COPY

IN THE COURT OF APPEALS OF THE STATE OF NEW MEXICO

COURT OF APPEALS OF NEW MEXICO
ALBUQUERQUE
FILED
JAN 14 2011

WILLIAM "MACK" VAUGHAN,

PLAINTIFF-APPELLANT,

vs.

ST. VINCENT HOSPITAL, INC.,

DEFENDANT-APPELLEE.

No. 30,395
Santa Fe County
D-101-CV-2006-00175

PLAINTIFF-APPELLANT'S REPLY BRIEF

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

Respectfully submitted by:

Stephen Durkovich
Nikko Harada
534 Old Santa Fe Trail
Santa Fe, New Mexico 87505
505.986.1800

Ray M. Vargas, II
Erin O'Connell
Garcia & Vargas, LLC
303 Paseo de Peralta
Santa Fe, NM 87501-1860
505.982.1873

Attorneys for William "Mack" Vaughan

TABLE OF CONTENTS

TABLE OF CONTENTS..2

TABLE OF AUTHORITIES 3

ARGUMENT...5

I. MR. VAUGHAN'S COMPLAINT ABSOLUTELY COMPLIED WITH RULE 1-008..5

II. NEW MEXICO LAW DOES NOT REQUIRE VICARIOUS LIABILITY TO BE SPECIFICALLY PLEAD 11

III. MR. VAUGHAN'S CLAIMS AGAINST ST. VINCENT'S DID NOT REQUIRE EXPERT TESTIMONY......................................12

IV. IF EXPERT TESTIMONY WAS REQUIRED, EXPERT TESTIMONY WAS BEFORE THE DISTRICT COURT SUPPORTING MR. VAUGHAN'S CLAIM OF NEGLIGENCE AGAINST ST. VINCENT'S HOSPITAL 15

V. ST. VINCENT'S FAILURE TO COMMUNICATE MR. VAUGHAN'S RADIOLOGY FINDINGS TO DR. VOLTURA DID CAUSE MR. VAUGHAN'S INJURY 19

CONCLUSION...23

TABLE OF AUTHORITIES

New Mexico Rules

Rule 1-008, NMRA....................5, 8

Uniform Jury Instructions

UJI 13-1119(A), NMRA 12, 14

New Mexico Cases

Biebelle v. Norero, 85 N.M. 182, 510 P.2d 506 (1973)....................8

Cronin v. Sierra Medical Center, 2000-NMCA-082, 10 P.3d 845 19

Galvan v. City of Albuquerque, 85 N.M. 42, 508 P.2d 1339 (Ct App. 1973)....................19

Gerety vs. Demers, 92 N.M. 396, 589 P.2d 180 (1978) 13

Houghland vs. Grant, 119 N.M. 422, 891 P.2d 563 (Ct. App. 1995) 7, 8, 9

Jaramillo vs. Kellog, 1998-NMCA-142, 966 P.2d 792....................13

Mascarenas vs. Gonzales, 83 N.M. 749, 497 P.2d 751 (Ct. App. 1972)......14

Pharmaseal Laboratories, Incorporated vs. Goffe, 90 N.M. 753, 568 P.2d 589 (1977) 13

Toppino vs. Herhahn, 100 N.M. 564, 673 P.2d 1297 (1983) 13

Other Jurisdictions

Gould vs. New York City Health & Hospitals Corporation, 490 N.Y.S.2d 87 (Sup.Ct. 1985)....................14

Robinson vs. Medical Center of Central Georgia, 456 S.E.2d 254 (Ga.App. 1995) 14

Sexton vs. St. Paul Fire and Marine Insurance Co., 631 S.W.2d 270 (Ark. 1982)……………………………………………………………......14

