

No. 370810

**COURT OF APPEALS, DIVISION III
OF THE STATE OF WASHINGTON**

ARTIE LEN REINERT, JR AND CONSUELA LEE REINERT,
APPELLANTS

v.

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

AMENDED BRIEF OF APPELLANTS

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I. INTRODUCTION

This is a medical malpractice action in which Artie Len Reinert, Jr., and his spouse, Consuela Lee Reinert, are plaintiffs/appellants (hereinafter “Reinerts”). The defendants are Allen C. Heller, M.D., a neurosurgeon and, vicariously, his employer, the entity once known as Rockwood Clinic (hereinafter “Dr. Heller”). Reinerts claim that Dr. Heller, a neurosurgeon, breached the standard of care during an anterior cervical disc fusion (ACDF) procedure performed on Mr. Reinert during October of 2012. During that procedure, Dr. Heller fused the wrong cervical disc level, which then required Mr. Reinert to undergo a second ACDF procedure to fuse the correct cervical disc level. A second procedure had certain complications which then required a third, and more complex, surgical procedure, which then required Mr. Reinert to remain hospitalized in the intensive care and regular care units for a period of time. Claims were made for severe, acute and permanent injury and damages, loss of consortium, and economic loss. The Dr. Heller denied breach the standard of care and liability. A trial was held in Spokane County Superior Court in June of 2019, which resulted in a defense verdict, and from which Reinerts appealed.

Reinerts claim that the trial court erred and abused its discretion in allowing: cumulative, prejudicial, and incorrect legal standard of care testimony from Dr. Heller’s neurosurgery expert Dr. Larson; cumulative,

prejudicial, impermissible, and irrelevant testimony from Dr. Heller's neuroradiology expert, Dr. Barakos; and that Dr. Heller's counsel constructively committed prejudicial misconduct by: failing to assure that Dr. Barakos' preservation deposition videotaped testimony was properly edited to reflect the trial court's orders in limine; and repeatedly misstating the law on standard of care as being modified to include a "Community Hospital" standard of care. Reinerts claim that the trial courts errors, irregularities in the trial proceedings, and the misconduct (constructive or otherwise) of Dr. Heller's counsel prevented Reinerts from receiving a fair trial.

II. ASSIGNMENTS OF ERROR

A. Assignments of Error

1. The trial court erred in allowing Dr. Heller's counsel to elicit testimony from one of its surgical experts, Dr. Larson, that the applicable standard of care for a surgeon performing an ACDF procedure was that of a "Community/Community Hospital."
2. The trial court erred in allowing the cumulative testimony of Dr. Heller's expert ACDF surgeons Dr. Berven (orthopedic) and Larson (neurosurgery) regarding the standard of care.

3. The trial court erred in allowing preservation deposition video testimony of Dr. Heller's neuroradiology expert Dr. Barakos: for which he lacked the requisite knowledge, skill, experience, training, education, and foundation; that was more prejudicial than probative; that was irrelevant; that could not be reasonably expected to assist the trier of fact to understand the evidence or to determine a fact in issue; that likely caused the jury to speculate about an issue that was not clearly before the jury; and that was cumulative.
4. The trial court's errors in allowing certain testimony by Dr. Barakos and Dr. Larson was compounded by the misconduct (constructive or otherwise) of Dr. Heller's counsel: in failing to assure prejudicial testimony subject to the trial court's orders in limine was removed or redacted from the Barakos preservation deposition video prior to being presented to the Jury; and repeated misstatement of the law on standard of care by repeated inquiry and reference to a "Community/Community Hospital" standard of care.

B. Issues Pertaining to Assignments of Error

1. Dr. Larson's Testimony. Dr. Larson is a neurosurgeon who performs ACDF surgeries. He was the second of Dr. Heller's expert ACDF surgeons to testify at trial, and the last witness at trial. He previously

practiced in Spokane, Washington, and currently practices in Coeur d'Alene, Idaho. Dr. Heller's other ACDF surgical expert, orthopedic surgeon Dr. Berven, is from the University of California, San Francisco, School of Medicine. Reinerts' ACDF surgical expert, neurosurgeon Dr. Hamilton, is from the University of Arizona School of Medicine. Dr. Heller's counsel argued that because Dr. Berven practiced in a metropolitan academic medical setting, Dr. Larson's testimony would not be cumulative, as it was based on his perspective of providing services in a "Community Hospital" setting. Reinerts' counsel objected to any testimony concerning a "Community Hospital" perspective as being inappropriate under Washington law when related to the standard of care. The trial court agreed that cumulative testimony was not warranted, but would reserve ruling until time of testimony. However, the trial court did allow Dr. Larson to testify from his "Community Hospital" perspective. On direct examination, Dr. Heller's counsel framed the inquiry into standard of care as that of a "Community Hospital," and Dr. Larson testified that the applicable ACDF surgery standard of care was a "Community Hospital" standard of care. Dr. Berven's and Dr. Hamilton's standard of care testimony did not encompass a "Community Hospital."

In Washington, where a claim is made that injury resulted from the failure of a health care provider to follow the accepted standard of care, is

the standard of care that which is associated with a “Community Hospital?”
Did such testimony cause or contribute to Reinerts’ failure to receive a fair trial?

(Assignments of Error 1 & 2)

2. Cumulative Testimony. Dr. Heller’s expert ACDF surgeon, Dr. Berven testified that Dr. Heller did not breach the applicable surgical standard of care. Later in trial, Dr. Heller’s second expert ACDF surgeon, Dr. Larson, repeated this testimony. Additionally, Dr. Heller’s neuroradiology expert, Dr. Barakos, testified by preservation deposition video that Dr. Heller did not breach the standard of care. This testimony was presented in violation of the trial court’s orders in limine, and the jury was instructed to disregard it.

Was standard of care testimony unnecessarily cumulative and prejudicial to Reinerts? Did such testimony cause or contribute to Reinerts’ failure to receive a fair trial?

(Assignments of Error 2)

3. Dr. Barakos’ Testimony. Dr. Barakos: a) is a neuroradiologist; b) is not a neurologist, neurosurgeon, or orthopedic surgeon that clinically correlates subjective symptoms and objective clinical and radiological findings to diagnose a neurogenic condition appropriate for ACDF surgery;

c) is not a surgeon who performs ACDF surgeries; d) is not a radiology technician who operates C-Arm fluoroscopes at the direction of an ACDF surgeon in in a surgical suite; and e) does not observe ACDF surgeries. Prior to Dr. Barakos' testimony, Dr. Heller testified he believed he did use a C-Arm fluoroscope in AP viewing mode during Mr. Reinert's first surgery in attempting to locate the surgical site. Dr. Heller also testified, using Mr. Reinert's imaging, about his own clinical diagnosis of Mr. Reinert's cervical spine condition and the need for ACDF surgery at the C6-7 disk space, but not at the C5-6 disk space. Over Reinerts' counsel's objections, the trial court allowed Dr. Barakos' testimony that: a) surgeons performing an ACDF surgery never use a C-Arm in AP view mode, when attempting to identify the proper cervical disk level target of the procedure; b) the C5-6 disk level that was mistakenly fused by Dr. Heller would likely, at some unspecified time in the future, have to be fused; c) while displaying and referring to Mr. Reinert's imaging, Dr. Barakos provided detailed and laborious testimony on the anatomy and pathology of Mr. Reinert's cervical spine and the pathology of his cervical disk degeneration at C5-6 and C6-7; and d) provided numerous long, non-responsive, and irrelevant answers to questions of counsel. While there was no claim that Dr. Heller had physical injured Mr. Reinert's spinal cord, Dr. Barakos repeatedly testified that MRI imaging revealed no spinal cord injury.

