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SPokane, WA

NO. 30864-2-III
(Consolidated with No. 30865-1-III)

COURT OF APPEALS, DIVISION III
OF THE STATE OF WASHINGTON

In Re the Estate of RUTH M. DORMAIER, Deceased,
by and through LOURENCE C. DORMAIER, Personal Representative;
and LOURENCE C. DORMAIER, individually,
and as the Beneficiary of his wife's Estate,

Respondents,

v.

COLUMBIA BASIN ANESTHESIA, P.L.L.C., a Professional Limited
Liability Company; ROBERT MISASI, C.R.N.A.; GRANT COUNTY
HOSPITAL DISTRICT #1, d/b/a SAMARITAN HEALTHCARE, a/k/a
SAMARITAN HOSPITAL, a Washington non-profit organization,

Appellants.

JOINT BRIEF OF APPELLANTS ROBERT MISASI, CRNA,
COLUMBIA BASIN ANESTHESIA, PLLC,
AND SAMARITAN HOSPITAL

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I. SUMMARY

Ruth Dormaier, 79, suffered a fatal cardiac arrest just after 3:00 p.m. on September 20, 2007, while undergoing urgent elbow-fracture surgery at Samaritan Hospital in Moses Lake. The cause of death was a massive pulmonary embolism from a pelvic vein thrombus (blood clot).¹ Her husband, Lourence Dormaier, brought this wrongful death action, alleging that her death was due to a decision by her anesthetist, Robert Misasi, to proceed with surgery despite what plaintiff's medical experts contended were signs that there were small clots in her lungs that warranted diagnostic testing and treatment.

Defendants appeal from a \$1.32 million judgment in Mr. Dormaier's favor that was based on a jury's special verdict findings that negligence by Mr. Misasi did not cause Mrs. Dormaier's death, but did cause a 70% diminution in her chance of survival. This Court should reverse because Mr. Dormaier (1) did not plead or give defendants notice of anything other than a wrongful death claim; (2) took a position with respect to negligence and causation that foreclosed any "loss of chance" claim as a matter of law; (3) did not present the type of expert medical testimony needed to support the giving of any instruction on "loss of

¹ "Thrombus" and "embolus" are both blood clots – a thrombus is a clot that is affixed to a blood vessel wall, and an embolus is a clot that has been freed from the vessel wall into the bloodstream RP 222, 291-92, 628-29, 904. A "pulmonary embolus" is a clot that migrates into the vessels serving the lung, RP 344; a big one is often fatal, RP 585, 906.

chance;” and (4) never raised any “loss of chance” issue until after the close of the evidence. Because the judgment is predicated on a “loss of chance” finding that the jury should never have been permitted to make, the judgment cannot stand and the case should be remanded for entry of judgment for defendants and dismissal of the complaint.

Alternatively, a new trial is in order because the trial court erred in refusing to permit apportionment of fault to Mrs. Dormaier’s internist and orthopedic surgeon, who both jointly decided with Mr. Misasi to proceed with the surgery, and/or because the jury’s finding of a 70% diminution in the chance of survival was precluded by Court’s Instruction No. 11.

Even if Mr. Dormaier was entitled to judgment based on the verdict, it should be reduced by the \$1.3 million the jury awarded him, because Court’s Instruction No. 12 allowed an award to him only because of his wife’s death, which the jury found Mr. Misasi had not caused, not because of any diminution in her chance of survival.

II. ASSIGNMENTS OF ERROR

1. The trial court erred in entering the April 12, 2012 and April 24, 2012 Judgments on Jury Verdict, CP 411-12, 414-17.
2. The trial court erred in giving Instruction No. 11, CP 273.
3. The trial court erred in denying defendants’ motion to dismiss at the close of plaintiff’s case, RP 1268-72.

4. The trial court erred in entering judgment for plaintiffs, CP 411-17, based on the jury's answers to Special Verdict Form Questions 3 and 4, rather than for the defendants based upon the jury's answers to Questions 1 and 2, CP 357-58.

5. The trial court erred in granting plaintiff's Motion in Limine No. 14, CP 667-70, and ruling that res judicata precluded defendants from allocating fault to Drs. Hart and Canfield, RP 127.

6. The trial court erred in giving Instruction No. 4, CP 266.

7. The trial court erred by including in the judgment, CP 411-17, the jury's award of \$1,300,000 to Mr. Dormaier individually, CP 358, or in the alternative by failing to discount that award by 30%.

III. ISSUES PERTAINING TO ASSIGNMENTS OF ERROR

Issues Pertaining to Assignments of Error Nos. 1 and 2

1. In a medical malpractice action involving care provided to a patient who died, may the plaintiff pursue a "loss of chance of survival" claim when he contends that defendant's negligence caused the death and offers expert testimony that the patient's chance of survival with proper care was 90% but no expert testimony that the chance of survival was reduced by negligence to a percentage greater than zero but less than 90%?

2. Did the defendants receive notice of a "loss of chance of survival" claim at a time and in a manner that enabled them to be prepared

to meet such a claim at trial?

3. Was a “loss of chance of survival” claim tried “by express or implied consent of the parties” within the meaning of CR 15(b)?

4. Were the defendants unfairly prejudiced by the trial court’s decision to give Court’s Instruction No. 11, CP 273?

5. Did the plaintiff present the kind of expert medical testimony necessary to support a “loss chance of survival” claim?

Issues Pertaining to Assignments of Error Nos. 1 and 3

6. Did plaintiff present sufficient expert testimony to enable the jury to find, without speculating, that, but for negligence by Mr. Misasi on September 20, 2007, Mrs. Dormaier’s cardiac arrest at 3:00 p.m. that day probably would have been prevented?

Issues Pertaining to Assignments of Error Nos. 1 and 4

7. Did the jury, having found in answer to Question 2 on the verdict form, CP 357, that negligence on Mr. Misasi’s part was *not* a proximate cause of Mrs. Dormaier’s death, fail to follow Court’s Instruction No. 11, CP 273, by finding in answer to Question 4 that negligence by Mr. Misasi caused a 70% diminution of a chance of survival, and/or make a finding that is inconsistent with its answer to Question 2?

8. If the jury’s answer to Question 4 on the verdict form failed to follow Instruction No. 11, or is inconsistent with its answer to Question

2, did the trial court err in not entering judgment in favor of the defendants, whom the jury absolved of liability for Mrs. Dormaier's death, rather than plaintiff, who bore the risk of nonpersuasion?

Issue Pertaining to Assignments of Error Nos. 1 and 5

9. Did the trial court erroneously rule that res judicata applied to bar defendants from pursuing their apportionment of fault affirmative defense pursuant to RCW 4.22.010 as to Drs. Hart and Canfield?

Issues Pertaining to Assignments of Error Nos. 1 and 6

10. Did the trial court err in entering judgment on the jury's award of \$1.3 million to Mr. Dormaier given Instruction No. 12, which permitted the jury to award Mr. Dormaier damages only for Mrs. Dormaier's death, and the jury's finding, in its answer to Special Verdict Form Question 2, that negligence by Mr. Misasi did not cause her death?

11. Did the trial court err in failing to discount the jury's damages awards by 30% to reflect the "70% loss of chance" finding?

IV. STATEMENT OF THE CASE

A. Mrs. Dormaier's Elbow Fracture and Fatal Pulmonary Embolism.

On September 15, 2007, Ruth Dormaier, 79, was picking pears on a hillside at her home in Moses Lake, when she fell and rolled down and over a 15 to 20 foot embankment. RP 691-92; CP 609. She was in severe pain and was taken by ambulance to Samaritan Hospital in Moses Lake,

Ex. P1 (000001-3), where she was examined, assessed, given morphine, and x-rayed. Ex. P2 (000004-11). She had a sore chest, right shoulder, and right clavicle, Ex. P2 (000004-5), and a badly fractured right humerus near the elbow. Ex. P2 (000006-9). Mrs. Dormaier was discharged home in a sling and with instructions to take Percocet for pain and to call an orthopedist on Monday for an appointment. Ex. P2 (000022, 24). She remained in terrible pain following her fall. RP 482, 485, 493-94, 706-07.

Dr. Canfield, the orthopedist, saw Mrs. Dormaier's x-rays on Monday, September 17, and ordered a CT scan of her elbow, which was of poor quality, so he ordered a repeat CT. Ex. P4 (000001). Based on the repeat CT scan, Dr. Canfield understood that Mrs. Dormaier had broken parts of her right humerus (upper arm bone) just above the elbow joint, and had several bone fragments in the joint. CP 609; RP 967, 970; Ex. P2 (000006); Ex. P4 (000005). That meant the elbow fracture was a "bad" one that "was going to be challenging . . . to put [] back together." RP 971, 1010-14; Ex. P4 (000001). Dr. Canfield tentatively scheduled Mrs. Dormaier for surgery on September 20, but first sent her to her long-time internist, RP 300, Dr. Hart, for a preoperative evaluation. Ex. P3 (000002); RP 974-75. Drs. Canfield and Hart were colleagues at Wenatchee Valley Medical Center's Moses Lake Clinic. RP 1025. Mrs. Dormaier saw Dr. Hart on September 18. Ex. P3. He examined her, ran

blood tests and an EKG, obtained an x-ray of her ribs, which showed no fractures, Ex. P3 (000005), cleared her for the surgery, and told her to stop taking aspirin (to lower her risk of bleeding at surgery, RP 981) but to take her hypertension medications and Percocet for pain. Ex. P3 (000003).

Mrs. Dormaier saw Dr. Canfield for the first time on September 19. Ex. P4 (000001); RP 970. Her chest and ribs were sore, and she had a slightly elevated respiration rate and low blood oxygen saturation levels, so Dr. Canfield ordered chest x-rays, which showed either a patchy infiltrate² or some atelectasis³ in the left lung lower lobe but an otherwise normal chest without rib fractures. Ex. P4 (000001, 2 and 7); RP 1015-18.

Lowered oxygen saturation levels can be caused by a variety of things, including pulmonary emboli, RP 224, which result when clots that have originated in and broken loose from a vein flow into the heart and are pumped back out into the pulmonary (lung) arteries, RP 222, 344, 566, 573-74, 599, 602-03, 899-901. When a clot is larger than the artery into which it is pumped, it blocks the arterial flow. *Id.* The larger the clot, the larger the lung artery it can block and the more the blockage will compromise lung function; the smaller the clot, the smaller the artery it can block and the less it will impair lung function. RP 245-46, 577, 585-

² Patchy infiltrate refers to an area of the lung where there is no air, RP 234-35, and is a nonspecific finding that may indicate pneumonia, RP 237-38.

³ Atelectasis is a collapse of areas of the lung. RP 235, 1019-20.

86, 595, 616, 905, 942. Large clots can break off intact or into pieces, “throwing off” what become pulmonary emboli of different sizes and effects. RP 293, 393, 450. Deep vein thrombosis (“DVT”) refers to the formation of large clots, usually in leg veins. RP 241-42, 244-45, 286-87, 579-85, 1143, 1155-56.

Dr. Canfield testified that Mrs. Dormaier was in a lot of pain, RP 981, 1007-08, 1030, 1036, 1051, and that surgical repair of her elbow, while non-emergent, was urgent because, after more than seven days post-fracture, repairing the joint successfully and without bone dying was going to become even more difficult. RP 972. Because Mrs. Dormaier also complained of hip discomfort during the September 17 visit, Dr. Canfield ordered an x-ray to check for hip fractures but scheduled it to be done the next morning at Samaritan Hospital, before she was prepped for surgery. RP 1029-30; Ex. P5 (000004). Dr. Canfield then discussed the respiratory and x-ray findings with Dr. Hart. RP 1025. Dr. Hart felt that, because Mrs. Dormaier had no fever, the x-rays probably indicated atelectasis due to splinted breathing⁴ and that Mrs. Dormaier’s lungs would probably only deteriorate if they held off on her surgery. Ex. P4 (000001); RP 1025-29. Dr. Canfield told Mrs. Dormaier that she would likely be left with some

⁴ “Splinted” breathing refers to shallow breathing to minimize pain from chest and lung expansion. RP 255, 1020-21.

limited motion in her arm, but that an attempt should be made to try to fix her elbow. Ex. P4 (000001); RP 1009-14, 1028-29.

