

NO. 44388-1-II

IN THE COURT OF APPEALS STATE OF WASHINGTON  
AT DIVISION II

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KEVIN ANDERSON,

Appellant/Plaintiff,

v.

CHARLES HAMON, M.D.,

Defendants/Respondents.

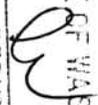
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BRIEF OF RESPONDENT CHARLES B. HAMON, M.D.

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**TABLE OF CONTENTS**

	<b>Page</b>
I. INTRODUCTION.....	1
II. ASSIGNMENTS OF ERROR.....	3
III. STATEMENT OF THE CASE .....	4
A. Mr. Anderson was diagnosed with sinusitis in Hawaii, his symptoms continued and worsened, and he refused to seek further treatment for almost two months. ....	4
B. Mr. Anderson sought treatment with Dr. Hamon, and an exam did not reveal any neurological abnormalities. ....	5
C. Mr. Anderson’s condition deteriorated after leaving Dr. Hamon’s office, and 911 was called.....	7
D. Mr. Anderson was airlifted to Harborview, where a CT scan revealed a brain abscess, and he underwent two craniotomies.....	8
E. Mr. Anderson sued Dr. Hamon for medical negligence. ....	10
F. Discovery revealed multiple indications of Mr. Anderson’s pre- and post-injury use of illegal drugs.....	10
G. Mr. Anderson unsuccessfully moved in limine to exclude all evidence of his prior drug use.....	12
H. Mr. Anderson repeatedly and unsuccessfully sought reconsideration of the trial court’s July 5, 2012 Order.....	13
I. During the November 2012 trial, all the admitted drug evidence was limited to the issues of causation, damages, and contributory negligence. ....	16
J. The jury returned a verdict for Dr. Hamon, concluding that he met the standard of care. ....	18
IV. SUMMARY OF ARGUMENT.....	19
V. ARGUMENT.....	20
A. This court should ignore major portions of Mr. Anderson’s Statement of the Case. ....	20
B. Mr. Anderson has the substantial burden of demonstrating that the trial court abused its discretion. ....	21

1.	A trial court’s decision to admit evidence is reviewed for abuse of discretion.....	21
2.	Mr. Anderson bears the burden of demonstrating that the trial court manifestly abused its discretion. ....	21
3.	This court may affirm the trial court’s decisions on any basis supported by the record.....	22
C.	Mr. Anderson abandoned multiple grounds under which he argued the drug evidence should have been excluded. .	23
D.	The trial court properly exercised its sound discretion in admitting evidence of Mr. Anderson’s prior drug use, which was highly relevant to causation, damages, and contributory negligence. ....	24
1.	Relevancy is defined extremely broadly. ....	24
2.	The evidence of Mr. Anderson’s pre-injury use of cocaine and methamphetamine was highly relevant to causation and damages. ....	25
3.	The evidence of Mr. Anderson’s use of cocaine and methamphetamine was highly relevant to Dr. Hamon’s defense of contributory negligence. ....	31
E.	The risk of unfair prejudice in admitting the limited pre-injury evidence of drug use did not substantially outweigh the high probative value. ....	34
1.	Exclusion under ER 403 is an extraordinary remedy, and relevant evidence is presumed admissible. ....	35
2.	The high probative value of the drug evidence was not substantially outweighed by the risk of prejudice to Mr. Anderson.....	36
3.	The trial court actively minimized any risk of unfair prejudice against Mr. Anderson.....	38
4.	Mr. Anderson’s arguments on the ER 403 issue are without factual or legal merit.....	39

F.	Even if admitting the drug evidence were error, it was harmless, because the jury never reached the issues on which it was admitted and is presumed to follow the jury instructions.....	43
1.	Mr. Anderson must demonstrate that the limited admission of the drug evidence would have changed the jury’s conclusion.....	44
2.	The jury never reached the issues on which the drug evidence was admitted.....	45
3.	The jury is presumed to have followed its instructions to decide the case on the evidence and not on prejudice. ....	47
4.	The case law Mr. Anderson cites does not apply to the harmful-error analysis that governs here. ....	48
VI.	CONCLUSION .....	50

## TABLE OF AUTHORITIES

Page(s)

### Table of Cases

#### Federal Cases

<i>Alpha v. Hooper</i> , 440 F.3d 670 (5th Cir. 2006).....	43
<i>Dillon v. Nissan Motor Co., Ltd.</i> , 986 F.2d 263 (8th Cir. 1993) .....	43
<i>Larkins v. Farrell Lines, Inc.</i> , 806 F.2d 510 (4th Cir. 1986).....	43
<i>Phillips v. Hillcrest Med. Ctr.</i> , 244 F.3d 790 (10th Cir. 2001) .....	43

#### State Cases

<i>Abel v. Abel</i> , 47 Wn.2d 816, 289 P.2d 724 (1955) .....	22
<i>Adcox v. Children's Hosp. and Med. Ctr.</i> , 123 Wn.2d 15, 864 P.2d 921 (1993).....	44
<i>Adkins v. Alum. Co. of America</i> , 110 Wn.2d 128, 750 P.2d 1257 (1988).....	48, 49
<i>Bertsch v. Brewer</i> , 97 Wn.2d 83, 640 P.2d 711 (1982).....	32, 45
<i>Carson v. Fine</i> , 123 Wn.2d 206, 867 P.2d 610 (1994).....	35, 36, 39
<i>City of Bellevue v. Kravik</i> , 69 Wn. App. 735, 850 P.2d 559 (1993) .....	47
<i>Cobb v. Snohomish County</i> , 86 Wn. App. 223, 935 P.2d 1384 (1997) .....	45
<i>Davidson v. Mun. of Metro. Seattle</i> , 43 Wn. App. 569, 719 P.2d 569 (1986).....	24
<i>Davis v. Globe Mach. Mfg. Co.</i> , 102 Wn.2d 68, 684 P.2d 692 (1984) .....	28
<i>Devine v. Goggin</i> , 69 Wn.2d 144, 417 P.2d 606 (1966) .....	22
<i>Dykstra v. County of Skagit</i> , 97 Wn. App. 670, 985 P.2d 424 (1999).....	23
<i>Erickson v. Robert F. Ferr, M.D., P.S., Inc.</i> , 125 Wn.2d 183, 883 P.2d 313 (1994) .....	35
<i>ESCA Corp. v. KPMG Peat Marwick</i> , 135 Wn.2d 820, 959 P.2d 651 (1998).....	32
<i>Estate of Stalkup v. Vancouver Clinic, Inc., P.S.</i> , 145 Wn. App. 572, 187 P.3d 291 (2008) .....	26, 28
<i>Ford v. Chaplin</i> , 61 Wn. App. 896, 812 P.2d 532 (1991).....	45
<i>Geschwind v. Flanagan</i> , 121 Wn.2d 833, 854 P.2d 1061 (1993) .....	32
<i>Gjerde v. Fritzsche</i> , 55 Wn. App. 387, 777 P.2d 1072 (1989).....	32
<i>Gross v. City of Lynnwood</i> , 90 Wn.2d 395, 583 P.2d 1197 (1978).....	22

<i>Havens v. C &amp; D Plastics, Inc.</i> , 124 Wn.2d 158, 876 P.2d 435 (1994) ....	24
<i>Hayes v. Weber Enter., Inc.</i> , 105 Wn. App. 611, 20 P.3d 496 (2001).....	35, 37
<i>Henderson v. Tyrell</i> , 80 Wn. App. 592, 910 P.2d 522 (1996).....	44, 45
<i>Hickok-Knight v. Wal-Mart Stores, Inc.</i> , 170 Wn. App. 279, 284 P.3d 749 (2012) .....	21
<i>Hizey v. Carpenter</i> , 119 Wn.2d 251, 830 P.2d 646 (1992) .....	21
<i>Holland v. City of Tacoma</i> , 90 Wn. App. 533, 954 P.2d 290 (1998) .....	23
<i>Jaeger v. Cleaver Const., Inc.</i> , 148 Wn. App. 698, 201 P.3d 1028 (2009).....	31
<i>Huston v. First Church of God</i> , 46 Wn. App. 740, 732 P.2d 173 (1987).....	31
<i>James S. Black &amp; Co. v. P &amp; R Co.</i> , 12 Wn. App. 533, 530 P.2d 722 (1975).....	44, 45
<i>Janson v. North Valley Hosp.</i> , 93 Wn. App. 892, 971 P.2d 67 (1999).....	25
<i>Jones v. Bowie Indus.</i> , 282 P.3d 316 (Alaska 2012) .....	42
<i>Kramer v. J.I. Case Mfg. Co.</i> , 62 Wn. App. 544, 815 P.2d 798 (1991) ....	45
<i>Lamborn v. Phillips Pac. Chem. Co.</i> , 89 Wn.2d 701, 575 P.2d 215 (1978).....	24, 34
<i>LaMon v. Butler</i> , 112 Wn.2d 193, 770 P.2d 1027 (1989) .....	22
<i>Lawson v. Boeing Co.</i> , 58 Wn. App. 261, 792 P.2d 545 (1990) .....	20
<i>Lewis v. Simpson Timber Co.</i> , 145 Wn. App. 302, 189 P.3d 178 (2008).....	22
<i>Lockwood v. AC &amp; S, Inc.</i> , 109 Wn.2d 235, 744 P.2d 605 (1987) .....	36
<i>Lockwood v. AC &amp; S, Inc.</i> , 44 Wn. App. 330, 722 P.2d 826 (1986) .....	35
<i>Maicke v. RDH, Inc.</i> , 37 Wn. App. 750, 683 P.2d 227 (1984).....	22, 45
<i>Mavroudis v. Pittsburgh-Corning Corp.</i> , 86 Wn. App. 22, 935 P.2d 864 (1997).....	45
<i>Mayer v. Sto Indus., Inc.</i> , 156 Wn.2d 677, 132 P.3d 115 (2006) .....	21
<i>McCarson v. Foreman</i> , 692 P.2d 537, 542 (N.M. 1984).....	43
<i>Nichols v. Lackie</i> , 58 Wn. App. 904, 795 P.2d 722 (1990).....	47
<i>Northlake Marine Works, Inc. v. City of Seattle</i> , 70 Wn. App. 491, 513, 857 P.2d 283 (1993) .....	20
<i>Raum v. City of Bellevue</i> , 171 Wn. App. 124, 286 P.3d 695 (2012) .....	23
<i>Rice v. Janovich</i> , 109 Wn.2d 48, 742 P.2d 1230 (1987) .....	44

