Significant Medical and Legal Negligence Cases and Developments during the Past Year – A Review and Some Observations

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Introduction

There were a number of Supreme Court decisions decided over the past 12 months relating to medical negligence litigation, as well as a decision to accept certiorari review of a legal negligence case involving the important issue of the extent of duties of attorneys to non-clients, and specifically the duty of an attorney representing a testator to the beneficiaries of the estate. There was one significant court of appeals decision, as well, regarding the exercise of judgment instruction set forth at CJI-Civ. 15:4, and its applicability to claims against claims against nurses. This article reviews those decisions and their impact on professional negligence litigation.

Medical Negligence

Supreme Court Decisions

Kelly v. Haralampopoulos – The Expanded Limits of CRE 803(4) Regarding Statements Made To Physicians for the Purposes of a Medical Diagnoses, and a Restricted View of the Limitations of CRE 403

Kelly v. Haralampopoulos[1] had been previously reviewed by the court of appeals. It involved post-mortem statements allegedly made by the plaintiff's girlfriend, Ms. Hurd, which the defendant physician and his attorneys, over plaintiff's objection, were allowed to repeatedly recount during the trial through the testimony of six medical experts, that the patient was a recreational cocaine user and prior to the first emergency room visit he may have been using cocaine because of his pain. This was used in support of the physicians' conclusions that plaintiff's permanent brain damage was not attributable to the defendant physician causing spillage of a cyst on plaintiff's liver by taking an ill-advised needle biopsy, but instead to plaintiff's reported cocaine use. As most attorneys who have practiced in this area would likely attest to, evidence of cocaine use (or any other defined bad health practice by the patient, e.g., smoking) likely will beat your case no matter what, and given this evidence, plaintiff was indeed unsuccessful with the jury at the trial court level.

The statement by Ms. Hurd, however, had been made approximately two weeks after the needle biopsy, and thus well after plaintiff had suffered the catastrophic injury he did that caused him to enter into an irreversible vegetative state. Thus, Ms. Hurd was not making the statements attributed to her by the defendant, to assist in treatment, but simply because in her words, she was at that point "searching for answers."[2] Plaintiff had thus challenged that the statements were admissible under the hearsay exceptions of CRE 803(4) (statements made for purposes of medical diagnosis) and CRE 807 (the miscellaneous hearsay exception), as well as after a proper CRE 403 analysis (probative value outweighed by its prejudicial effect), and raised these issues

on appeal.

At the court of appeals level, Judge Fox, writing for the majority, opined that Ms. Hurd's statement did not qualify under CRE 803(4) because it was not "consistent with the purpose of promoting treatment or diagnosis," nor was "the content of the statement . . . such as is reasonably relied upon by a physician in treatment or diagnosis."[3] Instead, the statement was more consistent with the non-medical but legal purpose of attributing fault for the patient's injuries to the patient. The court determined, as well, with regard to the miscellaneous hearsay exception at CRE 807, that the statement did not have the "necessary guarantees of trustworthiness" to qualify under such. The majority also opined that the evidence violated CRE 403, because of its unreasonably prejudicial nature. Thus, the judgment in favor of defendants was ordered reversed, with Judge Webb dissenting.

The Supreme Court, however, granted *certiorari* and the story continued. For better or worse, the case attracted significant attention, with three amicus briefs being filed supporting defendants' position, by the AMA, the Colorado Defense Lawyers Association, and the University of Colorado. The Supreme Court, with a three justice concurrence, reversed the court of appeals, with the majority opinion written by Justice Eid.

As described above, the key to the court of appeals' CRE 803(4) determination was that Ms. Hurd's statements had been made well after the plaintiff entered into a vegetative state such that further treatment was no longer an issue. Thus, to many, the special credibility of statements made to a treating physician under CRE 803(4) didn't exist. Specifically, 803(4) creates a hearsay exception for:

> Statements made for purposes of medical diagnosis or treatment and describing medical history, or past or present symptoms, pain, or sensations, or the inception or general character of the cause or external source thereof insofar as reasonably pertinent to diagnosis or treatment.

As mentioned by Justice Eid in her opinion, the U.S. Supreme Court has described the basis of the analogous federal rule as follows:

> [A] statement made in the course of procuring medical services, where the declarant knows that a false statement may cause misdiagnosis or mistreatment, carries special guarantees of credibility.[4]

When Ms. Hurd, however, made the statement she was not influenced by a likely concern that a misstatement by her might lead to a misdiagnosis or mistreatment, but simply was motivated by post-mortem curiosity. Thus, arguably Ms. Hurd's statements did not satisfy the basis for which Rule 803(4) existed. In the court of appeals' decision, Judge Fox had in fact reasoned that because of such, the statement was not admissible under 803(4), because the rule "contemplates prospective application only."

