DOCKET NO. CV-18-6086626-S	:	STATE OF CONNECTICUT
	:	
THOMAS AND RONEE COWEN,	:	SUPERIOR COURT
CO-ADMINISTRATORS OF THE	:	
ESTATE OF JUSTIN COWEN	:	JUDICIAL DISTRICT OF NEW HAVEN
	:	
V.	:	AT NEW HAVEN
	:	
YALE NEW HAVEN MEDICAL	:	
CENTER, INC., ET AL.	:	JUNE 10, 2024

MEMORANDUM OF DECISION
MOTION TO PRECLUDE (#237)

STATEMENT OF CASE AND PROCEDURAL HISTORY

The plaintiffs filed this medical malpractice action alleging that the defendants[1], through its neurosurgeon, Dr. DiLuna and other physicians failed to correctly diagnose and treat their son, Justin Cowen's malignant cervical osteosarcoma[2] in April 2015, leading to his untimely death on August 3, 2016 at the age of 13. The plaintiffs allege that the defendants erroneously assumed that Justin's cervical tumor was a benign osteoblastoma/osteoid osteoma[3] and hastily proceeded

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[1]The plaintiffs initially brought suit against Yale-New Haven Hospital, Yale University a/k/a Yale University Medical Center, Dr. Michael DiLuna, Dr. Jose Costa and Dr. Alexander Vortmeyer. The plaintiffs voluntarily withdrew the suit against the individual doctors and only the institutional defendants remain.

[2]Osteosarcoma is a cancer of the bone that usually affects the large bones of the arm or leg. It occurs most commonly in young people and affects more males than females. Also called osteogenic sarcoma. National Cancer Institute (NCI) https://www.cancer.gov/publications/dictionaries/cancer-terms/def/osteosarcoma

[3]Osteoblastoma is a type of bone tumor. It's nearly always benign (not cancer) but may cause pain or swelling. The bone tumor also increases your risk of fractures. Treatment always includes surgery to remove the mass. Some types of osteoblastoma may grow back after removal, especially if your provider could not remove the entire tumor. Osteoid osteoma is a noncancerous tumor in your long bones. This tumor often occurs in your shin and thigh bones. Providers diagnose these tumors with x-rays and bone scans. Osteoid osteomas may go away on their own. Providers also treat them with NSAIDs or surgery. Once treated, people with an osteoid osteoma usually live long, full lives. Cleveland Clinic,

with a piecemeal resection of the tumor, which deprived Justin of proper treatment and surgery causing the cancer to spread and costing Justin his life. In the operative complaint dated April 18, 2022, the plaintiffs allege that the defendants were negligent in that they:

"(a) Failed to adequately and properly care for, treat, diagnose, monitor and supervise Justin Cowen for a malignant spine tumor;

"(b) Failed to properly operate on a spinal tumor that had the potential of being a highly malignant tumor that needed to be treated with chemotherapy prior to a definitive surgery for its removal;

"(c) Failed to biopsy the tumor and obtain a definitive diagnosis prior to planning and/or performing surgery;

"(d) Failed to perform an en bloc resection (total removal) of a properly diagnosed and treated tumor of the cervical spine;

"(e) Failed to make the correct diagnosis of the tumor type (osteosarcoma) based on frozen section of tissue obtained during surgery;

"(f) Failed to inform and/or warn the neurosurgeon that a definitive and/or conclusive diagnosis of a benign tumor could not have been made on the frozen section tissue sample submitted to pathology;

"(g) Failed to make the correct pathologic diagnosis and/or correct its prior misdiagnosis, even after reviewing and analyzing the permanent sections';

"(h) Failed to recognize that Justin Cowen's continuing severe post-operative pain was

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https://my.clevelandclinic.org/health/diseases/22405-osteoid-osteoma
https://my.clevelandclinic.org/health/diseases/22400-osteoblastoma.

due to active growth of the residual tumor;

