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IN THE SUPREME COURT OF IOWA

SHARON K. SUSIE, an individual and LARRY D. SUSIE, an individual **Plaintiffs-Appellants** **v.** **FAMILY HEALTH CARE OF SIOUXLAND, P.L.C., D/B/A FAMILY HEALTH CARE OF SIOUXLAND URGENT CARE, a professional limited liability company; and SARAH HARTY, P.A.C., an individual** **Defendants-Appellees**	**S.CT. NO. 17-0908** **BRIEF FOR APPELLANT**

APPEAL FROM THE IOWA DISTRICT COURT
FOR WOODBURY COUNTY
HONORABLE JOHN D. ACKERMAN, JUDGE

APPELLANTS' BRIEF AND ARGUMENT AND REQUEST FOR ORAL ARGUMENT

Marc A. Humphrey AT0003843
300 Walnut Street, Suite 5
Des Moines, Iowa 50309
Telephone: (515) 331-3510
Facsimile: (515) 282-0318
Email: mhumphrey@humphreylaw.com

ATTORNEY FOR PLAINTIFFS/APPELLANTS

CERTIFICATE OF SERVICE

I certify that on the 27th day of November, 2017, I served one copy of the Plaintiff-Appellants' Notice of Appeal by mailing one copy to all of the following at their respective addresses as shown below:

Jack Hilmes/Eric Bergeland
FINLEY, ALT, SMITH, SCHARNBERG, CRAIG, HILMES & GAFFNEY, P.C.
699 Walnut Street, 1700 Hub Tower
Des Moines, IA 50309-3905
Attorneys for Defendants
(via E-mail and EDMS)

Clerk of the Iowa Supreme Court
Judicial Branch Building
1111 East Court Avenue
Des Moines, IA 50319
(via EDMS)

By:_/s/ Marc A. Humphrey___
Marc A. Humphrey AT0003843

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STATEMENT OF ISSUES PRESENTED FOR REVIEW

a. Did the trial court err in granting Defendants' untimely motion for summary judgment on the issue of causation when the Rule 1.508 expert summary of Dr. Schechter, coupled with the entire pre-trial record, demonstrated that more likely than not, the severe amputation consequences of an undiagnosed and treated deep tissue infection would have been avoided or minimized?

1. **Did the trial court abuse its discretion in even considering the untimely motion for summary judgment when the issues raised therein should have more appropriately been the subject of a motion for directed verdict?**

2. **Did the trial court inappropriately focus primarily on the pretrial sworn deposition testimony of Dr. Roger Schechter rather than the entire record presented to the court in resistance to Defendants' motion for summary judgment?**

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b. Did the trial court err in granting Defendants' untimely motion for summary judgment of Plaintiffs' loss of a chance causation argument when Plaintiffs' Rule 1.508 expert witness summary of Dr. Schechter and his sworn pre-trial deposition testimony factually supported the submission of such a theory of causation?

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ROUTING STATEMENT

The issues presented in this appeal should be decided by the Iowa Supreme Court because they involve several important issues to the citizens of this State who claim to have been the victim of substandard medical care. Included within those important issues are the following: Whether an Iowa Rule of Civil Procedure 1.508 expert summary, which includes a more likely than not causation opinion, provides a party sufficient basis to resist a motion for summary judgment; whether a submissible issue on causation in a medical negligence action may be generated not only from the opinions of retained experts, but also from the complete pre-trial record before the court; and whether a submissible jury issue on the alternative theory of causation known as loss of a chance can be generated not only from the opinions of retained experts, but also from the complete pre-trial record before the court. Oftentimes some of the most egregious cases of medical negligence present causation challenges by reason of the fact that the very things that should have been done were not done thereby creating a void in the medical record on the issue of causation. This case is one of those cases and presents important issues for the court to decide which will provide direction to future medical negligence litigants in the State of Iowa.

STATEMENT OF THE CASE

Sharon Susie, the Plaintiff-Appellant, now lives her life as a one-armed two-toed woman as a result of what she claims to have been a delay in diagnosing and treating a deep tissue infection in her right arm. (Plaintiff's answer to interrogatory 12, App. p. 0166). She filed her petition on September 26, 2014 in the Iowa District Court in and for Woodbury County. (Petition at Law and Jury Demand, App. pp. 0007-0017). After extensive discovery, which included both written discovery and a multitude of depositions,[1] the case was scheduled to go to trial beginning on March 8, 2016. Both Plaintiffs and Defendants had designated experts (Plaintiff's Designation of Experts, App. pp. 0019-0023; Defendants' Designation of Experts, App. pp. 0025-0027). Prior to the first trial, Defendants did not file a motion for summary judgment. However, Defendants did file two (2) motions in limine, the first was a timely filed motion on February 22, 2016; the second was an untimely motion in limine filed on March 2, 2016. (Defendants' Second Motion in Limine, App. pp. 0029-0043). The second motion in limine, Defendants raised the causation issue – specifically

[1] The written discovery included the following: Defendants served written interrogatories and requests for production of documents on Plaintiff; and Plaintiff served both written interrogatories and request for production on Defendants. In addition, the following depositions were taken prior to the scheduled trial which was to begin on March 8, 2016: Sharon Susie; Sarah Harty; Dr. Kevin Folchert; Dr. John Crew; Jeff Nicholson, P.A.; Dr. Roger Schechter; Brian Susie; Jody Russell; Dr. Mitchel Bauman; Dr. Daniel Lamptey; Dr. William Rizk; Dr. Ross Bacon; and Dr. Kham Vay Ung.

whether the diagnosis of Plaintiff Sharon Susie's infection in her right arm and the commencement of antibiotic therapy would have resulted in sufficient salvage of tissue to make medically unnecessary the eventual amputation of her right arm at the shoulder and eight (8) of her toes. Plaintiff resisted that motion (Plaintiffs' Resistance to Defendants' Second Motion in Limine, App. pp. 0045-0072). The Honorable Judge Ackerman overruled that motion in limine and the case was scheduled to proceed to trial, commencing March 8, 2016.

On the first day of trial, however, the case was continued to allow defense counsel to depose two (2) lay witnesses, both of whom had observed the appearance of Sharon Susie's arm in the days just prior to her presentation to the urgent care clinic on September 29, 2012. As such, the case had to again be scheduled for trial. The new trial was scheduled to begin on May 9, 2017 (Order of Continuance, App. pp. 0074-0076).

One of Plaintiffs' experts, Dr. John Crew, an expert on deep tissue necrotizing fasciitis infections, died prior to the second trial. Plaintiffs moved the court for substitution of experts. (Plaintiffs' Motion for Substitution of Experts, App. pp. 0078-0080) The court granted that request and a new expert was designated, Dr. Roger Schechter. Dr. Schechter

provided a Rule 1.508 summary of his opinions which included an opinion on causation and stated as follows:

> "Dr. Schechter will also opine to a reasonable of medical probability regarding the treatability of Sharon Susie's infection at the point of time she presented to the urgent care clinic on September 29, 2012. He is also expected to testify that had the infection been diagnosed on the day of her visit to the clinic, and treatment initiated immediately, the spread of the infection, more likely than not, could have been avoided, the infection would not have become systemic; and the amputation of Sharon's arm and toes would more likely than not have been avoided."

(Schechter Rule 1.508 Expert Summary, App. pp. 0082-0088).

Dr. Schechter was also deposed on April 25, 2017. (Schechter dep. App. pp. 0324-0454). In his deposition, he was asked a series of question as to whether he agreed with the prior sworn testimony of Dr. John Crew as to how Sharon Susie would have responded to antibiotic therapy had it been initiated at the time of the urgent care visit. The specific questions asked were as follows:

> Q. What I'm getting to, we are speculating on the effect of antibiotics had they been given to Sharon Susie on the afternoon of the 29th of September 2012; correct?
>
> A. Yes.

(Schechter dep. p. 128: 19-23, App. p. 0451).

Dr. Schechter's deposition was taken on April 25, 2017. Defendants filed their untimely motion for summary judgment on the Friday before the start of trial, May 5, 2017, forcing Plaintiff to spend valuable trial preparation time resisting the untimely motion. On the Monday before the start of the trial, May 8, 2017, a hearing was held on the motion for summary judgment. Judge Ackerman ruled that there was insufficient testimony to send the causation issue to the jury based upon Dr. Schechter's opinions; Judge Ackerman initially ruled that there was sufficient evidence to justify submission of the loss of chance alternative theory of causation. (Transcript of May 8, 2017 hearing, p. 5: 2-18, App. p. 0153). Later in the same hearing, he reversed himself and dismissed Plaintiff Sharon Susie's entire case on causation grounds (see transcript of hearing on May 8, 2017, p. 6, App. p. 0154).

Plaintiffs timely filed their notice of appeal on June 7, 2017 (Plaintiff's Notice of Appeal, App. pp. 0160-0162).

