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COURT OF APPEALS
DIVISION III
STATE OF WASHINGTON
By _____

No. 280471

THE COURT OF APPEALS
STATE OF WASHINGTON
DIVISION III

LINDA MOHR and CHARLES L. MOHR, her husband,

Appellants,

v.

DALE C. GRANTHAM, M.D. and JANE DOE GRANTHAM,
and their marital community; BRIAN J. DAWSON, M.D., and
JANE DOE DAWSON, M.D., and their marital community,
BROOKS WATSON II, M.D. and JANE DOE WATSON, and
their marital community; KADLEC MEDICAL CENTER, a
Washington corporation; and NORTHWEST EMERGENCY
PHYSICIANS, INC., a Washington corporation,

Respondents.

APPELLANTS LINDA MOHR and CHARLES L. MOHR'S
REPLY BRIEF TO RESPONDENTS GRANTHAM,
DAWSON, WATSON AND NORTHWEST EMERGENCY
PHYSICIANS

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I. INTRODUCTION

Defendant physicians¹ misunderstand the elements of a “lost chance” cause of action, and mischaracterize the Mohrs’ expert medical testimony. Here, plaintiffs’ medical experts testified that, on a more probable than not basis, defendant physicians violated the duty of care², and that on a more probable than not basis, said violations caused Mrs. Mohr to lose the opportunity to have a better outcome from her stroke. The “lost opportunity” is the injury, which was proximately caused by the defendants’ conduct. This showing is sufficient to survive a motion for summary judgment.

Furthermore, defendant physicians misstate the trial court’s holding. The trial court simply held that it was for the court of appeals to decide whether or not to adopt a cause of action for lost chance of a better outcome. (RP 44-45). Plaintiffs request this Court take up the trial court’s invitation by following the vast majority of “lost chance” jurisdictions that recognize “lost chance of a better outcome” in

¹ The term “defendant physicians” as used throughout this brief includes Drs. Grantham, Dawson, Watson and Northwest Emergency Physicians.

² See section II.A. *infra*.

addition to “lost chance of survival.”

II. ARGUMENT

A. **In the Medical Malpractice Context, There Is No Logical Reason to Distinguish Between “Lost Chance of Survival” Cases and “Lost Chance of Avoiding Serious Injury” Cases**

Defendant physicians make much of the fact that *Herskovits v. Group Health Cooperative of Puget Sound*, 99 Wn.2d 609, 664 P.2d 474 (1983), was a plurality opinion. By using the term “majority opinion” in the *Brief of Appellants*, plaintiffs merely adopted the terminology used by the *Herskovits* court itself.³ The *Brief of Appellants* makes clear that *Herskovits* was a plurality.⁴ The fact *Herskovits* was a plurality opinion, however, does not mean the opinion lacks precedential value.

“Where there is no majority agreement as to the rational for a decision, the holding of the court is the position taken by those concurring on the narrowest grounds.” *W.R. Grace & Co. - CONN v.*

³ The concurrence in *Herskovits* refers to the lead opinion as the “majority.” *Id.* at 619, *see infra*.

⁴ *Brief of Appellants*, at 27.

Department of Revenue, 137 Wn.2d 580, 593, 973 P.2d 1011 (1999).

In *W.R. Grace*, the Washington State Supreme Court determined the precedential value of *Digital Equip. Co. v. Department of Revenue*, 129 Wn.2d 177, 916 P.2d 933 (1996), a plurality decision. In *Digital*, the lead and concurring opinions were comprised of five justices, and while the two opinions disagreed on the reasoning, they agreed that a prior decision should be retroactively applied. *W.R. Grace*, 137 Wn.2d at 593-94. Given that five justices concurred on the issue of retroactivity, the *W.R. Grace* court held *Digital* was controlling precedent on the issue. *Id.* at 594.

