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COURT OF APPEALS
DIVISION III
STATE OF WASHINGTON
By _____

NO. 28047-1-III

COURT OF APPEALS, DIVISION III
OF THE STATE OF WASHINGTON

LINDA J. 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, 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 RESPONDENTS GRANTHAM, DAWSON, WATSON AND
NORTHWEST EMERGENCY PHYSICIANS

Mary H. Spillane, WSBA #11981
WILLIAMS, KASTNER & GIBBS PLLC
Attorneys for Respondents Grantham,
Dawson, Watson, and Northwest
Emergency Physicians

Two Union Square
601 Union Street, Suite 4100
Seattle, WA 98101
(206) 628-6600

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I. COUNTERSTATEMENT OF ISSUES PRESENTED FOR REVIEW

1. Did the trial court properly dismiss on summary judgment the Möhrs' medical malpractice claims against each defendant on grounds that *Herskovits v. Group Health Coop. of Puget Sound*, 99 Wn.2d 609, 664 P.2d 474 (1983), did not apply to this type of case where the Möhrs claimed not that an alleged delay in diagnosis and treatment caused Mrs. Mohr's stroke, but that the alleged delay in diagnosis and treatment caused a lost chance of a potentially, but unspecified and unascertainable, better outcome from her stroke?

2. Did the trial court properly conclude that the "substantial factor" test of causation articulated in the two-justice lead opinion in *Herskovits* was not the law governing medical malpractice actions in Washington?

3. Did the trial court properly decline to expand the "loss of a less than even chance of survival" exception to proximate cause articulated in the four-justice plurality opinion in *Herskovits* beyond wrongful death and survival actions to allow for recovery in medical malpractice cases of a chance of a potential, but unspecified and unascertainable, better outcome?

3. Even if such "a loss of chance of potentially better outcome" theory of causation were to be recognized, was the Möhrs'

evidence in support of that theory insufficient to establish proximate cause as to each defendant?

II. COUNTERSTATEMENT OF THE CASE

A. Nature of the Case.

In this medical malpractice case, Linda J. Mohr, and her husband Charles L. Mohr, sued emergency room physicians Dr. Dale C. Grantham and Dr. Brian J. Dawson, their group Northwest Emergency Physicians, hospitalist Dr. Brooks Watson II, and Kadlec Medical Center, alleging that they were negligent in failing to earlier diagnose and treat Mrs. Mohr for a trauma induced vascular injury (stroke). CP 410 (§ VII). All of the defendants moved for summary judgment dismissal of the Mohrs' claims based upon the Mohrs' inability to establish proximate cause.¹ CP 302-11, 322-40, 341-47, 348-49, 350-84; *see also* CP 29-32, 48-62, 63-77, 78-84. The Mohrs responded to defendants' motions, CP 85-250, 251-67; *see also* CP 19-24, not by trying to prove traditional proximate cause, but instead claiming that, under *Herskovits v. Group Health Coop. of Puget Sound*, 99 Wn.2d 609, 664 P.2d 474 (1983), they should be allowed to recover for a "lost chance or lost opportunity to have received a better outcome," CP 267. The trial court granted summary judgment,

¹ Kadlec Medical Center also moved for summary judgment on grounds that the individually named defendants were not its agents or ostensible agents for whose conduct it could be held vicariously liable. CP 311-18.

concluding that *Herskovits*, and other cases commenting on substantial factor causation or loss of a chance of survival did not apply. RP 45.

B. Factual Background.

On August 31, 2004, Mrs. Mohr was involved in an automobile accident, in which her automobile, after running into four cars and traffic, struck a light pole at approximately 45 miles per hour. CP 93, 109, 324. The Richland Fire Department was dispatched to the scene and conducted an initial assessment of Ms. Mohr's condition at 3:15 p.m. CP 109-10. Mrs. Mohr was bleeding from lacerations to her right eyebrow, right hand, and left shin. CP 109. She was conscious and told the paramedics that she was diabetic. CP 109. Her blood glucose was 39, and the cause of the accident appeared to be a hypoglycemic event, CP 93-94, 109, 324-25. Although the paramedics noted that Mrs. Mohr was initially confused and repeatedly asked the same questions, her condition improved after Dextrose was administered and she "became cognitive to the answers of her questions." CP 109. The paramedics noted no other signs of trauma, CP 109, and transported Mrs. Mohr to the emergency department at Kadlec Medical Center, arriving at 3:44 p.m. CP 110.

Mrs. Mohr was seen in the emergency department by Dr. Grantham at 3:55 p.m. CP 93-95, 324-26. Mrs. Mohr reported no numbness, no neck pain, and only mild pain. CP 93, 324. On neurologic

exam, Dr. Grantham noted no motor or sensory deficits. CP 93, 324. Blood samples were taken, finger stick glucose was performed, and Mrs. Mohr was taken to radiology for X-rays and a CT scan, which were all normal. CP 91, 93, 104, 324. Dr. Grantham sutured the lacerations of Mrs. Mohr's right eyelid and right hand, and noted that Mrs. Mohr remained alert and was able to walk to the bathroom. CP 94, 325. After several hours of observation in the emergency department, at 8:20 p.m., Mrs. Mohr was discharged home accompanied by her husband. CP 92, 94, 325. Her condition at discharge was good, stable, and improved. CP 92, 94, 325. Mrs. Mohr declined Vicodin, so Dr. Grantham gave her Darvocet upon discharge. CP 94, 325. The Mohrs were warned about the sedative effect of Darvocet, CP 91, and they were instructed to return or contact Mrs. Mohr's physician if her condition worsened, did not improve as expected, or other problems arose. CP 94, 325.

At 6:32 a.m. on September 1, 2004, the Richland Fire Department was called to the Mohr residence. CP 111-12. Mr. Mohr reported that his wife had been experiencing weakness and lack of coordination since her discharge the night before. CP 111. The paramedics found Mrs. Mohr to be lethargic, and complaining of weakness, slight headache and minor nausea. CP 111. They transported her back to the Kadlec Medical Center emergency department, arriving at 7:11 a.m. CP 111-12.

