IN THE SUPREME COURT OF THE STATE OF WASHINGTON

LINDA J. MOHR and CHARLES L. MOHR, her husband, Appellants, v. DALE C. GRANTHAM, M.D., and JANE DOE GRANTHAM, and their marital community; BRIAN J. DAWSON, M.D., and JANE DOE DAWSON, and their marital community; BROOKS WATSON II, M.D., and JANE DOE WATSON, and their marital community; KADLEC MEDICAL CENTER, a Washington corporation; and NORTHWEST EMERGENCY PHYSICIANS, INC., a Washington corporation, Respondents.	)	No. 84712-6 En Banc Filed October 13, 2011

OWENS, J. -- Linda Mohr suffered a trauma-induced stroke and is now permanently disabled. She and her husband, Charles, claim that negligent treatment by her health care providers diminished her chances of avoiding or greatly minimizing her disability. In other words, they claim that negligence caused Mrs. Mohr a loss of

the chance of a better outcome. In *Herskovits v. Group Health Cooperative of Puget Sound*, 99 Wn.2d 609, 611, 614, 664 P.2d 474 (1983) (Dore, J., lead opinion), this court recognized the lost chance doctrine in a survival action when the plaintiff died following the alleged failure of his doctor to timely diagnose his lung cancer. This case compels consideration of whether, in the medical malpractice context, there is a cause of action for a lost chance, even when the ultimate result is some serious harm short of death. We hold that there is such a cause of action and, accordingly, reverse the order of summary judgment.

Facts

In Richland, Washington, on the afternoon of August 31, 2004, Mrs. Mohr suffered a hypoglycemic event that caused her to run her car into a utility pole at approximately 45 m.p.h. She was taken by ambulance to the emergency room at Kadlec Medical Center (KMC). Having visible lacerations on her face from the car accident, Mrs. Mohr was given a neurological assessment upon arrival, at around 4:00 p.m., and a computerized tomography (CT) scan of her brain about an hour later. These tests were overseen or authorized by Dr. Dale Grantham, who was charged with Mrs. Mohr's care at KMC on August 31. The results were normal.

Following those neurological tests, however, Mrs. Mohr reported and was observed to have neurological symptoms, including being wobbly on her feet and

having severe pain after being administered pain medication.[1] Dr. Grantham informed one of Mrs. Mohr's physician sons, Dr. Brandt Mohr, by phone that he would carry out another neurological assessment before discharging her. He did not. Instead, he prescribed a narcotic, Darvocet, and sent Mrs. Mohr home with her husband. At that point, Mrs. Mohr could not walk herself to or from the car and had to be carried to bed by her husband when they arrived home. The Mohrs were not given discharge instructions that included specific information about head injuries.

Mrs. Mohr was again transported to KMC by ambulance just after 7:00 a.m. on September 1, 2004, because her husband was concerned that she remained very lethargic through the night. Dr. Brian Dawson was the attending emergency room physician that morning. By around 9:30 a.m., Mrs. Mohr was diagnosed as having a stroke. Specifically, she was first found to have an "evolving infarct . . . in the right middle cerebral artery territory," Clerk's Papers (CP) at 119, which relates to a cause of a stroke.[2] A magnetic resonance imaging (MRI) examination, performed shortly after 9:30 a.m., confirmed that Mrs. Mohr was in fact having a stroke.[3] However, Dr.

---

[1] The Mohrs also allege that Mrs. Mohr reported some numbness but that it was not recorded until the following day, when the hospital records indicate that "some numbness in her left hand . . . has persisted." Clerk's Papers (CP) at 122.

[2] An "infarct" is "an area of coagulation necrosis in a tissue . . . resulting from obstruction of the local circulation by a thrombus [(blood clot)] or embolus [(foreign particle circulating in the blood)]." Webster's Third New International Dictionary 1157 (2002). A known cause of strokes is "formation of an embolus or thrombus that occludes an artery." Taber's Cyclopedic Medical Dictionary 1847 (18th ed. 1997).

[3] Mrs. Mohr's medical records indicate that the "MRI . . . revealed a right frontoparietal

Dawson did not provide any anticoagulant or antithrombotic treatment or therapy. Around 11:30 a.m. Mrs. Mohr was transferred to the intermediate care unit, under the care of Dr. Brooks Watson.

