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IN THE CIRCUIT COURT OF THE FIRST CIRCUIT

STATE OF HAWAII

JARED JAMES,

Plaintiff,

vs.

PATRICK J. O'DONNELL, M.D.; SUSAN
TAN, M.D.; SELENA PETERS, M.D.;
MERLA TAKENAKA RN; KAPIOLANI
MEDICAL SPECIALISTS; KAPIOLANI
MEDICAL CENTER FOR WOMAN AND
CHILDREN; HAWAII PACIFIC HEALTH,

Defendants.

Civil No. 1CCV-21-0000683 (SMK)

**DEFENDANTS PATRICK J.
O'DONNELL, M.D.; SUSAN TAN, M.D.;
AND KAPI'OLANI MEDICAL
SPECIALISTS' MEMORANDUM IN
OPPOSITION TO PLAINTIFF'S
MOTION FOR PARTIAL SUMMARY
JUDGMENT FILED MARCH 30, 2026
[DKT. 365]; DECLARATION OF JOHN-
ANDERSON L. MEYER; EXHIBITS "A" –
"F"; CERTIFICATE OF SERVICE**

Hearing:

Date: April 29, 2026

Time: 11:00 a.m.

Judge: Honorable Shirley M. Kawamura

Trial: May 18, 2026

Judge: Honorable Shirley M. Kawamura

**DEFENDANTS PATRICK J. O'DONNELL, M.D.; SUSAN TAN, M.D.;
AND KAPI'OLANI MEDICAL SPECIALISTS' MEMORANDUM IN
OPPOSITION TO PLAINTIFF'S MOTION FOR PARTIAL SUMMARY
JUDGMENT FILED MARCH 30, 2026 [DKT. 3652]**

I. INTRODUCTION

Defendants Patrick J. O'Donnell, M.D.; Susan Tan, M.D.; and Kapi'olani Medical Specialists ("KMS Defendants") oppose Plaintiff's Motion for Partial Summary Judgment filed on March 30, 2026 [Dkt. 365].

Plaintiff's Motion seeks summary judgment on no fewer than ten separate issues, spanning battery, fraud, spoliation, vicarious liability, comparative fault, damages caps, statute of limitations, intentional infliction of emotional distress, *negligence per se*, and the so-called "ghost surgery" doctrine. This Court should deny the Motion in its entirety because Plaintiff has failed to demonstrate the absence of genuine issues of material fact on any of these issues in his favor, and many of his arguments rest on mischaracterizations of the record, improper speculation and inferences drawn in his own favor, repeated reliance on fake case citations, and legal conclusions that require expert testimony he has not provided, and he himself is not qualified to provide.

II. RELEVANT BACKGROUND

A. Plaintiff's Claims

Plaintiff filed his original Complaint in this Court on May 25, 2021 alleging medical negligence. Dkt. 1 (Complaint). On May 26, 2023, Plaintiff was retroactively granted leave to file a First Amended Complaint ("FAC", Ex. A).

According to the FAC, Plaintiff alleges he was referred to defendant Patrick J. O'Donnell, M.D., an otolaryngologist at Kapi'olani Medical Center for Women and Children (KMCWC), for treatment of nasal valve collapse.¹ Ex. A, FAC at ¶5. Plaintiff alleges that at an initial consultation on February 26, 2016, he requested a "single minor surgical procedure", that Dr. O'Donnell agreed and represented it would be a two-surgeon operation with co-defendant Susan Tan, M.D. *Id.* at ¶9. Plaintiff further alleges that he did not believe general anesthesia was necessary for the requested procedure but was not offered alternatives and, after the

¹ Plaintiff's original Complaint and FAC contain multiple allegations setting forth in the public arena what otherwise would be his confidential protected health information. Because Plaintiff has affirmatively alleged these facts and put into the public record what otherwise would be confidential, KMS Defendants have not sought to redact or seal their references to these portions of the publicly filed FAC.

surgeries, was told of an internal “nose cones” product that could brace his nostrils without surgery. *Id.* at ¶10.

Plaintiff contends that all surgical procedures took place on May 26, 2016 at KMCWC and alleges that he was “fully anesthetized” approximately two and one-half hours before surgery in a secluded room, resulting in hypothermia at the start of the procedure. *Id.* at ¶¶11, 31, 32. Plaintiff alleges that Dr. O’Donnell broke his turbinate “bones” and “cut out” his adenoid, and that he was never informed of this. *Id.* at ¶¶77-82.

Plaintiffs’ expert disclosure deadline and final naming of witnesses expired on January 20, 2026 (120 days prior to trial). No expert report was served by Plaintiff by his January 20, 2026 deadline; Plaintiff filed a very tardy final naming of witnesses on March 8, 2026, with no explanation or excuse for not having timely filed and identified his witnesses (*see* Dkt. 287)—no expert witness for the Plaintiff (other than cross examination of the Defendants’ experts) was identified in this filing, either. The discovery deadline passed on March 19, 2026.

On January 2, 2026 KMS Defendants filed their Motion for Judgment on the Pleadings (Dkt. 195). The Court granted the Motion, and dismissed “causes of action” Sections (A), (B), (C), (F), (G), and (H). Dkt. 333. Plaintiff filed a Motion for Reconsideration (Dkt. 240), which was denied (Dkt. 321).

The only remaining claims in the FAC are Section (D)-Medical Malpractice, and Section (E)-Breach of Contract. Under his Medical Malpractice claim, Plaintiff alleges: (1) Assault in the First Degree²; (2) False Imprisonment in the First Degree³; (3) Fraud; (4) Intentional Infliction of Emotional Distress; (5) Product Liability; and (6) Unnecessary Actions. Ex. A, FAC at 9-11. Under his Breach of Contract claim, Plaintiff alleges he made a deal with Dr. O’Donnell to use ear cartilage to brace vestibule collapse on February 26, 2016 which he claims was their first and only encounter before the day of surgery.

KMS Defendants moved for summary judgment on all claims, and that motion is pending with the Court, set for hearing on April 29, 2026. Dkts. 351 (public) and 353 (sealed).

² This is a criminal charge, not a civil cause of action.

³ This is a criminal charge, not a civil cause of action.

III. ARGUMENT

A. Plaintiff Has Violated HRCF Rule 11 By Filing This Motion And Citing To Nonexistent Authority.

Pursuant to HRCF Rule 11(c)(1)(B), Defendant requests that the Court issue an order to show cause why Plaintiff has not violated Rule 11(b) by filing his Motion for Partial Summary Judgment without any supporting admissible evidence or the required expert opinion. None of the arguments presented in Plaintiff's Motion are warranted by existing law or by a nonfrivolous argument for the extension, modification, or reversal of existing law or the establishment of new law. As such, Plaintiff's Motion violates HRCF Rule 11(b)(2). Further, by filing this frivolous motion, Plaintiff has caused the "needless increase in the cost of litigation" by forcing all of the Defendants to respond in opposition to a motion that is wholly unsupported by the required admissible evidence, and should never have been filed. *See* Rule 11(b)(1). Rule 11 applies with equal authority and effect to *pro se* litigants as to those represented by counsel. *See* Rule 11. As courts of other jurisdictions have found, a plaintiff's *pro se* status is no excuse for failure to comply with the same substantive and procedural rules that apply to represented parties:

Parties who decide to represent themselves are entitled to fair and equal treatment by the courts. The courts should take into account that many *pro se* litigants have no legal training and little familiarity with the judicial system. However, the courts must also be mindful of the boundary between fairness to a *pro se* litigant and unfairness to the *pro se* litigant's adversary. Thus, the courts must not excuse *pro se* litigants from complying with the same substantive and procedural rules that represented parties are expected to observe.

