

No. 49516-3

IN THE COURT OF APPEALS
OF THE STATE OF WASHINGTON
DIVISION II

LISA BARTON, an individual,

Appellant,

vs.

DR. STEVEN SANDIFER, D.C. and JANE DOE SANDIFER,
individually and their marital community, and CHAMPION
CHIROPRACTIC CENTER, INC., a Washington Corporation,

Respondents.

RESPONDENTS' RESPONSE BRIEF

Rebecca S. Ringer, WSBA 16842
Amber L. Pearce, WSBA No. 31626
Floyd, Pflueger & Ringer, P.S.
200 West Thomas Street, Suite 500
Seattle, WA 98119
Telephone: 206-441-4455
Facsimile: 206-441-8484

Attorneys for Respondents

TABLE OF CONTENTS

	Page
I. INTRODUCTION.....	1
II. NO ASSIGNMENT OF ERROR.....	1
III. RESTATEMENT OF THE ISSUES.....	2
IV. RESTATEMENT OF THE CASE.....	2
A. Dr. Sandifer Treated Ms. Barton Twice.	2
B. Ms. Barton Signed an Informed Consent Form.	4
C. Ms. Barton Had Only Two Chiropractic Adjustments.	4
D. Two Days Later, Ms. Barton Had a Stroke: Cause Unknown.....	5
E. Ms. Barton Filed Suit Against Dr. Sandifer, Alleging Medical Malpractice and Failure to Give Informed Consent.	6
F. Dr. Sandifer Moved for Summary Judgment Dismissal.....	7
V. LEGAL ARGUMENT	12
A. The Court Reviews Orders Granting Summary Judgment <i>De Novo</i>	12
B. RCW 7.70 Exclusively Governs Medical Malpractice Actions.	13
C. Dr. Sandifer Was Entitled to Summary Judgment because Ms. Barton Failed to Produce Competent Expert Testimony that (1) Dr. Sandifer Breached the Standard of Care; and (2) the Breach Caused Ms. Barton’s Stroke.	14

1. Ms. Barton Submitted No Medical Expert Testimony on the Standard of Care.....	16
2. Ms. Barton Submitted No Medical Expert Testimony on Causation.....	21
D. The Trial Court’s Dismissal of Ms. Barton’s Informed Consent Claim Should Be Affirmed because She Failed to Produce Competent Expert Testimony.....	22
VI. CONCLUSION.....	25

TABLE OF AUTHORITIES

	Page
 Cases	
<i>Archer v. Galbraith</i> 18 Wn. App. 369, 567 P.2d 1155 (1977).....	23
<i>Bays v. St. Luke's Hosp.</i> 63 Wn. App. 876, 825 P.2d 319 (1992).....	23
<i>Berger v. Sonneland</i> 144 Wn.2d 91, 26 P.3d 257 (2001)	21
<i>Bertsch v. Brewer</i> 97 Wn.2d 83, 640 P.2d 711 (1982)	23
<i>Branom v. State</i> 94 Wn. App. 964, 974 P.2d 335 (1999).....	13, 14
<i>Colwell v. Holy Family Hosp.</i> 104 Wn. App. 606, 15 P.3d 210 (2001).....	17
<i>Guile v. Ballard Cmty. Hosp.</i> 70 Wn. App. 18, 851 P.2d 689 (1993).....	12, 13
<i>Harris v. Groth</i> 99 Wn.2d 438, 663 P.2d 113 (1983)	12, 15, 17
<i>Las v. Yellow Front Stores, Inc.</i> 66 Wn. App. 831 P.2d 744 (1992).....	16
<i>Lockwood v. AD & S, Inc.</i> 109 Wn.2d 235, 744 P.2d 605 (1987)	19, 20
<i>McLaughlin v. Cooke</i> 112 Wn.2d 829, 774 P.2d 1171 (1989)	21
<i>Miller v. Kennedy</i> 11 Wn. App. 272, 522 P.2d 852 (1974), <i>aff'd and adopted</i> , 85 Wn.2d	

