95645-6

CASE NO.: 75369-0-I

COURT OF APPEALS, DIVISION I
IN AND FOR THE STATE OF WASHINGTON

Lynette Enebrad, et. ano.

Plaintiff-Appellant

v.

MultiCare Health Systems

Defendant-Respondents

ON APPEAL FROM THE COURT OF APPEALS, DIVISION I
IN AND FOR THE STATE OF WASHINGTON

PETITION FOR REVIEW

March 22, 2018.

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Identity of Petitioner

Lynette Enebrad, individually and as personal representative of the Estate of Robert Enebrad, asks this court to accept review of the Court of Appeals decision terminating review designated in Part B of this petition.

Court of Appeals Decision

Petitioner asks this court to review the decision by the Court of Appeals affirming the trial court's grant of summary judgment to defendants and the trial court's decision allowing evidence of Mr. Enebrad's past recreational drug. A copy of the decision is in the Appendix at pages A-1 through 15.

Statement of Issues

I. Should the court, as a matter of policy, uphold relaxation of proof requirements in loss of chance claims where defendant's own conduct is a factor in creating uncertainty on what specific percentage, or range of percentages, was lost?

II. Did the trial court err in allowing evidence of past recreational drug use on life expectancy without adequate evidence of long-term, irreversible adverse effects of such drug use on the plaintiff? Did the cumulative presentation of past drug use likely cause prejudice to plaintiffs?

Statement of the Case

Plaintiff incorporates by this reference the Statement of the Case set forth in plaintiff's Brief of Appellant, attached as Appendix A to this Petition.

Argument Why Review Should Be Accepted

I. The Issues Presented Are Of Substantial Public Importance.

Mrs. Enebrad's case presents an issue of substantial public importance reviewable under RAP 13.4(b)(4). The decision of the Court of Appeals, Division I, subverts the deterrence effect of tort law in medical malpractice cases by requiring harmed plaintiffs provide expert witness testimony stating a specific percentage, or range of percentages, of the "lost chance" of survival or a better outcome in situations where the defendant health care provider's own conduct is a factor in creating uncertainty on what percentage chance was lost. If a defendant health care provider's negligence is likely a substantial factor in increasing the patient's risk of harm but that negligence prevents any reviewing expert from opining as to a specific percentage the Court of Appeals decision will act to immunize tortious conduct by health care providers.

II. The Decision Is In Conflict With Decisions Of The Supreme Court.

The Court of Appeals decision is in conflict with the Supreme Court's decisions in *Herskovits v. Group Health Cooperative of Puget Sound*, **99 Wn.2d 609**, **664 P.2d 474** (1983) (plurality opinion); *Mohr v. Grantham*, **172 Wn.2d 844**, **262 P.3d 490** (2011) and Dunnington v. Virginia Mason Medical Center, 187 Wn.2d 629, 389 P.3d 498 (2017).

The Court of Appeals decision states "In both types of lost chance claim, the amount of the plaintiffs damages is based on the percentage of lost chance proximately caused by the negligence. Herskovits,99Wn.2d at 619 (Pearson, J., plurality opinion); Mohr, 172 Wn.2d at 858-

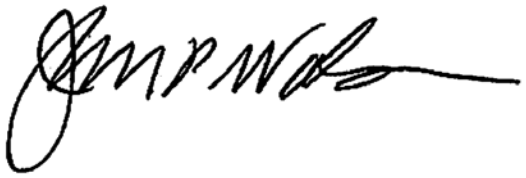
59." Nowhere in Herskovits or Mohr does this court state that a plaintiff is required to state a percentage of lost chance.

Conclusion

Lynette Enebrad asks this court to reverse the trial court's order granting summary judgment to MultiCare Health Systems, Healogics, Inc., and Mark Tseng, M.D. Petitioner also requests that this court reverse the trial court's ruling admitting evidence of Mr. Enebrad's past recreational drug use as it was prejudicial to Mrs. Enebrad's individual claim and the claims of the Estate's beneficiaries. Petition asks for a new trial as to all defendants.

Done and dated this 22nd day of March 2018.

Law Office of John P. Walsh



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John P. Walsh, WSBA # 12437
Attorney for Lynette Enebrad & Estate of Robert Enebrad

IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON

LYNETTE ENEBRAD, individually and as the Personal Representative of the ESTATE OF ROBERT ENEBRAD,

Appellant,

v.

MULTICARE HEALTH SYSTEM, d/b/a MULTICARE AUBURN MEDICAL CENTER, a Washington corporation doing business within the State of Washington, King County; MARK H. TSENG, M.D. and JANE DOE TSENG, and the marital community composed thereof; MARK H. TSENG, M.D., P.C., a Washington professional corporation doing business within the State of Washington, King County; HEALOGICS, INC., and its affiliated corporation, DIVERSIFIED CLINICAL SERVICES, both Delaware corporations registered to do business in Washington,

Respondents,

and

HEALOGICS, INC., and its affiliated corporation, DIVERSIFIED CLINICAL SERVICES, both Delaware corporations registered to do business in Washington,

Third Party Defendants.

No. 75369-0-I

DIVISION ONE

UNPUBLISHED OPINION

FILED: February 20, 2018

TRICKEY, A.C.J. — In this medical malpractice case, Lynette Enebrad, on behalf of her deceased husband, Robert Enebrad,[1] sued MultiCare Health System d/b/a MultiCare Auburn Medical Center (MultiCare Health), Healogics, Inc., Diversified Clinical Services, Inc. (DCS), and Dr. Mark H. Tseng (collectively, MultiCare). The trial court granted summary judgment dismissing Enebrad's loss of chance claims against MultiCare, thereby restricting the case to her claim that Dr. Von Chang negligently failed to diagnose Robert's cancer in 2013. At trial, the trial court admitted evidence of Robert's prior drug use on limited issues. The jury found that the Dr. Chang was not negligent.

Enebrad appeals, arguing that summary judgment was not appropriate and that the trial court abused its discretion when it admitted evidence of Robert's prior drug use. Because Enebrad failed to submit an expert declaration assigning a value to the percentage of lost chance proximately caused by the defendants and has not demonstrated that she was unfairly prejudiced by the trial court's admission of evidence of Robert's prior drug use, we affirm.

FACTS

Robert was a patient of Kent MultiCare Family Practice. On January 18, 2013, Robert saw Dr. Chang for an annual physical. Robert's medical records indicated that he had a skin graft on his left forearm, had a history of intravenous (IV) drug use along with heroin and cocaine abuse, and was taking methadone. Dr. Chang knew that Robert had a history of infections and cellulitis that led to his skin graft procedure in 2002. Even after the graft, Robert would occasionally develop ulcers in the scar tissue area of the graft.

Robert did not report any acute concerns to Dr. Chang at the visit. Dr. Chang

[1] We refer to Robert Enebrad as "Robert" and to Lynette Enebrad as "Enebrad" unless otherwise noted. No disrespect to the parties is intended.

observed that the skin donor site on Robert's left shin was dry but the skin graft site on his left forearm looked normal.

Dr. Chang saw Robert again on August 7, 2013. Robert was complaining of a growing lesion in his skin graft, which was two inches in diameter at the time of his visit. Dr. Chang referred Robert to the Wound Healing Clinic at MultiCare Health for immediate care.

On August 12, 2013, Robert saw Dr. Tseng at MultiCare Health. Dr. Tseng measured the lesion and ordered a biopsy. Dr. Tseng saw Robert for six more visits from August to early October. Robert's lesion grew aggressively.

Dr. Tseng did not see the results of the biopsy until October, although the biopsy report was dated August 14, 2013. The report concluded that "[t]he biopsy tissue is extensively involved by well differentiated squamous cell carcinoma with areas of necrosis."[2] Dr. Tseng recommended that Robert go to Harborview Medical Center's plastic surgery department for wound care and for covering of the lesion with a flap or graft.

On October 8, 2013, Dr. Jason Ko saw Robert at Harborview and reviewed his biopsy report from MultiCare Health. Dr. Ko diagnosed Robert as having a Marjolin's ulcer, a rare and very aggressive type of skin cancer.

On October 14, 2013, Enebrad and Robert had an appointment with Dr. Chang and requested stronger pain medication for Robert. Dr. Chang agreed to continue Robert's pain medication for a week. But after consulting a pain specialist, Dr. Chang decided to not provide Robert with future narcotics in light of his prior drug use.

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[2] Clerk's Papers (CP) at 64.

Robert had surgery to remove the cancer at Harborview. During the procedure, it was discovered that the cancer was more extensive than previously thought. On November 25, 2013, Robert's left arm was amputated. Despite the amputation, the cancer continued to spread, and Robert died on October 19, 2014.

In February 2014, Enebrad sued MultiCare Health for medical negligence and damages. Enebrad alleged that MultiCare Health, through its employee or agent Dr. Tseng, negligently misdiagnosed and failed to treat Robert's squamous cell skin cancer, failed to review the biopsy report in a timely manner, and failed to immediately take steps to refer Robert to specialist care. MultiCare Health responded that Robert's injuries were caused by third parties. Healogics and DCS operated the Wound Healing Clinic, and Dr. Tseng was not an employee of MultiCare Health. MultiCare Health also asserted a third-party indemnity claim against Healogics and DCS. In October 2014, Enebrad amended her complaint to assert claims against Dr. Tseng, Healogics, and DCS.

MultiCare moved for summary judgment on Enebrad's claims. MultiCare argued that Enebrad had not offered expert medical testimony to establish causation.

