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IN THE COURT OF APPEALS FOR
THE STATE OF WASHINGTON

DIVISION III

ARTIE LEN RENERT, JR AND CONSUELA LEE REINERT,

Appellants,

v.

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

Respondents.

BRIEF OF RESPONDENTS

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I. INTRODUCTION

Artie Reinert (Reinert) had advanced degenerative disc disease at two levels of his cervical spine: C5-6 and C6-7. The situation at C6-7 was the most serious because impingement of the spinal cord was causing neurologic symptoms/deficits that threatened to progress to the point of paraplegia. Reinert discussed a two-level surgery with neurosurgeon Allan Heller, MD (Dr. Heller) to address the issues, and Reinert and Dr. Heller decided to proceed with surgery at C6-7 urgently because of the extent of the pathology and the possible dire consequences of delay.

On October 2, 2012, Dr. Heller took Reinert into surgery at Deaconess Hospital with the objective of performing an anterior cervical discectomy and fusion (“ACDF”) at C6-7. As the name indicates, ACDF is performed via an anterior approach - through the front of the neck.

ACDF presents surgery site location challenges not present with a posterior approach. Because the patient is on his back, the surgeon cannot see or feel the bony prominences on the posterior of the spine that mark the location of individual spinal vertebrae. Accordingly, to properly identify the target vertebral space for ACDF, the surgeon uses a special x-ray machine called a c-arm fluoroscope to identify the proper location for the incision. After dissecting down to the cervical spine through the front of the neck, the surgeon, again using fluoroscopy, marks a known vertebral

space with a metallic marker. He then locates that space with his fingers, and using feel, counts down individual vertebrae and disc spaces until he reaches the target disc space. This method for locating the target space for ACDF is longstanding, universally accepted and in full compliance with the applicable standard of care.

Here, the counting technique was complicated by the extent of degenerative changes in Reinert's vertebrae which made the peaks and valleys between the vertebrae less pronounced. As a result, Dr. Heller miscounted by one vertebrae and operated on the wrong disc space – C5-6 instead of C6-7.

The error was discovered immediately after the surgery with the aid of CT and promptly disclosed to Reinert. An ACDF on C6-7 was then performed on October 4, 2012. During that surgery, because of the manner in which the disc was adhered to the spinal cord, removal of disc material caused a small hole, or dural leak, in the cord, a not uncommon occurrence during spinal disc surgery. The leak resulted in an emergency room visit and surgical correction by Dr. Heller on October 11, 2012.

Reinert sued Dr. Heller and his employer (Rockwood Neurosurgery and Spine Center), claiming Dr. Heller violated the standard of care by operating on the wrong cervical level on October 2, 2012. On the issue of damages, Reinert's claim, generally, was that the operation on the wrong

level on October 2, 2012 subjected him to a surgery he otherwise would not have required (ACDF on C5-6), that but for the wrong-level surgery on October 2, the dural leak at C6-7 and associated treatment therefor would not have occurred, and that symptoms Reinert experienced after all the surgeries, including neck pain, were caused, in whole or in part, by Reinert having undergone three surgeries instead of one.

Generally, Dr. Heller's defense was that the methods and techniques he used to ascertain the surgical level on October 2, 2012 were well established, universally accepted and in full compliance with the applicable standard of care. On the issues of causation and damages, Dr. Heller contended that, because of the nature and extent of the adhesions between the disc material and spinal cord, the October 4th dural leak and associated treatment would have happened even if the C6-7 surgery had taken place on October 2, as planned. Dr. Heller also claimed that surgery on C5-6 would most likely have been required eventually, and that the symptoms Reinert attributed to the additional surgeries were not the result of the surgeries themselves but, rather, were a consequence of the natural progression of Reinert's degenerative disc disease.

At trial, imaging technology - the characteristics, advantages/disadvantages, limitations, uses and availability of various imaging techniques and equipment - was a core issue. Reinert criticized

Dr. Heller for not taking additional and/or different views with the fluoroscope intraoperatively, for not summoning a radiologist to the operating room to assist in locating the appropriate surgical level, and for not aborting the operation and sending Reinert to a hospital in Seattle where he allegedly would have access to more sophisticated imaging techniques, equipment and expertise, including various intraoperative 3-D technologies. Reinert's expert on the standard of care, Alan Hamilton, MD, was from a large academic institution and actually helped develop some of the 3-D imaging techniques discussed.

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

findings on the imaging actually done on Reinert, including Dr. Heller's intraoperative fluoroscopy and pre- and post-operative MRIs.

Reinert objected to the testimony of Dr. Larson and Dr. Barakos on the ground of cumulativeness. A component of the objection was that Dr. Larson's offering a standard of care opinion from the perspective of a "community hospital" practitioner was improper. The trial court overruled the objection.

The court overruled the objection and, during Dr. Larson's direct examination, defense counsel and Dr. Larson made several references to a "community hospital." Despite those references, Reinert did not request a curative or special instruction on the standard of care. Instead, Reinert's counsel cross-examined Dr. Larson on the standard of care, and Dr. Larson testified that the standard of care for ACDF surgery site location is a national one, and the same in Spokane as it is in Seattle. Ultimately, the Court, without any objection from Reinert, gave the standard RCW 7.70.040-derived WPI on the standard of care.

Dr. Barakos testified via video perpetuation deposition. On direct examination, defense counsel confined his questioning to Dr. Barakos' qualifications, the imaging technology issues referenced above, and the actual images taken of Reinert. The standard of care was never mentioned. On cross-examination, in an effort to advance Reinert's standard of care

claim, Reinert's counsel first asked Dr. Barakos about the frequency with which surgeons doing ACDFs obtain post-operative imaging to see if they operated on the correct level. Counsel then accused Dr. Barakos of not having "first-hand experience in determining whether a wrong-level ACDF was due to a breach of the standard of care or inadequate imaging." In the course of responding to this line of questioning, Dr. Barakos stated, among other things, that wrong-level surgery was not seen as a breach of the standard of care.

