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No. ~~682679-1~~

COURT OF APPEALS, DIVISION I,
OF THE STATE OF WASHINGTON

LEWIS and TALENA COLLEY,

Plaintiffs/Appellants,

v.

PEACEHEALTH d/b/a ST. JOSEPH HOSPITAL,

Defendants/Respondents.

BRIEF OF RESPONDENTS

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I. INTRODUCTION

The jury rendered a unanimous verdict in favor of the defendant PeaceHealth St. Joseph Hospital (“Hospital”). The evidence was relatively clear that neither the Hospital nor Dr. Jian Sun were negligent in treating Mr. Colley, and the jury agreed. The trial court rulings were appropriate and even-handed – several went against the Hospital, as well. The trial court did not abuse its discretion in any way, and it did not improperly influence the jury.

For example, the appellants’ first argument about the cross-examination use of the statements of their experts (certificates of merit) strains reason. The invalidated statutory requirement of such certificates did not somehow negate the actual medical opinions of the experts themselves. The trial court properly allowed cross-examination of “prior statements” by such experts, and the trial court allowed the plaintiff to rehabilitate the experts, as they could. Such statements are no different than any prior declaration, prior notes, or prior publications, any of which go to the weight of the expert’s testimony and clarity of an expert opinion.

Even if other trial court rulings were “untenable” in some way (not proved the by the plaintiffs here), the appellants’ main subsequent arguments go to causation, which the jury never reached. The jury unanimously decided “no negligence” first, and thus they did not reach causation. The cause of Mr. Colley’s condition is not at issue on appeal, though hotly debated at trial. Thus, the appellants’ “assignment of errors”,

particularly as to the allowance of expert opinions relating to causation, are moot.

As for the remaining arguments, the appellants have not and cannot show any prejudicial effect that would have made a difference in the jury's deliberations. The unanimous jury verdict below should be upheld.

II. COUNTERSTATEMENT OF ISSUES

- A. Did the trial court appropriately allow the use of prior written statements of experts (certificates of merit) to cross-examine two of the appellants' expert witnesses? *Yes.*
- B. Did the trial court appropriately allow testimony from the Hospital's experts regarding causes of the brain damage claimed as an injury? *Though the issue does not address the jury finding of negligence, still the answer is "Yes".*
- C. Did the trial court appropriately allow evidence of Mr. Colley's prior alcohol use when (1) such evidence was necessary for both causation and damages defenses, and (2) the Hospital offered expert testimony that prior alcohol use contributed to his brain damage prior to the alleged injury? *Yes.*

III. COUNTERSTATEMENT OF THE CASE

A. Procedure

This medical negligence jury trial was held before the Honorable Ira J. Uhrig, in Whatcom County Superior Court, on November 8 through

November 23, 2011. After hearing all evidence and testimony, on November 28, 2011, the jury found unanimously in favor of the Hospital, answering “no” to the following question: “Was the defendant negligent?” (CP 19-20)

The plaintiffs Lewis and Talena Colley filed several motions *in limine* prior to trial, which Judge Uhrig denied. Specifically, Judge Uhrig denied (1) a supplemental motion *in limine* to prohibit the use of the Colleys’ experts’ certificates of merit for purposes of cross-examination; (2) motion *in limine* No. 11, to exclude the testimony of defense experts Gary K. Stimac, M.D., Ralph Pascualy, M.D., and Allan J. Ellsworth, Pharm.D., PA-C; and (3) motion *in limine* No. 16 to exclude evidence of Mr. Colley’s history of alcohol consumption. (RP 67) The Colleys appeal these rulings.

The Hospital submits that the trial court’s rulings are fully supported by the record, and the plaintiffs have not met their high burden of showing that these evidentiary rulings by the trial court constitute an abuse of discretion.

B. Relevant Facts

The Colleys filed suit on July 31, 2008, alleging that the Hospital failed to properly care for Lewis Colley during his admission to the Hospital in May 2006, during which he was given morphine for his pain. They claimed he suffered medication/sleep apnea-related respiratory distress, and that he suffered brain damage due to hypoxia. (CP 8)

Mr. Colley, up until May of 2006, had numerous medical problems and co-morbid features. He had not worked for over two years, was on disability, and suffered problems such as “memory loss”, “memory difficulties”, anxiety and panic attacks, depression, and severe sleep apnea, all documented in his medical records. (Exh. 14, 15, 17, 28, 36)

On May 4, 2006, Mr. Colley presented to St. Joseph’s ER with a sharp, burning pain in his upper left quadrant (pancreatitis suspected). The evening of May 4 and the morning of May 5, Mr. Colley was given multiple doses of morphine. (Exh. 1) ER physician Dr. Weiche wanted to send him home, but Mr. Colley wanted to stay because of the pain. (RP 1026) He was thus moved to the Observation Unit just before 2:00 a.m.

Just before the admission, he was given 8 mg of Morphine in the ER (4 mg at 1:00 a.m. and 4 mg at 1:30 a.m.). (Exh. 1, 19) Then, Dr. Weiche’s admission orders were for 4-8 mg of Morphine every 4 hours, if his pain was 6/10 or higher, and 1-2 mg every hour, if his pain was 5/10 or less. (Exh. 3) Nurse Dawn Hooker gave him 4 mg at 2:00 a.m. and 4 mg at about 2:14 a.m. (when his pain was still very high), then another 2 mg at 3:21 a.m., when his pain diminished (10 mg, total in the OBS unit). (Exh. 19) After 4:00 a.m., a nurse spoke with Dr. Sun about Mr. Colley’s pain, but Dr. Sun declined giving any additional order for medication. (RP 1028)

Ms. Hooker also learned after 3:30 a.m. from Mrs. Colley that the patient had been diagnosed with sleep apnea. (RP 457, 460) She gave no

more morphine thereafter. Ms. Hooker informed Dr. Sun of this, and the doctor testified that she gave a verbal order to “monitor the patient’s oxygen saturation”. (RP 1026, 1028) The nursing staff did so, when they took vital signs, but they did not interpret this order as requiring “continuous” monitoring by pulse-oximetry machine. (RP 460-461) The records show Mr. Colley’s O2 saturation levels as follows:

<u>Time</u>	<u>O2 Level</u>	<u>Note</u>
1:50 am	97	Taken with vital signs
2:13	97	Taken with vital signs
4:11	92	Taken with vital signs
5:45	“80’s”	Nurse’s note
After 5:45	92	Room air, Dr. Sun’s note
6:04	89.5	ABG lab report
Before 7:10	88	Report note by RT
7:10	98.5	On oxygen, RT note
7:25	98.5	ABG lab report

(Exh. 6, 11, 18)

Ms. Hooker testified that Mr. Colley was in pain throughout the night, mainly bolting up with pain (not snoring or gasping for breath, as a sleep apneic patient might do). (RP 458) In the early morning, he suffered respiratory distress, and Dr. Sun and the respiratory therapist were called in around 5:45 a.m. (Exh. 6) Mr. Colley was not hypoxic at any time. (RP 1031) Mr. Colley suffered respiratory acidosis and required intubation by the RT, and admission to the hospital ICU. (CP 306)

Despite the lack of a hypoxic incident, Mr. Colley claimed to have suffered permanent brain damage as a result of this event. (CP 307) However, the Hospital showed convincingly at trial that many of Mr.

Colley's claimed damages were documented as pre-existing this incident, according to his medical records. (*See, e.g.*, Exh. 14, 15, 17, 28, 36)

C. Motions In Limine

The Colleys moved *in limine* to prohibit defendant from cross-examining their experts about the contents of the certificates of merit that they had signed. They cited Putman v. Wenatchee Valley Med. Ctr., 166 Wn.2d 974, 216 P.3d 374 (2009) for the proposition that permitting the introduction of evidence on certificates of merit by way of cross-examination of the experts would result in unfairness. The Putman court ruled that the requirement that a plaintiff must submit a certificate of merit when filing a medical malpractice action was unconstitutional due to, among other things, its effect of limiting a plaintiff's access to the courts.