Enebrad had asked Dr. Ko to submit a declaration in support of her case. On June 26, 2014, Enebrad e-mailed Dr. Ko and specifically asked him to "assign a percentage to [Robert's lost] chance (or a range of percentage)."[3] Dr. Ko responded that he could "[]not assign a percentage (range) to [Robert's lost chance]."[4]

Enebrad ultimately submitted a declaration from Dr. Ko in response to MultiCare's motions for summary judgment. Dr. Ko stated that the delay between Dr. Tseng's biopsy and Dr. Ko's diagnosis negatively impacted Robert's chance of a better outcome but did

[3] CP at 430.
[4] CP at 429.

not assign any percentage to his loss of chance. At Dr. Ko's deposition in April 2015, he stated that his conclusion was that the delays in diagnosis and treatment did not change the ultimate outcome of Robert's treatment.

MultiCare responded that Dr. Ko had failed to identify a numerical percentage of lost chance in his declaration and, therefore, it was legally insufficient to prevent summary judgment on Enebrad's claims against MultiCare. The trial court granted Enebrad multiple continuances so that she could submit a revised declaration from Dr. Ko.

Enebrad eventually submitted a declaration from Dr. H. Thomas Temple instead of a revised declaration from Dr. Ko. Dr. Temple declared that Robert likely had a lesion on his skin graft at his January 18 appointment with Dr. Chang, which Dr. Chang failed to notice or record. Dr. Temple stated that "[a]t the likely stage of Mr. Enebrad's cancer [at the January 18 appointment] he would have had a 98% chance or better to not only avoid amputation of his left forearm but to survive his disease."[5]

In its supplemental reply, MultiCare argued that Dr. Temple's declaration only supported a claim of negligence against Dr. Chang, and did not establish causation between MultiCare's actions and Robert's harms. MultiCare moved for the trial court to dismiss Enebrad's claims with prejudice, except for "those claims arising out of care provided by [Dr. Chang] to Robert Enebrad on January 18, 2013."[6] The trial court granted summary judgment on the claims against MultiCare, leaving only the claims against Dr. Chang arising from the January 18, 2013 appointment.

Prior to trial, MultiCare filed a motion in limine requesting permission to offer evidence of Robert's prior drug use at trial. MultiCare argued that such evidence was

[5] CP at 495.
[6] CP at 618.

relevant to Dr. Chang's affirmative defense of contributory negligence and on the issues of Robert's life expectancy and truthfulness in reporting his symptoms. The trial court ruled that evidence of Robert's prior drug use was relevant to life expectancy and pain management, but reserved its decision on the relevancy of the evidence to contributory negligence defense for trial.

At trial, Enebrad argued that Robert had a visible lesion on his left forearm at his January 18 appointment, and that Dr. Chang negligently failed to observe, diagnose, or treat it.[7] MultiCare contended that Dr. Chang performed a thorough examination of Robert on January 18 and did not observe any lesions, as reflected in his notes from the appointment. Further, Dr. Kent Carson testified about how Robert's prior drug use and skin graft led to the cancer spreading to Robert's bones before it affected his skin.

During trial, the trial court gave the jury an oral limiting instruction sua sponte. During MultiCare's direct examination of Dr. Michael Kovar, the trial court instructed the jury: "The Court has admitted evidence regarding Mr. Enebrad's drug usage, at least in this context, for one purpose only. And that is there's going to be an issue that's going to be raised with you regarding life expectancy. And I'm admitting this evidence so that you can consider that issue. But you should not consider the drug usage for any other purpose."[8]

The jury found that Dr. Chang did not fail to comply with the standard of care. Enebrad appeals.

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[7] Dr. Temple testified via Skype at trial without giving prior notice to MultiCare or the trial court. The court reporter noted that Dr. Temple's entire testimony via Skype was inaudible and was not recorded. It is assumed that Dr. Temple's testimony at trial was substantively the same as his declaration.

[8] Report of Proceedings (RP) (May 2, 2016) at 482-83.

ANALYSIS

Summary Judgment

Enebrad argues that the trial court erred in granting summary judgment dismissing her loss of chance claims against MultiCare. Specifically, she contends that Dr. Ko's declaration sufficiently supported her claims, and that there were material issues of fact precluding summary judgment. Because the declarations of Dr. Ko and Dr. Temple did not assign a percentage of Robert's lost chance to MultiCare's actions, we disagree.

A lost chance claim is a form of a medical malpractice cause of action that can be based on a lost chance of survival or a lost chance of a better outcome. Rash v. Providence Health & Servs., 183 Wn. App. 612, 629-30, 334 P.3d 1154 (2014). A lost chance of survival claim arises when the patient died as a result of allegedly negligent treatment. Rash, 183 Wn. App. at 630. Specifically, in a lost chance of survival claim, although the patient's chance of dying was greater than 50 percent prior to the negligence, "the negligence reduced the patient's chances of surviving the condition." Rash, 183 Wn. App. at 630 (citing Herskovits v. Grp. Health Coop. of Puget Sound, 99 Wn.2d 609, 664 P.2d 474 (1983)).

In contrast, a lost chance of a better outcome occurs when the patient does not die but suffers adverse health consequences. Rash, 183 Wn. App. at 630-31. "In a lost chance of a better outcome claim, the mortality of the patient is not at issue, but the chance of a better outcome or recovery was reduced by professional negligence." Rash, 183 Wn. App. at 631 (citing Mohr v. Grantham, 172 Wn.2d 844, 857, 262 P.3d 490 (2011)). "[If] the malpractice reduced the chances of a better outcome by a percentage

of 50 percent or below," the case is analyzed as a lost chance of a better outcome. Rash, 183 Wn. App. at 631.

In both types of lost chance claim, the amount of the plaintiff's damages is based on the percentage of lost chance proximately caused by the negligence. Herskovits, 99 Wn.2d at 619 (Pearson, J., plurality opinion); Mohr, 172 Wn.2d at 858-59. 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." Rash, 183 Wn. App. at 636; see Christian v. Tohmeh, 191 Wn. App. 709, 731, 366 P.3d 16 (2015). Without this percentage, a trial court cannot determine whether to submit the case to the jury as a traditional malpractice wrongful death suit or as a lost chance claim or calculate the appropriate amount of damages. Rash, 183 Wn. App. at 636; Estate of Dormaier v. Columbia Basin Anesthesia, PLLC, 177 Wn. App. 828, 851, 313 P.3d 431 (2013).

An appellate court reviews "summary judgment rulings de novo, engaging in the same inquiry into the evidence and issues called to the attention of the trial court." Dowler v. Clover Park Sch. Dist. No. 400, 172 Wn.2d 471, 484, 258 P.3d 676 (2011).

Here, to survive summary judgment, Enebrad bore the burden of producing expert medical testimony establishing Robert's percentage of lost chance proximately caused by MultiCare. The declarations of Dr. Ko and Dr. Temple did not assign a percentage of Robert's lost chance to MultiCare. Dr. Temple's declaration only assigned a percentage of lost chance to Dr. Chang's individual negligence. Thus, Enebrad failed to carry her burden, and we conclude that the trial court did not err when it granted summary judgment dismissing her loss of chance claims against MultiCare.

Enebrad argues that Dr. Ko's declaration was sufficient by stating that the delay in diagnosis led to a delay in Robert's receipt of treatments "whose purpose is to significantly increase a patient's chance of a better outcome."[9] In support of her argument, Enebrad contends that the dictionary definition of "significant" supports an inference that Dr. Ko's statement included a percentage of lost chance.[10] She also analogizes the present case to Volk v. DeMeerleer, which held that it was not error to admit an expert's affidavit that did not provide a specific percentage of lost chance. 187 Wn.2d 241, 278-79, 386 P.3d 254 (2016).

Enebrad's arguments are unpersuasive. Her citation to the dictionary definition of "significant" cannot overcome case law clearly showing that Dr. Ko's declaration is legally insufficient. Further, Volk is inapposite because the lost chance doctrine did not apply. 187 Wn.2d at 276-79. We reject Enebrad's argument.

Enebrad also argues that a jury could have reasonably concluded that Robert suffered from lost chance due to his untimely diagnosis, and thus summary judgment was inappropriate.[11] Enebrad's argument ignores her failure to satisfy the legal requirement of providing an expert opinion assigning a percentage of lost chance in order to survive summary judgment. We reject Enebrad's argument.

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[9] Br. of Appellant at 30. At oral argument, the parties argued over whether Dr. Ko's deposition testimony contradicted his declaration. Because we conclude that Dr. Ko's declaration was insufficient to satisfy Enebrad's obligation to offer expert testimony establishing a percentage of lost chance, we decline to reach this issue.

[10] Br. of Appellant at 29-30 (citing MERRIAM-WEBSTER'S ONLINE DICTIONARY, https://www.merriam-webster.com/dictionary/significant (last visited Mar. 21, 2017)).

[11] Enebrad also states that "[Robert] and his family were deprived of a fair trial," citing to the trial judge's evidentiary and summary judgment rulings. Br. of Appellant at 34. Enebrad does not support this statement with citation to legal authority or significant argument. RAP 10.3(4), (6). We decline to address Enebrad's unsupported reference to her right to a fair trial.

Admission of Evidence of Prior Drug Use

Enebrad argues that the trial court abused its discretion when it admitted evidence of Robert's prior drug use. Specifically, she contends that MultiCare's arguments were pretextual and that the evidence was unfairly prejudicial. Because the evidence was probative and Enebrad has not established that she was unfairly prejudiced by its admission, we disagree.

"All relevant evidence is admissible" unless otherwise barred. ER 402. But relevant evidence "may be excluded if its probative value is substantially outweighed by the danger of unfair prejudice, confusion of the issues, or misleading the jury, or by considerations of undue delay, waste of time, or needless presentation of cumulative evidence." ER 403.