Before trial, both counsel agreed that direct or indirect standard of care testimony from Dr. Barakos was inappropriate, and stipulated to its redaction from the video to be shown at trial. Despite this agreement, a portion of Dr. Barakos' testimony about the standard of care was inadvertently played. At the request of Dr. Heller's counsel, the trial court immediately instructed the jury to disregard the testimony and, after a break, the video resumed. Reinert did not move for a mistrial or request a different or additional curative instruction.

In this appeal, Reinert seeks reversal of the jury's verdict in favor of Dr. Heller, claiming the trial court abused its considerable discretion with respect to the admission of expert testimony when it allowed Dr. Larson and Dr. Barakos to testify over his cumulative objection, including Dr. Larson's testimony on the standard of care from a "community

hospital” perspective. Reinert also claims that Dr. Barakos’ inadvertent testimony on the standard of care was the result of “misconduct” of defense counsel, and that the inadvertent testimony influenced the verdict.

All of Reinert’s assignment of error should be rejected and the jury verdict in favor of Dr. Heller upheld. The trial court’s rulings with respect to the testimony of Dr. Larson and Dr. Barakos were well within the court’s broad discretion, including Dr. Larson’s references to a “community” hospital. Significantly, neither defense counsel nor Dr. Larson ever defined the standard of care as being a “community” or local standard, and by statute (RCW 7.70.040), the circumstances under which a healthcare provider acts inform the standard of care and the imaging resources available at a larger hospital in Seattle compared to Deaconess was one of Reinert’s liability themes.

As for the irregularity that occurred during the playing of Dr. Barakos’ video perpetuation testimony, it is highly unlikely the testimony, although stipulated as inadmissible, in any way impacted the jury’s verdict. The testimony was fleeting, was given in the context of two other experts testifying that Dr. Heller complied with the standard of care and was immediately followed by a curative instruction, which the jury was presumed to follow.

II. STATEMENT OF CASE

A. Medical Treatment At Issue

Dr. Heller, a board certified neurosurgeon (RP 328-29), is the sitting chief of neurosurgery for Deaconess Hospital and has faculty positions with the University of Washington and Washington State University Medical Schools as a clinical instructor of neurosurgery. (RP 105).

Reinert had a large disc herniation at C6-7 which was compressing the spinal cord. (RP 179-180). He also had a left sided disc bulge and bone spur at C5-6. (Id.) Of the two levels, C7 was the most serious. (RP 179-180). It was an urgent situation because, if the pathology at that level had been left untreated, Reinert would have developed progressive dysfunction of the spinal cord, eventual paralysis, and be wheelchair bound. (RP 180; RP 283-84).

In his initial conversations with Reinert about surgical treatment, Dr. Heller addressed the “very obvious problem” at C6-7, as well as the bulging disc and bone spur complex at C5-6. (RP 153-154). They discussed doing surgery on both levels, but ultimately decided to treat only C6-7. (RP 153-154).

ACDF is a surgical procedure for addressing disc problems in the front of the cervical spine. (RP 109). The point of an ACDF is to

decompress neural structures – to take pressure off of the pinched spinal cord and pinched nerves. (RP 112).

ACDF (Anterior Cervical Discectomy and Fusion) is one of the most common spinal surgeries. (RP 106). During his residency, Dr. Heller performed approximately 200 such procedures (RP 108), and, by the time of trial, had probably performed 80-100 more. (RP 108).

On October 2, 2012, Dr. Heller took Reinert to surgery at Deaconess to perform the planned ACDF at C6-7. To localize the area for surgery, Dr. Heller first placed a metallic instrument on Reinert's throat and took an x-ray to make sure he was roughly over the target area. (RP 113). He then marked the location for his incision with a pen (Id.) and dissected down to the spinal column. (RP 122).

On lateral x-ray, it is not uncommon for the lower part of the cervical spine, especially C6-7, to be obscured by the shoulders, because the shoulders ride up and start darkening that area of the x-ray making it difficult to see the vertebrae clearly. (RP 114). When Reinert was positioned on the operating table, Reinert's shoulders were riding high (RP 115), and so one shoulder was taped down so the x-ray could see a little lower. (Id.) Even with that, on the first set of fluoroscopy films, the lowest level Dr. Heller could see was C3-C4. (RP 115).

After dissecting down to the spinal column as described above, Dr. Heller placed a metal needle into a disc and did fluoroscopy of that area, but was unable to determine location. (RP 122). Faced with that circumstance, Dr. Heller employed the method he was taught and what is universally recognized as proper technique: he counted vertebrae from the top down. (RP 123-124). To do that, Dr. Heller first performed an internal extension/dissection to open the neck wider. (RP 123). He then used a long metallic instrument called a “peanut”, which is simply a long clamp with a small bit of cotton at the tip to make it blunt. (RP 123). Dr. Heller ran the “peanut” up the spine as far as he could and took a fluoroscopic x-ray which showed the “peanut” to be at C3-4. (RP 123-124). He then palpated the front of the spine to the location of the “peanut,” and from there moved his finger down the front of the spine, counting as he went. (Id.).

In a healthy spine without significant degeneration, the contour of the anterior spine is fairly predictable. (RP 124-125). The vertebral bodies feel like valleys and the discs like peaks, and palpating the spine is similar to following the contour of the knuckles. (Id.) Using this method, Dr. Heller counted down to what he believed was C6-7. (RP 124-125).

