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Coombs v. Curnow Appellant's Reply Brief Dckt. 35157

IN THE SUPREME COURT OF THE STATE OF IDAHO

MELINDA COOMBS, natural mother of Michael Hall, deceased and the ESTATE OF MICHAEL HALL, as represented by Melinda Coombs, personal representative,

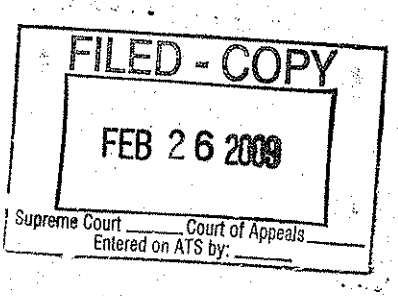
Plaintiffs/Appellants,

vs.

ADRIAN CURNOW, M.D.; RUSSELL GRIFFITHS, M.D.; and ELLEN REYNOLDS, M.D.,

Defendants/Respondents.

Docket No. 35157



APPELLANTS' REPLY BRIEF

Appeal from the District Court of the
Fourth Judicial District of Ada County

Honorable Deborah A. Bail
District Judge, Presiding

Donald W. Lojek
Lojek Law Offices, Chtd.
623 West Hays Street
Boise, ID 83702

Attorneys for the Appellants

Patricia M. Olsson
Nancy Jo Garrett
Moffatt Thomas Barrett Rock & Fields
101 South Capitol Blvd., 10th Floor
Boise, ID 83701-0829

Attorneys for the Respondents

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I. INTRODUCTION

This case involves the death of a small boy, Michael Hall, who had not yet reached his third birthday. He had surgery for a non-mortal wound and following the surgery he was sedated for some 92 hours in the ICU with a drug not indicated for the long-term sedation of pediatric patients. His physicians were unaware of the general properties of the drug. They did no research to educate themselves about those properties. They ignored critical laboratory and other reports showing that the boy, intubated and unable to speak, was in distress. They took no steps to correct dangerously low blood pressures, and omitted other corrective measures. After they signed off the case leaving the boy in the care of other physicians, but still maintaining him on the drug which was not indicated for long-term pediatric sedation, the boy was observed to be brain dead. His brain had been deprived of necessary oxygen and had become swollen to the point where it could no longer function.

A verdict was rendered against the Defendant doctors on September 19, 1977 after an eleven day trial. Approximately four months later, the district court entertained oral argument on the Defendants' motions for judgment notwithstanding the verdict. Approximately two months later, and without the benefit of a transcript of the trial testimony, the district court rendered its decision granting the motions for judgment notwithstanding the verdict. An appeal was quickly filed and this document now completes the briefing cycle on appeal.

The Defendants at trial were represented by two distinct law firms. The attorney for Defendant Griffiths subsequently left her firm and was employed by

the Moffat, Thomas firm – the firm representing Defendant Curnow. Notwithstanding any potential conflicts of interest, two Respondents' briefs have now been filed by the same law firm, albeit by different authors. The issues remain the same as to both Respondents, however, and Appellant will file only this one, single Reply Brief answering the arguments propounded by each Respondent.

As the Respondents have strayed from the true issue on this appeal, every effort will be made to confine this Reply Brief to that issue. Where the Respondents have taken different tacks, however, a brief reply will be noted where necessary.

II. ARGUMENT

A. SUMMARY OF ARGUMENT

The resolution of this appeal turns upon the sole issue of whether there was substantial, competent evidence to support the jury's verdict.

In this Reply Brief, the Appellants note that the medical doctors who are Respondents on appeal have impermissibly attempted to change the focus of review from the sole question of the substantiality and competence of the evidence admitted at trial to a review of competing and contradictory evidence as to causation and whether the Defendants met applicable standards of care.

As will be argued, *infra*, "Where there is conflicting evidence, the court is required [under Rule 50(b)] to construe all of the evidence in favor of the jury verdict, including all reasonable inferences therefrom, to determine whether there is substantial evidence to support the verdict." *Watson v. Navistar International Transportation Corporation,* 121 Idaho 659, 661, 827 P.2d 656, 699 (1992). The requisite standard is whether the evidence preceding the verdict is of sufficient quantity and probative value that reasonable minds could reach the same conclusion as the jury did in the case under consideration. *Id.*

The trial court – joined by the Respondents – has stated that in order to prevail in this case the Appellants needed to have peer-reviewed scientific journal evidence linking the application of the sedative drug Propofol to the death of Michael Hall. Rejected was Plaintiffs' experts' testimony which was admitted at trial under I.R.E. 702 and which was based upon the medical sciences of hematology, physiology, anesthesiology, chemistry, toxicology, biology, microbiology, pulmonology, cardiology and pathology as somehow not sufficiently "scientific" so as to support the jury verdict. If true, this would ignore the law of this jurisdiction as enunciated and reenunciated and approved and reapproved by this Court in numerous cases which hold, generally, that medical doctors can testify regarding the cause of death or injury and that this testimony is both substantial and competent.

B. WHAT IS THE ISSUE TO BE DECIDED BY THE COURT?

In Appellants' opening brief at p. 1, the issue – the single issue – on appeal was correctly stated as: "Was there substantial, competent evidence to support the jury's verdict?"

In Defendant Griffiths' Reply Brief, he apparently agrees with that single issue since he has only stated one "additional" issue at p. 13 of his brief where he posits that there are "*additional issues*" *i.e.,* "*Whether Dr. Griffiths is entitled to attorneys' fees on appeal.*" Dr. Griffiths has not raised either causation or standard of care among the issues present in this appeal and is interested, apparently, only in an award of attorneys' fees to him based upon the "frivolity" of this appeal.[1]

Defendant Curnow, on the other hand, – apparently unmindful that this is an appeal from a judgment notwithstanding the verdict under Rule 50(b) I.R.C.P. – has attempted to shift the issue to "Whether the district court correctly determined that Plaintiffs failed to present admissible evidence that, to a reasonable degree of medical certainty, Dr. Curnow caused Michael Hall's death." This issue, on its face, has to do with causation only, apparently ignores any issues relating to standard of care and, additionally, is not the test on an appeal from the granting of a Rule 50(b) motion.

[1] A truly surprising assertion since **not** to file an appeal from a ruling granting a motion notwithstanding the verdict after nearly three years of discovery, eleven days of trial and a favorable jury verdict awarding significant damages would certainly constitute evidence to support a malpractice claim against the attorney

Appellants maintain that there is a single question of law to be decided on this appeal. That question is whether there is substantial evidence upon which the jury could properly find a verdict in favor of the Appellants. *Quick v. Crane*, 111 Idaho 759, 727 P.2d 1187, 1191 (1986) observed that in making a Rule 50(b) motion "the defendants necessarily admitted the truth of all of the plaintiff's evidence and every legitimate inference that could be drawn therefrom in the light most favorable to the plaintiff." At 763 citing *Stephens v. Sterns*, 106 Idaho 249, 252-253, 678 P.2d 41, 44-45 (1984).