Hessmer v. Hessmer, 138 S.W.3d 901, 903 (Tenn. Ct. App. 2003) (internal citations omitted).

Plaintiff should not be permitted a "pass" for violations of Rule 11, simply because of his *pro se* status or his subjective belief in the merits of his arguments. *See, e.g., Lepere v. United Pub. Workers, Local 646, AFL-CIO*, 77 Hawai'i 471, 474, 887 P.2d 1029, 1032 (1995) ("[E]ven though a court may take into account a litigant's *pro se* status, a *pro se* litigant's subjective sincere belief in his or her claim is not sufficient to satisfy the mandates of FRCP Rule 11").

Further, Plaintiff's Motion is replete with fake case citations. On nearly every page in Plaintiff's Argument section (*e.g.*, pp. 12, 13, 14, 15, 16, 18, 19, 20, and 22), he provides specific page pin-cites to existing cases, but the pages cited do not stand for the proposition for which they are cited; he also quotes language that does not appear in the cited cases. *See* Exhibit "B" hereto, table setting forth inaccurate citations. From the above, it appears that Plaintiff has either made up case citations and quotations, or has relied on an Artificial Intelligence ("AI") system to

provide fictitious authority for his arguments. Neither is excusable. As the Intermediate Court of Appeal recently reiterated,

A fake opinion is not ‘existing law’ An attempt to persuade a court or oppose an adversary by relying on fake opinions is an abuse of the adversary system. Thus, using a fake opinion to support an argument is a violation of [Fed. R. Civ. P.] Rule 11(b)(2).

Keaau Development Partnership LLC, et al., v. v. Patrick John Lawrence, Jr. dba as Pj's Construction, et al., No. CAAP-24-0000494, 2025 WL 1366320, at *1 (Haw. Ct. App. May 12, 2025) (brackets in original; internal quotations and citations omitted), appended hereto at Exhibit “C”. In *Keaau Development Partnership*, the Court determined that citation to a nonexistent case was not reasonable under the circumstances, and constituted a violation of HRCF Rule 11(b)(2), subjecting the filer to sanctions. *Id.* at *2-3. Purporting to “quote” from existing cases but with language that is not contained in those cases, and relying upon citations to existing cases and pages which do not stand for the propositions for which they are cited is no more excusable than citation to a nonexistent case.

KMS Defendants respectfully request that the Court issue an additional order to show cause why Plaintiff should not be sanctioned under HRCF Rule 11(c)(1)(B) for violation of HRCF Rule 11(b), based on submission of fictitious case law to this Court.

B. Plaintiff’s Informed Consent Claim Fails Because He Has No Expert to Establish the Materiality of Risk.

Plaintiff continues to misrepresent his medical tort claims as “battery” claims. They are not. The only remaining claims in the FAC are Section (D)-Medical Malpractice, and Section (E)-Breach of Contract. Under his Medical Malpractice claim, Plaintiff alleges: (1) Assault in the First Degree; (2) False Imprisonment in the First Degree; (3) Fraud; (4) Intentional Infliction of Emotional Distress; (5) Product Liability; and (6) Unnecessary Actions. *Id.*

Plaintiff makes the conclusory assertion that “[b]attery does not require expert testimony” and then proceeds to cite a *Nishi v. Hartwell*, a medical malpractice action, for the proposition that “[w]here consent is wholly absent or procured by fraud, the act of surgery is itself the harm.” Motion at 12. First, the page Plaintiff cited in *Nishi* **does not stand for that proposition.**

Instead, the Supreme Court of Hawai‘i in *Nishi* held that a plaintiff’s arbitrary framing of a complaint and/or theory of the case will not stand if the underlying facts show that a different legal theory is more appropriate. See *Nishi v. Hartwell*, 52 Haw. 188, 191, 473 P.2d 116, 119 (1970), overruled on other grounds by *Carr v. Strode*, 79 Hawai‘i 475, 904 P.2d 489; *Territory of Hawaii v. Branco*, 42 Haw. 304, 311 (1958).

Second, regardless of his use of the word “battery”, it is apparent from his FAC that Plaintiff is alleging a medical tort and potentially a lack of informed consent claim. The cases that Plaintiff cites are cases addressing medical torts, not battery.

To the extent Plaintiff’s claim could be construed as alleging a failure to obtain informed consent, it fails. Plaintiff has no expert to carry his *prima facie* burden on to establish the materiality of risk. Under Hawai’i law, a plaintiff asserting an informed consent claim must demonstrate, among other elements, that the physician owed a duty to disclose the risk of the collateral injuries the patient suffered. *Barcai v. Betwee*, 98 Hawai’i 470, 483, 50 P.3d 946, 959 (2002). Critically, the Hawai’i Supreme Court has “strongly caution[ed] ... that our adoption of the patient-oriented standard does not relieve plaintiffs of their burden to provide expert medical testimony as to the ‘materiality’ of the risk.” *Carr*, 79 Hawai’i at 486, 904 P.2d at 500. As the Court explained, “a plaintiff maintains the burden of adducing expert medical testimony to establish the nature of risks inherent in a particular treatment, the probabilities of therapeutic success, the frequency of the occurrence of particular risks, and the nature of available alternatives to treatment.” *Id.* Following *Carr*, the Hawai’i Supreme Court further clarified in *Ngo v. Queen’s Medical Center*, 136 Hawai’i 54, 68, 358 P.3d 26, 40 (2015), that plaintiffs must first “adduce[] expert testimony establishing prima facie that the risk of harm that occurred is a ‘recognized material risk of serious complication or mortality.’” *Id.* Hawai’i Civil Jury Instruction 14.4 likewise explicitly requires expert testimony to support an informed consent claim. (Available at https://www.courts.state.hi.us/docs/legal_references/jury_instructions_civil.pdf, at Instruction 14.4)

Plaintiff has failed to timely disclose any qualified expert to provide an opinion on the materiality of any risk associated with the procedures performed on May 26, 2016. He has offered no expert testimony regarding (1) the nature of risks inherent in septoplasty, turbinate reduction, or alar batten grafting; (2) the probabilities of therapeutic success; (3) the frequency with which particular risks occur; or (4) the nature of available alternative treatments. Without expert testimony on these issues, Plaintiff cannot satisfy his *prima facie* burden, and any informed consent claim fails.

