IN THE SUPREME COURT
STATE OF NORTH DAKOTA

Michael Davis and Kimberly Davis, Plaintiffs and Appellees v. Mercy Medical Center d/b/a CHI St. Alexius Health Williston; and David Keene, M.D., Defendants and Appellants and Cherise Norby, N.P. Defendant	**Supreme Court No. 20220325** **Civil No. 53-2019-CV-00589**

ON APPEAL FROM JUDGMENT DATED MAY 18, 2022 (R:378),
AMENDED FINAL JUDGMENT DATED MAY 23, 2022 (R:387),
ORDER ENTERED JUNE 9, 2022 (R:391), AND
ORDER ENTERED AUGUST 30, 2022 (R:458)
WILLIAMS COUNTY DISTRICT COURT, NORTHWEST JUDICIAL DISTRICT
STATE OF NORTH DAKOTA
HONORABLE BENJAMEN J. JOHNSON

ORAL ARGUMENT REQUESTED

BRIEF OF APPELLANTS MERCY MEDICAL CENTER d/b/a CHI ST. ALEXIUS HEALTH WILLISTON AND DAVID KEENE, M.D.

Tracy Vigness Kolb (ND 05338)
Meagher & Geer, P.L.L.P.
1900 Brunt Boat Drive, Suite 101
Bismarck, ND 58503
Ph: 701.222.1315
Direct Ph: 701.333.0638
tkolb@meagher.com

Rodger A. Hagen (ND 05659)
Julia J. Nierengarten (P01894)
Meagher & Geer, P.L.L.P.
33 South Sixth Street, Suite 4400
Minneapolis, MN 55402
Ph: 612.338.0661
rhagen@meagher.com
jnierengarten@meagher.com

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STATEMENT OF THE ISSUES PRESENTED FOR REVIEW

[1] 1. Is Appellant entitled to judgment as a matter of law where Respondent failed to present sufficient evidence to establish proximate causation?

[2] 2. Is Appellant entitled to judgment as a matter of law where Respondent failed to present evidence sufficient to justify the damages awarded by the jury?

[3] 3. Did the district court err by not amending the judgment where the judgment as entered did not conform with its order for judgment and the jury verdict?

STATEMENT OF THE CASE

[4] This appeal follows a trial and verdict on Respondent Michael Davis's medical malpractice lawsuit. Davis brought claims against Appellant Dr. David Keene and Defendant Nurse Practitioner Cherise Norby, two providers—among many—whom he saw in the 18 months preceding his diagnosis with kidney disease. The jury found no negligence by N.P. Norby, and she is not a party to this appeal. The court dismissed Davis's direct claim against Mercy Medical Center before the case went to the jury. Davis alleged that Dr. Keene should have referred him to a nephrologist on September 15, 2017, and that, had he been so referred, his kidney disease would have been diagnosed early enough to avoid the need for a kidney transplant in March 2020. Davis was referred to a nephrologist by a different doctor in March 2018.

[5] This matter went to trial in April 2022. After a nine-day trial, the jury returned a verdict finding N.P. Norby not at fault for Davis's injuries, finding Dr. Keene at fault for his injuries, and awarding a total of $1,660,000 in damages against Dr. Keene. (R:298). Dr. Keene brought a post-trial motion for judgment as a matter of law under N.D. R. Civ. P. 50 at the close of Davis's case and after the jury's verdict, arguing that Davis had not presented sufficient evidence establishing that Dr. Keene's "failure" to refer him to a

nephrologist was the proximate cause of his injuries, nor did he present evidence sufficient to support the damages awarded by the jury. The trial court denied Dr. Keene's motion. (R:458).

[6] In addition to the post-trial motion, Dr. Keene also objected to the judgment as entered. In its order for judgment, the trial court correctly noted that N.P. Norby and Mercy Medical Center were a prevailing parties as against Davis and that Davis was a prevailing party as against Dr. Keene, and ordered that the parties be awarded their costs and disbursements accordingly. (R:376). The court clerk, however, entered a judgment awarding costs and disbursements to Davis *only*, and in the full amount requested, which did not exclude costs for the unsuccessful prosecution of his claims against N.P. Norby and Mercy Medical Center. (R:378). This judgment was amended to correct an error in the interest calculation, but not in the costs and disbursements awarded. (R:385). Despite the judgment not comporting with the trial court's order, the trial court refused to order an amendment to the judgment to correct the erroneous award of costs and disbursements. (R:391). Dr. Keene now appeals.

STATEMENT OF THE FACTS

I. Michael Davis's kidney disease diagnosis and transplant

[7] Respondent Michael Davis has a kidney disease known as IgA nephropathy. IgA nephropathy "is a form of glomerular disease, which is . . . an immune condition where there's inflammation inside the kidney." (R:477:560:11-13). Every person produces IgA, but where a patient has IgA nephropathy, "the immunoglobulin is formed in an abnormal shape, and it goes into the kidney, deposits, and causes the inflammation. . . . [O]ver time [patients] will develop kidney disease and hypertension and then progress to chronic kidney disease and end-stage renal disease." (R:477:560:17-24). IgA is an incurable kidney

disease with a variable course, the progression of which depends on the disease. (R:477:580-81:22-7). Some people with IgA respond favorably to treatment while others respond less favorably to treatment. (R:477:582-83:10-6). Not all patients with IgA follow the same course—some are more benign courses, some are more active courses. (*Id.*; R:481:1799:14-19). And not all patients with IgA progress at the same rate or respond the same to treatment, whatever treatment is initiated. (R:481:1799-1800:20-1). Every case of IgA nephropathy receives treatment.

[8] IgA nephropathy is diagnosed based on kidney biopsy. (R:481:1765:14-16). Although IgA "can be hard to treat" and "there is no good definite treatment for IgA nephropathy," (R:481:1807:22-25), standard treatment consists of blood pressure management, use of medications such as ACE inhibitor or ARBs and immunosuppressive therapy, and cholesterol and weight control. (R:481:1778:11-22; R:477:561:3-9, 582:10-15). If a patient's disease progresses to end-stage kidney failure, transplantation or dialysis is necessary. (R478:679:2-5).

[9] Davis's IgA nephropathy was diagnosed through a kidney biopsy at Mayo Clinic on March 29, 2018. Doctors do not know when Davis's kidney disease developed. IgA has a "wide spectrum of presentation and progression." (R:481:1779:19-21, 1807:25). "It can be very benign that doesn't do anything; it can be there for years. It can be slowly progressive, or it can be very aggressive and just comes. And then it just happens quick." (R:481:1807-08:25-3). In Davis's case, his treating nephrologists cannot state how long before his diagnosis Davis developed the disease, stating that such a fact "would be almost impossible to know." (R:481:1771:22). "[S]ometimes the duration could be shorter, but the disease could be aggressive, so it can develop scarring quick." (R:481:1771:19-21). One

of Davis's doctors testified that it would be "impossible to answer" whether more aggressive treatment would have been more effective in slowing his disease. (R:481:1802:21-24). When Davis's IgA diagnosis was made, his treating physicians determined that his disease was aggressive; Mayo Clinic treated it aggressively but the disease continued to progress. (R:481:1781:15-20, 1802:12-20). In March 2020, Davis had a preemptive living donor transplant. (R:477:562:13, 587:19-22).

[10] Since his diagnosis, Davis has been under the care of nephrology specialists at Mayo Clinic. Davis did very well after the transplant, although initially there was a mild rejection that was caught very early and resolved with treatment. (R:477:563:17-18). But a routine follow up kidney biopsy showed recurrence of IgA. (R:477:563:18-24). Doctors adjusted Davis's immunosuppression medication to try to control the recurrence. (R:477:563:18-24). Davis's IgA disease, as described by his treating post-transplant nephrologist, Dr. El Ters, is "challenging." (R:477:583:7-16).