Dr. Dawson evaluated Mrs. Mohr in the emergency department the morning of September 1. CP 115-16, 327-28. Mrs. Mohr complained of weakness and difficulty walking, but denied numbness and tingling, dizziness or altered mental status. CP 115, 327. On neurologic evaluation, Dr. Dawson found that Mrs. Mohr was drowsy, had normal speech, but had mild right lower extremity weakness, moderate left facial weakness, moderate left upper extremity weakness, mild left lower extremity weakness, and altered sensation to light touch on the left arm. CP 115, 327.

At 8:10 a.m., Mrs. Mohr underwent a second CT scan, CP 118, which revealed edematous changes in her frontal and temporoparietal lobes, which the radiologist felt "may be secondary to evolving infarct" in the territory of the right middle cerebral artery. CP 119. According to the radiologist's report: "These findings were not evident on prior CT scan of 8/31/04. It is unclear if the event causing these findings occurred prior to the patient's known MVA [motor vehicle accident] or after the accident." CP 119. The radiologist suggested "MRI examination of the brain for further evaluation." CP 119. Dr. Dawson discussed Mrs. Mohr's case with both the radiologist and Dr. Watson, and, after the MRI was performed, Mrs. Mohr was transferred to the Intermediate Care Unit around 11:38 a.m. under Dr. Watson's care. CP 116, 118, 124-25, 327-28,

329.

After the MRI was performed, Mrs. Mohr's workup led to the discovery of a "right internal carotid artery dissection." CP 329. Although the distal internal carotid artery could not be assessed on an ultrasound of the carotid arteries, a CT angiogram subsequently revealed the distal dissection of the right internal carotid artery. CP 329. Dr. Watson's plan of care for Mrs. Mohr included, among other things, aspirin therapy and neurology consult. CP 123-24. After trying to obtain local neurology input, Dr. Watson discussed Mrs. Mohr's case with Dr. Jerry Jurkovitz at Harborview Medical Center in Seattle, who agreed to accept and assume Mrs. Mohr's care. CP 329. Plans were made to life-flight Mrs. Mohr to Harborview. CP 329. Dr. Watson ordered intravenous heparin for stabilization, but after Mrs. Mohr's sons requested that it not be given, and after talking again with Dr. Jurkovitz, Dr. Watson arranged for Mrs. Mohr to be given an aspirin suppository. CP 329.

C. The Expert Testimony the Mohrs Proffered in Response to Defendants' Motions for Summary Judgment

In response to defendants' motions for summary judgment based upon the Mohrs' inability to establish proximate cause, the Mohrs asserted that their claim was one for lost chance or lost opportunity to have received a better outcome under *Herskovits*, and that they had sufficient

expert testimony to substantiate that claim against all defendants. CP 265-67. In support of their "lost chance" claim, the Mohrs' offered the testimony of two experts, Dr. Kyra Becker, a neurologist at Harborview who treated Mrs. Mohr, and Dr. A. Basil Harris, a long-retired neurosurgeon from the University of Washington. See CP 353.

Dr. Becker testified in deposition as follows:

Q. . . . Are you going to express any opinions that any of the health care providers involved violated the standard of care?

* * *

A. I guess probably the only place where I think that it's really pertinent is her being discharged from the emergency room on narcotics when she was not quite acting right, according to her family. Had had a head injury, and there was some concerns that she was slurring her speech, according to notes, that she wasn't walking well, according to nursing notes that were documented, and complaining of left hand numbness.

Q. I guess I need to know specifically are you going to testify that, first of all, the emergency room physician that was on duty that evening [August 31, 2004] and that was attending Mrs. Mohr violated the standard of care?

A. Yes.

Q. Are you going to testify that the nurses that provided care to Mrs. Mohr that evening of August 31, 2004 violated the standard of care?

A. No.

Q. I take it from your answer you're not going to express any standard of care opinions regarding the care provided on September 1, 2004?

A. That's correct.

Q. Are you going to express any opinions that any care provided on September 1, 2004 made any difference in the outcome, the ultimate outcome in this case?

A. I am not. You know, I guess I would have to say that I do think that things could have been done differently that day, but I don't think any of them would have changed the ultimate outcome.

Q. ... So you're not going to be expressing any opinions that any of the care provided on September 1, 2004 was a cause or proximate cause of any injury to Mrs. Mohr, correct?

A. Correct.

Q. ... [A]re you going to express the opinion that any care or failure to provide care on August 31, 2004 caused Mrs. Mohr injury?

A. You know, I know you guys always like very straightforward answers, and it's just hard to give one. If the dissection had been picked up that day and therapy instituted, it could have limited her ultimate brain injury and improved outcome. I guess I would have to say, yes, I think there is causation there.

Q. ... Is your opinion on a more probable than not basis based upon reasonable medical certainty if any care could have been provided on August 31, 2004 that would have changed Mrs. Mohr's ultimate outcome?

A. I'm going to hedge a little bit more, and say that if it is true that the physician was aware of her left hand numbness and her difficulty walking and her slurred speech and didn't investigate further, then, yes, I think -- I do believe that there was more probable than not a breach in the standard of care that led to her -- contributed to her brain injury.

CP 216-18 (Becker Dep. at 9-11).

Q. ... Your basis for saying in violation of standard of care, you only believe that's true if she had all three of

those clinical symptoms on the evening of August 31, 2004?

A. Yes. I think that if all three of those were present, probably would have warranted a little bit closer surveillance, maybe not necessarily doing a CTA [CT angiogram] but at least observing just a little bit longer.

Q. Do you have any opinion on a more probable than not basis if they would have observed her longer what that would have demonstrated?

A. If she had not received any further narcotics and had worsening of her speech, her gait, her numbness, that would have led to hopefully some sort of imaging at that time that it would make the diagnosis, and an intervention with an anti-thrombotic agent.

CP 219-20 (Becker Dep. at 42-43).

Q. As far as her additional clinical symptoms developing, you can't tell us more probably than not, and again using your assumption that no narcotics were administered, how soon those additional symptoms would develop?