The Supreme Court, however, disagreed and found that the language of 803(4) was

broader since it contains not only the term "treatment" but "diagnosis." Thus, CRE 803(4) is available as a hearsay exception even with regard to a "post-mortem pathological diagnosis,"[5] regardless of whether the declarant is being affected by the potential, as described in *White*: "that a false statement may cause misdiagnosis or mistreatment." In coming to this conclusion, the Supreme Court relied, in part, not only on the language of the rule, but on Supreme Court precedent in *King v. People*[6] where the court had previously approved the admissibility under 803(4) of statements made to a forensic psychiatrist by the defendant, offered into evidence by the defendant, where the psychiatrist was evaluating him solely for the purposes of testifying at trial. Justice Eid noted that a similar conclusion had as well been made in *People v. Vigil.*[7] Further she noted that the analogous FRE 803(4) "abolish[ed] the distinction between the doctor 'who is consulted for the purpose of treatment' and the doctor who examines a party 'for the purpose of diagnosis only,' even though the latter 'is consulted only in order to testify as a witness.'"[8] Thus, the court rejected the court of appeals' "prospectivity rationale,"[9] and seemingly any type of statement made by a person to anyone for the purposes of a medical diagnosis is admissible and can be used by any physician in his or her testimony, so long as the physician testifies that the statement is "reasonably pertinent to diagnosis or treatment."[10] This clearly represents an expansive view of the limits of 803(4).

The court of appeals had also ruled that the trial court had erred in admitting the evidence based upon a CRE 403 analysis, which recites the well-known maxim that evidence may be excluded "if its probative value is substantially outweighed by the danger of unfair prejudice …." The Supreme Court, through the words of Justice Eid however, rejected this as well. Instead it described a liberal approach of admissibility with regard to Rule 403 as follows:

> *Rule 403* strongly favors admissibility of relevant evidence, and an appellate court must afford the evidence the maximum probative value attributable by a reasonable fact finder and the minimum unfair prejudice to be reasonably expected from the evidence. Under *Rule 403*, trial courts are given broad discretion in balancing the probative value of the evidence against the danger of unfair prejudice. The trial court's decision under *Rule 403* will not be disturbed on review absent an abuse of discretion, defined as a decision that is manifestly arbitrary, unreasonable, or unfair. *Id.*[11]

Thus, per the Supreme Court, the proper analysis per Rule 403 involves a weighing process slanted in favor of admissibility, where the "maximum probative value attributable by a reasonable fact finder [to the evidence] and the minimum unfair prejudice to be reasonably expected," is the proper analytical process for the court, although the court noted as well that "trial courts are given broad discretion in balancing the probative value of the evidence against the danger of unfair prejudice." [12]

The Supreme Court, as well, described the meaning of the term "unfair prejudice," as follows:

> Unfair prejudice as the phrase is used in *Rule 403* "*does not mean prejudice that*

> *results from the legitimate probative force of the evidence*." Indeed, we have observed that "[a]ll effective evidence is prejudicial in the sense of being damaging or detrimental to the party against whom it is offered." Instead, "unfair prejudice" means "an undue tendency on the part of admissible evidence to suggest a decision made on an improper basis." Thus, even where the evidence might "reflect poorly" on the party about whom it concerns, it may still be admissible if the "trial court could have reasonably concluded that the potential prejudice was not unfair."[13]

The court noted as well:

> As we have observed, the requirement that the danger substantially outweigh the probative value of the evidence "is meant to make clear that the need for exclusion must be clear since exclusion is a drastic remedy and less restrictive measures, such as cautionary instructions to the jury, may suffice to reduce the danger of prejudice to an acceptable level."[14]

Justice Rice, in a concurring opinion discussed the problem concerning the questionable reliability of statements made to physicians for purposes other than treatment, and specifically "statements to a physician consulted only for the purposes of enabling him to testify." She explained, however, the historical development of how the Supreme Court ruled in *King* that a defendant's hearsay statements to a psychiatrist hired for trial were admissible under Rule 803(4). Thus, prior to *King* "statements to a testifying expert" were thought to be properly given the same treatment as they would under Rule 703, i.e. "for the limited purpose of serving as factual support for the [expert's] opinion."[15]

However, she noted that:

> Recognizing that it is unrealistic to expect a jury to distinguish between statements offered only as an explanation of the basis for the expert's opinion and statements offered for their truth, in *King* this Court held that *Rule 803(4)* abolished the common law distinction between doctors consulted for treatment and doctors consulted for diagnosis. Thus, we concluded that hearsay statements made to a non-treating physician "who examines a party for the purpose of diagnosis only" may be admissible under *Rule 803(4)* even though that physician was "consulted only in order to testify as a witness."[16]

Justice Rice, and the other concurring justices, however, would subject tendered Rule 803(4) evidence to an additional two step analysis before the statements were deemed to be admissible, described as follows:

> [F]irst determine whether the relevant hearsay statements are objectively pertinent to achieving a diagnosis. In other words, similar to a *Rule 703* analysis, the court should determine whether an expert in the germane field would be justified in relying upon the statements in formulating an expert opinion.

