2d Civil No. B172622

COURT OF APPEAL

FOR THE STATE OF CALIFORNIA

SECOND APPELLATE DISTRICT

DIVISION FOUR

NANCY McCORMICK-GORDON and
THE ESTATE OF GERALD GORDON,

Plaintiffs and Appellants,

v.

CEDARS-SINAI MEDICAL CENTER,

Defendant and Respondent.

Appeal from the Superior Court for the County of Los Angeles
Case No. BC 279 606
Honorable Jon Mayeda

RESPONDENT'S BRIEF

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INTRODUCTION

Gerald Gordon was a very sick man with multiple life-threatening health conditions. According to plaintiffs' own expert, he had only a 50% chance of surviving his 1999 lung transplant. Yet plaintiffs claim that he died because Cedars-Sinai Medical Center supposedly left a "small and uncomplicated" fragment of a urethral catheter in his body.

Apart from its many other problems, plaintiffs' case fails because their own expert's declaration conclusively established lack of causation. The expert, Dr. Rifkin, stated that "[a]pproximately 50% of lung transplantation patients die in the first five years after transplantation." (CT 99:16-17.) Since medical malpractice liability requires proof of causation to a "reasonable medical probability," the 50% chance of death following a lung transplant *negates* causation—it cannot be "more likely than not" that the catheter fragment caused his death. (*Bromme v. Pavitt* (1992) 5 Cal.App.4th 1487, 1498.)

And plaintiffs' case does have other problems. The trial court correctly granted summary judgment, because not only was Dr. Rifkin unqualified to testify, but his opinions lacked any reasonable basis to show a breach of the standard of care or causation.

Lack Of Qualifications. Dr. Rifkin had no specialized education or training in urology, catheter removal or infectious diseases—the topics about which he opined. Nor did he have any experience with catheters or treatment of infectious diseases. And neither his basic medical school

education, nor his recent work in a hair restoration practice and as a surgeon, qualified him.

No Reasonable Basis For Opinions. As to standard of care, Dr. Rifkin said that Cedars-Sinai should have conducted an examination of the catheter upon removal, but he did not describe when and how such an examination should be done. The lack of any specificity should not be surprising since there is no evidence that he has ever removed (or even watched the removal of) a urethral catheter.

Dr. Rifkin's causation opinions were even skimpier. He did not even attempt to refute the evidence of Cedars-Sinai's expert that catheters are designed to remain in the body at length without harming the patient. Nor did he try to explain why it was that an inert catheter fragment, rather than multiple, deadly health conditions, "played a major role" in Gordon's death. In fact that conclusion was contradicted by his own testimony that it was at least equally probable that Gordon's lung transplant killed him.

Res Ipsa Loquitur/Common Knowledge. Plaintiffs only seek to use these doctrines to establish a breach of the standard of care. If either Dr. Rifkin is unqualified or his causation opinions lack any reasonable basis, the Court does not need to reach this argument—the case fails on causation. And contrary to plaintiffs' argument, this situation does not fall into the line of foreign body cases. Unlike scalpels or surgical instruments, catheters are *supposed* to remain in the body.

The judgment must be affirmed.

STATEMENT OF FACTS

A. Gordon's History Of Multiple, Severe Health Problems Leading Up To His Death.

Gordon was in extremely poor health during the last years of his life. (CT 67:17-18.) He underwent a lung transplant in June 1999, which his body rejected. (CT 67:10 & 19; 98:1.) This resulted in severe immune suppression that, among other things, precipitated an outbreak of urethral warts. (CT 67:10-12; 98:4-7.) Because the warts caused intractable bleeding and lesions in the urethral tissue, they had to be surgically removed, which required installation of an indwelling urethral catheter and suprapubic tube. (CT 67:2-3 & 12-14.) Besides the urethral surgery, Gordon had various other surgical procedures, including a hip replacement and cataract removal. (CT 67:1-2.) Because of these many surgeries and his overall ill health, Gordon had numerous urethral catheters placed during his hospital stays at Cedars-Sinai and at several other facilities. (CT 67:21-22.)

Gordon suffered from many other diseases and disorders. He had suffered a heart attack and was diagnosed with severe and chronic lung disease, severe osteoporosis, and chronic anemia. (CT 67:4-7.) His body was saddled with chronic inflammation and riddled with drug-resistant infections, both viral and bacterial, that affected his lungs, windpipe, intestines and nasal passages. (CT 67:7-9 & 18-20; 98:3-7.)

Most likely during the periodic removal and replacement of one of his catheters, a "small and uncomplicated" fragment of the catheter was left

in his body. (CT 67:22-25; 68:8.) Gordon claimed that Cedars-Sinai left the catheter fragment. (CT 16:22-26.) Cedars-Sinai did not admit that it left the catheter fragment, but it did remove the fragment immediately upon discovering it in late April 2001. (CT 59-60; 67:22-25; 68:5-8.) Gordon died in August 2001 at the age of 67. (CT 97:26; 66:28.)

B. Trial Court Proceedings.

Gordon's wife and estate (plaintiffs) sued Cedars-Sinai and one of its doctors for medical malpractice. (CT 15-23.) After plaintiffs dismissed the individual doctor, Cedars-Sinai moved for summary judgment. (CT 2; 31-53.)

1. Cedars-Sinai's summary judgment motion: The catheter fragment did not cause Gordon's death and Cedars-Sinai did not breach the standard of care.

Cedars-Sinai argued that even if it was responsible for leaving the small catheter fragment in Gordon's body, doing so would not constitute a breach of the standard of care and did not cause Gordon's eventual death. (CT 31-53.) Cedars-Sinai supported its motion with a declaration from J. Bradley Taylor, M.D., a board-certified urologist with over 20 years experience in urology. (CT 66:3-12; 69-73.)