Did Dr. Heller's neuroradiology expert Dr. Barakos have sufficient knowledge, skill, experience, training, education, and/or foundation to: testify about ACDF surgeon's use of C-Arms during ACDF surgeries; and otherwise opine on a clinical/diagnostic/surgical matter concerning Mr. Reinert's C5-6 disk pathology? Did Dr. Barakos' testimony, or portions thereof: have a tendency to confuse the jury; cause the jury to speculate on issues not before the jury at trial; fail the test of relevancy; and/or constitute testimony more prejudicial than probative? Did such testimony cause or contribute to Reinerts' failure to receive a fair trial?

(Assignments of Error 3)

4. Attorney Misconduct. Dr. Heller's counsel failed to assure that Dr. Barakos' video preservation deposition testimony was edited to reflect the trial court's orders in limine. This resulted in the jury hearing neuroradiology expert Dr. Barakos testify about literature representing that 50% of spine surgeons perform at least one wrong level surgery during their careers, and that Dr. Heller didn't breach the surgical standard of care, as it was known that the "counting" method Dr. Heller used to locate the surgical site was the standard of care. At trial, Reinerts' counsel objected to the standard of care testimony, and the judge ordered the jury to disregard it. Further, as referenced above, Dr. Heller's counsel repeatedly framed the

standard of care as one of a “Community Hospital,” which is a misstatement of the law that can be viewed as misconduct.

Did Dr. Heller’s counsel’s acts or omissions constitute misconduct, even if it was unintentional/constructive misconduct? Did such misconduct cause or contribute to Reinerts’ failure to receive a fair trial?

(Assignments of Error 4)

5. Cumulative Error and Irregularity. When considering the forgoing did the irregularity in the proceedings, abuse of the trial court’s discretion, and/or the misconduct of the Dr. Heller’s counsel prevent Reinerts from receiving a fair trial?

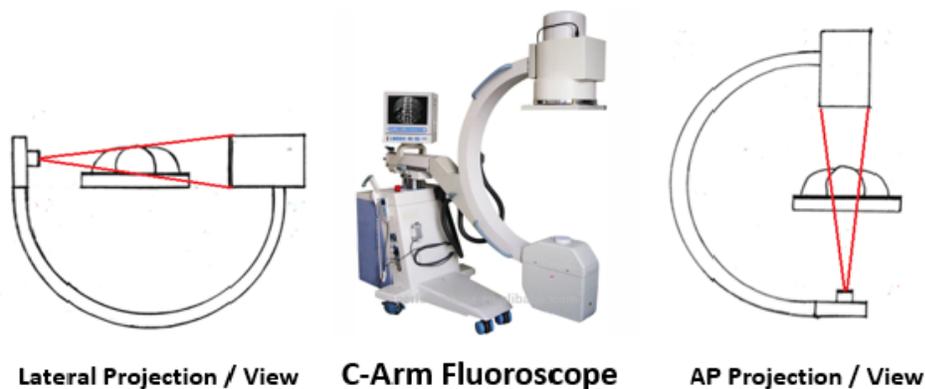
(Assignments of Error 1-4)

III. STATEMENT OF THE CASE

A. Undisputed Medical Facts

At all times pertinent to this litigation, Mr. Reinert was a large, corpulent man, six feet tall, broad at the shoulders, and with a short, thick “bull neck.” Based on prior imaging, clinical consultation, and correlation of symptoms, on October 2, 2012, Dr. Heller performed an anterior cervical discectomy

and fusion (“ACDF”) surgery on Mr. Reinert which was intended to be at the C6-C7 level. It is an ordinary procedure in such surgeries to have the patient placed under anesthesia, on the operating table, in a supine position (on their back, facing up). An appropriate technique, depending on the physical nature of the patient, such as flexibility, range of motion, body mass, etc., is attempted, to place the neck in gentle extension. It can be as simple as a placing a pad between the shoulder blades. It is also ordinary procedure for the ACDF surgeon to direct a radiology technician, operating a C-Arm fluoroscope (hereinafter, C-Arm), to use its’ real time imaging capability to aid in identifying the appropriate surgical site. In the case of a person such as Mr. Reinert, in order to better expose the patient’s neck for use of the C-Arm in helping to locate the surgical site, shoulders may be taped down, and arms pulled on by staff, all done in an effort to provide the best exposure of the neck for a lateral (horizontal) projection beam from the C-Arm. Occasionally, the C-Arm may be used in an AP projection mode (Anterior-Posterior) to aid in finding the spinal/body mid-line, or for any other purpose deemed necessary or advisable by the ACDF surgeon. See the following representations:



When there are limitations of the C-Arm’s effectiveness, a cervical disk level or other spinal “landmark” is identified with or without the aid of the C-Arm, and various other techniques are then attempted to extrapolate from that known site to the surgical site. A standard technique is counting the appropriate number(s) of disk spaces and/or vertebral bodies, in conjunction with physical anomalies or landmarks previously identified on imaging, such as arthritic change, bone spurs, etc. Counting is normally done by the surgeon with manual palpation (touch, by fingertip).

Due to Mr. Reinert’s large body habitus (large body mass index), the ordinarily accurate C-Arm imaging in “lateral” view mode could not be obtained. Dr. Heller marked and made a surgical incision lower than what was believed to be the C4 vertebral body on the right side of Mr. Reinert’s neck. After using appropriate techniques to open the surgical site down to Mr. Reinert’s anterior cervical spine, Dr. Heller used various techniques to place physical markers and correlate them in order to identify spinal

segments and disc spaces with more relative certainty. In correlation with these efforts, Dr. Heller then: counted down manually to what he believed to be the C6-7 disc space. There, he removed the disc material, sized and inserted a bone graft device, packed with a combination of synthetic bone graft material and Mr. Reinert's previously harvested blood. Dr. Heller stabilized the bone graft site with an anterior cervical disc plate, fastened to the upper and lower vertebral segments by two screws, bilaterally. He then closed the surgical site appropriately.

However, due to his inability to confirm he had performed the surgery at the correct level, he had a post-operative CT scan performed on Mr. Reinert. The CT scan revealed that the ACDF procedure was performed at the wrong, C5-6 level. Two days later, on October 4, 2012, Dr. Heller performed a corrective ACDF procedure. While removing C5-7 disk material during that procedure, he reopened and extended the prior surgical incision down to the C6-7 surgical site, and began to remove disc material. He then encountered what he believed to be small and somewhat firm and/or calcified disc fragments. In an effort to free fragment(s) from the spinal cord protective tissue, the dura, a small laceration occurred which allowed leakage of cerebral spinal fluid (CSF). Dr. Heller controlled the leakage and continued to remove disc material. He then attempted to stop the dura leak with a product often used to control post-surgical bleeding.

Believing it had stopped the leakage, he then performed a grafting procedure. He placed a plate between the C6-C7 vertebral discs in similar fashion as the first procedure, having some difficulty firmly placing the screws. The surgical site was then closed.

Mr. Reinert stayed in the hospital overnight and was discharged on October 5, 2012. Unfortunately, the dura leak was not fully controlled and, due to increased swelling in Mr. Reinert's neck, he returned to the emergency room at the hospital on October 9, 2012. There, in the emergency room, Dr. Heller attempted to drain the CSF fluid and relieve CSF pressure by placing a low back (lumbar) drain. Dr. Heller was unsuccessful and then had an interventional radiologist place a drainage needle into the spinal canal, but that was also not successful, as the spinal canal had likely become deflated due to the CSF leakage at its upper level.