Plaintiff emphasizes that the electronic medical record (“EMR”) does not contain a consent form with his signature. How medical records are kept and opinions about the EMR at issue here and what they contain and whether informed consent was obtained and/or appropriately documented is not something within the knowledge base of a lay juror. Expert

opinion is needed to explain the standard of care for medical record keeping and whether it was breached in this case, and whether any such breach was the *cause* of Plaintiff's alleged damages. Without competent expert testimony on these issues, Plaintiff's informed consent claim fails; summary judgment in KMS Defendants' favor and against Plaintiff is required.

C. Plaintiff's Argument Regarding "Normal" Anatomy Requires Expert Testimony

Plaintiff asserts that performing septoplasty and turbinate reduction on anatomy documented as "normal" in the limited pre-operative examination constitutes unauthorized surgery. Motion at 16. This argument fundamentally conflates pre-operative findings with intraoperative findings and clinical judgment, and is not within the knowledge of a lay juror.

Whether the intraoperative finding of a slight septal deviation was clinically accurate, and whether the procedures performed were within the scope of reasonable surgical judgment are questions that squarely require expert testimony on the standard of care under the circumstances. Plaintiff's attempt to resolve these medical questions through documentary comparison (*id.*)—without any expert opinion—is precisely the type of lay speculation that summary judgment cannot accommodate. A medical negligence claim based on exceeding the scope of consent provided in the surgical context requires expert testimony to establish what procedures were medically necessary and what a reasonable surgeon would have done under the same or similar circumstances. *Carr*, 79 Hawai'i at 483, 904 P.2d at 497.

Plaintiff's failure to provide expert testimony on this issue is fatal to his claim. "It is well settled that in medical malpractice actions, the question of negligence must be decided by reference to relevant medical standards of care for which the plaintiff carries the burden of proving through expert medical testimony." *Craft v. Peebles*, 78 Hawai'i 287, 298, 893 P.2d 138, 149 (1995). Plaintiff failed to serve any expert disclosures by his January 20, 2026 deadline. No expert was identified in Plaintiff's very tardy final naming of witnesses filed on March 8, 2026. Plaintiff belatedly disclosed "expert" reports (although he refuses to call them "experts" as an attempt to circumvent the discovery rules), and KMS Defendants have moved to strike that disclosure and preclude their testimony at trial. *See* Dkt. 414. Without expert testimony, Plaintiff cannot establish that the intraoperative finding of septal deviation was clinically unsupported, that the decision to perform septoplasty was outside the standard of care, or that the procedures were not medically appropriate. KMS Defendants' expert, Dr. Marc Stiefel, has affirmatively opined that "Dr. O'Donnell performed an appropriate procedure, in an appropriate fashion, using an appropriate cartilage graft, that met the standard of care expected of

an otolaryngologist,” and that for any surgery where the status of the preferred graft site is unknown, “it is commonplace to consent the patient to harvest a graft from an additional site, a procedure to be performed if needed.” Ex. D, Stiefel Report. This un rebutted expert testimony directly contradicts Plaintiff’s claim that any procedures on what he has described as “normal” anatomy were unauthorized. Plaintiff has no expert to counter Dr. Stiefel’s opinions, and his attempt to substitute lay documentary comparison for expert medical testimony is legally insufficient. Summary Judgment in KMS Defendants’ favor, and against Plaintiff is required on this issue.

D. Alleged Hypothermia Requires Expert Opinion

Plaintiff argues that a recorded core temperature of 34.9°C establishes hypothermia and that Dr. Peters’ Post-Anesthesia Evaluation “misrepresents the data” by citing a 9:15 a.m. pre-operative vital signs. Motion at 17. However, the clinical significance of a 34.9°C reading—whether it constitutes a complication, whether it was within an acceptable range for the procedure, and whether it required disclosure—are medical questions requiring expert testimony.

Plaintiff’s reliance on an unauthenticated article (*i.e.*, Sessler (2011)) (Motion at 17) to argue that the temperature data “scientifically” proves anesthesia began at 9:00 a.m. rather than 11:15 a.m. is speculative and is exactly the kind of issue which an expert opinion is required to explain.⁴ The Sessler article describes general thermoregulatory phases across populations; it does not establish duty, breach, causation, or damages. Plaintiff offers no expert to apply the Sessler framework to him or to the procedure at issue. The Court should not permit Plaintiff to offer his own lay opinions of how data apply to him; he is not a temperature physiology expert.

Plaintiff’s failure to provide any expert testimony on these medical issues is fatal to the hypothermia portion of his medical malpractice claim. Without an expert, Plaintiff cannot establish (1) the standard of care applicable to intraoperative temperature monitoring and post-anesthesia documentation, (2) that any Defendant breached that standard, or (3) that any purported breach caused his alleged injuries. *Craft*, 78 Hawai’i at 298, 893 P.2d at 149; *Barbee v. Queen’s Med. Ctr.*, 119 Hawai’i 136, 139, 194 P.3d 1098, 1101 (Ct. App. 2008) (holding that the failure to produce competent medical expert testimony on causation precluded recovery). Plaintiff’s expert disclosure deadline expired on January 20, 2026 without any expert disclosure.

⁴ Indeed, Defendant Dr. Peters has provided exactly the type of expert opinion necessary to explain the applicable standards and interpretation of data in the medical record. *See* [Dkt. 363], Dr. Peters’ Motion for Summary Judgment, and Exhibits “G” and “I” thereto, expert reports of Dr. Peters and Dr. Manago. Plaintiff has not provided any expert opinion to the contrary.

The absence of timely disclosed expert testimony is dispositive. Plaintiff cannot obtain summary judgment on an issue that requires expert proof he does not have.

E. Plaintiff Has Failed to Establish “Fraud”

To the extent Plaintiff’s Motion advances any fraud theory—whether based on CPT medical billing code discrepancies, the consent documentation, or the listing of Dr. Tan in his medical records—Plaintiff cannot satisfy the elements of fraud under Hawai‘i law. To prevail on a fraud claim, a plaintiff must establish: “(1) false representations were made by defendants, (2) with knowledge of their falsity (or without knowledge of their truth or falsity), (3) in contemplation of plaintiff’s reliance upon these false representations, and (4) plaintiff did rely upon them.” *Shope v. Gucci Am., Inc.*, 94 Hawai‘i 368, 386, 14 P.3d 1049, 1067 (2000). Plaintiff has failed to produce evidence sufficient to satisfy any of these elements.

As to the first and second elements, the allegations underlying Plaintiff’s purported fraud claims do not give rise to an actionable claim for fraud. They describe, at most, alleged deficiencies in the informed consent process and in medical record-keeping—*i.e.*, **medical torts**. There is no evidence that KMS Defendants made an affirmative false statement to Plaintiff with the intent that Plaintiff rely upon it.