STATEMENT OF THE FACTS

The tragic story of Sharon Susie begins innocently on about September 22, 2012. Sharon Susie tripped on an area rug in her living room and fell to the floor on her right arm and right rib area. (Sharon Susie dep. p. 38: 1-7; App p. 0170; Brian Susie dep. p.19: 23-25, App. p. 0181). She had bruising to the right forearm area (between her elbow and wrist) (Sharon Susie dep. pp. 61-62, App. pp. 0171-0172). The pain gradually worsened throughout the week but by Friday, September 28th, the pain had significantly worsened. (Susie dep. pp. 62-64, 67: 8-14, 126:17 – 127: 12, App. pp. 0172, 0173, 0175). Her son, Brian Susie, observed the appearance of her right forearm on the Thursday before she presented to the urgent care clinic (Brian Susie dep. p. 15: 18-19, App. p. 0180). He noticed significant bruising and an abrasion on the right forearm. (Brian Susie dep. pp. 22-28, App. pp. 0182-0188). The day before she presented to the urgent care clinic, her arm was observed by her mail carrier, Jody Russell, and she too observed bruising and swelling to the arm and a small abrasion. (Jody Russell dep. pp. 19-27, App. pp. 0196-0204). Because of the increase in pain and swelling to her right forearm, Sharon Susie made the decision to visit the urgent care clinic run by the Defendant, Siouxland Family Health Care on September 29, 2012. (Exhibit 1, App. pp. 0456-0458). When she

presented to the urgent care clinic, Sharon Susie has testified that she felt ill and thought she was going to faint. (Sharon Susie dep. p. 83: 21-23, App. p. 0174). When the receptionist told Sharon that she could not be seen because of an alleged unpaid bill, a fact that was proven to be false, Sharon Susie told her she needed to be seen immediately because she felt as though she was going to faint. (Sharon Susie dep. pp. 83: 21-23, 84: 1-4, App. p. 0174).

Sharon Susie was seen by a physician's assistant named Sarah Harty on that September 29, 2012 visit. The records generated by Sarah Harty and the triage nurse in conjunction with that visit are sparse. (Plaintiff's Exhibit 1, App. pp. 0456-0458). The only description of the right forearm reads as follows:

> **"Has pain and bruising to right elbow and right forearm."**
>
> History of present illness.
>
> **"Shooting pain down right arm, feels numb and pins…has noticed swelling bruising now that gradually came on."**

From the second page of the note:

> **"Ecchymosis/edema noted over posterior aspect of elbow and proximal forearm. Positive tenderness to palpation on right posterior elbow and proximal forearm."**

(Plaintiff's Exhibit 1, App. p. 0456-0457)

Sarah Harty testified that infection was on her differential diagnosis (Harty dep. p. 34:15, App. p. 0209). However, she concedes that she did no lab work or testing to rule out an infection. (Harty dep. pp. 35-38; App. pp. 0266-0267). Harty sent Sharon Susie home without any antibiotics. (Plaintiff's Exhibit 1, App. pp. 0456-0458).

Sharon Susie was too sick to drive herself home and called her husband. (Sharon Susie dep. p. 85: 14-15, App. p. 0174). When she returned home on September 29, 2012 in the afternoon, she went to bed in a separate bedroom from that of her husband because he had to get up early the next morning to go into work at Walmart. (Brian Susie dep. pp. 39-40, App. pp. 0190-0191). Sharon Susie has little recollection of the events of that evening but she presumably became very sick because when her son, Brian Susie, came to the house to check on her the next morning, there was an odor of vomit in the air. (Brian Susie dep. p. 40: 20-24, App. p. 0191). When he checked on his mother, she was extremely ill. *Id.* Her husband, Larry, took Sharon Susie to the emergency room at Mercy Hospital Medical Center. She was in septic shock and kidney failure at the time of her arrival. (Dr. Lamptey dep. pp. 25-33, App. pp. 0221-0223). The physicians caring for her initially were more concerned with treating her acute symptoms and saving her life; however, a deep tissue necrotizing fasciitis was on the

differential diagnosis of one of the first physicians to have evaluated her, Dr. Daniel Lamptey (Lamptey dep. pp. 31:23 – 32:1, App. p. 0222). Despite gallant efforts, the decision was made to surgically amputate Sharon Susie's right arm in an attempt to stop the progression of the deep tissue necrotizing fasciitis. (Rizk dep. pp. 16:21-22:3, App. pp. 0266-0272). Because of the severity of her systemic bloodborne infection at the time of her presentation, and because of certain types of medications that were administered to keep her alive, blood was diverted away from her toes toward her vital organs thereby resulting in necrosis or tissue death of the tissue of the eight (8) toes on both feet. Eventually, those eight (8) toes, like her right arm, had to be surgically amputated. (Bacon dep. pp. 22:2-23:24, App. p. 0318; Lamptey dep. pp. 51:11-52:2, App. p. 0227).

The bacterial culprit for the deep tissue necrotizing fasciitis was determined to be Group A Strep bacteria on cultures. (Exhibit 31, App. pp. 0460-0461). Importantly, sensitivity studies were done of the very bacterial agent involved to determine the most appropriate types of antibiotics in treating the infection. The Group A Strep bacterial bug at issue in Sharon Susie's case proved to be sensitive to eleven (11) different antibiotics, including anthocyanin, chloramphenicol, ceftriaxone, clindamycin,

cefotaxime, cefepime, erythromycin, levofloxacin, penicillin, tetracycline, and vancomycin. (Exhibit 31, App. p. 0460).

Sharon Susie's treating infectious disease specialist, Dr. Daniel Lamptey, as well as Defendants' infection disease expert, Dr. Ravi Vemuri, have both acknowledged that deep tissue necrotizing fasciitis may start out as a surface infection of the skin known as cellulitis. They both have acknowledged that Group A Strep cellulitis is an extremely common infection seen by infectious disease specialists. They acknowledged statistics from the Center for Disease Control that there are over **ten million** non-invasive Group A Strep infections which occur annually in this country, primarily involving throat and superficial skin infections. **Only nine thousand to eleven thousand five hundred** of those infections progress to invasive infections of the deep tissue, including necrotizing fasciitis. CDC publication entitled "Group A Strep for Clinicians." (Appendix to Plaintiff's Resistance to Defendants' Motion for Summary Judgment, pp. 169-170, App. pp. 0463-0464; Vemuri dep. pp. 42:25-44:22, App. p. 0247; Lamptey dep. pp. 79:14-80:10, App. p. 0234).

A. Dr. Roger Schechter, Plaintiffs retained expert:

In addition to the testimony of Dr. Schechter, there is a significant amount of additional support for Plaintiffs' causation argument from

Defendants' expert witnesses and from key treating physicians of Sharon Susie. Dr. Lamptey, the treating infectious disease physician of Sharon Susie at Mercy Hospital when she presented there approximately twenty-four (24) hours after having been at the urgent care clinic agrees with the statistics published by the Center for Disease Control (Lamptey dep. pp. 79:14-80:10, App. p. 0234). Dr. Vemuri, Defendants' retained infectious disease expert, and Dr. Lamptey, have testified that there is very good reason why so few Group A infections progress to a life-threatening infection of the deep tissue: Most cellulitis infections are caused by Group A Strep bacteria and are exquisitely sensitive to the early administration of a multitude of antibiotics. (Vemuri dep. p. 9:10-25, pp. 11-14, pp. 43:11-44:5, App. pp. 0239, 0240, 0247; Lamptey dep. pp. 39:13-40:6, p. 70:2-6, App. pp. 0223-0224, 0232). Dr. Rizk, Sharon Susie's treating orthopedic specialist who was involved in the amputation surgery, and Dr. Bacon, the pulmonary critical care treating physician of Sharon Susie, likewise agree that Group A Strep cellulitis of the skin is very treatable with a multitude of antibiotics (Rizk dep. p. 53:3-11, App. p. 0303; Bacon dep. pp. 17:3-18:6, 36:4-37:13, App. pp. 0316-0317, 0321).

The clinical presentation of Sharon Susie to the urgent care clinic on September 29, 2012 produced limited record documentation upon which an

expert could base causation opinions. Even though Sarah Harty acknowledged that an infection was on her differential diagnosis, there was no attempt to perform any studies which would have confirmed the diagnosis or provided a factual basis for the extent of tissue damage that had occurred from the infection by the time Sharon Susie presented to the urgent care clinic. As such, Plaintiffs' expert, Dr. Robert Schechter, was simply being honest when he testified that for him to opine as to the effectiveness of treatment with antibiotics had Sharon Susie received those antibiotics at the urgent care clinic on September 29, 2012 would be somewhat speculative. Any expert would be speculating on exactly the response of Sharon Susie to those antibiotics when in fact they were not given and the extent of any progression of that infection into the deeper tissue was not documented through any imaging studies or lab work. However, Dr. Schechter, in his sworn Rule 1.508 expert witness summary was prepared to approach the causation opinion from an objective perspective. Stated another way, he was prepared to emphasize the susceptibility of Group A Strep bacterial infections to a multitude of antibiotics; and he was prepared to testify, consistent with the CDC statistics, that the vast and overwhelming majority of Group A Strep bacterial infections, whether skin infections or throat infections, are quickly brought under control by the administration of

antibiotics before those infections progress to deep tissue necrotizing fasciitis. **Those questions were never asked in his deposition.** Instead, the course of questions of Dr. Schechter in his deposition were in essence to ask him if he agreed with prior sworn testimony of Plaintiffs' earlier expert who is now deceased. Dr. Schechter was never asked the follow up question: "Well if you cannot predict the response of Sharon Susie herself to the administration of antibiotics on September 29, 2012, how is it that you can develop the causation opinion set forth in your Rule 1.508 expert witness summary?" Had he been asked, he would have elaborated. He was never given that chance either in deposition or trial. Notwithstanding the fact that the above question was never asked, a reading of Dr. Schechter's deposition and his Rule 1.508 summary lend significant support to Plaintiffs' causation case:

1. Dr. Schechter's signed Rule 1.508 summary:

The first source of Dr. Schechter's opinions is his signed Rule 1.508 summary. At pages five and six, Dr. Schechter adopted, through his signature, the following summary of his opinions on causation:

> Dr. Schechter will also opine to a reasonable degree of medical probability regarding the treatability of Sharon Susie's infection at the point of time she presented to the Urgent Care Clinic on

> September 29, 2012. **He is also expected to testify that had the infection been diagnosed on the day of her visit to the clinic, and treatment initiated immediately, the spread of the infection, more likely than not, could have been avoided, the infection would not have become systemic; and the amputation of Sharon's arm and toes would more likely than not have been avoided**.