Two days later on October 11, 2012, Mr. Reinert was returned to surgery for a more complex third surgery. The first part of the procedure was placement of a ventriculostomy catheter in the right side of Mr. Reinert's skull. A small hole was drilled and the catheter was inserted through his brain into the ventricle area where there was an accumulation of CSF. The intent of this was to provide a temporary drainage of CSF to relieve CSF pressure on the dura tear at the C6-7 intervertebral location, to allow its repair to heal. Dr. Heller then undertook to create a more

permanent repair to the dura tear. He reopened the prior surgical incision down to the C5-7 region encountering a pocket or accumulation of CSF, which was drained. The hardware and graft materials were removed at C6-7, some of Mr. Reinert's tissues were placed over the dura laceration and the area was covered with surgical sealing and glue type materials. Dr. Heller then placed a nt bone graft construct at C6-7, removed the plate and screws at C5-6, and placed a longer plate over the C5, C6-7 vertebral bodies. Mr. Reinert was released from the hospital on October 18, 2011. In all, Mr. Reinert spent 12 days in the hospital, 6 of which were in the ICU.

B. Pre-Trial Motions in Limine.

Plaintiffs' Motions in Limine (CP 14-22) were heard on June 13, 2019. Of particular concern to Reinerts was the preservation deposition video testimony of Dr. Barakos, a neuroradiologist. (RP p. 4, L. 6 - p. 12, L. 17). In plaintiffs' Motions in Limine, the specific motion limiting Dr. Barakos was found in Paragraph K, which includes:

“Neuroradiologist Barakos comments on the intraoperative use of the C-Arm fluoroscope as do Drs. Larson and Berven, and this testimony is also cumulative. Further, Dr. Barakos has no presence in the operating suite, and does not perform intraoperative fluoroscopy. He acknowledges it is the surgeon, not a radiologist, who is responsible for the direction of intraoperative fluoroscopy. Thus his commentary on the standard of care in the use of same lacks foundation for purposes of expert testimony, and is irrelevant. ER 401, 402, 403, and 702. His testimony should not be allowed.”

(CP 19-20)

Reinerts also moved to limit cumulative neurosurgery expert testimony in Paragraph J, which included the following:

“Defendants have disclosed two neurosurgical expert witnesses (Drs. Larson and Berven) who testify virtually identically on relevant issues in this matter. Both testify there was no breach of the duty of care and no proximate cause of damages. They also testify about: the intraoperative use of C-Arm fluoroscopy in the lateral, but not AP or other modes for ACDF surgery, and imaging difficulties related thereto; the direction of the C-Arm radiology technician by the surgeon; and the “counting” method of vertebral surgical site location. The Court is requested to limit the number of testifying defense neurosurgeons one, as their testimony is patently cumulative.”

(CP 19)

Reinerts’ counsel and Dr. Heller’s counsel argued these objections in some detail. (RP p. 4, L. 16 – p. 12, L. 17). The trial court reserved ruling on these issues.

C. Trial.

Trial testimony began on June 18, 2019, with Reinerts calling defendant Dr. Heller as their first witness, who testified on June 18 and 19, 2019. (RP p. 176, p. 154, LL. 14 - 22). Dr. Heller intended to perform ACDF surgery at the C6-7 vertebral disk space level, as a necessity. There was no intent to perform an ACDF procedure at the C5-6 level that exhibited

some pathology on MRI imaging. (RP p. 176, L. 25 – p. 177, L. 5). Utilizing Mr. Reinert's imaging, Dr. Heller described the anatomy and pathology of Mr. Reinert's cervical spine to the jury, and then discussed his considerations in diagnosing the need for C6-7 surgery for Mr. Reinert. (RP p. 177, L. 6 – p. 181, L. 7). Dr. Heller also differentiated the role of a radiologist in interpreting images versus a clinician/surgeon in diagnoses and treatment of patients. (RP p. 181, LL. 13-18). Dr. Heller acknowledged that he believed that he had imaging performed by the C-Arm in every mode, in trying to locate Mr. Reinert's C6-7 disk space in the first surgery. (RP p. 356, L. 18 – p. 357, L. 2; RP p. 359, L.8 – p. 360, L. 8).

On June 20, the trial court held a hearing on the Reinert's objections to the testimony of Dr. Barakos, Dr. Heller's expert neuroradiologist. (RP p. 393, L. 7 – p. 398 L. 4) It was in part, a continuation of the June 13 Motions in Limine hearing. However, Reinerts' counsel argued much of Dr. Barakos' testimony dealt with: a) his denial that ACDF surgeons ever use the C-Arm in AP mode to help identify a cervical surgery site, which was something that Dr. Heller, the day before, had testified he probably did do; and b) the likelihood of the necessity of C5-6 surgery for Mr. Reinert, had it not already been performed by Dr. Heller, testimony, which was now obviated by Dr. Heller's own testimony. (RP p. 394, L. 3 – p. 396, L. 6) Reinert's counsel had presented the trial court and Dr. Heller's counsel with

a highlighted copy of Dr. Barakos' preservation deposition transcript. Blue highlighting was what Reinerts' counsel understood were redactions acceptable to Dr. Heller's counsel, and orange that which Reinerts' counsel wanted redacted (objected to), should the court not bar his testimony completely. (RP p. 393, L. 19 – p. 396, L. 6). To better clarify this for this Court on appeal, and lessen the possibility of confusion, the parties have stipulated to a post-trial motion and order which presents a single transcript of Dr. Barakos' preservation deposition testimony in which: a) that testimony which was heard (and seen) by the jury is not redacted, highlighted, or shadowed, and b) that which was not heard (and seen) by the jury is represented by grey highlighting or shadow. (CP 221, CP 224-315). The proposed blue and orange edits or redactions appearing in plaintiffs' counsel's submission to the court have been reduced to references to page numbers and line numbers of the deposition. (CP 218 – 219). The trial court took the matter under advisement and review. (RP p. 97, L. 9 – p. 98, L. 4).

On the morning of June 24, 2019, a final hearing was held regarding Dr. Barakos. The trial court decided to allow the entire testimony of Dr. Barakos, with redactions (objections) proposed by Dr. Heller's counsel accepted, and almost all redactions (objections) proposed by Reinerts' counsel denied. The cumulative result of the trial court's consideration of

Dr. Barakos' testimony was, by oral ruling and filed orders in limine. (RP p. 13, L. 8 – p. 18, L. 2) (CP 203-215). The trial court ordered redaction of testimony: a) referencing literature or information that half or 50% of surgeons had performed a wrong level surgery during their career; and b) standard of care of a surgeon performing an ACDF surgery. (RP p. 13, L. 8 – p. 18, L. 2) (CP 203-215)

That afternoon, Dr. Barakos' video testimony was Heard and d. **The redactions ordered by the court for the benefit of Reinerts were not made, and were played to the jury.** However, Reinerts' counsel did not interrupt the video testimony when references were made to the number of surgeons performing wrong level surgeries during their career, but did object to the standard of care testimony which, by the time the video technician was able to stop the video, had included the most objectionable testimony. (RP p. 22, L. 11 – p. 23, L. 19).

Dr. Barakos' testimony also included a review of Mr. Reinert's cervical spine imaging, including the pre-surgery condition of C5-6. (CP p. 250, L. 1 - p. 263, L. 9) This is testimony Reinerts' counsel had objected to. (CP p. 218 (left column)) Dr. Barakos, however, admitted during his testimony that he: is not a neurologist nor a clinician who examines patients (CP p. 306, LL. 15 - 1); does not clinically diagnose neurogenic injuries (CP p. 307, LL. 15 - 16); does not operate C-Arm fluoroscopes in the operating

room during ACDF surgeries (CP p. 274, LL. 13 - 17); and is not an ACDF surgeon (CP p. 294 L.L. 8-16). However, he does believe he is qualified to and did opine to the jury that Mr. Reinert would likely have needed the errant C5-6 ACDF procedure performed in the future, but was uncertain about when that might occur (CP p. 288, L. 21 – p. 290, L. 2.) The forgoing answers regarding Mr. Reinert’s C5-6 disk pathology are to questions posed by Reinert’s counsel on cross examination, and which were objected to at trial by Reinerts’ counsel. (CP p. 218 (column 1-3)) The forgoing answers are also representative of the character of Dr. Barakos’ testimony in providing complex testimony that expands substantially beyond the questions posed. Neither Dr. Heller nor his ACDF surgical experts Drs. Berven and Larson, provided any testimony regarding the likelihood of Mr. Reinert’s C5-6 disc requiring ACDF surgery in the future.

