UNITED STATES DISTRICT COURT
DISTRICT OF SOUTH DAKOTA
NORTHERN DIVISION

PAUL ARCHAMBAULT, Individually, and as Administrator of the Estate of HARRIET ARCHAMBAULT, Deceased, Plaintiff, v. UNITED STATES OF AMERICA, Defendant.	Case: 1:12-cv-01022-CBK **UNITED STATES' MEMORANDUM IN SUPPORT OF MOTION FOR SUMMARY JUDGMENT**

Comes now the United States of America, by and through its attorneys Brendan V. Johnson, United States Attorney, and Assistant United States Attorney Diana Ryan, and files this brief in support of its motion for summary judgment.

The United States is entitled to summary judgment as a matter of law under Rule 56(c) of the Federal Rules of Civil Procedure if there is no genuine issue of material fact. Although the trial court must view all facts in the light most favorable to the nonmoving party, *Matsushita Elec. Indus. Co., Ltd. v. Zenith Radio Corp.,* 475 U.S. 574, 587 (1986), once the moving party informs the court of the basis for its motion and identifies those portions of the record showing a lack of genuine issue under Rule 56(c), the nonmoving party must designate "specific facts showing that there is a genuine issue for trial." Fed. R. Civ. P. 56(e); *Celotex Corp. v. Catrett,* 477 U.S. 317, 324 (1986).

An issue of material fact is "genuine" if it has a real basis in the record. *Matsushita,* 475 U.S. at 586-87. The nonmoving party must substantiate her allegations with probative evidence that is more than just speculation. *Moody v. St. Charles Cnty.*, 23 F.3d 1410, 1412 (8th Cir. 1994). "Only disputes over facts that might affect the outcome of the suit under the governing law will properly preclude the entry of summary judgment." *Anderson v. Liberty Lobby, Inc.,* 477 U.S. 242, 248 (1986). If a party fails to make a sufficient showing of an essential element of a claim with respect to which that party has the burden of proof, then the opposing party is "entitled to a judgment as a matter of law." *Celotex Corp.,* 477 U.S. at 323.

SUMMARY OF ARGUMENTS

The United States is immune from suit absent an express waiver of its sovereign immunity. The Federal Tort Claims Act ("FTCA") provides a limited waiver of the United States' sovereign immunity to allow persons injured by federal-employee tortfeasors to sue the United States for damages in federal district court. 28 U.S.C. § 1346(b)(1). As a condition of the United States' waiver, the FTCA requires that the claim be properly presented to the federal agency prior to filing an action under the FTCA. 28 U.S.C. § 2675(a).

One of the presentment requirements imposed by the FTCA is submission of evidence that the plaintiff is authorized to act on behalf of the claimant. *Mader v. United States*, 654 F.3d 794, 803-04 (8th Cir. 2011) *en banc*. A claim that fails to satisfy the presentment requirements remains inchoate, unperfected, and not judicially actionable. 28 U.S.C. § 2675(a);

Mader, 654 F.3d at 807; *Runs After v. United States,* 511 Fed. App'x 596 (8th Cir. 2013).

In this case, the only evidence of authority for Paul Archambault's to handle Harriet Archambault's affairs provided to the agency during the administrative claim investigation was a document entitled "Interim Letters of Administration." The Interim Letters of Administration appointed Mr. Archambault in a limited capacity for the purpose of obtaining Harriet's medical records from the Indian Health Service. He failed to submit evidence showing Paul Archambault was appointed as the Executor of Harriet Archambault's estate. Accordingly, he failed to satisfy the presentment requirements, and this case must be dismissed or, in the alternative, summary judgment should be granted in favor of the United States.

To the extent that Plaintiff complains about the staffing of the McLaughlin IHS, the discretionary function exception to the FTCA bars suit. There is no mandatory regulation that would apply to specify how the McLaughlin Clinic is staffed, and the number of providers may fluctuate depending on circumstances, including the ability to hire providers for small remote clinics. Staffing of IHS clinics are understandably left to the discretion of IHS. The district court lacks jurisdiction over any claims based upon the fact that the McLaughlin IHS allegedly did not have enough medical staff.

Finally, there is no genuine dispute in material fact that the care and treatment provided to Harriet Archambault by the providers at the McLaughlin IHS met the required standard of care and did not cause her untimely, sudden

death. Harriet's high blood pressure was poorly controlled because she did not consistently take her blood pressure medication. As a result of her uncontrolled hypertension, her heart became enlarged due to left ventricular hypertrophy. At the time of her last medical appointment, Harriet did not report any new symptoms to the IHS providers that would have warranted further testing. However, even if further testing would have been done to discover her enlarged heart, her treatment plan would not have changed. Therefore, the United States is entitled to summary judgment because Harriet's death was not caused by negligent medical care, but rather was the result of a hypertension-related cardiovascular disease caused by her inconsistency in taking prescribed medications to control high blood pressure.

FACTS RELEVANT TO PLAINTIFF'S ADMINISTRATIVE CLAIM

Paul Archambault submitted his administrative claim, via Standard Form 95, to U.S. Department of Health and Human Services (HHS) headquarters and Indian Health Service Area Office (IHS) in Aberdeen, South Dakota. The SF 95 was signed by Paul Archambault on October 21, 2009, and submitted by Archambault's attorney, Rebecca Kidder, on October 22, 2009, and was received by HHS and IHS on October 23 and October 26, 2009, respectively. *See* Aff. of Diana Ryan, Ex. 1 (Declaration of Daniel Mendoza), Ex. 6, ¶ 3. Archambault's claim did not provide any evidence that Archambault was authorized to act on behalf of the estate of Harriet Archambault. Upon receipt of the claim, the agency requested, via letter dated November 5, 2009,

that Archambault provide evidence of the appointment of the administrator or the executor of the estate. Ryan Aff., Ex. 2, Ex. 6 ¶ 4.

Attorney Kidder responded to HHS on March 4, 2010, by providing an Order from the Standing Rock Sioux Tribal Court entitled "Interim Letters of Administration." Ryan Aff., Ex. 3, Ex. 4, Ex. 6 ¶ 5. This document appointed Paul Archambault "for the limited purpose of obtaining any medical records including those held by the Indian Health Service, relating to the care and treatment of Harriet Archambault." *Id.* The Interim Letters of Administration was the only information HHS received regarding the appointment of Paul Archambault to handle the affairs of Harriet's Estate. *Id.* at Ex. 6 ¶ 7. In addition, Kidder provided a document entitled "Declaration of Representation," whereby Paul Archambault confirmed he appointed Kidder as his representative for any and all communications, representations, employment, personnel or legal matters, and particularly as his representative in all administrative proceedings or lawsuits before, with, and inquiries or correspondence to the *Department of Veterans Affairs*, or its legal counsel (emphasis added). *Id.* at Ex. 5, Ex. 6 ¶ 6.

Attached as Ex. 7 is an order from Standing Rock Sioux Tribal Court (SRSTC), dated April 15, 2008, entitled Letters of Administration. This information was provided by Robin Zephier to AUSA Robert Gusinsky on November 5, 2012 (after the initiation of this lawsuit). *See* email from Gusinsky to Zephier, attached as Ex. 8. The 2008 Letters of Administration provides that the estate of Harriet Archambault had been represented by Robin Zephier of

Rapid City.[1] "However, the administrator advised the Court that he has retained James Cerney to represent the estate, instead." Ryan Aff., Ex. 7. Wherefore, after a hearing on April 15, 2008, the STSTC appointed Paul Archambault as the executor to prosecute any civil action on behalf of Harriet's estate. The court further ordered Mr. Cerney to advise the court of the status of any claim on behalf of Harriet's estate as soon as he completed his initial evaluation. *Id.* Attorney Cerney did not provide HHS with a copy of the Letters of Administration appointing Archambault as the executor of Harriet's estate. *See* Ex. 6 ¶ 8.

