of the whole picture. In his affidavit, Dr. Hance stated that "Dr. Watts breached the standard of care when he failed to consult plaintiff's primary care physician, Dr. Salisbury, before referring plaintiff to Dr. Kohler." He then stated that "if Dr. Watts had the information available from Dr. Salisbury, in my opinion there would have been no medical reason to refer plaintiff to Dr. Kohler or any other surgeon." (R.322). These are facts that the trial court should have viewed in

the light most favorable to plaintiff; i.e., as established facts. From these facts, it is reasonable to infer that if Watts had acted within the standard of care and had not referred Mrs. Johnson to Kohler or any other surgeon, she would not have had the surgery that indisputably injured her. Dr. Watts could foresee that Ms. Johnson, upon being referred to a surgeon, might be advised by that surgeon to have surgery. The issue is not the decision whether to have surgery. This issue is whether there should have been a surgical referral at all.

Once the nonmoving party, the plaintiff Ms. Johnson, has presented evidence that Dr. Watts' negligent failure to consult the primary care physician was a cause of Ms. Johnson's injury, the trial court should have accepted this evidence as fact. Then, the trial court should have drawn all the reasonable inferences from that. Here, one of the reasonable inferences is that Ms. Johnson would not have sustained the initial injury if she had not had the referral to Kohler and further that the referral foreseeably resulted in surgery.

Even without making reasonable inferences, Dr. Hance's affidavit has at least one sworn statement that establishes a causal link between Watts' negligence and Ms. Johnson's initial surgical injury. Hance directly states that "there would have been no medical reason to refer plaintiff to Dr.

Kohler . . .” and that “[t]he referral to Dr. Kohler led to the surgery performed by Kohler in which plaintiff was injured.”(R.322). The trial court should have viewed these statements in the light most favorable to plaintiff, accepting the statements as fact. Having done so, the trial court would then have had before it the “one sworn statement” establishing a dispute and summary judgment would have been inappropriate. Moreover, the dispute was a causation issue where summary judgment is appropriate *only if* there is *no* evidence upon which a reasonable jury could infer causation; the trial court’s grant of summary judgment thus becomes even more dubious.

There is evidence directly stating that Mrs. Johnson’s injury was caused by Watts’ failure to consult Dr. Salisbury. There is also evidence from which a reasonable inference can be drawn to the same effect. Finally, the negligent consultation of Dr. Kohler was reasonably foreseeable cause of a surgical injury. Accordingly, this Court should reverse the trial court’s decision.

C. There Is Evidence That Dr Watts’ Negligent Failure To Timely Consult A Surgeon On Re-Admitting Mrs. Johnson To The Hospital Caused Additional Injury.

The trial court erred in granting summary judgment on the second issue of causation in this case. Ms. Johnson claims that Dr. Watts’ negligent failure to consult a surgeon when she was re-admitted to the hospital on

November 6 caused additional injury and such additional injury would have been avoided with prompt and proper surgical consultation. Ms. Johnson presented evidence to establish this causal connection. The Utah Supreme Court has held that “[o]n a motion for summary judgment, a trial court should not weigh disputed evidence and its sole inquiry should be whether material issues of fact exist.” Kilpatrick, 909 P. 2d at 1292(citing Draper City v. Estate of Bernardo, 888 P. 2d 1097, 1100 (Utah 1995)). Again, the court in Kilpatrick stated that “it only takes one sworn statement under oath to dispute the averments on the other side of the controversy and create an issue of fact.” Id. Further, the court noted that the trial court should observe that “doubts about whether a nonmovant has established a genuine issue of material fact should be resolved in favor of permitting the party to go to the trial.” Id.(citing Butterfield v. Okubo, 831 P.2d 97,107 (Utah 1992)).

The trial court granted summary judgment because the court could find no expert testimony establishing a causal link between “Dr. Watts’ failure to consult with Dr. Kohler until November 9” and “specific complications.” (R. 808) This conclusion misses the point. Dr. Watts was negligent in failing to consult any surgeon and Dr. Hance clearly so states. Whatever treatment was or was not given by Dr. Watts during the two and one-half day wait for Kohler to return to town was, according to Dr. Hance’s

affidavit, inappropriate and the two and one-half day wait for appropriate treatment caused additional damage. "Because Dr. Watts failed to consult a surgeon in a timely fashion on and after November 6, 1998, plaintiff suffered pain and increasing infection for at least two and one-half days without appropriate treatment." (R. 321)

Dr. Hance also makes a direct connection between the failure to consult a surgeon and "specific complications" in his deposition testimony. Dr. Hance was asked directly about this issue in his deposition and this deposition testimony was before the court.

Question; Did you intend to render any opinions at trial, sir, with respect to any supposed delay in the performing of that second surgery?

Answer: Only that the delay in making the diagnosis of the perforation and undertaking the second surgery resulted in this large abscess that she had.

Question: Do you intend to testify that the supposed delay in doing the second surgery caused any of her problems in doing the second surgery between the time of that surgery and the present?

Answer: It caused large abscess to form. In other words, normally if you have a perforated small bowel and it's promptly recognized and promptly operated on, you do not expect a large abscess to form, which she did have she went to surgery several days later.
(R. 325)(emphasis added)

The testimony quoted above directly states that delay caused a “large abscess” to form. Directly asked whether such a “large abscess” would have formed had surgery been performed promptly, Dr. Hance replied in the negative. In other words, at the very least, a large abscess resulted from delay. Whether a “large abscess” constitutes “specific complications” is a question of fact for the jury to weigh. Even though the questioner appeared to ask what happened after the second surgery, Dr. Hance answers the question with respect to the delay in performing the second surgery. Clearly, Dr. Hance equates a “large abscess” to damage caused by delay in performing surgery.

The trial court also based summary judgment on the finding that Dr. Watts’ actions did not cause “any additional damages to the plaintiff not already remaining from the first surgery.” In direct contradiction to that finding, Dr. Hance states in his affidavit that, as a result of Watts’ delay in contacting a surgeon, Mrs. Johnson “suffered additional complications and additional hospitalization” and “incurred additional hospital bills.” (R. 321) Whether or not these are the type of “additional injuries” the court was looking for, this expert testimony clearly establishes their existence and the causal connection between delay and additional damages. It is for the jury to determine the significance of these “additional complications and additional

hospitalization” and “additional hospital bills.” Although Dr. Hance makes no direct statement that the “appropriate treatment” which he states was lacking for two and one-half days was necessarily another operation, the clear inference from his statements is that the lack of “appropriate treatment” of whatever nature resulted in these additional injuries.”

In another section of his deposition, Dr. Hance answers the question “[d]o you think there would be any difference in the ultimate outcome whether the surgery had been done on the 6th or the 9th?” with an affirmative answer. His statement again directly addresses the question of delay causing additional damages, in this case, the additional damages of large abscess, more scarring, fever and toxicity. “Yes. I think she would have had –not had the large abscess that had to be drained. She would have had much less scarring and-- . . . fever and toxicity as a result of that.” (R. 230, page 63, lines 21-25)

The testimony of Dr. Barton, surgeon expert for defendant Dr. Kohler, was also before the trial court. Dr. Barton likewise directly addresses the question of a causal link between delay and additional damages. In answer to a question about whether Mrs. Johnson’s infection increased in severity in the period between November 5 and November 9, Dr. Barton stated “yes, this probably would have gotten worse.” (R. 316, p. 80, lines 12-25) Again,

once evidence establishes the existence of the fact of the increasing severity of infection, it is the jury's province to weight the significance of that increase in infection.

Viewing this evidence in the light most favorable to the moving party, the evidence of Dr. Hance and Dr. Barton establishes a dispute as to whether Watts' failure to consult a surgeon on readmission of Mrs. Johnson caused additional injury. Summary judgment is precluded by this dispute.

The trial court also found that "[t]here is no evidence showing that surgery should have, would have been performed if Dr. Watts had contacted the surgeon earlier." (R. 808). Both Dr. Hance and Dr. Barton offered testimony that contradicts that assertion.

In his testimony, Dr. Barton states that surgery should have been performed upon recognition of the perforated bowel. He states that the appropriate treatment upon recognition of a perforated bowel is prompt surgical treatment. (R.316, p.79, line 18). This was in answer to a question about the appropriate course to be taken by Dr. Kohler if he had examined Mrs. Johnson and found a perforated bowel. The question assumes, of course, that Dr. Kohler would have acted non-negligently in examining Ms. Johnson on November 5 and therefore would have found such a condition.

Dr. Barton accepts that assumption and opines that immediate surgery is the only non-negligent course of action. R.316, p. 81, Line 13)

Likewise, Dr. Hance's deposition testimony directly stated that surgery should have been performed on readmission. In response to a question about the appropriate care if a general surgeon had been consulted on Ms. Johnson's readmission to the hospital, without any qualifiers as to whether or not a perforation was found by that surgeon, Dr. Hance states that "she would have been taken back to surgery and the perforation closed." (R. 325, p. 42, line 8) These statements of Drs. Barton and Hance both directly contradict the trial courts' conclusion as to whether or not surgery would have been performed if Dr. Watts had acted non-negligently on readmission of Mrs. Johnson to the hospital.

The court was called upon to determine if there was evidence presented that Dr. Watts' failure to consult a surgeon resulted in damage to Mrs. Johnson. The court concluded there was no such evidence and granted summary judgment. However, in direct affidavit statements and in inferences from deposition testimony, Dr. Hance and Dr. Barton both identified damages such as increased severity of infection, larger abscess, additional medical bills, additional hospitalization, additional pain, additional scarring, fever and toxicity and "additional complications." There

is a disputed issue of fact which should be submitted to the jury. The jury, not the court, should weight the significance of these additional damages.

CONCLUSION

The Appellant presented evidence to the trial court that Dr. Watts' failure to consult Ms. Johnson's primary care physician was a reasonably foreseeable cause of injury because his negligence caused a surgical referral that would not have happened in the absence of his negligence. Drawing the reasonable inference, the trial court should have recognized that without a surgical referral, there would have been no surgery and no injury.

The Appellant also presented evidence that Dr. Watts' failure to consult a surgeon on readmission of Mrs. Johnson to the hospital caused injury that was additional to that which she already had suffered. That additional injury, presented in the testimony of both Dr. Hance and Dr. Barton and by the affidavit of Dr. Hance, consisted at least of "additional complications", increased severity of infection, additional scarring, additional hospital bills, additional hospitalization, and a large abscess. The significance of these injuries is for the jury to weigh and summary judgment should not have been granted.

The court below failed to look at all the evidence in the light most favorable to Ms. Johnson and failed to draw reasonable inferences from that

evidence. The trial court's conclusion that there is "no evidence of causation" is error and, as a conclusion of law, is given no deference by this appellate court. Therefore, this Court should correct the error of the trial court, and reverse the grant of summary judgment to Dr. Watts.

DATED May 14, 2004

Signed Clark Newhall
Clark Newhall
Law Office of Clark Newhall MD JD
Attorney for Appellant

ADDENDA

A. Transcript of Hearing, June 16, 2003

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IN THE FOURTH JUDICIAL DISTRICT - PROVO COURT

UTAH COUNTY, STATE OF UTAH

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LUCY JOHNSON,)	ORAL ARGUMENT, MOTIONS
)	
Plaintiff,)	
)	
vs.)	
)	
GARY WATTS, MD, et al,)	Case 010400391
)	
)	
Defendant.)	Judge Steven L. Hansen
)	

BE IT REMEMBERED that this matter came on for hearing
before the above-named court on June 16, 2003.

WHEREUPON, the parties appearing and represented by
counsel, the following proceedings were held:

CERTIFIED TRANSCRIPT
(From Electronic Recording)

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A-P-P-E-A-R-A-N-C-E-S

FOR PLAINTIFF:

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SALT LAKE CITY UT 84101

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1 P-R-O-C-E-E-D-I-N-G-S

2 (June 16, 2003)

3 THE JUDGE: Okay. In the, is it MacLeod versus
4 Watts? Did I say that correctly?

5 MR. NEWHALL: Actually, Your Honor, her name has
6 been changed to Lucy Johnson and I think we've submitted a
7 motion some time back. And I don't believe there's any
8 argument about changing the caption to read Johnson versus
9 Watts.

10 THE JUDGE: Okay. Fine. All right. Everyone
11 that's going to be appearing arguing, state your names for
12 the record and who you represent.

13 MR. NEWHALL: Clark Hewhall, MD, JD for the record
14 for the plaintiff.

15 MR. FISHER: Philip Fishler for Dr. Kohler.

16 MR. DUBOIS: Scott DuBois for Dr. Watts.

17 THE JUDGE: All right. We have an oral argument
18 scheduled on the plaintiff's motion for arbitration,
19 plaintiff's motion to limit experts, plaintiff's motion to
20 videotape trial depositions, Dr. Kohler's motion for expert
21 fees, and I'm not sure, and a motion for summary judgment.
22 Correct?

23 MR. NEWHALL: Yes, Your Honor. But we will a,
24 we have, we have no problem dropping our motion for
25 arbitration. That seems to be, that was an issue that

1 seems to have gone by the board. At this point there's
2 not a reason to continue with that motion as far as I'm
3 concerned.

4 THE JUDGE: All right. We won't worry about
5 that.

6 All right. Do either of you or any of you have
7 any suggestions in what order you want to proceed? I won't
8 dictate that, I'll let you--

9 MR. NEWHALL: I do, Your Honor.

10 THE JUDGE: Okay.

11 MR. NEWHALL: I suggest, well, first of all
12 Mr. DuBois and I had a bit of a controversy beforehand.
13 There are a couple of motions here that, that are
14 supplementary, so to speak, to a motion to summary judgment.
15 The motion to strike Dr. Hance's affidavit is important to
16 the motion for summary judgment. And I agreed with
17 Mr. DuBois beforehand that even though that had not been
18 noticed up, so to speak, it could be argued at this hearing
19 in order to get the motion for a summary judgment out of the
20 way, if that's acceptable to Your Honor.

21 However my, my quid pro quo was that we would also
22 argue my motion for an alternative expert or to strike
23 Dr. Friedenbergs deposition testimony. A motion which,
24 which similar to the a, to the motion for striking the
25 affidavit, had not exactly been noticed up to the Court but

1 which I think is important to the issue of whether we can set
2 a trial date and when.

3 So I would like to argue the motion for summary
4 judgment and the affidavit striking motion first because
5 obviously that's germane to all the other issues. And then
6 should we be successful in opposing the summary judgment
7 motion I'd like to continue on to the motion to strike
8 Dr. Friedenbergs and add a plaintiff or alternatively add a
9 plaintiffs expert.

10 That would be my suggestion, Your Honor.

11 THE JUDGE: Thank you.

12 MR. DUBOIS: Your Honor, we're not prepared today
13 to talk about Dr. Friedenbergs, that motion to strike his
14 testimony and I, I need time to prepare to argue that
15 properly. And so I can't agree to the quid pro quo that's
16 been proposed.

17 THE JUDGE: Can we proceed on the motion for
18 summary judgment and the affidavit motion that you've
19 filed?

20 MR. DUBOIS: Yes.

21 THE JUDGE: Hear that today.

22 MR. DUBOIS: Sure.

23 THE JUDGE: Then we'll see depending on how that
24 turns out what to do next. Wouldn't that be efficient and
25 something we can take care of?

1 MR. NEWHALL: That's... I was trying to get more
2 of it done at once than we could by our agreement. But
3 that's okay with me, Your Honor.

4 THE JUDGE: All right. All right. Let's, let's
5 hear that then, the motion for summary judgment. And then
6 you can argue while you argue that the motion to strike the
7 affidavit of Dr. Hance.

8 MR. DUBOIS: Thank you, Your Honor.

9 ARGUMENT BY MR. DUBOIS

10 MR. DUBOIS: Your Honor, we filed a motion for
11 summary judgment on behalf of Dr. Watts because the plaintiff
12 has failed to prove a prima facie case of negligence against
13 him. Specifically the plaintiff has not provided expert
14 testimony that connects the treatment provided by Dr. Watts
15 to the injuries that the plaintiff is claiming. The
16 plaintiff has not produced expert testimony that connects her
17 past, and more particularly her current physical complaints,
18 to any negligence on behalf of Dr. Watts. And on that basis
19 we request that the Court enter a summary judgment in favor
20 of Dr. Watts.

21 Prior to discussing the substance of our motion a,
22 and memorandum in support I want to note a procedural
23 deficiency in the plaintiff's opposition to our motion for
24 summary judgment.

25 As the Court knows, Rule 4-501(b) requires the

1 plaintiff to specifically dispute facts that are contained
2 in our motion and memorandum for summary judgment. The
3 language in Rule 4-501(b) is mandatory, it's not
4 permissive. It indicates that the plaintiff shall, or the
5 person opposing a motion for summary judgment shall
6 specifically set forth paragraphs to which there is a dispute
7 in terms of material fact. And the plaintiffs, or the
8 plaintiff failed to do that in her opposition. There is no
9 specific denial of any specific factual paragraph that's
10 contained in the memorandum.

11 The rule indicates that to the extent that the
12 plaintiff, or the person opposing the motion for summary
13 judgment, does not specifically contradict or dispute the
14 material statement of fact that that fact shall be deemed
15 admitted. Again, the language is mandatory, not
16 permissive.

17 On that basis insofar as the facts that are set
18 forth in our motion for summary judgment, counsel in favor of
19 entry of summary judgment, I would submit that you enter
20 summary judgment. All of the facts have to be deemed
21 admitted and on that basis summary judgment is indicated.
22 I know that's a harsh remedy but that's what the rule
23 requires.

24 In addition a, to the extent that, that the
25 opposition does not specifically refute facts that are set

1 forth in the motion for summary judgment, the issues aren't
2 framed for the Court properly. You don't know which facts
3 are in dispute and which ones aren't. And they may claim
4 that there's an inference that there's a dispute as to
5 material fact because the opposition opposes some of the
6 arguments that are in the motion for summary judgment. But
7 that's not sufficient under the rule.

8 With that in mind I'm going to move on to the
9 substance of our argument for summary judgment.

10 The legal standard is a, that the plaintiff needs
11 to prove a prima facie, prima facie case of negligence. That
12 is the plaintiff must establish a duty, a breach of the duty,
13 they must show that that breach is the proximate cause of
14 injury, and they must prove that the plaintiff has suffered
15 damage. And there is ample legal authority supporting the
16 notion that the plaintiff must prove with competent expert
17 testimony that the alleged negligence is the cause of the
18 injuries that are being claimed. And the plaintiff
19 acknowledges that in the opposition that they must prove with
20 expert testimony that there is some causal connection between
21 the alleged negligence and the injury.

22 Based upon the depositions that have been taken and
23 all of the expert information that's been provided by the
24 plaintiff there is no causal connection between the alleged
25 negligence on behalf of Dr. Watts and the injuries that the

1 plaintiff claims that she suffered at the time, and more
2 particularly the a, injuries that she's claiming that she has
3 now. It's prudent to discuss each of the injuries that's
4 claimed by the plaintiff and see what kind of expert
5 testimony they've got supporting those claims.

6 The first injury that's identified by the plaintiff
7 is a, that she had a gall bladder surgery that was not
8 indicated, that she had a, some stomach complaints and some
9 indications that something was required. She subsequently
10 underwent a gall bladder surgery and she's saying that wasn't
11 necessary.

12 THE JUDGE: Let me, let me stop you here.

13 MR. DUBOIS: Sure.

14 THE JUDGE: I want you to, I want you to stick to
15 your argument but I'd like you to just summarize for us the
16 a, the case--

17 MR. DUBOIS: Okay.

18 THE JUDGE: -- from your point of view.

19 MR. DUBOIS: Okay.

20 THE JUDGE: What's this case about and a, why you
21 are arguing that there is no proximate cause here as a matter
22 of law.

23 MR. DUBOIS: Okay. I'd be happy to, Your Honor.
24 We, we set forth the, the history of the case and the history
25 of the treatment that was provided in our motion.

1 THE JUDGE: Uh-huh (affirmative).

2 MR. DUBOIS: But briefly, this case involves a, an
3 allegation that there was a surgery and some complications
4 with surgery. My client is Dr. Watts. Dr. Watts is the
5 plaintiff's nephew—

6 THE JUDGE: Okay.

7 MR. DUBOIS: — who provides radiology services
8 at Utah Valley. Ms., I'm going to call her MacLeod because
9 that's how we've been referring to her throughout the course
10 of the litigation, and in fact, even in supplemental
11 pleadings that have been filed by the, by the plaintiff after
12 her name change they still call her Mrs. MacLeod. So for
13 purposes of the hearing I'll call her Mrs. MacLeod. _____

14 Mrs. MacLeod had some, in October of 1998 had
15 complaints of stomach pain, problems. She a, sought out her
16 nephew and said I need you, you know, I've got these
17 complaints, I think that I need, something needs to be
18 done. Dr. Watts agreed to a, take a look at her and to make
19 a referral if appropriate.

20 Ms. MacLeod came down from, she lived in Logan at
21 the time, came down to Provo, saw her nephew, he conducted a
22 couple of radiographic studies. He referred her to a
23 gastroenterologist who also did some studies, and then
24 subsequently she was referred to Dr. Kohler.

