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

By Francis V. Cristiano, Esq.

Supreme Court Decisions

There was one Supreme Court decision rendered this past year that addressed medical negligence issues and one notable petition for writ of certiorari granted.

Ortega v. Colorado Permanente Medical Group, PC – Waiver of Physician-Patient Confidentiality of Medical Records Held by an HMO

Ortega v. Colorado Permanente Medical Group, PC[1] addressed an issue that had been brewing since the Colorado Supreme Court rendered its decision in *Alcon v. Spicer*.[2] *Alcon* narrowed the scope of discoverable medical documents in a personal injury context to those records directly related to the injuries alleged by the plaintiff, i.e. "those records that relate to the cause and extent of the injuries and damages [the plaintiff] claims."[3] The *Alcon* court also directed the plaintiff to utilize a privilege log to identify all other medical records that the plaintiff contended were in a category that went beyond the scope of permissible discovery by that rule. *Alcon* dealt with a third-party situation, where the defendant sought discovery of medical records of the plaintiff to which he or she would otherwise not have access.

In an HMO setting, however, both the HMO and the physicians who attend to HMO patients typically have access to the entire medical records of the patient for services rendered within the auspices of the HMO. Thus, the question arose as to whether in a medical negligence setting, where the patient sues the physician and/or the HMO, the same limitations should apply. That is, should the defendants be allowed to utilize, for litigation purposes, medical information beyond the permissible scope of *Alcon* merely because they already had access to such as the patient's HMO or HMO physician, even though the records weren't related to their treatment of the patient? *Ortega,* involving the HMO, Kaiser Permanente, addressed this issue.

The plaintiff in *Ortega* filed a motion for a protective order, challenging the right of Kaiser and the physician to access the plaintiff's entire medical record for the purposes of the litigation. The plaintiff offered instead to have the court scrutinize the proper scope of discoverable medical records by identifying those that were discoverable, based upon an *Alcon* analysis and those that the plaintiff contended were not discoverable, based upon a privilege log. The trial court, however, denied the protective order. Instead, it allowed both Kaiser and the physician unrestricted access to the entirety of the plaintiff's Kaiser medical records based upon the exception to confidentiality set forth at C.R.S. § 13-90-107(1)(d)(I) with regard to the rights of a "sued physician" and C.R.S. § 10-16-423 with regard to the rights of a health maintenance organization. The case garnered significant interest in the medical community and a total of four amicus curiae briefs were filed, all of which supported the notion that the record should be fully accessible by the defendants.

Justice Rice wrote the majority opinion that opened the doors to full access by both the physician and Kaiser based upon the privilege exceptions in C.R.S. § 13-90-107(1)(d)(I) with regard to a sued physician, and C.R.S. § 10-16-423 with regard to a sued health maintenance organization.

Thus, with regard to the sued physician exception to physician-patient confidentiality at § 13-90-107(1)(d)(I), the court emphasized the language of that provision that the physician-patient privilege:

> . . . **shall not apply to**:
>
> (I) A physician, surgeon, or registered professional nurse **who is sued** by or on behalf of a patient ... on **any cause of action arising out of or connected with the physician's** or nurse's care or treatment of such patient.[4]

Hence, where the defendant physician in an HMO setting, in Justice Rice's words, "acquires the entire medical record

in order to effectively evaluate and treat the patient,"[5] he or she is free to use any of those records deemed relevant and admissible by the trial court to defend him or herself in the lawsuit.

The court took the same approach with regard to the HMO exception to the physician-patient confidentiality in C.R.S. § 10-16-423, which defines the exception to the confidentiality of HMO members' medical information to occur " . . . in the event of claim or litigation between such person and the health maintenance organization wherein such data or information is pertinent."[6]

With respect to the relevancy criteria for discoverability, the court adopted the most conservative restrictions available, i.e. the relevancy criteria of C.R.C.P. 26(b) only, with no deference to *Alcon* limitations. The court noted, however, that "[n]either the trial court's ruling on the motion for protective order, nor our opinion here, affects plaintiff's opportunity to object to the relevance of medical information before trial to safeguard against admitting unrelated or irrelevant medical information into evidence." Thus, the trial court would base the admissibility of the information upon a C.R.E. 401 - 403 relevancy analysis. The rules defer little, if at all, however, to the patient's concerns about being forced to divulge confidential and potentially embarrassing medical information, as well as the concerns of society in maintaining strict confidentiality to encourage open and frank disclosure of information by a patient to medical health care professionals.

