Court of Appeals No. 323811

(Spokane County Superior Court No. 12-2-00182-5)

COURT OF APPEALS OF THE STATE OF WASHINGTON

DIVISION THREE

JOSHUA DRIGGS,

Appellant,

v.

ANDREW T.G. HOWLETT, M.D. and JANE DOE HOWLETT, and their marital community; PROVIDENCE PHYSICIAN SERVICES CO. aka Providence Orthopedic Specialties, a Washington Corporation,

Respondent.

BRIEF OF RESPONDENTS

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I. INTRODUCTION

In trial practice, qualifying one's expert witness is basic. That is particularly true in a medical malpractice case, where expert testimony on the standard of care and causation is required. Here, at a perpetuation deposition, plaintiff failed to qualify one of his experts, Dr. Lawrence Menendez, with respect to Dr. Menendez's knowledge of the standard of care in Washington. As a consequence, the trial court properly exercised its discretion in refusing to allow Dr. Menendez to give a standard of care opinion.

Also fundamental is ensuring that one's expert medical witness, if asked to express an opinion on causation, testifies in terms of what is more likely than not or probable than not, to a reasonable degree of medical certainty, as required by Washington law. Because Dr. Menendez failed to state his causation opinions to the degree of reasonable medical probability. The trial court properly exercised its discretion in excluding those opinions.

On the issue of informed consent, medical testimony is necessary on two aspects of materiality: the nature of the risk and the likelihood of its occurrence. Here, while Dr. Menendez identified fracture as a risk associated with the treatment at issue, he failed to properly quantify that risk. Accordingly, the trial court was well within its discretion in excluding Dr. Menendez's opinions on risks allegedly associated with the treatment.

Finally, Washington law recognizes different health care practitioners operate under different standards of care. For example, the standard of care for an EMT is different from that of an emergency room physician. Consequently, if a plaintiff wishes to assert a standard of care claim against a particular health care provider, that provider and the care at issue must be clearly identified in plaintiff's complaint. And, at trial, the plaintiff must then offer expert testimony from a qualified witness on that provider's failure to comply with the specific standard of care.

Here, plaintiff, in his Complaint, failed to identify Certified Physician's Assistant Brandi DeSaveur as a health care provider who violated the standard of care. Then, at trial, plaintiff failed to support his standard of care criticisms of PA-C DeSaveur with competent expert testimony. Accordingly, the trial court properly refused to include PA-C DeSaveur on the special verdict form as an individual to whom fault could be assigned under RCW 4.22.070.

II. COUNTER STATEMENT OF CASE

A. General Nature Of Case, Identity Of Parties, and Parties' Claims

This is a medical malpractice case. The Appellant, and plaintiff below, is Joshua Driggs (hereinafter referred to as "Mr. Driggs"). The Respondents, and defendants below, are Andrew Howlett, M.D., *et ux*, and

Providence Physician Services Company, *aka* Providence Orthopedic Specialties (hereinafter referred to respectively as "Dr. Howlett" and "Providence").

The case arises from a March 6, 2009, surgery performed by Dr. Howlett on Mr. Driggs' right lower extremity. CP 1-16. The purpose of the surgery, generally, was to remove a plate and screws that approximately five years earlier had been used to attach an allograft (cadaver bone) inserted in Mr. Driggs' distal tibia to replace an excised section of malignant bone. *Id.*

Mr. Driggs claimed Dr. Howlett violated the standard of care during the March 6, 2009, surgery by not replacing the plate and screws with some other form of fixation, such as a rod or another plate. CP 7, 9. Mr. Driggs alleged this lack of fixation hardware resulted in the development of a fracture postoperatively. CP 7. Mr. Driggs also claimed Dr. Howlett was negligent with respect to his post-operative care and treatment, particularly as it related to the initiation of weight bearing and physical therapy.[1] CP 6.

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1. At trial, Mr. Driggs also asserted negligence on the part of two additional health care providers who worked in Dr. Howlett's clinic and who had limited involvement in Mr. Driggs' postoperative care: Brandi DeSaveur, PA-C, a Certified Physician's Assistant, and Janet Worley, CNP, a Certified Nurse Practitioner. The trial court refused to include PA-C DeSaveur or CNP Worley on the special verdict form, and Mr. Driggs appeals that decision as it relates to PA-C DeSaveur. That aspect of the appeal is discussed *infra*.

Dr. Howlett denied his decision not to install a rod or plate during the March 6, 2009, surgery was a violation of the standard of care. CP 59-63. He also denied a rod or plate, even if it had been placed, would have prevented the fracture which eventually developed. *Id.* Finally, Dr. Howlett denied he was negligent with respect to Mr. Driggs' post-operative care. *Id.*

The jury returned a verdict in favor of Dr. Howlett and Providence. This appeal followed.

B. Mr. Driggs' Pertinent Medical History

In 2004, at age 15, Mr. Driggs was diagnosed with bone cancer in his right lower leg (distal tibia). VRP 1530. The "gold standard" treatment for a distal tibial sarcoma is a below-the-knee amputation. VRP 1376. Another treatment option, however, is excision of the bony malignancy and its replacement with a section of cadaver bone known as an "allograft." VRP 1376-78. The latter treatment option is commonly referred to as a "limb salvage procedure." *Id.*

There is a high rate of morbidity (complications) associated with limb salvage procedures for bone cancer in the distal tibia (VRP 1366-67), particularly those involving distal tibia allografts. VRP 1376. Distal tibial allografts are "typically fraught with problems," because of aging, wear and tear, the body's reaction to the foreign body allograft and the relatively high

stresses imposed upon them. VRP 1371-72. Thus, they usually require additional surgery over time.[2] *Id.*

Despite these risks and potential complications, Mr. Driggs, in July, 2004, underwent a limb salvage procedure by Dr. Conrad at the University of Washington. VRP 1530-31. Dr. Conrad removed 3.5 to 4 inches of the right tibia, just above the ankle, and replaced it with cadaver bone, securing the allograft with a plate and eight screws. VRP 1531-32.