Watson v. Navistar International Transportation Corporation, 121 Idaho 659, 661, 827 P.2d 656, 699 (1992) similarly held that "where there is conflicting evidence, the court is required [under Rule 50(b)] to construe all of the evidence in favor of the jury verdict, including all reasonable inferences therefrom, to determine whether there is substantial evidence to support the verdict.

More recently, this Court has stated in *Sheridan v. St. Luke's Regional Medical Center*, 135 Idaho 775, 786, 25 P.3d 88, 97 (2001) the following with respect to a motion for a directed verdict in a medical malpractice case:

> The evidence in this case was not uncontroverted; however, from our review of the record of the trial below, and drawing all inferences from the evidence in a light most favorable the non-moving party, there was substantial evidence regarding proximate cause and damages to justify submitting the case to the jury.

The standard is the same on a Rule 50(b) motion, and as stated in *Hudson v. Cobbs*, in ruling on a motion for judgment n.o.v. the trial court must view the facts as if the moving party has admitted the truth of all the non-moving party's evidence. 118 Idaho 474, 478, 797 P.2d 1322, 1326

(1990). It is suggested that this rule of appellate review be kept uppermost in mind: **All the Plaintiffs' evidence is true.**

C. WHAT EVIDENCE MUST BE REGARDED AS TRUE?

Plaintiffs' direct evidence, not counting cross-examination, spans some 885 pages of the transcript (*Tr.* 137-1022) and includes hundreds of pages of exhibits. It would take more space than is allowed to list all of the "true" facts Plaintiffs put into evidence. But keeping in mind the definitions of "substantial" as "*not imaginary or illusory*," "real," "important," considerable in quantity," (*Webster's Ninth New Collegiate Dictionary*, p. 1176) and "competent" as "proper or rightly pertinent" (*Id.* p. 268), we can list here enough to validate the jury's verdict. These facts are the same facts which the trial court must have somehow deemed "insubstantial" and "incompetent:"

1. Michael Hall suffered a non-mortal wound, *i.e.*, a dog bite.
2. Michael Hall was not expected to die from the dog bite.
3. Michael Hall did not die from the dog bite.
4. Before Michael was sedated with Propofol, his heart, lungs and brain were in good condition, he had no known allergies and he was a good surgical candidate. Tr. p. 1926, ll. 3-18. He had no hepatitis (Tr. p. 1978, ll. 10-12), no jaundice (Tr. p. 1981, ll. 11-13). He had all his immunizations (Tr. p.

1027, ll. 14-20). His heart and lungs were, on admission, found to be normal by Dr. Curnow. Tr. pp. 1029-1030.

5. Dr. Groben, the pathologist, stated that Michael was in "good condition" and a "normal little boy." "There was no cardiac reason for him to die." Tr. p. 161, ll. 9-10. There was no "structural abnormality with the heart." *Id.*, ll. 17-18.

6. Examination of Michael's organs on autopsy revealed no pathology, disease or sickness. Tr. p. 164, ll. 13-18. Tr. p. 145, ll. 6-22. No trauma or bruising was noted. Tr. p. 147, ll. 2-5.

7. Dr. Smagula, the anesthesiologist, testified that aside from the dog bite Michael was a healthy little boy. Tr. p. 1809, ll. 1-3.

8. Defendants' witness, Dr. Latchaw at Tr. 1643, ll. 1-3 stated "There was nothing systemically abnormal about this boy."

9. Oxygen and glucose are carried by the blood to the cells.

10. Inside the cell there is a process called mitochondrial function which produces energy. Tr. p. 328, ll. 6-25.

11. A byproduct of this exchange is water which needs to be pumped out of the cell. Tr. p. 331, l. 24 – 332, l. 17.

12. Insufficient energy production and low albumin creates cellular swelling because water cannot get out of cells. Tr. p. 337.

13. Cells break down if they are not oxygenated. Tr. p. 332.

14. Blood pressure is an indicator of circulation. Tr. p. 246.

15. Low hemoglobin means that the amount of oxygen being delivered to the cells is diminished. Tr. 340, ll. 12-20.

16. The liver manufactures proteins necessary for the circulation of the blood. Albumin is one of the proteins and a lack of albumin leads to cellular swelling. Tr. p. 734.

17. When the heart is not pumping well, oxygen deprivation can result and liver functions can be adversely affected. Tr. p. 247, ll. 10-25.

18. Cardiac arrhythmias decrease the amount of blood that the heart is pumping and the oxygen delivered to the brain is decreased. Tr. 352, ll. 8-16.

19. Propofol is a toxic drug and has toxic side effects. Tr. p. 245, ll. 10-25.

20. Propofol lowers the blood pressure. Beals Tr. 245, l. 25.

21. Propofol affects the contractility of the heart. The heart pumps less efficiently. Tr. p. 246, ll. 13-18.

22. When the contractile strength of the heart decreases, it reduces effective circulation of the blood. Beals Tr. 246, l. 16.

23. If Propofol causes blood pressure to drop, this can be corrected. Tr. 334, ll. 12-17.

24. The low blood pressure Michael experienced was not corrected by the Defendants. Appendix 1, Appellants' Brief.

25. When Michael's blood pressure was dangerously low, the Propofol dose was not decreased. Tr. 869, ll. 17-19.

26. Dr. Peck, a local radiologist, reported that Michael's cerebral edema was due to hypotension (low blood pressure). Exhibit 1, p. C00114.

27. Michael's blood was deficient in hemoglobin and hemocrit. Tr. p. 361, l. 11 – 362, l. 3.

28. Michael's blood pressure was life-threatening low during his stay in the ICU. Tr. p. 358, ll. 17-21.

29. Michael's liver was malfunctioning after 48 hours in the ICU. Tr. 364, ll. 7-24. Liver damage can be caused by hypotension. Tr. p. 216, l. 25 – 217, l. 6.

30. Michael's liver enzymes should have been in the range of 50 to 80. In fact, they soared to 899, evidencing liver damage. Tr. p. 359, ll. 3-7.

31. Michael had a fever in the ICU indicating a greater oxygen need for his brain. There was evidence of kidney and intestinal damage as time went on. Tr. p. 359, ll. 3-13.

32. The brain takes more oxygen than any other tissue in the body to keep itself functional. Tr. p. 247, ll. 15-18.

33. There was evidence of kidney and intestine damage related to the long-term use of Propofol in Michael. Tr. 366-367.

34. Michael developed an irregular heart beat in the ICU (arrhythmias). This causes a decrease of oxygen delivered by the blood. Tr. p. 352, ll. 8-16.

