

STATE OF MICHIGAN
IN THE SUPREME COURT

Appeal from the Court of Appeals
Deborah A. Servitto, PJ, and Michael J Talbot and Bill Schuette, JJ.

CARL STONE and NANCY STONE,

Plaintiffs-Appellees/Cross-
Appellants,

V

DAVID A. WILLIAMSON, M.D., JACKSON
RADIOLOGY CONSULTANTS, P.C. and W.A.
FOOTE MEMORIAL HOSPITAL,

Defendants-appellants/Cross-
Appellees.

Supreme Court No.: 133986

Court of Appeals No.: 265048

Jackson County Circuit Court
L.C. No.: 03-001912-NH

BRIEF AMICUS CURIAE ON BEHALF OF DR. ROY W. WADDELL

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STATEMENT OF QUESTIONS PRESENTED

I. WHETHER THE *FULTON* INTERPRETATION OF MCL 600.2912a(2) IS ERRONEOUS?

Amicus Dr. Waddell submits that it is.

II. WHETHER THE STATUTORY PHRASE "OPPORTUNITY TO ACHIEVE A BETTER RESULT" SHOULD BE APPLIED TO THE AGGREGATE RISK OF COMPLICATIONS, INCLUDING DEATH, AS OPPOSED TO MERELY THE INCREASED RISK OF THE SPECIFIC COMPLICATION INCURRED BY THE PATIENT?

Amicus Dr. Waddell submits that it should.

INTRODUCTION

The Michigan Bar Journal, in its March 2007 issue, published an article authored by the undersigned entitled *A Doctor's View of Opportunity to Survive: Fulton's Assumptions and Math Are Wrong*. In that article, it is pointed out that the *Fulton* interpretations of the "opportunity to survive", "opportunity to achieve a better result", and "greater than 50%" clauses in MCL 600.2912a(2) were incorrect. It was proposed that the court adopt a simple interpretation of these clauses that will better represent the intent of the statute and avoid the anomalies of the *Fulton* interpretation.

INTEREST OF AMICUS CURIAE

As a physician, the undersigned's interest in this case and in the issue noted above lies in a desire to see our public statutes interpreted in a way that is consistently fair to both physicians and the patients we care for that are sometimes injured through medical malpractice. It does not speak well of physicians if we are not our patients' advocates. This brief, although supporting the Appeals court ruling in *Stone*, is not so much in support of the plaintiffs as it is in support of a fresh interpretation of MCL 600.2912a(2) that is mathematically and medically more sound than that set forth by the court in *Fulton v William Beaumont Hospital*, 253 Mich App 70; 655 NW2d 569 (2002). Doing so will result in a more even-handed test that is fair to both plaintiffs and defendants.

STATEMENT OF FACTS

According to the trial testimony, the various statistics and risks associated with *Stone* are as follows. (Since this brief ultimately agrees with the ruling for the plaintiff by the Appellate Court, only the statistics that are generally more favorable to the defense are used.)

Elective repair of aneurysm:

95% chance of survival with good results (no deaths or serious complications)

5% chance of complications (including death), composed of:

1% chance of death

1% chance of amputation

3% chance of complications other than death or amputation

Ruptured aneurysm:

80% chance of death (i.e., 20% chance of survival)

12% chance of survival with good results (60% of the 20% overall survivors)

8% chance of significant complications short of death (40% of the 20% overall survivors)

88% chance of complications including death (80 + 8)

5% chance of amputation

ARGUMENT

I. THE METHOD OF CALCULATING "LOSS OF OPPORTUNITY" IN FULTON IS ERRONEOUS

The second sentence of MCL 600.2912a(2) states: "In an action alleging medical malpractice, the plaintiff cannot recover for loss of an opportunity to survive or an opportunity to achieve a better result unless the opportunity was greater than 50%."

The questions then arise, "What is the "opportunity?", and "How is it calculated?"

The previously considered interpretations:

A. Fulton:

The *Fulton* interpretation posits that the lost opportunity is the simple arithmetical difference between the non-negligence and the negligence survival rates. But it doesn't show clearly the effect of appropriate treatment on the underlying condition, and at higher negligence survival rates (50% or higher) the *Fulton* criteria cannot be met at all for recovery, even though the effect of appropriate treatment might have made a huge difference in the percentage of lives

saved. It is an interpretation that is grossly and unfairly defendant-biased.

