

1995

Judith Nester v. Pioneer Valley Hospital,
Department of Radiology at Pioneer Valley
Hospital, and John/Jane Does 10/-10 : Brief of
Appellee

Utah Court of Appeals

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IN THE COURT OF APPEALS
IN AND FOR THE STATE OF UTAH

JUDITH NESTER,
Plaintiff/Appellant,

vs.

PIONEER VALLEY HOSPITAL,
DEPARTMENT OF RADIOLOGY AT
PIONEER VALLEY HOSPITAL, and
JOHN/JANE DOES 10\ -10, ABC
CORPORATION,

Defendants/Appellees.

95-0127-24

Case No.: 94-0488
Priority No. 15

BRIEF OF APPELLEE

APPEAL FROM THE FINAL JUDGMENT OF
THE THIRD JUDICIAL DISTRICT COURT
IN AND FOR SALT LAKE COUNTY, STATE OF UTAH
CIVIL NO. 93-090-0506MP
THE HONORABLE J. DENNIS FREDERICK, PRESIDING

UTAH COURT OF APPEALS
CLERK

DOCKET NO. 940488

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IN AND FOR THE STATE OF UTAH

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JURISDICTION

The Court of Appeals has jurisdiction over this appeal by virtue of the Order of the Supreme Court of Utah dated February 16, 1995, and Utah Code Ann. § 78-2a-3(2)(k) (1993 Cum. Sup.).

STATEMENT OF ISSUES AND STANDARDS OF APPELLATE REVIEW

Appellee, Pioneer Valley Hospital, submits the following issues to be determined on appeal:

A. As to Ms. Nester's medical negligence claim, did the trial court properly enter summary judgment when Ms. Nester failed to produce any expert testimony regarding the performance of three-phase bone scans using the isotope Tc99m?

The standard of review for this issue is that applicable to questions of law. See Utah R. Civ. P. 56; Durham v. Margetts, 571 P.2d 1332 (Utah 1977); Briggs v. Holcomb, 740 P.2d 281 (Utah App. 1987). See also Bonham v. Morgan, 788 P.2d 497 (Utah 1989).

B. As to Ms. Nester's informed consent claim, did the trial court properly enter summary judgment because Ms. Nester failed to produce expert testimony regarding three-phase bone scans using the isotope Tc99m?

The standard of review for this question is that applicable to questions of law. See Utah R. Civ. P. 56; Durham v. Margetts, 571 P.2d 1332 (Utah 1977); Briggs v. Holcomb, 740 P.2d 281 (Utah App. 1987). See also Bonham v. Morgan, 788 P.2d 497 (Utah 1989).

C. As to Ms. Nester's res ipsa loquitur claim, did the trial court properly enter summary judgment because Ms. Nester failed to produce any expert testimony regarding three-phase bone scans using the isotope Tc99m?

The standard of review for this question is that applicable to questions of law. Utah R. Civ. P. 56; Durham v. Margetts, 571 P.2d 1332 (Utah 1977); Briggs v. Holcomb, 740 P.2d 281 (Utah App. 1987). See also Bonham v. Morgan, 788 P.2d 497 (Utah 1989).

DETERMINATIVE STATUTES AND RULES

The following statute is determinative on the informed consent issue.

Utah Code Ann. § 78-14-5. Failure to obtain informed consent -- Proof required of patient -- Defenses -- consent to health care.

(1) When a person submits to health care rendered by a health care provider it shall be presumed that what the health care provider did was either expressly or impliedly authorized to be done. For a patient to recover damages from a health care provider in an action based upon the provider's failure to obtain informed consent, the patient must prove the following:

(a) That a provider-patient relationship existed between the patient and health care provider; and

(b) The health care provider rendered health care to the patient; and

(c) The patient suffered personal injuries arising out of the health care rendered; and

(d) The health care rendered carried with it a substantial and significant risk of causing the patient serious harm; and

(e) The patient was not informed of the substantial and significant risk; and

(f) A reasonable, prudent person in the patient's position would not have consented to the health care rendered after having been fully informed as to all facts relevant to the decision to give consent. In determining what a reasonable, prudent person in the patient's position would do under the circumstances, the finder of fact shall use the viewpoint of the patient before health care was provided and before the occurrence of any personal injuries alleged to have arisen from said health care; and

(g) The unauthorized part of the health care rendered was the proximate cause of personal injuries suffered by the patient. (Emphasis added.)

(See Addendum A.)

The medical negligence and res ipsa loquitur claims are governed by Utah R. Civ. P. 56. (See Addenda A and B to Brief of Appellant.)

STATEMENT OF THE CASE

Nature of the Case.

This appeal arises from a grant of summary judgment in favor of the defendant Pioneer Valley Hospital. The plaintiff, Ms. Nester, claimed personal injuries arising from a three-phase bone scan performed on her at Pioneer Valley Hospital during which approximately 1.04 ccs of isotope Tc99m was injected into her left arm along with approximately 2 ccs of saline solution.

Course of Proceedings and Disposition Below.

Ms. Nester filed her Complaint on January 28, 1993. Approximately one year and four months later, plaintiff filed her

"Certification of Readiness for Trial," specifically stating that "counsel has completed all discovery."

After she had certified readiness for trial, the Court held a scheduling conference on June 2, 1994, at which time the case was set for a two-day non-jury trial on September 13, 1994. (R. 43, ¶¶ 1-3.)

Thereafter, on July 5, 1994, Ms. Nester filed her initial designation of witnesses, listing Dr. LaVerne S. Erickson (a neurosurgeon) and Dr. Craig D. Campbell (a chiropractor) as the only intended witnesses with any medical background at all. (R. 45-46.)

Thereafter, Pioneer Valley Hospital filed a Motion for Summary Judgment on July 21, 1994 (see R. 59-73), which motion the Court granted by minute entry dated 8-18-94, and by a formal "Summary Judgment" dated September 2, 1994. (R. 114-118.)