35. Michael's urine turned green.

36. The hypotension caused by Propofol is associated with an inadequate supply of blood and oxygen to the brain cells. Tr. 341, ll. 2-7.

37. All experts agreed that Michael's immediate cause of death was a hypoxic ischemic event, *i.e.*, inadequate blood flow and inadequate oxygen to the brain cells. Tr. pp. 149-150 (Groben); Tr. p. 1280, ll. 4-9 (Reichard).

38. Ischemia means inadequate blood flow to tissues. Tr. 339, ll. 6-11.

39. Hypoxic refers to an inadequate amount of oxygen available to the cell for its energy production to occur normally. Tr. 338.

40. Hemoglobin, oxygen and blood pressure are monitored in the ICU. Tr. 342.

41. The low hemoglobin was not caused by Propofol but from a loss of blood at the surgical site. Tr. 354, l. 25.

42. Lab tests are routinely done in the ICU to monitor critically ill children. Tr. 343.

43. When the brain swells, the pressure within the skull can increase rapidly and dramatically. Tr. p. 845, ll. 10-25.

44. A small change in volume within the skull will result in a huge pressure and the brain cells are deprived of oxygen. Tr. 337, ll. 1-23.

45. This increase in pressure because of an hypoxic ischemic event produces death and did cause Michael's death. Tr. pp. 150-151.

46. A physician using Propofol as it was used in Michael's case would be acting below the standard of care. Tr. 509, l. 25.

47. Sedation with Propofol for 92 hours is long-term sedation. Tr. 346. This is not indicated for children.

48. Scientific research explains the connection between Propofol and swelling of the brain cells. Tr. 866, l. 5, 867, l. 5.

49. The dose of Propofol used with Michael was excessive and never decreased. Tr. p. 449, ll. 1-16.

50. The Propofol caused or contributed significantly to the hypotension, and therefore, decrease in blood flow to vital organs in the body, including the brain, the heart, the liver, and other vital tissues.

51. Propofol caused the lipemia that in all likelihood contributed to Michael's demise because of the fatty acids that would be produced. And in all likelihood, the Propofol also had a negative effect on the energy generation of cells in the body.

52. These things are all in combination, especially with the low hemoglobin that the Propofol did not cause, but these events taking place simultaneously all resulted like a triple or a quadruple whammy, where they all resulted in diminished oxygen delivery to the brain, which ultimately caused the brain swelling, and also caused inadequate oxygen delivery to other organs in the body.

53. The low hemoglobin, again, was caused by bleeding. In the presence of bleeding and the low blood pressure that's caused or contributed to by the bleeding itself, one would have to be particularly mindful of the Propofol-related drop in blood pressure, so if a person is bleeding and their hemoglobin is low and their blood pressure is low, that's the time to decrease the Propofol or turn it off, if, in fact, you have been using it to begin with, which is another question.

54. These factors conspired, in a predictable fashion, to cause lethal organ injury, including brain injury. Tr. 355 and 356.

55. Propofol was a proximate cause of Michael's death. Tr. 452, ll. 1-4. The conduct of each Defendant was also a proximate cause of Michael's death. Tr. p. 445, l. 25 – 448, l. 10.

56. Dr. Hammer's testimony was based on basic medical science. Tr. 867, ll. 6-11.

57. The Propofol administered to Michael definitely caused or contributed to the low blood pressure, lipemia and toxicity to cells in Michael's body. Tr. p. 365, ll. 2-20.

58. A simple literature search by the Defendants in 2002 would have quickly yielded a series of articles regarding the hazards of Propofol in children for long-term sedation. Tr. 875, ll. 5-9.

59. The United States Food and Drug Administration promulgated information in 2002 which contra-indicated the use of Propofol for long-term sedation of children in the ICU. This was a national prohibition. Tr. 841-842, l. 8.

60. The anesthesiologist, Dr. Smagula, never recommended Propofol for Michael's long-term sedation nor was his advice ever sought in that regard. He did not approve of Michael

being kept on Propofol for 92 hours in the ICU. Tr. p. 1810, l. 20 – 1813, l. 15.

61. Dr. Hammer was familiar with the local standard of post-surgical care of pediatric patients. Tr. pp. 376-440.

62. Both of the Defendants fell below that standard. They chose a drug and maintained that drug for the sedation of Michael on a long-term basis when it was not indicated for that use. They did not acquaint themselves with the general properties of their drug of choice. They did not order sufficient lab tests to monitor organ toxicity. The lab reports they did order were not recognized properly. The Propofol was never titrated or decreased from a relatively high dose when Michael's blood pressure was low and there was evidence of damage to his organs. Tr. 445-451.

If all of the above must be deemed true – and this list could go on – then it is submitted that the trial court erred in granting the Defendants' motions for judgment notwithstanding the verdict. There is *more – much more – than a mere* temporal connection between the application of Propofol and Michael's death. *Swallow v. Emergency Med. of Idaho*, 138 Idaho 589, 67 P.3d 68 (2003) is inapposite. *Weeks v. E. Idaho Health Services,* 143 Idaho 834, 153 P.3d 1180 (2007) is, on the other hand, most helpful.

In *Weeks*, IRE 702 was discussed noting "A qualified expert is one who possesses 'knowledge, skill, experience, training or education.'" At 837, 839.

Weeks teaches that the conclusions reached by an expert witness do not have to be universally accepted and that a medical doctor's opinions can be based on his own experience and research and a "chain of circumstances" from which the ultimate fact can be determined. *Sheridan, supra,* at 786 is in accord. That happened here, primarily as to Dr. Hammer's testimony but also to that of Dr. Groben.

D. THE CONDUCT OF THE DEFENDANTS WAS ON TRIAL. PROPOFOL ITSELF WAS NOT ON TRIAL. ITS USE WAS.

Both Respondents – particularly Dr. Curnow – spend the majority of their time discussing whether or not Michael had signs of what has been labeled the "Propofol Infusion Syndrome," abbreviated as "PRIS." Respondents and the trial court were misguided in focusing on this issue.

The Respondents' approach in attempting to show that there was no evidence of PRIS is really the promotion of a straw man. Having set up the straw man, the Respondents set out to show that there was little evidence that PRIS existed and that, *ipso facto*, Propofol was in no way implicated in Michael Hall's death. In so doing, Respondents are like tone-deaf people trying to sing, hoping that their bogus PRIS theory will compensate for an inability to find a key.