25 THE JUDGE: Uh-huh (affirmative).

1 MR. DUBOIS: Dr. Kohler then made an independent
2 determination that a gall bladder surgery was indicated.
3 Ms. MacLeod underwent gall bladder surgery on November 3rd,
4 1998, was discharged on November 4th. Went to her niece's
5 home and recuperated for a couple of days. During that,
6 that, the course of those couple of days she continued to
7 have some stomach pain. Dr. Kohler a, went out, had to go
8 out of town after the surgery. So Mrs. MacLeod when she
9 didn't feel much better after the surgery called Dr. Watts
10 and said I don't feel well, and so Dr. Watts agreed to see
11 her. Dr. Watts knowing that Dr. Kohler was out of town
12 admitted Ms. MacLeod to the hospital, followed her for a
13 couple of days.

14 And then a, Dr. Kohler came back. At that point
15 it was determined that there had been a, a perforation to her
16 bowel during the surgery that needed to be repaired. That
17 was repaired on November 9th, 1998. After the second
18 surgery Ms. MacLeod was in the hospital, continued to receive
19 care, had some complications, she was discharged on a, from
20 the hospital on November 24th, 1998.

21 Our, our contention is that the plaintiffs have two
22 expert witnesses, both of them were asked their, their
23 opinions on causation. Neither of those experts would
24 testify that or could testify that Ms. MacLeod had suffered
25 or is suffering from any injury or complication after

1 November 24th, 1998.

2 In other words, in her complaint Ms. MacLeod
3 discusses a litany of current problems that she's got. In
4 her deposition she talked about some more injuries and
5 complications that she has currently.

6 Neither of the plaintiff's experts know what her
7 current condition is, they don't know what her complaints
8 are, they don't, and they are not willing and will not
9 testify that there's any connection between what Dr. Watts or
10 Dr. Kohler did in the hospital and the complaints that she's
11 currently got. So at the very least there's no, there's no
12 causation testimony that connects any treatment provided at
13 the hospital to any condition after November 24th of 1998.
14 That's been conceded by the plaintiff.

15 Now, on the front end, and I'm kind of getting
16 ahead of myself in terms of the argument, but our, our
17 argument is that the decision to a, to take Mrs. MacLeod to
18 surgery was made by Dr. Kohler. And so the plaintiffs have
19 no... I mean, in fact both plaintiff's experts conceded
20 that that decision was made by Dr. Kohler. And so the
21 plaintiffs have in a sense proven that Dr. Watts cannot be
22 held responsible for that decision and any injury associated
23 with this surgery that may or may not have been indicated.

24 I don't know if that provides a basis for--

25 THE JUDGE: Uh-huh (affirmative).

1 MR. DUBOIS: -- we've got more specific arguments
2 on some of the other issues of causation but I'd be happy
3 to--

4 THE JUDGE: Thank you.

5 MR. DUBOIS: -- provide more detail.

6 THE JUDGE: No.

7 MR. DUBOIS: Okay.

8 THE JUDGE: Thank you.

9 MR. DUBOIS: The first injury that I had, that I
10 had mentioned, and I just touched on it briefly, was that the
11 gall bladder surgery was not indicated. That's the
12 plaintiff's assertion. And that Dr. Watts should somehow be
13 held responsible for the decision to go forward with
14 surgery.

15 As I mentioned, in 1998 Dr. Watts was contacted by
16 a, Mrs. MacLeod regarding her complaints of stomach pain.
17 Dr. Watts arranged for testing to be done by Dr. Hemmert
18 (phonetic) and arranged for the surgical consultation by
19 Dr. Kohler. Dr. Kohler evaluated Mrs. MacLeod and made the
20 decision to go forward with surgery. Dr. Hance testified,
21 who is the plaintiff's radiology expert, testified that the
22 decision to go forward with surgery was made a, by
23 Dr. Kohler.

24 And in his deposition.

25 "Question: Is it your belief,

1 Dr. Hance, that Dr. Watts played any
2 active role in the actual decision of
3 whether or not to undergo surgery that
4 Dr. Kohler performed?

5 Answer: No.

6 Question: And you would concede, would
7 you not, that he had absolutely, that he
8 had absolutely nothing to do with that
9 decision?

10 Answer: He had nothing to do with the
11 decision. He just facilitated the
12 referral to Dr. Kohler and Dr. Kohler
13 made the decision to operate."

14 And then further in Dr. Hance's deposition.

15 "Question: Whether or not a person is
16 a candidate for surgery, is that
17 something that falls within the training
18 and experience of a general surgeon as
19 opposed to a radiologist?

20 Answer: The general surgeon is the one
21 that makes the ultimate decision whether
22 he's going to operate or not. A
23 radiologist cannot operate. So it has
24 to be the general surgeon that makes the
25 final decision.

1 Question: All right. And radiologists
2 always defer to the general surgeon, do
3 they not, after the studies are done?

4 Answer: That's right. You give them
5 the information and they take it from
6 there.

7 Question: So if opposed whether or not
8 surgery is indicated or not indicated it
9 would be beyond the training of a
10 radiologist to interpose himself in that
11 decision making process?

12 Answer: Correct."

13 In addition to the testimony of Dr. Hance, a, the
14 deposition of Dr. Anaise who is the plaintiff's plaintiff's
15 surgery expert was taken. And Dr. Anaise also testified that
16 the decision to take Ms. MacLeod to surgery was made by
17 Dr. Kohler and not by Dr. Watts.

18 Accordingly, Dr. Watts can't be held to be
19 responsible for the decision to go forward with surgery or
20 any injuries associated with that decision. And even if the
21 plaintiff is able to establish that surgery was not
22 indicated, a, and that Ms. MacLeod suffered some injury as a
23 result of that decision, Dr. Watts didn't cause the injury
24 according to the plaintiff's own experts. And whether or
25 not the surgery was in fact indicated or not is something

1 that will be determined at trial. We believe that it was.
2 But in any event, Dr. Watts can't be held responsible or
3 liable for that decision or any injuries associated with
4 that.

5 The a, second injury that Ms. MacLeod claims was
6 that her bowel was nicked during the first surgery which
7 required a second surgery. Now, Dr. Anaise and Dr. Hance
8 both testified that the second surgery was necessary a, due
9 to the complication that occurred in the first surgery. It
10 was going to have to happen one way or the other. And
11 insofar as Dr. Watts didn't make the decision to go forward
12 with the first surgery, Dr. Watts can't be held responsible
13 for the need for the second surgery.

14 Accordingly, again, if the plaintiffs can establish
15 some injury in connection with the decision to go, to take
16 her to surgery in the first place and the required second
17 surgery, Dr. Watts by the plaintiff's own experts'
18 depositions can't be held responsible for any of those
19 related injuries.

20 The third injury that the plaintiff claims in
21 connection with Dr. Watts' treatment is, is in connection
22 with Dr. Watts' treatment between November 6th and
23 November 9th when Dr. Watts admitted Ms. MacLeod to the
24 hospital.

25 As I mentioned, Ms. MacLeod's surgery was on

1 November 3rd, 1998. After her first surgery she testified
2 she had some stomach pains and other symptoms. Ms. MacLeod
3 contacted Dr. Watts because Dr. Kohler was out of town.
4 Dr. Watts admitted Ms. MacLeod to the hospital on
5 November 6th and provided supportive care until Dr. Kohler
6 returned on November 9 when the second surgery was done.

7 The plaintiff claims that there was some delay in
8 diagnosing the perforation that occurred during the first
9 surgery and that there was a delay in taking Ms. MacLeod back
10 for surgery. However, the plaintiffs must prove that
11 Dr. Watts' treatment and the supposed delay in taking her
12 back to surgery caused some actual specific injury.

13 Dr. Hance in his deposition and in his subsequent
14 affidavit testified that a, she had an abscess, that an
15 abscess formed during that interval. There is no
16 connection and no testimony that connects that abscess
17 to any subsequent injury that Ms. MacLeod suffered after her
18 second surgery on the 9th. There is no expert testimony
19 that makes any connection to that abscess to any subsequent
20 complication that she suffered after the surgery on
21 November 9th.

22 In addition there's no, there's absolutely no
23 testimony that connects that abscess or anything that
24 happened between November 6 and November 9 to any subsequent
25 injury that Ms. MacLeod suffered after her discharge from the

1 hospital on November 24th, 1998.

2 Therefore, even though, even if she did have an
3 abscess a, and that would, resulted during November 6th
4 through November 9 there is no testimony that connects that
5 abscess, which is a claimed injury, to any other injury at
6 all or any other medical complication.

7 In addition, there is no expert testimony that
8 Ms. MacLeod would have been taken back to surgery any sooner
9 than November 9th had a surgeon been contacted as they
10 suggest. There's no expert testimony that says that second
11 surgery would have happened any sooner, and so there really
12 is no connection to an actual injury if she wouldn't have
13 been taken back to surgery any sooner. And so on that basis
14 there is just no expert testimony that indicates, supports a
15 claim that Dr. Watts' alleged negligence caused any harm even
16 between November 6th and November 9th.

17 Lastly, Ms. MacLeod is currently claiming quite a
18 few problems. In her complaint Ms. MacLeod states that she
19 has medical and household expenses, chronic diarrhea and
20 other gastrointestinal disorders, disability, loss of
21 enjoyment of life, emotional distress. And in her deposition
22 Ms. MacLeod testified that she has fatigue, weight gain,
23 scarring, loss of physical strength. And she also tries to
24 make a connection between her treatment in November of 1998
25 and her divorce and some debts that were incurred that

1 weren't related to medical treatment.

2 Importantly, there is absolutely no expert
3 testimony that establishes any connection between
4 Ms. MacLeod's current complaints, her current condition, her
5 current complaints, her current claims of injury, and any
6 care provided by Dr. Watts.

7 Dr. Hance in his a, deposition testified that he's
8 not aware of Ms. MacLeod's current condition and has no
9 information in fact regarding her, her condition after
10 November 24th, 1998. In Dr. Hance's deposition on page 45
11 there's a question:

12 "Just so I'm clear, Doctor, do you
13 intent to render any opinions with
14 respect to Mrs. MacLeod's current
15 condition and whether or not any of the
16 current problems she claims to suffer
17 from were caused by this delay in doing
18 the second surgery?

19 Answer: I am not aware of her current
20 problems. My involvement ends with her
21 24 of November 1998."

22 He doesn't know her current conditions, he will not
23 offer any testimony that the care provided in November of
24 1998 is connected to any current complaint, problem, injury,
25 so forth.

1 On page 64 of Dr. Hance's deposition.

2 "Question: Do you know if after the
3 surgery that her symptomology improved?

4 Answer: Well, I've only reviewed until
5 the time of her discharge. And I know
6 she was very very sick there when she was
7 in the hospital so I won't call that, I
8 won't call that an improvement. After
9 discharge from the hospital I honestly
10 don't know and I can't answer your
11 question.".

12 Dr. Hance is not going to testify that any current
13 injury, complaint is connected in any way to the treatment
14 that was provided in November of 1998.

15 Dr. Anaise a, who is the plaintiff's surgery
16 expert, also was asked his opinions regarding a causation.
17 And Dr. Anaise in response to the questioning on page 76 of
18 his deposition:

19 "Question: Dr. Anece, you have been
20 asked to render opinions with respect to
21 the causation of any injuries".... Or
22 ..."have you been asked to render
23 opinions with respect to the causation of
24 any injuries or any complaints that
25 Ms. MacLeod has as they relate to any of

1 the events that took place from
2 November 3rd, 1998 through the conclusion
3 of the discharge from her second
4 hospitalization?

5 Answer: I think I'm rendering an
6 opinion about one particular damage and
7 that was the high probability of having
8 the bowel obstruction that I thought was
9 directly caused by the surgery that
10 preceded. I was not asked to comment but
11 mentioned in passing things like
12 hypoglycemia, fluid management or
13 pneumothorax and so on because I thought
14 they were going to be covered by the
15 other experts."

16 And then.

17 "Question: Doctor, apart from her
18 supposed increased likelihood of
19 suffering from a bowel obstruction of
20 some sort, do you intend to testify at
21 trial that to a reasonable degree of
22 medical probability any of Ms. MacLeod's
23 complaints or problems are proximately
24 caused by any of the events from
25 November 3rd to November 24th?

1 Answer: I was not prepared for this
2 question. And I think it's covered by
3 other experts."

4 And then there's a, some discussion on the
5 record. The answer continues:

6 "I am not prepared to testify to that at
7 this junction. I was led to believe
8 other experts would cover that. I think
9 it would be redundant at most.

10 Question. The answer as you sit here
11 today?

12 Answer: The answer is no."

13 The only thing that Dr. Anaise is going to speak to
14 is the possibility of a future bowel obstruction. No other
15 causation testimony, no other testimony that connects any
16 treatment in November of 1998 to any problems that
17 Ms. MacLeod claims that she is currently suffering from.

18 With respect to Dr. Anaise's testimony regarding a
19 high probability of future bowel obstruction, a, in Section B
20 of our memorandum in support of motion for summary judgment
21 we argued that Ms. MacLeod must show an actual injury, not
22 just the risk of injury to prove causation and to prove
23 damages. And that's the Hansen versus Mt. Fuel case,
24 Mt. Fuel Supply case.

25 The plaintiff did not address that argument in

1 the opposition. It has been conceded that they must show
2 an actual injury, not just a future possibility of injury.

3 Thus, even if Dr. Hance's affidavit is not
4 stricken, and we'll get to that next, even if that affidavit
5 is not stricken there is absolutely no testimony linking or
6 connecting the treatment provided by Dr. Watts to any injury
7 suffered or allegedly suffered after November 24th of 1998.
8 And in fact, if you look at the plaintiff's opposition the
9 plaintiff concedes that no connection has been made but
10 rather focuses on some injuries that may have occurred while
11 she was in the hospital. They don't talk about anything
12 that happened after November 24th of 1998, even in the
13 opposition.

14 THE JUDGE: Tell me why November 24th is the day
15 you keep talking about. I thought the--

16 MR. DUBOIS: The reason for November 24th is--

17 THE JUDGE: -- (short inaudible, two speakers)
18 November 9th. That was the second surgery.

19 MR. DUBOIS: Yes, Your Honor. There, there is
20 the plaintiff was a, after the second surgery--

21 THE JUDGE: Uh-huh (affirmative).

22 MR. DUBOIS: -- remained in the hospital--

23 THE JUDGE: Until--

24 MR. DUBOIS: -- until November 24th. That's
25 when she was discharged from the hospital.

1 THE JUDGE: Thank you.

2 MR. DUBOIS: And I'm sorry if that wasn't made
3 clear. And the reason why I, I note November 24th is
4 because Dr. Hance in his deposition testified that he had
5 reviewed all the records up through discharge, nothing after
6 discharge.

7 Briefly with respect to the affidavit of, of
8 Dr. Hance. After we filed the motion for summary judgment
9 pointing out the deficiencies in the plaintiff's experts'
10 deposition testimony, the plaintiff a, with the opposition
11 submitted the affidavit of Dr. Hance. Dr. Hance offers a
12 few supplemental opinions, things that he was, he was asked
13 about during his deposition but he didn't provide in direct
14 response, in response to questions at deposition.

15 We have made a motion to strike Dr. Hance's
16 affidavit a, or portions of his affidavit for several
17 reasons. One is that he lacks foundation to testify to, to
18 some of the things he testifies to. And second, the
19 affidavit impermissibly attempts to add opinions to his
20 deposition testimony. He was asked questions at his
21 deposition, he had the opportunity to provide all of his
22 opinions, and a, it's unfair for the plaintiffs to be able to
23 offer additional opinions in an affidavit where we don't have
24 the ability to cross examine Dr. Hance.

25 And the third reason to strike Dr. Hance's

1 deposition, or his affidavit, is that portions of the
2 affidavit a, where he attempts to establish some causation
3 and connection to some injury are conclusionary and vague.
4 For instance, Dr. Hance indicates that Ms. MacLeod suffered
5 additional hospitalization but, but doesn't say what
6 additional hospitalization, how many days, why it was, why
7 there's a connection to the treatment that was provided by
8 Dr. Watts.

9 Under Rule 56(e) affidavits must be made on
10 personal knowledge, shall set forth facts as would be
11 admissible in evidence, and shall show affirmatively that the
12 affiant is competent to testify to the matters that are
13 stated in the affidavit. Therefore, to the extent that
14 Dr. Hance's affidavit doesn't comport with Rule 56(e) it
15 should be stricken.

16 Dr. Hance is board certified in radiologist and
17 nuclear medicine. Dr. Hance conceded in his deposition that
18 he was not qualified to a, offer opinions regarding general
19 surgery issues. And a, you'll remember the, the deposition
20 testimony that I read just a moment ago he, he defers to a
21 general surgeon on the question of whether or not surgery is
22 indicated.

23 Dr. Hance also testified that the determination
24 of whether a person is a candidate for a surgery is made by
25 the general surgeon. That's the testimony that I read

1 earlier.

2 Paragraph 7(g) and 7(h) of Dr. Hance, his affidavit
3 offers an opinion that Dr. Watts' referral of Ms. MacLeod to
4 Dr. Kohler led to surgery. Dr. Hance doesn't have the
5 foundation to a, testify that Dr. Watts' referral led to
6 surgery. Dr. Watts' referral didn't lead to surgery, it led
7 to a referral. Whether or not Ms. MacLeod was ultimately
8 taken to surgery is a decision that he is not qualified to
9 make. He said he would not offer opinions about that.
10 And, therefore his, his affidavit to the extent that it
11 implies that Dr. Watts, his referral led to surgery should be
12 stricken because it's simply, he lacks foundation to offer
13 that opinion.

14 In addition, paragraph 7-L through 7-N should be
15 stricken because he lacks the foundation to offer opinions
16 regarding a, when a surgeon would have, would have taken her
17 to the second surgery. Dr. Hance says if a surgeon had been
18 contacted then she would have been taken to surgery more
19 quickly. He lacks foundation to offer that opinion. He
20 can't say when a surgeon would have taken her to surgery.

21 A--

22 THE JUDGE: Are there cases in your experience
23 where there's been liability on, based on a negligent
24 referral? Have you seen those?

25 MR. DUBOIS: I'm not aware of any. And the

1 plaintiffs don't cite any. And the plaintiff's argument is
2 that the simple referral led to surgery.

3 THE JUDGE: Uh-huh (affirmative).

4 MR. DUBOIS: And that would, that would hold water
5 if every referral resulted in a surgery. But they don't.
6 That's why you refer someone to a specialist so they can make
7 an independent determination based upon their, their
8 experience and knowledge of whether or not to take someone to
9 surgery or not. I mean, if the plaintiff's argument is
10 accepted that means that the person that drove Ms. MacLeod to
11 the hospital could be held liable too. If they hadn't driven
12 her to the hospital she wouldn't have had surgery. It's the
13 same kind of logic.

14 I would, I would suggest that the referral to a
15 specialist breaks the chain of causation.

16 THE JUDGE: Isn't it foreseeable though that an
17 intervenor such as Dr. Kohler could negligently perform a
18 surgery causing injury to the plaintiff?

19 MR. DUBOIS: I don't think so. And that argument
20 hasn't been made and it hasn't been briefed that it's a
21 foreseeable... That's, that's a separate issue. I, I think
22 that that, that's why you refer someone to a specialist is so
23 they can make an independent determination of whether or not
24 surgery is indicated.

25 Once Dr. Watts makes that referral he's out of the

1 picture, he's not making decisions, he's, and whether or not
2 a person is ultimately taken to surgery or not is up to the
3 specialist. And that's what Dr. Hance testified to and
4 that's what Dr. Anaise testified to.

5 THE JUDGE: I know it's not briefed and I
6 recognize that. But it was a question that I had that seems
7 to me that needs to be answered and that's why I asked about
8 the cases where there was an alleged negligent referral
9 caused subsequent injury as a result of the intervening
10 negligence of the surgeon or of a doctor.

11 MR. DUBOIS: That's not an allegation that's made
12 in this--

13 THE JUDGE: That's a theory though of the case.

14 MR. DUBOIS: It's not, that's, that's an
15 allegation that hasn't been especially made and it hasn't
16 been briefed. And I'm not, as I sit here today, Your Honor,
17 I'm not of aware of any cases. We could probably undertake
18 some supplemental research and, and brief that issue for
19 you.

20 THE JUDGE: Well, don't we have to address it
21 sooner or later? That's the theory of their case that a,
22 Dr. Watts referred the plaintiff to a surgeon without
23 consulting the primary care physician, Dr. Salisbury,
24 which resulted in this surgery, which resulted in this
25 damage.

1 MR. DUBOIS: And our argument is that once the
2 referral is made that the chain of causation is broken, that
3 the decision in this, that's the testimony of both their
4 experts is that once he makes the referral he's out of the
5 picture. Dr. Watts plays no role at all in the decision to
6 take her to surgery or not.

7 THE JUDGE: And the fact, and that there are no
8 disputed facts, it's undisputed that that's what happened and
9 as a matter of law this Court can decide an intervening act
10 question on proximate cause?

11 MR. DUBOIS: Correct. And that's the, that's the
12 testimony of their own experts.

13 THE JUDGE: Uh-huh (affirmative).

14 MR. DUBOIS: In addition to lacking foundation
15 we've, we've briefed the question whether Dr. Hance's
16 supplemental testimony is a, inconsistent with or attempts to
17 add to his deposition testimony. It's clear that his
18 supplemental opinions are just that, they're supplemental.
19 He was asked questions and he was allowed to offer opinions
20 during his deposition. He didn't offer those opinions
21 during his deposition a, with respect to causation and that's
22 that there was additional hospitalization and that there are
23 additional medical bills, that he didn't discuss that in his
24 deposition and we weren't provided with an opportunity to
25 cross examine him regarding those opinions. And based on

1 that we believe they should be stricken.