> If the court determines that the relevant statements are objectively pertinent, it should then determine whether the statements are also subjectively pertinent to the diagnosis rendered. In other words, the court should determine whether a non-treating physician hired for litigation actually relied on the hearsay statements in formulating his expert opinion.[17]

The bottom line to all this analysis, however, is that notwithstanding Judge Fox's description of the historic basis for the development of Rule 803(4) as an exception to the hearsay rule because of the inherent reliability of statements made by a patient to his or her physician to aid in their diagnosis or treatment, this has likely all gone by the wayside, and at this point any statements made by an individual that a physician, *whether a treating physician or not*, which the testifying physician can confirm as forming a reasonable basis for his or her opinions, are likely admissible under 803(4). Further the basis for objections under Rule 403 has been defined to be quite narrow, where admissibility is presumed.

Simpson v. Cedar Springs Hosp., Inc. **– The Reinforcement of the Quality Management Privilege**

Simpson v. Cedar Springs Hosp., Inc. [18] addressed the broad confidentiality afforded to health care facilities and practitioners with respect to peer review and quality management programs, at §25-3-109, C.R.S.

There are perhaps few things more frustrating to plaintiff's attorneys bringing claims against health care facilities and practitioners, than to be precluded from access to findings or opinions made during the course of meetings or investigations by the healthcare facility, which may run contrary to their asserted defense in the underlying negligence claim. Moreover, the thought that the medical profession will truly police its own through the means of confidential reviews, for which there could be no potential tort liability, to many seems naïve. Regardless, organized medicine has gotten the attention of state legislatures, who have consistently responded with legislation based upon the premise that the best path to establish and maintain quality medical programs is through an investigation and review processes, which is "unfettered" by the possibility that either the individual that the reviewers find fault with, or claimants who are injured by conduct which the reviewers find fault with, can have access to the information presented to the reviewers or the standards which they embrace in their analysis.

Thus, state legislatures across the country have established the confidentiality of professional or "peer review" proceedings of the type described in §12-36.5-101, *et seq.*, C.R.S. This same type of legislative confidentiality is embraced, as well, with regard to "quality management programs," as described in §25-3-109, C.R.S., where in this state, healthcare facilities are authorized to establish quality management programs "to evaluate and improve patient and resident care . . . [with regard to] the operation of healthcare facilities licensed or certified by the Department of Public Health and Environment pursuant to §25-1.5-103(1)(a)."

Simpson involved another effort by a plaintiff to break through these barriers, which in *Simpson* involved the quality management privileges. In *Simpson*, plaintiff had sought to obtain the

minutes from meetings of two of the petitioner, Cedar Springs Hospital, Inc.'s ("Cedar Springs"), committee meetings regarding issues that were implicated in plaintiff's claim against Cedar Springs. In response to plaintiff's motion to compel, the trial court ordered such to be produced because in its mind, Cedar Springs had not satisfied its burden to show that it had satisfied the criteria of subsection (2) of the Act, which was that its "quality management program [had been] approved by the Colorado Department of Public Health and Environment." ("CDPHE").

The Supreme Court accepted review of the issue as an original proceeding pursuant to C.A.R. 21. This case again garnered widespread interest, particularly by the healthcare industry, with five amicus curiae briefs being filed on behalf of healthcare facilities and other organizations that opposed the trial court's determination and supported confidentiality.

The facts involved the plaintiff ("Simpson") who sought treatment at Cedar Springs for depression, anxiety, and panic attacks. He was given a course of treatment by Cedar Springs, which involved prescriptions for medication, which he alleged resulted in complications including significant toxic brain and central nervous system damage. Simpson brought a medical malpractice suit against Cedar Springs as well as two of its on-staff psychiatrists, alleging that they negligently prescribed inappropriate medications, and inadequately monitored him and failed to take corrective action when he had negative reactions.

