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THE STANDARD OF CARE FOR HEALTH CARE PROVIDERS IN IDAHO

MONIQUE C. LILLARD*

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I. INTRODUCTION

The editors of this symposium issue asked me to write a descriptive article about the standard of care in medical malpractice law in Idaho. When, in casual conversation, I mentioned this project to people actively practicing law in the state, I was met with nearly identical exclamations from both the bench and the bar: “Oh! Do we ever need that! The law is a mess in that area!” This article, therefore, describes the current state of the law and begins the process of cleaning up the “mess” by suggesting future legislative action and some changes judicial application of the law.

After reading approximately forty-five cases on the topic, I conclude that the black letter rules on point are not in substantial disarray, so the “mess” is not attributable to a significant lack of clarity from the Idaho Supreme Court or the Idaho Legislature. The relevant statutory provisions—sections 6-1012 and 6-1013 of the Idaho Code—were enacted in 1976 and, despite a confusing start, the case law has been fairly consistent since the early 1990s. The court, as recently as spring 2007, has repetitively set out what plaintiffs need to establish, via affidavit, in order to withstand summary judgment.

Why, then, do so many Idaho lawyers and judges exclaim over the state of the law? Why has the learning curve been so long?

One reason for the seeming confusion is that the tone of the Idaho Supreme Court swings abruptly from case to case. Sometimes district courts are chided for not controlling discovery or failing to use the rules of civil procedure as tools of justice rather than as blockades to trial. Other times, the court seems to read the law in the narrowest fashion. The court is torn between attempting to enforce the statute and seeking to administer justice.

The main reason for the “confusion,” however, is that the results of some cases are unpalatable to the point of being incredible. The slowness to “understand” the law may have its roots in a refusal to accept the law. In several significant cases, uncontradicted experts have testified that the defendants’ behavior was substandard, and the behavior seems questionable even to a lay reader. Nevertheless, the plaintiffs’ cases are summarily dismissed before trial. These counter-intuitive results lead people to think they must have misunderstood

the rule or that the court must have misapprehended the case. Lawyers try, try again to get their experts to the jury.

In 1976, the Idaho legislature took what it considered “appropriate measures” in the public interest “to assure that a liability insurance market be available” at reasonable cost to healthcare providers in the state.¹ The idea was that availability of insurance would in turn assure the availability of healthcare providers in the state.² The “appropriate measures” included narrowing the established common-law standard of care in medical malpractice actions and specifying how the plaintiff would prove that standard.³ The key to the 1976 legislation was the imposition of a “strict locality” rule as the standard of care.⁴ As long as a healthcare provider practices to the standard of other providers in his⁵ geographic locale, he is not negligent.⁶ By creating a strict locality standard, the legislature intentionally fostered an atmosphere tolerant of some negligence. By its terms, the statute permits the standard of care to be negligence, as long as “that’s the custom” in the locality.

Idaho medical care providers are not deserving of any condescension. The reported cases do not indicate that Idaho practitioners in fact practice to low standards. Few, if any, appellate cases show proof that the local standard of care was significantly below that of the nation. Far more often—and this is the tragedy of Idaho malpractice law—the plaintiff cannot find experts “qualified” under the stringent tests imposed by the statute and the courts. The plaintiff then has no accepted proof of the local standard of care, cannot withstand summary judgment, and never gets to trial. The defendant’s victory then lies not in a conclusive determination that he did the right thing, but only in plaintiff’s inability to find witnesses who are willing and permitted to testify in court.

By creating the strict locality standard and by specifying exactly what evidence the plaintiff must present about the standard of care, the legislature used an evidentiary rule to huge substantive effect. The legislature micro-managed the question of what evidence is suffi-

1. Act of Mar. 31, 1976, ch. 277, § 1, 1976 Idaho Sess. Laws 951, 951.

2. *See id.*

3. *See* IDAHO CODE ANN. §§ 6-1012 to 6-1013 (2004). Another measure adopted to these same ends was the pre-litigation screening panel. *See id.* §§ 6-1001 to 6-1011.

4. *See id.* § 6-1012. There is provision for proof of the standard of care in a similar community, but that is rarely used, and it is available only if “there be no other like provider in the community and the standard of practice is therefore indeterminable.” *Id.* § 6-1012. The supreme court has interpreted this to include situations where the only other providers are part of one business entity. *See* Hoene v. Barnes, 121 Idaho 752, 754, 828 P.2d 315, 316 (1992).

5. Throughout this article the male pronoun will be used in order to avoid unnecessary verbiage.

6. *See* § 6-1012.

cient and then placed implementation of the question into the hands of the trial court, technically as a matter of discretion. Actually, the discretionary room to maneuver is far more restricted in medical malpractice actions than in other civil cases. The trial court's ruling can be disturbed only upon the hard-to-find "abuse of discretion."⁷ The plaintiff's failure to compile satisfactory evidence becomes grounds for the defendant's summary judgment.⁸ The summary judgment motion is effectively governed by what poses as an evidentiary statute.⁹

Both the trial courts and the appellate courts may feel bound to dismiss lawsuits that appear doomed to failure for insufficient evidence. The statutory language requires proof that an expert has knowledge of the local standard in the exact area of practice, in the exact place at the exact time of the alleged injury.¹⁰ The courts have tended to interpret this in such a narrow fashion that they leave little room for assumptions or even common sense. These interpretations, along with the difficulty in finding medical practitioners to testify against their fellows, lead to huge difficulties for plaintiffs. Some of the cases are jaw-dropping in their results, especially when highly questionable behavior by medical defendants is never brought before a jury.

This may well be the outcome desired by the legislature. Policy makers may deem it worth some cases of negligence going uncompensated in order to attract and keep healthcare providers in Idaho, particularly in rural and sparsely populated areas. That policy trade-off may be in the public interest, in the sense of benefiting the most people. Obviously, most doctors are not negligent, and even doctors who are occasionally negligent are not negligent most of the time. Probably most doctors—like most drivers, most lawyers, and most of us—are occasionally negligent. Overall, doctors do good and should be encouraged to serve all of Idaho's far-flung and isolated populations. The form of encouragement adopted in Idaho is to decrease the plaintiffs' chances of winning malpractice actions here than in other states. Idaho doctors are being protected when many other states are moving in a direction far less protective of doctors.¹¹ What must be faced is

7. *McDaniel v. Inland Nw. Renal Care Group-Idaho, L.L.C.*, 144 Idaho 219, __, 159 P.3d 856, 858 (2007) (citing *Dulaney v. St. Alphonsus Reg'l Med. Ctr.*, 137 Idaho 160, 163–64, 45 P.3d 816, 819–20 (2002)).

8. *Id.* at __, 159 P.3d at 859.

9. *See id.*

10. § 6-1012.

11. "Gradually, quietly, and relentlessly," reliance on medical custom may be ending. Philip G. Peters, Jr., *The Role of the Jury in Modern Malpractice Law*, 87 IOWA L. REV. 909, 913 (2002). Up to twenty state courts are abandoning, to one degree or another, the custom-based standard of care. *Id.* at 913–16. Of those maintaining it, quite a few are relaxing it by allowing the custom to be set by the "recommended" rather than actual practice. *Id.* at 916. Even in 1973 the "strict locality" rule was deemed an outdated and minority view. *See Dunham v. Elder*, 306 A.2d 568, 571 (Md. 1973); Hal R. Arkes & Cindy A.

that the corollary to giving doctors more protection is giving patients less protection.

After thirty-one years, the Idaho legislature has accomplished one of its primary goals. The *National Law Journal* recently listed Idaho as one of the two states with the standard of care rule that many people view as being the most doctor friendly.¹² According to a study done by the Idaho Trial Lawyers Association in 2006–2007, Idaho's non-economic damage cap, at \$250,000, is as low as any in the nation.¹³ Although Idaho, unlike four states, does allow punitive damages, only three states had even arguably lower punitive damage caps, and only one state had a higher standard of proof to meet when proving punitive damages.¹⁴ Only four states had shorter statutes of limitation.¹⁵ Idaho is at the top of some internet lists for states that are friendly to doctors.¹⁶

Friendliness may not translate into attraction and retention of doctors, especially in under-served areas. A recent study has found that the number of Idaho doctors is not keeping up with the state's rapidly growing population.¹⁷ Idaho has been ranked 49th of the 50 states in per capita ratio of doctors to population.¹⁸ The concentration of Idaho doctors is in the Boise area, and most other geographic regions in Idaho remain under-served by medical care professionals.¹⁹ Thus, the primary legislative goals may not be met.

Now is the time to assess whether Idaho's law of medical malpractice is indeed serving its purpose of attracting doctors and other medical care providers to the state, and whether another means of achieving the same goal could be adopted at lower cost to the courts, the doctors, and their patients. Idaho legislators should evaluate the costs, benefits, and general efficacy of their plan, and the courts should analyze whether their application and interpretation of the statutes are truly achieving justice.

Schipani, *Medical Malpractice v. The Business Judgment Rule: Differences in Hindsight Bias*, 73 OR. L. REV. 587, 603–05 (1994).

12. Tresa Baldas, *Localized Pain*, NAT'L L.J., July 16, 2007, at 1, 17.

13. Andrew M. Chasan, *The Basics of Interstate Trucking Litigation*, 35 IDAHO TRIAL LAW. ASS'N J. 60, 64 (2007).

14. *Id.* at 64–65.

15. *Id.*

16. See, e.g., States with Highest and Lowest Malpractice Premiums in Obgyn, <http://mdsalaries.blogspot.com/2007/10/states-with-highest-lowest-malpractice.html> (last visited Feb. 9, 2008) (noting that Idaho is one of the states with the lowest medical malpractice insurance premiums).

17. See MGT OF AMERICA, INC., MEDICAL EDUCATION STUDY FINAL REPORT 1-10 (2007), available at <http://www.boardofed.idaho.gov/publications/MedEdStudyRptFinal.pdf> (considering the expansion of medical education within Idaho).

18. *Id.*

19. *Id.* at 3-30 to -31.

Part II of this paper undertakes my original assignment, describing the black letter law on the standard of care, the qualification of experts, and the procedural steps involved in adjudication of these matters. Part III discusses how proof of substandard care is excessively difficult because of the combination of stonewalling by medical care providers and the implementation of law by the Idaho courts. Part IV recommends a fresh study by the legislature of the economic and public health impacts of the legislation. Part V suggests some changes in the judicial approach to these cases, particularly at the summary judgment stage, to maximize the administration of justice while at the same time complying with the statute. The appendix is a checklist for plaintiffs' lawyers.

II. THE STATUTE AND CASE LAW

This section describes the current Idaho law on the standard of care by placing the legislation in context, setting out the relevant language, and then examining the particulars of the standard of care and qualification of experts. The procedural ramifications of the rules, particularly upon motions for summary judgment, are considered. Significant time is spent discussing the facts of particular cases.²⁰

A. Overview of the Legislation

Before the 1976 statute, Idaho medical malpractice law, like that of many of the fifty states, based the standard of care on customary practices of the defendant's fellow professionals rather than on a mythic "reasonable doctor" standard.²¹ Custom in the medical malpractice realm differs from custom evidence used in non-medical negligence cases, because in medical malpractice cases, custom evidence is conclusive. The custom is not scrutinized for unreasonableness or inadequacy.²² The conventional understanding is that this use of cus-

20. The facts recited in appellate opinions are selective, truncated, and subjected to multiple filters. Yet they are the source of most of the assertions in this article. Many of the cases were decided upon summary judgment, so that the "facts" are largely allegations that have not been vetted by a jury. Certainly there is more to every story than the information that made its way into the Idaho Reports. Descriptions in this article of medical or legal action or inaction should be read with this understanding.

21. *Hoene v. Barnes*, 121 Idaho 752, 754-57, 828 P.2d 315, 317-19 (1992) (concluding that the standard of care prior to the 1976 statute was based on the customary practices of doctors in a similar locality).

22. The reliance on custom is explained in the leading case of *Robbins v. Footer*:

The conduct of a defendant in a negligence suit is usually measured against the conduct of a hypothetical reasonably prudent person acting under the same or similar circumstances. In medical malpractice cases, however, courts have required that the specialized knowledge and skill of the defendant must be taken into account. Although the law has thus imposed a higher standard of care on doctors, it has tempered the impact of that rule by permitting the

tom in medical malpractice cases is traditional.²³ But as early as the 1970s, states began moving away from custom as the standard, and this movement has continued.²⁴ Nevertheless, Idaho's law is still based on a custom. Until the 1976 legislation changed Idaho's common law, the rule in Idaho was that medical care providers were judged by the customary practices of doctors in "similar localities."²⁵ The legislature subsequently changed the standard of care so that it is now based on customary practices by doctors in the "same locality."²⁶

The strategy of the 1976 legislature was as follows:

It is the declaration of the legislature that appropriate measures are required in the public interest to assure that a liability insurance market be available to physicians and hospitals, in this state and that the same be available at reasonable cost, thus assuring the availability of such health care providers for the provision of care to persons in this state.²⁷

To further this interest, the Idaho legislature chose to encourage "nonlitigation resolution of claims" by creating a prelitigation hearing panel.²⁸ The panel was designed to weed out undeserving cases and explain the medicine to plaintiffs who were more nearly mystified than wronged.²⁹ The legislature then also, with the express intent to reduce liability exposure, "limited and made more definable" the standard of care "by a requirement for direct proof of departure from a

profession, as a group, to set its own legal standards of reasonable conduct. Whether a defendant has or has not conformed his conduct to a customary practice is generally only evidence of whether he has acted as a reasonably prudent person. In a malpractice case, however, the question of whether the defendant acted in conformity with the common practice within his profession is the heart of the suit.

553 F.2d 123, 126 (D.C. Cir. 1977) (citations omitted). See generally W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS § 33, at 193 (W. Page Keeton ed., 5th ed. 1984) (discussing the use of customary evidence to prove a community standard).

23. Philip G. Peters, Jr., *The Quiet Demise of Deference to Custom: Malpractice Law at the Millennium*, 57 WASH. & LEE L. REV. 163, 163 (2000).

24. *Id.* at 164; see also Peters, *supra* note 11, at 918 n.40. About eleven states have rejected medical custom as conclusive on the standard of care and another nine have endorsed the "reasonable physician" test. Peters, *supra* note 11, at 913-15.

25. See Hoene v. Barnes, 121 Idaho 752, 754-57, 828 P.2d 315, 317-19 (1992) (concluding that "similar localities" was the standard though the law was not beautifully clear).

26. See IDAHO CODE ANN. § 6-1012 (2004).

27. Act of Mar. 31, 1976, ch. 277, § 1, 1976 Idaho Sess. Laws 951, 951; *id.* ch. 278, § 1, 1976 Idaho Sess. Laws 953, 953.

28. *Id.* ch. 278, § 1, 1976 Idaho Sess. Laws at 953.

29. See Gary T. Dance, *Medical Malpractice: Prelitigation Screening Panels in Idaho*, 19 IDAHO L. REV. 31, 43-45 (1983).

community standard of practice.³⁰ The unstated key to the legislature's strategy was to increase Idaho's desirability as a place to practice relative to the other forty-nine states. Medical defendants in Idaho would get more protection than medical defendants in other states in order to entice those potentially in the defendant class to come to the state.³¹

Thus, road blocks, or at least check points, along plaintiffs' path to the courthouse were intended by the legislature. The changed standard of care and the screening panel work together to reduce the chances of any lawsuit being filed. The standard of care, the specificity and stringency of the expert qualification requirements, and the discretion vested in the trial court (disturbable only upon a finding of abuse of discretion) not only increase the chance that a defendant will win, but they also increase the chance that he will win at the pre-trial summary judgment stage, thereby saving legal fees and reducing the risk that a jury will get a chance to weigh the evidence and assess breach of the standard of care.

The essential statutory language reads:

In any case . . . for damages due to injury to or death of any person, brought against any [provider of healthcare]³² . . . on account of the provision of or failure to provide health care . . . such claimant or plaintiff must, as an essential part of his or her case in chief, affirmatively prove by direct expert testimony and by a preponderance of all the competent evidence, that such defendant then and there negligently failed to meet the applicable standard of health care practice of the community in which such care allegedly was or should have been provided, as such standard existed at the time and place of the alleged negligence of such . . . health care provider and as such standard then and there existed with respect to the class of health care provider that such defendant then and there belonged to and in which capacity he, she or it was functioning. Such individual providers of health care shall be judged in such cases in comparison with similarly trained and qualified providers of the same class in the same community, taking

30. Act of Mar. 31, 1976, ch. 277, § 1, 1976 Idaho Sess. Laws at 951.

31. This pro-defendant strategy has continued and has expanded out from the medical defendant. In 1987, the Idaho legislature passed damage cap legislation affecting all non-economic tort damages; then in 2004, it reduced the cap from \$400,000 to \$250,000. IDAHO CODE ANN. § 6-1603 (2004). Punitive damages are limited as well. *Id.* § 6-1604. The costs and benefits of this legislative strategy are discussed in Part IV.

32. Providers of healthcare named in the statute include physicians, surgeons, dentists, physicians' assistants, nurse practitioners, registered nurses, licensed practical nurses, nurse anesthetists, medical technologists, physical therapists, hospitals, nursing homes, "or any person vicariously liable for the negligence of them or any of them." IDAHO CODE ANN. § 6-1012 (2004).

into account his or her training, experience, and fields of medical specialization, if any. If there be no other like provider in the community and the standard of practice is therefore indeterminable, evidence of such standard in similar Idaho communities at said time may be considered. As used in this act, the term "community" refers to that geographical area ordinarily served by the licensed general hospital at or nearest to which such care was or allegedly should have been provided.³³

The applicable standard of practice and such a defendant's failure to meet said standard must be established . . . by . . . plaintiff by testimony of one (1) or more knowledgeable, competent expert witnesses, and such expert testimony may only be admitted in evidence if the foundation therefor is first laid, establishing (a) that such an opinion is actually held by the expert witness, (b) that the said opinion can be testified to with reasonable medical certainty, and (c) that such expert witness possesses professional knowledge and expertise coupled with actual knowledge of the applicable said community standard to which his or her expert opinion testimony is addressed; provided, this section shall not be construed to prohibit or otherwise preclude a competent expert witness who resides elsewhere from adequately familiarizing himself with the standards and practices of (a particular) such area and thereafter giving opinion testimony in such a trial.³⁴

In sum, the statute allows the standard to be set by the custom of the community, as established by direct testimony from an expert who has actual knowledge of the community standard at that time and place as practiced by that class of healthcare provider. The substantive liability standard and the legislative rule of evidence intertwine; the statute establishes a rule for admitting evidence that will suffice to meet the substantive standard of care. All modern Idaho cases build off this statute.³⁵

33. IDAHO CODE ANN. § 6-1012. This section was found to be constitutional in *Le-Pelley v. Grefenson*, 101 Idaho 422, 614 P.2d 962 (1980), *superseded on other grounds by* IDAHO CODE ANN. § 39-4301 (Supp. 2007). The attack was based on the equal protection clause. *Id.* at 427, 614 P.2d at 967. The statute survived the rational basis test, no fundamental right was found to be at issue, and no equal protection violations were found. *Id.* at 428, 614 P.2d at 968.

34. IDAHO CODE ANN. § 6-1013 (2004). This section has been adhered to by the Idaho Supreme Court. *See, e.g.,* *McDaniel v. Inland Nw. Renal Care Group-Idaho, L.L.C.*, 144 Idaho 219, ___, 159 P.3d 856, 859 (2007).

35. For two excellent articles giving an overview of Idaho's medical malpractice system, see J. Michael Wheeler & L. Reed Larson, *A Primer on Medical Malpractice*, THE

B. Applicability of the Statute

In proving medical malpractice, the plaintiff may not rely on a standard negligence instruction.³⁶ A trial judge instructing on a “best judgment” standard has committed reversible error.³⁷ One plaintiff asserted that her physical therapist engaged in “ordinary negligence” that would require “no specialized skill or knowledge” to assess.³⁸ That position was deemed so unconvincing as to be frivolous.³⁹ Rather, the standard for all alleged negligence on the part of a healthcare provider is set by Idaho Code section 6-1012.⁴⁰ This standard may not be avoided by pleading other torts, like intentional infliction of emotional distress or contract; if the matter involves negligence in the provision of medical services, the statute is implicated.⁴¹ Res ipsa loquitur is not available because the statute calls for direct, not circumstantial, evidence.⁴²

C. The Standard of Care

The crux of section 6-1012 is that the standard of care is (1) at the same time and place of the alleged malpractice and (2) of “simi-

ADVOCATE, May 2005, at 24, and John R. Goodell, *Idaho Medical and Health Care Malpractice Law: General Principles and Direct Expert Witness Evidentiary Requirements*, THE ADVOCATE, Jan. 2002, at 16.

36. Robertson v. Richards, 115 Idaho 628, 657, 769 P.2d 505, 534 (1987).

37. Leazer v. Kiefer, 120 Idaho 902, 906–07, 821 P.2d 957, 961–62 (1991).

38. Hough v. Fry, 131 Idaho 230, 233, 953 P.2d 980, 983 (1998).

39. *Id.* at 234, 953 P.2d at 984 (awarding attorneys fees to the defendant due to the frivolity of the plaintiff’s position and finding frivolity based on the plaintiff’s obvious belief that the statute applied right up until her expert changed his opinion and no longer saw the matter in her favor). For a discussion of the facts of this case, see *infra* notes 271–81 and accompanying text.

40. See IDAHO CIV. JURY INSTRUCTION 2.10.3 (2003); Puckett v. Verksa, 144 Idaho 161, ___, 158 P.3d 937, 943 (2007). An instruction given according to Idaho Code section 6-1012 is sufficient, and an additional instruction that “a bad medical result did not, in and of itself, establish a breach of the standard of care” may be properly refused. *Puckett*, 144 Idaho at ___, 158 P.3d at 943.

