IN THE COURT OF APPEALS OF THE STATE OF NEW MEXICO

WILLIAM "MACK" VAUGHAN,

PLAINTIFF-APPELLANT,

NO. 30,395
Santa Fe County
D-0101-CV-2006-00175

vs.

ST. VINCENT HOSPITAL, INC.,

Defendant-Appellee.

PLAINTIFF-APPELLANT'S BRIEF IN CHIEF

An Appeal from the First Judicial District Court
The Honorable Barbara J. Vigil

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I.
STATEMENT OF PROCEEDINGS

A. Dr. Voltura's Sworn Statement Taken Prior to Commencement of the Lawsuit.

Prior to filing suit, Mack Vaughan[1] took the statement of Dr. Anna Voltura on March 13, 2006. See Sworn Statement of Dr. Anna Voltura (taken ("Voltura Sworn Statement") at RP 119-23. Dr. Voltura had been called to treat Mr. Vaughan in the emergency room on August 8, 2002 for severe stomach pain. See St. Vincent's Emergency Physician Record, RP at 171. Dr. Voltura had discharged Mr. Vaughan that same evening despite the fact that a CT taken of Mr. Vaughan's abdomen in the ER on August 8th raised the possibility of a potential neoplasm in his pelvis. See Voltura Sworn Statement at 8:17-13:22, RP at 121-22.

Dr. Voltura never worked Mr. Vaughan up for a neoplasm that night or any other night and Mr. Vaughan's neoplasm was not discovered for almost another year in July of 2003. See Affidavit of John Bagwell (taken October 5, 2009)("Bagwell Aff.") ¶¶ 2-3, at 1, RP at 190.

In giving her sworn statement taken on March 13, 2006, Dr. Voltura was attended by her counsel Gary Gordon, and testified that the St. Vincent's

[1] It has been learned that Mr. Vaughan died in Lynchburg, Virginia, on July 13, 2010. A suspicion of the death has been filed and a personal representative will be appointed and substituted for Mr. Vaughan.

Voltura was not cc'd with a copy of the radiology report. See Voltura Sworn Statement at 8:25-9:10, RP at 121. While she had talked with Dr. Damron, the radiologist who read the CT for St. Vincent's on the night Mr. Vaughan was in the ER, Dr. Damron never mentioned anything about the potential of a neoplasm that evening. See Voltura Sworn Statement at 11:11-14, RP at 122.

Dr. Voltura testified that, at the very least, she absolutely should have been copied with Dr. Damron's report. See Voltura Sworn Statement at 17:15-20, RP at 123.

Dr. Voltura further testified that had she known of the report, Mr. Vaughan would have been worked up in an entirely different fashion, and surgery would have been performed that night on Mr. Vaughan to explore for the neoplasm. See Voltura Sworn Statement at 10:2-8, 11:13-17, RP at 122.

B. Mr. Vaughan's Initial Complaint.

Based on Dr. Voltura's statement, Mr. Vaughan filed a complaint, on January 27, 2006, against St. Vincent's Hospital. See Complaint for Medical Negligence (filed January 27, 2006) ("Complaint") at 1-2; Record Proper ("RP") at 1-2.

Mr. Vaughan's initial complaint alleged that, in August of 2002, he went to the emergency room at St. Vincent's Hospital ("St. Vincent's") suffering from severe abdominal pain. See Complaint, ¶ 3 at 1, RP at 1. While in St. Vincent's emergency room, he was worked up by the ER physician Dr. Morton Wilt and Dr. Anna Voltura, a surgeon. A number of examinations were ordered, including an abdominal CT read by Dr. John Damron, a radiologist at St. Vincent's. See Complaint ¶ 6, at 1, RP at 1.

While Dr. Damron and Dr. Voltura discussed Mr. Vaughan's CT the night of August 13, Dr. Damron did not dictate his radiology report on the following day. In the St. Vincent's Transcription Record, Dr. Damron expressly noted the diagnostic possibilities, and his concern, that Mr. Vaughan's CT showed either a diverticular abscess or a neoplasm. See Complaint, ¶ 6 at 1, RP at 1.

As a result, Dr. Voltura never learned of the potential neoplasm, never worked it up, and more importantly, never told Mr. Vaughan that his CT scan showed a potential cancerous mass in his abdomen. See Complaint ¶¶ 10-12, at 1-2, RP at 1-2.

The neoplasm, potentially identified in the radiology report of August 9, 2002, continued to grow for the next year until July 2003[1] when it was discovered that it invaded his bladder. See Complaint ¶ 14, at 2, RP at 2.

Mr. Vaughan alleged that the action of St. Vincent's, in not forwarding the Transcription Record[2] of the October 2002 CT scan to Dr. Voltura, was an administrative inadequacy that was negligent. See Complaint ¶ 13, 16, at 2.[3]

C. Mr. Vaughan's First Amended Complaint.

Mr. Vaughan filed a First Amended Complaint in 2006, which essentially set forth the same allegations that St. Vincent's was negligent

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[1] Mr. Vaughan did not learn until January of 2006 that there had been a Transcription Record in October 2002 identifying a mass in his abdomen that was potentially cancerous. See Complaint ¶ 14, at 2, RP at 2.

