STATE OF IDAHO)
County of KOOTENAI)ss

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CLERK OF DISTRICT COURT

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Deputy

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

JENNIFER KAY WAGNER, *Plaintiff*, vs. **KOOTENAI HOSPITAL DISTRICT, d/b/a KOOTENAI MEDICAL CENTER, KEVIN B. STRAIT, D.O., KEVIN B. STRAIT, PLLC, an Idaho Professional Limited Liability Company; NORTH IDAHO LUNG, ASTHMA AND CRITICAL CARE, PLLC, an Idaho Professional Limited Liability Company; JAMES P. OSMANSKI, II, D.O.; BRENDAN MIELKE, M.D.; ROCKWOOD CLINIC, P.S., a Washington Professional Services Corporation d/b/a ROCKWOOD KIDNEY AND HYPERTENSION CENTER – COEUR D'ALENE,** *Defendants*.

Case No. **CV 2011 8191**

MEMORANDUM DECISION AND ORDER DENYING PLAINTIFF'S MOTION FOR LEAVE TO FILE SECOND AMENDED COMPLAINT TO ALLEGE A CLAIM FOR PUNITIVE DAMAGES, and MEMORANDUM DECISION AND ORDER GRANTING PLAINTIFF'S MOTION FOR PARTIAL SUMMARY JUDGMENT

I. PROCEDURAL HISTORY AND FACTUAL BACKGROUND.

A. Procedural History.

This matter is before the Court on plaintiff Jennifer Wagner's (Wagner) "Motion for Partial Summary Judgment" filed February 1, 2013, and Wagner's "Motion for Leave to File Second Amended Complaint to Allege a Claim for Punitive Damages", filed April 3, 2013.

In her Motion for Partial Summary Judgment, Wagner requests summary judgment on the various defendants' affirmative defenses of comparative negligence. Plaintiff's Motion for Partial Summary Judgment, p. 2. The Court has reviewed the

following documents. In support of her motion, on February 1, 2013, Wagner filed her "Memorandum in Support of Plaintiff's Motion for Partial Summary Judgment", "Statement of Facts in Support of Plaintiff's Motion for Partial Summary Judgment", and "Affidavit of Eric. S. Rossman in Support of Plaintiff's Motion for Partial Summary Judgment".

On April 2, 2013, defendant Rockwood Clinic/Dr. Mielke (Mielke and Rockwood) filed "Rockwood Clinic's and Dr. Brendan Mielke's Response to Plaintiff's Motion for Partial Summary Judgment", "Affidavit of Markus W. Louvier", and "Affidavit of Juan Carlos Ayus". That same date, defendant Kootenai Hospital District (KHD) filed "Defendant Kootenai Hospital District's Memorandum in Opposition to Plaintiff's Motion for Partial Summary Judgment" and "Affidavit of Patrick E. Miller in Support of Kootenai Hospital District's Memorandum in Opposition to Plaintiff's Motion for Partial Summary Judgment". Also on that same date, defendant James Osmanski (Osmanski) filed his "Memorandum in Opposition to Plaintiff's Motion for Partial Summary Judgment" and "Affidavit of Michael E. Ramsden in Opposition to Plaintiff's Motion for Partial Summary Judgment". Also on that same date, defendant Kevin B. Strait/Kevin B. Strait, PLLC/North Idaho Lung, Asthma and Critical Care, PLLC (collectively Strait) filed "Defendants Kevin B. Strait, D.O.; Kevin B. Strait, PLLC; and North Idaho Lung, Asthma and Critical Care, PLLC's Joinder in Defendants' Opposition to Plaintiff's Motion for Partial Summary Judgment".

On April 10, 2013, Wagner filed her "Reply Memorandum in Support of Plaintiff's Motion for Partial Summary Judgment" and "Affidavit of Erica S. Phillips in Support of Plaintiff's Motion for Partial Summary Judgment".

On March 1, 2013, defendant Rockwood filed "Defendants Rockwood Clinic P.S.'s and Dr. Mielke's Motion for Summary Judgment" and "Memorandum of

Authorities in Support of Defendants Rockwood Clinic's and Brendan Mielke, M.D.'s Motion for Summary Judgment". On April 3, 2013 Wagner filed her "Memorandum in Opposition to Defendants Rockwood Clinic's and Brendan Mielke M.D.'s Motion for Summary Judgment" and "Affidavit of Richard Sterns, M.D." On April 16, 2013, counsel for Rockwood called the Clerk of this court to withdraw their motion for summary judgment, so that issue is no longer before this Court.

On March 29, 2013, Wagner filed "Plaintiff's Motion to Determine Sufficiency of Answers under IRCP 36(a) and 37(a)(4)", "Memorandum in Support of Plaintiff's Motion to Determine Sufficiency of Answers under IRCP 36(a) and 37(a)(4)", and "Affidavit of Eric S. Rossman in Support of Plaintiff's Motion to Determine Sufficiency of Answers under IRCP 36(a) and 37(a)(4)". On April 5, 2013, Rockwood filed "Defendants Rockwood Clinic and Dr. Mielke's Response to Plaintiff's Motion to Determine Sufficiency of Request for Admission Responses". On April 15, 2013, Wagner filed her "Reply Memorandum in Support of Plaintiff's Motion to Determine Sufficiency of Answers under IRCP 36(a) and 37(a)(4)".

Regarding Wagner's "Motion for Leave to File Second Amended Complaint to Allege a Claim for Punitive Damages", filed on April 3, 2013, the Court has reviewed the following documents also filed the same date: Wagner's "Memorandum in Support of Plaintiff's Motion for Leave to File Second Amended Complaint to Allege a Claim for Punitive Damages Against Defendant Brendan Mielke, M.D." and "Affidavit of Eric S. Rossman in Support of Plaintiff's Motion for Leave to File Second Amended Complaint to Allege a Claim for Punitive Damages". On April 9, 2013, KHD filed "Defendant Kootenai Hospital District's Memorandum in Opposition to Plaintiff's Motion for Leave to File Second Amended Complaint to Allege a Claim for Punitive Damages". On April 10, 2013, Osmanski filed his "Dr. Osmanski's Opposition to Plaintiff's Motion to Amend the

Complaint to Include a Claim for Punitive Damages". On April 11, 2013, Rockwood filed "Defendant Dr. Mielke's Response to Plaintiff's Motion to Amend re: Punitive Damages", "Affidavit of Allen Arieff, MD", "Affidavit of Brendan Mielke, MD re: Plaintiff's Motion on Punitive Damages" and "Affidavit of Robert F. Sestero, Jr. in Response to Plaintiff's Motion to Amend re: Punitive Damages". On April 16, 2013, Rockwood filed "Supplemental Affidavit of Robert F. Sestero, Jr. in Response to Plaintiff's Motion to Amend re: Punitive Damages with Corrected Exhibit C". On April 15, 2013, Wagner filed her "Affidavit of Erica S. Philips in Support of Plaintiff's Motion for Leave to File Second Amended Complaint to Allege a Claim for Punitive Damages", "Reply Memorandum in Support of Plaintiff's Motion for Leave to File Second Amended Complaint to Allege a Claim for Punitive Damages Against Defendant Brendan Mielke, M.D."

On April 11, 2013, Rockwood filed its "Motion to Continue Hearing on Plaintiff's Motion to Amend the Complaint re: Punitive Damages" and "Affidavit of Robert F. Sestero, Jr. in Support of Rockwood Clinic P.S.'s and Dr. Mielke's Motion to Continue Hearing on Plaintiff's Motion to Amend the Complaint re: Punitive Damages".
On April 15, 2013, Wagner filed her "Memorandum in Opposition to Defendants' Motion to Continue Hearing on Plaintiff's Motion to Amend the Complaint re: Punitive Damages" and "Affidavit of Eric S. Rossman in Opposition to Defendant's Motion to Continue Hearing on Plaintiff's Motion to Amend the Complaint re: Punitive Damages".

