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Idaho Supreme Court
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IN THE SUPREME COURT FOR THE STATE OF IDAHO

DEBRA DLOUHY, individually, and as surviving spouse of Duane Dlouhy, DUSTIN DLOUHY, individually, and as Personal Representative of the Estate of Duane Dlouhy, DRUE HATFIELD, individually, and DEMI DLOUHY, individually, Plaintiffs/Appellants, vs. KOOTENAI HOSPITAL DISTRICT, doing business as KOOTENAI HEALTH KOOTENAI CLINIC, LLC, and UNKNOWN BUSINESS ENTITIES I through X, Defendant/Respondent.	Docket No. 47165-2019 Kootenai County Case No. CV-17-4052

APPELLANTS' BRIEF

Appeal from the District Court of the First Judicial District for Kootenai County
Honorable Cynthia K.C. Meyer, District Judge Presiding

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I. STATEMENT OF THE CASE

A. Nature of Case

This is a wrongful death and medical malpractice action. Plaintiffs Debra Dlouhy, Dustin Dlouhy, Demi Dlouhy, and Drue Hatfield (hereinafter, "the Dlouhys") are the surviving heirs of Duane Dlouhy, who died as a result of a missed diagnosis of rectal cancer. The District Court granted Defendant Kootenai Hospital District d/b/a Kootenai Health (hereinafter, "Kootenai Health") summary judgment after finding that the Dlouhys' experts lacked the foundation to render opinions regarding the standard of care. The Dlouhys have initiated this appeal because the District Court abused its discretion in not considering the opinions of the Dlouhys' retained expert witnesses.

B. Course of Proceedings

On May 23, 2017, Duane and Debra Dlouhy filed a *Complaint and Demand for Jury Trial* alleging medical malpractice against Kootenai Clinic, LLC; Susan E. Hildebrandt, N.P., James P. McMahon, PA-C, and unnamed general business entities. (R., pp. 12-23). An *Amended Complaint for Wrongful Death and Demand for Jury Trial* was filed after the death of Duane Dlouhy and included his children as parties. (*Id.*, pp. 24-37.) The amended complaint also included Kootenai Hospital District d/b/a Kootenai Health; Jeffrey M. Zurosky, M.D.; Henry G. Amon, M.D.; Robert C. Seeley, M.D.; Western Medical Associates, PLLC; and Nicole S. Burbank, M.D. as named defendants. (*Id.*) Upon stipulation of the parties, a *Second Amended Complaint for Wrongful Death and Demand for Jury Trial* was submitted on January 22, 2018, which took Kootenai Clinic, LLC; Susan E. Hildebrandt, N.P.; and James P. McMahon, PA-C,[1] off the caption. (*Id.*, pp. 59-72.)

[1] Ms. Hildebrandt and Mr. McMahon were acknowledged to be employees of Kootenai Health, acting within the course and scope of their employment. Although they were dismissed in their individual capacities, their conduct and care of Mr. Dlouhy were continuing issues in the case.

Kootenai Health filed its *Answer to Plaintiffs' Second Amended Complaint for Wrongful Death and Demand for Jury Trial* on January 29, 2018. (*Id.*, pp. 73-88.) On July 20, 2018, a stipulation among the parties was filed dismissing Jeffrey M. Zurosky, M.D.; Henry G. Amon, M.D.; Robert C. Seeley, M.D.; and Western Medical Associates, PLLC from the action. (*Id.*, pp. 178-187.) On July 23, 2018, a stipulation dismissing Nicole S. Burbank, M.D. was submitted. (*Id.*, pp. 180-187.) The caption to the action was amended by order of the District Court on November 5, 2018, leaving Kootenai Health as the remaining defendant in the action. (*Id.*, pp. 192- 194.)

On March 20, 2019, Kootenai Health filed its *Motion for Summary Judgment* arguing that the Dlouhys' experts lacked actual knowledge of the community standard of care. (*Id.*, pp. 195-411.) The Dlouhys' filed their response and supporting materials on April 3, 2019. (*Id.*, pp. 412-733.) Oral argument was held on April 17, 2019. (Tr., pp. 3-45.)

On June 3, 2019, the District Court granted Kootenai Health's *Motion for Summary Judgment*. (R., pp. 757-85.) The *Judgment for Dismissal with Prejudice* was then entered on June 5, 2019, and an *Amended Judgment* was entered August 2, 2019. (*Id.*, pp. 786-87; pp. 828-29). The Dlouhys timely filed their *Notice of Appeal* on July 5, 2019. (*Id.*, pp. 788-91.)

C. Statement of Facts

Background Information

Duane and Debra Dlouhy were married on January 22, 1983, and together they had three children—Dustin, Drue, and Demi. (*Id.*, p. 451, Deposition of Debra Dlouhy, p. 11, ll. 21-25; p. 12, ll. 1-4; ll. 16-25; p. 13, ll. 1-4.) Duane was a star athlete at Boise State during the early 1980's. (*Id.*, p. 451, Deposition of Debra Dlouhy, p. 12, ll. 19-15.) He played football and basketball and had a short stint with the Washington Redskins after his career at Boise State.

(*Id.*) Prior to his death, he was working at Pita Pit in the capacity of Director of Construction. (*Id.*, p. 311.)

On May 24, 2015, Duane and Debra were boating on Lake Coeur d'Alene. (*Id.*, p. 455, Deposition of Debra Dlouhy, p. 27, ll. 8-25; p. 28, ll. 1-11.) At one point, Duane stood up and "blood went gushing" down his legs." (*Id.*) He got off the boat to get cleaned up. Because of this incident, they went immediately to Kootenai Hospital. (*Id.*)

First Admission to Kootenai Health

The Dlouhys were seen in the emergency room by Dr. Seeley. (*Id.*, pp. 483-84.) A CT scan was performed and they were told that everything "looked clear" and to follow up with a colonoscopy in a week. (*Id.*) They were discharged from the hospital and went home. (*Id.*)

Later that night, Duane passed out in the bathroom at his home. (*Id.*) Debra found him and saw that he had hit his head on the wall. (*Id.*) He was again bleeding from his rectum and there was blood all over the floor. (*Id.*)

Second Admission to Kootenai Health

The Dlouhys returned to Kootenai Health's emergency room where a CT of Duane's head was performed. (R. p. 488-89; 494.) The radiologist interpreting the CT scan noted "focal wall thickening of the rectum" and that a "neoplasm cannot be excluded." (*Id.*, p. 494.)

The Dlouhys were not informed that the CT scan could not exclude a possible neoplasm or that a neoplasm could be concerning for potential cancer. (*Id.*; R. p. 457, Deposition of Debra Dlouhy, p. 34, ll. 10-17.)

Duane was then admitted to the hospital. (*Id.*, p. 421.) To identify why he was bleeding from his rectum, gastroenterologist Dr. James was consulted. (*Id.*) He examined Duane and the medical record indicates that he noted that "the patient is likely having a diverticular bleed,

however, the findings on the CT scan are somewhat concerning…" (*Id*., p. 414; R. p. 497-98.) These concerns were not discussed with the patient. (R., p. 461, Deposition of Debra Dlouhy, p. 49, ll. 2-4.)

On the morning of May 25, Dr. James performed a colonoscopy. (R., pp. 500-01.) He noted that the "Rectum appeared normal, although complete views were not seen." (*Id*.) The colonoscopy noted that the bleeding source was likely diverticula. (*Id*.)

Dr. James informed the patient that the CT scan identified focal wall thickening and diverticulosis. (R., p. 460, Deposition of Debra Dlouhy, p. 48, ll. 8-21.) There was no mention of a potentially cancerous mass by Dr. James. (R., p. 474, Deposition of Debra Dlouhy, p. 101, ll. 13-25; p. 102, ll. 1-2.) The Dlouhys were never informed, by any provider, that when the colonoscopy was performed, that the entire rectum was not visualized. (R., p. 477, Deposition of Debra Dlouhy, p. 116, ll. 20-23.)

The Dlouhys were told that "everything looked good, that they had done all the tests, that he was clear of any of the scary – clears [sic] of cancers, CT scan looked good, his heart looked good, his EKG was good, that the concern would be the – a future bleed, that we needed to add more fiber to his diet, that they drew even things up on the board to kind of show it to us." (R., p. 461, Deposition of Debra Dlouhy, p. 52, ll. 8-25.)