Smith v. North Fulton Medical Center, 408 S.E.2d 468 (Ga.App. 1991)….14

ARGUMENT

I. Mr. Vaughan's Complaint Absolutely Complied With Rule 1-008.

A. Mack Vaughan's Complaint.

Mr. Vaughan's Complaint was not a notice pleading providing only "a short and plain statement" of Mr. Vaughan's claim as required by Rule 1-008(A)(2). Instead, it far exceeded the requirements of Rule 1-008.[1] It provided, in pertinent part:

> 3. In August of 2002, Mr. Vaughan went to the emergency room at St. Vincent Hospital suffering from severe abdominal pain.
>
> 4. He was worked up in the emergency room and a number of examinations were ordered including an abdominal CT scan.
>
> 5. The abdominal CT scan showed a mass adjacent to his sigmoid colon and his bladder.
>
> 6. The radiologist who read the CT scan determined that, given the mass, the diagnostic possibilities were either an abscess associated with diverticulitis or a neoplasm.
>
> 7. While the radiologist apparently called Anna Maria Voltura, the physician involved in Mr. Vaughan's care, it is not clear whether all of the diagnostic possibilities set forth in the CT scan report were communicated in that conversation.

---

[1] Mr. Vaughan's Complaint in any event is required to be interpreted to allow each claim to be decided on the merits as opposed to technicalities. See Biebelle v. Norero, 85 N.M. 182, 184, 510 P.2d 506, 508 (1973).

8. Whatever was said in the conversation, the radiology report itself was apparently never sent by St. Vincent Hospital to Dr. Voltura or to Dr. Wilt.

9. As a consequence, Dr. Voltura neither worked up nor ruled out the neoplasm mentioned as a second diagnostic possibility in the radiology report.

10. In fact, Dr. Voltura never even noted the potential existence of a neoplasm in any of her records.

11. Additionally, Dr. Voltura never told Mr. Vaughan that his CT scan showed a mass that was potentially a neoplasm.

12. Instead, Mr. Vaughan did not learn until the past week that there had been a radiology report in August of 2002 identifying a mass in his abdomen that was potentially a neoplasm.

13. As a consequence of the apparent failure by St. Vincent Hospital through an administrative inadequacy to forward the radiology report on to Dr. Voltura, Mr. Vaughan was treated for a diverticular abscess with antibiotics, allowing the neoplasm to continue to grow.

14. The neoplasm, which turned out to be cancerous, continued to grow over the next year until approximately July of 2003 when it was discovered that it had invaded the bladder and the colon was communicating with the bladder through a cancerous fistula.

15. By this time, the cancer was already in one of Mr. Vaughan's lymph nodes.

16. The action of St. Vincent Hospital in not forwarding on the radiology report of the August of 2002 CT scan showing the potential neoplasm to Dr. Voltura was negligent.

First Amended Complaint for Medical Negligence, RP 27-28.

Mr. Vaughan's Complaint described a simple wrong – not c.c.ing or otherwise communicating Mr. Vaughan's CT report to Mr. Vaughan's treating physicians and the resulting harm to Mr. Vaughan. Mr. Vaughan's Complaint clearly defined St. Vincent's error as one arising out of St. Vincent's administrative inadequacies, a term meant to cover all the administrative glitches that might have given rise to that error and to make it clear that no standard of care issues were involved.

Mr. Vaughan did not allege generally that St. Vincent's liability was vicarious or specifically allege that it arose in part from the apparent authority of the interpreting radiologist. No rule of the court or New Mexico case required such an allegation. See Part II at 11.

Mr. Vaughan, in fact, had no knowledge of the employment status of any of the individuals who had treated him at St. Vincent's on the night he entered St. Vincent's ER. Mr. Vaughan had no need to know of those facts and was entitled to presume that all of the providers that cared for him under St. Vincent's roof were in fact St. Vincent's employees under the express language of Houghland v. Grant, 119 N.M. 422, 427, 891 P.2d 563, 568 (Ct. App. 1995).

