IN THE COURT OF APPEALS OF IOWA

No. 0-487 / 09-0510
Filed October 6, 2010

BEATRICE M. KOHLES,
Plaintiff-Appellant,

vs.

MERCY HEALTH SERVICES-IOWA CORP., MASON CITY CLINIC, P.C., RAYMOND L. EMERSON, M.D., ADRIAN J. WOLBRINK, M.D., TRACY M. MIXDORF, D.O., NEW HAMPTON CLINIC-MAYO HEALTH SYSTEM, and COLONIAL MANOR OF ELMA, INC.,
Defendants-Appellees.

Appeal from the Iowa District Court for Cerro Gordo County, Stephen P. Carroll, Judge.

Medical malpractice plaintiff appeals pretrial summary judgment for three of the seven defendants and subsequent jury verdict for defendants. **AFFIRMED.**

Nathaniel W. Schwickerath of Schwickerath, P.C., New Hampton, and Nicholas C. Rowley of Rowley & Larrimore, Decorah, for appellant.

James A. Gerk, Christine L. Conover, and Webb L. Wassmer of Simmons Perrine Moyer Bergman P.L.C., Cedar Rapids, for appellees Tracy M. Mixdorf, D.O., and New Hampton Clinic-Mayo Health System.

Charles A. Blades and David E. Schrock of Scheldrup Blades Schrock Smith Arazana P.C., Cedar Rapids, for appellee Colonial Manor of Elma, Inc.

Frederick T. Harris, Stacie M. Codr, and Erik P. Bergeland of Finley, Alt, Smith, Scharnberg, Craig, Hilmes & Gaffney, P.C., Des Moines, for appellees Mason City Clinic, P.C., Raymond L. Emerson, M.D., and Adrian J. Wolbrink, M.D.

Roberta M. Anderson of Schroeder & Anderson, Mason City, for appellee Mercy Health Services-Iowa Corp.

Heard by Vaitheswaran, P.J., and Eisenhauer and Danilson, JJ.

EISENHAUER, J.

In this medical malpractice action, Beatrice Kohles seeks compensation for physical injuries due to post-surgical drug therapy involving Gentamicin. Kohles appeals the court's pretrial summary judgment order dismissing three defendants due to the statute of limitations. Kohles also alleges the court erred in its instructions to the jury and in denying her motions for new trial after the jury returned a verdict for the remaining defendants. We affirm.

I. Background Facts and Proceedings.

In 1986, Beatrice Kohles had a left total knee replacement. In 1997, Kohles underwent revision surgery on her left knee. On December 19, 2003, Dr. Wolbrink of Mason City Clinic, P.C. (Mason City Clinic) performed a total revision of eighty-one-year-old Kohles's left knee at Mercy Medical Center, North Iowa (Mercy Hospital).

On January 9, 2004, Dr. Wolbrink's partner, Dr. Emerson, examined Kohles and noted her surgical wound had not healed and she was having persistent drainage. Dr. Emerson diagnosed infection and believed urgent action was necessary. Dr. Emerson admitted Kohles to Mercy Hospital and performed surgery to evaluate the infection and to attempt to salvage her recent knee replacement. During surgery, tissue and fluid cultures were obtained and then sent to the pathology lab to identify the infection.

Dr. Emerson consulted with Mercy Hospital's pharmacy department. Dr. Emerson testified he selects the antibiotics and he asks "the pharmacy to become involved from the standpoint of deciding the appropriate dose of the

medication and monitoring the medication." Dr. Emerson's January 9, 2004 "Physicians Orders" instructs use of 350mg Gentamicin IV every twenty-four hours with a Gentamicin Intermediate Level taken on January 10. The Intermediate Level is a test to determine how much of the Gentamicin has been cleared from the kidneys and eliminated from the body. The monitoring is necessary because Gentamicin can cause kidney toxicity.

Dr. Rick Knutson, a Mercy Hospital pharmacist, explained "every interaction with pharmacy would be documented in Kohles's chart because [Kohles] was a formal consult. And when I say formal, it was referred in the physician's order that pharmacy should follow."