Dr. Taylor declared that, to a reasonable degree of medical probability, the catheter fragment did not cause or contribute to Gordon's death. (CT 68:2-4 & 10-13.) He explained that catheters are biocompatible and intrinsically designed to remain inside the body for an extended

period—their presence has no deleterious effect. (CT 67:28-68:2.) A small piece of a catheter left accidentally in a body would have no more effect than an entire catheter placed intentionally. (CT 67:26-28.) Dr. Taylor opined that Gordon most likely died of respiratory failure caused by pseudomonas infection. (CT 68:10-11.) Dr. Taylor concluded that in placing the catheters and removing the fragment immediately upon its discovery, Cedars abided by the standard of care for urologists in the community. (CT 68:5-15.)

2. Plaintiffs' opposition.

a. Evidence regarding Dr. Rifkin's qualifications.

The declaration of plaintiff's expert, Dr. Marc A. Rifkin, only supplied basic biographical data: He received his medical doctorate from the University of Guadalajara, he is board certified in general surgery, he is licensed in several states, and he has been an instructor or fellow in surgery at various institutions. (CT 97:2-24.) There was no evidence that Dr. Rifkin had ever received any training or specialized education in urology or infectious diseases, or that he had ever practiced in urology or infectious diseases. (CT 97-99.) Indeed, his practical experience only became evident when Cedars-Sinai submitted his resume in support of its evidentiary objections to his declaration. (CT 111.) That resume revealed that Dr. Rifkin had worked in a hair restoration practice for the prior 12 years. (CT 109, 111.) Before that, he spent a few years in private practice

as a surgeon. (CT 111.) Again, there was no evidence that any of his professional experience involved urology, catheters or infectious diseases.

b. Evidence regarding Cedars-Sinai's liability.

Dr. Rifkin assumed that the catheter fragment was left in Gordon's body during a hospitalization at Cedars-Sinai, and opined that the fragment had been there for three to twelve months before its April 2001 discovery. (CT 98:8-14.) He posited that, although failing to properly remove a catheter is "not an uncommon event," failing to detect the catheter fragment in an immune-suppressed patient like Gordon was a breach of the standard of care because the broken catheter should have been noticed when it was removed. (CT 98:15-16 & 98:26-99:5.)

Dr. Rifkin acknowledged that Gordon's medical history was "quite complex," that he had a "fairly complicated course after his transplant," and that "[a]pproximately 50% of lung transplantation patients die in the first five years after transplantation." (CT 97:28; 98:2-3; 99:16-17.) Nevertheless, he concluded that the catheter fragment "played a major role" in Gordon's death. (CT 99:19-21.) He did not explain how a catheter fragment created any more risk than an entire catheter, which he acknowledged Gordon had in his body throughout much of this time. (CT 99:6-21.)

3. The trial court rules that Dr. Rifkin is not qualified and has no reasonable basis for his conclusions.

The trial court struck Dr. Rifkin's testimony. (Gordon's Motion to Augment, Ex. A; Cedars-Sinai's Motion to Augment, Ex. 2.) Plaintiffs incorrectly assume that the trial court's only substantive summary judgment order was a September 4, 2003 Minute Order that relied solely on Dr. Rifkin's lack of qualifications. (See AOB 5, fn. 1; Gordon's Motion to Augment, Ex. A.) In fact, the court actually issued a formal order on October 1, 2003, in which it ruled that Dr. Rifkin "failed to state the basis of his opinion regarding the standard of care in the community." (CT 2; Cedars-Sinai's Motion to Augment, Ex. 1.) Indeed, at the motion hearing the trial court questioned Dr. Rifkin's declaration on both of these grounds. (Cedars-Sinai's Motion to Augment, Ex. 2 [RT 1:17-24; 6:25-7:8].)

Without an admissible expert declaration, plaintiffs had no evidence to counter Cedars-Sinai's expert evidence. The trial court therefore granted summary judgment. (CT 114.) Plaintiffs timely appealed. (CT 122.)

STANDARD OF REVIEW

Courts of appeal generally review summary judgments de novo. (*Ann M. v. Pacific Plaza Shopping Center* (1993) 6 Cal.4th 666, 673-674.) However, "it is also true that any determination underlying any order is scrutinized under the test appropriate to such determination." (*Aguilar v. Atlantic Richfield Co.* (2001) 25 Cal.4th 826, 859.) The underlying determination of whether an expert is qualified or whether there is a

reasonable basis for his opinion is reviewed for abuse of discretion. (*Jackson v. Deft, Inc.* (1990) 223 Cal.App.3d 1305, 1319-1320 [qualification]; *Korsak v. Atlas Hotels, Inc.* (1992) 2 Cal.App.4th 1516, 1523 [basis for opinion]; accord, AOB 5 [qualification].) That standard requires plaintiffs to show that the trial court's expert testimony rulings "exceeded the bounds of reason." (*Piscitelli v. Friedenberg* (2001) 87 Cal.App.4th 953, 972.)

Division Three of this Court very recently applied these principles in a procedurally identical context. In *In re Lockheed Litigation Cases* (2004) 115 Cal.App.4th 558, the trial court had granted summary judgment after determining that the plaintiff's expert evidence was inadmissible. The court of appeal held that the admissibility ruling must be reviewed for an abuse of discretion, even if the overall summary judgment should be scrutinized under independent review. (*Id.* at pp. 563-564.)[1]

Plaintiffs maintain that de novo review governs here, but the cases they cite all involved summary judgments where there was no underlying ruling with a different review standard. (See AOB 4, 7, citing *Branco v. Kearny Moto Park, Inc.* (1995) 37 Cal.App.4th 184, 189; *Campbell v. Arco Marine, Inc.* (1996) 42 Cal.App.4th 1850, 1855; and *Suidan v. County of San Diego* (1999) 72 Cal.App.4th 916, 920.)