C. Dr. Howlett's Background, Training and Experience

Dr. Howlett, an orthopedic surgeon, has extensive specialty training relevant to limb salvage procedures and distal tibial allografts. He attended medical school at the University of Washington. VRP 867. After graduating medical school, he did a five-year residency in orthopedic surgery, also at the University of Washington (VRP 869) which he completed in 2003. Next, Dr. Howlett did a fellowship in traumatology at Harborview Medical Center in Seattle, completing that in the summer of 2004. VRP 875-76. Dr. Howlett followed that with a fellowship in orthopedic oncology at the University of Washington, the VA and Children's Hospital in Seattle, starting the program in August, 2004, and completing it in July, 2005. VRP 877.

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2. Dr. Menendez, one of Mr. Driggs' experts, testified his failure rate for distal tibial allografts was 40% (VRP 1368-69) and that, as a result of those failures, the patient in each case underwent amputation. VRP 1371.

After finishing his orthopedic oncology fellowship in 2005, Dr. Howlett started practicing in Spokane (VRP 875), joining Providence in May of 2008. VRP 880.

Of the thousands of orthopedic surgeons in the country, only three are fellowship trained in both traumatology and orthopedic oncology, and Dr. Howlett is the only one in the State of Washington. VRP 882-883.

D. Dr. Howlett's Care and Treatment of Mr. Driggs

Dr. Howlett started seeing Mr. Driggs in January 2006. VRP 887. Dr. Howlett was already generally aware of Mr. Driggs and his medical situation because Mr. Driggs' primary limb salvage procedure had been performed by Dr. Conrad in 2004. Dr. Howlett did his orthopedic oncology fellowship with Dr. Conrad, and Mr. Driggs' case came up during the first week of Dr. Howlett's training. VRP 888.

Consistent with the general prognosis for distal tibial allografts, Mr. Driggs eventually required additional surgery.[3] In January 2006, Dr. Howlett performed an ankle fusion and osteotomy on Mr. Driggs to address developing arthritis and mal-alignment of the distal tibia, to improve

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3. During his care and treatment of Mr. Driggs, Dr. Howlett talked to Mr. Driggs on numerous occasions about amputation as an option and the benefits of the procedure. Mr. Driggs, however, was not interested in amputation. VRP 1002, 1006.

mechanics in the foot and to decrease pain. VRP 893-94; VRP 898; VRP 903-04. At the time of this surgery, the allograft installed by Dr. Conrad approximately a year and a half earlier was already failing. VRP 900-01.

Dr. Howlett operated on Mr. Driggs again in November 2006, removing a screw and performing a tendon release and debridement of part of the ankle joint in an effort to relieve pain and stiffness and increase function. VRP 915-20.

At various times, Mr. Driggs expressed to Dr. Howlett he wanted the hardware removed from his right lower leg. But because of concerns about the maturity of the allograft and the general risks associated with surgery, Dr. Howlett and Mr. Driggs elected to pursue non-operative management. VRP 932-33; VRP 1008-09; VRP 1089-90.

By January of 2008, however, Mr. Driggs was complaining of extreme pain and difficulty walking and standing. VRP 1015. Accordingly, Dr. Howlett and Mr. Driggs agreed, at that point, to proceed with removal of the fixation hardware. VRP 1015. That surgery was eventually performed on March 6, 2009. VRP 1024.

In advance of the March 6, 2009, surgery, Dr. Howlett told Mr. Driggs that if he found things during surgery indicating new fixation hardware was unnecessary, Dr. Howlett would try not to use it. VRP 1022. There are risks

and complications associated with the insertion of a rod or nail in the distal tibia. The rod itself can produce knee pain (VRP 983-84) and pain in the leg in general. *Id.* Insertion of a rod involves additional destruction of bone and the risk of fracture from the force necessary to install it. VRP 986-87; VRP 994. There is also the risk of the rod causing additional stress to an allograft and weakening of the tibia because of the placement of additional screws (VRP 991-95) as well as a risk of disruption of intramedullary blood supply. VRP 994.

There were also reasons not to replace the removed plate with another. A plate would provide fixation to the end of the allograft, but not below it. VRP 997. Thus, a new plate would not protect the ankle fusion. VRP 999-1000. In addition, installation of a new plate would require more screws, which would further weaken the distal tibia. VRP 998. Also, the plate and screws were the source of some of Mr. Driggs' pain, and replacing the plate with another would potentially defeat the purpose of the surgery. VRP 998.

Although installation of a rod to replace the plate and screws was considered in the months leading up to the March 6, 2009, surgery and mentioned in the consent form (VRP 1017), based on his surgical observations and findings on March 6, 2009, Dr. Howlett elected not to put in

a rod or new plate.[4] VRP 1027-29. During the surgery, Dr. Howlett observed that the allograft itself was bleeding, indicating it had developed vascular channels, was no longer a dead piece of bone and was actually becoming part of Mr. Driggs' bone. VRP 1027. Dr. Howlett also had imaging at his disposal which showed that the allograft had healed at its junctions, and had excellent union with good bony formation. VRP 1026-27. Dr. Howlett "found a construct" he felt would withstand physiological stress without hardware fixation. *Id.* The lateral strut portion of the graft, which Dr. Howlett directly visualized during the surgery, had enough "good bone" that Dr. Howlett had difficulty removing the screws. VRP 1027-28.

