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STATE OF MICHIGAN

IN THE SUPREME COURT

LYNDA DANHOFF and DANIEL DANHOFF,

Plaintiffs-Appellants,

v.

DANIEL K. FAHIM, M.D.,
MICHIGAN HEAD & SPINE INSTITUTE

Defendants-Appellees,

and

* DANIEL K. FAHIM, M.D., P.C.,
* KENNETH P. D'ANDREA, D.O., and
* WILLIAM BEAUMONT HOSPITAL, d/b/a BEAUMONT HOSPITAL – ROYAL OAK*,
Jointly and Severally,

Defendants.

Supreme Court Case No.

Court of Appeals No: 352648

Oakland County Circuit
Lower Court No: 18-166129-NH

*denotes dismissed from the case

PLAINTIFFS-APPELLANTS' SUPPLEMENTAL APPENDIX TO BRIEF

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PLAINTIFFS-APPELLANTS'
SUPPLEMENTAL APPENDIX TO BRIEF

EXHIBIT W

2023 WL 2394638
Only the Westlaw citation is currently available.
United States District Court, E.D. Kentucky,
Central Division.
(at Lexington).

Judith COLLINS, Individually and as Executor of the Estate of Michael N. Collins, Plaintiff,

v.

UNITED STATES of America, Defendant.

Civil Action No. 5: 22-008-DCR

Signed March 7, 2023

Attorneys and Law Firms

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Callie R. Owen, AUSA, Cheryl D. Morgan, AUSA, Tiffany Konwiczka Fleming, AUSA, U.S. Attorney's Office, Lexington, KY, for Defendant.

MEMORANDUM OPINION AND ORDER

Danny C. Reeves, Chief Judge

***1** Plaintiff Judith Collins filed this medical negligence action on behalf of herself and her late husband's estate under the Federal Tort Claims Act. Michael Collins was a veteran of the United States Army who received medical care at the Lexington, Kentucky VA Medical Center ("VAMC") and an affiliated outpatient care center in Hazard, Kentucky. The plaintiff contends that the VAMC was negligent by failing to provide Collins with low dose computed tomography ("LDCT") screenings for lung cancer, which he succumbed to in January 2020. However, the undersigned concludes that the defendant is entitled to summary judgment because the plaintiff has not raised a genuine issue of material fact indicating that the VA breached the applicable standard of care.

I.

Michael Collins was 67 years old when he passed away on January 19, 2020. He had a history of smoking a pack of cigarettes per day for 47 years. His other chronic health conditions included low back pain, mixed hyperlipidemia, hypertension, and chronic obstructive pulmonary disease. [*See* Record No. 38-5.] As a resident of Whitesburg, Kentucky, Collins received primary care services at a VA outpatient clinic in Hazard, Kentucky. Additionally, he visited the VAMC in Lexington on occasion. Primary care physician Renuka Reddy, M.D., ordered a chest x-ray in September 2014 due to Collins' history of smoking. The x-ray report noted "clear chest" and "no acute cardiopulmonary pathology." [*See* Record No. 38-12, p. 10.]

Collins saw primary care provider John Furcolow, M.D., in May 2015. He had no new complaints at that time. Furcolow made note of Collins' smoking history, the clear chest x-ray in 2014, and encouraged Collins to stop smoking. Collins saw Furcolow again in February 2016 for a follow-up visit regarding his chronic medical problems. Furcolow noted that Collins wanted a "repeat" chest x-ray. Furcolow educated Collins regarding smoking cessation; however, Collins declined assistance. Collins received a chest x-ray on March 18, 2016, which was again noted as "clear chest." [*See* Record No. 38-6, pp. 4-5.]

Collins began treatment with primary care provider Billy Banks, D.O., at the Hazard VA, on July 31, 2017. [*See* Record No. 38-9.] Banks noted that Collins was still smoking one pack of cigarettes per day. Collins wanted to quit smoking and Banks dispensed gum for Collins' nicotine dependence. Collins denied shortness of breath, coughing, or wheezing. Collins followed up with Banks in April 2018 and reported that he had cut down to one-half pack of cigarettes per day. *Id.* p. 4. He had no acute complaints and again denied shortness of breath, coughing, or wheezing. Banks continued to encourage smoking cessation. There is some dispute regarding whether Banks encouraged Collins to have additional lung screenings during this time.[1]

***2** Collins followed up with Banks again in January 2019.

He reported that he was still smoking one-half pack of cigarettes each day and was not ready to quit smoking completely at that time. *Id.* at 6. And Banks continued to encourage Collins to stop smoking. Collins saw Kim Gayheart, APRN, in June and July 2019, complaining of coughing and congestion. During these appointments, Collins denied chest pain, shortness of breath on exertion, or wheezing.

Collins returned to see Banks on August 16, 2019. During this examination, he complained of coughing and wheezing, which had improved, but denied having any shortness of breath. Banks prescribed medication for Collins' cough. Collins returned for a follow up visit with Banks on September 30, 2019, at which time Collins reported that his breathing had returned to a baseline level. He also denied chest pain, shortness of breath, coughing, or wheezing. Banks again urged Collins to stop smoking and offered assistance regarding his nicotine dependence. But Collins advised Banks he did not want to quit completely at that time. Collins returned for an appointment with Banks in October 2019 to discuss his blood pressure. He again denied shortness of breath, coughing, and wheezing.

Collins presented to the Lexington VAMC emergency department with transient neurological deficits in December 2019. He subsequently was admitted to the Lexington VAMC and diagnosed with atrial fibrillation, treated with blood thinner, and discharged. Soon thereafter, Collins began coughing up small amounts of blood and returned to the emergency department where a CT scan revealed a lung mass. Collins underwent a bronchoscopy with endobronchial ultrasound and endobronchial biopsy for the right lower lobe mass at the Lexington VAMC on January 16, 2020. After returning home from the procedure that evening, he went to the Whitesburg Appalachian Regional Hospital ("ARH") because he began coughing up blood.

Whitesburg ARH transferred Collins to the Lexington VAMC *via* ambulance on the morning of January 17, 2020. Shortly after his arrival, he began having massive hemoptysis with significant respiratory distress and was emergently intubated. Providers found that Collins had a clot sitting on the lung mass. The results from his bronchoscopy/biopsy came back as stage IIIc or IVa squamous cell carcinoma. On January 19, 2020, Collins was transferred to the University of Kentucky Medical Center. He died that day due to a large volume pulmonary hemorrhage.

In 2013, the U.S. Preventive Services Task Force ("Task Force") recommended annual screenings for lung cancer with LDCTs in 55 to 80-year-olds with a thirty-pack-year smoking history who currently smoke or had quit within the past 15 years. [Record Nos. 38-10, p. 5; 38-12] The American Cancer Society issued similar recommendations for the first time that year. [Record No. 38-10, p. 6] The VA created a "shared decision making document" entitled "Screening for Lung Cancer" in April 2014. The document outlines the Task Force's recommendations for annual screenings. [*Id.* at 8; 38-3] However, it is unclear if, how, and to whom it was distributed. In February 2015, the Centers for Medicare and Medicaid Services issued a decision memorandum adopting similar recommendations regarding lung cancer screening with LDCTs. *Id.* In August 2016, the VA's National Leadership Council "approved recommendations for lung cancer screening with [LDCTs]."

The Lexington VAMC began the process of purchasing a machine capable of performing LDCTs in 2016. *Id.* p. 12. It was installed in 2017 and "became operational" in February 2018. *Id.* In September 2018, the VA held a preplanning meeting for implementation of LDCT lung cancer screening. The following month, a VA summit was held to further discuss how to implement the LDCT screenings. The Lexington VA then considered a software purchase to "accomplish the tracking that is necessary when you [are] doing lung cancer screening." *Id.* LDCT lung cancer screenings first became available at the Lexington VAMC in January 2019.[2] *Id.* at 13.

***3** The plaintiff contends that, had Collins' primary care physicians provided LDCT lung cancer screenings, his cancer would have been detected earlier, he could have received more conservative interventions and treatment options, extending his life, and preventing subsequent complications that led to his death. Accordingly, she asserts a medical malpractice claim against the United States under the Federal Tort Claims Act ("FTCA"), 28 U.S.C. § 2671 *et seq.* The United States has moved to exclude the testimony and opinions of the plaintiff's expert witnesses or, in the alternative, for summary judgment.

II.

Rule 702 of the Federal Rules of Evidence governs the admission of expert testimony. Under Rule 702, a court should only admit relevant expert testimony if "(1) the testimony is based upon sufficient facts or data, (2) the testimony is the product of reliable principles and methods, and (3) the witness has applied the principles and methods reliably to the facts of the case." District

courts act as gatekeepers to exclude any testimony that is not relevant or reliable. *See Kumho Tire Co., Ltd. v. Carmichael*, 526 U.S. 137, 145 (1999) (citing *Daubert v. Merrell Dow Pharms., Inc.*, 509 U.S. 579 (1993)). Rule 702 applies regardless of whether the trier of fact is a judge or a jury. *UGI Sunbury LLC v. A Permanent Easement for 1.7575 Acres*, 949 F.3d 825, 832 (3d Cir. 2020) (observing that Rule 702 employs broader "trier of fact" language compared to Rule 403, which refers to "misleading the jury"); *Ky. Waterways All. v. Ky. Utils. Co.*, 539 F. Supp. 3d 696, 710 (E.D. Ky. 2021).

Summary judgment is appropriate if there is no genuine dispute with respect to any material fact and the moving party is entitled to judgment as a matter of law. Fed. R. Civ. P. 56(a). In other words, the moving party must show the absence of a genuine issue of material fact concerning an essential element of the opposing party's action. *See Celotex Corp. v. Catrett*, 477 U.S. 317, 323 (1986). In reviewing a motion for summary judgment, the Court must view all facts and draw all reasonable inferences in a light most favorable to the nonmoving party. *See Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 587-88 (1986). The moving party has the initial burden to show that there is no genuine issue of material fact, but once the moving party has met its burden, the nonmoving party must demonstrate that there is sufficient evidence from which the finder of fact could render a verdict in its favor. *See Celotex Corp.*, 477 U.S. at 324.

III.

The allegedly negligent acts occurred in the Commonwealth of Kentucky, so the substantive law of Kentucky applies in this case. *See Ward v. United States*, 838 F.2d 182, 184 (6th Cir. 1988); 28 U.S.C. § 1346(b). To establish medical malpractice under Kentucky law, the plaintiff must prove, by expert testimony: (1) the standard of care recognized by the medical community, as applicable to the particular defendant; (2) that the defendant departed from the standard of care; and (3) that the defendant's departure from the standard of care was a proximate cause of the plaintiff's injuries. *Heavrin v. Jones*, 2003 WL 21673958, at *1 (Ky. Ct. App. July 18, 2003).

The plaintiff presents the opinions and testimony of John Daniel, M.D., to establish the applicable standard of care. Daniel is a board certified internist with 42 years of experience. He works as a primary care provider in Virginia, but also remotely oversees occupational health clinics in Tennessee and Kentucky. Daniel provided a report that makes reference to the U.S. Preventive Service Task Force's 2013 recommendation regarding annual LDCTs for high risk individuals. He went on to state that the VA "adopted the same screening guidelines in 2014" and that Collins' primary care physicians' failure to order or recommend this testing from 2015 through 2019 "was a breach of the standard of care for reasonably prudent primary care providers." [Daniel Report, Record No. 38-13, p. 2]

***4** Daniel was questioned extensively regarding the standard of care during his deposition. He clarified that the 2013 Task Force recommendation did *not* establish the standard of care. Instead, it merely gave recommendations and "started the process rolling because of the federal bureaucracy to get an implementation." [Record No. 38-12, p. 17] In other words, the Task Force recommendations "could be the goal, but they're not going to set the standard."

When asked to provide his basis for concluding that the VA adopted the Task Force recommendations in 2014, Daniel responded:

> I got it from an article that was written about, when they did it, they said they adopted a medical form, I could find out different things, National Cancer Screening Utilization Trends and Veterans Administration lung cancer screening by geography. There's various other articles that the VA wrote that was 2014, and then they had an article that was here that was a JAMA article that said that they had approved, they underwent the reviews and those dates are in there as well for that article, that's implementation of lung cancer screening by the Veteran's Health Administration. So they were working on getting a protocol set together from 2013 to 2015.

Id. p. 10. Daniel went on to cite the 2014 shared decision making document, which he characterized as a "handout that was directed at patients rather than physicians." *Id.* at 11. He then testified that the VA National Leadership Council approved the recommendation for lung cancer screening with LDCTs in August 2016, although Daniel admitted he "[had] no idea how they decide things or implement things."[1] *Id.*

Courts rely on medical experts to provide information regarding the applicable standard of care. *Blair v. Eblen*, 461 S.W.2d 370, 373 (Ky. Ct. App. 1970). Kentucky law provides the guiding principle, however, that physicians are required to use knowledge, skill and care as is exercised by reasonable physicians under the same or similar circumstances. Evidence of the standard of care "may include the elements of locality, availability of

facilities, specialization or general practices, proximity of specialists and special facilities as well as other relevant considerations." *Id.*

While medical experts certainly may provide opinions based on their own training and experience, they may not provide opinions or testimony based on naked conclusions or unsupported facts. *See Kumho Tire Co., Ltd.*, 526 U.S. at 157 (noting that courts are not required to admit evidence that is connected to data only by the *ipse dixit* of the expert); *Ferguson v. United States*, 2016 WL 11784204 (W.D. Ok. Sept. 20, 2016) (declining to simply accept physician's opinion and observing that even a qualified physician must explain how his experience leads to his standard of care conclusions); *West v. United States*, 502 F. Supp. 3d 1243, 1251 (M.D. Tenn. 2020) (applying Tennessee law, explaining that experts must indicate how they are familiar with the standard).

***5** Daniel has not pointed to any facts supporting his assertion that the accepted standard of care for reasonable primary care providers during the relevant period was to order yearly LDCTs for patients like Collins. First, Daniel did not testify that he ordered such tests for his own patients. Further, he did not discuss the screening practices of other primary care providers in Kentucky or elsewhere. Daniel also failed to address how the availability of LDCTs impacted the standard of care. He appeared to suggest that the Lexington (and possibly Hazard) VAMC was lagging behind its private counterparts by failing to offer LDCTs in 2015 through 2019. However, Daniel failed to provide any information about whether LDCTs were available elsewhere in the community or in more remote locations. He conceded that he was unaware of whether the University of Kentucky Medical Center, a leading research hospital in the state, possessed the technology to perform this testing. [Record No. 38-12, p. 12] His vague assertion that "there are other places that were doing them at that time" is insufficient to establish that performing LDCTs was the standard of care. *See id.*

Although it is the plaintiff's burden to prove the standard of care through expert testimony, the Court also notes that the VA physicians' testimony suggests that yearly LDCTs were not the generally accepted standard of care at the relevant time. Jeffrey Honeycutt, M.D., is a radiologist at the Lexington VAMC and was instrumental in bringing LDCTs to that facility. Honeycutt explained that, prior to 2019, "[i]t was very hard to find any hospital systems or imaging establishments that could offer that service, especially in a timely fashion." [Record No. 35, p. 77] Collins' treating physician Billy Banks also did not recall LDCTs being available in the community until 2019.[1] [Record No. 29, pp. 48, 65]

Contrary to Daniels' assertion, Honeycutt's admission that annual LDCTs "are the best way that modern society has to catch early developing lung cancers in heavy smokers" does not establish that that LDCTs were required by the standard of care. [*See* Record No. 38, p. 19.] "A physician has the duty to use the degree of care and skill expected of a competent practitioner *of the same class and under similar circumstances.*" *Hyman & Armstrong, P.S.C. v. Gunderson*, 279 S.W.3d 93, 113 (Ky. 2008) (emphasis added). For that reason, factors such as locality, availability of facilities, and other circumstances are taken into consideration. As Daniel recognized in his deposition, recommendations set by bodies of medical experts may constitute goals but do not necessarily set the standard of care when all practical considerations are taken into account. *See Smith v. Bama Urgent Medicine, Inc.*, 2012 WL 13088764, at *7 (N.D. Ala. Feb. 29, 2012) (observing that American Cancer Society recommendations regarding colon cancer screening did not reflect the predominant standard of care).

Because the plaintiff has failed to raise a genuine issue of material fact regarding the standard of care for lung cancer screening with LDCTs from 2015 through 2019, the defendant is entitled to summary judgment.

IV.

Based on the foregoing analysis and discussion, it is hereby

ORDERED that the United States' motion for summary judgment [Record No. 36] is **GRANTED.**

All Citations

Slip Copy, 2023 WL 2394638

Footnotes

1 Banks did not remember a specific conversation with Collins but stated that his practice was to order LDCT lung cancer screenings for high risk patients when they became available at the VAMC. He could not recall exactly when they became available. Banks

remembered Collins as someone who did not like to travel to Lexington for tests and believed that he declined the test when it was offered. However, Banks did not document this information in his treatment notes.

2 The government's corporate designee, Jeffrey Honeycutt, M.D., discussed at length why the VA could not just "start doing scans" upon obtaining the machine. [Record No. 38-10, pp. 19-20]

3 During his deposition, Daniel also cited a 2022 article from the Annals of Internal Medicine, which he did not mention in his report. According to Daniel, this article includes a recommendation from the American College of Physicians-Internal Medicine "to keep doing the screening." [Record No. 38-12, p. 21] Daniel did not explain how the information presented in the article would inform the standard of care that existed from 2015 through 2019. It does not appear that the plaintiff has provided a copy of the article.

4 Dr. Furcolow testified that an LDCT "could be done in the community" in February 2016, but it is unclear whether he meant that LDCTs were actually available in the community or simply that veterans could be referred out to private providers for procedures that were unavailable at the VA. [Record No. 31, p. 20]

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EXHIBIT X

2023 WL 5837501
Only the Westlaw citation is currently available.
United States District Court, S.D. Georgia, Savannah Division.

Joel GREENE, Plaintiff,
v.
BOARD OF REGENTS OF the UNIVERSITY SYSTEM OF GEORGIA, et al., Defendants.

CIVIL ACTION NO.: 4:21-cv-277
|
Signed September 8, 2023

Attorneys and Law Firms

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Jason H. Kang, Georgia Attorney General's Office, Atlanta, GA, Peter F. Fisher, Georgia Department of Law, Atlanta, GA, for Defendants Board of Regents of the University System of Georgia, Georgia Department of Corrections, Dr. Olatunji Awe, P.A. Hall.

ORDER

R. STAN BAKER, UNITED STATES DISTRICT JUDGE

***1** Plaintiff Joel Greene brought this case in the State Court of Chatham County, Georgia, after his infected toe fell off while he was incarcerated at Coastal State Prison. (Doc. 1, pp. 30–45.) Plaintiff's remaining claims are (1) a medical malpractice claim asserted against Defendants Board of Regents of the University System of Georgia ("BOR"), the Georgia Department of Corrections ("GDC"), Physician Assistant ("P.A.") Latoya Hall, and Dr. Olatunji Awe; and (2) an Eighth Amendment deliberate indifference claim asserted against Hall in her individual capacity pursuant to 42 U.S.C. § 1983.[1] There are numerous motions presently before the Court: (1) GDC's Motion for Summary Judgment and BOR's Motion for Partial Summary Judgment, which have been consolidated and briefed together, (docs. 90); (2) Hall's Motion for Summary Judgment, (doc. 92); (3) GDC, BOR, and Hall's Motion to Exclude portions of the opinions of Plaintiff's expert, Dr. Robert Powers, (doc. 93); and (4) Plaintiff's Consolidated Motion for Partial Summary Judgment, Motion to Exclude the Opinions of Defendants' Experts, and Motion to Reconsider the Order dismissing Plaintiff's federal claims asserted against Awe, (doc. 100). The issues have been fully briefed. (Docs. 91, 92-2, 93, 100-1, 135–40, and 145–50.)

For the reasons stated below, the Court **GRANTS** GDC's Motion for Summary Judgment as to the claims asserted against GDC, (doc. 90), **DENIES** BOR's Motion for Partial Summary Judgment as to Plaintiff's claims based on Dr. Arlene Wilson's alleged negligence, (id.), **DENIES** Hall's Motion for Summary Judgment, (doc. 92), **DENIES as moot** BOR, GDC, and Hall's Motion to Exclude portions of Plaintiff's proffered expert's opinion, (doc. 93), **GRANTS in part and DENIES in part** Plaintiff's Motion for Partial Summary Judgment, (doc. 100), **GRANTS in part and DENIES in part** Plaintiff's Motion to Exclude certain portions of Defendants' experts' opinions, (id.), and **DENIES** Plaintiff's Motion for Reconsideration, (id.).

BACKGROUND

I. Factual History

A. Plaintiff's Medical Issues and 2017 Amputations

Plaintiff is a former state prisoner who was confined at Coastal State Prison (the "Prison") beginning in 2017 through at least December 2019. (Doc. 137-1, p. 1; doc. 138-1, p. 2.) Plaintiff suffers from several chronic medical conditions, including Type II diabetes and peripheral vascular disease ("PVD"). (Doc. 137-1, pp. 1–2; doc. 138-1, p. 2.) In October 2017, Plaintiff was hospitalized for treatment of diabetic foot ulcers on his left foot, and ultimately had his big toe, pinky toe, and a portion of the side of his foot amputated. (Doc. 137-1, pp. 6–7.) After the amputations, Plaintiff underwent surgery to have several stents placed into the arteries in his left leg because his left superficial femoral artery was occluded

(i.e., clogged) and inhibiting his foot's ability to heal. (Id. at p. 7.)

B. Plaintiff's Medical Issues Culminating in the Autoamputation of His Left Second Toe in June 2019

(1) Plaintiff's "Sick Call" on April 23 with Nurse Gatewood

*2 On April 19, 2019, Plaintiff noticed that his entire left food had swollen up overnight due to an abrasion/opening that had formed on the top of his left second toe. (Id. at p. 9.) Plaintiff put in a "sick call" request and was seen by nurse Melissa Gatewood on April 23. (Id.) Gatewood's notes for the visit indicate that Plaintiff had a "small open area" on the left second toe and that "pedal pulses [were] present." (Id.; doc. 108-1, p. 31.) Gatewood assessed Plaintiff as having "possible cellulitis." (Doc. 108-1, p. 31; doc. 122, p. 24.) Under the "disposition" section of the notes, Gatewood checked the "urgent" box and listed the date "4/23/19," (doc. 108-1, p. 31), which she testified meant that Plaintiff was to be seen by an advanced level provider ("ALP") that same day, (doc. 122, pp. 26, 28–29).

(2) Plaintiff's Appointment with Dr. Awe on April 25 or 26

Awe, the Prison's medical director, saw Plaintiff on April 25 or April 26. (Doc. 137-1, pp. 5, 10.) Awe testified that Plaintiff's left food had a "little sore" on it as well as "some redness" and "some warmth," the latter two of which are "clinical features of [ ] an infection, cellulitis." (Id. at p. 10 (quoting doc. 119, pp. 22, 51).) Awe also testified that Plaintiff's "peripheral pulses were good." (Doc. 119, p. 23.) Awe knew at the time that Plaintiff had PVD, had suffered prior amputations to the same foot, and had received stenting to restore blood flow to that foot. (Doc. 137-1, p. 10; see doc. 119, p. 24.) Awe prescribed Plaintiff daily bandage changes, ten days of Clindamycin (an oral antibiotic) for the infection, and Lasix (a water pill) for the swelling. (Doc. 137-1, p. 11; see doc. 107-1, p. 14.) Awe additionally scheduled Plaintiff to return to the clinic in three weeks. (Doc. 137-1, p. 11; see doc. 107-1, p. 14.)

(3) Plaintiff is Seen by Dr. Wilson on May 3 and May 16

Plaintiff returned to the Prison's medical center on May 3 and was seen by Dr. Arlene Wilson. (Doc. 137-1, p. 12.) At that point, Plaintiff had been on Clindamycin for nine days without improvement, and his second toe had developed a "superficial ulcer." (Id. (quoting doc. 108-1, p. 30).) Wilson knew that Plaintiff had PVD and prior amputations to his left foot but did not think it was necessary to urgently refer him to a vascular surgeon for arterial studies because Plaintiff had "palpable peripheral pulses," his skin was "warm to touch," his "capillary refill was normal," and there was "no necrosis." (Id. (quoting doc. 121, p. 32); doc. 121, p. 70.) Instead, Wilson discontinued Clindamycin, placed Plaintiff on different antibiotics, and ordered daily bandage changes.[2] (Id.)

Although Wilson told Plaintiff that he would be scheduled for a follow-up appointment within four to five days, Wilson did not see Plaintiff until May 16 (thirteen days later). (Doc. 137-1, pp. 12–13; see doc. 108-1, p. 29.) Wilson's notes from the visit indicate that Plaintiff's toe was still infected, describe the skin on his foot as "red," and list the degree of control of Plaintiff's PVD as "fair." (Doc. 108-1, p. 29; doc. 137-1, p. 13; doc. 121, pp. 49, 52.) Because Plaintiff's foot was not healing, Wilson requested that Plaintiff be referred to an outside wound care clinic on an urgent basis. (Doc. 137-1, p. 13.) Wilson testified that she did so because the Prison "only had certain types of dressings" and "sometimes you need special dressings in order to clear up a wound infection." (Doc. 121, p. 35.) Wilson further testified that she referred Plaintiff to wound care—instead of a vascular surgeon or specialist—"on the assumption that there was adequate blood flow to [Plaintiff's] extremity." (Id. at p. 36; see id. (stating that, in general, if she had seen a patient who lacked a "palpable pulse," indicating "restricted blood flow to the extremity," she "would not have referred them to wound care" because wound care "wouldn't have been able to help [the patient] in that situation").) Awe signed off on Wilson's wound care referral after discussing it with her and, thus, knew that Plaintiff's toe had not improved. (Doc. 137-1, p. 14.) Neither Awe nor Wilson ever referred Plaintiff to a vascular surgeon because of Plaintiff's May 16 visit. (Id.)

(4) Plaintiff's Visit to the Wound Care Clinic on May 29

*3 Plaintiff saw Dr. Douglas Hanzel at St. Joseph's Candler Center for Hyperbarics & Wound Care on May

29, 2019. (Doc. 137-1, p. 21.) This was the first time that Plaintiff had seen an outside provider about his toe. (Id.) Hanzel's records state that Plaintiff's left foot had no palpable pulse, a weak dorsalis pedis pulse with doppler, and no posterior tibial pulse with doppler. (Doc. 119-2, p. 12; see doc. 119, pp. 28, 35.) Hanzel described Plaintiff's wound as an "open diabetic ulcer" that was worsening due to "poor circulation." (Doc. 119-2, p. 15.) He further stated that the toe looked like it was almost autoamputated, and he noted that "there [was] tendon exposed," a "large amount of serosanguineous drainage," and "a medium (34-66%) amount of necrotic tissue within the wound bed." (Doc. 137-1, p. 22 (quoting doc. 119-2, pp. 12, 15, 17).) Hanzel also stated that Plaintiff "surely will need another vascular eval[uation]" because he suspected Plaintiff "may not have adequate circulation to heal [his] toe ulcer." (Id. (quoting doc. 119-2, p. 18).) Plaintiff testified that Hanzel told him his toe was "dead" and that Plaintiff needed to see a vascular surgeon about getting it amputated. (Doc. 118, pp. 46, 48; see doc. 92-4, p. 202 (medical encounter form dated June 5, 2019, which indicates that Plaintiff said he was told by the wound clinic to follow up with "vascular" to have an amputation).) However, Hanzel's records do not contain any information about what Hanzel personally told Plaintiff. (See generally doc. 119-2, pp. 10–31.)

(5) Plaintiff's Interactions with P.A. Hall on May 30 and June 5

Following Plaintiff's meeting with Hanzel, he was scheduled for a May 30 follow-up appointment with P.A. Hall. (Doc. 137-1, p. 23; doc. 138-1, p. 6 (admitting that Hall was supposed to see Plaintiff "as a follow up from an outside provider consult[ation]").) When an inmate is sent to an outside facility for a consultation, they have a follow-up with a provider at the Prison upon their return. (Doc. 138-1, pp. 6–7.) According to Hall, the purpose of these follow-ups is to ensure that the outside provider's directions are noted and followed by the Prison's medical unit and its providers. (Doc. 92-4, p. 4.)

Plaintiff and Hall had not interacted prior to the May 30 appointment, (doc. 138-1, pp. 5–6; doc. 92-4, p. 3), but Hall knew that Plaintiff had a history of PVD, that his toe was infected, and that he had been sent to the wound care clinic, (doc. 137-1, p. 23). The encounter form from May 30 states that Hall saw Plaintiff for a "consult" and "sick call." (Doc. 108-1, p. 19.) The form also indicates that no orders or follow-up plan were available from the wound clinic, but that Hall had requested such records. (Id.) Additionally, Hall noted in the form that Plaintiff would be scheduled to be seen once the records were received from the wound clinic. (Id.; see doc. 92-4, p. 4.) The form does not indicate that Hall evaluated Plaintiff's toe. (See doc. 108-1, p. 19.) Furthermore, Hall testified that she does not remember whether she viewed his foot or whether Plaintiff complained to her about the status of his toe on May 30. (Doc. 120, pp. 19–20.)

Plaintiff's account of the May 30 encounter with Hall is markedly different. According to Plaintiff, he "sat in the front room for five and a half hours ... and ... caught [Hall] as she was leaving out the door," at which point she told him, "Oh, I don't got anything for you to do today and I got to go eat lunch, bye." (Doc. 118, p. 49; see also id. at p. 94 (stating that Hall "blew [him] off completely").) Hall testified that she "did not tell [Plaintiff] that [she] would not treat his wound because [she] had to eat lunch," but rather, as documented in the encounter form, "took steps to obtain the orders from the wound care clinic ... to make sure the treatment of the wound would be consistent with the specialist's plan and instructions." (Doc. 92-4, p. 4.)

Plaintiff's second encounter with Hall occurred on the afternoon of June 5. That day, Plaintiff was sent to Augusta State Medical Prison ("ASMP") for a CAT scan follow-up related to his renal cancer. (Doc. 137-1, p. 25.) Plaintiff saw Hall when he returned to the Prison that afternoon as a follow-up to his visit to ASMP. (Id.; doc. 138-1, p. 11; doc. 120, p. 21.) According to Plaintiff, Hall told him that she still did not have any information from wound care, at which point he took off his shoe, which was full of blood, and said, "let's do something about this." (Doc. 118, p. 52.) Plaintiff testified that Hall responded, "Oh I guess we ought to do something about that," and they went to the Prison's E.R. to have the dressings changed. (Id. at pp. 52–53.) Plaintiff testified that, when the nurse unwrapped it, Hall said, "Don't be showing me shit like that, it will make me lose my lunch." (Id. at p. 53.) Hall concedes that Plaintiff showed her his foot and she examined it on June 5. (Doc. 120, p. 22.) However, Hall denies that she made the statement about her lunch and insists that her interaction with Plaintiff "was limited and as documented" in the medical encounter form from June 5 (discussed below). (Doc. 92-4, p. 6.)

***4** The medical encounter form Hall completed on June 5 states that Plaintiff was seen "last week for [a follow-up] to wound care," but that "no plan was on the chart." (Doc. 108-1, p. 15.) The form further notes that "[Plaintiff] stated he was told by [the] wound clinic that he was supposed to [follow-up] [with] Vascular to have an amputation." (Id.) The form indicates that Hall put

Plaintiff back on oral Clindamycin,[3] and ordered him to follow-up with the wound care clinic in two weeks. (Id.) Hall indicated on the encounter form that she instructed Plaintiff to "ask [the] wound clinic about vascular referral on his next visit." (Id.) Finally, the form states that "wound orders [were] written" and contains a notation to "see orders." (Id.) On a contemporaneous "Physician's Orders" form, Hall wrote that the wound clinic ordered the following: change dressings daily, cleanse with mild soap and water, and apply Aquacel Extra, dry gauze, and tape. (Doc. 92-4, p. 204; doc. 138-1, p. 16.)

Hall filled out a consultation request which states, "Please schedule an [appointment] to see wound clinic in 2 weeks." (Doc. 92-4, p. 206; doc. 138-1, pp. 16–17.) Awe approved the appointment. (Doc. 138-1, p. 17.) Neither Hall nor Awe referred Plaintiff to a vascular surgeon on June 5. (Doc. 137-1, pp. 28–29.) Hall testified that "[t]here was no referral to a vascular surgeon or vascular specialist in the wound care clinic records, and so [she] did not request or inquire about such a referral at that time." (Doc. 92-4, p. 5; see doc. 120, pp. 36 (noting that the wound clinic "didn't necessarily directly say that [Plaintiff] needed to go to see the vascular surgeon").) Hall also testified that she was "kind of following wound care's lead in terms of not referring him to a vascular [herself]," that she transcribed the wound clinic's orders because they are the "specialists," and she was only seeing him for a follow-up. (Doc. 120, pp. 35–36.)

(6) Plaintiff's Toe Autoamputates on June 7 and is Surgically Amputated on June 8

Plaintiff's toe fell off while he was in bed on the morning of June 7, and he was taken to the hospital later that day. (Doc. 137-1, pp. 29, 31.) The hospital performed an arterial Doppler which revealed that Plaintiff's left superficial femoral artery ("SFA") was completely occluded. (Doc. 137-1, p. 31; see doc. 108-1, p. 12.) Plaintiff was operated on the following day to have the remainder of the toe amputated. (Doc. 137-1, p. 31; doc. 108-1, p. 11.) A record from the hospital visit describes Plaintiff's injury as "partial amputation on left 2nd toe" and states that the amputated toe tested positive for MRSA. (Doc. 108-1, p. 11.) On June 10, Plaintiff underwent a revascularization surgery involving, *inter alia*, the following "[o]perative procedures": "[l]eft lower extremity angiogram"; "balloon angioplasty" of the left common femoral artery and the left profunda artery origin; and a "stent dilation" of the left SFA. (Doc. 115-1, p. 17.) The notes from the procedure indicate that the procedure improved blood flow and that Plaintiff had palpable pulses post procedure. (Id. at pp. 17–18.)

C. Pertinent Facts About Defendants and the Interagency Agreement

GDC and BOR (collectively, the "State Defendants") are entities of the State of Georgia. (Doc. 1, p. 161; doc. 137-1, p. 32.) The Prison is owned and operated by GDC. (Doc. 137-1, p. 6.) Augusta University, whose medical school is called the Medical College of Georgia ("MCG"),[4] is a unit of BOR. (Doc. 1, p. 161; doc. 137-1, p. 32.)

