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Court of Appeals
Division III
State of Washington

COA No. 326527
Superior Ct. No. 12-2-00325-9

**IN THE COURT OF APPEALS, DIVISION III
OF THE STATE OF WASHINGTON**

**ESTATE OF LORRAINE P. HENSLEY by and through its Personal
Representative, JESSICA WILSON and LORRAINE HENSLEY, by
and through her Personal Representative,
Appellants,**

v.

**COMMUNITY HEALTH ASSOCIATION OF SPOKANE (CHAS);
PROVIDENCE HOLY FAMILY HOSPITAL; SPOKANE EAR, NOSE
AND THROAT CLINIC, P.S., and MICHAEL CRUZ, M.D.,**

Respondents.

APPELLANT'S CONSOLIDATED REPLY AND RESPONSE BRIEF

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I. REPLY ARGUMENT.

- A. **Neither Respondents Providence Holy Family Hospital nor Community Health Association presented the requisite expert medical evidence necessary to create any genuine issue of material fact at summary judgment in spite of their opportunities to do so.**

As detailed in their opening brief, the Hensleys moved for summary judgment against all Respondents on the issues of liability, i.e., medical care below the standard of care, and causation, supported by expert medical evidence. *CP 41-70*. Dr. Steven Kmucha testified in detail how “all of the named medical providers in this case handled this patient’s medical condition in a manner below the standard of care for each at each stage of this proceeding ...” *CP 50*, ¶ 42: 2-5.

- 1) Holy Family Hospital intentionally failed to present expert evidence, relying on a claimed facial invalidity of Dr. Kmucha’s declaration as to a “national standard of care,” and thus failed to create a genuine issue of fact for trial.

Holy Family concedes that it did not present a shred of controverting expert medical evidence to that evidence presented by Dr. Steven Kmucha at summary judgment. Holy Family doesn’t complain that it wasn’t given proper time to do so—it argues that it just didn’t have to. It was “under no

obligation to respond,” it asserts, because the declaration of Dr. Kmucha was “facially invalid.” *See Response at p. 4.* Dr. Kmucha, it argues, “asserted, without support, that a national standard of care applied to this case.” No issue of fact is raised by this argument, and as a matter of law, the premise is wrong.

First, Holy Family offers no suggestion as to what “support” would be needed for a medical doctor to opine that an infectious process is treated in a standardized way throughout the country. Dr. Kmucha is Board-certified in his specialty, and if standards for the treatment of such an infectious process differed from state to state, he’d say so. *CP 42, ¶¶ 4-6.* If he was wrong, Holy Family’s medical expert would disagree with his testimony. None did.

Second, Dr. Kmucha testified that a *national* standard of care applies “in any state in this country” for the medical treatment of this particular acute sinusitis condition. *CP 42, ¶ 6:7-11; ¶ 5.* He states: “When I use the phrase ‘standard of care,’ I use it to mean that degree of care, skill, and learning expected of a reasonably prudent health care provider in the profession or class to which that provider belongs, acting in the same or similar circumstances *in any state in this country.*” *CP 42, ¶ 6: 7-11.* Washington is a state in this country. That testimony establishes the

Washington standard of care. Holy Family did not offer expert testimony to dispute this.

Third, it is well-established that a physician licensed in another state may provide admissible testimony that a national standard of care existed in Washington, and that the Defendant violated that standard. *Driggs v. Howlett*, _____ P.3d _____, 2016 WL 2591877 at *13 (March 2016), citing *Elber v. Larson*, 142 Wn.App. 243, 248, 173 P.3d 990 (2007) and *Pon Kwock Eng v. Klein*, 127 Wn.App. 171, 110 P.3d 844 (2005). Dr. Kmucha did this, testifying that the standard of care he described applied to any state in this country. His declaration properly establishes that standard of care in Washington. *Id.*

The trial court's assessment is instructive. Dr. Kmucha's testimony, noted the trial court, referred to the standard of care in Washington "as the standard of care for treating an infectious process, and an infectious process is the same in Washington as it is anywhere else in the country, and the treatment of an infectious process is the same anywhere else in the country as it is in Washington." *RP 3564: 14 – RP 3565: 7*. The trial court noted, "We're not dealing with esoteric or academic procedures here. We're dealing with the generic infectious processes which, as he says, apply to literally all qualified health care

providers. Dr. Kmucha is basically saying that this isn't a specialized physician issue. This is an infection going on inside the body, and the standard of care is well established."¹ *Id. at 3565: 8-11.*

With this uncontroverted evidence in the record, Holy Family could have requested the opportunity to supplement. The trial court allowed the Hensleys time to "complete the record" by supplement given Respondent's concern, essentially finding good cause to allow such. *See Coggle v. Snow*, 56 Wn.App. 499, 507, 784 P.2d (1990); *Butler v. Joy*, 116 Wn.App. 291, 300, 65 P.3d 671 (2003). As to the Respondent's claimed deficiency, the trial court concluded that Dr. Kmucha could likely very easily just supplement his declaration with an opinion from someone in the state of Washington, noting, "I just cannot imagine he could not." *RP 3568: 19-20.* Supplemental testimony was thus allowed from Kmucha to complete the record on a defense argument that the court did not ever clearly accept in the first place. *RP 3569: 1-2.* Dr. Kmucha provided that supplemental testimony.² *CP 167-70.* No objection was taken to this

¹ It was on this basis that the trial court refused to strike the declaration of Dr. Kmucha.

² By supplement, Dr. Kmucha clarifies that his use of the phrase "violation of the standard of care" includes Washington, "because those standards are the very same in Washington as they are in my own jurisdiction and anywhere else in this country as it relates to the treatment of this infectious process at issue, as this is the national standard of care." *CP 169, ¶ 11.* He goes further: "Infectious processes incur within nearly all areas of medicine, are well known phenomena, and the approach to such is as well

supplement. Holy Family did not avail itself of a similar opportunity to supplement, nor ask for leave to do so. Holy Family presented no expert medical evidence to controvert the Hensleys' evidence in any form, at any stage, and requested no opportunity to do so.

The Hensley Estate was entitled to summary judgment against Holy Family on both liability and causation under CR 56.

