

**FILED**

JUL 26 2010

COURT OF APPEALS  
DIVISION III  
STATE OF WASHINGTON  
By: \_\_\_\_\_

No. 288463 -III

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IN THE COURT OF APPEALS, DIVISION III,  
OF THE STATE OF WASHINGTON

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LAJUANA LEAVERTON, a single individual,  
Plaintiff/Appellant

v.

CASCADE SURGICAL PARTNERS, P.L.L.C.; and ROBERT J.  
CONROY, M.D.  
Defendants/Respondents

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BRIEF OF APPELLANT

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OTOROWSKI JOHNSTON MORROW & GOLDEN, PLLC  
Thomas R. Golden, WSBA #11040  
Attorneys for Appellant  
LAJUANA LEAVERTON

Thomas R. Golden, WSBA #11040  
OTOROWSKI JOHNSTON MORROW & GOLDEN, PLLC  
298 Winslow Way West  
Bainbridge Island, WA 98110  
Telephone (206) 842-1000  
Fax: (206) 842-0797

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## I. ASSIGNMENTS OF ERROR

1. The trial court erred in granting summary judgment against plaintiff when it concluded that the expert testimony submitted by plaintiff was not legally sufficient testimony.

## II. ISSUES PERTAINING TO ASSIGNMENTS OF ERROR

1. Did the trial court err in granting summary judgment in a medical negligence action on the basis that the expert testimony of plaintiff's board certified otolaryngologist witnesses was not competent expert testimony against a general surgeon performing a subtotal thyroidectomy when the expert otolaryngologists had knowledge and expertise with the procedure or medical problem at issue?

2. Did the trial court err in granting summary judgment in a medical negligence action where plaintiff's expert witnesses, both board certified otolaryngologists, familiar with thyroid disease and thyroidectomy<sup>1</sup>, testified to violations of the standard of care for any surgeon performing thyroid surgery with monopolar electrocautery?

3. Did the trial court apply the wrong legal standard or otherwise wrongly interpret *Hill v. Sacred Heart Medical Center*, 143 Wn. App. 438, 173 P.3d 1152 (2008); *Eng v. Klein*, 127 Wn. App. 171,

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<sup>1</sup> Surgical removal of the thyroid gland. Removal of a portion of the thyroid gland is a subtotal thyroidectomy.

110 P.2d 844 (2005); and *Seybold v. Neu*, 105 Wn. App. 666, 19 P.3d 1068 (2001); and *White v. Kent Medical Center Inc. P.S.*, 61 Wn. App. 163, 810 P2d 4 (1991), when the court held that the expert witnesses' lack of knowledge of general surgeons' training precluded consideration of their expert testimony?

4. Whether board certified otolaryngology expert witnesses who are knowledgeable and experienced in (1) thyroid disease; (2) surgical removal of the thyroid gland; and (3) the safe and proper use of monopolar electrocautery and preventing injury to the recurrent laryngeal nerve during thyroid surgery are competent to express expert standard of care opinions regarding the use of monopolar electrocautery and its injury to the patient's recurrent laryngeal nerve.

### **III. STATEMENT OF THE CASE**

#### **A. Facts.**

Lajuana Leaverton, then 47 years of age, was referred to Dr. Conroy of Cascade Surgical Partners, P.L.L.C., for surgical removal of the thyroid gland. Lajuana's initial visit with Dr. Conroy was on November 13, 2003. (CP 105, 184) Dr. Conroy's exam showed an enlarged thyroid with several nodules palpable on the right side and one small nodule palpable on the left side. (CP 105) Dr. Conroy made no notation prior to

surgery of any voice abnormality or hoarseness. (CP 105, 118)<sup>2</sup> Dr. Conroy did not examine Lajuana Leaverton's larynx or refer Lajuana Leaverton to an otolaryngologist (ENT) for a preoperative evaluation of her larynx and vocal cords. (CP 116)

Dr. Conroy and Lajuana Leaverton did discuss the surgical removal of her thyroid. A total thyroidectomy is the removal of the entire thyroid gland. A subtotal thyroidectomy is the removal of the majority of the thyroid leaving a portion behind. (CP 114) A decision to perform a subtotal thyroidectomy can be based upon difficulty of dissection, difficulty in identification of the recurrent laryngeal nerve, and difficulty in identification of the external branch of the superior laryngeal nerve. (CP115) Other complicating factors such as unusual anatomy, variances of the blood vessels, and/or thyroiditis, may determine whether a subtotal thyroidectomy is performed. In *Greenfield's Essentials of Surgery* it is noted:

The critical anatomic relations during the thyroidectomy are between the thyroid and the recurrent laryngeal nerve, superior laryngeal nerve, and parathyroid glands. Injury to the laryngeal nerves paralyzes the vocal cords on the ipsilateral side, the most

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<sup>2</sup> In his deposition, Dr. Conroy does describe hoarseness of Lajuana Leaverton's voice but did not consider this condition to be a permanent condition because of multiple possible factors including history of smoking and multiple episodes of bronchitis (CP 117)

serious consequences of which are loss of voice and airway obstruction. (CP 89)

On November 26, 2003, Dr. Conroy preformed a subtotal thyroidectomy, leaving a portion of the thyroid on Ms. Leaverton's left side. (CP 106-107) In the surgery, Dr. Conroy was not able to identify the left recurrent laryngeal nerve, at which point he decided to leave a small portion of the thyroid gland. Dr. Conroy used cautery to divide the thyroid gland. Dr. Conroy stated:

The recurrent nerve was not identified on the left side, so I divided the thyroid gland with the electrocautery, approximately 0.5 cm from its mediolateral-most component, and then dissected it off the trachea. (CP 106)

Dr. Conroy was able to identify the right recurrent laryngeal nerve.

He stated:

The recurrent laryngeal nerve on the right side was clearly identified. Initially when I rolled the gland medially, it appeared that the nerve was adhered to the gland. I had planned to divide the gland above the nerve, but when I started mobilizing it superiorly it came off the trachea pretty easily in that position and actually peeled off the nerve, and the nerve appeared intact. (CP 107)

Immediately postoperatively, Lajuana Leaverton was noted to have significant stridor. Stridor is a high pitched sound, or noisy breathing, that results from the turbulent air flow in the upper airway, primarily on

inspiration and sometimes on expiration. (CP 150) Otolaryngologist Dr. Palmer Wright was consulted and noted bilateral vocal cord abductor and adductor paralysis. (CP 108)

Lajuana Leaverton's follow-up care for vocal cord paralysis included care with Dr. Palmer Wright and further care at the University of Washington where a tracheostomy was performed on December 17, 2003. (CP 186) At the time of this surgery, Lajuana Leaverton was noted to have a 2mm airway and bilateral vocal cord paralysis. (CP 186) In June of 2004, Dr. Allen Hillel noted that Lajuana Leaverton's vocal cords were fixed in the midline position. (CP 151, 189).

**B. Procedural History.**

Lajuana Leaverton filed an action for medical negligence against Cascade Surgical Partners, P.L.L.C. and Robert J. Conroy, M.D. (hereinafter defendants "CSP" and "Conroy"). (CP 167-173) On November 2, 2009, defendants CSP and Conroy filed a Motion for Summary Judgment of Dismissal. (CP 179-181) Defendants' motion was supported by the Declaration of Megan Murphy, an attorney for CSP, and Conroy. (CP 179-181) Ms. Murphy attached certain medical records (CP 191, 193) and partial deposition page excerpts from plaintiff's otolaryngology experts, Dr. Charles R. Souliere, Jr. and Dr. Gregory

Chan. (CP 210-212, 214-216, 218-219, 221-222, 224-226, 228-230 and 232-233). Defendants CSP and Conroy argued:

Plaintiff did not declare and has not offered any expert testimony from a general surgeon regarding the applicable standard of care for a general surgeon practicing in the State of Washington in performing a subtotal thyroidectomy.

(CP 151-152)

In response, Lajuana Leaverton provided the trial court more extensive deposition testimony from otolaryngologists Dr. Souliere and Dr. Chan. Dr. Souliere and Dr. Chan provided deposition testimony regarding their training and experience with thyroid surgery, violations of standard of care for thyroid surgeons and medical causation testimony. See § III (C) infra.

In a written opinion letter filed on November 17, 2009, the trial court acknowledged the medical expertise of plaintiff's experts but nonetheless granted summary judgment. (CP 29) The written decision stated in part:

Plaintiff's experts are both well-qualified board certified otolaryngologists, who have experience and familiarity with thyroid disease and thyroidectomy. They both state candidly in their depositions that they are unable to express an opinion on the standard of care for a general surgeon with regard to the performance of subtotal thyroidectomy.

It is correct, as the cases cited by both counsel confirm, that physicians who testify against the treating physician do not necessarily have to have the same credentials, so long as the credentials they do have allow them to testify as to the treating physician's standard of care. In the cases cited by both parties the expert witnesses were all able to, and did, testify as to the treating physician's standard of care. In this case neither expert is able to do that. Summary judgment in favor of the defendant is therefore granted.

(CP 79)

Plaintiff timely sought reconsideration of the summary judgment of dismissal. (CP 73-78) Plaintiff argued that the "medical problem at issue was utilization of monopolar cautery adjacent to the recurrent laryngeal nerve, which was well within the training and expertise of both Drs. Souliere and Chan. (CP 74-75) Plaintiff also pointed out to the court that defendant Conroy's decision to perform a subtotal thyroidectomy was never an allegation of negligence. (CP 76)

On January 24, 2010, the trial court denied plaintiff's motion for reconsideration. (CP 13) This timely appeal followed. (CP 8-11)

**C. Expert Testimony Submitted in Opposition to Motion for Summary Judgment.**

Plaintiff Leaverton submitted deposition testimony of otolaryngology expert witnesses Dr. Charles Souliere and Dr. Gregory

Chan. The testimony from Dr. Souliere's August 29, 2009 deposition submitted to the court established their knowledge of the medical condition or surgical procedure at issue:

1. Dr. Souliere's training after completion of medical school included two years of general residency, three years of otolaryngology residency and one year fellowship in otolaryngology. (CP 120)

2. Dr. Souliere had training in thyroid surgery as a general surgery resident. His training included lobectomy, subtotal thyroidectomy and total thyroidectomy. His involvement and frequency of thyroid surgeries remained the same during his three-year otolaryngology residency. (CP120)

3. Since 1994, Dr. Souliere has performed between 5 and 10 thyroidectomies per year. (CP 121-122)

4. Dr. Souliere does either a lobectomy or a total thyroidectomy.

As explained by Dr. Souliere:

I either do a lobectomy or a total thyroidectomy. Otolaryngologists in thyroid surgery are trained to identify the recurrent laryngeal nerve, and if you follow that methodology, unless there is a carcinoma invading some structure you couldn't remove, there would be no reason to do a subtotal.

(CP 122)

5. Dr. Souliere did have training in subtotal thyroidectomy during his two-year general surgery residency but was not trained in subtotal thyroidectomy in his otolaryngologist training. (CP 122)

6. Dr. Souliere has assisted on subtotal thyroidectomy. (CP 123)

7. Dr. Souliere believes that most ear, nose and throat surgeons would not as a matter of course do a subtotal thyroidectomy based upon their training. (CP 124)

8. Dr. Souliere opines that the standard of care in thyroid surgery would have been to use a nerve monitor during thyroid surgery. Dr. Souliere was asked:

Q: In your opinion, at the time that the surgery was performed by Dr. Conroy in this case, in your opinion did the standard of care applicable to a general surgeon require the use of a nerve monitor during thyroid surgery.

A: I can't testify as to the standard of care for a general surgeon. I'm not a general surgeon. I know the standard of care for an otolaryngologist would certainly be to use a nerve monitor.

Q: So if I understand your answer is you believe that the standard of care applicable to an otolaryngologist at the time in question would have required the use of a nerve monitor in a subtotal thyroidectomy procedure, correct?

A: I don't believe an otolaryngologist does a subtotal thyroidectomy, or most don't, but I believe that the standard of care in thyroid surgery would have been to use a nerve monitor.

(CP 125)

9. Dr. Souliere explained that his standard of care opinions are based upon the standard of care for any physician performing thyroid surgery. (CP 125-126). Dr. Souliere testified:

Q: All right, sir. Fair enough. Okay. Do you have any opinions in this case that Dr. Conroy failed at any time during his involvement with the patient, that he failed to meet the standard of care of a reasonably prudent general surgeon practicing in the state of Washington at the time that he was rendering service to the patient?

A: In the general performance of thyroid surgery, I can offer standard of care since I perform that surgery. I cannot – I don't have knowledge specifically of what a general surgeon's standard of care would be and how that might differ from an otolaryngologist. In the journal articles, I do know that whether you're a general surgeon or ear, nose and throat surgeon protection of the recurrent laryngeal nerve is paramount.

Q: But as to whether or not Dr. Conroy met or violated the standard of care in the performance of this surgery as a reasonably prudent general surgeon, you're not able to so testify, correct?

A: I – I –

Mr. Golden: Object to the form. Go ahead and answer, Doctor.

A: I don't know that I have any opinion as to the standard of care for a general surgeon. As I mentioned, I have comment [sic] as to the standard of care for performing thyroid surgery in general.

(CP 125-126) (emphasis added)

10. Dr. Souliere opined that Dr. Conroy's preoperative work-up of Lajuana Leaverton was not reasonable and appropriate. Dr. Souliere noted that Dr. Conroy verbally indicated in his deposition that Lajuana Leaverton had some preoperative hoarseness although it is not mentioned in any written record. Given the patient's prior history of anterior cervical discectomy and a question of abnormality in the voice, it was imperative that the patient's larynx be evaluated preoperatively. (CP 127)

11. Dr. Souliere stated as a thyroid surgeon he does believe that it is the standard of care to use intraoperative nerve monitoring. (CP 128) (emphasis added)

12. He has been called into two cases where there has been recurrent laryngeal nerve injury during thyroid surgery. Both cases were thyroidectomies performed by general surgeons that needed emergent tracheostomy on the patient for bi-lateral vocal cord paralysis. One case

was a total thyroidectomy and the other case was a subtotal thyroidectomy. (CP 129-130)

13. Since 2006 Dr. Souliere has taught general surgeons in the community how to use the nerve monitor during thyroidectomy. (CP 131)

14. Dr. Souliere opined that if it is assumed that there was no previous injury to the left recurrent laryngeal nerve during the anterior cervical fusion procedure, then it is more probable than not that the use by Dr. Conroy of monopolar cautery immediately adjacent to the nerve damaged the recurrent laryngeal nerve. (CP 132)

15. Since Dr. Conroy did not identify the left recurrent laryngeal nerve, it could have conceivably been injured in other ways such as a crush injury or transection. However, the fact that there was some nerve functioning on electromyography suggests the nerve was not transected. There is no indication in Dr. Conroy's operative report, which would suggest there was a crush injury. Dr. Conroy opined that there was a stretch injury to the recurrent laryngeal nerve. (CP 133)

16. During his training in general surgery with respect to thyroid surgery, he was taught never to use monopolar cautery within the proximity of a nerve and that would include within a centimeter and a half. Additionally, in his ENT residency he was similarly trained not to use monopolar cautery within a centimeter and a half of a nerve. (CP 134)

17. Dr. Souliere opined that it is below the standard of care to use monopolar cautery adjacent to a nerve in any field of surgery, whether that is general surgery, ENT, neurosurgery, etc. This would also apply to any surgeon doing thyroid surgery. (CP 135) He testified:

Q: Now, Doctor, you said before that when you were undergoing your training in general surgery you were taught never to use monopolar cautery within the proximity of a nerve?

A: Yes.

Q: And would that be within a centimeter to a centimeter and half?

A: Yes.

Q: And was that also your training during the general surgery with respect to thyroid surgery?

A: Yes.

Q: And was it also – did I hear you correctly say that in your training in the ENT residency you were similarly trained not to use monopolar cautery within the vicinity of a nerve?

A: Yes.

Q: And, again, this would be a centimeter to a centimeter and a half?

A: Yes.

Q: And, Doctor, do you have an opinion in terms of general thyroid surgery practice whether it's below the standard of care for a physician to use monopolar cautery within a centimeter – or, excuse me, within point five centimeters of the area of the recurrent laryngeal nerve if that nerve cannot be identified?

Mr. Thorner: Object to the form of the question.

A: I believe it would be below the standard of care to use monopolar cautery adjacent to a nerve in any field of surgery, whether that's general surgery, ENT, neurosurgery, et cetera.

Q: And would that also apply to any surgeon doing thyroid surgery?

A: Yes.

(CP 134-135)

Dr. Chan's deposition testimony further established:

1. Dr. Chan is a board certified otolaryngologist. (CP 137, 141, 142)
2. Dr. Chan had been practicing thirty-four (34) years as of the time of his deposition. For the past ten (10) years he has been averaging approximately 12-20 thyroidectomy cases per year. (CP 138)
3. Dr. Chan had one year of general surgery residency and may have assisted in thyroidectomy during this first year. (CP 139-140)

4. Dr. Conroy's operative report raises a red flag when he writes that he divided the thyroid gland with electrocautery approximately .5 centimeters from the mediolateral most components. On a more probable than not basis, the left recurrent laryngeal nerve was injured because of this technique. (CP 143-144)

5. The right recurrent laryngeal nerve was injured when the nerve was "peeled off." (CP 145)

6. It is not reasonably prudent for Dr. Conroy to divide the thyroid gland with electrocautery. Electrocautery is a very powerful, high intensity thermal tool, which can cause collateral injury in deep tissues.

(CP 146) Dr. Chan testified:

Q: Now, let's look at this sentence for a minute. It says, "The recurrent nerve was not identified on the left side, so I divided the thyroid gland with the electrocautery."

Now, was it reasonable for him to divide the thyroid gland at this point of the surgery?

A: Probably not. Not with electrocautery.

Q: Why not?

A: Because electrocautery, the way I know it, is a very powerful, high intensity, high thermal tool that we know that can cause deep tissue collateral injury. ...

(CP 146)

7. Lajuana Leaverton has bilateral vocal cord paralysis. The vocal cord paralysis occurred during her thyroid surgery. There is no indication in Dr. Conroy's preoperative work-up of any unilateral vocal cord injury or paralysis. (CP 147)

8. Based on the standard of care of physicians performing thyroid removal surgery, it is below the standard of care to use electrocautery to divide the thyroid gland at or near within .5 centimeters of the recurrent laryngeal nerve. (CP 147-148) Dr. Chan testified:

Q: Now, Doctor, based on a standard of reasonably prudent care of physicians doing thyroid removal surgery here in the state of Washington, based on a patient such as Lajuana Leaverton, and taking into consideration your review of the medical records where the left recurrent laryngeal nerve was not identified, do you have an opinion as to whether cutting cautery at or near the trachea .5 centimeters is within or without the standard of care?