(Schechter Rule 1.508 expert summary, App. pp. 0086-0087) (emphasis added). So, when viewing this record in a light most favorable to Sharon Susie, because of his written opinion which is part of this record for purposes of considering a motion for summary judgment, there is at worst a conflicting opinion on record with regard to causation; at best, there is an opinion on causation which was not fully developed in the deposition taken by the defendants. Causation is a jury issue and when Dr. Schechter's written opinion on causation is considered, taking that opinion and his deposition in a light most favorable to Sharon Susie, the motion for summary judgment should have been overruled and the causation issue should have gone to the jury.

2. Dr. Schechter's deposition excerpts:

In addition, Dr. Schechter further elaborated on the issue of causation in his deposition. Key portions of the deposition opinions on causation reads as follows:

i. **The lack of progression of Sharon Susie's infection when she was evaluated at the urgent care clinic on September 29:**

At page 119, Dr. Schechter clarified the distinction between Sharon Susie's condition at the urgent care clinic and her condition at the emergency room on September 30:

Q. Dr. Schechter, I heard you say -- and I want to make sure I wrote this down correctly -- that when Sharon Susie was at the urgent care clinic, she was not septic. Did I understand that right?

A. Yes, she -- because she did not have any of the vital signs that would at that point in time be consistent with such a syndrome.

Q. Okay. And Mr. Hilmes talked to you about the SIRS criteria, S-I-R-S. She would not have met the SIRS criteria when she was at the urgent care clinic on September 29th, correct?

A. No, she would not.

Q. So I'm listening to your testimony and having reread Dr. Crew's deposition testimony and summary, I'm coming away with the impression that the development of this infectious process is in fact a progression. Is that your view of the progression of an infection?

A. Oh, yes. It doesn't -- it doesn't go -- for -- as analogy, it doesn't go from 0 to 60 in one second. It takes time for it to be evolve…

Q. I want to read you a quote from him [Dr. Crew] on Page 95 beginning at Line 11 in response to this question: "Do you believe that had antibiotics been started, more likely than not, Sharon's arm may have been saved?"

And he says beginning at Line 11: "I think it is" -- "it may well be more likely because, if you can stem the firestorm and let the body mobilize its immune system, which includes both cellular and chemical, you could slow something down. If you could do that and give the body a chance to fight it, I think it is likely that you could have shut down at least the progression. And when they finally did the procedure, it could have saved the arms. I've had arms almost half bad, but I do it a little different way so that treating it, you didn't have that privilege."

Do you agree with that -- that the earlier you get the antibiotics on board and the more you allow the body to mobilize in someone's immune system in response to this developing infection that you may well, more likely than not, have saved her arm?

A. To -- I would say it's **a significant possibility ranging as high as <u>probability</u> that early intervention with antibiotics could have either at least reduced the progression of the infection or slowed its progression and potentially have averted as much tissue loss as she experienced.**

(Schechter dep. pp. 119:18-121:22, App. p. 0442) (emphasis added); see also Schechter dep. pp. 101:23-102:10, App. 0424). (Sharon Susie did not have toxic shock at the urgent care clinic; she did not meet the SIRS criteria at the urgent care clinic; and she was not septic at the urgent care clinic).

ii. **Group A strep bacteria does not always develop into necrotizing fasciitis:**

Dr. Schechter clarified the fact that Group A strep bacterial infection does not always develop into necrotizing fasciitis:

Q. Group A strep bacteria does not always develop into necrotizing fasciitis in your experience. True?

A. That’s correct. I mentioned earlier that in my wound practice we culture every new patient or new wound that presents, and often I see people who have completely nonaffected -- noninfected-appearing wounds even those that are progressing towards healing, which have Group A strep present and yet they’re not having clinical disease.

(Schechter dep. pp. 121:24-122:7, App. pp. 0444-0445).

iii. **Sharon Susie’s pain at the urgent care clinic may have been from a skin infection known as cellulitis rather than from necrotizing fasciitis:**

Q. You can have pain from infection without having necrotizing fasciitis?

A. That’s correct.

Q. Is that consistent -- is that true?

A. That’s absolutely true.

(Schechter dep. p. 122:8-12, App. p. 0445).

iv. **What does her condition at the ER on September 30 tell us about the extent of her infection at the urgent care clinic on September 29:**

Q. Here’s the question I have for you: You know what her condition was when she went into the emergency room the day after she was at the urgent care clinic. Based upon her condition at that point, do you think that her body would have already been in some degree of inflammatory response to a developing infection when she was at the urgent care clinic?

A. One -- the two things that lead me to that conclusion are, number one that she did exhibit an elevated temperature, if not a frank fever; and number two, in her own testimony and the testimony of others, she was described as feeling

clinically ill and feeling or systemically ill. And I think that -- that -- at least the symptoms of systemic illness and the questionable vital sign of elevated temperature were signs that she more than likely was experiencing some type of inflammatory response but was not frankly in systemic -- she did not meet the criteria for systemic inflammatory response syndrome.

Q. All right. In your opinion, is it possible that when she was at the urgent care clinic on September 29th, that she had a Group A strep infection that had not yet progressed to her deep tissue necrotizing fasciitis?

A. Okay. It's possible.

Q. Are Group A strep bacteria that have not progressed to deep tissue necrotizing fasciitis more amenable to antibiotic therapy? …Is a Group A strep infection more amenable to antibiotics treatment when it has not progressed to necrotizing fasciitis at the deep tissue level than Group A strep bacterial infection that has progressed to the point of deep tissue necrotizing fasciitis …

A. Okay. If -- as I mentioned earlier in my testimony, there had not been destruction of the blood vessels, otherwise known as infarction of the blood vessels, and therefore the antibiotics were able to perfuse or come through in the blood supply, then yes, it is possible that you can forestall or kill the infection.

(Schechter dep. pp. 122:20-125:3, App. pp. 0445-0448).

v. **The cause of the amputation of Sharon Susie's eight (8) toes:**

Q. And Dr. Crew, I think, opined she had atherosclerotic disease and attributed the loss of her toes in part to that problem. Did you know that?

A. I understand that. I would have a hard time speculating on that.

Q. That's fine.

A. More than -- more often than not, people who lose their toes were septic-habit because of the vasopressor drugs utilized to maintain their kidney pulse, blood pressure, etc. Partly it might be from the toxins but it also could well be from the drugs that were used to save someone's life.

(Schechter dep. p. 126:13-24, App. p. 0449).

vi. **The effectiveness of antibiotic treatment for suspected soft tissue infection:**

Q. No, I'm talking about empiric administration of antibiotics because you think there might be an infection in a patient but you don't know for sure. So you don't know what antibiotics are to be given for sure in a setting of an urgent care like we had on the 29th. Right?

A. But the standard of care on empiric therapy for somebody who has a **suspected soft tissue infection**, if that diagnosis had been made and entertained, it is something that would act on gram positive organisms. That's the very first line.

Q. Well, some are better than others; right?

A. Yeah but you're – you're looking at an organism that's actually **uniquely sensitive** to most drugs for gram positive organisms.

(Schechter dep. p. 128:2-16, App. p. 0451) (emphasis added).

vii. **The effectiveness of antibiotics when an infection has progressed to necrotizing fasciitis:**

Q. Dr. Crew told us something like surgery is key because antibiotics cannot reach into this infected and damaged tissue. Fair?

A. Fair. **I think it depends on the degree of damage that has been done**. It's at what point do they cease to be effective? After the coagulation of the local blood vessels occur, then there's no way a systemic antibiotic can get there.

If there has not yet been a complete loss of the local small vessel blood supply – and that would be early on in the course of development of infection -- antibiotics may be of some use.

And they also are still part of the treatment protocol because on the margins of the necrotic tissue is a penumbra of tissue that may still have profusion but still have bacteria present, and therefore, antibiotics are still utilized. It's not – it's not as though you don't use antibiotics. You have to use antibiotics along with surgery.

(Schechter dep. pp. 90:15-91:8, App. pp. 0413-0414) (emphasis added).

viii. **The importance of early administration of antibiotics with regard to a soft tissue infection:**

Q. Isn't the bottom line, you don't know what would have happened to Sharon Susie had she had CBC testing, had she returned to the clinic in twenty hours or less than twenty-four hours, had a comprehensive physical exam been documented?

You don't know that the outcome would not have been exactly the same. True?