At trial, Judge Uhrig denied the Colleys' motion *in limine*, finding that "a witness can be given an opportunity to explain or deny any statements and [he didn't] think that reflects anything of the constitutional implications of the Putman v. Wenatchee Valley Med. Ctr. decision." (RP 67)

The Colleys also sought to exclude the testimony of defense experts Gary K. Stimac, M.D., Ralph Pascualy, M.D., and Allan J. Ellsworth, Pharm.D., PA-C. (all causation and damages experts, not standard of care experts) on grounds that their testimony would be speculative. Judge Uhrig disagreed and denied their motion *in limine* No. 11. (RP 67)

Finally, the Colleys moved *in limine* to exclude evidence of Mr. Colley's history of past alcohol consumption. The Hospital argued that multiple witnesses would testify that many of Mr. Colley's symptoms were in part or whole due to his history of drinking. Thus, they could not show on a more probable than not basis that any brain damage or memory loss was due to the respiratory incident in the Hospital. Judge Uhrig agreed to permit evidence of past alcohol consumption and denied motion *in limine* No. 16 as well. (RP 67)

D. Expert Testimony

The Hospital presented experts who testified that Mr. Colley's brain damage or memory loss was not due to his respiratory distress on May 5, 2006. The defense experts stated that on a more-probable-than-not basis, it was not possible to show that the incident at the Hospital caused the claimed brain damage and memory problems, that these memory problems pre-dated the incident at issue, and that multiple other causes for Mr. Colley's memory loss existed and were documented in his medical records. The Hospital also showed that the amount of morphine administered to Mr. Colley was not excessive.

i. *Dr. Stimac*

Dr. Stimac is a neuroradiologist who reviewed a CT scan of the brain dated 3/3/06 (prior to the incident in question), and an MRI scan of 6/27/06 (after the incident in question). When discussing his initial review of these scans, Dr. Stimac testified that he found that the brain showed a

“shrunk appearance compared with a normal person of that age”. In other words, there was a “diffuse loss of brain substance.” (RP 801) He noted that such a presentation is consistent with a person who had many previous medical issues as Mr. Colley had, and Dr. Stimac correlated his image reviews with the medical records of Mr. Colley showing such past medical issues relating to brain function. (RP 802-03)

His second finding was that “there [weren’t] any abnormalities, visible abnormalities of brain injury that would occur from a respiratory problem or a stroke or an asphyxia type of situation.” (RP 801-02) Dr. Stimac further stated that there were no changes in volume of the brain from March 2006 (pre-incident) and June 2006 (post-incident). There also was no change in the post-incident scan to suggest an insult to the brain. (RP 818).

This testimony was all offered on a “medically more probable than not basis”. (RP 802)

ii. Dr. Ellsworth

Dr. Ellsworth is a pharmacologist, whose expertise allows him to opine regarding the effects of drugs on the body and the therapeutic affects derived therefrom both for efficacious therapeutic reasons, as well as worrying about potential adverse effects. (RP 906-907) He answered “Yes” to the question: “And are the opinions that you are going to express on a medically more probable than not basis?” (RP 903)

Dr. Ellsworth explained that the body processes drugs through pharmacokinetics, which includes ADME -- absorption, distribution, metabolism and excretion. (RP 916) Absorption occurs when a drug enters the bloodstream. (RP 916) When a drug is given intravenously, the absorption phase is automatic. (RP 916) Peak drug levels happen within a half to one minute and the full affect from the drug is seen within a half hour. (RP 917) The therapeutic dose of a drug is one which provides the expected benefit. (RP 919) With morphine, the usual dose to provide pain relief is between 2.5 and 20 milligrams. (RP 919) This generally must be given intravenously every two to six hours as needed based on the pain and the response of the patient. (RP 920) The larger the adult, usually the larger dose of morphine required to make the therapeutic effect. (RP 920) He testified that a patient with severe chronic pain issues and a history of taking pain medications would have some tolerance with morphine so greater amounts of the drug could be needed for a therapeutic effect. (RP 922-923)

Dr. Ellsworth used an equation to extrapolate the level of morphine remaining in Mr. Colley's blood by the 5:20 a.m., and showed that the level had fallen very low by that time and did not even rise to a therapeutic level. (RP 926-929) This would cause decreasing pain effect and pain relief effect as well as a decreased effect on the respiratory system. (RP 929) Dr. Ellsworth further opined that the amount of morphine Mr. Colley

received at the Hospital was well within the recommended weight-based dosage. (RP 934-935)

iii. Dr. Pascualy

Dr. Pascualy is a board certified sleep medicine physicians and the Senior Medical Director of the Swedish Sleep Medicine Program. He was presented at trial as an expert on sleep apnea to address causation issues. (RP 940) Dr. Pascualy testified that Mr. Colley had a severe history of sleep apnea for a long time before the incident at PeaceHealth in May 2006. (RP 940) Dr. Pascualy testified that prior to the hospitalization, Mr. Colley had multiple conditions that affect memory such as untreated sleep apnea, diabetes, depression, and the use of medications. (RP 941) Dr. Pascualy examined the computer chip in Mr. Colley's C-PAP machine and testified that Mr. Colley used this machine inconsistently in 2009 and 2010 which contributed to his overall memory problems. (RP 946 - 947)

Dr. Pascualy also testified that chronic alcoholism is associated with long term and irreversible changes in memory. (RP 948) Dr. Pascualy concluded that "I would agree that the memory complaints prior to the hospitalization would make sense in someone who has a history of untreated sleep apnea, alcoholism, depression, anxiety in that those would be what we call multifactorial memory complaints associated with that, that would be a true statement." (RP 951)

IV. STANDARD OF REVIEW

Generally, a trial court's ruling on motions *in limine*, the admissibility of evidence, and the admissibility and scope of expert testimony is reviewed for abuse of discretion. Gammon v. Clark Equip. Co., 38 Wn. App. 274, 286, 686 P.2d 1102 (1984) (motions *in limine*); Hume v. American Disposal Co., 124 Wn.2d 656, 666, 880 P.2d 988 (1994) (admissibility of evidence); Christensen v. Munsen, 123 Wn.2d 234, 241, 867 P.2d 626 (1994) (admissibility and scope of expert testimony). A trial court abuses its discretion if its rulings are "manifestly unreasonable or based upon untenable grounds or reasons". Wick v. Clark County, 86 Wn. App. 376, 382, 936 P.2d 1201 (1997) (citations omitted).

As the Supreme Court explained it:

An appellate court will find an abuse of discretion only "on a clear showing" that the court's exercise of discretion was "manifestly unreasonable, or exercised on untenable ground, or for untenable reasons." State ex rel. Carroll v. Junker, 79 Wn.2d 12, 26, 482 P.2d 775 (1971). A trial court's discretionary decision "is based 'on untenable ground' or made 'for untenable reasons' if it rests on facts unsupported in the record or was reached by applying the wrong legal standard." State v. Rohrich, 149 Wn.2d 647, 654, 71 P.3d 638 (2003) (quoting State v. Rundquist, 79 Wn. App. 786, 793, 905 P.2d 922 (1995)).

T.S. v. Boy Scouts of Am., 157 Wn.2d 416, 423-24, 138 P.3d 1053 (2006). However, even if the trial court "abuses its discretion, in order for the error to be reversible, the appellant must demonstrate prejudice." Portch v. Sommerville, 113 Wn. App. 807, 810, 55 P.3d 661 (2002)(citations omitted).

Relevant evidence is admissible. ER 402. ‘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. Thus, “[a]ll facts tending to establish a theory of a party, or to qualify or disprove the testimony of his adversary, are relevant.” Fenimore v. Donald M. Drake Constr. Co., 87 Wn.2d 85, 89, 549 P.2d 483 (1976). Indeed, a trial court ruling may be affirmed on any ground supported by the record, Estep v. Hamilton, 148 Wn. App. 246, 255, 201 P.3d 331 (2008), *rev. denied*, 166 Wn.2d 1027 (2009) (citing LaMon v. Butler, 112 Wn.2d 193, 200-01, 770 P.2d 1027 (1989)), even if the court did not consider it. Nast v. Michaels, 107 Wn.2d 300, 308, 730 P.2d 54 (1986) (citing Reed v. Streib, 65 Wn.2d 700, 709, 399 P.2d 338 (1965)).

In this case, each decision of the trial court was founded on solid, sometimes overwhelming, evidence, and basic legal principles and case law. The trial court’s decisions to deny the *in limine* motions should be upheld.

V. ARGUMENT

- A. **Only the requirement of filing a certificate of merit has been found unconstitutional, due to its interference with a plaintiff’s right of access to the courts. The statement or opinion itself, made when the requirement was the law, has not been somehow invalidated. Thus, the trial court properly denied the plaintiffs’ supplemental motion *in limine*, finding that certificates of merit were simply prior statements by the experts and their use in cross-examination did not deny access to the courts.**

Former RCW 7.70.150 mandated that plaintiffs provide a signed statement from a health care provider, who meets the qualifications of an expert in the action, that there is a “reasonable probability” that the defendant’s conduct did not follow the accepted standard of care. RCW 7.70.150.

In Putman v. Wenatchee Valley, the Supreme Court invalidated this requirement to submit a “certificate of merit”, for two reasons. 166 Wn.2d 974, 985, 216 P.3d 374 (2009). First, the Court stated that RCW 7.70.150 unduly burdened the right of access to the courts. Id., at 979. Second, the Court held RCW 7.70.150 irreconcilably conflicts with procedural court rules and therefore is a violation of the separation of powers. Id., at 979-985.

The plaintiffs’ reliance on Putman here, however, is misplaced; the *use* of a certificate of merit in cross-examination does not burden plaintiffs’ right of access to the courts.

1. *ER 613 allows a “Prior Statement of a Witness” to be used for cross-examination.*

The certificates of merit signed by the plaintiffs’ experts are sworn statements, signed by these witnesses. They were required by the law at the time the experts signed them. ER 613 permits a party to examine a witness concerning a prior statement:

RULE 613. PRIOR STATEMENTS OF WITNESSES

- (a) Examining Witness Concerning Prior Statement. In the examination of a witness concerning a prior statement made by the witness, whether written or not, the court may require that the statement be shown or its contents disclosed to the witness

at that time, and on request the same shall be shown or disclosed to opposing counsel.