151 (1975).....	22
<i>Mohr v. Grantham</i> 172 Wn.2d 844, 262 P.3d 490 (2011)	13
<i>O'Donoghue v. Riggs</i> 73 Wn.2d 814, 440 P.2d 823 (1968)	21
<i>Orwick v. Fox</i> 65 Wn. App. 71, 828 P.2d 12 (1992).....	13
<i>Pannell v. Food Servs. of Am.</i> 61 Wn. App. 418, 810 P.2d 952 (1991).....	20
<i>Pelton v. Tri-State Mem. Hosp., Inc.</i> 66 Wn. App. 350, 831 P.2d 1147 (1992).....	16
<i>Preston v. Duncan</i> 55 Wn.2d 678, 349 P.2d 605 (1960)	18
<i>Reese v. Stroh</i> 128 Wn.2d 300, 907 P.2d 282 (1995)	21
<i>Ruffer v. St. Frances Cabrini Hosp.</i> 56 Wn. App. 625, 784 P.2d 1288 (1990)	12, 14, 25
<i>Seybold v. Neu</i> 105 Wn. App. 666, 19 P.3d 1068 (2001)	16, 23
<i>Sherman v. Kissinger</i> 146 Wn. App. 855, 195 P.3d 539 (2008).....	14
<i>Shoberg v. Kelly</i> 1 Wn. App. 673, 463 P.2d 280 (1969).....	15, 16
<i>Smith v. Shannon</i> 100 Wn.2d 26, 666 P.2d 351 (1983)	23, 24, 25
<i>W.G. Platts, Inc. v. Platts</i> 73 Wn.2d 434, 438 P.2d 867 (1968)	12

White v. Kent Med. Ctr.
61 Wn. App. 163, 810 P.2d 4 (1991)..... 16

Young v. Group Health Coop.
85 Wn.2d 534 P.2d 1349 (1975) 19

Young v. Key Pharm.
112 Wn.2d 216, 770 P.2d 182 (1989) 17

RULES AND STATUTES

	Page
Rules	
CR 56	18
CR 56(b)	3, 12
CR 56(c).....	13, 18
CR 56(e).....	22
CR 56(f)	11
ER 801(d)(2)	20
Statutes	
RCW 7.70	13
RCW 7.70.010	13
RCW 7.70.030	14
RCW 7.70.040	14, 15
RCW 7.70.050	23
RCW 7.70.050(1).....	23
RCW 7.70.050(2).....	23
RCW 7.70.050(3).....	24
Other	
WPI 105.07	16

I. INTRODUCTION

In this medical negligence case, Appellant Lisa Barton failed to submit competent medical expert testimony to support her claims in response to Dr. Sandifer and Champion Chiropractic Center's motion for summary judgment. Instead, she relied on her own self-serving declaration containing inadmissible hearsay. She opined about her interpretation of statements that Dr. Sandifer allegedly made in a telephone conversation with her.

At the summary judgment hearing, Ms. Barton conceded that there was no legal basis to support the admission of her self-serving hearsay statements for the purpose of defeating summary judgment dismissal, and the trial court agreed. Because Ms. Barton did not raise genuine issues of material fact, the trial court properly dismissed her claims, as a matter of law. For these reasons, Dr. Sandifer and Champion Chiropractic Center respectfully request that the Court of Appeals affirm the trial court.

II. NO ASSIGNMENT OF ERROR

Respondents Dr. Sandifer and Champion Chiropractic Center, Inc. respectfully submit that because Ms. Barton failed to proffer competent expert medical testimony to support her medical malpractice and informed consent claims, the trial court properly granted summary judgment dismissal

of those claims, as a matter of law. The trial court's dismissal should be affirmed.

III. RESTATEMENT OF THE ISSUES

- (1) Did the trial court properly dismiss, as a matter of law, Ms. Barton's medical malpractice claim against Dr. Sandifer because she failed to support this claim with competent medical expert testimony establishing: (1) a breach of the standard of care; (2) that proximately caused her injuries?
- (2) Did the trial court properly dismiss, as a matter of law, Ms. Barton's informed consent claim against Dr. Sandifer because (1) her signed consent form constitutes *prima facie* evidence that she gave her informed consent to the chiropractic treatment; and (2) she failed to support this claim with competent medical expert testimony establishing the *material facts* that were *allegedly withheld from her*?

IV. RESTATEMENT OF THE CASE

A. Dr. Sandifer Treated Ms. Barton Twice.

Appellant Lisa Barton (DOB 09/30/80) first visited Respondent Dr. Sandifer on July 14, 2014, complaining of lower back and neck pain,

headaches, and nausea.¹ Clerk's Papers (CP) 17. Ms. Barton stated that nothing helped relieve her pain and that it interfered with her sleep. CP 17. She reported that the following activities were difficult or painful: lying on her side or flat on her stomach, dressing herself, stooping, sitting, bending forward and backward, walking, standing for long periods, and turning her head side to side. CP 17. She also reported a medical history positive for a significant motor vehicle accident in 1982, and a slip and fall accident in 2000. CP 18.

