IN THE SUPREME COURT OF THE STATE OF MONTANA
DA 22-0250

TERRI GREENE,

Plaintiff and Appellant,

v.

GREGORY S. McDOWELL, M.D.,

Defendant and Appellee.

APPELLEE'S ANSWERING BRIEF

On Appeal from Montana Thirteenth Judicial District, Yellowstone County
Before the Honorable Ashley Harada
Case No. DV-19-0083

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STATEMENT OF THE ISSUES

Plaintiff and Appellant Terri Greene ("Greene") brings this appeal after a trial on the merits ended following Greene's case-in-chief with the District Court granting Defendant and Appellee Dr. Gregory S. McDowell's Motion for Judgment as a Matter of Law under Rule 50. Greene raises one issue on appeal:

1. Did the District Court properly grant Dr. McDowell's Motion for Judgment as a Matter of Law after concluding that Greene had failed to present required expert testimony demonstrating a breach of the standard of care for informed consent?

STATEMENT OF THE CASE

Greene filed her medical malpractice claim against Dr. McDowell on January 21, 2019. The case was tried to a jury from April 11 through April 14, 2021. Greene called one expert, Dr. Kade Huntsman, originally listed as an expert for Dr. McDowell but later cross-designated by Greene, to testify regarding the standard of care in obtaining informed consent for spinal surgeries such as Greene's anterior cervical disc fusion ("ACDF") revision surgery performed by Dr. McDowell on October 25, 2017. After Greene presented her case-in-chief, Dr. McDowell moved for a directed verdict on the basis that Greene had failed to present required expert testimony establishing that Dr. McDowell breached the

standard of care in obtaining informed consent. After a hearing outside the presence of the jury, the District Court granted the motion. Greene now appeals.

Importantly, Greene does *not* allege her ACDF revision surgery was performed negligently. Greene's only claim is that Dr. McDowell failed to meet the standard of care in obtaining her informed consent, and if she had known there was a remote chance of permanent vocal changes, she would not have proceeded with surgery without a second opinion. However, as the District Court correctly concluded in granting Dr. McDowell's motion for a directed verdict, Plaintiff failed to present required expert medical testimony establishing that Dr. McDowell deviated from the standard of care in obtaining Greene's consent for surgery. Further, the expert testimony presented at trial established, as a matter of law, that the risk of permanent injury to the right recurrent laryngeal nerve causing hoarseness or difficulty swallowing was so low that the standard of care did not require such a remote risk to be disclosed during the consent discussion.

STATEMENT OF RELEVANT FACTS

I. Medical Treatment and Informed Consent

This case arose from an anterior cervical disc fusion ("ACDF") revision surgery performed by Dr. McDowell on Greene on October 25, 2017, at St. Vincent Healthcare, and the exceedingly rare complication following the surgery.

Dr. Gregory McDowell is a Board-Certified Orthopedist specializing in spine surgery. He attended the University of Maryland medical school graduating in 1986 which was followed by a 6-year residency in general surgery and orthopedic surgery. Dr. McDowell then completed a Fellowship at the Hospital for Special Surgery, Cornell's Manhattan campus. Dr. McDowell and his family moved to Billings in 1993 where he has specialized in orthopedic spine surgery. (Tr. Transcr. vol. II, 118:6-127:15)

On October 2, 2017, Plaintiff made an appointment and met with Jennifer Kuhr, a Physician's Assistant (PA) at Ortho Montana who worked closely with Dr. McDowell. Plaintiff described two years of worsening pain, primarily in the neck but also in the shoulders and arms, as well as weakness, tingling, and numbness. Treatment to date included over 110 chiropractic visits and massage therapy. She was looking for definitive treatment to relieve her severe pain. (Tr. Transcr. vol. III, 313:6-315:14 (April 13, 2022); Tr. Ex. 509.)

During the initial visit, Greene completed a pain diagram in which she described her pain as the worst pain imaginable impacting every aspect of her life. (Tr. Transcr. vol. III, 309:23-313:8; Tr. Ex. 510-6 through 510-15.) An MRI was expedited at Greene's insistence due to her complaints of severe pain. (Tr. Transcr. Vol. III, 316:5-317:4.)

On October 10, 2017, Greene saw Dr. McDowell for her severe neck and shoulder pain. Dr. McDowell's impression was that Plaintiff had "spondylitic changes at C4-5 and C6-7 with C6-7 causing lateral recess stenosis that might be implicated in her neuropathic shoulder and right arm discomfort." Based on a thorough review of her history and radiological studies, Dr. McDowell offered Plaintiff a revision surgery comprised of an anterior cervical discectomy and fusion ("ACDF") from C4 to C7. Dr. McDowell discussed the benefits and risks of the proposed surgery with Plaintiff and documented "there are some increased risks associated with the exposure which include hoarseness and swallowing difficulties certainl[sic]." (Tr. Transcr. vol. II 148:12-15:1 (April 12, 2022); Tr. Ex. 510-17, 18.)