The discharge instructions did not specify any follow-up on the potentially cancerous mass identified by the CT scan. (R., p. 503.) There was no recommended follow-up to repeat the colonoscopy even though complete views were not obtained. (*Id*.) The instructions merely stated:

> ASSESSMENT AND PLAN: Lower gastrointestinal bleed, probably diverticular. Probably okay to go home later today. He was told to come back to the hospital if he has any recurrent signs of bleeding. Discussed high fiber diet and/or Metamucil at home with his diverticulosis. If he does have rebleeding, would recommend repeating stat tagged packed red blood cells scan with angiogram if positive. This was discussed with him and his wife.

(*Id.*)

Duane followed these discharge instructions and changed his diet pursuant to the recommendation of the medical professionals. (R., p. 463, Deposition of Debra Dlouhy, p. 59, ll. 10-24.) He added Metamucil to his routine and was cautious about what he was eating. (*Id.*) He continued to have stomach problems including excessive gas and bloating. (*Id.*)

Follow-up Care

On June 16, 2015, Duane had a follow-up appointment with Dr. Lindblad who reiterated the assessment of "diverticulosis." (R., pp. 505-08.) Nothing about a repeat colonoscopy or potentially cancerous mass was discussed. (*Id.*)

On June 30, 2015, Duane was seen by PA Jim McMahon. (*Id.*, pp. 510-12.) His note indicates a colonoscopy was performed and that it "was felt that he probably had a diverticular bleed." (*Id.*) PA McMahon also recommended a colonoscopy every 5 years. (*Id.*) Again, there was no mention of a concern for cancer or that the CT scan could not exclude a neoplasm. (*Id.*)

Duane's stomach problems persisted after this appointment. (*Id.*, pp. 464, Deposition of Debra Dlouhy, p. 63, ll. 4-25; p. 64, ll. 1-9.) This included severe diarrhea, an overall feeling of not feeling himself, and bloody stool. (*Id.*)

On September 1, 2015, Mr. Dlouhy was seen again by PA McMahon for these continuing issues. (*Id.*, pp. 514-15.) Again, PA McMahon stressed the importance of following the diet. (*Id.*, p. 465, Deposition of Debra Dlouhy, p. 66, ll. 1-9.) There was no discussion about a potential cancer or that the CT scan could not exclude a cancerous mass or neoplasm. (*Id.*, pp. 514-15.)

On January 21, 2016, the Dlouhys called the clinic to set up a "colonoscopy with Dr. James as soon as possible." (*Id.*, p. 523.) Penni Andrews called them back and let them know the labs were "normal." No colonoscopy was scheduled. (*Id.*)

On January 26, 2016, the Dlouhys met with NP Hildebrandt. (*Id.*, pp. 525-27.) She notes continued symptoms of rectal pain and bleeding. (*Id.*) A physical rectal exam was performed. (*Id.*) After the exam, she indicated that Duane could be suffering from hemorrhoids and prescribed medication. (*Id.*) Again, there was no discussion regarding potential cancer or the failure of the CT scan to exclude a cancerous mass. (*Id.*)

Discovery of Stage IV Rectal Cancer and Death

On August 3, 2016, Duane was seen by Dr. Pennings who did a rectal exam. (*Id.*, p. 474, Deposition of Debra Dlouhy, p. 102, ll. 6-20.) That exam revealed the existence of a mass in Duane's rectum. (*Id.*) A colonoscopy and a CT scan were performed on August 4, 2016. (*Id.*)

On August 4, 2016, Duane was seen by Dr. Bartels who diagnosed stage IV cancer. (*Id.*, p. 474, Deposition of Debra Dlouhy, p. 104, ll. 1-11.) He informed the Dlouhys that the cancerous mass was on the scan performed by Kootenai Health some 15 months earlier.

> Q. All right. Has any health care provider told you how long they suspect your husband had colorectal cancer?
> A. The day of the finding of when we were told that it was stage IV, his cancer doctor, I asked him point blank if it had been on his scan from 15 months prior that Kootenai had done. And he looked me dead in the eye and said, "I don't want to be a Monday morning quarterback, but you asked me a point-blank question, and, yes, it was there."
> Q. Okay. That was Dr. Bartels?
> A. That was Dr. David Bartels.

(*Id.*)

If discovered and treated early, rectal cancer has a high survival rate. (R., pp. 266-88.) Had the cancer properly identified and treatment started in May 2015, the survival rate was 82% to 89%. (*Id.*) By January 2016 when Duane was seen by NP Hildebrant, the cure rate drops between 64% to 83%. (*Id.*)

Even though the cancer was stage IV when it was discovered, Duane sought aggressive

treatment. (*Id.*, p. 477, Deposition of Debra Dlouhy, p. 113, ll. 9-25; p. 114, ll. 1-3.) He was treated by Dr. Bartels, received chemotherapy, went to the Mayo Clinic, and received a colectomy. (*Id.*) Despite that treatment, Duane succumbed to his cancer on June 5, 2017.

II. ISSUES PRESENTED ON APPEAL

A. Whether the District Court erred in determining that the Dlouhys' expert witnesses lacked foundation to testify to the community standard of care.

B. Whether the District Court erred in granting summary judgment to Kootenai Health.

III. ARGUMENT

A. The District Court erred by finding that Dr. Hammerman and Dr. Schmidt lacked the foundation necessary to testify to the community standard of care applicable to this case.

1. Standard of Review.

The 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) (internal citation omitted). Appellate courts engage "in a three-part inquiry when reviewing for an abuse of discretion: (1) whether the lower court rightly perceived the issue as one of discretion; (2) whether the court acted within the boundaries of such discretion and consistently with any legal standards applicable to specific choices; and (3) whether the court reached its decision by an exercise of reason." *Id.*

"The admissibility of expert testimony offered in conjunction with a motion for summary judgment is a threshold matter that is distinct from whether the testimony raises genuine issues of material fact sufficient to preclude summary judgment." *Id.* (internal citation and quotation omitted). "When deciding whether expert testimony is admissible, the liberal construction and reasonable inferences standard does not apply." *Id.* (citation omitted). "The trial court must look at the affidavit testimony and determine whether it alleges facts which, if taken as true, would render the testimony of that witness admissible." *Id.* (citation and internal quotation omitted).

Trial courts have been cautioned against employing a hyper-technical application of Idaho Code §§ 6-1012 and 6-1013 when viewing the disclosures of expert witnesses in conjunction with motions for summary judgment. *Wickel v. Chamberlain*, 159 Idaho 532, 538, 363 P.3d 854, 860 (2015).

2. The disclosure of Dr. Kenneth J. Hammerman, M.D.'s opinions.

The Dlouhys retained Dr. Hammerman to testify as to the care provided by Dr. Michael James, PA James McMahon; and NP Susan Hildebrandt. (R., pp. 231-264.) Those opinions were timely disclosed. (*Id.*) Dr. Hammerman is a licensed physician with over forty years of internal medicine and gastroenterology experience. (*Id.*, p. 232.) He is double board certified in internal medicine and gastroenterology. (*Id.*, p. 258-62.) He graduated from New York University School of Medicine in 1969. (*Id.*) He currently practices internal medicine and gastroenterology in San Francisco, California. (*Id.*)

Prior to rendering his opinions in this matter, Dr. Hammerman reviewed medical records of Mr. Dlouhy from 2015 until his passing. (*Id.*, pp. 246.) He reviewed depositions of Dr. James, PA McMahon, NP Hildebrandt, Mrs. Dlouhy, and Dr. Bartels. He also reviewed the *Complaint*, Kootenai Health's Policies and Procedures, the Patient Rights & Responsibilities pamphlet, documents from the Commission on Cancer, the employment agreement between Kootenai Health and Dr. James, PA McMahon's Delegation of Services Agreement, documents relating to Kootenai Health's participation in the Mayo Clinic Care Network, Awards and Recognition received by Kootenai Health, and Idaho Code § 54-1807A. (*Id.*)

Based on his education, experience, training, board certification, the care at issue, and the materials reviewed, Dr. Hammerman opined that the providers of Kootenai Health breached the standard of care in the following ways:

-Dr. James breached the standard of care by failing to order and schedule a follow-up colonoscopy or flexible sigmoidoscopy immediately after the abnormal CT scan and colonoscopy with incomplete views of the rectum; (R., p. 233.)

