FILED
SUPREME COURT
STATE OF WASHINGTON
8/15/2022 9:05 AM
BY ERIN L. LENNON
CLERK

NO. 101083-4

SUPREME COURT OF THE STATE OF WASHINGTON

ROBERT WILLIAMS,

Petitioner,

v.

FRANCISCAN HEALTH SYSTEM d/b/a ST. JOSEPH MEDICAL CENTER,

Respondent,

MULTICARE HEALTH SYSTEM d/b/a GOOD SAMARITAN HOSPITAL; and JOHN DOES 1-10,

Defendants.

RESPONDENT FRANCISCAN HEALTH SYSTEM d/b/a ST. JOSEPH MEDICAL CENTER'S ANSWER TO PETITION FOR REVIEW

Amanda K. Thorsvig, WSBA #45354
Michelle M. Garzon, WSBA #31558
FAIN ANDERSON VANDERHOEF ROSENDAHL O'HALLORAN SPILLANE, PLLC
Attorneys for Respondent Franciscan Health System, d/b/a St. Joseph Medical Center
1301 A Street, Suite 900
Tacoma, WA 98402
Ph: 253.328.7800
Email: amanda@favros.com
shelly@favros.com

TABLE OF CONTENTS

I. IDENTITY OF RESPONDING PARTIES 1

II. COURT OF APPEALS DECISION 1

III. COUNTERSTATEMENT OF ISSUE FOR REVIEW........................ 2

IV. COUNTERSTATEMENT OF THE CASE 2

A. Factual Background. 2

B. Litigation Background 5

C. Appeal. 10

V. ARGUMENT WHY REVIEW SHOULD BE DENIED 11

A. Division I's Decision is Not in Conflict with Any Decision of This Court. 13

B. Division I's Decision is Not in Conflict with Any Decision of the Court of Appeals. 17

C. Division I's Decision Does Not Involve a Significant Question of Law under the State or Federal Constitution. 19

D. Division I's Decision Does Not Involve an Issue of Substantial Public Interest. 26

VI. CONCLUSION.. 29

TABLE OF AUTHORITIES

STATE CASES **PAGE(S)**

Christian v. Tohmeh,
191 Wn. App. 709, 366 P.3d 16 (2015), *rev. denied*,
185 Wn.2d 1035 (2016) 12, 17, 18

Dunnington v. Virginia Mason Med. Ctr.,
187 Wn.2d 629, 389 P.3d 498 (2017) 12, 16

Enebrad v. MultiCare Health Sys.,
2018 Wash. App. LEXIS 385 (2018), *rev. denied*,
190 Wn.2d 1027 (2018).. 18, 27

Estate of Dormaier v. Columbia Basin Anesthesia, PLLC,
177 Wn. App. 828, 313 P.3d 431 (2013) 12

Guardado v. Valley Med. Ctr.,
2012 Wash. App. LEXIS 1004 (2012) 12

Guile v. Ballard Cmty. Hosp.,
70 Wn. App. 18, 851 P.2d 689 (1993) 29

Herskovits v. Group Health Cooperative of Puget Sound,
99 Wn.2d 609, 664 P.2d 474 (1983) ... 11-12, 13, 14, 16, 18,
.... 19, 21, 22

Mohr v. Grantham,
172 Wn.2d 844, 262 P.3d 490 (2011) 12, 14, 15, 16, 18,
.... 19-20, 20, 22, 27

Pitts v. Inland Imaging, LLC,
2017 Wash. App. LEXIS 1045 (2017), *rev. denied*,
189 Wn.2d 1014 (2017) 12-13

Rash v. Providence Health & Servs.,
183 Wn. App. 612, 334 P.3d 1154 (2014) 17-18, 19,
.... 21, 27

Reyes v. Yakima Health Dist.,
191 Wn.2d 79, 419 P.3d 819 (2018) 28

Seybold v. Neu,
105 Wn. App. 666, 19 P.3d 1068 (2001) 23

Shellenbarger v. Brigman,
101 Wn. App. 339, 3 P.3d 211 (2000) 12, 23

Sofie v. Fibreboard,
112 Wn.2d 636, 771 P.2d 711 (1989) 24

Volk v. DeMeerleer,
187 Wn.2d 241, 386 P.3d 254 (2016) 16, 23

STATUTES AND RULES

RCW 7.70.040 20

RAP 13.4(b)..11, 29

RAP 13.4(b)(1) 11

RAP 13.4(b)(2) 11

RAP 13.4(b)(3) 11, 26

RAP 13.4(b)(4) 11

OTHER AUTHORITIES

WPI 105.20 ....24, 25

I. IDENTITY OF RESPONDING PARTIES

Respondent Franciscan Health System, d/b/a St. Joseph Medical Center (St. Joseph) submits this Answer to Robert Williams' Petition for Review.

