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San Francisco County Superior Court

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SUPERIOR COURT OF CALIFORNIA
COUNTY OF SAN FRANCISCO
DEPARTMENT 613

COORDINATION PROCEEDING SPECIAL
TITLE
[RULE 3.550(c)]

PRADAXA® CASES

Case No. CJC-16-004863
JUDICIAL COUNCIL COORDINATION
PROCEEDING NO. 4863

This document relates to:

Rosemary Lawson
San Francisco Superior Court Case No.:
CGC-17-559611

ORDER GRANTING DEFENDANT'S MOTION
FOR SUMMARY JUDGMENT, OR IN THE
ALTERNATIVE, FOR SUMMARY
ADJUDICATION

INTRODUCTION

The above-entitled matter came on regularly for hearing on October 22, 2019. A court reporter was present. The appearances are as noted in the record. Following the hearing on October 22, 2019, the Court issued an order requesting further briefing on an isolated issue. Each party made timely, supplemental submissions.

Having reviewed and considered the argument and written submissions of all parties and being fully advised, the Court grants Defendants' motion for summary judgment, or in the alternative, summary adjudication ("MSJ/MSA").¹

¹ Because the Court separately considers the parties' preemption arguments in its order on Defendant's motion for summary judgment based on federal preemption, the Court does not consider the parties' arguments within the MSJ/MSA on federal preemption. (Compare MSJ, 10-13 and Reply, 4:21-5:2 with Opp., 20:26-21:28.)

1 **BACKGROUND AND FACTS**

2 Defendant Boehringer Ingelheim Pharmaceuticals, Inc. (“BI”) moved for summary judgment or, in
3 the alternative, summary adjudication, on Plaintiff Rosemary Lawson’s (“Plaintiff”) claims for strict
4 liability failure to warn, negligent failure to warn, negligent misrepresentation, fraud and intentional
5 misrepresentation, and punitive damages pursuant to Code of Civil Procedure section 437c, subds. (c) &
6 (p). Defendant McKesson Corporation (“McKesson”) joined the motion.² (See Motion, 1, fn. 1.)

7 Pradaxa is a prescription drug Defendant BI manufactures, and the Food and Drug Administration
8 (“FDA”) approved in October 2010, to reduce the risk of stroke and systemic embolism in patients with
9 non-valvular atrial fibrillation. (See Declaration of Wayne A. Wolff ISO Defendants’ Motions for
10 Summary Judgment (Oct. 8, 2019) [“Wolff Decl.”], Joint Appendix [“J.A.”] Ex. 205 [“Complaint”], ¶¶
11 13-14; Wolff Decl., J.A. Ex. 100 [“Pradaxa (Oct. 2010) Label”] at 1.)

12 Plaintiff was diagnosed with atrial fibrillation in January of 2010. (See Plaintiff’s Separate
13 Statement of Facts in Opposition to BI’s MSJ/MSA [“Plaintiff’s SSDF”] No. 1.) Plaintiff’s prescribing
14 physician and cardiologist, Dr. Khan³, testified that he was familiar with the risks and warnings contained
15 in the Pradaxa label at the time he prescribed Pradaxa to Plaintiff in November of 2010, and that he
16 discussed these risks with Plaintiff. (Khan Depo., at 50:13-51:2, [Dr. Khan generally was familiar with
17 the risks and warnings prior to recommending Pradaxa to Plaintiff], 51:3-52:4 and 150:21-151:7 [Dr.
18 Khan knew the FDA approved only two doses of Pradaxa, with the appropriate dose to be determined by
19

20 ² BI and McKesson are collectively referred to as “Defendants.”

21 ³ Plaintiff repeatedly refers to Mr. John Kitchell, Physician’s Assistant, as her prescribing doctor. (See
22 Oppo., 6:26-7:1 [citing Plaintiff’s SSF No. 8], 10:13-12:9 [citing Plaintiff’s SSF Nos. 56-72].) However,
23 the undisputed facts reveal that Dr. Khan was the doctor who evaluated Plaintiff and recommended she
24 take Pradaxa, and Mr. Kitchell is in fact *not* a doctor. (See Wolff Decl., J.A. Ex. 223, Gauhar Khan, M.D.
25 (5/22/19) Depo. [“Khan Depo.”], at 22:19-24:5; see also Plaintiff’s SSDF No. 8.) As discussed in more
26 detail, *infra*, case law makes clear that only *the prescribing and/or treating physicians’* potential change
27 in behavior is relevant to the causation analysis here. (See *Georges v. Novartis Pharmaceuticals*
28 *Corp.* (C.D. Cal., Nov. 2, 2012) 2012 WL 9083365, at *6.)

Further, and most importantly, while Plaintiff repeatedly refers to Mr. Kitchell and his experience with
Pradaxa and Ms. Lawson in the facts section of Plaintiff’s Oppo., Plaintiff’s entire argument section is
devoid of any reference to Mr. Kitchell. (See Oppo., 14-19 [discussing Dr. Khan, only].) Thus, any
evidence on Mr. Kitchell’s purported changes in this prescription decision or informed consent
discussions are irrelevant.

1 the patients' renal function], 55 [Dr. Khan was informed that if a patient, like Plaintiff, were taking
2 amiodarone (a p-gp inhibitor) that he did not need to adjust her Pradaxa dose]; 57:9-21 and 99:1-14 [Dr.
3 Khan knew Pradaxa increased the risk of significant bleeding, including fatal and intracranial bleeding,
4 and would have discussed this with Plaintiff], 68:16-69:21 and 165:24-166:10 [Dr. Khan knew there was
5 no reversal agent for Pradaxa at the time he prescribed it to Plaintiff, and is confident he would have
6 discussed this fact with Plaintiff], 90:19-91:2 [Dr. Khan knew the concomitant use of NSAIDs and
7 aspirin could further increase the risk of bleeding while on anticoagulation therapy, and Dr. Khan would
8 have instructed Plaintiff to avoid them], 99:15-21 [Dr. Khan knew Pradaxa had an increased risk of
9 bleeding for patients over 75, as compared to Warfarin, and would have discussed this with Plaintiff],
10 100:20-23 [Dr. Khan knew, and would have discussed with Plaintiff, that Pradaxa was not monitored with
11 blood tests], 101:3-5 [Dr. Khan knew, and would have discussed with Plaintiff, the need to look out for
12 signs of bleeding while taking Pradaxa.]