Unfortunately, Reinert’s spine had extensive bone spurring and disc bulging. (RP 126). As a result, there were multiple peaks Dr. Heller

misinterpreted as was he was counting down, and he ended up operating on C5-6 instead of C6-7¹. (Id.).

Immediately after the surgery, Dr. Heller spoke with Reinert and informed him of the difficulties he encountered in the operating room and how he was not completely certain of the level. (RP 153). Dr. Heller obtained a CT which he put up in Reinert's room and which showed the procedure was actually done on C5-6 instead of C6-7. (RP 153). Reinert responded that they had actually talked about doing that level anyway. (RP 153).

On October 4, 2012, Dr. Heller operated on Reinert again to accomplish the ACDF at C6-7. (RP 155). During that surgery, removal of a piece of disc and ligament off the spinal cord dura caused a hole in the dura, a not uncommon event during spinal surgery. (RP 156-157; RP 163). That, in turn, resulted in a spinal fluid leak. (Id.) To stop the leak, Dr. Heller placed patch material designed to eventually scar down and create new membrane and seal the hole. (RP 157). The seal failed to hold, however, and, as a result, after a visit to the emergency room, on October

¹ These degenerative changes do not necessarily show up on a pre-operative MRI. (RP 125). While an MRI is very good at showing soft tissues, it is not very good at showing bone and metal. (Id.)

11, 2012, Dr. Heller operated on Reinert again to definitively repair the dural hole. (RP 169-173; RP 347).

B. Pertinent Expert Testimony

1. Reinert's Counsel's Questioning of Dr. Heller

Reinert's liability theory was that Dr. Heller violated the standard of care by not using more sophisticated/different imaging techniques and technology to locate C6-7, or by not aborting the surgery and sending Reinert to a hospital where that more sophisticated imaging was purportedly available. In advancing that theory, Reinert's counsel began Reinert's case by calling Dr. Heller as a Plaintiff's witness. (RP 104). During his examination of Dr. Heller, counsel queried Dr. Heller at length about the characteristics, availability, and use of various imaging technologies and techniques, including fluoroscopy (RP 115-117), intraoperative MRI and CT scanning (RP 125-126), brain mapping (RP 145-146) and 3-D imaging (RP 147), including a form of 3-D imaging called stereotaxis (RP 147).

Counsel also asked Dr Heller whether, at the time he performed surgery on Reinert, he was "aware of the history of stereotactic imaging in the performance of spinal and cranial procedures at the University of Washington" (RP 147; RP 148), and whether, prior to Reinert's surgery, and during the time he did his residency and internship in California, he

had “kept abreast,” by reviewing literature or by doing independent study, as to the “state of the art when it comes to imaging, intraoperative imaging of ACDF surgeries.” (RP 205-206). Counsel then asserted, in a “question” to Dr. Heller that, prior to surgery, Dr. Heller was “really not aware of the status or the use and application of stereotactic or 3-D technology in cervical surgeries, whether ACDF or other types of cervical surgeries.” (RP 206-207).

2. Testimony of Plaintiff’s Expert Allan Hamilton, MD

Reinert’s expert on the standard of care and causation was Allan Hamilton, MD, a neurosurgeon on the faculty at the University of Arizona medical school (RP 6), who had not performed surgery since 2004, and whose “entire life,” by his own admission, had been devoted to “academic medicine.” (RP 4; RP 6).

Dr. Hamilton testified about doing a visiting professorship at the University of Washington devoted to extracranial stereotactic imaging – the ability to accurately map out structures outside of the head (RP 4; RP 11), and explained that, in 1994, he and a team of physicists worked on this problem – stereotaxis outside of the head – and “solved the problem.” (RP 12).

Dr. Hamilton testified Dr. Heller violated the standard of care in several ways. He claimed that because Reinert was a heavier man with a

thick neck (RP 15), Dr. Heller needed to anticipate a problem before he went into the operating room. (RP 15). Dr. Hamilton testified that once in the OR, Dr. Heller had a duty to be “precise and certain” about the level he was operating on. (RP 15-16). Dr. Hamilton further claimed that Dr. Heller, if he was unsure of his location, should have aborted the surgery and, in a subsequent procedure, used different technology (RP 36), or that Dr. Heller could have sent Reinert to a different hospital where intraoperative CT was available. (Id.)

On the issue of whether there was anything available to Dr. Heller at Deaconess to better resolve his location, Dr. Hamilton testified there were different fluoroscopy techniques Dr. Heller could have employed, including different views. (RP 18; RP 19). Dr. Hamilton also testified that another option available to Dr. Heller would be frameless, stereotactic MRI “so you know where you are when you are in the operating room.” (RP 35).² When asked if those technologies were available in 2012, Dr. Hamilton answered that he knew that they were at Swedish and at the

² When asked whether frameless, stereotactic MRI could have been achieved at Deaconess in 2012, Dr. Hamilton answered, “Yes, the technology exists. Yeah.” without confirming that the technology was actually available at Deaconess. RP 35.

University of Washington (both in Seattle). RP 36. He further testified that the University of Washington was actually “doing some very advanced work on imaging where they were able to link fluoroscopy up to both stereotactic MRI and CT.” (RP 36).

3. Testimony of Defendant’s Expert Sigurd Berven, MD

Sigurd Berven, MD, is a spine surgeon and chief of the spine service at the University of California – San Francisco. (RP 26).

Dr. Berven testified that the method Dr. Heller used to localize C6-7 – lateral fluoroscopy and tactile counting of vertebrae – was in full compliance with the standard of care (RP 37-39), and that the standard of care did not require different fluoroscopy views or intraoperative 3-D imaging. (RP 39-40).