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[1] Although *Jennings v. Palomar Pomerado Health Systems, Inc.* (2003) 114 Cal.App.4th 1108 suggests a somewhat more deferential standard of review of expert medical testimony in a jury trial case, the court nevertheless upheld the striking of testimony far more detailed than Dr. Rifkin's from an expert who was concededly qualified. (*Id.* at p. 1118, fn. 9.)

Accordingly, the Court must first decide whether the trial court abused its discretion in determining that Dr. Rifkin's opinions were inadmissible. The Court must then analyze the summary judgment on the basis of whatever evidence remains.

Although the record reveals that the trial court issued multiple orders reflecting different grounds for granting summary judgment, it is immaterial what grounds the trial court actually relied upon, because a reviewing court "must affirm so long as any of the grounds urged by [the moving party], either here or in the trial court, entitles it to summary judgment." (*Western Mutual Ins. Co. v. Yamamoto* (1994) 29 Cal.App.4th 1474, 1481; *Transamerica Ins. Co. v. Tab Transportation, Inc.* (1995) 12 Cal.4th 389, 399, fn. 4 ["[A] ruling or decision, itself correct in law, will not be disturbed on appeal merely because given for a wrong reason. If right upon any theory of the law applicable to the case, it must be sustained regardless of the considerations which may have moved the trial court to its conclusion"], quoting *Davey v. Southern Pacific Co.* (1897) 116 Cal. 325, 329.) This principle applies with equal force to the situation here—evidentiary rulings governed by the abuse-of-discretion standard. (*In re Marriage of Burgess* (1996) 13 Cal.4th 25, 32 [discretionary custody ruling affirmed if correct on any ground]; *Philip Chang & Sons Associates v. La Casa Novato* (1986) 177 Cal.App.3d 159, 173 [exclusion of evidence affirmed even if objection granted was incorrect because correct objection existed].)

ARGUMENT

I.

THE TRIAL COURT DID NOT ABUSE ITS DISCRETION IN RULING THAT DR. RIFKIN WAS NOT QUALIFIED.

"'[I]n any medical malpractice action, the plaintiff must establish: '(1) the duty of the professional to use such skill, prudence, and diligence as other members of his profession commonly possess and exercise; (2) a breach of that duty; (3) a proximate causal connection between the negligent conduct and the resulting injury; and (4) actual loss or damage resulting from the professional's negligence.'" (*Elcome v. Chin* (2003) 110 Cal.App.4th 310, 317, citations omitted.)

California law has long been settled that expert testimony is ordinarily necessary to establish both a breach of the standard of care and causation. (*Sinz v. Owens* (1949) 33 Cal.2d 749, 753 [standard of care]; *Jambazian v. Borden* (1994) 25 Cal.App.4th 836, 844 [standard of care]; *Bromme v. Pavitt*, *supra*, 5 Cal.App.4th at p. 1498 [causation].) In certain limited situations, the doctrine of res ipsa loquitur can substitute for expert testimony. But, as we will show, plaintiffs neither provided sufficient, qualified expert testimony nor established a basis for applying res ipsa.

A. Dr. Rifkin Had No Education, Training, Or Experience In Urology, Catheter Removal Or Infectious Diseases.

"A person is qualified to testify as an expert if he has special knowledge, skill, experience, training, or education sufficient to qualify him as an expert on the subject to which his testimony relates." (Evid. Code, § 720; *Moore v. Belt* (1949) 34 Cal.2d 525, 532.)

Dr. Rifkin had no specialized training or board certification in urology or infectious diseases. His only board certification was in general surgery. (CT 97:20-22.) So aside from whatever he may have learned at the University of Guadalaja, he had no education or specialized training in urological conditions, appropriate use of catheters, standards concerning placement and removal of catheters, or infectious diseases.

Dr. Rifkin's work experience also diverged far from the fields of urology and infectious diseases. At the time of his declaration, he had been working in a hair restoration practice for the previous 12 years. (CT 109, 111.) Before that, Dr. Rifkin spent a few years in private practice as a surgeon. (CT 111.) Plaintiffs presented no evidence that Dr. Rifkin had ever placed any catheters or done any urological examinations. There was also no evidence that any of Dr. Rifkin's work experience involved diagnosing or treating infectious diseases. Given this lack of relevant work experience, it is not surprising that plaintiffs didn't even bother to submit Dr. Rifkin's curriculum vitae, but instead relied solely on a generic, one-paragraph summary of his educational background. (CT 97:7-24.)

In the trial court, plaintiffs presented Dr. Rifkin as qualified because he received a medical doctorate from the University of Guadalajara, was admitted to practice in various states, and was a board-certified instructor and fellow in general surgery. (CT 97:7-24.) But a general medical education and some specialized training in surgery does not qualify one to opine about urology or infectious diseases. Apparently recognizing this problem, in their opening brief plaintiffs augment Dr. Rifkin's qualifications by drawing from his resume—which Cedars-Sinai, not plaintiffs, put into evidence—to show that Dr. Rifkin had other experience. (AOB 7.) This experience does not catapult Dr. Rifkin over the qualification hurdle, because it has nothing to do with urology, catheters or infectious diseases.

Indeed, plaintiffs acknowledge that the scope of Dr. Rifkin's qualifications are limited "to provid[ing] an opinion on medical treatments related to surgery or trauma." (AOB 7.) Yet Dr. Rifkin's opinions did *not* relate to surgical procedures or trauma, but rather to catheter removal and bacterial infections. As we will show, the limitation plaintiffs now place on the scope of Dr. Rifkin's qualifications is fatal to their argument.