Mrs. Dormaier checked in at Samaritan just before 10:00 a.m. on September 20. RP 455, 484. Her hip x-ray showed no fracture. Ex. P5 (000013). Dr. Canfield was in another patient's surgery with Robert Misasi, CRNA, who was going to be the anesthetist for Mrs. Dormaier's surgery.⁵ RP 1031-32. Mr. Misasi had more than ten years of experience as a CRNA, RP 1279, and he and Dr. Canfield had worked together since 2001, RP 1051, on hundreds of cases, RP 1322. Mr. Misasi had not previously met Mrs. Dormaier. RP 1285.

During the other patient's surgery, a nurse phoned Mr. Misasi to advise him that Mrs. Dormaier was in excruciating pain, and had an elevated respiratory rate, and an oxygen saturation level of 84. RP 1032-33, 1286-87. Mr. Misasi ordered Dilaudid for pain and oxygen to maintain a saturation level above 90. Ex. P5 (000021); RP 1287. Mrs. Dormaier was put on oxygen at 10:40 a.m. and Dilaudid at 10:58 a.m. Ex. P5 (000010); RP 1179. Mr. Misasi told Dr. Canfield they needed to discuss Mrs. Dormaier's condition and figure out what was going on. RP 1288-89, 1318. Dr. Canfield told Mr. Misasi that he had previously

⁵ Defendants did not dispute that CRNAs are subject to the same professional standard of care as anesthesiologists. *See* RP 178-79, 199-200, 210, and 332-34.

evaluated Mrs. Dormaier, a chest x-ray had shown atelectasis, and Mrs. Dormaier's internist, Dr. Hart, had agreed that her condition would only get worse unless the surgery proceeded. RP 1033-35, 1046-50, 1289.

After taking the other patient to recovery, Mr. Misasi saw Mrs. Dormaier. RP 1287-88. A nurse told him Mrs. Dormaier's breathing was wheezy, so he ordered duo-neb, RP 1289-90, a mist that opens up the airways, RP 255-56, which was given at 11:05, Ex. P5 (000010); RP 1146, 1302. Mr. Misasi learned that Mrs. Dormaier had a hip injury, which could affect surgical positioning, RP 1299, so he spoke with Dr. Canfield, RP 1290-91, who said a hip x-ray had ruled out fracture, RP 1299.⁶ Mr. Misasi then examined Mrs. Dormaier. RP 1302-04. Upon being told that she might have broken ribs, he again spoke with Dr. Canfield, who said an x-ray had ruled out rib fractures, RP 1307-08.⁷ In all, Mr. Misasi postponed Mrs. Dormaier's arrival in the operating room for more than an hour to evaluate her, confer with Dr. Canfield, and allow Dr. Canfield to re-confer by phone with Dr. Hart. RP 418, 1323. Dr. Canfield, Mr. Misasi, and Dr. Hart by phone, decided jointly to proceed with the elbow surgery. RP 1029-30, 1046-48, 1050, 1319-24.

⁶ The hip x-ray did not reveal, and no one contended an x-ray would have revealed, Mrs. Dormaier's pelvic vein clot. See RP 633, 800.

⁷ At some point, Mr. Misasi and Dr. Canfield reviewed with the radiologist a chest x-ray that had been done earlier that day and saw where the atelectasis was and that there were no broken ribs. RP 1308-09.

Mrs. Dormaier was put under anesthesia at 12:10 p.m. Ex. P5 (000023); RP 1052-53; . Shortly after 3:00 p.m., with two-thirds to three-fourths of the procedure of piecing her humerus together completed, RP 1053-54, Mrs. Dormaier abruptly had a cardiac arrest. Ex. P5 (000030); RP 1054-55. A “code” was called, but she could not be resuscitated and was pronounced dead at 4:06 p.m. Ex. P5 (000030-31); RP 1055-57.

There is no dispute that a pulmonary embolism killed Mrs. Dormaier – a massive clot from a pelvic vein broke loose spontaneously, flowed within seconds into her heart, and was pumped out of her heart, promptly blocking her main pulmonary arteries. CP 608-09; RP 244-45, 289-90, 407, 565-66, 799-800, 899-900, 1188. An autopsy revealed clots in the right and left pulmonary arteries and their branches ranging in size from 0.3 to 1.0 cm. Ex. P11 (000005). The experts agreed that a 1 cm. clot is a “massive” or “big” one. RP 280, 595-99, 799, 1188. The medical examiner attributed death to multiple pulmonary emboli secondary to deep venous thrombosis as a consequence of the right elbow fracture and fall. Ex. P6.

B. Plaintiff’s Wrongful Death Complaint Did Not Make Any Reference to “Loss of Chance”.

Mr. Dormaier, as personal representative of his wife’s estate and surviving spouse, sued Mr. Misasi, his employer, Columbia Basin Anes-

thetia, and Samaritan Hospital, CP 4-14, for malpractice. They all denied liability. CP 17-19, 21; 23-24.⁸ Mr. Dormaier also sued Drs. Canfield and Hart, but all claims against them were dismissed, CP 37-39, on a summary judgment motion that Mr. Dormaier did not oppose, *see* CP 566-74, 576.

Mr. Dormaier's "Complaint for Wrongful Death" made no reference to "loss of chance" of anything. It alleged that Mrs. Dormaier "died as a proximate result of the negligence of the Defendants," CP 9 (¶ 4.14), and "sustained injuries and damages and died due to the negligence of Defendants," CP 9 (¶ 5.1), and that Mr. Dormaier and other beneficiaries, "have suffered damages . . . as follows," then listing: emotional damages, past and future economic damages; and loss of support, love, affection, care, services, society and consortium, CP 12 (¶ 7.1).

C. Plaintiff's Pretrial Disclosures of Expected Expert Testimony Did Not Make Any Reference to Opinions About Percentage Chance or Percentage Diminution of Chance of Survival.

With his complaint, plaintiff filed Certificates of Merit stating:

[T]here is a reasonable probability that the defendants' conduct fell below the acceptable standard of care which is required to be exercised by the defendants . . . [who included Drs. Hart and Canfield].

⁸ Columbia Basin Anesthesia chose not to contest the allegation that it would be vicariously liable for any negligence by Mr. Misasi, and that issue was not submitted to the jury. The hospital contested through trial plaintiff's allegation, CP 11 (¶ 5.7), CP 622-23 that it was liable for any malpractice by Mr. Misasi under an apparent agency theory. CP 31 (¶ 5.7), 272. By the time of trial, plaintiff had dropped claims he had asserted, CP 11-12, for "lack of informed consent" and negligent infliction of emotional distress.

As a result of the inadequate care that RUTH DORMAIER received from the above stated defendants between September 15, 2007 AND September 20, 2007, it is my opinion that RUTH DORMAIER suffered and died.

CP 1259-61, 1262-64, 1265-67, 1268-70.

Plaintiff's Disclosure of Lay and Expert Witnesses, CP 50-56, advised that Drs. Hattamer, Smith, and Swenson were expected to testify to the opinions "set forth in [their] certificate[s] of Merit," and that their testimony "may also be based upon a review of all of Mrs. Dormaier's medical records, depositions, and other discovery information." CP 52-53. Mr. Dormaier also advised that Dr. Lloyd Halpern "may be called to testify . . . that there was a violation of the standard of care." CP 53. He provided no new information about rebuttal expert opinions. *See* CP 68-69. None of his expert disclosures made any reference to opinions about percentage chance, or percentage diminution of chance, of survival.

D. Plaintiff's Pretrial Submissions Did Not Give Any Indication That Plaintiff Intended to Pursue a "Loss of Chance" Cause of Action.

Plaintiff's trial memorandum characterized the case as "a claim . . . for negligent care resulting in the death of . . . Ruth Dormaier," CP 608, and asserted that, with appropriate anticoagulation therapy, "Mrs. Dormaier would be alive today." CP 609. It made no reference to any "loss of chance" claim. CP 610 (line 13). The record does not reveal that plaintiff ever submitted a proposed "loss of chance" instruction.

E. The Trial Court Grants Plaintiff's Motion in Limine No. 14, Depriving Defendants of Their Apportionment of Fault Defense.

Defendants' answers asserted the affirmative defense of fault of nonparties, including defendant(s) who might settle. CP 20, 31; RP 124. On the first day of trial, the trial court, on plaintiff's Motion in Limine No. 14, CP 667-70, which defendants opposed, CP 745-49, orally ruled that, because Mr. Misasi and Samaritan had not opposed Drs. Hart's and Canfield's motion for summary judgment dismissal of plaintiff's claims against them, *res judicata* precluded them from apportioning fault to Drs. Hart and Canfield. RP 127. The trial court reaffirmed its ruling at several points throughout the trial, RP 264-69, 452, 958-64, 991-1002, prohibiting Mr. Misasi and Samaritan from eliciting testimony from plaintiff's experts criticizing Drs. Hart's and Canfield's care of Mrs. Dormaier, or arguing to the jury that "fault" could be apportioned to them, *see* CP 669, 755.

Then, even though plaintiff elicited testimony from one of his experts, Dr. Swenson, that any medical practitioner with some degree of advanced training in medical science, including a physician, an advanced nurse, or a nurse anesthetist, should be able to recognize the signs and symptoms of pulmonary embolus, RP 260-61, that he opined Mr. Misasi had missed, RP 218-53, the court nevertheless instructed the jury that it had to "resolve the claims of the parties . . . based on the evidence admit-

ted, without regard to whether or not Dr. Canfield or Dr. Hart were negligent,” and that it could “consider the evidence regarding the conduct of Dr. Canfield and Dr. Hart, along with the other evidence in the case, in determining whether or not Mr. Misasi complied with the applicable standard of care.” CP 266 (Instr. No. 4).

F. Plaintiff’s Opening Statement Gave No Hint that Plaintiff Intended to Pursue Any “Loss of Chance” Claim.

Trial began March 7, 2012, before Judge Evan E. Sperline. In opening statement, plaintiff’s counsel told the jury that the case “involves the death of Ruth Dormaier,” RP 178, that decisions Mr. Misasi had made “proved to be fatal for Mrs. Dormaier,” RP 184, “resulted in her death,” RP 197, and “took her life,” RP 198. Plaintiff’s counsel told the jury that “[a]t the end [of trial], we’re going to ask that you find Mr. Misasi and Samaritan Hospital culpable, liable for Mrs. Dormaier’s death,” RP 199.

G. Plaintiff’s Medical Experts’ Trial Testimony Did Not Support a “Loss of Chance” Claim.

Plaintiff called four medical experts – Dr. Swenson, Dr. Hattamer, Dr. Reynolds, and Dr. Halpern. As detailed below, plaintiff’s standard of care experts opined that Mr. Misasi negligently failed to appreciate that Mrs. Dormaier had respiratory symptoms consistent with small pulmonary emboli, and should have refused to anesthetize Mrs. Dormaier for surgery.

No witness, for either side, testified that the surgery itself – the

anesthesia, how Mrs. Dormaier was positioned, or how Dr. Canfield tried to repair her humerus – caused or accelerated the separation of the fatal clot from her pelvic vein or its journey to her lung. Instead, plaintiff's experts were critical of Mr. Misasi for not appreciating signs they contended indicated that Mrs. Dormaier had already thrown off smaller clots and for not insisting that a pulmonologist, cardiologist, or internist come evaluate her. They claimed such an evaluation would have led to anticoagulation therapy and either detection and removal, or effective treatment, of the pelvic clot while the elbow surgery was postponed.

Plaintiff's experts did not opine that it was practically feasible to order and obtain the necessary diagnostic scans to search for and find any large clots in the legs, and then to arrange and perform an interventional procedure to remove the pelvic-vein clot, assuming it would have been found, in the few hours that elapsed between sometime after 10:30 a.m. on September 20, 2007, when Mr. Misasi first obtained information about Mrs. Dormaier's status, and 3:00 p.m., when she had her cardiac arrest. Nor did any of plaintiff's experts testify that anticoagulation therapy alone, if started at 11:00 a.m., would have acted quickly enough to have probably prevented what happened at 3 p.m.

1. Dr. Erik Swenson.

Dr. Swenson, a University of Washington pulmonologist, RP 216-

17, opined that Mrs. Dormaier presented with symptoms that were consistent with, among other things, potentially fatal pulmonary emboli. RP 218-53. He opined that any medical practitioner with some degree of advanced training in medical science, including a physician, an advanced nurse, or a nurse anesthetist, should be able to recognize the signs and symptoms of pulmonary embolus. RP 260-61.

