IN THE COURT OF APPEALS OF NORTH CAROLINA

No. COA17-820-2

Filed: 21 August 2018

Wake County, No. 15 CVS 12051

RAYMOND A. DA SILVA, Executor of the Estate of DOLORES J. PIERCE, Plaintiff,

v.

WAKEMED, WAKEMED d/b/a WAKEMED CARY HOSPITAL, and WAKEMED FACULTY PRACTICE PLAN, Defendants.

Appeal by Plaintiff from orders entered 13 February 2017 and 20 February 2017 by Judge Robert H. Hobgood in Wake County Superior Court. Heard in the Court of Appeals 7 February 2018. Petition for rehearing granted 20 June 2018. The following opinion supersedes and replaces the opinion filed 17 April 2018.

Law Offices of Gregory M. Kash, by Gregory M. Kash, for plaintiff-appellant.

Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan, L.L.P., by John D. Madden and Eva Gullick Frongello, for defendants-appellees.

HUNTER, JR., Robert N., Judge.

Raymond Da Silva ("Plaintiff"), executor of the Estate of Dolores J. Pierce ("Pierce"), appeals from orders: (1) disqualifying his expert witness; (2) granting summary judgment due to the absence of expert testimony to establish Plaintiff's

claim of negligence by WakeMed, WakeMed d/b/a/ WakeMed Cary Hospital, and WakeMed Faculty Practice Plan ("Defendants"); and (3) granting summary judgment due to the Plaintiff's failure to present sufficient evidence of the proximate cause of Pierce's injuries. Plaintiff contends the court erred in its expert disqualification because Dr. Genecin is of the same medical specialty as those who provided medical services to Pierce during her hospitalization and is, therefore, qualified to serve as an expert witness. Further, Plaintiff argues following a reversal of the trial court's disqualification of Dr. Genecin, Plaintiff met his burden to present expert testimony of Defendants' negligence. Lastly, Plaintiff asserts Dr. Genecin's testimony establishes the element of proximate cause, and any inconsistencies within his testimony is a matter to be contemplated by the jury. We reverse the trial court's disqualification of Dr. Genecin as an expert witness and the trial court's order granting summary judgment due to lack of evidence of proximate cause, and we vacate the trial court's order granting summary judgment due to absence of expert testimony.

I. Factual and Procedural Background

On 4 September 2015, Plaintiff filed a complaint against Defendants seeking monetary damages for medical malpractice, negligence, and the wrongful death of Pierce. Plaintiff's complaint alleges the following narrative.

At 1:22 p.m. on 30 October 2012, Pierce arrived at WakeMed Cary Hospital ("WakeMed") showing symptoms of "fever, altered mental status and weakness." Seventy-six years old, Pierce stood 5'4" tall and weighed 136 pounds. At the time of admission, Pierce "was charted to be taking Prednisone, a corticosteroid, on a daily basis." The emergency room physician[1] collected urine and blood cultures, in accordance with standard procedure for patients with suspected infection and sepsis. Subsequently, the physician ordered 500 mg of intravenous ("IV") Levaquin for Pierce.

At or near 4:57 p.m. on 30 October 2012, WakeMed "hospitalists"[2] assumed care of Pierce, following her transfer from the emergency department to the Telemetry/Intermediate Care floor of WakeMed. The same day, Dr. Grant Jenkins performed a medical history and physical on Pierce and diagnosed Pierce with "Pyelonephritis with sepsis," commonly referred to as a urinary tract infection ("UTI"). Dr. Jenkins then ordered 750 mg of Levaquin to be given to Pierce daily by IV, followed by 5 mg of Prednisone to be given daily by tablet.

On 31 October 2012, Dr. Faisal Daud, a hospitalist with WakeMed, continued orders for 750 mg of Levaquin by IV and 5 mg of Prednisone by tablet. On 1 November

[1] The record does not disclose: (1) the identity of the emergency room physician who collected urine and blood cultures from Pierce on 30 October 2012; (1) the identity of the emergency room physician who ordered Pierce be given 500 mg of Levaquin by IV; (3) or if these physicians were the same.

[2] Hospitalists denote the employees of WakeMed "who were actively involved as an attending physician of [Pierce's] care during the course of her inpatient hospitalization[.]"

2012, Pierce's urine and blood cultures tested positive for Klebsiella pneumonia. Klebsiella pneumonia is "an organism resistant to Ampicillin, but susceptible to . . . Amikacin, Ampicillin/sulbactam, Cefazolin, Cefepime, Cefozitin, Ceftazidime, Ceftriaxone, Ciprofloxacin, Ertapenem, Gentamicin, Imipenem, Levofloxacin, Nitrofurantoin, Tobramycin, and Trimethoprim/Sulfa." Dr. Daud continued orders for Levaquin and Prednisone through 2 November 2012, at which time he performed an interim summary of Pierce's care. Within the interim summary, Dr. Daud noted "Klebsiella Pneumonia sensitive to Levaquin and all other antibiotics except for Ampicillin."

