IN THE COURT OF APPEALS OF THE STATE OF NEVADA

JUSTIN LANCE REA, INDIVIDUALLY; AND CHRISTEN NELSON REA, INDIVIDUALLY AND AS THE REPRESENTAIVE OF THE ESTATE OF RILEY DEANNA REA,
Appellants,
vs.
SUNRISE HOSPITAL AND MEDICAL CENTER; ROBERT KILPATRICK, M.D.; ARLITA HIDALGO, R.N.; AND AISHA ASIF, M.D.,
Respondents.

No. 66075

ORDER OF AFFIRMANCE

This is an appeal from a district court order granting summary judgment in favor of respondents. Eighth Judicial District Court, Clark County; Adriana Escobar, Judge.

The facts of this case are tragic and sad.[1] Appellants Christen and Justin Rea (collectively, "Reas") brought their five-month old daughter, Riley, into respondent Sunrise Hospital and Medical Center's emergency room on Thursday, March 24, 2011. Riley was suffering from various ailments. Sunrise Hospital[2] conducted a physical examination,

[1]We do not recount the facts except as necessary to our disposition but we note that some of the facts asserted in the dissent are not consistent with the record on appeal or are not pertinent to this appeal based on the arguments raised by the parties.

[2]As used in the remainder of this order, "Sunrise Hospital" refers to respondents, Sunrise Hospital, Arlita Hidalgo, R.N., and Drs. Aisha Asif and Robert Kilpatrick collectively.

urinalysis, and chest x-ray, and ultimately diagnosed Riley with a viral upper respiratory infection. When Sunrise Hospital indicated it was going to release Riley, the Reas' pleaded with Sunrise Hospital to admit her, as she was obviously ill, but to no avail. Sunrise Hospital discharged Riley with instructions to return if Riley's condition worsened and to follow-up with her pediatrician.

Riley's condition worsened the following morning and the Reas took her to her pediatrician. While waiting for blood test results, Riley vomited a dark brown substance. Riley's pediatrician advised the Reas to immediately return to the emergency room at Sunrise Hospital. This time, Sunrise Hospital admitted Riley and began running tests. Within hours, Dr. Ronald Kline, a physician who is not a party to this action, determined Riley was suffering from acute myeloid leukemia ("AML"). Riley started chemotherapy the next day, but passed away on Sunday, March 27, 2011. Riley's death certificate, which is signed by a doctor not involved in the litigation, lists her immediate cause of death as *acute myeloid leukemia*, due to, or as a consequence of septic shock, pulmonary edema and acute renal failure.

The Reas initiated a medical malpractice action against Sunrise Hospital. After discovery concluded, Sunrise Hospital moved for summary judgment, arguing that even assuming Sunrise Hospital's treatment fell below the standard of care, the Reas' medical expert failed to opine that Riley would have survived and therefore, the Reas failed to establish the element of causation. The district court granted summary judgment in favor of Sunrise Hospital, agreeing with Sunrise Hospital

that the Reas failed to establish causation.[3] The Reas appeal alleging that, pursuant to *Perez v. Las Vegas Medical Center*, 107 Nev. 1, 805 P.2d 589 (1991), Sunrise Hospital's failure to admit Riley upon her initial presentment substantially reduced Riley's chance of survival. *See id.* at 6, 805 P.2d at 592.

We review a district court order granting summary judgment de novo, with no deference to the findings of the district court. *Wood v. Safeway, Inc.*, 121 Nev. 724, 729, 121 P.3d 1026, 1029 (2005). Summary judgment is appropriate if the pleadings and evidence demonstrate that no genuine issues of material fact remain and that the moving party is entitled to judgment as a matter of law. NRCP 56(c); *see also Wood*, 121 Nev. at 729, 121 P.3d at 1029. When reviewing such a motion, we must review the evidence and all reasonable inferences drawn from the evidence in a light most favorable to the nonmoving party. *Wood*, 121 Nev. at 729, 121 P.3d at 1029.

To overcome Sunrise Hospital's motion for summary judgment, the Reas bore the burden of setting forth, "by affidavit or otherwise, . . . specific facts demonstrating the existence of a genuine issue for trial." *Id.* at 732, 121 P.3d at 1031 (internal quotation marks omitted). To prevail on a medical malpractice claim, the plaintiff must show "(1)

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[3]Although we agree with the district court's conclusion, the form of the district court's order is concerning. The issue of summary judgment was squarely before the court, but, the district court's order fails to cite the correct legal standard under NRCP 56, apply the applicable substantive law under *Perez v. Las Vegas Medical Center*, 107 Nev. 1, 805 P.2d 589 (1991), or include specific findings as required by NRCP 52(a). Although these deficiencies do not affect our analysis because we review this matter de novo, we note them to encourage counsel and the district court to properly craft orders in the future.

that the doctor's conduct departed from the accepted standard of medical care or practice; (2) that the doctor's conduct was both the actual and proximate cause of the plaintiff's injury; and (3) that the plaintiff suffered damages." *Prabhu v. Levine*, 112 Nev. 1538, 1544, 930 P.2d 103, 107 (1996). While this standard sets forth the traditional preponderance requirement for causation, the Nevada Supreme Court modified this requirement in medical malpractice cases where the plaintiff's chance of survival due to a serious preexisting medical condition is equal to or less than fifty percent. *See Perez*, 107 Nev. at 5, 805 P.2d at 591. In these cases, the injury is not defined as the death itself, "but, rather, as the decreased chance of survival caused by the medical malpractice." *Id.* at 6, 805 P.2d at 592. Thus, to establish causation under the "loss of chance" doctrine in this case, the Reas had to "present evidence tending to show, to a reasonable medical probability, that some negligent act or omission by health care providers reduced a substantial chance of survival given appropriate medical care."[4] *Id.*