At the same time, Dr. Howlett considered the risks of an intramedullary rod or nail, as described above, and concluded the risks outweighed the potential benefits. VRP 1028.

On May 27, 2009, Mr. Driggs visited Dr. Howlett's office complaining of ankle swelling and pain. VRP 1248. He was seen by

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4. The consent form contained language which authorized Dr. Howlett to alter the procedure to address conditions encountered during the surgery. It stated, in pertinent part: "I recognize that during the course of the operation . . . unforeseen conditions may necessitate additional or different procedures than those set forth." VRP 1023. Consistent with this language, during the March 6, 2009, surgery, Dr. Howlett also performed a tarsal tunnel release (VRP 1017, 1018) and a tenolysis procedure (VRP 1020, 1021) even though these two procedures were not specifically identified on the consent form.

Dr. Howlett's Certified Physician's Assistant, Brandi DeSaveur. *Id.* An x-ray taken in the clinic was interpreted by Ms. DeSaveur as negative for fracture, and she diagnosed an ankle sprain. VRP 302-03.

On June 8, 2009, Mr. Driggs returned to the clinic. Dr. Howlett saw Mr. Driggs that day, and took new x-rays. VRP 1120. Dr. Howlett interpreted the new x-rays as showing a fracture at the graft/host junction site. VRP 1121. Dr. Howlett compared the new x-ray to the one taken on May 27, 2009, and, with the benefit of hindsight, concluded that the fracture was discernible on the May 27, 2009, study read by Ms. DeSaveur. VRP 935-37; VRP 1120-21. Because of the location of this fracture, it would not have been prevented even if Dr. Howlett had installed a rod or plate on March 6, 2009. VRP 1129-31; VRP 1136-37.

On June 11, 2009, Dr. Howlett performed another surgery on Mr. Driggs to address the fracture. VRP 1317. On this occasion Dr. Howlett used a rod in order to stabilize the fracture site and achieve union. VRP 1317-20.

E. Specific Allegations In Complaint

In his "Complaint for Negligence," Mr. Driggs named as defendants Dr. Howlett, his wife, and Providence. CP 3. Mr. Driggs alleged that: Dr. Howlett was an employee and agent of Providence and that all of his acts

were for the benefit and within the scope of the authority of Providence (CP 4); that he "suffered an insufficiency fracture in his right lower extremity as a result of Dr. Howlett's failure to install an intramedullary rod or other stabilization when he removed Joshua Driggs medical compression plate on March 9, 2009" (CP 7); that "Dr. Howlett's failure to install the intramedullary rod in the March 9 surgery fell below the standard of care" (*Id.*); and that as a "direct and proximate result of defendant's failure to provide reasonably prudent medical care, the plaintiff Joshua Driggs, suffered injury." CP 8.

Mr. Driggs further alleged that: Defendants' negligence included but was not limited to failure to place stabilization hardware, failure to properly perform installation of the intramedullary rod and the failure to obtain informed consent regarding not installing stabilization hardware all in connection with the March 6, 2009 surgery (CP 9); and that defendant Providence was independently negligent by and through the acts and/omissions of defendant Andrew T. G. Howlett. CP 9.

Nowhere in his Complaint did Mr. Driggs identify Brandi DeSaveur as a health care provider whom he alleged violated the standard of care. CP 3-12. Dr. Howlett' s decision not to place an intramedullary rod or other

fixation during the March 6, 2009, surgery was the only medical act/omission identified by Mr. Driggs as constituting a violation of the standard of care. *Id.*

F. Expert Testimony at Trial

At trial, Dr. Howlett and Providence's expert witnesses were James Bruckner, M.D., an orthopedic oncologist (VRP 6) and Brian Padrta, M.D., an orthopedic surgeon. VRP 184. Both testified to their familiarity with the standard of care in Washington for the surgical management of limb salvage involving a distal tibial allograft. VRP 25-26; VRP 197. Dr. Bruckner did a fellowship in musculoskeletal oncology at the University of Washington with Dr. Conrad (VRP 7) and then was an assistant and associate professor at the University of Washington Medical School and Dr. Conrad's partner at both the University of Washington and Seattle Children's Hospital. VRP 8. Since completing his education and affiliation with the University of Washington in 2004, Dr. Bruckner has been in private practice in Bellevue, specializing in orthopedic oncology. VRP 8-9. He has privileges at Overlake Hospital in Bellevue, Swedish Hospital in Seattle, Swedish Hospital in Issaquah, and Children's Hospital Medical Center in Seattle. VRP 20.

Dr. Padrta has practiced in Spokane, Washington, since 1995. VRP 185.

Both Dr. Bruckner and Dr. Padrta, after explaining their familiarity with the standard of care in Washington, testified Dr. Howlett's surgery of March 6, 2009, complied fully with the standard of care, particularly Dr. Howlett's decision not to install an intramedullary rod or other fixation hardware. VRP 57-58; VRP 197-98. Dr. Bruckner also testified that, based on a reasonable degree of medical certainty, installation of an intramedullary rod or a plate on March 6, 2009, likely would not have prevented the fracture that developed postoperatively. VRP 54-55.