Mr. Thorner: Object to form.

A: You got to repeat the question again.

(The last question was read back.)

A: The answer is yes.

Q: And what is your opinion?

A: My opinion is yes.

Q: And can you explain?

A: Based upon your statement that the nerve was not identified, that you used the word cutting cautery and near the trachea, that is a high intensity thermal instrument that can cause deep tissue burn as a collateral injury to the tissue. And that's how the nerve most probably be [sic] injured.

(CP 147-148)

#### IV. ARGUMENT

##### A. Standard of Review.

An order granting summary judgment is reviewed *de novo*. *Hill v. Sacred Heart Medical Center*, 143 Wn. App. 438, 445, 177 P.3d 1152 (2008); *Seybold v. Neu*, 105 Wn. App. 666, 675, 19 P.3d 1068 (2001). The *de novo* standard of review is used by an appellate court when reviewing all trial court rulings made in conjunction with a summary judgment motion. This standard of review is consistent with the requirement that evidence and inferences are viewed in favor of the non-moving party. *Folsom v. Burger King*, 135 Wash. 2d 658, 663, 958 P.2d 301 (1998); *Lamon v. McDonnell Douglas Corp.*, 91 Wash. 2d 345, 349, 580 P.2d 1346 (1979). The *de novo* standard of review is also consistent with the requirement that the appellate court conduct the same inquiry as the trial court. *Mountain Park Homeowners Ass'n v. Tydings*, 125 Wash 2d 337, 341, 883 P.2d 1383 (1994); *Folsom* at 663.

An expert's qualifications and opinions are part and parcel of a summary judgment. *Hill* at 445; *Seybold* at 678. The appellate court does not defer to the trial judge's rulings on evidence in passing on the propriety of a summary dismissal. The appellate court decides whether evidence is sufficient or should have been considered and to what extent. *Folsom* at 663; *Hill* at 446.

An order of summary judgment is proper only where there are no genuine issues of material fact for trial and the moving party is entitled to judgment as a matter of law. *Gustav v. Seattle Urological Associates*, 90 Wn. App. 785, 789, 954 P.2d 319 (1998), *rev. denied*, 136 Wn.2d 1023, 969 P.2d 1064 (1998); CR 56(c). The moving party bears the initial burden of showing the absence of genuine issues of material fact. *Young v. Key Pharmaceuticals*, 112 Wn.2d 216, 226, 770 P.2d 182 (1989). A material fact is one on which the outcome of the litigation depends, in whole or in part. *Ford v. Hagel*, 83 Wn. App. 318 (1996).

The non-moving party must set forth specific facts showing there is a genuine issue for trial. *Young*, 112 Wn.2d at 226. The court must consider those facts in the light most favorable to the nonmoving party and the motion should be granted, only if from all the evidence reasonable persons could reach but one conclusion. *Young v. Key Pharmaceuticals*, 112 Wn. 2d at 226; *Shellenbarger v. Brigman*, 101 Wn. App. 339, 345, 3

P.3d 211 (2000); *White v. Kent Medical Center, Inc.*, P.S., 61 Wn. App. 163, 810 P.2d 4 (1991). In determining whether the moving party has met its burden of excluding any real doubt as to the existence of any genuine issue of material fact for trial, the non-moving party should be treated with indulgence. *Adamski v. Tacoma General Hospital*, 20 Wn. App. 98 (1978). Summary judgment will be denied if the record shows any reasonable hypothesis that the non-moving party may be entitled to the relief sought. *White v. Kent Medical Center, Inc.*, P.S., 61 Wn. App. at 175; *Mostrom v. Pettibohn*, 25 Wn. App. 158, 162, 607 P.2d 864 (1991).

Issues of negligence in an action for medical malpractice are generally questions for the trier of fact and should be decided as a matter of law only in rare cases. *Thomas v. Wilfac, Inc.*, 65 Wn. App. 255, 261, 828 P.2d 597 (1992), *rev. denied*, 119 Wn. 2d 1020, 838 P.2d 692 (1992).

The foregoing principles guide the Court's review in this case.

**B. Summary of Argument**

The evidentiary law in Washington regarding the admissibility of testimony from competent expert witnesses to withstand summary judgment is well established. A physician with a medical degree is qualified to express an opinion on any sort of medical questions, including questions in areas in which the physician is not a specialist, so long as the physician has sufficient expertise to demonstrate familiarity with the

procedure of medical problem at issue in the medical negligence action.  
*Hill* at 447.

Otolaryngologists Dr. Charles Souliere, Jr. and Dr. Gregory Chan have extensive knowledge and personal experience diagnosing thyroid disease, surgically removing the thyroid gland, using electrocautery and avoiding injury to the recurrent laryngeal nerves during a thyroidectomy. Dr. Souliere and Dr. Chan expressed standard of care opinions applicable to all surgeons performing thyroid surgery and all surgeons utilizing monopolar electrocautery in close proximity to the recurrent laryngeal nerve. The testimony of Dr. Souliere and Dr. Chan established violations of the standard of care by defendant Dr. Conroy which caused permanent injury to Lajuana Leaverton's recurrent laryngeal nerves, resulting in bilateral vocal cord paralysis and a tracheostomy to breathe.

Even though Dr. Souliere and Dr. Chan are unquestionably qualified otolaryngologists and have knowledge of the medical condition and procedure at issue in this action, their admitted lack of knowledge of a general surgeon's training and standard of care for subtotal thyroidectomy was determined by the trial court as dispositive in not considering their expert testimony and granting summary judgment. The trial court clearly erred in its consideration of plaintiffs' expert testimony. Reversal of the summary judgment and remand is required.

C. **The Trial Court Erred in Granting Defendants' Motion For Summary Judgment.**

1. Washington Case Law Establishes That The Competency of Expert Witness Testimony is Based Upon the Witnesses' Familiarity with the Procedure or the Medical Condition at Issue.

In *White v. Kent Medical Center, Supra*, the plaintiff brought an action against defendant physicians for failing to order a vocal cord examination. An ENT specialist subsequently examined Mrs. White's larynx and discovered a mass on her left vocal cord, which was malignant. Following the granting of summary judgment of dismissal, an issue on appeal was the sufficiency of the plaintiff's opposing expert testimony. The defendant argued that Mrs. White's evidence of the applicable standard of care was inadequate because ENT specialists cannot testify as to the standard of care governing a general practitioner. *Id.* at 171. The appellate court held that while a general practitioner cannot normally be held to the standard of care of a specialist, this does not automatically render the specialist's testimony about the general practitioner's standard of care inadmissible. *Id.* at 173. The court held:

So long as a physician with a medical degree has sufficient expertise to demonstrate a familiarity with the procedure or medical problem at issue, 'ordinarily he or she will be qualified to express an opinion on any sort of medical question, including questions in areas which the physician is not a specialist.' 5A K. Tegland, Wash Prac.

*Evidence*, § 290[2], at 386 (3d ed. 1989).  
(Emphasis added)

*Id.* at 173.

The *White* court further referenced previous Washington cases where an osteopath was competent to testify in a medical negligence action against an allopath physician (*Swanson v. Hood*, 99 Wash. 506, 515, 170 P.2d 135 (1918)) and an orthopedic surgeon could testify about the podiatric standard of care so long as the surgeon and podiatrist use the same methods of treatment (*Miller v. Peterson*, 42 Wn. App. 822, 830, 714 P.2d 695, *rev. denied*, 106 Wn. 2d 1006 (1986)). See *White v. Kent Medical Center*, *supra* at 173-174. Division One stated:

It is the scope of the witnesses' knowledge and not the artificial classification by title that should govern the threshold [sic] question of admissibility' of expert testimony in a malpractice case. (quoting *Fitzmaurice v. Flynn*, 167 Conn. 609, 356 A.2d 887 (1975) and citing ER 704 (witness qualifies as expert by knowledge, skill, experience, training, or education)).

*White* at 174. (Emphasis added)

This same issue was revisited in *Seybold v. Neu*, *Supra*, which involves a medical negligence action against an orthopedic oncology surgeon. The defendant (Dr. Flugstad) brought a motion for summary judgment to dismiss the plaintiff's claims on the ground that they lacked the requisite testimony of a qualified expert to support their medical

negligence claims. At issue was the proper treatment of a subcutaneous tumor. Dr. Flugstad argued that Dr. Schneider, a reconstructive plastic surgeon and an expert in the surgical removal of cutaneous malignancies, lacked the requisite expertise in orthopedics or orthopedic oncology to be competent to testify. *Id.* at 675.

The plaintiff responded by establishing that Dr. Schneider had experience in the treatment of cutaneous malignancies, experience in large amounts of trauma surgery and experience in repairing bones that were either missing or do not heal. *Id.* at 672. The appellate court also noted that Dr. Schneider presented lectures to other physicians on various subjects, including cutaneous malignancies, and twice published written materials in reconstructive surgery, including one article written in conjunction with an expert on Mohs surgery, a technique that Dr. Schneider opined should have been utilized in Mr. Seybold's case. *Id.* at 672.

Dr. Flugstad argued that Dr. Schneider was not competent to testify as an expert witness because he was not an orthopaedic surgeon; he was not an expert in orthopedic oncology; he was not an oncologist; he was not trained in the Mohs technique himself and thus was not competent to testify that the Mohs technique should have been used for the removal

of Mr. Seybold's cutaneous malignancy. The court summarized the defendant's argument as:

In sum, Dr. Flugstad argues that Dr. Schneider is not his professional equal, and is, therefore, not qualified to opine as to the standard of care applicable to Dr. Flugstad's treatment of Mr. Seybold.

*Id.* at 679.

The Court of Appeals reversed the granting of summary judgment. The court initially noted that Mr. Seybold's condition was a cutaneous malignancy, which is a skin cancer located in the subcutaneous space and not a bone cancer. As such, the court concluded that the "relevant specialty" present was the removal of cutaneous malignancies located within the subcutaneous space. *Id.* at 679. Given Dr. Schneider's expertise in cutaneous malignancies, his expert testimony was admissible and relevant. The court held that it is not dispositive that Dr. Schneider was not an orthopedic surgeon, a musculoskeletal oncologist or trained in the Mohs technique. Relying upon *White v. Kent Medical Center, supra*, the Court held that so long as a physician with a medical degree has sufficient expertise to demonstrate familiarity with the procedure or medical problem at issue, he or she will ordinarily be considered qualified to express an opinion with respect to such procedure or problem, even if not a specialist with respect to same. *Id.* at 680.

In *Eng v. Klein, supra*, a medical negligence and wrongful death action was commenced against multiple physicians and Swedish Hospital Medical Center. Mrs. Eng had undergone a successful neurosurgery by Dr. Jacob Young on October 1, 1999. Seven days later, Mr. Eng contacted Dr. Young's partner, Dr. Klein, and reported that his wife had a high fever. Dr. Klein advised Mr. Eng to immediately take his wife to Swedish Emergency Department. *Id.* at 173. The emergency room physician believed there to be a significant bacterial infection and ordered a CT scan of Mrs. Eng's head and spine. The emergency room physician noted that Dr. Klein was present in the ER department and would follow through on the CT scan. The radiologist was directed to specifically page Dr. Klein with the CT report. *Id.* at 173. The CT scan was normal. Mrs. Eng was subsequently diagnosed as suffering from a rare form of meningitis. *Id.* at 174.

Dr. Klein moved for summary judgment. In opposition to the motion, the deposition and declaration of Dr. Vincent Quagliarello, an infectious disease expert with additional expertise in the diagnosis and treatment of meningitis was offered. *Id.* at 174. Dr. Quagliarello's expert testimony was premised upon the standard for diagnosing and treating meningitis, not a specific standard of care for neurosurgeons in the state of Washington. *Id.* at 174-175.

On appeal following granting of summary judgment, the court held that Dr. Quagliarello was, in fact, qualified to testify as to the diagnostic procedures for a patient presenting with symptoms like Mrs. Eng's. Further, the evidence indicated that the methods of treatment in this case were not specialty-specific, the court found that Dr. Quagliarello was competent to testify as to the standard of care in this case. *Id.* at 180.

More recently, in this Court's *Hill v. Sacred Heart Medical Center*, *supra*, this Court reversed a summary judgment of dismissal involving virtually identical legal issues. In *Hill*, the patient underwent bilateral knee surgery and developed post-operative heparin induced thrombocytopenia (HIT), which resulted in deep vein thrombosis, pulmonary embolism and stroke, which left Mr. Hill hemiplegic and unable to speak. *Id.* at 442-443. In response to the defendants' multiple motions for summary judgment, the Hills submitted declarations from hematologist Kenneth Bauer, M.D. and internist Katherine Willard, M.D. Dr. Bauer's affidavit concluded that the defendant physicians had violated the standard of care. *Id.* at 444. Internist Willard testified that the standard of care was violated and caused Mr. Hill's injuries. *Id.*

The trial court concluded that (1) Dr. Willard's affidavit was insufficient to adequately describe the 2004 standard of care for an internal medicine resident since her information was based upon

experience 20 years earlier; (2) Dr. Bauer did not have sufficient expertise in the area of residents or resident supervision; and (3) Dr. Willard failed to show competency in the specialty of gastroenterology and, therefore, could not express opinions on the care Dr. Gottlieb rendered. *Id.* at 445. The trial judge then dismissed the Hills' action against Sacred Heart and Drs. Andrus, Benson, Swanson, Harder, and Gottlieb. *Id.*

On appeal, this Court reiterated the admissibility standard for medical expert testimony:

The scope of the expert's knowledge, not his or her professional title, should govern 'the threshold question of the admissibility of expert medical testimony in a malpractice case.' *Pon Kwock Eng v. Klein*, 127 Wn. App. 171, 172, 110 P.3d 844 (2005) A physician with a medical degree is qualified to express an opinion on any sort of medical question, including questions in areas in which the physician is not a specialist, so long as the physician has sufficient expertise to demonstrate familiarity with the procedure or medical problem at issue in the medical malpractice action. *Morton v. McFall*, 128 Wn. App. 245, 253, 115 P.3d 1023 (2005). (Emphasis added)

***Hill v. Sacred Heart Medical Center*** at 447.

The ***Hill*** court set forth a two-part analysis for admissible expert medical testimony. These are (1) Is the expert a physician with a medical degree? and (2) Did the expert produce sufficient facts to demonstrate his

or her familiarity with the medical problem and/or condition and the procedures for diagnosing and treating the medical problem? *See Hill* at 451. In *Hill*, this Court noted that all of the physicians in the case have medical degrees and all practiced internal medicine in one form or another. *Hill* at 451-452. Second, the medical problem at issue is HIT, and the physicians are familiar with HIT and HIT-related procedures. The court of appeals noted that plaintiffs' experts belonged to the same profession and practiced in the same area as the defendant physicians, and that their knowledge of the medical problem and procedures at issue, that being the diagnosis and treatment of a patient presenting symptoms like Mr. Hill, is uncontested, and were competent to testify as to the standard of care in this case as to all physicians. *Hill* at 453.

In its holding, this Court rejected the defendant doctor's attempt to characterize the medical issue as a failure to properly evaluate Mr. Hill for a bowel obstruction. *Hill* at 452. This Court noted that the question is whether plaintiffs' experts (Dr. Willard and/or Dr. Bauer) were competent to testify as to the diagnostic and treatment procedures for patients who present symptoms like those of Mr. Hill. *Hill* at 452. The Court then stated:

. . . When the issue is so phrased and we can see the affidavits in a light most favorable to the Hills, that answer is obvious.

Reasonable inferences drawn from the experts address that both are familiar with HIT and the procedures to diagnose and treat HIT.

*Hill* at 452.

In the present case, the condition at issue is thyroid disease. The medical treatment in question is the surgical removal of all or part of the thyroid. Both the thyroid condition and surgery are treated by both general surgeons and otolaryngologists alike. Both Dr. Souliere and Dr. Chan have extensive personal experience in the surgical removal of the thyroid gland and the safe use of electrocautery. Applying the *White*, *Hill*, *Seybold*, and *Eng* test of whether the expert physician has “familiarity with procedure or medical problem at issue” (*Seybold* at 680 and *Hill* at 451), both Dr. Souliere and Dr. Chan have the knowledge and training as to the medical problem at issue – thyroid disease and treatment of thyroid surgery.<sup>3</sup> Both Dr. Souliere and Dr. Chan have the surgical knowledge and expertise in the use of electrocautery and the avoidance of injury to the recurrent laryngeal nerves. Dr. Souliere has had thyroid surgery training during both his general surgery residence and his otolaryngology residency. Dr. Chan has similar experience. Dr. Souliere has consistently performed thyroidectomy throughout his practice and

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<sup>3</sup> The admissibility standard of knowledge of the medical condition or procedure is in the disjunctive. Dr. Souliere’s and Dr. Chan’s knowledge base is both of the medical condition and surgery.

since 1994 has averaged approximately ten to fifteen such procedures per year. Dr. Souliere even teaches general surgeons performing thyroidectomy on the use of intraoperative nerve monitoring. Dr. Chan averages between twelve and twenty thyroidectomies per year.

Otolaryngology and general surgery are medical specialties where their training and expertise both encompass the surgical removal of the thyroid gland, the use of electrocautery and the prevention of injury to the recurrent laryngeal nerve. Applying *White*, Dr. Souliere's and Dr. Chan's scope of knowledge on the medical condition at issue and the surgery performed on Lujana Leaverton establish their competency to provide expert standard of care testimony. Applying *Seybold*, Dr. Souliere and Dr. Chan have both the required knowledge and familiarity of the medical condition and procedure at issue, as well as decades of experience in thyroid surgery. Just as the *Seybold* court held that the fact that Dr. Schneider was not an orthopedic surgeon/oncologist or trained in the Mohs technique is not dispositive on his competency to be an expert witness, this court cannot disqualify Dr. Souliere and Dr. Chan as expert witnesses when they clearly have the requisite knowledge and experience in thyroid disease, thyroid surgery and use of electrocautery during thyroid surgery despite their lack of awareness of a general surgeon's training in this area of medicine. Otherwise, this court would establishing a single

criterion as the dispositive fact in determining an expert witnesses testimonial competency rather than following *White, Seybold, Eng* and *Hill*.

In *Eng* and *Hill* the courts again refused to consider a physician's specific medical specialty training as the dispositive factor in considering his or her expert witness testimony. The courts applied a consistent analysis of reviewing the substance of the witnesses' knowledge of the medical condition or procedure at issue.