If the radiologist or transcriptionist turned out not to be St. Vincent's employee, St. Vincent's was nevertheless responsible under the doctrine of apparent authority for the actions of those persons who appeared to be its employees, unless St. Vincent's or their providers somehow made it clear to Mr. Vaughan during his ER visit that the providers were not its employees.[2] See Houghland, 119 N.M. at 429, 891 P.2d at 570.

St. Vincent's argument that Mr. Vaughan's Complaint violates Rule 1-008 because it allegedly gave no notice to St. Vincent's of any claim against it for the conduct of the radiologist noted in Mr. Vaughan's Complaint is a transparent attempt to impose on Mr. Vaughan, through Rule 1-008, a requirement that cannot be found in any New Mexico rule or appellate case. See Part II (New Mexico Does Not Require Vicarious Liability to be Specifically Plead) at 11. If there was no specific rule of the court or New Mexico case requiring vicarious or apparent authority to be specifically plead, it cannot be bootstrapped into Rule 1-008.

[2] Mr. Vaughan's affidavit made it clear that no one at St. Vincent's made that distinction to him on the evening of his treatment. See generally Affidavit of William "Mack" Vaughan, RP 325-27.

B. What St. Vincent's Knew Upon Service of Mr. Vaughan's Complaint.

St. Vincent's, upon reading Mr. Vaughan's Complaint, knew the general circumstance out of which its liability was alleged, i.e. Mr. Vaughan's visit to its ER in August of 2002; the precise act that was alleged to be negligent, i.e. the failure to transmit Mr. Vaughan's CT report to his treating physicians; and the consequences to Mr. Vaughan of that failure, i.e. the spread of his cancer.

St. Vincent's also knew that Mr. Vaughan was not alleging that this error was a treatment error raising issues as to the standard of care, but instead an administrative or operational error.

By virtue of its operation of the hospital, St. Vincent's knew both the name and the employment status of the radiologist noted in Mr. Vaughan's Complaint. St. Vincent's further knew there was no c.c. of St. Vincent's report, and the deficiency was the immediate result of either the radiologist's omission or its transcriptionist's omission.

Under Houghland v. Grant, New Mexico law since 1995, and the resulting Uniform Jury Instructions and commentary, St. Vincent's was also aware that it was liable under the doctrine of apparent authority for the conduct of hospital-based physicians under circumstances similar to, if not essentially the same, as those alleged in Mr. Vaughan's Complaint.

St. Vincent's also knew it was vicariously liable for the acts of its transcriptionist and potentially directly liable for failing to have in place a system that automatically transmitted radiology reports to any treating physicians noted in the record.

C. What St. Vincent's Learned Subsequent to Answering Mr. Vaughan's Complaint.

If St. Vincent's upon reading Mr. Vaughan's Complaint somehow did not understand that it was potentially negligent for the actions of the radiologist and its transcriptionist in not conveying the information in the radiologist's report to Mr. Vaughan's treating physicians, Dr. Voltura's Statement delivered to St. Vincent's three years prior to St. Vincent's motion[3] for summary judgment, brought it home in no uncertain terms.

> 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

[3] The Statement was delivered in June of 2006 when requested by St. Vincent's even though it was noted to be work product. St. Vincent's in its Answer points out that Dr. Voltura's statement was not obtained prior to Mr. Vaughan filing his suit as was stated in Mr. Vaughan's Brief in Chief, Instead it was furnished to St. Vincent's after suit commenced. St. Vincent's is absolutely correct. Mr. Vaughan's counsel apologizes to both St. Vincent's and the Court for the incorrect statement.

> 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 121-22.

II. New Mexico Law Does Not Require Vicarious Liability to be Specifically Plead.

St. Vincent's informed Judge Michael Vigil on October 22, 2009 that Mr. Vaughan could not claim negligence against St. Vincent's for the negligence of the radiologist who read the CT at St. Vincent's, because Mr. Vaughan had not plead apparent authority. See 10/22/09 Tr. 4:22-24, 14:1-17, 17:3-10. St. Vincent's makes the same claim to this Court.