Before the transfer, Mrs. Mohr's two physician sons had arrived at KMC to be by her side. They tried to get both Dr. Dawson and then, after her transfer, Dr. Watson to order a CT angiogram. A CT angiogram was not done until 2:30 p.m., after the Mohr sons had Dr. Watson repeatedly paged. Then, although the results were available at 3:27 p.m., Dr. Watson was not located or informed until 4:50 p.m. that the CT angiogram showed a dissected carotid artery. He still did not order anyone to administer anticoagulant therapy, antiplatelet agents, or any other treatment. Dr. Watson had prescribed aspirin around 2:00 p.m. but did not order its immediate administration.

Mrs. Mohr's sons finally arranged a transfer and transport to Harborview Medical Center. Dr. Watson signed the transfer form as a formality. Only shortly before her transport at 6:00 p.m. on September 1, 2004, was Mrs. Mohr finally given aspirin, though it had to be administered in suppository form because, by then, she could no longer swallow.

Mrs. Mohr is now permanently brain damaged; a quarter to a third of her brain

---

CVA." CP at 123. "CVA" is an abbreviation for a "cerebrovascular accident," also known as a stroke. Taber's, *supra*, at 350.

tissue was destroyed. In particular, the portions of her brain that were damaged are involved with motor control, sensation, and spatial reasoning.

Mrs. Mohr and her husband filed suit, claiming that Mrs. Mohr received negligent treatment, far below the recognized standard of care. They argue that the doctors' negligence substantially diminished her chance of recovery and that, with nonnegligent care, her disability could have been lessened or altogether avoided. The Mohrs' claim relies, at least in part, on a medical malpractice cause of action for the loss of a chance. In support of their claim, the Mohrs presented the family's testimony, including her two sons who are doctors, and the testimony of two other doctors, Kyra Becker and A. Basil Harris. The testimony included expert opinions that the treatment Mrs. Mohr received violated standards of care and that, had Mrs. Mohr received nonnegligent treatment at various points between August 31 and September 1, 2004, she would have had a 50 to 60 percent chance of a better outcome. The better outcome would have been no disability or, at least, significantly less disability.

On April 16, 2009, the Benton County Superior Court granted summary judgment for the defendants on the basis that the Mohrs did not show "but for" causation and the hesitancy of the court to expand *Herskovits* to the facts of this case. The Mohrs appealed, and the Court of Appeals certified the case for our review.

IssueS

1. In the medical malpractice context, is there a cause of action for a lost chance of a better outcome?

2. Did the trial court properly grant summary judgment for all defendants under CR 56(c)?

Analysis

1. *Lost Chance of a Better Outcome*

The medical malpractice statute requires the same elements of proof as traditional tort elements of proof: duty, breach, injury, and proximate cause. RCW 7.70.040. Whether there is a cause of action for a lost chance of a better outcome in the medical malpractice context is a question of law, which we review de novo. *Berger v. Sonneland*, 144 Wn.2d 91, 103, 26 P.3d 257 (2001). The standard formulation for proving proximate causation[4] in tort cases requires, "first, a showing that the breach of duty was a cause in fact of the injury, and, second, a showing that as a matter of law liability should attach." *Harbeson v. Parke-Davis, Inc.*, 98 Wn.2d 460, 475-76, 656 P.2d 483 (1983). In a medical malpractice case, for example, a plaintiff would traditionally seek to prove "cause in fact" by showing "that he or she would not

[4] To answer the question of whether there is a cause of action for a loss of a chance of a better outcome, we focus on the injury and proximate cause elements. At the outset, however, we note that, in order to prevail in a medical malpractice claim, a plaintiff still also bears the exacting burden to prove that a health care provider breached the standard of care.

have been injured but for the health care provider's failure to use reasonable care." *Hill v. Sacred Heart Med. Ctr.*, 143 Wn. App. 438, 448, 177 P.3d 1152 (2008) (citing *McLaughlin v. Cooke*, 112 Wn.2d 829, 837, 774 P.2d 1171 (1989)). However, as the plurality noted in *Herskovits*, "[t]he word 'cause' has a notoriously elusive meaning (as the writings on legal causation all agree)." 99 Wn.2d at 635 n.1 (Pearson, J., plurality opinion). For this reason, and in service of underlying tort principles, this court and others have recognized some limited exceptions to the strict tort formula, including recognition of lost chance claims. *See, e.g.*, *id*. at 619 (Dore, J., lead opinion), 634-35 (Pearson, J., plurality opinion).