(b) Extrinsic Evidence of Prior Inconsistent Statement of Witness. Extrinsic evidence of a prior inconsistent statement by a witness is not admissible unless the witness is afforded an opportunity to explain or deny the same and the opposite party is afforded an opportunity to interrogate the witness thereon, or the interests of justice otherwise require. . . .

The trial court properly ruled that the prior statements (certificates of merit) authored by the experts could be used for purposes of cross-examination under the direct language of the evidence rules.

2. *The use of a certificate of merit for purposes of cross-examination of plaintiffs' experts does not violate plaintiff's right to access the courts.*

In claiming the use of the certificate of merit “compounds the deprivation of due process,” the Colleys discuss only the first issue as raised in Putman, that RCW 7.70.150 unduly burdened the right of access to the courts. *Id.*, at 979. However, the opinion of the Supreme Court on this first issue is brief – there is no language therein that suggests or contemplates invalidating all past statements or precluding them from use on cross-examination.

Justice Barbara Madsen authored the concurring opinion in Putman, and agreed that reversal of RCW 7.70.150 was appropriate based on a violation of the separation of powers under the Washington State Constitution. She opined that “discussing whether the statute unduly burdens the right of access to courts is both unnecessary and problematic.” *Id.* at 986. The concurring Justices expressed the need to perform a

balancing of interests test before concluding that a limitation on discovery violates the right of access to courts, noting that there are many traditional limitations on discovery which do not rise to the level of impairing access to the courts. Id. They state “the requirement that a certificate of merit accompany a pleading may impede a plaintiff’s ability to advance to discovery but is reasonable when balanced against the efficiency interests of the courts and the interest of the legislature in creating affordable healthcare.” Id. at 987.

Ms. Putman insisted that the burden of having to produce a certificate of merit before discovery outweighs legislative interests, but she ignored the fact that the ability to provide a certificate of merit does not depend on discovery from the defendant. Id. The concurrence reasoned that plaintiffs have access to their own medical records, and the statement required in the certificate was to be based on the information currently available; therefore, obtaining a certificate was not dependent on discovery from the defendants. Id. Specifically, “patients have a right to their medical records and a right to share those medical records with other medical providers,” citing RCW 70.02.030, .090. Id. at 988. By way of example, the concurrence highlighted the fact that Ms. Putman obtained certificates of merit for her claims against two of the three defendants, which suggested to the Court that her failure to provide a certificate of merit for the third defendant health care provider was likely an oversight and not due to impossibility from lack of discovery. Id. at 988.

The court additionally cited the Illinois Supreme Court which was faced with a similar argument based on access to the courts. Id. In requiring a litigant to obtain a pretrial certificate from a health care professional stating that the action is meritorious “is essentially no different from the parallel requirement generally applicable in malpractice cases that the plaintiff in such an action present expert testimony to demonstrate the applicable standard of care and its breach.” DeLuna v. St. Elizabeth's Hosp., 147 Ill.2d 57, 73, 588 N.E.2d 1139, 167 Ill.Dec. 1009 (1992). It noted:

[i]n Washington, as well, a plaintiff will generally have to obtain expert testimony to establish the relevant standard of care and causation in a malpractice action against a health care provider. Harris v. Robert C. Groth, M.D., Inc., 99 Wash.2d 438, 449, 663 P.2d 113 (1983). No greater burden is placed on the plaintiff's access to courts by the certification requirement than is placed by the requirement that an expert establish these elements of a medical malpractice action.

Putman, 166 Wn2d at 989. The concurrence summarized its concerns with the majority's approach by stating that “the court should weigh all competing interests against the extent to which the statute burdens the plaintiff's right to access to the court when deciding whether the statute violates the right. In this case, the legislature's interest to curb malpractice insurance costs outweighs the moderate burden on the plaintiff.” Id. at 989.

There are many issues contemplated by the Putman court in making its ruling that requiring a certificate of merit prior to filing a law suit is unconstitutional. *However, not a single sentence is spent*

contemplating whether the signed statements themselves are misleading, inaccurate or made under some type of false pretense. Nothing about the Putman ruling makes the certificates of merit themselves fatally flawed in any manner, or prohibits their use for cross-examination purposes. There is nothing to suggest such declaration, for whatever purpose made, are false or misleading in any way.

The certificates of merit are prior statements of witnesses which are properly used under ER 613 for cross-examination. Putman does not in any way cite or invalidate that ER principle with regard to certificates of merit.

The Colleys attempt to string together a correlation that the use of these statements for cross-examination somehow limited their access to the court. The very fact that this argument was contemplated on the first day of a multi-week trial shows that the plaintiffs were not denied or limited access to the court. As Judge Uhrig stated, the use of the experts' statements did not "reflect anything of the constitutional implications of the Putman v. Wenatchee Valley Medical Center decision." (RP 67)

Judge Uhrig correctly found that the Colleys' medical experts could be given an opportunity to explain or deny any statements on re-direct examination. (RP 67) No abuse of discretion occurred in this ruling and it should not be overturned.

B. In denying plaintiffs' motion *in limine* No. 11, the trial court properly ruled that testimony by defense experts regarding causation was allowed when such testimony was given on a "medically more probable than not" basis and the plaintiffs were given the opportunity for cross-examination.

An initial point here – *the issue of causation testimony is moot.*

The jury unanimously decided "standard of care" or negligence only -- none. (CP 19-20) Thus, it did not even reach the issue of whether any supposed negligence caused Mr. Colley's problems.

1. The Hospital's Experts Gave Competent Expert Opinions.

If the Court considers this issue, however, it is evident that the Colleys' assignment of error is misplaced. Of course, that expert testimony must be given by qualified experts (each here was even admittedly qualified) on a medically more probable than not basis (each did) Thus, their expert opinions are admissible and probative. Harris v. Groth, 99 Wn.2d 438, 449, 663 P.2d 113 (1983).

The Harris court required that testimony in medical negligence cases be sufficient to establish that the alleged malpractice "more likely than not" was the cause (or vice versa, not the cause) of the plaintiff's subsequent condition:

In a case such as this, medical testimony must be relied upon to establish the causal relationship between the liability-producing situation and the claimed physical disability resulting therefrom. The evidence will be deemed insufficient to support the jury's verdict, if it can be said that considering the whole of the medical testimony the jury must resort to speculation or conjecture in determining such causal relationship. In many recent decisions of this court we have held that such determination is deemed based on speculation and conjecture if the medical testimony does not go beyond the expression of an

opinion that the physical disability "might have" or "possibly did" result from the hypothesized cause. To remove the issue from the realm of speculation, the medical testimony must at least be sufficiently definite to establish that the act complained of "probably" or "more likely than not" caused the subsequent disability. O'Donoghue v. Riggs, 73 Wn.2d 814, 440 P.2d 823 (1968).

Id. at 449.

In this case, the Hospital experts offered opinions on a medically more probably than not basis, specifically. (RP 802 [Dr. Stimac]; RP 903 [Dr. Ellsworth]; for Dr. Pascualy, see RP 936-951¹) The Colleys opening brief appears to focus of pre-trial arguments, not actual trial testimony. At trial, none of these experts was asked about "possibility" or "might have caused". After the experts' testimony, the plaintiff made not motion to strike any "inadequate" testimony.

Moreover, the experts specifically testified on the lack of a cause - - no evidence of brain injury on imaging taken of Mr. Colley's brain (RP 804-05); his sleep apnea and prior alcohol use "contributed" to his memory problems (RP 947-948); and the morphine given was not an excessive dose for Mr. Colley's size, particularly given his likely heightened tolerance from prior alcohol abuse. (RP 919-923) The Hospital's experts were specifically able to say that the hospitalization did not cause Mr. Colley's memory problems, at least not alone (this is

¹ Dr. Pascualy did not specifically say "more probable than not", but his testimony is technical, medical, scientific, and based on his years of experience as Washington's foremost sleep apnea expert. Upon cross-examination, counsel did not attempt to disqualify him by having him admit speculation, for example, and did not move to strike his testimony as inadequate, for example.

testimony on both causation and damages, had the jury gone there). However, they were able to state to a reasonable degree of medical probability that there was no evidence that the respiratory incident was the cause, and that there were several other factors that likely contributed to the memory problems.

Any inability to state the cause of the claimed damages conclusively does not lead to the testimony being inadmissible; it goes to the weight of the testimony. The Colleys' counsel had ample opportunity to cross-examine each of these witnesses and explore any areas of uncertainty. Allowing this testimony was not an abuse of discretion.

2. *ER 702 allows for the admission of medical expert testimony to assist the jury in determining a fact in issue.*

Under ER 702, “[i]f 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.”

The Colleys have not raised any issue that the three experts in question failed to qualify as experts. The Colleys instead summarized portions of each of these experts' testimony they did not like and called it speculative. This is incorrect, particularly when the witnesses testified their opinions were on a more probable than not basis. (RP 802, 903) Each of these witnesses offered specialized knowledge, which assisted the

jury in understanding difficult medical processes and evidence, in determining facts in issue, as required by ER 702.

3. *The Hospital's experts properly rebutted testimony by the plaintiffs' expert (that the Hospital caused brain damage leading to memory loss) by showing other causes of memory loss existed and the respiratory event could not have caused Mr. Colley's problems.*

- a. **Supanchick** does not support the Colleys' position.