B. Wickens:

The only other interpretation of the phrase appearing in a published opinion was the one argued for by the plaintiff in *Wickens v. Oakwood Healthcare System*, 465 Mich 53; 631 NW2d 686 (2001). (This court ruled in *Wickens* that a living plaintiff could not recover for a loss of opportunity to survive. But it did not specifically rule that the *Wickens* plaintiff's argument for the interpretation of "opportunity" was *per se* incorrect.) The plaintiff in *Wickens* argued that there need be only a non-negligence or pre-malpractice survival (or better result) rate of "greater than 50%" in order to satisfy the "opportunity" requirement. This would mean that if a plaintiff had a 51% chance of survival that fell to 50% because of negligence, then recovery would be allowed. At these rates, however, the impact of the malpractice is minimal. The result is anomalous, and *Wickens* interpretation of "opportunity" would be unfairly plaintiff-biased.

C. Language:

The central point made in "A Doctor's Opportunity" was that "survival rate" and "opportunity to survive" should not be considered equivalent terms. It is a rather odd use of the term "opportunity to survive" to mean a "chance of survival" in everyday parlance, let alone in medicine or epidemiology. The undersigned, in 38 years in the medical field, has never heard the concept of a chance of survival (or survival rate) referred to as an "opportunity". A man would not go to a physician and be told that he has a 50% chance of living 5 years, and then come home and tell his wife that the doctor told him he has a 50% "opportunity" to live 5 years. He might be told that he has an "opportunity" to improve those odds with X or Y treatment, but never that a single survival rate in an "opportunity". It is not clear to the undersigned where or when this equivalence of terminology crept into legal proceedings. There was, prior to the

statutory revision of MCL 600.2912a(2), certainly terminology referring to “lost chance doctrine” and the “loss of opportunity to survive”.

The Supreme Court in *Falcon v Memorial Hospital*, 436 Mich 443; 462 NW2d 44 (1990) referred to “loss of opportunity”. And at least from that case forward, the equivalence of the terms is commonplace in legal proceedings, both in the pleadings of defense and plaintiff, and in comments of the court. All parties seemed to assume that “loss of opportunity” was somehow related to chance of survival or the changes in this chance, and therefore simply began to use the phrase “survival rate” as the equivalent of an “opportunity to survive” in order to define its meaning when applying the statutory phrase to a given set of medical facts. In fact, both of the *Fulton* and *Wickens* interpretations are absolutely dependent on the terms being interchangeable, and each interpretation must have “initial” and “post malpractice” (variously stated) opportunities in order to arrive at their individual concepts of what the “true” opportunity (the one we want to know for purposes of the statute) is. If there are not at least 2 (*Wickens*) or 3 (*Fulton*) opportunities, then both analyses fail. *Fulton* requires at least two survival “opportunities” (an “initial” and a “post malpractice”) to calculate a third (the “true” opportunity). *Wickens* equates the “initial” survival rate (implying, at least, that there is a second) with the “true” opportunity. The undersigned proposes that there is in fact only one opportunity. It is calculated from survival rates, but not from other “opportunities”.

D. The proposed interpretation:

A third option is described herein and in *A Doctor’s View of Opportunity to Survive*. It eliminates the anomalies that arise with the other two interpretations, and is fair to both defendants and plaintiffs.

First, we need an understanding of that which we are talking about in malpractice cases

and possible recovery under the statute.

Consider the hypothetical condition with the following statistics:

With non-negligent treatment, the survival rate is 90%.

With negligent treatment, the survival rate is 60%.

The following chart, therefore, represents the outcomes for 2 groups of patients, 10 in each group:

Treatment Group	Survivors	Non-Survivors
Non-Negligent Treatment (90% survival rate)	XXXXXXXXXX	X
Negligent Treatment (60% survival rate)	XXXXXX	XXXX

There are survivors and deaths in both groups, and various ratios can be constructed:

- (1) If the survivors in the non-negligent group had had negligent treatment, their survival rate would have dropped by 30/90 or 33 1/3%.
- (2) If the survivors in the negligence group had had “good” treatment, their survival rate would have increased by 30/60 or 50%.
- (3) If the non-survivors in the non-negligence group had had negligent treatment, they would have seen their ranks swell by 300%.
- (4) Thirty more patients would have survived with appropriate treatment rather than negligent treatment. (the *Fulton* difference)

All of these ratios are irrelevant!