***5** In 1997, GDC and BOR, the latter acting on behalf of MCG, entered an "Interagency Agreement" in which MCG agreed "to deliver comprehensive healthcare to all GDC prisoners."[5] (Doc. 117-3, p. 1.) The title page of the "Scope of Services" section of the Interagency Agreement contains the heading, "Georgia Correctional HealthCare (GCHC)," and states, at the bottom of the page, "A partnership between [GDC]/[MCG]." (Id. at p. 6; see also id. at p. 8 (referring to the "MCG/GDC Partnership").) Georgia Correctional HealthCare is a "department within Augusta University." (Doc. 1, p. 161; doc. 137-1, p. 32.) According to the Medical Director for GDC, Sharon Lewis, "GCHC served as the vendor to provide all physical health care services in the [state's correctional] facilities." (Doc. 126, pp. 4, 30.)

At all relevant times, Hall has been employed by GCHC while working as a member of the Prison's medical staff. (Doc. 138-1, p. 3; doc. 92-4, p. 2; see doc. 139-3 (letter stating that Hall's "employment with GCHC" was scheduled to begin in October 2015).) Hall worked under the supervision of Awe and Wilson. (Doc. 138-1, p. 4; doc. 137-1, p. 5.) Awe began working at the Prison in 1999 and he, too, has been an employee of GCHC at all relevant times. (Doc. 137-1, p. 36; see doc. 139-2, p. 1 (Awe's offer for employment with GCHC).) Wilson served as a locum tenens physician at the Prison for about six months.[6] (Doc. 137-1, p. 36.) She was assigned to this position by a staffing agency, Consilium Staffing, LLC ("Consilium"). (Doc. 137-1, p. 37; doc. 139-1, pp. 3–4; see doc. 121, pp. 11–12; see also doc. 119, pp. 12–13.) Wilson testified that she worked for and was paid by Consilium, but that Consilium did not direct or guide her job performance. (Doc. 121, pp. 75–76.) In her role as a locum tenens physician at the Prison, Wilson had to comply with the Standard Operating Procedures ("SOPs") promulgated by GDC. (Doc. 137-1, p. 37.)

II. Procedural History

On August 18, 2021, Plaintiff filed this suit in the State Court of Chatham County against Defendants BOR, GDC, Awe, and Hall (collectively, "Defendants").[7] (Doc. 1, pp. 30–47.) Plaintiff originally brought a state law negligence claim against Defendants collectively and a Section 1983 deliberate indifference claim against Awe and Hall in their individual capacities. (Id. at pp. 41–43; see also doc. 35, pp. 7–8 (clarifying the nature of Plaintiff's Section 1983 claims).) Defendants Awe and Hall then moved to dismiss Plaintiff's Section 1983 claims. (Doc. 34.) In its August 1, 2022, Order (the "Order"), the Court dismissed the claim against Awe but allowed the claim against Hall to proceed. (Doc. 64.) Accordingly, Plaintiff's remaining claims are the negligence claim asserted against all Defendants and the Section 1983 deliberate indifference claim asserted against Hall in her individual capacity.

***6** There are numerous motions pending before the Court. GDC has moved for summary judgment on Plaintiff's claim against it on the ground that it did not employ any of the persons who provided medical care to Plaintiff. (Docs. 90, 91.) BOR similarly has moved for partial summary judgment as to any claim against it based upon Wilson's alleged misconduct on the grounds that it did not employ Wilson. (Docs. 90, 91.) Hall requests summary judgment as to Plaintiff's deliberate indifference claim against her, arguing, *inter alia*, that Plaintiff did not have an objectively serious medical need and that Hall was not subjectively aware of and did not disregard a substantial risk of serious harm. (Docs. 92, 92-2.) Plaintiff, for his part, requests summary judgment on various discrete issues pertinent to his negligence claim, including that Awe, Hall, and Wilson were all employed by GCHC and that GCHC violated the standard of care when its employees failed to refer him to a vascular surgeon. (Docs. 100, 100-1.) Plaintiff also seeks summary judgment that GCHC is a "joint enterprise" of GDC and BOR, and therefore the alleged negligence of GCHC's employees—Awe, Hall, and (according to Plaintiff) Wilson—is imputable to BOR *and* GDC. (Doc. 100-1, pp. 11–13.)

In addition, the parties have moved to exclude certain expert opinions. Specifically, Plaintiff moves to exclude the opinions of Defendants' experts, Drs. Thomas Horn and Thomas Fowlkes, related to the standard of care, whether the standard of care was violated, and causation. (Doc. 100-1, pp. 20–22.) GDC, BOR, and Hall have moved to exclude certain statements contained in the amended report of Plaintiff's expert, Dr. Robert Powers, for being conclusory, irrelevant, and outside the scope of proper expert testimony. (Doc. 93.) Finally, Plaintiff asks the Court to reconsider its Order dismissing Plaintiff's deliberate indifference claims against Awe. (Doc. 100-1, pp. 22–26.)

STANDARD OF REVIEW

Summary judgment "shall" be granted if "the movant shows that there is no genuine dispute as to any material fact and that the movant is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(a). A fact is "material" if it "might affect the outcome of the suit under the governing law." FindWhat Inv'r Grp. v. FindWhat.com, 658 F.3d 1282, 1307 (11th Cir. 2011) (quoting Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 248 (1986)). A dispute is "genuine" if the "evidence is such that a reasonable jury could return a verdict for the nonmoving party." Id.

The moving party bears the burden of establishing that there is no genuine dispute as to any material fact and that it is entitled to judgment as a matter of law. See Williamson Oil Co. v. Philip Morris USA, 346 F.3d 1287, 1298 (11th Cir. 2003). Specifically, the moving party must identify the portions of the record which establish that there are no "genuine dispute[s] as to any material fact and the movant is entitled to judgment as a matter of law." Moton v. Cowart, 631 F.3d 1337, 1341 (11th Cir. 2011). When the nonmoving party would have the burden of proof at trial, the moving party may discharge his burden by showing that the record lacks evidence to support the nonmoving party's case or that the nonmoving party would be unable to prove his case at trial. See id. (citing Celotex Corp. v. Catrett, 477 U.S. 317, 322–23 (1986)). If the moving party discharges this burden, the burden shifts to the nonmovant to go beyond the pleadings and present affirmative evidence to show that a genuine issue of fact does exist. Anderson, 477 U.S. at 257.

In determining whether a summary judgment motion should be granted, a court must view the record and all reasonable inferences that can be drawn from the record in a light most favorable to the nonmoving party. Peek-A-Boo Lounge of Bradenton, Inc. v. Manatee Cnty., 630 F.3d 1346, 1353 (11th Cir. 2011) (citing Rodriguez v. Sec'y for Dep't of Corr., 508 F.3d 611, 616 (11th Cir. 2007)). Thus, the Court will view the record and all reasonable inferences that can be drawn therefrom in Plaintiff's favor. However, "facts must be viewed in the light most favorable to the non-moving party only if there

is a 'genuine' dispute as to those facts." Scott v. Harris, 550 U.S. 372, 380 (2007). "[T]he mere existence of some alleged factual dispute between the parties will not defeat an otherwise properly supported motion for summary judgment; the requirement is that there be no genuine issue of material fact." Id. (citation and emphasis omitted).

DISCUSSION

I. Whether Liability for Plaintiff's Tort Claim May be Imputed to GDC and/or BOR

A. Overview of Sovereign Immunity, the Georgia Tort Claims Act, and the Parties' Arguments Concerning Imputing Liability to the State Defendants

*7 In this case, Plaintiff seeks to hold BOR and GDC liable for Awe, Wilson, and Hall's allegedly negligent treatment of his infected toe. (Doc. 1, pp. 41–43.) As entities of the state of Georgia, BOR and GDC have sovereign immunity which can only be waived by a constitutional provision or "an Act of the General Assembly that specifically provides that sovereign immunity is thereby waived and the extent of such waiver." Ga. Const. art. I, § II, para. IX(e). "The Georgia Tort Claims Act ('GTCA') is one such Act and provides for a limited waiver of sovereign immunity for the torts of State employees while acting within the scope of their employment." Ga. Dep't of Transp. v. Wyche, 774 S.E.2d 169, 172 (Ga. Ct. App. 2015); see O.C.G.A. § 50–21–23(a) (providing that the state "shall be liable for such torts in the same manner as a private individual or entity would be liable under like circumstances"). The GTCA "constitutes the exclusive remedy for any tort committed by a state officer or employee." O.C.G.A. § 50–21–25(a). For purposes of the GTCA, "[s]tate officer or employee" means "an officer or employee of the state ... and persons acting on behalf or in service of the state in any official capacity, whether with or without compensation, but the term does not include an independent contractor doing business with the state." O.C.G.A. § 50–21–22(7). Plaintiff, as the party seeking to benefit from the waiver of sovereign immunity, bears the burden of proving that the GTCA's waiver applies to his claims against the State Defendants. Coosa Valley Tech. Coll. v. West, 682 S.E.2d. 187, 190 (Ga. Ct. App. 2009). To meet that burden, Plaintiff must prove that Awe, Wilson, and Hall—the medical personnel whom Plaintiff contends were negligent—were state officers or employees and that they were "acting within the scope of their official duties or employment" at the time of their alleged misconduct. Id. at 191.

Plaintiff has attempted to meet that burden by showing that Awe, Wilson, and Hall were all employees of GCHC, which, he contends, is a "joint enterprise" of BOR and GDC. (Doc. 100-1, p. 11–15; doc. 139, pp. 2–8.) Therefore, according to Plaintiff, BOR and GDC are jointly liable for the negligent acts and omissions committed by all three individuals within the scope of their employment under the GTCA. (Doc. 139, pp. 3–4; doc. 100-1, p. 13.) GDC generally contends that its sovereign immunity has not been waived because it did not employ any of the individuals who provided care to Plaintiff and because the GTCA permits only a single entity of the State to be sued for the alleged tort of a state employee. (Doc. 91, pp. 6–7; doc. 137, p. 3.) According to GDC, "[s]overeign immunity ... has not been waived for a claim against another state entity on the basis of a common law claim of joint enterprise." (Doc. 137, p. 3.) BOR, for its part, argues that it has sovereign immunity from claims based on Wilson's conduct because she was not an "employee" of the State under the GTCA. (Doc. 91, pp. 7–10.)

B. Whether Liability May be Imputed to BOR for Awe, Hall, and/or Wilson's Conduct

(1) BOR's sovereign immunity is waived for Awe and Hall's conduct because they were employees of GCHC (and thus BOR).

It is undisputed that "Awe and Hall were employees of *GCHC*–Awe since 1999 and Hall since 2015." (Doc. 137-1, p. 36 (emphasis added).) BOR further concedes that it was the employer of the medical personnel working for GCHC because GCHC "is a department within Augusta University, which is a unit of the BOR." (Doc. 91, p. 7.) Accordingly, the Court finds that BOR's sovereign immunity is waived for any negligent acts taken by Awe and Hall during the course of their employment, and liability for such acts is imputable to BOR. Plaintiff's Motion is therefore **GRANTED** on this issue.

(2) There is a genuine dispute of fact concerning Wilson's employment status, which precludes summary judgment as to BOR's potential liability and entitlement to sovereign immunity.

Both the State Defendants and Plaintiff request summary judgment with respect to Dr. Wilson's employment status. Plaintiff contends that Wilson was an "employee" of GCHC (and therefore BOR), not an "independent contractor" under the GTCA, and, therefore, the GTCA's waiver of sovereign immunity applies to BOR. (Doc. 100-1, pp. 13–15; doc. 139, pp. 4–8.) The State Defendants, in contrast, contend that Wilson was not an "employee" of BOR because GCHC did not control the material aspects of her job, and, accordingly, BOR has not forfeited its immunity pursuant to the GTCA. (Doc. 91, pp. 7–10.)

The GTCA defines a state officer or employee as "an officer or employee of the state ... and persons acting on behalf or in service of the state in any official capacity, whether with or without compensation, but the term does not include an independent contractor doing business with the state." O.C.G.A. § 50-21-22(7). In Williams v. Department of Corrections, 481 S.E.2d 272 (Ga. Ct. App. 1997), the Georgia Court of Appeals observed that the 1991 version of the GTCA did not define the term "independent contractor," but "under the Code's general contract provisions, an independent contractor is one who 'exercises an independent business and ... is not subject to the immediate direction and control of the employer.' "[8] Id. at 275 (quoting O.C.G.A. § 51-2-4 (1997)). "The chief test to be applied in determining whether a person is employed as a servant or as an independent contractor ... [is] whether the contract gives, or the employer assumes, the right to control the time, manner, and method of the performance of the work, as distinguished from the right merely to require certain definite results in conformity with the contract." Id. (quoting Bowman v. C.L. McCord Land, etc., Dealer, 331 S.E.2d 882, 883 (Ga. Ct. App. 1985)); see also Royal v. Ga. Farm Bureau Mut. Ins. Co., 777 S.E.2d 713, 715 (Ga. Ct. App. 2015). The Georgia Court of Appeals has additionally outlined numerous factors to assist courts in determining whether an employer has the right to control the time, manner, and method of a physician's work. See Harris v. City of Chattanooga, 507 F. Supp. 365, 367–73 (N.D. Ga. 1980) (canvassing dozens of Georgia appellate court decisions and articulating several factors which Georgia courts consider to make this determination). These factors include the employer's right to "direct the work step-by-step," to inspect the individual's work, to control their time, and the "method of payment." Id. at 369–72. These factors have been applied and elaborated upon in the hospital context. See, e.g., Lee v. Satilla Health Servs., 470 S.E.2d 461, 462–63 (Ga. Ct. App. 1996); Cooper v. Binion, 598 S.E.2d 6, 9 (Ga. Ct. App. 2004).[9]

***8** It is undisputed that Wilson was assigned to work as a locum tenens physician at the Prison by Consilium, a staffing agency. (Doc. 137-1, pp. 36–37; doc. 139-1, pp. 3–4.) However, the precise nature of Wilson's assignment and her placement at the Prison are unclear from the record. The Court does not have before it a contract for Consilium to supply locum tenens physicians to the Prison's hospital, a contract between Consilium and Wilson detailing the terms of Wilson's assignment to the Prison, or a contract between Wilson and the Prison (or any other entity involved in this case). Nor have the parties supplied any other evidence concerning the agreements underlying Plaintiff's assignment that would allow the Court to evaluate the degree to which the manner, method, and means of Wilson's duties were controlled by one or more of these entities. The Court therefore is left to consider whether there is sufficient other evidence for a reasonable jury to find that GCHC did—or, instead, to find that it did not—assume sufficient control over the time, method, and means of Wilson's work.

There is evidence that cuts against Wilson being an employee of GCHC and tends to suggest she was an independent contractor. Awe testified that Wilson was an "agency doctor," "worked for the agency," and was "not an employee of GCHC." (Doc. 119, p. 12.) Gatewood testified that Wilson "was a contract provider [who] was [at the Prison] temporarily." (Doc. 122, p. 50.) Notably, Wilson herself testified that she "worked for," submitted her hours to, and was paid by Consilium, the staffing agency. (Doc. 121, pp. 75–76.) "[T]he basis of the pay, i.e., whether the hospital paid the physician," is an important factor for the Court to consider, and payment by a third party is indicative of independent contractor status. See Lee, 470 S.E.2d at 463.

On the other hand, the record could also support a finding that GCHC exercised considerable control over Plaintiff's assignments, schedule, and treatment decisions, all of which are factors cutting towards employee status. Defendants concede that, as a locum tenens physician, Wilson was assigned to a specific work area by the Prison and, when she started, Awe (the Prison's medical director and a GCHC employee) told her that she needed to see fifteen patients a day. (Doc. 137-1, pp. 38–39.) In fact, although Wilson initially was only supposed to provide yearly physicals for inmates in the chronic care division, Awe informed her that her role was being expanded to include sick calls. (Id. at p. 39.) Awe also assigned Wilson additional duties in the infirmary, as well as

on-call duties one day per week. (Id. at p. 40.) Wilson did not have the authority to refuse additional duties that Awe assigned to her. (Id.); see Blackmon v. Tenet Healthsystem Spalding, Inc., 653 S.E.2d 333, 338 (Ga. Ct. App. 2007) (evidence that an employee "could not refuse an order to do 'such and such' " is indicative of employer-employee relationship), *vacated in part on other grounds*, 667 S.E.2d 348 (Ga. 2008). Additionally, Wilson couldn't work whenever she wanted; someone at the Prison set her work hours and assigned her schedule. (Doc. 137-1, p. 39); see Cooper, 598 S.E.2d at 9 ("Where the hospital requires the physician to work certain hours or arranges the physician's schedule, this factor shows that the physician is an employee and may alone preclude summary judgment."); see id. (collecting cases). Furthermore, Wilson reported to Awe, who reviewed everything she did and had to sign off on Wilson's referrals to outside providers and her notes. (Doc. 137-1, pp. 39–40); see Lee, 470 S.E.2d at 462 (noting that the right of the employer to inspect the employee's work is indicative of employee status). Indeed, Wilson testified that, if she believed someone needed to see an outside provider, she would discuss the situation with Awe, and he would make the "ultimate decision" about the referral before it was scheduled. (Doc. 121, pp. 21–22.)

In sum, the Court finds that there is a genuine dispute of fact as to Wilson's employment status. On this record, a reasonable jury could find that she was an "employee" of GCHC (and, therefore, BOR), or it could instead reasonably find that she was not an "employee." Consequently, the record could support a finding that BOR has waived its sovereign immunity from liability arising from Wilson's conduct, but it also could support a finding that BOR retains its sovereign immunity. Accordingly, summary judgment is not warranted in either party's favor on this issue, and it will be for the trier of fact to determine whether Wilson was an employee and thus whether the GTCA applies.

C. Whether Liability May be Imputed to GDC

***9** GDC contends that it has sovereign immunity from Plaintiff's tort claims because neither Awe, nor Wilson, nor Hall were its "employees" under the GTCA. (Doc. 91, pp. 6–12.) Plaintiff does not argue that GDC directly employed these individuals; indeed, the Court has already found—per *Plaintiff's* request—that Awe and Hall were employees of BOR via their employment at GCHC, and, as discussed above, a factfinder must decide whether Wilson was an independent contractor or an employee of GCHC (and thus BOR). See Discussion Section I.B, supra. Plaintiff has not pointed to any evidence that any individual or representative of GDC exercised control over the method, means, or manner of Awe, Hall, or Wilson's work. Plaintiff instead contends (and requests summary judgment on the basis) that these individuals were employees of GDC (as well as BOR) because GCHC is a "joint enterprise" of BOR and GDC. (Doc. 100-1, pp. 11–15.) GDC responds that the GTCA "precludes liability of two state entities under a theory of joint enterprise," and, therefore, Plaintiff's claims against it must be dismissed. (Doc. 147, p. 2.)

Even assuming (without deciding) that the employees of a "joint enterprise" between two contracting entities qualify as "employees" of both entities under the GTCA, Plaintiff has failed to show that GCHC was a "joint enterprise" of BOR and GDC. Under Georgia law, a "joint enterprise" (more commonly referred to as a "joint venture") arises where "two or more parties combine their property or labor, or both, in a joint undertaking for profit, with rights of mutual control (provided the arrangement does not establish a partnership), so as to render all joint venturers liable for the negligence of the other." Kissun v. Humana, Inc., 479 S.E.2d 751, 752 (Ga. 1997); Fulcher's Point Pride Seafood, Inc. v. M/V "Theodora Maria", 752 F. Supp. 1068, 1072 (S.D. Ga. 1990). "The mere existence of a business interdependency does not create a joint venture." Lafontaine v. Alexander, 808 S.E.2d 50, 56 (Ga. Ct. App. 2017). Rather, "[f]or a joint venture to exist, [t]here must be not only a joint interest in the purpose of the enterprise ... but also an equal right, express or implied, to direct and control the conduct of one another in the activity causing the injury." Williams v. Chick-fil-A, Inc., 617 S.E.2d 153, 155 (Ga. Ct. App. 2005) (internal quotation omitted). Indeed, the Georgia Court of Appeals recently clarified that "mutual control is ... an essential element to establishing joint venture liability among government entities." Driskell v. Dougherty Cnty., 871 S.E.2d 283, 287 (Ga. Ct. App. 2022).

First, although there is some evidence in the record that GDC had some control over GCHC,[10] Plaintiff has not argued or cited to anything suggesting that GDC and BOR "combine[d] their property or labor, or both, in a joint undertaking *for profit*." Kissun, 479 S.E.2d at 752 (emphasis added). This Court has previously recognized that "sharing of profits and losses" is an important indicator of a joint venture relationship, and "[t]he absence of profit-sharing suggests the arrangement was not a joint venture." Fulcher's Point Pride Seafood, 752 F. Supp. at 1072–73. Nothing in the Interagency Agreement indicates that GCHC was intended to generate a profit. To the contrary, the Interagency Agreement describes the

parties' underlying intent as follows: "GDC desires to obtain appropriate health care services for prisoners of the State correctional system, consistently with the mission of its Office of Health Services to provide a constitutional level of care in an efficient and cost-effective manner," and "MCG desires to provide appropriate health care services for GDC prisoners in concert with the GDC Office of Health Services and under the general supervision of the GDC Director of Health Services." (Doc. 117-3, p. 1.) To effectuate these intentions, MCG "agree[d] to deliver comprehensive health care to all GDC prisoners," including, but not limited to, the services "more fully described" in the "Scope of Services" document incorporated into the Interagency Agreement. (Id.) That document similarly states that the Interagency Agreement is intended to accomplish GDC's medical mission of "provid[ing] the required constitutional level of health care to the inmates of the correctional system in the most efficient and effective manner possible." (Id. at p. 7.) This cuts against finding that GCHC was a joint undertaking for profit, and consequently cuts against a finding of a joint enterprise.

***10** Additionally, there is evidence that GDC and BOR intended to form a "partnership," which (while similar) is legally distinct from a "joint venture." The Georgia Court of Appeals has reiterated that a joint venture arises "where two or more parties combine their property or labor, or both, in a joint undertaking for profit, with rights of mutual control, *provided the arrangement does not establish a partnership.*" Mullinax v. Pilgrim's Pride Corp., 840 S.E.2d 666 (Ga. Ct. App. 2020) (emphasis added). Plaintiff explicitly argues that "GCHC is 'a partnership' between GDC and MCG." (Doc. 137-1, p. 33.) Indeed, as Plaintiff notes, the "Scope of Services" describes GCHC as a "*Partnership* Between [GDC/MDG]." (Doc. 117-3, p. 6.) Furthermore, the Interagency Agreement states that "a *partnership* is envisioned with each agency acting responsibly to carry out the necessary steps to achieve the goals" of the Interagency Agreement. (Id. at p. 7 (emphasis added).) While "[n]omenclature is not dispositive," the Interagency Agreement's explicit reference to GCHC as a "partnership," viewed in conjunction with the absence of any evidence GCHC was created to generate a profit, precludes a finding that GCHC was a "joint enterprise" of GDC and BOR. Jerry Dickerson Presents, Inc. v. Concert S. Chastain Promotions, 579 S.E.2d 761, 768 (Ga. Ct. App. 2003).

In sum, after reviewing the evidence before it, the Court finds that Plaintiff has failed to carry his burden, at this stage of the proceedings, of presenting sufficient evidence to enable a reasonable jury to find that Hall, Wilson, and/or Awe were "employees" of GDC (either under a "joint enterprise" theory or otherwise) pursuant to the GTCA. Thus, the Court finds that GDC is entitled to sovereign immunity from Plaintiff's claims against it. Accordingly, the Court **GRANTS** GDC's request for summary judgment on all claims against it, and **DISMISSES** GDC from this case.[11]

II. Plaintiff's Request for Summary Judgment on Issues Related to the Standard of Care, and Plaintiff's Related Motion to Exclude Experts (Doc. 100)

In Georgia, a medical professional owes a legal duty to exercise his or her profession with "a reasonable degree of care and skill." O.C.G.A. § 51-1-27. Accordingly, an essential element to a claim of medical malpractice is a determination that the defendant "breach[ed] ... that duty by failing to exercise the requisite degree of skill and care." Knight v. W. Paces Ferry Hosp., Inc., 585 S.E.2d 104, 105 (Ga. Ct. App. 2003). The plaintiff must also show that the breach is "the proximate cause of the injury sustained." Knight v. Roberts, 730 S.E.2d 78, 83 (Ga. Ct. App. 2012). "The standard to be used to establish professional medical negligence under O.C.G.A. § 51-1-27 is that standard of care 'which, under similar conditions and like circumstances, is ordinarily employed by the medical profession generally.'" Green v. United States, No. 1:19-cv-122, 2022 WL 966864, at *4 (S.D. Ga. Mar. 30, 2022) (quoting McDaniel v. Hendrix, 401 S.E.2d 260, 262 (Ga. 1991)). "Expert testimony is required to establish ... the standard of care ... in a particular case." Callaway v. O'Connell, 44 F. Supp. 3d 1316, 1326 (M.D. Ga. 2014) (citing Kapsch v. Stowers, 434 S.E.2d 539, 540 (Ga. Ct. App. 1993)). Accordingly, "Plaintiff must present competent expert testimony that [Awe, Hall, and/or Wilson] breached the applicable standard of care and that this breach proximately caused [his injuries]." Smith v. Am. Transitional Hosps., Inc., 330 F. Supp. 2d 1358, 1361 (S.D. Ga. 2004).

***11** Plaintiff requests summary judgment that GCHC violated the standard of care (1) "by failing to adequately monitor [Plaintiff's] [PVD] from 2018 through June 2019," (2) "when its employees failed to promptly refer [Plaintiff] to a vascular surgeon after he presented on or about April 25–26, ... on May 3, ... on May 16, ... on May 30, ... and on June 5, 2019," and (3) "when its employees ignored numerous nurse requests to re-examine [Plaintiff's] foot between his initial examination and the date on which [his] toe autoamputated." (Doc. 100-1, pp. 17–20.) Plaintiff also asserts that the Court may consult, in addition to expert testimony, certain written

standards/guidelines promulgated by GDC and other organizations to determine the applicable standard of care. (Id. at pp. 15–17.) Additionally, Plaintiff has moved to exclude the opinions of Defendants' experts, Dr. Fowlkes and Dr. Horn, on the standard of care and causation, arguing that their methodology is not sufficiently reliable under Daubert v. Merrell Dow Pharmaceuticals, Inc., 509 U.S. 579, 589 (1993). (Doc. 100-1, pp. 20–22.)

A. Plaintiff's Motion to Exclude Defendants' Experts' Standard of Care and Causation Opinions

Federal Rule of Evidence 702 governs the admissibility of expert testimony. The rule provides that

> A witness who is qualified as an expert by knowledge, skill, experience, training, or education may testify in the form of an opinion or otherwise if:
>
> (a) the expert's scientific, technical, or other specialized knowledge will help the trier of fact to understand the evidence or to determine a fact in issue;
>
> (b) the testimony is based on sufficient facts or data;
>
> (c) the testimony is the product of reliable principles and methods;
>
> and
>
> (d) the expert has reliably applied the principles and methods to the facts of the case.

Fed. R. Evid. 702. The Eleventh Circuit Court of Appeals has established a three-pronged inquiry encompassing these requirements to determine whether Rule 702 is satisfied. Under this inquiry, courts must evaluate whether

> (1) the expert is qualified to testify competently regarding the matters he intends to address;
>
> (2) the methodology by which the expert reaches his conclusions is sufficiently reliable as determined by the sort of inquiry mandated in Daubert; and
>
> (3) the testimony assists the trier of fact, through the application of scientific, technical, or specialized expertise, to understand the evidence or to determine a fact in issue.

United States v. Frazier, 387 F.3d 1244, 1260 (11th Cir. 2004) (citations omitted). The proponent of the expert opinion bears the burden of establishing each of these elements by a preponderance of the evidence. Id.

Plaintiff, here, is challenging Defendants' experts' opinions under the second prong enumerated by the Eleventh Circuit, contending that Defendants' experts' methodology was not "sufficiently reliable." Frazier, 387 F.3d at 1260. To assess the reliability of an expert's methodology, courts typically consider the following: (1) whether the theory or technique can be tested, (2) whether it "has been subjected to peer review and publication," (3) whether the technique has a "known or potential rate of error," and (4) whether the theory has attained "general acceptance" in the relevant community. Id. at 593–94. However, "[t]hese factors are illustrative, not exhaustive; not all of them will apply in every case, and in some cases other factors will be equally important." Frazier, 387 F.3d at 1262. Regardless of the specific factors considered, "[p]roposed testimony must be supported by appropriate validation—i.e., 'good grounds,' based on what is known." Daubert, 509 U.S. at 590. In most cases, "[t]he expert's testimony must be grounded in an accepted body of learning or experience in the expert's field, and the expert must explain how the conclusion is so grounded." Fed. R. Evid. 702, advisory committee's notes to 2000 amendment.

Bearing in mind the diversity of expert testimony, "the trial judge must have considerable leeway in deciding in a particular case how to go about determining whether particular expert testimony is reliable." Kumho, 526 U.S. at 152. "[W]hether the proposed testimony is scientifically correct is not a consideration for this court, but only whether or not the expert's testimony, based on scientific principles and methodology, is reliable." In re Chantix (Varenicline) Prods. Liab. Litig., 889 F. Supp. 2d 1272, 1280 (N.D. Ala. 2012) (citing Allison v. McGhan Med. Corp., 184 F.3d 1300, 1312 (11th Cir. 1999)). "[V]igorous cross-examination, presentation of contrary evidence, and careful instruction on the burden of proof are the traditional and appropriate means of attacking shaky but admissible evidence." Id. (alteration in original).

***12** Plaintiff contends that Fowlkes and Horn's opinions regarding the standard of care and causation are unreliable because they are not "based on any nationally or professionally recognized clinical guidelines from disease-specific organizations or medical and physician associations." (Doc. 100-1, p. 21.) According to Plaintiff, their opinions, instead, are based "entirely on [their] training, experience, and a review of [Plaintiff's] medical records," and neither expert explained how their prior experiences equip them to render these opinions. (Id.) Defendants do not dispute that Fowlkes and Horn relied primarily on their experience, training, and education to

support their opinions, but they contend that the opinions are reliable because they were formed "by applying their extensive, relevant knowledge, training, and experience to the information reviewed in the medical records." (Doc. 136, p. 14.)

While experts frequently base their opinions on professional research or literature, "[t]here is no inherent requirement that a medical expert cite or reference independent studies that support [his or] her conclusions." Smith v. Bama Urgent Med., Inc., No. 7:08-CV-1546-RDP, 2011 WL 8635359, at *4 (N.D. Ala. July 20, 2011). Additionally, "[n]either Daubert nor its progeny preclude experience-based testimony." Colony Ins. Co. v. Coca-Cola Co., 239 F.R.D. 666, 674 (N.D. Ga. 2007) (citing Kumho, 526 U.S. at 151). Indeed, the advisory committee notes to the 2000 amendments to Rule 702 clarify that "an expert may be qualified on the basis of experience," and "experience alone—or experience in conjunction with other knowledge, skill, training or education—may ... provide a sufficient foundation for expert testimony." Fed. R. Evid. 702, advisory committee's notes to 2000 amendment. Therefore, "[a] district court may decide that ... expert testimony is reliable based upon personal knowledge or experience." Am. Gen. Life Ins. Co. v. Schoenthal Fam., LLC, 555 F.3d 1331, 1338 (11th Cir. 2009) (internal quotations omitted).

However, "[i]f the witness is relying solely or primarily on experience, then the witness must explain *how* that experience leads to the conclusion reached, why that experience is a sufficient basis for the opinion, and how that experience is reliably applied to the facts.' " Frazier, 387 F.3d at 1261 (quoting Fed. R. Evid. 702, advisory committee's notes to 2000 amendment). " 'Presenting a summary of a proffered expert's testimony in the form of conclusory statements devoid of factual or analytical support is simply not enough' to carry the proponent's burden." Green, 2022 WL 966864, at *5 (quoting Cook ex rel. Est. of Tessier v. Sheriff of Monroe Cnty., 402 F.3d 1092, 1113 (11th Cir. 2005)); see also Frazier, 387 F.3d at 1261 ("If admissibility could be established merely by the *ipse dixit* of an admittedly qualified expert, the reliability prong would be, for all practical purposes, subsumed by the qualification prong."). Accordingly, the Court must decide whether Fowlkes and Horn's respective training, experience, and education provide adequate support for their standard of care and causation opinions.

(1) Defendants have failed to demonstrate the reliability of Fowlkes' challenged standard of care and causation opinions.

Fowlkes' expert report concludes that (1) the medical care Plaintiff received from Awe and Hall from April 23 to June 13, 2019, was reasonable, appropriate, and well within the acceptable standard of care for a known PVD patient with chronic diabetic foot infections, and (2) "no action or alleged inaction by the defendants in this case caused the loss of [Plaintiff's] second toe or any other damages." (Doc. 100-1, p. 55; see id. at pp. 52–57.) His report states that his opinions are based upon his "training, experience, and a review of the records in this case." (Id. at p. 52; see doc. 136-1, p. 93 (testifying that his opinions are "based on ... the entirety of [his] training, experience, education, and keeping up with the literature generally, so [his] general knowledge").)

***13** The curriculum vitae ("CV") attached to Fowlkes' report states that he is a "Certified Correctional Healthcare Professional" and a "Board certified emergency physician," and that he has served as the Medical Director at the Lafayette County (MS) Detention Center since 1998. (Doc. 100-1, p. 65.) The majority of Fowlkes' current and prior experience listed in the CV pertains to addiction medicine, substance abuse treatment, and mental health services. (See generally id. at pp. 65–66.) In his report, Fowlkes failed to address how this training and experience informed his opinion that the care Plaintiff received was within the standard of care. Fowlkes did not, for instance, detail how his employment as a medical director, drug court "medical consultant," and/or "outpatient provider of mental health services," led him to conclude that Plaintiff's "presentation should not have led a reasonable correctional primary care provider to suspect that [he] had a reversible stenosis, an ischemic limb, an endangered limb[,] or any other condition which required urgent referral to a vascular surgeon or any other action besides those which were being undertaken." (Id. at pp. 55, 65.)

