3-8-2019

Phillips v. Eastern Idaho Health Services, Inc. Respondent's Brief Dckt. 45890

IN THE SUPREME COURT OF THE STATE OF IDAHO

PENNY PHILLIPS, an individual; HUNTER PHILLIPS, an individual; and HALLE LINDSAY, an individual,

Plaintiffs/Appellants/Cross-Respondents,

vs.

EASTERN IDAHO HEALTH SERVICES, INC., dba EASTERN IDAHO REGIONAL MEDICAL CENTER dba BEHAVIORAL HEALTH CENTER AT EIRMC, an Idaho corporation; MATTHEW LARSEN, DO, an individual, IDAHO BEHAVIORAL HEALTH SERVICES, LLC dba EASTERN IDAHO RMC BEHAVIORAL HEALTH, an Idaho limited liability company,

Defendants/Respondents/Cross-Appellants,

BINGHAM COUNTY, an Idaho political subdivision; BINGHAM COUNTY SHERIFF OFFICE, an Idaho political subdivision; CRAIG T. ROWLAND, in his official capacity as Bingham County Sheriff, JORDYN NEBEKER, an individual employed by Bingham County,

Defendants.

Supreme Court Docket No. 45890-2018

Bonneville County Case No.: CV-2017-441

RESPONDENTS'/CROSS-APPELLANTS' BRIEF

Appeal from the District Court of the Seventh Judicial District of the State of Idaho, in and for the County of Bonneville Honorable Bruce L. Pickett, District Judge, Presiding

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I. STATEMENT OF THE CASE

A. Nature of the Case

Scott Phillips ("Decedent" or "Mr. Phillips") committed suicide at an Idaho Falls hotel one to two days after leaving Eastern Idaho Health Services, Inc. dba Eastern Idaho Regional Medical Center dba Behavioral Health Center at EIRMC ("EIRMC") against medical advice. As a result, Penny Phillips (spouse), Hunter Phillips (adult child), and Halle Lindsay (adult child) ("Plaintiffs") filed a wrongful death lawsuit against EIRMC, Dr. Matthew Larsen ("Dr. Larsen"), Idaho Behavioral Health Services, LLC ("IBHS") (collectively "Medical Defendants") and Bingham County, Bingham County Sheriff's Office, Craig T. Rowland, and Jordyn Nebeker (collectively "Bingham County Defendants").

The Medical Defendants and Bingham County Defendants were granted summary judgment on all claims. Plaintiffs have pursued this appeal against only the Medical Defendants.

B. Course of Proceedings

On August 25, 2017, EIRMC and Dr. Larsen noticed the deposition of Dr. Kayne Kishiyama, a local consulting psychiatrist who spoke with Plaintiff's expert, after Plaintiff agreed to the deposition. R., pp. 373-74, 376. On November 22, 2017, after Medical Defendants filed motions for summary judgment and on the last day to file dispositive motions, Plaintiff filed a motion to amend the district court's scheduling order to allow Plaintiff to file rebuttal expert opinions since the scheduling order did not provide for the disclosure of rebuttal expert opinions. R., pp. 1050-1052. On November 30, 2017, Plaintiff filed an Amended Motion to Amend Scheduling Order and supporting memorandum. R., pp. 1211-1218. Medical Defendants filed a memorandum opposing the motion on December 7, 2017. R., pp. 2085-2098. The district court granted Plaintiff's Amended Motion to Amend Scheduling Order on December 21, 2017, and entered an Order on January 12, 2018. Tr., pp. 60-61, ll. 19-25, 1-13; R. pp. 2204-2206.

On January 24, 2018, the district court granted Medical Defendants' motions for summary judgment, granted Medical Defendants' motion to strike Plaintiffs' expert, and entered a Judgment of Dismissal on January 25, 2018. R., pp. 2438-2500. On April 3, 2018, the district court entered a memorandum decision denying Plaintiffs' Combined Motion for Reconsideration and to Alter, Amend, or Vacate Judgment and also an opinion and order striking additional declarations of Plaintiffs' expert witness. Am. Supp. R., pp. 187-235, 236-243. After Plaintiffs filed their Notice of Appeal, Medical Defendants filed a Notice of Cross-Appeal on March 26, 2018. R., pp. 2999-3004.

C. Statement of Facts

Gin was the Decedent's drink of choice and in 2003 he started drinking every day. R., p. 1989 (p. 84, ll. 6-25). Decedent went to alcohol rehabilitation for approximately a month in 2008 because his alcohol abuse/binge drinking had gotten to the point where he was not even going to work. R., p. 1989 (p. 83, ll. 9-25; p. 84, ll. 1-23). Decedent relapsed and started drinking again in 2012. R., p. 1988 (p. 65, ll. 22-23). In September of 2013, the Decedent pushed or threw his wife Penny Phillips against the wall of their bedroom causing bruises to her arms and body. Decedent had been drinking at the time of the episode. R., p. 1994 (p. 125, ll. 4-25; p. 126, ll. 1-20). Penny Phillips filed for divorce from the Decedent in August of 2014 alleging habitual intemperance, adultery, and extreme emotional and physical cruelty. R., p. 1999 (p. 166, ll. 16-25; p. 167, ll. 1-25; p. 168, ll. 1-9). From August 2014 until late October 2014 Decedent would drink every day until he passed out and was intoxicated every day. R., p. 1992 (p. 115, ll. 13-25; p. 116, ll. 1-14).

In September of 2014, Penny Phillips reported to police that she was afraid of Decedent, that Decedent had been drinking heavily, and that one morning while they were separated she awoke and found the Decedent hovering over her. R., pp. 1993 (p. 122, ll. 23-25; p. 123, ll. 1-2),

1995 (p. 130, ll. 17-25; p. 131, ll. 1-7). In September of 2014, the Decedent came to the marital residence and damaged several items throughout the home. R., p. 1996 (pp. 142-144). In October of 2014, Penny Phillips reported to police that the Decedent came to her home and was drinking and carrying a firearm. R., p. 1997 (p. 148). In October of 2014, the Decedent also violated a no contact order Penny Phillips had in place and had a stand off with police for several hours when they attempted to arrest him for several outstanding warrants. R., pp. 1998 (p. 161, ll. 12-25, p. 162, ll. 1-4, p. 164, ll. 11-13), 2367. In November of 2015, Penny Phillips told her nurse practitioner that her marriage with the Decedent was jeopardized several times because of the Decedent's drinking. R., p. 1991 (p. 98, ll. 14-25).

On Thanksgiving Day of 2015, Halle Lindsay caught the Decedent playing an on-line game called Second Life and Decedent became angry and confronted Halle Lindsay and Penny Phillips with a gun. R., p. 1873. Penny Phillips told the Decedent he had to leave the house. R., p. 1873. After the Decedent left, Penny Phillips could track Decedent's location through OnStar on his vehicle and testified that he stayed at the Marriott Residence Inn most of the time from November 26-December 10, 2015. R., p. 2002 (p. 194, ll. 1-24). Penny Phillips believes the Decedent's statement to doctors that he was drinking a bottle of gin a day for two weeks after being kicked out of the house on Thanksgiving Day 2015. R., p. 2003 (p. 197, ll. 14-24).

At approximately 11:53 p.m. on December 7, 2015, Decedent was arrested on suspicion of DUI and brought to the Bingham County Sheriff's Office where it was determined he had a BAC of .220. R., pp. 539 (p. 195, ll. 1-14), 592. At the time of arrest, Decedent had a loaded gun in his possession and reported suicidal ideation. R., p. 591. According to arresting officer, Deputy Jordyn Nebeker, Decedent was cited with an excessive DUI and open container and then brought from Blackfoot, Idaho to Eastern Idaho Regional Medical Center ("EIRMC") in Idaho Falls, Idaho to evaluate Decedent's mental condition. R., pp. 537-538 (p. 12, ll. 18-25, p. 13, ll.

1-9), 590. Deputy Nebeker indicated that it had always been his intent to "cite and release" Decedent, and that Decedent was in fact released from the custody of the Bingham County Sheriff's Office at EIRMC. R., pp. 537-538, (p. 12, ll. 18-25, p. 13, ll. 1-9), 587 (p. 206, ll. 11-21), 590, 592. EIRMC security officer Eric Rose confirmed that voluntary patients at EIRMC are released from the custody of the arresting law enforcement agency prior to voluntary admission. R., p. 596 (p. 41, ll. 20-25; p. 42, ll. 1-23).

Decedent arrived at EIRMC's emergency department at approximately 1:05 a.m. on December 8, 2015. R., p. 598. Decedent agreed to a voluntary admission to the EIRMC Behavioral Health Center ("BHC"). R., p. 600. At approximately 3:25 a.m., Decedent was transferred from the Emergency Department and admitted as a voluntary patient at the BHC for further evaluation of his mental condition. R., pp. 598, 600. At approximately 3:50 a.m. on December 8, 2015, Decedent executed an EIRMC Conditions of Admission, which indicated that psychiatrists providing services at hospital facilities were independent contractors. R., pp. 602-605.

At approximately 9:00 a.m. on the morning of December 8, 2015, psychiatrist Dr. Matthew Larsen performed a psychiatric evaluation of Decedent. R., pp. 608 (p. 141, ll. 9-12), 618-621. In the evaluation, Decedent denied suicidal ideation and denied feeling manic. R., pp. 609 (p. 146, ll. 15), 615 (p. 180, ll. 8-17), 618, 621. During the evaluation, Decedent was calm and conversant, spoke at a regular rate and rhythm, was fully awake, alert, and oriented to person, place, time, and situation. R., p. 621. Decedent's evaluation also revealed that his thought process was logical and linear, and his thought content was non-bizarre, with no signs of psychosis. R., p. 621. Decedent demonstrated good impulse control and judgment at the time of the evaluation. R., p. 621. Dr. Larsen initiated alcohol withdrawal protocol, however, he cancelled the order because Decedent was not showing active signs of alcohol withdrawal. R.,

pp. 612 (p. 161, ll. 1-25; p. 162, ll. 1-2), 621. Dr. Larsen also performed a mental status exam of Decedent and concluded, based upon Decedent's responses to the questions posed, that Decedent was not impaired by alcohol. R., pp. 610-611 (pp. 149-155). At the time of the evaluation, Dr. Larsen anticipated Decedent's discharge on the morning of December 9, 2015. R., p. 621.