With whom is any malpractice case dealing?

- The survivors in the non-negligence group cannot bring an action for loss of opportunity to survive, both because they survived and because there was no negligence.
- The survivors in the negligence group have no cause of action because they survived.
- The non-survivors in the non-negligence group have no cause because there was no negligence.
- The only group that can bring an action and possibly recover are the non-survivors in the negligently-treated group (the lower-right box in the chart).

In the above example, there are 4 patients in the “possibly-eligible-to-recover” group. It

is clear from the chart that if these 4 patients had had appropriate treatment, 3 of them would have survived, i.e. 3 out of 4, $\frac{3}{4}$, or 75%.

It is proposed that this is the number that represents the true “lost opportunity”.

The *Fulton* interpretation would deny recovery because the survival rate difference is only 30%, even though 75% of the deaths are prevented. (The *Fulton* formula tells us that 30 patients (out of 100) move out of the “death with negligence “ category, but it doesn’t tell us anything about how many were in that category to begin with.) Likewise, in the example given earlier for *Wickens* (51% vs. 50%), the calculated opportunity would be 2%, and recovery would be disallowed. The anomalies are eliminated.

The formula for calculating the opportunity is:

$$\frac{\text{Survival (or better result) rate difference}}{100 - \text{negligence survival (or better result) rate}}$$

It also becomes clear that where the “point spread” lies on the survival rate percentage scale is critically important, a fact that *Fulton* ignores and which is responsible for most of the *Fulton* anomalies. Consider the following hypothetical, again with the same 30 percentage point spread, but with the negligence survival rate of 10% and the non-negligence survival rate of 40% (10 to 40 is “lower” on the percentage scale of 0 to 100 than 60 to 90):

Treatment group	Survivors	Non-Survivors
Non-Negligent (40% survival)	XXXX	XXXXXX
Negligent (10% survival)	X	XXXXXXXXXX

There are 9 patients in the non-survivors negligence group (again, the only group that has a possible cause of action). If these patients had been treated appropriately, only 3 of them

would have survived, 3/9, or 33 1/3%. So their lost opportunity is much smaller than in the first hypothetical, with the same 30 percentage point spread in survival rates.

At the other end of the 0 to 100 percent scale, consider the following hypothetical (again using the same 30% point spread):

Non-negligence survival rate = 100%
 Negligence survival rate = 70%

Treatment Group	Survivors	Non-Survivors
Non-Negligent (100% survival)	XXXXXXXXXX	0
Negligent (70% survival)	XXXXXXX	XXX

There are 3 patients in the non-survivors negligence group. With good treatment, all of them, 3/3, would have survived. The “lost opportunity” is 100%. *Fulton* doesn’t allow for a 100% opportunity unless the survival rates are 0% and 100%.

The defendants in their briefs submitted to this court (defense brief p.36-37, ProNational amicus brief p.22) argues that if the formula proposed is broken down into component parts, it becomes:

$$\frac{\text{non-negligence survival rate}}{100 - \text{negligence survival rate}} - \frac{\text{negligence survival rate}}{100 - \text{negligence survival rate}}$$

The denominator in each term is the “death rate” (non-survival rate) of the negligence group. The defense further argues that if the formula is thus broken down, the first term is comparing “apples to oranges”, a “mishmash” relating non-negligence survival rate to

negligence death rate, and is thus meaningless. However, it is not the “meaningfulness” of each term in a broken down form of the formula that matters. What is important is the final result, which tells us what percentage of the patients that die in the negligence group would have survived, absent negligence. Furthermore, the “survival rate difference” in the numerator is always exactly the same as the “death rate” difference.

$$90\% \text{ survival} = 10\% \text{ non-survival}$$

$$60\% \text{ survival} = 40\% \text{ non-survival}$$

$$\text{Survival rate difference} = 30\%$$

$$\text{Non-survival rate difference} = 30\%$$

Therefore, if the defense insists on breaking down the formula into a subtraction of two fractions, each of which has a clear relationship between the numerator and the denominator, then the formula can easily be re-expressed as:

$$\frac{\text{negligence death rate} - \text{non-negligence death rate}}{\text{negligence death rate}}$$

Or broken down:

$$\frac{\text{negligence death rate}}{\text{negligence death rate}} - \frac{\text{non-negligence death rate}}{\text{negligence death rate}}$$

Expressed this way, the formula represents the fraction of the patients in the negligence death group who would have died even without negligence (the second term) subtracted from the total of the patients in the negligence group. In either method of expressing the formula, the result is always exactly the same.