The Mercy Hospital progress notes state:

> 1/9/04 Pharmacy –
> Pt started on Ancef . . . and Gentamicin.
> . . . .
> Plan: Start Gentamicin at 350mg IV [every] 24 hours. Check Intermediate level on 1/10/04. Pharmacy will follow and adjust as necessary.
> . . . .
> 1/10/04 Pharmacy
> Gentamicin intermediate level at 12 hr after start of infusion was 3.1. Pt. appears to be clearing [Gentamicin] appropriately. Continue with current [Gentamicin] dose—schedule. Pharmacy will continue to follow.
> . . . .
> 1/12/04 Pharmacy –
> [Bacteria in surgical culture identified/listed with drugs to counteract] . . . Longterm . . . therapy with [Penicillin G] & Gentamicin IV. . . . Pharmacy following.

Dr. Knutson testified:

> Pharmacy to follow means the pharmacy department should be involved in this patient's care moving forward relative to whichever drug we're being consulted for. So, yes, that would be give us your input on how and what drug to order, how to dose it,

> and it would also be give us your input moving forward about how to monitor this drug, follow-up with the patient, those sorts of things.
>
> . . . .
>
> From our perspective, the acute care pharmacy, we are the hospital pharmacy. We service the hospital patients while they're in the bed . . . in the control or in the space of Mercy Hospital . . . .

On January 13, 2004, a Mercy Hospital social worker contacted Colonial Manor of Elma (Colonial Manor) to discuss whether a skilled nursing bed was available and whether Colonial Manor could perform IV infusion of the antibiotics. Colonial Manor stated it had a skilled nursing bed available January 14 for Kohles and also Colonial Manor could "do continuous IV starting [January 14]." The social worker's progress notes also state: "Dr. Wolbrink notified will plan on same/current dose of [antibiotics]."

At discharge, the Mercy Hospital social worker ensures the discharge summary and the transfer orders are both put "in the envelope that goes with the patient." Dr. Emerson's January 13 Interagency Transfer/Physician Orders (Transfer Orders) state Colonial Manor is the "Receiving Agency" and Dr. Tracy Mixdorf is the "Primary Care Physician." At this time, Dr. Mixdorf had been Kohles primary-care physician for approximately two years. Dr. Emerson ordered the antibiotics to continue for four weeks and "check with Dr. before discontinuing IV antibiotics." Dr. Emerson ordered a January 27 follow-up appointment with Dr. Wolbrink with designated lab tests.

At trial, Kohles presented expert testimony from neurologist Dr. Tindall, who stated he had no problem with the initial decision to put Kohles on Gentamicin. However, Dr. Tindall explained the Transfer Orders are "the written form of the treatment plan which is going from one facility to the next, from one

doctor to the next" and opined Kohles's Transfer Orders fall "below the standard of care." He stated the Transfer Orders have:

> [A] single laboratory test to be done on January 27th . . . . Those would all be relative to how much inflammation is still going on in the body. There's actually no measurement of kidney function and there are no orders on there to measure kidney function at any interval or to measure Gentamicin at any time.
>
> . . . .
>
> This form is sort of the heart and soul of this case. . . . [I]f this form had had the [Gentamicin] monitoring in it in one form or another, we wouldn't be here.

Dr. Emerson discharged Kohles to Colonial Manor on January 14, 2004, and his "Physicians Orders" state: "continue same [antibiotics]—monitoring by pharmacy." Kohles's "Orthopedic Discharge Summary" (Discharge Summary) was sent with her to Colonial Manor. The Discharge Summary diagnosed "post-op total knee infection," listed the culture grown from surgery, and noted Kohles started on IV Penicillin G/Gentamicin during her hospitalization. Further, Gentamicin "dose per pharmacy" and "[i]ntravenous antibiotics for at least 4 weeks."

Dr. Knutson explained the "Gentamicin dose per pharmacy" notation:

> Again, that's a discharge summary, it goes with the patient. That is an order to the referring pharmacy—or to the pharmacy that's being referred to and . . . the hospital pharmacy doesn't see that sheet of paper.

