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COURT OF APPEALS, DIVISION I
OF THE STATE OF WASHINGTON

SHARLA TAVARES, individually and as Guardian of the Estate of
MIRIAM TAVARES, a minor, and ERIK TAVARES,

Respondents/Cross-Appellants,

v.

EVERGREEN HOSPITAL MEDICAL CENTER, aka KING COUNTY
PUBLIC HOSPITAL DISTRICT #2,

Appellant/Cross-Respondent.

BRIEF OF APPELLANT

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I. ASSIGNMENTS OF ERROR

The trial court erred in:

(1) Entering its December 17, 2008 Order Denying Defendant Evergreen Hospital's Motion for JNOV and a New Trial, CP 2873-74.

(2) Entering its December 2, 2008 Final Judgment Order, CP 2602-03.

(3) Entering its September 30, 2008 Order Denying Defendant Evergreen Hospital Medical Center's Motion for Judgment as a Matter of Law Dismissing Plaintiff's Case for Failure to Establish Proximate Causation, CP 2295-96.

(4) Failing to rule as a matter of law that WAC 246-320-365 did not require an obstetrician's physical presence in the hospital 24 hours a day, 7 days a week; allowing witnesses to opine as to the WAC rule's meaning, applicability, and breach; entering its September 30, 2008 "Order Denying Defendant Evergreen Hospital Medical Center's Motion for Judgment as a Matter of Law Dismissing Claim that WAC 246-320-365 Requires Obstetricians in the Hospital 24/7," CP 2297-98; and allowing the jury, rather than the court, to decide the WAC rule's meaning.

(5) Allowing plaintiffs to present evidence and argument about claims of negligence that the trial court had dismissed on summary

judgment for want of evidence of proximate cause.

(6) Giving Court's Instruction No. 21, CP 2318, on particular susceptibility.

(7) Giving Court's Instruction No. 22, CP 2319, assigning to Evergreen the burden of proof for segregating damages and responsibility for any indivisible injury.

(8) Refusing to give Evergreen's Proposed Instruction No. 24, CP 2204, WPI 30.17, on aggravation of injury.

(9) Giving Court's Instruction No. 14, which directly quoted from a Joint Commission on Accreditation of Healthcare Organizations (JCAHO) voluntary standard (Standard HR.2), Ex. 222, as if it had the force of law.

(10) Admitting evidence of Nurse Alati's evaluation statement made several months before the treatment at issue that what satisfied her least about her job was "unsafe staffing and management instability."

II. ISSUES PRESENTED FOR REVIEW

1. Did the trial court err in denying Evergreen's motions for judgment as a matter of law, made at the close of plaintiffs' case and post-verdict, based on plaintiffs' failure to prove proximate causation, where there was no evidence that a reasonably prudent obstetrician would have delivered the minor plaintiff at or before the only time the Tavareses'

experts were willing to opine delivery more probably than not would have avoided her injury?

2. Did the trial court err in failing to rule as a matter of law that WAC 246-320-365 did not require an obstetrician's physical presence in the hospital 24 hours a day, 7 days a week; allowing plaintiffs' experts to opine as to the WAC rule's meaning, applicability and breach; and allowing the jury, rather than the court, to decide the WAC rule's meaning?

3. Did the trial court abuse its discretion in allowing plaintiffs to present evidence and argument concerning claims of negligence that the trial court had dismissed on summary judgment for want of evidence of proximate cause?

4. Did the trial court err in giving Court's Instruction Nos. 21 (CP 2318, WPI 30.18.01 – Particular Susceptibility) and 22 (CP 2319, a non-pattern instruction that assigned the burden of segregating injury to Evergreen and made Evergreen liable for the entirety of any indivisible injury), and refusing to give Evergreen's Proposed Instruction No. 24 (CP 2204, WPI 30.17 – Aggravation of Pre-Existing Condition)?

5. Did the trial court err in giving Court's Instruction No. 14, which effectively gave a guideline of a private, voluntary organization, JCAHO, that had been admitted into evidence the force and effect of law?

6. Did the trial court abuse its discretion in admitting evidence of Nurse Alati's evaluation statement, made several months before the treatment at issue, that what satisfied her least about her job was "unsafe staffing and management instability"?

7. Did the errors and abuses of discretion identified above, singly or cumulatively, prejudice Evergreen and deprive it of a fair trial?

III. STATEMENT OF THE CASE

A. Nature of the Case.

In this medical malpractice action, Erik Tavares, individually, and his wife, Sharla Tavares, individually and as Guardian of the Estate of Miriam Tavares, their minor daughter, sued Evergreen Hospital Medical Center, a/k/a King County Public Hospital District #2 ("Evergreen"), and Sharla's obstetrician, Debra Stemmerman M.D.,¹ claiming that they were negligent in the management of Mrs. Tavares' pregnancy, labor and/or delivery and that such negligence caused Miriam to sustain hypoxic ischemic encephalopathy and other injuries.² CP 20-25. Evergreen denied the Tavares' claims. RP 1019-24. Dr. Stemmerman ultimately settled with the Tavareses, *see* 9/2 RP 3-6, and the case against Evergreen was tried to a jury before Judge Steven Gonzalez, CP 3368-3406.

¹ The Tavareses also sued Dr. Stemmerman's group, Evergreen Women's Care. CP 20.

² In their original complaint, the Tavareses also sued neonatologist Roger Hinson, M.D., and his group, Pediatrix Medical Group of Washington. CP 3-8. All claims relating to Dr. Hinson and his group were dismissed by stipulation and order. CP 2889-91.

In its Special Verdict, the jury found negligence by Evergreen that was a proximate cause of injury or damage to Miriam, but not to Sharla and Erik,³ and found Miriam's total damages to be \$4,248,208 (\$348,208 past economic, \$2,500,000 future economic, and \$1,400,000 non-economic, damages). CP 2322-23. The trial court entered judgment on the jury's verdict, CP 2602-03, and denied Sharla and Erik's, CP 2604-17, and Evergreen's, CP 2618-39, motions for judgment notwithstanding the verdict and/or new trial, CP 2872-74. Evergreen appealed, CP 2875-81, and the Tavareses cross-appealed, CP 2882-88.

B. Mrs. Tavares' Prenatal Care and Treatment.

Dr. Debra Stemmerman was the obstetrician who provided prenatal care for Sharla Tavares during her pregnancy with Miriam in 2002 and 2003. RP 173, Ex. 104. Dr. Stemmerman was not employed by Evergreen, but had hospital privileges there. 9/15 RP 27.⁴

Mrs. Tavares had a history of an emergent pre-term C-section delivery of her son Alex due to a concealed placental abruption. Ex. 103 (pp. 4, 9-10);⁵ see 9/18 RP 14. Dr. Stemmerman discussed the risks of

³ At times, for clarity and ease of reference, the Tavareses are referred to by their first names. No disrespect is intended.

⁴ The transcript volumes are not consecutively paginated. Most begin with page 1. Thus, citations to the transcript are by "[date] RP [page number]".

⁵ Ex. 103, the Evergreen Hospital records for Mrs. Tavares, contain multiple copies of several documents, some but not all of which have a "Page Number" listed in the bottom

recurrence of placental abruption with Mrs. Tavares. 9/17 RP 176-78; Ex. 103 (pp. 10, 12). Unable to find any risk factors in Mrs. Tavares's history for placental abruption, Dr. Stemmerman, at least initially, thought that Mrs. Tavares was a reasonable candidate for a VBAC (vaginal birth after Cesarean) delivery. Ex. 103 (p. 10, 12); 9/17 RP 175-80. On December 26, 2002, Mrs. Tavares was given a VBAC consent form to review at her leisure. Ex. 103 (p.12); 9/17 RP 182. On January 23, 2003, she brought back the consent form, Dr. Stemmerman read and discussed it with her, and Mrs. Tavares signed it. Ex. 103 (p. 12, 42); 9/17 RP 182-83.

In February 2003, Dr. Stemmerman learned that Mrs. Tavares had increased risk factors for clotting and placental abruption when blood tests she ordered to rule out thrombophilia came back showing a protein S deficiency and prothrombin DNA mutation. 9/17 RP 179-80; Ex. 103 (pp. 4, 10, 12); Ex. 108. Dr. Stemmerman referred Mrs. Tavares to Dr. Daniel Gavrila, a maternal-fetal medicine specialist, who put Mrs. Tavares on various blood thinners during her pregnancy. Ex. 103 (pp. 10, 12); Ex. 108; 9/17 RP 180. When Dr. Gavrila saw Mrs. Tavares at 26 weeks gestation on February 12, 2003, he counseled her regarding "the potential 15-20% risk" of placental abruption if her thrombophilia was left

right hand corner. When citation is made to "Ex. 103 (pp. __-__)" the page numbers listed refer to those on the bottom right hand corner.

untreated, but that treatment would hopefully significantly decrease the risk, although he could not quantify it. Ex. 108; CP 316-17.

Starting at 38 weeks, Dr. Stemmerman began suggesting, and on at least 2 or 3 other occasions suggested, that the Tavareses schedule a C-Section. CP 290. By 40 weeks of gestation, Dr. Stemmerman was no longer comfortable going ahead with a VBAC delivery, because the baby was getting large, and Mrs. Tavares had a very unfavorable cervix, did not appear as though she would be delivering any time soon, and was not a good candidate for induction of labor.⁶ 9/17 RP 183-84. Although Dr. Stemmerman told the Tavareses that she wanted the baby delivered, she did not want them to be pregnant any longer, and they had her “between a rock and a hard place,” they would not allow her to schedule a C-section, preferring instead to let Mrs. Tavares continue to allow herself to go into spontaneous labor. 9/17 RP 184-85; CP 289. Dr. Gavrilas as well counseled against a VBAC. On April 28, 2003, upon learning that Mrs. Tavares was going to try to have a VBAC, he told Mrs. Tavares that, if he were in charge, he “would not allow her to have” one. CP 313-14; 53.

On May 20, 2003, once Mrs. Tavares was past her due date, Dr. Stemmerman had one of her discussions with the Tavareses about not

⁶ Mrs. Tavares denies that Dr. Stemmerman ever told her that she or Miriam were in any kind of danger if she didn't have a C-section. 9/18 RP 21.

wanting them to be pregnant anymore and her recommendation for a C-section. 9/17 RP 185-86; CP 291. As Dr. Stemmerman read her note of that date, 9/17 RP 186; *see* Ex. 104 (5/20/03 handwritten note):

Here today with husband. Long discussion about post-dates management, pros, cons, and increased risk with VBAC and an induction. They still want to try to VBAC and schedule an induction about 42 weeks if no spontaneous onset of labor, which is the SOL, as opposed to schedule to repeat C-section, which is the RC/S. Continue NSTs, which are non-stress tests, AFI, which is monitoring the baby's amniotic fluid, and DFM, which means daily fetal rubin (phonetic) count.