Dr. Swenson opined that a CT or VQ (ventilation perfusion) scan could have been ordered to look for clots in the lungs, and takes about an hour to perform. RP 225-26, 232-33. He testified that the survival rate in patients treated for pulmonary embolism who do not have a terminal illness is “upwards of 90 percent,” RP 233, and that, upon diagnosis of pulmonary emboli, the standard treatment is heparin, an anticoagulant, RP 246-47. Plaintiff’s counsel then asked Dr. Swenson:

Q. Doctor, . . . do you have an opinion as to whether or not had Mrs. Dormaier been properly diagnosed with pulmonary embolus and treated with anticoagulation, whether she would have survived?

A. It’s been my experience over the entire time of my career that, if we can diagnose this we have a good chance once beginning therapy to take a mortality rate of possibly 70 to 80 percent and bring it down into the ten to 20 percent rate.

RP 258. Dr. Swenson later opined that, if Mrs. Dormaier had been treated with heparin instead of undergoing the elbow surgery, she would probably have had a 90% chance of survival. RP 260.

Dr. Swenson testified that giving heparin reduces the threat that clots will migrate to the heart and be pumped to the lungs. RP 251. He did not quantify that threat or say by how much, or how quickly, the threat presented by a *1 cm.* clot is typically eliminated or reduced with heparin. Nor did he testify by how much or how quickly the risk would probably have been eliminated or reduced in Mrs. Dormaier's case, given the autopsy finding of a 1 cm. clot in her pulmonary artery. He also did not quantify Mrs. Dormaier's risk of death given the undiagnosed 1 cm. pelvic-vein clot that she already had when Mr. Misasi first became involved in her care, or the extent to Mr. Misasi's care (as opposed to Mrs. Dormaier's physicians' care) affected her risk of death from that clot.

In fact, on cross-examination, Dr. Swenson testified that:

Part of the reason that some people die with pulmonary embolism even if we start treatment is that the clots that may still be out elsewhere in the body may not have shrunk enough and become adherent enough to the blood vessels to remain there, and they still may migrate to the lung, and then if the lung function is already poor or there's already lots of clots in the lung, these new clots may be the straw that breaks the camel's back.

RP 282. He agreed that Mrs. Dormaier's fatal clot was "massive," RP 280, large enough to block the artery that feeds both lung branches, RP 245, and broke loose spontaneously, not because of the surgery, RP 287-88; that it takes five to ten seconds for a dislodged clot to reach the lungs,

RP 316; that heparin would not have dissolved the clot, because the body takes “hours to days” to dissolve a clot, RP 294-95; that heparin only would have stopped new clots from forming, *id.*; and that Mrs. Dormaier would have been lying down and remaining at risk for pulmonary embolism while any scans were done, if more had been ordered instead of proceeding with surgery, RP 310-12.

2. Dr. Steven Hattamer.

Dr. Hattamer, an anesthesiologist, addressed standard-of-care issues, RP 325-391, and opined that pulmonary emboli are “imminently [sic] survivable,” RP 392. In his opinion, Mrs. Dormaier had been “show-ering little emboli” before the surgery, presaging the “one or two [more clots] that is [sic] the straw that breaks the camel’s back.” RP 393. He did not opine as to Mrs. Dormaier’s chance of survival, the probability of survival of patients with very large pelvic clots, or the diminution of Mrs. Dormaier’s statistical chance(s) of survival because of decisions Mr. Misasi made or joined in.⁹ On cross, Dr. Hattamer acknowledged that anticoagulants do not dissolve existing clots, RP 450; that heparin would not have affected the large clot that killed Mrs. Dormaier, RP 410; and that the fatal clot could have broken loose at any time, RP 413.

⁹ Plaintiff’s counsel did ask Dr. Hattamer whether he disagreed with counsel’s characterization of Dr. Swenson’s testimony about success in using anticoagulation treatment, and he responded: “A. No. In fact, I know it’s a high number. I’m just not aware of the stat.” RP 395-96.

3. Dr. Jeffrey Reynolds.

Dr. Reynolds, a pathologist, RP 557, who had performed an autopsy for the Dormaier family on October 3, 2007, Ex. P12; RP 564, testified that he found various small emboli in Mrs. Dormaier's lungs that had been present for at least two days before she died. RP 569-70, 573-78, 596-98. On cross, he acknowledged that one cannot predict when a clot will break off, RP 630; that a clot as big as the one that killed Mrs. Dormaier will cause unconsciousness within 30 seconds and death within five minutes of reaching the lungs, RP 632; that heparin does not dissolve clots and the body takes days to do so, and that Mrs. Dormaier could still have thrown the fatal clot if her elbow surgery had been canceled, RP 634-35. He testified that, even if a large clot in a leg vein is detected, one would have to be "very lucky" to have a qualified surgeon present in time to remove a clot large enough to block an artery serving the lungs. RP 634.

4. Dr. Lloyd Halpern.

Dr. Halpern, an anesthesiologist, RP 1109, opined that Mr. Misasi should have been more suspicious that Mrs. Dormaier had pulmonary emboli, RP 1132, 1140-44, 1152-53, and should have ordered an EKG to rule out heart disease, RP 1158, then another chest x-ray, *id.*, then a CT scan or VQ scan of the lungs, RP 1154-55, 1159, and finally a transthoracic echo exam to evaluate the heart, RP 1160. He opined that such a scan

would have shown emboli in the lungs, and led to an ultrasound or CT scan to look for clots in the legs and pelvic area, RP 1155-57, anticoagulation therapy (heparin), RP 1161-62, and an embolectomy (removal of the pelvic clot by a cardiothoracic surgeon or radiologist), RP 1162-63. He testified that, in 2007, cardiothoracic surgeons at Sacred Heart Medical Center in Spokane could perform embolectomies, RP 1163, but on cross acknowledged that there were no cardiothoracic surgeons in Grant County (where Samaritan is located) in 2007.¹⁰ RP 1190-91.

Dr. Halpern also testified that the rate of success of treatment with anticoagulants for clots like Mrs. Dormaier's "is greater than 90 percent," meaning that "the deep clots in the pelvis dissolve, and also the clots in the lung." RP 1162. He did not quantify or otherwise describe the extent to which Mr. Misasi's alleged negligence on the morning of surgery had diminished Mrs. Dormaier's chance of not dying at 3 p.m. that afternoon from her undiagnosed 1 cm. pelvic vein clot. Terms like "loss of chance" or "diminution of a chance of survival" were not used by anyone during Dr. Halpern's (or any other witness's) examination.

On cross, Dr. Halpern acknowledged that a CT or VQ scan would not prevent a clot from breaking loose, RP 1189; that it would take some time (which he did not specify or estimate) to arrange surgery to remove a

¹⁰ As for interventional radiologists, Dr. Halpern could not say whether there were any in Grant County in 2007, RP 1190-91, and no one testified that there were.

clot, RP 1190-91; that there were no cardiothoracic surgeons (and he could not say whether there were any interventional radiologists) in Grant County in 2007, RP 1190-91; that heparin does not dissolve clots, but only prevents the formation of new ones while the body breaks down existing ones, which, in the case of large clots (like Mrs. Dormaier's), can take days or weeks, RP 1189-90; and that it is impossible to predict when a massive clot will break off from a vein, RP 1188-89.

On redirect, Dr. Halpern did not offer an estimate as to how long it would have taken to arrange for and complete the tests he said should be done to identify the clot, and then arrange for clot-removal surgery. Nor did he testify that even starting late morning on September 20, 2007, all those steps probably could have been completed before 3:00 p.m.

H. Defendants' Medical Experts Did Not Testify About Percentage Rates of Mrs. Dormaier's Chances of Survival.

Dr. John Hahn, an anesthesiologist, RP 1219-21, testified that Mr. Misasi's evaluation of Mrs. Dormaier and his decision, in consultation with Drs. Canfield and Hart, to allow the surgery to proceed were within the standard of care. RP 1228-30, 1238-39, 1257-58. Dr. Timothy Chestnut, an internist, pulmonologist, and critical care specialist, RP 754-58, opined that the massive embolism that killed Mrs. Dormaier had not been clinically predictable and that anesthetizing her for surgery had not

increased her risk of embolism, RP 799-800. Dr. Daniel Selove, a forensic pathologist with experience as a medical examiner, RP 884-92, opined that there was no valid medical evidence that Mrs. Dormaier had pulmonary emboli in her lungs until just before her cardiac arrest, RP 907.

No defense medical witness was asked on direct or cross-examination about percentage survival rates or percentage risks, or how any decisions Mr. Misasi made on September 20, 2007 affected such rates.

I. The Trial Court Denied Defendants' Motion to Dismiss at Close of Plaintiff's Case After Mistakenly Accepting as True Plaintiff's Counsel's Summary of Plaintiff's Experts' Testimony.

After plaintiff rested, RP 1217, defendants moved to dismiss for failure to prove causation, RP 1268. Defendants argued that plaintiff had failed to present evidence that putting Mrs. Dormaier on heparin after her arrival at Samaritan would probably have prevented the massive pelvic vein clot from breaking loose at 3:00 p.m. that afternoon, or even that the means existed at Samaritan at the time to conduct tests, find the clot, and remove it or prevent it from breaking loose and killing her. RP 1268-70.

Opposing the motion, plaintiff's counsel claimed that Dr. Swenson had testified that "anticoagulation therapy "works to dissolve the smaller clots," which was not true,¹¹ and "actually works to help bind the clot in the vein or in the area of the deep vein thrombosis . . . [which] would have

¹¹ Dr. Swenson testified, RP 295, that heparin itself *does not* dissolve clots.

helped prevent the release of the larger clot,” which was inaccurate.¹² RP 1270. Plaintiff’s counsel asserted that Dr. Reynolds had testified that keeping Mrs. Dormaier upright “would have helped with the prevention of the clot,” which mischaracterized the testimony,¹³ and that, if the (pelvic) clot had been discovered, she could “very well [have been] sent to Sacred Heart . . . where they could have done an emergency embolectomy,” RP 1270-71, which also was inaccurate,¹⁴ and that “all plaintiff’s experts on causation testified that would have saved this lady’s life, including the fatal clot,” RP 1271, which was not true.¹⁵

¹² Dr. Swenson testified only that heparin makes clots “*begin* to stick more closely to and more solidly to the vessel wall, making it *harder* for them to be dislodged.” RP 250-51 (italics added). He did not opine that heparin would *probably* have kept Mrs. Dormaier’s pelvic clot bound to the vessel wall for any particular period, or for enough time for surgical intervention to have been arranged and performed successfully. He acknowledged that “even if we start treatment . . . the clots that may still be out elsewhere in the body may not have shrunk enough and become adherent enough to the blood vessels to remain there, and they still may migrate to the lung . . .,” RP 282, and that the body takes *hours*, at least, to dissolve clots of any size, RP 295.

¹³ Dr. Reynolds testified to the effect that gravity works against blood flow from the legs to the heart when a person is upright, RP 584, 590-91, 594, but did not opine that Mrs. Dormaier’s clot’s separation from the pelvic vein wall would have been delayed for any particular amount of time had she been kept upright. In fact, plaintiff’s counsel gave Dr. Reynolds the chance to testify that gravity probably would have kept a 1 cm. pelvic clot in an upright patient from flowing to the heart, but he declined to so opine. RP 592-96.

¹⁴ Dr. Reynolds gave no testimony about embolectomy or whether or how Mrs. Dormaier could have been moved to a different hospital, and did not opine or profess personal knowledge that there was enough time to get Mrs. Dormaier to Sacred Heart Medical Center and operated on quickly enough to have probably removed the clot before it broke loose and killed her. Nor did any other expert give such testimony.

¹⁵ None of plaintiff’s experts opined that such steps could have been taken promptly enough to have probably prevented Mrs. Dormaier’s pulmonary embolism, cardiac arrest, and death at mid-afternoon on September 20, 2007, barely more than four hours after Mr. Misasi first had any involvement in her health care.

The trial court denied the motion to dismiss, accepting plaintiff's counsel's recitation of the facts for purposes of the motion. RP 1272.

J. No Mention Was Made of "Loss of Chance" Until the Discussion of Jury Instructions after the Close of Evidence.

On March 15, 2012, after the conclusion of all testimony, RP 1389, the court distributed its tentative jury instructions. RP 1391. Only then did the term "loss of chance" enter the case:

MR. KAMITOMO: Mr. Casey has also brought up, there's a new that we – I used in another med-mal case, it's loss of a chance, but it's the Supreme Court expounding on the old loss of a chance doctrine, and there's language in there that seems to suggest that it's much more expansive than just cancer, that it goes to all cases, and at least in the case I tried, that court agreed with me that even though you have testimony on a more probable than not basis and it meets that standard, you still get a loss of chance instruction. We at least would like to propose it for the court's consideration.