During the initial visit, Dr. Sandifer performed an extensive examination, including x-ray imaging, and determined that Ms. Barton suffered from a loss of cervical spine curve; mild post-body spurring at C3 vertebrae; rotation at C1/C2 vertebrae; and rotations at T11 and T2 vertebrae. CP 21-22. Dr. Sandifer diagnosed Ms. Barton with Spinal NMS dysfunction, cervical/cranial headaches, lumbar radiculitis, postural imbalance, and decreased range of motion. CP 23; CP 25. Dr. Sandifer's treatment plan was

¹ Dr. Sandifer submitted medical information from Ms. Barton's medical records to the trial court and here simply for background and context of her treatment before she filed a lawsuit. In the trial court, Ms. Barton did not object to the medical reports, and instead relied on them in her Response to Summary Judgment. *See* CP 66-67. Dr. Sandifer could and can just as easily rely exclusively on Ms. Barton's Complaint in moving for summary judgment dismissal. *See* CR 56(b) (the defending party "may move with or without supporting affidavits for a summary judgment in such party's favor as to all or any part thereof.") Ms. Barton's Complaint alleges that "On or about July 22, 2014, Defendant performed chiropractic manipulation upon the plaintiff. The manipulation was performed negligently

to perform chiropractic spinal adjustments three times per week for one week, two times per week for three weeks, and one time per week for six weeks; the treatment plan also included extremity treatment on Ms. Barton's hip joint. CP 23.

B. Ms. Barton Signed an Informed Consent Form.

Prior to treatment, Ms. Barton provided Dr. Sandifer with a signed and dated informed consent form. CP 32. Her signature acknowledged that receiving chiropractic adjustments and therapy exposed her to “some risks to treatment including, but not limited to, fractures, disc injuries, stroke, dislocations, sprains/strains, physiotherapy burns, and soft tissue injury.” CP 32. Ms. Barton also acknowledged that there were other “forms of treatment” to chiropractic care and the ability to “opt[] out of any and all treatment.” CP 32. Ms. Barton admits that she signed the informed consent form, though she does not recall signing it. App. Opening Br. at 4.

C. Ms. Barton Had Only Two Chiropractic Adjustments.

On July 16, 2014, Ms. Barton returned to Dr. Sandifer for her first chiropractic adjustment. CP 29. The medical records do not indicate that Ms. Barton complained of any pain or discomfort. CP 29. When Ms. Barton returned for her second adjustment on July 22, 2014, she reported that her

and without Plaintiff's informed consent. As a direct and proximate result, Plaintiff sustained

pain symptoms *improved* after the first July 16 adjustment. CP 30. Her Complaint only alleges that the July 22, 2014 treatment was negligent. CP 4.

D. Two Days Later, Ms. Barton Had a Stroke: Cause Unknown.

On July 24, Ms. Barton was admitted to Mason General Hospital where an MRI report stated “three foci of acute ischemia” stroke. CP 43. She was then transferred to Providence St. Peter Hospital (“Providence”) and received extensive testing, including a full serological workup, an MRI of her brain and spinal cord, an ultrasound of her lower extremities, an echocardiogram, and a computed tomography angiogram of her neck. CP 40-43.

The MRI report regarding the imaging of Ms. Barton’s brain states “no frank blood clot or luminal irregularity of the visualized bilateral distal vertebral artery and basal artery.” CP 43. The MRI report of Ms. Barton’s cervical spine showed was similarly unremarkable, showing no evidence of focal disc hernia, fracture, or soft issue injury; and further, the report states “[n]o evidence of vertebral artery dissection or luminal irregularity” and no focal blood clot adjacent to the bilateral vertebral arteries. CP 43. The CTA

a stroke, and accompanying injuries and damages.” CP 4:22-5:2.

report stated similar results, finding no evidence of a right vertebral artery dissection. CP 43.

Based on the MRIs and other testing, specialists at Providence reported “**no clear cause for a stroke was found**” and reported a diagnosis of “cryptogenic bilateral cerebellar hemispheric ischemic strokes.” CP 42; CP 40. Providence discharged her on July 28, 2014. “Cryptogenic” means “unknown etiology.”

A few weeks later, Ms. Barton followed up with her neurologist, Dr. Ramneantu, because she was experiencing cervical pain, mild depression, mild ataxia, and impairment of coordinated eye control. CP 45-46. Because Ms. Barton’s stroke etiology was undetermined, Dr. Ramneantu recommended lifelong aspirin therapy, and advised that she could return to work. CP 46. In December 2014, Ms. Barton visited Dr. Ramneantu for the last time. CP 48-49. She had no new neurological symptoms, and declined a referral to occupational therapy. CP 49.

E. Ms. Barton Filed Suit Against Dr. Sandifer, Alleging Medical Malpractice and Failure to Give Informed Consent.

Several years later, in February 2016, Ms. Barton filed a lawsuit against Dr. Sandifer and Champion Chiropractic Center, simply alleging that

the July 22 adjustment “was performed negligently and without Plaintiff’s informed consent.” CP 4:23. She alleged that as “a direct and proximate result, Plaintiff sustained a stroke, and accompanying injuries and damages.” CP 5:1-2. Dr. Sandifer’s Answer denied allegations of liability or causation, and asserted affirmative defenses. CP 7-8.