When Mrs. Tavares told Dr. Stemmerman that it was not uncommon for women in her family to go much further past dates by three, four, five weeks, Dr. Stemmerman told her that she would not allow her to go past 42 weeks, that that was her limit. 9/17 RP 188-89. When the Tavareses decided to schedule an induction at 42 weeks, as opposed to proceeding with a C-section, Dr. Stemmerman gave them two dates, May 27 or May 31, they chose May 31, 2003, and Dr. Stemmerman scheduled the induction for that date. 9/17 RP 189-90, 201-02.

On May 22, 2003, Mrs. Tavares called to see if they could move the induction up to May 27. 9/17 RP 201-03; Ex. 104 (5/22/03 note of phone call). Dr. Stemmerman's nurse called Evergreen to see if May 27 was still an option, but was told the slots for medical inductions that day had been filled. *Id.* Mrs. Tavares was put on the wait list for medical

inductions on May 27. *Id.*

Throughout her prenatal visits, right up to May 27, 2003, Dr. Stemmerman had Mrs. Tavares undergo non-stress tests, all of which were normal and reactive. 9/17 RP 198. And, right up to May 27, Mrs. Tavares was found to have a normal amniotic fluid index. 9/17 RP 200.

On May 30, 2003, Mrs. Tavares, at about 41 6/7 weeks gestation, saw Dr. Stemmerman for her last pre-natal visit. On that visit, Dr. Stemmerman placed a Foley catheter in Mrs. Tavares' cervix to try to ripen it so that the induction would likely be more successful. 9/17 RP 189-90. Mrs. Tavares told Dr. Stemmerman that the baby was less active and that she had been contracting for a couple of hours, and Dr. Stemmerman examined her, found normal fetal heart tones, and felt and heard the baby move. 9/17 RP 190-91. Mrs. Tavares was not in active labor and there did not appear to be anything emergent about her condition when seen in the office around 5:00 pm.⁷ 9/17 RP 191. Dr. Stemmerman had no concerns about the health of the baby on May 30. 9/17 RP 200.

Dr. Stemmerman told Mrs. Tavares that, if she had more painful contractions, if they were regular every five to seven minutes, if she broke her water, if her baby was not moving normally, or if she had bleeding,

⁷ Throughout Mrs. Tavares' prenatal care and up to May 27, 2003, Dr. Stemmerman had Mrs. Tavares undergo non-stress tests, which were all normal and reactive. 9/17 RP 198.

then she should go to the hospital. 9/17/ RP 192. Otherwise she was scheduled for an induction the next day. 9/17 RP 190. Dr. Stemmerman called Evergreen to inform the labor and delivery staff that Mrs. Tavares would likely be coming into the hospital the next day for an induction and to give them orders for her initial care. *See* Ex. 103 (p. 98).

C. Mrs. Tavares' Labor and Delivery at Evergreen.

After leaving Dr. Stemmerman's office, the Tavareses picked up some dinner and went home, and Mrs. Tavares took a bath to see if her contractions would calm down. 9/18 RP 26. When her contractions persisted, and she called the labor and delivery unit at 7:36 p.m. and told whoever answered the phone that she was having contractions and was high risk, she was told that, if she thought she was in labor, she should come to the hospital to be checked. 9/18 RP 27-28. When Paula Alati, R.N., the charge nurse, came out of report, she was told that a patient was coming in for a labor check, who had had a Foley inserted, and was contracting. 9/30 RP 203; *see* 9/23 RP 202. Nurse Alati asked Carolyn Short, R.N., to do the labor evaluation for Mrs. Tavares. 9/23 RP 201-02; 9/30 RP 203-04.

The Tavareses arrived at about 8:25 p.m. on May 30, 2003. RP 103 (p. 22). When they arrived at the labor and delivery unit, they were asked to wait a minute while another patient was taken care of. 9/17 RP

68; 9/22 RP 70. In less than a minute, Nurse Short met them in the hallway and, as she was walking them to their room, was handed Mrs. Tavares' prenatal records. 9/17 RP 68; 9/22 RP 70-71; 9/23 RP 204. While they were walking to the patient room, Nurse Short had already started her assessment, and begun taking a history. 9/23 RP 204-05. During her initial assessment, Nurse Short became aware that Mrs. Tavares had had a prior C-section for abruption at 31 weeks, was post-dates, wanted to do a VBAC, was GBS positive,⁸ and had had a Foley catheter inserted at the doctor's office earlier that evening. 9/23 RP 205.

When they got to the room, Nurse Short gave Mrs. Tavares a gown and had her go to the bathroom and give a urine sample, and to tug gently on her Foley to see if it had come out of her cervix, which it had not. 9/23 RP 205-07 When Mrs. Tavares came out of the bathroom, Nurse Short helped settle her in bed, put her on the fetal monitor, tilted her to her side to pick up the fetal heart tones, checked her vital signs, and did a sterile vaginal exam. 9/23 RP 210-11. Nurse Short found that Mrs. Tavares had no vaginal bleeding,⁹ her membranes were intact, her cervix was dilated one to two centimeters and was 50% effaced, and the baby was at minus 2

⁸ GBS refers to Group B strep, 9/18 172-73, a bacterial-invasive organism that can cause infection and sepsis in newborns, 9/22 RP 151-53.

⁹ Although Mrs. Tavares claims that she was having vaginal bleeding (more than just bloody show) when she changed into her gown, 9/22 RP 72, Nurse Short found no evidence of vaginal bleeding at any time she cared for Mrs. Tavares, nor did Mrs. Tavares report any vaginal bleeding to her. 9/23 RP 211-12.

station. 9/23 RP 211-12; 9/30 RP 3; Ex 103 (p. 119). By palpation, Mrs. Tavares' contractions were mild to moderate. 9/30 RP 6-7, 24-25; Ex. 103 (p. 119). Mrs. Tavares was not in active labor. 9/30 RP 3.

At about 8:33 p.m. the fetal monitor (*see* Ex. 4 for the fetal monitor strip), began picking up Mrs. Tavares' contractions, and after Mrs. Tavares was turned a little toward her left side, picked up a better signal of the fetal heart rate. 9/30 RP 3-4. Initially, Mrs. Tavares was having contractions, one and a half to two minutes apart. 9/30 RP 4-5. After a little less than ten minutes, the contractions started to space out to two to three minutes apart. 9/30 RP 5. Mrs. Tavares was breathing with her contractions, suggesting that the contractions were uncomfortable or painful, but she was able to rest and relax between them. 9/30 RP 5-6.

According to Nurse Short, it is very common to see a pattern of frequent contractions with a Foley catheter in place as it is exerting a lot of pressure on the cervix. 9/30 RP 7. Frequent contractions can also be seen with placental abruption but, with placental abruption, the contractions tend to increase in frequency and strength, while Mrs. Tavares' contractions spaced out. 9/30 RP 7.

Up to the time she left the room briefly at (or shortly before) 8:45 p.m. to do a blood sugar test on a baby across the hall, Nurse Short

assessed the fetal monitor strip as nonreactive with minimal variability.¹⁰ 9/30 RP 7-10. To her, that is a very normal part of any fetal heart tracing to have 20-40 minutes of minimal variability, which can be a fetal sleep cycle or just the fetus relaxing. 9/30 RP 9.

At about 8:53 p.m., Nurse Short returned to Mrs. Tavares' room, and looked at the monitor strip. 9/17 RP 77, 120; 9/30 RP 10, 24-25. She noted that, right after she had left the room, there had been a variable deceleration of the baby's heart rate that was a bit prolonged, and then two, maybe three, other variable decelerations, suggesting to her some cord compression. 9/30 RP 11-12, 24-25; Ex. 103 (p. 119). Nurse Short turned Mrs. Tavares farther onto her left side to try to shift the baby off the cord and resolve the variable decelerations, and called Nurse Alati to come and review the monitor strip. 9/30 RP 12-13, 24-25, 208; Ex. 103 (p. 119). Nurse Alati came right away, reviewed the strip, then initialed it at 8:58 p.m., received an update from Nurse Short, tore the fetal monitor tracing at 9:02 p.m., and took it with her to call Dr. Shauni Keys, Dr.

¹⁰ The Tavareses claim that, shortly after Nurse Short left the room, they noticed the baby's heart beat was fluctuating from 120 to 110 to 90, and Sharla became concerned about a repeat of what happened with Alex, and asked Erik to go find someone. 9/17 RP 73-75; 9/22 RP 74-75. Although Mr. Tavares claims that he went out and spoke with Nurse Alati and told her of Sharla's concerns, and that Nurse Alati patted him on the shoulder, and said "these things happen," they'd be in to check on it in a second, and then turned and walked the other way, 9/17 RP 76, Nurse Alati has no recollection of any such discussion, nor would she ever have blown anyone off like that, 9/30 RP 207. Had Mr. Tavares come out and said what he claims to have said, Nurse Alati would have gone to make sure all was well and would have remembered it. 9/30 RP 207-08.

Stemmerman's partner who was on call that evening.¹¹ 9/15 RP 53-54; 9/30 RP 13-14, 208-09; *see* Ex. 4. Meanwhile, Nurse Short had given Mrs. Tavares oxygen by mask, and had started an IV and IV fluids at 9:00 p.m.. Ex. 4; Ex. 103 (p. 119); 9/30 RP 14-15, 25.

Sometime before 9:05 p.m., Nurse Alati called Dr. Keys to have her come now and look at the strip. 9/15 RP 16; 9/30 RP 15-16, 158, 209-10. At 9:05 p.m., Nurse Alati returned to the room and wrote on the strip that Dr. Keys had been telephoned and was coming to the hospital. Ex. 4; Ex. 103 (p. 119); 9/30 RP 14-15. While Nurse Alati was out of the room, between 9:02 and 9:06 p.m., the monitor stopped picking up the fetal heart tones, and when Nurse Short had difficulty finding them, she pushed an emergency button on her badge to call Nurse Alati back. 9/30 RP 16. Nurse Alati, and a traveler nurse, Jeff Kreuger, responded. 9/30 RP 17.