Notably, although Fowlkes repeatedly states that the medical care Plaintiff received and the specific treatment decisions made by Defendants were within the standard of care, he fails to ever specify what the standard of care actually is. In addition to specifying how his or her experience has specifically led an expert to reach their conclusions, an expert must be able to articulate which standard of care they have employed. See Smith, 330 F. Supp. 2d at 1361 (explaining the plaintiff's burden to provide expert testimony that the defendant breached the applicable standard of care "subsumes the burden of providing expert testimony as to what the applicable standard of care is"). Nowhere in Fowlkes' expert report did he describe the care that is "ordinarily employed by

the medical profession generally" under circumstances similar to this case—namely, when a diabetic patient with PVD who has had prior amputations presents with a likely-infected wound on the same foot which had been partially amputated previously. Indeed, when asked questions such as from where specifically he gathered his supposed standard of care, Fowlkes could only offer the vague response that it "[was] his expert opinion .. based upon [his] education, training and experience." (Doc. 136-1, p. 87.) Additionally, when specifically asked what his basis was for opining that the standard of care did not require routine screening of people with a history of PVD, Fowlkes only responded, "Well, that would be on each individual circumstance." (Id. at p. 31.) These responses underscore the conclusory nature of Fowlkes' standard of care opinions. See Green, 2022 WL 966864, at *5 (finding an expert's standard of care opinions to be unreliable because they "appear[ed] almost entirely based on his varied, personal expertise in the field," and the expert "repeatedly decline[d] to offer a consistent standard of care, instead stating that the standard of care 'depends on the patient' "); see also Anderson v. Columbia Cnty., No. 1:12-cv-031, 2014 WL 8103792, at *11 (S.D. Ga. Mar. 31, 2014) (finding an expert's opinion that the standard of care was breached to be unreliable because the expert failed to "reference any specific experiences or materials upon which he relied in reaching his conclusion" and did not explain how his experience led to his conclusions); Dukes v. Ga., 428 F. Supp. 2d 1298, 1314–15 (N.D. Ga. 2006) (concluding that an expert's standard of care opinions were unreliable where he made "no reference to any specific experience or material upon which he relied in making his conclusions" and failed to specify what standard of care he was applying).

Fowlkes' causation opinions are equally unreliable. Fowlkes never explained how his experience, training, or education supported his opinion that "no action or alleged inaction by the [D]efendants in this case caused the loss of [Plaintiff's] second toe or any other damages." (Doc. 100-1, p. 55.) Furthermore, Fowlkes did not indicate that he employed any particular scientific method to reach his causation opinion. "Although no expert physician is required to employ ... any ... particular scientific method to arrive at their conclusion, their principles and methodology 'must be supported by appropriate validation,' so that the trial court does more than 'simply taking the expert's word for it.' " Magbegor v. Triplette, 212 F. Supp. 3d 1317, 1327 (N.D. Ga. 2016) (quoting Frazier, 387 F.3d at 1261). Nothing in Fowlkes' report sufficiently validates his opinion that the course of treatment undertaken by Awe, Hall, or Wilson did not contribute to the autoamputation of Plaintiff's toe. Fowlkes has offered no insight into how his experience guided his opinions, he references no specific method employed, and otherwise provides no independent support other than his personal opinion that Defendants did not cause Plaintiff's injury.

*14 Defendants, as the proponents of Fowlkes' opinions, were required to provide a basis for the admission of those opinions. Frazier, 387 F.3d at 1260. Defendants have attempted to do so by simply referring to Fowlkes' experience. However, "[a]ccepting [Dr. Fowlkes'] experience alone as evidence of the reliability of his statements is tantamount to disregarding entirely the reliability prong of the Daubert analysis." Dukes, 428 F. Supp. 2d at 1315. Rather than properly demonstrating the reliability of Fowlkes' expert opinions under Rule 702, Defendants essentially point to the *ipse dixit* of the expert. Consequently, the Court **GRANTS** Plaintiff's Motion to exclude Fowlkes' opinion that Defendants met the standard of care as well as his opinion that Defendants did not cause Plaintiff's injuries. (Doc. 100-1, pp. 20–22.)

(2) Defendants have failed to demonstrate the reliability of Horn's challenged standard of care opinions, but Defendants have shown the reliability of Horn's challenged causation opinions.

In his expert report, Horn concluded that "the eventual amputation of [Plaintiff's] second toe was unavoidable," and "[e]ven with prompt medical care, immediate referral to [a] specialist, and aggressive wound care," amputation would still have been required. (Id. at p. 29.) Horn additionally concluded that "the standard of care was not breached" because even if Plaintiff had been "referred at the time of his initial presentation of his infected toe, his outcome would have been the same." (Id. at pp. 29–30.) Horn's report states only that his standard of care opinion is based on his "medical opinion," (id. at p. 29), and, during his deposition, he indicated that it was based on his "medical experience" and his belief that "another physician would [not] have acted any differently, given the circumstances," (doc. 136-2, p. 48). The report indicates that he has ample relevant experience, stating that the "focus of [his] practice since 2005 is complex medical problems including complex peripheral wounds and limb threatening issues," that he works "closely with a vascular surgery group in the management of complex patients for limb salvage operations," and that he is on the staff at two local wound care centers. (Doc. 100-1, p. 28.)

"[W]hile an expert's overwhelming qualifications may bear on the reliability of his proffered testimony, they are

by no means a guarantor of reliability.... [Eleventh Circuit] caselaw plainly establishes that one may be considered an expert but still offer unreliable testimony." Quiet Tech. DC-8, Inc. v. Hurel-Dubois UK Ltd., 326 F.3d 1333, 1341–42 (11th Cir. 2003). As with Fowlkes, Defendants have failed to articulate "*how* [Horn's] experience leads to the conclusion reached, why that experience is a sufficient basis for the opinion, and how that experience is reliably applied to the facts.' " Evanston Ins. Co. v. Xytex Tissue Servs., LLC, 378 F. Supp. 3d 1267, 1279 (S.D. Ga. 2019) (emphasis added). Additionally, like Fowlkes, Horn did not articulate what the standard of care is for a patient like Plaintiff under the same or similar circumstances. Accordingly, the Court finds Defendants have failed to satisfy the reliability prong for Horn's opinions that Defendants did not violate the standard of care for the same reason the Court rejected Fowlkes' challenged standard of care opinion. See Discussion Section II.A.1, supra.

Notwithstanding the unreliability of Horn's standard of care opinion, his causation opinion—that eventual amputation of Plaintiff's toe was unavoidable and would have occurred regardless of the treatment he received—does not suffer the same flaw. Unlike his standard of care opinion, Horn applied his experience to the medical and administrative records to reach his conclusion:

> ***15** Upon reviewing the case of [Plaintiff], it is my conclusion that the eventual amputation of his second toe was unavoidable. [Plaintiff] has significant [PVD], and he can be defined as a vasculopath.... Even with prompt medical care, immediate referral to specialist, and aggressive wound care, the definitive treatment would still require an amputation of his second toe....
>
> *In my experience*, once an acute infection occurs within a lower extremity digit, despite aggressive wound care, hyperbaric oxygen treatment, and evaluation by vascular surgery, a significant majority of patients end up with an amputation of the involved digit. In [Plaintiff's] case[,] even prompt recognition and early evaluation by a vascular surgeon would not have changed the outcome of having his second toe amputated. *Upon examination of his vascular studies*, he has significant microvascular disease throughout the dorsum of his foot as noted by monophasic Doppler signals present within his foot.

(Doc. 100-1, pp. 29–30 (emphases added).) Accordingly, the Court rejects Plaintiff's contention that Horn's causation opinions should be excluded for inadequately explaining how his experience supported those opinions.[12]

In sum, based upon the forgoing, the Court **GRANTS** Plaintiff's Motion to Exclude Fowlkes' and Horn's opinions that Defendants did not violate the standard of care, and **GRANTS** Plaintiff's Motion to Exclude Fowlkes' opinion that Defendants did not cause Plaintiff's injuries. However, the Court **DENIES** Plaintiff's Motion to Exclude Horn's causation opinion.

B. Sources to Consider When Determining the Standard of Care

Plaintiff asks the Court to find that the standard of care for his treatment should be determined not only by the testimony of his experts, Dr. Richard Hershberger and Dr. Robert Powers, but *also* by consulting the following written sources: GDC's SOPs, standards promulgated by the National Commission on Correctional Health Care ("NCCHC") and the American Correctional Association ("ACA"), and clinical guidelines of the Federal Bureau of Prisons ("FBOP"). (Doc. 100-1, pp. 15–17.) Defendants respond that while SOPs and other written standards are guidelines to assist physicians, they do not, in and of themselves, establish the standard of care for physicians. (Doc. 137, pp. 9–10.)

There is some Georgia case law suggesting that written standards are relevant to determining the standard of care in a particular case. For example, in Byrd v. Medical Center of Central Georgia, Inc., the Georgia Court of Appeals determined that a "service manual used by the surgical department of [the defendant medical center]" was "clearly relevant to the jury's determination of the standard of care to be applied in this case." 574 S.E.2d 326, 328–29 (Ga. Ct. App. 2002). The court reasoned that the manual "established that the [defendant's] staff had recognized and adopted a guideline which strongly recommended" the type of care the plaintiff alleged should have been used. Id. at 329. Likewise, in Luckie v. Piggly-Wiggly Southern, the court found that "any evidence as would conceivably be 'illustrative' of what might constitute the exercise of 'ordinary care' in the specific situation at issue, including private guidelines, is relevant and admissible for whatever consideration in that regard the jury wishes to give to it." 325 S.E.2d 844, 845 (Ga. Ct. App. 1984). At least one of the Court's sister courts has also indicated that guidelines and other written materials are relevant to determining the standard of care. See, e.g., Cook v. Royal Caribbean Cruises, Ltd., No. 11–20723, 2012 WL 1792628, at *3 (S.D. Fla. May 15, 2012) ("[A]dvisory guidelines and recommendations, while not conclusive, are admissible as bearing on the standard of care in determining negligence.").

***16** However, to the extent Plaintiff is arguing that these written materials *are* the standard of care, the Court disagrees. "Georgia law requires evidence of compliance with the standards of the medical profession generally and not compliance with local standards." Summerour v. Saint Joseph's Infirmary, 286 S.E.2d 508, 508 (1981). The Court has previously stated that the standard of care in medical malpractice cases in Georgia is not "measured by a particular facility's policies and procedures." Smith, 330 F. Supp. 2d at 1361; see also Bayse v. Dozier, No. 5:18-CV-00049-TES-CHW, 2019 WL 2550321, at *2 (M.D. Ga. June 20, 2019) ("To the extent Plaintiff argues that the [the standards published by the World Professional Association for Transgender Health] *are* the standards to be applied to the evaluation and treatment of transgender inmates, and when not utilized, those inmates are not receiving proper treatment, such argument is misplaced.").

Additionally, the materials themselves and other evidence in the record negate the idea that the sources provide *the* standard of care applicable to Plaintiff in this case. With respect to GDC's SOPS, SOP 507.01.01 states that "[i]t is the intent of the ... GDC ... to deliver health care to inmates/probationers in a manner that *meets contemporary standards in the community*." (Doc. 117-13, p. 2 (emphasis added).) SOP 507.04.11 similarly indicates that the assessment of the need for an outside referral must consider whether "[r]epair or treatment of the problem is ... consistent with *community standard of care*." (Doc. 117-6, pp. 2–3 (emphasis added).) Jack Sauls, the Assistant Commissioner for GDC's Office of Health Services, also testified that "[t]he current standard of care and the community standard of care that may exist *out in the community*" are "applied to any considerations for SOP modifications, changes[,] or application of new policies." (Doc. 125, pp. 10–11 (emphasis added).) Viewed collectively, this evidence suggests that the standard of care is separate from the SOPs themselves. Moreover, none of the SOPs contained in the record deal with treating diabetic infections/ulcers, vascular issues, or even wound care in general.

Furthermore, although there is evidence that GCHC's employees were required to comply with NCCHC and ACA standards, the portions of these standards contained in the record fail, for various reasons, to supply a definitive standard of care. The only ACA record is a document titled "Standards and Expected Practices of Adult Correctional Institutions" that is dated *March 2021*—nearly two years *after* the events giving rise to this case took place. (Doc. 117-10, p. 1.) In addition, the version contained in the record consists merely of a table of contents and lists the criteria for a "plan for the treatment of offenders with chronic conditions such as ... diabetes." (Id. at p. 18; see generally doc. 117-10.) With respect to the NCCHC standards, Plaintiff submits "Standards for Health Services in Prisons" from 2018. (Doc. 117-9.) Notably, this document does *not* state that it provides any "standard of care." (See generally id.) To the contrary, it states that the standards therein "represent the official *position* of the [NCCHC] with respect to requirements for health services in prisons," and acknowledges that the standards "do not necessarily represent the official position of NCCHC supporting organizations or individuals serving on the NCCHC Board of Directors." (Id. at p. 2 (emphasis added).) This description cuts against a finding that this document provides the standard "ordinarily employed by the medical profession generally." McDaniel, 401 S.E.2d at 262. Additionally, the document Plaintiff submitted is predominantly a table of contents. The only substantive portion is a section titled, "P-F-01 ... Patients with Chronic Disease and Other Special Needs." (Doc. 117-9, p. 7.) This section vaguely states that the "[s]tandard" for patients with chronic diseases is to "receive ongoing multidisciplinary care aligned with evidence-based standards," encourages the development of a "treatment plan," and recommends "regular clinic visits for evaluation and management" for chronic disease patients. (Id. at pp. 7–9.) This is far too general to be the standard of care in this case.

***17** Finally, Plaintiff submitted the FBOP's March 2014 guideline for the "Prevention and Management of Acute and Chronic Wounds." (Doc. 117-12.) On the first page, the FBOP's guidelines caution that they are "made available to the public for informational purposes only" and that "*[p]roper medical practice necessitates that all cases are evaluated on an individual basis and that treatment decisions are patient-specific.*" (Id. at p. 1.) Additionally, the document states that the "purpose" of the guidelines is to "provide[ ] *guidance* on the prevention and treatment of common types of wounds." (Id. at p. 5 (emphasis added).) To fulfill this purpose, the document supplies a "Basic Supportive Wound Care Algorithm," which consists of a multi-step framework for treating a patient who presents with a wound, completing an "initial wound assessment," and developing a treatment plan by evaluating the wound bed. (See id. at p. 6.) Such a fact-dependent framework, while perhaps relevant to the jury's determination of the standard of care in this case, does not conclusively establish the standard of care here. See Smith, 2012 WL 13088764, at *7 ("[A]n unwarranted logical leap is required to reach to the conclusion that recommendations made in [an organization's guideline's] are actually the *standard of care* for any particular type of medical practice.").

C. Plaintiff's Request for Summary Judgment that Certain Acts or Omissions Violated the Standard of Care

(1) The Alleged Failure to Monitor Plaintiff's PVD from 2018 through 2019

Plaintiff asks the Court to find that Defendants violated the standard of care by failing to adequately monitor his PVD from 2018 through 2019. (Doc. 100-1, pp. 17–18.) Specifically, Plaintiff contends that it was a violation of the standard of care not to have been scheduled for an arterial duplex follow-up in 2018 or to have received an ankle brachial index (ABI) between his 2017 surgeries and his 2019 amputation. (Id. at p. 18.)

Plaintiff's original Complaint (the allegations of which are incorporated into the Amended Complaint) alleges that the first incident that is the subject of this action occurred on April 23, 2019, when Plaintiff saw Awe in the infirmary for an abrasion on the top of his second toe. (Doc. 1, p. 38.) Furthermore, the Complaint only alleges that the standard of care was breached because Plaintiff was not promptly referred to a board-certified vascular surgeon for evaluation at any point after he presented at the infirmary that day, (doc. 1, pp. 41–43); the Complaint is devoid of any mention of an arterial duplex or ABI, much less allegations that the failure to schedule or perform one or both of these tests constituted a breach of the standard of care. (See generally id. at pp. 30–45). Moreover, Plaintiff does not seek damages for events that occurred before April 23, 2019. (Doc. 148, p. 3; see doc. 1, pp. 114–116 (providing ante litem notice for torts allegedly committed between "April 23, 2019–June 13, 2019").) Accordingly, the Court declines to address whether it was a violation of the standard of care for Plaintiff not to have received an arterial duplex or ABI or, more generally, whether any act or omission alleged to have occurred prior to April 23, 2019, violated the standard of care and Plaintiff's request for summary judgment in his favor on this topic is **DENIED**.

(2) Failure to Refer Plaintiff to a Vascular Surgeon or Specialist

Plaintiff contends that Defendants violated the standard of care because they did not promptly refer Plaintiff to a vascular surgeon after he presented on or about the following dates in 2019: April 25–26; May 3; May 16; May 30; and June 5. (Doc. 100-1, p. 19.) Plaintiff largely relies on Hershberger's expert opinion that "[t]he standard of care for any patient with severe [PVD] who develops wounds and cellulitis to the foot is prompt referral to a board-certified vascular surgeon for evaluation." (Id. (quoting doc. 60, p. 5).) Plaintiff also cites FBOP guidance which, he contends, "clearly indicates that when a patient with arterial insufficiency or neuropathic disease ... presents with 'cellulitis, abscess, gangrene, or deep ulceration,' this is a 'potential life or limb threatening issue' for which the provider must 'consider immediate referral for treatment and amputation prevention.' " (Id. (quoting doc. 117-12, p. 8).)

***18** With respect to Hershberger's opinion, Defendants do not challenge its reliability, and, indeed, the Court finds that his statements are reliable under Daubert. Because the Court has excluded the standard of care opinions of Defendants' experts, see Discussion Section II.A., supra, Hershberger's opinions that the standard of care was violated by not referring Plaintiff to a vascular specialist are unopposed. However, "[e]ven in an unopposed motion, ... the movant is not absolve[d] ... of the burden of showing that [he] is entitled to a judgment as a matter of law," and the Court "must still review the movant's citations to the record to determine if there is, indeed, no genuine issue of material fact." Mann v. Taser Int'l, Inc., 588 F.3d 1291, 1303 (11th Cir. 2009) (alterations in original). To that end, the Court must "consider the merits of the motion" and "review all of the evidentiary materials submitted in support of the motion," United States v. One Piece of Real Prop. Located at 5800 SW 74th Ave., 363 F.3d 1099, 1101–02 (11th Cir. 2004), in order to "satisfy itself that the [movant's] burden has been satisfactorily discharged," Reese v. Herbert, 527 F.3d 1253,1268 (11th Cir. 2008).

Hershberger's opinions regarding the standard of care are based upon and assume that Plaintiff had an "ischemic digit" and/or Chronic Limb-Threatening Ischemia ("CLTI") when he first presented to the nurse on April 23, 2019.[13] (See generally doc. 92-5.) For example, Hershberger's Amended Expert Report provides that his "overall opinion in this matter is that [GDC] failed to recognize critical limb ischemia in [Plaintiff]." (Id. at p. 2.) Elsewhere in his report, Hershberger opines that Plaintiff's "toe ulcer was not healing because of lack of arterial flow to his foot" and that, "with the occlusion of [Plaintiff's] stents due to his multiple medical problems, [Plaintiff] was placed back into a limb threatening situation with CLTI." (Id. at pp. 13, 5.) Hershberger further states that "[Plaintiff] had a return of his CLTI as

he had a history of stenting that healed ulcerations to his foot," and his wound was "perpetuated by arterial insufficiency." (Id. at pp. 10, 13.) Hershberger proceeds to frame his standard of care opinions according to these assumptions. For instance, he states that the "[s]tandard of care for treatment of an *ischemic digit* is urgent referral to a vascular specialist for revascularization," and that Plaintiff's amputation would not have been necessary "if the *ischemic* nature of his left second toe had been recognized on April 23, 2019." (Id. at p. 2 (emphasis added).) Similarly, he opined, "[u]rgent referral to a vascular specialist in an individual with *ischemic changes* to the foot is standard of care," and, "*[a]s [Plaintiff] was placed back into CLTI*, a referral to a board-certified vascular surgeon was mandatory." (Id. at pp. 5–6 (emphasis added).)

There is a genuine dispute of fact as to whether Plaintiff's toe was ischemic or whether his CLTI had returned when he presented to Gatewood on April 23, to Awe on April 25 or 26, and to Wilson on May 3 and May 16. It is undisputed that, after Plaintiff's 2017 amputations, he underwent surgery to have several stents placed into the arteries in his left leg because his left superficial femoral artery was occluded. (Doc. 137-1, p. 7.) Hershberger explicitly acknowledged that the stents placed in Plaintiff's leg in 2017 "allowed him to heal his wounds and removed him from a limb threatening situation." (Doc. 92-5, p. 6; see doc. 119, p. 63 (Awe's testimony that contrast studies subsequent to Plaintiff's revascularization procedure "show[ed] his stents [were] patent several months after he was discharged by the specialist").) Yet, Hershberger nonetheless determined that Plaintiff's stents occluded, precipitating the return of Plaintiff's arterial flow issues and preventing his toe from healing. Hershberger based his determination on the fact that Plaintiff had palpable pedal pulses following revascularization procedures performed subsequent to the amputation of his left second toe. (Doc. 92-5, pp. 5, 12–13.) However, there is ample evidence that Plaintiff had palpable pedal pulses when he presented to nurse Gatewood for a sick call on April 23, when he saw Awe on April 25 or 26, and when he saw Wilson on May 3 and May 16. There are two areas to check pulses on a foot—the "dorsalis pedis pulse" and the "posterior tibialis pulse." (Doc. 119, p. 28; doc. 117-12, p. 13; doc. 121, p. 32.) The record from Plaintiff's appointment with Gatewood explicitly states that "pedal pulses [were] present," (doc. 108-1, p. 31), and Gatewood confirmed that she palpated for *both* pulses on April 23, (doc. 122, p. 23). Gatewood also testified that she was trained to palpate for pulses in the feet, and that the purpose of doing so was to ensure blood was flowing to Plaintiff's foot. (Id. at p. 24.) Awe similarly testified that he took Plaintiff's dorsalis pedis and posterior tibialis pulses and that, at that time, they were "good." (Doc. 119, pp. 26, 28.) Wilson testified that she checked both pulses, Plaintiff had "palpable peripheral pulses," and "there was no indication, from the two times that [she] saw him ..., that ... his pulses were absent." (Doc. 121, pp. 32–33.)

***19** The record also contains evidence from which a jury could find that, as of May 16, Plaintiff's wound presentation was inconsistent with that of a patient who was suffering from an occluded artery or arterial insufficiency. The FBOP guidelines Plaintiff relies upon provide that, in addition to palpating pulses, a basic vascular exam of a lower extremity includes assessing skin coloration/appearance, palpation of skin temperature, and capillary refill. (See doc. 117-12, p. 13.) The guidelines further state that the wound beds for "arterial insufficiency wounds" are usually covered with "dry necrotic tissue." (Id. at p. 29.) Wilson testified that when she saw Plaintiff, the skin was "warm to touch," his "capillary refill was normal," and there was "no necrosis." (Doc. 121, p. 70.) Wilson distilled from these observations that "[t]here was no indication that ... [she] needed to refer [Plaintiff] urgently to a vascular surgeon." (Id.) Awe similarly testified that, based on his clinical exam, Plaintiff lacked "any evidence of gangrene on his foot," and, instead, had "redness" and "increased warmth." (Doc. 119, p. 51.) According to Awe, these findings were inconsistent with "an occluded artery," in part, because "if his artery was occluded on that day ... it wouldn't have any pulse[,] and his foot probably would look black." (Id. at pp. 51–52.) In fact, Awe went as far as to say he knows "for a fact that [Plaintiff] didn't have [an] occluded SFA based on the clinical exam on April 23." (Id. at p. 51.) Finally, Fowlkes testified that he does not believe that Plaintiff "had signs and symptoms of ... critical limb ischemia that should have been identifiable to any of the[ ] providers on the day they saw him." (Doc. 136-1, p. 1.)

A reasonable jury could credit the forgoing testimony and evidence and conclude that Awe and Wilson did not violate the standard of care by failing to refer Plaintiff to a vascular specialist on April 25/26, May 3, or May 16. Simply put, the evidence, construed in Defendants' favor, cuts against a finding that Plaintiff's stents were occluded and that his arterial flow was compromised such that the standard of care (as articulated by Hershberger) required an immediate referral to a vascular specialist.

Plaintiff has a stronger argument for summary judgment on the issue of whether, *as of May 29*, the evidence establishes that the condition of Plaintiff's toe had deteriorated to the point that the standard of care required

prompt referral to a vascular specialist. May 29 is the date Plaintiff was seen by Hanzel at the wound care clinic. (Doc. 137-1, p. 21.) Hanzel noted that Plaintiff's left foot had no palpable pulse and that a doppler test indicated he had a "weak" dorsalis pedis pulse and "no" post-tibialis pulse. (Doc. 119-2, p. 12.) Hanzel listed one of Plaintiff's "active problems" as "atherosclerosis of native arteries of extremities, bilateral legs." (Id. at pp. 17–18.) Hanzel also stated that Plaintiff's wound was worsening due to "poor circulation." (Id. at p. 15.) Hanzel concluded by stating that he "would like to get vascular eval[uation] and angio[gram] results from [Plaintiff's] last hospitalization" and that Plaintiff "surely will need another vascular eval[uation] as [Hanzel] suspect[ed] [Plaintiff] may not have adequate circulation to heal [his] toe ulcer." (Id. at p. 18.)

Hall testified that she examined Plaintiff's toe on June 5, when she saw him for a follow-up to his wound care visit. (See doc. 120, pp. 22, 30–31.) It is undisputed that she knew Plaintiff had PVD and had prior amputations at that time. (See doc. 108-1, p. 15; see also doc. 120, pp. 31–32.) Additionally, she admitted that "the records from the wound care clinic had been obtained and were on [Plaintiff's] chart," and that she signed and reviewed them. (Doc. 92-4, p. 5.) It is also uncontroverted that Plaintiff told Hall that the wound care clinic instructed him to follow-up with "vascular" to have an amputation, and that Hall instructed Plaintiff to ask the clinic about a referral to a vascular specialist on his follow-up (which was scheduled for two weeks later). (Id.; doc. 108-1, p. 15.) Finally, Hall, as a P.A., could make a referral to an outside medical provider. (Doc. 137-1, p. 28; see doc. 126, p. 78.) The forgoing evidence, most notably the fact that Hall reviewed Hanzel's records describing Plaintiff's circulatory issues and absent/weak pulses, compels the conclusion that Hall was on notice that Plaintiff's PVD had returned and his ischemia/arterial insufficiency most likely was contributing to the deterioration of his wound. Consequently, if a jury accepts Hershberger's opinions regarding the standard of care, it appears it would find that the standard of care required Hall to recommend Plaintiff to a vascular specialist or surgeon on June 5, and that she breached that standard where, instead of doing so, she ordered *Plaintiff* to ask about such a referral two weeks later at his follow-up appointment. (See doc. 92-5, p. 1 (opining that the "[s]tandard of care for treatment of an ischemic digit is urgent referral to a vascular specialist for revascularization").)

***20** However, the Court must keep in mind that Plaintiff bears the burden of proof on this claim and, therefore, he cannot simply point to a lack of expert evidence from Defendant. As explained by the Middle District of Georgia,

> "If the moving party bears the burden of proof at trial, the moving party must establish all essential elements of the claim or defense in order to obtain summary judgment." Anthony v. Anthony, 642 F. Supp. 2d 1366, 1371 (S.D. Fla. 2009) (citing [United States v. Four Parcels of Real Prop., 941 F.2d 1428, 1438 (11th Cir. 1991)]). The moving party must carry its burden by presenting "credible evidence" affirmatively showing that, "on all the essential elements of its case on which it bears the burden of proof at trial, no reasonable jury could find for the nonmoving party." Four Parcels of Real Prop., 941 F.2d at 1438. In other words, the moving party's evidence must be so credible that, if not controverted at trial, the party would be entitled to a directed verdict. Id.

Jackson v. Heath, No. 5:19-CV-132 (MTT), 2020 WL 5647823, at *1 (M.D. Ga. Sept. 22, 2020). The Court recognizes that only a qualified expert may testify as to whether a medical professional breached the standard of care. The Court also recognizes that, given the Court's above rulings, Plaintiff has the only expert evidence as to whether Hall complied with the standard of care. However, "[e]ven uncontradicted expert opinion testimony is not conclusive, and the jury has every right not to accept it." Gregg v. U.S. Indus., Inc., 887 F.2d 1462, 1470 (11th Cir. 1989) (citing Remington Arms Co., Inc. v. Wilkins, 387 F.2d 48, 54 (5th Cir. 1967)). Consequently, Hershberger's opinions are not so credible that they would entitle Plaintiff to a directed verdict. In a similar situation, the District Court for Montana denied a plaintiff's motion for partial summary judgment and rejected "the proposition that the conclusions an expert reaches after opining on the standard of care are, as a matter of law, indisputable if [d]efendants have not offered a contrary opinion as to the standard of care." Reiner v. Warren Resort Hotels, Inc., No. CV 06-173-M-DWM, 2008 WL 5120682, at *2 (D. Mont. Oct. 1, 2008). The Court explained that, as the party bearing the burden of proof, the plaintiff had merely "made a prima facie case—met her burden of production—of negligence. It is for the trier of fact, not the Court, to determine whether she meets her burden of persuasion." Id. at *2; see also Slocum v. Int'l Paper Co., No. CV 16-12563, 2021 WL 4169416, at *2 (E.D. La. Sept. 14, 2021) (rejecting plaintiffs' arguments that they were entitled to summary judgment due to defendant's failure to offer expert to refute their allegations of negligence, explaining that "[p]laintiffs are both the movants and the party that bears [the] burden of proof at trial," and, "[p]ut differently, summary judgment as to [p]laintiff[s'] negligence claims is not warranted simply because [p]laintiffs have offered expert opinion testimony in support of [defendant's] liability and [defendant] has

not"); In re Engle Progeny Cases, No. 309-CV-10000-WGJ-JBT, 2015 WL 12839192, at *2 (M.D. Fla. Jan. 13, 2015) (denying plaintiff's motion for judgment as a matter of law on issue of whether plaintiff was addicted to nicotine because plaintiff "bore the burden of proof, [and, therefore,] the jury was free to 'disregard all evidence favorable to [plaintiff] that [it was] not required to believe,' " and " '[e]ven uncontradicted expert opinion testimony is not conclusive' " and, as such, "jury was not required to accept [expert's] uncontroverted opinion that [plaintiff] was addicted to nicotine") (quoting Akouri v. State of Fla. Dep't of Transp., 408 F.3d 1338, 1343 (11th Cir. 2005) and Gregg, 887 F.2d at 1470). Consequently, even in light of Plaintiff's uncontroverted expert opinion evidence, the question of whether Hall breached the standard of care should remain in the jury's hands.

***21** Accordingly, the Court **DENIES** Plaintiff's request for summary judgment on the issue of whether Hall, Awe, and Wilson breached the standard of care by not referring Plaintiff to a vascular surgeon or specialist at an earlier date.

(3) Ignoring Requests to Re-Examine Plaintiff's Toe Between His Initial Exam and the Date His Toe Was Autoamputated

Plaintiff alleges that Defendants "violated standard of care when [they] ignored numerous nurse requests to re-examine [his] foot between his initial examination and the date on which [his] toe autoamputated." (Doc. 100-1, pp. 19–20.) For support, Plaintiff points to Awe's testimony that the nurses performing Plaintiff's daily bandage changes would have asked one of the providers to see Plaintiff if they observed his wound getting worse. (Id. at p. 19 (quoting doc. 119, p. 73).) According to Plaintiff, "[a]t least two nurses did this more than once because they were concerned about [Plaintiff's] toe, yet neither Awe nor any other ALP bothered to re-examine [Plaintiff's] toe between May 17th and June 7th." (Doc. 100-1, p. 20.) This, Plaintiff contends, "clearly falls short of the 'reasonable degree of care' required by O.C.G.A. § 51-1-27." (Id.)

As a preliminary matter, Plaintiff has not cited any expert testimony establishing that a physician violates the standard of care by not following up on a nurse's request to re-examine a patient. (See id. at pp. 19–20.) However, even if Plaintiff had done so, there is a genuine dispute of fact that precludes summary judgment on this issue. Plaintiff cites his own testimony and the testimony of nurses Gatewood, Parker, and Amber Anderson to show that Gatewood and Anderson complained to a provider that Plaintiff's toe was worsening. (Doc. 100-1, p. 20 (citing doc. 137-1, p. 20).) Parker testified that in May or June of 2019, Gatewood told her that she had complained to Awe about Plaintiff's toe. (Doc. 123, pp. 43–45.) However, Gatewood herself testified that she did not recall telling Parker that she was concerned with Plaintiff's toe and could not say with certainty whether she voiced similar concerns to an ALP. (Doc. 122, pp. 38–39.) Thus, a reasonable juror could find that Gatewood did not request Awe to examine Plaintiff.

Furthermore, although nurse Amber Anderson testified that she "complained several times to [ALPs] ... at [the Prison] about [Plaintiff's] toe," she did not specify *which* ALPs she complained to. (Doc. 117-2, p. 2.) The Court, therefore, cannot determine, based on this testimony alone, whether Anderson complained to Awe or Hall, or instead to some other ALP at the Prison (who may not have even been a GCHC employee). Finally, despite Plaintiff's claim to the contrary, there *is* evidence that Plaintiff's foot was examined by an ALP between May 17 and June 7. Specifically, Hall testified that she examined Plaintiff's toe on June 5, and the medical encounter form from this date corroborates her testimony.[14] (Doc. 120, pp. 22, 24–25; doc. 108-1, p. 15.)

***22** Based on the forgoing, the Court **DENIES** Plaintiff's Motion for Summary Judgment on his claim that Defendants violated the standard of care when they ignored numerous nurse requests to re-examine his foot between his initial examination and the date on which his toe autoamputated.

III. Hall's Motion for Summary Judgment as to Plaintiff's Deliberate Indifference Claim Against Her (Doc. 92)

Hall contends that summary judgment is appropriate as to Plaintiff's Section 1983 claim against her because the evidence in the record satisfies neither the objective nor the subjective components necessary to prevail on a claim for deliberate indifference to medical needs. (Doc. 92-2, pp. 9–15.) According to Hall, this case amounts to a dispute over the proper course of treatment which does not amount to deliberate indifference. (Id. at pp. 15–17.) Alternatively, Hall contends that she is entitled to qualified immunity. (Id. at pp. 17–19.)

"[D]eliberate indifference to serious medical needs of prisoners constitutes the 'unnecessary and wanton

infliction of pain' [that is] proscribed by the Eighth Amendment." Estelle v. Gamble, 429 U.S. 97, 104 (1976) (internal citation omitted). "To show that a prison official acted with deliberate indifference to serious medical needs, a plaintiff must satisfy both an objective and a subjective inquiry." Brown v. Johnson, 387 F.3d 1344, 1351 (11th Cir. 2004). "First, the plaintiff must prove an objectively serious medical need. Second, the plaintiff must prove that the prison official acted with deliberate indifference to that need." Id. (internal citation omitted). In light of disputes between the parties concerning the proper applicable standard as well as recent guidance from the Eleventh Circuit, the Court will address each of these components in detail.