<i>Rounds v. Nelicor Puritan Bennett, Inc.</i> , 147 Wn. App. 155, 194 P.3d 274 (2008) .....	25, 26
<i>Salas v. Hi-Tech Erectors</i> , 168 Wn.2d 664, 230 P.3d 583 (2010).....	24, 29, 49
<i>Scott v. Rainbow Ambulance Serv., Inc.</i> , 75 Wn.2d 494, 452 P.2d 220 (1969).....	28
<i>Smith v. Rodene</i> , 69 Wn.2d 482, 418 P.2d 741 (1966).....	28
<i>State v. Coe</i> , 101 Wn.2d 772, 684 P.2d 668 (1984) .....	39
<i>State v. Gould</i> , 58 Wn. App. 175, 791 P.2d 569 (1990).....	36
<i>Stoneman v. Wick Const. Co.</i> , 55 Wn.2d 639, 349 P.2d 215 (1960).....	28
<i>Vandercook v. Reece</i> , 120 Wn. App. 647, 86 P.3d 206 (2004).....	47

**Statutes**

RCW 4.22.005 .....	32
RCW 7.70.030(1) .....	25
RCW 7.70.040(2) .....	2, 25, 28

**Rules and Regulations**

CR 59(a) .....	14
RAP 10.3(a)(5) .....	20
RAP 10.3(a)(6) .....	20
RAP 10.(f) .....	20
RAP 17.1(a).....	24
RAP 18.9(a).....	24

**Other Authority**

Tegland, 2A Wash. Prac., <i>Rules Practice</i> RAP 2.5 (7th ed. 2013) .....	22
Tegland, 5 Wash. Prac., <i>Evidence Law &amp; Practice</i> § 103.23 (5th ed. 2013).....	22
Tegland, 5 Wash. Prac., <i>Evid. Law &amp; Practice</i> § 103.24 (5th ed. 2013).....	44
Tegland, 5 Wash. Prac., <i>Evidence Law and Practice</i> § 403.1 (5th ed. 2013).....	37
Tegland, 5D Wash. Prac., <i>Handbook Wash. Evid.</i> ER 403 (2012-13 ed) .....	36

## I. INTRODUCTION

This medical-malpractice case involves the care and treatment that Defendant-Respondent Dr. Charles Hamon provided to Plaintiff-Appellant Kevin Anderson. Mr. Anderson brought a medical-malpractice action in Kitsap County Superior Court that went to a three-week jury trial in November 2012.

Mr. Anderson developed a sinus infection in March 2006. He then failed to follow medical advice, and as a result, his infection was incompletely treated and spread to his brain. He saw Dr. Hamon only once, on May 11, 2006, one day before his abscess was diagnosed and treated. Mr. Anderson alleged that Dr. Hamon should have diagnosed his brain abscess one day earlier or ordered emergent imaging testing.

The jury found that Dr. Hamon met the standard of care. It did not address proximate cause or contributory fault.

The limited issue on appeal is whether the trial court, Judge Sally F. Olsen, abused her discretion in allowing limited evidence of Mr. Anderson's pre-injury use of cocaine and methamphetamine, both of which are applied through the nasal passages. The pre-trial briefing on this issue was voluminous. The trial court's rulings were careful and well-reasoned. This court should affirm them. The evidence was directly relevant to Mr. Anderson's burden of proving proximate cause under

RCW 7.70.040(2). Under these facts, this burden required him to segregate those injuries caused by the one-day delay in diagnosis and treatment from those that would have occurred in any event. Defense expert Dr. Michael Kovar testified that Mr. Anderson's "snorting" cocaine through his nose contributed significantly to the spread of his sinus infection to his brain.

This evidence was also directly relevant to Dr. Hamon's contributory-negligence defense. It was undisputed that, regardless of Dr. Hamon's conduct, Mr. Anderson's brain abscess would have required extensive surgical treatment. Defense experts testified that Mr. Anderson's drug use, coupled with his failure to heed instructions to seek further treatment, allowed a routine sinus infection to progress into a brain abscess that undisputedly caused him harm separate from any harm caused by Dr. Hamon's alleged negligence.

The trial court took pains to avoid unfair prejudice to Mr. Anderson by excluding all the drug evidence it believed was not relevant to causation, limiting the admission of the drug evidence to specific issues, and instructing the jury when appropriate. Mr. Anderson's argument does not address the probative value of the evidence, or why the trial court's ER 403 analysis was incorrect, and instead offers only speculation about the "motives" of the defense in seeking to admit the evidence.

Finally, any error was harmless. Although this evidence was directly relevant to proximate cause and contributory fault, the jury found that Dr. Hamon was not negligent, and so did not reach those issues.

## II. ASSIGNMENTS OF ERROR

### *Assignments of Error*

Dr. Hamon assigns no error to the trial court's decisions.

### *Issues Pertaining to Assignments of Error*

(1) Whether the trial court acted within its sound discretion in admitting limited evidence of Mr. Anderson's pre-injury use of cocaine and methamphetamine, when:

- (a) the evidence was highly relevant to Mr. Anderson's ability to (1) prove the proximate-cause element of his claim, and (2) segregate the injuries caused only by Dr. Hamon's alleged negligence;
- (b) the evidence was directly probative of Dr. Hamon's affirmative defense of contributory negligence, as any harm that Mr. Anderson's own negligence caused would proportionately reduce any damage award;
- (c) the risk of unfair prejudice in admitting the evidence did not substantially outweigh its high probative value; and
- (d) the trial court actively minimized any risk of unfair prejudice by limiting the scope of the admitted drug evidence and by excluding

other additional evidence of drug use.

(2) Whether, if the limited admission of the evidence of Mr. Anderson's pre-injury cocaine and methamphetamine use was error, such error was harmless and not requiring reversal, when:

- (a) there was no prejudice to Mr. Anderson because the jury never considered the issue for which the evidence was admitted; and
- (b) the jury is presumed to have followed its instructions to decide the case on the evidence and not on prejudice.

### III. STATEMENT OF THE CASE

**A. Mr. Anderson was diagnosed with sinusitis in Hawaii, his symptoms continued and worsened, and he refused to seek further treatment for almost two months.**

In March 2006, Mr. Anderson sought treatment in Hawaii for a severe headache, associated with fever, photophobia (intolerance to light), nausea, and vomiting. RP (November 7, 2012 Testimony of Jennifer Ray) at 85:4-86:11. Mr. Anderson was diagnosed with a sinus infection and given antibiotics and pain medication. *Id.* at 86:13-86:17.

On March 22, 2006, Mr. Anderson called his then-girlfriend, Jennifer Ray, and said that his symptoms had persisted and worsened. *Id.* at 88:4-88:9. Ms. Ray drove Mr. Anderson to the emergency room shortly thereafter. *Id.* at 88:13-89:13. A CT scan confirmed that his symptoms were caused by a sinus infection; the scan was otherwise negative. *Id.* at

89:21-91:20; RP (November 7, 2012 of Francis Riedo, M.D.) at 211:4-212:5. Mr. Anderson was given a set of written instructions. RP (November 8, 2012 Testimony of Jennifer Ray) at 299:20-299:23.

Mr. Anderson did not seek follow-up treatment despite persisting symptoms, despite instructions from the doctor, and despite multiple pleas from Ms. Ray to seek treatment. RP (November 7, 2012 Testimony of Jennifer Ray) at 95:10-95:23; RP (November 8, 2012 Testimony of Jennifer Ray) at 301:6-302:10. It is also unknown whether Mr. Anderson ever completed his antibiotics. *Id.* at 299:24-300:6.

Almost two months after his diagnosis, Mr. Anderson traveled by plane, first to Arizona, then to the Seattle area. RP (November 7, 2012 Testimony of Jennifer Ray) at 96:4-97:22; 104:19-106:16. His symptoms worsened during this trip, and he finally acceded to seeing a doctor prior to the anticipated flight back to Hawaii. *Id.* at 113:5-113:18.

**B. Mr. Anderson sought treatment with Dr. Hamon, and an exam did not reveal any neurological abnormalities.**

On May 11, 2006, Mr. Anderson went to see Dr. Hamon in Bainbridge Island. *Id.* at 118:10-119:10. Ms. Ray accompanied him. *Id.* at 119:19-121:16. Mr. Anderson related his history, his earlier diagnosis and treatment in Hawaii, and the recent worsening of his symptoms. RP (November 13, 2012 Testimony of Charles Hamon, M.D.) at 619:15-

621:3; RP (November 14, 2012 Testimony of Charles Hamon, M.D.) at 681:12-682:23.

Dr. Hamon's examination, including a neurologic examination, confirmed a sinus infection and no other abnormalities. RP (November 13, 2012 Testimony of Charles Hamon, M.D.) at 635:10-638:14; RP (November 14, 2012 Testimony of Richard Wohns, M.D.) at 757:23-757:25. The optical fundi were benign, with sharp disc margins, indicating normal intracranial cerebrospinal fluid and no increased pressure. RP (November 9, 2012 Testimony of Terrence Davidson, M.D.) at 423:14-423:18; RP (November 14, 2012 Testimony of Charles Hamon, M.D.) at 706:3-709:15. There were no abnormal extraocular movements, retinal hemorrhages, or cranial nerve abnormalities. *Id.* at 708:13-710:23. Dr. Hamon tested Mr. Anderson's gait and station, and Mr. Anderson could walk across the examination room and back effectively. *Id.* at 713:21-715:6.

Dr. Hamon diagnosed an acute sinus infection that had been incompletely treated and was becoming chronic. RP (November 7, 2012 Testimony of Jennifer Ray) at 134:9-134:19. He prescribed antibiotics, a decongestant, and pain medication, and instructed Mr. Anderson to follow up with his primary care provider in Hawaii if he did not improve. *Id.* at 134:17-134:19; RP (November 8, 2012 Testimony of Jennifer Ray) at

329:8-329:11; RP (November 14, 2012 Testimony of Charles Hamon, M.D.) at 671:13-671:16, 675:12-675:18.