- 2) Burdens of production at summary judgment are set as to a moving and non-moving party, not as to a medical doctor versus a patient. Medical providers are not implicitly allowed more protection.

Holy Family argues that this Court should adopt a higher burden of production “and persuasion” at summary judgment for plaintiffs as against medical defendants. *See Response at pp. 26-28.* No Washington law supports the proposition. Where a moving party sustains its burden of proof at summary judgment, then the burden shifts to the other party “to set forth facts showing that there is a genuine issue of material fact.”

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universal among the areas of medicine.” *CP 170*, ¶ 12. He states that “all practitioners in the country, including Washington, must adhere to such practices. This is the standard of care.” *CP 169* ¶ 9. Dr. Kmucha testified that he confirmed with “Michael Glenn, M.D., an otolaryngologist and Physician-in-Chief at Virginia Mason Medical Center in Seattle, Washington, that the standard of care in the state of Washington relative to procedures related to infectious processes and to an acute sinusitis, does not deviate from those acceptable procedures, and consists of those same standards and expectations as are in my own jurisdiction (and anywhere else in the country).” *CP 169*, ¶ 10.

Wn.2d 912, 915, 757 P.2d 507 (1988), citing *Graves v. P.J. Taggares Co.*, 94 Wn.2d 298, 302, 616 P.2d 1223 (1980). Affidavits of expert medical witnesses must satisfy a burden of proof or create a material issue of fact for trial. *Id.*, and see *Peck v. Collins*, 181 Wn.App. 67, 91, 325 P.3d 306 (2014). Medical expert affidavits opposing summary judgment may not use “conclusory statements without adequate factual support.” *Id.*, relying on, e.g., *Guile v. Ballard Community Hospital*, 70 Wn.App. 18, 25, 851 P.2d 689 (1993).

Holy Family thus argues that this Court should adopt the, e.g., Eastern District of Texas standard for summary judgment. *Response*, p. 26, citing *Robax Corp. v. Professional Parks, Inc.*, 2008 WL 3244150 at *2 (N.D. Tx. 2008), or a standard out of New Hampshire, or law from the Fifth or Ninth Circuits. There is no support for the proposed standard here, and Respondents don’t offer why this state’s burden-shifting should be modified. Holy Family argues that *Graves v. Taggares*, 94 Wn.2d at 302 supports a higher standard, but *Graves* does not do so. *Graves* did not involve expert medical evidence or testimony on the standard of care violations. Instead, expert evidence was submitted on the issue of “agency as a matter of law,” but the facts asserted were not consistent with the conclusion of law. This case differs.

This state's law requires that a non-moving party come forward with responsive evidence that will create genuine issues of fact for trial, and Holy Family failed to do that. The Hensley estate was entitled to the entry of summary judgment on liability and causation.

3) Dr. Kmucha's declaration includes its supplement.

Holy Family argues that Dr. Kmucha's supplemental declaration was not considered by the trial court in denying the Hensleys' motion for summary judgment, because the court didn't identify a "supplemental" declaration in the order Holy Family prepared for the court. First, this is de novo review. *Smith v. Safeco Ins. Co.*, 150, Wn.2d 478, 483, 78 P.3d 1274 (2003). Dr. Kmucha's supplement is part of this Court's record on review. Second, even at the trial court level, the supplement was considered. A supplement is readily construed as part of the same declaration. Dr. Kmucha's supplement was filed July 5, 2012, CP 167, and the court's order was filed July 20, 2012. CP 176. The "Declaration of Steven T. Kmucha, M.D." referenced in the order at CP 177, ¶ 3 necessarily includes the July 5th supplemental. Nowhere does the court say that it rejected or excluded that supplement. A declaration includes its supplements and amendments. Holy Family did not object to, quarrel

with, or exclude the supplement in its proposed order for the trial court. It was part of the record.

- 4) The Hensleys properly preserved appeal of the denial of summary judgment. Even though the order of retrial with respect to Holy Family Hospital is not “final” in the sense that trial ended in mistrial, the same summary judgment issue must be decided against CHAS as an appeal from its final judgment, and Holy Family has cross appealed as if its retrial order is a final judgment. The Court should address the argument against both Respondents to prevent judicial waste and piecemeal appeals.

The trial court’s order denying summary judgment is appealable even after trial on the merits for the reasons stated in the Hensleys’ opening brief at p. 6. This concept appears to be unchallenged. Both Holy Family and CHAS argue instead that the Hensleys’ notice of appeal does not bring up for review an order denying a pretrial motion for summary judgment. In fact, it does.

The Rules of Appellate Procedure are to be “liberally interpreted to promote justice and facilitate the decision of cases on the merits.” *Hiner v. Bridgestone/Firestone, Inc.*, 138 Wn.2d 248, 265, 978 P.2d 505 (1999), citing RAP 1.2(a). An appellate court should normally exercise its

discretion in considering a case on its merits despite technical flaws in compliance with the Rules of Appellate Procedure, unless there are compelling reasons not to do so. The purpose of a notice of appeal is simply to notify the adverse party that an appeal is intended. *State v. Olsen*, 74 Wn.App. 126, 128, 872 P.2d 64 (1994), relying on RAP 5.3(a).

Here, appeal was taken from the final judgment as to CHAS. The trial court's order staying further proceedings against Holy Family until these matters are reviewed was also named in the notice. *CP 1034-39*. An appellate court will review a trial court order not designated in the notice under RAP 2.4(b).³ Under RAP 2.4(b), an order or ruling not designated in a notice is then reviewed by an appellate court if that order "prejudicially affects the decision designated in the notice," and is made before the appellate court accepts review. *Gomez v. Sauerwein*, 172 Wn.App. 370, 376, 289 P.3d 755 (2012). An order "prejudicially affects the decision designated in the notice" where the designated decision would not have occurred in the absence of the undesignated ruling or order. *Id.* Both criteria apply here.

