NO. 24768

IN THE INTERMEDIATE COURT OF APPEALS

OF THE STATE OF HAWAIʻI

JANET M. BOBBITT, Plaintiff-Appellant, v.
GREGORY H. CHOW, M.D., and ORTHOPEDIC ASSOCIATES OF HAWAII, INC., Defendants-Appellees, and
DOES 1-100, Defendants

APPEAL FROM THE CIRCUIT COURT OF THE FIRST CIRCUIT
(CIV. NO. 98-4397)

MEMORANDUM OPINION
(By: Burns, C.J., Lim and Foley, JJ.)

In this medical malpractice case, Plaintiff-Appellant Janet M. Bobbitt (Bobbitt) appeals from the November 28, 2001 Judgment entered by Judge Dan T. Kochi in favor of Defendants-Appellees Gregory H. Chow, M.D. (Dr. Chow), and Orthopedic Associates of Hawaii, Inc. (OAH), that resulted from the following order entered on November 6, 2001:

> IT IS ORDERED . . . that Defendants Gregory Chow, M.D. and Orthopedic Associates of Hawaii, Inc.'s Motion In Limine To Exclude Opinions of Thomas Lubin, M.D. filed on October 8, 2001 be and hereby is granted.
>
> Because Plaintiff can provide no expert testimony re standard of care and causation, IT IS FURTHER ORDERED that Defendants' oral motion to dismiss, with prejudice, is granted.

We affirm.

BACKGROUND

In 1975, Bobbitt was the victim of a motorcycle accident which resulted in a severe injury to her left knee. In

1988, Bobbitt's "knee was replaced by a device referred to as a 'Howmedica PCA Primary Knee.'"

On September 9, 1995, while on an airplane, Bobbitt began to suffer swelling and severe pain originating at the left knee prosthesis. She consulted with a medical doctor who, on September 19, 1995, aspirated the area, had the aspirate cultured, and x-rayed the knee. The x-rays revealed a shattered prosthesis.

On September 21, 1995, Bobbitt consulted with Dr. Chow, an orthopedic surgeon employed by OAH. On December 5, 1995, Dr. Chow surgically removed the prosthesis and replaced it with another one.

In a memorandum filed on October 6, 1999, counsel for Bobbitt stated, in relevant part, as follows:

> On December 18, 1995, [Bobbitt's] incision was described as well healed. On December 27, 1995, she appeared to have a wound infection which was cultured and treated aggressively. On December 28, 1995, surgical debridement was performed. Cultures were obtained. The cultures were negative.
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> **(At this point, an infectious disease consult should have been ordered.)**
>
> On **January 2**, 1996, the wound appeared to be healing well; however, on January 5, 1996, [Bobbitt] had **substantial effusion** which was **sent out for culture**. On **January 8**, 1996, the culture results came back **negative**. On that date, it was also noted that [Bobbitt's] **right knee was swollen considerably more and that she had significant pain and effusion**.
>
> On **January 15**, 1996, the **wound appeared to be well healed** and the antibiotics were discontinued, despite the fact that **effusion was still noted**. [Dr. Chow] stated that as long as the wound stayed sealed, he would follow over in another month. [Bobbitt] was to return right away if she had any wound problems.

> On **January 30**, 1996, [Bobbitt] returned with a woven [sic] that looked **slightly red and what** [sic] **intermittent effusions and some erythema**.
>
> On **February 5**, 1996, [Bobbitt] returned with her **ankle and leg swollen and with significant effusion, with the area of this stitch abscess opened and with continued knee swelling**. The plan was to follow-up as per the previous routine. This meant that [Bobbitt] was to return in one month unless she had any new wound problems.
>
> On **February 23**, 1996, [Bobbitt] returned with her lay [sic] and ankle being swollen and painful and with an **apparent infection in her prosthesis**. A culture was ordered. On **February 24**, 1996, [Bobbitt] was **admitted to the hospital for treatment of an infected left total the replacement**. On **February 28**, 1996, [Bobbitt's] wound was **irrigated and debrided**.
>
> On **March 1**, 1996, a **consult with an infectious disease specialist** was requested. **At that time, the infectious disease specialist noted that there were prior negative cultures but signs of infection and thus considered that there may have been: "infectious causes with negative bacterial cultures include bacteria which may need nutrient factors, such as nutrient-varient streptococcus, versus non-bacterial causes, such as fungal or mycobacteria infection."**
>
> On **March 3**, 1996, [Bobbitt] was **diagnosed with an infection caused by modified acid fast bacteria**, possibly Nocardia or actinomycosis, which would suggest why it grew in nutrient broth. The doctor thought that [Bobbitt] might also have an atypical mycobactrium.
>
> . . . .
>
> . . . The standard of care would have required that Dr. Chow enlist the services of an infectious disease specialist beginning on December 27, 1995, and following [Bobbitt] thereafter.