1. The CPT Codes Do Not Establish “Fraud” or Breach of the Standard of Care

Plaintiff identifies three sets of procedure descriptions—the consent plan (CPT 21235 and 30802), the operative narrative (CPT 30802 and 20912), and the billing codes submitted (CPT 30520 and 30140 RT)—and characterizes any inconsistency as “fraudulent record-keeping and false billing.” Motion at 2. As a preliminary matter, the CPT code system⁵ and the correct use of CPT coding are not topics within the knowledge base of a lay juror—expert testimony is required to explain the meaning and proper use of CPT coding and whether the coding was appropriate in this case. Plaintiff has no such expert, and his lay interpretation of this specialized coding system is unreliable and speculative. How and whether the codes he identifies were selected within the standard of care for medical coding is a factual question requiring evidence of

⁵ Although not defined by Plaintiff, it is presumed he is referring to the Current Procedural Terminology (CPT) codes promulgated by the American Medical Association. CPT codes describe medical services and procedures performed by physicians and other qualified health care professionals. See American Medical Association, Practice Management—CPT, available at <https://www.ama-assn.org/practice-management/cpt>, last visited April 19, 2026.

KMS Defendants' state of mind and more importantly, an expert opinion on the standard for medical billing. Plaintiff offers none; he is not entitled to summary judgment on this issue.

2. Dr. Susan Tan's Role in the Surgery Does Not Establish "Fraudulent Documentation" or Breach of the Standard of Care

Plaintiff contends that because KMS Defendants' Answer (Dkt. 84, ¶21) admits that Dr. Tan "had no active role" in the May 26, 2016 procedures, the medical records listing her name are "fraudulent." This argument fails.

First, the role of an assistant surgeon during surgery, and what the notation of their presence means in the medical and EMR context is not something within the knowledge base of a lay juror. Expert opinion is needed to explain the standard of care for an assistant surgeon, the standard of care for medical record keeping, whether they were breached, and whether any such breach caused injury to Plaintiff.

Second, whether Dr. Tan ultimately participated in the surgery does not establish that the records are fraudulent or were created with fraudulent intent. KMS Defendants' Answer (Dkt. 84, ¶10) explains that Dr. Tan's role was conditional—she would participate "only if harvest from the ear was necessary." The fact that a surgeon listed on pre-operative planning documents did not ultimately actively participate in a procedure is a commonplace occurrence in surgical practice and reflects the realities of intraoperative decision-making—not fraud. In addition, Plaintiff would need an expert to provide an opinion on Dr. Tan's role and actions during the surgery, as well as the medical documentation, and he has none. The Court should deny Plaintiff's request for summary judgment on this issue.

Furthermore, Plaintiff's repeated assertion that Dr. Tan "was not present" in the operating room (*see* Motion at 1, 13, 22, 23, and declaration of Plaintiff at 3, ¶1) is a misrepresentation of KMS Defendants' Answer and the evidence, and is a deliberate attempt to mislead the Court. Dr. Tan had no active role in the procedures performed (Dkt. 84, ¶21), but at no time has she or the other KMS Defendants stated that she was not present—quite the opposite.

3. There is No Evidence that Plaintiff Relied On Any of the Alleged Fraudulent Actions

As to the third and fourth elements, Plaintiff does not allege that he took any action or refrained from taking any action because of the alleged CPT code discrepancies, the alleged change in check-in time, the alleged false claims of communication, or the allegedly fraudulent consent signatures. There is no evidence of detrimental reliance on any purported misrepresentation. Even if Plaintiff could establish a false representation and reliance, he has not

produced evidence that any damages he allegedly suffered (*damages which he also has not provided any actual evidence or expert opinion to substantiate*) resulted from reliance on the alleged misrepresentations. The damages Plaintiff alleges flow from the medical procedures he underwent—not from any reliance on any representation. Plaintiff’s fraud theory cannot survive summary judgment, and it certainly does not support summary judgment in his favor.

F. Plaintiff Has Failed to Establish Any Element of His IIED Claim

Plaintiff asks the Court to find that KMS Defendants’ conduct was “extreme and outrageous” for purposes of intentional infliction of emotional distress. But Plaintiff’s Motion focuses exclusively on the “outrageous conduct” element while ignoring that he must establish all four elements of an IIED claim: “1) that the act allegedly causing the harm was intentional or reckless, 2) that the act was outrageous, and 3) that the act caused 4) extreme emotional distress to another.” *Hac v. Univ. of Hawaii*, 102 Hawai‘i 92, 107, 73 P.3d 46, 61 (2003). A plaintiff’s failure to establish even one element is fatal to the claim. Plaintiff has failed to establish any.

1. Plaintiff’s “Admitted Facts” Are Argument, Not Undisputed Facts — and Expert Testimony Is Required to Establish Intent or Outrageousness (Elements One and Two).

Plaintiff’s IIED argument rests entirely on what he characterizes as “admitted facts” — purportedly undisputed conduct so egregious that the Court can declare it outrageous. But these are not “admitted facts.” They are Plaintiff’s argumentative and incorrect characterizations of the record, not undisputed material facts in his favor established through admissible evidence.

Critically, Plaintiff’s IIED claim requires expert testimony that he has not provided. The term “‘outrageous’ has been construed to mean without just cause or excuse and beyond all bounds of decency.” *Young v. Allstate Ins. Co.*, 119 Hawai‘i 403, 429, 198 P.3d 666, 692 (2008). The consent process, the scope of procedures performed, and the documentation practices at issue are medical acts governed by the applicable medical standard of care. Whether those acts were “intentional or reckless” or “outrageous”—as distinguished from reasonable medical judgment or, at most, mere negligence—cannot be determined without expert testimony establishing what the standard of care required and whether Defendants’ conduct fell so far below it as to demonstrate intent or reckless disregard. Without an expert, Plaintiff is asking the Court and jury to infer intent from medical records that he interprets as a layperson—precisely the kind of speculation that summary judgment does not allow.

The Hawai‘i Supreme Court has held that “[w]hether the actions of the alleged tortfeasor are unreasonable or outrageous is for the court in the first instance, although where reasonable

people may differ on that question it should be left to the jury.” *Young*, 119 Hawai‘i at 429, 198 P.3d at 692. However, where, as here, Plaintiff has failed to provide qualified expert testimony to establish any applicable standard of care, breach, or causation, and KMS Defendants *have* provided qualified expert testimony (*see* Dkts. 351 (public Motion), 353 (sealed Motion), and 354 (sealed exhibits)), the underlying facts are undisputed in KMS Defendants’ favor. Plaintiff has produced no evidence that Dr. O’Donnell acted with the requisite intent or recklessness. To the contrary, KMS Defendants’ expert, Dr. Stiefel, has opined that Dr. O’Donnell met the standard of care and acted reasonably under the circumstances. *Id.* This unrebutted expert opinion directly undermines any inference of intentional or reckless conduct. Plaintiff has no expert to rebut Dr. Stiefel or to testify that any KMS Defendant’s conduct was intentional, reckless, or outrageous.

2. Plaintiff Has Not Established Causation (Element Three) — Expert Testimony Is Required.

The third element of an IIED claim requires proof that the defendant’s conduct actually caused the plaintiff’s emotional distress. Plaintiff has offered no evidence—expert or otherwise—establishing a causal nexus between any act of Dr. O’Donnell and any alleged emotional distress. Because the alleged emotional distress arises from a medical procedure and its aftermath, establishing causation requires expert testimony linking specific acts by KMS Defendants to specific injuries suffered by Plaintiff. *Barbee*, 119 Hawai‘i at 139, 194 P.3d at 1101 (holding that the failure to produce competent medical expert testimony on causation precluded recovery). Plaintiff has not disclosed any expert on causation, and the discovery deadline has passed. Without evidence of causation, Plaintiff’s IIED claim fails.