In *Herskovits*, the lead and concurring opinions formed a block of six justices in favor of recognizing a lost chance cause of action. Both opinions cited the same policy rationale in support: *i.e.* negligent physicians should not escape liability simply because their negligence has made it impossible to determine, on a more likely than not basis, whether plaintiff could have escaped injury. *Herskovits*, 99 Wn.2d at 616 (Dore, J., majority op., quoting *Hicks v. United States*, 368 F.2d 626 (4th Cir. 1996); “[r]arely is it possible to demonstrate with absolute

certainty what would have happened in circumstances that the wrongdoer did not allow to come to pass.”); *Id.* at 634 (Pearson, J., concurring op., citing five policy rationales in favor of recognizing a lost chance cause of action, including justice and deterrence: “[T]he all or nothing approach gives certain defendants the benefit of an uncertainty which, were it not for their tortious conduct, would not exist.”).

The *Herskovits* lead opinion held that a reduction in chance of survival was “sufficient evidence to allow the proximate cause issue to go to the jury.” *Id.* at 619. The *Herskovits* concurrence concluded: “[t]herefore, I would hold that plaintiff has established a prima facie issue of proximate cause by producing testimony that defendant probably caused a substantial reduction in Mr. Herskovits’ chance of survival.” *Id.* at 634. Both opinions are in agreement as to the following: (1) a cause of action for lost chance exists, (2) it is supported by the policy rationales of justice, deterrence, and not allowing negligent defendants to benefit from their negligent conduct, and (3) once medical testimony establishes a substantial reduction in chance of

avoiding death (i.e. injury), the issue of proximate cause is for the jury.

“Lost chance of a better outcome” was not before the court in *Herskovits*, and thus, nothing in the opinion bars this Court from adopting such a cause. Likewise, no Washington State case cited by defendant physicians holds “lost chance” is restricted to survival cases. The cases cited by defendants are simply “lost chance of survival” cases themselves, and thus, describe *Herskovits* in that context, or are considering whether to expand “lost chance” outside the medical malpractice context altogether.⁵

A similar issue was faced by the Supreme Court of Kansas in *Delaney v. Cade*, 255 Kan. 199, 873 P.2d 175 (Kan. 1994). In *Delaney*, plaintiff was transported by ambulance to a hospital emergency room after a car accident. 873 P.2d at 177. She was treated by Dr. Cade, the on call physician, who did not perform certain diagnostic tests. *Id.* Plaintiff was then transferred to another hospital, and after testing, was diagnosed with a thrombosed aorta. *Id.* Plaintiff asserted that had Dr.

⁵ See parenthetical list of cases cited in *Brief of Respondents Grantham, et al.*, at pp 32-33.

Cade timely diagnosed and treated her thrombosed aorta, she would not have suffered paralysis. *Id.* Plaintiff filed her claims in federal court, and the 10th Circuit certified questions to the Kansas Supreme Court regarding the lost chance doctrine. *Id.*

Ten years prior to *Delaney*, the Kansas Supreme Court had adopted the “lost chance” doctrine in *Robertson v. Counselman*, 235 Kan. 1006, 686 P.2d 149 (1984), a survival case. In *Delaney*, “the United States District Court found *Robertson* was limited to death cases and, primarily on public policy grounds, declined to extend or recognize the loss of chance doctrine to cases not involving death.” *Id.* 873 P.2d at 178. In finding the district court erred, the Kansas Supreme Court held, “[b]ecause the facts in *Robertson* involved a loss of survival case in no way detracts from the public policy expressed in the opinion.” 873 P.2d at 182. “We have found no authority or rational argument which would apply the loss of chance theory solely to survival actions or solely to loss of a better recovery actions and not to both.” 873 P.2d at 183.

The same is true here. Just because *Herskovits* was a medical

malpractice case that resulted in death, it does not follow that its reasoning cannot be applied to medical malpractice cases involving injuries other than death.

B. Medical Expert Testimony Established That Defendant Physicians Violated Their Individual Duties of Care, and That Those Violations Caused Damage to Plaintiffs

Defendant physicians assert there is insufficient medical expert testimony to establish that their negligence was the proximate cause of Mrs. Mohr's injuries. This assertion is demonstrably false.

Plaintiffs' medical expert, A. Basil Harris, M.D., is Professor Emeritus of Neurological Surgery at the University of Washington School of Medicine. (CP 413, 417). From 1967 to 2001, Dr. Harris was an attending physician at Harborview Medical Center, the very hospital Mrs. Mohr was taken the night of November 1, 2004. (CP 417). He is certainly qualified to testify to the standard of care, as well as to the issues of breach, causation and damages relating to medical malpractice.