A. I don't know, but the faster you get to care when you're sick the better off you are.

Q. Not necessarily true. Is it?

A. Almost always.

Q. Well, she had a firestorm brewing when she walked into the urgent care clinic, as Dr. Crew said, Dr. Crew telling us that she has the beginnings of necrotizing soft tissue disease then and there, do you think -- do you really think Sarah Harty can stop that?

A. I think Sarah Harty could have gotten through instructing this patient who was clearly ill throughout the night -- if she had been instructed that she should have all these untoward symptoms of any kind -- and it's -- it's generic. It's not specific to necrotizing fasciitis. It's generic to physical deterioration and infection regardless.

If she were given the appropriate instructions and her husband had the instructions, she -- which would state in this situation "Go to the ER," she would have gotten to the ER sooner. And it's speculative but clearly time is of the essence when you're getting progressively more ill.

There's a reason why we have a standard and emergency medicine for starting intravenous antibiotics within sixty minutes, for example, in someone who has pneumonia. **The sooner you initiate supportive care and the appropriate care, the lesser the potential for deterioration, especially in a situation such as infection.**

(Schechter dep. pp. 100:13-101:22, App. pp. 0423-0424) (emphasis added).

ix. **The effectiveness of the antibiotics is in large part dependent on how much tissue damage had occurred at the time of initiation:**

Q. You agree that if I give you antibiotics this minute, particularly in a Group A strep necrotizing soft tissue scenario, it's going to take a while for the antibiotics to do the desired job?

A. And again, this is speculative because while is not only a matter of opinion but **it's also a matter of how much tissue damage had occurred.**

(Schechter dep. p. 104:4-10, App. p. 0427) (emphasis added).

x. **The source of the infection according to Dr. Schechter:**

Q. Are you rendering an opinion in this case of where the bacteria came from?

A. Bacteria came from some type of break in the skin. That's my opinion…It's usually associated with either minor tissue trauma or even more major tissue trauma. And it's positive that it comes in through a break in the skin, whether it be a large break in the skin or something that can't even be seen by the human eye. But it doesn't take much to breach the integument and allow the penetration of bacteria…if you're unlucky enough to have a bad bacteria. And also more than likely, there's some underlying physiologic reason that some people get it and some people don't with the same bacteria.

(Schechter dep. pp. 107:3-108:1, App. pp. 0430-0431).

However, Dr. Schechter was not standing alone on the causation issue. In fact, the record before the trial court on the causation issue even without Dr. Schechter's deposition testimony, in and of itself generated a submissible jury issue on causation. That record included the following critical points on the causation issue from both defendants' retained infectious disease expert and from treating physicians of Sharon Susie:

B. Dr. Daniel Lamptey, treating infectious disease specialist:

Dr. Lamptey, the treating infectious disease specialist likewise shed important light on the progression of the infection from the time Sharon Susie was in the urgent care clinic on September 29, 2012 until such time as she presented to the emergency room at Mercy Hospital the next day, September 30, 2012. Defendant PA Sarah Harty had a very limited description of the appearance of Sharon Susie's right forearm at the time of the presentation at the urgent care clinic. (Exhibit 1, App. pp. 0456-0458). She described the arm as "showing ecchymosis/edema over the posterior aspect of the elbow and proximal forearm that was tender to palpation." (Exhibit 1, App. p. 0457). However, Dr. Lamptey indicates that when she presented at Mercy Hospital the next day, Sharon Susie's right arm "was swollen moderately, mildly to moderately, and the swelling involved whole in the upper right extremity – from the shoulder all the way to the wrist." (Lamptey dep. p. 25:17-20, App. p. 0221). In addition, there were fluid filled blisters draining serous fluid and her skin was actually peeling off mostly on the medial portion of the right forearm (Lamptey dep. pp. 26:17-27:1, App. p. 0221). In addition, Sharon Susie had developed redness on the whole vaginal area and that area also seemed to be peeling off a little bit, an indication of an infection that had now become systemic or bloodborne (Lamptey dep. p. 27:3-11, App. p. 0221). Sarah Harty did no lab work on

Sharon Susie at the urgent care clinic but by the time she got to the emergency room on September 30, Sharon Susie's lab work demonstrated that there were two (2) enzymes which were extremely elevated denoting destruction of muscle tissue – creatinine kinase and myoglobin (Lamptey dep. p. 28:10-20, App. p. 0221). According to both Drs. Lamptey and Bacon, it was pretty clear that the source of the bloodborne-systemic infection which existed when Sharon Susie presented to the emergency room at Mercy Hospital on September 30 was her right upper extremity (Lamptey dep. p. 31:8-16, App. p. 0222; Bacon dep. p. 29:13-16, App. p. 0319).

Sarah Harty observed enough to place an infection on her differential diagnosis on September 29, 2012 (Harty dep. p. 34:10-15, App. p. 0209). However, when Dr. Lamptey, the infectious disease treating physician saw her on October 1, 2012, he was immediately concerned about the possibility of necrotizing fasciitis – an infection of the deep tissue in her arm (Lamptey dep. pp. 31:23-32:1, App. p. 0222). When Dr. Lamptey saw her on October 1, her kidneys had shut down due to rhabdomyolysis – that is the breakdown of muscle tissue which then clogs the kidneys and causes them to shut down (Lamptey dep. pp. 32:2-33:13, App. pp. 0222-0223). Sarah Harty never diagnosed any such condition in the urgent care clinic back on September

29, 2012, another strong indication of the significant progression of this infectious disease process after Sharon Susie left the urgent care clinic.

Dr. Lamptey described the difference between cellulitis, which he defined as an infection of the skin and subcutaneous tissue under the skin, and necrotizing fasciitis. When Dr. Lamptey saw Sharon Susie on October 1, what he saw was necrotizing fasciitis, not cellulitis (Lamptey dep. pp. 35:20-36:10, App. p. 0223). Again, Sarah Harty observed a condition consistent with an infection of the surface tissue of Sharon Susie on September 29, a fact that prompted her to include infection on her differential diagnosis; however, she never made mention of necrotizing fasciitis and/or a concern about progression of infection to the deep tissue of Sharon Susie's right arm. Cellulitis can develop into necrotizing fasciitis (Lamptey dep. p. 36:19-21, App. p. 0223). Necrotizing fasciitis can start as a surface infection of the skin and move downward (Lamptey dep. p. 37:1-3, App. p. 0224). Dr. Lamptey acknowledged that Group A Strep is an organism that is highly susceptible to penicillin and when he uses the words "highly susceptible" he means that the group of antibiotics are very effective at killing Group A Strep bacteria (Lamptey dep. pp. 39:13-40:6, App. p. 0224). When you couple that testimony with the fact that Sarah Harty saw fit to not even prescribe antibiotics in the aftermath of the September 29,

2012 urgent care visit, significant support is generated to Plaintiffs' causation argument that the early administration of antibiotics would have had a significant effect in slowing or stopping the progression of this infection into Sharon Susie's deep tissue of her right arm. Dr. Lamptey testified that if you prescribe those types of penicillin early to Group A Strep cellulitis, he routinely has excellent outcomes (Lamptey dep. p. 40:3-6, App. p. 0224).

It is Dr. Lamptey's opinion that the source of the bloodstream infection was "felt to be from severe skin and soft tissue involving the right upper extremity" (Lamptey dep. pp. 41:21-42:5, App. p. 0225). In describing the progression of Sharon Susie's skin and soft tissue infection, Dr. Lamptey shared that the inflammatory response to the bacteria had progressed by the point he saw her through the subcutaneous layer of tissue, the fatty layer of tissue, the fascia, and into the muscle itself (Lamptey dep. pp. 43:25-44:14, App. p. 0225). Of course, Sarah Harty never documented any concerns about progression of infection into the deep tissue layers of Sharon Susie's right arm when she saw her on September 29. Dr. Lamptey also emphasized that intravenous antibiotics can more quickly impact a bacterial infection because it delivers the antibiotic into the bloodstream itself rather than into the stomach as when a person takes an antibiotic pill

orally (Lamptey dep. pp. 48:18-49:8, App. pp. 0226-0227). Obviously, Sarah Harty has to testify that she ruled out an infection on September 29 because had that infection progressed to the deep tissue layers of Sharon Susie's right arm as of that date, it would have been egregious care to let her walk out of that urgent care clinic without any antibiotics. By the time she presented to the emergency room, according to Dr. Lamptey, she was at risk of dying from the sepsis (Lamptey dep. p. 49:15-17, App. p. 0227).

According to the words of Dr. Lamptey:

> "So ordinarily cellulitis can make patients ill, but it doesn't typically make them this ill. When I saw her, she looked ill, ill and toxic is what I put in my physical examination. Her blood pressure was low. In fact, her systolic blood pressure was running between eighty (80) and ninety (90) systolic. The normal is one twenty (120). In my physical examination, I saw she had these – the swelling, the redness, the pain, the blistering lesions that I described, the purpuric lesions. It all fits the story of necrotizing fasciitis and that's why I made that diagnosis."

(Lamptey dep. p. 64:6-16, App. p. 0230). Dr. Lamptey emphasized that cellulitis in and of itself is not necrotizing fasciitis – according to Dr. Lamptey:

> "Cellulitis is basically inflammation and infection of the skin and subcutaneous tissue. Necrotizing fasciitis is a foramen destruction of the skin, subcutaneous tissue, fascia, fat and sometimes the muscle. So there's a clear – so I mean sometimes

> it's difficult to try to explain it. Necrotizing fasciitis is a much severe form of cellulitis during which there's a destruction of tissue."