To illustrate the "loss of chance" doctrine, we recount the facts of *Falcon v. Memorial Hospital*, 462 N.W.2d 44 (Mich. 1990), *superseded by statute as explained in O'Neal v. St. John Hospital & Medical Center*, 791 N.W.2d 853, 858 (Mich. 2010). In *Falcon*, the Supreme Court of Michigan affirmed the court of appeals decision to reverse and remand the trial court's grant of summary judgment in favor of the hospital and

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[4]Although the *Perez* court declined to state exactly how high the chances of survival must be in order to be "substantial," we need not reach the issue here as there was no evidence at all that, to a reasonable degree of medical probability, Sunrise Hospital's alleged negligence decreased Riley's chance of surviving AML. *See* 107 Nev. at 6-7, 805 P.2d at 592.

physicians in a medical malpractice action. 462 N.W.2d at 57. There, a newborn baby passed away almost immediately after delivery due to an amniotic fluid embolism, an unpreventable complication. *Id.* at 49. According to the mother's expert witness, the survival rate for an amniotic fluid embolism is 37.5 percent if doctors connect an intravenous line to the patient before the onset of the embolism. *Id.*

The doctors in *Falcon*, however, did not insert an intravenous line. *Id.* In affirming reversal of the order granting summary judgment, the supreme court explained that, by failing to insert the intravenous line, the doctors eliminated a 37.5 percent opportunity for survival. *Id.* at 52. Although the supreme court recognized that the baby was likely *to* not survive, it wrote "[a] 37.5 percent opportunity of living is hardly the kind of opportunity that any of us would willingly allow our health care providers to ignore." *Id.*

We agree with the district court that the record reveals that the Reas' expert witness failed to testify that, even if Sunrise Hospital's medical care fell below the standard of care upon her initial presentment on Thursday, it reduced a substantial chance of her surviving AML.[5] *See Perez*, 107 Nev. at 6, 805 P.2d at 592 (holding that, "in order to create a question of fact regarding causation in [loss of chance] cases, the plaintiff must present evidence tending to show, to a reasonable medical probability, that some negligent act or omission by health care providers

[5]To the extent our dissenting colleague asserts that the loss of chance doctrine should not be applied to Riley's AML, but rather to the septic shock, pulmonary edema and acute renal failure noted on her death certificate, we note that it is the Reas, and not this court, who frame the overarching issue in this matter as whether the alleged malpractice reduced a substantial chance of Riley surviving AML.

reduced a substantial chance of survival given appropriate medical care."). Indeed, not only did the Reas' expert not testify that a substantial chance of her surviving AML had been reduced, their expert did not even provide any testimony regarding Riley's chance of surviving AML if Sunrise Hospital had admitted her on Thursday and promptly diagnosed her with AML and commenced treatment, or her chance of surviving when Sunrise Hospital actually admitted her on Friday, with or without treatment. On the contrary, their expert conceded that he was neither familiar with, nor trained in, hematology or oncology, and, as a result, could not testify with any degree of medical probability as to the survival rates of infants with AML, their life expectancy, or the appropriate treatment.[6] *See* NRS 41A.100(2). While Sunrise Hospital's expert opined as to survival rates, he testified only that the survival rate of infants with AML is roughly 50 to 60 percent, and that that survival rate would have been the same had Riley's treatment began 15 hours earlier.

Therefore, because no doctors opined to a reasonable medical probability that a substantial chance of Riley surviving decreased as a result of Sunrise Hospital's alleged breach, the Reas failed to establish a genuine issue of material fact as to causation. While our dissenting colleague attempts to characterize this determination as limiting the applicability of *Perez*'s loss of chance doctrine to people with terminal illnesses, that assertion is simply incorrect. Rather than limiting *Perez*, our decision here merely follows the doctrine set out in *Perez* and concludes that no evidence was presented to show, to a reasonable medical

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[6]Based on this testimony, we find it inexplicable that no expert witness evidence was presented on the precise issue that needed to be demonstrated to the court.

probability, that the alleged malpractice reduced a substantial chance of Riley surviving AML.[7] Despite the dissent's suggestion to the contrary, the Reas' expert expressly stated that he could not testify that the alleged malpractice reduced a substantial chance of her surviving this condition to a reasonable medical probability. And without such evidence stated to a reasonable medical probability, the district court did not err by granting summary judgment in favor of Sunrise Hospital. Accordingly, we

ORDER the judgment of the district court AFFIRMED.