Herskovits involved a survival action following an allegedly negligent failure to diagnose lung cancer. Over the course of a year, Leslie Herskovits repeatedly sought treatment for persistent chest pains and a cough, for which he was prescribed only cough medicine. *Id*. at 611 (Dore, J., lead opinion). When he finally sought another medical opinion, Herskovits was diagnosed with lung cancer within three weeks. *Id*. His diagnosing physician testified that the delay in diagnosis likely diminished Herskovits's chance of long-term survival from 39 percent to 25 percent. *Id*. at 612. Less than two years after his diagnosis, then 60 years old, Herskovits died. *Id*. at 611. The trial court dismissed the case on summary judgment on the basis that Herskovits's estate, which brought suit, failed to establish a prima facie case of proximate cause: it

could not show that *but for* his doctor's negligence he would have survived because he "*probably* would have died from lung cancer even if the diagnosis had been made earlier." *Id*. Though divided by different reasoning, this court reversed the trial court, finding that Herskovits's lost chance was actionable.

The lead opinion, signed by two justices, and the concurring opinion, which garnered a plurality, agreed on the fundamental bases for recognizing a cause of action for the loss of a chance. The lead opinion explained:

> To decide otherwise would be a blanket release from liability for doctors and hospitals any time there was less than a 50 percent chance of survival, regardless of how flagrant the negligence.

Id. at 614. The plurality similarly noted that traditional all-or-nothing causation in lost chance cases "'subverts the deterrence objectives of tort law.'" *Id*. at 634 (Pearson, J., plurality opinion) (quoting Joseph H. King, Jr., *Causation, Valuation, and Chance in Personal Injury Torts Involving Preexisting Conditions and Future Consequences*, 90 Yale L.J. 1353, 1377 (1981)). Both opinions found that "the loss of a less than even chance is a loss worthy of redress." *Id*. With emphasis, the lead opinion agreed, stating that "'[*n*]*o matter how small that chance may have been• and its magnitude cannot be ascertained• no one can say that the chance of prolonging one's life or decreasing suffering is valueless*.'" *Id*. at 618 (Dore, J., lead opinion) (quoting *James v. United States*, 483 F. Supp. 581, 587 (N.D. Cal. 1980)).

The lead and plurality opinions split over *how*, not whether, to recognize a cause of action. Drawing from other jurisdictions, especially the Pennsylvania Supreme Court's holding in *Hamil v. Bashline*, 481 Pa. 256, 392 A.2d 1280 (1978), the lead opinion held that the appropriate framework for considering a lost chance claim was with a "substantial factor" theory of causation. The court summarized that

> once a plaintiff has demonstrated that the defendant's acts or omissions have increased the risk of harm to another, such evidence furnishes a basis for the jury to make a determination as to whether such increased risk was in turn a substantial factor in bringing about the resultant harm.

Herskovits, 99 Wn.2d at 616 (additionally noting the *Hamil* court's reliance on the *Restatement (Second) of Torts* § 323 (1965), which provides that one who renders services to another, necessary for the protection of that person, is liable if "his failure to exercise [reasonable] care increases the risk of [physical] harm").[5] The "substantial factor test" is an exception to the general rule of proving but for causation and requires that a plaintiff prove that the defendant's alleged act or omission was a substantial factor in causing the plaintiff's injury, even if the injury could have occurred anyway. *Fabrique v. Choice Hotels Int'l, Inc.*, 144 Wn. App. 675, 684, 183 P.3d 1118 (2008).