On April 9, 2010, attorney Kidder sent additional documents to HHS. Ryan Aff., Ex. 9; Ex. 6 ¶ 9. She provided HHS with a copy of a Motion to Amend the Letters of Administration issued by the SRSTC "to confirm legal counsel to the estate is Abourezk & Zephier, P.C." *Id.* Kidder indicated "a copy of the Amended Letters of Administration will be sent upon receipt from the Standing Rock Sioux Tribal Court." *Id.* No Amended Letters of Administration were ever provided to HHS. *Id.* at Ex. 6 ¶ 10.

The Motion to Amend Letters of Administration, dated March 16, 2010, which was provided to HHS, did not contain the referenced exhibits. *Id.* Kidder also provided a copy of the Affidavit of James Cerney, who states he was not retained to represent the estate of Harriet or to represent Paul Archambault as the administrator of the estate. *Id.* at Ex. 11.

[1] Robin Zephier and Rebecca Kidder both worked at Abourezk Law Firm.

On August 27, 2010, HHS denied Archambault's FTCA claim. *Id.* at Ex. 12. Approximately six months later, on February 23, 2011, attorney Robin Zephier wrote to HHS asking it to reconsider the denial of Archambault's FTCA claim. *Id.* at Ex. 13. Zephier did not provide the initial Letters of Administration or the Amended Letters of Administration in the request for reconsideration. *Id.* at Ex. 6 ¶ 12. On March 29, 2012, HHS denied Archambault's request for reconsideration. *Id.* at Ex. 14; Ex. 6 ¶ 13.

I. PLAINTIFF FAILED TO PRESENT PROPER EVIDENCE OF AUTHORITY AND IS JURISDICTIONALLY BARRED FROM ANY RECOVERY

"The United States, as sovereign, is immune from suit save as it consents to be sued, and the terms of its consent to be sued in any court define that court's jurisdiction to entertain the suit." *United States v. Sherwood*, 312 U.S. 584, 586 (1941); *Najbar v. United States*, 649 F.3d 868, 870 (8th Cir. 2011). 28 U.S.C. § 1346(b)(1) confers exclusive jurisdiction to federal district courts for claims against the United States for money damages for "personal injury or death caused by the negligent or wrongful act or omission of 'federal employees' under circumstances where the United States, if a private person, would be liable to the claimant in accordance with the law of the place where the act or omission occurred." This waiver of sovereign immunity is subject to the provisions of chapter 171 of this title, which is found at 28 U.S.C. §§ 2671-80, and known as the Federal Tort Claims Act (FTCA).

Even though events giving rise to a tort may occur on Indian tribal lands, state law is to be applied for the purpose of the FTCA. The Eighth Circuit held:

> . . . that where an act or omission occurs within the territorial boundaries of both a tribal reservation and the State, 'the law of the place' for purposes of the FTCA is the law of the State.

LaFromboise v. Leavitt, 439 F.3d 792, 796 (8th Cir. 2006). Under the law of South Dakota, "every action for wrongful death shall be for the exclusive benefit of the wife or husband and children, or if there be neither of them, then of the parents and next of kin of the person whose death shall be so caused; *and it shall be brought in the name of the personal representative of the deceased person*." SDCL § 21-5-5 (emphasis added). This statute makes it clear that the only person who may file a wrongful death action is someone who has been lawfully appointed as the personal representative of the deceased person and empowered to act on that person's estate.

A. Presentment Requirements

The FTCA prohibits the filing of an action in the United States District Court unless the claimant first presents the claim to the appropriate federal agency, and the claim has finally been denied. 28 U.S.C. § 2675(a). Pursuant to 28 U.S.C. § 2672, the United States Department of Justice promulgated regulations addressing administrative claim requirements. 28 C.F.R. § 14.2(a), expressly requires that the claim presenter include ". . . evidence of his authority to present the claim on behalf of the claimant as agent, executor, administrator, parent, guardian, or other representative." *Id.*

In an *en banc* decision, the Eighth Circuit Court of Appeals held that the evidence of authority requirement is contained within the meaning of 28 U.S.C. § 2675(a), and therefore, failure to furnish evidence of authority during the

presentment stage renders the administrative claim inchoate, unperfected, and not judicially actionable. *Mader*, 654 F.3d at 807 (*en banc*). The relevant facts in the *Mader* case are similar to the case at bar. Mader, a patient at the Veteran's Affairs Medical Center in Lincoln, Nebraska, tragically died of a self-inflicted gunshot wound approximately two months after the VA altered his course of treatment. *Id.* at 798. Mader's widow presented an administrative claim to the VA purporting to act as the personal representative of the estate of Robert L. Mader and sought to recover wrongful death damages from the VA. *Id.*

Just as in the present case, Mader presented her administrative claim through a Standard Form 95, which on its face required her to submit evidence of authority to present a claim on behalf of the claimant. Just as in the case at bar, Mader never presented such evidence to the VA and her claim was denied. *Id.* at 799.

Following the denial of Mader's claim, she brought a wrongful death action against the United States in Federal District Court under the FTCA. *Id.* The district court dismissed the action pursuant to Fed. R. Civ. P. 12(b)(1) on the basis that Mader failed to present the requisite evidence of authority at the administrative level. In doing so, the district court applied the Eighth Circuit's holding in *Lunsford v. United States*, 570 F.2d 221 (8th Cir. 1977) (holding that a representative must submit evidence of authority to act on behalf of a claimant in order to satisfy § 2675(a)'s jurisdictional presentment requirements). A divided panel reversed the district court choosing to follow the

Eighth Circuit's holding in *Farmers State Sav. Bank v. FHA* 866 F.2d 276 (8th Cir. 1989) (applying the "minimal notice" interpretation of Section 2675(a)).[2] The *en banc* appeal followed.

The Eighth Circuit explained: "Congress intended to give agencies the first opportunity to meaningfully consider and settle FTCA claims. And, as discussed above, agencies simply cannot meaningfully consider FTCA claims with an eye towards settlement if representatives fail to first present evidence of their authority to act on behalf of claim's beneficiaries." *Id.* at 803. In addition, the Eighth Circuit's holding is not limited to wrongful death cases. "Similar representation problems may also extend beyond the wrongful death context. Indeed, FTCA claims involving questions of age, competency, and numerosity, among others, will often require the appointment of an agent or trustee." *Id.* The Eighth Circuit held:

> For the foregoing reasons, we hold that a properly 'presented' claim under § 2675(a) must include evidence of a representative's authority to act on behalf of the claim's beneficiaries under state law. The presentation of such evidence is not a pointless administrative hurdle–it is fundamental to the meaningful administrative consideration and settlement process contemplated in §§ 2675(a) and 2672. Moreover, we note that the presentation of such evidence if far from burdensome. Assuming a representative is, in fact, duly authorized to present an FTCA claim on behalf of beneficiaries under applicable state law, evidence of such authority is uniquely in the representative's possession. *Id.* at 803-04 (emphasis added).

* * *

[2] The *Mader* court points out that the issue relating to evidence of authority was not before the court in *Farmers State Sav. Bank*. *Mader*, 654 F.3d at 799 n.5.

> . . . under the guidance of *Henderson*, we conclude that conformity with § 2675(a) is a jurisdictional term of the FTCA's limited waiver of sovereign immunity . . . *Id.* at 808 (emphasis added).
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> A claim that fails to satisfy § 2675(a)'s requirements remains inchoate, unperfected, and not judicially actionable. *Id.* at 807.

The *Mader* case was followed in *Runs After v. United States,* 511 Fed. App'x 596 (8th Cir. 2013). In *Runs After*, plaintiff's case was dismissed for failure to present evidence to the agency that plaintiff had authority to bring a personal injury action on behalf of a minor child. *Id.* at 597. The district court declined to create an extenuating circumstances exception to 28 C.F.R.'s presentment requirement, and the appellate court affirmed because providing evidence to satisfy the presentment requirement is "far from burdensome." *Id.* (citing *Mader*, 654 F.3d at 804).

B. Plaintiff Has Not Met Presentment Requirements

In this case, Archambault similarly failed to provide HHS with evidence of his authority to act on behalf of his wife's estate. Evidence of authority to act as an interim administrator for the purpose of obtaining Harriet's medical records from the Indian Health Service is not evidence of authority to act as her personal representative for purposes of bringing a wrongful death action. Under *Mader,* strict compliance with 28 U.S.C. § 2675(a) and the presentment requirement as set forth in 28 C.F.R. § 14.2 is a jurisdictional prerequisite to filing suit under the FTCA. *Mader,* 654 F.3d at 805. Accordingly, the United States respectfully submits that Archambault failed to comply with the

presentment requirements of § 2675(a), and therefore, this court is without jurisdiction to consider this action because the United States has not waived its sovereign immunity.