[2] The Radiology report at issue is labeled:

St. Vincent Hospital 455 St. Michaels Dr. Santa Fe, NM 87505 Transcription Report

Transcription Record (dated August 9, 2002) at 1, RP at 214 ("Transcription Record").

[3] Despite the Complaint being labeled as one for medical negligence, there was no allegation in the body of the Complaint of medical negligence.

for not forwarding the Transcription Record on to Dr. Voltura. See First Amended Complaint (filed August 17, 2006), RP at 27-28.

D. St. Vincent's Motion for Summary Judgment.

On June 30, 2009, St. Vincent's filed a motion for summary judgment appending the affidavit of Englewood emergency room physician Mark Kozlowski. Dr. Kozlowski's affidavit while citing the information upon which he based his opinion never noted reading Dr. Voltura's earlier sworn statement.

More importantly, Dr. Kozlowski's affidavit never addressed the specifics of Mr. Vaughan's Complaint and the radiology report that was never sent to Dr. Voltura. In fact, Dr. Kozlowski's affidavit never addressed any of the allegations of Mr. Vaughan's complaint except with a single conclusory sentence that there were no departures in the standard of care.[4]

> I believe that the employees and agents of St. Vincent's complied with the standard of care in handling the radiology report relating to MR. Vaughan's abdominal CT scan.

See Kozlowski Aff. ¶ 1, at 1, RP at 102. Dr. Kozlowski's opinion also overlooked the fact that no violations of the standard of care were alleged, instead only administrative failures to transmit a report that accurately

[4] Dr. Kozlowski's affidavit also set forth no foundation establishing his expertise to give an expert opinion on the matters raised in Mr. Vaughan's Complaint.

stated the possibility raised by Mr. Vaughan's August CT. Dr. Kozlowski's affidavit never disputed the assertion that the failure at issue was one of ordinary care. Further, no facts were set forth in support of Dr. Kozlowski's opinion.

E. Mr. Vaughan's Response.

On August 3, 2009, Mr. Vaughan filed his Response pointing out Dr. Kozlowski had stated no grounds establishing his expertise to opine on the matter at issue, that his opinion was totally conclusory and not supported by fact and most importantly that he had not read the written statement of Dr. Voltura. Dr. Kozlowski's affidavit provided no basis for summary judgment.

F. St. Vincent's Motion to Strike.

On August 17, 2009, St. Vincent's filed a motion to strike Mr. Vaughan's response stating it was not timely. St. Vincent's motion to strike also included in the second affidavit of Dr. Kozlowski stating that he had read the statement of Dr. Anna Voltura.[5]

[5] The amendment to Dr. Kozlowski's affidavit filed on August 20th effectively made August 20th the day from which the time began to run on St. Vincent's motion for summary judgment and the motions to strike any of the issues set forth in Mr. Vaughan's Complaint.

G. Mr. Vaughan's Motion for Summary Judgment.

On October 20, 2009, Mr. Vaughan filed a motion for summary judgment attaching the affidavits of radiologist Dr. Donald Wolfel and Mr. Vaughan's treating oncologist, Dr. John Bagwell. Dr. Wolfel's affidavit stated there was an absolute duty to communicate the potential abnormalities in a radiology report to treating physicians, and not doing so was negligent. However, there was no standard of care as to how the communication should be accomplished. Instead it was a basic communication issue no different than any other communication issue in any other walk of life. The answer depended on the situation.

Dr. Bagwell, Mr. Vaughan's treating oncologist, stated Mr. Vaughan's chance of survival had been significantly reduced by the transmission error. Mr. Vaughan currently had only a chance of survival, as opposed to the probability of surviving that he had in August of 2007.

H. St. Vincent's Response to Mr. Vaughan's Motion for Summary Judgment.

On September 15, 2009, St. Vincent's responded to Mr. Vaughan's motion for summary judgment with an affidavit of the oncologist at the University of New Mexico stating that there was no harm caused to Mr. Vaughan in the lapse in the period of time between when his cancer could

have been diagnosed in the emergency room on August 8, 2002 and when it was ultimately diagnosed in July of 2003.

I. The October 22, 2009 Hearing of Judge Michael E. Vigil.

The Honorable Mike Vigil held in abeyance his ruling on summary judgment. Judge Vigil did so because one of the parties potentially at fault for not communicating the radiology report to Dr. Voltura was Dr. John Damron the radiologist whom St. Vincent's had contracted to read the x-rays for emergency room patients such as Mack Vaughan. St. Vincent's contended that it was not liable for Dr. Damron's error because Dr. Damron was not its employee. Mr. Vaughan had pointed out that if Dr. Damron was responsible for the failure to transmit the report, St. Vincent's was nonetheless vicariously responsible under the doctrine of apparent authority set forth in Houghland vs. Grant.

St. Vincent's argued that that apparent authority could not be raised because it had not been pled and raising it now was untimely.

Judge Vigil asked the parties to brief the issue of apparent authority.

On January 8th of 2010, the case was transferred to the Honorable Barbara Vigil.

I. The February 10, 2010 Hearing of Judge Barbara J. Vigil.

On February 10, 2010, Judge Vigil heard St. Vincent's motion for summary judgment.