(i) Failed to adequately diagnose the cause of and to treat the pain Justin Cowen suffered from in the post-operative period dismissing the complaints as “anxiety and muscle spasm”;

“(j) Failed to recognize continued tumor progression in the post-operative period;

“(k) Failed to perform an en bloc removal of the tumor from the cervical spine;

“(1) Failed to provide physicians and surgeons who possessed the requisite knowledge, skill and experience to adequately and properly care for, treat, diagnose, monitor and supervise patients such as Justin Cowen;

“(m) Failed to stop the surgery when a definitive diagnosis of a benign condition was not given by the pathologist after reviewing material sent to pathology from Justin Cowen’s surgery;

“(n) Failed to recognize that Justin Cowen’s continuing severe post-operative pain was due to active regrowth of the residual tumor;

“(o) Failed to recognize that bone with malignant cells taken from the surgery could not be placed back into the surgical bed as fusion material (autograft);

“(p) Failed to obtain a contrast enhanced MRI on or about May 13, 2015 when evaluating Justin Cowen for worsening pain in the post-operative period; and

“(q) Failed to properly inform the Plaintiffs of the neurosurgeon’s actual experience in treating tumors of this type and whether he could adequately and properly care for, treat, diagnose, monitor and supervise patients such as Justin Cowen. Instead, the neurosurgeon knowingly misrepresented to the Plaintiffs that he had operated on several of these types of

tumors when in fact this type of pathology is very rare in the cervical spine and he likely had limited to no experience with them. This was a statement Plaintiffs relied on to their detriment. Pl. Second Am. Compl. Cts. 1-2, ¶ 8 (a) - (q).

On January 6, 2023, the plaintiffs disclosed Dr. Thomas Scharschmidt, an orthopedic surgeon, as an expert in this case. (Docket Entry No. 223). Dr. Scharschmidt was disclosed to testify on the standard of care as to Dr. DiLuna regarding the order of treatment provided to the plaintiffs' decedent and that a different course of treatment would have facilitated a complete resection of the subject tumor. More specifically, Dr. Scharschmidt was disclosed to testify that "the order of treatment provided to Justin Cowen should have been: (1) tissue diagnosis, (2) neoadjuvant chemotherapy, (3) surgery, and (4) chemotherapy. Dr. Scharschmidt was also disclosed to testify that Justin's case should have been discussed at an interdisciplinary meeting in order to determine how to establish the correct diagnosis and the most effective treatment plan; that if Justin Cowen's tumor was properly diagnosed the course of treatment would have included the administration of neoadjuvant chemotherapy followed by surgery of the tumor and then additional chemotherapy. This course of treatment would, more likely than not, have facilitated a complete resection of the subject tumor and the Plaintiff would more likely than not have survived. Dr. Scharschmidt will further testify that the survival rate decreased once the surgical field was contaminated from the resection of a high-grade tumor." Pl. Discl. Expert, Docket No. Entry 223. Dr. Scharschmidt was also disclosed to testify on causation.

On May 30, 2023, Dr. Scharschmidt was deposed. On December 8, 2023, the defendants, Yale University a/k/a Yale University School of Medicine and Yale New Haven Hospital, Inc., filed a motion for an order precluding Dr. Scharschmidt, from testifying at trial regarding the

standard of care applicable to Dr. Michael DiLuna, a neurosurgeon. The defendants argue that Dr. Scharschmidt's testimony is inadmissible because, as an orthopedic surgeon, he is not a "similar healthcare provider" as required by General Statutes § 52-184c and otherwise lacks the requisite expertise and training to testify as to the standard of care of a neurosurgeon.

On January 31, 2024, the plaintiffs filed an objection to the motion to preclude. The plaintiffs argue that Dr. Schaschmidt's testimony is admissible as he possesses the necessary training, experience, and knowledge to be able to testify as to the standard of care of a neurosurgeon in accordance with Connecticut General Statutes § 52-184c (d) (2).

The court heard oral argument on the motion on February 9, 2024.

