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** **REPLY BRIEF FOR APPELLANT**

APPEAL FROM THE IOWA DISTRICT COURT
FOR WOODBURY COUNTY
HONORABLE JOHN D. ACKERMAN, JUDGE
WOODBURY COUNTY NO. LACV162319

APPELLANTS' REPLY 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 4th day of December, 2017, I served one copy of the Plaintiff-Appellants' Notice of Appeal 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
c/o Donna Humpal
Iowa 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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IV. IMPORTANT FACTS WITH REGARD TO THE ISSUE DISCUSSED IN THIS REPLY BRIEF

Despite claiming that an infection was on her differential diagnosis list, Defendant Sarah Harty, the physician assistant who evaluated Sharon Susie in the urgent care clinic on September 29, 2012 records absolutely nothing in the record generated from that visit which would alert anyone that she had concerns about an infection. (Plaintiff's Exhibit 1, App. pp. 446-448). She did no lab work (*Id*.) she does not record anywhere whether the bruising and swelling on Sharon Susie's forearm was red or warm to the touch (*Id.*). There is absolutely nothing in the record that would suggest that Sharon Susie was progressing to a life threatening systemic infection that was flowing from a necrotizing fasciitis in the deeper tissues of her affected arm. The most anyone can discern from that record is that Sharon Susie had ecchymosis and edema over the posterior aspect of her elbow and proximal forearm and that she had tenderness to palpation of the right posterior elbow and proximal forearm that was discerned from passive range of motion done by Sarah Harty herself (active range of motion was not possible due to the extent of pain). (App. p. 457). Despite the paucity of information which would allow any healthcare provider to conclude that there was a deep tissue infection brewing which would manifest itself as a life threatening systemic infection, including necrotizing fasciitis of the deep tissue of Sharon Susie's

right arm, the Defendants in this case continue to argue that Sharon Susie's condition was so bad at the urgent care clinic on September 29, 2012 that there was absolutely nothing that could be done to save her arm or prevent massive tissue loss from the invasive infection that developed.

Sharon Susie, on the other hand, argues that reasonable inferences drawn from the evidence available suggests to the contrary. First of all, Sharon Susie fell on her right forearm – all indications leading up to her presentation to the urgent care clinic on September 29, 2012 suggested that her injury was limited to the surface area of her right forearm and elbow. (Sharon Susie dep. pp. 38:22-39:2, App. p. 170; Plaintiff's Exhibit 1, App. pp. 456-458). Overwhelmingly, group A strep bacteria, the bacterial culprit in this case, present as surface skin infections or strep throat. Some of those surface skin infections develop into cellulitis. Defendants' infectious disease specialist described group A strep cellulitis infections as the bread and butter of his infectious disease practice (Vemuri dep. p. 12:18-22, App. p. 0239). In this record, there is simply no suggestion other than the fact that the evolution of this horrifying journey for Sharon Susie began with the trauma to her right forearm and elbow. At the risk of sounding a bit facetious, Sharon Susie did not have a deep tissue infection that coincidentally came to light in the aftermath of the trauma to the surface area

of her right forearm and elbow. A jury could reasonably conclude based upon this record that this deep tissue infection began as a trauma to the right forearm and elbow and progressed to the deep tissue of Sharon Susie's right arm immediately below the location of that trauma. Many of the experts who were prepared to offer testimony at trial acknowledged that such a progression from the skin to the deep tissue where it later develops into a necrotizing fasciitis is a well-known progression (Vemuri depo 42-44, App. 247; Lamptey depo 37, 67-68, 79-80, App. 224, 231, 234; Schechter depo 121-125, App. 444-448)

