SUPREME COURT, STATE OF COLORADO 101 West Colfax Avenue, Suite 800 Denver, CO 80202	
Colorado Court of Appeals Case No. 10CA0668, Division III Fox, Roy, and Webb, J.J. District Court of the City and County of Denver Case No. 06CV12898 Honorable Michael A. Martinez Honorable Martin F. Egelhoff Honorable Christina M. Habas	▲ COURT USE ONLY ▲
Petitioners: JASON L. KELLY, M.D. and MAURICIO L. WAINTRUB, M.D. v. **Respondent:** VASILIOS HARALAMPOPOULOS, by his guardian JOHN HARALAMPOPOULOS	Case Number: 11SC889
Counsel for the American Medical Association, Colorado Medical Society, Colorado Chapter of the American College of Emergency Physicians, Colorado Radiological Society, and Colorado Society of Anesthesiologists Kari M. Hershey #34246 Hershey Skinner, LLC 10463 Park Meadows Drive, Suite 209 Littleton, Colorado 80124 Telephone Number: (303) 226-1669 E-mail: kari@hersheyskinner.com ***Counsel for Regents of the University of Colorado:*** Patrick T. O'Rourke, #26195 Office of University Counsel 1800 Grant Street, Suite 700 Denver, CO 80203 303-860-5691 E-mail: Patrick.Orourke@cu.edu	

BRIEF OF AMICI CURIAE AMERICAN MEDICAL ASSOCIATION, COLORADO MEDICAL SOCIETY, COLORADO CHAPTER OF THE AMERICAN COLLEGE OF EMERGENCY PHYSICIANS, COLORADO RADIOLOGICAL SOCIETY, COLORADO SOCIETY OF ANESTHESIOLOGISTS, AND REGENTS OF THE UNIVERSITY OF COLORADO

CERTIFICATION OF COMPLIANCE

I certify that this brief complies with all requirements of C.A.R. 28 and C.A.R. 32, including all formatting requirements set forth in these rules. Specifically, I certify that the petition complies with C.A.R. 28(g) because it contains 3,076 words.

C.A.R. 28(k) applies to a "party" and a "responding party." As such, amicus curiae are not subject to Rule 28(a), (b), (c), or (k).

Dated this 11th day of January, 2012.

HERSHEY SKINNER

s/ Kari M. Hershey

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Amici Curiae respectfully submit their brief in support of Petitioners Dr. Kelly and Dr. Waintrub. *Amici* believe that the trial court correctly determined that statements made to a physician about a patient's drug use, which likely affected the patient's condition, could be used to defend against claims of malpractice.

ISSUE PRESENTED

Whether, in defense of a medical malpractice lawsuit, a physician may introduce into evidence statements made to health care providers about a patient's health-related activities and the cause of a patient's condition if such information is not used in treatment.

STATEMENT OF INTEREST

Health care providers routinely receive personal and sensitive information in attending patients. The law recognizes the value of sharing such information in improving health care diagnoses and treatment. As the Court considers whether plaintiffs bringing claims for medical malpractice may exclude from evidence information that impacts a patient's health condition, *Amici* request that the Court consider this brief discussing the impact of health information on the provision of medical care and the relevance of such information to questions of liability, causation, and damages in a medical malpractice lawsuit.

I. American Medical Association

The American Medical Association (AMA) is the largest professional association of physicians, residents and medical students in the United States. Through state and specialty medical societies and other physician groups seated in its House of Delegates, substantially all US physicians, residents and medical students are represented in the AMA's policy making process. AMA members practice and reside in all states, including Colorado. The objectives of the AMA are to promote the science and art of medicine and the betterment of public health.

The AMA joins this brief on its own behalf and as a representative of the Litigation Center of the AMA and State Medical Societies. The Litigation Center is a coalition whose purpose is to represent the viewpoint of organized medicine in the courts.

II. The Colorado Medical Society

The Colorado Medical Society is a nonprofit organization whose more than 7,000 members include the majority of physicians practicing in Colorado. As Colorado's largest organization of physicians, residents, and medical students, the Society's mission is to promote the science and art of medicine, the betterment of public health, and the welfare of Colorado physicians and the patients they serve.