-Dr. James breached the standard of care by failing to provide the patient with adequate discharge and follow-up instructions, following the incomplete initial colonoscopy; (*Id.*, pp. 233-34.)

-Dr. James, PA McMahon and NP Hildebrandt failed to adequately disclose to Mr. Dlouhy that the CT scan report noted focal wall thickening and that a neoplasm could not be excluded. (*Id.*, p. 237-38.) This lack of disclosure impacted the ability of the patient to make informed decisions regarding his care; (*Id.*)

-PA McMahon failed to inform the patient of the inadequate prep and failed to recommend an urgent colonoscopy or flexible sigmoidoscopy. (*Id.*, p. 238.) There is no documentation that PA McMahon reviewed the CT scan or informed the patient of the CT findings. (*Id.*) PA McMahon failed to conduct a rectal exam; (*Id.*)

-NP Hildebrandt failed to recognize a mass in the patient's rectum during her digital exam on January 26, 2016. (*Id.*) At the time, that mass would have measured approximately 2.8 cm. (*Id.*) Instead of recognizing the tumor, she stated that the patient may be suffering from hemorrhoids. There is no evidence that the patient had hemorrhoids. (*Id.*) Due to her failure to recognize the mass, Mr. Dlouhys' treatment was delayed; (*Id.*)

-There was improper coordination of care between Dr. James, PA McMahon, and NP Hildebrandt. (*Id.*, pp. 243-44.) Dr. James had a continuing duty to supervise and review the medical records of mid-level providers. (*Id.*, p. 244.) This lack of communication and supervision was a breach of the standard of care; (*Id.*, pp. 244-45.)

The disclosure of this expert demonstrates that he had the requisite foundation to testify as to the standard of care at issue in this case and to provide his opinions as to the adequacy of that care. This disclosure demonstrates a multifaceted approach to Dr. Hammerman's foundation. Any one of the means by which Dr. Hammerman familiarized himself with the standard of care is sufficient under Idaho law, and, when viewed cumulatively, demonstrates conclusively that the District Court erred in excluding his opinions.

3. The disclosure of Dr. Judy L. Schmidt, M.D.'s opinions.

In addition to Dr. Hammerman, the Dlouhys retained Dr. Judy L. Schmidt to render

opinions on the standard of care and causation. (*Id*., pp. 247-49; 266-308.) Dr. Schmidt is triple board-certified in Medical Oncology, Internal Medicine, and Hematology. (*Id*., p. 247.) She reviewed the medical records in this case, the depositions of local providers, the policies and procedures of Kootenai Health, as well as Dr. Hammerman's disclosure. (*Id*., pp. 248-49.)

In her report, she opined that care provided to Duane Dlouhy by Dr. James, PA McMahon, and NP Hildebrandt failed to meet the standard of care. (*Id*., pp. 286-87.) Specifically, she opined that Dr. James' care breached the standard of care in the following ways:

> -Failure to indicate "missed cancer" as a risk on the colonoscopy consent process and form;
> -Failure to do a rectal examination on May 25, 2015;
> -Failure to repeat the colonoscopy in May 2015 due to inadequate preparation;
> -Failure to disclose to Mr. Dlouhy that the bowel prep was only "fair" which would increase the probability of "missed" colorectal cancers;
> -Failure to document the withdrawal time on the May 2015 colonoscopy;
> -Failure to identify the site of bleeding on the May 2015 colonoscopy;
> -Failure to do a rectal examination prior to the May 2015 colonoscopy with special attention to the left lateral wall (where the CT rectal wall thickening was noted);
> -Failure to recommend a pelvic MRI to better define the rectal abnormality seen on CT pelvis;
> -Failure to disclose that the radiologist was concerned about rectal cancer on the May CT;
> -Failure to obtain a colonoscopy after the September 1, 2015 office visit;
> -Failure to adequately supervise PA McMahon and NP Hildebrandt;
> -Failure to make clear to the Dlouhys that the major concern in the setting of rectal bleeding at his age is to determine if it is due to rectal cancer;
> -Failure to identify obesity as a risk for colorectal cancer.

(*Id*., p. 286.)

As to PA McMahon, Dr. Schmidt also opined that he breached the standard of care in his treatment of Mr. Dlouhy in multiple ways:

> -Failure to do a rectal exam on May 26, 2015;
> -Failure to disclose that the radiologist was concerned about rectal cancer as noted on CT scan;
> -Failure to make it clear to the Dlouhys that the major concern in the setting of rectal bleeding at his age is to determine if it is due to rectal cancer;
> -Failure to carefully review the CT scan of the abdomen/pelvis with the Dlouhys;

-Failure to disclose that the site of bleeding was not found on the May 25, 2015 colonoscopy;
-Failure to disclose that the preparation was inadequate and the rectum was not well visualized on the colonoscopy of May 25, 2015;
-Failure to have adequate supervising physician support;
-Failure to make sure a colonoscopy was done May 15, 2015 with adequate preparation.

(*Id.*, pp. 286-87.)

With respect to NP Hildebrandt, Dr. Schmidt opined that the care of Mr. Dlouhy fell below the applicable standard of care for nurse practitioners in the following ways:

-Inadequate training in the diagnosis of rectal cancer;
-Inadequate physician supervision/assistance;
-Failure to feel a rectal cancer on her rectal examination of January 26, 2016 at which time the tumor was approximately 2.8 cm;
-Failure to disclose that the radiologist was concerned about rectal cancer on the CT scan;
- Failure to make it clear to the Dlouhys that the major concern in the setting of rectal bleeding at his age is to determine if it is due to rectal cancer;
-Failure to carefully review the CT scan of the abdomen/pelvis with the Dlouhys;
-Recommending Anusol for an undiagnosed rectal bleed and delaying the diagnosis.

(*Id.*, p. 287.)

Like Dr. Hammerman, the timely disclosure of Dr. Schmidt demonstrates that she obtained foundation as to the applicable standard of care in a multitude of ways. It was clear error for the District Court to disregard these opinions on summary judgment.

4. The requirements of Idaho Code §§ 6-1012 and 6-1013.

Idaho law defines the applicable standard of care as: (a) the standard of care for the class of health care provider to which the defendant belonged and was functioning, taking into account the defendant's training, experience, and fields of medical specialization, if any; (b) as such standard existed at the time of the defendant's alleged negligence; and (c) as such standard existed at the place of the defendant's alleged negligence. Idaho Code § 6-1012; *Dulaney v. St.*

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

Idaho Code § 6-1013 governs the testimony of an expert witness on the community standard of care. That statute states:

> 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, establishing (a) that such an opinion is actually held by the expert witness, (b) that the said opinion can be testified to with reasonable medical certainty, and (c) that such expert witness possesses professional knowledge and expertise coupled with actual knowledge of the applicable said community standard to which his or her expert opinion testimony is addressed; provided, this section shall not be construed to prohibit or otherwise preclude a competent expert witness who resides elsewhere from adequately familiarizing himself with the standards and practices of (a particular) such area and thereafter giving opinion testimony in such a trial.

(emphasis added).

This Court has consistently stated that many avenues exist by which an out-of-area expert can become familiar with the standard of care and that courts should use a "measure of common sense" in so finding. These include familiarity with national standards of care for board-certified specialists, review of deposition testimony of local providers, review of policies and procedures of an institution, familiarity with government regulations, and others.

> The guiding question is simply whether the affidavit alleges facts which, taken as true, show the proposed expert has actual knowledge of the applicable standard of care. In addressing that question, courts must look to the standard of care at issue, the proposed expert's grounds for claiming knowledge of that standard, and determine-**employing a measure of common sense**-whether those grounds would likely give rise to knowledge of that standard. The obligation to demonstrate actual knowledge of the local standard of care is **not intended to be "an overly burdensome requirement**...." Nor is the standard static and firmly rooted in past medical practices. Standards of care are sensitive to evolving changes in the way health care services are delivered in the various communities of our State. Indeed, the Court has recognized that "governmental regulation, development of regional and national provider organizations, and greater access to the flow of medical information," have provided "various avenues by which a plaintiff may proceed to establish a standard of care...."