Here, CHAS obtained a final judgment that CHAS's proven

³ RAP 2.4(b) was intended to eliminate any "trap for the unwary," and to allow for review for any failure to appeal an appealable order which might prevent its review upon appeal from final judgment. *See Wlasiuk v. Whirlpool Corp.*, 76 Wn.App. 250, 259, 884 P.2d 13 (1994) (*cite omitted*).

violation of the standard of care did not “cause” the ultimate injury. *CP 1013* ¶ 2.1. That final causation judgment in favor of CHAS would not have occurred in the absence of the court’s order denying the Hensleys’ motion for summary judgment. The order denying summary judgment as to CHAS, *CP 176-78*, thus prejudicially affected the final order from which appeal is taken, *CP 1012-14*, and should be reviewed.

As to Holy Family, the trial court ordered a retrial on all issues—liability and causation included—because the jury could not reach a verdict on the preliminary liability. *CP 1006-08, CP 1007: 2-5, 8-10, and CP 907 (verdict)*. This “mistrial” order would also “not have occurred in the absence of the order denying the Hensley Estate summary judgment.”

Holy Family might have argued, or this Court might ask, whether the order denying summary judgment against Holy Family is appealable simply because no final judgment has yet been entered against Holy Family Hospital given the mistrial. Typically, error in an order denying summary judgment may be reviewed only on appeal from the final judgment. *See, e.g., Maybury v. City of Seattle*, 53 Wn.2d 716, 718, 336 P.2d 878 (1959). Interlocutory review is disfavored. *Minehart v. Morning Star Boys Ranch, Inc.* 156 Wn.App. 457, 462, 232 P.3d 591 (Div. III, 2010), citing *Maybury, supra*. But this is a unique “interlocutory review”

of sorts. Trial has already taken place. Moreover, CHAS received a final judgment, and the trial court's order denying summary judgment is unequivocally appealable as to CHAS. *CP 1012-14*. It would be wasteful to rule on the summary judgment only as to CHAS, and require a second trial against Holy Family after this appeal is concluded before potentially returning to this very same scenario and issue, and going over it again.

Moreover, Holy Family cross appealed the trial court's denial of its CR 50 motions, and therefore claims either "final judgment" or "authorized interlocutory status." *CP 1252-54*. Holy Family cites RAP 5.1(d)'s cross review and requests RAP 5.2(f) relief, i.e., relief from the trial court's decision. The parties and the trial court thus implicitly agreed that the legal issues arising from this trial should be resolved before any retrial, in order to conserve judicial and party resources, and prevent piecemeal appeals. The Hensleys obtained an order staying the retrial of Holy Family Hospital until all issues of law could be resolved by this Appellate Court. *CP 1006-08, citing CR 62(b) and (h)*.

The Appellate Court should address this trial court order denying summary judgment as to Holy Family now. The issues are fully briefed, the evidence is fully developed, the same denial of summary judgment on the same grounds must already be determined as to CHAS, and it makes

sense from a judicial economy and interests of justice basis to decide the summary judgment issue against both Respondents jointly to prevent duplicative and piecemeal appeals.

- 5) Community Health Association's expert evidence was insufficient to raise a genuine issue of material fact at summary judgment, CHAS was on notice of that deficiency, and it did not ask to supplement.

Community Health Association also failed to respond to the Hensleys' motion for summary judgment with medical expert evidence that was sufficient to raise a genuine issue of material fact.

CHAS argues that the reason the trial court denied relief to the Hensleys was because of defense claims that Dr. Kmucha lacked knowledge of the standard of care of the state of Washington. *See Response at p. 10, citing RP 3568-69.* While the trial court didn't ever truly state that it agreed with that premise, CHAS agrees that the trial court allowed the Hensleys to supplement their showing. CHAS complains that "no such opportunity was afforded CHAS, however, because the court deemed there was enough to state a genuine issue of material fact," *Id., citing RP 3591: 17-20.* Nowhere did the trial court hold that CHAS's evidence created genuine issues of material fact. *See RP 3591 at 17-20.* To the contrary, the trial court warned CHAS that its response was

insufficient to do so. *RP 3592: 17 – RP 3593: 2*. It told CHAS that its “expert” declaration—a declaration by the defendant doctor exonerating himself—was “one of the most conclusory declarations I ever read. It absolutely had no facts to support the conclusions in the declaration of any kind of meaningfulness to me ... just conclusions. I noted that when I was reading it.” *RP 3592: 17-25*.

Conclusory opinions are insufficient to generate a genuine issue of material fact. *Hash by Hash v. Children’s Orthopedic Hospital*, 49 Wn.App. 130, 133, 741 P.2d 584 (1987). An expert medical witness who states only conclusory opinions does not satisfy even the initial burden of the moving party to prove the non-existence of a material issue of fact. “Unsupported conclusional statements alone are insufficient to prove the existence or nonexistence of issues of fact.” *Id. (citations omitted)*.

CHAS now complains that it really didn’t have time to do Dr. Conovalcuic’s declaration properly. It argues that “[S]urely he could do so given sufficient time.” *Response, p. 11*. But CHAS could have asked for that time. CHAS claims “No such opportunity was afforded CHAS ...” *CHAS Response at p. 10*. But that is not true. CHAS never asked for that opportunity. CR 56(f) allows for a motion for additional time to secure additional affidavits that will justify opposition to summary

judgment. As noted above, a trial court has a duty to allow a party a reasonable opportunity to complete the record before ruling on the case, on a showing of good cause. *Coggle v Snow*, 56 Wn.App. at 507; *Butler v Joy*, 116 Wn.App. at 300 (holding that even a failure to comply with the strict rule of CR 56(f) is not fatal to a motion for a continuance). CHAS never asked to supplement the record. It stood on its declaration of Dr. Conovalciuc after being warned that the declaration was insufficient. The Hensleys were entitled to summary judgment.

- 6) CHAS's physician's declaration was insufficient to raise a genuine issue of material fact, because it was entirely conclusory.

CHAS argues that this Court should find that Dr. Conovalciuc's declaration was sufficient to create a genuine issue of material fact as to CHAS's compliance with the standard of care. It cannot properly do so. The document is entirely conclusory.

As noted above, affidavits of expert medical witnesses which are conclusory in nature are insufficient to satisfy a burden of proof or create a material issue of fact for trial. *Hash by Hash*, 110 Wn.2d at 915, citing *Graves*, 94 Wn.2d at 302; *Peck v. Collins*, 181 Wn.App. at 91. In particular, a medical expert affidavit opposing summary judgment may not use "conclusory statements without adequate factual support." *Hash, Id*,

relying on, e.g., Guile, 70 Wn.App. at 25.