LEGAL ANALYSIS

"The decision to preclude a party from introducing expert testimony is within the discretion of the trial court. . . . On appeal, that decision is subject only to the test of abuse of discretion. . . . [T]he testimony of an expert witness is necessary to establish both the standard of proper professional skill or care . . . and that the defendant failed to conform to that standard of care. . . . In order to render an expert opinion, the witness must be qualified to do so and there must be a factual basis for the opinion. . . . The standard of care required to be established and the qualifications of expert witnesses who may testify to establish that standard, in claims for damages alleged to have been caused by the negligence of a health care provider, are controlled by . . . § 52-184c. Whether a witness is qualified to testify as an expert is a matter that rests in the sound discretion of the trial court. . . . [Our Appellate Court] has consistently held that the trial court's exercise of that discretion will not be disturbed unless it has been abused or the error is clear and involves a misconception of the law. . . .

“[T]he test for admissibility of expert testimony involves, inter alia, a determination as to whether the witness has a special skill or knowledge directly applicable to a matter in issue. . . . (Emphasis in original; internal quotation marks omitted.) *Sherman* v. *Bristol Hospital, Inc.*, 79 Conn.App. 78, 85, 828 A.2d 1260 (2003); see also *Hayes* v. *Decker*, 263 Conn. 677, 683, 822 A.2d 228 (2003) (‘[e]xpert testimony should be admitted when: [1] the witness has a special skill or knowledge directly applicable to a matter in issue, [2] that skill or knowledge is not common to the average person, and [3] the testimony would be helpful to the court or jury in considering the issues’ [internal quotation marks omitted]); *Siladi* v. *McNamara*, 164 Conn. 510, 513, 325 A.2d 277 (1973) (‘Generally, expert testimony may be admitted if the witness has a special skill or knowledge, beyond the ken of the average juror, that, as properly applied, would be helpful to the determination of an ultimate issue. . . . The special skill or knowledge, however, must be directly applicable to the matter specifically in issue.’ [Citation omitted.]).

“Additionally, in medical malpractice cases specifically, ‘[a] trial court evaluating a prospective expert’s qualifications to testify in a medical malpractice action must either decide that the expert is either a similar health care provider as defined by subsections (b) or (c) of § 52-184c, *or* make a discretionary determination [pursuant to § 52-184c (d)] that, to the satisfaction of the court, [the expert] possesses sufficient training, experience and knowledge as a result of the practice or teaching in a related field of medicine, so as to be able to provide such expert testimony as to the prevailing professional standard of care in a given field of medicine. Such training, experience or knowledge shall be as a result of the active involvement in the practice or teaching of medicine within the five-year period before the incident giving rise to the claim.’ (Emphasis in original; internal quotation marks omitted.) *Bennett* v. *New Milford*

Hospital, Inc., 300 Conn. 1, 15, 12 A.3d 865 (2011).

"Section 52-184c sets forth four distinct, yet closely intertwined subsections. Section 52-184c (a) requires the plaintiff to prove, by a preponderance of the evidence, that the defendant breached the 'prevailing professional standard of care for that health care provider. . . .' That subsection then defines the 'prevailing professional standard of care for a given health care provider [as] that level of care, skill and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers.' . . . To testify as an expert, the health care provider must qualify as a similar health care provider under subsection (b) or (c), or, if he is not a similar health care provider, must satisfy the court under subsection (d) that he has sufficient training, practice, and knowledge including practice or teaching within the five-year period to qualify. . . . The statute defines 'similar health care provider' in two ways, depending on whether the defendant health care provider is a specialist or a nonspecialist. For specialists, a similar health care provider is defined by § 52-184c (c) as someone who '(1) is trained and experienced in the same specialty; and (2) is certified by the appropriate American board in the same specialty.' For nonspecialists, a similar health care provider is defined by § 52-184c (b) as someone who '(1) is licensed by the appropriate regulatory agency of this state . . . and (2) is trained and experienced in the same discipline or school of practice and such training and experience shall be as a result of the active involvement in the practice or teaching of medicine within the five-year period before the incident giving rise to the claim.' Section 52-184c (d) provides a 'catch all' provision for experts who do not qualify as a 'similar health care provider' under subsection (b) or (c). Under subsection (d) (2), a health care provider may testify if he 'possesses sufficient training,