II. THE DISCRETIONARY FUNCTION EXCEPTION TO THE FTCA DEPRIVES THE COURT OF SUBJECT MATTER JURISDICTION

The United States' waiver of its sovereign immunity through the FTCA is limited by important jurisdictional exceptions and exclusions. *See e.g.*, 28 U.S.C. §§ 1346(b), 2671, 2680. If the conduct asserted in an action falls within an exception, the court lacks subject matter jurisdiction over the action. *Dalehite v. United States*, 346 U.S. 15, 24 (1953); *Dykstra v. Bureau of Prisons*, 140 F.3d 791, 795 (8th Cir. 1998). In the present case, the most significant of these exceptions is the "discretionary function" exception. 28 U.S.C. § 2680(a).

The discretionary function exception precludes the imposition of liability against the United States for any claim that is "based upon the exercise or performance or the failure to exercise or perform a discretionary function or duty on the part of a federal agency or employee of the Government, whether or not the discretion involved be abused." 28 U.S.C. § 2680(a); *Dykstra*, 140 F.3d at 795. Consequently, if the United States' alleged negligence arose from protected discretionary conduct, this court lacks subject matter jurisdiction over Plaintiff's claims. *Id.*

The purpose of the discretionary function exception is to "prevent judicial 'second-guessing' of legislative and administrative decisions grounded in social, economic, and political policy through the medium of an action in tort." *United*

States v. S.A. Empresa de Viacao Aerea Rio Grandense (Varig Airlines), 467 U.S. 797, 814 (1984) (citation omitted). The discretionary function exception therefore "marks the boundary between Congress' willingness to impose tort liability upon the United States and its desire to protect certain governmental activities from exposure to suit by private individuals." *Id.* at 808; *Dykstra*, 140 F.3d at 795.

The United States Supreme Court's decisions construing the discretionary function exception — *Dalehite v. United States*, 346 U.S. 15 (1953); *United States v. Varig Airlines*, 467 U.S. 797 (1984); *Berkovitz v. United States*, 486 U.S. 531 (1988); *United States v. Gaubert*, 499 U.S. 315 (1991) — have developed a two-step test to determine whether governmental conduct is immune from suit under the discretionary function exception.[3] Both the Eighth

[3] In *Dalehite*, hundreds of persons were killed and a city leveled when fertilizer manufactured and shipped by contractors under the supervision and control of the Army disastrously exploded while it was being loaded for export. 346 U.S. at 23. The district court found that the United States negligently initiated the program, negligently designed and approved inadequate specifications, negligently failed to warn area residents of the dangers, and negligently supervised the fertilizer's storage and shipment. *Id.* at 45-47. The Supreme Court held that these findings were irrelevant because the discretionary function exception to the FTCA barred the action, notwithstanding the negligence of the United States. *Id.* at 36, 45.

In *Varig Airlines*, which involved two airplane crashes in which more than one hundred persons were killed, the plaintiffs contended that the Federal Aviation Administration (FAA) negligently certified that the airplanes were airworthy after its certification process failed to detect defects in airplane design. 467 U.S. 797. The Supreme Court held that the plaintiffs' claims were barred by the discretionary function exception. Because the FAA has the authority to establish safety standards for airplanes, its formulation and implementation of a 'spot check' plan for airplane inspection were protected by the exception. *Id.* at 815. Likewise, actions taken in furtherance of the program were protected, even if those actions were negligent. *Id.* at 820.

In *Berkovitz*, the Supreme Court held that allegations that the Food and Drug Administration licensed a manufacturer and released a lot of polio vaccine in direct contravention of federal statutes, regulations, and mandatory agency procedures were sufficient to withstand a motion to dismiss. 486 U.S. 531.

Most recently, *Gaubert* involved allegations that federal regulators had been negligent in supervising a federally insured savings and loan association. The Supreme Court held that "if a regulation allows the employee discretion, the very existence of the regulation creates a

Circuit and the District of South Dakota have consistently applied this two-part test. *See e.g. Chantal v. United States*, 104 F.3d 207, 210 (8th Cir. 1997); *Big Owl v. United States*, 961 F. Supp. 1304, 1308 (D.S.D. 1997).

First, a court must determine whether the conduct violated a mandatory regulation or policy that allowed no element of judgment or choice. *Gaubert*, 499 U.S. at 322. If a "federal statute, regulation, or policy specifically prescribes a course of action for an employee to follow," the conduct is not discretionary because the employee has no rightful option but to comply. *Berkovitz*, 486 U.S. at 536; *Chantal*, 104 F.3d at 210. When no such mandatory statute, regulation, or policy exists, however, "the governmental action is considered the product of judgment or choice (i.e., discretionary), and the first step is satisfied." *Dykstra*, 140 F.3d at 795.

Second, it must be determined whether the challenged conduct is "the kind that the discretionary function exception was designed to shield." *Berkovitz*, 486 U.S. at 536. By enacting the discretionary function exception, "Congress wished to prevent judicial 'second guessing' of legislative and administrative decisions grounded in social, economic, and political policy." *Varig Airlines*, 467 U.S. at 814; *Berkovitz*, 486 U.S. at 537. Therefore, "[w]here there is room for policy judgment and decision there is discretion" of the kind protected by the discretionary function exception. *Dalehite*, 346 U.S. at 36; *Berkovitz*, 486 U.S. at 537.

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strong presumption that a discretionary act authorized by the regulation involves consideration of the same policies which led to the promulgation of the regulations." 322 U.S. at 324.

If the challenged conduct meets this two-step discretionary function test, the exception applies and bars liability, even if the government employee was negligent in performing the discretionary conduct. *See* 28 U.S.C. § 2680(a) (precluding liability for the discretionary functions of government employees, "whether or not the discretion involved be abused"); *Hartje v. Fed. Trade Comm'n*, 106 F.3d 1406, 1408 (8th Cir. 1997). In the present case, the employment decisions by the IHS concerning the staffing of the McLaughlin IHS clinic or the manner in which appointments or walk-in patients are seen fall squarely within the two-part discretionary function test.

Plaintiff maintains that Harriet went to the McLaughlin IHS as a walk-in patient asking for an appointment, but she was repeatedly turned away because the clinic was already filled with other patients. Plaintiff maintains that the McLaughlin IHS saw only ten patients in the morning and ten patients in the afternoon, each day, on a first-come, first-served basis, and that Harriet was turned away every time she asked if there was any more walk-ins. Specifically, Plaintiff alleges “the administrative practice and/or protocol in only seeing a limited amount of patients at the clinic (10 in a.m., 10 in p.m., first-come, first-served) created a negligent lack of concern for patients with life threatening conditions, who fell outside of the protocol.” DCD 1, ¶ 8.

There is no mandatory regulation or policy that dictates how the McLaughlin IHS must be staffed. The IHS, acting under HHS, refers to Circular 92-5 when it comes to the allocation of resources to various areas and operating units served by the IHS in a reasonable and fair manner. *See* Ryan

Aff., Ex. 22. Resource allocation, as defined in this circular, means the decision making principles, rules, and procedures that are used to sub-divide resources among areas and operating units prior to their use and expenditure. *Id.* at 7, 8 ¶ 4.C. (emphasis in the original).

The IHS resource allocation was developed around several broad governing principles including local decision-making to the maximum extent possible; tribal consultation; phased incremental approach to reducing funding discrepancies; special conditions (remote locations, lack of sanitation services, lack of other health facilities); alternate resources such as Medicaid and Medicare or third-party insurers; data which measures the diverse and special conditions of the areas; consistent application and review; local discretion to meet local needs; exceptions where evidence shows the data is inaccurate, inappropriate, or misapplied; balance between competing values and strategies; reasonable assurance formulae; and funding principles related to the distribution of funds. *Id.* at 19-25. With regard to balancing the demands related to providing allocating resources for IHS care, "Generally speaking, there are no scientific or technical rules for making such judgments. Such choices must reflect the best programmatic judgment of experienced senior officials as tempered by consideration of the IHS mission, legislative intent, and the expressed values and desires of Indian people and tribes." *Id.* at 24-25 (referencing ¶ J).