THE COURT: Can you refer me to the case by name?

MR. KAMITOMO: I don't have that in front of me, but I could certainly get it to the court when I get back.

RP 1392-93.¹⁶ Defendants objected that no "loss of chance" theory had been pled, RP 1393-94, and the court then recessed for the day, RP 1394.

On Saturday, March 17, the trial court sent an e-mail, CP 233, to counsel advising them of its view that a "loss of chance instruction is

¹⁶ There is no pattern instruction on "loss of chance," and the transcript does not reflect plaintiff ever tendering a proposed one.

appropriate,” based on its recollection of testimony by Drs. Swenson, Hattamer, Reynolds, and Halpern, and concluding:

When viewed as an element of damages, as is required by *Mohr*[v. *Grantham*], it is clear to me that (1) it was not necessary to plead loss of chance as a cause of action, and (2) the parties addressed the issue (if under other terminology) on both sides of the case.

When court reconvened on Monday, March 19, Samaritan submitted a brief objecting to any “loss of chance” instruction, CP 181-90; RP 1402-03, and a declaration by Dr. Chestnut, CP 219-22, as to testimony he would have given if he had been asked to address “loss of chance”:

4. There is no data regarding or establishing the embolic rate from pelvic thrombus, with or without heparin intervention – that is, the frequency with which such clots embolize to the lungs. . . .

5. Additionally, there is no data that would allow a physician to quantify any reduction in embolic rate, following heparin intervention.

* * *

10. Not only would it be medically and scientifically impossible to state that heparin intervention would have prevented Mrs. Dormaier’s embolism, or to quantify any such impact, the data relied upon by Dr. Swenson is inappropriate [because] massive emboli like Mrs. Dormaier’s . . . represent approximately 5 percent or less of total pulmonary emboli [and] many patients who suffer from massive and/or fatal emboli do so while they are on heparin treatment. . . .

* * *

12. Had Dr. Swenson used his “90% opinion” to opine on some alleged reduction of Mrs. Dormaier’s chance of success or death, I would have offered contrary testimony. Dr. Swenson’s “90% opinion” does not apply to Ruth

Dormaier's clinical circumstances[, such that his] opinion is . . . totally inapplicable to a saddle embolism that arises from the pelvic veins.

Before taking formal exceptions to jury instructions, the trial court heard brief argument on the "loss of chance" issues, RP 1402-07. Mr. Misasi joined in Samaritan's objections, RP 1404; CP 281-91.

After formal exceptions to instructions were taken, RP 1407-19, the court announced that it would be tweaking the wording but would be giving a "loss or diminution of a chance to survive" instruction as Court's Instruction No. 11, CP 273, to which defendants had objected, RP 1404, 1411, 1422. Instruction No. 11, as finally worded, stated:

If you find that Defendant Robert Masasi [sic] failed to comply with the applicable standard of care and was therefore negligent, you may consider whether or not his negligence proximately caused damages to Ruth Dormaier in the nature of loss or diminution of a chance to survive the condition which caused her death.

If you find that such negligence proximately caused a loss or diminution of a chance to survive, then you will determine the magnitude of the loss or diminution by comparing two percentages: (1) Ruth Dormaier's chance of surviving the condition which caused her death as it would have been had defendant not been negligent, and (2) the chance of surviving as affected by any negligence you find on the part of defendant.

The difference in the two percentages, if any you find, is the percentage of loss or diminution in the chance of survival. If you find that the loss or diminution of a chance to survive was in excess of 50%, then you have found that such negligence was a proximate cause of the death.

On the other hand, if you find that the loss or diminution of a chance to survive was less than 50%, then any damages you find to have been experienced because of the death or Ruth Dormaier will be reduced by multiplying the total damages by the percentage of loss or diminution in the chance of survival.

CP 273.¹⁷ The trial court explained to counsel that:

In regard to the Loss of Chance not being pled, I believe that the state of the law . . . is that loss of chance is an element of injury and not a cause of action, and therefore is not required to be pled.

RP 1415. Plaintiff's counsel, offered an opportunity to comment on the "loss of chance" instruction as finally worded, stated:

I don't know if it's an exception, Your Honor, as much as a comment, and I don't know how the court proposes to handle it. I understand why the court has placed the change to loss of chance. The only concern I have is this, and *I don't want the jury to start speculating beyond what's been placed into the record.* Unless the court has a different recollection, my understanding is that the jury has had two percentages of survival placed in front of them, 90 percent by the plaintiffs, and zero percent by the defendants. And so *my concern is that the way the instruction is crafted allows the jury to speculate somewhat on both ends, and come up with a percentage that's perhaps not supported by the evidence.* But having said that, the instruction does allow us to make that argument. [Emphases supplied.]

¹⁷ It appears that the trial court drafted its own "loss of chance" instruction, incorporating some language defendants proposed on March 19, CP 211-12, 218 (subject to their objection that no "loss of chance" instruction should be given at all), after the trial court had told counsel in the March 17 email, CP 233, that it thought it appropriate to give a "loss of chance" instruction.

RP 1420-21. Defendants renewed their exceptions to the giving of a loss of chance instruction. RP 1421.

The court's proximate cause instruction, CP 270, was WPI (Civ.) 15.01 (including the "but-for" causation phrase "without which [the] injury would not have happened"). Its summary of claims instruction, No. 6, CP 268, told the jury in pertinent part that:

The plaintiffs claim that Robert Misasi failed to comply with the applicable standard of care in evaluating Ruth Dormaier for surgery, and that Mr. Misasi's conduct was a proximate cause of Ruth Dormaier's death and Plaintiffs' resulting damages.

In its damages instruction, No. 12, CP 274, the court told the jury that, if it found for plaintiff on Mr. Dormaier's individual claim, it "must determine the amount of money that will reasonably and fairly compensate [him] for such damages as you find were proximately caused by the death of [Mrs. Dormaier, considering] what [she] reasonably would have been expected to contribute to [him] in the way of marital consortium." Plaintiff did not except to that instruction. *See* RP 1407-08. Plaintiff did not ask for a "loss of chance" damages instruction. The court gave the jury a six-question Special Verdict Form. CP 357-58.

K. In Closing Argument, Plaintiff Told the Jury It Had to Chose Between a 90% and a 0% Chance of Survival.

The jury was instructed on March 20, RP 1428-44, and heard closing arguments. As to Instruction No. 11, plaintiff's counsel argued:

Instruction No. 11 is Loss of Chance. And this will undoubtedly confuse you, I'm sure it will, so I'm going to give you my understanding of what loss of chance is. There was testimony, from my recollection, from plaintiffs, that she had a 90 percent chance of survival. If they did the right thing. My recollection of the defense's position was that she had a zero percent chance of surviving. ***There's nothing in between. You get to decide whether you believe 90 percent or you believe zero percent. If you believe 90 percent, then we've met the loss of chance.*** That's my simplified version of the loss of chance. I would invite you to read that instruction, but that's my belief of what loss of chance means in this case. And you can find that if you believe she had a 90 percent loss of chance, then any conduct on his part is to be held accountable for that percentage. [Emphasis added.]

RP 1472. Addressing the verdict form, plaintiff's counsel argued:

[Questions] three and four are where loss of chance comes in, and you're only going to answer three, and you're only going to answer four if for some reason you answer two no on proximate cause. Three and four are where you decide whether or not there was a loss of chance of survival for Mrs. Dormaier, had things been different. And I'm confident again that if you go to this and you look at the testimony, you'll find that the loss of chance was 90 percent. And 90 percent is sufficient to answer those questions in the affirmative and move on.

RP 1477. At no point in his closing did plaintiff's counsel assert that there had been any medical testimony quantifying the percentage "loss of chance" that Ruth Dormaier was deprived of, except insofar as counsel implied that the loss was a complete loss of what had been a 90 percent chance of surviving if Mr. Misasi had refused to anesthetize her and had insisted on a physician other than Dr. Canfield evaluating her.

L. The Jury Finds, Negligence and No Proximate Cause of Death, But a 70% Loss of Chance of Survival.

Answering Question 1 on the verdict form, the jury found that Mr. Misasi had been negligent, CP 357, but answering Question 2, it found that his negligence was *not* a proximate cause of Mrs. Dormaier's death. *Id.* Answering Questions 3 and 4, it found that Mr. Misasi's negligence *had* been a proximate cause of "a loss or diminution of [Mrs.] Dormaier's chance to survive the condition which caused her death," and that "the percentage of loss or diminution in [Mrs.] Dormaier's chance to survive" was 70%. CP 358. Answering Question 5, the jury awarded the estate \$20,481.22 and Mr. Dormaier \$1.3 million. *Id.* Answering Question 6, it found that Mr. Misasi had been the hospital's apparent agent. *Id.*

M. The Trial Court Denies Defendants' Post-Verdict Renewed Motion for Judgment as Matter of Law and Defendants Appeal.

In a joint post-verdict motion for judgment as a matter of law, *see* CP 363, lines 8-9, defendants argued again that instructing on "loss of chance" had been error, and that judgment should be entered for defendants, CP 363-64, and could not be entered for plaintiffs, CP 364. Alternatively, they argued that any judgment on the verdict should be limited to the award of \$20,481.22 to the estate and should not include the award of \$1.3 million to Mr. Dormaier, because "loss of chance" damages were personal to Mrs. Dormaier and could be recovered only by her estate,

and because Mr. Dormaier's claim was based on his wife's *death*, which the jury found defendants had not caused. CP 365-66.

Rejecting defendants' arguments, CP 404-05, 1257, the trial court entered judgment for plaintiff for \$1,320,481.22 plus costs of \$2,763.24. CP 411-12. Defendants timely appealed. CP 418-29; 430-40. Thereafter, the trial court filed a Memorandum Opinion, CP 1255-58, explaining its reasons for its "loss of chance" rulings and its entry of judgment for plaintiff on jury's special verdict findings, and stating, CP 1257-58:

Based upon the jury's responses [to Questions 1-4 on the Special Verdict Form] the court concluded that there were two concurrent proximate causes of the death of Ms. Dormaier: a pulmonary embolism not caused by the negligence of Misasi, and a loss of chance to survive that condition which was caused by such negligence.

Had the jury found that the diminution of chance to survive was less than 50%, then the court would have been required to reduce the jury's finding of damages by that figure. However, where the reduction in chance to survive is itself found to be greater than 50%, it becomes, as a matter of law, a concurrent proximate cause of the death (or, of the "failure to survive").

V. STANDARD OF REVIEW

"[J]ury instructions are reviewed de novo, and an instruction that contains an erroneous statement of the applicable law is reversible error where it prejudices a party." *Cox v. Spangler*, 141 Wn.2d 431, 442, 5 P.3d 1265 (2000) (citation omitted). It is error to give an instruction that the

trial evidence does not support. *State v. Hughes*, 106 Wn.2d 176, 191, 721 P.2d 902 (1986).

To the extent that the trial court is deemed to have granted a motion by plaintiff to amend his complaint pursuant to CR 15(b) on grounds that “loss of chance” had somehow been tried by consent of the parties, such a ruling is reviewed for abuse of discretion, *Edmonds v. Scott Real Estate*, 87 Wn. App. 834, 851-52, 942 P.2d 1072 (1997), *rev. denied*, 134 Wn.2d 1037 (1998), the principal test being “whether the opposing party is prepared to meet the new issue.” *Id.*; *Bacon v. Gardner*, 38 Wn.2d 299, 305, 229 P.2d 523 (1951).

“A [trial] court abuses its discretion when its decision is manifestly unreasonable, or exercised on untenable grounds or for untenable reasons,” namely, when the court “relies on unsupported facts, takes a view that no reasonable person would take, ***applies the wrong legal standard, or bases its ruling on an erroneous view of the law.***” (Emphases added.)

Kelley v. Centennial Contractors Enters., Inc., 169 Wn.2d 381, 386, 236 P.3d 197 (2010) (citation omitted).

Whether the trial court’s grant of plaintiff’s Motion in Limine No. 14 to preclude evidence or argument concerning fault of Drs. Hart and Canfield is viewed as an evidentiary ruling or a ruling on a motion to dismiss, it is subject to *de novo* review. In granting the motion in limine and precluding any apportionment of fault to Drs. Hart and Canfield, the

trial court relied upon *res judicata*. The applicability of *res judicata* is a question of law subject to *de novo* review. *Harley H. Hoppe & Assocs., Inc. v. King County*, 162 Wn. App. 40, 50, 255 P.3d 819, *rev. denied*, 172 Wn.2d 1019 (2011).