Dr. Tindall was critical of the Discharge Summary, stating:

> [T]here's no indication . . . of monitoring of Gentamicin levels or the kidney function, which one would have expected to be part of and was in fact part of at least initially at Mercy Hospital. . . . All we have is a notation that Gentamicin dose per pharmacy and then it will go on for four weeks. So there's really no clear treatment plan that's being transmitted.

> As I mentioned earlier, a copy of the treatment plan from the pharmacy, the protocol, something that said this is what you need to do, this is the laboratory you need to collect, this is what you should base dosage changes on . . . if that had gone with this to flesh it out and provide the information, then that would be appropriate and, again, we wouldn't be here.

Dr. Emerson ordered Mercy Hospital's pharmacy to send along a bridge dose of both Gentamicin and Penicillin G during Kohles's transfer "as sort of filling the stopgap between her—Mrs. Kohles having access to the drug as she went to the skilled nursing facility at Colonial Manor before their clinical pharmacist got involved . . . ." The bridge dose prevented Kohles from missing the January 14 evening dose of her IV medications.

Mercy Hospital notes indicate Kohles complained of nausea each day of her hospitalization.

Prior to discharge, Mercy Hospital staff entered an order for Kohles to see her primary care physician (Dr. Mixdorf) on January 21, 2004, and have lab tests—a basic metabolic panel. Kohles's daughter called the Mason City Clinic for an explanation of these instructions. After checking with Mercy Hospital staff, Mason City Clinic staff told Kohles's daughter that Kohles "does not really need to see her physician next week and just needs to obtain the laboratory work."

The January 21 basic metabolic panel was done at Colonial Manor and included a creatinine test. Dr. Goetz, an expert witness for the defendants, testified the creatinine test is a measure of kidney function and the January 21 test was "reassuring as to kidney function." Dr. Tindall, plaintiff's expert witness, also discussed the January 21 testing:

> [T]here's obviously some degree of monitoring of something going on here, but there's nothing specific about Gentamicin . . . other than you would presumably have some kind of kidney function measurement, but . . . you wouldn't have had a Gentamicin blood level. . . . I think the last level was on the 12th, so this would have been nine days later and we got a kidney function, but we don't have any Gentamicin level, but yes, this is some kind of monitoring of something.

Dr. Wolbrink saw Kohles on January 27th and copied his notes to Dr. Mixdorf. Dr. Wolbrink stated Kohles was "getting along reasonably well" with her antibiotics, although she was having some nausea and had lost ten pounds since she had been in Colony Manor. Dr. Wolbrink noted Kohles "will continue with the antibiotics. It may be the GENTAMYCIN that is causing the nausea. She can discontinue them on February 6, 2004."

Dr. Tindall was critical: "[T]here's no indication who's monitoring the antibiotic. All it says is we are going to continue the antibiotics. There's no information about who's doing the monitoring, who's following." Dr. Tindall also stated nausea and weight loss can be a sign of Gentamicin toxicity and those symptoms "immediately focus[ ] you on medication as a possible cause." Dr. Tindall opined Kohles could have had a Gentamicin level and a creatinine drawn January 27th: "We're—18 days, between two and three weeks after the drug is started. And we have really effectively no data about the kidney or the drug at all at this point. We do have some data about the knee." Dr. Tindall criticized Dr. Wolbrink:

> He failed to react to a sign of toxicity. Could easily have established whether it was likely that this was due to the medication or not by doing a Gentamicin level, as should have been done up to now, recognizing that they hadn't been done. And simply ordering one, you know a week later, if need be. You could have established whether it was

> likely that the Gentamicin was doing this and, if it was, then the drug needed to be stopped and an alternative antibiotic initiated.
>
> . . . .
>
> [S]he had nine more days of Gentamicin from that point forward. If one had gotten a Gentamicin level that day and obviously creatinine that day as well, had they been elevated you would have stopped the drug at that point. . . .
>
> But at the time, January 27th, that that issue is raised—could these symptoms all be due to Gentamicin, no action is taken at all to clarify that.