II. Care giving rise to Michael Davis's medical negligence claim

[11] Before Davis went to the Mayo Clinic, he was seen in multiple clinic settings with multiple providers at different facilities that included Mercy Medical Center, Sidney Health Center, and Billings Clinic. The clinic visits included primary care, urology, podiatry, and hematology. Davis saw Dr. Keene on three occasions, one of which was at issue here, and Davis alleges that Dr. Keene should have referred him to a nephrologist after his September 15, 2017 visit. In addition, Davis was seen by N.P. Norby on February 25, 2016, October 26, 2016, and on June 7, 2017, (R:301, R:302); urologist Dr. Salem Shahin on January 7, 2017 and June 20, 2017, (R:324, R:335); a podiatrist on May 2 and 3, 2017; internal medicine physician Dr. Jerome Kessler at Sidney Health Center on June 15, 2017, (R:332); a hematologist on December 14, 2017, and January 25, 2018, (*see* R:479:19-21); and

internal medicine physician Dr. Bruce Pugatch on March 1, 2018, who referred Davis to a nephrologist, (R:342). He was also seen in the emergency departments at Holy Rosary Hospital in Miles City, Montana, on September 14, 2017, (R:307, R:360), and Sidney Health Center in Sidney, Montana, on February 28, 2018, (R:359).

[12] Davis's chief complaint at these encounters varied, sometimes he complained of frothy urine, or muscle cramps, or dehydration and painful urination. (*See, e.g.*, R:479:1004:1-2, 1005:22-24, 1060:2; 1061:25-1062:3, 1064:18-1065:1, 1075:17-19). Davis did not make known to the providers where he had been previously seen, by whom, or for what. (*See, e.g.*, R:479:1068:5-12, 1073:14-19). Among all the providers over this sixteen-month timeframe, Davis isolated N.P. Norby because of urinalysis tests that showed blood and protein in the urine and Dr. Keene because "[i]t was noted" that his blood urea nitrogen (BUN) and creatinine had been elevated. (R:70:¶ 18). According to Davis, these findings should have prompted Dr. Keene to refer him to a nephrologist, no later than June 7, 2017. Due to this alleged failure to refer, Davis's IgA nephropathy was not diagnosed until March 29, 2018, and, as a result of the alleged delay in diagnosis, Davis's kidney function deteriorated. (R:70:¶ 10). Davis further argued that, if there had been a timely diagnosis, he would not have reached end-stage kidney failure—thereby requiring a transplant—for another 15 years. (R:478:671:10-23).

[13] The evidence at trial showed that Dr. Keene did not have the lab results showing elevated BUN and creatinine, which had been performed only the day before at Holy Rosary Hospital ER in Miles City, Montana, which is not part of the CHI health system. (R:482:1925:10-19). The note in Davis's medical record from his September 15, 2017 visit explicitly states that Davis "denies any . . . past medical history of renal problems" other

than a kidney stone. (R:482:1927:10-17). Davis provided this information to Dr. Keene despite testifying that the providers at Holy Rosary told him that his "kidney function is weird." (R:479:1065:2-7; R:482:1929:1-4).

III. Michael Davis's prognosis

[14] Davis targeted N.P. Norby and Dr. Keene out of the numerous providers he saw in that period despite his treating nephrologists' opinions that it is impossible to know how many years it would take before Davis reached end-stage kidney failure. (R:481:1802:21-24). Davis obtained a preemptive living donor transplant at age 40, but his treating physician testified that she cannot predict whether or when Davis will progress to renal failure, nor what the course of his illness will be over the next 35 years. (R:477:586:12-21). Davis also continues to smoke, despite being advised to quit and that smoking can make kidney function worse. (R:478:773:25-774:1; R:479:1053:12-1054:13; R:480:1253:25-1254:8; R:481:1803:16-25). According to Dr. Zand, one of his treating physicians, Davis was probably going to progress to end-stage kidney failure regardless of an earlier diagnosis. (R:481:1803:2-5). And it cannot be stated that a "delay" in diagnosis made Davis's kidney disease "more difficult to treat." (R:481:1781:1-6). Dr. Zand said "possibly." (R:481:1781:1-6).

[15] Davis may need a second transplant, but it is not known if or when that is reasonably likely to occur. (R:477:586:12-17). Living donor transplants can last 20 to 30 years. R:477:581-82:25-5 ("Q. Okay. So it's your thinking that the life expectancy of a live donor transplant is 10 to 15 years? A. Yes. And we're talking about half-life, which is not quite the same because that means 50 percent of the kidneys are gone by then, but -- so there's still 50 percent that are still functioning.").

IV. The parties' expert nephrology opinions

[16] The trial testimony of Davis's treating physicians from Mayo Clinic regarding his kidney disease, its course, progression, and prognosis was consistent with the opinions of the defense nephrology expert, Dr. Smiley Thakur, and mostly consistent with Davis's nephrology expert, Dr. Bradley Denker.

[17] Dr. Thakur agrees with the Mayo Clinic physicians that it is pure speculation whether earlier treatment would have changed the progression of Davis's aggressive IgA nephropathy. (R:480:1358:3-18). Dr. Thakur testified that Davis is "his own control," meaning doctors "have his course before transplant, and then . . . his course after transplant." (R:480:1248:19-20). Dr. Thakur testified that Davis's underlying "resistan[ce] to treatment" has dictated the course and progression of the disease—not any alleged delay in diagnosis or treatment. (R:480:1248:11-1250:9). He noted, for instance, that Davis's "donor kidney did not have any IgA at the time of transplant, and then shortly after that, the kidney was already populated with IgA." (R:480:1249:1-3). Dr. Thakur actually described the IgA in Davis's donor kidney as "going to town" and "proliferating, and . . . was causing damage" to the kidney. (R:480:1249:4-5). This, Dr. Thakur noted, despite Davis being "heavily immunosuppressed." (R:480:1248:22). He then came back to the idea that Davis is his own control and that that explains the course of his disease, not the timing of his diagnosis:

> I'm trying to paint a picture why the transplant nephrologists are concerned, why they're giving him aggressive treatment, and what is actually happening, and this comes back to Mr. Davis is the control. If you postulate that if he had aggressive treatment before, we would have saved the day, but he's getting aggressive treatment now, and it's not working.
>
> To say that this is a different disease, there's no science behind that statement. This is Mr. Davis's disease, and he is resistant to treatment.

(R:480:1249:25-1250:9).

[18] Dr. Denker, while he agrees that Dr. Keene did not cause Davis's kidney disease, testified that Davis's "injury" is the "delay"—"the ongoing damage to the kidney during the time period of the delay" in diagnosis, during which he estimated 50% loss of kidney function. (R:478:762:24-763:2; R:478:657:7-15, 667:4-12). Dr. Denker's opinion is that "the drop-dead date, . . . the last date by which a nephrology referral [for Davis] should have been made here, . . . is June 7, 2017." (R:478:706:2-7). This date is three months before Davis ever saw Dr. Keene. But Dr. Denker agreed that, even with an earlier diagnosis and "optimal therapy," Davis would have progressed to end-stage kidney failure. (R:478:766:1-8). And Davis would have needed treatment for his kidney disease regardless when the disease was diagnosed. (R:478:763:10-14).

[19] If there had been a "timely" diagnosis, Dr. Denker estimates Davis would not have reached end-stage kidney failure for "15 years, plus or minus." (R:478:670:5-13). But he called this a "guestimate," (R:478:670:9), and did not disagree that it is "conjecture" whether Davis would have had a "less aggressive" disease if he had started treatment earlier. (R:478:767:12-768:7).