The Parties' Arguments.

St. Vincent's contended that Dr. Voltura communicated with Dr. Damron regarding his findings. See Transcript of Hearing (taken February 10, 2010)("2/10/2010 Tr.") at 1. St. Vincent's argued that Dr. Damron told Dr. Voltura that his impression was an abscess, which requires eventual surgery. See 2/10/2010 Tr. at 1. St. Vincent's contended that Dr. Voltura wanted to admit Mr. Vaughan to the hospital, but that Mr. Vaughan declined, and failed to follow up with her in her office, and failed to follow the recommendations of the VA. See 2/10/2010 Tr. at 1.

St. Vincent's further argued that Mr. Vaughan could not maintain his claim "without expert testimony on both the standard of care and causation." 2/10/2010 Tr. at 2. St. Vincent's contended that it was prejudiced because it was never put on notice of a claim against it for the conduct of Dr. Damron, since "[m]any years have passed since the date of treatment, and several years have passed since the Complaint was filed. And we haven't conducted discovery on that issue . . . and people's memories fade." 2/10/2010 Tr. at 5-6. St. Vincent did not detail whose

memories had failed and how a faded memory could have any effect on St. Vincent's vicarious liability for its hospital-based physician.

Mr. Vaughan noted that "[t]here is absolutely no law in New Mexico that requires you to plead a person's agency," because "[t]he standard in New Mexico is general notice pleading." 2/10/2010 Tr. at 8-9. Mr. Vaughan pointed out to the trial court that St. Vincent's was asking that he be held to a special pleading requirement addressed by rule 1-009. See 2/10/2010 Tr. at 10.

Mr. Vaughan explained that attached to his motion for summary judgment were affidavits from physicians attached "who testify about the standard of care and St. Vincent's falling below the standard in this case." 2/10/2010 Tr. at 13. Mr. Vaughan noted that Dr. Kozlowski is an emergency room doctor and was not qualified to testify regarding the standard of care for a radiologist, Dr. Wolfel, a board-certified radiologist who was qualified, found a deviation from the standard of care. See 2/10/2010 Tr. at 14. Mr. Vaughan also noted that the affidavit of Dr. Bagwell, as a board-certified oncologist, specifically found that Mr. Vaughan's cancer went undiagnosed when he had it in St. Vincent's emergency room in 2002. See 2/10/2010 Tr. at 14.

The Trial Court's Decision.

Judge Barbara Vigil found that Mr. Vaughan had the burden of demonstrating a legal duty, breach of the applicable standard of care, actual loss or damage, and causation. See 2/10/2010 Tr. at 16-17. Judge Vigil held that Mr. Vaughan was required to produce expert testimony on the area of administrative inadequacy to establish a breach of the standard of care and causation for Mr. Vaughan's injury. See 2/10/2010 Tr. at 17.

Despite the fact that Mr. Vaughan had pointed out the existence of the affidavits of Dr. Wolfel and Dr. Bagwell in the court record, Judge Vigil found that Mr. Vaughan failed to establish his claim by expert testimony. See 2/10/2010 Tr. at 17. Judge Vigil never mentioned or otherwise specifically addressed the affidavits of either Dr. Wolfel or Dr. Bagwell or the sworn statement of Dr. Voltura.

Judge Vigil found that Mr. Vaughan's "theory in this case that somehow Dr. Damron did something inappropriate by not sending this CT scan to Dr. Voltura is simply a moving target at this late date," and "late" 2/10/2010 Tr. at 17. Judge Vigil held Mr. Vaughan should not be permitted to assert a claim against Dr. Damron and to assert a claim under an agency theory against St. Vincent's. See 2/10/2010 Tr. at 17. Judge Vigil reasoned that "memories fade, people forget what occurred a year ago, two

years ago, three years ago, and now the Plaintiffs are asking the Court to give him an opportunity to allege . . . activity six years ago." 2/10/2010 Tr. at 17-18. Judge Vigil held it was unduly prejudicial and violated Rules 8 and 9 to allow Mr. Vaughan to assert a claim under the doctrine of apparent authority against St. Vincent's for Dr. Damron's conduct. See 2/10/2010 Tr. at 18. Judge Vigil found

> that as plead and as discovered thus far, that the Plaintiff has failed to establish the minimum requirements necessary to go forward on this malpractice claim against St. Vincent by failing to narrow the issue, what the facts are, and establish expert testimony to support it. For that reason, [she] grant[ed] St. Vincent's motion for summary judgment.[6]

2/10/2010 Tr. at 18.

II.
THE FACTS IN THE UNDERLYING RECORD

A. The Standard of Review.

Houghland v. Grant, 119 N.M. 422, 426, 891 P.2d 563, 567 (Ct. App. 1995), which is dispositive of the issues of apparent authority raised by St. Vincent's also sets forth the standard of review by this court in evaluating

[6] Judge Vigil did not hold that Mr. Vaughan's Response to St. Vincent's motion for summary judgment was untimely. Nor did she strike Mr. Vaughan's Response. St. Vincent's had never submitted a competent affidavit for Dr. Kozlowski until after Mr. Vaughan had filed his response to St. Vincent's motion for summary judgment. See Supplemental Affidavit of Mark Kozlowski (taken August 20, 2009), RP at 139.

the propriety of Judge Vigil's summary judgment motion. Houghland holds that

> [in] evaluating the propriety of summary judgment, a reviewing court must look to the whole record and take note of any evidence which puts material fact at issue.