The relevancy of the evidence is presumed, and the court's inquiry focuses on "whether its probative value is outweighed by its prejudicial effect." Carson v. Fine, 123 Wn.2d 206, 222, 867 P.2d 610 (1994). Evidence is probative if it has "any tendency to make the existence of any fact that is of consequence to the determination of the action more probable or less probable than it would be without the evidence." ER 401.

Shortened life expectancy is probative on the issue of recoverable damages in a medical malpractice case. See Adcox v. Children's Orthopedic Hosp. & Med. Ctr., 123 Wn.2d 15, 33, 864 P.2d 921 (1993); Woolridge v. Woolett, 96 Wn.2d 659, 666-67, 638 P.2d 566 (1981). Similarly, the health, habits, and activity of the person whose life expectancy is in question is relevant to the issue of damages. See Kramer v. J.J. Case Mfg. Co., 62 Wn. App. 544, 557-60, 815 P.2d 798 (1991).

"[U]nfair prejudice is caused by evidence likely to arouse an emotional response rather than a rational decision among the jurors." Carson, 123 Wn.2d at 223 (citing Lockwood v. AC&S, Inc., 109 Wn.2d 235, 257, 744 P.2d 605 (1987)). If the evidence at issue is probative to a central issue in the case, the likelihood of it being outweighed by the danger of unfair prejudice is "'quite slim.'" Carson, 123 Wn.2d at 224 (quoting United States v. 0.161 Acres of Land, 837 F.2d 1036, 1041 (11th Cir. 1988)).

If the possibly prejudicial evidence is admitted, an explanation should be made to the jury of the purpose for which it is admitted, and the trial court should give a cautionary instruction that it is to be considered for no other purpose or purposes. State v. Goebel, 36 Wn.2d 367, 378-79, 218 P.2d 300 (1950). "The jury is presumed to follow the court's instructions." Hizey v. Carpenter, 119 Wn.2d 251, 269-70, 830 P.2d 646 (1992).

"[T]he burden of showing prejudice is on the party seeking to exclude the evidence." Carson, 123 Wn.2d at 225. A trial court's decision to admit evidence under ER 403 will be reversed only for manifest abuse of discretion. Carson, 123 Wn.2d at 226.

Here, Robert's recreational drug use was probative on the issue of Robert's life expectancy. Dr. Temple stated in his deposition testimony that drug abuse was correlated with shortened life expectancy. At trial, Dr. Kovar testified that Robert's drug use habits considerably shortened his life expectancy. In addition, Dr. Carson testified about the aggressive nature of Marjolin's ulcers, and how trauma from Robert's drug use and his subsequent skin graft led to the cancer spreading to Robert's bones prior to breaking through the skin.[12] Thus, expert testimony from both parties established that Robert's prior drug use was probative to the issue of his life expectancy.

[12] Enebrad's statement of issues discusses the relevance of Robert's prior drug use to an alleged failure to mitigate damages. But Enebrad does not offer argument in support of this contention,

Because Robert's prior drug use was probative on the issue of his life expectancy, Enebrad bears the burden of demonstrating that the evidence's probative value was outweighed by unfair prejudice. Enebrad has not carried that burden. First, Enebrad argues that MultiCare "seized the opportunity to talk about drug use at every conceivable opportunity and with every single witness to take the stand," thereby putting Robert's character at issue and implying that he was not worthy of quality care.[13] This is not supported by the record. In questioning Enebrad's witnesses, MultiCare only asked Enebrad about Robert's prior drug use, and asked Dr. Temple about Robert's time in the methadone program. MultiCare did not raise the issue of Robert's prior drug use with two of its own medical expert witnesses. Further, MultiCare did not elicit testimony disparaging Robert's character.[14] Therefore, Enebrad's argument does not establish that she was unduly prejudiced by MultiCare's circumspect use of this evidence.

Second, Enebrad argues that the trial court's oral limiting instruction to the jury was ineffective, as demonstrated by a juror's question to Dr. Chang about whether Robert was completely sober during his visits. This is unpersuasive. The trial court provided the jury with a limiting instruction regarding Robert's drug use that reminded the jury to only consider it for the purpose for which it was admitted. Further, Dr. Chang responded to the juror's question by saying, "He's not impaired, no. He's very clear."[15] Dr. Chang's

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and instead focuses solely on the life expectancy issue. We decline to address this argument. RAP 10.3(a)(6).

[13] Br. of Appellant at 23.

[14] We note that Robert's family members used negative descriptions of Robert's drug use during direct examination by Enebrad's counsel. See RP (April 27, 2016) at 229 ("You know, he wasn't some gutter scum drug addict. He was a middle class drug addict."); RP (April 27, 2016) at 240 ("I know the defense is trying to paint my father to be like he was a drug addicted rock star, but that wasn't the case.").

[15] RP (April 27, 2016) at 210.

response is more related to whether Robert accurately reported his symptoms rather than his continuing drug use. Therefore, Enebrad has not demonstrated that the juror's question demonstrates that the trial court's limiting instruction was ineffective or that the jury was unfairly prejudiced.

Third, Enebrad argues that evidence of drug use is generally inadmissible because it is inherently prejudicial. See State v. Tigano, 63 Wn. App. 336, 344-45, 818 P.2d 1369 (1991); State v. Renneberg, 83 Wn.2d 735, 736-39, 522 P.2d 835 (1974). This is unpersuasive. Both cases cited by Enebrad were criminal matters concerning the use of evidence of the defendant's prior drug use for impeachment purposes. Enebrad brought a civil malpractice suit in which evidence of Robert's drug use was admitted on the issue of his life expectancy and pain tolerance. Therefore, Enebrad's citation to criminal cases does not establish unfair prejudice outweighing the evidence's probative value.

Enebrad also argues that MultiCare failed to provide substantial evidence that Robert's life expectancy was shortened by his recreational drug use, analogizing to Kramer v. J.I. Case Manufacturing Co., 62 Wn. App. 544, 815 P.2d 798 (1991). In Kramer, the Court of Appeals held that cross-examination of witnesses about the plaintiff's prior drug use before an offer of proof had been made was improper. It also held that the probative value of evidence of the plaintiff's prior drug use was unclear without evidence of its long-term adverse effects or how it affected his employment. Kramer, 62 Wn. App. at 559.

The present case is distinguishable from Kramer. MultiCare made an offer of expert testimony that established a link between Robert's drug use and his reduced life expectancy. Dr. Kovar testified about the long-term impacts of heroin and cocaine use

and about how Robert's prior drug use shortened his life expectancy. Dr. Carson testified about the connection between Robert's drug use and the development of the Marjolin's ulcer in his left forearm. Viewed together, MultiCare made an offer of expert medical testimony that established the negative impacts of Robert's prior drug use on his life expectancy and the progression of the Marjolin's ulcer. We conclude that Enebrad's analogy to Kramer is inapposite.[16]

In sum, evidence of Robert's prior drug use was probative on the issue of his life expectancy. Enebrad's arguments in support of her contention that she was unfairly prejudiced by the admittance of the evidence and her analogy to Kramer are unpersuasive. We conclude that the trial court did not abuse its discretion when it admitted evidence of Robert's prior drug use on the issue of life expectancy.

Sanctions

Dr. Tseng requests that this court impose sanctions on Enebrad's counsel for continuing to rely on Dr. Ko's declaration despite knowing it was legally insufficient.

> The appellate court . . . may order a party or counsel . . . who uses these rules for the purpose of delay, files a frivolous appeal, or fails to comply with these rules to pay terms or compensatory damages to any other party who has been harmed . . . or to pay sanctions to the court.

RAP 18.9(a).

Here, on appeal, Enebrad has raised debatable issues regarding the sufficiency of Dr. Ko's declaration and disputed the necessity of providing a percentage value of lost

[16] Enebrad also argues that Dr. Kovar's opinion was not factually supported, was inadmissible or incompetent, or was insufficient because he did not provide a specific number of years by which Robert's life expectancy was shortened. Enebrad has not cited legal authority or provided argument substantively challenging Dr. Kovar's qualification as a medical expert or his conclusions. We reject these arguments. RAP 10.3(a)(6).

chance to survive summary judgment. We conclude that her appeal is not frivolous, and decline to impose sanctions under RAP 18.9(a).

Affirmed.

Trickey, ACJ

WE CONCUR:

Mann, J.

Leach, J

CASE NO.: 75369-0-I

Court of Appeals, Division I
In and for the State of Washington

Lynette Enebrad, et. ano.

Plaintiff-Appellant

v.

MultiCare Health Systems

Defendant-Respondents

On Appeal From the King County Superior Court
In and for the State of Washington

Brief of Appellant

March 27, 2017.

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Statement of Issues

I. Whether it was prejudicial error for the trial court to admit evidence of Robert Enebrad's past recreational drug use because it was inflammatory and likely to outweigh any probative value on issues to be considered by the jury?

A. Whether defendant's stated reasons for admitting past drug use were a pretext for asking the jury to consider character evidence designed to prejudice the jury against Mr. Enebrad?

B. Whether admitting evidence of past drug use in consideration of Mr. Enebrad's life expectancy was error when defendant failed to offer competent expert testimony that Mr. Enebrad's life expectancy would be affected?

C. Whether allowing defendant to argue relevance of past drug as a failure to mitigate damages was proper when no affirmative proof was offered by defendant establishing Mr. Enebrad's need for increased pain medication during cancer therapy was related to his past drug use?

II. Did the trial court commit error when it summarily dismissed Robert Enebrad's claims against defendants Healogics, Dr. Tseng and MultiCare relative to their respective failure to diagnose and treat Mr. Enebrad's squamous cell carcinoma?

A. Whether plaintiff raised material questions of fact about defendants' failure to diagnose and treat Mr. Enebrad's skin cancer resulting in a loss of chance of a better outcome?