Mr. Driggs had two expert witnesses: Orthopedic surgeon Steven Graboff, M.D., from Huntington Beach, California, (VRP 325-26) and Lawrence Menendez, M.D., an orthopedic oncologist from Los Angeles who works in the Department of Orthopedic Surgery at the University of Southern California Medical Center. CP 1323. Dr. Graboff attended medical school in Guadalajara, Mexico, and at the University of California in Irvine. VRP 326-27. He did his orthopedic residency at UCLA and then had five years of post-medical school training there. VRP 327-28. From 1985 to 2005, Dr. Graboff had an orthopedic surgery practice in Huntington Beach, California. VRP 331.

Dr. Menendez attended medical school at NYU and did a surgical internship at Columbia Presbyterian Medical Center. CP 1324. He then did an

orthopedic residency back at NYU, followed by an orthopedic oncology fellowship at the University of Florida. *Id.* In July of 1985, Dr. Menendez joined the faculty at the University of Southern California in the Department of Orthopedic Surgery and has been there since. CP 1325.

Dr. Graboff testified Dr. Howlett violated the standard of care by not installing an intramedullary rod or other fixation during the March 6, 2009, surgery. VRP 395. He also opined that installation of a rod or other fixation would have prevented the fracture that developed postoperatively. VRP 406-07. He further testified regarding the risks associated with not installing a rod or other fixation during the March 6, 2009, surgery. VRP 385-87.

Mr. Driggs elected to present the testimony of Dr. Menendez by video perpetuation deposition. VRP 1540. Dr. Menendez addressed the general nature of limb salvage procedures and distal tibial allografts and his knowledge of Mr. Driggs' medical history. CP 1318-41. However, for the reasons discussed below, the trial court did not allow Dr. Menendez to offer opinions on the standard of care or causation, or on the risks allegedly associated with Dr. Howlett not installing an intramedullary rod or other fixation during the March 6, 2009, surgery, and that testimony was stricken

from the video deposition. VRP 673-675; [5]

G. Specific Trial Court Rulings Regarding The Admissibility Of Dr. Menendez's Opinions

Dr. Howlett and Providence objected to Dr. Menendez offering opinions on the standard of care, causation, and the risks allegedly associated with Dr. Howlett not installing an intramedullary rod or other fixation during the March 6, 2009, surgery. CP 522-530; VRP 148-56; VRP 660-70. With respect to the standard of care, Dr. Howlett and Providence argued Dr. Menendez had not shown that he was familiar with the standard of care in the State of Washington for the medical treatment at issue. *Id.* They argued that Dr. Menendez's causation opinions were not expressed in terms of medical probability, to a reasonable degree of medical certainty. *Id.* With respect to Dr. Menendez's testimony on risk, Dr. Howlett and Providence objected because, although Dr. Menendez identified fracture as a risk allegedly associated with Dr. Howlett not installing an intramedullary rod or other fixation, he did not quantify that risk in any way. *Id.* The trial court

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5. The testimony of Dr. Conrad was also presented to the jury by the reading of portions of his discovery deposition, which was noted by Mr. Driggs. VRP 1583; CP 1518-1621. Dr. Conrad testified there are circumstances where a surgeon would not install a rod or other fixation after removing a plate from the tibia (CP 1542-43) and that he has taught his students that a surgeon may no longer need to use hardware to stabilize an allograft like Mr. Driggs' if the graft is small, has vigorous bone formation around it, and looks like it is mostly incorporated and melded around the edges.

agreed with Dr. Howlett and Providence, and struck this testimony from Dr. Menendez's video perpetuation deposition. VRP 673-75.

H. Procedure Relative To Trial Court Decision Not To Include Brandi DeSaveur, PA-C, On The Special Verdict Form

Dr. Howlett and Providence objected to Brandi DeSaveur, PA-C, being included on the special verdict form because: (1) Mr. Driggs did not allege in his Complaint that Ms. DeSaveur violated the standard of care, or indicate that any of the specific treatment she provided was in violation of the standard of care, and (2) because no qualified expert witness testified on behalf of Mr. Driggs that Ms. DeSaveur failed to comply with the standard of care for a physician's assistant in the State of Washington. VRP 1599-1603. The trial court agreed with Dr. Howlett and Providence, and refused to include Ms. DeSaveur on the special verdict form. VRP 1603-04.

III. ARGUMENT AND AUTHORITIES

A. The Trial Court Properly Exercised Its Discretion In Finding That Dr. Menendez Was Not Qualified To Render An Opinion On The Applicable Standard Of Care In The State Of Washington.

Whether an expert witness is qualified to give opinion testimony is a matter of trial court discretion. ***In re: Detention of AS***, 138 Wn.2d 898, 917, 982 P.2d 1156 (1999); ***State v. Perez***, 137 Wn. App. 97, 104, 151 P.3d 249

CP 1547-48.

(2007). In a medical malpractice case, the trial judge must make a preliminary finding of fact under ER 104(a) as to whether an expert is qualified to express an opinion on the standard of care in Washington. ***Winkler v. Giddings***, 146 Wn. App. 387, 392, 190 P.3d 117 (2008).

In Washington, the applicable standard of care in a medical negligence case is that the health care provider "failed to exercise that degree of care, skill, and learning expected of a reasonably prudent healthcare provider at that time in the profession or class to which he belongs, in the State of Washington, acting in the same or similar circumstances" (emphasis added). RCW 7.70.040(1). In ***Harris v. Groth***, 99 Wn.2d 438, 663 P.2d 113 (1983), the Washington Supreme Court emphasized that RCW 7.70.040 sets a state standard of care:

> The legislative history does, however, indicate an intent to alter existing law in one respect—by limiting those who set the standard of care to health care providers within the State of Washington. *See*, Legislative Report of the 44th Second Extraordinary Session, 23 (1976). Thus, in attributing to the reasonably prudent health care provider the skills and training possessed by members of the same class or profession (*see*, RCW 4.24.290; W. Prosser, §32 at 162), the trier of fact must consider only those providers within the State of Washington. *See*, RCW 7.70.040 (emphasis added).