Ms. Nester also failed to timely file any memorandum in opposition to Pioneer Valley Hospital's Motion for Summary Judgment, and failed to contest any facts either by affidavit, or by stating a contrary version of facts in her memorandum. The hospital served its Motion for Summary Judgment on Ms. Nester's counsel by mail on July 20, 1994. (R. 59, 61.) Ms. Nester moved for enlargement of time on July 28, 1994, but there is no record that this motion was granted by the Court. (R. 88-89.) Therefore, on August 4, 1994, the hospital filed a notice to submit its Motion for Summary Judgment for decision. (R. 94-95.) Ms. Nester filed a second motion for enlargement of time on

August 8, 1994, but again there is no record that the Court granted this motion--and indeed, no extension of time was ever granted to Ms. Nester by the Court. (R. 96.) Finally, on August 15, 1994, Ms. Nester hand-delivered her Memorandum in Opposition (styled "Plaintiff's Answer to Defendant's Motion for Summary Judgment") to the hospital's counsel. The hospital filed its Reply Memorandum on August 17, 1994, and the judge ruled on the Motion for Summary Judgment the next day (without hearing oral argument, since trial was scheduled to begin in less than thirty days--on September 13, 1994.) (R. 43 ¶ 1; R. 114.)

Ms. Nester thereafter timely appealed. (R. 123.)

Statement of Facts.

The following facts were never disputed at the trial court level, and are the uncontroverted facts for purposes of appeal. (See R. 102--Plaintiff's Answer to Defendant's Motion for Summary Judgment, containing no contradictory statement of facts or opposing affidavits):

1. Dr. Mark Greene prepared a prescription order, dated January 29, 1991, ordering a "3-phase bone scan" for Ms. Nester. (R. 84 ¶ 9.) Mr. John Edward Bratke performed the isotope bone scan on Ms. Nester at Pioneer Valley Hospital on January 30, 1991. (R. 84 ¶ 9.)

2. When Ms. Nester reported to the radiology department for her test, Mr. Bratke asked her if she was either pregnant or breast feeding, which she denied. (R. 84, ¶ 10.)

3. Mr. Bratke prepared the patient and injected approximately 1.04 ccs of the isotope, 25.3 mCi of Tc99m tagged 2MMA, into the left arm, with approximately 2 ccs or less of saline as a flush. (R. 84, ¶ 11.)

4. Ms. Nester was instructed to drink large amounts of liquid to clear out the isotope from the soft tissue and to return in two and one half to three hours in order to complete the bone scan, since the isotope needs to be absorbed into the bones over that period of time. (R. 85, ¶ 15.)

5. As of January 30, 1991, Mr. Bratke had been director of Nuclear Medicine at Lakeview Hospital since 1977, and had been chief technologist for nuclear medicine at Pioneer Valley Hospital since 1985; he was (and is) a board-certified nuclear medicine technologist (R. 82-83 ¶¶ 2, 3, 4, and 6.)

6. On April 25, 1994, Ms. Nester filed her Certification of Readiness for Trial, through her attorney, J. Douglas Kinaterder, certifying "that in his judgment, this case is ready for trial . . ." (R. 64, ¶ 3.)

7. Ms. Nester's attorney stated, in support of such certification, inter alia:

2. That counsel has completed all discovery, that opposing counsel have had reasonable time to pursue discovery; and that all discovery of record has been completed.

3. That if medical testimony is contemplated or required, copies of all existing medical reports have been made available to all counsel or parties or [sic] record.

(R. 64, ¶ 4.)

8. Pursuant to the Scheduling Order and Trial Notice issued by the trial court on June 2, 1994, Ms. Nester was required to file its witness/exhibit list by July 5, 1994. (R. 64, ¶ 5.)

9. She sent by facsimile transmission plaintiff's initial designation of witnesses and list of exhibits, dated July 5, 1994. (R. 65, ¶ 6.)

10. She has failed to name an expert nuclear medicine technologist who is qualified or competent to testify that Pioneer Valley Hospital was negligent as alleged. (R. 65, ¶ 7.)

11. The hospital's Motion for Summary Judgment was supported by the affidavit of John Edward Bratke, an expert nuclear medicine technologist, to the effect that the appropriate standard of care was not breached in this case. This affidavit was never refuted. (R. 65, ¶ 8; R. 82-87; R. 102-104.)

SUMMARY OF ARGUMENT

Point I. The district court's grant of summary judgment is at issue in this case. The appellate court reviews a grant of summary judgment applying the same standard as the trial court. Since summary judgment determines, by definition, only questions of law, the appellate court reviews the trial court's determination of law for correctness.

Point II. The law of Utah consistently holds that, in a medical malpractice cause of action, plaintiff must establish a prima facie case of negligence (standard of care, breach of that standard, and proximate causation) by expert testimony. Utah law

has consistently held that on summary judgment, a defendant's motion for summary judgment, if supported by an expert affidavit, will be granted unless a plaintiff comes forward with the affidavit of an expert alleging specific facts to support the disputed elements of the prima facie case. In this case, contrary to Utah law, Ms. Nester has failed to produce any affidavit of any expert to contradict the hospital's properly supported motion for summary judgment.

The general rule under Utah law is that plaintiff must come forward, at summary judgment, with the affidavit of an expert in the same specialty as the defendant physician. There is an exception to this rule if plaintiff lays the foundation that plaintiff's expert is knowledgeable in and familiar with the standard of care in defendant's medical specialty. In this case, Ms. Nester failed to produce any affidavit whatsoever, let alone an affidavit establishing that her expert was familiar with the standard of care in the defendant's field of practice.

Ms. Nester's request that she be allowed to establish her expert's foundation at trial rather than on summary judgment is contrary to Utah law. Utah cases have consistently upheld a grant of summary judgment against a plaintiff who fails to produce an adequate foundation at the summary judgment stage, through the affidavit of an expert, when defendant's motion is properly supported by the affidavit of an expert.