A. Objective Component (Serious Medical Need)

Hall concedes that Plaintiff had an objectively serious medical need when he presented to her on May 30 and June 5, 2019. (Doc. 146, p. 3.) Additionally, there is support in this circuit for finding that Plaintiff's condition was an objectively serious medical need. See, e.g., Milton v. Turner, 445 F. App'x 159, 163 (11th Cir. 2011) (holding that for a diabetic, an infected toe, which was worsening and potentially risked amputation, presented a serious medical need); Walsh v. Jeff Davis Cnty., No. 2:10-cv-075, 2012 WL 12952564, at *7 (S.D. Ga. Mar. 29, 2012), ("[I]t is beyond question that reduced blood flow in a diabetic which is severe enough to cause a leg amputation is a serious medical need."), *aff'd*, 489 F. App'x 389 (11th Cir. 2012). Thus, according to Plaintiff, because he suffered from an objectively serious medical need, he has satisfied the objective component of his claim. There is support in this circuit for this conclusion. See Hayes v. Lewis, No. 6:16-cv-20, 2017 WL 104176, at *3 (S.D. Ga. Jan. 10, 2017), ("Plaintiff has shown that he has a serious medical need and has, therefore, satisfied the objective component of his deliberate indifference claim."), *report and recommendation adopted sub nom.* Hayes v. Toole, No. 6:16-CV-20, 2017 WL 898000 (S.D. Ga. Mar. 7, 2017); Dunn v. Hart, No. 5:13-cv-131, 2016 WL 5661058, at *4 (S.D. Ga. Sept. 29, 2016) ("The parties do not dispute that Plaintiff had a serious medical need following his attack and, therefore, agree that Plaintiff has satisfied the objective component of his deliberate indifference claim.").

***23** Notwithstanding, Hall maintains that summary judgment in her favor is warranted on the objective component. According to Hall, showing an objectively serious medical need is just the first prong necessary to satisfy the objective component, and the second prong requires showing that the public official's response to the plaintiff's serious medical need was "poor enough to constitute an unnecessary and wanton infliction of pain." (Doc. 92-2, p. 10 (quoting Taylor v. Adams, 221 F.3d 1254, 1257 (11th Cir. 2000)); doc. 146, p. 2 (same).) Plaintiff responds that "proving the 'unnecessary and wanton infliction of pain' is part of the subjective (deliberate indifference) prong, not the objective (serious medical need) prong." (Doc. 138, p. 13 n.15.)

The Eleventh Circuit's articulation of the objective component of deliberate indifference to serious medical needs claims has been somewhat inconsistent. Although Taylor and a handful of subsequent Eleventh Circuit cases (all of which cite Taylor) have included the "unnecessary and wanton" prong, see, e.g., Evans v. St. Lucie Cnty. Jail, 448 F. App'x 971, 974 (11th Cir. 2011); Bingham v. Thomas, 654 F.3d 1171, 1176 (11th Cir. 2011), in the vast majority of cases, the court has framed the objective component as merely requiring the plaintiff to show that he or she had an objectively serious medical need. See, e.g., Wright v. Sprayberry, 817 F. App'x 725, 730 (11th Cir. 2020) ("The objective inquiry requires that the prisoner show an objectively serious medical need.") (internal quotation omitted); Brennan v. Comm'r, Ala. Dep't of Corr., 626 F. App'x 939, 941 (11th Cir. 2015) ("To establish a claim of deliberate indifference under 42 U.S.C. § 1983, a plaintiff must satisfy an objective component by showing that he had a serious medical need.") (citing Goebert v. Lee Cnty., 510 F.3d 1312, 1326 (11th Cir. 2007)). This is the standard that the Eleventh Circuit has applied recently. See, e.g., Wade v. McDade, 67 F.4th 1363, 1370 (11th Cir. 2023) (stating that a "plaintiff-inmate must establish an objectively serious medical need" to satisfy the objective component and finding that "an unmedicated seizure disorder satisfies that objective threshold") (internal quotations omitted); Myrick v. Fulton Cnty., 69 F.4th 1277, 1305 (11th Cir. 2023) (noting that satisfying the objective component required a showing that the plaintiff "had an objectively serious medical need"). Indeed, this Court's recent decisions have followed suit, focusing the objective inquiry on the existence of a serious medical need and not requiring (or even mentioning) the need to show a wanton infliction of pain. See, e.g., Bayse v. Philbin, No. 1:22-cv-024, 2023 WL 2950633, at *7 (S.D. Ga. Feb. 23, 2023) ("To state a claim for deliberate indifference to serious medical needs, Plaintiff must allege: (1) a serious medical need—*the objective component*, (2) a defendant acted with deliberate indifference to that need—*the subjective component*, and (3) injury caused by a defendant's wrongful conduct.") (emphasis added), *report and recommendation adopted*, No. 1:22-cv-024, 2023 WL 2730664 (S.D. Ga. Mar. 31, 2023).

Accordingly, the Court follows the weight of authority in this Circuit and finds that, because Hall has conceded that Plaintiff had a serious medical need, the objective component is apparently satisfied, and summary judgment is not warranted in Hall's favor on this specific issue. See James v. Am. Int'l Recovery, Inc., 799 F. Supp. 1156, 1166 (N.D. Ga. 1992) ("The rule within the Eleventh Circuit is that in the event there is an intra-circuit conflict on a given issue, the district court is required to follow Supreme Court authority or the weight of authority within the circuit.") (collecting cases) (internal quotation omitted). Thus, the Court **DENIES** this portion of Hall's Motion for Summary Judgment.

B. Subjective Component (Deliberate Indifference)

***24** Earlier this year, in Wade v. McDade, the Eleventh Circuit clarified the standard for meeting the subjective component. 67 F.4th at 1370–74. Prior to this ruling, the precise level of negligence necessary to satisfy the subjective component in a deliberate indifference claim was unclear. As the Court noted:

> A deliberate-indifference claim's subjective component entails three subparts: The plaintiff must prove that the defendant (1) actually knew about a risk of serious harm; (2) disregarded that risk; and (3) acted with more than _____ negligence. To be clear, the blank in our paraphrase is intentional. For more than 25 years now, our case law regarding a deliberate-indifference claim's mens rea element has been hopelessly confused, resulting in what we'll charitably call a "mess." We've tried to clean up that mess at least twice, but seemingly to no avail, as panels continue to flip-flop between two competing formulations: "more than *mere* negligence" and "more than *gross* negligence." We find it necessary to address the mens rea issue once again—this time, we hope more definitively ....

Id. at 1370–71 (internal citation omitted). Ultimately, the court determined that the prior-panel-precedent rule compelled the court to follow the "more than gross negligence" standard expressly adopted by the panel in Townsend v. Jefferson County, 601 F.3d 1152, 1158 (11th Cir. 2010).[15] Wade, 67 F.4th at 1373. Thus, incorporating this clarified standard, to satisfy the subjective component of an Eighth Amendment deliberate-indifference claim after Wade, "a plaintiff must establish that the defendant (1) had subjective knowledge of a risk of serious harm, (2) disregarded that risk, and (3) acted with more than *gross* negligence." Id. at 1374.

(1) Subjective Knowledge

Subjective knowledge of the risk requires that the defendant be "aware of facts from which the inference could be drawn that a substantial risk of serious harm exists." Farmer, 511 U.S. at 837. It also requires the defendant to "draw the inference." Id. "Whether a prison official had the requisite knowledge of a substantial risk is a question of fact subject to demonstration in the usual ways, including inference from circumstantial evidence." Id. at 842. Furthermore, "a factfinder may conclude that a prison official knew of a substantial risk from the very fact that the risk was obvious." Id.

Viewed in the light most favorable to Plaintiff, a reasonable jury could find that Hall, as a medical professional, subjectively knew Plaintiff faced a serious risk when he presented to her. As set forth previously, there is no question that, on June 5, Hall knew that Plaintiff had diabetes, PVD, and prior amputations on his left foot, and that he had been sent to the wound care clinic for what the form termed a "diabetic foot ulcer." (See doc. 108-1, p. 15; see also doc. 120, pp. 31–32.) The risk of amputation for patients with diabetes and PVD who develop infections on their lower extremities is well-documented in the record. (See generally docs. 92-5, 92-6, 92-7, 92-8.) Indeed, Hall herself testified that she had dealt with toe infections in individuals with diabetes and that, in her opinion, diabetics "have a higher risk [of amputation]." (Doc. 120, pp. 27–28.) Additionally, there is evidence that Hall specifically appreciated the condition of Plaintiff's toe. Plaintiff testified that when he presented to Hall on June 5, he took off his shoe, which he stated was full of blood, and showed Hall his foot. (Doc. 118, p. 52; doc. 138-2, p. 2.) According to Plaintiff, Hall responded, "Oh I guess we ought to do something about that," and they went to the E.R. to have the dressings changed. (Doc. 118, pp. 52–53.) Plaintiff testified that, when the nurse unwrapped it, Hall said, "Don't be showing me shit like that, it will make me lose my lunch." (Id. at p. 53.)

***25** Finally, Hall testified that, when she saw Plaintiff on June 5, "the records from the wound care clinic had been obtained and were on his chart, and [she] signed that [she] reviewed [them] ..." (Doc. 92-4, p. 5.) These records stated that Plaintiff's left foot had a "pitting edema" and no palpable pulse, a weak dorsalis pedis pulse, and no posterior tibial pulse. (Doc. 119-2, p. 12.) The records described Plaintiff's wound as a "diabetic ulcer" that was worsening due to "poor circulation," stated that the toe looked like it was almost autoamputated, and noted that

"there is tendon exposed," a "large amount of serosanguineous drainage," and "a medium (34-66%) amount of necrotic tissue within the wound bed." (Doc. 137-1, p. 22 (quoting doc. 119-2, pp. 15, 17).) The records additionally provided that "a follow-up appointment should be scheduled" and that Plaintiff "surely will need another vascular eval[uation]" because, the wound care physician suspected, Plaintiff "may not have adequate circulation to heal [his] toe ulcer." (Id. (quoting doc. 119-2, p. 18).) Moreover, while not indicated in the wound care clinic records, Hall documented in the June 5 encounter form that Plaintiff "stated he was told by wound clinic that he was supposed to [follow up with] Vascular to have an amputation." (Doc. 108-1, p. 15.)

In light of the above, a reasonable jury could find that Plaintiff's medical issues were grave and obvious and that, on June 5, Hall subjectively knew and inferred that Plaintiff faced a substantial risk of serious harm. See Keele v. Glynn Cnty., 938 F. Supp. 2d 1270, 1296 (S.D. Ga. 2013) ("Because the seriousness of [the plaintiff's] medical needs was obvious, the Court must conclude ... that [the defendant nurse] subjectively knew that [the plaintiff] faced a substantial risk of serious harm.").

(2) Disregard of the Risk by Conduct that is More than Gross Negligence

After showing Hall's awareness of the substantial risk of harm, Plaintiff must then show that Hall disregarded that risk by conduct that is more than grossly negligent. Wade, 67 F.4th at 1374. "[M]ore than gross negligence" is " 'the equivalent of recklessly disregarding' a substantial risk of serious harm to the inmate." Id. at 1375 (quoting Cottrell v. Caldwell, 85 F.3d 1480, 1491 (11th Cir. 1991)). A defendant may disregard a risk with more than gross negligence by, among other conduct, "intentionally failing or refusing to obtain medical treatment, delaying treatment, providing grossly inadequate or inappropriate diagnosis or treatment, deciding to take an easier but less efficacious course of treatment, or providing medical treatment that is so cursory as to amount to no medical treatment at all." Davison v. Nicolou, No. 6:16-cv-039, 2016 WL 6404034, at *5 (S.D. Ga. Oct. 27, 2016) (citing McElligott v. Foley, 182 F.3d 1248, 1255 (11th Cir. 1999)).

A reasonable jury could find that Hall recklessly disregarded the serious risk to Plaintiff's health. As noted above, Plaintiff claims that when the ER nurse took off his bandages on June 5, Hall exclaimed, "Don't be showing me shit like that, it will make me lose my lunch," and proceeded to walk out of the ER and have the nurse attend to his foot. (Doc. 118, p. 53.) According to Plaintiff, Hall "literally only looked at [his] foot for about half a second." (Doc. 138-2, p. 2.) Though Hall denies making this statement, that merely raises a factual dispute for the jury to resolve. Moreover, the Court disagrees with Hall's contention that this statement is irrelevant. (Doc. 92-4, p. 6.) Hall conceded that she reviewed the wound care clinic's records which, as noted above, specifically stated that Plaintiff's toe was "almost auto[ ]amputate[ed]." (Doc. 119-2, p. 12; doc. 120, pp. 21–22, 31–32.) Moreover, Plaintiff told Hall that the wound care clinic told him that he needed to receive vascular care. In light of this evidence and the totality of the information concerning Plaintiff's grave condition—of which, under a construction most favorable to Plaintiff, Hall was fully aware—a jury easily could find that Hall's cursory evaluation of Plaintiff's foot and failure to refer him for vascular treatment, particularly after her alleged comment about losing her lunch, rises to the level of a reckless disregard of Plaintiff's medical needs. See Hardy v. Ga. Dep't of Corr., No. 1:17-cv-172, 2021 WL 3610466, at *7 (S.D. Ga. Aug. 13, 2021) (treating doctor's dismissive statements in response to diabetic plaintiff's complaints of pain as circumstantial evidence that the doctor disregarded the plaintiff's serious medical need).

***26** Hall contends that her conduct was not more than grossly negligent because "the evidence shows that she took reasonable steps to ensure that [Plaintiff] received treatment for his toe infection." (Doc. 92-2, p. 13.) She contends that she started Plaintiff on the antibiotic Clindamycin and instructed him to ask the wound care clinic about a referral to a vascular specialist at his follow-up in two weeks. (Id. at p. 15.) However, as noted above, Plaintiff contends that Hall never prescribed him Clindamycin or any other antibiotic. See note 3, supra. Moreover, although the encounter form documenting Hall and Plaintiff's June 5 appointment suggests that Hall took these steps, (doc. 108-1, p. 15), that does not preclude a finding that Hall's conduct exceeded gross negligence. "[A]n inmate is constitutionally entitled to medical care that is adequate to meet the needs of their particular situation." Brooks v. Wilkinson Cnty., 393 F. Supp. 3d 1147, 1164 (M.D. Ga. 2019). A jury could find that, by refusing to truly evaluate Plaintiff on June 5, Hall did not even evaluate the needs of Plaintiff's particular situation much less attempt to provide care adequate to meet those needs. For instance, even assuming that Hall prescribed Plaintiff Clindamycin on June 5, this could potentially cut *towards* a finding of deliberate indifference; just one month prior, Wilson had *discontinued* Clindamycin and prescribed a different antibiotic because, according to

Wilson, Plaintiff's infection "had not improved." (Doc. 121, pp. 30–31; see doc. 137-1, p. 12.) Indeed, the encounter form from May 3, 2019, contained in Plaintiff's medical records—with which Hall testified she was familiar, (see doc. 92-4, p. 6)—explicitly states that Plaintiff's toe infection was "not responsive to Clindamycin [for] 9 days," (doc. 108-1, p. 30). In essence, a jury could find that Hall failed to truly evaluate Plaintiff on June 5 and, therefore, provided him cursory treatment that was not designed, much less sufficient, to meet the specific needs he presented on that date and even conflicted with his prior course of treatment.

Additionally, a jury could find that it was reckless for Hall to instruct Plaintiff to ask about a referral rather than to request that referral herself, or, at the very least, to ask Awe whether such a referral would be appropriate. Hall concedes that she is "not a specialist in wound care or in the treatment of type II diabetes or in [PVD]." (Doc. 92-4, p. 6.) Plaintiff's expert, Dr. Powers, opined that Plaintiff's presentation on June 6 is an example of a situation where escalation to someone with a higher level of expertise and skill was required.[16] (Doc. 61, p. 6.) Despite this admitted lack of qualifications, Hall testified that she did not request or inquire about a referral to a vascular surgeon or specialist because "[t]here was no [such] referral" in the wound care clinic records. (Doc. 92-4, pp. 5–6.) According to Hall, "[t]here is no direct evidence in this case that [she] knew that escalation or referral to a vascular surgeon was required when she interacted with [Plaintiff]." (Doc. 92-2, p. 16.) The record, when viewed in the light most favorable to Plaintiff, belies this assertion. During her deposition, Hall conceded that the wound clinic indicated it "want[ed] to look at previous records[ ] and that [it] most likely would want a referral." (Doc. 120, p. 21.) Indeed, as noted above, Hanzel (the physician who evaluated Plaintiff at the wound care clinic) included in the records of the wound care visit that he "would like to get vascular eval[uation] and angio[gram] results from [Plainitff's] last hospitalization" and that Plaintiff "*surely* will need another vascular eval[uation]" because, Hanzel suspected, Plaintiff "may not have adequate circulation to heal [his] toe ulcer." (Doc. 119-2, p. 18 (emphasis added).) Hanzel also noted in the wound care records that Plaintiff had "no palpable pulse" in his left foot and that Plaintiff's wound "look[e]d like almost auto amputation." (Id. at p. 12.) Viewed in conjunction with the objective medical evidence as well as Plaintiff's statement to Hall during their June 5 encounter that Hanzel recommended he see a vascular surgeon to have the toe amputated, a jury could find that Hall's failure to take any action towards having Plaintiff see a vascular specialist or surgeon was more than grossly inadequate and essentially amounted to a complete disregard of his vascular condition.

***27** Hall maintains that her decision "not to pursue a particular course of treatment is a classic example of a medical judgment, an exercise of which does not represent cruel and unusual punishment." (Doc. 92-2, p. 15.) According to Hall, "[w]here a prisoner has received ... medical attention and the dispute is over the adequacy of the treatment, federal courts are generally reluctant to second guess medical judgments and to constitutionalize claims that sound in tort law." (Id. at p. 16 (quoting Hamm v. Dekalb Cnty., 774 F.2d 1567, 1575 (11th Cir. 1985)).) "Although courts hesitate to find an Eighth Amendment violation when an inmate has received medical care, [the Eleventh Circuit] has cautioned that such hesitation does not mean ... that the course of ... treatment of a prison inmate's medical ... problems can never manifest deliberate indifference." Kruse v. Williams, 592 Fed. App'x. 848, 858 (11th Cir. 2014) (internal quotations omitted) (ellipses in original).

As an initial matter, Hall's argument on this front appears to contradict her contention that she simply complied with the wound care clinic's directions to schedule Plaintiff for a follow-up in two weeks and to continue daily dressing changes. (Doc. 92-2, pp. 14–15.) That contention suggests that Hall did not exercise independent medical judgment or opt for a course of treatment she deemed appropriate based upon her review of Plaintiff's condition on June 5. A jury could find that rather than evaluating and treating Plaintiff, Hall essentially rubber-stamped the wound care clinic's orders, as she understood them, without considering whether a referral (or some other course of treatment) was medically necessary. During Hall's deposition, opposing counsel asked her, "[Y]ou didn't see the need at the time ... to refer him to either a vascular surgeon, or to send him to a hospital emergency room, is that right?" (Doc. 120, p. 35.) Hall responded, "I transcribe as the wound clinic orders, because that's what I was seeing him for, a follow-up wound clinic." (Id.) Counsel then asked Hall whether it was accurate that, "based on [her] review of ... what [she] saw, [she] didn't personally see the need to either send [Plaintiff] to a vascular surgeon as ... an urgent or emergent referral, or to send him straight to the hospital ER?" (Id.) Hall responded, "Well, I was seeing him for a follow-up wound clinic visit. He had just been seen by the wound clinic, and they didn't necessarily directly say that he needed to go to see the vascular surgeon, so the consult wasn't written." (Id. at pp. 35–36.) Finally, when asked whether she was "kind of following wound care's lead," Hall said, "Right. I transcribed it from the wound clinic, which are the specialists, which is why we sent him to wound clinic." (Id. at p. 36.) From this testimony, a jury

could find that Hall, a P.A. and (according to her own sworn testimony) an ALP at the Prison, blindly followed what she perceived to be the wound clinic's orders without meaningfully evaluating Plaintiff's condition or considering whether another course of action was necessary. Moreover, as explained above, the wound care clinic's records contained ample evidence that Plaintiff's condition had grossly deteriorated and that he needed treatment from a vascular specialist. Thus, the jury could reject Hall's contention that she read and followed the wound care clinic's directions.

The Court recognizes that deliberate indifference is a high bar, and Plaintiff cannot clear it by simply pointing to a more preferrable course of treatment or a bad outcome. However, in this case Plaintiff has produced evidence from which a jury could find that Hall's treatment of Plaintiff's condition amounted to no treatment at all. The evidence would permit a finding that Hall merely glanced at Plaintiff's toe despite his having presented to her for a follow-up from a referral to the wound clinic, that she only prescribed an antibiotic that had recently been discontinued for being ineffective and that would not in any event address the dire vascular conditions that he was facing, that she ignored evidence of his deteriorating condition, such as statements in the wound care clinic's notes that Plaintiff would need to be seen by a vascular surgeon, and that she failed to exercise the independent medical judgment called for by her position and Plaintiff's condition. Accordingly, a jury could find that Hall's conduct went beyond gross negligence and summary judgment is not warranted in Hall's favor on this issue. See Carswell v. Bay Cnty., 854 F.2d 454, 457 (11th Cir. 1988) (finding that there was sufficient evidence of deliberate indifference where, although the defendant-physician provided some treatment to the plaintiff, he ignored warnings that the plaintiff's condition was deteriorating and did "nothing significant to ensure that [he] received medical attention").

***28** For these reasons, the Court **DENIES** Hall's Motion for Summary Judgment as to the subjective component of Plaintiff's deliberate indifference claim.

C. Qualified Immunity

Hall contends, in the alternative, that she is entitled to qualified immunity because she was acting within her discretionary authority, her conduct did not rise to the level of deliberate indifference, and she did not violate clearly established law. (Doc. 92-2, pp. 17–19.)

"Qualified immunity protects government officials performing discretionary functions from suits in their individual capacities unless their conduct violates 'clearly established statutory or constitutional rights of which a reasonable person would have known.' " Dalrymple v. Reno, 334 F.3d 991, 994 (11th Cir. 2003) (quoting Hope v. Pelzer, 536 U.S. 730, 739 (2002)). To obtain qualified immunity, a defendant first must show that he acted within his discretionary authority. Mobley v. Palm Beach Cnty. Sheriff Dep't, 783 F.3d 1347, 1352 (11th Cir. 2015). Plaintiff does not dispute, and the record adequately supports, that Hall was acting within her discretionary authority as a P.A. at the Prison when she provided the challenged treatment to Plaintiff. (See generally doc. 138, pp. 24–26.)

Once a defendant establishes that she was acting within the scope of her discretionary authority, "the burden shifts to the plaintiff to show that qualified immunity is not appropriate." Nam Dang ex rel. Vina Dang v. Sheriff, Seminole Cnty., 871 F.3d 1272, 1279 (11th Cir. 2017). To make this showing, Plaintiff "must first prove that the facts alleged, construed in the light most favorable to [him], establish that a constitutional violation did occur." Shaw v. City of Selma, 884 F.3d 1093, 1099 (11th Cir. 2018). If Plaintiff establishes that a constitutional violation occurred, he then must demonstrate "that law existing at the time the conduct occurred clearly established that the conduct violated the constitution." Id.

The Court has already found that Plaintiff has raised a genuine dispute of fact as to whether Hall acted with deliberate indifference to his serious medical needs. See Discussion Sections, III, A–B. Additionally, Plaintiff has shown that such deliberate indifference would violate clearly established law. "The standard for determining whether a right is well-established for purposes of qualified immunity is whether the right violated is one about which a reasonable person would have known." Sparks v. Ingle, 724 F. App'x 692, 693 (11th Cir. 2018). In other words, the defendant must have "fair warning" that his or her conduct violated a constitutional right, which exists when there is "binding caselaw from the Supreme Court, the Eleventh Circuit, or the highest court of the state ... that make[s] it obvious to all reasonable government actors ... that what he [or she] is doing violates a federal law." Jones v. Fransen, 857 F.3d 843, 851 (11th Cir. 2017) (internal quotation omitted).

Decisions from the Supreme Court and the Eleventh Circuit gave Plaintiff "fair warning" that her alleged misconduct was unconstitutional. Id. In Estelle, the Supreme Court held that "deliberate indifference to serious medical needs of prisoners constitutes the

unnecessary and wanton infliction of pain, proscribed by the Eighth Amendment." 429 U.S. at 104 (internal citations and quotations omitted). Additionally, "[t]he Eleventh Circuit has ... stated in dicta that '[a] finding of deliberate indifference necessarily precludes a finding of qualified immunity; prison officials who *deliberately* ignore the serious medical needs of inmates cannot claim that it was not apparent to a reasonable person that such actions violated the law.' " Gartman v. Cheatham, No. 2:18-CV-534-MHT, 2021 WL 96467, at *9 (M.D. Ala. Jan. 11, 2021) (quoting Hill v. DeKalb Reg'l Youth Det. Ctr., 40 F.3d 1176, 1186 (11th Cir. 1994), *overruled in part on other grounds by* Hope, 536 U.S. 730). It has long been established that providing an easier or less efficacious course of treatment or grossly inadequate care constitutes deliberate indifference. See Waldrop, 871 F.2d at 1035; Steele v. Shah, 87 F.3d 1266, 1269–70 (11th Cir. 1996). Indeed, in 1988, the Eleventh Circuit held that a jail administrator who saw an inmate's deteriorating condition and was asked to get the inmate to a doctor could have been found deliberately indifferent for doing "nothing significant to ensure that [the inmate] received medical attention." Carswell, 854 F.2d at 457. Moreover, in 2007, the Eleventh Circuit found that "a decision to withhold medical care no matter what the circumstances actually were ... is deliberate indifference to the true facts of an inmate's medical condition and needs." Goebert, 510 F.3d at 1329.

***29** As already set forth in detail, the evidence, viewed in Plaintiff's favor, supports a finding that during Hall's June 5 follow-up to Plaintiff's wound care visit—the notes from which indicated that Plaintiff's toe was "almost auto-amputated"—Hall conducted an extremely cursory evaluation of Plaintiff's foot and ignored obvious signs that he had a severe medical need. There is also evidence that Hall ignored Plaintiff's statement that he was told to see a vascular surgeon to have his toe amputated and ignored the wound care records that stated that Plaintiff "surely" will need another vascular evaluation and described in detail the poor condition of Plaintiff's toe. Additionally, the evidence indicates that despite all indications of Plaintiff's grave condition, the only action Hall took, and even this action is disputed, was prescribing an antibiotic to Plaintiff that, as memorialized in Plaintiff's records, had been discontinued a few weeks prior for being ineffective. Additionally, the jury could determine that Hall failed to meaningfully evaluate Plaintiff's condition because she pre-determined that her role was merely to copy the wound clinic's orders. Put succinctly, the jury could determine that Hall's cursory treatment of Plaintiff amounted to no treatment at all. In light of precedent from this Circuit and the Supreme Court referenced above, most notably Carswell, a reasonable person would have known that Hall's conduct, when viewed in the light most favorable to Plaintiff, violated clearly established law.

Accordingly, the Court **DENIES** Hall's alternative request for summary judgment based on qualified immunity.

IV. Plaintiff's Motion for Reconsideration (Doc. 100)

Plaintiff asks the Court to reconsider its Order granting Defendants' prior motion for judgment on the pleadings as to Plaintiff's deliberate indifference claim against Awe, (doc. 64). (Doc. 100-1, pp. 22–26.) In the Order, the Court found that the Complaint failed to allege facts showing that Awe possessed the requisite knowledge to support a deliberate indifference claim or acted with "more than mere negligence."[17] (Doc. 64, pp. 8–15.)

The decision to grant a motion for reconsideration is committed to the sound discretion of the district court. Fla. Ass'n of Rehab. Facilities, Inc. v. State of Fla. Dep't of Health & Rehab. Servs., 225 F.3d 1208, 1216 (11th Cir. 2000). Motions for reconsideration are to be filed only when "absolutely necessary" where there is: (1) newly discovered evidence; (2) an intervening development or change in controlling law; or (3) a need to correct a clear error of law or fact or to prevent manifest injustice. Bryan v. Murphy, 246 F. Supp. 2d 1256, 1258–59 (N.D. Ga. 2003); Collins v. Int'l Longshoremen's Ass'n Loc. 1423, No. 2:09-cv-093, 2013 WL 393096, at *1 (S.D. Ga. Jan. 30, 2013). Motions for reconsideration are not appropriate to present the Court with arguments already heard and dismissed, to repackage familiar arguments, or to show the Court how it "could have done it better" the first time. Pres. Endangered Areas of Cobb's History, Inc. v. United States Army Corps of Eng'rs., 916 F. Supp. 1557, 1560 (N.D. Ga. 1995); Pottayil v. Thyssenkrupp Elevator Corp., 574 F. Supp. 3d 1282, 1301 (N.D. Ga. 2021). Furthermore, because reconsideration "is an extraordinary remedy to be employed sparingly," the movant "must set forth facts or law of a strongly convincing nature to induce the [C]ourt to reverse its prior decision." Armbuster v. Rosenbloom, No. 1:15-cv-114, 2016 WL 1441467, at *1 (S.D. Ga. Apr. 11, 2016).

A. Plaintiff's Judicial Notice Argument

Plaintiff first argues that facts already within the Court's knowledge raised a reasonable expectation that discovery would reveal evidence supporting his deliberate indifference claim against Awe. (Doc. 100-1, p. 22.) According to Plaintiff, the Court could have taken, and now should take, judicial notice of certain "facts" derived from Awe's sworn statements in prior lawsuits filed against him in this Court. (Id. at pp. 23–24.) Specifically, Plaintiff asks the Court to take judicial notice of the fact that Awe was the Prison's medical director as well as other facts concerning his supervisory responsibilities, arguing that these facts are "generally known within the [Court's] territorial jurisdiction" because they were stated in submissions in prior lawsuits against Awe.[18] (Id.) According to Plaintiff, these facts, along with the Complaint's allegations, "raise a reasonable expectation that discovery would reveal evidence that Dr. Awe had access to [Plaintiff's] medical history records, examined those records, [and] had subjective knowledge that Plaintiff was a high-risk vascular patient." (Id. at p. 24 (internal quotations omitted) (quoting doc. 64, p. 14).)

***30** This argument fails for multiple reasons. As a preliminary matter, "the Eleventh Circuit has distinguished between taking judicial notice of the fact that court records or court rulings *exist* versus taking judicial notice of the *truth* of matters stated within those court records or court rulings." Campo v. Granite Servs. Int'l, Inc., 584 F. Supp. 3d 1329, 1336 (N.D. Ga. 2022). Specifically, courts "may take judicial notice of a document filed in another court not for the truth of the matters asserted in the other litigation, but rather to establish the fact of such litigation and related filings." United States v. Jones, 29 F.3d 1549, 1553 (11th Cir. 1994) (internal quotations omitted). Plaintiff's request for judicial notice of Awe's position and responsibilities at the Prison exceeds that limited purpose. Plaintiff does not seek judicial notice simply to "establish the fact of such litigation and related filings"; he is attempting to establish the truth of assertions made in these cases and then to extrapolate that these facts show Awe possessed the requisite subjective knowledge for deliberate indifference. This is impermissible. See Campo, 584 F. Supp. 3d at 1336 (refusing to take judicial notice of a declaration filed in a separate case because the defendants sought "to establish the truth of the assertions contained in the filing itself"); Collier HMA Physician Mgmt., LLC v. NCH Healthcare Sys., Inc., No. 218-CV-408-FTM-38-MRM, 2019 WL 277733, at *3 (M.D. Fla. Jan. 22, 2019) (declining to take judicial notice of "the accuracy of the factual allegations, arguments, or legal conclusions contained within the state court filings").

Moreover, even if the Court were to take judicial notice of Plaintiff's proffered facts, this would not be a sufficient basis to grant Plaintiff's Motion to Reconsider. Setting aside whether Awe's sworn statements in other lawsuits would actually constitute "[n]ewly discovered evidence" that could justify reconsideration, Plaintiff fails to explain *how* Awe's statements make his deliberate indifference claim any more plausible. As identified in the Court's Order, the Complaint fails "to allege that ... Awe had access to Plaintiff's medical history records, examined those records, or had subjective knowledge that Plaintiff was a 'high-risk vascular patient.' " (Doc. 64, p. 14.) This deficiency was relevant in the Court's analysis because Plaintiff had to plausibly demonstrate, *inter alia*, that Awe subjectively knew Plaintiff faced the risk of serious harm in order to avoid dismissal for failure to state a claim. Haney v. City of Cumming, 69 F.3d 1098, 1102 (11th Cir. 1995). Plaintiff contends in conclusory fashion that Awe's sworn statements would address this shortcoming yet fails to explain how Awe's status as the Prison's medical director plausibly shows that Awe subjectively knew Plaintiff confronted a risk of serious harm. (See generally doc. 100-1, pp. 23–24.)

Finally, even if Plaintiff had done so, this *still* would not have been enough to state a claim for deliberate indifference because the Complaint's allegations did not plausibly allege that Awe acted with the requisite level of negligence. Indeed, the Court explicitly said so in the Order. (See doc. 64, p. 15 ("[E]ven if the Complaint alleged that ... Awe was subjectively aware that Plaintiff was a 'high-risk vascular patient,' Plaintiff still failed to allege facts sufficient to establish that ... Awe showed such indifference that can offend evolving standards of decency in violation of the Eighth Amendment.") (internal quotations omitted).)

Accordingly, the Court rejects Plaintiff's Motion for Reconsideration on this basis.

B. Evidence Brought to Light in Discovery

Plaintiff next argues that the Court should reconsider its Order because a jury could find Awe was deliberately indifferent based on evidence brought to light during discovery that shows "Awe's brazen and callous lack of concern for [Plaintiff]." (Doc. 100-1, pp. 24–25.) The Court disagrees. The only evidence Plaintiff points to in support is an exchange during Awe's deposition in which Awe insinuated that Plaintiff may have used a wheelchair because he was lazy and wanting pity. (Id. at p. 25) (citing doc. 119, pp. 67–68 (Awe speculating that Plaintiff did not really need to use a wheelchair but just did not want to

exercise).) However, this testimony provides no insight into the treatment of Plaintiff's toe and, aside from broadly asserting that such statements could support a punitive damages claim,[19] Plaintiff provides no explanation as to how this testimony could lead a jury to find that Awe's conduct from April 23 until Plaintiff's toe was amputated on June 7 violated the Eighth Amendment. Therefore, the Court will not reconsider its Order on the basis of this testimony.

***31** In sum, Plaintiff has failed to persuade the Court that it should reconsider its Order dismissing Plaintiff's deliberate indifference claim against Awe, and, accordingly, Plaintiff's Motion for Reconsideration is **DENIED**. (Doc. 100, pp. 22–26.)

CONCLUSION

Based on the forgoing, the Court **GRANTS** GDC's Motion for Summary Judgment as to the claims asserted against it because the Court finds that its sovereign immunity has not been waived. (Doc. 90.) Accordingly, the Court **DISMISSES** all claims against GDC and dismisses it from the case. The Court **DIRECTS** the Clerk of Court to update the docket accordingly. The Court **DENIES** BOR's Motion for Partial Summary Judgment as to Plaintiff's claims based on Wilson's alleged negligence because there is a genuine dispute of fact as to Wilson's employment status, which precludes a finding as to whether BOR has waived its sovereign immunity for claims arising from her alleged misconduct. (Id.) The Court **DENIES** Hall's Motion for Summary Judgment because sufficient evidence exists to support a verdict in Plaintiff's favor on his deliberate indifference claim against her and Hall has not proven she is entitled to qualified immunity. (Doc. 92.) The Court **DENIES as moot, and without prejudice,** BOR, GDC, and Hall's Motion to Exclude portions of Plaintiff's proffered expert's opinion. (Doc. 93.)