However, at approximately 12:30 p.m. on December 8, 2015, Decedent requested to leave the BHC facility to "go reconcile with [his] wife" and go to work. R., p. 623. At the time Decedent requested his release, Nurse Matthew Kalkwarf reported that Decedent's speech was clear, he was alert and oriented, was ambulatory without problems, and Decedent denied suicidal ideations. R., pp. 612 (p. 162, ll. 4-23), 616 (p. 244, ll. 3-11), 623. Nurse Kalkwarf contacted Dr. Larsen, who determined (based upon his prior evaluation of Decedent and the observations of Nurse Kalkwarf) that Decedent did not meet statutory criteria for an involuntary mental health hold, but requested that if Decedent insisted to be discharged that he be discharged against medical advice ("AMA"). R., pp. 612 (p. 163, ll. 1-11), 613 (p. 165, ll. 22-25; p. 166, ll. 1-10), 614 (p. 173, ll. 16-25; p. 174, ll. 1-18), 623, 625.

Decedent was discharged AMA from the BHC and executed a "Leaving Hospital Against Medical Advice" form which states as follows:

> 1. This is to certify that Scott Phillips, a patient in the above hospital, is leaving the hospital against the advice of the attending physician and hospital.
> 2. I have been informed of the risk involved and hereby release the attending physician and hospital from any and all responsibility for any ill effects resulting from this action.

R., p. 627.

Decedent refused to wait to speak with Dr. Larsen or case management before leaving the facility. R., p. 623. Decedent indicated that his brother would give him a ride home. R., p. 612 (p. 163, ll. 3-4.) After signing the applicable AMA discharge paperwork, Decedent left the BHC

facility sometime between 12:45 and 1:00 p.m. on December 8, 2015. R., pp. 623, 627. After leaving the BHC, Decedent called his brother, Jeff Phillips. Jeff Phillips testified that Decedent was coherent and logical during the phone call, however, Jeff did not give Decedent a ride. R., pp. 630 (p. 52, ll. 9-25), 631 (p. 53, ll. 1-25; p. 54, ll. 1-25, p. 55, ll. 1-25, p. 56, ll. 1-8), 632 (p. 76, ll. 8-11). Decedent then called his mother, Randi Phillips, who testified that Decedent asked her if she was in Idaho Falls, but she was not. Randi Phillips asked Decedent where he was and he responded that he had left the BHC and that he was going to go to Safe Haven. R., p. 635 (pp. 70-72). While the precise manner of his arrival is unknown, Decedent ended up at the Marriott Residence Inn in Idaho Falls. Jeff Phillips testified that after his conversation with Decedent on December 8, 2015, he found out Decedent was residing at the Marriott and believes his mother, Randi Phillips, gave him this information. R., p. 631 (p. 56, ll. 19-25). At some point late in the day on December 9 or on December 10, 2015, Decedent committed suicide by hanging himself in his hotel room.

II. ADDITIONAL ISSUES PRESENTED ON APPEAL AND CROSS-APPEAL

1. Whether the district court erred in granting Plaintiffs' Amended Motion to Amend Scheduling Order; and

2. Are Medical Defendants entitled to attorney's fees and costs on appeal pursuant to Idaho Code § 12-121 and Rules 40 and 41 of the Idaho Appellate Rules?

III. ARGUMENT

A. The district court was well within its discretion when it properly excluded Plaintiffs' expert witness based on his lack of familiarity with the applicable community standard of health care practice.

1. Standard of Review.

A district court's evidentiary rulings are reviewed for an abuse of discretion. *Samples v. Hanson*, 161 Idaho 179, 182, 384 P.3d 943, 946 (2016). When this Court reviews an alleged abuse of discretion by a trial court the sequence of inquiry requires consideration of *four*

essentials. Whether the trial court: (1) correctly perceived the issue as one of discretion; (2) acted within the outer boundaries of its discretion; (3) acted consistently with the legal standards applicable to the specific choices available to it; and (4) reached its decision by the exercise of reason. *Lunneborg v. My Fun Life*, 163 Idaho 856, 863, 421 P.3d 187, 194 (2018).

2. Argument.

In this case there is no question the district court perceived the decision to exclude Dr. Moss as one of discretion, acted within the outer boundaries of its discretion, acted consistently with legal standards, and reached its decision by the exercise of reason. R., pp. 2475-2498; Am. Supp. R., pp. 192-224. The Plaintiffs' argument on appeal, as it was at the reconsideration stage at the district court level, is a plea for this Court to find that the "whole" of Plaintiffs' familiarization efforts is greater than the sum of its parts. However, as set forth more fully below, when their efforts are considered individually or collectively, Plaintiffs have failed to establish Dr. Moss's foundational familiarity with the applicable community standard of healthcare practice.

a. A national board certification standard does not apply in this case because it is undisputed that Dr. Matthew Larsen was not and never had been board certified at the time of his treatment and care in this case.

Plaintiffs continue to assert, despite admonishment from the district court that they were misrepresenting the holding in *Samples v. Hanson*, 161 Idaho 179, 384 P.3d 943 (2016) (R., p. 2484), that all *Samples* was concerned with was rigorous education and training commensurate with board certification, not whether a physician had actually *become* board certified. Plaintiffs' position continues to be inconsistent with the holding in *Samples*, which states: "[i]f a person wrongly represents being board certified he or she ought to be held to that standard. On the other hand, if a person has received the rigorous training **and become board certified**, he or she ought

to live up to that standard." *Samples*, 161 Idaho at 184, 384 P.3d at 948 (emphasis added); R., p. 2484. The district court held that at the time in question Dr. Larsen was not board certified and "there is no evidence that he held himself out as board-certified." R., p. 2484. Attempts to compare Dr. Larsen with Dr. Hanson in *Samples* is unavailing because Dr. Hanson had actually *become* and had practiced as a board certified physician for thirty years prior to allowing his board certification to lapse. At the relevant time in this case, Dr. Larsen was not and never had been board certified. Accordingly, there is no basis under *Samples* to hold Dr. Larsen to national standards for board certified specialists.

Plaintiffs' contention that EIRMC required psychiatrists practicing in its facility to attain board certification thereby creating a *de facto* national standard misstates what EIRMC actually required of psychiatrists. The Professional Services Agreement ("PSA") between Dr. Larsen's employer, IBHS, and EIRMC requires *only board eligibility*, not board certification. R., p. 1698. The requirements of EIRMC's Medical Staff Bylaws are no different, requiring only *board eligibility* for initial physician applicants, such as Dr. Larsen (who was within the five year period described in the applicable Bylaw). R., p. 1745. Additionally, Dr. Denny, a psychiatrist with privileges at EIRMC during the time at issue, testified that psychiatrists with "on-call" contracts were not required to be board certified. R., p. 2832 (p. 16, ll. 5-16).

Since both the PSA and EIRMC Medical Staff Bylaws require only *board eligibility* as a condition for staff privileges, allow physicians to practice for defined periods of time without obtaining board certification, and even allow for the waiver of such a requirement upon a showing of exceptional circumstances, EIRMC has not adopted a facility-wide "board certification" standard for physicians with medical staff privileges. Indeed, the Bylaws demonstrate that there is **not** a facility-wide "board certification" standard by specifically envisioning the practice of medicine by non-board certified physicians at EIRMC *for a period of*

up to five years after graduation. Thus, the district court correctly determined that there was no national board certification standard of health care practice in this case.

b. The district court correctly determined that American Psychiatric Association ("APA") Practice Guidelines do not supplant the community standard of health care practice because such guidelines disavow setting standards of health care practice and Dr. Denny's equivocal, qualified deposition testimony cannot serve as a foundation for identifying the local standard of health care practice.

The APA Guidelines themselves state they "are not intended to be construed or to serve as a standard of medical care." R., p. 683. They also state that "these parameters of practice should be considered guidelines only . . . [and] [t]he ultimate judgment regarding a particular clinical procedure or treatment plan must be made by the psychiatrist in light of the clinical data presented by the patient and the diagnostic and treatment options available." R., p. 683. Dr. Denny reiterated this in his deposition testimony stating that the APA Guidelines were in fact guidelines with many caveats associated with them. R., p. 673 (p. 17, ll. 4-9). Clearly, by their own cautionary language, APA Guidelines do not establish a national standard of health care practice that supersedes the local community standard of health care practice.

Plaintiffs continue to erroneously contend that Dr. Denny's deposition testimony confirms that APA Guidelines have supplanted the local community standard of health care practice. This Court has held that in order for an out-of-state expert to rely on deposition testimony to become familiar with local standards of health care practice and further that national standards establish or supplant local standards of health care practice, the deposition testimony must: 1) "clearly articulate the local standard for the particular time, place and specialty at issue in order to meet the foundational requirements of I.C. § 6-1013" (*Suhadolnik v. Pressman*, 151 Idaho 110, 118, 254 P.3d 11, 19 (2011)); and 2) must unequivocally confirm or establish that the local standard of health care practice is governed by a national standard. *Morrison v. St. Luke's*

Reg'l Med. Ctr., Ltd., 160 Idaho 599, 605, 377 P.3d 1062, 1068 (2016); *see also Kozlowski v. Rush*, 121 Idaho 825, 829, 828 P.2d 854, 858 (1992) (finding that unequivocal deposition testimony confirming that national standard controlled was sufficient to establish a national standard of care).

Dr. Denny's deposition testimony failed to identify the local standard of health care practice for the community or the existence of a national standard of health care practice, much less testify that a national standard of health care practice had supplanted the local community standard of health care practice. While Dr. Denny testified that he practices according to the APA Guidelines, he testified that the APA Guidelines are guidelines for care with many caveats. R., p. 673 (p. 17, ll. 4-9). In response to a question about national standards of health care practice Dr. Denny testified: "So I would say **I don't know that there is a national standard that would cover all situations in terms of the management of an involuntary patient.**" R., p. 675 (p. 44, ll. 17-19) (emphasis added). When asked whether the applicable local standard of health care practice was consistent with or did not deviate from APA Guidelines, Dr. Denny responded: "**I can't speak for anyone else.**" R. p. 676 (p. 45, ll. 6) (emphasis added). Dr. Denny also made other statements disclaiming his ability to speak for others: "I can answer for myself"; "Without reviewing every chart from every psychiatrist, I would not be able to answer the question if every psychiatrist followed those standards . . ." R., p. 676 (p. 46, ll. 10-11; p. 47, ll. 2-5).