Dr. Conovalciuc's declaration is at CP 123-25. He testified only that he had reviewed Lorraine Hensley's medical care, and that it was his opinion that the standard of care didn't require an immediate referral to an ENT physician. *P. 124: 10-25.* In no respect did he address the violations and concerns identified by Dr. Kmucha. Dr. Kmucha testified in detail to the progression of the disease and CHAS treatment commencing even *before* January 9, 2009. *CP 43 at ¶ 13.* His testimony regarding CHAS goes through ¶ 26 of his declaration, i.e., through February 1, 2009. As of January 10, 2009, after CHAS's unsuccessful antibiotic treatment, ¶ 13, CT imaging of Jan. 10, 2009 showed a bony erosion process within the maxillary sinus, and an infectious process which was spreading into the right medial orbital region, "traveling through the vascular or lymphatic channels into the soft tissues of the orbit." *CP 43, ¶ 12.* The existence of the condition "triggered a standard of care referral." *CP 43: 23.* Thereafter, a "red flag" existed in the fact that previously prescribed oral antibiotics "were clearly not working, and there was a progressively worsening condition." *CP 45, ¶ 20.* There was no consideration of Ms. Hensley's type II diabetes, which further reduced her ability to fight the chronic infection as the process progressed. *CP 46, ¶ 25.* CHAS failed to

provide Ms. Hensley, not just a referral, but the more aggressive intervention needed at any time through this continuum of care. *CP 46*, ¶ 26.

In response, Dr. Conovalciuc does not discuss or controvert CHAS's failed antibiotic treatment, the CT imaging showing bone erosion or soft tissue involvement, or Ms. Hensley's diabetic vulnerability. He does not discuss how he or other CHAS providers followed the standard of care, what he or others did for Ms. Hensley, why they did what they did, or why he or the others chose *not* to refer given the medical conditions present. He simply states that the standard of care "did not require an immediate referral." This is a conclusory statement without adequate factual support, and it cannot create a genuine issue of fact for trial.

- 7) Dr. Kmucha was qualified to testify about "other specialty" standards of care with an infectious process.

CHAS argues Dr. Kmucha was not qualified to testify regarding the standard of care "of another specialty." *Response*, p. 10, citing *RP 3594: 10-16*. It argues that Dr. Kmucha has never been a family practice doctor. *RP 3593: 12 – RP 3594: 2*. But as noted in the Hensleys' opening brief, Dr. Kmucha's qualifications to treat this infectious process are well detailed within his declaration, and he attests that the treatment of this

process is the same across medical provider ranks. This is sufficient. *Morton v. McFall*, 128 Wn.App. 245, 253, 115 P.3d 1023 (2005); *Hill v. Sacred Heart Medical Center*, 143 Wn.App. 438, 447, 177 P.3d 1152 (2008). The trial court correctly assessed CHAS’s claim related to Dr. Kmucha’s not being a family physician: “You do not have to be an ER, you do not have to be [a] rocket scientist to figure out you should have done something.” *RP 3594: 10-14; see also RP 3564: 14 – RP 3565: 11*. At no point did the trial court rule that Dr. Kmucha was not qualified to testify as to the standard of care for the CHAS medical providers in addressing the infectious process, and the law supports that conclusion.

8) Respondents CHAS and Holy Family Hospital failed to raise any genuine issue of material fact.

All three collective Respondents pursued summary judgment against the Hensleys by claiming that the Hensleys had no medical expert testimony to support their claims. The Hensleys submitted that expert testimony, and they countermoved, claiming that it was the *Respondents* who could not defend their medical treatment, or dispute causation. The burden had shifted—Respondents now had to raise a genuine issue of material fact by their own medical expert testimony, as they were now the non-moving party against whom summary judgment was sought.

Respondent Spokane ENT responded to this burden shifting by submitting the detailed declaration of Dr. Michael Cruz. *CP 138-54*. Neither CHAS nor Holy Family responded. When the latter two Respondents were placed on notice that the trial court was allowing Dr. Kmucha to supplement the only single claimed deficiency they argued *may* have existed, neither Holy Family nor CHAS supplemented with expert evidence, nor asked for the right to do so. The Hensleys were entitled to summary judgment.

This Court should reverse and direct the entry of summary judgment against Holy Family and CHAS on liability and causation as sought by the Hensleys.

B. Trial Error.

- 1) Testimony required to establish “the” probability of a serious “possible” risk occurring does not require testimony that the serious possible risk will likely occur, much less that it will likely occur by some certain percentage.

The Hensleys argue that the trial court improperly dismissed their informed consent claims on grounds that they failed to show the “probability of occurrence.” *Opening Brief at Section III(B)(2), pp 26-32, citing RP 3358: 4-8*. In response, CHAS argues that the Hensleys’ experts didn’t testify as to the percentage of the risk actually occurring, arguing

that the Hensleys' experts "never quantified the percentage of the risk of the *development* of a brain infection." See *CHAS Response*, p. 32-35, *emphasis added*. Spokane ENT similarly argues that none of the Hensleys' experts gave testimony as to "the likelihood of that risk's occurrence." *Spokane ENT and Cruz Response*, p. 35. In dismissing the Hensleys' claims, the trial court ruled that the risk posed by the medical condition must be shown to *more likely than not come to fruition* in the absence of stated of care medical treatment.

These positions are not the statutory language. A recognized serious "possible" risk is a material fact. *RCW 7.70.050 (3)(d)*. Nowhere does the statute require testimony that these serious possible risks will actually occur, much less the percentage probability of that likely occurrence. *RCW 7.70.050 (3)(d)*.