The Colleys misstate Supanchick v. Pfaff, 51 Wn. App. 861, 765 P.2d 146 (1988). Rather, the court in Supanchick stated that although the appellant contended that the trial court committed prejudicial error by allowing the respondent to ask medical experts questions concerning other possible causes for the plaintiff's back condition, "[b]ecause we reverse and order a new trial [on other grounds], we need not decide whether prejudicial error occurred on this basis." The plaintiffs misconstrue the Supanchick court's citation to Washington Irrig. & Dev. Co. v. Sherman, 106 Wn.2d 685, 724 P.2d 997 (1986), as support for a finding of prejudicial error that did not even occur. The Supanchick court did not reach the question posed by the plaintiffs in this matter, and the manner in which this case is cited and relied upon is without merit and inapposite.

- b. **Miller** does not support the Colleys' position.

The Colleys also misguidedly rely on Miller v. Staton, 58 Wn.2d 879, 365 P.2d 333 (1961), for the proposition that a **defendant** must establish the causal relationship of an injury to a resulting physical condition by medical testimony on a more probable than not basis. That burden is the plaintiffs'. Indeed, the Miller court was examining whether the presented expert medical testimony most favorable to the plaintiff was sufficient to meet the *plaintiff's* burden of proving a causal relationship

between the incident and the claimed injury. Id. at 886. The plaintiff in Miller attempted to state that an injury to her diaphragm was related to her claims. Id. at 885-86. The doctor giving medical testimony on this issue would only state that it was “possible” and would not say it was “probable.” Id. at 886. The court found that “the medical testimony most favorable to the plaintiff does not establish...a causal relationship.” Id.

In this case, the Colleys confuse the burden of proof. The Hospital does not have to prove what caused Mr. Colley’s claimed injuries. It only needs to show that the plaintiffs have not met their burden of proof in establishing the elements of their claim. The Hospital experts offered testimony establishing the cause of Mr. Colley’s claimed brain damage and memory loss cannot be reasonably shown to be caused by the respiratory incident, and that there are several other factors contributing to his memory loss. (RP 803-05; 903-08; 947-49) This testimony was properly offered to rebut plaintiff’s claims and properly admitted for this purpose.

c. Stedman does not support the Colleys’ position.

The Colleys cite to the recent case of Stedman v. Cooper, 2012 WL 5835297 (Wash. A pp. Div. 1), to claim that the exclusion of an expert’s testimony in that case supports the exclusion of Dr. Stimac and Dr. Pascualy’s testimony. The Stedman court looked at the narrow issue of whether Allan Tencer, a biomechanical engineer whose testimony has been challenged many times before and excluded on several occasions, was offering testimony about whether the plaintiff got hurt in a car accident. Id. at 5. Mr. Tencer stated that he testifies “from a biomechanical rather than a medical perspective” and “disavowed any intention of giving an opinion about whether [the plaintiff] got hurt in the accident.”

However, his testimony was that since the forces generated by the impact and transmitted to the plaintiff were “low, relative to forces experienced in daily living” the accident was “not a likely source of significant forces” acting on the plaintiff’s body. *Id.* at 2.

The Stedman court examined the fact that Mr. Tencer had previously been barred from offering testimony regarding whether the force in a collision was sufficient to cause injury, particularly from comparing injuries to volunteers in Mr. Tencer’s studies to the injuries alleged by a plaintiff. *Id.* at 3. It examined Schultz v. Wells, 13 P.3d 846, 849 (Colo.App.2000) in which the court questioned the validity of using tests designed for testing cars for the different purpose of assessing a threshold of applied force for injury in rear-end car accidents. Stedman, at 5. The Stedman court stated that “Schultz persuasively explains why a trial court may regard such an opinion as more likely to be misleading than helpful.” *Id.*

However, the issues in Stedman are far different from those presented in the instant case. The plaintiffs try to use Stedman as a reason why defense experts should not have been permitted to testify about the other conditions Mr. Colley suffered from that could cause his claimed memory loss. But, these are doctors testifying about what they see based on their expertise and specialty. None was testifying outside his practice; none testified on standard of care of nurses or a hospitalist; none testified about pulmonary issues or neurology or psychiatry. Each was limited to his specialty and each testified on a more probable than not basis. And, none has ever been precluded as an expert, such as Mr. Tencer had been, giving rise to the objection in that case. *Stedman* does not support the Colley’s argument here.

4. *The Hospital properly rebutted the Colleys' causation theory.*

The attached unpublished Washington Appellate decision in Larson v. Nelson, 110 Wn. App. 1002 (Div.2, 2002), is illustrative and persuasive on this issue. In Larson, the plaintiffs appealed a jury verdict finding that a physician was not negligent in the pediatric care he provided to the plaintiffs' infant daughter, who suffered brain damage. Id. at 1. The defendant claimed that "although the cause of [the infant's] subsequent brain damage remains unknown, it was not caused by any negligence on [the physician's] part." Id. at 3.

The plaintiffs there objected to the admission of the parents' drug and alcohol abuse among other things as relevant to causation. Id. at 8. The court explained that the plaintiffs contended that the defendant doctor caused brain damage to the baby, and although they bore the burden of proving causation, the defendant doctor was "entitled to rebut their theory of causation with evidence of other 'possible causes.'" Id. at 8 (citing Wilder v. Eberhart, 977 F.2d 673, 676 [1st Cir.1992]). The court cited to State v. Warness, 77 Wn. App. 636, 643, 893 P.2d 665 (1995) for the proposition that "inadmissible speculation is not the same as a legitimate opinion regarding what 'could be' the truth so long as that opinion can be stated with the requisite scientific probability." Larson, at 10.

In the instant case, Mr. Colley has several other medical conditions which were likely causing his claimed short-term memory loss. (See

Exhs. 8, 14, 15, 16) The Hospital does not have to prove what caused any memory loss or brain damage. But the Hospital entitled to rebut the causation theory. The admission of testimony for this purpose was proper and certainly not an abuse of discretion.

5. *Testimony by pharmacist Dr. Ellsworth regarding the dosage and effects of morphine is proper to address claims that Mr. Colley was administered an excess of morphine.*

Dr. Ellsworth is an expert pharmacologist and he testified simply how morphine works and how it breaks down, scientifically. (RP 912-918, 929). He testified regarding the effect of the patient's size in determining the correct dosage of morphine, and the length of time for morphine to take effect and to leave the system, scientifically. Why should the jury guess about these matters when an expert can show them how it works? He testified on a more probable than not basis, pursuant to Harris, and his testimony was relevant to show the improbability of morphine causing the respiratory issue, pursuant to Larson. This testimony directly addressed that Colleys' contention that Mr. Colley was given an excess of morphine and was properly allowed. The trial court properly allowed it.

6. *The Colleys makes no showing of prejudice.*

If there is no prejudice to the plaintiff, the trial court's ruling (even if wrong or "untenable") does not allow reversal for a new trial. Thomas v. French, 99 Wn.2d 95, 104, 659 P.2d 1097 (1983) ("...for error without prejudice is not grounds for reversal.")

Here, the jury did not reach causation, and thus there can be no evidence from the trial court's rulings on causation and damages experts that the Colleys were prejudiced in any way. None of these experts addressed standard of care issues, the only issue decided by the jury.

C. The trial court properly denied the Colleys' motion *in limine* No. 16, allowing evidence of Mr. Colley's past history of alcoholism where the Hospital offered expert testimony that Mr. Colley's prior alcohol consumption had an effect on the brain and memory prior to the hospitalization.

The appellants' central claim was that that Mr. Colley suffered brain damage as a result of care provided by the Hospital. If something else potentially caused that brain damage, the defense had the right and duty to put on evidence to get at the truth.

Here, defense neuroradiology expert Dr. Gary Stimac testified that the CT the scan taken of Mr. Colley's brain prior to the incident at issue, shows the same diffuse loss of brain substance that the MRI scan taken after the incident shows. (RP 803-04) In regards to the findings on the CT scan, Dr. Stimac stated that "chronic" shrinkage of the brain is caused by a chronic problem (not an incident insult). (RP 808) On the MRI taken after the incident, Dr. Stimac noted evidence of a "chronic, long-term, diffuse loss of brain substance."

Causes of that chronic process, which contradict the "respiratory insult" theory of the Colleys, were noted by the medical records (E.g., Exh. 15, page 1, alcohol over usage) and expert opinion (mainly the sleep apnea expert, Dr. Pascualy). Mr. Colley's history of alcohol abuse had a

direct bearing on causation of his alleged brain damage and on the extent of the damages, and was properly allowed as evidence.

The Colleys cite to Kramer v. J.I. Case Manufacturing Co., 62 Wn. App. 555, 815 P.2d 798 (Div. 1, 1991), for support of their argument that evidence of Mr. Colley's alcohol consumption should have been excluded. However, this case does not support an exclusion of the evidence.

In Kramer, the defendant asserted that the plaintiff's history of alcohol abuse and marijuana use was relevant on the issues of the plaintiff's earning capacity and work-life expectancy. Id. at 556. The defendant argued that it would provide expert testimony that substance abusers have decreased work-life expectancies and earning capacity. Id. The trial court deferred ruling on whether to allow the evidence, pending briefing by the parties and an offer of proof by the defendant of the alleged expert testimony. Id. at 556-557. Although the defendant did not submit an offer of proof, the court trial allowed the evidence to be admitted. Id. at 557.