13 Specifically, and as outlined immediately above, Dr. Khan informed Plaintiff that Pradaxa carried
14 a risk of bleeding, including intracranial and fatal bleeding, which is increased in patients such as Ms.
15 Lawson, who is over the age of 75 and a female. (Khan Depo., at 99:1-21, 110 [Dr. Khan was aware that
16 Ms. Lawson's age and gender put her at an increased risk of bleeding while on Pradaxa]; Plaintiff's SSDF
17 Nos., 95-96.) Dr. Khan also informed Plaintiff that Pradaxa did not have a product-specific reversal
18 agent, and that Pradaxa was not monitored with blood tests. (*Id.* at 68:16-69:21, 100:20-23, 165:24-
19 166:10.) Dr. Khan testified he followed the dosing instructions, and prescribed Plaintiff the 150 mg dose
20 twice daily because she had normal kidney and renal function. (*Id.* at 51:21-56:17 [Dr. Khan prescribed
21 150 mg of Pradaxa twice daily after assessing Ms. Lawson's kidney and renal function, which was
22 measured by creatine clearance and accounted for one's weight, age, and gender], 115:6-116:20 [Dr.
23 Khan analyzed the risks and benefits and prescribed Pradaxa based on pre-2010 dosing guidelines].)⁴

24 Plaintiff began taking Pradaxa in January of 2011. (Wolff Decl., J.A. Ex. 207, PFS at 10.) She
25

26 ⁴ There is evidence that Dr. Khan did not recall the specific informed consent discussion with Ms.
27 Lawson. (See Plaintiff's SSDF 93-99.) However, this is a non-issue. Indeed, Plaintiff admits that
28 "[t]here is no reason to believe that Dr. Khan deviated from his normal risk/benefit discussion when
discussing Pradaxa with Ms. Lawson," which included the risks discussed in the two paragraphs, *supra*.
(Oppo., 17:10-24.)

1 testified that she relied on her doctors to decide the best medications for her and trusted their medical
2 judgment to make those decisions for her. (Wolff Decl., J.A. Ex. 221 [“Lawson Depo.”], at 16:9-12,
3 66:11-67:4.)⁵

4 On March 14, 2016, Plaintiff was admitted to Doctors Medical Center for an intracranial
5 hemorrhage. (Wolff Decl., J.A. Ex. 224, Belinda Kea, M.D. Depo., at 13:17-21.) There was no
6 subsequent required surgery, the hospital administered two doses of the Pradaxa reversal agent to Ms.
7 Lawson, and Ms. Lawson was stable throughout her hospitalization. (*Id.* at 24:18-12, 46:1-13, 65:4-16.)
8 Plaintiff’s expert, Dr. Rosengart, opined that the elevated levels of Pradaxa concentrations (which were
9 higher than the 215 nanograms per milliliter) in Plaintiff’s blood more likely than not caused her
10 intracranial bleed. (Plaintiff’s SSDF No. 73.) Dr. Rosenhart opined further that the elevated Pradaxa
11 levels were due to Plaintiff’s age, strong p-gp inhibitor use (i.e. amiodarone), weight, gender, inpatient
12 variability, and reduction in renal function.⁶ (*Id.*) Ms. Lawson had mild to stage two renal impairment at
13 the time of her intracranial bleed. (See Plaintiff’s SSDF, No. 66.)

14 Plaintiff filed the instant case on June 19, 2017, asserting claims for strict liability failure to warn,

15 ⁵ While Plaintiff also testified that *if* Dr. Khan informed her of the risk of serious, sometimes fatal,
16 bleeding, she “*probably*” would have refused Pradaxa or “*might* have told . . . him no” (see Lawson Depo,
17 75:12-16, 77:1-6 [emphasis supplied]) the undisputed evidence shows that (1) Dr. Khan *did* inform
18 Plaintiff of these risks (see Khan Depo., 99:1-14), and (2) Plaintiff does not recall what risks were
19 specifically discussed with her at the time of prescription. (See Lawson Depo., 73:13-17, 76:6-12.) Thus,
20 as discussed *infra*, Plaintiff’s speculative testimony precludes the Court from finding a triable issue of
21 material fact on causation. (See *Ochoa v. Pacific Gas & Electric Co.* (1998) 61 Cal.App.4th 1480, 1485–
22 1486 [He opined that the stroke, ‘was *more probably* a complication from the internal mammary
23 visualization procedure than a coincidence.’ The appellate court held that this testimony ‘is at best
24 speculative and conjecture and falls short of meeting the ‘probability’ standard of proximate cause.”]
25 [emphasis supplied].) Other case law also makes clear that in order to defeat summary judgment, Plaintiff
26 must testify that she *would* have refused the prescription if she had known certain information relevant to
27 her injury. (See e.g., *Hill v. Novartis Pharmaceuticals Corp.* (E.D. Cal. 2012) 2012 WL 600416, at *4
28 [denying summary judgment because prescribing physician, who had become aware after he prescribed
the drug to plaintiff that the drug could cause problems with a person’s jaw, testified that he now discloses
that fact to his patients, and *plaintiff testified she would not have taken the drug had she been made aware
of the same*].) Thus, testimony that she “probably” or “might have” refused to take Pradaxa had she
known relevant information relating to potentially fatal bleeding is insufficient.

⁶ The at-issue label had specific warnings that Pradaxa can cause serious, and sometimes fatal bleeding,
and also warned of increased risks of bleeding based on renal impairment, concomitant use of p-gp
inhibitors (like amiodarone), age (including geriatric patients), and concomitant use of other drugs. (See
“Pradaxa (Oct. 2010) Label” at 1, 3-6[.]) Further, the label advised that Pradaxa is administered based on
renal function, *not* by monitoring of anticoagulation tests or plasma levels (like Warfarin). (See *id.*)

1 negligent failure to warn, negligent misrepresentation, fraud and intentional misrepresentation, and
2 punitive damages. (See generally, Complaint.) Plaintiff alleged that the warnings accompanying Pradaxa
3 were deficient because BI failed to adequately warn prescribing physicians “that there was no reversal
4 agent that could stop or control bleeding in patients;” “that Pradaxa has a narrow therapeutic window, and
5 that it should be dose adjusted to patients to minimize their risk of bleeding;” “that approximately ten
6 percent of patients are ‘super absorbers’ who eliminate Pradaxa from their bodies slower than other
7 patients;” and “that the risks of Pradaxa outweigh the benefits in patients 80 years of age or older.” (*Id.*
8 ¶¶ 22, 24.)