1. Mr. Enebrad submitted a declaration from his treating plastic surgeon at Harborview Medical Center that raised material questions of fact regarding his loss of a chance at a better outcome.

2. Plaintiff's expert oncologist raised material questions of fact regarding Mr. Enebrad's loss of a chance of a better outcome.

3. MultiCare's initial motion for summary judgment implicated its own medical staff and raised material questions of fact whether its employees and agents caused its patient to lose a chance at a better outcome by failing to monitor Mr. Enebrad's high risk skin condition, failing to diagnose his skin cancer, failing to offer any known and effective treatment or timely referral for specialized treatment.

STATEMENT OF THE CASE.

Factual Background

This is an appeal from a medical negligence/personal injury/wrongful death case. The plaintiffs/appellants are Lynette Enebrad, individually and as personal Representative of the Estate of Robert Enebrad.[1] The respondents are MultiCare Health Systems (hereinafter referred to as MHS), Healogics, Inc. and Mark H. Tseng, M.D.

Procedural History

Robert Enebrad and Lynette Enebrad, individually and as a marital community, filed suit against MultiCare Health Systems on February 6, 2014 claiming medical negligence in losing a biopsy report that resulted in a two month delay diagnosing squamous cell carcinoma (skin cancer) resulting in a delay of known and effective treatment to increase Mr. Enebrad's chances of a better outcome . CP 1-12. On March 26,2014 MHS files its Answer and Third Party Complaint. CP 13-21. MHS filed a third party complaint against Defendant Healogics, an entity with a contractual agreement to operate the Wound Healing Center at MultiCare Auburn Medical Center where Mr. Enebrad was treated for a non-healing wound on his left forearm. Mark H. Tseng, MD was Mr. Enebrad's treating physician at the Wound Healing Center.

On June 13, 2014 MHS moves for summary judgment. In support of its motion MHS filed the declaration of Dr. Dan Lanz, a dermatopathological physician expert who opined "…it is my opinion, on a more probable than not basis, to a reasonable degree of medical certainty, Mr. Enebrad has had squamous cell skin cancer for years. Squamous cell skin cancers are quite

[1] Mr. Enebrad died from complications related to his cancer on October 19, 2014 at the UW Medical Center.

advanced by the time they ulcerate, and ulceration as significant as Mr. Enebrad's indicates that the tumor had been in that location for a significant amount of time." Dr. Lantz's declaration implicated Dr. Von Chang, a family practice physician and employee of MHS, and other MHS medical staff who failed to diagnose and treat Mr. Enebrad's squamous cell cancer over the years he was a patient at the Kent MultiCare Family Practice clinic. Plaintiff's initial focus in the lawsuit was MHS's not having in place a tracking system that would alert medical staff, including health care providers in MHS's Wound Healing Clinic of critical biopsy test results to insure timely diagnosis and referral for specialty treatment, including skin cancer. MHS defended initially claiming when Mr. Enebrad received a referral to MHS's Wound Healing Center his cancer was too advanced and losing the biopsy report causing a two month delay in treatment did not result in Mr. Enebrad's left arm amputation or, ultimately, death. CP 37. Realizing its mistake MHS later withdrew Dr. Lanz's declaration from consideration at the summary judgment hearing.

In opposition to the summary judgment motion Plaintiffs filed a declaration of Jason Ko, MD. Dr. Ko was Mr. Enebrad's attending plastic surgeon at Harborview. CP 86-94. Dr. Ko declared "In my opinion, the failure by MultiCare Auburn Medical Center and The Wound Healing Clinic staff to notify Dr. Tseng of the biopsy diagnosis of well differentiated squamous cell carcinoma was a departure from the expected standard of care and resulted in a delay in diagnosis and loss of the chance of a better outcome for Mr. Enebrad." CP 93. Dr. Ko further opined "…The delay in diagnosis caused a delay in known and effective treatments whose purpose is to significantly increase a patient's chance of a better outcome, including Mr. Enebrad." CP 94.

The summary judgment hearing was continued several times, with Dr. Tseng and Healogics, Inc. being added as party defendants. All defendants joined in a motion for summary judgment. Plaintiffs file a declaration from H. Thomas Temple, MD, an oncologist in opposition. Dr. Temple declared "It is my opinion, within a reasonable degree of medical probability, that MultiCare Health Systems failed to exercise the degree of skill, care, and learning expected of reasonably prudent health care employees and physicians acting the same or similar circumstances at the time of the care or treatment of Robert Enebrad. It is further my opinion that had MultiCare Health Systems complied with the standard of care that Robert Enebrad's squamous cell carcinoma would likely have been cured and Mr. Enebrad would not have had his arm amputated and would have survived his cancer." CP at 827. Dr. Temple, consistent with MultiCare's own expert Dan Lantz, MD, further opined "It is my opinion that Mr. Enebrad likely had a cancerous lesion within the scar on his left forearm at the time of …he received his physical by Dr. Chang on January 18, 2013. Dr. Change departed from the standard of care by failing to note the lesion…..[a]t the likely stage of Mr. Enebrad's cancer on January 18, 2013 he would have had a 98% chance or better to not only avoid amputation of his left forearm but to survive his disease." CP 828.

The trial court granted summary judgment to Dr. Tseng and Healogics, Inc. and, narrowly, to MHS relative to all medical negligence claims arising from Dr. Tseng's care of Mr. Enebrad at the Wound Healing Center within MultiCare Auburn Medical Center beginning August 12, 2013. The trial court found there were material questions of fact precluding summary judgment against MHS relative to Dr. Chang's care provided to Mr. Enebrad on January 18,, 2013. The trial court chose to restrict the plaintiff's claims to the single day Mr. Enebrad was

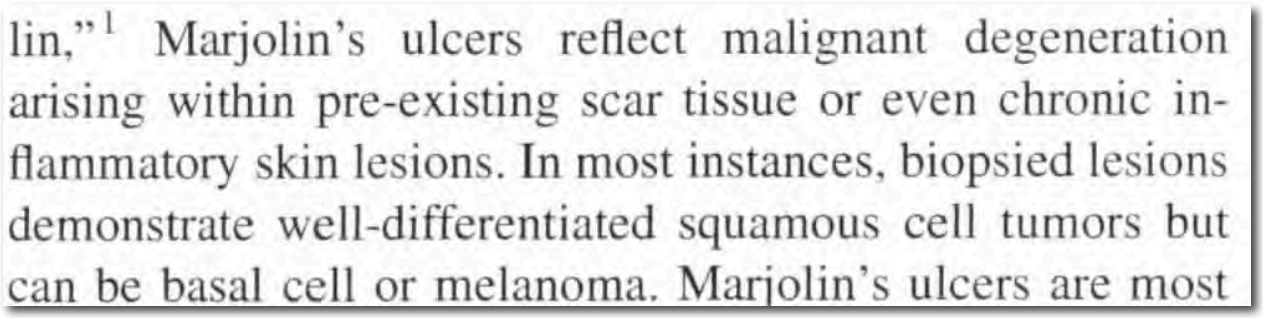
examined by Dr. Von Chang on January 18, 2013 and did not permit any claims or arguments of departures from the standard of care by other MHS medical staff and employees involved in Mr. Enebrad's care for the years leading up to the January 18, 2013 exam by Dr. Chang. CP 679-683; CP 631-635; CP 912-913.

Background Facts

Squamous cell carcinoma, a highly curable form of skin cancer, existed for years within a skin graft on Robert Enebrad's left forearm. (VRP at 534:5-16, Direct testimony of defense expert Omar Sangueza, MD). Squamous cell carcinoma has nearly a 100% cure rate if detected early. (VRP 195:7-23, testimony of Von Chang, MD). Death is an uncommon outcome of nonmelanoma skin caners. (VRP 195:23).

Mr. Enbebrad had undergone a skin graft procedure on his left forearm in 2002. (VRP 551). After the skin graft procedure in 2002 he would, from time to time, develop inflammatory skin lesions or ulcers within the borders of the scar tissue of the skin graft. (VRP 551:8-10.) MultiCare knew Mr. Enebrad experienced chronic inflammatory skin lesions within his skin graft since 2002. Chronic inflammatory skin lesions put patients at risk for developing full-blown Marjolin's ulcer (a form of squamous cell carcinoma). (VRP 551:11-18).

At trial, defense expert Omar Sangueza, MD, a dermatopathologist, cited as reliable authority exhibit 134, a peer reviewed medical journal article Pekarek B, Buck S. and Osher, L., *A Comprehensive Review on Marjolin's Ulcers: Diagnosis and Treatment*, Journal of the American College of Certified Wound Specialists, Vol. 3, No. 3, September 2011. The authors noted in the article:


lin,"[1] Marjolin's ulcers reflect malignant degeneration arising within pre-existing scar tissue or even chronic inflammatory skin lesions. In most instances, biopsied lesions demonstrate well-differentiated squamous cell tumors but can be basal cell or melanoma. Marjolin's ulcers are most

Dr. Sangueza agreed with the author's description of Marjolin's Ulcer. VRP 550: 6-9. Dr. Sangueza testified, on cross-examination, he reviewed Mr. Enebrad's records from MultiCare that "went back years" (VRP 551:1); he was aware "after the skin graft procedure, he [Mr. Enebrad] would from time to time develop ulcers within that scar tissue? A. Yes." (VRP 551: 8-10); "…when we describe it happening from time to time, that fits what we're talking about of chronic inflammatory skin lesions, right? A. …That's correct." (VRP 551: 11-14). Dr. Sangueza also testified about reviewing a biopsy report and biopsy slides taken August 12, 2013 from Mr. Enebrad's left forearm showing "well-differentiated" squamous cell carcinoma "A. That's correct." (VRP 558:13-19, see also VRP 563:8-11). Dr. Sangueza testified chronic inflammatory processes put the patient "at risk for finally developing the full-blown Marjolin's ulcer, right? A. Right." VRP 551:15-18.