Plaintiffs also argue that the district court improperly held that Dr. Denny would need to be familiar with what every practitioner did to be familiar with the standard of care. However, the district never held this and acknowledged the same in its *Memorandum Decision on Plaintiffs' Combined Motions for Reconsideration and to Alter, Amend, or Vacate Judgment.* Am. Supp. R., p. 205. Instead, the district court simply pointed out that (in accordance with

Idaho statute and case law precedent) "Dr. Denny must articulate a clear standard, applicable to the specialty of psychiatry as a whole. This does not require a familiarizing expert to be a panopticon, but it does require they give more than the qualified and non-responsive answers Dr. Denny supplied." Am. Supp. R., p. 205. In addition, contrary to Plaintiffs' assertion, no specific guidelines from the APA Guidelines were ever discussed during Dr. Denny's deposition. While Dr. Denny acknowledged he was familiar with the APA Guidelines for psychiatric evaluation of adults, treatment of patients with bipolar disorder, and treatment of patients with suicidal behaviors Dr. Denny was never asked and never identified what the specific guidelines for any of these topics were, whether all guidelines under each topic were the local standard of health care practice, and whether there were local deviations to any of the guidelines under each topic. R., p. 673 (p. 17, ll. 20-25; p. 18, ll. 1-7).

Plaintiffs also take issue with the district court pointing out that Dr. Larsen contradicted Dr. Denny's testimony relating to the APA Guidelines. It is curious that Plaintiffs take issue with the district court's consideration of Dr. Larsen's deposition testimony, when Plaintiffs also assert that Dr. Larsen's deposition testimony (in addition to Dr. Denny's testimony) established the community standard of health care practice. Dr. Larsen testified: "**There weren't national standards of practice. All standards are local.**" R., p. 679 (p. 211, ll. 19-20) (emphasis added). When questioned about use of the APA Guidelines, Dr. Larsen testified:

> Q. Do psychiatrists in December of 2015 use the APA guidelines for the assessment, treatment, and diagnosis of patients?
>
> . . .
>
> A. I don't know.
> Q. Did you?
> A. No.
> Q. Did other psychiatrists at BHC?
> A. I don't know.

R., pp. 679-80 (p. 212, ll. 16-18, 24-25; p. 213, ll. 1-3).

Read together, the deposition testimony of Drs. Larsen and Denny establishes what the district court held: "that [neither] Drs. Denny or Larsen articulated a clear standard of care with which Dr. Moss could familiarize himself." R., p. 2489. In light of the lack of any clear, coherent standard articulated by Drs. Larsen or Denny upon which Dr. Moss could familiarize himself, the district court could not determine whether the facts "likely give rise to knowledge" of the community standard of health care practice under *Mattox*. *Mattox v. Life Care Ctrs. of Am., Inc.*, 157 Idaho 468, 474, 337 P.3d 627, 633 (2014). Accordingly, the district court acted within its discretion and properly determined that Plaintiffs failed to demonstrate that APA Guidelines supplanted the community standard of health care practice.

c. The district court was correct in its determination that Dr. Kishiyama was incapable of familiarizing Dr. Moss with the applicable standard of health care practice.

Idaho Code § 6-1012 requires Plaintiffs to demonstrate their expert's familiarity with the applicable standard of health care for the relevant specialty, in the relevant community, at the relevant time. Significantly, Dr. Kishiyama testified that he last worked in an inpatient hospital setting in 2008, and had not admitted a psychiatric patient to the BHC since 2008. R., pp. 2835 (p. 29, ll. 16-19; p. 32, ll. 4-15), 2839 (p. 53, ll. 25; p. 54, ll. 1-2). Dr. Kishiyama also testified at his deposition that he last reviewed Idaho's involuntary hold statute while working in Twin Falls, where he worked from 1994-2004. R., pp. 2836 (p. 35, ll. 5-10), 2837 (p. 48, ll. 20-25). There is absolutely no evidence in the record suggesting Dr. Kishiyama had placed an involuntary mental health hold since at least 2008 when he last had privileges at BHC. In fact, the March 31, 2017, Declaration of Dr. Moss supports the position that Dr. Kishiyama was not applying the involuntary mental health hold criteria during the relevant timeframe because it indicated that Dr. Kishiyama would call the admitting physician at the hospital or the patient's family to facilitate an admission. R., p. 1604 (¶¶ 19-20); Am. Supp. R., p. 213. Thus, based on the record before

this Court, there is no indication that Dr. Kishiyama had knowledge of the local community standard of health care practice, specifically, the criteria used to initiate involuntary mental health holds within a hospital or facility in Idaho Falls, Idaho in December of 2015. Accordingly, there is no foundation to suggest that Dr. Kishiyama was familiar with how hold criteria were being applied in Idaho Falls, Idaho during the relevant time frame of December 2015.

There is no dispute that the Decedent was an inpatient at the BHC. Plaintiffs attempt to argue that the distinction between inpatient and outpatient psychiatry is illusory. However, the difference between inpatient and outpatient psychiatry in the context of an involuntary mental health hold is paramount in this case. Plaintiffs contend that the Decedent should have been held involuntarily at the BHC and not allowed to be discharged AMA. The mechanism by which this was to be accomplished was Idaho Code § 66-326. The language of § 66-326 is unambiguous and only grants authority to detain or involuntarily admit a mentally ill patient to peace officers and to certain members of a hospital's medical staff. As noted by the district court, there is nothing in the record showing that Dr. Kishiyama was a member of the staff at BHC or EIRMC or otherwise had admitting privileges to the BHC or any other inpatient facility in December of 2015. In fact, the evidence in the record shows that Dr. Kishiyama had not worked in an inpatient setting since 2008. Therefore, Dr. Kishiyama could not have legally placed a hold in December 2015 and had not participated in the involuntary mental health hold process since 2008, at least seven (7) years prior to the relevant time frame in this case.

In sum, the critical inpatient/outpatient distinction pointed out by Medical Defendants is not that "inpatient psychiatry" and "outpatient psychiatry" are substantively distinct branches of medicine – rather, the distinction is a legal and practical one going to Dr. Kishiyama's own knowledge of the applicable standard. Indeed, because Dr. Kishiyama: (1) had not practiced in

an inpatient setting or placed a hold since 2008; (2) was not a member of EIRMC's medical staff or any other facility's medical staff in 2015 that was capable of placing a hold; (3) and had not even reviewed the statutory hold criteria since 2004, he was not familiar with the community standard of health care practice applicable in this case (i.e. the community standard for implementation of statutory involuntary hold criteria in December 2015). Consequently, the district court acted within its discretion and pursuant to Idaho law when it held Dr. Kishiyama was not sufficiently acquainted with the applicable standard of health care practice to familiarize Dr. Moss as required by Idaho Code §§ 6-1012 and 6-1013.

d. The district court correctly determined that Dr. Larsen's critiques of Dr. Moss's statement of the standard of health care practice was inadequate to familiarize Dr. Moss with the applicable standard of health care practice in this case.

This Court "has never affirmed the admissibility of expert testimony based solely on an expert's review of deposition testimony" it has only stated "that this may be sufficient." *Suhadolnik v. Pressman*, 151 Idaho 110, 117, 254 P.3d 11, 18 (2011). To be sufficient, this Court has held that the deposition "testimony must clearly articulate the local standard for the particular time, place and specialty at issue in order to meet the foundational requirements of I.C. § 6-1013." *Id.* at 118, 254 P.3d at 19. Plaintiffs cite *Perry v. Magic Valley Reg'l Med. Ctr.*, 134 Idaho 46, 51, 995 P.2d 816, 821 (2000), for the proposition that a medical defendant's own description of the standard of care can be sufficient to provide foundation for purposes of Idaho Code §§ 6-1012 and 6-1013. Plaintiffs citation to *Perry* for this proposition is not entirely accurate, as the expert in *Perry* did much more than simply rely on a medical defendant's statement of the standard of care; the nursing expert also spoke with the executive director of the Idaho Board of Nursing and two faculty members at Idaho nursing schools. *Perry v. Magic Valley Reg'l Med. Ctr.*, 134 Idaho 46, 51, 995 P.2d 816, 821 (2000). Though *Perry* suggests that

a medical defendant's identification of a standard in conjunction with other familiarization efforts may be sufficient, it never holds that a medical provider's statement of the standard of care is alone sufficient.

However, even if *Perry* did apply, unlike the nursing experts in Perry, Dr. Larsen never "identifies" anything as the standard of health care practice. Dr. Larsen never affirmatively stated or acknowledged that his critique and changes to Dr. Moss's declaration constituted a complete statement of the community standard of health care practice rather than simply a correction of errors made by Dr. Moss. Thus, where Dr. Larsen merely corrected errors Dr. Moss had made in Dr. Moss's interpretation of the community standard of health care practice, Dr. Larsen never affirmatively sets forth or "identified" the applicable standard of health care practice.

It is interesting that Plaintiffs cite to several pages of Dr. Larsen's deposition testimony because such testimony clearly demonstrates that Dr. Larsen was only correcting inaccuracies, not affirmatively stating a standard of health care practice. A few key highlights from such testimony include:

- "20 is **inaccurate** because a direct admission does not go to the ER. That's the point of direct admission is to not go to the ER."
- "Again, 21 is regarding outpatient care and is not applicable to standard of care for inpatient.
- "23, the last line about providing an anti-suicide contract is **inaccurate**."
- "24 is **inaccurate**. You don't start a protective hold because someone has depression, bipolar, you start it because they are a suicidal risk."
- "25 is **inaccurate**. It is not the standard of care to bypass HIPAA laws and contact family without the patient's permission."
- "**I don't know if 27 is accurate** because I don't believe it's 72 hours between the first DE and the second DE."
- "28 is also **inaccurate** because they don't just usually send people from court directly to a State Hospital because they're more serious."

- "Again, his last statement is **incorrect** because **there isn't a national standard of health care practice regarding hospitalizations and treatment because the laws are different and the standards are local.**"

R., p. 1583 (pp. 228-232) (emphasis added).

Dr. Larsen's deposition testimony reveals that he never identified or clearly articulated the local standard of health care practice. At best, Dr. Larsen articulated what the standard of health care practice was not instead of what the standard actually is. While Dr. Larsen did testify what constituted a psychiatric evaluation, the issue in this case is not whether Dr. Larsen performed such an evaluation (he did, R. pp. 618-621) it is whether the Decedent should have been held involuntarily when he requested to leave against medical advice. Even if *Perry* stood for the proposition cited (it does not), the district court properly determined and acted within its discretion and pursuant to Idaho law when it determined that Dr. Larsen's deposition testimony was insufficient to familiarize Dr. Moss with the local standard of health care practice because it did not identify or clearly articulate the applicable local standard of health care practice.

e. The district court correctly determined that Dr. Erwin was not capable of familiarizing Dr. Moss with the applicable community standard of healthcare practice and that Idaho Falls and Pocatello are not overlapping communities.

Because the district court properly concluded that Pocatello and Idaho Falls were not the same community for purposes of Idaho Code § 6-1012, and because Dr. Erwin's experience was limited to the Pocatello community and outside the temporal scope of this case, the district court properly concluded that Dr. Erwin was not capable of familiarizing Dr. Moss with the applicable community standard of healthcare practice.