* * *

A. No, I mean, it's impossible to say.

Q. Based upon that, can you say more probable than not whether they would have been able to make the specific diagnosis of carotid artery dissection in a time frame where the anti-platelet therapy would be successful?

A. I do think that's the key question, and it's really difficult to say. I think that if they would have caught it early and she would have gotten aspirin, there's a reasonable chance it could have prevented things from getting worse.

Q. Reasonable. Again, we're talking about more probable than not. Does that mean more probable than not?

A. I would like to think so, yes.

CP 220-21 (Becker Dep. at 43-44).

Q. I take it from your earlier opinions that assuming that Mrs. Mohr received neurologic damage from this stroke all of that injury had occurred by the morning of September 1st?

A. I think so.

Q. I take it even if the anti-thrombolytic therapy had been started on the evening of August 31st, Mrs. Mohr would have incurred some type of neurologic damage?

A. It seems like she had already incurred some, so the aspirin wouldn't have reversed that.

Q. Is there any way to quantify even assuming appropriate treatment in your opinion had commenced what type of neurologic damage she would have had then as compared to now?

A. No.

Q. Is it fair to say that she potentially could have had the same type of neurologic damage even if therapy would have been started on the evening of August 31st?

A. Yes.

Q. Is it fair to say there's no way you can tell on a more probable than not basis the degree of injuries she would have had if therapy would have appropriately started as compared to now?

A. You know, as a person who likes to think they are a scientist, I would say that's true. There is no way to reasonably say.

CP 75-76 (Becker Dep. at 47-48).

Q. Even if Ms. Mohr had received anti-platelet agents on the evening of August 31st, understanding that you can't tell us, and I assume no one can tell us more probably than not how her condition would have been improved or different than it is today?

A. That's true.

Q. It would be speculation to say it would be any different than today?

A. Yes.

CP 375 (Becker Dep. at 60).

Q. This came up the other day that there are a number of times in medicine where patients are treated because it sort of seems like the right thing to do even though there is no – not necessarily any evidence that it ultimately makes a difference?

A. That's exactly right.

Q. And this would be one of those settings?

A. Pretty much, yes.

CP 376 (Becker Dep. at 61).

Q. So looking at Exhibit No. 2 as you have corrected it during the course of this deposition, does that represent your opinion today?

A. You know, I think there is a reasonable chance, 50 to 60 percent, that if anti-thrombotic therapy was given early, that she could have had some demonstrable benefit.

CP 377-78 (Becker Dep. at 71-72).

BY MR. RETTIG:

Q. The statement is, She, being you, feels there was a 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 not?

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 will 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 I can.

Q. . . . [B]ut 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. . . . 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?

* * *

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.

CP 223-25 (Becker Dep. at 74-76).

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 have had - she likely would have less disability.

Q. You can't say how much less?

A. No.

Q. In fact, you can't really say anything less, true?

* * *

A. Smaller infarct volume would likely correlate to less disability, but it really depends on where that infarct is located.

* * *

Q. . . . It doesn't necessarily translate to less disability?

A. You're right, it does not.

Q. It could be that there is less infarct volume and no less clinical disability?

A. Correct.

CP 225-26 (Becker Dep. at 76-77).

In his deposition, Dr. Harris, the Mohrs' second expert, testified:

Q. So am I right that you're not prepared to testify that Dr. Dawson violated the standard of care in any way?

A. It all depends on what I see between now and the time of trial.

Q. As we sit here today, you're not prepared to?

A. I'm not prepared to.

Q. . . . 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.

CP 68-69 (Harris Dep. at 140-41).

Q. . . . What was the percentage opportunity or chance that she could have received if . . . 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.

Q. And that's what you talked about with Dr. Becker?

A. Right.

CP 242-43 (Harris Dep. at 190-91).

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 Neosyneprine, 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.

* * *

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 –

CP 245-46 (Harris Dep. at 199-200).

Q. ... 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 [the evening of August 31, 2004], 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.

Q. Zero?

A. (Witness nodding head.)

Q. Would she have any cognitive problems today?

A. I don't know. Depends on how – see, this is subtraction again from what you can't do. All these problems are caused from this enormous stroke she had,

which happened during the night sometime after she got home. You cannot subtract from that, what she's got. You can't know unless you treated her – proactively until she treated her for it you can't know that. It would be unethical to do it.

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.

Q. Of the opportunity?

A. Yes.

Q. And you can't put a percentage on that opportunity?

A. Of course not. I wouldn't say opportunity if I had.

CP 246-48 (Harris Dep. at 200-02).

Q. . . . If any of us, you or me or Mr. Rettig or anyone else in the room try and say exactly how she would be,

what problems she would have or not have under your scenario, it's impossible?

A. Impossible to know because the – doesn't work that way.

Q. It would be speculation for all of us to do that, right?

A. It would be speculation if you said she didn't have that opportunity.

Q. Speculation to know if we did exactly what you want us to have done, it would be speculation of what the ultimate outcome would be?

* * *

A. You're asking me if I'm clairvoyant and I'm not. I don't know anybody else that is.

CP 384 (Harris Dep. at 203).

III. STANDARD OF REVIEW

Appellate courts review summary judgment orders de novo, “engaging in the same inquiry as the trial court.” *Rounds v. Nellcor Puritan Bennett, Inc.*, 147 Wn. App. 155, 161, 194 P.3d 274 (2008), *rev. denied*, 165 Wn.2d 1047 (2009); *Colwell v. Holy Family Hosp.*, 104 Wn. App. 606, 611, 15 P.3d 210, *rev. denied*, 144 Wn.2d 1016, 32 P.3d 283 (2001). A summary judgment will be affirmed if, viewing the evidence in the light most favorable to the nonmoving party, there are no genuine issues of material fact and the moving party is entitled to judgment as a matter of law. *Id.*; CR 56(c). A summary judgment may be affirmed on any basis supported by the record. *Rounds*, 147 Wn. App. at 162;

Fabrique v. Choice Hotels Int'l Inc., 144 Wn. App. 675, 682, 183 P.3d 1118 (2008).