41. Litz v. Robinson, 131 Idaho 282, 284, 955 P.2d 113, 115 (Ct. App. 1997).

42. Kolln v. Saint Luke’s Reg’l Med. Ctr., 130 Idaho 323, 334, 940 P.2d 1142, 1153 (1997). Res ipsa loquitur was not allowed in *LePelley v. Grefenson* on the grounds that the facts were not such that a layman could find it common knowledge that the injury would not have happened if due care had been exercised. 101 Idaho 422, 426, 614 P.2d 962, 966 (1980), *superseded on other grounds by* IDAHO CODE ANN. § 39-4301 (Supp. 2007). This reasoning might lead a reader to think that res ipsa loquitur was potentially available after passage of section 6-1012. *Kolln* dispelled any such thoughts, stating:

In *LePelley*, we assumed without holding that res ipsa loquitur may no longer be used . . . given I.C. § 6-1012’s requirement of direct expert testimony. Today, we explicitly hold that the doctrine is . . . not direct proof, but rather . . . it “creates an inference of the breach of the duty imposed and replaces direct evidence with a permissive inference of negligence.”

130 Idaho at 334, 940 P.2d at 1153 (citations omitted).

larly trained and qualified providers of the same class” as defendant.⁴³ The Idaho courts have construed this narrowly and literally.

Regarding the first prong, the time and the place must be established “then and there”⁴⁴ with great precision. Thus, 1988 is not 1983,⁴⁵ 1992 is not 1994,⁴⁶ Boise is not Fruitland,⁴⁷ and neither Idaho Falls nor Potlatch is Pocatello.⁴⁸ Idaho Falls is not necessarily Blackfoot even though they are only thirty miles apart and partially served by the same hospital.⁴⁹ The local standard of care must be used even as to matters that, seemingly, would not vary from locality to locality, such as how much medicine to give a patient.⁵⁰

For the second prong, those in defendant’s “class” are those who are similarly trained, qualified, and specialized in that same community. An optometrist is not an ophthalmologist,⁵¹ a thoracic specialist is not a cardiovascular specialist,⁵² internal medicine is not emergency medicine,⁵³ and neurology is not orthopedics.⁵⁴ However, as discussed

43. IDAHO CODE ANN. § 6-1012 (2004).

44. *Id.*

45. *Gubler v. Boe*, 120 Idaho 294, 296–97, 815 P.2d 1034, 1036–37 (1991). *But see Dulaney v. St. Alphonsus Reg'l Med. Ctr.*, 137 Idaho 160, 172, 45 P.3d 816, 828 (2002) (Kidwell, J., dissenting) (declaring that “an in-depth examination of *Gubler* reveals that this Court did not reach the time specificity issue on appeal”).

46. *See Dulaney*, 137 Idaho at 171, 45 P.3d at 827 (Kidwell, J., dissenting) (noting the district court’s finding that knowledge of the standard in 1992 did not suffice for knowledge of the standard in 1994). The majority did not address the time issue because it found that the testimony was inadmissible on other grounds. *Id.* at 168, 45 P.3d at 824.

47. *See Grover v. Smith*, 137 Idaho 247, 46 P.3d 1105 (2002) (finding knowledge of a statewide standard sufficient although the district court had found that familiarity with a Boise standard was not sufficient to be familiar with the Fruitland standard).

48. *See, e.g., Gubler*, 120 Idaho at 295, 815 P.2d at 1035 (affirming the district court’s finding that the expert was not qualified because he was familiar with the standard of care in Idaho Falls and not Pocatello); *LePelley v. Grefenson*, 101 Idaho 422, 427, 614 P.2d 962, 967 (1980) (finding that the locality rule is not discriminatory despite the plaintiff’s claim that having different standards for Pocatello and Potlatch denies equal protection under section 6-1012), *superseded on other grounds by* IDAHO CODE ANN. § 39-4301 (Supp. 2007).

49. *See Ramos v. Dixon*, 144 Idaho 32, ___, 156 P.3d 533, 536–37 (2007). The existence of a competing hospital in Idaho Falls would not preclude the two towns from being in the same geographical area, but whether the two towns were ordinarily served by the Blackfoot hospital was a factual issue about which no evidence was in the record. *Id.* at ___, 156 P.3d at 536.

50. *See Edmunds v. Kraner*, 142 Idaho 867, 876, 136 P.3d 338, 347 (2006).

51. *Evans v. Griswold*, 129 Idaho 902, 905–06, 935 P.2d 165, 168–69 (1997).

52. *See Hoene v. Barnes*, 121 Idaho 752, 756, 828 P.2d 315, 319 (1992). In that case, the majority considered cardiovascular surgery to be a speciality unto itself. *Id.* Justice Bakes, in dissent, argued that the broader category of thoracic surgery was the relevant category. *Id.* at 758, 828 P.2d at 321 (Bakes, J., dissenting).

53. *Dulaney v. St. Alphonsus Reg'l Med. Ctr.*, 137 Idaho 160, 166, 45 P.3d 816, 822 (2002).

54. *Id.* at 167–68, 45 P.3d at 823–24.

in the next section, an expert may familiarize himself with another related specialty.

Plaintiffs have argued that nationally certified specialists ought to be held to a national standard because their "community" is the entire nation.⁵⁵ After a confusing start, the law in Idaho has held steady since 1987. The nationally certified specialist is permitted "local deviations" from the national standard;⁵⁶ thus, a local standard applies.

Only in limited situations may a statewide or nationwide standard trump a local practice or standard. If a specific standard of care is set by state or federal law, then those standards govern. However, the mere existence of federal regulation in an area does not set a national standard unless there are specific regulations about what should or should not be done.⁵⁷ Minimal statewide licensing standards may not be ignored; they form a baseline below which the local standard may not dip.⁵⁸ However, standards voluntarily adopted by the defendant may not be used to set the standard of care, even if the healthcare provider is contractually bound to abide by them.⁵⁹

55. See, e.g., *Strode v. Lenzi*, 116 Idaho 214, 215, 775 P.2d 106, 108 (1989). For a discussion of whether nationally certified specialists should be held to a national standard, see *infra* Part III.F.

56. See *id.*; *Gubler v. Boe*, 120 Idaho 294, 304, 815 P.2d 1034, 1044 (1991). In *Buck v. St. Clair*, the court wrote, "We believe that for board-certified specialists, the local standard of care is equivalent to the national standard of care. Our reasons for this decision are simple Our ruling today is limited to board-certified doctors practicing in the same area of specialty." 108 Idaho 743, 745, 702 P.2d 781, 783 (1985) (emphasis added). Only two years later, the court characterized this language as dicta, despite the dissenters' objection that such a finding was "a convoluted, indirect and a sub-rosa attempt at limiting our *Buck* holding, with the trial court designated as scapegoat." *Grimes v. Green*, 113 Idaho 519, 522, 746 P.2d 978, 981, (1987); *id.* at 525, 746 P.2d at 984 (Huntley, J., dissenting). The *Grimes* majority's "limit[ing] and clarify[ing]" of *Buck* was reaffirmed in *Frank v. E. Shoshone Hosp.*, 114 Idaho 480, 482 n.3, 757 P.2d 1199, 1201 n.3 (1988), and *Gubler*, 120 Idaho at 304, 815 P.2d at 1044. This *Buck/Grimes* sequence of cases goes a long way toward explaining the confusion felt by many members of the Idaho bar about the law concerning the standard of care.

57. Compare *Hayward v. Jack's Pharmacy Inc.*, 141 Idaho 622, 628, 115 P.3d 713, 719 (2005) (stating that the standard of care in a nursing home is governed by federal and state guidelines), with *McDaniel v. Inland Nw. Renal Care Group-Idaho, L.L.C.*, 144 Idaho 219, ___, 159 P.3d 856, 859-60 (2007) (stating that kidney dialysis is covered by SSI, Social Security, Medicare, or Medicaid benefits, but that no standards are set by those programs about how dialysis should be administered).

58. *Grover v. Smith*, 137 Idaho 247, 252, 46 P.3d 1105, 1110 (2002).

59. In *Dekker v. Magic Valley Reg'l Med. Ctr.*, the defendant doctors and hospital had adopted the standards established by the Joint Commission on Accreditation of Hospitals (JCAH) as their operating standards and were therefore contractually bound to follow those standards. See 115 Idaho 332, 335, 766 P.2d 1213, 1216 (1988) (Huntley, J., dissenting). But the majority of the court still required evidence that the JCAH standards were the local standard, even in the absence of any evidence that the local standard was below the JCAH standards. See *id.* at 334, 766 P.2d at 1215 (majority opinion); *id.* at 335, 766 P.2d at 1216 (Huntley, J., dissenting). The JCAH standards were referred to as "optimal patient care." *Id.* at 334, 766 P.2d at 1215 (Huntley, J., dissenting). This label rings of

Evidence of the nationwide standard is admissible only if the plaintiff's expert can confirm that the local standard does not vary from the national standard.⁶⁰ The expert must be able to explain how he became acquainted with the local standard, whether by practicing in the area, reviewing depositions of local care providers, or speaking directly with a local provider.⁶¹

D. The Experts

Whether they arise as summary judgment cases or appeals on sufficiency of evidence, many of the cases do not address the standard of care per se but turn rather on the statutorily linked question of which experts are qualified to testify.⁶² Idaho Code section 6-1013 requires that (1) the expert be professionally knowledgeable, expert, and competent; (2) the expert actually hold the opinion and testify to it with "reasonable medical certainty"; and (3)—this is crucial—the expert possess "actual knowledge of the applicable . . . community standard to which his or her expert opinion testimony is addressed."⁶³

1. Professional Knowledge, Expertise, and Competence

The requirement of professional knowledge, expertise, and competence is met if the expert's training is similar to the defendant's. Lay people, including the plaintiffs themselves, are incompetent to testify about the standard of care.⁶⁴ Experts must be trained in a similar fashion to the person whose conduct they are assessing.⁶⁵ For example, in one case, plaintiff's daughter, identifying herself as an "Emergency Medical Technician Ambulance" and "CNA home health-care professional," attempted to testify against her mother's physi-

aspiration rather than reality, and perhaps it helps to explain the majority's refusal to rely on the JCAH standards to set the local standard.

60. See *Edmunds v. Kraner*, 142 Idaho 867, 875, 136 P.3d 338, 346 (2006); *Strode*, 116 Idaho at 216, 775 P.2d at 108.

61. *Edmunds*, 142 Idaho at 876-77, 136 P.3d at 347-48; *Perry v. Magic Valley Reg'l Med. Ctr.*, 134 Idaho 46, 51, 995 P.2d 816, 821 (2000).

62. This is partially because so many of the cases arise upon summary judgment.

63. IDAHO CODE ANN. § 6-1013 (2004); see also IDAHO R. EVID. 702 (requiring the qualification of experts to be based on "knowledge, skill, experience, training, or education"). At summary judgment, competence must be affirmatively shown by affidavits. IDAHO R. CIV. P. 56(e); see also *Dunlap v. Garner*, 127 Idaho 599, 605-06, 903 P.2d 1296, 1302-03 (1994).

64. *Kolln v. Saint Luke's Reg'l Med. Ctr.*, 130 Idaho 323, 330, 940 P.2d 1142, 1149 (1997). Plaintiffs, whatever their training, may testify about their own bodily symptoms but not about whether the standard of care was breached nor about the medical causes of their injuries. See *id.*; IDAHO R. EVID. 701 (providing for the admissibility of lay opinion evidence).

65. See § 6-1013; *Evans v. Griswold*, 129 Idaho 902, 905, 935 P.2d 165, 168 (1997); *Litz v. Robinson*, 131 Idaho 282, 285, 955 P.2d 113, 116 (Ct. App. 1997).

cians.⁶⁶ She was found not to be an expert, presumably because of her lack of training rather than her relation to the plaintiff.⁶⁷

Defendant healthcare providers are experts in their own fields and may testify on their own behalf.⁶⁸ Similarly, defendants may make admissions against themselves.⁶⁹ But an expert's opinion must be clear and non-conclusory.⁷⁰ Thus, a doctor's vague, informal statement, "I obviously messed up," or the doctor's waiver of the bill are not evidence that he breached the standard of care.⁷¹

Experts with knowledge or training in care settings related to, but not identical to, those at issue may familiarize themselves with the standard of care applicable to the defendant.⁷² This applies to both classes of care providers and fields of medical specialization.⁷³ Thus,

66. *Litz*, 131 Idaho at 285, 955 P.2d at 116.

67. *See id.*

68. *See Evans v. Griswold*, 129 Idaho 902, 935 P.2d 165 (1997); *Rook v. Trout*, 113 Idaho 652, 656, 747 P.2d 61, 65 (1987), *overruled on other grounds by Sherwood v. Carter*, 119 Idaho 246, 805 P.2d 452 (1991).

69. Idaho has joined the growing number of states statutorily permitting doctors to apologize without fear that the apology will be used in court as an admission of negligence. IDAHO CODE ANN. § 9-207 (Supp. 2007).

Admissibility of Expressions of Apology, Condolence and Sympathy. In any civil action brought by or on behalf of a patient who experiences an unanticipated outcome of medical care, or in any arbitration proceeding related to, or in lieu of, such civil action, all statements and affirmations, whether in writing or oral, and all gestures or conduct expressing apology, sympathy, commiseration, condolence, compassion, or a general sense of benevolence, including any accompanying explanation, made by a health care professional or an employee of a health care professional to a patient or family member or friend of a patient, which relate to the care provided to the patient, or which relate to the discomfort, pain, suffering, injury, or death of the patient as the result of the unanticipated outcome of medical care shall be inadmissible as evidence for any reason including, but not limited to, as an admission of liability or as evidence of an admission against interest.

Id.

70. *Dulaney v. St. Alphonsus Reg'l Med. Ctr.*, 137 Idaho 160, 164, 45 P.3d 816, 820 (2002).

71. *See Maxwell v. Women's Clinic, P.A.*, 102 Idaho 53, 56, 625 P.2d 407, 410 (1981).

72. Judge—now Dean—Burnett explains this cogently in *Kunz v. Miciak*:

[T]he expert witness must possess "professional knowledge and expertise *coupled with* actual knowledge of the applicable said community standard . . ." (Emphasis added) The phrase "coupled with" denotes a contemporaneous relationship; awareness of the standard must exist when the expert testimony is given. If contemporaneous awareness is not demonstrated, the expert's testimony is subject to being excluded or stricken at trial.

118 Idaho 130, 131, 795 P.2d 24, 25 (Ct. App. 1990) (citing IDAHO CODE ANN. § 6-1013 (2004)).

73. *Hayward v. Jack's Pharmacy, Inc.*, 141 Idaho 622, 628, 115 P.3d 713, 719 (2005). Sometimes it is not clear in what capacity the defendant was acting. *See, e.g., id.* at 626–27, 115 P.3d at 717–18 (discussing whether the defendant was acting as a doctor or as the medical director of a facility).

an ophthalmologist is differently trained than an optometrist to such an extent that he is in a different class of care provider, but he can make himself sufficiently familiar with the work of optometrists in the area that he will be allowed to testify.⁷⁴ A doctor may make himself familiar with how a hospital provides care.⁷⁵ Also a non-board-certified physician may testify against a board-certified physician.⁷⁶ People in related specialties may familiarize themselves with each other's work.⁷⁷ Occasionally, the exact context of the alleged malpractice is not particularly relevant. For example, in *Grover v. Isom*, an expert CRNA (certified registered nurse anesthesiologist) was testifying about the actions of a defendant CRNA.⁷⁸ The expert was licensed in three states, had practiced for nearly twenty years, and had administered anesthesia with dentists, but had never done so in an oral surgeon's office.⁷⁹ Although the alleged tort had occurred in an oral surgeon's office, the expert's testimony was allowed because he testified that the difference in setting did not affect the standard of care.⁸⁰

2. Opinion Based on Reasonable Medical Certainty

The expert must hold the opinion and testify to it with reasonable medical certainty. The question of what "certainty" is "reasonable" implicates the questions presented by *Daubert*⁸¹ and its progeny: What is scientifically knowable? And what is acceptable science? In Idaho, these questions have not arisen in the context of breach of the

74. See *Evans v. Griswold*, 129 Idaho 902, 905, 935 P.2d 165, 168 (1997). In that case, the ophthalmologist had expressly not familiarized himself with the standard of care for the optometrist, so summary judgment for the defendant was upheld. *Id.*

75. *Dunlap v. Garner*, 127 Idaho 599, 605, 903 P.2d 1296, 1302 (1994). The court held that the expert trained as a physician could not testify against the hospital administrator on the question of hospital management because his affidavits did not affirmatively show that he possessed the requisite training or experience, but such a showing was "theoretically possible." *Id.* Indeed, another doctor in the case "had consulted with the State of Idaho Hospital Licensing Board for the specific purpose of learning the applicable standard relative to hospitals." *Id.* at 602, 903 P.2d at 1299. The second doctor's affidavit was sufficient to overcome the defendant's motion for summary judgment as to the hospital. *Id.* at 606, 903 P.2d at 1303.

76. *Pearson v. Parsons*, 114 Idaho 334, 337, 757 P.2d 197, 200 (1988).

77. *Dulaney v. St. Alphonsus Reg'l Med. Ctr.*, 137 Idaho 160, 168, 45 P.3d 816, 824 (2002) (requiring the expert, who was a neurologist, to have knowledge of the standards for emergency room physicians), *aff'g* *Clarke v. Prenger*, 114 Idaho 766, 760 P.2d 1182 (1988) (allowing obstetrician-gynecologist to testify against a family practitioner); see also *Newberry v. Martens*, 142 Idaho 284, 292, 127 P.3d 187, 195 (2005) (allowing an ophthalmologist to testify against a family practitioner).

78. 137 Idaho 770, 774, 53 P.3d 821, 825 (2002).

79. *Id.*

80. *Id.* at 775, 53 P.3d at 826.

81. *Daubert v. Merrell Dow Pharm., Inc.*, 509 U.S. 579 (1993).

standard of care.⁸² Usually these “knowability” questions come up in the matter of causation.⁸³ Causation is not a local matter as, presumably, it does not vary from town to town.

3. Actual Knowledge of the Applicable Community Standard

The ideal is that the expert be from the same community, practicing alongside the defendant care provider. Some older cases refer to a “same neighborhood” standard.⁸⁴ Nevertheless, out-of-towners are allowed to testify as experts as long as they can testify, with specificity, that they have actual knowledge of the local standard.⁸⁵ The usual

82. Idaho has not adopted the *Daubert* standard for admissibility of an expert's testimony but “has used some of *Daubert*'s standards in assessing whether the basis of an expert's opinion is scientifically valid.” *Weeks v. E. Idaho Health Servs.*, 143 Idaho 834, 838, 153 P.3d 1180, 1184 (2007) (citing *Swallow v. Emergency Med. of Idaho, P.A.*, 138 Idaho 589, 595 n.1, 67 P.3d 68, 74 n.1 (2003)).

83. See *Weeks*, 143 Idaho at 837–40, 153 P.3d at 1183–86; *Kolln v. Saint Luke's Reg'l Med. Ctr.*, 130 Idaho 323, 329–30, 940 P.2d 1142, 1148–49 (1997). *Kolln* went in for surgery on her neck, and came out with a rotator cuff injury in her shoulder. *Kolln*, 130 Idaho at 325, 940 P.2d at 1144. These facts are strikingly similar to the leading *res ipsa loquitur* case of *Ybarra v. Spangard* where the plaintiff went in for abdominal surgery and came out with a painful shoulder. 154 P.2d 687 (Cal. 1944). In *Kolln*, Justice Silak would have granted summary judgment because the plaintiff's expert had no factual basis for his opinions; he had only speculation about what might have happened, which was too close to the disallowed *res ipsa loquitur*, *Kolln*, 130 Idaho at 334, 940 P.2d at 1153; *id.* at 337–38, 940 P.2d at 1156–57 (Silak, J., dissenting). Justice Silak was correct that the expert did not exactly state facts with reasonable medical certainty about the cause of plaintiff's injury. But her conclusion that the matter should therefore be dismissed without jury determination seems to overstep the purviews of summary judgment. The expert had narrowed the cause of the shoulder injury down to two possibilities, both within the ambit of defendants' alleged malpractice. See *id.* at 333, 940 P.2d at 1152 (majority opinion). Viewing the facts in the light most favorable to the non-moving party, there remain factual questions about what did happen. It is the jury's role to assess credibility and to determine crucial material facts—especially whether or not the hospital took adequate care of the plaintiff's shoulder.

84. See *Hoene v. Barnes*, 121 Idaho 752, 828 P.2d 315 (1992) (discussing the court's past use of the phrase “same neighborhood”); *Buck v. St. Clair*, 108 Idaho 743, 748, 702 P.2d 781, 786 (1985) (Donaldson, J., dissenting) (suggesting that the same community is that of the same neighborhood).

85. *Strode v. Lenzi*, 116 Idaho 214, 216, 775 P.2d 106, 108 (1989); *Keyser v. Garner*, 129 Idaho 112, 118, 922 P.2d 409, 415 (Ct. App. 1996). The requirement of local consultation has been criticized when nationally certified specialists are on trial:

It is simply a fundamental logic process that if: (1) All board certified orthopedic surgeons must at a minimum listen to the carotid artery; and (2) Doctor William Lenzi is a board certified orthopedic surgeon; therefore, (3) his standard is to place the stethoscope on the neck and listen to the artery.

Stated another way, if a witness testifies that no board certified doctor in the world should fail to listen to that artery, and Boise, Idaho is a part of the world, then the Boise standard has been met.

Strode, 116 Idaho at 217, 775 P.2d at 109 (Huntley, J., dissenting). Justice Huntley was particularly galled in that case by the fact that the defendant had produced no evidence

way of gaining this knowledge is by asking one or more qualified local medical practitioners of the same specialty or class.⁸⁶ Anonymous local sources are permitted as long as the expert testifies to having spoken to someone.⁸⁷ If information on the local standard is directly available in a deposition, the expert may simply read what is stated in the transcript of the deposition.⁸⁸ However, mere review of hospital records and of the actions of a local physician is insufficient to establish knowledge of the local standard of care.⁸⁹

An illustrative and recent case is *Newberry v. Martens*.⁹⁰ The district court, affirmed by the supreme court, allowed a board-certified ophthalmologist to testify against a family practitioner even though the ophthalmologist had a different degree of training, had a different specialty, and had not asked any family practice physicians in the area about the standard of care.⁹¹ The ophthalmologist's testimony was allowed because he testified at trial "that he [had] learned the standard of care by practicing alongside family practice physicians in [the area], by providing and obtaining referrals, and by discussing patient care with them."⁹² The ophthalmologist had thereby complied with the law because he had stated how he became familiar with the

that there was a local deviation from the national standard of care. *Id.* For an analysis of the courts' application of the majority's rule, see Part III.B.