The Center for Disease Control and Prevention confirms the overwhelming probability that Sharon Susie's infection developed as a cellulitis infection to her skin and progressed downward. (App. pp. 463-464). It issued a document entitled "Group A Strep for Clinicians" which reviewed literature from 1995, from 2002, from 2007 and 2012 and offered the following statistical evidence concerning the presentation of group A strep infections. Group A strep bacteria presents as noninvasive disease in the cases of strep throat and impetigo. Invasive disease caused by group A strep include necrotizing fasciitis (NF), streptococcal toxic shock syndrome (STSS), **cellulitis**, bacteremia, pneumonia, puerperal sepsis. Important in the CDC's guidance to clinicians with regard to group A strep infections is

its emphasis that there are over ten million noninvasive group A strep infections (**primarily throat and superficial skin infections**) which occur annually in the United States. Only nine thousand (9,000) to eleven thousand five hundred (11,500) cases of invasive disease occur each year in the United States. Streptococcal toxic shock syndrome (STSS) and necrotizing fasciitis (NF) each accounted for only approximately six (6) to seven (7) percent of the invasive cases. (App. p. 463). Multiple physicians in this case agreed that a group A strep bacterial infection may begin at the skin level, that is a superficial skin infection or cellulitis, and then progress to the deeper tissue where it can become necrotizing fasciitis. (Vemuri dep. pp. 42:25-44:22, App. p. 247; Lamptey dep. pp. 79:14-80:10, App. p. 234).

Most importantly, group A strep bacterial infections which begin at the surface level as a skin cellulitis are extremely common; are often diagnosed without lab work; are routinely treated with antibiotics; and result in complete recoveries without the infection progressing to the deeper tissue where it develops into necrotizing fasciitis. (Vemuri dep. pp. 9:4-14:17, 43:20-44:22, App. pp. 239-240, 247; Lamptey dep. pp. 39:13-40:6, 70:2-12, App. pp. 223-224, 232; Rizk dep. p. 53:1-11, App. p. 303; Bacon dep. pp. 17:19-18:6, 36:4-37:13, App. pp. 316-317, 321).

Sarah Harty cannot state out of one side of her mouth that there was insufficient clinical indication to diagnose an infection and then state out of the other side of her mouth that the infection had so dramatically progressed to the deep tissue of Sharon Susie's right arm, that there was absolutely nothing she could have done to have prevented the amputation of that arm. She cannot have it both ways.

The record before the trial court was methodically put together like a mosaic puzzle. Sharon Susie knew that there was little documentation of her condition at the time of presentation to the urgent care clinic. As such, through her counsel, she clearly documented the following opinions through medical witnesses that would allow the jury to conclude, more likely than not, that had appropriate treatment been commenced at the time of the urgent care visit, this tragic and dramatic outcome could have been avoided. The degree of tissue loss would have been minimized, including the need for surgical amputation of her right arm and eight (8) of her toes.

V. BRIEF POINT I

IOWA RULE OF CIVIL PROCEDURE 1.981(3) REQUIRES THE TRIAL COURT TO REVIEW ALL PLEADINGS, DEPOSITIONS, ANSWERS TO INTERROGATORIES, AND ADMISSIONS ON FILE, TOGETHER WITH THE AFFIDAVITS, IF ANY, TO DETERMINE WHETHER THERE IS AN ISSUE SUBMISSIBLE TO THE JURY ON THE ISSUE OF CAUSATION.

By his own admission, the trial court herein ignored the express mandate of Iowa Rule of Civil Procedure 1.981(3). The trial court was required to review this **entire** record, not just the sworn deposition testimony of Dr. Roger Schechter, so as to determine there was a submissible jury issue on causation. *Griglione v. Martin*, 525 N.W.2d 810, 813 (Iowa 1994) (emphasizing that in filing or resisting a motion for summary judgment, reference must be made to legitimate portions of the record which include admissions in the pleadings, affidavits or **depositions**, **answers to interrogatories** and admissions on file). Of course, admissions in support of the Plaintiff's theory of the case may come from the testimony of the Defendant herself or experts designated on behalf of the Defendants. See *Oswald v. Legrand*, 453 N.W.2d 634, 640 (Iowa 1990); *Hill v. McCartney*, 590 N.W.2d 52 (Iowa Ct. App. 1998). Plaintiff specifically reserved the right to utilize testimony from the "any other healthcare professionals involved in Sharon Susie's care, including treating physicians starting on or after September 30, 2012" and "any of Defendants' experts or to utilize any portions of the Defendants' experts' discovery depositions." (App. 19-22). Such testimony was anticipated to be an integral part of Plaintiff's proof, particularly with regard to causation.