Plaintiff complains specifically about a memo authored by the former McLaughlin IHS clinic administrator on December 27, 2007 (one month after Harriet's death). The memo is titled "Daily Patient Limit." It states:

> At this time, the McLaughlin Health Center has only one provider, which limits the amount of patients that can be seen daily. There have been 10 patients seen in the morning and 10 patients seen in the afternoon.

First, it is worth noting that the memo is dated a month after Harriet passed away, and specifically references "at this time." In addition, the actual patients seen at the McLaughlin IHS from the date of Harriet's last appointment on October 26, 2007, and the date of her death on November 27, 2007, have been pulled from the patient management resource system and clearly show that during those days, more than twenty patients per day were seen. *See* Ryan Aff., Ex. 19.

However, even if this were not the case and the court assumes that the memo correctly sets forth a limited access to care due to only one provider, no mandatory statutes or regulations are violated by this circumstance. Accordingly, the first step in the two-part test — that the challenged conduct does not violate a mandatory regulation — is satisfied. *Gaubert*, 499 U.S. at 322.

Because the decisions regarding how many providers are working at the McLaughlin IHS involved broad discretion, the issue becomes whether such a decision is susceptible to policy analysis. *Gaubert*, 499 U.S. at 325. In this regard, "the focus of the inquiry is not on the agent's subjective intent in exercising the discretion conferred by statute or regulation, but on the nature

of the actions taken and whether they are susceptible to policy analysis." *Id.* Further, "[w]hen established governmental policy, as expressed or implied by statute, regulation, or agency guidelines, allows a Government agent to exercise discretion, it must be presumed that the agent's acts are grounded in policy when exercising that discretion." *Id.* at 324; *Chantal*, 104 F.3d at 212.

The IHS staffing is inextricably linked to the primary goals of IHS delivery of healthcare to Native Americans through the utilization of small community service units in rural areas. IHS resource allocation decisions involve political considerations such as funding by the legislative branch as balanced by requests for services by tribal governments. Resource allocation also involves social considerations such as poverty levels, lack of sanitation, lack of running water and electricity, lack of housing, and lack of public transportation on an Indian reservation. Additionally, there are economic factors that come into play with regard to third party payers like Medicaid, Medicare, the Veterans' Administration or private insurance companies as far as what resources can IHS recover from those other sources that would allow the best use of IHS funds to support the greatest needs. When the agency determines the extent to which it will staff a rural ambulatory clinic, it is exercising discretionary authority of the most basic kind similar to the FAA's decision to operate their aircraft inspections in the *Varig Airlines* decision.

In *Varig Airlines*, the FAA determined that a program of "spot checking" manufacturers' compliance with minimum safety standards best accommodates the goal of air transportation safety given the limited agency

resources. 467 U.S. at 820. Here, IHS determined that operating a small clinic with reduced staff is, likewise, the best way to meet IHS goals for the delivery of healthcare given limited agency resources.

Allowing FTCA claims like the present one that allege negligent staffing would require courts to engage in "judicial second-guessing," which Congress specifically intended to avoid through the discretionary function exception. *Tonelli*, 60 F.3d at 496; *see also Varig Airlines*, 467 U.S. at 814 (FAA's alleged negligence in failing to check specific items in certifying aircraft falls within the discretionary function). In *Big Owl*, the lawsuit concerned staffing at a tribally controlled school. The court succinctly illustrated the discretionary nature of such employment decisions:

> The School Board made the determination that Ms. Big Owl was no longer the right person to hold the position as the kindergarten teacher. This court is in no position to "second guess" that determination.

961 F. Supp. at 1309.

Plaintiff's claims in this case ask the court to "second guess" the McLaughlin IHS's decision about the number of providers at the McLaughlin IHS. Such judicial second-guessing is prohibited by the discretionary function exception. *See Tonelli*, 60 F.3d at 496; *Varig Airlines*, 467 U.S. at 814. Any allegations related to improper administration such as provider staffing should accordingly be dismissed with prejudice.

III. HARRIET ARCHAMBAULT RECEIVED PROPER MEDICAL CARE

On the afternoon of November 27, 2007, Harriet was found unresponsive in the shower by her family. Emergency responders and law enforcement

officers arrived to find that Harriet had passed away at age forty-one. Ryan Aff., Ex. 25. The cause of death was determined to be related to longstanding hypertensive cardiovascular disease. Harriet had an enlarged heart (cardiomegaly) due to left ventricular hypertrophy. *Id.* Harriet did not die from a myocardial infarction (acute heart attack caused by blockage) or from congestive heart failure. *Id.* Rather, her death was due to a sudden arrhythmia caused by her enlarged heart. *Id.*; *see also* Ex. 26.

Harriet's husband, Paul, filed the instant case against Indian Health Service (IHS), claiming that Harriet was denied reasonable care that resulted in her death. Specifically, Plaintiff alleges that employees of IHS noted Harriet's increased blood pressure and "[d]efendants did not reschedule a recheck appointment earlier than three (3) months out. Decedent was not properly screened to ensure her blood pressure was stable and controlled under her current dosage while at McLaughlin IHS." DCD 1 ¶ 5.

A. Harriet's Hypertension and Prescription History

In the month prior to her death, Plaintiff alleges that Harriet "was experiencing new symptoms of shortness of breath, chest pains and dizziness, and presented herself physically at the McLaughlin IHS repeatedly between October and November 2007." *Id.* ¶ 6. Plaintiff contends that Harriet died because the employees of McLaughlin IHS "failed to exercise reasonable care and/or the level of care according to the standard of care required of medical specialty, when they failed to examine, screen, treat and refill the Decedent's medication, and/or reasonably examine, test, triage or treat Decedent's

immediate complained of conditions to determine if Decedent's health and well-being were in danger." *Id.* ¶ 8.

There is no dispute about the fact that Harriet suffered from long standing hypertension, which was first diagnosed in 1999. At that time, Harriet was placed on one hypertension medication, Lisinopril (or Prinivil). *See* Ryan Aff., Ex. 15-1. In 2000, Harriet's hypertension treatment was augmented by the addition of another medication, Hydrochlorothiazide 25 mg daily to combat fluid retention. *Id.* at 15-2. In 2001, her treating provider at that time noted Harriet was "doing well when on meds." *Id.* at 15-3. Harriet's medications were adjusted in 2003 by increasing the Lisinopril to 20 mg daily and continuing the existing dose of Hydrochlorothiazide. *Id.* at 15-4.

The first notation that Harriet was not taking her medication regularly, and was "out for over a week" is documented at her visit on November 29, 1999. *Id.* at 16-1. Thereafter, Harriet had varying levels of compliance in taking her blood pressure medication. For example, on April, 10, 2000, the provider documented "pt has not had meds for 1 mo." *Id.* at 16-2. The next month, it was again documented, "34 year old female patient has been out of meds." *Id.* at 16-3. From 2000 to her death in 2007, there were multiple entries documenting that Harriet had been out of her medication for days, weeks, and even months before she sought refills at the McLaughlin IHS. *Id.* at 4-12, 15-18.

This pattern is consistent with what is recorded in the BIA law officer's reported conversation with Paul Archambault immediately following the

discovery of Harriet's body. The BIA officer who responded to the Archambault home on the afternoon of Harriet's death noted in his report that Paul Archambault told him Harriet had a medical history of having problems with her high blood pressure (hypertension). Ryan Aff., Ex. 25 at 4. "He advised that she [Harriet] hasn't been very consistent in taking her medications, that she will take her medications, will run out and not have anymore and then, will get more and take them again. . . .There were four (4) bottles within the hutch, three (3) of which were empty: Ranitidine (150 mg), Hydrochlorothiazide (25 mg) and Doxycycline (100 mg) and one (1) bottle of Lisinopril (20 mg) that contained four (4) pills."