By 9:06 p.m., the monitor began picking up fetal heart tones in the 60s to 90s, Mrs. Tavares was again turned, and between 9:05 and 9:06 p.m., Nurses Alati and Short took the Foley catheter out, did a vaginal exam to rule out cord prolapse, and stimulated the fetal scalp which produced heart tones to the 90s for about 5-10 seconds when they again dropped back to the 70s and 80s. 9/30 RP 17-19. 25-26; Ex. 103 (p. 119).

¹¹ Nurse Alati called Dr. Keys because she was concerned about the minimal variability, the variables, and a wandering baseline, with the wandering baseline being her primary concern. 9/30 RP 209.

Nurse Alati left to call the team for the operating room, and Nurse Short administered Terbutaline at 9:15 p.m. to help relax Mrs. Tavares' uterus because of the baby's bradycardia, and also called Jeff Kreuger to get a stretcher. 9/30 RP 17-18, 26; Ex. 103 (p. 119). Dr. Keys arrived at 9:18 p.m., and they took Mrs. Tavares to the operating room in her bed, rather than transfer her to the stretcher that Jeff Kreuger had brought. 9/30 RP 19-20, 26; Ex. 4; Ex. 103 (p. 119).

Anesthesia began at 9:20 p.m., 9/30 RP 20, and Miriam was delivered by C-section at 9:24 p.m., within six minutes of Dr. Keys' arrival in Mrs. Tavares' room. Ex. 103 (p. 119). The baby looked dead to Dr. Keys, was listless, floppy and pale, without movement or respiratory effort, and was handed off to the neonatal team in attendance to resuscitate. Ex. 103 (p. 20). The baby's condition was very depressed with Apgars of 0, 0, 1 and 3. *Id.* Dr. Keys was really surprised that the baby was so depressed – the fetal monitor strip did not match with the baby's condition, and Dr. Keys thought they would deliver a baby that was going to do a lot better. 9/30 RP 194.

When Dr. Keys ruptured the membranes to deliver the baby, she found little amniotic fluid, and really olive green meconium. 9/30 RP 168; 196-97; Ex. 103 (pp. 20, 118). She did not find any fresh red blood inside the amniotic sac. 9/30 RP 169. The baby, placenta, and umbilical cord

were all stained green from exposure to the meconium. 9/17 RP 196; 9/30 RP 168. Dr. Keys noted that the placenta was of normal size, but very calcified and had a clot the size of a grapefruit sitting on top of it. 9/30 RP 168-69. The clot was not bright, bright red and thus appeared to Dr. Keys to be an old clot. 9/30 RP 169. Cord gases were obtained and Dr. Keys noted that the cord pH, base excess, and pCO₂ were consistent with “*chronic* oxygen deprivation.” Ex. 103 (p. 21) (emphasis added). The pathology on the placenta and cord revealed chorioamnionitis (infection of the membranes), and funisitis (infection of the cord), as well as meconium staining of the membranes and the cord. 9/17 RP 195-96.

Dr. Hinson, the neonatologist in attendance, performed Miriam’s resuscitation. Ex. 105 (p. 16). He suctioned below the vocal cords and found no meconium. *Id.* He then intubated Miriam and connected her to a ventilator, and prescribed antibiotics for possible sepsis. Ex. 105 (pp. 16-17). Miriam’s chest x-rays were consistent with pneumonia. On May 31, the intubation tube became obstructed when it began to fill up with meconium coming from Miriam’s lungs. Ex. 105 (p. 367) The tube was changed and Miriam was diagnosed as having meconium aspiration syndrome (MAS). Ex. 105 (p. 375).

Dr. Stemmerman saw the Tavareses on May 31, 2003. When she told them that she wished they had done a C-section a couple of weeks

earlier, Mr. Tavares told her that they did not regret or second-guess their decision. 9/17 RP 193; Ex. 103 (p. 117).

Mrs. Tavares was discharged from Evergreen by Dr. Stemmerman on June 2, 2003. Ex. 103 (p.4). Miriam remained in Evergreen's NICU until July 2, 2003, when she was discharged home to her parents. 9/17 RP 91, 146.

D. The Trial Proceedings.

1. The parties' claims.

The Tavareses claimed that Evergreen was negligent in (1) not having a qualified doctor available to deliver Miriam by C-section in a safe and timely manner; (2) not consulting with and notifying a doctor regarding Sharla's and Miriam's conditions in a timely manner; (3) not timely reporting warning signs to a doctor; (4) not timely transporting Sharla to the delivery room; and (5) not providing adequate or sufficiently trained or supervised nursing staff. CP 2305.

Evergreen denied the Tavareses' claims of negligence, denied that it proximately caused the Tavareses' claimed injuries, and disputed the extent of the claimed injuries. *Id.*

2. The Tavareses' theories of the case and evidence.

The Tavareses called two experts on the standard of care – perinatologist Dr. Donald Taylor and Nurse Laura Mahlmeister. Over

Evergreen's objections, *see* CP 147-48, 1010-12, Dr. Taylor testified, among other things, that Evergreen violated WAC 246-320-365 and the standard of care by failing to have an obstetrician present in the hospital (or on the hospital campus) 24 hours a day 7 days a week. 9/10 RP 36-41, 100-07. Nurse Mahlmeister, without direct reference to the WAC, also testified that Evergreen violated the standard of care by not having an obstetrician on campus 24/7. 9/15 RP 42.

Both Dr. Taylor and Nurse Mahlmeister testified that Mrs. Tavares was a high-risk patient, 9/10 RP 45-50, 9/15 RP 122-24, and that the nurses violated various hospital policies and the standard of care by, among other things, (1) failing to review the records when Mrs. Tavares called and to notify Dr. Keys that, Mrs. Tavares, a high-risk patient of Dr. Stemmerman's, was coming in for evaluation, 9/10 RP 60-64, 75-77; 9/15 RP 124-29, 131-32; (2) failing to notify Dr. Keys of Mrs. Tavares' arrival, 9/15 RP 133; (3) failing to call Dr. Keys either when the patient began showing abnormal contractions on the fetal monitor strip, 9/10 RP 78-80, when the fetal monitor showed minimal variability and the first deceleration at 8:45 p.m., 9/10 RP 81-82; 9/15 RP 139, or when decelerations persisted and the baby developed bradycardia around 8:56 to 8:58 p.m., 9/10 RP 82-85, 9/15 RP 140; failing to tell Dr. Keys that the baby was in bradycardia and that there was an emergency when the nurse

called Dr. Keys at 9:05 p.m., 9/10 RP 85-86; and (4) failing to take Mrs. Tavares to the operating room before Dr. Keys arrived, 9/10 RP 87; 9/15 RP 140-41.

Over Evergreen's objections, CP 1482-87; 9/2 RP 37-46; 9/5 RP 199-214, Nurse Mahlmeister also testified that Evergreen and/or its nurses violated the standard of care: (1) in letting Nurse Short care for Mrs. Tavares without direct supervision, in part because Nurse Short had allegedly not taken a formal fetal monitoring course before working as a labor nurse, 9/15 RP 121-23, (2) in directing Mrs. Tavares to tug on her Foley catheter to see if it she could remove it, 9/15 RP 131, and (3) in their medical record documentation by making overwrites, not documenting a note as a late entry or indicating the time it was written, and not making sure that all of the information put on the delivery summary, whether put there by nurses or physicians, was accurate before the nurse left her shift, 9/15 RP 144-49.

On causation, the Tavareses called obstetrician Dr. Michael Nageotte and pediatric neurologist Dr. Stephen Glass.¹² Both testified that

¹² The Tavareses also called pediatric neuroradiologist Dr. Patrick Barnes, who testified that the injury seen in Miriam's brain on MRI is most likely due to a lack of oxygen due to near-zero blood flow, occurring during "the immediate peripartum period" from a day and a half before delivery to a day and a half after delivery, 9/16 RP 66-68, 96-98, and that the injury is consistent with a history of placental abruption that evolved from a partial bleed to a near total interruption of blood flow, lasting anywhere from 10-15

Miriam's brain damage, which Dr. Glass described as a diffuse static (non-progressive) encephalopathy and mixed cerebral palsy, was more likely than not caused by a placenta abruption that caused ischemia and hypoxia, or asphyxia, with acidosis, that occurred while Mrs. Tavares was in the hospital. 9/8 RP 104-06, 107-09, 116-22; 9/9 RP 11-13, 30-31, 43-44. Both Dr. Nageotte and Dr. Glass testified that it was possible that the placental abruption occurred before Mrs. Tavares went into the hospital. 9/8 RP 151-52, 164; 9/9 RP 184.

Dr. Nageotte opined that Miriam more likely than not would not have suffered brain damage if she had been delivered by 9:06 p.m., and could not say beyond that whether brain damage would necessarily be present if delivery would have occurred after 9:06 p.m. 9/8 RP 123. Dr. Glass opined that the asphyxia occurred during the last 30-35 minutes before delivery, and that the severe acidosis that resulted in the brain damage occurred after 9:02 p.m. 9/9 RP 12-13, 43-44. On cross-examination, Dr. Glass, using his "base excess" threshold of injury calculations, placed the range that the acidosis resulted in brain damage as between 9:02 p.m. and 9:06 p.m. 9/9 RP 198.

Dr. Nageotte acknowledged that chorioamnionitis, funisitis, GBS, and meconium all can be associated with an increased risk of brain

minutes to 20-30 minutes or more. 9/16 RP 79-81. Dr. Barnes disclaimed any radiological evidence of brain injury pre-existing birth. 9/16 RP 134-35.

damage, but opined that it was far more likely that Miriam's injury was due to what was shown on the fetal monitor strip. 9/8 RP 126-28. Dr. Glass too opined that chorioamnionitis, funisitis, meconium and inflammation did not cause Miriam's injury, but "could have" predisposed her to a more severe injury with asphyxia. 9/9 RP 81-82.

3. Evergreen's theory of the case and evidence.

Evergreen's theory of the case was that neither Evergreen nor its nurses were negligent and that Miriam's injury occurred before her mother's arrival at the hospital. Evergreen's two standard of care experts, obstetrician Dr. Thomas Garite and maternal-fetal medicine specialist Dr. David Luthy testified that Evergreen and its nurses complied with the applicable standard of care, Evergreen's policies and procedures. 9/18 RP 94, 99-101; 9/23 RP 55-59, 66-67, 70-74. Dr. Luthy testified that WAC 246-320-365 did not require a hospital to have a physician in house 24 hours a day, 7 days a week, and that Evergreen's call arrangements met the standard of care and complied with the WAC requirement to have the capability to perform C-sections 24 hours a day. 9/23 RP 41-43, 48-49, 54-55. Similarly Dr. Garite testified that Evergreen did not violate ACOG guidelines for the presence of an obstetrician in house when a VBAC patient is in active labor, because Mrs. Tavares was never in active labor. 9/18 RP 96-97.