9 During his deposition, Plaintiff’s counsel cross-examined Dr. Khan and presented to him various
10 medical literature, references to BI company documents, and regulatory documents. (MSJ, 3:2-3.) Dr.
11 Khan testified that none of the additional risk information or documents presented to him would have
12 changed his decision to prescribe Pradaxa to Plaintiff, or the informed consent discussion he had with her
13 about Pradaxa. (Khan Depo., 116:4-118:1 [presently, Dr. Khan stands by his decision to prescribe
14 Plaintiff the 150mg dose of Pradaxa, and his risk benefit information communication to Plaintiff even
15 after her intracranial hemorrhage, and believes it was the best medication for her in March of 2016],
16 167:24-168:23 [Dr. Khan stood by his decision to prescribe Pradaxa even after all additional risks and
17 documents were presented to Dr. Khan during deposition].)

18 However, Dr. Khan also testified that had he known that there was a mechanism to monitor and
19 measure the Pradaxa plasma concentrations in the blood, that he would have wanted to know that such
20 measuring/monitoring was possible, and would have *measured* a patient’s Pradaxa concentrations to see if
21 they ran a risk of a major bleed. (See Plaintiff’s SSDF Nos. 20-21, 26, 76, 85; see also *id.* at Nos. 22, 27,
22 77, 86 [testifying that if Dr. Khan knew there were documents showing that there was large variability in
23 plasma concentrations, that would have “an impact” on whether or not to prescribe Pradaxa].) With
24 respect to monitoring specifically, Dr. Khan testified that he was unaware that the risk of bleeding
25 increases substantially above 215 nanograms per milliliter, and he would have wanted to be aware of that
26 fact at the time he prescribed Pradaxa. (See *id.* at Nos. 18-19, 47.) Dr. Khan further testified that if he
27 knew that there were 543 deaths associated with the use of Pradaxa in May of 2012, he “probably” would
28 have ceased Ms. Lawson’s Pradaxa prescription. (See *id.* at Nos. 32-35, 54, 87; see also *id.* at No. 35 [if

1 Dr. Khan knew that Pradaxa caused more deaths and major bleeds than Warfarin, Dr. Khan would take
2 that into consideration when prescribing Pradaxa].) Dr. Khan also testified that he would have wanted to
3 be made aware of a therapeutic range for Pradaxa, if one existed, and if he knew this information, “he
4 would have adjusted” his risk/benefit calculation in determining whether to prescribe Pradaxa. (See *id.* at
5 Nos. 36-41, 74-75, 82-83, Reply, 2:13-18.) Lastly, Dr. Khan testified that he would have adjusted his
6 risk/benefit analysis if knew the levels at which major bleeding increases and benefits remain constant
7 (also known as the therapeutic range). (See Plaintiff’s SSDF Nos. 23, 39, 30, 53, 75, 73.)⁷

8 **EVIDENTIARY OBJECTIONS**

9 Defendants object to various pieces of Plaintiff’s evidence to the extent such evidence is (1)
10 immaterial to the disposition of the MSJ/MSA, (2) duplicative of prior evidence, or (3) not a fact, but
11 rather an improper hypothetical or legal argument. (See Defendants’ Responses to Plaintiff’s SSDF, Nos.
12 1-114.) The Court overrules Defendants’ objections. Defendants’ objections go to the weight to be given
13 to the Plaintiff’s evidence, not its admissibility (and the Court will not consider irrelevant facts at
14 summary judgment). The Court need not consider the remainder of Defendants’ objections, as they are
15 immaterial to the Court’s analysis below. (See Defendants’ Responses to Plaintiffs’ SSDF, Nos. 115-136;
16 Code of Civ. Proc. § 437c(q).)

17 Plaintiff does not object to any of Defendants’ supporting evidence. (See generally, Plaintiff’s
18 Statement in Response to BI’s Separate Statement of Undisputed Facts ISO BI’s MSJ/MSA [“Plaintiff’s
19 Response to BI’s SSF”] (Sept. 10, 2019).)

20 **LEGAL STANDARD**

21 In the words of Code of Civil Procedure Section 437c, “any party may move for summary
22 judgment in any action or proceeding if it is contended that the action has no merit or that there is no
23 defense to the action or proceeding.” The party moving for summary judgment “bears the burden of
24 persuasion that there is no triable issue as to any material fact and that he is entitled to a judgment as a
25 matter of law.” (*Aguilar v. Atlantic Richfield Co.* (2001) 25 Cal.4th 826, 850.) Moreover, the moving
26 party also “bears an initial burden of production to make a prima facie showing of the nonexistence of any

27 ⁷ As discussed in Discussion and Analysis Part II.A, *infra*, the legal relevance of the facts in this
28 paragraph are what prompted the request for further briefing. (See Order After Defendant’s (1) Motion
For Summary Judgment, or in the Alternative, for Summary Adjudication and (2) Motion for Summary
Judgment on the Basis of Federal Preemption (Oct. 22, 2019) (“Further Briefing Order”).)

1 triable issue of material fact.” (*Id.*)

2 A defendant moving for summary judgment carries his burden of persuasion and/or production by
3 “present[ing] evidence that would require such a trier of fact not to find any underlying material fact more
4 likely than not. In the alternative, he may simply point out - he is not required to present evidence - that
5 the plaintiff does not possess, and cannot reasonably obtain, evidence that would allow such a trier of fact
6 to find any underlying material fact more likely than not.” (*Id.* at 845.)

7 If the moving party carries his burden of production, “he causes a shift, and the opposing party is
8 then subjected to a burden of production to make a prima facie showing of the existence of a triable issue
9 of material fact.” (*Id.* at 850.) But if the moving party fails to carry his initial burden, he would not be
10 entitled to judgment as a matter of law, and would have to present his evidence to a jury. (*Id.* at 851.)

11 DISCUSSION AND ANALYSIS

12 Defendants moved for summary judgment or, in the alternative, summary adjudication on
13 Plaintiff’s strict liability failure to warn claim, as well as Plaintiff’s other claims for negligent failure to
14 warn, negligent misrepresentation, and fraud and intentional misrepresentation, on the grounds that
15 Plaintiff cannot establish proximate causation. Defendants also seek summary adjudication of Plaintiff’s
16 punitive damages claim on the grounds that Plaintiff cannot meet her burden of proof to recover punitive
17 damages under Connecticut’s “reckless disregard” standard. For the reasons stated below, the Court
18 concludes that Plaintiff cannot demonstrate that Pradaxa is a proximate cause of her injury.
19 Accordingly, Defendants are entitled to summary judgment on Plaintiff’s claims, and the issue regarding
20 punitive damages is moot.⁸

21 **I. Background Law**

22 To establish a failure to warn claim, a plaintiff must prove that the inadequacy or absence of the
23 warning caused the plaintiff’s injury. (*Webb v Special Elec. Co., Inc.* (2016) 63 Cal.4th 167, 181.)