The defendants' preoccupation with the fact that plaintiff's expert witnesses are not general surgeons and do not perform a subtotal thyroidectomy is irrelevant and cannot be considered dispositive on the admissibility of these experts' opinions. See *White* at 174, *Seybold* at 680; *Hill* at 451. At best, such facts go to the weight given to the expert's trial testimony, not admissibility.

Defendants ask this Court to adhere to medical class distinctions no longer relevant in present day medicine. In the series of cases of *White, Seybold, Eng* and *Hill*, the court has consistently held that the standard for admissibility of expert testimony is the witness's knowledge of and familiarity with both the medical condition and the medical treatment at issue. Both Dr. Souliere and Dr. Chan are experienced thyroid surgeons knowledgeable about the recurrent laryngeal nerves and

the proper surgical treatment of thyroid disease and therefore can render expert opinions in this case as to the care provided by Dr. Conroy. This is especially true when the surgical question focuses upon the prevention of injury to the recurrent laryngeal nerves. In keeping with *Hill*, Dr. Souliere and Dr. Chan have “demonstrable familiarity” with both the procedure and medical condition at issue such that the trial court clearly erred in not applying *White, Seybold, Eng* and *Hill*. See *Hill* at 447.

2. Other States Have Adopted the Same Expert Witness Testimonial Standard as *White, Seybold, Eng* and *Hill*.

Other jurisdictions, which have encountered expert testimony issues at summary judgment, have followed the same principles as *White, Seybold, Eng* and *Hill*. In a medical negligence action presenting an identical legal issue as in the present case, the Texas Court of Appeals in *Blan v. Ali*, 7 S.W.3d 741 (Court of Appeals of Texas 1999), held a neurologist is qualified to testify as to the standard of care for treating strokes by cardiologists and emergency room physicians.<sup>4</sup> In *Blan*, the patient, who had a previous history of stroke, suffered a presumed stroke at home and was taken to the emergency room. The patient’s wife telephoned the patient’s cardiologist and related to him the events of that morning. The defendant cardiologist, Dr. Ali, did not come to the

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<sup>4</sup> The summary judgment was affirmed on other grounds that the plaintiff did not adequately establish medical causation from the negligence testimony of Dr. Reisbord.

hospital, but did consult with the hospital emergency room physician. *Blan* at 743. Later that day Mr. Blan suffered another stroke. Allegations of negligence against the cardiologist included, delaying the initiation of the appropriate treatments including steroids and anticoagulation therapy; failing to obtain proper examination of the patient by a neurologist; delaying the patient's admission to the hospital intensive care unit and failing to come to the hospital to personally examine Mr. Blan. *Id* at 743. Allegations of negligence against the emergency room physician, Dr. Bartasis, included delaying treatment including medications, negligently monitoring the patient's condition, and delaying the patient's admission to the hospital from the emergency room. *Id* at 743.

The patient and his family utilized board certified neurologist, Dr. David A. Reisbord. Dr. Reisbord was chief of neurology at three hospitals over the course of his career and signed an affidavit. He included that he had personal knowledge of the appropriate standard of care for the diagnosis, treatment and care of a patient suffering from stroke such as Mr. Blan. *Id* at 743. Dr. Reisbord's affidavit testimony proved that the standard of care at issue applied to any physician, regardless of his/her area of expertise, that undertakes the treatment and care of a patient suffering from a stroke. *Id* at 743. (Emphasis in original) At his deposition, Dr. Reisbord acknowledged that he had no knowledge of the

standard of care for either emergency room physicians or cardiologists. *Id* at 744. Dr. Ali and Dr. Bartasis brought a motion to strike Dr. Reisbord's expert testimony regarding the standard of care for cardiologists and from testifying as an expert in emergency medicine. Summary judgment of dismissal followed. *Id* at 744.

The Texas Court of Appeals reversed the trial court exclusion of Dr. Reisbord's expert opinions. The Court of Appeals recognized expert witness testimony principles recognized in Washington case law, where the expert witness need not be a specialist in the particular branch of the profession for which the testimony is offered, a medical witness who is not of the same school of practice may be qualified to testify if he or she has practical knowledge of what is usually and customarily done by other practitioners under circumstances similar to those as that confronted by the defendant, and, if the subject matter is common to and equally recognized and developed in all fields of practice, any physician familiar with the subject may testify as to the standard of care. *Id* at 745-746.

The test to determine if a particular expert is qualified is rooted in the expert's training, experience, and knowledge of the standards applicable to the "illness injury or condition *involved in the claim*" (Emphasis added.) Here the condition involved in the Blan's claim is a CVA or stroke. In his affidavit, Dr. Reisbord specifically lists his experience and training as a board certified neurologist,

enunciates the standard of care for a patient suffering a stroke... Dr. Reisbord is qualified by training and experience to offer expert testimony regarding the diagnosis, care, and treatment of neurological conditions such as a stroke. The appellees/doctors neither challenged Dr. Reisbord's qualification as a neurologist nor contend that he does not know how to treat strokes; rather they argue that he does not know the standard of care as applied to emergency medicine physicians and cardiologists. Dr. Ali (cardiologist) and Dr. Bartasis (emergency room physician) argue that because Dr. Reisbord (neurologist) admitted in his deposition that he is not familiar with the standard of care of either a *cardiologist* or an *emergency room physician* he cannot possibly be qualified to give expert testimony as to whether they violated the standard of care in the treatment of Blan's stroke. We disagree. The doctors' argument ignores the plain language of the statute and focuses *not* on the defendant doctor's area of expertise, *but on the condition involved in the claim*. (Citations omitted).

*Id* at 746.

In the present case, defendant CSP and Dr. Conroy adopt the same argument asserting that Drs. Souliere and Chan, both otolaryngologists, did not know the standard of care of a general surgeon, notwithstanding, Dr. Souliere's and Dr. Chan's undisputed knowledge and experience in

treating thyroid disease, performing thyroid surgery, and aware of the risks and dangers that a recurrent laryngeal nerve by monopolar electrocautery.<sup>5</sup>

The *Blan* court further explained:

...the appellees/doctors' argument that Dr. Reisbord is unqualified to give an opinion because he does not know the standard of care applicable to cardiologists and emergency room physicians would be persuasive, if not determinative, *if* Dr. Reisbord were purporting to offer expert medical opinions in matters peculiar to the fields of cardiology or emergency medicine. *He is not.* Dr. Reisbord seeks to offer expert testimony about matters clearly within his knowledge. (Italics in original. Emphasis added).

*Id* at 746.

In *Glassman v. Costello*, 267 Kan. 509, 986 P2d 1050 (1999), the Kansas Supreme Court held that the state statute governing expert testimony in a medical negligence action does not require that only a physician practicing in a particular specialized area may qualify as an expert witness as to the standard of care. In this case, Cathy Glassman died as a result of hypoxia brought about by inadequate anesthesia induction and a failure to intubate prior to initiation of a cesarian section. *Id* at 1055. After a settlement with the certified registered nurse

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<sup>5</sup> In a summary judgment order, the trial court recognized the knowledge and expertise of Drs. Souliere and Chan. The court noted, "plaintiff's experts are both well-qualified board certified otolaryngologists who have experience and familiarity with thyroid disease and thyroidectomy." (CP 79)

anesthetist (CRNA), the case proceeded to trial against the obstetrician. The trial court granted the defendant's motion to prohibit plaintiff's expert witnesses, pathologists, from testifying as to the standard of care applicable to obstetrician Dr. Costello. *Id* at 1055. The Kansas Supreme Court reversed finding that one of the pathology experts for plaintiff, Dr. Sperry, had previously served as an intern in a hospital for three years, had delivered over 200 babies as a family physician and had given standard of care opinions as a component of his position as a forensic pathologist and Deputy Chief Medical Examiner for Fulton County in Atlanta, Georgia. *Id* at 1056. The Supreme Court noted that Kansas law "was never intended to require that a medical doctor could only give standard of care opinions when both physicians practice the same medical specialty." *Id* at 1058.

In *Payant v. Imobersteg*, 681 N.Y.S.2d 135, 256 A.D.2d 702 (1998), the Appellate Division reversed a trial court granting of summary judgment brought by the defendant orthopedic surgeon. In *Payant*, one of the plaintiff's expert witnesses, an infectious disease physician, was precluded from providing standard of care testimony based on the fact that he was an infectious disease specialist and not an orthopedist. *Id* at 704. In reversing the trial court, the Appellate Division stated:

With respect to Crane, while the fact that he was not an orthopedic specialist could conceivably affect the weight of his testimony, it did not render it inadmissible as there is no requirement that a medical expert witness be a specialist in the same field as the parties to the lawsuit. (Citations omitted.)

*Id* at 704.

In the present case, the Washington expert witness admissibility requirement is that the expert witness be knowledgeable on the medical condition at issue or procedure is both reasonable and logical and never intended to exclude otherwise qualified witnesses.<sup>6</sup> The standard established in *Blan* that the expert witness have training, experience and knowledge of the standard applicable to the illness, injury or condition involved in the claim is no different than *White, Seybold, Eng* and *Hill*.

Without question, the singular fact of a physician's knowledge of another specialty training must not and cannot be the sole testimonial admissibility criterion when, without question, expert witnesses such as

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<sup>6</sup> Even before *White v. Kent Medical Center, Supra*, this court noted an abandonment of any specific criterion to qualify as an expert witness. In *Breit v. St. Luke's Hospital*, 39 Wn. App. 461, 743 P2d 1254 (1987), it noted:

Thus, whether an expert is licensed to practice medicine is an important, but not dispositive, factor to be considered when the court makes its determination as to whether an expert is qualified. *Harris v. Gross*, 99 Wn. App. 438, 450-451, 663 P2d 113 (1983).

Breit at 465.

Dr. Souliere and Dr. Chan undisputedly are skilled and knowledgeable otolaryngologists who have knowledge of thyroid disease, thyroid surgery, use of monopolar electrocautery and prevention of injury to the recurrent laryngeal nerve.

3. Defendants' Reliance Upon **Miller v. Peterson**, 42 Wn. App. 822, 714 P.2d 695 (1986) is Misplaced and Does Not Support the Exclusion of Plaintiff's Expert Opinions

Defendants CSP and Conroy argued for the first time in their opposition to Leaverton's Motion for Reconsideration that **Miller v. Peterson** 42 Wn. App. 822, 714 P2d 695 (1986), support the exclusion of Dr. Souliere's and Dr. Chan's adverse opinions. Such an argument is erroneous and misconstrues the "schools of medicine" referenced in **Miller**.

In **Miller v. Peterson**, the court allowed an orthopedic surgeon (M.D.) to testify against a doctor of podiatric medicine (D.P.M.), two different schools of medicine. In the present case the testimony establishes that this case does not present two different schools of medicine such as a medical doctor versus a podiatrist. **Miller v. Peterson** recognized three exceptions to the general rule that a practitioner in one school of medicine is not competent to testify as an expert in a malpractice

action against a practitioner of another school of medicine. *Miller* at 831.

The three exceptions are:

- 1) The methods of treatment in the defendant's school and the school of the witness are the same;
- 2) The method of treatment in the defendant's school and the school of the witness should be the same; or
- 3) The testimony of a witness is based on knowledge of the defendant's own school.

*Id.* at 831

*Miller* is inapplicable to the present case. Dr. Conroy, Dr. Souliere and Dr. Chan all are from the same school of medicine, i.e. medical doctors. The present case does not involve differing schools of medicine but rather overlapping medical specialties within the same school of medicine. Without any legal authority, defendants wish this court to expand *Miller v. Peterson* to different specialties within the same school of medicine.

As shown by the qualifications of Dr. Souliere and Dr. Chan, they both have a medical doctor degree (M.D.), training in general surgery followed by a residency in otolaryngology. Thyroid surgery is a recognized component of otolaryngology training and practice. Thyroid surgery is a common medical condition that is surgically treated by both otolaryngologist and general surgeons. Plaintiff respectfully submits that

medical doctors having different specialties does not equate to being from different schools of medicine requiring a *Miller v. Peterson* analysis.

Even if this were to be the case, thyroid surgery is a recognized component of otolaryngology training and practice. Thyroid surgery is a common medical condition and is surgically treated by both otolaryngologists and general surgeons. Clearly, the *White, Seybold, Eng* and *Hill* decisions establish it is the scope of the expert's knowledge, not the professional title that governs admissibility. Where an otolaryngologist and general surgeon both deal with the same medical condition or procedure, i.e. thyroidectomy, each is able to comment on the care for that condition.

Further, the issue of whether plaintiff's experts have familiarity with a subtotal thyroidectomy is a classic "red herring" when otolaryngologists have knowledge and experience in thyroid lobectomy and total thyroidectomy procedures. Dr. Conroy's choice of a subtotal thyroidectomy is not an issue of alleged fault. Rather, it is the utilization of monopolar electrocautery within close proximity (less than .5 centimeters) of the recurrent laryngeal nerve. As explained by Dr. Souliere, this is a basic surgical technique that should be known and practiced by all surgeons, whether they are otolaryngologists, general surgeons or neurosurgeons. (CP 135)

*Arguendo*, if under a *Miller v. Peterson* analysis, it is respectfully submitted that contrary to defendant's position, the testimony of Dr. Souliere and Dr. Chan fall within exception (2) of *Miller v. Peterson*. This is "the method of treatment in the defendant's school and the school of the witness should be the same." It is clearly applicable that Dr. Souliere's testimony that avoiding the monopolar cautery in close proximity to nerves for all types of surgery is a common principle in the training for the schools of medical doctors (M.D.'s) and the avoidance of monopolar electrocautery injury is not specifically confined to the otolaryngology specialty. Therefore, the deposition testimony of Dr. Souliere and Dr. Chan is clearly admissible under *Miller v. Peterson* and subsequent cases such as *Hill*.

Defendants attempt to characterize the otolaryngologist as a separate and distinct school of medicine from that of a general surgeon is unsupportable and in direct conflict with the holdings in *Eng*, *Seybold*, *White*, and *Hill*. The potential for nerve injury by monopolar cautery is present in procedures carried out by multiple specialties including otolaryngology and general surgery. Therefore, the deposition testimony of Dr. Souliere and Dr. Chan is clearly admissible under *Miller v. Peterson*.

V. CONCLUSION

Defendants erroneously ask this court to use any lack of familiarity of a general surgeons training in a subtotal thyroidectomy as a dispositive threshold criterion for admissibility rather than knowledge and experience in thyroid disease, thyroid surgery and the safe use of monopolar cautery. The appropriate legal test is that set forth in *Hill*, which is the scope of the expert's knowledge and his/her familiarity with the medical problem or procedure at issue. *Hill* at 447.

The trial court's dismissal should be reversed and the action remanded to the trial court.

Respectfully submitted,

OTOROWSKI JOHNSTON MORROW & GOLDEN, PLLC

By:   
Thomas R. Golden, WSBA #11040  
Attorney for Appellant Lajuana Leaverton

## APPENDICES

1. Trial Court letter opinion
2. *Blan v. Ali*, 7 S.W.3d 741 (Court of Appeals of Texas, 1999)
3. *Glassman v. Costello*, 264 Kan. 509, 986 P.2d 1050 (1999)
4. *Payant v. Imobersteg*, 681 N.Y.S.2d 135, 256 A.D.2d 702 (1998)

**CERTIFICATE OF SERVICE**

The undersigned certifies under penalty of perjury under the laws of the State of Washington, that she is now, and at all times material hereto, was a citizen of the United States, a resident of the State of Washington, over the age of eighteen years, not a party to, or interested in, the above-entitled action, and competent to be a witness herein. I caused to be served on the 23<sup>rd</sup> day of July, 2010, a copy of the pleading entitled: Brief of Appellant to:

David A. Thorner, Esq.	<input type="checkbox"/> Legal Messenger
Megan Murphy, Esq.	<input type="checkbox"/> Hand Delivered
Thorner, Kennedy & Gano, P.S.	<input type="checkbox"/> Facsimile
101 South Twelfth Avenue	<input checked="" type="checkbox"/> First Class Mail
PO Box 1410	<input type="checkbox"/> UPS, Next Day Air
Yakima, WA 98907-1410	

Signed at Bainbridge Island, Washington this 23<sup>rd</sup> day of July, 2010.

  
Liz Alvarado, Legal Assistant

# Appendix 1



Superior Court of the State of Washington  
for the County of Yakima

Judge C. James Lust  
Department No. 8

128 North 2nd Street  
Yakima, Washington 98901  
(509) 574-2710  
Fax No. (509) 574-2701

December 16, 2009

Megan K. Murphy, Attorney at law  
Thorner, Kennedy and Gano P.S.  
101 South 12<sup>th</sup> Avenue,  
P.O. Box 1410  
Yakima, WA 98907-1410

Thomas R. Golden, Esq.  
Oterowski Johnson Diamond & Golden, PLLC  
298 Winslow Way West  
Bainbridge Island, WA 09110

Re: Leaverton v. Cascade Surgical Partners, PLLC & Robert J. Conroy, M.D.  
Defendant's Motion for Summary Judgment

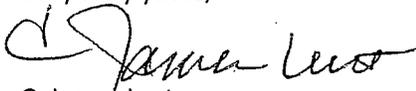
Dear Counsel:

The defendant, Dr. Conroy is a board certified general surgeon. On November 26, 2003 Dr. Conroy performed a subtotal thyroidectomy on Ms. Leaverton, leaving a portion of the thyroid on her left side. After surgery she suffered from stridor, or in common terms a vocal cord paralysis, and alleges this was caused from the surgery performed by Dr. Conway. After-care by other physicians was unable to correct this problem. Dr. Conroy's position is that his surgery did not violate that standard of care for a reasonable and prudent general surgeon practicing in the State of Washington

Plaintiff's experts are both well-qualified board certified otolaryngologists, who have experience and familiarity with thyroid disease and thyroidectomy. They both state candidly in their depositions that they are unable to express an opinion on the standard of care for a general surgeon with regard to the performance of subtotal thyroidectomy.

It is correct, as the cases cited by both counsel confirm, that physicians who testify against the treating physician do not necessarily have to have the same credentials, so long as the credentials they do have allow them to testify as to the treating physician's standard of care. In the cases cited by both parties the expert witnesses were all able to, and did, testify as to the treating physician's standard of care. In this case neither expert is able to do that. Summary judgment in favor of the defendant is therefore granted.

