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COURT OF APPEALS
DIVISION III
STATE OF WASHINGTON
By _____

No. 280471

THE COURT OF APPEALS
STATE OF WASHINGTON
DIVISION III

LINDA MOHR and CHARLES L. MOHR, her husband,

Appellants,

v.

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

Respondents.

BRIEF OF APPELLANTS
LINDA MOHR and CHARLES L. MOHR

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I. INTRODUCTION

When a physician accepts a patient he or she undertakes a duty of care. This duty includes reasonable steps to investigate, diagnose and treat preexisting conditions to prevent those conditions from causing additional injury or death. Even if the physician's negligent acts or omissions result in a less than 50% "lost chance" to recover, the plaintiff has a prima facie case, and the issue of proximate cause is a question of fact for the jury. *Herskovits v. Group Health Cooperative of Puget Sound*, 99 Wn.2d 609, 664 P.2d 474 (1983).

Despite the vast majority of jurisdictions holding otherwise, the trial court found *Herskovits's* "lost chance" causation standard only applied to "lost chance of survival" cases. Any medical malpractice action rooted in misdiagnosis and delayed treatment is, at its heart, a "lost chance" case. The case before this Court is no different. Here, a patient with an evolving stroke was misdiagnosed and released from the hospital. When she returned by ambulance the next day, she was eventually diagnosed, but not timely treated, resulting in permanent brain injury. Medical experts confirm that she lost a 50-60% chance at

a better outcome from the stroke due to negligent misdiagnosis and treatment.

This Court should follow the vast majority of other courts who have adopted “lost chance” causation, and apply the causation standard to “lost chance of a better outcome.” This Court should also follow the majority of “lost chance” rulings, and find, since the defendants’ negligence deprived plaintiff of the opportunity to recover, the issue of what her disability would have been, but for their actions, is a question of fact for the jury.

II. ASSIGNMENTS OF ERROR

1. The trial court erred in granting Defendants’ Motion for Summary Judgment and ordering plaintiffs’ case be dismissed.

Issues Pertaining to Assignments of Error

A. Can a plaintiff in a medical malpractice action recover for a 50-60% lost chance of a better outcome from a stroke?

B. In a “lost chance of a better outcome” case, does expert medical testimony need to establish, on a more probable than not basis, exactly how disabled plaintiff would have been if no medical

malpractice occurred?

III. STATEMENT OF THE CASE

On August 31, 2004, Linda Mohr, then age 61, was driving her vehicle in Richland, Washington, when she had an unexpected hypoglycemia event, lost consciousness, and struck a utility pole going approximately 45 miles per hour. (CP 109, 111). She was found in the driver's seat holding a cloth to her forehead to stop the bleeding from a laceration to her right eyebrow. *Id.* Pictures of her vehicle evidence severe front end damage as well as a broken windshield. (CP 113). She was thereafter transported by ambulance to Kadlec Medical Center E.R., where she arrived at approximately 3:49 p.m. (CP 109, 111).

On arrival she was given an initial neurological assessment (4:00 p.m.) and a CT scan of the brain which was normal (5:10 p.m.). (CP 90-92, 104-05). Thereafter she developed neurological deficits, including difficulty walking (6:22 p.m), numbness in her left hand (reported, but not recorded until 9/1/2004), drowsiness (6:22 p.m.) and severe pain (8:20 p.m.) after being administered pain medication at 8:02 p.m. (CP 90-92, 122)

During the course of the evening the attending E.R. physician, defendant Dale Grantham, M.D., advised Linda Mohr's family, including a physician son by phone, that he would carry out another neurological assessment on Mrs. Mohr before discharging her. (CP 186-188). He did not. Had an assessment been done, it would have likely disclosed that Mrs. Mohr's neurological deficits were the result of an evolving stroke. (CP 219-20, 236-40).

To make matters worse, Dr. Grantham ordered the administration of a narcotic medication, Darvocet, that was given to Mrs. Mohr shortly before her discharge at 8:20 p.m. (CP 91, 94, 96) At that time, she was so neurologically impaired that she could not walk out of the hospital, had to be transported to her husband's car by wheelchair, and all but carried from the car to her bed when the Mohrs arrived home. (CP 92, 210-13).

The Mohrs were not given "Head Injury" discharge instructions. Those instructions, had they been followed by Dr. Grantham before discharge, would have led to the administration of a non-narcotic pain medication for Mrs. Mohr. Instead, she was administered Darvocet,

which causes drowsiness and masks, to an untrained person, the developing symptoms of stroke. (CP 94, 250). Accordingly, Mrs. Mohr, once given Darvocet, should not have been discharged, but admitted to the hospital for overnight observation. (CP 222, 236-38).

Mrs. Mohr returned to Kadlec Medical Center E.R., by ambulance at 7:22 a.m. the morning of September 1, 2004, after she was awakened by her husband and found to be very lethargic. (CP 111-12, 115-16, 122). Her two physician sons, Benno J. Mohr, M.D., and Brandt Mohr, M.D., were notified that morning of her admission and drove to Kadlec to be by her side. (CP 89-91). She was then under the care of attending E.R. physician, defendant Brian Dawson, M.D. (CP 116).

By 9:31 a.m. Linda Mohr was diagnosed on a repeat CT scan as having an "evolving infarct," i.e. a stroke. (CP 119-120). Mrs. Mohr remained under Dr. Dawson's care until 11:38 a.m. when she was transferred from the emergency room to Kadlec's intermediate care unit under the care of defendant Brooks Watson, M.D, a Kadlec hospitalist. (CP 118, 123)

Inexplicably, Dr. Dawson did not provide any anti-coagulant or anti-thrombotic treatment or therapy for Mrs. Mohr during this two-hour time period and reportedly referred to Linda Mohr as “just an old lady having a stroke.” A comment Dr. Dawson denies saying. (CP 208).