Dr. Berven also testified that the methods and techniques used to localize the surgical level for ACDF involve judgment (RP 35; RP 39; RP 43), that the surgical outcome or the occurrence of a complication does not determine whether the surgeon complied with or violated the standard of care, and that the issue is whether the surgeon used the appropriate process. (RP 37-38). Dr. Berven further testified that if he had the information Dr. Heller had available on October 2, which was a very good lateral x-ray showing a peanut on a 3-4 disc, he would have done what Dr. Heller did, which was to count down from C3-4. (RP 402).

In rebuttal to Dr. Hamilton's testimony about the use and availability of sophisticated 3-D imaging, Dr. Berven, after describing how 3-D imaging relies on a metallic "fiducial" to mark a fixed location in space, explained that establishing a fixed location is not possible with ACDF, and that, accordingly, even at large academic centers, intraoperative 3-D imaging is not used for ACDF. (RP 43-44).

On the issue of whether Dr. Heller should have terminated the surgery and considered a different approach or sent Reinert elsewhere, Dr. Berven outlined the risks associated with aborting a surgery and transporting the patient to a tertiary care center like Seattle. (RP 45-46). He then testified that the surgery could not have been done any differently or better in Seattle, (RP 45-46), that Dr. Heller did not violate the standard of care by not aborting the surgery (RP 46), and that it was appropriate for Dr. Heller to proceed with surgery at Deaconess using the best available evidence and his judgment. (RP 46).

With respect to the dural leak from the C6-7 surgery on October 4, Dr. Berven testified that dural leaks are a known possible complication with ACDF (RP 49), that a tear can occur despite appropriate surgical conduct and technique (Id.), and are not uncommon despite the best technique (RP 49-50), and that Reinert was likely to have a dural leak if C6-7 had been done on October 2. (RP 458). Dr. Berven also testified that

whether Dr. Heller operated on C6-7 on October 2 or October 4, the probability of a dural leak was the same (RP 50).

Dr. Berven also testified that if C5-6 had not been addressed on October 2, there was a high risk of Reinert needing surgery at that level eventually (RP 52-53), that Dr. Heller's surgeries did not cause a diagnosable injury or damage (RP 50), and that the probable cause of Reinert's post-discharge neck pain was his pre-existing multi-level disc degeneration. (RP 50-51).

On the matter of "certainty" with respect to ACDF surgical level, Dr. Berven testified that the standard of care does not require 100% certainty (RP 43), that there is never complete certainty in surgery, and what the standard of care requires is that the surgeon proceed using his judgment and the best available evidence. (RP 58).

4. Testimony of Defendants' Expert Jeffrey Larson, MD³

Jeffrey Larson, MD, is a board-certified neurosurgeon. (RP 70, RP 71, RP 73). Since 1997, he has practiced in the Spokane/Coeur d'Alene area, (RP 73-74), and performs surgery at Kootenai Medical Center and

³ The references to a "community hospital" during Dr. Larson's testimony are discussed in detail, *infra* at pages 24-26.

Deaconess. (RP 73; RP 77). Kootenai Medical Center and Deaconess are community hospitals as opposed to academic institutions. (RP 74; RP 77).

Dr. Larson testified that, in terms of localizing the target level for ACDF, the standard of care from his perspective in 2012, and now, was to localize a cervical level laterally with fluoroscopy, and then to count down from that point to the target level. (RP 77-80). The standard of care did not, and does not, require 100% certainty about the appropriate level. (RP 79). Rather, you get as certain as possible with the methods available. (RP 71). The standard of care did not require Dr. Heller to refer Reinert to an academic center like Harborview at the University of Washington. (RP 80; RP 89).

5. Testimony of Defendants' Expert Jerome Barakos, MD⁴

a.) Direct Examination by Dr. Heller's Counsel

Dr. Barakos is a board-certified neuroradiologist. (CP 225; CP 227, CP 229). Since 1992, he has been the Director of Neuro Imaging for the Sutter Hospital system in Northern California. (CP 229-230). The Sutter system is a complex of 32 hospitals in the California and Bay region that

⁴ Dr. Barakos' testimony was presented via videotape but not transcribed by the court reporter at trial. By stipulation, the transcript of Dr. Barakos' video perpetuation deposition has been included in the Clerk's Papers and it is located at CP 224-307.

comprises one of the largest teaching private medical centers in the country. (CP 230).

On direct examination, Dr. Barakos testified regarding the characteristics and uses of fluoroscopy, (CP 231-33), the set up and interpretation of imaging technology relative to ACDF, (CP 234), the reasons lateral view fluoroscopy is used during ACDF, (CP 235-37), and the complications and limitations associated with anterior-posterior (AP) fluoroscopy, including the phenomenon of parallax. (CP 236-37).

Dr. Barakos also testified regarding the nature of other imaging technologies and their uses in connection with ACDF, including Stealthstation (CP 239), Brainlab (CP 240-41), stereotaxis (CP 240), and 3-D navigation (CP 241-42), and why those technologies are not used for ACDF. (Id.).

With the actual studies as exhibits, Dr. Barakos also testified regarding the imaging done on Reinert, including the intraoperative fluoroscopy, pre- and post-operative MRIs, and the post-operative CT. (CP 245-257).

On the issue of damages, Dr. Barakos testified that the post-operative imaging did not reveal any pathology caused by Dr. Heller's surgeries. (CP 258-261). He also reviewed and interpreted the MRI done on August 14, 2012, roughly two months before Reinert's first surgery (CP

244), and described the pathology at C5-6 and C6-7, including the “moderate” stenosis at C5-6 and the “severe” stenosis at C6-7. (CP 246-249).

b.) Cross-Examination by Reinert’s Counsel

Dr. Barakos indicated that he understood the basis of the case was a wrong level fusion – a discectomy and fusion by Dr. Heller removing the C5-6 disc and fusing C5-6 level as opposed to the planned operation at C6-7. (CP 265).