Rather than looking to the causation element, the plurality opinion in *Herskovits*

[5] While recognizing the lost chance doctrine, the most recent *Restatement* asserts that the reliance by many courts on § 323 of the *Restatement* (*Second*) as support for the doctrine is misplaced. Restatement (Third) of Torts: Liability for Physical and Emotional Harm § 26 cmt. n (2010). The reporter's note explains that § 323 addressed affirmative duties, not causation or the nature of injury.

focused instead on the nature of the injury. *Herskovits*, 99 Wn.2d at 634 (Pearson, J., plurality opinion) ("[T]he best resolution of the issue before us is to recognize the loss of a less than even chance as an actionable injury."). The plurality noted among its concerns about the "all or nothing" traditional tort approach to recovery that it "creates pressure to manipulate and distort other rules affecting causation and damages in an attempt to mitigate perceived injustices." *Id.* In part, this characterizes what the *Herskovits* lead opinion does by prescribing that causation in *all* lost chance cases is to be examined under the substantial factor doctrine. The plurality found it more analytically sound to conceive of the injury as the lost chance. *Id.*

Though this court has not reconsidered or clarified the rule of *Herskovits* in the survival action context or, until now, considered whether the rule extends to medical malpractice cases where the ultimate harm is something short of death, the *Herskovits* majority's recognition of a cause of action in a survival action has remained intact since its adoption. "Washington recognizes loss of chance as a compensable interest." *Shellenbarger v. Brigman*, 101 Wn. App. 339, 348, 3 P.3d 211 (2000); *see Zueger v. Pub. Hosp. Dist. No. 2*, 57 Wn. App. 584, 591, 789 P.2d 326 (1990) (finding that the *Herskovits* "plurality represents the law on a loss of the chance of survival");16 David K. DeWolf & Keller W. Allen, Washington Practice: Tort Law and Practice § 4.10, at 155-56, § 15.32, at 488 (3d ed. 2006) ("Washington courts recognize the doctrine of

'loss of a chance' as an exception to a strict application of the but-for causation test in medical malpractice cases."). In *Shellenbarger*, the Court of Appeals reversed summary judgment of a medical malpractice claim of negligent failure to diagnose and treat lung disease from asbestos exposure in its early stages. 101 Wn. App. at 342. Expert witnesses testified that had Shellenbarger received nonnegligent testing and early diagnosis, which would have led to treatment, he would have "had a 20 percent chance that the disease's progress would have been slowed and, accordingly, he would have had a longer life expectancy." *Id.* at 348. The court concluded, "We find no meaningful difference between this and *Herskovits*' lost chance of survival." *Id.* at 349.

Washington courts have, however, generally declined to extend *Herskovits* to other negligence claims. *See, e.g.*, *Daugert v. Pappas*, 104 Wn.2d 254, 260-62, 704 P.2d 600 (1985) (declining to apply *Herskovits* in a legal malpractice claim); *Fabrique*, 144 Wn. App. at 685 (following *Daugert* and finding "no authority supporting the application of the 'substantial factor' definition of proximate cause to a negligence or strict liability action involving a contaminated food product"); *Sorenson v. Raymark Indus., Inc.*, 51 Wn. App. 954, 957, 756 P.2d 740 (1988) (distinguishing *Herskovits* from an asbestos exposure claim that the plaintiff's risk of cancer was increased). Such limitation is common: "[T]he courts that have accepted lost

opportunity as cognizable harm have almost universally limited its recognition to medical-malpractice cases." Restatement (Third) of Torts: Liability for Physical and Emotional Harm § 26 cmt. n at 356-57 (2010).

Herskovits has been widely cited as an authority by other state courts and in journal articles for recognizing a cause of action in lost chance cases. *See, e.g.*, *Matsuyama v. Birnbaum*, 452 Mass. 1, 16, 890 N.E.2d 819 (2008); *McMackin v. Johnson County Healthcare Ctr.*, 2003 WY 91, ¶¶ 16-17, 73 P.3d 1094, 1100, *adhered to on reh'g*, 2004 WY 44, 88 P.3d 491; Tory A.Weigand, *Loss of Chance in Medical Malpractice: The Need for Caution*, 87 Mass. L. Rev. 3, 9 (2002). Since *Herskovits*, the majority of states that have considered the lost chance doctrine have adopted it, although with varying rationales. *Matsuyama*, 452 Mass. at 10 n.23 (listing 20 states and the District of Columbia that have recognized the lost chance doctrine); *see* Weigand, *supra*, at 7-10. Several states have rejected the doctrine. *Matsuyama*, 452 Mass. at 10 n.23 (listing 10 states that have declined to adopt the doctrine). And others have not yet reviewed the issue or have declined to reach the question. *Id.*

The rationales underpinning the lost chance doctrine have generally been applied the same in wrongful death claims and medical malpractice claims where the ultimate harm is something short of death. *See, e.g.*, *Shellenbarger*, 101 Wn. App. at 349. In *Delaney v. Cade*, 255 Kan. 199, 873 P.2d 175 (1994), the Kansas Supreme

Court recognized a cause of action for loss of chance of a better outcome. The court observed that

> many jurisdictions are like Kansas, in that the issue has only come up in a loss of survival case or a loss of a better recovery case . . . .
>
> We have found no authority or rational argument which would apply the loss of chance theory solely to survival actions or solely to loss of a better recovery actions and not to both.