Point III. To make out a claim for lack of informed consent against a medical practitioner, a plaintiff must prove

all of the elements of the informed consent statute, U.C.A. § 78-14-5(1)(a)-(g). A plaintiff must produce expert testimony to support an informed consent claim to establish the materiality of the risks of which the patient was or was not informed. In this case, Ms. Nester failed to produce any expert testimony, by affidavit or otherwise, addressing the materiality of the risks of which she was or was not informed.

Point IV. Under Utah law, mere invocation of the doctrine of res ipsa loquitur is not sufficient to avoid summary judgment. In claims for medical malpractice, an undesired result produced by a medical procedure might appear to a lay person to be caused by negligence, when in fact no negligence occurred. Thus, expert testimony is almost always necessary to establish the foundation for a legitimate res ipsa loquitur inference. When the health care rendered lies within the knowledge of experts, expert testimony is necessary to establish the incident was more likely than not caused by negligence. In rare cases, as when a foreign object such as a sponge or needle is left in the body, the negligence is obvious to a lay person so that no expert testimony is required. However, a complaint of pain during performance of a three-phase bone scan, accompanied by injections of radioactive isotopes, is not obviously negligent. Injections hurt, and it takes an expert to say whether the pain was more than expected, or not.

Point V. Ms. Nester's "Answer to Defendant's Motion for Summary Judgment" was also deficient on procedural grounds:

it was not timely, and it contained no affidavit or specific facts to contradict the affidavit produced in the hospital's motion for summary judgment. When confronted by the hospital's motion for summary judgment, which was properly supported by affidavit, Ms. Nester was not allowed to rest on the mere allegations of her Complaint, but was required to come forward with specific facts. This she failed to do.

ARGUMENT

POINT I

STANDARD OF REVIEW

In reviewing a grant of summary judgment, the appellate court applies the same standard as that applied by the trial court. Durham v. Margetts, 571 P.2d 1332 (Utah 1977); Briggs v. Holcomb, 740 P.2d 281 (Utah App. 1987). Inasmuch as a challenge to summary judgment presents for review conclusions of law only, because by definition summary judgment does not resolve factual issues, the appellate court reviews those conclusions for correctness. Bonham v. Morgan, 788 P.2d 497 (Utah 1989).

POINT II

AS TO MS. NESTER'S MEDICAL NEGLIGENCE CLAIM, THE TRIAL COURT'S ENTRY OF SUMMARY JUDGMENT WAS PROPER BECAUSE SHE FAILED TO PRODUCE THE AFFIDAVIT OF ANY EXPERT.

A. The *Burton v. Youngblood* Case Does Not Require the Court To Wait Until The Close of Evidence To Enter Summary Judgment.

The sole authority on which Ms. Nester relies for this point is Burton v. Youngblood, 711 P.2d 245 (Utah 1985).

However, she misreads this case. The passage of dicta which she cites speculating about what would have happened "had Burton's counsel laid adequate foundation" says nothing about when such foundation must be laid. 711 P.2d at 247. Although the Burton case did not involve a summary judgment, it did involve a dismissal of plaintiff's claim as a matter of law, and that dismissal was affirmed on appeal as a matter of law. Since summary judgment also determines questions of law, the same rule holds true in Ms. Nester's case, and summary judgment should be affirmed because she in fact did not present an adequate foundation, nor indeed any foundation at all, for her claim of medical negligence.

Moreover, many other cases under Utah law have affirmed grants of summary judgment for failure to produce an adequate expert affidavit at a pretrial summary judgment motion. See Hunt v. Hurst, 785 P.2d 414, 416 (Utah 1990) (affirming a motion for summary judgment granted by Judge J. Dennis Frederick); Martin v. Mott, 744 P.2d 337, 338 (Utah App. 1987) (the Court of Appeals, per Judge Bench, affirmed the grant of summary judgment); Hoopiiaina v. Intermountain Health Care, 740 P.2d 270, 271 (Utah App. 1987) (the Court, per Judge Greenwood, affirmed the grant of summary judgment); Robinson v. Intermountain Health Care, 740 P.2d 262, 264 (Utah App. 1987) (the Court, per Judge Jackson, affirmed the grant of summary judgment).

B. In a Medical Malpractice Claim, A Plaintiff Must Establish Duty, Breach, And Proximate Cause By the Use of Expert Testimony.

The requirements for proving a medical malpractice cause of action are clearly established in the State of Utah. As noted by the Utah Supreme Court:

The general rule is that a person asserting a medical malpractice claim must prove (1) the standard of care required of physicians under similar circumstances practicing in the same field or specialty, (2) that the applicable standard of care was breached, (3) that the injury to the plaintiff was proximately caused by the defendant's negligence, and (4) that damages occurred as a result of defendant's breach of duty.

Dalley v. Utah Valley Regional Medical Center, 791 P.2d 193, 195 (Utah 1990) (citations omitted). See also Martin v. Mott, 744 P.2d 237, 338 (Utah App. 1987); Hoopiiaina v. Intermountain Health Care, 740 P.2d 270, 271 (Utah App. 1987); Robinson v. Intermountain Health Care, 740 P.2d 262, 264 (Utah App. 1987).

It is similarly well established that in medical malpractice cases, as a general rule, expert testimony is required to establish duty, breach, and causation. The Dalley court stated the rule as follows:

To establish the standard of care required of a physician in a particular field, breach of that standard, and proximate cause, the plaintiff is generally required to produce an expert witness who is acquainted with the standard of care in the same or a similar field as the defendant doctor.

791 P.2d at 195-96 (emphasis added). See also, Butterfield v. Okubo, 831 P.2d 97, 102 (Utah 1992); Nixdorf v. Hicken, 612 P.2d 348, 352 (Utah 1980); Chadwick v. Nielsen, 763 P.2d 817, 821 (Utah App. 1988); Martin, at 388; Hoopiiaina, at 721; Robinson,

at 264-53. Accord, Burton v. Youngblood, 711 P.2d 245 (Utah 1985); Anderson v. Nixon, 104 Utah 262, 139 P.2d 216 (1943); Edwards v. Clark, 96 Utah 121, 83 P.2d 1021 (1938); Baxter v. Snow, 78 Utah 217, 2 P.2d 57 (1931). Expert testimony is required because the complex, technical nature of modern medical science is outside "the common knowledge and experience of the layman." Nixdorf, at 352; Chadwick, at 821.