Lynette Enebrad, Robert Enebrad's widow, testified about the condition of her husband's left forearm in 2012. (VRP 338:1). Mrs. Enebrad testified about certain portions of the skin graft being "very scaly." (VRP 338:17). "And I think that's what caused this itch a whole lot every single night. But he'd scratch them and accidentally opened them…"(VRP 338:20-22). Mrs. Enebrad described giving her husband Neosporin and the wound would "heal. It actually would close. In another…few weeks or a month later, it gets itchy again. An then he would scratch it in

his sleep, and it would open again." (VRP 339:9-14). Mrs. Enebrad described the lesion within the skin graft as "dime sized" in 2012. (VRP 339:17/340:4-6).

Mrs. Enebrad's observations of her husband's chronic skin lesions before 2013 is supported by the testimony of Wanda Roberton, MD, an attending physician called by the defense at trial.[2] Dr. Roberton was Mr. Enebrad's attending physician at the CRC Clinic in Renton, i.e. the clinic where Mr. Enebrad received his methadone treatment. (VRP 593:6-21; 597:17-19).

Dr. Roberton testified she examined Mr. Enebrad's skin. (VRP 597:20-25). Dr. Roberton testified Mr. Enebrad had "skin issues." (VRP 598:1-2). Dr. Roberton testified Mr. Enebrad had an "open lesion on the left arm" when she examined Mr. Enebrad on April 3, 2009. (VRP 597:11-12; 598: 7-9). Dr. Roberton referred Mr. Enebrad for treatment to his "private doctor….as soon as possible regarding the left arm infection." (VRP 598:14-16). Mr. Enebrad was seen one week later at a Kent MultiCare clinic by a physician's assistant. (VRP 608:1-21). Exhibit number 118, page one of Dr. Roberton's physical exam notes of April 3, 2009, was admitted. (VRP 598:17-21). On cross examination plaintiff's counsel marked page two of Dr. Roberton's physical exam notes as exhibit 118A and the court admitted the exhibit. Dr. Roberton read from page two of the intake physical note "[l]eft forearm skin graft – skin graft scars, bandage on the open lesion. One open lesion." (VRP 607:20-23). Dr. Roberton acknowledged Mr. Enebrad's family physician in May 2010 was Robert Baucke, MD of the Kent MultiCare Clinic. (VRP 609:4-7). Dr. Roberton testified the "marks or these lesions in the skin graft would not likely go away, would they likely be there in 2012 as well? A. Yes." (VRP 611:19-25). Finally, Dr. Roberton was of the opinion that

[2] Defendant called Dr. Roberton as a witness and extensively questioned her about Mr. Enebrad's drug use. The vast majority of defense counsel's inquiries had to do with drug use.

a physician should be able to observe the marks or lesions and should write or note it in the chart. (VRP 612:2-12). Nici Enebrad, Robert Enebrad's daughter, testified that she could see the scarring in 2012 left by the lesions after they healed. (VRP 239/240:20-25/1-4).

Lynette and Nici Enebrad's and Dr. Roberton's testimony was corroborated by Shirley Enebrad: "Q. Now let's shift gears a little bit. When did you hear the news that Bobby was sick? A. He called me and said – well, I know about the ulcers on his arm because that was there for years. And he called me, and he said that he'd been having experiences with it where it would come and go and he would have to put Neosporin on it and that he accidentally scratched it and it wouldn't stop bleeding…" (VRP 221:20-25).

Robert Enebrad was seen by Von Chang, MD at the Kent MultiCare Clinic on January 18, 2013 for an annual physical exam "Bobby came to me as a brand new patient in that first visit, January 18th, 2013." (VRP 134:20-21). Dr. Chang's chart note of January 18, 2013 was marked and admitted as exhibit 3. (VRP 144:18-25). Dr. Chang testified he only "vaguely" remembered the visit and his "recall" was based on his review of the chart notes. (VRP 144:14-23). Dr. Chang was asked "Q. So my question is: You did not diagnose skin cancer on January 18, 2013, did you? A. No." (VRP 172:2-4). Dr. Chang was asked whether he agreed with the following statement "Suspicious spots should trigger a referral to a dermatologist because the urgency of the situation can only be determined by expert examinations and by a biopsy." Dr. Chang answered "A. In general, yes." (VRP 190:7-11). Dr. Chang agreed that "squamous cell carcinoma …are expected to be more frequent in individuals older than 45 to 50 and more common in males than females…A. I think I would agree, yes." (VRP 190-191:23-25/1-2). On January 18, 2013 Robert Enebrad was 53 years old. (VRP 191:3-5). Dr. Chang agreed that early detection increases the

patient's ability to beat skin cancer "A. I agree." (VRP 192:1-3). "Q. And so you're trying to increase the patient's chances of a better outcome by making the earliest possible referral to the skin specialist, right? A. I agree for – for – yes, for a diagnosis to confirm it and to manage – ultimately to manage it." (VRP 192:4-8).

In sum, by the time Robert Enebrad arrived for an annual physical examination by Dr. Chang on January 18, 2013 he had been seen by multiple MultiCare health care personnel over the years for lesions occurring within the skin graft on his left forearm yet no one diagnosed or sought to investigate whether the observable lesions represented skin cancer. The medical records in evidence, the testimony of defendant's own experts, the testimony of Dr. Roberton and the Enebrad family members presented overwhelming evidence that suspicious lesions were present and there to be seen, noted and acted upon yet nothing was done by MultiCare to intervene on Mr. Enebrad's behalf.

Mr. Enebrad was deposed on October 17, 2014 on his death bed by lawyers from MultiCare, Healogics, Inc. and the attorney for Dr. Tseng, the Wound Healing Center attending physician. Mr. Enebrad's deposition was read to the jury on April 27, 2016. (VRP 251-252). Defendant MHS argued at trial there were no visible lesions or suspicious scarring present within Mr. Enebrad's skin graft on his visit with Dr. Chang on January 18, 203. The basis for defendant's argument was 1) Dr. Chang did not record any findings of lesions; 2) the growth rate of the lesion from August 7, 2013 when it was first noted by Dr. Chang; and 3) the defense claim that Mr. Enebrad testified in his deposition that a lesion[3] first appeared in either February or April 2013. ("Dr. Sangueza expressed opinions at that time regarding the sort of natural history

[3] Merriam-Webster's MedlinePlus medical dictionary defines lesion as "an abnormal change in structure of an organ or part due to injury or disease; especially : one that is circumscribed and well defined."

of it and that, in his opinion, in January there would not have been a visible ulcer based on " what was seen in August, among other things. VRP 516:7-9 – colloquy by defense counsel during argument during motions in limine); (Do you have an opinion in terms of reasonable medical probability whether in January of 2013 there would have been a visible lesion? A. Probably not. Probably not. It's not 100 percent sure, but, you know, probably not because these lesions, they grow very fast. They tend to grow very fast. VRP 544:11-17 – testimony of defense expert Omar Sangueza, MD); (A. My opinion is that he did not have a visible lesion January 2013. Q. (By Mr. Johnson) And what leads you to that conclusion? A. The first would be Dr. Chang's record where he doesn't describe that lesion. The second would be the tremendous growth that occurred in subsequent visits documented from August 7th through his surgery in November. Those would be my two reasons for that opinion. VRP 581:17-24 – testimony of defense expert Stacy Lewis, MD); ("I believe there was no ulcer present on Mr. Enebrad's left arm at the site of his skin graft in January of 2013. VRP 406:13-14; "Mr. Enebrad, in his deposition…said that the ulcer started in April of 2013, not January but April." VRP 406:2023 – testimony of defense expert Ken Carson, MD).

Mr. Enebrad's deposition testimony read to the jury was quite different from what was represented by the defense experts. MHS's attorney asked Mr. Enebrad during the deposition "·Q.· ·Okay.· Let me ask you:· When did you first notice that this ulcer had *come back* on your arm -- your left arm? A.· ·Right before I went to Dr. Chang."[4] (page 16:6-19 of deposition) emphasis added. MHS's attorney asked Mr. Enebrad to "draw on Exhibit 1, …how big that ulcer was when you first noticed that you were getting *a return of your ulcer*?...A. (Witness complies.) Q. Okay. So

[4] Mr. Enebrad mistakenly recalled first seeing Dr. Chang at the Kent MultiCare Family Clinic in June. There is no material dispute that the first time Mr. Enebrad saw Dr. Chang was January 18, 2013.

that would have been – you said a couple months before June, so that would have been like April or so of 2013? A. Yes." (Robert Enebrad dep. at 18:8-17). Emphasis added. It is interesting to note that "a couple of months" before Mr. Enebrad visited Dr. Chang for the very first time in January 2013 places the time frame in October 2012, i.e. the same time frame Dr. Chang recorded in his chart note of August 7, 2013. See Exhibit 103, MultiCare Health System 8/7/2013 Office Visit with Dr. Chang. Again, this is further corroborating evidence of the presence of a lesion before the January 18, 2013 visit with Dr. Chang.

At the August 7, 2013 office visit Dr. Chang diagnosed "Open wound of upper arm, without mention of complication." Ex. 103 at bates stamped page MHS 000280. Again, it is beyond dispute that Dr. Chang did not diagnose squamous cell skin cancer (VRP 206:14-17; VRP 207:16-17)), did not record any such concern in his chart and did not discuss any such concern with anyone (VRP 206:23-25), including his patient Robert Enebrad (VRP 208:5-9). On August 7, 2013 Dr. Chang referred Mr. Enebrad to the Wound Healing Center at MultiCare Auburn Medical Center for a consult on his non-healing wound. Ex. 103.