3. Plaintiff Has Not Established Severe Emotional Distress (Element Four) — He Has Not Proven His Damages.

Plaintiff has failed to produce any evidence that he suffered “extreme” emotional distress as required by the fourth *Hac* element. Plaintiff bears the burden of proving that he suffered severe emotional distress, and he has not provided any admissible evidence to carry that burden. There is no evidence in the record of any medical diagnosis, treatment, or counseling related to emotional distress. While Plaintiff claims in his interrogatory responses that he is seeing a psychiatrist, “Dr. Hyman,” he has failed to produce any records from Dr. Hyman or any other mental health provider supporting his alleged emotional distress. The discovery deadline passed on March 19, 2026 without any such production.

Plaintiff's self-serving declarations that he has suffered "post-traumatic stress disorder" and "severe psychological distress" are insufficient to establish the "extreme" emotional distress element on summary judgment. *See, e.g., Sakaguchi v. University Of Hawai'i, et al.*, No. CAAP-23-0000670, 2026 WL 1005954, at *7 (Haw. Ct. App. Apr. 14, 2026) (appended hereto as Exhibit "E") (holding that the plaintiff's self-serving declaration on summary judgment, without more, "did not sustain her burden to 'demonstrate specific facts, as opposed to general allegations, that present a genuine issue worthy of trial.'" (citing *Ralston v. Yim*, 129 Hawai'i 46, 56-57, 292 P.3d 1276, 1286-87 (2013))).

IIED requires more than conclusory allegations of emotional harm—it requires evidence of "extreme" distress and causal connection. Plaintiff has offered no evidence of any kind supporting the existence or severity of his claimed emotional injuries or alleged diagnosis with "post-traumatic stress disorder".

Plaintiff cannot obtain summary judgment on an IIED claim when he has not even produced evidence that he suffered the type of severe emotional distress the tort requires. His failure to provide admissible evidence of damages is independently fatal to the claim. Plaintiff has failed to support his IIED claim; summary judgment in KMS Defendants' favor is required.

G. The "Ghost Surgery" Doctrine Was Not Pled and Has Not Been Adopted in Hawai'i

Plaintiff invokes an undefined and unsupported "undisclosed surgeon substitution doctrine." Dkt. 365 at 20, H. Plaintiff has not provided any authority that his so-called "ghost surgery" doctrine for undisclosed surgeon substitution exists or has ever been endorsed by Hawai'i courts. Plaintiff asks this Court to adopt this novel legal doctrine on summary judgment—an inappropriate procedural vehicle for expanding the law.

Furthermore, Plaintiff's "ghost surgery" theory is inconsistent with his own allegations. Plaintiff does not identify any "undisclosed surgeon" who performed procedures. He alleges Dr. Tan was absent (which is not true, she just did not actively participate in the surgery), not that an unknown surgeon took her place. In any event, Plaintiff did not allege the "ghost surgeon theory" in his FAC, so he cannot obtain summary judgment on this issue.

H. Allegations of Spoliation Do Not Warrant Summary Judgment or the Requested Adverse Inference

Plaintiff seeks both a finding of spoliation and a specific adverse inference instruction regarding the paper chart and the Stryker video recording. Summary judgment is not the

appropriate vehicle for resolving discovery or spoliation disputes, which involve factual inquiries into intent, notice, and prejudice. Summary judgment on this issue must be denied.

I. Plaintiff's Claims Are Time-Barred

Plaintiff bears the burden of establishing the timeliness of his claims. HRS § 657-7.3 imposes a two-year statute of limitations for medical tort claims. As established in KMS Defendants' Motion for Summary Judgment (Dkts. 351 (public) and 353 (sealed)), Plaintiff's claims are time-barred.

Plaintiff's fraudulent concealment argument under HRS § 657-20 depends on establishing that KMS Defendants took "affirmative steps" to conceal his cause of action. But the record shows that Plaintiff's primary complaints—the alleged failure to obtain informed consent and the procedures performed—were known to him and knowable from the medical records, which were available to Plaintiff, and in any event, do not establish a lack of informed consent. The listing of Dr. Tan on practice letterhead and in medical records (Motion at 2) does not constitute "affirmative concealment" of a cause of action.

Notably, Plaintiff's repeated argument that he did not and could not have known about Dr. Tan's lack of active involvement in the surgery until KMS Defendants' Answer is a bald misrepresentation of the facts and his own evidence. As part of his production of documents and things, Plaintiff included an audio file titled "JJ00015 7-Day Post-Op Audio (2016 06) 02 - 091259," which appears to be a clandestine recording made by Mr. James at his June 2, 2016, seven-day post-operation visit with Dr. O'Donnell. Meyer Dec. at ¶4. At that visit, as memorialized in the recording produced by Plaintiff, a person who sounds like Mr. James asked about Dr. Tan's involvement in his operation and was expressly told by the other individual at the visit (presumably Dr. O'Donnell) that Dr. Tan was there "just for moral support," because they had not known whether harvesting cartilage from the ear would be necessary; "she was ready to go if need be," but (as Dr. O'Donnell noted elsewhere in his medical record charting) Dr. Tan was not needed, once it became clear that there was sufficient cartilage that could be harvested from Mr. James' deviated septum:

Q. [By Mr. James] What, ah, did Dr. Tan...

A. [By Dr. O'Donnell] She was there the whole time, yeah.

Q. Did she do anything, or was it mostly just this?

A. It was mostly me, yeah. She was, I guess, there just for moral support, if you will. Because we didn't know if we were going to do this part. So, she was ready to go if need be, but --

B. Yeah, 'cause like I was saying, I was worried about like the look of it and it's changing, like, the way it looks. [...]

Exhibit “F,” recording produced by Plaintiff titled “JJ00015 7-Day Post-Op Audio (2016 06) 02 -091259” (available at https://drive.google.com/file/d/1T88ah5T_husX72ECjP5Eqata8or1yUT2/view (last visited April 21, 2016), at time stamp [13:46-14:09]).⁶ Plaintiff knew of Dr. Tan's lack of involvement in his surgery at the latest by this June 2, 2016 seven-day post-op visit. His argument to the contrary in his Motion is a misrepresentation of his own evidence.

The two-year (730-day) limitations period began running when Plaintiff discovered, or through reasonable diligence should have discovered, his injuries. *See*, HRS § 657-7.3(a). Plaintiff's medical records provided with his initial Complaint (Dkt. 1), and his documents filed with the MICP both indicate that he had discovered any alleged injuries well before he filed his MICP Inquires. Using even this latest possible accrual date, and the broadest possible interpretation of the limitations period, Plaintiff failed to file his original Complaint by the end of the limitations period, as more fully briefed in KMS Defendants' motion for summary judgment (Dkts. 351 (public) and 353 (sealed)), and incorporated herein by reference.