Houghland v. Grant, 119 N.M. at 426, 891 P.2d at 567.

> Because resolution on the merits is favored, a reviewing court view[s] the facts in a light most favorable to the party opposing the motion and draw[s] all reasonable inferences in support of a trial on the merits.

Edward C. v. City of Albuquerque, --- P.3d ---, 2010 WL 4058665 at * 15 (N.M. Sep. 3, 2010)(internal quotation marks omitted).

B. Dr. Voltura's Sworn Statements.

Mr. Vaughan's emergency room CT scan was read at St. Vincent's by Dr. Damron. See Transcription Record, RP at 214.

After reading the CT scan, Dr. Damron and Dr. Anna Voltura, the surgeon that had been called in by Dr. Wilt to consult regarding Mr. Vaughan's abdominal pain, both reviewed the CT and discussed the results. See Deposition of Anna Voltura (taken January 18, 2008)("Voltura Depo.") at 20:3-8, RP at 94.

According to Dr. Voltura, she and Dr. Damron concluded that Mr. Vaughan had a small diverticular abscess, based on that CT scan, his physical exam, and his white count. See Voltura Depo. at 20:3-8, RP at 94.

Based on that, she told Mr. Vaughan that he had a diverticular abscess and:

> It was my suggestion he be admitted to the hospital for IV antibiotics, and also discussed the probable need for sigmoid colectomy in the future which hopefully we could do electively. . . and he decided that he did not want to be admitted.[7]

Voltura's First Statement at 8:19-24, RP at 121.

In that regard, small diverticular abscesses like Mr. Vaughan's, if treated conservatively, did not require immediate surgery, but could be treated conservatively with antibiotics. See Voltura's First Statement at 8:19-20, RP at 121. And, in fact, Mr. Vaughan was discharged on the same night on August 8 on antibiotics.

The following day, on August 9, Dr. Damron dictated his impressions of the CT scan in a radiology report entitled the St. Vincent's Transcription Record. See RP at 214. Upon noting abnormalities in the area of Mr. Vaughan's colon and the upper portion of his bladder. Dr. Damron concluded as follows:

> An abscess associated with a diverticulitis would be a first consideration with a neoplasm as the etiology being the second consideration.

[7] Mr. Vaughan never refused to be admitted. Dr. Voltura merely "suggested that Mr. Vaughan be admitted for IV antibiotics" and discussed the probable need for a colectomy in the future which hopefully they could do "electively". It was in response to that suggestion with the facts at hand that Mr. Vaughan "decided" as opposed to refused not to be admitted.

Voltura's First Statement at 7:16-18, RP at 121 (emphasis added).

Dr. Damron stated in the Transcription Record that "the results of this study were communicated to Dr. Wilt and Dr. Voltura." Voltura's First Statement at 7:6-7, RP at 121. However, Dr. Wilt and Dr. Voltura, were not "cc'd" or copied with St. Vincent's Transcription Record. See Voltura's First Statement at 8:25-2, RP at 121; Voltura Depo. at 73:12-17, RP at 101; Transcription Record.

In fact, Dr. Voltura never got Dr. Damron's dictated report, despite her expectations to the contrary. See Voltura's First Statement at 9:10-16, 12:24-13.2, RP at 121-22; Voltura Depo. at 67:19-22, RP at 100.

> Having seen Mr. Vaughan in the emergency room as a patient and the fact that my name is in the body of the report, I would expect that I would – I should get it. However, there's nowhere that I'm cc'd to get it.
>
> If [Dr. Damron] had any second thoughts, he would have called me. And he would have said I am reviewing this and I think there is a cancer. He wouldn't have just dictated it and left it at that. He would have called me and said you know this might be a cancer.

Voltura's First Statement at 9:5-10:8, RP at 121-22.

The consequences of the omission were enormous to Mr. Vaughan. First, Dr. Voltura would have told Mr. Vaughan that he possibly had a

perforated cancer. See Voltura's First Statement at 11:13-14:8, RP at 122-23.

Second, and equally important, Dr. Voltura would have undertaken a totally different course of action in treating Mr. Vaughan:

> A perforated cancer is dealt with completely different than a small perforated diverticulum." If we thought this was a cancer, we would have done a bowel prep and operated on him that hospitalization.
>
> So this is not something that – a perforated cancer is not something that work up as an outpatient – a perforated cancer is something that you take care of right then and there. . . . I would have been adamant that you need to be admitted. I would have dictated that in my consult that this is possibly a perforated cancer which needs to be taken care of right now not something that you can do electively.
>
> . . . So yes I would have not just blown that off – If I would have seen the word neoplasm in a report I would have called back and say hey we didn't discuss that that night, why are you putting that in the body now.
>
> And if you do think it's a cancer than yes I would have tried to do whatever I could to get a hold of the patient.

Voltura's First Statement at 11:16-14:8, RP at 122-23.