Oral argument on the above motions was held on April 17, 2013. At that hearing, Rockwood/Mielke withdrew their Motion to Continue Hearing on Plaintiff's Motion to Amend the Complaint re: Punitive Damages. At that hearing, the Court granted Plaintiff's Motion to Determine Sufficiency of Answers under IRCP 36(a) and 37(a)(4) in

all but two aspects. At the conclusion of oral argument, the Court took under advisement Wagner's Motion for Partial Summary Judgment and Wagner's Motion for Leave to File Second Amended Complaint to Allege a Claim for Punitive Damages.

While those motions were under advisement, on May 14, 2013, the Court was scheduled to hear summary judgment motions on behalf of Strait and KHD. At that hearing, Wagner stipulated to partial summary judgment on vicarious liability claims against KHD as Strait, Osmanski and Mielke were independent contractors with KHD, not employees. Wagner also stipulated to summary judgment on all claims against Strait, his PLLC and North Idaho Lung Asthma and Critical Care, PLLC.

This case is scheduled for a four-week jury trial beginning January 6, 2014.

B. Factual Background.

A brief non-technical summary of the facts is as follows: In an effort to self-detox from alcohol, Wagner over-hydrated herself by drinking large amounts of fluids, which resulted in dangerously low sodium levels in her body. Wagner had a seizure and was taken to Kootenai Medical Center, where she claims she was administered a solution of intravenous sodium at too fast a rate causing permanent damage to her brain. Failure to immediately address her low sodium level would have resulted in brain damage. However, replacing her sodium too quickly also causes brain damage. What is in dispute is what is the standard of care regarding the maximum allowable rate at which a physician should replace the sodium.

This case is a medical malpractice case arising from treatment Wagner received at Kootenai Medical Center (KMC) on October 18-21, 2009. Statement of Facts, p. 2. Prior to her treatment, Wagner had an alcohol dependency problem she had battled on and off for several years, for which she attempted inpatient and outpatient rehabilitation

on multiple occasions. *Id*. On several occasions prior to the events surrounding this lawsuit on October 18-21, 2009, Wagner's alcohol issues resulted in Wagner's hospital admission to obtain intravenous fluids, resuscitation relating to seizures and other alcohol consumption or withdrawal related symptoms, *Id*.

In mid-October 2009, Wagner had found employment and so attempted to wean herself off of alcohol by consuming large amounts of water, cranberry juice and other fluids. *Id*. Wagner began her self-weaning off alcohol and consumption of other fluids on October 15, 2009. Rockwood's Response to MPSJ, p. 3. On October 17, 2009, Wagner began vomiting and on October 18, 2009, Wagner had a seizure at which point her friend Laurie Gold (Gold) called 911. Statement of Facts, p. 2. Paramedics arrived and took Wagner to KMC's Emergency Department, arriving at approximately 2:46 p.m. *Id*. She was initially seen by Wallace Chun, M.D. (Chun), an emergency medicine specialist, who ordered fluid replacement at approximately 3:04 p.m. *Id*. Chun documented the following diagnoses: alcohol withdrawal seizure; hyponatremia; altered level of consciousness; delirium with postictal state and doubt status elepticus. Statement of Facts, p. 3. Wagner was then transferred to the care of Kevin Strait, M.D. (Strait), the on-call internal medicine/critical care medicine specialist, in the intensive care unit (ICU) based on her continued confused state, severe hypoatremia and hypokalemia. *Id*.

Strait assumed care of Wagner from approximately 5:33 p.m. on October 18, 2009, to approximately 7:00 a.m. on October 19, 2009. *Id*. At approximately 10:30 p.m. on October 18, 2009, Strait ordered sodium replacement of 3% hypertonic saline at 100 cc/hr by IV. *Id*. At approximately 7:00 a.m. on October 19, 2009, James Osmanski, M.D. (Osmanski), another internal medicine/critical care specialist, assumed care of

Wagner. *Id*. Osmanski contacted Brendan Mielke M.D. (Mielke), a nephrology specialist, regarding Wagner's electrolyte replacement therapy at which point Mielke began writing orders at approximately 10:15 a.m. *Id*. Though the use of IV normal saline and hypertonic saline, Wagner's sodium levels increased 20 mm/L over the first 25 hours and 25 mm/L over the first 36 hours of treatment. *Id*. The sodium increased 23 mm/KL over the first 24 hours and 29 mm/L over the first 48 hours of treatment following the lowest sodium laboratory entry of 102 mm/L at 12:44 a.m. on October 19, 2009. Statement of Facts, pp. 3-4.

Mielke was an employee of Rockwood Clinic, P.S. (Rockwood). Complaint, p. 3, ¶ 8; Answer of Brendan Mielke, M.D., and Rockwood Clinic, P.S. d/b/a Rockwood Kidney and Hypertension Center – Coeur d'Alene, pp. 2-3, ¶ 8.

On October 29, 2009, Wagner, pursuant to an MRI, was diagnosed with Central Pontine Myelinolysis (CPM), a severe permanent brain injury. Statement of Facts, p. 4.

Wagner alleges all defendants were negligent in their care and treatment by allowing her serum sodium to increase at a rate "grossly exceeding community standards of care for internal medicine, critical care and nephrology specialists prevailing at the time and place of treatment." *Id*.

In their response, Rockwood states Dr. Geoffrey Emry (Emry), a board-certified family physician, saw Wagner on October 3, 2008, almost one year prior to the incident leading up to this lawsuit. Rockwood's Response to MPSJ, p. 2. Emry instructed Wagner to cease consuming alcohol and recommended she enter into a treatment program. *Id*. On October 17, 2008, Emry again saw Wagner and stated her blood tests were consistent with liver damage. *Id*. Lab tests by Emry confirmed Wagner suffered from severe alcoholism and alcoholic hepatitis. KHD Memo in Opposition to MPSJ, p. 3.

Despite Emry's advice that Wagner stop drinking in the setting of a supervised inpatient treatment, Wagner declined inpatient alcohol treatment. Rockwood's Response to MPSJ, pp. 2-3. Emry saw Wagner again on October 22, 2008, at which point he again advised Wagner to enter inpatient treatment, which she declined. Rockwood's Response to MPSJ, p. 3. Rockwood argues Wagner's attempts to wean herself from alcohol were dangerous and unreasonable given the nature of her past experiences and advice from medical providers. Rockwood's Response to MPSJ, p. 4.

Rockwood makes the Affirmative Defense, "That Plaintiff's unreasonable conduct is greater than 50% of the cause or basis for any asserted injury or harm." Answer of Brendan Mielke, M.D., and Rockwood Clinic, P.S. d/b/a Rockwood Kidney and Hypertension Center – Coeur d'Alene, p. 8, Affirmative Defense No. 3; Answer of Brendan Mielke, M.D., and Rockwood Clinic, P.S. d/b/a Rockwood Kidney and Hypertension Center – Coeur d'Alene, to First Amended Complaint, p. 10, Affirmative Defense No. 3. Osmanski claims, "Plaintiff was negligent or otherwise at fault, which proximately caused or contributed to her injuries and damages, if any, as alleged." Answer of Defendant James P. Osmanski, II, D.O. p. 9; Affirmative Defense No. 2; Answer of Defendant James P. Osmanski, II, D.O., to First Amended Complaint, p. 9; Affirmative Defense No. 2. KHD alleges, "That Plaintiff's damages may be the result of Plaintiff's own negligent conduct which was the proximate cause of injury and which may have been the proximate cause of injury and harm." Answer to Plaintiff's First Amended Compliant, p. 7, Affirmative Defense No. 1. KHD argues Wagner's decision to stop drinking without inpatient supervision and consumption of water led to her hospitalization and hyponatremia and that there is a causal connection between Wagner's alleged negligent conduct and the alleged brain injury for which she claims damages. KHD's

Memo in Opposition to MPSJ, p. 5. Strait makes no such affirmative defense of Wagner's contributory negligence.