B. Harriet's Overall Health in 2007

On January 4, 2007, Harriet was seen at McLaughlin IHS for medication refills. Ryan Aff., Ex. 15-6. The IHS health summary shows she received sixty days' worth of medications on that date. *Id.* at Ex. 17 at 14.

On February 27, 2007, Harriet had an annual wellness exam at the McLaughlin IHS. In addition to her high blood pressure, Harriet's other known medical conditions included ulcer/gastrointestinal disease (heartburn) and obesity. Id. at 15-3, 15-5, 15-8. She smoked one-half pack of cigarettes (ten cigarettes) per day. *Id.* at 15-8. She drank eight cans of beer once weekly. *Id.* Harriet's wellness exam revealed normal labs, good kidney function, good control of blood sugar, and a normal white blood cell count. Ryan Aff., Ex. 29 (Martinez dep. 33:19-25 to 35:1-9); Ex. 15-7. At that visit, Harriet was advised

to discontinue smoking, decrease her use of alcohol, and increase her exercise. *Id.* at 15-7.

Harriet's personal health choices included smoking, drinking alcohol, and obesity. Smoking can elevate a person's blood pressure. Ryan Aff., Ex. 29 (Martinez dep. 31:8-11). Smoking causes similar increased pressure in the arteries, similar to a garden hose under pressure, which can cause a worn artery to burst, causing a stroke. *Id.* at 31:13-25, 32:1-9.

Alcoholic beverages also increase blood pressure. *Id.* at 32:12-22. Harriet's reported habit of drinking eight cans of beer once weekly is something that would increase her blood pressure. *Id.* Salt intake causes fluid retention, which also contributes to an increase in blood pressure. *Id.* at 33:1-5. Finally, being overweight is an additional factor that can contribute to high blood pressure. *Id.* at 42:9-10. Harriet was 5 feet, 8 inches tall and weighed 254 pounds, which was overweight. *Id.* at 41:10-25, 42:1-3.

Patients like Harriet with high blood pressure are educated on lifestyle changes they can make to improve their health, which consists of diet, exercise, and getting rid of controllable factors like smoking and drinking alcohol. *Id.* at 22:9-16. Those are consistent with directions given to Harriet at her annual physical in February of 2007. Ryan Aff., Ex. 15-7; Ex. 29 (Martinez dep. 35:11-25).

On March 8, 2007, Harriet refilled the following prescription medications at the McLaughlin IHS pharmacy:

- Lisinopril 20 mg for high blood pressure – 100 tablets

- Hydrochlorothiazide 25 mg for high blood pressure– 100 tablets
- Ranitidine 150 mg for stomach – 100 tablets
- Doxycycline 100 mg for acne – 100 tablets.

See Ryan Aff., Ex. 15-10, 15-11; Ex. 17 at 14.

IHS pharmacist Michael Carter started working as the pharmacist at McLaughlin IHS in 1995 and was still working there at the time of his deposition in 2013. Ryan Aff., Ex. 33 (Carter dep. 3:22-24). Carter recalled Harriet had a problem getting refills, so he started giving her a 100-day supply at a time instead of giving her a month at a time. *Id.* at 4:16-25. This would be consistent with the 100-pill refill Harriet received in March 2007. Ryan Aff., Ex. 15-11.

Harriet filled her hypertension prescriptions for 100 pills on March 8, 2007, and she had one refill remaining on that prescription. According to Carter, the March refill would have lasted Harriet through March, April, May, and June. Harriet never picked up a second refill of her hypertension medications, even though she did not need to be seen in order to get the refill. Instead, Harriet went without her hypertension medications during July, August, and September, until she finally returned to McLaughlin IHS for an appointment on October 25, 2007. Ryan Aff., Ex. 33 (Carter dep. 15:15-21, 19:3-8); Ex. 21.

At the McLaughlin IHS pharmacy, if a patient needs medications refilled but is not able to see a provider, the pharmacist would provide the patient with a week to two-week supply of medications until that patient can be seen by a provider. Ryan Aff., Ex. 33 (Carter dep. 7:17-25, 8:1-9; 14:15-21). This is

consistent with documentation in Harriet's record of December 5, 2005, when a CHR (community health representative) called to pick up medications for Harriet. The documentation stated she needed to be seen by a provider, but two weeks of medications were provided. Ryan Aff., Ex. 16-12.

According to the pharmacy records, Harriet's last medication fill was October 25, 2007. Ryan Aff., Ex. 33 (Carter dep. at 12:17-18). At the time of her death on November 27, 2007, Harriet had two available refills on her hypertension prescription medications. *Id.* at 12:20-25. Harriet did not need to see a medical provider prior to having those prescriptions filled. *Id.* at 13:1-13.

The pharmacy has signs posted by patient registration and the pharmacy describing how to refill prescriptions. Ryan Aff., Ex. 31 (Fischer dep. at 21:10-14). To refill medications at McLaughlin IHS, people either called in their refills or took in a pink refill slip to the pharmacy and their medicine was ready within 24 hours or the same day. *Id.* at 20:2-4. Refill slips are put out near the walk-in sign up slips, so if somebody is coming in for refills, the pink slip is filled out by the patient and taken to the pharmacy. *Id.* at 20:5-9, 30:22-23; Ex. 20. Patients do not have to go through patient registration in order to refill their medications when they still have more refills available. Ryan Aff., Ex. 31 (Fischer dep. at 20:16-25, 21:1-7). Harriet had been filling her prescriptions at McLaughlin IHS all of her adult life.

C. Harriet's October 25, 2007 Visit to McLaughlin IHS

In between March 8, 2007, and October 24, 2007, Harriet was not seen at McLaughlin IHS. On October 25, 2007, Harriet had a scheduled

appointment to be seen by Nurse Practitioner Allysa Ann DeCoteau. Ms. DeCoteau has since changed her last name to Martinez and will be referred to by her current name used at the time of her deposition. Ryan Aff., Ex. 29 (Deposition of Allysa Martinez, hereafter Martinez dep. at 22:19-22). Martinez did not know Harriet prior to treating her on October 25, 2007, and this was the only time Martinez ever treated her. *Id.* at 20:3-5; 20:21-23.

Martinez was raised in Cannonball, ND, on the Standing Rock Indian Reservation and is an enrolled member of the Standing Rock Sioux Tribe. *Id.* at 5:16-25. Martinez graduated from nursing school in 1996. She worked as a registered nurse and then obtained a master's degree in the nurse practitioner program. Since 2004, she has been working as a nurse practitioner for IHS. *Id.* at 7:11-22. She loves working for Native people. *Id.* at 6:17-24, 7. Martinez initially worked at the IHS facility in Belcourt, ND, and then transferred to the IHS facility in Fort Yates, ND, on the Standing Rock Indian Reservation in 2007. *Id.* at 9:1-9.

At the time Martinez began working in Fort Yates, the doctor who had worked at McLauglin IHS for many years (Dr. Richard Kraft) had retired. *Id.* at 11:1-11. As a result, the administrator at the Fort Yates IHS, who oversaw the operation of the McLaughlin IHS clinic, decided to temporarily staff McLaughlin IHS with employees working in Fort Yates. Martinez volunteered to work at the McLaughlin IHS in the fall of 2007. *Id.* at 11:20-23. Martinez recalled that at the time she worked at the McLaughlin IHS, the clinic was staffed by two nurse practitioners – herself and Carletta Aberle. *Id.* at 14:9-13. In the fall of 2007,

Martinez testified that the McLaughlin IHS had some appointment times for patients with chronic care conditions. In addition, providers saw walk-in patients. *Id.* at 13:24-25, 14:1-2; 15:5-12.

Registered nurse Jamie Giroux was the nurse who initially saw Harriet when she came to the clinic on October 25, 2007. Ryan Aff., Ex. 30 (Giroux dep. at 32:1-15). Giroux graduated from Cheyenne Eagle Butte High School and is also an enrolled member of the Standing Rock Sioux Tribe. *Id.* at 5:9-13, 6:25, 7:1. She has been a licensed registered nurse since 1992. *Id.* Giroux's entry that day reads, "here for refills of blood pressure pills. Out times two months." *Id.*; *see also* Ex. 15-12.