F. Dr. Sandifer Moved for Summary Judgment Dismissal.

Seven months later, on September 2, 2016, Dr. Sandifer moved for summary judgment dismissal of Ms. Barton’s two claims because she had no competent medical expert witness opining that: (1) Dr. Sandifer breached the requisite standard of care; (2) the breach more likely than not proximately caused her injuries; and (3) Dr. Sandifer failed to inform her of a material fact relating to the treatment; she consented to the treatment without being aware or fully informed of the material fact relating to her treatment; and that the treatment proximately caused her injury. CP 11; CP 57-61.

In response, Ms. Barton did not submit medical expert testimony to support her medical negligence and informed consent claims. She did not rely on deposition testimony, interrogatory answers/responses, answers to requests for admissions, or any other form of admissible discovery.

Instead, she relied on the medical records submitted by Dr. Sandifer, and her own declaration. CP 66-67; CP 75-78. Ms. Barton admitted that she

signed the informed consent form (CP 76:3-4), but did not recall signing it, and stated that “nobody went over its contents with me.” CP 76:4-5. Ms. Barton’s self-serving declaration also opined that in January 2015, Dr. Sandifer “apologized profusely” and “told me that he had ““had not been able to sleep for a month’” after my stroke because he was so upset at having caused it.” CP 77:4-6. Dr. Sandifer’s purported statements to Ms. Barton were not gleaned from discovery answers, requests for admissions, depositions, or any other form of discovery.

The parties continued the September 2 summary judgment hearing twice: to September 23, 2016, then to September 30. CP 91. Despite that one-month delay, Ms. Barton still did not secure expert medical opinion to support her claims. On September 30, 2016, the Honorable Carol Murphy heard oral argument. Verbatim Report of Proceedings (VRP) 4-21 (Sept. 30, 2016).

Ms. Barton argued she was not seeking a continuance of the summary judgment hearing, (VRP 10:19-20) but that she had another three and a half months to identify experts, therefore the motion for summary judgment was premature. (VRP 10:22-11:3) “I clearly believe this motion should be denied,

because it's in direct conflict with the letter and certainly the spirit of the case schedule[.]” (VRP 14:8-11)

The trial court challenged her argument, stating that “every case schedule has deadlines for disclosure, but when a motion for summary judgment is filed, the non-moving party then has obligations under the rules.” (VRP 14:21-24) In response, Ms. Barton explained that her process was to first depose the defendant; obtain medical records; then “we begin the process of finding experts who are willing to step into a medical malpractice case and form opinions.” (VRP 15:24-16:3-5) Here, Ms. Barton had not taken Dr. Sandifer’s deposition and had not retained a medical expert witness—contending that she still had three months to identify one. (VRP 17:2-7) Her response is significant because: (1) none of the steps in the process was taken; and (2) she clearly acknowledged the necessity of “finding experts who are willing to step into a medical malpractice case and form opinions.”

Ms. Barton also argued that her own declaration, wherein she stated that Dr. Sandifer “agreed that his treatment caused her stroke” was (1) admissible; and (2) sufficient to defeat the summary judgment motion. (VRP 11:4-18) She also contended that Dr. Sandifer’s apology was sufficient to

prove that he breached the standard of care and that the breach proximately caused his injuries. (VRP 12:1-13).

The trial court challenged these arguments. “Counsel, are you aware of any cases in which the defendant’s own words have been used to justify a denial of summary judgment when the defendant’s words to the court record only through the declaration of the plaintiff?” (VRP 12:15-18) Ms. Barton’s counsel answered “No, I am not aware of any reported case discussing that issue, but I think you get there through the traditional Rules of Evidence.” (VRP 12:19-21)

Dr. Sandifer objected to Ms. Barton’s declaration and argued that he had expressly denied negligence in his Answer, and that Ms. Barton’s self-serving declaration “is not the proper medical expert testimony establishing a breach in the standard of care and a proximate cause of the plaintiff’s injuries. That is simply not the law in the state of Washington.” (VRP 17:19-23)

Ms. Barton admitted that expert testimony is required to support her informed consent claim. “In terms of the informed consent issue, the law requires some expert testimony of the risks involved, and their informed consent form, which they offer as evidence of satisfaction of their duty to

inform my client of the risk, I submit is sufficient evidence that there is some risk of this.” (VRP 13:19-24)

Judge Carol Murphy granted Dr. Sandifer full summary judgment dismissal, with prejudice. CP 101-02. The trial court ruled that: (1) even though the motion for summary judgment was filed earlier than usual, “the legal standard that is imposed on the non-moving party” is “quite clear.” (VRP 19:17-19) The trial court noted that Ms. Barton had not moved for a continuance under CR 56(f), and that the record did not support a continuance, even if she had. (VRP 19:20-23)

Finally, the trial court stated that it had reviewed the cases cited by Ms. Barton, but “could not find a case in which a plaintiff in this case overcame a motion for summary judgment based solely upon the declaration of a plaintiff that purports to quote the defendant, and I have not seen a case like that.” (VRP 20:6-10) The trial court acknowledged “we don’t have a formal admission through discovery. We don’t have deposition testimony here, and we certainly don’t have any testimony of an expert witness on behalf of the plaintiff.” (VRP 20:14-18)

Ms. Barton appealed the Order of dismissal. CP 103.