The Court **GRANTS in part and DENIES in part** Plaintiff's Motion for Partial Summary Judgment. (Doc. 100.) Specifically, the Court finds that Awe and Hall were employees of GCHC during all relevant times and, thus, BOR has waived its sovereign immunity for claims arising from their negligence, and the Court, therefore, **GRANTS** Plaintiff summary judgment on this issue. However, the Court finds there is a genuine dispute of fact as to whether Wilson was an employee of GCHC or was an independent contractor, precluding a finding that BOR has waived its sovereign immunity from claims arising from Wilson's alleged negligence. Thus, the Court **DENIES** Plaintiff summary judgment as to this issue. The Court also **DENIES** Plaintiff's request for summary judgment in his favor on the issue of whether GDC's sovereign immunity has been waived. Next, the Court **DENIES** Plaintiff's request that the Court enter summary judgment in his favor "find[ing] that the standard of care is determined by" certain specified SOPs, standards, and guidelines (in addition to the testimony of Plaintiff's experts).[20] (See doc. 100, p. 2.) The Court also **DENIES** Plaintiff's request for summary judgment regarding whether the standard of care was violated prior to April 23, 2019 (the date set forth in the ante litem notice). The Court also **DENIES** Plaintiff summary judgment on his claims that GCHC violated the standard of care when its employees purportedly ignored requests to re-examine Plaintiff's foot and also when its employees failed to refer Plaintiff to a vascular surgeon after he presented for care on or about April 25 through 26, 2019, on May 3, 2019, on May 16, 2019, on May 30, 2019, and on June 5, 2019. These latter two issues are for a factfinder to determine.

***32** The Court **GRANTS in part and DENIES in part** Plaintiff's Motion to Exclude portions of Defendants' experts' opinions. (Doc. 100.) Specifically, the Court **GRANTS** Plaintiff's Motion to exclude Fowlkes' opinion that Defendants met the standard of care as well as his opinion that Defendants did not cause Plaintiff's injuries. The Court also **GRANTS** Plaintiff's Motion to exclude Horn's opinion that Defendants met the standard of care, but the Court **DENIES** Plaintiff's Motion to exclude Horn's opinion that Defendants did not cause Plaintiff's injuries.

Finally, the Court **DENIES** Plaintiff's Motion to reconsider the Court's Order dismissing Plaintiff's Section 1983 claim against Awe because Plaintiff has failed to convince the Court that reconsideration is necessary or warranted. (Id.)

SO ORDERED, this 8th day of September, 2023.

All Citations

Slip Copy, 2023 WL 5837501

Footnotes

1 In its Order dated August 1, 2022, the Court dismissed Plaintiff's Eighth Amendment claims against Awe (in his official and

individual capacities) and Hall (in her official capacity). (Doc. 64.) The Court also dismissed any Eighth Amendment claims asserted against BOR and GDC. (Id.)

2 The nurses who were performing the daily dressing changes realized that Plaintiff's toe had been "off" for a while and that what they were doing was not helping, so they voiced concerns and placed requests for Awe or another ALP to examine him. (Doc. 137-1, p. 19; see doc. 36, pp. 36–37; doc. 117, p. 2.) Specifically, Gatewood expressed concerns to Vinetta Parker, a nurse in the emergency room, at least twice about Plaintiff's toe and told Parker that she (Gatewood) had shared these concerns with either Awe or some other ALP. (Doc. 137-1, p. 20.) Plaintiff additionally testified that Gatewood told him that she had asked Awe to re-examine his toe multiple times, but Awe did not answer her. (Doc. 137-1, p. 20; doc. 118, p. 91.)

3 Plaintiff denies that Hall prescribed him Clindamycin or any other antibiotic. (Doc. 138-2, p. 3 ("At no time in 2019 did Hall ever prescribe me Clindamycin ....").) Plaintiff's testimony is seemingly corroborated by the absence of a record for this prescription on Plaintiff's prescription log. (See generally doc. 138-6.) Thus, there is a genuine dispute of fact as to whether Hall, in fact, "started [Plaintiff on] Clindamycin," as indicated on the form. (Doc. 108-1, p. 15.)

4 The Court takes judicial notice of this fact. See https://www.augusta.edu/mcg/.

5 In their Response to Plaintiff's Statement of Material Facts, State Defendants object to the portions which discuss or cite to the Interagency Agreement, arguing that it is "unauthenticated hearsay" and was not identified "by any witness with knowledge." (See doc. 137-1, pp. 32–36.) The authentication objection is absurd because State Defendants *produced* the Interagency Agreement during discovery. Additionally, even if the Interagency Agreement were hearsay (the Court is not weighing in one way or the other), the Court may consider it at summary judgment because it could be reduced to an admissible form at trial. See Jones v. UPS Ground Freight, 683 F.3d 1283, 1293–94 (11th Cir. 2012) ("[A] district court may consider a hearsay statement in passing on a motion for summary judgment if the statement could be reduced to admissible evidence at trial or reduced to admissible form.").

6 "Locum tenens" is defined as "one filling an office for a time or temporarily taking the place of another—used especially of a doctor or clergyman." *Locum tenens*, Merriam-Webster Online Dictionary (2023), https://www.merriam-webster.com/dictionary/locum% 20tenens.

7 The Complaint also named Dr. Wilson, Awemd, Inc. and John/Jane Does 1–10 as Defendants. (Doc. 1, p. 30.) Plaintiff filed an Amended Complaint substituting Consilium for Jane/John Doe 1. (Doc. 1, pp. 151–52.) Subsequently, Plaintiff moved for the dismissal of Wilson and Consilium, (docs. 44, 48), and Awemd, Inc., (docs. 82, 85). Although not addressed by the parties, John/Jane Does 2–10 are still named as Defendants in this case. "As a general matter, fictitious-party pleading is not permitted in federal court." Turner v. Martin, 521 F. Supp. 3d 1310, 1323 (S.D. Ga. 2021) (quoting Richardson v. Johnson, 598 F.3d 734, 738 (11th Cir. 2010)). Although a limited exception to the rule exists, id., it is not applicable in this case, and, accordingly, the remaining John/Jane Doe Defendants are **DISMISSED** from the case.

8 While Williams was decided before the Code was amended in 1994, this definition remains the same in the current version of the Code. See O.C.G.A. § 51-2-4.

9 In 2005, the Georgia legislature enacted O.C.G.A. § 51-2-5.1(f), which provides that "[w]hether a health care professional is ... an

employee[ ] or an independent contractor shall be determined *by the language of the contract between the health care professional and the hospital.*" O.C.G.A. § 51-2-5.1(f) (emphasis added). This "effectively superseded Lee and Cooper by allowing the language of the contract to control." Pendley v. S. Reg'l Health Sys., Inc., 704 S.E.2d 198, 201 n.3 (Ga. Ct. App. 2010). Section 51-2-5.1 also prohibited courts from considering some of the Lee and Cooper factors if there is no contract or the contract is unclear or ambiguous as to the relationship between the hospital and the doctor. Id.; see O.C.G.A. § 51-2-5.1(g). The Court has not been directed to evidence that the Prison's medical facility or GCHC is a "hospital," which Section 51-2-5.1(a)(2) defines to mean "a facility that has a valid permit or provisional permit issued by the Department of Community Health under Chapter 7 of Title 31." Nothing that the Court has found in the extensive record indicates that either of them holds such a permit. Accordingly, the Court cannot find on this record that the statute applies, and, therefore, concludes that it may rely upon Lee and Cooper when determining Wilson's employment status. See Barney v. Peters, No. 4:20-173, 2022 WL 18673310, at *3 n.4 (S.D. Ga. Dec. 15, 2022).

Moreover, even if the statute were applicable, the record lacks a "contract between [Wilson] and the hospital" which would be controlling under Section 51-2-5.1(f). O.C.G.A. § 51-2-5.1(f). Consequently, this case would instead be governed by Section 51-2-5.1*(g)*, which essentially permits courts to consider whatever factors they deem relevant, except for a few prohibited factors outlined in paragraph (2). See O.C.G.A. § 51-2-5.1(g) (providing that "[i]f the court finds that there is no contract or that the contract is unclear or ambiguous as to the relationship between the hospital and health care professional, the court shall apply" certain specific factors enumerated in paragraph (1) and "*factors not specifically excluded in paragraph (2)*") (emphases added). The prohibited factors in paragraph (2) are not particularly relevant here and have not been considered, irrespective of Section 51-2-5.1.

10 For example, GDC and BOR acknowledge that the "GDC Medical Director could review the work of any GCHC employee or contractor, ... [and] recommend oral or written counseling, reduction in privileges, suspension, or separation to the GCHC Medical Director." (Doc. 137-1, pp. 34–35.) Furthermore, Lewis testified that GCHC's medical staff had to follow GDC's SOPs. (Doc. 126, pp. 30–31.) However, beyond following the SOPs, Lewis denied that "GDC controlled what providers actually did on a daily basis in the prisons." (Id. at p. 30.)

11 Plaintiff appeared to move for summary judgment on the issue of whether GCHC was a joint enterprise of Defendants GDC and BOR and, therefore, whether GDC is liable, pursuant to the GTCA, for the actions of Awe, Hall, and Wilson. (Doc. 100, p. 1; doc. 100-1, pp. 11–12.) For the reasons set forth herein, the Court finds that not only has Plaintiff not produced sufficient undisputed evidence to warrant judgment in his favor on this issue, but he has also not produced evidence from which a rational trier of fact could find in his favor even when viewing this issue in the light most favorable to him. Accordingly, the Court **DENIES** Plaintiff's Motion for Partial Summary Judgment as to his contentions that GCHC was a joint enterprise of Defendants GDC and BOR and that, therefore, GDC could be held liable for the actions of Awe, Hall, and/or Wilson.

12 In his Reply in support of his Motion to Exclude, Plaintiff raises new arguments for why Horn's causation analysis is unreliable. Issues raised for the first time in a reply brief are not properly before the Court where they could and should have been presented previously, Evans v. Berryhill, No. 3:15-cv-096, 2017 WL 989274, at *6 (S.D. Ga. Feb. 21, 2017), and it is well-established that the Court need not consider them, Kellner v. NCL (Bahamas), LTD., 753 F. App'x 662, 667 (11th Cir. 2018). Accordingly, the Court need not address these arguments. The Court is satisfied that Horn's ample experience "with the management of complex wounds" and "limb salvage operations," which Horn sufficiently connected to his causation opinions, provides a reliable basis for his opinion that Plaintiff's toe would have had to be amputated even if he had been referred to a vascular surgeon earlier. (See doc. 100-1, p. 28.)

13 Merriam-Webster's Medical Dictionary defines "ischemia" as a "deficient supply of blood to a body part (as the heart or brain) that is due to obstruction of the inflow of arterial blood." *Ischemia*, Merriam-Webster's Medical Dictionary, https://www.merriam-webster.com/dictionary/ischemia#medicalDictionary. Dr. Hershberger defined CLTI as "ulceration to the foot caused by a lack of blood flow." (Doc. 60, p. 5.)

14 In Hall's Response to Plaintiff's first set of interrogatories, she stated under penalty of perjury that physician's assistants such as herself are ALPs. (Doc. 138-3, p. 4; see id. at p. 8 (signed verification of Hall's responses).)

15 "[U]nder [the Eleventh Circuit's] prior-panel-precedent rule, a prior panel's holding is binding on all subsequent panels unless and until it is overruled or undermined to the point of abrogation by the Supreme Court or by [the Eleventh Circuit] court sitting *en banc*." In re Lambrix, 776 F.3d 789, 794 (11th Cir. 2015) (internal quotations omitted).

16 Defendants have moved to exclude certain bolded portions of Powers' expert report on the grounds that they are improper legal conclusions and are "not proper areas for expert testimony." (Doc. 93, pp. 5–8.) Defendants ask that the Court refuse to consider the statements in ruling on Hall's Motion. The Court has not considered any of the objected-to statements in its analysis. Accordingly, the Court **DENIES as moot** the Motion. (Doc. 93.) This denial is **WITHOUT PREJUDICE** and thus, to the extent that Defendants seek to exclude the bolded portions from being considered *at trial*, they can re-raise their objections at a later date.

17 The Court framed the standard as "more than *mere* negligence" rather than "more than *gross* negligence," as it has in this Order, because Wade, 67 F.4th at 1366, had not yet been published. (See doc. 64, p. 9.) To be sure, the Court's analysis in the Order is not undermined by Wade's clarification that the standard is "more than gross negligence" rather than "more than mere negligence" because if the Complaint did not allege enough to meet the former version of the standard, it most certainly would not have been able to meet the latter standard (which is more burdensome on plaintiffs as it requires a stronger allegation of negligence).

18 Plaintiff also appears to argue that certain allegations in the Complaint, such as Paragraph 38, plausibly showed that Awe refused to treat or withheld treatment from Plaintiff. (See doc. 100-1, p. 24 (arguing the allegation is enough to support an inference that Awe "refused to treat Plaintiff" because it alleges that no one examined his toe from May 3–28).) This is an attempt to re-litigate an issue that has already been decided. (See doc. 64, pp. 14–15.) The Complaint's allegations are not "newly discovered evidence," and, thus, are not an appropriate basis for reconsideration.

19 To the extent Plaintiff argues that it would be unfair to "let Awe off the hook individually" because it would limit Plaintiff's ability to recover punitive damages, this argument fails. (Doc. 100-1, pp. 25–26.) Plaintiff reasons that he will not be able to recover punitive damages against GDC or BOR because punitive damages may not be awarded against the state under the GTCA. (Id.) Plaintiff has not pointed to—and the Court has not found—any authority which supports the proposition that a decision that limits a plaintiff's ability to recover punitive damages or reduces the value of a potential award is manifestly unjust or fundamentally unfair. (Id.) The Court finds that this concern is far too speculative to warrant reconsideration of the Order.

20 As explained earlier within this Order, the written standards proffered by Plaintiff are relevant in determining the standard of care, but they do not, in and of themselves, *establish* the standard of care.

End of Document

EXHIBIT Y

2022 WL 4243567
Only the Westlaw citation is currently available.
United States District Court, D. Puerto Rico.

Brenda IRIZARRY-PAGAN et al.,
Plaintiffs,
v.
METRO SANTURCE, INC. et al.,
Defendants.

Civil No. 18-1532 (JAG/BJM)
|
Signed August 8, 2022

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REPORT AND RECOMMENDATION

BRUCE J. McGIVERIN, United States Magistrate Judge

***1** Plaintiffs Brenda Irizarry Pagan *et al.* (collectively "Plaintiffs") filed a wrongful death action against Metro Santurce, Inc. *et al.* (collectively "Defendants") after their relative Mercedes Ferrer Pérez ("the patient") died in front of them at Hospital Pavia Santurce. Defendants have filed a joint motion *in limine* to exclude the opinions and testimony of Plaintiffs' expert witness Dr. Ian Cummings ("Dr. Cummings"), a medical expert with experience in both teaching and practicing medicine, pursuant to Fed. R. Civ. P. 26, Fed. R. Evid. 702 and 703, and *Daubert v. Merrell Dow Pharm.*, 509 U.S. 579 (1993). Dkt. 91. Plaintiffs have opposed, Dkt. 103, Defendants have replied, Dkt. 128, and Plaintiffs filed a supplemental motion to their previous motion. Dkt. 132. This court has already denied Defendants' motion to exclude Dr. Cummings's testimony pursuant to Fed. R. Civ. P. 26, Dkt. 140; however, the court has yet to rule on whether Dr. Cummings's testimony should be excluded pursuant to *Daubert*. *Id.* The motion has been referred to me for a report and recommendation. *Id.* The parties have agreed that a *Daubert* hearing need not be held and that the motion can be resolved based on the submissions already filed with the court. Dkts. 143, 144. For the following reasons, I recommend that the motion to exclude the opinions and testimony of Dr. Cummings be **GRANTED IN PART**.

BACKGROUND

The following factual allegations are drawn from the complaint in this matter, Dkt. 1, and are undisputed for the purpose of determining the outcome of this motion; I make no factual findings here and merely present the following for context.

Plaintiffs Brenda M. Irizarry Pagán, Dr. Emily E. Irizarry Pagán, Federico Pérez Irizarry, and Cristian Pérez Irizarry are adult grandchildren of the patient. Plaintiff Juan Carlos Izquierdo Amieiro is a grandchild-in-law of the patient. Defendants are Metro Santurce, Inc., a

corporation that owns Hospital Pavia Santurce ("Hospital Pavia"); Dr. Sylmarie Marrero Martínez ("Dr. Marrero"), a specialist in internal medicine; Dr. Héctor Maldonado ("Dr. Maldonado"), a specialist in family medicine; Dr. Luis Cabrera De la Mata ("Dr. Cabrera"), a specialist in family medicine; Dr. José Rodríguez Escudero ("Dr. Rodríguez"), a specialist in internal medicine with a sub-specialization in cardiovascular disease; Dr. Reynerio Pérez Ramírez ("Dr. Perez"), a specialist in internal medicine with a sub-specialization in cardiovascular disease; Dr. Guillermo Vázquez Andino ("Dr. Vazquez"), a specialist in internal medicine with a sub-specialization in infectious disease; Dr. Carlos García Rodríguez ("Dr. Garcia"), a specialist in internal medicine with a sub-specialization in pulmonology; and various unnamed doctors and insurance companies.

Plaintiffs allege as follows: on July 22, 2016, the patient checked her oxygen saturation at home. Her oximeter showed that she had a blood oxygen saturation level of 84%. She informed her cardiologist, who referred her to Hospital Pavia Santurce's emergency room ("ER") to be evaluated by the on-duty cardiologist. According to the ER's triage nursing notes, two EKGs (or electrocardiograms) were performed on the patient. The EKGs suggested that Mrs. Ferrer Pérez was possibly suffering from an anterior myocardial infarction. As a result, the attending ER physician ordered blood laboratories, cardiac marker tests, and several diagnostic studies. One of the tests, an "NT Pro BNP," was not performed in timely fashion; when it was eventually performed, this test supposedly suggested that the patient was suffering from an acute myocardial infarction or renal insufficiency. Other tests ordered by the physician were not performed at all. The attending physician reached initial diagnoses of hypercapnia and hypoxia and consulted codefendants Dr. Marrero and Dr. Maldonado. Dr. Marrero admitted the patient to the hospital with diagnoses of hypercapnia, respiratory failure, pneumonia, hypoxemia, atrial fibrillation with anticoagulants, cellulitis in the left leg, bronchial asthma, and CHF (or congestive heart failure). However, although CHF was one of Dr. Marrero's diagnoses, she did not consult the cardiology department or follow up on the tests that were previously ordered but never performed on the patient. Although Dr. Marrero was the admitting physician, the patient was admitted to the hospital "under the services" of Dr. Cabrera.

***2** Dr. Maldonado evaluated the patient on the morning of July 23, 2022. Although Dr. Maldonado seemingly reached the same diagnoses as Dr. Marrero, he did not consult with the cardiology department for some time or follow up on the missing tests despite being informed of the test results suggesting that the patient was suffering from an acute myocardial infarction or renal insufficiency. On July 26, 2022, the patient was sent by Dr. Maldonado for a consultation with the cardiology department. Dr. Rodriguez took charge of the consultation. That day, an echocardiogram revealed that the patient had "preserved ejection fraction, mild multi-valvular pathology, a small pericardial effusion and dilated left atrium," while an EKG allegedly showed results consistent with myocardial infarction; however, no sequential tests to measure the patient's troponin levels were ordered (which supposedly would have helped assess whether the patient was suffering from acute myocardial infarction). During this time, the patient's CHF diagnosis was allegedly downplayed while the individuals treating the patient focused on addressing chronic respiratory failure instead; the individuals also failed to rule out myocardial infarction as a principal diagnosis. The patient's blood urena nitrogen ("BUN") to creatinine levels continued to rise while her carbon dioxide levels stayed high, allegedly suggestive of myocardial infarction and gastrointestinal bleeding. On August 1, 2016, she had an x-ray that suggested she had a pulmonary edema associated with a plural effusion.

On August 2, 2016, the patient's relatives (including her doctor granddaughter) noticed that the patient was exhibiting symptoms consistent with having had a stroke. A nurse told the family that the patient "had nothing," while Dr. Cabrera did not act because he did not believe that the patient had had a stroke. He also told the family that he would order the patient's discharge home with oxygen treatment. The patient was supposed to be discharged on August 4, 2016, apparently while already in the process of experiencing acute renal failure, respiratory failure, and acute heart failure. On the morning of August 4, a nurse noticed that the patient was not connected to telemetry equipment even though she had been ordered to be. An EKG taken that morning yet again supposedly showed symptoms consistent with a myocardial infarction. After the EKG was taken, the patient began to bleed from the anus, suffered a vasovagal event, and fainted in the bathroom. As a result, the patient was not discharged but was kept under observation and telemetry. The family asked if the patient's blood coagulation levels had been measured, but a nurse told them that she did not have anything to say to them in that regard. The patient was allegedly in critical condition but Dr. Cabrera did not go to see her despite being notified of changes in her condition for the worse.

On the afternoon of August 4, Dr. Vazquez noted in an evaluation that the patient's vital signs were adequate and that her white blood cell count had increased. However,

the patient's family claim to have not seen him that day despite being in the room at the time he allegedly evaluated the patient; Plaintiffs also claim that the patient's blood pressure signs were not adequate despite the evaluation. A pulmonologist told the family that he would put the patient on respiratory support, but the patient turned purple and died soon afterwards. Dr. Cabrera noted on the patient's death certificate that the initiating cause of the events leading to the patient's death was a cardiac infarction, that she subsequently experienced hypercapnia and cardiac failure, and that her actual cause of death was atrial fibrillation.

Plaintiffs claim that the patient underwent needless pain and suffering and that she died sooner than she otherwise would have as a result of her treatment. They argue that the treatment the patient received was substandard and inappropriate at many junctures. Plaintiffs claim that they themselves suffered emotional harm as a result of this substandard treatment. They accuse the defendants of negligence amounting to medical malpractice and request a declaration that the defendants committed medical malpractice as well as an award of $75,000.00 each plus costs for non-economic damages.

Plaintiffs are attempting to use Dr. Cummings as an expert witness in support of their claims. Dr. Cummings has produced a report, Dkt. 93-1, in which he states that many deviations from medical standards of care occurred in the present matter. Dr. Cummings claims that Dr. Marrero deviated from standards of care by failing to admit the patient to telemetry or the ICU; failing to consider CHF as the cause of the patient's hypercarbia and respiratory distress while diagnosing chronic respiratory failure instead; failing to pursue a diagnosis of myocardial infarction despite symptoms suggesting its presence; failure to immediately consult cardiology and follow up on tests; and failure to react to certain test results and diagnose CHF sooner. He claims that Dr. Maldonado deviated from standards of care for the same reasons. Dr. Cummings states that Dr. Cabrera deviated from standards of care for all of the same reasons as well, but adds that Dr. Cabrera failed to respond immediately to the family's claims that the patient might be undergoing a neurological emergency; failed to document his visit the day after the family noticed this possible neurological event; failed to order a brain CT scan, seek neurologic consultation, or consider potential life-threatening causes of the patient's rectal bleeding; failed to administer proton pump inhibitors and pump drip, cease administration of Xarelto, or reverse Xarelto anticoagulation upon becoming aware of gastrointestinal bleeding; failed to consult gastroenterology for emergent esophagogastro-duodenoscopy, recognize the implications of dramatically elevated blood urea nitrogen levels, or recognize that the patient's lack of consciousness was likely hypovolemia, all suggestive of, symptomatic of, or related to treating upper gastrointestinal bleeding; and failed to immediately respond to, evaluate, and treat the patient during her final moments.

***3** Dr. Cummings goes on to accuse Dr. Vazquez of deviating from standards of care by failing to answer a consultation to infectious diseases within twenty-four hours and fraudulently documenting a patient visit that did not actually occur. Dr. Cummings says that Dr. Rodriguez deviated from standards of care by failing to consider CHF as the cause of the patient's hypercarbia and respiratory distress while diagnosing chronic respiratory failure instead; failing to follow up on test results; failing to react to certain test results and diagnose CHF sooner; and failing to consider percutaneous coronary intervention in an effort to save the patient's life. He accuses Dr. Perez of deviating from standards of care for the same reasons while accusing Dr. Garcia solely of failure to consider CHF as the cause of the patient's hypercarbia and respiratory distress while diagnosing chronic respiratory failure instead. Dr. Cummings accuses Hospital Pavia of violating standards of care by failing to pursue a diagnosis of myocardial infarction immediately; failing to enact multiple physician's orders; failing to report certain test results to the patient's attending physician in a timely manner; improperly withholding information from the patient's family related to her care; and failing to initiate a "code blue" emergency response when the patient became unresponsive (as she allegedly did not have a valid "do not resuscitate" order in place). Depositions of Dr. Cummings have already taken place, and Defendants are now attempting to preclude his testimony.

APPLICABLE LEGAL STANDARDS

This is a diversity action; thus, the substantive law of the forum state controls. *See Erie R.R. Co. v. Tompkins,* 304 U.S. 64, 78 (1938). For this purpose, Puerto Rico is treated as the functional equivalent of a state. *See, e.g., Rolón–Alvarado v. Mun'y of San Juan,* 1 F.3d 74, 77 (1st Cir. 1993). Plaintiffs who seek to prove medical malpractice under Puerto Rico law must establish three elements. First, they must establish the "duty owed (i.e., the minimum standard of professional knowledge and skill required in the relevant circumstances)." *Cortés–Irizarry v. Corporación Insular De Seguros,* 111 F.3d 184, 189 (1st Cir. 1997). Relevantly, "Puerto Rico holds health care professionals to a national standard of

care." *Id.* at 190. Second, they must establish "an act or omission transgressing that duty." *Id.* at 189. With respect to this requirement, "Puerto Rico law presumes that physicians exercise reasonable care." *Id.* at 190. Third, they must establish "a sufficient causal nexus between the breach and the claimed harm." *Id.* at 189. A plaintiff "ordinarily must adduce expert testimony to limn the minimum acceptable standard and confirm the defendant doctor's failure to meet it." *Id.* at 190.

A witness who is qualified as an expert by knowledge, skill, experience, training, or education may testify in the form of an opinion or otherwise if: "(a) the expert's scientific, technical, or other specialized knowledge will help the trier of fact to understand the evidence or to determine a fact in issue; (b) the testimony is based on sufficient facts or data; (c) the testimony is the product of reliable principles and methods; and (d) the expert has reliably applied the principles and methods to the facts of the case." Fed. R. Evid. 702. The trial court acts as a gatekeeper, and the judge must ensure an expert's testimony is both relevant and reliable. *See Daubert*, 509 U.S. at 597; *United States v. Mooney*, 315 F.3d 54, 62 (1st Cir. 2002).

DISCUSSION

I note (as I did above) that this court has already denied the portion of the present motion calling for the preclusion of Dr. Cummings's testimony pursuant to Fed. R. Civ. P. 26. I also note that in doing so, this court stated that "the supplemental or corrective information was disclosed during the two expert depositions held in 2019 and 2021 and, thus, no obligation to supplement existed" and that "there is no surprise since the new information was disclosed to Defendants in the expert's supplemental report, rebuttal reports, and depositions." Dkt. 140. As a result, my review of Defendants' motion is strictly limited to issues arising under *Daubert* and ancillary issues arising under Fed. R. Evid. 702 and 703. *Id.*

Defendants make two *Daubert* arguments: first, that Dr. Cummings's report does not identify the standards of care applicable to each of the defendants and the scope of these standards or fails to identify the source of or basis for any standards of care he does identify; and second, that his report fails to establish how each defendant caused or contributed to the harms claimed by Plaintiffs in this matter. I shall deal with these arguments in turn.

***4** Defendants take the position that Dr. Cummings's report makes deficient references to unspecified standards of care. While Dr. Cummings clearly identifies what he considers to be standards of care in his report, Defendants claim that Dr. Cummings did not "correlate" the standards of care he identifies with a certification process, medical literature, or any other reliable source, stating that this makes his claims wholly conclusory. Defendants also claim that Dr. Cummings did not establish that the standards he applied to physicians are national in scope or that the standards he applied to the hospital and its staff apply specifically to this locality.

In support of these arguments, Defendants correctly note that merely demonstrating that an expert has experience does not render every opinion and statement by that expert reliable. Defendants also state that establishing that a given standard of care is applicable nationally is done by referencing a published standard, discussion of the described course of treatment with practitioners at seminars or conventions, or through presentation of relevant data. These are indeed ways in which an expert could establish a national standard of care, but as Plaintiffs note, this list is not exhaustive; an expert does not describe a national standard of care by merely stating what he would have done differently, but he does not necessarily need to adhere strictly to the three categories cited by Defendants in establishing a national standard either. *See Vargas-Alicea v. Cont'l Cas. Co.*, 15-CV-1941 (PAD), 2020 WL 3470325, at *3 (D.P.R. June 25, 2020). An expert also need not mention or produce medical literature when identifying a standard of care in her report, as Federal Rules of Evidence 703 and 705 place the full burden of exploration of the facts and assumptions underlying the testimony of an expert witness squarely on the shoulders of opposing counsel's cross-examination. *See Toucet v. Mar. Overseas Corp.*, 991 F.2d 5, 10 (1st Cir. 1993) (citing *Smith v. Ford Motor Co.*, 626 F.2d 784, 793 (10th Cir. 1980)); *Vargas-Alicea*, 2020 WL 3470325 at *5. As a result, Dr. Cummings need not necessarily cite literature or a published standard in demonstrating that he has relevant expertise here; instead, his personal experience alone may be sufficient. *See, e.g.*, *Delgado v. Dorado Health Inc.*, 14-CV-1735 (PAD), 2016 WL 4742257, at *4 (D.P.R. Sept. 2, 2016) (report and recommendation subsequently adopted in 2016 WL 4742259) (noting that experience alone can be sufficient to establish that an expert is qualified to offer opinions regarding standards of care under Fed. R. Evid. 702). The sufficiency of Dr. Cummings's personal experience has not actually been challenged here, and regardless, Dr. Cummings appears to have sufficiently established that he has relevant expertise through deposition testimony and other means. *See generally, e.g.*, Dkt. 55-4 (deposition testimony outlining Dr. Cummings's extensive expertise in relevant areas in some detail).

Again, Defendants also claim that Dr. Cummings did not establish that the standards he applied to physicians are national in scope or that they apply locally. In addressing whether Dr. Cummings's report failed to identify local or national standards of care, I shall turn to an issue that Defendants allude to only in passing. Defendants provide a cursory citation to a case in which Dr. Cummings's testimony was precluded by this court, *Santa Cruz-Bacardi v. Metro Pavia Hosp., Inc.*, 16-CV-2455 (RAM), 2019 WL 3403367 (D.P.R. July 26, 2019). Defendants do not craft any particular argument in citing the case, only noting that this court has previously precluded Dr. Cummings's testimony. Nonetheless, *Santa Cruz-Bacardi* encompasses other issues raised by Defendants and goes directly to the issue of whether Dr. Cummings's testimony in the present matter is deficient or conclusory when it comes to establishing standards of care. In *Santa Cruz-Bacardi*, this court noted that "Dr. Cummings' report clearly fails to establish how he reached the conclusions he did regarding standards of care." *Id.* at *5 (emphasis removed). The case arguably implies that it is necessary to cite some form of medical literature or other reputable source in establishing a national standard of care. *Id.* at *6. Additionally, while this court acknowledged in *Santa Cruz-Bacardi* that "a doctor testifying as an expert witness may sometimes imply a standard of care in their testimony without articulating the 'magic words,' " or in other words directly referencing a standard of care, the court found that Dr. Cummings had not done so because the closest he came to referencing a standard of care was discussing what "most pulmonologists" or "good pulmonologists" do. *Id.* at *5. The court reached this conclusion despite Dr. Cummings including a section in his report titled "Summaries of Failures to Meet the Standards of Care by Defendants" that laid out purported violations of standards of care; this is almost identical to the layout of Dr. Cummings's report in the present matter. *See id.*, Dkt. 64-4 at 9. If there is no substantive distinction between *Santa Cruz-Bacardi* and the present matter, then an argument could be made that as a result, Dr. Cummings's testimony should be precluded here.

***5** This argument appears reasonable on its face, as at first glance there is no immediately obvious substantive distinction between the report in *Santa Cruz-Bacardi* and Dr. Cummings's report in the present matter. Unfortunately for Defendants, however, the First Circuit recently made it clear in *Martinez v. United States*, 33 F.4th 20 (1st Cir. 2022), that the *Daubert* standard in this circuit is significantly more relaxed than Defendants (and arguably *Santa Cruz-Bacardi*) suggest. There is no clear indication that the medical expert in *Martinez* referenced any particular outside source, materials, or other basis for an opinion in crafting his report within the report itself, nor does it seem that any such indications arose during his deposition testimony. *See Martinez et al. v. United States*, 16-CV-2430 (RAM), 2019 WL 3022497 at Dkt. 33-2 (D.P.R. July 10, 2019). Instead, the expert made vague references to "accepted clinical practice" and "departures" from "accepted medical practice" without articulating how he gained awareness as to what the bounds of the relevant accepted clinical and medical practices actually were or explicitly stating that these principles were national in scope. *Id.* Nevertheless, the First Circuit overturned this court's determination that the expert's testimony should be excluded and found these and similar references acceptable when it came to establishing national standards of care. Furthermore, in regards to one of the standards of care the First Circuit also found that it was enough that the expert made one of these seemingly vague references within deposition testimony rather than within the report itself. *Martinez*, 33 F.4th at 28-29.

While I otherwise might have been inclined to read *Santa Cruz-Bacardi* as supporting the notion that Dr. Cummings's testimony failed to adequately establish standards of care, it is now clear that under *Martinez*, the *Daubert* standard in the First Circuit when it comes to establishing standards of care is exceedingly broad and much looser than a cursory reading of *Santa Cruz-Bacardi* would suggest. *Martinez* establishes that general references to the "prevailing medical standard" or "accepted clinical practice" can be enough to establish standards of care in context, even without clear bases established for these standards from medical literature or any other source material, while a relevant standard of care need not be elucidated in an expert report itself but can be laid out within a deposition or elsewhere instead. *Martinez*, 33 F.4th at 28-29. *See also Cortes-Irizarry*, 111 F.3d at 190. Given these unexacting parameters for establishing standards of care, I am not convinced that this court would reach the same result in *Santa Cruz-Bacardi* today, and as a result I believe that *Santa Cruz-Bacardi* does not have controlling effect here.

