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NO. 53248-4-II

COURT OF APPEALS, DIVISION II
OF THE STATE OF WASHINGTON

CHRISTOPHER W. SARTIN and ROSE M. RYKER,
individually and as a marital community,

Appellants,

v.

THE ESTATE OF ALONZO MCKPIKE; PIERCE COUNTY PUBLIC
TRANSPORTATION BENEFIT AREA CORPORATION, a/k/a PIERCE
TRANSIT, MULTICARE HEALTH SYSTEM, a Washington corporation
d/b/a TACOMA GENERAL HOSPITAL; MULTICARE
OCCUPATIONAL MEDICINE; and RICHARD GILBERT, M.D.,
individually,

Respondents.

BRIEF OF RESPONDENTS RICHARD GILBERT, M.D.,
AND MULTICARE HEALTH SYSTEM

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I. INTRODUCTION

This appeal arises out of a multiple vehicle collision that took place when Respondent Alonzo McPike suffered a sudden loss of consciousness while driving a Pierce Transit bus. Appellants Christopher W. Sartin and Rose M. Ryker (collectively “Mr. Sartin”) sued Respondents MultiCare Health System and Richard Gilbert, M.D. (collectively “Dr. Gilbert”)¹ claiming that Dr. Gilbert, a physician and licensed CDL examiner, committed negligence or medical negligence when he certified that Mr. McPike was medically qualified to operate commercial motor vehicles within the State of Washington. The trial court correctly concluded that Dr. Gilbert was entitled to summary judgment as matter of law.

There are multiple bases upon which this Court can affirm the trial court’s ruling. Firstly, Dr. Gilbert, a licensed Medical Examiner, did not owe a duty to Mr. Sartin absent a special relationship with his examinee, Mr. McPike. Secondly, even if such a special relationship existed, which Dr. Gilbert denies, the scope of any resulting duty was limited to foreseeable risks. Mr. McPike’s sudden loss of consciousness was unforeseeable as a matter of law. Thirdly, Mr. Sartin failed to create a genuine issue of material fact with respect to proximate cause.

¹ Mr. Sartin alleges that MultiCare, as Dr. Gilbert’s employer, is vicariously liable. They are therefore referred to collectively herein as “Dr. Gilbert.”

To establish proximate cause, Mr. Sartin relied solely on the testimony of his expert, Dr. Fletcher. Dr. Fletcher opined that a cardiac workup would have revealed severe coronary artery disease (“CAD”), and that CAD triggered an arrhythmia causing Mr. McPike to crash the bus. Dr. Fletcher’s testimony was insufficient to submit the issue of causation to the jury because (a) Dr. Fletcher was not qualified to testify on cardiac issues; (b) Dr. Fletcher based his opinions on assumptions not in evidence; and (c) Dr. Fletcher could not establish, without resorting to speculation and conjecture, that additional workup would have made a difference. The trial court therefore appropriately struck Mr. Fletcher’s testimony as to cardiac issues and causation. In the absence of admissible expert medical testimony on proximate cause, Mr. Sartin’s claims against Dr. Gilbert failed as a matter of law. If this Court concludes that any one of these three bases entitled Dr. Gilbert to summary judgment, the trial court’s ruling in favor of Dr. Gilbert should be affirmed.

II. COUNTERSTATEMENT OF ISSUES PRESENTED FOR REVIEW

1. Did the trial court correctly find that Dr. Gilbert was entitled to summary judgment as a matter of law where Mr. Sartin lacks standing to pursue a claim for medical malpractice?
2. Did the trial court correctly find that Dr. Gilbert was entitled to summary judgment as a matter of law where a single visit for a regulatory examination is insufficient to create a special

relationship triggering a duty to protect third parties against foreseeable dangers?

3. Did the trial court correctly find that Dr. Gilbert was entitled to summary judgment as a matter of law where Mr. McPike's sudden loss of consciousness was unforeseeable?
4. Did the trial court correctly strike Dr. Fletcher's testimony on cardiac issues and causation where he admitted that he was not an expert in cardiac issues, he based his opinions on assumptions wholly unsupported by the evidence, and he could not establish that additional workup would have made a difference without resorting to speculation and conjecture?
5. Did the trial court correctly find that Dr. Gilbert was entitled to summary judgment as a matter of law where Mr. Sartin failed to come forward with admissible medical testimony on the issue of proximate cause?

III. COUNTERSTATEMENT OF THE CASE

A. Bus Drivers Must Submit to Periodic Regulatory Examinations.

Mr. McPike was employed as a Pierce Transit bus driver for approximately 18 years. CP 74. To operate Pierce Transit buses, Mr. McPike was required to maintain a Commercial Driver's License ("CDL") issued by the Washington State Department of Licensing. CP 75. Renewal of his CDL license required Mr. McPike to submit to periodic regulatory examinations performed by licensed CDL examiners. CP 1571. Licensed CDL examiners are authorized to evaluate and screen truck and bus drivers for potentially disqualifying medical conditions and to certify drivers who meet the health criteria indicating the drivers' ability to safely operate a bus

or truck. CP 1571. CDL examiners are not treating physicians; they perform isolated regulatory exams. CP 1439. The care and treatment of a patient is left to their primary care physician. CP 1439.

B. Dr. Larson's November 2012 Cardiac Workup Revealed No Evidence of CAD.

In November 2012, Mr. McPike underwent a cardiac workup performed by Dr. Tim Larson, a cardiologist. CP 1482, 1507-08, 1514-16, 1534-35. Dr. Larson recommended Mr. McPike undergo testing with a Holter monitor. CP 1514-16. Dr. Larson reported that the results of the Holter monitoring were "fairly benign." CP 1515. Dr. Larson also performed a transthoracic echocardiogram ("ECHO"), a non-invasive test similar to an ultrasound that is used to evaluate cardiac function and blood flow. CP 1507-08, 1515, 1535. The ECHO showed normal heart function. CP 1507-08, 1515, 1535. Dr. Larson did not diagnose any cardiac abnormalities or CAD and had no specific recommended follow up. CP 1482, 1507-08, 1515, 1534-35.

C. Dr. Harmon Issues 90-Day Card in November 2014.

On November 7, 2014, Mr. McPike presented to the MultiCare Occupational Medicine Clinic for a CDL exam. CP 1443-44. Patients like Mr. McPike who present to MultiCare for CDL exams are advised of the limited scope of the exam:

This is a LIMITED SCOPE exam for employment purposes only. There is no health screening or primary health care objectives which is the examinees responsibility. Any non work related findings will be communicated if discovered and is the examinees responsibility to follow up on.