_____, C.J.
Gibbons

_____, J.
Silver

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[7]Additionally, while the dissent presents an interesting discussion regarding possible distinctions between the loss of a chance of survival, as discussed in *Perez*, and the loss of a chance at a more favorable recovery, as discussed in *Prabhu v. Levine*, 112 Nev. 1538, 930 P.2d 103 (1996), that issue is not properly before us on appeal. *See Powell v. Liberty Mut. Fire Ins. Co.*, 127 Nev. 156, 161 n.3, 252 P.3d 668, 672 n.3 (2011) ("Issues not raised in an appellant's opening brief are deemed waived."). Notably, the Reas' briefs provide no discussion of or citation to *Prabhu*, and while their opening brief contains a single mention of a "reduced [ ] substantial chance for a more favorable recovery," the Reas do not endeavor to distinguish this language from the reduced substantial chance of survival phrasing articulated in *Perez*. Instead, their arguments focus only on asserting that the evidence presented demonstrated that the alleged malpractice reduced Riley's substantial chance of survival.

TAO, J., dissenting:

I don't interpret the "loss of chance" doctrine as a judicial inquiry into whether Riley had a chance of ultimately "surviving" her leukemia (AML) and living a full and cancer-free life. Instead, I interpret it as asking whether the hospital's negligence deprived her of a substantial chance for a "more favorable recovery" had the things that actually caused her death – the septic shock, pulmonary edema, and acute renal failure that killed her in three days – been timely treated.

Even if a patient like Riley suffered from a disease like leukemia from which there may be little hope of a complete recovery and likely would have taken her life someday over the course of time, she would still possess a viable legal claim against any hospital or doctor whose negligence killed her before the disease would have.

At least that's how I understand the "loss of chance" doctrine. Because my colleagues see things differently and define the doctrine in such a way that it could not apply to most patients suffering from any terminal disease, I respectfully dissent.

I.

The Respondents read the "loss of chance" doctrine as narrowly limited to permitting recovery only upon a showing, to a reasonable degree of medical probability, that medical malpractice reduced a plaintiff's substantial chance of "surviving" a deadly condition. *See Perez v. Las Vegas Medical Center*, 107 Nev. 1, 6, 805 P.2d 589, 592 (1991).

But a more recent case, *Prabhu v. Levine*, 112 Nev. 1538, 930 P.2d 103 (1996), clarified that reduced "survival" is not the only type of injury recognized by the "loss of chance" doctrine; the doctrine is far more

broad and also applies when a patient has been deprived of a substantial chance for a "more favorable recovery" but for a caregiver's negligence. Continued "survival" is merely one of many types of potential "more favorable recoveries" the loss of which are actionable under the doctrine.

Nonetheless, employing only the more narrow definition, my colleagues conclude that summary judgment is appropriate because Riley probably wouldn't have "survived" her leukemia (AML). Thus:

> the Reas' expert witness failed to testify that, even if Sunrise Hospital's medical care fell below the standard of care upon her initial presentment on Thursday, it reduced a substantial chance of her surviving AML. Indeed, not only did the Reas' expert not testify that a substantial chance of her surviving AML had been reduced, their expert did not even provide any testimony regarding Riley's chance of surviving AML if Sunrise Hospital had admitted her on Thursday and promptly diagnosed her with AML and commenced treatment, or her chance of surviving when Sunrise Hospital actually admitted her on Friday, with or without treatment. On the contrary, their expert conceded that he was neither familiar with, nor trained in, hematology or oncology, and, as a result, could not testify with any degree of medical probability as to the survival rates of infants with AML, their life expectancy, or the appropriate treatment. While Sunrise Hospital's expert opined as to survival rates, he testified only that the survival rate of infants with AML is roughly 50 to 60 percent, and that that survival rate would have been the same had Riley's treatment began 15 hours earlier. (Citations and footnotes omitted.)

But there are two problems with this line of reasoning: it misapplies the "loss of chance" doctrine, and it applies the doctrine to the wrong condition.

First, the condition: Riley didn't die of AML. According to her death certificate, she died from septic shock, pulmonary edema, and acute renal failure. Although she had leukemia (a cancer affecting red blood cells, white blood cells, and blood-forming tissues), leukemia rarely kills by itself; many patients can live for years with it. More typically, leukemia eases the way for another mechanism of death by impairing the body's immune system and making a patient more vulnerable to catching, and then dying from, other diseases and conditions that frequently would not have killed a healthy person.

So it seems to me that the question should be whether, but for the negligence, Riley would have "survived" those immediate complications that were the actual and immediate mechanism of her death rather than the cancer that was not. Indeed, that's precisely how *Perez* itself defines the question of "survival." In *Perez*, the decedent suffered from a congenital (meaning chronic or permanent) defect in an artery that caused persistent headaches and seizures. 107 Nev. at 3, 805 P.2d at 590. On the day in question, this congenital defect triggered a sudden brain hemorrhage that killed Perez, and Perez's estate sued his doctors for negligence for failing to timely respond to the hemorrhage. In applying the "loss of chance" doctrine, the Nevada Supreme Court did not weigh whether Perez would have ultimately survived his long-term congenital defect; it only weighed whether, but for the alleged negligence, he could have survived the sudden brain hemorrhage that immediately caused his death. *Id.* at 7, 805 P.2d at 592.

One could argue, I suppose, that Riley's cancer should be considered because it played some indirect role in her death; the argument would be that, had she not already had leukemia, she probably would not

have gotten septic shock, pulmonary edema, or acute renal failure in the first place, and even if she did, without leukemia they might not have struck her so severely. But the exact same thing could be said about Marco Perez – without his pre-existing congenital artery defect, he probably would not have suffered a spontaneous massive brain hemorrhage either – and that's not how the supreme court applied the doctrine.