II. STANDARD OF REVIEW.

A. Motion for Summary Judgment.

A court may properly grant a motion summary judgment only where there are no genuine issues of material fact and the moving party is entitled to judgment as a matter of law. I.R.C.P. 56(c). In determining whether any issue of material fact exists, this court construes all facts and inferences contained in the pleadings, depositions, and admissions, together with the affidavits, if any, in a light most favorable to the non-moving party. *Partout v. Harper*, 145 Idaho 683, 685, 183 P.3d 771, 773 (2008). The Court draws all inferences and conclusions in the non-moving party's favor and if reasonable people could reach different conclusions or draw conflicting inferences, then the motion for summary judgment must be denied. *Zimmerman v. Volkswagen of America, Inc.*, 128 Idaho 851, 854, 920 P.2d 67, 70 (1996).

However, if the evidence shows no disputed issues of material fact, then summary judgment should be granted. *Smith v. Meridian Joint School District No. 2*, 128 Idaho 714, 718, 918 P.2d 583, 587 (1996); *Loomis v. City of Hailey*, 119 Idaho 434, 437, 807 P.2d 1272, 1275 (1991). A mere scintilla of evidence or only slight doubt as to the facts is not sufficient to create a genuine issue for purposes of summary judgment. *Samuel v. Hepworth, Nungester & Lezamiz, Inc.*, 134 Idaho 84, 87, 996 P.2d 303, 306 (2002). The non-moving party "must respond to the summary judgment motion with specific facts showing there is a genuine issue for trial." *Id*.

In ruling on the motion, the Court considers only material contained in the affidavits and depositions which are based on personal knowledge and which would be

admissible at trial. *Samuel*, 134 Idaho 84, 88, 996 P.2d 303, 307. Summary judgment is appropriate where a non-moving party fails to make a sufficient showing to establish the existence of an element essential to its case when it bears the burden of proof. *Id.*

B. Motion to Amend Complaint to Add Claim of Punitive Damages.

A punitive damage claim must be proven at trial by clear and convincing evidence of oppressive, fraudulent, malicious or outrageous conduct by the party against whom the claim for punitive damages is asserted. I.C. § 6-1604(1). To make such a claim at trial, the party must file a pretrial motion, requesting leave of the court to amend the pleadings to include a prayer for relief seeing punitive damages. I.C. § 6-1604(2). The court shall allow the motion to amend the pleadings if, after weighing the evidence presented, the court concludes the moving party has established a reasonable likelihood of proving facts at trial sufficient to support an award of punitive damages. *Id.*

Because the decision to allow amendment of a complaint to add a claim for punitive damages is committed to the discretion of the trial court, appellate review is by an abuse of discretion standard. Where the district court acted consistent with legal standards applicable to punitive damages and reached its decision by an exercise of reason, the court did not abuse its discretion in determining not to allow the jury to consider the plaintiff's claim for punitive damages. *Polk v. Robert D. Larrabee Family Home Ctr.,* 135 Idaho 303, 315, 17 P.3d 247, 259 (2000), *citing Sun Valley Shopping Center, Inc. v. Idaho Power,* 119 Idaho 87, 94, 803 P.2d 993, 1000 (1991).

III. ANALYSIS.

A. Wagner's Motion for Partial Summary Judgment.

Wagner seeks partial summary judgment against the defendants on their comparative negligence affirmative defenses. Specifically, Wagner seeks to prevent

defendants' argument that Wagner was negligent in causing the conditions (hyponatramia; hypokalemia; seizure disorder and confusional state) giving rise for treatment by defendants. Memo in Support of MPSJ, p. 3. Wagner claims that while Idaho appellate courts have not squarely addressed the issue of comparative negligence in the medical malpractice setting, other courts have and have rejected such a defense. Memo in Support of MPSJ, pp. 3-4.

Idaho Code § 6-108 states:

> Contributory negligence or comparative responsibility shall not bar recovery in an action by any person or his legal representative to recover damages for negligence, gross negligence or comparative responsibility resulting in death or in injury to person or property, if such negligence or comparative responsibility was not as great as the negligence, gross negligence or comparative responsibility of the person against whom recovery is sought, but any damages allowed shall be diminished in the proportion to the amount of negligence or comparative responsibility attributable to the person recovering.

I.C. § 6-801.

Idaho has not addressed the defense of comparative negligence by the plaintiff patient in the context of medical malpractice. Thus, this Court turns to foreign case law. Before doing so, the Court notes that IDJI (Idaho Civil Jury Instructions) approved by the Idaho Supreme Court do not contain any instruction on the contributory negligence or comparative fault of the plaintiff patient. IDJI 2.10.1 – 2.10.3. In reviewing foreign case law, as well as the Restatements, the Court is mindful of the distinction between *causation* and *fault* in tort law. Fault relates to responsibility for the negligent act. Causation relates to whether that act was the cause in fact and proximate cause of the injury sustained. In a negligence case, a negligent act, the *fault* of one person (or more than one person), might *cause* an injury to another. In that situation, injury is the result of or is caused by the negligent actor, and thus, the negligent actor is at fault and is responsible for the damages caused. In a different case, a negligent act might not

cause the injury. For example, the injury might have pre-existed the negligent act and not have been exacerbated by the negligent act. In that situation, while there is a negligent act, the injury is not the fault of the negligent actor.

This Court is convinced that having the jury decide the issue of Wagner's comparative *fault* would be legal error. This Court concludes Wagner's comparative fault is not a proper issue to be presented to the jury. The jury will not be allowed to apportion a percentage of fault to the defendant physicians and to Wagner.

However, the issue of what *caused* Wagner's injuries is certainly an issue for the jury to decide. Thus, if the defendants have evidence that Wagner's injuries, specifically the damage to her brain, were caused even in part by the alcohol Wagner consumed prior to October 2009, or by Wagner's actions in consuming large amounts of water and other fluids, the jury will be allowed to hear such evidence and apportion *causation*.

At first blush, this distinction may seem to be without a difference. However, the effect of the distinction is profound. If Wagner's contributory fault (the extent her negligent action in over-hydrating resulted in her damages) is 50% or greater, she recovers nothing for her injuries. If the jury apportions the percentage of causation, then even if Wagner's action of over-hydrating caused more than 50% of her injuries, there is no bar to recovery. For example, if the jury apportioned causation of Wagner's injuries to Wagner's action of over-hydrating at 70%, and apportion causation of Wagner's injuries to the negligent acts of the doctors (collectively), then Wagner can still recover 30% of her injuries from the doctors.

Three cases show up continuously in the briefing submitted to this Court: *Shinholster v. Annapolis Hosp.*, 471 Mich. 540, 685 N.W.2d 275 (2004); *Krklus v.*

Stanley, 359 Ill.App.3d 471, 833 N.E.2d 952 (Ill.App.2005); and *Mercer v. Vanderbilt University, Inc.*, 134 S.W.3d 121 (Tenn.2004). The Court will address each in turn.

In *Shinholster*, the Michigan Supreme Court analyzed the issue of whether, and to what extent, Michigan law "permits a trier of fact in a medical malpractice action to consider the plaintiff's own pre-treatment negligence to offset, at least in part, the defendant's fault". 471 Mich. 540, 546, 685 N.W.2d 275, 278. In that case, the decedent's husband sued the hospital and the treating physicians for failing to recognize his wife had been experiencing "mini-strokes" prior the suffering the massive stroke which killed her. *Shinholster*, 471 Mich. 540, 547, 685 N.W. 2d 275, 278. The defendants argued the wife was comparatively negligent by not taking her prescribed blood pressure medication. The Michigan Supreme Court in *Shinholster* cited the Michigan Statute:

> Michigan Compiled Law 600.6304 states:
>
> (1) In an action based on tort or another legal theory seeking damages for personal injury, property damage, or wrongful death involving fault of more than 1 person, including third-party defendants and nonparties, the court, unless otherwise agreed by all parties to the action, shall instruct the jury to answer special interrogatories or, if there is no jury, shall make findings indicating both of the following:
> (a) The total amount of each plaintiff's damages.
> (b) The percentage of the total fault of all persons that contributed to the death or injury, including each plaintiff and each person released from liability under section 2925d, regardless of whether the person was or could have been named as a party to the action.

