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FIFTH JUDICIAL DISTRICT COURT
IN AND FOR IRON COUNTY, STATE OF UTAH

DAVID HINSON, Plaintiff, v. **DARRELL L. WILSON, M.D.; JARED C. COX, D.O.; KIMBERLY D. HAYCOCK, P.A.; DOE INDIVIDUALS 1 through 10 and ROE ENTITIES 1 through 10, inclusive,** Defendants.	**DEFENDANT DARRELL L. WILSON, M.D.'S TRIAL BRIEF** Case No. 170500085 Judge Jeffrey C. Wilcox

Defendant Darrell L. Wilson, M.D. (hereafter "Defendant" or "Dr. Wilson"), by and through counsel, hereby respectfully submits *Defendant Darrell L. Wilson's Trial Brief* in this matter:

I. Brief Summary of Case

This case involves allegations centering on claims of medical malpractice related to care and treatment provided to David Hinson ("Plaintiff" or "Mr. Hinson") at Valley View Medical Center in Ceder City, Utah between July 9 – 15, 2015 by Dr. Wilson, defendants Jared C. Cox ("Dr. Cox"), and Kimberly D. Haycock, P.A. ("Ms. Haycock").

A. Plaintiff David Hinson – Plaintiff David Hinson is represented by attorneys Ashton Hyde, Matthew Purcell, and McKay Corbett, of the law firm Younker Hyde McFarlane.

B. Defendant Dr. Darrell L. Wilson – Defendant Dr. Wilson is an emergency room physician. He is represented by attorneys Vaun B. Hall, and Derek J. Williams of the law firm Campbell, Williams, Ference & Hall.

C. Defendants Dr. Jared C. Cox & Kimberly Haycock, P.A. – Defendants Dr. Cox, and Ms. Haycock are represented by attorneys Nan Bassett & Kirk Gibbs of the law firm Kipp & Christian.

II. Facts Of The Case

In July 2015, David Hinson ("Plaintiff"), a 46 yr. old resident of Texas, was visiting family members in Antimony, Utah. On or about July 4, the Plaintiff injured his left shoulder while lifting his young daughter onto a horse. Five days later, on July 9 at 09:14 AM, the Plaintiff presented to Valley View Medical Center Emergency Department in Cedar City, Utah. He was seen by Jeffery Bleazard, M.D. for a complaint of left shoulder pain. The Plaintiff told Dr. Bleazard that he had injured his left shoulder two-years prior and has been experiencing pain ever since. He believed he reinjured his shoulder lifting his daughter and felt the shoulder may be dislocated. He informed Dr. Bleazard that he has tried to avoid shoulder surgery due to his ongoing heart valve condition and Marfan syndrome (*Marfan syndrome is a genetic disorder that leads to problems with connective tissue, which supports the bones, muscles, and organs).*

Importantly, the Plaintiff reported that he was taking Coumadin, a blood thinner used to reduce the risk of stroke in heart valve replacement patients. Dr. Bleazard did not order a PT/INR test to determine if the Plaintiff's blood was too thin. Dr. Bleazard ordered a shoulder x-ray (normal) and performed a physical examination. Dr. Bleazard noted there was tenderness

and bruising on the anterior portion of the shoulder, with limited range of motion. Dr. Bleazard discharged the Plaintiff with a diagnosis of shoulder pain, bruising and rotator cuff syndrome. The Plaintiff was given a sling and swathe, a prescription for pain medication, and instructions to return to the emergency department if his symptoms worsened. He was also provided with the name and contact information for an orthopedic surgeon in Cedar City, Dr. Lex Allen, to call if needed.

The following day, July 10 at 02:42 AM (16.5 hours after his previous discharge), the Plaintiff returned to the emergency department and was seen by Darrell Wilson, M.D. ("Dr. Wilson"). The Plaintiff complained the pain medication he was given the day before isn't even "touching the pain." He said that he just wanted some pain control.

Dr. Wilson performed a physical exam and noted bruising and swelling near the Plaintiff's left shoulder and down toward his elbow. Dr. Wilson appropriately diagnosed the Plaintiff with a left arm hematoma (bruise). The hematoma appeared to be compressing the soft tissues in the Plaintiff's left shoulder. The Plaintiff complained of severe pain and "some occasional numbness and tingling is his hand and fingers." During Dr. Wilson's physical exam, he noted reassuringly that, "[t]here is good distal circulation and sensation in the forearm, hand and fingers."