An initial deposition of the director of nursing revealed that various committees including the pharmacy and therapeutics committee, as well as the performance improvement committee, maintained minutes of their meetings to review adverse drug reactions. Simpson thereafter requested production of the minutes. When Cedar Springs objected pursuant to the confidentiality provisions of §25-3-109, C.R.S. regarding quality management programs, Simpson responded that while Cedar Springs had obtained initial approval by CDPHE concerning its program, CDPHE had also requested that Cedar Springs "submit a schedule for implementation of the plan within 90 days", which Cedar Springs didn't do.[19] Thus, Simpson successfully argued to the trial court that because Cedar Springs had failed to produce evidence that it had complied with CDPHE's directive that it submit a schedule for implementation within 90 days, that its program could not thereby be deemed "approved."[20]

This conclusion, however, received little support from the Supreme Court. Justice Eid, writing for the majority, made it clear that the Court favors confidentiality, and that a mere lack of "regulatory compliance" by the healthcare facility was not going to be sufficient to override the privilege. Instead, the key to the inquiry per Justice Eid, was whether Cedar Springs maintained its CDHPE license during the time frame subsequent to CDPHE's acceptance of its plan, which it did. The court reasoned as follows:

> The legislature recognized the privilege because, as noted above, "it is necessary that the collection of information and data by such licensed or certified health care facilities be reasonably unfettered so a complete and thorough evaluation and improvement of the quality of patient and resident care can be accomplished." *§ 25-3-109(1)*. In other words, quality management teams must be able to speak openly and honestly about the quality of services delivered in order for those services to be improved. There is nothing in the statutory scheme to suggest that a privilege

> determination should be used as a backstop for regulatory compliance. Indeed, the privilege is designed to encourage frank and open discussion about quality management, not to punish a facility for failure to have approval documentation "immediately in place," as suggested by the trial court.[21]

Justice Marquez dissented, noting that in her view:

> . . . a hospital that relies on ongoing licensure as evidence of the Department's continued approval of its quality management program must establish that it notified the Department of changes made to the quality management plan—or otherwise establish that it did not need to report the changes made. Here, Cedar Springs failed to meet this (minimal) burden because it neither submitted a description of its 2008 plan changes to CDPHE nor otherwise established that the 2008 changes were non-substantive and therefore did not have to be reported.[22]

Thus, in addition to the privileges set forth with regard to peer review, at §12-36.5-101, *et seq*., C.R.S., quality management privileges are likely to be strongly enforced as well by the Supreme Court, with or without regulatory compliance by the healthcare facilities, so long as its regulatory deficiencies don't affect the facility's licensing status.

***Chapman v. Harner* – Per CRE 301, Res Ipsa Loquitar Shifts the Burden of Moving Forward but Not the Burden of Proof**

As reported in last year's Trial Talk article,[23] the issue of the effect of CRE 301 defining presumptions as shifting only the burden of coming forward versus supreme court precedent that preceded CRE 301, i.e. the eloquently written 1958 case of Weiss *v. Axler,*[24] which held at least with regard to medical malpractice claims that it shifted the *burden of proof*. This lead to the court of appeals' decisions decided after the passage of CRE 301 of *Ochoa v. Vered*[25] where regardless of CRE 301 the court of appeals upheld the precedent of *Weiss* that the presumption shifted the burden of proof, as well as *Harner v. Chapman*[26] which came to the same conclusion. In both *Ochoa* and particularly *Harner*, however, the court of appeals suggested and indeed in *Harner invited* Supreme Court review.

The Supreme Court accepted the invitation and in *Chapman v. Harner,*[27] ruled that CRE 301 should prevail, with *res ipsa liquitar* only shifting the burden of coming forward, and to the extent that "*Weiss* . . . or any other previously decided case holds to the contrary," such cases were overruled. In doing such, the court not only had to overrule *Weiss*, but as well, overcome statements it had made in two previous cases rendered after the passage of CRE 301. These cases included *Stone's Farm Supply, Inc. v. Deacon,*[28] where the court had stated in a footnote that *res ipsa loquitar* "allows an inference of breach of duty and causation, and requires the defendant to prove by preponderance of the evidence that he was not negligent,"[29] which the court found to be dicta.[30] In *Kendrick v. Pippen*[31] it had cited *Stone's Farm* for the proposition that *res ipsa loquitar* "establishes a rebuttable presumption that the defendant was negligent" and in a concurring opinion, Justice Martinez stated that *res ipsa loquitar* is "a presumption that shifts the burden to the defendant to prove that he or she was negligent,"[32] which the court dismissed as dicta as well. Further, *Ochoa* was

accurately characterized by plaintiff as binding authority based upon the fact that it was a published court of appeals' opinion, where certiorari was denied,[33] but was characterized in *Chapman* as a case where the court of appeals had merely ruled that the trial court had not abused its' discretion since the law at the time was unsettled. [34]

Weis was more challenging, since clearly the court had specifically been confronted with the issue and decided that it shifted the burden of proof. The court, however, characterized *Weiss* as a case that was primarily based upon standards involving common carriers, and that the "burden shifting approach approved by *Weiss*" as being a "fringe position."[35] The court concluded as well that CRE 301 represents better policy,[36] which "unifies the state and federal effects of the presumption,"[37] and thereby overruled *Weiss* and any of its progeny.