86. *Newberry v. Martens*, 142 Idaho 284, 292, 127 P.3d 187, 195 (2005); see also *Keyser*, 129 Idaho at 119, 944 P.2d at 416 (rejecting the argument that more than one local doctor must be consulted in areas where there is no national standard of care).

87. See *Grover v. Smith*, 137 Idaho 247, 251, 46 P.3d 1105, 1109 (2002) (suggesting that speaking with anonymous doctors is a means of becoming familiar with the standard if all of the other requirements of section 6-1013 are met). This practice of consulting local doctors is permissible under the hearsay rules. IDAHO R. EVID. 703.

88. *Perry v. Magic Valley Reg'l Med. Ctr.*, 134 Idaho 46, 51, 995 P.2d 816, 821 (2000). The court will scrutinize what was established by the deposition testimony. Compare *Rhodehouse v. Stutts*, 125 Idaho 208, 211-12, 868 P.2d 1224, 1227-28 (1994) (finding review of the defendant doctor's deposition and the hospital records insufficient to become familiar with the standard of care), with *Kozlowski v. Rush*, 121 Idaho 825, 828, 828 P.2d 854, 857 (1992) (allowing the expert to become familiar with the standard of care based on deposition review). If the expert relies on deposition testimony, he must spell out that the local standard of care was the same as the national standard. *Rhodehouse*, 125 Idaho at 212, 868 P.2d at 1228. Also, the deposition on which the expert relies must contain direct evidence about the standard of care; the expert may not merely make inferences based on the deposition. *Id.* at 214, 868 P.2d at 1230 (Silak, J., specially concurring). See generally Goodell, *supra* note 35, at 16-18 (setting forth the relevant case law on how an expert may lay an adequate foundation for the admission of his testimony).

89. *Rhodehouse*, 125 Idaho at 212, 868 P.2d at 1228 (citing *Gubler v. Boe*, 120 Idaho 294, 297-98, 815 P.2d 1034, 1037-38 (1991)).

90. 142 Idaho 284, 127 P.3d 187 (2005).

91. *Id.* at 291-92, 127 P.3d at 194-95.

92. *Id.* at 292, 127 P.3d at 195.

standard of care.⁹³ Even though he had not made a direct inquiry, he did have actual knowledge of the local standard.⁹⁴

Occasionally no local practitioner other than the defendant exists, making the local standard indeterminable. If plaintiff can so demonstrate, section 6-1012 expressly allows for testimony about the standard of care in “similar” communities: “If there be no other like provider in the community and the standard of practice is therefore indeterminable, evidence of such standard in similar Idaho communities at said time may be considered.”⁹⁵ The inquiry, by its terms, turns not on whether any other provider in the community will testify but on whether another provider exists in the community.⁹⁶ The court has understood this provision to mean that when the only other practitioners in the community were in the same professional association with the defendant, and hence were “one business entity,” they were one “provider” under section 6-1012.⁹⁷ But, an assertion that “doctors practicing in the . . . community at the relevant time were either unavailable or biased in favor of [defendant]” was insufficient to invoke the “similar communities” standard.⁹⁸

E. Procedural Framework and Rules

Many of the reported Idaho cases have arisen upon summary judgment motion. Idaho Rule of Civil Procedure (I.R.C.P.) 56(c) establishes that the question on summary judgment is whether there exists a “genuine issue as to any material fact.”⁹⁹ The weight of the evidence should not be examined¹⁰⁰ nor should the trial court make determinations of credibility.¹⁰¹ I.R.C.P. 56(e) instead requires the trial court to examine affidavits to see that they are made on personal knowledge, setting forth “such facts as would be admissible in evidence” and showing affirmatively that the affiant is competent to testify to the matters stated.¹⁰²

For medical malpractice plaintiffs “to survive a summary judgment motion for the defendant,” plaintiffs must comply with I.R.C.P.

93. *Id.*

94. *Id.*

95. IDAHO CODE ANN. § 6-1012 (2004). For use of this provision, see *Morris v. Thomson*, 130 Idaho 138, 145–47, 937 P.2d 1212, 1219–21 (1997), and *Hoene v. Barnes*, 121 Idaho 752, 753–57, 828 P.2d 315, 316–20 (1992).

96. *Morris*, 130 Idaho at 146, 937 P.2d at 1220.

97. *Hoene*, 121 Idaho at 754, 828 P.2d at 317.

98. *Morris*, 130 Idaho at 147, 937 P.2d at 1221.

99. IDAHO R. CIV. P. 56(c).

100. See, e.g., *Watts v. Lynn*, 125 Idaho 341, 346, 870 P.2d 1300, 1305 (1994); *Dunlap v. Garner*, 127 Idaho 599, 605, 903 P.2d 1296, 1302 (1994).

101. *Mains v. Cach*, 143 Idaho 221, 225, 141 P.3d 1090, 1094 (2006). An exception would be the rare event where the evidence was clear that the expert’s affidavit was deserving of no credence. *Id.*

102. IDAHO R. CIV. P. 56(e).

56(e) and submit expert testimony by way of affidavits that creates a material issue of fact as to defendant's negligence.¹⁰³ In order for these affidavits to be admissible, plaintiffs must also comply with Idaho Code section 6-1013, which requires that their experts have "actual knowledge" of the local community standard of care.¹⁰⁴ The specificity of the I.R.C.P. and the Idaho Code may blur two separate questions: what evidence is admissible (for example, whether the expert is qualified) with what admissible evidence is insufficient to make a prima facie showing that there is an issue of material fact.

It is "axiomatic"¹⁰⁵ that upon a summary judgment motion, the court should liberally construe the record in the light most favorable to the party opposing the motion, drawing all reasonable inferences and conclusions in that party's favor.¹⁰⁶ However, because of the specificity of section 6-1013, before this construction of the record can take place, the threshold question of I.R.C.P. 56(e) must be addressed—whether the information in the supporting affidavits is admissible.¹⁰⁷

The liberal construction and reasonable inferences standard [for summary judgment] does not apply . . . when deciding whether or not testimony offered in connection with a motion for summary judgment is admissible. The trial court must look at the witness' affidavit or deposition testimony and determine whether it alleges facts which, if taken as true, would render the testimony of that witness admissible.¹⁰⁸

103. *Dulaney v. St. Alphonsus Reg'l Med. Ctr.*, 137 Idaho 160, 163–64, 45 P.3d 816, 819–20 (2002); see also *Anderson v. Hollingsworth*, 136 Idaho 800, 802–03, 41 P.3d 228, 230–31 (2001). "The non-moving party's case must be anchored in something more than speculation, and a mere scintilla of evidence is not enough to create a genuine issue of fact." *Anderson*, 136 Idaho at 802–03, 41 P.3d at 230–31. While upon summary judgment the burden of proving the absence of material facts is upon the moving party, and "the non-moving party has no burden to respond with evidence supporting" its claim, the "non-moving party may not rest on its pleadings, but must offer affidavits or other admissible evidentiary materials which demonstrate that an issue of fact remains." *Id.* at 803, 41 P.3d at 231.

104. IDAHO CODE ANN. § 6-1013 (2004); *Dulaney*, 137 Idaho at 164, 45 P.3d at 820.

105. *Rhodehouse v. Stutts*, 125 Idaho 208, 210, 868 P.2d 1224, 1226 (1994).

106. *Dulaney*, 137 Idaho at 163, 45 P.3d at 819 (2002).

107. *Grover v. Smith*, 137 Idaho 247, 251, 46 P.3d 1105, 1109 (2002) (quoting *Rhodehouse*, 125 Idaho at 211, 868 P.2d. at 1227). A contrasting approach can be found in neighboring Washington state where usually the qualifications of an expert are within the discretion of the trial judge though "that is not the rule when those qualifications and opinions are part and parcel of a summary judgment proceeding; review is instead de novo." *Elber v. Larson*, 173 P.3d 990, 992 (Wash. Ct. App. Dec. 2007).

108. *Dulaney*, 137 Idaho at 163, 45 P.3d at 819 (citations omitted);

Once the trial court determines that the affidavits are admissible, then the trial court may consider whether the testimony therein creates an issue of fact to withstand summary judgment.¹⁰⁹

Appellate review of the summary judgment decision is de novo.¹¹⁰ In contrast, the question of admissibility of an expert opinion is for the trial court,¹¹¹ and its decision will not be disturbed absent a showing of an abuse of discretion.¹¹² The abuse of discretion review is far more deferential than the de novo review.

Put another way, the burdens of proof and standards of review for the evidentiary motion take precedence over those for summary judgment.¹¹³ By bringing the motion for summary judgment in a medical malpractice case, the defendant can turn the tables. The defendant can go from bearing the fairly heavy burden of summary judgment to forcing the plaintiff into an early show of his best proof.¹¹⁴ On the other hand, summary judgment is intended to be "summary," that is, the defendant should win only if the plaintiff's affidavits fail to such an extent that there is no material fact in issue. The question is whether plaintiff's affidavits indicate that future evidence and future testimony will be sufficient to support a jury verdict in plaintiff's favor.

109. *Id.*

110. Clark v. The Spokesman-Review, 144 Idaho 427, __ n.2, 163 P.3d 216, 220 n.2 (2007) (citing Post Falls Trailer Park v. Frødekind, 131 Idaho 634, 636, 962 P.2d 1018, 1020 (1998)).

111. IDAHO R. EVID. 104(a).

112. McDaniel v. Inland Nw. Renal Care Group-Idaho, L.L.C., 144 Idaho 219, __, 159 P.3d 856, 858–59 (2007) (citing *Dulaney*, 137 Idaho at 163–64, 45 P.3d at 819–20). In reviewing a claim of abuse of discretion, the court considers "(1) whether the lower court rightly perceived the issue as one of discretion; (2) whether the court acted within the boundaries of such discretion and consistently with any legal standards applicable to specific choices; and (3) whether the court reached its decision by an exercise of reason." *Id.*

113. Increasing stringency, on the part of trial courts, in admitting evidence and qualifying experts may stem in part from the influence of national cases like *Daubert v. Merrell Dow Pharm., Inc.*, 509 U.S. 579 (1993). *Daubert* and its progeny established the trial judge as not only the person with the power to screen out unreliable evidence, but also as the gatekeeper who has the obligation to keep unqualified evidence out of the jury's hearing. Margaret A. Berger, *The Supreme Court's Trilogy on the Admissibility of Expert Testimony*, in REFERENCE MANUAL ON SCIENTIFIC EVIDENCE 11–13, (2d ed. 2000). This has led to more challenges, exclusion of expert testimony, and summary judgments. Nicole Waters, *Standing Guard at the Jury's Gate: Daubert's Impact on the State Courts*, in THE WHOLE TRUTH? EXPERTS, EVIDENCE, AND THE BLINDFOLDING OF THE JURY: REPORT OF THE 2006 FORUM FOR STATE APPELLATE COURT JUDGES 49 (Pound Civil Justice Inst. 2007). *Daubert* has not been adopted in Idaho, but the increased role of the judge as gatekeeper may be seeping in. See *Weeks v. E. Idaho Health Servs.*, 143 Idaho 834, __, 153 P.3d 1180, 1184 (2007).

114. See *Ramos v. Dixon*, 144 Idaho 32, __, 156 P.3d 533, 536 (2007) ("To avoid summary judgment for the defense in a medical malpractice case, the plaintiff must offer expert testimony indicating that the defendant health care provider negligently failed to meet the applicable standard of health care practice." (quoting *Dulaney*, 137 Idaho at 164, 45 P.3d at 820)). *Dulaney*, however, remains the leading case on point.

That the trial courts' rulings on admissibility are reviewed for abuse of discretion highlights the twist of sections 6-1012 and 6-1013. Under the guise of an evidentiary provision, the legislature is narrowing the substantive law. Further, an essential and pivotal part of the malpractice case-in-chief is decided before trial, on the defendant's timeline rather than the plaintiff's, and is only minimally scrutinized on appeal because of the abuse of discretion standard. This has not gone without criticism.¹¹⁵ By addressing both the standard of care and the admissibility of expert testimony, the legislature maximized the likelihood that these cases could be decided on summary judgment, thereby avoiding the risk to defendants that a jury would weigh the evidence and apply the standard.

But the legislation did not remove from the courts all power to exercise logic and administer justice. Trial courts retain control over granting extensions to allow plaintiffs ample time to supplement their evidence. In practice, many Idaho trial courts eventually refuse to allow extra time to establish knowledge of the local standard.¹¹⁶ Even if they do allow time for the supplementation of affidavits, defendants may seize this opportunity to attack the credibility of the affiant/expert.¹¹⁷ Plaintiffs must not miss opportunities to ask for ex-

115. See, e.g., *Strode v. Lenzi*, 116 Idaho 214, 218, 775 P.2d 106, 110 (1989) (Bistline, J., dissenting). Justice Bistline was troubled that the plaintiff's expert's qualifications and testimony were required before trial. *Id.* He noted that sections 6-1012 and 6-1013 purported to direct and control how, when, and where an expert qualifies to testify. *Id.* But

it certainly is not required that time and money be expended in doing so *before trial* and in a summary judgment proceeding. I ask, find if you can more explicit language than this:

... such claimant or plaintiff must, as an essential part of his or her case in chief, affirmatively prove by direct expert testimony, . . .

The insurance carriers defending medical malpractice cases have been having a heyday by reason of the district courts' failures to hold them to the plain language of the statute. The statute is there, and it is there to be followed.

The defense in a case is certainly able to engage in discovery as to who will be plaintiff's experts at trial, and undoubtedly has the right to depose them in advance of trial, but the drafters of this particular legislation went this far, and this far only: "Be prepared *at trial* to meet the requirement of putting forth qualified experts."

Id. (quoting IDAHO CODE ANN. § 6-1012 (2004)).

116. See, e.g., *Rhodehouse v. Stutts*, 125 Idaho 208, 214, 868 P.2d 1224, 1230 (1994) (upholding the trial court's denial of leave to amend the expert's affidavit); *Gubler v. Boe*, 120 Idaho 294, 318-19, 815 P.2d 1034, 1058-59 (1991) (Bistline, J., dissenting) (noting that a lawsuit was lost because of the district court's denial of "what likely would have been a continuance of two hours" for the plaintiffs to qualify their experts).

117. See, e.g., *Mains v. Cach*, 143 Idaho 221, 225, 141 P.3d 1090, 1094 (2006) (considering whether the subsequent affidavit "should be disregarded" for contradicting prior testimony).

tensions of time, and if necessary, they must move for reconsideration.¹¹⁸ The Idaho Supreme Court recently reminded trial courts to use their discretion to maintain order and fairness.¹¹⁹

Further, neither the malpractice legislation nor other rules of evidence or procedure render it impermissible for the trial court or the reviewing court to indulge the evidence and make logical inferences from the statements made in the affidavits.¹²⁰ While the plaintiff may not submit affidavits that are merely conclusions¹²¹ at the point of summary judgment, the plaintiff's proof does not need to be impeccable. The courts must keep in mind that if the plaintiff survives summary judgment, the plaintiff's expert may again be scrutinized during motions in limine before trial.¹²² In that context, the expert may be cross-examined about the basis for his assertions.¹²³ Motions in limine are brought much closer to trial than the typical summary judgment motion.¹²⁴ Even after trial has begun and the plaintiff's experts have testified in open court, a motion for a directed verdict may also be made. In other words, the summary judgment motion is only the first of many opportunities for the trial court to re-examine the plaintiff's evidence to ensure that sections 6-1012 and 6-1013 have been obeyed.

To recap, in response to defendant's motion for summary judgment, a plaintiff must establish that his expert's evidence is competent, admissible, and supportive of a conclusion that the defendant healthcare provider negligently failed to meet the applicable standard

118. See, e.g., *Ramos*, 144 Idaho at __, 156 P.3d at 539 (noting that the plaintiff failed "to file a timely motion for reconsideration"); *Puckett v. Verksa*, 144 Idaho 161, __, 158 P.3d 937, 941 (2007) (noting that the district court found summary judgment inappropriate after granting a timely motion for reconsideration because the expert had subsequently become familiar with the standard).

119. *Edmunds v. Kraner*, 142 Idaho 867, 873, 136 P.3d 338, 344 (2006) (encouraging even-handed treatment of plaintiffs and liberality in allowing plaintiffs to add witnesses in response to defendants' witness disclosures); see also discussion *infra* notes 393-408 and accompanying text.

120. This point was made expressly in the medical malpractice context by Justice Bistline, writing for the majority in *Clarke v. Prenger*, 114 Idaho 766, 768, 760 P.2d 1182, 1184 (1988). The composition of the court has changed since then, and the law in Idaho has evolved toward a much stricter approach. But no case has challenged the power of both the trial and the appellate courts to make logical inferences from the information in affidavits presented at summary judgment, even in matters governed by Idaho Code sections 6-1012 and 6-1013.

121. *Ramos*, 144 Idaho at __, 156 P.3d at 536.

122. See, e.g., *Puckett*, 144 Idaho at __, 158 P.3d at 941 (noting that the plaintiff filed a motion in limine before trial and that the district court allowed the expert to be examined).

123. See, e.g., *id.*

124. In federal court, pre-trial disclosure of expert testimony is dealt with separately, usually in pre-trial motions filed close to the date of trial. See FED. R. CIV. P. 26(a)(2)-(3). However, in *Ramos*, the summary judgment motion, motions in limine, and trial dates were all on top of each other. 144 Idaho at __, 156 P.3d at 535.

of healthcare.¹²⁵ The plaintiff does that by submitting an affidavit of an expert showing that he is familiar with the local standard of care; how he became familiar with the local standard of care; what the standard of care was in the relevant time, community, and profession; and detailing how, in his opinion, that standard of care was breached.¹²⁶ The obligation is squarely upon the plaintiff's lawyer to ensure that the expert attests exactly, specifically, and with detail to these facts. Of these required facts, plaintiffs have the most difficulty meeting the requirement that the expert attest to "[t]he magic words"¹²⁷—how *exactly* he became familiar with the local community standard.¹²⁸

F. Some Examples

Analysis of the plaintiff's expert's qualification to testify about the local standard often requires review of the credentials and experience of *both* the expert *and* the local doctor with whom he consults. Readers attempting to skim the cases can get confused about who is attesting to what. I will use "the expert" to designate the plaintiff's primary witness to discuss the standard of care and whether or not it was breached. I will use "the local doctor" for the local contact who is asked by the plaintiff's expert to confirm or modify his understanding of the local standard of care; the local doctor is usually not intended to be a trial witness in the case.

125. *E.g.*, *McDaniel v. Inland Nw. Renal Care Group-Idaho, L.L.C.*, 144 Idaho 219, ___, 159 P.3d 856, 859 (2007); *Dulaney v. St. Alphonsus Reg'l Med. Ctr.*, 137 Idaho 160, 163–64, 45 P.3d 816, 819–20 (2002); *Kolln v. Saint Luke's Reg'l Med. Ctr.*, 130 Idaho 323, 331, 940 P.2d 1142, 1150 (1997). Kelley Ann Porter provides a checklist of requirements for plaintiffs' attorneys attempting to qualify an out-of-area medical expert. Kelley Ann Porter, *Dulaney v. Saint Alphonsus Regional Medical Center: Reconstructive Surgery for Plaintiffs' Medical Nightmare—A Call for Reform of the Local Standard of Care*, 38 IDAHO L. REV. 597, 633 (2002). I have made a similar attempt in the appendix to this article.

126. *E.g.*, *Kolln*, 130 Idaho at 331, 940 P.2d at 1150. The plaintiff must comply with section 6-1013 by offering

evidence showing: (a) that such opinion is actually held by the expert witness; (b) that the expert witness can testify to the opinion with a reasonable degree of medical certainty; (c) that the expert witness possesses professional knowledge and expertise; and (d) that the expert witness has actual knowledge of the applicable community standard of care to which his expert opinion testimony is addressed.

Dulaney, 137 Idaho at 164, 45 P.3d at 820.

127. See *Kozlowski v. Rush*, 121 Idaho 825, 829, 828 P.2d 854, 858 (1992).

128. The cases turning on this are too numerous to list. For an example of how to do things correctly, see *Anderson v. Hollingsworth*, 136 Idaho 800, 803–04, 41 P.3d 228, 231–32 (2001), and *Perry v. Magic Valley Reg'l Med. Ctr.*, 134 Idaho 46, 51–52, 995 P.2d 816, 821–22 (2000).

The details of the leading case show how extremely precise the plaintiff's evidence must be. In *Dulaney v. St. Alphonsus Regional Medical Center*, the plaintiff sued a hospital, an emergency room physician, and an orthopedic surgeon.¹²⁹ In 1994, in Boise, the plaintiff fell.¹³⁰ She was taken to the emergency room, x-rays were taken, and she was released.¹³¹ A few days later she collapsed in excruciating pain.¹³² She was taken back to the emergency room.¹³³ The emergency room physician and a consulting orthopedic surgeon examined her and reviewed the two-day-old x-rays.¹³⁴ They did not order an MRI.¹³⁵ They released her even though she was still in pain and unable to walk.¹³⁶ Two days after that, the plaintiff returned to her home out-of-state and drove directly to the emergency room.¹³⁷ The next day she was given an MRI.¹³⁸ It turned out that she had a block in her spine.¹³⁹ The delay allegedly rendered her a paraplegic.¹⁴⁰

The plaintiff had a hard time finding experts and local doctors. A Washington-based expert testified against the Idaho emergency room physician.¹⁴¹ To learn the local standard of care, he telephoned a former co-worker in Boise who was board certified in both Emergency Medicine and Internal Medicine, but who did not practice emergency room medicine in Boise at the time of the alleged malpractice.¹⁴² This consultation with the local doctor was insufficient to meet the statute because there were no facts showing that the local doctor had knowledge of the standard of care for emergency room physicians in Boise.¹⁴³ It might have been possible that, while practicing internal medicine in Boise, the local doctor had become familiar with the local standard of care for emergency room doctors, but no facts in the record established that familiarity, so no adequate foundation was shown.¹⁴⁴ Because the local doctor's familiarity with the standard was insufficient, there was no adequate foundation for the expert's testimony.¹⁴⁵

129. 137 Idaho at 162, 45 P.3d at 818.