As the court in *Rounds*, 147 Wn. App. at 162, explained, in reviewing a summary judgment in a medical malpractice case based on plaintiff's failure to prove proximate cause:

Summary judgment in favor of the defendant is proper if the plaintiff fails to make a prima facie case concerning an essential element of his or her claim." *Seybold v. Neu*, 105 Wn. App. 666, 676, 19 P.3d 1068 (2001). If the defendant meets the burden of showing no material facts remain and the plaintiff lacks sufficient evidence to support an essential element in the case, "the burden shifts to the plaintiff to produce evidence sufficient to support a reasonable inference that the defendant was negligent." *Id.* Medical negligence elements are "duty, breach, causation, and damages." *Colwell*, 104 Wn. App. at 611. Specifically, the plaintiff must prove "the injury resulted from the failure to follow the accepted standard of care . . . [and][s]uch failure was a proximate cause of the injury complained of." RCW 7.70.040.

IV. ARGUMENT

- A. Summary Judgment Was Properly Granted as to Each Defendant Because Plaintiff Failed to Produce Competent Medical Expert Testimony Establishing that the Claimed Injury Was Proximately Caused by the Defendant's Alleged Failure to Comply with the Applicable Standard of Care.

Under RCW 7.70.040, a medical malpractice plaintiff has the burden of proving that: (1) the health care provider failed to comply with the applicable standard of care; and (2) that such failure was a proximate

cause of plaintiff's claimed injury.² "A 'proximate cause' of an injury is defined as a cause which, in a direct sequence, unbroken by any new, independent cause, produces the injury complained of and without which the injury would not have occurred." *Rounds*, 147 Wn. App. at 162 (quoting *Fabrique*, 144 Wn. App. at 683).

Proximate cause consists of two elements – cause in fact and legal causation. *Id.* "[B]oth elements must be satisfied." *Id.* The first element – cause in fact – refers to the "the 'but for' consequences of an act, or the physical connection between an act and the resulting injury."³ *Id.* In a medical malpractice case, "to establish the cause in fact, the plaintiff must show that he or she would not have been injured but for the health care provider's failure to use reasonable care." *Hill v. Sacred Heart Med. Ctr.*, 143 Wash. App. 438, 448, 177 P.3d 1152 (2008) (citing *McLaughlin v. Cooke*, 112 Wn.2d 829, 837, 774 P.2d 1171 (1989)).

² RCW 7.70.040 provides:

The following shall be necessary elements of proof that injury resulted from the failure of the health care provider to follow the accepted standard of care:

- (1) The health care provider failed to exercise that degree of care, skill, and learning expected of a reasonably prudent health care provider at that time in the profession or class to which he belongs, in the state of Washington, acting in the same or similar circumstances;
- (2) Such failure was a proximate cause of the injury complained of.

³ In contrast, the second element – legal causation – "rests on policy considerations as to how far the consequences of a defendant's acts should extend [and] involves a determination of whether liability *should* attach as a matter of law given the existence of cause in fact." *Fabrique*, 144 Wn. App. at 683 (quoting *Hartley v. State*, 103 Wn.2d 768, 778, 698 P.2d 77 (1985)).

“[T]he general rule in Washington is that expert medical testimony on the issue of proximate cause is required in medical malpractice cases.” *Reese v. Stroh*, 128 Wn.2d 300, 308, 907 P.2d 282 (1995) (citing *McLaughlin*, 112 Wn.2d at 837; *O’Donoghue v. Riggs*, 73 Wn.2d 814, 824, 440 P.2d 823 (1968)). “Generally, in medical negligence cases, ‘the plaintiffs must produce competent medical expert testimony establishing that the injury was proximately caused by a failure to comply with the applicable standard of care.’” *Rounds*, 147 Wn. App. at 162-63 (quoting *Seybold v. Neu*, 105 Wn. App. 666, 676, 19 P.3d 1068 (2001)). The “expert testimony must be based on a reasonable degree of medical certainty.” *Rounds*, 147 Wn. App. at 163 (citing *McLaughlin*, 112 Wn.2d at 836). It “‘must be based on the facts in the case, not speculation or conjecture.’” *Id.* at 163 (quoting *Seybold*, 105 Wn. App. at 677).

Expert testimony is insufficient to establish proximate cause if “it can be said that, considering all the medical testimony presented at trial, the jury must resort to speculation or conjecture in determining the causal relationship.” *McLaughlin*, 112 Wn.2d at 837 (citing *O’Donoghue*, 73 Wn.2d at 824). “To remove the issue from the realm of speculation, the medical testimony must at least be sufficiently definite to establish that the act complained of ‘probably’ or ‘more likely than not’ caused the subsequent disability.” *O’Donoghue*, 73 Wn.2d at 824.

The testimony must be sufficient to establish that the injury-producing situation “probably” or “more likely than not” caused the subsequent condition, rather than the accident or injury “might have,” “could have,” or “possibly did” cause the subsequent condition.

Rounds, 147 Wn.2d at 163 (quoting *Merriman v. Toothaker*, 9 Wn. App. 810, 814, 515 P.2d 509 (1973)); see also *O'Donoghue*, 73 Wn.2d at 824; *Attwood v. Albertson's Food Ctrs.*, 92 Wn. App. 326, 331, 966 P.2d 351 (1998).

In response to defendants' motions for summary judgment, the Mohrs did not claim that their experts' testimony established traditional “but for” causation. See CP 251-67. Instead, they asserted that, under *Herskovits*, they should be allowed to recover for a “lost chance or lost opportunity to have received a better outcome.” CP 267 Although the Mohrs now assert on appeal, *App. Br. at 32-33*, that the trial court erred in holding that they failed to establish traditional proximate cause, the expert testimony they proffered does not rise above speculation and conjecture, or establish more probably than not, to a reasonable degree of medical certainty, that but for any alleged breach of the applicable standard by any defendant, Mrs. Mohr would not have suffered her internal carotid artery dissection, stroke, or concomitant disability. Contrary to the Mohrs' assertion, *App. Br. at 33*, their experts do not “establish a ‘more probable

than not' causal link between a breach of each defendant's duty of care, and plaintiff's resulting brain injury."