Plaintiff presented for surgery with Dr. McDowell on October 25, 2017. The surgery date was moved up at Plaintiff's insistence, as she claimed to be suffering 10 out of 10 pain, the worst pain imaginable. (Tr. Transcr. vol. II 160:16-161:6; Tr. Transcr. vol. III 247:1-3; Tr. Ex. 510:20.) Prior to surgery, Dr. McDowell fully explained the risks of surgery, including but not limited to risk associated with exposure, limitations in movement associated with the fusion, lack of satisfaction with the surgical result and potential need for reoperation. He recorded, "after discussing in full the risks and benefits with the surgery and the treatment expectations and alternatives have been reviewed clearly as well, she as such elects

to proceed with surgery and offers her informed consent." (Tr. Transcr. vol. II 158:17-164:12; Tr. Ex. 9.) Based on his 25 years of practice, Dr. McDowell knows he did not advise Plaintiff that the risks of injury to the right recurrent laryngeal nerve (RRLN) causing (voice hoarseness) and dysphagia (difficulty swallowing) would only be temporary; Dr. McDowell advised Plaintiff that in most cases, such symptoms are temporary, but that there was a risk of serious and lasting injury particularly for revision surgeries such as Greene's. This was the same discussion he had with Greene on October 10, 2017. (Tr. Transcr. vol. II 156:2-159:9.)

Plaintiff signed a consent for the surgical procedure and consent for treatment, exam, and admission in which she acknowledged the risks and benefits of the proposed surgery had been explained to her, that all her questions had been answered, and that while a good outcome was expected, there was no guarantee. (Tr. Ex. 9.)

At trial, Greene acknowledged she signed a consent form, but claimed she "just kind of glanced at it." (Tr. Transcr. vol. III, 253:12-15.) Greene also testified that before she signed the consent form, she and Dr. McDowell discussed temporary hoarseness as a potential side effect to the surgery, among other potential complications such as infection or bleeding. (Tr. Transcr. vol. III, 252:23-253:11.) Ultimately, Greene had to admit she had a very limited and incomplete

recollection of her discussions with Dr. McDowell on October 25, 2017, prior to signing the consent form.

> Q. And what I would like you to do is go to deposition Page 107, and we are looking at Line 4.
>
> A. Okay.
>
> Q. And you have written there -- not written there, but I asked you the question, "Prior to being provided with this form, was there any discussion between you and Dr. McDowell? Did I read the question correctly?
>
> A. You did.
>
> Q. And your answer was, "I don't recall the exact discussion that we had. There again, it is two years ago. I do recall him coming in and going over that the surgery shouldn't take no more than two hours and going over the disc with me"; did I read that correctly?
>
> A. You did.
>
> Q. And that was your testimony a couple years ago at your deposition; correct?
>
> A. Yes.
>
> Q. And the next question I asked, "When you say 'going over the disc with you', your answer was, "What we were doing." Correct?
>
> A. Correct.
>
> Q. And then the next question I asked you, "Any other discussion that you recall with Dr. McDowell?" And what was your answer?
>
> A. I said, "No, that I recall."

Q. What you specifically said, "Not that I recall, no, sir"; correct?

A. Yes.

Q. And you also went on to agree that there are portions of that conversation that you just don't remember; correct?

A. I was nervous on this, yes.

. . .

Q. No, at the time of the surgery before you signed your consent form, you had the ability to ask Dr. McDowell questions?

A. I did.

Q. And you don't remember what those are at this point?

A. I was getting ready for surgery, I don't remember.

Q. And I also -- do you remember what Dr. McDowell told you regarding the risks associated with the surgery during your discussion October 25th, 2012?

A. I remember the hoarseness distinctly because of my voice.

Q. Okay. Well, let's look at how you answered that question during your deposition, and I have to find the right section -- at the bottom of Page 108, do you have that?

A. Yes.

Q. And I specifically asked you, "Do you remember what Dr. McDowell told you regarding the risks associated with the surgery during your discussion on October 25th, 2012, and what was your answer?

A. "I cannot -- no, sir, I cannot recall exactly what he said."

(Tr. Transcr. vol. III 293:17-296:5.)