The decision was not, however, unanimous, and Justice Bender wrote an extensive dissent.

In his dissent, Justice Bender challenged the majority's basic assumptions including such things as the majority's conclusion that "when a [Kaiser] physician attends to a patient" he "**acquires** the entire medical record in order to effectively evaluate and treat the patient." Instead, in Justice Bender's mind, the majority confused the word "acquire" with "access." Justice Bender stated that "[t]here is no evidence that Dr. Lieuwen actually acquired or used all of Ortega's medical records in his treatment of Ortega, only that he had access to the records in Kaiser's system," and the words "acquire" and "access" have entirely different meanings, with the former being the criteria for waiver, not the latter. He noted, as well, that the exception of

> . . . 13-90-107(1)(d)(I) applies [only] to information the physician acquired "that was necessary to enable him or her to prescribe or act for the patient." In this case, there has been no showing that almost 10 years of Ortega's medical history, containing nearly 700 records were necessary for Dr. Lieuwen to treat Ortega's chest, neck, shoulder, and back pain.[7]

Thus, Dr. Lieuwen had failed to show that the entirety of Ortega's medical records had been used to treat Ortega, which in his mind should be a necessary showing to trigger the applicability of C.R.S. § 13-90-107(1)(d)(I).

Perhaps most importantly, Justice Bender also emphasized that the "doctrine of implied waiver" and the restrictions of the doctrine consistent with *Alcon* should be as applicable in medical negligence settings as they are in general personal injury cases. He argued that to hold otherwise would be to ignore well-defined precedent, including the precedent from such cases as *Hartmann v. Nordin*[8], *Samms v. Dist. Court*[9] and *Reutter v. Weber.*[10] From among them, the most noteworthy language arguably was that found in the relatively recent case of *Reutter*, which represents the most liberal assessment by the Supreme Court concerning the waiver of physician-patient privileges in medical negligence settings, but nevertheless recognized *Alcon* restrictions, with the following language from *Reutter* (as noted by Justice Bender in his dissent):

> [I]n some instances, the waiver of the physician-patient privilege resulting from filing the medical malpractice action might cover virtually all that was discussed between a physician and patient. In other cases, it might cover only a small portion of what was discussed. In such instances, some or all of such discussions will remain subject to the privilege.[11]

Thus, in Justice Bender's dissent, the considerations of *Alcon* and its progeny, including *Hartmann*, should limit the scope of permissible discovery, i.e., "implied waivers rarely amount to consent to general disclosure of all of the patient's communications with his or her physician," and "[d]iscovery must be tailored to the injuries and damages claimed by the plaintiff which are the subject of the lawsuit."[12] Further, issues concerning the discoverability of what the plaintiff contends to be privileged medical records should be dealt with by way of a privilege log, as prescribed in *Alcon*.

Haralampopoulos v. Kelly - Statements Made for Purposes of a Medical Diagnosis or Treatment per CRE 803(4), and the Miscellaneous Hearsay Exception of CRE 807- Petition for Writ of Certiorari Granted

Haralampopoulos v. Kelly,[13] which the author reported in last year's review, involved a prejudicial post-incident statement made by the plaintiff's girlfriend, Ms. Hurd, which the defendant physician and his attorneys were allowed to recount repeatedly during the trial.

More specifically, according to the defendant physician, after the patient's seizure, Ms. Hurd advised him that the patient was a recreational cocaine user and that prior to his first emergency room visit, the patient had been using a significant amount of cocaine because of his pain. The physician and attorneys repeated this during the trial, even though Ms. Hurd, in rebuttal, denied that she had made such a statement. The statement created obvious prejudice to the plaintiffs during the trial. The defendants thereby were able to convince the jury that the patient's seizure and anaphylactic shock, which caused permanent brain damage, was not attributable to the physician causing spillage of a cyst on plaintiff's liver, by taking an ill-advised needle biopsy of such, but instead to plaintiff's alleged cocaine use.