II. COURT OF APPEALS DECISION

In a unanimous unpublished opinion, Division I affirmed the trial court's summary judgment order dismissing Williams' loss of chance lawsuit against St. Joseph, holding, consistent with opinions of this Court and the Court of Appeals, that "a plaintiff in a loss of chance case bears the burden of establishing by expert testimony that the percentage or range of percentage of the lost chance of a better outcome amounted to either 50 percent or less," which Williams did not do. *Slip Op. at 14.* Division I concluded that Williams' expert made "speculative and conclusory statements" "insufficient to survive summary judgment," *id.* at 11, and rejected Williams' argument that requiring an expert to provide an opinion as to the percentage lost chance unconstitutionally invades the jury's province, because it

"in no way improperly limits the amount of the damages that the jury may award," *id. at 15*.

III. COUNTERSTATEMENT OF ISSUE FOR REVIEW

Did the trial court properly dismiss Williams' loss of chance lawsuit on summary judgment because his expert failed to identify a percentage or range of percentage of the reduced chance?

IV. COUNTERSTATEMENT OF THE CASE

A. Factual Background.

On September 15, 2015, seven hours before arriving at St. Joseph, Williams went to prompt care complaining of ear and head numbness with dizziness that began two hours earlier. CP 32-34. The doctor referred Williams to an emergency room (ER) for further evaluation. CP 34.

Williams' wife drove him to MultiCare Good Samaritan Hospital's ER, where a nurse evaluated him at 6:20 p.m. CP 34, 38. Williams told the nurse that he had 9/10 pain, could barely hear out of his ear, and felt like he was going to pass out. CP 38.

Williams reiterated his complaints to the doctor. CP 36. He underwent laboratory tests, a head CT, which was normal, and a head and neck CT angiogram, which showed no significant stenosis in the vessels. CP 37. The doctor diagnosed intractable vertigo and concluded that Williams needed to be admitted because, although his imaging was negative, he could not get up without symptom exacerbation. CP 37. Because Williams was a Group Health patient, however, he required transfer to St. Joseph. CP 37. Although the doctor documented that he spoke to an on-call St. Joseph physician before transfer, his note does not state what information he relayed. CP 37.

Williams did not arrive at St. Joseph until 12:46 a.m. on September 16, 2015—over six hours after he had presented to the Good Samaritan ER. CP 40. The medical records contained in the clerk's papers are silent as to when a nurse or doctor first examined him at St. Joseph, and instead reflect only that one particular doctor, Dr. John Stam, authored the History and Physical note at 3:21 a.m., and spent an hour with Williams

performing an examination, reviewing his symptoms and prior test results, and developing a plan. CP 41-45. Dr. Stam noted that the Good Samaritan provider had diagnosed vertigo, and that the CT scans were normal. CP 41, 43-44. Williams denied focal neurologic deficits, and had no headache, weakness, numbness, or lost sensation when Dr. Stam examined him. CP 41-45. Dr. Stam's impression was that Williams had acute onset vertigo with persistent symptoms, and he ordered an MRI for further evaluation. CP 45.

Williams does not remember his time at St. Joseph before or during the MRI. CP 83. Although Williams' expert, Dr. Aaron Heide, averred in his declaration that Williams developed numbness and right-sided facial droop at 7:00 a.m., that the MRI, which revealed a stroke, did not occur until 8:35 a.m., and that Williams did not receive Plavix until 10:03 a.m., CP 102-04, he attached no medical records to support these assertions. *See* CP 101-05.

B. Litigation Background

Williams sued Good Samaritan and St. Joseph, alleging negligent medical care, but not identifying any specific doctors, nurses, or other health care providers who allegedly breached their standards of care. CP 1-3. St. Joseph denied the allegations. CP 9-12.