The Declaration of Dr. A. Basil Harris states, in relevant part:

“Based on my review of the forgoing medical records

and imaging of Linda Mohr, it is my opinion that because Linda Mohr did not receive anti-platelet agents, anti-coagulants or general brain protective care, on either the evening of August 31, 2004 or the morning or afternoon of September 1, 2004, she was denied the opportunity or chance of receiving significant or meaningful benefit in lessening the damage to her brain that has left her with her current disabilities and impairment.” (CP 415).⁶

At his deposition, Dr. Harris testified that the above statement was still his expert medical opinion. (CP 241-43).

As to the individual physicians, Dr. Harris testified at his deposition that Dr. Watson violated the standard of care by failing to timely order and review a CT angiogram, and by failing to timely administer Aspirin. (CP 230-31). When asked whether the delay in getting a CT angiogram put Mrs. Mohr at risk for additional stroke, Dr. Harris testified, “[i]t’s probable that it did, not just possible.” (CP 232).

As to Dr. Grantham, Dr. Harris testified that he violated the standard of care by: (1) failing to recognize obvious signs of a head injury, (2) failing to admit Mrs. Mohr to the hospital for 24 hour observation, (3) failing to do a follow up neurological evaluation and

⁶ The Mohrs’ expert medical testimony is set forth at length in the *Brief of Appellants*.

imaging, (4) failing to give head injury discharge instructions, and (5) prescribing Mrs. Mohr a narcotic drug while sending her home with her medically naive husband. But for those violations, Dr. Harris testified that Mrs. Mohr would have had a 50-60% chance at “a lot better outcome” from her stroke. (CP 236-38, 246-247). Dr. Harris defined “a lot better” as having “zero” left-side problems. (CP 246-47).

In testimony applicable to all three defendant physicians, Dr. Harris testified that time is of the essence and any delay leads to “more embolization and brain damage every hour, every minute that goes by...” (230). Furthermore, “[c]ertainly the two delays diagnosis on 8/31 and 9/1 were probably the deviations which prevented her from a better outcome.” (CP 235) [sic].

Drs. Dawson and Watson failed to timely order a CT scan and administer Aspirin on September 1, 2004. (CP 192-99) (143-44). While Dr. Harris stated at his deposition that he was not at that time prepared to testify to violations of the standard of care by Dr. Dawson (CP 236), he did testify that Dr. Watson violated the standard of care by failing to timely order a CT scan and administer Aspirin. (CP 232).

Since Dr. Dawson also failed to order a CT scan and administer Aspirin, Dr. Harris's statements regarding Dr. Watson should be likewise applicable to Dr. Dawson.⁷

As to causation, Dr. Harris testified that any failure to timely diagnose and treat Mrs. Mohr's stroke, on either October 31, 2004 or September 1, 2004, resulted in a decreased chance of a better outcome. (CP 230, 71-72, 415). Dr. Harris testified, on a more likely than not basis, that had Mrs. Mohr not received any treatment she would have died. (CP 229).⁸ Dr. Harris testified "[e]very delay is just a delay, delay, worsening condition resulting." (231). Dr. Harris further testified that it was "probable" (i.e. more likely than not), that failures to timely diagnose Mrs. Mohr's stroke and administer treatment on September 1, 2004 "permitted additional brain infarction." (CP 233).

Additionally, Dr. Harris testified that data on strokes showed a

⁷ Dr. Dawson treated Mrs. Mohr for two hours prior to her transfer to Dr. Watson. (CP 118, 123). Therefore, if Dr. Watson violated the standard of care by failing to timely order a CT angiogram and administer Aspirin, so did Dr. Dawson. *See also* CP 235, describing issues on September 1, 2004 causing a reduced chance of a better outcome.

⁸ Aspirin was administered on the orders of Linda Mohr's son, Dr. Brandt Mohr, after Dr. Watson failed to have it administered. (CP 129, 145-48, 201-03).