The trial court bought into this straw man argument as is evident from its Memorandum Opinion entered on March 20, 2008. The trial court clearly weighed the evidence and concluded, improperly, "there is no substantial

evidence from which a reasonable jury could conclude that the long-term use of Propofol was *the* proximate cause of Michael Hall's cerebral edema." R. p. 132. (emphasis added). [2] Another example: "There is no proof that Propofol causes PRIS." R. p. 27.

The Respondents and the trial court alike have failed to note that in the Complaint, R. pps. 20-22, filed by Michael Hall's mother and his estate, in the Plaintiffs' opening statement Tr. 6-38, in their closing argument, Tr. 2361-2397, and in their final argument Tr. 2469-2495, the thesis was never advanced that Michael Hall died as a consequence of or suffering all the symptoms of PRIS. PRIS is first brought up by defense counsel in evidence at Tr. 464, l. 15. Until then the term had not seen the light of day.

The cause of Michael's death, overall, was the *conduct* of the Defendants. That conduct consisted not only of the selection of a drug that was not indicated for use for the long-term sedation of children, but also the failure, among other errors, to recognize or to treat the constant and dangerous low blood pressure which led to a comment by Dr. Peck, a local radiologist treating Michael at the time, that Michael's brain scan showed "extensive ischemic injury likely secondary to hypotension." Exhibit 1, p. C00114.

The Respondents have joined with the trial court and totally ignore the abundant evidence from Dr. Groben, Mr. Beals, Dr. Hammer and all of the lab reports regarding very basic issues reflecting the lack of care or the inappropriate

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[2] The erroneous focus ignores the jury instruction on proximate cause which did not require the jury to find that Propofol was "the" cause of death or even "a" cause. The operative instructions were Nos. 5 and 6 which focus on whether "the acts of [the Defendants] which failed to meet the applicable standard of care were a proximate cause of Michael Hall's death." Propofol is nowhere mentioned in the entire set of jury

care of Michael while intubated, sedated and helpless in the ICU. These basic items include the failure to control the obvious and dangerously low blood pressure, the failure to ensure adequate oxygenation of the tissues, the inability of the blood to provide enough oxygen to the brain, the low hemoglobin, the low hemocrit, and signs of liver and kidney damage, all of which were imposed upon this little boy who unfortunately and as a consequence was unable to reach his third birthday. Propofol most probably played a part in producing the unrecognized and untreated adverse symptoms suffered by Michael Hall. But causation in this case is related to the combination of a) Propofol, b) the Propofol dosage, c) the length of time Propofol was administered, d) dangerously low blood pressure which was constant, e) low hemocrit, f) low hemoglobin, g) heart problems which developed, and h) liver damage as evidenced by elevated enzymes, kidney damage, intestinal damage and the ultimate cerebral edema, which was recognized by everyone to be the immediate cause of death.

Propofol, used properly, is a useful sedative. But it must be skillfully used. Like any other substance it can be misused or overused. Too much morphine will cause death. A cocktail before dinner is benign. A quart of bourbon whiskey, quickly consumed, can stop the heart. So to analyze this case in terms of an issue not propounded by Plaintiffs and then to focus on only one element among a constellation of causative agents is very misguided.

E. WAS THERE SUBSTANTIAL, COMPETENT EVIDENCE LINKING THE CONDUCT OF THE DEFENDANTS TO MICHAEL'S DEATH?

To ask this question really is to answer it. The trial court itself validated Dr. Hammer's expertise. "Dr. Hammer is a board-certified pediatrician and anesthesiologist with a sub-board in pediatric critical care. He is on the faculty of the Stanford Medical School where he is a professor of anesthesiology and pediatrics. He is the author of numerous articles and a textbook on pediatric intensive care." R. p. 116. The trial court also observed with respect to Dr. Hammer: "He is a gifted and well-trained physician who practices and teaches at one of the foremost medical centers in the world." R. p. 133.

While Dr. Hammer indicated that Propofol began a chain of events which caused, over time, an inability of Michael to process oxygen which, in turn, led to multiple adverse physiological effects including the swelling of his brain and ultimate brain death, Dr. Hammer did not focus solely on Propofol as a direct or sole cause of the death. Rather, Dr. Hammer, utilizing his medical training and his knowledge of scientific areas such as anesthesiology, biology, microbiology, chemistry, toxicology, pathology, physiology as well as basic medicine, explained carefully the "chain of circumstances" which led to this tragic death. As stated in the Complaint which, long ago, started this process of justice, the care given to Michael was rendered negligently and caused his death. The drug Propofol was *misused* in this case by its application with a child over such a long time, and, as the evidence showed, caused extreme hypotension, fever, low hemoglobin, low hemocrit, liver and other organ damage, each contributing to limiting the amount

of oxygen available for utilization by Michael's brain. But Propofol was not on trial. Astra Zeneca, the manufacturer of Propofol, was never a defendant in this case. Dr. Hammer admitted that Propofol is a useful sedative and can be used safely for short-term sedation of children.

In Appellants' opening brief, it was argued that the trial court erred in focusing on the fact that Propofol was not shown to be *"the"* proximate cause of Michael's death. That was not the test according to the jury instructions given by the Court. Instruction No. 12 stated as follows:

> When I use the expression "proximate cause," I mean a cause that, in natural or probable sequence, produced the injury, the loss or the damage complained of. It need not be the only cause. It is sufficient if it is a substantial factor in bringing about the injury, loss or damage. It is not a proximate cause if the injury, loss or damage likely would have occurred anyway. There may be one or more proximate causes of an injury. When the negligent conduct of two or more persons or entities contributes concurrently as substantial factors in bringing about an injury, the conduct of each may be a proximate cause of the injury regardless of the extent to which each contributes to the injury.

This is the basic IDJI pattern jury instruction approved by this Court. The trial court, therefore, joined eagerly by the Respondents, erroneously threw up a hurdle that the Appellants did not have to clear, *i.e.*, that Propofol had to be "the" cause of Michael's death. In Dr. Curnow's brief, for example, at pps. 18, 25 and 33, the argument is made again and again that there was insufficient evidence to support the jury's verdict that the long-term use of Propofol was *"the"* proximate cause of Michael's death. That was not necessary to the jury's verdict. Then, without any citation to the record, at p. 25 of the Curnow Brief, the statement is made "despite the lack of any scientific support for his opinions in the medical

literature, Dr. Hammer insisted that Propofol was *the* cause of Michael Hall's fatal cerebral edema." Curnow Brief, p. 25. Again, that is not true. The reason there is no defendant's citation to this "insistence" by Dr. Hammer is that Dr. Hammer has never insisted that Propofol was *"the"* cause of Michael Hall's fatal cerebral edema. All that Dr. Hammer did was trace the chain of circumstances backwards from the cerebral edema through the difficulties Michael was having in the ICU which went unrecognized and untreated. Propofol was *"a"* cause of the death, but certainly it was not isolated from the post-surgical conduct and neglect of both physicians.