On June 26, 2019, after Dr. Barakos’ testimony, Dr. Heller’s first ACDF surgical expert, Dr. Berven, an orthopedic surgeon, testified that he understood Dr. Heller used C-Arm AP views during his ACDF surgery on Mr. Reinert. (RP 59, L. 10-19). Dr. Berven also testified regarding Dr. Barakos’ statement that ACDF surgeons never used C-Arm fluoroscopes in the AP view during ACDF surgery, that:

“Again, **Dr. Barakos is a radiologist. He’s not a surgeon.** So what actually happens in the operating room, I think I’d be -- I’d be in a position to testify to.”

(RP p. 61, L. 2 – 4) (Emphasis added)

The defendants' second ACDF surgical expert, Dr. Larson, was the defenses last witness, and testified after Dr. Berven on June 26, 2019. (RP p. 70, LL. 7 – p. 93, LL. 22). Prior to Dr. Larson's testimony, on June 25, 2019, the court heard counsel's arguments on Reinerts' motion to exclude the testimony of Dr. Larson as, based upon his discovery deposition. Reinerts' counsel believed his testimony would be entirely cumulative. (RP p. 64, LL. 7-18). Dr. Heller's counsel argued that Dr. Larson's testimony would not be cumulative, as Dr. Larson would provide the perspective of a "Community Hospital" surgeon. (RP p. 65, L. 21 - p. 66, L. 2).

Dr. Heller's counsel differentiated Dr. Larson from Dr. Berven, who is associated with the academic teaching hospitals of the University of California San Francisco. (RP p. 65, LL. 9 - 16) The trial court concluded that it did not want to hear cumulative evidence, but that it would allow the jury to hear Dr. Larson's testimony, as he would not provide different expertise, but would bring different experience to the table. (RP p. 67, LL. 105) Reinerts' counsel objected to Dr. Heller's counsel's comingling the term "Community Hospital" with respect to ACDF surgeries and the surgical standard of care in the State of Washington, and with respect to this litigation, as it had been established that the Washington standard of care

was equivalent to the national standard of care. (RP p. 68, LL. 11 – 15). During Dr. Larson’s testimony, Dr. Heller’s counsel made reference to the term “Community Hospital” five times and in response to Dr. Heller’s counsel’s questions, Dr. Larson made reference to the term “Community Hospital” eight times. (RP p. 70, L. 19, p. 93, L. 23). Dr. Heller’s counsel specifically phrased standard of care questions in the context of a “Community Hospital,” and Dr. Larson specifically testified that the applicable standard of care was a “Community Hospital” related standard of care. (RP p. 77, L. 6 – P. 78). In one instance, Dr. Heller’s counsel phrased a standard of care question in terms of a “community spinal surgeon.” (RP p. 80, L.L. 2-5)

On cross-examination, Dr. Larson acknowledged that the applicable standard of care was national, but attempted to phrase it within the context of “this community.” (RP p. 83, LL. 1 - 25). After Dr. Larson’s testimony, the matter was put to the jury, which returned a defense verdict.

V. ARGUMENT

A. Applicable Law

1. Trial Court Rulings Subject to Abuse of Discretion Standard

A trial court’s rulings on admission of evidence and of expert

testimony are review by an appellate court for abuse of discretion. An abuse of discretion occurs when a decision is manifestly unreasonable or exercised on untenable grounds. A discretionary decision: rests on untenable grounds if the trial court relies on unsupported facts or applies the wrong legal standard; and/or is manifestly unreasonable if the trial court adopts a view that no reasonable person would take.

“We review a trial court's evidentiary rulings for an abuse of **Rulings that are manifestly unreasonable or based on untenable grounds include those that are unsupported by the record or result from applying the wrong legal standard.** Furthermore, “[a] reviewing court may not find abuse of discretion simply because it would have decided the case differently—it must be convinced that **“no reasonable person would take the view adopted by the trial court.**”

We also review the admissibility of expert testimony under this standard. In this context, “[i]f the basis for admission of the evidence is “fairly debatable,” we will not disturb the trial court's ruling.”

Gilmore v. Jefferson Cty. Pub. Transp. Benefit Area, 190 Wash. 2d 483, 494, 415 P.3d 212, 218 (2018) (Internal citations omitted) (Emphasis added.) See, also, *Hoffman v. Kittitas Cty.*, 194 Wash. 2d 217, 449 P.3d 277 (2019)

2. Only Relevant Evidence Admitted – Subject to Qualifications

Admission of evidence is tested by its relevancy:

“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.”

ER 401 (Emphasis added.)

Relevant evidence is admissible, **but evidence that is not relevant is not admissible.** ER 402. **Further, relevant evidence may be excluded if it could be unduly prejudicial, confusing, misleading, wastes time, and/or cumulative:**

“Although relevant, evidence may be excluded if its probative value is substantially outweighed by the danger of unfair prejudice, confusion of the issues, or misleading the jury, or by considerations of undue delay, waste of time, or needless presentation of cumulative evidence.”

ER 403

3. Assessment of Expert’s Qualifications and Testimony Required

A trial court is required to determine if a proposed expert witness has the requisite knowledge, skill, experience, training, or education to provide testimony that will assist the trier of fact.

“If scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education, may testify thereto in the form of an opinion or otherwise.”

ER 702

ER 702 has been construed to require that the testimony will assist the trier of fact and that the witness qualifies as an expert. *Lakey v. Puget Sound Energy*, 176 Wn.2d 909, 918, 296 P.3d 860 (2013). The emphasis

is on whether the witness could be helpful to the trier of fact rather than on the specific nature of the witness's credentials. 5B K. Tegland, Wash.Prac., Evidence Law and Practice, 702.5 at 47 (2016). The issue the trial court must determine is whether the witness's knowledge of the subject matter is such that his opinion will most likely assist the trier of fact in arriving at the truth. *Id.* **Whether an expert's testimony is admissible depends upon whether the subject matter is within his or her area of expertise.** See *In re Marriage of Katare*, 175 Wn.2d 23, 38, 283 P. 3d 546 (2012). Expert witness testimony **is subject to the tests of relevancy, and unfair prejudice:**

“To be admissible, expert witness testimony must be relevant and helpful to the trier of fact. Conclusory or speculative expert opinions lacking an adequate foundation will not be admitted. **When ruling on somewhat speculative testimony, the court should keep in mind the danger that the jury may be overly impressed with a witness possessing the aura of an expert.**”

Stedman v. Cooper, 172 Wash. App. 9, 16, 292 P.3d 764, 767 (2012) (Internal citations omitted.) (Emphasis added.)

4. Washington's State-Wide Health Care Provider Standard of Care

In Washington, since 1975, there has been only a single, state-wide standard of care applied to a claim of negligence in the provision of health care by a regulated professional:

“RCW 7.70.040 Necessary elements of proof that injury resulted

from failure to follow accepted standard of care.

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 or she 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.”

RCW 7.70.040 (Emphasis added.)

The standard of proof for a claim of injury due to breach of the standard of care is by a preponderance of the evidence. See RCW 4.24.290.

5. Violation of Order in Limine / Misstatement of Law / Attorney Misconduct

The violation of an order in limine itself, where erroneous, preserves the issue for appeal, regardless if objected to at time of trial. *State v. Brooks*, 20 Wash. App. 52, 59-60, 579 P.2d 961 (1978). An attorney’s repeated misstatement of the law in a civil trial may be misconduct, the type of which may or may not be cured by a curative instruction from the trial judge. *Kuhn v. Schnall*, 155 Wash. App. 560, 228 P.3d 828 (2010). Attorney misconduct by misstatement of the law is reviewed for its potential impact on the jury’s decision, and also for cumulative effect.