In all due respect to the trial court, he focused almost exclusively on the deposition testimony of Dr. Schechter. He clearly disregarded his Rule 1.508 Expert Witness Summary. In fact, at the hearing on the motion for summary judgment, he concedes that his focus was primarily on the sworn deposition testimony of Dr. Roger Schechter. During that hearing, the trial court stated:

> "Now, Schechter, every time he was really forced or asked the major question, he said speculation, I don't know what the outcome would have been, may have made a difference. **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."

(App. p. 152).

However, he did give a more likely than not causation opinion in his Rule 1.508 supplemental answer to interrogatory, one of the pleadings which the trial court was compelled to review under the mandate set forth in Iowa Rule of Civil Procedure 1.981(3). In his Rule 1.508 Summary, **which was signed by Dr. Schechter**, he offers the following opinion:

> 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.

(App. pp. 86-87) (emphasis added).

The trial court goes to great lengths to suggest that Dr. Schechter is bound by his deposition testimony. Dr. Schechter was deposed by a defense lawyer, Jack Hilmes, who has perhaps more experience than any other defense lawyer currently defending medical negligence cases in Iowa. The Iowa Rules of Civil Procedure do not require Plaintiff's attorney to do the work of defense counsel during the course of the deposition. Nowhere in that deposition is there a question asked of Dr. Schechter as to whether he has voiced all final opinions on the issue of causation. It is particularly telling to look at the language of Mr. Hilmes' question during the deposition of Dr. Schechter:

> Q: But I would just ask, between your report **which we've marked as Exhibit 4 in this case** [Exhibit 4 in Dr. Schechter's deposition was his Rule 1.508 written summary] and the discussion that we discussed today, have you offered to me all of the opinions and criticisms that you have on the subject of the standard of care to have been provided by Sarah Harty?
>
> A. Yes.

Q. Alright. As we've talked about more of the causation side of this case, I've heard you say – and I think in some parts fairly – that the treatment of necrotizing fasciitis isn't your area of expertise. That would be the surgeon or ID people that – who actually got involved in this case at Mercy; right?

A. Yes.

Q. And when an opinion that we've discussed in this case has been speculative or speculation, you have freely told me that today, haven't you?

A. Yes.

Q. Alright. I appreciate that. Those are all the questions I have. And you're right, I am tired.

(Schechter dep. pp. 118:14-119:10, App. pp. 441-442) (emphasis added).

In his questions, Mr. Hilmes acknowledges that Dr. Schechter's opinions are contained in both his Rule 1.508 written summary and his sworn deposition testimony of April 25, 2017. *Id.* Nowhere did Mr. Hilmes ask Dr. Schechter if he had any additional opinions on causation other than the specific questions he had been asked in the deposition. Had that question been asked, Dr. Schechter would have used the CDC's statistics as contained in its bulletin providing guidance to clinicians with regard to group A strep bacteria to support his opinion, **more likely than not**, that had the early administration of antibiotics been commenced at the time of the