The only situation in which expert testimony is not required is when (as in the case of leaving a needle inside a surgery patient) the negligence is so obvious to a lay person that the doctrine of res ipsa loquitur applies. Dalley, at 196; Nixdorf, at 352; Chadwick, at 821; Martin, at 338; Robinson, at 264. (This issue is addressed in Point IV, infra.) In short, expert testimony is absolutely required in medical malpractice cases unless res ipsa loquitur is alleged; if res ipsa loquitur is alleged, expert testimony is still generally required to demonstrate that the incident more likely than not was a result of negligence. Nixdorf, at 352-53.

A party's failure to present expert medical testimony is fatal to the plaintiff's cause of action. See Chadwick v. Nielsen, 763 P.2d at 821.

Moreover, even if an expert affidavit is submitted, an affidavit which fails to counter or contradict the affidavit offered by the party moving for summary judgment is insufficient to avoid summary judgment. Arnold v. Curtis, 846 P.2d 1307, 1310 (Utah 1993) ("the affidavit [of plaintiff's expert] in no way

counters or contradicts the opinion of Dr. Johnson [defendant's expert affiant] that an earlier diagnosis . . . would not have permitted earlier treatment.")

The foregoing rule, from Arnold v. Curtis, is particularly important in this case. The undisputed testimony of defendant's expert is as follows:

19. On the basis of my personal knowledge and review of the applicable records described above, it is my opinion that my performance of the bone scan, including the injection of the isotope in question on Judith Nester on January 30, 1991, complied in all respects with the standard of professional care . . .

20. It is further my opinion that despite reasonable and prudent care on the part of a nuclear medical technologist injecting the small amount of isotopes in connection with the bone scans, extravasation of some of the substance outside of the vein can occur which can cause pain, bruising and some soreness in the region.

21. Despite that result, the risk of complication of a permanent nature is remote and not substantial and significant. Pain, soreness and bruising following the injection of this type does not indicate a breach of the standard of care or that the procedure was not properly performed. (Emphasis added.)

(R. 86.) Ms. Nester has alleged that she experienced pain immediately after the injection. However, injections are inherently painful, no matter how carefully performed. The injection of radioactive isotopes, and the procedures for conducting a three-phase bone scan, are not within the knowledge and experience of the normal lay person, and it would take an expert to say whether the facts alleged in this case amounted to negligence.

The only expert testimony of record in this case is the expert testimony that there was no breach of the standard of care, and that pain can result even if the procedure is done properly. Ms. Nester has provided no expert testimony which would contradict this opinion. Therefore, entry of summary judgment was proper.

C. The Expert Testimony Must Be From One Who Is Competent As An Expert In The Same Field As The Defendant.

Ms. Nester has framed the issues in her appeal very narrowly--namely, that summary judgment was improper merely because she did not provide the affidavit of a nuclear medicine technician. However, this obscures the larger fact that she provided no affidavit whatsoever to oppose the motion for summary judgment. In any event, lack of an affidavit from a nuclear medicine technician is still fatal to Ms. Nester's claim.

Summary judgment in favor of a medical malpractice defendant is appropriate where plaintiff fails to establish the standard of care and breach of that standard through an expert who is competent to testify concerning the standard of care applicable to defendant's medical specialty. In order to establish the competency of an expert witness, the plaintiff must show that the expert is a member of the defendant's particular medical specialty or school--or must demonstrate that the standard of care of the expert's different specialty is common to both specialties. See Burton v. Youngblood, 711 P.2d 245, 248 (Utah 1985); see also, Green v. Thomas, 662 P.2d 491, 493, (Colorado App. 1982) quoted in Martin v. Mott, 744 P.2d 337, 339

(Utah App. 1987) ("The party offering the witness must establish the witness' knowledge and familiarity with the standard of care and treatment commonly practiced by physicians engaged in the defendant's specialty.")

Attempts by plaintiff to defeat summary judgment by designating a medical doctor as an expert witness have proved unsuccessful where the expert is incompetent, as demonstrated by the facts of Martin v. Mott, supra.. In that case, the plaintiff designated a medical doctor as an expert witness relating to misdiagnosis by a podiatrist. Plaintiff's expert medical doctor testified that he was unfamiliar with the standard of care expected of podiatrists, but that in his opinion, if the defendant were a physician, he would consider him in violation of the standard of care. The Utah Court of Appeals found that the plaintiff "clearly failed to establish by expert testimony the standard of care applicable to podiatrists such as defendant." Because of this, plaintiff's expert "clearly was not competent to testify as to any breach of such standard," and summary judgment was affirmed. Id., 744 P.2d at 339.

The Utah Court of Appeals has recently reiterated this requirement. In the case of Dikeou v. Osborn, 881 P.2d 943 (Utah App. 1994), Judge Greenwood presented the opinion of a unanimous panel that an expert in the field of emergency room medicine was not competent to serve as an expert against a cardiologist. The court held as follows:

Therefore, as Dr. Bushnell's specialty is not the same as Dr. Osborn's, Dr. Bushnell must establish that

he was knowledgeable before being retained as an expert witness about the standard of care in Dr. Osborn's specialty of cardiology or that the standard of care for emergency room physicians is the same as cardiologists. Dr. Bushnell failed to establish in his affidavit that he had sufficient knowledge regarding the appropriate standard of care prior to his review of the documents. Furthermore, he has not established that the standard of care for emergency room physicians is the same as for cardiologists. Accordingly, we affirm the trial court's decision that summary judgment was appropriate in this case.

