IN THE SUPREME COURT
FOR THE STATE OF WASHINGTON

No. 100470-2

From Court of Appeals
No. 37081-0-III

ARTIE LEN REINERT, JR AND CONSUELA LEE REINERT,

Appelants,

v.

ALLEN C. HELLER, M.D. and STEPHANIE A. HELLER, husband and wife, and the marital community composed thereof; ROCKWOOD CLINIC, P.S.; ROCKWOOD NEUROSURGERY AND SPINE CENTER; and DOES 1-10,

Respondents.

ANSWER TO PETITION FOR REVIEW

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I. INTRODUCTION

In this spine surgery medical negligence case, the jury returned a verdict in favor of Respondent (and Defendant below) Allen Heller, M.D. finding that, even though Dr. Heller inadvertently performed ACDF surgery at the wrong level of Petitioner (and Plaintiff below) Artie Reinert's cervical spine (C5-6 instead of C6-7), he did not violate the standard of care. Generally, Dr. Heller's defense was that, although he mistakenly operated on the wrong level, that, alone, was not a violation of the standard of care, and the methods and techniques he used to ascertain the surgical level were well established, universally accepted and in full compliance with the applicable standard of care.

At trial, imaging technology - the characteristics, advantages/disadvantages, limitations, uses and availability of various imaging techniques and equipment - was prominent. Reinert criticized Dr. Heller for not taking additional and/or different views with the fluoroscope intraoperatively, for not summoning a radiologist to the operating room to assist in locating the appropriate surgical level, and for not aborting the operation and sending Reinert to a hospital in Seattle where he allegedly would have access to more sophisticated imaging techniques, equipment and expertise, including various intraoperative 3-D technologies. Reinert's expert on the standard of care, Alan Hamilton, MD, was from a large

academic institution and actually helped develop some of the 3-D imaging techniques discussed.

To respond to these criticisms, Dr. Heller called three experts. To address the standard of care from the perspective of a practitioner at a large academic institution (like Dr. Hamilton), Dr. Heller called orthopedic surgeon Sigurd Berven, MD. To address the standard of care from the perspective of one practicing spinal surgery, including ACDF procedures, in the community of north Idaho and eastern Washington, and who was personally familiar with the imaging resources available at Deaconess, Dr. Heller called neurosurgeon Jeffrey Larson, MD. Finally, because of the prominent role of imaging technology in the case, Dr. Heller called Jerome Barakos, MD, a neuroradiologist, to testify on the nature, limitations, typical uses and availability of various imaging technologies and techniques. Dr. Barakos also viewed and testified to the findings on the imaging actually done on Reinert, including Dr. Heller's intraoperative fluoroscopy and pre- and post-operative MRIs.

Pre-trial, Reinert objected to the testimony of both Dr. Larson and Dr. Barakos on the ground it was cumulative to that of Dr. Berven. In articulating the objection, Reinert's counsel remarked that Dr. Larson's offering a standard of care opinion from the perspective of a "community hospital" practitioner was irrelevant to the applicable standard of care. The

trial court overruled the objection, indicating that, in the court's opinion, compared to Dr. Berven, Dr. Larson brought a "different set of experiences" to the case. Also, because cumulativeness is a matter of degree, the court instructed Reinert to object along the way. Reinert never specifically argued that a reference by Dr. Larson or defense counsel to a "community hospital" constituted a misstatement of the law. Likewise, Reinert never brought a motion to specifically exclude references to a "community hospital" in connection with an expert's expression of a standard of care opinion.