**C. Mr. Anderson's condition deteriorated after leaving Dr. Hamon's office, and 911 was called.**

Mr. Anderson went to bed immediately upon arriving at Ms. Ray's mother's house. RP (November 7, 2012 Testimony of Jennifer Ray) at 141:4-142:11. At approximately 8 a.m. the next morning, Ms. Ray found urine on the bathroom floor and Mr. Anderson's pajama bottoms on the bedroom floor, wet with urine. *Id.* at 147:3-148:15; RP (November 8, 2012 Testimony of Jennifer Ray) at 283:20-284:20.

Ms. Ray left to go shopping with her mom, her sister, and her aunt, between 9:30 and 9:45 a.m.; they were gone until about 6:30 p.m. RP (November 7, 2012 Testimony of Jennifer Ray) at 149:15-151:7. When they returned, Mr. Anderson was asleep and "snoring." *Id.* at 150:17-150:25. At about 7:30 p.m., Ms. Ray tried to wake him, but was unsuccessful. *Id.* at 151:13-151:19. Mr. Anderson had wet himself again. RP (November 8, 2012 Testimony of Jennifer Ray) at 292:8-292:10. Ms. Ray called her mother and sister, who were 10 minutes away. RP (November 13, 2012 Testimony of Lynn Ray) at 602:15-603:2. Ms. Ray's sister came to check on Mr. Anderson, and called 911 sometime around 8:15 p.m. *Id.* at 602:24-603:13; RP (November 7, 2012 Testimony of

Jennifer Ray) at 153:2-153:14.

**D. Mr. Anderson was airlifted to Harborview, where a CT scan revealed a brain abscess, and he underwent two craniotomies.**

The responders arrived just before 9 p.m. and found Mr. Anderson unresponsive. *Id.* at 154:3-154:20. He was airlifted to Harborview Medical Center. *Id.* at 154:7-154:20. Ms. Ray arrived at Harborview around 11:00 p.m., and a doctor requested permission to operate because they found an abnormality with Mr. Anderson's brain. *Id.* at 155:16-155:17. A head CT scan revealed a 7-cm abscess in the frontal lobe, behind the frontal sinus; Ms. Ray was told that an infection had grown in Mr. Anderson's brain. *Id.* at 155:18-156:18; RP (November 7, 2012 Testimony of Francis Riedo, M.D.) at 169:14-170:3. He was taken to surgery just after midnight, a craniotomy was performed, and the abscess was drained. *Id.* at 169:16-170:21; RP (November 13, 2012 Testimony of Lynn Anderson) at 471:24-471:25.

Mr. Anderson was placed in the ICU on May 13, 2006. *Id.* at 465:2-465:4. Mr. Anderson underwent a sinus procedure, and on May 28, 2006, he underwent a second craniotomy procedure for drainage of a persistent frontal fluid collection. *Id.* at 471:11-472:16; *id.* at 574:15.

Mr. Anderson still showed several areas of limitation consistent with his brain injury and its treatment, including visual and cognitive

limitations and right-sided hemiplegia. *Id.* at 473:9-473:25, 479:3-479:9, 484:11-484:14.

Mr. Anderson was discharged to his parents' home in Georgia on July 7, 2006; Ms. Ray went with him. RP (November 7, 2012 Testimony of Jennifer Ray) at 157:7-157:23; RP (November 8, 2012 Testimony of Jennifer Ray) at 260:20-261:1. He was prescribed several medications, including anti-seizure medication. RP (November 13, 2012 Testimony of Lynn Anderson) at 538:17-538:21. His progress after his discharge was limited. RP (November 8, 2012 Testimony of Jennifer Ray) at 262:21-264:6; RP (November 14, 2012 Testimony of Rebecca Anderson) at 853:12-854:10.

Mr. Anderson experiences permanent injuries as a result of the brain abscess, herniation, and craniotomies. RP (November 7, 2012 Testimony of Jennifer Ray) at 254:25-256:17. His vision remains compromised, and he has hemiparesis, with right arm and significant hand pain. *Id.*; RP (November 8, 2012 Testimony of Jennifer Ray) at 262:21-263:17; RP (November 14, 2012 Testimony of Richard Wohns, M.D.) at 735:17-736:18. He suffered a seizure in October 2008 after he stopped taking his anti-seizure medications; he regressed after the seizure. RP (November 13, 2012 Testimony of Lynn Anderson) at 525:1-525:5, 536:16-539:3. Mr. Anderson suffered another seizure on March 6, 2009.

*Id.* at 652:8-652:540:13.

**E. Mr. Anderson sued Dr. Hamon for medical negligence.**

On January 13, 2010, Mr. Anderson sued Dr. Hamon for medical negligence in Kitsap County Superior Court. CP 3-8. He alleged that Dr. Hamon was negligent for failing to order “proper imaging testing for Mr. Anderson.” CP 6. In his answer to the complaint, Dr. Hamon specifically alleged the affirmative defense of contributory negligence. CP 357.

**F. Discovery revealed multiple indications of Mr. Anderson’s pre- and post-injury use of illegal drugs.**

The May 12, 2006 Harborview emergency room notes stated that Mr. Anderson had a history of pain pill abuse. CP 309.

A May 13, 2006 patient admission chart written by a nurse at Harborview stated in the “Substance abuse” category that Mr. Anderson had a history of marijuana and crystal meth, and that he quit using pain medications one year ago. CP 310. The same record noted that “[f]riend called and stated patient has current daily cocaine habit.” *Id.*

A May 16, 2006 patient history chart dictated by one of Mr. Anderson’s physicians at Harborview stated, “Of note, friend contacted nursing staff yesterday and endorsed cocaine use by [patient], suggesting possible mechanism for spread of sinusitis.” CP 311.

A May 18, 2006 physical therapy progress note stated that the patient had a history of “daily cocaine and meth use.” CP 312.

A May 19, 2006 occupational therapy note stated that Mr. Anderson “uses tobacco, alcohol, [marijuana], crystal meth, cocaine (daily habit).” CP 313.

A June 2, 2006 Rehabilitation and Consultation note likewise stated under “Family & Social History” that Mr. Anderson had a history of marijuana, crystal meth, and cocaine. CP 314. A social work note produced at Harborview noted the same drug history. CP 315.

A September 28, 2006 letter from one care provider from Savannah Neurology, P.C. in Savannah, Georgia, to another stated that Mr. Anderson’s father “informed me privately that his son has had abuse of narcotics in the past. In fact, Mr. Anderson has [been] asking for narcotics several times during our exam today.” CP 353.

In a April 23, 2007 medical record from Southeastern Orthopedic Center, the physician concluded that Mr. Anderson will be referred to a pain management specialist because “[h]e has a history of **admitted** addictive [personality] to drugs [.]” CP 536 (emphasis added).

On October 3, 2008, more than two years after Mr. Anderson’s brain abscess and surgeries, he tested positive for amphetamines at the East Georgia Regional Medical Center. CP 351.

Ms. Ray, Mr. Anderson’s then-girlfriend, testified at deposition that she knew of Mr. Anderson’s prior use of cocaine, and that she told the

doctors and nurses about it while he was at Harborview. CP 330. She also testified that Mr. Anderson admitted to her, “after everything happened,” that when he came home to Statesboro, Georgia for Christmas in 2005, he used cocaine. CP 331. Ms. Ray also testified that Mr. Anderson admitted to her that he used crystal methamphetamine when he lived in Statesboro. *Id.*

Rebecca Anderson, Mr. Anderson’s mother, testified at deposition that when she was in Seattle after Mr. Anderson was taken to Harborview, a doctor told her that what happened to Mr. Anderson can happen when you use cocaine. CP 349. Lynn Anderson, Mr. Anderson’s father, likewise testified at deposition that one of Mr. Anderson’s doctors told him that “sometimes cocaine use can cause this [.]” CP 344.

**G. Mr. Anderson unsuccessfully moved in limine to exclude all evidence of his prior drug use.**

Before trial, Mr. Anderson filed Plaintiff’s First Motions in Limine re: Drug Use and Limitation of Experts. CP 9-20. He argued that all the evidence of his drug use was irrelevant and prejudicial. CP 12-17. Dr. Hamon opposed the motion, CP 38-53, and offered deposition testimony of family practitioner Dr. Michael Kovar, who testified that cocaine is a risk factor for a sinus infection to become chronic, and potentially lead to a brain abscess: “It’s a direct causative risk factor and a major one.” CP

41; *see* CP 71-85. Dr. Hamon also argued that the evidence of Mr. Anderson's drug use is directly relevant to (1) the cause of his brain abscess and (2) his contributory negligence in allowing a sinus infection progress into a brain abscess. CP 44-45. Dr. Hamon further argued that Mr. Anderson failed to meet the high threshold for excluding evidence under ER 403 because the evidence's probative value as to causation and contributory negligence outweighed the risk of unfair prejudice to Mr. Anderson. CP 46-48.

Judge Sally F. Olsen heard the motions on June 22, 2012. RP (June 22, 2012 Hearing) at 1-31. After extensive argument from both parties, the trial court granted Mr. Anderson's motion in part. *Id.* at 18. The trial court concluded that Dr. Kovar could not testify that Mr. Anderson's prior use of cocaine and meth explain why he did not seek earlier medical treatment. *Id.* However, the trial court stated that it "does find some relevance insofar as the cause of the brain abscess" and held that some of the drug evidence was admissible on that point. *Id.* The court entered a written Order to that effect on July 5, 2012. CP 203-06.

**H. Mr. Anderson repeatedly and unsuccessfully sought reconsideration of the trial court's July 5, 2012 Order.**

On July 11, 2012, Mr. Anderson moved for reconsideration, CP 207-17, arguing that the court should exclude all evidence of Mr.

Anderson's prior drug use as to causation because Dr. Kovar lacked adequate foundation for his opinion, that the cause of the brain abscess was irrelevant, and that the evidence was unduly prejudicial. CP 212-15.