I recommend finding that Dr. Cummings has met the burden for identifying violations of standards of care as it is elucidated in *Martinez*. In the medical report cited by Defendants, Dr. Cummings includes a lengthy list with the heading "Deviations from standards of care" and lays out a long list of specific deviations from standards of care purportedly taken by the various defendants in this matter. Dkt. 91-1 at 9-14. He also mentions that he has attempted to determine if the medical and nursing staff at the hospital "engaged in departures from the standard of medical care in the hospital setting." *Id.* at 1. Under

Martinez, at this stage of the proceedings these admittedly cursory references to standards of care are enough to establish that the deviations that follow are violations of national standards of care. The court in *Martinez* made it clear that an expert's report that lacked any explicit references to "national" standards still established national standards of care, finding as noted above that even a general statement about "accepted clinical practice" made in a deposition was enough to establish such a standard. In reaching this finding, the court noted that "affiants and witnesses need not be precise to the point of pedantry" with regards to establishing a national standard of care. *Martinez*, 33 F.4th at 29 (citing *Cortes-Irizarry*, 111 F.3d at 90).

Under *Martinez*, there is every reason to believe that requirements are highly similar when it comes to establishing local (as opposed to national) standards of care. Moreover, it is not clear that local standards of care are entirely distinct from national ones in this context. *See Cortes-Irizarry*, 111 F.3d at 190 ("Puerto Rico holds health care professionals to a national standard of care"). Though Defendants cite *Pages-Ramirez v. Hosp. Espanol Auxillo Mutuo De Puerto Rico, Inc.*, 547 F. Supp. 2d 141, 149 (D.P.R. 2008), for the notion that nurses are held to a local standard of care, it is unclear why nurses are not subject to the national standard owed by medical professionals towards patients in addition to any local standard specifically for nurses. *See id.* at 148-49 ("Puerto Rico courts have explained the duty owed to a patient as that level of care which, recognizing the modern means of communication and education, meets the professional requirements generally acknowledged by the medical profession.... The standard is considered national and should generally be proven through expert testimony").

***6** Furthermore, the source of or bases for Dr. Cummings's references to standards of care are no less articulated or explained than those in *Martinez*. In *Martinez*, the court made it clear that even highly general references to source material and personal experience were enough to establish that expert testimony had a basis in reliable principles and methods. The court noted that Dr. Cummings clearly relied on review of the relevant medical records in forming his opinion. 33 F.4th at 32. The court also found it relevant that in a deposition, the expert used the words "[i]t says in the literature" in establishing that parts of the medical records suggested that standards of care were violated and that the expert had established that he had personal expertise in the area he could rely upon as well. *Id.* These factors alone allowed the court to find that "the medical records, combined with [the expert's] own clinical experience, provided a sufficiently reliable basis for his opinions." *Id.* at 32–33. Similarly, Dr. Cummings has provided a list of literature that he relied upon in forming at least some of his opinions, Dkt. 91-7, and reportedly brought literature generally undergirding his opinions to his depositions; he has established that he has a significant level of expertise in areas relevant to the opinions he has offered; and he has clearly reviewed pertinent medical records in some detail in forming his opinions. He has therefore clearly met the standard for showing that there is a sufficiently reliable basis for his opinions as it is outlined in *Martinez*.

In his report, Dr. Cummings states that the purported failures on the part of individual defendants in this matter are each "[d]eviations from standards of care," a much more precise and explicit reference to standards of care than any that appears in *Martinez*. He has also sufficiently shown that he has relevant expertise and has reviewed relevant literature and medical records in reaching his conclusions. As a result of this and all of the above, I recommend finding that Dr. Cummings has sufficiently identified standards of care.

I next turn to the issue of whether Dr. Cummings fails to establish how each defendant caused or contributed to the harms claimed by Plaintiffs in this matter. As noted above, Plaintiffs must establish "a sufficient causal nexus between the breach and the claimed harm." *Cortés–Irizarry*, 111 F.3d at 189. Dr. Cummings's report is clearly deficient in this regard. Although Dr. Cummings concludes his report by saying that "it can be stated within a reasonable degree of medical certainty that the departures from the standard of care by the medical and nursing personnel at Hospital Pavia Santurce were the direct and proximate cause that led to the death of Mrs. Mercedes Ferrer Perez," he does not explain how or to what degree any individual departure from standards of care contributed to her death. Without more, Dr. Cummings has not established a sufficient causal nexus between the alleged breaches of standards of care and the harms claimed by Plaintiffs in this matter, as Dr. Cummings has not explained whether or not the patient's death would still have occurred if any particular departure or departures from standards of care had not happened.

However, although Dr. Cummings failed to establish causation in his report, *Martinez* makes it clear that even if the report itself does not establish causation, causation can be established via deposition testimony as well. 33 F.4th at 30-31. Plaintiffs acknowledge that Dr. Cummings must explain causation, but argue that Dr. Cummings explicitly stated in his deposition testimony how each individual deviation from standards of care contributed to causing the patient's demise. Plaintiffs go on to provide a supplemental motion in which they purportedly identify

the points at which Dr. Cummings identified how each individual deviation contributed to the patient's death.

The vast majority of Dr. Cummings's deposition testimony and several of the points highlighted in Plaintiffs' supplemental motion fail to explain causation despite Plaintiffs' claims. Although Dr. Cummings claimed during deposition testimony that his report adequately explains how Dr. Rodriguez's failure to consider percutaneous coronary intervention contributed to the patient's death, Dr. Cummings's report and subsequent explanation are insufficient because he does not claim that the patient would have survived if Dr. Rodriguez had done so; instead, he merely states of patients that "if you don't save their life, they die" without addressing whether the patient would have died anyway. Dkt. 132 at ¶ 8. Regarding Dr. Cummings's statements as to Dr. Vazquez's alleged actions, while Dr. Cummings states that the patient "would've possibly had the opportunity" to survive if Dr. Vazquez had been present when the patient began her "death spiral," Dkt. 132-2 at 155, he offers little to no explanation as to why this would be the case or how much less remote this possibility would have been, so the causal chain is incomplete. *See, e.g.*, *Cortés–Irizarry*, 111 F.3d at 189 (in order to successfully raise a medical malpractice claim, a plaintiff must establish a sufficient causal nexus between the breach and some resultant harm). Dr. Cummings also opined during the deposition that if the nurses at the hospital had told the patient's family members, one of whom was a physician, more about her condition, then her death may have been avoidable because they would have "advocated" for her, Dkt. 132-2 at 226-29; however, Dr. Cummings fails to adequately explain how increased advocacy from family members could have led to the patient's chances of survival increasing, so the causal chain is again incomplete. At other points, Dr. Cummings did not specifically address causation at all, or if he did, he failed to explain how causation tied to each individual alleged failure he raised. *See* Dkt. 132 at ¶¶ 3-4, 9.

*7 On the other hand, in a few of the points highlighted in the supplemental motion, Dr. Cummings does adequately explain causation. Dr. Cummings states that Dr. Marrero's alleged failure to "admit" the patient to telemetry or the ICU was connected to her demise because the factors that led to her death would have been more appropriately responded to in a telemetry or intensive care setting well in advance of her death, which he notes could have staved off her demise; this statement adequately explains how Dr. Marrero's purported failure supposedly connects to the patient's death. Dkts. 132 at ¶ 5, 132-2 at 69-71. This point implicates Drs. Maldonado and Cabrera as well, as Dr. Cummings claims that they too should have admitted the patient to telemetry or the ICU. As to the patient's "do not resuscitate" (or "DNR") order, Dr. Cummings adequately explains how he believes that the patient did not have a valid DNR order in place, states that her symptoms were allegedly not appropriately responded to as a result, and accuses Hospital Pavia of failing to call a code blue emergency response to the patient becoming unresponsive in part because the patient had an invalid DNR; he then goes on to note that the patient would have had a better chance of survival if the invalid DNR had not been in place. Dkts. 132 at ¶ 6, 132-2 at 112-15. Dr. Cummings goes on to sufficiently explain his belief that Dr. Rodriguez contributed to the patient's death by not considering that certain of her problems might have been caused by CHF, thereby allegedly feeding into the decision to not take an EKG of the patient, which in turn purportedly led to the patient not being treated for cardiac issues when Dr. Cummings claims that she still "could have been salvaged." Dkts. 132 at ¶ 10, 132-2 at 239-42. This last explanation implicates most of the other doctors named in the suit as well, as Dr. Cummings states in his report that Drs. Marrero, Maldonado, Cabrera, Perez, and Garcia all failed to sufficiently consider CHF. To a limited extent, Dr. Cummings has therefore adequately explained how he believes Hospital Pavia and Drs. Marrero, Maldonado, Cabrera, Rodriguez, Perez, and Garcia caused or contributed to the patient's death.

Ultimately, through his deposition testimony Dr. Cummings successfully explains causation as to some purported violations of standards of care that he cites in his report, but he fails to explain causation as to the majority of the violations he cites. Except as stated above, Dr. Cummings fails to explain whether or not each doctor (and Hospital Pavia) actually caused or contributed to the patient's death via their alleged violations of standards of care. As a result, and since I have already recommended finding that Dr. Cummings's opinions and testimony should not be excluded for insufficiently identifying standards of care, I recommend finding that testimony as to the purported violations of standards of care that Dr. Cummings has successfully explained caused or contributed to the patient's death (as outlined above) be permitted, but all other opinions and testimony offered by Dr. Cummings be excluded.

CONCLUSION

For the foregoing reasons, I recommend that the motion to exclude the opinions and testimony of Dr. Cummings be **GRANTED IN PART**. Testimony as to Dr. Cummings's

opinion that Drs. Marrero, Maldonado, and Cabrera violated standards of care by allegedly failing to admit the patient to telemetry or the ICU should be permitted; testimony as to Dr. Cummings's opinion that Hospital Pavia violated standards of care by allegedly failing to initiate a "code blue" emergency response due in part to a supposedly invalid DNR when the patient became unresponsive should be permitted; testimony as to Dr. Cummings's opinion that Drs. Marrero, Maldonado, Cabrera, Rodriguez, Perez, and Garcia violated standards of care by allegedly not sufficiently considering that CHF was contributing to her other medical issues should be permitted; and all other opinions and testimony outlined by Dr. Cummings in his report should be excluded.

This report and recommendation is filed pursuant to 28 U.S.C. 636(b)(1)(B) and Rule 72(d) of the Local Rules of this Court. Any objections to the same must be specific and must be filed with the Clerk of Court within fourteen days of its receipt. Failure to file timely and specific objections to the report and recommendation is a waiver of the right to appellate review. *See Thomas v. Arn*, 474 U.S. 140, 155 (1985); *Davet v. Maccorone*, 973 F.2d 22, 30–31 (1st Cir. 1992); *Paterson-Leitch Co. v. Mass. Mun. Wholesale Elec. Co.*, 840 F.2d 985 (1st Cir. 1988); *Borden v. Sec'y of Health & Human Servs.*, 836 F.2d 4, 6 (1st Cir. 1987).

IT IS SO RECOMMENDED.

All Citations

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EXHIBIT Z

2023 WL 5314557
Only the Westlaw citation is currently available.
United States District Court, W.D. New York.

Dana MOBIUS and Hans Mobius, Plaintiffs,
v.
QUEST DIAGNOSTICS CLINICAL LABORATORIES, INC., Quest Diagnostics Incorporated, Quest Diagnostics of Pennsylvania Inc., Quest Diagnostics Holdings Incorporated, and John Doe #1, Defendants.

Case No. 1:19-cv-00499
|
Signed August 18, 2023

Synopsis
Background: Patient brought action against operators of outpatient clinical laboratories, asserting claims under New York law for medical malpractice and failure to obtain informed consent in connection with allegedly negligent blood draw, and patient's husband brought action for loss of consortium. Defendants moved to strike patient's expert and moved for summary judgment.

Holdings: The District Court, Christina Reiss, J., held that:

[1] anesthesiologist's declaration was not appropriate supplemental expert disclosure;

[2] anesthesiologist's liability opinion was significant due to its possible impact on court's decision to admit his expert testimony, thus weighing in favor of denying request to strike;

[3] granting continuance was not in the best interests of litigation, weighing in favor of striking testimony;

[4] anesthesiologist was qualified to provide expert opinion;

[5] expert's opinion concluding that phlebotomist complied with relevant standard of care was not excludable as merely serving as a conduit for hearsay;

[6] phlebotomist's testimony concerning typical venipuncture procedure should come from phlebotomist pursuant to rule governing admission of habit evidence, rather than through opinion of expert who reviewed phlebotomist's statements; and

[7] whether practice described by phlebotomist was followed by her in drawing patient's blood, and whether that breached an applicable standard of care, were material fact issues.

Motion for summary judgment denied, motion to strike granted in part and denied in part.

West Headnotes (57)

[1] **Summary Judgment** Sham affidavits or evidence

The "sham issue of fact doctrine" prohibits a party from defeating summary judgment simply by submitting an affidavit that contradicts the party's previous sworn testimony.

[2] **Summary Judgment** Sham affidavits or evidence

As applied to expert witness affidavits, a sham issue of fact exists, thereby prohibiting a party from defeating summary judgment with a sham affidavit, only when the contradictions in an expert witness's testimony are inescapable and unequivocal in nature.

[3] **Summary Judgment** Sham affidavits or evidence

Anesthesiologist's deposition testimony, that it

was very rare for physicians in his current practice, including himself, to perform blood draws, was not contradicted by statement in declaration, that he was routinely required to start and insert intravenous therapy (IV), and thus sham issue of fact doctrine, prohibiting a party from defeating summary judgment simply by submitting an affidavit that contradicts the party's previous sworn testimony, did not apply to preclude testimony on summary judgment motion in medical malpractice action.

[4] **Summary Judgment** Sham affidavits or evidence

Anesthesiologist's deposition testimony, that it was very rare for physicians in his current practice, including himself, to perform blood draws, was not unequivocally contradicted by later statement in declaration, that anesthesiologists regularly performed blood draws, based on ambiguity as to whether declaration statement referred to anesthesiologist's own practice or to practice of anesthesiologists generally, and thus sham issue of fact doctrine, prohibiting a party from defeating summary judgment simply by submitting an affidavit that contradicts the party's previous sworn testimony, did not apply to preclude testimony on summary judgment motion in medical malpractice action.

[5] **Summary Judgment** Sham affidavits or evidence

Any contradiction between anesthesiologist's deposition testimony, that phlebotomists have different qualifications and positions than doctors or nurses, and later declaration stating that medical professionals of all types must follow the same standard of care when conducting venipunctures, including blood draws, such that a phlebotomist must adhere to the very same protocol and standard of care as anesthesiologist did, did not rise to level of sham affidavit subject to exclusion on summary judgment motion in medical malpractice action under sham issue of fact doctrine, prohibiting a party from defeating summary judgment simply by submitting an affidavit that contradicts the party's previous sworn testimony, absent explanation as to how or why occupational and educational differences between phlebotomists and physicians should result in adherence to different standards of care for blood draws.

[6] **Federal Civil Procedure** Depositions and Discovery

Like most duties, supplemental expert disclosure exists for the benefit of the opposing party, not the proffering one. Fed. R. Civ. P. 26(e).

[7] **Federal Civil Procedure** Depositions and Discovery

An expert may not use supplementation of expert disclosures as a guise for merely reiterating opinions from his or her initial report or adducing previously available information to strengthen those opinions; rather, it is only if the expert subsequently learns of information that was previously unknown or unavailable, that renders information previously provided in an initial report inaccurate or misleading because it was incomplete, that the duty to supplement arises. Fed. R. Civ. P. 26(e).

[8] **Federal Civil Procedure** Depositions and Discovery

Information provided in anesthesiologist's declaration was not previously unknown or unavailable such that initial report was rendered inaccurate or misleading, and therefore

declaration was not appropriate supplemental expert disclosure in patient's medical malpractice action against operators of clinical laboratories related to allegedly negligent blood draw; timing and content of declaration, which was specific to criticisms raised in motion to strike anesthesiologist's declaration, suggested that patient sought to use it to bolster anesthesiologist's initial opinions. Fed. R. Civ. P. 26(e).

[9] **Federal Civil Procedure** Depositions and Discovery

Rule governing supplementation of expert disclosures does not give parties a free pass to supplement expert reports whenever they want to. Fed. R. Civ. P. 26(e).

[10] **Federal Civil Procedure** Failure to respond; sanctions

Because preclusion of an improper expert report may be a harsh sanction, courts must consider the following factors when determining whether to strike an improper expert report: (1) the party's explanation for the failure to comply with the discovery order; (2) the importance of the testimony of the precluded witness; (3) the prejudice suffered by the opposing party as a result of having to prepare to meet the new testimony; and (4) the possibility of a continuance. Fed. R. Civ. P. 26(e).

[11] **Federal Civil Procedure** Failure to respond; sanctions

Patient provided no explanation for improper supplementation of anesthesiologist's report in medical malpractice action relating to allegedly negligent blood draw, weighing in favor of sanction of striking supplemental expert disclosure, as requested by operators of clinical laboratories for purposes of deciding operator's summary judgment motion. Fed. R. Civ. P. 26(e).

[12] **Federal Civil Procedure** Failure to respond; sanctions

Anesthesiologist's liability opinion in declaration concerning applicable standard of care and his qualifications to opine on that standard was central to merits of patient's medical malpractice case relating to allegedly negligent blood draw, and addressed issues in case which required expert testimony, so that declaration was significant due to its possible impact on court's decision to admit anesthesiologist's expert testimony, thus weighing in favor of denying request to strike expert's testimony as sanction for inappropriate supplemental expert disclosure for purposes of deciding summary judgment motion filed by operators of clinical laboratories. Fed. R. Civ. P. 26(e).

[13] **Federal Civil Procedure** Failure to respond; sanctions

Where an expert report is produced after discovery is complete, courts routinely find prejudice because the opposing party has no opportunity to depose the expert concerning his new opinions or produce rebuttal reports absent time consuming and expensive discovery continuances. Fed. R. Civ. P. 26(e).

[14] **Federal Civil Procedure** Failure to respond; sanctions

Granting a continuance for operators of clinical laboratories to re-depose anesthesiologist was not in the best interests of patient's medical malpractice litigation relating to allegedly negligent blood draw that had been pending for five years, thereby weighing in favor of excluding anesthesiologist's declaration as sanction for improper supplemental expert disclosure, for purposes of ruling on operators' summary judgment motion. Fed. R. Civ. P. 26(e).

[15] **Evidence**➧Necessity of both reliability and relevance
Evidence➧Gatekeeping in general

Pursuant to *Daubert*, rule governing admission of expert testimony obligates the court to serve as a gatekeeper for expert testimony, ensuring that an expert's testimony both rests on a reliable foundation and is relevant to the task at hand. Fed. R. Evid. 702.

[16] **Evidence**➧Presumptions, Burden, and Degree of Proof

Under *Daubert*, the proponent of expert testimony bears the burden of establishing by a preponderance of the evidence that the testimony complies with requirements of rule governing admission of expert testimony. Fed. R. Evid. 702.

[17] **Evidence**➧Knowledge, experience, and skill
Evidence➧Training or education

Whether a witness is qualified as an expert by his knowledge, skill, experience, training, or education is a threshold question that the court must resolve before determining whether his or her opinions are admissible under *Daubert* and rule governing admission of expert testimony. Fed. R. Evid. 702.

[18] **Evidence**➧Necessity in general

The initial question of whether a witness is qualified to be an expert is important, among other reasons, because an expert witness is permitted substantially more leeway than lay witnesses in testifying as to opinions that are not rationally based on his or her perception. Fed. R. Evid. 702.

[19] **Evidence**➧Knowledge, experience, and skill
Evidence➧Training or education

Assertions that a witness lacks particular educational or other experiential background generally go to the weight, not the admissibility, of the testimony. Fed. R. Evid. 702.

[20] **Evidence**➧Knowledge, experience, and skill
Evidence➧Training or education

To determine whether a witness qualifies as an expert, courts compare the area in which the witness has superior knowledge, education, experience, or skill with the subject matter of the proffered testimony. Fed. R. Evid. 702.

[21] **Evidence**➧Medicine and health care in general

An expert need not be a specialist in the exact area of medicine implicated by the plaintiff's

injury in a medical malpractice action, but he must have relevant experience and qualifications such that whatever opinion he will ultimately express would not be speculative. Fed. R. Evid. 702.

[22] **Evidence** Necessity in general

Where expertise of witnesses is too general or too deficient, the court may properly conclude that witnesses are insufficiently qualified despite the relevance of their testimony. Fed. R. Evid. 702.

[23] **Evidence** Restriction to one's own field

Anesthesiologist was qualified to provide expert opinion regarding experience starting intravenous therapy (IV), similarities between starting IVs and blood draws, that venipuncture standards of care were nationwide, and that operators of clinical laboratories breached standard of care in performing patient's blood draw, as element of patient's medical malpractice claim under New York law, although anesthesiologist had not worked with, observed, or supervised phlebotomists conducting blood draws in his practice and could not remember the order of non-preferential veins when performing a blood draw, and even though anesthesiologist's venipuncture training and practice were dated and more recently had been focused almost exclusively on starting IVs; contention that expert lacked practical experience specific to blood draws went to weight and credibility, not admissibility. Fed. R. Evid. 702.

[24] **Health** Elements of malpractice or negligence in general

Health Degree of proof

Under New York law, to establish a claim of medical malpractice, a plaintiff must prove by a preponderance of the evidence: (1) the standard of care in the locality where the treatment occurred, (2) that the defendants breached that standard of care, and (3) that the breach of the standard was the proximate cause of injury.

[25] **Health** Locality rule

For purposes of determining the standard of care in the locality where the treatment occurred, as element of a medical malpractice claim under New York law, the general standard of care for physicians in New York requires a physician to exercise that reasonable degree of learning and skill that is ordinarily possessed by physicians in the locality where he practices; the law holds the physician liable for an injury to his patient resulting from want of the requisite knowledge and skill, or the omission to exercise reasonable care, or the failure to use his best judgment.

[26] **Health** Locality rule
Health Admissibility

Parties may introduce evidence establishing that the standard of care in a locality is the same as the standard of care nationally, for purposes of determining the standard of care in the locality where the treatment occurred, as element of a medical malpractice claim under New York law.

[27] **Evidence** Scope and extent of expert's qualifications or competency; limitation to expertise

Because a witness qualifies as an expert with

respect to certain matters or areas of knowledge, it by no means follows that he or she is qualified to express expert opinions as to other fields. Fed. R. Evid. 702.

[28] **Evidence**🡐Scope and extent of expert's qualifications or competency; limitation to expertise

If an expert has educational and experiential qualifications in a general field closely related to the subject matter in question, the court will not exclude the testimony solely on the ground that the witness lacks expertise in the specialized areas that are directly pertinent. Fed. R. Evid. 702.

[29] **Summary Judgment**🡐Burden of Proof

The party moving for summary judgment always bears the initial responsibility of informing the district court of the basis for its motion, and identifying those portions of the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, which it believes demonstrate the absence of a genuine issue of material fact. Fed. R. Civ. P. 56.

[30] **Summary Judgment**🡐Essential elements; burden of proof at trial
Summary Judgment🡐Favoring nonmovant; disfavoring movant

A nonmoving party can defeat a summary judgment motion only by coming forward with evidence that would be sufficient, if all reasonable inferences were drawn in its favor, to establish the existence of an element at trial. Fed. R. Civ. P. 56.

[31] **Summary Judgment**🡐Role of court in general

The function of the district court in considering a motion for summary judgment is not to resolve disputed questions of fact but only to determine whether, as to any material issue, a genuine factual dispute exists. Fed. R. Civ. P. 56.

[32] **Summary Judgment**🡐Speculation or conjecture; mere assertions, conclusions, or denials

A non-moving party cannot avoid summary judgment simply by asserting a metaphysical doubt as to the material facts. Fed. R. Civ. P. 56.

[33] **Summary Judgment**🡐Scintilla of evidence; minimal amount

If the evidence is merely colorable, or is not significantly probative, summary judgment may be granted. Fed. R. Civ. P. 56.

[34] **Summary Judgment**🡐Weighing evidence, resolving conflicts, and determining credibility

For purposes of deciding a summary judgment motion, credibility determinations, the weighing of the evidence, and the drawing of legitimate inferences from the facts are jury functions, not those of a judge. Fed. R. Civ. P. 56.

[35] **Evidence**🡐Showing system or habit
Evidence🡐Showing custom or course of business

"Habit," for purposes of admission of evidence of a person's habit or an organization's routine practice to prove that on a particular occasion the person or organization acted in accordance with the habit or routine practice, is a specific concept which describes one's regular response to a repeated specific situation. Fed. R. Evid. 406.

[36] **Evidence**🡐Hearsay

A party may not call an expert simply as a conduit for introducing hearsay under the guise that the testifying expert used the hearsay as the basis of his testimony. Fed. R. Evid. 703.

[37] **Evidence**🡐Hearsay

An expert witness may rely on hearsay evidence while reliably applying expertise to that hearsay evidence, but may not rely on hearsay for any other aspect of his testimony. Fed. R. Evid. 703.

[38] **Evidence**🡐Opinions, records, or reports of others

An expert witness may opine on a medical provider's possible malpractice by relying on an interview with or deposition testimony from that provider. Fed. R. Evid. 703.

[39] **Evidence**🡐Particular procedures
Summary Judgment🡐Hearsay

Expert's opinion reviewing phlebotomist's statements about her normal practice in drawing blood, and concluding that phlebotomist complied with relevant standard of care, was not excludable as merely serving as a conduit for hearsay testimony, for purposes of deciding summary judgment motion filed by operators of clinical laboratories, in patient's medical malpractice action under New York law. Fed. R. Civ. P. 56; Fed. R. Evid. 703.

[40] **Evidence**🡐Showing system or habit
Evidence🡐Health care; medical malpractice
Summary Judgment🡐Personal knowledge; hearsay
Summary Judgment🡐Necessity

Testimony of typical venipuncture procedure of phlebotomist who performed patient's blood draw should come from phlebotomist in the first instance as the person with personal knowledge of her habits, pursuant to rule governing admission of habit evidence, rather than through opinion of expert who reviewed phlebotomist's statements, for purposes of deciding summary judgment motion filed by operators of clinical laboratories in patient's medical malpractice action under New York law; possibility of slight variations between patients in phlebotomist's normal practice was consistent enough to establish degree of specificity and frequency of uniform response that was semiautomatic in nature for admission as habit evidence upon a proper foundation. Fed. R. Evid. 406, 703.

[41] **Health**🡐Breach of Duty
Health🡐Medical judgment
Health🡐Degree of proof

Because an error in medical judgment by itself does not give rise to liability for malpractice under New York law, a plaintiff must show by a preponderance of the evidence that the medical professionals treating him or her failed to conform to accepted community standards of practice.

[42] **Health**🡐Necessity of Expert Testimony
Health🡐Gross or obvious negligence and matters of common knowledge

Unless the deviation from the proper standard of care is so obvious as to be within the understanding of an ordinary layperson, the plaintiff must establish each element of his or her medical malpractice claim under New York law by expert medical opinion.

[43] **Health**🡐Breach of Duty
Health🡐Proximate Cause
Summary Judgment🡐Duties and Liabilities of Practitioners; Negligence and Malpractice

A defendant moving for summary judgment dismissing a complaint alleging medical malpractice under New York law must establish, prima facie, either that there was no departure from the standard of care in the community or that any departure was not a proximate cause of the plaintiff's injuries. Fed. R. Civ. P. 56.

[44] **Summary Judgment**🡐Duties and Liabilities of Practitioners; Negligence and Malpractice

Once the defendant moving for summary judgment makes the requisite prima facie showing for a medical malpractice claim under New York law, either that there was no departure from the standard of care in the community or that any departure was not a proximate cause of the plaintiff's injuries, the burden shifts to the plaintiff to demonstrate the existence of a triable issue of fact, but only as to the elements on which the defendant met the prima facie burden.

[45] **Summary Judgment**🡐Duties and Liabilities of Practitioners; Negligence and Malpractice

To establish its prima facie entitlement to summary judgment in a medical malpractice action under New York law, the moving party may rely on the submission of affidavits and/or deposition testimony and medical records which rebut the plaintiff's claim of malpractice with factual proof. Fed. R. Civ. P. 56.

[46] **Evidence**🡐Health care; medical malpractice
Health🡐Presumptions
Summary Judgment🡐Duties and Liabilities of Practitioners; Negligence and Malpractice

The party moving for summary judgment may rely on expert testimony based on admissible habit evidence to satisfy the party's burden in a medical malpractice action under New York law; however, evidence of habit only provides a basis for the jury to draw an inference. Fed. R. Evid. 406.

[47] **Health**🡐Weight and Sufficiency in General

Expert testimony based on admissible habit evidence cannot be the basis for judgment as a matter of law in a medical malpractice action under New York law, because a medical provider's usual practice does not conclusively prove that he or she followed that practice in the

pending case. Fed. R. Evid. 406.

[48] **Health**–Weight and Sufficiency in General

New York courts apply strict standards in determining when a defendant may rely upon habit evidence to satisfy its prima facie case in a medical malpractice action under New York law, either that there was no departure from the standard of care in the community or that any departure was not a proximate cause of the plaintiff's injuries. Fed. R. Evid. 406.

[49] **Health**–Questions of Law or Fact and Directed Verdicts
Summary Judgment–Duties and Liabilities of Practitioners; Negligence and Malpractice

Genuine issues of material fact existed as to whether practice described by phlebotomist was followed by her in drawing patient's blood and whether that breached an applicable standard of care precluding summary judgment in favor of operators of clinical laboratories in patient's medical malpractice action under New York law.

[50] **Health**–Jury questions
Summary Judgment–Consent

Genuine issue of material fact existed as to whether operators of clinical laboratories failed to obtain informed consent relating to patient's blood draw precluding summary judgment in favor of operators in patient's medical malpractice action under New York law. N.Y. Public Health Law §§ 2805-d, 2805-d(1), 2805-d(2), 2805-d(3).

[51] **Marriage and Cohabitation**–Loss of Spouse's Services, Society, or Consortium

Under New York law, loss of consortium is a common law concept that arises out of an injury to the marital relationship.

[52] **Marriage and Cohabitation**–Loss of Spouse's Services, Society, or Consortium

A claim for loss of consortium under New York law includes not only loss of support or services of a husband or wife but also such elements as love, companionship, affection, society, sexual relations, solace, and more.

[53] **Marriage and Cohabitation**–Nature of underlying claim or injury
Marriage and Cohabitation–Relation to and viability of underlying claim

Under New York law, loss of consortium is a derivative claim that traditionally may be maintained pursuant to such common law torts as negligence.

[54] **Marriage and Cohabitation**–Relation to and viability of underlying claim

Where a loss of consortium claim under New York law is purportedly derived from a statutory claim, courts must examine the statute at issue to determine whether it authorizes a spouse to bring a derivative action.

N.Y. Public Health Law § 2805-d.

[55] **Health**-Informed consent in general; duty to disclose

Despite the codification of the informed consent cause of action, New York courts characterize lack of informed consent as a genre of medical malpractice claims. N.Y. Public Health Law § 2805-d.

[56] **Marriage and Cohabitation**-Nature of underlying claim or injury
Marriage and Cohabitation-Relation to and viability of underlying claim

Because loss of consortium claims are traditionally derived from such common law torts as negligence, and medical malpractice is but a species of negligence, New York statute providing an action for lack of informed consent, as predicted by federal court, supports a derivative claim for loss of consortium. N.Y. Public Health Law § 2805-d.

[57] **Health**-Questions of Law or Fact and Directed Verdicts
Health-Jury questions
Summary Judgment-Duties and Liabilities of Practitioners; Negligence and Malpractice
Summary Judgment-Consent

Genuine issues of material fact existed as to whether practice described by phlebotomist was followed by her in drawing patient's blood and whether that breached an applicable standard of care for purposes of patient's medical malpractice claim under New York law, and whether operators of clinical laboratories failed to obtain informed consent relating to patient's blood draw, precluding summary judgment in favor operators on loss of consortium claim under New York law filed by patient's husband.

Attorneys and Law Firms

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OPINION AND ORDER GRANTING IN PART AND DENYING IN PART DEFENDANTS' MOTION TO STRIKE PLAINTIFFS' EXPERT NEAL BLAUZVERN AND DENYING DEFENDANTS' MOTION FOR SUMMARY JUDGMENT

Christina Reiss, District Judge

***1** Plaintiffs Dana Mobius ("Ms. Mobius") and Hans Mobius ("Mr. Mobius," or collectively with Ms. Mobius, "Plaintiffs") bring this action against Defendants Quest Diagnostics Clinical Laboratories, Inc., Quest Diagnostics Incorporated, Quest Diagnostics of Pennsylvania Inc., Quest Diagnostics Holdings Incorporated, and John Doe #1 (collectively, "Defendants"), alleging that on November 2, 2015, John Doe #1 negligently drew Ms. Mobius's blood at one of Defendants' locations in Orchard Park, New York, "causing [her] severe, serious[,]

and permanent injuries." (Doc. 1–2 at 9, ¶ 25.) Plaintiffs assert three causes of action: (1) medical malpractice; (2) failure to obtain Ms. Mobius's informed consent; and (3) loss of consortium on behalf of Mr. Mobius as a result of Ms. Mobius's injuries.

Pending before the court are Defendants' January 31, 2023 motion to strike Plaintiffs' expert Neal Blauzvern, D.O. ("Dr. Blauzvern"), and motion for summary judgment. (Doc. 75.) After receiving leave from the court to file an untimely response, Plaintiffs opposed the pending motions on March 27, 2023. (Doc. 89.) Defendants replied on April 7, 2023 (Doc. 91), at which time the court took the motions under advisement.

Plaintiffs are represented by Anne B. Rimmler, Esq., Philipp L. Rimmler, Esq., Elizabeth Katherine Bacher, Esq., and William A. Quinlan, Esq. Defendants are represented by Michael T. Hensley, Esq., Lauren Elizabeth Fenton-Valdivia, Esq., V. Christopher Potenza, Esq., and Patrick B. Curran, Esq.

I. Whether to Strike Plaintiffs' Expert Dr. Blauzvern.

Plaintiffs seek to introduce the expert opinion of Dr. Blauzvern in support of their claim that Defendants negligently performed Ms. Mobius's blood draw on November 2, 2015. Defendants ask the court to strike Dr. Blauzvern's opinion on the grounds that his recently disclosed opinions are untimely. Pursuant to Fed. R. Evid. 702, they further argue he is not qualified to opine regarding the applicable standard of care for blood draws and whether that standard of care was breached.

Dr. Blauzvern is a Doctor of Osteopathic Medicine who is board-certified in anesthesiology and licensed by the State of Texas to practice anesthesiology and pain management. He has more than thirty years of experience in those fields. In 1983, he graduated from the New York College of Osteopathic Medicine before completing an internship in internal medicine at Long Island College Hospital and a residency and fellowship in pain management and pediatric anesthesiology at the State University of New York at Stony Brook.