experience and knowledge as a result of practice or teaching in a related field of medicine, so as to be able to provide such expert testimony as to the prevailing standard of care in a given field of medicine. Such training, experience or knowledge shall be as a result of the active involvement in the practice or teaching of medicine within the five-year period before the incident giving rise to the claim.' General Statutes § 52-184c (d) (2)." (Citations omitted; emphasis in original; internal quotation marks omitted.) *Ruff* v. *Yale New Haven Hospital, Inc.*, 72 Conn.App. 699, 712, 161 A.3d 552 (2017).

Our Supreme Court has explained that the provisions of § 52-184c "have done nothing to abrogate the fundamental requirement . . . that an expert testifying about the standard of care must know what that standard is in a particular situation. . . . [T]he requirements under § 52-184c (d) do not affect the trial court's discretion to determine whether a proffered expert is qualified to testify as an expert. See Conn. Code Evid. §§ 1-320 and 7-2 . . . . Indeed, § 52-184c merely sets out minimum qualification standards for experts in medical malpractice cases. Thus, a trial court that permits a physician to testify as an expert without first determining whether he or she has a sufficient basis for knowing the 'prevailing' standard of care is abdicating its evidentiary gatekeeping responsibilities." (Citations omitted; footnotes altered.) *Grondin* v. *Curi*, 262 Conn. 637, 656–57, 817 A.2d 61 (2003).

The plaintiffs conceded during oral argument that Dr. Scharschmidt does not satisfy the requirements of General Statutes § 52-184c (c). He is neither "trained and experienced" in neurosurgery nor "certified by the appropriate American Board in the same specialty" of neurosurgery. Thus, Dr. Scharschmidt does not qualify as a similar healthcare provider as to Dr. DiLuna, a neurosurgeon, as defined by § 52-184c (c). Therefore, in order to testify on the

standard of care, this court must find that Dr. Scharschmidt meets the criteria set forth in § 52-184c (d) (2).

Dr. Scharschmidt is board-certified in orthopedics and practices as an orthopedic surgical oncologist. Dr. Scharschmidt obtained his board certification in orthopedic surgery by the American Board of Orthopedic Surgeons in July 2011. Dr. Scharschmidt is a full professor in orthopedic oncology who regularly treats patients with musculoskeletal cancers. He is fellowship trained in both orthopedic oncology and spine surgery and he is the director of the Pediatric Orthopedic Oncology Program at Nationwide Children's Hospital and an Associate Professor in Orthopedics at the Ohio State University Medical Center and James Cancer Hospital. One of the grounds upon which the defendants rely to claim that Dr. Scharschmidt is not qualified to testify, is that he participated in an unaccredited fellowship spine surgery and that he "encountered one patient with an osteosarcoma of the cervical spine, like the plaintiff's decedent; however this patient was in his or her 30's or 40's." Def. Mot. Prcld., p. 4.

The court reviewed Dr. Scharschmidt's curriculum vitae and his deposition testimony regarding his fellowship at the Texas Back Institute. The fellowship in which Dr. Scharschmidt participated at the Texas Back Institute was "a fellowship that was set up particularly with one individual at Texas Back Institute, a gentleman by the name of Dr. [Isadore] Lieberman, whose primary practice deals with complex spine cases, whether they're revision cases or oncological cases. So my entire time at Texas Back was spent with Dr. Lieberman."[4] Pl. Ex. 6, p. 11. Dr.