Dr. Hammer was very careful in describing not a *theory* but scientific fact or series of facts leading to the reasons for lack of oxygen available for Michael's brain, the brain being the most needy organ and the most sensitive to the lack of oxygen. Significantly, *none* of the Defendants' experts testified that Dr. Hammer or Mr. Beals were wrong about the lack of oxygen, the lack of sufficient APT to provide energy, the cellular processing of oxygen, the inability of Michael's brain cells to excrete fluid leading to the edema and the like. All had to agree that Michael died as a result of a hypoxic ischemic event (swelling of the brain). Significantly, each of the Respondents' many experts stated that they had no explanation as to why Michael died.[3]

The trial court states erroneously that there is no "substantial evidence" to support the jury's conclusion "that the long term use of Propofol was *the* proximate cause of Michael Hall's cerebral edema." R. p. 132. (emphasis

[3] Defendant Griffiths argues incorrectly that his $9,000 per day expert, Dr. Lachtaw, found a cause of death. That is nonsense. The most that could be said is that Dr. Lachtaw said that he"speculated" that there

added). Is Dr. Hammer's reliance on his knowledge of anesthesiology, biology, microbiology, cellular function, pediatric critical care, chemistry, physiology, toxicology and pathology, a species of voodoo or witchcraft? Or are these areas not themselves branches of substantive scientific knowledge? Is not the critical care of pediatric patients in the ICU something that is based on science? Did the trial court forget about the toxicology testimony from the toxicologist, Mr. Beals, or the pathology testing from the pathologists? Are these not sciences?

Neither the Respondents nor the trial court say anything about the testimony of Dr. Groben or Mr. Beal, the toxicologist, who both testified at length. Propofol is toxic. It compromises the heart which pumps less blood. Lack of oxygen causes liver damage. There is an important function of the liver which is to make protein and albumin. Tr. 249. Prolonged hypotension causes an "inotropic effect" and the lack of albumin defeats the normal "osmotic tension" which allows fluid to flow through the cell's membrane walls and return on the venous side of the circulatory process. A lack of albumin leads to retention of fluid in the cell and the cells swell. The brain is the most sensitive to this process because it is encapsulated in the skull and the pressure goes up rapidly. Tr. pp. 733-735.

If the liver is damaged and not producing albumin and protein, that is signaled by an increase of enzymes called ALT or AST "and relatively simple laboratory tests are used to measure this on a routine basis." Tr. p. 736, l. 11 – 737, l. 3. If these enzymes rise that "is indicative of damage to the tissues." Tr. 737, ll. 10-18. Thus, Propofol can affect the metabolism of the body in several

ways. Tr. 742, ll. 9-17. Mr. Beals went on at great length to explain the chemistry, biochemistry, cellular microbiology, the development of lipemia, the concept of free fatty acids and how Propofol inhibits the process of the free fatty acid chains getting inside the cell where they are needed.

This is heady stuff. Too much of it will cause a lay person's eyes to glaze over. But it is scientific information about how the body works in both gross and submolecular terms. Yet, the trial court seems to dismiss all of this because it is not at all mentioned in the court's memorandum decision. Why? Mr. Beals had a Master's Degree in toxicology, he taught at BSU, he managed the Schools of Medical Technology at both St. Luke's and St. Alphonsus in Boise for many years. Tr. p. 749. He was also a clinical chemist and toxicologist at the Boise VA Medical Center for more than twenty years prior to his retirement. Even a quick review of Mr. Beal's evidence will indicate that a solid foundation was laid for subsequent testimony by Dr. Hammer. And, please note, this was a scientific foundation if there ever was one.

Respondents argue and the trial court placed great weight on the lack of evidence that the "literature" has not specifically coupled the use of Propofol with the end result of cerebral edema. But where is the evidence in the record from the Respondents' experts which indicates that there is any evidence anywhere that a little boy who has not yet attained the age of three was subjected to an *abuse* of Propofol, *i.e.*, a high dosage of Propofol for approximately 92 hours coupled with consistently and dangerously low blood pressure, fever, low

hemocrit, low hemoglobin, demonstrable liver damage [4] and cardiac arrhythmias? There is none of this evidence and for obvious reasons. This abuse and neglect is beneath the standard of care. Doctors do not subject their pediatric patients to this constellation of symptoms without correction.

There is probably no literature indicating that placing a little boy in a hot, unventilated, small closet without food or water for five or six days can cause the death of that little boy. That is because, thank God, this circumstance is not a daily event as, for example, was the ingestion of Cipro or Benedactin by thousands upon thousands of patients which made research and studies possible with reference to those drugs as reported in *Daubert* or *Swallow*. But do we need such literature? In this jurisdiction, can our medical doctors specializing in pediatric critical care not testify as to the cause of death? Are all death certificates in this state signed by a doctor of medicine invalid? It was not within the standard of care here, there or anywhere to put a small boy on a ventilator and sedate him with Propofol for 92 hours in spite of the boy's compromised vital signs. That was the evidence which must be regarded as true.

None of the many medical doctors who testified in this case had *ever* used Propofol for the long-term sedation of children in the ICU. If no medical doctors were subjecting their pediatric patients to 92 hours of sedation with Propofol and ignoring a dangerous trend in vital signs, then where are the data to do research, to write articles and to have those articles peer-reviewed? Do we really need scientific, peer-reviewed journals before we can hold accountable the person

[4] Dr. Smith, one of the Defendants' experts, admitted that hypotension can also cause liver damage. Tr. p.

who placed the little boy in this dangerous situation? Is it not permissible to have a medical doctor state his opinion that the lack of oxygen caused the death? It certainly was *admissible* in the judgment of the trial court because the opinion was allowed to be stated multiple times at different points in the trial. Or, with reference to this case, do we have to have multiple experiments where dozens of little boys are placed in life-threatening circumstances similar to that of Michael Hall followed by peer-reviewed journal articles commenting on the ugly results before we can ever conclude that the care – or lack of care – that Michael received was the cause of his death?

Respondents want to embrace the *Daubert* decision (*Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579, 113 S.Ct. 2786 (1993) as creating inviolate standards and observing that "[s]cientific methodology today is based on generating hypotheses and testing them to see if they can be falsified; indeed, this methodology is what distinguishes science from other fields of human inquiry." *Daubert*, 509 U.S. at 593. Are the Respondents indicating that it would be ethical or wise or humane to replicate the facts of Michael's subjection to Propofol at the same dosage for the same amount of time and under the same oxygen-deprived circumstances without correcting any of the distress signals to see what will happen? Nazi Germany condoned such experiments. Michael's mother and other mothers in these United States would disagree with such an approach.[5] It is not dispositive, therefore, or even important that Dr. Hammer acknowledged that he was unaware of any direct correlation in the medical

[5] And it does not strain the imagination that our federal and state courts at all levels would similarly

literature between the long-term use of Propofol and death caused exclusively by cerebral edema. *See, e.g.,* Curnow Brief, p. 25; Griffiths' Brief, p. 36. If Michael's last hours on this earth are not replicated by the actions of other physicians with other little boys because they know better, then that lack of literature means nothing more or less than the Defendants were out of bounds in Michael's case.

