NO. 86242-1-I

COURT OF APPEALS, DIVISION I
OF THE STATE OF WASHINGTON

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STEPHANIE BELISLE (fka BELISLE-WILLIAMSON),

Appellant,

And

JOHN ANDREW WILLIAMSON,

Plaintiff,

v.

PROLIANCE SURGEONS, INC., P.S.; DANIEL SEELY, MD and wife and their marital community, ROGER ZUNDEL, MD and wife and their marital community; JOHN and JANE DOES 1-50 and their marital communities,

Respondents

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# BRIEF OF RESPONDENTS

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## I. INTRODUCTION

After a multi-week trial in which both sides presented expert testimony, the jury returned a defense verdict in Stephanie Belisle's medical malpractice action against Dr. Daniel Seely, concluding he was not negligent in performing her tonsillectomy. Making numerous legally unsupported and factually incorrect claims, Belisle asks this Court to overturn the jury's verdict. The trial court's orders were correct, and ample evidence supports the defense verdict.

First, the trial court correctly concluded as a matter of law that Dr. Zundel, who did not perform the procedure at issue, had no legal duty to obtain informed consent for another physician, Dr. Seely, who did perform the procedure. Any duty to obtain informed consent rests with the physician who performs the procedure, which Dr. Zundel did not. Belisle offers no authority to the contrary.

Second, the trial court properly exercised discretion in denying Belisle's unsupported motion to shorten time on her

equally unsupported summary judgment motion regarding medical bills' reasonableness and necessity. Belisle provided no justification to the court for considering untimely summary judgment past the dispositive motion deadline. On appeal, as below, Belisle also fails to provide authority that she was even entitled to summary judgment on the issue of her medical bills.

Third, Belisle complains about the trial court allowing a defense expert to testify "on the eve of trial" when that expert did not even testify.

Fourth, the trial court never "muzzled" Belisle; it allowed her hours of testimony and considerable latitude to describe her medical diagnoses and conditions in detail.

Fifth, the trial court properly exercised discretion in excluding Dr. Seely's Parkinson's disease diagnosis because Belisle admitted she had no evidence that it impacted the procedures he performed on her years before his diagnosis.

Sixth, Belisle improperly asks this Court to reweigh the evidence and overturn the jury's determination that Dr. Seely

was not negligent when ample evidence supports the verdict, and she never preserved this issue by seeking a new trial.

This Court should affirm the trial court's rulings and the jury's verdict.

## II. ISSUES COUNTERSTATEMENT

1. Did the trial court properly grant Dr. Zundel summary judgment on Belisle's informed consent claim because he had no legal duty to obtain informed consent for a procedure he did not perform or control?

2. Did the trial court properly exercise discretion in denying Belisle's motion to shorten time on her summary judgment motion to establish reasonableness and necessity of medical bills when she provided no justification for filing an untimely dispositive motion?

3. Is Belisle's complaint about the trial court allowing defense expert Dr. Rubenstein to testify moot because he did not testify?

4. Did the trial court properly exercise discretion in allowing Belisle wide latitude to testify about her medical diagnosis and conditions, subject only to occasional objections, none of Belisle preserved as claimed error?

5. Did the trial court properly exercise discretion in excluding evidence of Dr. Seely's Parkinson's diagnosis when Belisle admitted she had no evidence that it impacted the procedures he performed on her years before his diagnosis?

6. Should this Court refuse to overturn the jury's verdict because the evidence amply supports its conclusion that Dr. Seely was not negligent and because Belisle failed to preserve this issue for appeal?

## III. CASE COUNTERSTATEMENT

### A. Dr. Seely performs a tonsillectomy in April 2016.

Dr. Daniel Seely is an experienced otolaryngologist (ENT) practicing for over 20 years when he saw Belisle on April 4, 2016. 5-RP 2341-43. Belisle sought Dr. Seely's care for

recurrent, severe pharyngotonsillitis[1] necessitating urgent care, antibiotics, and missed work. CP 74, 76.

After taking a thorough history and completing an examination, Dr. Seely concluded that Belisle was a candidate for tonsillectomy with possible adenoidectomy. CP 76. He documented that he "discussed the options for further treatment in detail" and "the nature of this surgery … including its risks, benefits and alternatives." CP 76. Dr. Seely provided Belisle with a surgical packet, which he reviewed with her. CP 76. Belisle wished to proceed with surgery. CP 76.

On April 27, 2016, Belisle signed a consent for tonsillectomy and adenoidectomy. CP 837. In it, Belisle acknowledged that "nerve injury" was among the risks. CP 837. Dr. Seely then performed the procedure, which was successful. CP 80-81.

[1] A throat infection occurring when the throat (pharynx) and tonsils are inflamed.

B. Dr. Seely recommends a second surgery to evaluate Belisle's continuing symptoms.

In Belisle's first post-operative visit on May 12, 2016, she reported a difficult recovery because she took very little analgesia, but she was otherwise significantly improved. CP 72. The PA-C informed Belisle that she should continue to improve. CP 72. When Belisle saw Dr. Seely several weeks later, she reported new dysphagia (difficulty swallowing). CP 70. Dr. Seely performed a flexible fiberoptic laryngoscopy, which was unremarkable. CP 70-71. He discussed with Belisle that a barium swallow study may be indicated if her symptoms persisted, and he also recommended a speech pathology evaluation. CP 71.

On June 17, 2016, Belisle returned to Dr. Seely with continuing symptoms. CP 1211. He prescribed antibiotics to ensure Belisle did not have a localized infection, and he planned a diagnostic barium swallow study. CP 1211. He documented that "[u]ltimately if she remains severely symptomatic, return to the operating room for direct inspection of the tonsillar fossa may be considered. This was discussed in detail and her questions

were answered." CP 1211. Belisle would follow up in two weeks with one of Dr. Seely's partners. CP 1211.

C. Belisle sees Dr. Zundel twice in the clinic.

On July 1, 2016, Belisle saw Dr. Seely's colleague, Dr. Roger Zundel. CP 1208. Dr. Zundel was covering for Dr. Seely while Dr. Seely was out of town. CP 1499 (80:8-12). Dr. Zundel conducted a physical examination, which was normal. CP 1209. He recommended that Belisle treat her acid reflux and undergo a diagnostic barium esophagogram. CP 1209. If this did not identify the problem, Dr. Zundel thought "a repeat endoscopy, esophagoscopy and examination of her tonsillar area under general anesthesia would be indicated." CP 1209. Dr. Zundel would "discuss her case with Dr. Seely and she will follow up after the esophagogram to discuss options." CP 1209.

On July 13, 2016, Belisle again saw Dr. Zundel because Dr. Seely remained out of town. CP 1205. Belisle reported persistent gagging. CP 1205. Dr. Zundel did "not have a solid explanation for why she is experiencing this." CP 1206. He

observed that the fiberoptic examination and barium swallow study were normal. CP 1205. While Dr. Zundel got Belisle on the schedule for an esophagoscopy with biopsy, he documented that he needed to discuss with Dr. Seely and wanted Belisle to explore medical treatment or management options first:

> I would offer direct microlaryngoscopy and esophagoscopy to see if we could identify a pocket that could be exteriorized in some way. Before that happens, though, I would like her to consult with Dr. Georgia Rees-Lui to see if there is a medical treatment option or other management option. I will discuss this in more detail with Dr. Seely when he is available.

CP 1206.

D. Dr. Seely returns Belisle to surgery on August 3, 2016.

On August 3, 2016, Dr. Seely and Belisle signed a written consent. CP 1223. The form explained that the planned procedure was a "Micro Direct laryngoscopy with biopsy, esophagoscopy" to evaluate Belisle's oropharyngeal dysphagia. CP 1223. In signing the form, Belisle acknowledged that "during the course of the operation, … unforeseen conditions may necessitate additional or different procedures than those set

forth," and she authorized performing such other procedures as necessary. CP 1223. Belisle also acknowledged that she had been informed of certain risks and complications, including "nerve injury." CP 1223.

Although the consent form "authorize[d] Dr. Roger Zundel, MD, and/or such associates or assistants, including, if applicable, other physicians who will have an active process in the surgery, and other health care providers as may be selected by said physician" to perform the procedure, CP 1223, it is undisputed that Dr. Zundel did not participate in and was not otherwise involved in the August 3 procedure, *see* CP 1213-14, 1218-20.

Dr. Seely returned Belisle to surgery for a microlaryngoscopy and esophagoscopy, both of which were negative. CP 1213. Because he saw a "tiny amount of residual lymphoid tissue at the right inferior tonsillar pole," Dr. Seely also performed a biopsy, removing the tissue and sending it for

pathological evaluation. CP 1213. These are the exact procedures that the consent form lists. CP 1223.

E. Belisle files her complaint against many providers.

Belisle commenced this action on April 30, 2020. CP 1. She sued 16 defendants for alleged medical malpractice in performing her tonsil surgeries, claiming continuing issues as a result, CP 1-12, although most of these individuals were not involved in Belisle's care, CP 42-43.[2] She also asserted that Dr. Seely and Dr. Zundel failed to obtain informed consent prior to the surgeries. CP 5.

F. Belisle's counsel deposes Dr. Seely on April 19, 2023.

Belisle's counsel deposed Dr. Seely on April 19, 2023, for nearly three hours. CP 1479-1501. During his deposition, Belisle's counsel asked when Dr. Seely retired, and Dr. Seely disclosed that he "went out on medical leave" on May 14, 2018.

[2] The trial court dismissed all defendants except for Dr. Seely, Dr. Zundel, and Proliance. CP 199-201.

CP 1480 (4:16-19). Counsel never asked Dr. Seely any follow up questions about the nature of his medical leave. *See* CP 1480.

Throughout his deposition, Dr. Seely defended his care, testifying that he performed the procedure correctly and did not go too deep so as to injure the vagus nerve, as Belisle claimed. *See, e.g.,* CP 1492 (51:4-16). In addition to performing the surgery himself, Dr. Seely also reviewed the pathology report from the procedure, which confirmed he only removed tonsils with no additional muscles or nerve tissue. CP 1492 (51:9-13); *see also* CP 88 (pathology).

Dr. Seely also denied that Dr. Zundel was the one who recommended the second surgery; Dr. Seely had already discussed it with Belisle before she saw Dr. Zundel, and Dr. Zundel was simply covering for Dr. Seely while he was out of the office. CP 1498 (75:18-76:5), 1499 (80:12). Dr. Seely testified that "our intent … was to always have the same doctor who did the surgery do any follow-up procedures, whether it was tonsil related or otherwise." CP 1499 (80:16-19).

Belisle's counsel did not ask Dr. Seely about his informed consent procedures or discussions with Belisle during his deposition. *See* CP 1478-1502. Belisle's counsel did not depose Dr. Zundel.

G. Dr. Seely and Dr. Zundel seek dismissal of Belisle's informed consent claims.

Following discovery and numerous trial continuances, Proliance, Dr. Seely, and Dr. Zundel moved for summary judgment dismissal on June 16, 2023. CP 696. Belisle's experts had been deposed, and their testimony failed to sufficiently support Belisle's case. CP 696-722. On Belisle's informed consent claims, neither of her two ENT experts, Dr. Michael Kaplan and Dr. Meir Hershcovitch, opined that Dr. Seely or Dr. Zundel failed to obtain informed consent. CP 717-20, 761 (14:22-15:6), 779 (71:24-73:18).

In opposing dismissal, however, Belisle produced declarations from Dr. Kaplan and Dr. Hershcovitch relying on prior reports in which they purported to criticize the informed consent process, despite their testimony to the contrary. CP 808-

10, 817-18, 889-90. Belisle also submitted a declaration in which she claimed that "[t]here was no mention of surgery and no discussion of informed consent with Dr. Zundel," although he mentioned that they should return to the operating room since Belisle's issues persisted. CP 934; *see also* CP 1165 (29:9-30:6) (Belisle only saw Dr. Zundel in the office and did not know why her attorney had sued him). Dr. Seely then performed the second surgery, for which Belisle contended she did not provide informed consent. CP 935-36.

At argument, the trial court appreciated that it was difficult to piece together what Belisle's evidence was against Dr. Zundel. 1-RP-127. While the trial court allowed most of Belisle's claims to proceed, it dismissed Belisle's claim that Dr. Zundel breached the standard of care. CP 1181. It denied the defendant's motion to dismiss the informed consent claim against Dr. Seely, and it denied without prejudice the motion to dismiss the informed consent claim against Dr. Zundel with leave to refile. CP 1181-83.

Dr. Zundel timely sought reconsideration because, notwithstanding Belisle's experts' vague assertions, Dr. Zundel had no legal duty to obtain informed consent as he did not perform the procedure in question. CP 1188-1201.

Belisle countered that because Dr. Zundel was "in the same practice as the second ENT, Seely", and his name was listed on the consent forms, Dr. Zundel needed to provide informed consent to Belisle despite Dr. Seely ultimately performing the procedure. CP 1237.

The trial court granted reconsideration, dismissing the informed consent claims against Dr. Zundel. CP 1265-67.

H. Belisle files a "motion for summary judgment" that her medical bills are reasonable and necessary, which the trial court refuses to consider as untimely.

On September 28, 2023, with trial scheduled to begin on October 30, 2023, Belisle filed a three-page "motion for summary judgment," asking the court to rule that her medical bills were reasonable and necessary. CP 1319-21. Although she provided declarations from providers in which they declared in

conclusory fashion that they believed her medical bills were reasonable and necessary, *see* CP 1322-61, her motion contained no legal authority, analysis, or argument indicating why she was entitled to a dispositive ruling on the issue, *see* CP 1319-21.

Five days later, on October 3, 2023, Belisle filed a half page motion to shorten time on summary judgment. CP 1388-89. She appreciated that the rules required her to note the summary judgment motion hearing at least 28 days after she filed the motion: October 27, 2023, nearly two weeks after the October 16, 2023 dispositive motion deadline. CP 1388. Belisle asked the court to move the hearing to October 16, 2023 to comply with the deadline. CP 1388. Her only explanation was that "[b]oth parties have had these medical records and bills for many months," and she did not believe there was any "genuine issue as to whether these medical records and bills show reasonable and necessary treatments and billings." CP 1388.

Dr. Seely opposed Belisle's motion to shorten time, clarifying that he absolutely opposed summary judgment

because medical causation was hotly contested, and causation was central to the reasonableness of medical care and necessity of medical bills for such care. CP 1397-98. Not allowing Dr. Seely adequate time for opposing a legal determination that over $90,000 of medical bills were reasonable and necessary would prejudice Dr. Seely, who needed to conduct discovery on the new, previously undisclosed expert opinions regarding the bills. CP 1397-99. Dr. Seely also highlighted that Belisle offered no reasonable excuse for the delay in bringing her motion. CP 1398.

On October 9, 2023, the trial court denied Belisle's motion to shorten time. CP 1415-18. Its detailed ruling appreciated that the dispositive pretrial motion deadline was October 16, 2023, but that Belisle had noted her summary judgment motion for October 27, 2023, past the deadline. CP 1416-17. It found that she failed to justify her untimeliness:

> On September 28, 2023, [Belisle] filed a "Motion for Summary Judgment re: Medical Treatment and Bills Reasonable and Necessary." The motion is three pages long. It contains no citations to legal authorities, no legal argument and primarily

> consists of a description of accompanying declarations. At the time of filing, [Belisle] noted the motion for a hearing on October 27, 2023, past the deadline for hearing dispositive motions. She did not get approval from the court for this hearing date. …
>
> Five days later, [Belisle] filed a motion to shorten time to have the motion for summary judgment heard on October 16, 2023. In the motion to shorten time, she offers no explanation as to why the motion for summary judgment was not filed earlier. Nor does she explain why she waited five days to file the motion to shorten time.
>
> The defendants have objected to the motion to shorten time, noting, among other things, that [Belisle] offered no reasons as to why the motion for summary judgment was late and that they did contest the reasonableness and necessity of the medical bills.
>
> * * *
>
> Given that [Belisle] has never offer any explanation for the late filing of her motion for summary judgment, the motion to shorten time is DENIED.

CP 1416.

Contrary to Belisle's incorrect assertions on appeal, the trial court never denied Belisle's summary judgment motion. The reasonableness and necessity of medical bills remained issues for trial.

I. The trial court precludes evidence of Dr. Seely's Parkinson's Disease.

During pretrial hearings on November 2, 2023, Dr. Seely's counsel informed the court that Dr. Seely had been diagnosed with Parkinson's Disease in 2018, that this had nothing to do with the care he provided in 2016, and it was generally well-controlled, but they needed several accommodations, including regarding timing his medications and how long he could comfortably testify without a break. 1-RP 284-85. Additionally, his counsel asked the Court to tell the jury about Dr. Seely's condition so that they did not speculate about his tremor:

> I would ask that Court tell the jury before trial about Dr. Seely's condition because he has – for several months – and especially when he starts to get tired, he does exhibit some tremor. And I don't want the jury to be speculating about what's going on with Dr. Seely.

1-RP 285. Belisle's counsel agreed: "I agree that … we should tell the jury and it should be first thing at the beginning of trial," and he asked Dr. Seely's counsel to prepare the stipulation. 1-RP

287. The "only little point" Belisle's counsel wanted added was an instruction not to give Dr. Seely "any sympathy." 1-RP 287.

Five days later, on November 7 before the jury arrived, the trial court inquired whether the parties had agreed on a preliminary instruction regarding Dr. Seely. 1-RP-456. Dr. Seely's counsel said he would send it to Belisle's counsel, who said "[i]t's probably going to be just fine, your Honor." 1-RP 457.

However, after the recess, Belisle's counsel changed his mind and refused the earlier stipulation. 1-RP 463. He argued that "we just found out about this," and he claimed without providing specifics that "doctors" are "all telling us" Dr. Seely's Parkinson's must have been manifesting earlier. 1-RP 463. Ignoring Dr. Seely had openly disclosed during his deposition that he had retired for medical reasons in 2018, CP 1480 (4:16-22), Belisle's counsel insisted that he "didn't know about this at the time of his deposition, so I didn't ask him when did he first have signs and all these other things," 1-RP 463.

Because Belisle's counsel now objected, Dr. Seely's counsel withdrew the stipulation. Dr. Seely's counsel also made an oral motion in limine to exclude evidence or argument about Dr. Seely's Parkinson's because it was not and had never been an issue in the case. 1-RP 464-65. He explained that "Dr. Seely wasn't diagnosed until two years [after Belisle's care] and never exhibited any sort of symptoms that would in any way impact his medical practice until even last year. There's just no evidence on this." 1-RP 465.

Belisle's counsel countered that "it's years in the making and the early signs are tremors … Wikipedia, everybody is saying this. And, no, we don't have an expert on it. We didn't prepare any testimony on it because we've never heard from him when he got it and all that." 1-RP 466. The court asked Belisle's counsel whether there was any admissible evidence that Dr. Seely may have been suffering from Parkinson's symptoms and that it impacted the surgery, to which counsel responded, "no, I don't have any evidence." 1-RP 467.

The court accordingly ruled: "there's no evidence Plaintiff has that this condition was involved or impacted the surgery in this case. … [T]he law's pretty clear, you can't speculate and ask the jury to speculate, so I'm going to exclude any evidence … or argument that Parkinson's was somehow implicated in this surgery or the alleged malpractice. … Because there's been no evidence and counsel's admitted he has no evidence on that front." 1-RP 469.

Belisle's counsel asked if the court would make the ruling "without prejudice," to which the court responded that evidentiary rulings are rarely with prejudice but cautioned counsel that attempting to introduce new evidence in the middle of trial would raise all kinds of issues, and "I don't want to even speculate as to what the rule will be." 1-RP 471.

Belisle's counsel then orally sought reconsideration, claiming that he had not received adequate discovery responses on Dr. Seely's health. 1-RP 472-73. Because this raised a more complicated issue, the court stated: "I'm not doing to deal with

this issue right now before opening given all those circumstances." 1-RP 473. The court then invited Belisle's counsel to "make an appropriate written motion with the facts showing that would justify allowing evidence;" if Belisle did so, the court "would certainly consider argument." 1-RP 473.

Belisle's counsel never raised the issue of Dr. Seely's Parkinson's again.

J. Trial proceeds on November 6, 2023, which Belisle's counsel's inefficiencies frequently delayed.

Trial commenced on November 6, 2023. It was frequently delayed, not because Belisle had to establish the reasonableness and necessity of her medical bills, *see Appellant Br. at 48*, but due to her counsel's many inefficiencies.

For instance, days before trial, Belisle listed 1,115 exhibits she intended to present to the jury. CP 2056. Her counsel repeatedly failed to arrive at trial with organized exhibits. *See, e.g.,* 2-RP 564-65 (Belisle's counsel presenting a box of unstapled documents with Post-it notes as exhibits); 2-RP 650-51 (counsel providing numerous exhibits at midnight the night

before trial; trial court observing that Belisle's exhibits are "going poorly. … I think that's a fair observation"); 2-RP 675 (exhibits not ready, being presented wholesale, counsel should have come in early to deal with it).

Belisle's counsel also arrived late to trial repeatedly, conducted inefficient examination of witnesses, and was generally unprepared. *See, e.g.,* 2-RP 647 (Belisle's counsel late for trial the second time, with everyone, including the jury, present before him; trial court had warned him multiple times about prior tardiness and that "this is going to come out of Plaintiff's time for presenting her case"); 2-RP 664-70; (counsel struggling with screen sharing, no copies of exhibits made, early recess because counsel unprepared); 2-RP 827 (spending "over double the amount of time you had budgeted" on Dr. Ciment when his testimony did not involve medical bills and court admonishing Belisle's counsel to "be mindful of how much time is being taken"); 2-RP 941-42 ("approaching double" the amount of time for Dr. Kaplan); 2-RP 970 (court admonishing counsel

outside jury's presence regarding repetitive questioning; "I hope you're paying attention to the jury's behavior … and not waste their time"); 3-RP 1363 (counsel late to trial again, "at some point when you seem to be the only one who can't get here on time, it's apparent to the Court that's a problem. So it does come out of Plaintiff's time"); 4-RP 1673 (warning counsel outside jury's presence that he is going over time again, with "a lot of dead time when you're conferring with your associate trying to figure out another question"); 5-RP 2325-26 (repeatedly making statements to the jury while questioning witnesses and court warning him to stop); 5-RP 2441-68 (repetitive questioning); 5-RP 2477-80, 6-RP 2566-67, 2570, 2573, 2581 (improper conduct during cross examination).

The trial court recognized outside the jury's presence that Belisle's counsel's inefficiencies, not the medical bills, accounted for the protracted proceedings:

> What I've observed already is I'm worried you're going to need more time and it has nothing to do with bills. So I'm trying to give you advance notice

> of this well ahead of time …. [I]t's not my job to tell you how to try the case and how to … use your time. I've advised both parties they have a limited amount of time and I've told you already it appears to be exceeded. And I'm starting to hear I am going to bring motion … for some other reason, and I'm warning you, I've already seen things are not going smoothly and time is being used for reasons other than what you've already articulated to be the reasons you're going to ask for more time.
>
> 2-RP 829.
>
> * * *
>
> [E]verything I've observed are delays are coming for other reasons. … I'm not even sure the medical bills in and of themselves is an excuse to give you more time. … [F]rankly, what I'm observing is not efficient.
>
> 2-RP 941-42.

The evidence on the bills' reasonableness and necessity took minutes. *See, e.g.*, 2-RP 973-76 (questioning Dr. Kaplan on reasonableness and necessity of bills).

K. The trial court denies a motion to preclude Belisle from testifying about her mental and emotional pain and suffering, and reserves ruling on a motion to prevent non-physician testimony about medical facts.

The trial court denied Dr. Seely's motion in limine seeking to prevent Belisle from testifying about her mental and emotional

pain and suffering. 1-RP 240. The court reserved ruling on Dr. Seely's motion to exclude non-physician testimony regarding medical facts, standard of care, or causation, finding that Belisle might be allowed to testify about some medical facts and that counsel needed to object at the time of questioning. 1-RP 267-68. Belisle's counsel, who provided no written responses to Dr. Seely's motions in limine, 1-RP 213-14, did not object to either of these rulings at the hearing, which were favorable to his client, *see* 1-RP 240, 267-68.