With the “60 to 90” hypothetical, using survival rates, the result becomes:

$$\text{Not broken down: } \frac{90-60}{100-60} = \frac{30}{40} = 75\%$$

$$\text{Broken down: } \frac{90-60}{100-60} = \frac{90}{40} - \frac{60}{40} = \frac{30}{40} = 75\%$$

Using death rates:

$$\text{Not broken down: } \frac{40-10}{100-60} = \frac{30}{40} = 75\%$$

$$\text{Broken down: } \frac{40-10}{100-60} = \frac{40}{40} - \frac{10}{40} = \frac{30}{40} = 75\%$$

So whether the formula appears to be a “mishmash” to the defense or not, it still gives the same answer however it is stated.

Survival rates, rather than death rates, were used in the original article simply because survival rates are usually what are quoted in medical studies or medical testimony, and because the statute uses the term opportunity to “survive”. But death risk reduction in non-survivors is really the issue, so either method is perfectly valid.

A second defense argument (defense brief p.38, ProNational brief p.23-25) is that it is illogical and anomalous that small differences in survival rates in some scenarios is actionable, while much larger differences in other scenarios is not. It is definitely neither illogical nor anomalous.

Again, the only reasonable way to view “loss of opportunity” is in relation to the non-survivors in the negligence group, the ones who have actually “lost” an “opportunity”, not in relation to the survivors, who have lost nothing. The survivors in the non-negligence group, the survivors in the negligence group, and the non-survivors in the non-negligence group are not seeking redress, because they have no actionable cause. The only group that can possibly qualify for damages is the group that died (or got a poorer result) and were treated negligently. It is to this group alone that a computation of lost opportunity applies. If “greater than 50%” of these

patients could have been saved (or given a “better result”), they qualify. If 50% or less, they don’t. It does not matter whether it is greater than 50% of 70 patients (out of 100), or greater than 50% of 4 patients (out of 100). The first example might arise from survival rates of 66% vs. 30% (70 non-survivors). The second might arise from survival rates of 99% vs. 96% (4 non-survivors). The previous analysis shows that a smaller survival rate point spread is required to reach the 50% threshold as the point spread moves upward on the 0 to 100% range.

This is also the reason that the ProNational (p.24-25) argument is invalid. In that example, it doesn’t make sense to the defense that a 2% difference from 96% to 98% is not compensable, but a 2% difference from 97% to 99% is. The point spread in the second situation (97 to 99%) takes less than a 2% difference to reach the 50% threshold. In fact, it only takes 1.5% ($\frac{1}{2}$ of 3%) because the 2% point spread is higher on the scale from 0 to 100 than 96 to 98. (The threshold is reached at $\frac{1}{2}$ of whatever the difference is between 100 and the lower (negligence) survival rate.

There are many situations in medical studies in which the survival or complication rate differences are relatively small, but have been repeatedly confirmed as highly statistically significant because they are based on a population of literally thousands or even hundreds of thousands of cases. One such example (of “better result”) was footnoted in *A Doctor’s View of Opportunity to Survive*, regarding infection in joint replacement surgery. The infection rate is relatively low without prophylactic antibiotics, approximately 4%. But with prophylactic antibiotics the infection rate can be lowered to less than 1%, resulting in a highly significant reduction of 75% (or more). Certainly, therefore, a death rate (or complication rate) difference of 0.3% vs. 0.1% (using the defense brief example p.37-38) is in fact a 67% “opportunity” as long as the numbers are statistically significant. The statistical significance of the figures of the

numbers being used is a matter for testimony in the court, certainly not for statutory interpretation. If the differences are not statistically significant, it does not invalidate the formula, it only invalidates the numbers that go into the formula. In *Stone*, the numbers don't seem to be in dispute to any great extent.

A final comment about statistics. The defense brief in *Stone* (p.32) states: "Subtraction of one probability, as expressed in a percentage, from the other the other probability, also expressed in a percentage, represents the best and most accurate means of comparing the two distinct probabilities of survival or of a better result to determine the "opportunity" that was actually lost as a result of the claimed malpractice". The statement actually contains two assertions. The first is that subtraction of one probability from the other is a good way to compare two probabilities. The second is that the probabilities that should be compared in "opportunity to survive" cases are the probabilities of survival or of a better result. The proposed formula for the interpretation of MCL 600.2912a(2) contained herein does, in fact, when re-expressed, consist of the subtraction of one probability from another, but not the probabilities of survival. Survival probabilities compared to each other by subtraction alone don't give any information about the non-survivors, the only group at issue.