Mr. Enebrad was seen at the Auburn MultiCare Auburn Medical Center's Wound Healing Center beginning on August 12, 2013. (CP 42 and deposition of Mark H. Tseng, MD, 32:4-6). Dr. Tseng wrote in his chart note under Wound History "53 year old [male right hand dominant with] left elbow open wound. [Patient] said it started one year ago." CP 29, ex. B (6.13.14 declaration of MHS attorney Michelle Garzon).

It was noted in the Wound Healing Center's chart notes for August 7, 2013 that Dr. Tseng testified that "if the physician suspects cancer, for example skin cancer, that diagnosis must be put at the top of the differential diagnoses list, right?...A. Correct." (Dep. of Tseng 25:9-

20). Tseng testified if a physician fails to take a biopsy in a suspected skin cancer case it is a violation of the standard of care. (Tseng dep. 25:21-25). It is also the responsibility of the physician to follow up and determine the results of the biopsy. (Tseng dep. 26:4-9). Patient safety requires it. (Tseng 26:10-15). If the physician doesn't follow up and determine the results of the biopsy "A. You're unable to adequately treat the patient...The skin cancer can continue to be left untreated…A. The disease can continue to progress." (Tseng 26:16-25; 27:1-3). The sooner you treat the patient's skin cancer the better chance the patient will have to survive the cancer. (Tseng 31: 2-5). For patient safety it is better to diagnose squamous cell skin cancer earlier in patients. (Tseng 31:21-24).

Dr. Tseng testified about potential treatments for squamous cell carcinoma, to include Mohs surgery. Dr. Tseng described this excisional surgery as a "known effective treatment". (Tseng 34:17-22). For patient safety it is better to get Mohs surgery done sooner because you want to give the patient a better chance of surviving. (Tseng 35:1-10).

Dr. Tseng was not sure whether the Wound Healing Center had "any protocols or procedures to ensure that the medical staff and nursing staff are made aware of lab results? A. I'm not sure…..But I would hope so, yes…So we can adequately treat the patient." (Tseng 37:9-22).

Dr. Tseng ordered a biopsy of Robert Enebrad's left forearm on August 12, 2013 "because you suspected squamous cell skin cancer? A. That's correct." (Tseng 38:16-22). Dr. Tseng acknowledged there is a specific treatment protocol for squamous cell carcinoma and that it is different from the treatment protocol for treating a non-healing forearm ulcers. (Tseng 39:11-20). "It's very different." (Tseng 39: 21-22).

Dr. Tseng took the biopsy from Robert Enebrad's left forearm. (Tseng 46:1-4). Dr. Tseng gave the biopsy to the nurse and instructed her to send it to the pathologist on the second floor of the MultiCare Auburn Medical Center for analysis. (Tseng 46:7-16). Dr. Tseng testified that it is important to have a pathology lab close by to the facility that is treating patients with squamous cell carcinoma, for patient safety, "A. So, you know, the patients can be – get the diagnosis earlier, usually….Q. …Get the diagnosis earlier so that the doctors can begin treating the patient earlier and – A. That's correct. Q. Okay. And try to prevent the cancer from spreading, right? A. That's correct." (Tseng 47:3-9). The biopsy report was completed within two days, on August 14, 2013. (Tseng 48:6-17). Dr. Tseng expected the biopsy report to be brought to his attention before he next saw Mr. Enebrad in the Wound Healing Center. (Tseng 48:18-22). Dr. Tseng testified if he received the report on August 14, 2013 he would have proceeded to get Mr. Enebrad into either Harborview or the University of Washington. (Tseng 49:5-24). The first mention in the Wound Health Center records authored by Dr. Tseng of transferring Mr. Enebrad's care to Harborview as September 30, 2013. (CP 29, exhibit C at bates stamp page 500).

Dr. Tseng next saw Mr. Enebrad on August 19, 2013 and he did not have the biopsy report. (Tseng 52:21-25). Mr. and Mrs. Enebrad asked Dr. Tseng about the biopsy results at the August 19, 2013 visit. Dr. Tseng testified that he "repeatedly" asked the front desk and the nurse at the Wound Healing Center where the report was. (Tseng 53: 8-21).

Dr. Tseng acknowledged that he never recorded the term "squamous cell carcinoma" or "skin cancer" in his treatment records of Mr. Enebad. (Tseng 53:22-25; 54:1-5). Dr. Tseng next saw Mr. Enebrad on August 26, 2013 and still did not have the biopsy report which caused him to

ask the front desk and the nurse for its whereabouts. (Tseng54:15-23). Dr. Tseng saw Mr. Enebrad again on September 9, 2013 and he recorded a diagnosis of "left arm ulcer" and did not write a diagnosis of squamous cell skin cancer. (Tseng 57:2-15; 58:1-4). Dr. Tseng did not "write anyplace in the chart that your working diagnosis was squamous cell skin cancer? A. No, I don't believe so." (Tseng 58:17-20). Dr. Tseng saw Mr. Enebrad next on September 23, 2013. (Tseng 58:21-24). On the September 23, 2013 visit Dr. Tseng discussed with Mr. Enebrad transferring his care to Harborview. (Tseng 59:6-12).

Dr. Tseng first saw the biopsy report diagnosing squamous cell skin cancer in October 2013. (Tseng 66:4-12). Dr. Tseng then called Mr. Enebrad and left a voice mail "I'm calling from the Wound Care Center. Please me a call back. My number is 718-541-1367. Yeah, I just want to kind of regarding the wound and, you know, the – you have a skin cancer on that wound and that's why it broke down. So please give me a call as soon as possible. Okay? Thank you and have a good day. Bye-bye." (Tseng 67:1-6).

Dr. Tseng testified that the biopsy report had been faxed to his office. Dr. Tseng found the biopsy report in a pile of correspondence. Dr. Tseng said he was not expecting the biopsy report to be faxed to his office. (Tseng pp. 68-70). Dr. Tseng was asked "Q. Yeah. Is it standard of care for the biopsy report to have been sent to the Wound Healing Center? A. Yes." (Tseng 70:23-25). "Q. Okay. Was it your expectation at that time that any biopsy report would be faxed to the Wound Healing Center? A. Absolutely." (Tseng 71:3-6). Dr. Tseng said "A. It is my expectations that a report will be, you know, to my attention when I see the patient at the Wound Care Center. Q. Okay. But that didn't happen in Mr. Enebrad's case, did it? A. No, it did not." (Tseng 72:2-7). Dr. Tseng said that violates the standard of care. (Tseng 72:8-9).

Dr. Tseng next saw Mr. Enebrad on September 30, 2013. (Tseng 72:11-14). Dr. Tseng noted that Mr. Enebrad's wound was now "foul smelling." (Tseng 72:11-15). Dr. Tseng saw Mr. Enebrad for the last time on October 7, 2013. "Q. ..You didn't write down any diagnosis of skin cancer on that date, did you? A. I don't believe so. Q. Okay. But you recommended transfer to Harborview? A. I recommended -- yes, at that time, he said that he has an appointment with Harborview…" (Tseng 74:16-24).

Dr. Tseng testified he went to his medical director at the Wound Healing Center and "told him my concern and – you know, about the pathology report, and, you know, we need to hold a meeting so something like this doesn't happen again – Q. Yeah. A. – for patient safety." (Tseng 78:4-8). "I was angry that this happened and, you know, I would be angry if it happened to any other person's patient." (Tseng 78:11-15). Dr. Tseng asked for and received a meeting with the entire staff of the Wound Healing Center. (Tseng 81:3-8).

Dr. Tseng confirmed that he was not aware of anything in the medical records where any doctor, any clinician, anyone, described Mr. Enebrad's wound as being squamous cell carcinoma before he was admitted to Harborview on October 8, 2013. (Tseng 110:15-24).

Tom Fain, attorney for Healogics, during Dr. Tseng's deposition, handed Dr. Tseng a copy of a screen shot provided by MultiCare that showed confirmation the biopsy report was faxed to Dr. Tseng's office on August 14, 2013. (Tseng 114:12-19).

CP 42, the declaration of John P. Walsh, includes exhibit E containing the October 8, Plastic Surgery – Outpatient Record dictated by Martin Paukert, MD and co-signed by Jason Ko, MD, Mr. Enebrad's attending plastic surgeon at Harborview.

Of note is Mr. Enebrad's report to Dr. Paukert and Dr. Ko that "he had essentially no problems with it until approximately 1 year ago. He began developing breakdown over the graft on the dorsal aspect of his forearm just distal to the elbow…this was proceeded to form a dime-sized area of ulceration that slowly worsened." Again, Mrs. Enebrad was asked to describe the lesion she saw in 2012. (VRP 338:1-3). Mrs. Enebrad testified "…but it was not large. It was pretty small…dime size…" (VRP 339:15-17).

Defense expert Kent Carson testified on cross "Q. Okay. If it was pimple size or dime size how big is that in centimeter? A. I don't know what a pimple size is. But a dime is probably a little more than a centimeter. Q. …a family practice doctor should be able to – to should notice, right? A. I have no doubt that a quarter – or dime size ulcer would be noted, yes.." (VRP 449:14-22).

The overwhelming substantial evidence was that a suspicious lesion was present within Mr. Enebrad's left skin graft scar for years before his admission to Harborview Medical Center in October 2013.

ARGUMENT

I. THE TRIAL COURT ERRED IN PERMITTING UNDULY PREJUDICIAL EVIDENCE OF RECREATIONAL DRUG USE.

A. Mr. Enebrad's past recreational drug use had scant probative force and was offered as a pretext to invite the jury to judge the plaintiff's character.

