STATE OF IDAHO)
County of KOOTENAI)ss
FILED 5/16/2023
AT 1:35 O'Clock A. M
CLERK OF DISTRICT COURT
Deputy

IN THE DISTRICT COURT OF THE FIRST JUDICIAL DISTRICT OF THE STATE OF IDAHO IN AND FOR THE COUNTY OF KOOTENAI

SHELLEY C. WILLIAMS and ARTHUR F. WILLIAMS, wife and husband,

Plaintiffs,

vs.

NORTHWEST SPECIALTY HOSPITAL,

Defendant.

Case No. **CV28-20-2733**

MEMORANDUM DECISION AND ORDER DENYING DEFENDANT'S SECOND MOTION FOR SUMMARY JUDGMENT

I. PROCEDURAL HISTORY AND FACTUAL BACKGROUND.

This medical malpractice case arises out of the treatment and care of plaintiff Shelley Williams (Ms. Williams) at a facility operated by defendant North Idaho Day Surgery, LLC, d/b/a Northwest Specialty Hospital (NWSH). The matter currently before the Court is NWSH's (second) Motion for Summary Judgment.

NWSH is a specialty acute care hospital located in Post Falls, Idaho. Dr. Adam Duke, M.D. (Dr. Duke) is a board-certified OB/GYN specializing in minimally invasive gynecological surgery. Mem. in Opp'n to Def. Northwest Specialty Hosp.'s Mot. for Summ. J. 2 (Mem. in Opp'n to Def. NWSH's Mot. for Summ. J.). Dr. Duke has been employed at a Post Falls clinic within NWSH, Northwest Women's Care, since July 2016. *Id.*

On July 20, 2018, Dr. Adam Duke (Dr. Duke) performed a "laparoscopic lysis of [numerous] pelvic adhesions and diagnostic cystoscopy" Ms. Williams, who was 72 years old. Compl. and Demand for Jury Trial (Compl.) ¶ 6; Ans. to Compl. and Demand

for Trial by Jury (Ans.) 3, Second Defense VI. During surgery, Dr. Duke noticed a small hole in Ms. Williams' colon and repaired it. *Id.* ¶ 7. Following the procedure, Dr. Duke transferred Ms. Williams to the post-anesthesia care unit for recovery. Compl. ¶ 9; Ans. 3 2d Def. IX. Ms. Williams alleges that she post-operatively "reported severe abdominal pain, no appetite and was voiding red/amber urine with no flatus or return of bowel movements", for which she received pain medication. Compl. ¶¶ 11-12; Ans. 2d Def. XI. Ms. Williams alleges that she refused to be discharged because she was in severe pain after the surgery, and that Dr. Duke did not evaluate her condition after the operation, despite her extreme pain. Compl. ¶¶ 13-17. On July 21, 2018, Ms. Williams received an increased dosage of Percocet from Dr. Duke. *Id.* ¶ 19; Ans. 2d Def. XII. Ms. Williams alleges that she "informed the nurse she was reluctant to be discharged home. However, she was encouraged to ambulate that morning in preparation for discharge." Compl. ¶ 21. Ms. Williams was discharged later that day. *Id.* ¶ 22; Ans. 2d Def. XIII. Ms. Williams alleges she "was not evaluated or seen by Dr. Duke on July 21, 2018, prior to her discharge from Northwest Specialty Hospital." *Id.* ¶ 23. Ms. Williams alleges that, in addition to Dr. Duke's failure to prescribe her antibiotics, after her discharge, her abdominal pain continued and worsened, and she was admitted to Kootenai Health's emergency room on July 23, 2018. *Id.* ¶¶ 24-26. She had a rapid heartrate, had an intra-abdominal infection, nausea, and diarrhea. *Id.* ¶ 26. She received a CT scan, which showed she had a collection of gas and fluid in the pelvis, and a severely inflamed intestine. *Id.* ¶ 27. Dr. Stackow performed a confirmatory laparoscopy. *Id.* ¶ 28. He noted significant contamination and performed an open procedure. *Id.* ¶ 29. He performed a colostomy and a sigmoidectomy. *Id.* 30. After this operation, her elevated heartrate persisted, and she also developed hypoxia and

lactic acidosis, and one day later went into anuric acute renal failure and had to be transferred to the intensive care unit. *Id.* ¶¶ 31-32. She remained in the intensive care unit for five days, where they treated her for renal failure, severe sepsis, and atrial fibrillation. *Id.* ¶ 33. Additionally, she claims:

> [Ms. Williams]] was discharged to an extended care facility on July 28, 2018, but was returned to Kootenai Hospital on August 2, 2018, for septic shock and necrosis at the colostomy site. [Ms. Williams] was admitted for another six days of treatment.
>
> During the second admission to Kootenai Health, [she] underwent a colostomy revision for necrosis and resection of the distal and transverse colon due to ischemia.
>
> Following her second admission, [she] returned to the extended care facility for approximately one month, where she required dialysis for the renal failure and colostomy care. Once home, [she] required health nursing and wound care for ongoing difficulty with the colostomy.
>
> [Ms. Williams] had the colostomy reversed in November 2018. She required an additional surgery performed by Dr. Stackow in October 2019, to address a subsequent abdominal hernia that developed.
>
> Defendants' delay of diagnosis and treatment of the additional intraoperative enterotomy on July 20, 2018 – July 21, 2018, placed [Ms. Williams] in a life threatening situation, causing severe sepsis, septic shock, renal failure, acute hypoxic respiratory failure, peritonitis, lactic acidosis, and atrial fibrillation with rapid ventricular rates, for which she required extended and multiple hospital admissions and medical are, further bowel resection and placement of a colostomy, dialysis and wound care treatment, significant permanent injuries and damages, [sic] unnecessary pain and suffering.

Compl. ¶¶ 34-38 (internal paragraph numbers omitted).

On April 24, 2020, the Williams filed a Complaint and Demand for Jury Trial (Complaint) against NWSH for medical malpractice. Ms. Williams' complaint alleges medical negligence against Dr. Duke and medical negligence against NWSH under the

theory of respondeat superior and corporate negligence.[1] Compl. ¶¶ 39-49. The complaint also includes Mr. Williams' claim for loss of consortium as a third-party plaintiff against both Dr. Duke and NWSH. *Id.* ¶ 53. On July 10, 2020, NWSH filed its Answer to Complaint and Demand for Trial by Jury (Answer). Both parties have requested a trial by jury.

On July 1, 2021, NWSH filed its Motion for Partial Summary Judgment, seeking to dismiss the Williamses claims of Corporate Negligence against NWSH, and dismiss against any claims against NWSH and its nursing staff under a theory of respondent [sic] superior. Mot for Partial Summ. J. 2. On July 20, 2021, the Williamses filed their Non-Opposition to Defendant's Motion for Partial Summary Judgment. As a result, on August 20, 2021, this Court entered its Order Granting Defendant Northwest Specialty Hospital's Motion for Partial Summary Judgment.

On April 11, 2022, NWSH filed its (second) Motion for Summary Judgment and Memorandum in Support of Motion for Summary Judgment.[2] On April 28, 2022, the Williams submitted their Memorandum in Opposition to Defendant NWSH Hospital's Motion for Summary Judgment and Affidavit of Alan R. Swajkoski, M.D. (Swajkoski Affidavit) in support of its motion. On May 5, 2022, NWSH filed its Reply in Support of Motion for Summary Judgment.

---

[1] On August 20, 2021, this Court granted NWSH's uncontested motion for partial summary judgment, dismissing both the claim for corporate negligence against NWSH and the claim for "medical malpractice based on vicarious liability for its employed nursing staff and other staff" with prejudice and declared that "Plaintiff's remaining claim of medical malpractice against Defendant NWSH based on the vicarious liability for the medical acts or omissions of its employee Dr. Duke is Plaintiffs [sic] only remaining claim of medical malpractice liability against Defendant NWSH." August 2, 2021, Order Granting Defendant Northwest Specialty Hospital's Motion for Partial Summary Judgment 2.

[2] NWSH does not file any declarations with its motion; however, it incorporates its Affidavit of Counsel in Support of Partial Summary Judgment, filed with its initial motion for summary judgment on July 1, 2021.

On May 12, 2022, this Court heard oral argument on NWSH's second motion for summary judgment. At the conclusion of that hearing, this Court took the matter under advisement.

II. STANDARD OF REVIEW

Idaho Rule of Civil Procedure 56 governs motions for summary judgment. According to that Rule, summary judgment must be granted "if the movant shows that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." I.R.C.P. 56(a). A party asserting that there is no genuine dispute as to any material fact, or a party asserting that a genuine dispute exists, must support that assertion by "citing to particular parts of materials in the record" or "showing that the materials cited do not establish the absence or presence of a genuine dispute, or that an adverse party cannot produce admissible evidence to support the fact." *Id.*

> If a party fails to properly support an assertion of fact or fails to properly address another party's assertion of fact as required by Rule 56(c), the court may:
>
> (1) give an opportunity to properly support or address the fact;
> (2) consider the fact undisputed for purposes of the motion;
> (3) grant summary judgment if the motion and supporting materials, including the facts considered undisputed, show that the movant is entitled to it; or
> (4) issue any other appropriate order.