II. Post-operative Complication

Dr. McDowell noted no significant problems during surgery. (Tr. Transcr. vol. II, 168:23-169:1, 170:10-12.) Postoperatively, Greene woke with a hoarse voice. (Tr. Transcr. vol. II, 171:14-21.) When the hoarseness did not improve, upon referral by Dr. McDowell Greene saw an otorhinolaryngologist (an ear, nose, and throat specialist), Dr. Brian T. Pelczar. (Tr. Transcr. vol. II, 77:2-11.) Dr. Pelczar diagnosed Greene with right-sided vocal cord palsy and a glottic gap, causing dysphonia (a hoarse voice) and dysphagia (difficulty with swallowing.) (Tr. Transcr. vol. II, 60:10-63:3.) After pursuing vocal therapy and ongoing monitoring with Dr. Pelczar, Greene made good progress in recovering vocal cord function and voice recovery; Dr. Pelczar testified that by May of 2019, he was seeing significant movement of the right true vocal cord, “really good abduction,” “near total approximation with phonation,” that the glottic gap had “narrowed dramatically,” although it was not 100% completely normal. (Tr. Transcr. vol. II, 91:2-92:2.)

Dr. Pelczar performed two (2) tests to determine if Greene’s swallowing difficulties were related to an injury to the right recurrent laryngeal nerve. Dr. Pelczar testified that based on testing, any problems that Greene may have with

swallowing cannot be attributed to an injury to the right recurrent laryngeal nerve. The first test, a video swallow study, was within normal limits and did not reveal any evidence of aspiration or penetration. (Tr. Transcr. vol. II, 78-13; 79:22-81:3, Ex. 514.) The second test, an esophagram barium swallowing test, likewise showed no evidence of aspiration but a small amount of gastroesophageal reflux unrelated to the injury to the right recurrent laryngeal nerve. (Tr. Transcr. vol. II, 78:1-83:7.)

> Q. So these are an issue that's unrelated to the current laryngeal nerve?
>
> A. That is correct.
>
> Q. And you would agree as far as physically, and based on your examination, there is no reason to believe -- no reason -- or medical reason that it would be easier to drink from a straw as opposed to drinking from a glass?
>
> A. No. I believe that's more patient preference.

(Tr. Transcr. vol. II 83:8-85:3.)

III. Expert Testimony Regarding Standard of Care for Informed Consent and Rarity of Lasting Injury to Recurrent Laryngeal Nerve.

Kade Huntsman, M.D. was called as an expert witness by Greene. (Tr. Transcr. vol. III 376:1.) Dr. Huntsman is a Board-Certified orthopedic spine surgeon who is experienced in performing ACDF revision surgeries such as that involving Greene. (Tr. Transcr. vol. III 378:12-379:9; 402:2013.)

Dr. Huntsman explained that while a temporary injury to the recurrent laryngeal nerve happens 10 to 14% of the time, a lasting injury to the recurrent laryngeal nerve resulting in hoarseness or difficulty swallowing is extremely rare and unusual. (Tr. Transcr. vol. III 402:11-403:17.)

> Q. And in preparing for your -- we are looking at this case, and preparing for your testimony, did you try to determine to the best you can about how rare this type of condition is?
>
> A. Yes. So some of my colleagues at Case Western, people that I've trained with have done some research on that, and it's actually one of the studies here, and I think if you look at the rare -- so there's two things -- this is a rare situation, and this is a severe situation, so with a rare, severe injury like this, the rate of this is about 0.3, 0.4 percent, so well, well below 1 percent.
>
> Q. And is there any literature out there that establishes standard of practice to warn of this 0.3 or 0.4 percent risk?
>
> A. No. I think, as I was trying to state earlier, the academies, the societies, no one has come out with a position statement that says here's what you should do for an informed consent on an ACDF, so I've never seen or heard anybody say that we should discuss this very rare situation with all patients.

(Tr. Transcr. vol. III 403:18-404:14.)

While Dr. Huntsman advises patients of the remote possibility of a permanent injury, he strongly believes the standard of care does not require such a discussion.

> Q. Do you believe -- that's your personal practice, but -- maybe you already touched on this -- do you believe that the standard of

practice requires a specific discussion regarding permanent hoarseness or difficulty swallowing?

A. So I would argue adamantly that it absolutely must include a discussion of hoarseness and of difficulty swallowing, but it does not need to include whether or not that's going to be long lasting or permanent or transient or last for a week or month or year because, quite honestly, we can't predict that, and that rate of 0.3 or 0.4 percent is -- again, that's the best guess that we have right now based on the literature, but that's pretty darn rare, and if I discussed everything that was that rare, I'm not sure that we would ever get through the office visit.