2 And we've also briefed the question of whether or
3 not his a, deposition testimony is vague and conclusionary.
4 We suggest that it is, and there is case law that suggests
5 that an affidavit should be stricken to the extent that it is
6 vague and conclusionary. That is that there were additional
7 complications or additional a, medical bills. Dr. Hance
8 didn't testify what specific hospitalization was additional,
9 he didn't testify what specific hospital bills were
10 incurred.

11 And that's the danger of allowing him to produce
12 supplemental opinions through an affidavit where we're not
13 allowed to or have the opportunity to, to question him about
14 those opinions and so--

15 THE JUDGE: But he did give an opinion about the
16 referral.

17 MR. DUBOIS: He did.

18 THE JUDGE: He did say that he didn't think that
19 was appropriate.

20 MR. DUBOIS: Well, he--

21 THE JUDGE: I may not have used the right word
22 but--

23 MR. DUBOIS: I think that--

24 THE JUDGE: — he did give an expert opinion that
25 that referral should never have been made.

1 MR. DUBOIS: I think he made, he did give an
2 opinion to that extent. But I think that his affidavit
3 testimony is inconsistent with and contradicted by the
4 deposition testimony that he gave which is a, he's, he's
5 implying in his affidavit that Dr. Watts is responsible for
6 the decision to go forward with the surgery, which is
7 contradicted and is inconsistent with his deposition
8 testimony where he said the, that Dr. Watts had, doesn't have
9 the foundation to, to, or Dr. Watts isn't involved in the
10 decision of whether or not to take her to surgery. That's a
11 surgeon's call. Once the referral is made he is completely
12 out of the picture. That's what Dr. Hance said in his
13 deposition.

14 THE JUDGE: Uh-huh (affirmative).

15 MR. DUBOIS: And so that contradicts his
16 affidavit.

17 THE JUDGE: I understand.

18 MR. DUBOIS: With that, I don't believe that we've
19 got anymore.

20 THE JUDGE: I'll ask Counsel. I'm not sure that's
21 their theory but a, we'll ask them.

22 MR. DUBOIS: Okay.

23 THE JUDGE: We'll see what he says.

24 It's not your theory is it, Counsel, that, that
25 Dr. Watts had anything to do with the decision to perform the

1 surgery in this case? That was Dr. Kohler. And a, you're
2 not claiming that there was any negligence on the part of
3 Dr. Watts in that regard, are you?

4 ARGUMENT BY MR. NEWHALL

5 MR. NEWHALL: You're correct, Your Honor. We're
6 claiming that Dr. Watts' referral was negligent--

7 THE JUDGE: Uh-huh (affirmative).

8 MR. NEWHALL: -- and that that negligent referral
9 was the reason this lady underwent surgery which caused her
10 injury. And that but for that negligent referral she would
11 not have had the injury. This is a but for case. It's
12 much clearer than a foreseeable case.

13 If you're looking for a foreseeability case on
14 negligent referral I have to admit that I don't have one.
15 But it seems to me similar to the case that, that I learned
16 about in torts so many years ago where the radio disk jockey
17 driving around town broadcasting that his license plate was
18 visible and people could win a prize if they called in a
19 certain number. It was foreseeable that if people called in
20 that number chasing the disk jockey around they might get
21 into an accident. And he was held liable on the basis of
22 that foreseeability similar to the, to the claim take we're
23 making.

24 THE JUDGE: But you have to, you have to have
25 that. You can't just rely on the but for.

1 MR. NEWHALL: Well, Your Honor--

2 THE JUDGE: That doesn't establish causation.

3 MR. NEWHALL: Well, Your Honor, I believe that not
4 only is it but for, but it is foreseeable. After all--

5 THE JUDGE: How is it foreseeable?

6 MR. NEWHALL: -- this, this lady would not have
7 seen a surgeon, she would never have been to see this
8 surgeon. It's foreseeable that her nephew the surgeon is
9 going, or I'm sorry her nephew the radiologist is going to
10 send her to a surgeon and that she will have surgery as a
11 result of having her seen by the surgeon.

12 THE JUDGE: Do you have any case in any
13 jurisdiction where liability had been found for a negligent
14 referral?

15 MR. NEWHALL: A negligent medical referral. No,
16 I do not, the additional--

17 THE JUDGE: Well that's, that's your case, isn't
18 it? I mean, I don't mean to be simplistic but--

19 MR. NEWHALL: As you put it, Your Honor, it is my
20 case. And, and if I have to search for a case of that
21 nature then I'm sure I can find one. But I didn't brief
22 that, as Mr. DuBois points out, because we're not as
23 perceptive as you and haven't figured out that that's the
24 case I guess.

25 But that's not the only issue as to negligence with

1 respect to Dr. Watts. Mr., Mr. DuBois points out again and
2 again that his claim that, that Mrs. MacLeod suffered,
3 Ms. Johnson suffered no injuries after November 24th, there's
4 several things that he fails to note, however.

5 First of all, Dr. Hance opined that for Dr. Watts
6 to admit Mrs., Ms. Johnson to the hospital and not consult
7 the surgeon was negligent.

8 Dr. Barton who is the a, expert surgeon for
9 Dr. Kohler and whose deposition is included, as I recall it
10 was taken after--

11 THE JUDGE: Well, just a minute. I'm lost on the
12 facts.

13 MR. NEWHALL: Okay.

14 THE JUDGE: He, Dr. Watts refers her to
15 Dr. Kohler.

16 MR. NEWHALL: Dr. Watts referred her.

17 THE JUDGE: Dr. Kohler admitted her into the
18 hospital.

19 MR. NEWHALL: I'm sorry. On the second
20 admission. Dr. Kohler admitted her the first time,
21 operated, sent her home, went out of town. This lady
22 complained of not a little bit of abdominal pain but a lot of
23 abdominal pain. References to her stomach being on fire
24 were made.

25 THE JUDGE: Uh-huh (affirmative).

1 MR. NEWHALL: She then called her nephew a couple
2 of times, who after a couple of calls put her into the
3 hospital. And rather than calling the surgeon who was on
4 call for Dr. Kohler and was in the hospital almost 24 hours a
5 day, according to him, rather than call the on call surgeon,
6 Dr. Watts chose to take care of this lady himself--

7 THE JUDGE: I see.

8 MR. NEWHALL: -- for a period of--

9 THE JUDGE: From the 6th to the 9th until the
10 doctor came.

11 MR. NEWHALL: Correct. For a period of three
12 days.

13 THE JUDGE: Okay.

14 MR. NEWHALL: During that time he administered
15 virtually no treatment except at the very end when he started
16 antibiotics apparently after calling Dr. Kohler Sunday night,
17 the night of the 8th.

18 Dr. Barton, who is the surgeon expert for
19 Dr. Kohler, opined that it was more likely than not that
20 that delay of two days caused an increase in the infection,
21 an increase in the abscess, an increase in the cellulitis.
22 And certainly we can assume, I think without even expert
23 testimony, that those two days involved medical costs that
24 she would not have borne had she been treated earlier.

25 In any case, that's the second of our contentions

1 as to his negligence.

2 Now, as a result of that second surgery she had a
3 very large scar. We didn't feel it was necessary to point
4 out that that scar, which took time to heal after she was
5 discharged from the hospital on the 24th, and which required
6 further medical treatment after she was treated, I'm sorry,
7 discharged on the 24th, it didn't seem necessary to point
8 out that that constituted damages as a result of the
9 surgery.

10 But it's necessary to point that out we can refer
11 to Dr. Salisbury, her treating physician, who noted the scar
12 and noted the treatment, and noted that he ordered home
13 health care treatment for her to take care of that scar after
14 the 24th, her discharge date.

15 I don't think that... I admit that there's no
16 negligent referral case that I can point to. I don't think
17 though that it's outside the realm of anyone's a, common
18 knowledge that if someone is referred to a surgeon, surgery
19 when it ensues can involve complications, and again, those
20 complications can be negligent or nonnegligent.

21 In this case we're contending that the
22 complications were negligent. But even if they weren't,
23 Dr. Kohler's decision to perform surgery is certainly a
24 foreseeable one to a doctor, let alone a layman, when someone
25 is referred to surgery, to a surgeon. If Dr. Watts didn't

1 foresee that referring this lady to a surgeon might involve
2 surgery, then why in the world would he refer her to a
3 surgeon? Why leave her with gastroenterologist who doesn't
4 perform surgery.

5 That seems to me to be an argument that doesn't
6 require any kind of case support. A doctor's role as a
7 professional is to refer patients appropriately. And a
8 doctor's role as a professional is to know what those
9 referrals might involve before making those referrals.

10 After all, if a doctor refers a patient for lab
11 tests, a doctor ought to know that the person might get stuck
12 for the lab test and might end up with an infection from the,
13 from the point of being stuck. Now, if the doctor
14 negligently referred someone for the lab test then, then it
15 would be foreseeable that that negligent act could result in
16 injury.

17 THE JUDGE: So a doctor who is conservative in his
18 practice and decides to make a referral to a specialist to
19 examine a potential problem could open him or herself up to
20 liability if that specialist then negligently performs a test
21 or a procedure?

22 MR. NEWHALL: Only if that doctor, one, knew that
23 the surgeon was likely to perform a negligent procedure, and
24 two, the doctor himself were negligent in making the
25 referral. In this case we have the second of those two, the

1 doctor himself was likely, or I'm sorry, the doctor himself
2 knew, should have known that this referral was unnecessary.
3 So his negligence is continued through by the injury that
4 occurred.

5 If we had not asserted that Dr. Kohler was
6 negligent and if we had not put Dr. Kohler into this lawsuit
7 the situation would be exactly the same. Dr. Watts makes
8 the referral negligently. Whether Dr. Kohler is in the
9 middle or not is irrelevant. If Dr. Watts had not made the
10 referral negligently, if he had talked to say Dr. Salisbury
11 and said gee, Dr. Salisbury, this lady seems to have
12 problems, she seems to have problems that require surgical
13 consultation, we have surgeons down here, what do you think.
14 Dr. Salisbury, who knows this lady very well, goes over the
15 things with Dr. Watts and says yes, I agree, that's probably
16 a good idea, let's have a, let's have a referral to a
17 surgeon, maybe, maybe she needs an operation. I don't see
18 any negligence, I don't see how we can say that the
19 foreseeability of the surgery as a result of the negligence
20 was the fault of Dr. Watts.

21 But he didn't make a reasoned decision, he made a
22 negligent decision to refer her.

23 THE JUDGE: Let's talk about the time period from
24 the 6th through the 9th, what your experts say that Dr. Watts
25 did wrong.

1 MR. NEWHALL: Our experts say that Dr. Watts
2 should have consulted a surgeon rather than try to take care
3 of his aunt himself.

4 THE JUDGE: Everybody agrees that he can't
5 decide whether to have surgery or not. Your expert agreed
6 as well.

7 MR. NEWHALL: That's right. But they also agree
8 that he doesn't know what to do to take care of somebody who
9 has a surgical or post surgical problem.

10 Dr. Barton, who is the surgical expert for Kohler,
11 says that it's more likely than not that this lady's problems
12 in that intervening period grew worse without the use of
13 antibiotics, without the intervention of a surgeon. And
14 that if Dr. Kohler had seen her and if Dr. Kohler had found
15 the findings which she claims were present, and which we
16 don't know whether they were present according to Watts or
17 not because he didn't write a note about his physical exam,
18 Barton says that if those finding had been present she
19 probably would have been operated on the 5th rather than on
20 the 9th, sorry, 6th.

21 We think that all of that information is sufficient
22 to justify that this case go to trial on the issue of
23 Dr. Watts' negligence and the causation. The foreseeability
24 issue is, is an issue of law, I'll concede that. But I
25 don't think it's an issue that requires an expert opinion

1 to tell you that it's foreseeable that, that a doctor's
2 negligence can result in another doctor's negligence causing
3 a problem.

4 The analogy to the driver of the car is, is
5 inapposite because the driver of the car is not negligent
6 driving someone to the hospital, it is not foreseeable that
7 the driver of the car taking someone to the hospital was
8 going to be, to the hospital, to a surgeon even, that the
9 person is going to be operated on.

10 But here where Dr. Watts had clearly worked this
11 lady up, sent her to gastroenterologist, knew her history, of
12 course he knew that sending her to a surgeon meant more
13 likely than not surgery. Why else would he send her to a
14 surgeon? That's not the, he's not getting an answer as to
15 what is this lady's problem from a surgeon. He's getting an
16 answer as to whether or not she needs surgery. And he
17 already knew that because he had already worked her up.

18 So that's my argument on that issue, Your Honor.
19 Did you have other questions?

20 THE JUDGE: No. Thank you.

21 MR. NEWHALL: Did I... Do you need me to quote
22 from Dr. Barton's deposition, which wasn't included in
23 your--

24 THE JUDGE: Well, I'm troubled by this negligent
25 referral. I'll be open with you about that. I'm not as

1 troubled, I want to hear the opposing side, about what
2 happened after he put her back in the hospital. If there's
3 expert opinions that something should have been done during
4 that period of time I might let that go to the jury. But
5 I'm troubled with this first theory. I'm, I'm having a hard
6 time finding a basis--

7 MR. NEWHALL: I understand.

8 THE JUDGE: — for a negligent referral.

9 MR. NEWHALL: Your Honor, I didn't brief it as,
10 and neither did Mr. DuBois. And I'm sure we'd be happy, we'd
11 be happy to do that and come back another day and discuss it
12 in greater detail.

13 THE JUDGE: Okay. Thank you. Your reply?

14 MR. DUBOIS: Yes. Just a couple of words,
15 Your Honor. I know that we're a little short on time.

16 THE JUDGE: Getting close, getting close. You're
17 all right.

18 ARGUMENT BY MR. DUBOIS

19 MR. DUBOIS: With respect to this notion that this
20 is a negligent referral, Counsel had every opportunity to
21 brief that issue, argue that issue in the opposition. That
22 was not done. And I wouldn't, there's no reason to, I think
23 at this point to allow them to do supplemental briefing on
24 that issue.

25 I... It is our contention and this is supported by

1 the, their own expert's deposition, that once Dr. Watts makes
2 the referral the decision of whether or not to go forward
3 with surgery is out of his hands, he has no role in that
4 decision at all. And so I, our argument would be is that
5 the referral itself is not a, does not make it foreseeable
6 that surgery is going to happen. It might if every referral
7 led to surgery, but they don't. That's why you refer a case
8 to a specialist. The referral to a specialist breaks the
9 chain of causation. And it would, as you noted, it would be
10 an intervening act that would break the chain of causation
11 and, therefore, would not be a proximate cause of the
12 surgery. And that's a, echoed in both of the depositions of
13 both of the plaintiff's experts.

14 You know, when faced with a patient like this it
15 likely would be negligent not to refer to a specialist to
16 make a decision about whether or not she should, she should
17 have surgery or not.

18 In any event there's, there's no case before you,
19 there's no argument before you on negligent referral, and we
20 believe that it's an intervening act which breaks the chain
21 of causation and that's supported by the deposition testimony
22 of the plaintiff's.

23 Mr. Newhall noted that Dr. Barton stated that
24 there, there may have been some increase in infection and an
25 abscess between the 6th and the 9th. Our argument is even

1 if you assume that's true, there's still no testimony that
2 says she would have been taken to surgery any sooner.
3 There's no, there's no dispute to that. There is no
4 testimony that says, expert testimony that says she would
5 have been taken to surgery.

6 THE JUDGE: Well, why do you need that? Why isn't
7 expert testimony sufficient that a, something should have,
8 appropriate treatment should have been undertaken through a
9 treatment with antibiotics and other treatment?

10 MR. DUBOIS: Well, that's a separate question.
11 Dr. Barton didn't say that appropriate treatment wasn't
12 given. He just said that there was a leak in her bowel
13 between the 6th and the 9th and that led to infection and,
14 and abscess. I mean, if you you assume that--

15 THE JUDGE: The only, the only thing that
16 Dr. Barton--

17 MR. DUBOIS: That would have happened anyway.
18 That's our argument.

19 THE JUDGE: Dr. Barton said that it was, the
20 only thing that should have been done was surgical
21 intervention--

22 MR. DUBOIS: Right.

23 THE JUDGE: -- and that takes a surgeon.

24 MR. DUBOIS: And that... Well, it takes a
25 surgeon. And there's no expert testimony that says that--

1 THE JUDGE: Uh-huh (affirmative).

2 MR. DUBOIS: -- second surgery would have
3 happened any sooner than the 9th.

4 THE JUDGE: Than the 9th.

5 MR. DUBOIS: So she's going to have that abscess
6 and that infection anyway. That's, that's our argument.
7 There's no expert testimony that says that the surgery would
8 have--

9 THE JUDGE: Well, isn't the argument that a,
10 Dr. Watts should have called the surgeon?

11 MR. DUBOIS: There is. But our argument is--

12 THE JUDGE: And your argument is that surgeon
13 might have sat until the 9th--

14 MR. DUBOIS: That's, that's the--

15 THE JUDGE: -- before he did anything.

16 MR. DUBOIS: -- the first part of the argument is
17 that he didn't call a surgeon. But they need the second
18 part of the, the argument which is if you called a surgeon on
19 the 2nd then you have a surgery on the 9th. And they don't
20 have the second part. If... They, they have the issue you
21 should have called the surgeon. But they don't have anybody
22 that says if you'd called a surgeon she would have been
23 operated on sooner than the 9th so--

24 THE JUDGE: How could they ever get that?

25 MR. DUBOIS: Well, it would be easy. They could,

1 they, a surgeon could say if I, if I saw this patient on the
2 6th I would have operated on her on the 6th given her
3 condition or her presentation, given the medical records that
4 I've, that I've reviewed. And they don't have an expert
5 that will say that.

6 THE JUDGE: I see.

7 MR. DUBOIS: But even if you do assume that, that
8 it wasn't, it was negligent not to get a surgeon on the 6th
9 and that led to some, you know, an abscess or an infection,
10 there's no expert testimony that connects the abscess or
11 infection to any injury that occurred other than just the
12 fact that she had an abscess and infection. There's no
13 connection between any of her post operative complications
14 after the surgery on the 9th. So in other words, there's no
15 testimony that connects an abscess to the things that she
16 suffered between the 9th and the 24th when she was
17 discharged. There's no expert testimony that establishes
18 any connection between the abscess and the infection to any
19 injury that she's claiming she has now.

20 And that's, that's our argument is that even if
21 you do have expert testimony that says there was an abscess
22 and infection, you can't just say it's common sense that that
23 prolonged her post operative recuperation. They need expert
24 testimony to that effect and they don't have it.

25 THE JUDGE: Didn't they say that the a, the

1 infection and abscesses causing the abdominal pain
2 increased in severity during the period from the 6th to
3 the 9th?

4 MR. DUBOIS: Yes. And I'm willing to concede
5 that. But they don't make any, they don't make any
6 connection between abscess and infection that may have
7 increased in severity to any subsequent injury or medical
8 complaint, complication, anything that, that happened after
9 the 9th, from the 9th to the 24th.

10 And, and Your Honor, you know, that may be an issue
11 of fact whether or not a, there was an increase in infection
12 and maybe we go to trial on that issue.

13 But we're entitled to partial summary judgment at
14 the, at the least that the a, there is no connection between
15 the alleged negligence and any, certainly any injury,
16 complaint, any of the things that have been identified in the
17 complaint or the deposition after her discharge on
18 November 24th. We're entitled to, I believe, partial
19 summary judgment at least on that issue. There is no expert
20 testimony that connects the, the alleged negligent treatment
21 to any injury, any condition, any complaint that may have
22 occurred after her discharge on November 24th of 1998.

23 And we are I believe also entitled to summary
24 judgment or partial summary judgment on the question of was
25 her condition, increased infection, abscess, if you grant

1 them that, between the 6th and the 9th, there's no connection
2 between those conditions and injury that is alleged to have
3 occurred between November 9th, the day of the second surgery,
4 and her discharge.

5 And I believe that we're also entitled to partial
6 summary judgment on the issue of this wasn't Dr. Watts' call
7 whether she went to surgery or not, so we can't be held
8 liable for damages that might be claimed to be associated
9 with the first or the second surgery.

10 THE JUDGE: Okay. Thank you.

11 MR. DUBOIS: Thank you.

12 MR. NEWHALL: Your Honor, may I point out just some
13 deposition testimony?

14 THE JUDGE: Yes. Go ahead.

15 FURTHER ARGUMENT BY MR. NEWHALL

16 MR. NEWHALL: That didn't... Because this issue
17 wasn't briefed didn't come into a question earlier.

18 Dr. Watts in his deposition, and this issue was
19 brought up in an earlier motion which never got responded to,
20 a motion to exclude hearsay of Dr. Watts. But Dr. Watts in
21 his deposition indicated that he saw his aunt, referred her
22 to a gastroenterologist, and that the gastroenterologist
23 supposedly spoke to him and said go see a surgeon, I think
24 she's having intermittent bowel obstruction, send her to a
25 surgeon and he'll operate, the only way we can find out is to

1 explore her. Now that's hearsay testimony. We haven't had
2 the deposition of, of the gastroenterology who supposedly
3 said that because he's in Florida somewhere and there's
4 difficulty arranging it.