Importantly, Dr. Wilson discussed with the Plaintiff whether he had had his blood tested recently. The Plaintiff assured Dr. Wilson he had no recent changes to his Coumadin therapy, and that his INR had been monitored regularly. Despite these assurances, Dr. Wilson wanted to double check his PT/INR, so Dr. Wilson ordered a Prothrombin Time ("PT") test to check if the Plaintiff's blood was too thin. Unfortunately, the Plaintiff refused this test telling Dr. Wilson, "[h]e does not really want any further workup on that [PT] tonight. He just would like some pain

control…" The Plaintiff denies he refused a PT test, despite there being a contemporaneous order in the medical record.

Dr. Wilson gave the Plaintiff some pain medication in the emergency department and a prescription for Percocet to fill. He was instructed to return to the emergency department if his symptoms "get worse or has other concerning symptoms."

Two days later, on July 12 at 11:42 AM, the Plaintiff presented again to the Valley View Medical Center Emergency Department requesting a refill of his pain medication for the drive back to Texas. He was seen by Kimberly Haycock, PA (who was being supervised by Jared Cox, M.D.). The Plaintiff informed PA Haycock that his bruise had <u>not</u> gotten any bigger over the last couple of days. He said he had "some tingling in his hands on and off." He also denied any weakness in his extremities.

PA Haycock performed a physical examination the revealed "good range of motion in all extremities… He does have neurovascular intact distally." This means the Plaintiff's circulation and sensation were intact in his hands and fingers. The Plaintiff allowed PA Haycock to perform a PT test that revealed an elevated INR of 7.1. In order to lower his INR, PA Haycock instructed the Plaintiff to stop taking his Coumadin for two days until he could return to Texas and see his primary care provider.

According to the Plaintiff, he left Utah the following day, Monday July 13, to return to Texas. The trip took two days to complete. Along the way, the Plaintiff and his family stopped in New Mexico for the night. The following day, Tuesday July 14, they arrived in Frisco, Texas, a distance of 743 miles. While enroute to Texas, the Plaintiff's symptoms began to change. <u>During the drive home, the Plaintiff lost "complete feeling" in his hand</u>. Despite this significant change in condition, the Plaintiff did not attempt to go to the hospital during the entire

drive from New Harmony, Utah to Frisco, Texas. Despite this significant change in his condition, the Plaintiff did not go to the emergency department when he arrived home in Frisco, Texas; instead, he went home and slept in his bed.

The following morning, July 15, the Plaintiff didn't immediately go to the emergency department in his hometown, even though he was unable to move his left hand. Later that same day, at approximately 10:00 AM, he saw his primary care provider who sent him to the emergency department at Baylor Regional Medical Center ("BRMC"). At 11:15 AM, on July 15, the Plaintiff presented to the BRMC Emergency Department complaining of shoulder and arm pain and weakness. An MRI of the shoulder was performed that revealed a hematoma (collection of blood) in his brachial plexus shoulder area. Surgery was recommended to remove the hematoma. Despite the recent changes in the Plaintiff's condition, surgery wasn't performed until more than 31 hours later the following day July 16 at 18:10 PM.

Now, more than eight years later, the Plaintiff continues to complain of pain and limited use of his left shoulder and arm.

III. Allegations

Plaintiff alleges that the Defendants breached the standard of care in the following ways:

1. Failure to timely and appropriately diagnose and treat bleeding and hematoma formation.
2. Failure to obtain a complete history and physical examination.
3. Failure to obtain appropriate laboratory and other testing.
4. Failure of informed consent.
5. Failure to arrange for appropriate specialty consultations and treatment.
6. Failure to communicate with members of the health care team.

IV. Legal Standard

In Utah, to establish that a physician is at fault, the Plaintiff has the burden of proving each of the following elements: (1) the standard of care by which the physician's conduct is to be measured; (2) breach of that standard of care by the physician; and (3) the harm caused by the physician's breach of the standard of care. Model Utah Jury Instructions ("MUJI") CV301B. The jury will be given an additional instructions that define what "standard of care" means. *See* MUJI CV301C.