Plaintiffs assert that they were deprived of having the district court draw all reasonable inferences in their favor as required on summary judgment. In making this argument, Plaintiffs ignore that they were the moving party with respect to this issue (because it was raised on Plaintiffs' motion for partial summary judgment and because Plaintiffs bear the burden under

Idaho Code § 6-1013). Am. Supp. R., p. 214[1]. In any event, *Bybee* makes clear that determining the "community" is an evidentiary issue in the district court's discretion pursuant to Idaho Rule of Evidence 104(a). *Bybee v. Gorman*, 157 Idaho 169, 176, 335 P.2d 14, 21, fn. 4 (2014) ("The Bybees are incorrect in their assertion that the jury is the factfinder as to the geographical scope of the community. Rather, I.R.E. 104(a) places this responsibility upon the judge."). Moreover, because the parties were in fundamental agreement about the facts (and given that the only factual dispute on this issue was construed in Plaintiffs' favor), *Bybee*'s concerns about the trial court improperly weighing facts or resolving controverted factual issues are not present here. Am. Supp. R., p. 215, fn. 102.

Bybee recognized that trial judges may reach differing conclusions as to whether patients from a particular location use a hospital's services on a regular or common basis. *Id.* at 176–77 ("The imprecision of this definition of community lies in the word ordinarily. Although the word signifies some degree of frequency, judges viewing the same evidence may reach differing conclusions as to whether patients from a particular location use a hospital's services on a regular or common basis. Although perhaps creating uncertainty for the parties and their lawyers, this is entirely consistent with the discretionary nature of the decision confronting a trial judge addressing a challenge to the admissibility of a medical expert's testimony."). Plaintiffs may take issue with the district court's determination that Pocatello is not "ordinarily" served by EIRMC with "some degree of frequency," but there is absolutely no basis upon which to determine that decision was an abuse of the district court's discretion granted by Idaho Rule of Evidence 104(a) and *Bybee*.

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[1] While not expressly noted by the district court in its opinion, other than a minor exception (in which the district court used Plaintiffs' rather than Defendants' data), the parties agreed on the operative facts and data bearing on the issue of whether Idaho Falls and Pocatello were overlapping communities. Am. Supp. R., p. 215, fn. 102. Thus, to extent the district court was able to draw inferences in the Plaintiffs' favor, it did so.

As the district court noted, Pocatello patients accounted for approximately one percent of EIRMC's total patients in 2015 and 2016. Am. Supp. R., p. 216. Additionally, the district court noted that EIRMC served approximately two percent of Pocatello's total population in 2015 and 2016. Am. Supp. R., p. 217. Based on this data, the district court concluded that "[t]he data supplied only demonstrates the miniscule number of Pocatello residents treated in Idaho Falls[.]" *Id.* Therefore, the district court determined that *Bybee*'s "some degree of frequency" requirement had not been met. *Id.* at 217-18; *Bybee*, 157 Idaho at 176, 335 P.2d at 21.

Plaintiffs argue that the district court erred in focusing on the volume, ratio, and percentages of patients going from Pocatello to Idaho Falls, and instead should have focused on whether Pocatello patients regularly, consistently, and ordinarily traveled to Idaho Falls for healthcare. Medical Defendants agree that regular, consistent, ordinary use is clearly part of the inquiry under *Bybee*. However, in the absence of considering volume, ratios, and percentages, how is a district court to determine whether a certain population group is a regular, consistent, and ordinary user of a hospital's services "with some degree of frequency?" Raw data—in the absence of the context provided by volume, ratios, and percentages—is an incomplete basis upon which to conclude whether *Bybee*'s "some degree of frequency" standard has been met. In considering the overall context of the data presented, the district court properly exercised its discretion in concluding that Pocatello—which sent approximately two percent of its population to EIRMC in 2015 and 2016 (which accounted for approximately one percent of EIRMC's total patient base in 2015 and 2016)—was not an area ordinarily served by EIRMC with "some degree of frequency" at the time Medical Defendants provided care to Mr. Phillips.

Additionally, Plaintiffs have failed in their offer of proof. Based on guidance from *Bybee*, raw patient numbers—without additional comparative data to provide further context and

comparison—is an incomplete record upon which a district court could rule that Pocatello is an area "ordinarily served" by EIRMC. *Bybee* noted:

> The only evidence as to whether Pocatello is within the geographical area ordinarily served by EIRMC is found in the Supplemental Affidavit. There, Dr. Osborn attempted to define the applicable community by reference to a licensed general hospital, stating: "The community, in terms of the area served by EIRMC hospital in Idaho Falls, consisted of people from both Idaho Falls and Pocatello." We find this statement to be too conclusory to satisfy the foundation requirements of Idaho Code sections 6–1012 and 6–1013. **This statement does not identify the basis of Dr. Osborn's knowledge as to where EIRMC patients come from and, more importantly, it does not attempt to identify, or even approximate, the frequency which patients from Pocatello elect to receive services at EIRMC *as opposed to Portneuf Medical Center, Bingham Memorial Hospital, MVH or other hospitals.* In the absence of such evidence, we find the district court's error to be harmless.**

Bybee, 157 Idaho at 177, 335 P.3d at 22 (emphasis added). Here, Plaintiffs rely only on raw data of the number of Pocatello patients seen at EIRMC in 2015, 2016, and early 2017. However, Plaintiffs did not provide the district court with any evidence of the rates at which Pocatello patients sought treatment at Portneuf Medical Center (Pocatello), Bingham Memorial Hospital (Blackfoot), or Mountain View Hospital (Idaho Falls) as opposed to EIRMC in 2015, 2016, or 2017. Such evidence, as suggested by *Bybee*, is necessary for a district court to evaluate whether Pocatello residents seeking treatment at EIRMC as opposed to other area hospitals is an "ordinary" occurrence relative to rates at which Pocatello residents seek treatment at other southeast Idaho hospitals.

In addition, the district court properly ruled that there was a temporal defect in Dr. Erwin's ability to familiarize Dr. Moss with the community standard of health care practice. Am. Supp. R., pp. 218-19. Dr. Erwin first began working in Pocatello in January 2016 – a month after Mr. Phillips died. In an attempt to close that loop, Dr. Erwin then confirmed with Dr. Ravsten (a Pocatello psychiatrist) that the standard of healthcare practice in Pocatello did not

change between December 2015 and 2016. *Id.* This Court has never approved such an attenuated multi-step approach to familiarization and should not do so here. However, even if it did, as Plaintiffs point out, Dr. Ravsten only confirmed there had been no change in the *Pocatello* community standard of healthcare practice between December 2015 and January 2016. Because Pocatello and Idaho Falls are not overlapping communities, Dr. Erwin's knowledge of then-existing *Pocatello* standards is irrelevant. Knowledge of the applicable *Idaho Falls* community standard was necessary to enable Dr. Erwin to familiarize Dr. Moss.

f. The district court correctly determined that the issue of indeterminability was never properly before it, was not part of its interlocutory order, and therefore could not be reconsidered.

The district court did not abuse its discretion in refusing to consider the indeterminability issue at the reconsideration stage. Counsel for Plaintiffs admitted at the December 21, 2017, hearing that he did not make a motion that the standard of health care practice in this matter was indeterminable and that Idaho Falls and Pocatello were similar communities. Tr., pp. 218-219, ll. 20-25, 1-20. In fact, all parties agreed at the December 21, 2017, hearing that indeterminability was not an issue before the district court. R., pp. 219-220. This fact is further reflected in the district court's memorandum decisions issued on January 24, 2018, none of which discuss the issue of indeterminability. R., pp. 2420-2498.

As this Court acknowledged in *Pandrea v. Barrett*, 160 Idaho 165, 173, 369 P.3d 943, 951 (2016), the rule on motions for reconsideration allows the reconsideration of any order entered before or within fourteen days after the entry of a final judgment and plainly does not consider deciding an entirely new claim not previously raised. In this case, the district court was tasked with reconsideration of several orders, none of which involved the issue of indeterminability. Thus, the rule does not consider deciding an entirely new issue which was

never raised by Plaintiffs or considered by the district court in the orders in which Plaintiffs sought reconsideration.

Plaintiffs should be judicially estopped from raising indeterminability for the first time on reconsideration. Plaintiffs filed numerous documents with the district court implicitly representing that the standard of health care practice was determinable, and that Dr. Moss familiarized himself with the same (based on conversations with Drs. Kishiyama and Erwin, national standards of practice, etc.). In other words, Plaintiffs were satisfied that the efforts they took to familiarize Dr. Moss were sufficient and represented the same to the district court. This is precisely the type of evolving and shifting of positions to fit the exigencies of particular circumstances that the doctrine of judicial estoppel was designed to prevent. *McCallister v. Dixon*, 154 Idaho 891, 894, 303 P.3d 578, 581 (2013) (noting that "[j]udicial estoppel precludes a party from advantageously taking one position, then subsequently seeking a second position that is incompatible with the first.").

Even if the Court reaches the merits of this new indeterminability argument, Plaintiffs have not shown that the community standard of health care practice is indeterminable within the meaning of Idaho Code § 6-1012. In support of their indeterminability arguments, Plaintiffs cite *Lepper v. E. Idaho Health Servs., Inc.*, 160 Idaho 104, 369 P.3d 882 (2016) and *Hoene v. Barnes*, 121 Idaho 752, 828 P.2d 315 (1992). The *Hoene* case dealt with a unique factual situation that is discussed at length in *Morris By & Through Morris v. Thomson*, 130 Idaho 138, 146–47, 937 P.2d 1212, 1220–21 (1997) -- that of all practitioners of a particular specialty in a community practicing in the *same physician group*. *Morris*, 130 Idaho at 146–47, 937 P.2d at 1220–21. This particular circumstance is factually distinct from that in *Hoene*. Here, unlike the "unique circumstances" presented by professional associations of physicians (i.e. physician groups) who

practice together as "one business entity," independent physicians and hospitals/facilities are, by definition, **not** "one business entity."

More fundamentally, Plaintiffs gloss over the fact that *Lepper* requires that the party asserting indeterminability "make a sufficient showing that *concerted efforts* have been made to secure information on the standard of care from a like provider, but that those efforts failed *due to refusal of the providers to opine.*" *Lepper*, 160 Idaho at 115, 369 P.3d at 893 (emphasis added). Here, there were *five (5) psychiatrists* with admitting privileges at BHC in December 2015 that did not have any contractual or employment relationship with EIRMC/BHC and that were free to be contacted by medical malpractice plaintiffs to familiarize a plaintiff's testifying expert. R., pp. 2846-53. However, there is absolutely nothing by way of affidavit or otherwise in the record showing that Plaintiffs made any efforts – let alone concerted efforts – to contact these like providers in the community or that these like providers refused to opine.