This Court found this to be in error for three reasons: (1) the ruling was premature because the defendant had not submitted an offer of proof; (2) it was difficult to discern the probative value of the plaintiff's marijuana smoking practices; and (3) nothing in the records indicated that the plaintiff's drug and alcohol abuse affected his employment, prior to the incident at issue in the law suit. Id. at 559. As this Court later stated in the Dewey v. State case, on this same issue:

Dewey relies heavily on [Kramer] in support of his argument that defense alcoholism evidence did not meet the criteria for admission into evidence. Dewey asserts such evidence requires proof of impact on earning capacity and work-life expectancy before admission at trial. Kramer does not stand for this proposition. . . . We held that the trial court abused its discretion in allowing the testimony when no evidence connecting it to the proffered reasons for the testimony was provided. Kramer did not involve a defense argument that the symptoms claimed to result from the injury were or might be alcohol symptoms, . . . It is true that alcohol evidence is obviously prejudicial, and trial courts should be careful to require evidence regarding the legitimacy of the diagnosis and its relevancy before admitting the evidence. Here Ms. Smith provided such evidence.”

Dewey v. State, 96 Wash. App. 1046 (Div. I, 1999)(citations to Kramer omitted); unpublished opinion, attached hereto.

Here, as well, the Hospital has provided such evidence. The first two Kramer reasons are not applicable to the question raised by the Colleys. The third reason simply proves why Mr. Colley’s alcohol consumption should be admissible -- Mr. Colley’s medical records show the effect of alcohol consumption on his various medical conditions (Exh. 15, page one), including the effect on his brain imaging prior to the hospitalization at issue. Dr. Pascualy agreed it was relevant on memory loss issues: “chronic alcoholism is associated with long term and irreversible change in memory, and many patients who are drinking at that level, that’s another problem.” (RP 948; see 951 also) Also, Dr. Kristopher Rhoads, the neuropsychology expert from Virginia Mason,

testified on the contributing factor of alcohol on brain damage and causation as follows:

[C]ertainly we know alcohol is neurotoxic to the brain and there is a whole host of memory, attention, concentration, executive functioning, [l]ots of cognitive effects from alcohol, especially for years of alcohol use at fairly high levels. . . .

Q. You mention the affect on cognitive function. How does that factor in?

A. So, one of the first areas that alcohol affects are the frontal lobes here, the front part of the head, and it's usually a suppression of inhibition centers and decreases, things like acquisition and getting things from the outside world, and from the brain for memory, planning, problem solving, judgment at times.

(RP 1081-82) His history of alcohol consumption was, thus, as the expert testimony showed, a reason for any alleged brain damage. This evidence was not offered "to prove character and show action in conformity therewith", as the plaintiff would like to argue. It is instead relevant to the central claims in this case. The probative value of this evidence far outweighs any prejudicial effect and it should be admissible. ER 403

However, even if the admission of Mr. Colley's "drinking beer like a fish" (Exh. 15, page 1) is found to be prejudicial, Kramer shows that it is not a basis for reversal. The Kramer court found that even though the admission of the plaintiff's drinking and drug use was in error, since "[the plaintiff] was not alleged to have been intoxicated at the time of the accident...the improper evidence concerning his alcohol and drug use was only relevant to the issue of damages. The jury never reached the damage issue and instead entered a defense verdict on the basis of a lack of

improper conduct.” *Id.* at 560. The court found that accordingly, it was unable to conclude that the admission of this evidence was a basis for reversal. *Id.*

This is identical to the instant case, in which there are no allegations that Mr. Colley was drinking at the time of the incident (quite to the contrary, the evidence was clear that he had not been drinking for years) and his past alcohol use went solely to the issue of damage to his brain. The jury never reached this issue and entered a defense verdict based solely on negligence.

Mr. Colley’s history of drinking was relevant and admissible, but even if it was admitted in error, it should not be a basis for reversal.

VI. CONCLUSION

The Colleys have cited no compelling reasons for disturbing the unanimous jury verdict or for criticizing the trial court decisions on evidence. They simply did not meet their burden in proving to the jury that the Hospital or Dr. Sun violated the standard of care in any way. Their arguments here, to the extent even relevant to the standard of care issue (the only issue decided by the jury), do not rise to any level of proving “abuse of discretion” or requiring reversal and a new trial.

The Court should affirm the jury verdict, and affirm the trial court’s ruling regarding plaintiffs’ motions in limine and deny plaintiffs’ request for a reversal.

Dated this 28th day of January, 2013.

Respectfully submitted,

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I certify under penalty of perjury
under the laws of the State of
Washington that I faxed, mailed,
emailed and/or delivered via
messenger to all counsel of record
a copy of the document on which
this certificate is affixed.

Signed on 1/28/13
Sandra Cameron

Attachments

Not Reported in P.3d, 110 Wash.App. 1002, 2002 WL 77763 (Wash.App. Div. 2)
 (Cite as: 2002 WL 77763 (Wash.App. Div. 2))

C

NOTE: UNPUBLISHED OPINION, SEE RCWA
 2.06.040

Court of Appeals of Washington, Division 2.

Taleia LARSON, a minor by and through her guardian ad litem, Jan MILLAM; Kasia Tune, the natural mother of Taleia Larson; and Brian Larson, the natural father of Taleia Larson, Appellants,
 v.

Chris E. NELSON, M.D., and Tammy Nelson, husband and wife, and the marital community composed, et al., Respondent.

No. 26194-4-II.
 Jan. 18, 2002.

Appeal from Superior Court of Lewis County, Docket No. 98-2-01509-6, judgment or order under review, date filed 06/21/2000; David R. Draper, Judge.

George M. Riecan, Riecan & Hall, Tacoma, WA, for appellant(s).

John A. Rosendahl, Elizabeth L. McAmis, Williams Kastner & Gibbs PLLC, Tacoma, WA, Mary H. Spillane, Williams Kastner & Gibbs, Seattle, WA, for respondent(s).

George M. Riecan, Riecan & Hall, Tacoma, WA, for guardian(s) ad litem.

UNPUBLISHED OPINION

HUNT, J.

*1 Kasia Tune and Brian Larson appeal a jury's special verdict finding that Dr. Chris Nelson was not negligent in the pediatric care he provided to their infant daughter, Taleia, who suffered brain damage. Holding that substantial evidence supports the jury's verdict, and finding no abuse of discretion in the trial court's evidentiary rulings or instructions, we affirm.

I. Facts

A. Injury of unknown cause

1. Pediatrician's treatment through July 19, 1994

Dr. Chris Nelson is a board-certified pediatrician who, as of July 19, 1994, had been practicing at Steck Medical Center in Chehalis, Washington, for at least 10 years. Over the years, he had seen thousands of children with fever.^{FN1} He had been Taleia's pediatrician since her birth on April 17, 1993. Before July 19, 1994, he had seen her 13 previous times for well-child evaluations, diaper rash, a mouth yeast infection, an eye infection, umbilical cord redness, and ear infections.

FN1. Dr. Nelson estimated that he sees maybe one or two children a month in his office with a fever as high as 105.6.

On July 19, 1994, Taleia's father, Brian Larson, and her paternal grandmother brought Taleia to see Dr. Nelson because Taleia had a fever, a runny nose, and a slight red rash.^{FN2} At Dr. Nelson's office, Taleia's rectal temperature was 105.6; after being given Tylenol, her temperature dropped to around 103. According to Dr. Nelson, a fever of 105.6 is not dangerous in itself, but he wanted to know the cause.

FN2. Larson had taken Taleia to the park the previous day, which had been hot. When he brought Taleia to his sister's apartment that evening about 7:00 p.m., Taleia was fussy. Taleia was still fussy and her head felt warm when Tune picked her up. When Larson went to Tune's apartment the next morning, July 19, to take Taleia for the day, Tune told him that Taleia was sick and needed to be taken to the doctor. She thought Taleia was cutting teeth because Taleia was still fussy, had a fever, was not eating as much, and was less active than usual. Larson took Taleia's tem-

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perature with a strip thermometer and it was 103.5. They then called Dr. Nelson's office and made an appointment for later that day.

When he examined Taleia, Dr. Nelson noted that she was active and alert, but fussy.^{FN3} She appeared 'mildly ill, mildly toxic, mildly sick.' Her ears were not infected. Her throat was not inflamed. But her nose was congested, suggesting that she had an upper respiratory viral infection or a cold. Her neck was supple, and there was no meningismus, indicating that she did not have meningitis. Her neck lymph nodes were not enlarged, she had a regular heart rate and rhythm, and her lungs were clear. Her abdomen was soft, non-tender, and without evidence of appendicitis. There was a fine rash on her abdomen.

FN3. Larson claimed that, although Taleia was fussy, she was not active and was not very responsive.

Dr. Nelson's physical exam of Taleia did not reveal the fever source. He knew that it was uncommon for a cold to produce such a fever. So he ordered a complete blood count (CBC) and a urinalysis. The CBC showed that Taleia very likely had some sort of infection, most likely bacterial, rather than viral. The urinalysis indicated a likely urinary tract infection.^{FN4} Thus, Dr. Nelson's impression was that Taleia had a high fever with urinary tract infection^{FN5} and an upper respiratory infection.