50-60% chance of a better outcome if treatment is administered within six hours of onset. (CP 241, 243). Dr. Harris testified that Dr. Grantham violated the standard of care on October 31, 2004, by failing to admit Mrs. Mohr to the hospital for 24 hour observation. (CP 236-38). Dr. Harris likewise testified that had Mrs. Mohr been admitted on October 31, 2004, proper medical care “would have” (i.e. more likely than not) resulted in diagnosis and treatment during the six hour window. (CP 237).

Defendant Physicians claim Dr. Harris’s testimony on causation is based solely on the testimony of Dr. Becker, which is not true. Dr. Harris testified to this issue at his deposition:

Q. Yes. Would you defer to Dr. Becker regarding the causal relationship between the care of any of the defendants in this case and Mrs. Mohr’s ultimate outcome?

Mr. RETTIG: Objection.

A. No.
(CP 249).

In short, Dr. Harris testified that defendant Grantham, more likely than not, violated the standard of care, and that his violation,

more likely than not, deprived Mrs. Mohr of a 50-60% chance at a substantially better outcome. (CP 237). Dr. Harris further testified that Dr. Watson, more likely than not, violated the standard of care, and that his violation, more likely than not, deprived Mrs. Mohr of chance at a better recovery (CP 233). Dr. Watson's violations were likewise committed by Dr. Dawson, and should be attributed to him as well.⁹

C. As the Defendant Physicians' Negligence Has Deprived Mrs. Mohr of the Chance to Prevent Serious Injury, the Extent of What Her Injuries Would Have Been, but for Their Negligence, Is an Issue of Fact for the Jury

Defendants allege that, even if their negligence damaged Mrs. Mohr by reducing her ability to recover from her stroke, plaintiffs' medical experts must still establish, on a more probable than not basis, what Mrs. Mohr's post-stroke condition would have been "but for" their negligence. Defendants further allege that plaintiffs' medical experts must establish, on a more probable than not basis, the exact percentage chance of recovery Mrs. Mohr lost as a result of defendants'

⁹ See (CP 71-72), referencing failures on September 1, 2004 to give antiplatelet agents or general brain protective care, and how those failures deprived Mrs. Mohr of an opportunity to prevent brain damage.

negligence. By forcing plaintiffs to prove the impossible, defendants' attempt to avoid liability even if the fact of harm is undisputed.

Here, multiple actors committed numerous violations of the duty of care over a period of two days. The cumulative effect of the defendants' negligence was Mrs. Mohr losing a significant chance to prevent injury from another source, i.e. her stroke. In these types of cases, "the fact finder is put in the position of having to consider not only what *did* occur, but what *might have* occurred." *Herskovits*, 99 Wn.2d at 616 (Dore, J. lead op.). The *Herskovits* lead opinion quoted the following from the Supreme Court of Pennsylvania, *Id.* at 614:

"Such cases by their very nature elude the degree of certainty one would prefer and upon which the law normally insists before a person may be held liable. Nevertheless, in order that an actor is not completely insulated because of uncertainties as to the consequences of his negligent conduct, Section 323(a) tacitly acknowledges this difficulty and permits the issue to go to the jury upon a less than normal threshold of proof." *Hamil v. Bashline*, 481 Pa. 256, 392 A.2d 1280 (Pa. 1978).

In adopting lost chance of a better outcome, the Supreme Court of Kansas held, *Delaney*, 873 P.2d at 183:

We acknowledge that the vast majority of cases we have

reviewed involved death of the patient and a loss of chance of survival. We also recognize that the apportionment of damages may be more difficult in a loss of a better recovery case than in the cases resulting in death. However, the fact that most cases have involved death of the patient and that damages may be difficult to resolve in a loss of a better recovery case should not be grounds to refuse to recognize the doctrine when medical malpractice has substantially reduced a person's chance of a better recovery.

Likewise, the Supreme Court of Arizona held the following in a medical malpractice "lost chance of a better outcome" case, *Thompson v. Sun City Comm. Hosp., Inc.* 141 Ariz. 597, 608, 688 P.2d 605, 616 (Ariz. 1984):

Defendant's negligent act or omission made it impossible to find with certainty what would have happened and thus forced the court to look at the proverbial crystal ball in order to decide what might have been. Such determinations, of course, have traditionally been the province of the jury.