III. The Colorado Chapter of The American College of Emergency Physicians

The Colorado Chapter of the American College of Emergency Physicians (ACEP) is a medical specialty society formed in 1968 to improve emergency care by setting high standards for emergency medical education and practice. Colorado ACEP has more than 550 members working in Colorado to preserve the integrity of emergency medical practice and the ability of emergency medicine physicians to best care for their patients.

IV. The Colorado Radiological Society

The purpose of the Colorado Radiological Society is to advance the science of radiology, improve radiologic service to the patient, study the socioeconomic aspects of the practice of radiology, and encourage improved and continuing education for radiologists and allied professional fields. The Society is a not-for-profit organization representing approximately 500 Radiologists in the state.

V. The Colorado Society of Anesthesiologists

The Colorado Society of Anesthesiologists (CSA) is a Colorado nonprofit physician organization committed to patient safety, educational advancement, and providing the best anesthesia care to patients.

VI. The Regents of the University of Colorado

The Board of Regents of the University of Colorado governs the University of Colorado system. *Colo. Const. Article IX, §12.* The system consists of three campuses: University of Colorado at Boulder; University of Colorado at Denver and Health Sciences Center; and University of Colorado at Colorado Springs. More than 1,500 faculty in five schools, including nurses, dentists, pharmacists, physicians, and other allied health care professionals, contribute to the University's mission of providing education, research, clinical care, and community service.

DISCUSSION

These *Amici* ask this Court to grant certiorari for one fundamental reason: the underlying majority opinion construes Colorado Rule of Evidence 803(4) in a manner that threatens physicians' ability to defend against medical malpractice claims. Left unchecked, the underlying majority opinion is inconsistent with this Court's admonition that "our rules of evidence must be construed to ensure that truth may be ascertained and proceedings justly determined." *People v. Huckleberry,* 768 P.2d 1234, 1244 (Colo. 1989).

I. Statement of Facts Underlying Amici Interest

Drs. Kelly and Waintrub provide an overview of the disputed evidence, which obviates the need for *Amici* to include a lengthy recitation of the facts. The following facts, however, underlie the *Amici's* consideration of the issues:

- Mr. Haralampopoulos underwent a needle biopsy procedure to determine the nature of a cyst. During the procedure, Mr. Haralampopoulos suffered cardiac arrest and was resuscitated only after significant effort.

- After resuscitation, Mr. Haralampopoulos was determined to have an anoxic brain injury, but the reason for the difficulty in resuscitating him (leading to the injury) remained unknown.

- Ms. Hurd, a close friend living with Mr. Haralampopoulos in the weeks before the biopsy, approached Dr. Kelly and inquired whether Mr. Haralampopoulos' cocaine use (the extent and timing of which is disputed) "could have interacted with the anesthesia or could it have set him into cardiac arrest . . . I was searching for some kind of answer or reason why this happened."

- Defense experts opined that cocaine use, whether recent or remote, explained why it was difficult to resuscitate Mr. Haralampopoulos after his cardiac arrest.

In denying a motion *in limine* to preclude evidence of Mr. Haralampopoulos' cocaine use, the trial judge observed that this evidence was "really the key to this case." A trial court's decision to admit or exclude evidence is not reversible unless its decision is "manifestly arbitrary, unreasonable, or unfair." *E-470 Public Highway Authority v. 455 Co.*, 3 P.3d 18, 23 (Colo. 2000).

II. Causation in Medical Cases

The underlying majority opinion summarized its view of the evidence by stating, "[t]his case should have been about whether [Drs.] Waintrub and Kelly met their respective standards of care." This statement incorrectly describes the nature and extent of the relevant evidence in a medical malpractice trial.

As this Court has recognized, a plaintiff presenting a claim for medical negligence must show: (1) a legal duty on the defendant's part; (2) breach of that duty; (3) injury; and (4) causation, i.e., that defendant's breach caused plaintiff's injury. *Greenberg v. Perkins,* 845 P.2d 530, 533 (Colo. 1993); *HealthONE v. Rodriguez*, 50 P.3d 879, 888 (Colo. 2002). Independent of evidence about the standard of care, medical malpractice cases often turn on whether "the defendant's breach caused the plaintiff's injury." *See Estate of Ford v. Eicher*, 250 P.3d 262, 265 (Colo. 2011) (observing that there were competing theories of causation of an infant's brachial plexus injury and holding that the jury should hear both theories).