Very truly yours,

  
C. James Lust  
Judge

# Appendix 2

7 S.W.3d 741  
(Cite as: 7 S.W.3d 741)



Court of Appeals of Texas,  
Houston (14th Dist.).  
Cecil Ray **BLAN**, Mary **Blan**, Michael **Blan**, Rich-  
ard **Blan**, and Lori Bender, Appellants,  
v.  
Abdul **ALI**, M.D., and Dennis Lee Bartasis, D.O.,  
Appellees.  
No. 14-98-00581-CV.

Nov. 18, 1999.

Patient and his family filed medical malpractice action against cardiologist and emergency room physician. The 295th District Court, Harris County, Tracy Christopher, J., granted summary judgment in favor of doctors. Patient and family appealed. The Court of Appeals, Frost, J., held that: (1) neurologist was qualified to testify as to standard of care for treating strokes and whether cardiologist and emergency room physician breached that standard of care in their treatment and care of patient who suffered stroke; (2) genuine issue of material fact existed as to whether cardiologist and emergency room physician breached the standard of care applicable to any physician who undertakes to treat and care for a patient suffering from a stroke, precluding summary judgment for doctors on ground that patient failed to establish standard-of-care element of medical malpractice claim; but (3) conclusory statement in neurologist's affidavit that negligence of cardiologist and emergency room physician was proximate cause of patient's injury was insufficient to create genuine issue of fact as to causation.

Affirmed.

West Headnotes

**[1] Appeal and Error 30** **961**

**30** Appeal and Error

**30XVI** Review

**30XVI(H)** Discretion of Lower Court

**30k961** k. Depositions, Affidavits, or Discovery. Most Cited Cases  
Court of Appeals reviews a trial court's decision to

strike an expert's affidavit for an abuse of discretion.

**[2] Health 198H** **611**

**198H** Health

**198HV** Malpractice, Negligence, or Breach of Duty

**198HV(B)** Duties and Liabilities in General

**198Hk611** k. Elements of Malpractice or Negligence in General. Most Cited Cases

(Formerly 299k18.12 Physicians and Surgeons)

In order to prevail on a medical malpractice claim, plaintiffs must establish the following elements of a prima facie case: (1) a duty requiring the defendants to conform to a certain standard of conduct; (2) the applicable standard of care and its breach; (3) resulting injury; and (4) a reasonably close causal connection between the alleged breach of the standard of care and the alleged injury.

**[3] Health 198H** **821(1)**

**198H** Health

**198HV** Malpractice, Negligence, or Breach of Duty

**198HV(G)** Actions and Proceedings

**198Hk815** Evidence

**198Hk821** Necessity of Expert Testimony

**198Hk821(1)** k. In General. Most Cited Cases

(Formerly 299k18.80(6.1) Physicians and Surgeons)

**Judgment 228** **185.3(21)**

**228** Judgment

**228V** On Motion or Summary Proceeding

**228k182** Motion or Other Application

**228k185.3** Evidence and Affidavits in Particular Cases

**228k185.3(21)** k. Torts. Most Cited

Cases

Expert testimony is necessary in a medical malpractice case to meet the plaintiff's burden as well as to establish or preclude summary judgment.

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**[4] Health 198H** ⚡️618

198H Health

198HV Malpractice, Negligence, or Breach of Duty

198HV(B) Duties and Liabilities in General

198Hk617 Standard of Care

198Hk618 k. In General. Most Cited

Cases

(Formerly 299k14(1) Physicians and Surgeons)

The threshold issue in a medical malpractice case is the standard of care.

**[5] Evidence 157** ⚡️538

157 Evidence

157XII Opinion Evidence

157XII(C) Competency of Experts

157k538 k. Due Care and Proper Conduct in General. Most Cited Cases

A non-physician witness cannot testify as to a physician's standard of care in a medical malpractice case.

**[6] Evidence 157** ⚡️538

157 Evidence

157XII Opinion Evidence

157XII(C) Competency of Experts

157k538 k. Due Care and Proper Conduct in General. Most Cited Cases

The physician serving as the expert witness in a medical malpractice case need not be a specialist in the particular branch of the profession for which testimony is offered; the statute setting out the requisite qualifications focuses not on the defendant doctor's area of expertise, but on the condition involved in the claim. Vernon's Ann.Texas Civ.St. art. 4590i, § 14.01(a).

**[7] Evidence 157** ⚡️538

157 Evidence

157XII Opinion Evidence

157XII(C) Competency of Experts

157k538 k. Due Care and Proper Conduct in General. Most Cited Cases

Because the determination of an expert's qualifications is based on knowledge, training, or experience, it is incumbent upon the plaintiff in a medical malpractice case to present expert testimony of a medical

doctor with knowledge of the specific issue which would qualify him or her to give an opinion on that subject. Vernon's Ann.Texas Civ.St. art. 4590i, § 14.01(a); Rules of Evid., Rule 702.

**[8] Evidence 157** ⚡️538

157 Evidence

157XII Opinion Evidence

157XII(C) Competency of Experts

157k538 k. Due Care and Proper Conduct in General. Most Cited Cases

Neurologist was qualified to testify in medical malpractice case as to the standard of care for treatment of strokes and whether cardiologist and emergency room physician breached that standard of care in their treatment and care of patient suffering from stroke, even though neurologist admitted that he could not give an opinion as to a cardiologist breaching the standard of care in cardiology and that he did not know the standard of care for physicians practicing emergency medicine, where neurologist had the requisite knowledge, training and experience on the subject of strokes. Vernon's Ann.Texas Civ.St. art. 4590i, § 14.01(a); Rules of Evid., Rule 702.

**[9] Judgment 228** ⚡️181(33)

228 Judgment

228V On Motion or Summary Proceeding

228k181 Grounds for Summary Judgment

228k181(15) Particular Cases

228k181(33) k. Tort Cases in General.

Most Cited Cases

Genuine issue of material fact existed as to whether doctors who treated patient suffering from stroke breached the standard of care applicable to any physician who undertakes to treat and care for a patient suffering from stroke, precluding summary judgment for doctors on ground that patient failed to establish standard-of-care element of medical malpractice claim. Vernon's Ann.Texas Rules Civ.Proc., Rule 166a.

**[10] Judgment 228** ⚡️185(5)

228 Judgment

228V On Motion or Summary Proceeding

228k182 Motion or Other Application

228k185 Evidence in General

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228k185(5) k. Weight and Sufficiency.

Most Cited Cases

Conclusory statements by an expert are not sufficient to support or defeat summary judgment; rather, the expert must explain the basis of his statement to link his conclusions to the facts.

**[11] Judgment 228**  **185.1(4)**

228 Judgment

228V On Motion or Summary Proceeding

228k182 Motion or Other Application

228k185.1 Affidavits, Form, Requisites and Execution of

228k185.1(4) k. Matters of Fact or Conclusions. Most Cited Cases

Conclusory statement in medical expert's affidavit that doctors' negligence was proximate cause of patient's injury was insufficient to create genuine issue of material fact as to causation, as required to preclude summary judgment on patient's medical malpractice claim. Vernon's Ann.Texas Rules Civ.Proc., Rule 166a.

**[12] Health 198H**  **820**

198H Health

198HV Malpractice, Negligence, or Breach of Duty

198HV(G) Actions and Proceedings

198Hk815 Evidence

198Hk820 k. Admissibility. Most Cited Cases

(Formerly 299k18.70 Physicians and Surgeons) Nonexpert testimony by patient's wife that patient was tapering off his medication on advice of his physician was purely factual information to refute the notion that patient stopped taking his medication on his own, and thus was admissible in medical malpractice action.

**[13] Health 198H**  **821(3)**

198H Health

198HV Malpractice, Negligence, or Breach of Duty

198HV(G) Actions and Proceedings

198Hk815 Evidence

198Hk821 Necessity of Expert Testimony

198Hk821(3) k. Proximate Cause.

Most Cited Cases

(Formerly 299k18.80(7) Physicians and Surgeons) In a medical negligence action, proximate cause is an element that ordinarily must be proven by expert testimony.

**[14] Appeal and Error 30**  **523.2**

30 Appeal and Error

30X Record

30X(B) Scope and Contents

30k521 Evidence

30k523.2 k. Affidavits. Most Cited Cases

Summary judgment affidavit containing allegedly hearsay statements were part of the record on appeal, where party opposing affidavit failed to obtain a ruling on its objections in the court below. Rules App.Proc., Rule 33.1(a).

**[15] Judgment 228**  **185.3(21)**

228 Judgment

228V On Motion or Summary Proceeding

228k182 Motion or Other Application

228k185.3 Evidence and Affidavits in Particular Cases

228k185.3(21) k. Torts. Most Cited Cases

Affidavit by patient's wife that patient was tapering off his medication on advice of his physician was insufficient to create genuine issue of material fact as to causation, as required to preclude summary judgment on patient's medical malpractice claim against other doctors who treated him following a stroke, even if it refuted doctors' claim that patient caused his own injuries by taking himself off his medication. Vernon's Ann.Texas Rules Civ.Proc., Rule 166a. \*743 Howard L. Glass, Houston, for appellants.

Joseph R. Alexander, Jr., Richard F. Callaway, Jr., Houston, for appellees.

Panel consists of Chief Justice MURPHY and Justices EDELMAN and FROST.

**OPINION**

KEM THOMPSON FROST, Justice.

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This is an appeal of a medical malpractice case granting summary judgment in favor of the appellees, Abdul Ali, M.D., and Dennis Lee Bartasis, D.O. In two points of error, the appellants, Cecil Ray Blan, Mary Blan, Michael Blan, Richard Blan, and Lori Bender (collectively, the “Blans”) contend the trial court erred in (1) striking their expert's affidavit and (2) granting summary judgment based on their inability to establish the breach of the standard of care and proximate cause elements of their negligence claim. We affirm.

### FACTUAL BACKGROUND

In the early morning hours of July 18, 1994, Cecil **Blan's** family found him slumped over in the shower of his home and rushed him to the emergency room of Memorial City Hospital. **Blan**, who was fifty-four years old at the time, had a history of systematic lupus erythematosus and a past cerebral vascular accident (“CVA”), commonly known as a stroke. **Blan's** wife immediately telephoned Dr. **Ali**, a cardiologist whom **Blan** had seen only a few days before during a routine office visit, and told him of the morning's events. Dr. **Ali** did not come to the hospital at that time but consulted by telephone with Dr. Bartasis, the hospital's emergency room physician. Dr. **Ali** instructed Dr. Bartasis to call a neurologist. After administering a series of tests, the hospital staff admitted **Blan** to the hospital under the care of Dr. **Ali**. That afternoon **Blan** suffered another stroke.

The **Blans** filed suit against both Dr. **Ali** and Dr. Bartasis. The **Blans** alleged that Dr. **Ali** (cardiologist) was negligent in (1) failing to properly investigate and monitor **Blan's** medical history and condition on initial evaluation; (2) failing to come to the hospital to personally examine **Blan**; (3) delaying the initiation of appropriate treatment, including steroids and/or anticoagulation therapy; (4) failing to obtain prompt examination of **Blan** by a neurologist; and (5) delaying **Blan's** admission to the hospital's Intensive Care Unit (“ICU”). They allege that Dr. Bartasis (emergency room physician) was negligent in (1) delaying treatment, including medications; (2) negligently monitoring **Blan's** condition; and (3) delaying **Blan's** admission to the hospital.

To support their medical malpractice claim, the **Blans** relied on David A. Reisbord, M.D., a neurolo-

gist in private practice. Dr. Reisbord has been a medical doctor for more than thirty-five years and board-certified in neurology by the American Academy of Psychiatry and Neurology for more than twenty years. He has served as Chief of the Neurology sections of at least three hospitals over the course of his career. Testifying by affidavit, Dr. Reisbord set forth in detail his medical credentials and professional experience and stated that he had personal knowledge of the appropriate standard of care for the diagnosis, treatment, and care of a patient suffering from a stroke by which the acts or omissions of practicing physicians, such as Dr. Ali and Dr. Bartasis, are measured. According to Dr. Reisbord, the standard of care he describes in his affidavit applies to “*any physician*, regardless of his/her area of expertise, that undertakes to treat and care for a patient *suffering from a stroke* along with the neurological complications of lupus cerebriids.”<sup>FNI</sup> In his affidavit, Dr. Reisbord states that his opinions are based on his experience, expertise, and training as well as his knowledge of the care and treatment of **Blan**.

<sup>FNI</sup>. Emphasis added.

In his oral deposition taken as part of pretrial discovery in the case, Dr. Reisbord \*744 (neurologist) acknowledged that he has no knowledge of the standard of care for either emergency medicine physicians or cardiologists. Relying on these general admissions, Dr. Ali (cardiologist) and Dr. Bartasis (emergency room physician) successfully moved the trial court to strike Dr. Reisbord as an expert on the grounds that he failed to meet the statutory requirements under section 14.01(a) of the Medical Liability Insurance and Improvement Act. In granting the doctors' motions to strike Dr. Reisbord's expert testimony, the trial court signed two orders. In the first order, entered in connection with the granting of Dr. Ali's motion, the court struck Dr. Reisbord's testimony “as to the standard of care for a cardiologist.” In the second order, entered in connection with the court's granting of Dr. Bartasis' motion, the court disqualified Dr. Reisbord “from testifying as an expert in emergency medicine at the time of trial” and “from giving expert testimony regarding the standard of care and appropriateness of treatment of [Blan] as to [Bartasis].” Shortly after entering these orders, the trial court found that the **Blans**, who were left without vital expert testimony as to the applicable standard of care, had no proof of the doctors' negligence. The trial

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court signed two separate orders granting summary judgment for Dr. Ali and Dr. Bartasis.

### ***STRIKING OF THE BLANS' EXPERT AFFIDAVIT***

[1] In their first issue presented for review, the Blans challenge the trial court's striking of Dr. Reisbord as an expert on the standard of care. The Blans argue that the trial court erred in precluding Dr. Reisbord, a board certified neurologist, from testifying to the doctors' treatment of Blan's stroke, an inherently neurological condition. We review the trial court's decision to strike an expert's affidavit for an abuse of discretion. See Gammill v. Jack Williams Chevrolet, Inc., 972 S.W.2d 713, 718 (Tex.1998). We will find an abuse of discretion only if the trial court acted without reference to any guiding rules and principles. See Goode v. Shoukfeh, 943 S.W.2d 441, 446 (Tex.1997).

#### ***Requirements for Prima Facie Case of Medical Malpractice***

[2] At the outset, we note that in order to prevail on a medical malpractice claim, the Blans, as plaintiffs, must establish the following elements of a *prima facie* case: (1) a duty requiring the defendants (Dr. Ali and Dr. Bartasis) to conform to a certain standard of conduct; (2) the applicable standard of care and its breach; (3) resulting injury; and (4) a reasonably close causal connection between the alleged breach of the standard of care and the alleged injury. See Martin v. Durden, 965 S.W.2d 562, 564 (Tex.App.-Houston [14<sup>th</sup> Dist.] 1997, pet. denied). In the court below, the appellees/doctors, in separately filed motions, each sought to negate the elements of breach of standard of care and proximate cause.

#### ***Requirements for Expert Testimony***

[3] Expert testimony is necessary in a medical malpractice case to meet the plaintiff's burden as well as to establish or preclude summary judgment. See LeNotre v. Cohen, 979 S.W.2d 723, 727-28 (Tex.App.-Houston [14<sup>th</sup> Dist.] 1998, no pet.); Durden, 965 S.W.2d at 564. In determining the qualifications of experts in a medical malpractice case, we look to Texas Rule of Evidence 702 and the Medical Liability and Insurance Improvement Act (the "Medical Liability Act") as well as interpretive case

law. Together, these sources provide the guiding rules and principles against which we evaluate the trial court's decision to strike the Blans' medical expert.

Rule 702 allows a witness "qualified as an expert by knowledge, skill, experience, training, or education" to offer his opinion if it will assist the trier of fact. TEX.R. EVID. 702. Section 14.01(a) of the Medical Liability Act, which specifies the qualifications for a witness in a medical malpractice case, states:

\*745 (a) a person may qualify as an expert witness on the issue of whether the physician departed from accepted standards of medical care *only* if the person is a physician who:

- (1) is practicing medicine at the time such testimony is given or was practicing medicine at the time the claim arose;
- (2) has knowledge of accepted standards of medical care for *the diagnosis, care, or treatment of the illness, injury, or condition involved in the claim*; and
- (3) is qualified on the basis of training or experience to offer an expert opinion regarding those accepted standards of medical care.

TEX.REV.CIV. STAT. ANN. art. 4590i, § 14.01(a) (Vernon's Pamph.1999) (emphasis added).

[4][5][6][7] The threshold issue in a medical malpractice case is the standard of care. See Durden, 965 S.W.2d at 565. A non-physician witness cannot testify as to a physician's standard of care. See Ponder v. Texarkana Mem'l Hosp., 840 S.W.2d 476, 478 (Tex.App.-Houston [14<sup>th</sup> Dist.] 1991, writ denied). The physician serving as the expert witness, however, need *not* be a specialist in the particular branch of the profession for which the testimony is offered. See Hernandez v. Altenberg, 904 S.W.2d 734, 738 (Tex.App.-San Antonio 1995, writ denied); Simpson v. Glenn, 537 S.W.2d 114, 116 (Tex.Civ.App.-Amarillo 1976, writ ref'd n.r.e.). For example, an orthopedic surgeon can testify as to the standard of care for a radiologist because the two professions work closely together, and their specialties are intertwined. See Silvas v. Ghiatas, 954 S.W.2d 50, 54

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(Tex.App.-San Antonio 1997, writ denied). Likewise, a general surgeon is qualified to testify regarding the standard of care for post-operative procedures performed by a gynecologist because post-operative procedures are common to both fields. See Simpson, 537 S.W.2d at 116-18. On the other hand, a pediatrician who admits that he knows little about gynecological matters may not testify in a medical malpractice case against an obstetrician/gynecologist as to matters involving post-surgical pain in a patient's pubic area. See Roberson v. Factor, 583 S.W.2d 818, 821 (Tex.Civ.App.-Dallas 1979, writ ref'd n.r.e.). Because the determination of an expert's qualifications under both Rule 702 and section 14.01(a) is based on knowledge, training, or experience, it is incumbent upon the plaintiff in a medical malpractice case to present expert testimony of a medical doctor with knowledge of the specific issue which would qualify him or her to give an opinion on that subject. See Broders v. Heise, 924 S.W.2d 148, 152 (Tex.1996) (upholding the exclusion of testimony from a doctor not qualified by knowledge or experience to give an expert opinion on the specific practices alleged to be negligent).