At trial, the court allowed Belisle latitude to testify about her medical issues. *See, e.g.,* 2-RP 581 (testifying about what medical providers told her were the issues with her voice); 2-RP 597-99 (testifying about lack of asthma history, explaining anaphylaxis event, defining and describing types of bronchitis, defining tonsillitis); 2-RP 627-30, 632-36 (testifying at length about symptoms following April 2016 tonsillectomy); 2-RP 638-42 (testifying about her diagnoses and different diagnostic and treatment modalities); 3-RP 1019-26 (summarizing her medical

history, testimony limited only as to hearsay); 3-RP 1027-28 (testifying about her medical course); 3-RP 1182-1216 (describing diagnostic tests, further medical course, treatment, and symptoms, subject only to the trial court sustaining occasional hearsay, leading, and foundation objections); 3-RP 1294, 1296-1309, 1326-41 (testifying about her medical care and symptoms, limited only for occasional hearsay and foundation objections); 4-RP 1897-1902, 5-RP 2003-18, (testifying about medical care and symptoms); 5-RP 2089-96 (testifying about her medical care and symptoms, limited only for occasional hearsay and foundation objections); 5-RP 2231-38 (testifying about medical care and symptoms); 5-RP 2242-50 (testifying about her medical care and symptoms, limited only for occasional hearsay and foundation objections).

Belisle's testimony was hours long, covering multiple days. There were five times that the trial court limited Belisle's testimony about medical issues, and each time Belisle's counsel withdrew the question and rephrased.

First, the court limited Belisle's testimony when asked generally about how medical providers treat tonsillitis:

> Q. What's tonsillitis?
>
> A. Tonsillitis is an infection of your tonsils.
>
> Q. Right. And what do they do for it?
>
> A. They can give you antibiotics or they can do certain things like if they think it's just viral they'll give you, like gargling salt water, things like that to help –
>
> MR. WINFREY: Objection, Your Honor. … Medical Testimony from a lay witness.
>
> * * *
>
> THE COURT: I'll allow some limited testimony on this. But … obviously this is coming from the lay witness.
>
> MR. BUDIGAN: I understand, Your Honor. And I want to ask her what she was treated with.
>
> THE COURT: You can ask her what she was treated with.
>
> Q. What were you treated with?
>
> * * *
>
> A. I've been treated with antibiotics. And then there was another episode and they gave me antibiotics. There was one other episode that I remember, and they gave me antibiotics and

they said if it does not cure, they you take the antibiotics.

2-RP 599-600.

Second, the trial court limited Belisle's testimony when she attempted to testify about what medical providers do when they perform a laryngeal EMG (LEMG):

Q. [W]hat happens in this test?

A. They put a[n] electrode through your –

MR. WINFREY: Objection, Your Honor.

* * *

THE COURT: … Do you want to rephrase your question?

MR. BUDIGAN: I'll rephrase it.

THE COURT: All right.

Q. Did you undergo an LEMG?

A. Yes.

* * *

Q. And what did they do during that test to you, physically, that you observed?

A. Thet stuck a needle through my throat directly into the vocal cord and they did it four times, twice on each side.

2-RP 642-43.

Third, when Dr. Seely's counsel objected that Belisle could not go beyond her own personal knowledge in discussing a nerve injury, Belisle's counsel withdrew the question:

> Q. … I want to [go] at least through Mayo Clinic. So Swedish Issaquah ENT, what's that?
>
> A. So this is where … I'm not really sure … how much I can say because I am a nurse – I know that nerve – like I felt as though I had nerve damage that was –
>
> MR. WINFREY: I'm going to object, Your Honor, to the extent that she's doing beyond her own personal –
>
> THE COURT: This witness isn't testifying as an expert, that's correct, Mr. Budigan, as to nerve damage in the throat?
>
> MR. BUDIGAN: I withdraw the question. I don't think it's responsive to what I was asking anyways.

3-RP 1026-27.

Fourth, the trial court sustained an objection on a foundational, rather than medical testimony, basis when Belisle testified about procedures regarding a PEG feeding tube that one provider had recommended, but that Belisle did not have placed:

Q. … [W]hat do they feed you through a PEG tube?

A. High caloric liquid nutrition. It's formulated for you.

Q. Okay. What color?

A. It looks like a latte. …

Q. … And how often do you have to clean it?

A. Every time –

MR. WINFREY: Objection – objection, Your Honor. Foundation and this is medical testimony.

MR. BUDIGAN: Well, they discussed it with her.

THE COURT: Well, I'll sustain the foundation objection.

Q. Did they discuss with you … what you have to do with this PEG tube if you … say yes to it and they put a PEG tube in you? Did they discuss what the steps are that you have to deal with this thing?

A. That was discussed with me. The process … of having … how often I would have to have the PEG tube replaced.

3-RP 1216-17.

Fifth, the court sustained an objection when Belisle was generally asked about "long myotomy:"

Q. … What's long myotomy?

A. Long – long –

MR. WINFREY: Objection, Your Honor.

Q. Okay. Let me ask another question.

THE COURT: All right.

MR. BUDIGAN: I'll withdraw.

Q. Did you hear the testimony of Dr. McDonnell yesterday? …

3-RP 1295-96.

L. Dr. Seely and his experts defend his care, Belisle's experts disagree, and the jury returns a defense verdict.

At trial, Dr. Seely testified, defending his care and his informed consent process. *See, e.g.,* 5-RP 2353-60 (informed consent)[3]; 5-RP 2361-2380 (standard of care). Dr. Seely explained that he performed nearly 3,000 tonsillectomies during his decades-long career. 5-RP 2346. With Belisle's chronic, recurrent symptoms, tonsillectomy was warranted, but they also

[3] After Belisle rested her case, Dr. Seely successfully moved for directed verdict on her informed consent claim against him, CP 2789-95 (motion); 6-RP 2914-16 (court's ruling), which Belisle does not appeal.

discussed symptom-management methods. 5-RP 2351-52. He testified that, consistent with his chart notes, he discussed the alternatives, benefits, and risks of tonsillectomy. 5-RP 2352-58.

Dr. Seely next described his surgical technique. 5-RP 2358-81. He testified unequivocally that he did not cut too deep to injure Belisle's nerves:

> Q. You've heard testimony about potentially going – as it's been said – too deep in the surgery such that you got back and injured nerves back here. Did that happen?
>
> A. No.
>
> Q. Did you go too deep in the surgery with Stephanie Belisle?
>
> A. No.
>
> Q. … [D]id you jam a scalpel or a[n] electrocautery device into the superior constrictor muscle?
>
> A. No.
>
> Q. … And would you ever do that?
>
> A. No.
>
> Q. Did you use the cautery device to stop the little bleeding vessels that you talked about?
>
> A. Yes.

Q. … Did you use it for anything – anything else to, you know, cut or take out tissues of anything like that?

A. No.

5-RP 2382. He testified that he complied with the standard of care in performing Belisle's April 2016 tonsillectomy. 6-RP 2537-38.

Dr. Seely explained that the second surgery in August 2016, was indicated to further evaluate Belisle's symptoms. 6-RP 2543-44. Because he saw one small part of the tonsil remaining, and because Belisle had ongoing symptoms, he made the judgment to remove and biopsy that small piece during the procedure. 6-RP 2545-46. There were no complications, and Dr. Seely did not go too deep. 6-RP 2546.

Both parties offered several experts and Belisle's treating providers.

Belisle called two ENT experts, Dr. Kaplan and Dr. Hershcovitch. They testified generally that the standard of care requires not going too deep with a tonsillectomy, which they

believe Dr. Seely did and damaged the vagus nerve. 2-RP 814-15, 883-84, 899, 913, 920, 991-93. Neither could describe with certainty how any purported nerve injury had occurred. 2-RP 920-21; 4-RP 1643, 1657. Neither testified that Dr. Seely breached the standard of care in performing the second procedure. *See, e.g.,* 3-RP 1008-10.

Belisle also called several experts who did not render standard of care opinions, but addressed Belisle's causation and damages claims about her asserted nerve injury. *See* 2-RP 653-784 (Gary Ciment, anatomy expert); 3-RP 1042-1146 (Michael McDonald, gastroenterologist expert); 3-RP 1391-4-RP 1501 (Paul Fogel, speech and language expert); 4-RP 1503-1625 (John Berg, vocational expert).

Dr. Seely called one ENT expert, Dr. Dinesh Chhetry. Dr. Chhetry confirmed that Dr. Seely did not breach the standard of care and appropriately performed both procedures. 4-RP 1745-46, 1767. He explained that to injure the glossopharyngeal nerve or the vagus nerve during a tonsillectomy, Dr. Seely would have

had to cut through muscle and fat, which there is no evidence of him doing. 4-RP 1737, 1746, 1749. He likewise testified no evidence supported that Dr. Seely injured the superior laryngeal nerve or vagus nerve when using the electrocautery, which would be anatomically impossible and not supported by the tests that Belisle had, which showed normal nerve function. 4-RP 1749-50, 1754-55, 1761, 1766, 1767-68.

Like Belisle, Dr. Seely also called several causation experts who testified that neither Belisle's symptoms nor her objectively normal swallow studies indicate that she has a vagus or superior laryngeal nerve injury. *See, e.g.,* 5-RP 2400, 2404-06, 2411, 2414-16, 2424-25 (Michael Fennerty, gastroenterology and internal medicine expert); 5 RP 2266-68, 2287-88 (Peter Kahrilas, gastroenterology esophageal motility expert). Dr. Seely's experts opined that Belisle learned and adapted her swallowing deficit following some altered sensation post-surgery and now simply needs to retrain her swallowing mechanism. 5-RP 2418-19, 2425-26.

Numerous treating providers also testified, including Dr. Zundel, 5-RP 2039, 2044, 2056-57, Belisle's speech pathologist Karen McNett, 6-RP 2653, 2659, 2663, gastroenterologist Dr. Francisco Ramirez, 6-RP 2677, neurologist Dr. Marc Kirshner, 6-RP 2765, and laryngologist Dr. Tanya Meyer, 6-RP 2839, 2868, whose testimony largely refuted Belisle's causation theories. Dr. Meyer testified that a diagnostic laryngeal EMG was not medically indicated because Belisle's vocal fold motion was normal bilaterally, and she had significant recovery of her voice. 6-RP 2854.

The jury returned a verdict on December 7, 2023, finding Dr. Seely not negligent. CP 3180-82.

Belisle appeals.

## IV. ARGUMENT

### A. The trial court properly dismissed Belisle's informed consent claim against Dr. Zundel.

This Court reviews summary judgment de novo. *Michael v. Mosquera-Lacy*, 165 Wn.2d 595, 601, 200 P.3d 695 (2009). Courts properly grant summary judgment when, viewing the

facts in the light most favorable to the non-movant, no genuine issue of material fact exists, and the movant is entitled to judgment as a matter of law. CR 56; *Michael*, 165 Wn.2d at 601.

Confusing the parties' respective burdens on summary judgment, Belisle argues that Dr. Zundel's summary judgment motion "should not have gotten past the initial stage" because she contends that he did not prove by uncontroverted facts that she "ever gave informed consent to a second tonsillectomy … by Dr. Seely," *Appellant Br. at 42*. Numerous problems arise from such a position.

First, a defendant moving for summary judgment may meet its initial burden by challenging the sufficiency of the plaintiff's evidence supporting an element essential to their case. *Young v. Key Pharm., Inc.*, 112 Wn.2d 216, 225, 770 P.2d 182 (1989). "The moving defendant may meet the initial burden by 'showing'—that is, pointing out to the district court—that there is an absence of evidence to support the nonmoving party's case." *Id.* at 225, n.1 (quoting *Celotex Corp. v. Catrett*, 477 U.S.

317, 325, 91 L. Ed. 2d 265, 106 S. Ct. 2548 (1986)) (internal quotation marks omitted). The burden then shifts to the nonmoving party to present affidavits or declarations based on personal knowledge setting "forth specific facts showing that there is a genuine issue for trial" to defeat the motion. *Young*, 112 Wn.2d at 225-26 (citing CR 56(e)).

Second, Belisle ignores, *Appellant Br. at 44-47,* the threshold question of legal duty, offering no authority that a physician who does not perform a procedure has a duty to obtain informed consent for the procedure. Belisle's argument, *Appellant Br. at 42, 44,* illuminates the fallacy of her position that the trial court erred in dismissing an informed consent claim against **Dr. Zundel** because she claims **Dr. Seely** performed the second procedure without obtaining informed consent.[4] The

[4] Belisle's brief is misleading at times regarding the rulings she challenges. She posits in her factual recitation that Dr. Seely failed to secure informed consent for the first procedure, *Appellant Br. at 8-10*, but the trial court did **not** dismiss on summary judgment the informed consent claim against Dr. Seely. CP 1181-82. The trial court later dismissed the informed

physician who performed the treatment at issue has the duty to obtain informed consent prior to proceeding with treatment, which here was Dr. Seely, not Dr. Zundel.

Informed consent originated in the common law before chapter 7.70 RCW's 1976 enactment. Early decisional authority predating the statute emphasized that the duty to obtain informed consent rests with the physician who actually performs the procedure. *See Mason v. Ellsworth*, 3 Wn. App. 298, 306, 474 P.2d 909 (1970) ("**a surgeon who performs an operation** without his patient's consent commits an assault, for which he is liable in damages.") (emphasis added); *Hunter v. Brown,* 4 Wn. App. 899, 902-03, 484 P.2d 1162 (1971) ("[d]amages are recoverable from a surgeon **who operates** without the consent of his patient"; "[i]t is also well established that damages are recoverable from a physician **who undertakes** a surgical

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consent claim against Dr. Seely when it granted his motion for directed verdict at the close of Belisle's case at trial, 6-RP 2915-16, a ruling Belisle does not appeal, *see Appellant Br. at 2-3*.

procedure for which he has not obtained a patient's 'informed' consent.") (emphasis added), *aff'd,* 81 Wn.2d 465 (1972); *Zebarth v. Swedish Hosp. Med. Ctr.*, 81 Wn.2d 12, 23 (1972) ("[i]nformed consent … puts the physician under a duty to advise the patient of such risks **before initiating the treatment**.") (emphasis added).

Following RCW 7.70.050's enactment, it continues to emphasize that informed consent applies to treatment a physician provides without first fully informing the patient of material risks:

> (a) That the **health care provider** failed to inform the patient of a material fact or facts relating to the **treatment**;
>
> (b) That the patient consented to the **treatment** without being aware of or fully informed of such material fact or facts;
>
> (c) That a reasonably prudent patient under similar circumstances would not have consented to the **treatment** if informed of such material fact or facts;
>
> (d) That the **treatment** in question proximately caused injury to the patient.

RCW 7.70.050(1) (emphasis added); *see also* RCW 7.70.050(2) and (3) (referring to "treatment" in specific elements). "The statute clearly uses the word 'treatment,' demonstrating the intent to limit informed consent claims to treatment situations." *Anaya Gomez v. Sauerwein*, 180 Wn.2d 610, 617, 331 P.3d 19 (2014).

No Washington statutory nor decisional authority holds that a physician who did not perform or otherwise control the treatment provided has a duty to obtain informed consent. Health care providers do not have equal informed consent obligations. "To provide for equal informed consent obligations as to every person and entity falling within the definition [of "health care provider"] would not be justified." *Howell v. Spokane & Inland Empire Blood Bank*, 114 Wn.2d 42, 55, 785 P.2d 815 (1990).

In *Howell,* the Supreme Court rejected that a hospital had a duty to obtain informed consent because the "risk of a procedure is more properly left to the attending physician." *Id.; see also Alexander v. Gonser*, 42 Wn. App. 234, 239, 711 P.2d

347 (1985) (decision about what risks to disclose "is particularly one calling for the exercise of medical judgment" within the attending provider's purview), *rev. denied*, 105 Wn.2d 1017 (1986). Dr. Seely was Belisle's attending ENT physician. Dr. Zundel only saw Belisle to fill in for Dr. Seely when he was out of town—after Dr. Seely had already recommended a second procedure. Dr. Seely intended to perform any follow-up procedures. CP 1498 (75:18-76:5), 1499 (80:12, 16-19). The duty to obtain informed consent for any procedures prior to performing them rested with him.

To the extent Dr. Zundel agreed with Dr. Seely's recommendation for the second procedure, because he did not ultimately perform, participate in, or control it, he had no duty to obtain informed consent. In *Bottemiller v. Gentle Dental Serv. Corp.*, Nos. 26838-8-II, 27051-0-II, 2002 Wash. App. LEXIS

3193, *2, *32-35 (Dec. 31, 2002) (unpublished)[5], the Court of Appeals held that a referring physician had no duty to obtain informed consent because he did not participate in or control the surgery at issue. The patient saw an orthodontist, who referred her to an otolaryngologist for tonsillectomy before proceeding with orthodontia. *Id.* at *2. After suffering complications during the tonsillectomy, her family sued the otolaryngologist and the orthodontist, alleging that they failed to obtain informed consent. *Id.* at *6-7.

Rejecting plaintiffs' argument that the orthodontist had a duty to obtain informed consent because he recommended a tonsillectomy, the Court of Appeals held that the orthodontist was entitled to judgment as a matter of law on the informed consent claim. *Id.* at *28-36. Recognizing the majority rule that a physician who does not perform the procedure has no duty to

[5] Although Bottemiller predates March 1, 2013, under GR 14.1, it is cited not as authority, but simply to reflect controlling precedent applied in a more factually-analogous scenario.

obtain informed consent for it, the court reasoned that because the orthodontist "did not participate in or control" the patient's surgery, he had no duty to obtain informed consent. *Id.* at *36; *see also Brotherton v. United States*, 2018 U.S. Dist. LEXIS 132800, *12-13 (E.D. WA Aug. 7, 2018) (unpublished, GR 14.1) (referring physician who had not participated in or controlled the procedure had no duty to obtain informed consent because the "physician performing a procedure should advise on the risks of the procedure.").

This rule is logical. Only the physician who ultimately performs the procedure knows and controls how he specifically will perform it and the attendant risks and benefits; therefore, only that physician has the duty to obtain informed consent before operating. This was Dr. Seely. Dr. Zundel had no duty to obtain informed consent.

Most courts around the country support this conclusion. *See, e.g., Fajardo v. Boston Sci. Corp.*, 267 A.3d 691, 701 (2021) (only provider who actually gives the treatment or performs the

operation has a duty to obtain informed consent); *Torres v. Carrese,* 2012 Conn. Super. LEXIS 52, *25 (Sup. Ct. January 3, 2012) (affirming summary judgment dismissal of informed consent claim against physician who neither performed nor participated in surgery at issue), *aff'd,* 90 A.3d 256 (Conn. App.), *rev. denied*, 93 A.3d 595 (Conn. 2014); *Logan v. Greenwich Hosp. Asso.*, 465 A.2d 294, 305-06 (1983) (internist who referred patient for surgery and explained some procedure risks to her had no duty to secure informed consent because he did not participate in procedure); *Ortega v. Stiefel*, 2022 N.Y. Misc. LEXIS 47617, *10 (Sup. Ct. Nov. 23, 2022) (holding that physician who did not perform the procedure was not liable for lack of informed consent) (unpublished, GR 14.1); *Shinal v. Toms*, 162 A.3d 429, 453 (Pa. 2017) ("informed consent rests solely upon the healthcare provider performing a medical procedure").

Consistent with the majority rule, Washington law does not endorse the position that a physician who did not participate in or exercise control over the procedure in question had a duty

to obtain informed consent for someone else to perform it. Belisle offers no authority to the contrary. The trial court correctly dismissed Belisle's informed consent claim against Dr. Zundel.

B. The trial court properly denied Belisle's motion to shorten time on her "motion for summary judgment" to find her medical bills reasonable and necessary.

Belisle misleadingly assigns error to a purported order "summarily den[ying] Plaintiff's motion for summary judgment regarding the medical bills," *Appellant Br. at 47*. *See also Appellant Br. at 26-27* (erroneously claiming that de novo review applies to trial court denying Belisle's summary judgment motion). The trial court did no such thing. It never reached the untimely summary judgment motion. Instead, the court simply denied Belisle's motion to shorten time.

"A trial court has discretion when ruling on a motion to shorten time." *State ex rel. Citizens v. Murphy*, 151 Wn.2d 226, 236, 88 P.3d 375 (2004). "An appellate court will overturn a discretionary ruling only for a manifest abuse of discretion." *Id.*

(citation omitted). A trial court also has "discretionary authority to manage its own affairs so as to achieve the orderly and expeditious disposition of cases." *Woodhead v. Discount Waterbeds, Inc.*, 78 Wn. App. 125, 129, 896 P.2d 66 (1995), *rev. denied*, 128 Wn.2d 1007 (1996).

The trial court properly exercised discretion in denying Belisle's motion to shorten time and enforcing its scheduling order. The scheduling order required deciding dispositive motions by October 16, 2023, two weeks before the October 30, 2023 trial date. CP 1388. Under CR 56(c), a summary judgment motion "shall be filed and served not later than 28 calendar days before the hearing."

Belisle filed a dispositive motion on September 28, 2023, outside the required 28-day window before the dispositive motion deadline. CP 1319-21. Days later, she filed a half page motion to shorten time with no legal authority, asking the court to consider her motion on October 16, 2023. CP 1388-89. Her only explanation was that the parties had the medical bills and

records for months and she did not believe anyone disputed their reasonableness or necessity. CP 1388. Dr. Seely, for his part, clarified that he opposed summary judgment because medical causation was contested, and he needed the time that CR 56 provided to respond. CP 1397-99.

In a detailed ruling demonstrating proper discretion, the trial court denied Belisle's motion to shorten time because she offered no explanation justifying why she failed to file the summary judgment motion earlier. CP 1416-17. Belisle provides no authority that the trial court abused its discretion in denying her unjustified motion to shorten time. *See Christian v. Tohmeh*, 191 Wn. App. 709, 728, 366 P.3d 16 (2015) (appellate court "does not review issues not argued, briefed, or supported with citation to authority.") (citation omitted), *rev. denied*, 185 Wn.2d 1035 (2016). Presumably, Belisle finds none. *See Helmbreck v. McPhee*, 15 Wn. App. 2d 41, 57, 476 P.3d 589 (2020) (courts "are not required to search out authorities, but may assume that

counsel, after diligent search, has found none."), *rev. denied*, 196 Wn.2d 1047 (2021).

Contrary to Belisle's incorrect assertions on appeal, the trial court never denied, much less issued any kind of ruling, on the merits of Belisle's summary judgment motion itself. The trial court, however, correctly observed that Belisle's summary judgment motion contained "no citations to legal authorities, no legal argument and primarily consists of a description of accompanying declarations." CP 1416. She filed a three-page motion asking the court to rule that her medical bills were reasonable and necessary without providing any legal authority, analysis, or argument why she was entitled to such a dispositive ruling. CP 1319-21. As below, Belisle again fails on appeal to demonstrate that she was entitled to relief on her summary judgment motion even had the trial court substantively considered it.

To the extent Belisle's summary judgment motion might be considered to have been "denied," which it was not, any such

denial was harmless because Belisle was still able to put on a case for her medical bills' reasonableness and necessity. The trial court did not preclude this claim or limit her evidence; Belisle merely had to prove her case. Any claimed distractions that Belisle asserts, *Appellant Br. at 48*, occurred because she had to present evidence of the medical bills' reasonableness and necessity was a problem of her own making and certainly did not cause her counsel's many inefficiencies. *See Section III., K., infra.* Moreover, the jury did not even reach damages, finding Dr. Seely not negligent. There was no error, let alone prejudicial error that would warrant reversal. .

C. Belisle fails to show that the trial court abused discretion in its evidentiary rulings.

This Court reviews the trial court's evidentiary rulings for abuse of discretion. *Veit v. Burlington N. Santa Fe Corp.*, 171 Wn.2d 88, 99, 249 P.3d 607 (2011) (citation omitted). "A trial court abuses its discretion when the ruling is manifestly unreasonable or based upon untenable grounds or reasons." *Id.* (quotations and citations omitted). A "reviewing court may not

find abuse of discretion simply because it would have decided the case differently—it must be convinced that no reasonable person would take the view adopted by the trial court." *Gilmore v. Jefferson Cnty. Pub. Transp. Benefit Area*, 190 Wn.2d 483, 494, 415 P.3d 212 (2018) (quotations and citations omitted).