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[4]Dr. Isadore Lieberman is a fellowship trained Orthopaedic and Spinal Surgeon. He is board certified by the American Board of Orthopaedic Surgery and holds specialist certification from the Royal College of Physicians and Surgeons of Canada. He completed medical school and residency at the University of Toronto and completed Spine surgery and Trauma surgery fellowships at the Toronto Hospital in Canada and at Queen's Medical Center in Nottingham,

Scharschmidt acknowledged that his fellowship was not accredited by the Accreditation Counsel for Graduate Medical Education (ACGME) however he explained, that "[w]hen I say not accredited, it was not accredited through our ACGME, which is sort of the governing board for fellowships, which about half of the spine fellowships are not accredited. So it just means it doesn't go through the ACGME as far as – as far as oversight over that fellowship." Id., p. 12.[5]

Dr. Scharschmidt has experience diagnosing and treating osteosarcomas of the spine and

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England. Dr. Lieberman specializes in the surgical treatment of spinal disorders. His clinical interests include adolescent and adult scoliosis, deformity reconstruction and spinal tumors. https://texasback.com/location/texas-back-institute-plano/

[5]The Accreditation Council for Graduate Medical Education (ACGME) is an independent, 501(c)(3), not-for-profit organization that sets and monitors voluntary professional educational standards essential in preparing physicians to deliver safe, high-quality medical care to all Americans. Graduate medical education (GME) refers to the period of education in a particular specialty (residency) or subspecialty (fellowship) following medical school; the ACGME oversees the accreditation of residency and fellowship programs in the United States. Not all residency and fellowship programs in the United States are ACGME accredited. ACGME accreditation is a voluntary which the institutions that sponsor them choose to complete. There are residency and fellowship programs that are not accredited by the ACGME. In some cases, this is because the ACGME does not yet accredit a particular specialty or subspecialty. In other cases, programs and/or institutions have opted not to apply for accreditation from the ACGME. See, https://www.acgme.org/.

The court agrees with the defendant that the accreditation or lack thereof of the spine fellowship in which Dr. Scharschmidt participated, goes to the weight of his testimony and not its admissibility. Accreditation alone, does not determine whether the expert possesses the requisite knowledge, training and experience to render an opinion on the standard of care. As state above, "a health care provider may testify if he 'possesses sufficient training, experience and knowledge as a result of practice or teaching in a related field of medicine, so as to be able to provide such expert testimony as to the prevailing standard of care in a given field of medicine. Such training, experience or knowledge shall be as a result of the active involvement in the practice or teaching of medicine within the five-year period before the incident giving rise to the claim." General Statutes § 52-184c (d) (2). "The witness must demonstrate a knowledge acquired from experience . . . of the standards of the specialty of the defendant physician . . . [T]he crucial question is whether . . . [the expert] knows what . . . [the standards of practice] are." *Pool* v. *Bell*, supra, 209 Conn. 542.

"take[s] care of probably 20 osteosarcomas a year and the treatment principals [used in the extremities are the same as the treatment principals used for the cervical spine] regardless of the anatomic location of that tumor." Pl. Ex. 6, p. 27. Dr. Harschmidt described those principles: "Principal 1 is to obviously give full staging and imaging after your history and physical exam. If there's any concern on the imaging, which would include MRI of the affected body part, typically a CT scan of that area and of the lungs, plus or minus a bone scan and/or PET scan along with a perforated laboratory work. Then the next step would be to obtain a biopsy whether that's by imaging or an open biopsy to establish tissue diagnosis. . . Once the tissue – if it turns out to be an osteosarcoma, then in most cases chemotherapy is the next step, followed by local control surgery followed by more chemotherapy." Pl. Ex. 6, p. 27. Dr. Harschmidt further testified that "[t]he main surgical goal [of doing a surgical resection of an osteosarcoma] is to get an [en bloc][6] resection . . . An [en bloc] resection is taking the tumor out in as much of one piece as possible with hopefully a cuff of normal tissue around it. The ultimate goal would be to get what we call RO or negative margin resection. But sometimes in the spine the R1 resection or having microscopically positive margin is the best that can be obtained as well, but the main goal is to get as much of the tumor out in one piece as possible so you don't contaminate the surrounding