There can be no liability without causation attributable to the defendant, and juries have broad discretion to determine the cause of an injury. *Shultz v. Linden-Alimak, Inc.,* 734 P.2d 146, 149 (Colo. App. 1986); *Vento v. Colorado National Bank of Pueblo*, 907 P.2d 642 (Colo. App. 1995). Given the uncertainty about why

Mr. Haralampopoulos's physicians could not immediately resuscitate him – i.e., causation -- the case was about more than the standard of care.

III. Scope of C.R.E. 803(4) – Statements Made for Medical Diagnosis or Treatment

Although it is true that the Colorado Rules of Evidence exclude some hearsay statements, it is equally true that the rules allow trial courts to admit other hearsay statements. The difference between the admissible and inadmissible lies in the fact that "under appropriate circumstances a hearsay statement may possess circumstantial guarantees of trustworthiness" sufficient to justify admission. *Advisory Comment to Fed. R. Evid. 803* (construing identical provision of federal law). *C.R.E. 803(4)* identifies an instance where a statement has guarantees of trustworthiness and the following type of statement is "not excluded by the hearsay rule, even though the declarant is available as a witness":

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

The reason statements made for medical diagnosis or treatment are admissible is common sense — "a patient's medical care depends on the accuracy of the information she provides, the patient has a selfish motive to be truthful;

consequently a patient's statements to her physician are likely to be particularly reliable." *United States v. Pacheco*, 154 F.3d 1236, 1240 (10th Cir. 1998). Stated another way, "a statement made in the course of procuring medical services, where the declarant knows that a false statement may cause misdiagnosis or mistreatment, carries special guarantees of credibility." *White v. Illinois*, 502 U.S. 346, 356 (1992). Although many statements within the scope of *Rule 803(4)* come from patients, "statements by bystanders, family members, and others" routinely fall within the exception. *Federal Rules of Evidence Manual*, §803.02[5][d] (8th Ed. 2002), *Stephen A. Saltzburg et al.*

As observed by Neil O'Connor, MD "when faced with a critical health issue, family, friends, paramedics, bystanders, police, and others can be reliable historians and physicians routinely rely on information provided by them in diagnoses and treatment." *Declaration of Neil O'Connor, MD* at 8. Dr. O'Connor is an Emergency Medicine physician who "routinely relies on information from others to diagnose and treat patients" because "[f]requently when patients arrive in the emergency department, their condition prevents them from communicating on their own behalf." *O'Connor Declaration* at 7.

"Under Rule 803(4), the declarant's motive to promote treatment or diagnosis is the factor crucial to reliability." *Danaipour v. McLarey*, 386 F.3d 289,

298 (1st Cir. 2004). Consequently, the key inquiry is whether Ms. Hurd's statements were motivated by a desire to "promote treatment or diagnosis." Ms. Hurd's statements, quoted by the underlying majority opinion, demonstrate such motivation, even if the extent of Mr. Haralampopoulos' cocaine use is disputed:

> I said, "[he] used to do drugs in the past, he used to do a little cocaine, and, you know, could it have been in his system and could it have interacted with the anesthesia or could it have set him into cardiac arrest or" – you know, I was – I don't know if I was asking it right, but I was searching for some kind of answer or reason why this happened.

Transcript dated 2/1/2011 at p. 238: 9-15.

Asking a physician for "some kind of answer or reason why this happened" is the essence of "diagnosis," whether that term is used in legal, medical, or common parlance. *See Black's Law Dictionary* (6th Ed. 1990) (defining "diagnosis" as including "the discovery of the source of the patient's illness . . ."); *Taber's Cyclopedic Medical Dictionary* (19th Ed. 2001) (defining "diagnosis" as including "the use of scientific or clinical methods to determine the cause and nature of a person's illness"); *Webster's Encyclopedic Unabridged Dictionary of the English Language* (1996) (defining "diagnosis" as including "a determining or analysis of the cause or nature of a problem or situation").