130. *Id.*

131. *Id.*

132. *Id.*

133. *Id.*

134. *Id.*

135. *Id.*

136. *Id.*

137. *Id.*

138. *Id.*

139. *Id.*

140. *Id.*

141. *Id.* at 164-65, 45 P.3d at 820-21.

142. *Id.* at 165, 45 P.3d at 821.

143. *Id.* at 166-67, 45 P.3d at 822-23.

144. *Id.* at 166, 45 P.3d at 822.

145. *Id.* at 167, 45 P.3d at 823.

The *Dulaney* plaintiff also sought to rely on the testimony of another expert, a Washington doctor who was board certified in neurology.¹⁴⁶ That expert telephoned a former associate, who was then living in California but who had practiced neurology in Boise, to ask about neurological tests performed by the defendant orthopedist.¹⁴⁷ But the former associate had presumably not practiced orthopedics or emergency room medicine in Boise.¹⁴⁸ Nor was he asked about the practices of orthopedic surgeons.¹⁴⁹ The district court was also concerned that the former associate had practiced in Boise in 1992 but not in 1994 (the year of plaintiff's injury).¹⁵⁰ Because the local doctor's familiarity with the standard was insufficient, it could not provide foundation for the expert's testimony.¹⁵¹

Finally, the *Dulaney* plaintiff tried to qualify the neurologist by having him speak with an anonymous medical doctor and professor, "a qualified orthopedic physician that is familiar with the standard of care in Boise, both now [at the time of their conversation in 1997 or 1998] and in 1994 [the date of plaintiff's injury]."¹⁵² That anonymous professor had trained orthopedic physicians that "presently" practiced in Boise, but he did not state whether they were practicing in Boise in 1994.¹⁵³ Although he had lectured in Boise, he did not state when.¹⁵⁴ Even though the difference in time was only a few years, this was insufficient to provide information on the standard of care in Boise in 1994 and was thus insufficient to prevent summary judgment for the defendant.¹⁵⁵

Dulaney is a harsh case. Even at this pre-trial, summary judgment stage in the proceedings, neither the supreme court nor the district court viewed it as their job to draw any reasonable inferences that the standard of care in a metropolitan area had not changed in two years, nor were they persuaded by one expert's assertion that the standard was applicable "to any Emergency Department within the

146. *Id.*

147. *Id.* at 172-73, 45 P.3d at 828-29 (Kidwell, J., dissenting).

148. *Id.* at 168, 45 P.3d at 824 (majority opinion).

149. *Id.*

150. *Id.* at 172, 45 P.3d at 828 (Kidwell, J., dissenting). However, the supreme court majority did not to base its decision on those grounds. *Id.* at 168, 45 P.3d at 824 (majority opinion) ("[W]e do not address the issue of whether [the doctor's] knowledge would have complied with the relevant time requirement of Idaho Code § 6-1012.").

151. *Id.*

152. *Id.* at 169, 45 P.3d at 825.

153. *Id.*

154. *Id.*

155. *Id.* The *Dulaney* majority was not moved by the plaintiff's difficulty in finding a local doctor to speak to the expert. Letters had been sent to twenty-two orthopedic physicians in Idaho; none were willing to testify. *Id.* at 173, 45 P.3d at 829 (Kidwell, J., dissenting).

United States of America,"¹⁵⁶ or another expert's assertion that "it would be unlikely that there would be any variations" in the standard.¹⁵⁷ There was no question about the learnedness and experience of the experts, the local doctors, or the anonymous professor. There was no evidence that the standard of care was anything other than what the experts and local doctors had described. The basis for the disqualification turned on the exact specialty in the exact year. The moral of *Dulaney* is that the standard of precision is exceedingly high.

Given the state of Idaho law after *Dulaney*, the very recent unanimous decision in *Ramos v. Dixon*¹⁵⁸ is not a surprise. It is more nearly a cautionary tale for plaintiffs' lawyers. In *Ramos*, the alleged malpractice occurred in Blackfoot, Idaho, in May 2003.¹⁵⁹ The plaintiff alleged failure to diagnose and treat a cardiac condition, resulting in her husband's death.¹⁶⁰ The plaintiff's lawyer told his out-of-state expert to contact a local doctor.¹⁶¹ The local doctor told the expert that he had worked in Blackfoot, but when the expert drafted his affidavit, he could not recall the nature of the local doctor's experience in Blackfoot.¹⁶² Upon the defendant's motion for summary judgment, the plaintiff submitted the affidavit of the expert in which he stated, "I am familiar with the standard of care applicable to family physicians and emergency room physicians in Blackfoot, Idaho, during May 2003."¹⁶³ But the expert failed to provide any facts showing *how* he was familiar with the standard of care in Blackfoot.¹⁶⁴

In view of *Dulaney*'s ruling on a nearly identical statement, the trial court deemed this insufficient, refused to grant leave for the local doctor to clarify his Blackfoot experience, and held that plaintiff had failed to lay an adequate foundation showing that the expert had acquainted himself with the applicable standard of care as it existed in Blackfoot in May 2003.¹⁶⁵ The trial court, therefore, granted summary judgment, which was unanimously upheld on appeal.¹⁶⁶ *Ramos*

156. *Id.* at 171, 45 P.3d at 827.

157. *Id.* at 167-68, 45 P.3d at 823-24 (majority opinion).

158. 144 Idaho 32, 156 P.3d 533 (2007).

159. *Id.* at __, 156 P.3d at 534.

160. *Id.* at __, 156 P.3d at 535.

161. *Id.* at __, 156 P.3d at 536.

162. *Id.* at __, 156 P.3d at 537.

163. *Id.*

164. *Id.* The expert had spoken for twenty-five minutes with the local doctor. *Id.* The expert was asked, in deposition, whether the local doctor had conveyed or whether the expert knew when the local doctor had started practicing in Idaho. *Id.* The expert replied, "I do not remember those details, no." *Id.* The expert's compound answer to the compound question leads one to wonder whether he did not know because he had not asked or because he did not remember. The continuing deposition testimony, transcribed in the opinion, appears to indicate that the expert and the local doctor had indeed spoken about the local doctor's experience and training. *See id.*

165. *Id.* at __, 156 P.3d at 538-39.

166. *Id.*

reaffirmed *Dulaney's* refusal to apply the "liberal construction and reasonable inferences" standard of summary judgment to the question of whether the plaintiff has made the requisite affirmative showing about competence.¹⁶⁷

Idaho law is clear that affidavits must not merely state conclusions but "must present admissible evidence, and must not only be made on the personal knowledge of the affiant, but must show that the affiant possesses the knowledge asserted."¹⁶⁸ The affidavit is "inadmissible to show the *presence* of a genuine issue of material fact if it merely states conclusions and does not set out the underlying facts."¹⁶⁹

Ramos sheds some light on which statements are too conclusory to be allowed.¹⁷⁰ The affiant's statement in *Ramos* was specific about place, time, and medical specialty—"I am familiar with the standard of care applicable to family physicians and emergency room physicians in Blackfoot, Idaho, during May 2003."¹⁷¹—but was still not good enough because it did not provide the background facts, which the court could then scrutinize as it did in *Dulaney*. This was in keeping with the earlier case of *Rhodehouse v. Stutts*. There the expert stated in his affidavit that he was familiar with the applicable local standard of care, but he did not state how he became familiar with it, nor did he indicate that he had contacted a local doctor.¹⁷² Although he had reviewed the deposition of the defendant doctor, the expert had never made direct reference to the local standard of care.¹⁷³

The *Ramos* court made a further point. The plaintiff's attorney had "simply" put the expert in touch with the local doctor and "left it up to [the expert] to make a sufficient inquiry into the applicable standard of care."¹⁷⁴ This was unwise to the point of being "an error."¹⁷⁵ "The attorney must be directly involved in advising the expert

167. *Id.* at __, 156 P.3d at 538 (quoting *Dulaney v. St. Alphonsus Reg'l Med. Ctr.*, 137 Idaho 160, 163–64, 45 P.3d 816, 819–20 (2002)).

168. *Pearson v. Parsons*, 114 Idaho 334, 340 n.1, 757 P.2d 197, 203 n.1 (1988) (Bakes, J., concurring) (quoting *Walling v. Fairmont Creamery Co.*, 139 F.2d 318, 322 (8th Cir. 1943)).

169. *Id.* at 340, 757 P.2d at 203 (citing *Casey v. Highlands Ins. Co.*, 100 Idaho 505, 508, 600 P.2d 1387, 1390 (1979)).

170. *Ramos*, 144 Idaho at __, 156 P.3d at 538.

171. *Id.*

172. *Rhodehouse*, 125 Idaho at 212, 868 P.2d at 1228.

173. *Id.* If the only showing of knowledge of the local standard is an unsupported conclusory statement, that is an insufficient foundation. *Id.* at 213, 868 P.2d at 1229; see also *Strode v. Lenzi*, 116 Idaho 214, 216, 775 P.2d 106, 108 (1989) (finding that the expert's conclusory statements did not create a genuine issue of fact).

174. *Ramos*, 144 Idaho at __, 156 P.3d at 538.

175. *Id.* Nineteen years earlier Justice Huntley hoped that the court was providing sufficient elucidation so that the statute would "no longer serve as a trap for the unwary." *Frank v. E. Shoshone Hosp.*, 114 Idaho 480, 484, 757 P.2d 1199, 1203 (1988) (Hunt-

as to how to learn the applicable standard of care and in determining whether the expert has done so.¹⁷⁶ That message is clear from reading *Dulaney* as well. The lawyers, especially the plaintiff's counsel, must control not only their own deposition questions but also the nature of the underlying exchange between the expert and the local doctor.

The *Ramos* court may have been exasperated by plaintiff's counsel's possible nonchalance about the case.¹⁷⁷ The court was expressly critical of the lawyer's failure to obtain additional affidavits and then file for reconsideration of the order granting summary judgment.¹⁷⁸ The court's approval of the refusal to grant additional time may have largely been an attempt at negative reinforcement of the attorney's behavior.¹⁷⁹ On the other hand, both the trial court and the appellate court may have viewed the affidavit's lack of precision not as a mere oversight but as an indication that the expert was in fact insufficiently versed in the local standard.¹⁸⁰

*Grover v. Smith*¹⁸¹ may be viewed as a case endorsing a slight relaxation in the standards applied to the local expert rule when the defendant doctor allegedly did not meet even the minimum standards required to practice in the state. In that case, the defendant dentist had failed to take a medical history of his patient, the plaintiff.¹⁸² He therefore attributed her headaches to tooth problems, rather than to pre-stroke symptoms, and failed to refer her to a medical doctor.¹⁸³ The plaintiff's out-of-state expert had a hard time finding local dentists willing to go on the record about the local standard of care, but

ley, J., concurring). Alas, his hopes appear to have been too high, as we are still covering the same ground.

176. *Ramos*, 144 Idaho at __, 156 P.3d at 538.

177. The plaintiff's attorney based his plea for more time on the fact that he "was out of the country on a cruise when the [local doctor's] affidavit was obtained and that his paralegal had prepared and obtained it." *Id.* at __, 156 P.3d at 537.

178. *Id.* at __, 156 P.3d at 539.

179. See *id.* Compare *Ramos* with *Gubler*, where the supreme court affirmed a district court's refusal to grant a motion for continuance resulting in dismissal. See *Gubler v. Boe*, 120 Idaho 294, 297, 815 P.2d 1034, 1037 (1991). Because the supreme court felt the "plaintiffs had ample time prior to trial to prepare their witness," the court found that the plaintiffs were not entitled to more time to determine whether the standard of care was the same in 1983 as in 1988 and was the same in Pocatello as in Idaho Falls. *Id.* at 295, 297, 815 P.2d at 1035, 1037. In *Gubler*, the majority opinion appears to fault plaintiffs' counsel for failure to qualify the witness and to reserve the right to recall a witness. *Id.* at 298, 815 P.2 at 1038 (Bistline, J., dissenting). However, the dissent characterized plaintiffs' counsel's efforts as "stalwart." *Id.*

180. See *id.* Deposition testimony of the plaintiff's expert is set out in the case, and is replete with "I do not remember." *Id.* at __, 156 P.3d at 537. On the other hand, the local doctor's affidavit was simply lacking in detail. *Id.* Presumably, the local doctor had some reason for asserting his familiarity with the local standard. See *id.*

181. 137 Idaho 247, 46 P.3d 1105 (2002).

182. *Id.* at 252, 46 P.3d at 1110.

183. *Id.* at 248, 46 P.3d at 1106.

the expert himself claimed to be familiar with a minimum statewide standard regarding the failure to take a health history.¹⁸⁴ The expert testified that an Idaho dental student who failed to take a medical history during the state licensing exam would fail.¹⁸⁵ Crucial to the allowance of this testimony was the expert's testimony about his intimate familiarity with Idaho, the Idaho state exam, and Idaho dentistry students whom he had taught.¹⁸⁶ He was not testifying about a general statewide standard; rather, his testimony was that the care provided by the defendant was below a statewide minimal standard under which no Idaho dentist should fall.¹⁸⁷

Grover should not be read broadly. In other cases, testimony that "no board-certified doctor in the world"¹⁸⁸ or "[no] Emergency Department within the United States of America"¹⁸⁹ would deviate from a specific standard is *not* sufficient evidence of the local standard.¹⁹⁰ While this testimony is quite close to testimony about a minimum state standard, it is, according to current Idaho jurisprudence, insufficient to meet the requirements of section 6-1013. We can guess that the crucial difference in *Grover* is that the expert had specific experience with the Idaho statewide competency test and testified about what performance on that state test would be failing. Certainly, the current Idaho approach to this question can be criticized. In 1989, Justice Huntley wrote in a case alleging failure to detect carotid artery disease before surgery:

I would rule that for purposes of summary judgment,

184. *Id.* at 251–52, 46 P.3d at 1109–10.

185. *Id.*

186. *Id.* *Grover* was decided a few weeks after *Dulaney*. See *Grover v. Smith*, 137 Idaho 247, 46 P.3d 1105 (2002) (decided April 12); *Dulaney v. St. Alphonsus Reg'l Med. Ctr.*, 137 Idaho 160, 45 P.3d 816 (2002) (decided March 21).

187. *Smith*, 137 Idaho at 251–52, 46 P.3d at 1109–10. For a detailed discussion of this case and the plaintiff's attempts to recover damages for medical malpractice, see *infra* notes 324–57 and accompanying text.

188. *Strode v. Lenzi*, 116 Idaho 214, 217, 775 P.2d 106, 109 (1989) (Huntley, J., dissenting) (suggesting that doctors should be held to minimum world-wide standards if applicable). In an earlier case, Justice Huntley had agreed with Justice Bistline (writing for the majority and finding for the defendant) about the wisdom of a "bright line" rule requiring the plaintiffs' expert to become familiar with the local community standard of care, even though the plaintiffs contended that treatment had violated a standard of care in every Idaho community. *Frank v. E. Shoshone Hosp.*, 114 Idaho 480, 484, 757 P.2d 1199, 1203 (1988) (Huntley, J., concurring). *Frank* was a case confused both legally and factually. The opinion does not quote any expert's statement that a state-wide standard of care had been violated, and the expert made the damning statement that he was not familiar with the local standard of care. *Id.* at 481, 757 P.2d at 1200 (majority opinion). The plaintiffs' loss was not surprising.

189. *Dulaney*, 137 Idaho at 171, 45 P.3d at 827 (Kidwell, J., dissenting) (quoting the expert's testimony and concluding that it should be sufficient to create an issue of fact).

190. *Id.* at 166, 45 P.3d at 822 (majority opinion).

when we are dealing with basic, widely acknowledged fundamentals of the practice of medicine, that a prima facie case is made out which will survive summary judgment if a doctor who is board certified testifies as to the minimum standard for all doctors of that certification everywhere.

It is simply a fundamental logic process that if: (1) All board certified orthopedic surgeons must at a minimum listen to the carotid artery; and (2) [the defendant] is a board certified orthopedic surgeon; therefore, (3) his standard is to place the stethoscope on the neck and listen to the artery.

Stated another way, if a witness testifies that no board certified doctor in the world should fail to listen to that artery, and Boise, Idaho is part of the world, then the Boise standard has been met.¹⁹¹

III. CONCERNS

Review of the cases addressing the standard of care raises several related concerns about how this statute is implemented, the incentives that it provides to the medical and legal professions, and the very conception that the local standard of care is the only applicable standard. This section first discusses the problem of professional stonewalling, which prevents plaintiffs from obtaining doctors willing to testify and is increased by the social pressures in small communities in our sparsely populated state. Next, this section examines cases where some trial and appellate courts, in applying the statute, have eschewed making reasonable and logical inferences and granting extensions of time, thereby giving the appearance of distaste for allowing the plaintiff to proceed to trial. Attention is then given to the troubling rule that nationally certified specialists are held accountable to a local, and potentially lower, standard of care rather than the national standard. Then the question is raised whether some cases of negligence have gone unaddressed because of the language of sections 6-1012 and 6-1013 and the courts' interpretation of those provisions and procedural rules. Finally, this section concludes with the suggestion that the interpretation and application of the statutory provisions have the cumulative effect of preventing deserving plaintiffs from obtaining compensation.

191. *Strode*, 116 Idaho at 217, 775 P.2d at 109 (Huntley, J., dissenting).

A. Stonewalling and Small Communities

Lore and law have recognized the reluctance of doctors to testify against each other.¹⁹² Idaho is not immune from this reticence born of combined camaraderie and self-interest. In *Dulaney*, one out-of-state expert contacted twenty-two orthopedic physicians licensed in Idaho, yet none would serve as a local contact.¹⁹³ Even the out-of-state professor/doctor spoke with the expert only anonymously.¹⁹⁴ This may indicate that professional as well as geographic loyalty was at play. In *Grover*, only one of three local dentists was willing to be identified by name even when the defendant's care allegedly fell below statewide minimums.¹⁹⁵ In *Gubler v. Boe*, "the defendant doctor's professional association included all the doctors in Pocatello who could state the applicable standard of care, and these doctors did not make themselves available to the plaintiffs' counsel."¹⁹⁶ In *McDaniel v. Inland Northwest Renal Care Group-Idaho, L.L.C.*, the defendant dialysis service was the only dialysis provider in Coeur d'Alene.¹⁹⁷ In that case, the plaintiffs did not turn to other "similar" Idaho communities because all were allegedly owned by the same parent company and part of the same network as defendant.¹⁹⁸

In occasional cases, local doctors appear to have changed their stories once their local colleagues—defendants—got in touch with them. In *Dunlap v. Garner*, the out-of-state expert stated that he had consulted with two local doctors.¹⁹⁹ He included their telephone num-

192. JOHN BANJA, MEDICAL ERRORS AND MEDICAL NARCISSISM 3 (2005). "An intentional policy of concealing medical errors appears to have begun in the United States in the late 1920s. Before then, surgeons occasionally published case reports that included mention of their errors." *Id.* This practice of concealment evolved from multiple factors, including the rise of malpractice suits. "[T]oday's malpractice climate can make the healthcare professional's honest disclosure of serious harm-causing errors . . . a terrifying, if not foolhardy, affair." *Id.* "[D]isclosing one's own error or a colleague's error poses the risk of financial ruin and loss of professional credibility." Beverly Jones, *Nurses and the "Code of Silence,"* in MEDICAL ERROR, WHAT DO WE KNOW? WHAT DO WE DO? 84, 91 (Marilynn M. Rosenthal & Kathleen M. Sutcliffe eds., 2002). Stonewalling is a national problem. See Baldas, *supra* note 12, at 1, 17 ("It's impossible to get an expert in a small community to testify against a colleague for a plaintiff. The brotherhood is just too tight." *Id.* (quoting a North Carolina plaintiff's attorney)); *Dulaney*, 137 Idaho at 173, 45 P.3d at 828 (Kidwell, J., dissenting).

193. *Dulaney*, 137 Idaho at 173, 45 P.3d at 829 (Kidwell, J., dissenting).

194. *Id.* at 169, 45 P.3d at 825 (majority opinion).

195. *Grover v. Smith*, 137 Idaho 247, 248–49, 46 P.3d 1105, 1106–07 (2002). In that case, the court notes that by filing her lawsuit, the plaintiff was taking on a leader in her church. *Id.*

196. 120 Idaho 294, 299 n.4, 815 P.2d 1034, 1039 n.4, (1991) (Bistline, J., dissenting).

197. 144 Idaho 219, __, 159 P.3d 856, 860 (2007).

198. *Id.*

199. 127 Idaho 599, 602, 903 P.2d 1296, 1299 (1994).

bers and the substance of their conversations.²⁰⁰ Defendants then submitted two rebuttal affidavits from those local doctors, stating that they did not recall speaking with the expert and disputing specific statements attributed to them.²⁰¹ The district court believed the local doctors, found that the expert's testimony lacked foundation, and dismissed the law suit.²⁰² The district court was in error, as it stepped into the province of the jury in determining the credibility question.²⁰³ The supreme court overturned the summary judgment without comment on the fairly extraordinary circumstance of medical professionals apparently accusing each other of lying.²⁰⁴

In *Watts v. Lynn*, an out-of-state dentistry (endodontity) expert attested that he had confirmed the standard of care with a local dentist; the local dentist then submitted a contradictory affidavit.²⁰⁵ The court appropriately overturned the district court's grant of summary judgment because "the trial court [had] erroneously involved itself in weighing conflicting evidence rather than determining whether, for purposes of surviving a summary judgment, [the plaintiff] had offered sufficient evidence."²⁰⁶ Again, either the dentists had a colossal misunderstanding or one was not quite impeccable with his word.