On 3 November 2012, Dr. Saifullah Afridi cared for Pierce, continuing daily orders for 750 mg of Levaquin by IV and 5 mg of Prednisone by tablet. This dosage continued through 4 November 2012, until Dr. Afridi increased Pierce's Prednisone dosage to 30 mg by tablet, twice a day with meals, and wrote an additional order for 125 mg of Methylprednisolone[3] ("Solu-medrol") to be given by IV. On 5 November 2012, Dr. Afridi gave Pierce 750 mg of Levaquin by tablet, and 30 mg of Prednisone by tablet. On the same date, still caring for Pierce, Dr. Afridi prepared discharge orders for Pierce to move to the Rex Rehabilitation and Nursing Care Center of Apex ("Rex Rehabilitation"). In his discharge orders, Dr. Afridi directed Rex Rehabilitation to give Pierce 750 mg of Levaquin by tablet for four more days, and 60 mg of

[3] Methylprednisolone is a corticosteroid.

Prednisone (30 mg twice a day) by tablet, tapered over a three-month period. Rex Rehabilitation gave Pierce the medication as ordered.

On 19 November 2012, Dr. Ronald Summers evaluated a left Achilles tendon rupture on Pierce. On 27 November 2012, Dr. Summers performed a repair surgery to Pierce's left Achilles tendon. Unsuccessful in her rehabilitation efforts following surgery, Pierce became "essentially bedridden" and required nursing care for extended periods of time until her death. On 7 September 2013, Pierce died. The State of North Carolina Certificate of Death indicates pneumonia and debility caused Pierce's death.

In his complaint, Plaintiff asserted Pierce's pneumonia and debility arose from her Achilles tendon injury and alleged Pierce's death was proximately caused by the negligence of WakeMed. Plaintiff's complaint further alleged WakeMed hospitalists, Drs. Jenkins, Daud, and Afridi, owed Pierce a duty of care "in accordance with the skill, training and experience of a physician and/or pharmacist practicing in the same or similar community[.]" Moreover, Plaintiff contended hospitalists, Drs. Jenkins, Daud, and Afridi, breached their duties by, *inter alia*: (1) failing to assess, obtain and document accurate information in Pierce's medical records; (2) administering Levaquin to a seventy-six year old woman taking corticosteroids, contradictory to the Levaquin black box warning; (3) failing to recognize other medications were available for Pierce's sickness; (4) increasing the dosage of Pierce's Prednisone while continuing

to prescribe Levaquin; and (5) discharging Pierce with orders to continue giving Levaquin concomitantly with a corticosteroid.

On 9 November 2015, Defendants filed an answer and motion to dismiss Plaintiff's complaint, listing four possible defenses. First, Defendants moved to dismiss, pursuant to Rule 12(b)(6) of the North Carolina Rules of Civil Procedure. Second, Defendants moved to dismiss Plaintiff's complaint, if discovery indicated Plaintiff failed to comply with the requirements of Rule 9(j) of the North Carolina Rules of Civil Procedure. Third, Defendants asserted the actions of the hospitalists complied with the applicable standard of care, and, therefore, the case should be dismissed. Lastly, Defendants contended even if an individual hospitalist acted negligently, such negligence was not the proximate cause of Pierce's injury or death.

While in discovery on 26 January 2016, Plaintiff filed a response to Defendants' motion to dismiss, pursuant to Rule 9(j) of the North Carolina Rules of Civil Procedure. In his response, Plaintiff provided the information of his expert witness, Dr. Paul Genecin. Dr. Genecin is board certified in internal medicine and holds the position of clinical associate professor in the department of internal medicine at Yale School of Medicine. Dr. Genecin works ten months out of the year in a clinical setting and sees patients on a daily basis. He "do[es] all of the direct patient-care activities involved in internal medicine[,]" and serves as an attending physician at Yale Health for the remaining two months of the year. Additionally, Plaintiff averred on 5 March

2014 Plaintiff first contacted Dr. Genecin, who advised Plaintiff's counsel that Defendants' hospitalists violated the standard of care. Dr. Genecin stated he was willing to testify as to those violations.