CP 1444. Dr. Harmon performed Mr. McPike's CDL exam and cleared him to operate a commercial vehicle for 90 days. CP 1443-44. He found Mr. McPike's blood pressure was well controlled but wanted him to undergo a screening sleep study for sleep apnea. CP 1441, 1443-44. He also asked him to obtain blood pressure readings from his primary care physician, Dr. Brooks, to demonstrate his blood pressure was under control. CP 1441. Dr. Harmon issued Mr. McPike a 90-day card so that he could complete these tasks and come back for recertification. CP 1441. Dr. Harmon did not find any evidence of heart disease or cardiac issues. CP 1440. He did not refer Mr. McPike for a cardiac workup. CP 1443-44.

D. Sleep Apnea Treated and Under Control

In December 2014, Mr. McPike underwent a sleep study which disclosed that he had severe sleep apnea. CP 1539. His sleep apnea was controlled with CPAP therapy. CP 1539. Mr. McPike was 100% complaint, and the treatment was effective in controlling his sleep apnea. CP 1449; 1539.

E. Dr. Gilbert Issues One-Year CDL Card in January 2015.

Mr. McPike re-presented to MultiCare Occupational Medicine on January 30, 2015 and was seen by Dr. Gilbert, a licensed CDL examiner. CP 1571. Dr. Gilbert noted that Mr. McPike's diabetes was well controlled. CP 1571. This was confirmed by an Intrastate Waiver Application signed by Dr. Wang, Mr. McPike's endocrinologist treating his diabetes. CP 1571. Dr. Wang certified that "Mr. McPike's diabetes was not likely to interfere with the ability to safely drive." CP 1492.

In addition, Dr. Gilbert concluded that Mr. McPike's hypertension was well controlled. CP 1447. Mr. McPike had obtained a signed compliance letter from his primary care physician, Dr. Brooks, with three normal readings. CP 1447, 1486. Dr. Brooks certified that Mr. McPike's blood pressure was under adequate control and that he was safe to drive a commercial motor vehicle. CP 1483, 1486, 1579. Dr. Gilbert also reviewed the sleep study results. CP 1447, 1449, 1571. He noted excellent compliance and that the sleep apnea was appropriately treated and under control. CP 1447, 1449, 1571.

During the exam, Dr. Gilbert identified an irregular cardiac rhythm he thought might be a PAC (Premature Atrial Contraction). CP 1572. Mr. McPike informed Dr. Gilbert that he had a cardiac workup earlier and that everything was okay from a cardiac standpoint. CP 1448. Dr. Gilbert did

not see a need for additional cardiac workup given the fact that Mr. McPike had no signs or symptoms of cardiac problems. CP 1448, 1450, 1572. Mr. McPike's 2012 cardiac workup with Dr. Larson confirmed Dr. Gilbert's judgment. CP 1451. The cardiac workup had been normal, and Mr. McPike had no signs or symptoms of CAD. CP 1451. Another cardiac workup was not indicated. CP 1451. Finding that Mr. McPike had satisfied Dr. Harmon's conditions for recertification and met the DOT standards, Dr. Gilbert issued Mr. McPike a one-year CDL card. CP 1486, 1571-72.

F. Mr. McPike Had No Subsequent Signs of CAD or Indication for a Cardiac Workup.

Mr. McPike had subsequent appointments with Dr. Brooks, his primary care physician, and Dr. Wang, his endocrinologist, in March 2015. CP 1453-54, 1483. Neither physician noted any concerns that Mr. McPike might suffer a loss of consciousness. CP 1453-54, 1483. Both doctors performed cardiac exams which were normal. CP 1453-54, 1483. Mr. McPike never complained of any signs or symptoms that could be related to CAD. CP 1453-54, 1483.

Neither Dr. Brooks nor Dr. Wang saw a need for cardiac referral. CP 1484, 1491. Dr. Brooks testified:

Although Mr. McPike had medical conditions that can increase the risk for developing cardiac disease, he never presented with signs or symptoms such as syncope, dizziness, chest pain, shortness of breath,

weakness, palpitations and the like. Nor on examination did he exhibit any ventricular vulnerability. Mr. McPike did not have a history of coronary artery disease, and he had been given a good bill of health from the cardiologist, Dr. Tim Larson. From 2012 to the last visit I had with Mr. McPike in March 2015, I saw no evidence of coronary artery disease or a need for a cardiac referral.

CP 1484.

G. Mr. McPike Suffers Sudden Loss of Consciousness.

On the morning of May 26, 2015, Mr. McPike was driving a Pierce Transit bus northbound on Portland Avenue East when he suddenly lost consciousness. CP 43, 74, 121. He lost control of the bus and collided with several vehicles. CP 43, 74, 121. Appellant Christopher Sartin was injured in the collision. CP 1-6. Medics from Tacoma Fire Department initiated CPR and other treatments, and Mr. McPike was transported to Tacoma General Hospital with a suspected massive heart attack. CP 1552.

H. Post-Accident Care Indicates Cardiac Arrest of Unknown Cause.

When he arrived at Tacoma General Hospital, a cardiac workup was performed by Dr. Momah. CP 1468, 1509, 1535, 1548-50. Dr. Momah reviewed EKGs and an ECHO. CP 1468. The EKGs did not show any acute changes, and the ECHO showed preserved left ventricle function with no wall abnormalities. CP 1468, 1509, 1535, 1548-50. The ejection

fraction was within normal range, identical to what Dr. Larson found in 2012. CP 1468, 1509, 1514-16, 1535, 1548-50. Myocardial infarction, or heart attack, was ruled out and it was concluded that Mr. McPike likely had a cardiac arrest. CP 1468, 1509, 1535, 1548-50. However, the cause of the arrest remained unclear. CP 1456. Dr. Momah made no finding of CAD. CP 1468-72, 1509, 1535, 1548-50. In fact, no physician at Tacoma General mentioned CAD. CP 1536.

Mr. McPike remained in the hospital for a little over a month but unfortunately passed away on June 30, 2015. CP 1458. The hospital discharge summary noted the cause of death to be “severe anoxic brain injury as a consequence of cardiac arrest.” CP 1458. Neither the discharge summary nor the death certificate mentioned CAD. CP 1458-59, 1474.

I. Experts Confirm No Evidence of CAD.

In the proceedings below, Mr. Sartin’s expert, Dr. Fletcher, opined that Mr. McPike suffered from severe CAD which ultimately led to his cardiac arrest and the crash of the bus. CP 1466. In fact, Dr. Fletcher maintained that he was “100% convinced” that if a cardiac workup had been performed in the Spring of 2015, it would have revealed CAD. CP 1771. However, Dr. Fletcher admitted he was not a cardiac expert and that he would defer to a cardiologist on the interpretation and importance of EKGs and ECHOs. CP 1462-64. He also conceded that Mr. McPike did not have

any signs or symptoms of CAD before or after the collision. CP 1463-65. He testified that the first manifestation of CAD is often sudden death due to cardiac arrhythmia and believed that to be what happened to Mr. McPike on the day of the accident. CP 1465.