V. LEGAL ARGUMENT

A. The Court Reviews Orders Granting Summary Judgment *De Novo*.

CR 56(b) enables a defendant to move for summary judgment dismissing an action or any part thereof. The summary judgment procedure dispenses with the time and cost of litigating meritless actions through trial. *W.G. Platts, Inc. v. Platts*, 73 Wn.2d 434, 442-43, 438 P.2d 867 (1968).

A defendant may move for summary judgment without supporting affidavits on the grounds that the plaintiff lacks competent evidence to support an essential element of his case. *Guile v. Ballard Cmty. Hosp.*, 70 Wn. App. 18, 23-24, 851 P.2d 689 (1993) (citations omitted). In a medical malpractice case, expert testimony is usually required to establish standard of care and causation. *Harris v. Groth*, 99 Wn.2d 438, 451, 663 P.2d 113 (1983). Expert testimony is also required to establish lack of informed consent. *Ruffer v. St. Frances Cabrini Hosp.*, 56 Wn. App. 625, 634, 784 P.2d 1288 (1990).

Once Dr. Sandifer demonstrates that Ms. Barton lacks admissible expert testimony, “the burden shifts to the plaintiff to produce an affidavit from a qualified expert witness that alleges specific facts establishing a cause of action. Affidavits containing conclusory statements without adequate

factual support are insufficient to avoid summary judgment.” *Guile*, 70 Wn. App. at 25. Consequently—and as happened here—medical negligence and informed consent claims lacking supportive expert testimony cannot survive summary judgment.

A trial court’s order granting summary judgment is reviewed *de novo*. *Mohr v. Grantham*, 172 Wn.2d 844, 859, 262 P.3d 490 (2011). Dr. Sandifer is entitled to summary judgment where there are “no genuine issues as to any material fact and . . . [it] is entitled to judgment as a matter of law.” *Id.* (quoting CR 56(c)).

B. RCW 7.70 Exclusively Governs Medical Malpractice Actions.

RCW 7.70 exclusively governs all Washington civil actions based in tort, contract, or otherwise from damages arising from health care after June 25, 1976. RCW 7.70.010. “RCW 7.70 modifies procedural and substantive aspects of all civil actions for damages for injury occurring as a result of health care, regardless of how the action is characterized.” *Branom v. State*, 94 Wn. App. 964, 969, 974 P.2d 335 (1999); *see also Orwick v. Fox*, 65 Wn. App. 71, 86, 828 P.2d 12 (1992) (“By its terms, RCW 7.70 applies to all actions against health care providers, whether based on negligence or intentional tort.”) Health care is “the process in which [a health care

provider] utilize[es] the skills which [he or she] has been taught in examining, diagnosing, treating or caring for” the patient. *Branom*, 94 Wn. App. at 970-71 (citations omitted).

The Legislature has expressly limited medical malpractice actions against health care providers “to claims based on the failure to follow the accepted standard of care, the breach of an express promise by a health care provider, and the lack of consent.” *Sherman v. Kissinger*, 146 Wn. App. 855, 866, 195 P.3d 539 (2008) (citing RCW 7.70.030).

For Ms. Barton’s medical negligence claim to survive summary judgment, Ms. Barton was required to make a *prima facie* showing that: (1) Dr. Sandifer breached the acceptable standard of care; and (2) the breach was the proximate cause of Ms. Barton’s injuries. RCW 7.70.040. Ms. Barton was also required to make a *prima facie* showing for her informed consent claim, which—as she admits—must be supported by competent expert testimony. (VRP 13:19-24) *See Ruffer*, 56 Wn. App. at 634.

C. Dr. Sandifer Was Entitled to Summary Judgment because Ms. Barton Failed to Produce Competent Expert Testimony that (1) Dr. Sandifer Breached the Standard of Care; and (2) the Breach Caused Ms. Barton’s Stroke.

RCW 7.70.040 sets forth the following necessary elements of proof that a plaintiff's alleged injury resulted from failure to follow the accepted standard of care. The statute states as follows:

- (1) The health care provider failed to exercise that degree of care, skill, and learning expected of a reasonably prudent health care 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;
- (2) Such failure was a proximate cause of the injury complained of.

RCW 7.70.040.