Dr. Blauzvern practiced at the Pain Management Practice of Central Texas Spine Institute from 1994 until 2016, when he began practicing at the Capitol Pain Institute in Austin, Texas. Since 2018, he has served as the medical director for the Center for Speciality Surgery.

Dr. Blauzvern's current clinical practice focuses on pain management, including diagnosing and treating chronic regional pain syndrome ("CRPS"). Although he treats patients with all types of pain, including pain associated with nerve injuries, he is particularly interested in spinal cord stimulation, neuropathic pain, and pediatric pain. In his previous practice, Dr. Blauzvern administered "all types of anesthesia" and supervised nurses and anesthesia students. (Doc. 75 at 8, ¶ 25.)

***2** It is "very rare" that Dr. Blauzvern or any other doctor performs blood draws at the Capitol Pain Institute, because they "attempt, as a surgery center, to have all of that preoperative evaluation done ahead of time" and "blood is just not drawn there." (Doc. 75-5 at 12-13.) Dr. Blauzvern does not recall the last time he performed a blood draw. He believes that it has been "[p]robably months to years" since he last performed a blood draw, although he "do[es] start IVs ..., which is basically the same technique." *Id.* at 12. He remembers performing one blood draw during 2022 but cannot approximate how many times he performed blood draws in the five years prior to 2022 because "[i]t's just a very routine kind of thing" and "[i]t's just not ... an event, it's not an action, it's not a clinical duty that registers as anything special that I would remember to any extent." *Id.* at 13. In his previous position at the Central Texas Spine Institute, he "was responsible" for performing blood draws and starting IVs for his patients when necessary, although he does not remember how frequently he did so. *Id.*

Dr. Blauzvern testified in deposition that he received training in performing blood draws and starting IVs during medical school, which he attended from 1979 to 1983, and as part of his residency from 1984 to 1986, and of his fellowship from 1986 to 1987. He has not received further phlebotomy training or been licensed as a phlebotomist or nurse. He has not attended any phlebotomy conferences, given presentations on venipuncture, or read or drafted any publications[1] or standard operating procedures on blood draw requirements for phlebotomists.

Dr. Blauzvern is unaware of whether Capitol Pain Institute maintains any policies related to venipuncture performance. He has not reviewed any venipuncture performance policies at the local hospitals where he maintains privileges, nor has he participated in drafting standard operating procedures related to venipunctures. He has never supervised phlebotomists or managed a medical laboratory.

Although Dr. Blauzvern has served as an expert witness in cases related to nerve injuries and CRPS, he has not served as an expert witness, provided an expert report for,

been deposed in, or otherwise reviewed any cases related to phlebotomy. No court has qualified him to serve as an expert on the standard of care for a phlebotomist performing a blood draw. There is no evidence that he has practiced osteopathic medicine in New York after his fellowship or that he remains knowledgeable regarding the phlebotomy standard of care in New York, although he contends the standard of care is a national one.

Dr. Blauzvern opined that Ms. Mobius's November 2, 2015 blood draw breached the venipuncture standard of care because the phlebotomist who performed the blood draw did not use a tourniquet; caused injury to the surrounding nerves and tissues; and failed to immediately withdraw the needle when Ms. Mobius complained of severe pain. Because the phlebotomist did not use a tourniquet, Dr. Blauzvern opined that "the location of the venipuncture, towards the top of the forearm, did not follow the standard of care either." *Id.* at 32 (internal quotation marks omitted). He concluded that the blood draw caused severe and permanent nerve injury to Ms. Mobius, which developed into CRPS.

In opposition to the pending motions, Plaintiffs submitted a sworn Declaration from Dr. Blauzvern dated March 27, 2023 (the "March 2023 Declaration"), in which he averred:

> Venipuncture for blood sampling is a basic medical procedure, and the related standards of care are universal. Anesthesiologists, such as myself, as well as many other medical professionals, aside from Phlebotomists, regularly perform such blood draws .... Most notably, medical professionals of all types must follow the same standard of care when conducting such venipunctures, including blood draws. Thus, a Phlebotomist must adhere to the very same protocol and standard of care as I do as an Anesthesiologist. By virtue of my knowledge and familiarity with the applicable medical literature and the procedure to be followed, as well as the fact that standards for venipunctures are the very same for doctors and Phlebotomists, I am qualified to testify to the standard of care applicable to the Phlebotomist, who performed the subject blood draw on Dana Mobius.

***3** (Doc. 89-3 at 3, ¶¶ 3-4.)

He further averred that he was "fully trained in performing all types of venipunctures, including blood draws, starting IVs, and intravenous injections" during his medical training. *Id.* ¶ 5. According to his March 2023 Declaration, Dr. Blauzvern has used these skills throughout his career, including by "routinely" starting and inserting IVs in his current practice, "which is essentially the same technique as blood draw, as both require a venipuncture." *Id.* at 4, ¶ 6. Because his work with CRPS patients requires him to be aware of the causes of CRPS, "including negligently performed venipunctures[,]" his "practice requires that [he] be cognizant of the standards of care concerning blood draws, in order to recognize the causative effects of deviations from due care, which result in certain conditions, such as CRPS." *Id.* ¶ 7.

A. Whether to Strike Dr. Blauzvern's March 2023 Declaration.

[1] [2]Defendants contend that the court should strike the March 2023 Declaration as a "sham affidavit" contradicting Dr. Blauzvern's deposition testimony or as an improper supplemental expert report. (Doc. 91 at 5.) The "sham issue of fact" doctrine "prohibits a party from defeating summary judgment simply by submitting an affidavit that contradicts the party's previous sworn testimony." *In re Fosamax Prods. Liab. Litig.*, 707 F.3d 189, 193 (2d Cir. 2013). "If a party who has been examined at length on deposition could raise an issue of fact simply by submitting an affidavit contradicting his own prior testimony, this would greatly diminish the utility of summary judgment as a procedure for screening out sham issues of fact." *Hayes v. N.Y.C. Dep't of Corr.*, 84 F.3d 614, 619 (2d Cir. 1996) (internal quotation marks omitted). As applied to expert witness affidavits, "a sham issue of fact exists only when the contradictions in an expert witness's testimony are inescapable and unequivocal in nature." *In re Fosamax Prods. Liab. Litig.*, 707 F.3d at 194.

[3]Defendants argue that Dr. Blauzvern's deposition testimony that it is "very rare" for physicians in his current practice, including himself, to perform blood draws (Doc. 75-5 at 12) is contradicted by his statement in the March 2023 Declaration that he is "routinely required to start and insert IVs, which is essentially the same technique as blood draw[s]." (Doc. 89-3 at 4, ¶ 6.) The latter statement does not contradict his deposition testimony. Dr. Blauzvern testified that although physicians in his practice rarely perform blood draws, "we do start IVs ..., which is basically the same technique." (Doc. 75-5 at 12.) Regardless of whether this testimony is accurate in terms of whether IVs and blood draws involve the same technique, there is no direct contradiction.

[4]Defendants also contend that Dr. Blauzvern's deposition testimony is contradicted by the statement in his March 2023 Declaration that "[a]nesthesiologists, such as

myself, ... regularly perform such blood draws." (Doc. 89-3 at 3, ¶ 3.) Whether this statement contradicts his earlier testimony is more ambiguous, as it could refer either to Dr. Blauzvern's own practice, in which he testified he rarely performs blood draws, or to the practice of anesthesiologists generally. Due to this ambiguity, the March 2023 Declaration does not unequivocally contradict Dr. Blauzvern's deposition testimony.

*4 [5]Pointing to Dr. Blauzvern's testimony during his deposition that phlebotomists have different qualifications and positions than doctors or nurses, Defendants note that his March 2023 Declaration states that "medical professionals of all types must follow the same standard of care when conducting such venipunctures, including blood draws. Thus, a Phlebotomist must adhere to the very same protocol and standard of care as I do as an Anesthesiologist." (Doc. 89-3 at 3, ¶ 4.) Defendants do not explain why or how the occupational and educational differences between phlebotomists and physicians should result in their adherence to different standards of care for blood draws. Any contradiction between Dr. Blauzvern's deposition testimony and the March 2023 Declaration therefore does not rise to the level of a sham affidavit.

[6] [7]Even if it is not a sham affidavit, whether the March 2023 Declaration constitutes an improper Fed. R. Civ. P. 26(e) supplemental disclosure merits close consideration. Rule 26(e) requires parties to supplement their Rule 26(a) expert disclosures in a timely manner "if the party learns that in some material respect the disclosure or response is incomplete or incorrect, and if the additional or corrective information has not otherwise been made known to the other parties during the discovery process or in writing" or "as ordered by the court." Fed. R. Civ. P. 26(e)(1)(A)-(B). "Like most duties, it exists for the benefit of the opposing party, not the proffering one." *In re Terrorist Attacks on Sept. 11, 2001*, 2023 WL 2366854, at *3 (S.D.N.Y. Mar. 6, 2023). An expert thus may not use Rule 26(e) supplementation as a guise for merely reiterating opinions from his or her initial report or adducing previously available information to strengthen those opinions. Rather, "[i]t is only if the expert subsequently learns of information that was previously unknown or unavailable, that renders information previously provided in an initial report inaccurate or misleading because it was incomplete, that the duty to supplement arises." *S.W. v. City of New York*, 2011 WL 3038776, at *2 (E.D.N.Y. July 25, 2011) (internal quotation marks omitted) (quoting *Sandata Techs., Inc., v. Infocrossing, Inc.*, 2007 WL 4157163, at *3-4 (S.D.N.Y. Nov. 16, 2007)).

[8]Although the parties have not submitted Dr. Blauzvern's expert report to the court, Dr. Blauzvern's initial Declaration executed January 3, 2022 discusses his qualifications in general terms. It provides no details about his familiarity with venipuncture standards, although he testified in deposition that he learned how to perform blood draws and start IVs during his medical training. The March 2023 Declaration provides a much more extensive discussion of Dr. Blauzvern's familiarity with venipuncture standards.[2] Even if it addresses related matters, none of the information provided in the March 2023 Declaration was "previously unknown or unavailable" to Dr. Blauzvern such that his initial report was rendered inaccurate or misleading. *S.W.*, 2011 WL 3038776, at *2.

[9]"Rule 26(e) does not give parties a free pass to supplement expert reports whenever they want to." *In re Terrorist Attacks*, 2023 WL 2366854, at *3 (alteration adopted) (internal quotation marks omitted) (quoting *Sandata Techs.*, 2007 WL 4157163, at *4); *see also Cedar Petrochemicals, Inc. v. Dongbu Hannong Chem. Co.*, 769 F. Supp. 2d 269, 278 (S.D.N.Y. 2011) ("[E]xperts are not free to continually bolster, strengthen, or improve their reports by endlessly researching the issues they already opined upon, or to continually supplement their opinions.") (internal quotation marks omitted). Both the timing and content of the March 2023 Declaration, which is specific to the criticisms raised in Defendants' motion to strike, suggest that Plaintiffs seek to use it to bolster Dr. Blauzvern's initial opinions. The March 2023 Declaration is thus not appropriate supplementation under Rule 26(e).

*5 [10]Because preclusion of even an improper expert report may "be a harsh sanction[,]" *id.* (internal quotation marks omitted), courts must consider the following factors when determining whether to strike an improper expert report: "(1) the party's explanation for the failure to comply with the discovery order; (2) the importance of the testimony of the precluded witness; (3) the prejudice suffered by the opposing party as a result of having to prepare to meet the new testimony; and (4) the possibility of a continuance." *Softel, Inc. v. Dragon Med. & Sci. Commc'ns, Inc.*, 118 F.3d 955, 961 (2d Cir. 1997) (citing *Outley v. City of New York*, 837 F.2d 587, 590-91 (2d Cir. 1988)).

[11]With regard to the first *Outley* factor, Plaintiffs provide no explanation for their improper supplementation of Dr. Blauzvern's report. The first *Outley* factor thus weighs in favor of Defendants' requested sanction.

[12]With respect to the second *Outley* factor, as Dr. Blauzvern's liability opinion is "central to the merits of

this case and addresses issues in this case which require expert testimony[,]" the question of its admissibility is an important one. *Allen v. Dairy Farmers of Am., Inc.*, 2013 WL 211303, at *3 (D. Vt. Jan. 18, 2013). The March 2023 Declaration's discussion of the applicable standard of care and his qualifications to opine on that standard is significant due to its possible impact on the court's decision to admit his expert testimony. Its importance to the merits of Plaintiffs' case weighs in favor of denying Defendants' request to strike. *See Zerega Ave. Realty Corp. v. Hornbeck Offshore Transp., LLC*, 571 F.3d 206, 213 (2d Cir. 2009) (trial court abused its discretion in excluding expert opinion for noncompliance with pretrial order where, among other things, "the testimony of [the excluded expert] was critical to [the defendant's] defense on the issue of causation."); *see also Dairy Farmers of Am.*, 2013 WL 211303, at *3 (finding rebuttal report's importance on the merits weighed in favor of denying motion to strike).

[13]Pursuant to the third *Outley* factor, where an expert report is produced after discovery is complete, "[c]ourts routinely find prejudice" because "the opposing party has no opportunity to depose the expert concerning his new opinions or produce rebuttal reports" absent "time consuming and expensive discovery continuances." *In re Terrorist Attacks*, 2023 WL 2366854, at *5 (alteration adopted) (internal quotation marks omitted). By "effectively sandbagging" Defendants with additional evidence which appears intended to "create a genuine issue of material fact on the eve of summary judgment[,]" *id.* (internal quotation marks omitted), Plaintiffs' improper supplementation of Dr. Blauzvern's opinion prejudices Defendants. Any prejudice in admitting the March 2023 Declaration is mitigated by Defendants' ability to address the affidavit in their reply brief. The lack of significant contradictions between Dr. Blauzvern's deposition testimony and the March 2023 Declaration also reduces any prejudice. Defendants had the opportunity to depose Dr. Blauzvern. They were aware at that time that his qualifications as an expert regarding the applicable standard of care would be a key issue. They did not, however, have an opportunity to question him about his March 2023 Declaration. The third *Outley* factor is thus in equipoise.

[14]Finally, with regard to the fourth *Outley* factor, a continuance is not in the best interests of this litigation. This action has been pending for five years. *See Softel, Inc.*, 118 F.3d at 963 ("[T]he enormous length of every step of the proceedings in this case militated against any more continuances."). Granting a continuance for Defendants to re-depose Dr. Blauzvern would result in further "significant[ ] delay[ ] [of] the adjudication of the merits of this dispute." *Dairy Farmers of Am.*, 2013 WL 211303, at *4. The final *Outley* factor weighs in favor of excluding the March 2023 Declaration.

**6 On balance, the *Outley* factors weigh against admitting the March 2023 Declaration as improper expert witness supplementation. The court therefore GRANTS Defendants' request to strike it for purposes of ruling on summary judgment.

B. Whether Dr. Blauzvern is Qualified as an Expert Witness Under Rule 702.

[15] [16]Defendants contend that Dr. Blauzvern is not qualified to provide an expert opinion regarding the standard of care applicable to Ms. Mobius's negligence claim. The admissibility of expert testimony is governed by Federal Rule of Evidence 702:

> A witness who is qualified as an expert by knowledge, skill, experience, training, or education may testify in the form of an opinion or otherwise if: (a) the expert's scientific, technical, or other specialized knowledge will help the trier of fact to understand the evidence or to determine a fact in issue; (b) the testimony is based on sufficient facts or data; (c) the testimony is the product of reliable principles and methods; and (d) the expert has reliably applied the principles and methods to the facts of the case.

Rule 702 obligates the court to serve as a gatekeeper for expert testimony, ensuring "that an expert's testimony both rests on a reliable foundation and is relevant to the task at hand." *Daubert v. Merrell Dow Pharms., Inc.*, 509 U.S. 579, 597, 113 S.Ct. 2786, 125 L.Ed.2d 469 (1993). The proponent of expert testimony bears the burden of establishing by a preponderance of the evidence that the testimony complies with Rule 702's requirements. *See id.* at 593 n.10, 113 S.Ct. 2786 ("Preliminary questions concerning the qualification of a person to be a witness, the existence of a privilege, or the admissibility of evidence ... should be established by a preponderance of proof.") (internal quotation marks omitted).

[17] [18]Whether a witness is qualified as an expert by his knowledge, skill, experience, training, or education is a "threshold question" that the court must resolve before determining whether his or her opinions are admissible. *Nimely v. City of New York*, 414 F.3d 381, 396 n.11 (2d Cir. 2005). "The initial question of whether a witness is qualified to be an 'expert' is important, among other reasons, because an 'expert' witness is permitted substantially more leeway than 'lay' witnesses in

testifying as to opinions that are not 'rationally based on [his or her] perception[.]' " *Id.* (first alteration in original) (quoting *United States v. Garcia*, 291 F.3d 127, 139 n. 8 (2d Cir. 2002)).

[19]"Courts within the Second Circuit have liberally construed expert qualification requirements when determining if a witness can be considered an expert." *Lickteig v. Cerberus Cap. Mgmt., L.P.*, 589 F. Supp. 3d 302, 328 (S.D.N.Y. 2022) (internal quotation marks omitted). Generally, "[a]ssertions that the witness lacks particular educational or other experiential background, 'go to the weight, not the admissibility, of [the] testimony.' " *In re Zyprexa Prods. Liab. Litig.*, 489 F. Supp. 2d 230, 282 (E.D.N.Y. 2007) (quoting *McCullock v. H.B. Fuller Co.*, 61 F.3d 1038, 1044 (2d Cir. 1995) (second alteration in original)).

[20] [21] [22]"To determine whether a witness qualifies as an expert, courts compare the area in which the witness has superior knowledge, education, experience, or skill with the subject matter of the proffered testimony." *United States v. Tin Yat Chin*, 371 F.3d 31, 40 (2d Cir. 2004). An expert "need not be a specialist in the exact area of medicine implicated by the plaintiff's injury," but "he must have relevant experience and qualifications such that whatever opinion he will ultimately express would not be speculative." *Loyd v. United States*, 2011 WL 1327043, *5 (S.D.N.Y. Mar. 31, 2011) (internal citations and quotation marks omitted), Where an expert witness's "expertise is too general or too deficient[,]" the court "may properly conclude that witnesses are insufficiently qualified despite the relevance of their testimony[.]" *Stagl v. Delta Air Lines, Inc.*, 117 F.3d 76, 81 (2d Cir. 1997).

*7 [23] [24] [25] [26]Plaintiffs argue that a physician specializing in one area of medicine may testify as an expert witness regarding a different medical specialty provided the witness demonstrates sufficient familiarity with the relevant subject and standard of care.[3] Defendants do not, however, argue that an anesthesiologist is never qualified to testify regarding phlebotomy. Rather, they contend that Dr. Blauzvern's training, education, and experience do not qualify *him* as an expert on phlebotomy. Regardless of whether "numerous other medical providers [such as anesthesiologists] routinely perform phlebotomy services[,]" *Baptist Healthcare Sys., Inc. v. Miller*, 177 S.W.3d 676, 681 (Ky. 2005), the issue is whether Dr. Blauzvern is qualified to provide a helpful opinion to the jury on the standard of care in 2015 for venipuncture in New York.[4]

*8 Defendants compare Dr. Blauzvern's qualifications with those of their expert witness Cathy Coyle and assert that Ms. Coyle's extensive phlebotomy education and experience demonstrate that Dr. Blauzvern is not similarly qualified. The fact that Ms. Coyle appears to be well qualified does not mean that Dr. Blauzvern is not qualified. Plaintiffs point to his medical education and practical experience as an anesthesiologist, as well as his testimony that he considers conducting blood draws to be "just a very routine kind of thing" (Doc. 75-5 at 13), although he rarely performs them himself. Dr. Blauzvern has not worked with, observed, or supervised phlebotomists conducting blood draws in his practice. When questioned regarding the order of preference among arm veins for a phlebotomist performing venipuncture, Dr. Blauzvern stated that he "think[s] that's going to depend on the phlebotomist, but most are going to use the antecubital vein." *Id.* at 22. He could not remember the order of "non-preferential veins" when performing a blood draw. *Id.* at 22.

Dr. Blauzvern also noted that, as an anesthesiologist, he often starts IVs, a procedure which he claims utilizes the same techniques as blood draws. Although he did not believe phlebotomists insert IVs and had "never had one do that[,]" he also explained that "[y]ou would always use a tourniquet for insertion of an IV unless it's a ... major trauma going on[.]" *Id.* at 34. He explained that the importance of using a tourniquet is that "[y]ou can't palpate the vein without a tourniquet there." *Id.* Defendants adduce no evidence contradicting Dr. Blauzvern's equation of starting IVs and performing blood draws. Nor do Defendants present any evidence contradicting his sworn statements that the standard of care for blood draws is the same nationwide.

Dr. Blauzvern's venipuncture training and practice are admittedly dated and more recently have been focused almost exclusively on starting IVs. His medical education and thirty years of practical experience, however, provide him with specialized "knowledge, skill, experience, training, or education" regarding the 2015 nationwide standard of care for starting IVs. Fed. R. Evid. 702.

[27] [28]"[B]ecause a witness qualifies as an expert with respect to certain matters or areas of knowledge, it by no means follows that he or she is qualified to express expert opinions as to other fields." *Nimely*, 414 F.3d at 399 n.13. However, "[i]f the expert has educational and experiential qualifications in a general field closely related to the subject matter in question, the court will not exclude the testimony solely on the ground that the witness lacks expertise in the specialized areas that are directly pertinent." *In re Zyprexa Prods. Liab. Litig.*, 489 F. Supp. 2d at 282. In light of the Second Circuit's "liberal"

construction of Rule 702's qualification requirements, Dr. Blauzvern is qualified to testify regarding his experience starting IVs, the similarities between starting IVs and blood draws, and his opinion that venipuncture standards of care are nationwide. *Lickteig*, 589 F. Supp. 3d at 328. He may further testify that Defendants breached the standard of care in performing Ms. Mobius's blood draw. Defendants' contention that Dr. Blauvzern lacks practical experience specific to blood draws go to his "testimony's weight and credibility—not its admissibility." *McCullock*, 61 F.3d at 1043. On cross-examination, Defendants have wide latitude to explore Dr. Blauzvern's "alleged shortcomings." *Id.*

For the reasons stated above, Defendants' motion to strike is therefore GRANTED IN PART and DENIED IN PART.

II. Defendants' Motion for Summary Judgment.

Arguing that Plaintiff cannot establish the required elements of her medical malpractice claim without Dr. Blauzvern's expert testimony, Defendants seek summary judgment in their favor on all of Plaintiffs' claims. Because the court is sitting in diversity, Plaintiffs' claims are governed by New York law. *See Gasperini v. Ctr. for Humans., Inc.*, 518 U.S. 415, 427, 116 S.Ct. 2211, 135 L.Ed.2d 659 (1996) ("Under the *Erie* doctrine, federal courts sitting in diversity apply state substantive law and federal procedural law.").

A. Standard of Review.

***9** The court must grant summary judgment when "there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(a). "A fact is 'material' ... if it 'might affect the outcome of the suit under the governing law.' " *Rodriguez v. Vill. Green Realty, Inc.*, 788 F.3d 31, 39 (2d Cir. 2015) (quoting *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248, 106 S.Ct. 2505, 91 L.Ed.2d 202 (1986)). "A dispute of fact is 'genuine' if 'the evidence is such that a reasonable jury could return a verdict for the nonmoving party.' " *Id.* at 39-40 (quoting *Anderson*, 477 U.S. at 248, 106 S.Ct. 2505). The court "construe[es] the evidence in the light most favorable to the non-moving party" and "resolve[s] all ambiguities and draw[s] all permissible factual inferences in favor of the party against whom summary judgment is sought." *Lenzi v. Systemax, Inc.*, 944 F.3d 97, 107 (2d Cir. 2019) (internal quotation marks omitted). There is no genuine dispute where "the record taken as a whole could not lead a rational trier of fact to find for the non-moving party[.]" *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 587, 106 S.Ct. 1348, 89 L.Ed.2d 538 (1986) (citation omitted).

[29] [30]The moving party always "bears the initial responsibility of informing the district court of the basis for its motion, and identifying those portions of the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, which it believes demonstrate the absence of a genuine issue of material fact." *Celotex Corp. v. Catrett*, 477 U.S. 317, 323, 106 S.Ct. 2548, 91 L.Ed.2d 265 (1986) (internal quotation marks omitted). "Once the moving party demonstrates that there are no genuine issues of material fact, the nonmoving party must come forth with evidence sufficient to allow a reasonable jury to find in [its] favor." *Spinelli v. City of New York*, 579 F.3d 160, 166 (2d Cir. 2009) (internal quotation marks omitted) (alteration in original). "Thus, a nonmoving party can defeat a summary judgment motion only by coming forward with evidence that would be sufficient, if all reasonable inferences were drawn in [its] favor, to establish the existence of [an] element at trial." *Id.* at 166-67 (internal quotation marks omitted) (alterations in original).

[31] [32] [33] [34]"The function of the district court in considering the motion for summary judgment is not to resolve disputed questions of fact but only to determine whether, as to any material issue, a genuine factual dispute exists." *Kaytor v. Elec. Boat Corp.*, 609 F.3d 537, 545 (2d Cir. 2010) (citation omitted). "A non-moving party cannot avoid summary judgment simply by asserting a 'metaphysical doubt as to the material facts.' " *Woodman v. WWOR-TV, Inc.*, 411 F.3d 69, 75 (2d Cir. 2005) (quoting *Matsushita*, 475 U.S. at 586, 106 S.Ct. 1348). "If the evidence is merely colorable, or is not significantly probative, summary judgment may be granted." *Anderson*, 477 U.S. at 249-50, 106 S.Ct. 2505 (citations omitted). However, if the evidence "presents a sufficient disagreement to require submission to a jury[,]" the court should deny summary judgment. *Id.* at 251-52, 106 S.Ct. 2505. "Credibility determinations, the weighing of the evidence, and the drawing of legitimate inferences from the facts are jury functions, not those of a judge." *Kaytor*, 609 F.3d at 545 (internal quotation marks and emphasis omitted).

B. The Undisputed Facts.

Ms. Mobius's rheumatologist, Karen Krutchick, M.D., treats Ms. Mobius for lupus. In 2015, Dr. Krutchick ordered a blood draw for Ms. Mobius, who underwent a blood draw at a Quest Patient Service Center on November 2, 2015. According to Ms. Mobius, the Quest phlebotomist who performed the blood draw, Kari Fistola,[5] did not put a tourniquet on her arm before performing the draw. Unlike in prior blood draws taken from the same area of the antecubital fossa near Ms. Mobius's elbow joint, Ms. Fistola drew blood from the top of Ms. Mobius's left forearm, closer to her wrist than to her antecubital fossa.

***10** Ms. Mobius looked away as Ms. Fistola inserted the needle and did not see the needle go into her arm. When the needle was inserted, Ms. Mobius felt a "shock-like sensation" throughout her body (Doc. 75-3 at 18), as well as "stinging, burning[,]" and "[a] throbbing in [the] area" of the needle. *Id.* at 20. The shock was "very intense[,]" causing her to "scream[ ] out" and "cr[y] out." *Id.* at 19. Although the shock sensation improved over the subsequent days, Ms. Mobius continued to experience stinging, burning, and throbbing sensations in her forearm. Two weeks later, Mr. Mobius called Quest to complain about his wife's experience during the November 2, 2015 blood draw. He later called a second time to report the incident in 2016.

In January 2016, Ms. Mobius experienced increasing pain and continued burning, stinging, and pressure in her left forearm, which became swollen "throughout ..., pushing up into [her] elbow." *Id.* at 25. She was subsequently diagnosed with Reflex Sympathetic Dystrophy ("RSD") or CRPS by Dr. Krutchick, as well as by a vascular doctor, Dr. Karamanoukian; a neurologist, Dr. Silvestri; and a pain management doctor, Dr. Waghmarae. According to Ms. Mobius, since 2016 her CRPS has spread to other parts of her body, including her right arm, both legs, and throat, tongue, and sinus area, which she asserts her doctors attribute to the November 2, 2015 blood draw. Since late 2017, she has continued to experience "the same pain symptoms, throbbing, burning, stinging, swelling, [and a] sense of bleeding in th[e] spot where the needle had been." *Id.* at 41.

C. The Disputed Facts.

The parties dispute whether Ms. Fistola used a tourniquet when she drew Ms. Mobius's blood on November 2, 2015. Defendants' expert witness Ms. Coyle interviewed Ms. Fistola and reviewed Plaintiffs' depositions, discovery disclosures, and medical records. She opined that although Ms. Fistola does not remember the November 2, 2015 blood draw, Ms. Fistola "can attest based on her habit and custom that all Quest policies and standard operating procedures were followed." (Doc. 75-6 at 3.) Ms. Fistola's usual practice included registering the patient, verifying the patient's insurance, and entering the test codes, before seating the patient in the phlebotomy chair, checking both arms for suitable veins, selecting a vein, using a tourniquet, cleaning the area, and performing the venipuncture. Despite not recalling the specific blood draw, Ms. Fistola "is absolutely certain that she used a tourniquet[.]" *Id.* Based on Ms, Fistola's description of her normal practice, Ms. Coyle concluded that "Ms. Fistola complied with the standard of care in performing the blood draw of Ms. Mobius." *Id.* at 4. She further opined that Defendants' "[v]enipuncture standard operating procedure complied with the standard of care." *Id.*

Plaintiffs argue that Ms. Mobius's testimony that Ms. Fistola did not use a tourniquet contradicts Ms. Coyle's expert testimony. They assert that because Ms. Coyle's expert opinion is based on inadmissible habit evidence from an "undisclosed, unilateral interview" with Ms. Fistola. (Doc. 89-8 at 13), under New York law it cannot be considered by the court in deciding Defendants' motion for summary judgment.

[35]Under Fed. R. Evid. 406, "[e]vidence of a person's habit or an organization's routine practice may be admitted to prove that on a particular occasion the person or organization acted in accordance with the habit or routine practice." "Habit" is a "specific" concept which "describes one's regular response to a repeated specific situation." *Crawford v. Tribeca Lending Corp.*, 815 F.3d 121, 125 (2d Cir. 2016). It describes actions that are "semi-automatic." Advisory Committee Notes, 1972 Proposed Rules, Fed. R. Evid. 406 (internal quotation marks omitted).

***11** [36] [37]Under Fed. R. Evid. 703, "[a]n expert may base an opinion on facts or data in the case that the expert has been made aware of or personally observed." The Second Circuit has held that "expert witnesses can testify to opinions based on hearsay or other inadmissible evidence if experts in the field reasonably rely on such evidence in forming their opinions[.]" *United States v. Dukagjini*, 326 F.3d 45, 57 (2d Cir. 2003) (internal quotation marks omitted); *see also* Fed. R. Evid. 703 ("If experts in the particular field would reasonably rely on those kinds of facts or data in forming an opinion on the subject, they need not be admissible for the opinion to be admitted."). A party may not, however, "call an expert simply as a conduit for introducing hearsay under the guise that the

testifying expert used the hearsay as the basis of his testimony." *Marvel Characters, Inc. v. Kirby*, 726 F.3d 119, 136 (2d Cir. 2013). For this reason, "an expert witness may rely on hearsay evidence while reliably applying expertise to that hearsay evidence, but may not rely on hearsay for any other aspect of his testimony." *Dukagjini*, 326 F.3d at 58.

[38] [39]An expert witness may opine on a medical provider's possible malpractice by relying on an interview with or deposition testimony from that provider. Ms. Coyle's opinion reviews Ms. Fistola's statements about her normal practice and concludes that Ms. Fistola complied with the relevant standard of care. Because it is permissible for Ms. Coyle to rely on hearsay for this purpose, she is not serving merely as a "conduit" for Ms. Fistola's testimony and her opinion need not be excluded on that basis. *Marvel Characters*, 726 F.3d at 136.

[40]According to Ms. Coyle, Ms. Fistola became trained in phlebotomy in 2006 and has worked as a phlebotomist since then. She has completed annual compliance training and an annual certification process. Ms. Coyle opined that phlebotomists conduct multiple blood draws every day. Ms. Fistola provided a step-by-step description of her venipuncture process to Ms. Coyle and indicated she followed the same steps every time. Her statement that there are "very few instances" in which a tourniquet is not used indicates that cases in which she does not do so are rare. (Doc. 75-6 at 3.) Although Ms. Fistola explained that her choice of venipuncture location ultimately depends on the availability and location of a suitable vein, indicating some patient-to-patient variation within her procedure, this variation is limited by the hierarchy of preferred veins in Defendants' Venipuncture Standard of Care.

Ms. Fistola's typical venipuncture procedure is consistent enough to "establish the degree of specificity and frequency of uniform response that ensures more than a mere tendency to act in a given manner, but rather, conduct that is semiautomatic in nature." *LeClair v. Raymond*, 2022 WL 219609, at *5 (N.D.N.Y. Jan. 25, 2022) (internal quotation marks omitted). This testimony should, however, come from Ms. Fistola in the first instance as the person with the personal knowledge of her habits. The possibility of slight variations between patients in Ms. Fistola's normal practice is proper fodder for cross-examination. As habit evidence is admissible under Fed. R. Evid. 406 with a proper foundation, it may be considered on summary judgment. *See Picard Tr. for SIPA Liquidation of Bernard L. Madoff Inv. Sec. LLC v. JABA Assocs. LP*, 49 F.4th 170, 181 (2d Cir. 2022) ("[O]nly admissible evidence need be considered by the trial court in ruling on a motion for summary judgment," and a "district court deciding a summary judgment motion has broad discretion in choosing whether to admit evidence.") (alteration in original) (internal quotation marks omitted) (quoting *Presbyterian Church of Sudan v. Talisman Energy, Inc.*, 582 F.3d 244, 264 (2d Cir. 2009)). *But see Celotex*, 477 U.S. at 324, 106 S.Ct. 2548 (observing that evidence produced by the nonmoving party need not be "in a form that would be admissible at trial in order to avoid summary judgment").

***12** Assuming Ms. Fistola's habit evidence is admissible at trial, there remains a disputed issue of fact as to whether she complied with the standard of care when performing Ms. Mobius's blood draw.

D. Whether Defendants Are Entitled to Summary Judgment on Plaintiffs' Medical Malpractice Claim.

[41]Under New York law, "[t]he essential elements of medical malpractice are (1) a deviation or departure from accepted medical practice, and (2) evidence that such departure was a proximate cause of injury[.]" *Scopelliti v. Westmed Med. Grp.*, 193 A.D.3d 1009, 146 N.Y.S.3d 656, 658 (2021) (internal quotation marks omitted). Because "[a]n error in medical judgment by itself does not give rise to liability for malpractice[,]" a plaintiff "must show by a preponderance of the evidence that the medical professionals treating [him or her] failed to conform to accepted community standards of practice." *Greasley v. United States*, 2021 WL 935731, at *6 (W.D.N.Y. Mar. 11, 2021) (internal citations and quotation marks omitted).