Dr. Garite further went through the fetal monitor strip and explained that the decelerations that began after the first 10 to 15 minutes of the strip through 9:00 p.m. were common and not concerning. 9/18 RP 64-70, 77-78. Even when the heart rate dropped and the baby began having bradycardia, while no longer reassuring, that was not a reason to do an immediate C-section. 9/18 RP 78-82. The nurse should assess such a patient, make sure there was no cord prolapse or that the baby was about to deliver, and if the situation persists for five minutes, then notify the physician and take steps to move the patient to the operating room and mobilize the necessary operating room personnel. 9/18 RP 81. Dr. Garite opined that it takes at least 15-20 minutes to deliver a baby after the decision is made to do a C-section, and that the standard of care is 30 minutes or less. 9/18 RP 84-86. Dr. Luthy testified that he would have started moving toward performing a C-section shortly after 9:00 p.m., 9/23 RP 82-83, which was consistent with Dr. Keys' testimony that she would have made the decision to go for a C-section around 9:02 or 9:03 p.m. 9/30 RP 183-84.

With respect to causation, Dr. Luthy testified that the placental pathology showed evidence that Miriam had intermittent cord occlusion and decrease of blood and oxygen and had sustained injury before Mrs. Tavares got to the hospital. 9/23 RP 76-77, 87-88. Pediatrician Dr. Gary

Spector testified that the marked inflammatory response found in the umbilical cord and the meconium that was found at birth led to dysfunction in the placenta and cord, impairing exchange of blood gases with the mother, and that, based on the meconium staining, the injury occurred at least 36 hours before birth. 9/22 RP 152, 157-63. He also testified that there was no clinically acute abruption shortly before birth, 9/22 RP 173, and that Miriam's response after birth was like that of a baby who had undergone long-term stress, 9/22 RP 176-78.

Perinatal pathologist Carolyn Salafia testified that the abruption Mrs. Tavares had was an old one given the extent of the deterioration of placental tissues that started due to a blood clot several days before delivery and that Miriam had a dysfunctional umbilical cord due to infection that developed 2-3 days before birth, 9/18 RP 163-66, and that led to decreased oxygen flow to the baby, 9/18 RP 197. Pediatric neuroradiologist Dr. Robert Zimmerman testified that an ultrasound done right after Miriam's birth shows the type of damage that appears up to 48 to 96 hours after a brain injury, and that in his opinion Miriam suffered her brain injury on May 29, 2003.¹³ 9/22 RP 29-30.

¹³ Dr. Zimmerman also testified that an MRI done a month after birth showed a profound asphyxic injury consistent with a partial prolonged asphyxia existing more than 24 hours before the ultrasound that was taken right after birth. 9/22 RP 32-41.

Finally, pediatric neurologist Dr. Michael Painter testified that, based on his examination of Miriam at age five and neuroimaging studies that show a kind of brain damage that takes a minimum of an hour to produce, and not the kind of brain damage that a shorter (20-25 minute) hypoxic injury would produce, Miriam has cerebral palsy due to brain damage that occurred 1-3 days before birth as a result of prolonged partial asphyxia. 9/23 RP 142-43, 147-48, 152-53, 154-160, 167-69.

E. The Verdict, Entry of Judgment, Post-Trial Motions, and Appeal.

The jury found negligence by Evergreen that was a proximate cause of injury to Miriam, but not to Sharla and Erik, and that Miriam's total damages were \$4,248,208. CP 2322-23. The trial court entered judgment on the jury's verdict, CP 2602-03, and denied Sharla and Erik's, CP 2604-17, and Evergreen's, CP 2618-39, motions for JNOV and/or new trial, CP 2872-74. Evergreen appealed, CP 2875-81, and the Tavares's cross-appealed, CP 2882-88.

IV. ARGUMENT

A. The Trial Court Erred in Denying Evergreen Hospital's Motions for Judgment as a Matter of law and JNOV When the Plaintiffs Failed to Prove Proximate Causation.

Evergreen Hospital moved for judgment as a matter of law at the close of the Tavares' case, CP 3410-17, and again after the verdict, CP 2618-41, 2689-2728; *see also* CP 2729-2814 (the Tavereses' response),

2815-60 (Evergreen's reply), because the Tavareses failed to prove that Evergreen's alleged negligence was more probably than not a proximate cause of their injuries. The trial court denied both motions. CP 2295-96, 2873-74. The trial court erred in so doing.

1. Standard of review.

When reviewing a trial court's decision to deny a motion for judgment as a matter of law the appellate court applies the same standard as the trial court. Granting a motion for judgment as a matter of law is appropriate when, viewing the evidence most favorable to the nonmoving party, the court can say, as a matter of law, there is no substantial evidence of reasonable inference to sustain a verdict for the nonmoving party.

Sing v. John L. Scott, Inc., 134 Wn.2d 24, 29, 948 P.2d 816 (1997). "Substantial evidence" means "that character of evidence which would convince an unprejudiced thinking mind of the truth of the fact" *Davis v. Microsoft Corp.*, 149 Wn.2d 521, 531, 70 P.3d 126 (2003) (emphasis omitted; citation omitted) (quoting *Thomson v. Virginia Mason Hosp.*, 152 Wash. 297, 300-01, 277 P. 691 (1929)). It "has likewise been described as evidence 'sufficient . . . to persuade a fair-minded, rational person of the truth of a declared premise.'" *Id.* (quoting *Helman v. Sacred Heart Hosp.*, 62 Wn.2d 136, 147, 381 P.2d 605 (1963)). "A verdict cannot be founded on mere theory or speculation." *Campbell v. ITE Imperial Corp.*, 107 Wn.2d 807, 818, 733 P.2d 969 (1987).

2. The Tavareses' burden of proof.

RCW 4.24.290 provides that:

In any civil action for damages based on professional negligence against . . . a physician . . . , the plaintiff in order to prevail shall be required to prove by a preponderance of the evidence that the defendant . . . failed to exercise that degree of skill, care, and learning possessed at that time by other persons in the same profession, ***and that as a proximate result of such failure the plaintiff suffered damages.*** [Emphasis added.]

RCW 7.70.040, in turn, sets forth the necessary elements of proof on a claim that injury resulted from a defendant's failure to follow the accepted standard of care as follows:

The following shall be necessary elements of proof that injury resulted from the failure of the health care provider to follow the accepted standard of care:

- (1) The health care provider failed to exercise that degree of care, skill, and learning expected of a reasonably prudent health care provider at that time in the profession or class to which he belongs, in the state of Washington, acting in the same or similar circumstances;
- (2) ***Such failure was a proximate cause of the injury complained of.*** [Emphasis added.]

Expert testimony is generally necessary to prove both the standard of care and causation. *Harris v. Robert C. Groth, M.D., Inc.*, 99 Wn.2d 438, 449, 663 P.2d 113 (1983); *McLaughlin v. Cooke*, 112 Wn.2d 829, 836-37, 774 P.2d 1171 (1989).

3. The Tavareses failed to prove that Evergreen's alleged negligence proximately caused their claimed damages.

Here, whether any of Evergreen's claimed negligence was a proximate cause of Miriam's injuries hinged on whether, had Dr. Keys been present in the hospital, or been notified sooner of Mrs. Tavares' and the baby's condition, a C-section delivery would have been accomplished in time to prevent Miriam's brain damage.¹⁴ The Tavareses failed to prove that this more probably than not would have occurred.

One of the Tavareses' causation experts, obstetrician Dr. Michael Nageotte, testified that, if the delivery had occurred by 9:06 p.m., more likely than not Miriam would not have had brain damage. 9/8 RP 123. That was all he could say to a reasonable degree of medical probability. He could not say whether, had the delivery occurred later than 9:06 p.m., brain damage necessarily would have been present, *id.*, and he admitted that he was unable to determine by what time Miriam had experienced clinically significant brain injury, 9/8 RP 140-41, 160-61.

Although the Tavareses' standard of care expert, perinatologist Dr. Donald Taylor, testified that, if an obstetrician had been present, Miriam would have been delivered much earlier and the injury would have been

¹⁴ Indeed, the Tavareses' counsel himself argued on motions in limine that, "when Dr. Keys would have intervened" was "directly relevant to our case on proximate causation, because the timing that she would have intervened is critical because that sets . . . the timing that the baby would have been delivered."¹⁴ 9/4 RP 183.

avoided, 9/10 RP 41, he did not explain by what time that meant. He never testified when a reasonably prudent obstetrician, if present in the hospital, would have made the decision to perform a C-section, or once that decision was made, whether delivery probably could have been accomplished in time to avoid injury. At most, he indicated that, while the baby was still okay at 8:45 p.m., 9/10 RP 82, if a reasonably prudent physician had been there then and seen the monitor strip, the physician would probably be talking to Mrs. Tavares about doing a C-section, *id.*, that about 8:55 or 8:56 p.m. was the “land of our opportunity to intervene,” 9/10 RP 83, that from 9:05 p.m. the baby was really getting into trouble, but the trouble started at about 8:56 and the baby had not recovered for 10 minutes, 9/10 RP 83-84, and that, by 9:05 or 9:06 p.m., the baby was acidotic, 9/10 RP 185-86.

Dr. Keys testified that, even if she had been told by the nurses, while she was still at the hospital, that her partner’s patient, who was a VBAC patient with a history of abruption, protein S deficiency, and prothrombin DNA mutation, and who was having cramping and increased contractions, had arrived, she probably would not have stayed at the hospital, but would have run home to get dinner, so that she would be prepared for an all night laboring VBAC patient who still needed to be evaluated by the nurses to determine whether she was really in labor. 9/30

RP 179-82. If she had stayed to watch the patient, and saw the decelerations that began at about 8:45 p.m., Dr. Keys would have stayed at the bedside and continued to watch the strip to see what happened. 9/30 RP 182. Dr. Keys further testified that, if she had been in Mrs. Tavares' room seeing the fetal monitor strip, she would not have been operating on the patient at 9:02 or 9:03 p.m.; that is when she would have made the decision to go for a C-section. 9/30 RP 183-84. According to Dr. Keys, from the time the decision is made to go for a C-section, it would take five to ten minutes to mobilize the necessary staff, open and get all the equipment and sterile supplies set up the operating room, and transfer the patient, and then four to five minutes to get the baby out. 9/30 RP 163-66.