Here, Belisle's challenges to three of the trial court's evidentiary rulings fail to demonstrate that the rulings were manifestly unreasonable.

1. The trial court did not limit Belisle's testimony about her medical diagnoses.

Belisle cites, *Appellant Br. at 23, 50*, two pages from the verbatim reports of proceedings that she claims represent a trial court ruling "preventing" her from discussing her own medical diagnoses as she understood them as a trained nurse. Neither 1-RP 238 nor 229 shows any such thing. It is difficult to even discern the source of Belisle's claimed error. She offers no examples of the trial court "muzzling" her. Appellate courts "do not consider conclusory arguments" such as Belisle's. *Christian*, 191 Wn. App. at 728 (citation omitted).

More than being conclusory, it is patently incorrect. Belisle's assignment of error that the trial court's "granting of a motion to essentially muzzle Stephanie Belisle and not allow her to speak about her conditions as she normally would as an ER nurse," *Appellant Br. at 32-33,* is wrong. The trial court **denied** Dr. Seely's motion, ruling that Belisle could testify about her mental and emotional pain and suffering. 1-RP 240. It also did not "grant[] one that prevented Ms. Belisle from talking about her own medical diagnoses," *Appellant Br. at 23.* It **reserved ruling** on Dr. Seely's motion to exclude non-physician testimony regarding medical facts, finding that Belisle might be allowed to testify about some medical facts and that counsel needed to object at the time of any such testimony. 1-RP 267-68.

Further, examples abound showing that the trial court **allowed** Belisle to testify about the very things she erroneously claims on appeal it would "not allow her to speak about," *Appellant Br. at 32-33.* Belisle testified for hours, scattering Volumes 2, 3, 4, and 5 of the reports of proceedings. Belisle's

testimony about her medical diagnoses, symptoms, conditions, and their effects on her spans no less than 140 pages, largely uninterrupted except for occasional hearsay or foundational objections. *See, e.g.,* 2-RP 581, 597-99, 627-30, 632-36, 638-42; 3-RP 1019-26, 1027-28, 1182-1216, 1294, 1296-1309, 1326-41; 4-RP 1897-1902; 5-RP 2003-18, 2089-96, 2231-38, 2242-50.

During these hours of testimony, counsel objected, and the trial court sustained, just five objections when Belisle stepped outside her personal knowledge: **(1)** objecting to a question about what "they do" for tonsillitis, and court allowing Belisle to testify about what treatment she specifically received (2-RP 599-600); **(2)** objecting to question about "what happens" in a laryngeal EMG, to which Belisle's counsel rephrased his question to what Belisle experienced physically during the test and Belisle was permitted to answer (2-RP 642-43); **(3)** objecting to Belisle's testimony that she knows she had nerve damage, to which Belisle's counsel withdrew the question (3-RP 1026-27); **(4)** objecting to Belisle testifying about what providers told her

would be involved in PEG placement, but trial court sustaining objection only as to foundation, which counsel provided and Belisle was able to respond (3-RP 1216-17); **(5)** objecting to the question, "What's long myotomy", to which counsel withdrew question (3-RP 1295-96).

Sustaining these objections was correct. A witness may only testify from personal knowledge. ER 602 ("witness may not testify to a matter unless evidence is introduced sufficient to support a finding that the witness has personal knowledge of the matter."). And even an expert witness—which Belisle was not—can only testify to topics within the scope of her knowledge. *See Frausto v. Yakima HMA, LLC*, 188 Wn.2d 227, 234, 393 P.3d 776 (2017) (scope of expert's knowledge governs admissibility of expert testimony in medical malpractice actions).

Moreover, Belisle fails to demonstrate prejudice. To the extent Belisle had sufficient knowledge to answer the objectionable questions, counsel provided that foundation, rephrased his question, and the court allowed Belisle to so testify.

Otherwise, counsel simply withdrew his question. Five objections in hours of testimony in no way "muzzled" Belisle, who responded to the majority of the questions. "'[E]videntiary error is grounds for reversal only if it results in prejudice.'" *Bengtsson v. Sunnyworld Int'l, Inc.*, 14 Wn. App. 2d 91, 99, 469 P.3d 339 (2020) (citation omitted). Belisle fails to demonstrate any prejudice. She gave robust testimony about her medical conditions, treatment, and symptoms; regardless, the jury did not reach her causation or damages claims.

Further, if Belisle's counsel disagreed with the trial court's individual rulings regarding Belisle's testimony, he failed to preserve any claimed error. *See State v. Roosma*, 19 Wn. App. 2d 941, 949, 498 P.3d 59 (2021) ("'[W]hen a ruling on a motion in limine is tentative, any error in admitting or excluding evidence is waived unless the trial court is given an opportunity to reconsider its ruling' when the evidence is submitted at trial.") (quoting *State v. Powell*, 126 Wn.2d 244, 257, 893 P.2d 615 (1995) (internal quotations omitted) (alteration original).

The trial court's evidentiary rulings regarding allowing Belisle to testify about medical facts were not error, much less preserved, prejudicial error.

2. The trial court did not err in ruling that it would not prohibit Dr. Rubenstein from testifying; Dr. Rubenstein did not even testify.

Belisle next complains that "the trial court erred in allowing defendants' late-disclosed expert Dr. Michael Rubenstein, to testify," *Appellant Br. at 51*. Dr. Rubenstein did **not** testify. *See* CP 1424 (Dr. Seely's trial witness list excluding Dr. Rubenstein as an expert witness); CP 1867-68 (Dr. Seely's time estimates of witnesses' testimony, which does not include Dr. Rubenstein); CP 1873-74 (same); CP 1895 (statement of evidence excluding Dr. Rubenstein); CP 1824 (indicating withdrawal of Dr. Rubenstein as witness); *see also* RP generally (no testimony from Dr. Rubenstein).

Although Dr. Seely moved on September 26, 2023, to allow Dr. Rubenstein, who is a neurologist, to testify as a rebuttal witness, if necessary, in trial scheduled to begin over a month

later, CP 1292-97, Dr. Seely ultimately did not call Dr. Rubenstein to testify. Harmless rulings cannot form the basis for reversal. *Veit*, 171 Wn.2d at 99 (trial court's ruling that a party contends is error "is harmless if it is trivial, or formal, or merely academic, and was not prejudicial to the substantial rights of the party assigning it, and in no way affected the final outcome of the case.") (quotations and citations omitted).

The trial court's order was not error regardless. Belisle incorrectly frames the order as "allowing" Dr. Rubenstein to testify. The trial court did not "allow" Dr. Rubenstein to testify; it refused to exclude Dr. Rubenstein as a trial witness based on Belisle's failure to establish that exclusion was an appropriate remedy under *Burnet v. Spokane Ambulance,* 131 Wn.2d 484, 933 P.2d 1036 (1997). CP 1392-93 (ruling that Belisle failed to address and establish *Burnet* factors). Belisle faults the trial court for not considering some sanction short of exclusion, *Appellant. Br. at 52*, but overlooks that Belisle did not request any other relief. *See* CP 1367-68.

Belisle's assignment of error is not even factually correct, much less legally sound.

3. The trial court did not err in excluding argument regarding Dr. Seely's Parkinson's disease diagnosis because Belisle failed to establish its relevance.

Long on rhetoric and short on facts and authority, Belisle incorrectly argues the trial court erred in excluding evidence of Dr. Seely's 2018 Parkinson's diagnosis. Trial courts enjoy "wide discretion" in making evidentiary rulings. *Bengtsson*, 14 Wn. App. 2d at 99. Appellate courts defer to the trial court's judgment unless they are "convinced that *no reasonable person* would take the view adopted by the trial court." *Gerlach v. Cove Apts., LLC*, 196 Wn.2d 111, 119, 471 P.3d 181 (2020) (citations and quotations omitted, emphasis original). The trial court did not make a manifestly unreasonable decision in preventing Belisle from introducing evidence or argument about Dr. Seely's Parkinson's diagnosis when Belisle failed to establish its relevance with admissible evidence.

Belisle baldly asserts that Parkinson's "was likely causing Dr. Seely problems at the time he operated on Ms. Belisle," *Appellant Br. at 59*, without providing evidence or citations to the record supporting this proposition. No such evidence exists. Below, Belisle insisted only that "Wikipedia, everybody is saying this." 1-RP 466. Wikipedia is not evidence. Nor are counsel's arguments below or on appeal. *See Green v. A.P.C.*, 136 Wn.2d 87, 100, 960 P.2d 912 (1998) ("Argument of counsel does not constitute evidence.").

The issue of whether Dr. Seely's Parkinson's could have impacted his care years before he was diagnosed is a complex medical issue requiring admissible expert medical testimony to support. *See Harris v. Robert C. Groth, M.D., P.S.*, 99 Wn.2d 438, 449, 663 P.2d 113 (1983) ("expert testimony is required when an essential element in the case is best established by an opinion which is beyond the expertise of a layperson.") (citation omitted). Belisle had no such evidence.

That is precisely why the trial court correctly granted Dr. Seely's motion in limine to exclude any evidence on or argument about Dr. Seely's Parkinson's:

> THE COURT: … [I]s there any admissible evidence you're offering that Dr. Seely may have been suffering from Parkinson's symptoms and how that impacted the surgery? Is there any evidence along those lines?
>
> MR. BUDIGAN: We're scrambling since Thursday to find that but, no, I don't have any evidence, Your Honor.

1-RP 467. The Court accordingly granted Dr. Seely's motion because "you don't have any evidence that it's relevant to the malpractice claim in this case," 1-RP 470, and "you can't speculate and ask the jury to speculate," 1-RP 469. This ruling was correct.

Evidence must be relevant to be admissible. ER 402. "[T]he question of whether evidence is relevant is for the judge, not the jury, to decide." *Davidson v. Metro. Seattle*, 43 Wn. App. 569, 573-74, 719 P.2d 569 (citation omitted), *rev. denied*, 106 Wn.2d 1009 (1986). "That determination is within the broad

discretion of the trial court, and is reviewable only for manifest abuse." *Id.* (citation omitted). The trial court did not manifestly abuse its discretion in ruling that, without evidence that Dr. Seely's Parkinson's diagnosis in 2018 may have impacted his medical skills years earlier, it was not relevant and would have been prejudicial.

Insisting she was unable to obtain expert support because she only learned of Dr. Seely's diagnosis days earlier, *Appellant Br. at 60,* Belisle also overlooks that she could have discovered this information sooner with diligence. *See Buhr v. Stewart Title of Spokane, LLC*, 176 Wn. App. 28, 36-37, 308 P.3d 712 (2013) (upholding trial court's refusal to extend discovery when party failed to demonstrate diligence); *Harris v. Drake*, 152 Wn.2d 480, 493, 99 P.3d 872 (2004) (trial court did not abuse its discretion in refusing to grant another trial continuance even though ruling left her without a medical witness because "[a]t some point a trial must proceed.")

Dr. Seely was diagnosed with Parkison's in 2018—five years before the trial. He carried the diagnosis on April 19, 2023, when Belisle's counsel deposed him for three hours. CP 1479-1502. Belisle's counsel asked when Dr. Seely retired, to which Dr. Seely disclosed that he "went out on medical leave" on May 14, 2018. CP 1480 (4:16-19). Counsel never asked Dr. Seely about the nature of his medical leave at his deposition. *See* CP 1480. Belisle's counsel also claimed that he was "starting to get a little concerned" about Dr. Seely's health after his deposition—seven months before trial—and he vaguely asserted that he "communicated with" Dr. Seely's counsel following the deposition and "got a no-type response," but apparently did nothing further. 1-RP 472. Thus, to the extent Belisle felt Dr. Seely's health was relevant, she had ample opportunity to discover more information but failed to do so.

This lack of diligence continued when the trial court invited Belisle's counsel to "make an appropriate written motion with the facts showing that would justify allowing evidence;" if

Belisle did so, the court "would certainly consider argument." 1-RP 473. Belisle never availed herself of that opportunity.

The trial court did not err in excluding irrelevant, prejudicial evidence that Belisle had ample opportunity to discover earlier with diligence.

D. Belisle improperly asks this Court to reweigh the evidence and overturn the jury's verdict that Dr. Seely was not negligent—an issue she also failed to preserve.

Many problems arise from Belisle's argument that the totality of evidence does not support the jury's defense verdict, *Appellant Br. at 53*, not the least of which is failing to preserve this issue for appeal. RAP 2.5(a) provides that an appellate court "may refuse to review any claim of error which was not raised in the trial court," subject to several exceptions inapplicable here. Our Supreme Court has routinely observed that

> In a plethora of decisions, involving many varying situations, this court has steadfastly adhered to the rule that a litigant cannot remain silent as to claimed error during trial and later, for the first time, urge objections thereto on appeal. The trial court must have an opportunity to consider and rule upon a litigant's theory of the case before this court can consider it on appeal.

*Bellevue Sch. Dist. v. Lee*, 70 Wn.2d 947, 950, 425 P.2d 902 (1967).

The purpose underlying the insistence on issue preservation is to encourage "the efficient use of judicial resources." *State v. Scott*, 110 Wn.2d 682, 685, 757 P.2d 492 (1988). Issue preservation serves this purpose by ensuring that the trial court can correct any errors, thereby avoiding unnecessary appeals. *State v. Robinson*, 171 Wn.2d 292, 304-05, 253 P.3d 84 (2011).

This is particularly evident when a plaintiff claims that the evidence does not support a defense verdict, as here. The civil rules provide the plaintiff with avenues specifically for raising the issue with the trial court in the first instance. *See* CR 59; CR 60. Belisle acknowledges that she failed to move for a new trial based on insufficient evidence below and correctly appreciates that the standard of review is based on a trial court's decision on a motion for new trial: "when reviewing a decision on a motion for a new trial premised on alleged evidentiary errors, matters

within the discretion of the trial court, the proper standard of review is abuse of discretion" *Bengtsson,* 14 Wn. App. 2d at 112 (citation omitted). Belisle filed no such motion here.

Not only did Belisle fail to preserve her claimed error, but she also improperly asks this Court to invade the jury's province and reweigh the evidence in her favor. She provides no justification for doing so. "Overturning a jury verdict is appropriate only when it is clearly unsupported by substantial evidence." *Burnside v. Simpson Paper Co.*, 123 Wn.2d 93, 107-108, 864 P.2d 937 (1994). Appellate courts "will not willingly assume that the jury did not fairly and objectively consider the evidence and the contentions of the parties relative to the issues before it." *Id.* (citation and quotations omitted). Indeed, witness credibility and the weight of evidence "are matters within the province of the jury and even if convinced that a wrong verdict has been rendered, the reviewing court will not substitute its judgment for that of the jury, so long as there was evidence

which, if believed, would support the verdict rendered." *Id.* (citation and quotations omitted).

Both parties here presented evidence arguing their case, including experts on each side. Belisle called two ENT experts and Dr. Seely called one. Dr. Seely's expert explained in detail why Dr. Seely did not breach the standard of care. Dr. Seely personally testified, defending his care and explaining why he was not negligent. The jury apparently found Dr. Seely and his expert credible. Following weeks of trial, eleven out of twelve jurors concluded Dr. Seely was not negligent. 7-RP-3071-73. Belisle's fleeting barrage of vague complaints about the defense experts' testimony, *Appellant Br. at 53-59,* without assigning error to any of it, cannot form the basis for reversal. RAP 10.3(a).

Moreover, Belisle's argument, *Appellant Br. at 55-58*, that the evidence does not support the jury's verdict because she claims the defense experts speculated about causation is not only incorrect but unavailing. Belisle bore the burden of proof on each element at trial. Courts thus treat plaintiffs' evidence on

causation differently than they treat the defense evidence to rebut causation. *See Colley v. PeaceHealth,* 177 Wn. App. 717, 728, 312 P.3d 989 (2013) (defense experts may offer competing causation theories without speaking in terms of medical probability); *Johnson v. Carbon*, 63 Wn. App. 294, 300, 818 P.2d 603 (1991) (defendant "had the right to examine all aspects of the causal relationship," including other possible causes), *rev. denied*, 118 Wn.2d 1014 (1992). She failed to meet her burden.

Ample evidence supports the jury's verdict. This Court should refuse Belisle's untenable challenge to the verdict, which she also failed to preserve.

E. Belisle provides no reasoned argument or authority on her assignment of error about the University of Washington purportedly "manipulating" care.

Belisle "assigns error," *Appellant Br. at 3, 5*, to some belief—never raised below—that the jury should hear purported evidence that "has since come to light" about the University of Washington supposedly "manipulating care" when patients have legal cases against its doctors. Dr. Seely does not work for the

University of Washington, and the surgeries did not occur there. One of Belisle's nonparty treating providers, Dr. Tayna Meyer, works for the University of Washington. Belisle argues for the first time on appeal, without any evidence, that Dr. Meyer cancelled Belisle's laryngeal EMG "upon learning that Ms. Belisle was suing one of her colleagues," *Appellant Br. at 38,* to "intentionally deprive [Belisle] of the best evidence that would demonstrate Dr. Seely's negligence," *Appellant Br. at 39*. Many problems arise from such an argument.

Preliminarily, Belisle never raised this issue below, including in a motion for new trial under CR 59(a)(4), newly discovered evidence which the party could not with reasonable diligence have discovered and produced at trial, or for relief from judgment under CR 60(b)(3), newly discovered evidence which by due diligence could not have been discovered in time to move for new trial under CR 59(b). The trial court committed no "error" in failing to consider an issue that Belisle never raised.

Belisle's brief also fails to address this "assignment of error" with reasoned argument and pertinent legal authority in violation of RAP 10.3(a)(6), let alone to show how such evidence is relevant to whether Dr. Seely, who is not a University of Washington employee, complied with the standard of care—the only issue the jury decided. "Passing treatment of an issue or lack of reasoned argument is insufficient to merit appellate review." *Christian*, 191 Wn. App. at 728 (citations omitted).

The evidence does not remotely support Belisle's assertions. Dr. Meyer was not a defendant in the lawsuit. The University of Washington was not a defendant in the lawsuit. They had no interest in the outcome of the trial, and any argument otherwise is pure speculation. Indeed, Belisle's own testimony refutes her attempt to argue on appeal that all University of Washington providers were somehow attempting to sabotage her. *See, e.g,* 3-RP 1212 (testifying that Dr. Eugenio with the University of Washington "saved my life because she heard me when I was at my darkest hour").

Dr. Meyer's testimony directly rebuts the unsubstantiated allegation that she cancelled an EMG for nefarious purposes. Dr. Meyer testified that she was never planning to do a laryngeal EMG because Belisle "has normal vocal fold motion bilaterally, and she had near complete recovery of her voice … so I did not see any indication for a laryngeal EMG … I didn't think that she would be a candidate for a laryngeal EMG. And I never offered a laryngeal EMG in either of my notes." 6-RP 2854.

Belisle's counsel repeatedly cross-examined her about this issue, 6-RP 2862-63, even exploring that some non-medical reason could account for Dr. Meyer's refusal to perform a laryngeal EMG, which Dr. Meyer expressly denied, 6-RP 2865-66. To the extent Belisle implies some bias that Dr. Meyer or the University of Washington had, however unfounded, her counsel was free to—and apparently did-—explore it on cross-examination. It cannot form the basis for reversal.

## V. CONCLUSION

This Court should affirm the trial court's orders, all of which were correct. Ample evidence supports the jury's verdict, which was not the product of any erroneous trial court rulings and which this Court should not disturb.

I declare that this document contains 11,788 words.

RESPECTFULLY SUBMITTED this 2nd day of January, 2025.

FAIN ANDERSON VANDERHOEF
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## GR 14.1(d) APPENDIX

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|---|---|
| 1. | *Brotherton v. United States*, NO. 2:17-CV-00098-JLQ, 2018 U.S. Dist. LEXIS 132800 (E.D. WA Aug. 7, 2018) |
| 2. | *Ortega v. Stiefel*, 2022 N.Y. Misc. LEXIS 47617 (Sup. Ct. Nov. 23, 2022) |
| 3. | *Torres v. Carrese,* 2012 Conn. Super. LEXIS 52 (Sup. Ct. January 3, 2012), *aff'd,* 90 A.3d 256 (Conn. App.), *rev. denied*, 93 A.3d 595 (Conn. 2014) |

# Brotherton v. United States

United States District Court for the Eastern District of Washington

August 7, 2018, Decided; August 7, 2018, Filed

NO. 2:17-CV-00098-JLQ

**Reporter**
2018 U.S. Dist. LEXIS 132800 *; 2018 WL 3747802

PATRICK G. BROTHERTON, Plaintiff, v. UNITED STATES OF AMERICA, Defendant.

**Prior History:** Brotherton v. United States, 2017 U.S. Dist. LEXIS 138030 (E.D. Wash., Aug. 28, 2017)

## Core Terms

surgery, patient, diabetes, informed consent, standard of care, surgeon, argues, blood, primary care physician, risks, medical negligence, healing, summary judgment, medical clearance, preoperative, contends, rebuttal, wound, expert testimony, material fact, inform, ankle, opine, healthcare provider, referring physician, legal duty, uncontrolled, causation, infection, surgical

**Counsel:** **[*1]** For Patrick G Brotherton, a single man, Plaintiff: Jess Gregory Casey, LEAD ATTORNEY, M Casey Law PLLC, Spokane, WA.

For United States, Defendant: Rudolf J Verschoor, LEAD ATTORNEY, United States Attorney's Office, Spokane, WA; Joseph P Derrig, U S Attorney's Office - SPO, Spokane, WA.

**Judges:** JUSTIN L. QUACKENBUSH, SENIOR UNITED STATES DISTRICT JUDGE.

**Opinion by:** JUSTIN L. QUACKENBUSH

## Opinion

ORDER RE: DEFENDANT'S MOTION FOR SUMMARY JUDGMENT

BEFORE THE COURT is Defendant' Motion for Summary Judgment (ECF No. 28). Response and Reply briefs have been filed. (ECF No. 35 & 41). The court heard oral argument on the Motion on July 26, 2018. Plaintiff was represented by Jess Casey and Marshall Casey. Assistant United States Attorneys Joseph Derrig and Rudolf Verschoor appeared on behalf of Defendant. This Order memorializes and supplements the court's oral rulings.

### I. Introduction

Plaintiff, Patrick Brotherton, filed this action against Defendant, the United States of America, on March 15, 2017. Plaintiff brings two claims relating to medical care he received in January 2014. Plaintiff asserts failure to secure informed consent in violation of RCW 7.70.050 and medical negligence under RCW 7.70.040. These claims are asserted on the basis of care provided **[*2]** by "Dr. Sim or the VA medical personnel."

The Defendant (hereafter "Government") argues Dr. Sim, the VA physician, had no duty to obtain informed consent because that duty belongs to the surgeon, Dr. Barrow, not to the referring physician. On the negligence claim, the Government argues Dr. Sim did not breach a duty as he conveyed lab results to Dr. Barrow. Further the Government argues there is no causation between Dr. Sim and Plaintiff's injury as Dr. Barrow performed the surgery which ultimately led to amputation[1].

Plaintiff argues his expert Dr. Leo opines Dr. Sim "is not allowed to just abandon [Plaintiff] and do nothing when [Plaintiff] faces a significant and modifiable risk due to diabetes." (ECF No. 35, p. 3). On informed consent, Plaintiff argues Dr. Sim had a duty because he had specific knowledge of Plaintiff's history of uncontrolled diabetes. (*Id.* at p. 19-20).