Id. at 209-10. *But cf. Weymers v. Khera*, 454 Mich. 639, 653, 563 N.W.2d 647 (1997) ("we reject scrapping causation (the bedrock of our tort law) in negligence cases where the injury alleged by the plaintiff is something less than death").[6] We find no *persuasive* rationale to distinguish *Herskovits* from a medical malpractice claim where the facts involve a loss of chance of avoiding or minimizing permanent disability rather than death. To limit *Herskovits* to cases that result in death is arbitrary; the same underlying principles of deterring negligence and compensating for injury apply when the ultimate harm is permanent disability.

We note that, significantly, nothing in the medical malpractice statute precludes a lost chance cause of action. In relevant part, chapter 7.70 RCW provides that, in order to prove "that injury resulted from the failure of the health care provider to follow the accepted standard of care," a plaintiff must establish:

> (1) The health care provider failed to exercise that degree of care,

[6] The *Restatement* characterizes the *Weymers* holding as "without any good explanation." Restatement (Third) of Torts: Liability for Physical and Emotional Harm § 26 Reporter's Note cmt. n at 375.

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

RCW 7.70.040. The chapter does not define "proximate cause" or "injury." RCW 7.70.020.

The principal arguments *against* recognizing a cause of action for loss of a chance of a better outcome are broad arguments, similar to those raised when *Herskovits* was decided: concerns of an overwhelming number of lawsuits and their impact on the health care system; distaste for contravening traditional tort law, especially regarding causation; discomfort with the reliance on scientific probabilities and uncertainties to value lost opportunities. *See* Joseph H. King, Jr., *"Reduction of Likelihood" Reformulation and Other Retrofitting of the Loss-of-a-Chance Doctrine*, 28 U. Mem. L. Rev. 491, 506 (1998); *Matsuyama*, 452 Mass. at 15 (noting criticisms of the doctrine, namely that it "upends the long-standing preponderance of the evidence standard; alters the burden of proof in favor of the plaintiff; undermines the uniformity and predictability central to tort litigation; results in an expansion of liability; and is too complex to administer") However, none of these arguments effectively distinguish the Mohrs' claim from *Herskovits* and seem instead to agitate for its overruling. Now nearly 30 years since *Herskovits* was decided, history assures

us that *Herskovits* did not upend the world of torts in Washington, as demonstrated by the few cases relying on *Herskovits* that have been heard by Washington appellate courts.

We hold that *Herskovits* applies to lost chance claims where the ultimate harm is some serious injury short of death. We also formally adopt the reasoning of the *Herskovits* plurality. Under this formulation, a plaintiff bears the burden to prove duty, breach, and that such breach of duty proximately caused a loss of chance of a better outcome. This reasoning of the *Herskovits* plurality has largely withstood many of the concerns about the doctrine, particularly because it does not prescribe the specific manner of proving causation in lost chance cases. Rather, it relies on established tort theories of causation, without applying a particular causation test to *all* lost chance cases. Instead, the loss of a chance is the compensable injury.

The significant remaining concern about considering the loss of chance as the compensable injury, applying established tort causation, is whether the harm is too speculative. We do not find this concern to be dissuasive because the nature of tort law involves complex considerations of many experiences that are difficult to calculate or reduce to specific sums; yet juries and courts manage to do so. We agree that

> [s]uch difficulties are not confined to loss of chance claims. A wide range of medical malpractice cases, as well as numerous other tort actions, are complex and involve actuarial or other probabilistic estimates.

Matsuyama, 452 Mass. at 18. Moreover, calculation of a loss of chance for a better outcome is based on expert testimony, which in turn is based on significant practical experience and "on data obtained and analyzed scientifically . . . as part of the repertoire of diagnosis and treatment, as applied to the specific facts of the plaintiff's case." *Id*. at 17. Finally, discounting damages responds, to some degree, to this concern.