5 But it seems to me that Dr. Watts clearly knew, not
6 on the basis of his own knowledge perhaps, maybe, maybe so,
7 maybe not, who cares, but on the basis of what this doctor
8 allegedly told him that this lady was going to have
9 surgery. And clearly any time someone has surgery the risk
10 of complications, negligent or otherwise, is not cut off.

11 So I think that answers the issue of
12 foreseeability. It was easily foreseeable to Dr. Watts.
13 That's, that's my argument. And that's in Dr. Watts'
14 deposition.

15 And actually I think we reported that in an earlier
16 motion which you have but which did not get noticed up
17 because there was no, no response to it.

18 THE JUDGE: All right. Just a minute.

19 MR. NEWHALL: I'm sorry.

20 THE JUDGE: Let me ask you in response to the
21 request for partial summary judgment as to any alleged claims
22 or damages after November 24th. What do your experts say
23 about that?

24 MR. NEWHALL: Our experts didn't address that,
25 I'll admit it. Dr. Salisbury, this lady's treating

1 physician, said that he treated her by way of home health
2 care for a scar, not a scar, I'm sorry, an open wound, and
3 that that open wound was something that commonly occurs after
4 surgeries for infections. And her testimony was that she
5 had that open wound for several weeks and it required several
6 weeks of treat. And then we have, of course, the medical
7 bills related to that. But it didn't seem necessary to have
8 expert opinion to point to the open wound as being the result
9 of surgery.

10 THE JUDGE: Okay. Thank you. I'll let you know
11 and take it under advisement. Thank you very much for the
12 briefing and the arguments. I need to think about it.

13 MR. NEWHALL: Okay.

14 THE JUDGE: Appreciate the...

15 Do you have anything you would like to add,
16 Mr. Fishler?

17 MR. FISHLER: To this motion, no, Your Honor.

18 THE JUDGE: I know you're here but if you'd like
19 to--.

20 MR. FISHLER: Well, there are other motions
21 pending.

22 THE JUDGE: Oh, I thought we were just going to
23 hear the summary judgment today and then everything is
24 triggered on that. If the case is thrown out it's thrown out
25 as to Dr. Watts.

1 MR. FISHLER: Yes. But there's another issue
2 and it's a very simple one. It's kind of after hearing
3 these eloquent arguments my issues are kind of penny-anti I
4 admit.

5 THE JUDGE: Well, go ahead. I'm sorry if I
6 overlooked that. I don't mean that in any way. I was just
7 assuming that you were here to observe but I didn't see. We
8 have Dr. Kohler's motions today as well?

9 MR. FISHLER: Well, I don't know if it's
10 Dr. Kohler's motions or a--

11 MR. NEWHALL: Your motion was for expert fees.

12 MR. FISHLER: Yes. And one of the, and it's in the
13 shortness of time--

14 THE JUDGE: And we have 17, 17 pleadings here so
15 I'm--

16 MR. FISHLER: I will be kind enough to argue
17 Mr. Newhall's side of the argument.

18 THE JUDGE: Go ahead.

19 ARGUMENT BY MR. FISHLER:

20 MR. FISHLER: It's the same thing we've talked
21 about before on other cases, Your Honor.

22 Both doctors have what we call retained experts
23 that you pay that review the documents, and they have a
24 certain expertise and they testify. We both, Dr. Watts and
25 Dr. Kohler have identified themselves as experts because we

1 want to be in a, we don't want to be in a position, what
2 Mr. Newhall is saying that he has one expert radiologist and
3 one expert surgeon, we're only entitled to one surgeon and
4 one radiologist.

5 THE JUDGE: Uh-huh (affirmative).

6 MR. FISHLER: We do that. But if we're limited in
7 that way, if the two physicians are limited in that way they
8 cannot testify that they adhered to the standard of care.

9 It's an argument I made to Your Honor—

10 THE JUDGE: Uh-huh (affirmative).

11 MR. FISHLER: — some months ago on another case.

12 THE JUDGE: Let me, let me... I understand your
13 argument and I've ruled on this.

14 Counsel, let me talk to you about this.

15 MR. NEWHALL: Yes, sir. I'm, I'm simply... I
16 guess I didn't do a very good job arguing. I'm not taking
17 you out to lunch anymore.

18 THE JUDGE: No, no. I understand this argument
19 and I've had it before and so I—

20 MR. NEWHALL: The argument is--

21 THE JUDGE: — want to talk to you about it
22 because—

23 MR. NEWHALL: — for the payment of expert fees,
24 Your Honor.

25 THE JUDGE: What's that?

1 MR. NEWHALL: The argument is only for payment of
2 expert fees. I have no problem with him naming both his
3 doctor and--

4 THE JUDGE: Oh, okay.

5 MR. FISHLER: I thought that--

6 THE JUDGE: I thought that was the rub.

7 MR. FISHLER: I thought that was the rub too.

8 Now the next issue--

9 MR. DUBOIS: Can I weigh in here just briefly?

10 THE JUDGE: Uh-huh (affirmative).

11 MR. DUBOIS: There is a pending motion--

12 THE JUDGE: There is.

13 MR. DUBOIS: -- that was filed by the plaintiff
14 to limit us to one expert and or to add additional experts.
15 And I think that's what Mr. Fishler was just speaking to.

16 THE JUDGE: Right. But he says he has no problem
17 with it.

18 MR. DUBOIS: Are you withdrawing that motion?

19 ARGUMENT BY MR. NEWHALL

20 MR. NEWHALL: That was, that was for Friedenbergs
21 testimony only. Oh, I'm sorry. Okay.

22 If that was, if that was for that, for that, both
23 motions and you're prepared to say look they both, they get
24 both guys, that's fine.

25 THE JUDGE: I'm not prepared. I want to talk to

1 you about it.

2 MR. NEWHALL: Okay.

3 THE JUDGE: I want you to talk to me and persuade
4 me.

5 MR. NEWHALL: Okay.

6 THE JUDGE: All right. Here's the way I see
7 this.

8 MR. NEWHALL: Yes, Your Honor.

9 THE JUDGE: I see that the doctors get to testify
10 about the standard of care as experts. And they also get to
11 call in expert witnesses so that their testimony isn't the
12 only testimony going to the jury. That doesn't mean now
13 that the plaintiff gets two experts. It means that the
14 plaintiff gets an expert as well to support the plaintiff's
15 theory of the case. It isn't a question of counting
16 experts. It's a question of having each side having an
17 expert witness.

18 The doctor is by very definition an expert. And
19 that's the way it is with a lawyer on trial, that's the way
20 it is with a doctor or accountant on trial, they get to say
21 about their performance and whether or not it fell below the
22 acceptable standard of care.

23 MR. NEWHALL: I have no problem with, with
24 Your Honor's lucid argument.

25 My argument is that certainly they can testify that

1 their care was within the standard of care.

2 THE JUDGE: Uh-huh (affirmative).

3 MR. NEWHALL: But that's it. They cannot go into
4 on direct anything more than was your care within the
5 standard of care. Yes. Beyond that they rely on their
6 retained expert to explain why it was within the standard of
7 care, to explain what it was that the standard of care
8 involves, to explain where the standard of care might have
9 been breached and wasn't breached.

10 Now, if I choose to go into that on cross then on
11 redirect they can open it up again.

12 But my point is that they are limited to answering
13 the question that Mr. Fishler, Mr. DuBois both say is the
14 only question they want to ask, was your care within the
15 standard. For everything else related to the standard of
16 care and negligence they rely on their retained expert.
17 They cannot explain to the jury. Because in my view that's
18 prejudicial to have two doctors up there saying not only was
19 I within the standard of care, but the standard of care
20 involves this, this, this and this and these are the things I
21 did, so forth and so on and so on. And then to have it
22 buttressed by another expert, I think that's impermissible.

23 I think that they're limited to the questions that
24 Mr. DuBois and Mr. Fishler say they want to ask only, was
25 your care within the standard of care. Fine. Then if I

1 cross examine anyone them on the standard of care and
2 Mr. Fishler and Mr. DuBois care to come in on redirect and
3 elicit further testimony, that's not buttressing in my
4 view.

5 But I think that I get two experts to explain the
6 standard of care if they get two experts to explain the
7 standard of care. That's my view.

8 THE JUDGE: All right. Thank you.

9 Okay. I disagree. I think the doctor should be
10 able to explain his conduct, explain what happened, the
11 circumstances, the medicine involved, the, the patient's
12 treatment, why he did what he did or she did what she did
13 under the circumstances, and what the doctor feels was the
14 appropriate treatment and why. To limit and restrict that
15 party's testimony to simply a narrow, funneled view of the
16 case denies them the opportunity to defend themselves. And
17 they should have their day in court as well as your client
18 gets to explain in her point of view what happened to her and
19 what damage it caused her and go through the circumstances in
20 her life as well.

21 So both sides get to be able to explain their,
22 their conduct.

23 MR. NEWHALL: I accept your argument, Your Honor.

24 ARGUMENT BY MR. FISHLER

25 MR. FISHLER: One last item, Your Honor.

1 He has previously deposed Dr. Kohler as a fact
2 witness in this case. I don't know if Dr. Kohler was a party
3 at that time or not. He apparently, I'll take Mr. Newhall's
4 word for that. He now wants to redepose Dr. Kohler as an
5 expert. And in my view he's making, this is a lot to do
6 about nothing or very little. A tempest in a tea cup. I'm
7 saying if he wants to take two hours of Dr. Kohler's time he
8 ought to pay a fair amount for those two hours if he's
9 deposing him. He's already deposed him as a fact witness,
10 we've got that. Now he wants to talk about this expert
11 thing. If he does we just want a fair rate and my, I would
12 suggest it would be the lowest rate of any expert so far
13 who's been deposed rather than just picking just a number out
14 of the hat.

15 THE JUDGE: Counsel?

16 MR. FISHLER: Just for the deposition time.

17 THE JUDGE: You want to take his deposition twice
18 and the first time you didn't feel that maybe you covered
19 what you needed to cover regarding his expertise? Is that
20 what I'm hearing?

21 MR. NEWHALL: No, Your Honor. I, the first time
22 I didn't ask him his opinions about his own standard of
23 care--

24 THE JUDGE: Okay.

25 MR. NEWHALL: -- because I didn't expect that he

1 would be a defendant. But a--

2 THE JUDGE: You didn't expect him to be a
3 defendant? You mean an expert?

4 MR. NEWHALL: Correct. He was a fact witness and
5 I didn't expect he would be--

6 THE JUDGE: You hadn't sued him at that time?

7 MR. NEWHALL: Correct.

8 THE JUDGE: Oh.

9 MR. NEWHALL: The complaint was amended--

10 THE JUDGE: I see.

11 MR. NEWHALL: -- to add Dr. Kohler.

12 THE JUDGE: I see.

13 MR. NEWHALL: So, and it was after his deposition
14 that I did that, partly based on his deposition but more
15 based on further information that came to light from my own
16 experts.

17 THE JUDGE: All right. I understand. Anything
18 else?

19 MR. FISHLER: I think Your Honor understands the
20 issue.

21 THE JUDGE: Okay. Yes. I'm going to allow him
22 to take a second deposition at no cost, and understanding
23 that he didn't understand fully the, the extent of his
24 involvement, and he's amended him in the complaint and
25 brought him into the complaint as a defendant and may

1 examine him on the standard of care and his expertise.

2 Okay?

3 MR. NEWHALL: Thank you.

4 THE JUDGE: Thank you. Anything else that I
5 overlooked?

6 MR. FISHLER: What about preparing an order,
7 Your Honor?

8 THE JUDGE: That would be great. Who wants to do
9 that? I'd love to have that done. I've ruled both ways.
10 Let's have—

11 MR. DUBOIS: This is typically where Mr. Fishler
12 says, DuBois, take care of it.

13 MR. FISHLER: I don't think I took up a lot of the
14 Court's time today so I just think that's somebody else's
15 job. But I can do it if—

16 THE JUDGE: I know. But the only thing I've
17 really ruled on is what you brought up so, isn't that
18 right?

19 MR. FISHLER: That's true, Your Honor.

20 THE JUDGE: All right. You prepare the
21 appropriate order.

22 MR. FISHLER: I'll do it.

23 MR. NEWHALL: Your Honor, can we get a, can we get
24 a further date? Because even if Mr., Dr. Watts is kicked out
25 we're going to need some more time to set pretrial and so

1 forth for Dr. Kohler who remained.

2 THE JUDGE: Let's wait and see. I'm not going to
3 be the judge after the first of July on this case so we all
4 need to know that. I'm going to rule on what's before me.
5 I'm going into criminal felony cases the first of July.
6 Judge Taylor is taking the civil calendar so we'll leave that
7 up to him. I'm going to decide what we have to decide and
8 then we'll let you talk to him about that. Okay?

9 MR. NEWHALL: Thank you.

10 MR. DUBOIS: Thank you, Your Honor.

11 THE JUDGE: Thank you all for coming. I'll get
12 this decision out as soon as possible.

13 MR. NEWHALL: Thank you.

14 MR. DUBOIS: Thank you.

15 THE JUDGE: We'll be in a short recess.

16 WHEREUPON, the hearing was concluded.

17 =====

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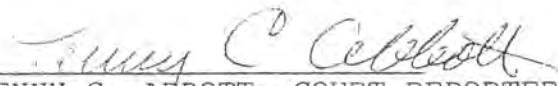
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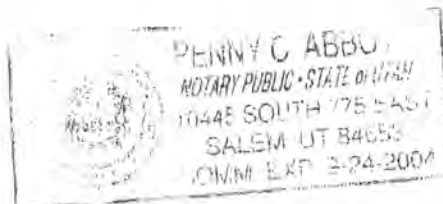
REPORTER'S CERTIFICATION

STATE OF UTAH)
) SS.
COUNTY OF UTAH)

I, Penny C. Abbott, a Certified Shorthand Reporter and Notary Public in and for the State of Utah, do hereby certify that I received the electronically recorded video #104 in the matter of JOHNSON VS. WATTS, hearing date June 16, 2003, and that I transcribed it into typewriting and that a full, true and correct transcription of said hearing so recorded and transcribed is set forth in the foregoing pages numbered 1 through 60, inclusive except where it is indicated that the tape recording was inaudible.

WITNESS my hand and official seal this 27th day of December, 2003.


PENNY C. ABBOTT, COURT REPORTER
License 22-102811-7801
Notary Public, Comm Exp 9-24-04



B. Order Certifying Judgment as Final, November 11, 2003 (R. 855-57)

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Attorney for Plaintiff

FILED
Fourth Judicial District Court
of Utah County, State of Utah

11-10-03 Deputy

IN THE FOURTH JUDICIAL DISTRICT COURT, UTAH COUNTY, STATE OF UTAH

LUCY JOHNSON aka LUCY MacLEOD,
Plaintiff,

vs.

GARY WATTS MD and DOUGLAS
KOHLER MD,
Defendants.

**ORDER CERTIFYING JUDGMENT
AS FINAL**

Civil No. 010400391

Division VII

Judge James R. Taylor

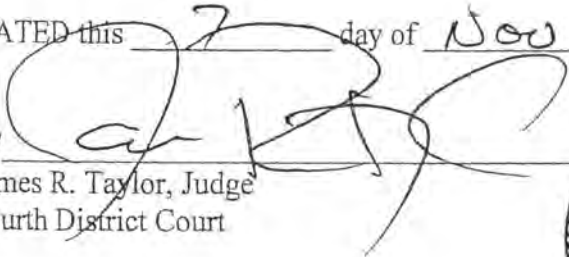
This matter is before the Court on Plaintiff's Rule 54(b) Motion for Order Directing Entry of Final Judgment filed with this Court on August 6, 2003. Defendant filed its Memorandum in Opposition on August 20, 2003 and this Court issued its Memorandum Decision dated October 1, 2003. Based upon the facts in this case and for the reasons set forth in the Court's Memorandum Decision and good cause appearing therefore;

IT IS HEREBY ORDERED, ADJUDGED AND DECREED that the Order Granting Gary Watts MD's Motion For Summary Judgment dismissing all claims against

Defendant Watts and dated July 22, 2003 be certified as a **FINAL JUDGMENT** pursuant to Rule 54(b), Utah Rules of Civil Procedure.

BY THE COURT:

DATED this 22 day of Nov., 2003

ss/ 
James R. Taylor, Judge
Fourth District Court



CERTIFICATE OF MAILING

I HEREBY CERTIFY that on Oct 24, 2003, I caused a true and correct copy of the above and foregoing **ORDER CERTIFYING JUDGMENT AS FINAL** to be served by depositing in the U.S. Mail, postage prepaid, to:

Curtis Drake Scott DuBois Snell & Wilmer 15 W. South Temple Suite 1200 Salt Lake City, UT 84101	Phillip Fishler Strong & Hanni 9 Exchange Place, Suite 600 Salt Lake City, UT 84121
--	--

s/



C. Order Granting Gary Watts, MD's Motion for Summary
Judgment (R. 815-7)

Prepared by:

CURTIS J. DRAKE [A0910]

SCOTT A. DuBOIS [A7510]

TROY L. BOOHER [A9419]

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Salt Lake City, Utah 84101

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Attorneys for Defendant

Gary Watts, M.D

FILED

Fourth Judicial District Court
of Utah County, State of Utah

7-22-03 Deputy

IN THE FOURTH JUDICIAL DISTRICT COURT OF UTAH COUNTY

STATE OF UTAH

LUCY MacLEOD,

Plaintiff,

vs.

GARY WATTS, M.D. and DOUGLAS
KOHLER, M.D.,

Defendants.

**ORDER GRANTING GARY WATTS,
M.D.'S MOTION FOR SUMMARY
JUDGMENT**

Civil No. 010400391

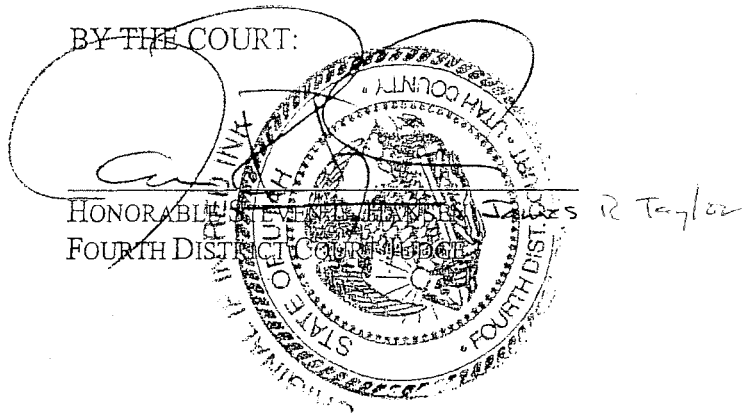
Judge Steven L. Hansen

This matter is before the Court on Gary Watts, M.D.'s *Motion for Summary Judgment* (the "Motion"), which was filed on January 29, 2003 together with his Memorandum in Support of Motion for Summary Judgment. Plaintiff served her Memorandum in Opposition to the Motion together with the Affidavit of Darwood Hance, M.D. on February 12, 2003. Gary Watts, M.D. filed his Reply to Plaintiff's Opposition to Motion for Summary Judgment on February 21, 2003. The Court heard oral argument regarding the Motion on June 16, 2003.

IT IS HEREBY ORDERED as follows:

- DATED this 22 day of July, 2003.

HONORABLE STEVEN L. HANSEN
FOURTH DISTRICT COURT, JUDGE

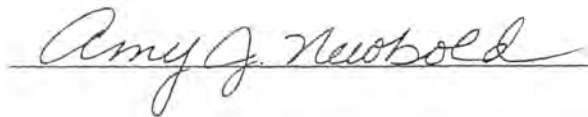


CERTIFICATE OF SERVICE

I certify that on this 9th day of July, 2003, a true and correct copy of the foregoing document was mailed, first class mail, postage prepaid to:

S. Clark Newhall, Esq.
Law Office of Clark Newhall, M.D., J.D., L.C.
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Attorney for Plaintiff
Lucy MacLeod

Phillip R. Fishler, Esq.
Catherine M. Larson, Esq.
STRONG & HANNI
9 Exchange Place, #600
Salt Lake City, Utah 84111
Attorneys for Defendant
Douglas Kohler, M.D.



D. Memorandum Decision, June 27, 2003 (R. 806-11)

FILED
Fourth Judicial District Court
Utah County, State of Utah
7-7-03

IN THE FOURTH JUDICIAL DISTRICT COURT
UTAH COUNTY, STATE OF UTAH

LUCY MacLEOD,

Plaintiff*,

vs.

GARY WATTS, M.D. and
DOUGLAS KOHLER, M.D.,

Defendant*.

MEMORANDUM DECISION

Case No. 010400391

Date: June 27, 2003

Judge Steven L. Hansen

Before the Court is Defendant Gary Watts, M.D. Motion for Summary Judgment. The Court, having heard arguments on the motion and having reviewed all relevant memoranda, now grants Defendant's Motion.