**II. Factual Background**

In summary judgment proceedings, the facts are viewed in a light most favorable to the non-movant, in this case the Plaintiff. The following facts are set forth in a light favorable to the Plaintiff and key factual disputes are noted. Defendant filed a 75-paragraph Statement of Facts (ECF No. 29). Plaintiff filed **[*3]** a 55-paragraph Statement of Facts in Response (ECF No. 36). Local Rule 56.1(b) provides a responding party "must explicitly identify any fact(s) asserted by the moving party which the opposing party disputes or clarifies. (E.g.: "Defendant's fact #1: Contrary to Plaintiff's fact #1 ...)". Plaintiff's Statement of Facts in Response only specifically identifies two of the Government's facts which he disputes -- Government's Facts #5 and # 13. Therefore, the facts at issue are largely undisputed.

Plaintiff was first diagnosed with diabetes in 1996. For some period of time he took insulin, but after having gastric bypass surgery in 2004, he ceased taking insulin. (ECF No. 36, ¶¶ 4, 6). Dr. Daniel Sim, M.D., was Plaintiff's primary care physician at the Mann-Grandstaff VA Medical Center (hereafter "VA"). (ECF No. 29, ¶ 1). Plaintiff first saw Dr. Sim for medical care at the VA in August 2004, and the medical records from the visit note an A1C of 8.3. (ECF No. 29, ¶ 6). A hemoglobin A1C reading represents a three-month historical view of a patient's blood glucose level. (ECF No. 36, ¶ 1).

Over the years, Plaintiff's A1C level was routinely higher than the desired score of 7.0 or lower. Dr. Sim testified Plaintiff's **[*4]** diabetes was "uncontrolled". Over the years, Dr. Sim recommended and prescribed various medications, but Plaintiff preferred to attempt to control his diabetes through lifestyle changes. Plaintiff tried the medication, Metformin, but had side effects, and was resistant to trying another, Glipizide.

On January 29, 2013, Dr. Morton, a podiatrist at the VA, diagnosed Plaintiff with a diabetic foot ulcer on his left foot. (ECF No. 29, ¶ 9). On May 30, 2013, Dr. Morton referred Plaintiff to a non-VA orthopedic surgeon for evaluation and treatment of Plaintiff's malunion right ankle fusion. (*Id.* at ¶ 11). The VA authorized a visit to the surgeon for evaluation and treatment of the right ankle. (*Id.* at ¶ 12). Plaintiff was referred to Dr. Craig Barrow, who is not a VA employee or U.S. government employee. (*Id.* at ¶ 4). Dr. Barrow first saw Plaintiff on August 19, 2013. Dr. Barrow was aware of Plaintiff's diabetes and the ulcer on his left foot. Plaintiff, on his intake form, wrote his diabetes was "controlled". (*Id.* at ¶ 18).

At the August 19, 2013, appointment, Dr. Barrow discussed the treatment plan for a corrective osteotomy surgical procedure on Plaintiff's right ankle. Dr. Barrow discussed **[*5]** the risks of surgery, including amputation. (ECF No. 29, ¶ 20-21). Plaintiff signed a consent form for the planned surgery. (*Id.* at ¶ 22). On September 5, 2013, Dr. Sim sent Plaintiff a letter informing him his A1C level was 8.2, with a recommended target of less than 7.0. He recommended Plaintiff take the medication, Glipizide. (*Id.* at ¶ 25). Dr. Sim then saw Plaintiff for various issues on September 10, 2013; October 10, 2013; and October 23, 2013. (*Id.* at ¶ 26-29).

On October 28, 2013, Plaintiff saw Dr. Barrow again, and Dr. Barrow examined the ulcer on the left toe and noted it was improving and slowly healing. Dr. Barrow saw Plaintiff again on November 25, 2013, and again noted the ulcer on the left foot was still slowly healing. Dr. Barrow was waiting to perform the surgery on the right ankle until after the ulcer on the left foot had fully healed. At an office visit on January 7, 2014, Dr. Barrow found the left foot had sufficiently healed and decided to proceed with surgery. (*Id.* at ¶ 34).

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[1] The court has been informed Plaintiff has pending claims against Dr. Barrow in state court. (ECF No. 5-4).

At the January 7, 2014 office visit, Dr. Barrow explained the risk of surgery and Plaintiff signed a consent form. Dr. Barrow requested some pre-surgical labs, but did not request a medical **[*6]** clearance evaluation from Dr. Sim or the VA. On January 10, 2014, Plaintiff telephoned Dr. Sim's office and left a message that he was having the surgery on January 17, 2014, and asked if he could have his blood work done at the VA. The blood work was done and showed an A1C of 9.6[2]. The lab results were sent to Dr. Barrow on January 16, 2014, the day before the surgery. (ECF No. 29, ¶ 39). Dr. Barrow testified he did not review the A1C report prior to the surgery, but did conduct a blood glucose test the morning of the surgery. (ECF No. 29-2, Depo. of Dr. Barrow, p. 30-31).

Dr. Barrow's opinion is the A1C test was not a contraindication to surgery, and from the blood sugar test performed the morning of the surgery, Dr. Barrow determined Plaintiff's blood sugar level was sufficient to proceed with the surgery. (*Id.* at ¶ 40-41). Plaintiff signed another consent form on the day of the surgery advising of the risks of surgery. The surgery was performed on January 17, 2014, and on January 20, 2014, Plaintiff was discharged. (*Id.* at ¶ 49). Discharge instructions told Plaintiff to monitor his blood sugar closely, take diabetic medications as directed, or otherwise he would be at "an increased **[*7]** risk of infection, wound problems and bone healing delays." (*Id.* at ¶ 50).

Plaintiff states his blood sugar level was 283 at discharge and claims Dr. Barrow did not instruct him on blood sugar monitoring. (ECF No. 36, ¶ 46). Three days after discharge, on January 23, 2014, Plaintiff contacted the VA and requested post-surgical care and assistance, including possibility of placement in a skilled nursing facility. (*Id.* at ¶ 47). Placement in a nursing facility was not immediately available, and on January 29, 2014, Plaintiff reported he was doing fine at home and declined nursing facility placement.

Plaintiff was admitted to Holy Family Hospital on February 8, 2014, for I & D (irrigation and debridement) for "wound dihiscence" and ulcer and cellulitis of the surgical site. (ECF No. 29-2; Ex. F-143). By February 20, 2014, after further attempts at debridement and wound treatment, Dr. Barrow discussed with Plaintiff the need for a below-knee amputation. (Id. at Ex. F-144). The amputation procedure was performed on March 19, 2014.

## III. Discussion

### A. Summary Judgment Standard

The purpose of summary judgment is to avoid unnecessary trials when there is no dispute as to the material facts before **[*8]** the court. *Northwest Motorcycle Ass'n v. U.S. Dept. of Agriculture*, 18 F.3d 1468, 1471 (9th Cir. 1994). The moving party is entitled to summary judgment when, viewing the evidence and the inferences arising therefrom in the light most favorable to the nonmoving party, there are no genuine issues of material fact in dispute. Fed. R. Civ. P. 56; *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 252, 106 S. Ct. 2505, 91 L. Ed. 2d 202 (1986). While the moving party does not have to disprove matters on which the opponent will bear the burden of proof at trial, they nonetheless bear the burden of producing evidence that negates an essential element of the opposing party's claim and the ultimate burden of persuading the court that no genuine issue of material fact exists. *Nissan Fire & Marine Ins. Co. v. Fritz Companies*, 210 F.3d 1099, 1102 (9th Cir. 2000). When the nonmoving party has the burden of proof at trial, the moving party need only point out that there is an absence of evidence to support the nonmoving party's case. *Devereaux v. Abbey*, 263 F.3d 1070, 1076 (9th Cir. 2001).

Once the moving party has carried its burden, the opponent must do more than simply show there is some metaphysical doubt as to the material facts. *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 586, 106 S. Ct. 1348, 89 L. Ed. 2d 538 (1986). Rather, the opposing party must come forward with specific facts showing that there is a genuine issue for trial. *Id.*

Although a summary judgment motion is to be granted with caution, it is not a disfavored remedy: "Summary judgment procedure is properly regarded not as a disfavored procedural shortcut, **[*9]** but rather as an integral part of the Federal Rules as a whole, which are designed to secure the just, speedy and inexpensive determination of every action." *Celotex Corp. v. Catrett*, 477 U.S. 317, 327, 106 S. Ct. 2548, 91 L. Ed. 2d 265 (1986)(citations and quotations omitted).

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[2] According to the records, Plaintiff took the pre-operative lab orders(including CBC, CMP) to the VA on Monday January 13, 2014, but only the A1C was done at that time, and the other tests were performed at Holy Family Hospital the morning of surgery. (ECF No. 15-3, p. 10).

**B. The 'Informed Consent' Claim**

Plaintiff's Complaint asserts two claims. The first is a failure to secure informed consent, and Plaintiff cites to RCW § 7.70.050. Plaintiff alleges: "Dr. Sim or the VA medical personnel failed to inform Mr. Brotherton of the material risk that Mr. Brotherton would lose his foot as a result of the surgery." (ECF No. 1, ¶ 4.3). A claim based on failure to secure informed consent has four elements under Washington law. *Backlund v. Univ. of Washington*, 137 Wash.2d 651, 975 P.2d 950 (1999); RCW § 7.70.050. The claimant must establish:

1) The health care provider failed to inform the patient of a material fact or facts relating to treatment;
2) The patient consented to the treatment without being aware of or fully informed of such material fact or facts;

3) A reasonably prudent patient under similar circumstances would not have consented to the treatment if informed of such material fact or facts; and

4) The treatment in question proximately caused injury to the patient.

*Id.*

The critical issue here is whether Dr. Sim, who did not perform the surgery, had a legal duty **[*10]** to secure informed consent regarding Brotherton's ankle surgery performed by Dr. Barrow. "The existence of a legal duty is a question of law and depends on mixed considerations of logic, common sense, justice, policy, and precedent." *Christensen v. Royal School Dist.*, 156 Wash.2d 62, 67, 124 P.3d 283 (2005). "The concept of duty is a reflection of all those considerations of public policy which lead the law to conclude that a plaintiff's interests are entitled to legal protection against the defendant's conduct." *Volk v. DeMeerleer*, 187 Wash.2d 241, 266, 386 P.3d 254 (2016).

Dr. Sim did not have a legal duty to obtain informed consent for the surgery, or to advise Plaintiff of the risks of surgery — that legal obligation belonged to the surgeon, Dr. Barrow. The Washington case which most directly addresses the legal duty of a referring physician under Washington law is *Bottemiller v. Gentle Dental*, 2002 Wash. App. LEXIS 3193, 2002 WL 31895159 (Wash. Ct. App. 2002)(unpublished). There the court examined the duty of a referring physician to provide informed consent and stated, "the majority of jurisdictions that have addressed whether referring physicians have a duty to obtain a patient's informed consent have concluded that they do not." 2002 Wash. App. LEXIS 3193, [WL] at *10. The court observed a minority of courts have imposed a duty when "the referring physician has retained a degree of participation and control in the treatment." 2002 Wash. App. LEXIS 3193, [WL] at *11. The *Bottemiller* ***[*11]*** court concluded that because the referring physician did not participate in or control the surgery, there was no duty to inform the patient that experts disagreed as to the benefit of the surgery or advise as to alternatives to surgery.

The parties cited, and referred to at argument, *Alexander v. Gonser*, 42 Wash.App. 234, 711 P.2d 347 (1985) and *Howell v. Spokane & Inland Empire Blood Bank*, 114 Wash.2d 42, 785 P.2d 815 (1990), however neither case is directly on point. Both cases involve the duty of informed consent as between a physician and hospital staff. They do not address the duty between a primary care/referring physician and a specialist/surgeon. In *Alexander*, the issue was "whether a hospital has an independent duty to inform a patient of test results administered at the request of the treating physician." 42 Wash.App. at 235. The court answered in the negative. To the extent it is applicable, *Alexander* supports the conclusion Dr. Barrow had the informed consent duty, and not the VA or Dr. Sim.

In *Howell*, the court again rejected an argument that the hospital, Deaconess Hospital, had an informed consent duty, and instead found the duty rested with the physician. The court stated: "To provide for equal informed consent obligations as to every person and entity falling within the definition [of health care provider] would not be justified." **[*12]** *Id.* at 55. The Washington Supreme Court further stated, "it is the duty of the physician to inform patients of the risks, general or specific, involved in surgical procedures." *Id.* at 56. Here, the physician performing the procedure was the surgeon, Dr. Barrow.

It is undisputed Dr. Sim did not participate in or control the surgery. Plaintiff's expert, Dr. Leo, testified that in his review of the medical records he saw nothing indicating Dr. Sim planned the surgery, participated in the surgery, or advised Plaintiff to have the surgery. (Depo. of Dr. Leo, at ECF No. 45-1, p. 34-35). It was Dr. Morton, a VA podiatrist, who referred Plaintiff to Dr. Barrow. (ECF No. 29, ¶ 11). Further, Plaintiff's expert, Dr. Leo, testified he did not expect a referring primary care physician to obtain informed consent from the patient for the procedure they are being referred for. Specifically, he testified when asked:

"No. I do not view it as my duty or the duty of a primary care physician to obtain consent for a specific procedure that assumes a fund of knowledge regarding the benefits, risks, and alternatives to that particular procedure that most primary care doctors wouldn't have." (*Id.* at p. 19-20).

This makes common sense. The physician **[*13]** performing a procedure should advise on the risks of the procedure. When a primary care physician refers a matter to a specialist, it is not logical to impose a legal duty on the primary care physician to explain the risk of a procedure which the specialist may perform. Generally the reason for the referral to a specialist is because the specialist has more training, knowledge, or experience in the particular area of medicine.

Dr. Sim had no legal duty to obtain informed consent from Mr. Brotherton for the surgery performed by Dr. Barrow. Further, even if this court were to find Dr. Sim had a duty to advise of the risks of surgery, which it does not, it is undisputed Dr. Barrow did advise of surgical risks[3]. Dr. Barrow first discussed the risks of surgery at an office visit on August 19, 2013, and Plaintiff signed a consent form at that time. (ECF No. 29, ¶ 21-22). Dr. Barrow then discussed the risks of surgery at an office visit on January 7, 2014, ten days before the surgery. (*Id.* at ¶ 34-35). Dr. Barrow advised again of the risks of surgery on January 17, 2014, the day of surgery, and Plaintiff signed a consent form. (*Id.* at 43-44). *See Bynum v. Magno*, 125 F.Supp.2d 1249, 1255 (D. Hawaii 2000)("where the surgeon obtains informed consent, the referring **[*14]** physician's duty to obtain it may be discharged because the chain of causation is broken.").

Defendant's Motion for Summary Judgment on the first claim in the Complaint--failure to secure informed consent, is **GRANTED**.

**C. Medical Negligence Claim**

Plaintiff's second claim of negligence, pursuant to RCW § 7.70.040, alleges Dr. Sim "failed to exercise the degree of skill, care, and learning expected of a reasonably prudent surgeon." (ECF No. 1, ¶ 5.2). The allegations of the Complaint are Dr. Sim knew of Plaintiff's impending ankle surgery, knew of his diabetic condition, ordered an A1C blood test in preparation for surgery, received the blood test results, reported them to Plaintiff, but did not advise against having the surgery. (*Id.* at ¶ 2.2-2.6).

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 or she belongs, in the state of Washington, acting in the same or similar circumstances;
>
> (2) Such failure **[*15]** was a proximate cause of the injury complained of.

A negligence claim requires a showing of duty, breach, causation, and damages. *Ranger Ins. Co. v. Pierce Co.*, 164 Wn.2d 545, 552, 192 P.3d 886 (2008). "The existence of a legal duty is a question of law and depends on mixed considerations of logic, common sense, justice, policy, and precedent." *Christensen v. Royal School Dist.*, 156 Wash.2d 62, 67, 124 P.3d 283 (2005). Generally expert testimony is required to establish the standard of care. *McLaughlin v. Cooke*, 112 Wash.2d 829, 836, 774 P.2d 1171 (1989). Expert testimony is typically also required on the issue of proximate cause in medical malpractice cases. *Id.* at 837. "The concept of duty is a reflection of all those considerations of public policy which lead the law to conclude that a plaintiff's interests are entitled to legal protection against the defendant's conduct." *Volk v. DeMeerleer*, 187 Wash.2d 241, 266, 386 P.3d 254 (2016).

As expert testimony is required to establish the standard of care and causation in medical negligence cases, the court now addresses the Government's **Motion to Exclude Opinions of Dr. Leo and Dr. Coleman (ECF No. 43)**. The Government filed, on the same day as its Reply in support of summary judgment, a Motion to Exclude three of the opinions stated by Dr. Leo, and to entirely exclude Dr. Coleman as an improper rebuttal expert. Response and Reply briefs were filed (ECF No. 44 & 49).

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[3] Any challenge Plaintiff may have to the adequacy or thoroughness of Dr. Barrow's advice and consent forms is not before this court. It appears Plaintiff is pursuing an informed consent claim against Dr. Barrow in state court. (ECF No. 5-4).

The Government argues three of Dr. Leo's opinions **[*16]** lack an adequate foundation and are unreliable: 1) that the standard of care required Dr. Sim, a primary care physician, to perform a preoperative evaluation for surgery, even though one was not requested by the surgeon; 2) that a preoperative A1C of 9.6 required cancellation of Plaintiff's surgery; and 3) that Plaintiff's preoperative A1C caused his infection. (ECF No. 43, p. 2). The Government contends Dr. Coleman is not a rebuttal expert and should be excluded. The Government argues Dr. Coleman did not even review the initial reports of Defendant's experts, but rather only reviewed Dr. Leo's report and deposition. Thus, the Government argues Dr. Coleman was been listed only to endorse Dr. Leo's opinion and is cumulative and improper rebuttal testimony.

Plaintiff responds Dr. Leo is qualified and his testimony is reliable and should be allowed. Plaintiff argues Dr. Coleman's testimony was rebuttal to the extent it was offered to counteract the implication that Dr. Leo, who practices in California, was not qualified to testify as to the Washington standard of care.

The day after the Government's Motion to Exclude was filed, the Washington Supreme Court issued its opinion in *Reyes v. Yakima Health District*, 191 Wn.2d 79, 419 P.3d 819 (Slip Op. June 21, 2018), where **[*17]** the court stated: "This is a case about the sufficiency of expert witness testimony in a medical malpractice suit." The Court stated: "Allegations amounting to an assertion that the standard of care was to correctly diagnose or treat the patient are insufficient. Instead, the affiant must state specific facts showing what the applicable standard of care was and how the defendant violated it." (*Id.* at 9). The Government argues in part Dr. Leo's opinion lacks specificity and does not "establish the nature and contours" of the standard of care. (ECF No. 43, p. 1).

The Government essentially argues the three opinions of Dr. Leo, outlined *supra*, do not meet the *Daubert* standard. In *Daubert v. Merrell Dow Pharmaceuticals*, 509 U.S. 579, 113 S. Ct. 2786, 125 L. Ed. 2d 469 (1993), the Supreme Court set forth the standard for admitting expert scientific testimony. A federal court is guided by Federal Rule of Evidence 702, and the court serves a gatekeeping function. The court is to attempt to ensure "an expert's testimony rests both on a reliable foundation and is relevant to the task as hand." *Id.* at 597. In assessing reliability, the court may look to whether a scientific theory or technique has been tested, whether it is subject to peer review, whether there is a known error rate for the study or technique, and whether there is **[*18]** "general acceptance" of the theory or technique. *Id.* at 593-95. The inquiry under FRE 702 is a "flexible one" which seeks to assess the "scientific validity and thus the evidentiary relevance and reliability of the principles that underlie a proposed submission." *Id.* at 594-95.

Dr. Leo is a licensed medical doctor. He is board-certified and has practiced internal medicine for over 30 years. At his deposition, he testified that he has given testimony as an expert witness over 300 times. He has been consulting as an expert witness for approximately 20 years and testified it is roughly 50/50 as to whether he is consulting for plaintiffs or defendants. He testified he has extensive medical training in diabetes and that roughly 10 to 20% of the patients he sees in his practice are diabetic. (ECF No. 45-1, p. 14-15).

Under Federal Rule of Evidence 702, Dr. Leo is qualified by his "knowledge, skill, experience, training, or education" to offer expert testimony. Under *Daubert*, the court must still assess the reliability of the proffered testimony and whether it will assist the trier of fact. The Government appears to argue Dr. Leo's opinion is not based on sufficient or reliable facts and data: "Instead of responding with a treatise, medical journal, **[*19]** practice guide, policy, hospital standards, or industry practices supporting Dr. Leo's 'duty to inform Dr. Barrow' opinion . .", the Government argues Dr. Leo rests his opinion only on his own experience. (ECF No. 49, p. 2). However, Dr. Leo's opinion is, at its most basic, that there should have been better communication between Dr. Sim and Dr. Barrow concerning Plaintiff's "uncontrolled diabetes" and the A1C result. One would not expect to find a treatise, medical journal, or studies on when one physician should phone another with test results. When the court inquired at oral argument, Plaintiff's counsel did not direct the court to any treatise or medical journal, but instead relied on language from *Gray v. Davidson*, 15 Wn.2d 257, 267, 130 P.2d 341 (1942), specifically: "It is the general rule that when a physician undertakes to treat a patient, it is his duty to continue to devote his best attention to the case until either medical attention is no longer needed, he is discharged by the patient, or he has given the patient reasonable notice of his intention to cease to treat the patient, so that another physician may be obtained."

The Government rests its argument in part on a recent case from this District: *Wright v. United States*, 2:15-CV-0305-TOR, 2017 U.S. Dist. LEXIS 91599, 2017 WL 2590339 (E.D. Wash. 2017) **[*20]** . Therein, the plaintiff made a medical negligence claim involving the VA and argued both that a nurse had inadequately communicated with the plaintiff, and that a nurse had inadequately attempted to persuade a physician to order a CT scan. Judge Rice found the nursing expert's opinion lacked a

sufficient "basis for the proposed standard of care or any explanation other than a bald conclusion" that the nurses' conduct fell below the standard of care. (p. 6). Judge Rice cited to Washington Practice Tort Law and Practice § 16.21 (4th ed.) concerning the duty of nurses: "Like pharmacists, nurses do not owe a duty to patients that would place them in a position to second-guess the physician or otherwise substitute their judgment in place of that provided by the physician." (p. 8). Ultimately, the motion to exclude the expert testimony was denied as moot, because even considering the expert's opinion, the court granted defendant's summary judgment motion.

The *Wright* case is somewhat analogous to the case at bar as both involve claims of inadequate communication between medical professionals and between medical professionals and patients. The *Wright* court found no duty for a nurse to second-guess physicians. Here, Dr. Leo, who admits he is not qualified to opine as to the standard of care for orthopedic surgeons, argues Dr. Sim, a primary care physician, should have intervened with the orthopedic surgeon, Dr. Barrow, and told him how to proceed, or not to proceed, with a surgical procedure.

Dr. Leo's opinion is essentially the A1C test result was cause for concern, and Dr. Sim should have communicated that concern to Dr. Barrow and Plaintiff. Dr. Leo contends the elevated A1C result posed an increased **[*21]** risk of post-surgical infection. Dr. Leo filed a Second Declaration (ECF No. 38) stating the risk of infection in a patient with well controlled diabetes was 1.7%, and with poor diabetes control (like Plaintiff) it was 6.8%. Dr. Leo thus contends there was a four-fold increase in risk of infection. In *Daubert v. Merrell Dow* ("Daubert II), 43 F.3d 1311 (9th Cir. 1995), after the case was remanded from the Supreme Court, the Ninth Circuit held there must be at least a two-fold increase in the relative risk for their to be legal causation. The court stated: "In terms of statistical proof, this means that plaintiffs must establish not just that their mothers' ingestion of Bendectin increased somewhat the likelihood of birth defects, but that it more than doubled it---only then can it be said that Benedictin is more likely than not the source of their injury." *Id.* at 1320. Here, Dr. Leo claims the relative risk posed by the elevated A1C was four. The Government's expert, Dr. Kraemer, appears to agree there is some support in the medical literature for this calculation, but that even if accepted, an increase from 1.7% to 6.8% "does not even come close to approaching an incidence of infection that is more likely than not." (ECF No. 29-2, p. **[*22]** 145 of 188).