881 P.2d at 947-48. In summary, a physician from another specialty is not absolutely barred from serving as an expert, but the foundation must be laid before testimony is submitted. In this case, Ms. Nester never made any attempt to supply the trial court with the foundation necessary to avoid summary judgment.

D. In A Medical Malpractice Case, The Foundation For An Expert Affidavit Establishing The Standard of Care Must Be Provided At The Time of Summary Judgment.

Ms. Nester asserts, without the benefit of supporting authority, that she should be allowed to lay the foundation for an expert opinion at trial, rather than on summary judgment. This position is contrary to Utah law.

In the case of Martin v. Mott, 744 P.2d 337 (Utah App. 1987), Judge Bench delivered the opinion of a unanimous court affirming a grant of summary judgment for lack of proper foundation. In the Martin case, the plaintiff's allegation was very similar to the allegation made here--that her expert, a physician, was qualified to testify as an expert witness in all fields of medicine when certain types of procedures were at issue. The Court specifically rejected this analysis, holding:

To establish this foundation and thereby qualify a witness as an expert on the applicable standard of care "the party offering the witness must establish the witness's familiarity with the standard of care and treatment commonly practiced by physicians engaged in the defendant's specialty." . . . As plaintiff's evidence failed to raise a material issue of fact as to negligence, summary judgment was appropriate.

744 P.2d at 339.

The Utah Supreme Court has specifically noted that affidavits of experts are insufficient to defeat summary judgment unless foundational facts are set forth supporting their opinions and conclusions. King v. Searle Pharmaceutical, Inc., 832 P.2d 858, 864, n.2 (Utah 1992). The Utah Supreme Court stated that "the major purpose of summary judgment is 'to avoid unnecessary trial by allowing the parties to pierce the pleadings to determine whether there is a genuine issue to present to the fact-finder.'" King, 832 P.2 864 n.2. Other cases have also required the foundational facts for an expert opinion to be set forth at the time of summary judgment. See Butterfield v. Okubo, 831 P.2d 97, 104 (Utah 1992) (expert's affidavit must assert specific facts to support the expert's conclusion); Burton v. Youngblood, 711 P.2d at 248 (foundation must be shown to avoid dismissal); Robinson v. IHC, 740 P.2d at 264-65 (plaintiff must make a foundational showing to create a genuine issue sufficient to avoid summary judgment.) Summary judgment has uniformly been affirmed when the foundation is inadequate at summary judgment.

E. Ms. Nester Failed to Meet These Standards At The Trial Court Level.

Ms. Nester's position is essentially that although she failed to establish the proper foundation at summary judgment, she would be glad to do so if permitted to go to trial.¹ However, this position is contrary to Utah law, as demonstrated above.

Ms. Nester failed to provide the affidavit of any expert whatsoever at summary judgment. A review of her response to summary judgment, styled "Plaintiff's Answers to Defendant's Motion For Summary Judgment And Consent To Request For a Hearing" contains no opposing affidavits whatsoever. (R. 102-104.)

She has also failed to mention any expert who would be competent to testify in the same field of expertise as the defendant. She claims, without benefit of any supporting expert affidavit, that she should be permitted to lay a foundation as to the competency of her witness, a neurologist named Dr. LaVerne Erickson. However, even the foundation which Ms. Nester proposes to lay at trial does not contradict the affidavit of defendant's expert that even when the disputed procedure is performed properly, pain and bruising may result--which is rather obvious, since an injection with a long, sharp needle is inherently painful. It would take an expert to say if Ms. Nester's complaint

¹However, remanding this case for a trial would probably have little practical effect on the outcome. This case was scheduled for a bench trial, not a jury trial. Hence, remand to the trial court will merely result in factfinding by the same judge that granted summary judgment in the first place.

of pain was due to the ordinary, inherent character of an injection or was due to negligence.

Finally, this foundation was not provided at summary judgment. As discussed above, in many cases (including cases in which an expert affidavit was actually furnished in response to the motion for summary judgment) the appellate courts have upheld motions for summary judgment when a proper foundational showing was not made at the summary judgment stage. That is clearly what happened in this case, and summary judgment should likewise be affirmed in this case.

In view of Ms. Nester's filing of the Certification of Readiness, and of her designation of witnesses, she should be foreclosed from attempting to bring in additional experts to meet the required burden to prove the standard of care in this case. Because she has failed to provide any testimony from an expert competent to testify as to the proper standard of care for nuclear medicine technologists performing injections of radioactive isotopes in connection with three-phase bone scans, Ms. Nester's cause of action must fail and summary judgment should be affirmed in favor of Pioneer Valley Hospital.

POINT III

AS TO MS. NESTER'S INFORMED CONSENT CLAIM, THE TRIAL COURT'S ENTRY OF SUMMARY JUDGMENT WAS PROPER BECAUSE SHE FAILED TO PRODUCE THE AFFIDAVIT OF ANY EXPERT.

Ms. Nester's complaint might arguably contain a cause of action for informed consent; however, such a claim is, on its face, fatally deficient. (See R. 4-5, ¶ 13(a).)

Under Utah law, in order for a patient to recover damages from a health care provider based upon the failure of the provider to obtain informed consent, the patient must prove all the elements of the informed consent statute. Burton v. Youngblood, 711 P.2d at 249. The informed consent statute requires proof of seven elements:

(a) That a provider-patient relationship existed between the patient and health care provider; and

(b) The health care provider rendered health care to the patient; and

(c) The patient suffered personal injuries arising out of the health care rendered; and

(d) The health care rendered carried with it a substantial and significant risk of causing the patient serious harm; and

(e) The patient was not informed of the substantial and significant risk; and

(f) A reasonable, prudent person in the patient's position would not have consented to the health care rendered after having been fully informed as to all facts relevant to the decision to give consent . . . ; and

(g) The unauthorized part of the health care rendered was the proximate cause of the personal injuries suffered by the patient.

Utah Code Ann. § 78-14-5(1) (1992 Repl.) (emphases added).