92 Wn.2d at 447, fn. 4.

In ***Adams v. Richland Clinic***, 37 Wn. App. 650, 655, 681 P.2d 1305 (1984), the court characterized the standard of care under RCW 7.70.040(1)

as being a "statewide determination," and noted that to establish a claim for violation of the standard of care, the plaintiff "must present evidence of a statewide standard of care." *Id.* Consistent with the above, the only type of expert competent to testify as to the standard of care required of a practitioner in the State of Washington is an expert who knows the practice and standard of care in Washington. ***McKee v. American Home Products***, 113 Wn.2d 701, 706-07, 782 P.2d 1045 (1989).

Testimony that the standard of care for the medical procedure or care at issue is a "national standard", standing alone, is insufficient to satisfy the statutory requirement. *See*, ***Winkler***, *supra*.[6]

In the instant case, the trial court properly found under ER 104(a) that

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6. In other jurisdictions with some form of "local" standard of care (either statewide or community), the courts have held that the mere proclamation that a "national standard" exists for the care and treatment at issue is not sufficient to qualify the witness. Rather, the witness must also demonstrate that he has done some inquiry or investigation to determine whether the state or community standard is, in fact, the same as the purported national standard. *See*, e.g., ***Hall v. Rocky Mountain Emergency Physicians, LLC***, 155 Idaho 322, 312 P.3d 313 (2013); ***Suhadolnik v. Pressman***, 151 Idaho 110, 254 P.3d 11 (2011); ***Robinson v. LeCorps***, 83 S.W.3d 718 (Tenn. 2002); ***Harville v. Vanderbilt University***, 95 Fed. Appx. 719 (6th Circ. 2003, Tennessee). In addition, the mere existence of a national board or certification for the defendants' medical specialty is not enough. *See*, ***Robinson***, *supra*, at 721-22. That is understandable, since the existence of a national board and a practitioner's membership therein do not account for the possibility of differences in practice methods, particularly with respect to such things as surgical techniques/methods, which, as was mentioned in ***Winkler***, can vary from region to region.

Dr. Menendez was not qualified to render a standard of care opinion because he did nothing to investigate or determine what the standard of care was in Washington (CP 1403), and simply expressed his belief that there was a "national standard of care" for the treatment at issue. CP 1343-46.

Mr. Driggs relies on ***Elber v. Larson***, 142 Wn. App. 243, 173 P.3d 990 (2007) and ***Hill v. Sacred Heart Medical Center***, 143 Wn. App. 438, 177 P.3d 1157 (2008) in support of his argument that Dr. Menendez's assumption that the applicable standard of care was a "national standard" was sufficient to satisfy the statutory requirement. But as the court pointed out in ***Winkler***, those cases are distinguishable because the trial court rulings in both were made in the context of summary judgment proceedings, where the standard of review is *de novo* and all evidence is construed in favor of the non-moving party. ***Winkler***, *supra* at 391-92.

Significantly, in ***Winkler***, the purported expert, Dr. Ruckerstein, simply made the "educated assumption" that the standard of care was the same across the country. There was no evidence he did anything to investigate whether the standard of care in the state of Washington was the same as the standards he was familiar with, for example, in Pennsylvania. ***Winkler***, *supra*, at 392. In the instant case, by his own admission Dr. Menendez did nothing to determine whether the standard of care in

Washington for the procedure at issue was a "national standard." CP 1403-04.

Winkler makes it clear that the mere *ipse dixit* proclamation by an expert that the standard of care for the procedure at issue is a "national standard" and that the standard of care in Washington is the same as the so-called national standard is not enough. The trial court here recognized the insufficiency of the testimony in making its preliminary determination under ER 104(a). Indeed, when the trial court made its ruling, it was in the context of the court having heard testimony about the complex nature of oncological limb salvage surgery and the multiple factors considered by a surgeon in deciding to use stabilization hardware for an allograft. The court had also heard testimony that, in Washington, limb salvage surgeries and surgical follow up are typically done by orthopedic oncologists (VRP 28), and that orthopedic oncologists "disagree a lot." VRP 97. The court had also heard testimony from Washington practitioners that, in Washington, fixation hardware is not always replaced when removed from a distal tibial allograft. VRP 57-58; CP 1542-43; CP 1547-48. By contrast, Mr. Driggs' experts, both of whom were trained and/or practiced in California, testified that distal tibial fixation hardware, if removed, must be replaced by substitute hardware. VRP 395; CP 1345-46.