Nurse practitioner Martinez's documentation of Harriet's October 25, 2007, visit is as follows:

> Subjective: As above, patient has not taken meds for a couple of months. Heartburn episodes. Denies any shortness of breath.
> Objective: 41-year-old female in no acute distress, or NAD. Vital signs. I comment that the blood pressure was elevated at 157/103. TMs clear. Nose clear. Throat clear. Neck supple. Lungs clear to asculation bilateral. CTA bilat. Cardiovascular, regular rhythm and rate. I documented that I instructed Harriet on the disease process, risk of stroke.
>
> The purpose of the visit was hypertension noncompliance and acne.
> Medications prescribed were Lisinopril, 20 mg per day and Hydrochlorothiazide, 25 mg. per day; Zantac 150 mg per day; and Doxycycline 100 mg per day.

Id. at Ex. 15-12; Ryan Aff., Ex. 29 (Martinez dep. at 23:3-25).

Martinez refilled Harriet's prescriptions, providing for thirty pills each, and ordered two more refills ("RF2") in addition to one written to be filled on

October 25, 2007. Ryan Aff., Ex. 29 (Martinez dep. at 24:1-8). Harriet did not need to be seen by a doctor or nurse practitioner in order to refill her medications. *Id.* at 24:9-12; *see also* Ex. 15-12.

Martinez conducted a physical examination of Harriet and specifically asked Harriet if she had any shortness of breath in order to assess if she was experiencing any symptom of fluid buildup that could be caused by congestive heart failure or another condition that may be developing from her hypertension. *Id.* at 25:1-14. Harriet denied she had any shortness of breath. *Id.* at 15:18-19; *see also* Ex. 15-12 ("denies any SOB").

Martinez indicated that she documented Harriet's complaint of heartburn episodes. *Id.* at 25:21-22. This has been a longstanding condition of Harriet's for many years. When asked if Harriet complained of dizziness or fatigue, she indicated that if Harriet would have complained about it, Martinez would have documented her complaint. In essence, Martinez viewed Harriet's visit as being prompted by the need to refill her existing medications. *Id.* at 26:1-11. Martinez indicated that Harriet did not have any new symptoms such as fluid retention, crackles in the lungs, shortness of breath, dizziness, fatigue, or chest pain that would have warranted a more extensive medical examination or additional tests. *Id.* at 44:1-11; 53:25, 54:1-15; 62:4-25, 63:1-8.

Martinez documented Harriet's non-compliance with her hypertension medications because she noticed there were a number of months where Harriet did not take her medications. Martinez said for someone to not take their medications, knowing that they have a serious medical condition, is essentially

choosing to not be compliant in the plan of care that was prescribed for them. *Id.* at 39:1-15; Ex. 15-12. Martinez spent time with Harriet instructing her on the disease process related to high blood pressure even though Harriet seemed to be asymptomatic. *Id.* at 39:16-25. She talked to Harriet about the risk factors and things that can happen if you are not taking your medications and you have an elevated blood pressure. *Id.* at 40:1-7. Those risks included stroke, kidney failure, and heart failure. *Id.* at 40:13-25; Ex. 15-7. Martinez indicated that it appeared that Harriet's prescribed blood pressure medications may be controlling her blood pressures when she took them, so Martinez did not change Harriet's medications. *Id.* at 36:15-25, 27:1-4; *see also* Ex. 15-3. Harriet was directed to schedule a follow up appointment in three months and to return "PRN," which means "as needed." *Id.* at 47:17-23; *see also* Ex. 15-12.

Harriet was not seen by any medical provider at McLaughlin IHS after the visit with Martinez on October 25, 2007, and she did not present herself at any IHS facility with complaints involving chest pain, shortness of breath, or dizziness in the days leading up to her death.

D. Daily Patient Procedures in 2007

McLaughlin IHS saw a variable number of patients on a daily basis, determined by the number of providers present. Ryan Aff., Ex. 19 (Fischer Aff. ¶ 5). The patient registration clerk at McLaughlin IHS would ask the providers how many walk-in patients could be seen that day prior to opening the clinic. *Id.* ¶ 6. Once that number had been reached, she would inform patients that "that's all we can take for now." *Id.* In the fall of 2007, McLaughlin IHS also

took patients by appointment, which diminished the number of walk-in patient slots available each day. Ryan Aff., Ex. 31 (Fischer dep. 17: 13-16).

Fischer explained that she signs up the walk-in patients who are standing in line on a first-come, first-served basis. She rotates between the providers so they each get a fair number of patients. When there are no more spots for patients to be signed up, they are told that there is no more room. These patients can go to Fort Yates, or they can come back the following day or the following afternoon if this was the morning sign up. *Id.* at 15:2-15. Fischer would tell them they could come back or they could sit in the waiting room and if somebody did not show up for their appointment, the provider or the nurses would call and say they can do a few more walk-ins. *Id.* at 15:25, 16:1-7. This walk-in number was not written in stone, and if the providers were ahead of schedule and there were more people to be seen, Fischer would call back and ask if they could fit a patient in. *Id.* at 10:15-21.

As a provider at McLaughlin IHS, Martinez did not have an arbitrary cut-off for the number of patients treated[4] and there were times when she and her coworker treated more than ten patients in the morning and ten patients in the afternoon. Ryan Aff., Ex. 29 (Martinez dep. at 15:13-25); *see also* Ex. 19 (Fischer Aff. and attached patient chart). In addition, Martinez recalled that

[4] Martinez was shown the memo that discusses a daily patient limit dated December 27, 2007. She had never seen a memo like that. Ryan Aff., Ex. 20 (Martinez dep. at 15:14-25, 16:1-3) (referring to Ex. 18). Registered Nurse Jamie Giroux also testified she did not recall this memo. Ryan Aff., Ex. 30 (Giroux dep. at 26:6-17). Giroux recalled clinic meetings where the discussion included the flow of the clinic and daily patient limits. *Id.* at 27:3-8. The daily patient limits were dependent on clinic provider staffing. *Id.* at 27:17-20.

when the OB-GYN specialist, Dr. Obritsch, came to McLaughlin, he used two of the exam rooms, leaving one exam room and the procedure room for other patients. Ryan Aff., Ex. 29 (Martinez dep. at 16:8-16). Dr. Obritsch came to see patients at McLaughlin IHS one day a month. *Id.* at 16:15-21, 17:1-10. On those days when Dr. Obritsch was present, Martinez indicated the clinic was "very, very, very, very busy." *Id.* at 17:11-14.

When there were more walk-in patients at McLaughlin IHS than could be seen, Nurse Giroux's practice was to tell patients they could wait to see if someone cancelled or did not take as long as they were supposed to and she would try to see them. Ryan Aff., Ex. 30 (Giroux dep. 16:10-25, 17:1-4). Giroux made an effort to try to get patients in even if they were beyond the daily limit of patients to be seen. *Id.* 17:9-13. In addition, patients who could not be seen at the McLaughlin IHS always had the option to go to Fort Yates IHS. *Id.* at 31:14-15.

Patients were also able to make appointments at the McLaughlin IHS in 2007. Ryan Aff., Ex. 31 (Fischer dep. at 17:6-10). Every day at the McLaughlin IHS was different as far as how many patients were treated. There were some days there were not any patients standing in line to be seen. On other days there were far more patients than the daily limit allowed. The clinic staff tried their best to accommodate everybody. *Id.* at 19:8-14.

McLaughlin IHS uses a resource patient management system to calculate the number of provider visits per day at McLaughlin IHS Health Center on a daily basis. Fischer used this system to ascertain the number of provider visits

per day from October 25, 2007 (Harriet's last appointment) to November 27, 2007 (Harriet's date of death). Ryan Aff., Ex. 19 ¶ 7. Fischer put those numbers in a spread sheet, which is attached to Fischer's Aff., Ex. 19. Dr. Obritsch is noted on the spread sheet because he is an obstetric specialty provider who comes to the clinic once a month to see prenatal and gynecology patients. His patients are included in the McLaughlin IHS provider counts because he uses the clinic exam rooms to see patients, and those days are noted on the spread sheet (inserted below). Ex. 19 ¶ 7.