V. The outcome at trial

[20] The jury returned a verdict finding that Dr. Keene's co-defendant, N.P. Norby, was not liable for Davis's injuries, but that Dr. Keene was, and awarded approximately $1.6 in damages. (R:298). The trial court judge issued an order for entry of judgment, declaring Mercy Medical Center and N.P. Norby prevailing parties in Davis's claims against them, and Davis as prevailing party as against Dr. Keene, and ordered the parties costs and fees. (R:376). The court clerk, however, signed Davis's proposed order for judgment, which did not include the information about Mercy Medical Center and N.P. Norby's status as

prevailing parties and that granted all of Davis's claimed costs and expenses even though he was not the prevailing party in the underlying action. (R:378; R:386). Dr. Keene objected to the judgment as entered, (R:383), and the trial court refused to amend it to comport with the order and verdict, (R:391).

[21] Dr. Keene also moved for judgment as a matter of law under N.D. R. Civ. P. 50, arguing that Davis failed to establish the elements of his claim at trial and that the evidence did not support the verdict. (R:392). The trial court denied Dr. Keene's motion (R:458), and this appeal follows.

LAW AND ARGUMENT

I. Standard of review on appeal from a Rule 50 motion

[22] Under N.D. R. Civ. P. 50(a)(1), a trial court may grant a motion for judgment as a matter of law "[i]f a party has been fully heard on an issue during a jury trial and the court finds that a reasonable jury would not have a legally sufficient evidentiary basis to find for the party on that issue." *See Greenwood v. Paracelsus Health Care Corp. of N. Dakota Inc. Corp.*, 2001 ND 28, ¶ 6, 622 N.W.2d 195 ("The trial court's decision on a motion brought under N.D. R. Civ. P. 50 to grant or deny judgment as a matter of law is based upon whether the evidence, when viewed in the light most favorable to the party against whom the motion is made, leads to but one conclusion as to the verdict about which there can be no reasonable difference of opinion."). A party moving for judgment as a matter of law "is, in effect, claiming that the evidence is insufficient to create a question of fact for the jury. And whether or not the evidence is sufficient to create a question of fact for the jury is itself a question of law to be decided by the trial court." *Bjorneby v. Nodak Mut. Ins. Co.*, 2016 ND 142, ¶ 7, 882 N.W.2d 232 (quotation omitted).

[23] On appeal from a post-trial motion for judgment as a matter of law under N.D. R. Civ. P. 50, "this Court examines the trial record and applies the same standard as the district court was required to apply initially." *Pavlicek v. Am. Steel Sys., Inc.*, 2019 ND 97, ¶ 8, 925 N.W.2d 737. The dispositive issue on appeal from a post-trial order granting or denying judgment as a matter of law is whether, "when viewing the evidence in the light most favorable to [the non-moving party], accepting the truth of all of [his] evidence, and giving [him] the benefit of all reasonable inferences to be drawn from the evidence, the jury could reach only one conclusion with no reasonable difference of opinion." *Greenwood*, 2001 ND 28 at ¶ 10.

II. Dr. Keene is entitled to judgment as a matter of law because Davis failed to present evidence supporting elements of his malpractice claim.

[24] Under North Dakota law, a plaintiff alleging medical malpractice "must produce expert evidence establishing the applicable standard of care, violation of that standard, and a causal relationship between the violation and the harm complained of." *Johnson v. Mid Dakota Clinic, P.C.*, 2015 ND 135, ¶ 11, 864 N.W.2d 269; *Winkjer v. Herr*, 277 N.W.2d 579, 585 (N.D. 1979). "Thus one claiming medical malpractice cannot ordinarily have his case submitted to a jury without expert testimony supporting his claim of professional negligence." *Id.*

A. Davis failed to establish the causation element of his medical malpractice claim through expert testimony.

1. Davis did not establish proximate causation through expert testimony.

[25] At the conclusion of plaintiff's case, Dr. Keene moved for judgment as a matter of law under N.D. R. Civ. P. 50, arguing that Davis failed to establish proximate cause through expert testimony. Specifically, to establish a medical negligence claim here, Davis was

required to prove that any deviation from the applicable standard of care was the proximate cause of his damages. *Winkjer*, 277 N.W.2d at 579. "A proximate cause is a cause which, as a natural and continuous sequence, unbroken by any controlling intervening cause, produces the injury, and without which it would not have occurred." *Johnson*, 2015 ND 135 at ¶ 17 (quotation omitted); *see Frank v. Mercer Cnty.*, 186 N.W.2d 439, 446 (N.D. 1971) (stating to be the proximate cause of the damage complained of, the "damage must be direct and proximate and not merely such as is possible, as may be conceived by the imagination"). Proximate cause is "ordinarily [a] question[] of fact for the trier of fact," except where it becomes "a question of law . . . when the evidence is such that reasonable minds can draw but one conclusion therefrom." *Peterson v. Hart*, 278 N.W.2d 133, 135 (N.D. 1979) (quotation omitted).

[26] Davis failed to establish proximate cause through his expert's trial testimony. The injury Davis alleges is the need for a kidney transplant, but he does not allege that Dr. Keene *caused* his IgA nephropathy, which was the reason he ultimately needed that kidney transplant. (R:478:762:16-19). Instead, Davis's argument at trial was that, if Dr. Keene had referred to a nephrologist on September 15, 2017, he would have gone "plus or minus" 15 more years without needing a kidney transplant, but that, because he was not referred to a nephrologist until March 2018, Davis needed a kidney transplant in 2020. (R:478:669:21-670:13). This theory is premised on two things: (1) the results of lab tests dated September 14, 2017, from Holy Rosary Hospital—a completely separate health system—that Dr. Keene did not have on September 15, 2017, and did not know about when he saw Davis for "ongoing muscle cramps in hands and feet," (R:482:1916:24-25, 1925:10-14), and (2) an opinion from Davis's nephrology expert, Dr. Denker, that "the drop-dead date, . . . the

last date by which a nephrology referral should have been made here, . . . is June 7, 2017." (R:478:706:2-7). Neither of these things establish that Dr. Keene's "failure" to refer Davis to a nephrologist on September 15, 2017, was a cause that, "as a natural and continuous sequence, unbroken by any controlling intervening cause," required Davis's kidney transplant, "and without which [the transplant] would not have occurred." *Johnson*, 2015 ND 135 at ¶ 17.

[27] Dr. Denker gave inconsistent testimony and ultimately failed to connect the "failure" to refer to Davis's need for a kidney transplant. Specifically, Dr. Denker denied the ability to "predict the future" had Davis been referred on June 7, 2017, (R:478:762:1-4), but also that it was "impossible to opine on [whether June 7, 2017, was a 'point of no return,' because] [i]t would depend on what the biopsy showed on that date," (R:478:773:5-6). He admitted that he cannot know the condition of Davis's kidney on June 7, 2017, his "drop-dead date," but insisted that he is "certain that it would have shown IgA, and . . . that it would have shown less scarring," (R:478:773:8-10), and also insisted with certainty—despite the "impossibility" to "predict the future"—that a referral on that date "would have delayed the need for a kidney transplant," (R:478:762:1-5). This despite his testimony that the "drop-dead date" for referral was months before Dr. Keene ever saw him. (R:478:706:2-7). Dr. Denker also agreed that "even with optimal treatment," (i.e., aggressive treatment beginning in September 2017), Davis "was going to end up with kidney failure" as a result of his IgA nephropathy, (R:478:766:6-8), and that doctors "could hope" to slow the progression of Davis's disease, but that it was only "a guestimate" that Davis would gain "somewhere on the order of 15 years, plus or minus," before needing a transplant had he been referred to a nephrologist earlier. (R:478:670:5-13, 671:20-23). He