24
25 ⁸ BI also moved for summary judgment on Plaintiff’s design defect and failure to test claims to the extent
26 Plaintiff asserts such claims. (See MSJ, 10:2-9 [claiming no evidence of a design defect and preemption
27 of such claim], 13:4-21 [failure to test claim].) However, Plaintiff makes clear she is not asserting any
28 design defect or failure to test claims apart from her failure to warn claim. (See Oppo., 20-22 [“Plaintiff’s
claims of inadequate testing relate directly to [Defendants’] failure to warn about the dangers of
Pradaxa”]; see also Reply, 1 [noting Plaintiff’s concession that she is not pursuing a design defect claim],
4:5-20 [arguing Plaintiff conceded that her failure to test claim is indistinct from her failure to warn
claim].)

1 Legal or proximate cause is a “flexible concept” that generally “refers to the basic requirement that there
2 must be some direct relation between the injury asserted and the injurious conduct alleged.” (*Paroline v.*
3 *U.S.* (2014) 572 U.S. 434, 444.) “[P]roximate cause is ordinarily concerned, not with the fact of
4 causation, but with the various considerations of policy that limit an actor’s responsibility for the
5 consequences of his conduct.” (*State Dept. of State Hospitals v. Sup. Ct.* (2015) 61 Cal.4th 339, 353.)
6 Indeed, “rules of legal cause...operate to relieve the defendant whose conduct is a cause in fact of the
7 injury, where it would be considered unjust to hold him or her legally responsible.” (*Id.*) Where
8 reasonable minds cannot differ, the question of proximate cause is one of law, not of fact. (*Id.*)

9 Under the learned intermediary doctrine, the question is whether different or additional warnings
10 would have altered the conduct of the prescribing physician. (*Motus v. Pfizer, Inc.* (9th Cir. 2004) 358
11 F.3d 659, 661; see also *Carlin v. Sup. Ct.* (1996) 13 Cal.4th 1104, 1116 [California courts apply the
12 learned intermediary doctrine to warning claims arising from the use of prescription medications];
13 *Tucker v. Wright Medical Technology, Inc.* (N.D. Cal., Mar. 19, 2013) 2013 WL 1149717, at *12 [“A
14 manufacturer of a prescription drug is obligated warn *physicians*, not patients, of potential side effects
15 associated with its pharmaceutical products.”].)

16 “[A] product defect claim based on insufficient warnings cannot survive summary judgment if
17 stronger warnings *would not have altered the conduct* of the prescribing physician.” (*Id.* [citing *Motus*,
18 *supra*, 358 F.3d at 661] [emphasis supplied].)

19 **II. Application⁹**

20 As stated above, Plaintiff alleges BI failed to adequately warn prescribing physicians “that there
21 was no reversal agent that could stop or control bleeding in patients;” “that Pradaxa has a narrow
22 therapeutic window, and that it should be dose adjusted to patients to minimize their risk of bleeding;”
23 “that approximately ten percent of patients are ‘super absorbers’ who eliminate Pradaxa from their bodies
24 slower than other patients;” and “that the risks of Pradaxa outweigh the benefits in patients 80 years of
25 age or older.” (Complaint, ¶¶ 22, 24.) To prevail on her claims, Plaintiff must show a sufficient causal
26 connection between Defendants’ alleged failure to warn and Plaintiff’s injury.

27
28 ⁹ The Court notes that no party cited California state court cases to support its arguments. Thus, the Court does not have any binding precedent on the causation issue. Rather, the Court must rely on federal, mainly unpublished opinions, which are persuasive.

1 Defendants present evidence demonstrating that additional warnings would not have altered the
2 conduct of Plaintiff's prescribing physician. Here, Dr. Khan testified that none of the additional risk
3 information regarding Pradaxa presented to him by Plaintiff's counsel during his deposition, which
4 included information relating to measuring and/or monitoring plasma concentrations, would have changed
5 his decision to prescribe Pradaxa to Plaintiff, or the kind of informed consent discussion he had with her
6 about the drug.¹⁰ This evidence is sufficient to demonstrate that Defendants' alleged failure to warn did
7 not proximately cause Plaintiff's injury.

8 Plaintiff relies upon Dr. Khan's testimony that he would have measured Plaintiff's concentration
9 levels had he been informed he could do so.¹¹ In essence, Plaintiff argues that had Dr. Khan measured
10 Plaintiff's concentration levels, as he testified he would have done had he been informed he could do so,
11 he would have discovered that Plaintiff's Pradaxa levels were elevated or her renal function was reduced
12 (as testified to by Plaintiff's expert), and would have then prescribed Plaintiff a lower dose of Pradaxa or
13 a different anticoagulant as a result. Based on Dr. Khan's testimony, however, whether he would have
14 prescribed Plaintiff a lower dose of Pradaxa or a different anticoagulant is dependent on whether *he* would
15 have concluded that Plaintiff's Pradaxa levels were so high or her renal function was so reduced such that
16 a change in her prescription was warranted. In this respect, Plaintiff's theory for proximate causation is
17 speculative as there is no evidence to suggest that *Dr. Khan* would have reached that conclusion even if
18
19

20 ¹⁰ Defendants dispute that any change in Dr. Khan's informed consent discussion is relevant to the
21 causation inquiry. (See MSJ, 6:11-7:8.) The Court disagrees. Absent any new, compelling case law to
22 the contrary, the Court is persuaded by Judge Wiss's previous holding that the prescribing and/or treating
23 doctor's informed consent discussion is relevant to the causation inquiry. (See Wolff Decl., J.A. 419
24 [*Fourzon* Order Denying Motion for Partial Summary Judgment], at 7:26-8:13.) Nonetheless, the Court
25 agrees with Judge Wiss's analysis, and concludes separately that the prescribing and/or treating doctor's
informed consent discussion is relevant to the causation inquiry. (*Stanley v. Novartis Pharm. Corp.* (C.D.
Cal. 2014) 11 F.Supp.3d 987, 1003.) Regardless, Dr. Khan's testimony unequivocally demonstrates that
Dr. Khan would not have communicated different information to Plaintiff Lawson if Dr. Khan had
additional warnings.

26 ¹¹ As discussed *infra*, in *Narain* the prescribing doctor testified that he would have followed the warning
27 "had he been instructed to do so *in the label*." (see J.A., Ex. 201; see also Khan Depo., 127:23-128:16
28 [testimony regarding measuring].) While at first glance it appears Dr. Khan may not have testified
regarding *labeling* instructions specifically, the deposition testimony reveals that his testimony is
sufficiently tethered to the *label*. (See *id.* ["If the FDA said check it I would have checked it for sure."].)