DATE	DAY	OUTPATIENT VISITS	# of providers		
10/25/2007	Thursday	24	2		
10/26/2007	Friday *	9	1		* Fridays are afternoons only
10/29/2007	Monday	49	3		Dr. Obritsch day
10/30/2007	Tuesday	28	2		
10/31/2007	Wednesday	24	1		
11/1/2007	Thursday	27	2		
11/2/2007	Friday *	11	1		* Fridays are afternoons only
11/5/2007	Monday	42	2		
11/6/2007	Tuesday	37	3		
11/7/2007	Wednesday	28	1		
11/8/2007	Thursday	26	2		
11/9/2007	Friday *	16	2		* Fridays are afternoons only
11/12/2007	Monday	HOLIDAY-CLOSED	0		
11/13/2007	Tuesday	25	2		
11/14/2007	Wednesday	27	2		
11/15/2007	Thursday	32	2		
11/16/2007	Friday *	16	1		* Fridays are afternoons only
11/19/2007	Monday	35	2		
11/20/2007	Tuesday	21	1		
11/21/2007	Wednesday	26	2		
11/22/2007	Thursday	HOLIDAY-CLOSED	0		
11/23/2007	Friday *	11	1		* Fridays are afternoons only
11/26/2007	Monday	43	3		Dr. Obritsch day
11/27/2007	Tuesday	32	2		

Looking at the table above, it is clear that on most of those days, McLaughlin IHS saw more than ten patients in the morning and ten patients in the afternoon. The exception to that was on Fridays, which was because the clinic was not open on Friday mornings. Ryan Aff., Ex. 33 (Fischer dep. at 8:13-14).

E. Ways the McLaughlin IHS Handled Patients with Shortness of Breath, Chest Pain, or Dizziness

There is a sign at the patient registration window where walk-in patients sign up at McLaughlin IHS that instructs patients who are experiencing shortness of breath, chest pain, or dizziness to notify the nurse immediately. *Id.* at 35:17-20. If a patient registration clerk is notified by a patient that they are experiencing these symptoms, the clerk calls a nurse. *Id.* at 35:21-22. A patient may also walk straight to the nurses' station without speaking with the registration clerk. *Id.* at 35:23-24. If a patient had an urgent need to be seen and there was no more room for walk-in patients, a nurse would be immediately contacted and would come and get the patient to administer immediate care. *Id.* at 19:15-20.

Virgil Taken Alive, one of Harriet's cousins, testified that because he was a diabetic and had open heart surgery in 2001, he was very familiar with McLaughlin IHS. Ryan Aff., Ex. 32 (Taken Alive dep. at 6:4-8). He testified he has experienced inconsistencies in the number of walk-in patients the McLaughlin IHS could see, and that in order to be seen he would have to be at the clinic by 7:30 a.m. *Id.* at 6:8-24. Taken Alive also was aware of the signs

indicating a patient suffering from chest pain, shortness of breath, or dizziness should seek help immediately, and that he did so when he personally experienced these symptoms and was seen immediately. *Id.* at 8: 8-11. Taken Alive recalls the signs had been posted in McLaughlin IHS for "as far as I can remember previous to that" day when he sought immediate help. *Id.* at 9: 6-7.

Debra Wimmer, a former patient registration clerk at McLaughlin IHS, also stated that if a patient informed her that the patient was experiencing chest pain, shortness of breath, or dizziness, the patient was immediately taken to the nurse's station to be evaluated by a provider. Ryan Aff., Ex. 23 ¶ 12.

According to Martinez, if a walk-in patient came to McLaughlin IHS and complained of chest pain, dizziness, or shortness of breath, the nurse would have assessed the patient and informed the provider on duty so a decision could be made as to whether the patient needed to be sent by ambulance to a higher level of care. Ryan Aff., Ex. 29 (Martinez dep. at 44:12-25). If necessary, an ambulance would be called to transport the patient. *Id.* at 45:1-8. A patient who reported such symptoms to staff at the McLaughlin IHS would not be ignored. *Id.* at 45:0-12.

F. Harriet's Prior Attempts to Be Seen

Fischer has no recollection of Harriet Archambault repeatedly trying to be seen at McLaughlin IHS. However, she does recall seeing Harriet in line once, but Harriet left when Fischer told the patients before her that the clinic

was full, so Fischer did not actually speak to Harriet that day. Ryan Aff., Ex. 19 ¶ 8.

Fischer also recalls Harriet coming into McLaughlin IHS clinic on the afternoon of November 26, 2007, the day prior to Harriet's death. Harriet asked whether there was any walk-in availability. *Id.* ¶ 10. When she was told there was none, Harriet smiled and politely said "O.K., thank you," and left. *Id.* Harriet did not tell Fischer or any other employees at McLaughlin IHS she was suffering from chest pain, dizziness, or was having difficulty breathing. *Id.* ¶¶ 10, 12.

November 26, 2007, was one of the busy days when Dr. Obritsch was on site. On that day there were forty-three patients seen at McLaughlin IHS. *Id.* ¶ 11; Ryan Aff., Ex. 31 (Fischer dep. at 38:23-25, 39:1-7). The regular providers saw thirty-one patients, while an additional twelve patients were OB patients. *Id.* at 39:17-24.

Fischer verified there is a sign posted at the sign-up window in McLaughlin IHS that tells patients if they are having shortness of breath or chest pain or dizziness, they are supposed to notify the nurse immediately. Fischer dep. at 35:17-20. Fischer testified that if Harriet would have indicated that she was having chest pains or difficulty breathing or severe dizziness, she would have directed Harriet to go to the nurses' station immediately. Ryan Aff., Ex. 19 ¶13; Ex. 31 (Fischer dep. at 36:7-20).

G. The Day Harriet Died

On November 27, 2007 — the day Harriet died — she had planned on driving her daughter, Diane Archambault, to Bismarck to be induced into labor. Ryan Aff., Ex. 34 (Diane Archambault dep. at 41:19-20). However, earlier on the morning of November 27, 2007, Harriet drove her daughter Leah Archambault to her new job at the Prairie Knights Casino and then returned to her home in Bullhead. Ryan Aff., Ex. 35 (Leah Archambault dep. at 4:21-22). The trip was approximately forty miles each way. *Id.* at 5:20. Harriet did not tell Leah that she was suffering from any symptoms. *Id.* at 7:23-25.

While driving Leah to Prairie Knights Casino on the morning of her death, Harriet drove past the Ft. Yates Hospital twice, once on the trip to the casino, and again on the way back. Fort Yates IHS has a 24-hour emergency room. Ryan Aff., Ex. 28 (Rand report at 4). If Harriet had been experiencing any life threatening conditions such as shortness of breath, chest pains, or dizziness, she could have easily gone to the Fort Yates IHS emergency room. Harriet also drove right past McLaughlin IHS on her way home. Again, Harriet made no attempt to seek care at McLaughlin IHS on November 27, 2007.

When Harriet returned home, she did not indicate to her husband that she was suffering from chest pain, shortness of breath, or dizziness. Ryan Aff., Ex. 36 (Paul Archambault dep. at 44:18-23). Harriet told her husband that she was going to shower and prepare to take their oldest daughter, Diane, to Bismarck. *Id.* at 38:8-9. From the time of Harriet's last appointment at McLaughlin IHS on October 25, 2007, until her death on November 27, 2007,

Harriet did not complain of having chest pain to her husband. *Id.* at 69:17-21. Harriet also did not attempt to make an appointment at any time in the month leading up to her death. *Id.* at 77:6-7.

H. Medical Evidence of Standard of Care and Cause of Death

The United States has provided an expert opinion that the care Harriet received for her hypertension on October 25, 2007, was appropriate, and the follow up for re-evaluation in three months was reasonable. Plaintiff has no expert to rebut that testimony. Accordingly, Plaintiff failed to sustain his burden of proof on summary judgment and Defendant is entitled to a judgment as a matter of law on this FTCA claim.