Linda’s two physician sons, believing the stroke might be caused by a dissected carotid artery, first tried to get Dr. Dawson to order a CT angiogram and, after her care was transferred to Dr. Watson, tried repeatedly to get Dr. Watson to perform the angiogram.(CP 192-99, 143-44). However, Dr. Watson appeared disinterested and wanted to wait. (CP 143-44, 195-96).

At about 1:52 p.m., Dr. Watson prescribed 325 mg of Aspirin as anti-coagulant therapy, but neglected to order its immediate administration. (CP 122-26, 155-77). Anti-coagulants, anti-platelet agents and general brain protective care reduce the damage caused by strokes. *See, Declaration of A. Basil Harris, M.D.*, (CP 414-15). Dr. Watson wrote the anti-coagulant therapy as a “day order” and during his deposition refused to answer when, on September 1, 2004, he intended the medication to have been administered, finally indicating,

after 20 pages of examination on this issue, that anytime before 11:59 p.m that evening was acceptable. (CP 155-77).

At approximately 2:30 pm, after Linda Mohr's sons paged Dr. Watson 4 or 5 times, a CT angiogram was performed. (CP 127-28, 143-44, 195-99). At about 3:27 p.m., the test results were available. (CP 127-28). Since Dr. Watson could not be located, Linda's sons tracked down a hospital employee and obtained the test results themselves. (CP 170). Dr. Brandt Mohr, then a resident in Radiology, interpreted the images and diagnosed a dissected carotid artery. (CP 143-44, 179, 199).

Because Dr. Watson's inaction was jeopardizing his mothers life, Dr. Brandt Mohr personally contacted the Harborview Neurology Department and arranged for his mother to be airlifted to their facility. (CP 142-43, 199-201, 204-06).

At 4:50 p.m., Dr. Watson was located and informed that the CT angiogram showed a dissected carotid artery. (CP 128). However, he still did not order anyone to administer anti-coagulant therapy, anti-platelet agents, or any other treatment. (CP 155-77).

After their repeated demands to administer Aspirin fell on deaf ears, Dr. Brandt Mohr was forced to order the anti-coagulant therapy himself. However, by that time Linda could no longer swallow, so he ordered it in suppository form. At 6:00 p.m., the anti-coagulant therapy prescribed at 1:57 p.m. was finally administered on Dr. Brandt Mohr's orders. (129, 145-48, 201-03).

Under pressure from Linda Mohr's sons, Dr. Watson said he would not stand in their way and agreed to sign the paperwork to transfer Mrs. Mohr to Harborview. (CP 142-43, 149-51, 199-20, 204-206). All the transfer arrangements had already been made by Brandt Mohr, so signing the paperwork was only a formality. *Id.*

Linda Mohr is now profoundly brain damaged. (CP 181-84). A quarter to a third of her brain tissue has been destroyed, including much of the portions involved with motor control, sensation, and spacial reasoning. *Id.*

In addressing the events of August 31, 2004, and the issue of causation, Dr. Becker, a neurologist at Harborview, and co-director of its stroke center, has testified by deposition as follows:

Q. The statement is, She, being you, feels there was 50 to 60 percent chance with early intervention that Mrs. Mohr would have likely seen some measurable improvement in her eventual outcome. That's more than half. That's more likely than not that's probable. Is that your opinion or no?

A. You know, this is really tough because I would like to think early intervention would improve outcome, and I would certainly feel really guilty if a patient like this came in and I didn't treat them and they worsened, but there are certainly no guarantees that treating them actually would prevent them from worsening. So can I really say that on a more probable than not basis that if they had given her aspirin, this would have not happened. I don't think that I can.

Q. The issue isn't not happened, but would she have likely seen measurable improvement had they treated her on 8/31 with anti-thrombotics.

A. I would like to say that it would have improved her outcome, but I don't think that one can be confident in saying that.

Q. Well, then what was her lost opportunity if in fact you're saying that it's unlikely or not probable that she would have seen measurable improvement? Is there a percentage of opportunity that she did not receive that opportunity because she didn't receive that treatment?

A. Right. So there is lost opportunity, right. So had she received medication, then there is a chance that this would have had a better outcome.

Q. Well, I thought - - you told me when we talked it

was 60 to 70. Today you've reduced it to 50 to 60. Now you've reduced it to something less than that. What is it, Doctor?

A. I guess the bottom line is that we don't really know for sure.

Q. Understand, but you're dealing in a science and we have to deal with some kind of evaluation or percentages. What percentage are you comfortable with?

MR. ANDERSON; Object to the form.

MR. AIKEN: Join.

A. I guess I do feel comfortable saying that if she had received anti-thrombotic therapy there's at least a 50 to 60 percent chance that things could have had a better outcome.

MR. RETTIG: That's good. That's all. Thank you.

BY MR. ANDERSON:

Q. You can't define for us what the better outcome would be?

A. Less disability, less neglect, less you know, of the symptoms of right hemispheric stroke. If the stroke were smaller in size, she may had had - - she likely would have less disability.

(CP 174-77)

Q. Is it fair to say you cannot say on a more probable than not basis if she threw more than one clot?

A. I would actually say on a more probable than not basis she threw several clots, just knowing the pathophysiology of dissection, so, yes, I would say she threw more than one.

Q. Is it fair to say that you cannot say on a more probable than not basis when she threw more than one clot?

A. It seems likely that she threw them sometime between the time she went home from the hospital and she woke up in the morning.