Mattox v. Life Care Centers of America, Inc., 157 Idaho 468, 474, 337 P. 3d 627, 633 (2014) (internal citations omitted).

In reviewing expert disclosures, trial courts must recognize that "experts are not confined to some formulistic process for becoming familiar with the community standard of health care practice and affidavits are not required to include particular phrases in order to establish adequate foundation under Idaho Code § 6-1013." *Samples v. Hanson*, 161 Idaho 179, 183, 384 P.3d 943, 947 (2016). The disclosure must only demonstrate that the expert's proffered testimony meets the "minimum requirements" of the statute and no "magic language" is required. *Id.* Trial courts are not to employ some hyper-technical application of Idaho Code §§ 6-1012 and 6-1013 in evaluating the proffered testimony. *Wickel v. Chamberlain*, 159 Idaho 532, 538, 363 P.3d 854, 860 (2015).

With these established standards in mind, a review of the Dlouhys' expert disclosures demonstrate that foundation for their opinions meets and far exceeds the requirements of Idaho law.

5. Dr. Hammerman's disclosure demonstrated that he had actual knowledge of the community standard of care applicable to this case.

(a) *For board-certified specialists such as Dr. James, the standard of care is a national standard of care.*

It is clear under Idaho law that for board-certified physicians, there is a national standard of care. Here, it is undisputed that both Defendant Dr. James and the Dlouhys' expert, Dr. Hammerman, are board-certified gastroenterologists.

In *Samples v. Hanson*, this Court specifically addressed the standard of care as it applies to board certified specialists. 161 Idaho 179, 384 P.3d 943 (2016). In that case, plaintiff was admitted to the hospital and diagnosed with cholecystitis. *Id.*, p. 181. The defendant physician

performed a laparoscopic cholecystectomy on the patient. *Id.* It was alleged that the procedure was negligently performed resulting in sepsis and respiratory distress. *Id.*

In support of their claim of medical malpractice, the plaintiffs disclosed an out-of-area board certified general surgeon, practicing in the same area of specialty as the defendant doctor. *Id.*[2] After a deposition, the defendant moved to strike the plaintiffs' expert arguing that he lacked foundation to testify as to the applicable community standard of care. *Id.* The trial court agreed, struck the plaintiffs' expert, and granted summary judgment as requested by the defendants. *Id.*

On appeal, the plaintiffs raised three issues: (1) whether the trial court erred in finding that their expert was an "out-of-area" expert; (2) whether the trial court erred in finding that the expert failed to familiarize himself with the applicable standard of care; and (3) whether the trial court erred in denying the plaintiffs relief from the pretrial order. *Id.*, p. 182. Importantly, this Court only addressed the second issue in reversing the trial court, finding that the other two were moot. *Id.*

This Court rejected the defendants' argument that board certification was insufficient to establish the requisite foundation to testify as to the standard of care, stating:

> By enacting this section [I.C. § 6-1012] we believe the legislature, in its wisdom, recognized that the standard of care for nationally board-certified specialists was the same throughout our nation and that one board-certified specialist could testify regarding the standard of care against another nationally board-certified specialist practicing in the same area of medicine.

Id. (*citing Buck v. St. Clair*, 108 Idaho at 745-46, 702 P.2d at 783-84) (emphasis added). Again, citing *Buck*, this Court reiterated:

[2] The plaintiffs in *Samples* failed to comply with the district court's scheduling order, resulting in the testimony of their expert being limited as a sanction. *Samples*, 161 Idaho, p. 180. There was no limitation of the Dlouhys' experts as they were timely disclosed.

> We believe that for board-certified specialists, the local standard of care is equivalent to the national standard of care. Our reasons for this decision are simple: board-certified medical specialists are highly-trained individuals who become certified after completing a rigorous training program. Medical schools are accredited by a national team of physicians and administrators. The residency training programs are approved by a single board of specialists, and a physician is certified as a specialist only after passing a nationally administered exam consisting of both oral and written components. The board-certified specialists practicing within the state are the product of nationally designed education programs. The standard of care familiar to any board-certified physician in this state is a national standard of care. We see no reason to believe there is a local standard of care which deviates from the national standard of care for board-certified physicians. Our ruling today is limited to board-certified doctors practicing in the same area of specialty.

Id. (emphasis added).[3] Simply put, pursuant to Idaho law, a national standard of care rather than a local standard of care applies to board-certified specialists such as Dr. James.

Idaho law is consistent with the disclosure of Dr. Hammerman which speaks to the national standard of care at issue in this case. His disclosure states that "Dr. James is bound to the national standard of care that requires the physician to timely address concerning diagnostic findings, such as a wall thickening and a potential neoplasm, by immediately ordering proper follow up including a repeat colonoscopy. The duty to order appropriate follow-up procedures is a national standard of care, rather than a "local" standard of care. Performing diagnostic testing is meaningless if the findings reported are not acted upon or dealt with." (R., p. 234.)

Pursuant to Idaho Code § 6-1012 and the well-established precedent of this Court, a national standard of care applies to the conduct of Dr. James. There is no dispute that both Dr. James and Dr. Hammerman were board certified in gastroenterology by the American Board of Internal Medicine throughout 2015 and 2016. (*Id.*) As such, Dr. Hammerman had the requisite foundation to levy his opinions regarding the care and conduct of Dr. James.

[3] The Court in *Samples* clarified and modified the "holding out" requirement articulated in *Buck*. As both Dr. James and Dr. Hammerman were board-certified physicians practicing gastroenterology at the time of the alleged negligence, the "holding out" distinction has no bearing on this case.

(b) *There is no evidence Kootenai Health lacks access to current medical information or the necessary equipment to meet the standard of care.*

Not only is Dr. James a board-certified and nationally trained physician, he works for a well-connected facility with access to the resources that set the applicable standard of care. Underlying the requirement that an expert be familiar with the local community standard of care is the legislature's concern in the disparity in resources and technology between urban and rural areas. *McDaniel v. Inland Northwest Renal Care Group-Idaho, LLC*, 144 Idaho 219, 159 P.3d 856 (2007) (*citing Buck v. St. Clair*, 108 Idaho 743, 746, 702 P.2d 781, 784 (1985)). "Understandably, the practice of medicine in Idaho has historically involved a good number of doctors practicing in small communities with limited resources, limited access to the flow of information, and limited support from like providers. Such doctors, if held to the same standard of practice as urban communities, would face inequities stemming from the geographic location of their practice." *Id.*

In this case, there is no concern that Kootenai Health and Dr. James lacked the resources necessary to comply with the standard of care or that they lacked the necessary access to information or support from like providers due to its geographic location. In fact, the opposite is true. Kootenai Health is part of a formal collaboration with the Mayo Clinic since 2011. (R., pp. 234-35.) Specifically, this partnership consists of a:

> … national network of like-minded organizations that share a commitment to better serving patients and their families. The network, which began in 2011, includes organizations across the nation that are interested in working with Mayo Clinic to improve health care delivery by sharing knowledge and promoting collaboration between physicians.

(*Id.*) (emphasis added). Through this national network, Kootenai Health and Dr. James has access to additional resources such as: AskMayoExpert, eConsults, eBoards, Patient Education Materials, and Mayo Clinic Grand Rounds. (*Id.*) The relationship with the Mayo Clinic provides

Kootenai Health with "access to the Mayo Clinic's knowledge and expertise." (*Id*.)

Furthermore, Kootenai Health touts itself as a "Top Quality Performer in the Premier Hospital Quality Incentive Demonstration" among all hospitals nationwide. (*Id*.) It is also one of the Top 100 Most Wired hospitals in the entire country. (*Id*.)

With this evidence, there can be no doubt that Kootenai Health and its providers are not a rural isolated hospital lacking in the necessary resources or cut off from the flow of medical information. There is simply no reason to hold Kootenai Health and Dr. James to some lower standard of care than is expected of other nationally board-certified providers and physicians.