At trial, Dr. Heller's counsel, consistent with the trial court's previous observation that Dr. Larson brought a "different set of experiences" to the case, asked Dr. Larson three questions that included references to Dr. Larson's experience at a "community hospital." To the extent Reinert objected, it was on the ground of cumulativeness. When Dr. Heller's counsel asked a fourth question that referenced a community hospital, Reinert's counsel finally objected on the ground that reference to a community hospital assumed a mistaken or incorrect standard of care. Dr. Larson, however, did not respond. Dr. Heller's counsel rephrased the question, omitting any mention of a community hospital, a community practice, or a community standard, and referencing instead the "circumstances" under which Dr. Heller provided care to Reinert. Reinert's

counsel did not object to this question. Accordingly, Dr. Larson actually presented no testimony based on a community or local standard of care. On cross examination, Dr. Larson testified that the standard of care for ACDF surgery site location is a national one, and the same in Spokane as in Seattle. Ultimately, the court, without any objection from Reinert, gave the standard RCW 7.70.040-derived WPI on the standard of care.

Dr. Barakos testified via video perpetuation deposition. On direct examination, Dr. Heller's counsel confined his questioning to Dr. Barakos' qualifications, the imaging technology issues referenced above, and the actual images taken of Reinert. The standard of care was never mentioned. On cross-examination, in an effort to advance Reinert's standard of care claim, Reinert's counsel first asked Dr. Barakos about the frequency with which surgeons doing ACDFs obtain post-operative imaging to see if they operated on the correct level. Counsel then accused Dr. Barakos of not having "first-hand experience in determining whether a wrong-level ACDF was due to a breach of the standard of care or inadequate imaging." In the course of responding to this line of questioning, Dr. Barakos stated, among other things, that literature reflected that fifty percent of all spinal surgeons had performed surgery on an incorrect vertebral level, and wrong-level surgery was not seen as a breach of the standard of care.

Before trial, the parties agreed that direct or indirect standard of care testimony from Dr. Barakos was inappropriate, and counsel stipulated to redaction of the "fifty percent" statistic and standard of care testimony referenced above. Despite this agreement, at trial Dr. Barakos' testimony about the "fifty percent" statistic and standard of care was inadvertently played. Reinert did not object to the statistic testimony at that time. However, both Reinert and Dr. Heller's counsel objected to the inadvertent standard of care testimony. At the request of Dr. Heller's counsel, the trial court immediately instructed the jury to disregard the testimony and, after a break, the video resumed. Reinert did not move for a mistrial or request a different or additional curative instruction.

In the wake of the jury's verdict in favor of Dr. Heller, Reinert did not move for a new trial. Instead, he filed an appeal, challenging the trial court's discretionary rulings with respect to the testimony of Dr. Barakos and Dr. Larson, claiming that counsel and Dr. Larson's references to a "community hospital" during Dr. Larson's direct examination constituted prejudicial error, and that Dr. Heller's counsel's failure to redact the fifty percent and standard of care testimony from Dr. Barakos' video, and the inadvertent playing of that portion of Dr. Barakos' testimony at trial, constituted prejudicial attorney misconduct.

On September 14, 2021, the Court of Appeals, in a thorough, unpublished 54-page opinion, rejected Reinert's arguments and affirmed the verdict in favor of Dr. Heller. This Petition for Review followed.

For the reasons set forth below, the Court of Appeals correctly decided the issues before it, and the Petition for Review should be denied.

II. STATEMENT OF THE CASE

Because of page/word count limitations, Dr. Heller adopts and incorporates by reference the recitation of facts and trial court procedure contained in the Court of Appeals opinion.

III. ARGUMENT

A. With Respect to Dr. Larson's "Community Hospital" Testimony, the Court of Appeals Correctly Concluded that Reinert Failed to Preserve this Issue

An appellant challenging evidentiary error may do so only on the basis of a specific ground asserted before the trial court. *State v. Kirkman*, 159 Wn.2d 918, 926, 155 P.3d 125 (2007). This rule gives the trial court the first opportunity to prevent or cure alleged error by excluding or striking the challenged testimony. *Id.* While Reinert's counsel, pre-trial, alluded to the irrelevance of Dr. Larson offering a standard of care opinion from a "community hospital perspective" in the course of his general objection on the ground of cumulativeness, he never specifically objected to any reference to a "community hospital" in Dr. Larson's testimony on the

ground that such references were a misstatement of the law – an incorrect articulation of the applicable standard of care. It was only during Dr. Larson's testimony that, after several objections on the ground of cumulativeness, Reinert's counsel objected on the ground that "the foundation as to community hospital is not relevant to standard of care". At that point, although the court overruled the objection, Dr. Heller's counsel rephrased the question by removing the word "community" and, instead, referencing Dr. Heller's actions "under the circumstances that existed on October 2, 2012."