"Determining the cause of a patient's condition, whether or not such cause impacts treatment, is central to medical diagnosis. The process of diagnosis is ongoing, incorporating new information as it is available." *O'Connor Declaration* at 14. Ms. Hurd's statements fall squarely within the plain language Rule 803(4).

IV. The Majority Opinion Misconstrues the Nature of Medical Practice in Interpreting Rules 403 and 803(4)

With this understanding of the principles of causation and Rule 803(4), these *Amici* believe the underlying majority opinion erred in three principal respects. Combined, these errors deny physicians the ability to present meaningful causation defenses in medical malpractice trials.

First, the majority repeatedly asserts that Rule 803(4) did not apply because Dr. Kelly did not "use" information about Mr. Haralampopoulos's cocaine use. But whether information is used by the receiving physician has never been the justification for information falling within the hearsay exception. Instead, the exception applies because the declarant's statements have "circumstantial guarantees of trustworthiness" sufficient to justify admission. *Advisory Comment to Fed. R. Evid. 803.*

For the medical diagnosis exception, the guarantee of trustworthiness is that the declarant understands that the quality of medical care may be impacted by

providing truthful information. *Pacheco*, 154 F.3d at 1240; *White*, 502 U.S. at 356. If the declarant's motive is to provide potentially useful information to a medical provider, the reliability of that information is not undermined if the physician ultimately does not "use" it in treatment.

Indeed, this Court has not required a physician to use medical information to treat a patient to apply the exception in Rule 803(4). In *King v. People*, 785 P.2d 596 (Colo. 1990) a psychiatrist examined a patient more than a year after the events giving rise to the prosecution, and there was no assertion that the patient's statements were used for treatment. Nonetheless, this Court found the patient's statements admissible because they "were reasonably pertinent to the patient's diagnosis." *King*, 785 P.2d at 601.

This Court's recognition that use for treatment purposes is not determinative of whether a statement falls within the exception is consistent with the nature of medical practice. Christopher Unrein, DO is a Professor at the University of Colorado School of Medicine and Rocky Vista University College of Osteopathic Medicine. He is Board certified in Internal Medicine and Hospice and Palliative Medicine, and provides long term, hospice, and palliative medicine to patients at health care facilities throughout the Denver area. *Declaration of*

Christopher Unrein, DO at 2-4. Dr. Unrein uses the example of an elderly patient with a fracture to illustrate that medical diagnosis does not stop with determining a fracture exists. "[I]t also encompasses determining the underlying cause of the condition. In the case of a fracture, we attempt to determine if the patient fell, has osteoporosis, cancer, or is subject to abuse. Although such information may or may not change treatment of the patient's fracture, it is nonetheless important to health care providers and is part of the overall diagnostic and therapeutic processes." *Unrein Declaration* at 7.

The same situation exists here where experts were able to consider Ms. Hurd's statements to Dr. Kelly (in addition to other evidence, such as an echocardiogram demonstrating that Mr. Haralampopoulos had cardiac abnormalities) to explain why initial resuscitation efforts failed.

Second, the majority determined that the medical diagnosis exception did not apply because *Clark v. People,* 86 P.2d 257, 259 (Colo. 1939) bars statements of fault. Irrespective of whether *Clark* remains good law after passage of the Colorado Rules of Evidence, the majority's reliance on *Clark* stems from its misconception that a medical malpractice trial should be solely about "whether [the physicians] met their respective standards of care." As described above, a claim

for medical malpractice involves more; it involves a determination of "causation, i.e. that the defendant's breach caused the plaintiff's injury." *Greenberg,* 845 P.2d at 533; *HealthONE,* 50 P.3d at 888. In fact, Rule 803(4) explicitly allows trial courts to admit statements reasonably pertinent to the "cause or external source" of "past or present symptoms."

Instead of viewing diagnosis as an ongoing process that includes the cause of a patient's health condition, the majority conflates "cause" with "fault." Yet, the very nature of medical practice involves interpreting "information from a variety of sources to form a clinical picture — before and after a primary diagnosis is made. The diagnostic process is complex and ever-evolving. The information physicians obtain from others when assessing a patient is a significant part of that process, regardless of whether it is used to assign a primary diagnosis or to determine the underlying cause of a patient's condition." *Unrein Declaration* at 7.