On February 4, 2004, Kohles complained to Colony Manor staff of dizziness and worsened vision. The staff passed the complaint on to Dr. Mixdorf, told her Kohles would be discharged in two days, and stated they believed she wasn't having any different symptoms from "what she had when she came in." Dr. Mixdorf advised Colony Manor staff to bring Kohles to the emergency room for further evaluation if "something worsened."

On February 6, 2004, Kohles was discharged from Colony Manor and saw Dr. Mixdorf's partner at New Hampton Clinic-Mayo Health System (New Hampton Clinic). The clinic's notes state:

> [Kohles] comes in today for removal of PIC line. She had a PIC line placed for antibiotic associated with infection after knee replacement. She has been doing quite well; she has lost a little weight. Has been a little nauseated but is feeling a little better. Has had a little bit of blurred vision. This may all be secondary to the IV antibiotics. . . .

Dr. Tindall opined:

> Q. [W]e decide to give Getamicin [and] we leave everything from that point forward with respect to the Gentamicin to the pharmacy department, would your opinion be that that would be okay, the standard of care? A. No, not really. . . . Here, where you're giving a medication known to have problems which can be permanent . . . and you're going to give it for a month, four weeks, you may let pharmacy decide the dose and dosing schedule . . . but you're going to have to do some monitoring to make sure that the monitoring is being done. [Y]ou're going to have to look to see if

> the blood levels are being done, the kidney function's being done . . . somebody's got to supervise. Somebody's got to stay in charge. And that's what didn't seem to happen here.

Subsequently, the April 20, 2004 New Hampton Clinic notes state: "Daughter calling—Mother's vision has not improved—apt. made at Wolfe Clinic . . . [for] April 26." On April 26, 2004, Dr. Woodlief of Wolfe Clinic examined Kohles and noted: "I see nothing wrong with her eyes."

On April 29, 2004, Kohles saw Dr. Remington in Decorah. Dr. Remington noted: "Self-referred 82-year-old female from Elma, Iowa who usually sees [Dr. Mixdorf] in New Hampton." Kohles requested "a copy of today's note to [Dr. Mixdorf]." Dr. Remington noted: "IMPRESSION: 1. Dizziness and imbalance with possible hearing loss. 2. Recent left knee replacement with postoperative infection and four weeks of IV Gentamycin (aminoglycoside)." Dr. Remington scheduled Kohles for testing on May 3 at Rochester Mayo Clinic.

The next day, April 30, Kohles went to Mercy Hospital's emergency room for left knee issues and was examined by Dr. Delaney. Dr. Delaney's "History of Present Illness" notes state: "She also has residua of some visual changes and vertiginous type symptoms that *she feels* are related to her previous Gentamycin treatment." (Emphasis added.) Further:

> PLAN:
> 1. . . . The patient was noted to have some possible reaction to Gentamycin in the past, with what she feels is visual disturbance and perhaps some lightheadedness or vertiginous-type symptoms.

Kohles testified about Dr. Delaney's April 30 evaluation in her August 2006 deposition:

> Q. And at that time you told a Dr. Delaney that you thought the Gentamicin might be causing you some visual changes and vertigo-type symptoms. Is that correct? A. I did, because I had been to the Wolfe Clinic before that. And they told me that's what it was too.
>
> Q. Who at the Wolfe Clinic told you that? A. The doctor.
>
> Q. Okay. Do you remember the doctor's name? A. Oh, I don't know what his name was . . . . I went in for an eye exam, and he said my eyes were good . . . so then I told him what I had been taking. And he said, well, his mother also had that and she couldn't walk. So we figured out that's what it was.
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> . . . .
>
> Q. And then we've got this note . . . in April of '04 and you saw . . . Dr. Delaney where you think your visual changes are related to your previous Gentamicin treatment, and that was something you suggested to him. Is that accurate? A. Probably.
>
> Q. And is that the information you believe you received from the eye doctor over at the Wolfe Clinic? A. And also from Dr. Remington from Decorah. He's an eye doctor in Rochester.