On plaintiffs' appeal to the court of appeals, the court engaged in a thorough discussion of the limits of C.R.E. 803(4) regarding statements made for purposes of medical diagnosis, as well as the miscellaneous hearsay exception of C.R.E. 807. The end result was that Judge Fox, writing for the majority, opined that Ms. Hurd's statement did not qualify under C.R.E. 803(4) because the statement 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."[14] Instead, the statement was more consistent with the non-medical but legal purpose of attributing responsibility for the patient's injuries to the patient. The court determined, as well, with regard to the miscellaneous hearsay of exception of C.R.E. 807, that the statement did not have the "necessary guarantees of trustworthiness" to qualify under such.

This decision constituted a significant gain for plaintiffs' litigation, where plaintiffs are too often confronted by non-medically related statements in the medical record that have no real significance other than to support the defense in an ensuing medical negligence lawsuit and prejudice the plaintiff. Judge Webb, however, disagreed with the majority's conclusions and wrote a dissenting opinion. The Supreme Court has now granted certiorari review and the story continues.[15]

Court of Appeals Decisions

There were two finalized court of appeals' decisions rendered during the previous year and a couple of non-finalized decisions worthy of note awaiting determinations concerning motions for rehearings or petitions for writs of certiorari.

Schuessler v. Wolter – C.J.I. 15:4 Revisited

Schuessler v. Wolter,[16] a medical negligence case, resulted in a plaintiff's verdict. During the trial, the defendant tendered a C.J.I. 15:4 instruction:

> 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.

Upon plaintiff's objection, the trial court rejected such, concluding that it was inapplicable because the surgery successfully resolved the cervical disk problems that had led to the surgery, and thus there was not a "bad result." The defendant raised this as error on appeal.

The same plaintiff's counsel in Schuessler had previously argued in *Day v. Johnson*,[17] a Colorado Supreme Court case, that C.J.I. 15:4 was improper because it:

> (1) conflicted with the standard of care introducing subjectivity into an objective standard of care; (2) was duplicative; (3) commented on the evidence; (4) overemphasized the defense's theory of the case; and (5) was not supported by the evidence.[18]

Although the court in *Day* ruled that the third sentence of C.J.I. 15:4 states the law, it did not address whether the instruction, as a whole "was duplicative, commented on the evidence, overemphasized the defense's theory of the case or was not supported by the evidence because those issues were not preserved for appeal."[19] Thus the court's determination was simply that the third sentence correctly stated the law, i.e. that "an exercise of judgment that results in an unsuccessful outcome does not, by itself, mean that a physician was negligent." This determination left many unanswered questions. These included each one of the five contentions made by the plaintiff on appeal, and very importantly, as well, whether it would be reversible error for a trial court **not** to include such an instruction if tendered by the defendant and objected to by the plaintiff.

Unfortunately for the plaintiff, Judge Casebolt, writing for the court of appeals, articulated that the instruction was not only proper, but also that the trial court's rejection of its tender constituted reversible error. He stated, "A party is entitled to an instruction embodying his or her theory of the case if is supported by competent evidence and is consistent with existing law."[20] He added, "While a party's theory of the case may be contained in a single instruction [C.J.I. 2:1], a theory of the case may also require discrete instructions on relevant, specific principles of law."[21] Also, with regard to the plaintiff's contention that the instruction was discretionary because its "Notes on Use" state, ". . . **may** be given . . . when the evidence of malpractice includes an unsuccessful outcome," the court reiterated that the applicable law "requires the trial court to instruct on a party's theory of the case if it is supported by competent evidence."[22]

All this does not seem to be necessarily consistent with what the Court suggested in *Day*, and perhaps subject to some modification by the Court upon certiorari review. It also did not address the issue of whether 15:4 should be given in the face of a res ipsa loquitur instruction pursuant to C.J.I. 9:17, which eliminates the propriety of utilizing the similar instruction at C.J.I. 9:12.[23]

Gray v. University of Colorado Hosp. Authority - Waived I mmunity of Public Employees for Willful and Wanton Conduct

Gray v. University of Colorado Hosp. Authority[24] involved allegations of negligence as well as willful and wanton conduct against the University of Colorado and its healthcare employees, including Mark Spitz, M.D. The alleged facts were compelling. The patient suffered from epilepsy and in an effort to determine whether surgery would afford him relief from his condition, he sought the services of the epilepsy monitoring unit at the University Hospital in October 2007. He was admitted to its facility and the purpose of the admission was to monitor the nature and extent of his seizures as he was being weaned from anti-seizure medication that had been prescribed to him. This plan created a risk of serious injury or death if the patient suffered from a seizure during his stay that was not immediately attended to and rectified by medical personnel. The monitoring process required several nights in the hospital. Concerned for his safety, members of his family asked whether they should stay with the patient and render their assistance in monitoring his seizures. Someone from the hospital, however, assured the patient and his family that hospital personnel would monitor him constantly around the clock. The hospital later admitted that this assurance was contrary to fact. Thus, on the fifth night of the patient's stay, the monitoring technician left him unattended for about an hour in order to "troubleshoot" another patient's electrodes. During that time, the patient suffered a seizure and stopped breathing. The hospital staff was unable to revive him and he died.