Dr. Barakos explained that AP fluoroscopy is used in other types of surgery; an example being abdominal surgery. (CP 265).

Dr. Barakos testified that, if he had been called by Dr. Heller to come to the surgical suite because Dr. Heller was not getting imaging that gave him sufficient confidence he was at the right level, he would not be able to provide any information beyond what Dr. Heller had already obtained. (CP 268-69). There were no different radiology techniques or “tricks” available. (Id.) The fluoroscopy images taken by Dr. Heller were the same images that would have been obtained under his direct guidance and that is the information from which the surgeon is going to work. (CP 269).

The problematic testimony from Dr. Barakos started when Reinert’s counsel asked: “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?” (CP 269). Dr. Barakos answered: “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” (Id.) After an objection, Dr. Barakos continued his answer, and said:

“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 ask, 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%. And that’s a reflection of the fact that the literature shows about 50% of all surgeons at one point or another in their career have been off a level or more.”

(CP 270).

Reinert’s counsel then asked: “Doctor, how many times have you, in your recollection, actually – how many times do you recall an instance where a surgeon performing an ADF procedure sent a patient in for imaging after the surgery to determine whether the appropriate level was the site that was operated on?” (CP 270-71). Dr. Barakos answered: “As I have outlined, several times every few years, it’s relatively infrequent.

More often than not, the purpose is to identify the positioning of the hardware. But as I outlined, probably once every few years.” (CP 271).

After Dr. Barakos conceded that he was not aware of every wrong-level cervical surgery actually performed at one of the institutions he is associated with, (CP 271-72), Reinert’s counsel asked: “And so you don’t have any personal experience with determining whether or not a wrong-level surgery was due to either a breach of the standard of care or just inadequate imaging, do you?” (CP 272). In direct response to this question, Dr. Barakos testified that a “wrong-level surgery is not seen as a breach of the standard of care” and explained why. (CP 273).

Regarding the pathology at C5-6, Dr. Barakos testified, with reasonable medical probability, based on his experience, that if someone did a C6-7 surgery, the literature supports the concept of adjacent segment degenerative disease, which means that if the C6-7 level is a solid fused block, it is going to apply forces to contiguous levels. (CP 279-80). And since C5-6 already showed significant degeneration with impingement, based on reasonable medical probability sometime down the road Reinert would have needed surgery at that level (C5-6). (CP 279-80).

C. **Relevant Trial Court Procedure**

Reinert's brief correctly describes the relevant trial court procedure, particularly the parties' motions in limine and mid-trial objections.

III. **ARGUMENT AND AUTHORITIES**

A. **Standard of Review**

Trial court rulings on the admissibility of expert testimony are a matter of trial court discretion, and the standard review is thus abuse of discretion. *L.M. by and through Dussault v. Hamilton*, 193 Wn.2d 113, 134, 436 P.3d 803 (2019). *State v. Arndt*, 194 Wn.2d 784, 797, 453 P.3d 696 (2019). Expert testimony is admitted under ER 702 when the trial court determines (1) that the witness qualifies as an expert and; (2) that the testimony will assist the trier of fact. *Arndt*, 194 Wn.2d at 799, citing *In Re Det. of McGary*, 175 Wn. App 328, 338-39, 306 P.3d 1005 (2013). "Trial courts are given a large degree of freedom when making these determinations, subject to reversal only for a clear abuse of discretion." *Arndt* at 799, citing *State v. Yates*, 161 Wn.2d 714, 762, 168 P.3d 359 (2007). "A trial court abuses its discretion when its decision is manifestly unreasonable or exercised on untenable grounds or for untenable reasons." *Id.*, quoting *State v. Lord*, 161 Wn.2d 276, 283-84, 165 P.3d 1251 (2007).

“A reviewing court may not hold that a trial court abused its discretion ‘simply because it would have decided the case differently.’” *L.M. by and through Dussault, supra*, at 134, quoting *Gilmore v. Jefferson County Public Transportation Benefit Area*, 190 Wn.2d 483, 494, 415 P.3d 212 (2018). To find abuse of discretion, a court “must be convinced that no reasonable person would take the view adopted by the trial court.” *L.M. by and through Dussault*, at 135, quoting cases. “[I]f the basis for admission of the evidence is fairly debatable, a court “will not the trial court ruling.” *L.M. by and through Dussault*, at 135, quoting *State v. Salgado-Mendoza*, 189 Wn.2d 420, 427, 403 P.3d 45 (2017).

The determination that evidence is cumulative, and whether to admit cumulative evidence, also lie within the trial court’s discretion. *Mullin v. Builders Development and Finance Service, Inc.*, 62 Wn.2d 202, 206, 381 P.2d 970 (1963). See also *Christensen v. Munsen*, 123 Wn.2d 234, 241, 867 P.2d 626 (1994).

B. Response to Reinert’s Assignments of Error

1. Dr. Larson And Defense Counsel’s References To A Community Hospital Were Not Inappropriate And, In Any Case, Were Harmless

On this issue, it is important to consider the context in which Dr. Larson and defense counsel referenced a “community hospital.” On direct examination, defense counsel first asked Dr. Larson about his moving to

Coeur d'Alene, Idaho in 2003 to set up a private practice, how he had done surgeries out of Kootenai Medical Center since 2003, and how Kootenai Medical Center is a "community hospital" as opposed to an academic institution. (RP 73-74). Dr. Larson was then asked to "explain the distinction between an academic medical center and a community hospital," and he did. (RP 74). Counsel then asked Dr. Larson to give an approximation of how many ACDFs he had performed "in the community center or setting" since he came to the northwest, and Dr. Larson answered "thousands, roughly 120 to 125 a year." (RP 74-75).