Defense expert Dr. Kudenchuk, a physician board-certified in internal medicine, cardiology, and clinical cardiac electrophysiology (a specialty in heart rhythm disturbances), reviewed the ECHO imaging from 2012 and 2015. CP 1534. He also studied over 200 pages of EKG recordings from the continuous heart rhythm monitoring performed on Mr. McPike at Tacoma General Hospital following the collision. CP 1535-36. Dr. Kudenchuk found no evidence of severe CAD before or after the accident. CP 1535-36. As Dr. Kudenchuk explains:

15. ...Meaning, if significant coronary artery disease causing blockage led to Mr. McPike's cardiac arrest, there would have been evidence of wall motion abnormalities, a decline in cardiac function and/or ECG changes indicative of heart damage resulting from this "ultimate stress test". This was not the case, indicating that he did not have severe underlying coronary heart disease as the cause of the event nor sufficient coronary disease to result in signs of cardiac dysfunction in the aftermath of a major CPR stress.

16. Based on this evidence, it is my opinion that Mr. McPike's sudden loss of consciousness and cardiac arrest were not the result of coronary artery disease. This conclusion is further supported by the numerous physicians who treated Mr. McPike following the

accident at Tacoma General Hospital. None of the physicians indicated that Mr. McPike had severe coronary artery disease nor related the cardiac arrest to severe coronary artery disease.

CP 1536. Defense expert Dr. Epstein, a physician also board-certified in internal medicine, cardiology, and clinical cardiac electrophysiology, concurred. CP 1508.

J. CAD Could Not Have Caused Mr. McPike's Sudden Loss of Consciousness.

Dr. Kudenchuk also reviewed video footage of the bus accident which included footage of the EMT arrival and subsequent efforts to resuscitate Mr. McPike. CP 1536-37. When the medics arrived, they found Mr. McPike to be in asystole, a condition where the heart stops beating and there is no discernable electrical activity; in other words, a flat line. CP 1537. CAD is not a cause of asystole. CP 1537-38. This is more likely attributable to a hypoxic event, where a lack of oxygen leads to cardiac arrest. CP 1537-38. Consequently, CAD could not have led to the cardiac arrest. CP 1538.

...In my opinion based on the evidence described above, the arrest was not caused by coronary artery disease. Nor, based on his prior Holter monitoring and protracted period of rhythm monitoring during his hospitalization, was there any evidence that he might have had asystole as a primary or unprovoked rhythm event. Had this been the case, one would have seen "warning periods" of profound

bradycardia or asystole periodically during the course of his monitoring, which was never observed.

* * *

In summary, Mr. McPike did not have significant coronary artery disease which led to his cardiac arrest. There is simply no evidence to support such a conclusion and in fact significant evidence to the contrary.

CP 1538-39.

Dr. Kudenchuk was also able to definitively rule out all of Mr. McPike's other known medical conditions as playing a role in his loss of consciousness. CP 1538-39. Because the cause of the loss of consciousness cannot be determined, even in hindsight, no one could have anticipated this event. CP 1539-40. Mr. McPike's unfortunate cardiac arrest was therefore not only unexpected, it was also unpreventable. CP 1540.

K. Chronology

For the sake of convenience, the following table summarizes the key events concerning Mr. McPike's medical care:

DATE:	PROVIDER:	EVENT:	CAD
11/12/2012	Dr. Larson	Holter monitoring benign	No
11/20/2012	Dr. Larson	ECHO – no structural abnormality and LVEF of 50-60%	No
11/07/2014	Dr. Harmon	DOT exam – no cardiac complaints or symptoms. 90-day certification with follow up for sleep study and blood pressure compliance	No

1/14/2015	Dr. Brooks	Signs blood pressure compliance certifying Mr. McPike safe to drive	N/A
1/23/2015	Dr. Wang	Signs diabetes application certifying Mr. McPike safe to drive	N/A
1/30/2015	Dr. Gilbert	DOT exam -- issues one-year CDL card	No
3/3/2015	Dr. Wang	Follow up -- no cardiac symptoms	No
3/27/2015	Dr. Brooks	Follow up -- no cardiac symptoms	No
5/26/2015	Tacoma Fire Department	Found in asystole	No
5/26/2015	Dr. Kranick	Cause of arrest unclear	No
5/26/2015	Dr. Momah	Normal ECHO and LVEF, no CAD	No
6/30/2015	Dr. Kranick	No mention of CAD in summary	No
6/30/2015	Dr. Michaels	No mention of CAD on Death Certificate	No

CP 1443-44, 1453-54, 1456, 1458-59, 1468, 1474, 1483, 1486, 1492, 1515, 1552, 1571-72.

L. Procedural Background

On August 26, 2016, Mr. Sartin filed a negligence lawsuit against Respondents Pierce Transit and the Estate of Alonzo McPike (collectively “Pierce Transit”) based on personal injuries allegedly suffered as a result of the May 26, 2015, collision. CP 1-6. Pierce Transit subsequently moved for summary judgment, and the motion was denied. CP 16-38, 972-73.

Thereafter, Mr. Sartin filed a separate lawsuit against Dr. Gilbert alleging that Dr. Gilbert committed negligence or medical negligence when he certified that Mr. McPike was medically qualified to operate commercial motor vehicles within the State of Washington. CP 976. The trial court granted the parties' joint motion to consolidate the cases. CP 974-982, 983-985.

On November 30, 2018, Pierce Transit filed a Renewed Motion for Summary Judgment. CP 1009-24. This time, the trial court had the benefit of Dr. Fletcher's deposition testimony. CP 1431; RP 22. The trial court granted Pierce Transit's Renewed Motion on January 4, 2019, finding that Mr. McPike's sudden loss of consciousness was unforeseeable. CP 1292-94, 1432-33; RP 23-24. The trial court also found that Dr. Fletcher's opinions amounted to no more than speculation. CP 1432; RP 23. The trial court articulated its position as follows:

I believe that the issue of foreseeability can be decided as a matter of law, that there is not a sufficient showing that's been presented that either Mr. McPike or Pierce Transit were on notice in 2015 that Mr. McPike was at risk of sudden incapacitation and shouldn't be driving.

Everything that was presented is really speculation on the part of Dr. Fletcher and Mr. Grill as far as what could or could not have been done or what may have been done, but there's no indication that either Mr. McPike or Pierce Transit were on notice of this risk that it may happen, the sudden incapacitation, and

really that there's speculation that further evaluations were needed, what they might reveal, whether they would reveal a disqualifying medical condition. We have the evidence of the EKG in the hospital after this incident happened.