While this court has required the medical expert to be of "the same school of practice" as the defendant-physician,<sup>FN2</sup> we also have held that a medical witness who is not of the same school of practice may be qualified to testify if he or she has practical knowledge of what is usually and customarily done by other practitioners under circumstances similar to those that confronted the defendant charged with malpractice. See Marling v. Maillard, 826 S.W.2d 735, 740 (Tex.App.-Houston [14<sup>th</sup> Dist.] 1992, no writ) (citing Bilderback v. Priestley, 709 S.W.2d 736, 740 (Tex.App.-San Antonio 1986, writ ref'd n.r.e.)). The Texas Supreme Court has made it clear that if a subject of inquiry is substantially developed in more than one field, a qualified expert in *any* of those fields may testify. See Broders, 924 S.W.2d at 152. Likewise, this court has held that if the subject matter is common to and equally recognized and developed in all fields of practice, any physician familiar with the subject may testify as to the standard of \*746 care. See Garza v. Keillor, 623 S.W.2d 669, 671 (Tex.Civ.App.-Houston [14<sup>th</sup> Dist.] 1981, writ ref'd n.r.e.) (infection process); Hersh, 626 S.W.2d at 154 (taking a medical history, discharging a patient); Sears v. Cooper, 574 S.W.2d 612, 615 (Tex.Civ.App.-Houston [14<sup>th</sup> Dist.] 1978, writ ref'd n.r.e.) (use of a diuretic).

FN2. See Bradley v. Rogers, 879 S.W.2d 947, 953 (Tex.App.-Houston [14<sup>th</sup> Dist.] 1994, writ denied); see also Hersh v. Hendley, 626 S.W.2d 151, 154 (Tex.App.-Fort Worth 1981, no writ).

[8] The test to determine if a particular expert is qualified is rooted in the expert's training, experience and knowledge of the standards applicable to the "illness, injury, or condition involved in the claim." See TEX.REV.CIV. STAT. ANN. art. 4590i, § 14.01(a) (emphasis added). Here, the condition involved in the Blans' claim is a CVA or stroke. In his affidavit, Dr. Reisbord specifically lists his experience and training as a board certified neurologist and enunciates the standard of care for a patient suffering a stroke in accordance with the requirements of section 14.01(a) and Rule 702. See Marling, 826 S.W.2d at 739. As a board certified neurologist, Dr. Reisbord is qualified by training and experience to offer expert testimony regarding the diagnosis, care, and treatment of a neurological condition, such as a stroke. The appellees/doctors neither challenge Dr. Reisbord's qualifications as a neurologist nor contend that he does not know how to treat strokes; rather, they argue that he does not know the standard of care as applied to emergency medicine physicians and cardiologists. Dr. Ali (cardiologist) and Dr. Bartasis (emergency room physician) argue that because Dr. Reisbord (neurologist) admitted in his deposition that he is not familiar with the standard of care of either a *cardiologist* or an *emergency room physician*, he cannot possibly be qualified to give expert testimony as to whether they violated the standard of care in the treatment of Blan's stroke. We disagree. The doctors' argument ignores the plain language of the statute, which focuses *not* on the defendant doctor's area of expertise, *but on the condition involved in the claim*. See TEX.REV.CIV. STAT. ANN. art. 4590i, § 14.01(a).

Despite the fact that we live in a world of niche medical practices and multilayer specializations, there are certain standards of medical care that apply to multiple schools of practice and any medical doctor. To categorically disqualify a physician from testifying as to the standard of care solely because he is from a different school of practice than the doctors charged with malpractice ignores the criteria set out in section 14.01(a) of the Medical Liability Act and

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Rule 702. The appellees/doctors' argument that Dr. Reisbord is unqualified to give an opinion because he does not know the standard of care applicable to cardiologists and emergency room physicians would be persuasive, if not determinative, *if* Dr. Reisbord were purporting to offer expert medical opinions in matters peculiar to the fields of cardiology or emergency medicine. *He is not*. Dr. Reisbord seeks to offer expert testimony about matters clearly within his knowledge. His affidavit states that the standard of care he describes applies to *any* physician treating a patient suffering from a stroke and lupus, regardless of the physician's area of expertise.<sup>FN3</sup> Dr. Reisbord is not precluded from giving an opinion that two doctors breached the standard of care in an area in which he has knowledge, skill, \*747 training and experience, and where the subject of the claim (strokes) falls squarely within his medical expertise, merely because he acknowledged that he "could not give an opinion as to a cardiologist breaching the standard of care in *cardiology*"<sup>FN4</sup> or that he does not know the standard of care for physicians practicing emergency medicine. Given his testimony that the standard he describes applies to any physician who undertakes to treat and care for a patient suffering from stroke, Dr. Reisbord is qualified to testify as to the appellees/doctors' treatment of Blan's stroke.

<sup>FN3</sup> Drs. Ali and Bartasis contend that the trial court could not consider Dr. Reisbord's supplemental affidavit, in which he states that the standard of care applies to any physician treating a stroke victim. While we agree that *Farroux v. Denny's Restaurants, Inc.*, 962 S.W.2d 108, 111 (Tex.App.-Houston [1<sup>st</sup> Dist.] 1997, no pet.), precludes the trial court from considering an affidavit that contradicts deposition testimony without an explanation for the change in testimony, the supplemental affidavit does *not* contradict Dr. Reisbord's deposition testimony. To the contrary, the supplemental affidavit states that the standard enunciated in Dr. Reisbord's original affidavit was applicable to *all* physicians, including Dr. Reisbord. Although Dr. Reisbord stated at his deposition that he was not familiar with the standard of care specifically applicable to emergency medical physicians and cardiologists, it is not necessary that he be able to enunciate a standard of care applicable to a specialty other than his own.

<sup>FN4</sup> Emphasis added.

[9] Because the record demonstrates that Dr. Reisbord has the requisite knowledge regarding the subject of inquiry (strokes) and is qualified based on his training or experience to offer his opinions on that subject, we find the trial court abused its discretion in excluding Dr. Reisbord's proof against Dr. Ali as to the standard of care for a cardiologist to the extent that standard encompasses matters common to all physicians. Likewise, it was an abuse of discretion for the trial court to exclude Dr. Reisbord's proof against Dr. Bartasis as to the standard of care developed in neurology and common to all physicians. Having found that Dr. Reisbord was qualified to testify as to the standard of care at issue in this case, we find that the **Blans** raised genuine issues of material fact as to the standard of care and that the trial court erred in granting summary judgment based on the **Blans'** inability to establish that element of a *prima facie* case.

#### **GRANTING OF SUMMARY JUDGMENT FOR THE APPELLEES/DOCTORS**

In their second issue for review, the **Blans** contend the trial court erred in granting summary judgment in favor of the doctors on the element of proximate cause. In seeking to demonstrate proof of proximate cause, the **Blans** offered Dr. Reisbord's affidavit, in which he stated that the negligence of the appellees/doctors proximately caused **Blan's** injuries. In addition, the **Blans** point out that Mary **Blan** (**Blan's** wife) presented a fact issue regarding the appellees/doctors' claims that **Blan** contributed to his stroke by failing to take medication that would have prevented it.

#### **Standards of Review on Appeal**

Dr. **Ali** filed a traditional motion for summary judgment. See TEX.R. CIV. P. 166a. A summary judgment is appropriate when the movant establishes there is no genuine issue of material fact as to one or more essential elements of each of the non-movant's claims. See *Science Spectrum, Inc. v. Martinez*, 941 S.W.2d 910, 911 (Tex.1997). In reviewing a summary judgment, we accept as true all proof favorable to the non-movants (the **Blans**) and indulge in every reasonable inference in their favor. See *id.*

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Dr. Bartasis filed a “no evidence” motion for summary judgment. See TEX.R. CIV. P. 166a(i). In considering a “no evidence” summary judgment, we review the proof in the light most favorable to the non-movants and disregard all contrary proof and inferences. See Lampasas v. Spring Center, Inc., 988 S.W.2d 428, 432 (Tex.App.-Houston [14<sup>th</sup> Dist.] 1999, no pet.). We sustain a “no evidence” summary judgment if: (a) there is a complete absence of proof of a vital fact; (b) the court is barred by rules of law or evidence from giving weight to the only proof offered to prove a vital fact; (c) the proof offered to prove a vital fact is no more than a mere scintilla; or (d) the proof conclusively establishes the opposite of the vital fact. See *id.* If the non-movants' proof rises to a level that would enable reasonable and fair minded people to differ in their conclusions, then they have presented more than a scintilla. See *id.* at 432-33. If, on the other hand, the proof is so weak as to do no more than create mere surmise or suspicion of a fact, then it is less than a scintilla. See *id.* at 432. Where, as here, the trial court granted the motions for summary judgment \*748 without stating the grounds on which it relied, we must affirm the summary judgment if *any* ground argued in the motions was sufficient. See Star-Telegram, Inc. v. Doe, 915 S.W.2d 471, 473 (Tex.1995).

### *The Appellees/Doctors as the Proximate Cause of Injury*

In addition to moving for summary judgment on the issue of standard of care, the appellees/doctors also argued an absence of proof of proximate cause. Dr. Ali asserted that, by providing his own affidavit testimony as to the standard of care at issue in this case and affirmatively stating that he had not breached it, he effectively negated proximate cause. In support of his contention that there was no proof of proximate cause, Dr. Bartasis argued his expert, Dr. Arlo Weltge, established with his affidavit that Dr. Bartasis did not cause Blan's injuries.

The Blans relied in part on Dr. Reisbord's affidavit to respond to the proximate cause challenges; therefore, we must decide whether his affidavit was sufficient to raise a fact issue on this element. With regard to causation, Dr. Reisbord's affidavit states:

By their negligent acts and omissions, Drs. Ali and

Bartasis allowed Mr. **Blan's** condition to deteriorate. Prompt recognition and treatment of Mr. **Blan's** condition would have led to appropriate treatment of his condition, and more likely than not have led to an improved outcome for Mr. **Blan**.

\* \* \* \*

It is further my opinion that Drs. **Ali** and Bartasis' negligence was a proximate cause of Mr. **Blan's** injuries.

[10] Conclusory statements by an expert are not sufficient to support *or defeat* summary judgment. See Wadewitz v. Montgomery, 951 S.W.2d 464, 466 (Tex.1997). Rather, the expert must explain the basis of his statement to link his conclusions to the facts. See Earle v. Ratliff, 998 S.W.2d 882, 890 (Tex.1999) (holding that the medical expert's affidavit was insufficient for failing to explain *why* implantation of additional devices was medically warranted in light of the patient's history).

[11] In this case, Dr. Reisbord's affidavit does not: (1) identify what aspect of Blan's condition deteriorated as a result of the alleged negligent acts; (2) explain how or why the alleged negligent acts caused Blan's condition to deteriorate in that manner; (3) identify what better outcome could have been produced by different actions; or (4) explain how or why a different treatment could have produced such an improved outcome. Therefore, the affidavit is conclusory and insufficient to create a fact issue on the element of causation.

[12][13][14][15] The Blans also assert that Mary Blan's affidavit raised a triable issue of fact concerning proximate cause. In their motions for summary judgment, both doctors offered proof that Blan caused his own injuries by taking himself off medications. In response, the Blans offered the affidavit of Mary Blan, <sup>FNS</sup> which stated that Blan had tapered off his medication under the advice of his physician. <sup>FNG</sup> A plaintiff claiming medical negligence against a defendant doctor must prove the doctor's negligence, if any, caused his injuries. See \*749 Martin v. Durden, 965 S.W.2d 562, 564 (Tex.App.-Houston [14<sup>th</sup> Dist.] 1997, pet. denied). Even assuming Mary **Blan's** affidavit conclusively established that **Blan** did not cause his own injuries, it is no proof that alleged negligence of Drs. **Ali** and Bartasis was the

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proximate cause of **Blan's** injuries. **Blan's** fault is therefore irrelevant. See Barefield v. City of Houston, 846 S.W.2d 399, 404 (Tex.App.-Houston [14<sup>th</sup> Dist.] 1992, writ denied) (noting that the plaintiff's negligence is irrelevant when the defendants conclusively negated the duty element).

FN5. In a medical negligence action, proximate cause is an element that ordinarily must be proven by expert testimony. See Lopez v. Carrillo, 940 S.W.2d 232, 236 (Tex.App.-San Antonio 1997, pet. denied). Although Mary Blan is not an expert, we may consider the purely factual information she provided to refute the notion that Cecil Blan stopped taking his medication on his own. There is no reason to require an expert's testimony to state these facts.

FN6. Although the appellees/doctors argue on appeal that the affidavit of Mary Blan contained hearsay statements, they failed to obtain a ruling on these objections in the court below and, therefore, they are part of the record before us on appeal. See TEX.R.APP. P. 33.1(a); Wal-Mart Stores, Inc. v. McKenzie, 997 S.W.2d 278, 280 (Tex.1999).

Because the Blans offered no evidence of the element of proximate cause in response to Dr. Ali's traditional summary judgment motion and Dr. Bartasis's "no evidence" summary judgment motion, Drs. Ali and Bartasis were entitled to judgment as a matter of law on the issue of proximate cause. We overrule the Blans' second appellate issue and affirm the judgment of the trial court.

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# Appendix 3



## Supreme Court of Kansas.

Jerome Alan GLASSMAN, as Administrator of the Estate of Cathleen Lyn Glassman, Deceased, and Jerome Alan Glassman, Individually, for and on behalf of Jerome Alan Glassman, Surviving Spouse of Cathleen Lyn Glassman, and Shaylyn Janae Glassman, a Minor, and Surviving Child of Cathleen Lyn Glassman, Appellants/Cross-Appellees,

v.

J. William COSTELLO, M.D., Appellee/Cross-Appellant.  
 No. 78,905.

July 9, 1999.

Administrator of estate of mother who suffered anesthesia-related death during cesarian delivery of child brought medical malpractice action against obstetrician and certified registered nurse anesthetist (CRNA). After CRNA entered pretrial settlement, jury trial was held, and the Ellis District Court, Edward E. Bouker, J., entered judgment on jury verdict which found CRNA 99% at fault and obstetrician 1% at fault. Appeals were taken, and the Supreme Court, Larson, J., held that: (1) statute governing expert testimony in medical malpractice actions does not require that only a physician practicing in a particular specialized area may qualify as an expert witness as to standard of care applicable to physician practicing in the same specialized area; (2) exclusion of testimony of two pathologists called by administrator as experts was reversible error; (3) nature and extent of obstetrician's duty to direct and supervise CRNA was factual issue for jury; (4) jury instructions were proper; and (5) obstetrician's expert was properly precluded from testifying regarding changes in rules and regulations governing CRNAs.

Reversed and remanded for new trial.

Six, J., concurred.

West Headnotes

**[1] Evidence 157** **512**157 Evidence157XII Opinion Evidence157XII(B) Subjects of Expert Testimony157k512 k. Due Care and Proper Conductin General. Most Cited Cases

Admissibility of testimony of an expert witness in a medical malpractice action is primarily governed by statute which specifically addresses that subject, although general statute relating to expert testimony is collaterally involved. K.S.A. 60-3412; Rules of Evid., K.S.A. 60-456.

**[2] Statutes 361** **176**361 Statutes361VI Construction and Operation361VI(A) General Rules of Construction361k176 k. Judicial Authority and Duty.Most Cited Cases

Interpretation of a statute is a question of law.

**[3] Appeal and Error 30** **842(1)**30 Appeal and Error30XVI Review30XVI(A) Scope, Standards, and Extent, inGeneral30k838 Questions Considered30k842 Review Dependent on WhetherQuestions Are of Law or of Fact30k842(1) k. In General. Most CitedCases

Appellate court's review of questions of law is unlimited.

**[4] Statutes 361** **181(1)**361 Statutes361VI Construction and Operation361VI(A) General Rules of Construction361k180 Intention of Legislature361k181 In General361k181(1) k. In General. MostCited Cases

Fundamental rule of statutory construction, to which all other rules are subordinate, is that the intent of the legislature governs if that intent can be ascertained.

**[5] Evidence 157 ↪ 538**

157 Evidence

157XII Opinion Evidence

157XII(C) Competency of Experts

157k538 k. Due Care and Proper Conduct in General. Most Cited Cases

Statute governing use of testimony of expert witnesses in medical malpractice actions prevents the use of “professional witnesses” in such cases, but was not intended to require that only a physician practicing in a particular specialized area could qualify as an expert witness as to the standard of care of a physician practicing in the same specialized area. K.S.A. 60-3412.

**[6] Appeal and Error 30 ↪ 1056.1(11)**

30 Appeal and Error

30XVI Review

30XVI(J) Harmless Error

30XVI(J)11 Exclusion of Evidence

30k1056 Prejudicial Effect

30k1056.1 In General

30k1056.1(11) k. Particular

Types of Evidence. Most Cited Cases  
(Formerly 30k1056.1(3))

**Evidence 157 ↪ 512**

157 Evidence

157XII Opinion Evidence

157XII(B) Subjects of Expert Testimony

157k512 k. Due Care and Proper Conduct in General. Most Cited Cases

Trial court committed reversible error by refusing to allow qualified pathologists to offer expert testimony regarding applicable standard of care of obstetrician in medical malpractice action arising from anesthesia-related death of a mother during course of cesarean delivery of a healthy child. K.S.A. 60-3412.

**[7] Evidence 157 ↪ 538**

157 Evidence

157XII Opinion Evidence

157XII(C) Competency of Experts

157k538 k. Due Care and Proper Conduct in General. Most Cited Cases

Requirement under statute governing admissibility of expert witness testimony in medical malpractice actions that witness must have spent at least 50% of his practice time during previous two-year period in actual clinical practice in same profession as defendant physician seeks to prohibit testimony of professional witnesses, and was never intended to require that a physician may only give standard of care opinions when both he and defendant physician practice the same medical speciality. K.S.A. 60-3412.

**[8] Appeal and Error 30 ↪ 843(1)**

30 Appeal and Error

30XVI Review

30XVI(A) Scope, Standards, and Extent, in General

30k838 Questions Considered

30k843 Matters Not Necessary to Decision on Review

30k843(1) k. In General. Most Cited

Cases

When a new trial has been ordered, Supreme Court will hesitate to consider issues unless doing so is likely to assist the trial court and the parties.

**[9] Appeal and Error 30 ↪ 842(4)**

30 Appeal and Error

30XVI Review

30XVI(A) Scope, Standards, and Extent, in General

30k838 Questions Considered

30k842 Review Dependent on Whether Questions Are of Law or of Fact

30k842(4) k. Questions as to Negligence. Most Cited Cases

Existence of a legal duty is a question of law over which appellate court exercises unlimited review.