Id. 56(e).

The burden of proof is on the moving party to demonstrate the absence of a genuine issue of material fact. *Rouse v. Household Fin. Corp.*, 144 Idaho 68, 70, 156 P.3d 569, 571 (2007) (citing *Evans v. Griswold*, 129 Idaho 902, 905, 935 P.2d 165, 168 (1997)). "Such an absence of evidence may be established either by an affirmative showing with the moving party's own evidence or by a review of all the nonmoving party's evidence and the contention that such proof of an element is lacking." *Heath v.*

Honker's Mini-Mart, Inc., 134 Idaho 711, 712, 8 P.3d 1254, 1255 (Ct. App. 2000) (citing *Dunnick v. Elder*, 126 Idaho 308, 311, 882 P.2d 475, 478 (Ct. App. 1994)). "A material fact is one upon which the outcome of the case may be different." *Peterson v. Romine*, 131 Idaho 537, 540, 960 P.2d 1266, 1269 (1998).

Once the moving party meets their burden of establishing the absence of a genuine issue of material fact, the burden shifts to the non-moving party to provide specific facts showing there is a genuine issue for trial. *Kiebert v. Goss*, 144 Idaho 225, 228, 159 P.3d 862, 864 (2007) (citing *Hei v. Holzer*, 139 Idaho 81, 85, 73 P.3d 94, 98 (2003)). To do so, the non-moving party "must come forward with evidence by way of affidavit or otherwise that contradicts the evidence submitted by the moving party, and that establishes the existence of a material issue of disputed fact." *Chandler v. Hayden*, 147 Idaho 765, 769, 215 P.3d 485, 489 (2009) (citing *Kiebert v. Goss*, 144 Idaho 225, 228, 159 P.3d 862, 865 (2007)). "Circumstantial evidence can create a genuine issue of material fact. . . . However, the non-moving party may not rest on a mere scintilla of evidence." *Shea v. Kevic Corp.*, 156 Idaho 540, 545, 328 P.3d 520, 525 (2014) (quoting *Park West Homes, LLC v. Barnson*, 154 Idaho 678, 682, 302 P.3d 18, 22 (2013)). In determining whether material issues of fact exist, all allegations of fact in the record and all reasonable inferences from the record are construed in the light most favorable to the party opposing the motion. *Edmondson v. Shearer Lumber Prod.*, 139 Idaho 172, 176, 75 P.3d 733, 737 (2003) (citing *City of Kellogg v. Mission Mountain Interests Ltd., Co.*, 135 Idaho 239, 240, 16 P.3d 915, 919 (2000)).

> "The admissibility of expert testimony, however, is a threshold matter that is distinct from whether the testimony raises genuine issues of material fact sufficient to preclude summary judgment." *Arregui* [*Gallegos-Main*], 153 Idaho [801,] 804, 291 P.3d [1000,] 1003 (citing *Dulaney v. St. Alphonsus Reg'l Med. Ctr.*, 137 Idaho 160, 1636, 45 P.3d 816, 819 (2002)). On the threshold issue of admissibility, "the liberal construction and reasonable inferences standard does

> not apply . . . ." *Mattox* [*v. Life Care Ctrs. Of Am. Inc.*], 157 Idaho [468,] 473, 337 P.3d [627,] 632 (citing *Dulaney*, 137 Idaho at 163, 45 P.3d at 819). Instead, "the trial court must look at the witness' affidavit or deposition testimony and determine whether it alleges facts which, if taken as true, would render the testimony of that witness admissible." *Id.*

Fisk v. McDonald, 167 Idaho 870, 879, 477 P.3d 924, 933 (2020).

> Under Idaho Code section 6-1012, a medical malpractice plaintiff must affirmatively prove the standard of care element by direct expert testimony "was an essential part of his or her case in chief." In other words, when confronted by a defendant's motion for summary judgment in a medical malpractice case, the only way for a plaintiff to establish a prima facie case is through competent expert testimony on the standard of care.

Id. at 890, 477 P.3d at 944.

Matters of admissibility of expert testimony are within the discretion of the trial court. *Id.* at 879, 477 P.3d at 933 (quoting *Navo v. Bingham Mem'l Hosp.*, 160 Idaho 363, 369-70, 373 P.3d 681, 687-88 (2016) (quoting *Mattox*, 157 Idaho at 473, 337 P.3d at 632)). When reviewing a lower court's decision for abuse of discretion, the appellate court considers four essentials, including whether the trial court: "(1) correctly perceived the issue as one of discretion; (2) acted within the outer boundaries of its discretion; (3) acted consistently with the legal standards applicable to the specific choices available to it; and (4) reached its decision by the exercise of reason." *Id.* (quoting *Lunneborg v. My Fun Life*, 163 Idaho 856, 863, 421 P.3d 187, 194 (2018) (citation omitted)).

III. ANALYSIS

NWSH's sole argument on summary judgment is that the Williams have not proffered admissible "expert testimony on the applicable community standard of health care practice as it existed in Post Falls Idaho [sic] in July 2018", as the Idaho Medical Malpractice Act requires. Mem. in Supp. of Mot. for Summ. J. 2. NWSH argues that the Williams' chosen expert, Dr. Alan Swajkoski, a general OB/GYN who practiced in Boise, Idaho, failed to adequately learn the community standard of health care because

the OB/GYN he consulted with, Dr. Jon Cutting, is a general OB/GYN in Coeur d'Alene who retired in 2016. *Id.* 3. NWSH has two primary reasons that Dr. Swajkoski's testimony should be deemed inadmissible: (1) Dr. Swajkoski's training and experience is different than and inferior to that of Dr. Duke; and (2) Dr. Swajkoski does not have actual knowledge of the local community standard of care applicable to Dr. Duke because (a) the local physician Dr. Swajkoski consulted with, Dr. Cutting, lacks actual knowledge of the local standard of care because: (i) he was not a practicing surgeon in 2018, and (ii) his training and experience was different than and inferior to that of Dr. Duke.

To withstand summary judgment in a medical malpractice case, "the plaintiff must offer expert testimony indicating that the defendant health care provider negligently failed to meet the applicable standard of health care practice." *Dulaney v. St. Alphonsus Reg'l Med. Ctr.*, 137 Idaho 160, 164, 45 P.3d 816, 820 (2002); I.C. § 6-1012. In order to offer expert testimony on the local standard of health care practice, the plaintiff must lay a proper foundation as set forth in Idaho Code § 6-1013. The plaintiff lays a proper foundation for admission of his or her expert's testimony by demonstrating:

> (a) that such an opinion is actually held by the expert witness, (b) that the said opinion can be testified to with reasonable medical certainty, and (c) that such expert witness possesses professional knowledge and expertise coupled with actual knowledge of the applicable said community standard to which his or her expert opinion testimony is addressed . . . .

I.C. § 6-1013. The applicable community standard of health care practice:

> is specific to 'the time and place of the alleged negligence' and 'the class of health care provider that such defendant then and there belonged to . . . .' The defendant's care is judged against 'similarly trained and qualified providers of the same class in the same community, taking into account his or her training, experience, and fields of medical specialization if any.'

Mattox, 157 Idaho at 473, 337 P.3d at 632 (citing I.C. § 6-1012). The Idaho Supreme Court has stated:

> The guiding question is simply whether the affidavit alleges facts which, taken as true, show the proposed expert has actual knowledge of the applicable standard of care. In addressing that question, courts must look to the standard of care at issue, the proposed expert's grounds for claiming knowledge of that standard, and determine—employing a measure of common sense—whether those grounds would likely give rise to knowledge of that standard.

Id. at 474, 337 P.3d at 633.

> The obligation to demonstrate actual knowledge of the local standard of care is not intended to be "an overly burdensome requirement . . . ." *Frank v. E. Shoshone Hosp.,* 114 Idaho 480, 482, 757 P.2d 1199, 1201 (1988). Nor is the standard static and firmly rooted in past medical practices. Standards of care are sensitive to evolving changes in the way health care services are delivered in the various communities of our State. Indeed, the Court has recognized that "governmental regulation, development of regional and national provider organizations, and greater access to the flow of medical information," have provided "various avenues by which a plaintiff may proceed to establish a standard of care . . . ." *Suhadolnik v. Pressman,* 151 Idaho 110, 121, 254 P.3d 11, 22 (2011).

Navo v. Bingham Memorial Hosp., 160 Idaho 363, 371-72, 373 P.3d 681, 689-90 (2016) (quoting *Mattox v. Life Care Centers of America, Inc.,* 157 Idaho 468, 474, 337 P.3d 627, 633 (2014)). Where the parties submit conflicting testimony at the summary judgment stage, a trial court should not involve itself in weighing conflicting evidence" and should "refrain from making such factual determinations until evidence is heard on the disputed facts. . . . [T]he trial court must accept the affidavit as true and look to the affidavit itself to determine if it creates a question of fact sufficient to survive summary judgment." *Watts v. Lynn*, 125 Idaho 341, 346-47, 870 P.2d 1300, 1305-06 (1994) (citing *Dunlap v. Garner*, Dkt. No. 18920 (Idaho 1993)).