The trial court entered a Consent Discovery Scheduling Order ("DSO") on 1 March 2016. The trial court issued this DSO to schedule the parties' identification, designation, and discovery of witnesses, pursuant to Rule 26(f1) of the North Carolina Rules of Civil Procedure. Under the order, "[o]n or before May 1, 2016, the Plaintiff shall identify all expert witnesses that may be called to testify at the trial . . . ." On 2 May 2016, Plaintiff designated Dr. Genecin as an expert witness.[4]

On 17 May 2016, Plaintiff deposed Dr. Daud. Dr. Daud stated his specialty as internal medicine and his areas of practice as both internal medicine and as a hospitalist. Additionally, he answered affirmatively when asked if it is common for a hospitalist to have a background in internal medicine. Dr. Daud testified as follows with regard to his role as a hospitalist:

> Q. Can you describe for me your role as a hospitalist at WakeMed? What does a hospitalist do?
>
> A. A hospitalist is a general internist who works typically in the hospital exclusively and takes care of patients that are sick enough to be admitted to the hospital as opposed to a primary care physician that does so in the outpatient clinic setting. We treat a variety of conditions. It could be pneumonia. It could be MI, heart attack, a GI bleed. That's not a comprehensive list, but those are just some examples.

[4] The record lacks any claim by Defendants acknowledging or objecting to Plaintiff's failure to comply with the DSO.

> And then if those problems are felt to be severe enough that they cannot be managed in the outpatient setting, then we take care of those in the hospital.
>
> Q. Okay. Do you manage patients in step-down units from surgical floors?
>
> A. Yes.
>
> Q. And in your role as a hospitalist for those nonsurgical cases where say patients are admitted through the emergency room for general medicine problems like, for example, a UTI, like Ms. Pierce, are you considered as a hospitalist assigned as the attending physician?
>
> A. Yes.
>
> Q. And the attending physician would have the primary responsibility for the overall management and care for the patient?
>
> A. Yes.

On 28 July 2016, Plaintiff deposed Dr. Jenkins. Dr. Jenkins is board certified in internal medicine. When asked about his role as a hospitalist at WakeMed, Dr. Jenkins testified:

> Q[:] Okay. And tell me what role or what duties an admitting physician has . . . .
>
> A[:] Well, the emergency room will call the hospitalist when they have a patient that they either need a consult on or need -- feel need -- needs admission.
>
> So we would go down, we would evaluate the patient, determine whether or not the patient needs to be admitted. If so, to what level of care. Write the orders for that admission. And write the history and physical for the admission.

> Q[:] Does the admitting physician have a duty to do a medication reconciliation?
>
> A[:] That is one of the -- one of the tasks, yes.
>
> Q[:] Okay. And -- and can you explain to me what a -- what a medication reconciliation is?
>
> A[:] Medication reconciliation would be reviewing the home medications, indicating whether they should be continued while in the hospital or discontinued while the patient is in the hospital, as well as writing the orders for any new medications.
>
> Q[:] Okay. Would that also involve reviewing any medications that were started by emergency room physicians in the emergency room when the patient first presented?
>
> A[:] It would, yes.
>
> Q[:] Okay. And I assume in doing a medication reconciliation and evaluating each medication, you would look at the risks versus the benefits of that medication for the particular patient?
>
> A[:] That's correct.

Additionally, Dr. Jenkins admitted to knowing, on the date of Pierce's admission to the hospital, Levaquin's and fluoroquinolones's association with problems such as tendon rupture.

On the same day, Plaintiff deposed Dr. Afridi, with substantially the same line of questioning as Dr. Jenkins. Dr. Afridi is board certified in internal medicine. Dr. Afridi supported Dr. Jenkins's testimony as to a hospitalists role, stating "Most of us

[hospitalists] are internal medicine physicians. And we take care of the patients who are admitted and are acutely sick . . . . And pretty much our practice is limited to the hospital medicine." Further, Dr. Afridi answered affirmatively when asked if following assumed care of a patient it "would have been [his] job or responsibility to ensure that proper medications were administered[.]"

On 3 January 2017, Plaintiff deposed Dr. Genecin for trial. When cross-examined as to his job responsibilities, the following exchange occurred:

> Q[:] So would you agree with me that your practice, given that you practice as an attending in the hospital two months out of the year and that Drs. Jenkins or Afridi and Daud do that 12 months out of the year, would you agree with me that your practice is different from theirs?
>
> A[:] Yes, my practice scope is broader, but it includes what the practice scope is of Drs. Jenkins, Daud, and Afridi within the scope of what I practice.

When further asked to differentiate his position with a hospitalist, Dr. Genecin stated:

> [t]here's no difference in the duty and standard of care. And I teach hospitalists. Many of my residents leave residency training and do years of work as a hospitalist on route to whatever is their next step in their career. But the standard of care is -- with respect to obligations to the patient, are the same.