“The Court of Appeals diminished **the prejudicial effect of misstating the law** because the State produced sufficient circumstantial evidence to allow the jury to find actual knowledge. However, deciding whether a prosecuting attorney commits prejudicial misconduct “is not a matter of whether there is sufficient evidence to justify upholding the verdicts.” “Rather, the question is whether there is a substantial likelihood that the instances of misconduct affected the jury's verdict.” The Court of Appeals' reliance on the sufficiency of the evidence is misplaced. Second, the misstatement of law was repeated multiple times. **Repetitive misconduct can have a “cumulative effect.”**”

State v. Allen, 182 Wash. 2d 364, 375-76, 341 P.3d 268, 274 (2015) (internal citations and paragraph break omitted.) (Emphasis added.)

Where attorney misconduct is prejudicial, the error preserved for appeal, and not cured by the trial court's instructions to disregard (all determined within the context of the record), a new trial is warranted. *Mears v. Bethel Sch. Dist. No. 403*, 182 Wash. App. 919, 332 P.3d 1077 (2014).

6. Definition of Words

Generally, the courts will give words their ordinary meanings. However, when words are used as technical terms or terms of art, the courts will impose those meanings. *Health Pros Nw. Inc. v. Dep't of Corr.*, 10 Wash. App. 2d 605, 622-23, 449 P.3d 303 (2019)

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7 “Community Hospital” Defined

In 2019 (as in 2020) the American Hospital Association clearly defined “Community Hospitals” as follows:

“Community Hospitals are defined as all nonfederal, short-term general, and other special hospitals. Other special hospitals include obstetrics and gynecology; eye, ear, nose, and throat; long term acute-care; rehabilitation; orthopedic; and other individually described specialty services. **Community Hospitals include academic medical centers or other teaching hospitals if they are nonfederal short-term hospitals.** Excluded are hospitals not accessible by the general public, such as prison hospitals or college infirmaries.”

ARCHIVED: Fast Facts on U.S. Hospitals, 2019: AHA. <https://www.aha.org/statistics/2020-01-07-archived-fast-facts-us-hospitals-2019> (Accessed 06/27/2020) (Emphasis added.)

According to the online version of the Journal of the American Medical Association (JAMA), the medical community accepts this definition:

“Community Hospitals (Nonfederal Acute Care)

Most US hospitals are classified as **Community Hospitals** according to the American Hospital Association. Two-thirds are located in large cities. Some Community Hospitals provide general care, and others focus on certain diseases and conditions, such as orthopedics, to provide specialty care. A general Community Hospital might also have areas of concentration or expertise, such as trauma and cancer care that are often verified by accreditation organizations like the American College of Surgeons. **Community Hospitals can have as few as 6 beds or more than 500 beds.**

Community Hospitals can also be classified as major teaching, minor teaching, or nonteaching hospitals. Teaching hospitals

train future physicians and other health care professionals. They also have ongoing research projects or clinical trials and provide care for patients with rare or complex conditions. Major teaching hospitals, or academic medical centers, may be affiliated with a medical school. Nonteaching hospitals have professionally trained medical staff and focus on providing essential care for patients in a community rather than medical training and research.”

Types of Hospitals in the United States, Jason B. Liu, <https://jamanetwork.com/journals/jama/fullarticle/2702148>. (Accessed 6/27/2020) (Emphasis added.)

Further, under the Centers for Medicare and Medicaid Services (CMS), the prospective payment system is a method of reimbursement in which payment is made based on a predetermined, fixed amount. The payment amount for a particular service is derived based on the classification system of that service (for example, diagnosis-related groups for inpatient hospital services). Under the prospective payment system, CMS has designated certain benefits for “**Sole Community Hospitals.**” For various reasons, CMS makes adjustments in payment to them, in order for them to remain economically viable. See 42 CFR § 412.92.

B. Irregularity in the Proceedings, Abuse of the Trial Court’s Discretion, and the Constructive Misconduct of the Prevailing Party Prevented Reinerts from Receiving a Fair Trial

1. Dr. Larson’s “Community Hospital” Standard of Care Testimony

a. Reinerts' Objections Reinerts' counsel vociferously objected to Dr. Larson's testimony, in advance. Concern was first as to its cumulative nature, then as an inappropriate statement on the standard of care, when Dr. Heller's counsel raised the specter of a "Community Hospital" standard of care "perspective."

"MR. RICCELLI: I'm advised that Dr. Jeff Larson, a neurosurgeon, is the next witness for the defense. And I'm -- I'm unsure as to what he has to offer which wouldn't be cumulative. I understand he's going to testify to the standard of care and counting down method and use of AP fluoroscopy.

THE COURT: So are you making an objection --

MR. RICCELLI: I'm object -- I'm --

THE COURT: -- as to cumulative testimony by Dr. Larson?

MR. RICCELLI: **Yes, I'm making objection to -- from what I know from his deposition, his entire testimony is cumulative.**

THE COURT: All right. Mr. Sestero?

MR. SESTERO: Your Honor, I have the same response that was briefed and argued in opposition to plaintiff's motion in limine on this very topic, which is that --

THE COURT: Which I didn't really rule on. I think I reserved.

MR. SESTERO: Okay.

THE COURT: **I indicated I would allow, but of course I've got to hear it. If it's cumulative, I -- there's no reason to allow it. I mean, we don't need to plow the same field over and over, do we?**

MR. SESTERO: No, and it's not my intention to plow all of the same field.

THE COURT: Okay.

MR. SESTERO: **But the perspectives of the respective experts are different.** And just like Mr. Riccelli tried to analogize a neuroradiologist to a surgeon inappropriately, **Dr. Berven is an academician who works at a major medical center in a major metropolitan area, Dr. Larson is acutely familiar with the resources and practices here locally and in a Community Hospital –“**

(RP p. 64, L. 7 – p. 66, L. 15) (Emphasis added).

“MR. RICCELLI: **If I may, the standard of care is a national standard of care.*** ... **But I don't understand the offer of a community -- a Community Hospital perspective. I don't think it has any place in this litigation.**

THE COURT: **All right. So I'm going to let Dr. Larson testify. I think he brings just a different -- not necessarily a different expertise but a different set of experiences to the table....”**

(RP p. 66, L.15 – p. 6, L. 13) (Emphasis added) (*Non-pertinent transcription removed).

“MR. RICCELLI: -- Mr. Sestero if he -- he said something about standard of care; but I'm not sure that there's any issue of standard of care that wouldn't be related to **the national standard of care, which is similar to the Washington standard of care,** and as discussed by the previous witnesses.

THE COURT: Okay. So I've already indicated I'm going to allow the testimony. As we go through this, you're free to object **but...**

MR. RICCELLI: Okay....”

(RP p. 68, LL. 9 – 19) (Emphasis added).

Here, the trial court clearly indicated and ruled:

(1) It wasn't interested in hearing cumulative testimony;

(2) It believed Dr. Larson's "different set of experiences" as a Community Hospital surgeon was relevant to the standard of care issue, thus making such testimony different from Academician Dr. Berven, and thus non-cumulative; and

(3) Reinerts' counsel could object as to "Community Hospital" and standard of care, and be overruled, as the only reasonably contextual meaning of the trial court's use of the dangling conjunction "but. . . ."