William's only expert, Dr. Heide, testified at deposition as to the standard of care concerning St. Joseph:

> Q. … [D]o you have any opinions in this case about St. Joseph Medical Center and its care of Mr. Williams?
>
> A. I think the initial assessment of this case is mainly the initial workup for standard of care. By the time they arrived, I believe, at St. Joseph he was outside the window for intravenous tPA. …
>
> So in terms of the initial assessment in the acute phase of intervention at St. Joseph's, I don't see any intervention that they could have done at that time based on the criterial for intervention.
>
> With regards to the workup and assessment, they may have been delayed in terms of getting the assessment based on the transfer and receipt of the patient. But in terms of the

standard of care for acute treatment for the patient, I didn't see any abnormalities.

Q. …. And outside the initial assessment in that acute phase, do you have any other criticisms or opinions about the care provided at St. Joseph Medical Center?

A. Not at this time. …

CP 50-51.

Dr. Heide never testified in deposition that he believed anyone at St. Joseph caused Williams to lose the chance for a better outcome. *See* CP 48-53, 134, 137-38, 140, 142-43. Rather, he testified that, because Williams' symptoms started around 3:00 p.m. at the earliest, and the timeframe for the only acute therapy available to Williams, tPA, must be administered within four and a half hours of symptom onset (here, not later than 7:30 p.m.), Williams was outside the window for acute therapy because he did not arrive at St. Joseph until after midnight. CP 48-50, 52-53. Regarding other medical interventions, Dr. Heide testified:

A. … The question is would the treatment have been given earlier, would there be a better outcome? And we can't revise history. All I

can say is that quicker and more information is better. Determining the mechanism of the injury allows you to treat quicker and better. And so eventually getting the treatment based on assessment and mechanistic injury determination at a later date, I don't think we can go back in history and say if he had received aspirin or statin or IV fluid earlier, would he had a better outcome, because we don't have that luxury.…

All we know is from the standard of care is quicker, earlier, the better.

Q. So are you able to say more likely than not, if he had received, for example, aspirin earlier, his outcome would be different?

A. I'm not that powerful of a being to know that. But we do know in acute stroke, quicker and sooner is better. …

He may have gotten this in – the treatment within the standard guidelines. …

[D]id he receive the care within the window of his stroke, I think the answer is yes. …

CP 142-43.

St. Joseph moved for summary judgment, asserting Williams could not prove standard of care or causation. CP 14-22.

In response, Williams for the first time raised a loss of chance theory, CP 74-91, and produced a declaration from Dr. Heide, averring:

> 7. Mr. Williams was not seen by a doctor at St. Joseph until 3:14 a.m. The doctor at that time ordered an MRI to rule out stroke. The MRI did not take place until 8:35 a.m. Unfortunately a little after 7:00 a.m. obvious signs of stroke appeared, including numbness of the right side of the face and right facial droop.
>
> 8. With stroke time is brain. In other words the longer treatment is delayed the more brain is damaged.
>
> 9. Since stroke was on the differential, St. Joseph needed to act expeditiously in assessing Mr. Williams. It failed to do so, and that failure violated the required standard of care.
>
> 10. The delay led to delay of treatment. Delay of treatment led to the loss of chance for a better outcome.
>
> 11. It is likely MRI imaging performed at St. Joseph at any time after Mr. Williams arrives would have revealed the stroke, presumably leading to an appropriate response, which likely would have included Plavix, among other therapies. Because ischemic stroke was not diagnosed until 8:35 a.m. and Plavix was not given until 10:03 a.m., Mr. Williams lost a chance for a better outcome. It is possible that Plavix administration before the onset of the more serious symptoms at 7:00 a.m. would

> have prevented the later more serious brain injury suffered by Mr. Williams.
>
> * * *
>
> 13. It is not possible to determine with precision the extent of brain damage caused by the delay in treatment at St. Joseph. However, it is clear that Mr. Williams' stroke related symptoms considerably worsened while at St. Joseph prior to the MRI and diagnosis. This likely represented worsening damage to Mr. Williams' brain as time passed.
>
> * * *
>
> 15. The reason aspirin, statin and IV fluids are given in the sub acute phase of a stroke is to improve outcome. Failure to MRI sooner delayed delivery of therapies. Harm caused the brain as a result cannot be quantified, but it is known that time is brain in stroke and quicker is better. Delay in this case resulted in a loss of chance for a better outcome.
>
> 16. Mr. Williams is now totally disabled. He cannot walk without assistance. He cannot drive. He has lost hearing in one of his ears. He has lost peripheral vision. With appropriate intervention at Good Samaritan and St. Joseph it is possible these problems could have been minimized or avoided altogether.