First, with respect to Dr. Dawson, the emergency room physician, and Dr. Watson, the hospitalist, who saw Mrs. Mohr on September 1, 2004, the day after her automobile accident, Dr. Becker conceded that she was not going to express any opinions that any care provided on September 1, 2004 made any difference in the ultimate outcome in this case, or that any of the care provided on September 1, 2004 was a proximate cause of any injury to Mrs. Mohr:

Q. Are you going to express any opinions that any care provided on September 1, 2004 made any difference in the outcome, the ultimate outcome in this case?

A. I am not. . . .

Q. . . . So you're not going to be expressing any opinions that any of the care provided on September 1, 2004 was a cause or proximate cause of any injury to Mrs. Mohr, correct?

A. Correct.

CP 217. Similarly, Dr. Harris limited his testimony concerning a 50-60% chance for a better outcome to a six-hour window that began on August 31, 2004, and ended some time before Mrs. Mohr awoke on September 1, 2004, and returned to the hospital:

Q. . . . 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. . . . [I]t'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.

CP 236-38.⁴ When asked to quantify the lost chance associated with the care provided on September 1, 2004, Dr. Harris was unable to do so. *See*

CP 71-72. The most he could say was:

⁴ Dr. Harris' criticism of Dr. Watson was "whatever contribution he made to the delay, by not acting properly while [Mrs. Mohr] was under his care." CP 233. When asked

... I will tell you again, an opportunity missed is a chance taken, and time is of the essence when you're dealing with strokes and breaking out clots, and *you cannot in any way subtract from morning or afternoon or day what the result would be had you been doing earlier*. All we can say is with each contraction of the heart that blood goes through that aperture where the clots are coming from, and there's absolutely nothing, as long as you don't do something, there's nothing to prevent the break out of getting more stroke, be it late, middle, otherwise.

CP 71-72 (emphasis added).

Because the Mohrs proffered no expert testimony from either Dr. Becker or Dr. Harris establishing more probably than not, to a reasonable degree of medical certainty, that any alleged violation of the applicable standard of care by either Dr. Dawson or Dr. Watson on September 1, 2004, was a proximate cause of Mrs. Mohr's claimed injury, the trial court properly granted summary judgment as to Drs. Dawson and Watson.

Even with respect to Dr. Grantham, the emergency room physician who saw Mrs. Mohr on August 31, 2004, the Mohrs' expert testimony on the issue of causation failed to rise above speculation and conjecture, or establish more probably than not, to a reasonable degree of medical certainty, what better outcome would have been achieved had Dr. Grantham done all of things that the Mohrs' experts claimed he should have done. According to Dr. Becker, if Dr. Grantham had been aware of

whether he was prepared to testify that Dr. Dawson violated the standard of care, Dr. Harris testified that he was not prepared to do so at his deposition. CP 68, 236.

Ms. Mohr's left hand numbness, difficulty walking, and slurred speech, he should have observed her longer. CP 218-19. If Mrs. Mohr did not receive further narcotics and had worsening of her speech, gait, and numbness, "that would have led to hopefully some sort of imaging at that time that it would make the diagnosis, and an intervention with an anti-thrombotic agent. CP 219-20. She did not testify more probably than not that Dr. Grantham should have been aware of any hand numbness or speech or gait difficulty prior to discharging Mrs. Mohr, and conceded that it was impossible to say how soon additional symptoms would have developed. CP 220-21. She could not say more probably than not that Dr. Grantham could have made the diagnosis of carotid artery dissection in a time frame where anti-platelet therapy would have been successful; she could only say that "if they would have caught it early and [Mrs. Mohr] would have gotten aspirin, there's a reasonable chance it could have prevented things from getting worse." CP 220-21.

Dr. Becker acknowledged that Mrs. Mohr had already sustained some type of neurologic damage on August 31, 2004 that aspirin would not have reversed, that there was no way to quantify more probably than not how Mrs. Mohr's condition would have been improved had anti-platelet agents been started the evening of August 31, and that it would be speculation to say that her condition would have been any different. CP

75-76, 375. While ultimately the Mohrs' counsel was able to get Dr. Becker to say that, if Mrs. Mohr had received anti-thrombotic therapy on August 31, 2004, "there's at least a 50 to 60 percent chance that things could have had a better outcome," CP 225, Dr. Becker could not say more probably than not that how much less disability there would be or even that there necessarily would be any less disability CP 225-26.

Nor could Dr. Harris. When asked what the percentage opportunity or chance of Mrs. Mohr receiving significant or meaningful benefit would have been if antiplatelet therapy had been given on August 31, 2004, Dr. Harris testified:

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 242-43. Dr. Harris's testimony concerning a 50 to 60 percent chance of a better outcome was premised on Dr. Becker's testimony. *See* CP 243, 246. And, although at one point, Dr. Harris testified that, if all the things he wanted done had been done the evening of August 31, 2004,⁵ Mrs. Mohr had a 50 to 60 percent chance of not having any left-sided problems,

⁵ The things Dr. Harris wanted to have happen on August 31, 2004, were that Mrs. Mohr "is in the hospital, she's getting checked, they find she's worse, she gets a CT angiogram, it diagnoses artery dissection, she gets Plavix, she gets fluids, she gets Neosynephrine" and she gets "anticoagulation if she hadn't had a big stroke already." CP 245.

CP 247, a proposition Dr. Becker's testimony would not substantiate, Dr.

Harris subsequently acknowledged:

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.

Q. Of the opportunity?

A. Yes.

Q. And you can't put a percentage on that opportunity?

A. Of course not. I wouldn't say opportunity if I had.

CP 246-48.

Q. . . . If any of us, you or me or Mr. Rettig or anyone else in the room try and say exactly how she would be, what problems she would have or not have under your scenario, it's impossible?

A. Impossible to know because the – doesn't work that way.

Q. It would be speculation for all of us to do that, right?

A. It would be speculation if you said she didn't have that opportunity.

Q. Speculation to know if we did exactly what you want us to have done, it would be speculation of what the ultimate outcome would be?