The undisputed facts in this action support a ruling that all the claims are untimely.

J. Comparative Fault Is A Valid Defense

Plaintiff seeks a pre-trial ruling that comparative fault under HRS § 663-31 is inapplicable to intentional battery. However, as discussed at length in this action, and in this Opposition, Plaintiff has pleaded medical negligence, *not intentional battery*. As a result, comparative fault remains a valid defense. In addition, summary judgment is not the proper vehicle to determine this issue.

K. The Noneconomic Damages Cap Applies

Plaintiff argues that the HRS § 663-8.7 noneconomic damages cap does not apply on two grounds: (1) that “mental anguish,” “disfigurement,” and “loss of enjoyment of life” are

⁶ This excerpt from the audio recording is embedded in the copy of this .pdf file that has been filed under seal. Click on the linked red text to hear the embedded audio in the copy of this document that has been filed under seal.

separately enumerated in HRS § 663-8.5(a) and fall outside the cap; and (2) that the intentional tort exception in HRS § 663-10.9(2)(A) removes the cap from battery counts.

First, summary judgment is not the proper vehicle to determine this issue.

Second, any intentional tort exception applies only if Plaintiff's claims are in fact intentional torts. They are not. Plaintiff has pled medical torts, which are negligence claims.

IV. CONCLUSION

For the foregoing reasons, KMS Defendants respectfully request that Plaintiff's Motion be denied in its entirety.

DATED: Honolulu, Hawai'i, April 21, 2026.

/s/ John-Anderson L. Meyer
JOHN-ANDERSON L. MEYER
JANNA WEHILANI AHU

Attorneys for Defendants
PATRICK J. O'DONNELL, M.D.;
SUSAN TAN, M.D.; and KAPIOLANI
MEDICAL SPECIALISTS

IN THE CIRCUIT COURT OF THE FIRST CIRCUIT
STATE OF HAWAII

JARED JAMES,

Plaintiff,

vs.

PATRICK J. O'DONNELL, M.D.; SUSAN
TAN, M.D.; SELINA PETERS, M.D.;
MERLA TAKENAKA RN; KAPIOLANI
MEDICAL SPECIALISTS; KAPIOLANI
MEDICAL CENTER FOR WOMAN AND
CHILDREN; HAWAII PACIFIC HEALTH,

Defendants.

Civil No. 1CCV-21-0000683

**DECLARATION OF
JOHN-ANDERSON L. MEYER**

DECLARATION OF JOHN-ANDERSON L. MEYER

I, John-Anderson L. Meyer, declare that:

1. I am an attorney licensed to practice before the courts of this State and I am an attorney with the law firm of DENTONS US LLP, counsel for PATRICK J. O'DONNELL, M.D.; SUSAN TAN, M.D.; and KAPIOLANI MEDICAL SPECIALISTS ("Defendants") in the above-entitled action.
2. I make this declaration based on my personal knowledge and am competent to testify about the matters contained in this declaration.
3. I make this declaration in support of Defendants' *Memorandum in Opposition to Plaintiff's Motion for Partial Summary Judgment*, filed on March 30, 2026 [Dkt. 365].
4. As part of his production of documents and things, Plaintiff included an audio file titled "JJ00015 7-Day Post-Op Audio (2016 06) 02 -091259," which appears to be a clandestine recording made by Mr. James at his seven-day post-operation visit with Dr. O'Donnell.
5. Attached as Exhibit "A" is a true and correct copy of Plaintiff's Amended Complaint filed on May 26, 2023 (Dkt. 65).

6. Attached as Exhibit “B” is a table setting forth inaccurate citations and inaccurately quoted language identified in Plaintiff’s Motion for Partial Summary Judgment filed on March 30, 2026 [Dkt. 365].

7. Attached as Exhibit “C” is a true and correct copy of *Keaau Development Partnership LLC, et al., v. v. Patrick John Lawrence, Jr. dba as Pj's Construction, et al.*, No. CAAP-24-0000494, 2025 WL 1366320 (Haw. Ct. App. May 12, 2025).

8. Attached as Exhibit “D” is a true and correct copy of the report prepared by Marc A. Stiefel, M.D., dated February 13, 2026.

9. Attached as Exhibit “E” is a true and correct copy of *Sakaguchi v. University Of Hawai`i, et al.*, No. CAAP-23-0000670, 2026 WL 1005954 (Haw. Ct. App. Apr. 14, 2026).

10. Attached as Exhibit “F” is a true and correct copy of the audio recording produced by Plaintiff on March 4, 2026 with file name “JJ00015 7-Day Post-Op Audio (2016 06) 02 - 091259”. This full recording was accessed via the Google Drive site provided by Plaintiff, and is available at https://drive.google.com/file/d/1T88ah5T_husX72ECjP5Eqata8or1yUT2/view (last visited April 21, 2016).

I declare under penalty of perjury that the foregoing is true and correct.

Executed in Honolulu, Hawai`i, on April 21, 2026.

/s/ John-Anderson L. Meyer
John-Anderson L. Meyer

EXHIBIT “D”

TO

**DEFENDANTS PATRICK J. O’DONNELL, M.D.;
SUSAN TAN, M.D.; AND KAPI’OLANI MEDICAL
SPECIALISTS’ MEMORANDUM IN OPPOSITION
TO PLAINTIFF’S MOTION FOR SUMMARY
JUDGMENT FILED MARCH 30, 2026 [DKT. 365]**

**SUBMITTED
UNDER SEAL**



Pinnacle ENT
ASSOCIATES LLC

EAR, NOSE, & THROAT
ADULT & PEDIATRIC CARE

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February 13, 2026

To: John-Anderson L. Meyer, Esq.
Dentons US LLP
1001 Bishop Street
Suite 1800
Honolulu, HI 96813
(808) 524 1800

Re: Care of Jared James by Patrick J. O'Donnell, MD

Dear Mr. Meyer:

I am a board-certified Otolaryngologist in private practice in Doylestown, PA. I have been asked to review the records for the above-mentioned case and provide an independent, expert opinion regarding the medical care of Jared James. As part of the scope of my practice in general otolaryngology, I regularly see and treat, both medically and surgically, patients with diseases of the nasal cavity and sinuses, including deviated nasal septum and nasal airway obstruction. Thus, I feel I am in an excellent position to discuss the care of Mr. James as it pertains to these issues.

For the purposes of providing such an expert opinion I have reviewed the following medical records:

1. Medical record of Jared James from Hawai'i Pacific Health
2. Anesthesia records from Hawai'i Pacific Health

Case Summary

Please allow me to briefly summarize Mr. James' history, compiled from the records I have reviewed, for the sake of completeness.

Jared James, born August 12, 1982, presented to Dr. Patrick O'Donnell on February 26, 2016, complaining of nasal obstruction and difficulty breathing. He had a past medical history significant for depression, for which he was taking sertraline daily. Mr. James had a previous surgical history of nasal septal surgery and turbinate reduction performed in Alaska in 2011. Initially, after that surgery, he did admit to having some benefit. However, his nasal symptoms eventually worsened, causing him to again seek medical attention. At this visit, Mr. James noted significant collapse of the outside part of his nose when breathing in. Mr.