As a threshold matter, to defeat a dispositive motion, Ms. Barton needed to produce admissible expert testimony establishing (1) that Dr. Sandifer breached the applicable standard of care in his treatment of Ms. Barton, and (2) that the breach proximately caused Ms. Barton's injury. *See Harris*, 99 Wn.2d at 449 ("expert testimony will generally be necessary to establish the standard of care . . . and most aspects of causation"); *Shoberg v. Kelly*, 1 Wn. App. 673, 677, 463 P.2d 280 (1969) (affirming summary judgment dismissal of medical negligence claims on the grounds that "plaintiffs were under the necessity of showing at the minimum through a medical expert, or otherwise, that they had or would have medical expert

testimony to prove the applicable standard of care and its violation”). Without expert medical testimony, Ms. Barton cannot prove negligence, and therefore, cannot recover damages against a health care provider. *Id.* Because she failed to meet her burden of proof at the summary judgment stage, the trial court properly dismissed her claims as a matter of law. Under de novo review, the dismissal should be affirmed on appeal.

1. Ms. Barton Submitted No Medical Expert Testimony on the Standard of Care.

An injury, standing alone, is insufficient to create an inference of negligence. *Las v. Yellow Front Stores, Inc.*, 66 Wn. App. 196, 831 P.2d 744 (1992); *see also* WPI 105.07 (“A poor medical result is not, by itself, evidence of negligence”). A plaintiff’s expert evidence must rise to the level of a “reasonable medical certainty,” *Pelton v. Tri-State Mem. Hosp., Inc.*, 66 Wn. App. 350, 355, 831 P.2d 1147 (1992); thus, a plaintiff’s expert cannot merely state his or her personal opinion that he or she would have chosen a different course of action than the defendant health care provider. *White v. Kent Med. Ctr.*, 61 Wn. App. 163, 172, 810 P.2d 4 (1991). Further, a medical expert cannot base his or her testimony on speculation or conjecture. *Seybold v. Neu*, 105 Wn. App. 666, 681, 19 P.3d 1068 (2001).

The medical expert witness generally must practice in the defendant's relevant specialty. *Young v. Key Pharm.*, 112 Wn.2d 216, 229, 770 P.2d 182 (1989). In *Young*, the Supreme Court noted, "not even a medical degree bestows the right to testify on the technical standard of care; a physician must demonstrate that he or she has sufficient expertise in the relevant specialty." *Id.* (holding that a pharmacist may not provide medical expert testimony against a physician). In Washington, the general rule "is that a practitioner of one school of medicine is not competent to testify as an expert in a malpractice action against a practitioner of another school of medicine." *Colwell v. Holy Family Hosp.*, 104 Wn. App. 606, 612, 15 P.3d 210 (2001) (citation omitted); *see also Harris*, 99 Wn.2d at 448.

Here, Ms. Barton failed to provide testimony from a competent medical expert witness that, on a more probable than not basis, Dr. Sandifer's July 22 chiropractic treatment fell below the standard of care. Instead, she submitted excerpts from her own self-serving declaration interpreting a conversation that she had with Dr. Sandifer after her stroke as "proof" that his treatment fell below the standard of care. Dr. Sandifer has denied any negligent care, as stated in his Answer and Affirmative Defenses. To survive summary judgment, Plaintiff may not rely merely on allegations or self-

serving statements, but must set forth specific facts showing that genuine issues of material fact exist. CR 56(c).

Ms. Barton's attorney admitted that his litigation "process" involved first deposing the defendant medical provider; then obtaining the medical records; and finally securing supportive expert medical opinions. (VRP 15:22-16:6) Having failed to take these steps, Ms. Barton's lawsuit was correctly dismissed.

Ms. Barton's reliance on her own declaration—purporting to interpret an alleged conversation with Dr. Sandifer—including what he did or did not say, is legally insufficient to defeat summary judgment. And Ms. Barton admits that she "is not aware of any reported case discussing that issue." Instead, she circuitously argues that her interpretation of what Dr. Sandifer purportedly said to her is an admission of a party opponent, and therefore evidence that Dr. Sandifer breached the standard of care and proximately caused her injuries. But the purpose of the summary judgment procedure is to distinguish what is real and supported by the facts from what is insubstantial and not supported by the facts. It is a "liberal measure, liberally designed for arriving at the truth." *Preston v. Duncan*, 55 Wn.2d 678, 683, 349 P.2d 605 (1960). Here, Dr. Sandifer had the right to put Ms. Barton to

her burden—requiring her to provide competent medical expert testimony to prove standard of care and causation. Ms. Barton has failed to meet her obligation.

Ms. Barton’s reliance on *Young v. Group Health Coop.*, 85 Wn.2d 332, 534 P.2d 1349 (1975) is misplaced. In *Young*, a defendant doctor made a statement in his *deposition* that conflicted with his *trial testimony*. *Id.* at 335-36. The Supreme Court held that the trial court erred in refusing to allow the plaintiffs to impeach the doctor *at trial* with his prior inconsistent opinion/statement made in his *deposition*. *Id.* at 335.