Thus, with a decision to go for C-section at 9:02 or 9:03 p.m., five to ten minutes for mobilization of personnel, preparation of the operating room, and transfer of Ms. Tavares to the operating room, and best case scenario of delivery in four to five minutes thereafter, Miriam would have been delivered at 9:11 p.m. at the earliest, or by 9:18 p.m. at the latest. The Tavareses presented no evidence that Miriam's outcome probably would have been avoided if she had been delivered by 9:11 p.m. or somewhere between 9:11 and 9:18 p.m. Dr. Taylor testified that Miriam was already incurring damage by 9:05 p.m., 9/10 RP 83-84, and the most Dr. Nageotte could say was that if Miriam had been delivered by 9:06

p.m., more likely than not she would not have had brain damage, 9/8 RP 123. And, Dr. Glass, using his “base excess” threshold of injury calculations, placed the period in which Miriam’s acidosis resulted in brain damage as between 9:02 p.m. and 9:06 p.m. 9/9 RP 198. The Tavareses offered no testimony establishing, to a reasonable degree of medical probability, that Miriam’s brain damage would have been avoided or lessened had she been delivered between 9:11 and 9:18 p.m., or any time after 9:06 p.m.

While the Tavareses’ counsel argued in closing that the jury could find Miriam’s injuries would have been less or would have been avoided if she had been delivered at 9:12, 9:15, or 9:18 p.m., 10/1 RP 21, there had been no expert medical testimony substantiating that argument. His argument merely invited the jury to speculate that delivery at any of those times would have altered Miriam’s outcome. “A verdict cannot be founded on mere speculation or conjecture.” *Campbell*, 107 Wn.2d at 818. To establish cause in fact, the Tavareses had to introduce competent expert testimony establishing that, “but for” Evergreen’s alleged negligence, Miriam’s injury would not have occurred. *E.g.*, *Estate of Borden ex rel. Anderson v. State, Dept. of Corrections*, 122 Wn. App. 227, 240, 95 P.3d 764 (2004) (“There is cause-in-fact if a plaintiff’s injury would not have occurred “but for” the defendant’s negligence. Cause-in-

fact does not exist if the connection between an act and the later injury is indirect and speculative.”)

Here, the most the Tavareses’ experts established was that Miriam’s injuries would not have occurred if she had been delivered by 9:06 p.m. They presented no expert testimony establishing that reasonably prudent obstetrician, if present in Mrs. Tavares’s room and watching the fetal monitor strip, would have made the decision to go for a C-section in time to deliver Miriam by 9:06 p.m. Dr. Keys’ testimony as to when she would have made the decision to go for a C-section, and how much time it would have taken from that decision to delivery stands un rebutted and does not establish that Miriam would have been delivered by 9:06 p.m.

Because the Tavareses failed to present substantial evidence, as opposed to mere speculation, that Miriam would have been delivered in sufficient time to avoid or lessen her injuries had Evergreen made sure that Dr. Keys was physically present and fully informed the evening of May 30, 2003, their claims of negligence against Evergreen should not have gone to the jury. The trial court erred in denying Evergreen’s motions for judgment as a matter of law. Because the evidence was insufficient to establish proximate cause, this Court should reverse the trial court’s Final Judgment Order and its orders denying Evergreen’s motions for judgment as a matter of law, and remand the case for entry of judgment in

Evergreen's favor. If the Court does so, then the Court need not reach any of the other issues raised on appeal.

B. The Trial Court Erred in Failing to Rule as a Matter of Law that WAC 246-320-365 Did Not Require an Obstetrician to Be Physically Present in the Hospital 24 Hours a Day 7 Days a Week and in Allowing the Experts to Opine About, and the Jury to Determine, the WAC's Meaning.

WAC 246-320-365, attached as Appendix A, dealing with specialized patient care services by hospitals, provides, among other things, that hospitals will:

- (7) If providing obstetrical services:
 - (a) Have capability to perform cesarean sections twenty-four hours per day; or
 - (b) Meet the following criteria when the hospital does not have twenty-four hour cesarean capability:
 - (i) Limit planned obstetrical admissions to "low risk" obstetrical patients as defined in WAC 246-329-010(13) childbirth centers;
 - (ii) Inform each obstetrical patient in writing, prior to the planned admission, of the hospital's limited obstetrical services as well as the transportation and transfer agreements[.]

Once Evergreen became aware that one of the Tavareses' experts, Dr. Donald Taylor, a perinatologist from Illinois, was prepared to opine that WAC 246-320-365(7) means that a hospital like Evergreen had to have an obstetrician physically present at the hospital 24 hours a day, seven days a week, Evergreen moved repeatedly to have the trial court dismiss any such claim and to rule as a matter of law that the WAC

imposed no such requirement. *See* CP 147-48, 1610-12, CP 2083-85, CP 2092-98, CP 2624-28.

The trial court, however, refused to do so. *See* CP 3361, 3366. At the argument on motions in limine, when the Tavareses' counsel sought to preclude Evergreen or its experts from testifying that Evergreen met the standard of care vis-à-vis the WAC's requirements, *see* CP 1424-25, 9/4 RP 162-74, the trial court made clear that it was not ruling that the WAC did or did not require an obstetrician to be present in the hospital 24 hours a day 7 days a week. 9/4 RP 165-66. After reviewing Evergreen's supplemental authority, CP 2083-85, the trial indicated, 9/5 RP 233:

THE COURT: Let me say something about the WAC. The WAC sets forth a requirement to have 24/7 coverage. I am not finding as a matter of law that it requires to have a doctor present. That is certainly one way to comply with it. I am going to leave it to the jury to decide whether or not the hospital complied with it in this case. The WAC itself and what it says is relevant and certainly can be argued from both sides in this case.

In light of the trial court's ruling, WAC 246-320-365(7) was admitted as Plaintiff's Ex. 83, and the entirety of WAC 246-320-365 was admitted as Defendant's Ex. 210. Both were admitted, not as an illustrative exhibits, but as substantive evidence. Both sides' experts and other witnesses were permitted to opine as to the WAC's meaning. 9/10 RP 36-39, 97-108; 9/15 RP 27-33, 72-73; 9/23 RP 40-48; 9/30 RP 78-79.

At some point, the trial court changed its mind, albeit briefly, and found as a matter of law that WAC 246-320-365(7) does require an obstetrician to be physically present in the hospital or on the hospital campus 24 hours a day. See CP 2214, 2235. After Evergreen moved for reconsideration, CP 2235-2239, the trial court changed its mind again and, over Evergreen's objection, instructed the jury:

Washington Administrative Code 246-320-365 is an administrative rule. The violation, if any, of an administrative rule is not necessarily negligence, but may be considered by you as evidence in determining negligence.

Court's Instruction No. 15, CP 2314. The trial court did not set forth the WAC in its instructions or tell the jury whether or not it required the presence of an obstetrician in the hospital 24/7, instead leaving it to the jury to decide based on the evidence presented what the WAC required.

1. Standard of review.

Agency regulations are interpreted the same way that statutes are interpreted, as questions of law subject to de novo review. *State v. Reier*, 127 Wn. App. 753, 757, 112 P.3d 566 (2005), *rev. denied*, 156 Wn.2d 1019 (2006).

2. It was error to consign the interpretation of the WAC to the experts or the jury.

"A determination of the applicable law is within the province of the trial judge, not that of an expert witness." *Hyatt v. Sellen Constr. Co.*,

Inc., 40 Wn. App. 893, 899, 700 P.2d 1164 (1985). “[T]he meaning of a statute’s terms is a question of law; the question is not one amenable to resolution based upon trial testimony.” *Cowiche v. Canyon Conservancy v. Bosley*, 118 Wn.2d 801, 814, 828 P.2d 549 (1992). It was for the trial court to decide what the WAC at issue meant. It either did or didn’t require the presence of an obstetrician in the hospital 24 hours a day, 7 days a week. The trial court, however, refused to decide the issue, and instead left it to the witnesses to opine as to, and the jury to decide, the WAC’s meaning. In so doing the trial court erred as a matter of law.

3. The trial court should have ruled that WAC 246-320-365(7) does not require the presence of an obstetrician in the hospital 24 hours a day 7 days a week.

WAC 246-320-365(7)(a) provides that hospitals providing obstetrical services will “[h]ave capability to perform cesarean sections twenty-four hours per day.” It does not provide that hospitals providing obstetrical services must have an obstetrician physically presence in-house 24 hours per day. Indeed, when hospitals must have specific personnel present in the hospital 24 hours a day 7 days a week, the WAC explicitly says so.

For example, WAC 246-320-365(9) states that a hospital providing a neonatal intensive care nursery must have:

- (a) Nursing, laboratory, pharmacy, radiology, and respiratory care services appropriate for neonates available in the hospital at all times;
- (b) An anesthesia practitioner, neonatologist, and a pharmacist on call and available in a timely manner twenty-four hours a day; and
- (c) One licensed nurse trained in neonatal resuscitation in the hospital when infants are present[.]

Similarly, WAC 246-320-365(6), dealing with post-anesthesia recovery units (PACUs), requires the adoption of policies and procedures requiring:

- (a) The availability of an authorized practitioner in the facility capable of managing complications and providing cardiopulmonary resuscitation for patients when patients are in the PACU; and
- (b) The immediate availability to the PACU of a registered nurse trained and current in advanced cardiac life support measures[.]

Similarly, in addressing staffing requirements for hospital emergency departments, WAC 246-320-365(14) requires:

- (a) Capability to perform emergency triage and medical screening exam twenty-four hours per day;
- (b) At least one registered nurse skilled and trained in care of emergency department patients on duty in the hospital at all times . . .

Agency regulations are interpreted the same way that statutes are interpreted. *State v. Reier*, 127 Wn. App. at 757. Statutes are construed as a whole, trying to give effect to all the language and to harmonize all provisions. *City of Seattle v. Fontanilla*, 128 Wn.2d 492, 498, 909 P.2d 1294 (1996) (citation omitted). “Every provision must be viewed in

relation to other provisions and harmonized if at all possible.” *In re Estate of Kerr*, 134 Wn.2d 328, 335, 949 P.2d 810 (1998) (citation omitted).

Where a statute specifically designates the things or classes of things upon which it operates, an inference arises in law that all things or classes of things omitted from it were intentionally omitted by the legislature under the maxim *expressio unius est exclusio alterius* - specific inclusions exclude implication.