/

/

A. Genuine issues of material fact exist regarding whether Dr. Swajkoski possesses enough professional knowledge and expertise to make him competent to testify to the standard of care applicable to Dr. Duke.

NWSH argues:

> Desiring to specialize in minimally invasive gynecological surgery, Dr. Duke completed a two-year, [American Association of Gynecological Laparoscopists (AAGL)] affiliated Fellowship in Minimally Invasive Gynecological Surgery at the University of Tennessee College of Medicine. This fellowship and specialized training allowed Dr. Duke to perform complex and difficult surgeries that are beyond the scope of practice and training of a general OB/GYN physician.
>
> Following his fellowship, Dr. Duke worked in a general OB/GYN practice for one-and-one-half years, then focused exclusively on complex gynecological surgery at [NWSH] starting in 2016. Dr. Duke regularly if not exclusively handles difficult/higher risk cases, where conservative treatment has proven ineffective. Further, as part of his surgical practice, Dr. Duke routinely does bowel resections (removal of a portion of bowel) and is therefore well practiced in suturing/repairing bowel tissue.
>
> Specializing in minimally invasive gynecological surgery, Dr. Duke performs hundreds of surgeries similar to the procedure performed on Mrs. Williams. Despite the difficult nature of the surgeries, and the significant number performed annually, Dr. Duke does not recall another instance of causing an incidental bowel injury as the one that occurred with Mrs. Williams. Nevertheless, it is undisputed that bowel perforation is a known risk of pelvic/abdominal procedures and therefore Dr. Duke disclosed to Mrs. Williams this risk and Mrs. Williams executed a written Informed Consent demonstrating her knowledge and consent to this known risk.
>
> . . . .
>
> . . . Dr. Duke's "practice differs from a general OB/GYN physician in that he practices exclusively in performing minimally invasive gynecological surgeries and does not practice as an obstetrician. Further, as compared to a general OB/GYN physician, Dr. Duke has had significantly more and different education and training, which specialized in minimally invasive surgery.

Mem. in Supp. of Mot. for Summ. J. 6-8 (citations omitted). NWSH continues:

> While Dr. Swajkoski, Dr. Cutting, and Dr. Duke are board certified OB/GYN physicians, it cannot genuinely be disputed by Plaintiffs that Dr. Swajkoski and Dr. Cutting have significantly different education, training, and/or work experience from that of Dr. Duke. Specifically, Dr. Swajkoski's education and background appears consistent with many general OB/GYN physicians, which does include training to perform gynecological surgeries. However, neither Dr. Swajkoski nor Dr. Cutting reveal any specialized education or training in advanced laparoscopic surgery, neither reveal any AAGL fellowship or similar training or experience, and neither worked exclusively as an OB/GYN specializing in complex minimally invasive gynecological surgery. While Dr. Swajkoski and Dr. Cutting were certainly qualified to perform gynecological

surgeries within the scope of practice of a general OB/GYN, they do not have actual knowledge of the community standard of health care practice for Dr. Duke who has advanced training to perform, and does perform, more complex surgeries based on his area of specialization, education, training, experience and expertise.

These differences in standards are reflected in the general nature of Plaintiff's disclosed opinions for Dr. Swajkoski, especially with his opinions regarding the actual surgery performed by Dr. Duke. For example, Dr. Swajkoski opines that conservative non-surgical treatment may have been indicated rather than proceeding with surgery. However, this opinion ignores that the fact [sic] that Dr. Duke practices exclusively as a surgeon and therefore would have been seeing Mrs. Williams for a surgery consultation and that he advised Mrs. Williams of conservative care which Mrs. Williams rejected because she had tried that and it did not work. Similarly, Dr. Swajkoski criticizes Dr. Duke's use of a laparoscopic procedure, where, he opines it could have been converted to an open procedure. Again, Dr. Swajkoski has no knowledge of the standard of health care practice for an OB/GYN specializing in and receiving advanced training in minimally invasive laparoscopic surgery. Finally, Dr. Swajkoski opines that an incidental enterotomy and repair required a formal consult or assist by a general surgeon. However, this opinion is also not based on actual knowledge of the community standard of health care practice for an OB/GYN similarly situated to Dr. Duke who is specially trained and whose practice specializes exclusively in laparoscopic surgery, and who performs and repairs bowel resections as a routine part of his surgical practice.

. . . Notwithstanding OB/GYN board certifications, it is undisputed that Dr. Duke's practice and training is in a subspecialty in which neither Dr. Swajkoski nor Dr. Cutting have demonstrated the requisite education, knowledge, experienced [sic] or expertise. Based on this area of specialization, the standard of health care practice for which Dr. Duke is held is different from that for [sic] Dr. Swajkoski and Dr. Cutting.

Id. at 14-15 (citations omitted).

The Williams respond:

. . . Defendant NWSH has misstated the facts surrounding the qualification of Dr. Swajkoski as an expert on the standard of care applicable to Dr. Duke. . . . The standard of care in the performance of [a laparoscopic lysis of pelvic adhesions] does not change because of Dr. Duke's additional training.

Mem. in Opp'n to Def. NWSH Hospital's Mot. for Summ. J. 3. Later in their memorandum, the Williams argue:

Specifically, for purposes of this motion, the standard of care in question is that or Dr. Duke, a Board-Certified OB/GYN, practicing in Post Falls, Idaho, in July 2018. The procedure in question is a laparoscopic lysis of pelvic adhesions, a minimally invasive gynecological surgery that is routinely performed by OB/GYN physicians, without the need for advanced or specialized training.

> Defendant NWSH first argues that Dr. Swajkoski and Dr. Cutting cannot be familiar with the standard of care applicable to Dr. Duke because of Dr. Duke's subspeciality training, completely ignoring the fact that both Dr. Swajkoski and Dr. Cutting in their gynecological practices have performed precisely the same surgery as Dr. Duke performed in this case. . . .
>
> NWSH's position that Dr. Swajkoski or Dr. Cutting are required to have the similar advanced surgical training such as Dr. Duke is a misstatement of the law and the facts. NWSH wishes the Court to believe that Dr. Duke's practice is drastically different than that of Dr. Swajkoski, by drawing attention to the fact that Dr. Duke exclusively performs "minimally invasive gynecological surgeries" and does not practice as an obstetrician. This is irrelevant, as there was no obstetrician care provided to Mrs. Williams in this case. What is relevant is the applicable standard of care for gynecologist consulting and treating a patient for pelvic pain, including performing a laparoscopic lysis of pelvic adhesions. Both Dr. Swajkoski and Dr. Cutting have vast experience and training in the field of gynecology medicine and surgery. In particular, both have experience managing and treating pelvic pain and performing the exact surgery involved in this case. The fact that Dr. Duke has limited his practice to exclusively performing minimally invasive gynecological surgeries does not overshadow the education, training and experience of Dr. Swajkoski and Dr. Cutting, and actually has narrowed Duke's practice and experience.
>
> Defendant NWSH further claims that Dr. Duke has "significantly more and different education and training" than Dr. Swajkoski in minimally invasive surgery. This is factually incorrect. There is no advanced training in minimally invasive laparoscopic surgery required to perform the lysis of pelvic adhesions, as was performed in this case, and which had been being performed by Dr. Swajkoski and Dr. Cutting long before Dr. Duke. NWSH acknowledged that the subspecialties or advanced training within a medical profession has not been addressed by the Idaho Supreme Court as being a requisite for expert testimony. Moreover, Fellowship training does not create a separate and distinct standard of care for the procedure involved in Mrs. Williams' surgery. There is not an additional board or medical certification for Fellowship training over and above the boards that certify OB/GYN physicians. Why then should we recognize a distinct and separate standard of care for Dr. Duke performing a surgery that is routinely performed by those with board certification as obstetricians and gynecologists?

Id. at 7-8 (citations omitted).

NWSH replies:

> . . . Plaintiffs simply assert that because Dr. Swajkoski and Dr. Cutting are general OB/GYN physicians, who are also trained and qualified to perform lysis of adhesions procedures, then they are qualified to offer any and all opinions regardless of Dr. Duke's fellowship training and specialization.
>
> This conclusory argument ignores the fact that Dr. Duke's fellowship training, specialization, and qualifications are highly relevant and critical to the standard of care opinions Dr. Swajkoski attempts to introduce. . . . Plaintiffs cannot simply rely on their titles as OB-GYNs [sic], or the facts [sic] that they

> perform similar procedures alone without adequate inquiry into Dr. Duke's specialized training and qualifications, scope of his practice, and the capacity in which he functions as a surgeon practicing in a surgical hospital.

Reply in Supp. of Mot. for Summ. J. 6. NWSH continues: "The mere fact that Dr. Swajkoski and Dr. Cutting have also performed adhesiolysis surgery is insufficient to foundation opinions on community standard of care for Dr. Duke". *Id.* at 11.