B. Mr. Vaughan's Affidavit – Issues of Apparent Authority.

On November 16, 2009, Mr. Vaughan attached his affidavit to his Reply to St. Vincent's Response to his motion for summary judgment. See RP at 317-27; Affidavit of William "Mack" Vaughan (taken November 30, 2009)("Vaughan 2nd Aff."), RP at 325-27. In his second affidavit, Mr.

Vaughan explained that it was his "understanding that if [he] went to St. Vincent's, all medical functions would be taken care of by St. Vincent's employees and would be billed by St. Vincent's." Vaughan 2nd Aff. ¶ 23, at 2, RP at 327. Mr. Vaughan further explained that: "To this day I do not know about any of those contractual relationships, and as far as I know, all the people who treated me at St. Vincent's, excepting Dr. Voltura, were St. Vincent's employees." Vaughan 2nd Aff. ¶ 25, at 2, RP at 327.

C. Dr. Wolfel's Affidavit.

On October 20, 2009, Mr. Vaughan filed a motion for summary attaching the affidavit of longtime New Mexico radiologist Dr. Donald Wolfel.

Dr. Wolfel, a radiologist who had headed Presbyterian Hospital's Radiology Department for twenty years, testified that when a radiology report is dictated the day after a face-to-face consultation with the treating physician, there is always the possibility of an afterthought by the radiologist upon additional reflection or another look at the CT. See Affidavit of Donald Wolfel (taken October 16, 2009) ¶ 12, at 3, RP at 223 ("Wolfel Aff.").

Dr. Wolfel further testified that while communicating significant results from a CT scan was absolutely mandatory and failure to do so was

negligent there was no standard of care for how that communication was to be accomplished.[8] See Wolfel Aff. ¶¶ 2, 9, at 1-2, RP at 221-22. Instead, the standard of care required only that the critical information in the report be communicated in some manner. See Wolfel Aff. ¶ 15, at 3, RP at 223.

Dr. Wolfel further testified that the failure in Mr. Vaughan's case to communicate the information about the potential neoplasm could have been the result of a transcription error, a failure to have the results called to Dr. Voltura, or a failure of the radiologist to copy Dr. Voltura with his Transcription Record. See Wolfel Aff. ¶ 18, at 4, RP at 224. The communication failure at issue here is one of ordinary negligence. See Wolfel Aff. ¶ 15, at 3, RP at 223.

D. Dr. Bagwell's Affidavit.

Mr. Vaughan's motion for summary judgment also included the affidavit of Dr. John Bagwell.

Dr. John Bagwell, a Board certified oncologist, and Mr. Vaughan's treating physician, stated that the potential cancer mentioned in Mr.

[8] The duty of a radiologist reading a diagnostic film to communicate the results of his diagnostic impression to treating physicians is a matter of medical negligence. However, the process by which the diagnostic impression is transmitted is a matter of ordinary negligence. Whether the transmittal process is negligently-handled by a physician or a transcriptionist, the standard for judging the reasonableness of the transmission is still a matter of ordinary negligence.

Vaughan's St. Vincent's CT report was in fact a cancer and that the lapse in time between August of 2002 and July of 2003 allowed the cancer to increase from a stage two to a stage three cancer, cutting Mr. Vaughan's chances of survival thirty-five percent, thus making a cure only a possibility for Mr. Vaughan in 2003 as opposed to the probability of a cure that Mr. Vaughan had in August of 2002.[9] See Affidavit of John Bagwell (taken October 5, 2009)("Bagwell Aff.") at ¶¶ 3-7, at 1-2, RP at 190-91.

III.
ARGUMENT AND AUTHORITY

Introduction

The central issue in this appeal is both fundamental and simple. Summary judgment may not be entered when there are outstanding issues of material fact. See Pharmaseal Lab., Inc. v. Goffe, 90 N.M. 753, 756, 568 P.2d 589, 592 (1977).

Here Mr. Vaughan brought suit against St. Vincent's for the breach of its duty to communicate a radiology report containing results from the

[9] The facts in Dr. Bagwell's affidavit were never noted in the trial court's decision or order. Judge Vigil's order instead stated that expert testimony was required to answer the questions of causation as a result of the "alleged malpractice" and there was no expert testimony on those issues.

As explained above, both those questions were already answered in the record by Dr. Bagwell. See Bagwell Aff., RP at 190-91. Dr. Bagwell as a Board-certified oncologist is no less an expert for being Mr. Vaughan's treating physician. See Bagwell Aff. at ¶ 1, at 1, RP at 190. In fact, as a treating physician his testimony is even more deserving of consideration.

radiologist St. Vincent's had contracted to interpret the CT performed on its CT scanner to the surgeon St. Vincent's had called in to work up Mr. Vaughan when Mr. Vaughan came into St. Vincent's emergency room.

The delivery system for radiology reports, with a single exception involves only administrative personnel. The administrative personnel are software specialists, computer programmers, medical transcriptionists, fax operators, and couriers. The one healthcare provider involved in the entire transmission process is the radiologist who in her or his dictation report can determine who receives copies (if that isn't already taken provided for by default in the hospital's computer software, i.e., copying to go to all physicians noted in the radiology report, all physicians noted in the patient's record, etc.)