* * *

A. You're asking me if I'm clairvoyant and I'm not. I don't know anybody else that is.

CP 384.

Because the expert testimony proffered by the Mohrs failed to rise above speculation and conjecture, or establish more probably than not, to a reasonable degree of medical certainty, what improvement or better outcome Mrs. Mohr would have had had Dr. Grantham kept Mrs. Mohr in the hospital, discovered a worsening of her neurologic condition, gotten a CT angiogram and diagnosed her carotid artery dissection and stroke, and implemented anti-thrombotic therapy some time during the evening of August 31, 2004, the trial court properly granted Dr. Grantham's motion for summary judgment.

B. As the Trial Court Correctly Determined, *Herskovits* Does Not Establish Either a Substantial Factor Test of Causation or a Loss of a Chance of Better Outcome Claim for Medical Malpractice Cases in Washington.

The *Herskovits* decision can perhaps best be characterized as a

fractured opinion that was largely a product of the unique factual situation presented to the court. There is no clear majority opinion – only a two-justice lead opinion authored by Justice Dore, *Herskovits*, 99 Wn.2d at 610-19; a four-justice plurality opinion authored by Justice Pearson, *id.* at 619-36; a two-justice dissenting opinion authored by Justice Brachtenbach, *id.* at 636-42; and a dissenting opinion by Justice Dolliver, *id.* at 642-45.

In *Herskovits*, a wrongful death and survival action in which the decedent's estate brought a professional negligence action for failure to timely diagnose lung cancer, the trial court, applying the traditional “but for” test, held that defendant's actions were not the proximate cause of the decedent's death since the decedent probably would have died from his lung cancer regardless of the defendant's actions. *Herskovits*, 99 Wn.2d at 610-11. The parties had stipulated for purposes of summary judgment (based on affidavit of plaintiff's expert), that the decedent's chances of survival were less than 50 percent and the defendant's actions reduced the decedent's chance of survival from 39 percent to 25 percent. *Id.* at 610-12. The Supreme Court reversed the summary judgment employing two distinct theories, neither of which was endorsed by a majority of the court.

The two-person lead opinion, written by Justice Dore, rejected the traditional “but for” test of proximate cause in favor of a “substantial

factor” test, and held that, in situations where Restatement (Second) of Torts § 323 (1965) applies,⁶ medical proof that defendant’s actions caused a substantial reduction in survival is sufficient to allow a jury to resolve whether the defendant’s conduct was a substantial factor in producing decedent’s injuries. *Id.* at 610-19; *see Zueger v. Public Hosp. Dist. No. 2 of Snohomish Cty.*, 57 Wn. App. 584, 589, 789 P.2d 326 (1990).

The four-justice plurality opinion, written by Justice Pearson, recognized a new actionable injury for loss of a less than even chance of survival, retaining the traditional “but for” test of proximate cause, and shifting the focus of the inquiry by defining the decedent’s injury as a reduction in the chance of survival, rather than death. *Herskovits*, 99 Wn.2d at 619-36; *see Zueger*, 57 Wn. App. at 590. The plurality thus held that a plaintiff in a wrongful death and survival action can establish “a prima facie issue of proximate cause by producing testimony that defendant probably caused a substantial reduction in [the decedent’s] chance of survival.” *Herskovits*, 99 Wn.2d at 634.

⁶ Restatement (Second) of Torts § 323 provides:

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 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, . . .

Thus, contrary to the Mohrs' assertion, *App. Br. at 27*, no majority of the *Herskovits* court was "in favor of using the 'substantial factor' test in leu [sic] of traditional proximate cause in medical malpractice cases involving preexisting conditions..." Nor did a majority, or even a plurality, of the court recognize a loss of chance of a better outcome as a compensable interest in medical malpractice cases. At most, a plurality of the *Herskovits* court recognized a new actionable injury for loss of a less than even chance of survival under the wrongful death and survival statutes. As the court explained in *Zueger*, 57 Wn. App. at 591:

When no rationale for a decision of an appellate court receives a clear majority the holding of the court is the position taken by those concurring on the narrowest grounds. *Lakewood v. Plain Dealer Pub'g Co.*, 486 U.S. 750, 100 L. Ed. 2d 771, 108 S. Ct. 2138, 2148 n.9 (1988); *Southcenter Joint Venture v. National Democratic Policy Comm.*, 113 Wn.2d 413, 427-28, 780 P.2d 1282 (1989). Following this principle, if *Herskovits* stands for anything beyond its result, we believe the plurality represents the law on a loss of the chance of survival. The plurality would allow instructions on a loss of a chance of survival in this case only if the evidence shows (1) a substantial reduction in the chance of survival, and (2) the negligence of the defendant caused the reduction.

With only two justices concurring in the use of a "substantial factor" test of proximate cause in *Herskovits*, it cannot be said that *Herskovits* stands for the proposition that the "substantial factor" test now governs the determination of proximate cause in medical malpractice

personal injury cases in Washington. Indeed, the Mohrs cite no post-*Herskovits* case in Washington involving a medical malpractice or other general negligence personal injury claim that has applied “substantial factor” test of proximate cause. As the court in *Fabrique*, 144 Wn. App. App. at 685, explained, in declining to extend the substantial factor test of proximate cause to a negligence or strict liability action involving a contaminated food product:

Washington courts have applied the substantial factor test in only four types of cases – those involving (1) discrimination or unfair employment practices; (2) securities; (3) toxic tort cases, including multi-supplier asbestos injury cases; and (4) medical malpractice cases where the malpractice reduces a patient’s chance of survival. *Sharbono v. Universal Underwriters Ins. Co.*, 139 Wn. App. 383, 420-21, 161 P.3d 406 (2007) [*rev. denied*, 163 Wn.2d 1055 (2008)] .