(Lamptey dep. pp. 64:22-65:5, App. pp. 0230-0231). According to Dr. Lamptey, you can have a cellulitis that's been rampant and left untreated, for, say weeks; and that individual may not have necrotizing fasciitis. Dr. Lamptey went on to emphasize that there is not a natural progression from cellulitis to necrotizing fasciitis. In Dr. Lamptey's words:

> "Well [necrotizing fasciitis] starts out like cellulitis, you know, the skin becomes swollen. It becomes red. It becomes warm. And then the fascia, and then the subcutaneous tissue and then the muscles get involved and so the skin goes through various progression. I mean it goes from red, it becomes darker red, it becomes – it then becomes black. Some people form – some patients form blisters, which are filled with serous fluid, and later the fluid becomes hemorrhagic. So there's kind of a natural progression of the way the infection behaves. It starts ordinarily like cellulitis and then gets worse and worse and worse and worse."

(Lamptey dep. pp. 67:17-68:4, App. pp. 0231).

Dr. Lamptey emphasized that you can have a cellulitis from Group A Strep bacteria and oftentimes those conditions are very treatable with multiple different antibiotics which keep it from progressing to something more serious (Lamptey dep. pp. 69:21-70:6, App. p. 0232). According to Dr. Lamptey, **if you begin antibiotics for what appears to be a cellulitis,**

<u>you would expect a complete recovery for that patient</u> (Lamptey dep. p. 70:7-12, App. p. 0232). "The sooner you can see a patient with an infectious condition and start the antibiotics, the better the likelihood you can have some impact on the progression of this disease into something more serious" (Lamptey dep. pp. 70:24-71:5, App. p. 0232). Because the punch biopsy done in the hospital of the tissue of Sharon Susie's right forearm indicated that the deep tissue layers, there is not yet any inflammatory response, Dr. Lamptey agreed that that would suggest that the migration of the bacteria to the deeper tissues, at that point in time, was still in the early stage of progression of necrotizing fasciitis (Lamptey dep. pp. 73:25-74:6, App. p. 0233). Of course, the lack of inflammatory response in the deeper tissue at the time of the punch biopsy on September 30th would lend further support for the premise that administration of antibiotics at the time of Sharon's urgent care visit on September 29th would more likely than not have stopped the progression of this Group A bacteria, negating the need for the amputation of her arm. Dr. Lamptey agreed that if he's lucky enough to see a patient with a cellulitis infection, and he was able to effectively commence antibiotics, he may well stop it from progressing to the more severe form of infection if the bacteria is not yet producing toxins (Lamptey dep. p. 76:13-21, App. p. 0233). Of course, because Sarah Harty saw fit not to do any lab

work, there is no clear evidence of whether toxins were already being produced at the time she saw Sharon Susie on September 29; however, what we do know is that from Sarah Harty's observations, she did not even think her presentation warranted a diagnosis of a skin infection or cellulitis, and in the absence clinical factors which would have compelled such a medical diagnosis, there would be no production of toxins to the deeper layers of tissue in the patient's arm.

Importantly, Dr. Lamptey testified that there are millions of Group A Strep skin or cellulitis infections diagnosed annually in this country. Because only a very small percentage of those cellulitis infections develop into deep tissue infections, Dr. Lamptey testified that if he was fortunate enough to be called in to look at the cellulitis at the early stages and if he commenced appropriate antibiotics, **he would fully expect that person to recover from the Group A Strep cellulitis infection** (Lamptey dep. p. 80:2-10, App. p. 0234).

C. Dr. William Rizk, treating general surgeon:

Dr. Rizk, Sharon Susie's treating general surgeon who was involved in the amputation of her right arm, agreed under oath that time equals tissue, meaning the longer an infection is allowed to progress, the more tissue you're going to have to remove to save the patient's life in dealing with a

necrotizing fasciitis (Rizk dep. pp. 50:20-51:4, App. pp. 0300-0301). According to Dr. Rizk, Group A Strep is very susceptible to a wide number of antibiotics. If you get the antibiotics on board early, they usually work, according to Dr. Rizk (Rizk dep. p. 53:8-11, App. p. 0303). Dr. Rizk described how these cellulitis infections can progress to a deep tissue infection:

> "Typically these start as some sort of a little nick or scrape that always starts as a very innocuous appearing small thing that, for most people, wouldn't cause any problems. And whether these patients are immunocompromised or for whatever the reason, there becomes this cascade of events that cause this massive infection in a small percentage of people. I think most of the time it starts as a small superficial – that's how the bacteria gain entrance to the skin is through a small break in the skin, however, trauma, pimple, whatever."

(Rizk dep. pp. 53:24-54:13, App. pp. 0303-0304).

Dr. Rizk acknowledged that the Group A bacteria cultured in Sharon Susie was demonstrated to be sensitive to ten (10) or eleven (11) different antibiotics. According to Dr. Rizk, Group A Strep bacterial infections are very treatable if you get it early in most cases (Rizk dep. p. 58:22-24, App. p. 0308).

D. Dr. Ravi Vemuri, Defendants' infectious disease specialist:

Plaintiff deposed Dr. Ravi Vemuri, Defendants' retained infectious disease specialist. His deposition would have been read to the jury but for the trial court ruling on causation. His sworn deposition testimony adds yet further support to Plaintiffs' causation theory.

According to Dr. Vemuri, cellulitis "is the bread and butter" of Dr. Vemuri's infectious disease practice (Vemuri dep. p. 12:18-25, App. p. 0239). In his words: "It is very common. It is the thing that we day in and day out." (Id.). Importantly, Dr. Vemuri routinely diagnoses cellulitis without blood work (Vemuri dep. p. 13:1-3, App. p. 0240). He routinely diagnoses a cellulitis condition from his visual observation and from palpation of the area (Id.). Cellulitis is a form of infection and when he diagnoses cellulitis in his patients, he routinely treats it with antibiotics (Vemuri dep. p. 13:12-15, App. p. 0240). Dr. Vemuri stated that when a physician is evaluating the skin and soft tissue situation from trauma, infection is always on his differential (Vemuri dep. p. 17:10-16, App. p. 0241). Using Exhibit 4, a medical illustration showing the layers of tissue, he testified: "The skin typically will have about eight (8) or nine (9) layers of cells and then below that will be a layer of tissue called the deep fascia and then below that are the muscles. So cellulitis would involve all those structures of skin above the deep fascia" (Vemuri dep. p. 11:10-15, App. p.

0239). Dr. Vemuri testified that there are three (3) classic features of a cellulitis infection: "redness, warmth and tenderness." (Vemuri dep. p. 12:11-15, App. p. 0239). Sarah Harty did not document the existence of those three (3) classic features, according to Dr. Vemuri (Vemuri dep. p. 20:9-21, App. p. 0241). Dr. Vemuri would have included such documentation in his written record had he been the examiner (Vemuri dep. pp. 20:22-21:11, App. p. 0241; p. 42:20-24, App. p. 0247). According to Dr. Vemuri, cellulitis can progress downward into the deeper tissue and develop into necrotizing fasciitis (Vemuri dep. p. 21:15-18, App. p. 0242). It's easier to diagnose an infection that starts at the surface layers of the patient's skin and is moving downward (Vemuri dep. p. 22:3-7, App. p. 0242). Dr. Vemuri agrees that the earlier an infection is diagnosed and the earlier an appropriate antibiotic is prescribed, the better the likely outcome for the patient (Vemuri dep. p. 37:8-13, App. p. 0246).

ARGUMENT

BRIEF POINT I

THE TRIAL COURT ERRED IN GRANTING DEFENDANTS' UNTIMELY MOTION FOR SUMMARY JUDGMENT ON THE ISSUE OF CAUSATION WHEN THE RULE 1.508 EXPERT WITNESS SUMMARY OF DR. SCHECHTER, COUPLED WITH HIS PRE-TRIAL DEPOSITION TESTIMONY AND THE ENTIRE PRE-TRIAL RECORD, DEMONSTRATED THAT MORE LIKELY THAN NOT, THE SEVERE AMPUTATION CONSEQUENCES OF AN UNDIAGNOSED AND UNTREATED DEEP TISSUE INFECTION WOULD HAVE BEEN AVOIDED OR MINIMIZED.

Preservation of Error

Plaintiff preserved error on this issue by filing an extensive resistance to Defendants' motion for summary judgment on or about May 6, 2017. (App. pp. 0106-0108). In that resistance, both factual and legal support for the issues raised in Brief Point I are specifically addressed.

Standard of Review

With regard to Brief Point I, the standard of review is a de novo review for correction of errors of law. See Iowa Rule of Appellate Procedure 6.907; *Smith v. Iowa State University*, 851 N.W.2d 1, 18 (Iowa 2014). The role of the appellate court in this case is to decide whether there was sufficient evidence to overrule the defendants' motion for summary judgment and justify submitting Sharon Susie's case to the jury when viewing the evidence in a light most favorable to the non-moving party.