admitted that no one "ha[s] [a] crystal ball[]" to tell them when a disease will progress to the point of requiring transplant, (R:478:770:9-16), and that it is not possible to know when that transition occurred for Davis because such a determination is made by biopsy and "a biopsy is a snapshot in time of what's happening in the kidneys," (R:478:773:5-13). He testified that he was "certain" a biopsy on June 7, 2017, "would have shown IgA," but that he cannot say whether the disease was already too far progressed by then—or by September 15—that a kidney transplant would not have been necessary by March 2020. (R:478:773:5-13). He does not "know with any certainty with what the ultimate course would have been." (R:478:768:13-20). In other words, Dr. Denker did not—and *cannot*—say what the state of Davis's kidney disease was as of June 7, 2017—his stated drop-dead date for referral—such that transplant on the same timeline was not inevitable. And, indeed, Dr. Denker agreed with Davis's treating nephrologist, Dr. Mirielle El Ters, that the course of Davis's disease cannot be predicted. (R:478:776:3-14; *see* R:477:583:7-16; R:477:586:12-21 (Dr. El Ters testimony Davis has particularly challenging/aggressive disease for indeterminate reasons and doctors cannot predict when it will progress to kidney failure).

[28] "The term 'proximate cause' strictly contemplates 'an immediate cause which in natural and probable sequence produces the injury complained of' and expressly excludes any assignment of legal liability 'based on speculative possibilities, or circumstances and conditions remotely connected with the events leading up to the injury.'" *Johnson*, 2015 ND 135 at ¶ 17 (quotation omitted). It is true that Dr. Keene saw Davis in clinic in September 2017 at a time when he likely had IgA nephropathy, but the fact that Dr. Keene saw Davis for complaints related to cramping is only remotely connected with the events leading up to the injury, i.e., Davis's development of aggressive and "challenging" IgA

nephropathy and his progression into kidney failure. But nothing in Dr. Denker's testimony establishes proximate cause, that is, that had Dr. Keene not "failed" to refer Davis to a nephrologist in September 2017, Davis would not have needed a kidney transplant in March 2020. Nothing in Dr. Denker's testimony establishes that the lack of referral in September 2017, in the "natural and continuous sequence" of events produced Davis's need for a kidney transplant in March 2020. *Klimple v. Bahl*, 2007 ND 13, ¶ 5, 727 N.W.2d 256. In fact, Dr. Denker's testimony was that Davis would have needed a kidney transplant even with earlier diagnosis of his disease. (R:478:671:20-23; R:478:766:1-5). It is pure speculation to say that, had Dr. Keene referred Davis to a nephrologist in September 2017, he absolutely would not have needed a kidney transplant in March 2020.

[29] Davis's form of IgA is aggressive and is challenging to treat, and his treating physicians cannot say why Davis—or any other IgA patient—has a more aggressive and challenging form of the disease. (R:477:583:1-16). Dr. Denker testified that, regardless when Davis's IgA nephropathy was diagnosed, he would have absolutely required treatment. (R:478:660:25-661:8). Dr. Denker also testified that—even with early detection and "optimal" treatment—it is "unfortunately . . . true" that Davis's disease would have progressed to end-stage kidney failure, which is treatable only through kidney transplant and/or dialysis. (R:478:766:6-8). Dr. Denker testified that doctors "could hope" to slow the progression of Davis's disease, but that it was only "a guestimate" that Davis would gain "somewhere on the order of 15 years, plus or minus," before needing a transplant had he been referred to a nephrologist earlier. (R:478:670:5-13, 671:20-23). This is not sufficient to establish proximate causation, and Dr. Keene is entitled to judgment as a matter of law.

2. Davis did not establish loss-of-chance causation through expert testimony.

[30] The most generous view of Dr. Denker's testimony reveals that the sum total of that testimony is that Davis lost a chance at a "more favorable" outcome, i.e. the ability to forego the inevitable kidney transplant for some period of time longer than the two years between his kidney biopsy in March 2018 and his transplant in March 2020. In fact, when pressed on the issue, Dr. Denker admitted that his opinion is essentially that the "injury" Davis suffered was the "loss of a more favorable outcome" or the "opportunity to slow the progression of the disease." (R:478:762:24-763:9). This is not proximate cause, i.e., "'an immediate cause which in natural and probable sequence produces the injury complained of' and expressly excludes any assignment of legal liability based on speculative possibilities, or circumstances and conditions remotely connected with the events leading up to the injury." *Johnson*, 2015 ND 135, ¶¶ 17-18 (quotation omitted).

[31] Such a "loss of chance" claim (where it is recognized) supplants traditional proximate causation with a different standard and permits a patient to "recover damages when a physician's negligence causes the patient to lose a chance of recovery or survival." *Dickhoff v. Green*, 836 N.W.2d 321, 329 (Minn. 2013). In that circumstance, rather than showing it was more probable than not that the claimed injury resulted from a doctor's alleged negligence, "the plaintiff must sustain the burden of proving that the defendant negligently deprived her of a chance of a better outcome." *Id.*

[32] North Dakota has not recognized "loss of chance" as a basis for medical negligence actions. The last time this Court addressed a loss-of-chance claim in this context was in *VanVleet v. Pfeifle*, decided in 1980. *See* 289 N.W.2d 781 (N.D. 1980). There the Court discussed the concept of a lessened chance of survival based on the plaintiff's allegations that her husband's doctors were negligent in delaying his lung cancer diagnosis, which, she

argued, resulted in his death earlier than would have happened if the cancer had been discovered sooner. *Id.* at 783-785. The Court acknowledged that lung cancer would likely have led to the patient's death even with earlier discovery, but concluded that there was a fact question about whether "there was a probability that life would have been sustained for a greater number of years, or possibly [the patient] could have been cured." *Id.* at 785. The Court then reversed the summary judgment the trial court had entered in the defendant's favor and remanded for trial. *Id.* at 783. But regardless whether *VanVleet* is read as a tacit approval of the loss-of-chance doctrine, at least with respect to those specific facts at the summary judgment stage, there is no attempt by this Court in that opinion to define the alternative causation standard that would apply in such a claim, to extend the doctrine's application to injury actions, or to provide any guidance as to how damages are measured.

[33] Moreover, even if *VanVleet* is read to recognize loss-of-chance in North Dakota, Davis failed to prove such a claim by expert testimony (and he expressly disclaimed the theory, and rested his claims solely on traditional proximate cause, (*See generally* R:131; R:424)). Specifically, Davis did not (and cannot) present expert testimony that he lost some opportunity to slow the progression of his IgA nephropathy by not obtaining a more "timely" referral to a nephrologist. Looking to other jurisdictions—a necessary circumstance where North Dakota does not recognize or define the parameters of a loss-of-chance claim—Davis still carries the burden to prove causation by a preponderance of the evidence.

[34] The Minnesota Supreme Court recognized the loss-of-chance doctrine in a medical negligence claim in its opinion, from which two justices dissented, in *Dickhoff v. Green*,

836 N.W.2d 321 (Minn. 2013). The allegation there was that a family medicine physician was informed about and examined a lump on a newborn infants buttock at her two-week well-baby visit, but did not refer her to another physician for examination of the lump until after her one-year well-baby visit. *Id.* at 325. A subsequent referral to a third doctor resulted in a diagnosis of a rare and aggressive childhood cancer that had metastasized. *Id.* The plaintiffs' specific allegations were that the child's "cancer was 'curable' if timely diagnosed, but now [the child's] cancer most likely is fatal." *Id.* at 326.