urgent care visit, the dramatic tissue loss, including the amputation of Sharon Susie's right arm and eight (8) of her toes would have been prevented. It is again emphasized that the group A strep bacteria that was isolated in Sharon Susie's body went through antibiotic sensitivity lab evaluation and was found to be sensitive to eleven (11) different forms of antibiotics (Exhibit 31, App. p. 460). This was not an antibiotic resistant bacteria. This was a bacteria that was exquisitely sensitive to antibiotics. The presentation of this group A strep bacterial infection began as a cellulitis and candidly, the defense has no counter evidence to that assertion. A reasonable jury could infer that this began as a skin cellulitis and progressed to a deep tissue infection by simply looking at her clinical presentation at the urgent care clinic and then following the progression of her illness up to the time she presented to the emergency room at Mercy Hospital in Sioux City some twenty-four (24) hours later. Further, it is important to emphasize that the punch biopsy done in the hospital of the tissue of Sharon Susie's right forearm indicated that at the deep tissue layers, there was not yet any inflammatory response, a fact that Dr. Lamptey opined would suggest that the migration of the bacteria to the deeper tissues was still in the early stage of progression of necrotizing fasciitis (Lamptey dep. pp. 73:25-74:6, App. p. 233). Of course, the lack of inflammatory response in the deeper tissue at

the time of the punch biopsy on September 30 would lend further support to the premise that administration of antibiotics at the time of Sharon Susie's urgent care visit on September 29 would more likely than not have stopped the progression of this group A strep bacteria, negating the need for such massive surgical removal of tissue, including Sharon's right arm and eight (8) of her toes.

There are categories of expert witnesses in medical negligence litigation. Some experts will say virtually anything. Others are honest. Dr. Schechter falls in the category of an honest expert witness. He simply conceded that it is speculative to opine as to the impact of the administration of antibiotics to Sharon Susie, herself, beginning at the time of her urgent care visit on September 29. Candidly, there is no expert that can opine as to the effect of those antibiotics specifically on Sharon Susie on that date because Sarah Harty did not order antibiotics in response to Sharon Susie's clinical presentation. However, Dr. Schechter can base a causation opinion on the fact that there are over ten million group A strep infections annually in this country which primarily manifest as throat or superficial skin infections or cellulitis. He can also compare that number to the only nine to eleven thousand five hundred cases of invasive disease which include necrotizing fasciitis and conclude that under all the facts in this case, Sharon

Susie more likely than not presented with a surface infection of the skin known as cellulitis and that the overwhelming number of those infections, which are treated annually in this country, are successfully treated with antibiotics because of the extreme sensitivity of the group A strep bacteria to antibiotics. Plaintiff supported that conclusion with a multitude of medical experts and evidence from this record. Perhaps the most persuasive components of that evidentiary presentation in support of such an opinion was the fact that this particular group A strep bug was determined to be sensitive to eleven (11) different antibiotics (App. 460-462); and the fact that the punch biopsy demonstrated that the inflammatory response at the deep tissue level on September 30, when Sharon presented to the Mercy Hospital ER, was still at its early stages suggesting that the infection was progressing downward toward the deeper tissue and that it did not start there and progress upward (Lamptey depo. 73-74, App. 233).

As a trial judge, you can't pick and choose the evidence and become an advocate. The trial court's ruling did not consider the entire mosaic of the record that had been established which brought home the causation issue despite the existence of critical information which was either never evaluated by Sarah Harty at the urgent care clinic on September 29 or never documented in her record. To rely exclusively on the sworn deposition of

Dr. Roger Schechter in the face of this record constitutes reversible error. Sharon Susie respectfully asks for her day in court.

VI. BRIEF POINT II

THE ENTIRE RECORD BEFORE THE TRIAL COURT CLEARLY GENERATED A SUBMISSIBLE CAUSATION ISSUE ON PLAINTIFF'S ALTERNATIVE CAUSATION THEORY – LOSS CHANCE OF RECOVERY.

Plaintiff was prepared to submit evidence satisfying the evidentiary proof requirements of her direct causation case and her alternative causation case based upon loss chance of recovery. Despite the trial court initially concluding that there was sufficient evidence to submit Plaintiff's alternative causation theory of loss chance of recovery, he reversed that conclusion and dismissed the whole case.