1 he had measured Plaintiff's blood concentrations.¹²

2 In supplemental briefing, Plaintiff argues courts have found triable issues of fact on causation
3 where the "plaintiff shows that their physician would have used monitoring tests if adequately warned to
4 do so." (Plaintiff's Supp. Brief (Oct. 28, 2019), 4 [emphasis added] [citing *Holley v. Gilead Sciences,*
5 *Inc.* (N.D. Cal. 2019) 379 F.Supp.3d 809, 830].) Thus, because the testimony of Dr. Khan shows that he
6 would have "monitored¹³ to ensure [Plaintiff] was within the safe therapeutic range," Plaintiff insists she
7 has demonstrated a triable issue of fact on causation. (See Plaintiff's Supp. Brief, 2-4.) On the other
8 hand, Defendant argues the same result in *Narain* should follow here. (See Defendant's Supp. Brief
9 (Oct. 28, 2019), 5-7 [citing J.A., Ex. 201 [*Narain* Order Granting Defendants' Motion for Summary
10 Judgment].) In *Narain*, and similar to the evidence discussed in the preceding paragraph, Plaintiff
11 pointed to the physician's testimony that he (1) would have monitored Plaintiff if he had been instructed
12 to do so in the label, and (2) "probably" would have prescribed a lower Pradaxa dose had the monitoring
13 revealed the Plaintiff was over-anticoagulated. While, as with *Narain*, Dr. Khan stated he would have
14 measured his patients' blood concentrations to see if his patients' were at a risk of a major bleed if there
15 was a method of doing so, unlike *Narain*, there is no corresponding testimony that Dr. Khan would have
16 "probably" prescribed a different dose or anticoagulant for Ms. Lawson (if he found her blood
17 concentration levels to be high).¹⁴ In sum, Dr. Khan's testimony does not show that a particular warning,
18 such as a warning to measure blood concentration levels, would have prevented Plaintiff's brain bleed.

19
20 ¹² As noted in footnote 7, *supra*, the legal relevance of all other warning information identified *supra*, at 5:18-6:7 is addressed in Part II.A, *infra*.

21 ¹³ Here, the Court notes that, specifically, Dr. Khan testified that he *would* have wanted to *measure* the
22 concentration levels of Pradaxa, if possible, to ensure there was no risk of a major bleed. (See Khan
23 Depo., 127:23-128:16.) However, there is no similar testimony that he "would have" *monitored* Plaintiff.
24 Thus, it appears Plaintiff uses "monitoring" and "measuring" interchangeably. The Court assumes that
25 this is accurate for purposes of this motion.

26 ¹⁴ Based on footnote 13, *supra*, the Court also disagrees with Defendant's statement that "[t]hough Dr.
27 Khan testified that he would have adjusted his risk-benefit discussion in response to additional
28 information posed by Plaintiff's counsel, he never testified that he would have taken a 'next step' as
exemplified in the cited cases above – i.e. *chosen to monitor*." (Defendant's Brief, 6:26-7:2 [emphasis
supplied].) Regardless, *Narain* did not find a choice to monitor (or similarly here, a choice to measure)
dispositive on the causation analysis. *Narain* assumed that the doctor's testimony about monitoring was
true, and still found causation too speculative. The same follows for Dr. Khan's "measuring" testimony
(especially in light of the even more attenuated testimony here as compared to *Narain*, as discussed in this
paragraph).

1 Further, as stated in the preceding paragraph, Plaintiff Lawson has not provided similar evidence
2 to the one case cited in *Holley (In re Xarelto (Rivaroxaban) Products Liability Litigation* (E.D. La., Apr.
3 17, 2017) 2017 WL 1393480, at *1-3 [applying Louisiana law]¹⁵), addressing the issue of monitoring .
4 Indeed, in *In re Xarelto*, “Plaintiffs point[ed] to evidence that both doctors *would have used* PT tests had
5 they been adequately instructed to do so, and therefore *would have* been equipped to adjust treatment to
6 avoid injury. Specifically, for Plaintiff Orr, Dr. Bui, her neurosurgeon, *would have known* Ms. Orr was
7 not anticoagulated and *would have* proceeded with her surgery much sooner. Because of the delay,
8 however, Ms. Orr experienced significant medical issues.” (*Id.* [emphasis supplied].) Unlike *In re*
9 *Xarelto*, and as stated *supra* at 9:8-10:1, there is no evidence that, had Dr. Khan measured Plaintiff’s
10 blood concentration levels, he *would have* known Ms. Lawson’s blood concentration levels were too
11 high/she ran a risk of a major bleed, *would have* provided a lower dose of Pradaxa or a different
12 anticoagulant, and/or *would have* taken steps to prevent her brain bleed. While *Holley’s* and *In re*
13 *Xarelto’s* discussion that triable issues of fact may exist where “plaintiffs have presented evidence that
14 their physicians *would have* used monitoring tests if adequately warned to do so,” the evidence presented
15 in *In re Xarelto* provided for all of the necessary links in the causal chain; whereas the evidence here
16 does not. (Compare *In re Xarelto*, *supra*, 2017 WL 1393480, at *2 [quoted language above] with at 9:8-
17 10:1, *supra*.)

18 Plaintiff relies upon the expert testimony of Dr. Rosengart who opined that the elevated levels of
19 Pradaxa concentrations in Plaintiff’s blood more likely than not caused her intracranial bleed. (Plaintiff’s
20 SSDF No. 73.) However, regardless of Dr. Rosengart’s opinions, what matters to the causation inquiry in
21 this case is *Dr. Khan’s* opinions, that is, as the learned intermediary¹⁶, whether *Dr. Khan* would have
22 changed his course of treatment or provided different warnings to Plaintiff. As stated above, nothing in
23 the record establishes that Dr. Khan would have concluded, if Dr. Khan had measured Plaintiff’s blood
24 concentration levels, that Plaintiff had elevated Pradaxa concentrations in the blood, such that Dr. Khan
25

26 ¹⁵ While the Court analyzes *In re Xarelto* here, it notes that it does not address California law.