In sum, because Plaintiffs have failed to meet their threshold burden of showing that the standard of health care practice is indeterminable, the Court need not address whether Idaho Falls and Pocatello are similar communities. *Morris*, 130 Idaho at 147, 937 P.2d at 1221 (noting that "[b]ecause [plaintiff] did not demonstrate that the standard of care...was indeterminable, [plaintiff] could not use the standard of care in similar communities.").

g. The district court properly determined that Dr. Moss lacked the foundation to offer medical expert testimony with respect to EIRMC, nursing care, and/or other non-psychiatric medical specialties.

The district court correctly ruled that Dr. Moss lacked the foundation to offer standard of care opinions with respect to EIRMC, the facility[2]. R., p. 2493-95; Am. Supp. R., pp. 221-24.

[2] As reflected in the record, the district court also precluded Dr. Moss from offering any opinions as to nursing care, other entities, or medical specialties other than psychiatry. Plaintiffs do not appeal this issue as to any Defendant other than EIRMC, so the district court's other rulings on this issue are not addressed here.

The district court's ruling was consistent with *Morrison v. St. Luke's Reg'l Med. Ctr., Ltd.*, 160 Idaho 599, 606, 377 P.3d 1062, 1069 (2016), which plainly establishes that entities such as EIRMC are subject to a different standard of care than medical specialists (i.e. physicians, nurses, mid-levels, or other specially-trained and/or educated health care providers).

On appeal, Plaintiffs argue that the district court erred in refusing to find that "EIRMC Standards of Care" (general statements that appeared in EIRMC's nursing-related medical records) established a "coextensive" psychiatric standard applicable to EIRMC and Dr. Larsen. Revealingly, Plaintiffs do not provide in their briefing any actual examples of the "EIRMC Standards of Care," which include generalities such as "patient receives care reflecting an ongoing process of assessment, problem identification, goal setting" and "patient and significant others will be supported in their effort to retain personal identity, self-worth, and patient's rights." R., p. 2494-95; Am. Supp. R., p. 223.

As the district court properly noted "[t]hese statements do not provide any basis to ascertain the 'standard of healthcare practice' required. Rather, they are more consistent with goals EIRMC and the others seek to attain in their treatment of patients." R., p. 2495. On reconsideration, the district court went further, finding that "[n]othing about these statements above speaks to the issue of ascertaining whether a patient who is voluntarily committed [sic] to a mental hospital should be allowed to leave against medical advice, or be subjected to an involuntary hold instead." Am. Supp. R., pp. 222-23. In other words, none of the "EIRMC Standards of Care" cited by Plaintiffs have anything to do with the provision of psychiatric care (let alone the community's application of hold criteria) and are therefore entirely inapposite to this case.

Plaintiffs argue that Dr. Larsen and Dr. Denny "conceded" that the "EIRMC Standards of Care" accurately identified the community standard of healthcare practice, and that there was a

"coextensive" uniform "psychiatric standard" for EIRMC and psychiatrists in the community. Appellant Brief at 22. However, this misrepresents Dr. Larsen's and Dr. Denny's testimony. R., pp. 1580 (pp. 218-220), 2786-89. There is absolutely nothing in the testimony of Dr. Denny or Dr. Larsen that amounts to a concession that these vague, nebulous, "EIRMC Standards of Care" establish the entirety of the community standard of health care practice for EIRMC or psychiatrists in the community, let alone that a single, uniform "psychiatric standard" applies to both facilities and psychiatrists. Plaintiffs' position is inconsistent with both *Morrison* (which patently rejects the concept of a "coextensive" uniform psychiatric standard for both entities and psychiatrists) and the testimony of Drs. Larsen and Denny and should be rejected.

h. The district court properly determined that Dr. Moss lacked foundation to offer an opinion as to alcohol dissipation rates.

The district court correctly held that Dr. Moss failed to lay sufficient foundation for expert testimony on the topic of alcohol dissipation rates. Idaho Rules of Evidence 702 states that "[i]f scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education, may testify thereto in the form of an opinion or otherwise." To offer expert testimony under Rule 702, "an expert witness must be shown to be competent with regard to the issues as to which the witness will give expert testimony." *Dabestani v. Bellus*, 131 Idaho 542, 961 P.2d 633 (1998) (accident reconstruction expert not qualified to base opinion on likely effect of alcohol on driver); *Sidwell v. William Prym, Inc.*, 112 Idaho 76, 730 P.2d 996 (1986) (expert metallurgist not shown to be qualified to render opinions concerning whether metal pins were defective or unreasonably dangerous); *State v. Johnson*, 119 Idaho 852, 810 P.2d 1138 (Ct. App. 1991) (doctor with no experience in child sexual abuse evaluation unqualified to testify as expert).

The sole timely-disclosed item cited to for such claimed foundation was a passing reference on Dr. Moss's *curriculum vitae* that he had experience treating addiction. R., p. 1248. However, treatment of addiction is fundamentally different from toxicological knowledge and knowledge of alcohol dissipation rates, and the district court correctly ruled that addiction treatment did not adequately lay a foundation for Dr. Moss's toxicological opinion on alcohol dissipation rates. R., pp. 2496-97; Am. Supp. R., pp. 220-21.

In addition, Plaintiffs attempted to submit a declaration of Dr. Moss on November 30, 2017 offering new and untimely opinions and foundation. The district court's scheduling order specifically required all of Plaintiffs' expert witnesses, including the subject matter on which the expert witness would testify and the underlying facts and data upon which the expert opinions were based no later than October 5, 2017. R., p. 2086. In the November 30, 2017, declaration Dr. Moss claimed for the first time that his opinion on alcohol dissipation was based upon his experience, training, and skill as a psychiatrist. However, beside the fact that this alleged foundation was untimely, "[a]n expert cannot rely on 'experience' without explaining in detail how the experience and other materials consulted support the opinion rendered." *Farley v. Oceania Cruises, Inc.*, No. 13-20244-CIV, 2015 WL 1131015, at *7 (S.D. Fla. Mar. 12, 2015). There is absolutely nothing in Plaintiffs' Expert Witness Disclosure or in Dr. Moss's Report demonstrating or explaining how Dr. Moss's experience in treating addiction has given Dr. Moss foundational knowledge of toxicology or alcohol dissipation rates and Plaintiffs' Expert Witness Disclosure and Dr. Moss's Report do not cite to any academic treatise, paper, study, article or any other source of foundation to offer expert opinions on alcohol dissipation. R., pp. 540-48, 550-58, 637-39.

Plaintiffs reliance on *Weeks v. E. Idaho Health Servs. Inc.*, 143 Idaho 834, 153 P.3d 1180 (2007) is also misplaced. In *Weeks*, the district court's decision to exclude the testimony was not

based on whether the physician was qualified to testify, but instead "focused on whether evidence was admissible and based upon sound scientific principles." *Id.* at 837, 153 P.3d at 1183. In this case, the district court's rationale was not focused on the inadmissibility of evidence or the soundness of scientific principles, but instead on Dr. Moss's patent failure to provide the district court with any information upon which it could conclude that Dr. Moss had laid a foundation to testify as to the rate of alcohol dissipation, i.e., that Dr. Moss had not demonstrated he was *qualified* to offer such opinions. Unlike the district court in *Weeks*, the district court properly considered whether Dr. Moss was *qualified* to offer such opinions and through an exercise of its discretion determined he was not.

Therefore, the district court properly exercised its discretion and did not err in holding that Dr. Moss lacked the foundation to offer any opinion as to alcohol dissipation rates.

B. The district court properly granted summary judgment in favor of Medical Defendants.

1. Standard of Review.

The Medical Defendants agree with and adopt the standard of review for summary judgment as set forth by Plaintiffs. Appellant Brief at 23.

2. Argument.

As set forth above, the district court properly granted summary judgment in favor of Medical Defendants after it correctly excluded Dr. Moss as an expert witness. Additionally, the district court properly granted summary judgment for the alternative reasons set forth below.

a. The district court properly ruled that the release contained in the Leaving Hospital Against Medical Advice Form ("AMA Form") barred the Plaintiffs from bringing this suit.

The district court correctly ruled that Medical Defendants were, alternatively, entitled to summary judgment by virtue of the release contained in the AMA Form. R., pp. 2448-51; Am.

Supp. R., pp. 229-31. Pursuant to *Bevan v. Vassar Farms, Inc.*, 117 Idaho 1038, 1041, 793 P.2d 711, 714 (1990), the AMA Form is binding on Mr. Phillips's heirs, the Plaintiffs. The operative portion of *Bevan* relied on by the district court states:

> It necessarily follows based on the well established law in this jurisdiction that if a defendant is not liable for injuries to the decedent had death not ensued, then there is no basis for recovery by the decedent's heirs. If a defendant's conduct does not make him liable to an injured party, then that defendant cannot be held liable in the event of death for damages resulting from the same conduct.

Id. at 1041 (emphasis added). Though *Bevan* dealt with comparative/contributory negligence, Medical Defendants agree with the district court that *Bevan* is controlling and its rationale applies equally to these circumstances (as it does to all circumstances dealing with substantive defenses). Whether based on the application of comparative fault principles or by operation of a signed release, *Bevan* holds that when a defendant is not *liable* for injuries to the decedent, it similarly is not liable to the heirs.

Plaintiffs argue that while *Bevan* is distinguishable, it does contain a "linchpin principle" that the defendant need only have committed a "wrongful act" or "negligence" against the decedent in order for the heirs to recover. Plaintiffs also lean on *Castorena v. Gen. Elec.*, 149 Idaho 609, 238 P.3d 209 (2010), which dealt with the separate procedural issue of statute(s) of limitations for wrongful death claims, and argue that the crux of the Idaho Supreme Court's decision was that "the timing of the complaint did not change the fact that the defendant committed a wrongful or negligent act against the decedent." *Id.* In Plaintiffs' view the only question is whether a wrongful or negligent act was committed by defendant against the decedent.

Plaintiffs' position is entirely foreclosed by *Bevan*. In *Bevan*, "[t]he special verdict form returned by the jury listed the negligence of decedent and Vassar Farms each at fifty percent." *Bevan*, 117 Idaho at 1039, 793 P.2d at 712. In other words, *defendant Vassar Farms was found*

to have committed a negligent act against Mr. Bevan. However, despite the jury's finding of a negligent act committed by the defendant, Idaho's comparative fault statute provided a **substantive bar** on any recovery by the decedent, and as held in *Bevan*, his heirs. Similarly here, even if the Court assumes for the sake of argument that Medical Defendants committed any negligent or wrongful act against Mr. Phillips (they did not), the AMA Form provides a **substantive bar** on any recovery by Mr. Phillips, and under the rationale in *Bevan*, by his heirs the Plaintiffs. Plaintiffs also cite *Russell v. Cox*, which notably, was later superseded by statute. In any event, key to the Court's ruling in *Russell* was that the asserted substantive defense did not apply. *Russell v. Cox*, 65 Idaho 534, 148 P.2d 221, 223 (1944). Here, the substantive defense of the AMA Form, like the contributory/comparative negligence defense in *Bevan*, does apply.