CP 1432-1433; RP 23-24.

On January 22, 2019, Dr. Gilbert filed a Motion for Summary Judgment. CP 1379-1405. As part of his motion, Dr. Gilbert moved to strike Dr. Fletcher's testimony as to cardiac issues and causation. CP 1791-93. By Order dated March 1, 2019, the trial court granted Dr. Gilbert's Motion for Summary Judgment, including his Motion to Strike Dr. Fletcher's testimony as to cardiac issues and causation. CP 1837-39. This appeal followed. CP 1840-51.

IV. ARGUMENT

A. Standard of Review

On appeal of summary judgment, the standard of review is de novo, and the appellate court performs the same inquiry as the trial court. *Nivens v. 7-11 Hoagy's Corner*, 133 Wn.2d 192, 197-98, 943 P.2d 286 (1997). When ruling on a summary judgment motion, the court is to view all facts and reasonable inferences therefrom most favorably toward the nonmoving party. *Weyerhaeuser Co. v. Aetna Cas. & Sur. Co.*, 123 Wn.2d 891, 897, 874 P.2d 142 (1994). A court may grant summary judgment if the pleadings, affidavits, and depositions establish that there is no genuine issue

as to any material fact and the moving party is entitled to judgment as a matter of law. *Ruff v. County of King*, 125 Wn.2d 697, 703, 887 P.2d 886 (1995); *see also* CR 56(c).

B. The Trial Court Correctly Dismissed Mr. Sartin's Negligence Claim Against Dr. Gilbert.

Mr. Sartin cannot maintain a negligence/medical malpractice claim against Dr. Gilbert since Mr. Sartin was not Dr. Gilbert's patient. Washington law does not recognize a cause of action for medical malpractice absent a physician/patient relationship. *Volk v. DeMeerleer*, 187 Wn.2d 241, 254, 386 P.3d 254 (2016); *see also Paetsch v. Spokane Dermatology Clinic, PS*, 182 Wn.2d 842, 850, 348 P.3d 389 (2015) (recognizing that medical malpractice imposes a duty on the medical professional to act consistently with the standards of the medical profession, and the duty is owed to the medical professional's patient). The Washington Supreme Court has declined to adopt the view that medical malpractice suits are available to nonpatient third parties. *Paetsch*, 182 Wn.2d at 850 n.6. Accordingly, Mr. Sartin could not state a claim for negligence/medical malpractice against Dr. Gilbert and the trial court appropriately entered summary judgment in Dr. Gilbert's favor.

C. The Trial Court Correctly Dismissed Mr. Sartin’s Medical Negligence Claim Against Dr. Gilbert.

1. Dr. Gilbert Owed No Duty to Mr. Sartin in the Absence of a Special Relationship with Mr. McPike.

a. A Single Regulatory Exam Does Not Create a “Special Relationship” Duty to Third Parties.

The trial court also appropriately dismissed Mr. Sartin’s claim for medical negligence—an alternate duty to that imposed by medical malpractice. *Volk*, 187 Wn.2d at 255. Generally, a person has no duty to prevent a third party from causing physical harm to another. *Id.* A claim for medical negligence based on Restatement § 315 is an exception to the general common law rule of nonliability for the acts of third parties and requires a special relationship. *Id.* Restatement § 315 states:

There is no duty to control the conduct of a third person as to prevent him from causing physical harm to another unless

(a) A special relation exists between the actor and the third person which imposes a duty upon the actor to control the third person’s conduct, or

(b) A special relation exists between the actor and the other which gives to the other a right of protection.

RESTATEMENT (SECOND) TORTS § 315.

The Washington Supreme Court has consistently refused to impose a duty under § 315 in the absence of a definite, established and continuing relationship. In *Honcoop v. State*, 111 Wn.2d 182, 184, 759 P.2d 188

(1988), dairy operators sued the State for losses suffered when their dairy herds became infected with brucellosis. *Id.* at 184-85. The Department of Agriculture was charged with authority to prevent the spread of infectious disease. *Id.* at 185-86. The gravamen of the dairy operators claim against the State was that the State negligently failed to enforce brucellosis statutes and regulations against Holloway, the cattle dealer who the infection was traced back to. *Id.* at 189. The dairy operators argued that although these regulations were enacted for the public welfare and public health, a special relationship existed between the State and the dairy operators giving rise to an actionable duty. *Id.* at 191. The *Honcoop* court declined to find a special relationship. *Id.* at 192.

A review of the cases applying section 315 discloses that a duty to a particular individual will be imposed only upon a showing of a definite, established and continuing relationship between the defendant and the third party. *E.g., Petersen v. State, supra; Tarasoff v. Regents of Univ. of Cal.*, 17 Cal.3d 425, 551 P.2d 334, 131 Cal. Rptr. 14, 83 A.R.R.3d 1166 (1976). The relationship between the State and Holloway is too tenuous and unsubstantial to warrant application of Restatement section 315. Here, the director had regulatory authority over Holloway. Regulatory control over a third party is not sufficient to establish the necessary control which can give rise to an actionable duty.

Id. at 193 (emphasis added).

Two additional Washington Supreme Court cases have addressed circumstances where a special relationship duty is imposed on physicians to protect third parties against injuries caused by their patients. In *Petersen v. State*, 100 Wn.2d 421, 422 , 671 P.2d 230 (1983), a patient seriously injured himself with a knife and displayed delusional and hallucinogenic tendencies while in the ER. *Id.* He was evaluated by a mental health professional and admitted to Western State Hospital on a 72-hour involuntarily hold. *Id.* While involuntarily committed at Western State Hospital, he was treated by a psychiatrist. *Id.* The psychiatrist learned that the patient was on probation as a result of a burglary conviction and had an extensive history of drug use, including the frequent use of angel dust during the previous year. *Id.* The patient told the psychiatrist he had taken angel dust just prior to harming himself. *Id.* The psychiatrist diagnosed the patient as having a schizophrenic reaction to the use of angel dust and prescribed antipsychotic medication. *Id.* The psychiatrist also successfully petitioned the court to have the patient involuntarily detained an additional 14 days. *Id.* at 424.