**[10] Health 198H ↪ 707**

198H Health

198HV Malpractice, Negligence, or Breach of Duty

198HV(C) Particular Procedures

198Hk707 k. Anesthesiology. Most Cited Cases

(Formerly 299k15(21) Physicians and Surgeons) Statute requires registered nurse anesthetist to per-

form his or her duties and functions in an interdependent role as a member of a physician-directed health care team. K.S.A. 65-1158(b).

**[11] Health 198H ☞786**

198H Health

198HV Malpractice, Negligence, or Breach of Duty

198HV(F) Persons Liable

198Hk786 k. Multiple Professionals or Health Care Workers in General. Most Cited Cases  
(Formerly 299k16 Physicians and Surgeons)

Under "captain of the ship theory," where recognized, a physician may be liable solely by reason of his or her relationship to those he or she has a duty or right to control, rather than by reason of any negligence attributable to him or her personally.

**[12] Health 198H ☞780**

198H Health

198HV Malpractice, Negligence, or Breach of Duty

198HV(F) Persons Liable

198Hk780 k. In General. Most Cited Cases  
(Formerly 299k16 Physicians and Surgeons)

Statute governing health care provider insurance abrogates vicarious liability for health care provider who has duty or right to control second health care provider, where both health care providers are covered by Health Care Stabilization Fund. K.S.A. 40-3401(f), 40-3403(h).

**[13] Health 198H ☞825**

198H Health

198HV Malpractice, Negligence, or Breach of Duty

198HV(G) Actions and Proceedings

198Hk824 Questions of Law or Fact and Directed Verdicts

198Hk825 k. In General. Most Cited Cases

(Formerly 299k18.90 Physicians and Surgeons)  
Nature and extent of obstetrician's duty to direct and supervise certified registered nurse anesthetist (CRNA) during cesarian delivery, under circumstances and in light of the individual technical duties of the different health care providers, was a factual

issue for jury to consider in deciding if obstetrician negligently breached his duty, for purposes of medical malpractice action brought following mother's anesthesia-related death during course of cesarian delivery. K.S.A. 65-1158.

**[14] Health 198H ☞825**

198H Health

198HV Malpractice, Negligence, or Breach of Duty

198HV(G) Actions and Proceedings

198Hk824 Questions of Law or Fact and Directed Verdicts

198Hk825 k. In General. Most Cited Cases

(Formerly 299k18.90 Physicians and Surgeons)

In medical malpractice action against obstetrician arising from course of treatment in which anesthesia was administered by a certified registered nurse anesthetist (CRNA), trial court may allow nature and extent of obstetrician's duty of direction to be a factual issue as part of the jury's determination whether the obstetrician negligently breached his or her duty. K.S.A. 65-1158.

**[15] Health 198H ☞786**

198H Health

198HV Malpractice, Negligence, or Breach of Duty

198HV(F) Persons Liable

198Hk786 k. Multiple Professionals or Health Care Workers in General. Most Cited Cases

(Formerly 299k16 Physicians and Surgeons)

Obstetrician was not vicariously liable for actions of certified registered nurse anesthetist (CRNA) during cesarian delivery of child, for purposes of medical malpractice action brought following anesthesia-related death of mother during delivery; however, statute eliminating vicarious liability did not bar any potential liability on part of obstetrician. K.S.A. 40-3403(h).

**[16] Trial 388 ☞295(1)**

388 Trial

388VII Instructions to Jury

388VII(G) Construction and Operation

388k295 Construction and Effect of Charge

as a Whole

388k295(1) k. In General. Most Cited

Cases

Instructions in any given case are to be considered together as a whole, and where they fairly instruct the jury on the law governing a case, and are substantially correct, such that the jury could not reasonably have been misled by them, instructions will be approved on appeal.

**[17] Health 198H ↪827**

198H Health

198HV Malpractice, Negligence, or Breach of Duty

198HV(G) Actions and Proceedings

198Hk827 k. Instructions. Most Cited

Cases

(Formerly 299k18.100 Physicians and Surgeons)

Instruction stating that a health care provider has no responsibility for any injury or death arising out of rendering or failure to render services by any other health care provider was not warranted in medical malpractice brought against obstetrician after mother sustained anesthesia-related death during cesarian delivery, in connection with which certified registered nurse anesthetist (CRNA) entered pretrial settlement; vicarious liability was not an issue in case, and jury's finding of 99% fault on part of anesthesiologist and 1% on part of obstetrician indicated that it understood issue it was required to resolve.

**[18] Evidence 157 ↪546**

157 Evidence

157XII Opinion Evidence

157XII(C) Competency of Experts

157k546 k. Determination of Question of

Competency. Most Cited Cases

Qualifications of an expert witness and the admissibility of expert testimony are matters entrusted to the broad discretion of the trial court.

**[19] Trial 388 ↪136(1)**

388 Trial

388VI Taking Case or Question from Jury

388VI(A) Questions of Law or of Fact in General

388k136 Questions of Law or Fact in Gen-

eral

388k136(1) k. In General. Most Cited

Cases

Where trial is by jury, it is the sole province of the court to decide questions of law, as distinguished from questions of fact.

**[20] Evidence 157 ↪506**

157 Evidence

157XII Opinion Evidence

157XII(B) Subjects of Expert Testimony

157k506 k. Matters Directly in Issue. Most Cited Cases

Expert witness for obstetrician against whom medical malpractice action had been brought arising from anesthesia-related death of mother during cesarian delivery of child was properly precluded from testifying regarding changes in administrative rules and regulations governing certified registered nurse anesthetists (CRNAs), where witness was allowed to testify regarding interdependent role of physician and CRNA, that rule regarding physician supervision had changed, and that CRNA received all the direction he was entitled to receive. Kan.Admin. Reg. 28-34-17a, 28-34-17b.

**\*\*1053 \*509 Syllabus by the Court**

1. The admissibility of the testimony of an expert witness in a medical malpractice action is primarily governed by K.S.A. 60-3412, although the general statute relating to expert testimony, K.S.A. 60-456, is collaterally involved.

2. Interpretation of a statute is a question of law. An appellate court's review of questions of law is unlimited.

3. K.S.A. 60-3412 prevents the use of "professional witnesses" in medical malpractice actions. The statute was not intended to require that only a physician practicing in a particular specialized area could qualify as an expert witness as to the standard of care of a physician practicing in the same specialized area.

4. The legislative history shows K.S.A. 60-3412 was never intended to require that a medical doctor in a medical malpractice action could only give standard of care opinions where both the testifying physician

and the defendant physician practiced the same medical specialty.

5. Under the facts of this case, it was reversible error for the trial court to refuse to allow two qualified pathologists to testify as to their opinion of the standard of care of an obstetrician in a medical malpractice action.

6. Under the provisions of K.S.A. 65-1158(b), a registered nurse anesthetist shall perform duties and functions in an interdependent role as a member of a physician or dentist directed health care team.

7. Under the provisions of the Health Care Provider Insurance Availability Act, K.S.A. 40-3401 \*510 et seq., a health care provider who is qualified for coverage under the Health Care Stabilization Fund shall have no vicarious liability or responsibility for any injury or death arising out of the rendering of or the failure to render professional services inside or outside this state by any other health care provider who is also qualified for coverage under the Fund. The provisions of this subsection shall apply to all claims filed on or after July 1, 1986. K.S.A. 40-3403(h).

8. In a medical malpractice action against an obstetrician, where anesthesia had been administered by a nurse anesthetist, the trial court may allow the nature and extent of an obstetrician's duty of direction under K.S.A. 65-1158 to be a factual issue as part of the jury's determination whether the obstetrician negligently breached his or her duty.

9. Under the facts of this case, while an obstetrician is not vicariously liable for the actions of a nurse anesthetist where both are covered by the Health Care Stabilization Fund, the obstetrician's contention of no possible liability as the result of the provisions of K.S.A. 40-3403(h) was properly rejected by the trial court.

10. Under the facts of this case, the instructions considered together as a whole fairly instructed the jury on the law governing the case and were substantially correct such that the jury could not reasonably have been misled by them.

11. Based on our rule that the qualifications of expert witnesses and the admission of expert testimony are

matters entrusted to the broad discretion of the trial court, an expert witness under the facts of this case was properly excluded from testifying about specifics of legislative and regulatory changes and not unduly restricted in his testimony.

Fred E. Stoops, Sr., of Stoops & Clancy, P.C., of Tulsa, Oklahoma, argued the cause, and Thomas C. Boone, of Hays, was with him on the briefs for appellants/cross-appellees.

Michael R. O'Neal, of Gilliland & Hayes, P.A., of Hutchinson, argued the cause, and Tara L. Bragg, of the same firm, was with him on the briefs for appellee/cross-appellant.

**\*511 LARSON, J.:**

This appeal arises from an anesthesia-related death of a mother during the course of a cesarean section delivery of a healthy child. The mother's survivors sued the anesthetist and the obstetrician. After a settlement was reached with the anesthetist, the claim against the obstetrician was tried to a jury. The jury found the anesthetist 99% at fault \*\*1054 and the obstetrician 1% at fault, and awarded damages of \$2,007,385.47.

The mother's survivors appeal, contending the trial court erred in refusing to allow testimony as to the standard of medical care by two pathologists. The obstetrician cross-appeals, raising issues of the instructions given as to the duties of surgeons, the questioning of expert witnesses, and the damage award.

*Facts:*

The sad facts of this case reveal the death of Cathleen (Cathy) Glassman on September 11, 1994, during the course of a cesarean section delivery of a healthy baby girl (Shaylyn Glassman).

Cathy had experienced an uneventful pregnancy when labor commenced on September 10, 1994, and she was taken to Hays Medical Center about 8 p.m. Her obstetrician, Dr. Doss, and his backup, Dr. Bauer, were both unavailable, and she was assigned to the obstetrician on call, Dr. J. William Costello.

Dr. Costello checked on Cathy until around 2 a.m., when he determined the labor had not progressed

satisfactorily and it was necessary to prepare Cathy for surgery so he could perform a cesarean delivery.

Dr. Costello ordered anesthesia services and Certified Registered Nurse Anesthetist (CRNA) Greg Mahoney was assigned to administer the anesthesia to Cathy. Mahoney discussed the options available with Cathy and her husband, Jerome Glassman. Dr. Costello was not a part of this discussion. A spinal rather than a general anesthetic was chosen and administered by Mahoney.

As the surgery began, the testimony of what happened became inconsistent. Dr. Costello claimed he only nicked the skin with the first incision. Jerome testified the first incision was 4 to 6 inches in length and Cathy said: "I can feel that, you'll have to stop, its not \*512 deadened." Jerome stated a mask was placed over Cathy's face, CRNA Mahoney said "go ahead," and Dr. Costello deepened the original incision. At this point, Jerome was excluded from the operating room.

There was also testimony that Dr. Costello immediately discontinued the surgery. Because the spinal was "spotty," Mahoney determined that additional anesthesia was necessary. A general anesthesia was chosen. Mahoney placed an oxygen mask over Cathy's mouth for 3 to 4 minutes in order to increase the oxygen (oxygenation) to her lungs. Oxygenation raises the content of oxygen in the blood and increases the patient's safety during surgery. Mahoney then administered Curare (a muscle relaxant), Sodium Pentothal (sleeping agent and respiration depressant which makes it impossible for the patient to breath on her own), and Anectine (paralyzes the muscles completely).

According to Dr. Costello, he continued with the surgery and performed a second incision only after Mahoney had administered the general anesthesia and after he asked of Mahoney, "May I start?" and Mahoney told him to proceed. Mahoney said Dr. Costello asked him if the oxygen tube was in place. Mahoney responded, "I said no, it's not. You can go ahead and take the baby." Dr. Costello then continued the surgery.

With the help of nurse Barb King, Mahoney attempted to intubate (place a tube down the trachea) in order to supply Cathy with oxygen during the proce-

dure. A pulse oximeter measuring the oxygen content was attached. The oximeter tones continuously. The tone changes as the level of oxygen in the patient increases or decreases. Mahoney placed the tube. Dr. Costello made a third incision into the abdomen to remove the infant and encountered dark, red blood (an indicator that the patient is not receiving an adequate supply of oxygen). Dr. Costello testified he was unaware the patient had not been properly intubated until he encountered dark, red blood in the patient's abdomen. Furthermore, at that time the tone from the oximeter indicated a sharp decrease in Cathy's oxygen level.

According to nurse King, Mahoney pulled the tube, masked the patient in order to supply her with oxygen, and placed a second \*513 tube. Nurse King was reading the oximeter and testified that Cathy's oxygen level rose and fell several more times. Mahoney testified he tried to maintain Cathy's airway with a bag (squeezing the bag forcing air into her \*\*1055 lungs) and an oxygen mask until the baby was delivered at 5:37 a.m.

After the baby was delivered, there were continued efforts to oxygenate Cathy. Mahoney administered additional Anectine and attempted another intubation. Mahoney had difficulty because he encountered airway resistance. Additional assistance from other hospital staff was provided in an attempt to resuscitate Cathy. Their efforts failed and Cathy died due to hypoxia brought about by inadequate anesthetic induction and a failure to intubate prior to initiation of the cesarean section.

This medical malpractice action for the wrongful death of Cathy was brought by Jerome Glassman and on behalf of Shaylyn against Mahoney, Dr. Costello, and others. After settlement or dismissal of all parties except Dr. Costello, the case preceded to a jury trial against him only. The Glassmans contended Dr. Costello was guilty of negligence in (1) failing to direct and monitor nurse Mahoney in the administration of anesthesia, (2) beginning surgery after the failure of a spinal anesthesia administered under his direction, (3) ignoring the oral representation of Mahoney that Cathy was not intubated, and (4) continuing with surgery when he knew, or should have known, that Cathy was inappropriately intubated.

Prior to trial, Dr. Costello moved in limine to prohibit

Drs. Noordhoek and Sperry, both pathologists, from testifying as to the standard of care applicable to him, an obstetrician. This motion argued that K.S.A. 60-3412, as interpreted by our court in *Tompkins v. Bise*, 259 Kan. 39, 910 P.2d 185 (1996), disqualified the pathologists because they did not practice in a field similar or related to that of Dr. Costello. Dr. Costello contended our holding in *Wisker v. Hart*, 244 Kan. 36, 766 P.2d 168 (1988), that a physician is allowed to testify about issues outside his or her area of specialization with such testimony subject to cross-examination and arguments as to weight and credibility was limited by the language of *Tompkins*.

\*514 The Glassmans argued that both pathologists fully complied with the requirements of K.S.A. 60-3412 in that 50% of their professional time within the 2-year period preceding the incident was devoted to actual clinical practice of the same medical profession in which Dr. Costello is licensed. Both were licensed to practice medicine in Kansas by the Board of Healing Arts, as was Dr. Costello. Their involvement in the case was in their official capacities as Deputy District Coroners under K.S.A. 22a-226(a). The Glassmans stated both doctors had sufficient experience and expertise to render an opinion as to the standard of care of Dr. Costello and the jury was entitled to hear those opinions. They further contended *Tompkins* did not limit the holding of *Wisker*, but rather expanded it to allow a dentist who performed the same procedures and had comparable training as the medical doctor who performed oral and maxillofacial surgery to testify as an expert witness notwithstanding the difference in their profession and the fact they were licensed by different boards.

The trial court granted the motion to prohibit Drs. Sperry and Noordhoek from testifying as to the standard of care applicable to Dr. Costello. The written decision referred to K.S.A. 60-3412, and recognized that in *Wisker*, it was held to be error to prohibit a medical doctor surgeon from testifying as to the standard of care applicable to a medical doctor general practitioner and vice-versa. The trial court did not read *Tompkins* to expand the *Wisker* test as the Glassmans argued but rather focused on whether the witness was engaged in a “similar or related area of practice” as that of the defendant.

The trial court admitted the legislative history of

K.S.A. 60-3412 referred to in *Tompkins* revealed that a provision requiring the witness to practice the same specialty as the defendant had been rejected in the final version of the statute. However, the trial court looked to specific *Tompkins* wording and reasoned:

“It is convincing to note two of the emphasized portions of the quotations above, which are clear and unequivocal: ‘The definition of “profession” must be related to whether the expert is qualified to perform the procedure at issue and is not limited to the particular licensure of the defendant or the expert’ 259 Kan. at 49, 910 P.2d 185, and ‘The statute requires that an expert \*\*1056 witness in a medical malpractice action \*515 be engaged in a similar or related area of practice as the defendant health care provider’ 259 Kan. at 50, 910 P.2d 185. This plain language is entirely contrary to the position advocated by the plaintiffs.”

The trial court further supported its decision that *Tompkins* restricted the holding of *Wisker*, by pointing to the wording of Justice Six’s dissent in *Tompkins*, which stated: “By adopting the ‘performing a similar medical procedure test’ the majority has rewritten K.S.A. 60-3412.” 259 Kan. at 50, 910 P.2d 185.

Finally, the trial court ruled “before Dr. Sperry and Dr. Noordhoek are allowed to testify concerning the standard of care applicable to Dr. Costello in this case, it must be shown that they have spent at least 50 percent of their professional time in the last two years in a ‘similar or related’ field as that in which Dr. Costello practiced.”

The Glassmans moved at trial to reconsider the earlier ruling on the motion in limine. They argued (1) both physicians clearly spend more than 50% of their time in clinical practice, (2) forensic pathology is related to surgery, (3) the pathologist’s opinions were formed as a part of their official duties as District Deputy Coroners, and (4) an anesthesiologist expert of Dr. Costello was expected to give standard of care testimony as to Dr. Costello and this had been mentioned in Dr. Costello’s opening statement.

After a full and complete argument, the trial court reaffirmed its previous decision that Drs. Sperry and Noordhoek would not be allowed to offer a standard of care opinion as to the actions of Dr. Costello.

The Glassmans then presented proffers. Dr. Noordhoek would say there was a major miscommunication or noncommunication between Dr. Costello and Mahoney. He would opine Dr. Costello had the duty to know what was going on with the patient before he proceeded with the surgery, and his failure to do so was a deviation from the standard of care of a surgeon.

In the proffer of Dr. Sperry, it was revealed he had written and lectured extensively on the standard of care of physicians, he had lectured on and had a special interest in maternal deaths and specifically the anesthesia and surgical procedures relating thereto, he had probably done more autopsies in this area than 98% of pathologists, \*516 and he was a licensed Kansas doctor who had given opinions in Kansas as a forensic pathologist 10 or 12 times. It was his opinion that Dr. Costello's actions in this case fell below the standard of care by failing to ensure that Cathy was adequately anesthetized and being ventilated and oxygenated to the extent necessary before initiating the surgical procedure.