Third, the majority determined that the evidence of Mr. Haralampopoulos's cocaine use violated Rule 403. But the majority could make this determination only because it misconstrued Rule 803(4)'s medical diagnosis exception. Once it is understood that: (1) the medical diagnosis exception focused upon the declarant's statement of mind when making the statement; and (2) evidence of

cocaine use is extremely probative on the issue of why Mr. Haralampopoulos could not be immediately resuscitated after his cardiac arrest, the trial court was correct when it described this evidence as "the key to the case." The majority could reach the conclusion that this evidence was substantially more prejudicial than probative only because it mislabeled powerful causation evidence as a hearsay statement relating to fault.

Importantly, information about substance abuse that may be viewed as inconsequential by a lay person may, in fact, be medically significant. As noted by Dr. O'Connor, "Substance abuse can have life threatening implications to patients receiving medical care. Absent an outright acknowledgment by a patient that they are a substance abuser, physicians may have to deduce substance abuse from a variety of external sources, including the patient's medical condition, test results, or reactions, and statements by the patient's family and friends. It is important to do so because such information is critical to our overall diagnostic and therapeutic processes." *O'Connor Declaration* at 10.

The addictive nature of cocaine and evidence supporting both past and recent cocaine use, left medical experts with the opinion that cocaine was a key factor in the inability to resuscitate the patient — which, in turn, is highly

probative of a key element of Plaintiff's claim and the physician's ability to defend.

CONCLUSION

The opinion of the Court of Appeals does not accurately reflect the medical diagnostic and therapeutic processes. Even if nothing could have been done to change Mr. Haralampopoulos's condition at the time of Ms. Hurd's statements, much could be done to explain his failure to respond to resuscitation. Testimony on this issue is within the realm of "diagnosis" and "the use of scientific or clinical methods to determine the cause and nature of a person's illness." *Taber's.* Denying Dr. Kelly and Dr. Waintrub the ability to present a causation defense because the evidence of Mr. Haralampopoulos' cocaine use is prejudicial to his claim is inimical to *C.R.E. 102*'s instruction that courts apply "the law of evidence to the end that the truth may be ascertained and proceedings justly determined."

Physicians are "entrusted with using appropriate judgment in considering information from others in attending patients and should not be precluded from submitting that very same information when called to account for [their] care. Medical care would be less effective and could be misguided without such information. An after-the-fact evaluation of that same care would be just as

misguided and inaccurate were such information not included in the critique."

Unrein Declaration at 11.

Respectfully Submitted this 11th day of January 2012:

Kari M. Hershey #34246
Patrick T. O'Rourke, #26195
Counsel for American Medical Association, Colorado Medical Society, Colorado Chapter of the American College of Emergency Physicians, Colorado Radiologic Society, and Colorado Society of Anesthesiologists and Regents of the University of Colorado

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing **AMICUS REGENTS OF THE UNIVERSITY OF COLORADO, AMERICAN MEDICAL ASSOCIATION, COLORADO MEDICAL SOCIETY, COLORADO CHAPTER OF THE AMERICAN COLLEGE OF EMERGENCY PHYSICIANS, COLORADO RADIOLOGICAL SOCIETY, AND COLORADO SOCIETY OF ANESTHESIOLOGISTS** was served by depositing a true copy thereof in the United States Mail, postage prepaid, addressed to the following on this 11th day of January, 2012:

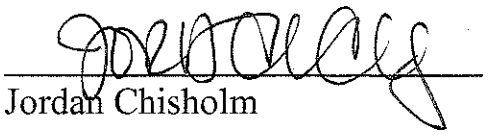
Teresa Locke
Keeya Jeffrey
HOLLAND & HART, LLP
555 Seventeenth Street, Suite 3200
P.O. Box 8749
Denver, CO 80201-8749

Kay J. Rice
Beth N. Nesis
COOPER & CLOUGH, P.C.
1512 Larimer Street, Suite 600
Denver, Colorado 80202

Douglas Wolanske
FARACI WOLANSKE, LLC
1512 Larimer Street, Suite 950
Denver, CO 80202