Failures by any of the administrative personnel in the communication or delivery process were ordinary negligence. The administrative personnel are not health care providers, they are not providing healthcare. Thus, their failure is ordinary negligence. The action of the dictating radiologist in failing to c.c. a copy to the attending physician (in the absence of the default system which would automatically route the report to all treating physicians) likewise involves the failure of the radiologist to perform an administrative act.

The trial court granted summary judgment to St. Vincent's holding Mr. Vaughan had provided no medical testimony about St. Vincent's malpractice despite the fact that Mr. Vaughan's Complaint expressly did not allege medical malpractice, but rather administrative (ordinary) negligence.

Mr. Vaughan attached the affidavit of Dr. Donald Wolfel, a radiologist, and Dr. John Bagwell, Mr. Vaughan's treating oncologist, to Mr. Vaughan's own motion for summary judgment. These affidavits when taken together with Dr. Voltura's statement, established all of the elements necessary for Mr. Vaughan to proceed against St. Vincent's, whether St. Vincent's negligence was medical or ordinary.

The law is clear that any affidavit existent before the trial court prior to the time of summary judgment, must be considered by the court. (Compare Lujan v. City of Albuquerque, 2003-NMCA-104, 75 P.3d 423 with North v. Pub. Serv. Co., 97 N.M. 406, 640 P.2d 512 (Ct. App. 1982).

Based on the above, the trial court's decision was clearly in error.

POINT ONE
EXPERT TESTIMONY WAS NOT NECESSARY TO DETERMINE ORDINARY NEGLIGENCE

Mack Vaughan never alleged medical negligence in either of his Complaints. The omission at issue was a matter of ordinary negligence, i.e., St. Vincent's systems failure to get the dictated report from its

radiologist, Dr. Damron who read Mr. Vaughan's CT, to the surgeon Dr. Voltura, who St. Vincent's called in to work up Mr. Vaughan. While they both viewed the CT scan together on August 8th, what was communicated verbally between the two, on August 8th, had all of the inherent problems of all conversations made on the fly. Doctors are busy, doctors have preoccupations, doctors think statements are made, and recollections differ thereafter.

Thus, a system is necessary for communicating a patient's radiology results in writing from one physician to another to confirm that the results of a patient's radiology study are actually communicated to all physicians involved in a patient's radiology study are actually communicated to all physicians involved in a patient's care.

St. Vincent's apparently had such a system in place requiring their radiologist to explicitly set forth in writing their impressions and transmit them to the treating physician. However, in Mr. Vaughan's case St. Vincent's was unable to get the dictated and transcribed impressions of Dr. Damron whom it had contracted with to view a CT scan performed on St. Vincent's CT machine to the surgeon who St. Vincent's ER staff had called to come in and work up Mr. Vaughan.

The error was simply a transcription or delivery error, i.e. ordinary negligence by administrative personnel or Dr. Damron in failing to c.c. the report.

The potential reasons why Dr. Voltura never got St. Vincent's Transcription Record are many. First, the fact it wasn't copied to Dr. Voltura may have been due to the negligence of the St. Vincent's transcriptionist. See Wolfel Aff. ¶¶ 14, 18, at 3-4, RP at 223-24. Second, the Transcription Record might not have been delivered to Dr. Voltura whether she was copied with it or not. See Wolfel Aff. ¶ 14, at 3, RP at 223. Third, Dr. Damron might have either overlooked the need to get his report to Dr. Voltura or he simply didn't dictate a "c.c." to Dr. Voltura. See Wolfel Aff. ¶ 18, at 4, RP at 224. Another more obvious possibility is that St. Vincent had not programmed its software or implemented a policy or procedure mandating its transcriptionists to automatically copy any physician mentioned in the body of a Transcription Record as were Drs. Wilt and Voltura in Mr. Vaughan's Transcription Record.

St. Vincent's is directly liable for any negligence involved in three of the four possibilities for the Transcription Report not being communicated to the treating surgeon who would use the Report. St. Vincent's direct liability is ordinary negligence.

Only one of the four possibilities explaining why Dr. Voltura never got Mr. Vaughan's Transcription Report involves potential negligence by Dr. Damron, i.e. Dr. Damron forgot to c.c. the report to Dr. Voltura or didn't think it was necessary since he had communicated the results to both physicians the day before. Dr. Damron's failure also involves ordinary negligence requiring no expert testimony.

While that negligence directly implicates Dr. Damron,[10] St. Vincent's is nonetheless vicariously liable for Dr. Damron's negligence under Houghland, which has been the law in New Mexico since 1995. (See Point Three).

[10] In deciding a case on summary judgment, the trial court was to give all the inferences to Mr. Vaughan, where it was unknown who had been responsible for the failure to transmit the radiology report to Dr. Voltura. Inferring that it was the transcriptionist's failure to c.c. Dr. Voltura was required of the trial court.

POINT TWO
THE AFFIDAVITS OF DRS. WOLFEL AND BAGWELL AND THE SWORN STATEMENT OF DR. ANNA VOLTURA PROVIDED EXPERT TESTIMONY SUPPORTING MR. VAUGHAN'S NEGLIGENCE CLAIM AGAINST ST. VINCENT'S HOSPITAL WHETHER ORDINARY OR MEDICAL AS WELL AS CAUSATION

Granting summary judgment against Mr. Vaughan due to the absence of expert testimony on behalf of Mr. Vaughan on the relevant matters at issue was clearly error.