In addition to the proffer there was evidence in the record that Dr. Sperry had served as an intern in a hospital for 3 years, had delivered over 200 babies as a family doctor, and giving standard of care opinions was a part and parcel of his job as a forensic pathologist as Deputy Chief Medical Examiner for Fulton County in Atlanta, Georgia. In this case he had been employed as a consultant to Dr. Noordhoek. His hiring was authorized by K.S.A. 22a-233, and his report was contended to be admissible as competent evidence under the wording of K.S.A. 22a-235.

It was also shown that Dr. Noordhoek is a pathologist and coroner licensed to practice medicine and surgery in Kansas. He investigated the death of Cathy in his official capacity as Deputy District Coroner.

After a week-long trial, the jury apportioned 1% of the fault to Dr. Costello and assessed the remaining 99% of the fault against Nurse Mahoney. The \$2,007,385.47 damage award was the entire amount requested by the Glassmans. The Glassmans appeal. Dr. Costello cross-appeals.

#### GLASSMANS' ISSUE ON APPEAL

*Did the trial court err in refusing to allow Drs. Noordhoek and Sperry, both pathologists, to testify as to the standard of care of Dr. Costello, an obstetrician, in performing a surgical procedure?*

[1] The admissibility of the testimony of an expert witness in a medical malpractice action is primarily governed by K.S.A. 60-3412, although the general statute relating to \*\*1057 expert testimony, K.S.A. 60-456, is collaterally involved.

[2][3][4] Dr. Costello suggests an abuse of discretion standard of review, relying on *Sterba v. Jay*, 249 Kan. 270, 283, 816 P.2d 379 (1991). The Glassmans argue that interpretation of K.S.A. 60-3412 involves \*517 an issue of law with unlimited appellate review. We held in *Tompkins*:

“Interpretation of a statute is a question of law. An appellate court's review of questions of law is unlimited. *State v. Donlay*, 253 Kan. 132, Syl. ¶ 1, 853 P.2d 680 (1993).... It is a fundamental rule of statutory construction, to which all other rules are subordinate, that the intent of the legislature governs if that intent can be ascertained. *City of Wichita v. 200 South Broadway*, 253 Kan. 434, 436, 855 P.2d 956 (1993).” 259 Kan. at 43, 910 P.2d 185.

The result we reach in this case is based on our interpretation of K.S.A. 60-3412 and the application of the two Kansas cases we have referred to previously, *Wisker* and *Tompkins*.

K.S.A. 60-3412 provides:

“In any medical malpractice liability action, as defined in K.S.A. 60-3401 and amendments thereto, in which the standard of care given by a practitioner of the healing arts is at issue, no person shall qualify as an expert witness on such issue unless at least 50% of such person's professional time within the two-year period preceding the incident giving rise to the action is devoted to actual clinical practice in the same profession in which the defendant is licensed.”

[5] *Wisker* is directly on point with our facts and held:

“K.S.A.1987 Supp. 60-3412 prevents the use of ‘professional witnesses’ in medical malpractice actions, all as is more fully discussed in the opinion. The statute was not intended to require that only a physician practicing in a particular specialized area could qualify as an expert witness as to the standard of care of a physician practicing in the same specialized area.” 244 Kan. 36, Syl. ¶ 3, 766 P.2d 168.

The trial court in *Wisker* construed K.S.A.1987 Supp. 60-3412 as precluding a surgeon from testifying as to the standard of care applicable to a general practitioner and a general practitioner from testifying as the standard of care applicable to a surgeon. The plaintiff there, as the plaintiffs do here, contended this was an erroneous construction of 60-3412. We unanimously agreed. In reaching the decision set forth above in Syllabus ¶ 3, we pointed out the intent of 60-3412 was to require that a practitioner of the healing arts must spend 50% or more of his or her time in clinical practice (a requirement met by both Drs. Noordhoek and Sperry) to keep from being considered a “professional witness.” Critical to the issue we face here, we said:

**\*518** “The statute was not intended to require that only a surgeon could testify as to the standard of care of another surgeon, etc. The weight afforded the testimony of physicians testifying outside their area of professional specialization is a matter to be determined by the jury.” 244 Kan. at 44, 766 P.2d 168.

[6] We did not reverse the trial court in *Wisker*, despite an erroneous instruction, because we found the testimony to be cumulative to properly admitted evidence as to the standard of care of both the general practitioners and the surgeon. It should be clear from what we have previously said herein that unless the clear holding of *Wisker* has been materially narrowed by our later decision of *Tompkins*, reversal of the trial court is required and a new trial must be ordered with instructions to allow both pathologists to give their opinions as to the standard of care of Dr. Costello.

The precise issue in *Tompkins* was whether it was erroneous for the trial court to allow a licensed dentist with an additional 3 years of training in oral and maxillofacial surgery to testify as an expert witness in a trial where the defendant was a medical doctor

with specialized training in oral and maxillofacial surgery. The trial court reasoned that since both parties were qualified to perform the same procedure, the dentist was qualified as an expert witness.

**\*\*1058** The Court of Appeals in *Tompkins v. Bise*, 20 Kan.App.2d 837, 893 P.2d 262 (1995), focused on the wording in K.S.A. 60-3412 relating to the 50% of clinical practice required to be in the same “profession” and held in a 2 to 1 decision that since the dentist and the medical doctor were licensed by separate boards they did not fall under the same “profession.” Therefore, the opinion should not have been allowed. The dissent reasoned this construction of the word “profession” was entirely too limited because the dentist spent more than 50% of his actual clinical practice performing the identical surgery that the defendant doctor had performed in the case in issue. 20 Kan.App.2d at 843-44, 893 P.2d 262 (Gernon, J., dissenting).

We granted a petition for review, reversed the Court of Appeals, and affirmed the trial court's admission of the dentist testimony. In doing so, we first held the wording concerning the witness being in the same “profession” should not be limited as to licensure and was related to whether the expert is qualified to perform the procedure at issue. While there is wording in the *Tompkins* opinion **\*519** that speaks of the witness being engaged in a similar or related area of practice or performing the procedure at issue, it must be read to explain our approval of testimony by a dentist against a medical doctor because he was qualified based on the circumstances stated. It was never intended to limit admissibility of opinions by experts who are within the same profession or who hold the same basic licensure.

The result of our opinion in *Tompkins* is an expansion, not a limitation, of the individuals who qualify as medical experts. When we refused to construe the “same profession” wording literally, we tied the admissibility of the opinion of the witness outside the defendant's profession to the requirement of expertise in a similar or related area of practice or the witness' qualifications to perform the procedure at issue.

The language of *Tompkins* that the trial court relied on here was necessary to justify the result reached in that case because of the licensure difference. But, it is not to be applied to restrict testimony of experts hold-

ing the same licenses. Nor does it limit or alter our holding in *Wisker* that one medical doctor may testify as to the standard of care applicable to another, irrespective of the area of specialization of either.

[7] We noted in *Tompkins* that “the language requiring that the witness practice the same specialty as the defendant was not included in the final version of the statute.” 259 Kan. at 49, 910 P.2d 185. The result the trial court reached here directly contradicts the teaching of this statement and what our legislative history shows was the intent of K.S.A. 60-3412. The 50% of clinical practice requirement was intended to prohibit the testimony of “professional witnesses.” But, the legislative history shows K.S.A. 60-3412 was never intended to require that a medical doctor could only give standard of care opinions where both physicians practiced the same medical specialty.

The trial court committed reversible error in its ruling on the motion in limine and on its reconsideration at trial. The Glassmans were deprived of compelling testimony by Kansas licensed physicians that went to the heart of their case. The trial court is reversed and a new trial is ordered.

#### \*520 DR. COSTELLO'S ISSUES ON CROSS-APPEAL

Dr. Costello contends the trial court erred in (1) imposing a duty on him to direct the administration of anesthesia by a nurse anesthetist based on the provisions of a nursing statute and in refusing Dr. Costello's requested instruction on vicarious liability, (2) allowing one of the Glassmans' expert medical witnesses to give allegedly new opinions at trial that were not previously disclosed, (3) limiting the testimony of defense expert Steve Preston regarding the changes in the CRNA rules and regulations, and (4) allowing an award of pecuniary damages contrary to the evidence.

In light of our decision to reverse and remand for a new trial, we will not reach or discuss cross-appeal issue (2) because the medical expert's allegedly new opinions should pose no surprise during the retrial \*\*1059 and discovery can be supplemented if such is required.

Nor do we consider cross-appeal issue (4) because the amount of damages to be awarded, if any, will be

subject to consideration by a new jury, with new evidence presented. The admissibility and sufficiency of the evidence will remain within the control of the trial court.

[8] When a new trial has been ordered, we hesitate to consider issues unless our doing so is likely to assist the trial court and the parties. We also recognize that testimony may vary and the chemistry in the courtroom may be altered, rendering our statements of limited value. With this disclaimer in mind we do, however, believe that cross-appeal issues (1) and (3) are likely to be crucial questions on retrial.

*Did the trial court err in imposing a duty on Dr. Costello to direct the administration of anesthesia by CRNA Mahoney based on the provisions of a nursing statute, and if such duty exists, should his requested instruction on vicarious liability have been given?*

Dr. Costello's first issue in reality encompasses two contentions: First, he argues the trial court erred in concluding an obstetrician performing surgery which requires anesthesia has any duty to direct the administration of anesthesia by a nurse anesthetist. Second, he argues that if such a duty exists, the trial court should have \*521 given his requested instruction on the absence of vicarious liability under K.S.A. 40-3403(h).

We first consider the existence of a duty to direct as it relates to the Glassmans' claim of negligence against Dr. Costello.

[9] The existence of a legal duty, *McGee v. Chalfant*, 248 Kan. 434, Syl. ¶ 3, 806 P.2d 980 (1991), and the interpretation of a statute, *Tompkins v. Bise*, 259 Kan. at 43, 910 P.2d 185, are both questions of law over which this court exercises unlimited review.

This case was submitted to the jury on four claims of asserted liability, all as stated in jury instruction No. 2. That instruction, in applicable part, states:

“Plaintiff's contend that the defendant, J. William Costello, M.D., is guilty of the following specific acts of negligence, which plaintiffs contend constituted malpractice:

“a. In failing to direct and monitor nurse Ma-

honey in the administration of the anesthesia; and

“b. In beginning surgery after the failure of a spinal anesthesia administered under his direction; and

“c. In ignoring the oral representation of Greg Mahoney, CRNA, that decedent was not intubated; and

“d. In continuing with surgery when he knew, or should have known, that Cathleen Lyn Glassman was inappropriately intubated.”

The Glassmans' contentions that Dr. Costello owed a duty which he violated center on K.S.A. 65-1158 as it read at the time applicable to this case. The terms of that statute were given to the jury by the trial court as instruction No. 10. That instruction reads:

“(a) Each registered nurse anesthetist shall:

(1) Conduct a pre- and post-anesthesia visit and assessment with appropriate documentation;

(2) develop an anesthesia care plan with the physician or dentist which includes procedures for administration of medications and anesthetic agents;

(3) induce and maintain anesthesia at the required levels;

(4) support life functions during the perioperative period;

(5) recognize and take appropriate action with respect to patient responses during anesthesia;

(6) provide professional observation and management of the patient's emergence from anesthesia;

(7) participate in the life support of the patient;

\*522 (8) participate in periodic and joint evaluation of services rendered, including, but not limited to, chart reviews, case reviews, patient evaluation, and outcome of cases statistics; and

\*\*1060 (9) participate in the joint reviews and revision of adopted protocols or guidelines.

“(b) A registered nurse anesthetist shall perform duties and functions in an interdependent role as a member of a physician or dentist directed health care team.”

[10] Critical to the Glassmans' claims is the wording in subparagraph (b) that the duties and functions of a registered nurse anesthetist are to be performed “in an interdependent role as a member of a physician ... *directed* health care team.” (Emphasis added.)

Dr. Costello's argument that he had no responsibility for the acts of CRNA Mahoney are based on the change in the wording of an administrative regulation and on the 1986 enactment of the Health Care Provider Insurance Availability Act, K.S.A. 40-3401 *et seq.*

K.S.A. 40-3403 pertains to the Health Care Stabilization Fund established for the purpose of paying damages for personal injury or death arising from the negligent rendering or failure to render professional services by health care providers. K.S.A. 40-3403(h) provides:

“A health care provider who is qualified for coverage under the fund shall have no vicarious liability or responsibility for any injury or death arising out of the rendering of or the failure to render professional services inside or outside this state by any other health care provider who is also qualified for coverage under the fund. The provisions of this subsection shall apply to all claims filed on or after [July 1, 1986].”

An administrative regulation, 1992 K.A.R. 28-34-17, entitled “Surgery department,” stated in subsection (p) that in hospitals providing surgical care, “[a]ll anesthetics shall be given by a physician, or shall be given under the supervision of a physician.” But, this regulation was revoked effective June 28, 1993. It was replaced by two separate regulations, K.A.R. 28-34-17a (Anesthesia services) and K.A.R. 28-34-17b (Surgical services), neither of which includes any provision stating that anesthetics shall be given by a physician or under a physician's supervision. K.A.R. 28-34-17a(d)(1) instead states: “The governing body shall determine the extent of anesthesia services and

shall define the degree of collaboration required \*523 for the administration of anesthesia. Certified registered nurse anesthetists shall work in an interdependent role with other practitioners.”

[11] Historically, our case law provided that a physician may be vicariously liable for the negligence of other members of the health care team under the so-called “captain of the ship” theory. Under this theory, a physician may be liable solely by reason of his or her relationship to those he or she has a duty or right to control, rather than by reason of any negligence attributable to him or her personally. See *Leiker v. Gafford*, 245 Kan. 325, 355-58, 778 P.2d 823 (1989); *McCullough v. Bethany Med. Center*, 235 Kan. 732, 737-38, 683 P.2d 1258 (1984); *Voss v. Bridwell*, 188 Kan. 643, 364 P.2d 955 (1961).

[12] The adoption of K.S.A. 40-3403(h) abrogates vicarious liability where both health care providers, as defined by K.S.A. 40-3401(f), are covered by the Health Care Stabilization Fund, as was the case here. However, the liability the Glassmans claim is not Dr. Costello's vicarious liability but rather the liability for his individual acts and actions.

In the absence of vicarious liability, Dr. Costello consistently contended in the trial court that he had *no* duty to control, monitor, or supervise CRNA Mahoney or the administration of anesthesia. He stated this in his answer to the petition and later submitted a brief on this issue to the trial court. Dr. Costello argued below, as he does now, that although he would have had such a duty under 1992 K.A.R. 28-34-17, he had no such duty after its 1993 repeal and could not have otherwise been liable under the “captain of the ship” theory after the enactment of K.S.A. 40-3403(h). He claims the repeal of the regulation is evidence that physicians were intended to be relieved of the duty to supervise the administration of anesthesia.

The Glassmans concede Dr. Costello cannot be held vicariously liable for the negligent\*\*1061 acts or omissions of CRNA Mahoney. But, the Glassmans argue Dr. Costello had the duty to direct the CRNA, he was obligated to communicate properly with the CRNA, and his obligations were recognized in K.S.A. 65-1158. They also contend that even though K.A.R. 28-34-17(p) was repealed, the duty \*524 is implicit when the surgeon in charge of the health care

team is conducting the procedure.

The trial court resolved the issue in a pretrial memorandum decision. The trial court noted that all were in agreement that Dr. Costello could not be held vicariously liable for the acts or omissions of another professional covered by the Fund. It concluded, however, that Dr. Costello could be liable for his own negligent acts or omissions. The trial court believed that K.S.A. 65-1158(b) makes clear that the physician is the one in charge of directing the health care team performing the surgery or procedure, and that, accordingly, Dr. Costello had “some duty” of direction and that it was for the jury to decide whether he negligently breached that duty.

During trial, the trial court expressed the opinion that it was for the jury to decide exactly what degree or quality of direction was required under the circumstances and in light of the respective professions and individual technical duties of the different health care providers. The trial court allowed the parties to argue and introduce evidence to the jury regarding the meaning of “direct” and the extent of this duty of direction.

Both parties make essentially the same arguments on appeal as they did to the trial court.

In *Bair v. Peck*, 248 Kan. 824, 811 P.2d 1176 (1991), we held K.S.A.1990 Supp. 40-3403(h) was constitutional and that the curtailment of vicarious liability affected a “remedy by due course of law” that was allowed by Sections 1, 5, and 18 of the Bill of Rights of the Kansas Constitution, 248 Kan. at 838, 848, 811 P.2d 855. In discussing the legislation giving rise to the issue before the court, we said:

“The Health Care Provider Insurance Availability Act was a comprehensive compulsory insurance plan mandating minimum amounts of malpractice insurance as a condition of providing health care in Kansas. The purposes and details of the Act have been discussed and reviewed in numerous cases and we need not repeat that history here. See *Kansas Malpractice Victims Coalition v. Bell*, 243 Kan. 333, 757 P.2d 251 (1988); *State ex rel. Schneider v. Liggett*, 223 Kan. 610, 576 P.2d 221 (1978). The Act, as originally adopted, consisted of nineteen sections (K.S.A.1976 Supp. 40-3401 through 40-3419; L.1976, ch. 231), practically all

of which have been amended one or more times or repealed, and four new sections have been added (K.S.A. 40-3420 through 40-3423). Some of the changes in the \*525 original Act have been beneficial to malpractice claimants while others have benefitted medical care providers and/or the Fund.” 248 Kan. at 839, 811 P.2d 1176.

The interrelation of K.S.A. 40-3403(h) with claimed hospital liability as limited by K.S.A. 65-442(b) was the subject of McVay v. Rich, 255 Kan. 371, 874 P.2d 641 (1994), but McVay is so factually different from our facts that it is of no assistance here.

Dr. Costello cites our decision of Oberzan v. Smith, 254 Kan. 846, 869 P.2d 682 (1994), as a case showing that in construing K.S.A. 40-3403(h), we declined to allow a plaintiff to apply the “captain of the ship” doctrine to impose vicarious liability on a physician for the acts of an x-ray technician. This reliance is misplaced.

In Oberzan, Davis, an ex-ray technician employed by a hospital, perforated Oberzan's rectum while preparing her for a barium enema. Dr. Smith, a radiologist, was not in the room when the perforation occurred.

We affirmed summary judgment on Dr. Smith's behalf, stating respondeat superior is not applicable to the radiologist because the technician was neither the radiologist's employee nor under his personal control and supervision at the time of the injury, and K.A.R. 28-34-12(c) does not create a legal duty for a designated medical staff physician to personally supervise all activities that occur in a radiology department of a hospital.