(Tr. Transcr. vol. III 406:2-18.)

Dr. Huntsman further testified:

Q. I will give you a hypothetical, if Dr. McDowell advised Ms. Greene that temporary hoarseness and swallowing difficulties were more likely than anything else, would that be consistent, at least in your opinion, with the standard of practice?

A. Yes, definitely.

Q. If you also told her that there could be the possibility of long lasting or severe problems, would that also be consistent with the standard of practice?

A. Yes. I want to say it's consistent with, but not necessarily required.

(Tr. Transcr. vol. III 406:19-407:6.)

Dr. McDowell, like Dr. Huntsman, testified to the rarity of a lasting or permanent injury to the recurrent laryngeal nerve following ACDF surgery based on his own experience and the literature.

> Q. And that's talking about your personal practice; what about what does your training and experience and the literature tell you about the risk of a lasting injury to the recurrent laryngeal nerve?
>
> A. If you look at the literature carefully, even that that we have here assembled here today in our exhibits, you will see that the proven numbers relative to the risk of lasting recurrent laryngeal nerve injuries that are serious or severe are generally under 1 percent.
>
> Q. And is that consistent with your experience performing that type of surgery?
>
> A. It actually is. I was trying to do some of the numbers, and I think conservatively I've probably done about 200 spine cases a year in my work here on average, and I've always estimated that about 30 percent of those are cervical spine cases so that would be about 60 of those cases, and conservatively, I would say one in three are probably revisions or difficult multilevel revision cases which brings that number down to 20, but then over 30 years, that's about 600 cases, and so seeing 3 in 600 would be one half of 1 percent that I've referred for treatment.

(Tr. Transcr. vol. II 106:12-107:11.)

STANDARD OF REVIEW

The standard of review for a district court's decision to grant or deny a Rule 50 motion for a directed verdict is *de novo* as an issue of law. *Wagner v. MSE Tech. Applications, Inc.*, 2016 MT 215, ¶ 15, 384 Mont. 436, 383 P.3d 727. However, "whether evidence on behalf of a plaintiff is sufficient to take a case to the jury is a question of law for the trial judge. A bare scintilla of evidence is not sufficient to require submission to the jury." *Collins v. Itoh*, 160 Mont. 461, 472, 503 P.2d 36, 42 (1972) (internal citations omitted).

SUMMARY OF ARGUMENT

The District Court correctly applied the law to the facts of this case when it granted Dr. McDowell's Motion for Judgment as a Matter of Law under Rule 50.

The District Court's review of the evidence at trial recognized that Greene did not present any expert testimony that Dr. McDowell failed to meet the standard of care for informed consent. Because Greene failed to present this evidence, a directed verdict on Greene's informed consent claim was appropriate. The expert Greene called at trial, Dr. Huntsman, testified that the standard of care did not require a discussion of the remote possibility of a lasting or permanent injury to the recurrent laryngeal nerve causing hoarseness or difficulty swallowing and Dr. McDowell had, in fact, adhered to the standard of care on the issue of Greene's informed consent. Because Greene failed to provide an expert to testify to the standard of care that was alleged to have breached by Dr. McDowell in obtaining consent, Greene failed to provide sufficient evidence to allow her claim to go to the jury as a matter of law. A *de novo* review of the evidence confirms this to be true, and that the District Court properly granted Dr. McDowell's Rule 50 motion.

ARGUMENT

I. The District Court correctly granted Judgment as a Matter of Law under Rule 50.

Greene begins her argument to this Court by stating that the elements of a lack of informed consent claim are:

1. A risk disclosure was required.
2. The risk disclosure was not made.
3. Causation – ie. Terri would not have had the surgery if full risk disclosure had been made; and
4. The risk not disclosed was the actual cause of injury.
   Collins v. Itoh, 160 Mont. 461, 467-68, 503 P.2d 36, 40 (1972)
   Neggard v. Estate of Feda, 152 Mont. 47, 55, 446 P.2d 436, 441 (1968).

(App.'s Open. Br. [Revised],19.)

While acknowledging that a Plaintiff must normally present expert witness testimony about the risk to be disclosed, Greene appears to argue the District Court erred when it granted Dr. McDowell's motion for three alternate reasons: (1) that expert testimony is not required in this case to establish a breach of the standard of care; (2) Dr. McDowell's own testimony is sufficient to establish the standard of care and breach; and (3) that the personal practice testimony of Dr. Huntsman is sufficient to establish the standard of care and a breach of the standard of care. However, these arguments ignore already established Montana law and the facts.