Additionally, this Court has long held that the practice of medicine is subject to evolving practices, new technologies, and changes in the flow of information. In *McDaniel*, for example, it was recognized that "[r]ecent years have witnessed increasing standardization in the health care profession, due to a variety of factors…. Standardization has also resulted from the development of regional and national provider organizations." 144 Idaho at 224. This would certainty apply to Kootenai Health and its providers as evidenced by their participation in organizations such as the American Board of Internal Medicine and the Mayo Clinic network.

The *McDaniel* decision was in 2007. For context, that was two months before the first iPhone was released. The interconnectedness and standardization in the medical industry recognized by this Court twelve years ago has only increased and expanded since that time. In *Mattox*, it was emphasized that the standard of care is not static nor is it "firmly rooted in past medical practices." 157 Idaho at 474. Given that Dr. James was board certified by a national organization and Kootenai Health was not a rural hospital without access to critical resources or access to current medical information, there is no reason to conclude that the national standard of care does not apply to the care and conduct in this case.

(c) *Although not strictly required by Idaho law, the Dlouhys demonstrated that no deviation from the national standard of care exists for Board-Certified providers in Coeur d' Alene, Idaho.*

Since *Samples*, it has been established that nationally board-certified physicians are competent to testify to the national standard of care that applies to their practice due to their rigorous training. Thus, any argument that Idaho law requires a board-certified expert, familiar with the national standard of care, to also be familiar with the local community standard of care by ensuring no deviations between the two is outdated and no longer the law of this state.

Even though not required by Idaho, it was conclusively established that there was no deviation when it comes to practicing gastroenterology for board-certified physicians at Kootenai Health, such as Dr. James. In his disclosure, Dr. Hammerman explains that the local standard, as applied to Dr. James, is the national standard established through the training and testing of American Board of Internal Medicine through which Dr. James is certified. (R. p. 240.) But, more importantly, Dr. James testified as follows:

Q. And you were board certified in 2014?
A. Yes.
Q. And '15?
A. Yes.
Q. Is there anything different about the practice of gastroenterology in – with Kootenai or in Coeur d'Alene that is different than the way you practiced when you were doing your fellowship in San Francisco?
A. I get to wear what I want.
Q. Other than dress.
A. Other than the blue – the blue shirt and blue coat, yeah.
Q. The dress isn't military standard; is that –
A. Right.
Q. -- what you're saying? Okay.
A. **Otherwise, no**.

(*Id*., p. 625, Deposition of Dr. James, p. 19, ll. 11-25; p. 20, l. 1.) (emphasis added).

The Dlouhys have done all that could reasonably and legally be required to do to demonstrate that a national standard of care applies to the care at issue and that there were no

deviations as applied to Dr. James or his practice at Kootenai Health. *Samples* is the controlling case here. Dr. Hammerman shares the same board certification as Dr. James, and they were both board certified at the time the care was provided to Mr. Dlouhy. As such, Plaintiffs' expert disclosures sufficiently explain how Dr. Hammerman is familiar with the local standard of care applicable to Dr. James.

(d) *The District Court's determination that a national standard of care does not apply to board-certified specialists is inconsistent with Idaho law and an abuse of discretion.*

In its ruling on Kootenai Health's *Motion for Summary Judgment*, the District Court found that a national standard of care did not apply to this case and that the Dlouhys' reliance on this Court's holding in *Samples* was "mistaken." (R. p. 777.) The District Court found *Samples* to be distinguishable on the basis that the challenged medical expert in that case "had actual knowledge of the standard of care" based on his experience working at Bingham Memorial Hospital beginning in 2011, two years subsequent to the alleged negligence. *Id.* In other words, that expert did not practice in the same community during the applicable time frame as the negligence at issue.

The District Court misconstrued the holding of that case. In *Samples*, plaintiffs raised three issues on appeal: (1) whether the trial court erred in finding that their expert was an "out-of-area" expert; (2) whether the trial court erred in finding that the expert failed to familiarize himself with the applicable standard of care; and (3) whether the trial court erred in denying the plaintiffs relief from the pretrial order. *Samples*, 161 Idaho at p. 182. It was clearly and specifically stated by this Court that it was deciding the case only on the second issue as determination of that issue rendered the other two issues "moot." *Id.* Thus, any discussion that the challenged physician expert was not an "out-of-area" expert is not central to the holding of

the case and is merely dicta.

In this case, the District Court relying on *Grimes v. Green*, 113 Idaho 519, 746 P.2d 978 (1987), held that even a board-certified physician "must inquire of the local standard in order to insure there are no local deviations from the national standard under which the defendant-physician and witness-physician were trained." *Id*. at 521. This requirement from *Grimes* was plainly abrogated by *Samples*. There simply is no requirement that a board-certified physician inquire of the local standard in order to establish the requisite foundation to render opinions against another board-certified physician practicing in the same specialty. The District Court disregarded the more recent jurisprudence of this Court and abused its discretion by determining that a national standard of care did not apply to Dr. James as a board-certified gastroenterologist.

Even if it was required to inquire of the local standard to ensure no deviations from the national standard of care, the District Court overlooks the substantial efforts of the Dlouhys in this regard. Specifically, there is no analysis by the District Court of Dr. James' own testimony that the only difference in his practice of gastroenterology as compared to San Francisco (where Dr. Hammerman practices) is the type of scrubs he wears. This alone is sufficient evidence to demonstrate there is no deviation from the national standard of care as applied to Dr. James.

Additionally, the District Court improperly disregarded the substantial efforts of the Dlouhys to inquire of the local standard of care by obtaining policies and procedures of Kootenai Health. As discussed in detail below, these are specific care-oriented policies that confirm the standard of care as articulated by Dr. Hammerman. Further, there is no acknowledgement by the District Court of the specific deposition testimony of local medical providers such as Dr. James, PA McMahon, NP Hildebrandt, and Dr. Bartels which specifically address the local standard of care. That testimony is recounted in detail below.

Thus, even if the Dlouhys were required to inquire of the local standard of care to qualify Dr. Hammerman—they did so and those efforts were not properly considered by the District Court. By ignoring the evidence adduced regarding the standard of care, the District Court abused its discretion.

6. Both Dr. Hammerman and Dr. Schmidt gained actual knowledge of the community standard of care applicable in this case by reviewing depositions of local physicians as well as policies and procedures of Kootenai Health.

(a) *The standard of care in this case is a basic, universal standard.*

Basic standards are the norm, not the exception and it should be a question of fact whether even basic standards were breached in a particular case once established. Here, both Drs. Hammerman and Schmidt state that the standard of care in this case is basic, universal, and a matter of common sense for all medical professionals. (R., pp. 232-49; pp. 266-89.) Consider this Court's holding in *Grover* discussing the very basic standard of taking an adequate patient history:

> The standard is basic and applicable to all dentists in Idaho, whether in Fruitland, Boise, or Lewiston. No *local standard of care* would result in this minimum standard being altered in any way.
>
> Respondent's suggestion that, if local dentists so chose, community standards of care could fall below minimum statewide standards is not persuasive. At issue in this case is a minimum statewide standard of care, not a lack of advanced technology, conditions unique to the area, or particular specializations with which the expert is unfamiliar. While it may be understood that a small Idaho town may not have the technology used in a big city, thus necessitating a different local standard of care, choosing not to adhere to the basic dental standards established by the Idaho Board of Dentistry is not. Taking a patient's medical history is a minimum requirement that must be met to become a licensed dentist in Idaho. Respondent's contention that professionals in a community could decide to adopt a local standard of care that is inferior to the bare minimum statewide standards is without merit.

Grover, 137 Idaho at 253, 46 P.3d at 1111.

What this discussion illustrates is that so-called basic standards are sufficient to establish

the foundational requirements necessary to qualify an expert under the statute.

> An examination of the wording found in I.C. §§ 6-1012, -1013 does not mandate the conclusion reached by the district court. Nothing in the language of either code section precludes an expert witness, when forming his opinion, from relying on a statewide standard of care that has been adopted by that profession's governing board.

Grover, 137 Idaho at 1112 46 P.3d at 254.