Reinert maintains that he did specifically object to references to a "community hospital" in Dr. Larson's testimony on the ground such references were an incorrect statement of the law – an erroneous description of the standard of care. But a review of counsel's exchange with the court during motions *in limine* and a review of the transcript of Dr. Larson's trial testimony, as conducted by the Court of Appeals shows otherwise.

Reinert contends the Court of Appeals raised the failure to preserve issue "*sua sponte*." That is incorrect. On page 27 of the "Amended Brief of Respondents" Dr. Heller identified as a "threshold issue" whether Reinert preserved the "community hospital" issue for appeal by making timely and focused objections at trial.

B. Even If Reinert Had Preserved The Issue By Making A Timely And Focused Objection, Defense Counsel and Dr. Larson's References To A "Community Hospital" In Connection With The Standard Of Care Were Not Inappropriate.

The Court of Appeals did not reach the issue of whether the references to a "community hospital" in connection with the standard of care were substantively appropriate because of its conclusion that Reinert had failed to preserve the question. But assuming Reinert had preserved the issue for appeal, counsel and Dr. Larson's references to a "community hospital" in connection with the standard of care were not inappropriate, for several reasons.

First, and fundamentally, neither counsel nor Dr. Larson ever described or defined the standard of care as being "the care, skill and learning expected of a reasonably prudent provider at or in a 'community hospital' or 'in the defendant's community'."

Second, RCW 7.70.040 defines the standard of care as failure to exercise "that degree of care, skill, and learning expected of a reasonably prudent healthcare provider at that time..., acting in the same or similar circumstances; ... " (emphasis added). RCW 7.70.040(1)(a). The size, characteristics and available resources of the medical facility where treatment takes place are "circumstances" under which compliance with the standard of care is measured. Indeed, in pre-RCW 7.70 cases, Washington

courts held that, while the standard of care in Washington was not a locality standard, it was "coextensive" with the "medical and professional means available to the defendant." See e.g. *Pederson v. Dumouchel*, 72 Wn.2d 73, 79, 431 P.2d 973 (1967); *Meeks v. Marks*, 15 Wn. App. 571, 575, 550 P.2d 1158 (1976); *Stone v. Sisters of Charity of House of Providence*, 2 Wn. App. 607, 610-611, 469 P.2d 229 (1970); *Workman v. Chinchinian*, 807 F. Supp. 634, 641 (ED Wash 1992) (Post-*Pederson*, locality rule "has no present-day vitality except that it may be considered as one of the elements to determine the degree of care and skill which is to be expected of the average practitioner of the class to which he belongs").

Here, the nature of the medical facility where the treatment took place – Deaconess - was relevant because of the imaging technology and resources available there, compared to a large academic medical institution. Indeed, both sides' experts testified to the importance of "available" imaging technology and resources when voicing their standard of care opinions. Dr. Hamilton, Reinert's expert, testified that a surgeon must "use the tools that are available to you" until you have achieved the level of certainty regarding surgical location "whatever those tools may be." (RP 313 - Supplemental Verbatim Report of Proceedings, Volume II). Dr. Hamilton also testified, in the course of asserting that one of Dr. Heller's options was to abort the surgery, (RP 317-Supplemental Verbatim Report

of Proceedings, Volume II), that "obviously circumstances vary on hospital availability in terms of equipment, intraoperative CT, stereotaxis, bringing the radiologist down to the OR." (RP 317-18-Supplemental Verbatim Report of Proceedings, Volume II). Similarly, Dr. Berven testified that, in ascertaining the correct surgical level for an ACDF, the standard of care requires that the surgeon use good judgment and "the best available evidence." (RP 404-05; RP 430). And Dr. Larson testified that Deaconess Medical Center in 2012 did not have intraoperative CT technology available. (RP 77).