The Government's Motion to Exclude (ECF No. 43) first challenged three opinions of Dr. Leo: "(1) the standard of care required Dr. Sim to perform an unrequested preoperative evaluation; (2) a preoperative A1C of 9.6 required cancellation of the surgery, and (3) Mr. Brotherton's preoperative A1C caused his infection." (ECF No. 43, p. 2). However, the Motion concludes by seeming to request exclusion of all Dr. Leo's opinions, stating, "Dr. Leo's opinions are unreliable and inadmissible." (ECF No. 43, p. 10). The court does not view Dr. Leo's Rule 26 report as opining Dr. Sim was required to perform an unrequested evaluation. Dr. Leo's deposition testimony would not support that conclusion. Nor does Dr. Leo appear to opine an A1C of 9.6 requires cancellation of surgery in all circumstances. Rather, he admits "there is no specific evidence-based target for hemoglobin A1C recommended prior to surgery." (ECF No. 20-1, p. 7). His opinion is it depends on whether the surgery is elective or emergent, and his opinion appears to be Brotherton's surgery should have been postponed until he was medically optimized. As to causation, Dr. Leo opines of the four-fold increase in risk of infection, **[*23]** as discussed *supra*. The Government's request to strike the opinions of Dr. Leo is **DENIED**.

Dr. Coleman has filed a one-page report (ECF No. 39-1), and it is improper rebuttal. It is not "intended solely to contradict or rebut evidence on the same subject matter identified by another party". Fed.R.Civ.P. 26(a)(2)(D)(ii). Dr. Coleman's report does not purport to rebut the opinions of the Government's experts. Rather, Dr. Coleman's report appears to be an attempt to bolster Dr. Leo's report and is in such respect cumulative. See *Titus v. Progressive Casualty Ins. Co.*, 2011 WL 1323343 (D. Ariz. 2011)(excluding improper rebuttal expert which the court viewed as not rebuttal but an attempt to bolster prior witnesses or select a "better" expert). Dr. Coleman states: "The opinions Dr. James Leo expresses on the standard of care for a primary care physician are the standard of care in Washington." (*Id.*). He then repeats portions of Dr. Leo's opinion, states agreement with those opinions, and concludes the "opinions by Dr. Leo reflect the standard of care for a reasonably prudent primary care physician in the State of Washington." (*Id.*).

To the extent Dr. Coleman was used to rebut the implicit contention the California and Washington standards of care are not the same, such testimony is permissible **[*24]** rebuttal: Dr. Coleman states: "There is no difference in the standard of care in Washington compared to California or nationally." (ECF No. 39-1). However, it does not appear the Government presses the contention Dr. Leo is unqualified to testify on Washington standard of care because he practices in California. Although Dr. Coleman's brief report does appear to be improper rebuttal testimony and largely cumulative, the court in the exercise of its discretion and for the purpose of this motion, **DENIES** the request to strike Dr. Coleman's report.

Returning to Plaintiff's medical negligence claim, and the Government's Motion for Summary Judgment, the Washington Supreme Court recently stated, in *Reyes v. Yakima Health District*, 191 Wn.2d 79, 419 P.3d 819 (Slip Op. June 21, 2018): "In a medical malpractice case, plaintiffs must show that 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 or she belongs, in the state of Washington, acting in the same or similar circumstances." (Slip Op. at p. 5 citing RCW 7.70.040(1)). In *Reyes*, the Supreme Court affirmed the lower court's grant of summary judgment for the defendants and addressed whether plaintiff's **[*25]** expert had created a genuine issue of material fact. The Court stated: "In the context of medical malpractice, this requires an expert to say what a reasonable doctor would or would not have done, that the defendants failed to act in that manner, and that this failure caused the injuries. The expert may not merely allege that the defendants were negligent and must instead establish the applicable standard and how the defendant acted negligently by breaching that standard. Furthermore, the expert must link her conclusions to a factual basis." (Slip Op. at 6) (internal quotations and citations omitted). Brotherton has offered expert testimony in support of his claims, and Dr. Leo contends Dr. Sim failed to meet the standard of care.

Dr. Leo contends there was inadequate communication between Dr. Sim and Dr. Barrow and between Dr. Sim and Plaintiff. Dr. Leo submitted an affidavit with his opinion on standard of care (ECF No. 9-1), provided a Rule 26 Report (ECF No. 20-1), and gave deposition testimony. (ECF No. 45-1). Dr. Leo, testified at deposition: "the significant part of this case has to do with the failure of communication." (ECF No. 45-1, p. 48).

Dr. Leo's Rule 26 Report sets forth six ways in **[*26]** which he contends Dr. Sim failed to meet the standard of care (ECF No. 20-1, p. 6):

1. Failing to recognize the poor diabetes control represented by the preoperative hemoglobin A1C of 9.6 obtained on January 13, 2014 represented a markedly increased and modifiable risk of poor surgical wound healing and infection;

2. Failing to contract Dr. Barrow to determine whether the surgery was elective or emergent;

3. Failing to ensure Dr. Barrow was aware of uncontrolled nature of Mr. Brotherton's diabetes;

4. Failing to notify Dr. Barrow that Plaintiff was not medically stable to proceed with surgery;

5. Failing to specifically inform Brotherton that his uncontrolled diabetes greatly increased the likelihood of his developing postoperative wound complications; and

6. Failing to fulfill his duty as a PCP in acting to minimize his patient's risks for complications, regardless of Dr. Sim's feelings about his patient's non-compliance, "including not abdicating his duty to provide preoperative medical clearance or non-clearance for the planned surgery." (ECF No. 20-1, p. 6).

Dr. Leo contends the standard of care requires a physician to recognize the impact of poorly controlled diabetes on the post-operative **[*27]** risks of infection and poor wound healing. (ECF No. 9-1, ¶ 5-6; ECF No. 20-1, p. 6). Dr. Leo contends Dr. Sim did not fully understand the relationship between diabetes and poor wound healing. The record is not clear Dr. Sim failed to recognize such risk, and Dr. Leo himself testified it is a generally known medical fact: "It is well known that uncontrolled hyperclycemia impairs white blood cell function and raises the risk of infection." (ECF No. 45-1, p. 37). Further, Dr. Sim's specific amount of knowledge concerning the issue and the extent to which he communicated it to Plaintiff, did not cause Plaintiff's injury (the amputation). Plaintiff had been living with diabetes since 1996, had been on insulin in 2003, and testified he was told diabetes "could cause severe things up and to blindness, wounds not healing very well, loss of limb, death." (ECF No. 29, ¶ 57-58). Further, Dr. Barrow was aware Plaintiff was diabetic, and was aware of slow wound healing, as he monitored the slow healing ulcer on Plaintiff's left foot for several months before performing the surgery on the right ankle.

Dr. Leo further opines it would be a violation of the standard of care for a primary care physician **[*28]** in the state of Washington, who is aware of a patient's A1C of 9.6 to approve the patient for an elective ankle surgery. (ECF No. 9-1, ¶ 7). Stated somewhat differently, in the Rule 26 Report, Dr. Leo states Dr. Sim should have notified Dr. Barrow that Plaintiff's diabetes was uncontrolled and Plaintiff was not medically stable to proceed with surgery. (ECF No. 20-1, p. 6). Dr. Sim did not "approve" the surgery because no pre-surgical medical clearance was requested by Dr. Barrow. Dr. Leo testified it is the general practice for a surgeon to request medical clearance if he deems it necessary from a primary care physician. (ECF No. 45-1, p. 69). Dr. Leo testified that in his experience, medical clearance would be requested a month before the surgery, and Dr.

Leo would either schedule a specific preoperative medical clearance office visit, or if the patient recently had an annual exam, clear the patient without further evaluation. (*Id.* at p. 71-72).

Dr. Barrow did not request a pre-surgical clearance of Plaintiff. Rather, Dr. Barrow requested some lab tests, and those tests were performed. Concerning Dr. Leo's opinion that Dr. Sim should have intervened to stop the surgery because of the A1C test result, it **[*29]** is undisputed the test result was sent to Dr. Barrow. (ECF No. 29, ¶ 39). Dr. Barrow testified he also ordered a blood glucose test the morning of the surgery, and the result of that test was more important to him than an A1C score. Additionally, Dr. Leo admits there is not a clear medical consensus on what A1C score would make surgery contraindicated. He states in his Rule 26 Report "there is no specific evidence-based target for hemoglobin A1C recommended prior to surgery," but that studies have shown an increased risk of infection. (ECF No. 20-1, p. 7).

All of these criticisms by Dr. Leo essentially amount to a contention that Dr. Sim should have been more concerned with the A1C result, communicated his concern to Dr. Barrow and Plaintiff, and recommended the surgery not go forward. Dr. Leo believes the surgery should have been postponed until Plaintiff was medically optimized. The Government contends Plaintiff cannot show the surgery would not have proceeded. However, Dr. Barrow testified he had not reviewed the A1C prior to the surgery, and had he seen it, he "possibly" would have still performed the surgery because he does not view the A1C as a contraindication to surgery. (ECF No. 29-2, **[*30]** p. 21-22 of 188).

Dr. Leo is not a surgeon. He testified, "I hesitate to opine as to the standard of care of an orthopedic surgeon." (ECF No. 45-1, p. 42). He further testified: "The question as to what Dr. Barrow's duty was in obtaining a medical clearance for this patient with a number of different medical problems aside from this Type 2 diabetes, is one that I will defer to the orthopedic expert in this case." (*Id.* at 42-43). Thus Dr. Leo does not opine Dr. Barrow should have sought pre-surgical medical clearance, and Dr. Barrow did not seek Dr. Sim's opinion as to medical clearance. However, Dr. Leo claims Dr. Sim had a "duty as the primary care physician to say this patient is not medically cleared or optimized to proceed with surgery and to contact Dr. Barrow and let him know " (*Id.* at 41).

Viewing the facts in the light most favorable to Plaintiff for the purposes of this summary judgment motion, and considering the opinions of Plaintiff's expert, Dr. Leo, the court finds the Government has not established it is entitled to judgment as a matter of law on the medical negligence claim.

**IV. Conclusion**

The Complaint in this matter asserts two claims: 1) Failure to Secure Informed Consent; and 2) Medical **[*31]** Negligence. The court finds as a matter of law Dr. Sim had no duty to secure informed consent for the surgical procedure performed by Dr. Barrow. Dr. Sim did not plan or participate in the surgery. Plaintiff saw Dr. Barrow on multiple occasions prior to the surgery. Plaintiff's informed consent claim was not supported by expert testimony.

Plaintiff's claim of medical negligence was supported by the testimony and report of Dr. Leo, and additionally by the conclusory opinion of Dr. Coleman. The Government's position is supported by its three experts: Dr. Oakley, Dr. Kraemer, and Dr. Ledgerwood. The medical negligence claim thus presents a material dispute between expert witnesses concerning the standard of care, whether it was breached, and causation. Given this dispute, the court denies summary judgment on the medical negligence claim.

**IT IS HEREBY ORDERED:**

1. The Government's Motion to Exclude (ECF No. 43) is **DENIED**.

2. The Government's Motion for Summary Judgment (ECF No. 28) is **DENIED IN PART AND GRANTED IN PART**. The Government is granted summary judgment on Plaintiff's claim that Dr. Sim or VA medical personnel failed to secure informed consent. The Government's Motion is denied as **[*32]** to the medical negligence claim.

**IT IS SO ORDERED**. The Clerk is hereby directed to enter this Order and furnish copies to counsel.

**DATED** this 7th day of August, 2018.

/s/ Justin L. Quackenbush

JUSTIN L. QUACKENBUSH

SENIOR UNITED STATES DISTRICT JUDGE

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# Ortega v. Stiefel

Supreme Court of New York, Westchester County

November 23, 2022, Decided; November 28, 2022, Filed

Index No.: 58488/2018

**Reporter**
2022 N.Y. Misc. LEXIS 47617 *

LYDIA ORTEGA, deceased by KIM MERCADO, as Administratrix of her Estate, GUILLERMO ORTEGA, Plaintiff, v. MICHAEL F. STIEFEL, M.D., QINGLIANG WANG, M.D., WESTCHESTER MEDICAL REGIONAL PHYSICIAN SERVICES, P.C., Q.T. WANG, M.D., NEUROLOGY P.C., WESTCHESTER MEDICAL ADVANCED PHYSICIAN SERVICES, WESTCHESTER MEDICAL CENTER and WESTCHESTER COUNTY HEALTH CARE CORP., Defendants.

## Core Terms

cause of action, summary judgment, informed consent, negligent hiring, Defendants', malpractice, patient, summary judgment motion, issue of material fact, Plaintiffs', unopposed, stroke, brain

## Opinion

**[*1] JUDGMENT**

Defendants, MICHAEL F. STIEFEL, M.D. and WESTCHESTER MEDICAL ADVANCED PHYSICIAN SERVICES, by their attorneys DENLEA & CARTON LLP, having moved the Court by Notice of Motion filed on March 8, 2022, for an Order awarding summary judgment pursuant to CPLR § 3212 and dismissing all claims against the moving defendants with prejudice;

AND, plaintiffs, having not opposed defendants' motion;

AND, after due deliberation the Court (Hon. David S. Zuckerman, AJ.S.C.) having issued a Decision Order dated July 7, 2022, granting defendants' motion in its entirety, which was served on all parties with Notice of Entry on July 7, 2022;

NOW, on the basis of the attached Decision Order dated July 7, 2022, it is hereby ADJUDGED, that the plaintiffs' complaint against MICHAEL F. STIEFEL, M.D. and WESTCHESTER MEDICAL ADVANCED PHYSICIAN SERVICES is dismissed in its entirety as against these defendants, with prejudice, and without costs or disbursements.

JUDGMENT entered this 23rd day of November, 2022.

**WAIVER OF BILL OF COSTS**

**IT IS HEREBY AGREED** that the defendants MICHAEL F. STIEFEL, M.D. and WESTCHESTER MEDICAL ADVANCED PHYSICIAN SERVICES waive costs and expenses, and request that Judgment be entered without costs **[*2]** or expenses against any party.

Dated: White Plains, New York

September 30, 2022

DENLEA & CARTON LLP

By: ***/s/ John L. Leifert***

John L. Leifert

Attorneys for Defendants

MICHAEL F. STIEFEL, M.D., and WESTCHESTER MEDICAL CENTER ADVANCED PHYSICIAN SERVICES, P.C., s/h/a WESTCHESTER MEDICAL ADVANCED PHYSICIAN

2 Westchester Park Drive, Suite 410

White Plains, New York 10604

(914)331-0100

**DECISION/ORDER WITH NOTICE OF ENTRY**

PLEASE TAKE NOTICE that the within is a true copy of the Order of the Honorable David S. Zuckerman, A.J.S.C., of the within Court, granting summary judgment and dismissing the Complaint as against MICHAEL F. STIEFEL, M.D., ("STIEFEL") and WESTCHESTER MEDICAL CENTER ADVANCED PHYSICIAN SERVICES, P.C., s/h/a WESTCHESTER MEDICAL ADVANCED PHYSICIAN ("WMCAPS"), dated and entered in the office of the County Clerk on July 7, 2022.

Dated: White Plains, New York

July 7, 2022

DENLEA & CARTON LLP

By: ***/s/ John L. Leifert***

John L. Leifert

Attorneys for Defendants

MICHAEL F. STIEFEL, M.D., and WESTCHESTER MEDICAL CENTER ADVANCED PHYSICIAN SERVICES, P.C., s/h/a WESTCHESTER MEDICAL ADVANCED PHYSICIAN

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White Plains, New York 10604

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DECISION/ORDER

ZUCKERMAN, J.

The papers **[*3]** filed in NYSCEF as Documents 1 through 86 were read in connection with Defendants Michael F. Stiefel, M.D., and Westchester Medical Advanced Physician Services' (collectively, "Moving Defendants") motion, pursuant to CPLR 3212, for an Order granting summary judgment and dismissal. The motion is unopposed.

This action concerns Plaintiffs' decedent Lydia Ortega ("Decedent") who, on July 4, 2014, underwent successful treatment for a subarachnoid hemorrhage (a life-threatening stroke caused by bleeding around the brain). In 2016, during a follow-up procedure, there were complications leading to another stroke and subsequent injuries. Decedent passed on January 31, 2020.

Plaintiff Kim Mercado is Decedent's daughter and administrator of her estate. Plaintiff Guillermo Ortega was Decedent's husband. The Complaint sets forth four causes of action: negligence, lack of informed consent, loss of services and negligent hiring.

Defendant Michael F. Stiefel, M.D., ("Stiefel") performed the 2014 procedure. Defendant Qingliang Wang, M.D., ("Wang") performed the 2016 procedure. Westchester Medical Regional Physician Services, P.C. ("Regional") and Westchester Medical Advanced Physician Services, P.C ("Advanced") **[*4]** are alleged to have employed Stiefel and Wang, and Stiefel and Wang are alleged to have an ownership interest in them. Q.T. Wang, M.D., Neurology P.C. ("Wang PC") is alleged to have employed Wang and Wang is alleged to have an ownership interest in it. Westchester Medical Center ("WMC") and Westchester County Health Care Corp. ("WCHCC") are also alleged to have employed Steifel and Wang.

**FACTS**:

In July, 2014, at WMC, Stiefel successfully treated Decedent for a brain aneurysm. As part of the standard aftercare regime, in January, 2015, Steifel performed a digital subtraction cerebral angiogram ("DSA") on Decedent without incident. At the time, Decedent was functioning well, and was able to drive, cook, clean and generally be independent. The DSA revealed that the site of Decedent's brain aneurysm had significantly degraded. It was decided that, in February, 2016, Decedent should undergo another DSA.

On February 2, 2016, Wang performed the subsequent DSA. Prior to the procedure. Decedent executed an informed consent form authorizing Wang to perform the DSA. During the course of the procedure, Decedent suffered another stroke and Wang called in Stiefel to assist him. On February 3, 2016, **[*5]** Stiefel performed a decompressive hemicraniotomy to relieve swelling of Decedent's brain.

After the February 2, 201G procedure, Decedent was paralyzed, unable to follow commands, fed via feeding tube and supplied with oxygen via a tracheal port. She was placed in a nursing home where she remained until her passing.

**APPLICABLE LEGAL STANDARD**:

Pursuant to CPLR § 3212(b), a motion for Bummary judgment "shall be granted if, upon all of papers and proof submitted, the cause of action or defense shall be established sufficiently to warrant the court as a matter of law in directing judgment in favor of any party." The Court of Appeals has explained that

> [s]ummary judgment is designed to expedite all civil cases by eliminating from the Trial Calendar claims which can properly be resolved as a matter of law ... when there is no genuine issue to be resolved at trial, the case should be summarily decided, and any unfounded reluctance to employ the remedy will only serve to swell the Trial Calendar and thus deny to other litigants the right to have their claims promptly adjudicated

(*Andre v Pomeroy*, 35 NY2d 361, 364 [1974]).

In a summary judgment motion, the movant bears the initial burden of presenting evidence, in competent and admissible form, establishing **[*6]** the absence of any material issues of fact. (Viviane Efcienne *Medical Care v Country-Wide* Insurance Company, 25 NY3d 498 [2015]; *Bank of New York Mellon v Gordon*, 171 AD3d 197 [2d Dept 2017]; *Winegrad v New York University Medical Center*, 64 NY2d 851 [1985]). In the event that initial burden is met, the non-moving party must come forward with proof, also in admissible form, that there are material issues of fact which require a trial of the action (*Alvarez v Prospect Hospital*, 68 NY2d 320 [1986] ) .

In *Celardo v. Bell*, 222 AD2d 547 [2d Dept 1995], the court stated:

> It is axiomatic that summary judgment is a drastic remedy which should only be granted if it is clear that no material issues of fact have been presented. Issue finding, rather than issue determination, is the court's function (*Sillman v*

*Twentieth Century-Fox Film Corp.*, 3 NY2d 395 [1957] ) . If there is any doubt about the existence of a triable issue of fact or if a material issue of fact is arguable, summary judgment should be denied (*Museums* at *Stony Brook v Village of Pachogue Fire Dept.*, 146 AD2d 572 [1989]).

In analyzing the contrasting factual allegations, the court may not engage in weighing the evidence. Rather, the court must draw all reasonable inferences in favor of the non-moving party (*Rizzo v Lincoln Diner Corp.* 215 AD2d 546 [2nd Dept 2000] ) . Then, the court must determine whether "by no rational process could the trier of facts find for the non-moving party" (*Jastrzebski v. N Shore Sch Dist*, 232 AD2d 677 678 [2nd Dept 1996]) . Where facts are in dispute, there are issues of credibility, or conflicting inferences may be drawn from the evidence, summary judgment will not lie (*Id.* at 678).

**DISCUSSION**:

**The Negligence Claim**

Plaintiffs' first cause, of action is for negligence/medical **[*7]** malpractice. In it, Plaintiffs offer a litany of boilerplate allegations that every aspect of the care Decedent received in connection with the February 2, 2016 procedure was improper. Moving Defendants argue that the negligence/medical malpractice claim must be dismissed because the evidence shows that they met the applicable standard of care.

"'A defendant seeking summary judgment in a medical malpractice action bears the initial burden of establishing, *prima facie*, either that there was no departure from the applicable standard of care, or that any alleged departure did not proximately cause the plaintiffs injuries" (*Michel v Long Is. Jewish Med Ctr.*, 125 AD3d 945 [2d Dept. 2015] *lv denied* 26 NY3d 905 [2015]) . Expert opinion evidence is required when evaluating the "performance of functions that are an integral part of the process of rendering medical treatment and diagnosis to a patient" (*D'Elia v Menorah Home and Hosp. for the Aged & Infirm*, 51 AD3d 848, 859 [2d Dept 2008]; *Koster v Davenport*, 142 AD3d 966 [2d Dept. 2016] lv to *appeal denied* 28 NY3d 911 [2016]). Additionally, the conclusions reached by the defendant and his or her expert (s) must be supported by evidence in the record. (*Poter v Adams*, 104 AD3d 925 [2d Dept 2013]).

As part of the follow up monitoring after Decedent's initial stroke, Steifel directed that a DSA be performed. Moving Defendants' expert, John Farhbach (*Farhbach"), asserts that the DSA which Decedent underwent is the "gold **[*8]** standard" for treatment following a brain hemorrhage. Farhbach adds that the DSA is minimally invasive, Decedent had no counter indications for the procedure, and Decedent successfully underwent two prior DSA's in 2014 and 2015.

Farhbach further affirms that it is routine for another doctor in the practice to perform a prescribed DSA; in this case Dr. Wang. Farhbach adds that the procedure is not without risk. One of the risks is clotting, which was the cause of Decedents second stroke. Farhbach also affirms that all of the procedures Stiefel performed after being called in by Wang were appropriate and that there were no other appropriate medical options to pursue.

The court finds that Moving Defendants have demonstrated, *prima facie*, entitlement to summary judgment. "Once a defendant physician has made such a showing, the burden shifts to the plaintiff to demonstrate the existence of a triable issue of fact as to the elements on which the defendant met the prima facie burden" (*Williams v Halstead*, 202 AD3d 891, 892 [2d Dept 2022] [internal citations omitted]). Plaintiffs have not submitted any opposition. Thus, they have not met their burden to establish a triable issue of fact. Therefore, Moving Defendants' unopposed summary judgment **[*9]** motion to dismiss the negligence/medical malpractice cause of action must be granted.

**The Failure to Obtain Informed Consent Claims**

In their Complaint and bills of particulars, Plaintiffs allege that Moving Defendants did not provide Decedent with enough information regarding the riskB of undergoing the 2016 DSA. Moving Defendants argue that Stiefel did not perform the procedure and, thus, is not responsible for obtaining informed consent. Moving Defendants further argue that, in any event, no prudent patient would refuse the DSA.

> To establish a cause of action to recover damages for malpractice based on lack of informed consent, a plaintiff must prove (1) that the person providing the professional treatment failed to disclose alternatives thereto and failed to inform the patient of reasonably foreseeable risks associated with the treatment, and the alternatives, that a reasonable medical practitioner would have disclosed in the same circumstances, (2) that a reasonably prudent patient in the same position would not have undergone the treatment if he or she had been fully informed, and (3) that the actual procedure performed for which there was no informed consent was the proximate cause **[*10]** of the injury

*Schussheim v Barazanl*, 136 AD3d 787, 789 [2d Dept 2016] . "A referring physician may not be held liable for failing to obtain a patient's informed consent where that informed consent was obtained by the treating physician to whom the patient was referred" (*Shkolnik v Hosp. for Joint Diseases Orthopaedic Inst.*, 211 AD2d 347 [1st Dept 1995]).