> Just because a physician or surgeon is familiar with or performed a specific type of procedure does not mean that they are qualified to offer opinions as to every surgeon who performed what they assume is a similar procedure. Abdominal adhesiolysis is a procedure that can be performed by a variety of specialists including general OB-GYNs [sic], general surgeons, or colorectal surgeons. It cannot be disputed that Dr. Swajkoski is not qualified to offer opinions on a general surgeon or colorectal surgeon simply because he also performs the same procedure. This is because the training for a general or specialty surgeon is different from a general OB-GYN [sic]. Rather, in order to offer standard of care opinions, Dr. Swajkoski would have been required to inquire into the training, standards and practices to learn the community standard of health care practice for such a surgeon.
>
> . . . Dr. Swajkoski attempts to offer opinions that Dr. Duke should have either had a general surgeon perform, or at least scrub in and officially consult on the repair of an the [sic] incidental enterotomy during Mrs. Williams' surgery. However, because of his training and scope of practice, Dr. Duke does not have the same standard of care as Dr. Swajkoski or even Dr. Cutting. Specifically, because of his advanced surgical training and specialty, Dr. Duke is qualified to perform and suture bowel resections (removal of bowel tissue) which is more involved and complicated that [sic] suturing a 2 mm entertomy. If Dr. Swajkoski believes general surgeon consult or assist is required for repair [sic] a small enterotomy, it is safe to assume he likewise did not perform bowel resections and repairs during his practice as a general OB-GYN [sic].
>
> Similarly, Dr. Swajkoski attempts to offer opinions regarding whether Mrs. Williams should have had an open procedure rather than a laparoscopic adhesiolysis procedure. However, again the standards for considering an open procedure versus a laparoscopic procedure is not the same between Dr. Duke and Dr. Swajkoski or Dr. Cutting . . . Again, Dr. Swajkoski fails to reveal any basis for his opinions that the standard of health care practice for Dr. Duke was the same for either himself or Dr. Cutting.

Id. at 11-12.

The Idaho Code requires that an expert possess professional knowledge and expertise comparable to that of the defendant, taking into consideration the defendant's

"training, experience, and fields of medical specialization." *Mattox*, 157 Idaho at 473, 337 P.3d at 632.

In *Pearson v. Parsons*, 114 Idaho 334, 339, 757 P.2d 197, 202 (1988), the Idaho Supreme Court held that the affidavit of a physician who was not certified in surgery or pediatrics could establish a genuine issue of material fact as to the appropriate standard of care. In that case, the plaintiff filed suit against two physicians, a board-certified pediatrician and a board-certified surgeon for complications resulting from appendicitis. *Id.* at 335, 757 P.2d at 198. The plaintiff's retained expert was a practicing Doctor of Medicine, who did not have board-certification in either of those specialties but who testified he had "actual knowledge of the standards of practice for physicians and surgeons in the State of Idaho, particularly, with respect to the diagnosis and treatment of appendicitis." *Id.* at 336-37, 757 P.2d at 199-200. The Idaho Supreme Court in *Pearson* found that:

> There is no requirement in [I.C. §§ 6-1012 or 6-1013] that an expert witness whose testimony is offered to establish a case of medical malpractice against a board-certified physician must also be board-certified in the same specialty. We specifically hold that to fulfill the requirement of presenting expert testimony in a medical malpractice case against a board-certified specialist, plaintiff may offer the testimony of a physician who is not board-certified in the same specialty as the defendant physician, so long as the testimony complies with the requirements of [those statutes].

Id. The Idaho Supreme Court found that, when measured by the summary judgment standard, the requirements of I.C. §§ 6-1012 and 6-1013 were satisfied, thus raising a genuine issue of material fact as to what the applicable standard of care was and whether it had been met. *Id.* at 338, 757 P.2d at 201. The Idaho Supreme Court in *Pearson* specifically found the following statements in the expert's affidavit to satisfy the statutes' requirements:

1. Dr. Weeks demonstrated that he was judging Dr. Parsons and Dr. Thueson "in comparison with similarly trained and qualified [physicians] in the same community, taking into account his or her training, experience, and fields of medical specialization." I.C. § 6-1012.
("Dr. Parsons and Dr. Thueson did not comply with the applicable standard of practice for physicians of their specialties in Blackfoot, Idaho." . . .)
2. He was a "knowledgeable, competent expert witness." I.C. § 6-1013.
("I am a practicing doctor of medicine." . . .)
3. He actually held an opinion about the "applicable standard of practice" and the failure of Dr. parsons and Dr. Thueson to meet the standard I.C. § 6-1013(a).
("[I]t is the opinion of your Affiant . . . that the recommendation that child be brought back for reexamination should significant improvement not occur in the child's condition and/or should the child become worse, is not the standard which is to be followed by a practicing physician and that under the circumstances . . . Dr. Parsons and Dr. Thueson did not comply with the applicable standard[s] . . . in the care and treatment they rendered to Emily Pearson . . . .
4. His opinion was rendered "with reasonable medical certainty." I.C. § 6-1013(b).
("[I]t is the opinion of your Affiant, to a reasonable degree of medical certainty . . .")
5. He possessed "professional knowledge and expertise coupled with actual knowledge of the applicable . . . community standard to which his . . . expert opinion testimony is addressed. I.C. § 6-1013(c).
("I am also familiar with the standards of the community regarding the diagnosis and treatment of suspected and actual appendicitis." . . .)

Id. at 338-39, 757 P.2d at 201-02.

Other, more recent cases have also established that an expert need not practice in the same specialty as the defendant in a medical malpractice case. *See, e.g.*, *Newberry v. Martens*, 142 Idaho 284, 127 P.3d 187 (2005) ("Dr. Martens correctly concedes that it is unnecessary for an expert witness to be of the same specialty as the defendant so long as the expert establishes he possesses actual knowledge of the standard of care to be applied."). In *Fisk v. McDonald*, 167 Idaho 870, 884-85, 477 P.3d 924, 938-39 (2020), the Idaho Supreme Court affirmed this Court's 2018 decision, finding that a primary-care physician was not familiar with the standard of care applicable to nurses in the same local area. The Idaho Supreme Court did find that it was possible for a physician to become familiar with the standard of care applicable to

nurses but that the plaintiff's expert's declaration did not demonstrate this in that case. *Id.* Thirty years before the Idaho Supreme Court decided *Fisk*, that Court held:

> The unmistakable general trend in recent years has been toward liberalizing the rules relating to the testimonial qualifications of medical experts. ....
>
> There are sound and persuasive reasons supporting this trend toward permitting admissibility more readily, rather than rigidly compelling rejection of expert testimony. It is obvious that an overly strict standard of qualification would make it difficult and in some instances virtually impossible to secure a qualified expert witness. In the present case, for example, it is doubtful that plaintiff could produce a medical doctor who was qualified to testify as to the standard of care in view of the rarity of the operation and the fact that the surgery had occurred in a comparatively small and isolated community 23 years prior to trial.
>
> On the other hand, if the threshold test of general testimonial qualification is found to be met and the witness is permitted to testify on direct examination, he is subject to as penetrating a cross-examination as the ingenuity and intellect of opposing counsel can devise. This inquiry may challenge not only the knowledge of the witness on the specific subject at issue, but also the reasons for his opinion and his evaluation of any written material upon which he relied in preparation for his testimony. (Evid.Code, § 721.) Further, a defendant is free to argue that the witness' testimony is not entitled to acceptance of credibility because he lacks personal acquaintance with the subject at the time the alleged negligent act occurred, and defendant may produce his own witnesses in rebuttal. These measures are more than adequate to protect a defendant's interests.

Gubler v. Boe, 120 Idaho 294, 308, 815 P.2d 1034, 1048 (1990).

Applying four of the five factors examined by the *Pearson* case, this Court finds that Dr. Swajkoski has demonstrated the requisite experience to testify in this case.[3] *See* 114 Idaho at 338-39, 757 P.2d at 201-02. Dr. Swajkoski has demonstrated that he was judging Dr. Duke "in comparison with similarly trained and qualified [physicians] in the same community, taking into account his or her training, experience, and fields of medical specialization", I.C. § 6-1012, by finding that "Dr. Duke fell below the standard of healthcare practice for a Board-Certified OB/GYN." Swajkoski Aff. ¶ 13. Dr.

[3] The Court will address the factor of whether he possessed "actual knowledge of the applicable . . . community standard to which his . . . expert opinion testimony is addressed", I.C. § 6-1013(c), below.

Swajkoski is a "knowledgeable, competent expert witness", I.C. § 6-1013, because he is a board-certified OB/GYN, practicing in Boise, Idaho. *Id.* ¶ 2. His opinion was rendered "with reasonable medical certainty", I.C. § 6-1013(b), because he stated that his opinion is "to a reasonable degree of medical probability". *Id.* ¶ 13. Dr. Swajkoski actually held an opinion about the "applicable standard of practice" and the failure of Dr. Duke to meet the standard of care, I.C. § 6-1013(a), because incorporated by reference his complete expert disclosure, *id.* ¶ 13, where he stated:

> It is Dr. Swajkoski's opinion that Dr. Duke's preoperative evaluation of Shelley Williams was wholly inadequate. . . . Dr. Duke exercised poor clinical judgment in proceeding in the manner chosen. Dr. Duke should have understood that with Mrs. Williams' proclivity of adhesion formation, that risks of complications were increased with a laparoscopic procedure, and that any surgery would result in further adhesions. . . . He should have considered having an experienced colorectal or general surgical assist in this case. . . . It is clear that Dr. Duke failed to fully appreciate his patient's presentation. Having only seen Mrs. Williams once in clinic for ½ hour on July 17, 2018 for consult and pre-op visit, and taking her to surgery three days later, July 20, 2018, was poor practice of medicine in Dr. Swajkoski's opinion.
>
> Dr. Swajkoski holds the opinion and will testify that Dr. Duke was not only negligent, but reckless, in his surgical and medical care and treatment of Shelley Williams.