So, under *Perez*, the "loss of chance" doctrine should be focused upon the particular conditions that actually caused Riley's death so quickly on the day she died, not upon her leukemia.

II.

The second problem is that the Respondents misunderstand how the "loss of chance" doctrine applies to any condition. *Perez* defines the doctrine in a relatively narrow way, as testing the patient's chance of "survival," while *Prabhu* defines it far more broadly, as an inquiry into whether the patient was deprived of the chance of a "more favorable recovery." Why the difference? The answer seems fairly obvious to me: whether the broad or narrow test ought to be applied depends on whether the condition that killed the patient was a long-term disease or a sudden event.

"Survival" is generally defined as "remaining alive; living beyond the happening of an event so as to entitle one to a distribution of property or income." *Surviving*, BLACK'S LAW DICTIONARY (10th ed. 2014). It seems to me the word can have very different meanings when applied to sudden one-time events than when applied to incurable terminal diseases. When a patient is injured by a sudden event such as a car crash or a massive brain hemorrhage, we typically use the word "survive" only to

mean that the event itself did not kill the patient at the particular instant in time when it happened. That's how the *Perez* court used the word: in its short-term sense to ask only whether Marco Perez would have lived past his massive brain hemorrhage, not whether he would have also lived beyond that long enough to someday bounce his grandchildren on his knee.

Here, much like Marco Perez, Riley suffered from a long-term condition (cancer) but died from immediate events that occurred quickly (septic shock, pulmonary edema, and acute renal failure; in other words, infection). But the majority takes the word "survival" that *Perez* applied to Marco's sudden event and instead applies it to Riley's long-term cancer. This is a misunderstanding of *Perez*, and it ignores *Prabhu*, which employed a completely different test: *Prabhu* involved an alleged failure to diagnose a brain tumor, and the supreme court moved away from the word "survival" and toward a "more favorable recovery" in applying the "loss of chance" doctrine to a cancer case. 112 Nev. at 1544, 930 P.2d at 107.

In many cases it may be fairly easy to figure out whether someone "survived" a single event or not, but it's far less clear what "survival" means when dealing with a long-term disease. Colloquially, we say that someone "survived" cancer to mean that the patient no longer has the disease, and "cancer survivors" are what we call those who are now cancer-free. Conversely, when a terminal disease kills a patient slowly over the course of many years, we can't accurately say that the patient "survived" the disease. That wouldn't be true; the disease eventually caused death. Consequently, when applied to cancer, the word "survive"

really means something close to "cure" or "remission," or at least that the cancer won't kill the patient at any time either now or in the future.

The Respondents argue that Riley's case isn't worthy of a trial because she can't prove that – but for the failure to treat her septic shock, pulmonary edema, and acute renal failure – the cancer won't kill her someday five, ten, twenty, thirty, forty, or fifty years from now. But this errs on two levels: it places the focus of the "loss of chance" doctrine upon the wrong thing (the leukemia rather than the conditions that actually killed her in three days) and it also uses the word "survival" to mean something that neither *Perez* nor *Prabhu* intended it to mean. The correct inquiry should have involved the application of *Prahbu*, not *Perez*: even if it's true that Riley's leukemia might have killed her someday down the line, if the hospital's failure to properly treat her immediate infection in the days just before she died deprived her of the chance for a "more favorable recovery" even without ultimately curing the leukemia, then she possesses a viable claim under the "loss of chance" doctrine.

The overarching problem with using the word "survival" in the way that the Respondents do is that the "loss of chance" doctrine would never apply to any patient who happens to suffer from any disease that is terminal in the long run – even if the disease isn't what actually kills the patient in the short run. If a disease will someday kill a patient no matter how far in the future that might happen, then the "loss of chance" doctrine can never apply to any negligence that killed the patient before the disease would have, because the patient wouldn't have "survived" anyway.

Under this interpretation, until the day cancer is cured – if we are ever fortunate enough to see that day arrive – terminal cancer patients can't bring suit under the "loss of chance" doctrine for any

negligence that kills them early. This runs exactly counter to *Perez*, which expressly held that:

> "by adopting the 'loss of chance' doctrine, a health care provider will not be able to avoid responsibility for negligent conduct simply by saying that the patient would have died anyway, when that patient had a reasonable chance to live."

Perez, 107 Nev. at 8, 805 P.2d at 593.

As I understand it, the "loss of chance" doctrine doesn't require that the hospital's negligence must have deprived a deceased patient of a reasonable chance to ultimately "survive" a disease long enough to collect Social Security. Rather, it only requires that, but for the negligence, a reasonable chance existed that the patient might have experienced a "more favorable recovery" (which in the case of cancer means living longer than she actually did) either with or without the disease. *Prabhu*, 112 Nev. at 1544, 930 P.2d at 107. To me, living a little while longer, even with cancer, is by definition a "more favorable" recovery than dying early from an untreated infection; a rational jury could certainly think so, and that's enough to let Riley's case go to trial.

III.