Q. Can you say that on a more probable than not basis?

A. Yes.

(CP 178)

Dr. A. Basil Harris, a consulting neurosurgeon and former attending physician at Harborview, has signed a Declaration in this case dated April 10, 2008 and filed with the trial court on April 25, 2008, where he addressed the issue of causation and states:

3. Based on my extensive experience and education in the field of the neurosurgery and care of stroke victims, I can state with absolute certainty that in caring for stroke victims, time is of the essence. Moreover, the earlier you treat a stroke victim, as discussed above, the greater the benefit and eventual outcome to the patient.
4. Based on my review of the foregoing medical records and imaging of Linda Mohr, it is my opinion that because Linda Mohr did not receive anti-platelet agents, anti-coagulants or general brain protective care, on either the evening of August 31, 2004 or the morning or afternoon of September 1, 2004, she was denied the opportunity or chance of receiving significant or meaningful benefit in lessening the damage to her brain that has left her with her current disabilities and impairment.

(CP 414)

Thereafter, Dr. Harris was deposed on July 1, 2008 and testified in pertinent part, as follows:

Q. Do you have an opinion on more likely than not basis what would have happened to her if she hadn't been treated at all?

A. She would die more likely than not.

Q. Why?

A. There would have been more emboli, more strokes, more cerebral edema, and sudden death, and the brain would have thrown up, and she would have died.

(CP 229)

Q. Well, what do you believe the standard of care required for Dr. Watson, a hospitalist, in terms of the timing of his history and physical following her admission to the intermediate care unit?

A. Since time is of the essence in a case like this, it can be almost immediate, and any gross delay is just a gross time to treat her, leaving more embolization and brain damage every hour, every minute that goes by, the blood pressure not being what it would be, more emboli are available to go in and she's had so many, it's hard to detect a difference between 100 percent and 99 percent. However, that 1 percent might be enough to make a big difference.

(CP 230)

Q. So it's possible that a delay in getting a CT angiogram could put the patient at risk for additional stroke?

A. It's probable that it did, not just possible, because there's nothing filtering it. It's a wide open avenue.

(CP 231)

Q. As part of the testimony that you've been asked about criticism of Dr. Watson?

A. In my opinion, Dr. Watson's part in this case -- (witness reviewing documents.) It's also probable that had the cause neurology declined been diagnosed earlier on 9/1/04 the delays about 12 hours to Kadlec transferred to -- permitted additional brain infarction before any treatment was still started when she was given an aspirin suppository before helicopter evacuation. Whatever his role was in that, yes.

Q. Have you formed an opinion about what his role was in that?

A. I think he was part of the delay.

Q. If you do, we'll come back and do the dance again. Let's talk about Dr. Grantham. What do you believe Dr. Grantham did or didn't do that violated the standard of care on the night of August 31st?

A. Failure to recognize that Mrs. Mohr had a head injury, a loss of consciousness during the MVA, with external evidence of head trauma to the right forehead and face. Either erroneously denied loss of consciousness with a forehead and face injuries are solely attributed to hypoglycemia and denied her forehead and face injuries were important. Had she been treated as a head injury who lost her consciousness as she should have since she had experienced new symptoms in the ER and should have been admitted to the hospital for 24 hour observation as a head injury patient with serial

neurologic evaluations to be sure a serious underlying neurologic problem did not exist.

Q. Is that it?

A. Had this been done in the hospital the symptoms from the carotid artery dissection would have been found and diagnostic imaging would have allowed treatment in the six-hour interval window for stroke to give her a 50 to 60 percent chance for a better outcome. The second deviation was a failure to do a complete neurologic evaluation. He said he did one in his deposition, quote, while he was sewing her up, before she was inappropriately discharged for home under the care of medically naive husband with no specific instructions given to what and what to do and when. Since the Mohr residence is a short drive away from Kadlec Hospital it's probable that had a neurologic examination been done as was assured to be done to her by her M.D. sons, it's probable that had such an examination been done just before she was discharged from the Kadlec Hospital, the weakness that Mr. Mohr found in getting her to home, out of the vehicle and into the house would have been revealed before she left the hospital, Kadlec. The importance of this means the onset of neurologic change would have been prior to discharge and diagnosis been started in six-hour interval for better treatment outcome. It is probable that Darvocet was inappropriate to a head injury patient, clouded issues completely, and should have been obvious to him that would cause these new symptoms, that it was not appropriate, because it was the deviation and the direct complication that fogged the whole issue.

(CP 232-33)

Q. Are there any other violations of the standard of care that you believe Dr. Grantham committed or have we covered it?

A. Didn't do a direct neurologic examination.

Q. You did tell me that. When do you think he should have done that?

A. He should have done as -- he promised her sons, her M.D. sons that he would do it before he let her out of the hospital. If he had done that, he would probably have found the condition where she arrived home as short time from her house.

Q. What did that need to entail?

A. Found that she was unable to walk.

Q. What testing did he need to do?

A. He had to carry her in the house.

Q. What neurologic testing did Dr. Grantham need to do in your opinion before he discharged her?

A. He didn't do that. Mr. Mohr is the one that did that. Dr. Grantham failed to know that was going on.

(CP 239-240)

Q. Now, if you'll turn to Page 2 of your declaration,

paragraph 4, and I know before you pipe up and say it, I know your opinion about removing anticoagulants from that, so I'm with you on that. Let's take that out, in fact, is that fair?

A. I'll take it out.

Q. So if it says -- it's line 2: It is my opinion that because Linda Mohr did not receive antiplatelet agents or brain protective care on either the evening of August 31, 2004 -- one extra zero there -- or the morning or afternoon of September 1st she was denied the opportunity or chance of receiving significant or meaningful benefit in lessening the damage through her brain that has left her with her current disabilities and impairments. First of all did I read that right?

A. Yes, except there's another typo on Page 2 where it says in the filed, "based on education in the filed," f-i-l-e-d.

Q. Don't worry about Page 2. The section I just read on paragraph 4 with the removal of the word "anticoagulants" I read correctly?

A. Yeah.

Q. And is that still your opinion?

A. Yes.

Q. Does that accurately state what is currently your opinion?

A. Yes.

Q. She was denied the opportunity or chance of receiving significant or meaningful benefit. What was the percentage opportunity or chance that she could have received if he she had been given antiplatelet agents or brain protective care or –

A. At what time?

Q. Let's start with August 31st -- or would placing a percentage number on it be too speculative?

A. It's too speculative. All we can say is had she had it done on the 31st when she first began to have symptoms and with the six-hour window she would have 50 to 60 percent better chance than she would had she hadn't been treated. That's what the stroke people say.