471 Mich. 540, 548, 685 N.W.2d 275, 279. (footnote omitted). The Michigan Supreme Court analyzed this statute and concluded "[s]ubsection 6304(1)(b) is unambiguous and calls for the trier of fact to assess by percentage "the total fault of *all* persons that contributed to the death or injury, *including each plaintiff*,"... as long as that fault constituted a proximate cause of the plaintiff's injury and subsequent damage.

Shinholster, 471 Mich. 540, 551, 685 N.W.2d 275, 281 (emphasis in original). The Court concluded that under Michigan law "if a defendant presents evidence that would allow a reasonable person to conclude that a plaintiff's negligence constituted a proximate cause of her injury and subsequent damage, the trier of fact must be allowed to consider such evidence in apportioning fault." *Shinholster*, 471 Mic. 540, 552, 685 N.W.2d 275, 281. However, the Michigan Supreme Court acknowledged its Court of Appeals reached a different decision based on out-of-state authority and specifically stated "we presume the legislators were aware of those approaches and chose to depart from them in establishing Michigan law." *Id*. The Court went on to state the wife's failure to properly take her medications did not merely "create the condition" leading her to seek treatment, but may have constituted the proximate cause of her death. *Shinholster*, 471 Mich. 540, 554, 685 N.W.2d 275, 282.

Krklus is an Illinois case against the hospital and treating physician brought by surviving spouse whose husband died from complications of a ruptured aortic dissection. 359 Ill.App.3d 471, 473, 833 N.E.2d 952, 955. The defendants sought to raise the defense of comparative negligence, alleging the husband was negligent in: failing to follow the physician's instructions to take his blood pressure medication; misinforming the physician he was taking the medication (when he wasn't); smoking cigarettes; and failing to adequately identify the site of his pain. *Id*. The Illinois Appellate Court held generally a patient's prior conduct should not be considered in assessing damages, but Illinois recognizes that exceptions exist under certain circumstances. *Krklus*, 359 Ill.App.3d 471, 480, 833 N.E.2d 952, 960. Specifically, in a medical malpractice case, a comparative negligence instruction is appropriate if a party "presents a theory of the case in which the patient's negligence precedes or is

contemporaneous with the physician's malpractice" i.e. when a patient delays in seeking treatment. *Id*. However, the Court emphasized the determination of whether comparative negligence is appropriate in a medical malpractice case must be on a case-by-case basis. *Krklus*, 359 Ill.App.3d 471, 481, 833 N.E.2d 952, 961.

The Illinois Court further acknowledged that:

> …*courts have not allowed evidence of contributory negligence in cases where a patient negligently creates the need for treatment*. However we note that courts have allowed evidence of contributory negligence in cases where the need for treatment is *independent* of the patient's negligence, but the patient's *subsequent* negligence complicates the ability of the physician to provide treatment.

Krklus, 359 Ill.App.3d 471, 482-83, 833 N.E.2d 952, 962 (emphasis added). At this point in the present case, it seems Wagner's negligent act in self-detoxing and over-hydrating caused her to present to the hospital, as the *Krklus* court stated, "…*where a patient negligently creates the need for treatment.*" Upon arrival at Kootenai Medical Center's Emergency Room, there seems to be no evidence of Wagner's "*subsequent* negligence."

As examples, the *Krklus* court noted a number of cases from other jurisdictions, many of which are cited by the parties in this case: *Harding v. Deiss*, 300 Mont. 312, 3 F.3d 1286 (2000) (comparative negligence as a defense does not apply where a patient's pre-treatment behavior, riding a horse when she knew she had asthma, merely furnishes the need for care or treatment which later becomes the subject of a malpractice claim); *Fritts v. McKinne*, 934 P.2d 371 (Okla. 1996) (plaintiff's actions prior to seeking medical treatment may be considered evidence of contributory negligence, including the plaintiff's delay in seeking medical treatment, failure to provide an accurate medical history and failure to follow the advice and instructions of a doctor); *DeMoss v. Hamilton*, 644 N.W.2d 302 (Iowa 2002) (a patient's lifestyle choices of failing to follow

the doctor's advice to stop smoking, lose weight and lower cholesterol merely created the patient's need for treatment); and *Cavens v. Zaberdac*, 820 N.E.2d 1265 (Ind.App. 2005) (a patient's smoking would merely have created the need to seek treatment but her conduct in delaying seeking treatment and overmedicating herself did not create the need for treatment but was unreasonable and complicated the ability of the doctor to treat her acute asthma attack).

In *Krklus*, the Illinois Court held the husband/decedent's negligence in failing to follow the advice of the physician to take blood pressure medication and in misinforming the physician that he had been taking that medication (when he hadn't been taking such), not only complicated the physician's *ability to treat* the husband, but the decedent's aortic dissection was directly caused by the decedent's failure to treat his hypertension with the medication he wasn't taking and misinformed his doctor about. 359 Ill.App.3d 471, 485, 833 N.E.2d 952, 964 (emphasis added). However, the Illinois Court also noted its conclusion was "firmly rooted to the specific facts at bar" and it "did not wish to imply that evidence of a patient's failure to comply with his physician's advice to improve his general health should be admissible as evidence of the patient's comparative negligence." *Id*. The Court used as an example a patient who does not heed a doctor's general direction to lose weight, stop smoking or exercise. *Id*. The Appellate Court of Illinois held:

> Finally, we note that our conclusion is firmly rooted in the specific facts of the case at bar. We do not wish to imply that evidence that of patient's failure to comply with his physician's advice to improve his general health should be admissible as evidence of the patient's comparative negligence. Surely a doctor's unheeded general directions to, for example, lose weight, stop smoking or exercise should not be considered in assessing a patient's comparative fault. However, in this case, Krklus, a patient with a serious medical condition, failed to heed Stanley's advice to take medication to control the condition and subsequently misinformed Stanley that he had, in fact, complied with the

> advice. Furthermore, here, the experts agreed that Krklus' underlying hypertensive condition was related to the development of his aortic dissection. Curran and Kopin further testified that the cause of the dissection was Krklus' failure to heed Stanley's advice to control his hypertension with medication and that, had he taken his medication, Krklus' aorta would not have dissected. Accordingly, here, where such a strong nexus exists between the negligent acts of the patient and his resulting condition and death, comparative negligence is an appropriate affirmative defense.

Id. In the present case, Wagner did not misinform the physician/defendants who treated her. While Wagner's condition presented extreme medical challenges, the Court at this time has not been presented with any evidence that Wagner's condition was masked or made more difficult to assess due to her drinking alcohol for many years and drinking copious amounts of water and other liquids in the days prior to admission.