F. DR. HAMMER DID NOT SIMPLY RELY ON INFORMATION PUBLISHED AFTER MICHAEL'S DEATH. THAT ARGUMENT IS SIMPLISTIC.

The Trial court at R. p. 125 indicated, incorrectly, that "Dr. Hammer relied on two sources in forming his opinion but neither study identifies cerebral edema alone in young children as a cause of death even associated with Propofol." *That finding is not correct.*

While Dr. Hammer admitted on cross-examination that he referenced the two articles brought up only on cross-examination, on his direct examination he referenced at least a dozen journal articles available in 2002 or earlier as well as the 2002 Physician's Desk Reference. Tr. 218, ll. 11-24. While Dr. Hammer utilized these articles to illustrate his testimony, his testimony was not an application of these articles to Michael's death in the exclusion of the laboratory reports monitoring results and the autopsy reports – all coupled with the long-term application of Propofol.

G. THE TRIAL COURT IMPERMISSIBLY WEIGHED THE EVIDENCE.

In rejecting Dr. Hammer's opinions as lacking "scientific evidence," the Court referenced the testimony of Dr. Reed who was one of the Respondents' witnesses, R. p. 127. Virtually the entire Memorandum Decision authored by the trial court indicates a weighing of the evidence strongly indicating the Court simply did not agree with the jury's verdict.

What the trial court has confused is its function as a "gatekeeper" and its function as a trial court sitting on a Rule 50(b) motion. In the latter situation the court is to determine whether reasonable minds could have reached the same conclusion as the jury. *Hudson, supra*, at 478. The court, in weighing the evidence, never reached that point. Instead, the court became a post-trial jury of one.

In the first instance, a court as gatekeeper can keep out of evidence those opinions not sufficiently supported by scientific or technical knowledge. In the second instance, a court has to look at the evidence that was actually admitted and considered by the jury on a "reasonable minds" standard. Here, Dr. Hammer's opinions were preliminarily subjected to a great deal of argument in support of objections by the Defendants against admissibility. In due course, the trial court determined that Dr. Hammer's opinions were admissible under I.R.E 702. The jury heard those opinions. There were no hip shots or giant leaps of faith taken by Dr. Hammer. His opinions were well-reasoned and, as found in the

record, based on scientific knowledge. Those opinions were never stricken by the court.

Six months after the jury came in with a Plaintiffs' verdict, and without the benefit of a trial transcript, the trial court seems to have decided that Dr. Hammer's opinions should be ignored. Perhaps the trial court forgot Mr. Beals' and Dr. Groben's foundational evidence. How else can one explain the Court's comment at R. p. 131 "the evidence on cause is grossly insufficient." There was no evidence from the defense experts that Propofol absolutely could not produce Michael's brain death. No defense expert was critical of Dr. Hammer's analysis regarding the effect of Propofol on the heart, the dangers of critically low blood pressure, the cellular function leading to the rupture and death of brain cells, the importance of albumin in allowing nature's osmotic effect in the cell walls. As previously stated, however, there is nothing in the literature to indicate that the exact set of circumstances that Michael was subjected to has ever been encountered by other children. Knowledgeable and careful physicians do not do what the Defendants here did.

First, physicians in the shoes of the Respondents were, in 2002, warned by the PDR not to use the medication for the long-term sedation of children. That warning certainly reduced the number of children who receive Propofol for long-term sedation to the point of zero. Second, there is no evidence in the record that any physician anywhere would observe and then allow the incredibly low blood pressures suffered by Michael all during his stay in the ICU while he was under the Propofol sedation. In fact, as soon as the Propofol was stopped by Dr.

Reynolds when Michael began to exhibit damage to his heart, the blood pressure did improve. But by that time, as observed by the radiologist, Dr. Peck, there was brain damage secondary (caused by) to hypotension. Exhibits 1, p. C00114. One must think that radiology, too, is a species of scientific knowledge.

In relying on the lack of medical literature coupling Propofol directly with cerebral edema, the trial court has clearly weighed the evidence. On one side of the scale is a lack of literature versus the other side of the scale which is Dr. Hammer's, Dr. Groben's and Mr. Beal's well-reasoned opinions. These opinions were based on this exact case and were expressed both as to factual foundation and ultimate opinion over hundreds of pages of the transcript. On the other side of the scale, there is an absence of evidence indicating that any child had been subject to that which Michael was subject to. Also on that side of the scale is the fact that none of the Respondents' experts could testify as to why Michael died. Yet, the trial court not only utilizes this scale in impermissibly weighing the evidence, but finds that the scale tips in favor of the Respondents based on the false and misleading issue of PRIS put forward by the Respondents and the erroneous notion that the Plaintiffs had to prove that the Propofol was "the" cause of death. That weighing of the evidence has been forbidden by this Court in a Rule 50(b) motion as previously noted.

While incorrectly chastising Dr. Hammer for utilizing a 2003 article which helped to explain his position on cellular function, the trial court itself at R. p. 128 in fn. 6 cites to a 2005 article not in evidence which "is designed to aid physicians in evaluating the claims made in different studies." The trial court clearly used

resources unavailable to the jury and not in evidence to assist it in weighing the evidence. This is even beyond weighing evidence – it is adding "evidence" six months after the jury was discharged.

In attacking Dr. Hammer's opinions as unsound, both the trial court and the Respondents have done nothing more than point out that the medical literature does not reflect a death of a small boy where both cerebral edema and Propofol are involved. Without being unnecessarily redundant, Appellants would offer that it is not just the Propofol that is involved in this case, but a continuation of that sedative drug for days on end in sedating a helpless, small child who was intubated and could not cry out for help. It was not merely the initial and continued ignorance of both Defendants in not doing the slightest amount of research regarding their sedative drug of choice – which research would have caused them to recognize the caution flags raised by lab reports and monitors. It was not just the refusal to heed the warnings of a nurse who confronted Dr. Curnow and questioned the use of this drug on this child.[6] It was not simply the failure of the Defendant physicians to appropriately address consistent and extreme hypotension, fever, low hemoglobin, liver enzymes far from normal, low hemocrit, and signs of kidney damage, each one being an indicator of low amounts of oxygen available for Michael's utilization. It was a collection of these things that constituted errors of both omission and commission and which supported Dr. Hammer's opinions.