The dissenting opinion in *Perez* is even more blunt about what the "loss of chance" doctrine is supposed to mean: after noting that, for Marco Perez, "survival . . . did not include prospects for complete or substantial recovery," the dissent observes that "[t]he fact that a patient had a ninety percent chance of succumbing to his or her affliction has no relevance under the majority's rule." *Perez*, 107 Nev. at 13, 805 P.2d at 597. The dissent further notes that *Perez* adopted "the premise that any showing of a chance of survivability, *irrespective of the meaning or quality*

of the survival prospect, will support a cause of action against the physician whose conduct may have reduced the patient's chance of survival." *Id.* at 16, 805 P.2d at 598 (italics in original). Thus, a chance at a complete "recovery" from a long-term disease is not needed to bring the "loss of chance" doctrine into play.

Ironically, it's the dissenting opinion in *Perez* that propounds the interpretation that the Respondents ask us to adopt: the *Perez* dissent proposed that the "loss of chance" doctrine should be interpreted to require that evidence be presented "supporting the proposition that medical negligence deprived [the patient] of a demonstrably significant chance for a meaningful recovery." *Id.* at 16, 805 P.2d at 598.

This proposition, rejected by the *Perez* majority, is now made law by a majority of this court in this case: Riley's claim cannot proceed to trial because she could not prove "a substantial chance of her surviving AML." If the leukemia would have killed Riley anyway at some point in the future no matter how distant, even many decades from now, then she would not have "survived" it – and therefore she cannot recover anything from a hospital whose negligent failure to treat something other than the leukemia (namely septic shock, pulmonary edema, and acute renal failure) may have prematurely killed her years before the cancer might have without the negligence.

This is exactly the "so what?" defense that the "loss of chance" doctrine was intended to overrule. *See* Turner W. Branch, *Misdiagnosis of Cancer and Loss of Chance*, 30 Am. Jur. Trials 237 (originally published in 1983; updated August 2016) (citing *Hicks v. United States*, 368 F.2d 626 (4th Cir. 1966)).

IV.

There are actually two variants of liability when malpractice deprives a patient of a "chance" at something better: the first is the approach articulated in *Perez*, commonly known as the "loss of chance" doctrine. The second is known as the "increased risk" doctrine, which is not recognized in Nevada. *See* Restatement (Second) of Torts, § 323; *see, e.g., Mayhue v. Sparkman*, 653 N.E.2d 1384, 1388-1389 (Ind. 1995).

Among the states that have adopted the "loss of chance" doctrine, two primary approaches have emerged: one in which the lost chance is categorized as a discrete recoverable injury, the liability for which is measured under the traditional causation standard; and another in which the "loss of chance" represents a relaxation of the element of causation, rather than as a separate category of injury. *See* Robert S. Bruer, *Loss of A Chance As A Cause of Action in Medical Malpractice Cases*, 59 Mo. L. Rev. 969, 978–82 (1994) (analyzing numerous cases including both *Perez* and *Falcon*). The majority mistakenly describes *Perez* as the latter when it is actually the former: *Perez* did not modify the "preponderance" standard for causation but rather adopted the discrete-injury approach. *See Perez*, 107 Nev. at 6, 805 P.2d at 592 ("the injury to be redressed by the law is not defined as the death itself, but rather, as the decreased chance of survival caused by the medical malpractice [and] the traditional rule of preponderance is fully satisfied.").

No state (including Nevada) limits the "loss of chance" doctrine only to cases where a patient can prove a chance of long-term "survival" in the face of cancer; instead, a mere chance of a "more favorable" outcome had the negligence not occurred, including the possibility of living longer even with the underlying disease, would

suffice.[8] *See Prabhu*, 112 Nev. at 1544, 930 P.2d at 107 ("more favorable recovery"); *Matsuyama v. Birnbaum*, 890 N.E.2d 819, 832 (Mass. 2008)

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[8]In place of *Prabhu*, the majority quotes and discusses at length the case *Falcon v. Memorial Hosp.*, 462 N.W.2d 44 (Mich. 1990). But *Falcon* is not only not the law in Nevada, it's not even the law in the state in which the decision was issued, as the case was expressly overruled by the Michigan Legislature a mere three years after its issuance.

> It is generally accepted that the 1993 amendment to § 2912a was adopted in a direct reaction to *Falcon*, meaning that it repudiated *Falcon*'s reduced proximate causation theory. Thus, it is generally accepted that in adopting this amendment, the Legislature intended to limit medical malpractice claims to the pre-*Falcon* state of the law: if it was more probable than not that the plaintiff would have died even with the best of treatment, a claim for medical malpractice is precluded.

O'Neal v. St. John Hosp. & Med. Ctr., 791 N.W.2d 853, 858 (2010) (footnotes omitted).

And even if it were good law, *Falcon* doesn't support the majority's interpretation of the doctrine. *Falcon* does not say a patient must survive his or her underlying illness to maintain a malpractice claim under the "loss of chance" doctrine. Quite to the contrary, *Falcon* explicitly states:

> "[w]e thus see the injury resulting from medical malpractice as not only, or necessarily, physical harm, but also as including the loss of opportunity of avoiding physical harm. A patient goes to a physician precisely to improve his opportunities of avoiding, ameliorating, or reducing physical harm and pain and suffering."