FACTS

1. In October of 1998, Ms. MacLeod consulted with defendant Gary Watts, M.D. for undiagnosed abdominal pain.
2. Dr. Watts referred Ms. MacLeod to Dr. Kohler, a general surgeon.
3. Dr. Kohler evaluated Ms. MacLeod and determined that she needed to have surgery to have her gall bladder removed.
4. Dr. Kohler performed the surgery on November 3, 1998, resulting in a small perforation to her bowel.
5. Dr. Watts did not participate in the operation.
6. Ms. MacLeod continued to experience abdominal pain in the days following surgery.
7. Since Dr. Kohler was out of town, Ms. MacLeod contacted Dr. Watts to discuss the pain.

8. On November 6, 1998, Dr. Watts admitted Ms. MacLeod to Utah Valley Regional Medical Center and assumed her care from November 6- November 9.
9. On November 9, Dr. Kohler returned to town and resumed the care of Ms. MacLeod.
10. Dr. Kohler found Ms. MacLeod to have extensive abdominal wall cellulites for which he re-operated, finding an intra-abdominal abscess.
11. Dr. Kohler removed a portion of the Ms. MacLeod's small intestine.
12. Ms. MacLeod was discharged from the hospital on November 24, 1998.

ANALYSIS AND RULING

This suit results from Ms. MacLeod's claim that Dr. Watts was negligently cared for her in at least two aspects. First, that Gary Watts was negligent in referring the Ms. MacLeod to a surgeon without consulting her primary care physician. Second, Dr. Watts was negligent in consulting a surgeon for the increasing abdominal pain Ms. MacLeod told him about on November 6. Dr. Watts brings his motion for Summary Judgment arguing as a matter of law that there is no causation.

Dr. Watt's Referral to a General Surgeon

Dr. Watts brings this motion arguing that as a matter of law his actions regarding Ms. MacLeod were not negligent. The Plaintiff argues that Dr. Watts was negligent in referring the Plaintiff to Dr. Kohler without first consulting the Plaintiffs primary care physician.

Summary Judgment is appropriate where there are no genuine issues of material fact and the moving party is entitled to judgment as a matter of law. Utah R. Civ. P. 56(c). To establish a *prima facie* case of negligence, a plaintiff must establish that the (1) defendant owed plaintiff a

duty of care; (2) defendant breached that duty; (3) defendant's breach of that duty was the actual and proximate cause of plaintiff's injuries; and (4) that plaintiff suffered damages as a result of defendant's breach of duty. *Dalley v. Utah Valley Reg'l Med. Ctr.*, 791 P.2d 407 (Utah 1990).

The question before the court is whether Dr. Watts referral was the proximate cause of the injuries suffered by the Plaintiff during and after surgery. Where this is a medical malpractice case, expert testimony is required to establish that the defendant physician was the proximate cause of plaintiff's injuries. *Kent v. Pioneer Valley Hospital*, 930 P.2d 904, 906 (Utah App. 1997). A court may rule as a matter of law on the issue of proximate cause if, "there is no evidence to establish a causal connection, thus leaving causation to jury speculation." *Bansasine v. Bodell*, 927 P.2d 675, 675 (Utah Ct. App. 1996).

Dr. Hance, the Plaintiff's radiology expert, acknowledged in his deposition that the decision to take a patient to surgery is made by the surgeon. Dr. Hance testified that Dr. Watts "had nothing to do with that decision." Dr. Anaise, the Plaintiff's expert surgeon, agreed that Dr. Watts, as a radiologist, did not have input into the decision to perform surgery. Because Dr. Watts' involvement with Ms. MacLeods' care ended with his referral to an experienced surgeon, Dr. Kohler, there is no causal connection between any harm Ms. MacLeod suffered from surgery and Dr. Watts initial referral. Where Dr. Kohler acted independent of Dr. Watts, there is a break in the chain of causation. Ms. MacLeod has failed to provide evidence sufficient to establish even a prima facie case of negligence.

As a matter of law, this court finds that Dr. Watt's referral was not the cause of any damage suffered by the plaintiff.

Interim Treatment

Dr. Watts argues further that Ms. MacLeod has failed to provide expert testimony that any complication she suffered was actually related to a "delay" in surgery between November 6 and November 9. Ms. MacLeod argues that Dr. Watt's failure to consult a surgeon on November 6 resulted in increased infection/abscess causing an additional abdominal pain. Defendant also argues that this failure increased the risk of complications as well.

Ms. MacLeod did not provide expert testimony that Dr. Watt's failure to consult with Dr. Kohler until November 9 actually caused specific complications. There is no evidence showing that surgery should have, or would have, been performed if Dr. Watts had contacted the surgeon earlier. The facts as provided in affidavit do not establish that Dr. Watts' actions caused any additional damages to the plaintiff not already remaining from the first surgery. Accordingly, because there is no evidence of causation, the court hereby finds that, as a matter of law, Dr. Watts was not negligent and grants his motion for Summary Judgment.

CONCLUSION

The Plaintiff has failed to provide expert testimony that Dr. Watts referral to a surgeon caused injuries to the plaintiff during and after surgery. The Plaintiff has also failed to demonstrate that the care provided between November 6 and November 9 actually caused a specific injury in addition to those caused by the first surgery.

Therefore, the Court concludes that no genuine issues of material fact exists, and Gary Watts M.D. is entitled to judgment as a matter of law.

Dr. Watts' counsel is to prepare an order consistent with this ruling and submit it for the Court's signature.

DATED this 7 day of July, 2003

BY THE COURT



STEVEN L. HANSEN, JUDGE



CERTIFICATE OF NOTIFICATION

I certify that a copy of the attached document was sent to the following people for case 010400391 by the method and on the date specified.

METHOD NAME

Mail	SCOTT A DUBOIS ATTORNEY DEF 15 W SOUTH TEMPLE STE 1200 SALT LAKE CITY, UT 84101
Mail	PHILIP R FISHLER ATTORNEY DEF 9 EXCHANGE PLACE STE 600 SALT LAKE CITY UT 84111
Mail	CLARK NEWHALL ATTORNEY PLA 320 W 200 S STE 100B PO BOX 284 SALT LAKE CITY UT 84110-0284

Dated this 7 day of July, 2003.


Tina Perry
Deputy Court Clerk

E. Minutes, Oral Argument, June 16, 2003 (R. 804-5)

4TH DISTRICT COURT, PROVO DEPT COURT
UTAH COUNTY, STATE OF UTAH

LUCY JOHNSON,	:	MINUTES
Plaintiff,	:	ORAL ARGUMENT
	:	
	:	
vs.	:	Case No: 010400391 MP
	:	
GARY WATTS MD Et al,	:	Judge: STEVEN L. HANSEN
Defendant.	:	Date: June 16, 2003

Clerk: taras

PRESENT

Plaintiff's Attorney(s): CLARK NEWHALL
Defendant's Attorney(s): SCOTT A DUBOIS
PHILIP R FISHLER

Video

Tape Number: 104 Tape Count: 9:07

HEARING

TAPE: 104 COUNT: 9:07

This matter comes before the court for oral argument on Plaintiff's Motion for Arbitration, Plaintiff's Motion to Limit Experts, Kohler's Motion for Expert Fees and Gary Watts, M.D.'s Motion for Summary Judgment.

Mr. Newhall withdraws plaintiff's motion for arbitration. Mr. Newhall requests the court hear argument on plaintiff's motion to strike deposition testimony of defendant Watts' expert Marvin J. Friedenberg M.D. Mr. Dubois objects to arguing motion.

The Court grants objection and will not hear argument on plaintiff's motion to strike deposition testimony of defendant Watts' expert Marvin J. Friedenberg M.D. today.

Mr. Dubois argues Gary Watts, M.D.'s motion for summary judgment.

Mr. Newhall responds. Final reply by Mr. Dubois. Mr. Newhall points out deposition testimony. The Court takes Gary Watts, M.D.'s motion for summary judgment under advisement.

Mr. Fishler addresses plaintiff's motion to limit experts and Kohler's motion for expert fees. Mr. Fishler argues motion to

Case No: 010400391
Date: Jun 16, 2003

limit experts. . Mr. Newhall responds. The Court denies plaintiff's motion to limit experts.

Mr. Fishler argues Kohler's motion for expert fees. Mr. Newhall responds. The Court denies Kohler's motion for expert fees and allows Mr. Newhall to take Kohler's deposition at no cost. Mr. Fishler will prepare the order.

F. Plaintiff's Memorandum in Opposition to Defendant Watts'
Motion for Summary Judgment (R. 310-337)

4TH DISTRICT COURT
PROVO DEPARTMENT

2003 FEB 13 P 1:45 *by*

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IN THE FOURTH JUDICIAL DISTRICT COURT, UTAH COUNTY, STATE OF UTAH

LUCY MacLEOD,
Plaintiff,

vs.

GARY WATTS MD et al,
Defendants.

PLAINTIFF'S MEMORANDUM IN
OPPOSITION TO DEFENDANT
WATTS' MOTION FOR SUMMARY
JUDGMENT

Civil No. 010400391

Judge Steven Hansen

Plaintiff submits this Memorandum in opposition to defendant Gary Watts' Motion for Summary Judgment. Defendant Watts bases his motion on the supposed lack of expert testimony to establish causation of plaintiff's damages. Plaintiff contends that the deposition and the affidavit of Dr. Hance, radiology expert, and the deposition of Dr. Barton, co-defendant Kohler's surgical expert, establish that Dr. Watts' negligent medical treatment of plaintiff from November 5 through November 9, 1998 caused damage to plaintiff in the form of worsening infection which actually occurred, increased risk of complications which actually occurred, additional hospitalization and increased medical bills. With material facts in dispute, defendant Watts' Motion for Summary Judgment should be denied.

BACKGROUND

Plaintiff sought the advice of her nephew, defendant Gary Watts MD, a radiologist at Utah Valley Hospital, regarding a long-standing complaint of abdominal pain on or about October 30, 1998. After performing various x-ray tests, Watts referred plaintiff to a surgeon, co-defendant Kohler. Kohler performed a laparoscopic cholecystectomy on November 3, 1998 and discharged plaintiff from the hospital on November 4, 1998. On or about November 5 and again on November 6, plaintiff telephoned Watts complaining of abdominal pain. Watts admitted plaintiff to hospital on November 6 where he was her only physician from November 6 through Kohler's return to town on November 9. On November 9, Kohler re-operated on plaintiff, discovering a perforated viscus (leaking bowel) and intra-abdominal infection in the vicinity of the entry site for the laparoscopic instrument.

ADDITONAL MATERIAL FACTS

- 1) Dr. Darwood Hance, plaintiff's radiology expert, stated that he has experience in the expected postoperative course of patients who have undergone laparoscopic cholecystectomy, the surgery plaintiff had on November 3. Exhibit A, Hance deposition 39:23-40:22.
- 2) Dr. Hance stated that he had experience in evaluating postoperative laparoscopic cholecystectomy patients with abdominal pain who are referred to him for consideration of bowel leak, the complication that plaintiff suffered. Ex. A 40:11.
- 3) Dr. Hance stated that the negligent failure of Dr. Watts to consult a surgeon after the second call from plaintiff on November 6 "resulted in damage to Mrs. MacLeod." Ex. A 36:13.
- 4) Specifically, Dr. Hance stated that Dr. Watts' negligent delay in consulting a surgeon resulted in "this large abscess that she [the plaintiff] had." Ex. A 44:6-11, 44:20-45:2.

- 5) In his affidavit, Dr. Hance stated that Dr. Watts' negligent delay caused additional pain and suffering, increased intra-abdominal infection, additional hospitalization and additional hospital bills. Exhibit B, Hance Affidavit, ¶ 7(l)-(m).
- 6) Dr. Hance stated that Dr. Watts breached the standard of care when he "interposed" himself as plaintiff's primary physician and undertook to diagnose and refer plaintiff for treatment of abdominal pain. Ex. A, 22:1-19, 25:18-24.
- 7) Dr. Hance stated that Dr. Watts' negligent failure to consult plaintiff's primary care physician, Dr. Salisbury, was followed by a referral to a surgeon that would not have been made if Dr. Salisbury had been consulted. Ex. A, 27:9-23, Ex. B 7(g)-(h).
- 8) Dr. Hance and Dr. Barton, defendant Kohler's expert surgeon, agree that the perforation of the plaintiff's bowel occurred at the time of the November 3 surgery. Ex. A, 40:24-41:23; Exhibit C, Barton deposition, 26:12-27:9.
- 9) Dr. Barton stated that in the period from November 5 to November 9, plaintiff probably suffered an increase in her intra-abdominal infection. Ex. C, 80:5-25.
- 10) Dr. Barton stated that the appropriate treatment upon recognition of an intra-abdominal infection in plaintiff's circumstances is prompt surgical treatment. Ex. C, 79:10-24.
- 11) Dr. Barton opined that a surgeon should have been consulted about plaintiff's abdominal pain when it was increasing after November 5. Ex. C, 87:11-88:2.
- 12) Dr. Barton opined that the failure to consult a surgeon regarding plaintiff's increasing abdominal pain resulted in failure to timely perform the appropriate surgical treatment. Ex. C, 91:9-92:11.

13) During her hospitalization from November 6 through November 24, plaintiff suffered the complications of hypoglycemia, fluid overload and pneumothorax (collapsed lung.) Exhibit D, Deposition of Dr. Corneia, 7:10-16, 9:16-22, 20:5-16.

ARGUMENT

Pursuant to Utah Rule of Civil Procedure 56, summary judgment can only be rendered if there is no genuine issue as to any material fact and the movant is entitled to judgment as a matter of law. The party opposing a summary judgment motion "is entitled to have the court survey the evidence and all reasonable inferences fairly to be drawn therefrom in the light most favorable to him." *Morris v. Farnsworth Motel*, 123 Utah 289, 259 P.2d 297 (1953); *Thompson v. Ford Motor Co.*, 16 Utah 2d 30, 395 P.2d 62 (1964); *Bowen v. Riverton City*, 656 P.2d 434 (Utah 1982).

Accordingly, summary judgment is a drastic measure and a party seeking to dispose of another's interests in this manner bears a heavy burden of proof. Defendant Watts is unable to meet this burden because there are disputed issues of fact. The fact in dispute is whether Watts' negligence caused damage to plaintiff. Defendant's motion has focused exclusively on damages that may or may not have occurred after hospitalization, ignoring completely the damage that occurred during or as a result of surgery and hospitalization.

Plaintiff's radiology expert, Dr. Hance, established his expertise to render an opinion as to the treatment performed by Dr. Watts; his expertise in this area is undisputed. He opined that the negligence of Dr. Watts had at least two aspects. First, Dr. Watts referred plaintiff to a surgeon without consulting plaintiff's primary care physician, Dr. Salisbury. Second, Dr. Watts

failed to consult a surgeon for the increasing abdominal pain plaintiff told him about on November 6.

Dr. Hance states that the surgery performed on November 3 the laparoscopic cholecystectomy, was completely unnecessary and no surgical referral was medically indicated. He opines that a surgical referral would not have been made if Dr. Salisbury had been consulted by Dr. Watts. Both Dr. Hance and Dr. Barton agree that the perforated viscus (bowel leak) that led to all of plaintiff's subsequent injuries occurred at the time of the laparoscopic surgery. It is reasonable to infer that the plaintiff would have suffered no injury if Watts had not negligently referred plaintiff to Kohler, the surgeon. Even though Dr. Watts may not have made the decision to perform a laparoscopic cholecystectomy on plaintiff, absent a referral to a surgeon it is reasonable to infer that the plaintiff would never had any abdominal surgery in the first place and therefore would not have suffered the initial injury. Plaintiff is entitled to the benefit of that reasonable inference. Viewed in the light most favorable to plaintiff, these statements and inferences alone are enough to establish a disputed fact as to damages caused by Watts' negligence.

Both Dr. Hance and Dr. Barton opined that the only appropriate treatment for plaintiff's condition was surgical intervention. Because Dr. Watts, a non-surgeon, chose to treat plaintiff himself rather than consult a surgeon on November 6, she had no appropriate surgical treatment until November 9. Both Dr. Hance and Dr. Barton opined that the intra-abdominal infection/abscess causing plaintiff's abdominal pain increased in severity during the period from November 6 to November 9. In addition to increasing severity of the infection, Dr. Barton also

stated that the risk of complications increased as well, and plaintiff did in fact suffer complications during her hospitalization. It is reasonable to infer that these complications would not have occurred with prompt surgical treatment. Dr. Hance identified two other aspects of damage caused by the delay in treatment: increased duration of hospitalization and increased cost of hospitalization. It is reasonable to infer that the increased severity of the intra-abdominal infection caused by the delay led to the increased cost and duration of hospitalization. Plaintiff is entitled to the benefit of these reasonable inferences.

CONCLUSION

Watts' motion relies upon the supposed lack of connection between Watts' negligence and any damages following plaintiff's second hospitalization, completely ignoring the damages that occurred at surgery and during subsequent hospitalization. Viewed in the light most favorable to plaintiff, the facts connecting Watts' negligent referral to a surgeon and the initial bowel injury raise a disputed issue of material fact that is sufficient to defeat this motion. Going further, it is reasonable to infer that the delay in surgical treatment caused by Watts' negligence resulted in additional damages to plaintiff. There are genuine issues of material fact in this case and the defendant's motion should be denied.

DATED this 12th day of February, 2003

ss/ Clark Newhall
Clark Newhall
Attorney for Plaintiff

1 don't anymore.

2 Q. I had begun to follow up on your explanation of
3 your opinions, Dr. Hance, by asking about the first point
4 in time which you believe Dr. Watts deviated from the
5 standard of care. You told me in essence that was the
6 beginning the referral process, if you will, that led up
7 to surgery.

8 When is the next point in time when is your
9 opinion Dr. Watts deviated from the standard of care?

10 A. When she called him after -- well, the first
11 time she called him after she went home he did consult
12 Dr. Kohler and, I think, got Dr. Kohler involved in that.
13 And certainly that was -- he was an intermediary. But
14 that was not inappropriate.

15 Called Dr. Kohler and say "What should I do? My
16 aunt's having trouble."

17 And Dr. Kohler gave the instructions, which he
18 relayed to his aunt.

19 That was certainly within the appropriate realm.

20 The second time when --

21 Q. May I stop you there.

22 I want to make sure in the sense of chronology
23 we understand when we are talking about.

24 What is your understanding of when that first
25 contact took place between Ms. MacLeod and Dr. Watts?

1 Q. What is your understanding of when this next
2 call took place?

3 A. That probably was on the 6th, I think, is when
4 he admitted her.

5 Q. So do you have any criticism of Dr. Watts
6 between that first call, which you believe took place on
7 the 5th, and the second call which led to the admission
8 on November 6?

9 A. That's when I think he got out of line because
10 that call should have been deferred to the surgeon who
11 had treated her, who knew what was going on in her belly.

12 And that failure to defer to the surgeon or to
13 the surgeon's associate who was taking the calls resulted
14 in damage to Ms. MacLeod.

15 Q. What is it, sir, that you believe required
16 Dr. Watts to either get Dr. Kohler or his assistant,
17 Dr. Fullmer, involved on the 6th at or near the time
18 Dr. Watts admitted her to the hospital?

19 A. That's because they had operated on the patient.
20 They knew about the adhesions. And they knew about the
21 dangers of perforation of the small bowel, which is a
22 known complication which every surgeon who does
23 laparoscopic surgery knows.

24 And they would have responded differently to
25 that initial time when she was admitted. They'd have

1 A. That was after she had gone home. It was the
2 first call that she was having pain. And Dr. Kohler got
3 involved with it at that point appropriately.

4 Q. But when did that call take place?

5 A. I don't remember the exact date. I think it was
6 probably about the 5th because she went home on the 4th I
7 believe.

8 Q. What is the source of your information about
9 when that call took place?

10 A. That was in Dr. Watts' deposition. I'm pretty
11 sure. I may be off one day on the date. But it was the
12 first time she called he consulted Dr. Kohler.

13 And I forget what he advised -- some laxative or
14 something for her. And that was his job. But
15 Dr. Kohler's job to advise what his aunt should do.

16 Q. Then what is the next point in time at which you
17 believe Dr. Watts fell below the standard of care in
18 whatever he did or didn't do?

19 A. That was the next time when she called and she
20 said she was worse. And that's when he performed an
21 X ray on her and started, you know, admitting her into
22 the hospital and treating her as a primary care physician
23 or as a surgeon. I don't know which. But not certainly
24 as a radiologist.

25 He went beyond the realm of the radiologist.

1 come in -- had they been called, they'd have come in,
2 checked her out, said --

3 MR. FISHLER: I'm going to have to object on the
4 basis of foundation, any opinion concerning standard of
5 care of a surgeon.

6 Q. BY MR. DRAKE: Dr. Hance, what I'm trying to get
7 at, sir, is some sense of whether your opinion is based
8 upon Ms. MacLeod's condition at the time this call was
9 placed or whether it was simply the fact she was a
10 post-laparoscopic surgery patient who was calling
11 Dr. Watts with a problem.

12 Do you understand that distinction?

13 MS. MAGID: Object. That's a compound question.
14 If you could simplify it, that would be great.

15 Q. BY MR. DRAKE: You can go ahead and answer,
16 Dr. Hance.

17 A. Yes. It involved that she was a post-op
18 laparoscopic cholecystectomy patient and therefore in
19 that early post-op period you're looking for surgical
20 complications.