C. Even If The References To "Community Hospital" Were Improper, Which They Were Not, The References Were Harmless.

Improper evidence is harmless unless it affects the outcome of the case. *Brown v. Spokane County Fire Prot. Dist. No. 1*, 100 Wn.2d 188, 196, 668 P.2d 571 (1983). It is highly unlikely that the references to a "community hospital" affected the verdict. Again, neither Dr. Heller's counsel nor Dr. Larson ever actually defined the standard of care as being "the care, skill and learning expected of a reasonably prudent provider at or in a 'community hospital' or 'in the defendant's community'." After the references to "community hospital" on direct, on cross-examination Dr. Larson clarified that the standard of care for ACDF localization is a national standard and the same in Spokane as it is in Seattle. (RP 82-83). Finally,

the Court gave the standard WPI-based instruction on the standard of care, derived directly from RCW 7.70.040 (CP 328), and jurors are presumed to follow the court's instructions. *Spivey v. City of Bellevue*, 187 Wn.2d 716, 738, 389 P.3d 504 (2017).

D. The Court of Appeals Correctly Held the Trial Court Did Not Abuse Its Discretion in Allowing Dr. Barakos to Testify because Dr. Barakos Was Eminently Qualified, His Testimony Was Highly Relevant, and Reinert's Claims that Barakos' Testimony Was at Times Contradictory and/or Confusing Went to Weight, Not Admissibility.

1. Standard of Review

Trial court rulings on the admissibility of expert testimony are a matter of trial court discretion, and the standard of review is thus abuse of discretion. *L.M. v. Hamilton*, 193 Wn.2d 113, 134, 436 P.3d 803 (2019). *State v. Arndt*, 194 Wn.2d 784, 797, 453 P.3d 696 (2019). Expert testimony is properly admitted under ER 702 when the trial court determines (1) that the witness qualifies as an expert and; (2) that the testimony will assist the trier of fact. *Arndt*, 194 Wn.2d at 799, *citing In Re Det. of McGary*, 175 Wn. App 328, 338-39, 306 P.3d 1005 (2013). "Trial courts are given a large degree of freedom when making these determinations, subject to reversal only for a clear abuse of discretion." *Arndt* at 799, citing *State v. Yates*, 161 Wn.2d 714, 762, 168 P.3d 359 (2007). "A trial court abuses its discretion when its decision is manifestly unreasonable or exercised on untenable

grounds or for untenable reasons." *Id.*, quoting *State v. Lord*, 161 Wn.2d 276, 283-84, 165 P.3d 1251 (2007).

2. Allowing Dr. Barakos, a Neuroradiologist, to Testify About Imaging Technology and the Imaging Taken of Reinert was a Proper Exercise of Trial Court Discretion.

Here, Dr. Barakos was eminently qualified to testify. And his testimony as a neuroradiologist was helpful to the jury, particularly because of the central role spinal imaging played in the case with respect to both liability and causation/damages. Dr. Barakos addressed the general nature of fluoroscopy, how fluoroscopy is used in connection with ACDF procedures, the differences between various views, particularly the lateral view and the AP view, and what a lateral view of the cervical spine will show as opposed to an AP view. He also interpreted the images actually taken in this case, identifying various structures, spinal levels, and the location relevance of the "peanut" marker. In addition, he explained the various available forms of 3-D imaging generally, how they work, their limitations, and how 3-D imaging is utilized in connection with cervical spinal surgery. He also testified regarding the phenomenon of parallax and how it affects AP fluoroscopy views compared to lateral views.

On the issue of causation and damages, Dr. Barakos provided helpful testimony on the cervical pathology depicted in pre- and post-operative imaging, particularly the nature and extent of stenosis and

degenerative changes at C5-6 and C6-7 and the likelihood of continued degeneration at C5-6.