Although Decedent was referred by Stiefel, Wang performed the 2016 DSA that is the subject of Plaintiffs' cause of action for lack of informed consent. Moving Defendants have produced evidence that Wang obtained Decedent's written consent prior to performing the procedure. Thus, pursuant to *Skolnik*, Moving Defendants have demonstrated, prima *facie*, entitlement to summary judgment. Plaintiffs have not submitted any evidence to establish a material issue of fact. Therefore, Moving Defendants' unopposed summary judgment motion to dismiss the cause of action for lack of informed consent must be granted.

**Negligent Hiring**

"A cause of action for negligent hiring and retention requires allegations that an employer knew of its employee's harmful propensities, that it failed to take necessary action, and that this failure caused damage to others" (*Waterbury v New York City Ballet, Inc.*, 205 AD3d 154, 160 [lat Dept 2022]). "In those instances where an employer cannot be held vicariously liable for torts committed by its employee, the employer can still **[*11]** be held liable under theories of negligent hiring and negligent retention" (*Sheila C. v Povich*, 11 AD3d 120, 129 [1" Dept 2004]). "A necessary element of [negligent hiring] is that the employer knew or should have known of the employee's propensity for the conduct which caused the injury. The employer's negligence lies in having placed the employee in a position to cause foreseeable harm, harm which would most probably have been spared the injured party had the employer taken reasonable care in making decisions respecting the hiring and retention of the employee" (*Johansmeyer v New York City Dept. of Educ*, 165 AD3d 634, 635-36 [2d Dept 2018] [internal citations omitted]). On the other hand, "[a]n underlying requirement in actions for negligent hiring or retention is that the employee is individually liable for a tort or guilty of a claimed wrong against a third person, who then seeks recovery against the employer" NY PJI 2:240, Comment; *Primeau v Town of Amherat*, 303 AD2d 1035, 1038 [4th Dept 2003]).

Here, the underlying cause of action against Moving Defendants for negligence/medical malpractice has been dismissed. There is no remaining allegation that Stiefel is individually liable for a tort or guilty of a claimed wrong against Decedent. Consequently, pursuant to *Primeau*, the negligent hiring cause of action must be dismissed. Therefore, Moving Defendants' unopposed summary **[*12]** judgment motion to dismiss the cause of action for negligent hiring must be granted.

**Lobs of Services**

A cause of action for loss of services, also known as loss of consortium, seeks redress for "such elements as love, companionship, affection, society, sexual relations, solace and more" (*Millington v Southern Elevator Co.*, 22 NY2d 498, 502 [1968]) . As the court held in *Pinto v Ancona*, 262 AD2d 472, 473 [2d Dept 1999]:

> "It has been observed that the * consortium plaintiff * * * has suffered no direct injury of [his or her] own' (*Maidman v. Stagg*, 82 AD2d 299, 305 [2d Dept 1981]). Rather, the 'right to recover is derived, both in a literal and legal sense, from the injury suffered by [a] spouse' (*Maidman v Stagg, supra* at 305; *see also, Cody v. Village of Lake George*, 177 AD2d 921, 576 M.Y.S.2d 912, supra). Further, '[t]he consortium claim and the principal personal injury claim are closely interconnected; together they represent the total, compensable damages—direct and indirect—suffered as a result of the plaintiff's injury (*Maidman v Stagy*, supra at 305)" (*Buckley v Nat'l Freight, Inc.*, 220 AD2d 155, 157, [2d Dept 1996], aff'd, 90 NY2d 210 [1997]). Thus, an action for loss of services has been characterized as a ""derivative action"

Here, the underlying causes of action against Moving Defendants for negligence/medical malpractice and negligent hiring have been dismissed. Consequently, since a "cause of action alleging loss of consortium is derivative in nature" (Many *v Lossef*, 190 AD3d 721 [2d Dept 2021], Plaintiffs' loss of **[*13]** services cause of action likewise must be dismissed. Therefore, Moving Defendants' unopposed summary judgment motion to dismiss the cause of action for loss of services must be granted.

Based upon the foregoing, it. is hereby

**ORDERED**, that the motion by Defendant Michael* P. Stiefel, M.D. for summary judgment dismissing the Complaint as to him is granted; and it is further;

**ORDERED**, that the motion by Defendant Westchester Medical Advanced Physician Services for summary judgment dismissing the Complaint as to it is granted.

The foregoing constitutes the Opinion, Decision & Order of the Court.

Dated: White Plains, New York

July 7, 2022

/s/ David S. Zuckerman

HON. DAVID S. ZUCKERMAN, A.J.S.C.

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# Torres v. Carrese

Superior Court of Connecticut, Judicial District of Fairfield At Bridgeport

January 3, 2012, Decided; January 3, 2012, Filed

CV065011368

**Reporter**
2012 Conn. Super. LEXIS 52 *; 2012 WL 266321

Erika Torres v. Alexander A. Carrese et al.

**Notice:** THIS DECISION IS UNREPORTED AND MAY BE SUBJECT TO FURTHER APPELLATE REVIEW. COUNSEL IS CAUTIONED TO MAKE AN INDEPENDENT DETERMINATION OF THE STATUS OF THIS CASE.

**Subsequent History:** Affirmed by Torres v. Carrese, 149 Conn. App. 596, 90 A.3d 256, 2014 Conn. App. LEXIS 167 (Apr. 22, 2014)

**Prior History:** Torres v. Carrese, 2011 Conn. Super. LEXIS 854 (Conn. Super. Ct., Apr. 5, 2011)

Torres v. Carrese, 2011 Conn. Super. LEXIS 665 (Conn. Super. Ct., Mar. 14, 2011)

Torres v. Carrese, 2009 Conn. Super. LEXIS 176 (Conn. Super. Ct., Jan. 27, 2009)

## Core Terms

informed consent, cesarean, patient, placenta, hysterectomy, risks, advise, referring physician, quotation, surgery, marks, lack of informed consent, experienced, inform, bladder, emergency exception, internist, delivery, percreta, vaginal, summary judgment motion, surgical procedure, genuine issue of material fact, no duty, bleeding, accreta, surgeon, argues, defendants', performing

## Case Summary

**Overview**
Where plaintiff conceded that she would have had a cesarean hysterectomy regardless of whether defendant otherwise obtained her informed consent, and where there was no allegation nor evidence that defendant was not competent, prepared, and experienced to perform a cesarean hysterectomy, there was no genuine issue of material fact that defendant did not violate any duty to plaintiff by not advising her that she might have the surgery performed by more experienced physicians or more specialized physicians. Thus, were entitled to summary judgment lack of informed consent claim.

**Outcome**
Defendants' motions for summary judgment granted.

## LexisNexis® Headnotes

Civil Procedure > ... > Summary Judgment > Entitlement as Matter of Law > General Overview

*HN1*[] **Summary Judgment, Entitlement as Matter of Law**

Conn. Gen. Prac. Book, R. Super. Ct. § 17-49 provides that summary judgment shall be rendered forthwith if the pleadings, affidavits and any other proof submitted show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law. In deciding a motion for summary judgment, the trial court must view the evidence in the light most favorable to the nonmoving party.

Civil Procedure > ... > Summary Judgment > Entitlement as Matter of Law > General Overview

Civil Procedure > ... > Summary Judgment > Burdens of Proof > Movant Persuasion & Proof

Civil Procedure > ... > Summary Judgment > Burdens of Proof > Nonmovant Persuasion & Proof

*HN2*[] **Summary Judgment, Entitlement as Matter of Law**

In seeking summary judgment, it is the movant who has the burden of showing the nonexistence of any issue of fact. The moving party for summary judgment has the burden of showing the absence of any genuine issue as to all the material facts, which, under applicable principles of substantive law, entitle him to a judgment as a matter of law. To satisfy his burden the movant must make a showing that it is quite clear what the truth is, and that excludes any real doubt as to the existence of any genuine issue of material fact. A material fact is a fact that will make a difference in the result of the case. The party opposing such a motion must provide an evidentiary foundation to demonstrate the existence of a genuine issue of material fact. The test is whether the party moving for summary judgment would be entitled to a directed verdict on the same facts.

Healthcare Law > Medical Treatment > Patient Consent > Informed Consent

Torts > Negligence > Types of Negligence Actions > General Overview

*HN3*[] **Patient Consent, Informed Consent**

A claim of lack of informed consent is an action in negligence.

Torts > Negligence > Elements

Torts > ... > Elements > Duty > General Overview

*HN4*[] **Negligence, Elements**

The essential elements of a cause of action in negligence, are: duty; breach of that duty; causation; and actual injury. Thus, the existence of a duty of care is a prerequisite to a finding of negligence. The existence of a duty is a question of law, and only if such a duty is found to exist does the trier of fact then determine whether the defendant breached that duty in the particular situation at hand. If a defendant owed no duty to a plaintiff with respect to a particular claim of negligence, the defendant is entitled to summary judgment.

Healthcare Law > Medical Treatment > Patient Consent > Informed Consent

Torts > ... > Elements > Duty > General Overview

*HN5*[] **Patient Consent, Informed Consent**

A referring physician, who will not participated in an actual surgical procedure, has no duty to ensure that his patient has given her informed consent to that procedure when the surgery had been performed by another physician.

Healthcare Law > Medical Treatment > Patient Consent > Informed Consent

Torts > ... > Elements > Duty > General Overview

*HN6*[] **Patient Consent, Informed Consent**

The duty to obtain informed consent, prior to beginning the surgical procedure, rests wholly upon the attending physician.

Governments > Legislation > Interpretation

*HN7*[] **Legislation, Interpretation**

A court must construe an act as it find it, without reference to whether the court think it would have been or could be improved by the inclusion of other provisions. Courts may not by construction supply omissions in a statute, or add exceptions merely because it appears to them that good reasons exist for adding them.

Healthcare Law > Medical Treatment > Patient Consent > Right to Refuse Treatment

*HN8*[] **Patient Consent, Right to Refuse Treatment**

A competent individual has the right to refuse life-saving medical treatment.

Civil Procedure > Pleading & Practice > Pleadings > Rule Application & Interpretation

*HN9*[] **Pleadings, Rule Application & Interpretation**

Construction of pleadings is a question of law. Pleadings should be read broadly and realistically, and not narrowly and technically.

Healthcare Law > Medical Treatment > Patient Consent > Informed Consent

*HN10*[] **Patient Consent, Informed Consent**

In order to prevail on a cause of action for lack of informed consent, a plaintiff must prove both that there was a failure to disclose a known material risk of a proposed procedure and that such failure was a proximate cause of his injury. Unlike a medical malpractice claim, a claim for lack of informed consent is determined by a lay standard of materiality, rather than an expert medical standard of care which guides the trier of fact in its determination. The elements that must be addressed in the

physician's disclosure to the patient in order to obtain valid informed consent involves four specific factors: (1) the nature of the procedure; (2) the risks and hazards of the procedure; (3) the alternatives to the procedure; and (4) the anticipated benefits of the procedure.

Healthcare Law > Medical Treatment > Patient Consent > Informed Consent

***HN11***[] **Patient Consent, Informed Consent**

The lay standard of informed consent requires a physician to provide the patient with that information which a reasonable patient would have found material for making a decision whether to embark upon a contemplated course of therapy. Materiality may be said to be the significance a reasonable person, in what the physician knows or should know is his patient's position, would attach to the disclosed risk or risks in deciding whether to submit or not to submit to surgery or treatment.

Healthcare Law > Medical Treatment > Patient Consent > Informed Consent

***HN12***[] **Patient Consent, Informed Consent**

Courts do not require a physician to disclose information that a particular patient might deem material to his or her decision, but, rather, limit the information to be disclosed to that which a reasonable patient would find material.

Healthcare Law > Medical Treatment > Patient Consent > Informed Consent

***HN13***[] **Patient Consent, Informed Consent**

Information personal to the physician, whether solicited by the patient or not, is irrelevant to the doctrine of informed consent. The doctrine of informed consent clearly focuses on imparting information relative only to the surgery itself'. This is an objective, rather than subjective analysis; its calculus does not shift depending on how inquisitive or passive the particular patient is.

Healthcare Law > Medical Treatment > Patient Consent > Informed Consent

***HN14***[] **Patient Consent, Informed Consent**

A surgeon who is qualified to perform a particular operation does not have a duty to advise the patient that there are more experienced surgeons in the area who are less likely to make a mistake.

**Judges: [*1]** Bruce L. Levin, Judge of the Superior Court.

**Opinion by:** Bruce L. Levin

## Opinion

MEMORANDUM OF DECISION

On September 29, 2006, the plaintiff, Erika Torres, filed this medical malpractice action against the defendants, Alexander Carrese and Abraham Yaari. The plaintiff alleges the following in count one of her April 21, 2011, two-count revised complaint. The defendants are each "duly licensed physician[s] engaged in the practice of medicine in the [s]tate of Connecticut

and [are] specialist[s] in the field of obstetrics and/or gynecology." For several months prior to August 5, 2004, Carrese provided prenatal care services to the plaintiff. Carrese improperly performed the prenatal care because he failed, *inter alia*, to detect the plaintiff's conditions of placenta previa, placenta accreta and/or placenta percreta.[1] Specifically, Carrese "(e) . . . failed to advise the plaintiff in timely fashion of her options with respect to complete bed rest, early delivery or other means of dealing with potentially life threatening complication of placenta percreta in a timely and appropriate fashion . . . (g) . . . failed to advise the plaintiff of the possibility of complications during delivery due to her condition(s) **[*2]** of placenta previa, placenta accreta and/or placenta percreta . . . [and] (j) . . . failed to advise the plaintiff of the risk that her bladder would be injured during the cesarean [hysterectomy] . . ."[2] As a result of Carrese's negligence, the plaintiff was required to undergo a hysterectomy and sustained bladder damage that rendered her incontinent.[3]

In **[*3]** count two of the revised complaint, the plaintiff alleges that Yaari performed the plaintiff's cesarean hysterectomy on August 5, 2004. The plaintiff further alleges, *inter alia*, that Yaari "failed to adequately advise the plaintiff of the risk that her bladder would be injured during the [cesarean hysterectomy] and failed to warn her and obtain her informed consent of what [Yaari] knew, or should have known, to be a known material risk, of which she was unaware, that she had a substantially elevated likelihood of suffering massive bleeding due to a likely placenta accreta and/or placenta percreta which could lead to damage to her urinary tract, including to her ureters if the surgeon had to become involved, during the cesarean [hysterectomy], in attempting to separate her placenta from adjoining organs and in attempting to achieve hemostasis, thereby depriving her of the choice to seek the intervention of physicians more experienced in and/or specializing in dealing with this type of condition . . ." According to the revised complaint, Yaari's negligence required the plaintiff to undergo a hysterectomy and the plaintiff suffered bladder damage that rendered her incontinent.

On March **[*4]** 7, 2011, the court granted the defendants' motion to dismiss on the ground that the plaintiff failed to attach an opinion letter from a "similar health care provider" to the good faith certificate that accompanied the original complaint, as required by General Statutes §52-190a.[4] See *Bennett v. New Milford Hospital, Inc.*, 300 Conn. 1, 29, 12 A.3d 865 (2011) ("a motion to dismiss pursuant to §52-190a(c) is the only proper procedural vehicle for challenging deficiencies with the opinion letter, and . . . dismissal of a letter that does not comply with §52-190a(c) is mandatory"). The court subsequently reconsidered and vacated its decision only as to the plaintiff's claims of informed consent because the requirement of a good faith certificate and a written opinion letter from a similar health care provider does not apply to a claim of lack of informed consent.[5] *Shortell v. Cavanagh*, 300 Conn. 383, 385, 15 A.3d 1042 (2011).

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[1] Placenta previa is a condition in which the placenta is implanted in the lower segment of the uterus, thereby partially or completely obstructing the internal bone of the cervix. T. Stedman, Medical Dictionary (28th Ed. 2006), p. 1502. Placenta accreta is a condition in which the placenta has grown through the placental membrane and into the middle layer of the uterine wall, so that it cannot be detached without removing the uterus. *Id*. Placenta percreta is a condition in which the placenta grows through the uterine wall. *Id.* In rare and severe instances, placenta percreta can involve the urinary bladder. *Id.*

[2] When relevant and appropriate, the operative procedures involving the cesarean section and the hysterectomy will be referred to collectively as "the cesarean hysterectomy."

[3] A hysterectomy is the removal of the uterus. T. Stedman, *supra*, p.

[4] General Statutes §52-190a provides in relevant part: "(a) No civil action or apportionment complaint shall be filed to recover damages resulting from personal injury or wrongful death . . . in which it is alleged that such injury or death resulted from the negligence **[*5]** of a health care provider . . . The complaint, initial pleading or apportionment complaint shall contain a certificate of the attorney or party filing the action or apportionment complaint that such reasonable inquiry gave rise to a good faith belief that grounds exist for an action against each named defendant or for an apportionment complaint against each named apportionment defendant. To show the existence of such good faith, the claimant or the claimant's attorney, and any apportionment complainant or the apportionment complainant's attorney, shall obtain a written and signed opinion of a similar health care provider . . . that there appears to be evidence of medical negligence and includes a detailed basis for the formation of such opinion . . . The claimant or the claimant's attorney, and any apportionment complainant or apportionment complainant's attorney, shall retain the original written opinion and shall attach a copy of such written opinion, with the name and signature of the similar health care provider expunged, to such certificate . . . (c) The failure to obtain and file the written opinion required by subsection (a) of [§52-190a] shall be grounds for the dismissal of **[*6]** the action."

[5] This argument had not been raised by the plaintiff in her opposition to the defendants' motions to dismiss.

On July 28, 2011, Carrese moved for summary judgment on the grounds that the plaintiff did not allege lack of informed consent or alternatively, to the extent that a lack of informed consent claim was pleaded, no triable issue existed. In support of his motion, Carrese submitted his affidavit. On August 1, 2011, Yaari also filed a motion for summary judgment. In support of his motion, Yaari submitted excerpts from the deposition transcripts of: (1) Dr. Daniel Miller, (2) Dr. Jeffrey Richardson, (3) Dr. Frederick Rau, (4) Dr. Frank Boehm, (5) Dr. Jay Matola, (6) Dr. Jeffrey Small, (7) the plaintiff, and (8) Eliezer Torres. The parties have also submitted the hospital records of St. Vincent's Medical Center and Bridgeport Hospital.

The plaintiff has filed separate memoranda in opposition to the defendants' motions for summary judgment. On the morning of October 3, 2011, moments before oral argument on the defendants' motions, the plaintiff filed two second supplemental objections to the defendants' motions for summary judgment. In support of each second supplemental **[*7]** objection, the plaintiff submitted her own affidavit and a copy of a hospital record dated May 28, 2004. The plaintiff also submitted excerpts from the depositions of: (1) Dr. Yaari; (2) the plaintiff; (3) Eliezer Torres; (4) Dr. Boehm; and (5) Dr. Rau. That morning, the plaintiff also filed a third supplemental objection to Yaari's motion for summary judgment. In support of her third supplemental objection, the plaintiff submitted an excerpt from the deposition of Dr. Richardson.

On November 7, 2011, the court ordered the plaintiff and Yaari to file supplemental briefs discussing the relevance, if any, of *DeGennaro v. Tandon*, 89 Conn.App. 183, 873 A.2d 191, cert. denied, 274 Conn. 914, 879 A.2d 892 (2005), and *Duffy v. Flagg*, 279 Conn. 682, 905 A.2d 15 (2006), to the plaintiff's claims against Yaari. Both the plaintiff and Yaari complied with this order.

***HN1***[↑] "Practice Book §17-49 provides that summary judgment shall be rendered forthwith if the pleadings, affidavits and any other proof submitted show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law. In deciding a motion for summary judgment, the trial court must **[*8]** view the evidence in the light most favorable to the nonmoving party." (Internal quotation marks omitted.) *Unifund CCR Partners v. Schaeppi*, 126 Conn.App. 370, 379-80, 11 A.3d 723 (2011). ***HN2***[↑] "In seeking summary judgment, it is the movant who has the burden of showing the nonexistence of any issue of fact. The courts are in entire agreement that the moving party for summary judgment has the burden of showing the absence of any genuine issue as to all the material facts, which, under applicable principles of substantive law, entitle him to a judgment as a matter of law . . . To satisfy his burden the movant must make a showing that it is quite clear what the truth is, and that excludes any real doubt as to the existence of any genuine issue of material fact." (Internal quotation marks omitted.) *Taylor v. Lantz*, 129 Conn.App. 437, 442, 20 A.3d 88 (2011). "A material fact is a fact that will make a difference in the result of the case . . . The party opposing such a motion must provide an evidentiary foundation to demonstrate the existence of a genuine issue of material fact." (Internal quotation marks omitted.) *Ferrucci v. Middlebury*, 131 Conn.App. 289, 293-94, 25 A.3d 728, cert. denied, **[*9]** 302 Conn. 944, 31 A.3d 382 (2011). "The test is whether the party moving for summary judgment would be entitled to a directed verdict on the same facts." (Internal quotation marks omitted.) *Blumberg Associates Worldwide, Inc. v. Brown & Brown of Connecticut*, 132 Conn.App. 85, 89, 30 A.3d 38 (2011).

Viewing the evidence in a light most favorable to the plaintiff, the following facts are relevant for purposes of the defendants' motions. Carrese is a board certified obstetrician-gynecologist. He had been the plaintiff's obstetrician-gynecologist since she was sixteen. Carrese successfully performed two cesarean sections on the plaintiff for her two prior pregnancies. In 2004, the plaintiff again became pregnant. During her 2004 pregnancy, the plaintiff and Carrese discussed that she would deliver by cesarean section. The plaintiff was scheduled to deliver her child in September 2004.

Carrese was aware that the plaintiff experienced vaginal bleeding and suffered from abdominal pains during her 2004 pregnancy. In the fourth or fifth month of the pregnancy, Carrese informed the plaintiff that she had placenta previa and described the condition as "placenta before baby." Moreover, Carrese explained **[*10]** that the placenta was locking the path out of the womb. Carrese told the plaintiff not to worry about the condition, and to return home and relax. "[Carrese] never told [the plaintiff] of the risks that a woman with multiple prior cesarean sections, placenta previa, bleeding and abdominal pain was likely to face during cesarean delivery due to the greatly increased likelihood of placenta accreta and/or placenta percreta (including the likelihood of severe hemorrhage and of permanent urologic damage)." Furthermore "[Carrese] never told [the

plaintiff] of [the option] of having [her] cesarean delivery take place at an appropriate tertiary facility[6] and of having it handled by a team of specialists experienced in dealing with very difficult, potentially life threatening lower abdominal surgery."

In early August 2004, Carrese left the state for a vacation. Prior to departing, Carrese arranged for Yaari to cover his patients. Yaari, too, is a board certified obstetrician-gynecologist. On August 5, 2004, while Carrese was away on vacation, the plaintiff went into labor. She presented to Yaari at the St. Vincent's Medical Center in Bridgeport, thirty-five weeks pregnant, with some vaginal bleeding and uterine contractions.

The plaintiff had been seen by Yaari once before. Specifically, on May 28, 2004, she was seen by Yaari at the Bridgeport Hospital with signs of vaginal bleeding.[7] While the plaintiff was dressed and sitting up on a bed, she informed a nurse that she wanted to leave. The plaintiff signed out "AMA," meaning against medical advice.[8] According to the plaintiff, Yaari never advised her that she had placenta previa nor did Yaari advise the plaintiff **[*12]** that she "probably had placenta accreta or . . . placenta percreta even though he thought this was likely . . ."