While testifying to the cause of Pierce's injuries, Dr. Genecin presented conflicting testimony during direct and cross examination. During direct examination, Dr. Genecin asserted:

> Q[:] Okay. Doctor, I'm going to ask you about -- in this case, do you have an opinion as to -- that is a[n] opinion to a reasonable degree of medical certainty and one that's satisfactory to yourself, as to whether or not the prescription of Levaquin caused an injury to Ms. Pierce?
>
> A[:] Yes.
>
> …
>
> That Levaquin was the cause of the tendon rupture that Mrs. Pierce had . . . . And that's the – a preventable complication that she suffered.

Later in direct examination, Dr. Genecin again stated his opinion: "That she suffered a tendon rupture as a consequence of unsafe use of Levaquin because of her age and corticosteroid use."

However, during cross examination, Dr. Genecin stated:

> Q[:] . . . Would you agree with me that all you can say, with respect to any connection between the Levaquin and the resulting injury to Ms. Pierce, is that if the Levaquin had been stopped by either Drs. Jenkins, Daud, or Afridi, that all that would have done would have been to reduce the risk or, say it another way, improve her chances of avoiding an Achilles tendon rupture?
>
> A[:] That's true.

Dr. Genecin further testified Levaquin is a prescription antibiotic belonging to a class of drugs known as Quinolones or Fluoroquinolones. Levaquin may be administered orally or intravenously in the hospital. The U.S. Food & Drug Administration ("FDA") mandated Levaquin include a "boxed warning" or "black box

warning." The box warning on Levaquin, in place at the time relevant to this case, read:

> Fluoroquinolones, including Levaquin, are associated with an increased risk of tendinitis and tendon rupture in all ages. This risk is further increased in older patients usually over 60 years of age, in patients taking corticosteroid drugs, and in patients with kidney, heart or lung transplants. In addition, it may exacerbate muscle weakness in people with a disease called myasthenia gravis and should be avoided in those cases.

(quotation marks omitted). Dr. Genecin asserted:

> The boxed warning is the highest level of warning. It's the highest level of concern. It's higher than a contraindication or a warning or a precaution. It's: Please pay attention; there's a red light here; you can harm a patient by giving them this drug under these circumstances. And that's what a boxed warning means.

Further, WakeMed's medication delivery software contained a "pop up" for those requesting Levaquin or levofloxacin with the following warning: "Concurrent use of quinolones and corticosteroids may increase the risk of tendinitis and/or tendon rupture. This effect is most common in the Achilles tendon . . . ."

On 17 January 2017, Defendants filed a Motion for Summary Judgment, pursuant to Rule 56 of the North Carolina Rules of Civil Procedure. In support of the motion, Defendants asserted Dr. Genecin "negated the essential element of causation for the allegations of negligence[.]"

On 1 February 2017, Defendants filed a motion to disqualify Dr. Genecin as an expert witness. Defendants contended, pursuant to Rule 702(b) of the North Carolina Rules of Evidence, Dr. Genecin lacked the proper qualifications to render an opinion on the standard of care applicable to a hospitalist. Defendants supported their arguments by distinguishing between a hospitalist's full time work in a hospital and the majority of Dr. Genecin's time spent as a clinical practitioner.

On 3 February 2017, Plaintiff filed a notice of partial voluntary dismissal without prejudice, dismissing the wrongful death allegations within the complaint. The trial court held hearings on the parties' motions on 3 and 6 February 2017.

In an order entered 13 February 2017, the trial court concluded "Dr. Genecin does not meet the requirements of Rule 702(b)[,]" and granted Defendants' motion to disqualify Dr. Genecin as an expert witness. Accordingly, the court prohibited Dr. Genecin "from providing opinion testimony at the trial of this matter, as to the alleged negligence of WakeMed's employee-hospitalists." In a second order entered the same day, the court also concluded "This case is of the nature that requires expert testimony to establish Plaintiff's claims of alleged negligence on the part of WakeMed's hospitalists; and . . . . [w]ithout any such expert testimony being offered by the Plaintiff, Defendants are entitled to summary judgment[.]" Accordingly, the court granted Defendants' motion for summary judgment.

In another order entered 20 February 2017, the court concluded "Dr. Genecin's testimony [is] legally insufficient on the issue of proximate causation[.]" Consequently, Plaintiff failed to provide "a sufficient forecast" of evidence on the issue of proximate causation. The court granted Defendants' motion for summary judgment. Plaintiff filed timely notice of appeal.

II. Standard of Review

" 'Ordinarily, whether a witness qualifies as an expert is exclusively within the discretion of the trial judge.' " *FormyDuval v. Bunn*, 138 N.C. App. 381, 385, 530 S.E.2d 96, 99 (2000) (brackets omitted) (quoting *State v. Underwood*, 134 N.C. App. 533, 541, 518 S.E.2d 231, 238 (1999)). "However, where an appeal presents questions of statutory interpretation, full review is appropriate, and a trial court's conclusions of law are reviewable *de novo*. *Id.* at 385, 530 S.E.2d at 99 (citation omitted). "Under *de novo* review, we consider the matter anew and substitute our judgment for that of the trial court." *Westmoreland v. High Point Healthcare, Inc.*, 218 N.C. App. 76, 79, 721 S.E.2d 712,716 (2012) (citation omitted).