[35] After the district court granted summary judgment in favor of the defendants and the court of appeals reversed, the supreme court granted review and affirmed the reversal. In so doing, the supreme court discussed the primary obstacle to recovery in a traditional malpractice action: Where a plaintiff can establish that a doctor's negligence "more probably than not" caused her harm, she recovers 100 percent of her damages, and recovers nothing if she cannot meet that burden. *Id.* But, as the court noted, "[u]nder that 'all or nothing' rule, a patient whose pre-negligence odds of survival were 50 percent or lower can *never* establish, as a matter of law, that an alleged faulty diagnosis 'more likely than not' was the cause of the patient's injury." *Id.* (emphasis original). The loss-of-chance doctrine, the court said, was developed in response to this, which it called "particularly acute in the medical malpractice context." *Id.*

[36] The court then discussed the doctrine: "[T]he 'loss of chance' doctrine recognizes that a patient values her chance of recovery or survival and she suffers a real injury when a physician's negligence reduces that chance, regardless of whether the patient's chance of survival was above or below 50 percent at the time of the physician's negligence." *Id.* at 333-334. It noted that, when a doctor's actions "diminish[] or destroy[] a patient's chance

of survival, the patient has suffered real injury. The patient has lost something of great value: a chance to survive, to be cured, or otherwise to achieve a more favorable medical outcome." *Id.* at 334 (citing *Matsuyama v. Birnbaum*, 890 N.E.2d 819, 823 (Mass. 2008) (recognizing loss of chance in the "limited domain of medical negligence")). Accordingly, the court concluded, "a physician harms a patient by negligently depriving her of a chance of recovery or survival and should be liable for the value of that lost chance" with the reduction of the chance of recovery or survival defined as the "injury." *Id.* at 334.

[37] A vigorous dissent rejected the adoption of the loss-of-chance doctrine, noting that the court had twice previously considered and declined to adopt the doctrine. *Id.* at 338-343. The dissent noted the loss-of-chance doctrine represents a departure from "a fundamental principle of tort law, that a 'defendant should be responsible only for the injuries that are legally caused by the defendant's negligence." *Id.* at 344. The loss of chance doctrine "holds physicians liable for harms that are not caused by their negligence" because "it is the underlying disease, not the physician, that directly inflicts the actual harm on the patient." *Id.* Dr. Keene opposes adoption of the loss of chance doctrine for the reasons explained by the dissent in *Dickhoff*.

[38] The majority also articulated the burden of proof in a loss-of-chance claim. It noted that, in some jurisdictions that have endorsed loss-of-chance claims, courts have simply "relax[ed] the plaintiff's burden on causation," and unequivocally rejected this approach. *Id.* Instead, the court adopted a burden of proving causation by showing that a physician's negligence more likely than not "reduce[d] a patient's chance of recovery or survival." *Id.* at 334-35. The court also articulated how to measure damages in such a claim: "loss of chance damages are measured as the percentage probability by which the defendant's

tortious conduct diminished the likelihood of achieving some more favorable outcome." *Id.* at 335. The value of the "loss" is calculated by applying a proportional-recovery approach, resulting in the rule that, where a patient is still alive, "the appropriate measure of damages is the value of the reduction of the plaintiff's life expectancy from her pre-negligence life expectancy." *Id.* at 336.

[39] As with the plaintiff in *Dickhoff*, Davis necessarily *cannot* establish traditional proximate causation because he agrees that Dr. Keene did not cause his kidney disease. Likewise, Davis's kidney disease would require treatment regardless when he was diagnosed, and his disease eventually would have progressed to end-stage kidney failure even with an earlier diagnosis and the best treatment. These facts all prevent Davis from showing it was "more likely than not" that Dr. Keene's alleged "failure" to refer him to a nephrologist in September 2017 proximately caused his injury. The only potential alternative, then, is loss of chance.

[40] Davis did not, however, allege loss of chance, nor did he attempt to prove loss of chance. Instead, he hung his hat on traditional negligence, that is, negligence that requires proof of proximate causation of the ultimate injury. The only thing that Davis proved at trial is that Dr. Keene treated him before he was diagnosed with IgA nephropathy, and that Dr. Keene did not refer him to a nephrologist. *This is not proximate cause*, i.e., it was not something that, through the natural and continuous sequence of events, unbroken by any controlling intervening cause, produced Davis's injury *and without which the injury would not have occurred*. *Johnson*, 2015 ND 135 at ¶ 17. Davis's own expert testified unequivocally that his injury *would absolutely occur* regardless whether Dr. Keene referred

him to a nephrologist in September 2017. (R:478:763:10-14). That fact alone undermines the jury's liability finding and entitles Dr. Keene to judgment as a matter of law.

[41] Moreover, Davis failed to show causation consistent with *Dickoff*. Under the standard articulated there, Davis had to show that *Dr. Keene's* conduct "more likely than not" reduced his chance of survival. Dr. Keene saw Davis twice in less than seven days for cramping in his hands and feet—a condition all doctors who testified is not a symptom of kidney disease—in September 2017. This was three months after Dr. Denker's arbitrary and unverifiable "point of no return" in terms of the progression of Davis's disease. The evidence at trial was that Davis *also* saw other doctors on at least four occasions after June 7, 2017, and visited two ERs at two different hospitals, neither of which were part of CHI's health system. Dr. Keene did not have the Holy Rosary ER records when he saw Davis on September 15 and 18, therefore nothing in those records shows negligence by Dr. Keene.

[42] Davis sought to lay the blame for his kidney disease at Dr. Keene's feet even though there is no dispute that Dr. Keene did not cause his disease. The closest his evidence got was an opinion from his expert that "earlier is better" with respect to diagnosing kidney disease, and bald speculation about what the future would have held for Davis if he had been diagnosed in September 2017 despite it being "impossible to know" the future and the state of Davis's kidneys at that point in time. (R:478:771:17-773:13). This does not equate to actually establishing Dr. Keene caused Davis any "loss of chance" damages, nor does it quantify any loss of chance damages. Dr. Keene should be awarded judgment as a matter of law.

B. Davis failed to present sufficient evidence supporting the damages amounts awarded by the jury.

[43] Separate from the deficiencies in Davis's causation evidence, Dr. Keene is also entitled to judgment as a matter of law on certain damages awarded to Davis by the jury.

1. The vast majority of Davis's past economic damages (medical expenses) is not supported by any evidence.

[44] First, Davis failed to present evidence of past medical expenses sufficient to support the jury's $400,000 damages award for that category of damages. While it is true that a court generally defers to a jury's damages determination, the verdict must be "reasonably within the scope of the evidence presented and the instructions of the court." *Condon v. St. Alexius Med. Ctr.*, 2019 ND 113, ¶ 30, 926 N.W.2d 136. Where "no reconciliation is possible and the inconsistency [between the evidence and the verdict] is such that the special verdict will not support the judgment entered . . . , then the judgment must be reversed." *Anderson v. Jacobson*, 2001 ND 40, ¶ 6, 622 N.W.2d 730 (quotation omitted).

[45] Medical expenses are compensable as economic damages, i.e. "monetary losses," under North Dakota law. *See* N.D.C.C. § 32-03.2-04. Economic damages are susceptible to specific calculation, and, in a circumstance where a plaintiff seeks to recover past medical expense, that calculation would be achieved by presenting evidence of actual medical bills from which the value of the medical-expense loss can be adduced. *See, e.g.*, *Condon*, 2019 ND 113 at ¶ 20 (concluding plaintiff's testimony about medical bills was sufficient foundation for past medical expenses).