In *Thompson*, plaintiff's medical experts could not quantify the chance of recovery. 688 P.2d at 615. Instead, they testified "there would have been a substantially better chance of a full recovery had surgery been performed at once." *Id.* Moreover, they testified "that the longer the delay, the greater the risk of residual injury." *Id.* Citing

Herskovits, the *Thompson* court found there was sufficient evidence to create a jury question on the issue of proximate cause. *Id.* at 606-08, 688 P.2d at 614-616.

Likewise, the Supreme Court of New Jersey held the following, *Reynolds v. Gonzalez*, 172 N.J. 266, 281, 798 A.2d 67, 75 (N.J. 2002):

[T]he difficulties of identifying, defining, and proving injury in certain types of medical malpractice cases justifies the application of a standard of causation that is more flexible than that used in conventional tort claims.

In *Reynolds*, the Supreme Court of New Jersey reaffirmed its substantial factor test for all “lost chance” cases. Under the New Jersey test, a plaintiff must present evidence “demonstrating within a reasonable degree of medical probability that negligent treatment increased the risk of harm posed by a preexisting condition.” 798 A.2d at 76. Once an increased risk is established, the issue of proximate cause goes to the jury. 798 A.2d at 76. If the jury finds proximate cause, then the burden to prove that damages can be apportioned between the preexisting medical condition and the defendants’ negligence falls on the defendants. *Scafidi v. Seiler*, 119 N.J. 93, 113-14, 574 A.2d 398, 408 (N.J. 1990). The role of the jury is to

“determine the likelihood, on a percentage basis, that the [resulting damage] would have occurred even if defendant’s treatment was faultless.” *Id.*

In *Scafidi*, the Supreme Court of New Jersey held that asking the jury to find whether a “lost chance” resulted in proximate cause, “imposes no novel burden on jurors, who are routinely instructed in tort cases to apportion fault in order to permit the trial court to mold the verdict.” *Id.*

A burden shifting principle similar to *Scafidi* has been adopted by Washington State in tort cases. See *Phennah v. Whalen*, 28 Wn.App. 19, 621 P.2d 1304 (1980); *Cox v. Spangler*, 141 Wn.2d 431, 5 P.3d 1265 (2000).¹⁰ Once a plaintiff has established more than one at fault party caused his injury, the burden to apportion damages between those at fault parties falls on the defendants. *Id.*

Defendants’ reliance on *Zueger v. Public Hospital District No. 2 of Snohomish County*, 57 Wn.App. 584, 789 P.2d 326 (1990), is

¹⁰ *Wagner v. Monteilh*, 43 Wn.App. 908, 720 P.2d 908 (1986). In a non-“lost chance” case, plaintiff made proper showing, “in so far as reasonably possible,” what condition his hand would have been in, but for the physician’s negligence.

misplaced. In that case, four physicians testified at trial that a 3 day delay in performing a D & C was not a contributing factor to decedent's death. *Id.* at 592-93, 789 P.2d at 330-31. One physician briefly testified that decedent's sickness increased the risk from delaying surgery. 594, 789 P.2d at 331. However, the physician did not make the connection between the later surgery and plaintiff's death. *Id.* There was simply no testimony saying there was an increased risk of death. *Id.*

Here, defendants have not put forward any expert medical testimony. Plaintiff's expert, Dr. Harris, testified that defendant physicians' negligence increased the risk of more stroke. (CP 71-72, 231, 233). Therefore, there is a direct connection here between the increased risk, and the result (i.e. more stroke).

The "lost chance" cause of action exists because it is virtually impossible to establish, on a more probable than not basis, exactly what would have happened in the absence of medical negligence of the kind that occurred here. Mrs. Mohr suffered a stroke, and Dr. Harris testified as to the standard of care for diagnosis and treating a stroke. Dr. Harris

further testified to numerous violations of the standard of care by defendant physicians, and that those violations substantially increased the risk of harm to plaintiff. (CP 415). The very nature of a stroke, however, prevents the medical community from stating, on a more likely than not basis, what precise damage the stroke would have caused if timely diagnosed and treated, and what percentage of chance was lost on September 1, 2004. (CP 246-248).