Washington Nat. Gas v. Disto, 77 Wn.2d 94, 98, 459 P.2d 633 (1969); *Sulkosky v. Brisebois*, 49 Wn. App. 273, 277, 742 P.2d 193 (1987).

Viewing the provisions of WAC 246-320-365 in relation to each other, it is clear that, when the Department requires a hospital to have specific personnel available in the hospital at all times or 24 hours a day, it explicitly so states. It did not specifically state in WAC 246-320-365(7) that hospitals providing obstetrical services must have an obstetrician on duty in the hospital at all times or 24 hours a day. Because the Department of Health did not so specifically state in WAC 249-320-365(7), it must be inferred that it intended to omit such a requirement from the obstetrical services provision.¹⁵

¹⁵ That the Department of Health did not intend to impose such a requirement is further evidenced by the fact that the hospital has annually surveyed Evergreen for its compliance with its administrative codes, and has never cited Evergreen for violation of WAC 246-320-365(7) because Evergreen did not require obstetricians to be physically present in the hospital 24 hours a day. 9/15 RP 30-32. Moreover, there is nothing in the

The trial court erred in failing to rule as a matter of law that WAC 246-320-365(7) does not require that hospitals providing obstetrical services to have an obstetrician physically present in-house 24 hours per day, and by leaving it the witnesses to opine as to what the WAC means and whether it was violated. The error was not harmless. Even the Tavareses' counsel argued below that "expert" testimony about the law . . . offered by legally untrained and unqualified medical and nursing experts . . . is very likely to mislead and confuse the jury." CP 1125.

C. The Trial Court Abused Its Discretion in Allowing Plaintiffs to Present Evidence and Argument Concerning Claims of Negligence that Had Been Dismissed on Summary Judgment for Want of Evidence of Proximate Cause.

Evergreen moved pre-trial for summary judgment dismissal of various negligence claims by the Tavareses, including ones that were not supported by evidence of proximate cause. CP 137-153, 767-73. The trial court granted Evergreen's motion in part and dismissed, among others, the following claims of negligence:

- A. Claim that personnel employed by Evergreen Hospital altered medical records;
- B. Claim that documentation by Carolyn Short was negligent because she did not title notes as "late entries" and because she did not write "error" after a time correction;

* * *

record to suggest that the Department of Health has ever interpreted WAC 246-320-365(7) to contain such a requirement.

D. Claim of negligent record keeping by Evergreen Hospital;

* * *

I. Claim that Ms. Short was not an adequately trained labor and delivery nurse because she did not attend a “formal” fetal monitoring class;

* * *

K. Claim that it was negligent to allow Mrs. Tavares to determine if the foley catheter would come out [.]

CP 3365-66. When Evergreen later moved in limine to exclude evidence and argument regarding those same claims, CP 1482-87; 9/2 RP 37-46; 9/5 RP 199-214, however, the trial court refused to exclude evidence or argument as to negligence with respect to those claims, precluding instead only evidence or argument that the claimed negligence proximately causes the Tavareses’ claimed injuries. *See* CP 2077; 9/5 RP 213-14. When Evergreen’s counsel specifically asked the trial whether the Tavareses’ nursing expert, Laura Mahlmeister, “was going to be able to get up there and testify that all these were negligent,” with respect to the record-keeping issues, 9/5 RP 213, the trial court indicated that “[w]hether it is negligent or just not the proper way of keeping records is a matter of semantics. I am not limiting that testimony from witness Mahlmeister.” 9/5 RP 214. When Evergreen’s counsel asked the same question about the Foley catheter issue, 9/5 RP 214, the trial court indicated only that “[i]f she testifies to any causation, I will be striking the testimony and perhaps her testimony altogether.” 9/5 RP 215.

The Tavareses were permitted to elicit testimony from their Nurse Mahlmeister, that (1) Evergreen violated the standard of care in letting Nurse Short care for Mrs. Tavares without direct supervision, in part because Nurse Short had allegedly not taken a formal fetal monitoring course before working as a labor nurse, 9/15 RP 121-23, (2) Nurse Short violated the standard of care in directing Mrs. Tavares to tug on her Foley catheter to see if it she could remove it, 9/15 RP 131, and (3) the nurses violated the standard of care in their medical record documentation, 9/15 RP 144, by making overwrites, not documenting a note as a late entry or indicating the time it was written, and not making sure that all of the information put on the delivery summary, whether put there by nurses or physicians, was accurate before she left her shift, 9/15 RP 144-48.

The trial court erred in denying Evergreen's motion in limine to exclude, and in admitting, evidence of claims of negligence that had been dismissed on summary judgment for want of evidence of proximate cause. The trial court further erred in denying Evergreen's motion for new trial that was based in part on this issue. *See* CP 2628-29.

1. Standard of review.

A trial court's decision to admit or exclude evidence is reviewed for abuse of discretion. *State v. Johnson*, 132 Wn. App. 454, 459, 132 P.3d 767 (2006). An abuse of discretion is "discretion manifestly

unreasonable, or exercised on untenable grounds, or for untenable reasons.” *State ex rel. Carroll v. Junker*, 79 Wn.2d 12, 26, 482 P.2d 775 (1971).

The denial of a motion for new trial is also reviewed for abuse of discretion. *ALCOA v. Aetna Cas. & Sur. Co.*, 140 Wn.2d 517, 537, 998 P.2d 856.

2. Evidence and argument concerning claims of negligence that were not a proximate cause of injury should not have been admitted.

Summary judgment is proper only if there is no genuine issue of material fact and the moving party is entitled to judgment as a matter of law. CR 56(c). A material fact is one upon which the outcome of the litigation depends. *Lipscomb v. Farmers Ins. Co. of Washington*, 142 Wn. App. 20, 27, 174 P.3d 1182 (2007). As the trial court’s own summary judgment rulings correctly reflected, evidence of a violation of the applicable standard of care, in itself, does not present a genuine issue of material fact, absent evidence that violation of the standard of care proximately caused injury to the plaintiff. Nor is it actionable, absent proof that it proximately caused injury to the plaintiff. *See* RCW 4.24.290; 7.70.040. The claims of negligence based on documentation, having Mrs. Tavares check her Foley catheter, or Nurse Short’s alleged failure to attend a “formal” fetal monitoring class were dismissed on

summary judgment because the Tavareses were unable to tie such alleged negligence to the injury at issue. Such claims of negligence thereupon ceased to have any relevance to the lawsuit, as they were no longer of consequence to the determination of the action. See ER 401 (“‘Relevant evidence’ means evidence having any tendency to make the existence of any fact that is of consequence to the determination of the action more probable or less probable than it would be without the evidence.”)

Testimony concerning such alleged negligence became nothing more than “other wrongs” testimony, which ER 404(b) requires a trial court to *exclude* (unless it is admissible to prove some element of a claim or defense such as motive, opportunity, or intent, none of which were at issue or relevant here). See Tegland, 5 *Wash. Prac., Evidence Law and Practice*, § 404.10 (5th ed. 2007) (ER 404(b) is “based upon the belief that [other wrongs] evidence is too prejudicial – that despite its probative value, *the evidence is likely to be overvalued by the jury, and the jury is too likely to jump to a conclusion of guilt without considering other evidence presented at trial*” [emphasis supplied]). Thus, to be admissible under ER 404(b), “other wrongs” evidence “must be relevant to a material issue [in the case] and its probative value must outweigh its prejudicial effect.” *State v. Everybodytalksabout*, 145 Wn.2d 456, 465-66, 39 P.3d 294 (2002). As Tegland explains:

The clear trend is towards excluding [other wrongs] evidence unless a careful analysis shows that the evidence truly is probative on a disputed, material issue, other than the person's general tendency towards misconduct. The newer federal cases are to the same effect. And even if the evidence does relate to a disputed, material issue, the court should carefully consider the prejudicial effect of the evidence and admit the evidence only if its probative value outweighs its prejudicial effect. [Footnotes omitted.]

Tegland, 5 *Wash. Prac.* at § 404.17.

Testimony by Nurse Mahlmeister that the charting, the request that Mrs. Tavares gently tug on her Foley catheter, or Nurse Short's alleged failure to attend a "formal" fetal monitoring course constituted negligence, or a violation of the standard of care, served only to create prejudice; it had no probative value as to any material issue in the case against which to weigh its prejudicial effect. *See* ER 403. Nor was the admission of such testimony harmless. Indeed, any argument that its admission was harmless, is belied by the emphasis the Tavareses' counsel placed on it opening statement, 9/8 RP 23, 24 (documentation), in examination of multiple witnesses other than Mahlmeister, 9/15 RP 19-24, 9/23 RP 18-19, 9/30 RP 52-55 (charting), 9/11 RP 169-74 (fetal monitoring training), 9/11 RP 199-202 (Foley catheter), and in closing argument, 10/1 RP 10-11 (fetal monitoring training, and Foley catheter). That the jury took note of the claims of negligence in charting and in Nurse Short's not having attend

formal fetal monitoring training is apparent, as the jurors themselves asked questions of the nurses about them. See 9/23 RP 26, 9/30 RP 64-66.

D. The Trial Court Erred in Giving Court's Instruction Nos. 21 and 22 and In Refusing to Give Evergreen's Proposed Instruction No. 24.

Over Evergreen's exceptions, 10/1 RP 108, 113-14; CP 2108-09, the trial court gave Court's Instruction Nos. 21 (CP 2318, WPI 30.18.01 – Particular Susceptibility) and 22 (CP 2319, a non-pattern instruction that assigned the burden of segregating injury to Evergreen and made Evergreen liable for the entirety of any indivisible injury), and refused to give Evergreen's Proposed Instruction No. 24 (CP 2204, WPI 30.17 – Aggravation of Pre-Existing Condition). The trial court erred in so doing.

1. Standard of review.

“Jury instructions must be relevant to the evidence presented.”

State v. Linehan, 147 Wn.2d 638, 643, 56 P.3d 542 (2002).

The standard of review we apply to jury instructions depends on the decision under review. The instructions must be sufficient to allow the parties to argue their theory of the case. *Havens v. C & D Plastics, Inc.*, 124 Wn.2d 158, 165, 876 P.2d 435 (1994). Whether or not that standard has been met is a question of law. *Cox v. Spangler*, 141 Wn.2d 432, 442, 5 P.3d 1265, 22 P.3d 791 (2000). And, of course whether the court's instructions to the jury are accurate statements of the law is also a question of law that we review de novo. *State v. Becklin*, 163 Wn.2d 519, 525 182 P.3d 944 (2008). But once these threshold requirements have been met, we then review the judge's wording, choice, or the number of instructions for abuse of discretion. *Stiley v. Block*, 130 Wn.2d 486, 925 P.2d 194 (1996).