The trial court called for a response by Dr. Hamon. CP 227. Dr. Hamon argued that Mr. Anderson had failed to identify upon which grounds under CR 59(a) he sought reconsideration and had merely repeated the same unsuccessful arguments. CP 278-83. Dr. Hamon argued that there was adequate foundation for the evidence of Mr. Anderson's drug use, multiple hearsay exceptions applied, and Dr. Kovar reasonably relied on the evidence under ER 703. CP 283-88. Dr. Hamon also argued that the evidence was relevant to causation, segregation of damages, and contributory negligence, and that the probative value of the evidence on those issues greatly outweighed any risk of prejudice to Mr. Anderson. CP 298-305.

On July 27, 2012, before the trial court's ruling on his Motion for Reconsideration, Mr. Anderson filed his Third Motions in Limine. CP 229-245. Mr. Anderson reiterated the same foundation, relevancy, and prejudice arguments made regarding the drug evidence. CP 231-35.

On July 31, 2012, the trial court denied Mr. Anderson's Motion for Reconsideration, ruling that Mr. Anderson failed to (1) specify a particular ground upon which he brought his motion under CR 59(a), or (2) make a

sufficient showing to warrant reconsideration. CP 425-26.

On August 6, 2012, Dr. Hamon filed his Response to Plaintiff's Third Motions in Limine. CP 461-504. Dr. Hamon argued that the trial court's July 31, 2012 Order had confirmed that much of the drug evidence was relevant and admissible, that adequate foundation supported it, and that Dr. Kovar reasonably relied on it. CP 462-72.

On September 14, 2012, the trial court heard the parties' respective motions in limine. RP (September 14, 2012 Hearing) at 1-64. During argument by Dr. Hamon's counsel, the trial court interrupted and stated "in terms of brevity, I will rule one through four are denied. I have dealt with these in prior rulings." *Id.* at 10.

Those four motions in Mr. Anderson's Third Motions in Limine sought exclusion of: (1) evidence of drug use while Mr. Anderson was living in Maui; (2) evidence of cocaine use during the Christmas holiday in 2005; (3) the Harborview records memorializing the phone call about Mr. Anderson's daily cocaine use; and (4) evidence of drug use prior to Mr. Anderson's move to Maui in 2005. CP 231-35.

However, the trial court excluded the urine test from 2008, concluding that although relevant, its prejudicial effect outweighed its probative value. RP (September 14, 2012 Hearing) at 12. As to Mr. Anderson's motion regarding marijuana, Dr. Hamon's counsel stated that

he did not intend to bring up Mr. Anderson's marijuana use; the trial court granted Mr. Anderson's motion on that issue. *Id.* at 13. The trial court reserved ruling on admissibility of the pain pill evidence and invited Mr. Anderson to file a one-page response as to that evidence. *Id.* at 16-17.

On September 20, 2012, Mr. Anderson filed his Response Regarding the Relevance of Plaintiff's Prior Use of Pain Pills as a Cause. CP 602-03. On September 25, 2012, the trial court issued an order excluding all evidence of Mr. Anderson's use of pain pills, holding, "This Court finds that evidence regarding Plaintiff's prior use of pain pills is of minimal relevance to the issues in this case, and is unduly prejudicial to the Plaintiff." CP 605.

On October 17, 2102, the trial court issued its Order on Plaintiff's Third Motions in Limine and Defendant's First Motions in Limine, memorializing the above rulings. CP 607-12.

**I. During the November 2012 trial, all the admitted drug evidence was limited to the issues of causation, damages, and contributory negligence.**

Trial began November 5, 2012. CP 638. Mr. Anderson's counsel addressed the issue of drugs in his opening statement to the jury. RP (November 6, 2012 Plaintiff's Opening Statement) at 35-37. He also conceded that as of May 11, 2006, Mr. Anderson would need brain surgery regardless of Dr. Hamon's alleged negligence. *Id.* at 37.

Dr. Hamon's defense counsel likewise raised Mr. Anderson's drug use during opening statement, but confined his discussion of drug use to (1) the cause of Mr. Anderson's brain abscess and (2) Dr. Hamon's experts' opinions regarding Mr. Anderson's failure to seek earlier treatment to prevent the abscess from developing. RP (November 6, 2012 Defendant's Opening Statement) at 59-60.

On November 19, 2012, prior to the testimony of Dr. Kovar, counsel for Mr. Anderson again objected to the mention of the prior drug use on hearsay grounds and asked that any mention of cocaine be limited to the record. RP (November 19, 2012 Argument re: Admission of Drug Evidence) at 1-9. The trial court heard argument and said that it would review its notes from the previous hearings and decide whether to allow testimony regarding daily cocaine use. *Id.* at 8-9. The trial court ruled later that day that it reviewed the motion in limine "extensively" and would not change its previous rulings. RP (November 19, 2012 Court's Ruling re: Cocaine and Prior Rulings) at 2.

During trial, multiple witnesses testified to whether snorting cocaine or methamphetamine can worsen a sinus infection, or to their knowledge of Mr. Anderson's usage of those drugs. *See, e.g.*, RP (November 7, 2012 Testimony of Francis Riedo, M.D.) at 229:2-231:13, RP (November 7, 2012 Testimony of Jennifer Ray) at 248:22-251:13; RP

(November 8, 2012 Testimony of Jennifer Ray) at 302:11-312:11; 318:20-319:10; RP (November 9, 2012 Testimony of Terrence Davidson, M.D.) at 435:25-436:9); RP (November 13, 2013 Testimony of Lynn Anderson) at 569:8-573:8; RP (November 14, 2012 Testimony of Rebecca Anderson) at 840:12-840:17.

Further, a juror specifically asked one expert witness whether it was possible “the delivery system of either drug mentioned, cocaine or meth, could have caused/contributed to the abscess?” RP (November 7, 2012 Testimony of Francis Riedo, M.D.) at 241:12-241:25.

Counsel for both parties addressed the drug evidence in closing arguments. *See, e.g.*, RP (November 21, 2012 Plaintiff’s Closing Argument) at 26:5-26:7; RP (November 21, 2012 Defense Closing Argument at 21:22-24:20 (arguing that daily cocaine use was supported by the record and explained spread of sinusitis to brain abscess); RP (November 21, 2012 Plaintiff’s Rebuttal Closing Argument) at 7:4-7:11.

**J. The jury returned a verdict for Dr. Hamon, concluding that he met the standard of care.**

On November 26, 2012, the jury returned a verdict in favor of Dr. Hamon, and found that Dr. Hamon had met the standard of care and was therefore not negligent. CP 636-37, 710. Judgment on the Verdict was entered December 7, 2012. CP 711-12.

#### IV. SUMMARY OF ARGUMENT

Mr. Anderson cannot meet, and has not met, his burden of demonstrating that the trial court abused its sound discretion in admitting the limited drug evidence at trial. First, the evidence was highly relevant to Mr. Anderson's ability to prove proximate cause, and to Mr. Anderson's duty to segregate what injuries and damages resulted only from Dr. Hamon's alleged negligence. Damages that resulted from Mr. Anderson's own negligence, or that were medically inevitable, could not rightfully be attributed to Dr. Hamon's alleged negligence.

Second, any slight risk of unfair prejudice could not outweigh the high probative value of the evidence, which was presumed admissible and was admitted for a limited purpose. Furthermore, the trial court actively mitigated or eliminated the risk of unfair prejudice.

Third, even if admitting the drug evidence amounted to error, it was harmless error. Nothing exists in the record that would show that the drug evidence had any effect on the outcome of trial, as the jury never reached the issues for which the evidence was admitted. Further, nothing exists in the record to rebut the presumption that the jury followed the jury instructions to decide the issues in the case based only on the evidence and not bias, preference, or any other illegitimate grounds.

## V. ARGUMENT

### A. **This court should ignore major portions of Mr. Anderson's Statement of the Case.**

Much of Mr. Anderson's Statement of the Case violates the RAPs. RAP 10.3(a)(5) requires a citation to the record for each factual statement. Argument requires citations to authority and the relevant record. RAP 10.3(a)(6); RAP 10.4(f).

In the first paragraph of Mr. Anderson's Statement of the Case, only one of the four sentences has a citation to the record. App. Br. at 2. Many other sentences in his Statement of the Case likewise lack any citation to the record, such as the statements that Ms. Ray assisted Mr. Anderson walking into Dr. Keyes's facility, *id.* at 4; that most of the time of the exam was to obtain a history from Ms. Ray, "and not Kevin Anderson," *id.* at 6; that "Kevin cannot live independently or hold down a job," *id.* at 8; that Mr. Anderson does not have a criminal record, *id.* at 9; and many other bald assertions.

The court should ignore any statement or argument that Mr. Anderson fails to support with a citation to the record. *See, e.g., Northlake Marine Works, Inc. v. City of Seattle*, 70 Wn. App. 491, 513, 857 P.2d 283 (1993); *Lawson v. Boeing Co.*, 58 Wn. App. 261, 271, 792 P.2d 545 (1990) (failure to cite to record is not a formality, but placed unacceptable burden on opposing counsel and court, warranting \$250 fine).

**B. Mr. Anderson has the substantial burden of demonstrating that the trial court abused its discretion.**

**1. A trial court's decision to admit evidence is reviewed for abuse of discretion.**

Mr. Anderson's lone assignment of error for entering judgment for Dr. Hamon is premised on the admission of certain evidence. "We review a trial court's evidentiary rulings for abuse of discretion." *Hickok-Knight v. Wal-Mart Stores, Inc.*, 170 Wn. App. 279, 313, 284 P.3d 749 (2012); *see also Hizey v. Carpenter*, 119 Wn.2d 251, 268, 830 P.2d 646 (1992).

A trial court can abuse its discretion in two ways. First, a trial court abuses its discretion if it based its decision on untenable grounds or reasons. *Hickock- Knight*, 170 Wn. App. at 313. If the trial court relies on unsupported facts, or applies the wrong legal standard, then its decision is exercised on untenable grounds or for untenable reasons. *Mayer v. Sto Indus., Inc.*, 156 Wn.2d 677, 684, 132 P.3d 115 (2006). Second, an abuse of discretion occurs if its decision was manifestly unreasonable. This standard applies when, "despite applying the correct legal standard to the supported facts, [the court] adopts a view that no reasonable person would take." *Mayer*, 156 Wn.2d at 684.