This placed Reinerts' counsel in a conundrum. Objecting to any standard of care testimony as cumulative, whether or not in the proper context of Washington law, is still correct as the ultimate cumulative nature is that of two ACDF surgeons were testifying as to Dr. Heller not breaching the standard of care. Such an objection would give the trial court an opportunity to rethink its position during the course of the testimony. Objecting as to "Standard of Care" and being overruled each time would serve to magnify and reinforce the improper framing of a "Community Hospital" standard of care. Having made a clear record on objecting to "Community Hospital" testimony, Reinerts' counsel chose the lesser confrontational approach. However, after having heard inquiry and response repeatedly referring to "Community Hospital," Reinerts' counsel objected, and was promptly overruled. (RP p. 80, LL. 10 – 17). **Here, the**

trial court applied the wrong legal standard to Dr. Larson’s testimony which modified for the jury Washington’s medical standard of care law to be that of a “Community Hospital.”

b. Dr. Larson’s Testimony Re: Community Hospital Standard Of Care

Following are excerpts of Dr. Heller’s counsel’s direct examination of its second expert ACDF surgeon, Dr. Larson:

“Q. In the Community Hospitals that you worked at and were aware of in Spokane and Coeur d’Alene in 2012, what did the standard of care require for localization of the surgical level in a C6-7 ACDF operation on a patient like Mr. Reinert?”

MR. RICCELLI: Objection. Again, it's cumulative

THE COURT: Okay, overruled.

A. The standard of care in the Community Hospital in this area in Spokane then in 2012 is the same as it is now in 2019.”

(RP p. 77, L. 19 – p. 78, L. 3) (Emphasis added).

“Q. Based on your review of all the materials and your education, skills, and experience, and given your community practice of neurosurgery, do you have an opinion whether Dr. Heller met or violated the standard of care when he performed the operation on Mr. Reinert on October 2, 2012?”

MR. RICCELLI: Objection to the form of the question. It's cumulative.

THE COURT: Okay, overruled.”

(RP p. 77, L. 21 – p. 78, L. 1) (Emphasis added).

Q. Given that Deaconess was a Community Hospital and given the challenges presented by the imaging on October 2, 2012, did the standard of care as it applied to Dr. Heller that day require him to refer Mr. Reinert out to an academic center?

MR. RICCELLI: Object to the form of the question. The foundation as to Community Hospital is not relevant to standard of care.

THE COURT: Okay, overruled.

(RP p. 80, L.L. 10-17) (Emphasis added).

Not only was referencing a “Community Hospital” standard of care a wrong statement of Washington law, Dr. Heller’s counsel’s construct of a “Community Hospital” standard of care misused the accepted terminology. By the accepted terminology, non-federally owned non-metropolitan hospitals, such as Deaconess in this instance, share the “Community Hospital” moniker with no-federally owned metropolitan teaching center hospitals. Dr. Larson’s direct examination and testimony stated otherwise

As Dr. Larson had practiced in Spokane, Washington, prior to relocating to Coeur d’Alene Idaho, perhaps he confused the Washington state-wide standard of care rule with Idaho’s “Community” standard of care rule, which qualifies the standard of care to the practices of those professionals in the geographic service areas of the local general hospital. IC 6-1012. The Idaho law does not establish a “Community Hospital” standard of care. Regardless, even if Dr. Larson may have been confused

as to the applicable law, **there is no excuse for the trial court allow, and for Dr. Heller’s counsel to elicit, Dr. Larson’s “Community Spinal Surgeon” and “Community Hospital” surgeon’s “perspective” or “experience” on the standard of care in performing ACDF surgery in Spokane, Washington, in 2012.**

On cross examination, Dr. Larson did begrudgingly admit the applicable standard of care was a national standard of care, but in the context of **“this community.”** (RP p. 83 L.L. 1-25)

2. Cumulative Standard of Care Testimony

The trial court stated it didn’t want Dr. Heller’s counsel to plow old ground by producing cumulative testimony with Dr. Larson. Dr. Heller’s counsel said he wouldn’t, as Dr. Larson would provide a perspective of his practice in a “Community Hospital,” one different than that of Dr. Berven (and by analogy, that of Reinert’s’ expert ACDF surgeon, Dr. Hamilton). However, critical review of Dr. Larson’s testimony reveals he did not testify to any differing perspective or experience (a term used by the trial court) in his purported “Community Hospital” practice as an ACDF surgeon. The sum of Dr. Larson’s testimony was merely a conclusion that there was some undefined difference in his practice in a “Community Hospital” setting that made it a different type of practice when compared to those who practice in

metropolitan academic teaching center hospitals. This then purportedly allowed the false construct of a “Community Hospital” standard of care to be put before the jury. In doing so, this obviously had the effect of diminishing the quality and nature of both Dr. Berven’s and Dr. Hamilton’s testimony, and that of Dr. Barakos. The effect, however, was to leave only Dr. Heller with an expert who had an accurate and definitive knowledge of the applicable “Community Hospital” standard of care, Dr. Larson. Unfortunately, to fully appreciate the nature and effect of Dr. Larson’s testimony on “Community Hospital” standard of care is to read it in its entirety. (See RP p. 70 L. 18 – p. 93 L. 22).

As is more fully developed in the next section below, given the testimony received by the jury from Dr. Barakos on standard of care, and the trial court’s weak admonishment to disregard it, it is likely the jury considered the testimony to some degree. Dr. Barakos was an “Expert” who, through lengthy, complex, irrelevant, and nonresponsive testimony probably confused the jury into thinking he was an expert beyond their comprehension, and it was only his conclusions that really mattered. Additionally, the testimony that Dr. Heller did not breach the standard of care resonated in harmony with the testimony of Drs. Berven and Larson.

The jury was left with a prejudicial “box score” on cumulative standard of care testimony as follows:

PARTY	EXPERTS	BREACHED Std of Care	NO BREACH Std of Care	Com Hosp Std of Care	Disregard Testimony
Heller	3	0	3	1	1
Reinerts	1	1	0	0	0

Dr. Heller's experts' standard of care testimony was prejudicially cumulative. The trial court erred and abused its discretionary authority in; a) allowing the cumulative standard of care testimony of Dr. Larson; and b) allowing the testimony of Dr. Barakos (discussed below), generally, which led to his errant testimony on standard of care. This all combined to result in denying Reinerts a fair trial.

3. Dr. Barakos' Testimony

In this instance, **the record is clear that the trial court abused its discretion in allowing any testimony by Dr. Barakos.** The record found above in the Statement of the Case displays that Dr. Barakos has no direct knowledge or experience regarding an ACDF surgeon's use and application of a C-Arm during an ACDF surgery. Dr. Barakos also has no experience in clinically assessing a patient's subjective and objective symptoms, and correlating them with imaging and the knowledge and experience in

providing non-surgical and surgical treatments. Further, much of his testimony was irrelevant.

Prior to Dr. Barakos' testimony, which included his denial of ACDF surgeons use of C-Arms in AP mode to assist in locating cervical disk spaces, defendant Dr. Heller essentially testifies to the contrary regarding trying to locate the C6-7 level during Mr. Reinert's first surgery. (RP p. 358, L. 24 – P. 359, L. 17). This was even confirmed by Dr. Heller's first expert ACDF surgeon, Dr. Berven:

“Q. Now, you said you understand that Dr. Heller used AP views?”

A. That's my understanding, is there was, again, somewhere between six -- 16 1/2 seconds of fluoroscopy would be somewhere between 60 and 80 images. And **it's my understanding that those included both some AP and lateral images.** In general, the most reliable images are going to be the lateral images, and those are the ones that I've relied upon most.”

(RP p. 59, LL. 10 – 17)

In addition to Dr. Heller, ACDF surgeons Drs. Berven and Larsen were to testify on behalf of Dr. Heller. They had the experience on C-Arm use issues, instead of radiologist Barakos. Dr. Heller's expert Dr. Berven agrees:

“Q. Okay. But my question was about Dr. Barakos, who stated yesterday he doesn't think AP surgeons ever use the AP view. Is he incorrect in that statement as far as your practice is concerned?”