Sickle Construction Co. v. Wachovia Commercial Mortgage Inc., 783 N.W.2d 684, 687 (Iowa 2010). To justify submitting the case to the jury, substantial evidence must support each element of the plaintiff's claim. *Id.* Evidence is deemed to be substantial if "reasonable minds would accept the evidence as adequate to reach the same findings." *Doe v. Central Iowa Health System*, 766 N.W.2d 787, 790 (Iowa 2009).

Having said that, however, with regard to Brief Point IA, the standard of review is for abuse of discretion. See *Provezano v. Wetrich, McKeown, and Haas, P.C.*, 481 N.W.2d 536, 539-540 (Iowa 1991). In order to show an abuse of discretion, one generally must show that the court exercised its discretion "on grounds or for reasons clearly untenable or to an extent clearly unreasonable." See *State v. Blackwell*, 238 N.W.2d 131, 138 (Iowa 1976) quoting *State v. Burnor*, 132 Vt. 603, 326 A.2d 138, 140 (1974).

INTRODUCTION

As was discussed above, Sharon Susie was prepared to have her day in court on two (2) separate occasions. Defendants' argument with regard to Plaintiffs' causation case was raised in a late filed motion in limine just prior to the start of the first scheduled trial, a trial which ended up being continued by reason of Defendants' complaints about two (2) witnesses listed on Plaintiffs' witness list. The trial court overruled that motion in limine which

attacked the sufficiency of Plaintiffs' causation case in this tragic amputation injury. The case was then reset for trial some fourteen months later in order to accommodate the schedules of defense counsel. While Sharon Susie would acknowledge that by reason of the death of one of her experts and the need for a substitution of expert witnesses, the deposition of Dr. Roger Schechter was not taken until a point in time approximately two (2) weeks prior to trial. However, Dr. Schechter's Rule 1.508 written summary of his opinions was provided well in advance of his deposition on April 11, 2017 (App. pp. 0082-0088). It is important to note that Defendants filed yet another motion for continuance on April 17, 2017 (App. pp. 0090-0093) which was denied by the trial court on April 27, 2017 (App. pp. 0102-0104).

The Defendants' motion for summary judgment attacking Plaintiffs' causation case was not filed until May 4, 2017 (Defendants' Motion for Summary Judgment, App. pp. 0106-0109). The trial was scheduled to start on May 9, 2017 (Order, App. pp. 0102-0104). Because the Iowa Rules of Civil Procedure provide fifteen (15) days for the non-moving party to resist a motion for summary judgment, Plaintiffs did not even have the amount of time allotted in the rules to resist Defendants' motion. (See Iowa Rule of Civil Procedure 1.981(3)). Thus, during the period of time that is generally devoted to an intense trial preparation, Plaintiffs' counsel was busy resisting

a motion for summary judgment which was filed some fifty-five (55) days late under Iowa Rules of Civil Procedure 1.981(3).[2] Importantly, Iowa Rules of Civil Procedure 1.981(3) provides that the: "Judgment sought shall be rendered forthwith if the pleadings, **depositions**, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." (emphasis added)

The first problem with the trial court's granting of Defendants' motion for summary judgment in this case focuses on the untimely filing of the motion. That component of the court's error will be addressed in Brief Point IA. The second problem with the court's granting of Defendants' motion for summary judgment is the fact that the trial court appears to have focused exclusively on the sworn deposition of Plaintiffs' expert, Dr. Roger Schechter, without studying compelling testimony from other health care witnesses on causation. Dr. Schechter's sworn Rule 1.508 written summary in and of itself was sufficient basis to overrule the motion, notwithstanding Dr. Schechter's sworn deposition testimony. However, there was an abundance of additional medical testimony in the record before the trial

[2] Iowa Rules of Civil Procedure 1.981(3) provides that a motion for summary judgment shall be filed not less than sixty (60) days prior to the date the case is set for trial, unless otherwise ordered by the court. It further provides that any party resisting the motion shall file a resistance within fifteen (15) days, unless otherwise ordered by the court, from the time when a copy of the motion has been served.

court that further reinforces the conclusion that the granting of the motion for summary judgment was an error at law. That aspect of the court's error is addressed in Brief Point IB.

A. The trial court abused its discretion in even considering the untimely motion for summary judgment when the issues raised therein should have more appropriately been the subject of a motion for directed verdict at that stage of the litigation.

As was emphasized above, Defendants' motion for summary judgment was not filed until five (5) days before the start of the trial in this matter. As such, it was fifty-five (55) days late under the expressed wording of Iowa Rules of Civil Procedure 1.981(3). The trial court had been down this very road just prior to the start of the first scheduled jury trial in this case when Defendants filed a late motion in limine on causation grounds. The trial court overruled that motion and told defense counsel that if at the close of Plaintiffs' case, there were deficiencies in Plaintiffs' causation case, a motion for directed verdict was the vehicle to raise that deficiency.

Certainly the trial court had discretion to allow a motion for summary judgment to be filed closer in time to the start of this trial than the sixty (60) day deadline set forth in Rule 1.981(3). In fact, the rule itself provides that "the motion for summary judgment must be filed not less than sixty (60) days prior to the date the case is set for trial, **unless otherwise ordered by the court**."

Dr. Schechter was provided with the necessary information and formulated his review and generated a summary of his opinions by April 11, 2017. (Schechter Rule 1.508 expert summary, App. pp. 0082-0088). When Dr. Schechter's Rule 1.508 summary specifically provides that he will testify on the issue of causation, the question simply becomes whether it was an abuse of discretion for the trial court to even consider a motion for summary judgment which was not filed until five (5) days before the start of trial.

In order to show an abuse of discretion, Sharon Susie must show that the court exercised its discretion "on grounds for reasons clearly untenable or to an extent clearly unreasonable." *Provezano v. Wetrich,* 481 N.W.2d 540. The decision to entertain the motion for summary judgment was a clear abuse of discretion by the trial court for the following reasons:

1. The trial court had previously been put in this same position with Defendants' late filed motion in limine prior to the scheduled start of the first trial and correctly overruled that motion, stating that the causation issue was an issue that was better brought to the attention of the court by way of a motion for directed verdict at the close of Plaintiffs' case.

2. By the express reading of Iowa Rules of Civil Procedure 1.981(3), the court seemed to base the appropriateness of the late filed motion for summary judgment on the timing of Dr. Schechter's deposition (April 25, 2017). That reasoning is flawed because the very language of Rule 1.981(3) compels the court

to review **all** pleadings, **depositions**, answers to interrogatories and admissions on file, together with affidavits, if any, before determining whether there are genuine issues of material fact which would justify submission of the case to the jury. Dr. Schechter's Rule 1.508 sworn summary of his opinions in and of itself would call into question the validity of even filing the motion for summary judgment; however, when reviewing the other medical depositions taken in the case, there is an abundance of testimony justifying submission of the causation case to the jury.

3. The timing of the motion forced Sharon Susie's counsel to pull off of intense trial preparation and work the entire weekend preparing a resistance to that motion. Such a compact resistance schedule was both untenable and unreasonable.

4. The trial court's willingness to entertain such a late motion makes no sense unless the court gives undue emphasis on the sworn deposition of expert Dr. Roger Schechter. A reading of the trial court's comments at the time of the hearing on Monday morning, May 8, 2017, the day prior to trial, shed some insight on the court's thinking:

> "I don't care what's in his 1.508 because when you're asked under oath in a deposition are these your final opinions, he's stuck with those. And he didn't give more likely than not in his deposition."

(Transcript from May 8, 2017 hearing p. 4, App. p. 0152).

Thus, a careful reading of Dr. Schechter's deposition clearly demonstrates that he was never asked the question of whether his testimony that day constitutes his entire and final opinions in the case. All Dr. Schechter did on April 25, 2017 was respond candidly to the specific questions posed to him by defense counsel. In all due respect to the trial court, Rule 1.981(3) compels him to consider not only the deposition of Dr. Schechter but his Rule 1.508 sworn interrogatory answers setting forth his opinions. Dr. Schechter was never asked how it was that he had formulated a causation opinion given the fact that it would be speculation to opine how Sharon Susie herself would have responded to certain types of antibiotics because they were not given. However, consistent with the testimony of Dr. Daniel Lamptey, Dr. Vemuri, and Dr. Rizk as set forth earlier in this brief, statistically, given the extreme sensitivity of Group A strep bacteria to a multitude of antibiotics and given the low percentage of Group A strep cellulitis infections which progressed to deep tissue infections, there is a sound objective basis for opining that had Sharon Susie been given antibiotics in response to her urgent care visit on September 29, this Group A strep bacterial cellulitis infection would have been successfully stopped in its tracks and she would not have needed an amputation of her arm or toes. It is disingenuous under this record for the Defendants to argue that there was

not enough clinical evidence to diagnose an infection on September 29th out of one side of their mouths but then to argue that the undiagnosed infection had progressed to such an extent that all treatment would have been worthless. Yet, the trial court's ruling in effect allowed the defendants to take such a position.

It was fundamentally unfair for the trial court to even consider a summary judgment motion in a case as complex as this case with such a vast medical record prior to trial. It was fundamentally unfair for the trial court to focus his attention exclusively on the sworn deposition testimony of Dr. Schechter to the exclusion of his Rule 1.508 sworn written summary. It was fundamentally unfair for the trial court to ignore strong medical testimony from other witnesses, two (2) of which were infectious disease specialists. Plaintiffs should have been allowed to present their entire case to the jury. To entertain and rule on a late filed motion for summary judgment five (5) days before the start of the trial in the face of this pervasive record on causation constitutes an abuse of discretion.