CP 101-04.

St. Joseph's reply emphasized that Dr. Heide's declaration, which also violated the *Marshall* rule, contained

conclusory causation opinions and lacked a percentage or range of percentage needed for a cognizable loss of chance claim. CP 119-25.

The trial court granted St. Joseph summary judgment, concluding that Dr. Heide's declaration was insufficient to raise a genuine issue of material fact because Heide did not include a percentage or range of percentage of reduced chance as Washington law requires. RP 15-18; CP 144-46.

After stipulating to dismiss the remaining claims against MultiCare, CP 147-49, Williams appealed the order granting St. Joseph summary judgment, CP 150-60.

C. Appeal.

Division I affirmed, holding that "[b]ecause Williams did not proffer evidence that included expert testimony setting forth an opinion, on a more likely than not basis, as to the percentage or range of percentage reduction of a chance of a better outcome suffered by Williams, the trial court did not err by granting Franciscan Health's motion for summary judgment." *Slip Op. at*

10. Division I also found that Dr. Heide's "speculative and conclusory statements" were "insufficient to survive summary judgment. *Id.* at 11.

V. ARGUMENT WHY REVIEW SHOULD BE DENIED

No RAP 13.4(b) consideration warrants this Court's review. While the grounds upon which Williams seeks review are unclear, as he has failed to cite RAP 13.4(b), he implies that Division I's decision raises a significant constitutional question or an issue of substantial public interest, RAP 13.4(b)(3), (4). It does not.

Nor does any other RAP 13.4(b) consideration warrant this Court's review, as Division I's decision is not inconsistent with decisions of this Court, RAP 13.4(b)(1), or of the Court of Appeals, RAP 13.4(b)(2). Every Washington appellate decision permitting recovery for a lost chance has involved expert testimony that includes an opinion as to the percentage or range of percentage of reduced chance. *See, e.g., Herskovits v. Group Health Cooperative of Puget Sound*, 99 Wn.2d 609, 611, 664

P.2d 474 (1983) (14 percent reduced chance of survival); *Mohr v. Grantham*, 172 Wn.2d 844, 849, 262 P.3d 490 (2011) (50 to 60 percent chance of better outcome); *Dunnington v. Virginia Mason Med. Ctr.*, 187 Wn.2d 629, 636, 389 P.3d 498 (2017) (40 percent chance plaintiff's cancer would not recur and 60 percent chance it would); *Shellenbarger v. Brigman*, 101 Wn. App. 339, 348, 3 P.3d 211 (2000) (20 percent chance disease progress would have been slowed); *Christian v. Tohmeh*, 191 Wn. App. 709, 366 P.3d 16 (2015), *rev. denied*, 185 Wn.2d 1035 (2016) (40 percent chance of diminished symptoms with nonnegligent treatment); *Estate of Dormaier v. Columbia Basin Anesthesia*, PLLC, 177 Wn. App. 828, 313 P.3d 431 (2013) (negligence reduced chance of survival by 50 to 70 percent); *Guardado v. Valley Med. Ctr.*, 2012 Wash. App. LEXIS 1004 (2012) (30 to 40 percent chance of survival sufficient to support loss of chance claim); *Pitts v. Inland Imaging, LLC*, 2017 Wash. App. LEXIS 1045 (2017), *rev. denied*, 189 Wn.2d 1014 (2017) (loss of chance inapplicable with expert testimony stating 90 percent chance of

favorable result).

A. Division I's Decision is Not in Conflict with Any Decision of This Court.

Williams contends, *Pet. at 10-11,* that this Court has never required expert testimony as to the percentage lost chance. Although this Court has not expressly stated that such testimony is required, all four of this Court's loss-of-chance decisions have discussed percentages as an integral component in loss of chance analysis.

This Court first evaluated loss of chance in *Herskovits v. Group Health*, 99 Wn.2d 609 (1983), to determine "whether a patient, with less than a 50 percent chance of survival, has a cause of action against the hospital and its employees if they are negligent in diagnosing a lung cancer which reduces his chances of survival by 14 percent." *Id*. at 610-11 (emphasis added). This Court answered in the affirmative, with Justice Dore's lead opinion, *id*. at 610-19, concluding that "medical testimony of a reduction of chance of survival from 39 percent to 25 percent is sufficient evidence to allow the proximate cause issue to go to

the jury," *id*. at 619, and Justice Pearson's controlling plurality opinion, *id*. at 619-36, holding that such testimony was sufficient to create a material issue of fact, *id*. at 622, 634.