Mercer involved a patient who was seriously injured in a vehicle accident in which he sustained a mild-to-moderate concussion and multiple facial fractures and while being treated was given sedation drugs and put on a ventilator which ran out of oxygen, causing him to sustain severe and permanent brain damage. 134 S.W.3d 121, 125-26. The treating physician and hospital sought to introduce a defense of comparative negligence related to the patient's negligence in driving while intoxicated. *Mercer*, 134 S.W.3d 121, 127-28. The Tennessee Supreme Court named a number of jurisdictions which hold "a health care provider may not reduce or avoid liability for negligent treatment by asserting that the patient's injuries were originally caused by the patient's own negligence", many of which have been cited by the parties here: *Harvey v. Mid-Coast Hosp.*, 36 F.Supp.2d 32 (D.Me. 1999) (a patient's intentional or negligence ingestion of a drug may not be compared with the physician's subsequent, negligent treatment); *Harding*, 3 P.3d 1286 (Mont. 2000); *Jensen v. Archbishop Bergan Mercy Hosp.*, 236 Neb. 1, 459 N.W.2d 178 (Neb. 1990) (a patient's failure to lose weight could

not be compared with the physician's negligence); *Eiss v. Lillis*, 233 Va. 545, 357 S.E.2d 539 (Va. 1987) (a patient's negligent ingestion of aspirin and heart medication could not be compared with the physician's negligence); *Fritts*, 934 P.2d 371 (Okla. Ct.App. 1996). The Tennessee Supreme Court also quoted the Restatement of Torts, which states, "In a case involving negligent rendition of a service, including medical services, a factfinder does not consider any plaintiff's conduct that created the condition the service was employed to remedy." Restatement (Third) of Torts: Apportionment of Liability § 7 cmt. m (2000).

However, the Tennessee Court also acknowledged a majority of jurisdictions have allowed a patient's fault to be considered in medical malpractice cases under very limited circumstances such as delay in seeking or returning for medical treatment, failure to follow a physician's advice or instructions, furnishing false, incomplete or misleading information to the physician and attempting to treat the injury before seeking medical attention. *Mercer*, 134 S.W.3d 121, 129. The Tennessee Court held, "A patient's negligent conduct that occurs *prior* to a health care provider's negligent treatment and provides only the occasion for the health care provider's *subsequent* negligence may not be compared to the negligence of the health care provider." *Mercer*, 134 S.W.3d 121, 130 (emphasis added).

In this case, all defendants set forth virtually similar arguments (except Strait, who has not made a comparative negligence defense); thus, this Court will address Rockwood's argument specifically, but extends its holding to KHD and Osmanski's arguments as well. Rockwood argues the language of I.C. § 6-801 allows comparative negligence law to apply to "all negligence actions where there is negligence attributable to the person seeking to recover", citing *Adams v. Krueger*, 124 Idaho 97, 856 P.2d 887

(Ct.App. 1991). Rockwood requests this Court give the statute its literal meaning that "all" negligence actions include medical malpractice actions and reject Wagner's request for "judicial modification of I.C. § 6-801." Rockwood Response to MPSJ, p. 5. Rockwood claims Dr. Juan Carlos Ayus (Ayus), a physician board-certified in both internal medicine and nephrology who has reviewed Wagner's pertinent medical records and depositions in the case, has opined on a more probable than not basis Wagner's alcohol abuse was the cause of her CPM and brain lesions, and concludes "Ms. Wagner's alcoholism, despite admonitions that she needed to discontinue alcohol use, and her unsupervised and unmonitored attempt to wean herself from the alcohol through copious consumption of water, were acts that directly caused the brain lesions which she asserts as damage or injury in her lawsuit." Rockwood Response to MPSJ, p. 6. Rockwood asserts Ayus will testify that her "failure to seek treatment and failure to engage in *supervised* weaning of alcohol led to her current presentation". Rockwood Response to MPSJ, p. 7. Rockwood compares Wagner's case to the examples of allowed comparative negligence in malpractice claims stated in *Mercer*, specifically instances where a patient: 1) delays in seeking or returning for medical treatment; 2) fails to follow a physician's advice or instructions; and 3) attempts to treat his or own injury before seeking medical attention. *Id*. However, a reading of the case law presented shows Rockwood's comparison to the present case is far too broad.

It is true, some jurisdictions allow for comparative negligence in medical malpractice cases when a patient delays in seeking or returning for medical treatment. However, this case is different than the situation in *Cavens*, where the patient was having an asthmatic attack and delayed in seeking treatment. Here the alleged "delay" is Wagner failing to seek in-patient treatment when it was suggested to her by Emry almost a year prior to the incident in October 2009. Wagner's failure to seek treatment

is more akin to a patient's failure to stop smoking or lose weight when advised by a physician, it is a lifestyle choice which cases such as *DeMoss* and *Jensen* do not allow comparative fault to be presented to the jury. Rockwood argues this case is not comparable to *Mercer* because, here, Wagner was "explicitly advised by medical professionals of the dangers of engaging in a risky "self-help" alcohol program." Rockwood's Response to MPSJ, pp. 7-8. There are two problems with this claim: The first is factual, the second is legal.

On a factual basis, while Emry testified he was concerned about Wagner's independent attempts to come off of alcohol without supervision or monitoring due to her history of seizures when doing so, when Emry was asked whether Emry expressed that specific concern to Wagner, Emry answered, "I don't recall". Emry Deposition, p. 16, Ll. 13-20. On multiple occasions, Emry "suggested" Wagner attend some form of treatment program. Emry Deposition, p. 15, Ll. 10-25; p. 20, L. 21 - p. 21, L. 7. That is hardly the strong "advice" given in *Krklus*, where the doctor specifically instructed the patient to take his blood pressure medication. "In this case, defendants introduced evidence that Krklus was negligent in failing to follow Stanley's medical advice to regularly take medication to control his blood pressure." 359 Ill.App.3d 471, 482, 833 N.E.2d 952, 961. In *Krklus*, the doctor's instruction was a command for treatment, compounded by the decedent's deception in response to that command. In the present case, Emry's testimony appears to show in-patient treatment was a suggestion. Furthermore, there was no testimony by Emry that he warned her of the risks of ingesting massive amounts of water. The only reason Emry gave for suggesting or recommending inpatient treatment was "…because of the risk of withdrawing from alcohol could be dangerous." Emry Deposition, p. 44, Ll. 4-9. It is hard to imagine that a suggestion, made by a

doctor almost a year prior to the incident, regarding a lifestyle choice, *where there is no strong evidence Wagner was specifically warned about the dangers of self-help weaning*, rises to the level of negligence required by the above cases to warrant submitting the issue of comparative negligence to the jury in this case.

The fact that Emry did not warn Wagner of the specific risks of de-toxing on her own (just the general warning that it could be dangerous) and the fact that Emry did not discuss at all the risks of de-toxing by drinking copious amounts of water are more important to this Court than the fact that Emry "suggested" or "recommended" inpatient de-toxing to Wagner, rather than ordering/directing/commanding her into inpatient treatment. This is due to the physician/patient relationship. The fact that the decedent in *Krklus* was ordered or directed as opposed to suggested or recommended in the present case is of limited importance to this Court. Although the decedent in *Krklus* was ordered or directed, the fact remains *Krklus* could not be forced to take his medication. The Court is mindful that, short of a commitment proceeding, no physician could have *forced* Wagner to take any specific action in the years and months prior to October 2009. Emry testified as to this fact:

> Q. What was your response to her suggestion that she could do it on her own?
>
> A. I suppose that she – I would have believed that she was in a precontemplative state of change, which means that she was not ready to accept a treatment program. And, you know, being free to do as she wishes, that's – you know, I don't have the ability to compel her to do treatment at this point.

Emry Deposition, p. 16, Ll. 5-12.

All defendants specifically cite and discuss *Shinholster* as persuasive argument to this Court to allow comparative negligence in this case. However, *Shinholster* is distinguishable for one important reason, the language of the Michigan statute. The

Michigan Supreme Court in *Shinholster* specifically noted its holding was contrary to out-of-state authority but was permissible given the language of the statute included the phrases "all persons" and "including each plaintiff." 471 Mich. 540, 553, n, 8, 685 N.W.2d 275, 282, n. 8. Idaho Code § 6-801 does not have this same language. That statute simply says comparative negligence shall not bar recovery in an action by "any person", without specifically including plaintiffs. While the two statutes seem at first glance to be similar, this different language calls for a different result under the Michigan statute, as compared to the Idaho statute and statutes in most other states. Also, *Shinholster* is distinguishable because the wife's negligence lay in her failure to take her prescribed blood pressure medication; whereas, here, Wagner's alleged negligence is failure to follow up on her doctor's "suggestion" to go through inpatient detox, when the real harm seems to be caused by the over-hydrating, an issue not discussed by Emry.