**2. Mr. Anderson bears the burden of demonstrating that the trial court manifestly abused its discretion.**

Mr. Anderson bears the substantial burden of showing that that the

trial court abused its discretion in admitting the limited drug evidence. *See Lewis v. Simpson Timber Co.*, 145 Wn. App. 302, 328, 189 P.3d 178 (2008); *see also Devine v. Goggin*, 69 Wn.2d 144, 148, 417 P.2d 606 (1966). An abuse of judicial discretion is “never presumed.” *Abel v. Abel*, 47 Wn.2d 816, 819, 289 P.2d 724 (1955).

This is a particularly difficult burden to meet when appealing the failure to exclude evidence. “The practioner hoping to reverse an evidentiary ruling on appeal will find little encouragement in the reported decisions.” Tegland, 5 Wash. Prac., *Evidence Law & Practice* § 103.23 (5th ed. 2013). “For the most part, appellate courts are far more forgiving when it comes to the administration of evidence rules than when the issue is one of substantive law.” *Id.*

**3. This court may affirm the trial court’s decisions on any basis supported by the record.**

This court may affirm the trial court on any basis the record supports. *See, e.g., LaMon v. Butler*, 112 Wn.2d 193, 200-01, 770 P.2d 1027 (1989); *Maicke v. RDH, Inc.*, 37 Wn. App. 750, 752, 683 P.2d 227 (1984); *Gross v. City of Lynnwood*, 90 Wn.2d 395, 401, 583 P.2d 1197 (1978); Tegland, 2A Wash. Prac., *Rules Practice* RAP 2.5 (7th ed. 2013) (“[a] trial court’s ruling on the admissibility of evidence will not be disturbed on appeal if it is sustainable on alternative grounds”).

**C. Mr. Anderson abandoned multiple grounds under which he argued the drug evidence should have been excluded.**

Mr. Anderson has apparently abandoned several of the arguments he raised repeatedly below, *i.e.*, that portions of the drug evidence consisted of inadmissible hearsay, and that the evidence, and Dr. Kovar's opinions based on it, lacked adequate foundation. *See, e.g.*, CP 16-17, 190-93, 208-14, 231-35.

This court cannot find error based on an argument not raised on appeal. *See, e.g., Raum v. City of Bellevue*, 171 Wn. App. 124, 149, 286 P.3d 695 (2012) (challenge on evidentiary rulings rejected where plaintiff "provides no meaningful legal analysis and cites no authority in support of his arguments"); *Holland v. City of Tacoma*, 90 Wn. App. 533, 538, 954 P.2d 290 (1998) ("Passing treatment of an issue or lack of reasoned argument is insufficient to merit judicial consideration").

Thus, this court may not reverse based on arguments Mr. Anderson has abandoned on appeal. Nor may Mr. Anderson cure this problem by offering those arguments in his reply brief, because doing so would violate RAP 10.3(c). *See also Dykstra v. County of Skagit*, 97 Wn. App. 670, 676, 985 P.2d 424 (1999) (declining to consider issues raised by appellants in their reply brief, "because there was no opportunity for the opposing party to respond"). If he does, Dr. Hamon will move to strike

those portions of the reply brief pursuant to RAPs 17.1(a) and 18.9(a).

**D. The trial court properly exercised its sound discretion in admitting evidence of Mr. Anderson’s prior drug use, which was highly relevant to causation, damages, and contributory negligence.**

Mr. Anderson offers three sentences of argument in support of his first contention on appeal, *i.e.*, that the trial court abused its discretion in allowing the drug evidence because it was “irrelevant.” App. Br. at 13.

**1. Relevancy is defined extremely broadly.**

ER 401 defines “relevant evidence” very broadly as “evidence having any tendency to make the existence of any fact ... more probable or less probable.” “Minimal” logical reliance is all that is required under ER 401. *See Salas v. Hi-Tech Erectors*, 168 Wn.2d 664, 670, 230 P.3d 583 (2010) (“[t]he relevance requirement is not a high hurdle”). Further, “[u]nder ER 402, **all relevant evidence is admissible**, unless otherwise excluded by the evidence rules.” *Havens v. C & D Plastics, Inc.*, 124 Wn.2d 158, 168, 876 P.2d 435 (1994) (emphasis added).

Indeed, the definition of relevant evidence “include[s] facts which offer direct or circumstantial evidence of any element of a claim or defense.” *Davidson v. Mun. of Metro. Seattle*, 43 Wn. App. 569, 573, 719 P.2d 569 (1986); *see also Lamborn v. Phillips Pac. Chem. Co.*, 89 Wn.2d 701, 706, 575 P.2d 215 (1978) (“facts tending to establish a party’s theory, or to qualify or disprove the testimony of an adversary, are relevant”).

“As a general rule, the trial court must admit evidence that tends to make the existence of a material fact more or less probable.” *Janson v. North Valley Hosp.*, 93 Wn. App. 892, 902, 971 P.2d 67 (1999).

**2. The evidence of Mr. Anderson’s pre-injury use of cocaine and methamphetamine was highly relevant to causation and damages.**

Here, although the jury never reached the issue because it concluded that Dr. Hamon met the standard of care in all respects, the cocaine and methamphetamine evidence was directly relevant to the causation element of Mr. Anderson’s claim, and his ability to segregate the injuries allegedly caused only by Dr. Hamon’s alleged negligence.

As the plaintiff in a medical-malpractice case, Mr. Anderson was required to demonstrate not only a failure to meet the standard of care by Dr. Hamon, but also present sufficient evidence establishing that that alleged negligence caused the alleged injury and damages. *See* RCW 7.70.030(1); RCW 7.70.040(2) (plaintiff must show that violation of standard of care “was a proximate cause of the injury complained of”). *See, e.g., Rounds v. Nelcor Puritan Bennett, Inc.*, 147 Wn. App. 155, 162, 194 P.3d 274 (2008).

A plaintiff must demonstrate that the alleged negligence was both (1) the cause in fact of the injury alleged, and (2) the legal cause of the injury. *Id.* at 162. Indeed, even if negligence is shown, dismissal or a

defense verdict is required if the plaintiff cannot demonstrate that the negligence proximately caused the alleged harm. *See, e.g., Estate of Stalkup v. Vancouver Clinic, Inc., P.S.*, 145 Wn. App. 572, 585-91, 187 P.3d 291 (2008) (error for trial court to not enter judgment on jury verdict that found physician negligent but did not cause plaintiff's injury); *Rounds*, 147 Wn. App. at 164-65 (dismissal for failure to show that physician's negligence proximately caused injuries warranted when none of plaintiff's experts could establish that trach tube malfunction more likely than not caused inflatable cuff to rupture). Importantly, Dr. Hamon had no burden to disprove Mr. Anderson's causation theories. *Stalkup*, 145 Wn. App. at 590.

Mr. Anderson conceded that while he experienced permanent injuries based on his brain abscess alone, at least some portion of his injuries was unavoidable and not attributed to any negligence by Dr. Hamon. It was undisputed as of the trial court's pre-trial rulings, and at trial, that Mr. Anderson almost certainly already had a brain abscess at the time he was examined by Dr. Hamon on May 11, 2006. CP 170, 300.

It was also undisputed in pre-trial briefing and at trial that Mr. Anderson suffered injuries simply because of the presence of the brain abscess. It was also undisputed in pre-trial briefing and at trial that Mr. Anderson would have needed surgical intervention regardless of Dr.

Hamon's alleged negligence. CP 300-01; RP (November 14, 2012 Testimony of Steven Klein, M.D.) at 777:12-777:16; RP (November 14, 2012 Testimony of Richard Wohns, M.D.) at 732:9-732:13, 751:19-751:20. The court entered a pre-trial order establishing the same. On March 9, 2012, the trial court granted Dr. Hamon's motion for partial summary judgment, ruling as a matter of law (1) that Mr. Anderson would have required the first and second craniotomies regardless of his alleged negligence, and (2) that the seizure disorder he developed in 2008 was not proximately caused by any alleged negligence by Dr. Hamon. CP 544-45.

It was also undisputed in pre-trial briefing and at trial that the necessary surgeries would, and did, cause Mr. Anderson permanent physical injuries. RP (November 14, 2012 Testimony of Richard Wohns, M.D.) at 736:2-736:6.

Evidence detailing the source of injuries that cannot be attributed to Dr. Hamon is highly relevant, and for obvious reasons. It was central to Dr. Hamon's defense that Mr. Anderson lacked sufficient expert testimony establishing to a reasonable degree of medical certainty what physical injuries resulted from the 24- to 27-hour delay in surgery caused by Dr. Hamon's conduct, as opposed to injuries that were medically unavoidable. "If an event would have happened regardless of the defendant's negligence, that negligence is not a proximate cause of the event."

*Stoneman v. Wick Const. Co.*, 55 Wn.2d 639, 643, 349 P.2d 215 (1960); *see also Davis v. Globe Mach. Mfg. Co.*, 102 Wn.2d 68, 74, 684 P.2d 692 (1984). Thus, if Mr. Anderson could not segregate the injuries, he could not prove proximate cause at all, or at a minimum, it was for the jury to decide the extent to which Dr. Hamon's alleged negligence proximately caused any additional injury. Again, the burden was not on Dr. Hamon to demonstrate what injuries his alleged negligence did not cause to Mr. Anderson. *See* RCW 7.70.040(2); *see also Stalkup*, 145 Wn. App. at 590.

Instead, the burden was on Mr. Anderson to present sufficient evidence of what injuries only Dr. Hamon's alleged negligence caused; this inherently required him to segregate the injuries that resulted from other causes, including his own negligence. *See, e.g., Scott v. Rainbow Ambulance Serv., Inc.*, 75 Wn.2d 494, 495-98, 452 P.2d 220 (1969); *Smith v. Rodene*, 69 Wn.2d 482, 485-86, 418 P.2d 741 (1966).