Falcon, 462 N.W.2d at 52. Even *Falcon* doesn't require a patient to prove a substantial chance of full recovery from an illness to prevail on a medical malpractice claim; it would be enough that the allegedly negligent doctor

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("The patient has lost something of great value: a chance to survive, to be cured, or otherwise to achieve a more favorable medical outcome."); *Delaney v. Cade*, 873 P.2d 175, 178 (Kan. 1994) ("Most of the recorded cases involve factual scenarios in which the patient died when there was a possibility of survival or died sooner than would otherwise have resulted if properly treated."); *see also Greco v. U.S.*, 111 Nev. 405, 411, 893 P.2d 345, 349 (1995) ("Greco's claim here can be compared to one in which a physician negligently fails to diagnose cancer in a patient. Even though the physician did not cause the cancer, the physician can be held liable for damages resulting from the patient's decreased opportunity to fight the cancer, and for the more extensive pain, suffering and medical treatment the patient must undergo by reason of the negligent diagnosis."); *James v. United States*, 483 F. Supp. 581, 587 (N.D. Cal. 1980) (under Federal Tort Claims Act, "no one can say that the chance of prolonging one's life or decreasing suffering is valueless"); *Holton v. Memorial Hosp.*, 679 N.E.2d 1202, 1210 (Ill. 1997) ("where the malpractice has lessened the effectiveness of treatment or increased the risk of an unfavorable outcome to the plaintiff"); *Mayhue v. Sparkman*, 653 N.E.2d 1384, 1388 (Ind. 1995) (adopting increased-risk doctrine and citing *Perez*: "The compensable injury is not the result, which is usually death, but the reduction in the probability that the patient would recover or obtain better results if the defendant had not been negligent"); *Dickhoff ex rel. Dickhoff v. Green*, 836 N.W.2d 321, 333 (Minn. 2013) ("It should be beyond dispute that a patient regards the chance to survive or achieve a more favorable medical outcome

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deprived a patient of the opportunity to merely reduce his or her physical harm and suffering.

as something of value."); *Evers v. Dollinger*, 471 A.2d 405 (N.J. 1984) (adopting the increased-risk doctrine and recognizing the growth of a tumor, resulting in mental and emotional suffering from delayed diagnosis and treatment, as a discrete injury: "Plaintiff's claim for mental and emotional suffering from delayed diagnosis and treatment will not be diminished or defeated by a demonstration that delay itself was not the cause of her ultimate physical injury."); *Alberts v. Schultz*, 975 P.2d 1279, 1282 (N.M. 1999) ("The essence of the patient's claim is that, prior to the negligence, there was a chance that he or she would have been better off with adequate care.").

Thus, most courts recognize that "to live" cannot mean only "to live disease-free indefinitely as if the disease had never occurred"; any lost time on Earth, however small, and even while suffering from the disease, has value. *See Matsuyama*, 890 N.E.2d at 832 ("No one can say that the chance of prolonging one's life or decreasing suffering is valueless." (quoting *James v. United States*, 483 F. Supp. 581, 587 (N.D. Cal. 1980)).

The most frequently cited secondary source on the loss-of-chance doctrine is Joseph H. King, Jr., *Causation, Valuation, and Chance in Personal Injury Torts Involving Preexisting Conditions and Future Consequences*, 90 Yale L.J. 1353 (1981), which the Nevada Supreme Court itself cited in *Perez*. The American Journal of Trial Advocacy summarized Professor King's analysis of the doctrine:

> In partial loss cases, the plaintiff **does not claim loss of an opportunity for a complete cure**; instead, the attempt is made to recover for tortious conduct that delayed treatment or failed to slow progress of the disease. Once partial loss is established, the question becomes the extent of that loss. This kind of loss is compensable, just as

> the definitive type; there is no difference. Both types of cases should be compensable.

Robert A. Reisig, Jr., *The Loss of A Chance Theory in Medical Malpractice Cases: An Overview*, 13 Am. J. Trial Advoc. 1163, 1179–80 (1990) (emphasis added).

The injury claimed by Riley here is not just the loss of a substantial chance to eventually triumph over leukemia over the long term (although it includes that as well); the claimed injury is the loss of a substantial chance of having more time on Earth with her parents even while continuing to suffer from cancer, had her septic shock, pulmonary edema, and acute renal failure been properly treated. I think that presents a viable claim.

V.

Here is how I think the doctrine should properly have been applied in this case.

In *Perez*, the court held that testimony that a patient had a "reasonable" chance of surviving the immediate cause of death (brain hemorrhage in *Perez*; septic shock, pulmonary edema, and acute renal failure in Riley's case), even though not greater than fifty percent, was sufficient to overcome summary judgment and warrant a jury trial. 107 Nev. at 3, 805 P.2d at 590. Consequently, summary judgment is not appropriate when a patient's chance of survival is more than "truly negligible" even if less than fifty percent, so long as it's "reasonable" or "substantial." Other courts agree that survival percentages well below fifty percent are sufficient to constitute a "substantial" chance. *See, e.g., Kallenberg v. Beth Israel Hosp.*, 45 A.D.2d 177, 180 (N.Y. 1974) (affirming jury verdict for plaintiff in malpractice action where expert opined there was loss of 20% to 40% chance of survival).