In the case of Chadwick v. Nielsen, the Utah Court of Appeals has stated (per Judge Orme) that the better reasoned cases from other jurisdictions hold: "expert testimony is required in cases alleging a lack of informed consent to prove the materiality of the risk involved." 763 P.2d at 821 n.4. For the reasons set forth in Point II, supra, any cause of action

alleging lack of informed consent must be dismissed, since Ms. Nester has failed to designate any competent medical expert able to say whether the risks of the isotope injection were so substantial and material that Ms. Nester should have been told of them.

Moreover, as established by the uncontradicted affidavit of Mr. Bratke, Ms. Nester's complaint of pain, soreness and bruising following the isotope injection does not indicate a breach of the standard of care or that the procedure was not properly performed. Mr. Bratke also stated in his unchallenged affidavit that "the risk of complication of a permanent nature is remote and not substantial and significant." (R. 86, ¶ 21.)

Where the health care rendered does not carry a substantial and significant risk of causing serious harm to the patient, informed consent of the patient is not required. See Utah Code Ann. § 78-14-5(1)(d).

POINT IV

AS TO MS. NESTER'S RES IPSA LOQUITUR CLAIM THE TRIAL COURT'S ENTRY OF SUMMARY JUDGMENT WAS PROPER BECAUSE SHE FAILED TO PRODUCE THE AFFIDAVIT OF ANY EXPERT.

The "mere invoking" of res ipsa loquitur in response to a defendant's motion for summary judgment is not sufficient to create a material issue of fact. Otherwise, summary judgment would never be available to a defendant in a res ipsa loquitur case. King v. Searle Pharmaceutical, Inc., 832 P.2d 858, 863 (Utah 1992).

The Utah Supreme Court has observed that an undesired result resulting from a medical procedure might appear to have been caused by negligence when reviewed by a lay person, when in fact, that is not the case. King, 832 P.2d at 862.

"Accordingly, expert evidence is usually necessary to establish either direct evidence of malpractice or a foundation for a legitimate *res ipsa* inference," because the medical profession and its practice are removed from the knowledge and understanding of the average citizen. 832 P.2d at 862 (quoting Nixdorf v. Hicken, 612 P.2d 348, 352 (Utah 1980)). Moreover, expert testimony is still required to show that the incident was more likely than not caused by the negligence. Nixdorf, at 352-53.

The Utah Supreme Court held that in order for a plaintiff to raise an issue of material fact to defeat a motion for summary judgment in the face of "particularized assertions in the movant's affidavit," the Court has ruled that "the res ipsa loquitur inference must be strong enough to survive a motion for directed verdict at the close of the plaintiff's case." King v. Searle, 832 P.2d at 862. Despite this mention about the close of the plaintiff's case, the King court held that the expert's affidavit was not sufficient to create a factual issue on the res ipsa loquitur doctrine at the summary judgment stage. 832 P.2d at 864.

Since the King case held that the affidavit of an expert was insufficient to raise a *res ipsa loquitur* issue sufficient to avoid summary judgment, it follows logically that

the complete absence of any expert affidavit is even less adequate to create a res ipsa loquitur issue. Therefore, summary judgment on this cause of action was likewise proper.

As stated above, performance of three-phase bone scans accompanied by injection of radioactive isotopes is highly technical, and outside the experience of lay persons. It is not a proper subject of res ipsa loquitur. Moreover, all injections are inherently painful, and it would require expert testimony to say if this incident was out of the ordinary.

POINT V

MS. NESTER'S "ANSWER TO DEFENDANT'S MOTION FOR SUMMARY JUDGMENT" WAS ALSO DEFICIENT ON PROCEDURAL GROUNDS; IT WAS LATE, AND HAD NO COUNTERAFFIDAVITS.

Plaintiff failed to comply with the requirements of Utah Code of Judicial Administration Rule 4-501 which requires a memorandum in opposition to a motion for summary judgment to be filed within 10 days of the service of the motion. Through a stipulated extension, plaintiff had ample time in which to file her opposition memorandum by August 8, 1994. This was not done. No order of the Court or stipulation by the parties extended the time beyond the stipulated August 8th deadline for plaintiff's response. Therefore, Ms. Nester's response, entitled "Plaintiff's answer to Defendant's Motion for Summary Judgment and Consent to Request for Hearing" was late.

Moreover, Ms. Nester failed to supply the trial court with any affidavit whatsoever to contradict the hospital's

properly supported Motion for Summary Judgment. Rule 56(e) of the Utah Rules of Civil Procedure states, in pertinent part:

When a motion for summary judgment is made and supported as provided in this rule, an adverse party may not rest upon the mere allegations or denials of its pleading, but his response, by affidavit or as otherwise provided in this rule, must set forth specific facts showing that there is a genuine issue for trial. If he does not so respond, summary judgment, if appropriate, shall be entered against him.

Utah R. Civ. P. 56(e) (emphasis added). The proffered, speculative foundation of plaintiff's counsel is inadequate to serve as expert testimony and is a self-serving attempt to establish a standard of care. Her efforts to avoid summary judgment do not meet the criteria established by Utah law.

The Utah Supreme Court has unequivocally ruled that Utah R. Civ. P. 56(e) requires, first, an expert's affidavit to counter the affidavit submitted by defendant's expert. More importantly, the affidavit must contain specific facts, not "bare assertions" or opinions without sufficient foundation, to defeat summary judgment. See King v. Searle, 832 P.2d at 864 n.2; Butterfield v. Okubo, 831 P.2d 97, 103 (Utah 1992).

Ms. Nester has failed, altogether, to establish by anything other than bare allegations by her attorney, that any harm which she suffered could not have occurred to her in the absence of negligence on the part of defendant.

Utah R. Civ. P. 56(e) supports an entry of summary judgment because plaintiff's counsel has failed to produce an affidavit of a competent expert witness. Counsel has only made bare assertions of what plaintiff's witness, Dr. LaVerne S.