Plaintiffs next argue that *Northern Pacific Railway Co. v. Adams*, 192 U.S. 440, 24 S. Ct. 408, 409, 48 L. Ed. 513 (1904), and *Earley v. Pac. Elec. Ry. Co.*, 176 Cal. 79, 79–80, 167 P. 513 (1917), are two of the most important cases for resolving this issue. Medical Defendants agree that *Adams* and *Earley* are illustrative. *Adams* dealt with a pre-injury release—a release of future liability or express assumption of the risk by Mr. Adams. *Earley* dealt with a post-injury settlement/release of an existing claim. In *Adams*, the United States Supreme Court established the now settled rule in holding that a decedent's pre-injury release of negligence/duty and/or express assumption of the risk functioned as a **substantive bar** to a later wrongful death claim by the heirs. *See also Eriksson v. Nunnink*, 233 Cal. App. 4th 708, 725, 183 Cal. Rptr. 3d 234, 249 (2015); *Ruiz v. Podolsky*, 50 Cal. 4th 838, 851–52, 237 P.3d 584, 593 (2010); *see Rountree v. Boise Baseball LLC*, 154 Idaho 167, 296 P.3d 373 (2013) (citing *Salinas v. Vierstra*, 107 Idaho 984, 695 P.2d 369 (1985)) (recognizing continued vitality of express assumption of risk in Idaho).

As in *Adams*, Mr. Phillips *prospectively* released Medical Defendants of any legal duty or liability by signing an AMA Form at the time of discharge. Because the AMA Form is a release of the same duty at issue in the heirs' wrongful death claim, it has rightfully been asserted by Medical Defendants as a complete defense to the wrongful death claim. *See Castorena*, 149 Idaho at 616, 238 P.3d at 216 (concluding that "[t]he decedent's waiver eliminated the railway company's *duty*, as to negligence, toward the travelling attorney in *Northern Pacific*; the statute of limitations at issue here does not affect Respondents' *duty* toward the Decedents.") (citing *N. Pac. Ry. Co. v. Adams*, 192 U.S. 440 (1904)).

By contrast, *Earley* is an example of a post-injury settlement of an already ripe claim against a defendant. *See Earley v. Pac. Elec. Ry. Co.*, 176 Cal. 79, 167 P. 513 (1917). The AMA Form is a clear-cut example of a pre-injury release of duty/express assumption of risk like *Adams*, not a post-injury settlement of damages entered into by a decedent prior to a decedent's death as in *Earley*[3]. *Bevan* and *Adams* thus apply to this case, and the Court correctly ruled that the AMA Form is binding on Mr. Phillips' heirs.

Plaintiffs argue that the AMA Form, even if deemed enforceable, did not function as a release of Dr. Larsen, because Dr. Larsen was not a signatory to the AMA Form. However, the AMA Form expressly releases the "attending physician," and there is no dispute as to Dr. Larsen's status as Mr. Phillips' attending physician. R., p. 627; Am. Supp. R., p. 232. Further,

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[3] Plaintiffs argue that they allege negligent conduct by Medical Defendants prior to the time Mr. Phillips signed the AMA Form. However, even assuming that Plaintiffs arguments for Medical Defendants' negligence had merit (they do not), the focus is on when the *injury/damage* occurred (i.e. whether the signing of the release preceded liability attaching), not on whether there had been inchoate antecedent negligence. *See Eriksson v. Nunnink*, 233 Cal. App. 4th 708, 725, 183 Cal. Rptr. 3d 234, 249 (2015); *Ruiz v. Podolsky*, 50 Cal. 4th 838, 851–52, 237 P.3d 584, 593 (2010). At the time Mr. Phillips signed the release, neither he nor plaintiffs had suffered any injury/damage. In any event, the only alleged negligence that could even conceivably be causally connected to Mr. Phillips' demise is the decision to allow Mr. Phillips to leave BHC. It is undisputed that Mr. Phillips signed the release *before* he left the facility. The AMA Form is a textbook example of a pre-injury release/express assumption of risk, not a post-injury settlement.

because prospective releases like the AMA Form can be gratuitous, Dr. Larsen need not be a signatory or provide any consideration for the release to obtain its benefit. *Holve v. Draper*, 95 Idaho 193, 195, 505 P.2d 1265, 1267 (1973) (noting that "a release is a surrender of the cause of action, which may be *gratuitous, or given for inadequate consideration.*") (citing Prosser, HANDBOOK OF THE LAW OF TORTS, 3d ed. 1964, pp. 268-269). In Idaho, as Plaintiffs point out, a release is effective as to other tortfeasors when "the agreement contains specific language to that effect." *Holve*, 95 Idaho at 197, 505 P.2d at 126. The AMA Form did just that by expressly releasing the "attending physician" – Dr. Larsen. R., p. 627.

Plaintiffs also argue that the release in the AMA Form should be deemed void as a matter of public policy. However, the district court correctly held that Idaho has a strong public policy of enforcing releases in the absence of unfair conduct or strong reasons, and that the release in the AMA Form did not implicate unfair conduct or strong reasons. Am. Supp. R., at pp. 228-229. In addition to the reasons stated by the district court, Medical Defendants assert that the release should be enforced because: (1) Idaho has a strong statutory public policy of honoring a patient's right to consent or to refuse or to withdraw his or her consent to medical treatment (see I.C. §§ 39-4502(7), 39-4503, and 39-4504(3); (2) there is no public duty at issue here nor unequal bargaining power (*Lee v. Sun Valley Co.*, 107 Idaho 976, 978, 695 P.2d 361, 363 (1984)); (3) enforcing the terms of the AMA release is consistent with case law, and with the legislature's statutory enactment of limitations of liability; (4) releases may be gratuitous and need not be supported by consideration (Prosser, HANDBOOK OF THE LAW OF TORTS at 268-69 (3d ed. 1964); *Holve v. Draper*, 95 Idaho 193, 195, 505 P.2d 1265, 1267 (1973)).

Plaintiffs further argue there were questions about Mr. Phillips's competency at the time he signed the AMA Form. However, the district court correctly found that based on its decision to strike Dr. Moss as an expert witness, there is no triable issue of fact as to Mr. Phillips's

competency/capacity. Am. Supp. R., p. 228. As argued *supra*, the district court's decision to strike Dr. Moss was correct and there continues to be no triable issue of fact as to Mr. Phillips's competency. In any event, even if this Court were to find that Dr. Moss adequately familiarized himself with the applicable community standard of health care practice, Dr. Moss's failure to provide any foundation to offer expert opinion on *alcohol dissipation rates* is fatal to the issue of Mr. Phillips's competency/capacity. As a result, because the Medical Defendants' fact and expert testimony supporting that Mr. Phillips was competent at the time of discharge is unrebutted, there is no genuine dispute of material fact as to Mr. Phillips's capacity/competence to sign the AMA Form. R., pp. 612 (p. 162, ll. 4-23), 616 (p. 244, ll. 3-11), 623, 630 (p. 52, ll. 9-25), 631 (p. 53, ll. 1-25; p. 54, ll. 1-25, p. 55, ll. 1-25, p. 56, ll. 1-8), 632 (p. 76, ll. 8-11), 779-815.

Plaintiffs also argue, (but have cited no foundation, authority, or evidence for) the proposition that Mr. Phillips's bipolar condition could have affected his legally presumed capacity to sign a release and withdraw consent to healthcare treatment. *See* Idaho Code §§ 29-101, 39-4503. Thus, unless this Court holds that Dr. Moss is qualified to opine as to alcohol dissipation, summary judgment continues to be proper pursuant to the AMA Form, irrespective of the resolution of other issues.

Lastly, Plaintiffs argue that there is a triable issue of fact as to whether Mr. Phillips's signature appears on the AMA Form. However, the district court correctly ruled, based on the unrebutted testimony of forensic document examiner, Matthew G. Throckmorton, that there was no triable issue of fact as to the authenticity of Mr. Phillips's signatures on the AMA Form. Am. Supp. R., pp. 226-228. The district court correctly noted that Penny Phillips's "speculations" about the authenticity of the signature based solely on EIRMC's response to her initial records request was insufficient to create an issue of fact. *Id.* Moreover, there is absolutely no evidence

in the record supporting that Penny Phillips is a handwriting expert. Under the Idaho Rules of Evidence, a lay witness such as Ms. Phillips may offer lay opinion testimony to identify Mr. Phillips's signature. *See* I.R.E. 903 (noting that a lay witness may offer "[n]onexpert opinion as to the genuineness of handwriting, based upon familiarity not acquired for purposes of the litigation."); *State v. Eubanks*, 86 Idaho 32, 36, 383 P.2d 342, 344 (1963). Medical Defendants do not dispute that Ms. Phillips is familiar with Mr. Phillips's signature and is able to offer such lay opinion testimony. In fact, Ms. Phillips *did testify* that the signatures on the AMA Form looked like Mr. Phillips's signature. R., pp. 2005-06 (p. 248, ll. 11-25; p. 249, ll. 1).

However, here – in addition to not being disclosed as an expert – Ms. Phillips has demonstrated no foundation to offer *expert* handwriting testimony on identifying forgeries, fabrications, alterations, copy/paste jobs, or any other fraud in handwritten signatures. She is not a forensic document examiner. She claims no special experience or training in detecting fraud in handwritten signatures. She is not qualified to offer such expert testimony. As a result, she is not qualified to offer (and has not offered) testimony to rebut the testimony of a handwriting expert such as Mr. Throckmorton. For this reason, Mr. Throckmorton's testimony is unopposed and there is no genuine dispute as to the signature's authenticity.

The district court correctly granted summary judgment based on the alternative ground of the release in the AMA Form.

b. The district court properly held that EIRMC cannot be liable for Dr. Larsen's conduct under a theory of apparent agency.

As a threshold matter, this Court need not even reach the issue of apparent agency vis-à-vis Dr. Larsen and EIRMC if it affirms either: (1) the district court's decision to strike and exclude Dr. Moss; or (2) the district court's decision to grant summary judgment in favor of EIRMC based on the AMA Form.