FN4. The urinalysis result, 3  ketones, meant that Taleia had not been eating well for a few hours. The specific gravity was normal, but suggested that Taleia's urine was somewhat concentrated. An elevated specific gravity does not automatically mean that a child is dehydrated. Urine concentration can occur in children who are out playing on a warm day or who have not taken much fluid for several hours.

FN5. Dr. Nelson did not think that Taleia had pyelonephritis, a kidney infection, because children with pyelonephritis look much sicker than Taleia looked.

Dr. Nelson concluded that it was appropriate to treat Taleia as an outpatient because she did not meet the criteria for hospitalization.^{FN6} She was not too sick to be treated as an outpatient, she was not dehydrated, and she could keep down oral medications. He ordered a urine culture^{FN7} and prescribed Tylenol for the fever and an antibiotic for the presumed urinary tract infection. Taleia was to return in one week, but if her fever was not improving, then she was to return within the next two days. Larson was given a fever instruction sheet.

FN6. Larson claimed that he was so concerned about Taleia's condition that he asked Dr. Nelson if Taleia should be hospitalized. But Larson did not check on Taleia when he returned home from his alcohol abuse meeting at 8:00 p.m.

FN7. It takes one to two days for urine culture results.

2. Home-Evening of July 19 through morning of July 20, 1994

*2 Unbeknownst to Dr. Nelson, Taleia's parents had extensive histories of drug and alcohol abuse.^{FN8} Because Larson had an alcohol abuse meeting on the evening of July 19, he returned Taleia to Tune's care for the night. Rushed, he told Tune that Taleia had a urinary tract infection and a high temperature, and gave her Dr. Nelson's instructions, some Tylenol samples, the antibiotic, some Popsicles, and apple juice.^{FN9} There was no bruise on Taleia's face at this time.

FN8. Larson and Tune concede that they never revealed their extensive drug and alcohol abuse problems to Dr. Nelson. Both testified that their extensive drug and alcohol abuse has affected their memories. Tune acknowledged a history of blackouts

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and hallucinations associated with her drug use, including methamphetamines.

FN9. He told Tune to give Taleia the Tylenol every four hours, to keep her cooled down, and to give her Popsicles.

Tune's boyfriend, Marc Stern, was staying with her that night.^{FN10} Tune described Taleia as not very active that evening—she lay on one end of the couch and slept, while Tune lay on the other end and watched television with Stern. Between 8:00 and 9:00 p.m., Tune put Taleia to bed and gave her medications and a bottle of apple juice. Taleia's hospital records reflect that Stern cared for Taleia throughout the night because Tune was sleeping. But Tune testified that she was the one who took care of Taleia that night. The hospital records reflected that Taleia had been sleeping well, was last checked at midnight, and was not checked again until 8:00 or 8:30 a.m. the next morning, July 20. But Tune testified that she had checked on Taleia at 4:00 a.m. because Taleia was fussy; Tune said that she had found Taleia's juice bottle empty and had given her a new bottle. She said that Taleia had not felt warm,^{FN11} so she did not administer any Tylenol. The hospital records, however, said that Tune had not given Taleia Tylenol after 9:00 p.m. on July 19 because Tune's supply had run out.

FN10. Stern could not be located and he did not testify at trial.

FN11. According to hospital admission assessment records, Taleia's temperature at 4:00 a.m. was reported as 99.

Sometime before 8:15 a.m. on July 20, Stern got up to check on Taleia and found her 'laying {sic} blue, unconscious, with her eyes rolled up and a few seconds later began having generalized seizures.' Tune testified that (1) Taleia was not seizing when Stern checked on Taleia; (2) when Stern told Tune something was not right with Taleia, Tune found that Taleia was cold, not feverish, light purple in color, and not breathing right;

(3) she picked up Taleia, took her to the living room, laid her on the floor, told Stern to watch her, and went next door to call her mother; (4) when Tune returned home, Taleia was seizing, so Tune went next door again and called 911 not more than 10 minutes later; (5) Tune did not return to her apartment but instead waited outside for the paramedics; (6) at some point, she went to get Larson. The paramedic records indicated that Taleia had been seizing for about an hour before 911 was called.

When the fire department aid crew arrived at 8:16 a.m. and ambulance arrived at 8:27 a.m., Taleia was unconscious, having mild seizures, appeared in respiratory distress, had an axillary temperature of 101.6, and had bruising on the left side of her face. With assisted respiration, Taleia's color improved; with Valium, her respiratory effort improved. But her seizures persisted as she was transported to Providence Centralia Hospital.

3. Providence Hospital-Centralia

*3 When Taleia arrived at the emergency room at 8:47 a.m., her temperature was 107.4. Treatment stopped her seizures and brought down her fever. She was admitted under the care of Dr. James Miller. Nurses noted bruising on the left side of Taleia's face and a 'red area around neck.'

Dr. Nelson resumed Taleia's care on July 21. He ordered a number of diagnostic procedures to find a cause for Taleia's condition, but he could find no explanation for her fever and no cause for her seizures. Urine culture, blood culture, and spinal tap were all negative for infection.^{FN12}

FN12. Initially, the medical staff thought that Taleia had experienced a prolonged febrile seizure, which had caused a postictal state which, in turn, combined with the medications to control the seizures, had made Taleia drowsy and unarousable. Postictal is defined as, 'Following a seizure, e.g., epileptic.' *Stedman's Medical Dictionary*, 1413 (26th

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ed.1995).

When Taleia had still not awakened on July 23, Dr. Nelson reported her history, testing, and treatment to Children's Hospital. Children's told him that it did not know what more could be done, but suggested hyperpyrexia hemorrhagic encephalopathy (also known as hemorrhagic shock encephalopathy) as a possible cause for Taleia's illness.

4. Children's Hospital-Seattle

Larson and Tune wanted Taleia transferred, and Dr. Nelson wanted to find out what was causing Taleia's problems. So Dr. Nelson transferred her to Children's on July 24. She arrived in a persistent vegetative state, did not respond to treatment, and remained in that state for the duration of her hospitalization. Despite multiple evaluations, the cause of Taleia's brain damage remained unknown. Among the possibilities considered were child abuse, brain infection, hypoxia and hemorrhagic shock encephalopathy. Taleia's discharge diagnosis was '{p}ersistent vegetative state of uncertain etiology.'

5. Post-hospitalization

On August 13, 1994, Taleia was discharged from Children's to Tune. Because caring for Taleia was hard, Tune significantly increased her methamphetamine use in order to cope. In late 1994, unaware of Tune's drug and alcohol problems (other than recreational drug use), Jan Millam agreed to provide respite care in her home three days a week. In January 1995, after Millam had taken Taleia for a second three-day period, Tune did not return for Taleia.

Millam called the DSHS caseworker, who explained that Tune had been arrested and jailed for felony possession of methamphetamine. After Tune was released from jail, Millam cared for Taleia in her home four days a week. Tune was jailed again. Millam assumed Taleia's full-time care, ultimately became her foster mother, and obtained permanent custody.

B. Trial

Claiming that Dr. Nelson had negligently failed to hospitalize Taleia on July 19, 1994, Taleia's guardian ad litem, Millam, sought damages for Taleia's permanent and serious brain damage. Taleia's parents, Tune and Larson, each sued individually claiming damages for the destruction of their parent-child relationship.

Dr. Nelson denied plaintiffs' claims. He presented evidence that (1) his care and treatment of Taleia, including his decision to treat her on an outpatient basis for a presumed urinary tract infection, complied with the applicable standard of care; and (2) although the cause of Taleia's subsequent brain damage remains unknown, it was not caused by any negligence on his part. Dr. Nelson also denied the extent of Taleia's and her parents' claimed damages.

1. Plaintiffs' theory of the case; expert testimony

*4 Larson's and Tune's theory of the case was that Dr. Nelson should have hospitalized Taleia on July 19 and that proper inpatient treatment would have prevented her injury. They called as an expert witness Dr. Lori D. Frasier, a general pediatrician with a special focus on child abuse from the University of Missouri. Dr. Frasier testified that in her opinion, more probably than not hypoxic ischemic encephalopathy^{FN13} was the cause of Taleia's brain damage; i.e., Taleia had sepsis (a bacterial infection in the blood stream), which led to high fever, which led to seizure, which led to hypoxia, which caused the brain damage.^{FN14}

FN13. 'Hypoxic ischemic encephalopathy' is not defined in the record. Generally, it refers to a subnormal oxygenation of arterial blood in the brain tissue, caused by obstruction or constriction of the arteries. See, *Stedman's Medical Dictionary*, 566, 841, 842 (26th ed.1995).

FN14. Dr. Frasier conceded, however, that if Taleia was not warm at 4:00 a.m., as Tune testified, or if her axillary temperature was 101 .6 when the paramedics ar-

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rived, as their records reflect, then high fever did not cause Taleia's seizures. Moreover, Dr. Frasier acknowledged that the physicians at Children's considered sepsis (hypoxic ischemic injury), but found no evidence to support such a diagnosis.