Over the course of the three-week involuntary commitment, the psychiatrist learned that the patient's behavior could be unpredictable. *Id.* at 428. The psychiatrist knew that if the patient used angel dust again, he was likely to continue having delusions and hallucinations, especially if he

quit taking the antipsychotic medication. *Id.* The psychiatrist also knew that the patient was reluctant to take the antipsychotic medication and thought it quite likely that he would revert to using angel dust again. *Id.* The psychiatrist nevertheless discharged the patient one day after he was apprehended by hospital security personnel for recklessly driving his car on hospital grounds. *Id.* at 424. It was the psychiatrist's opinion that the patient had recovered from the drug reaction, was in full contact with reality, and was back to his usual type of personality and behavior. *Id.*

Five days later, the patient ran a red light while traveling approximately 50-60 miles per hour and struck Ms. Petersen's vehicle. *Id.* at 422-23. Witnesses claimed the patient appeared to be greatly influenced by drugs. *Id.* The *Peterson* court held that these facts were sufficient to establish a special relationship between the psychiatrist and the involuntarily committed patient which gave rise to a duty on the part of the psychiatrist to take reasonable precautions to protect anyone who might foreseeably be endangered by the patient's drug-related mental problems. *Id.* at 428.

Most recently, the Washington Supreme Court recognized the existence of a special relationship in *Volk*. In *Volk*, a mental health patient murdered his former girlfriend and one of her sons, attempted to kill a second son, and committed suicide. 187 Wn.2d at 246. The psychiatrist

had been treating the patient on an outpatient basis for nine years leading up to the attack, during which time the patient expressed suicidal and homicidal ideations. *Id.* In recognizing these facts as sufficient to establish the existence of a special relationship, the *Volk* court reiterated its previous holding in *Honcoop* “that a special relationship exists under § 315, triggering the imposition of a duty to protect against foreseeable dangers, on a showing that a definite, established, and continuing relationship exists between the defendant and the third party.” *Id.* at 256.

Here, the facts do not support the existence of a special relationship between Dr. Gilbert and Mr. McPike. Unlike *Petersen*, this case does not involve a three-week treating physician relationship in an involuntary commitment setting. Unlike *Volk*, this case does not involve a nine-year treating physician relationship on an outpatient basis. In fact, this case does not involve a treating physician relationship at all. Rather, this case involves a single regulatory exam for the purpose of CDL certification. A single, regulatory exam hardly gives rise to the definite, established, and continuing relationship necessary to overcome Washington’s general rule of nonliability for the acts of third parties.

Recognizing that CDL examiners do not have a definite, established and ongoing relationships with their examinees, Mr. Sartin gloms onto the following language in the *Volk* decision: “the nature of the relationship in

Petersen gave the doctor unique insight into the potential dangerousness of his patient as well as the identity of the potential victims.” 187 Wn.2d at 261. In *Petersen*, however, the nature of the relationship was that of a treating physician and the unique insight was garnered through three weeks of involuntary treatment in a psychiatric hospital. 100 Wn.2d at 424, 428. During that time, the physician learned the patient’s behavior could be unpredictable and reckless, the patient was reluctant to take his antipsychotic medication, and the patient was likely to revert to using angel dust. *Id.* There are stark differences between the nature of the relationship in *Petersen*, wherein the treating psychiatrist observed the patient for three weeks in an involuntary commitment setting, and the nature of the relationship between Dr. Gilbert and Mr. McPike, whose sole interaction was during a single regulatory exam for the purpose of CDL certification. This limited interaction did not give Dr. Gilbert any unique insight into the potential dangerousness of Mr. McPike which would warrant the finding of a special relationship. Accordingly, § 315 does not provide a basis for imposing a duty on Dr. Gilbert, and the trial court appropriately entered summary judgment in his favor.

b. Mr. Sartin's Reliance on *Kaiser* Is Misplaced.

The decision in *Kaiser v. Suburban Transp. System*, 65 Wn.2d 461, 398 P.2d 14 (1965), does not justify the imposition of a duty on Dr. Gilbert in this case. In *Kaiser*, decided by the Washington Supreme Court over fifty years ago, a bus driver was prescribed a drug by his treating physician which caused him to lose consciousness and crash his bus. *Id.* at 462-63. Prior to the accident, the bus driver presented to his treating physician for his routine annual checkup and complained about a nasal condition. *Id.* at 469-70 (Hale, J., dissenting). The treating physician told the bus driver that the condition could be readily taken care of but became either too busy or forgot to make out a prescription. *Id.* The bus driver returned to his treating physician's office the following week to remind him about the condition at which time the treating physician issued the prescription. *Id.* The bus driver took the first pill the next morning. *Id.* He subsequently lost consciousness while driving his bus and crashed into a telephone poll. *Id.* at 462. The *Kaiser* court found that an injured bus passenger could sue the treating physician for failing to warn the bus driver of dangerous side effects of the drug such as drowsiness. *Id.* at 464.

Unlike the doctor in *Kaiser*, Dr. Gilbert did not treat Mr. McPike for any medical condition. Rather, Mr. McPike's medical conditions were

being followed by his treating physicians, Dr. Brooks and Dr. Wang. Washington law recognizes that the duty of a doctor in an employment exam is not the same, nor as extensive, as that of a treating physician. *See Judy v. Hanford Environmental Health Foundation*, 106 Wn. App. 26, 38-39, 22 P.3d 810 (2001) (holding that unlike treating physicians, medical examiners merely have a duty to perform employment screenings competently, to not inflict injury, and to inform the examinee of any unknown morbid condition disclosed). Indeed, patients who present to MultiCare for CDL exams are advised of the limited scope of the exam:

This is a LIMITED SCOPE exam for employment purposes only. There is no health screening or primary health care objectives which is the examinees responsibility. Any non work related findings will be communicated if discovered and is the examinees responsibility to follow up on.

CP 1444.

Moreover, and contrary to Mr. Sartin's contention, *Kaiser* does not "indicate[] that the traditional requirements of a special relationship were not of particular importance to the court in the commercial driver context." Appellants' Brief at p. 41. The *Kaiser* case was decided in January 1965—the same year as (and likely before) the Restatement (Second) of Torts was published. Mr. Sartin's contention also ignores that a special relationship did in fact exist between the physician and the bus driver—he was the bus

driver's treating physician. 65 Wn.2d at 469-70 (Hale, J., dissenting). He performed the bus driver's routine annual exam and the bus driver followed up with his doctor thereafter to obtain the prescription. *Id.* This demonstrates the existence of a relationship that was definite, established and ongoing. The Washington Supreme Court's more recent decisions in *Petersen*, *Honcoop*, and *Volk* leave no doubt that as in *Kaiser*, a definite, established and ongoing relationship must exist before a duty will be imposed to protect third parties from the harm of another. *Petersen*, 100 Wn.2d at 426-28; *Honcoop*, 111 Wn.2d at 193; *Volk*, 187 Wn.2d at 256. It would therefore strain reason to conclude that something less than a special relationship is required to impose a duty on a CDL examiner like Dr. Gilbert. Because no special relationship existed between Dr. Gilbert and Mr. McPike, Dr. Gilbert owed Mr. Sartin no duty and the trial court appropriately entered summary judgment in Dr. Gilbert's favor.

c. A Single Regulatory Exam Does Not Create a "Take Charge" Duty to Third Parties.