Two of our sister states have held that losing a chance of survival even as little as 10% could be sufficient to satisfy the doctrine. *Pipe v. Hamilton*, 56 P.3d 823, 828-29 (Kan. 2002) ("As a matter of law, even a 10 percent loss of chance cannot be said to be token or de minimis."); *Stewart v. New York City Health and Hospitals Corp.*, 207 A.D.2d 703, 704 (N.Y. 1994) (in reinstating jury award for plaintiff where experts opined that plaintiff would have had less than 50% chance or only 5% to 10% chance of conceiving a child naturally, court noted that if jury found that plaintiff lost even a 5% to 10% chance the verdict would be justified).

Thus, the bulk of the case law, and *Perez* itself, clearly indicate that a viable "loss of chance" exists even when the chance of survival (or for a "more favorable recovery") may be well below 50%, even as low as 10%.

Furthermore, in determining where on this scale a particular set of facts may fall, the *Perez* court cautioned that any uncertainty in applying this otherwise somewhat amorphous standard ought to be held against the doctor rather than the patient:

> Health care providers should not be given the benefit of the uncertainty created by their own negligent conduct. To hold otherwise would in effect allow care providers to evade liability for their negligent actions or inactions in situations in which patients would not necessarily have survived or recovered, but still would have had a significant chance of survival or recovery.

107 Nev. at 5-6, 805 P.2d at 591 (quoting *McKellips v. St. Francis Hospital, Inc.*, 741 P.2d 467, 474 (Okl. 1987). Other courts have also held that any uncertainty in applying this doctrine should be held against the alleged wrongdoer. *See Matsuyama v. Birnbaum*, 890 N.E.2d 819, 831

(Mass. 2008) (noting that it would be particularly unjust to deny recovery to a plaintiff unable "to demonstrate to an absolute certainty what would have happened in circumstances that the wrongdoer did not allow to come to pass").

In the case at hand, the Reas' expert, Dr. Bronston, testified during his deposition to a reasonable degree of medical probability that the Respondents' actions fell below the standard of care; that their failure to timely treat Riley contributed to her death via septic shock, pulmonary edema, and acute renal failure; and that proper treatment would have prolonged Riley's life. However, Dr. Bronston testified he did not know precisely how much longer Riley would have lived had Riley been properly treated. Specifically, Dr. Bronston testified as follows:

> I can't testify that ultimately a month, five months down the line, ten years down the line whether the infant would have ultimately survived. I can tell you that not doing the things that were appropriate contributed to her death with the caveat that I can't tell you how long it may have prevented a death, and I can't tell you within a reasonable degree of medical probability, how I define it, which means over 50 percent, that it – it would have.
>
> But when I say "contributed to," what I mean, at least it would have prolonged her life, I believe. How much longer – I couldn't tell you that. So that's what I mean by "contributed," that it – that it would have delayed the death.

Additionally, Dr. Kline, Riley's treating oncologist, also testified leukemia patients typically have a 50% chance of long-term survival, because 50% of cases are, or can become with treatment, non-terminal. Kline also testified that, out of all of the leukemia patients he had ever treated, Riley was the only one who had ever died so quickly. Taken together, this

testimony indicates that Riley's chance of survival would have been considerably more than "truly negligible" and would have been "reasonable" but for the alleged negligence.

Neither Dr. Bronston nor Dr. Kline ever use the exact words "reasonable" or "substantial" (something that the Respondents make much of in their briefing), but on summary judgment "we must draw all inferences from [a witness'] statement in a manner which is favorable to the party opposing summary judgment." *Perez*, 107 Nev. at 7, 805 P.2d at 592. In *Perez* itself, the witness never used the proper legal term ("substantial") but the Nevada Supreme Court nonetheless concluded that the witness' testimony "fairly imply" this conclusion. *Id.*

Consequently, the relevant question is not whether the witness used a particular magic word, but rather what the testimony "fairly implies" in its meaning. Here, when viewed in the light most favorable to the Reas, the fair implication of Bronston and Kline's testimony is that Riley would have had a reasonable chance of surviving at least somewhat longer than she did had she been timely and properly treated for septic shock, pulmonary edema, and acute renal failure. To conclude otherwise – that when Dr. Bronston says he believes that Riley would have survived, he nevertheless meant that the chance would not have been "reasonable" – is to reach the bizarre conclusion that Dr. Bronston thinks that his own beliefs and conclusions are unreasonable. That is hardly the fairest implication of his testimony, and it falls far short of constituting the liberal interpretation most favorable to the Reas demanded under the standards of NRCP 56.

VI.

The Respondents argue that summary judgment was appropriate because Dr. Bronston could not testify that Riley would have lived past March 27. Specifically, Dr. Bronston was asked the following question: "So is it your opinion that had all of this treatment been administered on March 24th, 2011, that Riley Rea would not have succumbed on the 27th, I believe it was?" His answer was: "I can't say that for sure. No . . . it contributed to her death on that -- on that day and I believe she would have lived longer. It contributed to it, but I can't say within a reasonable degree of medical probability that it would -- it would have." Later, he also repeats that, assuming everything was done appropriately, he cannot state that Riley would not have passed away on March 27th.

The Respondents contend that this testimony fails to prove that Riley had a "substantial" and "non-negligible" chance of survival because even Dr. Bronston concedes that he cannot conclude with medical certainty that Riley would have lived past March 27th. But Dr. Bronston clearly and unequivocally testifies, to a reasonable degree of medical probability, that Riley would have lived longer but for the asserted negligence. He just doesn't know, to a reasonable degree of medical probability, how much longer she would have lived beyond March 27.