As for cumulativeness, while certainly there was some overlap in the testimony of Dr. Barakos and other experts on the nature and use of various imaging technology and techniques, it was not an abuse of discretion for the court to allow it, particularly in light of Dr. Barakos' status and experience as a neuroradiologist. See e.g. *Christensen v. Munson*, 123 Wn.2d 234, 241, 867 P.2d 626 (1994).

Finally, with respect to Reinert's claim that Dr. Barakos' testimony was confusing or conflicted with the testimony of other experts, those alleged deficiencies went to the weight of the testimony, not its admissibility.

E. The References by Dr. Heller's Counsel to a "Community Hospital" and the Inadvertent Playing of the Inadmissible Portions of Dr. Barakos' Video Perpetuation Deposition Were Not Prejudicial Attorney Misconduct.

1. As a Threshold Issue, the Court of Appeals Correctly Concluded that Reinert Failed to Preserve His Objection to Dr. Barakos' Testimony on the Fifty Percent Statistic.

"If the defendant does not object to the alleged misconduct at trial, the issue of [attorney] misconduct is usually waived unless the conduct was "so flagrant and ill-intentioned that it evinces an enduring and resulting prejudice that could not have been neutralized by an admonition to the jury."

State v. Weber, 159 Wn.2d 252, 270, 149 P.3d 646 (2006), quoting *State v. Stenson*, 132 Wn.2d 668, 719, 940 P.2d 1239 (1997).

Here, the inadvertent playing of Dr. Barakos' 50 percent statistic testimony cannot reasonably be characterized as "flagrant" and "ill-intentioned." Indeed, Reinert conceded that the playing of the testimony was inadvertent. Accordingly, it was incumbent upon Reinert's counsel to object at the time the testimony was given.

Citing *State v. Brooks*, 20 Wn. App. 52, 579 P.2d 961 (1978), Reinert asserts that the violation of an order *in limine* alone, where erroneous, preserves the issue for appeal, regardless of whether the evidence is objected to at the time of trial. That is incorrect, as the Court of Appeals explained. If the trial court denies a motion *in limine*, the losing party has a standing objection to the allegedly inadmissible evidence and need not object during trial. *State v. Sullivan*, 69 Wn. App. 167, 847 P.2d 953 (1993). See also *State v. Weber*, 159 Wn.2d 252, 149 P.3d 646 (2006). [1] However, if the objecting party receives a favorable ruling on its motion *in limine*, and the losing party then violates the order *in limine* by offering the evidence during trial, the other party must object at that time. *Id.* That is because the

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[1] In *Weber*, the court adopted the result and reasoning of the Court of Appeals in *Sullivan*, describing it as a "commonsense approach." 159 Wn. 2d at 272.

issue, at that point, is whether there has been a violation of the order *in limine* and, so, what remedy the trial court should impose. *Id.* Here, it was incumbent upon Reinert to object to the "fifty percent" testimony when it was offered. He failed to do so. Thus, the Court of Appeals correctly concluded Reinert failed to preserve this issue.

2. Defense Counsel's References to a "Community Hospital" Were Not Misconduct.

Having failed to object to the "fifty percent" testimony of Dr. Barakos at trial, as well as having failed to specifically object to the "community hospital" references (on the ground the references misstated the law) Reinert casts the inadvertent playing of the "fifty percent" testimony, and the references to a "community hospital" as attorney misconduct, citing *State v. Allen*, 182 Wn.2d 364, 375-76, 341 P.3d 268, 274 (2015) and *Kuhn v. Schnall*, 155 Wn. App. 560, 228 P.3d 828 (2010). But Dr. Heller's references to a "community hospital" were far from the repeated misstatements of the law, in violation of a clear court order or ruling, featured in those cases.