21 And yes, her condition was that she was having
22 increasing pain.

23 Q. Let me get at it this way, sir.

24 Is it your belief that any call from someone
25 who's undergone the procedure that Ms. MacLeod did on

CERTIFICATE OF MAILING

I HEREBY CERTIFY that on February 12, 2003, I caused a true and correct copy of the above and foregoing **PLAINTIFF'S MEMORANDUM IN OPPOSITION TO DEFENDANT WATTS' MOTION FOR SUMMARY JUDGMENT** to be served by depositing in the U.S. Mail, postage prepaid, to:

Curtis Drake
Snell & Wilmer
15 W. South Temple
Suite 1200
Salt Lake City, UT 84101
Phillip Fishler
Strong & Hanni
9 Exchange Place, Suite 600
Salt Lake City, UT 84121

(also delivered by hand)

Fourth District Court
125 N. 100 West
Provo, UT 84601

s/ 
Clark Newhall

EXHIBIT A

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1 Let's start with the first. And in terms of
 2 chronology or sequence of events, what was the first
 3 point in time in your opinion where Dr. Watts deviated
 4 from the standard of care?
 5 A. He undertook to get involved in her care without
 6 consulting or receiving the permission of the doctor who
 7 had been treating her for a long period of time,
 8 Dr. Salisbury.
 9 In other words, he lacked all of the information
 10 that Dr. Salisbury had.
 11 He didn't review her medical records from
 12 Dr. Salisbury, did not talk to Dr. Salisbury about her
 13 problems and the workup that she had had, the medications
 14 she had been on in the past.
 15 And that's below the standard for somebody in
 16 family practice or primary care medicine, which he was
 17 practicing at that time, and certainly out of line for a
 18 radiologist to even get involved with anybody, especially
 19 a relative.
 20 Q. What is your understanding of the circumstances
 21 that led to Ms. MacLeod first contacting Dr. Watts to
 22 request that he become involved in trying to secure some
 23 treatment or care for the problems she was having in late
 24 1998?
 25 A. My understanding was that she made him aware --

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1 MS. MAGID: Object. That implies facts not in
 2 evidence.
 3 There's nothing in evidence to ascertain how she
 4 contacted the radiologist in the first place.
 5 MR. DRAKE: Perhaps part of my question was not
 6 heard on your end.
 7 My question was what is his understanding, which
 8 really doesn't go to anything that's in evidence
 9 whatsoever.
 10 Did you not hear that?
 11 MS. MAGID: It's the same objection.
 12 MR. DRAKE: That's fine. We'll move on.
 13 Q. Go ahead, Dr. Hance.
 14 A. My understanding is Dr. Watts, because he was
 15 related to her, became aware that she had been suffering
 16 from abdominal pain for three years and that she had
 17 undergone numerous tests and the pain was continuing.
 18 Q. What is your understanding of the first thing
 19 that Dr. Watts did in response to that inquiry from
 20 Ms. MacLeod to attempt to secure treatment or assistance
 21 for her?
 22 A. It was my understanding that he contacted
 23 Dr. Kohler and arranged for, also, his performance of the
 24 Hida scan.
 25 Q. Is it your understanding that Dr. Kohler

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1 performed the Hida scan?
 2 A. No. Dr. Watts performed the Hida scan. When I
 3 said "his," I meant Dr. Watts himself.
 4 Q. Were you -- are you aware of any other
 5 physicians who consulted on Ms. MacLeod's case prior to
 6 the surgery that Dr. Kohler did on November 3?
 7 A. I don't know exactly what the time was of the
 8 other doctor whose spelling we had a problem. But I
 9 think his was after the surgery, not before.
 10 And I think the answer is no.
 11 Q. Would it change any of your opinions, sir, if in
 12 fact there were other physicians who were involved in
 13 consulting on Ms. MacLeod's case to determine whether or
 14 not surgery was appropriate under the circumstances?
 15 MS. MAGID: Objection. It's a hypothetical that
 16 doesn't call into question all of the facts that would be
 17 necessary for him to be able to answer the hypothetical.
 18 Q. BY MR. DRAKE: Go ahead, sir.
 19 A. Yeah. I'm --
 20 Which doctor are you referring to is this?
 21 Q. Any, sir. I'm just trying to probe the extent
 22 of your knowledge about the case and the basis for your
 23 opinions.
 24 A. I'm aware she was also seeing an OB/GYN doctor,
 25 Dr. Dancie Young-Hawkins. But that was not at the time of

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1 her admission.
 2 Q. Are you aware of any involvement of a
 3 gastroenterologist prior to the surgery that she went
 4 through on November 3?
 5 A. Gastroenterologist had seen her and she
 6 had this -- that's what I was referring to -- the upper
 7 and lower endoscopic examinations. Yes.
 8 Q. And does that in any way affect your opinion
 9 that Dr. Watts acted somehow inappropriately in trying to
 10 secure consultations and evaluations for Ms. MacLeod?
 11 A. Yes. Because Dr. Watts was not her doctor;
 12 Dr. Salisbury was. And you know, he -- he didn't belong
 13 in the mix there. He's a nephew who's a radiologist.
 14 But he didn't belong in the mix as acting on her behalf
 15 as a primary care physician.
 16 She had primary care physician who had been
 17 involved with her for a long time.
 18 Q. Is it your testimony that he was acting as the
 19 primary care physician for Ms. MacLeod shortly before the
 20 November 3 surgery by Dr. Kohler?
 21 A. He certainly was. At least -- and even more so
 22 afterwards. In other words, he was making referrals to a
 23 surgeon and afterwards he was admitting her to the
 24 patient himself -- to the hospital himself.
 25 Q. My question, sir, was limited to the November 3.

<p style="text-align: right;">Page 26</p> <p>1 For the ease of discussion, I wanted to stop at that 2 point. 3 Is your answer the same if we limit it to 4 November 3? 5 A. November 3 less than later when later involved. 6 But he did interpose himself. The referral was not made 7 by Dr. Salisbury, who would have been the appropriate one 8 to make the referral. 9 Q. Are you aware of the interaction that 10 Ms. MacLeod and Dr. Watts had had in, say, the preceding 11 ten or so years from time to time when Ms. MacLeod would 12 inquire about Dr. Watts and enlist his help in getting 13 studies and referrals? Things of that nature. 14 MS. MAGID: Objection. Calls into question 15 facts not in evidence. 16 Q. BY MR. DRAKE: If in fact there had been fairly 17 frequent involvement between the two them over the course 18 of the preceding years, would that change your mind as 19 the propriety of Dr. Watts acting to facilitate securing 20 care for her in late 1998? 21 MS. MAGID: I'm going to object to that being a 22 hypothetical that doesn't give all of the facts that the 23 doctor would need to answer that question. 24 Q. BY MR. DRAKE: Go ahead. 25 A. I think it's still inappropriate for a</p>	<p style="text-align: right;">Page 28</p> <p>1 Foundation. 2 Q. BY MR. DRAKE: Is it your belief, Dr. Hance, 3 that Dr. Watts played any active role in the actual 4 decision of whether or not to undergo the surgery that 5 Dr. Kohler performed? 6 A. No. 7 Q. And you would concede, would you not, that he 8 had absolutely nothing to do with that decision? 9 A. He had nothing to do with that decision. He 10 just facilitated the referral to Dr. Kohler, and 11 Dr. Kohler made the decision to operate. 12 Q. And you think that was below the standard of 13 care? 14 A. I think it was. 15 Q. Have you ever been asked by a relative, 16 Dr. Hance, to act as a facilitator -- if I may use that 17 word -- to try to secure a consultation or a visit to 18 another physician? 19 A. Yes. 20 Q. How frequently have you been called upon by your 21 relative to do that, sir? 22 A. Fairly frequently. 23 Q. How often? 24 A. Couple times a year. 25 Q. That's as often as it occurs?</p>
<p style="text-align: right;">Page 27</p> <p>1 radiologist of a relative to interpose himself in the 2 care of a patient who is being cared for by a qualified 3 physician. 4 Q. What's your understanding of Dr. Salisbury's 5 area of expertise? 6 A. He's an internist. Internal medicine. 7 Q. With a specialty in cardiology? 8 A. Yes. 9 Q. Is it your belief that Dr. Salisbury was unaware 10 of the consultations that Ms. MacLeod was receiving in 11 October/November, '98, that led up to the surgery? 12 A. I'm sure he was unaware and certainly would not 13 have recommended -- according to his deposition, would 14 not have recommended the surgery. 15 Q. Is it your opinion that the surgery was not 16 needed or was in some manner unnecessary? 17 MR. FISHLER: Objection. Foundation. 18 THE WITNESS: It's my belief that the surgery 19 was totally unnecessary. 20 Q. BY MR. DRAKE: Why? 21 A. Because she did not have an acute gallbladder 22 disease. She had symptoms of irritable bowel syndrome. 23 And they're not cured by cholecystectomy. 24 MR. FISHLER: I'm going to interpose an 25 objection to that last question.</p>	<p style="text-align: right;">Page 29</p> <p>1 A. Yeah. 2 Q. Tell me some of the kinds of things that you've 3 done for relatives in terms of securing consultations or 4 visits, examinations. Things of that nature. 5 A. It usually involves somebody who would call with 6 a medical problem and ask what kind of specialist to 7 consult with that. And I'd ask them, you know, what is 8 your problem? 9 Well, if it's a hearing problem, you need to 10 call an EMT doctor and they take care of hearing 11 problems. If it's a sight problem, you need to call an 12 ophthalmologist. 13 It's that sort of generic advise that I give 14 them. 15 Go on and call an ophthalmologist or EMT doctor. 16 If they're bleeding, call a gastroenterologist. 17 Q. Have you ever secured a surgical consult for a 18 relative? 19 A. No. 20 Q. Never have? 21 A. No. That's -- you don't want to get involved on 22 that end of it. Let the subspecialist or the primary 23 care doctor pick the surgeon. Because I don't live in 24 the community where most of my relatives live in. 25 Q. In what community is that, sir, that your</p>

1 November 3 -- any such patient who calls and asks for
2 assistance warrants an immediate referral to the surgeon
3 who performed the surgery?

4 MS. MAGID: Objection. It mischaracterizes his
5 testimony.

6 MR. FISHLER: Objection. Foundation, misstated.

7 Q. BY MR. DRAKE: And your answer, sir, is?

8 A. Answer is yes.

9 Q. So really, the clinical picture is what -- one
10 need not say unimportant. But it's just simply the fact
11 that that surgery has taken place and you got a post-op
12 complaint.

13 That series of events alone you believe warrants
14 a referral to the surgeon. Correct?

15 A. Absolutely.

16 Q. Was there anything in your mind that was
17 particularly worrisome or troublesome about Ms. MacLeod's
18 condition on November 6 immediately prior to the time she
19 was admitted to the hospital?

20 A. Yes. That normally after you've had a
21 laparoscopic cholecystectomy and you go home, you're --
22 with time you're getting better and your symptoms are
23 going away. In other words, everybody has postoperative
24 discomfort. But with the passage of time, it's getting
25 better with each hour and each day.

1 patients who have had laparoscopic cholecystectomies and
2 having some symptoms and some concerns.

3 Q. When you say "see" these patients -- sent to the
4 radiology department for a study?

5 A. Correct.

6 Q. You're not following them on the floor or
7 clinically? Anything of that nature?

8 A. I'm not making surgical rounds on them. I see
9 them in the X ray department when they come down for
10 post-op chest or they come down for three-way abdomen,
11 for ileus or pain and come down for a CT worrying about
12 perforation or bowel leak.

13 So we're evaluating them in that sort of
14 situation. We're not surgeons making rounds on the ward.
15 Right.

16 Q. Would you defer to a surgeon, sir, as to what
17 the expected postoperative course ought to be in a
18 post-laparoscopic cholecystectomy patient?

19 A. I would defer to a patient. But I know for a
20 fact that the normal postoperative course is that of
21 improvement. And when you deviate from that and you get
22 a patient who is getting worse, that's the time the
23 surgeon has to get involved.

24 Q. Sir, do you intend to render any opinions in
25 this case as to when -- how the perforation in the bowel

1 And she's describing increasing problems. So
2 something is not going according to the expected course
3 of events.

4 MR. FISHLER: Objection. Foundation.
5 Misstated.

6 Q. BY MR. DRAKE: Dr. Hance, what experience, sir,
7 have you had in following patients in the immediate
8 postoperative period following a laparoscopic
9 cholecystectomy?

10 A. We're asked to see these patients on a regular
11 basis and perform various imaging studies, including CT
12 on them, on a regular basis. And we talk to these
13 patients and we know what to expect.

14 Q. How frequently do you do that, sir, at the
15 present time?

16 A. Well, when I'm practicing in the hospital, we do
17 it several times in a day. We got post-op patients that
18 are having problems and we evaluate them with our imaging
19 studies and we talk to the patients.

20 Q. For the purpose of my question, I intended to
21 limit it to patients who have undergone laparoscopic
22 cholecystectomies.

23 Are you able to address your experience with
24 just that subset of patients?

25 A. Probably couple times a week we're seeing

1 occurred first of all?

2 A. I think how it occurred, I don't know. When it
3 occurred, it occurred at the time of surgery.

4 MR. FISHLER: Objection --

5 Q. BY MR. DRAKE: You intend to render such an
6 opinion at trial?

7 A. Absolutely. That's when perforations in the
8 small bowel occur in laparoscopic procedures, is when you
9 introduce the instrument through abdominal wall.

10 MR. FISHLER: Objection. Foundation.

11 He's not a general surgeon.

12 Q. BY MR. DRAKE: In any of the rather extensive
13 number of medical/legal cases in which you've been
14 involved historically, have you ever been qualified to
15 give an opinion on general surgery issues in the court of
16 law?

17 A. I'm not a general surgeon and I'm not qualified.

18 I do know that the time of the perforation in
19 laparoscopic cholecystectomy -- and you'll read this in
20 the literature. Every doctor reads this in the
21 literature -- is at the time of the introduction of the
22 instrument. That's the dangerous time.

23 MR. FISHLER: Objection. Foundation.

24 Q. BY MR. DRAKE: My question to you, sir, have you
25 ever been qualified to render such an opinion in court?

<p style="text-align: right;">Page 42</p> <p>1 I take it your answer is no?</p> <p>2 A. No.</p> <p>3 Q. Do you intend to render any opinions in this</p> <p>4 case as to what the appropriate care or treatment should</p> <p>5 have been if a general surgeon had been consulted on or</p> <p>6 about November 6 when Ms. MacLeod was readmitted to the</p> <p>7 hospital?</p> <p>8 A. She would have been taken back to surgery and</p> <p>9 the perforation closed.</p> <p>10 MR. FISHLER: Objection. Foundation.</p> <p>11 Q. BY MR. DRAKE: Would you defer to a general</p> <p>12 surgeon, sir, as to the timing of that decision in this</p> <p>13 case?</p> <p>14 A. As to the timing, yes.</p> <p>15 Q. What is your understanding, Dr. Hance, of --</p> <p>16 well, strike that.</p> <p>17 You testified earlier, sir, that at the point</p> <p>18 when Dr. Watts admits her on November 6 that he didn't do</p> <p>19 an adequate history.</p> <p>20 Did I understand your testimony correctly --</p> <p>21 A. History and physical. Yes, sir.</p> <p>22 Q. Is it your belief, sir, that that supposed</p> <p>23 failure had anything to do with her future course and her</p> <p>24 outcome in this case?</p> <p>25 A. I don't know.</p>	<p style="text-align: right;">Page 44</p> <p>1 ultimately found at the second surgery that Dr. Kohler</p> <p>2 performed that at some point Ms. MacLeod was going to</p> <p>3 need another surgery to address this perforation of the</p> <p>4 bowel?</p> <p>5 A. Absolutely. The sooner the better.</p> <p>6 Q. Did you intend to render any opinions at trial,</p> <p>7 sir, with respect to any supposed delay in the performing</p> <p>8 of that second surgery?</p> <p>9 A. Only that the delay in making the diagnosis of</p> <p>10 the perforation and undertaking the second surgery</p> <p>11 resulted in this large abscess that she had.</p> <p>12 MR. FISHLER: Objection. Foundation as stated.</p> <p>13 Q. BY MR. DRAKE: Again, do you intend to render</p> <p>14 any opinions at trial that any aspect of the -- either</p> <p>15 the hospitalization that she underwent after the second</p> <p>16 surgery or anything at all was proximately caused by the</p> <p>17 supposed delay in doing the second surgery?</p> <p>18 A. I'm not sure I understand your question, sir.</p> <p>19 Q. I don't know how else to do it, sir.</p> <p>20 Do you intend to testify that the supposed delay</p> <p>21 in doing the second surgery caused any of her problems</p> <p>22 between the time of that surgery and the present?</p> <p>23 A. It caused the large abscess to form. In other</p> <p>24 words, normally if you have a perforated small bowel and</p> <p>25 it's promptly recognized and promptly operated on, you do</p>
<p style="text-align: right;">Page 43</p> <p>1 Q. So as I understand your testimony, sir, at the</p> <p>2 time that Ms. MacLeod contacts with Dr. Watts on November</p> <p>3 6, you believe that he should have contacted Dr. Kohler</p> <p>4 or Dr. Fullmer to report that Ms. MacLeod was supposedly</p> <p>5 having problems.</p> <p>6 Correct?</p> <p>7 A. Correct.</p> <p>8 Q. Anything else that he should have done at that</p> <p>9 time?</p> <p>10 A. That's what he should have done at that time and</p> <p>11 leave it in the hands of the surgeon.</p> <p>12 Q. And how the course of events would have gone</p> <p>13 from there in terms of timing and other treatment you're</p> <p>14 going to leave to others to say.</p> <p>15 Correct?</p> <p>16 A. Correct.</p> <p>17 Q. What is your understanding of how Ms. MacLeod</p> <p>18 did in terms of her clinical course on November 7?</p> <p>19 A. According to doctor notes, she appeared to be</p> <p>20 improving on the antibiotics that he'd put her on.</p> <p>21 Q. When was she first placed on antibiotics?</p> <p>22 A. I'd have to look that up. I don't remember.</p> <p>23 But somewhere in that thing Dr. Watts placed her on</p> <p>24 antibiotics and she appeared to him to be improving.</p> <p>25 Q. Would you agree, Dr. Hance, based upon what was</p>	<p style="text-align: right;">Page 45</p> <p>1 not expect a large abscess to form, which she did have</p> <p>2 when she went to surgery several days later.</p> <p>3 Q. Just so that I'm clear, doctor, do you intend to</p> <p>4 render any opinions with respect to Ms. MacLeod's current</p> <p>5 condition and whether or not any of the current problems</p> <p>6 she claims to suffer from were caused by this delay in</p> <p>7 doing the second surgery?</p> <p>8 A. I'm not aware of her current problems. My</p> <p>9 involvement ends with her 24 of November, '98.</p> <p>10 Q. Okay. Did you read through her medical records</p> <p>11 to determine what involvement Dr. Watts had with her</p> <p>12 between the time of the second surgery and when she was</p> <p>13 discharged?</p> <p>14 A. I read those records and I know he was, you</p> <p>15 know, interested in her course and visited her.</p> <p>16 But that's about all.</p> <p>17 Q. What is your understanding of these</p> <p>18 circumstances surrounding Dr. Cornica's being brought in</p> <p>19 to consult on the case?</p> <p>20 A. He was brought in as a consultant for some of</p> <p>21 the problems she was having. And she had bilateral</p> <p>22 plural effusions and she had had the central line placed,</p> <p>23 developed a pneumothorax, but denied the need to -- or</p> <p>24 refused to have them put a chest tube in. And it</p> <p>25 resolved without it.</p>

EXHIBIT B

CLARK NEWHALL (#7091)
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Salt Lake City, Utah 84101-3757
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(801) 363-8888
Fax (801) 596-8888
Attorney for Plaintiff

IN THE FOURTH JUDICIAL DISTRICT COURT, UTAH COUNTY

STATE OF UTAH

LUCY MacLEOD,
Plaintiff,

vs.

GARY WATTS MD et al,
Defendants.

AFFIDAVIT OF DARWOOD HANCE

Civil No. 010400391

Judge Steven Hansen

STATE OF CALIFORNIA

County of

)
:ss
)


Darwood Hance MD, Affiant, being first duly sworn and under oath, deposes and
says:

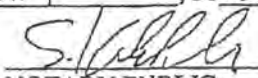
- 1) I am a physician licensed in California.
- 2) I am board certified in Radiology and am a practicing radiologist.
- 3) I am a designated expert witness in the above-entitled case.
- 4) I have reviewed the medical records of Lucy Johnson nee MacLeod for the hospital
admissions of November 3, 1998 and November 6, 1998,
- 5) I have reviewed the depositions of Gary Watts MD, Steven Salisbury MD and
Douglas Kohler MD taken in the above-entitled case.