Andrew M. Low
Kyle W. Brenton
DAVIS GRAHAM & STUBBS LLP
1550 Seventeenth St., Suite 500
Denver, CO 80202

David H. Yun, #23448
JAUDON & AVERY LLP
600 Grant Street, Suite 505
Denver, Colorado 80203



Jordan Chisholm

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Counsel for Regents of the University of Colorado: Patrick T. O'Rourke, #26195 Office of University Counsel 1800 Grant Street, Suite 700 Denver, CO 80203 303-860-5691 E-mail: Patrick.Orourke@cu.edu **Counsel for Colorado Medical Society and Colorado Chapter of Emergency Physicians** Kari M. Hershey #34246 Hershey Skinner, LLC 10463 Park Meadows Drive, Suite 209 Littleton, Colorado 80124 Telephone Number: (303) 226-1669 E-mail: kari@hersheyskinner.com	
DECLARATION OF CHRISTOPHER UNREIN, D.O.	

1. I am a physician licensed to practice medicine in the State of Colorado.

2. I am a Professor of Internal Medicine at Rocky Vista University College of Osteopathic Medicine and a Clinical Professor at the University of Colorado School of Medicine. I serve on the Board and am past president of the Colorado Foundation for Medical Care. I also serve on the Board of Trustees for the Colorado Society of Osteopathic Medicine. I am a Fellow of the American College of Physicians. I am past president for the Colorado Society of Internal Medicine. I am past president and a member of the Colorado Medical Society. I am a member of the Arapahoe-Douglas-Elbert Medical Society, the American Medical Association, the American Osteopathic Association, the American Medical Directors Association and the American Academy of Hospice and Palliative Medicine.

3. I hold Board certifications in Internal Medicine and Hospice and Palliative Medicine through the American Board of Internal Medicine. I am a certified nursing home medical director by American Medical Directors Association.

4. I specialize in geriatric and palliative medicine, serving as the Executive Medical Director at Hospice of Saint John and providing long term, hospice, and palliative medicine to patients at health care facilities throughout the Denver area.

5. Geriatrics is the medical specialty dedicated to diagnosis, care, and treatment of the elderly. Hospice and palliative medicine is the medical specialty dedicated to holistic care of patients at the end of life.

6. Frequently as they decline, patients cannot provide information on their own behalf, and this is particularly true in elderly patients with dementia and those who have reached the stage of end of life. Accordingly, I routinely receive and rely on information about my patients from family members, friends, coworkers, and caregivers. Information from such a variety of sources is assimilated into my overall assessment of my patients and their conditions.

7. It is not uncommon to diagnose a patient with a particular condition without initially knowing the underlying cause of the condition. For example, an elderly patient may have a fracture. Medical diagnosis; however, does not stop there – it also encompasses determining the underlying cause of the condition. In the case of a fracture, we attempt to determine if the patient fell, has osteoporosis, cancer, or is subject to abuse. Although such information may or may not

change treatment of the patient's fracture, it is nonetheless important to health care providers and is part of the overall diagnostic and therapeutic processes.

8. Similarly, we may know that a patient has a diagnosis of terminal cancer. Although the diagnosis code is not affected, information from family and friends is invaluable in many of the aspects of end-of-life care.

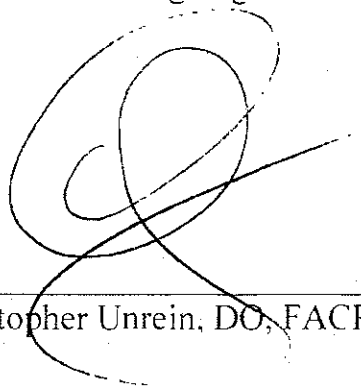
9. Sometimes, we receive information well after the time the information has the ability to impact the care of a patient. Such information is nonetheless important to the medical diagnostic process. For example, in my professional calling as a physician caring for patients at the end of life, I complete many death certificates. In order to complete this vital document accurately, information is often derived from many sources apart from the deceased and well after it can impact the treatment of the patient.

10. Physicians are trained to interpret information from a variety of sources to form a clinical picture — before and after a primary diagnosis is made. The diagnostic process is complex and ever-evolving. The information we obtain from others when assessing a patient is a significant part of that process, regardless of whether it is used to assign a primary diagnosis or to determine the underlying cause of a patient's condition.