A. Again, **Dr. Barakos is a radiologist. He's not a surgeon. So what actually happens in the operating room, I think I'd be -- I'd be in a position to testify to.** And we use the best available images. Dr. Heller used somewhere around 60 to 80 images. And he did a lot of work, two hours of fluoroscope technician time, to try and identify the level. And I think that's appropriate and consistent with what I'd expect –

Q. Well, excuse me.

A. -- my surgeon to do.”

(RP p. 60, L. 23 – p. 61, L 10).

Dr. Barakos also testified extensively, referring to MRI imaging of Mr. Reinert. Dr. Barakos then provided a diagnostic opinion that Mr. Reinert’s C5-6 disk level would have required surgery at an indefinite time in the future (had Dr. Heller not errantly fused it).,” (CP p. 288. L.21 – p. 290, L. 2). This testimony was allowed over Reinerts’ counsel’s objections. (CP p. 218 (column 1)). However, Dr. Heller intended to perform surgery only on C6-7 as a necessity, while surgery at any time on Mr. Reinert’s C5-6 disk space was not:

“Q. No, I mean do your clinical notes reflect the fact that you discussed potentially doing C5-6?

A. My clinic notes discuss the pathology at C5-6 but does not go into any detail about that discussion, no.

Q. And the plan was to do 6-7. And do -- as you can recall, was it a medical necessity to do 5-6 at the time?

A. **No.**

Q. Was it a medical necessity to do 6-7?

A. Absolutely.”

(RP p. 154, LL. 14 – 22) (Emphasis added).

During his testimony, Dr. Heller acknowledged his role as a clinician and surgeon:

“Q. Okay. Now, Doctor, you -- as a clinician and surgeon, you're the person who decides what condition the patient's in from both clinical assessment and radiology and you decide whether surgery is necessary, advisable, or unadvisable, correct?

A. That's correct.”

(RP p. 176, L. 25 – p. 177, L. 5).

Utilizing Mr. Reinert’s imaging, Dr. Heller described the anatomy and pathology of Mr. Reinert’s cervical spine, and then discusses his considerations in diagnosing the need for C6-7 surgery for Mr. Reinert. (RP p. 177, L. 6 – p. 181, L. 7). Dr. Heller also differentiated the role of a radiologist in interpreting images versus a clinician/surgeon:

“Q. Do radiologists, do they make clinical decisions and recommendations on surgery to patients?

A. **No.** You will sometimes see a radiologist report -- **they're the people who just interpret the images.** If they see something, they might suggest neurosurgical consultation; but that's for things in an emergency setting.”

(RP p. 181, LL. 13-18) (Emphasis added).

Neither defendant Dr. Heller nor defense ACDF surgical experts Drs.

Berven and Larson, provided any testimony regarding the likelihood of Mr. Reinert's C5-6 disc requiring ACDF surgery in the future. Dr. Heller's Counsel elicited evidentiary insufficient testimony from Reinert's Expert ACDF surgeon, Dr. Hamilton, on cross examination:

“Q. And on a more probable than not basis, was Mr. Reinert going to need surgery at C5-6 at some point in the future?

A. Yeah, I -- **I don't feel comfortable -- I would be speculating. I would say that I would -- if you were asking me as a patient, I would say probably about a 50 percent chance that you're going to have to have surgery at a higher level because of adjacent segment disease.**

Q. I don't want to talk about generalities about patients.

A. No, I'm talking about Mr. Reinert.

Q. All right. So in terms of Mr. Reinert and the C5-6 level, if there had been a one-level fusion at C6-7, **is it your opinion that he had a 50 percent chance of needing surgery at C5-6 eventually?**

A. **About, yes.**”

(RP p. 268, L. 20 – 269, L. 8) (Emphasis added).

The only witness that concluded surgery was likely for Mr. Reinert's C5-6 disk level (at some indefinite time) was non-surgeon and non-clinician Dr. Barakos. Dr. Barakos was patently unqualified to testify about an ACDF surgeon's use of a C-Arm, or lack thereof during surgery, and about any surgical diagnosis as to Mr. Reinert's C5-6 disk space. Dr. Barakos lacked the expertise, knowledge, skill, experience, training, or education to

do so. He also had no foundation to do so, as that would have required him interpret Mr. Reinert's medical records as would be done by a neurologist or neurosurgeon to assess objective and subjective symptoms, in addition to correlation with imaging. Allowing him to testify as an expert in these matters was a patent abuse of discretion by the trial court.

Dr. Barakos' testimony was also replete with irrelevant medical gobbledeygook. Much of this was in relation to his use of MRI images for the jury's consumption. Often, this was all found in an answer that was lengthy, complex, and non-responsive to the question posed:

“Q. Okay. So the purpose in presenting this image from your standpoint, then, how does that relate to the issue of whether the two-level fusion occurred or miss-occurred due to imaging?”

A. Yes, sir. A good point. And the point is although using the MRI we can clearly see that the primary disc pathology is at C6-7, operating room, you do not have this information. In other words, you do not have this ability to localize. Remember, the fluoroscopy being used intraoperatively just shows you these faint outlines of the vertebra. It doesn't show you the disc, the soft tissues, the degenerative disease, or the spinal canal stenosis. So the reality, the purpose of this image is to show, yes, this MRI is a very powerful tool that can show us where the pathology is. But when you're in the operating room, you don't have this information. All you see are some faint outlines in the vertebra, and to get this level you need to do what the standard procedure consists of, namely, counting vertebra from the C2 down. So I think that's the important point to understand. It's not as if intra-operatively the surgeon can see exactly where this disc is. They have to rely on the vertebral localization.

Q. So my question, again, is what is the relevance, then, of this image as to whether or not Dr. Heller breached the standard of care

or did not due to fluoroscopic imaging as opposed to MRI imaging – MRI imaging? What is the relevance of this particular MRI scan to be shown to the jury?

A. Yes, sir. It has great relevance. Namely, it shows the indication for why the patient needed the surgery and also lays the foundation for the anatomy which is the entire basis of the information that the surgeon is going to be using intraoperatively to help them identify and localize the disease. So this is the essence of why the surgery is being done and gives us the factual foundation of understanding how the surgeon is going to use this information to localize the area of surgery.”

(RP p. 62 L.19 – p. 65 L. 9).

Recall, there was no dispute as to Mr. Reinert’s need for C6-7 surgery. Unfortunately, the only way to fully appreciate the large quantity of irrelevant and non-responsive testimony of Dr. Barakos is to read the transcript of his testimony, most of which Reinerts’ counsel specifically objected to due to Dr. Barakos being unqualified to testify on clinical/surgical issues, relevance, and foundation. (See CP, p. 216 – 315).

Dr. Barakos’ testimony, when viewed in total, had an overwhelming likelihood of confusing the jury, not assisting it in addressing relevant factual issues. One most egregious example is the repetitive inquiry by Dr. Heller’s counsel into whether Dr. Heller’s surgeries left any physical injury to Mr. Reinert’s spinal cord that is identifiable on imaging. This testimony was specifically objected to as irrelevant, confusing, and cumulative, as: such injury wasn’t being claimed; Dr. Heller had already

testified to this; and Dr. Hamilton, Reinerts' expert ACDF surgeon, had already testified to this:

“THE COURT: So the orange is what you want out?

MR. RICCELLI: Yeah. And -- and basically Dr. Barakos testified as to the sagittal view of the spine and pointing out the two levels of disc, you know, the 5-6, 6-7, the same testimony that Dr. Hamilton and Dr. Heller agreed there was degenerative disease there. He testified that there may be a Likelihood of more degeneration over time, which both Dr. Hamilton and Dr. Heller agree to, and that basically it's -- it goes through the laundry list of no -- based on the imaging, there's no definable neurological injury, which Dr. Hamilton and Dr. Heller agree to.”