The United States hired a cardiologist to review the medical care and treatment provided to Harriet. Dr. Elden Rand conducted a comprehensive review of Harriet's hypertension medication compliance and found from 8/20/1999 to 11/27/2007, during a span of 3,021 days that Harriet was on blood pressure medications, she was out of medication for 624 of those days. Ryan Aff., Ex. 26 (Deposition of Dr. Eldon Rand, hereafter Rand dep. at 25:21-25); Ex. 28 (Rand report). Failure to consistently take her medication resulted in Harriet's hypertension being uncontrolled. Uncontrolled hypertension is the most common cause of developing left ventricular hypertrophy (a thickening of the heart wall) and an enlarged heart. Ryan Aff., Ex. 42 (Deposition of examining pathologist Dr. Donald Habbe, hereafter Habbe dep. at 9:14-25, 10:1-2); Ex. 26 (Rand dep. at 17:13-14).

Harriet's enlarged heart is what predisposed her to a sudden heart arrhythmia, which caused her death. Ryan Aff., Ex. 24 (autopsy report); Ex. 42 (Habbe dep. at 8:19-25; 29:2-22). According to Dr. Habbe, the scary thing about having an enlarged heart is that a person does not have symptoms that would alert them to the condition. Ryan Aff., Ex. 42 (Habbe dep. at 11:3-6).

There was no evidence upon autopsy that Harriet had congestive heart failure. Specifically, there was no fluid accumulation in her lungs or lower extremities, blood congestion in the liver, or any of the other findings that occur when a person has congestive heart failure. *Id.* at 22:21-25, 23:1-15, 26:1-11. The build-up of fluid in the lungs is what will cause someone in congestive heart failure to become short of breath. The lack of fluid in Harriet's lungs is consistent with her statement to nurse practitioner Martinez on October 25, 2007, that she denied any shortness of breath.

According to Dr. Rand, many medical tests, especially cardiac tests, require the presence of symptoms before they can be ordered. Ryan Aff., Ex. 26 (Rand dep. at 28:11-14). During Harriet's medical appointment on October 25, 2007, Harriet indicated she was not suffering from symptoms that would require any sort of cardiac testing, such as an EKG, an echocardiogram, or a stress test. *Id.* at 29:3-6. Such symptoms include chest pain, exertional shortness of breath, palpitations, lower extremity swelling, congestion, or difficulty breathing. *Id.* at 29:11-14. Without the presence of those symptoms, ordering an echocardiogram for Harriet would have fallen outside the standard of care. *Id.* at 29:20-21.

A stress test would not be a test used to assess if a patient had left ventricular hypertrophy. *Id.* at 33:1-2; Ex. 26 ¶ 6. Moreover, chest pain is indicative of a heart blockage or an acute myocardial infarction or congestive heart failure. Ryan Aff., Ex. 26 at 4. Harriet did not report these symptoms to her medical providers. *Id.* This would be consistent with the autopsy findings that Harriet did not have those conditions.

An echocardiography is the test that could have revealed Harriet's left ventricular hypertrophy and enlarged heart. Ryan Aff., Ex. 26 (Rand dep. at 30:9-12); Ex. 28 ¶ 5. However, it is not ordered for asymptomatic patients like Harriet. *Id.* Even if an echocardiography had been ordered and a diagnosis of left ventricular hypertrophy was made, there would have been no change in her treatment, which included placement on appropriate high blood pressure medications and counseling on the importance of high blood pressure control. Ryan Aff., Ex. 26 (Rand dep. at 30:21-23, 31:1-4); Ex. 28 ¶ 7. Here, Harriet was already on the standard medications that would have been prescribed upon discovery of left ventricular hypertrophy. Ryan Aff., Ex. 26 (Rand dep. at 31:3-6). Aside from being placed back on medications, a patient with left ventricular hypertrophy would have been placed on a plan for re-evaluation. *Id.* at 32:8-9. Harriet was told to return to McLaughlin IHS in three months or as needed by Martinez, which was a reasonable plan for reevaluation. *Id.* at 32:11-14.

Although Harriet did come to McLaughlin IHS on November 26, 2007, Harriet did not present herself as having life threatening symptoms. When she was told that the walk-in spots were full, she smiled and said, "O.K. Thank

you." Harriet did not indicate she had an emergent need to be seen. It was one of the busiest days of the month, with the obstetrical specialist on site and forty-three patients were seen in the McLaughlin clinic that day. Thus, the December 27, 2010, memo stating that due to having only one provider, they have been seeing ten patients in the morning and ten in the afternoon has no causal relationship to Harriet's death.

The autopsy verified that Harriet did not have a heart blockage or congestive heart failure, which could be expected to result in chest pain or shortness of breath symptoms. This is consistent with the fact that Harriet did not present with those symptoms to McLaughlin IHS. Even on the morning of her death, Harriet did not mention any chest pain or shortness of breath to her husband, Paul, or to her daughter, Leah. If Harriet had been having emergent symptoms such as chest pain, shortness of breath, or dizziness, she had two opportunities on the morning of her death to avail herself of the Fort Yates IHS emergency room. She drove by that facility without stopping. In essence, there is no evidence Harriet was ever symptomatic until the sudden onset of her heart arrhythmia.

The United States has provided an expert opinion that the care Harriet received for her hypertension on October 25, 2007, was appropriate, and the follow up for re-evaluation in three months was reasonable. Plaintiff has no expert to rebut that testimony. *See Mattke v. Deschamps*, 374 F.3d 667, 672 (8th Cir. 2004) (citing Minnesota law that "[i]n order to prove medical negligence in a malpractice action, a plaintiff must offer expert medical

testimony both to state the standard of medical care and the treatment recognized by the medical community and to establish that the defendant physician in fact departed from that standard[.]"); *Thompson v. Lillehei*, 273 F.2d 376, 381 (8th Cir. 1959) ("Ordinarily, because of the technical and specialized subject matter, expert medical testimony is required to establish failure to use such due care under the circumstances."). Thus, Plaintiff has failed to sustain his burden of coming forth with evidence sufficient to establish Defendant breached its duty or standard of care. *See Wierzbicki v. United States*, --- F. Supp. 2d ----, 2014 WL 3530142, at *10 (D.S.D. July 15, 2014) ("Ultimately, [plaintiff] bears the burden of proof that the standard of care was breached[.]").

Plaintiff's only expert witness is a forensic pathologist, who based his opinion upon the assumption that Harriet had an onset of chest pain and shortness of breath, for which IHS denied appropriate treatment. *See* Ryan Aff., Ex. 27 (report of Dr. Bux). His opinion is that had she been evaluated for shortness of breath and chest pain, IHS would have "evaluated and treated her." Dr. Bux is not a cardiologist, and he does not describe the standard of care for the treatment of hypertension. He lacks credibility and foundation to contradict Dr. Rand's assessment that the proper treatment for an enlarged heart is placement on high blood pressure medications and re-evaluation or that the re-evaluation in three months was appropriate for an asymptomatic patient.

Absent conflicting expert evidence to the contrary, there is no genuine dispute that Defendant did not breach its duty or standard of care. Moreover, it is undisputed that Harriet's untimely death was caused by a sudden heart arrhythmia caused by the severe thickening of her heart tissue muscle resulting in an enlarged heart. This condition was, in turn, caused by Harriet's long term uncontrolled high blood pressure. The uncontrolled high blood pressure was not the fault of IHS providers. Rather, it was caused by Harriet's habitual intermittent noncompliance with her prescribed hypertension medication therapy. The standard of care for the treatment of Harriet's hypertension was met by the McLaughlin IHS providers. For these reasons, the United States is entitled to summary judgment as a matter of law.

CONCLUSION

There is no genuine dispute in fact that Plaintiff failed to satisfy the agency presentment requirements necessary to maintain this cause of action. This court does not have jurisdiction over the claim because the United States has not waived its sovereign immunity when the discretionary function exception applies. Finally, Plaintiff failed to sustain his burden of proof on the issue of whether Defendant breached its duty or standard of care when he did not offer expert testimony to contradict Defendant's expert, who concluded Defendant had met the requisite standard of care and that Harriet's untimely death was not caused by the conduct or actions of Defendant. Accordingly, summary judgment is appropriate.

Dated this 12th day of August, 2014.

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/s/ Diana Ryan

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