If professional protectionism leads to a dearth of local experts, that problem is compounded in small and socially tight communities. Because of the very problem the legislature was trying to fix by enacting section 6-1013—the low number of medical care providers in certain areas—it can be difficult to find any local doctor other than the defendant, much less find one who is willing to participate in a lawsuit against his fellow townsman. The difficulty may be compounded if a local doctor was on the pre-litigation screening panel for the case. At least one district court has struck a local doctor's affidavit on these grounds.²⁰⁷

In small communities, jurors may be former or current patients of the defendant doctor.²⁰⁸ The Idaho Supreme Court has refused to

200. *Id.*

201. *Id.* at 603, 903 P.2d at 1300.

202. *Id.* at 604–05, 903 P.2d at 1301–02.

203. *Id.* at 605, 903 P.2d at 1302.

204. *See id.* at 605–06, 903 P.2d at 1302–03.

205. 125 Idaho 341, 343–44, 870 P.2d 1300, 1302–03 (1994).

206. *Id.* at 346, 870 P.2d at 1305.

207. *See Shane v. Blair*, 139 Idaho 126, 128, 75 P.3d 180, 182 (2003). The district court struck the local doctor's affidavit because he had sat on the prelitigation screening panel. *Id.* The court granted summary judgment. *Id.* The summary judgment was overturned on other grounds and the Idaho Supreme Court did not reach the issue. *Id.* at 131, 75 P.3d at 185.

208. *See, e.g., Morris v. Thomson*, 130 Idaho 138, 141, 937 P.2d 1212, 1215 (1997). In cases like *Gubler*, where all of the similar care providers are in one practice, juror acquaintance with the doctors is almost inescapable. *See, e.g., Gubler v. Boe*, 120 Idaho 294, 299 n.4, 815 P.2d 1034, 1039 n.4 (1991) (Bistline, J., dissenting) (noting the fact that "the

create a per se rule automatically disqualifying such jurors, despite the relationship of intimate trust between a doctor and a patient.²⁰⁹ In small, isolated communities, the parties may be socially connected or part of other hierarchical systems. For example, imagine the intense emotional pressure on a plaintiff who had first met the defendant doctor because he held a leadership position in her church.²¹⁰ According to J. Michael Wheeler and Reed W. Larsen, lawyers practicing in healthcare law in southeastern Idaho:

[P]hysicians, as a group, are, generally speaking, highly respected members of our communities. Physicians are perceived by most potential jurors as providing an invaluable service to the community. Coupling this positive perception with the conservative make-up of a large portion of the juror

defendant doctor's professional association included all the doctors in Pocatello who could state the applicable standard of care").

209. *Morris*, 130 Idaho at 140, 937 P.2d at 1214. This is not an easy case. The court was probably concerned about the practicalities of finding jurors and trying cases in small communities against popular and successful doctors. More than one juror in the pool had a patient/doctor relationship with the defendant. *Id.* at 141, 937 P.2d at 1215. All but one were excused. *Id.* In its opinion, the court set out the questioning of the one remaining juror. *Id.* at 142, 937 P.2d at 1216. She had seen defendant as a patient and stated "that if she were to go back to a doctor, she would probably return to him," although she had not been to see him for over a year. *Id.* at 141 n.1, 937 P.2d at 1215 n.1. She had stated during voir dire that "she believed that her relationship with Dr. Thomson could affect her ability to render a verdict fair to plaintiff." *Id.* at 142, 937 P.2d at 1216.

The defendant's counsel then led her to change her mind as evidenced by the fact that no question mark appears at the end of his statement to her: "Well, because you think that you wouldn't want someone in your frame of mind sitting on your jury if you were bringing a case, does that mean that you—you *wouldn't certainly be unfair* to either side, I take it." *Id.* (emphasis added). The juror responded: "No, I wouldn't." *Id.* She later testified that she could avoid bias. *Id.*

Surely the standard for juror impartiality in Idaho is higher than "wouldn't *certainly* be unfair." But the majority of the court was satisfied that the prospective juror's subsequent questioning by the court amounted to assurance of her fairness and impartiality. *Id.* at 141, 937 P.2d at 1215. Justice Schroeder, in his concurrence, cautioned extreme care in this matter. *Id.* at 148, 937 P.2d at 1222 (Schroeder, J., specially concurring).

The juror was challenged under IDAHO R. CIV. P. 47(h)(3) as a debtor of the doctor. *Id.* at 140, 937 P.2d at 1215 (majority opinion). As Justice Schroeder noted, most current patients of a doctor would be viewed as a debtor. *Id.* at 148, 937 P.2d at 1222 (Schroeder, J., specially concurring). But also, "[i]ronically, most people are probably more concerned with retaining goodwill with their doctor than with a creditor." *Id.*

Perhaps a better grounds for exclusion would have been IDAHO R. CIV. P. 47(h)(7): "The existence of a state of mind in the juror evincing . . . bias to or against either party." The focus on exclusively financial reasons for bias ignores the most human of human realities. A patient is in an intimate relationship with a doctor. He has touched her and learned her secrets and most private concerns. She has, literally, trusted him with her life in the past. She may need to rely on him in the future—especially given the shortage of doctors in Idaho.

210. See *Grover v. Smith*, 137 Idaho 247, 248, 46 P.3d 1105, 1106 (2002).

population in Idaho, and it is easy to see why claims against physicians are much more difficult than other negligence claims.²¹¹

Crafty lawyering can further exacerbate the difficulty plaintiffs face in bringing their cases to trial.²¹² In *Mains v. Cach*, an expert testifying on behalf of the plaintiff questioned a local doctor about the community standard of care but failed to ask specifically about the relevant year.²¹³ The district court gave the expert seven days in which to update his opinion on the standard of care at the time of the injury.²¹⁴ During those seven days, the defendant retained the local doctor as an expert, thereby foreclosing him from further consultation by the expert retained by the plaintiff.²¹⁵

One solution is for the plaintiffs to move for protective orders to avoid disclosure of the name of the local doctor who speaks with the plaintiff's expert. The motion would be filed in camera and would need to state that the local doctor did not want his name disclosed out of fear of reprisals from other local physicians. One Idaho attorney reports mixed results: the trial judge in one case granted such a motion; a judge in another case denied it and granted summary judgment which he then reversed after she filed for reconsideration.²¹⁶

B. Judges, Juries, and "Super-technical Gloss"²¹⁷

As the cases previously discussed demonstrate, Idaho Code sections 6-1012 and 6-1013 have been used to foreclose jury trials in the medical malpractice area. The statutory locality standard is already a limitation on the plaintiff's proof, especially as it has been interpreted by the supreme court to apply to nationally certified doctors as well as general practitioners.²¹⁸ The trial courts' frequently narrow interpretation and application of the procedural rules have been used to shut down plaintiffs' cases. These practices have been upheld on appeal, as

211. Wheeler & Larsen, *supra* note 35, at 25–26.

212. For an example of abusive litigation tactics, including designation of fifty-three experts, see *Edmunds v. Kraner*, 142 Idaho 867, 877, 136 P.3d 338, 348 (2006). The trial court allowed this and other procedural maneuvering before granting summary judgment, but the supreme court reversed, finding abuse of discretion. *Id.*

213. 143 Idaho 221, 225, 141 P.3d 1090, 1094 (2006).

214. *Id.* at 226, 141 P.3d at 1095.

215. *Id.* The district court dismissed the case because it found the expert's testimony to be contradictory. *Id.* at 224, 141 P.3d at 1093. The supreme court reversed, holding that it is not appropriate for the district court to weigh the evidence and finding that the testimony could be interpreted as consistent. *Id.* at 226, 141 P.3d at 1095.

216. E-mail from Connie W. Taylor, Partner, Clark & Feeney to author (Nov. 26, 2007, 15:18 PST) (on file with author).

217. See *Strode v. Lenzi*, 116 Idaho 214, 218, 775 P.2d 106, 110 (1989) (Bistline, J., concurring in opinion of Huntley, J.).

218. See discussion *supra* Part II.

the supreme court views sections 6-1012 and 6-1013 as statutory mandates to scrutinize the plaintiff's breach evidence prior to trial.²¹⁹

On the other hand, dissenters, and occasionally the majority of the court, have felt compelled to warn against undue incursions on the role of the jury and undue interference with a plaintiff's right to trial.²²⁰ The lengthiest plea came from Justice Bistline in *Gubler*.²²¹ He viewed the question as one of constitutional dimension²²² and cautioned that "procedural regulations should not be so applied as to defeat their primary purpose, that is, the disposition of causes upon their substantial merits without delay or prejudice."²²³ Justice Kidwell made similar objections to *Dulaney's* outcome of dismissal, providing substantial authority for his assertion that sections 6-1012 and 6-1013 were "not intended to be overly burdensome for the plaintiff to meet,"²²⁴ and supporting a conclusion that plaintiff should have had "her day in the Idaho court system."²²⁵ Over the years, dissenters have flung charges that the court was being supertechnical, formalistic, formulaic, and "overly strict and parochial."²²⁶

219. *Id.*

220. *See, e.g., Strobe*, 116 Idaho at 218, 775 P.2d at 110 (Bistline, J., concurring in the opinion of Huntley, J.) (contending that the majority ignored the "plain language" of sections 6-1012 and 6-1013 by applying a "super-technical gloss"); *Clarke v. Prenger*, 114 Idaho 766, 768, 760 P.2d 1182, 1184 (1988) ("We take this occasion to express our disapproval of what appears to be a growing practice among the trial courts of this state dismissing medical malpractice cases at the summary judgment point on the basis that plaintiffs' expert witnesses are not sufficiently familiar with the standard of care to be expected from defendant-physicians."); *Sparks v. St. Lukes Reg'l Med. Ctr.*, 115 Idaho 505, 518, 768 P.2d 768, 781 (1988) (Huntley, J., dissenting) ("I must respectfully dissent because the summary judgment was not properly granted in view of facts and inferences which require resolution by a jury. . . . We should more carefully resist the temptation to invade the province of Idaho juries."); *Maxwell v. Women's Clinic*, 102 Idaho 53, 60, 625 P.2d 407, 414 (1981) (Bistline, J., dissenting) ("It is important to keep in mind that it is not our function to presuppose that a plaintiff's case may not persuade a jury. Nor is the trial court to do so. All that is at stake is whether the plaintiff, as a matter of law, is precluded from placing her case before a jury.")

221. *Gubler v. Boe*, 120 Idaho 294, 298, 815 P.2d 1034, 1038 (1991) (Bistline, J. dissenting).

222. *Id.* at 299, 815 P.2d at 1039. Article 1, section 7 of the Idaho Constitution guarantees the right of trial by jury in civil actions. For a discussion of this section of the Idaho Constitution, see DENNIS C. COLSON, IDAHO'S CONSTITUTION: THE TIE THAT BINDS 43 (1991).

223. *Gubler*, 120 Idaho at 300, 815 P.2d at 1040 (Bistline, J., dissenting) (quoting *Stoner v. Turner*, 73 Idaho 117, 121, 247 P.2d 469, 471 (1952)).

224. *Dulaney v. St. Alphonsus Reg'l Med. Ctr.*, 137 Idaho 160, 169-70, 45 P.3d 816, 825-26 (2002) (Kidwell, J., dissenting). The *Dulaney* case was first issued as a reversal of the district court's ruling, but that opinion was withdrawn. For a critique of the substitute opinion which has become a landmark case, see Porter, *supra* note 125.

225. 137 Idaho at 169, 45 P.3d at 825.

226. *See, e.g., id.*

The unanimous supreme court has held that the end-purpose of procedural rules and findings should be the administration of justice, not termination on a procedural technicality.²²⁷ Yet that same court, at other times, seems to pounce on minor gaps in affidavits, refusing to make inferences. Certainly, given the statutory mandate, the district courts must require that the expert have knowledge of the local standard of care. *Dulaney* stands for that rule. But that does not mean that the courts must be so strict as to be blind. The supreme court's discussion of the disqualification of experts in *Dulaney* is technically accurate, but what it really means is that the plaintiff lost—she never even got to a jury even though at least five doctors in good standing, three of whom had practiced in Boise, agreed on the standard of care. One expert in *Dulaney* stated that the care given the plaintiff would be unacceptable in “any Emergency Department within the United States of America.”²²⁸ That same expert stated, “I think what took place was outside the standard of care of modern Emergency Medicine practice.”²²⁹

Something is wrong when cases like this are dismissed before trial. One answer may be to blame the plaintiff's lawyer. Insufficiently assiduous legwork may underlie some opinions, like *Ramos*, but that charge is harder to levy against the lawyers in *Dulaney*, who sent letters to over “twenty-two orthopedic physicians licensed in Idaho.”²³⁰ None, not even those from out of state, would testify.²³¹ Another answer may be to blame the doctors for their stonewalling. Nonetheless, some accountability must be placed on the trial and the appellate courts for their, at times, crabbed interpretation of the facts presented in affidavits.

C. Logical Inferences

Precision in proof and compliance with sections 6-1012 and 6-1013 are admirable, but the courts can make some logical inferences. Returning to *Dulaney* as the poster child for troubling results: the trial court, and possibly some members of the supreme court,²³²

227. *Edmunds v. Kraner*, 142 Idaho 867, 873, 136 P.3d 338, 344 (2006); *see also Gubler*, 120 Idaho at 299–300, 815 P.2d at 1039–40 (Bistline, J., dissenting) (quoting *Stoner*, 73 Idaho at 121, 247 P.2d at 471).

228. *Dulaney*, 137 Idaho at 171, 45 P.3d at 827 (Kidwell, J., dissenting).

229. *Id.*

230. *Id.* at 173, 45 P.3d at 829.

231. *See id.*

232. Reference is made in the dissent to the question of time but not in the majority. *See id.* at 172, 45 P.2d at 828 (Kidwell, J., dissenting) (“Consequently, the time specificity issue remains unaddressed by this Court.”). *Dulaney* was a legally troubled case with an opinion issued first going in the plaintiff's favor, then withdrawn and reissued going in the defendant's favor. The withdrawn opinion turned on the trial court's error in refusing to admit evidence of the standard in 1992 when “there [was] no evidence or suggestion in

were unwilling to infer that the standard of care had not changed in two years, so that a local doctor who had practiced in 1992 could not provide information about the standard of care in 1994. The proposed local information was that the 1992 standard of care had been breached. To find fault with that information, one must infer that the following two propositions are sufficiently possible to preclude qualification of the expert: (1) that the standard of care might have changed in two years and (2) that it might have changed for the worse. The defendant had presented no evidence that supported either proposition.²³³ In rejecting the plaintiff's local doctor, the district court and the concerned members of the supreme court were making a judgment call that two years was too large of a gap to satisfy the statute. What if the local doctor had practiced only months before (or after) the alleged injury; would that also have been insufficient?²³⁴ At some point reasonable people say, "that's close enough."

Even given the plaintiff's burden to establish the competence of experts under section 6-1013, logical and rational inferences are permissible. This is particularly true in the summary judgment context of I.R.C.P. 56(e), given the pretrial nature of the proceeding and the opportunity for later visitation of the competence question—along with the possibility of cross examination—at a motion in limine closer to trial. Yet several key members of Idaho's judiciary have refused to make such inferences in *Dulaney* and other cases. This practice should be corrected, and the court should expressly instruct district courts to make reasonable, logical, and common sense inferences when evaluating the competence of medical malpractice experts.

D. Unrefuted Assertions

In *Ramos*, the court rejected an argument that has been suggested by dissenters over the years: when some attempt to articulate the local standard of care has been made, the plaintiff's expert could be allowed to testify unless the defendant's expert can articulate a

the record that the standard of care changed in the two-year time period ranging from 1992-1994." *Id.*

233. *Id.*

234. The courts in *Gubler* made similar judgment calls by disallowing evidence given in 1988 about the standard of care in 1983. *See Gubler v. Boe*, 120 Idaho 294, 298, 815 P.2d 1034, 1038 (1991). In that case, five years had elapsed, and it is not impossible that the standard of care had improved between 1983 and 1988, although the expert testified that the standard had been the same for twenty years. *See id.* at 304, 815 P.2d at 1044 (Bistline, J., dissenting); *supra* note 179 and accompanying text. In *Dulaney*, the difference in time was two years, and the earlier 1992 standard of care was the arguably higher one. *See* 137 Idaho at 172-73, 45 P.3d at 828-29 (Kidwell, J., dissenting). It is less logical to entertain a meaningful possibility that a standard had gone down in that time.

lower local standard of care.²³⁵ In other words, when the plaintiff's expert plausibly defines the standard of care and that assertion is not contradicted, then this scenario could meet at least the summary judgment standard.²³⁶ Such a rule would be a change in the existing law, but not an implausible one. As the court has noted, the 1976 legislation was intended to protect doctors but not to be a nearly impenetrable shield for defendants against whom strong evidence of negligence could be amassed.²³⁷

Requiring the defendant to counter the plaintiff's expert's articulation of the standard of care would indicate due respect for the professional status of the affiant experts. If they plausibly assert that they are familiar with the local standard of care and are fairly specific in their statements, naming the locale and the date, they are entitled to some credibility. Even if an assertion seems insufficiently detailed—like the one by the plaintiff's expert in *Ramos*: "I am familiar with the standard of care . . . in Blackfoot, Idaho during May, 2003"²³⁸—is still more than a "mere scintilla" of evidence.²³⁹ That assertion complies with section 6-1013 by indicating familiarity with "the standards and practices of (a particular) such area."²⁴⁰ It could be enough to meet the plaintiff's rule 56(e) burden on the affidavit, thereby returning the burden to the defendant to prove the absence of an issue of material fact for summary judgment purposes.²⁴¹

E. Generosity in Extensions of Time

The courts' opinions demonstrate a desire to follow the will of the legislature, to protect judicial and administrative resources, and to keep plaintiffs' counsel from carelessly filing and maintaining cases that they cannot prove. But the judiciary has not forgotten its call to administer justice, as the supreme court has recently reiterated.²⁴² Perhaps *Ramos* is so peculiar on its procedural facts that not too

235. See *Ramos v. Dixon*, 144 Idaho 32, __, 156 P.3d 533, 538 (2007).

236. See *Strode v. Lenzi*, 116 Idaho 214, 217, 775 P.2d 106, 109 (1989) (Huntley, J., dissenting); *Dulaney*, 137 Idaho at 171–72, 45 P.3d at 827–28 (Kidwell, J., dissenting).

237. See, e.g., *Hoene v. Barnes*, 121 Idaho 752, 756, 828 P.2d 315, 319 (1992).

238. *Ramos*, 144 Idaho at __, 156 P.3d at 537.

239. "The non-moving party's case must be anchored in something more than speculation, and a mere scintilla of evidence is not enough to create a genuine issue of fact." *Anderson v. Hollingsworth*, 136 Idaho 800, 802–03, 41 P.3d 228, 230–31 (2001) (citing *Tuttle v. Sundenga Indus., Inc.*, 125 Idaho 145, 150, 868 P.2d 473, 478 (1994)).

240. IDAHO CODE ANN. § 6-1013 (2004).

241. It might have been more appropriate, in a procedurally tangled case like *Ramos*, for the trial court to hold the full-blown hearing on the motions in limine rather than to rule on the summary judgment. That would have signaled a preference for more fact-finding, rather than less, and more attention to who really knew what as opposed to who had filed what court papers. Note that it is hard to decipher from the opinion exactly which motions were heard and argued when. See *Ramos*, 144 Idaho at __, 156 P.3d at 535.

242. See *Edmonds v. Kraner*, 142 Idaho 867, 878, 136 P.3d 338, 349 (2006).

much should be generalized from the rulings it generated.²⁴³ Nonetheless, that trial court's apparent refusal to grant more time, apparently upheld by the supreme court, seems misplaced.²⁴⁴ Both courts were irritated by their perception of inadequate lawyering and a failure to make the proper motions in a timely fashion. The supreme court concluded its *Ramos* opinion with a quote praising the virtue of reconsideration: "The chief virtue of a reconsideration is to obtain a full and complete presentation of all available facts, so that the truth may be ascertained, and justice done, as nearly as may be."²⁴⁵ This is a curious way to end an opinion that precludes a plaintiff from gathering additional evidence and shuts her out of court before the facts of her case have been given full airing.²⁴⁶

The *Ramos* court apparently wanted to teach the plaintiffs' bar a lesson, namely, that they must work with their experts to provide more detail in depositions and affidavits. The lawyer's job is to make sure the proper facts are gathered and then asserted in proper evidentiary fashion. Even so, it was extreme not to allow the expert more time to add further details about his conversation with the local doctor,²⁴⁷ especially at this summary judgment stage in the proceedings. Keep in mind that the expert had consulted a local doctor in Idaho Falls about the standard of care in Blackfoot, thirty-two miles away; there is overlap in the hospital service to both towns.²⁴⁸

Thus, the concern returns full circle to the Idaho courts' refusal to make logical, rational inferences that are not precluded by the stat-

243. See *supra* notes 158–76 and accompanying text.

244. At the hearing on summary judgment, counsel asked for leave to confer with the local doctor. *Ramos*, 144 Idaho at __, 156 P.3d at 537–38. The court indicated that counsel should have obtained another affidavit from the expert and then filed for reconsideration. *Id.* at __, 156 P.3d at 539. Obviously the ideal—or even the standard—practice would be to have this information in place well before the summary judgment hearing.

245. *Id.* at __, 156 P.3d at 539 (quoting *J.I. Case Co. v. McDonald*, 76 Idaho 223, 229, 280 P.2d 1070, 1073 (1995)).

246. Even after trial there can be significant debate about whether a sufficient foundation was laid. See, e.g., *Kozlowski*, 121 Idaho 825, 837–38, 828 P.2d 854, 866–67 (1992) (Bakes, J., dissenting); *id.* at 841, 828 P.2d at 870 (Boyle, J., dissenting).

247. For another extreme case, see discussion of *Gubler v. Boe*, 120 Idaho 294, 815 P.2d 1034 (1991), *infra* notes 283–315 and accompanying text.