(CP 241-43)

Q. Now, let's assume on the evening of the 31st she's in the hospital as you want her to be, the nurses are doing the checks you wanted them to have, they determine that she's worse, they call the doctor, doctor says get a CT angiogram, that takes however long it takes and she comes back. They make a diagnosis of a carotid artery dissection and they treat her with antiplatelet agents and increase her blood pressure.

A. Yes, Neosynephrine.

Q. Let's assume --

A. Raise her blood pressure.

Q. Let's assume they do all that.

A. What this does is it raises the pressure, it squirts -- see, when red blood cells travel through the brain, they go to big arteries, middle arteries, smaller arteries, arterials, and there's capillaries. They are taken up by bigger veins, bigger veins and taken back to the heart. That capillary bed is like the filter, and if you have a lot of clots in there, it will fill up and back up into the arteries which causes the stroke. As long as you can raise the pressure, tends to make them slip through easier just like red blood cells do. Platelets are not very big. They are not as big as red blood cells, and they can slip through as you raise the pressure a little bit. The other thing is you may hydrate them more, that will cause the pressure to go too. You can give her Plavix she hadn't already developed a great big stroke. That would tend to make platelets less sticky. If all those things initiated that night, then she has a better chance.

Q. Let's assume all those things happened just as I just laid it out: She's in the hospital, she's getting checked, they find she's worse, she gets a CT angiogram, it diagnoses the artery dissection, she gets Plavix, she gets fluids, she gets Neosynephrine, anything else?

A. That's it.

Q. She gets all of those things.

A. You might add anticoagulation if she hadn't had a big stroke already.

Q. Okay. Let's throw in the anticoagulation.

A. In that case, you would do that right away.

Q. We give her all those things.

A. And you would raise the pressure and give her anticoagulation Heparin and that would tend to flush them through too.

Q. It would be speculation still for us, you and me sitting here today, to know how much better or what would be better in Mrs. Mohr's condition in 2008?

A. No, not within six hours.

Q. So you think that if you did all those things within six hours she would be flat normal?

A. I don't know about flat normal. All I can say is that as Becker says she would have from the data 50 to 60 chance of being a lot better –

Q. Of improvement.

MR. RETTIG: Let him finish.

A. A lot better.

Q. (BY MR. ANDERSON) And if we assume that 50 to 60 percent chance of being a lot better it's still

speculation to say what conditions she has that are residual anyway, isn't it?

A. No. This is hearsay, and it involves not paying attention to the 50 to 60 percent chance of being better. How much better -- when it says you don't know how much worse she would have been, nobody is ever going to do this experiment. Nobody is ever going to take them off to see how bad she gets when they stop it.

Q. Let me ask it this way. If we did all those things -- if we did all the same things that you wanted her to have done that evening, just what we talked about, would Mrs. Mohr have any left-sided problems today?

A. She had a 50 to 60 percent chance of not having it.

Q. Of not having any?

A. Any.

(CP 244-247)

Q. And that's what I'm suggesting, we don't know that, do we? We don't know that if we treated her proactively as you want us to what the outcome would be today. We know that there's a better chance of improvement, but we don't know what that improvement is.

A. That's all we can say, what the chance for improvement is.

Q. And we don't know what that clinically translates to in any individual patient?

A. True.

Q. That would be speculation, because it didn't happen.

A. We don't know yet. With a 50 to 60 percent chance, it's not speculation.

Q. No, but what that turns into for Mrs. Mohr is we don't know what her improvement would have been. We don't know whether she would have gotten totally better, whether she had gotten a little better, whether she would have gotten no better, right?

A. All I'm saying is the treatment she received deprived her of the opportunity to have a better outcome.

(CP 247-248)

Before trial, the defendants collectively brought motions for summary judgment on various issues including causation. (CP 320, 341, 350). The trial court granted defendants' motions on the causation issue only, ruling that "but for" causation was not established and the lost chance/substantial factor causation standard articulated by *Herskovits* and other jurisdictions did not apply to lost chance of a better outcome, as opposed to lost chance of survival. (RP 44-45).

IV. ARGUMENT

At least twenty-two states have adopted a "lost chance" cause of

action. See *Matsuyama v. Birnbaum*, 890 N.E.2d 819, fn 23 (Mass. 2008) (citing twenty state supreme court decisions including *Herskovits*, that have adopted the “lost chance doctrine,” but overlooking *Lord v. Lovett*, 770 A.2d 1103 (N.H. 2001) and *Sharp v. Kaiser Foundation Health Plan of Colorado*, 741 P.2d 714 (Colo.1987)).

When given the opportunity, no state court that has adopted the lost chance doctrine in a “lost chance of survival” case has refused to apply the doctrine to a “lost chance of a better outcome” case. *Delaney v. Cade*, 255 Kan.199, 209-210 (1994) (the Kansas Supreme Court found that every court that had adopted the lost chance doctrine had applied it to “lost chance of a better outcome,” when given the opportunity).