Moreover, " '[w]e review a trial court's ruling on summary judgement *de novo*.' " *Grantham v. Crawford*, 204 N.C. App. 115, 117 (2010) (quoting *Barringer v. Wake Forest Univ. Baptist Med. Ctr.*, 197 N.C. App. 238, 246, 677 S.E.2d 465, 472 (2009)). "When reviewing the evidence on a motion for summary judgment, we review evidence presented in the light most favorable to the non-moving party." *Seraj v.*

Duberman, ___ N.C. App. ___, ___, 789 S.E.2d 551, 557 (2016) (citing *Summey v. Barker*, 357 N.C. 492, 496, 586 S.E.2d 247, 249 (2003)).

III. Analysis

We review Plaintiff's contentions in two parts: (A) whether the trial court erred in granting the motion to disqualify Dr. Genecin as an expert and, consequently, erred in granting summary judgment due to absence of expert testimony to establish negligence; and (B) whether the trial court erred in granting summary judgment due to lack of evidence of proximate causation.

A. Whether the trial court erred in granting Defendant's motion to disqualify Dr. Genecin and in granting summary judgment due to absence of expert testimony to establish negligence.

i. Dr. Genecin's Qualifications under Rule 702(b)

Rule 702(b) "is designed to protect the defendant from being compared with the higher standard of care required from one who holds himself out as an expert in the field." *FormyDuval*, 138 N.C. App. at 390, 530 S.E.2d at 102 (citations omitted). Rule 702(b) provides, in pertinent part:

> (b) In a medical malpractice action . . . a person shall not give expert testimony on the appropriate standard of health care . . . unless the person is a licensed health care provider in this State or another state and meets the following criteria:
>
> > (1) If the party against whom or on whose behalf the testimony is offered is a specialist, the expert witness must:

> a. Specialize in the same specialty as the party against whom or on whose behalf the testimony is offered; or
>
> b. Specialize in a similar specialty which includes within its specialty the performance of the procedure that is the subject of the complaint and have prior experience treating similar patients.
>
> (2) During the year immediately preceding the date of the occurrence that is the basis for the action, the expert witness must have devoted a majority of his or her professional time to either or both of the following:
>
> a. The active clinical practice of the same health profession in which the party against whom or on whose behalf the testimony is offered, and if that party is a specialist, the active clinical practice of the same specialty or a similar specialty which includes within its specialty the performance of the procedure that is the subject of the complaint and have prior experience treating similar patients; or
>
> b. The instruction of students in an accredited health professional school or accredited residency or clinical research program in the same health profession in which the party against whom or on whose behalf the testimony is offered, and if that party is a specialist, an accredited health professional school or accredited residency or clinical research program in the same specialty.

N.C. R. Evid. 702(b) (2017).

Therefore, Plaintiff's expert must be "of the same specialty [as Defendants' hospitalists] or a similar specialty which includes within its specialty the performance[.]" *Id.* *See Edwards v. Wall*, 142 N.C. App. 111, 542 S.E.2d 258, (2001). Additionally, Plaintiff's expert must have devoted the majority of his professional time to either: (1) the active clinical practice of hospitalists' purported specialty or similar specialty; or (2) the instruction of students in the same or similar specialty. N.C. R. Evid. 702(b)(2)(a)-(b). For the purposes of Rule 702(b), this Court defines a "specialist" as "a doctor who is either board certified in a specialty or who holds himself out to be a specialist or limits his practice to a specific field of medicine[.]" *FormyDuval*, 138 N.C. App. at 388, 530 S.E.2d at 101.

The parties do not contest Drs. Jenkins, Afridi, Daud, and Genecin all hold board certifications in internal medicine. However, Defendants contend hospitalists, who are board certified in internal medicine and who practice only in a hospital setting, are of a distinct specialty. This is opposed to a physician, who is board certified in internal medicine and who does not solely practice in a hospital setting.

To support this argument, Defendants rely on this Court's decision in *FormyDuval*. There, this Court distinguished between the defendant, a general practitioner, and the expert at issue, an emergency room physician who "h[eld] himself out to be such a specialist and largely limit[ed] his practice to that specialty." *Id.* at 390, 530 S.E.2d at 102. This Court affirmed the trial court, noting a specialist

may not testify against a general practitioner. *Id.* at 390, 530 S.E.2d at 102. In distinguishing the two practitioners, this Court held the language of Rule 702(b) to be unambiguous, stating "only general practitioners are allowed to testify against general practitioners. Specialists, who are more qualified than general practitioners, may testify only against other specialists." *Id.* at 390, 530 S.E.2d at 102.