First, St. Vincent's asked for summary judgment based on an affidavit unquestioned by the trial court, which was absolutely invalid under Rule 1-056 NMRA as totally conclusory from the beginning and which as a result never put any portion of Mr. Vaughan's case at issue under Rule 1-056. See Rule 1-056(E) NMRA (noting: "Supporting and opposing affidavits shall be made on personal knowledge, shall set forth such facts as would be admissible in evidence, and shall show affirmatively that the affiant is competent to testify to the matters stated therein").

The St. Vincent's affidavit that initiated the entire summary judgment process was a one-page affidavit by Dr. Mark Kozlowski, an emergency room physician from Engelwood, Colorado, in which Dr. Kozlowski stated in a single, sweeping sentence, that there was no breach of the standard care in the care or treatment of Mr. Vaughan or the communication of radiology results from the St. Vincent's Radiology Department of Dr. Voltura. See

Affidavit of Mark Kozlowski, M.D. (taken June 29, 2010) ¶ 3,, at 1 RP at 102

> I believe that the employees and agents [emphasis supplied] of St. Vincent's complies with the standard of care in handling the radiology report to Mr. Vaughan's abdominal CT scan.

("Kozlowski Aff."). Dr. Kozlowski's far-reaching conclusion was delivered with absolutely no underlying facts establishing Dr. Kozlowski's professional ability to deliver such an opinion or cite any facts supporting that opinion.

Mr. Vaughan's case involved the actions of a surgeon who was never given the Transcription Report of Mr. Vaughan's CT dictated by a radiologist used by the hospital to interpret its CT results. Dr. Kozlowski is neither a radiologist, nor a surgeon. See Kozlowski Aff. ¶ 1, at , RP at 102.

Understandably, given his lack of credentials, Dr. Kozlowski gives no basis for how he, as an emergency room physician, has any expert knowledge on the issue of communicating transcription reports or on how a surgeon responds to those reports or why St. Vincent's handling of Mr. Vaughan's radiology reports complied with the standard of care. His affidavit is totally conclusory and did not support summary judgment.

Stated differently, Dr. Kozlowski's affidavit never put at issue the essence of Mr. Vaughan's Complaint.

But more importantly, the trial court had before it the affidavits of Drs. Wolfel and Bagwell as well as the sworn statement of Dr. Voltura, which established all the elements necessary for Mr. Vaughan to proceed and to in fact win on summary judgment himself. Those affidavits established:

- A radiologist has an absolute duty to communicate abnormal results to treating physicians. (See Wolfel Aff. ¶ 8, at 2, RP at 222)

- Mr. Vaughan's results were never communicated to Dr. Voltura and should have been (See Voltura Statement at 8:25-17:20, RP at 121-23).

- The potential neoplasm mentioned in the CT report of Dr. Damron was in fact a cancer. (See Bagwell Aff. ¶ 2, at 1, RP at 190).

- Because the results were not communicated to Dr. Voltura, Dr. Voltura didn't perform surgery on Mr. Vaughan on August 8, 2002, which he would have had based on the information in the radiology report. (See Voltura Statement at 10:2-5, at RP 122)

- Because Mr. Vaughan's cancer noted August of 2002 was not discovered until July 2003, Mr. Vaughan's cancer had advanced to a Stage III cancer which meant that instead of having the probability of survival, which would have been the case had it been discovered in August 2003, his chances had been reduced 35% to the point where it is now only a possibility that he would survive. (See Bagwell Aff. ¶¶ 6 and 7, at 2, RP at 191.)

- A failure by the transcriptionist to know to c.c. Dr. Voltura and Dr. Wilt (See Wolfel Aff. ¶ 18, at 4, RP at 224).

- Failure to deliver the report to Dr. Voltura. (See Wolfel ¶ 17, at 4, RP at 224).

- Failure of Dr. Damron to copy the report to Dr. Wilt. See Wolfel Aff. ¶ 17. at 4, RP at 224)

Given these affidavits, and their contents, the trial court should have granted summary judgment to Mr. Vaughan.

POINT THREE
HOUGHLAND V. GRANT PROVIDES THE LEGAL FOUNDATION FOR ST. VINCENT'S VICARIOUS LIABILITY FOR THE ACTIONS OF ITS HOSPITAL-BASED RADIOLOGIST AND DOES NOT HAVE TO BE SPECIFICALLY PLED

A. The Houghland Rationale and Holding.

Since 1995, the law of New Mexico has been clear that a hospital assumes responsibility for any negligence committed, incidental to the operation of its emergency room, where the hospital creates the appearance that the doctors providing that care were its own agents. The basis for this imposition of authority is set forth in two cogent quotes from the Court in Houghland vs. Grant:

> By calling itself a hospital and by being a full service hospital, including an emergency room as part of its facilities, an institution makes a special statement to the public when it opens its emergency room to provide emergency care for people. In essence, an agency by estoppel is established by creating an effect: that is, the appearance that the hospital's agents, not independent contractors, will provide medical care to those who enter the hospital. The patient relies upon this as a fact and he believes he is entering a full service hospital. . . .
>
> [Thus,] regardless of any contractual arrangements between the doctors and other medical staff on emergency room duty in

> the hospital, the hospital would be liable for injuries caused by the doctor's malpractice . . . When members of the public seek care at a modern hospital emergency room, they reasonably assume that the hospital is responsible for their care.