Of the twenty-two states that have adopted the lost chance doctrine, seventeen have applied it in the context of a “lost chance of a better outcome,” unrelated to survival. *Delaney v. Cade*, 255 Kan. 199, 873 P.2d 175 (Kan. 1994) (reduced chance of a better recovery from an auto accident and resulting paralysis); *Hargroder v. Unkel*, 888 So.2d 953 (La.App. 2 Cir. 10 10/29/04) (loss of a chance of a better

outcome from a stroke); *Aasheim v. Humberger*, 215 Mont. 127, 695 P.2d 824 (Mont. 1985) (lost chance for a better outcome to preserve knee, which had to be removed due to a large giant cell tumor); *Gradel v. Inouye*, 491 Pa. 534, 421 A.2d 674 (Pa. 1980) (medical negligence increased risk that child would lose arm); *Lord v. Lovett*, 146 N.H. 232, 770 A.2d 1103 (N.H. 2001) (lost chance for a better outcome from a spinal cord injury); *Thompson v. Sun City Community Hospital, Inc.*, 141 Ariz. 597, 688 P.2d 605 (Ariz. 1984) (lost chance for a better recovery from a leg injury); *Alberts v. Schultz*, 126 N.M. 807, 975 P.2d 1279 (N.M. 1999) (lost chance to save a leg from amputation due to gangrene); *Reynolds v. Gonzalez*, 172 N.J. 266, 798 A.2d 67 (N.J. 2002) (lost chance to for a better recovery from compartment syndrome resulting from a fractured tibia); *Northern Trust Company v. Louis A. Weiss Memorial Hospital*, 143 Ill.App.3d 479, 493 N.E.2d 6 (Ill.App.1986) (lost chance to prevent newborn with meconium aspiration from getting brain damage); *Wolfe v. Estate of Custer*, 867 N.E.2d 589 (Ind.App.2007) (lost chance to prevent multiple organ failure, from which plaintiff survived); *Sharp v. Kaiser Foundation Health Plan of Colorado*, 710 P.2d 1153 (Colo.App.1985) *affirmed by*

741 P.2d 714 (Colo.1987) (20 to 25% lost chance to prevent nonfatal heart attack); *Thornton v. Camc, etc.*, 172 W.Va. 360, 305 S.E.2d 316 (W.Va.1983) (lost chance to prevent amputation of injured leg); *R.D. Prabhu v. Levine*, 112 Nev.1538, 930 P.2d 103 (Nev.1996) (lost chance to have a less evasive surgery to remove brain tumor); *Starkey v. St. Rita's Medical Center*, 117 Ohio.App.3d 164, 690 N.E.2d 57 (Ohio.App.1997) (lost chance to prevent nonfatal heart attack); *Soper v. Bopp*, 990 S.W.2d 147 (Mo.App.1999) (lost chance to delay the premature delivery of a child; *Ehlinger v. Sipes*, 155 Wis.2d 1, 454 N.W.2d 754 (Wis.1990) (lost chance to prevent injuries to premature twin newborns due to failure to diagnose multiple pregnancy; *Robinson v. Oklahoma Nephrology Associates, Inc.*, 154 P.3d 1250 (Okla.2007) (court analogized to lost chance cases to find doctor liable for increasing risk of harm to patient). The remaining five states have not taken up the issue.

As one of the seminal "lost chance" cases, *Herskovits* has given hope to untold numbers of people who, due to their doctor's negligence, have lost the chance to prevent serious injury or death. The case has been cited by numerous states as supporting "lost chance of a better

outcome,” and forms the basis for much of the law in this area. *See Supra.*

This Court should follow the unanimous precedent sent by other jurisdictions by reversing the trial court, and holding that the “lost chance” rule applies equally to injury cases (better outcome) as well as death cases (i.e. survival). This Court should further find that plaintiffs have made a prima facie case of “lost chance of a better outcome.”

A. Standard of Review.

When reviewing an order for summary judgment, the reviewing court engages in the same inquiry as the trial court. *Wilson v. Steinbach*, 98 Wn.2d 434, 437, 656 P.2d 1030 (1982). All evidence and reasonable inferences therefrom are construed in a light most favorable to the nonmoving party. *Young v. Key Pharmaceuticals, Inc.*, 112 Wn.2d 216, 226, 770 P.2d 182 (1989). Issues of law are reviewed de novo. *McCoy v. American Suzuki Motor Corp.*, 136 Wn.2d 350, 355, 961 P.2d 952 (1988).

B. Herskovits v. Group Health Cooperative of Puget Sound

In *Herskovits v. Group Health Cooperative of Puget Sound*, the Washington State Supreme Court recognized loss of chance as a

compensable interest. *Herskovits*, 99 Wn.2d at 619. In that case, the court held that a 14% reduced chance of survival caused by medical malpractice was sufficient to allow the proximate cause issue to go to the jury. *Id.* Nothing in the opinion, however, states that the rule is limited to lost chance of survival cases.

The *Herskovits* court was split on the basis for its holding. The majority opinion, supported by two justices, held that plaintiff need only show that defendant's negligence was a "substantial factor" contributing to the injury. *Id.* at 618. It was the province of the jury to determine whether a substantial factor was the proximate cause of the injury. *Id.* at 618-19. The concurring opinion, supported by four justices, found the injury involved was not "death" but rather the lost chance itself. *Id.* at 634. The four concurring justices would have permitted recovery in the event the defendant's conduct, "more likely than not," caused the 14% "lost chance." *Id.* at 634. Therefore, the majority was in favor of using the "substantial factor test" in lieu of traditional proximate cause in medical malpractice cases involving preexisting conditions, while the concurring opinion simply redefined the "injury" as the "lost chance."

The *Herskovits* decision is based, in part, on a duty physicians and hospitals have to render aid. This duty is set forth the Restatement (Second) of Torts § 323 (1965):

“One who undertakes ... to render services to another which he should recognize as necessary for the protection of the other’s person or things, is subject to liability to the other person for physical harm resulting from his failure to exercise reasonable care to perform his undertaking, if
(a) his failure to exercise such care increases the risk of such harm, ...” *As quoted by Herskovits*, 99 Wn.2d at 613.