As noted previously, the formula can be re-expressed as:

$$\frac{\text{Negligence death rate}}{\text{Negligence death rate}} - \frac{\text{non-negligence death rate}}{\text{negligence death rate}}$$

The first term is the probability of dying for the non-survivors in the negligence group (100%. They all die by definition.) The second term is the probability of the patients in the same group dying if they had not had negligent treatment. The result of subtracting these two fractions is the probability of a patient in the non-survivor negligence group surviving if he had

had non-negligent treatment. As discussed earlier, the only patients who have a possible cause of action are the non-survivors who have had negligent treatment. There's no opportunity lost to the survivors.

The defense brief then continues with a lengthy discussion of “standard error”, “confidence intervals”, and “sample size”, all of which relate to the reliability of the statistics, discussed earlier, and a topic for trial testimony, not statutory interpretation. A discussion ensues of P-values, “odds”, and finally the “odds ratio”, with the suggestion that statisticians use an “odds ratio” to compare two odds, not a subtraction of two odds. The hypothetical is cited which was used in *A Doctor's View of Opportunity to Survive* of a 99% survival rate vs. a 51% survival rate to calculate an “odds ratio” of 95.19, a whole number, not a percent. I.e.: “Survival is 95.19 times more likely to occur without negligence than with negligence.” That sounds highly significant, and probably is. (Note that the hypothetical was an example of a case that would not qualify for recovery under *Fulton*, but would easily qualify under the proposed interpretation.) But then the subject of “odds ratios” was abruptly dropped, with no guidance whatsoever as to how the “odds ratio” whole number might be converted into a relevant lost opportunity percentage (as required by the statute).

E. Risk reduction:

Ironically, the defense itself came close to a correct view of “opportunity” in using the concept of risk reduction in discussing the amputation risk in *Stone* (defense application for leave to appeal, p.9-10, and 17-18), because risk reduction is, in fact, exactly the issue. Unfortunately, the math they use is atrocious. To argue that a risk reduction of 5% to 1% is only a 4% reduction is absurd. It is a reduction of 4/5, or 80%, just as a reduction in rainfall from 5 inches last month to 1 inch this month is an 80% reduction in rainfall (in inches per month), or a reduction in

wages from \$5 per hour to \$1 per hour is an 80% reduction in wages, or a reduction in walking speed from 5 miles per hour to 1 mile per hour is an 80% reduction in walking speed. With “opportunity”, it is just a percent reduction in percent, not in inches per month or dollars per hour or miles per hour.

“Risk reduction” is, in fact, the same thing as “opportunity” for the purposes here. Whether survival rates or death rates are used in the numerator of the formula, the result is exactly the same. A 5% risk of an adverse outcome is the same thing as a 95% chance of not having the outcome. A 1% risk is a 99% chance of not having the outcome. Thus, a risk reduction of 5% to 1% is $(5-1)/5$, or $(99-95)/(100-95)$, resulting in exactly the same ratio, $4/5$, or 80%.

II THE LOSS OF OPPORTUNITY MUST INCLUDE THE AGGREGATE INCREASED RISK OF COMPLICATIONS, NOT MERELY THE INCREASED RISK OF THE SPECIFIC COMPLICATION INCURRED BY THE PATIENT

MCL 600.2912a(2) differentiates between “opportunity to survive” and “opportunity to achieve a better result”. The defense argues in this case that because “loss of opportunity to *survive*” (emphasis added) excludes complications other than death, that the converse is true, i.e. that the “loss of opportunity to achieve a *better result*” (emphasis added) should exclude deaths, and by extension perhaps any other non-amputation (in this case) complication. Essentially the defense is arguing that the two clauses are mutually exclusive. There is no reason to assume this. In the plain language of the statute, “survival” is a specific term, and so necessarily considers only non-survival (deaths). But “better result” is non-specific, and so properly considers all possible complications (including death) that give a poorer result. They are not mutually exclusive terms.