Sometime after the plaintiff was admitted to the hospital on August 5, 2004, Yaari suspected and subsequently confirmed that she had placenta previa. Because the plaintiff had previously undergone two cesarean sections, Yaari also suspected that the plaintiff had placenta increta. Yaari tried to stop the contractions and, according to the contemporaneous hospital record, he "explained to the [plaintiff] that there is a good chance that we might need to remove the uterus and there might be damage to the bladder during this kind of operation because of the location of the previous uterine incisions. The [plaintiff] consented. This was also explained to her husband."

In her affidavit in opposition to the defendants' motions for summary judgment, however, the plaintiff states **[*13]** that "Yaari . . . did not advise me of the risks associated with undertaking a cesarean section in the presence of placenta accreta or placenta percreta nor did he tell me anything about my alternatives at that time (or in May 2004), including that of having my cesarean delivery take place at an appropriate tertiary facility and of having it handled by a team of specialists experienced in dealing with very difficult, potentially life-threatening lower abdominal surgery . . . Yaari did not tell me that he suspected that I had placenta accreta or placenta percreta nor did he mention anything about my bladder or my ureters potentially being damaged should he go ahead with the surgery."

The plaintiff signed a consent form giving Yaari permission to perform a "repeat C-Section, Possible Hysterectomy, Possible [illegible]." Specifically, the form states: "My condition, the nature of the above procedure, risks and hazards of the procedure, the benefits of the procedure, any problems related to recuperation, the likelihood of success of the procedure, all viable alternatives to the procedure and the same type of information regarding such alternatives have been explained to my satisfaction **[*14]** by . . . Yaari." Yaari also signed the consent form, affirming that he had provided the information to the plaintiff.

After performing the cesarean section, Yaari discovered that the plaintiff in fact had placenta percreta and that the placenta had invaded the wall of the bladder causing substantial bleeding, requiring a hysterectomy. The contemporaneous hospital record signed by Yaari further states that the plaintiff "was taken to the operating room and a cesarean section was performed. A live baby girl was delivered . . . She weighed 5 pounds and 8 ounces. Because of the severe bleeding that we could not prevent even though the incision on the uterus was in the fundal area, we had to pursue a cesarean hysterectomy. Because of the location of the placenta at the lower level of the uterus, it penetrated the posterior wall of the bladder and this was removed with the uterus

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[6] The term "tertiary" is not defined. According to Yaari's reply memorandum, Dr. Daniel Miller, an expert witness disclosed by the plaintiff, testified in his deposition: "A tertiary care facility is a facility that is a referral center. They have lots of specialists. They handle a lot of types of medicine. They have a big support staff, residents, fellows, and probably the major thing is that they **[*11]** have a referral center. Albany Medical Center in upstate New York, Columbia University, NYU, these are places that have a lot of specialists. And people refer their problem patients to them." However, Yaari fails to attach a copy of the transcript of this testimony. Nonetheless, the plaintiff's arguments embrace this definition.

[7] The record does not disclose why the plaintiff was seen by Yaari rather than Carrese at the Bridgeport Hospital on May 28, 2004.

[8] See e.g., *Tyler v. Tyler*, Superior Court, judicial district of Hartford, Docket No. FA 06 4024421 (July 2, 2008, Simon, J.) (stating that "AMA" means "against medical advice").

and we called for intraoperative urology evaluation. The urology team arrived, headed by Dr. Small, and the patient had later on a reconstruction of the bladder and reimplantation of the one of the ureters."

Additional facts will be set forth as necessary.

I

The court first addresses Carrese's motion for summary judgment. **[*15]** Carrese argues, inter alia, that he had no duty to obtain the plaintiff's informed consent, because he did not perform surgery on her.[9] In her opposition memorandum, the plaintiff asserts that Carrese did have such a duty because he knew for several months that: (1) the plaintiff would have a cesarean section; and (2) the plaintiff had placenta previa that would present complications during delivery. The court agrees with Carrese.

***HN3***[] "A claim **[*16]** of lack of informed consent is an action in negligence." *Hammer v. Mount Sinai Hospital*, 25 Conn.App. 702, 706 n.4, 596 A.2d 1318, cert. denied, 220 Conn. 933, 599 A.2d 384 (1991). ***HN4***[] "The essential elements of a cause of action in negligence, are well established: duty; breach of that duty; causation; and actual injury." (Internal quotation marks omitted.) *Twin Oaks Condo. Ass'n v. Jones*, 132 Conn. App. 8, 12, 30 A.3d 7 (2011). Thus, "[t]he existence of a duty of care is a prerequisite to a finding of negligence." (Internal quotation marks omitted.) *Leon v. DeJesus*, 123 Conn.App. 574, 576, 2 A.3d 956 (2010). "The existence of a duty is a question of law"; *Sic v. Nunan*, 128 Conn.App. 692, 699, 18 A.3d 667, cert. granted on other grounds, 301 Conn. 936, 23 A.3d 729 (2011); "and only if such a duty is found to exist does the trier of fact then determine whether the defendant [breached] that duty in the particular situation at hand." (Internal quotation marks omitted.) *Leon v. DeJesus, supra*, 576. If a defendant owed no duty to a plaintiff with respect to a particular claim of negligence, the defendant is entitled to summary judgment. *Lachowicz v. Rugens*, 119 Conn.App. 866, 989 A.2d 651, **[*17]** cert. denied, 297 Conn. 901, 994 A.2d 1287 (2010).

Resolution of this issue is informed by two Connecticut Supreme Court cases addressing whether a referring physician has a duty to obtain a patient's informed consent. In *Logan v. Greenwich Hospital Asso.*, 191 Conn. 282, 465 A.2d 294 (1983), the seminal case in Connecticut on informed consent, a plaintiff commenced a medical malpractice action against an internist, a urologist, a radiologist, and a hospital. *Id.*, 284-87. The plaintiff suffered injuries after her gallbladder was punctured during a closed needle kidney biopsy. *Id.* An internist had informed the plaintiff that she had lupus and advised her to undergo the biopsy in order to determine the extent of lupus involvement in her kidneys. *Id.*, 284-85. The internist described generally the operative procedure to the plaintiff and informed her of some of the risks. *Id.*, 285. However, the internist never mentioned the danger of her gall bladder being punctured. *Id.* Another physician performed the biopsy.

At trial, the plaintiff claimed that the internist failed to obtain her informed consent for the biopsy. *Id.*, 287. After the plaintiff rested her case at trial, the internist moved **[*18]** for a directed verdict. *Id.*, 284. The court denied the motion and submitted the case to a jury. *Id.* The jury returned a verdict in favor of the internist and the plaintiff appealed. *Id.* On appeal, the Supreme Court determined that the trial court should have granted the internist's motion for a directed verdict. *Id.*, 304. The court observed: "Although it is undisputed that [the internist] did discuss the kidney biopsy with the plaintiff and describe the procedure generally, there was no evidence that it was his duty to do so. In fact, the testimony indicated the contrary. The plaintiff's expert witness . . . testified that an internist . . . had no obligation to discuss the surgical procedure with the plaintiff or to obtain her informed consent. He stated unequivocally that those duties rested upon the physician who was to perform the operation." *Id.*, 305. "We hold that under the circumstances of this case [the internist], as the referring physician, had no obligation to inform the plaintiff of viable alternative procedures but might reasonably have relied upon [the urologist] . . . to provide such information." *Id.*, 305-06.

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[9] Carrese also makes the following arguments: (1) The plaintiff has not pleaded a cause of action based on lack of informed consent, but rather has only pleaded an action sounding in medical negligence; and (2) the plaintiff has failed to disclose an expert to testify on the existence of any medical risks or alternatives. Moreover, the plaintiff sets forth the following additional arguments: (1) Carrese's claim that the plaintiff did not plead a lack of informed consent cause of action should have been addressed by a request to revise; and (2) expert testimony is not required for a claim of lack of informed consent. Because the court holds that Carrese had no duty to obtain the plaintiff's informed consent, the court does not address these arguments.

In *Petriello v. Kalman*, 215 Conn. 377, 576 A.2d 474 (1990), **[*19]** a plaintiff commenced a medical malpractice action against two defendants, a physician and a hospital. *Id.*, 378. Specifically, the physician told the plaintiff that he intended to perform a dilatation and curettage after concluding that the plaintiff's fetus died. *Id.*, 379. A nurse employed by the hospital administered medication to the plaintiff without authorization from the physician and without the plaintiff's informed consent. *Id.* Later, while the plaintiff was under the effects of the medication, the plaintiff signed an informed consent form and the physician performed the operation. *Id.*, 380. During the operation, the physician perforated the plaintiff's uterus and drew portions of small intestine through the perforation. *Id.* Subsequently, the plaintiff sued the hospital alleging "that the hospital was negligent . . . by permitting [the physician] to perform the surgical procedure without having first obtained her informed consent . . . and . . . by failing to obtain the plaintiff's informed consent itself, before [the physician] performed the surgical procedure." *Id.*, 382. At the close of the evidence, the trial court granted the hospital's motion for a directed verdict. *Id.*

On **[*20]** appeal, the Supreme Court first considered the plaintiff's claim that the hospital had a duty to obtain her informed consent before allowing the physician to perform the operation. *Id.*, 382-85. At the outset, the court stated that it previously addressed a similar issue in *Logan*, "a case in which [the Supreme Court] concluded that ***HN5***[↑] a referring physician, who had not participated in the actual surgical procedure, had no duty to ensure that his patient had given her informed consent to that procedure when the surgery had been performed by another physician. [The Supreme Court] held . . . that under the circumstances of [that] case [the doctor], as the referring physician, had no obligation to inform the plaintiff of viable alternative procedures but might reasonably have relied upon [another physician], the specialist, to provide such information." (Internal quotation marks omitted.) *Id.*, 384.

The Supreme Court in *Petriello* continued: "In *Logan*, we also upheld the direction of a verdict for the hospital with respect to claims of corporate negligence that included an allegation of failure of the hospital to obtain the plaintiff's informed consent to the operation. No testimony was presented **[*21]** to indicate that reasonably prudent hospital practice imposed any duty upon this defendant to supervise the physicians who participated in the operation in any of the respects claimed . . . Implicitly we rejected the claim that a hospital has a duty with respect to obtaining a patient's informed consent for a surgical procedure to be performed by a nonemployee physician. *Since, in this case, there was no evidence of any involvement by a physician employed by the hospital prior to the start of the surgical procedure* and since the plaintiff does not claim it was the duty of the nurse actually to obtain the plaintiff's informed consent prior to administering the preoperative medication, ***HN6***[↑] *the duty to obtain such consent, prior to beginning the surgical procedure, rested wholly upon [the physician], the plaintiff's attending physician.*" (Citation omitted; emphasis added; internal quotation marks omitted.) *Id.*, 384-85; see also *Sherwood v. Danbury Hospital*, 278 Conn. 163, 171 n.8, 192, 194, 896 A.2d 777 (2006) (duty to inform a patient of risks of blood transfusion is owed by a physician performing the surgery and him "alone"); *Wright v. Hutt*, 50 Conn.App. 439, 453-54, 718 A.2d 969, cert. **[*22]** denied, 247 Conn. 939, 723 A.2d 320 (1998) (any possible confusion caused by a court allowing a defendant to question a plaintiff's referring physician in connection with whether the referring physician advised the plaintiff against the surgery was remedied by the court "clearly instructing the jury that the duty to obtain informed consent rested solely with the defendant [surgeon]"); accord *Glover v. Griffin Health Services*, Superior Court, complex litigation docket at Waterbury, Docket No. X06 CV 05 5001692 (June 21, 2006, Stevens, J.) (41 Conn. L. Rptr. 527, 2006 Conn. Super. LEXIS 1841); *Thompson v. Saint Francis Hospital & Medical Center*, Superior Court, judicial district of Hartford, Docket No. CV 97 0568065, 2000 Conn. Super. LEXIS 3321 (November 27, 2000, Beach, J.) (29 Conn. L. Rptr. 343); *Daley v. Sava*, Superior court, judicial district of Stamford-Norwalk at Stamford, Docket No. CV 92 0121524 (May 23, 1995, Lewis, J.) (14 Conn. L. Rptr. 314, 315, 1995 Conn. Super. LEXIS 1530) ("[b]ecause [a defendant's] services were purely for consultation [and to provide a second opinion], and [the defendant] had no involvement with the actual surgical procedure, [the defendant] had no duty to obtain the plaintiff's informed consent"); *Weidl v. Gfeller*, Superior Court, judicial district of Hartford-New Britain at Hartford, No. CV 88 0351404, 1992 Conn. Super. LEXIS 2665 (Sept. 3, 1992, Burns, J.) **[*23]** ("the general rule is that the duty of obtaining [a] patient's informed consent rests only on the physician performing a medical procedure on the patient"); 3 D. Louisell & H. Williams, Medical Malpractice (2001) §22.07, p. 30 ("[g]enerally, the responsibility for making the proper disclosure rests with the attending physician . . . [although] [t]his task may be delegated to an assistant . . . In the case of surgical procedures, generally it is the principal surgeon rather than those assisting who is responsible for obtaining informed consent").

Outside of Connecticut, "the majority of jurisdictions that have addressed whether referring physicians have a duty to obtain a patient's informed consent have concluded that they do not. See . . . *Stovall v. Harms*, 214 Kan. 835, 522 P.2d 353, 359 (1974) (in the absence of unusual circumstances a general practitioner who referred a patient to a psychiatric specialist had no duty to advise patient of risks and dangers incident to psychiatric treatment); *Davis v. St. Charles [General Hospital]*, 598 So.2d 1244,

1246 [(La.App. 1992)] (only the medical professional **[*24]** actually performing the procedure, not the referring physician, must provide informed consent); *Herrara v. Atlantic City Surgical Group*, 277 N.J. Super. 260, 649 A.2d 637, 641 (1994) (treating physician, not referring physician, had duty to explain options and risks involved in course of treatment); *Shaw v. Kirschbaum*, 439 Pa.Super. 24, 653 A.2d 12, 17 (1994) (referring physician has no duty to provide information to patient to aid patient in giving informed consent to surgeon); *Johnson v. Whitehurst*, 652 S.W.2d 441, 445 [(Tex.App. 1983)] (doctor who did not participate in surgery had no duty to inform appellant of possible risks and complications).

"Where courts have imposed a duty on referring physicians to obtain a patient's informed consent, the referring physician has retained a degree of participation and control in that . . . treatment." *Bottemiller v. Gentle Dental Service Corp*., Washington Court of Appeals, Division Two, Docket No. 26838-8-*Bottemiller v. Gentle Dental Service Corp*., Washington Court of Appeals, Division Two, Docket No. 26838-8-II, 2002 Wash. App. LEXIS 3193 (December 31, 2002); see also *Rosado v. Miller*, 22 Misc.3d 1124[A], 880 N.Y.S.2d 876, 2009 NY Slip Op 50271[U] (2009) ("courts generally have refused to impose liability for lack of informed consent upon surgical assistants or physicians who neither order nor performed **[*25]** the subject procedure" [internal quotation marks omitted]); *Squyres v. Our Lady of Lourdes Regional Medical Center, Inc*., 954 So. 2d 897, 902 (La.App. 2007) (per statute); *Koapke v. Herfendal*, 2003 ND 64, 660 N.W.2d 206, 214 (N.D. 2003) ("[a] referring physician can be held liable only when that physician has formally ordered a procedure or actually participated in the treatment or procedure"); *Billebault v. DiBattiste*, United States District Court, Docket No. 96-6501, 1998 U.S. Dist. LEXIS 7399 (E.D.Pa. May 19, 1998) ("[u]nder Pennsylvania law, the doctrine of informed consent generally applies only to [a] surgeon who performs an operation without first obtaining the informed consent of [a] patient"); *Nisenholtz v. Mount Sinai Hospital*, 126 Misc.2d 658, 663, 483 N.Y.S.2d 568 (1984) ("a physician who merely refers a patient to another doctor does not become liable should that second doctor perform surgery without informed consent").

Here, Carrese was not even a referring physician. The plaintiff does not dispute that Carrese neither performed nor participated in the plaintiff's cesarean hysterectomy. Therefore, Carrese had no duty to obtain the plaintiff's informed consent. Carrese's motion for summary judgment is granted.[10]

II

The court turns to Yaari's **[*27]** motion for summary judgment. Yaari argues that (1) the plaintiff's claim of lack of informed consent is barred by the emergency doctrine, (2) the plaintiff's informed consent was not necessary because there was no alternative to a cesarean hysterectomy, (3) the plaintiff fails to state a claim upon which relief can be granted because she fails to allege that the failure to adequately advise her was the proximate cause of her injuries, (4) there was no need for him to obtain the plaintiff's informed consent since, having had two prior cesarean sections, she already was aware of the risks of that procedure, and (5) he obtained the plaintiff's informed consent prior to operating on her.

The plaintiff argues that (1) there is no emergency exception to informed consent in Connecticut, (2) she has adequately alleged that the failure to obtain her informed consent caused her injuries, (3) Dr. Yaari failed to advise the plaintiff that she had placenta accreta or that she had the option of having her cesarean hysterectomy at a tertiary facility with a team of experts present, including a urologist and a gynecologist oncologist.

A.

The court first addresses Yaari's claim that he was excused from **[*28]** obtaining the plaintiff's informed consent by virtue of the "emergency exception" to the rule of informed consent. The plaintiff contends that no such exception exists. The court concludes that, assuming such an exception exists, there is a genuine issue of material fact as to its applicability.

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[10] At **[*26]** oral argument, the plaintiff stated briefly that Yaari was Carrese's agent, as Carrese arranged for Yaari to cover for him while he was away. The revised complaint is devoid of this allegation. A complaint must allege facts giving rise to an agency relationship. *Hollister v. Thomas*, 110 Conn.App. 692, 705-07, 955 A.2d 1212, cert. denied, 289 Conn. 956, 961 A.2d 419 (2008). As the Florida Supreme Court has held, applying pleading rules similar to those of the Connecticut Practice Book, a physician cannot be found liable for the medical negligence of a covering physician under a theory of vicarious liability that is not specifically pled. *Goldschmidt v. Holman*, 571 So.2d 422, 423 (Fla. 1990). Moreover, absent evidence that a physician has the right to control the covering physician, the latter is not the agent of the former. *Hall v. Frankel*, 190 P.3d 852, 860-61 (Colo.App. 2008); see also annot., "Liability of One Physician or Surgeon for Malpractice of Another," 397 Pa. 28, 153 A.2d 255, 85 A.L.R.2d 889 (1962) (discussing whether an attending physician is liable for the acts of a covering physician, who is acting as an agent). Nothing in the record suggests such right of control.

There is no genuine issue of material fact that placenta percreta is a life-threatening condition. Nor is there any question that the plaintiff's life was threatened by the condition. She lost a large amount of blood at St. Vincent's Medical Center, requiring a transfusion of nine units of blood.

Whether there is an emergency exception to the doctrine of informed consent has received little consideration in Connecticut case law. As the defendant Yaari observes, there is a statute providing an emergency exception for medical or surgical procedures, General Statutes §17a-543. However, that statute applies only to persons being treated in "any inpatient or outpatient hospital, clinic or other facility, for the diagnosis, observation or treatment of persons with psychiatric disabilities." General Statutes §17a-540. ***HN7***[] "We must construe the act as we find it, without reference to whether we think it **[*29]** would have been or could be improved by the inclusion of other provisions . . . Courts may not by construction supply omissions in a statute, or add exceptions merely because it appears to them that good reasons exist for adding them." (Internal quotation marks omitted.) *State v. Nelson*, 126 Conn. 412, 416, 11 A.2d 856 (1940).

The court need not determine whether §17a-540 was intended to be merely declaratory of the common law nor whether Connecticut recognizes an emergency exception to the doctrine of informed consent because, assuming there is such an exception, there is a genuine issue of material fact as to whether the exception applies here.

"The emergency exception to the informed consent doctrine has been widely recognized and its component elements broadly described." *Shine v. Vega*, 429 Mass. 456, 464, 709 N.E.2d 58 (1999). "The emergency exception has deep roots in the common law. See *Schloendorff v. Soc'y of N.Y. Hosp.*, 211 N.Y. 125, 129-30, 105 N.E. 92 (1914) ("Every human being of adult years and sound mind has a right to determine what shall be done with his own body . . . except in cases of emergency where the patient is unconscious and where it is necessary to operate **[*30]** before consent can be obtained" (emphasis added) (citations omitted), overruled in part on other grounds by *Bing v. Thunig*, 2 N.Y.2d 656, 143 N.E.2d 3, 163 N.Y.S.2d 3 (1957); Restatement (Second) of Torts §892D (1979) (a person is privileged to act without consent in order to prevent harm to another when an emergency makes it infeasible to obtain consent). It is based on the impracticality of having an adequate, informed consent discussion in the midst of a medical emergency, and the importance of allowing a physician to maintain focus on providing lifesaving treatment to the patient. See *Canterbury v. Spence*, 150 U.S.App.D.C. 263, 464 F.2d 772, 788-89 (1972) [cert. denied, 409 U.S. 1064, 93 S.Ct. 560, 34 L.Ed.2d 518 (1972)]. The presumption underlying the emergency exception is that the harm from a failure to treat outweighs any harm threatened by the proposed treatment. *Id.* at 789." *Stewart-Graves v. Vaughn*, 162 Wn.2d 115, 123-24, 170 P.3d 1151 (2007). Indeed, *Canterbury v. Spence*, *supra*, a leading case on informed consent and the emergency exception to it, was cited by the Connecticut Supreme Court in its seminal case on informed consent, *Logan v. Greenwich Hospital Association*, 191 Conn. 282, 291-92, 465 A.2d 294 (1983). **[*31]** The exception has also been codified by statute in several states.

Several formulations of the emergency exception have been articulated in the various jurisdictions. One authority fairly summarizes the essential elements of the exception as follows: "(1) there was a medical emergency; (2) treatment was required in order to protect the patient's health; (3) it was impossible or impractical, to obtain consent from either the patient or someone authorized to consent for the patient; and (4) there was no reason to believe that the patient would decline the treatment, given the opportunity to consent." 4 Louiselle & Williams, Medical Malpractice, op cit. §2202[2][a].

It is unnecessary to determine whether there is or should be an emergency exception to the informed consent doctrine in Connecticut and, if so, what its precise contours are. There is a genuine issue of material fact as to whether it was impossible or impractical to obtain consent from the plaintiff because Yaari in fact *did* have the plaintiff sign an informed consent form. In light of this fact, Yaari cannot be heard to claim that there is no genuine issue of fact that the plaintiff was unable to receive the necessary information **[*32]** and give her informed consent.

B.

The court briefly discusses certain other arguments of the defendant Yaari in support of his motion for summary judgment.

Yaari argues that informed consent was not necessary because there was no alternative to a cesarean hysterectomy. First, "[t]he Supreme Court of the United States has recognized that ***HN8***[] a competent individual has the right to refuse life-saving medical treatment. *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261, 110 S. Ct. 2841, 111 L. Ed. 2d 224 (1990); see also *Washington v. Glucksberg*, 521 U.S. 702, 117 S.Ct. 2258, 117 S. Ct. 2302, 138 L.Ed.2d 772 (1997)." *Lantz v. Coleman*, Superior Court, judicial district of Hartford, No. HHD CV 084034912 (March 9, 2010, Graham, J.) [49 Conn. L. Rptr. 560,

2010 Conn. Super. LEXIS 621]. Therefore, there was an option to the procedure, refusal. Second, however, this argument misses the point. The plaintiff does *not* claim that she would have chosen not to have the hysterectomy, but that she should have been advised that it could better be done at another facility with other doctors present.

Yaari argues that the plaintiff fails to state a claim of informed consent upon which relief can be granted because she fails to allege that the failure **[*33]** to adequately advise her was the proximate cause of her injuries. ***HN9***[] "Construction of pleadings is a question of law." *Kovacs Construction Corp. v. Water Pollution & Control Authority*, 120 Conn.App. 646, 659, 992 A.2d 1157, cert. denied, 297 Conn. 912, 995 A.2d 639 (2010). "Pleadings should be read broadly and realistically, and not narrowly and technically." *LeConche v. Elligers*, 215 Conn. 701, 716, 579 A.2d 1 (1990). The plaintiff's allegation of lack of informed consent is contained in a paragraph which lists her specifications of medical negligence against Yaari. That paragraph begins with the words: "The plaintiff's injuries were caused by the negligence of the defendant, Yaari, in one or more of the following respects . . ." The court concludes that the plaintiff has adequately alleged that the failure to obtain her informed consent was the proximate cause of her injuries. See *Lombardi v. J.A. Bergren Dairy Farms, Inc*., 153 Conn. 19, 22-23, 213 A.2d 449 (1965).