B. Dr. Rifkin's General Medical Knowledge And Unrelated Work Experience Were Not Sufficient To Establish His Qualification To Opine On The Specialized Issues Present Here.

General medical knowledge is not enough when the issue involved is specialized. For example, in *Moore v. Belt, supra*, 34 Cal.2d 525, the plaintiff sued for medical malpractice over an infection that followed a urological examination, but lost at trial after the trial court found his expert not qualified. (*Id.* at pp. 527 & 531.) Although the plaintiff's expert had been an autopsy surgeon for over 29 years and was educated about the anatomy and infections in the genital-urinary system, our Supreme Court found he was not qualified to testify on the standards related to urological exams. (*Id.* at pp. 531-532.) The Court emphasized that the expert was not a urologist, had never done urological examinations and was not familiar with the current standards of practice in urology. (*Ibid.*) Dr. Rifkin similarly exhibited no experience or familiarity with the current practice standards in urology. Indeed, spending the last 12 years in a hair restoration practice negates any such experience or familiarity. (CT 109, 111.)

An expert's lack of directly relevant education and training likewise doomed his ability to testify in *Pearce v. Linde* (1952) 113 Cal.App.2d 627. There, an internist who had read about foot surgeries opined on an orthopedic surgeon's negligence in performing foot surgery. (*Id.* at p. 629.) The court upheld the expert's disqualification, ruling that "the testimony of

an expert in internal medicine would be no more persuasive than that of a layman who had read and heard what was the proper professional practice." (*Id.* at p. 630.) Dr. Rifkin's general medical school education and board certification in general surgery made him no more suitable to testify than reading about another specialty, which the Court rejected in *Pearce*. (See also *Huffman v. Lindquist* (1951) 37 Cal.2d 465, 476-479 [longtime county coroner, medical examiner, experienced pathologist and autopsyist not qualified to testify about treatment of brain injuries].)

Even if Dr. Rifkin's education sufficed, his lack of experience with urological conditions, catheters or infectious diseases rendered him unqualified. In *Bennett v. Los Angeles Tumor Institute* (1951) 102 Cal.App.2d 293, the plaintiff had received burns from X-ray treatment for papillomae on the soles of her feet. (*Id.* at p. 295.) The plaintiff relied on testimony from a chiropodist who was licensed to treat foot conditions and use X-ray treatment and who had studied dermatological foot conditions and X-rays, but who had never actually used X-ray treatment. (*Id.* at p. 297.) In upholding his disqualification, the Court of Appeal focused on the fact he had never been trained in or actually used X-ray treatment. (*Ibid.*) Similarly, although Dr. Rifkin's medical license may have permitted him to conduct urological examinations and to place and remove catheters, there is no evidence he has ever actually done so. Indeed, Dr. Rifkin was less qualified than the expert in *Bennett*, since he had never even received any training or education in urology. Thus, plaintiffs were right when they limited the scope of his qualifications to "medical treatments related to

surgery or trauma" (AOB 7)—outside of this arena, Dr. Rifkin was unqualified.

Mann v. Cracchiolo (1985) 38 Cal.3d 18 (cited at AOB 5) does not require a different result. There the plaintiff's decedent, while receiving foot X-rays in preparation for surgery, fell and broke her neck and eventually died. (*Id.* at p. 31.) The plaintiff proffered an expert neurosurgeon who opined that the defendants, particularly the radiologists, failed to discover the neck fracture and order the correct X-rays after her fall. (*Id.* at pp. 34-35.) The trial court found the expert not qualified, but the Supreme Court reversed. It noted that since the expert "regularly read X-rays and radiologists' reports," he was familiar with the standard of care for reading those reports. (*Id.* at p. 38.) Dr. Rifkin's experience was not remotely comparable. The expert in *Mann* learned from practical experience what he lacked in formal education or training. But Dr. Rifkin had nothing to offer—no urology or infectious disease education, no training, and no practical experience.

Chadock v. Cohn (1979) 96 Cal.App.3d 205, the only other decision plaintiffs cite on this subject (AOB 7), is no closer to the mark. There, the plaintiff sued a doctor for negligently performing foot surgery. The plaintiff lost when the trial court found that her expert was not qualified because he was a podiatrist, not a physician. (96 Cal.App.3d at p. 207.) The court of appeal reversed, ruling that the podiatrist had specialized education about foot injuries, had performed many foot surgeries including the particular procedure at issue, and was familiar with the standard of care for foot surgery. (*Id.* at pp. 209-215.) Again, Dr. Rifkin had none of those

qualifications—no specialized education, no experience or training with catheters, and no familiarity with urological or infectious disease standards.

Given the admittedly limited scope of Dr. Rifkin's qualifications, the unrelated education and the dearth of experience, plaintiffs cannot show that the trial court abused its discretion in refusing to find him qualified.

II.

THE TRIAL COURT DID NOT ABUSE ITS DISCRETION IN RULING THAT THERE WAS NO REASONABLE BASIS FOR DR. RIFKIN'S OPINIONS.

A. Dr. Rifkin's Standard-Of-Care Conclusions Lacked Any Reasonable Basis.

The sum total of Dr. Rifkin's testimony on the standard of care was: "When one removes a catheter, one looks at it to determine whether or not it is intact. If a piece is missing, it is clear that something is wrong. Failure to detect the broken catheter and take corrective action in this immunosuppressed patient falls below the standard of care in the community." (CT 98:27-99:5.) Dr. Rifkin provided none of the necessary factual foundation and no reasonable explanations for these conclusions.