By allowing the jury to consider Mr. Enebrad's past recreational drug use the trial court asked the jury to perform the impossible task of ignoring a highly inflammatory and prejudicial topic. The prejudicial impact was hardly blunted by the court's attempt to "limit" the jury's consideration of drug use to the issues of life expectancy and contributory negligence. Defendant and his experts seized the opportunity to talk about drug use at every conceivable opportunity and with every single witness to take the stand. It became abundantly clear that defendant, through repetition and over-emphasis, was bent on putting Mr. Enebrad's character squarely at issue. Defendant presented no specific facts that Mr. Enebrad's past drug use impacted his life expectancy. The trial court allowed defense experts to render conclusory opinions that lacked adequate foundation. Defendant successfully shifted the focus away from its own failings and choices. Defendant cast Mr. Enebrad as unworthy of receiving the same quality medical care as anyone walking into the Kent Primary Care Clinic. The truth is undiagnosed and untreated cancer in any patient is dangerous regardless of the patient's background. Mr. Enebrad was entitled to competent medical care and he didn't get it. Inflammatory evidence of past drug use was not helpful to the jury's determination of MultiCare's accountability for his harms and losses

B. Evidence of past recreational drug use, as anticipated, had a prejudicial impact on the jury.

Admission or exclusion of evidence under ER 403 is in the discretion of the trial judge. *State v. Coe*, 101 Wn.2d 772 (1984). The trial court engages in the process of balancing the probative value of evidence against its potential prejudicial impact. *State v. Coe*, *supra*. Rule 403 allows the trial court to

exclude evidence that would result in "unfair prejudice." Unfair prejudice is generally understood to mean prejudice caused by evidence that is more likely to arouse an emotional response than a rational decision by jurors. 5 Wash. Prac., Evidence Law and Practice § 403.3 (5th ed.); *White v. Cohen*, 635 F.2d 761 (9th Circuit 1981). The major function of ER 403 is to exclude "matter of scant or cumulative probative force, dragged in by the heels for the sake of its prejudicial effect."

The issue of Mr. Enebrad's past drug usage was presented in a cumulative fashion through witness after witness and through multiple exhibits displayed on a 10 foot screen in every segment of the trial. There was nothing limiting about it. "In view of society's deep concern today with drug usage and its consequent condemnation by many if not most, evidence of drug addiction is necessarily prejudicial in the minds of the average juror." *State v. Renneberg*, 83 Wn.2d 735 at 737, 522 P.2d 835 (1974). Evidence of drug use is admissible for impeachment only where a reasonable inference exists that the individual was under the drug's influence either during the event or when testifying. *State v. Tigano*, 63 Wn.App. 336, 344, 818 P.2d 1369 (1991), review denied, 118 Wn.2d 1021 (1992). Evidence of drug use on other occasions, or of drug addiction, is generally inadmissible on the ground that it is impermissibly prejudicial. *Tigano*, 63 Wn.App. at 344-45 (citing *State v. Renneberg*, 83 Wn.2d 735, 737, 522 P.2d 835 (1974)).

How do we know that substance abuse issues had an effect on the jury's view of the case? Here is the very first question asked by a juror in the case: "THE COURT: Doctor Chang, the first question (from the juror) reads: Was Robert Enebrad completely sober during his visits with you?" (VRP 210:6-7). It was through this lens the jury was asked to evaluate the case. The repeated reference to drug usage "dragged in by the heels for the sake of its prejudicial effect" undeniably had its effect early was reinforced throughout the trial.

C. Defendant failed to provide substantial evidence, based on specific facts, that Mr. Enebrad's life expectency was shortened and the trial court erred in allowing defense expert testimony based on speculation.

The case of *Kramer v. J.I. Case Mfg. Co*, 62 Wn. App. 544, 556-560 (1991) is directly on point. In *Kramer*, the plaintiff moved in limine to exclude evidence of his past marijuana and alcohol use. The defendant in *Kramer*, as here, argued past substance use was relevant on the issue of life expectancy and future wage loss. The defendant in *Kramer* represented expert witness testimony would establish that substance abusers have decreased work-life expectancy and earning capacity. *Kramer*, 62 Wn.App. at 556. The court deferred ruling on whether to allow the evidence pending briefing by the parties and an offer of proof by defendant. *Kramer* at 556-557. Just as in *Kramer* defendant here was allowed to cross-examine plaintiff's family members on the issue of Mr. Enebrad's past recreational drug use. The cross-examination of lay witnesses in *Kramer* was allowed without any offer of proof establishing that the evidence was relevant to the injured plaintiff's employment. In Mr. Enebrad's case his family members were cross-examined on Mr. Enebrad's past drug use without an offer of proof of relevance to his life expectancy and the extent of drug use at the time of his treatment at MHS in 2010 through the time of his death from cancer in October 2014.

In *Kramer* at 62 Wn.App. at 559 the court held "absent evidence of long-term, irreversible, adverse effects from marijuana smoking, it is difficult to discern the probative value of Kramer's pre-accident marijuana smoking practices. Third, nothing in the record indicates that Kramer's drug and alcohol use prior to the 1985 accident affected his employment. Absent such evidence, the trial court had no basis to conclude that Kramer's substance abuse affected his earning capacity or work-life expectancy." Here, defendant did not offer any proof that Mr. Enebrad's previous drug usage had "long-term, irreversible, adverse effects" that likely would shorten his life expectancy. Yes, Mr. Enebrad's past IV drug usage resulted in the need for skin graft surgery. Yes, skin grafts and burn wounds place patients at higher risk of developing skin cancer. But if the scar is appropriately monitored by medical personnel any squamous cell skin cancer has nearly a 100% cure rate. Hardly an "irreversible, adverse effect." Unlike *Kramer* the trial court allowed defense medical opinion witness Michael Kovar, MD, to opine "I just

didn't see him [Mr. Enebrad] surviving very long." (VRP 485:14). Defense counsel also asked his witness, Dr. Kovar, "Q. Doctor, do you have an opinion, in terms of reasonable medical probability, whether Mr. Enebrad's life expectancy would be impacted by his struggles with addiction? A. I do. Q. And what is that? A. That it would be considerably shortened, but I couldn't place a time on that." (VRP 485:17-24).

Dr. Kovar failed to provide specific facts reasonably relied upon by qualified experts to support his conclusion that Mr. Enebrad wouldn't survive "very long." The record, on its face, directly contradicts Dr. Kovar's statement. Mr. Enebrad used herion "off and on"over a 25 year period from 1980 until his skin graft in 2002. (Ex. 114 – CRC Renton Clinic – 3/19/09 Patient Data Sheet). Defense expert Kent Carson also gratuitously mentioned to the jury that "…, such as Mr. Enebrad, who since the 1980s was injecting heroin into his arm." (VRP 391:14-16). Mr. Enebrad experienced years when he was completely off heroin from 2001/2002 until 2008/2009, when he again enrolled in the CRC methadone program. (Ex. 118 – CRC Renton Clinic -4/3/09 Intake Physical – PG 1). Ex. 126, CRC lab results, offered by defendant, show sustained periods with no positive testing for heroin.

"We recognize the broad discretion afforded a trial court in balancing the prejudicial impact of evidence against its probative value. E.g., *State v. Coe*, 101 Wn.2d 772, 782, 684 P.2d 668 (1984). Nevertheless, the circumstances of this case lead us to conclude that by allowing Kramer to be cross examined about his substance abuse, the trial court abused its discretion. First, the ruling was premature because Case had not made an offer of proof establishing the probative value of the evidence. Cf. *Wilson v. Lund*, 74 Wn.2d 945, 949, 447 P.2d 718 (1968) (improper for court to find potential evidence irrelevant without an offer of proof or its equivalent). This is a particularly significant problem because the trial court ultimately decided to exclude expert testimony about the effect of substance abuse on work-life expectancy. Second, absent evidence of long-term, irreversible, adverse effects from marijuana smoking, it is difficult to discern the probative value of Kramer's re- accident marijuana smoking practices. Third, nothing in the record indicates that Kramer's drug and alcohol use prior to the 1985 accident effected his

employment. Absent such evidence, the trial court had no basis to conclude that Kramer's substance abuse affected his earning capacity or work-life expectancy."

Here, the Court has no basis to conclude that Mr. Enebrad's past drug use had any long-term, irreversible, adverse affects on his life expectancy. Mr. Enebrad had stopped using heroin years before the missed cancer diagnosis in this case. Mr. Enebrad's overall health was good save for the chronic skin condition of his forearm graft.[5] Defendant has the burden of proving its affirmative defense and has not come forward with admissible evidence. Defendant cannot point to any medical finding or condition that would have reduced Mr. Enebrad's life expectancy.

In regard to ER 401, comments and speculative opinion testimony are derogatory, prejudicial, and demeaning to the deceased. Such questions are meant to cast deceased as a bad character. As to ER 404, these types of inquiries would mislead and confuse the jury. *White v. Peters*, 52 Wn.2d 824 (1958*), Irrigation & Dev. Co. v. Sherman*, 106 Wn.2d 685 (1986), *Bohnsack v. Kirkham*, 72 Wn.2d 183 (1967) *Madill v. Los Angeles Seattle Motor Express*, 64 Wn.2d 548 (1964), *Ward v. Zeugner*, 64 Wn.2d 570 (1964), *Murray v. Amrine*, 28 Wn. App. 650, 657 (1981), *Cameron v. Boone*, 64 Wn.2d 420 (1963).

II. The Trial Court Erred In Granting Summary Judgment Because Plaintiff Offered Proof Of A Departure From The Standard Of Care By All Defendant's And Resultant Harm.