Mr. Sartin also erroneously contends that the facts of this case give rise to a "take charge" duty under Restatement § 319. Restatement § 319 defines a "take charge" relationship as: "One who takes charge of a third person whom he knows or should know to be likely to cause bodily harm to others if not controlled is under a duty to exercise reasonable care to control

the third person to prevent him from doing such harm.” RESTATEMENT (SECOND) TORTS § 319. The Washington Supreme Court has interpreted a “take charge” relationship as follows:

As we have interpreted § 319, a take charge duty to act for the benefit of reasonably foreseeable victims exists in certain relationships, including the parole officer/parolee relationship, the probation officer/probationer relationship, and the corrections officer/community custody offender relationship.

...[I]n all take charge relationships...the government assumed a duty of supervision over the third party to ensure compliance with certain conditions and was therefore required to exercise reasonable care in monitoring compliance and dangerousness.

Volk, 187 Wn.2d at 259-60.

Unlike parole officers, probation officers, and corrections officers, CDL examiners like Dr. Gilbert do not assume a duty of supervision over their examinees. In fact, the Washington Supreme Court has made clear that the facts of this case do not give rise to a “take charge” relationship. Specifically, the *Volk* court recognized that *Petersen*—which involved a psychiatrist’s treatment of an involuntarily committed patient in a psychiatric hospital for nearly three weeks—“was not a take charge case,” and expressly refused “to interpret the *Petersen* duty and the take charge duty as one in the same.” 187 Wn.2d at 259, 262. If a three-week ongoing relationship between a treating psychiatrist and a patient in an involuntarily

commitment setting at a psychiatric hospital does not give rise to a “take charge” duty, then a single regulatory exam for the purpose of renewing a CDL license certainly cannot do so. *See also Houston v. Bedgood*, 263 Ga.App. 139, 142, 588 S.E.2d 437, 440 (Ga. Ct. App. 2003) (recognizing that the performance of a CDL exam does not give rise to a duty to control a patient for the protection of third parties because a CDL examiner lacks the legal authority to place restraints on the liberty of his patient). Accordingly, Dr. Gilbert did not owe a § 319 duty to Mr. Sartin, and the trial court appropriately entered summary judgment in Dr. Gilbert’s favor.

d. Out-of-State Authority Does Not Support Mr. Sartin’s Position.

The out-of-state authority relied on by Mr. Sartin does not support the imposition of a duty on Dr. Gilbert. Indeed, the decision in *Hollywood Trucking, Inc. v. Watters*, demonstrates that no such duty exists. 385 Ill. App. 3d 237, 242, 895 N.E.2d 3, 8 (Ill. Ct. App. 2008). In *Hollywood Trucking*, the court expressly recognized that “the absence of a special relationship between [a CDL licensee] and [a CDL examiner] eliminates from consideration any of the recognized exceptions to the general rule that a person has no duty to control the conduct of a third party to prevent him from causing harm to another.” *Id.* (emphasis added). *Accord, Houston*, 263 Ga.App. at 142; 588 S.E.2d at 440 (holding that medical examiner

physician who certified commercial driver as fit to drive did not owe a duty to protect the decedent because the medical examiner and commercial driver did not have the requisite special relationship).

The other out-of-state decisions cited by Mr. Sartin are inapposite. In *Wharton Transport Corp. v. Bridges*, the court never reached the issue of a special relationship giving rise to a duty to protect third parties because the plaintiff/truck driver's employer was in privity with the CDL examiner. 606 S.W.2d 521, 523, 528 (Tenn. 1980). In *E.E.O.C. v. Texas Bus Lines*, the court did not address the liability of a CDL examiner at all. 923 F.Supp. 965 (S.D.Tex. 1996). Rather, the court addressed the liability of an employer for disability discrimination where a job applicant was not hired based on a physician's refusal to issue her a Medical Examiner's Certificate. *Id.* at 967-68.

In this case, there is no need to resort to out-of-state authority because the Washington Supreme Court has unequivocally held that there is no duty to third parties in the absence of a special relationship, and that a special relationship is one that is definite, established and continuing. *Petersen*, 100 Wn.2d at 426-28; *Honcoop*, 111 Wn.2d at 193; *Volk*, 187 Wn.2d at 256. Because no such relationship existed between Dr. Gilbert and Mr. McPike, Dr. Gilbert owed no duty to Mr. Sartin and the trial court appropriately entered summary judgment in Dr. Gilbert's favor.

2. The Trial Court Correctly Dismissed Mr. Sartin's Medical Negligence Claim because Mr. McPike's Loss of Consciousness Was Unforeseeable as a Matter of Law.

The existence of a duty depends on the foreseeability of the harm. *Mortensen v. Moravec*, 1 Wn. App. 2d 608, 615-616, 406 P.3d 1178 (2017). Thus, even if a single regulatory exam could give rise to a duty to third parties, which Dr. Gilbert denies, the scope of that duty is limited to foreseeable risks. Harm to a person is foreseeable if the risk from which it results was known or in the exercise of reasonable care should have been known. *Travis v. Bohannon*, 128 Wn. App. 231, 238, 115 P.3d 432 (2005). When the injury is so highly extraordinary or improbable as to be wholly beyond the range of expectability, it is not foreseeable. *Tortes v. King County*, 119 Wn. App. 1, 84 P.3d 252 (2003) (finding that County could not have foreseen injuries to a bus passenger when the bus driver was shot and killed). As to the scope of a duty, foreseeability may be decided by the Court as a matter of law where reasonable minds cannot differ. *Mortensen*, 1 Wn. App. 2d at 616.

In the proceedings below, the trial court correctly found Mr. McPike's loss of consciousness was unforeseeable as a matter of law. CP 1432-1433; RP 23-24. Dr. Gilbert was not Mr. McPike's treating physician, had no definite, established and continuing relationship with Mr. McPike,

and had no indication or knowledge that Mr. McPike might have a sudden loss of consciousness while driving the bus. Experts for both sides consistently testified that the first indication of any problem was Mr. McPike's cardiac arrest on the day of the accident.

Dr. Epstein testified that sudden death is the number one cause of death in the United States. CP 1509. In as many as 25% of the cases, the cause is unknown. CP 1509.

20. Sudden death is the largest killer of Americans. Sudden death can be the result of either cardiac or non-cardiac issues, and in as many as 25% of the cases, we simply do not know what caused the cardiac arrest. That is the case with Mr. McPike.

21. We know that Mr. McPike ultimately suffered a cardiac arrest- an abnormal rhythm of the heart. However, we do not know what led to his sudden loss of consciousness and the ultimate arrest. Many times, the first indication that anyone has of an underlying problem is the cardiac arrest.