No Familiarity With Urology Standard Of Care. Dr. Rifkin presented no evidence that he was familiar with the standard of care for urologists in Southern California or for the removal of catheters. Indeed, there was no evidence that Dr. Rifkin has ever removed a catheter or even

watched one being removed. Without any established familiarity with the standard of care, his conclusions about how Cedars-Sinai allegedly breached it lack any reasonable basis.

No Precise Description Of The Allegedly Required Examination Of A Removed Catheter. Dr. Rifkin did not explain how a urologist or nurse is supposed to conduct an examination of the removed catheter. Is it done visually, tactilely, under a microscope, or by a laboratory? Dr. Rifkin stated that improperly removing a catheter is "not an uncommon event." (CT 98:16.) Surely if this is not an uncommon event, there must be an established procedure for detecting fragments—a standard of care. But then again, Dr. Rifkin also did not quantify "uncommon" or explain why (according to him) catheters are commonly removed improperly. Nor did he demonstrate how he came by this supposed knowledge without ever having had any experience in placing or removing catheters or even reading about doing so. Yet another gap in Dr. Rifkin's reasoning is that while he implicitly equated improper removal with breakage, he gave no reasons.

No Explanation Of When Such "Examination" Is Necessary. The fragment discovered in Gordon's bladder was "small and uncomplicated." (CT 68:8.) Do the need and scope of Dr. Rifkin's amorphous "examination" depend on the size of the fragment? If so, is the failure to look for breakage a breach of the standard of care when the fragment is small? Dr. Rifkin's declaration gave no clues to answer these important questions.

"[A]n expert opinion is worth no more than the reasons upon which it rests." (*Kelley v. Trunk* (1998) 66 Cal.App.4th 519, 524.) Thus, in *Kelley* the court reversed a defense summary judgment because it was "based on a conclusory expert declaration which states the opinion that no malpractice has occurred, but does not explain the basis for the opinion." (*Id.* at p. 521.) The expert had only described a few background facts and then leapt to the conclusion that the defendant had acted within the standard of care. (*Id.* at p. 522.) Dr. Rifkin also provided practically no reasoning and no factual detail at all to support his conclusion that Cedars-Sinai breached the standard of care.

B. Dr. Rifkin Not Only Failed To Establish Any Basis For Causation, But His Opinions Actually Negated Causation.

Even if Dr. Rifkin's declaration crossed the threshold for showing a breach of the standard of care, it fell woefully short in its attempt to show causation. One shortfall is that Dr. Rifkin's causation opinions established no reasonable medical probability that the fragment caused Gordon's death. Quite the opposite: His opinion *negates* that result.

The linchpin of causation in medical malpractice case is reasonable medical probability. (*Jennings v. Palomar Pomerado Health Systems, Inc.*, *supra*, 114 Cal.App.4th at p. 1117.) *Jennings* explained the "distinction between a reasonable medical '*probability*' and a medical '*possibility*'" this way: "A possible cause only becomes 'probable' when, in the absence of other reasonable causal explanations, it becomes more likely than not that the injury was a result of its action." (*Id.*, emphasis added and omitted.)

Although Dr. Rifkin said that the catheter fragment played a "major role" in Gordon's death (CT 99:20), elsewhere he made clear that, whatever "major role" means, it does *not* mean "reasonable medical probability." That is because, according to Dr. Rifkin, Gordon had only a 50% chance of surviving his lung transplant, *irrespective* of any other health conditions or catheter fragments,. (CT 99:16-17.) This probability means that it *cannot* be "more likely than not" that the catheter fragment, rather than the lung transplant—to say nothing of all Gordon's other ailments—was what caused Gordon's death.

The court in *Bromme v. Pavitt, supra*, 5 Cal.App.4th 1487 came to precisely the same conclusion: "California does not recognize a cause of action for wrongful death based on medical negligence where the decedent did not have a greater than 50 percent chance of survival had the defendant properly diagnosed and treated the condition." (*Id.* at pp. 1504-1505.) In *Bromme* the plaintiff claimed that the defendant's failure to diagnose his wife's colon cancer caused her death. (*Id.* at p. 1492.) But since the experts agreed that as of a certain date the wife only had a 50% chance of survival, the court found that as to any conduct after that date, the plaintiff failed the more-likely-than-not standard—thus he could not show causation to the required degree of a reasonable medical probability. (*Id.* at pp. 1499-1504.)[2] According to Dr. Rifkin, Gordon's situation was identical: Even if

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[2] See also *Duarte v. Zachariah* (1994) 22 Cal.App.4th 1652, 1657-1658 (overprescription of chemotherapy drug could not be cause of medical malpractice injury because there was, at best, only a 50% chance chemotherapy would avert reoccurrence of the cancer); *Dumas v. Cooney* (1991) 235 Cal.App.3d 1593, 1603 (failure to diagnose plaintiff's lung

(continued...)

a catheter fragment had never been left in Gordon's body, Gordon, like all "lung transplantation patients" and like the wife in *Bromme*, had only a 50% chance of survival. (CT 99:16-17.) Therefore, like Mr. Bromme, plaintiffs cannot establish causation.

C. Dr. Rifkin's Causation Opinions Supplied No Reasonable Basis.

Even if Dr. Rifkin's opinions established the requisite reasonable medical probability, they were still inadmissible because they contained no reasonable basis. Dr. Rifkin simply concluded that the presence of the catheter fragment made antibiotic treatment of Gordon's urinary tract infection impossible and led to the emergence of pseudomonas blood poisoning that caused Gordon's death. (CT 99:6-15.) He also cryptically opined that the fragment was a "potentially catastrophic problem in a patient who has been treated with immunosuppressant drugs." (CT 98:17-18.) But there are gaping and unexplained holes in his reasoning.