How much longer a deceased patient might have otherwise lived is not an essential element of the "loss of chance" doctrine. As a matter of logic and common sense, no physician can testify to a reasonable degree of medical probability how long anyone will live, even a completely healthy patient; if doctors could do that then we could all medically predict the date of our own deaths. We all know that doctors can't do that.

More pointedly, no published case from any state applies the "loss of chance" doctrine in such a way that the doctrine depends upon exactly how much longer a deceased patient might have lived absent the negligence. Quite to the contrary, "in those situations where a health care provider deprives a patient of a significant chance for recovery by negligently failing to provide medical treatment, the health care professional should not be allowed to come in after the fact and allege that the result was inevitable inasmuch as that person put the patient's chance beyond the possibility of realization." *McKellips*, 741 P.2d at 474.

All that is required to meet Nevada's "loss of chance" doctrine is testimony, to a reasonable degree of medical probability, that a patient was deprived of a chance for a "more favorable recovery" but for the negligence. *Prabhu*, 112 Nev. at 1544, 930 P.2d at 107. How long the patient would have lived – whether minutes, hours, days, weeks, months, years, or decades – might go to the amount of damages the patient can recover, but not to whether the doctrine has been met and the elements of a provable claim established. *See id.; see also Perez*, 107 Nev. at 7, 805 P.2d at 592 (citing *McKellips v. Saint Francis Hosp., Inc.*, 741 P.2d 467, 475 (Okl. 1987)) ("we do not require that the expert testimony specifically quantify the percentage chance of survival in order to create a question of fact on causation; specific percentages are necessary only at later stages in determining the precise measure of damages.").

Furthermore, even when assessing damages, the Nevada Supreme Court permits some measure of uncertainty; the amount of damages need not be proven to a medical certainty. *See Frantz v. Johnson*, 116 Nev. 455, 469, 999 P.2d 351, 360 (2000) ("damages need not be proven with mathematical exactitude, and that the mere fact that some

uncertainty exists as to the actual amount of damages sustained will not preclude recovery"). Instead, in "loss of chance" cases, juries may use "probabilities" and "statistical evidence" to determine how long a patient might have lived. *See McKellips*, 741 P.2d at 475 ("statistical evidence combined with evidence linking the probabilities to the patient in the case should be considered by the jury in apportioning damages"). Thus the inability of Dr. Bronston to do what doctors cannot do and predict exactly how long a dead child would have lived had things gone differently is insufficient to warrant summary judgment on either the question of causation or damages.

In this case, Bronston unequivocally states to a reasonable degree of medical probability that Riley would have lived longer than she did, but he cannot say to a reasonable degree of medical probability precisely how much longer she would have lived, including whether she would have lived past the 27th, due to the seriousness of her condition. That alone is sufficient to meet the elements of a "loss of chance" case and defeat summary judgment. Even construing that testimony in the most narrow way possible (the exact opposite of how it should be construed on summary judgment), Dr. Bronston's testimony establishes that Riley would have lived longer on the 27th, but might or might not have lived past the 27th; merely because Riley might not have lived past the 27th does not mean that she wouldn't have lived longer on the 27th. Even under this extremely narrow construction, Riley's recoverable damages might be limited to the value of a child living one day longer than she did, but she would be entitled to some amount of damages for that – precisely how much constitutes a question for the jury, not for the court on summary judgment.

Additionally, there exists another alternative way of interpreting Bronston's lack of certainty that might entitle Riley to considerably more damages than only one day of life. The undisputed evidence was that children suffering from the kind of cancer that Riley did have an overall 50% survival rate, meaning 50% of them will die, but 50% will survive if treated properly. Dr. Bronston's uncertainty regarding whether Riley would have lived beyond March 27 could be interpreted as simply saying that he no longer has any way of knowing, to a reasonable degree of medical probability, which group of leukemia patients Riley would have eventually belonged in had she received timely treatment for her septic shock, pulmonary edema, and acute renal failure. If this is what he meant, then Riley might have had a 50% chance of living a full life of many years if she fell into the non-fatal category, had she been given a chance to outlive the septic shock, pulmonary edema, and acute renal failure that, left untreated, killed her in three days.

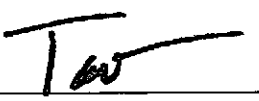
Unfortunately, during Bronston's deposition neither party asked the proper follow-up questions to enable us to determine which of these two alternative conclusions was intended by Bronston. But either of these conclusions renders summary judgment wholly inappropriate.

VII.

Taken as a whole and viewed in the light most favorable to the Reas, Dr. Bronston's testimony demonstrated, to a reasonable degree of medical probability, that the Respondents' conduct fell below the standard of care; that their conduct contributed to Riley's death; and that, but for their conduct, Riley would have lived longer. If believed by a jury, that testimony is sufficient to support all of the elements of a "loss of chance" claim, including the elements of duty, breach, and causation. The amount

of damages to which the Reas might be entitled is a matter for the jury. At the very least, the Respondents should not benefit from the uncertainty in Riley's life expectancy that their own inaction created.

In sum, viewing this evidence in the light most favorable to the Reas, I cannot conclude that no genuine issues of material fact remain in this case and that the Respondents have demonstrated that they are entitled to judgment as a matter of law based upon the existing record. Accordingly, I respectfully dissent.



_____, J.
Tao

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