Mr. Driggs contends he was able to establish through witnesses other than Dr. Menendez that the standard of care for the procedure at issue is a national one.[7] Mr. Driggs offers no authority for the proposition that, in a medical negligence case, an expert's qualifications, particularly his familiarity with the standard of care--can be established by testimony from someone other than the witness himself. A leading treatise on Washington evidence law states: "The physician who testifies must be familiar with the standard of care applicable in the case at hand." 5 Karl B. Tegland, Washington Practice: Evidence Law and Practice, §702.9, at 54 (5th Ed. 2007). The lack of authority for such a procedure is understandable, as allowing it would make it awkward for opposing counsel and the court to determine a witness' qualification in advance of the witness' testimony. The usual procedure is for a proponent to establish, as a matter of foundation, an expert witness' qualifications before the witness is allowed to express an expert opinion. As part of the witness qualification process, the court may be required to make a preliminary finding of fact under ER 104(a). And opposing counsel is afforded the opportunity to *voir dire* the witness with respect to his/her qualifications. Allowing a witness's familiarity with the

7. Mr. Driggs also claims one of Dr. Howlett's experts, Dr. Bruckner, agreed that the applicable standard of care was a national one. But, Dr. Bruckner's testimony was that a surgeon's exercise of judgment during a surgical

applicable standard of care to be "back filled," or established through other witnesses would subvert this procedure.

Mr. Driggs claims the Court of Appeals recently recognized that an out of state expert can give testimony to a national standard when the national standard is the same as the Washington standard of care, *citing,* ***Volk v Demeerler***, 184 Wn. App. 389, 337 P.3d 372 (2014). Mr. Driggs fails to point out that in ***Volk***, the plaintiffs' standard of care expert, Dr. Knoll, submitted a declaration where he claimed to be familiar with the standard of care as a psychiatrist in the state of Washington based on his education, training, experience, and his consultation with a colleague in the state of Washington.[8] Based on this, Dr. Knoll stated that, in his opinion, the standard of care in Washington "equates to the standard of care nationally." ***Volk***, *supra*, at 410.

In the instant case, unlike in ***Volk***, Dr. Menendez did nothing to determine whether the standard of care in the State of Washington for the sophisticated surgical procedure at issue equated to some purported national standard of care.

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procedure, generally, is universal. VRP 96-97; VRP 139-42.

8. Over defendants' objection, Dr. Graboff was allowed to express an opinion on the standard of care because days before trial he consulted with two orthopedic surgeons from Washington regarding the standard of care. VRP 375.

B. The Trial Court Properly Exercised Its Discretion When It Excluded Dr. Menendez's Opinions On Medical Causation.

A trial court's decision whether to exclude evidence, either as a sanction or on substantive grounds, is reviewed for abuse of discretion. ***Katare v. Katare***, 175 Wn.2d 23, 38, 283 P.3d 546 (2012); ***Philippides v. Bernard***, 151 Wn.2d 376, 393, 88 P.3d 939 (2004).

In Washington, expert testimony on causation must be expressed in terms of probability or likelihood, and also expressed to a "reasonable degree of medical certainty." ***Davies v. Holy Family Hospital***, 144 Wn. App. 483, 492-93, 183 P.2d 283 (2008), *citing* ***McLaughlin v. Cooke***, 112 Wn.2d 829, 836, 774 P.1171 (1989). *See also*, ***Reese v. Stroh***, 128 Wn.2d 300, 309, 907 P.2d 282 (1995).

In the instant case Dr. Menendez failed to express his causation opinions in terms of likelihood/probability, to a reasonable degree of medical certainty. While Mr. Driggs' counsel proclaimed during Dr. Menendez's perpetuation deposition that he wanted Dr. Menendez to express his opinions in such terms, (VRP 47) Dr. Menendez never agreed to do so or acknowledged that he would. *Id.* Accordingly, the trial court was within its discretion in excluding Dr. Menendez is causation opinions for not meeting the required evidentiary standard.

Mr. Driggs argues causation testimony is no longer required to meet the standard of ***McLaughlin*** and ***Reese***, *citing* ***White v. Kent Medical Center Inc.***, 61 Wn 163, 172, 810 P.2d 4 (1991) and ***Leaverton v. Surgical Partners, PLLC***, 160 Wn. App. 512, 520 (2011). Mr. Driggs' reliance on ***White*** and ***Leaverton*** is misplaced. ***White*** was a summary judgment case where the defendant, in its summary judgment reply brief, argued for the first time that the plaintiff had not submitted any evidence that the defendant caused her damage. The court reversed summary judgment, holding it was improper for the defense to raise for the first time in a reply brief a challenge to the plaintiff's evidence on proximate cause. The adequacy of an expert witness's testimony on causation was not at issue.

The defendants in ***White*** did argue that none of the plaintiffs' medical witnesses testified in terms of "standard of care." The court noted that one of the plaintiffs' medical witness testified it would be negligent to order a vocal cord examination for a patient with the plaintiff's history. Applying the summary judgment standard of review, the ***White*** court held that the plaintiffs' expert's testimony that it was "neglect" for the defendant doctor not to order the examination was sufficient to raise a material fact. ***White***, *supra*, at 171.

Leaverton was also an appeal from summary judgment in favor of the defendant. The case did not involve the adequacy of causation testimony. Rather, the issue was whether plaintiffs' experts, both otolaryngologists, were qualified to express an opinion on the standard of care for a general surgeon. Both of plaintiffs' experts testified the use of an electrocautery device within close proximity (less than 0.5 cm) of the recurrent nerve would be a violation of the standard of care for anyone performing the surgery. ***Leaverton***, *supra*, at 518. In light of this testimony, the court concluded the plaintiff had raised a material issue of fact on the standard of care, and summary judgment in favor of the defendants was reversed.

Mr. Driggs attempted to satisfy the deficiencies in Dr. Menendez's perpetuation deposition testimony by submitting two curative declarations from Dr. Menendez. But those declarations were inadmissible hearsay. Moreover, defense counsel had no opportunity to cross-examine Dr. Menendez on the declarations. Accordingly, the trial court, in its discretion, properly refused to consider the declarations relative to Dr. Menendez's qualifications.