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[6]Dr. Harschmidt's deposition transcript refers to "unblocked" resection which is an error. Based upon the court's review of Dr. Harschmidt's description of an unblocked resection and the court's research, he is referring to an "en bloc" resection. En bloc resection involves the surgical removal of the entirety of a tumor without violating its capsule, and requires resection of the lesion encased by a continuous margin of healthy tissue. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6595209/#:~:text=En%20bloc%20resection%20involves%20the,continuous%20margin%20of%20healthy%20tissue. Note Dr. Harschmidt's description of an en bloc resection: "An unblocked resection is taking the tumor out in as much of one piece as possible with hopefully a cuff of normal tissue around it. The ultimate goal would be to get what we call RO or negative margin resection." Pl. Ex. 6, p. 37.

tissue." Pl. Ex. 6, pp. 36-37.

Dr. Harschmidt testified that regarding the plaintiffs' decedent, he "believe[d] an [en bloc] resection was possible. I think it probably would have been what we call a marginal resection on the dura and potentially on the vertebral artery, but an [en bloc] resection was possible. Dr. Hardschmidt testified that "[t]he majority of our complex resections here, our practice is to in most cases do these as a combined case with whatever respective teams are needed for that case. So for a lot of the complex spine, whether it's cervical, thoracic or lumbopelvic, we do those with myself and one of our neurosurgeons working in tandem." Id., p. 19. When questioned on whether he would have performed the en bloc resection procedure that he described, Dr. Harschmidt testified:

"Q: By the way, Doctor, is that resection procedure, which involves a tumor abutting the dura and very close to the vertebral artery, something that you would have performed?

A: Correct. Yes.

Q: So as an orthopedic surgeon with – not involved in the case involving a pediatric cervical spine osteosarcoma with that location, you yourself would feel comfortable doing that surgery; that's correct?

A: That's correct. I would likely use some of my specialist team here with me because, again, we think that's safer for the patient, but I am technically capable and comfortable performing that surgery as well.

Q: And when you say you would use some of the technical people that you have available to you, what type of specialties would that involve?

A: Likely would involve our ENT team for this location to help exposure down in the lateral neck area. Likely, again, we do most of these cases combined with orthopedics and neurosurgery. Potentially a vascular team if we're going to reconstruct the vertebral artery. So it would be a multi-team case to do this degree of resection. But we know achieving an unblocked resection gives – gives the best chance of not having a local recurrence or, you know, ultimately spread. So that's why we employ all the specialists for that.

Q: What are the -- what would have been the role of the neurosurgeon?

A: Again, there's a lot of crossover in training between orthopedics and neurosurgery of the spine. In particular, managing the dura and the nerve roots. The neurosurgeons, I think, get more training in that than orthopedics do. I don't have an ego in the game and would like to have the most expertise in the room if we're performing this level of resection. So typically we'd have them involved to help peel things off of the dura and potentially manage the nerve roots in that area." Id., 39-40.

Expert testimony may be admitted from a health care provider who is certified in a different or overlapping field from that of the defendant when there is evidence that the treatment or procedure is common to that specialty as well as to the defendant's specialty and that likewise the standard of care for that treatment or procedure is also common. *Katsetos* v. *Nolan*, 170 Conn. 637, 646-47, 368 A.2d 172 (1976); *Marshall* v. *Yale Podiatry Group*, 5 Conn.App. 5, 8-9, 496 A.2d 529 (1985). "Medical specialties overlap, and it is within the court's discretion to consider that fact in exercising its discretion . . . It is not the artificial classification of a witness by title that governs the admissibility of the testimony, but the scope of the witness's knowledge of the particular condition." *Marshall* v. *Hartford Hospital*, 65 Conn.App. 738, 758, 783 A.2d

1085 (2001). "The witness must demonstrate a knowledge acquired from experience . . . of the standards of the specialty of the defendant physician . . . [T]he crucial question is whether . . . [the expert] knows what . . . [the standards of practice] are." (Citations omitted; internal quotation marks omitted.) *Pool* v. *Bell*, 209 Conn. 536, 542, 551 A.2d 1254 (1989).