[46] Davis did not present actual evidence of all of his claimed past medical expenses. Instead, he testified that he reviewed claim payout summaries from his insurance company—definitively *not* medical bills themselves—to determine his "past medical expenses." (R:288). The documents contained in this exhibit expressly state that they are "not a bill" on their face. (*See, e.g.*, R:288:7). Davis also submitted a document titled

"MEDICAL BILLS INDEX" that contains a mere five lines to information to "support" a "total due" of $386,919.04:

PROVIDER	BALANCE
1. Provider 1	$162.90
2. Provider 2	$275.73
3. Provider 3	$307,064.17
4. Provider 4	$35,102.08
5. Provider 5	$44,314.16

(R:309). More than 90% of the total "balance" listed here was unsupported by sufficient evidence to establish that amount as economic damages at trial. Specifically, items 3-5 do not represent the actual expenses Davis incurred as payment for medical care attributable to Dr. Keene's alleged negligence. Specifically, the Item 3 balance ($307,067.17) correlates to a BC/BS Anthem "Medical and Rx Paid Claims Itemization – Summary" dated March 28, 2022, (*see* R:288:42-55), but only $157.50 of this amount is supported by actual evidence of an *amount paid* on this document, leaving $306,906.67 of this total unsupported by evidence actually establishing his economic damages. The Item 4 balance ($35,102.08) correlates to a BC/BS ND benefit summary dated March 28, 2022, (*see* R:288:56-61), but this benefit summary is not a medical bill, does not show the actual cost incurred, and does not even indicate what service each enumerated claim was for. And the Item 5 balance ($44,314.16) correlates to an Optum for United Health Care Med Payment Summary dated March 24, 2022, (*see* R:288:66-69), but, of this amount, nearly half ($18,048.95) is unsupported by any actual medical bills establishing the actual cost incurred for past medical care. As a result, of the more than $385,000 Davis claimed as monetary losses for past medical expenses incurred, he failed to present documentary evidence for more than $360,000 of that amount. Despite this dearth of evidence supporting more than 90% of Davis's claimed past medical expenses damages, the jury awarded him

$400,000 for past medical expenses—*more* than the amount he even claimed in the first place.

[47] Moreover, Davis also failed to present sufficient foundational support for any medical bills by not reviewing any bills. He testified that he "never looked at" his medical bills or compared them to anything, including his insurance claim payment summaries. (R:479:1078:13-1079:7). Despite the ease with which foundation for medical expenses is typically established, even this "rudimentary element of foundation" cannot be established when "the plaintiff has not seen, cannot find, or cannot remember the [medical] bills." 23 Am.Jur. 3d 243, § 22, *Establishing an Adequate Foundation for Proof of Medical Expenses* (June 2022); *see Condon*, 2019 ND 113 at ¶ 20 (explaining foundation can be established by testimony from the plaintiff that she reviewed her *medical bills* and the bills were related to the claimed injury). Davis was not competent to establish foundation because he never looked at the bills. He simply failed to present evidence to support the damages the jury ultimately awarded in past medical expenses.

[48] The deficiencies in Davis's proof of his past medical expenses are not a matter of credibility, they are a complete failure of foundation and evidence. The verdict falls far outside the range of evidence actually supporting an economic-damages claim presented at trial. As a result, the past economic damages award is "perverse and clearly contrary to the evidence," *Anderson*, 2001 ND 40 at ¶ 6, and should have been reduced by the trial court to comport with the actual evidence presented at trial.

2. Davis failed to present evidence sufficient to support the jury's award of future economic damages.

[49] Davis also failed to present evidence supporting the future economic damages the jury awarded. Specifically, there is no dispute that Davis had preexisting kidney disease

that would have required treatment in the future regardless the timing of his diagnosis. (*See, e.g.*, R:478:763:10-14 (Dr. Denker testifying as such)). But Davis made no attempt to differentiate future damages arising from the alleged delay in diagnosing his IgA nephropathy from the future costs to treat his disease that he would have incurred regardless as part of the natural progression of that disease.

[50] A plaintiff is only "entitled to recover compensation for all detriment proximately caused by the defendant's wrongful act." *Shoemaker v. Sonju*, 15 N.D. 518, 108 N.W. 42, 43 (1906); *see Dickhoff*, 836 N.W.2d at 344 (Dietzen, J., *dissenting*) ("The burden of proof . . . remains on the plaintiff to segregate her damages and identify which specific compensable harms were the result of defendant's aggravation of her disease, as opposed to those that were the result of the disease itself"). Where a plaintiff seeks to recover for future medical damages, "there must be substantial evidence to establish with reasonable medical certainty that such future medical services are necessary.'" *Erdmann v. Thomas*, 446 N.W.2d 245, 247 (N.D. 1989) (quotation omitted); *see Olmstead v. Miller*, 383 N.W.2d 817, 822 (N.D. 1986) ("Future damages must be proved with reasonable certainty; they cannot be awarded on the basis of speculative possibilities or conjecture."). If a plaintiff fails to distinguish future damages resulting from the alleged negligence from the future costs to treat an incurable disease during the course of its natural progression, he fails to present sufficient evidence to sustain the future damages award. *See McDonnell v. Monteith*, 59 N.D. 750, 231 N.W. 854, 857 (1930) (holding that, where the evidence at trial shows more than one proximate cause for the "result complained of," i.e., future medical costs, "and the jury can only conjecture or speculate as to which was the cause of such result, a verdict for damages therefore cannot be sustained"). "The trier of fact must be

furnished data sufficient to determine damages without resort to mere speculation or conjecture," *Johnson v. Monsanto Co.*, 303 N.W.2d 86, 95 (N.D. 1981), and a plaintiff's failure to differentiate delay-related costs from natural-progression costs leaves a jury with no choice but to impermissibly speculate as to future medical costs, *see Olmstead*, 383 N.W.2d at 822 ("Damages based on the mere possibility of future medical treatment will not be allowed.").

[51] Davis's claim against Dr. Keene is that his "failure" to refer Davis to a nephrologist in September 2017 allowed his undiagnosed IgA nephropathy to progress and cause damage that would have been slowed or delayed had he been referred to a nephrologist sooner than March 2018. But Davis does not allege that Dr. Keene *caused* his disease, meaning his disease would require future treatment regardless when he was diagnosed.

[52] The evidence Davis presented of future damages, however, did not account for this distinction. Rather than presenting evidence of future damages attributable to the actual alleged negligence—delayed referral and alleged advancement of his disease—Davis's life-care expert simply laid out all of the treatment Davis may need in the future as a result of his kidney disease, and presented a life-care plan in excess of $3.9 million. (R:478:820:1-6; *see generally* R:478:798-838 (life care expert testimony). In fact, after much testimony about "actual costs" of Davis's future care, his life-care expert testified:

> Q. . . . . Your life care plan does not account for any care or treatment that Mr. Davis would have had to have simply because he has a kidney disease; correct?
>
> A. No; that is correct.

(R:478:837:3-6). The same is true for Davis's vocational evaluator, who testified:

> Q. . . . [D]id you take into account in arriving at your figures that at some point the natural progression of his disease process—and it's disputed here when— . . . would have resulted him going into kidney failure and needing

a transplanted kidney?

A. I did not.

(R:479:887:16-22). Likewise, his vocational evaluator also testified:

> Q. Did you factor into your earning losses, any testimony that if a diagnoses had been made, Mike would not have needed a kidney transplant for 15 to 20 years and would be able to work without any loss?
>
> A. Did I factor that into my report?
>
> Q. Yes
>
> A. No.

(R:479:894:8-14). None of Davis's future-damages experts bothered to isolate the costs attributable to Dr. Keene's alleged negligence here from the costs attributable to the natural progression of his kidney disease, which is incurable and will naturally continue to worsen over the course of his life.