Swajkoski Aff., Pls' R. 26 Expert Witness Disclosures 15-16. The Court finds that the contents of Dr. Swajkoski's expert witness disclosure are enough to overcome summary judgment on this occasion. Subject to the Court's analysis of Dr. Cutting's expertise and experience, the Court finds that Dr. Swajkoski possesses the relevant professional knowledge as required by four of the five factors discussed in *Pearson*. Additionally, the Court finds that the case law cited above show that NWSH is incorrect in their assertions that Dr. Swajkoski is not competent to testify because he has less advanced training and does not exclusively perform the types of surgeries in which Dr. Duke specializes. Dr. Swajkoski has testified that laparoscopic lysis of pelvic adhesions is routinely performed by OB/GYNs, no specialized or advanced training is needed to be

able to perform them, and Dr. Swajkoski has performed this type of surgery, "thousands" of them. Mem. in Opp'n to Def. NWSH Mot. for Summ. J. 7-8; Swajkoski Aff. 2, ¶ 2. The Court agrees with the Williams' assertion that "The fact that Dr. Duke has limited his practice to exclusively performing minimally invasive gynecological surgeries does not overshadow the education, training, and experience of Dr. Swajkoski and Dr. Cutting, and actually has narrowed Duke's practice and experience." *Id.* However, the Court is mindful that Dr. Duke's specialized education and experience mean that he would likely react differently than Dr. Swajkoski in certain instances. Nevertheless, Dr. Swajkoski has testified, "Surgical lysis of pelvic adhesions performed laparoscopically (minimally invasive) is a procedure that can be performed by a Board-Certified OB/GYN. There is no specialized training or education that an OB/GYN physician must undergo to perform this surgery in a hospital setting." Swajkoski Aff. 4, ¶ 9. Additionally, Dr. Swajkoski testified that he has performed several hundred complex gynecological laparoscopy procedures", thus making him adequately familiar with the procedure in question. *Id.* The Court must accept these statements as this summary judgment juncture. *Watts v. Lynn*, 125 Idaho 341, 346-47, 870 P.2d 1300, 1305-06 (1994). Thus, there is at least a genuine issue of material fact regarding the issue of whether more advanced training is needed to perform the surgery in question and whether Dr. Swajkoski meets the foundational requirements of I.C. § 6-1013.

In essence, NWSH's argument that because Dr. Duke has been through a fellowship in minimally invasive gynecological surgery and "has performed complex and difficult surgeries that are beyond the scope of practice and training of a general OB/GYN physician" (Mem. in Sopp of Mot. for Summ. J. 6), and Dr. Swajkoski has not, Dr. Swajkoski cannot render an opinion on the standard of care, entirely misses the mark. NWSH's argument to that effect is not even relevant. Dr. Duke's fellowship and

whether he can perform complex and difficult surgeries is not relevant because the surgery he performed on Ms. Williams was not complex, it was routine. This was not some space-age surgery performed by some rare as a unicorn surgical savant, this was a "laparoscopic lysis of [numerous] pelvic adhesions and diagnostic cystoscopy" (Compl. and Demand for Jury Trial (Compl.) ¶ 6; Ans. to Compl. and Demand for Trial by Jury (Ans.) 3, Second Defense VI, during which Dr. Duke noticed a small hole in Ms. Williams' colon and repaired it. Compl. ¶ 7. All of Dr. Duke's training for his subspecialty do not change the fact that the surgery he performed and the colon repair, are common, and certainly within the expertise of Dr. Swajkoski and Dr. Cutting.

Not only is NWSH's argument that Dr. Duke's fellowship and specialized training separates him from more pedestrian obstetrician-gynecologist surgeons like Dr. Swajkoski and Dr. Cutting not relevant, it is also not based on any evidence. While the burden is on the Williamses to survive summary judgment (they have met that burden), one would have thought that since NWSH is trying to convince this Court to do something the Idaho appellate courts have not done up to this point in time (subspecialties or advance training as being a requisite for expert testimony), they would have testimony by deposition or affidavit by Dr. Duke or someone else, as to why Dr. Duke's "significantly more and different education and training" makes him so much better than Dr. Swajkoski and Dr. Cutting, that Dr. Swajkoski can no longer qualify as an expert. NWSH asks this Court to create new law in Idaho, without giving this Court any facts, any evidence at all, upon which to take that leap. At least NWSH acknowledges it would be a leap, writing "no opinion has ever considered or addressed recognized subspecialties or advanced training within a nationally recognized board certification." Mem. in Supp. of Mot for Summ J. 13. Counsel for the Williams also noted this, and

this Court agrees with the Williamses' entire argument, which places that fact in context:

> Defendant NWSH further claims that Dr. Duke has "significantly more and different education and training" than Dr. Swajkoski in minimally invasive surgery. This is factually incorrect. There is no advanced training in minimally invasive laparoscopic surgery required to perform the lysis of pelvic adhesions, as was performed in this case, and which had been being performed by Dr. Swajkoski and Dr. Cutting long before Dr. Duke. NWSH acknowledges that the subspecialities or advanced training within a medical profession has not been addressed by the Idaho Supreme Court as being a requisite for expert testimony. Moreover, Fellowship training does not create a separate and distinct standard of care for the procedure involved in Mrs. Williams' surgery. There is not an additional board or medical certification for Fellowship training over and above the boards that certify OB/GYN physicians. Why then should we recognize a distinct and separate standard of care for Dr. Duke performing a surgery that is routinely performed by those with board certification as obstetricians and gynecologists?

Mem. in Opp'n to Def. NWSH Hospital's Mot. for Summ. J. 3.

B. Genuine issues of material fact exist regarding whether a national standard of care applies to Dr. Duke and to whether Drs. Swajkoski and Dr. Cutting possessed actual knowledge of the applicable local community standard of care.

In his declaration, Dr. Swajkoski testifies about the local standard of care for physicians performing lararoscopic lysis of pelvic adhesions and diagnostic cystoscopy in the Post Falls, Idaho, area. Swajkoski Decl. 2, ¶ 3. To determine the local standard of care, Dr. Swajkoski states he consulted with a local physician, Dr. Jon Cutting, who is board-certified OB/GYN practicing in Coeur d'Alene, Idaho. *Id.* at 3, ¶ 6. Based on that consultation, Dr. Swajkoski states that he believes his medical opinions are consistent with the local standards of care in the Post Falls, Idaho, area in July of 2018 because there is a national standard of care. *Id.* at 4-5, ¶ 12.

To testify about the standard of care in a medical malpractice case, "the medical expert must show that he or she is familiar with the standard of health care practice for the relevant medical specialty, during the relevant timeframe, and in the community

where the care was provided." *Bybee v. Gorman*, 157 Idaho 169, 174, 335 P.3d 14, 19 (2014) (citing *Suhadolnik v. Pressman*, 151 Idaho 110, 116, 254 P.3d 11, 17 (2011); *Dulaney*, 137 Idaho at 164, 45 P.3d at 820). He or she "must also state *how* they became familiar with the standard of care for the particular health care professional." *Perry v. Magic Valley Reg'l Med. Ctr.*, 134 Idaho 46, 51, 995 P.2d 816, 821 (2000) (citing *Kolln v. Saint Luke's Reg'l Med. Ctr.*, 130 Idaho 323, 331, 940 P.2d 1142, 1150 (1997) (emphasis in original)).

1. A genuine issue of material fact exists regarding whether a national standard of care applies to Dr. Duke's practice.

NWSH argues that the Williams' assertion that there is a national standard of care for board-certified OG/GYNs is incorrect and that its motion for summary judgment cannot be denied on that ground. Reply in Supp. of Mot for Summ. J. 6.

The Williams argue:

> . . . Dr. Swajkoski and Dr. Duke are similarly trained Board-Certified OB/GYNs, practicing in the State of Idaho. The scope of Dr. Swajkoski's knowledge as a Board-Certified OB/GYN provides him more than adequate grounds to speak to the standard of care applicable to Dr. Duke. Dr. Swajkoski will testify regarding his opinion that the same standard of care applies throughout Idaho for OB/GYNs who are Board-Certified, as the board-certification process does not differentiate for physicians based on their geographic region of practice. Dr. Swajkoski will testify that board-certification creates a national standard of care, taking into account the criteria for sitting for the boards, the material used to study for the boards, the global issues covered as part of the boards, renewal of board-certification requirements, and that all board-certified OB/GYNs practice to a national standard of care by virtue of being board-certified. Dr. Swajkoski also read the deposition of Dr. Duke and Defendant's expert disclosures to further gain knowledge of the applicable standard of care.