In reaching its conclusion, the plurality discussed the important role that the percentage of reduced chance serves as a parameter for damages, allowing a loss of chance plaintiff to recover only those proportional damages that the alleged negligence actually caused—which the percentage established. *Id*. at 635. The lead opinion similarly mitigated concerns about loss of chance claims' potentially speculative nature, highlighting that "[w]here percentage probabilities and decreased probabilities are submitted into evidence, there is simply no danger of speculation on the part of the jury." *Id*. at 618. With the percentage as a guardrail, *Herskovits* recognized loss of chance.

This Court expanded loss of chance in *Mohr v. Grantham*, 172 Wn.2d 844, 857 (2011), to reach lost chance of a better outcome, and clarified that the loss of chance was the

compensable injury. In facts similar to those here, Mohr suffered a stroke that left her permanently disabled, and she alleged that she would have had a chance for a better outcome with earlier diagnosis. *Id*. at 846. Unlike Williams, however, Mohr produced medical experts who opined that, had she received anti-thrombotic therapy, she would have had a "50 to 60 percent chance of a better outcome." *Id*. at 860. This Court concluded that, with expert testimony establishing the range of percentage reduced chance, the plaintiff had presented a prima facie loss-of-chance case to survive summary judgment. *Id.*

In so holding, this Court again alleviated concerns about speculative harm by pointing to "calculation of a loss of a chance for a better outcome … based on expert testimony," which in turn discounted damages to ensure that the defendant was liable, not for full damages associated with the adverse outcome, but only those that the lost chance actually caused. *Id*. at 857-58. Addressing the "criticism of holding individuals or organizations liable on the basis of uncertain probabilities," *Mohr* formally

adopted the *Herskovits* plurality's proportional damages approach; for example, "if the loss were a 40 percent chance of survival, the plaintiff could recover only 40 percent of what would be compensable under the ultimate harm of death or disability (*i.e.,* 40 percent of traditional tort recovery) …." *Id.* at 858.

Loss of chance came before this Court again in *Volk v. DeMeerleer*, 187 Wn.2d 241, 386 P.3d 254 (2016), but it did not reach the claim's merits because the plaintiff alleged that negligence caused 100% of the lost chance for survival, making the alleged tortfeasors responsible for the actual outcome, not the loss of chance. *Id.* at 279. *Volk* therefore re-emphasized the vital role that a percentage plays in determining whether a loss of chance claim applies at all. Williams' reliance, *Pet. at 11,* on *Volk* is misplaced.

Finally, this Court in *Dunnington v. Virginia Mason*, 187 Wn.2d 629 (2017), reviewed whether "but for" or "substantial factor" causation applied in a loss of chance case. In clarifying

that "but for", not "substantial factor", causation generally applies in loss of chance cases, this Court discussed *Rash v. Providence Health & Servs.*, 183 Wn. App. 612, 334 P.3d 1154 (2014), *rev. denied*, 182 Wn.2d 1028 (2015), and *Christian v. Tohmeh*, 191 Wn. App. 709 (2015), both of which held that an expert must establish a percentage or range of percentage of reduced chance. *Id.* at 635-37. This Court did not criticize or question the percentage requirement stated in those decisions, but instead cited their analyses on causation favorably. *See id.*

Division I's decision is thus not in conflict, but consistent, with decisions of this Court.

B. Division I's Decision is Not in Conflict with Any Decision of the Court of Appeals.

Division I's decision follows multiple Court of Appeals' decisions holding that plaintiffs seeking recovery for loss of chance must present expert medical testimony "that includes an opinion as to the percentage or range of percentage reduction in the chance." *Rash*, 183 Wn. App. at 636 (expert's testimony that hospital error was a substantial factor in accelerating death does

not satisfy plaintiff's burden to articulate percentage); *Christian*, 191 Wn. App. at 731 ("In a lost chance suit, a plaintiff carries the burden of producing expert testimony that includes an opinion as to the percentage or range of percentage reduction of the better outcome.") (citing *Herskovits*, 99 Wn.2d at 611; *Mohr*, 172 Wn.2d at 849); *Enebrad v. MultiCare Health Sys.*, 2018 Wash. App. LEXIS 385, *9-10, *rev. denied*, 190 Wn.2d 1027 (2018) ("The plaintiff must submit testimony from an expert health care provider that includes an opinion as to the percentage or range of percentage reduction in the chance of survival."). They have done so for important reasons that this Court has also articulated, namely identifying when to submit a loss of chance claim to a jury and ensuring that a defendant is liable only to the extent of the lost chance it caused.