In comparing its facts with that of a Pennsylvania Supreme Court decision, *Hamil v. Bashline*, 481 Pa. 256, 392 A.2d 120 (1978), the *Herskovits* majority reasoned:

“In the typical tort case, the “but for” test, requiring proof that damages or death probably would not have occurred, “but for” the negligent conduct of the defendant, is appropriate. In *Hamil* and the instant case, however, the defendant’s act or omission failed in a *duty* to protect against harm from *another source*. Thus, as the *Hamil* court noted, the fact finder is put in the position of having to consider not only what did occur, but also what *might have* occurred.” *Id.* at 616, *Italics in original.*

The *Herskovits* majority was concerned the “more likely than not” standard was too high a burden in cases of misdiagnosis and delayed treatment. It is much easier to diagnose the source of direct

harm, then to predict what would have occurred if a specific pill, test, or treatment was administered. The majority quoted the following from

Hamil:

“Such cases by their very nature elude the degree of certainty one would prefer and upon which the law normally insists before a person may be held liable. Nevertheless, in order that an actor is not completely insulated because of uncertainties as to the consequences of his negligent conduct, [Restatement (Second) of Torts § 323(a)] tacitly acknowledges this difficulty and permits the issue to go to the jury upon a less than normal threshold of proof.” *Id.* at 616

For example, it is common knowledge that Ibuprofen can lessen pain. After being administered, a person who took Ibuprofen can state its effectiveness on a scale of “one to ten.” If the Ibuprofen is never administered, however, the person cannot state with certainty how much it would have helped. The best she could say is that by not taking Ibuprofen, she lost a substantial chance to reduce her pain.

The difficulties in predicting what could have happened, but for the defendant’s negligence, are further increased when dealing with a combination of factors. If physician “A” delays diagnosis for 6 hours, physician “B” fails to timely administer a pill, and physician “C” administer’s medication that masks the underlying condition, there are

multiple factors that, in combination, resulted in a lost opportunity. Proving through medical expert testimony exactly how much each factor contributed to the resulting “lost opportunity” is exceedingly difficult. Consequently, requiring such proof places too high a burden on persons who have actual injuries, and who can prove negligent defendants deprived them of a substantial opportunity to avoid or lessen that injury.

Therefore, the *Herskovits* majority correctly reasoned that failure to allow recovery for “lost chances” of less than 50%, “would be a blanket release from liability for doctors and hospitals any time there was less than a 50 percent chance of survival, regardless of how flagrant the negligence.” *Id.* at 614. The same is true if “lost chance of a better outcome” is not recognized as a cause of action.

If the defendants’ position was accepted as law, doctors and hospitals would have blanket immunity for any negligent failure to give treatments that, if administered, would have substantially increased the chance a person would have less disability, or in this case, less brain damage.

The *Herskovits* concurring opinion was persuaded by the policy

rational set forth in: *King, Causation, Valuation and chance in Personal Injury Torts Involving Preexisting Conditions and Future Consequences*, 90 Yale L.J. 1353 (1981). *Herskovits*, 99 Wn.2d at 632. King argues against an “all or nothing” approach in both lost chance of survival and lost chance of a better outcome cases. According to King, difficulties with all varieties of “lost chance” cases can be solved by making loss of chance itself a compensable injury.

The *Herskovits* concurrence also noted that loss of a greater than even chance was recoverable under existing Washington State law. *Id.* The concurring justices considered a 4th Circuit case, *Hicks v. United States*, 368 F.2d 626 (4th Cir.1966), where the defendant physician’s negligent failure to diagnose a bowel obstruction deprived the plaintiff of a greater than 50% chance of survival. The concurrence found negligence that causes a lost chance of greater than 50% was clearly sufficient to establish proximate cause under then existing Washington State law:

“*Hicks v. United States*, therefore, appears to be authority for no more than the proposition that proximate cause may be established on a probability of survival. This, of course, is entirely consistent with the existing principles of this state under *O’Donoghue v. Riggs*, and provides little direct support for plaintiff in the present case.” *Id.*

at 630.

The *Herskovits* concurrence discussed two similar cases with a greater than 50% lost chance, and found all three consistent with existing law:

“The three cases where the chance of survival was greater than 50 percent (*Hicks, McBride, and Hamil*) 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 the probabilities. Such a result is consistent with existing principles in this state, and with cases from other jurisdictions cited by defendant.” *Id.* at 631.

The four concurring justices recognized that even before *Herskovits*, Washington State permitted recovery for loss of a greater than 50% chance. The justices went on to hold that lost chances of less than 50% were likewise recoverable, and the “disability” in those cases was the loss of chance itself. *Id.* at 634.

C. **The Trial Court Erred in Holding Plaintiff’s Case Did Not Meet Traditional *Pre-Herskovits* Causation Standards**

Plaintiffs’ experts agree that Mrs. Mohr suffered a 50-60% lost chance of a better outcome from her stroke due to the defendant’s negligence. Dr. Becker defined the better outcome as less disability (CP 177) and Dr. Harris defined the better outcome as a complete

recovery (CP 247). As stated in *Herskovits*, loss of a better than even chance has always been recoverable in Washington State. See also *McLaughlin v. Cooke, D.O.*, 112 Wn.2d 829, 774 P.2d 1171 (1989) (sufficient evidence existed to support jury verdict finding Physician, who failed to intervene sooner and remove existing hematoma, was proximate cause of plaintiff's non-fatal injury and resulting complications).

Medical expert testimony is not required to establish every cause:

“It is not always necessary to prove every element of causation by medical testimony. If, from the facts and circumstances and the medical testimony given, a reasonable person can infer that the causal connection exists, the evidence is sufficient. Further, expert medical testimony is not necessary if the questioned practice of the professional is such a gross deviation from ordinary care that a lay person could easily recognize it.” *McLaughlin*, 112 Wn.2d at 837 (internal citations removed).

When their deposition testimony is taken as a whole, plaintiff's experts establish a “more probable than not” causal link between a breach of each defendant's duty of care, and plaintiff's resulting brain injury. The experts' credibility, methodology and consistency are issues of fact for the jury.