The Supreme Court also analyzed whether the agent/doctor’s opinion/statement was admissible against the principal/defendant Group Health. The Court stated that “w[hile we have been hesitant to allow the opinions of agents to serve as admissions in a suit brought against the principal, we feel that under the facts of this case it would have been proper.” *Id.* at 337. Because the doctor was a speaking agent for Group Health, “his [deposition] statement does constitute an admission against Group Health.” *Id.* at 338.

Ms. Barton’s reliance on *Lockwood* and *Pannell* does not advance her position. In *Lockwood v. AD & S, Inc.*, 109 Wn.2d 235, 261-62, 744 P.2d

605 (1987), the statements at issue were contained in *documents and reports* “addressing research about the health hazards of asbestos to workers in asbestos mines and factories,” including post-exposure evidence. *Id.* at 240-60. The Supreme Court held that if a declarant has the authority to make a statement on behalf of a party, ER 801(d)(2) does not distinguish between admission of facts and admissions in the form of opinions. Accordingly, statements in the documents were admissible.

Ms. Barton’s self-serving declaration contains hearsay statements that do not fall under the exception of ER 801(d)(2). She is not authorized to make a statement for or on Dr. Sandifer’s behalf. *See Lockwood*, 109 Wn.2d at 262 (Under ER 801(d)(2), “[i]n order for a statement to satisfy these requirements, the declarant must be authorized to make the particular statement at issue, or statements concerning the subject matter, on behalf of the party); *see also Pannell v. Food Servs. of Am.*, 61 Wn. App. 418, 810 P.2d 952 (1991) (a statement by an employee *who is authorized to speak* on the subject matter is admissible as an admission by a party opponent under ER 801(d)(2)). Dr. Sandifer objected to Ms. Barton’s self-serving declaration, and the trial court agreed that there was no legal authority to

support admitting her interpretation of a purported telephone conversation with Dr. Sandifer. This evidentiary ruling should be affirmed.

2. Ms. Barton Submitted No Medical Expert Testimony on Causation.

In addition to providing medical expert testimony on the standard of care, Ms. Barton was required to produce medical expert testimony that proved causation. *Berger v. Sonneland*, 144 Wn.2d 91, 111-12, 26 P.3d 257 (2001) (requiring expert medical evidence as to causation where causation is not observable by lay person); *Reese v. Stroh*, 128 Wn.2d 300, 308, 907 P.2d 282 (1995) (“the general rule in Washington is that expert testimony on the issue of proximate cause is required in medical malpractice cases”); *McLaughlin v. Cooke*, 112 Wn.2d 829, 837, 774 P.2d 1171 (1989) (“[a]s a general rule, expert medical testimony on the issue of proximate cause is also required in medical malpractice cases”). The expert’s testimony must establish that the particular event more likely than not caused the injury, and most reasonably exclude as a probability every other hypothesis. *O’Donoghue v. Riggs*, 73 Wn.2d 814, 824, 440 P.2d 823 (1968) (emphasis added).

Thus, in the trial court, Ms. Barton needed to provide competent medical expert testimony that, more probable than not, Dr. Sandifer’s alleged

breach in the standard of care caused her stroke. Here, according to the medical records, the cause of Ms. Barton's stroke was undetermined. The radiographic testing performed on Ms. Barton "showed entirely normal vessels," and there was no sign of vertebral artery dissection or other injury.

Even if the Court ignores all of Ms. Barton's medical records and imaging reports and solely relies on her complaint, summary judgment dismissal was still appropriate, as a matter of law. Under CR 56(e), Ms. Barton "must set forth specific facts showing that there is a genuine issue for trial. If the adverse party does not so respond, summary judgment, if appropriate, shall be entered against the adverse party." The trial court's grant of summary judgment dismissal should be affirmed.

D. The Trial Court's Dismissal of Ms. Barton's Informed Consent Claim Should Be Affirmed because She Failed to Produce Competent Expert Testimony.

Generally, health care providers must obtain a patient's informed content prior to any treatment. *Miller v. Kennedy*, 11 Wn. App. 272, 286, 522 P.2d 852 (1974), *aff'd and adopted*, 85 Wn.2d 151 (1975). To support a medical negligence claims based on informed consent, "expert testimony is necessary to prove the existence of a risk, its likelihood of occurrence, and the type of harm in question." *Smith v. Shannon*, 100 Wn.2d 26, 34, 666 P.2d 351 (1983); *see also* RCW 7.70.050.

RCW 7.70.050 provides the necessary elements of proof for a plaintiff's medical negligence claims based on informed content:

- (a) That the health care provider failed to **inform the patient of a material fact** or facts relating to the treatment;
- (b) That the patient **consented to the treatment without being aware of or fully informed** of such material fact or facts;
- (c) That a **reasonably prudent patient under similar circumstances would not have consented** to the treatment if informed of such material fact or facts;
- (d) That the **treatment in question proximately caused injury** to the patient.