27 ¹⁶ While Plaintiff argues that, “[n]eglecting to educate physicians, via the drug label or otherwise,
28 prohibits a defendant from asserting that the physician is a learned intermediary,” Plaintiff cites to no case
law to support this argument. (See *Oppo.*, 14:26-15:5)

1 would have changed his course of treatment or provided different warnings to Plaintiff. It is this absence
2 of evidence that is fatal to Plaintiff here. (See *Aguilar, supra*, 25 Cal.4th at 845; see generally
3 Defendant's Response to Plaintiff's SSDF ["Plaintiff has adduced no testimony that any of her warnings
4 criticisms would have caused Dr. Khan to *change his prescribing decision or his patient counseling* of
5 Ms. Lawson."]) [emphasis added].) As such, the Court finds that Plaintiff failed to establish that
6 additional warnings would have altered Dr. Khan's conduct. (See *Motus, supra*, 358 F.3d at 661; see also
7 *Stanley, supra*, 11 F.Supp.3d at 1003 [finding a genuine issue of material fact as to causation and failure
8 to warn where, "Dr. Molina and Dr. Nakamura both testified that they *would have [had] a different*
9 *conversation* with their patients regarding the risks and benefits in taking bisphosphonates [had they
10 known of the undisclosed risks]. Additionally, Dr. Molina testified that he *would now prescribe the drug*
11 *in a more conservative manner*, which would include dental monitoring."]) [emphasis supplied]; *Motus v.*
12 *Pfizer Inc.* (C.D. Cal. 2001) 196 F.Supp.2d 984, 999, *aff'd sub nom. Motus v. Pfizer Inc.* (Roerig
13 Div.) (9th Cir. 2004) 358 F.3d 659 ["Ms. Motus points to no evidence establishing that Dr. Trostler would
14 have acted differently had Pfizer provided an adequate warning about the alleged risk that Zolof causes
15 those who ingest it to commit suicide."].) Consequently, Plaintiff fails to demonstrate that any alleged
16 failure to warn caused Plaintiff's injury.¹⁷

17
18 ¹⁷ While Plaintiff asks this Court to find that a triable issue of material facts exists because (1) Dr. Khan's
19 past actions with a similar drug, Warfarin, indicates he would have communicated additional warnings to
20 Ms. Lawson in 2010 (see *Oppo.*, 17:8-18:3 [citing Plaintiff's SSDF Nos. 93-99] [arguing mainly, that "a
21 jury could certainly infer that if he discussed the importance of monitoring before prescribing Warfarin,
22 he would have likewise discussed the importance of monitoring with Pradaxa if he had the important
23 safety information that [BI] failed to disclose to prescribing physicians such as Dr. Khan], and Reply,
24 3:8-16), and that (2) as an "engaged patient," Plaintiff would have made different decisions had she had
25 additional information regarding the risks of taking Pradaxa (see *Oppo.*, 18:4-19:15 [citing Plaintiff's
26 SSF Nos. 100-114] [arguing that a jury could certainly find that Ms. Lawson was an informed patient,
27 who would not take medication without consideration, simply because her doctor gave it to her.], Reply
28 3:17-4:2), such arguments are insufficient under the law.

25 Indeed, Plaintiff's one cited case (*Stanley, supra*, 11 F.Supp.3d at 1003) undermines Plaintiff's argument,
26 and confirms that definitive testimony from the prescribing doctor that the (1) doctor would not have
27 prescribed the drug, or (2) had a different informed consent conversation, is required. Other cases are in
28 accord, and add that Plaintiff must also definitively testify that she would not have taken the drug had she
been informed of certain risks that were causally connected to her injury. (See e.g., *Georges, supra*,
2012 WL 9083365, at *5-6 [citing several district court cases denying summary judgment where the
plaintiff provided evidence that the physician would have changed a prescription or treatment procedure];
Hill, supra, 2012 WL 6004161, at *4 [denying summary judgment because prescribing physician, who

1 **A. Supplemental Briefing**

2 As noted, *supra*, the Court requested further briefing on whether Dr. Khan’s testimony noted at
3 pp. 5:18-6:7, *supra*, creates a triable issue of fact. (See Further Briefing Order, 2:12-4:5.) In sum, the
4 supplemental briefing demonstrates that Plaintiff fails to sufficiently show a causal connection between
5 additional warnings and information Dr. Khan would have liked to have known, and Plaintiff’s actual
6 injury.¹⁸

7 **1. Analysis¹⁹**

8 Plaintiff argues here that a physician’s “conduct” is not limited to the decision not to prescribe the
9 drug. (Plaintiff’s Supp. Brief (Oct. 28, 2019), 4.) Indeed, courts have found triable issues of fact on
10 causation where the “plaintiff shows that their physician would have used monitoring tests if adequately
11 warned to do so²⁰, or that they would have altered their prescription practices *in a manner that may have*
12 *prevented the injury.*” (*Id.* [emphasis added]; [citing *Holley v. Gilead Sciences, Inc.* (N.D. Cal. 2019)
13 379 F.Supp.3d 809, 830].) Plaintiff further insists that “[c]autioning the patient about risks factors or
14

15
16 had become aware after he prescribed the drug to plaintiff that the drug could cause problems with a
17 person’s jaw, testified that he now discloses that fact to his patients, and plaintiff testified she would not
18 have taken the drug had she been made aware of the same].) Because Plaintiff cannot establish that
either she or Dr. Khan would have taken different action if they knew of the additional warning
information, her arguments are lacking.

19 What’s more, a triable issue of fact does not exist where, as here, the evidence amounts to conjecture and
20 lacks the quality in order for the Court to conclude that a triable issue of material facts exists as to
causation. (*Nardizzi v. Harbor Chrysler Plymouth Sales, Inc.* (2006) 136 Cal.App.4th 1409, 1415.)

21 ¹⁸ Plaintiff devotes significant portions of its supplemental briefing to arguments that (1) were not
22 expressly authorized by this Court, and (2) are nearly identical to arguments made in its initial briefing
23 (which the Court rejects in footnote 17, *supra*.) (Compare Plaintiff’s Supp. Brief, 4-8 with Oct. 22, 2019
24 Order [additional briefing], MSJ Oppo., 17:8-18:3 [arguing mainly, that “a jury could certainly infer that
25 if he discussed the importance of monitoring before prescribing Warfarin, he would have likewise
discussed the importance of monitoring with Pradaxa if he had the important safety information that [BI]
failed to disclose to prescribing physicians such as Dr. Khan], and *id.* at 18:4-19:15 [arguing that a jury
could certainly find that Ms. Lawson was an informed patient, who would not take medication without
consideration, simply because her doctor gave it to her].)

26 ¹⁹ The primary issue with the federal cases here is that (1) they are unclear as to whether Plaintiff must
27 show the warnings “*would have*” or “*may have*” prevented Plaintiff’s injury; and (2) they often lack the
requisite factual specificity to be able to adequately compare them to the case at bar.

28 ²⁰ Because this is addressed in Part II, *supra*, the Court does not address it here.