* * *

23. While it may seem counter-intuitive, those who do not have known heart disease are the ones at greatest risk for sudden death. This makes sudden death particularly hard to identify, and in many cases, unpreventable. It is my opinion that Mr. McPike suffered sudden death which was unexpected and unpreventable. This is the tragedy of sudden death.

CP 1509-10.

Similarly, Dr. Kudenchuk explained as follows:

Mr. McPike likely suffered a hypoxic event leading

to loss of consciousness which culminated in asystolic cardiac arrest. Given that we cannot determine what caused the actual loss of consciousness, no one could have anticipated this event. Likewise, since we are unable to determine, even in hindsight, precisely what may have caused Mr. McPike's sudden loss of consciousness, his unfortunate arrest was not only unexpected, but also unpreventable.

CP 1539-40.

Even Mr. Sartin's own expert, Dr. Fletcher, conceded the issue of unforeseeability:

...20 percent of the time the first manifestation of coronary artery disease is sudden death due to cardiac arrhythmia. And that's what I believe happened here.

CP 1465. Because, as Mr. Sartin's own expert admits, the first manifestation of any problem was the cardiac arrhythmia that happened the day of the accident, Mr. McPike's loss of consciousness was unforeseeable as a matter of law. CP 1465. Mr. Sartin's injuries are therefore too remote to create a duty, and the trial court appropriately entered summary judgment in Dr. Gilbert's favor.

3. The Trial Court Correctly Dismissed Mr. Sartin's Medical Negligence Claim because He Failed to Meet His Burden on Proximate Cause.

In all personal injury actions, plaintiffs must prove the causal relationship between the acts of the defendant and the injuries for which they seek relief. *Moyer v. Clark*, 75 Wn.2d 800, 804, 454 P.2d 374 (1968).

Generally, expert medical testimony is necessary on the issue of proximate cause in any medical malpractice action. *Harris v. Groth*, 99 Wn.2d 438, 449, 663 P.2d 113 (1983). The only expert testimony submitted by Mr. Sartin in opposition to Dr. Gilbert's Motion for Summary Judgment was the testimony of Dr. Fletcher, a physician specializing in occupational medicine. CP 1617, 1738-84. Dr. Fletcher's testimony, however, was insufficient to create a genuine issue of material fact on the issue of causation. Firstly, Dr. Fletcher is not qualified to testify on issues relating to cardiology. Secondly, Dr. Fletcher's opinions are wholly unsupported by the facts. Thirdly, Dr. Fletcher's testimony is insufficient to remove the issue of proximate cause from the realm of speculation and conjecture. Consequently, the trial court appropriately struck Dr. Fletcher's testimony as to cardiac issues and causation. In the absence of admissible expert testimony on the issue of proximate cause, Mr. Martin cannot meet his burden, and summary judgment was appropriately entered in Dr. Gilbert's favor.

a. Dr. Fletcher Was Not Qualified on Issues Relating to Cardiology.

Dr. Fletcher based his entire opinion on the presence of cardiac problems. CP 1466. However, he admitted he was not a cardiac expert.

- Q: Are you an expert in cardiac disease?
A: I am not an expert in cardiac disease.

CP 1462. He also admitted that he would defer to a cardiologist on the interpretation and importance of EKGs and ECHOs, and that Mr. McPike did not have any signs or symptoms of CAD. CP 1463-65.

Despite his admitted lack of expertise in cardiac disease, his need to defer to cardiologists on the interpretations and importance of EKGs and ECHOs, and his concession that Mr. McPike had no signs or symptoms of CAD, Dr. Fletcher maintained that he was “100% convinced” that Mr. McPike had significant CAD which ultimately triggered an arrhythmia while he was driving the bus. CP 1466, 1771. Dr. Fletcher’s lack of qualification in cardiac disease precludes him from testifying as an expert with respect to the cause of Mr. McPike’s sudden loss of consciousness or his cardiac arrest. He failed to demonstrate the requisite knowledge of cardiac issues, and his opinions would not assist the trier of fact. ER 702.

Unable to avoid the issues concerning Dr. Fletcher’s qualifications, Mr. Sartin has attempted to change course and now contends that this case is not about cardiac issues. *See* Appellants’ Brief at p. 48. Any such contention is belied by the record. Dr. Fletcher based his entire opinion on his assumption that Mr. McPike had significant CAD which in turn triggered an arrhythmia while he was driving the bus. CP 1466. When asked if anything else could have triggered the arrhythmia, Dr. Fletcher’s answer

was a resounding “No.” CP 1466. He testified not only that he was “very comfortable with that opinion,” but also that he was 100% convinced that had Dr. Gilbert referred Mr. McPike for a cardiac workup, it would have revealed CAD. CP 1466, 1771. Because Mr. Sartin’s entire theory of causation was based on cardiac issues, and because Dr. Fletcher was not qualified to testify concerning the same, the trial court appropriately struck his testimony on cardiac issues and causation and entered summary judgment in Dr. Gilbert’s favor.

b. Dr. Fletcher’s Opinions Are Wholly Unsupported by the Facts.

Even if Dr. Fletcher was qualified to testify on cardiac issues, which Dr. Gilbert denies, his opinions concerning cardiac issues and causation are wholly supported by the facts in this case. ER 703 does not allow an expert to offer an opinion wholly unsupported by the facts. *See Riccobono v. Pierce County*, 92 Wn. App. 254, 268, 966 P.2d 327 (1998) (holding that expert may not base opinions on assumptions for which there is not factual basis). “An opinion of an expert which is simply a conclusion or is based on an assumption is not evidence which will take a case to the jury.” *Theonnes v. Hazen*, 37 Wn. App. 644, 648, 681 P.2d 1284, 1286-87 (1984); *see also Doe v. Puget Sound Blood Center*, 117 Wn.2d 772, 787, 819 P.2d 370, 378 (1991) (holding “[t]he opinion of an expert which is only a

conclusion or which is based on assumptions is not evidence which satisfies summary judgment standards”).

Here, the evidence demonstrates that Mr. McPike did not have CAD. Dr. Fletcher does not provide any evidence to the contrary, other than his own conclusory testimony. Indeed, Dr. Fletcher even concedes that Mr. McPike did not have any signs or symptoms of CAD either before or after the collision. CP 1463-65.

Dr. Fletcher’s lack of a factual basis to support his opinions was criticized by Dr. Epstein as follows.