The plaintiffs, who are the decedent's estate and his survivors, after having been unsuccessful with a federal civil rights claim, brought a tort claim against the hospital and certain of its employees. At the outset, they brought a claim for negligence based upon the sovereign immunity waiver of medical negligence claims set forth in C.R.S. § 24-10-106(1). The university essentially dealt with this claim by depositing with the court the maximum recoverable amount ($150,000) pursuant to C.R.S. § 24-10-106, and the trial court determined that

portion of the claim to be moot. This was easily affirmed by the court of appeals, referencing the precedent of *DeForrest v. City of Cherry Hills Village,*[25] which approved the rule.

The viability of a claim for willful and wanton conduct, however, was much more challenging, and ultimately resulted in a conclusion by the court of appeals that the trial court had erred in dismissing the willful and wanton claim against one of the employees of the hospital, Dr. Spitz, based upon the language in §24-10-105(1), which triggers a full waiver of sovereign immunity of public employees working within the scope of their employment for acts or omissions of governmental employees that are "willful and wanton."

The court of appeals, however, found no such exception with regard to the governmental entity, i.e. the University of Colorado Hospital Authority and thus, the language at §24-10-106(1) prevails, which states that "[a] public entity shall be immune from liability in all claims for injury which lie in tort or could lie in tort . . . except as provided otherwise in this section," inasmuch as there are no other defined exceptions for public entities for willful and wanton conduct, as there are for public employees by way of §105(1).

The concept that a public employee might incur this type of liability creates an additional issue in terms of indemnification and recoverability, inasmuch as §24-10-110(1)(a) requires that the public entity provide "defense costs for all employees **unless** the fact finder determines he or she was acting outside the scope of duty [by acting willfully and wantonly] when the injury creating the liability occurred."[26] However, an important corollary to this rule as noted by the court of appeals is ". . . the public entity may agree to defend the employee against such a punitive damage claim, or agree to pay or settle such a claim, if it determines, at a public meeting and by resolution, that it is in the public interest to do so."[27] This was seemingly the route the University of Colorado had in mind with regard to the claim against Dr. Spitz that, by the court of appeals' decision, survived his motion to dismiss.

The allegations against Dr. Spitz were well detailed in the plaintiffs' complaint, and the court of appeals noted the requirement that, at a minimum, such allegations must "set forth such specific facts to support a reasonable inference that the employee was consciously aware that his or her acts or omissions created danger or risk to the safety of others, and that he or she acted, or failed to act, without regard to the danger or risk."[28] Here, these types of allegations clearly existed in the complaint although many of them were based upon "information and belief." Because of such, the trial court had ruled that the complaint did not set forth a cognizable claim against Dr. Spitz for willful and wanton conduct, because such allegations could not be based upon "information and belief." This of course brings up the age-old dilemma of how a plaintiff can be that specific about facts where at least at that point, access to such facts is largely, if not exclusively, controlled by the defendant. An important component to the court of appeals' determination, however, was that they "respectfully disagreed" with the trial court's conclusions concerning such, stating:

> "[I]information and belief" pleadings are generally deemed permissible under the Federal Rules, especially in cases in which the information is more accessible to the defendant. *Johnson v. Johnson*, 385 F.3d 503, 531 n. 19 (5th Cir. 2004); *see also* 5 Charles Alan Wright, Arthur R. Miller, Mary Kay Kane & Richard L. Marcus, Federal Practice and Procedure §1224 (3d ed.) (collecting cases). The parties have not provided us with any Colorado authority stating that we follow a different path than federal courts interpreting federal rules of pleading in this regard, and we have not found any such authority independently. Thus, because the general rules of pleading in our C.R.C.P. 8 are similar, although not identical, to those contained in Fed. R. Civ. P. 8, we conclude that the reasoning in cases such as *Johnson* is persuasive. Therefore, we will apply it here. *See Dave Peterson Electric, Inc. v. Beach Mountain Builders, Inc.*, 167 P.3d 175, 177 (Colo. App. 2007) (looking to Fed. R. Civ. P. 8(c) for guidance in interpretation of C.R.C.P. 8(c) because the federal rule was similar).[29]

All this, of course, is not only good guidance with regard to governmental immunity claims, such as in *Gray*, but likely fraud claims as well, and the pleading specificity required by C.R.C.P. 9.