(Emphases in the original.)

In Plaintiff's Pretrial Statement filed on July 19, 1999, Bobbitt alleged, in relevant part, as follows:

> Finally, on March 1, 1996, Dr. Chow asked for a consultation with Russell Wong, M.D., an infectious disease specialist. Dr. Wong, noting the prior negative cultures but signs of infection, considered that: "infectious causes with negative bacterial cultures include bacteria which may need nutrient factors, such as nutrient-variant streptococcus, versus non-bacterial causes, such as fungal or mycobacteria infection. On March 3, 1996, [Bobbitt] was diagnosed with an infection caused by modified acid fast bacteria, possibly Nocardia or actinomycosis, which would suggest why it grew in nutrient broth. Dr. Wong thought she might also have an atypical mycobacterium.

She was placed on Bactrim for Nocardia, and Cefoxitin and Amikacin for Atypical Mycobactrium coverage.

On March 18, 1996, [Bobbitt] was, again, seen by Dr. Chow who stated that she would continue with antibiotics.

On April 23, 1996, [Bobbitt] was, again, seen by Dr. Chow who noted watery, greenish tinged drainage. He discussed removal of the prosthesis and knee fusion, continued antibiotics.

On May 16, 1996, [Bobbitt] was, again, seen by Dr. Chow who discussed removal of the prosthesis and knee fusion. Continued antibiotics.

On June 13, 1996, [Bobbitt] was, again, seen by Dr. Chow who prescribed continued antibiotics.

On June 25, 1996, [Bobbitt] was, again, seen by Dr. Chow who stated in a pre-op visit that he was going to remove the prosthesis and put in antibiotic impregnated methyl methacrylate spacers.

On June 26, 1996, [Bobbitt] was, again, seen by Dr. Chow who operated and removed the prosthesis. He put in a spacer. It was also noted that [Bobbitt] had become allergic to Cefoxitin, which was used to treat the organism (Atypical Mycobacterium).

On July 4, 1996, [Bobbitt] was seen by Dr. Wong who noted infection of Atypical Mycobacterium, treated with erythromyein and Amikacin and noted possibility of peptostreptococcus treated with Cefoxitin (organism sensitive to penicillin and ampicillin, but [Bobbitt] had developed a rash in the past).

On July 6, 1996, [Bobbitt] was, again, seen by Dr. Chow for pain management.

On July 10, 1996, [Bobbitt] was, again, seen by Dr. Chow who stated that the incision looked good and the spacer was well placed.

On July 27, 1996, [Bobbitt] was, again, seen by Dr. Chow who stated that things looked okay.

On July 29, 1996, [Bobbitt] was, again, seen by Dr. Chow who changed her cast.

On August 26, 1996, [Bobbitt] was, again, seen by Dr. Chow for swelling, aspiration, specimen sent for culture -- out of cast.

On September 9, 1996, [Bobbitt] was, again, seen by Dr. Chow who noted a thick, greenish drainage which was a reactivation of the infection. Discussed knee fusion.

On September 16, 1996, [Bobbitt] was, again, seen by Dr. Chow who operated, irrigated, and debrided and removed the beads and cement block spacers.