VI. ARGUMENT

A. Judgment Should Be Entered for Defendants Because the Jury Absolved Mr. Misasi of Causal Responsibility for Mrs. Dormaier's Death and Plaintiff Was Not Entitled to a Fallback "Loss or Diminution of Chance to Survive" Theory and Jury Instruction.

1. "Loss of chance" was not a legally viable theory.
 - a. Plaintiff insisted that Mrs. Dormaier's chance of survival had been greater than 50%.

It is important to understand what a "loss of chance" claim *is*. In *Mohr v. Grantham*, 172 Wn.2d 844, 262 P.3d 490 (2011), the Supreme Court formally adopted the plurality opinion in *Herskovits v. Group Health Coop. of Puget Sound*, 99 Wn.2d 609, 619-636, 664 P.2d 474 (1983), a case involving a patient who had died and which recognized a "loss of chance of survival" claim. *Mohr* extended the *Herskovits* plurality's recognition of a loss of chance of *survival* claim to allow recovery when a patient did not die but allegedly lost a chance, expressed as a percentage based on scientific data, of a better outcome.

The *Herskovits* plurality recognized that "existing principles" of causation and injury in the medical malpractice context already cover

cases in which the decedent patient's chance of survival, even with exemplary care, had been greater than even (*i.e.*, greater than 50 percent):

[C]ases where the chance of survival was greater than 50 percent . . . are unexceptional in that they focus on the death of the decedent as the injury, and they require proximate cause to be shown beyond the balance of probabilities[, which] result is consistent with existing principles in this state. . . .”

Herskovits, 99 Wn.2d at 631. What the *Herskovits* plurality was persuaded to do was to “recognize the loss of a less than even chance [of survival] as an actionable injury.” *Id.* at 634. Thus, when a decedent's chance of survival was *more* than even, *Herskovits* classifies the claim as an “unexceptional” wrongful death claim, in which the plaintiff must prove that defendant's alleged malpractice probably caused the *death*, not some “loss of chance of survival.” Stated another way, while *Herskovits* recognized a new cause of action for loss of chance where before any negligence there was already a less-than-even chance of survival with or without negligence, a cause of action for loss of a *better*-than-even chance of survival is simply a wrongful death claim under long-standing tort principles.

Mr. Dormaier's argument and expert testimony in this case kept his claim from *being* a “loss of chance of survival” claim. He argued and presented expert testimony not that Mrs. Dormaier's chance of survival with proper care had been less than 50%, but that her chance of survival

had been 90%. Even in closing argument, just after the trial court instructed the jury on “loss of chance” as well as wrongful death, plaintiff’s counsel, addressing “loss of chance,” told the jury that plaintiff’s expert testimony had been that Mrs. Dormaier “had a 90 percent chance of survival,” and that “[i]f you believe 90 percent, then we’ve met the loss of chance . . .,” RP 1472, and that “if you . . . look at the testimony, you’ll find that the loss of chance was 90 percent,” RP 1477. Under *Herskovits*, what plaintiff’s counsel described was a wrongful death claim, not a “loss of chance of survival” claim.

The trial court erroneously instructed the jury on both wrongful death and “loss of chance,” giving Mr. Dormaier two chances to prevail on the same claim.¹⁸ *Herskovits* does not suggest that a personal representative suing for medical malpractice may pursue simultaneously *both* a claim that defendant caused the death *and* a claim that defendant caused a “loss of chance of survival” based on exactly the same evidence. In Washington, a loss of chance of survival claim assumes as a given that the decedent was more probably than not going to die even if he or she had received exemplary care.

Allowing a personal representative suing for wrongful death to

¹⁸ The trial court’s post-judgment order, CP 1255-58, seems to confirm this, although prior to judgment the record is clear that the parties thought they were talking about loss of chance, not an alternative causation argument.

also pursue a fallback “loss of chance” claim predicated on a chance of survival that *exceeded* 50% does not comport with the *Herskovits* plurality’s reasoning. As the court sensibly held in *Haney v. Barringer*, 2007 Ohio 7214, 2007 Ohio App. Lexis 6306 (Ohio Ct. App. Dec. 27, 2007), “the loss-of-chance doctrine is not simply a fallback position when a plaintiff cannot establish proximate cause . . .,” and loss of chance does not apply “in a case where the injured patient had a greater-than-even chance of recovery at the time of the alleged medical negligence.” *Id.*, 2007 Ohio App. Lexis 6306 **9.

- b. Plaintiff did not contend that, after Mr. Misasi’s alleged negligence, Mrs. Dormaier was left with a reduced chance of survival; he claimed that she was left with *no* chance of survival.

“Loss of chance” theory under both *Herskovits* and *Mohr* is predicated on the plaintiff starting out, before his or her interaction with the defendant health care provider, with a certain percentage chance of a certain preferred outcome (whether survival or less disability), and ending up, after the defendant’s alleged malpractice, with a different and lower – but still greater than zero – chance of that outcome. As the *Mohr* court explained, “[t]he lost opportunity [for which a plaintiff can be compensated under “loss of chance” theory] may be thought of as the adverse outcome discounted by the difference between [1] the *ex ante*

probability of the outcome in light of the defendant's negligence and [2] the probability of the outcome absent the defendant's negligence.”¹⁹ Neither *Herskovits* nor *Mohr* held or contemplated that a plaintiff should be able to recover when his or her theory, supported by expert medical testimony, is that the patient whose care is at issue would probably have survived (in this case would have had a 90% chance of survival) and that the defendant health care provider's negligence eliminated that chance completely – reduced it to zero. As *Herskovits* recognized, that theory describes a wrongful death claim, in which proof that the defendant completely destroyed what had been a likelihood of survival entitles the plaintiff to what Mr. Dormaier claimed in this case: judgment for 100% of the damages awarded. Neither *Herskovits* nor *Mohr* allows assertion of a fallback “loss of chance” claim when the plaintiff has not offered a “reduced to” percentage chance of survival greater than zero.

2. No loss of chance instruction should have been given because defendants were not given any notice of a “loss or diminution of chance” claim.

The *Mohr* majority, in adopting the *Herskovits* plurality opinion, observed that, under that opinion's “formulation, a plaintiff bears the burden to prove duty, breach, and that such breach of duty proximately caused a loss of chance of a better outcome.” *Mohr*, 172 Wn.2d at 857.

¹⁹ *Mohr*, 172 Wn.2d at 858 (quoting Restatement (Third) of Torts: Liability for Physical and Emotional Harm §26 cmt. n at 356 (2010)).

Thus, the occurrence of a “loss of chance” is among the essential elements of any type of “loss of chance” claim.

- a. Plaintiff pled a wrongful death claim, not a “loss of chance” claim.

One of defendants’ objections to plaintiff’s request for a “loss of chance” instruction after the close of the evidence was that “loss of chance” had not been pled. RP 1393-94; CP 187. The court’s stated basis for rejecting that objection was that “loss of chance” is merely a form that the injury element of an RCW 7.70.040 medical malpractice claim may take, and thus need not be explicitly pled. CP 233; RP 1415. The court’s reasoning cannot be squared with *Mohr*, however, because the majority in *Mohr* referred to “loss of chance” as a claim (in the noun form) seven times²⁰ and as a cause of action no fewer than twelve times.²¹ “Loss of chance” is a claim or cause of action defined by the injury for which damages are sought, in the same way that a claim for negligent infliction of emotional distress or a claim for false-light defamation is. “Loss of chance” thus should have to be pled before a plaintiff is entitled to have such a claim presented to a jury. It was not pled here, so it was error for the trial court to instruct on “loss of chance.”

²⁰ *Mohr*, 172 Wn.2d at 849, 851, 852, 857 (twice), 859, and 862.

²¹ *Mohr*, 172 Wn.2d at 847 (twice), 849, 850 (thrice, including Statement of Issue No. 1 and footnote 4), 851, 852, 853, 856 (twice), and 862 (“[w]e hold that there is a cause of action in the medical malpractice context for the loss of a chance of a better outcome”).

Whether or not “loss of chance” is technically a *cause of action*, “loss of chance of survival” and death are *different grounds for relief*, and a plaintiff can recover for “loss of chance of survival” only if there is percentage-based expert medical testimony establishing the chance of survival and the extent of its diminution. When a medical malpractice plaintiff asserts in a Complaint for Wrongful Death that the defendant negligently caused *death*, but nowhere alleges or even implies that the defendant’s negligence caused a diminution in the chance of survival even if it did *not* cause the death, the intent of the Civil Rules is disserved.

Under the liberal rules of procedure, pleadings are intended to give notice to the court and the opponent of the general nature of the claim asserted. *Lewis v. Bell*, 45 Wn. App. 192, 197, 724 P.2d 425 (1986). Although inexpert pleading is permitted, insufficient pleading is not. [*Id.*] at 197. “***A pleading is insufficient when it does not give the opposing party fair notice of what the claim is and the ground upon which it rests.***” [*Id.*] (citation omitted).

Dewey v. Tacoma Sch. Dist. No. 10, 95 Wn. App. 18, 23, 974 P.2d 847 (1999) (holding that complaint for wrongful discharge did not sufficiently plead First Amendment claim, and affirming denial of motion for leave to amend complaint to include First Amendment claim in response to summary judgment motion); *see also Saluteen-Maschersky v. Countrywide Funding Corp.*, 105 Wn. App. 846, 857, 22 P.3d 804 (2001) (affirming striking of claims first asserted in response to summary

judgment motion because the “complaint neither cited . . . the [claims], nor mentioned any factual basis to support them”). As explained in *Berge v. Gorton*, 88 Wn.2d 756, 762-63, 567 P.2d 187 (1977):

Even our liberal rules of pleading require a complaint to contain direct allegations sufficient to give notice to the court and the opponent of the nature of the plaintiff’s claim . . . Equivalent federal rules are construed similarly by federal courts.

A reading of . . . a host of . . . cases suggests that the complaint, and other relief-claiming pleadings need not state with precision all elements that give rise to a legal basis for recovery as long as fair notice of the nature of the action is provided. However, ***the complaint must contain either direct allegations on every material point necessary to sustain a recovery on any legal theory***, even though it may not be the theory suggested or intended by the pleader, ***or contain allegations from which an inference fairly may be drawn that evidence on these material points will be introduced at trial.*** [Emphases added and citation omitted.]

While CR 15(b) gives a trial court discretion to amend pleadings to conform to the evidence at any stage in the action, “amendment under CR 15(b) cannot be allowed if actual notice of the unpled issue is not given, if there is no adequate opportunity to cure surprise that might result from the change in the pleadings, or if the issues have not in fact been litigated with the consent of the parties.” *Green v. Hooper*, 149 Wn. App. 627, 636, 205 P.3d 134, *rev. denied*, 166 Wn.2d 1034 (2009) (citation omitted).

- b. Defendants were not put on notice of a “loss of chance” claim in any manner before the close of the evidence.

If, as the trial court reasoned, “loss of chance” need not be expressly *pled* because it is just a type of injury compensable in an RCW 7.70.040 medical malpractice cause of action, that does not mean that defendants were entitled to no pre-trial notice *at all*, in *any* form, that plaintiff would seek a “loss of chance” instruction and verdict.

In his complaint, Mr. Dormaier did not simply allege malpractice and causation plus an *unspecified* “injury” and leave it to defendants to ascertain what the injury was through discovery. He filed a *Complaint for Wrongful Death*, alleging causation of (a) death and (b) nine other injuries (past and future economic damages, and loss by Mr. Dormaier of support, love, affection, care, services, society and consortium) that did not include “loss of chance.” CP 9-12. In discovery, he did not disclose any expert who would testify as to “loss of chance of survival.” He disclosed experts who would attribute Mrs. Dormaier’s *death* to negligence by Mr. Misasi (and Drs. Hart and Canfield). CP 50-56, 68-69, 1259-70. In his trial memorandum and opening statement, he likewise referred to death, not any “loss of chance.” See CP 608-24; RP 178, 184, 196-99.