[53] By presenting expert testimony as to the *total* estimated costs for his future treatments (testified to by life-care planner Loretta Lukens) and the estimated lost vocational earnings (testified to by vocational expert Thomas Karrow), but not isolating the costs arising from Dr. Keene's alleged negligence, Davis furnished insufficient data to the jury from which it could "determine damages without resort to mere speculation or conjecture." *Johnson*, 303 N.W.2d at 95. There is no basis in the evidence for a $1.1 million future economic damages award where the evidence undisputedly establishes that Davis would have required extensive future medical care—including transplants and dialysis—as a result of his incurable disease *regardless* when he was diagnosed with that disease. (*See, e.g.*, R:478:763:10-14 (Dr. Denker agreeing that "Davis would have required treatment for his kidney disease regardless when it was detected"); R:478:765:14-22 ("Q. And I think we've established already, a number of times, that IgA nephropathy is an

incurable progressive disease; fair to say? A. It's a chronic disease that's treatable. Q. Okay. And if a patient progresses to kidney failure, your options are transplant; correct? A. Yes. Q. Or dialysis? A. Yes."); R:478:766:6-8 (Dr. Denker agreeing that "even with optimal treatment [Davis] was going to end up with kidney failure"); R:478:776:10-14 ("Q. Okay. Do you agree that it cannot be predicted whether or when Mr. Davis will progress to end-state kidney failure? A. Not with any degree of certainty, but we know how long transplanted kidneys last."); R:478:778:2-6 (Dr. Denker agreeing that "Davis was going to have to have treatment for his kidney disease regardless of Miss Norby and Dr. Keene's role in his care"). Davis needs to have brought forth "substantial evidence to establish with reasonable medical certainty that such future medical services are necessary," *Erdmann*, 446 N.W.2d at 247, but he must also establish which future medical costs result from Dr. Keene's alleged negligence because he is only "entitled to recover compensation for all detriment *proximately caused by*" the alleged wrongful act, *Shoemaker*, 108 N.W. at 43.

[54] Likewise, Davis presented insufficient evidence to support the jury's future wage loss damages. Specifically, Davis presented no *actual facts* establishing any future wage loss attributable to Dr. Keene's alleged negligence, and his own experts contradicted each other on this subject at trial. (*See, e.g.*, R:479:962:21-25 (plaintiff expert Scot Stradley testifying he based his economic opinion on "a different set of circumstances" from those used by vocational expert Karrow); R:479:951:6-12 (Stradley testifying that Karrow's basis for his opinion "make[s] sense, but not in application to Mr. Davis's set of circumstances"). Davis's economist expressly testified, when asked the factual basis for his estimated percentages regarding time away from work in the future, that he "ha[s] nothing factual to base that on. It's an estimate." (R:479:968:10-24). Likewise, Karrow

admitted "[t]here are no indications in the medical records, or otherwise, that support a conclusion that it's reasonably certain that Mr. Davis will not be able to continue working as a truck driver in the future." (R:479:891:15-22). All of this contradiction amounts to Davis failing to distinguish future damages arising from Dr. Keene's alleged malpractice from the future costs he would necessarily incur for treatment of his incurable disease.

[55] Where a plaintiff seeks to recover for future damages, "there must be substantial evidence to establish with reasonable medical certainty that such future medical services are necessary." *Erdmann*, 446 N.W.2d at 247 (quotation omitted). "Damages based on the mere possibility of future medical treatment will not be allowed." *Olmstead*, 383 N.W.2d at 822. "[A]ll future damages must be proved with reasonable certainty," *Erdmann*, 446 N.W.2d at 247, and Davis's failure to distinguish costs attributable to Dr. Keene's alleged negligence from his future medical costs generally is fatal. Dr. Keene is entitled to judgment as a matter of law.

III. The district court erred by not correcting the court clerk's award of costs and disbursements in a manner inconsistent with the court's order and the jury's verdict.

[56] At the conclusion of trial, the trial court ordered entry of judgment as follows:

> NOW, THEREFORE, IT IS HEREBY ORDERED:
>
> 1. That Plaintiffs take nothing with respect to their direct claim against Defendant Mercy Medical Center and this action in all respects be dismissed with prejudice as to that claim against Defendant Mercy Medical Center.
>
> 2. That Plaintiffs take nothing with respect to Defendant Cherise Norby, N.P. and this action in all respects be dismissed with prejudice as to Defendant Cherise Norby, N.P.
>
> 3. That Plaintiffs recover $1,660,000.00 with respect to Defendant Mercy Medical Center based on vicarious liability for Defendant David Keene, M.D., plus post-judgment interest in accordance with N.D.C.C. § 28-26-13.

> 4. That the parties have judgment entered in their favor in accordance with this Order and be awarded costs to be taxed by the clerk of court.

(R:376). But the court clerk signed Davis's proposed judgment, which did not reflect either the court's order for judgment or the jury's verdict. (R:378). The judgment as entered awards Davis more than $200,000 in costs and disbursements, which reflects nearly 100% of his claimed costs, disbursements, and fees (which represented all of Davis's costs except expert-witness fees for one witness), even though Davis did not prevail on all of his claims. The judgment awards nothing in costs to Mercy Medical Center or N.P. Norby. Dr. Keene objected to the judgment as entered, but the trial court refused to correct the error even though it was inconsistent with its own order for judgment. It erred in so doing.

A. Davis is not a prevailing party.

[57] First, Davis is not the prevailing party. "The determination of who is a prevailing party is a question of law" that this Court reviews de novo. *Braunberger v. Interstate Eng'g, Inc.*, 2000 ND 45, ¶ 13, 607 N.W.2d 904. "In order to be considered a prevailing party in a tort action, a party must prevail at least on the issues of negligence and proximate cause." *Andrews v. O'Hearn*, 387 N.W.2d 716, 732 (N.D. 1986); *see Lemer v. Campbell*, 1999 ND 223, ¶ 9, 602 N.W.2d 686 ("Generally, the prevailing party to a suit, for the purpose of determining who is entitled to costs, is the one who successfully prosecutes the action or successfully defends against it, prevailing on the merits of the main issue, in other words, the prevailing party is the one in whose favor the decision or verdict is rendered and the judgment entered."). "When each party prevails on some issues in the district court, there is no single 'prevailing party' against whom the clerk can tax disbursements under Section 28-26-06, N.D.C.C." *Blackburn, Nickels & Smith, Inc. v. Nat'l Farmers Union Prop. & Cas. Co.*, 482 N.W.2d 600, 605 (N.D. 1992) (citation omitted).

[58] Davis prevailed as against Dr. Keene, but he did not prevail as against N.P. Norby or on his direct claim against Mercy Medical Center. Accordingly, there is no prevailing party for purposes of N.D.C.C. § 28-26-06. *See WFND, LLC v. Fargo Marc, LLC*, 2007 ND 67, ¶ 50, 730 N.W.2d 841 (concluding that, where "both parties prevailed on their respective claims, . . . there is no prevailing party for purposes of N.D.C.C. § 28-26-06"). The trial court recognized this in its order for judgment, where it noted that both Mercy Medical Center and N.P. Norby were prevailing parties as against Davis, that Davis was the prevailing party as to Dr. Keene, and ordering that the parties be awarded costs as taxed by the court clerk. The court clerk, however, did not follow the order as dictated by the trial court, and instead entered judgment with an award of costs *only* to Davis. (R:378; R:386). This was both erroneous under the law and contradictory to the trial court's order.