Additionally, under Utah law, the fault of an emergency physician such as Dr. Wilson must be proven by a heightened "clear and convincing evidence" standard. *See* Utah Code. Ann. § 58-13-2.5(1). "Proof by clear and convincing evidence requires a greater degree of persuasion than proof by a preponderance of the evidence but less than proof beyond a reasonable doubt." MUJI CV118.

V. Defenses

A. Standard of Care Defenses

Defendant Dr. Wilson, by and through his own testimony, the testimony of his expert witness Kenneth Bramwell, M.D. — identified in Dr. Wilson's Pretrial Disclosures),[1] the testimony of other fact and expert witnesses (also identified in Dr. Wilson's Pretrial Disclosures), and through various exhibits (also identified in Dr. Wilson's Pretrial Disclosures), will present evidence and argue that his actions throughout his care of Plaintiff complied with the standard of care in all respects, including a complete and thorough work-up and evaluation of the Plaintiff. Dr. Wilson appropriately evaluated the patient and correctly diagnosed him with a left shoulder/arm hematoma. Dr. Wilson correctly and appropriately diagnosed that the hematoma

[1] Which were served on November 7, 2023.

was causing the Plaintiff's complaints of pain and occasional numbness and tingling in his left hand and fingers. Dr. Wilson's own exam revealed the Plaintiff was neurovascularly intact; meaning both his circulation and sensation were intact. Dr. Bramwell will testify why this is an important distinction between the Plaintiff's condition when he saw Dr. Wilson on July 10, and his deteriorated condition on July 14, 15 and 16; when he could no longer feel or move his left hand.

Dr. Bramwell will testify that soft tissue injuries are more often than not treated conservatively; without surgery and heal on their own. Surgery carries its own set of risks and is not the first line of treatment.

Dr. Bramwell will testify that Dr. Wilson appropriately ordered a PT test to determine if the Plaintiff's Coumadin needed to be adjusted. The Plaintiff refused the PT test, and inaccurately reassured Dr. Wilson that his Coumadin regimen had not changed and that his INR values were monitored regularly. This more likely than not impacted Dr. Wilson's treatment plan.

Dr. Bramwell will testify that the Plaintiff's presentation to PA Haycock two days after his interaction with Dr. Wilson was reassuring the Dr. Wilson had made the correct diagnosis and treatment plan, i.e. the Plaintiff's bruising was not any worse, his pain was being controlled by the medication, and the Plaintiff's left shoulder and arm continued to be neurovascularly intact.

Dr. Bramwell will testify that the Plaintiff failed to follow Dr. Wilson's discharge instructions to return to the emergency department if his condition worsened. The Plaintiff did not go to the emergency department during the two-day journey back to Texas during which time his shoulder and arm were becoming weaker, to the point where he could not feel or move his

left hand.

In sum, Dr. Bramwell will testify that Dr. Wilson's care and treatment of the Plaintiff met or exceeded the standard of care in all material respects.

B. Causation Defenses

The Defendants' primary causation defense is that Mr. Hinson was instructed by PA Haycock to seek medical attention if his symptoms got worse after leaving Valley View Hospital on July 12, 2015, and started driving home to Texas. On July 12th, his pain was improving, and his numbness/tingling was only intermittent. Experts will testify that the permanent damages that he is now experiencing had not occurred when he left the care of PA Haycock on July 12th. Over the following days, while driving back to Texas, Mr. Hinson did not seek any medical attention when he could and probably should have if the symptoms of numbness/tingling, and pain were worsening.

When he arrived home on the night of July 14th, he did not go to the hospital. Instead, he waited until the next day, July 15th when he did not go to a hospital, but to his primary care provider. He reported to this physician that the symptoms had significantly worsened over the previous night, and at that time he could not feel his hand. Thus, the damages alleged were not caused by anything done or not done in the ER. They were caused by Mr. Hinson's own decisions not to follow PA Haycock's discharge instructions to seek care immediately if his symptoms worsened.