Because Division I's decision is not in conflict with any decision of this Court or of the Court of Appeals, this Court should decline review.

C. <u>Division I's Decision Does Not Involve a Significant Question of Law under the State or Federal Constitution.</u>

Williams argues, *Pet. at 7-15*, that requiring an expert to provide a percentage or range of percentage of reduced chance of better outcome unconstitutionally invades the jury's province to determine damages. Extreme in oversimplification, Williams contends, *Pet. at 7-9*, that the loss of chance is simply general damages like lost enjoyment of life that a lay jury can determine without medical evidence. This argument poses many problems.

First, loss of chance is not just an element of general damages. While it is not an independent cause of action, but a theory contained by medical malpractice, *Rash*, 183 Wn. App. at 629-30*,* the unique issue in loss of chance cases is "primarily one of causation, resolution [of which] requires us to identify the nature of the injury." *Herskovits,* 99 Wn.2d at 623 (plurality). The *Herskovits* plurality characterized the injury as "the loss ***of a less than even*** chance." *Id.* at 634 (emphasis added); *see also Mohr,* 172 Wn.2d at 850-51 (discussing "cause in fact" in traditional medical malpractice cases," but "in service of

underlying tort principles, this court and others have recognized some limited exceptions to the strict tort formula, including recognition of loss of chance claims").

Although confirming that the lost chance is the compensable "injury," *Mohr* went on to clarify that "injury" and "damages" are not equivalent. *Id.* at 857, 860. Addressing respondents' argument that they were entitled to dismissal because the Mohrs had not proved damages, *Mohr* underscored that such argument was a "misconception of the requirements of medical malpractice tort law. *See* RCW 7.70.040. The Mohrs have made a prima facie case of injury: lost chance of a better outcome." *Id.* at 860. They did so by providing expert testimony that Mohr would have had a 50 to 60 percent chance of a better outcome with non-negligent care. *Id.* at 859-60.

Second, expert testimony that includes an opinion as to the percentage loss of chance is essential to evaluating what claim to submit to a jury. Without it, determining whether the loss or reduction of the chance was "less than even" so as to allow a loss

of chance theory to proceed, or greater than 50 percent so as to require plaintiff to prove proximate cause of the ultimate harm by traditional tort principles, as posited in *Herskovits*, 99 Wn.2d at 634, is impossible.

Third, contrary to Williams' claim, *Pet. at 15*, a lay jury does not have specialized, scientific knowledge to determine without expert medical testimony what percentage chance of better outcome a plaintiff would have had with non-negligent care. That expert testimony grounds the percentage of lost chance ensures the jury's verdict does not rest on speculation. Unlike life experiences from which a jury can derive general damages, for example in cases involving loss of enjoyment of life or loss of consortium, *Pet. Br. at 15*, what scientific chance of a better outcome a plaintiff would have had with non-negligent care is not within the ken of a lay jury.

"[A]ccurate calculations and use of percentages" are essential in loss of chance claims. *Rash*, 183 Wn. App. at 637. As Division I recognized, they are of particular importance in

ensuring "that the jury, in awarding damages, does not hold the defendant responsible for damages caused by the underlying injury as opposed to damages caused by the negligence that resulted in the lost chance." *Slip Op. at 15; see also Herskovits,* 99 Wn.2d at 632 (plurality) ("the defendant is liable, not for all damages arising from the death" or the worse-than-expected outcome, "but only for damages to the extent of the diminished or lost chance"); *Mohr,* 172 Wn.2d at 857-58 ("calculation of a loss of a chance for a better outcome … based on expert testimony" alleviates concerns about speculative harm).

Williams argues, *Pet. at 16,* that "any opinion expressing a percentage of lost chance is at best applying population statistics to an individual case and at worst rank speculation." This argument makes no sense for many reasons, chiefly that adopting it would render all loss of chance cases incapable of proof. His argument runs contrary to modern medicine, which uses statistics-based algorithms to develop prognostic projections and treatment guidelines, and his own expert's testimony that relies

entirely on statistics to posit that "time is brain in stroke and quicker is better," CP 104.