If the Court does reach this issue, it should affirm the district court. In *Jones v. HealthSouth Treasure Valley Hospital*, 147 Idaho 109, 116, 206 P.3d 473, 480 (2009), this Court held that "a hospital **may** be found vicariously liable under Idaho's doctrine of apparent authority for the negligence of independent personnel assigned by the hospital to perform support services." *Id.* Under *Jones*, two basic elements govern whether Dr. Larsen may be deemed an apparent agent of EIRMC: (1) holding out by EIRMC that would lead a person to reasonably believe Dr. Larsen was its agent; (2) acceptance of Dr. Larsen's service by one who reasonably believes it is rendered on behalf of EIRMC. *Id.*

However, if a patient is on notice of a physician's independent contractor status, a patient is usually foreclosed from arguing the appearance of agency between the independent contractor and hospital. *York v. Rush-Presbyterian-St. Luke's Med. Ctr.*, 222 Ill.2d 147, 202, 854 N.E.2d 635, 665-66 (Ill. 2006); *Floyd v. Humana of Virginia, Inc.*, 787 S.W.2d 267, 270 (Ky. Ct. App. 1989). That is precisely the circumstance present here. Mr. Phillips signed a Conditions of Admission form that advised him that psychiatrists providing services at EIRMC are independent contractors. R., pp. 602-605. Because the Conditions of Admission form conclusively establishes Dr. Larsen's independent contractor status, the Plaintiffs have, as a matter of law, failed to establish the second element of Jones as Mr. Phillips could not, as a matter of law, have reasonably believed Dr. Larsen was an employee or agent of EIRMC. Therefore, there is no reason to look to any of EIRMC's alleged "other acts" purportedly "holding out" Dr. Larsen as its agent. The district court therefore properly determined that Dr. Larsen was not EIRMC's apparent agent and rightly granted EIRMC summary judgment on that ground.

If this Court does reach this issue, Medical Defendants further incorporate their arguments set forth at the district court level on this issue. *See* R., pp. 715-23, 1949-57, 2803-07.

c. The district court properly granted summary judgment in favor of Defendant IBHS.

The district court properly granted IBHS (Dr. Larsen's employer) summary judgment. To the extent this Court affirms the district court's rulings, it should affirm the district court's grant of summary judgment with respect to IBHS.

C. The district court properly allowed the depositions of the local consultants.

1. Standard of Review.

The standard of review for a trial court's decision to compel discovery is abuse of discretion. *Quigley v. Kemp*, 162 Idaho 408, 410, 398 P.3d 141, 143 (2017). The four criteria to be considered as part of this Court's abuse of discretion review are set forth *supra* in Section III.A.1.

2. Argument.

The district court properly perceived the issue of whether to grant or deny a protective order as one of discretion and acted within the outer boundaries of its discretion and consistent with legal standards when it allowed the depositions of Drs. Kayne Kishiyama and Kathleen Erwin to move forward. R., p. 462; Am. Supp. R. 31[4].

Plaintiffs argue that the district court erred in not treating the local consulting physicians as retained, non-testifying experts pursuant to Idaho Rule of Civil Procedure 26(b)(4)(D) (formerly Rule 26(b)(4)(B)). Appellant Brief at 38-39. Plaintiffs also argue that allowing depositions of local consultants will have a "chilling effect" on local practitioners' participation in medical malpractice actions and that such depositions are "unnecessary" and "cumulative." *Id.* at 39-40. Medical Defendants respectfully disagree with these arguments.

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[4] After the district court allowed Dr. Kishiyama's deposition to move forward, the parties stipulated to allow the deposition of Dr. Erwin to move forward on the same terms, with Plaintiffs and Medical Defendants preserving the issue for appeal. R., p. 470.

First, this Court's holding in the case of *Quigley v. Kemp* – that Rule 26(b)(4)(B) (now Rule 26(b)(4)(D)) "does not apply to non-testifying medical experts who have been called to provide the foundation for a testifying witness' testimony" – completely forecloses the prospect of invoking Rule 26(b)(4)(D) protection for local consulting physicians in medical malpractice actions. 162 Idaho 408, 398 P.3d at 145; *see* R., pp. 449-451. In *Quigley*, this Court specifically held that it would be inequitable to shield the identity of the local consultant from discovery under Rule 26(b)(4)(D) (then Rule 26(b)(4)(B)), because it would deprive the defense of discovery of the foundational underlying facts or data considered by a testifying trial expert. *Quigley*, 162 Idaho at 412, 398 P.3d at 145. Plaintiffs' suggestion that Medical Defendants be required to show "exceptional circumstances" to depose a local consultant is tied to Rule 26(b)(4)(D). Because Rule 26(b)(4)(D) does not apply to local consultants, Plaintiffs' "exceptional circumstances" argument fails.

The typical policy justifications for precluding discovery related to retained, non-testifying experts simply do not apply to local consultants in Idaho medical malpractice actions. Am. Supp. R., pp. 21-23. By definition, local consultants are not asked to form opinions as to any breach of the standard of health care practice or to test any scientific or technical theories. Local consultants do not form substantive expert opinions that could end up being prejudicial to the retaining party if subjected to discovery. Unlike true "trial preparation" experts, there is no risk that any discoverable information that a local consultant possesses could be unfairly prejudicial to plaintiffs. Therefore, the public policy rationale for Rule 26(b)(4)(D)—preventing unfair prejudice to the retaining party that would result if the retained, non-testifying expert's shelved opinions were revealed in discovery—does not apply to the unique, limited role local consulting physicians play in Idaho medical malpractice actions. Instead – as recognized in *Quigley* – the opposite is true. Shielding otherwise relevant discovery related to the local

consultant would deprive the defense of discovery of the foundational underlying facts or data considered by a testifying trial expert, foreclose effective cross-examination, and undermine the expert disclosure requirements of Rule 26. Am. Supp. R., pp. 26-28.

While *Quigley* did not specifically address the question of whether a defendant is entitled to depose a local consultant in a medical malpractice action after discovery of the local consultant's identity, that conclusion flows naturally from this Court's holding in *Quigley*. Indeed, if Rule 26(b)(4)(D) "does not apply to non-testifying medical experts who have been called to provide the foundation for a testifying witness' testimony," then there is no remaining bar to further, relevant discovery related to the local consultant. In the absence of some affirmative bar on discovery (such as Rule 26(b)(4)(D)), the sole question should be whether the requested discovery is relevant. Undoubtedly, a limited-scope deposition regarding the local consultant's own knowledge and credentials and his or her conversations with the retained, testifying expert is certainly relevant to a key issue in every Idaho medical malpractice case – a testifying expert's foundational familiarity with the community standard of healthcare practice. Moreover, a limited-scope deposition of the local consultant is also necessary for meaningful discovery into and cross-examination of the underlying facts or data considered by a testifying trial expert in a medical malpractice action.

Additionally, the text of the *Quigley* opinion itself foreshadows at least a limited-scope deposition of the local consultant by suggesting examples of how disclosure of the local consultant's identity might prove useful to a medical defendant in preparing its defense (i.e. discovery that the conversation never took place, that the consultant did not actually work in the relevant community, that the local consultant has an "ax to grind" against the healthcare provider being sued). *Quigley*, 162 Idaho at 412, 398 P.3d at 145. In the absence of a deposition of the local consultant, there is virtually no way for a medical defendant to discover the hypotheticals

suggested by the Court, let alone obtain sufficient information to effectively cross-examine on these points or other similar points.

Plaintiffs' argument that allowing a limited-scope deposition (of the type approved by the district court here) would have a "chilling effect" on participation is nothing more than speculation. In any event, it is entirely reasonable to require an individual providing a testifying expert with prerequisite, foundational knowledge of a community standard of healthcare practice to participate in a limited-scope deposition regarding the consultant's own knowledge and credentials and his or her conversations with the retained, testifying expert.

Lastly, Plaintiffs' final argument that depositions of local consultants are "unnecessary" and "cumulative" is undermined by the outcome at the district court level in this very case. The depositions of Dr. Kishiyama and Dr. Erwin in this case revealed fatal defects in what Plaintiffs claimed to be Dr. Kishiyama's and Dr. Erwin's personal knowledge of the community standard of healthcare practice. *See supra* Sections III.A.2.c. and e. Thus, far from being "unnecessary" or "cumulative," the depositions of the local consultants were key in evaluating whether Dr. Moss was actually familiar with the applicable community standard of healthcare practice. Such depositions serve a gatekeeping function of authenticating and probing a testifying expert's claimed foundation, preserving effective cross-examination, and honoring the expert disclosure requirements of Rule 26.

Based on the foregoing, the district court properly exercised its discretion in allowing the depositions of Drs. Kishiyama and Erwin to take place.

D. The district court properly granted Medical Defendants' Motion for a Protective Order concerning the scope of EIRMC's 30(b)(6) deposition.

1. Standard of Review.

The standard of review for a trial court's decision to grant a protective order is abuse of discretion. *Quigley*, 162 Idaho at 410, 398 P.3d at 143. The four criteria to be considered as part of this Court's abuse of discretion review are set forth supra in Section III.A.1.

2. Argument.

Plaintiffs requested EIRMC to designate a representative to testify at its 30(b)(6) deposition as to "the community standard of health care practice, as that term is used in Idaho Code §§ 6-1012 & 6-1013, for psychiatrists practicing medicine in Idaho Falls, Idaho, during December 2015." R., p. 223. The district court perceived the issue of whether to grant or deny a protective order as one of discretion and acted within the outer boundaries of its discretion and consistent with legal standards when it granted a protective order limiting the scope of Plaintiffs' Rule 30(b)(6) deposition of EIRMC. R., p. 340.