In asserting *FormyDuval* is analogous to the instant case, Defendants draw a tenuous correlation between the comparison of a general practitioner and specialist and the comparison of a specialist and another specialist. This Court acknowledged a general practitioner is defined as a "physician whose practice covers a variety of medical problems in patients of all ages." *Id.* at 387, 530 S.E.2d at 101 (citation and quotation marks omitted). In the case at bar, Dr. Genecin testified he "do[es] all of the direct patient-care activities involved in *internal medicine practice*." (emphasis added). Further, "a physician who 'holds himself out as a specialist' must be regarded as a specialist, even though not board certified in that specialty." *FormyDuval*, 138 N.C. App. at 388, 530 S.E.2d at 101 (citation omitted). Defendants' hospitalists may be regarded as specialists, as they have held themselves out to be such specialists. However, recognition of a hospitalists as a specialist does not disqualify Plaintiff's expert from being a similar specialist. Rather, Dr. Genecin, through his testimony, has emphasized his practice, like Defendants' hospitalists, is specialized towards internal medicine. Further, Dr. Genecin, as a clinical associate professor of internal

medicine, teaches individuals who go onto specialize as hospitalists. Therefore, we conclude Dr. Genecin, by holding himself out to be a specialist of internal medicine, is of a similar specialty to Defendants' hospitalists. ii. Dr. Genecin's Practice Setting and Medical Procedures

Claims of medical malpractice are *sui generis*, and, therefore, each claim must be confined to its own facts. Rule 702(b)(1) requires not only an expert witness "specialize in a similar specialty" but requires the specialty to "include[ ] within its specialty the performance of the procedure that is the subject of the complaint and have prior experience treating similar patients." N.C. R. Evid. 702(b)(1). Defendants contend Dr. Genecin needed to have spent a majority of his time practicing in a hospital setting to have the requisite expertise necessary to serve as an expert witness. We disagree. Our inquiry into this contention is two-fold: (1) Dr. Genecin's practice setting; and (2) requisite expertise for an expert witness.

(1) Practice Setting

This Court held the physician expert and physician defendant need not work in exactly the same practice setting in *Edwards v. Wall* and *Sweatt v. Wong*, 145 N.C. App. 33, 549 S.E.2d 222 (2001). *See also Roush v. Kennon*, 188 N.C. App. 570, 656 S.E.2d 603 (2008).

In *Edwards*, plaintiff brought suit against pediatricians who failed to diagnose plaintiff's acute appendicitis prior to the rupture of her appendix. 142 N.C. App. at

112, 542 S.E.2d at 260-61. Plaintiff designated Dr. Marvin Ament as an expert witness in pediatrics to testify as to defendants' alleged violation of the standard of care. *Id.* at 112-13, 542 S.E.2d at 261. Plaintiff tendered Dr. Ament as an expert in pediatrics and pediatric gastroenterology. *Id.* at 113, 542 S.E.2d at 261. The trial court concluded Dr. Ament, as a professor at UCLA Medical School, "[wa]s a specialist specializing in the field of pediatric gastroenterology" while defendants' medical malpractice was in "the general practice of pediatrics." *Id.* at 116, 542 S.E.2d at 263. Subsequently, the trial court concluded Dr. Ament was not qualified to testify as an expert and granted defendants a directed verdict. *Id.* at 113, 542 S.E.2d at 261. This Court reversed, stating:

> We have found no case law in this state holding that Rule 702 requires that the physician expert and the physician defendant work in exactly the same practice setting, as contended by defendants. Similarly, Rule 702 does not require that a physician, who specializes in pediatrics, be prepared to prove the percentages of each type of ailment that he treats within his practice.

Id. at 117-18, 542 S.E.2d at 264.

This Court again refused to require a physician expert and physician defendant have the same work setting in *Sweatt*. 145 N.C. App. 33, 549 S.E.2d at 222. In *Sweatt*, the jury found defendants, Dr. She Ling Wong and Dr. Eugene Stanton, negligent in the care and diagnosis of plaintiff. *Id.* at 34-35, 549 S.E.2d at 223. Plaintiff experienced adnominal pain, which a doctor later diagnosed as multiple

gallstones and "possible acute cholecystitis." *Id.* at 35, 549 S.E.2d at 223. The emergency room admitted plaintiff as a patient and performed surgery. *Id.* at 35, 549 S.E.2d at 223. Defendant Dr. Wong performed surgery and reported the surgery had gone well, but plaintiff's condition continued to worsen. *Id.* at 35, 549 S.E.2d at 223. At trial, Dr. Stanton, who also treated plaintiff, testified he believed plaintiff had an abdominal abscess, yet took no action to treat the infection. *Id.* at 35, 549 S.E.2d at 223. Subsequently, another doctor determined plaintiff needed an emergency laparotomy,[5] which he performed later that day. *Id.* at 35, 549 S.E.2d at 223.