After laying this foundation, counsel asked Dr. Larson, whether, based on his review of the materials, his education and experience, and "given your community practice of neurosurgery" he had an opinion on whether Dr. Heller met or violated the standard of care. (RP 77). Reinert objected on the ground the testimony was cumulative, and the Court overruled the objection. (RP 77). At this point, Reinert did not object on the ground that the question improperly defined the standard of care. (Id.)

Counsel then asked Dr. Larson whether "in the community hospitals that you worked at and were aware of in Spokane and Coeur d'Alene in 2012, what the standard of care required for localization of the surgical level in a C6-7 ACDF" (RP 77). Again, Reinert's counsel objected on the ground that the testimony was cumulative, and the Court

overruled the objection. (RP 78). Counsel did not object on the ground that the question improperly stated or defined the standard of care. (Id.).

Defense counsel then asked Dr. Larson whether, “as a community spinal surgeon, did the standard of care under the circumstances that existed on October 2, 2012 require Dr. Heller to refer Mr. Reinert out of the community hospital to a different level of care?” (RP 80). When Dr. Larson asked counsel to rephrase the question, counsel asked “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 applied to Dr. Heller that day require him to refer Mr. Reinert out to an academic center?” (RP 80). Only then did Reinert object on the ground that the “foundation as to community hospital is not relevant to standard of care.” (RP 80). The Court overruled the objection. (Id.) Dr. Larson did not immediately answer. Rather, he asked counsel to rephrase the question, and counsel then asked “Did Dr. Heller need to refer Mr. Reinert out to an academic center like Harborview or the University of Washington under the circumstances that existed on October 2, 2012?” (RP 80). Dr. Larson answered in the negative. (Id.).

A threshold issue is whether Reinert preserved this issue for appeal by making timely and focused objections at trial. A party may claim evidentiary error on appeal only if a specific objection is made at trial.

State v. Kirkman, 159 Wn.2d 918, 926, 155 P.3d 125 (2007). That is because a specific objection “gives a trial court to prevent or cure error.” *Id.*, citing *State v. Boast*, 87 Wn.2d 447, 451, 553 P.2d 1322 (1976).

Before Dr. Larson took the stand, Reinert objected to Dr. Larson addressing the standard of care at all on the ground the testimony would be cumulative to that of Dr. Berven. (RP 64.) Dr. Heller responded that Dr. Larson’s testimony would be from the perspective of a practitioner at a community hospital as opposed to a large academic institution. (RP 66-67).

The court overruled the objection and indicated Dr. Larson would be allowed to testify. (RP 67). And because cumulativeness is, by definition, a matter of degree, the trial court instructed Reinert’s counsel to “make objections as we go along.” (RP 67).

During Dr. Larson’s testimony, Dr. Heller’s counsel twice referenced a “community hospital” or “community setting” in posing a standard of care question to Dr. Larson, and both times Reinert’s counsel failed to object, either to the question or the answer, on the ground that the question improperly defined the standard of care. The third time a standard of care question was prefaced with a reference to Dr. Larson being a “community spinal surgeon” or to Deaconess being a “community hospital”, Reinert’s counsel objected on the ground that the “community

hospital is not relevant to standard of care.” (RP 80). But then the question was rephrased and all “community” references were removed. (RP 80). Under these circumstances, Reinert should not now be permitted to assign error to the “community hospital” references in Dr. Larson’s testimony⁵.

Notwithstanding the above, counsel and Dr. Larson’s references to a “community hospital” in connection with the standard of care were entirely appropriate for several reasons. First, and fundamentally, neither counsel nor Dr. Larson ever described or defined the standard of care as being “the care, skill and learning expected of a reasonably prudent provider at or in a ‘community hospital’ or ‘in the defendant’s community’.”

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

⁵ Reinert’s counsel did not ask that any of Dr. Larson’s testimony be stricken, nor did he request a curative or clarifying instruction on the standard of care. Rather, without any objection from Reinert, the Court ultimately gave the standard WPI on standard of care, based on RCW 7.70.040. CP 328.

measured. Indeed, in pre-RCW 7.70 cases, Washington courts held that, while the standard of care in Washington is not a locality standard, is “coextensive” with the “medical and professional means available to the defendant.” See e.g. *Pederson v. Dumouchel*, 72 Wn.2d 73, 79, 431 P.2d 973 (1967); *Meeks v. Marks*, 15 Wn. App. 571, 575, 550 P.2d 1158 (1976); *Stone v. Sisters of Charity House of Providence*, 2 Wn. App. 607, 610-611, 469 P.2d 229 (1970); *Workman v. Chinchinian*, 807 F. Supp. 634, 641 (ED Wash 1992) (Post-*Pederson*, locality rule “has no present-day vitality except that it may be considered as one of the elements to determine the degree of care and skill which is to be expected of the average practitioner of the class to which he belongs”).

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

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

Third, because Dr. Hamilton and Dr. Berven were both from large academic institutions, it was appropriate for Dr. Larson to voice a standard of care opinion based on his experience as a surgeon in the community hospitals of Kootenai Medical Center and Deaconess where he had first-hand knowledge of the available imaging resources.