Mem. in Opp'n to Def. NWSH Hospital's Mot. for Summ. J. 12-13.

NWSH replies:

> an out of area expert, in addition to demonstrating knowledge of a national standard by certification, must still confirm that the relevant and specific community standard of health care practice does not deviate from the national standard. . . .

> . . . While Dr. Duke and Plaintiff's expert may have received similar training via board certification, Dr. Duke also received significant additional and specialized training during his two-year AAGL fellowship and specialization in minimally invasive gynecological surgery. For this reason, he does not have the same standard of health care practice as a board-certified general OB-GYN [sic]. . . . [W]hile it is a non-boarded subspecialty, minimally invasive gynecological surgery is expressly recognized by the ACOG as a fellowship trained subspecialty. . . . While Plaintiffs attempt to dismiss Dr. Duke's fellowship training and specialization by explaining that it does not carry a board certification, there is simply no authority for the proposition that a specialty must carry a board certification to be considered an area of specialization under I.C. § 6-1012. Like board certifications, AAGL accredited fellowship training involves extensive surgical training above and beyond what general [sic] OB/GYN receives. Accordingly, Plaintiffs cannot rely exclusively on their expert's OB-GYN [sic] board certification without accounting for and inquiring into Dr. Duke's additional training and specialization. As it is apparent that they have instead simply dismissed Dr. Duke's training and area of specialization, they are without foundation to offer standard of care opinions regarding the surgery performed by Dr. Duke.

Reply in Supp. of Mot. for Summ. J. 9-10 (citations omitted).

One way that the foundational requirements of I.C. § 6-1013 can be met is if an expert "demonstrates that a local standard of care has been replaced by a statewide of national standard of care". *Suhadolnik*, 151 Idaho at 116, 254 P.3d at 17 (footnotes omitted)). "Specifically, an out-of-area expert can demonstrate familiarity with a local standard by speaking to a local specialist and by reviewing deposition testimony that establishes the local standard is governed by a national standard." *Id.* (citing *Kozlowski v. Rush*, 121 Idaho 825, 828–29, 828 P.2d 854, 857–58 (1992)). However,

> Conclusory statements that an expert is familiar with the local standard because he is familiar with the national standard are insufficient to meet the requirements of Idaho Code § 6-1013. At a minimum, an out-of-state expert making such a claim is required to "inquire of a local specialist to determine whether the local community standard varies from the national standard." *Id.*

McDaniel v. Inland Northwest Renal Care Group-Idaho, LLC, 144 Idaho 219, 223, 159 P.3d 856, 860 (2007) (citing *Strode v. Lenzi,* 116 Idaho 214, 216, 775 P.2d 106, 108 (1989)) (internal citations omitted).

Here, Dr. Swajkoski testified that he consulted with Dr. Cutting regarding the standard of care in Post Falls, Idaho, who agreed with Dr. Swajkoski that "there is a national standard of care applicable to Dr. Duke as a Board-Certified OB/GYN", including "clinical consulting, evaluating, surgical, and non-surgical care, and treatment of patients similar to Shelley Williams." Aff. of Alan R. Swajkoski, M.D. ¶ 12. Thus, this requirement set forth in *McDaniel* has been met by the Williams. The question then becomes whether Dr. Cutting's determination that the standard of care in Post Falls, Idaho is the same as the national standard, is correct.

In *Watts v. Lynn*, 125 Idaho 341, 347, 870 P.2d 1300, 1306 (1994) (citing *Kozlowski v. Rush*, 121 Idaho 825, 828 P.2d 854 (1992) and *Clarke*, 114 Idaho at 766, 760 P.2d at 1182), the Idaho Supreme Court found that it is enough to survive summary judgment when an expert states in an affidavit that "he familiarized himself with the community standards for the relevant time period by conferring with a local [physician] and was aware of no deviation from national standards."

> [W]here an expert demonstrates that a local standard of care has been replaced by a statewide or national standard of care, and further demonstrates that he or she is familiar with the statewide or national standard, the foundational requirements of I.C. § 6-1013 have been met. Specifically, an out-of-area expert can demonstrate familiarity with a local standard by speaking to a local specialist and by reviewing deposition testimony that establishes that the local standard is governed by a national standard. *Kozlowski v. Rush*, 121 Idaho 825, 828-29, 828 P.2d 854, 857-58 (1992). In *Kozlowski*, the plaintiff's expert reviewed the defendant's deposition testimony, wherein the defendant stated that the local standard was equivalent to the national standard and governed by a particular handbook. 121 Idaho at 829, 828 P.2d at 858. Because the expert was familiar with the handbook mentioned as embodying the national standard, and was board-certified in the specialty area, the Court held the expert demonstrated sufficient knowledge of the local standard of care. *Id. See also Perry*, 134 Idaho at 51-52, 995 P.2d at 821-22 (finding no abuse of discretion in the admission of expert testimony relying on the depositions of three hospital nurses and the review of a particular text, when the depositions identified that the local standard was equivalent to the national standard and governed by the text reviewed by the expert). Therefore, knowledge of a local standard can be established by

> reviewing deposition testimony and by speaking to local experts confirming that the standard has been replaced by a national standard.

Suhadolnik v. Pressman, 151 Idaho 110, 117, 254 P.3d 11, 18 (2011).

Board certification alone is not sufficient to establish that the national standard of care replaces the local standard of care. *See, e.g.*, *Watts v. Lynn*, 125 Idaho 341, 345-46, 870 P.2d 1300, 1304-05 (1994) (citing *Strode v. Lenzi*, 116 Idaho 214, 775 P.2d 106 (1989) (holding that the Idaho Supreme Court in *Strode v. Lenzi* affirmed the "trial court's grant of summary judgment for defendant where plaintiff's expert did not state he made a local inquiry because, since he was board-certified in the same specialty and standard as defendant, he was familiar with what would be expected of a board-certified orthopedic surgeon in Boise); *Dulaney v. St. Alphonsus Reg'l Med. Ctr.*, 137 Idaho 160, 166, 45 P.3d 816, 822 (2002) (finding that a physician who was board certified in emergency medicine but who only practiced internal medicine could not show that he is familiar with the local standard of care for emergency medicine); *McDaniel v. Inland Northwest Renal Care Grp-Idaho, LLC*, 144 Idaho 219, 224, 159 P.3d 856, 861 (2007) (citing *Strode*, 116 Idaho at 216, 775 P.2d at 108) (finding that more than a "conclusory assertion by plaintiff's medical expert that he knew what the standard of care was because it was a national standard of care" is needed to satisfy the requirements of I.C. §§ 6-1012 and 6-1013). The Idaho Supreme Court held in *Phillips v. E. Idaho Health Servs.*, 166 Idaho 731, 747, 463 P.3d 365, 381 (2020), that "for board-certified specialists, the local standard of care is equivalent to the national standard of care." However, shortly thereafter, in *Dlouhy v. Kootenai Hospital Dist.*, 167 Idaho 639, 646, 474 P.3d 711, 718 (2020), the Idaho Supreme Court clarified that "board-certified specialists are not automatically subject to the national standard of care by virtue of their certification." The Idaho Supreme Court cited its earlier decision in

Grimes v. Green, 113 Idaho 519, 521-22, 746 P.2d 978, 980-81 (1987), to support its holding. The Idaho Supreme Court held that in *Grimes v. Green*, the Court implied that I.C. § 6-1012 "requires evidence that the local standard of care does not deviate from the national standard of care before a defendant who is board certified can be held to the national standard". *Dlouhy*, 167 Idaho at 646, 474 P.3d at 718. The Idaho Supreme Court in *Dlouhy* held that in order for an expert to establish that the national standard of care replaces the local standard of care:

> two elements must be met. First, the out-of-area expert must be "board-certified in the same specialty as that of the defendant-physician." This demonstrates that the out-of-area expert has "knowledge of the appropriate standard of care of board-certified physicians practicing in the specialty in question." Second, "an out-of-area [expert] must inquire of the local standard in order to insure there are no local deviations from the national standard under which the defendant-physician and witness-physician were trained."

Id. (quotations omitted) (quoting *Buck v. St. Clair*, 108 Idaho 743, 746, 702 P.2d 781, 784 (1985)). The Idaho Supreme Court in *Dlouhy* also clarified that its holding in *Samples v. Hanson* was that "a board-certified specialist can be held to a national standard of care, regardless of whether the specialist holds himself out as board certified. It does not . . . hold that board-certified specialists are *automatically* subject to a national standard of care." 167 Idaho at 647, 474 P.3d at 719. (italics in original, footnote omitted).

In *Perry v. Magic Valley Regional Medical Center*, 134 Idaho 46, 995 P.2d 816 (2000), the plaintiff retained an out-of-area expert to testify regarding the standard of care for administering intramuscular injections in Twin Falls, Idaho. *Id.* at 51, 995 P.2d at 821. To determine whether the local standard differed from the national standard, the out-of-area expert reviewed depositions from three of the defendant hospital's nurses, reviewed a standard nursing text identified by the defendant hospital's nurses

as their standard for nursing procedures, talked to the executive director of the Idaho Board of Nursing, and talked with nursing faculty members at two Idaho nursing schools. *Id.* Based on this, the out-of-area expert ultimately concluded that the local standard did not differ from the statewide or national standard. *Id.* The trial court determined that the out-of-area expert was qualified to testify about the local standard of care, and the Idaho Supreme Court affirmed that decision.[4] *Id.* at 51-52, 995 P.2d at 821-22.