Gordon's Bad Health History. It is not clear whether Dr. Rifkin fully understood and accounted for the gravity of Gordon's myriad health problems, since he only "reviewed selected medical records"—none of which he identified or described. (CT 97:25-26.) Dr. Rifkin did acknowledge that Gordon's health condition had taken a "fairly complicated course" over the last few years, that he had been beset with

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[2] (...continued)
cancer two years earlier not a cause of death because causation cannot exist "in cases where the evidence indicates that there is less than a probability, i.e., a 50-50 possibility or a mere chance").

multiple, chronic infections, and that 50% of lung transplant patients die in the first five years. (CT 98:2-7; 99:16-17.) Yet he nevertheless concluded that it was the catheter fragment—not Gordon's rejection of the lung transplant, his multiple, longstanding infections, his heart attack, or the many other conditions that plagued Gordon—that "played a major role" and "was a substantial factor" in Gordon's death. (CT 99:19-21.)

Dr. Rifkin's Incomplete Causation Chain. There are also many missing links in Dr. Rifkin's causation chain. He did not explain how the catheter fragment, rather than Gordon's immune-suppressed status following his rejection of the lung transplant, could be responsible for the pseudonomas infection. Nor did he explain how the pseudonomas led to blood poisoning and how that led to Gordon's death. Most critically, Dr. Rifkin did not explain why the catheter fragment posed more of a risk to Gordon than the complete catheters that Gordon concededly had in his body during this time. Indeed, Dr. Rifkin did not rebut or even respond to Dr. Taylor's testimony that catheters (whether entire or partial) are *designed* to remain in the body for extended periods, much less explain why a fragment should behave differently. Finally, he did not describe how "immunosuppressant drugs" could combine with a catheter fragment to create a "catastrophic problem."

1. Recent California cases reject causation opinions like Dr. Rifkin's because they are unreasoned and unsupported.

Two recent California decisions reject unreasoned and unsupported causation opinions like Dr. Rifkin's. In *Jennings v. Palomar Pomerado Health Systems, Inc.*, *supra*, 114 Cal.App.4th 1108 the plaintiff suffered a subcutaneous abdominal infection following surgery, and his expert opined that the infection was caused by the defendants' having negligently left a retractor in his abdominal cavity after the surgery. (*Id.* at p. 1111.) It was undisputed that (1) postoperative wound infections (like this one) are common, (2) the site of this infection was separated from the peritoneal cavity in which the retractor was left by muscles, fascia and the peritoneal wall, and (3) there was no evidence of infection in the peritoneal cavity. (*Id.* at pp. 1112-1113.) Finally, it was accepted that the plaintiff had an increased risk of infection because of his age, weight and type of surgery. (*Id.* at p. 1113.)

The plaintiff's expert opined that the retractor was contaminated as it was placed in the wound, that it remained contaminated through several irrigations of the wound during surgery, and that before the body encased the retractor with a protective covering, bacteria from the contaminated retractor migrated across the peritoneal wall and caused the infection. (*Id.* at pp. 1114-1115.) The trial court struck the expert's opinion as speculative. (*Id.* at p. 1111.) The court of appeal agreed, observing that there was no evidence supporting the assumed bacterial migration:

"[W]hen an expert's opinion is purely conclusory because unaccompanied by a reasoned explanation connecting the factual predicates to the ultimate conclusion, that opinion has no evidentiary value." (*Id.* at p. 1116.)

Dr. Rifkin's opinion suffers from similar deficiencies. He acknowledged (1) that catheter removal problems are not uncommon, (2) that Gordon suffered from many infections completely separate from whatever the catheter fragment might have caused, and (3) that Gordon had an increased risk of infections because of his immune-suppressed state. Nevertheless, Dr. Rifkin concluded that a small fragment of a catheter—which is designed to remain in the body—played a "major role" in Gordon's death. Since Dr. Rifkin provided no reasonable explanation to connect the catheter fragment to Gordon's eventual death—to *explain* its supposed "major role"—his opinion "has no evidentiary value." (*Ibid.*)

The court in *In re Lockheed Litigation Cases, supra*, 115 Cal.App.4th 558 excluded an expert's causation opinion on similar grounds. The court affirmed summary judgment against the plaintiffs, who had sued for wrongful death allegedly caused by exposure to toxic chemicals manufactured by the defendants. (*Id.* at p. 561.) The court explained how expert opinions should be evaluated:

> "'The value of opinion evidence rests not in the conclusion reached but in the factors considered and the reasoning employed. Where an expert bases his conclusion upon assumptions which are not supported by the record, upon matters which are not reasonably relied upon by other experts, or upon factors which are speculative, remote or

conjectural, then his conclusion has no evidentiary value.'"

(*Id.* at p. 563, citations omitted.)

The court held that it was unreasonable for the plaintiffs' expert to rely solely on a study finding that painters exposed to the chemicals at issue were more likely to contract cancer, because the painters in the study were exposed to some 130 different chemicals. (*Id.* at pp. 564-565.) Likewise, even if the catheter fragment left in Gordon's body made him more prone to infection, that fact would not establish that the fragment caused his death, since the panoply of deadly diseases and infections that afflicted Gordon long before (and after) the catheter fragment were equally probable causes.

The trial court did not abuse its discretion in excluding Dr. Rifkin's causation opinions.[3]

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[3] The outcome should be the same even if the Court finds that Dr. Rifkin's opinions were admissible. In *Ochoa v. Pacific Gas & Electric Co.* (1998) 61 Cal.App.4th 1480 the court found that the plaintiff's expert's contradictory causation opinion was admissible, but that it still did not create a triable issue because it was "equivocal and speculative" and because "he has no expertise in the relevant subject matter." (*Id.* at p. 1485.) As shown above, Dr. Rifkin's opinion is equally unqualified and speculative.

III.