Dr. Frasier further opined that because of Taleia's age, the height of her fever, and her high white blood cell count, a reasonably prudent pediatrician should have suspected pyelonephritis,^{FN15} or bacteremia or sepsis from some other source,^{FN16} and should have hospitalized Taleia and treated her with intravenous fluids and antibiotics.^{FN17} In Dr. Frasier's opinion, hospitalization and appropriate inpatient treatment would have prevented Taleia's brain damage.

FN15. Dr. Frasier conceded that trying to decide whether a child has a urinary tract infection or pyelonephritis is a complex decision that involves evaluating many factors, about which there could be room for disagreement among reasonably prudent physicians. Moreover, she conceded that the laboratory studies did not confirm that Taleia had pyelonephritis.

FN16. No bacteria were identified on cultures of Taleia's blood or cerebral spinal fluid.

FN17. When impeached with her deposition, Dr. Frasier conceded that even pyelonephritis could be treated on an outpatient basis as long as the child did not appear toxic or dehydrated and could take oral medications. She conceded that Taleia could keep down oral medications, that there was no laboratory or clinical evidence of dehydration, and that deciding whether a child appears toxic is a judgment call based on experience. She also agreed that on July 19, 1994, Dr. Nelson (1) took an appropriate history, (2) did an appropriate physical exam, (3) appropriately ob-

tained a CBC and urinalysis, (4) appropriately concluded, based on the presence of 20-30 white cells in the urine, that Taleia had a urinary tract infection, and (5) appropriately prescribed the antibiotic Augmentin for the urinary tract infection.

2. Dr. Nelson's theory of the case; expert testimony

Dr. Nelson's theory of the case was that he complied with the applicable standard of care when he chose to treat Taleia on an outpatient basis for her presumed urinary tract infection. In addition to his testimony, the defense presented Dr. Michael Radetsky, a pediatric infectious disease and critical care specialist from Loveless Clinic in Albuquerque, New Mexico, and the University of New Mexico, and Dr. Bill Robertson, a pediatrician and medical toxicologist at Children's in Seattle. Both testified that Dr. Nelson complied with the applicable standard of care in treating Taleia.^{FN18}

FN18. Both testified, among other things, to the appropriateness of Dr. Nelson's work-up to try to determine the cause of Taleia's fever; the appropriateness of Dr. Nelson's decision, based on that work-up, to treat Taleia for a presumed urinary tract infection pending the results of a urine culture; and the appropriateness of Dr. Nelson's conclusion that Taleia's condition was such that she did not need hospitalization, but could properly be treated on an outpatient basis.

Dr. Nelson's theory was that the cause of Taleia's brain damage and persistent vegetative state was unknown, but it was not caused by any negligence on his part. Consistently, the cause of Taleia's injury was unknown to the physicians at Children's. Dr. Nelson testified that he did not know what had caused Taleia's brain damage; but, in his opinion, because it happened so suddenly and devastatingly, hospitalizing her would not have prevented it.

Dr. Radetsky testified that there was nothing

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Dr. Nelson could have done to prevent Taleia's brain damage. Dr. Radetsky testified further about pediatric infectious disease, that he did not know what Taleia's illness was, and that it was a 'mystery illness.' Of the four possibilities he considered (hemorrhagic shock encephalopathy (HSE), viral encephalitis, heat stroke, and toxic shock syndrome), he stated that the most likely cause was HSE, a tragic, unpreventable, and untreatable disease.^{FN19} In reaching that conclusion, Dr. Radetsky relied on these facts: (1) on July 20, 1994, Taleia's brain (and not her other organs) sustained the worst damage; (2) she had a very high fever, diarrhea, anemia, excessive acid in her blood, some liver problems and blood clotting abnormalities; and (3) she did not have shock, significant rash, or kidney problems. Dr. Radetsky concluded that HSE was the most likely cause because Taleia had all the features of HSE except shock (which is not always present) and kidney failure.

FN19. Half the children who develop HSE die, and about 90 percent to 95 percent of those who survive are brain damaged.

*5 Dr. Radetsky explained that viral encephalitis was less likely because (1) there was no evidence of brain infection, and (2) Taleia had a very high fever, bleeding problems, liver damage, anemia, and diarrhea, which are not usually present with viral encephalitis. Toxic shock syndrome was even less likely because there was no shock or low blood pressure and no total-body, sunburn-like rash. Heat stroke was even less likely because there was no environmental source of her high fever and her convulsions occurred with a low fever as measured by the paramedics.

Dr. Radetsky did not consider Dr. Frasier's hypothesis of sepsis and hypoxia to be a real possibility. He explained that Taleia could not have had sepsis because no bacteria were found in her blood and she did not have shock. She also could not have had prolonged hypoxia, because only the front part of her brain was injured and her kidneys were not.

Dr. Nelson also presented the causation opinion testimony of Dr. Carter Snead, an internationally prominent pediatric neurologist with a subspecialty in epilepsy from the Hospital for Sick Children in Toronto. Dr. Snead, like Dr. Radetsky, disagreed with Dr. Frasier's causation theory. First, Taleia was never in shock, never had a decrease in blood pressure, never had a positive culture, and had no evidence of sepsis. Second, there was no evidence of high fever.^{FN20} Finally, Taleia's seizure was too short to produce brain damage,^{FN21} and Taleia did not have damage to the back part of her brain, which is where the damage occurs when induced by seizure.

FN20. When the paramedics saw Taleia actively seizing, her fever was less than 102. Her temperature did not reach 107 until she got to the emergency room, suggesting that the prolonged seizures made her fever worse.

FN21. Dr. Snead has never seen extensive brain damage with seizures of less than six or eight hours duration.

It was Dr. Snead's opinion that the cause of Taleia's brain damage was bilateral compression of her carotid arteries, occurring between 11:00 p.m. on July 19 and 4:00 a.m. on July 20, which produced severe hypoxic damage to the front part of her brain, the part to which the carotid arteries supply blood. The severe brain injury manifested initially as seizures, and the seizures in turn caused Taleia's fever to rise. Dr. Snead's opinion was based on: the two CT scans,^{FN22} which showed evidence of hypoxic ischemic injury to both sides of the front part of the brain; ^{FN23} the evidence of external trauma consisting of bruising on the left side of the face and a red neck; the acuteness of the injury; and the absence of shock, brain infection, or of injury to the back part of the brain. Dr. Snead considered these factors together with the family history of drug and alcohol abuse, a major risk factor for child abuse and neglect, and the discrepancies in the history given to the paramedics and the hospital per-

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sonnel concerning how long the seizure had lasted before 911 was called.^{FN24} In Dr. Snead's opinion, there was a 'pretty compelling case' that more likely than not bilateral carotid artery compression (strangulation) was the initial trauma that triggered the events leading to Taleia's brain damage.^{FN25} Dr. Snead had no opinion as to who or what caused the bilateral carotid compression or whether it occurred intentionally or accidentally.

FN22. 'CT scan' is the abbreviation for computerized tomography, which images anatomical information from a cross-section plane of the body. *Stedman's Medical Dictionary*, 418, 1819-20 (26th ed.1995).

FN23. Although the radiologist who read the first CT scan reported it as normal, Dr. Snead showed the jury that it was not normal; rather it showed very early brain swelling in the front, but not the back, part of the brain.

FN24. The paramedics noted that Taleia had been seizing for about an hour before 911 was called. The records at Providence indicate that Taleia was found seizing at approximately 8:20 a.m., or 8:25 a.m. even though the fire department aid crew was dispatched at 8:15 a.m.

FN25. Dr. Snead testified that the next leading likely cause would be HSE, the cause Dr. Radetsky believed was the most likely.

3. Plaintiffs' motions in limine

*6 Before trial, Larson and Tune moved in limine to exclude any evidence of their drug and alcohol abuse, criminal history and convictions, and allegations of child abuse or neglect.

They contended that such evidence was 'impermissibly prejudicial' and had no 'relevancy or materiality to the pertinent issues of liability and damages.' Dr. Nelson responded with a detailed

showing as to why Tune's (and her boyfriend Stern's) drug and alcohol abuse were relevant to causation; why Tune's and Larson's drug and alcohol abuse were relevant to their ability accurately to perceive or to recall events at issue;^{FN26} and why their drug and alcohol abuse, criminal history and convictions, and allegations of child abuse or neglect were relevant to their claim for damages for loss of the parent-child relationship.

FN26. Larson admitted in his deposition that his use of drugs had negatively affected his memory of the events. And Tune admitted that she was 'pretty out there' when using methamphetamines and had 'no clue' what her mental state was like as a result of her drug use. Tune acknowledged that she was using methamphetamine in July 1994, and that she and Stern quite often did methamphetamine on the nights he stayed over. She told treatment providers in 1996, that she had started using methamphetamines in 1988, and had used them '{d}aily.'

Larson and Tune also moved in limine to exclude Dr. Snead's testimony that the most likely cause of Taleia's brain damage was bilateral compression of her carotid arteries. They contended that his causation opinion testimony was speculative, unreliable, and prejudicial.