Mr. Anderson argued repeatedly to the trial court that the cause of his brain abscess was irrelevant because he was not blaming Dr. Hamon for causing or not detecting the brain abscess. CP 17, 172, 208, 214 ("The question for our jury is whether Dr. Hamon breached the standard of care when he failed to send Mr. Anderson for further care"). One party's claims or theories is but a part of the relevancy analysis under ER 401. Evidence having any tendency to show that part of Mr. Anderson's

injuries were caused by factors not legally attributable to Dr. Hamon's negligence not only met and meets the low bar of "minimal logical relevance" required by law, but was central to Mr. Anderson's ability or inability to prove an element of his claim separate from negligence, and necessarily, Dr. Hamon's defense. *See Salas*, 168 Wn.2d at 670.

Moreover, the drug evidence that the trial court admitted was for the limited issue of causation exactly for the reasons specified above, and was large basis of the testimony of Dr. Kovar. Dr. Kovar was deposed November 9, 2011. CP 71. Dr. Kovar testified at deposition that he anticipated testifying before the jury as to why a brain abscess occurred in this case, and that in his opinion, Mr. Anderson's daily use of cocaine "would be the one factor that I feel is directly causative to his subacute ongoing or partially treated sinusitis and thus brain abscess [.]" CP 77. He added that the drug use "certainly comes into causation" and that cocaine use is "certainly in causation of a acute and chronic sinusitis. It's a major risk factor for sinus infections." CP 83-84. The trial court was provided the above excerpts of Dr. Kovar's testimony before ruling on Mr. Anderson's first attempt to exclude all the drug evidence. CP 71-85.

Dr. Kovar's trial testimony was consistent with his deposition, and the drug evidence was limited in scope as the trial court had ordered. He testified that cocaine is a "very powerful" vaso constrictor, causing the

blood vessels in the sinuses to constrict, which impacts the body's ability to fight infections. RP (November 19, 2012 Testimony of Michael Kovar, M.D.) at 51:5-51:18. Dr. Kovar explained that the use of such a strong vasoconstrictor causes a "vicious cycle" where the lining of the nose swells as the effects wear off, which blocks the ostia, thus impeding sinus drainage. *Id.* at 52:2-52:18. He stated that the use of cocaine would help explain why this infection could develop into a brain abscess when such an occurrence is so rare. *Id.* at 52:23-53:23.

Mr. Anderson baldly asserts, "There was no testimony about any causal relationship between purported drug use and Kevin Anderson's brain abscess." App. Br. at 13. This assertion is false: Dr. Kovar testified at trial that cocaine use was a "big factor" in the perpetuation of the sinus infection, and Mr. Anderson's lack of response to antibiotics or his body's inability to fight the infection, or both. RP (November 19, 2012 Testimony of Michael Kovar, M.D.) at 53:16-53:23. He testified that he considered daily or frequent use of cocaine to be a "major factor" in sinus infections and in preventing the resolution of them. *Id.* at 52:16-52:18. Dr. Kovar testified that he believes Mr. Anderson's cocaine use was a plausible explanation for why he had a sinus infection that did not resolve "and, in fact, **worsened to the point of a brain abscess.**" *Id.* at 57:16-57:20 (emphasis added).

The drug evidence was therefore a large basis of an expert's testimony that the brain abscess that would cause inevitable injury, including the harm of the necessary surgeries, could not be attributed to Dr. Hamon's negligence, and was attributable to Mr. Anderson's own negligence. It was for the jury to determine what of Mr. Anderson's injuries were attributable only to Dr. Hamon's alleged negligence, and the evidence regarding the physiology of how the injuring-causing event occurred was relevant in the event the jury had to make that determination.

**3. The evidence of Mr. Anderson's use of cocaine and methamphetamine was highly relevant to Dr. Hamon's defense of contributory negligence.**

Furthermore, the drug evidence was relevant because it made it more probable that Mr. Anderson's own negligence in both delaying treatment against doctor orders and using drugs proximately caused either all or at least some of his physical injuries. (Mr. Anderson does not even argue that the evidence was irrelevant for this purpose, and he confines his argument to causation. App. Br. at 13.)

It is axiomatic that "[a] claimant is contributorily negligent if he fails to exercise the care for his own safety that a reasonable person would have used in the same situation." *Jaeger v. Cleaver Const., Inc.*, 148 Wn. App. 698, 713, 201 P.3d 1028 (2009). As stated in *Huston v. First Church of God*, 46 Wn. App. 740, 746-47, 732 P.2d 173 (1987):

In determining whether a person was contributorily negligent, the inquiry is whether or not he exercised that reasonable care for his own safety which a reasonable man would have used under the existing facts and circumstances and, if not, was his conduct a legally contributing cause of his injury.

The contributory negligence of a claimant “diminishes proportionately the amount awarded as compensatory damages.” RCW 4.22.005. *See also ESCA Corp. v. KPMG Peat Marwick*, 135 Wn.2d 820, 830, 959 P.2d 651 (1998) (“[a] plaintiff’s negligence directly reduces plaintiff’s recovery by the percentage of negligence involved”). A contributory-negligence defense is entirely proper in a medical-malpractice action. *See, e.g., Bertsch v. Brewer*, 97 Wn.2d 83, 92, 640 P.2d 711 (1982); *Gjerde v. Fritzsche*, 55 Wn. App. 387, 392-94, 777 P.2d 1072 (1989). The issue of contributory negligence ordinarily is one for the jury. *See, e.g., Geschwind v. Flanagan*, 121 Wn.2d 833, 837, 854 P.2d 1061 (1993).

Dr. Hamon asserted the affirmative defense of contributory-negligence in his Answer. CP 357. He based that defense on two key facts: (1) Mr. Anderson’s decision to use drugs may have caused the sinusitis, and the progression and exacerbation of the same into a brain abscess; and (2) the delay in seeking medical treatment against doctor’s orders further allowed this exacerbation to continue, eventually culminating into a brain abscess that caused inevitable harm.

Both of Dr. Hamon's contributory negligence theories were supported by Dr. Kovar. It is undisputed that Mr. Anderson did not seek medical treatment for his persistent sinus infection between his ER visit in Hawaii in March 2006 and his one meeting with Dr. Hamon almost two months later; this was despite the instructions of his care providers and the pleas of Ms. Ray that he seek help for his symptoms. *See, e.g.*, CP 321-22; RP (November 7, 2012 Testimony of Jennifer Ray) at 95:10-95:23; RP (November 8, 2012 Testimony of Jennifer Ray) at 301:10-302:10.

Dr. Kovar testified in discovery that he anticipated opining on the issue of Mr. Anderson's failure to exercise patient responsibility in seeking further medical treatment when his sinusitis persisted. CP 76-77. At trial, he testified that Mr. Anderson's use of drugs was a possible explanation for why he had a sinus infection that did not resolve, and worsened to the point of a brain abscess. RP (November 19, 2012 Testimony of Michael Kovar, M.D.) at 57:16-57:20.

Mr. Anderson does not appeal the trial court's decision to allow Dr. Hamon to allege a contributory-negligence defense. He does not challenge the sufficiency of the evidence in any finding that Mr. Anderson was contributorily negligent; indeed, the jury never reached the issue of causation or contributory negligence. CP 636. Instead, the narrow issue is whether or not the trial court manifestly abused its sound discretion to

allow the limited admission of drug evidence, in light of Mr. Anderson's injuries and his burden of proof, and when a qualified medical expert was prepared to testify in support of a contributory negligence defense premised in part on that evidence.

Dr. Hamon easily met the low bar for relevance of the drug evidence as to his contributory-negligence defense. The jury was entitled to determine whether the inevitable injuries were caused by Mr. Anderson's own contributory negligence in using drugs and in failing to follow medical advice and seek treatment for his persistent sinusitis to prevent the development of the brain abscess. The jury was entitled to assess the relative weight of the drug evidence and any opinions based upon them; indeed that is the jury's primary obligation. Dr. Hamon was entitled to defend himself against all aspects of Mr. Anderson's claim, and to present competent evidence in his defense. *Lamborn*, 89 Wn.2d at 706.

**E. The risk of unfair prejudice in admitting the limited pre-injury evidence of drug use did not substantially outweigh the high probative value.**

Instead of substantively addressing the balancing test under ER 403, and why the trial court supposedly abused its discretion in admitting the drug evidence under that test, Mr. Anderson offers a list of factors that he believes demonstrates the improper motives of Dr. Hamon. App. Br. at 13-14. These grounds fail to establish abuse of discretion.

1. **Exclusion under ER 403 is an extraordinary remedy, and relevant evidence is presumed admissible.**

The trial court may exclude relevant evidence “if its probative value is substantially outweighed by the danger of unfair prejudice.” ER 403. “The burden of showing prejudice is on the party seeking to exclude the evidence.” *Hayes v. Weber Enter., Inc.*, 105 Wn. App. 611, 618, 20 P.3d 496 (2001). Exclusion under ER 403 is an extraordinary remedy. *Carson v. Fine*, 123 Wn.2d 206, 224, 867 P.2d 610 (1994). Indeed, there is a presumption favoring admissibility under ER 403. *Erickson v. Robert F. Ferr, M.D., P.S., Inc.*, 125 Wn.2d 183, 190, 883 P.2d 313 (1994). The trial court has “considerable discretion” in administering ER 403 as a vehicle for excluding evidence. *Carson*, 123 Wn.2d at 226 (“[b]ecause of the trial court’s considerable discretion in administering ER 403, reversible error is found only in the exceptional circumstance of a manifest abuse of discretion”); *see also Erickson*, 125 Wn.2d at 191.

However, the trial court’s discretion under ER 403 is limited:

The text of the rule requires balancing the prejudicial costs of the evidence against its benefits. If its probative value is not “substantially” outweighed by the danger of unfair prejudice **the court has no discretion to exclude the evidence: it must be admitted.**

*Lockwood v. AC & S, Inc.*, 44 Wn. App. 330, 350, 722 P.2d 826 (1986) (emphasis added). When the balance is even under ER 403, the evidence

must also be admitted. *Id.* at 350-51.

Additionally, ER 403 requires more than a showing that the evidence is adverse to the opposing party. *State v. Gould*, 58 Wn. App. 175, 183, 791 P.2d 569 (1990). “The term ‘unfair prejudice’ as it is used in Rule 403 usually refers to prejudice that results from evidence that is more likely to cause an emotional response than a rational decision by the jury.” *Lockwood v. AC & S, Inc.*, 109 Wn.2d 235, 257, 744 P.2d 605 (1987); *see also Salas*, 168 Wn.2d at 671.