On May 2, 2004, Dr. Jones operated on Kohles's left knee and she was subsequently released to Colony Manor for recovery. Accordingly, Kohles was unable to keep her May 3 appointment at Rochester Mayo Clinic.

On June 16, 2004, Kohles contacted Dr. Remington and requested to go to Rochester Mayo Clinic for the previously-scheduled vestibular testing. Dr. Remington's office arranged an appointment for June 22, 2004.

In January 2006, Kohles filed suit against Mercy Hospital, Mason City Clinic, P.C., Dr. Wolbrink, and Dr. Emerson alleging physical injuries from Gentamicin therapy. Kohles's pleading asserted she "discovered the nature of her injuries and the negligence of the Defendants sometime during the month of June 2004."

In January 2007, Kohles filed an application to amend her petition asserting additional defendants were "identified through discovery." Kohles

added defendants: Dr. Mixdorf, New Hampton Clinic, and Colonial Manor. Kohles again alleged physical injuries from Gentamicin and again alleged she "discovered the nature of her injuries and the negligence of the Defendants sometime during the month of June 2004." In February 2007, the court granted Kohles's leave to amend.

In July 2007, Dr. Mixdorf and New Hampton Clinic moved for summary judgment arguing Kohles's claims are barred by the two-year statute of limitations applicable to medical malpractice claims. In August 2007, Colonial Manor also moved for summary judgment based on the statute of limitations.

Kohles's resistance to the motions for summary judgment states she "learned of her vestibular hypofunction in June 2004 as alleged." The court granted summary judgment in September 2008, and dismissed Dr. Mixdorf, New Hampton Clinic, and Colonial Manor.

Immediately prior to trial, on January 22, 2009, Dr. Tindall was deposed and opined:

> [Kohles] suffered and continues to suffer to some degree problems with balance and vision . . . as a result of Gentamicin toxicity. As a result of the Gentamicin she was given from—well, during January and February 2004.
>
> The Gentamicin was not properly monitored, nor was her kidney function properly monitored to be certain that she continued to clear the drug. And that the dose, therefore, was correct during the time she received the drug, with the sole exception of the first monitoring on January the 10th while she was still at Mercy.
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> . . . .
>
> Dr. Wolbrink and Dr. Emerson don't write orders specifically as to how the drug should be monitored. The pharmacy was the one that was [undertaking] that responsibility, but yet both—whichever physician does the discharge orders and summary is responsible for making sure that the receiving institution knows what the treatment plan is. That simply didn't happen in this lady.

> And that's the crux of the issue in this case. The failure to properly communicate the needs the patient had to the physicians and the facility to which she was sent.

On January 27, 2009, the court granted partial summary judgment in favor of the defendants on several of Kohles's theories of recovery, but declined to grant summary judgment "on the theory of recovery for negligence in failing to monitor administration of Gentamicin." The three-week jury trial concluded on February 12, 2009. On February 13, 2009, the jury returned a unanimous verdict for the defendants. Kohles's post-trial motions were unsuccessful and this appeal followed.

II. Medical Malpractice Statute of Limitations.

Kohles argues the district court erred in granting summary judgment to Dr. Mixdorf, New Hampton Clinic, and Colonial Manor based on the statute of limitations. We review rulings on motions for summary judgment for errors at law. *Sain v. Cedar Rapids Cmty. Sch. Dist.*, 626 N.W.2d 115, 121 (Iowa 2001). Summary judgment is appropriate only when the entire record demonstrates that no genuine issue of material fact exists and the moving party is entitled to judgment as a matter of law. *Stevens v. Iowa Newspapers, Inc.*, 728 N.W.2d 823, 827 (Iowa 2007). We review the evidence in the light most favorable to the nonmoving party. *Id*.