C. The Court Properly Struck Dr. Menendez's Opinions Regarding Medical Risk.

Under RCW 7.70.050, the informed consent statute, a health care provider has an obligation to disclose to a patient only "material" risks.

The determination of materiality is a two-step process. The first step is to ascertain the scientific nature of the risk and the likelihood or probability of its occurrence. ***Ruffer v. St. Francis Cabrini Hospital of Seattle***, 56 Wn. App. 625, 631, 784 P.2d 1288 (1990), *citing*, ***Smith v. Shannon***, 100 Wn.2d 26, 33, 666 P.2d 351 (1983). Only a physician or other qualified expert is capable of determining the existence of a given risk and the chance of it occurring. ***Id.*** "The court in ***Shannon*** observed that just as patients require disclosure of risks by their physicians to give informed consent, 'a trier of fact requires description of risks by an expert to make an informed decision.'" Testimony regarding the mere existence of a risk "is not enough." ***Ruffer***, *supra*, at 632.

In the instant case, while Dr. Menendez, at his perpetuation deposition, mentioned the possible consequences of not installing fixation hardware (VRP 41, 42, 51), he never quantified the risk in any way. The closest he came was to state that if you "don't put fixation in, it's more likely that you'll have a fracture. . ..." VRP 51. He never quantified in any way, how much more likely it would be for a fracture to occur in the absence of fixation. Thus, the trial court properly excluded Dr. Menendez's testimony on risks associated with Dr. Howlett's treatment.

Mr. Driggs cites ***Adams v. Richland Clinic***, 37 Wn. App. 650, 681 P.2d 1305 (1984) for the proposition that a plaintiff's expert need not quantify a risk in order for the issue of materiality to reach the jury. In ***Adams***, the trial court directed a verdict in favor of the defendant on the issue of informed consent, and the Court of Appeals reversed. While the ***Adams*** opinion contains a lengthy discussion of the various risks and complications of the procedure at issue (gastric bypass surgery), none of which were conveyed to the plaintiff, the opinion does not indicate that any expert witness ever quantified those risks. Regardless, the ***Adams*** court reversed, concluding, without explanation, that there was "sufficient expert testimony" to submit the issue of informed consent to the jury. 37 Wn. App. at 660.[9]

It is difficult to reconcile this aspect of ***Adams*** with ***Smith***, *supra,* where the Supreme Court stated, in clear terms:

> Understood in this context, ***Miller's*** seemingly absolute language must be qualified somewhat. The determination of materiality is a 2-step process. Initially, the scientific nature of the risk must be ascertained, *i.e.*, the nature of the harm which

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9. Significantly, the defendant in ***Adams*** failed to provide important information to the patient about the "benefits" of gastric bypass surgery, including that the surgery would not eliminate the requirement that the plaintiff diet in order to maintain weight loss. And, after the surgery, the defendant failed to inform the patient of a test result which showed that the surgery was failing. This omitted information did not amount to "risks" that required quantification by an expert. But the defendant's failure to provide this information may explain the court's holding that there was sufficient evidence produced at trial to take the issue of informed consent to the jury.

> may result and the probability of its occurrence. *See* ***Canterbury v. Spence***, *supra* at 787-88; Waltz & Scheunemann, *supra* at 641; Comment, *Informed Consent in Medical Malpractice*, 55 Cal.L.Rev. 1396, 1407 n. 68 (1967). The trier of fact must then decide whether that probability of that type of harm is a risk which a reasonable patient would consider in deciding on treatment. (Emphasis added.)

100 Wn.2d at 33.

Since ***Smith*** was decided, the Court of Appeals has affirmed that the question of materiality requires an expert witness to establish the existence of a risk and its likelihood of occurrence. *See*, ***Ruffer***, *supra. See also*, ***Brown v. Dahl***, 41 Wn. App. 565, 571, 705 P.2d 781 (1985). Thus, in light of ***Smith*** and its progeny, the trial court did not err when it excluded Dr. Menendez's "risk" testimony for his failure to quantify the risk.

D. Even If The Trial Court Erred In Excluding The Opinions Of Dr. Menendez On The Standard Of Care, Causation And Risk, The Error Was Harmless Because Mr. Driggs' Other Expert, Dr. Graboff, Testified On Those Same Issues.

Exclusion of evidence is not harmful error where the excluded evidence is merely cumulative. ***Tumelson v. Todhunter***, 105 Wn.2d 596, 603, 716 P.2d 890 (1986). Thus, exclusion of a witness is not prejudicial error unless the witness' testimony would have differed in a material respect from the testimony of other witnesses. ***Mason v. Bon Marche Corp.***, 64 Wn.2d 177, 179, 390 P.2d 997 (1964).

In the instant case, Mr. Driggs' other expert witness, Dr. Graboff, was allowed to testify on the standard of care, causation, and the risks associated with Dr. Howlett not inserting an intramedullary rod or other fixation during the March 6, 2009, surgery. Accordingly, Dr. Menendez's opinions on these issues were cumulative, and the trial court's exclusion of those opinions, even if erroneous, was harmless.

E. The Trial Court's Decision Not To Include Brandi DeSaveur, PA-C, On The Special Verdict Form Was Not Error

The trial court was justified in excluding Brandi DeSaveur from the special verdict form for two reasons. First, she was not a defendant and Mr. Driggs never alleged in his Complaint that Ms. DeSaveur violated the standard of care or that any health care provider violated the standard of care with respect to interpretation of the May 27, 2009, x-ray, or in issuing post-operative instructions to Mr. Driggs on that date.