Even if the references to “community hospital” were improper, which they were not, the references were harmless. Improper evidence is harmless unless it affects the outcome of the case. *State v. Jackson*, 103 Wn.2d 689, 695, 689 P.2d 76 (1984). It is highly unlikely the references to a “community hospital” affected the verdict. Again, neither defense counsel nor Dr. Larson ever actually defined the standard of care as being “the care, skill and learning expected of a reasonably prudent provider at or in a ‘community hospital’ or ‘in the defendant’s community’.” And after the references to “community hospital” on direct, on cross-

examination Dr. Larson clarified that the standard of care for ACDF localization is a national standard and the same in Spokane as it is in Seattle. (RP 82-83). Finally, the Court gave the standard WPI-based instruction on the standard of care, derived directly from RCW 7.70.040 (CP 328), and jurors are presumed to follow the court's instructions. *Spivey v. City of Bellevue*, 187 Wn.2d 716, 738, 389 P.3d 504 (2017).

2. Allowing Both Dr. Berven and Dr. Larson to Testify on the Standard of Care Even Though the Testimony was Somewhat Overlapping Was a Proper Exercise of Trial Court Discretion, Because Each Witness Had a Distinct Set of Experiences Relative to the Standard of Care

On the issue of cumulative expert testimony in a medical negligence case, *Christensen v. Munsen*, 123 Wn.2d 234, 867 P.2d 626 (1994), is instructive. In that medical malpractice case, both sides had multiple experts testify on the standard of care and causation. The overarching issue was whether the admission of allegedly cumulative expert testimony violated the trial court's pre-trial order limiting each side to "one expert per specialty area, not to exceed two experts per specialty." 123 Wn.2d at 240. However, in holding that the trial court did not abuse its discretion in permitting multiple experts to address the standard of care and causation, the court observed:

The specialty areas in this case were highly technical and also inter-related. The trial court may have deemed some cumulative testimony helpful to the jury's understanding of

the issues, and some similar responses may have been unavoidable given the fact that several ophthalmologists testified. In any case, both parties' witnesses produced overlapping testimony to a limited extent, and the court did not abuse its discretion in allowing such testimony.

123 Wn.2d at 241⁶.

Here, the trial court's decision to allow both Dr. Larson and Dr. Berven to testify on the standard of care was well within the trial court's discretion. Both witnesses were clearly qualified under ER 702 to address the standard of care, and different standard of care perspectives were helpful to the jury. One of the prominent issues at trial was the contrast between large academic medical institutions and community hospitals with respect to the utilization and availability of imaging technology. Dr.

⁶ In other contexts, courts have held the trial court did not abuse its discretion in allowing multiple witnesses to testify to the same fact or set of facts. See e.g. *State v. Campbell*, 78 Wn. App. 813, 822, 901 P.2d 1050 (1995) (trial court did not abuse its discretion in allowing several lay witnesses to testify that Campbell was a gang member); *State v. Dunn*, 125 Wn. App. 582, 105 P.3d 1022 (2005) (In child abuse case, trial court did not abuse its discretion in allowing multiple witnesses to testify regarding child victim's hearsay statements). See also *Driggs v. Howlett*, 193 Wn. App. 875, 900, 371 P.3d 61 (2016) (In medical malpractice case, "RCW 7.70.040 does not preclude a party from relying on more than one medical expert with respect to whether the defendant complied with the standard of care.).

See also *Richter v. Harrington*, 2020 WL 1158097 (March 2020) (No trial court error in allowing pediatric neurologist to testify on causation even though medical negligence defendant had called other obstetric experts). Per GR 14.1(a), this case is cited as persuasive, rather than precedential authority.

Berven and plaintiff's expert, Dr. Hamilton, were from large academic institutions. Dr. Larson, on the other hand, was an actively practicing neurosurgeon in northern Idaho/eastern Washington who was familiar with the facilities and imaging technologies available at Deaconess Hospital, where Mr. Reinert's surgery occurred. Significantly, in responding to counsel's argument that Dr. Larson's testimony on the standard of care would be cumulative and that references to a "community hospital perspective" on the standard of care had no place in the litigation, the trial judge observed she was going to let Dr. Larson testify "because he brings not necessarily a different expertise but a different set of experiences to the table." (RP 67).

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

Here, Dr. Barakos was eminently qualified to testify. And his testimony as a neuroradiologist was helpful to the jury, particularly because of the central role spinal imaging played in the case with respect to both liability and causation/damages. Dr. Barakos addressed the general nature of fluoroscopy, how fluoroscopy is used in connection with ACDF procedures, the differences between various views, particularly the lateral view and the AP view, and what a lateral view of the cervical spine will show as opposed to an AP view. He also interpreted the images actually

taken in this case, identifying various structures, spinal levels, and the location relevance of the “peanut” marker. In addition, he explained the various available forms of 3-D imaging generally, how they work, their limitations, and how 3-D imaging is utilized in connection with cervical spinal surgery. He also testified regarding the phenomenon of parallax and how it affects AP fluoroscopy views compared to lateral views.

On the issue of causation and damages, Dr. Barakos provided helpful testimony on the cervical pathology depicted in pre- and post-operative imaging, particularly the nature and extent of stenosis and degenerative changes at C5-6 and C6-7 and the likelihood of continued degeneration at C5-6.

As for cumulativeness, while certainly there was some overlap in the testimony of Dr. Barakos and other experts on the nature and use of various imaging technology and techniques, it was not an abuse of discretion for the court to allow it, particularly in light of Dr. Barakos’ status and experience as a neuroradiologist.

4. Dr. Barakos’ Video Testimony Relative to the Standard of Care Was Inadvertent and Harmless

Before trial, both counsel agreed that the testimony of Dr. Barakos regarding the standard of care set forth, *supra*, at pages 21-22, was inappropriate and should be redacted from the video. Despite this

agreement, due to an editing oversight, the jury heard Reinert's counsel's question about "wrong level" surgery being a breach of the standard of care and a portion of Dr. Barakos' answer. (CP 272-73).