If Wagner's actions of long-term drinking or the way in which she over-hydrated herself caused her any injury, and thus any damage, for which Wagner seeks recompense, Wagner should not recover damages for such injuries. However, this Court finds that such result is due to *causation* and not *fault*. That distinction has a significant difference. First, as mentioned above, the practical effect of that is that defendants in this case are not allowed to avail themselves of the 50% absolute bar due to a plaintiff's comparative fault in Idaho. If the issue comes down to causation, and the jury believes that the defendants' malpractice caused less than 50% of her damage, then Wagner would still recover, but only in proportion to the extent the defendants' malpractice *caused* her injury and her damage. Second, if the jury is unable to apportion Wagner's injuries and her damage, but still finds the defendants to have committed malpractice which to some extent (but where the jury cannot agree on the percentage of that extent) caused those injuries and damages, then defendants are

liable for all damages. Idaho Jury Instruction IDJI 9.02, discusses "Aggravation of pre-existing condition" and reads:

> A person who has a pre-existing condition or disability is entitled to recover damages for the aggravation of such preexisting condition, if any, that is proximately caused by the occurrence. The person is not entitled to recover damages for the pre-existing condition or disability itself.
>
> If you find that before the occurrence causing the injuries in this case the plaintiff had a preexisting bodily condition or disability, and further find that because of the new occurrence in this case the pre-existing condition or disability was aggravated, then you should consider the aggravation of the condition or disability in fixing the damages in this case. You should not consider any condition or disability that existed prior to the occurrence, or any aggravation of such condition that was not caused or contributed to by reason of this occurrence.
>
> You are to apportion, if possible, between the condition or disability prior to this occurrence and the condition or disability caused by this occurrence, and assess liability accordingly. If no apportionment can reasonably be made by you, then the defendant is liable for the entire damage.

IDJI 9.02, citing *Blaine v. Byers,* 91 Idaho 665, 429 P.2d 405 (1967); *Bushong v. Kamiah Grain Growers,* 96 Idaho 659, 534 P.2d 1099 (1975).

Wagner's actions that led up to her presenting at the hospital needing emergency critical care were certainly "negligent." Negligence is defined as "failure to use ordinary care in the management of one's property or person". IDJI 2.20. "Ordinary care" means "the care a reasonably careful person would use under circumstances similar to those shown by the evidence." *Id.* "Negligence may thus consist of the failure to do something which a reasonably careful person would do, or the doing of something a reasonably careful person would not do, under circumstances similar to those shown by the evidence." *Id.* Wagner's actions in becoming an alcoholic were arguably negligent, her decision to not follow Emry's advice was negligent, and her decision to detox by overhydrating was negligent. It would seem that many, if not most, emergency room admissions are due to negligent actions, maybe grossly negligent actions and criminal actions. This would run the continuum from the person who has a gradual degradation

from otherwise good dietary habits which eventually results in obesity, to the person who becomes an alcoholic over time, to the thief who is shot and injured by law enforcement, to the person who is unsuccessful in a suicide attempt. All are negligent or worse. All should expect good medical care when they present with an emergency situation, and none should have their negligent (or worse) pre-admission actions be offset against a doctor's negligence when they do not get good medical care, especially when their negligent action was the percipient event for that care.

To hold otherwise would present two different standards for all health care providers and hospitals. One standard of providing high care and attention to those who presented with an illness (not of their own making), or who were injured at the hand of a third party (a car accident where they were not to any degree at fault). This population then would be the only ones allowed to sue for medical malpractice and fully recover for the damage caused. The other standard would be a lowered standard of care, or at least escaping liability in whole or in part for providing a lowered standard of care (negligence), when the person was injured due to their own negligence or contracted an illness due to their own negligence. The continuum of when to allow contributory negligence in this dual standard provides absurd results. If a person had travelled to a foreign land where the person knew there was a risk of contracting a rare (and expensive to treat) illness, and contracted a rare illness, then any malpractice claim involved in treating that rare illness would be reduced by their own percentage of fault for intentionally travelling to a place where they were put at risk. Does it matter if the purpose of travel was: their job where they had no choice; as part of a volunteer humanitarian effort where they had choice but travel was for noble purpose; or for a bachelor party? A person who grew up in Libby, Montana, and who knew of the risk of asbestosis due to the mine yet failed to move, would be at the lower level of care, but

the ignorant citizen of that same town would recover fully if malpractice were later committed.

To hold as Rockwood, Mielke and Osmanski urge, this Court would carve out a safe harbor in tort law *for only medical providers in a medical malpractice claim*. Would what they urge not apply to legal malpractice? If a criminal defense attorney failed to investigate witnesses who would have provided exculpatory evidence which would have prevented the death penalty being imposed, are we going to allow as a defense against his heirs in the legal malpractice trial that the jury be allowed to offset the award due to the fact that the person was a criminal? Do we allow a civil attorney to defend his malpractice case by saying, "Yes, I botched their wills by completely failing to consider the tax ramifications, but this elderly couple wouldn't have had to come see me in the first place if they'd have been responsible by using trusts to plan their financial matters in their earlier years"?

Why wouldn't what Rockwood, Mielke and Osmanski urge apply to general tort law (outside all malpractice)? Are they then willing to live in a world where a person, driving an old Ford Pinto, sitting at a stop light, is engulfed in flames when his or her car is hit from behind by an intoxicated driver in his new one-ton pickup driving 40 miles per hour, and the inebriated driver escapes liability because the driver of the Pinto knew it was unsafe, yet too poor to purchase anything else?

Where would we draw the line? Contrary to Rockwood's claim that Wagner is asking this Court for a "judicial modification of I.C. § 6-801" (Rockwood Response to MPSJ, p. 5), it is Rockwood that is asking this Court to make a radical and unfounded departure from Idaho law, the law from other jurisdictions, logic, and common sense.

Another impossible problem to overcome is the defendant physicians (except for Strait) are asking this Court to allow the jury to compare that which is absolutely

incapable of being *compared*. These physicians are asking this Court to allow the jury to compare their fault and negligence as physicians who have a special standard of care, with the fault and negligence of Wagner who must simply exercise reasonable care. Because the standards of care are different, it is simply not possible to compare the negligence of the physicians against the negligence of Wagner. Wagner's standard of care was to use ordinary care for her own safety and for the safety of the defendants. IDJI 2.00.2. Wagner did not use ordinary care for her own safety in making the choices she made that resulted in her needing emergency medical care, but once she presented for medical care, there is no evidence she failed to use ordinary care for her own safety, and there is absolutely no evidence that she harmed any of the defendants. Thus, even using simple duty of care standards, and applying that standard to the physicians as well, the concept of contributory fault in the present case makes no sense. Wagner did nothing wrong, was not at fault, was not negligent, upon her arrival at the hospital and all times thereafter. But the defendant physicians have a different and much more stringent standard of care as compared to Wagner.

> A health care provider undertaking the treatment or care of a patient has a duty to possess and exercise that degree of skill and learning ordinarily possessed and exercised by other health care providers of the same or similar specialty practicing in the community in which such care is provided. It is further the duty of health care providers to use reasonable care and diligence in the exercise of their skill and the application of their learning.

IDJI 2.10.1. The defendant physicians have a duty to not fall below the standard of skill and learning practiced by others in their specialty in their community. That standard of care simply does not apply to Wagner.