11. We are entrusted with using appropriate judgment in considering information from others in attending our patients and should not be precluded from submitting that very same information when called to account for our care. Medical care would be less effective and could be misguided without such information. An after-the-fact evaluation of that same care would be just as misguided and inaccurate were it not included in the critique.

12. I declare under penalty of perjury that the foregoing information is true and accurate.

Dated this 8th day of January 2012:



Christopher Unrein, DO, FACP, CMD

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DECLARATION OF NEAL O'CONNOR, M.D.	

1. I am a physician licensed to practice medicine in the State of Colorado.

2. I am president of the Colorado Chapter American College of Emergency Physicians and a member of the Colorado Medical Society, along with the Aurora-Adams County Medical Society. I also serve on the Quality and Performance Committee of the National American College of Emergency Physicians.

3. I am a fellow of the American College of Emergency Physicians and am certified in Emergency Medicine through the American Board of Emergency Medicine.

4. I received both my undergraduate and medical degrees from Louisiana State University in Baton Rouge. I completed my internship and residency at The Johns Hopkins Hospital in Baltimore.

5. I am the Chief Medical Officer of CarePoint, an emergency medicine group providing vital emergency services at facilities throughout Colorado. I hold privileges at Swedish Medical Center, The Medical Center of Aurora, SkyRidge Medical Center, and Centennial Healthcare Plaza.

6. Emergency Medicine is the specialty dedicated to diagnosis and treatment of acute illness or injury requiring immediate medical attention.

7. Emergency medicine physicians routinely rely on information from others to diagnose and treat patients. Frequently, when patients arrive in the emergency department, their condition prevents them from communicating on their own behalf.

8. When faced with a critical health issue, family, friends, paramedics, bystanders, police, and others can be reliable historians and physicians routinely rely on information provided by them in diagnoses and treatment. In fact, there is hardly a day that goes by that I do not rely on information from others in diagnosing or treating patients with emergency medical conditions.

9. When patients can communicate for themselves, they may be reluctant to provide certain information. This is particularly true when information concerns substance use. Nonetheless, emergency medicine physicians routinely treat patients whose conditions are impacted by substance use.

10. Substance use can have life threatening implications to patients receiving medical care. Absent an outright acknowledgment by a patient that they have used substances, physicians may have to deduce substance use from a variety of external sources, including the patient's medical condition, test results, or behaviors, and statements by family, friends, or others. It is important to do so because such information is critical to our overall diagnostic and therapeutic processes.

11. For example, a patient presenting to the emergency room with a seizure may have any number of causes for that seizure including trauma, epilepsy, overdose, or intoxication. The initial management of that patient's seizure (including performing a head CT or administering medications emergently) is often dependent on the history obtained by family members and paramedics since the patient may be unable to give an accurate medical history. It is critical to our overall assessment to determine if the seizure was the result of a primary seizure disorder (such as epilepsy), or as a response to trauma, alcohol withdrawal, drug use or overdose to prescription medication since each of these causes warrant different testing and treatment.

12. Similarly, we may determine that a patient has suffered a cardiac arrest, however, the cause of the arrest is an integral part of our diagnostic process. This is because the underlying cause of a patient health condition has both treatment and non-treatment based implications. Treatment for a drug induced arrest can be different than treatment for an arrest secondary to cardiac disease.

13. Yet, even if a patient has expired, the underlying cause of the arrest is still important to the diagnostic process. For example, heart disease is hereditary and has implications for a patient's family members. Thus, even when we receive information that does not affect future treatment, it is still a part of our medical diagnosis.

14. Consequently, determining the cause of a patient's condition, whether such cause impacts treatment or not, is central to medical diagnosis. The process of diagnosis is ongoing, incorporating new information as it is available.

15. Physicians must be able to use the information available to them relating to their interactions with patients when called to account for such care. To preclude such information in the accounting is tantamount to giving a physician only partial information with which to make a diagnosis.

16.I declare under penalty of perjury that the foregoing information is true and accurate.

Dated this 10th day of January 2012:

Neal O'Connor, MD