[59] "A trial court's decision on fees and costs under N.D.C.C. § 28-26-06 will not be overturned on appeal unless an abuse of discretion is shown." *Braunberger*, 2000 ND 45 at ¶ 14. "A trial court abuses its discretion when it acts in an arbitrary, unreasonable, or unconscionable manner." *Id.* The trial court then refused to correct the mistake, essentially tacitly approving an award of costs to only one party even though it was inappropriate to award costs and disbursements to Davis alone. *E.g.*, *Huber v. Oliver Cnty.*, 1999 ND 220, ¶ 22, 602 N.W.2d 710 ("If each party prevails on certain parts of a lawsuit, the trial court need not award costs to either party."); *Uren v. Dakota Dust-Tex, Inc.*, 2002 ND 81, ¶ 31, 643 N.W.2d 678 ("A trial court abuses its discretion if it acts in an arbitrary, unreasonable, or unconscionable manner, or if it misinterprets or misapplies the law."). This tacit acceptance of a *court clerk's* erroneous determination that Davis was the sole prevailing

party entitled to more than $200,000 in costs and disbursements was arbitrary and unreasonable and was an abuse of the trial court's discretion.

B. Davis's claimed fees are not confined to the costs and disbursements attributable to the claim on which he prevailed.

[60] In addition to the erroneous award of costs and disbursements to Davis alone, the amount awarded to him constitutes an abuse of the trial court's discretion.

[61] As discussed above, Davis was not the sole prevailing party. He prevailed on his malpractice claim against Dr. Keene, but N.P. Norby and Mercy Medical Center prevailed on his claims against them. Yet Davis sought more than $200,000 in costs and disbursements, an amount that reflects both costs that are not taxable and costs associated with his failed claims against N.P. Norby and Mercy Medical Center that have now been *awarded* to him as against Dr. Keene. For instance, Davis sought to tax costs as follows: (1) Costs for a mediation ($1,575), even though the parties had agreed to "equally split" the mediator's fee, (R:374), and mediation expenses are not recoverable under N.D.C.C. § 28-26-06, *see Heng v. Rotech Med. Corp.*, 2006 ND 176, ¶ 35, 720 N.W.2d 54 (finding abuse of discretion in awarding plaintiff mediation fees where the parties agreed those fees would be "borne equally"); (2) $1,800 in witness fees for Dr. Jerome Kessler, one of Davis's treating physicians one of Davis's treating physicians, even though he was who testified as a fact witness not an expert witness, *see* N.D.C.C. § 31-01-16 (limiting witness fees to $25 per day); (3) $800 in witness fees for Dr. El Ters even though she testified as a fact witness rather than an expert witness, *see id.*; (4) the full cost of deposition fees for Dr. El Ters ($1,600) even though the defendants had already agreed to pay—and had paid—half of that cost; (5) costs to retrieve medical records retrieval ($16,370.23), even though the parties had agreed to share the cost of obtaining Davis's records, the defendants

had already paid their share of that cost, the taxed cost was duplicative, and the actual cost for Davis's share of the medical-records cost was only $4,504.56; (6) Copying, postage and shipping, and legal, medical, and expert research ($18,684.24), even though these costs are generally considered overhead expenses of a law firm to be reimbursed by a client, *see Uren*, 2002 ND 81, ¶¶ 31-34, and he provided no explanation for or breakdown of those charges such that the court or the defendants could tell why or whether any of the charges could properly be taxed to defendants, *see, e.g.*, *Heng*, 2006 ND 176, ¶ 37 ("electronic legal research fees are a component of attorney fees and cannot be separately taxed as costs"); and (7) retainer fee charged by OnPoint Consulting ($4,800), an expert-witness service entity Davis retained but precluded the defendants from mentioning at trial.

[62] Davis made no effort to segregate costs attributable to his claims against the prevailing defendants from the costs attributable to his claim against Dr. Keene and he blatantly sought to tax costs that are not taxable under section 28-26-06, yet the trial court declined to correct the court clerk's erroneous award of his entire claimed amount. This was an abuse of the trial court's discretion and should be reversed.

CONCLUSION

[63] For the reasons stated above, Dr. Keene respectfully asks this Court to reverse and remand for entry of judgment in his favor.

Dated: March 16, 2023

/s/ Tracy Vigness Kolb

Tracy Vigness Kolb (ND 05338)
Meagher & Geer, P.L.L.P.
1900 Brunt Boat Drive, Suite 101
Bismarck, ND 58503
Ph: 701.222.1315
Direct Ph: 701.333.0638
tkolb@meagher.com

Rodger A. Hagen (ND 05659)
Julia J. Nierengarten (P01894)
Meagher & Geer, P.L.L.P.
33 South Sixth Street, Suite 4400
Minneapolis, MN 55402
Ph: 612.338.0661
rhagen@meagher.com
jnierengarten@meagher.com

STATEMENT REGARDING ORAL ARGUMENT

[64] The case has an exceptionally large record and raises many challenging issues. Both the Court and the parties will greatly benefit from oral argument.

CERTIFICATE OF COMPLIANCE

[65] Pursuant to Rule 32(e) of the North Dakota Rules of Appellate Procedure, this brief complies with the page limitation and consists of 38 pages.

Dated: March 16, 2023

/s/ Tracy Vigness Kolb
Tracy Vigness Kolb

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IN THE SUPREME COURT
STATE OF NORTH DAKOTA

Michael Davis and Kimberly Davis, Plaintiffs and Appellees v. Mercy Medical Center d/b/a CHI St. Alexius Health Williston; and David Keene, M.D., Defendants and Appellants and Cherise Norby, N.P. Defendant	**Supreme Court No. 20220325** **Civil No. 53-2019-CV-00589** **Certificate of Service**

[1] I hereby certify that on March 16, 2023, a true and correct copy of **Brief of Appellants Mercy Medical Center d/b/a CHI St. Alexius Health Williston and David Keene, M.D.,** and this **Certificate** were filed electronically with the Court and served electronically by email on the following:

Plaintiffs Attorney

Mark V. Larson	larslaw@srt.com
Jed Kurzban	jed@kktplaw.com
Lauren Gallagher	lgallagher@kktplaw.com

[2] I further certify that a copy of these documents will be served under N.D.R.Civ.P.5(b)(3) on the following persons who are exempt from electronic service by email:

None

Dated this 16th day of March, 2023.

/s/ Tracy Vigness Kolb

Tracy Vigness Kolb, ND ID# 05338
MEAGHER + GEER, P.L.L.P.
1900 Burnt Boat Drive, Suite 101
Bismarck, ND 58503
Ph: 701.222.1315
Direct Ph: 701.333.0638
tkolb@meagher.com
Attorney for Defendants-Appellants

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IN THE SUPREME COURT
STATE OF NORTH DAKOTA

Michael Davis and Kimberly Davis, Plaintiffs and Appellees v. Mercy Medical Center d/b/a CHI St. Alexius Health Williston; and David Keene, M.D., Defendants and Appellants and Cherise Norby, N.P. Defendant	**Supreme Court No. 20220325** **Civil No. 53-2019-CV-00589** **Certificate of Service**

[1] I hereby certify that on March 20, 2023, a true and correct copy of **Brief of Appellants Mercy Medical Center d/b/a CHI St. Alexius Health Williston and David Keene, M.D.,** and this **Certificate** were filed electronically with the Court and served electronically by email on the following:

Plaintiffs Attorney

Mark V. Larson	larslaw@srt.com
Jed Kurzban	jed@kktplaw.com
Lauren Gallagher	lgallagher@kktplaw.com

[2] I further certify that a copy of these documents will be served under N.D.R.Civ.P.5(b)(3) on the following persons who are exempt from electronic service by email:

None

Dated this 20th day of March, 2023.

/s/ Tracy Vigness Kolb

Tracy Vigness Kolb, ND ID# 05338
MEAGHER + GEER, P.L.L.P.
1900 Burnt Boat Drive, Suite 101
Bismarck, ND 58503
Ph: 701.222.1315
Direct Ph: 701.333.0638
tkolb@meagher.com
Attorney for Defendants-Appellants