All of that was likely the easy part. What the effects of a presumption that shifts the burden of coming forward, versus one that shifts the burden of proof, is more difficult to describe. As for a description of the effects of the doctrine, the court described it as something that is destroyed when the defendant comes forward with prima facie evidence that he or she was not negligent, but nevertheless allows for a "permissible inference of negligence [that] remains … where the jury may consider [such] inference alongside the other evidence in determining whether the plaintiff satisfied his burden to prove that the defendant was negligent"[38] – although the court added, as well, that "the trial court has discretion to determine whether or not to instruct the jury on the remaining permissible inference."[39]

All of this, as well as the confusing nature of the stock instruction of CJI-Civ. 9:17, itself, where the jury is instructed that it must conclude that: "2. such injuries would not have occurred unless someone was negligent . . . ;" and "3. that at the time and in the way such negligence probably occurred, it was more likely the negligence of the defendant than the negligence of anyone else that caused the plaintiff's injuries," likely gave rise to plaintiff's argument that merely shifting the burden of coming forward turned the presumption intended by *res ipsa loquitar* into an "illusory remedy"[40] where the proponent of the doctrine is reduced to arguing about a confusingly described doctrine that at best creates a permissible inference. The court, however, was not persuaded.

Court of Appeals Decisions

Gasteazoro v. Catholic Health Initiatives Colo. – C.J.I. 15:4 Instruction for Nurses – Medical Experts Testifying Outside their Area of Specialty

Gasteazoro v. Catholic Health Initiatives Colo.[41] is a significant case court of appeals case and deals at the outset with stock instruction 15:4, oftentimes referred to as the "exercise of judgment" or "unsuccessful outcome" instruction. The instruction states:

> A *physician* does not guarantee or promise a successful outcome by simply treating or agreeing to treat a patient. An unsuccessful outcome does not, by itself, mean that a physician was negligent. An exercise of judgment that results in an unsuccessful outcome does not, by itself, mean that a physician was

negligent. (Emphasis added).

The instruction was challenged in *Day v. Johnson*,[42] based upon multiple grounds, including that it: (1) conflicts with the standard of care introducing subjectivity into an objective standard of care; (2) is duplicative; (3) comments on the evidence; and (4) overemphasizes the defense's theory of the case. Although certiorari was granted, because of preservation issues, the Supreme Court ruled only with regard to whether the third sentence correctly stated the law, i.e. that "an unsuccessful outcome does not, *by itself*, mean that a physician was negligent", (emphasis theirs), although the court of appeals' approval of it was more broad based.[43] Thus, its viability as a proper instruction has never been comprehensively ruled on by the Supreme Court. There as well exists language in the Supreme Court's decision, which emphasizes that "a physician *may be held liable for an exercise of judgment*, but only when his judgment deviates from the objective standard of care,"[44] which suggests that such language could or probably should be included in the instruction. At this point, however, the instruction is almost always given in its present form if requested by a defendant physician, save and except where a *res ipsa loquitur* instruction is given,[45] even though it might behoove a plaintiff to tender an alternative form of the instruction with the words "by itself" italicized and the above language included.

Gasteazoro involved the issue of whether 15:4 should be used in conjunction with a *nursing* malpractice claim. The facts in the case were described as follows:

When plaintiff arrived at the defendant hospital's emergency room, a nurse (Yerger) saw her first. Plaintiff presented with complaints of headaches, nausea, dizziness, and neck pain. Her vital signs also included high blood pressure and low blood oxygen saturation. An emergency room physician (Dr. Overholt) diagnosed her with a cervical sprain and ordered her discharged. Dr. Overholt did not order an MRI, CT scan, or any other diagnostic tests. Another nurse (Scolardi) processed the discharge, although plaintiff's blood pressure remained elevated. Ten days later, plaintiff suffered a severe hemorrhagic stroke resulting from a ruptured aneurysm in her brain. The stroke caused serious and debilitating injuries.

Plaintiff, through her conservator, sued the hospital for the alleged negligence of its employees, the two nurses, as well as Dr. Overholt. Plaintiff's contentions were as follows:

- Nurse Yerger did not properly triage her.
- Dr. Overholt failed to recognize that her symptoms were consistent with an impending cerebral vascular incident ("CVA") and did not order tests that would have detected a CVA or aneurysm.
- Nurse Scolardi did not follow the hospital's policies in discharging her despite unstable vital signs, rather than acting as her advocate by challenging the discharge order.