However, St. Vincent's ultimately admits to this Court what Mr. Vaughan previously informed the district court – i.e. there is no New Mexico requirement that vicarious liability of any sort be plead.[4] See St. Vincent's Answer Brief at 18.

St. Vincent's admission in its brief eliminates the entire issue of the timeliness of Mr. Vaughan's motion to amend his Complaint after St. Vincent's erroneous argument before the district court, a motion filed simply

---

[4] St. Vincent's cites the Court instead to cases from Iowa, Illinois, and Georgia. Whatever the merits of these cases, attorneys in New Mexico are not required to look to the rules of the appellate cases from Iowa, Illinois, and Georgia in drafting their pleadings – only New Mexico law. And New Mexico law imposed no such requirement when Mr. Vaughan drafted his Complaint.

to dispense with the issue by pleading it and allowing the case to proceed. Because no rule or New Mexico case requires it to be plead, there is no need for the amendment. The matter is moot and will not be argued further here.

III. Mr. Vaughan's Claim Against St. Did Not Require Expert Testimony.

A. The Error At Issue Was Operational or Administrative Error Not Requiring Expert Testimony.

The fact that the error of St. Vincent's radiologist or transcriptionist occurred within the four walls of St. Vincent's Hospital does not carry with it the requirement that expert testimony is required to prove that negligence.

UJI 13-1119(A) expressly sets out the requirements for proving liability against the hospital arising in an operational context, an instruction that is notable for the absence of any requirement as to expert testimony.

> In _______ (*insert description of conduct in question*), a hospital is under a duty to use ordinary care to avoid or prevent what a reasonably prudent person would foresee as an unreasonable risk of injury to another. A hospital that fails to do so is negligent. "Ordinary care" is that care which a reasonably prudent person would use in the conduct of the person's own affairs. What constitutes ordinary care varies with the nature of what is being done. As the risk of danger that should reasonably be foreseen increases, the amount of care required also increases. In deciding whether ordinary care has been used, the conduct in question must be considered in the light of all the surrounding circumstances.

UJI 13-1119(A), NMRA.

B. The Cases Cited by St. Vincent's Do Not Apply to the Negligence at Issue Here.

Each of the cases cited to this Court by St. Vincent's involve medical treatment which rightly requires expert testimony. See Jaramillo v. Kellog, 1998-NMCA-142, ¶¶ 7-9, 966 P.2d 792, 794 (death of a mental health patient involving five-point restraint and a sedative); Gerety v. Demers, 92 N.M. 396, 402-403, 589 P.2d 180, 186-87 (1978)(medical complications arising from hernia repair and ileostomy revision); Pharmaseal Lab., Inc. v. Goffe, 90 N.M. 753, 756, 758, 568 P.2d 589, 592, 594 (1977)(damages resulting from insertion of K-2R Kaslow intestinal tube with the assistance of a metallic mercury filled balloon).

Mr. Vaughan's point is that putting a c.c. on a report or otherwise making sure that the report is transmitted to another physician does not require special expertise and thus does not require expert testimony.

C. Issues within the common experience of the jury do not require expert testimony.

New Mexico courts have consistently held that where the error at issue is something that is within the common experience of the average juror it can be decided without expert testimony. See, e.g. Toppino v. Herhahn, 100 N.M 564, 568, 673 P.2d 1297, 1301 (1983)(expert testimony unnecessary in medical malpractice action involving five plastic surgeries to

reconstruct plaintiff's right breast because the fact that implant should balance its healthy counterpart in size and location was in common knowledge of average person); Mascarenas v. Gonzales, 83 N.M. 749, 752, 497 P.2d 751, 754 (Ct. App. 1972)(expert testimony unnecessary because lay persons know that exerting undue force on a patient's back could fracture ribs).