As addressed in the Hensleys' opening brief at pages 31-32, "possible" is a probability. Testimony that a serious risk is possible establishes a level of probability at the same time. This is the statutory language. *RCW 7.70.050(3)(d)*. *Smith v. Shannon*, 100 Wn.2d 26, 33-34, 666 P.2d 351 (1983) is consistent. The first step of the analysis requires that an expert attest to the nature of the harm that may result, i.e. the serious possible risk, and "the probability of its occurrence." *Id at 33*. "The" probability

of an occurrence doesn't mean that it "is" probable. It just means that the expert must opine on "the" probability. "Its" likelihood of occurrence, doesn't mean testimony that it "is" likely that it will occur. *Id.*, 100 *Wash.2d* at 34. It just means that the expert must opine on "its" likelihood. The likelihood of the serious possible risk may thus be, e.g. very likely, likely, possible, unlikely, not likely at all, or impossible (except in the latter case it won't qualify as a serious "possible" risk in the first place). Any of this testimony meets the statutory requirements, and *Shannon's* first step. Whatever the probability of this serious possible risk actually occurring, *the jury* must now take over *Shannon's* step two. They must now balance, given the nature of the serious possible risk, and whatever the probability identified--high, low, likely, possible or unlikely—whether a reasonable patient would want to consider that risk in deciding on treatment. 100 *Wn.2d* at 33. As an example, if the serious possible risk of Ms. Hensley's condition was a cold, and that probability was extremely high, then that risk may not warrant much attention by the patient. But if the serious possible risk was one of death by brain hemorrhage, then even were the probability to be low, a reasonable patient may want to consider that risk in deciding on treatment. This balance doesn't require the expert to set a percentage of probable occurrence, it

requires that the expert deliver a concept that a jury can balance. Any other reading of the statute, or *Shannon*, is deviation from the plain language of both.

- 2) Testimony was presented that the end result of this type of condition “is” death. Testimony was presented that death from this condition is “very very very freak.” Both are probabilities of this serious possible risk, and both satisfy the statutory requirement. The case must be submitted to the jury.

The Hensley experts attested that the serious possible risk was death. This infectious process was lethal. And the end result of that serious possible risk was death. *RP 850:12-851:7; RP 705: 4-6; RP 718: 20-24; RP 1112: 23-25; CP 3357: 1-2.* If the end result “is” death, then “the” probability of this serious possible risk is extremely high, which is exactly what the trial court noted, even before dismissing the claims. *CP 3356:24 – 3357:2.* Given the serious possible risk, with this extremely high probability of occurrence, the case was required to be submitted to the jury to determine whether a reasonable patient would likely want to know about that in selecting from alternative forms of treatment within the

standard of care.⁴

Respondent Spokane ENT details some of the Hensley experts' testimony. Spokane ENT's Response at pp. 35-38 cites, e.g., testimony that Lorraine Hensley's medical condition carried a "very high risk," i.e., a "very high risk CT scan," *RP 596*, a "really high risk," *RP 598*, an infection that "will" extend into the lining of the brain causing meningitis, *RP 606-07*, a "life threatening" condition, *RP 598*, a "very serious, dangerous, and life-threatening condition," *RP 808*, the risk being "death," with death as "the" end point of the condition, *RP 850*, the risk of "severe potential complications," and again, the "end point" of the condition as brain abscess and meningitis. *RP 1112-13*. Respondents argue that the words "by what percentage would this likely occur?" are the magic language that must be uttered. That is not the statutory language. "The" probability is that the end point *is* death.

But even if the Hensleys' experts didn't establish "the" probability to the Respondents' liking, defense experts did. As one example, Holy Family's expert Dr. Jeffrey Larson concurred that the risk of death, a serious risk, was possible. He testified that a brain abscess scenario was

⁴ That probability could of course be minimized by standard of care medical treatment, but that is a different issue. The issue here is one of informed consent.

“very rare...I’ve never seen one in 32 years but I know it’s reported, I know it’s out there. And we try to always rule out the worst thing, so I ordered the CT of the brain to make sure that she didn’t have any swelling or abscess that had worked its way up there.” *RP 2005:10-17*. Dr. Larson repeatedly reiterated that this serious risk was possible, i.e. that it was “out there.” But, he opined, “its” likelihood, death, was a rarity. *RP 2068: 12-16*. But it was still a rarity that needed to be medically ruled out. “With regards to sinusitis in rare instances becoming life threatening, did you have that in mind on February 1st? Answer: I wanted to rule out any of the possibilities of it becoming life threatening.” *RP 2068: 15-16*. A subdural empyema, which Dr. Larson testified occurred here, was “generally rare.” *RP 1726: 17-25*. Such was “usually the end result of an intracranial infectious process, usually.” *RP 1726: 24-25*. Dr. Larson reiterates that sinusitis with intracranial complications was “rare,” but typically appears in the form of an epidural abscess. *RP 1843: 16-19*. An intracranial event occurring from a frontal sinus infection was “rare” and typically an epidural abscess, not a subdural empyema as occurred here. *RP 1853: 24-1854-3*. Dr. Larson summed it up—death is indeed a serious possible risk of this condition and the processes leading to it therefore should be ruled out. But the probability of death ultimately occurring from it was “very,

very, very freak, rare.” *RP 1849: 2-5.*

In sum, even looking at defense expert testimony alone, the first step of *Shannon* was satisfied. Death was the serious possible risk. Its likelihood from intracranial complications was either, per Plaintiffs’ evidence, extremely high, where the very end point of the condition is death, or, per defense expert Larson, very, very, very, freak. Both views established “the” probability of this serious possible risk. All facets of RCW 7.70.050 (3) and *Shannon*’s step one assessment were evidenced. It was now up to the jury. Given the seriousness of the possible risk being intracranial complications including death (the nature of the risk), then perhaps they would find that even a very very very freak probability was a probability that a reasonably prudent patient would still want to know about in deciding on treatment.

Finally, Respondents’ position urging that percentage testimony be adopted as a requirement is unreasonable and inhumane. A physician can’t ethically quantify the actual percentage of how likely it is that this condition will progress to death because reasonable medical providers do not *let* this condition progress to death. As illustrated here, the Respondent providers’ negligent anecdotal study on Ms. Hensley proved a 100% death rate when her stage of progression was reached—one patient

out of the one they had. In any reasonable world, such statistics would require the repetition of the very negligence seen here, and such evidence cannot be mandated. The first step of *Shannon* could never be met.

The trial court erroneously dismissed the Hensleys' well-supported informed consent claim, and denied the Hensleys a jury on this.

- 3) Respondent providers are not protected from the reach of the informed consent statute by claiming "lack of understanding" of the medical condition at issue—they understood the condition; they simply minimized the risk.