1 reducing the dose²¹ may constitute changes in prescriptions practices.” (Plaintiff’s Supp. Brief, 2 [citing
2 *Holley, supra*, 379 F.Supp.3d at 831.])²² Because the testimony of Dr. Khan shows that he would have
3 (1) “made a more informed risk/benefit analysis before he prescribed [Pradaxa to Ms. Lawson]”, (2)
4 monitored to ensure [Plaintiff] was within the safe therapeutic range²³, and (3) Dr. Khan “may” not have
5 prescribed Pradaxa to Plaintiff at all, Plaintiff insists she has demonstrated a triable issue of fact on
6 causation.²⁴ (See Plaintiff’s Supp. Brief, 2-4.)

7 However, Defendant is correct on the relevant background law here. Upon a review of the case
8 the legal inquiry on causation is not, as Plaintiff suggests, “whether the prescribing physician would have
9 changed his conduct or the manner in which his would have prescribed the drug if he had received the
10 warning or risk information of which he was unaware at the time.” (Plaintiff’s Supp. Brief, 2.) Such a
11 standard is too broad. Rather, the change in a physician’s conduct or prescription procedures must have
12 sufficiently prevented the Plaintiff’s injury, and/or be sufficiently connected to the injury. (See *Motus*,
13 *supra*, 196 F.Supp.2d at 991 [“A plaintiff asserting causes of action based on a failure to warn must
14

15 ²¹ There is no testimony here about reducing Ms. Lawson’s dose.

16 ²² Plaintiff also cites to the Court’s decision in *Fourzon*. (*Id.* at 2 [*Fourzon* Order Denying Motion for
17 Partial Summary Judgment], at 6-8.). Yet, *Fourzon* does not assist Plaintiff here. In *Fourzon*, the court
18 found triable issues of fact existed because (1) the prescribing physician said he *would have had* a
19 different informed consent discussion with the Plaintiff if he was provided certain warnings; and (2)
20 Plaintiff testified that he would have taken Warfarin instead of Pradaxa if he knew one in five patients are
21 over or under dosed. The issues in *Fourzon* do not bear on the Court’s request in supplemental briefing,
22 and none of the probative facts in *Fourzon* are present here.

23 ²³ Because this is addressed in Part II, *supra*, the Court does not address it here.

24 ²⁴ Though Plaintiff again points to Dr. Khan’s testimony that if he knew that there were 543 deaths
25 associated with the use of Pradaxa in May of 2012, he “probably” would have ceased Ms. Lawson’s
26 Pradaxa prescription, such testimony is too attenuated under the law. (See *Motus, supra*, 196 F.Supp.2d
27 at 995–996 [“The burden [is] on the plaintiff to demonstrate that the additional non-disclosed risk *was*
28 *sufficiently high that it would have* changed the treating physician’s decision to prescribe the product for
the plaintiff.”] [emphasis supplied].) Thus, Plaintiff’s attempt to argue at the hearing that Dr. Khan’s use
of the word “probably” creates a triable issue of fact on whether it is “more likely than not” that Dr. Khan
would have changed his prescription decision fails. In sum, it is plainly too speculative. Regardless, Dr.
Kahn still unequivocally testified that, even after knowing the 543 death statistic, he stood by his decision
to prescribe Pradaxa to Ms. Lawson.

Further, the fact that Dr. Khan “may” not have prescribed Pradaxa to her at all is insufficient to create a
trialable issue of fact. The case law makes clear that Plaintiff must demonstrate that Dr. Khan *would have*
decided not to prescribe Pradaxa to Ms. Lawson if he was provided with additional warnings, and Dr.
Khan testified unequivocally to the contrary.

1 prove not only that no warning was provided or the warning was inadequate, *but also that the inadequacy*
2 *or absence of the warning caused the plaintiff's injury.*”] [emphasis supplied]; *In re Aredia and Zometa*
3 *Products Liability Litigation* (M.D. Tenn., Aug. 13, 2009) 2009 WL 2497692, at *2 [applying California
4 law] [“A plaintiff asserting causes of action based on a failure to warn must prove not only that no
5 warning or an inadequate warning was given, *but also that the inadequacy or absence of the warning*
6 *caused the plaintiff's injury.* Plaintiff must prove that the alleged failure to warn was a “substantial
7 factor” in bringing about the injury.”] [emphasis supplied].) To hold otherwise would obviate the
8 causation standard. Put differently, “[a]ny reasonable physician would want to know more information,
9 even where that information would have no impact on his behavior [or the injury] whatsoever.”
10 (Defendant’s Supp. Brief, 4:12-13.) Indeed, Defendant’s cited case law demonstrates that such a
11 connection between the physician’s change in conduct *and* the prevention of the Plaintiff’s injury is
12 necessary. (See Defendant’s Supp. Brief 2-3 [citing *Stanley v. Novartis Pharm. Corp.* (C.D. Cal. 2014)
13 11 F.Supp.3d 987, 1002-1003 [prescribers testified they *would have* had a different informed consent
14 discussion with their patients about the risks and benefits between taking bisphosphonates” and the “later
15 development of osteonecrosis of jaw (ONJ)” (i.e. Plaintiff’s suffered injury)]; *In re Aredia, supra*, 2009
16 WL 2497692, at *2 [prescribing physician (non-dentist) *would have* changed how he prepared his
17 patients for the drug, if he knew what he knows now about ONJ (the injury) and Zometa (the drug), like
18 “having teeth checked out by a dentist” and having the patients’ dentist perform an x-ray to see if the
19 patients’ teeth were “in good repair”]; see *id.* [“For purposes of summary judgment, there are genuine
20 issues of material fact as to whether different warnings would have made a difference in either the onset
21 or the extent of Mr. White's ONJ.”]²⁵; *Georges v. Novartis Pharmaceuticals Corp.* (C.D. Cal., Nov. 2,
22 2012) 2012 WL 9083365, at *5 [“The standard in Defendant's own citation to *Ingram* notes that Plaintiff
23 may alternatively demonstrate changes in “prescribing practices” if such changes *may* have prevented her
24 injury.”] [emphasis supplied].)²⁶

25
26 ²⁵ Had Dr. Khan testified that the risk/benefit information discussed at 5:18-6:7, *supra*, *would have*
27 changed how he (1) prepared Ms. Lawson for Pradaxa (by way of an informed consent discussion, or in
the types of tests he would have ordered for Ms. Lawson while taking Pradaxa), or (2) his actual
prescription decision, the result may be different here. (See *id.*)

28 ²⁶ Apart from *Holley*’s cited cases, the Court agrees with Defendant’s claim that *Holley* itself does not
assist the Court’s analysis here. (See Defendant’s Brief, 3:17-4:4.)