See UJI 13-1119(A), cmt, NMRA **comparing** Gould v. NY City Health & Hosp. Corp., 490 N.Y.S.2d 87 (Sup.Ct. 1985)(where hospital rule required bedrails to be erected for patients over 50 years of age, expert testimony was not needed to support claim that violation of rule was negligent); Smith v. N. Fulton Med. Ctr., 408 S.E.2d 468 (Ga.App. 1991)(claim of negligence based on failure to raise bedrails in accordance with written nursing assessment did not require expert testimony) **with** Robinson v. Med. Ctr. of Cent. Ga., 456 S.E.2d 254 (Ga.App. 1995)(claim that hospital was negligent in particular case by failing to raise patient's bedrails required support from expert witness); Sexton v. St. Paul Fire & Marine Ins. Co., 631 S.W.2d 270 (Ark. 1982)(claim of negligence in failing to place restraint vest on patient required evaluation of professional judgment applied to patient's circumstances and hence could not be established without expert testimony).

The Real Dynamic

St. Vincent's contention that expert testimony is required to prove Mr. Vaughan's claim is a transparent attempt to transmute the ridiculously simply issue of the need for a c.c. easily understood by any juror, into a complex issue of medical malpractice requiring protracted discovery, a battle of experts at mind-numbing expense ending in a long, money-consuming trial. Hospitals always become the favored party in this type of setting.

IV. If Expert Testimony Was Required, Expert Testimony Was Before the District Court Supporting Mr. Vaughan's Claim of Negligence Against St. Vincent's Hospital.

A. Expert Evidence Arising from Subsequent Discovery and Affidavits.

1. *Dr. Voltura's Statement.*

Dr. Voltura in her Sworn Statement testified that she should have been c.c.'d with the radiology report and that Dr. Damron should have called her with his changed interpretation:

> 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 121-22.

Dr. Voltura also testified that she would have undertaken a totally different course of action in treating Mr. Vaughan had she received the information:

> 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.

2. *Dr. Wolfel's Affidavit.*

Dr. Wolfel's affidavit clearly stated:

> 8. It is absolutely the standard of care that a radiologist reading a diagnostic film communicate the results of his diagnostic impression to the physicians known to be managing the care of the patient, particularly so when the

observed condition is considered urgent or potentially cancerous.

9. <u>However, there is no medical standard for how this communication is to be accomplished</u>.

10. <u>It is simply a basic communication issue</u> no different than any other communication issue in any other walk of life. How does a person or entity communicate important information in such a way to ensure the message gets across? The answer simply depends on the situation.

***

13. The only way to ensure the entirety of the radiologist's impression is communicated in a circumstance such as that, particularly when it contains information about a potential neoplasm, is to copy the radiologist's diagnostic impression to the consulting physicians.

14. This was not done with the August 9 radiology report for Mr. Vaughan. It was unreasonable for the radiology report containing the information about the potential neoplasm not to have been copied to (or personally delivered) to Dr. Voltura.

15. <u>In making this statement, I am again not stating that not copying it to Dr. Voltura was medically negligent, because there was no medical standard</u>. It was simply unreasonable or wrong as a matter of common sense not to do so.

16. <u>This is simply an operational or administrative matter</u> that the hospital and the hospital's radiologist have to decide for themselves, knowing that the hospital and the radiologist are ultimately responsible for making sure that <u>the entire impression</u> to be communicated is in fact communicated.

***

> 18. Whether the failure to copy Dr. Voltura with the radiology report was due to the negligence of St. Vincent's transcriptionist, or whether St. Vincent's radiologist, Dr. Damron, simply overlooked the need to get his complete report to Dr. Voltura, cannot be discerned from Mr. Vaughan's records.
>
> 19. The point is that it was negligent for the St. Vincent's August 9 written radiology report not to have been conveyed to Dr. Voltura on that date.