In *Samples*, this Court reaffirmed the standards of *Grover* in the context of care provided by board-certified physicians:

> This is not a complicated standard of care. It merely calls for basic post-operative care to ensure that the patient does not suffer infection or complications. It is not a standard of care that requires detailed specialization, intricate treatments, expensive equipment, or detailed knowledge of drug interactions. One would hope that any surgeon, regardless of whether operating in the backwoods or a metropolitan hospital, would monitor the patient post-operatively to ensure a decent recovery without infection or complications.

161 Idaho at 186.

Similarly, in this case, the Dlouhys' experts are opining as to basic and universal standards regarding post-operative care. The experts in this case are merely stating that the standard of care requires the physician to immediately order a follow-up colonoscopy or flexible sigmoidoscopy when the initial colonoscopy had incomplete views of the rectum. (R., pp. 234-47.) Further, the patient and his family are entitled to be informed of clinically significant medical findings and be provided with adequate follow-up and discharge instructions. (*Id*.) As was the case in *Samples*, one would hope that any gastroenterologist regardless of geographic location would order a repeat test if the first test was inadequate, tell the patient of any potential cancer identified on imaging, and provide proper follow-up and discharge instructions. These are simple universal standards of care that the experts in this case are competent to speak to.

(b) *All local physicians confirmed the basic standard of care through depositions.*

When determining whether an expert has actual knowledge of the standard of care, this Court has consistently recognized there are several ways actual knowledge can be demonstrated and that courts can use a "measure of common sense" in so finding. *Mattox v. Life Care Centers of America, Inc*., 157 Idaho 468, 474, 337 P.3d 627, 633 (2014) (internal citations omitted).

It is well recognized that an expert witness may familiarize themselves with the standard of care by reviewing depositions. *See Perry v. Magic Valley Reg. Med. Cnt.,* 134 Idaho 46, 995 P.2d 816 (2000); *Rhodehouse v. Stutts*, 125 Idaho 208, 868 P.2d 1224 (Idaho 1994).

In *Garriott v. Western Medical Associates, PLLC*, the Court recognized that Idaho law allows an out-of-area witness to become familiar with the standard of care by reviewing depositions of local providers. Case No. 2:16-cv-00081-CWD (Signed 08/02/2017) (*citing Perry v. Magic Valley Reg. Med. Cnt.,* 134 Idaho 46, 995 P.2d 816 (2000); *Rhodehouse v. Stutts*, 125 Idaho 208, 868 P.2d 1224, 1228 (Idaho 1994)). Relying on this Court's precedent and specifically applying it to Kootenai Health, Judge Dale stated, "Upon review of the depositions, the Court finds that, taken together as a whole, the four depositions provide a complete picture of the standard of care applicable to the emergency room physicians for someone presenting to Kootenai Health with symptoms similar to those of Mr. Garriott on March 31, and April 2, 2015." *Id*.

It was also recognized that a substantive review of the depositions was appropriate but that there was no requirement to use "magic words." *Id*. (*citing Samples v. Hanson,* 384 P.3d 943, 947 (Idaho 2016); *Kozlowski v. Rush*, 828 P.2d 854, 858 (Idaho 1991)).

Here, consistent with the national standard of care, the policies and procedures of Kootenai Health, and Drs. Hammerman's and Schmidt's education and experience, the treating physicians'

test confirms the standard of care.

In his deposition, Dr. James explained that it was imperative to visualize the rectum in this case, given the presentation of the patient:

> Q. Can you wait? Is there another way to visualize the rectum?
> A. No. You need to put a scope in there and look.
> …
> Q. Okay. If lay people think that a doctor can use a hand-held scope and look up someone's rectum to visualize the entire thing, they would be mistaken?
> A. I mean, there's all different sizes of scopes. There's anus scopes. There's a flex sigmoidscope. All the same thing. **You've got to be able to see**.

(R., p. 634, Deposition of Dr. James, p. 57, ll. 10-13; p. 56, ll. 1-6.) (emphasis added).

After confirming that he could not view the complete rectum during the colonoscopy, Dr. James confirmed that the standard of care required a repeat colonoscopy:

> Q. And if you can't see, what do you need to do?
> A. **Well, the best thing is to – we see him in follow up and recommend they get another colonoscopy**.
> Q. And why would you do that?
> A. To get a better prep, get a better look.
> Q. You don't think you had a good look on this one?
> A. No. And that's what I stated.
> Q. What about the prep wasn't good?
> A. It didn't clean him out completely.

(*Id*., p. 635, Deposition of Dr. James, p. 57, ll. 3-12.) (emphasis added).

This confirms the standard of care as articulated by the Dlouhys' experts and provides the requisite foundation for the experts in this case to testify as to the standard of care as it existed in Coeur d'Alene, Idaho at all times in 2015. Consistent with the disclosures of Drs. Hammerman and Schmidt, this is a basic common-sense standard of care. Further, it is undisputed that Dr. James did not order, recommend, or perform a follow-up colonoscopy:

> Q. Did you personally do any follow up with this patient?
> A. I didn't see him again after this.

(*Id*., p. 635, Deposition of Dr. James, p. 57, ll. 23-25; *see also*, R., pp. 500-01; p. 503.)

Next, Drs. Hammerman and Schmidt opined that the standard of care requires patients to be informed of findings, concerns for cancer, and the need for follow-up care. This was required of Dr. James, PA McMahon, and NP Hildebrandt as confirmed by the depositions in this case:

Q. And with respect to those functions, diagnosing, writing prescriptions, making recommendations, is it fair to say that part of that responsibility would be make sure you communicate with the patient all of the relevant clinical information?
A. Yes.
Q. Put another way, a patient would have to have all the right information in order to make the most intelligent decision about their care, right?
A. Sure.
Q. If there's something significant about a finding or diagnostic study, those are things that a patient needs to be told in order for them to take your recommendation, correct?
A. Sure.
Q. And it would be beneath the standard of care not to provide that information and expect a patient to make the decision in that vacuum, correct?
A. Beneath the standard of care?
Q. Yeah.
A. Sure.

(*Id*., pp. 547-48, Deposition of NP Hildebrandt, p. 28, ll. 9-25; p. 29, ll. 1-4.)

Dr. Bartels, a board-certified oncologist practicing medicine in Coeur d'Alene, Idaho, in 2015 and 2016, and who treated Duane testified as follows:

Q. And shifting away from statistics or prognosis or probabilities, I want to focus more on an underlying, a concerning finding, because you would agree with me that there might be different treatment options depending on what the finding is.
A. True.
Q. And a patient has a right to make decisions about how to treat a certain disease based on that finding?
A. Yes.
Q. And in order to do that, the patient needs the complete and accurate information about the underlying diagnosis to do that?
A. Yes.
Q. And it's the standard of care to give them that information –
A. Uh-huh.
Q. As soon as you know it?

MR. HAZEL: Object to the form. Go ahead and answer.

A. Yes.

BY MR. HANBY:

Q. And that's not dependent on a medical specialty or geographic location, that's just a basic patient fundamental right.
A. Uh-huh.
Q. Is that true?

MR. HAZEL: I'm going to object to the form. Dr. Bartels, I just have to get objections on the record. I'm not trying to break this up, but I just need to put it on the record. So sorry if I'm interrupting your train of thought.

Q. You would agree that that's true?
A. Yes.

(*Id*., pp. 28-9, Deposition of Dr. David Bartels, p. 28, ll. 3-25; p. 29, ll. 1-13.)

Despite this simple, basic, and universal standard of care, Debra Dlouhy testified that key information regarding diagnostic findings and Duane's medical prognosis were not relayed to them. She stated they were told "everything looked good, that they had done all the tests, that he was clear of any of the scary – clears [sic] of cancers, CT scan looked good, his heart looked good, his EKG was good, that the concern would be the – a future bleed, that we needed to add more fiber to his diet, that they drew even things up on the board to kind of show it to us." (R., p. 461, Deposition of Debra Dlouhy, p. 52, ll. 8-25.)

The Dlouhys' experts also found that the standard of care for Dr. James was to supervise the mid-level providers in this case. (R., pp. 232-88.) He did that by reviewing the notes of PA McMahon and NP Hildebrandt when Duane returned for follow-up care.