18. I disagree strongly with Dr. Fletcher’s opinion that he is 100% certain that Mr. McPike had significant coronary artery disease, and that led to his cardiac arrest. I did not see any clinical evidence for Dr. Fletcher’s opinion, and it is contrary to the objective evidence with testing before and after the incident. Dr. Fletcher merely identifies risk factors that the patient had. Nor are Dr. Fletcher’s opinions consistent with the fact that multiple doctors who saw Mr. McPike over the years none of whom suspected that Mr. McPike had coronary artery disease or reported any signs or symptoms of such, including Dr. Larson, the cardiologist who did a cardiac workup.

19. Patients who have risk factors like Mr. McPike are not referred for cardiac workup or treatment. Instead, appropriate treatment is provided for the underlying risk factors. For example, providing hypertensive medication to control blood pressure and insulin for diabetic control. That is exactly what Mr. McPike needed and received.

CP 1509.

The objective and admissible facts in this case are as follows:

- No treating physician suspected CAD;
- No signs or symptoms of CAD;
- No testing revealed CAD before or after the accident;
- No evidence that CAD can cause asystole;
- No mention of CAD in the hospital following accident; and
- No reference of CAD on Mr. McPike's Discharge Summary or Death Certificate.

There are therefore no facts in this case that provide a basis for Dr. Fletcher's opinion that Mr. McPike had severe CAD. His conclusory testimony based on an unsupported assumption does not constitute evidence which will take a case to the jury. Because Dr. Fletcher's testimony failed to satisfy Mr. Sartin's burden, the trial court appropriately struck his testimony on cardiac issues and causation and entered summary judgment in Dr. Gilbert's favor.

c. Dr. Fletcher Could Not Establish that Further Cardiac Workup Would Have Made Any Difference.

Dr. Fletcher's testimony was also insufficient to remove the issue of proximate cause from the realm of speculation. Medical testimony that a defendant's acts "might have" or "possibly did" cause a condition is not sufficiently definite to create a genuine issue of material fact on summary judgment. *O'Donoghue v. Riggs*, 73 Wn.2d 814, 824, 440 P.2d 823, 830

(1968). In *O'Donoghue*, the Washington Supreme Court set forth the type of medical testimony which is required:

In a case such as this, medical testimony must be relied upon to establish the causal relationship between the liability-producing situation and the claimed physical disability resulting therefrom. The evidence will be deemed insufficient to support the jury's verdict, if it can be said that considering the whole of the medical testimony the jury must resort to speculation or conjecture in determining such causal relationship. In many recent decisions of this court we have held that such determination is deemed based on speculation and conjecture if the medical testimony does not go beyond the expression of an opinion that the physical disability 'might have' or 'possibly did' result from the hypothesized cause. To remove the issue from the realm of speculation, the medical testimony must at least be sufficiently definite to establish that the act complained of 'probably' or 'more likely than not' caused the subsequent disability.

73 Wn.2d at 824.

Once again, the only evidence Mr. Sartin offered on causation was the testimony of Dr. Fletcher. Dr. Fletcher opined that Mr. McPike should have had a cardiac workup which he believes, with 100% certainty, would have revealed severe CAD. CP 1771. However, Dr. Fletcher contradicted himself by testifying that "20 percent of the time the first manifestation of coronary artery disease is sudden death." CP 1465. He also testified that even if an EKG was done, it could come out clean because CAD can be sudden and without symptoms. CP 1465-66. Indeed, Dr. Fletcher admitted

that he did not know what further cardiac workup would have shown or that

it would have made any difference:

Q. When we broke we were talking a little bit about cardiac stuff. And you said he should have had a work-up, cardiac work-up at some point here. Let's assume he got a work-up. Either Gilbert ordered one or shortly afterwards Brooks orders one. What difference, what would it have shown and what difference would it have made?

A. Well, if he had had a cardiac evaluation that was thorough and included doing stress testing and nuclear imaging, it would be my belief that it would show that he had coronary artery disease, and that he next would have had a cardiac catheterization to determine the nature and extent of his coronary artery disease, did he need stenting? Did he need bypass surgery? What kind of medical management needed to be done to confirm a diagnosis that was obvious based on his risk factors? And how does that play in the realm of him and commercial driving? It would all depend on what was found and what treatment was recommended.

* * *

Q. Okay. And in this case you have no idea what the coronary artery disease -- what the extent or grade or anything else is of the coronary artery disease, is that right?

A. I don't.

Q. Except it's your belief it was significant?

A. My belief it was significant because that's what caused the sudden cardiac death.

CP 1050, 1211, 1402-03.

Dr. Fletcher's inability to establish a causal relationship without resorting to speculation and conjecture is underscored by the admitted absence of any signs or symptoms of CAD. As observed by Dr. Epstein:

16. Further review of the record indicates that there were no signs or symptoms of coronary heart disease following Dr. Larson's workup. This is a critical fact. Mr. McPike was asymptomatic from a cardiac perspective from 2012 up until the time of his accident. There simply is no additional indication for further cardiac workup.

17. Moreover, even if further workup had been performed, it is impossible to say what would have been found or that it would have changed his outcome. Not only was Mr. McPike asymptomatic, but following his accident, there was a subsequent cardiac workup performed at Tacoma General Hospital. Again, an ECHO was performed and Mr. McPike's LVEF was unchanged, 55-60%, which is entirely normal. The doctors found no evidence of myocardial infarction (or heart attack) or indication of significant coronary artery disease.

CP 1508-09.

At the end of the day, Dr. Fletcher did not and could not say on a more probable than not basis that additional testing would reveal a disqualifying condition, much less whether additional workup would have prevented the accident. A jury cannot be permitted to resort to speculation or conjecture in determining a causal relationship between Dr. Gilbert's CDL exam and Mr. Sartin's injuries. Dr. Fletcher's testimony was therefore insufficient to meet Mr. Sartin's burden on summary judgment.

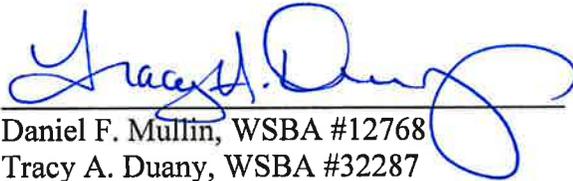
Accordingly, this Court should affirm the trial court's ruling striking Dr. Fletcher's testimony on cardiac issues and causation and entering summary judgment in Dr. Gilbert's favor.

V. CONCLUSION

For the foregoing reasons, the trial court's Order Granting Defendants MultiCare Health System and Richard Gilbert, M.D.'s Motion for Summary Judgment should be affirmed.

RESPECTFULLY SUBMITTED this 30th day of August, 2019.

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CERTIFICATE OF SERVICE

I hereby certify that I electronically served a true and correct copy of the foregoing in Court of Appeals Cause No. 53248-4-II upon the following parties:

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

DATED this 30th day of August, 2019.

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