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EXHIBIT "D"

James had tried Nasonex nasal steroid spray and nasal breathing strips with minimal success. A physical examination by Dr. O'Donnell at that visit revealed normal turbinates and a midline septum. There was some significant external nasal valve collapse noted on inspiration, which did improve when a Cottle maneuver was performed. A nasal endoscopy was completed at that visit and was documented to be within normal limits. Dr. O'Donnell diagnosed Mr. James with external nasal valve collapse. It was felt that Mr. James could benefit from surgical intervention, including alar batten grafts. Dr. O'Donnell wanted to discuss the surgical options with his partner, Dr. Tan, prior to proceeding with surgery.

Dr. O'Donnell did make an amendment to this office note on February 29, 2016. This addendum stated that, after speaking with Dr. Tan and Mr. James, a decision was made to move forward with surgery. The proposed procedure was inferior turbinate reduction and alar batten grafting of the external nasal valve. It was also discussed that harvesting ear cartilage from the concha may be necessary in order to obtain sufficient graft material for the procedure. Mr. James was made aware of the risks of the surgery, including the chance that he could experience no significant improvement in his symptoms. He was also advised of the chance of possible cosmetic changes to the nose and ear. Mr. James was interested in proceeding with surgery and the necessary arrangements were to be made.

On March 3, an associate from Dr. O'Donnell's office called Mr. James to schedule the surgery which consisted of bilateral lateral alar batten grafting using conchal auricular cartilage and inferior turbinate reduction. The surgery was scheduled on April 8, 2016 at 1:30 PM. Mr. James did verbalize his understanding of the proposed procedure. Unfortunately, two days prior to this date, Mr. James became ill. Therefore, the procedure was postponed until May 26, 2016.

Mr. James eventually successfully underwent his procedure at Kapi`olani Medical Center for Women and Children in Honolulu, Hawai`i on May 26, 2016. By all accounts, the procedure seems to have gone smoothly. Dr. O'Donnell, assisted by Dr. Tan, performed bilateral nasal alar batten grafts using cartilage harvested from the nasal septum and partial resection of the inferior turbinates bilaterally. The right ear was prepped and draped as the donor site for surgery. However, based on my reading of the operative report, once Dr. O'Donnell started the surgery and further examined Mr. James' nasal septum under anesthesia, he found that adequate nasal cartilage was available to use as a graft. Therefore, he did not need to harvest the ear cartilage to serve as a cartilage donor, and Dr. Tan apparently had no active role in the procedure. No complications were encountered during the surgery and it seems to have taken approximately 90 minutes. Mr. James was transferred to the postanesthesia care unit and recovered successfully and without incident. He was discharged the same day back to his home on Keflex antibiotics, oxycodone for pain, and nasal saline spray.

Mr. James was next seen back in the office by Dr. O'Donnell 6 days later, on June 2, 2016. This was his first postoperative follow-up visit. Merocel packs and Doyle splints were removed from the nose at this visit. Dr. O'Donnell noted the septum appeared straight and to be healing well. The turbinates were within normal limits and there was no obvious nasal valve collapse noted. Mr. James was instructed to avoid any trauma to his nose and asked to follow-up again in 3 months.

On September 12, 2016, Mr. James was again seen in the office by Dr. O'Donnell. At this visit, he reported to Dr. O'Donnell that he experienced no significant improvement in his nasal symptoms following his procedure. Mr. James felt he continued to have nasal valve collapse despite the recent surgical intervention. As a result, he continued to use Breathe Right nasal strips and nasal cones. Mr. James expressed frustration at his lack of progress. He questioned Dr. O'Donnell's decision not to use auricular cartilage. Dr. O'Donnell explained to Mr. James that during the surgery, some deviated cartilaginous septum was still noted and this was resected, leaving an adequate amount of cartilage for the alar batten graft. Dr. O'Donnell felt that to minimize morbidity a decision was made to use the septal cartilage versus harvesting separate donor cartilage from the auricle. He noted that this was a possibility that had been discussed with

Mr. James in the preoperative area on the day of surgery.

Physical examination on September 12, 2016 revealed a well-healed and midline nasal septum with no perforation or residual deflection. The turbinates were again within normal limits. There was some residual nasal valve collapse with maximal inspiration. Very minimal collapse was noted with normal breathing. The remainder of the exam was unremarkable.

Dr. O'Donnell had a thorough discussion of the surgery and the outcome with Mr. James. It was recommended that he try a nasal steroid spray or consider a possible second opinion at a tertiary care center such as UCSF. Dr. O'Donnell asked Mr. James to report back on his progress so he could help manage his condition in the future.

No other visits between Mr. James and Dr. O'Donnell are documented in the chart. However, on Friday, December 19, 2016, Dr. O'Donnell made an addendum to the medical record stating he had spoken with Mr. James in person on December 19. Dr. O'Donnell noted that Mr. James looked very well appearing, and no longer had markings from Breathe Rite strips on the nasal dorsum. Mr. James reported feeling okay but still had significant difficulty breathing through his nose. Dr. O'Donnell attempted to refer Mr. James to a facial plastic specialist, Dr. Dan Knott, at UCSF. Mr. James declined stating he would rather seek out his own medical care.

I have reviewed no other medical records relating to Mr. James' medical care subsequent to that conversation with Dr. O'Donnell on December 16, 2016.

Expert Opinion

After reviewing the medical records available to me regarding the care of Jared James by Dr. Patrick O'Donnell, I find no evidence that Dr. O'Donnell breached the standard of care in any way. Dr. O'Donnell first saw Mr. James in the office and appropriately evaluated him, noting his previous history of nasal surgery. He diagnosed Mr. James with external nasal valve collapse and, after thoughtful consideration and in consultation with his partner Dr. Tan, offered to repair the nasal valve collapse surgically. Alar batten grafting is a standard and common surgical procedure to strengthen the external nasal valve and prevent it from collapsing. This is most commonly done by reinforcing the nasal valve with additional cartilage. Strengthening the external valve with this cartilage prevents it from collapsing, especially during inspiration, thereby improving nasal breathing.

The most common source of a cartilage graft for alar batten grafting is the nasal septum. Most of the time, this procedure is done in conjunction with a septoplasty. By removing the crooked cartilage of the nasal septum, the nasal airway is further improved. This crooked cartilage then serves as a donor site for the external nasal valve procedure.