What Dr. Harris did testify to, was that had Dr. Grantham followed the appropriate standard of care, he would have caught the stroke within six hours of onset. (CP 236-238). If properly treated within those first six hours, Mrs. Mohr would have a “50-60% chance of being a lot better.” (CP 246). Dr. Harris defined “a lot better” as having “zero” left-side problems. (CP 246-47). He could not state with certainty what exactly her cognitive problems would be, but for Dr. Grantham’s negligence, because of the nature of a stroke. *Id.* As to the care on September 1, 2004, Dr. Harris testified that had the proper standard of care been followed there would have been less stroke, and thus, deviations from the standard of care on that day prevented Mrs.

Mohr from having a better outcome. (CP 71-72, 231, 233, 235). Less stroke means greater opportunity to recover. (CP 71-72). Had the stroke been allowed to follow its natural course, Mrs. Mohr would have died. (CP 229).

The above cited testimony presents an issue of fact for the jury on the question of proximate cause for all defendants. We ask juries to apportion fault, award damages for pain and suffering, divide “indivisible” damages¹¹, and decide whether a “lost chance” is sufficient to establish proximate cause¹². When damage (i.e. a decreased chance at recovery) is caused by medical malpractice, the jury is competent to hear the testimony and render a verdict.

As the lead opinion in *Herskovits* quoted from *James v. United States*, 483 F.Supp. 581 (N.D.Cal. 1980):

“As a proximate result of the defendant’s negligence, James was deprived of the opportunity to receive early treatment and the chance of realizing any resulting gain in his life expectancy and physical and mental comfort.

¹¹ see *Tagman v. Accident Medical Investigations, Inc.*, 150 Wn.2d 102, 75 P.3d 497 (2003) (jury required to apportion damages between intentional and unintentional torts, even if damages appeared “indivisible”).

¹² *Herskovits*, 99 Wn.2d at 619 (Dore, J. lead op), *Id.* at 634 (Person, J. Concurrence).

No matter how small that chance may have been-and its magnitude cannot be ascertained-no one can say that the chance of prolonging one's life or decreasing suffering is valueless. “ *Herskovits*, 99 Wn.2d at 619 (emphasis in original).

D. A “Lost Chance” Cause of Action Is Not a Substantial Deviation from the Standard Medical Malpractice Cause of Action.

Defendants are wrong to assert that recognizing a cause of action for lost chance of a better outcome would “swallow the traditional proximate cause rule.” *Brief of Respondents Grantham, et al*, at 34. Of the 22 states that *currently* recognize the lost chance doctrine, 17 have applied it to outcome cases. The remaining five have not taken up the issue. *Brief of Appellants*, at 23-25. These states certainly did not find that adopting lost chance of a better outcome would result in a windfall to plaintiffs.

Furthermore, under RCW 7.70.040, a plaintiff asserting a lost chance cause of action must still establish with medical expert testimony (1) the duty of care, (2) at least one violation of the duty of care, (3) a lost chance to avoid injury, and (4) that the lost chance was the proximate cause of plaintiff's injury. Once the first three elements

are established, the lost chance cause of action simply lets the jury decide the fourth element, proximate cause. The jury then determines what damages are attributable to each defendant.

III. CONCLUSION

Appellants respectfully request the trial court's Order Granting Defendants' Motion for Summary Judgment and dismissing plaintiff's claims be reversed.

RESPECTFULLY SUBMITTED this 3rd day of December, 2009.

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NO. 28047-1-III

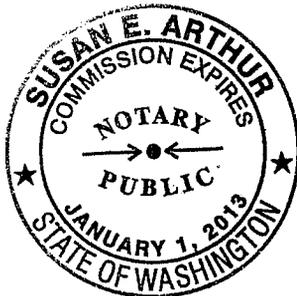
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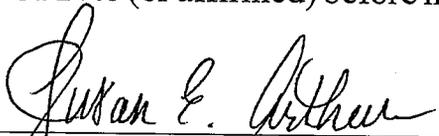
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CAROLINE G.D. FERGEN

SIGNED AND SWORN to (or affirmed) before me this 3rd
day of December, 2009.




NOTARY PUBLIC, State of Washington
Residing at Richland
My Commission Expires 01/01/2013