And, with only a four-justice plurality recognizing an actionable injury for loss of a less than even chance of survival in *Herskovits*, it also cannot be said that *Herskovits* stands for the broader proposition that plaintiffs in medical malpractice or other general negligence personal injury actions can recover for loss of a chance of a potentially better outcome.⁷ The Mohrs cite no Washington case holding to the contrary. Since *Herskovits*, Washington courts have consistently refused to expand

⁷ Indeed, the plurality opinion in *Herskovits* would “allow instructions on a loss of a chance of survival in this case only if the evidence shows (1) a substantial reduction in the chance of survival, and (2) the negligence of the defendant caused the reduction.” *Zueger*, 57 Wn. App. at 591.

its limited holding. See *Daugert v. Pappas*, 104 Wn.2d 254, 704 P.2d 600 (1985) (declining to apply loss of chance theory or substantial factor test in legal malpractice case);⁸ *Sorenson v. Raymark Indus., Inc.*, 51 Wn. App. 954, 957, 756 P.2d 740 (1988) (declining to apply loss of chance theory in asbestos case); *Zueger*, 57 Wn. App. at 591-94 (finding no error in trial court's refusal to instruct on *Herskovits* theory, where plaintiff failed to produce sufficient evidence of substantial reduction in chance of survival); *Koker v. Armstrong Cork, Inc.*, 60 Wn. App. 466, 481-82, 804 P.2d 659 (1991) (error in instructing jury on 'lost chance of survival' for which there was not proof); *Rounds*, 147 Wn. App. at 166 ("Because Ms. Rounds fails to make out a prima facie case on causation, we do not need to discuss if her loss of chance theory applies on the issue of damages.").

As the trial court correctly recognized, *Herskovits* did not establish either a substantial factor test of proximate cause or a loss of a chance of a potentially better outcome claim in medical malpractice personal injury cases in Washington.

⁸ As *Daugert*, 104 Wn.2d at 261, made clear: "The primary thrust of *Herskovits* was that a doctor's misdiagnosis of cancer either deprives a decedent of a chance of surviving a potentially fatal condition or reduces that chance."

C. This Court Should Decline to Expand *Herskovits* to Recognize a Claim for “Loss of a Chance of a Better Outcome” in Medical Malpractice Personal Injury Actions in Washington.

1. Recognition of such a claim would eviscerate proximate cause in medical malpractice cases.

If this Court were to extend the *Herskovits* rationale to medical malpractice cases involving loss of a chance of a potential better outcome, it would serve to create an exception that would swallow the traditional proximate cause rule. That is even more true, where as here, plaintiffs’ experts can only speculate as to what the better outcome of which they claim plaintiff lost a chance would look like or be.

In virtually every medical treatment setting, choices have to be made and diagnostic and treatment options have to be selected to the exclusion of others at a certain point in time. And, there is always the possibility that the diagnostic and treatment options not selected might have led to the same or a different, or a potentially better outcome. Thus, if this Court were to expand *Herskovits* to recognize a claim for “loss of a chance of a potentially better outcome,” then virtually every medical malpractice case would become a “loss of a chance of a better outcome” case, and time-honored, long-standing medical malpractice law requiring proof, through competent medical expert testimony rising above speculation, conjecture, or mere possibility, that but for defendant’s alleged failure to comply with the applicable standard of care, plaintiff,

more probably than not, to a reasonable degree of medical certainty, would not have suffered injury, would no longer apply. Such a claim would make treating health care providers strictly liable for any breach of the applicable standard of care, if a different course of action might have produced a more favorable result.

Recognition of the “loss of a chance of a potential better outcome” claim advocated by the Mohrs could lead to situations where liability results even though plaintiff’s injury would still more likely than not have occurred absent the defendant’s negligence and even in cases where the negligence had no substantial effect on the plaintiff’s injuries. Plaintiff’s only burden would be to show that some opportunity for a potential better outcome existed, and that the defendant more likely than not was the cause of the deprivation of that opportunity, not the injury itself. That is not now, and should not be, the law in Washington.

2. Even if such a claim were to be recognized, the Mohrs lack sufficient expert testimony to establish that the alleged negligence of any defendant proximately caused a substantial reduction in Mrs. Mohr’s chance of a specific ascertainable different outcome.

In *Zueger*, the court reviewed whether it was error for the trial court to refuse to submit an instruction on “lost chance of survival” to the jury. *Zueger*, 57 Wn. App. at 585. The plaintiff in *Zueger* was admitted to the hospital for pneumonia and respiratory distress. *Id.* at 585. While

admitted, she suffered an incomplete spontaneous abortion. *Id.* at 586. There was a three-day delay in performing the dilation and curettage procedure, and in providing antibiotic treatment. *Id.* Mrs. Zueger died early the next morning. *Id.* The trial court “refused to submit plaintiff’s requested instruction on loss of a chance of survival” *Id.* On appeal the court addressed whether the plaintiff was entitled to a *Herskovits* instruction. *Id.* at 588-89.

The court began its analysis by noting that the trial court did not instruct on a loss of a chance or survival for two reasons. “First, the court thought the rule was limited to diseases with a statistical probability of survival over a period of time. Second, the court did not believe the evidence supported the instructions proposed.” *Id.* at 591. The court did not address the first concern because it found that the evidence was not sufficient. The *Zueger* court found the testimony of the plaintiff’s expert as to whether the defendant’s negligence caused a reduction in survival lacking for the following reason:

While Dr. Buchanan [Plaintiff’s expert] asserted that Michele [Zueger] was at a greater risk for the surgery, he does not directly state that not performing the D & C reduced her chance of survival, nor that the reduction in her chance of survival was substantial, nor what that reduction might have been. The medical testimony on an increased risk was minimal at best.

Id. at 594. Absent expert testimony establishing that there was a substantial reduction in her right to survival, or what that reduction might amount to, the *Zueger* court determined that a *Herskovits* instruction was not appropriate. *Id.*

Here, ignoring that this is not a lost chance of survival case, the Mohrs cannot meet the standard of proof required under *Zueger* for a loss of a chance claim. The court in *Zueger* found that even the *Herskovits* “loss of a less than even chance of survival” claim did not apply where plaintiff was unable to establish with sufficient evidence what the loss of a chance would amount to and that the loss of the chance was substantial.