The law is well-settled that experts cannot base their opinions on "rank speculation" to defeat summary judgment, but they can, and do, use statistics and statistics-based medicine to support their opinions. *Volk*, 187 Wn.2d at 277; *see also Seybold v. Neu*, 105 Wn. App. 666, 677, 19 P.3d 1068 (2001) ("expert testimony must be based on facts in the case, not speculation or conjecture"). Courts routinely look to statistics-based evidence in evaluating causation and damages. *See, e.g., Shellenbarger,* 101 Wn. App. at 349 (using statistical life expectancy to evaluate additional years of life plaintiff may have had without lost chance).

Fourth, Williams' contention, *Pet. at 10-15,* that requiring expert testimony as to the percentage lost chance unconstitutionally imposes a damages "formula" on jurors is incorrect. Division I correctly distinguished such a requirement, which "in no way improperly limits the amount of the damages

that the jury may award," *Slip Op. at 15,* from the arbitrary and therefore unconstitutional damages cap in *Sofie v. Fibreboard*, 112 Wn.2d 636, 771 P.2d 711 (1989), that applied regardless of a jury's verdict, about which the jury was not informed, and over which the jury had no control. Requiring a plaintiff to produce expert testimony as to the percentage or range of percentage of reduced chance caused by the alleged negligence is nothing like the unconstitutional damages cap in *Sofie*.

Nor, as Williams argues, *Pet. at 16,* is it unclear "what the jury is supposed to do with the percentage testimony." Washington Pattern Verdict Form WPI 105.20 makes it perfectly clear what the jury is supposed to do. Had Williams produced adequate expert testimony and otherwise established a prima facie case to defeat summary judgment, the jury could have been presented with a verdict form like WPI 105.20:

> QUESTION 1: Was (name of defendant) negligent?
>
> ANSWER: (Write "yes" or "no")

***

QUESTION 2: Was (name of defendant)'s negligence a proximate cause of a reduction in [(name of decedent)'s] [(name of plaintiff)'s] chance to [survive the condition which caused [his] [her] death] [have a better outcome]?

ANSWER: (Write "yes" or "no")

***

QUESTION 3: What do you find to be the percentage reduction in [(name of decedent)'s] [(name of plaintiff)'s] chance to [survive] [have a better outcome] proximately caused by the negligence of (name of defendant)?

ANSWER: % (cannot exceed 50%)

***

QUESTION 4: What do you find to be the [(name of decedent)'s] [(name of plaintiff)'s] total amount of damages?

ANSWER: $___________.

WPI 105.20.

The jury thus assigns damages to the entire injury, be it disability or death, in whatever sum they believe the evidence supports. No cap exists. While the trial court then reduces that jury-determined sum by the percentage of lost chance, the jury *also* decides the percentage of lost chance based on expert

testimony to ensure that its determination does not derive from speculation. The jury is instructed that this percentage will reduce the award to ensure that the defendant is liable only for the damages it proximately caused, which is the lost chance. The jury determines both the total damages and the lost chance. The jury retains the power to decide the full extent of plaintiff's damages.

Because requiring a plaintiff to produce expert testimony as to the percentage does not unconstitutionally invade the jury's ability to determine damages, Williams fails to satisfy RAP 13.4(b)(3).

D. Division I's Decision Does Not Involve an Issue of Substantial Public Interest.

Finally, Williams contends, *Pet. at 14-15*, that the wrongdoer, not the victim, should bear uncertainty's risk, claiming that requiring him to present expert testimony as to the percentage of lost chance improperly burdens him. But all loss-of-chance plaintiffs face this hurdle. And for good reason. It is the compromise courts have struck to allow loss of chance claims

while addressing concerns about disproportionate damages and these claims' potentially speculative nature. Some plaintiffs have surmounted this hurdle—even with an allegedly delayed stroke diagnosis like Williams, *see, e.g., Mohr,* 172 Wn.2d at 859-60 (50 to 60 percent chance of better outcome with timely anti-thrombotic therapy in face of stroke)—and others have not, *see, e.g., Rash,* 183 Wn. App. at 620 (unable to provide "mathematical figure" as to reduced chance); *Enebrad*, 2018 Wash. App. LEXIS 385, *5 (unable to assign percentage to alleged reduced chance, though it was "significant"). No Washington appellate court has held that difficulty in obtaining expert testimony as to a percentage or range of percentage of an alleged loss of chance justifies excusing a plaintiff from that requirement in loss-of-chance cases.