Respondent CHAS argues that its providers had no duty of informed consent, because the CHAS doctors didn't understand the medical condition or its risk. Holy Family Hospital urges that precedent relieves a medical provider from liability for failure to inform a patient "regarding pertinent fact and risks" unless that provider is "subjectively aware of those facts and risks." They argue that this a "mistaken diagnosis." See *Holy Family Hospital* at p. 32, and e.g. *Backlund, Gustav, and Burnett*.⁵

This was not a mistaken diagnosis. All providers understood that

⁵ *Backlund v. Univ. of Washington*, 137 Wn.2d 651, 661, 975 P.2d 950 (1999); *Bays v. St. Luke's Hospital*, 63 Wn.App. 876, 881-82, 825 P.2d 319 (1992); *Gustav v. Seattle Urological Ass'n*, 90 Wn.App. 785, 789, 954 P.2d 319 (1998); and *Burnett v. Spokane Ambulance*, 54 Wn.App. 162, 168-69, 772 P.2d 1027 (1989), review denied, 113 Wn.2d 1005 (1989).

Ms. Hensley had a right frontal sinusitis condition, with, ultimately, soft tissue swelling in the right frontal scalp region—this was an infectious process sitting in the sinus cavity right outside the front wall of her cranium. See Holy Family’s PAC John Hunter at *RP 2006: 19-23; RP 2033: 16-18; RP 2043: 1-16 (agreeing that Ms. Hensley’s right frontal sinus was completely opacified by February 1st)*; Holy Family’s Dr. Christopher Tullis at, e.g., *RP 2668: 7 (confirming his awareness of Ms. Hensley’s headache in the frontal maxillary and occipital areas), and e.g. 2670 (confirming his review of both the January 9th and February 1st CT images)*; Defendant’s expert Eric Pinczower at *RP 3007-3010, RP 3008: 5-25, (confirming that the February 1st CT showed the forehead and frontal scalp soft tissue swelling greater to the right of the midline overlying the frontal sinus)*; Dr. Michael Cruz, *3275:11-3276:7 (agreeing that Ms. Hensley’s situation was “not a common situation” and gave rise to the suspicion that her frontal sinus bacteria could be strep viridans bacteria, among others, and 3041:6-3042:7, confirming that he observed maxillary erosion on the January 9th CT scan)*. The condition that Ms. Hensley had (i.e., bony erosion and the frontal sinusitis), was not undiagnosed. It was present in living color on CT imaging.⁶ These

⁶ Defense expert Eric Pinczower agreed, stating, “Apparently the radiologist also saw some swelling.” *RP 3009 at 2-4.*

providers didn't fail to diagnose the condition, they simply minimized the risk of the known condition. They chose not to tell Mrs. Hensley about her condition, or alternative treatments.

This supports a classic informed consent deprivation under RCW 7.70.050. Plaintiffs' experts testified that the serious possible risk of death from that would happen as an end point. Respondents' experts testified that the serious possible risk of death was very rare. It was now up to the jury to determine, given the nature of the risk and "its" probability, whether a reasonable person would have wanted to know. Dismissal was error.

4) Jury Misconduct.

The Hensleys request a retrial against all Respondents on the grounds of jury misconduct. Retrial is already required against Holy Family, and it therefore does not respond to the argument. Respondents CHAS and Spokane ENT respond in similar fashion, and both arguments are addressed as one.

Spokane ENT cites a recent decision as a supplemental authority, *Long v. Brusco Tug and Barge, Inc.*, 185 Wn.2d 127, 368 P.3d 478 (2016). The case is instructive. The Hensley case does not involve a misunderstanding of an instruction or influence by an improper remark.

The Hensley case involves an undisclosed bias held by two jurors—one being the foreman—and a refusal to follow the judge’s instructions because of it. Such actions do not inhere in the verdict under *Long*—they sound in misconduct. *Id. at 480.*

The Respondents argue that with respect to undisclosed bias, juror “Jay” was not asked specifically about the particular bias. But in *Hill v. GTE Directories Sales Corp.*, 71 Wn.App. 132, 104, 856 P.2d 746 (1993), cited by Respondents, the undisclosed fact was a juror’s association with a member of defense counsel’s law firm. *Id. at 142.* The information withheld would not have supported a challenge for cause, but only the use of a peremptory. *Id. at 140-41.* The Hensley jurors’ biases were substantially more structural. Their bias was a bias against suing doctors entirely. Juror Jay tried to make jurors feel guilty about voting against doctors. *CP 939, ¶ 5.* Two jurors, including the jury *foreman*, asserted to other jurors that no doctor should be sued for just trying to do his job, that no doctor should be sued if the doctor only saw a patient once, that CHAS shouldn’t be sued because they deal with “a lot of poor people,” and that CHAS doctors weren’t properly paid and shouldn’t be held responsible for the same standard of care. *CP 938: 1-11.* These are inherent biases in favor of immunity. These jurors advocated those biases that doctors

should not be sued as the determinative basis for a verdict. This bias in favor of physician immunity from lawsuit is in direct controversion of the court's instructions. The jury's job is to assess the evidence in a fair manner, not to lobby for tort immunity. The jurors' undisclosed bias in favor of, and advocacy of this immunity, was misconduct.

Moreover, it was this very same tort reform advocate, Juror Jay, who also injected his own medical expertise into the jury pool to support his already biased advocacy. Courts have been reluctant to find misconduct when a juror injects personal knowledge and experience known to the parties into deliberation. *Long, supra*. But in *Long*, the court could not determine exactly what the involved juror had said about applicable laws. This case is different. Ironically, all three Respondents argue the many shades of why an experienced otolaryngologist is not qualified to testify as to the standard of care in Washington, and why percentages of risk must be quantified before such testimony is properly probative; yet these same Respondents argue that Juror Jay should just "have at it" in the jury pool and inject his own professed medical expertise of the symptomology of intravenous Dilaudid for the jury's deliberation. It is duplicitous to impose markedly rigid and demanding standards for doctors to prevent juror confusion through complex medical testimony,

but then conclude that Juror Jay can clear it all up in the jury room by his own observations.

The Hensleys stand on their briefing. The verdicts should not stand.