**\*\*1062** We first point out that the incident at issue in Oberzan occurred in February 1988, before K.A.R. 28-34-17(p) had been amended. In addition, it did not take place in an operating room. Finally, and most importantly, issue two of the appeal, which was stated as follows:

“[B]ased on K.S.A. 40-3403(h), Smith could not be held vicariously liable for the negligent acts of the x-ray technician (40-3403[h] is a statute abrogating vicarious liability between two health care providers [K.S.A. 40-3401(f)] who are both qualified for coverage under the Health Care Stabilization Fund”

was not addressed by our opinion. We said: “The health care provider liability abrogation issue need not be reached because Oberzan's contention under issue two relies on Davis being a joint \*526 agent of the hospital and of Smith. Oberzan's reliance is misplaced.” 254 Kan. at 847, 869 P.2d 682.

As much as we would wish to utilize Oberzan in assisting us to answer the question posed here, Oberzan is completely different factually, it does not involve an operating room situation, it occurred at a time when the applicable administrative regulations differed, and the issue critical to us in this case was not addressed.

[13][14] Based on the clear statement of K.S.A. 65-1158, that when anesthesia is being administered by a nurse anesthetist, we are dealing with a “physician ... directed health care team,” we hold the trial court properly allowed the nature and extent of Dr. Costello's duty of direction, under the circumstances and in light of the individual technical duties of the different health care providers, to be a factual issue for the jury to consider in deciding if he negligently breached his duty.

[15] In addition, we hold the trial court correctly ruled that while Dr. Costello is not vicariously liable for the actions of CRNA Mahoney, his argument of no possible liability as the result of K.S.A. 40-3403(h) was properly rejected.

Dr. Costello next argues that because he cannot be vicariously liable for the acts or omissions of CRNA Mahoney under K.S.A. 40-3403(h), the trial court should have given his proposed instruction on that point. The instruction he requested reads as follows:

“A health care provider shall have no responsibility for any injury or death arising out of the rendering or failure to render professional services by any other health care provider. The definition of health care provider includes a physician licensed by the Kansas board of healing arts and a certified registered nurse anesthetist licensed by the Kansas board of nursing.”

We note the proposed instruction differs from the exact statutory language by deletion of the reference

to the existence of coverage under the Fund, which would not have been appropriate, and states there is “no responsibility,” whereas the statute provides there is “no vicarious liability or responsibility.”

The Glassmans opposed such an instruction and noted the possibility of the issue becoming even more confused because, if the requested instruction were given, it might necessitate giving jury \*527 instructions on the various aspects of respondeat superior and the differences between direct and vicarious liability.

The trial court concluded vicarious liability was not an issue in the case, expressed concern that introducing an instruction on nonrelevant law would tend to confuse the jury, and declined to give the proposed instruction.

[16] Instructions in any given case are to be considered together as a whole, and where they fairly instruct the jury on the law governing a case, and are substantially correct, such that the jury could not reasonably have been misled by them, then the instructions will be approved on appeal. *In re Application of the City of Great Bend for Appointment of Appraisers*, 254 Kan. 699, 713, 869 P.2d 587 (1994).

[17] Based on all of the evidence in the record and specifically the jury's finding of only 1% of the fault to Dr. Costello and 99% of the fault to CRNA Mahoney, it is difficult to conclude anything other than the jury clearly understood the issue it was required \*\*1063 to resolve. We can only conclude that under our standard of review the trial court did not improperly refuse to give the requested instruction in this case.

This is not to say that under some factual situations, or possibly with different testimony, that some instruction or direction as to the absence of vicarious liability or responsibility of one health care provider for the acts of another might not be appropriate.

*Did the court err in limiting the testimony of defense expert Preston regarding changes in the CRNA rules and regulations?*

Dr. Costello argues the trial court did not allow his expert, Preston, to testify as to why 1992 K.A.R. 28-

34-17 was repealed and replaced with K.A.R. 28-34-17a and K.A.R. 28-34-17b.

Dr. Costello argues that Preston was actively involved in the legislative process of revising regulations and statutes related to nurse anesthetists, and his qualifications and experience provided him with knowledge which could have educated the jury regarding the law.

[18] The qualifications of an expert witness and the admissibility of expert testimony are matters entrusted to the broad discretion of \*528 the trial court. *Simon v. Simon*, 260 Kan. 731, Syl. ¶ 1, 924 P.2d 1255 (1996).

[19] In addition, we point out that it is undisputed that “[w]here trials are by jury, it is the sole province of the court to decide questions of law as distinguished from questions of fact.” *Hunter v. Brand*, 186 Kan. 415, 419, 350 P.2d 805 (1960). In 31A Am.Jur.2d, Expert and Opinion Evidence § 136, pp. 143-44, it is stated:

“While witnesses may be permitted, in a proper case, to give an opinion on the ultimate *fact* involved in the case, there is a strong consensus among jurisdictions, amounting to a general rule, that witnesses may not give an opinion on a question of domestic law or on matters which involve questions of law. The fundamental problem with testimony containing a legal conclusion is that conveying the witness' unexpressed, and perhaps erroneous, legal standards to the jury amounts to a usurpation of the court's responsibility to determine the applicable law and to instruct the jury as to that law.”

Dr. Costello relies on *In re Marriage of Bunting*, 259 Kan. 404, 912 P.2d 165 (1996), to argue that expert testimony may be allowed for the purpose of educating a jury regarding the legislative and regulatory intent behind particular changes in statutes and regulations. We do not agree.

[20] *Bunting* involved the interpretation of K.S.A. 60-1610(a)(1)(C), a child support issue. We noted that an attorney who helped draft the amendment was allowed to testify before the trial judge as to the purpose behind the amendment. *Bunting* is not to be applied as Dr. Costello argues. First, the propriety of

the admission of the testimony was not at issue in *Bunting*. Second, the testimony was presented to the court, which was determining an issue of law. It invades the authority of the court to allow an individual to present testimony to a jury as to what a change in the law was intended to accomplish.

It was not improper for the trial court to refuse to allow Preston to testify to the jury about the specifics of the legislative and regulatory changes. Preston was allowed to testify regarding the interdependent role of the physician and the nurse anesthetist, that the rule as to physician supervision had changed in 1993, and that CRNA Mahoney received all the direction he was entitled to receive. The trial court did not erroneously limit Preston's testimony.

**\*529** The contentions and arguments of Dr. Costello's cross-appeal are denied.

This case is reversed and remanded for a new trial subject to the comments of this opinion.

SIX, J., concurring.  
Kan., 1999.  
Glassman v. Costello  
267 Kan. 509, 986 P.2d 1050

END OF DOCUMENT

# Appendix 4

256 A.D.2d 702, 681 N.Y.S.2d 135, 1998 N.Y. Slip Op. 11196  
(Cite as: 256 A.D.2d 702, 681 N.Y.S.2d 135)

**C**

Supreme Court, Appellate Division, Third Department, New York.

Peter A. PAYANT et al., Appellants-Respondents,  
v.

A. Michael IMOBERSTEG, Respondent-Appellant,  
and

Champlain Valley Physicians Hospital, Respondent,  
et al., Defendant.

Dec. 3, 1998.

Patient brought medical malpractice action against hospital and physician. Defendants moved for summary judgment. The Supreme Court, Clinton County, Dawson, J., granted summary judgment, and patient appealed. The Supreme Court, Appellate Division, White, J., held that: (1) attorney's affidavit made without personal knowledge could not support summary judgment motion; (2) fact that infectious disease specialist was not an orthopedic surgeon did not render his testimony regarding standard of treatment for an orthopedic surgeon inadmissible; and (3) new trial was warranted.

Reversed and remanded.

## West Headnotes

**[1] Health 198H**  **782**198H Health

198HV Malpractice, Negligence, or Breach of Duty

198HV(F) Persons Liable

198Hk781 Hospitals or Clinics

198Hk782 k. In General. Most Cited

Cases

(Formerly 204k7 Hospitals)

Hospital will not be vicariously liable for acts of emergency room physician where patient entered hospital through its emergency room, hospital did not maintain control over the manner and means of physician's work through the operation of its emergency room, and patient sought treatment from physician rather than from hospital.

**[2] Judgment 228**  **185.1(3)**228 Judgment

228V On Motion or Summary Proceeding

228k182 Motion or Other Application

228k185.1 Affidavits, Form, Requisites and Execution of

228k185.1(3) k. Personal Knowledge or Belief of Affiant. Most Cited Cases

Attorney's affidavit made without personal knowledge lacked probative value and could not support summary judgment motion.

**[3] Evidence 157**  **546**157 Evidence

157XII Opinion Evidence

157XII(C) Competency of Experts

157k546 k. Determination of Question of Competency. Most Cited Cases

Trial court has initial responsibility of determining whether witnesses, on the basis of experience and study, have the necessary standing to be regarded as experts.

**[4] Evidence 157**  **538**157 Evidence

157XII Opinion Evidence

157XII(C) Competency of Experts

157k538 k. Due Care and Proper Conduct in General. Most Cited Cases

Fact that infectious disease specialist was not an orthopedic surgeon did not render his testimony regarding standard of treatment for an orthopedic surgeon inadmissible in malpractice action against orthopedic surgeon, since medical expert witness is not required to be a specialist in the same field as the parties to the lawsuit.

**[5] Evidence 157**  **538**157 Evidence

157XII Opinion Evidence

157XII(C) Competency of Experts

157k538 k. Due Care and Proper Conduct in General. Most Cited Cases

Where medical expert proposes to testify about

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minimum medical standards applicable throughout the United States, "locality rule," should not be invoked to bar testimony.

[6] Evidence 157 ↪ 536

157 Evidence

157XII Opinion Evidence

157XII(C) Competency of Experts

157k536 k. Knowledge, Experience, and

Skill in General. Most Cited Cases

Physician's alleged lack of skill or expertise goes to the weight of his testimony, not to its admissibility.

[7] Appeal and Error 30 ↪ 1056.1(11)

30 Appeal and Error

30XVI Review

30XVI(J) Harmless Error

30XVI(J)11 Exclusion of Evidence

30k1056 Prejudicial Effect

30k1056.1 In General

30k1056.1(11) k. Particular

Types of Evidence. Most Cited Cases

(Formerly 30k1056.1(3))

Where trial court's exclusion of medical experts' testimony substantially prejudiced plaintiffs in medical malpractice action by preventing them from establishing prima facie case, a new trial was warranted.

**\*\*135** Livingston L. Hatch, Plattsburgh, for appellants-respondents.

Carter, Conboy, Case, Blackmore, Napierski & Maloney (Nancy E. May-Skinner of counsel), Albany, for respondent-appellant.

Stafford, Trombley, Purcell, Owens & Curtin (William Owens of counsel), Plattsburgh, for respondent.

Before CARDONA, P.J., WHITE, YESAWICH and PETERS, JJ.

\*703 WHITE, Justice.

(1) Appeal from an order of the Supreme Court (Dawson, J.), entered June 30, 1997 in Clinton County, which granted defendant Champlain Valley Physicians Hospital's motion for summary judgment dismissing the complaint against it, (2) appeal from

the judgment entered thereon, (3) appeal from a **\*\*136** judgment of said court, entered July 21, 1997 in Clinton County, upon a dismissal of the complaint against defendant A. Michael Imobersteg at the close of plaintiffs' case, and (4) cross appeals from an order of said court, entered April 7, 1998 in Clinton County, which partially granted defendant A. Michael Imobersteg's motion to preclude plaintiffs from presenting certain evidence.

On June 4, 1990 in the City of Plattsburgh, Clinton County, plaintiff Peter A. Payant (hereinafter plaintiff) was involved in a severe motorcycle accident which resulted in the partial amputation of his lower right leg. Following the accident, plaintiff was taken to the emergency room at defendant Champlain Valley Physicians Hospital (hereinafter CVPH) where he was treated by defendant Krishan G. Gulati, a vascular surgeon, and defendant A. Michael Imobersteg (hereinafter defendant), an orthopedic surgeon. Instead of immediately amputating the leg, the doctors decided to try to salvage it by performing vascular surgery to restore blood flow and applying an external fixator device. Plaintiff remained in CVPH until June 12, 1990 when he was transferred to Fletcher Allen Medical Center in Burlington, Vermont. When plaintiff's leg was examined on June 15, 1990, a large amount of necrotic muscle was discovered which left no alternative other than to amputate the leg. Subsequently, plaintiffs commenced this medical malpractice action <sup>FN1</sup> claiming, *inter alia*, that defendant and CVPH failed to diagnose and treat a gross infection in his right leg. On the eve of trial in June 1997, CVPH moved for summary judgment which Supreme Court granted on the ground that vicarious liability could not be imposed upon the hospital. The case against defendant proceeded to trial but was never submitted to the jury because, after Supreme Court precluded the testimony of plaintiffs' two expert medical witnesses, it granted defendant's motion to dismiss predicated on plaintiffs' failure to establish a prima facie case. These appeals ensued.

FN1. Plaintiffs' action against Gulati was dismissed prior to trial and is not involved in this appeal.

[1][2] We shall first consider plaintiffs' appeal from the order and judgment granting summary judgment to CVPH. Since plaintiff **\*704** entered the hospital

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through its emergency room, to prevail on its motion CVPH had to come forward with admissible evidence showing that it did not maintain control over the manner and means of defendant's work through the operation of its emergency room and that plaintiff sought treatment from defendant rather than from it (see, Hill v. St. Clare's Hosp., 67 N.Y.2d 72, 79-81, 499 N.Y.S.2d 904, 490 N.E.2d 823; GTF Mktg. v. Colonial Aluminum Sales, 66 N.Y.2d 965, 967, 498 N.Y.S.2d 786, 489 N.E.2d 755; Ryan v. New York City Health & Hosps. Corp., 220 A.D.2d 734, 633 N.Y.S.2d 500; Nagengast v. Samaritan Hosp., 211 A.D.2d 878, 621 N.Y.S.2d 217; Citron v. Northern Dutchess Hosp., 198 A.D.2d 618, 603 N.Y.S.2d 639, lv. denied 83 N.Y.2d 753, 612 N.Y.S.2d 107, 634 N.E.2d 603). The record shows that CVPH did not satisfy its burden as it primarily supported its motion with the affidavit of its attorney which was without probative value due to his lack of personal knowledge of the facts (see, Murray-Gardner Mgt. v. Iroquois Gas Transmission Sys., 229 A.D.2d 852, 854, 646 N.Y.S.2d 418). Consequently, Supreme Court erred in granting CVPH's motion for summary judgment.<sup>FN2</sup>

<sup>FN2</sup>. In light of this disposition, we need not consider whether CPLR 3212(a) applies to this case.

[3] As mentioned, at trial plaintiffs proffered the testimony of two expert medical witnesses, Neil Crane, a board-certified infectious disease specialist, and Howard Balensweig, a board-certified orthopedic surgeon. Supreme Court precluded the testimony of Crane on the ground that he was not qualified to testify as to what the standard of treatment for an orthopedic surgeon was in 1990 based on the fact that he was an infectious disease specialist. Balensweig was not allowed to testify because he had not performed surgery since 1974 and could not readily recall the steps he had taken to keep abreast of current medical procedures and trends. It is unquestioned that Supreme Court had the initial responsibility of determining whether these witnesses, on the basis of experience and study, had the necessary standing to **\*\*137** be regarded as experts (see, Beck v. Albany Med. Ctr., 191 A.D.2d 854, 857, 594 N.Y.S.2d 844). In our view, Supreme Court exceeded its authority in fulfilling this role as it blurred the distinction between the witnesses' qualifications and the weight to be given to their testimony, which is an issue for the jury (see, 3

Bender's N.Y. Evidence § 7.02 [1][a] ).

[4][5] With respect to Crane, while the fact that he was not an orthopedic specialist could conceivably affect the weight of his testimony, it did not render it inadmissible as there is no requirement that a medical expert witness be a specialist in the same field as the parties to the lawsuit (see, Fuller v. Preis, 35 N.Y.2d 425, 431, 363 N.Y.S.2d 568, 322 N.E.2d 263; Farkas v. Saary, 191 A.D.2d 178, 181, 594 N.Y.S.2d 195; Joswick v. Lenox Hill Hosp., 161 A.D.2d 352, 355, 555 N.Y.S.2d 104; see also, Prince, Richardson\*705 on Evidence § 7-315, at 482 [Farrell 11th ed] ). Supreme Court also seemed to imply that, since Crane was not familiar with the practice of medicine in the Plattsburgh area, his testimony would contravene the "locality rule". Although the "locality rule" was promulgated 100 years ago, it is still extant (see, Pike v. Honsinger, 155 N.Y. 201, 209, 49 N.E. 760; Riley v. Wieman, 137 A.D.2d 309, 314, 528 N.Y.S.2d 925); however, the development of vastly superior medical schools and postgraduate training, modern communications, the proliferation of medical journals, along with frequent seminars and conferences, have eroded the justification for the rule. Thus, where, as here, a medical expert proposes to testify about minimum standards applicable throughout the United States, the locality rule should not be invoked (see, Hoagland v. Kamp, 155 A.D.2d 148, 150-151, 552 N.Y.S.2d 978; Purtill v. Hess, 111 Ill.2d 229, 95 Ill.Dec. 305, 489 N.E.2d 867). Therefore, for these reasons, Supreme Court erred in precluding Crane's testimony.

[6] We reach the same conclusion with respect to Balensweig's testimony because his alleged lack of skill or expertise goes to the weight of his testimony, not its admissibility (see, Smith v. City of New York, 238 A.D.2d 500, 656 N.Y.S.2d 681; Behan v. Data Probe Intl., 213 A.D.2d 439, 623 N.Y.S.2d 886).

[7] As there is no question that the exclusion of the experts' testimony substantially prejudiced plaintiffs as it prevented them from establishing a prima facie case, a new trial is warranted (see, Misel v. N.F.C. Cab Corp., 240 A.D.2d 294, 658 N.Y.S.2d 625; Khan v. Galvin, 206 A.D.2d 776, 615 N.Y.S.2d 111). We note that the remittal of this matter for a new trial makes it unnecessary for us to reach the parties' remaining contentions.

ORDERED that the order entered June 30, 1997 and

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judgment entered thereon are reversed, on the law,  
with costs, and motion denied.

ORDERED that the judgment entered July 21, 1997  
is reversed; on the law, with costs, and matter remit-  
ted to the Supreme Court for a new trial.

ORDERED that the cross appeals from the order en-  
tered April 7, 1998 are dismissed, as moot.

CARDONA, P.J., and YESAWICH and PETERS,  
JJ., concur.  
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