Affidavit of Donald Wolfel, M.D. ¶¶ 8-10, 13-16, 18-19, at 2-4, RP 222-24 (emphasis added).

Dr. Voltura's sworn statement and Dr. Wolfel's affidavit provided facts upon which the district court should have granted summary judgment to Mr. Vaughan as requested in his motion.[5]

At a minimum, they provide facts sufficient to defeat St. Vincent's motion for summary judgment, which was based on the totally conclusory affidavit of an Dr. Mark Kozlowsi, RP 102-103, an ER physician with no stated qualifications or experience on the matters at issue, i.e. the process by which a radiologist or the hospital conveys transcriptions of radiology reports to the actual physician in need of those reports for patient care, and no opinions that actually addressed those issues. See Cronin v. Sierra Med.

[5] None of the information contained in the affidavits of any of Mr. Vaughan's experts or Dr. Voltura's Statement was noted by the district court in argument or in the district court's decision. Instead, the court ruled that there was no expert testimony supporting Mr. Vaughan's claim. It is this error that requires reversal.

Ctr., 2000-NMCA-082, ¶ 26, 10 P.3d 845, 852; Galvan v. City of Albuquerque, 85 N.M. 42, 45, 508 P.2d 1339, 1342 (Ct. App. 1973).

V. St. Vincent's Failure to Communicate Mr. Vaughan's Radiology Findings to Dr. Voltura Did Cause Mr. Vaughan's Injury.

A. Dr. Voltura's Testimony.

St. Vincent's argues that there was no expert testimony on the issue of causation and cites extensively from Dr. Voltura's Deposition to the effect that the absence of a c.c. to Dr. Voltura did not cause the subsequent spread of Mr. Vaughan's cancer. Instead, if Mr. Vaughan would have appeared for subsequent examinations at her office or the VA, the cancer could have been discovered well in advance of October 2003 when it was ultimately diagnosed.

First, whatever Mr. Vaughan did or did not do after he was seen in the ER when Dr. Voltura did not know about the potential for a neoplasm is irrelevant because none of that would have come to pass if Dr. Voltura had done surgery as she said she would have had she known that fact. St. Vincent's ignores Dr. Voltura's testimony in her Statement where she stated that she 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.

Second, in citing different testimony from Dr. Voltura's later deposition, St. Vincent's proves at most that there is a dispute as to material fact requiring resolution by a jury.

B. Dr. Bagwell's Affidavit.

St. Vincent's also completely ignores the affidavit of Dr. John Bagwell, Mr. Vaughan's treating oncologist, in which he explained:

> 2. I believe from the standpoint of reasonable medical probability that Mr. Vaughan had a cancer of the colon when seen in the St. Vincent Hospital Emergency Department in August 2002.

***

> 5. I believe from the standpoint of reasonable medical probability that Mr. Vaughan's colon cancer in August 2002 was at was at a Stage II (TNM T2, N0, M0) or a better prognostic Stage III (TNM T3, N0, M0).
>
> ***
>
> 4. Mr. Vaughan's colon cancer was a well to moderately well differentiated Stage III (MAC C3) TNM T4N1M0 when diagnosed in October 2003.
>
> ***
>
> 6. Based on available statistical evidence, the delay in diagnosis between August 2002 and October 2003, allowing a stage progression of the colon cancer, as a matter of reasonable medical probability reduced Mr. Vaughan's 5-year disease-free survival, and his potential for cure, by 35%.
>
> 7. Stated differently, the delay in diagnosis changed Mr. Vaughan's chances of a 5-year disease-free survival from a clear probability of survival to a 50/50 chance of survival, or less.
>
> ***
>
> 3. I believe the delay of 14 months between the August 2002 St. Vincent's Hospital Emergency Department evaluation and the ultimate diagnosis of Stage III Colon cancer in October 2003 had a significant impact on Mr. Vaughan's 5-year disease-free survival and potential for cure.