PLAINTIFFS CANNOT REMEDY THEIR FAILURE OF PROOF BY RESORTING TO THE COMMON KNOWLEDGE EXCEPTION OR RES IPSA LOQUITUR.

Plaintiffs contend that they can fill the holes in Dr. Rifkin's declaration by invoking the common knowledge exception or the doctrine of res ipsa loquitur. (AOB 9-10.) But while these can occasionally substitute for the usually-required expert testimony, this case doesn't present such an occasion.

Indeed, plaintiffs acknowledge that, at best, they can use these doctrines only to establish a breach of the standard of care, not causation. (AOB 9 & 10.) This concession is unavoidable, since at most the doctrines could establish Cedars-Sinai's responsibility for the catheter fragment's presence in Gordon's body; only expert testimony could possibly link the fragment's presence to any medical condition, much less to Gordon's death. And, as shown in the preceding section, plaintiffs did not present sufficient expert causation testimony because Dr. Rifkin's opinions lacked any reasonable basis. Thus, even if plaintiffs can use res ipsa loquitur or common knowledge to establish a breach of the standard of care, they still have not carried their burden of showing all the negligence elements, and the judgment should be affirmed.

Plaintiffs' use of res ipsa/common knowledge to establish a breach of the standard of care requires a gross oversimplification. Their argument

is that catheters shouldn't fragment in a patient's body and therefore Cedars-Sinai must have breached the standard of care. (AOB 10.) It's not quite that simple.

A. The Proper Standard Of Care For Removing Catheters Is Not Commonly Understood By Most Laypersons.

The common knowledge exception cannot apply here because the proper standard of care for placing or removing urethral catheters is not something that most laypersons understand. This lack of obviousness about the standard of care is evident because even Dr. Rifkin's *expert* testimony concerning a breach of the standard of care is vague. How then is a layperson supposed to have a clear understanding?

The fact that something unexpected happens during a medical procedure does not mean it is common knowledge that there was negligence. As one court recently observed, "results that might be considered 'freakish' or 'improbable' may actually be known complications, or might be unavoidable given the circumstances. Thus, while a layperson might find it surprising to learn that blindness can result from an operation upon a patient's back even in the absence of negligence, that is exactly what defendants' expert testimony demonstrated." (*Curtis v. Santa Clara Valley Medical Center* (2003) 110 Cal.App.4th 796, 803.) Similarly, a layperson might find it surprising that breakage of catheters occurs commonly. (CT 98:15-16.) But that was Dr. Rifkin's testimony here.

Our Supreme Court long ago explained that "[t]he 'law has never held a physician or surgeon liable for every untoward result which may occur in medical practice.'" (*Huffman v. Lindquist, supra*, 37 Cal.2d at p. 473 [nonsuit affirmed]; see also *Sanchez v. Rodriguez* (1964) 226 Cal.App.2d 439, 449 ["A doctor is not a warrantor of cures nor is he required to guarantee results and in the absence of a want of reasonable care and skill will not be held responsible for untoward results"].) Cedars-Sinai likewise cannot be held as a guarantor.

The case plaintiffs cite, *Bardessono v. Michels* (1970) 3 Cal.3d 780 (AOB 9), presents a much more obvious common knowledge situation. The defendant gave the plaintiff, who was otherwise healthy, several cortisone shots in his sore shoulder; soon after, the plaintiff suffered paralysis and nerve damage. (*Id.* at pp. 784-786.) It is easy for any layperson to conclude that an injection should not result in paralysis or nerve damage in a healthy person. It is *not* commonly understood whether, when and how urethral catheters fragment and whether the fragmenting of a catheter or the failure to discover a fragment breaches the standard of care—particularly in an elderly patient who has had repeated catheterizations.

B. Res Ipsa Loquitur Does Not Apply.

For this doctrine to apply, "(1) the accident must be of a kind which ordinarily does not occur in the absence of someone's negligence; (2) it must be caused by an agency or instrumentality within the exclusive control of the defendant; (3) it must not have been due to any voluntary action or contribution on the part of the plaintiff." (*Folk v. Kilk* (1975) 53

Cal.App.3d 176, 184, internal quotation marks omitted.) Plaintiffs bear the burden of showing each of these elements. (*Newing v. Cheatham* (1975) 15 Cal.3d 351, 364.) They cannot do so.

1. Plaintiffs failed to show that the catheter fragmentation probably occurred because of some negligence by Cedars-Sinai.

To use res ipsa loquitur to establish a breach of the standard of care, plaintiffs had to show that the catheter fragmentation or the failure to discover the fragment was "of such a nature that it can be said, in the light of past experience, that it probably was the result of negligence by someone and that the defendant is probably the person who is responsible." (*Siverson v. Weber* (1962) 57 Cal.2d 834, 836 [nonsuit affirmed after res ipsa instruction refused].) They cannot make that showing.

Here, it is not evident that the fragmenting of a catheter is necessarily the result of someone's negligence. Indeed, according to Dr. Rifkin catheter breakage is not an uncommon event. (CT 98:15-16.) And Dr. Taylor opined—without refutation by Dr. Rifkin—that urethral catheters are intrinsically designed to remain in the body, so a catheter fragment poses no special danger. (CT 67:26-68:4.) Therefore, even if

Cedars-Sinai were responsible for leaving the catheter fragment in Gordon's body, that fact would not establish that Cedars-Sinai was negligent.[4]

Plaintiffs' invocation of res ipsa loquitur's "classic example"—"the X-ray revealing a scalpel left in the patient's body following surgery" (AOB 10)—does not rescue them, because the situation here is quite different. A scalpel is not intended or designed to remain in the human body, but rather only to be used during surgery and then removed. A urethral catheter, and therefore a fragment of a catheter, *is* intended to remain in the body indefinitely. If the presence of a urethral catheter in someone's body caused blood poisoning and death, then the newspapers