Pleadings are construed to do substantial justice CR 8(f); ***Burchfiel v. Boeing Corp.***, 149 Wn. App. 468, 495, 205 P.3d 145 (2009). The allegations of a complaint must be sufficient to place the defendant on notice of each of the claims asserted. ***Kirby v. The City of Tacoma***, 124 Wn. App. 454, 470, 98 P.3d 827 (2004); ***Trask v. Butler***, 123 Wn.2d 835, 844, 872 P.2d 1080 (1994).

A pleading is insufficient when it does not give the opposing party fair notice of what a claim is and the ground(s) upon which it rests. ***Northwest line Constructors v. Snohomish County Public Utility District 1***, 104 Wn. App. 842, 17 P.3d 1251 (2001).

In ***Kirby***, the plaintiff alleged his indication in a Notice of Claim that he was asserting "constitutional tort claims" against the City of Tacoma was sufficient to put the City on notice that plaintiff was asserting a First Amendment claim. In rejecting that argument, the court stated:

> The trial court noted that "the words "free speech" or "first amendment" usually manage to alert the other side." (Citation omitted). But Kirby's "notice of claim" merely referenced "constitutional tort claims." The variation among potential constitutional tort claims are significant. As the City argued at summary judgment, this variation presented myriad ways of preceding within defense in conducting discovery, resulting in actual prejudices to the city. The city should not be required to guess against which claims they will have to defend." (Emphasis added.)

124 Wn. App. at 470.

In a healthcare negligence case, at the very least, the fair notice requirement of CR 8(f) and ***Kirby*** requires the plaintiff to identify which healthcare providers are alleged to have violated the standard of care, and the specific care/treatment that violated the standard of care.[10] Without such an

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10. A physician's assistant is specifically and separately identified in RCW 7.70.020(1) as a "healthcare provider" within the meaning of the

indication, the complaint presents "myriad ways of proceeding with a defense in conducting discovery." Here, Mr. Driggs, in his Complaint, never identified PA-C DeSaveur as a health care provider who violated the standard of care. Nor did he specifically identify the treatment provided by Ms. DeSaveur as violative of the standard of care. Dr. Howlett and Providence, like the defendant in ***Kirby***, should not have been required to guess against which specific standard of care claims they were required to defend.

Mr. Driggs argues that Dr. Howlett's and Providence's own witnesses addressed whether Brandi DeSaveur violated the applicable standard of care. That is true. But they only did so after Mr. Driggs' expert, Dr. Graboff, over defendants' objection, was allowed to testify that Ms. DeSaveur, on May 27, 2009, "negligently interpreted" the x-ray by failing to diagnose a fracture. VRP 399, 402, 403.

In ***Kirby***, the City, after objecting, did attack the merits of plaintiff's First Amendment claim. Among other things, the plaintiff responded that the City thus implicitly tried the issue within the meaning of CR 15. In rejecting that argument, the court stated:

> Here, the City argued at summary judgment that Kirby failed to plead a First Amendment theory of recovery. Only after this

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statute.

> argument did the City hesitantly attack the merits of Kirby's unpleaded claims. The City should not be penalized for attempting a defense for which it was ill prepared as a result of Kirby's procedural failures.

124 Wn. App. at 471.

Here, like in ***Kirby***, Dr. Howlett and Providence should not be penalized for responding to Dr. Graboff's purported standard of care criticism of Ms. DeSaveur after he was allowed to offer those opinions over defendants' objection.

Second, the trial properly excluded Ms. DeSaveur from the special verdict form because no expert witness for the plaintiff testified he was familiar with the standard of care in Washington for a Physician's Assistant in Ms. DeSaveur's position and that Ms. DeSaveur failed to comply with that standard of care. Mr. Driggs attempted to elicit testimony from Dr. Graboff regarding whether Ms. DeSaveur complied with the applicable standard of care. VRP 399-403. But Dr. Graboff never testified he was familiar with the standard of care for a Physician's Assistant in the State of Washington participating in the post-operative management of a patient like Mr. Driggs. Dr. Graboff simply testified he was familiar with standard of care for orthopedic surgeons in the state of Washington, and that it was a "national standard." VRP 376, 377.

As for the diagnosis reached and treatment recommendations issue by Ms. DeSaveur on May 27, 2009, Dr. Graboff never even attempted to testify Ms. DeSaveur, in that regard, violated the standard of care in the state of Washington for a Certified Physician's Assistant. Rather, he simply testified it was a violation of the standard of care for an orthopedic surgeons to delegate such post-operative management to a physician's assistant. VRP 405.

In sum, because Mr. Driggs never plead a standard of care claim against Ms. DeSaveur, and failed to support a standard of care claim against Ms. DeSaveur with qualified expert testimony, the trial court properly refused to include Ms. DeSaveur on the special verdict form.

IV. CONCLUSION

Dr. Howlett and Providence respectfully submit that all of the trial court's rulings regarding the testimony of Dr. Menendez, as well as its ruling regarding placing Brandi DeSaveur on the special verdict form, were appropriate. Thus, Dr. Howlett and Providence respectfully request that the trial court's rulings be affirmed.

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DATED this 13 day of April, 2015.

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By_____
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CERTIFICATE OF SERVICE

Pursuant to RCW 9A.72.085, the undersigned hereby certifies under penalty of perjury under the laws of the state of Washington, that on the 13th day of April, 2015, the foregoing was delivered to the following persons in the manner indicated:

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VIA REGULAR MAIL [X]
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4-13-15 /Spokane, WA
(Date/Place)

Amy S. Calkins