- 6) I hold the opinion that Dr. Watts breached the applicable standard of care in rendering medical care to the plaintiff in this case.
- 7) I hold the opinion that one or more of Dr. Watts' breaches of the standard of care caused damage to plaintiff.
 - a) Specifically, the following facts support my opinions:
 - b) Dr. Watts referred plaintiff to the surgeon, Dr. Kohler.
 - c) Dr. Watts breached the standard of care when he failed to consult plaintiff's primary care physician, Dr. Salisbury, before referring plaintiff to Dr. Kohler.
 - d) Dr. Salisbury stated that plaintiff had had symptoms of irritable bowel syndrome for many years
 - e) Dr. Salisbury noted that the physicians at Utah Valley Hospital did not request information from him about plaintiff's prior history of abdominal symptoms or prior examinations.
 - f) Dr. Salisbury stated that plaintiff's "irritable bowel syndrome was misinterpreted as gallbladder disease" by physicians at Utah Valley Hospital.
 - g) If Dr. Watts had the information available from Dr. Salisbury, in my opinion there would have been no medical reason to refer plaintiff to Dr. Kohler or any other surgeon.
 - h) The referral to Dr. Kohler led to the surgery performed by Kohler in which plaintiff was injured.
 - i) Plaintiff's injury, a perforated intestine with intra-abdominal and abdominal wall infection, occurred most likely at the time of her surgery on November 3, 1998.

- j) Plaintiff's intra-abdominal infection continued and worsened following November 5, 1998, when she first complained of abdominal pain to Dr. Watts.
- k) When plaintiff informed him of her continuing abdominal pain on November 6, 1998, Dr. Watts breached the standard of care by failing to consult either Dr. Kohler or the surgeon on call for Dr. Kohler.
- l) Because Dr. Watts failed to consult a surgeon in a timely fashion on and after November 6, 1998, plaintiff suffered pain and increasing infection for at least two and one-half days without appropriate treatment.
- m) Because Dr. Watts failed to obtain surgical consultation on November 6, 1998, plaintiff more likely than not suffered additional complications and additional hospitalization.
- n) In addition to the pain and suffering associated with the two and one-half days that plaintiff went without appropriate treatment, plaintiff more likely than not incurred additional hospital bills.

8) Further affiant sayeth naught.


Darwood Hance MD
AFFIANT

SUBSCRIBED AND SWORN TO before me this 5TH day of
FEBRUARY, 2003

NOTARY PUBLIC

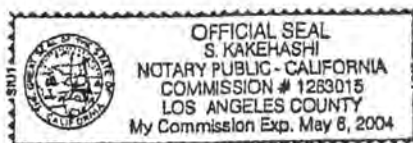


EXHIBIT C

<p style="text-align: right;">Page 23</p> <p>1 and every one?</p> <p>2 A. Yes.</p> <p>3 Q. And it's important to do that in order to know</p> <p>4 what you're going to do at the time of surgery?</p> <p>5 A. Yes.</p> <p>6 Q. In planning a laparoscopic cholecystectomy,</p> <p>7 would knowledge of previous abdominal surgeries be</p> <p>8 important?</p> <p>9 A. Yes.</p> <p>10 Q. I want to take you to the records of Dr. Danny</p> <p>11 Young Hawkins. This is an obstetrician, I'll tell you,</p> <p>12 who treated Mrs. MacLeod, and I'm going to refer you to</p> <p>13 a note that I believe is dated 10-23-98, so it would be</p> <p>14 not too long before the surgeries at issue, and I'm</p> <p>15 going to read you a portion of the deposition that</p> <p>16 refers to that note because you have not yet --</p> <p>17 MR. FISHLER: Can I see that note?</p> <p>18 MR. NEWHALL: Yes, you can.</p> <p>19 Q. You have not yet had the opportunity to look at</p> <p>20 that deposition, but I'm going to read you from pages 59</p> <p>21 to 60 of the deposition that refers to that note:</p> <p>22 "QUESTION: Okay. Now, let's look at this drawing</p> <p>23 that you've put here on this page.</p> <p>24 ANSWER: Uh-huh.</p> <p>25 QUESTION: Can you just illustrate for us what it</p>	<p style="text-align: right;">Page 25</p> <p>1 the abdominal wall vertical incision begin?</p> <p>2 ANSWER: Oh, my drawings aren't precise enough to</p> <p>3 tell you that.</p> <p>4 QUESTION: Okay. I'll represent to you, since you</p> <p>5 weren't aware of this, that Mrs. MacLeod had had a</p> <p>6 hysterectomy through a Pfannenstiel's incision and then</p> <p>7 following that had had at least one episode of small</p> <p>8 bowel obstruction due to adhesions, and at the time of</p> <p>9 at least one of these episodes she had had a midline --</p> <p>10 lower midline incision for release of the bowel</p> <p>11 obstruction."</p> <p>12 Okay?</p> <p>13 A. Okay.</p> <p>14 Q. And we'll just take that as a given while we're</p> <p>15 talking about this whether you know about that or not</p> <p>16 from previous records.</p> <p>17 A. Okay.</p> <p>18 Q. Okay. Given that fact that I just told you, is</p> <p>19 it likely that Mrs. MacLeod, at the time of Dr. Kohler's</p> <p>20 surgery, had abdominal adhesions?</p> <p>21 MR. FISHLER: Objection. Foundation. Answer if you</p> <p>22 can.</p> <p>23 THE WITNESS: I think it's very possible.</p> <p>24 BY MR. NEWHALL:</p> <p>25 Q. Would it, say, be more likely than not?</p>
<p style="text-align: right;">Page 24</p> <p>1 means, what it is you're seeing, the bottom line, the</p> <p>2 horizontal line that he's representing the</p> <p>3 Pfannenstiel's incision?</p> <p>4 ANSWER: The little loop at the top is her belly</p> <p>5 button, and then the lines on the side are showing the</p> <p>6 separation of the abdominal wall muscle. The "X" is on</p> <p>7 the Pfannenstiel's incision where I thought there might</p> <p>8 have been a defect in that scar.</p> <p>9 QUESTION: And then the heavy vertical line?</p> <p>10 ANSWER: That is showing the midline of the abdomen,</p> <p>11 and I think it might be an incision. I don't recall if</p> <p>12 she had one there or not.</p> <p>13 QUESTION: Let's go over and look at your notes just</p> <p>14 adjacent there.</p> <p>15 ANSWER: To the right?</p> <p>16 QUESTION: Yes.</p> <p>17 ANSWER: Okay.</p> <p>18 QUESTION: Do you record a vertical incision?</p> <p>19 ANSWER: No, I don't there.</p> <p>20 QUESTION: Do you know whether she had an abdominal</p> <p>21 wall vertical incision?</p> <p>22 ANSWER: I think she did because she had a bowel</p> <p>23 obstruction in '76.</p> <p>24 QUESTION: Right. And how far up from the -- I</p> <p>25 guess I should say at what point along the umbilicus did</p>	<p style="text-align: right;">Page 26</p> <p>1 MR. FISHLER: Same objection.</p> <p>2 THE WITNESS: Yes.</p> <p>3 BY MR. NEWHALL:</p> <p>4 Q. Okay. And would it be likely that the</p> <p>5 adhesions, if they were present adherent to the</p> <p>6 underside of the -- or to the anterior right abdominal</p> <p>7 wall at the point of the previous lower midline</p> <p>8 incision?</p> <p>9 MR. FISHLER: Objection. Foundation.</p> <p>10 THE WITNESS: That would be the likely spot.</p> <p>11 BY MR. NEWHALL:</p> <p>12 Q. Okay. Did you make a deduction as to when the</p> <p>13 injury occurred -- well, let me take it back. Did you</p> <p>14 make a deduction as to when the bowel perforation that</p> <p>15 was eventually discovered by Dr. Kohler occurred?</p> <p>16 A. I think there are possibilities, a couple of</p> <p>17 possibilities. One possibility would be upon entry into</p> <p>18 the abdominal wall and --</p> <p>19 Q. You mean entry with a trocar?</p> <p>20 A. Yes. And the other possibility would be when</p> <p>21 instruments are being reintroduced in and out of the</p> <p>22 trocars, you know, I suppose it's always possible to</p> <p>23 poke something then. I can't say that I've ever seen</p> <p>24 that happen, but we are always taught to look and make</p> <p>25 sure we don't poke something as we slide, you know, the</p>

1 instruments, the forceps and things in and out of the
2 trocars. But those would be the two opportunities that
3 you would think that it would -- could likely occur.

4 Q. And, of those two, which is the most likely?

5 A. Based on the fact that I have heard of injuries
6 when the trocar is first inserted, that I have not
7 actually seen one caused by instruments inserted later,
8 I would have to say the most common is when the trocar
9 is first inserted.

10 Q. Okay. Are you aware of any statistics related
11 to bowel injuries and trocar insertion?

12 A. I'm not aware of specific statistics.

13 Q. Okay. I take it, though, that you review the
14 medical literature, the surgical literature fairly
15 regularly?

16 A. Yes, I do.

17 Q. Okay. What journals do you particularly
18 review?

19 A. The ones that I read most commonly would be
20 Critical Care Medicine, Journal of Trauma would probably
21 be the big ones but also Surgeons of Surgery and what
22 used to be SG&O and now is the Journal of the American
23 College of Surgeons. Those are the journals that I
24 take.

25 Q. Okay. And are there any particular textbooks

1 those much anymore because it's not clear to me that
2 it's an advantage to do it that way. I've done some
3 laparoscopic ventral hernia repairs which can
4 sometimes be done better that way. I've done
5 laparoscopic nissen funduplications. That's another
6 procedure that lends itself, I think, to laparoscopic
7 approaches.

8 And then, finally, we use laparoscopy once in awhile
9 for -- for trauma, mostly to see if the peritoneal
10 cavity has been violated, a stab wound. And our
11 approach there is if we see a hole on the inside of the
12 peritoneum, we usually open them up and explore them
13 more formally, but if we don't find a hole under the
14 abdomen, we stop and say it was a flesh wound.

15 Q. In other words, if you don't find that parietal
16 peritoneum breach, you consider that it's not --

17 A. Yeah.

18 Q. -- needing open laparoscopic surgery? Okay.

19 A. We'll use them for other odd reasons. I've
20 used them for laparoscopy, for the placement of
21 jejunostomy feeding tubes for liver biopsy. My point is
22 I don't do laparoscopic adrenalectomy, laparoscopic
23 colon resection and that sort of thing.

24 Q. I understand. And, I take it, you've done
25 laparoscopic surgery since 1998 at least?

1 that you use in your practice or recommend to your
2 residents as textbooks for surgery practice?

3 A. Textbooks for surgery, again, I use several. I
4 have a Sabiston, I have a Schwartz, and I have a
5 Cameron. I also have a copy of one put out that our own
6 surgeon is one of the editors of. It's called "The
7 Scientific Basis of Surgical Practice." I have those.
8 I haven't read it as much.

9 Q. Naughty, naughty.

10 MR. FISHLER: Get on that.

11 BY MR. NEWHALL:

12 Q. And do you have any books that you use that
13 reference laparoscopic surgery?

14 A. I'm trying to think what's on my shelf. I
15 don't have one that I've used, that I've used
16 regularly. I may have a small -- meaning a throw-away
17 type -- laparoscopic surgical text or one that was given
18 to me. I have not bought a major laparoscopic text.

19 Q. Do you, yourself, perform or supervise, rather
20 than performing, some laparoscopic surgery?

21 A. Lots of types -- I should say some types of
22 laparoscopic surgery, yes; other types, no. I do lots
23 of laparoscopic cholecystectomies. That's kind of the
24 modern standard. Do some -- in the past I've done
25 laparoscopic inguinal hernia repairs, don't tend to do

1 A. Yes. Probably since 1992.

2 Q. Would you like to get that phone? We'll take a
3 break.

4 (Whereupon a discussion was held off the record.)

5 BY MR. NEWHALL:

6 Q. All right. I was on track and got off track a
7 little bit, I think. I think we've established that the
8 likeliest cause of the perforation or the bowel injury,
9 in your view, is the trocar insertion?

10 A. Probably the entry into the abdomen.

11 Q. Okay.

12 A. The one thing that I think is pertinent to note
13 is that he did do this by what's referred to as the open
14 technique which is appropriate. In other words, many
15 times when we do laparoscopic surgery we grab the
16 abdominal wall with clamps penetrating, towel clips lift
17 it up and poke a needle called a verus needle through,
18 fill the abdomen with CO2. That's done blindly. It is
19 appropriate in someone who's had previous surgery to
20 make an incision and to go in and direct visualization,
21 which is what he did, at least as I can interpret the
22 operative report.

23 Q. Yeah. That's very interesting to me because it
24 seems like I have a different impression myself. Can I
25 ask you to refer to the operative report that you have

1 likely that the infection would get worse in the two and
 2 a half days without antibiotics —
 3 MR. DRAKE: Objection.
 4 MR. NEWHALL: — and treatment?
 5 MR. DRAKE: Sorry. Same objections.
 6 MR. NEWHALL: Thank you.
 7 THE WITNESS: If it were untreated, presumably, it
 8 would get worse.
 9 MR. NEWHALL: Thank you.
 10 Q. If Dr. Kohler had examined Mrs. MacLeod on the
 11 5th and had determined that she had an intra-abdominal
 12 infection, what would have been the appropriate course
 13 at that time?
 14 Well, let me take it even farther than that. If he
 15 had examined her on the 5th and determined that she had
 16 a perforated viscus, what would be the appropriate
 17 course at that time?
 18 A. To operate on it and fix it.
 19 Q. And —
 20 A. And fix it meaning either repair it, resect it,
 21 do an ostomy. There are lots of options, depends on
 22 what you thought but —
 23 Q. I understand.
 24 A. — treat it surgically.
 25 Q. I know in hindsight — sorry. We know in

1 BY MR. NEWHALL:
 2 Q. You've earlier indicated that the procedure
 3 that one should undertake when presented with a
 4 perforated viscus of this type is to operate; is that
 5 right?
 6 A. That's what I would do.
 7 Q. So a nonoperative course, such as is used in
 8 perforated ulcers, is not an alternative in this case;
 9 is that right?
 10 A. It wouldn't have been my choice. Now, a
 11 nonoperative course in perforated ulcers is not done
 12 here either, but it's done in the United Kingdom.
 13 Q. But in this particular instance a nonoperative
 14 treatment is not a course of action that you believe is
 15 within the standard of care?
 16 A. No.
 17 Q. Okay. Now, if Dr. Kohler, as we know it, was
 18 not available in the period sometime after
 19 Lucy MacLeod's surgery and until November 9th, you agree
 20 with that, he was out of town?
 21 A. That's what it seems to be suggesting.
 22 Q. If that is the case, should he have had another
 23 surgeon on call to handle problems on his patients,
 24 recently operated patients, I should say?
 25 A. That would normally be the case. I will say

1 hindsight that Mrs. MacLeod did have a perforated viscus
 2 on November 5th more likely than not, do we not? Do you
 3 agree with that?
 4 A. I think the evidence suggests that.
 5 Q. Okay. And knowing that in hindsight, would you
 6 agree that the period of time, November 5th to the point
 7 which she actually did have an operation, November 9th,
 8 probably resulted in an increase in the severity of the
 9 infection that she did have?
 10 MR. DRAKE: Objection. Assumes facts not in
 11 evidence. Calls for speculation.
 12 THE WITNESS: It may have resulted in an increase
 13 from — in the severity.
 14 BY MR. NEWHALL:
 15 Q. Well, let's try that once again then. I'm
 16 asking you for a probability. Would you agree that it
 17 more likely than not did result in an increase in the
 18 infection severity?
 19 MR. DRAKE: Same objections.
 20 THE WITNESS: Again, I have to say I can't know
 21 that. I would say based on what we usually see, yes,
 22 this probably would have gotten worse; on the other
 23 hand, as I'm sure you're aware, there's literature of
 24 perforated ulcers, for instance, being managed
 25 nonoperatively altogether.

1 that in a patient who has gone home, that may not be the
 2 case. In other words, when I go out of town, if I'm
 3 leaving a patient in the hospital, I absolutely find out
 4 who is going to — you know, who is going to cover for
 5 me and who is going to see that patient while that
 6 patient is in the hospital. Do we have something worked
 7 out like if I have patients at home, well, yeah, we
 8 always have somebody in our practice on call, but I may
 9 not specifically — if I don't have patients in the
 10 hospital, I may not specifically find someone to cover
 11 for me. It would be one of my partners. There's always
 12 someone on call that would handle that.
 13 Q. Would you agree that if Dr. Kohler did hear
 14 from Dr. Watts, as we've described on November 5th, that
 15 he should have asked Dr. Watts to — no matter what the
 16 concern was with Lucy MacLeod, simply that she had
 17 abdominal pain on November 5th, would you agree that
 18 Dr. Kohler should have said to Dr. Watts that
 19 Dr. Fullmer was on call and could take care of Lucy if
 20 something arose?
 21 A. If that was the case, if Dr. Fullmer was indeed
 22 on call.
 23 Q. He was, I'll tell you that.
 24 A. Then, yeah, that would be appropriate.
 25 Q. And —

<p style="text-align: right;">Page 87</p> <p>1 A. Oh, 40, line eight, I'm sorry, "Did you 2 consult any other physicians at that time? No, I did 3 not." 4 Q. Okay. So does that suggest that Dr. Fullmer 5 was not consulted about Mrs. MacLeod? 6 MR. FISHLER: Objection. Speculation. 7 THE WITNESS: It suggests that he says -- that he 8 says I made an attempt to reach Dr. Fullmer but it kind 9 of sounds like he didn't but -- 10 BY MR. NEWHALL: 11 Q. And earlier you said that one of the 12 considerations in -- if you were to have heard about 13 Lucy MacLeod on November 5th, one of the considerations 14 would be if she got worse, if she got worse from 15 November 5th on, what would be the appropriate course 16 for a surgeon, prudent surgeon? 17 A. To bring her back to the hospital and to begin 18 to sort things out. 19 Q. And would a prudent surgeon want to have the 20 radiologist perform that function solely -- 21 MR. FISHLER: Objection. 22 MR. NEWHALL: -- and not be involved himself? 23 MR. FISHLER: Vague and ambiguous. 24 THE WITNESS: In general, no. 25 BY MR. NEWHALL:</p>	<p style="text-align: right;">Page 89</p> <p>1 palpate it, visually inspect it. 2 Q. Would you describe your examination in writing 3 if you did those things? 4 A. I would. It would probably be brief, but it 5 would be things like abdomen is distended and tender or 6 abdomen is absolutely soft and non tender, in those 7 terms. It wouldn't be a lengthy description but it 8 would be somewhat. 9 Q. Would some of your description also comprise 10 the history in your written description? 11 A. Yes. 12 Q. Would some of your description comprise the 13 visual inspection portion of your examination? 14 A. Yes, it would. 15 Q. Would some of your description be comprised of 16 the bowel sounds portion of your examination? 17 A. Usually would be bowel sounds positive or 18 negative. It would be simple but it would probably be 19 there. 20 Q. Would some of your description be comprised of 21 the heart and lung examination that you performed? 22 A. Usually would. 23 Q. Would it be below the standard of care for a 24 surgeon to fail to document an examination such as 25 you've described --</p>
<p style="text-align: right;">Page 88</p> <p>1 Q. Why not? 2 A. Well, I guess radiologists are radiologists and 3 surgeons are surgeons. 4 Q. And -- 5 A. Meaning specifically that a radiologist would 6 not normally be who you would choose to examine your 7 patients. 8 Q. Why not? 9 A. Well, because they are trained in radiology but 10 they're not trained in surgery. 11 Q. And if Lucy MacLeod worsened after the 5th of 12 November and you brought her back to the hospital, what 13 sorts of things would you do at that time? 14 A. I would examine her. 15 MR. DRAKE: Objection. Vague. 16 THE WITNESS: Find out what had been going on, in 17 other words, take a history exam of her. I would check 18 the white count, look at her vital signs. That's where 19 I would start. 20 BY MR. NEWHALL: 21 Q. And by "examination," what sorts of things 22 would you do? 23 A. I'd listen to her heart and lungs. I'd check 24 her pulse. I'd look at her blood pressure. I would 25 examine her abdomen, obviously, listen for bowel sounds,</p>	<p style="text-align: right;">Page 90</p> <p>1 MR. DRAKE: Objection. Vague. 2 MR. NEWHALL: -- in a situation like this? 3 MR. DRAKE: Same objection. 4 THE WITNESS: Well, when you say "below the standard 5 of care," I mean because of the very things that we are 6 dealing with now, it would obviously help if those 7 things were better documented. Does everybody always do 8 that? No. 9 BY MR. NEWHALL: 10 Q. Well, I'm just asking about the standard. 11 A. I'm sure there are times when attending 12 physicians write an interpretation, I think this patient 13 has blank and this is what I'm going to do about it, and 14 may not write anything more detailed than that. For 15 obvious reasons, that's -- for the problems that we're 16 having now, that's sometimes tough to deal with. It's 17 tough to go back and look two years later and find out 18 what did you really do and what did you really think. 19 Q. Well, it's actually a pretty simple question. 20 You as a surgeon and an expert are supposed to be able 21 to comment on the standard of care applicable to the 22 surgeon, so I just want to know if a surgeon fails to 23 document a physical examination in a situation such as 24 this, is that below the standard of care? 25 MR. DRAKE: Objection. Vague.</p>