248. *Ramos*, 144 Idaho at __, 156 P.3d at 535. Compare Blackfoot, Idaho Detailed Profile, <http://www.city-data.com/city/Blackfoot-Idaho.html> (last visited Feb. 12, 2008), with Idaho Falls, Idaho Detailed Profile, <http://www.city-data.com/city/Idaho-Falls-Idaho.html> (last visited Feb. 12, 2008). Blackfoot is slightly closer to Pocatello than to Idaho Falls. The Blackfoot webpage lists its own Bingham Hospital and some Pocatello hospitals. The Idaho Falls webpage lists its own hospitals and the Blackfoot Hospital. The *Ramos* court writes that "whether Idaho Falls is within the geographical area ordinarily served by the hospital in Blackfoot is a factual issue, and there is no evidence in the record on that issue." 144 Idaho at __, 156 P.3d at 536. Plaintiff's counsel agreed during oral argument "that the applicable standard of care was that practiced in Blackfoot." *Id.* at __, 156 P.3d at 536–37.

ute. If Idaho Falls and Blackfoot were not at least partially served by the same hospital, the legislation in section 6-1012 would preclude considering an Idaho Falls doctor "local" in Blackfoot. But given the overlap in hospital coverage, the proximity of the towns, and the specific assertion of the professional in good standing that he was familiar with the Blackfoot standard of care, the plaintiff's case seems undeserving of pre-trial and summary dismissal. The refusal to grant more time seems unduly hasty.

F. Local Standard for Nationally Certified Specialists

In non-medical negligence law, the defendant's behavior is usually assessed against the reasonable person standard. The standard is external and objective, rather than individual and subjective. The common wisdom is that the law should have no favorites, so the standard should not vary from case to case. "At the same time, it must make proper allowance for the risk apparent to the actor, for his capacity to meet it, and for the circumstances under which he must act."²⁴⁹ In other words, that objective standard is gentled by taking into account the situation in which the defendant finds himself.

The 1976 legislature exercised its prerogative to treat medical care providers as "favorites" by continuing, and even narrowing, the traditional "local custom" standard rather than adopting the reasonable person standard. It is true that in Idaho, especially in far-flung or impoverished areas, hospitals, equipment, and other facilities may not be as extensive as they are where most American specialists practice. It does not follow, however, that "local" custom for nationally certified specialists is anything other than that of the national community.

To be in keeping with established negligence law, the standard of care for nationally certified specialists could be that of the national expert in the place where the defendant care provider was working. Thus, the standard would not change with the locality, but the circumstances would change with the situation presented to this particular medical provider when he was treating this particular plaintiff. So, if a piece of equipment were not available to the Idaho practitioner, the standard would be that of the national specialist who did not have the equipment available. The essential question might become when a patient should be sent to a place with better medical facilities. In some ways, this would be more friendly to defendants than the current rule. For example, the behavior of a defendant might vary with the weather and the possibility of air-lifting a patient to another larger or more specialized hospital. The temporary or permanent limitations of working in a given community should be taken

249. KEETON ET AL., *supra* note 22, § 32, at 174.

into account in order to be fair, but the standard itself need not dip below the national standard for someone nationally trained and certified, subjected to national continuing education requirements, and charging specialist rates.

This was the position taken in *Buck v. St. Clair* by a majority of the court, over a strong dissent.²⁵⁰ It was effectively reversed two years later by *Grimes v. Green*, over an even stronger dissent.²⁵¹ This quick change in rules was regrettable, and the likelihood is small that the supreme court will reverse once again. Any change is unlikely to come from the legislature if it wants to guard Idaho's reputation as more protective of doctors than other states.²⁵² Nonetheless, this article would not be complete without calling into question whether a nationally certified specialist should be held to a local, rather than a national, standard.

G. Tolerance of Negligence?

The most serious charge against the current state of the law in Idaho is that it tolerates negligent provision of medical care. The strict locality requirement imposed by section 6-1012 indicates on its face that no further inquiry will be made as long as the medical provider complies with the standard of his fellows in the locality.

The statute, as interpreted by the court, has become even more narrow than its language mandated. It is by judicial ruling that Idaho's nationally certified board specialists are not held to a national standard.²⁵³ The court has also strictly enforced and strengthened procedural and evidentiary burdens: requiring painstaking specificity in affidavits, upholding refusals to grant more time, and allowing frequent granting of summary judgment motions.

The current medical malpractice jurisprudence of Idaho could lead to a failure to compensate plaintiffs injured by a healthcare provider's negligence. It may even be designed to lead to such a result. This could happen for one of two reasons: (1) the local standard of care is so low as to be below the national standard or is objectively negligent or (2) the plaintiff is procedurally blocked from proving that

250. 108 Idaho 743, 745, 702 P.2d 781, 783 (1985).

251. 113 Idaho 519, 524, 746 P.2d 978, 983 (1987) (Huntley, J., dissenting). The court might have done better to reverse *Buck* outright as the majority opinion seems disingenuous in its attempt to reconcile the cases. See *id.* at 522, 746 P.2d at 981 (majority opinion); *supra* note 85.

252. In reality, the change in a rule would probably not be apocalyptic as the Idaho doctors do not appear often to fall below national standards. See *infra* notes 254-62 and accompanying text.

253. See, e.g., *Grimes*, 113 Idaho at 521-22, 746 P.2d at 980-81.

the provider's conduct fell below the local standard, even if the local standard of care is reasonable and on a national level.

First, reading the appellate cases, there is *not* much clear evidence that the local standard in Idaho is actually inferior to the national standard, nor that the standards are often in conflict. One case that does so indicate resulted in a defense verdict because of the statutorily mandated local standard.²⁵⁴ *Grimes v. Green* arose in 1981 in Blaine County.²⁵⁵ The alleged malpractice was that a nationally board-certified obstetrician-gynecologist failed to make a sufficiently early diagnosis of amnionitis.²⁵⁶ Amnionitis is a bacterial infection of the amniotic fluid surrounding the fetus.²⁵⁷ The delay allegedly caused the still birth of the baby and a hysterectomy for the mother.²⁵⁸ The plaintiffs' experts testified to a national standard of care for a board-certified obstetrician-gynecologist.²⁵⁹ The national standard, under these circumstances, was to use amniocentesis to diagnose amnionitis.²⁶⁰ Amniocentesis involves insertion of a needle "into the amniotic sac to withdraw a sample of the amniotic fluid for analysis."²⁶¹ The defendant's experts "testified that amniocentesis was not routinely used in the Twin Falls area due to the danger that the insertion of a needle into the amniotic sac might convey into the sac bacteria from other infected tissue."²⁶²

The plaintiffs in *Grimes* also alleged that the doctor failed to note any tests or results on her chart for the first three days she was in his care (presumably because he thought she was going to die).²⁶³ He also failed to conduct follow-up Gram Stains or cervical cultures.²⁶⁴ The plaintiffs' experts testified that these tests should have been given.²⁶⁵ The case went to a jury, which was instructed to apply the local standard.²⁶⁶ Ten hours into deliberation, the jury requested clarification of the "standard of care at Twin Falls" and was told that it was a "fact question solely in the province of this jury to determine based upon the testimony given in open court and the instructions already given in the case."²⁶⁷ The jury found for the defendant.²⁶⁸ The instructions were upheld and the verdict was allowed to stand.²⁶⁹

254. *See id.*

255. *Id.* at 519, 746 P.2d at 978.

256. *Id.* at 520, 746 P.2d at 979.

257. *Id.* at 519, 746 P.2d at 978.

258. *Id.* at 520, 746 P.2d at 979.

259. *Id.*

260. *Id.*

261. *Id.*

262. *Id.*

263. *Id.* at 522, 746 P.2d at 981 (Huntley, J., dissenting).

264. *Id.*

265. *Id.*

266. *Id.* at 520, 746 P.2d at 979 (majority opinion).

267. *Id.* at 523, 746 P.2d at 982 (Huntley, J., dissenting).

The defense verdict in *Grimes* may be exactly what the legislature intended. The doctor was working in a smaller, less well-equipped hospital than that in which the mother's life was ultimately saved. It is possible that the local standard of care—not using amniocentesis—reflected the lack of relevant emergency equipment available in the area.²⁷⁰

Grimes is one of the few cases where the independent experts disagreed about what was the appropriate standard of care. It is also one of the few examples where the local standard of care may have been what most doctors across the nation would deem negligent.

Another example of conflict may be *Hough v. Fry*,²⁷¹ but it is hard to tell from the opinion as this question was not at issue. The alleged malpractice in that case took place in Emmett where plaintiff had sought "physical therapy for chronic ankle instability."²⁷² She was doing better, to the point that the defendant physical therapists determined that she could step on a balance board without the aid of parallel bars to grab onto if she fell.²⁷³ The defendants' employee instead used his hands to steady her, but alas, "the board shot away and she fell on her buttocks."²⁷⁴ Testimony of the parties varied whether the plaintiff sustained any injuries and immediate pain from the fall, but the plaintiff alleged that the incident led to the need for neck surgery.²⁷⁵

At first, the plaintiff thought that no other physical therapists practiced in Emmett apart from those affiliated with defendant.²⁷⁶ She therefore sought an Orofino expert to testify about the standard in Orofino, a comparable community.²⁷⁷ The Orofino expert indicated that the defendant's care was below the standard for Orofino.²⁷⁸ It turned out that other physical therapists did practice in Emmett, and after consultation with them, the Orofino expert reversed his opinion,

268. *Id.* at 522, 746 P.2d at 981 (majority opinion).

269. *Id.* *Grimes* was decided during the confusion following *Buck v. St. Clair*, 108 Idaho 743, 702 P.2d 781 (1985), and the legal issue was whether or not the local or the national standard should prevail for nationally certified board specialists. The jury's verdict in *Grimes* was upheld despite the trial court's granting of a new trial. *Id.*

270. Of course, a lack of facilities or equipment could be taken into account when a national standard of care is applied, and there are many arguments for using a national standard of care for nationally board certified specialists. *See, e.g., id.* at 524–25, 746 P.2d at 983–84 (Huntley, J., dissenting). For an argument that the national standard should be the presumed standard, see the discussion in Part III.D.

271. 131 Idaho 230, 953 P.2d 980 (1998).

272. *Id.* at 231, 953 P.2d at 981.

273. *Id.* at 231–32, 953 P.2d at 981–82.

274. *Id.* at 232, 953 P.2d at 982.

275. *Id.*

276. *Id.*

277. *Id.*

278. *Id.*

concluding that the community standard of care for Emmett had been met.²⁷⁹ This may indicate that the standard of care for Emmett was below that of Orofino. The plaintiff thereupon tried to argue that the negligence was so obvious as to be "ordinary," so the statute did not apply and no expert was needed.²⁸⁰ This was deemed to be a frivolous position, and attorneys' fees were awarded to the defendants.²⁸¹

Second, and far more often, the local standard of care is never established in open court. A plaintiff may have found an expert who believes the defendant did not behave appropriately. The expert may further believe that the defendant's behavior is below the local standard of care. But the plaintiffs can find no way to establish that these experts have sufficient knowledge of the local standard of care, so the expert's opinion is excluded. This can happen if no one, not even the defendant doctor, testifies that the local standard of care is different or lower than that stated by the expert. It can happen even when the defendant has fallen below its own operating standards.²⁸² Yet the plaintiff's case still fails, often at summary judgment, for insufficient direct proof of the standard of care. These cases are extremely troubling because the jury is not getting to hear evidence—or is not being convened at all—due to procedural blockades to the airing of the full story.

For example, the following facts emerge from a reading of *Gubler*, where a urinary tract infection and obstruction went undetected for in a newborn for six months, resulting in lifelong medical problems for the child.²⁸³ The allegation was that the defendant doctor, a nationally board-certified specialist, failed to palpate the child's bladder, failed to read the nurse's notes, failed to read the results of a test he had ordered, and failed to order follow up tests.²⁸⁴ The alleged malpractice occurred in Pocatello in 1983.²⁸⁵ All of the other pediatricians in Pocatello were associated with the defendant clinic.²⁸⁶ In 1988, plaintiff's expert had consulted with an Idaho Falls doctor in an at-

279. *Id.*

280. *Id.* at 232-33, 953 P.2d at 982-83.

281. *Id.* at 233-34, 953 P.2d at 983-84.

282. *See, e.g.,* Dekker v. Magic Valley Reg'l Med. Ctr., 115 Idaho 332, 335, 766 P.2d 1213, 1216 (1988) (Huntley, J., dissenting).

283. *Gubler v. Boe*, 120 Idaho 294, 295, 815 P.2d 1034, 1035 (1991).

284. *Id.* at 297, 815 P.2d at 1037. "The record is unclear whether he requested the hospital to forward him a copy of the SMAC test report from the lab. He testified that the first time he saw the actual written report was in preparation for trial." *Id.* at 297 n.3, 815 P.2d at 1037 n.3.

285. *Id.* at 295, 815 P.2d at 1035.

286. *Id.* at 299 n.4, 815 P.2d at 1039 n.4 (Bistline, J., dissenting). The dissent noted that because all of the other pediatricians in Pocatello were associated with the defendant clinic, the pre-litigation medical screening panel used an Idaho Falls doctor. *Id.* at 299, 815 P.2d 1039. The plaintiff's expert at trial was also from Idaho Falls. *Id.*

tempt to get local information.²⁸⁷ Idaho Falls is forty-eight miles away from Pocatello and is comparable in size to Pocatello, but it is not served by the same hospital.²⁸⁸ The “local Idaho Falls doctor” was, therefore, deemed to be insufficiently local to Pocatello.²⁸⁹ It was not impossible that he could have some personal knowledge of local practice in Pocatello,²⁹⁰ but he was not specifically asked this question.²⁹¹ Nor was he asked about the local practice in the specific year of 1983.²⁹² Rather, the conversation between him and the expert turned on the practice in 1988.²⁹³ No one who has been keeping up with the cases of the last sixteen years of cases will be surprised to read that this was deemed insufficient to comply with the statute. But looking further into the facts of the case, this is a troubling result.

In an irregular move, the district court itself engaged in questioning of plaintiff's expert during a motion to exclude the expert.²⁹⁴ Both the expert and the defendant doctor testified in this hearing on the evidence, a hearing that the district court deemed, “on a foundational matter, it's somewhat like a court trial.”²⁹⁵ The judge asked plaintiff's expert if he was familiar with the local standard of care.²⁹⁶ Dissatisfied with the answers, the judge ruled that the expert was not qualified to testify.²⁹⁷ The judge impatiently allowed the expert ten to fifteen minutes to try to call the Idaho Falls doctor he had previously consulted, but not surprisingly, he was unable to reach him.²⁹⁸ The plaintiff moved the court to recall the defendant to testify as to the local standard.²⁹⁹ This was denied for failure to “reserve the right to recall him.”³⁰⁰ The plaintiff then moved for a continuance to allow the plaintiffs to further qualify their expert.³⁰¹ This was denied,³⁰² and the

287. *Id.* at 298, 815 P.2d at 1038.

288. *See id.* at 299, 815 P.2d at 1039.

289. *Id.* at 295, 815 P.2d at 1035 (majority opinion).

290. For a case coincidentally also involving Idaho Falls and Pocatello, in which a Utah consultant was deemed to have personal knowledge on the standard of care in both towns, see *Shane v. Blair*, 139 Idaho 126, 130, 75 P.3d 180, 184 (2003).

291. *Gubler*, 120 Idaho at 304, 815 P.2d at 1044 (Bistline, J., dissenting).

292. *Id.*

293. *Id.*

294. *Gubler*, 120 Idaho at 298, 815 P.2d at 1038.

295. *Id.* at 311, 815 P.2d at 1051.

296. *Id.* at 312, 815 P.2d at 1052.

297. *Id.* at 299 n.5, 815 P.2d at 1039 n.5.

298. *Id.* at 301–02, 815 P.2d at 1041–42.

299. *Id.* at 295, 815 P.2d at 1035 (majority opinion).

300. *Id.*

301. *Id.*

302. *Id.* at 296–97, 815 P.2d at 1037–38 (“From the Court's perspective, plaintiff's counsel failed to adequately prepare Dr. Tune to testify as to the appropriate standard of care . . .”).

action was dismissed in what the supreme court majority called "summary judgment" and what the dissent called a "directed verdict."³⁰³

This defense verdict was granted in the face of evidence that the expert asked the Idaho Falls doctor whether the local standard deviated from the national standard, and was told that it did not.³⁰⁴ Additionally, the expert testified that the standard of care had not changed in the last twenty years, nor in the last seven, and that the diagnosis of urinary tract infection and obstruction was "classic text book material learned in medical school as basic medical training."³⁰⁵ The Idaho Falls doctor had confirmed this, stating that "he had practiced medicine in four states and the standard was the same throughout."³⁰⁶ Further, the defendant doctor did not contradict the expert as to the standard of care in the area and, in fact, arguably corroborated it. He testified that his own "custom" was to review tests after they were ordered, and he admitted that in this case he did not.³⁰⁷ The follow-up tests at issue were not ordered as a matter of medical judgment, not because of geographic isolation or regional poverty. The defendant doctor admitted that he had failed to order follow-up tests even though they were available in the locality and that he had ordered them in the past.³⁰⁸ In the court's characterization of his testimony, "[t]his isn't a sophisticated test."³⁰⁹

The trial judge himself was concerned that his own ruling gave the expert only fifteen minutes to speak with the Idaho Falls doctor.³¹⁰ He wrote that he had looked for a way to grant a new trial, but was "unable to find any provision in Rule 59(a) or (e) which would allow the court to grant a new trial to avoid what may be a miscarriage of justice."³¹¹ This is an astonishing statement, as the purpose of procedural rules vesting discretion in the trial judge is to allow the judge to carry out justice.

But the result from the supreme court majority is even more astonishing—the dismissal was upheld.³¹² To recap, the dismissal was in the face of the following: the questionable procedural posture of the

303. Compare *id.* at 295–96, 815 P.2d at 1035–36, with *id.* at 302 n.7, 815 P.2d at 1042 n.7 (Bistline, J., dissenting). The distinction matters because in moving for a directed verdict, a defendant is admitting the truth of all the plaintiff's evidence "and [of] every inference that may legitimately be drawn therefrom in the light most favorable to the opposing party." *Id.* at 314, 815 P.2d at 1054 (Bistline, J., dissenting) (quoting *All v. Smith's Mgmt. Corp.*, 109 Idaho 479, 480, 708 P.2d 884, 885 (1985)).

304. *Id.* at 318, 815 P.2d at 1058.

305. *Id.*

306. *Id.* at 312, 815 P.2d at 1052.

307. *Id.* at 306–07, 815 P.2d at 1046–47.

308. *Id.* at 308, 815 P.2d at 1048.

309. *Id.*

310. See *id.* at 302, 815 P.2d at 1042.

311. *Id.* at 318, 815 P.2d at 1058.

312. *Id.* at 298, 815 P.2d at 1038 (majority opinion).

case, the trial judge's displeasure with the result, the high likelihood that the local standard of care at the time of the alleged tort was exactly that testified to by the expert, the near-admissions by the defendant, and the presumptions in favor of the non-moving party. One would expect all this to lead to reversal of the dismissal. Failure to read notes and test results seems negligent even to a lay person. Dissenting Justice Boyle simply cited testimony that to him established substantial "direct and poignant" evidence of breach of the local standard of care.³¹³ Yet the plaintiff's case was dismissed before the jury could convene, hear evidence, or deliberate. The reason for this dismissal was that a doctor living forty-eight miles away from the locus of the alleged tort was not deemed a "local doctor," and because in the expert's inquiry about the local standard, he did not ask about a potential five-year difference in standards.³¹⁴ Dismissal was upheld despite the stated belief of two professionals (the expert and the Idaho Falls doctor), unrefuted by a third doctor (the defendant doctor), that the local standard was as stated by the expert.³¹⁵ This is formalism *ad absurdum*.

By validating what even the district judge called a miscarriage of justice, the three justices in the majority must have been trying to make a point.³¹⁶ Perhaps it was no more than to register impatience with the imperfections of plaintiffs' trial lawyers and endless delays. Or perhaps the point was even simpler: to remind legal practitioners that "the statute is both site and time specific."³¹⁷ The learning curve has been long in medical malpractice. In 2007, sixteen years after *Gubler*, the supreme court is still chiding plaintiffs' lawyers for providing conclusory assertions and affidavits,³¹⁸ and this article is being written largely to remind the bar of the court's insistence upon site and time specificity.

But even so, the result in *Gubler* is hard to defend. Back in 1991, when the case was decided, the law was still in some flux. Dissenting Justice Bistline was still arguing for application of a national standard against a nationally certified specialist and asserting the viability of *Buck*, which had been questioned only four years before in

313. *Id.* at 319–20, 815 P.2d at 1059–60 (Boyle, J. dissenting).

314. *See id.* at 299–300, 815 P.2d at 1038–39 (Bistline, J., dissenting).

315. *Id.* at 298, 815 P.2d at 1038.

316. Emotions on the court must have been running high as this case was discussed. The majority opinion is singularly disingenuous. The majority oddly noted that the expert had not examined the plaintiff when he was sick (obviously not). They seemed blind to the essence of plaintiff's case—that the negligence lay in the doctor's omission to palpate the bladder. *See id.* at 297, 815 P.2d at 1037 (majority opinion). Justice Bistline's twenty-one page dissent, complete with prologue and personal recollections, is far ranging and nearly explosive in rebuttal. *Id.* at 298–319, 815 P.2d at 1038–59 (Bistline, J., dissenting).

317. *Id.* at 296, 815 P.2d at 1036 (majority opinion).

318. *See Ramos v. Dixon* 144 Idaho 32, ___, 156 P.3d 533, 536 (2007).

Grimes.³¹⁹ Given the confusion in the law, the lawyers might have been excused for failing to ask perfect questions. Even if the members of the majority were irritated with the lawyers, they seem unconcerned that a small failure by counsel could end a trial of this magnitude—the boy was permanently disabled. *Gubler* seems to stand more nearly for the proposition that speedy resolution of matters overrides deliberation on the facts by the jury.