A. Plaintiff provided expert opinion that plaintiff's loss of chance of a better outcome were "significantly" decreased.

The definition of "Significant." Merriam-Webster.com. Merriam-Webster, n.d. Web. 21 Mar. 2017, includes "of a noticeably or measurably large amount" and "probably caused by something other than mere chance" "statistically significant correlation between vitamin deficiency and disease". Here, Dr. Jason Ko, MD, Robert Enebrad's board certified attending

[5] Mr. Enebrad was not suffering any effects from Hepatitis C and was not symptomatic. There was no evidence offered at trial that Mr. Enebrad was suffering any untoward effects from that curable disease.

physician at Harborview Medical Center signed a declaration stating "Because MultiCare Auburn Medical Center and its agent operating the Wound Healing Center did not have a tracking and reporting system in place to promptly communicate the biopsy result of squamous cell skin cancer to Dr. Tseng this caused a delay in diagnosis of nearly 8 weeks. In my opinion, this represented a departure from the standard of care expected of a reasonably prudent hospital and wound clinic under the circumstances. The delay in diagnosis caused a delay in known and effective treatments whose purpose is to significantly increase a patient's chance of a better outcome, including Mr. Enebrad." CP at 94.

In *Mohr v. Grantham*, 172 Wn.2d 844 (Wash. 2011) 262 P.3d 49, our Supreme Court addressed the question whether a patient has a cause of action for the loss of the chance at a better outcome. *Mohr* at 846-47. The *Mohr* court held:

> In other words, they claim that negligence caused Mrs. Mohr a loss of the chance of a better outcome. In Herskovits v. Group Health Cooperative of Puget Sound, 99 Wash.2d 609, 611, 614, 664 P.2d 474 (1983) (Dore, J., lead opinion), this court recognized the lost chance doctrine in a survival action when the plaintiff died following the alleged failure of his doctor to timely diagnose his lung cancer. This case compels consideration of whether, in the medical malpractice context, there is a cause of action for a lost chance, even when the ultimate result is some serious harm short of death. We hold that there is such a cause of action and, accordingly, reverse the order of summary judgment.

Id.

The *Mohr* Court quoted from the plurality in Herskowitz and noted:

> Though divided by different reasoning, this court reversed the trial court, finding that Herskovits's lost chance was actionable.
>
> The lead opinion, signed by two justices, and the concurring opinion, which garnered a plurality, agreed on the fundamental bases for recognizing a cause of action for the loss of a chance. The lead opinion explained:

> To decide otherwise would be a blanket release from liability for doctors and hospitals any time there was less than a 50 percent chance of survival, regardless of how flagrant the negligence. Id. at 614, 664 P.2d 474.
>
> The plurality similarly noted that traditional all-or-nothing causation in lost chance cases " ‘ subverts the deterrence objectives of tort law.’ "[262 P.3d 494] Id. at 634, 664 P.2d 474 (Pearson, J., plurality opinion) (quoting Joseph H. King, Jr., Causation, Valuation, and Chance in Personal Injury Torts Involving Preexisting Conditions and Future Consequences, 90 YALE L.J. 1353, 1377 (1981)). Both opinions found that " the loss of a less than even chance is a loss worthy of redress." Id. With emphasis, the lead opinion agreed, stating that " ‘ [n] o 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. ’ " Id. at 618, 664 P.2d 474 (Dore, J., lead opinion) (quoting James v. United States, 483 F.Supp. 581, 587 (N.D.Cal.1980)).

[emphasis supplied].

The trial court in Mr. Enebrad’s case granted summary judgment because plaintiff’s expert’s did not assign a specific percentage to his loss of chance of a better outcome. In *Volk v. DeMeerlee*r, 187 Wn.2d 241, 386 P.3d 254 (2016), our Supreme Court affirmed it was not error to admit an expert’s affidavit that did not provide a specific percentage of decreased loss of chance of a better outcome:

> Still, despite Ashby's disagreement with Knoll's conclusions, *the trial court did not err by admitting Knoll's affidavit*. ER 702 states that a court may permit a witness [386 P.3d 277] qualified as an expert to provide an opinion regarding " 'scientific, technical, or other specialized knowledge'" if such testimony " 'will assist the trier of fact.'" State v. Yates, 161 Wn.2d 714, 762, 168 P.3d 359 (2007) (quoting State v. Cauthron, 120 Wn.2d 879, 890, 846 P.2d 502 (1993), overruled in part on other grounds by State v. Buckner, 133 Wn.2d 63, 941 P.2d 667 (1997)). Admission is proper provided the expert is qualified and his or her testimony is helpful. Id. The expert's opinion must be based on fact and cannot simply be a conclusion or based on an assumption if it is to survive summary judgment. Melville v. State, 115 Wn.2d 34, 41, 793 P.2d 952 (1990). Unreliable testimony is not considered helpful to the trier of fact and should be excluded. Lakey v. Puget Sound Energy, Inc., 176 Wn.2d 909, 918, 296 P.3d 860 (2013) (citing Anderson v. Akzo Nobel Coatings, Inc., 172 Wn.2d 593, 600, 260 P.3d 857 (2011)). Importantly, speculation and conclusory statements will not preclude summary judgment. Elcon Constr., Inc. v. E. Wash. Univ., 174 Wn.2d 157, 169, 273 P.3d 965 (2012) (citing Greenhalgh v. Dep't of Corr., 160 Wn.App. 706, 714, 248 P.3d 150 (2011)). The concern about speculative testimony is that the trier of fact will be forced to speculate as to

causation without an adequate factual basis. Little v. King, 160 Wn.2d 696, 705, 161 P.3d 345 (2007).

[emphasis supplied].[6]

B. Plaintiff raised material issues of fact precluding summary judgment and it was improper for the court to resolve inferential disputes.

The just published Division I case of Bryan Kelley And Dorre Don LLC. V. Beverly L. Tonda, Et Al., March 27, 2017 reiterated the long standing rules applying to summary judgment:

> Some cases simply must be tried. In today's legal culture, there seemingly prevails a belief that all lawsuits are somehow, someway subject to resolution by dispositive motion. But that never has been—and never will be—true. Instead, even where, as here, all of the key participants and eye witnesses are long since dead, a trial is necessary when the material facts are not agreed.

The court went on:

> We review de novo a trial court's order granting summary judgment, performing the same inquiry as the trial court. MacMeekin v. Low Income Hous. Inst.,Inc., 111 Wn.App.188,195,45 P.3d570(2002). An order granting Summary judgment may be entered when there is no genuine issue of material fact and the moving party is entitled to judgment as a matter of law. CR 56(c). In Reviewing a summary judgment order, we view the facts and all reasonable inferences therefrom in the light most favorable to the nonmoving party. Holmquist v. King County, 182 Wn. App.200,207,328 P.3d 1000(2014). "The object and function of summary judgment procedure is to avoid a useless trial. A trial is not useless, but is absolutely necessary where there is a genuine issue as to any material fact." Barber v. Bankers Life & Cas.Co.,81 Wn.2d 140, 144, 500P.2d88(1972)." A material fact is one upon which the outcome of the litigation depends." Balisev.Underwood,62Wn.2d 195,199, 381 P.2d 966(1963). Importantly, "even if the basic facts are not in dispute, if the facts are subject to reasonable conflicting inferences, summary judgment is improper." Southside Tabernacle v. Pentecostal Church of God, Pac. Nw. Dist., Inc., 2Wn.App.814,821, 650P.2d 231(1982). Indeed, summary judgment

[6] In *Volk* at 272 the court stated "As part of Volk's medical malpractice claim, she asserts that Ashby's allegedly deficient treatment resulted in a loss of a chance for survival and better outcome for Schiering and her sons. Ashby contends that in order to establish a loss of chance claim, an expert opinion must state the conclusion in terms of a percentage of lost chance. We need not reach Ashby's argument about the requirement for an actual percentage. We affirm and hold the loss of chance doctrine does not apply to Volk's claim."

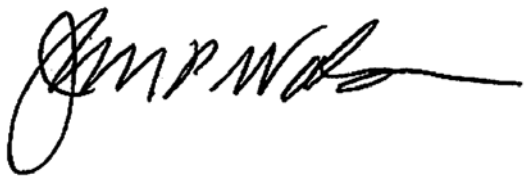
> procedures are not designed to resolve inferential disputes." Sandersv. Day, 2 Wn.App.393, 398, 468P.2d452(1970). "It seems obvious that in situations where, though evidentiary facts are not in dispute, different inferences may be drawn therefrom as to ultimate facts such as intent,...a summary judgment would not be warranted." Preston v. Duncan,55 Wn.2d 678,681-82,349 P.2d 605(1960);accord Weisert v. University Hosp.,44 Wn.App. 167,172, 721 P.2d 553(1986).

Here, a jury could have reasonably concluded that Robert Enebrad's chances of avoiding amputation of his left arm and surviving his cancer were significantly lessened due to defendants failure to timely diagnosis and refer him for specialty care with known and effective treatment. Mr. Enebrad and his family were deprived of a fair trial. The jury was forced to judge the case through the inflammatory, and wholly unnecessary, evidence of drug use that had scant probative nature as to any issue the jury was asked to decide. The Enebrad's were unfairly limited in the scope of their proofs because the trial judge made the case about one single day, January 18, 2013, and the jury was not allowed to weigh the substandard and shoddy medical practices of each of the defendants to this tragedy. Plaintiffs ask for a new trial against all defendants and asks they be

allowed to try the case free from the prejudicial evidence of past drug use and references to Hepatitis C.

Dated this 27th day of March 2017.

LAW OFFICE OF JOHN P. WALSH



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