In the case of Mr. James, he had previously had a septoplasty performed in Alaska in 2011, 5 years prior to his presentation with Dr. O'Donnell. Therefore, Dr. O'Donnell had no idea the extent of cartilage resection that Mr. James previously underwent. Some surgeons will remove the least amount of cartilage possible, leaving enough cartilage for future procedures if necessary. Others will remove all of the cartilage they can from the nasal septum, sparing only enough to serve as supporting struts for the nasal skeleton. A third option is to remove all the cartilage, but trim out and reshape the crooked areas, and then place the cartilage back within the mucoperichondrial pocket to reinforce the nasal septum and keep it in situ in the patient's nose, should it be needed for an additional procedure down the line. Dr. O'Donnell had no idea which method was employed in the previous septoplasty for Mr. James, and thereby had no idea whether or not any cartilage would be present in the nose that would be suitable to act as a graft for his needs—this information could not have been gleaned from the examination and nasal endoscopy he had previously

performed on February 26, 2016. He therefore, appropriately, decided to consent Mr. James for harvesting of an autologous donor site, in this case the right auricle. When additional cartilage is necessary to repair the nose, it is most commonly taken from the ear. Other donor sites can be used, including the outer table of the skull and ribs.

Since there are unknowns when performing any surgery, surgeons tend to hope for the best and plan for the worst. For any surgery where the status of the preferred graft site is unknown, it is commonplace to consent the patient to harvest a graft from an additional site, a procedure to be performed if needed. This need is left up to the intraoperative discretion of the primary surgeon and his team. Whenever possible, it is the surgeon's preference not to harvest cartilage from outside the nose and to exclusively use nasal septal cartilage. Harvesting cartilage from an additional donor site increases the risks of surgery. The patient can have a cosmetic deformity and additional scarring to that site, causing an unwanted outcome. Plus, there is another surgical site, which is then a possible location for an infection. For these reasons, it is much preferred to use the deviated nasal septal cartilage, which is generally superfluous at the completion of a septoplasty anyway. If an appropriate amount of septal cartilage can be repurposed to strengthen the external nasal valve, that is the best possible outcome for everyone involved.

Hoping for the best and planning for the worst is exactly what Dr. O'Donnell did in this case. He consented Mr. James for possible use of his ear cartilage as a graft. This was noted on the surgical consent and discussed with Mr. James in the preoperative holding area prior to the surgery. During the operation, Dr. O'Donnell found that the nasal septal cartilage that remained was adequate to use as a graft. Therefore, he did not need to harvest the auricular cartilage, and he was able to spare Mr. James the morbidity of a second donor site and possible negative outcomes related to that site. Based on the operative note, Dr. O'Donnell was able to perform an adequate alar batten graft in a standard fashion. I can find no indication that Dr. O'Donnell performed a subpar surgery as a result of his use of nasal septal cartilage instead of auricular cartilage. Furthermore, it is not possible to say within a reasonable degree of medical certainty that Mr. James would have had a different or improved surgical outcome had Dr. O'Donnell used auricular cartilage in this procedure, in lieu of the nasal septal cartilage that he ultimately did use. In summary, Dr. O'Donnell performed an appropriate procedure, in an appropriate fashion, using an appropriate cartilage graft, that met the standard of care expected of an otolaryngologist.

Dr. O'Donnell also performed an inferior turbinate reduction on Mr. James, concomitantly with his septoplasty and nasal valve repair. These procedures are commonly done in conjunction with one another, in order to open the nasal airway as widely as possible and give patients the best possible outcome with respect to improving their breathing. Based on the description of the procedure in the operative report, Dr. O'Donnell performed a submucous resection of the bilateral inferior turbinates with a coblation turbinate reduction wand. Submucous reduction of the inferior turbinates is the most commonly used procedure to perform the inferior turbinate surgery. By reducing the bulk of the internal tissue of the inferior turbinate, and leaving the external mucosa and underlying bone intact, the overall structure of the inferior turbinate is largely unchanged, and therefore it has limited effect on the overall nasal anatomy. This significantly decreases the risk of empty nose syndrome, which in the distant past used to happen when the majority of, or the entire inferior turbinate, was removed. Due to this unintended morbidity, submucous resection has replaced removal of the inferior turbinate as the procedure of choice. To further reposition the turbinate out of the path of nasal airflow without significantly effecting its overall size, an outfracture of the nasal turbinates is generally performed once a submucous resection has been completed. In this case, Dr. O'Donnell performed a conservative submucous resection of the inferior turbinates, followed by outfracture of the turbinates, in an attempt to give Mr. James the best chance for improved breathing following his surgery. The surgical procedure performed by Dr. O'Donnell on the inferior turbinates met the standard of care and in no way put Mr. James at an elevated risk of a negative surgical outcome.

When Mr. James returned to Dr. O'Donnell's office 3 months after surgery, unfortunately he did not have

the expected outcome he would have liked. He was again appropriately interviewed and examined at that visit, and found to have some mild residual nasal valve collapse with maximal inspiration. This is a common finding. When anyone tends to take a deep breath through their nose, there is always some degree of nasal valve collapse, due to the rapid airflow and decreased pressure of the air entering the nasal cavity. Nasal airflow is a highly subjective complaint and it is difficult to objectively assess in patients. Surgeons try to optimize airflow by controlling the 3 anatomic areas in which obstruction most likely occurs: The nasal septum, the inferior turbinates, and the external nasal valve. Dr. O'Donnell tried to address all 3 of these areas during Mr. James's surgery. He straightened a deviated septum, he shrunk the inferior turbinates, and he reinforced the external nasal valve with a cartilage graft. It was obviously Dr. O'Donnell's hope that Mr. James would find his nasal breathing improved after completing this procedure. However, it was disclosed to him preoperatively, and documented appropriately in the notes from the preoperative visit, that a risk of nasal surgery is that there may be no significant subjective improvement in nasal symptoms. Any experienced otolaryngologist will tell you that despite a surgery going technically well, and seeing the anatomy significantly improve postoperatively, the results do not always match expectations. That seems to have happened in this case. Mr. James continued to report difficulty breathing through his nose despite Dr. O'Donnell's best efforts. The fact that Mr. James did not note any subjective improvement does not mean that Dr. O'Donnell in any way breached the standard of care. By appropriately disclosing to Mr. James that he may not experience any improvement in his nose postoperatively, and performing an proper surgery in an attempt to relieve Mr. James of his nasal obstruction, Dr. O'Donnell most certainly met the standard of care. When Mr. James still had the same complaints postoperatively, Dr. O'Donnell appropriately referred him to a tertiary care center and to facial plastics surgeon who could possibly offer him additional treatment options.

I make these assertions based on the medical records and materials provided to me as of the date on this letter and my opinion is stated within a reasonable degree of medical certainty. I reserve the right to change my opinion as necessary should new information or documentation come to light.

Respectfully,



Marc Stiefel, MD

EXHIBIT “F”

TO

**DEFENDANTS PATRICK J. O’DONNELL, M.D.;
SUSAN TAN, M.D.; AND KAPI’OLANI MEDICAL
SPECIALISTS’ MEMORANDUM IN OPPOSITION
TO PLAINTIFF’S MOTION FOR SUMMARY
JUDGMENT FILED MARCH 30, 2026 [DKT. 365]**

**SUBMITTED
UNDER SEAL**

James v.
Patrick J. O'Donnell, M.D., et al.
Civil No. 1CCV-21-0000683

Exhibit F to
KMS Defendants' Memo in Opp
to Plaintiff's MPSJ



EXHIBIT "F"