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[4] Although plaintiffs only seek to use res ipsa loquitur to establish a breach of the standard of care, causation issues still rear their heads—"res ipsa loquitur does not apply where it is equally probable an accident was caused by some fault for which defendant was not responsible." (*Gicking v. Kimberlin* (1985) 170 Cal.App.3d 73, 77; see also *LaPorte v. Houston* (1948) 33 Cal.2d 167, 170 [res ipsa did not apply because it "was at least equally probable" that a mechanical defect, rather than the defendant's negligence, caused the accident].) Another way the courts have expressed it is that res ipsa cannot apply when "[n]one of the alternative explanations for plaintiff's injuries is inherently more probable than the others." (*Elcome v. Chin*, *supra*, 110 Cal.App.4th 310, 320 [after bladder surgery plaintiff had arm and back pain]; see also *Brown v. Poway Unified School Dist.* (1993) 4 Cal.4th 820, 827 [res ipsa was inapplicable where repairman slipped and fell on a piece of lunch meat on the school building floor, because the possibility that a school employee dropped the meat is not "inherently more probable" than other explanations].) Here there are several "inherently more probable," or at least "equally probable" explanations for Gordon's death—he had suffered a heart attack, his body had rejected a lung transplant, and he suffered from multiple, chronic infections, all of which pre-dated and were unrelated to the catheter fragment.

would be reporting that scores of patients had been dying after having catheters placed.

This is why plaintiffs' reliance on *Gannon v. Elliot* (1993) 19 Cal.App.4th 1 (AOB 10) is misplaced. *Gannon* involved a "large foreign body"—the 3 cm x 1 cm rubber cap of a surgical instrument—that the surgeon left in the plaintiff's body during a hip replacement surgery. (*Id.* at p. 4.) The plaintiff's expert said that given the size of the cap, it should have been easy to feel or see in the surgical field. (*Ibid.*) The catheter fragment here, on the other hand, was "small and uncomplicated." (CT 68:8.) And the catheter fragment is not a traditional "foreign body" because it is designed to remain in the body, as opposed to surgical instrument caps that are not. *Gannon* also is different because there it was undisputed that the presence of the large cap caused the plaintiff to need another, more destructive hip surgery. (*Gannon v. Elliot, supra*, 19 Cal.App.4th at p. 4.) Here, the connection between the catheter fragment and Gordon's death is, at best, tenuous.

2. Gordon failed to show that Cedars-Sinai was exclusively responsible for the catheter fragment.

The second element of res ipsa loquitur is that the plaintiff's injury must be caused by something within the defendant's exclusive control. (*Folk v. Kilk*, *supra*, 53 Cal.App.3d at p. 184.) Plaintiffs fail this test, too.

Even assuming plaintiffs can show the catheter fragment caused Gordon's death, they must also establish that Cedars-Sinai was exclusively

responsible for leaving the fragment in Gordon's body. But their own expert's testimony negates their ability to do so. Dr. Rifkin offered no direct evidence that Cedars-Sinai left the fragment; instead, he stated that the fragment had been there between three months and a year before its April 2001 discovery. (CT 98:10-14.) The sheer breadth of that time period illuminates how difficult it is to definitively determine when this catheter fragmented and who was responsible.

This is particularly true since Dr. Rifkin gave no explanation for how he calculated the three- to twelve-month period except to say that "problems"—not described—would have become evident well before the fragment was removed. (CT 98:10-14.) This is no explanation at all, among other reasons because it is undisputed that many "problems" had been evident throughout this time—Gordon was fighting multiple drug-resistant infections, and his body was rejecting the lung transplant. (CT 67:7-9 & 18-20; 98:3-7.) And if the fragment purportedly posed a "catastrophic problem," how could those problems take twelve months to reveal themselves? (CT 98:17.) Why couldn't the fragment have been in Gordon's body for two, three or four years prior to its discovery? Dr. Rifkin gave no explanation. In fact, tracing any temporal connection between any "problems" and a particular catheter removal would be difficult since Gordon had many catheters placed and removed in several facilities over the last few years of his life. (CT 67:21-22.)

"'The value of opinion evidence rests not in the conclusion reached but in the factors considered and the reasoning employed.'" (*In re Lockheed Litigation Cases, supra*, 115 Cal.App.4th at p. 563.) The absence

of any explanation of "the factors [Dr. Rifkin] considered and the reasoning [he] employed" in reaching his three- to twelve-month estimate means that the estimate has no evidentiary value and must be rejected.

Plaintiffs' only other evidence on this point is Ms. Gordon's statement that Gordon had been hospitalized only at Cedars-Sinai since May 1999. (CT 100:12-14.)[5] But since Dr. Rifkin's opinion was too vague and unsupported to be admissible, Ms. Gordon's statement alone does not establish that Cedars-Sinai had exclusive control over the fragmenting catheter.

Plaintiffs did not establish the requisites to use res ipsa loquitur as a substitute for showing that Cedars-Sinai breached the standard of care.

CONCLUSION

Gordon's death surely was a tragedy for his family. But to blame Cedars-Sinai for that death because it might have left a small catheter fragment in his body defies both science and California medical malpractice

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[5] In the first line of their opening brief, plaintiffs embellish on Ms. Gordon's statement and Dr. Rifkin's opinion, stating—with no record support whatever—that a Cedars-Sinai "nurse left the balloon tip of a catheter." (AOB 1; see also AOB 2.)

law. Plaintiffs cannot avoid summary judgment by relying on an unqualified expert witness and his wholly unsupported and conclusory opinions, nor by relying on the ill-fitting doctrine of res ipsa loquitur. The Court should affirm the summary judgment.

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