Yaari claims that there was no need for him to obtain the plaintiff's informed consent since, having had two prior cesarean sections, she already was aware of the risks of that procedure. However, the defendant does not claim **[*34]** that the plaintiff was informed in those two prior occasions that she might have a cesarean hysterectomy and that she had the option of having it at another facility with other doctors present.

C.

The court turns to the plaintiff's principal claim against Yaari. Yaari argues that there is no genuine issue of material fact that he disclosed all material risks to the plaintiff. The plaintiff, on the other hand, argues that Yaari had a duty to advise her of the option of having a cesarean hysterectomy at a tertiary facility, with other doctors present, including a urologist and a gynecologist oncologist.[11] Yaari argues that he had no such duty under the law of informed consent. The court agrees with Yaari.

In her complaint, the plaintiff alleges that the defendant Yaari "failed to adequately **[*35]** advise the plaintiff of the risk that her bladder would be injured during the cesarean section and/or related procedures and failed to warn her and obtain, of which she was unaware, that she had a substantially elevated likelihood of suffering massive bleeding due to a likely placenta accreta and/or placenta percreta which could lead to damage to her urinary tract, including to her ureters if the surgeon had to become involved, during the cesarian section, in attempting to separate her placenta from adjoining organs and in attempting to achieve hemostasis, thereby depriving her of the choice to seek the intervention of *physicians more experienced in and/or specializing* in dealing with this type of condition . . ." (Emphasis added.)

Preliminarily, it is important to emphasize that there is no genuine issue of material fact that the plaintiff would have undergone a cesarian hysterectomy. She said so through her counsel.[12] (These remarks were made against the backdrop of a record that

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[11] At oral argument on the defendants' motions, the plaintiff clarified that the crux of her claim was not that she would not have had a cesarean section or a hysterectomy if provided with additional information, but rather that she should have been told that the procedure should have been completed at a "tertiary facility," by a more skilled surgeon, with a team of specialists present. See footnote 12.

[12] The following are remarks of the plaintiff's attorney at the hearing on the defendants' motions for summary judgment.

> ATTY. PERKINS: Thank you, your Honor. Your Honor, as to the-just addressing quickly the informed-sorry, the consent form that the defendant, Dr. Yaari has provided a copy of it, Exhibit C to his memorandum in support of the motion for summary judgment, all it says is repeat c-section and possible hysterectomy. It says something else, possible greater, I can't read the words, but it says nothing, your Honor, and the testimony is, and we've provided that in our second and third supplement filed today, and we've alluded to a fair amount of it in the-the brief we filed about a week and a half ago.
>
> There's-at no time did Dr. Yaari tell this **[*37]** young lady that because she'd had multiple prior c-sections and had a placenta previa, she was at a substantially increased risk of suffering from placenta percreta and/or placenta accreta. Placenta percreta is a more advanced or complicated version. And in fact, she did suffer from placenta percreta. And he never had a percreta or accreta discussion with her ever, your Honor. This is not withstanding that-
>
> THE COURT: What would have changed if she had?

leaves little doubt that the procedure was necessary to save the plaintiff's life.[13]) Therefore, all specifications of the plaintiff's claim of lack of informed consent against Yaari except the last lack **[*36]** a causal connection to any possible injury sustained

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ATTY. PERKINS: Pardon me?

THE COURT: What would have changed if she had?

ATTY. PERKINS: What would have changed, your Honor, firstly, in May of 2004, she was at Bridgeport Hospital. Dr. Yaari was again covering for Dr. Carrese and was the responsible physician. We've attached that record, I believe at Exhibit A to our papers today. And the hospital says that suspected placenta previa, will tell Dr. Yaari when he calls in an hour, something to that effect.

And so that he knew so many months before the delivery, it is our position, and it certainly is an issue of fact on this, at least that she had a placenta previa condition, and he knew about her prior c-sections. Under those circumstances, we've put some stuff in here from a number of experts, **[*38]** your Honor. What our experts are saying-were saying is that well, certainly she should have been given the risks and the alternatives to that. One of those alternatives, your Honor, was-

THE COURT: This is alternatives to what?

ATTY. PERKINS: To-I'm sorry, to having Dr. Carrese and/or Dr. Yaari perform this cesarean section, cesarean section hysterectomy. A lot of them are saying, and most-certainly all the plaintiff's experts and a number of the defendant's experts, that it would have been preferable to have an experienced general pelvic surgeon. It's very unusual occurrence, this placenta accreta, in the life of an-of an obstetrician gynecologist. And it's-it's the plaintiff's position that she would have liked to have known that she was in an elevated risk of suffering lower urinary tract injury and that she could have gone and she would like to have known the alternative of going to, and having present, an experienced, let's say, gynecological oncologist to this procedure on her. When-

THE COURT: Gynecological oncologist, did you say?

ATTY. PERKINS: Yes. Yes, your Honor, in other words, a doctor who specializes in complicated lower urinary tract surgeries, for example, So, rather-and **[*39]** she could have, if she'd known, if this had been brought to her attention, it could have-you know, she could have had an alternative of having somebody who specializes in this kind of complicated condition deal with it. In fact, she was told nothing about it. She only found about placenta precreta, placenta accreta after the delivery. They told her nothing about it.

And in fact, Dr. Boehm, Dr. Yaari's expert, says that Dr. Yaari knew ahead of time or suspected strongly that she had an accreta. And Dr.-Dr. Richardson, one of the plaintiff's experts, testified that, in fact, he suspected that she-oh, testified that Dr. Yaari did anticipate on August 5th, before the delivery was attempted, there was a placenta accreta and/or percreta present, and that urologic injury could occur during the procedure.

And that because of knowing about it ahead of time, he, quote, he had the luxury of time. In other words, we don't accept that there is an emergency exception, your Honor. I believe that all that the defendant has cited to on this issue is a state regulation, it's not a statute, that simply says that hospitals should make sure that doctors get informed consent. That's essentially what that **[*40]** regulation says. It doesn't say anything about doctors don't have to get informed consent if there's an emergency.

But beyond that, it's our position, your Honor, that there was not an emergency, that she-there was sufficient time for her to give informed consent, to have a discussion about possible bladder injury, about possible urethral injury, about an option of having a urologist or a gynecological oncologist deal with the procedure. She wasn't given any of these options. She was not told the risks. She was not told the alternatives. And, your Honor, it's the plaintiff's position that that's exactly what informed consent is about. She should have been told of these risks and alternatives, and she was not. Was not told the risks. She was not told the alternatives. And, your Honor, it's the plaintiff's position that that's exactly what informed consent is about. She should have been told of these risks and alternatives, and she was not.

THE COURT: What-other than getting a-what other alternatives were there, again, other than you mentioned an experience pelvic surgeon or gynecological oncologist?

ATTY. PERKINS: She would have, your Honor, have had to undergo an operation where her uterus **[*41]** was removed. She would have had to undergo a hysterectomy. But, your Honor, it is our view that had she been given this option of going with someone who knew what he was doing and did this as a specialist, she would not be permanently unable to use the bathroom today. She wasn't given that option because she wasn't told about it.

(Emphasis added.)

[13] In the deposition of Dr. Frederick Rau, an obstetrician-gynecologist, the following exchange occurred:

by the plaintiff. Additionally, there is no allegation nor any evidence that Yaari was not competent to perform the procedure. It is the final specification of the plaintiff's claim of lack of informed consent-that Yaari "depriv[ed] her of the choice to seek the intervention of physicians more experienced in and/or specializing in dealing with this type of condition"-that is at issue.

As observed *supra*, ***HN10***[⬆] "[i]n order to prevail on a cause of action for lack of informed consent, a plaintiff must prove both that there was a failure to disclose a known material risk of a proposed procedure and that such failure was a proximate cause of his injury. Unlike a medical malpractice claim, a claim for lack of informed consent is determined by a lay standard of materiality, rather than an expert medical standard of care which guides the trier of fact in its determination." *Shortell v. Cavanagh*, *supra*, 300 Conn. 388. "[T]he . . . elements that must be addressed in the physician's **[*43]** disclosure to the patient in order to obtain valid informed consent . . . involves four specific factors: (1) the nature of the procedure; (2) the risks and hazards of the procedure; (3) the alternatives to the procedure; and (4) the anticipated benefits of the procedure." (Internal quotation marks omitted.) *Duffy v. Flagg*, *supra*, 279 Conn. 692.

The Supreme Court has adopted an objective standard in order to determine the materiality of risk. Specifically, ***HN11***[⬆] "the lay standard of informed consent requires a physician to provide the patient with that information which a *reasonable* patient would have found material for making a decision whether to embark upon a contemplated course of therapy." (Emphasis in original; internal quotation marks omitted.) *Id.* "Materiality may be said to be the significance a reasonable person, in what the physician knows or should know is his patient's position, would attach to the disclosed risk or risks in deciding whether to submit or not to submit to surgery or treatment." (Internal quotation marks omitted.) *Logan v. Greenwich Hospital Assn.*, *supra*, 191 Conn. 291.

In a literal sense, the plaintiff's "informed consent" claim has little to do with any known **[*44]** material risk of a cesarean hysterectomy. She concedes that she would have undergone the procedure. Her claim is that Yaari should have informed her that she could "seek the intervention of physicians more experienced in and/or specializing in dealing with this type of condition."

No Connecticut case has addressed a claim closely analogous to this. However, two appellate cases, *Duffy v. Flagg*, *supra*, 279 Conn. 682, and *DeGennaro v. Tandon*, 89 Conn.App. 183, 873 A.2d 191, cert. denied, 274 Conn. 914, 879 A.2d 892 (2005), inform the resolution of the plaintiff's claim. In *Duffy*, "[d]uring the course of her prenatal care for her second child, the plaintiff discussed with [the defendant] Flagg and other members of [Flagg's obstetric group] the possibility of having her second child born vaginally despite the fact that her first child had been delivered by cesarean section. During these discussions, the defendants informed the plaintiff of the risks of the procedure known as 'vaginal birth after cesarean section,' including the risk of uterine rupture and the possibility of a resulting risk of death to the plaintiff and her infant. On one occasion, while discussing the procedure with Flagg, **[*45]** the plaintiff asked Flagg whether she had encountered any

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> Q. And in reviewing all the records, have you developed any opinions as to whether or not . . . Yaari conformed to the standard of care in his care and treatment of [the plaintiff] in this particular situation?
>
> A. I believe that . . . Yaari did conform to the standard of care in this very difficult situation . . . I don't think he had any choice but to proceed with the operation, perform the cesarean hysterectomy, and then manage the bleeding and urologic issues after the hysterectomy.

(Emphasis added.)

> Yaari submitted a portion of an uncertified deposition transcript of Dr. Jeffrey Richardson, an obstetrician-gynecologist, who testified that the hysterectomy saved the plaintiff's life. The pertinent deposition testimony is as follows:
>
> Q. Okay. **[*42]** Did the hysterectomy that was done in this case save [the plaintiff's] [life]? "Attorney Perkins. Object to form.
>
> A. I would say the hysterectomy saved her [life].
>
> Additionally, *the plaintiff* submits a portion of an certified deposition transcript of Dr. Frank Boehm, an obstetrician-gynecologist, who testified that the circumstances of the plaintiff's case constituted a life threatening situation. The pertinent deposition testimony is as follows:
>
> A. [T]his is a life threatening situation, placenta percreta with a previa. The amount of blood loss was obviously enormous; the [plaintiff] received nine units of blood.

difficulty in her prior vaginal birth after cesarean section deliveries. Flagg responded that there had been 'a bad outcome' because of a uterine rupture. The plaintiff did not inquire further about the result of the uterine rupture, and Flagg did not tell the plaintiff that the infant had died as a result of that uterine rupture. The plaintiff thereafter decided to attempt a vaginal birth after cesarean delivery and executed written consent forms therefor, which specifically detailed the nature, risks, alternatives and benefits of the procedure." *Duffy v. Flagg*, *supra*, 685. During delivery, the plaintiff suffered a uterine rupture and her child subsequently died. She sued the defendants, alleging both medical malpractice and lack of informed consent. *Id.*, 686. The defendants "filed a motion in limine seeking to exclude all evidence related to the fact that Flagg previously had encountered a uterine rupture during an attempted vaginal birth after cesarean section delivery, including the existence of a lawsuit against Flagg for the death of the infant that resulted from that attempt, and all testimony from or reference to the **[*46]** former patient involved in that delivery." *Id.*, 686. The trial court granted the motion.

On appeal, the Supreme Court upheld the action of the trial court, stating, "The plaintiff's contention, that Flagg's prior experience with vaginal birth after cesarean section became relevant to informed consent because the plaintiff asked about Flagg's experience, is at variance with two fundamental principles of our informed consent jurisprudence in this state. First, the claim runs afoul of our adoption and consistent application of an objective standard of disclosure. ***HN12***[↑] We do not require a physician to disclose information that a particular patient might deem material to his or her decision, but, rather, limit the information to be disclosed to that which a reasonable patient would find material. *Second, the information that the plaintiff sought to admit into evidence did not relate to any of the four specific factors encompassed by informed consent as we have defined it. Before granting the defendants' motion in limine, the trial court in the present case carefully ascertained that the plaintiff did not claim, and was not offering any evidence that, Flagg's prior experience with vaginal birth **[*47]** after cesarean section increased the risks or hazards of that procedure for the plaintiff. The evidence therefore had no relevance to any of the four established elements of informed consent in this state*." (Emphasis added.) *Id.*, 693.

The court explained further: "Our conclusion and reasoning are supported by the decisions of courts in several other states. The Supreme Court of Pennsylvania addressed this same issue in *Duttry v. Patterson*, [565 Pa. 130, 771 A.2d 1255 (2001)]. In *Duttry*, the plaintiff brought an action against her physician alleging medical malpractice and lack of informed consent. *Id.*, 133. At trial, the plaintiff sought to introduce evidence demonstrating that the physician had misrepresented his experience with a certain medical procedure when he responded to the plaintiff's inquiry during a presurgery consultation. *Id.* The Pennsylvania Supreme Court upheld the trial court's ruling that the evidence concerning the physician's prior experience performing the procedure was inadmissible because ***HN13***[↑] 'information personal to the physician, whether solicited by the patient or not, is irrelevant to the doctrine of informed consent.' *Id.*, 137. The court acknowledged that the **[*48]** doctrine of informed consent 'clearly focuses on imparting information relative only to the surgery itself'; *id.*, 136; and reaffirmed that '[t]his is an objective, rather than subjective analysis; its calculus does not shift depending on how inquisitive or passive the particular patient is.' *Id.*, 136-37. Indeed, the court cautioned that making evidence related to the physician's personal experience relevant whenever a particular patient requests such information is 'highly problematic' and 'divorced from the fundamental principle of the informed consent doctrine that information is material to the procedure at hand, and therefore must be divulged in order to obtain the patient's informed consent, if a reasonable person would wish to know it.' *Id.*, 136; see also *Wlosinski v. Cohn*, 269 Mich.App. 303, 308, 713 N.W.2d 16 (2005) ('physician has no duty to disclose to a patient the physician's success rates for a particular medical procedure, and [the physician's] failure to advise the decedent of his success rates could not, as a matter of law, taint the patient's consent'); *Whiteside v. Lukson*, 89 Wn. App. 109, 112, 947 P.2d 1263 (1997) (holding that physician does not have duty to disclose to patient information about physician's experience in performing proposed procedure in order to obtain patient's informed consent). We agree with the reasoning of these courts . . ." (Footnote omitted.) *Id.*, 693-94.

The **[*49]** plaintiff contends that *DeGennaro v. Tandon*, *supra*, 89 Conn.App. 183, supports her claim that Yaari should have disclosed that there were better facilities or better doctors to perform the cesarean hysterectomy. Yaari argues that *DeGennaro* is distinguishable. The court agrees with Yaari.

In *DeGennaro*, the plaintiff had a toothache and scheduled an appointment with the defendant dentist, who had purchased the practice from the plaintiff's regular dentist. *Id.*, 185. The defendant "told the plaintiff that she was going to remove the plaintiff's old filling and replace it with a medicated filling." *Id.*, 186. "In order to drill the plaintiff's tooth . . the defendant used some of the equipment she had purchased from the dental practice. Specifically, the defendant used a twenty to twenty-five year old unit to power the drill. This unit . . . had several components to it. One component was a hose to which the defendant could connect her drill, and the unit would provide the power to the drill. Another part of the unit provided suction. The suction

for this unit, however, was not dependable, something which was known widely throughout the dental community. In order to compensate for the unit's **[*50]** failings, the defendant brought in a separate portable suction unit to use on the plaintiff. She threaded the hose of this suction device through a tongue guard . . . which enabled the defendant both to guard the plaintiff's tongue from injury and to suction excess saliva from the plaintiff's mouth at the same time. The defendant could not recollect having any training or previous experience with either the [old unit or the tongue guard] prior to using both on the plaintiff at the March 19, 1997 appointment. The defendant did not inform the plaintiff that she had not used this equipment before, nor did she inform the plaintiff that she usually had an assistant present when performing this type of procedure." *Id*., 186-87. The plaintiff developed serious complications and sued the defendant based on medical negligence and lack of informed consent. *Id*., 187-88. "The plaintiff's lack of informed consent claim rested solely on the defendant's failure to inform the plaintiff of her lack of experience with the equipment she used on the plaintiff, her lack of readiness to treat the plaintiff and her lack of staff to aid her in the procedure." *Id*., 188. The jury found in the plaintiff's favor **[*51]** and the defendant appealed, claiming, *inter alia*, that there was insufficient evidence for the jury to find that she failed to inform the plaintiff of all material risks of the procedure.

The Appellate Court concluded that there was sufficient evidence for the jury to determine that there was a lack of informed consent when the defendant dentist failed to disclose such "provider specific" information to the plaintiff. *Id*., 197. Specifically, the defendant failed to inform the plaintiff of her inexperience with certain equipment that was used in the procedure to be performed on the plaintiff, that the defendant usually had an assistant present during this type of procedure, but would not have one present during the plaintiff's procedure, and that the defendant's office was not officially open for business at the time the procedure was performed. *Id*., 185-87. In ruling as it did, the Appellate Court concluded that such information should not be excluded from the dentist's duty to inform "simply because that information was provider specific as opposed to procedure specific." *Id*., 191.

The court agrees with Yaari that *DeGennaro* is distinguishable. First, unlike the plaintiff in *DeGennaro*, **[*52]** the plaintiff here concedes that she would have had a cesarean hysterectomy, the procedure during which her bladder was injured but without which she would have continued bleeding. The plaintiff in *DeGennaro*, who was treated by the defendant for a toothache at a scheduled appointment, could have opted not to have her toothache treated at all. The plaintiff here had no such option. Second, and more telling, in *DeGennaro* the plaintiff complained that the defendant failed to inform her "of her inexperience with certain equipment that was used in the procedure to be performed on the plaintiff, that the defendant usually had an assistant present during this type of procedure, but would not have one present during the plaintiff's procedure, and that the defendant's office was not officially open for business at the time the procedure was performed." As the Supreme Court stated in *Duffy v. Flagg*, *supra*, 279 Conn. 682, in distinguishing its holding in that case from the holding in *DeGennaro*: "In *DeGennaro*, the provider specific information was related to the 'the risks posed by the circumstances under which the defendant performed the procedure' and was therefore relevant to one of the four **[*53]** established elements of informed consent in this state. *Id*., 189. Conversely, in the present case, there was absolutely no evidence that Flagg's prior experience with vaginal birth after cesarean section had any bearing on the risks to the plaintiff from the procedure or that it was otherwise relevant to any of the four established elements of informed consent." *Duffy v. Flagg*, *supra*, 279 Conn. 695-96.

Here, the plaintiff's complaint does not allege, nor is there evidence submitted in connection with the motion, that Yaari was inexperienced, unprepared or incompetent to perform a cesarean hysterectomy,[14] or that there was *anything* in his past experience that affected his ability to competently and skillfully perform the surgery. Nor is there anything in the complaint or the evidence that St. Vincent's Medical Center was not a appropriate facility at which to perform the surgery. To be sure, in every endeavor there is virtually always someone more experienced. But there is a vast distinction between a claim that a physician or facility is unqualified, inexperienced or unprepared and a claim that another physician or facility is more qualified or more experienced. The former may be material **[*54]** to the risk of a procedure. The latter is not. Compare *Foard v. Jarman*,

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[14] In response to the court's Nov. 7, 2011 request for supplemental briefs discussing *DeGennaro v. Tandon*, *supra*, and *Duffy v. Flagg*, *supra*, the plaintiff for the first time argued that "Dr. Yaari also failed to inform the plaintiff of his lack of experience with this very complicated surgery." Plaintiff's Supplemental Brief, Nov. 25, 2011. No reference to the record followed this statement. There is no evidence to support it. Moreover, "[t]he allegations of a complaint limit the issues to be decided on the trial of a case and are calculated to prevent surprise to opposing parties . . . It is fundamental in our law that the right of a plaintiff to recover is limited to the allegations of his complaint . . . A plaintiff may not allege one cause of action and recover upon another. Facts found but not averred cannot be made the basis for a recovery." (Citations omitted; internal **[*56]** quotation marks omitted.) *Lundberg v. Kovacs*, 172 Conn. 229, 232-33, 374 A.2d 201 (1977).

326 N.C. 24, 30-31, 387 S.E.2d 162, 167 (1990) (refusing to recognize an affirmative duty on the health care provider to discuss his or her experience); *Abram v. Children's Hospital of Buffalo*, 151 A.D.2d 972, 542 N.Y.S.2d 418 (1989), and *Duttry v. Patterson*, *supra*, 565 Pa. 134-37, with *Goldberg v. Boone*, 396 Md. 94, 126-27, 912 A.2d 698, 711-12 (2006) (stating: "In this case, the factual context controls. Mr. Boone alleged that it was the combination of his having a pre-existing hole in his dura, which elevated the complexity of his revisionary mastoidectomy, with the fact that *Dr. Goldberg had performed only one revisionary mastoidectomy over the past three years*, that gave rise to Dr. Goldberg's duty to inform him that there were other more experienced surgeons in the region that could perform the procedure. It was a factual issue for the jury to determine whether a reasonable person, in Mr. Boone's position, would have deemed this information material to the decision whether to risk having the revisionary mastoidectomy undertaken by Dr. Goldberg" [emphasis added]); see also *Whiteside v. Lukson*, 89 Wash.App. 109, 947 P.2d 1263, 1265 (1997). **[*55]** As a leading treatise on the subject states: ***HN14***[⬆] "A surgeon who is qualified to perform a particular operation does not have a duty to advise the patient that . . . 'there are more experienced surgeons in the area who are less likely to make a mistake.'" 4 Louiselle & Williams, Medical Malpractice (LexisNexis) §22.05[1].

Under the circumstances of this case, where the plaintiff concedes that she would have had a cesarean hysterectomy regardless of whether Yaari otherwise obtained her informed consent, and where there is no allegation nor evidence that Yaari was not competent, prepared and experienced to perform a cesarean hysterectomy, there is no genuine issue of material fact that Yaari did not violate any duty to the plaintiff by not advising her that she might have the surgery performed by more experienced physicians or more specialized physicians.

The defendants' motions for summary judgment are granted.

BY THE COURT

Bruce L. Levin

Judge of the Superior Court

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CERTIFICATE OF SERVICE

I hereby certify under penalty of perjury that under the laws of the State of Washington that on the 2nd day of January, 2025, I caused a true and correct copy of the foregoing document, "Brief of Respondents Proliance Surgeons, Inc., P.S. and Daniel Seely, M.D.," to be delivered in the manner indicated below to the following counsel of record:

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DATED this 2nd day of January, 2025, at Seattle, Washington.

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# FAVROS LAW

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