At trial, plaintiff called Dr. David Wellman, a general surgeon certified in laparoscopic procedures. *Id.* at 36, 549 S.E.2d at 224. Dr. Wellman, director of the emergency department at Duke University Medical Center, "examined and diagnosed patients who . . . presented signs and symptoms similar to those of [plaintiff]." *Id.* at 36, 549 S.E.2d at 224. Defendants argued Dr. Wellman was not qualified to testify against defendants, since they were general surgeons, and Dr. Wellman specialized in emergency medicine. *Id.* at 36-38, 549 S.E.2d at 223-25. However, because Dr. Wellman's active clinical practice caused him to engage in the same diagnostic procedures as defendants, this Court affirmed Dr. Wellman's qualifications to testify as an expert witness. *Id.* at 38, 549 S.E.2d at 225.

[5] A laparotomy is a surgical procedure used to explore a patient's abdomen for diagnosis or in preparation for surgery.

Here, Dr. Genecin practices in a clinical setting ten months out of the year and in a hospital setting two months out of the year. He practices in the overall management and care of a patient, which includes prescribing medications and obtaining medical consultations or medical specialists. Additionally, Drs. Afridi, Jenkins, and Daud testified the overall management and care of a patient falls within their duties as hospitalists. Similar to the expert in *Sweatt*, Dr. Genecin engages in the same medical actions as in Plaintiff's complaint. *Id.* at 38, 549 S.E.2d at 225. Therefore, Dr. Genecin's qualification as an expert witness is not determined by the fact he does not solely practice in a hospital setting, contrary to Defendants' contention.

(2) Requisite Expertise

This Court held an expert witness's failure to possess knowledge and experience with the procedures of a specific specialty as grounds for expert disqualification in *Allen v. Carolina Permanente Medical Group., P.A.,* 139 N.C. App. 342, 533 S.E.2d 812 (2000). In *Allen*, plaintiff contended defendant, board certified in family medicine and working in an Urgent Care facility, actually practiced as a general practitioner or in emergency medicine. *Id.* at 349, 533 S.E.2d at 816. There, plaintiff's expert witness, a general surgeon, did not qualify as an expert witness against defendant because he lacked knowledge and experience with the procedures of the family practitioner. *Id.* at 349, 533 S.E.2d at 816. When asked about the

patient's care, the expert, a general surgeon, answered, "I have an opinion as to how [the patient] possibly could have been treated, but as far as the way [the patient] should have been, again it falls in the expertise out of my field." *Id*. at 350, 533 S.E.2d at 816-17 (emphasis omitted). Accordingly, the requisite experience necessary for an expert witness will be determined by knowledge and experience of the procedures in dispute, and knowledge of the relevant standard of care owed to a given plaintiff.

Here, Defendants contend Dr. Genecin is not qualified as an expert due to his inexperience in administering intravenous medication. However, the use of an intravenous medication is not at issue in the present case. Rather, the issue is rooted in the selection of medication, subsequent prescription of medication, and alleged failure to mind potential drug interactions. Dr. Genecin's experience prescribing medication and recognizing how pharmaceutical drugs interact with one another is apparent by his teaching position and patient care activities in the clinical setting.

Additionally, Dr. Genecin is capable of providing testimony regarding the relevant standard of care in the instant case. Our review of the record indicates Dr. Genecin testified, during his deposition, to the applicable standard of care Defendants owed to Pierce in this case. Unlike *Allen*, where the general surgeon could not speak to the standard of care, Dr. Genecin is able to testify regarding the standard of care owed to Pierce. *Allen*, 139 N.C. App. at 350, 533 S.E.2d at 816-17. Further, Dr.

Genecin is willing to testify Defendants breached the standard of care owed to Plaintiff, and how the breach occurred.

Even though Dr. Genecin does not share the exact specialty with Defendants' hospitalists, he is experienced in the procedures performed by Drs. Afridi, Jenkins, and Daud and can testify as to their actions as hospitalists. Thus, we conclude Dr. Genecin qualifies as an expert in this case, based on his familiarity and experience in the actions taken by Defendants' hospitalists, and ability to speak to the relevant standard of care. We, therefore, conclude the trial court erred in disqualifying Dr. Genecin as Plaintiff's expert witness. Because we conclude the trial court erred in disqualifying Dr. Genecin, we vacate the trial court's grant of summary judgment due to absence of expert testimony to establish negligence.