Although the claim against Dr. Overholt was simple and straightforward, involving age old questions regarding practice standards for physicians, the claims against the nurses went into somewhat uncharted territory. The practice of nursing is governed by the Nurse Practice Act at

§§12-38-101, *et seq.*, C.R.S. ("the Act"). Essentially "the practice of professional nursing" includes "the performance of independent nursing functions *and* delegated medical functions."[46] The non-delegated nursing functions set forth in the statute include: (I) evaluating health status through the collection and assessment of health data; (II) health teaching and health counseling; (III) providing therapy and treatment that is supportive and restorative to life and well-being either directly to the patient or indirectly through consultation with, delegation to, supervision of, or teaching of others; . . . (V) referring to medical or community agencies those patients that need further evaluation or treatment; and (VI) reviewing and monitoring therapy and treatment plans.

Thus, it is thought by some, and oftentimes raised as a defense that a nurse is responsible for performing only these roles and not for making "medical decisions," even though a nurse is responsible for closely related functions, including such things as properly "executing delegated medical functions" pursuant to subsection (IV), as well for properly "reviewing and monitoring therapy and treatment plans" pursuant to subsection (VI). The statutory exception to the above analysis, however, is with regard to "advanced practice nursing," which Colorado, in line with the national trend, has authorized and defined to mean "an expanded scope of professional nursing in a scope, role, and population focus approved by the board," and specifically includes by its statutory language "prescribing medications as may be authorized pursuant to §12-38-111.6." Pursuant to the statutory language concerning practice areas "approved" by the board, however, the nursing board has defined additional advanced practice areas to include those of a: Nurse Practitioner (NP), Certified Registered Nurse Anesthetist (CRNA), Certified Nurse Midwife (CNM), and Clinical Nurse Specialist (CNS).[47] Certainly in advanced practice nursing, "medical judgment" becomes much more relevant.

In *Gasteazoro*, however, there were no allegations of advanced practice nursing. Nevertheless, allegations were made against the hospital's nurses including that they did not properly triage plaintiff, as well as made the decision to discharge plaintiff despite her unstable vital signs, rather than acting as her advocate by challenging the physician's discharge order. Clearly, these functions involve judgment, and the plaintiffs were in fact challenging such judgment. Given that so far instruction 15:4 has been approved by at least the court of appeals, it was not particularly difficult for the court of appeals, which reviewed the matter based upon an abuse of discretion standard, to affirm the trial court's decision to give the instruction. The court gave as its reasons that: (1) the language in CJI-Civ. 15:4 "supports extending the instruction to health care professionals other than physicians;" (2) "one Colorado case and several statutes classify nurses as medical professionals;" and (3) "the hospital's policy vesting nurses with the prerogative of challenging a physician's order refers to 'good clinical judgment' in carrying out 'authorized physician orders.'"[48]

What perhaps is of much greater significance, however, is the acceptance of the plaintiff's contentions with regard to failing to follow the hospital's policies in discharging a patient in unstable condition, as well as failing to act "as her advocate by challenging the discharge order." Thus, if one follows the precedent of the case, the refuge of nurses to the Nurse Practice Act in contesting the scope of their duty has been downgraded, and the failure of a nurse to exercise good clinical judgment in properly triaging a critical patient, or failure to exercise "good clinical

judgment" in carrying out "authorized physician orders," including implementing physician discharge orders of patients who are in unstable condition, represent viable claims against nurses.

Gasteazoro also presented the issue of whether defendants' expert, Dr. Shogan, a well-known local neurosurgeon should have been allowed to testify concerning whether plaintiff's presenting signs and symptoms were consistent enough with an impending CVA, so as to alert a reasonably careful and competent physician of the need to order additional tests to detect a possible CVA or aneurysm. Dr. Shogan was voir dired concerning his testimony, and admitted that he had not worked as an emergency room physician for over 30 years as well as had not done "any specific medical research in emergency medicine on what the standard of care would require in this case."[49]

This evoked a good discussion by the court of appeals about the propriety and permissibility of calling a physician practicing in a different specialty than the defendant. At the outset, plaintiff had herself called a neurosurgeon, Dr. Horowitz, to testify concerning causation. Moreover, the court of appeals reiterated law that clearly allows such. As set forth by the court of appeals:

> A trial court "shall not permit an expert in one medical subspecialty to testify against a physician in another medical subspecialty unless, in addition to such a showing of substantial familiarity, there is a showing that the standards of care and practice in the two fields are similar."[50]

These criteria were found by the court to have been satisfied with regard to Dr. Shogan. The court, as well, referenced a type of "higher standards" rule, meaning that a necessary piece of the analysis would include whether the witness testifying practices in a higher specialty, with the court stating, for example, that "a specialist in internal medicine could not testify to the standard of care of a general surgeon."[51]