II. RESPONSE TO CROSS APPEALS

A. Restatement of the Issues.

1. Counter Appellant Holy Family Hospital did not contest agency at trial. It cannot do so here.

2. Reasonable medical certainty is a standard for a pretrial motion in limine, not a question during a jury trial. If the expert is on the stand testifying, then that expert is testifying with reasonable medical certainty.

B. Argument.

1. Counter Appellant Holy Family Hospital conceded that it was acting through its agents.

Holy Family cross appeals the trial court's denial of its motion to dismiss Ms. Hensley's claim against Holy Family on the grounds that she did not show the "agency" of the emergency room providers. Holy Family claims that "agency" was in dispute from the inception of the case, citing its answer filed at the outset of the case. *See Response Brief at p.*

18. It was not. Agency was admitted at summary judgment, and was never in contention as an issue for the jury.

First, during the parties' motions for summary judgment, Holy Family counsel acknowledged that agency would not be contested. He stated that the activities of Dr. Tullis and PAC Hunter were activities of "at a minimum, ostensible agents. They're not employees, they are independent contractors. But I think under *Adamski*, they are ostensible agents."⁷ Holy Family counsel noted "I am responsible for their conduct but I don't represent them." *RP 3572:17-24*. The court concludes "Everybody acknowledges that Holy Family Hospital...would have vicarious liability for the actions of the medical providers involved who are not presently before the court so that is not an issue before me on summary judgment." *RP 3589:6-11*.

By pretrial joint trial management report, the parties listed all issues in dispute for trial. Again, Holy Family did not indicate that the issue of agency was in dispute:

⁷ *Adamski v. Tacoma Gen. Hosp.*, 20 Wn.App. 98, 579 P.2d 970 (1978).

E. **LIST EACH ISSUE THAT IS DISPUTED** (Issues not identified here may not be raised at trial without leave of court):

1. **Standard of Care;**
2. **Informed Consent;**
3. **Res Ipsa Loquitor;**
4. **Wrongful Death;**
5. **Medical Causation;**
6. **Nature and extent of any damages;**
7. **Comparative fault.**

Supplemental Clerks Papers still to be delivered but will likely be at CP 1256, ¶.E.

Third, Holy Family filed proposed jury instructions eight months before trial on September 9, 2013, nowhere identifying or defining agency as an issue in dispute. *CP 303-319.*

Fourth, in the Defendants' Joint Trial Brief, authored by Holy Family's counsel, Holy Family again conceded that agency was not a contested issue. Nowhere does it identify the issue of agency as a fact or legal issue in contention. *CP 595-614.*

All of this led to a proper conclusion that agency was conceded. Yet following Plaintiffs' case in chief, Holy Family counsel then moved to dismiss Holy Family from the suit arguing that there was "no evidence on ostensible agency even offered, even tried, even attempted." *RP 1860: 19-21.* This was an ambush. The Hensleys' counsel pointed out that agency was not disputed coming into trial, was not listed as such on the joint

report, and that this had all been discussed at summary judgment. *RP 1863: 7-22*. The Hensleys' also noted that the Hensleys produced evidence of agency in any event, including the providers' chart notes themselves, which were on Holy Family's chart notes. *RP 1864*. The court agreed that "[W]ith regard to the issue about ostensible agency, is late." *RP 1869: 20-24*. The trial court denied Holy Family's motion, while also debunking the defense argument made.⁸ The court denied the motion. But even then, the trial court left open the possibility of additional evidence being presented that might convince the court to change its mind. *RP 1869, ln. 10-11*. Holy Family thereafter presented no further evidence that its providers were not agents of Holy Family Hospital at the time that they were acting.

Finally, on May 27th, Holy Family submitted jury instruction D-15, proposing that the jury be instructed that each of the Holy Family Providers, naming each individually, "was an ostensible agent of Providence Holy Family Hospital when he provided care and treatment to Lorraine Hensley. Therefore any act or omission of (Mr. Hunter/Dr. Tullis) was the act or omission of Providence Holy Family Hospital." *CP*

⁸ It stated "[I]n my view clearly they were acting on behalf of Holy Family, these were the people that treated Ms. Hensley, there isn't anything to indicate that anything different would have happened, I guess, in terms of their relationship with Ms. Hensley because they were independent contractors as opposed to employees of the hospital." *RP 1869: 11-17*.

660, *Defendant's Proposed Supplemental Jury Instruction No. D-15*.

Nowhere in its proposed verdict form did Holy Family identify agency as a disputed issue. *CP 661-662*.

In the ensuing charging conference for jury instructions, Holy Family argued that its instruction D-15 was a proper iteration of the *Adamski* factors regarding agency, and “conforms to the evidence here...” *RP 3392: 22-25*. The court ultimately used its Instruction No. 6, as opposed to Holy Family’s Instruction No.15, but the instruction is essentially the same thing. *Compare Defendant’s Instruction No. 15 at 660, verses court’s Instruction No. 6, CP 887, where all Respondents concede the agency of their acting providers. CP 303-320, and 659-663.*

Holy Family thus waived any dispute regarding agency by this continuing course of conduct, commencing at summary judgment and continuing through its very proposal of a jury instruction conceding ostensible agency. Any error regarding this issue “was invited error,” and it should not be allowed to be challenged on appeal, *State v. Eplett*, 167 *Wn.App.* 660, 664, 274 *P.3d* 401, 403 (2012), citing *State v. Heddrick*, 166 *Wn.2d* 898, 909, 215 *P.3d* 201 (2009) (a party cannot set up an error and then claim such error on appeal even when the alleged error is of constitutional magnitude). Agency was conceded, it was a “non-issue” in

this trial, and Holy Family's appeal should be denied.

- C. Reasonable medical certainty is a standard for a pretrial motion in limine, not a question during a jury trial. If the expert is on the stand testifying, then that expert is testifying with reasonable medical certainty.

Spokane ENT, Dr. Cruz and Holy Family Hospital argue by cross appeal that the trial court erred by failing to dismiss the Hensleys' standard of care claim "because Hensleys' experts did not give their respective standard of care opinions in terms of reasonable medical certainty." They are incorrect.