Erickson, a neurologist, might say. There is no proof, first of all, that Dr. Erickson has the requisite knowledge, training and ability to opine as to the proper standard of care of a nuclear medicine technologist. But, more importantly, plaintiff has failed even to attempt to establish by competent affidavit a genuine issue of material fact. Failure to establish by expert testimony the standard of care applicable to a nuclear medicine technologist requires summary judgment to be entered in favor of Pioneer Valley Hospital.

CONCLUSION

Ms. Nester claimed, at the trial court level, that she experienced pain after receiving an injection. The hospital moved for summary judgment, including an affidavit of an expert in nuclear medicine that pain can result from an isotope injection even when due care is being rendered. This makes good sense--it is often the case that being stuck with a needle hurts. Plaintiff has produced no affidavit from any expert to contradict this testimony. Nor is the expert which she would propose to use at trial an expert competent to discuss the standard of care and the causation issues associated with the injection of radioactive isotopes during the performance of a three-phase bone scan. Summary Judgment is proper when these affidavits are not produced in response to a properly supported motion for summary judgment.

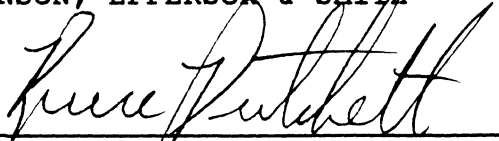
Ms. Nester's informed consent claim and res ipsa loquitur claims were also properly dismissed by the trial court

on summary judgment, because they too require an expert affidavit.

For these reasons, and the analysis more fully set forth above, the trial court's grant of summary judgment was proper, and its decision should be AFFIRMED.

RESPECTFULLY SUBMITTED this 28TH day of February, 1995.

HANSON, EPPERSON & SMITH



DAVID H. EPPERSON
BRUCE M. WRITCHETT, JR.
Attorneys for Appellee
Pioneer Valley Hospital

within two years after the plaintiff or patient discovers, or through the use of reasonable diligence should have discovered the injury, whichever first occurs, but not to exceed four years after the date of the alleged act, omission, neglect or occurrence, except that:

(a) In an action where the allegation against the health care provider is that a foreign object has been wrongfully left within a patient's body, the claim shall be barred unless commenced within one year after the plaintiff or patient discovers, or through the use of reasonable diligence should have discovered, the existence of the foreign object wrongfully left in the patient's body, whichever first occurs; and

(b) In an action where it is alleged that a patient has been prevented from discovering misconduct on the part of a health care provider because that health care provider has affirmatively acted to fraudulently conceal the alleged misconduct, the claim shall be barred unless commenced within one year after the plaintiff or patient discovers, or through the use of reasonable diligence, should have discovered the fraudulent concealment, whichever first occurs.

(2) The provisions of this section shall apply to all persons, regardless of minority or other legal disability under Section 78-12-36 or any other provision of the law, and shall apply retroactively to all persons, partnerships, associations and corporations and to all health care providers and to all malpractice actions against health care providers based upon alleged personal injuries which occurred prior to the effective date of this act; provided, however, that any action which under former law could have been commenced after the effective date of this act may be commenced only within the unelapsed portion of time allowed under former law; but any action which under former law could have been commenced more than four years after the effective date of this act may be commenced only within four years after the effective date of this act. 1979

78-14-4.5. Amount of award reduced by amounts of collateral sources available to plaintiff — No reduction where subrogation right exists — Collateral sources defined — Procedure to preserve subrogation rights — Evidence admissible — Exceptions.

(1) In all malpractice actions against health care providers as defined in Section 78-14-3 in which damages are awarded to compensate the plaintiff for losses sustained, the court shall reduce the amount of such award by the total of all amounts paid to the plaintiff from all collateral sources which are available to him; however, there shall be no reduction for collateral sources for which a subrogation right exists as provided in this section nor shall there be a reduction for any collateral payment not included in the award of damages. Upon a finding of liability and an awarding of damages by the trier of fact, the court shall receive evidence concerning the total amounts of collateral sources which have been paid to or for the benefit of the plaintiff or are otherwise available to him. The court shall also take testimony of any amount which has been paid, contributed, or forfeited by, or on behalf of the plaintiff or members of his immediate family to secure his right to any collateral source benefit which he is receiving as a result of his injury, and shall offset any reduction in the award by such amounts. No evidence shall be received and no

reduction made with respect to future collateral source benefits except as specified in Subsection (4).

(2) For purposes of this section "collateral source" means payments made to or for the benefit of the plaintiff for:

(a) medical expenses and disability payments payable under the United States Social Security Act, any federal, state, or local income disability act, or any other public program, except the federal programs which are required by law to seek subrogation;

(b) any health, sickness, or income disability insurance, automobile accident insurance that provides health benefits or income disability coverage, and any other similar insurance benefits, except life insurance benefits available to the plaintiff, whether purchased by the plaintiff or provided by others;

(c) any contract or agreement of any person, group, organization, partnership, or corporation to provide, pay for, or reimburse the costs of hospital, medical, dental, or other health care services, except benefits received as gifts, contributions, or assistance made gratuitously; and

(d) any contractual or voluntary wage continuation plan provided by employers or any other system intended to provide wages during a period of disability.

(3) To preserve subrogation rights for amounts paid or received prior to settlement or judgment, a provider of collateral sources shall serve at least 30 days before settlement or trial of the action a written notice upon each health care provider against whom the malpractice action has been asserted. The written notice shall state the name and address of the provider of collateral sources, the amount of collateral sources paid, the names and addresses of all persons who received payment, and the items and purposes for which payment has been made.

(4) Evidence is admissible of government programs that provide payments or benefits available in the future to or for the benefit of the plaintiff to the extent available irrespective of the recipient's ability to pay. Evidence of the likelihood or unlikelihood that such programs, payments, or benefits will be available in the future is also admissible. The trier of fact may consider such evidence in determining the amount of damages awarded to a plaintiff for future expenses.