Legal Negligence

Supreme Court Decisions

Baker v. Wood, Ris & Hames, P.C. – Attorney duties to non-clients

On February 3, 2014 the Supreme Court accepted certiorari review of *Baker v. Wood, Ris & Hames, P.C.*[52] *Baker* was a non-reported case decided by the court of appeals, where malpractice assertions were made against a testator's estate planning attorneys by the beneficiaries of the estate, who were not in privity with the attorneys, but who arguably were intended beneficiaries of the legal services. The court of appeals had affirmed the dismissal of the case based upon lack of duty. The extent of an attorney's duties in this regard has received increased attention in the State of Colorado, although for various reasons it remains a largely undecided area of law. It has received much more definition on a national level, with the modern trend seeming to embrace the recognition of attorney-client duties in selected areas, not restricted by privity.[53] At the forefront of this seems to be the recognition of duties to non-client beneficiaries of wills and trusts.[54]

In 2011, the Supreme Court addressed the issue of non-client liability in *Allen v. Steele*.[55]

Allen, however, involved an attorney's duty to a "prospective client," defined by the Rules of Professional Conduct to be "a person who discusses with a lawyer the possibility of forming a client-lawyer relationship."[56] In *Allen*, plaintiffs contended they had been given negligent advice concerning the statute of limitations by an attorney with whom they had sought advice concerning a potential negligence claim, which they alleged they relied upon and allowed the statute of limitations to pass without filing a suit.

The plaintiffs thereby brought forward not only a claim for professional negligence against the attorneys, but a claim for negligent misrepresentation based upon §552 of the Restatement (Second) of Torts, i.e., negligent misrepresentation in a business transaction. This type of claim had been recognized by the Supreme Court in *Mehaffy, Rider, Windholz & Wilson v. Central Bank Denver*.[57] In *Mehaffy*, however, the allegedly negligent advice was with regard to a clearly business matter, i.e., preparing opinion letters to induce a third party participation in a business transaction. In *Allen* the characterization of the transaction between the attorney and the prospective client regarding a personal injury claim as a business transaction was not so clear. Nevertheless, plaintiff's negligent misrepresentation claim was upheld as a viable claim by the court of appeals - finding enough of a business relationship between the prospective client and the attorney to justify such, although the court of appeals, as well, affirmed the dismissal of the professional negligence claim for lack of duty. When plaintiff appealed to the Supreme Court, however, it for some reason conceded the issue of professional negligence and appealed only the trial court's dismissal of their negligent misrepresentation claim. Because of this, only half of the questions regarding this important issue were answered, i.e., those dealing with claims for negligent misrepresentation based upon §552 of the Restatement (Second) of Torts.

Justice Bender, writing for the majority, opined that there was an insufficient "business relationship" for §552 to apply, which required the underlying transaction to "involve a business or commercial relationship or transaction."[58] Left for another day, however (with particularly Justices Bender and Eid expressing different opinions on the issue), was the question of whether a professional duty existed between the prospective client and the attorney, and particularly the applicability of §15 of the Restatement (Third) of the Law Governing Lawyers, which states in pertinent part:

> (1) When a person discusses with a lawyer the possibility of their forming a client-lawyer relationship for a matter and no such relationship ensues, the lawyer must. . .
>
> (c) use reasonable care to the extent the lawyer provides the person legal services.

Baker addresses the more commonly addressed issue of an attorney's duties to non-client beneficiaries of estates and trusts. Although the approaches to this issue vary, as one commentator has stated: "only a few American jurisdictions have refused to find a duty of care to an intended beneficiary or injured heir."[59] A more expansive and general approach has been that taken by the California supreme court in the 1958 landmark decision of *Biankaja v. Irving*,[60] which set forth a six part test involving a claim against a notary, which was followed by *Lucas v. Hamm*,[61] with the six pronged *Biankaja/Lucas* analysis being described as follows:

> A defendant's liability to a third person not in privity in a particular case "is a matter of policy and involves the balancing of various factors, among which are: [1] the extent to which the transaction was intended to affect the plaintiff, [2] the foreseeability of harm to him, [3] the degree of certainty that the plaintiff suffered injury, [4] the closeness of the connection between the defendant's conduct and the injury suffered, [5] the moral blame attached to the defendant's conduct, and [6] the policy of preventing future harm."[62]

The Restatement (Third) of the Law Governing Lawyers, §51, provides a balancing test, as well, imposing a "duty to use care":

> (3) To a non-client when and to the extent that:
> (a) The lawyer has reason to know that the client intends as one of the primary objectives of the representation that the lawyer's services benefit the non-client; and
> (b) Such a duty would not significantly impair the lawyer's performance of obligations to the client; and
> (c) The absence of such a duty would make enforcement of those obligations unlikely.[63]

More restrictive approaches typically involve a third-party beneficiary analysis.[64] Where the Colorado Supreme Court decides to go with this very important issue has yet to be decided.