“Loss of chance” did not come up at all – in any way, shape, or form – until after the close of evidence. Not only did *defendants* not

receive notice of a “loss of chance” claim until after the close of evidence, but also the record shows that *neither* side believed during trial that “loss of chance” was an issue. *See* RP 1392-93 (plaintiff’s counsel advised the court that “Mr. Casey has also brought up, there’s a new case that we – I used in another med-mal case, it’s loss of a chance, . . . We at least would like to propose it for the court’s consideration”).

The civil rules “shall be construed and administered to secure the just . . . determination of every action.” CR 1. Under the spirit of CR 1, defendants were entitled, whether by pleading or otherwise, to fair and timely notice in *some* form, before trial, that the plaintiff would argue that, even if negligence by Mr. Misasi did not cause Mrs. Dormaier’s death, it nonetheless caused a loss of a percentage chance of survival, such that “loss of chance” was a theory they should consider preparing to meet. Defendants did not get fair and timely notice of a “loss of chance” claim.

- c. A “loss of chance to survive” claim was not tried by express or implied consent.

Two days after the trial court’s March 17, 2012 e-mail indicating that it would be giving a “loss of chance” instruction, plaintiff asked the court to deem his complaint amended pursuant to CR 15(b) on the ground that “loss of chance” had been tried “by the express or implied consent of the parties.” CP 171-72 He claimed that Drs. Hattamer, Swenson and

Halpern had testified that Mrs. Dormaier, with proper treatment and/or intervention, would have had a 90% chance of survival. *Id.* As explained above, a claim of a loss of a 90% chance of survival is not a legally viable “loss of chance” claim, but, even if it were, the trial court did not make any ruling granting a CR 15(b) motion. Instead, it treated “loss of chance” as having been adequately pled *to begin with*.

Even if the trial court’s statement in its March 17, 2012 e-mail to counsel that “the parties addressed the issue (if under other terminology) on both sides of the case,” CP 233, is taken as a *sua sponte* ruling amending the complaint under the “tried by consent” clause of CR 15(b),²² the record does not support a conclusion that defendants consented to try a “loss of chance” claim. The record confirms that neither side’s lawyers thought they were trying a “loss of chance” claim while evidence was being presented.

As noted already, plaintiff’s counsel apparently thought up a loss of chance theory after the fact, RP 1392-93, and wrongful death and “loss of chance” claims are, according to *Herskovits*, mutually exclusive. Thus, defendants had no reason to think a “loss of chance” claim was being tried along with the wrongful death claim that plaintiff had pled, litigated, and

²² Plaintiff did not invoke CR 15(b) until March 19, two days after the court’s March 17 e-mail. CP 170-72.

told the jury he would prove. Given that “loss of chance” was never mentioned in pleadings, discovery, opening statement, presentation of the evidence, and that no expert gave any “percentage diminution of chance of survival” opinion testimony, it cannot be said that a “loss of chance” claim was tried by express or implied consent. The record reveals that, through the close of the evidence, no one knew or thought they were trying a “loss of chance” claim.

3. Plaintiff’s expert testimony on “success rate” for heparin treatment would not have justified a “loss of chance” instruction even if plaintiff had made (and given notice of) such a claim.

Crucial to the *Herskovits* plurality opinion was stipulated medical evidence as to (a) the decedent’s statistical chance of survival when his lung cancer was Stage 1, and (b) the decedent’s statistical chance of survival when his cancer became Stage 2. As the *Mohr* court explained, “[t]he lost opportunity [for which a plaintiff can be compensated under “loss of chance” theory] may be thought of as the adverse outcome discounted by the difference between [1] the *ex ante* probability of the outcome in light of the defendant’s negligence and [2] the probability of the outcome absent the defendant’s negligence,” and calculation of a “loss of chance” must be based on expert testimony that “in turn is based on significant practical experience and ‘on data obtained and analyzed

scientifically . . . as part of the repertoire of diagnosis and treatment, *as applied to the specific facts of the plaintiff's case.*” *Mohr*, 172 Wn.2d at 857-58 (citations omitted; emphasis added). The *Mohr* court characterized *Herskovits* as a case where the “diagnosing physician testified that the delay in diagnosis likely diminished Herskovits’s chance of long-term survival from 39 percent to 25 percent.” *Mohr*, 172 Wn.2d at 851. Applying the *Herskovits* plurality’s “formulation” of loss of chance to cases where a patient has not died, the *Mohr* court also emphasized the plaintiff’s ability to present medical expert testimony stating, in percentage terms, what chance of a better outcome the plaintiff had lost. *Id.* at 849, 859-60. Here, plaintiff did not present expert testimony that would have warranted a “loss of chance” instruction even if he had expressly pled or given defendants notice of such a claim before trial.

- a. Plaintiff’s “percentage chance of survival” testimony was actually an opinion that Mrs. Dormaier probably would not have died with proper care.

Dr. Swenson opined that Mrs. Dormaier’s chance of survival would have been 90% or better with proper care from Mr. Misasi on September 20, 2007. RP 260. Plaintiff also presented statements of general survival rates for patients who receive anticoagulation treatment upon being diagnosed with pulmonary emboli (not venous clots), RP 395-96, 1162. But all such testimony was presented to support opinions that

Mrs. Dormaier would have survived but for Mr. Misasi's alleged negligence, not to establish a reference point for a "loss or diminution of chance" opinion, which none of plaintiff's experts expressed.

- b. None of plaintiff's experts opined as to the extent to which negligent care diminished Mrs. Dormaier's chance of survival.

As noted above, *Herskovits* and *Mohr* were cases in which the expert evidence established the "before" and "after" percentage chances of survival (in *Herskovits*) or of a better outcome (as in *Mohr*) that in both instances were greater than zero. Here, plaintiff offered neither. The absence of any "after" testimony further confirms that plaintiff's counsel was not trying anything other than a wrongful death claim until he persuaded the trial court – after the close of evidence, and to counsel's own surprise – to give a "loss of chance" instruction. Because none of the experts opined as to the extent to which any negligence by Mr. Misasi diminished Mrs. Dormaier's chance of survival, there was no competent expert medical testimony to support a "loss of chance" claim, and the trial court erred in instructing the jury on "loss of chance" at all. The "loss of chance" instruction cannot be justified by inferring from plaintiff's experts' testimony that negligence by Mr. Misasi reduced Mrs. Dormaier's chance of survival from 90% to 0%, because that testimony describes a conventional wrongful death claim, not a *Herskovits* "loss of chance of

survival” claim, or a *Mohr* “loss of chance of a better outcome” claim.

- c. Dr. Swenson’s reference to “10 to 20 percent” was not “percentage diminution” testimony.

Plaintiff may try to argue that Dr. Swenson provided the requisite percentage diminution evidence when he stated:

... if we can diagnose [pulmonary embolism] we have a good chance once beginning therapy to take a mortality rate of possibly 70 to 80 percent and bring it down into the ten to 20 percent rate.

RP 258. Aside from the facts that Dr. Swenson gave that testimony in support of a causation of *death* opinion before “loss of chance” became a claim in this case, and plaintiff’s counsel did not argue in closing for a “diminution of chance” finding based on any number except the “90% survival rate” testimony Dr. Swenson had given, the testimony quoted above was not specific to *Mrs. Dormaier* (neither Dr. Swenson nor any other expert offered any opinion, to a reasonable degree of medical certainty, that Mrs. Dormaier lost an specified percentage of survival), and does not amount to, or imply, an opinion that *she* suffered a diminution of a chance of survival from 70 to 80% down to 10 to 20% because of negligence during the less than four-and-a-half-hour window in which Mr. Misasi was involved in her care. The 10 to 20% testimony (undifferentiated by patient’s age, condition, or type, location or advanced condition of deep vein clots) referred to living patients who have *diagnosed*

pulmonary emboli – clots that already have migrated to the lungs and are causing symptoms but not death – and not to a survival rate for patients with *undiagnosed* massive pelvic vein clots that, as is now known, were less than four and a half hours away from breaking loose and blocking arteries serving both lungs.

4. Defendants would have tried the case differently had they known the jury might be instructed on “loss of chance”.

The instruction on “loss of chance” obviously was prejudicial to the defense because they tried a wrongful death case, yet were held liable solely on a belatedly asserted “loss of chance” theory. Defendants had no notice that plaintiff’s experts’ off-hand “percentage” testimony would be cited, after the close of evidence, as a basis for a “loss or diminution of a chance to survive” claim.

Had plaintiff’s experts’ anticoagulant therapy “success rate” testimony been offered in support of a properly pled “loss of chance” claim as well as, or instead of, the wrongful death claim that plaintiff actually litigated, defense counsel and Dr. Chestnut would have explained why general figures based on experience of patients at the University of Washington with all sizes of already diagnosed pulmonary emboli are not probative of the chance of survival of a 79-year-old patient at Samaritan in Moses Lake with a badly broken elbow who was less than four and a half

hours away from having an undetected massive pelvic-vein clot break loose. *See* CP 220-21. When the trial court decided, after all expert witness examinations had been completed, to give an instruction that allowed plaintiff's counsel to argue "loss of chance" from "percentage success" testimony that had been offered to prove wrongful *death*, the defense had no responsive testimony to argue to the jury. And, because the plaintiff also had no "percentage chance of *survival*" testimony to argue to the jury, it was perversely unjust to allow liability to be imposed on defendants for Mrs. Dormaier's "failure to survive," given the jury's finding that negligence by defendants was not a proximate cause of her death.

5. Remand for dismissal is the proper remedy.

Because the jury should never have been instructed on "loss of chance," and because the judgment in plaintiff's favor was predicated solely on a "loss of chance" finding, the judgment should be vacated and the case remanded for dismissal of the complaint with prejudice.

B. The Trial Court Erred in Denying Defendants' Motion to Dismiss Because Plaintiff Failed to Present Evidence that there Was Enough Time, and Resources Available, to Prevent the Massive Pelvic Vein Clot from Breaking Loose and Killing Mrs. Dormaier.

The trial court's erroneous decision to instruct on "loss of chance" was not the only prejudicial and reversible error it committed. Another was its denial of defendants' CR 50(a) motion to dismiss. RP 1268-72.

Before trial, the plaintiff let the court dismiss his malpractice claims against Drs. Hart and Canfield, who had started providing care to Mrs. Dormaier more than two days before she checked in for elbow surgery on September 20, 2007. Mr. Misasi's care of Mrs. Dormaier began less than four and a half hours before she coded and died. That less-than-four-and-a-half-hour period was the critical window into which any relevant causation testimony and evidence had to fit.

As defense counsel explained in moving to dismiss after plaintiff rested, plaintiff offered no competent testimony that there was enough time, or that the medical means probably were available at Samaritan, to prevent what actually happened during that four-and-a-half-hour window. RP 1268-70. In denying the motion to dismiss, the trial court cited "testimony . . . referred to by plaintiff's counsel [at RP 1270-71]" and "testimony . . . that other patients with similar symptoms and signs and with similar DVT have survived when given anticoagulation treatment at a much higher rate." RP 1272. But plaintiff's counsel had mischaracterized the testimony to which he referred in opposing the motion,²³ and anecdotal testimony about one other patient not dying or other patients surviving after being given anticoagulants was "could have" testimony, not "probably would have" testimony specific to Mrs. Dormaier.

²³ See footnotes 11-15, *supra*.

In any event, no evidence the court referred to, or the jury heard or saw, conformed to the critical causation window presented at trial. No witness opined that Mrs. Dormaier, who as of 10:30 a.m. on September 20, 2007, was a patient at Samaritan in Moses Lake (not the University of Washington in Seattle, or Sacred Heart in Spokane), probably would not have thrown her undiagnosed and asymptomatic massive pelvic clot at 3:00 p.m. (or ever) but for Mr. Misasi's decision to anesthetize her for surgery instead of having a cardiologist, pulmonologist, or internist see her. No witness opined that the anesthesia or the surgery made her throw the massive clot. No witness testified that all the things plaintiff's experts say should have been done – a consult by a cardiologist, pulmonologist, and/or internist, the ordering, performance, and reading of scan(s) capable of diagnosing a pelvic clot, and the arranging for and successful performance of an embolectomy – could have been done at Samaritan, much less within the less than four and a half hours between the time Mr. Misasi first became involved in Mrs. Dormaier's care or concurred in the decision to proceed with surgery and the time she threw her massive clot at 3:00 p.m. Nor did any witness testify that there was time to transport her to another hospital and get the pelvic clot removed before 3 p.m. And, no witness testified that *heparin*, if started sometime after Mr. Misasi's

involvement in her care after 10:30 a.m., probably would have prevented or delayed the breaking-off of the pelvic clot that occurred at 3:00 p.m.