To prove a lack of informed consent claim, a plaintiff must show (1) the standard of care; (2) that the defendant failed to meet that standard of care; and (3) the failure to meet the standard of care caused the plaintiff's injury. *Howard v. Replogle*, 2019 MT 244, ¶ 17, 397 Mont. 379, 450 P.3d 866 (citing *Estate of Willson v. Addison*, 2011 MT 179, ¶ 17, 361 Mont. 269, 258 P.3d 410). "Expert testimony is required to establish these elements." *Howard*, ¶ 17 (citing *Horn v. St. Peter's Hosp.*, 2017 MT 298, ¶ 20, 389 Mont. 449, 406 P.3d 932).

The District Court granted Dr. McDowell's directed verdict because Greene failed to produce expert testimony establishing that Dr. McDowell violated the standard of care. (Tr. Transcr. vol. IV, 457:21-460:9.) Without proof of a legal duty to disclose the risk of permanent vocal cord paralysis, Greene's claim necessarily fails as a matter of law. It is undisputed that the only expert called by Greene at trial testified that a discussion of the very remoted possibility of permanent paralysis of the right recurrent laryngeal nerve causing hoarseness or difficulty swallowing was not required to meet the standard of care. (*See* Statement of Relevant Facts, III.)

Further, Montana caselaw has explicitly ruled that testimony of personal practice is insufficient evidence to establish the standard of care. This applies to expert witnesses, such as Dr. Huntsman, as well as hybrid expert witnesses such as Dr. McDowell.

Because Greene failed to provide expert testimony necessary to establish elements one and two of her case as required by law, Greene's medical malpractice claim is fatally flawed. The District Court properly granted Dr. McDowells Rule 50 motion.

A. Greene failed to provide expert testimony that Dr. McDowell breached the standard of care.

Greene argues that no expert testimony was required to establish the standard of care or to demonstrate a breach of the standard of care, because Dr.

McDowell testified that he advised her of the possibility of lasting hoarseness and difficulty swallowing, and Greene testified that she was not told about the risk of *permanent* hoarseness and dysphagia, only a risk of temporary injury. (App.'s Open. Br. [Revised], 19-20.) However, this confuses the difference between the standard of care at issue in this case, which is the minimum of what a reasonable practitioner *must* tell a patient about the risks, and a practitioner being required to disclose every *possible* risk to a patient. Additionally, her argument ignores plainly decided Montana caselaw holding that expert testimony is required to establish the elements of a lack of informed consent case.

As a threshold note, at the hearing on Dr. McDowell's directed verdict, April 14, 2022, counsel for Greene admitted that an expert is required to testify that a defendant practitioner violated the standard of care in an informed consent case. Counsel stated in answering a question from the Court, ***"[t]here is a requirement of expert testimony in an informed consent case***." (Tr. Transcr. vol. IV, 450:13-15 (emphasis added).) Moments later in the same dialogue, Greene's counsel stated, "Judge, it's real simple, ***I say that expert testimony is required as to what should be disclosed***, and that's it." (Tr. Transcr. vol. IV, 452:3-5 (emphasis added).) As summarized above in the Statement of Relevant Facts, Plaintiff's expert, Dr. Huntsman, testified that the standard of care or standard of practice, terms which are considered interchangeable, did not require a discussion with the patient

regarding the very remote possibility of a lasting or permanent injury causing hoarseness or difficulty swallowing.

Under Montana law, to prove their case,"[the p]laintiff is required to produce expert testimony to establish a standard of medical practice and show defendant's deviation from that standard." *Llera v. Wisner*, 171 Mont. 254, 262, 557 P.2d 805, 810 (1976) (citing *Zebarth v. Swedish Hospital Medical Center*, 81 Wash.2d 12, 499 P.2d 1). "Without expert testimony to establish these elements [of a lack of informed consent claim], no genuine issue of material fact exists and the defendant is entitled to judgment as a matter of law." *Brookins v. Mote*, 2012 MT 283, ¶ 65, 367 Mont. 193, 292 P.3d 347 (citing *Estate of Willson*, ¶ 17). *See* also *Montana Deaconess Hosp. v. Gratton*, 169 Mont. 185, 189, 545 P.2d 670, 673 (1976) ("[t]he medical standard of care must be established by expert medical testimony" (citing *Evans v. Bernhard*, 23 Ariz. App. 413, 533 P.2d 721 (1975)); *Griffin v. Moseley*, 2010 MT 132, ¶ 31, 356 Mont. 393, 234 P.3d 869 ("a plaintiff has the burden in a medical malpractice case of presenting evidence on the medical standard of care 'by expert medical testimony…' Failure to present such evidence is fatal to the plaintiff's claim" (internal citation omitted) (citing *Gratton*)); *Howard*, ¶ 17 ("[e]xpert testimony is required to establish these elements [of a lack of informed consent claim]"); *Llera*, 171 Mont. at 262, ("[p]laintiff is required to

produce expert testimony to establish a standard of medical practice and show defendant's deviation from that standard").