> On September 16, 1996, [Bobbitt] was, again, seen by Dr. Wong for a consult. Dr. Wong noted infection and placed [Bobbitt] on vancomycin.
>
> On September 30, 1996, [Bobbitt] was, again, seen by Dr. Chow who noted knee aspirate from August 26, 1996. Had grown the bacterium.
>
> Because of the nature of the infection and the problems it caused, [Bobbitt's] only option was to have the left knee fused, which she did. [Bobbitt] has lost bone and muscle from multiple surgical procedures, resulting in loss of leg length, loss of balance, and torsion of the hip. She is still at risk for losing her leg. She is unable to stand without the use of a full leg cast, which remains on her leg for all of her waking hours. She has constant pain and discomfort and is unable to work or engage in any meaningful physical activities.
>
> . . . .
>
> [Dr. Chow] carelessly and negligently examined, diagnosed, prescribed for, performed surgery on, and cared for and treated [Bobbitt] for her medical conditions, carelessly and negligently failed to monitor and supervise the condition of [Bobbitt], and carelessly and negligently failed to administer appropriate care following such medical care work, misdiagnosed conditions, failed to diagnose conditions, failed to refer [Bobbitt] to an appropriate specialist, and [Dr. Chow] provided medical services, care, and attention in a manner which fell below the standard of care, all of which was a substantial factor in causing permanent injury and disability to [Bobbitt], all as set forth herein, for which [Bobbitt] seeks special and general damages.

BOBBITT'S SOLE "EXPERT" WITNESS

Bobbitt's sole "expert" witness is Thomas Lubin, M.D. (Dr. Lubin). Dr. Lubin graduated from Vanderbilt University Medical School in 1976, and has a general practice in Edgartown, Massachusetts. Dr. Lubin is not board certified in any specialty. By his choice, he does not have any hospital privileges.

In his deposition, Dr. Lubin noted that when the culture Dr. Chow requested on December 25, 1995, was negative, Dr. Chow did not ask for fungal or acid-fast bacilli cultures. Dr. Lubin opined that Dr. Chow should have enlisted the services

of an infectious disease expert. Dr. Lubin's reasons for this opinion were as follows. The fact that the site looked infected compared with the fact that the requested routine cultures were negative should have told Dr. Chow that he did not look for all the potential causes of infection such as a mycobacterium abscesses infection. The severe harmful consequences that would occur if there was one or more such infections should have caused Dr. Chow to enlist the services of an infectious disease expert. Dr. Chow's failure to do what an infectious disease expert would have done continued a situation that allowed the primary infection to persist and cause damage. It also allowed the secondary tertiary infections peptostreptococcus and coagulant negative to occur. However, it was speculative to say that Bobbitt's prognosis would have been any different had the infection been found earlier.

WRITTEN MOTION IN LIMINE, ORAL MOTION TO DISMISS

In their motion in limine filed on October 8, 2001, Dr. Chow and OAH sought

> to exclude the opinions of Thomas Lubin, M.D. Dr. Lubin is a general practitioner with no specialized training in orthopedic surgery or infectious diseases, is not board certified in any specialty, has never practiced in Hawaii, and has no knowledge of local medical practices. Further, many of his opinions are admittedly speculative, and his opinions on causation lack factual support or cognizable methodology.

At the October 12, 2001 hearing on the motion in limine, counsel for Bobbitt agreed

> that the Court should construe this as both a motion in limine and as a dispositive motion, be it a motion for summary judgment or a

> motion for a directed verdict or a motion for judgment as a matter of law. It only makes sense to do that because, in fact, I would be submitting Dr. Lubin's deposition. And as I believe this Court has ruled a number of times, the experts are limited at trial to what they've testified to in their depositions anyway. I know this Court doesn't allow experts to come in and give opinions outside what have been offered in the deposition.

QUESTIONS POSSIBLY PRESENTED

As noted above, the court dismissed the case because Bobbitt could "provide no expert testimony re standard of care and causation[.]" The court's decision is ambiguous in that it could have been based on one of the two following possibilities: (1) Dr. Lubin was not an expert regarding standard of care and causation, or (2) Dr. Lubin was an expert, but did not testify, regarding Dr. Chow's (a) standard of care and (b) causation of Bobbitt's excess medical problems and limited options.