Q. Okay. What goes into your supervisory role with respect to the P.A. or the N.P.?
A. Well, we – at the hospital we just review the patients in the hospital.
Q. All of them or just –
A. All of them.
…

Q. With respect – and I – let me finish. With respect to Duane Dlouhy's chart?
A. Yes, I did.
Q. You did?
A. Right.
Q So when they had an interaction with Mr. Dlouhy, you then reviewed that?
A. Yes.
Q. So the follow-up appointments he had, you reviewed that?
A. The note.
Q. The note.
A. Yes.
Q. As part of your supervisory role?
A. At that time we were reviewing notes. We don't anymore. The policy changed. But at that time they would see a patient, dictate a note. They would give it to us to read. That's what we did.
Q. Okay. And did you – do you ever recall taking any corrective steps or suggesting any additional treatment or intervention with respect to their seeing Mr. Dlouhy?
A. No, I don't.

(R., pp. 636-37, Deposition of Dr. James, p. 64, ll. 1-6; p. 65, ll. 1-23.) This is a clear and definite statement of what the standard of care required of physicians supervising mid-level providers after the care of a patient like Duane Dlouhy.

It should also be noted that the standard of care for mid-level providers is no different than that of a physician when the patient is seen in the clinical setting.

Q. Are PAs held to the same standard of care as doctors?

MR. HAZEL: Object to the form. Go ahead and answer. Go ahead and answer.

THE WITNESS: Oh, repeat the question again.

BY MR. HANBY:
Q. Are PAs held to the same standard of care as doctors? In other words, should a patient expect a lower level of care if they're seen by a PA in a clinic versus a medical doctor?

MR. HAZEL: Same objection. Go ahead and answer.

THE WITNESS: I don't think so.

BY MR. HANBY:

Q. So you would agree that the – a physician's assistant is essentially held to the same standard of care as a doctor?
A. Yes.

(R., p. 532, Deposition of PA McMahon, p. 13, ll. 16-25; p. 14, ll. 1-8.) Thus, in the clinical setting when a patient is seen for follow up, mid-level providers are held to the same standard of care as physicians. This is further confirmed by the national certification and training that physician assistants and nurse practitioners must obtain to practice. (R., p. 531, Deposition of PA McMahon, p. 11, ll. 15-25, p. 12, ll. 1-11; R., p. 544-45, Deposition of NP Hildebrandt, p. 14, ll. 2-16, p. 18, ll. 1-17.)

Just as was the case in *Garriott*, *Perry*, and *Rhodehouse*, the deposition testimony of these local providers provides a complete picture of the standard of care as it existed in Coeur d' Alene in 2015 and 2016. This testimony provides sufficient foundation for the Dlouhys' experts to rely upon when forming their opinions in this case. The testimony was direct, specific, and spoke directly to the standard of care. The District Court abused its discretion in finding that the depositions were somehow insufficient to establish foundation.

(c) *The policies and procedures of Kootenai Health confirm the standard of care*.

One of the well-recognized methods by which an expert may familiarize himself with the local standard of care is by reviewing the policies and procedures of an institution. *Sparks v. St. Luke's Regional Medical Center, Ltd*., 115 Idaho 505, 768 P.2d 505. Here, it is undisputed that Drs. Hammerman and Schmidt reviewed the policies and procedures of Kootenai Health applicable to Dr. James, PA McMahon, and NP Hildebrandt as part of their review of this case. (R., pp. 232-49.)

In *Sparks*, the plaintiff brought a medical malpractice case following injuries sustained in a car accident. *Id*., p. 769. In that case, one of the allegations was that the defendant's nursing

staff failed to properly monitor plaintiff. *Id*. In that case, the Court found that the internal policy of defendant regarding monitoring "clearly set forth" the applicable standard of care. *Id*., p. 509-510. Also, consistent with *Mattox*, allowing an expert to become familiar with the local standard of care via policies and procedures of a facility is simply a matter of common sense.

Here, it was an admitted fact that the standard of care required the providers of Kootenai Health, including Dr. James, PA McMahon, and NP Hildebrandt were required to comply with policies and procedures of Kootenai Health.

> Q. Would you have expected them to comply with the hospital policies and protocols with respect to follow-up?
> A. Yes.
> Q. With respect to providing information to patients?
> A. Yes.
> Q. That would be standard of care for those two, wouldn't it, following hospital policies and protocols?
> A. For the clinic, yes.
> Q. And same as for you, correct?
> A. Right.
> Q. You have to follow those rules?
> A. Yep.

(R., pp. 637, Deposition of Dr. James, p. 66, ll. 18-25, p. 67, ll. 1-6.)

The policies and procedures of Kootenai Health clearly set forth the standard of care applicable in this case. Both Dr. Hammerman and Dr. Schmidt opined that the standard of care required patients to be informed of critical findings, such as a potential neoplasm or cancer. This is a national standard of care which is confirmed by the hospital's policies:

> **Patient Rights & Responsibilities**
> At Kootenai Health our primary concern is to provide professional care at the highest standard in collaboration with the families we serve. Our patients may exercise these rights without regard to race, sex, culture, economic, educational religious backgrounds, gender identity, sexual orientation, disability or their source of payment for their care.
> **Patient Rights**
> **As a patient, you are entitled to:**
> …

> Receive sufficient information to give consent prior to treatment except in life threatening situations.
> --Be informed concerning your diagnosis, treatment, and prognosis as well as the names of those responsible for your care. (The primary physician responsible for coordination of your care and relationships of other professionals involved in your care.)
> --Participate in decisions about your care, treatment and services provided to you.

(R., pp. 685-704.) (emphasis added).

It was also alleged that the providers breached the standard of care by failing to provide the patient with adequate discharge and follow-up instructions, following the incomplete initial colonoscopy. (*Id.*, pp. 233-34.) Foundation for this opinion can be found in Kootenai Health's Hospital Wide Discharge Planning policy. (*Id.*, pp. 658-70.) Pursuant to that policy, the standard of care required:

> -All patients to be screened for discharge planning needs;
> -Collaboration among medical professionals which will result in a multi-disciplinary approach identifying and planning the patient's ongoing health needs;
> -Involvement of the patient in mutually determining the discharge plan, support, education, and guidance;
> -Documentation of the discharge plan.

(*Id.*) Here, the discharge instructions merely stated:

> ASSESSMENT AND PLAN: Lower gastrointestinal bleed, probably diverticular. Probably okay to go home later today. He was told to come back to the hospital if he has any recurrent signs of bleeding. Discussed high fiber diet and/or Metamucil at home with his diverticulosis. If he does have rebleeding, would recommend repeating stat tagged packed red blood cells scan with angiogram if positive. This was discussed with him and his wife.

(*Id.*, p. 503.)

Despite incomplete views of the rectum during the colonoscopy, no plan for a follow-up or repeat colonoscopy was made. Communication to the patient and his family that the potential neoplasm or cancer was not relayed. Such actions violated the internal policies and standard of care of Kootenai Health.

As described by Dr. Hammerman, the standard of care further required coordination of care between Dr. James, PA McMahon, and NP Hildebrandt. (*Id.*, pp. 243-44.) The standard of care required set forth in the Clinical Communication Using ISBARD policy adopted by Kootenai Health requires physicians transferring responsibility of a patient to the care of another to provide pertinent patient information to ensure continuity of care. (*Id.*, pp. 706-07.) This policy provides adequate foundation for the Dlouhys' experts to testify as to the standard of care.

Finally, the Patient Transfer/Release of Medical Information Policy recognizes that the standard of care is to provide "continuity of care among settings" as well as "consistent patient care" and "service coordination." (*Id.*, pp. 709-26.)

The policies and procedures of Kootenai Health, when viewed in conjunction with the deposition testimony above, far exceed the foundational requirements for the Dlouhys' experts to testify as to the standard of care. By finding that Drs. Hammerman and Schmidt lacked the foundation to render opinions in this case even after familiarizing themselves with these standards of care, defies common sense and was an abuse of discretion.

(d) *Federal regulations also confirm the standard of care.*

The Dlouhys' experts also cite to portions of regulations regarding CMS and Medicare standards. Pursuant to Idaho law, these sources provide foundation for their opinions. Again, this Court has recognized the following:

> Standards of care are sensitive to evolving changes in the way health care services are delivered in the various communities of our State. Indeed, the Court has recognized that "**governmental regulation,** development of regional and national provider organizations, and greater access to the flow of medical information," have provided "various avenues by which a plaintiff may proceed to establish a standard of care...."