In *Kozlowski v. Rush*, 121 Idaho 825, 828, 828 P.2d 854, 857 (1992), the Idaho Supreme Court found that the trial court abused its discretion when it struck an expert's testimony. The Idaho Supreme Court found that the expert's testimony should not have been precluded because:

> Dr. Broms testified that he was a board-certified obstetrician-gynecologist, that he was familiar with the standard of care through regular reading of regional and national medical journals, and that he was familiar with the local standard through his specialty training combined with his questioning of Dr. Roberge, a Caldwell board-certified obstetrician-gynecologist who told Dr. Broms that the local standard of care was equivalent to the national standard of care. At that point Dr. Broms possessed actual knowledge of the applicable said community standard as required by I.C. § 6-1013(c). Furthermore, we believe this degree of

---

[4] In affirming the trial court, the Idaho Supreme Court explained: [The out-of-area expert] reviewed the depositions of three Hospital nurses and then reviewed the text upon which they relied. Marlys Massey, the Hospital's nursing director for the emergency department, helped formulate Hospital nursing policies and co-authored the Hospital emergency room's Nursing Policy and Procedure Manual. In her deposition, Massey testified that the standard for intramuscular injections at the Hospital was the same way that nursing curricula throughout the United States taught the technique. She agreed that the Kozier text provided the basic manner, applicable anywhere in the country, for giving intramuscular injections, and that the local standard was the same as the universal standard. Massey also testified that she would refer nurses specifically to the Kozier text for brush-up on intramuscular injection techniques. Janie Draney, the Hospital's nursing administrator, testified in her deposition that, if the Hospital did not have a written policy or guideline in effect for a particular procedure, she would advise a nurse to consult the most current best method in a core reference text such as the Kozier text. In her deposition, Teresa Phillips testified that the Hospital used the Kozier text, which she stated was "the nursing standard for injection . . . as far as selecting sites." [The out-of-area expert's] reading of the nurses' depositions, coupled with her subsequent review of the text identified by the nurses as providing the standard for intramuscular injections, gave her a sufficient foundation to testify to the local standard of care. *Perry*, 134 Idaho at 52, 995 P.2d at 822.

> inquiry was adequate. Had Dr. Broms been told there was not a uniform standard, then further investigation would have been merited. However, Dr. Broms had every reason to believe the statement of a Caldwell obstetrician-gynecologist that there was a national standard of care for physicians practicing in this specialty. Upon learning this, further inquiry was not warranted.

Id.

Here, the Williams have stated:

> board-certification creates a national standard of care, taking into account the criteria for sitting for the boards, the material used to study for the boards, the global issues covered as part of the boards, renewal of board-certification requirements, and that all board-certified OB/GYNs practice to a national standard of care by virtue of being board-certified.

Mem. in Opp'n to Def. NWSH Hospital's Mot. for Summ. J. 13. Additionally, Dr. Swajkoski testified that, "Dr. Cutting and I agreed . . . that to a reasonable degree of certainty with respect to the medical issues presented by Mrs. Williams' case, there is a national standard of care applicable to Dr. Duke as a Board-Certified OB/GYN." Swajkoski Aff. ¶ 12. This is far from conclusory. Dr. Swajkoski indicated that Dr. Cutting agreed with him that a national standard of care applies to the specific procedure Dr. Duke performed on Ms. Williams. The Court finds that at least a genuine issue of material fact exists regarding whether a national standard of care applies, when taking the statements made by both parties as true.

2. Genuine issues of material fact exist regarding whether Dr. Cutting possesses actual knowledge of the local standard of care that applies to Dr. Duke.

To testify about the standard of care in a medical malpractice case, "the medical expert must show that he or she is familiar with the standard of health care practice for the relevant medical specialty, during the relevant timeframe, and in the community where the care was provided." *Bybee v. Gorman*, 157 Idaho 169, 174, 335 P.3d 14, 19 (2014) (citing *Suhadolnik v. Pressman*, 151 Idaho 110, 116, 254 P.3d 11, 17 (2011); *Dulaney*, 137 Idaho at 164, 45 P.3d at 820). He or she "must also state *how* they

became familiar with the standard of care for the particular health care professional." *Perry v. Magic Valley Reg'l Med. Ctr.*, 134 Idaho 46, 51, 995 P.2d 816, 821 (2000) (citing *Kolln v. Saint Luke's Reg'l Med. Ctr.*, 130 Idaho 323, 331, 940 P.2d 1142, 1150 (1997) (emphasis in original)). While the Idaho Code does not enumerate an exhaustive list of ways an out-of-area expert can familiarize him- or herself with the local community standard of care, recent cases have delineated some ways an expert may do so. A common way for an out-of-area expert to obtain knowledge of the local standard of care is by inquiring of a local specialist. *Id.* Another way is by reviewing "a deposition stating that the local standard does not vary from the national standard, coupled with the expert's personal knowledge of the national standard." *Perry,* 134 Idaho at 51-52, 995 P.2d at 821-22. Dr. Swajkoski's affidavit makes no reference to reviewing depositions to familiarize himself with the local standard of care. However, Dr. Swajkoski did consult with a local OB/GYN, Dr. Jon Cutting, to familiarize himself with the local standard of care, and the two agreed that a national standard of care applies. The Court will address each of these issues, beginning with a national standard of care.

a. At least a genuine issue of material fact exists regarding whether Dr. Cutting was practicing surgery in 2018.

NWSH argues that Dr. Swajkoski's opinions are inadmissible because Dr. Cutting was not a practicing surgeon in July 2018 because he retired from surgical practice in 2016. The Williams assert that Dr. Cutting was not retired in 2016 but rather retired in 2021. Mem. in Opp'n to Def. NWSH Hospital's Mot. for Summ. J. 3.

Specifically, NWSH argues:

> Dr. Swajkoski's purported foundation for actual knowledge of the relevant community standard of health care practice suffers a temporal defect. Specifically, Dr. Swajkoski relies upon Dr. Cutting for actual knowledge of the community standard of health care practice as it existed in July 2018. However,

> Dr. Cutting retired from surgical practice in 2016, terminating his clinical privileges at Kootenai Health at that time. Thereafter, Dr. Cutting limited his practice to a clinical private practice. It is undisputed that Dr. Duke does not maintain a clinical practice, instead practicing exclusively in minimally invasive laparoscopic gynecological surgery.
>
> It has not been established that Dr. Cutting maintained the requisite familiarity with the applicable standard of health care practice for a general OB/GYN performing laparoscopic procedures between 2016 and 2018. . . .
>
> NSWH recognizes that the Supreme Court has been willing to overlook temporal defects on special and limited facts or circumstances, such as situations where the testifying expert immediately replaced the defending physician, and therefore likely learned the preceding standard of health care practice. *See e.g. Samples v. Hanson*, 161 Idaho 179, 185, 284 P.3d 943, 949 (2016). However, no special circumstances are present in this matter. Dr. Swajkoski and Plaintiffs have failed to establish that Dr. Cutting was or could have been familiar with the relevant community standard of health care practice in July 2018 where he retired from surgical practice in 2016.

Mem. in Supp. of Mot. for Summ. J. 16.

The Williams respond:

> The Court will find that between 2016 and 2021, Dr. Cutting continued clinical practice, regularly consulting with his partners in the evaluation and treatment of all clinic patients, including surgical cases . . .

Mem. in Opp'n to Def. NWSH Hospital's Mot. for Summ. J. 3. No citation was given for that proposition by the Williams, but it is borne out in the Swajkoski Affidavit. Swajkoski Aff. 3, ¶ 6. The Williams argue:

> Dr. Cutting's actual knowledge of the standard of care applicable to gynecological surgeries did not cease to exist as of 2016, as NWSH suggests. While Dr. Cutting's focus was his clinical practice as of 2016, he did not stop assessing and consulting with his partners as to patient's evaluations, diagnoses and treatments, including surgeries. Although Dr. Cutting did not personally perform surgery in July 2018, he was actively seeing patients in his clinic, he was actively discussing and consulting all clinic patients with his partners, and actively discussing and consulting with his patients on gynecological surgeries.
>
> . . . .
>
> A careful review of the physicians' conversation reveals Dr. Cutting practiced in Coeur d'Alene, Idaho for over 40 years and retired in 2021. While in surgical practice, Dr. Cutting was performing 30 to 40 surgeries a month. Dr. Cutting and Dr. Swajkoski discussed the intricacies of the surgery performed by Dr. Duke, comparing it with their own practice because each had performed the same minimally invasive gynecological surgery in their career. Dr. Cutting and Dr. Swajkoski have combined almost 80 years of experience practicing and operating as an OB/GYN in the State of Idaho.