STANDARD OF REVIEW

In State v. Cababaq, 9 Haw. App. 496, 503-05, 850 P.2d 716, 720-21 (1993), this court stated, in relevant part, as follows:

> In Larsen v. State Sav. & Loan Ass'n, 64 Haw. 302, 640 P.2d 286 (1982), the Hawaii Supreme Court specified three decisions the trial court must make before admitting expert testimony into evidence. They are that (1) the witness is in fact an expert; (2) the subject matter of the inquiry is of such a character that only persons of skill, education, or experience in it are capable of a correct judgment as to any facts connected therewith; and (3) the expert testimony will aid the jury to understand the evidence or determine a fact in issue. See State v. Castro, 69 Haw. 633, 756 P.2d 1033 (1988).
>
> With respect to decision (1), the Larsen court said:
>
> It is not necessary that the expert witness have the highest possible qualifications to testify about a particular matter, . . . , but the expert witness must have such skill, knowledge, or experience in the field in question as to make it appear that his opinion or inference-drawing would probably aid the trier of fact in arriving at the

> truth. . . . Once the basic requisite qualifications are established, the extent of an expert's knowledge of the subject matter goes to the weight rather than the admissibility of the testimony.
>
> Larsen, 64 Haw. at 304, 640 P.2d at 288 (citations and footnote omitted).
>
> In our view, the question whether a person is an expert is a question of law. The person either is or is not an expert, and there is only one right answer. However, Larsen also stated that:
>
> > The question of whether a witness qualifies as an expert is a matter addressed to the sound discretion of the trial court, and such determination will not be overturned unless there is a clear abuse of discretion.
>
> Id. (citations omitted).
>
> Thus, Larsen is authority that:
>
> > Liberality and flexibility in evaluating qualifications should be the rule; the proposed expert "should not be required to satisfy an overly narrow test of his own qualifications." The trial court has wide discretion in determining the competency of a witness as an expert with respect to a particular subject.
>
> M. Graham, FEDERAL PRACTICE AND PROCEDURE: EVIDENCE § 6642 (Interim Ed. 1992) (citations omitted). In other words, the trial court's discretion to qualify a witness as an expert is wider than its discretion not to do so.

Id.

In Cababag, this court stated its view that "the question whether a person is an expert is a question of law. The person either is or is not an expert, and there is only one right answer." After stating this view, this court recognized that Larsen stated a contrary and controlling precedent that the trial court has wide discretion in determining the competency of a witness as an expert with respect to a particular subject.

In State v. Cordeiro, 99 Hawai‘i 390, 404, 56 P.3d 692, 706 (2002), the Hawai‘i Supreme Court cited Cababag as authority that (1) "the question whether a person is an expert is a

question of law. The person either is or is not an expert, and there is only one right answer" and (2) "[t]he question of whether a witness qualifies as an expert is a matter addressed to the sound discretion of the trial court, and such determination will not be overturned unless there is a clear abuse of discretion." In doing so, the Hawai‘i Supreme Court did not note that "(2)" contradicts "(1)", and did not decide which of them was right.

DISCUSSION

Bobbitt argues that

> Dr. Lubin's opinions and testimony as to standard of care should have been admitted because Dr. Lubin expressed opinions based on his education and experience as it related to the treatment of an infection in a patient with a prosthetic joint. Dr. Lubin provided admissible testimony on causation and what the likely effect would have been if the infection had been discovered earlier.

Dr. Chow and OAH argue that the court

> properly excluded Dr. Lubin's opinions because Dr. Lubin (1) was not an expert in orthopedics, knee replacements, or infectious diseases; (2) did not support his opinions with reliable underlying facts or methodology; and (3) conceded that he could not opine with any degree of medical certainty that Dr. Chow's treatment of [Bobbitt] caused any damages.

Our review of the record shows that Bobbitt's statement that "Dr. Lubin provided admissible testimony on causation and what the likely effect would have been if the infection had been discovered earlier" is not supported by the record. Dr. Lubin testified, in relevant part, as follows:

> Q. You don't know as you sit here today whether [Bobbitt's] prognosis would have been any different had the infection been found two months earlier? Same infection, same treatment, same patient. You don't know?

A. That would be -- that would be speculation.

Based on the record, we decide that, even assuming Dr. Lubin was an expert regarding causation, Dr. Lubin's deposition testimony does not support a finding of causation that was Bobbitt's burden to prove.

CONCLUSION

Accordingly, we affirm the November 28, 2001 Judgment dismissing this case for lack of evidence.

DATED: Honolulu, Hawai‘i, January 30, 2003.

On the briefs:

Charles J. Ferrera
for Plaintiff-Appellant.

Chief Judge

Jeffrey S. Portnoy and
Stephen J. Rafferty
(Cades Schutte Fleming &
Wright)
for Defendants-Appellees.

Associate Judge

Associate Judge