Here, the “better outcome” of which the Mohrs claim to have lost a chance is inherently speculative and unascertainable. The Mohrs’ experts are unable to say to any reasonable degree of medical certainty what the better outcome was that they say Mrs. Mohr had a 50 to 60 percent chance of obtaining had Dr. Grantham kept Mrs. Mohr in the hospital, discovered a worsening of her neurologic condition, gotten a CT angiogram and diagnosed her carotid artery dissection and stroke, and implemented anti-thrombotic therapy some time during the evening of August 31, 2004. *See* discussion at pages 24-28, *supra*. And, as to Drs. Dawson and Watson, the Mohrs’ experts do not claim that the 50 to 60 percent chance of a

better outcome applies to those physicians' care and treatment of Mrs. Mohr. See discussion at pages 22-24, *supra*.

Ultimately, the proffered testimony of the Mohrs' experts boils down to testimony concerning a loss of a chance on August 31, 2004, of a potentially different, albeit unspecified and unascertainable, outcome. Under a *Herskovits* "lost chance of survival" claim, the injury is specified and ascertainable – the decedent has suffered a substantial, measurable percentage reduction in survival or life expectancy. Here, however, the Mohrs seek to recover for a lost chance of an immeasurable and unascertainable, unspecified potentially better outcome.

Without competent medical expert testimony establishing a measurable and ascertainable specified "better outcome" that would not have occurred but for a given defendant's alleged failure to adhere to the applicable standard of care, there is no way for a jury to assess what loss is attributable to that defendant's alleged negligence, or to determine the value of that loss, without resort to speculation and conjecture. The requirement that medical expert testimony establishing proximate cause in medical malpractice cases must rise above speculation, conjecture, or mere possibility, *see, e.g., Reese*, 128 Wn.2d at 309; *McLaughlin*, 112 Wn.2d at 837, was not overturned when *Herskovits* recognized a new actionable injury for loss of a less than even chance of survival, nor should

it be overturned even if a new actionable injury for loss of a chance of a potential better outcome. Moreover, while Washington courts have stated that “[r]ecovery should not be denied because the extent or amount of damages cannot be ascertained with mathematical precision,” they also make clear that that is true “provided the evidence is sufficient to afford a reasonable basis for estimating losses.” *Sherrell v. Selfors*, 73 Wn. App. 596, 601, 871 P.2d 168 (1994) (citing *Jacqueline's Wash., Inc. v. Mercantile Stores Co.*, 80 Wn.2d 784, 786, 498 P.2d 870 (1972)). “Damages must be proved with reasonable certainty or be supported by competent evidence in the record.” *Id.* (citing *Iverson v. Marine Bancorporation*, 86 Wn.2d 562, 546 P.2d 454 (1976)). Here, the expert testimony falls short of meeting these requirements. Allowing a jury to calculate the loss of a chance a potential better outcome in this case would simply be too speculative.

For these reasons as well, this Court should decline the Mohrs’ invitation to expand *Herskovits* to recognize a new actionable injury of loss of a chance of a potential better outcome in medical malpractice cases.

3. The cases the Mohrs cite from other jurisdictions do not establish an overwhelming consensus concerning the propriety of adopting a “substantial factor” proximate cause theory or a “loss of chance of better outcome” theory in medical malpractice personal injury cases.

Respondents Grantham, Dawson, Watson, and Northwest Emergency Physicians join in that portion of the “Brief of Defendant Kadlec Medical Center” (pages 33-36) that addresses this issue.

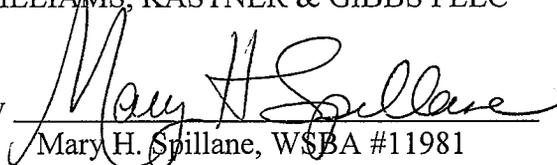
V. CONCLUSION

For the foregoing reasons, the trial court’s grant of summary judgment in favor of Defendants should be affirmed.

RESPECTFULLY SUBMITTED this 3rd day of November, 2009.

WILLIAMS, KASTNER & GIBBS PLLC

By


Mary H. Spillane, WSBA #11981

Attorneys for Respondents Grantham,
Dawson, Watson, and Northwest Emergency
Physicians

Two Union Square
601 Union Street, Suite 4100
Seattle, WA 98101
(206) 628-6600

CERTIFICATE OF SERVICE

I hereby certify under penalty of perjury that, under the laws of the State of Washington that on the 3rd day of November, 2009, I caused a true and correct copy of the foregoing document, "Brief of Respondents Grantham, Dawson, Watson and Northwest Emergency Physicians," to be delivered to the following counsel of record in the manner indicated below:

Counsel for Appellants

Diehl R. Rettig, WSBA #792
RETTIG OSBORNE FORGETTE, LLP
6725 W. Clearwater Avenue
Kennewick, WA 99336
Ph: (509) 783-0858

SENT VIA:

- Fax
- ABC Legal Services
- Express Mail
- Regular U.S. Mail
- E-file / E-mail

Counsel for Kadlec Med. Ctr.:

Jerome R. Aiken, WSBA #14647
MEYER, FLUEGGE & TENNEY, P.S.
PO Box 22680
Yakima WA 98907-2680
Ph: (509) 575-8500

SENT VIA:

- Fax
- ABC Legal Services
- Express Mail
- Regular U.S. Mail
- E-file / E-mail

Co-counsel for Defendants Dr. Grantham,

Dr. Dawson and NW Emergency
Physicians, Inc.:
Christopher H. Anderson, WSBA #19811
FAIN SHELDON ANDERSON &
VANDERHOEF PLLC
701 - 5th Ave., Suite 4650
Seattle, WA 98104
Ph: (206) 749-0094

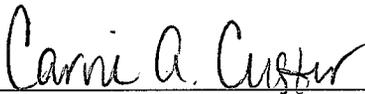
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Co-counsel for Respondents Watson:
Donna M. Moniz, WSBA #12762
JOHNSON GRAFFE KEAY MONIZ
& WICK
925 - 4th Ave., Suite 2300
Seattle, WA 98104
Ph: (206) 223-4770

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DATED this 3rd day of November, 2009, at Seattle, Washington.



Carrie A. Custer