In *Herskovits*, both the lead and concurring opinions discussed limiting damages. 99 Wn.2d at 619 (Dore, J., lead opinion), 635 (Pearson, J., plurality opinion). This is a common approach in lost chance cases, responsive in part to the criticism of holding individuals or organizations liable on the basis of uncertain probabilities. Restatement (Third) of Torts: Liability for Physical and Emotional Harm § 26 cmt. n at 356 ("Rather than full damages for the adverse outcome, the plaintiff is only compensated for the lost opportunity. The lost opportunity may be thought of as the adverse outcome discounted by the difference between the ex ante probability of the outcome in light of the defendant's negligence and the probability of the outcome absent the defendant's negligence."). Treating the loss of a chance as the cognizable injury "permits plaintiffs to recover for the loss of an opportunity for a better outcome, an interest that we agree should be compensable, while providing for the proper valuation of such an interest." *Lord v. Lovett*, 146 N.H. 232, 236, 770 A.2d

1103 (2001). In particular, the *Herskovits* plurality adopted a proportional damages approach, holding that, if the loss was a 40 percent chance of survival, the plaintiff could recover only 40 percent of what would be compensable under the ultimate harm of death or disability (i.e., 40 percent of traditional tort recovery), such as lost earnings. *Herskovits*, 99 Wn.2d at 635 (Pearson, J., plurality opinion) (citing, King, *supra*, 90 YALE L.J. at 1382). This percentage of loss is a question of fact for the jury and will relate to the scientific measures available, likely as presented through experts. Where appropriate, it may otherwise be discounted for margins of error to further reflect the uncertainty of outcome even with a nonnegligent standard of care. *See* King, *supra*, 28 U. Mem. L. Rev. at 554-57 ("conjunction principle").

We find that the *Herskovits* plurality has withstood the broad policy criticisms raised against it and comports with the medical malpractice statute. We find no meaningful basis to distinguish permanent disability from death for the purposes of raising a loss of chance claim. Accordingly, we hold that *Herskovits* applies to medical malpractice cases that result in harm short of death and formally adopt the rationale of the plurality opinion that the injury is the lost chance. For the reasons discussed next, as it relates to the facts of this case, we reverse the order of summary judgment.

2. *Summary Judgment*

An order granting summary judgment is reviewed de novo. *Rivas v. Overlake Hosp. Med. Ctr.*, 164 Wn.2d 261, 266, 189 P.3d 753 (2008). Summary judgment "shall be rendered forthwith if . . . there is no genuine issue as to any material fact and . . . the moving party is entitled to a judgment as a matter of law." CR 56(c). We review the evidence in the light most favorable to the nonmoving party. *Miller v. Jacoby*, 145 Wn.2d 65, 71, 33 P.3d 68 (2001).

Interpreting the facts in the light most favorable to the Mohrs, they have made a prima facie case under the lost chance doctrine that, on August 31 and September 1, 2004, the respondents breached the recognized standard of care for treating a head trauma victim with Mrs. Mohr's symptoms and that their breaches caused Mrs. Mohr a diminished chance of a better outcome. The Mohrs presented the expert testimony of doctors Becker and Harris. Their testimony included opinions regarding breaches of the standard of care: that once given a narcotic, Mrs. Mohr should not have been discharged but observed overnight; that, had Mrs. Mohr been held overnight, her neurological deficits would have been earlier discovered to be a stroke; and that anticoagulants, antiplatelet agents, and general brain protective care reduce the damage caused by strokes. The expert testimony also included information regarding causation, including Dr. Becker's opinion that had Mrs. Mohr "received anti-thrombotic therapy there's at least a 50 to 60 percent chance that things could have

had a better outcome. . . . Less disability, less neglect, less . . . of the symptoms of right hemispheric stroke." CP at 225-26. Dr. Harris testified that had Mrs. Mohr received nonnegligent treatment at various points between August 31 and September 1, 2004, she would have had a 50 to 60 percent chance of a better outcome. This included the possibility, according to Dr. Harris, that Mrs. Mohr may have had no disability if she had been properly treated. We find, on this evidence, a prima facie showing of duty, breach, injury in the form of a lost chance, and causation.