The Respondents, other than carping about Dr. Hammer's opinions and methodology, could have pointed to something in the record indicating that Dr.

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[6] That [illegible] was in the nursing notes and available to Dr. Griffiths

Hammer's opinions were not reasonable or not supported by basic medical science. This they have failed to do. The Respondents had many high-paid experts who did not attack Dr. Hammer's theories of oxygen deficiency which caused the hypoxic ischemic brain event. In fact, they could not. As Dr. Hammer himself testified, this was not "rocket science." Rather, he was testifying about basic care in the ICU, "things we learned in medical school, things we think about directly or indirectly every day, especially in the Intensive Care Unit where we are thinking a lot about making sure that the tissues in the body have enough oxygen, the right amount of glucose, the laboratory values are monitored, blood pressure is very important, those sorts of things." Tr. p. 353, ll. 6-14. Not "rocket science," perhaps, but science nevertheless and well within the ambit of Rule 702.

H. THE RESPONDENTS HAVE NOT RESPONDED TO THE ARGUMENT THAT THE TRIAL COURT DID NOT ABUSE ITS DISCRETION IN ADMITTING OPINION EVIDENCE ON CAUSATION AND STANDARD OF CARE.

In Appellants' opening brief, Appellants cited *Grover v. Isom*, 137 Idaho 770, 774, 53 P.3d 821, 825 (2002) to illustrate that in a medical malpractice case "whether a witness is qualified as an expert is reviewed for an abuse of discretion." *See, also*, *Ramos v. Dixon*, 144 Idaho 32, 35 156 P.3d 533, 536 (2007).

Dr. Hammer was allowed to testify. He was deemed qualified to give an expert opinion and allowed to state his opinions despite strenuous and very

lengthy objections by the Respondents after which the court ruled that Dr. Hammer could testify and could state his opinions. Neither of the Respondents on this appeal has argued this was an abuse of discretion by the court. The evidence stands as admitted. Although it is supposed to be deemed "true," that evidence is now being attacked on appeal in an attempt to have this Court second-guess the trial court which can only be done if the trial court abused its discretion. That argument has not even been made. The only real question is whether Dr. Hammer's opinions, taken with the other evidence at trial, constitutes substantial and competent evidence. If, as Respondents argue, Dr. Hammer's testimony is nothing more than speculation, then no physician's testimony at trial regarding his or her diagnosis of a medical condition or cause of death could ever be relied upon to support a jury verdict.

I. A MERE TEMPORAL CONNECTION OR RELATIONSHIP DID NOT FORM THE BASIS FOR DR. HAMMER'S OPINION.

From the foregoing, we can see that Dr. Hammer did not base his evidence on "a mere temporal relationship" as alleged by the trial court. In other words, Dr. Hammer did not fail to analyze the causal steps between a ninety-two hour intubation and sedation under the influence of Propofol and the cerebral hypoxic ischemic event. Simple reference to the transcript will spike this weak argument, proffered by Respondents and erroneously accepted by the trial court.

J. STANDARD OF CARE FOR DR. CURNOW AND DR. GRIFFITHS WAS VIOLATED.

Dr. Hammer testified that his opinions on the breach of standard of care were held with reasonable medical certainty, that he actually held an opinion regarding the failure of each of the Defendants to meet the applicable standard of practice and that he had actual knowledge of the applicable community standard in June of 2002. Tr. pp. 378-379. The trial court ruled that Dr. Hammer had familiarized himself with the local standard of care in like communities and that his opinions were admissible. What Dr. Hammer had done, coupled with his own knowledge, was sufficient to lay a foundation for his standard of care opinions. The standards are those standards basic in medicine and, in this case, are taught in medical school. Tr. 439, ll. 4-19. Both Dr. Curnow and Dr. Griffiths were responsible for Michael Hall's post-surgical care. Each agreed that he had a direct responsibility. Each agreed that medical doctors are expected to know generally the contraindications and properties of the drugs which they prescribe for their patients. Yet, here we have neither Dr. Curnow nor Dr. Griffiths ever taking the smallest step to familiarize themselves with the application of the drug Propofol, not for short-term surgeries, but for prolonged sedation of a small child in the ICU.[7] Research tools were available to both of these physicians via the PDR and computers, but neither did the slightest thing to take advantage of those tools. Nurse Crockett recorded in the nursing notes which were available to both physicians that she questioned the use of Propofol for this child. She was

[7] Even after receiving a warning from Nurse Crockett, Dr. Curnow did no research on Propofol. Tr. p. 1052, ll. 17-21. Dr. Griffiths similarly did nothing to acquaint himself regarding the properties and contra-

ignored, her opinions dismissed out of ignorance. But she was correct. The doctors were not. Clearly, both Defendants had errors of omission and commission in the selection of this drug for long-term use. They did not even arrange for an anesthesiologist to monitor Michael in the ICU on a routine basis. Tr. p. 1049, l. 23 – 1050, l. 5.

Additionally, and as significant evidence of the 2002 standard of care, no physician who testified at trial uses Propofol for long-term sedation of children. None had any experience with it as a long-term sedative for children. None knew of any physicians in their hospital or locale who were using Propofol for the long-term sedation of children. That, alone, constitutes evidence of the standard of care not only in Boise (Dr. Curnow, Dr. Griffiths, Dr. Smagula, Dr. Smith, Dr. Vestal) but also in Alabama (Dr. Georgeson), in California (Dr. Latchaw), in New Mexico (Dr. Reichard) in Oregon (Dr. Silan), and in South Carolina (Dr. Johnston).[8] No doubt this lack of use was because of the many medical journals which, by 2002, had cautioned against the use of Propofol for the long-term sedation of children. Tr. p. 842, l. 20 – 843, l. 11. The PDR and FDA warnings also had national applications.

Both physician Defendants then failed to monitor the patient for appropriate blood pressure, glucose, and other adverse side effects. Tr. 446, ll. 5-15. These numbers in the lab reports do not lie. They are not arbitrary. They are not insubstantial. The numbers on the lab tests are generated by scientific instruments. Respondents have not argued – nor can they – that the blood

[8] As previously stated there were no other pediatric surgeons or pediatric plastic surgeons in Idaho so, among other sources, Dr. Hammer familiarized himself with the standard of post- surgical care in Eugene, Salem and Medford, Oregon.

pressure readings, the lab reports, the autopsy report from the pathologist who actually saw Michael's body shortly after his death, the nurse's notes, the PDR entry stating that Propofol is not indicated for pediatric use – are not competent and substantial evidence. They support the testimony of Dr. Hammer. They support the verdict.