D. The Trial Court Erred in Holding a Cause of Action for “Lost Chance of a Better Outcome” Does Not Exist

To date, no Washington State appellate or supreme court decision has confronted the issue of whether the “lost chance” cause of action articulated by *Herskovits* applies to cases involving “lost chance of a better outcome.”

Herskovits was a medical malpractice action where failure to timely diagnose and treat cancer reduced the chance plaintiff would survive by 14%. This case is a medical malpractice action where failure to timely diagnose and treat a stroke reduced the chance of avoiding disability by 50-60%. There is no reasonable basis to find proximate cause in one case but not the other.

In 1985, the Washington State Supreme Court issued *Daugert v. Papass*, 104 Wn.2d 254, 704 P.2d 600 (1985), its only opinion since *Herskovits* to substantively discuss the “lost chance” proximate cause standard. In *Daugert*, an attorney was sued by a former client for failing to timely file a petition for review of a Court of Appeals decision. *Id.* at 255. The client argued the “lost chance” rule should apply to cases of attorney malpractice. In declining to extend the “lost chance” proximate cause standard to attorney malpractice, the court

held:

“A reduction in one’s opportunity to recover (loss of chance) is a very real injury which requires compensation. On the other hand, where the issue is whether the Supreme Court would have accepted review and rendered a decision more favorable to the client, there is no lost chance. The client in a legal malpractice case can eventually get the case reviewed. ... Furthermore, unlike the medical malpractice claim wherein a doctor’s misdiagnosis of cancer causes a separate and distinguishable harm, i.e., diminished chance of survival, in a legal malpractice case there is no separate harm. Rather, the attorney will be liable for all the client’s damages if review would have been granted and a more favorable decision rendered...” *Id.* at 261-262.

The *Daugert* court then discussed the “substantial factor test,” and held it inapplicable to attorney malpractice because it “is normally justified only when a plaintiff is unable to show that one event alone was the cause of the injury.” *Id.* at 262. The court described three situations where the substantial factor test normally applies:

“First, the test is used where either one of two causes would have produced the identical harm, thus making it impossible for plaintiff to prove the but for test. Second, the test is used where a similar, but not identical, result would have followed without the defendant’s act. Third, the test is used where one Defendant has made a clearly proven but quite insignificant contribution to the result, as where he throws a lighted match into a forest fire.” *Id.*

Based on *Daugert*, Division 1 has held a “lost chance” established proximate cause when (1) the defendant negligently rendered aid, (2) the “lost opportunity” will never return, and (3) the defendant’s negligence caused a “separate and distinguishable harm.” *Sorenson v. Raymark Industries, Inc.*, 51 Wn.App. 954, 957, 756 P.2d 740 (1988) (lost chance and substantial factor causation did not apply to plaintiff’s claim for increased risk of cancer from asbestos exposure where plaintiff had yet to contract cancer). Moreover, citing *Daugert*, Division 1 found substantial factor causation applied when a plaintiff cannot show that one event alone caused the injury. *Id.*

Based on the cases of *Herskovits*, *Daugert* and *Sorenson*, a lost opportunity for a better outcome from a stroke is actionable under Washington State law. Here, the defendants negligently failed to render aid. The failure resulted in a 50-60% lost opportunity for a better outcome from the stroke. The damage is done. Plaintiff will never again have the chance to avoid it.

Furthermore, plaintiff has suffered a separate and distinguishable harm, *i.e.*, a lost chance to avoid permanent disability. Unlike the legal malpractice victim in *Daugert*, whose lost opportunity was not truly lost

because he could still sue his attorney, there is no second chance to prevent profound brain damage. The defendants have deprived plaintiff of the only opportunity she had to avoid her current condition.

Additionally, the “substantial factor test” applies to these facts. Here, one event did not cause the injury. Instead, it was caused by a stroke, and the acts and omissions of multiple defendants over a period of two days. The substantial factor test is specifically designed for situations where multiple parties and other factors were “substantial causes” of plaintiff’s injuries, making individual causation on a “more likely than not” basis difficult to establish. Under these facts, the jury’s role is to determine what “substantial factors” equate proximate cause. *See Herskovits*, 99 Wn.2d at 619.

In addition to other situations, the *Daugert* court found the substantial factor test applied when, “a similar, but not identical, result would have followed without the defendant’s act.” *Daugert*, 104 Wn.2d at 262. Misdiagnosis and delayed treatment are the best examples of malpractice which causes similar, but not identical, results to what would have occurred if the physician had done nothing. In fact,

the *Herskovits* majority applied the substantial-factor test to harm (i.e. death) resulting from a misdiagnosed medical condition.

Given the above, the following substantial factor test as articulated by *Herskovits* is applied to this case:

“It is not necessary for a plaintiff to introduce evidence to establish that the negligence resulted in the injury or death, but simply that the negligence increased the *risk* of injury or death. The step from increased risk to causation is one for the jury to make.” *Herskovits*, 99 Wn.2d at 617.

A cause of action for “lost opportunity for a better outcome” is entirely consistent with Washington State law. Whether it be from describing the lost opportunity itself as the injury, or using a “substantial factor” causation standard, allowing recovery for a lost opportunity to prevent disability from a stroke satisfies every test put forth by the supreme court under *Herskovits* and *Daugert*. The trial court’s ruling should be overturned as a matter of law.

E. This Court Should Adopt the “Lost Chance” Rule as Applied in Other Jurisdictions

Approximately twenty-two states have adopted a “lost chance rule.” Of those, at least seventeen have applied it to “lost chance of a

better outcome.” See list of cases *Supra*. The remaining five have not taken up the issue.

If not specifically, the cases at least implicitly echo the reasoning found in *Herskovits*. The courts who recognize “lost chance” either find the “loss of chance of a better outcome” is the injury itself, apply a substantial factor test, or use some combination of the two. See *Supra*.