Kohles knew Dr. Mixdorf was her primary care physician, knew she received Gentamicin during her stay at Colonial Manor, and in her pleadings admits she knew in June 2004 the Gentamicin therapy caused her to suffer physical injury. Kohles argues, however, a June 2006 limitations date does not

apply to these defendants because she did not know Dr. Mixdorf and Colonial Manor had a *duty* to monitor the Gentamicin therapy until she took the August 2006 depositions of Drs. Wolbrink and Emerson.

Resolving this "triggering event" issue requires a discussion of the history of Iowa's medical malpractice statute of limitations. In *Baines v. Blenderman*, 223 N.W.2d 199 (Iowa 1974), the Iowa Supreme Court applied the discovery rule in a medical malpractice action. The doctor in *Baines* argued the cause of action should accrue under the discovery rule when the patient knows or should know of the injury and that it was caused by medical care. *Id*. at 201. The Iowa Supreme court rejected that argument and held a plaintiff must not only discover the injury and its cause, but must also discover the physician was negligent. *Id*. at 202.

In 2008, the Iowa Supreme Court discussed its *Baines* analysis:

> Yet, we reached this conclusion without acknowledging the rule followed in other jurisdictions that discovery of the injury and its *factual cause* trigger the statute of limitations. . . . [W]e simply assumed the discovery rule meant the statute of limitations was triggered upon discovery of the cause of action, which included the negligence of the physician, and gave no consideration to a discovery rule that would trigger commencement of the limitations period upon actual or imputed knowledge of the injury and its cause.

Rathje v Mercy Hosp., 745 N.W.2d 443, 452 (Iowa 2008) (emphasis added).

In 1975, one year following *Baines*, the Iowa legislature repudiated *Baines*:

> While the Iowa legislature adopted the discovery rule concept, it defined the rule to begin the two-year statute of limitations when the patient "knew, or through the use of reasonable diligence should have known [of] . . . the *injury* or death for which damages are

> sought . . . ." Iowa Code § 614.1(9). In contrast, the definition of the discovery rule in *Baines* provided for the cause of action to accrue not only upon the discovery of the injury and its cause, but also the discovery of the negligent conduct.

Id. at 455-56. (emphasis added). However, "[s]ection 614.1(9) does not define the term 'injury.'" *Murtha v. Cahalan*, 745 N.W.2d 711, 715 (Iowa 2008). In 2008, the Iowa Supreme Court discussed its cases analyzing the legislation:

> As a whole, our cases interpreting section 614.1(9) have given rise to the rule that the statue of limitations begins to run when the plaintiff knows or, through the use of reasonable diligence, should have known of the physical harm. Moreover, we have narrowly defined the injury as physical harm and have applied inquiry notice to commence once symptoms of the physical harm are experienced by a patient during or after medical treatment, even though there is no indication of *a cause or negligent conduct* by the doctor. Consequently, we have severely restricted the discovery rule, essentially using it to require only inquiry notice of physical harm. In narrowly construing the statute *as not requiring discovery of the negligent conduct of the physician, we have not considered the role of any form of causation as a part of the analysis*.

Rathje, 745 N.W.2d at 457 (emphasis added) (citations omitted).

In 2008, the *Rathje* court departed "from the direction we have taken in our prior cases" because "[t]he contemporary circumstances do not reasonably suggest our legislature actually sought to narrow the triggering event for the statute of limitations to discovery of a mere 'physical injury.'" *Id*. at 460, 463. While the Iowa "legislature clearly narrowed the discovery rule . . . to *exclude any requirement that a plaintiff discover that the injury was caused by negligence or wrongdoing of the physician*," prior case law has "failed to identify the role of *factual causation* as an element of the statutory discovery rule." *Id*. at 460 (emphasis added). The *Rathje* court supplemented the definition of injury to include "cause in fact" as a second component of the "triggering event."