Dr. Schechter shared his opinion that had antibiotics been commenced, there was a range of potential outcomes in this case which went as high as a strong probability to as low as a possibility that the outcome would have been different. His specific testimony, from his April 25, 2017 deposition, reads as follows:

> Q. Do you agree with that – that the earlier you get the antibiotics onboard 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 **probability** 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. 119-121, App. p. 442) (emphasis added). Such testimony, when considered in conjunction with the additional testimony from both treating physicians and opposing experts, certainly justified submission of the loss chance of recovery theory to the jury. Dr. Schechter was simply providing the range of his opinion as to Sharon Susie's outcome had treatment been commenced at the time of the urgent care clinic visit. That range encompassed "strong possibility to probability" and it was then up to the jury to determine the monetary value of that loss chance of recovery. See *Grismore v. Consolidated Products Co*., 232 Iowa 328, 5 N.W.2d 646, 657 (1942) ("The true rule is, and should be, that the witness may use such expression as voices his true state of mind on the matter, whether it be possibility, probability, or actuality. To insist that witness confine his testimony to an expression of possibility or probability when his real judgment or conviction is actuality, or fact, is unfair to the witness and the jury, and unjust to the party offering the testimony.")

What Defendants argument misses, however, is the fact that the submissibility of the loss chance of recovery theory is not limited to the opinions of Dr. Schechter as quoted above. The submissibility of the alternative causation theory known as loss chance of survival or recovery also requires the trial court to examine the entire record and determine whether the record as a whole would justify the submission of that theory to the jury. *DeBurkarte v. Louvar*, 393 N.W.2d 131, 135-138 (Iowa 1986); *Wendland v. Sparks*, 574 N.W.2d 327, 332 (Iowa 1998). Plaintiff has gone to great lengths in detailing the record produced in this case which supports her primary causation theory and her alternative causation theory. What she would emphasize in this brief point, however, is that Dr. Schechter's opinion as quoted above is buttressed by the testimony of Dr. Lamptey; by the testimony of Dr. Vemuri; by the testimony of Dr. Rizk; by the punch biopsy; by the antibiotic sensitivity study done of the particular group A strep bug that was isolated in Sharon Susie's body; and from the lay testimony presented. This court has made is clear that under a loss chance of survival or recovery, the injured party need not present proof demonstrating that the loss chance of recovery was more likely than not. *Wendland v. Sparks*, 574 N.W.2d 327, 332 (Iowa 1998). In changing his ruling and dismissing the

loss chance of recovery alternate theory of causation, the trial court entered a ruling that is inconsistent with existing legal authority.

Again, the trial court seems to have focused exclusively on Dr. Schechter's testimony when the entire record supports the submission of the alternative causation theory known as loss chance of recovery. Plaintiff Sharon Susie again urges this court to reverse the trial court's ruling and remand this case so that she may have her day in court. Through the multitude of medical experts which would have been presented to this jury, at a minimum, Sharon Susie clearly has satisfied her evidentiary obligation justifying submission of the alternative theory of loss of a chance of recovery. However, when this record is read in total, without focusing exclusively on the sworn deposition testimony of Dr. Roger Schechter, there is likewise evidence justifying the submission of her primary causation theory to the jury. She would ask this court to correct that error, reverse the ruling of the trial court on Defendants' motion for summary judgment, and remand this case for a well-deserved jury trial.

VII. CONCLUSION

For the reasons set forth in their initial brief, coupled with the absence of any prejudice to the Defendants herein as articulated in the Reply Brief, Plaintiffs Sharon Susie and Larry Susie do respectfully urge this court to

reverse the rulings of the trial court striking her experts and granting summary judgment and remand this case to the trial court for a resolution on the merits.

VIII. REQUEST FOR ORAL ARGUMENT

Sharon Susie and Larry Susie, the Appellants herein, do 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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