Respondents also argue that the case cannot go forward because the Mohrs have not proved damages. This is a misconception of the requirements of medical malpractice tort law. *See* RCW 7.70.040. The Mohrs have made a prima facie case of injury: lost chance of a better outcome.

Finally, KMC separately asserts that the trial court's order of summary judgment in its favor should be affirmed because it is not vicariously liable for the negligence of the codefendant physicians.[7] However, the Mohrs' and KMC's competing contentions regarding apparent agency and resulting vicarious liability present a question of fact that is not disposable on summary judgment as a matter of law. We therefore reverse the order of summary judgment as to KMC.

Under apparent authority, an agent (e.g., a doctor) binds a principal (e.g., a

[7] This court may sustain a trial court ruling on any correct ground. *Nast v. Michels*, 107 Wn.2d 300, 308, 730 P.2d 54 (1986).

hospital) if objective manifestations of the principal "cause the one claiming apparent authority to actually, or subjectively, believe that the agent has authority to act for the principal" and such belief is objectively reasonable. *King v. Riveland*, 125 Wn.2d 500, 507, 886 P.2d 160 (1994). A finding of apparent agency can subject a hospital to vicarious liability for the negligence of contractor physicians or staff working at the hospital. *See, e.g.*, *Adamski v. Tacoma Gen. Hosp.*, 20 Wn. App. 98, 107-08, 579 P.2d 970 (1978).

KMC and the Mohrs dispute whether the Mohrs could and did reasonably believe that any of the codefendant physicians were employees or agents of KMC. The Mohrs signed a form that included the following language:

> Patient care is under the control of the patient's attending physician who:
> is an independent provider and not an employee or agent of the hospital:
> May request other physicians to provide services during hospitalization
> (i.e. pathologists, anesthesiologists, radiologists).

CP at 107. Without considering the clarity of this language, we note that there are other relevant considerations, including: discharge instructions from the "[KMC] Emergency Department" that included information about treatment by Dr. Grantham at KMC; physician name tags that included KMC with the doctors' names; billing statements from KMC; and identification of Dr. Watson as a "'Hospitalist'" for KMC. *Id*. at 108, 268-70. It is also informative that KMC's emergency room is an essential part of its operation. *See Adamski*, 20 Wn. App. at 115.

In *Adamski*, the Court of Appeals considered several factors that it found relevant to the question of whether an independent-contractor physician was an apparent agent of the hospital. *Id*. at 115-16. It stated that "courts generally look to all of the facts and circumstances to determine if the hospital and doctor enjoy such a 'significant relationship' that the rule of respondeat superior ought to apply." *Id*. at 108. Similarly, the published model jury instructions enumerate seven relevant factors for the determination of apparent agency in the hospital and independent-contractor physician context. 6 Washington Practice: Washington Pattern Jury Instructions: Civil 105.02.03 (5th ed. 2005). One factor is "[w]hether the hospital made any representations to the patient, verbally or in writing, regarding their relationship with the physician." *Id*. However, "no one of [the factors] is controlling." *Id*. Thus, the notice that the Mohrs received disclaiming an agency relationship between KMC and the treating physicians is but one factor to consider.

KMC argues that even if there is apparent agency, the hospital is not liable for negligent acts of physicians that it could not control. *Cf. McLean v. St. Regis Paper Co.*, 6 Wn. App. 727, 729-30, 496 P.2d 571 (1972). However, the negligence alleged here concerns the provision of medical services and is well within the scope of the apparent agency relationship alleged between the physicians and KMC. As in *Adamski*, we find that a hospital may be, depending on the facts found by a jury, liable

for the negligence of its contractor doctors, who are held out to be agents of the hospital. Accordingly, we reverse the order of summary judgment.

Conclusion

We hold that there is a cause of action in the medical malpractice context for the loss of a chance of a better outcome. A plaintiff making such a claim must prove duty, breach, and that there was an injury in the form of a loss of a chance caused by the breach of duty. To prove causation, a plaintiff would then rely on established tort causation doctrines permitted by law and the specific evidence of the case. Because the Mohrs made a prima facie case of the requisite elements of proof, we reverse the order of summary judgment and remand to the trial court for further proceedings.

AUTHOR:

Justice Susan Owens

WE CONCUR:

Justice Mary E. Fairhurst

Justice Charles W. Johnson

Justice Debra L. Stephens

Justice Tom Chambers

Justice Charles K. Wiggins