> In some instances, the cause of medical malpractice injuries may be evident from facts of the injury alone, but in other cases it may not. Yet, in all cases, a plaintiff must at least *know the cause of the injury resulted or may have resulted from medical care* in order to be protected from the consequences of the statute of limitations by seeking expert advice from the medical and legal communities. . . .
>
> [O]ur legislature intended the medical malpractice statute of limitations to commence upon actual or imputed knowledge of both the injury and its cause in fact. Moreover, it is equally clear this twin-faceted triggering event must at least be identified by sufficient facts to put a reasonably diligent plaintiff on notice to investigate.
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> . . . .
>
> The statute begins to run only when the injured party's actual or imputed knowledge of the injury and *its cause reasonably suggest an investigation is warranted*.
>
> . . . .
>
> We emphasize the knowledge standard under the statute is predicated on actual or imputed *knowledge of the facts to support the injury and of the facts to support a cause*. Importantly, we continue to adhere to the rule that *the plaintiff does not need to discover that the doctor was negligent*.

Id. at 461-63 (emphasis added) (citations omitted).

Utilizing the *Rathje* test in the context of the development of Iowa's medical malpractice statute of limitations, we agree with the district court—there is no genuine issue of material fact as to when Kohles had "knowledge of the facts to support the injury and of the facts to support a cause." In April of 2004, Kohles was suffering from visual changes and vertigo-type symptoms and Kohles testified two physicians not involved in her Gentamicin treatment (Dr. Woodlief/Wolfe Clinic and Dr. Remington) informed her that the Gentamicin therapy was the likely cause of her symptoms. In June 2004, Kohles was evaluated at Mayo Clinic and Kohles admitted in her pleadings she had knowledge of the facts to support a Gentamicin-related cause for her symptoms in June 2004. This knowledge "reasonably suggested an investigation was

warranted," thereby triggering the statute of limitations. We affirm the district court's dismissal of claims against Dr. Mixdorf, New Hampton Clinic, and Colonial Manor.

III. Jury Instructions.

Kohles argues the court's specifications of negligence in the jury instructions were too narrow. The jury was instructed:

> 1. The Defendant Doctor was negligent:
> a. In failing to provide to Colonial Manor an adequate treatment plan for the monitoring of Plaintiff's use of Gentamicin; or
> b. In failing to properly monitor the Plaintiff's use of Gentamicin after her transfer to Colonial Manor.

The jury instructions for Mercy Hospital's alleged negligence required Kohles to prove: "The Defendant Corporation was negligent in failing to provide to Colonial Manor an adequate treatment plan for the monitoring of Plaintiff's use of Gentamicin."

Kohles does not contest the initial choice to use Gentamicin therapy. However, Kohles argues she "was entitled to a broader instruction that the [defendants] were negligent in failing to properly monitor or dose the Gentamicin not only after discharge, but prior to discharge as well."

Our standard of review concerning alleged errors in respect to jury instructions is for the correction of errors at law. *Banks v. Beckwith*, 762 N.W.2d 149, 151 (Iowa 2009). We review to determine whether prejudicial error has occurred. *City of Cedar Falls*, 617 N.W.2d at 20.

In rejecting Kohles's proposed instructions asserting negligent monitoring of Getamicin *prior to discharge*, the court reviewed plaintiff expert—Dr. Tindall's:

(1) November 2006 opinion letter; (2) deposition testimony a week before trial; and (3) trial testimony. Generally, medical negligence cases require expert testimony "to establish the standard of care and a breach thereof." *Schroeder v. Albaghdadi*, 744 N.W.2d 651, 656 (Iowa 2008).

The court stated the expert's opinion letter is "critical of the monitoring, but again, with specific reference to the period of time after discharge from the hospital and, in fact, he mentions the 17th, the 24th, and the 31st."