Less than a month after *Herskovits*, the Arizona Supreme Court issued its state’s seminal “lost chance” opinion. *Thompson v. Sun City Community Hospital, Incorporated*, 141 Ariz. 597, 688 P.2d 605 (1984). In *Thompson*, a hospital delayed surgery on an injured child and transferred him to another hospital for financial reasons. *Id.* at 601, 609. The plaintiff’s medical experts testified that earlier surgery would have given the plaintiff’s son a “substantially better chance” of avoiding disability, but could not quantify that chance. *Id.* at 607, 615. Quoting the *Herskovits* majority and citing the concurrence, the *Thompson* court expressly adopted the *Herskovits* majority’s “substantial factor” approach. *Id.* 606-607, 614-615. The court then

ruled that presenting expert medical testimony of an unquantifiable loss of a “substantially better chance” was sufficient to allow the case to go to the jury. *Id.* at 607, 615.

The *Thompson* court held the “substantial factor test” only applied to a limited class of cases, so adopting it did not radically alter the existing tort system:

“We must remember further, that we are dealing with the limited class of cases in which defendant undertook to protect plaintiff from a particular harm and negligently interrupted the chain of events, thus increasing the risk of that harm. Defendant’s negligent act or omission made it impossible to find with certainty what would have happened and thus forced the court to look at the proverbial crystal ball in order to decide what might have been. Such determinations, of course, have traditionally been the province of the jury rather than the judge.” *Id.* at 608, 616.

In *Lord v. Lovett, M.D.*, 146 N.H. 232, 770 A.2d 1103 (N.H.2001), the New Hampshire Supreme Court expressly recognized “loss chance of a better outcome.” *Id.* at 236, 1106. In that case, plaintiff suffered a broken neck from an automobile accident and was taken to the local hospital. The defendant physicians negligently diagnosed her spinal cord injury and failed to administer steroid

therapy, causing her to lose the opportunity for a substantial recovery. *Id.* at 233, 1104. The defendants moved to dismiss on two grounds “(1) New Hampshire law does not recognize the loss of opportunity theory of recovery; and (2) the plaintiff failed to set forth sufficient evidence of causation.” The trial court granted the dismissal. *Id.* at 234, 1104.

After reviewing various approaches, the New Hampshire Supreme Court held, “we agree with the majority of courts rejecting the traditional “all-or-nothing” approach to loss of opportunity cases, and find the third approach most sound.” *Id.* at 236, 1106. The “third approach” was defined as follows:

“Accordingly, we hold that a plaintiff may recover for a loss of opportunity injury in medical malpractice cases when the defendant’s alleged negligence aggravates the plaintiff’s preexisting injury such that it deprives the plaintiff of a substantially better outcome.” *Id.* at 236, 1106.

In response to the defendant’s argument that loss of opportunity “is intangible and, thus, is not amenable to damages calculations” the *Lord* court held:

“[W]e fail to see the logic in denying an injured plaintiff recovery against a physician for the lost opportunity of a better outcome on the basis that the alleged injury is too

difficult to calculate, when the physician's own conduct has caused the difficulty." *Id.* at 239, 1108.

The concurring opinion in *Herskovits* based its decision, in large part, on *King, Causation, Valuation and chance in Personal Injury Torts Involving Preexisting Conditions and Future Consequences*, 90 *Yale L.J.* 1353 (1981). In 1998, King issued a follow up to that article: *King, "Reduction of Likelihood" Reformulation and Other Retrofitting of the Loss-of-a-Chance Doctrine*, 28 *U. Mem. L. Rev.* 491 (1998). This follow up argues that courts recognize the lost chance theory in the following cases:

"(1) the defendant tortiously failed to satisfy a duty owed to the victim to protect or preserve the victim's prospects for some more favorable outcome; (2) either (a) the duty owed to the victim was based on a special relationship, undertaking, or other basis sufficient to support a preexisting duty to protect the victim's likelihood of a more favorable outcome, or (b) the only question was how to reflect the presence of a preexisting condition in calculating the damages for a materialized injury that the defendant is proven to have probably actively, tortiously caused; (3) the defendant's tortious conduct reduced the likelihood that the victim would have otherwise achieved a more favorable outcome; and (4) the defendant's tortious conduct was the reason it was not feasible to determine precisely whether or not the more favorable outcome would have materialized but for the tortious conduct." *Id.* at 495.

King argues against the necessity of proving a “literal chance” because, in many cases, the condition may have been “totally unpredictable” since the defendant deprived the plaintiff of the opportunity for that chance:

“Rather, whether a claim is addressed by causation or valuation (loss-of-a-chance) principles should be guided by whether the defendant’s tortious conduct was the reason the trier of fact was unable to know the effect of the defendant’s tortious conduct on the victim’s interests. This line separating the reach of causation from valuation principles should not be based on the variable perceptions of whether the issue related to past or future events or the extent to which the evidence was deemed personal as opposed to statistical.” *Id.*

Likewise, in developing its holding, the *Herskovits* majority quoted the Northern District of California, which ruled:

“James was deprived of the opportunity to receive early treatment and the chance at realizing any resulting gain in his life expectancy and physical and mental comfort. No matter how small that chance may have been-and its magnitude cannot be ascertained-no one can say that the chance of prolonging one’s life or decreasing suffering is valueless.” *Herskovits*, 99 Wn.2d at 618, quoting *James v. United States*, 483 F.Supp. 581 (N.D. Cal.1980).

This Court should follow *Herskovits* and its multi jurisdictional progeny in adopting a cause of action for lost chance of a better

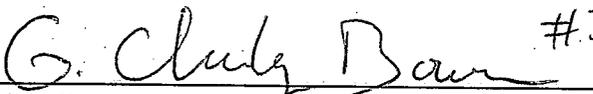
outcome. This Court should further find that plaintiff's medical experts have established a prima facie case of loss of chance of a better outcome.

V. CONCLUSION

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

RESPECTFULLY SUBMITTED this 4th day of September, 2009.

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