Colorado Medical Soc. v. Hickenlooper - Advanced Practice Nurses and Their Ability to Perform Non-Delegated Functions

Colorado Medical Soc. v. Hickenlooper[30] addressed the issue of the expanding roles of nurses, and in particular advanced practice nurses, as well whether advance practice nurses can perform non-delegated functions without physician supervision, and be responsible for the decisions they make concerning such. The answer per *Hickenlooper* seems to be yes.

The issues of *Hickenlooper* came in the context of a challenge by the Colorado Medical Society (CMS) to the

notion that certified registered nurse anesthetists (CRNAs) can administer anesthesia without supervision by a physician, and thus whether it was proper for Colorado to opt out of the federal Medicare requirement that CRNAs be supervised by physicians.

After seeking advice from the Colorado Board of Nursing, on September 27, 2010, former Governor Bill Ritter, Jr., notified the Centers for Medicare and Medicaid by letter that Colorado was exercising its option to opt-out of this requirement as to all critical access hospitals in Colorado and 13 specifically identified rural general hospitals. Later, he added a 14th rural general hospital to the opt-out. Sixteen states other than Colorado have opted out of the federal requirement as well. On the following day, September 28, 2010, the Colorado Medical Society filed for declaratory judgment requesting injunctive relief in the form of an order to the Governor withdrawing the opt-out. The district court subsequently granted the Governor's motion to dismiss and thus upheld the decision that Colorado statutes and regulations permit the delivery of anesthesia by a CRNA without physician supervision, and the appeal to the court of appeals followed.

The Nurse Practice Act ("the Act")[31] governs the practice of nursing. Essentially "the practice of professional nursing" includes "the performance of independent nursing functions and delegated medical functions."[32] 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; and (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.[33]

From a legal practitioner's standpoint, it's helpful to understand these definitions and the defined scope of permissible nursing services, inasmuch as a nurse is typically only responsible for performing 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 concept of advanced practice nursing, however, for better or worse, takes this one step further, where advanced practice nurses are in fact licensed to engage in what has traditionally been referred to as making "medical decisions."

In line with a continuing trend, Colorado recognizes the concept of advanced practice nursing, 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).[34]

Hickenlooper dealt with the issue of CRNAs and the CMS's challenge that the statutory intent necessarily precluded authority for CRNAs to administer anesthesia except as a delegated and supervised medical function. Their arguments were based upon statutory construction and intent, which both the trial court and the court of appeals rejected based primarily upon the statutory language that the "practice of advanced nursing" included "an expanded scope of professional nursing, scope, and population focus **approved by the [nursing] board**"[35] that the nursing board in fact created the concept of CRNAs with its regulations.

CMS contended as well that their reading of the Act was more appropriate because of the common law "captain of the ship" doctrine that subjects physicians to vicarious liability for the acts of CRNAs. In addressing this, the court noted that the "captain of the ship" doctrine "only applies when the surgeon has the right to supervise and control other personnel who are present in the operating room." To the extent they are not in the operating room, and not supervised by doctors, the court noted that "injured patients will need to seek redress from the CRNAs who were present in the operating room,"[36] despite the fact, as also noted by the court, that CRNAs are required to carry only half of the liability insurance amount ($500,000) required of physicians ($1,000.000).

Thus, advanced practice nurses carrying on independent, non-delegated medical functions within their scope of practice, are responsible in their own right, for the quality of the medical care rendered. This is clearly a higher role and responsibility than what existed with regard to conventional nursing, and attorneys dealing in this area of the law should be aware of this.

Hiner v. Johnson – C.R.C.P. 102 Writs of Attachment for Settlement Proceeds to Satisfy Costs Judgments

Hiner v. Johnson[37] involved a case where the plaintiff had settled with the hospital prior to a related trial against the involved physicians, where the physicians were successful and obtained a costs judgment against the plaintiff. The defendant-physicians thereafter sought to enforce the costs judgment against the plaintiff by way of an ex parte C.R.C.P. 102 writ of attachment of the settlement proceeds, after having posted a $50,000 bond.