Finally, these physicians are asking this Court to allow the jury to compare the fault of Wagener with the fault of the physicians, when the fault, the actions of the parties, took place at completely different times. There is no temporal connection to the

respective fault of the parties. Wagner was negligent in the extent of her alcohol consumption, according to Emry she was negligent in not entering inpatient treatment and she was negligent in not detoxing in a supervised setting, and she was negligent in the quantity of liquids she consumed. None of Wagner's actions or inactions took place after she had her seizure. Thus, all of Wagner's actions or inactions to took place at a different time as compared to the physicians.

The cases above are persuasive law and under the facts of this case set before the Court, Wagner's motion for summary judgment regarding the affirmative defense of comparative negligence must be granted. It should be noted this does not preclude the defendants from arguing causation. Wagner realizes this fact. "In this case, the Defendants, following subsequent Motions for Summary Judgment and/or Motions in Limine, may be free at trial to offer limited evidence of Plaintiff's pre-treatment conduct on the issues of causation and/or damages, but any presentation of evidence or argument on the comparative negligence defenses should be barred." Memorandum in Support of Plaintiff's Motion for Partial Summary Judgment, p 6.

KHD additionally argues Wagner's motion is premature as this is a "hypothetical evidentiary argument" and should be brought as a motion in limine before trial, rather than a motion for summary judgment. Defendant KHD's Memorandum in Opposition to Motion for Partial Summary Judgment, pp. 6-7. However, the affirmative defense of comparative negligence has been made by most of the defendants in this case and, as it is legal argument, is appropriately brought as a motion for summary judgment. *Galloway v. Walker,* 140 Idaho 672, 675, 99 P. 3d 625, 628 (Ct.App. 2004), makes it clear the issue can be brought to the Court's attention either as a motion for summary judgment *or* as a motion in limine.

For the reasons stated above, this Court must grant summary judgment in favor of Wagner that no claims of comparative fault will be submitted to the jury. If there is evidence that some or all of Wagner's injuries (and thus, damages) were caused by her own conduct, the jury will be instructed to apportion causation similar to a pre-existing condition. Truly, such would be a pre-existing condition because if such existed, it existed the moment she arrived at the hospital seeking care.

B. Wagner's Motion to Amend Complaint to Allow Claim of Punitive Damages.

Wagner seeks leave of this Court to allow her to amend her complaint to add a claim of punitive damages. Before pleading punitive damages in a complaint, I.C. § 6-1604 requires the plaintiff demonstrate to the court a "reasonable likelihood of proving facts at trial sufficient to support an award of punitive damages." I.C. § 6-1604(2). At trial, the plaintiff must prove by clear and convincing evidence, oppressive, fraudulent, malicious or outrageous conduct, by the party against whom the claim is asserted. I.C. § 6-1604(1).

The decision whether or not to submit the question of punitive damages to a jury rests within the trial court's sound discretion. *Hoglan v. First Security Bank of Idaho N.A.,* 120 Idaho 682, 687. 819 P.2d 100, 105 (1991); *Polk v. Robert D. Larrabee Family Home Ctr.,* 135 Idaho 303, 315, 17 P.3d 247, 259 (2000), *citing Sun Valley Shopping Center, Inc. v. Idaho Power,* 119 Idaho 87, 94, 803 P.2d 993, 1000 (1991).

Wagner's motion pertains only as to her claims against Mielke. Memorandum in Support of Plaintiff's Motion for Leave to File Second Amended Complaint to Allege a Claim for Punitive Damages, p. 2. Wagner claims Mielke's conduct was "willful or reckless misconduct" under I.C. § 6-1604. *Id.,* p. 9.

As is frequently the case, the medical expert retained by Wagner has a different

opinion than that of the expert retained by Mielke. It would be rare to find a medical malpractice case where the opinions of the experts involved were not divergent.

However, as explained below, this Court finds that in order for Wagner to be allowed to amend her complaint to add a claim of punitive damages, the opinions held by Mielke and his expert would need to be more than just divergent with Wagner's expert; the opinions of Mielke and his expert would essentially need to be *unfounded*.

The Court finds those opinions would need to be unfounded because Wagner must prove Mielke's actions were "an extreme deviation from reasonable standards of conduct, and that the act was performed by [Mielke] with an understanding of, or disregard for, its likely consequences." *Seininger Law Office, P.A. v. North Pacific Ins. Corp.,* 145 Idaho 241, 250, 178 P.3d 606, 615 (2008); *Cheney v. Palos Verdes Investment Corp.,* 104 Idaho 897, 905, 665, 661, 669 (1983). Mielke must have committed a "bad act" and had a "bad state of mind." *Myers v. Workmen's Auto Ins. Co.,* 140 495, 503, 95 P.3d 977, 985 (2004). The bad state of mind is defined as "an extremely harmful state of mind, whether that be termed malice, oppression, fraud or gross negligence; malice, oppression, wantoness; or simply deliberate or willful." *Seininger,* 145 Idaho 241, 250, 178 P.3d 606, 615; *Cheney,* 104 Idaho 897, 905, 665, 661, 669. "Willful and/or reckless" under the statute has been defined by the Idaho Supreme Court as actions "taken under circumstances where the actor knew or should have known that the actions not only created an unreasonable risk of harm to another, but involved a high degree of probability that such harm would actually result." IDJI 2.25; *citing DeGraff v. Wight,* 130 Idaho 577, 579, 944 P.2d 712, 714 (1997); *Hunter v. Horton,* 80 Idaho 475, 479, 479, 333 P.2d 459, 462 (1958); *Johnson v. Sunshine Mining Co., Inc.,* 106 Idaho 866, 873, 684 P.2d 268, 275 (1984). The Court lacks

sufficient evidence at this time to find Mielke and his expert's opinions are *unfounded*.

Wagner's expert is Richard Sterns, M.D., (Sterns), a board certified nephrologist. Affidavit of Richard Sterns, M.D., p. 2, ¶ 1. In his affidavit, Sterns states the local and national standard of care in Coeur d'Alene, Idaho, in October 2009 called for a maximum rate of correction of serum sodium concentration in a hyponatremic patient, of no greater than 10-12 mEq/L over the first 24 hours of treatment after the lowest sodium value and 18 mEq/L over a 48-hour period. *Id.,* pp. 7-8, ¶ 17. Sterns states that in 2007, the recommendations of an expert panel, of which he was part of, were published in the American Journal of Medicine, and Sterns attached those Guidelines to his Affidavit. *Id.,* p. 8, Exhibit B. Sterns stated:

> The Guidelines were developed from a comprehensive review of prior studies and case reports documenting the association of Central Pontine Myelinolysis (CPM) and Extrapontine Myelinolysis (EPM), also known as "Osmotic Demyelination Syndrome" (ODS) with the rapid elevation of sodium in patients with chroninc hyponatremia. In the publication, we recommended that in patients with risk factors that increase the likelihood of developing ODS, the rate of correction should be kept well below the above limits. Alcohol dependence is a serious risk factor for the development of IDS following a rapid elevation of the serum sodium concentration. Subsequent to the publication of the Guidelines, researchers have advocated for a rate of correction in high risk patients that is considerably slower than the Guidelines. See Adrogue and Madias, *The Challenge of Hyponatremia*, Journal of the American Society of Nephrology, 23: 1140-1148 (advocating for a rate of correction of 6-8 mEq/L over 24-hours of treatment); 2012, attached hereto as Exhbiit "C" and incorporated herin by this reference.
>
> 18. With a patient like Ms. Wagner, who presented to the Kootenai Medical Center emergency department on October 18, 2009 with chronic hyponatremia, a long history of alcohol dependence and an initial sodium value of 103 mEq/L (severe hyponatremia), one must consider the patient at extremely high risk for the development of ODS unless sodium replacement is managed carefully to avoid an excessive rate of correction. Because of the patient's severe hyponatremia, seizure risk and symptoms, the use of hypertonic saline for a short period of time to accomplish an initial sodium elevation of 4-6 mEq/L over 4-6 hours followed by the immediate discontinued use of hypertonic saline may be indicated. However, the maximum rate of correction over 24 hours must not be exceeded for risk of causing severer and often irreversible brain damage to the patient. Limits on the rate of correction of hyponatremia

> constituted nation and community standards of care in October, 2009. Standards of care calling for caution in the replacement of sodium in high risk patients, have been taught at all major medical schools and have been thoroughly disseminated in numerous textbooks, articles and publications for a period of over twenty years. All physicians trained in the treatment of hyponatremic patients are expected to understand and apply these standards of care.