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[1] 2014 CO 46, 327 P.3d 255 (Colo. 2014).
[2] *Id*. ¶8.
[3] *Haralampopoulos v. Kelly,* 2011 Colo. App. LEXIS 1645 (Colo. Ct. App., Oct. 13, 2011) at *18.
[4] *White v. Illinois,* 502 U.S. 346, 356, 112 S. Ct. 736, 116 L. Ed. 2d 848 (1992).
[5] *Kelly v. Haralampopoulos*, ¶24, 327 P.3d at 263.
[6] 785 P.2d 596 (Colo. 1990).
[7] 127 P.3d 916, 927 (Colo. 2006).
[8] *King*, 785 P.2d at 601 (citing *United States v. Iron Shell*, 633 F.2d 77, 83 (8th Cir. 1980), *cert denied*, 450 U.S. 1001, 101 S. Ct. 1709, 68 L. Ed. 2d 203 (1981).
[9] *Kelly*, ¶25, 327 P.3d at 263.
[10] *Id*. ¶40, 327. P.3d at 266.
[11] *Id*.¶45, 327 P.3d at 267-68 (internal citations omitted).
[12] *Id*.
[13] *Id*. ¶47, 327 P.3d at 268 (emphasis added).
[14] *Id*. ¶48, 327 P.3d at 268 (internal citations omitted).
[15] *Id*. ¶59, 327 P.3d at 271.
[16] *Id*. ¶60, 327 P.3d at 271 (internal citations omitted).

[17] *Id.* ¶¶63-64, 327 P.3d at 272.
[18] 2014 CO 73, 336 P.3d 180 (Colo. 2014).
[19] *Id.* ¶2.
[20] *Id.*
[21] *Id.* ¶24.
[22] *Id.* ¶30.
[23] Cristiano, Francis V., "Significant Professional Negligence Cases and Developments during the Past Year – A Review and Some Observations," *Trial Talk*, Vol. 63, Issue 1 (January/December 2014), pp. 21-24.
[24] 137 Colo. 554, 328 P.2d 88 (1958).
[25] 212 P.3d 963 (Colo. App. 2009).
[26] COA 218 (2012).
[27] 2014 CO 78.
[28] 805 P.2d 1109 (Co. 1991).
[29] *Id.* at 1114 n.10.
[30] *Chapman*, ¶11.
[31] 252 P.3d 1052 (Colo. 2011).
[32] *Id.* 1069.
[33] See *Martin v. Dist. Court In & for Montrose Cnty.*, 191 Colo. 107, 109, 550 P.2d 864, 865 (1976).
[34] *Chapman*, ¶11.
[35] *Id.* ¶23.
[36] *Id.* ¶21.
[37] *Id.* ¶24.
[38] *Id.* ¶25.
[39] *Id.* ¶24.
[40] *Id.*
[41] 2014 COA 134 (Not in final version and subject to revision upon final publication).
[42] 255 P.3d 1064 (Colo. 2011).
[43] 232 P.3d 175 (Colo. App. 2009).
[44] *Day*, 255 P.3d at 1072 (emphasis added).
[45] See CJI-Civ. 9:17 Notes on Use, 12.
[46] §12-38-103(10)(a), C.R.S.
[47] 3 Code Colo. Regs. 716-1:XIV-1.11 (2012).
[48] *Gasteazoro*, ¶ 34.
[49] *Id.* ¶42.
[50] §13-64-401, C.R.S.
[51] *Gasteazoro*, ¶38.
[52] 2014 Colo. LEXIS 65; 2014 WL 351016.
[53] 1 *Mallen*, Legal Malpractice (2010 Ed.), §7:8.
[54] *Id.*, §34:5.
[55] 252 P.3d 476 (Colo. 2011).
[56] Colo. RPC. 1.18.
[57] 892 P. 2d 230 (Colo. 1995).
[58] *Allen*, 252 P.3d at 484.
[59] 4 *Mallen* Legal Malpractice (2010 Ed.), §34:5, p. 3.
[60] 49 Cal.2d 647, 320 P.2d 16, 65 A.L.R.2d 1358 (1958).
[61] 56 Cal.2d 583, 15 Cal.Rptr. 821, 364 P,2d 685 (1961).
[62] *Biankaja*, 49 Cal.2d at 950, 320 P.2d at 19.
[63] 1 *Mallen* Legal Malpractice (2010 Ed.), §7:8.
[64] E.g. *Blair v. Ing*, 95 Haw. 247, 21 P.3d 452 (2001), and *Succession of Killingsworth*, 292 So.2d 536 (La. 1973).