Reinert characterizes the inadvertent playing of this portion of Dr. Barakos' video deposition as "attorney misconduct." A threshold question is whether that label is appropriate, given that the error occurred because the video tape was not properly edited by the videography company that had been hired to play the deposition video⁷. Typically, "attorney misconduct" refers to the knowing and intentional introduction of inadmissible evidence or the advancing of improper argument. See e.g. *Teter v. Deck*, 174 Wn.2d 207, 274 P.3d 336 (2012) (persistently asking knowingly objectionable questions); *State v. Fisher*, 165 Wn.2d 727, 202 P.3d 937 (2009) (References by prosecutor to evidence outside of the

⁷ It is worth noting that during direct examination, Dr. Heller's counsel did not mention the standard of care, the frequency with which spinal surgeons operate on the wrong level, or how often spinal surgeons order a post-operative CT to confirm the surgical level. The objectionable and admittedly inadmissible testimony from Dr. Barakos on these issues came in response to beyond-the-scope questions posed by Reinert's counsel on cross-examination. While this circumstance likely does not rise to the level of invited error, see *State v. Mercado*, 181 Wn. App. 624, 326 P.3d 154 (2014) (Under the invited error doctrine, a party may not set up an error at trial and then complain about it on appeal), it should be considered in the face of Reinert's accusation of attorney misconduct.

record and bald appeals to passion and prejudice constitute misconduct). *State v. Jones*, 13 Wn. App. 2d 386, 463 P.3d 738 (2020) (Attorney commits misconduct by misstating the law); *In Re Glasmann*, 175 Wn.2d 696, 286 P.3d 673 (2012) (Prosecutor engaged in misconduct by expressing personal opinion of defendant's guilt through slide show presentation and argument). On the other hand, the inadvertent playing of an inadmissible portion of an audio recording has been held not to constitute attorney misconduct. See, *State v. Jones*, 114 Wn. App. 284, 183 P.3d 307, (2008) (Prosecutor's inadvertent playing of inadmissible portion of body wire recording did not rise to level of attorney misconduct)⁸.

Rather than attorney misconduct, the inadvertent playing of the inadmissible portion of Dr. Barakos' testimony is better described as an "irregularity" in the proceedings, with the question being whether there is

⁸ For additional examples of the inadvertent admission of inadmissible evidence, see *Rich v. Starczewski*, 29 Wn. App. 244, 628 P.2d 831 (1981) (police officer inadvertently mentions issuing citation after accident – trial court did not abuse discretion in failing to declare a mistrial); *Lyster v. Metzger*, 68 Wn.2d 216, 412 P.2d 340 (1966) (inadvertent injection of evidence of insurance not grounds for mistrial); *State v. Hopson*, 113 Wn.2d 273, 287, 778 P.2d 1014 (1989) (inadvertent testimony regarding criminal defendant's inadmissible criminal history not grounds for mistrial where court gave curative instruction and jurors are presumed to follow court's instructions to disregard evidence or testimony).

a substantial likelihood of prejudice from the irregularity that effected the jury's verdict. See e.g. *State v. Young*, 124 Wn. App 468, 472-73, 119 P.3d 870 (2005). In determining whether a trial irregularity affected the trial's outcome, the court examines: (1) the seriousness of the irregularity; (2) whether it involved cumulative evidence; and (3) whether the trial court properly instructed the jury to disregard it. *State v. Young*, 129 Wn. App. 468, 473, 119 P.3d 870 (2005); *State v. Babcock*, 145 Wn. App. 157, 163, 185 P.3d 1213 (2008).

Applying these factors to the instant case, the irregularity was not serious, was brief, and occurred toward the middle of Dr. Barakos' lengthy testimony of approximately 2 hours. (5:56 p.m. – 8:12 p.m.) (CP 224-307). Dr. Barakos' testimony about the standard of care was also cumulative to the standard of care testimony offered by Dr. Larson and Dr. Berven. Finally, the trial court instructed the jury to disregard it. (RP 24). Jurors are presumed to follow instructions to disregard improper evidence. *State v. Munguia*, 107 Wn. App. 328, 337, 26 P.3d 1017 (2001), citing *State v. Russell*, 125 Wn.2d 24, 84, 882 P.2d 747 (1994)⁹.

⁹ As further evidence of the harmlessness of the testimony, Reinert failed to move for a mistrial at the time of the irregularity. Such a failure "strongly suggests to a court that the argument or event in question did not appear critically prejudicial [to the party] in the context of the trial." *State v. Swan*, 114 Wn.2d 613, 661, 790 P.2d 610 (1990).

IV. CONCLUSION

Based on the foregoing argument and authorities, Dr. Heller respectfully requests that the court reject Reinert's assignments of error and affirm the judgment on jury verdict in favor of Dr. Heller.

Respectfully submitted this 8 day of October, 2020.

EVANS, CRAVEN & LACKIE, P.S.



Robert F. Sestero, WSBA #23274
Christopher J. Kerley, WSBA #16489

CERTIFICATE OF SERVICE

Pursuant to RCW 9A.72.085, the undersigned hereby certifies under penalty of perjury under the laws of the State of Washington, that on the 8 day of October, 2020, the foregoing was delivered to the following persons in the manner indicated:

Michael J. Riccelli Michael J. Riccelli, P.S. 408 S. Jefferson St., Ste. 112 Spokane, WA 99201 <u>mjrps@mjrps.net</u>	VIA REGULAR MAIL [] VIA CERTIFIED MAIL [] VIA EMAIL [X] HAND DELIVERED []
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DATED this 8 day of October, 2020.



Christopher J. Kerley, WSBA #16489

EVANS CRAVEN & LACKIE, P.S.

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