(RP p. 395, LL. 5 - 15)

It was manifestly unreasonable an abuse of the trial court's discretion to allow the testimony of Dr. Barakos: for which he lacked the requisite knowledge, skill, experience, training, education, and foundation; that was more prejudicial than probative; that was irrelevant; that could not be reasonably expected to assist the trier of fact to understand the evidence or to determine a fact in issue; that likely caused the jury to speculate about an issue that was not clearly before the jury; and that was cumulative. This all resulted in Reinerts' failure to receive a fair trial.

4. Misconduct

Although Dr. Heller's counsel utilized a purported Audio/Visual/ Technical service individual from Seattle to compile, display, edit, and

produce trial exhibits, video testimony, and other enhancements at trial, counsel remained responsible to assure testimony subject to the trial court's orders in limine was not presented to the jury. Unfortunately, the jury heard the following testimony from Dr. Barakos' preservation deposition video that was restricted by the trial court's orders. In the following excerpts which represent testimony heard by the jury, that which is underlined is testimony that was subject to the trial court's orders in limine, and was to be edited out of the video:

“Q. How often do you see a surgeon doing an ACDF procedure have a patient imaged immediately or close to immediately after the surgery to see if the level that was operated on was the correct level?
A. I would say that's less common. I mean we do know that the literature shows that about half of all surgeons have operated at the wrong level at some time in their career –“

(CP p. 278, LL. 14 - 21) (Emphasis added,).

“THE WITNESS: I'm sorry. So the question basically was how often do I see a surgeon obtain a film immediately following surgery specifically for a question you asked, how often do they obtain it when they think they may have been at the wrong level?
. . . . And I was saying I'm thinking, I know that at our institution, again, directly responsive to your question, that our rate of wrong levels reflects what the literature, what the medical literature shows, that it's -- it's less than 1 percent. **And that's a reflection of the fact that the literature shows about 50 percent of all surgeons at one point or another in their career have been off a level or more.** . . .
. . . **So my answer is it's infrequent, but I have seen it several times over my 25-plus year career.**”

(CP p. 279, LL. 5 - 19). (Emphasis added,)

THE WITNESS: **Let's see. So a wrong-level surgery is not seen as a breach of the standard of care. Why? Because the methods**

employed to identify the appropriate level of surgery are well defined and well accepted. And just as in this case, the standard is one of counting, numerically counting.”

(CP p. 282 L.L. 4-9). (Emphasis added,)

Curiously, the last two excerpts of testimony represent testimony in which the questions were edited out of the video, but not the answers. All three statements are highly prejudicial. The literature Dr. Barakos was referring to was not restricted to ACDF surgeries, and Dr. Barakos, not being a surgeon, had no experience, foundation, etc., to testify about literature on surgery. Also, literature and statistics on the frequency of a generic “wrong level surgery” is not relevant to the issue of breach of standard of care, in any particular case. Testimony by a radiology expert on surgical standard of care is patently objectionable and prejudicial. Regardless, failure to object does not obviate appeal on this testimony, as it was testimony subject to the court’s orders in limine, breach of which by Dr. Heller’s counsel preserves the issue for appeal. The jury heard this prejudicial testimony on frequency of occurrence twice. Had objection been made, and the court made two curative orders, the entire process would have burned the testimony into the minds of the jurors.

As to the errant standard of care testimony, the objection was made as it struck at the heart of a medical negligence case. The very reason it was subject to an order in limine was its highly prejudicial and inappropriate

nature, coming from a neuroradiologist. Further, its prejudicial nature was enhanced as it was cumulative to standard of care testimony by Drs. Berven and Larson. Unfortunately, the trial judge was apparently not following the video testimony carefully at the critical moment of concern, and gave the jury what only can be described as a weak, obtuse, and/or opaque curative instruction:

(A VIDEO DEPOSITION IS BEING PLAYED.)

“MR. RICCELLI: Your Honor?

THE COURT: Is there an issue?

(VIDEO DEPOSITION PAUSED.)

MR. SESTERO: That should have been omitted from line 22 before...

THE COURT: I'm sorry?

MR. SESTERO: That should have been omitted from line 22 of page 53.

MR. RICCELLI: Subject to the motion in limine.

MR. SESTERO: I have no problem with an instruction to the jury that the most recent answer should be stricken.

THE COURT: Page 53, line 22?

MR. SESTERO: That's what I have written down.

THE COURT: Okay.

MR. SESTERO: That it's gone into page 54

.

THE COURT: All right, so that should have been redacted? It should not have been played?

MR. SESTERO: That most recent answer should have been redacted.

MR. RICCELLI: Yes.

THE COURT: You agree. So I'll –

MR. RICCELLI: Yes.

THE COURT: -- instruct the jury to disregard the last -- I guess the question?

MR. SESTERO: It's all -- it's the answer.

MR. RICCELLI: The answer about the national standard of care --

THE COURT: Okay.

MR. RICCELLI: -- and which he's not a surgeon.

(VIDEO DEPOSITION WAS RESTARTED FOR A SECOND AND IMMEDIATELY STOPPED.)

THE COURT: Okay, I don't know that he got – actually got into the answer. In any regard, disregard the last question-and-answer series, please.”

(RP p. 22, L. 10 – p. 23, L. 19).

Once again, Reinerts' counsel faced a conundrum. The trial court's curative instruction was grossly inadequate in the context it was given, revealing the trial court's lack of assuredness that any harm had occurred. However, as the trial court appeared not to have been following the video testimony, any attempt to have the instruction revised would require a

replay of the testimony, or a rendering from the transcript, either of which were inadvisable courses of action in front of the jury. Alternatively, the jury could be recessed, and the matter then taken up, after which any revised curative instruction would have necessarily involved, at minimum, summarizing the nature of the testimony, then giving the instruction to disregard it. Understandably, Reinerts' counsel chose not to pursue a revision to the curative instruction. Reinerts are not alleging Dr. Heller's counsel's omission in failing to assure the video testimony had been properly edited before presentation to the jury was an intentional act of misconduct. However, given that the testimony was obviously prejudicially irrelevant and/or improper, the omission is substantial in nature, and should be considered constructive misconduct by this Court.

Similarly, as Dr. Heller's counsel is a well experienced medical malpractice defense attorney, he is presumably well aware of the extent and nature of Washington's medical standard of care law as found in RCW 7.70.040. While he may have considered the construct of a "Community Hospital" framed standard of care permissible litigation "gamesmanship," repeated misstatement of the law, or repeated inferences thereon, in front of the jury, should also be considered by this Court as misconduct of a constructive nature. Perhaps the trial court was not extremely familiar with medical standard of care actions or trials, and

acceded to Dr. Heller's counsel's arguments about a "Community Hospital" perspective of testimony too easily. This does not excuse the trial court's error by abusing its discretion in ruling favorably for Dr. Heller on this issue. Dr. Heller's counsel is immersed in litigation concerning RCW 7.70.040 daily. Perhaps counsel considered the "Community Hospital" ploy litigation "Gamesmanship." Regardless of intent, Dr. Heller's counsel should be presumed to fully know and understand the standard of care law of Washington, and should not be allowed to escape responsibility for such prejudicial acts which surely deprived Reinerts a fair trial.

V. CONCLUSION

As is set out in detail above, the individual and cumulative irregularities in the proceedings, abuse of the trial court's discretion, and misconduct attributable to the prevailing party prevented Reinerts from receiving a fair trial. Mr. and Mrs. Reinert respectfully request this Court to grant them a new trial on all claims.

RESPECTFULLY SUBMITTED this 9th day of July, 2020.

MICHAEL J RICCELLI PS



By: _____
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Attorney for Appellants Reinert

CERTIFICATE OF SERVICE

I hereby certify that on the 9th day of July, 2020, I caused a true and correct copy of the Amended Brief of Appellant to be served on the following in the manner indicated below:

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