Plaintiff's experts gave what merely amounted to "could have" testimony about medical causation, which is legally insufficient to support a plaintiff's verdict. *Rounds v. Nellcor Puritan Bennett, Inc.*, 147 Wn. App. 155, 163, 194 P.3d 274 (2008), *rev. denied*, 147 Wn.2d 274 (2009) (affirming summary dismissal of medical malpractice claim under principles that expert medical causation testimony must be (1) based on facts in the case, not speculation or conjecture and (2) "sufficient to establish that the injury-producing situation 'probably' or 'more likely than not' caused the subsequent condition, rather than [that] the accident or injury 'might have,' 'could have,' or 'possibly did' cause the subsequent condition" (citation omitted). The trial court erred by treating such legally insufficient causation testimony as evidence that had to be viewed "most favorably to" the plaintiff. RP 1272. In so doing, the court confused the *weighing* of testimony – which it could not do unless sitting as finder of fact, *e.g.*, *Baldwin v. Seattle*, 55 Wn. App. 241, 247, 776 P.2d 1377 (1989) – with the sufficiency of the testimony to defeat a motion to dismiss, a legal issue, *Haugen v. Minn. Mining & Mfg. Co.*, 15 Wn. App. 379, 380, 550 P.2d 71 (1976); *Hough v. Ballard*, 108 Wn. App. 272, 279, 31 P.3d 6 (2001) (same in summary judgment context), and thus an issue for the

court, not a jury. *Mega v. Whitworth College*, 138 Wn. App. 661, 672, 158 P.3d 1211 (2007). Plaintiff's evidence was legally insufficient to establish causation given the narrow window into which the evidence had to fit. That is true whether or not it was error to instruct on both wrongful death and "loss of chance." The trial court erroneously denied defendants' CR 50(a) and RCW 4.56.150 motion to dismiss. The judgment for plaintiff should be reversed and the case remanded for dismissal with prejudice.

C. The Trial Court Erred in Entering Judgment Against Defendants Instead of Against Plaintiff Given How the Court Instructed on "Loss of Chance" and How the Jury Answered Special Verdict Form Questions 2 and 4.

Based on Instruction No. 11, once the jury found Mr. Misasi negligent, it could only proceed to find that his negligence either (1) caused Mrs. Dormaier's death, or (2) caused a "loss or diminution of a chance of survival" of less than 50%, or (3) did not cause either her death or any loss of chance. It could not, consistent with Instruction No. 11, find that his negligence did not cause Mrs. Dormaier's death, but nonetheless caused a greater than 50% loss or diminution in her chance of survival. But that is what the jury did despite the instruction.

1. The court should have disregarded the jury's answer to Question 4 instead of the answer to Question 2.

As plaintiff, Mr. Dormaier bore the "burden of proof," and thus the risk of nonpersuasion. *See State v. Paul*, 64 Wn. App. 801, 806-07, 828

P.2d 594 (1992). Although there are no Washington decisions on point, the general rule is that “[a] special verdict will be construed most strongly against the party on whom rests the burden of proof” 89 C.J.S. *Trial* § 1012 (2001) at 624 (citing *Brittain v. Wichita Forwarding Co.*, 168 Kan. 145, 211 P.2d 77 (1949)). And, where one jury finding in defendant’s favor precludes a second finding in plaintiff’s favor but the converse is not true, judgment should be for defendant, not plaintiff. *E.g.*, *North Am. Catamaran Racing Ass’n, Inc. v. McCollister*, 480 So.2d 669, 671 (Fla. Dist. Ct. App. 1985), *rev. denied*, 492 So.2d 1333 (1986) (where inconsistency in jury’s special findings is “of a fundamental nature,” entry of judgment for defendant, rather than new trial, is appropriate).

The jury answered “no” to the question of whether negligence by Mr. Misasi caused Mrs. Dormaier’s death. In light of Instruction No. 11’s statement that a finding of a loss of a greater than 50% chance of survival would be the same as finding proximate causation of death, the jury’s “70%” answer to Question 4 (even assuming there had been any nonspeculative basis in the record for the 70% number) amounted to an answer of “sort of” to the same question to which it had previously answered “no.” To “reconcile” the jury’s answers to Questions 2 and 4, the trial court deemed the “sort of” answer to Question 4 to be a “yes” answer to an unasked question of whether negligence by Mr. Misasi

caused a “failure to survive,”²⁴ CP 1257-58, and ignored the jury’s “no” answer to Question 2 and entered judgment by treating the jury’s answer to Question 4 as if it amounted to a “yes” answer to Question 2. That determination lacked any basis in law, logic, or the instructions the court had given the jury.²⁵ The more sound and proper course was to enter judgment in *defendants’* favor (and let plaintiff try to persuade an appellate court that a new trial should be ordered) because (1) Instruction No. 11 permitted the “yes” answer to Question 2 but expressly precluded an answer to Question 4 of more than 50%; (2) the meaning of the jury’s “no” answer to Question 2 is clear and the meaning of its answer to Question 3 is not clear in light of Instruction No. 11; (3) plaintiff, not defendants, bore the risk of nonpersuasion as to causation of any injury; and (4) the jury’s “70%” answer to Question 4 means it was persuaded of some proposition that Instruction No. 11 excluded from its factfinding inquiry.

²⁴ Not only was the jury not asked to determine a “failure of survival,” Instruction No. 11 actually *precluded* an answer to Question 4 of a “loss or diminution of a chance to survive” that was greater than 50%.

²⁵ It also gave plaintiff the benefit of a result his own counsel had previously admitted the *evidence would not support*:

[M]y understanding is that the jury has had two percentages of survival placed in front of them, 90 percent by the plaintiffs, and zero percent by the defendants. And so my concern is that the way the instruction is crafted allows the jury to speculate somewhat on both ends, and come up with a percentage that’s perhaps not supported by the evidence.

RP 1420-21. Although plaintiff’s counsel’s assumptions about what a “loss of chance” claim involves by way of comparative percentage testimony was flawed for reasons discussed above, he plainly recognized that if the jury answered “yes, no, and yes” to Questions 1, 2 and 3, the testimony would allow no answer to Question 4 other than “90%,” and that the evidence did not support any other such percentage answer.

2. The court was not entitled to reinterpret Instruction No. 11 to reconcile the jury's answers to Questions 2 and 4.

Instruction No. 11 told the jury:

If you find that the loss or diminution of a chance to survive was in excess of 50%, then you have found that such negligence was a proximate cause of the death.

On the other hand, if you find that the loss or diminution of a chance to survive was less than 50%, then any damages you find to have been experienced because of the death of Ruth Dormaier will be reduced by multiplying the total damages by the percentage of loss or diminution in the chance of survival.

CP 273. The jury found a loss or diminution of a chance to survive of 70% but that negligence was *not* a proximate cause of Mrs. Dormaier's death. CP 357-58. Although Instruction No. 11 plainly did not permit both findings, and despite the jury's finding that Mr. Misasi's negligence had *not caused* Mrs. Dormaier's death, the court declared *post hoc*, that its instructions authorized the jury to find two concurrent proximate causes of death: a pulmonary embolism that Mr. Misasi did not cause, and a "failure to survive" that condition that Mr. Misasi's negligence had caused, even though the term "failure to survive" appears nowhere in the court's instructions or Washington tort law:

Based upon the jury's responses [to Questions 1-4] the court concluded that there were two concurrent proximate causes of the death of Ms. Dormaier: a pulmonary embolism not caused by the negligence of Misasi, and a loss of chance to survive that condition which was caused by such negligence.

Had the jury found that the diminution of chance to survive was less than 50%, then the court would have been required to reduce the jury's finding of damages by that figure. However, where the reduction in chance to survive is itself found to be greater than 50%, it becomes, as a matter of law, a concurrent proximate cause of the death (or, of the "failure to survive"). [CP 1257-58.]

Thus, even though the jury made an explicit finding that Mr. Misasi's negligence was not a proximate cause of Mrs. Dormaier's death, the court nonetheless announced that the jury had found that his negligence was a concurrent proximate cause of her death. In so doing, the court not only accepted a finding negated by the jury's answer to Question 2 and precluded by Instruction No. 11, but also entered judgment for 100% of the damages awarded even though Instruction No. 11 had told the jury that a *permissible* percentage-loss-of-chance finding would result in a commensurate *reduction* of the plaintiff's damages.

The trial court impermissibly rewrote Instruction No. 11 after the jury found what Instruction No. 11 told the jury it could not find. No authority supports that kind of *ex post facto* revision of jury instructions and verdicts. To the extent applicable authority exists, it holds that a party may not complain that a jury's answers to questions on a verdict form were not consistent when that party failed to except to instructions that permitted such an inconsistency. *ESCA Corp. v. KPMG Peat Marwick*, 86 Wn. App. 628, 638-39, 939 P.2d 1228 (1997), *aff'd*, 135 Wn.2d 820

(1998). The opposite happened in this case, though. Instruction No. 11 did *not* permit the inconsistent findings that the jury made.

D. The Trial Court Erred in Holding that *Res Judicata* Precluded Defendants from Allocating Fault to Drs. Hart and Canfield.

The trial court ruled in limine that *res judicata* precluded defendants from introducing evidence of, or apportioning fault for, the potential negligence of Drs. Hart and Canfield, both of whom, together with Mr. Misasi, made the collective decision to proceed with Mrs. Dormaier's surgery on September 20, 2007. The trial court erred in so ruling.

The gravamen of plaintiff's case against Mr. Misasi was not that he negligently delivered Mrs. Dormaier's anesthesia or that the anesthesia or surgery caused her death. Rather, his claim was that Mr. Misasi, who first saw Mrs. Dormaier sometime after 10:30 a.m. on September 20, negligently went ahead and anesthetized her, allowing her surgery to proceed, rather than have a specialist evaluate her for possible clots.

Defendants had pled in their answers that there were others whose negligence caused or contributed to plaintiff's loss, and to whom fault should be apportioned. Mr. Misasi alleged in relevant part, CP 20:

10.2 Discovery may reveal that Plaintiffs' injuries or damages, if any, are the result of conduct of others over whom Defendants Misasi had no control or right to control. ***Defendants Misasi reserve the right to name additional entities and designate such individuals and entities as non-parties at fault*** pursuant to CR 12(i), if discovery

reveals the basis for such claims, at any time during the pendency of this lawsuit, ***including currently named and future-named Defendants who may settle before trial.*** Defendants request fault be apportioned amongst all persons or entities responsible for Plaintiffs' alleged damages including these and other non-parties at fault.

10.6. Request for allocation of fault per RCW 4.22. Plaintiffs alleged that all named Defendants were negligent. If the jury agrees with Plaintiffs' position that the Defendants were negligent, Defendants Misasi request that fault be apportioned amongst all persons or entities responsible for Plaintiffs' alleged damages. Defendants intend to rely in part upon witnesses and evidence produced by all parties, including witnesses retained by Plaintiffs. ***These answering Defendants intend to allocate fault to any settling Defendants by way of a special verdict form, and Plaintiffs are hereby notified of Defendants intent to so allocate fault at the time of trial.*** Defendants reserve the right to read portions of depositions and any evidence necessary regarding allocation of fault, even if other Defendants settle before trial. [Emphases added.]

Samaritan alleged in relevant part, CP 31:

10.2 The death of Ruth Dormaier was due to acts or omissions of third parties over whom this answering defendant had not control or right of control.

10.3 An allocation of fault, if any, should be done at time of trial.

Plaintiff originally sued both Dr. Hart and Dr. Canfield. CP 4. Dr. Hart examined Mrs. Dormaier on September 18, 2007 and cleared her for surgery. RP 304, 413-14, 437. Dr. Canfield examined Mrs. Dormaier on September 19, 2007, and cleared her for surgery. RP 438. Drs. Hart and Canfield conferred on September 19, and re-conferred on September 20 and re-cleared her for surgery that day. RP 438. When Drs. Hart and

Canfield moved for summary judgment dismissal of plaintiff's claims, Cp 479-80, 566-74, plaintiff did not oppose the motion (even though he had evidence raising a triable issue as to their negligence, CP 52-53, 1259-70; RP 121), CP 576. Plaintiff never moved for summary judgment dismissal of any defendant's apportionment of fault affirmative defense.