[42]"[U]nless the deviation from the proper standard of care is so obvious as to be within the understanding of an ordinary layperson[,]" the plaintiff must establish each element of his or her claim "by expert medical opinion[.]" *Id.*; *see also Sitts v. United States*, 811 F.2d 736, 739-740 (2d Cir. 1987) (noting that "in the view of the New York courts, the medical malpractice case in which no expert medical testimony is required is 'rare' "); *Fiore v. Galang*, 64 N.Y.2d 999, 489 N.Y.S.2d 47, 478 N.E.2d 188, 189 (1985) ("[E]xcept as to matters within the ordinary experience and knowledge of laymen, in a medical malpractice action, expert medical opinion evidence is required to demonstrate merit[.]").[6]

In this case, Plaintiffs assert that Ms. Fistola failed to use a tourniquet and did not comport with the standard of care. They rely on Dr. Blauzvern for his expert opinion that blood draws and IVs involve the same procedure and there is a national standard of care. Plaintiffs point out

that Ms. Mobius's injuries have no other origin. In the light most favorable to Plaintiffs, this evidence is sufficient to render the duty and standard of care a contested issue of fact.

[43] [44]"A defendant 'moving for summary judgment dismissing a complaint alleging medical malpractice must establish, *prima facie*, either that there was no departure [from the standard of care in the community] or that any departure was not a proximate cause of the plaintiff's injuries.' " *Kurtz v. Hansell*, —— F.Supp.3d ——, ——, 2023 WL 2648190, at *20 (S.D.N.Y. Mar. 27, 2023) (alteration in original) (quoting *Gillespie v. N.Y. Hosp. Queens*, 96 A.D.3d 901, 947 N.Y.S.2d 148, 150 (2012)). Once the defendant makes the requisite prima facie showing, "the burden shifts to the plaintiff to demonstrate the existence of a triable issue of fact, but only as to the elements on which the defendant met the prima facie burden[.]" *Gillespie*, 947 N.Y.S.2d at 150.

***13** [45] [46] [47]To establish its prima facie entitlement to summary judgment, the moving party may rely on "the submission of affidavits and/or deposition testimony and medical records which rebut [the] plaintiff's claim of malpractice with factual proof." *Kurtz*, —— F.Supp.3d at ——, 2023 WL 2648190, at *20 (internal quotation marks omitted); *see also Guido v. Fielding*, 190 A.D.3d 49, 134 N.Y.S.3d 34, 53 (2020) ("A defendant makes a prima facie case of entitlement to summary judgment in a medical malpractice action by submitting an affirmation from a medical expert establishing that the treatment provided to the injured plaintiff comported with good and accepted practice or that the plaintiff was not injured thereby[.]"). The moving party may rely on expert testimony based on admissible habit evidence to satisfy their burden; however, "[e]vidence of habit only provides a basis for the jury to draw an inference[.]" *Id.* at 55. "[I]t cannot be the basis for judgment as a matter of law[,]" because a medical provider's usual practice "does not conclusively prove" that he or she followed that practice in the pending case. *Id.*

[48]Defendants proffer Ms. Coyle's testimony regarding Ms. Fistola's venipuncture procedure to establish they did not depart from the standard of care in the community. Although Ms. Coyle's testimony may be admissible, New York courts apply strict standards in determining when a defendant may rely upon habit evidence to satisfy its prima facie case. In *Rivera v. Anilesh*, 8 N.Y.3d 627, 838 N.Y.S.2d 478, 869 N.E.2d 654, 659 (2007), the New York Court of Appeals found that the defendant dentist met her prima facie burden of proof on summary judgment where she presented an expert opinion reviewing her routine practice and the "record ... contain[ed] proof of a deliberate and repetitive practice[.]" 838 N.Y.S.2d 478, 869 N.E.2d at 659 (internal quotation marks omitted). There, the defendant dentist "described the specific procedure that she used when injecting an anesthetic and her expert confirmed that this procedure was within the accepted standard of care for dentistry." *Id.*, 838 N.Y.S.2d 478, 869 N.E.2d at 658. "[N]o evidence suggest[ed] that [the dentist's] pre-extraction injection procedure would vary from patient to patient depending on the particular medical circumstances or physical condition of the patient." *Id.*, 838 N.Y.S.2d 478, 869 N.E.2d at 658-59; *Rigie v. Goldman*, 148 A.D.2d 23, 543 N.Y.S.2d 983, 984 (1989) (permitting testimony of dentist that he "[i]nvariably" gave a particular warning to patients before they underwent wisdom tooth surgery).

[49]As in *Rivera*, Ms. Fistola "provided a step-by-step description of the procedure she used" to perform blood draws, *Rivera*, 838 N.Y.S.2d 478, 869 N.E.2d at 656, and Ms. Coyle opined that Ms. Fistola's treatment of Ms. Mobius was within the applicable phlebotomy standard of care. Unlike the *Rivera* defendant, however, Ms. Fistola's choice of vein varied between patients, albeit within certain limits, and she admitted that on rare occasions she may not use a tourniquet. *Guido*, 134 N.Y.S.3d at 54 (holding doctor's testimony regarding his routine practice was insufficient basis for defendant's prima facie case because doctor failed to lay a foundation proving that his surgical practice "did not vary from patient to patient"). An issue of fact thus exists as to whether "the practice described by [Ms. Fistola] was followed by [her] in this particular case[.]" *Id.* at 55. ("The fact that [the defendant surgeon] usually inspects and palpates a patient's bowel does not conclusively prove that he did so on this occasion.").

Because there is a disputed issue of fact as to how Ms. Mobius's blood was drawn and whether that breached an applicable standard of care, Defendants are not entitled to judgment as a matter of law on Plaintiffs' medical malpractice claim and their motion for summary judgment on that claim (Count I) is DENIED.

E. Whether Defendants Are Entitled to Summary Judgment on Plaintiffs' Failure to Obtain Informed Consent Claim.

New York Public Health Law § 2805-d codifies the elements which a plaintiff alleging failure to obtain informed consent must prove at trial. Under that statute, "[t]he right of action to recover for medical ... malpractice

based on a lack of informed consent is limited to those cases involving either (a) non-emergency treatment, procedure or surgery, or (b) a diagnostic procedure which involved invasion or disruption of the integrity of the body." N.Y. Pub. Health Law § 2805-d(2). To prevail on a lack of informed consent claim under § 2805-d, the plaintiff must "establish[ ] that a reasonably prudent person in the patient's position would not have undergone the treatment or diagnosis if he [or she] had been fully informed and that the lack of informed consent is a proximate cause of the injury or condition for which recovery is sought." *Id.* § 2805-d(3). "Lack of informed consent" is statutorily defined as "the failure of the person providing the professional treatment or diagnosis to disclose to the patient such alternatives thereto and the reasonably foreseeable risks and benefits involved as a reasonable medical, dental or podiatric practitioner under similar circumstances would have disclosed, in a manner permitting the patient to make a knowledgeable evaluation." *Id.* § 2805-d(1).

***14** Despite seeking summary judgment in their favor on all of Plaintiffs' claims, Defendants' only argument is that the exclusion of Dr. Blauzvern's expert witness opinion entitles them to dismissal of the Complaint in its entirety. They do not address, nor is it readily apparent, how Dr. Blauzvern's testimony regarding the venipuncture standard of care bears on the issue of whether Defendants obtained Ms. Mobius's informed consent.

[50]As the party moving for summary judgment, Defendants are "initially responsible for demonstrating the absence of a genuine issue of material fact." *Holcomb v. Iona Coll.*, 521 F.3d 130, 137 (2d Cir. 2008) (citing *Celotex Corp.*, 477 U.S. at 323, 106 S.Ct. 2548). Having failed to fulfill their "initial responsibility of informing the district court of the basis for [their] motion[,]" Defendants are not entitled to summary judgment on Plaintiffs' failure to obtain informed consent claim. *Celotex Corp.*, 477 U.S. at 323, 106 S.Ct. 2548; *see also* Fed. R. Civ. P. 56(c) ("A party asserting that a fact cannot be or is genuinely disputed *must support the assertion* by: (A) citing to particular parts of materials in the record ...; or (B) showing that the materials cited do not establish the absence or presence of a genuine dispute[.]") (emphasis supplied). Defendants' motion for summary judgment as to Count II is therefore DENIED.

F. Whether Defendants Are Entitled to Summary Judgment on Plaintiff Hans Mobius's Loss of Consortium Claim.

[51] [52]Under New York law, loss of consortium is a common law concept which "arises out of an injury to the marital relationship[.]" *Buckley v. Nat'l Freight, Inc.*, 90 N.Y.2d 210, 659 N.Y.S.2d 841, 681 N.E.2d 1287, 1288 (1997). It includes "not only loss of support or services of a husband or wife[,]" but also "such elements as love, companionship, affection, society, sexual relations, solace and more." *Goldman v. MCL Cos. of Chicago, Inc.*, 131 F. Supp. 2d 425, 427 (S.D.N.Y. 2000) (internal quotation marks omitted).

[53] [54]Loss of consortium is a derivative claim which "traditionally may be maintained pursuant to such common law torts as negligence[.]" *Fleming v. State*, 60 Misc.3d 1055, 80 N.Y.S.3d 850, 853 (N.Y. Ct. Cl. 2018) (internal quotation marks omitted) (quoting *Goldman*, 131 F. Supp. 2d at 427); *see also Goldman*, 131 F. Supp. 2d at 427 ("It is well established ... that a loss of consortium claim is not an independent cause of action, but is derivative in nature, and may only be maintained where permitted pursuant to the primary tort.") (alteration adopted) (internal quotation marks omitted). "In contrast, 'where ... a loss of consortium claim is purportedly derived from a statutory claim, courts must examine the statute at issue to determine whether it authorizes a spouse to bring a derivative action[.]' " *Fleming*, 80 N.Y.S.3d at 853 (alteration adopted) (quoting *Goldman*, 131 F. Supp. 2d at 427).

With regard to Plaintiffs' lack of informed consent claim, the parties cite no authority regarding whether New York courts have interpreted § 2805-d to authorize a spouse to bring a derivative action. At least one district court has found that a plaintiff could "recover loss of consortium damages for the medical malpractice and lack of informed consent claims" in New York, however, the court did not explain the basis for its decision. *Powers v. Mem'l Sloan Kettering Cancer Ctr.*, 2022 WL 874846, at *5 (S.D.N.Y. Mar. 24, 2022). Other state and federal courts applying New York law have addressed the issue only indirectly. *See, e.g.*, *Mirshah v. Obedian*, 200 A.D.3d 868, 158 N.Y.S.3d 226, 232 (2021) (holding that because lower court erred by granting summary judgment on informed consent claims, it also erred by granting summary judgment on derivative loss of consortium claims); *Ingutti v. Rochester Gen. Hosp.*, 145 A.D.3d 1423, 44 N.Y.S.3d 274, 276 (2016) (upholding lower court's decision to deny motion to dismiss derivative cause of action where the court properly denied motion to dismiss lack of informed consent claim); *Hazel v. Montefiore Med. Ctr.*, 243 A.D.2d 344, 663 N.Y.S.2d 165, 166 (1997) (holding that where informed consent and medical malpractice claims were dismissed as time-barred, "[t]he cause of action for loss of consortium was also properly dismissed,

since it is derivative of the other claims").

***15** In the absence of controlling precedent as to whether New York's informed consent statute supports Mr. Mobius's loss of consortium claim, this court must predict the outcome under New York law. *See Cont'l Cas. Co. v. Pullman, Comley, Bradley & Reeves*, 929 F.2d 103, 105 (2d Cir. 1991) (finding that where a state's highest court has never decided the issue at bar, the court must "make [its] best estimate as to how [that state's] highest court would rule in this case") (internal citation omitted). Because § 2805-d does not expressly provide for or prohibit the recovery of derivative losses, the question is whether the legislative intent animating the statute otherwise supports such a claim. *See Alifieris v. Am. Airlines, Inc.*, 63 N.Y.2d 370, 482 N.Y.S.2d 453, 472 N.E.2d 303, 305 (1984) ("The guiding principle in such [statutory construction] cases is to give effect to the legislative intent and that intent is to be sought first in the words of the statute under consideration[.]").

[55] [56]The statute's plain language identifies a remedy only for patients undergoing certain "non-emergency treatment[s]" or "diagnostic procedure[s,]" § 2805-d(2). It "makes no provision for the families of those [patients]" whose informed consent was not sought. *Fleming*, 80 N.Y.S.3d at 853. Despite the codification of the informed consent cause of action, however, courts characterize lack of informed consent as a genre of medical malpractice claims. *See, e.g., Figueroa-Burgos v. Bieniewicz*, 135 A.D.3d 810, 23 N.Y.S.3d 369, 372 (2016) (explaining elements of "the cause of action in negligent malpractice for failure to inform"). Because loss of consortium claims are traditionally derived from "such common law torts as negligence," *Fleming*, 80 N.Y.S.3d at 853, and "medical malpractice is but a species of negligence[,]" *Weiner v. Lenox Hill Hosp.*, 88 N.Y.2d 784, 650 N.Y.S.2d 629, 673 N.E.2d 914, 916 (1996), it follows that § 2805-d supports a derivative claim for loss of consortium.

[57]Because Defendants are not entitled to summary judgment on Plaintiffs' medical malpractice or informed consent claims, they also fail to establish that, as a matter of law, Mr. Mobius cannot maintain a derivative loss of consortium claim associated with his wife's claims. Defendants' motion for summary judgment as to the loss of consortium claim (Count III) is therefore DENIED.

CONCLUSION

For the foregoing reasons, Defendants' motion to strike Plaintiffs' expert Neal Blauzvern is GRANTED IN PART and DENIED IN PART. Defendants' motion for summary judgment is DENIED. (Doc. 75.)

SO ORDERED.

All Citations

--- F.Supp.3d ----, 2023 WL 5314557

Footnotes

1 Dr. Blauzvern's sole publication is an article he published in 1989 entitled "Effects on Pain Reduction and Simple Reaction Time – A Preliminary Report." (Doc. 75-5 at 9.)

2 Dr. Blauzvern's testimony reflected uncertainty regarding how blood draws are typically performed:

> Q. Is there a specific order of the non-preferential veins in performing a venipuncture?
>
> ...
>
> A. Usually [they] will go to the lateral antecubital fossa to pick up -- I think it's the -- the basilic or the cephalic over on that side. But -- but yeah. I mean, that's -- typically -- typically they will look for veins in -- in the antecubital fossa, either medial or lateral.
>
> Q. In the lateral portion of the arm, is that the basilic or the cephalic vein, Doctor?
>
> A. I don't remember at this point which one of those two it is.

(Doc. 75-5 at 22-23.)

3 *See, e.g.*, *Gaydar v. Sociedad Instituto Gineco-Quirurgico y Planificacion*, 345 F.3d 15, 24 (1st Cir. 2003) ("The mere fact that Dr. Rodriguez was not a gynecologist does not mean that he was not qualified to give expert testimony regarding Gaydar's pregnancy. The proffered expert physician need not be a specialist in a particular medical discipline to render expert testimony relating to that discipline."); *I.M. v. United States*, 362 F. Supp. 3d 161, 197-98 (S.D.N.Y. 2019) ("The Court is not aware of a case in the Second Circuit holding that a doctor in a specialty cannot testify as an expert about nursing in that same specialty[.]"); *Est. of Sumrall v. Singing River Health Sys.*, 303 So. 3d 798, 806 (Miss. Ct. App. 2020) (holding expert doctor was qualified to testify as to applicable standard of care where "the record before [the court] [was] devoid of any evidence showing that a medical doctor would remove a patient's central line differently than a registered nurse" and expert "demonstrated 'satisfactory familiarity' with the procedure required") (alteration adopted).

4 Under New York law, "[t]o establish a claim of medical malpractice, a plaintiff must prove by a preponderance of the evidence: '(1) the standard of care in the locality where the treatment occurred, (2) that the defendants breached that standard of care, and (3) that the breach of the standard was the proximate cause of injury.' " *K.R. ex rel. Perez v. United States*, 843 F. Supp. 2d 343, 355 (E.D.N.Y. 2012) (internal quotation marks omitted).

> Under the first element, the general standard of care for physicians in New York is well established and requires a physician to "exercise that reasonable degree of learning and skill that is ordinarily possessed by physicians ... *in the locality where he practices* .... The law holds [the physician] liable for an injury to his patient resulting from want of the requisite knowledge and skill, or the omission to exercise reasonable care, or the failure to use his best judgment."

Id. (emphasis supplied) (omissions in original) (quoting *Perez v. United States*, 85 F. Supp. 2d 220, 226 (S.D.N.Y. 1999)). The parties may, however, introduce evidence establishing that the standard of care in a locality is the same as the standard of care nationally. *See, e.g.*, *McCullough v. Univ. of Rochester Strong Mem'l Hosp*, 17 A.D.3d 1063, 794 N.Y.S.2d 236, 237 (2005) ("A court may deviate from applying the locality rule and instead apply a minimum statewide standard of care or even a nationwide standard of care[.]") (internal citations omitted); *Greasley v. United States*, 2021 WL 935731, at *25 (W.D.N.Y. Mar. 11, 2021) (admitting expert who was not board-certified in New York because he testified that his opinions in medical malpractice action were based on national standards for general emergency room treatment). Here, plaintiffs seek to introduce Dr. Blauzvern's opinion that the phlebotomy standard of care is a national one.

5 The parties have also identified the witness's last name as "Fistula."

6 At least one court has found that the phlebotomy standard of care must be established by expert testimony. That court found:

> The phlebotomy process is extremely complex and involves language that is alien and technical. This process is not within the general purview of a common juror's knowledge, and without expert testimony on the standard of care common to the phlebotomy process, a trier of fact would not be able to understand the nature of the standard of care required by [d]efendant. As such, expert testimony is required to establish the applicable standard of care for [p]laintiff's phlebotomy and subsequent treatment.

Cruz v. The Am, Nat'l Red Cross, 2021 WL 1999084, at *3 (D. Kan. May 19, 2021), *aff'd sub nom. Cruz v. Am. Nat'l Red Cross*, 2022 WL 2813237 (10th Cir. July 19, 2022).

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EXHIBIT A-A

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United States District Court, W.D. Washington, at Seattle.

Brandon Lee STANLEY, Plaintiff,
v.
UNITED STATES of America, et al., Defendants.

Cause No. C15-0256RSL
|
Signed October 31, 2022

Attorneys and Law Firms

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Whitney Passmore, US Attorney's Office, Seattle, WA, for Defendants United States of America, Jack Fox.

ORDER GRANTING IN PART DEFENDANT'S MOTION TO EXCLUDE EXPERT TESTIMONY AND MOTION FOR SUMMARY JUDGMENT

Robert S. Lasnik, United States District Judge

***1** This matter comes before the Court on the United States' "Motion for Summary Judgment" (Dkt. # 77) and "Motion to Exclude Expert Opinions of Elisa Marks" (Dkt. # 79). Plaintiff alleges that defendants failed to provide basic first aid and follow-up care when he broke his hand on April 6, 2013, while in custody. In particular, plaintiff asserts that a seventeen day delay between the x-ray that confirmed the fracture and the corrective surgery, the failure to immobilize the break before surgery, and the failure to provide physical therapy as prescribed following surgery all violated the standard of care and caused permanent injuries. Dkt. # 86 at 2; Dkt. # 89 at 2. Plaintiff offers the testimony of an occupational and certified hand therapist, Elisa Marks, to establish both the applicable standards of care and causation. Defendant seeks to exclude the testimony of Ms. Marks under Federal Rule of Evidence 702 because (1) she is not qualified to opine on the standard of care for medical providers; (2) her testimony on the standard of care will not assist the trier of fact; (3) she is not qualified to opine that any breach of the standard of care caused plaintiff's alleged injuries; and (4) her testimony regarding causation is unreliable. Without expert testimony to support the claim of medical negligence, defendant argues, plaintiff's claims must be dismissed.

Having reviewed the memoranda, declarations, and exhibits submitted by the parties and taking the evidence in the light most favorable to plaintiff, the Court finds as follows:

BACKGROUND

On Saturday, April 6, 2013, plaintiff fell while in custody at the Federal Detention Center ("FDC") SeaTac. Plaintiff complained of pain in his right hand and requested medical care. The hand was x-rayed on Monday, April 8, 2013, and revealed a fracture of his right thumb. Defendant provided ice and ibuprofen to plaintiff while he waited for surgery, but the hand was not immobilized. Defendant was able to obtain an appointment for plaintiff with an orthopedic surgeon for April 15, 2016, but the U.S. Marshals Service was unable to transport him at the specified time. Plaintiff was ultimately seen by an orthopedic surgeon on April 23, 2013, who diagnosed plaintiff with a Rolando-type fracture of the right thumb and recommended surgical repair. Surgery occurred two days later, on April 25, 2013. On or about June 12, 2013, the orthopedic surgeon removed the pins that had been used to fix the fracture.

On July 2, 2013, a Bureau of Prisons physician removed plaintiff's stiches and put in a request for physical therapy. That request was approved, and plaintiff had five appointments with an outside physical therapist in September and October 2013 before he was transferred to FDC Sheridan. Although the physical therapist had recommended two therapy sessions a week for four to six weeks, plaintiff's visits were not that frequent and ended when he was transferred. Plaintiff twice requested that his physical therapy be reinstated while at FDC Sheridan, but it never happened. Plaintiff's hand "remains visibly damaged," he has difficulty holding objects, and he is prevented from pursuing a career as a welder. Dkt. # 90 at ¶ 6.

DISCUSSION

A. Medical Negligence Under Washington Law

*2 A medical negligence claim, like other negligence claims, requires a showing of duty, breach, causation, and damages. "[T]o recover damages for medical negligence, the plaintiff must establish that (1) the health care provider breached the accepted standard of care and (2) the breach was a proximate cause of the injury complained of." *Hill v. Sacred Heart Med. Ctr.*, 143 Wn. App. 438, 447 (2008). In order to show that a health care provider failed to follow the accepted standard of care, one must prove that the "provider failed to exercise that degree of care, skill, and learning expected of a reasonably prudent health care provider at that time in the profession or class to which he or she belongs, in the state of Washington, acting in the same or similar circumstances." RCW 7.70.040(1)(a). Expert testimony is generally required to establish the standard of care and causation in medical malpractice cases. *Brotherton v. U.S.*, No. 2:17-CV-00098-JLQ, 2018 WL 3747802, at *5 (E.D. Wash. Aug. 7, 2018) (citing *McLaughlin v. Cooke*, 112 Wn.2d 829, 836-37 (1989)).

B. Qualification as an Expert

"The admission of expert testimony is governed by Federal Rule of Evidence 702." *F.T.C. v. BurnLounge, Inc.*, 753 F.3d 878, 888 (9th Cir. 2014). Rule 702 provides that "[a] witness who is qualified as an expert by knowledge, skill, experience, training, or education, may testify in the form of an opinion" if the expert's "specialized knowledge will help the trier of fact ..., the testimony is based on sufficient facts or data, ... the testimony is the product of reliable principles and methods, and ... the expert has reliably applied the principles and methods to the facts of the case." Defendant argues that Ms. Marks, an occupational therapist, is not qualified to opine regarding the standard of care that governed the conduct of the physicians, nurse practitioners, and physician assistants who scheduled plaintiff's orthopedic consult and surgery, chose not to immobilize the thumb before surgery, and delayed initiation of physical therapy and/or chose not to reinstate therapy following plaintiff's transfer to FDC Sheridan. Plaintiff does not dispute that Ms. Marks is not a member of the professions whose conduct she purports to judge. He nevertheless argues that her education, training, and experience qualify Ms. Marks to testify that the standard of care for treating a Rolando fracture involves prompt surgical intervention, immobilization prior to surgery, and a certain quantum and schedule for rehabilitative services.

According to her deposition testimony, Ms. Marks generally sees patients only after a hand injury has been diagnosed, managed, and, if appropriate, surgically repaired by health care providers. Her role is to review the referring physician's prescription and to outline a treatment plan that is designed to improve the patient's functional status as much as possible. If her treatment plan conflicts with the physician's instructions, she notifies the physician and requests an alteration in the prescription. Ms. Marks states that "I like to make sure that I'm on the same page as my referring provider, so that I'm treating – you know, especially in a surgical case, they've been in there, so they know what it looks like, and I want to make sure I'm using their professional expertise to guide my care." Dkt. # 87-1 at 32. Ms. Marks' understanding of the standard of care is based almost exclusively on how the physicians with whom she works handle hand fracture management. Dkt. # 80-14 at 24.

Based on her experiences and plaintiff's medical records, Ms. Marks seeks to testify that:

> 1. The standard of care for rehabilitation of a Rolando-type metacarpal fracture involves early surgical intervention in order to avoid bony healing and the necessity of additional manipulation during surgery;
>
> 2. Plaintiff's reduced thumb function was caused by the delay in obtaining surgery;
>
> *3 3. The standard of care for an unstable fracture such as plaintiff's is to immobilize the injury until surgical care is available;
>
> 4. Plaintiff's reduced thumb function was caused by the failure to immobilize the fracture prior to surgery;
>
> 5. The standard of care for rehabilitation of plaintiff's type of injury involves early rehabilitation through a skilled physical or occupational therapist;
>
> 6. Plaintiff's reduced thumb function was caused by the delay in rehabilitative care and the limited number of visits he received.

The Court agrees with plaintiff that there is no hard and fast rule that only another physician can testify regarding the standard of care or causation in a medical negligence case. Although the Washington Supreme Court had

previously specified that the testimony of a "peer" was necessary to establish the standard of care, *see McKee v. Am. Home Prods., Corp.*, 113 Wn.2d 701, 706-07 (1989), it has since recognized that the issue under Rule 702 is whether the witness has "sufficient expertise in the relevant specialty," even if he or she is not part of the specialty, *see Frausto v. Yakima HMA, LLC*, 188 Wn.2d 227, 232 (2017). "[D]epending on the circumstance, a nonphysician might be qualified to testify in a medical malpractice action ... [T]he line between chemistry, biology, and medicine is too indefinite to admit of a practicable separation of topics and witnesses." *L.M. v. Hamilton*, 193 Wn.2d 113, 135 (2019) (internal citations and quotation marks omitted). In the absence of a *per se* admissibility rule, the Court must determine whether Ms. Marks "is qualified as an expert by knowledge, skill, experience, training, or education" to offer the opinions listed above. FRE 702. *See Hood v. King Cnty.*, No. C15-828RSL, 2017 WL 979024, at *11 (W.D. Wash. Mar. 14, 2017) ("[W]hile 'artificial classification by professional title' does not control 'the threshold question of admissibility of expert medical testimony in a malpractice case,' 'the scope of a witness's knowledge' does.") (quoting *Eng v. Klein*, 127 Wn. App. 171, 172 (2005)).

For the most part, Ms. Marks does not have the qualifications to testify to the opinions offered. Her expertise is in occupational and hand therapy. She is rarely involved in a patient's care before surgery, and her knowledge of and experience regarding the scheduling of surgery and immobilization options are based on what she is told when a patient is referred to her for rehabilitative therapy. She has no insight into the decision-making process of the health care providers or the standards that guide their choices. Absent expertise regarding the "degree of care, skill, and learning expected of a reasonably prudent health care provider" when diagnosing, managing, and treating a Rolando-type fracture, Ms. Marks will not be permitted to offer opinions on those matters.

The Court finds, however, that Ms. Marks has the expertise necessary to opine regarding the standard of care for the rehabilitation of plaintiff's type of injury, including the timing and extent of the rehabilitative therapy, and whether the deficits plaintiff is experiencing are causally related to the delay in providing therapy and/or its curtailment. This is the witness' bailiwick. Ms. Marks has years of experience dealing with patients who begin therapy post-surgery and can testify regarding the standard practice regarding the initiation of that therapy. Defendant's emphasis on the fact that it is the physician who decides whether physical therapy is warranted misses the point in this case. Plaintiff is not challenging the physician's referral for physical therapy, but rather the delay in initiating the therapy that was prescribed. To the extent plaintiff is challenging the frequency and duration of the therapy appointments once begun, there is evidence in the record that it is the therapist who generally establishes how often to see the patient and over how many weeks. Ms. Marks therefore has the expertise to testify regarding the standard frequency and duration recommendations for a Rolando-type fracture. Finally, with regards to causation, Ms. Marks has experience with what happens when patients miss appointments, fail to do their recommended exercises, or otherwise curtail the recommended therapy. The Court finds that she has the expertise to opine regarding whether inconsistent therapy appointments and their cessation after five sessions would cause the type of deficits of which plaintiff complains.[1]

C. Admissibility of Expert Testimony

***4** In *Daubert v. Merrell Dow Pharm., Inc.*, 509 U.S. 579 (1993), the United States Supreme Court charged trial judges with the responsibility of acting as gatekeepers to prevent unreliable expert testimony from reaching the jury. The gatekeeping function applies to all expert testimony, not just testimony based on the hard sciences. *Kumho Tire Co. v. Carmichael*, 526 U.S. 137 (1999). To be admissible, expert testimony must be both reliable and helpful. The reliability of expert testimony is judged not on the substance of the opinions offered, but on the methods employed in developing those opinions. *Daubert*, 509 U.S. at 594-95. In general, the expert's opinion must be based on principles, techniques, or theories that are generally accepted in his or her profession and must reflect something more than subjective belief and/or unsupported speculation. *Daubert*, 509 U.S. at 590. The testimony must also be "helpful" in that it must go "beyond the common knowledge of the average layperson" (*U.S. v. Finley*, 301 F.3d 1000, 1007 (9th Cir. 2002)) and it must have a valid connection between the opinion offered and the issues of the case (*Daubert*, 509 U.S. at 591-92). Plaintiff, as the party offering Ms. Marks as an expert, has the burden of proving both the reliability and helpfulness of her testimony. *Cooper v. Brown*, 510 F.3d 870, 942 (9th Cir. 2007).

Defendant argues that Ms. Marks' opinions regarding the standard of care for rehabilitative therapy are not relevant because she does not practice in Washington, does not practice in a prison setting, and does not practice in the same field as a physician, nurse practitioner, or physician

assistant. These arguments go to her qualifications for offering opinion testimony (discussed above), not to the relevance of that testimony. Ms. Marks' testimony regarding the degree of care, skill, and learning expected of a reasonably prudent health care provider when obtaining rehabilitative services for a patient recovering from a Rolando-type fracture is clearly relevant to plaintiff's negligence claim.

With regards to causation, defendant argues that Ms. Marks' opinions are not reliable because she lacks the medical training or experience to determine whether the symptoms and deficits of which plaintiff complains "were specifically caused by any perceived failure of the standard of care." Dkt. # 79 at 9. Relying on her training, experience, education, and knowledge, Ms. Marks is of the opinion that if a patient with plaintiff's injury starts physical therapy immediately following cast removal and continues two times per week for six to eight weeks, one would expect the patient to regain functional use of the thumb. Thus, plaintiff's failure to regain the use of his thumb is likely caused by the failure to provide the standard of care for this type of injury. This testimony is not unassailable, but it is within her area of expertise and appears to be based on the types of data and methods she would use to make clinical judgments when treating patients.

D. Summary Judgment

Summary judgment is appropriate when, viewing the facts in the light most favorable to the nonmoving party, there is no genuine issue of material fact that would preclude the entry of judgment as a matter of law. The party seeking summary dismissal of the case "bears the initial responsibility of informing the district court of the basis for its motion" (*Celotex Corp. v. Catrett*, 477 U.S. 317, 323 (1986)) and "citing to particular parts of materials in the record" that show the absence of a genuine issue of material fact (Fed. R. Civ. P. 56(c)). Once the moving party has satisfied its burden, it is entitled to summary judgment if the non-moving party fails to designate "specific facts showing that there is a genuine issue for trial." *Celotex Corp.*, 477 U.S. at 324. The Court will "view the evidence in the light most favorable to the nonmoving party ... and draw all reasonable inferences in that party's favor." *Colony Cove Props., LLC v. City of Carson*, 888 F.3d 445, 450 (9th Cir. 2018). Although the Court must reserve for the trier of fact genuine issues regarding credibility, the weight of the evidence, and legitimate inferences, the "mere existence of a scintilla of evidence in support of the non-moving party's position will be insufficient" to avoid judgment. *City of Pomona v. SQM N. Am. Corp.*, 750 F.3d 1036, 1049 (9th Cir. 2014); Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 252 (1986). Factual disputes whose resolution would not affect the outcome of the suit are irrelevant to the consideration of a motion for summary judgment. *S. Cal. Darts Ass'n v. Zaffina*, 762 F.3d 921, 925 (9th Cir. 2014). In other words, summary judgment should be granted where the nonmoving party fails to offer evidence from which a reasonable fact finder could return a verdict in its favor. *Singh v. Am. Honda Fin. Corp.*, 925 F.3d 1053, 1071 (9th Cir. 2019).

***5** In the absence of evidence regarding the "degree of care, skill, and learning expected of a reasonably prudent health care provider" treating a Rolando-type fracture (RCW 7.70.040(1)(a)), plaintiff cannot succeed on his medical negligence claim related to the timing of surgery or the pre-operative care he received. Defendant is therefore entitled to judgment on those aspects of the claim. There are, however, triable issues of fact regarding whether defendant was negligent in obtaining and providing rehabilitative services and whether that negligence caused plaintiff's injuries.

For all of the foregoing reasons, defendant's motions for summary judgment (Dkt. # 77) and to exclude expert testimony (Dkt. # 79) are GRANTED in part and DENIED in part.

All Citations

Not Reported in Fed. Supp., 2022 WL 16553273

Footnotes

1 Defendant's objections based on the fact that Ms. Marks is unfamiliar with the provision of healthcare in a prison setting or the standard of care in Washington are unavailing.

The standard of care in medical malpractice cases is that degree of care expected of the average, competent practitioner in the class to which he belongs, acting in the same or similar circumstances. *Pederson v. Dumouchel*, 72 Wn.2d 73 (1967). Here, the jail physician, a general practitioner, is required to exercise the same standard of care of the average, competent doctor, and

this is the class to which he belongs.

Shea v. City of Spokane, 17 Wn. App. 236, 246 (1977), *aff'd*, 90 Wn.2d 43 (1978). With regards to Ms. Marks' familiarity with rehabilitative services in Washington, there is evidence in the record that the standards applicable to the practice of occupational therapy are national and that Ms. Marks is familiar with those standards.

> In other words, the standard for [an occupational therapist] doing this work in Washington is not any different than the standard for [an occupational therapist] doing this work in California, Vermont, or anyplace else in the United States. Now, the necessary inference from this is that [she] is familiar with the standard of care in Washington because the standard of care is a national standard of care and [she] is familiar with that standard.

Elber v. Larson, 142 Wn. App. 243, 247 (2007).

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