Greene did not produce expert testimony that established a standard of care requiring Dr. McDowell to advise Greene of the remote possibility of permanent hoarseness or difficulty swallowing, or that Dr. McDowell deviated from that standard. In fact, her only expert witness that she called on this topic, Dr. Huntsman, testified that Dr. McDowell did, in fact, meet the standard of care, and that discussion of potentially permanent paralysis of the recurrent laryngeal nerve causing permanent hoarseness or difficulty swallowing was not required to meet the standard of care.

Without this expert testimony, a plaintiff like Greene cannot prove all the elements of a claim of lack of informed consent. Even viewing all evidence in the light most favorable to Greene, her claim fails as a matter of law because she failed to produce expert testimony that Dr. McDowell did not adhere to the standard of care. *See Collins*, 160 Mont. at 465-66. The District Court properly granted Dr. McDowell's Motion for Judgment as a Matter of Law.

B. Greene's case does not fall under the expert testimony exception and as a matter of law, a discussion of the very remote possibility of a permanent or long-lasting vocal cord paralysis was not required.

As analyzed above, expert testimony is required to establish the medical standard of care and a resulting breach of the standard of care. However, an

exception exists where "the conduct complained of is readily ascertainable by a layman." *Gratton*, 169 Mont. at 189 (citing *Evans v. Bernhard*, 533 P.2d 721 (Ariz. App. 1st Div. 1975)). In the context of informed consent, this means the medical standard of care of risk disclosure required to obtain informed consent must be established by an expert witness, unless the risk is of such magnitude that it is "readily ascertainable by a layman" that the risk must be disclosed. The risk in question is *not* the magnitude of *injury*, as implied by Greene. (App.'s Open. Br. [Revised], 18 n. 1.) Instead, the "risk" contemplated is the *likelihood* of a particular complication occurring, and whether the *frequency of occurrence* of that complication makes it a "known risk" such that it is obvious to a layperson that a reasonable practitioner must disclose that risk. *Collins*, 160 Mont. at 468.

In *Collins v. Itoh*, this Court held that an incidence rate of approximately 0.5% to 3% of a particular complication is not of a sufficient magnitude to make the complication a "known risk" that requires disclosure by a reasonable practitioner. *Collins*, 160 Mont. at 468. There, this Court held that "[t]he statistical evidence presented, even when viewed in the light most favorable to plaintiff, *does not demonstrate an urgent need to disclose such information to the patient*. The evidence presented was not sufficient to present a question of fact for the jury." *Id.* (emphasis added).

As noted by the District Court in Greene's case, *if* the incidence of permanent vocal cord paralysis were as high as 15%, it might be ascertained by laymen that disclosure would be necessary, and expert testimony to establish the standard of care would *not* be required. (*See* Appendix A, Order Regarding Defendant's Motions for Summary Judgment, 15 (March 27, 2022).) However, at trial, both Dr. McDowell and Dr. Huntsman testified that although the rate of *temporary* nerve paralysis ranges from 0.2% to 24.2% (Trial Transcript II, 180:5-10), the incidence rate of *permanent* vocal cord paralysis is far lower, approximately 0.3% to 0.4%. (Tr. Transcr. vol. II, 106:17-107:11, 111:25-112:10, 112:15-113:6, 113:16-21, 197:8-190:13, 200:18-23, Tr. Transcr. vol. III, 406:2-18.) The risk of permanent vocal cord paralysis is extremely small; as was held by this Court in *Collins v. Itoh*, a risk as small as 0.3% to 0.4% is not a risk high enough to be considered a "known risk" that would be readily identifiable by a layman as a complication that must be disclosed by a reasonable practitioner, and thus this very low risk required expert testimony to establish the standard of care. *See Collins*, 160 Mont. at 468.

Because the risk of vocal cord paralysis is so minimal, based on long-standing precedent, a *de novo* review shows the District Court properly granted Dr. McDowell's Rule 50 motion.

C. Testimony of personal practice by Dr. Huntsman is insufficient to establish the standard of care, and Dr. Huntsman's testimony that Dr. McDowell met the standard of care is undisputed.