C. Damages Defenses

Plaintiff is alleging both economic and non-economic damages. Plaintiff designated a life care planner (Sheryl Wainright) and a forensic economist (Alan Stephens). Plaintiffs are seeking the following categories of damages:

1. Future Medical Expenses (Life Care Plan)

Plaintiff's life care planning expert, Ms. Sheryl Wainright, has provided a life care plan dated September 13, 2019. In this life care plan, she opines that Mr. Hinson will require medical and other supportive services for the remainder of his lifetime as a result of the alleged negligence of defendants. Specifically, Ms. Wainright says that Mr. Hinson will need the following:

a. **Physician/Medical Services – 3 visits per year with a neurologist.**
b. **Physical Therapy – 8-12 visits for physical therapy per year.**
c. **Counseling Services –** For Mr. Hinson, she recommends 2 x month for the first year, then 1 x month each year after for the rest of his life. She also recommends 10 visits of couples counseling for Mr. Hinson and his wife for one year.
d. **Medications –** Cymbalta 60mg/day for his lifetime.
e. **Replacement Services – Yard Care** – 37 weeks per year for his lifetime.
f. **Replacement Services - Seasonal Cleaning** – 2 x year for 3 hrs per session for his lifetime.
g. **Replacement Services - Assistant Care** – 10 hrs per week for his lifetime
h. **Replacement Services - Car Maintenance** – 1 x year for two cars for his lifetime.

Using the costs for these life care items generated by Ms. 0Wainright, Mr. Stephens has calculated the present value of this life care plan to be **$393,173.00.**

2. Past Medical Expenses

At this point, it is unclear how much Plaintiff is claiming in past medical expenses. In his February 14, 2020 economic report, Mr. Stephens said that he anticipates calculating past medical expenses, but as of that time, had not been provided any evidence to support any past medical expenses. Plaintiff has identified in their pre-trial disclosures, a document called "David Hinson – Medical Bill Summary". This summary includes alleged past medical bills. The total of those medical bills is **$64,980.56.**

3. Past and Future Lost Wages/Income

Through recent correspondence with Plaintiff's counsel, Plaintiff has withdrawn any claim to past lost wages or future lost earning capacity. Therefore, the parties should be able to reduce the number of exhibits that related to Mr. Hinson's employment, income, and earning capacity.

D. Non-Economic Damages

The statutory cap on non-economic damages for this case, pursuant to Utah Code Ann. §78B-3-410(1), is 450,000.00. If the jury were to award more than $450,000.00 in general damages, then post-trial, the Court will reduce such an award to this statutory cap amount.

E. Defendants' Response to Plaintiff's Damages

Defendants will respond to the alleged damages through cross-examination of Mr. Hinson, his wife, Ms. Wainwright, and Mr. Stephens. There are legitimate questions regarding the foundation and credibility of Ms. Wainright's opinions. Mr. Hinson and his wife are on record in their deposition describing what Mr. Hinson is able and not able to do, and that testimony contradicts Ms. Wainright's opinions. Additionally, Mr. Hinson is not currently using most of Ms. Wainright's services and he has not see a physician that say they are necessary. The costs quoted by Ms. Wainwright will also be challenged on cross examination and through the affirmative testimony of Defendants' own life care planner (Lora White) and economist (Brad Townsend).

Defendants anticipate that Ms. White will testify that there is only a need for Cymbalta medication, but available at a much lower monthly cost. Additionally, she believes that because

Mr. Hinson has not had any type of therapy on his arm since 2016, it is unclear whether therapy is indicated. To address this, Ms. White recommends a physical therapy assessment to determine whether therapy would be helpful, and if so how many sessions. It is speculative to know what therapy will be indicated and helpful, if any, for his lifetime without first having an assessment. Overall, Defendants' economist, Brad Townsend, calculates the future cost of Lora White's recommended life care plan items to have a present value of **$2,968.00.** If a supplemental economic report or life care plan is produced by Ms. Wainwright or Mr. Stephens that calculates or updates any category of damages, Mr. Townsend will similarly provide a supplemental report.

Summary and Conclusion

Defendants are prepared to defend this case on the elements of standard of care, causation, and damages. They will do so through the use of exhibits, including medical records, testimony of Mr. Hinson's treating providers, and testimony from Plaintiff and Defendants and their experts. We look forward with working with the Court to efficiently getting this case tried to the jury and assisting them in reaching their decision.

DATED this 14th day of November, 2023.

CAMPBELL, WILLIAMS, FERENCE & HALL

/S/ Derek J. Williams____________________
VAUN B. HALL
DEREK J. WILLIAMS
Attorneys for Darrell L. Wilson, M.D.

MAILING CERTIFICATE

On this 14th day of November, 2023, I delivered by U.S. and/or electronic mail, a true and correct copy of the foregoing **DEFENDANT DARRELL L. WILSON, M.D.'S TRIAL BRIEF,** to the following:

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