As recognized by the above cited cases, where medical specialties overlap and the standard of care is common to each, a medical expert from either of the overlapping groups who is familiar with that common standard is qualified to testify as to the standard of care. Here, Dr. DiLuna's practice of neurosurgery overlaps with the practice of Dr. Scharschmidt's practice of orthopedic oncological surgery/spine surgery such that Dr. Scharschmidt is qualified to testify to the standard of care applicable to Dr. DiLuna. Dr. Scharschmidt need not be within the same specialty as Dr. DiLuna, "he . . . must demonstrate a knowledge acquired from experience . . . of the standards of the specialty of the defendant physician . . . [T]he crucial question is whether . . . [the expert] knows what . . . [the standards of practice] are." Id. Here, based on Dr. Scharschmidt's testimony, which the court has carefully reviewed, he has demonstrated such knowledge.

Regarding the standard of care applicable to the neurosurgical care provided by the defendants, Dr. Scharschmidt testified that "these are rare tumors in a rare location with a rare presentation, which to me makes it of utmost importance to get a tissue diagnosis before proceeding with any sort of definitive treatment. So the deviation of the standard of care was not obtaining a tissue diagnosis before performing a definitive curettage and reconstruction in this case. . . . I think that the issue is – and this was mentioned in multiple depositions that I reviewed as well – is that this is – has to make sense from a correlation standpoint. So the radiography, the

imaging studies, the patient presentation and the ultimate pathologic diagnosis all need to sort of coincide. And none of these decisions can be made off of a frozen section either, which has been shown not to be sort of after the diagnosis of primary bone tumors. So an osteoid osteoma, you know, by definition is less than 2 centimeters, which already doesn't fit the radiographic principals. The other thing about osteoid osteoma is there's one small central nidus, usually about a centimeter or less, and around that is thick, sclerotic, hard bone, which was very different than what was encountered in the operating room. So if that pathological diagnosis came at that point in time. So, again, that's – that's after the fact and you're hoping you guessed right at that point in time. But that – that diagnosis needs to be made before you proceed with any sort of definitive fixation. All that the frozen section said was this was an osteoblastic tumor. You cannot differentiate malignant versus benign off the frozen section." Pl. Ex. 6, 20, 21, 22, 24.

It is clear from Dr. Scharschmidt's testimony that he has the necessary training, experience and knowledge to provide expert testimony on the applicable standard of care of a neurosurgeon as both specialties operate by the same principles and standards of care. Dr. Scharschmidt has particular knowledge and expertise in the area of treatment of osteosarcoma's as clearly demonstrated by his training as an orthopedic oncologist, which is evident in his testimony.[7] Accordingly, the defendant's motion to preclude is denied.

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[7]The court's research revealed that in addition to neurosurgeons, orthopedic surgeons who specialize in operating on cancers that affect the bones, called orthopedic oncologists treat osteosarcomas. Osteosarcoma typically needs to be treated by a team of specialists, which may include, for example: Orthopedic surgeons who specialize in operating on cancers that affect the bones, called orthopedic oncologists. Other surgeons, such as pediatric surgeons. The type of surgeons depends on the site of the cancer and the age of the person with osteosarcoma. Doctors who specialize in treating cancer with chemotherapy or other systemic medicines. These might include medical oncologists or, for children, pediatric oncologists. Doctors who study tissue to diagnose the specific type of cancer, called pathologists. Rehabilitation specialists who can help

CONCLUSION

For the forgoing reasons, defendants' motion to preclude is denied. The plaintiff's objection thereto is sustained.

Juris No. 421279
Wilson, J.

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in recovery after surgery. https://www.mayoclinic.org/diseases-conditions/osteosarcoma/diagnosis-treatment/drc-20351053#:~:text=Orthopedic%20surgeons%20who%20specialize%20in,of%20the%20person%20with%20osteosarcoma.