The entirety of Plaintiffs' argument is premised on the assumption of a distinction between testimony regarding what the community standard of care is (which Plaintiffs insist is purely factual and discoverable from non-expert sources, including a Rule 30(b)(6) corporate designee), and testimony regarding a *breach* of the community standard of care (which Plaintiffs agree is solely the province of expert testimony). Plaintiffs' argument is rebutted by the plain language of Idaho Code § 6-1013, which provides that both the standard of healthcare practice itself and a breach thereof must be established by direct expert testimony. Idaho Code § 6-1013 ("The applicable standard of practice and such a defendant's failure to meet said standard must be established in such cases by such a 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...") (emphasis added); *Grover v. Isom*, 137 Idaho 770, 775, 53

P.3d 821, 826 (2002) (noting that I.C. § 6-1013 "states that that the standard of care must be established by expert testimony."). In any event, whether the community standard of health care practice is: (1) an expert opinion; (2) a legal conclusion reached by a jury after considering expert testimony; or (3) as Plaintiffs argue, an objective fact, it is, by Idaho statute (and Idaho case law), unquestionably the product of *expert testimony*. While a matter of first impression in Idaho, numerous federal courts have indicated that expert testimony is beyond the scope of a Rule 30(b)(6) corporate deposition.[5] *See Loop AI Labs Inc v. Gatti*, No. 15-CV-00798-HSG(DMR), 2016 WL 913377, at *3 (N.D. Cal. Mar. 10, 2016) (holding that "Rule 30(b)(6) witnesses are not required to provide expert testimony, but 'must testify about information known or reasonably available to the organization.'"); *Babcock Power, Inc. v. Kapsalis*, No. 3:13-CV-717-CRS-CHL, 2016 WL 6804909, at *2 (W.D. Ky. Nov. 16, 2016) (noting that "[t]he Court agrees that plaintiffs' Rule 30(b)(6) deponent(s) is not required to give expert testimony; rather, the deponent must have knowledge of the *factual* basis for plaintiffs' claims."); *Trustees of Boston Univ. v. Everlight Elecs. Co.*, No. 12-CV-11935-PBS, 2014 WL 5786492, at *4 (D. Mass. Sept. 24, 2014) (noting that "[a] party may properly resist a Rule 30(b)(6) deposition on the grounds that the information sought is more appropriately discoverable through...expert discovery."); *In re Indep. Serv. Organizations Antitrust Litig.*, 168 F.R.D. 651, 654–55 (D. Kan. 1996) (listing "expert testimony" as a matter "inappropriate for Rule 30(b)(6) purposes").

Additionally, requiring a corporate medical defendant to produce an expert witness at a Rule 30(b)(6) deposition effectively turns the burden imposed on a malpractice plaintiff by Idaho Code §§ 6-1012 and 6013 on its head, by, in essence, requiring a corporate medical defendant to provide a plaintiff at its Rule 30(b)(6) deposition with the foundational knowledge of the

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[5] *Sierra Club v. BNSF Ry. Co.*, No. C13-0967-JCC, 2016 WL 4528452, at *3 (W.D. Wash. Aug. 30, 2016); *Boyer v. Reed Smith, LLP*, No. C12-5815 RJB, 2013 WL 5724046, at *3–4 (W.D. Wash. Oct. 21, 2013).

applicable community standard of healthcare practice needed to familiarize a plaintiff's out-of-community expert. Further, even if the prior arguments were to be set aside, the specific request at issue sought testimony from EIRMC regarding the standard of healthcare practice for psychiatrists, not the entity-specific standard applicable to EIRMC. R., p. 223; *see also Morrison v. St. Luke's Reg'l Med. Ctr., Ltd.*, 160 Idaho 599, 606, 377 P.3d 1062, 1069 (2016) ("An entity and its employee physicians do not have the same standard of care because...[a]n entity does not have the similar training, experience, and fields of medical specialization as its employee physicians, and an entity does not provide direct care to patients."). EIRMC is not a licensed psychiatrist, does not establish standards of care for the practice of psychiatry, and does not employ psychiatrists. Thus, even if the specific request were deemed to be seeking a type of discovery that is proper in the context of a Rule 30(b)(6) deposition, EIRMC, by definition, is incapable of establishing the community standard of health care practice for psychiatrists in Idaho Falls, Idaho in December 2015. To the extent EIRMC had policies and procedures bearing on the standard of healthcare practice for psychiatry in December 2015, those policies and procedures were produced and available to Plaintiffs, and an individual was designated for purposes of EIRMC's Rule 30(b)(6) deposition to discuss Plaintiffs' topics concerning hospital policies and procedures. R., pp. 227-28.

Based on the foregoing, the district court properly exercised its discretion in issuing a protective order limiting the scope of Plaintiffs' Rule 30(b)(6) deposition of EIRMC.

E. The district court erred in granting Plaintiffs' Amended Motion to Amend Scheduling Order.

1. Standard of Review.

A trial court's decision to amend its own scheduling order is subject to an abuse of discretion review. The four criteria to be considered as part of this Court's abuse of discretion review are set forth *supra* in Section III.A.1.

2. Argument.

The district court perceived the issue of whether its scheduling order should be amended as one of discretion and acted within the outer boundaries of its discretion by allowing its scheduling order to be amended. However, the district court did not act consistently with Idaho's legal standards when it allowed its scheduling order to be amended and thus abused its discretion.

The scheduling order the district court issued on May 8, 2017, did not allow for the disclosure of rebuttal expert opinions. R., p. 2086. At the time of the scheduling conference and for over six (6) months after the scheduling order was entered Plaintiffs did not request or file a motion to amend the scheduling order to allow for the disclosure of rebuttal expert opinions. R., p. 2087. Only after Medical Defendants had filed their dispositive motions and filed their expert witness disclosures did Plaintiffs seek to amend the district court's scheduling order. R., p. 2087.

Rule 16(a)(3) of the Idaho Rules of Civil Procedure provides that the deadlines for disclosing expert witnesses must not be modified "except by leave of the court on a showing of good cause . . . " This Court has held that in making a good cause showing under I.R.C.P. 4(a)(2) and 40(c) a party must present sworn testimony by affidavit or otherwise setting forth facts that demonstrate good cause. *See Morgan v. Demos*, 156 Idaho 182, 186-87, 321 P.3d 732, 736-37 (2014); *Taylor v. Chamberlain*, 154 Idaho 695, 698, 302 P.3d 35, 38 (2013). Logically, and per the foregoing cases, one can only deduce that in order to make a showing of good cause under Rule 16, a party must present sworn testimony by affidavit or otherwise setting forth facts that demonstrate good cause. Plaintiffs did not provide an affidavit or other sworn testimony

from anyone in this matter attempting to set forth facts that would demonstrate the required good cause. Thus, the motion should have been denied on this basis alone.[6] Further, the district court, in granting the motion to amend the scheduling order did not identify or make a finding that the required good cause had been demonstrated. Tr., pp. 60-61.

Additionally, even if sworn testimony had been introduced in this matter, there are no facts that would support a showing of good cause because of the delay and lack of diligence on the part of Plaintiffs. In a case examining whether good cause existed in a Rule 4 service of process context this Court observed: "If a plaintiff fails to make any attempt at service within the time period of the rule, it is likely that a court will find no showing of good cause." *Harrison v. Board of Professional Discipline of the Idaho State Board of Medicine*, 145 Idaho 179, 183, 177 P.3d 393, 397 (2008); *see also Johnson v. Mammoth Recreations, Inc.*, 975 F.2d 604, 609 (9th Cir. 1992) (. . . Rule 16(b)'s "good cause" standard primarily considers the diligence of the party seeking the amendment. . . . Moreover, carelessness is not compatible with a finding of diligence and offers no reason for a grant of relief. . . . If that party was not diligent, the inquiry should end.") (internal citations omitted).[7]

In this case, Plaintiffs made no attempt to modify or amend the scheduling order for over six (6) months, and only after their deadline for disclosing expert witnesses had expired and after Medical Defendants filed dispositive motions. Thus, where there was no diligence by Plaintiffs

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[6] *Taylor v. Chamberlain*, 154 Idaho 695, 698, 302, P.3d 35, 38 ("Because Plaintiff did not present any sworn testimony alleging facts that he contends constituted good cause for failing to serve the Defendants timely, he failed to even create a record upon which the issue of good cause could have been presented to the district court. It was his burden to do so. Absent even an attempt to put facts in the record explaining why Plaintiff failed to serve the Defendants timely, the only conclusion that the district court could have reached was that there was no good cause.")

[7] Idaho has modeled its Rules of Civil Procedure on the Federal Rules of Civil Procedure. "Where the Idaho Rules of Civil Procedure mirror the federal rules, we have applied the interpretations of the federal courts to the Idaho Rules." *In Re Contest of Election (primary election-Republication nomination) for State Representative in Legislative District No. 7, Position "B"*, 164 Idaho 102, 425 P.3d 1245, 1250 (2018) (internal citation omitted).

to modify or amend the scheduling order there can be no good cause and the inquiry should end.[8] Accordingly, the district court abused its discretion in granting Plaintiffs' motion to amend the scheduling order and such order should be reversed.

F. Medical Defendants are entitled to a portion of their attorney's fees and costs on appeal pursuant to Idaho Code § 12-121 and Rules 40 and 41 of the Idaho Appellate Rules.

This Court has held that a party is "entitled to attorney fees on appeal pursuant to I.C. § 12-121 if this Court is left with the abiding belief that the appeal was brought or pursued frivolously, unreasonably, and without foundation." *Rowley v. Fuhrman*, 133 Idaho 105, 109-110, 982 P.2d 940, 944 (1999). While the majority of the arguments raised on appeal present novel issues of first impression, the Plaintiffs' continued reliance on Penny Phillips's wholly unsupported speculations about the authenticity of Mr. Phillips's signature on the AMA Form was again frivolously, unreasonably, and without foundation raised on appeal. Medical Defendants respectfully request a prorated award of their attorney fees on appeal attributable to this issue.

IV. CONCLUSION

Based upon Idaho statute, Idaho case law precedent, persuasive case law precedent, and the foregoing argument, the district court correctly perceived the issue as one of discretion, acted within the outer boundaries of its discretion, acted consistently with the legal standards applicable to the specific choices available to it, and reached its decision by the exercise of reason when it properly struck Plaintiffs' expert witness for lack of familiarity with the applicable standard of health care practice and held said expert was not qualified to testify as to

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[8] *See Edmunds v. Kraner*, 142 Idaho 867, 873, 136 P.3d 338, 344 (2006) ("We are mindful that the Rules of Civil Procedure equip both sides with tools to ensure fair pretrial procedure, *see* I.R.C.P. 16, 26, and we have little sympathy for attorneys who do not utilize these tools to the extent reasonable."); *Priest v. Landon*, 135 Idaho 898, 901, 26 P.3d 1235, 1238 (Ct. App. 2001) ("Neither did Priest object to the form of the pretrial order . . .").

alcohol dissipation rates. Similarly, the district court, pursuant to well-established Idaho case law precedent and other persuasive case law precedent, correctly determined that the Medical Defendants were entitled to summary judgment based upon the AMA release signed by Decedent.

The district court should also be affirmed on its ruling allowing limited depositions of local familiarization experts and order concerning the scope of a 30(b)(6) deposition pursuant to Idaho statute and case law precedent. Finally, the district court's order granting Plaintiffs' Amended Motion to Amend Scheduling Order should be reversed based upon Plaintiffs failure to make a showing of good cause as required by Idaho law. Therefore, Medical Defendants respectfully request that this Court affirm the district court with respect to its summary judgment and evidentiary rulings and reverse the district court with respect to its ruling amending its scheduling order. Medical Defendants would further respectfully request that this Court award Medical Defendants their costs and a portion of attorney fees on appeal.

DATED THIS 8th day of March, 2019.

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