Burchfiel v. The Boeing Corp., 149 Wn. App. 468, 491, 205 P.3d 145 (2009). “[A]n instruction’s erroneous statement of the law is reversible error where it prejudices a party.” *Hue v. Farmboy Spray Co., Inc.*, 127 Wn.2d 67, 92, 896 P.2d 682 (1995).

The standard of review of a refusal to give a proposed instruction “depends on whether the refusal to give was based upon a matter of law or of fact.” *State v. Walker*, 136 Wn.2d 767, 771, 996 P.2d 883 (1998). “A trial court’s refusal to give instructions to a jury, if based on a factual dispute, is reviewable only for abuse of discretion.” *Id.* at 771-72. “The trial court’s refusal to give an instruction based upon a ruling of law is reviewed de novo.” *Id.* at 772.

Jury instructions are sufficient if they allow the parties to argued their theories of the case, do not mislead the jury and, when taken as a whole, properly inform the jury of the law to applied.

Hue, 127 Wn.2d at 92.

2. It was error to give Court’s Instruction Nos. 21 and 22 and to refuse to give Evergreen’s Proposed Instruction No. 24.

Evergreen’s theory of the case was that, not only had it not been negligent, but also that Miriam injuries had already occurred before her mother arrived at the hospital. Evergreen presented substantial evidence that Miriam had already sustained injury and brain damage prior to her

mother's arrival at Evergreen on May 30, 2003.¹⁶ Evergreen's position was that it was not responsible for any injuries that Miriam sustained prior to her mother's arrival at the hospital, and that, at most, it would be responsible for any aggravation of Miriam's pre-existing injury that the Tavareses could prove was proximately caused by its alleged negligence.

WPI 30.17 is the approved pattern instruction for aggravation of injury, which provides:

If your verdict is for the plaintiffs, and if you find that:

(1) before this occurrence the plaintiff had a pre-existing bodily/mental condition that was not causing pain or disability; and

(2) because of this occurrence the condition or the pain or the disability was aggravated,

then you should consider the degree to which the condition or the pain or the disability was aggravated by this occurrence.

However, you should not consider any condition or disability that may have existed prior to this occurrence, or from which the plaintiff may now be suffering, that was not caused or contributed to by this occurrence.

Although Evergreen proposed this instruction, CP 2204, the trial court declined to give it, apparently finding that a fetus could not have an injury causing pain and disability that could be aggravated. *See* CP 2629. This

¹⁶ See pages 21-24 *supra*. Even the Tavareses' expert neuroradiologist gave a range of time for Miriam's injuries that included time before her mother's arrival at the hospital. 9/16 RP 65-67, 95-97. And, Dr. Nageotte and Dr. Glass conceded the possibility that the placental abruption occurred before Mrs. Tavares went into the hospital. 9/8 RP 151-52, 164; 9/9 RP 184.

was not only error, but contrary to the expert testimony Evergreen presented, and the failure to give Evergreen's proposed aggravation of injury instruction deprived Evergreen of the ability to argue its theory of the case.

Instead the aggravation of injury instruction, the court gave, as its Instruction No. 21, WPI 30.18.01, the particular susceptibility instruction proposed by the Tavareses, CP 2134, which told the jury:

If your verdict is for the plaintiff, and if you find that:

- (1) before this occurrence the plaintiff had a bodily condition that was not causing pain or disability; and
- (2) the condition made the plaintiff more susceptible to injury than a person in normal health, then you should consider all the injuries and damages that were proximately caused by the occurrence, even though those injuries, due to the pre-existing condition, may have been greater than those that would have been incurred under the same circumstances by a person without that condition.

There may be no recovery, however, for any injuries or disabilities that would have resulted from natural progression of the pre-existing condition even without this occurrence [sic].

The giving of this instruction was error as well because the Tavareses did not present substantial evidence establishing, to a reasonable degree of medical probability, that Miriam's pre-existing conditions made her more susceptible to the injuries they claim were proximately caused by Evergreen's alleged negligence. Indeed, it was plaintiff's claim that Miriam was not injured at all before her mother's arrival at Evergreen, not

that some pre-existing injury made her more susceptible to injury. “Jury instructions must be relevant to the evidence presented.” *State v. Linehan*, 147 Wn.2d at 643.

Even if there were substantial evidence supporting the giving of the particular susceptibility instruction, that did not mean that it was proper for the trial court to refuse to give Evergreen’s proposed aggravation of injury instruction. As the Note on Use to WPI 30.17, the aggravation of injury instruction, makes clear:

Use this instruction if the pre-existing condition was causing pain or disability. If the pre-existing condition was merely an infirmity that was not causing pain or disability, use WPI 30.18 or 30.18.01. If the evidence is in dispute as to the existence of such pre-existing pain or disability, use both instructions.

Nor was it proper for the trial court to give Court’s Instruction No. 22, CP 2319, proposed by the Tavareses, CP 2175, which told the jury:

If you find that the defendant was negligent and was a proximate cause of plaintiff’s injury, and if you find that any brain injury to plaintiff Miriam Tavares occurred both before and after she arrived at the defendant hospital on May 30, 2003, then the defendant hospital has the burden of proof for segregating that injury before and after she arrived at the hospital. If you further find that that injury is indivisible, then the defendant hospital is responsible for the entire injury.

It was error to give this instruction for several reasons. First, Instruction No. 22 is not a pattern jury instruction, nor has it ever been approved for use in a medical malpractice case. Second, the Tavareses did not meet

their burden of proving that Miriam's injuries, or some component of them, were indivisible from her pre-existing injuries.

Third, the factual circumstances under which the court in *Cox v. Spangler*, 141 Wn.2d 431, 442-43, 5 P.3d 1265, 22 P.3d 791 (2001), approved the giving of this instruction do not exist here. This is not a case involving a claim of an indivisible injury caused by "successive tortfeasors" that would warrant shifting the burden to the defendants of segregating damages between them. Evergreen was the only alleged tortfeasor, and the Tavareses had the burden of proving what, if any, damages were proximately caused by Evergreen's alleged negligence. RCW 4.24.290; RCW 7.70.040; see also *Wagner v. Monteilh*, 43 Wn. App. 908, 910-12, 720 P.2d 847, rev. denied, 106 Wn.2d 1014 (1986) (in case involving alleged negligence in treating a hand injury, jury properly instructed that plaintiff had burden of proving defendant's negligence and that such negligence proximately caused him injury, and that defendant was not liable for damages caused by the initial injury).

Finally, Instruction No. 22 impermissibly and prejudicially allowed the jury, if it thought the injuries could not be divided, to hold Evergreen liable for pre-existing injuries that Evergreen did not cause. That is not and should not be the law. "[A]n instruction's erroneous

statement of the law is reversible error where it prejudices a party.” *Hue*, 127 Wn.2d at 92.

The trial court prejudicially erred in giving Court’s Instructions Nos. 21 and 22, and in failing to give Evergreen’s proposed aggravation of injury instruction. The trial court further abused its discretion in failing to grant Evergreen’s motion for new trial that was based in part on the giving of the indivisible injury instruction and the failure to give the requested aggravation of injury instruction. *See* CP 2629-31.

E. The Trial Court Erred in Giving Court’s Instruction No. 14, Elevating a JCAHO Standard to the Force and Effect of Law.

Evergreen excepted to Court’s Instruction No. 14, CP 2314, on the grounds that it was taken from a JCAHO standard, which does not have the force of law, and because it gave undue emphasis to the Tavareses’ theories of the case. 10/1 RP 109; *see also* CP 2105. Instruction No. 14 told the jury:

The hospital is required to provide an adequate number of staff members whose qualifications are consistent with job responsibilities.

The instruction directly quoted a JCAHO standard (Standard HR.2) that had been admitted into evidence, Ex. 222, and not just as an illustrative exhibit, *see* CP 2345.

The court’s decision to instruct on, and not just to admit evidence of, the JCAHO standard, and thereby to elevate the JCAHO above the

status of evidence and to the status of law, was reversible error precisely for the reason the defense gave for objecting: the instruction unduly emphasized, and in an erroneous way, the Tavareses' theory concerning the import of the JCAHO standard and its alleged breach, and gave the JCAHO standard the force of law. Instead of being told to *weigh* the evidence presented concerning the JCAHO standard along with other evidence as to what was the standard of care required, the jury was told that the JCAHO standard was *the law*. The JCAHO standard was evidence of the standard of care, and nothing more. *See Folden v. Robinson*, 58 Wn.2d 760, 762-65, 364 P.2d 924 (1961 (prejudicial error to instruct jury that provisions of National Electric Code were the law in Washington State); *Pfeiffer v. Eagle Manuf. Co.*, 771 F. Supp. 1133, 1136 (D. Kan. 1991) (standards of private voluntary organizations do not have "the force of law").¹⁷ The court erred in giving Instruction No. 14, and the error was not harmless, especially given the emphasis the Tavareses' counsel placed on it in closing argument to bolster his arguments about the Tavareses' inadequate staffing claim, 10/1 RP 8:

[Y]ou're instructed in jury instruction 14, the hospital is required to provide an adequate number of staff members, this is the JCAHO, the national staffing rule.

¹⁷ JCAHO standards are standards voluntarily adopted by hospitals. *See Pedroza v. Bryant*, 101 Wn.2d 226, , 233, 677 P.2d 166 (1984); *Bays v. St. Lukes Hosp.*, 63 Wn. App. 876, 885, 825 P.2d 319, *rev. denied*, 119 Wn.2d 1008 (1992),

F. The Trial Court Abused Its Discretion in Admitting Nurse Alati's Evaluation Statement Made Several Months Before the Treatment at Issue that What Satisfied Her Least About Her Job Was "Unsafe Staffing and Management Instability".

As part of the evaluation process, Evergreen's nurses are asked to critique their own performance and areas for improvement, and to tell Evergreen what satisfies them most and least about their job. *See* Ex. 56. In her 2003 yearly evaluation dated 2/21/03, Nurse Alati wrote that what satisfied her least about her job was "unsafe staffing, management instability." . . . Evergreen moved in limine, CP 1122-25, to limit any evidence or reference to inadequate staffing to the night in question, May 30, 2003, and to exclude Nurse Alati's evaluation statement made back in February 21, 2003. Evergreen argued that no expert had testified that there were not enough labor and delivery nurses working the night in question, and that Nurse Alati's statement made several months before does not show or mean that there was inadequate staffing on May 30. 9/5 RP 236-37. The trial court denied the motion, stating: "The issue of adequacy of staffing is not just a numeric issue." 9/5 RP 237.