RCW 7.70.050(1) (emphasis added); *see, e.g., Bertsch v. Brewer*, 97 Wn.2d 83, 90, 640 P.2d 711 (1982); *Seybold*, 105 Wn. App. at 681; *Bays v. St. Luke's Hosp.*, 63 Wn. App. 876, 880-81, 825 P.2d 319 (1992); *Archer v. Galbraith*, 18 Wn. App. 369, 376, 567 P.2d 1155 (1977).

A “material fact” is a fact that “a reasonably prudent person in the position of the patient . . . would attach significance to [when] deciding whether or not to submit to the proposed treatment.” RCW 7.70.050(2). The plaintiff **must** establish the following material facts by expert testimony:

- (a) The **nature and character of the treatment proposed** and administered;
- (b) The **anticipated results of the treatment proposed** and administered;

(c) The recognized **possible alternative forms of treatment**;
or

(d) The recognized **serious possible risks, complications, and anticipated benefits** involved in the treatment administered and in the recognized possible alternative forms of treatment, including nontreatment.

RCW 7.70.050(3) (emphasis added).

The materiality determination is a two-step process. First, the scientific nature of the risk must be determined, including the nature of the harm and the probability of its occurrence. *Seybold*, 105 Wn. App. at 681 (quoting *Smith v. Shannon*, 100 Wn.2d 26, 31, 666 P.2d 351 (1983)). The trier of fact then determines whether that probability of harm is a risk a reasonable patient would consider in deciding on treatment. *Id.*

The first step requires expert testimony because “[o]nly a physician (or other qualified expert) is capable of judging what risks exist and their likelihood of occurrence. . . . Just as patients require disclosure of risks by their physicians to give an informed consent, a trier of fact requires description of risks by an expert to make an informed decision.” *Id.* at 682 (quoting *Smith*, 100 Wn.2d at 33-34). For this reason, expert testimony is required to “prove the existence of a risk, its likelihood of occurrence, and the type of harm in question.” *Id.*; see also *Ruffer*, 56 Wn. App. at 634

(affirming trial court's summary judgment dismissal where plaintiff failed to adduce any expert support for informed consent claim).

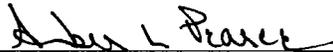
Because Ms. Barton failed to produce medical expert testimony to support her informed consent claim, this Court should affirm the trial court's dismissal, as a matter of law.

VI. CONCLUSION

The Court of Appeals should affirm summary judgment dismissal of Ms. Barton's medical malpractice and informed consent claims because she did not produce competent expert testimony establishing: (1) a deviation from the accepted standard of care by Dr. Sandifer; (2) failure to inform Ms. Barton of material facts prior to providing the care at issue; and (3) proximate causation of harm to Ms. Barton.

Respectfully submitted this 23rd day of January, 2017.

FLOYD, PFLUEGER & RINGER, P.S.



Rebecca S. Ringer, WSBA 16842
Amber L. Pearce, WSBA 31626
Attorneys for Respondents

CERTIFICATE OF SERVICE

The undersigned hereby certifies under penalty of perjury under the laws of the State of Washington, that on the date noted below, a true and correct copy of the foregoing was delivered and/or transmitted in the manner(s) noted below:

David A. Williams
Law Offices of David A. Williams
9 Lake Bellevue Drive, Suite 104
Bellevue, WA 98005
daw@bellevue-law.com

Facsimile
 Messenger
 U.S. Mail
 E-Mail via COA
Div. II

DATED this 23rd day of January, 2017.


Susan L. Klotz, Legal Assistant

FLOYD PFLUEGER & RINGER PS

January 23, 2017 - 4:17 PM

Transmittal Letter

Document Uploaded: 4-495163-Respondents' Brief.pdf

Case Name: Barton v. Sandifer

Court of Appeals Case Number: 49516-3

Is this a Personal Restraint Petition? Yes No

The document being Filed is:

Designation of Clerk's Papers Supplemental Designation of Clerk's Papers

Statement of Arrangements

Motion: _____

Answer/Reply to Motion: _____

Brief: Respondents'

Statement of Additional Authorities

Cost Bill

Objection to Cost Bill

Affidavit

Letter

Copy of Verbatim Report of Proceedings - No. of Volumes: _____

Hearing Date(s): _____

Personal Restraint Petition (PRP)

Response to Personal Restraint Petition

Reply to Response to Personal Restraint Petition

Petition for Review (PRV)

Other: _____

Comments:

No Comments were entered.

Sender Name: Susan L Klotz - Email: sklotz@floyd-ringer.com

A copy of this document has been emailed to the following addresses:

apearce@floyd-ringer.com

daw@bellevue-law.com

sklotz@floyd-ringer.com