119 N.M. at 427, 891 P.2d at 568 (internal quotation marks and citations omitted.)

The New Mexico Uniform Jury Instruction is clear that Houghland applies to all hospital-based physicians, i.e. emergency room physicians, radiologists, and pathologists, all of whom are selected by the hospital rather than by the patient for patient care. The applicable New Mexico Uniform Jury Instruction provides:

> **13-1120B Hospital Vicarious Liability Non-Employees.**
>
> **A hospital is responsible for injuries approximately resulting from the negligence of health care providers who are not hospital employees such as in [Insert description of the applicable department, such as in "a full-service emergency room".] If the hospital through its conduct created the appearance that it was the provider of these services to the public.**
>
> Directions for use. This instruction should be given when a plaintiff claims that a hospital is vicariously liable for the negligent conduct of a nonemployee practitioner providing hospital-based patient care.

UJI 13-1120B NMRA (bolding and emphasis added).

B. Matters of Pleading.

Nothing in Houghland, or any other New Mexico case, requires apparent authority to be pled initially in the plaintiff's complaint. In Houghland itself, the issue of apparent authority wasn't even raised with the district court until the time of summary judgment, and then only as a matter of argument by Houghland's counsel in an effort to encompass the negligence of Northeastern's independent contractor emergency room physicians in his claim against Northeastern Hospital.

Thus, Judge Vigil's holding that for Mr. Vaughan had to plead apparent authority in advance is in direct conflict with the actual facts of Houghland and Houghland's underlying rationale which allows patients to presume that physicians selected by the hospital to perform services upon patients under the roof of the hospital are in fact the hospital's employees and the hospital is responsible for their negligence. That was Mr. Vaughan's presumption as to all rendered care at St. Vincent's on the night of August 8, 2002 and one to which he was fairly entitled. See Vaughan's Second Affidavit, RP at 325-27.

Thus, the trial court's holding that vicarious liability must be specifically pled was in clear conflict with Houghland.[11]

C. Matters of Prejudice.

There is no prejudice to St. Vincent's by holding it vicariously liable for any of Dr. Damron's actions. St. Vincent's has known since the date of the Houghland decision in 1995 that it is vicariously liable for all the hospital-based physicians and personnel who provide care to the patients which visit its emergency room. St Vincent's was well aware of that issue throughout the lawsuit.[12]

Thus, there is no prejudice, and can be no prejudice, to St. Vincent's resulting from the imposition of liability for its apparent agents.

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[11] It is important to note that Mr. Vaughan's effort to specifically plead vicarious liability four years after the filing of his Complaint was in response to St. Vincent's claim that it had to be pled. See Transcript of Proceedings (taken October 22, 2009) at 16:25-17:3; Defendant's Supplemental Memorandum in Support of Defendant St. Vincent Hospital's Motion for Summary Judgment (filed November 16, 2009), RP at 266-76. As a matter of getting on with the lawsuit, St. Vincent's claim that apparent authority had to be specifically pled was easily addressed by simply amending the pleadings.

[12] St. Vincent's knew of its vicarious liability from the beginning and fashioned the single exculpatory sentence in Dr. Kozlowski's affidavit to include the hospital's agents, which of course includes its apparent agents: "Specifically I believe the employees and agents complied with the standard of care." Kozlowski Aff. ¶ 3, at 1. RP at 102 (emphasis added).

CONCLUSION

In short, it is clear that St. Vincent's motion for summary judgment was without a factual or legal basis from the date of filing.

The Court should order of reversal, because the record as a whole overwhelming supports an order granting summary judgment for Mr. Vaughan.

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I hereby certify that on November 12, 2010, I have caused a true and correct copy of this Brief in Chief to be served by hand delivery on:

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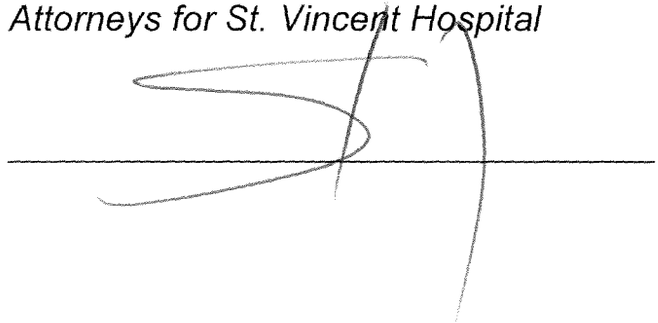

STATEMENT OF COMPLIANCE

Pursuant to Rule 12-213(A), (F) & (G), Plaintiff-Appellant states that the total word count contained in the body in the body of this brief is 6,622 words, using Microsoft Office Word 2008.

March 12, 2010 _____

Dated