ER 403 does not allow for exclusion of evidence simply because the evidence is “too good” or “too powerful.” Tegland, 5D Wash. Prac., *Handbook Wash. Evid.* ER 403 (2012-13 ed) (citing *Gould*, 58 Wn. App. at 183). As the State Supreme Court noted, “Equally important to recognize is that nearly all evidence will prejudice one side or the other in a lawsuit. Evidence is not rendered inadmissible under ER 403 just because it may be prejudicial.” *Carson*, 123 Wn.2d at 224.

**2. The high probative value of the drug evidence was not substantially outweighed by the risk of prejudice to Mr. Anderson.**

If relevant at all, the limited evidence of Mr. Anderson’s prior drug use had high probative value because of its relevance to the issues addressed above. Indeed, even by arguing that the evidence should have been excluded under ER 403, Mr. Anderson is necessarily conceding that

the evidence is relevant. See Tegland, 5 Wash. Prac., *Evidence Law and Practice* § 403.1 (5th ed. 2013) (“Rule 403 is **not concerned with irrelevant evidence**”) (emphasis in original). Mr. Anderson in fact does not even argue that the evidence was not probative or was of low probative value. App. Br. at 14-15.

Since Mr. Anderson concedes that the brain abscess itself would and did cause both physical injuries and the necessary surgeries to drain the abscess, which also caused physical injuries, the causes of the abscess had high probative value to both causation and the segregation of damages. These were fundamental elements of Mr. Anderson’s prima facie burden at trial.

The question is not whether the limited evidence of Mr. Anderson’s drug usage was prejudicial — all evidence is prejudicial from the perspective of the party against whom it is offered. “Nearly all evidence will prejudice one side or the other in a lawsuit.” *Hayes*, 105 Wn. App. at 618. Instead, Mr. Anderson must show that the drug evidence posed **unfair** prejudice. The trial court acted within its sound discretion here because Mr. Anderson does not even try to argue the relevant test. There was no unfair prejudice that would substantially outweigh the inarguably high probative value of the evidence.

**3. The trial court actively minimized any risk of unfair prejudice against Mr. Anderson.**

The trial court took pains to minimize the risk of any unfair prejudice to Mr. Anderson with the admission of drug evidence. The trial court limited the admissibility of Mr. Anderson's drug use to pre-injury instances where it was relevant to causation. CP 204-05. It excluded any evidence of opinion testimony about how Mr. Anderson may have not sought medical treatment because of his addiction to drugs. RP (June 22, 2012 Hearing) at 18:4-18:15; CP 204-05. The trial court excluded all evidence of the positive urine test from 2008 because it believed the probative value of this evidence was outweighed by the risk of prejudice to Mr. Anderson. CP 204-05, 607-12. After careful deliberation, and inviting briefing from Mr. Anderson, the trial court likewise excluded pain pill evidence. CP 605. Moreover, when a witness inadvertently referenced the pain pill use, the trial court instructed the jury to disregard on two occasions. RP (November 19, 2012 Testimony of Michael Kovar, M.D.) at Dr. Kovar) at 59:8-59:9, 63:25-64:3 ("You're further instructed that there's no evidence of pain pill abuse or addiction with respect to Kevin Anderson").

This shows that the trial court entered thoughtful and careful rulings and actively balanced the relative probative value of the drug

evidence against the risk of unfair prejudice to Mr. Anderson. This is exactly how ER 403 is supposed to work, and exactly why the trial court is allowed so much discretion in such decisions. *Carson*, 123 Wn.2d at 226.

The trial court, not this court, is in the best position to decide, after reviewing the briefing, the testimony attached to the same, and argument from counsel that are more familiar with the medical facts and legal issues than anyone, whether specific evidence meets the high bar for exclusion under ER 403. As the State Supreme Court has noted, quoting the U.S. Supreme Court addressing the ER 403 issue:

Broad discretion must be accorded to the trial judge in such matters for the reason that he is in a superior position to evaluate the impact of the evidence, since he sees the witnesses, defendant, jurors, and counsel, and their mannerisms and reactions. He is therefore able, on the basis of personal observation, to evaluate the impressions made by witnesses, whereas we must deal with the cold record.

*State v. Coe*, 101 Wn.2d 772, 782, 684 P.2d 668 (1984) (citation omitted).

The trial court's exclusion of much of the drug evidence that Mr. Anderson sought to exclude, and admission of only certain drug evidence on narrow grounds, not only mitigated any unfair prejudice to Mr. Anderson, but also shows how carefully the trial court analyzed the issue.

**4. Mr. Anderson's arguments on the ER 403 issue are without factual or legal merit.**

Aside from Mr. Anderson's failure to articulate how the balancing

test under ER 403 warranted exclusion, his arguments are addressing the quality of the evidence and the supposed motives of Dr. Hamon, which are not the subject of this appeal. First, Mr. Anderson argues that the evidence of the “purported” use of cocaine was admitted only to provoke a negative emotional response, demonstrated by the fact that Mr. Anderson tested negative for cocaine on May 12, 2006. App. Br. at 14. This is a red herring, and the citation to Dr. Kovar’s trial testimony is incomplete.

There is no dispute that Mr. Anderson tested negative for cocaine on May 12, 2006. However, as Dr. Kovar testified at trial, the urinalysis does not show whether Mr. Anderson had used cocaine “three, four, five days before,” and cocaine does not stay in the system “that long.” RP (November 19, 2012 Testimony of Michael Kovar, M.D.) at 56:6-56:17. He opined that a negative drug test did not affect his conclusion that cocaine may have been a cause of the sinusitis. *Id.* at 56:1-56:3.

Second, Mr. Anderson asserts that Dr. Hamon had no proof “tying Kevin Anderson to drug use after December 2005.” App. Br. at 14. He is wrong. The Harborview records, on which Dr. Kovar relied, documented a May 12, 2006 phone call from a friend of Mr. Anderson stating that Mr. Anderson had a “current daily cocaine habit.” CP 310, 311, 312. There is no reasonable basis to conclude that Mr. Anderson’s use of cocaine stopped at Christmas 2005, barely a month before his cold developed.

Third, Mr. Anderson asserts that Dr. Kovar “admitted on cross-examination that he had no evidence whatsoever tying Kevin Anderson to the use of any illegal drugs.” App. Br. at 14. This too is false. As to the negative May 12, 2006 drug test, Dr. Kovar testified that he is not offering any opinion on whether Mr. Anderson took drugs. RP (November 19, 2012 Testimony of Michael Kovar, M.D.) at 88:15:88:18. Dr. Kovar testified that, assuming the indications of Mr. Anderson’s drug use and history are true, cocaine usage would explain how a regular sinusitis developed into a brain abscess for multiple reasons. *Id.* at 52:20-53:23. These are two distinct points. Dr. Kovar had multiple admissible sources of evidence for his opinions, including the Harborview records and the testimony of Jenny Ray.

Fourth, Mr. Anderson asserts that Dr. Kovar “admitted” he had no scientific literature to support his causation theory that cocaine use can cause and worsen a sinusitis. App. Br. at 14. This mischaracterizes Dr. Kovar’s testimony. Dr. Kovar testified that he did not base his causation testimony on medical literature, but that he did not feel the need to do any research on the issue because he “considered that to be a common knowledge of a clinician.” RP (November 19, 2012 Testimony of Michael Kovar, M.D.) at 67:7-67:8.

Fifth, Mr. Anderson cites *Jones v. Bowie Indus.*, 282 P.3d 316

(Alaska 2012) for the notion that evidence of past drug use presents a danger of unfair prejudice must be excluded. In *Jones*, the evidence of the injured plaintiff's chemical dependency history was allowed only to rebut testimony that was never offered. Moreover, once the evidence was admitted, defense counsel argued in closing that the plaintiff had a "long history" of drug use, that he did not use his money for child support but to buy drugs, and that he used worker's compensation money also for drugs. *Id.* at 331. The *Jones* court also noted that the jury recommended that any future economic damage award be put in trust, which suggested "that it used the drug use testimony for more than an assessment of [plaintiff's] future earning capacity." *Id.*

*Jones* is obviously inapposite. Here, unlike in *Jones*, the drug evidence was offered on the points on which the court ruled it admissible, including through Dr. Kovar. There is no evidence that the jury used the drug evidence for an improper purpose or that it made any decision whatsoever based on it. Further, defense counsel's arguments here did not come close to the inflammatory references by defense counsel in *Jones* regarding the plaintiff's drug history; Mr. Anderson cannot suggest otherwise. *Jones* does not aid Mr. Anderson.

Indeed, past history of drug use, including cocaine and meth, is routinely and properly ruled admissible by trial courts under an ER 403

analysis. *See, e.g., Alpha v. Hooper*, 440 F.3d 670, 671-72 (5th Cir. 2006) (methamphetamine use of plaintiff relevant and not unduly prejudicial); *Phillips v. Hillcrest Med. Ctr.*, 244 F.3d 790, 800 (10th Cir. 2001) (patient's use of street drugs relevant to evaluation of physical condition in medical malpractice case, and admission of evidence not unduly prejudicial); *Dillon v. Nissan Motor Co., Ltd.*, 986 F.2d 263, 270 (8th Cir. 1993) (plaintiff's cocaine and marijuana use relevant and not unduly prejudicial under ER 403 when relevant to claims of emotional injuries); *Larkins v. Farrell Lines, Inc.*, 806 F.2d 510, 515 (4th Cir. 1986) (not error to allow evidence of plaintiff's history of alcoholism under ER 403 analysis when it was relevant to causation and the complaints of medical malpractice); *McCarson v. Foreman*, 692 P.2d 537, 542 (N.M. 1984) (cocaine charge indicated use of cocaine, which was relevant and admissible under ER 403 as to negligent entrustment claim).