1 With respect to Plaintiff's first argument on Dr. Khan's risk/benefit analysis (see 5:18-6:7,
2 *supra*), Defendant shows that a physician's desire for certain additional risk information, without more
3 (and specifically without a sufficient causal connection to the actual injury Plaintiff suffered), is
4 insufficient to support causation. (See Defendant's Supp. Brief, 4-5 [citing *Nix v. SmithKline Beecham*
5 *Corp.* (D. Ariz., Sept. 5, 2007) 2007 WL 2526402, at *3] [applying California law] [finding the
6 following testimony insufficient on causation: "Dr. Hoehne did testify that he *would have liked to have*
7 *known more about deaths* associated with Serevent and that generally the lack of accurate information
8 about potential side effects makes it difficult to perform *a risk-benefit analysis.*"'] [emphasis added]; see
9 *id.* ["But merely raising the possibility that Dr. Hoehne *might* have acted differently is not enough to
10 satisfy Plaintiffs' burden of proof on causation."'] [emphasis supplied]; *Gaghan v. Hoffman-La Roche*
11 *Inc.* (N.J. Super. Ct. App. Div., Aug. 4, 2014) 2014 WL 3798338, at *15-16 [applying California law]
12 ["But Gaghan's counsel could not get Dr. Hartman to testify that he would have warned Gaghan of an
13 IBD side effect if the Roche warnings had been as plaintiffs' evidence and argument would have
14 required."'].²⁷ Though a New York state case, *Gaghan* makes clear that California law requires that, if a
15 doctor testifies he would have wanted to know certain risk-benefit information prior to prescription, a
16 doctor must then also testify that the doctor *would have communicated* the risk-benefit information to the
17 patient (or as noted, *supra*, footnote 25, would have concretely prepared the patient in a different way).
18 As with the prescribing doctor in *Gaghan*, Dr. Khan's did not state that he would have communicated
19 any additional risk-benefit information to Ms. Lawson. Rather, as noted, *supra*, his testimony
20 demonstrates the opposite.

21
22 ²⁷ While Defendant's other cited cases seem to be in accord, they do not apply California law. However,
23 some of these jurisdictions do apply the learned intermediary doctrine (or assume it applies), so they may
24 be instructive. (See, Defendant's Supp. Brief, n. 2 [citing *Hanson v. Boston Scientific Corp.* (S.D.W. Va.,
25 Apr. 12, 2016, No. 2:13-CV-10653) 2016 WL 1448868, at *5 ["Assuming...in her risk/benefit
26 calculus."]; *Hoffman v. Boston Scientific Corp.* (S.D.W. Va., Oct. 6, 2015) 2015 WL 5842785, at *5
27 ["Indeed, such evidence requires a reasonable juror to speculate, based only on mere possibility, that Dr.
28 Crouch would have altered his decision to prescribe the product simply because of 'cause for concern.'"]; *Vanderwerf v. SmithKlineBeecham Corp.* (D. Kan. 2008) 529 F.Supp.2d 1294, 1312 ["Dr. Creek clearly testified that even today, he would still prescribe Paxil for Mr. Vanderwerf. The speculative argument that Dr. Creek "may not" have used Paxil "in a certain individual" does not raise a genuine issue of material fact whether Dr. Creek would have declined to prescribe Paxil for Mr. Vanderwerf if he had received any of the three warnings which plaintiffs propose."]; see also *id.* at 1313 [discussing monitoring claim, and how Plaintiff failed to present any evidence that additional monitoring would have prevented suicide]]).)

1 In sum, unlike the cited cases, here, Dr. Khan testified that even with additional warnings
2 information, he still would have prescribed Ms. Lawson Pradaxa and would not have changed his
3 informed consent discussion with Ms. Lawson. Further, Dr. Khan did not testify that he would have
4 reduced her prescribed dosage or not prescribed Pradaxa if he (a) knew about additional risk factors, or
5 (b) had measured Plaintiff's blood concentration levels.

6 **B. Conclusion.**

7 For all of the foregoing reasons, the Court finds that there is no genuine issue of material fact as
8 to causation and the failure to warn.

9 **II. Plaintiff's Other Claims.**

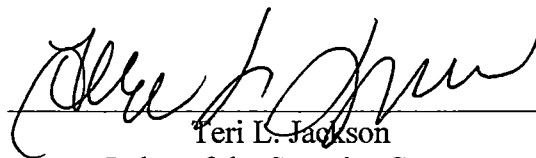
10 Plaintiff's other claims for negligent failure to warn, negligent misrepresentation, fraud and
11 intentional misrepresentation, also fail for lack of causation because these claims are based on the same
12 facts as Plaintiff's failure to warn claims. (See MSJ, 9:19-10:1; see, e.g., *Valentine v. Baxter Healthcare*
13 *Corp.* (1999) 68 Cal.App.4th 1467, 1481-83 ["We conclude the directed verdict on negligent failure to
14 warn was correct because the strict liability verdict foreclosed a finding of negligent failure to
15 warn...[T]he manufacturer's strict liability duty to warn is greater than its duty under negligence, and thus
16 negligence requires a greater showing by plaintiffs"]; *Motus, supra*, 358 F.Supp.2d at 999 [granting
17 defendant's motion for summary judgment finding that plaintiff's claims for wrongful death, fraud, and
18 breach of warranty are premised on the failure to warn claim].) Accordingly, Defendants are entitled to
19 summary judgment on Plaintiff's claims, and the summary adjudication regarding punitive damages is
20 moot. (Compare MSJ, 16:21-23:15 and Reply 6-14, with Oppo., 25-34.)²⁸

21 **CONCLUSION AND ORDER**

22 For all of the foregoing reasons, Defendants' motion for summary judgment is granted.)

23 IT IS SO ORDERED.

24 Dated: November 8, 2019

25 
26 Teri L. Jackson
27 Judge of the Superior Court
28

²⁸ Defendants separately argue that Plaintiff's claims fail because the Pradaxa warnings were adequate as a matter of law. (Compare MSJ, 14:1-16:20 and Reply, 5:3-26 with Oppo., 22-25.) Because the Court finds that summary judgment is warranted based on causation alone, the Court need not reach this issue.

CERTIFICATE OF ELECTRONIC SERVICE
(CCP 1010.6(6) & CRC 2.260(g))

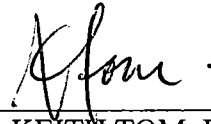
I, KEITH TOM, a Deputy Clerk of the Superior Court of the County of San Francisco, certify that I am not a party to the within action.

On November 8, 2019, I electronically served the ATTACHED DOCUMENT(S) via File&ServeXpress on the recipients designated on the Transaction Receipt located on the File&ServeXpress website.

Dated: November 8, 2019

T. Michael Yuen, Clerk

By: _____



KEITH TOM, Deputy Clerk