Dr. Curnow argues that he did monitor the patient. That may be. But he did not monitor his patient carefully and with a sufficient awareness so that he could detect danger signals, or if he did detect them, he did nothing to correct the underlying problem. Dr. Curnow argues in his brief that he monitored for signs of PRIS. That is patently untrue since Dr. Curnow did not know anything about PRIS or the long-term application of Propofol until after this unfortunate death occurred. Dr. Curnow had to admit at trial that he had never used Propofol either before or after Michael Hall's death for the long-term sedation of children in the ICU. How, then, could he monitor for PRIS? More importantly, how could he not monitor for basic vital signs – signals of a deprivation of energy – producing oxygen being utilized in a normal fashion? Dr. Curnow not only admitted that he did not ever use Propofol for the long-term sedation of children, he did not even know what the dosage should be. Tr. p. 1042, ll. 2-10. He thus violated his own self-acknowledged standard regarding the knowledge a physician should possess when his or her patient is being medicated.

Dr. Griffiths, too, was unfamiliar with Propofol and had never before ordered it for the sedation of a child. Tr. p. 1091, ll. 11-14. He agreed that "when a doctor of medicine orders a drug for a patient, he or she should know generally

the properties and contra-indications of the drug." Tr. p. 1092, ll. 12-17. Yet, he never changed his order for the drug and even while noting the extremely low blood pressure, and other low values he never reduced or stopped the drug. Tr. p. 1107, ll. 20-24.

Dr. Griffiths might be a good pediatric plastic surgeon possessing sufficient skills when it comes to hands-on surgical procedures. As previously stated, however, the criticism of Dr. Griffiths comes not from his unsuccessful attempt to revascularize the piece of flesh that the dog had removed from Michael's cheek.[9] On the contrary, what Dr. Griffiths attempted so poorly was, among other things, monitoring Michael in the ICU on a post-surgical basis in a location to which he had discharged Michael rather than discharging him to the pediatric ICU at St. Luke's Regional Medical Center, a nearby medical center specializing in pediatric care and to keep him on a drug not indicated for children. The ICU at St. Alphonsus was not a pediatric ICU, and Michael was mixed in with adult patients and subject to the care of nurses who may or may not have been especially attuned to children's needs. Dr. Hammer was critical of the failure of both Defendants to seek out a pediatric intensivist to care for Michael in the ICU. Neither Dr. Curnow nor Dr. Griffiths could provide that level of care. Dr. Curnow knew that Dr. Christiansen, a pediatric intensivist, who practiced at St. Luke's, was available but did not involve him in Michael's ICU care (Tr. pp. 1034-1035; 1045-47) even though Dr. Curnow thought Dr. Christiansen was an "excellent" physician based on his personal knowledge.

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[9] This attempt included placing leeches on Michael's face so as to draw blood through the wound. The blood so lost could not carry oxygen to Michael's brain.

Dr. Griffiths was also forced to admit at trial that there was no "quarterback" regarding the post-surgical care of Michael (Tr. p. 1112, ll. 8-9), that he had never used Propofol, that he did nothing to educate himself about the danger signals involved in using the drug and that, yes, he was equally responsible for Michael's post-surgical care including, but not limited to, the monitoring of his vital signs. Tr. p. 2239, ll. 19-21. That monitoring was done poorly, missing those basic signs and symptoms which are taught in medical school. Additionally, Dr. Griffiths breached the standard of care by not giving the anesthesiologist sufficient information about his plan of care. Tr. 489, l. 19 – 490, l. 24.

The cases cited by Dr. Griffiths in his Brief all involve situations where the expert proffered by plaintiff was not allowed to testify because of a lack of familiarity with the standard of care. Here, after exhaustive argument in pre-trial hearings and at trial, Judge Bail allowed Dr. Hammer to testify regarding the basic care standards involving basic medicine which should have been observed. That was not an abuse of discretion.

In Appellants' opening brief, pps. 40-42, the familiarization by Dr. Hammer of the local standard of care was recited and another recitation is not necessary here. Clearly, Dr. Hammer had sufficient information about the local standard as well as the activities or omissions of both Dr. Curnow and Dr. Griffiths to express an opinion on that subject. Dr. Hammer did know the standard of care applicable to these surgeons involved in pediatric post-surgical care and testified at length that standard of care in the application of basic medicine was violated. This is

similar to the court's ruling in *Grover v. Isom.* The post-surgical care and monitoring required was "basic medicine" and the Defendants did not meet it. Additionally, the PDR is clearly a national standard. Tr. 841. The FDA prohibition is an additional national standard. *Id.* The use of Propofol violated these standards when a boy not yet three years of age was sedated with the drug for 92 hours even while he showed signs of distress and decline.

K. ATTORNEYS' FEES ON APPEAL.

In an earlier footnote in this Reply Brief, it is stated that under the circumstances existing here, the failure to file and to prosecute an appeal in this case would be evidence of professional negligence. This action followed the death of a little boy in 2002. Many months and years of discovery followed the filing of the Complaint in 2004. The trial was held in 2007, and lasted eleven days and saw nineteen expert witnesses from various scientific disciplines testify on both sides. The Plaintiffs evidence was both substantial and competent as evidenced elsewhere in this briefing exercise. The jury's verdict was for the Plaintiff and substantial damages were awarded. To state as the Respondents state that the Appellants are simply asking an appellate court to now second-guess the trial court or that this appeal was brought or pursued frivolously, unreasonably or without foundation is inappropriate. It is submitted that Respondents' attorneys know better.

III. CONCLUSION

For the foregoing reasons, the jury's verdict should be upheld on the basis of Plaintiffs' evidence at trial – evidence both substantial and competent. The truth of this evidence must be admitted. The decision of the trial court should, therefore, be reversed and remanded with instructions to enter judgment for the Plaintiffs *nunc pro tunc* consistent with the jury's verdict of September 19, 2007.

RESPECTFULLY SUBMITTED this 27th day of February, 2009.

LOJEK LAW OFFICES, CHTD.

By: Donald W. Lojek – Of the Firm
Attorneys for Plaintiffs/Appellants

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on the 27th day of February, 2009, four true and correct copies of the foregoing instrument were served on the following by the method indicated below, and addressed as follows:

[ ]	Hand Delivery	Patricia M. Olsson
[x]	U.S. Mail, postage paid	Nancy Jo Garrett
[ ]	Overnight Express Mail	Moffatt, Thomas, Barrett, Rock & Fields, Chtd.
[ ]	Facsimile Copy: 385-5384	101 S. Capitol Blvd., 10th Floor PO Box 829 Boise, ID 83701-0829

Attorneys for Adrian Curnow, MD and Russell Griffiths, M.D.

Donald W. Lojek