**F. Even if admitting the drug evidence were error, it was harmless, because the jury never reached the issues on which it was admitted and is presumed to follow the jury instructions.**

Mr. Anderson argues that a new trial is necessary because “there can be no reasonable doubt that drugs affected the outcome of the trial.” App. Br. at 15-16. Mr. Anderson's argument is simply more bald speculation as to the defense's supposed motives and fails to meet the

legal standards that govern this evidentiary dispute.

**1. Mr. Anderson must demonstrate that the limited admission of the drug evidence would have changed the jury's conclusion.**

Error is prejudicial only if “it affects, or presumptively affects, the outcome of the trial.” *James S. Black & Co. v. P & R Co.*, 12 Wn. App. 533, 537, 530 P.2d 722 (1975); *see also Henderson v. Tyrell*, 80 Wn. App. 592, 620, 910 P.2d 522 (1996) (“reversal is required only if there is a substantial likelihood the error affected the jury’s verdict”). This rule exists to protect the judicial process from abuse:

Appellate courts long ago rejected the notion that reversal is necessary for any error committed by a trial court. Our judicial system is populated by fallible human beings, and some error is virtually certain to creep into even the most carefully tried case. The ultimate aim of the system, therefore, is not unattainable perfection, but rather fair and correct judgments ... . When a court blindly orders reversal of a judgment for an error without making any attempt to assess the impact of the error on the outcome of the trial, the court encourages litigants to abuse the judicial process and bestirs the public to ridicule it [.]

Tegland, 5 Wash. Prac., *Evid. Law & Practice* § 103.24 (5th ed. 2013).

Indeed, even when the reviewing court “strongly disapproves” of the actions of the trial court, absent a showing of prejudice, an error “does not constitute grounds for reversal.” *Rice v. Janovich*, 109 Wn.2d 48, 63, 742 P.2d 1230 (1987); *see also Adcox v. Children’s Hosp. and Med. Ctr.*, 123 Wn.2d 15, 36-37, 864 P.2d 921 (1993).

**2. The jury never reached the issues on which the drug evidence was admitted.**

Washington law is ironclad that an erroneous trial court evidentiary ruling is harmless where the jury never reaches the issue for which the evidence was admitted. *See, e.g., Bertsch*, 97 Wn.2d at 88; *Cobb v. Snohomish County*, 86 Wn. App. 223, 236, 935 P.2d 1384 (1997); *Mavroudis v. Pittsburgh-Corning Corp.*, 86 Wn. App. 22, 36, 935 P.2d 864 (1997); *Ford v. Chaplin*, 61 Wn. App. 896, 902, 812 P.2d 532 (1991) (“[a]n error relating to damages is harmless when the verdict establishes that the defendant is not liable”); *Kramer v. J.I. Case Mfg. Co.*, 62 Wn. App. 544, 548-50, 815 P.2d 798 (1991) (erroneous application of Tort Reform harmless because jury never reached allocation issue or damages); *Maicke*, 37 Wn. App. at 754.

Mr. Anderson ignores that the **jury never reached the issues of causation, damages, or contributory negligence**. CP 636. The jury answered one question, finding that Dr. Hamon met the standard of care. *Id.* To win reversal, Mr. Anderson must show the admission of the evidence actually or presumptively affected the outcome of the jury’s verdict. *See, e.g., Henderson*, 80 Wn. App. at 620; *James S. Black & Co.*, 12 Wn. App. at 537. It is impossible for this court to so conclude.

The trial court repeatedly stated on the record and in orders that the

evidence of cocaine and methamphetamine use was relevant, and thus admissible, on the issue of the cause of the brain abscess. *See, e.g.*, RP (June 22, 2012 Hearing) at 18:4-18:15; CP 204-05; RP (November 19, 2012 Court's Ruling re: Cocaine and Prior Rulings) at 2:15-2:22. Consistent with the court's rulings, all of the admitted drug evidence was in the context of causation, damages, and contributory negligence. *See, e.g.*, CP 204-05; RP (November 7, 2012 Trial Testimony of Francis Riedo, M.D.) at 229:2-231:13; RP (November 9, 2012 Testimony of Terrence Davidson, M.D.) at 435:25-436:9; RP (November 19, 2012 Testimony of Michael Kovar, M.D.) at 50:14-53:23.

Not one witness or lawyer remotely suggested to the jury that Mr. Anderson's past drug use damaged his credibility or was any reason for the jury to disregard or discount his physical damages. The testimony of Mr. Anderson, because of his memory problems, was almost entirely confined to his damages. His credibility as to his liability claim was simply not at issue. Further, Dr. Hamon's counsel in closing explicitly confined his discussion of the drug evidence to the issue of why the extremely rare instance of a sinusitis developing into a brain abscess may have occurred in this case. RP (November 21, 2012 Defense Closing Argument) at 23:24-24:20.

Mr. Anderson must demonstrate that the verdict would have

changed, *i.e.*, the jury would have found Dr. Hamon negligent, if not for erroneous the admission of the drug evidence. *Vandercook v. Reece*, 120 Wn. App. 647, 652, 86 P.3d 206 (2004). To reach that conclusion, this court must not only engage in rank speculation but also completely disregard the medical experts that testified that Dr. Hamon met the standard of care in all respects. Without any showing in the record that the jury considered the drug evidence for the wrong reasons, and there is none, there is no basis to conclude that the jury considered the drug evidence at all. Thus, any error in admitting the evidence was harmless.

**3. The jury is presumed to have followed its instructions to decide the case on the evidence and not on prejudice.**

The jury here was specifically instructed that it must decide the issues in the case based only on the evidence, and not on bias or preference toward or against any party. *See* CP 614-16. “A jury is presumed to follow jury instructions.” *Nichols v. Lackie*, 58 Wn. App. 904, 907, 795 P.2d 722 (1990). This presumption also applies to the court’s instructions regarding evidentiary rulings. *See City of Bellevue v. Kravik*, 69 Wn. App. 735, 742, 850 P.2d 559 (1993). Moreover, “[t]hat presumption will prevail **until it is overcome by a showing otherwise.**” *Nichols*, 58 Wn. App. at 907 (emphasis added).

Mr. Anderson’s entire argument on this issue is that the evidence

of his past drug use was so monumentally prejudicial that the jury must have disregarded its instructions, disregarded the testimony of Dr. Hamon's standard-of-care experts, and found that Dr. Hamon met the standard of care. This unsupportable and purely speculative assumption cannot defeat the presumption that the jury followed its instructions.

Instead, the only indication that the jury considered the drug evidence **in any regard** was completely consistent with the trial court's limited pre-trial order, and Dr. Hamon's position. Specifically, one of the members of the jury asked Dr. Riedo at the end of his testimony, "Is it possible the delivery system of either drug mentioned, cocaine or meth, could have caused/contributed to the abscess?" RP (November 7, 2012 of Francis Riedo, M.D.) at 241:12-241:15.

**4. The case law Mr. Anderson cites does not apply to the harmful-error analysis that governs here.**

Mr. Anderson cites *Adkins v. Alum. Co. of America*, 110 Wn.2d 128, 750 P.2d 1257 (1988), which clarified Washington's prohibition of "golden rule" arguments to the jury. There, defendant's counsel improperly asked jurors to place themselves in the position of a litigant while they deliberate. *Id.* at 138-40. Mr. Anderson's reliance on *Adkins* fails. The *Adkins* Court was addressing a different type of error, with a different presumptive level of prejudice. Mr. Anderson conflates a

situation where the trial court allowed an argumentative statement universally condemned in all jurisdictions, directly appealing to the biases or passions of the jury, and the admission of evidence that there is no indication the jury ever considered in rendering its verdict. Moreover, the Court illustrated the prejudicial effect of the improper argument by comparing between two trials, one in which the improper argument occurred and one in which it did not. As the Court noted, the jury found defendant 80% at fault in the trial in which counsel did not make the improper argument, and reached a defense verdict in the second trial, when counsel did make the argument. *Id.* at 143. No such empirical comparison exists here, leaving Mr. Anderson to resort to speculation.

Mr. Anderson also cites *Salas v. Hi-Tech Erectors*, 168 Wn.2d 664, 673, 230 P.3d 583 (2010). *Salas* has no application here. The *Salas* Court held that the danger of unfair prejudice outweighed the minimal probative value of evidence of the plaintiff's immigration status on the issue of future lost wages. *Id.* at 672. The error was not harmless because there was "no way to know what value the jury placed" on the improper evidence. *Id.* at 673. Here, we know exactly what value the jury placed on the evidence: zero. The jury never got beyond the question of liability, where the evidence had no application. *See* CP 636-37. To hold that the jury probably would find for Dr. Hamon solely because it saw and heard

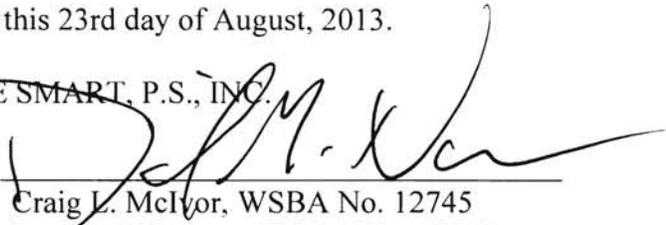
the drug evidence, this court must conclude that the jury also completely disregarded the standard-of-care testimony of multiple well-qualified defense medical experts. It is not Dr. Hamon's burden to show that the "error" was harmless. It is Mr. Anderson's burden to show that the error was prejudicial and thus reversible, and he has failed to do so.

## VI. CONCLUSION

Mr. Anderson has not met his burden of demonstrating that the limited admission of the drug evidence was an abuse of discretion. The evidence was highly relevant to the causation and damages elements of Mr. Anderson's medical-negligence claim, and Dr. Hamon's contributory-negligence affirmative defense. Moreover, the highly probative nature of the evidence was not substantially outweighed by the risk of unfair prejudice to Mr. Anderson, which the trial court actively minimized through other rulings and instructions to the jury. Lastly, to the extent the admission of this evidence was error, any such error was harmless when the jury never reached the issue for which the evidence was admitted.

Respectfully submitted this 23rd day of August, 2013.

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By: 

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**CERTIFICATE OF SERVICE**

The undersigned certifies under penalty of perjury under the laws of the State of Washington, that on August 23, 2013, I caused service of the foregoing Brief of Respondent on each attorney of record herein:

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