At trial, the Tavareses' nursing expert, Nurse Mahlmeister, stated her reasons for her opinion that Evergreen did not provide enough qualified nurses to provide for Mrs. Tavares' needs were that Nurse Short had not completed an advanced fetal monitoring course and had stated in

her own evaluation that she felt insecure with some aspects of providing nursing care to labor and delivery patients, 9/15 RP 121-23, and that there was only one charge nurse on duty, 9/15 RP 163. The Tavareses presented no evidence that Nurse Alati's evaluation statement about "unsafe staffing or management instability" had anything to do with Nurse Short's fetal monitoring training or insecurity, or the fact that there are not more than one charge nurses on duty at a time. Nurse Alati certainly did not so testify. Rather, she testified that Nurse Short (Carolyn) is "fabulous," 9/30 RP 204, and that what she was trying to get across in her evaluation statement about "unsafe staffing" was that she wanted to make sure management would renew the travelling nurses' contracts and they would not lose them. 9/30 RP 213.

Under the circumstances, evidence of Nurse Alati's February 2003 evaluation statement about "unsafe staffing and management instability," had no tendency to make the determination of whether there was unsafe staffing on May 30 more probable or less probable than it would be without the evidence. Thus, it was not relevant under ER 401. And, even if it had some marginal relevance, its probative value was substantially outweighed by the danger of unfair prejudice, such that it should have been excluded under ER 403.

The denial of the motion in limine and the admission of the evidence was prejudicial, as evidenced by the use the Tavares' counsel made of it in opening statement, when he asserted that "[t]he hospital's records show that this hospital's management ignored its own labor and delivery nurses warnings of unsafe staffing," and that "Nurse Mahlmeister will testify that Evergreen Hospital violated the standard of care by ignoring its nurses' warnings about unsafe staffing," 9/8 RP 31-32, as well as the use he made of it in closing, when he argued again that the hospital ignored Nurse Alati's warnings and did not follow-up. 9/30 RP 8-9. There simply was no evidence that Nurse Alati's evaluation statement had anything to do with Nurse Short's competency or the number of charge nurses, such that acting on it would have made any difference here.

G. The Trial Court's Erroneous Rulings, Whether Viewed Singly or Cumulatively, Were Not Harmless and Deprived Evergreen of a Fair Trial.

If this Court does not reverse the trial court's denial of Evergreen Hospital's motions for judgment as a matter of law and remand for entry of judgment in the hospital's favor, then, based on the accumulation of the trial court's legal, evidentiary, and instructional errors that prejudiced Evergreen and deprived it of a fair trial, the Court should reverse the judgment on the jury's verdict and remand for a new trial. What the court

stated in *State v. Coe*, 101 Wn.2d 772, 789, 684 P.2d 668 (1984) (citations omitted), is equally apt here:

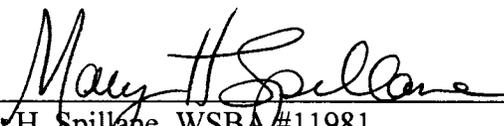
While it is possible that some of these errors, standing alone, might not be of sufficient gravity to constitute grounds for a new trial, the combined effect of the accumulation of errors most certainly requires a new trial.

V. CONCLUSION

Because plaintiffs failed to establish proximate cause, the trial court's denials of Evergreen's motions for judgment as a matter of law and JNOV should be reversed and the case remanded for entry of judgment in favor of Evergreen. Alternatively, the trial court's multiple other erroneous legal and evidentiary rulings should be reversed and the case remanded for a new trial consistent with this Court's opinion.

RESPECTFULLY SUBMITTED this 22nd day of June, 2009.

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APPENDIX A

WAC 246-320-365 Specialized patient care services. The purpose of the specialized patient care services section is to guide the development of the plan for patient care. This is accomplished by ensuring availability of materials and resources and through establishing, monitoring, and enforcing policies and procedures that promote the delivery of quality health care in specialized patient care areas.

Hospitals will:

- (1) Meet the requirements in Inpatient care services, WAC 246-320-345;
- (2) Adopt and implement policies and procedures which address accepted standards of care for each specialty service;
- (3) Assure physician oversight for each specialty service by a physician with experience in those specialized services;
- (4) Assure staff for each nursing service area are supervised by a registered nurse who provides a leadership role to plan, provide, and coordinate care;
- (5) If providing surgery and interventional services:
 - (a) Adopt and implement policies and procedures that address appropriate access:
 - (i) To areas where invasive procedures are performed; and
 - (ii) To information regarding practitioner's delineated privileges for operating room staff;
 - (b) Provide:
 - (i) Emergency equipment, supplies, and services available in a timely manner and appropriate for the scope of service; and
 - (ii) Separate refrigerated storage equipment with temperature alarms, when blood is stored in the surgical department;
- (6) If providing a post anesthesia recovery unit (PACU), adopt and implement written policies and procedures requiring:
 - (a) The availability of an authorized practitioner in the facility capable of managing complications and providing cardiopulmonary resuscitation for patients when patients are in the PACU; and
 - (b) The immediate availability to the PACU of a registered nurse trained and current in advanced cardiac life support measures;
- (7) If providing obstetrical services:
 - (a) Have **capability** to perform cesarean sections twenty-four hours per day; or
 - (b) Meet the following criteria when the hospital does not have twenty-four hour cesarean **capability**:
 - (i) Limit planned obstetrical admissions to "low risk" obstetrical patients as defined in WAC 246-329-010(13) childbirth centers;

(ii) Inform each obstetrical patient in writing, prior to the planned admission, of the hospital's limited obstetrical services as well as the transportation and transfer agreements;

(iii) Maintain current written agreements for adequately staffed ambulance and/or air transport services to be available twenty-four hours per day; and

(iv) Maintain current written agreements with another hospital to admit the transferred obstetrical patients;

(c) Ensure one licensed nurse trained in neonatal resuscitation is in the hospital when infants are present;

(8) If providing an intermediate care nursery, have nursing, laboratory, pharmacy, radiology, and respiratory care services appropriate for infants:

(a) Available in a timely manner; and

(b) In the hospital during assisted ventilation;

(c) Ensure one licensed nurse trained in neonatal resuscitation is in the hospital when infants are present;

(9) If providing a neonatal intensive care nursery, have:

(a) Nursing, laboratory, pharmacy, radiology, and respiratory care services appropriate for neonates available in the hospital at all times;

(b) An anesthesia practitioner, neonatologist, and a pharmacist on call and available in a timely manner twenty-four hours a day; and

(c) One licensed nurse trained in neonatal resuscitation in the hospital when infants are present;

(10) If providing a critical care unit or services, have:

(a) At least two licensed nursing personnel skilled and trained in care of critical care patients on duty in the hospital at all times when patients are present, and:

(i) Immediately available to provide care to patients admitted to the critical care area; and

(ii) Trained and current in cardiopulmonary resuscitation including at least one registered nurse with:

(A) Training in the safe and effective use of the specialized equipment and procedures employed in the particular area; and

(B) Successful completion of an advanced cardiac life support training program; and

(b) Laboratory, radiology, and respiratory care services available in a timely manner;

(11) If providing an alcoholism and/or chemical dependency unit or services:

(a) Adopt and implement policies and procedures that address development, implementation, and review of the individualized treatment plan, including the participation of the multidisciplinary treatment team, the patient, and the family, as appropriate;

(b) Ensure provision of patient privacy for interviewing, group and individual counseling, physical examinations, and social activities of patients; and

(c) Provide staff in accordance with WAC 246-324-170(3);

(12) If providing a psychiatric unit or services:

(a) Adopt and implement policies and procedures that address development, implementation, and review of the individualized treatment plan, including the participation of the multidisciplinary treatment team, the patient, and the family, as appropriate;

(b) Ensure provision of patient privacy for interviewing, group and individual counseling, physical examinations, and social activities of patients;

(c) Provide staff in accordance with WAC 246-322-170(3); and

(d) Provide:

(i) Separate patient sleeping rooms for children and adults;

(ii) Access to at least one seclusion room;

(iii) For close observation of patients;

(13) If providing a long-term care unit or services, provide an activities program designed to encourage each long-term care patient to maintain or attain normal activity and achieve an optimal level of independence;

(14) If providing an emergency care unit or services, provide basic, outpatient emergency care including:

(a) **Capability** to perform emergency triage and medical screening exam twenty-four hours per day;

(b) At least one registered nurse skilled and trained in care of emergency department patients on duty in the hospital at all times, and:

(i) Immediately available to provide care; and

(ii) Trained and current in advanced cardiac life support;

(c) Names and telephone numbers of medical and other staff on call must be posted; and

(d) Communication with agencies as indicated by patient condition;

(15) If providing renal dialysis service:

(a) Meet the *Association for the Advancement of Medical Instrumentation (AAMI) Standards*,

Dialysis Edition, 2005:

- (i) The cleaning and sterilization procedures if dialyzers are reused;
 - (ii) Water treatment, if necessary to ensure water quality; and
 - (iii) Water testing for bacterial contamination and chemical purity;
- (b) Test dialysis machine for bacterial contamination monthly or demonstrate a quality assurance program establishing effectiveness of disinfection methods and intervals;
- (c) Take appropriate measures to prevent contamination, including backflow prevention in accordance with the state plumbing code;
- (d) Provide for the availability of any special dialyzing solutions required by a patient; and
- (e) Through a contract provider, that provider must meet the requirements in this **section**.

[Statutory Authority: Chapter 70.41 RCW. 08-14-023, § 246-320-365, filed 6/20/08, effective 7/21/08. Statutory Authority: RCW 70.41.030 and 43.70.040. 99-04-052, § 246-320-365, filed 1/28/99, effective 3/10/99.]

CERTIFICATE OF SERVICE

I hereby certify under penalty of perjury that under the laws of the State of Washington that on the 22nd day of June, 2009, I caused a true and correct copy of the foregoing document, "Brief of Appellant," to be delivered by U.S. mail, postage prepaid, to the following counsel of record:

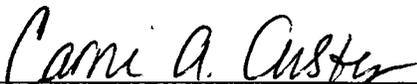
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