The court quoted from Dr. Tindall's deposition, taken immediately prior to trial:

> [Q.] Is it fair for me to conclude that you have no criticisms of the monitoring that took place while the patient was hospitalized at [Mercy Hospital] from January 9th through January 14th? [A.] . . . No. They did an intermediate level on the 10th. The next one that would have been done was the 17th, so that was after discharge. Creatinine levels were in fact looked at on several occasions. There wasn't a specific order three times a week, but that's fair in the post-op period.
>
> . . . .
>
> [Q.] Hospitalization from January 9th through January 14th. You have no problem with the level of dosage that was used during that five-day period of time; is that correct? [A.] That's correct. Because the level, the intermediate level that was obtained was within generally accepted levels, two to ten.
>
> . . . .
>
> [Q.] The only criticism I understand you—as I understand you here today, is that you believe that Doctor Knudson or any of the other physicians involved, that being Doctor Emerson or Doctor Wolbrink, should have provided more guidance to the receiving facility with respect to the monitoring aspect of Gentamicin; is that correct? [A.] Yes, I felt they had a general duty under the standard of care, since they had started that treatment, to provide the referring facility with a treatment plan.

Finally, the court reviewed the expert's trial testimony:

> [H]e talked about the baton concept, the continuity of care. His trial testimony again focused on not—not care at the hospital,

> but focused on what he perceived to be two huge problems and, one, failing to adequately communicate [the] treatment plan, particularly as to the monitoring of Gentamicin when [Kohles] went to [Colonial Manor] and, two, the failure to monitor when she was at Colonial Manor. At one point he said there was no clear treatment plan transmitted. So his trial testimony, in the main, was consistent with his deposition testimony.

The trial court declined to instruct on negligent monitoring of Gentamicin prior to discharge because it concluded there was no expert testimony as to breach of standard of care or as to causation:

> So there's no one in this record who said, did you look at the care she had in the hospital? Yes. Do you have an opinion as to whether that care met the standard of care relative to monitoring of Gentamicin while she was there? Yes, I have such an opinion. What is your opinion? Well, it deviated. Why? Well, it deviated because they left their own protocol. There is no testimony like that.

After reviewing the record, we agree with the district court and find no error in the jury instructions.

IV. Motions for New Trial.

Kohles argues the court erred in denying her motions for new trial. "A ruling on a motion for new trial following a jury verdict is a matter for the trial court's discretion." *Condon Auto Sales & Serv., Inc., v. Crick*, 604 N.W.2d 587, 595 (Iowa 1999). "[T]he time [ten days] for filing a motion for new trial commences upon the filing of the jury's verdict with the clerk of court." *Milks v. Iowa Oto-Head & Neck Specialists, P.C.*, 519 N.W.2d 801, 805 (Iowa 1994).

On February 17, 2009, the "Instructions to the Jury" with "Verdict Forms" were filed with the clerk of court. The verdict forms were not separately file-stamped. The online court information system lists:

17-FEB-09 08:39 AM 0 INST C
Description INSTRUCTIONS
Filed by . . . [Judge] Carroll, Stephen P
Comment(s) INSTRUCTIONS TO THE JURY W/VERDICT FORMS

On February 26, the court entered a judgment of dismissal. On March 9, Kohles filed her first motion for new trial. On March 11, Kohles filed her second motion for new trial. On March 25, the court denied the motions *sua sponte*:

> I conclude that the time for filing the Motion for New Trial began to run with the filing of the verdict with the Clerk of Court, which occurred on the morning of February 17, 2009. The Motions for New Trial were filed outside the ten-day period of time for filing such motions. Accordingly, they are not timely and I do not have jurisdiction to rule on them.
>
> Presumably, because the ministerial act of entry of judgment of dismissal was filed on February 26, 2009, the 30-day period of time within which Plaintiff may appeal begins to run on that date. Because [I concluded] the motions were untimely, I decided to rule immediately rather than waiting for the Defendants' responses and a hearing on the issue. Had I waited to rule, the Plaintiff would have been deprived of her ability to consider an appeal . . . the time to appeal would have run. Accordingly, I have decided to rule at this time on the Motions for New Trial.

Several of Kohles's arguments on appeal attempting to excuse the untimeliness of her motions were not brought before the district court and therefore will not be considered for the first time on appeal. *Meier v. Senecaut*, 641 N.W.2d 532, 537 (Iowa 2002). We find those arguments that were addressed by the district court to be without merit. Accordingly, we find no abuse of discretion.

AFFIRMED.