First, the phrase "reasonable medical certainty" was used by Dr. Elliot Felman with respect to CHAS. *RP 586-587*. Dr. Richard Beck confirmed that his opinions as to *all* providers were those of "reasonable medical certainty." *RP 804-805*. Dr. Sokolov did the same. *RP 1071-1073 (standard of care), 1114-1115 (causation)*.

The bigger issue presented is whether jury questions have to be formalized with the phrase "reasonable medical certainty," as part of the script. They do not. Medical expert testimony must be based on a reasonable degree of medical certainty to be admitted at all. *See Reese v. Stroh, 128 Wn.2d 300, 305-306, 907 P.2d 282 (1995)*. If the witness is already

testifying, then his opinions are already based on reasonable medical certainty or his testimony wouldn't be allowed in the first place. Reasonable medical certainty is a *Frye* standard, not a trial question.⁹

Reasonable medical probability and reasonable medical certainty are used interchangeably. *Anderson v. Akzo Nobel Coatings, Inc.*, 172 Wn.2d at 607. This state adheres to the *Frye* standard in its civil cases. *Anderson* at 602-603, citing *Frye*, 54 App. D.C. 46. Expert medical testimony “must meet the standard of reasonable medical certainty or reasonable medical probability.” *Id.* at 606-607, *emphasis added*, citing the *Restatement of Torts*. The phrase “meet the standard” necessarily means that the witness must meet the *Frye* standard to be allowed to testify at all. Once a witness is qualified as a medical expert, and their testimony admitted under ER 702 as being helpful to the jury, then the expert's opinions are admissible. *Anderson* at 600, 602, citing *e.g. Reese v. Stroh*, 128 Wn.2d at 305-306, and *Frye and Daubert*. Those opinions are necessarily held to a reasonable medical probability or certainty, or the expert wouldn't be on the stand testifying.¹⁰

⁹ *Frye v. United States*, 54 App.D.C. 46, 293 F. 1013 (1923), cited in *e.g. Anderson v. Akzo Nobel Coatings, Inc.*, 172 Wn.2d 593, 602-603, 607, 260 P.3d 857 (2011), and also citing *Daubert v. Merrell Dow Pharm., Inc.*, 509 U.S. 579, 113 S. Ct. 2786, 125 L. Ed. 2d 469 (1993)

¹⁰ Evidence rules provide “significant protection against unreliable, untested or junk science.” *Id.*, citing 5(B) KARL B. TEGLAND, *WASHINGTON PRACTICE: EVIDENCE LAW & PRACTICE* § 702.19 at 88 (5th EDITION 2007), noting that *Frye* continues to apply in civil cases “until the Washington Supreme Court explicitly says otherwise.” See *e.g.*

None of the Respondents moved to exclude any of the Hensleys' physicians on grounds that their opinions were not based on a standard of reasonable medical probability or certainty. *See Defendant's Motion in Limine, CP 490-517*. Thus, any quarrel at trial with an expert's stating his opinions during his already qualified testimony can be "tested by the adversarial process within the crucible of cross examination, and adverse parties are permitted to present other challenging evidence." *Anderson, at 607, citing Daubert, 509 US at 596*. Even in absence of a "statistically significant basis" for an opinion, such would not render testimony inadmissible, it would go only to the weight of the testimony. *Id. at 610*.

Respondents assert it to be "settled law" that medical opinions must be "expressed" accompanied by the words "with reasonable medical certainty" to make the answer probative. Their support does not so state. *McLaughlin v. Cook, 112 Wn.2d 829, 836-837 (1989)* does not require expert witnesses to testify in a particular format, as such would elevate form over substance. In order to be admissible, it is only necessary that the expert's standard of care testimony be based on general professional standards, e.g. that the opinion be more than a personal opinion. *White v. Kent Med. Ctr., Inc., P.S., 61 Wn.App. 163, 172, 810 P.2d 4, 10 (1991)*;

Anderson at 602 and 606.

and *Leaverton v. Cascade Surgical Partners, PLLC*, 160 Wn. App. 512, 520, 248 P.3d 136 (2011). *McLaughlin* is easily read consistently with *Anderson* and *Frye*. It holds that medical expert testimony must be based upon a reasonable degree of medical certainty. *Id.* at 836-837. If a physician witness is qualified and already testifying at trial as to his or her professional opinions about standard of care and causation, then the witness is a doctor testifying about medicine, and he is necessarily giving opinions based upon “reasonable medical certainty” unless he says otherwise.

The court was correct in refusing to dismiss the Hensley’s’ claims for the failure of medical evidence to support those claims.

III. CONCLUSION.

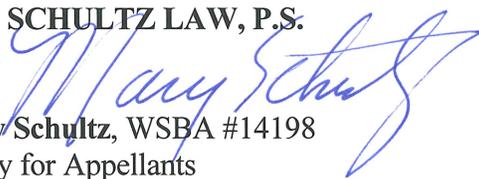
On the Respondents’ cross appeals, each should be denied. Medical trials should be about substance, not technical traps and formulaic landmines.

On the Hensleys’ appeal, this Court should reverse the order denying summary judgment in favor of Respondents CHAS and Holy Family Hospital, direct the entry of summary judgment as to those providers’ violation of the standard of care and causation, and order retrial against both as to damages. This Court should reverse the directed verdict in favor of all Respondents on the dismissal of the Hensleys’ informed

consent complaint, and remand for retrial against all Respondents on those claims. The Court should reverse the judgment as to liability and causation in favor of Spokane ENT and Michael Cruz as a result of jury misconduct, and order retrial against Spokane ENT on the claims of liability and causation, with liability and causation already established against the HFH and CHAS Respondents through summary judgment.

Respectfully submitted this 27th day of May, 2016.

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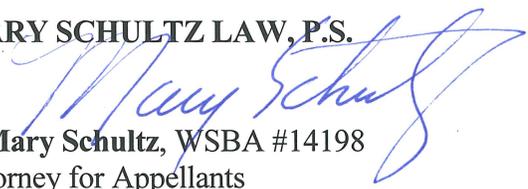
CERTIFICATE OF SERVICE

The undersigned hereby certifies that on the 27th day of May, 2016, the foregoing document was delivered to the following individuals in the manner indicated below:

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