Stone’s injury was a complication with serious permanent consequences. In his case, it

happened to be a double amputation, but it could have been any of a number of serious complications, such as chronic renal failure or brain damage. The defense argument that only the increased risk of his highly specific result should be considered is absurd. Should the court only consider the increased risk of Stone’s actual left-sided through-the-hip amputation combined with his right-sided mid-thigh amputation? The argument can obviously be reduced to absurdity.

In addition, the defense’s concept of risk is flawed. Risk is always prospective. We look retrospectively only to determine what category Stone ended up in terms of a “better result” (the statutory language) as follows:

Treatment Group	Better Result	Worse Result
Non-negligent treatment	?	?
Negligent treatment	?	?

The numbers are then filled in according to the trial testimony. It is obvious that Stone ended up in the lower right category. (He would have no cause of action otherwise.) There is no provision in the statute for an “amputation” category, or for any other specific complication, for that matter. But the lower right box is designed to include patients with any number of other serious complications, including death.

The defense also objects to the testimony of plaintiff’s expert, Dr. Flanagan, to the effect that Stone’s risk of amputation was 100%, as being retrospective. However, it then asserts that only the risk of the specific injury that Stone retrospectively incurred should be considered in the lost opportunity to achieve a better result. The defense wants it both ways.

If deaths and other complications are not aggregated in interpreting the “better result”

clause, anomalies can arise. Consider the hypothetical for a moment that aortic aneurysm has the following statistics, altering slightly the statistics testified to in *Stone*:

Elective repair of aneurysm:

95% good results (no deaths or complications)

5% amputations

0% deaths

Ruptured aneurysm:

12% good results

0% amputations

80% deaths

8% complications other than amputation

With non-negligent treatment, there are 95% good results and 5% amputations vs. only 12% good results but no amputations in the negligence group.

If you are the physician, and a patient comes to you and says that he has an aortic aneurysm and wants to know what to do, you can tell him (truthfully):

- (a) If you have this electively repaired, you have a 5% risk of needing an amputation.
- (b) If you don't have it treated, in a year or two or five it will rupture, we will rush you to the hospital and operate on on it then, and assuming you survive, you will have a 0% risk of needing an amputation.

If this is the only information you give to the patient, he might very well conclude that it's better to let his aneurysm rupture! But if, given all the relevant information including the risks of dying and other complications, the patient still chooses not to have the surgery, he should probably see a psychiatrist before he sees a vascular surgeon! Not considering all the information is exactly the false comparison that the defense is arguing for by "factoring out" the deaths. If deaths are "factored out", it is entirely possible that the risk of a specific complication can be the same or even higher in the non-negligent situation. Why would there be 5% amputations in the non-negligently treated group and no amputations in the negligently treated

group? Because negligent treatment may be pushing many of the patients who would have survived with amputations into the *death* category so that they are not counted!

Factoring out deaths in determining a “better result” opportunity therefore makes no sense, violates the plain language of the statute by erroneously assuming mutual exclusivity of the “survival” and “better result” clauses, and can falsely make the negligent treatment look like the better option. Deaths and other complications should thus be aggregated in determining the “better result” opportunity.

The following are the “opportunities” calculated for *Stone*:

Aggregating the risks of death and complications (considered the correct interpretation):

$$\text{Opportunity to achieve a better result} = \frac{95 - 12}{100 - 12} = \frac{83}{88} = 94.3\%$$

Aggregating the non-death complications, but “factoring out” the deaths:

$$\text{Opportunity to achieve a better result} = \frac{95 - 60}{100 - 60} = \frac{35}{40} = 87.5\%$$

Considering only the specific complication of amputation:

$$\text{Opportunity to achieve a better result} = \frac{99 - 95}{100 - 95} = \frac{4}{5} = 80\%$$

So even if the calculation is restricted only to survivors, 87.5% is the lost opportunity with the proposed formula, i.e., the percentage of patients with complications in the rupture group that would not have had complications had their aneurysms been repaired electively.

And even if the calculation is restricted only to the specific complication incurred by Stone (amputation), the lost opportunity is 80%.

CONCLUSION

In summary, the appellate court ruled correctly in aggregating the risk of death and complications when interpreting MCL 600.2912a(2) in *Stone v. Williamson*, and a correct interpretation of “opportunity to achieve a better result” should result in this Court upholding the decision of the Court of Appeals, and replacing the incorrect *Fulton* test with one more fitting the realities of medicine and mathematics, and which would be fair to plaintiffs and defendants alike.

Respectfully submitted,

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