(5) No provider of collateral sources is entitled to recover the amounts of such benefits from a health care provider, the plaintiff, or any other person or entity as reimbursement for collateral source payments made prior to settlement or judgment, including any payments made under Title 26, Chapter 19, except to the extent that subrogation rights to amounts paid prior to settlement or judgment are preserved as provided in this section. All policies of insurance providing benefits affected by this section are construed in accordance with this section. 1993

78-14-5. Failure to obtain informed consent — Proof required of patient — Defenses — Consent to health care.

(1) When a person submits to health care rendered by a health care provider, it shall be presumed that what the health care provider did was either expressly or impliedly authorized to be done. For a patient to recover damages from a health care provider in an action based upon the provider's failure to obtain informed consent, the patient must prove the following:

(a) that a provider-patient relationship existed between the patient and health care provider; and

(b) the health care provider rendered health care to the patient; and

(c) the patient suffered personal injuries arising out of the health care rendered; and

(d) the health care rendered carried with it a substantial and significant risk of causing the patient serious harm; and

(e) the patient was not informed of the substantial and significant risk; and

(f) a reasonable, prudent person in the patient's position would not have consented to the health care rendered after having been fully informed as to all facts relevant to the decision to give consent. In determining what a reasonable, prudent person in the patient's position would do under the circumstances, the finder of fact shall use the viewpoint of the patient before health care was provided and before the occurrence of any personal injuries alleged to have arisen from said health care; and

(g) the unauthorized part of the health care rendered was the proximate cause of personal injuries suffered by the patient.

(2) It shall be a defense to any malpractice action against a health care provider based upon alleged failure to obtain informed consent if:

(a) the risk of the serious harm which the patient actually suffered was relatively minor; or

(b) the risk of serious harm to the patient from the health care provider was commonly known to the public; or

(c) the patient stated, prior to receiving the health care complained of, that he would accept the health care involved regardless of the risk; or that he did not want to be informed of the matters to which he would be entitled to be informed; or

(d) the health care provider, after considering all of the attendant facts and circumstances, used reasonable discretion as to the manner and extent to which risks were disclosed, if the health care provider reasonably believed that additional disclosures could be expected to have a substantial and adverse effect on the patient's condition; or

(e) the patient or his representative executed a written consent which sets forth the nature and purpose of the intended health care and which contains a declaration that the patient accepts the risk of substantial and serious harm, if any, in hopes of obtaining desired beneficial results of health care and which acknowledges that health care providers involved have explained his condition and the proposed health care in a satisfactory manner and that all questions asked about the health care and its attendant risks have been answered in a manner satisfactory to the patient or his representative; such written consent shall be a defense to an action against a health care provider based upon failure to obtain informed consent unless the patient proves that the person giving the consent lacked capacity to consent or shows by clear and convincing proof that the execution of the written consent was induced by the defendant's affirmative acts of fraudulent misrepresentation or fraudulent omission to state material facts.

(3) Nothing contained in this act shall be construed to prevent any person eighteen years of age or over

from refusing to consent to health care for his own person upon personal or religious grounds.

(4) The following persons are authorized and empowered to consent to any health care not prohibited by law:

(a) any parent, whether an adult or a minor, for his minor child;

(b) any married person, for a spouse;

(c) any person temporarily standing in loco parentis, whether formally serving or not, for the minor under his care and any guardian for his ward;

(d) any person eighteen years of age or over for his or her parent who is unable by reason of age, physical or mental condition, to provide such consent;

(e) any patient eighteen years of age or over; (f) any female regardless of age or marital status, when given in connection with her pregnancy or childbirth;

(g) in the absence of a parent, any adult for his minor brother or sister; and

(h) in the absence of a parent, any grandparent for his minor grandchild.

(5) No person who in good faith consents or authorizes health care treatment or procedures for another as provided by this act shall be subject to civil liability. 1979

78-14-6. Writing required as basis for liability for breach of guarantee, warranty, contract or assurance of result.

No liability shall be imposed upon any health care provider on the basis of an alleged breach of guarantee, warranty, contract or assurance of result to be obtained from any health care rendered unless the guarantee, warranty, contract or assurance is set forth in writing and signed by the health care provider or an authorized agent of the provider. 1979

78-14-7. Ad damnum clause prohibited in complaint.

No dollar amount shall be specified in the prayer of a complaint filed in a malpractice action against a health care provider. The complaint shall merely pray for such damages as are reasonable in the premises. 1979

78-14-7.1. Limitation of award of noneconomic damages in malpractice actions.

In a malpractice action against a health care provider, an injured plaintiff may recover noneconomic losses to compensate for pain, suffering, and inconvenience. In no case shall the amount of damages awarded for such noneconomic loss exceed \$250,000. This limitation does not affect awards of punitive damages. 1999

78-14-7.5. Limitation on attorney's contingency fee in malpractice action.

(1) In any malpractice action against a health care provider as defined in Section 78-14-3, an attorney shall not collect a contingent fee for representing a client seeking damages in connection with or arising out of personal injury or wrongful death caused by the negligence of another which exceeds 33 1/3% of the amount recovered.

(2) This limitation applies regardless of whether the recovery is by settlement, arbitration, judgment, or whether appeal is involved. 1999

JUDITH NESTER,

Plaintiff/Appellant,

vs.

PIONEER VALLEY HOSPITAL,
DEPARTMENT OF RADIOLOGY AT
PIONEER VALLEY HOSPITAL, and
JOHN/JANE DOES 10\10, ABC
CORPORATION,

Defendants/Appellees.

Case No.: 94-0488
Priority No. 15

COMES NOW DAVID H. EPPERSON and BRUCE M. PRITCHETT, JR., attorneys for appellee, and hereby certifies that he hand delivered two true and correct copies of the Brief of the Appellee to counsel for appellant, J. Douglas Kinatader, 2046 East 4800 South, Suite 108, Salt Lake City, Utah 84117, on the 28th day of February, 1995.

DATED this 28TH day of FEBRUARY, 1995.

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