B. The trial court inappropriately focused primarily on the pretrial sworn deposition testimony of Dr. Roger Schechter rather than the entire record presented to the court in resistance to Defendants' motion for summary judgment.

The trial court seems to ignore strong causation testimony from other medical experts in this case. The landmark case of *Speed v. State* makes clear that the testimony of a properly trained physician regarding what he would have done under facts similar to those presented in the case at issue is admissible as relevant on the question of negligence. *Speed v. State,* 240 N.W.2d 901 (Iowa 1976). In *Speed,* plaintiff brought an action for medical negligence contending that doctors at the University of Iowa Hospitals and Clinics negligently cared for him, resulting in blindness. On appeal, the Iowa Supreme Court ruled that the evidence supported the trial court's conclusion that the defendant doctor was negligent. The Supreme Court first examined the testimony of plaintiff's expert witnesses. Next, the Supreme Court stated that the trial court's conclusion that the defendant doctor was negligent was supported by testimony from the <u>**defense**</u> experts in response to questions regarding what they would have done if confronted with a similar situation. The Court stated:

> In addition, several of the witnesses called by the State gave testimony from which the trial court could infer negligence on the part of [the defendant doctor] in taking no further action after considering brain abscess aid septicemia. Dr. Robert Hardin, Vice President for Health Affairs at the University of Iowa, testified that if he had an impression of septicemia, he would do an immediate blood culture, and if he had an impression of brain abscess, he would arrange

> for a brain scan. Dr. Adolph Sahs, a witness for the State and Head of the Department of Neurology at University Hospitals, testified that if he had an impression of brain abscess, he would do a spinal tap and a brain scan `as quickly as possible.'

Id. at 905. All of the foregoing testimony by defendant's own witnesses was admissible as to the negligence of the defendant. *Id.*

This Court has therefore previously opened the door for consideration of all of the testimony which is summarized above and which is part of the record that would have been heard by the jury. Plaintiffs' have videotaped all of the treating physicians who have shared their expertise and knowledge on pertinent medical issues in this case and will offer that testimony in their case in chief. Further, Dr. Vemuri's deposition will be read to the jury in its entirety pursuant to IRCP 1.704(4). Dr. Vemuri is the defendants' retained infectious disease expert. Whether the record supports the argument that a submissible case on causation has been generated does not come from a single witness. **It comes from the entire record presented to the jury and Plaintiffs' counsel has prepared this case knowing that fact.**

In addition, it is further emphasized that most courts will not defeat the probative value of an expert's opinion based on semantics alone. *Hansen v. Cent. Iowa Hosp. Corp.,*686 N.W. 2d 476, 485 (Iowa 2004). In *Hansen,*

the court stated that "[b]uzzwords like 'reasonable degree of medical certainty' are therefore not necessary to generate a jury question on causation." *Id.* (expert testimony indicating probability or likelihood of causal connection sufficient to generate question on causation).

As highlighted by *Hansen,* the Iowa Supreme Court has long followed a liberal rule with respect to the admission of expert testimony in medical malpractice cases, having expressly held that "magic phrases" and semantics alone will not defeat an expert's opinion. Prior to *Hansen,* the Iowa Supreme Court held that a qualified expert should be allowed to state his opinion, either as to probable or even merely possible causation. The court held that the use of terms like "I believe" or "I think" or "it appears to me" are permissible, if it is apparent that such language is meant to express a witness's professional opinion. Specifically, the court stated:

> We cannot agree that this evidence was inadmissible. Almost all courts have held the opinion of expert need not be couched in definitive, positive or unequivocal language. The use of the terms like "I believe;" or "I think;" or "it appears to me" have all been held permissible if it is apparent such language is meant to express the witness's professional opinion.

Id. at 593. That liberal rule on admissibility further supports the premise that under the objective, statistically based prong of a medical causation analysis, supported in this case by the CDC publication addressing Group A

Strep infections, the causation issue must be submitted to the jury for determination, especially given the new causation standards as adopted by the Iowa Supreme Court in ***Thompson v. Kaczinski***, 774 N.W.2d 829 (Iowa 2009).

After *Thompson v. Kaczinski*, the jury in this case was deprived of considering all of the testimony on causation. Certainly, it is undisputed that the record contains sufficient cause in fact testimony (See complete deposition testimony of Dr. Lamptey, Dr. Vemuri, Dr. Rizk and Dr. Schechter, App. pp. 0215-0235, 0237-0249, 0251-0310, 0324-0454). Further, this jury could have reasonably concluded, viewing all of the evidence in a light most favorable to Sharon Susie, that Sharon presented to the Urgent Care Clinic on September 29th with a skin infection known as cellulitis; that the bacterial cause of that skin infection was Group A bacteria; that Group A bacteria is exquisitely sensitive to early administration of antibiotics and standard of care requires the administration of those drugs as early as possible; that the strain of Group A strep bacteria responsible for Sharon Susie's cellulitis or skin infection was sensitive to eleven different types of antibiotics; that when she presented to the Urgent Care Clinic on September 29th, her infection had not become blood borne—she was not septic; likewise, she was not in kidney failure or septic shock;

that based upon the punch biopsy done at the hospital, there still was minimal inflammatory response at the **deep tissue layers** at the time she arrived at the hospital and so the infection had more likely than not spread to the deep tissues a day earlier at the Urgent Care Clinic; that the infection likely began as a skin infection or cellulitis and began progressing downward to the deeper tissue; that once it began spreading downward it began generating toxins which had the effect of speeding up the progression; and that had the diagnosis been timely made on September 29th and antibiotics commenced on that date, a full recovery was likely because the treatment would have predated the release of the toxins which make treatment of deep tissue infections problematic because the release of those toxins would have impaired the ability to deliver antibiotics to the deep tissue. A careful reading of the depositions of not just Dr. Schechter, but also Drs. Lamptey, Vemuri, Rizk and Bacon would reasonably have allowed the jury to so conclude. Certainly, under this record, the jury could have found that the failure to diagnose the cellulitis and treat it with antibiotics was not only a cause in fact of Sharon Susie's catastrophic outcome but also find that this outcome is clearly within the scope of liability of the defendants herein. The jury should have been given that opportunity. The

trial court's ruling constitutes reversible error and Sharon Susie respectfully urges this Court to make it right and give Sharon her day in court.

BRIEF POINT II

THE TRIAL COURT ERRED IN GRANTING DEFENDANTS' UNTIMELY MOTION FOR SUMMARY JUDGMENT ON PLAINTIFFS' LOSS OF A CHANCE CAUSATION ARGUMENT WHEN PLAINTIFFS' RULE 1.508 EXPERT WITNESS SUMMARY OF DR. SCHECHTER AND HIS SWORN PRETRIAL DEPOSITION TESTIMONY FACTUALLY SUPPORTED THE SUBMISSION OF SUCH A THEORY OF CAUSATION TO THE JURY.

Preservation of error

Plaintiff preserved error on this issue by filing an extensive resistance to Defendants' motion for summary judgment on or about May 6, 2017. (App. pp. 0111-0147). In that resistance, both factual and legal support for the issues raised in Brief Point I are specifically addressed.

Standard of review

With regard to Brief Point I, the standard of review is a de novo review for correction of errors of law. See Iowa Rule of Appellate Procedure 6.907; *Smith v. Iowa State University*, 851 N.W.2d 1, 18 (Iowa 2014). The role of the appellate court in this case "is to decide whether there was sufficient evidence to overrule the defendants' motion for summary

judgment and justify submitting Sharon Susie's case to the jury in viewing the evidence in a light most favorable to the non-moving party." *Sickle Construction Co. v. Wachovia Commercial Mortgage Inc.*, 783 N.W.2d 684, 687 (Iowa 2010). To justify submitting the case to the jury, substantial evidence must support each element of the plaintiff's claim. *Id.* Evidence is deemed to be substantial if "reasonable minds would accept the evidence as adequate to reach the same findings." *Doe v. Central Iowa Health System*, 766 N.W.2d 787, 790 (Iowa 2009).