B. Whether the trial court erred in granting summary judgment due to lack of evidence of proximate causation.

Lastly, Plaintiff contends the trial court erred in granting summary judgment due to lack of evidence of proximate causation. Specifically, Plaintiff contends Dr. Genecin's deposition testimony was sufficient evidence of proximate causation to withstand Defendants' motion for summary judgment. We agree.

For a medical malpractice action, a plaintiff must present evidence of the following elements: (1) the applicable standard of care; (2) a breach of such standard of care by defendant; (3) the injuries suffered by plaintiff were proximately caused by such breach; and (4) damages resulting to plaintiff. *Purvis v. Moses H. Cone Mem'l*

Hosp. Serv. Corp., 175 N.C. App. 474, 477, 624 S.E.2d 380, 383 (2006) (citation omitted). "To forecast evidence of proximate causation in a medical malpractice action, expert testimony is needed." *Seraj*, ___ N.C. App. at ___, 789 S.E.2d at 558 (citing *Cousart v. Charlotte-Mecklenburg Hosp. Auth.*, 209 N.C. App. 299, 303, 704 S.E.2d 540, 543 (2011)). "While proximate cause is often a factual question for the jury, evidence 'based merely upon speculation and conjecture . . . is no different than a layman's opinion, and as such, is not sufficiently reliable to be considered competent evidence on issues of medical causation.' " *Cousart*, 209 N.C. App. at 303, 704 S.E.2d at 543 (ellipses in original) (quoting *Gaines v. Cumberland Cty. Hosp. Sys., Inc.*, 203 N.C. App. 213, 219, 692 S.E.2d 119, 123 (2010)).

When comparing an expert's testimony on direct and cross examination, our Court considered whether the testimony on cross examination "nullif[ied]" the direct examination testimony. *Matthews v. Food Lion, Inc.*, 135 N.C. App. 784, 787, 522 S.E.2d 587, 589-90 (1999). *See also Springs v. City of Charlotte*, 209 N.C. App. 271, 278-79, 704 S.E.2d 319, 324-25 (2011). To determine if direct examination is nullified, we consider whether the witness recanted, corrected, or contradicted his opinion on direct examination. *Springs*, 209 N.C. App. at 279, 704 S.E.2d at 325; *Matthews*, 135 N.C. App. at 787, 522 S.E.2d at 589-90.

While it may be true Dr. Genecin's testimony on cross examination, alone, would be insufficient evidence, that portion of his deposition is not the only testimony

regarding causation. *Cf. White v. Hunsinger*, 88 N.C. App. 382, 386, 363 S.E.2d 203, 206 (1988) (citations omitted) (stating "proximate cause in a malpractice case requires more than a showing that a different treatment would have improved the patient's chances of recovery"). On direct examination, Dr. Genecin unequivocally opined, twice, Pierce's injuries were proximately caused by Defendants' actions. Viewing the evidence in the light most favorable to Plaintiff, the nonmoving party, Dr. Genecin's testimony on cross examination did not recant, contradict, or correct his opinion on direct examination. *Springs*, 209 N.C. App. at 278, 704 S.E.2d at 325; *Matthews*, 135 N.C. App. at 787, 522 S.E.2d at 589-90.

Defendants contend reversal would run afoul of the rule "that a party opposing a motion for summary judgment cannot create a genuine issue of material fact by filing an affidavit contradicting his prior sworn testimony." *Pinczkowski v. Norfolk S. Ry. Co.*, 153 N.C. App. 435, 440, 571 S.E.2d 4, 7 (2002) (citations omitted). We disagree. This rule exists because "[i]f a party who has been examined at length on deposition could raise an issue of fact simply by submitting an affidavit contradicting his own prior testimony, this would greatly diminish the utility of summary judgment as a procedure for screening out sham issues of fact." *Mortg. Co. v. Real Estate, Inc.*, 39 N.C. App. 1, 9-10, 249 S.E.2d 727, 732 (1978) (quotation marks and citation omitted). Unlike in the cases cited by Defendants, Plaintiff, here, did not file a

contrasting statement when faced with a motion for summary judgment. *Cf. Cousart*, 209 N.C. App. at 306-07, 704 S.E.2d at 545 (citation omitted).

We conclude Plaintiff presented sufficient evidence of proximate causation to withstand Defendants' motion for summary judgment. Accordingly, we reverse the trial court's grant of summary judgment due to lack of evidence of proximate causation.

IV. Conclusion

For the foregoing reasons, we reverse the trial court's order disqualifying Dr. Genecin as Plaintiff's expert witness and vacate the trial court's grant of summary judgment due to lack of expert testimony. We also reverse the trial court's order granting summary judgment due to lack of evidence of proximate causation. Accordingly, we remand for further proceedings.

REVERSED IN PART; VACATED IN PART; REMANDED.

Judges ELMORE and DIETZ concur.

Report per Rule 30(e).