If *Gubler* stood alone, it would not warrant so much attention in this article. But the supreme court's formalistic approach has continued. Again, *Dulaney* stands out as a case where the law was applied so strictly as to have been misapplied. The court was so wedded to formulaic recitals of the local standard that it upheld dismissal of the case, despite the agreement of five doctors about a basic standard of care.³²⁰ It does not strain credulity to learn that a patient complaining of a back injury "should not have been discharged from the Emergency Department if she couldn't walk."³²¹ The case was dismissed before trial, even before motions in limine and cross examination of her experts, because the plaintiff could not satisfy the court that she had complied with the statute.³²² The defense offered no proof that emergency room care in Boise differed from the standards established by the experts' testimony.³²³ Yet the case was summarily dismissed at a stage so preliminary that it is unknown whether the defendant could have countered the plaintiff's evidence about the standard of care.

H. The Combination

The potential conspiracy of silence among medical professionals, the narrow legislative confines of acceptable experts, and the courts' reticence to make logical inferences combine to put plaintiffs in a difficult position. The story of Sharon Grover provides a telling example. Unlike a fair number of Idaho plaintiffs, she was partially successful in recovering from her injuries, although not without two trips to the Idaho Supreme Court.³²⁴

319. *Gubler*, 120 Idaho at 303–04, 815 P.2d at 1043–44 (Bistline, J., dissenting); see also *Buck v. St. Clair*, 108 Idaho 743, 702 P.2d 781 (1985), distinguished by *Grimes v. Green*, 113 Idaho 519, 521, 746 P.2d 978, 980 (1987).

320. *Dulaney v. St. Alphonsus Reg'l Med. Ctr.*, 137 Idaho 160, 45 P.3d 816 (2002); see also *supra* notes 129–57 and accompanying text.

321. *Id.* at 165, 45 P.3d at 821.

322. *Id.* at 162–63, 45 P.3d at 818–19.

323. See *id.* at 172, 45 P.3d at 828 (Kidwell, J., dissenting).

324. *Grover v. Isom*, 137 Idaho 770, 772, 53 P.3d 821, 823 (2002); see also *Grove v. Smith*, 137 Idaho 247, 46 P.3d 1005 (2002).

Grover's tooth pain began in the small town of Fruitland, Idaho.³²⁵ She "had chronic problems with her upper left teeth" and then began having headaches "on the upper right side of her head, above her temple."³²⁶ Over the telephone, without examining Grover, her dentist "diagnosed the pain as a continuing problem with her upper left teeth."³²⁷ He prescribed painkillers.³²⁸ A month or so later, she still had pain. Still over the telephone, the dentist told her that "a tooth [or two] would need to be pulled".³²⁹ He sent her to an oral surgeon over the border in Ontario, Oregon.³³⁰ She appeared at his office and "completed a patient intake questionnaire."³³¹ The questionnaire "did not contain any questions regarding headaches."³³² Grover testified that she told the receptionist, the oral surgeon, and the surgeon's certified registered nurse anesthetist (CRNA) "that she had been experiencing severe right-sided headaches."³³³ None of these three people remembered her making those statements.³³⁴

She was anesthetized and the surgery was completed, but she did not wake up.³³⁵ She had suffered a stroke.³³⁶ After an operation at St. Alphonsus in Boise she was revived but lost the use of her left arm, had difficulty walking, required assistance in daily living, and was divorced by her husband.³³⁷

She sued the oral surgeon and his CRNA in Idaho court "because all parties were Idaho domiciliaries."³³⁸ The court applied Oregon law because the oral surgeon's office—the site of the alleged tort—was located just over the border in Ontario, Oregon.³³⁹ The jury found that the oral surgeon³⁴⁰ had breached the standard of care, but that his

325. *Smith*, 137 Idaho at 248, 46 P.3d at 1106. On its website, the town of Fruitland describes itself: "We are a small rural community of just over 4,250 residents located in southwest Idaho." City of Fruitland—Welcome to Our Website!, <http://www.fruitland.org> (last visited Feb. 10, 2008). Another website states: "The population of Fruitland is approximately 3,805 (2000). The approximate number of families is 1,165 (2000)." Fruitland Idaho Profile and Resource Guide, <http://www.usacitiesonline.com/idcountyfruitland.htm#location> (last visited Feb. 10, 2008).

326. *Smith*, 137 Idaho at 248, 46 P.3d at 1106.

327. *Id.*

328. *Id.*

329. *Id.*

330. *Isom*, 137 Idaho at 772, 53 P.3d at 823.

331. *Id.*

332. *Id.*

333. *Id.*

334. *Id.*

335. *Id.*

336. *Id.*

337. *Id.*

338. *Id.*

339. *Id.*

340. The Oregon Board of Dentistry took action against the oral surgeon. *Id.* at 775, 53 P.3d at 825.

CRNA had not.³⁴¹ But the jury found that her stroke began before she visited the oral surgeon's office and, astonishingly, that she "contributed 100% to her own injuries."³⁴² One can only guess at the reason for this placement of full responsibility on her shoulders—possibly resulting from her ignoring her own symptoms, failing to seek help from a medical doctor, and failing to inform the oral surgeon and the CRNA of her symptoms in a way that they would not forget.

She fared better in her suit against the general dentist for failing to refer her to a medical doctor.³⁴³ The tort occurred in Idaho, so Idaho law applied. Summary judgment was granted against her but was overturned by the supreme court.³⁴⁴ Her expert was from Nebraska.³⁴⁵ He was well qualified in many ways but had a hard time finding a local dentist to speak with.³⁴⁶ He consulted with one Boise dentist and two anonymous Nampa dentists.³⁴⁷ He also reviewed the testimony of a second Boise dentist in an unrelated lawsuit.³⁴⁸ None of the dentists he spoke with were from Fruitland or the area served by the Holy Rosary Medical Center.³⁴⁹

The district court found his testimony inadmissible because none of the dentists the expert consulted with had "practiced general dentistry in the Idaho localities served by Holy Rosary Medical Center."³⁵⁰ The supreme court, upon review, pointed out that the one Boise dentist and additional anonymous dentists "would be insufficient to meet the requirements of Idaho Code section 6-1013."³⁵¹ The court nonetheless overturned the summary judgment and disagreed with the evidentiary ruling for the following three reasons. First, the expert taught at a school with a reciprocity program with Idaho dentistry students, so he had taught Idaho students and had observed the ad-

341. *Id.*

342. *Id.*

343. *Grover v. Smith*, 137 Idaho 247, 46 P.3d 1105 (2002).

344. *Id.* at 249, 46 P.3d at 1107.

345. *Id.* at 248, 46 P.3d at 1106.

346. *Id.* at 249, 46 P.3d at 1107.

347. *Id.*

348. *Id.* at 252, 46 P.3d at 1110.

349. *Id.* at 252, 46 P.3d at 1110. Fruitland is fifty miles west of Boise, thirty-seven miles from Nampa. Several healthcare providers advertise services in "Boise-Meridian-Nampa-Fruitland." See, e.g., Contact Sinus Center-Idaho, http://www.sinuscenters.com/contact_us.shtml (last visited Feb. 10, 2008); Allergy Clinic of Idaho Locations, <http://allergyclinic-idaho.com/Locations/locations.asp> (last visited Feb. 10, 2008).

Holy Rosary Medical Center serves "the healthcare needs of our friends in Eastern Oregon and Southwestern Idaho." Mark Dalley, A Welcome Message from Our President and CEO, <http://www.holyrosary-ontario.org/index.html> (last visited Feb. 10, 2008). In particular, the medical center includes the City of Fruitland and the City of Payette as members of its community. Welcome to Malheur County Oregon, <http://www.holyrosary-ontario.org/Community.htm> (last visited Feb. 10, 2008).

350. *Smith*, 137 Idaho at 252, 46 P.3d at 1110.

351. *Id.* at 251, 46 P.3d at 1109.

ministration of the Idaho State Dental Board Examination.³⁵² Second, the expert indicated that

the fundamental standard at issue is one that would not vary from town to town in Idaho. Taking a health history of a patient is a basic, elementary standard for all dentists in Idaho. . . . [A]n Idaho dental student who did not take a health history of the patient during the exam would fail it.³⁵³

Finally, the local dentists' lack of *practice* experience in the area served by Holy Rosary Medical Center was not enough to disallow their testimony because they were "*familiar* with the local standard."³⁵⁴

After finding the expert's testimony admissible, the Idaho Supreme Court found that the dentist had an obligation to meet minimum standards established by the state board dentistry, regardless of the local standard of care.³⁵⁵

Respondent's suggestion that, if local dentists so chose, community standards of care could fall below minimum statewide standards is not persuasive. At issue in this case is a minimum statewide standard of care, not a lack of advanced technology, conditions unique to the area, or particular specializations with which the expert is unfamiliar. While it may be understood that a small Idaho town may not have the technology used in a big city, thus necessitating a different local standard of care, choosing not to adhere to the basic dental standards established by the Idaho Board of Dentistry is not. Taking a patient's medical history is a minimum requirement that must be met to become a licensed dentist in Idaho. Respondent's contention that professionals in a community could decide to adopt a local standard of care that is inferior to the bare minimum statewide standards is without merit.³⁵⁶

This sounds like the correct decision because there was a great deal of evidence that the standard of care includes taking a health history of a dental patient. The case stands for the common sense proposition that the expert had testified that the alleged malpractice fell below the state minimum licensing standards and that this was not permissible.³⁵⁷

352. *Id.* at 251–52, 46 P.3d at 1109–10.

353. *Id.*

354. *Id.* at 252, 46 P.3d at 1110 (emphasis added).

355. *Id.*

356. *Id.*

357. *Id.* at 253, 46 P.3d at 1111; *see also id.* at 251, 46 P.3d at 1109.

But then why, in other cases decided both before and since *Grover*, has the court deemed the evidence insufficient even though experts with *undisputed* national qualifications give *undisputed* testimony that the given standard of care was applicable in *any* setting in the United States?³⁵⁸ Or that a medical textbook would indicate the standard of care?³⁵⁹ Or that this standard of care was learned during residency in a specialty?³⁶⁰ It seems like hair splitting to make a case-stopping difference between these statements and the one in *Grover*. The only way to reconcile the cases is to note that the *Grover* expert provided knowledge of an Idaho-specific licensing standard and that this was a minimum standard.³⁶¹ The message to plaintiffs' lawyers is that the expert must mention Idaho and must link the testimony to a state minimum standard.³⁶²

Further, this statewide *minimum* standard should not be confused with a statewide *general* standard. *Grover* does not stand for the allowance of a statewide standard of care in certain matters; instead it provides only the small comfort that behavior below the licensing minimum will not be allowed.

Grover had a great deal of trouble getting to trial. Even if the district court had been fully aware through competent testimony that this defendant had engaged in sub-standard practice, the court could have still dismissed her case. In doing so, the district court would have been following precedent, which requires the trial judge to be an absolute stickler. The expert must provide precise details showing that he knows the extremely local standard of care at the time and place of the alleged injury. Otherwise, the plaintiff's suit is dismissed before trial, and the defendant is not only free of liability but is also exempted from the ordeal of trial. Despite the court's protestations to the contrary,³⁶³ the statute's locality requirement, the court's procedural strictness, and the reticence of local doctors to testify against each other work together to place high hurdles in front of the plain-

358. See, e.g., *Dulaney v. St. Alphonsus Reg'l Med. Ctr.*, 137 Idaho 160, 170–70, 45 P.3d 816, 826–27 (2002) (Kidwell, J., dissenting) (discussing that the testimony of a board-certified emergency room doctor was held inadmissible by the majority).

359. See, e.g., *Kunz v. Miciak*, 118 Idaho 130, 131, 795 P.2d 24, 25 (Ct. App. 1990).

360. See, e.g., *Gubler v. Boe*, 120 Idaho 294, 304, 815 P.2d 1034, 1044 (1991) (Bistline, J., dissenting).

361. See *Grover v. Smith*, 137 Idaho 247, 253, 46 P.3d 1105, 1111 (2002).

362. For example, the court in *Grover* found the expert's testimony to link these two things. The court summarized that

an Idaho dental student who did not take a health history of the patient during the [Idaho State Dental Board Examination] would fail it. The standard is basic and applicable to all dentists in Idaho, whether in Fruitland, Boise, or Lewiston. No local standard of care would result in this minimum standard being altered in any way.

Id. at 251–52, 46 P.3d at 1109–10.

363. See *Hoene v. Barnes*, 121 Idaho 752, 756, 838 P.2d 315, 319 (1992).

tiff's case.³⁶⁴ Herculean efforts are sometimes required to overcome these hurdles.³⁶⁵

IV. A CALL FOR LEGISLATIVE REASSESSMENT

Thirty-one years have passed since the enactment of the malpractice legislation.³⁶⁶ It is time for the legislature to assess the benefits and costs of the statutory approach, including reductions in protection of medical patients, compensation of injured plaintiffs, and deterrence of medical errors.

A. Benefits of the Legislation

It has been suggested that a pro-defendant legal environment would reduce malpractice premiums in Idaho relative to other states. This in turn would give healthcare providers a financial incentive, as well as emotional and psychological incentives, to move to Idaho. By nature, medical practitioners have "dedication to eradicating disease, overcoming disability, restoring function, and prolonging life [that] suggests considerable resistance to the reality of life's naturally entropic course."³⁶⁷ The exigencies of medical school attract, foster, and endorse active, even rigid, control and perfectionism. The successful doctor presumably finds it unbearably shaming to be confronted with accusations of **FAULT, ERROR, NEGLIGENCE**, or any other similar criticism that looms large, dark, and bold. The sting is sharper when the accusations are flung publicly in an open courtroom. The prospect of lowering the level of care that will occur should have the benefit of providing considerable incentive for doctors and medical professionals to come to and stay in Idaho.

The accuracy of these assumptions should be tested by the legislative fact-finding processes. Are Idaho malpractice premiums indeed lower than those in other states?³⁶⁸ Are malpractice premiums the

364. See, e.g., *Dulaney v. St. Alphonsus Reg'l Med. Ctr.*, 137 Idaho 160, 173, 45 P.3d 816, 829 (2002) (Kidwell, J., dissenting).

365. But see *Frank v. E. Shoshone Hosp.*, 114 Idaho 480, 484, 757 P.2d 1199, 1203 (1988) (Huntley, J., concurring) ("[I]t does not take a Herculean effort for an expert to become familiar with the local standard of care.").

366. See Act of Mar. 31, 1976, ch. 277, § 1, 1976 Idaho Sess. Laws 951, 951; *id.* ch. 278, § 1, 1976 Idaho Sess. Laws 953, 953.

367. BANJA, *supra* note 192, at 196.

368. The indicators are that Idaho doctors pay among the lowest malpractice premiums in the nation—and did so even before the legislature's 2004 decrease in damage caps. See Wayne J. Guglielmo, *America's Best Places to Practice*, MED. ECON., May 18, 2007 (noting that current medical malpractice insurance rates make certain locations more attractive to physicians); Berkeley Rice, *Malpractice Rates: How High Now*, MED. ECON., Jan. 9, 2004, at 57, 59 (discussing which states had the highest and lowest medical malpractice insurance rates in 2004). In 2007, across the nation, rates held steady or

main driver for where doctors choose to practice?³⁶⁹ Are more doctors coming here than to other states? Do malpractice insurance rates rise and fall because of the number of lawsuits filed and won?³⁷⁰ Trial lawyers have long asserted that the real reason for the rise in premiums is the declining return on the insurance companies' investments, not the number of malpractice lawsuits,³⁷¹ which has remained steady or dropped in recent years.³⁷²

dropped. Wayne J. Guglielmo, *Exclusive Survey-Malpractice Premiums: Starting to Level Off*, MED. ECON., Dec. 7, 2007, at 32.

369. See generally Kaiser Family Found., *Coverage and Access—Malpractice Insurance' Premium Increases Have Small Effect on Physicians, Study Finds*, DAILY REPORTS, May 9, 2006, http://www.kaisernetwork.org/daily_reports/rep_index.cfm?hint=3&DR_ID=37133 (discussing a study from Suffolk University that concludes that malpractice premiums had small effect on physicians' total income or practice expenses); MICHELLE M. MELLO, ROBERT WOOD JOHNSON FOUND., *MEDICAL MALPRACTICE: IMPACT OF THE CRISIS AND EFFECT OF STATE TORT REFORMS* (2006), available at http://www.rwjf.org/pr/synthesis/reports_and_briefs/pdf/no10_researchreport.pdf (discussing claims that the malpractice environment affects physician availability and evaluating the quality of the studies that have explored these claims); U.S. GEN. ACCOUNTING OFFICE, *MEDICAL MALPRACTICE: IMPLICATIONS OF RISING PREMIUMS ON ACCESS TO HEALTH CARE* (2003), available at <http://www.gao.gov/new.items/d03836.pdf> (finding that in some states malpractice actions reduced access to healthcare, but that they had no effect on access to healthcare in other locations). But see Ralph Blumenthal, *After Texas Caps Malpractice Awards, Doctors Rush to Practice There*, N.Y. TIMES, Oct. 5, 2007, at A21 (suggesting that the Texas constitutional amendment limiting damage awards in medical malpractice cases had led to a dramatic increase in the number of doctors practicing there).

370. Discussion about the reasons for high malpractice premiums is a can of worms. See generally Liz Kowalczyk, *Rising Doctors' Premiums Not Due to Lawsuit Awards*, THE BOSTON GLOBE, June 1, 2005, at D1, available at http://www.boston.com/business/articles/2005/06/01/rising_doctors_premiums_not_due_to_lawsuit_awards/ (discussing a study from Dartmouth College); Patricia H. Born, W. Kip Viscusi & Tom Baker, *The Effects of Tort Reform on Medical Malpractice Insurers' Ultimate Losses* (University of Connecticut School of Law, Working Paper No. 61), available at <http://lsr.nellco.org/cgi/viewcontent.cgi?article=1060&context=uconn/ucwps> (finding that long-run effects of reforms across the nation are even larger than what the insurers predicted, but the effect is not evenly distributed throughout the insurance market); U.S. GEN. ACCOUNTING OFFICE, *MEDICAL MALPRACTICE INSURANCE: MULTIPLE FACTORS HAVE CONTRIBUTED TO INCREASED PREMIUM RATES* (2003), available at <http://www.gao.gov/new.items/d03702.pdf> (finding that malpractice premiums and increases in malpractice premiums vary widely from state to state and from region to region within a state for a multitude of reasons); Tom Baker, *Medical Malpractice and the Insurance Underwriting Cycle*, 54 DEPAUL L. REV. 393 (2005) (providing a primer on the insurance underwriting cycle and asserting that increased malpractice premiums result from losses in that cycle rather than from malpractice claim payments). The Journal of the American Association for Justice devoted an entire issue entitled *Broken Promises: The Insurance Industry Exposed* to issues with the insurance industry. See TRIAL, July 2007.

371. Rebecca Porter, *The Truth About Med-Mal Premiums*, TRIAL, May 2004, at 36, 36–37.

372. See *Updated Medical Malpractice Data Shows Continued Decline in Case Filings*, MEDICALMALPRACTICE.COM, April 11, 2005, <http://www.medicalmalpractice.com/national-content.cfm/Article/21806/-Medical-Malpractice-Data-Shows-Continue.html>.

B. Costs of the Legislation

Some plaintiffs do win medical malpractice claims in Idaho. Some defendant care providers do win on the merits because juries determine that they were not negligent. Of concern are cases falling into three other categories. The first is apparently rare, made possible by the locality standard, but not evident in the reported cases—cases where an entire community of medical care providers is performing at a level that would be deemed negligent in most other parts of America but that is protected in Idaho. The second category does appear with some frequency in the reporters—cases where plaintiffs may well have been injured through a medical care provider's negligence, but they lost because of a combination of the reticence of other local professionals to testify and the strictly construed statutory locality standard. The third is the most elusive but of at least equal concern—cases, or rather potential cases, that are not brought because the plaintiffs' bar has read the law and concluded that the case cannot be won. Rule 11 concerns, as well as the lawyers' own bottom line financial reckonings, mitigate against filing a lawsuit where negligence cannot be proved in the fashion prescribed by the courts and the legislature. If frivolous claims are not brought, so much the better.³⁷³ But evidence suggests that the economics of law practice already discourage the pursuit of frivolous claims, so that tort reform measures are largely halting or reducing recovery in meritorious claims.³⁷⁴

Insofar as the intent of the legislation was to reduce plaintiffs' tort victories, some time must be spent assessing the reason for tort recoveries and malpractice litigation.

The purpose of medical malpractice law is to protect patients from substandard medical care and to compensate them for injuries sustained as a result of substandard care. Each medical malpractice case serves an additional function by further delineating the medical care that is legally acceptable in a particular field.³⁷⁵

373. "No one's ever been healed by a frivolous lawsuit." President George W. Bush, Address at the Midwest Airlines Center, Milwaukee, Wisconsin (Oct. 3, 2003), available at <http://www.whitehouse.gov/news/releases/2003/10/20031003-4.html> (uttering these words to applause).

374. See David M. Studdert et al., *Claims, Errors and Compensation Payments in Medical Malpractice Litigation*, 354 NEW ENG. J. MED. 2024, 2031 (2006) (discussing the manner in which the national debate is being distorted by the specter of frivolous claims and opportunistic trial lawyers); WILLIAM HALTOM & MICHAEL MCCANN, DISTORTING THE LAW: POLITICS, MEDIA AND THE LITIGATION CRISIS 74 (2004).

375. Michelle Huckaby Lewis et al., *The Locality Rule and the Physician's Dilemma: Local Medical Practices vs. the National Standard of Care*, 297 JAMA 2633, 2636 (2007).