> Dr. Cutting was not retired in July 2018, as NWSH suggests. From 2016 until 2021, Dr. Cutting remained involved in clinical practice and was actively consulting and discussing the assessments, diagnoses, and treatments of all clinic patients, including surgical patients, with his partners. This ongoing, active involvement in patient and surgical care cannot be anything less than actual knowledge of the standard of care of an OB/GYN in North Idaho, in July 2018.

Id. at 9, 11-12.

NWSH replies:

> Plaintiffs assert that by practicing as an OB-GYN [sic] clinician, Dr. Cutting maintained familiarity with surgical standard [sic] of health care practice by consulting with partners and consulting on surgery patient cases. However, it is NWSH [sic] position that this is insufficient to demonstrate knowledge of community [sic] standard of health care practice for a surgeon such as Dr. Duke in 2018. Specifically, as Dr. Duke does not practice as a clinician, Dr. Cutting's clinical practice is irrelevant. Further, consulting with partners and the clinical/office treatment of surgical patients is not the same thing as the performance of an actual surgical procedure. In this regard, this case is fundamentally different from *Newberry*, where familiarity with standard [sic] of care could be established through discussing and consulting family eye practice patient care for eye trauma and obtaining referrals for specialized eye care. These discussions and referrals with family practice physicians were directly relevant to the standard of care questions in *Newberry*. In this case, there has been no similar demonstration that Dr. Cutting discussed the standard of care issues relevant to this matter with any other OB-GYN [sic]. There is nothing on the record to reveal that Dr. Cutting consulted with or treated a patient who underwent an adhesiolysis procedure during this time, or that surgical repair of incidental enterotomics was discussed. In this case, there is nothing on the record to demonstrate that Dr., [sic] Cutting maintained adequate familiar [sic] with the specific standard of care questions raised in this case.

Reply in Supp. of Mot. for Summ. J. 15.

Dr. Swajkoski testified that his consultations with Dr. Cutting revealed that in 2016 Dr. Cutting "focused on his private practice, seeing patients 3 days a week, and continuing to associate with his partners, assisting with consultations and discuss[ing] surgical treatment of his partners [sic] cases. Dr. Cutting did not fully retire from practice until 2021." Swajkoski Aff. 3, ¶ 6. Again, the Court accepts these statements as true for summary judgment purposes and finds that the Williams have rebutted

NWSH's assertion that Dr. Cutting retired in 2016 and a genuine issue of material fact exists.

b. Genuine issues of material fact exist regarding whether Dr. Cutting's experience, training, and experience make him competent to familiarize Dr. Swajkoski with the applicable local community standard of care.

In 2018 (Dr. Duke's surgery on Ms. Williams was on July 20, 2018), Dr. Cutting maintained a clinical practice, Health Care for Women, which serves patients throughout the area, including Post Falls. Swajkoski Aff. 3, ¶ 6. He is a Fellow of the American College of Obstetrics and Gynecology. *Id.* Dr. Cutting was employed at Kootenai Health from 1975 to 2016, where he performed thirty to forty surgeries per month. *Id.* In 2016, he opened his private practice, "seeing patients 3 days a week, and continuing to associate with his partners, assisting with consultations and discuss surgical treatments of his partners [sic] cases." *Id.*

Dr. Cutting has previously performed surgical lysis of pelvic adhesions laparoscopically, which Dr. Swajkoski asserts is "a procedure that can be performed by any Board-Certified OB/GYN. There is no specialized training or education that an OB/GYN physician must undergo to perform this surgery in a hospital setting." *Id.* 4, ¶¶ 8-9. Dr. Swajkoski also testifies that "physicians currently completing residency are trained in advanced and complex laparoscopy including lysis of adhesions." *Id.* ¶ 9. Based on his consultation with Dr. Cutting, Dr. Swajkoski states that he believes his medical opinions are consistent with the local standards of care in the Post Falls, Idaho, area in July of 2018 because there is a national standard of care. *Id.* at 4-5, ¶ 12.

The Court incorporates its earlier discussion about experience and training here. Additionally, the Idaho Supreme Court has heard several cases addressing the qualifications of local experts used as consults.

There is no requirement that the expert testimony be rendered by a local expert, only that they have familiarized themselves with the standard for a particular profession for the relevant community and time period and that the non-local expert state how they became familiar with the standard of care for the particular health care specialist. *Perry*, 134 Idaho at 51, 995 P.2d at 821. A common way for an out-of-area expert to obtain knowledge of the local standard of care is by inquiring of a local specialist. *Id.* When an out-of-area expert consults with a local specialist, "the specialist need not have practiced in the same field as the defendant, so long as the consulting specialist is sufficiently familiar with the defendant's specialty." *Suhadolnik*, 151 Idaho at 116, 254 P.3d at 17. However, the out-of-area expert must show that "the local specialist interviewed has actual knowledge of the local standard of care." *Mattox v. Life Care Ctrs. Am., Inc.*, 157 Idaho 468, 476, 337 P.3d 627, 635 (2014) (citing *Dulaney*, 137 Idaho at 166–67, 45 P.3d at 822–23).

> . . . [I]n *Arregui v. Gallegos-Main,* a plurality of this Court concluded that in a medical malpractice case brought against a chiropractor, testimony from an out-of-area expert who allegedly consulted with a local chiropractor was properly excluded where that expert failed to identify the local chiropractor, did not describe his chiropractic practice, and did not explain how he became familiar with the local standards of care. 153 Idaho at 809, 291 P.3d at 1008. Alternatively, in *Mattox,* this Court held that an out-of-area nurse had satisfied the actual knowledge requirement where she had consulted both with a local doctor and an associate professor teaching in the practical nursing program at Lewis-Clark State College, to familiarize herself with the local standard of care for nursing in Lewiston, Idaho. 157 Idaho at 479, 337 P.3d at 638.

Navo, 160 Idaho at 372, 373 P.3d at 690.

In *Dulaney v. St. Alphonsus Regional Medical Center*, 137 Idaho 160, 45 P.3d 816 (2002), the Idaho Supreme Court held that an out-of-area expert's affidavit lacked foundation because the affidavit did not set forth any facts demonstrating that the local specialist had actual knowledge of the type of care provided. *Id.* at 166, 45 P.3d at 822.

In that case, the plaintiff asserted that an emergency room physician in Boise violated the applicable standard of health care practice by prematurely discharging her from the emergency room. *Id.* at 162-63, 45 P.3d at 818-19. The plaintiff retained an out-of-area emergency room physician to testify about the local standard of health care practice applicable to emergency room settings. *Id.* at 164-65, 45 P.3d at 820-21. To familiarize himself with the local standard of care, the out-of-area expert consulted with a local physician in Boise who specialized in internal medicine. *Id.* at 165-66, 45 P.3d at 821-22. The Idaho Supreme Court affirmed the district court's holding that the out-of-area expert's resulting affidavit did not meet the foundational requirements of Idaho Code § 6-1013 because there were no facts in the affidavit demonstrating that the local specialist had knowledge of the standard of care for emergency room physicians in Boise. *Id.* at 166-67, 45 P.3d at 822-23.

The Court finds that the evidence before the Court at this time distinguishes the instant case from *Dulaney*. Unlike in *Dulaney*, where the affidavit did not set forth any facts demonstrating actual knowledge, Dr. Swajkoski has set forth such facts. Here, as discussed above in detail, although Dr. Cutting does not exclusively practice minimally invasive gynecological surgery as Dr. Duke does, he does have experience performing the type of procedure Dr. Duke performed on Ms. Williams. Dr. Swajkoski described how he became familiar with the local standards of care—by consulting with Dr. Cutting and by discussing what happened before, during, and after surgery and what happens when they perform such surgeries. Dr. Swajkoski demonstrated that Dr. Cutting was "sufficiently familiar" with the specific procedure in question. *Navo*, 160 Idaho at 372, 373 P.3d at 690. While it may be the case that Dr. Cutting is not familiar with the intricacies of every type of surgery that Dr. Duke performs, Dr. Swajkoski has testified

as to how Dr. Cutting is familiar with the pertinent procedures which Dr. Duke *actually* performed upon Ms. Williams. That is enough to overcome summary judgment. As with Dr. Swajkoski, the Court finds that there is certainly enough evidence to create a genuine issue of material fact regarding whether Dr. Cutting possesses actual knowledge of the local community standard of care that applies to Dr. Duke in this situation.

IV. CONCLUSION AND ORDER.

For the foregoing reasons, defendant's second motion for summary judgment must be denied.

IT IS HEREBY ORDERED Defendant NWSH's (second) Motion for Summary Judgment is **DENIED.**

Entered this 16th day of May, 2022.

John T. Mitchell, District Judge

Certificate of Service

I certify that on the 16 day of May, 2022, a true copy of the foregoing was mailed postage prepaid or was sent by interoffice mail or facsimile to each of the following:

Lawyer	email	Lawyer	email
David E. Comstock	decomstock@comstockbush.com	John A. Bush	jabush@comstockbush.com
Nancy J. Garrett	nancy@garrettrichardson.com	Justin K. Widner	justin@garrettrichardson.com

Jeanne Clausen, Deputy Clerk