In *Allen*, the criminal defendant was an alleged accomplice. The law clearly required the defendant to have actual knowledge that the principal would commit the crime for accomplice liability to exist. Nevertheless, the prosecutor repeatedly indicated to the jury that

constructive knowledge was sufficient by using the phrase "should have known" when referring what the State was required to prove. In addition, in closing argument, the prosecuting attorney presented a slide show which repeated the erroneous constructive knowledge standard. After the jury convicted, as evidence of the prejudicial nature of these repeated misstatements of the law, the court, among other things, pointed to the jury asking, in a question to the court, whether "if someone should have known does that make them an accomplice." The court noted that the misstatements of the law were made "so repeatedly and egregiously that there was a substantial likelihood that it affected the verdict."

In *Kuhn*, the defendant healthcare provider was accused of medical malpractice, sexual battery and negligent inflection of emotional distress for sexually abusing minor male patients. In addition to actual damages, the plaintiff sought costs and attorney's fees under RCW 9.68A.130, based on the allegation that the defendant had communicated with the patient-plaintiffs for immoral purposes while they were minors, in violation of RCW 9.68A.090. After the jury awarded actual damages, the court instructed the jury for the second phase of deliberations which required it to determine whether the defendant had communicated with a minor for immoral purposes under the statute.

Before the second phase of deliberations, the defendant proposed, and the court rejected, an instruction that would have required the jury to find that the defendant's communications with the minor patient-plaintiffs had "the predatory purpose of promoting [the patient-plaintiffs'] exposure to an involvement in sexual misconduct." (emphasis added). The court refused to give this instruction and instead instructed the jury that it had to find that the communications were "for immoral purposes of a sexual nature." *Id.*

Despite this clear ruling, during closing argument, defense counsel showed the jury an enlarged printout of a Washington Supreme Court opinion that contained the "predatory purpose" language. Counsel then argued twice, over sustained objections, that the jury needed to find a "predatory purpose" of promoting "severe sexual conduct." The jury found that the defendant did not communicate for immoral purposes with any of the plaintiffs while they were minors.

In the instant case, Defense counsel's references to a "community hospital" in his questions to Dr. Larson were far short of the repeated and deliberate misstatements of the law, contrary to a clear court order or ruling, featured in *Schnall* and *Allen*. Significantly, unlike in *Schnall* and *Allen*, the trial court never made a definitive, final ruling, in response to a specific objection, that references to "community hospital" in questions put to Dr.

Larson were improper because they incorrectly defined the standard of care and thus were a misstatement of the law. In addition, unlike *Schnall* and *Allen*, where counsel made repeated misstatements of the law during closing argument, Reinert, in the instant case, does not point to any references to "community hospital" made by defense counsel during closing argument.

3. Notwithstanding Reinert's Failure to Preserve, Dr. Barakos' Fifty Percent Statistic Testimony and Defense Counsel's Reference to a "Community Hospital", Alone or Together, Were Harmless.

Even if an attorney engages in misconduct, reversal is not required "unless, within reasonable probabilities, the outcome of the trial would have been materially affected had the error not occurred." *State v. Weber*, 159 Wn.2d 252, 270, 149 P.3d 646 (2006). Here, for the reasons discussed *supra*, at pages 15-16, it is highly unlikely counsel's references to a "community hospital" had any effect on the outcome of the case. As for Dr. Barakos' testimony, it was fleeting, the court issued a curative instruction, which the jury was presumed to follow, and the standard of care testimony was given in the context of the favorable standard of care testimony given by Dr. Larson and Dr. Berven.

IV. CONCLUSION

For the reasons set forth above, Respondents respectfully request that Reinert's Amended Petition for Review be denied.

V. CERTIFICATE OF COMPLIANCE

The undersigned certifies that the foregoing Answer to Amended Petition for Review contains 4,006 words.

RESPECTFULLY SUBMITTED this 18th day of January, 2022.

EVANS, CRAVEN & LACKIE, P.S.

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I certify that I caused to be filed and served a copy of the foregoing ANSWER TO PETITION FOR REVIEW on the 18th day of January, 2022, as follows:

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