This is in line with the generally accepted purposes of tort law: first, to compensate plaintiffs injured through the fault of another; second, to spread the cost of the plaintiff's injuries as much as possible among individuals best able to bear the cost; and, third, to deter and punish careless behavior so as to reduce the risk of future injury. This should be accomplished with as much administrative efficiency as possible.³⁷⁶

The compensation goal addresses dollars and cents. Assuming that some otherwise meritorious claims fail or are never brought because of the legislation, it falls to the legislature to study the resultant effect of the reduction in compensation on the Idaho economy and on the lives of its citizens. Injured people may be finding alternative funding for losses through their own private insurance, private charity,³⁷⁷ or public assistance.³⁷⁸ Or they may be living with their injuries, uncompensated, and no longer as productive as they could be if made whole.³⁷⁹ The financial impact of the legislation may be far reaching and indirect.³⁸⁰

The deterrence goal may be compromised if the legislature allows the tort system to negatively reinforce negligent healthcare practices. But poor care may be deterred by various means outside of the courtroom. The first and most significant check on substandard care is the medical professional's own sense of pride and perfectionism; this same impulse is what makes unlikely any widespread problem with the local community providing inferior care. The very char-

376. See DALE GOBLE, *NEGLIGENCE: IDAHO CASES AND MATERIALS*, xvii–xix (2003). The desire to compensate plaintiffs is grounded not so much in pity as in the desire to reinstate them as contributing members of society. The goal of risk spreading is ably served by insurance. This is particularly true in medical malpractice. Assuming that a certain number of negligent mistakes are inevitable, how better to spread the loss than have all of those who potentially might make the mistakes contribute to the pool of available funds to pay for the mistakes? Obviously, compensation of plaintiff and risk spreading cannot be the sole goals of tort law or the system would quickly slip into a mere compensation fund. This leads to the need for another set of goals—punishment and deterrence of negligence and other fault. Ironically, the tort system's long-standing emphasis on fault is precisely what infuriates medical defendants, who point out that they were “only trying to help.”

377. Involuntary private donations may be in the form of paying more for healthcare to cover those who cannot pay.

378. The public assistance could come from federal or local government. Medicaid has a statutory subrogation right. But the reimbursement rates from Medicaid may be so low that few doctors are willing to take on Medicaid patients, with the result that patients may continue having problems obtaining needed medical care.

379. The legislature must investigate what groups constitute the likely victims of malpractice and whether tort reform measures fall disproportionately on certain types of plaintiffs.

380. On the broader matter of damage caps, see Lucinda M. Finley, *The Hidden Victims of Tort Reform: Women, Children, and the Elderly*, 53 EMORY L.J. 1263 (2004). There is an additional and related consideration—if the local standard of care results in a lower standard of care, this may disproportionately impact those financially unable to seek specialized care outside of the state.

acter traits that make medical professionals so averse to being sued make them anxious to perform at their best for their patients.

Second, that professional pride, coupled with financial concerns, leads to possibly the most effective means of keeping practices to a high standard: systemic error reduction efforts by hospitals and medical practice administrators. Healthcare analysts are increasingly aware that “medical errors are often due to breakdowns in whole systems of care.”³⁸¹ Peer review may be an effective way to reduce those problems.³⁸² But the question remains whether these systemic approaches will be undertaken if the pressure of tort liability is significantly reduced.

Third, the formal sanction of a hearing in front of the Board of Medicine is available for professional discipline.³⁸³ The legislature needs to rigorously study whether this process is effective in protecting Idaho citizens from poor doctoring. Fourth, word of mouth is inefficient and unreliable, but it is a potentially effective means of deterring negligent medical practices.³⁸⁴ Finally, the legislation has by no means eradicated the threat of tort suits. That fear alone remains a strong deterrent to any but the safest practices.³⁸⁵ To be thorough, the legislature should study how often Idaho practitioners engage in “defensive medicine”—overly and inefficiently cautious practices—merely out of the fear of being sued.

C. Discernment of the Best Means

Even if the current approach—cutting back on successful medical malpractice tort cases—is a good strategy to bring good medical care to Idaho, the legislature should take another look at whether the strict locality rule is the best way to accomplish this goal. A recent article in the *Journal of the American Medical Association* questions

381. MICHELLE M MELLO, ROBERT WOOD JOHNSON FOUND., RESEARCH SYNTHESIS REPORT NO. 8, UNDERSTANDING MEDICAL MALPRACTICE INSURANCE: A PRIMER 7 (2006), available at http://www.rwif.org/pr/publications/synthesis/reports_and_briefs/pdf/no8_primer.pdf. For a thoughtful, subtle, and sensitive look at the cause of medical errors, read BANJA, *supra* note 192.

382. See generally Ilene N. Moore et al., *Rethinking Peer Review: Detecting and Addressing Medical Malpractice Claims Risk*, 59 VAND. L. REV. 1175 (2006) (analyzing whether peer review reduces a doctor's risk of malpractice claims).

383. For more information about the formal discipline process, see Idaho Board of Medicine, www.bom.state.id.us/discipline/index.html (last visited Feb. 13, 2008).

384. The internet may be rendering word of mouth more efficient. “Zagat Survey has joined hands with the insurance company WellPoint to provide a rating system for patients can use to grade their experience with their doctor.” Sanjay Gupta, *Rating Your Doctor*, TIME, Jan 14, 2008, at 62.

385. One cost that may delight legislators and ordinary citizens alike is that reduced litigation hurts both defense and plaintiffs' lawyers. See generally Terry Carter, *Tort Reform Texas Style*, 92 A.B.A. J. 30 (2006).

whether the locality rule makes practical or ethical sense and even whether it helps doctors out at all.³⁸⁶ The strict locality rule may cause difficulties for a physician who practices in multiple states. Ethical conflicts may develop. For example, “physicians may face the choice to do either what they believe is best for their patients or what they believe is in their own best interests by abiding by the local standard of care to minimize their legal risk.”³⁸⁷ The authors conclude that the locality rule serves to promote the practice of substandard medicine, thwart research, and “inhibit the incorporation of scientific progress into practice standards.”³⁸⁸ The potentially lower standard of care may also be used to lure citizens in border towns to get their healthcare in other states.³⁸⁹

More fundamentally, the legislature should consider alternatives to the torts system. Public medical malpractice insurance plans, which are similar to automobile no-fault provisions, spread the cost of medical malpractice liability over the general public and have the potential to lower malpractice premiums.³⁹⁰ Another growing trend is non-courtroom dispute resolution, such as mediation, negotiation, or “unlimited insurance subrogation.”³⁹¹

V. RECOMMENDATIONS TO THE COURTS

The Idaho Supreme Court has stated its rules many times, citing an ever-growing litany of cases all more or less in agreement, that the plaintiff’s expert must be qualified and must provide testimony that creates a genuine issue of fact in order for the plaintiff to survive summary judgment.³⁹² Yet these black letter assertions cannot dispel lingering confusion among the bench and bar about the standard of care. The problem may well lie in the unusual and still-surprising-

386. See Lewis et al., *supra* note 375, at 2636.

387. *Id.* at 2636.

388. *Id.* at 2633.

389. I have heard anecdotal evidence that statements to that effect have been made by doctors in Pullman, Washington, advising patients not to seek care in Moscow, Idaho. Such statements are unprofessional and have the potential to backfire, but I have heard the allegations on more than one occasion.

390. See Frank A. Sloan et al., *Public Medical Malpractice Insurance: An Analysis of State-Operated Patient Compensation Funds*, 54 DEPAUL L. REV. 247, 247–48 (2005). *But see* Mark A. Hall, *Can You Trust a Doctor You Can’t Sue?*, 54 DEPAUL L. REV. 303, 303 (2005) (asserting that the ability to sue a physician is necessary to ensure patient trust).

391. Kenneth S. Reinker & David Rosenberg, *Improving Medical Malpractice Liability by Allowing Insurers to Take Charge*, (Harvard John M. Olin Discussion Paper No. 556, 2006), available at <http://www.law.uchicago.edu/files/conf/malpractice/rosenberg.pdf>. This paper is shrill and over broad, but it presents an alternative to tort litigation which—though it may not be satisfactory in itself—may start the reader thinking in new directions. For a rich discussion of possible changes to the system, see Paul Weiler, *Reforming Medical Malpractice in a Radically Moderate—and Ethical—Fashion*, 54 DEPAUL L. REV. 205 (2005).

392. See *supra* Part II.

after-all-these-years strictness of the court's interpretation and application of the statute and the rules of procedure and evidence. This section will suggest that the court put its efforts toward three related goals: first, continuing to encourage trial courts to use the rules of civil procedure even-handedly to increase fairness and full disclosure; second, encouraging district courts to make logical and reasonable inferences, especially at the summary judgment stage; and third, encouraging generous extensions of time for supplemental affidavits and information on the local standard of care. In pursuing these goals, the court can thereby ensure that the evidence and the standard remain within the narrow target drawn by the legislature, but still allow for full and fair administration of justice within that circle.

A. Encourage Fair Use of Civil Procedure Rules

The court should continue to encourage district courts to avoid using their discretionary rulings to block plaintiffs from trial. In the recent case of *Edmunds v. Kraner*, the supreme court faced a discovery battle that had culminated in summary judgment for the defendant.³⁹³ *Edmunds* does not add much to the jurisprudence on the standard of care, but it opens a window on litigation tactics practiced in Idaho. The plaintiffs, a husband and wife, alleged that the defendant hospital and numerous other defendants had overdosed the husband on an antibiotic, leading to his permanent disability.³⁹⁴ The opinion focuses on the litigation saga emanating from the situation.³⁹⁵ The plaintiffs apparently missed deadlines, although the clarity of the deadlines was in question.³⁹⁶ Interrogatories and motions to exclude flew.³⁹⁷ Testimony and witnesses' names were filed at the last minute just before hearings.³⁹⁸ The defendant deluged the plaintiffs by designating fifty-three experts to testify at trial.³⁹⁹ The appellate opinion paints the picture of a trial court unsympathetic to the plaintiffs' case. The trial court refused the plaintiffs' motion to supplement an expert's testimony.⁴⁰⁰ It struck the testimony of another of the plaintiffs' experts for untimeliness, even though the trial was still two

393. 142 Idaho 867, 870, 136 P.3d 338, 341 (2006).

394. *Id.*

395. *See id.* at 872–75, 877–78, 136 P.3d at 343–46, 348–49.

396. *Id.* at 874, 136 P.3d at 345.

397. *See id.* at 872, 136 P.3d at 343.

398. *Id.* at 873, 136 P.3d at 344.

399. *Id.* at 877, 136 P.3d at 348.

400. *Id.* at 873, 136 P.3d at 344. The supreme court affirmed the trial court's order, although it wrote: "we do not look favorably upon discretionary decisions by district judges that encourage last-minute witness disclosure and unreasonably prevent plaintiffs from responding, particularly in complex medical malpractice cases where experts will be furnishing the jury with the bulk of the necessary, and often technical, facts." *Id.*

months away.⁴⁰¹ It refused to limit the number of expert witnesses designated by defendant.⁴⁰² It granted the defendant's motion for summary judgment despite a statement by the defendant's own expert that established a genuine issue of material fact.⁴⁰³ It adopted verbatim, from the bench, the defendant's written findings of fact and conclusions of law on the same day that the plaintiffs filed their opposition to them.⁴⁰⁴

The unanimous supreme court wisely sent this matter back to trial. The case exposes the morass of machinations that lawyers can devise. But it also encapsulates the apparent sentiments, on the part of trial courts, that their job is to end the litigation in defendants' favor. This may be part of a national trend toward summary disposition of cases. Idaho's first rule of civil procedure sets the goal of "just, speedy and inexpensive determination of every action and proceeding."⁴⁰⁵ In their rush to speedy and inexpensive, the courts must not forget the just.⁴⁰⁶

The Idaho courts are conscious of the legislature's apparent desire to protect medical defendants from even non-frivolous lawsuits. But it is the job of the courts to temper the push for expedience ahead of justice and to ensure that plaintiffs' right to access to the courts and redress of wrongs is not trammled in the name of attracting medical care providers to Idaho.

Several times in *Edmunds* the court delivered some well-needed sermons on the role of the trial judge in litigation. Trial courts must facilitate pre-trial fact gathering with twin goals in mind: fairness and expediency.⁴⁰⁷ Trial courts must maintain order in pretrial proc-

401. *Id.* at 874, 136 P.3d at 345. The court struck the supplemental affidavit not for failure to lay an adequate foundation as required by Idaho Code sections 6-1012 and 6-1013, but for untimeliness. *Id.* An abuse of discretion was found. *Id.* The trial court's order about discovery deadlines should not have been allowed to supersede "these statutes and rules surrounding such disclosures in medical malpractice cases." *See id.* The supplemental testimony was "seasonable," coming two months before trial, and in compliance with IDAHO R. CIV. P. 26(e)(1)(B). *Id.* at 875, 136 P.3d at 346.

402. *Id.* at 877, 136 P.3d at 348. This was overturned as an abuse of discretion because the trial court misapprehended the law. *Id.* at 877-78, 136 P.3d 348-49.

403. *Id.* at 877, 136 P.3d at 348. This was overturned by the supreme court. *Id.*

404. *Id.* at 871, 136 P.3d at 342. The propriety of this was not reached because the summary judgment was reversed. *Id.* at 878, 136 P.3d at 349.

405. IDAHO R. CIV. P. 1(a).

406. *Stoner v. Turner* provides an eloquent call to justice that still rings true after over fifty years:

The object of statutes and rules regulating procedure in the courts is to promote the administration of justice. . . . [E]xcept as to those which are mandatory or jurisdictional, procedural regulations should not be so applied as to defeat their primary purpose, that is, the disposition of causes upon their substantial merits without delay or prejudice.

73 Idaho 117, 121, 247 P.2d 469, 471 (1952).

407. *Edmunds v. Kraner*, 142 Idaho 867, 878, 136 P.3d 338, 349 (2006).

ess and lead when necessary. “It is clear under our rules that courts must remain disinterested, but may not proceed disconnected from the case.”⁴⁰⁸

The court should continue to expand this point. The courts must not be so disconnected from the case and so blinded by the technicalities of the rules that they fail to recognize the difficulties of proof faced by plaintiffs. They must not be so wedded to the formulas created by precedent that they fail to give expert testimony credence when it presents evidence that the expert knows the local standard of care.

B. Encourage District Courts to Make Logical and Reasonable Inferences, Especially at Summary Judgment

Perhaps there is a trend for the courts to engage in more reasonable rules of interpretation of Idaho Code section 6-1013. Since *Dulaney* in 2002, seven standard of care cases have gone entirely or partially in the plaintiffs’ direction, four in the defendants’.⁴⁰⁹ But the main tack the court could take to ameliorate the law as it currently stands is to continue to back away from the type of rule application seen in *Dulaney*. The court can, and should, obey the legislative mandate requiring detail and precision. The black letter law of *Dulaney* need not be altered. But a common-sense, reality-based reading of the rule of *Dulaney* may have let the plaintiff proceed to trial.

The issue of the qualification of the expert should be viewed as a threshold matter—a way to keep junk science and irrelevant opinions out of the court room. It should not be viewed as a tool to shut plaintiffs out of court. This is especially true when the matter arises in the context of summary judgment. The qualification of the expert does rest on the plaintiff’s shoulders, but once qualification has been established (he has medical credentials, he is familiar with the facts of the case, he has spoken to a local provider, and has inquired about the local standard of care) that burden has been satisfied. Excruciating detail should not be required, nor should rational explanations and inferences be ignored or discounted. At that point the burden should

408. *Id.* at 875, 136 P.3d at 346.

409. There are seven cases at least partially for plaintiffs. See *Puckett v. Verksa*, 144 Idaho 161, 158 P.3d 937 (2007); *Mains v. Cach*, 143 Idaho 221, 141 P.3d 1090 (2006); *Edmunds*, 142 Idaho at 876, 136 P.3d at 347; *Newberry v. Martens*, 142 Idaho 284, 127 P.3d 187 (2005); *Hayward v. Jack’s Pharmacy Inc.*, 141 Idaho 622, 115 P.3d 713 (2005); *Shane v. Blair*, 139 Idaho 126, 75 P.3d 180 (2003); *Grover v. Smith*, 137 Idaho 247, 46 P.3d 1105 (2002).

There are four cases for defendant. See *McDaniel v. Inland Nw. Renal Care Group-Idaho, L.L.C.*, 144 Idaho 219, 159 P.3d 856 (2007); *Ramos v. Dixon*, 144 Idaho 32, 156 P.3d 533 (2007); *Swallow v. Emergency Med. of Idaho, P.A.*, 138 Idaho 589, 67 P.3d 68 (2003); *Grover v. Isom*, 137 Idaho 770, 53 P.3d 821 (2002).

be on the defendant, as moving party, to show that the matter should not proceed to trial.

C. Encourage Generous Extensions of Time

Finally, the difficulties facing plaintiffs in finding local experts should not be minimized.⁴¹⁰ It takes time to contact and talk with medical care providers, already disinclined to help out a plaintiff, because they are busy with their work and their lives. Ample time should be allowed so that justice is served.

VI. CONCLUSION

The legislature, and to some extent the courts, have made it difficult for plaintiffs to prove breach of the standard of care in medical malpractice cases in Idaho. The statutory locality rule, coupled with the rules of evidence and summary judgment, make it difficult for a plaintiff to get to trial, even in cases where a finding of negligence seems highly plausible. This paper exhorts the legislature and other policy makers to gather facts, reassess, and reconsider medical malpractice policy in Idaho. This is not necessarily a call for huge changes in the administration of medical malpractice disputes, although consideration of radical and innovative change should not be ruled out.

The courts are urged to maximize fairness and justice within the legislative requirements set forth in sections 6-1012 and 6-1013. Although it is the plaintiff's job to establish the admissibility of his own affidavits and testimony, the courts should find an expert qualified and competent if he has knowledge of the local standard either personally (the ideal), because of review of a detailed deposition, or because of inquiry made of a local doctor. If the expert and/or the local doctor submit affidavits that provide plausible information which shows they do indeed have knowledge of the local standard, they should be considered qualified, especially at the summary judgment stage in the proceedings. If the expert's testimony creates a genuine issue of material fact, whether or not the trial court believes him, the trial court should allow the matter to proceed toward trial. If a pro-

410. This article addresses only the standard of care. Plaintiffs face other hurdles as well, including proof of actual cause. See *Anderson v. Hollingsworth*, 136 Idaho 800, 803-04, 41 P.3d 228, 231-32 (2001). For example, in a case of obvious breach where the plaintiff was given three times as much medicine as recommended, the plaintiff lost because of medical uncertainty on whether the overdose can cause a heart attack. *Swallow v. Emergency Med. of Idaho, P.A.*, 138 Idaho 589, 591, 67 P.3d 68, 70 (2003). In another case, the court reversed the refusal to admit expert evidence on causation. *Weeks v. E. Idaho Health Servs.*, 143 Idaho 834, 837, 153 P.3d 1180, 1183 (2007). Once plaintiffs have established duty, breach, causation, and damage, they are confronted with damage caps and reduction from collateral sources.

professionally competent expert says that no one in America could have a lower standard of care than the one to which he testifies, and if someone with knowledge of the local area agrees, that should be sufficient to get to trial. The defendants described in this article—presumably caring and generally competent professionals—doubtless have rejoinders and responses to the allegations against them. That is exactly what jury trials are for—to allow for a full airing of the facts using the process of allegation followed by counter allegation. This will benefit medical care providers as well as their patients and will serve the interests of justice.

VII. APPENDIX

Checklist for Plaintiffs Attempting to Prove Breach of the
Standard of Care

Before filing the complaint, plaintiff's counsel should begin trying to line up an expert to testify about (a) the local standard of care and (b) whether or not it was breached.

Regarding the expert, plaintiff's lawyer should be able to establish:

- 1) What are the expert's qualifications? What establishes his professional competence and expertise?
- 2) Is the expert certain, within accepted medical science, of his testimony?
- 3) Is the expert knowledgeable of the defendant's speciality, training, and experience?
- 4) Is the expert knowledgeable about how the defendant's speciality is practiced in the defendant's community, that is, the geographical area ordinarily served by the licensed general hospital nearest to where the care at issue was provided?
- 5) Is the expert knowledgeable about how the defendant's speciality was practiced in the defendant's community at the exact time of plaintiff's alleged injury?
- 6) Is the expert able to state exactly what he asked to whom, or how else he is knowledgeable about points 3, 4, and 5, above?
- 7) Does the expert have notes made contemporaneously to support his testimony in answer to question 5, above?
- 8) What is the standard of care?
- 9) Did the defendant meet the standard of care or fall below it?

If the expert is not local himself and will be calling local doctors to familiarize himself with the local standard of care, the expert should be encouraged to take extensive notes and, if possible, tape the conversation. The plaintiff's attorney should prepare in advance for

the expert a list of questions to ask the local doctor. This list should include:

- 1) What is the locality in which you practice?
- 2) When did you start (and stop, if relevant) practicing there?
- 3) What specialities, exactly, did you practice, and when, exactly?
- 4) What did you do in a situation similar to that in the plaintiff's case?
- 5) What did you observe others in your speciality do in a situation similar to that in the plaintiff's case? Who? When? Where? Under what circumstances?
- 6) [If the local doctor is not of the same speciality as the defendant,] what is your means of knowing what those in the defendant's speciality would do in a similar situation? What, exactly, have you observed? When? Where?
- 7) In your opinion, did the course of treatment alleged by the plaintiff meet or fail to conform with what you or others in the defendant's speciality would have done?
- 8) Are you willing to have your name used in open court? What if it were kept secret by means of a protective order?
- 9) May I call you back if the lawyers tell me they need more information from you? When and where can I reach you?

If there is no local doctor available, the plaintiff's lawyer must not be afraid to leap to proof of the standard of care in a similar community. This is far preferable to insufficient proof of the local standard of care.

Because so much discretion vests in the trial court, the plaintiff's counsel should thoroughly research the judge's proclivities toward medical malpractice cases, extensions of time, and technicalities of civil procedure. The more plaintiffs' lawyers do a careless job, the more defense counsel are encouraged to seek summary judgment. The instructions from *Ramos* must be taken to heart: the plaintiff's counsel must leave nothing to chance but must be "directly involved" in every aspect of the gathering and presentation of the expert's testimony.⁴¹¹

411. See *Ramos v. Dixon*, 144 Idaho 32, __, 156 P.3d 533, 538-89 (2007).