Greene claims that the testimony of Dr. Huntsman, revealing his personal practice in discussing the risks of permanent vocal cord paralysis, is sufficient to establish the standard of care despite Dr. Huntsman's own testimony that his personal practice was and is *not* the standard of care. Greene claims this question should have been submitted to the jury, so that the jury might weigh the credibility of Dr. Huntsman's testimony of his personal practice against Dr. Huntsman's testimony of the standard of care (Tr. Transcr. IV, 451:-452:2.) In her Brief, Greene claims that Montana has not ruled on this issue, and that Montana should allow personal practice testimony because personal practice testimony is allowed for some purposes in other jurisdictions, and cites a string quote from *Contra v. Atlanta Orthopaedic Group, P.C.*, 681 S.E. 2d. 152, 155 (Ga. 2009). (App.'s Open. Br., 21 (Sept. 26, 2022).)[1] However, Greene is incorrect; this issue in fact *has* been settled in Montana already, and there is no need to look to other jurisdictions for guidance. As explained below, Montana does not allow personal practice testimony to establish a standard of care.

This Court has held that an expert's opinion about their own personal practice in a medical malpractice case is irrelevant if not based on national

[1] The cases cited by Greene do not stand for the proposition that personal practice testimony establishes the standard. Instead, they stand for the proposition that personal practice testimony may be used for impeachment.

standards. *Norris v. Fritz*, 2012 MT 27, ¶ 44, 364 Mont. 63, 74, 270 P.3d 79; *Gratton*, 169 Mont. at 190. Consequently, one practitioner's personal practice *cannot* be the only basis upon which to infer that the defendant departed from the reasonable standard of care. *Collins*, 160 Mont. at 469.

Here, Dr. Huntsman testified that in his own practice, he will discuss with patients that vocal cord paralysis may be permanent. (Tr. Transcr. vol. III, 406:2-18, 407:1-408:7, 409:2-10.) However, Dr. Huntsman also testified that discussing permanent paralysis is *not* the standard of care because of the extreme rarity of permanent paralysis, explaining that:

> I would argue adamantly that [an informed consent conversation] absolutely must include a discussion of hoarseness and of difficulty swallowing, but ***does not need to include whether or not that's going to be long lasting or permanent*** or transient or last for a week or month or year because, quite honestly, we can't predict that, and ***that rate of 0.3 or 0.4 percent is… pretty darn rare***, and if I discussed everything that was that rare, I'm not sure that we would ever get through the office visit.

Id. (emphasis added).

As already noted by the District Court, Greene could not rely upon Dr. Huntsman's personal practice to establish the standard of care for informed consent. (Or. Regarding Def.'s Mots. S.J., 13 (March 27, 2022) (citing *Norris*, ¶ 44)). The Montana caselaw cited above confirms. The personal practice of one practitioner is insufficient evidence of the standard of care, and Greene's reliance on Dr. Huntsman's personal practice is insufficient to prove the required standard

of care in obtaining her informed consent. Because Greene cannot rely on Dr. Huntsman's personal practice testimony, Dr. Huntsman's testimony that Dr. McDowell met the standard of care is undisputed. Greene failed to show a violation of the standard of care, her claim must fail as a matter of law. A *de novo* review shows the District Court correctly granted Dr. McDowell's Rule 50 motion.

D. Testimony of personal practice by Dr. McDowell does not relieve Greene of her obligation to provide expert testimony establishing the standard of care and breach of the standard of care.

Greene cites *Montana Deaconess Hosp. v. Gratton* for the proposition that because Dr. McDowell testified that he did disclose a risk of longer-term vocal cord paralysis during his informed consent conversation with Greene, Greene no longer has an obligation to prove the standard of care at trial.

Nowhere does *Gratton* suggest that a physician's admission of personal practice, if any, relieves the plaintiff of the burden of proving the standard of care. At one point, the *Gratton* court cites *Evans v. Bernhard*, 23 Ariz. App. 413, 533 P.2d 721 (1975), for the proposition that a physician's own testimony may establish the standard of care when that personal practice is directly based on national standards of care. *Gratton*, 169 Mont. at 189 (quoting from *Evans*, "third party expert testimony is not always necessary as this standard can be established by the defendant doctor's own testimony" (internal citation omitted)).

However, *Gratton* goes on to specifically comment on the use of a physician's testimony about their own personal practice for establishing the standard of care, holding that unless personal practice is based on the national standard of care, "***[a] defendant doctor's testimony as to his usual personal practice is not sufficient to establish a general medical standard of care***." *Gratton*, 169 Mont. at 190 (emphasis added).