<p style="text-align: right;">Page 91</p> <p>1 THE WITNESS: I suppose that the standard of care 2 would involve adequate documentation. 3 BY MR. NEWHALL: 4 Q. Okay. Would that also be true of a physician 5 of any type? 6 MR. DRAKE: Objection. Lacks foundation, vague. 7 THE WITNESS: Yes, I suppose so. 8 BY MR. NEWHALL: 9 Q. If an earlier diagnosis of intra-abdominal 10 viscus perforation — that's an ontology — of 11 perforated viscus had been made on Lucy MacLeod earlier 12 than November 9, you've indicated that surgery is the 13 only choice in such a situation, I believe; is that 14 correct? 15 A. I think so. 16 Q. If an earlier diagnosis had been made, would 17 surgery done at the time of that earlier diagnosis 18 likely have made a difference in her hospital course? 19 MR. DRAKE: Objection. Vague. 20 MR. NEWHALL: And, yes, again this is one of those 21 likely/not likely type questions, no certain answer can 22 be ascertained, I'm sure. 23 THE WITNESS: It's very difficult to say. I would 24 say the longer you wait, probably the worse the chance 25 of complications in general.</p>	<p style="text-align: right;">Page 93</p> <p>1 is unlikely to become inflamed? 2 A. No, I don't think that's generally true. I 3 think one can get acalculous cholecystitis in the 4 absence of an obstructive stone. 5 Q. Well, the question was a likely and unlikely. 6 In the absence of an obstructing stone, is the 7 gallbladder likely to become inflamed? 8 A. It depends upon the clinical scenario. For a 9 outpatient, less likely; for somebody who's a patient in 10 the ICU, for example, and has been hypotensive, it's 11 actually quite likely. 12 Q. Yes, I'm just referring to the, you know, 13 normal person walking down the street pretty much. 14 A. Acalculous cholecystitis is in the absence of a 15 stone or, again, cholecystitis in the absence of a stone 16 is less likely than in other circumstances. 17 Q. In fact, it's very unlikely, is it not? 18 MR. FISHLER: Objection. Vague and ambiguous. 19 THE WITNESS: Relatively unlikely. 20 BY MR. NEWHALL: 21 Q. And in the absence of cardiac disease and 22 diabetes, it's nearly unheard of, is it not, in a person 23 walking around on the street? 24 A. In an otherwise healthy person, that's probably 25 true. As we've kind of said all along, it sort of</p>
<p style="text-align: right;">Page 92</p> <p>1 BY MR. NEWHALL: 2 Q. Okay. 3 A. Would it have been different, I don't know. 4 Q. No, I don't ask you to know. I'm just asking 5 for a probability one way or the other, if you can say. 6 MR. DRAKE: Same objections. 7 MR. FISHLER: If you can, give him only probability. 8 MR. NEWHALL: Yes. 9 THE WITNESS: As I said, the longer you wait, I 10 think potentially the worse the complications in 11 general. 12 BY MR. NEWHALL: 13 Q. Okay. Do you agree that in someone who has 14 intra-abdominal surgery and bowel obstruction from 15 adhesions that the more subsequent abdominal surgeries 16 they have, the more likely they are to develop bowel 17 obstruction later? 18 MR. DRAKE: Objection. Vague, speculation. 19 THE WITNESS: I think that is true. 20 BY MR. NEWHALL: 21 Q. Okay. 22 A. Adhesions tend to beget adhesions so-to-speak, 23 so the more you have, the more you're going to get. 24 Q. Do you agree that in the absence of obstruction 25 of a gallbladder, a gallbladder now, that a gallbladder</p>	<p style="text-align: right;">Page 94</p> <p>1 repeatedly mentions the chronic acalculous 2 cholecystitis. As I've said, that's not a specific 3 diagnosis. It just may be that the physician says that 4 kind of in reference to chronic gallbladder problems or 5 pain could well have those problems without specifically 6 having them be chronic acalculous cholecystitis. 7 Q. Does the presence of a midline abdominal scar 8 and previous small bowel obstruction increase the 9 incidence of perforated bowel with laparoscopic 10 cholecystectomy? 11 A. I would say yes, it probably does. I can't 12 quote you the numbers. 13 Q. In the event that a patient has lower midline 14 incision and previous abdominal surgery and small bowel 15 obstruction in their past history, I think you've 16 testified that an open procedure with hemostats on the 17 sides of the fascia to look in the abdomen was your 18 procedure of choice; is that right? 19 A. Hassan type open procedure, yes. 20 Q. Yeah. If one does that procedure but omits the 21 step in which the hemostats are applied to the fascia 22 and the fascia's elevated, is that a — is that 23 something that you would do in your practice? 24 A. I would want to elevate the fascia in some way, 25 whether grabbing it by hemostats or putting in a heavy</p>

EXHIBIT D

1 lower right-hand corner and page 11 is the
2 beginning of progress notes and the first section
3 are the physicians orders. Let me just ask you
4 generally first, do you recall how it was that you
5 became involved in Mrs. MacLeod's care?

6 A. Yes. I was called that day. The
7 surgeons involved were concerned about her sugars
8 mostly and I was called for that and when I came to
9 see her there were other problems I had to take
10 care of as well.

11 Q. And which surgeons contacted you with
12 respect to consulting on her care?

13 A. I don't remember who the surgeon was. I
14 remember Dr. Fullmer helping take care of her but
15 other than that, I don't remember exactly but I
16 think it was -- let me refer to -- I mentioned in
17 my admission note the patient was admitted by
18 Dr. Kohler.

19 Q. You're referring to a typewritten note
20 in the exhibit on pages 18 and 19?

21 A. Let me see. Yeah.

22 Q. Okay. So as to whether it was
23 Dr. Kohler or Dr. Fullmer that asked you to
24 consult, you don't recall.

25 A. I don't recall.

1 remember more of the medical details than -- or
2 some of the medical details.

3 Q. Looking at your typewritten note of
4 November 13th, which is pages 18 and 19 of the
5 exhibit-- you're welcome to look on whichever copy
6 you want. You have duplicates in front of you and
7 that's fine. With respect to the history of
8 present illness, where did you obtain that
9 information? Was that from the patient, from
10 Dr. Kohler, Dr. Fullmer, from the chart or some
11 other source?

12 A. Mostly it was obtained from the patient
13 and from the notes. Dr. Kohler, Dr. Fullmer were
14 not there at the time of my seeing her.

15 Q. Okay. And as to Mrs. MacLeod's care
16 prior to your involvement on November 13th of 1998,
17 I take it any information you have about that care
18 would have been through the records or through
19 conversations with the patient or her surgeons and
20 not from any direct involvement.

21 A. Prior to that, no.

22 Q. Okay. Were any portions of your
23 physical examination significant with respect to
24 the purpose for which you were asked to consult on
25 this patient?

1 Q. And it's your recollection, if I'm
2 understanding you correct, that the purpose for
3 your initial consultation was with respect to
4 Mrs. MacLeod's blood sugars.

5 A. Yes.

6 Q. Was it your understanding that her blood
7 sugars were elevated or low?

8 A. They were having troubles controlling
9 her sugars, at first high and then low.

10 Q. And at the time you were first consulted
11 would that have been on November 13, 1998?

12 A. Yes.

13 Q. And at that time were Mrs. MacLeod's
14 blood sugars too high or too low?

15 A. Too low.

16 Q. Okay. Do you recall meeting with Lucy
17 MacLeod and performing a history and physical
18 examination?

19 A. Yes.

20 Q. Okay. As you sit here today do you
21 recall the patient? Can you visualize what she
22 looked like?

23 A. I can't visualize her face or what she
24 looked like. I remember she was elderly. Other
25 than that, I can't remember too much more. I

1 A. I'm not sure I understand that question.
2 You're saying was the physical exam significant
3 regarding her sugars?

4 Q. Correct.

5 A. There wasn't -- there's nothing much on
6 exam you see when someone's been sugar resuscitated
7 so --

8 Q. From an internal medicine standpoint,
9 were there any findings in your physical
10 examination that were of concern to you?

11 A. On physical examination?

12 Q. Correct.

13 A. She had a murmur and swelling in her
14 legs as well as in her sacral area.

15 Q. And why would that information be
16 significant to you?

17 A. Because of the patient's abdominal
18 problems and inability to take food. She was on IV
19 fluids with D5 for nutrition and because of the
20 fluids, her fluid status had become elevated so
21 that she was beginning to retain fluid and that's
22 one of the other things I addressed in my consult.

23 Q. Okay. To your knowledge, for what
24 period of time had Mrs. MacLeod been NPO prior to
25 your seeing her on the 13th of November?

<p style="text-align: right;">Page 10</p> <p>1 A. She had only been in the hospital, again 2 just referring to notes, it appears three days or 3 so but she had been discharged from the hospital 4 previously and wasn't eating much at home either 5 and so I think in my dictated text I say here she's 6 been NPO for almost a week. 7 Q. Okay. And you indicated that at the 8 time you first consulted, her blood sugars were on 9 the low side. 10 A. Uh-huh. 11 Q. Okay. And do you have any information 12 as to why her blood sugars were low at the time of 13 your first visit? 14 A. Her blood sugars were low because of the 15 insulin they were using. Its scale was a little 16 too high and it caused her sugars to go low. 17 Q. Do you know why she was on insulin? 18 A. She was on insulin because of the high 19 sugar she was having. 20 Q. Okay. Was Mrs. MacLeod on TPN at the 21 time of your first consultation? 22 A. No. 23 Q. Did you have any involvement in 24 adjusting the insulin that she was getting? 25 A. I did.</p>	<p style="text-align: right;">Page 12</p> <p>1 with respect to her nutrition. You indicate that 2 her albumen is low and total protein is low. Of 3 what significance were those findings? 4 A. The significance of low protein in a 5 surgical patient is the difficulty with healing 6 and so we started the TPN to try to increase her 7 protein stores and increase her ability to heal. 8 Q. And were you involved in writing the 9 initial TPN orders? 10 A. I did. 11 Q. And did you continue throughout your 12 involvement during her hospital stay to monitor and 13 write the TPN orders? 14 A. I did. 15 Q. Okay. I don't think I was the only one 16 who wrote them. I had a partner cover for me for 17 the weekend and things but -- 18 Q. Would that have been Dr. Day? 19 A. I believe it was. Again I don't have 20 those notes here. 21 Q. Our records seem to reflect that. But 22 as far as you know, it was you or Dr. Day or some 23 other colleague of yours -- 24 A. I believe so. 25 Q. -- that monitored the TPN and wrote the</p>
<p style="text-align: right;">Page 11</p> <p>1 Q. And I take it that you adjusted the 2 insulin at the time of your first consultation in 3 order to try to bring her blood sugars back to a 4 normal range. 5 A. I did. 6 Q. Do you know if other than some transient 7 low blood sugars whether Mrs. MacLeod suffered any 8 permanent effects from whatever low blood sugar she 9 might have had prior to your consultation? 10 A. Again I don't have all the orders here 11 but I believe she was sugar resuscitated, so it 12 wasn't for a long period of time she was 13 hyperglycemic. And so having never met her before, 14 I don't remember she was -- as the hospital course 15 went on she was able to speak to me. She wasn't 16 delirious. She was able to tell me what was going 17 on, as I recall. 18 Q. When you first met with her on the 13th 19 of November, do you recall what her level of 20 consciousness was, whether she was alert and able 21 to provide a history to you? 22 A. As I recall, she was alert but sort of 23 lethargic and feeling poorly. 24 Q. Okay. Now you refer on the second page 25 of your typewritten note under item number three</p>	<p style="text-align: right;">Page 13</p> <p>1 orders for TPN. Is that yes? 2 A. I believe so. 3 Q. Okay. Did you have any indication at 4 the time of your first consultation as to how long 5 Mrs. MacLeod would have required TPN? 6 A. No. No. At that point she'd been a 7 week without food and didn't know exactly how long 8 this was going to go on. 9 Q. You indicated the second-to-last 10 sentence on your dictated note, "As her bowels 11 resolve, we will wean off TPN as soon as possible." 12 A. Uh-huh. 13 Q. Tell me what you meant by that. 14 A. We were hoping that her intestines were 15 able to heal and be able to take food. We try to 16 get people on food as quickly as possible and off 17 TPN as quickly as we can, too. 18 Q. Are there risks associated with TPN 19 administration? 20 A. There are. 21 Q. What are those? 22 A. Most often you'll see an elevation of 23 liver enzymes. It's usually reversible when the 24 TPN is taken off. I've had experience through 25 residency with people who are short gut syndrome</p>

<p style="text-align: right;">Page 18</p> <p>1 A. At this point -- let me see here. Let 2 me refer to her TPN orders. I don't see the date. 3 Q. If I look at the physicians orders maybe 4 this will help. On pages 4 and 5 there's an 5 11-17-98 order that indicates TPN orders. There's 6 also an order on the next day, the 18th, that 7 indicates TPN orders. 8 A. Yes. 9 Q. And then it's not until the 19th that 10 the order indicates TPN held. 11 A. Yes. 12 Q. So at least from what we can see in the 13 records on 11-17-98, would that suggest that 14 Mrs. MacLeod is still getting TPN? 15 A. Yes. 16 Q. But being allowed to eat in addition. 17 A. Yes. 18 Q. Okay. And I suppose at some point in 19 time when she was eating and drinking sufficiently, 20 the TPN would be weaned and subsequently 21 discontinued? 22 A. Exactly. 23 Q. Did you have the decision making role in 24 making that determination? 25 A. I believe I was the one who ordered the</p>	<p style="text-align: right;">Page 20</p> <p>1 Q. Okay. Number four, is that PTX? 2 A. Yes. 3 Q. For pneumothorax? 4 A. Pneumothorax, yes. 5 Q. Do you know how Mrs. MacLeod developed a 6 pneumothorax? 7 A. I believe that happened over the weekend 8 and again we don't have the notes here from that 9 but I believe they were placing a central line and 10 she developed a pneumothorax secondary to the 11 central line. 12 Q. I take it that you weren't participating 13 in any way in placement of the central line. 14 A. No. 15 Q. Do you know if placement of the central 16 line was necessitated for the TPN? 17 A. Central line is required for TPN. 18 Q. Do you know if she would have required a 19 central line in the absence of needing it for TPN? 20 A. I don't. 21 Q. Okay. And at the time of your 22 evaluation on the 17th of November, how did you 23 determine that the pneumothorax was stable? 24 A. Her saturations and oxygen were good. 25 She wasn't complaining of shortness of breath or</p>
<p style="text-align: right;">Page 19</p> <p>1 TPN to be stopped. 2 Q. Okay. Thank you. So looking again on 3 page 13, just so I can understand your writing, 4 assessment, is that DM again? 5 A. Uh-huh. 6 Q. Okay. Not requiring insulin? 7 A. Uh-huh. 8 Q. Okay. Do you know if -- did you order a 9 sliding scale insulin -- 10 A. Yes. 11 Q. -- in addition to the insulin that was 12 in the TPN? 13 A. Originally we used a low level sliding 14 scale insulin and then we added it to the TPN and 15 the sliding scale was continued to be used as 16 needed but it became less and less required. 17 Q. Okay. Looking at number three, does 18 that say fluid even now? 19 A. Uh-huh. 20 Q. Continue PO? 21 A. Yes. 22 Q. Okay. So insofar as retaining excess 23 fluid it appears that she wasn't, at least as of 24 the time of this examination. 25 A. Exactly.</p>	<p style="text-align: right;">Page 21</p> <p>1 having problems in any way regarding her breathing 2 and in addition, I put arrow pulmonary. My 3 intention there is to say this is being followed by 4 the pulmonologists. 5 Q. Okay. Do you know who the pulmonologist 6 was that was following her pneumothorax? 7 A. I don't. 8 Q. Okay. Do you have any indication that 9 Mrs. MacLeod suffered any permanent effects from 10 having developed a pneumothorax during this 11 hospitalization? 12 A. My recollection is she didn't have any 13 sequelae from the pneumothorax. It never became 14 much more of a problem after that. 15 Q. Okay. And is it your understanding that 16 that pneumothorax ultimately resolved and her lung 17 reexpanded? 18 A. That's my understanding. 19 Q. Okay. Number five, you refer to an 20 increased white blood count. You've got question 21 mark, CDIF. What does it say after that? 22 A. Check stools for toxin and culture if 23 she has lots of stools. And then I say the rest 24 should be covered by imipenem, which was the 25 antibiotic she was on.</p>

6 (Pages 18 to 21)

Cornea deposition

<p style="text-align: right;">Page 22</p> <p>1 Q. Okay.</p> <p>2 A. Meaning any other infection she may have</p> <p>3 would be covered by imipenem.</p> <p>4 Q. Do you have any understanding as to</p> <p>5 whether any stool cultures came back positive for</p> <p>6 CDIF?</p> <p>7 A. My recollection is she never had large</p> <p>8 amounts of stool so we never had to check for CDIF</p> <p>9 and her white count started to come down and her</p> <p>10 abdomen improved.</p> <p>11 Q. What do you mean by her abdomen</p> <p>12 improved?</p> <p>13 A. She was able to take food. Her</p> <p>14 abdominal pain improved. She was weaned off TPN.</p> <p>15 She was tolerating PO intake well.</p> <p>16 Q. You indicated earlier that when you were</p> <p>17 first asked to consult, you consulted with respect</p> <p>18 to Mrs. MacLeod's blood sugars and then there were</p> <p>19 other matters that you took under your care.</p> <p>20 Anything in addition to what we're talking about</p> <p>21 now as far as what your role was with respect to</p> <p>22 her care?</p> <p>23 A. I'm not sure if I understand that</p> <p>24 question.</p> <p>25 Q. Do you recall in particular any of the</p>	<p style="text-align: right;">Page 24</p> <p>1 morning but the morning of the 19th they came up to</p> <p>2 133 so --</p> <p>3 Q. And that would be a finding that would</p> <p>4 be accepted?</p> <p>5 A. Improvement.</p> <p>6 Q. Okay. Other than the weekend, you've</p> <p>7 mentioned that there was a weekend that one of your</p> <p>8 colleagues would have covered for you. Would you</p> <p>9 have gone in to see Mrs. MacLeod daily from the</p> <p>10 13th until the last day of your involvement?</p> <p>11 A. I believe so.</p> <p>12 Q. Okay. And we'll get to that in just a</p> <p>13 minute then. Looking to the next page, 15, is that</p> <p>14 your note at the top of the page?</p> <p>15 A. Yes.</p> <p>16 Q. Okay. Over in the right side of the</p> <p>17 page there is some writing with a circle around it</p> <p>18 and then an arrow, refer to surgery. Tell me what</p> <p>19 that says and what the significance of that is.</p> <p>20 A. The white count continued to stay up at</p> <p>21 this point. The patient was on Primaxin, which</p> <p>22 covers a large amount of antibiotic or a large</p> <p>23 amount of infections. I wasn't sure why the white</p> <p>24 count wasn't going down and so the differential</p> <p>25 included a possible abscess.</p>
<p style="text-align: right;">Page 23</p> <p>1 other issues that you were specifically addressing</p> <p>2 with regard to this patient as opposed to the</p> <p>3 pulmonologists or the surgeons?</p> <p>4 A. No. I helped to take care of her</p> <p>5 sugars, her nutrition status, her fluid status and</p> <p>6 that was essentially it.</p> <p>7 Q. Okay. Turning to the next page, is that</p> <p>8 your note on the top of the page next to the 1-18?</p> <p>9 A. Yes.</p> <p>10 Q. And looking at your assessment and plan,</p> <p>11 were there any findings that were of concern or was</p> <p>12 Mrs. MacLeod continuing on a course that you</p> <p>13 considered to be an appropriate --</p> <p>14 A. Seems like they were improving. Sugars</p> <p>15 were improved. She was increasing her intake. She</p> <p>16 was fluid negative. She just looked improved.</p> <p>17 Q. You've got a reference next to number</p> <p>18 four; is that low sodium?</p> <p>19 A. Low sodium.</p> <p>20 Q. Recheck.</p> <p>21 A. Recheck.</p> <p>22 Q. Okay. Do you have any indication as to</p> <p>23 what her sodium level was on that date and what the</p> <p>24 recheck showed?</p> <p>25 A. I don't. The labs were pending that</p>	<p style="text-align: right;">Page 25</p> <p>1 At that point I suggested with the white</p> <p>2 count being up there was elevated alkaline</p> <p>3 phosphatase, a liver enzyme, that we could do an</p> <p>4 ultrasound versus a CAT scan versus a white blood</p> <p>5 cell scan. I deferred to surgery as I was</p> <p>6 primarily taking care of her sugars, nutrition and</p> <p>7 her fluid status and thus I suggested rather than</p> <p>8 ordered those tests.</p> <p>9 Q. Okay. Do you recall if you suggested</p> <p>10 directly to Dr. Fullmer or Dr. Kohler doing a white</p> <p>11 cell scan or ultrasound or CT or if you made your</p> <p>12 note and anticipated that they would review your</p> <p>13 note?</p> <p>14 A. I did that. I anticipated they would</p> <p>15 read my note.</p> <p>16 Q. Okay. Do you know if an abscess was</p> <p>17 ever found sometime on or after this date?</p> <p>18 A. Not that I'm aware of, no.</p> <p>19 Q. Okay.</p> <p>20 A. 11-19 Dr. Kohler refers, says the</p> <p>21 abscess seems unlikely, so it appears he got my</p> <p>22 message.</p> <p>23 Q. Okay. And other than the increased</p> <p>24 white count on the 19th, does Mrs. MacLeod's course</p> <p>25 with respect to your involvement appear to be</p>

7 (Pages 22 to 25)

Corneia deposition