On the eve of trial, plaintiff moved *in limine* to preclude Mr. Misasi and Samaritan from offering any evidence of negligence on the part of Dr. Hart or Dr. Canfield or arguing that fault should be apportioned to them. CP 667-70. The trial court stated that "Samaritan and Misasi could have litigated the question of the potential negligence of Hart and Canfield in the summary judgment proceeding and chose not to do that," RP 127, and ruled, RP 127:

I think the law of res judicata is that the preclusive effect is the same as if they had participated, had alleged the negligence of Hart and Canfield, and lost. Which then, in my view, precludes the claim, including the attribution of fault to Hart and Canfield. So . . . this jury will never be asked to consider the negligence of Hart and Canfield, or to apportion fault to Hart and Canfield.

The trial court adhered to that ruling during trial, forbidding testimony as to the judgment exercised by Drs. Hart and Canfield, RP 264-69, 452, 958-64, 991-1002, and giving Instruction No. 4, CP 266; RP 1433-34, which told the jury:

In this case, there is no issue for you to consider regarding the negligence, if any, of Daniel Canfield, MD or of Kenneth Hart, MD. You must not speculate regarding any such negligence, or the absence thereof, and must resolve the claims of the parties in this case based upon the evidence admitted, without regard to whether Dr. Canfield or Dr. Hart were [sic] negligent.

The trial court erred in ruling as it did on apportionment of fault. *Res judicata*, based on the unopposed order dismissing on summary judgment plaintiff's claims against Drs. Hart and Canfield, did not bar Mr. Misasi and Samaritan from apportioning fault to Drs. Hart and Canfield.

1. Res judicata did not apply because Drs. Hart's and Canfield's motion for summary judgment did not purport to adjudicate Mr. Misasi's and Samaritan's affirmative defense of apportionment of fault.

As a "doctrine of claim preclusion," *res judicata* bars relitigation of a *claim* that has been determined by a final judgment and applies "where the subsequent action involves (1) the same subject matter, (2) the same cause of action, (3) the same persons or parties, and (4) the same quality of persons for or against whom the decision is made as did a prior adjudication." *Williams v. Leone & Keeble, Inc.*, 171 Wn.2d 726, 730, 254 P.3d 818 (2011) (citing *In re Estate of Black*, 153 Wn.2d 152, 170, 102 P.3d 796 (2004)).

Here, the trial court erred in its application of *res judicata* (1) because the summary judgment proceeding determined only that plaintiff had not supported *his* claims against Drs. Hart and Canfield, not that Drs.

Hart and Canfield had done nothing that a jury could find constituted “fault” within the meaning of RCW 4.22.015 (defining “fault” to include “acts or omissions . . . that are in any measure negligent . . . toward the person . . . of the actor or others . . .”); and (2) because Misasi and Samaritan had no *claims* against Drs. Hart and Canfield for the court to adjudicate; and (3) because the summary judgment order did not purport to adjudicate the apportionment defense that the trial court recognized, RP 124, Mr. Misasi and Samaritan had asserted as to Drs. Hart and Canfield if they settled. Thus, there was no identity of parties or causes of action as between the summary judgment ruling and the apportionment defense that Mr. Misasi and Samaritan were asserting, and a final judgment did not resolve that defense. The trial court misapplied *res judicata* reasoning to fault apportionment under RCW 4.22.070(1), which is mandatory if there is evidence to support it (as there would have been but for the court’s order granting plaintiffs’ motion *in limine*, see RP 121; CP 52-55; CP 1259-70), and which allows juries to apportion “fault” even to nonparties who have prevailed on defenses of their own against the claimant or who are immune from liability to the claimant.

2. The trial court's refusal to allow defendants to apportion fault to Drs. Hart and Canfield cannot be squared with RCW 4.22.070(1).

To see that the trial court erred, this Court need look no farther than RCW 4.22.070(1) which provides, in relevant part:

In all actions involving fault of more than one entity, the trier of fact *shall* determine the percentage of the total fault which is attributable to *every entity* which caused the claimant's damages except entities immune from liability to the claimant under Title 51 RCW [workers' compensation]. The sum of the percentages of the total fault attributed to at-fault entities shall equal one hundred percent. *The entities whose fault shall be determined include the claimant or person suffering personal injury or incurring property damage, defendants, third-party defendants, entities released by the claimant, entities with any other individual defense against the claimant, and entities immune from liability to the claimant*, but shall not include those entities immune from liability to the claimant under Title 51 RCW. . . . [Emphases added.]

RCW 4.22.070(1)'s mandate that apportionment include "entities released by the claimant, and entities with any other individual defense against the claimant, and entities immune from liability to the claimant" is directly contrary to the trial court's conclusion, RP 125, that Mr. Misasi and Samaritan could not apportion fault to former parties who had prevailed on individual defenses or who had effectively been released by plaintiff. Release, settlement, or prior adjudication (*res judicata*) are all "individual defenses" despite which Mr. Misasi and Samaritan were entitled to have the jury consider apportioning fault to Drs. Hart and Canfield.

RCW 4.22.070 “evidences legislative intent that fault be apportioned and that generally an entity be required to pay that [its] proportionate share of damages only.” *Washburn v. Beatt Equip. Co.*, 120 Wn.2d 246, 294, 840 P.2d 860, 886 (1992). The trial court’s ruling *in limine* deprived Mr. Misasi and Samaritan of their right as “entities” to limit their liability to that percentage share of damages that Mr. Misasi’s fault – rather than Drs. Hart’s and Canfield’s fault – caused.²⁶

Under the evidence and logic of the case plaintiff presented, Drs. Hart and Canfield, who shared in Mr. Misasi’s decision-making, were negligent if Mr. Misasi was, yet the jury was not given an opportunity to apportion any “fault” to them. Dr. Hart, a medical doctor and Mrs. Dormaier’s longtime internist, had tested her and cleared her for surgery on September 18, Ex. P3, and the next day consulted with Dr. Canfield, the surgeon evaluating Mrs. Dormaier, and again concurred that surgery was appropriate. Ex. P4 (000001). The day Mrs. Dormaier died, Dr. Hart again conferred with Dr. Canfield, who had done additional tests, and

²⁶ The trial court supposed that Mr. Misasi and Samaritan could have preserved their right by pleading cross-claims against Drs. Hart and Canfield, but that was no answer because it runs afoul of the clear policy of RCW 4.22.040-.050 (providing jointly and severally liable defendants a right to seek contribution against one another in a separate action up to a year after judgment in the original action) to relieve defendants of the “cruel dilemma” of choosing between asserting contribution against a co-defendant (thus compromising the defense to a plaintiff’s claims) and not asserting such claims (to improve the defense) and losing them. It would also require defendants to plead cross-claims for contribution even though they will not know until after judgment is entered whether they will have any joint and several liability with a co-defendant.

again cleared her for surgery. RP 1046-50.²⁷ Dr. Swenson testified at trial not only that a nurse anesthetist should be able to recognize the signs and symptoms of pulmonary embolus, but that any physician should be able to as well. RP 260-61. Under Court's Instruction No. 1, WPI (Civ.) 1.02, "[e]ach party [was] entitled to the benefit of all of the evidence, whether or not that party introduced it." CP 260. Thus, defendants were entitled to the benefit of that opinion of Dr. Swenson, which provided a basis for the jury to apportion fault to either or both physicians under RCW 4.22.070(a) and to argue that, if Mr. Misasi was negligent, Drs. Hart and Canfield were at fault, too. Instead, plaintiff got to paint Drs. Hart and Canfield as being just as allegedly negligent as Mr. Misasi, free of any concern of a verdict limiting Mr. Misasi's liability accordingly.

Mr. Misasi and Samaritan were entitled to argue that fault should be apportioned to Drs. Hart and Canfield, in the context where Mr. Misasi, who was not a medical doctor and who had never seen Mrs. Dormaier before 10:30 a.m. on the day she died (at 3:00 p.m.), was alleged to have been negligent for his part in what was an undisputedly joint decision to proceed with surgery that was made with both Drs. Hart and Canfield. RP 1029-30, 1047-52, 1320, 1323-24. The trial court's refusal to allow Mr. Misasi and Samaritan to allocate fault to Drs. Hart and Canfield because

²⁷ Dr. Swenson, plaintiff's lead expert, held the opinion that Dr. Hart's care was substandard, CP 1259-61, but defendants could not make that known to the jury.

they did not oppose Drs. Hart's and Canfield's motion for summary judgment dismissal of plaintiff's claims against them, a motion that had nothing to do with Mr. Misasi's and Samaritan's apportionment of fault affirmative defenses, was error and should be reversed.

E. The Trial Court Erred in Including in the Judgment the Jury's Award to Mr. Dormaier Individually for Damages Due to Mrs. Dormaier's Death.

Court's Instruction No. 12 permitted the jury to make an award of damages to Mr. Dormaier, personally, only for Mrs. Dormaier's *death*:

If your verdict is for plaintiffs on the claim brought on behalf of Lourence C. Dormaier individually, then you must determine the amount of money that will reasonably and fairly compensate [him] for such damages as you find were proximately caused by the death of Ruth M. Dormaier.

CP 274. Plaintiff's counsel took no exception to Instruction No. 12 and did not request that "or by the loss or diminution of Ruth Dormaier's chance of surviving the condition that caused her death" be added to the end of the sentence quoted above. The instruction did not permit an award to Mr. Dormaier of "such damages as you find were proximately caused by Mrs. Dormaier's loss or diminution of a chance of survival." Plaintiff waived any complaint about Instruction No. 12's wording, including the limiting of Mr. Dormaier's damages to those caused by his wife's death. *See, e.g., Daniels v. Pac. Northwest Bell Tel. Co.*, 1 Wn. App. 805, 807, 463 P.2d 795 (1970). The jury having conclusively found in its answer to

Verdict Form Question 2 that negligence by Mr. Misasi *did not cause* Mrs. Dormaier's *death*, no basis existed, under the law of this case established for plaintiff by Instruction No. 12,²⁸ for any award of damages to or for Mr. Dormaier individually. If judgment was properly entered at all on the verdict, it should have excluded the \$1.3 million award to him. This Court should remand for amendment of the judgment to delete that award.

F. Even if No Other Errors Occurred, Any "Loss of Chance" Recovery Must Reflect the Percentage by Which the Jury Found the Chance of Survival Had Been Diminished.

If this case truly had been a "loss of chance case," even though plaintiff never claimed or presented any evidence that Mrs. Dormaier had a less-than-even-chance of survival no matter what, recoverable damages in a "loss of chance" case are limited by the percentage diminution of the chance. *See Mohr*, 172 Wn.2d at 858 ("the *Herskovits* plurality adopted a proportional damages approach, holding that, if the loss was 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"). Even if the jury in this case was properly instructed on "loss of chance," and even if there were evidence to support a finding of a 70% diminution in Mrs. Dormaier's chance of survival in its answer to Question 4 (notwithstanding what Instruction No. 11 said and how the jury answered

²⁸ *E.g., Roberson v. Perez*, 156 Wn.2d 33, 41, 123 P.3d 824 (2005) ("instructions that are not objected to are treated as the properly applicable law for purposes of appeal").

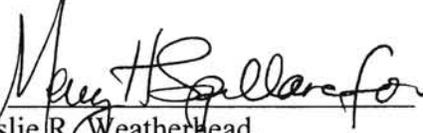
Question 2), it was error for the trial court to treat the jury's answer to Question 4 as superseding its answer to Question 2 and to enter judgment for 100% of the damages the jury found in its answer to Question 5. At most – again assuming that “70%” was a permissible answer to Question 4 despite Instruction No. 11 and the jury's answer to Question 2, and that there was evidence to support such a finding – the judgment could be for no more than 70% of the awards – *i.e.*, \$924,308.84, not \$1,320,441.22.

VII. CONCLUSION

Judgment should have been entered for the defendants because the jury absolved Mr. Misasi of liability for Mrs. Dormaier's death and should not have been instructed on “loss or diminution of a chance to survive.” This Court should reverse the trial court's “loss of chance” rulings, vacate the judgment entered for plaintiff, and remand for dismissal with prejudice.

RESPECTFULLY SUBMITTED this 9th day of November, 2012.

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I hereby certify under penalty of perjury that under the laws of the State of Washington that on the 9th day of November, 2012, I caused a true and correct copy of the foregoing document, "Joint Brief of Appellants Robert Misasi, CRNA, Columbia Basin Anesthesia, PLLC and Samaritan Hospital," to be delivered in the manner indicated below to the following counsel of record:

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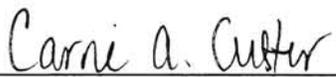
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