Id., pp. 8-9, ¶ 18. If the last two sentences of Sterns' opinion are indeed the accepted local and national standard of care, then Wagner is likely entitled to amend her complaint to add a claim for punitive damages.

The problem at this point in the litigation is the local and national standard of care is in dispute, each side claiming a wholly different standard. Mielke and his expert both claim a rate of correction *more than double* the less conservative rate (no greater than 10-12 mEq/L over the first 24 hours of treatment after the lowest sodium value and 18 mEq/L over a 48-hour period) set forth by Sterns (the more modern and conservative maximum rate set forth by Sterns is 6-8 mEq/L over 24-hours of treatment). Sterns' opinion appears at this time only by his affidavit, and has not been subject to the crucible of cross-examination. All the Court has at present are two wildly divergent opinions on the standard of care. In her motion, Wagner must convince this Court she has a reasonable likelihood of proving at trial that Mielke's conduct was "an extreme deviation from reasonable standards of conduct, and that the act was performed by [Mielke] with an understanding of, or disregard for, its likely consequences" (*Seininger* 145 Idaho 241, 250, 178 P.3d 606, 615), and at this point in time, "reasonable standard of conduct" is hotly disputed.

Mielke testified that he understood the risk of CPM from the rapid elevation of sodium of a hyponatremic patient. Mielke deposition, p. 38, Ll. 14-23. Mielke testified he believed the appropriate replacement rate was 25 millequivalents or less in 48 hours. *Id.,* p. 39, L 10 – p. 40, L. 1, Affidavit of Brendan Mielke, M.D., p. 3, ¶ 6. Mielke

based that on a 1986 or 1987 article in the New England Journal of Medicine. *Id.,* p. 23, L. 6 – p. 24, L. 4.

Mielke's expert is Allen Arieff, M.D. (Arieff). Arieff is board certified in internal medicine and nephrology. Affidavit of Allen Arieff, M.D., p. 2, ¶ 1. Arieff is a professor of medicine emeritus at University of California San Francisco. *Id.,* ¶ 2. The focus of Arieff's clinical practice, teaching, lecturing, research and publications relates to the proper care and treatment of hyponatrimia (low sodium levels). *Id.,* ¶ 3. Arieff spoke with an (unidentified) Idaho nephrologist. *Id.,* ¶ 4. Arieff stated:

> This physician further indicated it is his belief that most nephrologists in the local community titrated and calibrated sodium replacement in symptomatic patients depending upon the patient's symptoms, co-morbid conditions, and with recognition of a suggested maximum of sodium replacement of approximately 25 mmol/L over the first 48 hours of treatment.

Id. Arieff concludes: "There is no clear, scientific evidence supporting Dr. Sterns' advocated guidelines of limiting sodium resuscitation to certain levels at 24 and 48 hours." *Id.,* p. 4, ¶ 14.

Again, for Wagner to prevail on her motion to add a claim for punitive damages, she must convince this Court she has a reasonable likelihood of proving at trial that Mielke's conduct was "an extreme deviation from reasonable standards of conduct, and that the act was performed by [Mielke] with an understanding of, or disregard for, its likely consequences." *Seininger* 145 Idaho 241, 250, 178 P.3d 606, 615. However, at present the "reasonable standard of conduct" is disputed, each side presenting wildly differing opinions, and each side supporting those wildly differing opinions with well-credentialed experts. Without the benefit of deposition testimony and cross examination of these experts, the Court is unable to determine which experts are more believable, let alone whether the opinion of Arieff and Mielke are unfounded.

Wagner's expert, Sterns, in his affidavit discusses the evidence which sheds light on Wagner's condition when she presented to Kootenai Medical Center, but his affidavit does not discuss if or how her condition might affect the maximum rate at which sodium should be replaced. Sterns' affidavit gives more of a bright line maximum rate which applies to all conditions.

In addition to claiming a standard more than double Wagner's expert (Sterns), Mielke's expert (Arieff) states the patient's condition is very important, specifically, whether the patient's hyponatremia is chronic or acute is very important. Sterns states his review of the medical records show Wagner presented to Kootenai Medical Center with "chronic hyponatremia." Affidavit of Richard Sterns, M.D., p. 8, ¶ 18. Arieff states:

> 8. Chronic hyponatremia involves a patient who has low serum sodium levels for at least 48 hours prior to a medical assessment or symptoms. Conversely, acute hyponatremia speaks to a discrete event causing abnormally low sodium levels in the patient. Symtomatic [sic] hyponatremia speaks to a patient with low sodium levels who presents with a variety of symptoms from the low sodium. These symptoms can be variable but often include neurological symptoms like tremors, confusion, altered consciousness, speech abnormalities, and communication deficits.
>
> 9. Ms. Wagner's presentation to KMC on October 18, 2009 included confusion, prior seizures, difficulty communicating, and the symptoms were the neurologic effects of hyponatremia. The characterization of Ms. Wagner's hyponatremia as being chronic is unsubstantiated in the records. Dr. Chun testified in his deposition that there was no information suggestion [suggesting] Ms. Wagner had low sodium for 48 hours prior to the presentation. Ms. Wagner's neurological symptoms existed briefly before and then at the time of the hospital presentation before sodium treatment was started.

Affidavit of Allen Arieff, M.D., p. 3, ¶¶ 8-9. Thus, not only do the experts disagree as to the reasonable standard of care (maximum rate of sodium replacement) applicable to Mielke, they disagree as to whether Wagner's hyponatremia upon presentation at Kootenai Medical Center was chronic, and they disagree as to whether chronic hyponatremia even makes a difference as to the applicable standard of care (maximum rate of sodium replacement).

The Court cannot conclude at this time that Wagner has a reasonable likelihood of proving at trial that Mielke's actions were "an extreme deviation from reasonable standards of conduct, and that the act was performed by [Mielke] with an understanding of, or disregard for, its likely consequences." *Seininger,* 145 Idaho 241, 250, 178 P.3d 606, 615. Accordingly, Wagner's motion for leave to amend her complaint to add a claim of punitive damages must be denied. This issue can be raised again at a later time, but at present, the Court does not have sufficient information to grant Wagner's motion. Essentially, this Court would need to find that not only are the experts' opinions divergent, but that the only physicians walking the face of the earth that have the opinion espoused by Mielke and Arieff are Mielke and Arieff. The Court cannot make that finding at the present time.

IV. CONCLUSION AND ORDER.

For the reasons stated above,

IT IS HEREBY ORDERED Wagner's Motion for Partial Summary Judgment is GRANTED, no claims of comparative fault will be submitted to the jury.

IT IS FURTHER ORDERED Wagner's Motion for Leave to File Second Amended Complaint to Allege a Claim for Punitive Damages is DENIED.

Entered this 21st day of May, 2013.

_____
John T. Mitchell, District Judge

Certificate of Service

I certify that on the _____ day of May, 2013, a true copy of the foregoing was mailed postage prepaid or was sent by interoffice mail or facsimile to each of the following:

Lawyer	Fax #	Lawyer	Fax #
Eric S. Rossman	208-342-2170	Robert F. Sestero, Jr.	509-455-3632
Michael Ramsden	664-5884	Patrick E. Miller	664-6338
Matthew F. McColl	208 780-3930		

_____
Jeanne Clausen, Deputy Clerk