The trial court initially granted the writ, but later on set it aside, concluding that the settlement proceeds were subject to an attorney's lien that was filed by plaintiffs' counsel, and thus found it would be improper to issue a writ to attach funds that would not be transferred to the plaintiffs, but instead subsumed by their attorney's lien to recovered proceeds. The matter was appealed to the court of appeals which affirmed the trial court's order setting aside the writ, but based upon its finding that C.R.C.P. 102 attachments are not proper unless the defendant asserts a counterclaim, which the defendant had not done.

Thus, per this decision, attachments under Rule 102 for costs judgments are not available to defendants in medical negligence suits who have not filed counterclaims. ▲▲▲

Francis V. Cristiano is a long time CTLA member and member of its Board since 2003. His offices are in the Denver Technological Center, and his practice emphasizes professional negligence, serious personal injury, and business torts. He is Trial Talk's professional negligence editor. He can be reached at 303-407-1777.

Endnotes

[1] *Ortega v. Colo. Permanente Med. Group, PC*, 265 P.3d 444 (Colo. 2011).

[2] *Alcon v. Spicer,* 113 P.3d 735 (Colo. 2005).

[3] *Id.* at 741.

[4] *Ortega,* 265 P.3d at 448 (emphasis added).

[5] *Id.*

[6] *Id.* at 449.

[7] *Id.* at 453.

[8] *Hartmann v. Nordin,* 147 P.3d 43, 48 (Colo. 2006).

[9] *Samms v. Dist. Court,* 908 P.2d 520, 524 (Colo. 1995).

[10] *Reutter v. Weber,* 179 P.3d 977, 983 (Colo. 2007).

[11] *Id.* at 983 (citations omitted).

[12] *Ortega,* 265 P.3d at 455.

[13] *Haralampopoulos v. Kelly*, ___ P.3d ___ (Colo. App. 2011) (not selected for publication).

[14] *Id.*, *citing People v. Allee*, 77 P.3d 831, 834 (Colo.App. 2003).

[15] *Haralampopoulos*, *cert. granted* (Sept. 24, 2012).

[16] *Schuessler v. Wolter,* 2012 COA 86, ___ P.3d ___ (Colo. App. 2012).

[17] *Day v. Johnson,* 255 P.3d 1064 (Colo. 2011).

[18] *Id.* at 1068.

[19] *Id.*

[20] *Schuessler*, ¶12.

[21] *Id.* at ¶22.

[22] *Id*. at ¶25, *citing Gordon v. Benson*, 925 P.2d 775, 777-78 (Colo. 1996).

[23] CJI 9:12, "The occurrence of an accident does not raise any presumption of negligence on the part of either the plaintiff or the defendant." *See* Notes on Use: "This instruction should not be given in cases where the happening of an accident does give rise to a presumption of negligence, e.g., rear-end collision cases (Instruction 11:12) and res ipsa loquitur cases (Instruction 9:17).

[24] *Gray v. University of Colorado Hosp. Authority,* 284 P.3d 191 (Colo. App. 2012).

[25] *DeForrest v. City of Cherry Hills Vill.*, 72 P.3d 384, 387 (Colo. App. 2002).

[26] *Gray*, 284 P.3d at 198 (emphasis added), *citing Middleton v. Hartman*, 45 P.3d 721, 728 (Colo. 2002).

[27] *Id.*, *citing* C.R.S. § 24-10-118(5).

[28] *Id.*

[29] *Id.* at 200.

[30] *Colorado Medical Soc. v. Hickenlooper*, 2012 COA 121, ___ P.3d ___ (Colo. App. 2012).

[31] C.R.S. §§ 12-38-101 to 133.

[32] C.R.S. § 12-38-103(10)(a).

[33] C.R.S. § 12-38-103(9)(a).

[34] 3 C.C.R. 716-1:XIV-1.11 (2012).

[35] §12-38-103(8.5)(a) (emphasis added).

[36] *Hickenlooper*, 2012 COA 121 at ¶53.

[37] *Hiner v. Johnson*, 2012 COA 164, ___ P.3d ___ (Colo. App. 2012).