Moreover, in this case Williams did not have all he needed to defeat summary judgment absent percentage testimony. Dr. Heide's testimony contained numerous deficiencies. He failed to causally connect a specific St. Joseph healthcare provider's

alleged standard-of-care breach to the lost chance for a better outcome. He speculated throughout his declaration by referring broadly to "appropriate response" and "possible" therapies that some unidentified person "presumably" might have instituted had an MRI been performed "expeditiously." CP 102-04. He did not establish who should have acted more expeditiously, or how soon "expeditiously" was, *i.e.*, when to comply with the standard of care an evaluation needed to occur, the MRI needed to be done, or Plavix or any other sub-acute therapies needed to be ordered and commenced, or and that the failure to so comply proximately caused the lost chance on a more probable than not basis. He opined only that "[d]elay in this case" caused a lost chance, without explaining who caused the delay, why it was negligent, or what exactly any healthcare providers needed to do to comply with their standard(s) of care, as an expert opinion sufficient to defeat summary judgment needed to have done. *Reyes v. Yakima Health Dist.*, 191 Wn.2d 79, 86-87, 419 P.3d 819 (2018). Affidavits like Dr. Heide's, "containing conclusory

statements without adequate factual support[,] are insufficient to defeat a motion for summary judgment." *Guile v. Ballard Cmty. Hosp.*, 70 Wn. App. 18, 25, 851 P.2d 689 (1993). Division I correctly so concluded, stating "[t]he speculative and conclusory statements made by Dr. Heide were insufficient to survive summary judgment." *Slip Op. at 11*.

Because these problems are unique to Williams' poorly-supported medical negligence lawsuit, no issue of substantial public interest requires this Court's review.

VI. CONCLUSION

Williams has failed to establish any RAP 13.4(b) consideration warrants this Court accepting review.

I declare that this document contains 4,955 words.

RESPECTFULLY SUBMITTED this 15th day of August, 2022.

FAIN ANDERSON VANDERHOEF
ROSENDAHL O'HALLORAN SPILLANE,
PLLC

s/Amanda K. Thorsvig
Amanda K. Thorsvig, WSBA #45354
Michelle M. Garzon, WSBA #31558
Attorneys for Respondent Franciscan
Health System, d/b/a St. Joseph
Medical Center
1301 A Street, Suite 900
Tacoma, WA 98402
Ph: 253.328.7800
Email: amanda@favros.com
shelly@favros.com

CERTIFICATE OF SERVICE

I hereby certify under penalty of perjury that under the laws of the State of Washington that on the 15th day of August, 2022, I caused a true and correct copy of the foregoing document, "Respondent Franciscan Health System, d/b/a St. Joseph Medical Center's Answer to Petition for Review," to be delivered in the manner indicated below to the following counsel of record:

Counsel for Petitioner:	SENT VIA:
Carl A. Taylor Lopez	☐ Fax
LOPEZ & FANTEL, INC., P.S.	☐ ABC Legal Services
2292 W. Commodore Way, Suite 200	☐ Express Mail
Seattle, WA 98199	☐ Regular U.S. Mail
Ph: 206.322.5200	☑ E-file / E-mail
Email: clopez@lopezfantel.com	

DATED this 15th day of August, 2022, at Seattle, Washington.

s/Carrie A. Custer
Carrie A. Custer, Legal Assistant

FAVROS LAW

August 15, 2022 - 9:05 AM

Transmittal Information

Filed with Court:	Supreme Court
Appellate Court Case Number:	101,083-4
Appellate Court Case Title:	Robert Williams v. Franciscan Health System
Superior Court Case Number:	19-2-10589-1

The following documents have been uploaded:

- 1010834_Answer_Reply_20220815090339SC044079_7351.pdf
  This File Contains:
  Answer/Reply - Answer to Petition for Review
  The Original File Name was Answer to Petition for Review.docx.PDF

A copy of the uploaded files will be sent to:

- Shelly@FAVROS.com
- clopez@lopezfantel.com
- deidre@favros.com
- elizabethu@favros.com

Comments:

Sender Name: Carrie Custer - Email: carrie@favros.com
Filing on Behalf of: Amanda Kathleen Thorsvig - Email: amanda@favros.com (Alternate Email: carrie@favros.com)

Address:
701 Fifth Ave
Suite 4750
SEATTLE, WA, 98104
Phone: (206) 749-0094

Note: The Filing Id is 20220815090339SC044079