Medical negligence cases often present unique challenges on the issue of causation because of what the defendant health care provider failed to do. Stated another way, the negligent professional omissions often create a void in the available information contained in the plaintiff patient's chart which would allow causation opinions to be voiced with absolute certainty. The very omissions complained of often make it difficult for experts to find sufficient factual basis in the patient's chart to conclusively predict what the impact would have been to the patient's health care been consistent with accepted standards of medical care and practice. This case presents a clear example of that challenge. Sarah Harty's record keeping does not allow Plaintiff's experts to conclusively know how far along this infection was on September 29, 2012. She failed to diagnose an infection despite the fact that

it was on her differential diagnosis list. And, she did no lab work which likely would have generated information compelling the diagnosis and shedding light on the extent of progression to the deep tissues of Sharon's body. It will be undisputed from knowledgeable health care providers, both treating physicians and retained expert physicians that this infection began days before Sharon presented to the Urgent Care Clinic. (Vemuri dep. p. 26:17:25, App. 0243; Schechter dep. p. 103:12-19, App. 0426). Further, from the description of the arm and the pathological evaluation of tissue harvested through biopsy or surgery at Mercy Medical Center on October 1 and 2 of 2012, it is clear that the infection began at the skin level of that arm. No one is able to know whether the cellulitis infection had become necrotizing as of September 29th or the extent it had already begun to spread to the deeper tissue of that right arm as of that date. **There is simply inadequate documentation from Defendant Harty for any of the experts to make that call. However, through lay witnesses, including Sharon herself, who saw the arm before and on September 29th, what is clear is that there was indeed a cellulitis infection to the skin and likely the subcutaneous tissue at the time of the Urgent Care Clinic visit. The initiation of antibiotics on that date would have made a difference. Sharon may have needed some degree of debridement which would**

have resulted in tissue loss but she likely would have not lost her arm and toes because the administration of the antibiotics would have begun to kill the microorganism (the Group A Strep Bacteria). The systemic elimination of the bacteria would have in turn minimized the release of toxins which resulted from the interaction between the bacteria and Sharon's tissue. As a result, Sharon's own immunity system would have kicked into gear to as to minimize the ravaging effects of the necrotizing process to preserve her arm. Further, the loss of her eight toes on both feet resulted from the fact that her body was diverting oxygenated blood from her extremities to her vital organs, especially her kidneys which were in failure at the time she presented to Mercy. Had the antibiotics been started some 24 hours earlier, she likely would not have progressed to severe septic shock thereby minimizing the need for blood shunting and the need for vasopressors to bring her blood pressure back. Both of those factors have been implicated in the loss of her toes. This bacteria is exquisitely sensitive to antibiotic administration. The bacteria responsible for Sharon's infection was found to be sensitive to eleven (11) different antibiotics (Exhibit 31, App. 0460). There is a reason why only 6-7% of Group A bacterial infections progress to invasive infections like Sharon's infection? Why? Because these infections are

the bread and butter of an infectious disease practice and when seen, antibiotics are routinely prescribed even without blood work, according to Dr. Vemuri, and he would routinely expect a full recovery. (Vemuri dep p.12-13, App. p. 0239-0240).

Restatement (Second) of Torts, section 323 speaks to this very issue. It provides that "one who undertakes…to render services to another which she should recognize as necessary for the protection of the other's person…is subject to liability… for physical harm resulting from his failure to exercise reasonable care to perform her undertaking, if

> (a) her failure to exercise such care **increases the risk of such harm**…

It is that very Restatement section which formed the basis for Iowa's adoption of the concept of **loss chance of survival**. See ***DeBurkarte v. Louvar,*** 393 N.W.2d 131, 135-138 (Iowa 1986). In discussing the concept, one court succinctly articulated the policy reasons for adopting such a concept:

> When a defendant's negligent action or inaction has effectively terminated a person's chance of survival, **it does not lie in the defendant's mouth to raise conjecture as to the measure of the chances that she has put beyond the possibility of realization. If there was any substantial possibility of survival and defendant has destroyed it, she is answerable. Rarely is it possible to demonstrate to an absolute certainty what would have happened in circumstances that the**

> **wrongdoer did not allow to come to pass. The law does not …require the plaintiff to show to a _certainty_ that the patient would have lived had she been hospitalized and operated on promptly.**

Hicks v. United States, 368 F.2d 626,632 (4th Cir. 1966) (emphasis added).

In this case, Sharon Susie lost her best chance to save her arm and toes. "Allowing recovery for the lost chance is…the most equitable approach because 'but for the defendant's tortious conduct, it would not have been necessary to grapple with the imponderables of chance.'" ***DeBurkarte v. Louvar***, 393 N.W.2d at 137 (quoting from **King, *Causation, Valuation, and Chance in Personal Injury Torts Involving Preexisting Conditions and Future Consequences*, 90 Yale L.J. 1353, 1363-64 (1981)**) Iowa's adoption of the concept of loss chance of survival has been expended to include situations like this where the patient did not lose her chance to survive but instead lost her chance to minimize the health effects of the defendant's substandard or negligent care. See "Note" following Uniform Civil Jury Instruction 1600.16 which states: "However, a lost chance of survival claim can exist in a non-death case. See, e.g. ***DeBurkarte v. Louvar*** 393 N.W.2d 131 (Iowa 1986)." In addition, the Iowa Supreme Court has conclusively held that loss of a chance claims are submissible to the jury even if the chance of a more favorable outcome is less than 50%. See ***Wendland v. Sparks***, 574 N.W.2d 327, 332 (Iowa 1998) ("*DeBurkarte* suggests that the

loss of a chance of less than 50% is compensable, 393 N.W.2d 136-37, and *Sanders* reinforced that suggestion, 421 N.W.2d at 522-23. We now specifically so hold and therefore reverse and remand for further proceedings.")

Further, it is emphasized to the Court that the adoption of the lost chance of survival concept in Iowa predated the Iowa Supreme Court case entitled ***Thompson v. Kaczinski***, 774 N.W.2d 829 (Iowa 2009). In the Thompson v. Kaczinski case, the Iowa Supreme Court did away with the traditional proximate cause analysis in favor of a "but for" causation requirement coupled with a "scope of liability" concept. I*d* at 836-839. Two newly adopted uniform instructions set forth the new causation proof requirements:

> **Instruction 700.3 Cause Defined.** The conduct of a party is a cause of damage when the damage would not have happened except for the conduct. There can be more than one cause of an injury or damage.
>
> **Instruction 700.3A Scope of Liability—Defined.** You must decide whether the claimed harm to plaintiff is within the scope of defendant's liability. The plaintiff's claimed harm is within the scope of a defendant's liability if that harm arises from the same general types of danger that the defendant should have taken reasonable steps to avoid.
>
> Consider whether repetition of defendant's conduct makes it more likely harm of the type plaintiff claims to have suffered would happen to another. If not, the harm is not within the scope of liability.

In this case, there is absolute certainty in the opinions of both Dr. Schechter and Jeffrey Nicholson, P.A. that the failure to institute antibiotics has resulted in tissue damage to Sharon Susie. The cause in fact requirement will clearly be met. In addition, the type of harm sustained by Sharon Susie is the very type of harm that is intended to be avoided by the standard of care which requires infections to be diagnosed and treated as early as possible. "Time is tissue" when it comes to untreated infections and when those infections are allowed to become a systemic sepsis (a blood borne infection) which is becoming necrotizing, a ***time delay in diagnosing and treating the infection results in the sacrifice of significant amounts of tissue.*** In Sharon's case, it resulted in the loss of her right arm; the loss of eight of her toes; the loss of significant muscle and fascia in her shoulder, her back, her breast and chest, her hip, her low back and her feet. The Defendants cannot have it both ways. They cannot argue that there was no reason to have diagnosed and treated a developing infection on September 29th and then argue that it was so far advanced that there was nothing that could have been done to save Sharon's arm, her toes and the significant amount of muscle and fascia that had to be sacrificed. In this case, there will be more than enough proof to submit this case under **<u>both</u> a "cause in fact/scope of liability causation analysis" and a "loss of chance causation**

analysis". Under the facts of this case, it does not lie in Sarah Harty's mouth to raise conjecture as to the measure of the chances that she has put beyond the possibility of realization. With regard to the alternative form of causation proof, Dr. Schechter was prepared to give the jury significant direction:

> Q. I want to read you a quote from him [Dr. Crew] on Page 95 beginning at Line 11 in response to this question: "Do you believe that had antibiotics been started, more likely than not, Sharon's arm may have been saved?"
>
> And he says beginning at Line 11: "I think it is" -- "it may well be more likely because, if you can stem the firestorm and let the body mobilize its immune system, which includes both cellular and chemical, you could slow something down. If you could do that and give the body a chance to fight it, I think it is likely that you could have shut down at least the progression. And when they finally did the procedure, it could have saved the arms. I've had arms almost half bad, but I do it a little different way so that treating it, you didn't have that privilege."
>
> Do you agree with that -- that the earlier you get the antibiotics on board and the more you allow the body to mobilize in someone's immune system in response to this developing infection that you may well, more likely than not, have saved her arm?
>
> B. To -- I would say it's **a significant possibility ranging as high as <u>probability</u> that early intervention with antibiotics could have either at least reduced the progression of the infection or slowed its progression and potentially have averted as much tissue loss as she experienced.**

(Schechter dep. pp. 119:18 - 121:22, App. pp. 0442-0444) (emphasis added).

With that direction, the jury should have been allowed to decide the loss of a chance issue. The trial court's ruling taking away that opportunity on the part of the jury was reversible error.

VIII. CONCLUSION

For the reasons expressed herein, Plaintiff/Appellant respectfully urges this Court to reverse the order of the trial court granting Defendants' Motion for Summary Judgment and remand this case for trial.

REQUEST FOR ORAL ARGUMENT

Sharon Susie, the Appellant herein, does hereby request oral argument on the issues raised for consideration in this appeal.

HUMPHREY LAW FIRM, P.C.

/s/ Marc A. Humphrey

Marc A. Humphrey AT0003843
300 Walnut Street, Suite 5
Des Moines, Iowa 50309
Telephone: (515) 331-3510
Facsimile: (515) 282-0318
Email:
mhumphrey@humphreylaw.com

ATTORNEY FOR PLAINTIFFS/APPELLANTS

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