Regardless, Dr. McDowell testified that he did, in fact, meet the standard of care in obtaining informed consent from Greene. (Trial Transcript II, 103:25-104:7, 164:8-12, 190:12-14.) Additionally, Dr. McDowell testified that in Greene's case, he *did* discuss with Greene prior to surgery that because it was a revision surgery, she may experience side effects that are "more severe and lasting." (Tr. Transcr. vol. II, 157:4-15; 159:7-9, 184:20-24, 191:2-192:2.) In effect, based on testimony from Dr. Huntsman, Dr. McDowell went above and beyond what was required of the standard of care.

Dr. McDowell's testimony about his personal practice is insufficient to establish the general medical standard of care in this case and excuse Greene from her obligation to provide expert testimony. The expert testimony from Dr. Huntsman is undisputed that the standard of care did not require a discussion of the very remote possibility of a lasting or permanent injury. Because Greene could not rely on personal practice testimony to establish the standard of care, a *de novo*

review shows District Court properly held that Greene's claim was fatally flawed as a matter of law.

II. Arguing that Greene would not have obtained the surgery had she known of the risk of permanent vocal cord paralysis is not credible, nor a proper basis for this appeal.

Greene claimed at trial, and now claims throughout her Brief, that had she known permanent vocal cord paralysis was a risk, she would not have proceeded with the surgery. (Tr. Transcr. vol. III, 254:8-12, 322:14-21, 323:14-19; App.'s Open. Br. [Revised], 20.) However, at the time of the District Court's ruling, this was not at issue; the District Court granted Dr. McDowell's Rule 50 motion based on Greene's abject failure to produce the required expert testimony establishing a breach of the standard of care. Because this claim was not involved in the District Court's ruling, it is not a proper basis for this appeal.

In addition, Plaintiff's claim is highly suspect. Evidence at trial established that before Dr. McDowell's surgery, Greene was in great pain and desperate for treatment. She couldn't sleep and was getting migraines (Tr. Transcr. vol. III, 241:11-16); she was unable to participate in daily activities or "do [her] job correctly," and her pain was impacting every aspect of her life (Tr. Transcr. vol. III, 242:11-14, 312:8-18); that Greene couldn't think of any worse pain than what she was suffering (Tr. Transcr. vol. III, 311:11-21, 323:1-5); before the surgical consult, Greene tried "over 110 chiropractic visits, massage, nonprescription-

strength antiinflammatories (sic), prescription-strength antiinflammatories (sic), Percocet, Robaxin, Gabapentin, and using a tennis ball on trigger points" to reduce her pain (Tr. Transcr. vol. III, 314:24-315:10); that Greene asked to rush the MRI to obtain treatment faster (Tr. Transcr. vol. III, 316:5-317:4); that Dr. McDowell presented Greene with several other non-surgical options, but Greene instead preferred to do something "more definitive" to resolve her chronic pain (Tr. Transcr. vol. III, 315:11-14, 318:17-319:3); and that even after her surgery had been scheduled, Greene called and requested her surgery be moved up because she was in so much pain, and so her surgery date was moved up by several weeks (Tr. Transcr. vol. III, 246:21-247:21, 321:22-322:3.)

For Greene to suggest that if she had known there was a tiny, *less than one percent (1%) chance* of permanent vocal cord paralysis she would have canceled the surgery is simply not credible. However, this entire issue, raised by Greene in this appeal, is simply irrelevant.

CONCLUSION

For the foregoing reasons, Appellee Dr. McDowell respectfully requests this Court affirm the District Court's ruling. A *de novo* review establishes the District Court correctly granted Dr. McDowell's Rule 50 motion because when Terri Greene rested her case at trial, she had failed to provide any expert testimony to establish the standard of care that defines a practitioner's legal duty and that a

breach had occurred. Without this expert testimony, she failed to prove the first element of a lack of informed consent case, and her claim fails as a matter of law.

Dated this 23rd day of November, 2022.

BROWNING, KALECZYC, BERRY & HOVEN, P.C.

By /s/ Oliver H. Goe
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CERTIFICATE OF COMPLIANCE

Pursuant to Rule 11(4), Mont.R.App.P., I certify that **Appellee's Answering Brief** is double spaced, is a proportionately spaced 14-point Times New Roman typeface, and contains 6,260 words.

/s/ Oliver H. Goe
BROWNING, KALECZYC, BERRY & HOVEN, P.C

CERTIFICATE OF SERVICE

I, Oliver Hayes Goe, hereby certify that I have served true and accurate copies of the foregoing Brief - Appellee's Response to the following on 11-23-2022:

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