Mattox v. Life Care Centers of America, Inc., 157 Idaho 468, 474, 337 P.3d 627, 633 (2014) (internal citations omitted) (emphasis added).

For example, Dr. Hammerman's disclosure cites to regulation 42 CFR 482.43(d) which governs what information must be provided for follow-up care:

> **Standard: Transfer or referral**. The hospital must transfer or refer patients, along with necessary medical information, to appropriate facilities, agencies, or outpatient services, as needed, for follow up or ancillary care.

After identification of the potential neoplasm and focal wall thickening, and incomplete colonoscopy, Mr. Dlouhy required follow up and further evaluation.

Further, under federal law, patients have a right to be informed about their care, their treatment options and have the right to participate and make decisions about their care:

> **42 CFR 482.13—Condition of Participation: Patient's Rights.**
>
> (b) *Standard: Exercise of rights.*
>
> (1) The patient has the right to participate in the development and implementation of his or her plan of care.
>
> (2) The patient or his or her representative (as allowed under State law) has the right to make informed decisions regarding his or her care. The patient's rights include being informed of his or her health status, being involved in care planning and treatment, and being able to request or refuse treatment. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate.

These federal standards add extra support to the argument that the experts in this case have the foundation necessary to render their opinions and that the standard of care at issue is a national standard rather than a local standard.

> (e) *Dr. Schmidt need not share the same specialty as Dr. James to opine as to the standard of care.*

Dr. Schmidt is competent to testify as to the standard of care applicable to the medical providers in this case. "Idaho Code § 6-1012 requires a plaintiff bringing a medical malpractice claim to prove, by direct, competent expert testimony and by a preponderance of the evidence, that the defendant negligently failed to meet the applicable standard of health care practice. That

standard is specific to 'the time and place of the alleged negligence' and 'the class of health care provider that such defendant then and there belonged to. . ..'" *Mattox v. Life Care Ctrs. of Am., Inc.*, 157 Idaho 468, 473, 337 P.3d 627, 632 (2014) (quoting I.C. § 6-1012). "To be considered competent, the medical expert must show that 'he or she is familiar with the standard of health care practice for the relevant medical specialty, during the relevant timeframe, and in the community where the care was provided' and 'must explain how he or she became familiar with that standard of care.' *Bybee v. Gorman*, 157 Idaho 169, 174, 335 P.3d 14, 19 (2014) (internal quotation marks omitted); *see also* I.C. § 6-1013.

Despite the ruling of the District Court, this Court has unambiguously stated that "*it is unnecessary for an expert witness to be of the same specialty as the defendant*, so long as the expert establishes he possesses actual knowledge of the standard of care to be applied." *Mattox v. Life Care Ctrs. of Am., Inc.*, 157 Idaho 484, 337 P.3d 627 (2014) (*citing Newberry v. Martens*, 142 Idaho 284, 292, 127 P.3d 187, 195 (2005) (emphasis added)).

In *Newberry*, for example, the defendant physician was a family practice doctor. 142 Idaho at 286. Plaintiffs' expert was an ophthalmologist. *Id*., p. 292. Like in this case, defendant argued that because the expert did not speak with a family practice doctor, he lacked the foundation to testify. *Id*. This Court found that the expert's interactions through referrals and other methods provided sufficient foundation for the testimony, even though he did not specifically speak to a family doctor about the facts of that case. *Id*.

In *Mattox*, the trial court excluded the testimony of plaintiffs' expert physician in part because he was not a nurse in a skilled nursing facility like the defendant. 157 Idaho at 475. This Court vacated and remanded affirming that it is unnecessary for the expert to be of the same specialty as the defendant. *Id*. Rather, the overriding question is whether that expert has

knowledge of the standard of care at issue. *Id.*

Here, Dr. Schmidt is not a gastroenterologist like Dr. James. However, she is triple board-certified internist, hematologist and medical oncologist. (R., pp. 266-88.) She is familiar with the classic symptoms of rectal cancer of which Duane presented with in May 2015. (*Id.*, p. 267.) During her career, she "was exposed to a plethora of benign and malignant tumor diagnosis, workup, and management issues …." (*Id.*) In her role as a solo practitioner in Montana, she "was responsible for the internal medicine care of over 95%" of her patients and "regularly recommended screening and surveillance colonoscopies" for her patients. (*Id.*, p. 268.) Dr. Schmidt has been a member of eight hospital medical staffs, participated in hospital committees, and has "assisted with the credentialing of all hospital health care professionals (including physicians and nurse practitioners…." (*Id.*)

Given Dr. Schmidt's extensive career in internal medicine and in recognizing and treating cancer patients for many years, and review of the materials in this case, it was an abuse of discretion of the District Court to conclude that she was not qualified to render opinions in this case. (R., pp. 780-82.) Because the Dlouhys have demonstrated that this disclosure far exceeds the foundational requirements of Idaho Code §§ 6-1012 and 6-1013, Dr. Schmidt's opinions regarding the standard of care should have been considered by the District Court.

B. Because the disclosure of Drs. Hammerman and Schmidt raise genuine issues of material fact, the District Court erred in granting summary judgment to Kootenai Health.

1. Standard of Review.

"On appeal from the grant of a motion for summary judgment, this Court utilizes the same standard of review used by the district court originally ruling on the motion." *Samples v. Hanson*, 161 Idaho 179, 181-82, 384 P. 3d 943, 945-46 (2016) (*citing Arregui v. Gallegos-Main*,

153 Idaho 801, 804, 291 P.3d 1000, 1003 (2012)). "Summary judgment is proper if the pleadings, depositions, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." *Id.* (internal quotation omitted). "When considering whether the evidence in the record shows that there is no genuine issue of material fact, the trial court must liberally construe the facts, and draw all reasonable inferences, in favor of the nonmoving party." *Id.* (*citing Dulaney v. St. Alphonsus Reg'l Med. Ctr.*, 137 Idaho 160, 163, 45 P.3d 816, 819 (2002)).

2. The Dlouhys are entitled to have a jury consider their claims against defendants.

As demonstrated above, the District Court abused its discretion in not considering the proffered opinions of Dr. Hammerman and Dr. Schmidt. Those disclosures, when properly considered and when viewed in a light most favorable to the Dlouhys as required, raise genuine issues of material fact as to whether Kootenai Health's care and treatment of Duane Dlouhy complied with the applicable standard of care and whether their treatment was a substantial contributing factor in his death.

IV. CONCLUSION

This Court has stated that trial courts should review the proffered opinions of expert witnesses in a medical malpractice action with a measure of common sense and not through the lens of a hyper-technical interpretation of Idaho Code §§ 6-1012 and 6-1013. It has been recognized repeatedly that familiarizing an out-of-area expert with the local standard of care was not meant by the legislature to be an overly burdensome requirement on a plaintiff.

To meet this minimal burden, the Dlouhys retained highly trained, nationally board-certified expert physicians. These physician witnesses were provided direct, specific, and precise

deposition testimony regarding the standard of care from physicians who practiced in the geographic community during the applicable time frame. These expert witnesses reviewed policies and procedures, medical records, and other material directly from Kootenai Health to confirm the standard of care at issue in this case. These experts opined that not only was the standard of care at issue a national standard of care, but also that it was a basic and universal standard that would apply to any competent physician in the same circumstance.

The disclosures of the Dlouhys' expert witness far exceed the minimal foundational requirements found in Idaho Code §§ 6-1012, 6-1013, and this Court's jurisprudence. Despite that fact, the Dlouhys still faced a *Motion for Summary Judgment* and this appeal. In granting Kootenai Health's motion, the District Court abused its discretion and deprived the Dlouhys of their constitutional right to have this dispute decided by a jury of their peers.

The Dlouhys respectfully request that this Court reverse the decision of the District Court, vacate the judgment, and remand for further proceedings.

DATED this 1st day of November, 2019.

PEDERSEN and WHITEHEAD

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 1st day of November, 2019, a true and correct copy of the foregoing was served on the following by the manner indicated:

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☐ First Class Mail
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☐ Facsimile
☒ Electronic Filing

/s/ Michael J. Hanby II
Michael J. Hanby II