Affidavit of John Bagwell ¶¶ 2, 5, 4, 6, 7, 3, at 1-2, RP 190-91.

C. St. Vincent's Never Contested Dr. Voltura's Statement or the Affidavits of Mr. Vaughan's Experts to the District Court on the Grounds Argued Here.

In an effort to avoid Mr. Vaughan's expert testimony, St. Vincent's argues to this Court that Dr. Voltura, Dr. Wolfel, and Dr. Bagwell were not qualified to offer opinions on ER procedure because they were not employed

in an ER department or that these opinions were speculative. St. Vincent's argument misses the mark for a number of obvious reasons.

First, St. Vincent's never made those arguments to the district court below. In fact, the substance of the affidavits of Dr. Bagwell, Dr. Wolfel, and Dr. Voltura's Statement were never even argued to the district court by St. Vincent's or noted even by the district court in its order.

Second, the fundamental issues of liability and causation are not ER issues. While arising out of Mr. Vaughan's ER visit, they involve issues of how hospitals communicate radiology reports to treating physicians and how the failure to communicate those reports impacted Mr. Vaughan. These are not ER issues.[6] They involve the specialties of radiology, surgery, and oncology. Dr. Wolfel, a radiologist, and Dr. Voltura, a surgeon, were thus qualified by virtue of their respective specialties to testify as to the first two issues, Dr. Voltura and Dr. Bagwell by virtue of their respective specialties as a surgeon and an oncologist were qualified to testify on the final issue – how the failure to communicate the CT findings impacted Mr. Vaughan.

---

[6] The fact that the cause of error and the resulting harm was not an ER issue, and thus not subject to the opinion of an ER physician was raised in the district court by Mr. Vaughan, see Response to St. Vincent's motion for summary judgment, RP 116, but went unnoted in the district court's decision. However, the fact that it was raised with the district court allows it to be raised here.

Again, questions as to the qualifications of these physicians were never brought to the attention of the district court below.

CONCLUSION

The Court of Appeals should order reversal because the record as a whole overwhelmingly supports a remand for a jury trial to resolve the disputed facts, if not an order granting summary judgment for Mr. Vaughan. St. Vincent's cannot change the rules under which complaints are plead or the evidentiary requirements under which negligence is proven. Mr. Vaughan requests oral argument because it would be helpful to resolution of the issues given the parties' disagreement about the controlling law.

Respectfully submitted,

Stephen Durkovich
Nikko Harada
534 Old Santa Fe Trail
Santa Fe, New Mexico 87505
Phone: (505) 986-1800
Fax: (505) 986-1602

and

Garcia & Vargas, LLC
Ray M. Vargas, II
Erin B. O'Connell
303 Paseo de Peralta
Santa Fe, New Mexico 87501
Phone: (505) 982-1873
Fax: (505) 982-8012

Attorneys for William "Mack" Vaughan

I hereby certify that on January 14, 2011, I have caused a true and correct copy of this Reply to be served by regular U.S. Mail on:

The Court of Appeals for the State of New Mexico
Post Office Box 2008
Santa Fe, New Mexico 87504-2008

The Honorable Barbara J. Vigil
The First Judicial District Court of the State of New Mexico
Post Office Box 2268
Santa Fe, New Mexico 87504

Carmela McAlister, Official Court Reporter
The First Judicial District Court of the State of New Mexico
Post Office Box 2268
Santa Fe, New Mexico 87504

Hinkle, Hensley, Shanor & Martin, L.L.P.
William P. Slattery
Dana S. Hardy
218 Montezuma Avenue
Post Office Box 2068
Santa Fe, New Mexico 87504
Attorneys for St. Vincent Hospital

STATEMENT OF COMPLIANCE

Pursuant to Rule 12-213(A), (C), & (G), Plaintiff-Appellant states that the total word count contained in the body of this Reply is 4,383 words, using Microsoft Word 2008 for Mac and Times New Roman font.

Dated: 1-14-11