Dr. Nelson responded with a detailed showing as to why Larson's and Tune's contentions were incorrect. He noted that Dr. Snead's testimony was based on facts and data of the type reasonably relied on by experts in the field, including: (1) the observations of the paramedics and/or nurses of the bruise on Taleia's face and her reddened neck; (2) the carotid artery anatomic distribution of the brain injury seen on her CT scans; (3) the absence of other findings that could have produced that anatomic distribution; and (4) the mother's (and her boyfriend's) admitted drug abuse history, a major risk factor for child abuse or neglect.

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The **trial court** denied both **motions in limine**. But it excluded DSHS caseworker opinions that the parents should have only supervised visitation and no increased contact with Taleia until they underwent certain evaluations and treatment. The **trial court** ruled that the parents' drug and alcohol abuse, etc., was relevant to the quality of the parent-child relationship, the accuracy of their memory and description of events at issue, and causation.^{FN27}

FN27. After the court denied plaintiffs' motion in limine, plaintiffs' counsel indicated that if the court was ruling that the evidence was relevant only as to damages, then he would move to bifurcate trial of damages and causation issues. He also asked the court to clarify whether it was ruling that the evidence was relevant to causation. The court reiterated that the evidence was probative of the quality of the parent-child relationship (damages), causation, and the accuracy and reliability of the parents' memory. Plaintiffs' counsel did not then move to bifurcate and did not seek a limiting instruction.

The **trial court** found that Dr. Snead's causation opinion testimony was not based on speculation and conjecture, but on evidence. When plaintiffs' counsel argued that there was no evidence to support Dr. Snead's opinion, the **trial court** stated: 'Well, before you go on, you keep saying no evidence. I have read about evidence of a bruise on the cheek and redness on the throat on the day in question.' Report of Proceedings (RP) at 32. The **trial court** acknowledged that '{i}'t's inherently prejudicial to talk about drug abuse.' But in weighing probative value against unfair prejudice, the **trial court** found that Larson and Tune had not shown that the danger of unfair prejudice substantially outweighed the probative value of the evidence.

4. Plaintiffs' Objections to Social Worker Testimony

*7 Sally Stuart is a social worker with (1) the

University of Washington's Center on Human Development and Disability, where she cares for children with developmental disabilities, and (2) its High Risk Infant Follow Up Clinic, where she sees children with high risk conditions, including parental substance abuse. At both clinics, she works with victims of child abuse and with children who are wards of the State. She also screens for risks associated with child abuse or neglect, has had substance-abuse training, and has worked as a volunteer probation counselor doing presentence interviews for persons convicted of driving while intoxicated or driving under the influence.

Dr. Nelson called Stuart to testify concerning (1) the services available through government programs to care for children with special needs, like Taleia; (2) the risk factors for child abuse and neglect; (3) the presence of such risk factors for Taleia's parents; and (4) her opinion as to whether, given the risk factors present, it was likely that Taleia would have remained under her parents' care even if she had not sustained brain damage.^{FN28}

FN28. Stuart had reviewed the hospital discharge summaries, the social work notes from Children's, Taleia's outpatient records since discharge from Children's, Taleia's DSHS social work and Medicaid records, DSHS records for Tune, including CPS referrals, drug treatment records of Tune and Larson, criminal records and court files for Tune and Larson, Lewis County Public Health Department records, Lewis County Special Education records, and depositions of Millam, Tune, Larson, Dr. Pope, and plaintiffs' life care planner. ('Life care planner' is not defined in the record, but from the context, it appears that this would be similar to a health care planner, in that the provider would assess the individual's situation, recommend a plan of treatment, and co-ordinate that plan).

Larson and Tune initially objected to Stuart's testimony about the kinds of government services

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available to children with special needs; but they withdrew their objection when Dr. Nelson pointed out that Taleia was already receiving those services. When Stuart was asked to explain the various risk factors for child abuse and neglect, plaintiffs objected, stating that the line of questioning was neither relevant nor material as to damages, was speculative and conjectural, lacked foundation, and invaded the province of the jury. After argument outside the jury's presence,^{FN29} the **trial court** overruled the objection, finding the evidence relevant to the parents' claim for damages for loss of the parent-child relationship.

FN29. Plaintiffs' counsel also objected to a question about multiple CPS referrals and investigations, which he claimed were not in evidence and mischaracterized the evidence. After clarifying that these referrals were in evidence in Exhibit 8 (admitted under ER 904), defense counsel withdrew the question.

Thereafter, Stuart explained why parental substance abuse, criminal activity and incarceration, family history of abuse or neglect, low educational attainment, lack of economic resources, chaotic lifestyle, lack of social support, domestic violence, and difficult interpersonal relationships are risk factors for child abuse and neglect. She explained the extent to which each of those risk factors was present for Tune and Larson. Based upon her review of the records and her assessment of the risk factors, she then opined that Taleia likely would have been removed from Tune's and Larson's care even if she had not been brain damaged. Stuart stated: 'These same risk factors are also the risk factors that we see that result in children being removed from their parents' home, and at that time Tyler^{FN30} was removed {from Tune's care} for many of those risk factors.' RP at 893. Stuart also noted that (1) although Larson had visitation with Taleia, she had never been placed in his care; and (2) given that he had the same risk characteristics as Tune, it was unlikely that Taleia would have

been placed in his care once removed from Tune's care.

FN30. Tyler was another of Tune's children who was removed from her care when she was jailed for possession of methamphetamines in January 1995.

*8 Plaintiffs also objected when Stuart was asked about psychologist David Hawkins' report concerning Tune's psychological make-up and ability to overcome her substance abuse problems. Larson and Tune argued that although Stuart could rely on Hawkins' report, she could not testify about his opinions because they were hearsay. The **trial court** overruled the objection because Hawkins' report, including his opinions and conclusions, was already in evidence as part of Dr. Nelson's ER 904 submission, to which plaintiffs had not timely objected.

5. Plaintiffs' exceptions to Instructions Nos. 6 and 7

The **trial court** gave the standard **medical malpractice** jury instructions on burden of proof, standard of care, and proximate cause. Larson and Tune's sole exception to Instruction No. 6, a 'poor result' instruction, was that they did not believe it was 'appropriate in this particular case' because there was no evidence or representation of any guarantee of a good result, and '{i}n every case ... of medical negligence case, there's generally a bad result....' RP at 958.

Larson and Tune also objected to 'poor result' 'error of judgment'

Instruction No. 7, arguing that it was (1) a comment on the evidence, 'a comment on potential factual scenarios in which the standard of care may or may not have been adhered to,' (2) redundant with the standard of care instruction, 'that the word 'alternative' implies to the jury that there might be two or more satisfactory courses of treatment,' and (3) unsupported by evidence of two satisfactory alternative courses of treatment.

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RP 958-59.

The jury returned a special verdict for Dr. Nelson, answering 'No' to the first question: 'Was Dr. Nelson negligent?' The jury never reached the issues of proximate cause and damages.

ANALYSIS

I. Motions in limine and other evidence

A. Standard of Review

Absent an abuse of discretion, we will not disturb on appeal a trial court's rulings on motions in limine, the admissibility of evidence, and the admissibility and scope of expert testimony.^{FN31} 'A trial court abuses its discretion if its ruling is 'manifestly unreasonable or based upon untenable grounds or reasons.' *Wick v. Clark County*, 86 Wn.App. 376, 382, 936 P.2d 1201 (1997) (citations omitted).

FN31. See *Gammon v. Clark Equip. Co.*, 38 Wn.App. 274, 286, 686 P.2d 1102 (1984) (motions in limine); *Hume v. American Disposal Co.*, 124 Wn.2d 656, 666, 880 P.2d 988 (1994), (admissibility of evidence); *Christensen v. Munsen*, 123 Wn.2d 234, 241, 867 P.2d 626 (1994) (admissibility and scope of expert testimony).

All relevant evidence is admissible. ER 402. '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. Thus, '{a}ll facts tending to establish a theory of a party, or to qualify or disprove the testimony of his adversary, are relevant.' *Fenimore v. Donald M. Drake Constr. Co.*, 87 Wn.2d 85, 89, 549 P.2d 483 (1976).

B. Parents' Drug and Alcohol Abuse, Criminal Histories, Child Abuse Allegations

I. Relevance to causation

Larson and Tune contended that Dr. Nelson's failure to diagnose properly and to hospitalize Taleia caused her brain damage. Although they bore the burden of proving causation,^{FN32} Dr. Nelson was entitled to rebut their theory of causation with evidence of other 'possible causes.' See *Wilder v. Eberhart*, 977 F.2d 673, 676 (1st Cir.1992).

FN32. *O'Donoghue v. Riggs*, 73 Wn.2d 814, 824, 440 P.2d 823 (1968); *Miller v. Staton*, 58 Wn.2d 879, 886, 365 P.2d 333 (1961).

*9 Dr. Snead testified that, of the possible causes he considered, bilateral compression of the carotid arteries occurring between 11:00 p.m. on July 19 and 4:00 a.m. on July 20 as a result of child abuse or neglect was the most likely (and more probable than not) cause.^{FN33} Central to his causation opinion was that a history of substance abuse was a major risk factor for child abuse or neglect.

FN33. Such injury could have been caused intentionally by strangulation or accidentally, i.e., if the child had slipped between couch cushions. There is evidence that Taleia was sleeping on the couch on the night in question.

Here, Larson's, Tune's, and Stern's drug and alcohol abuse were relevant to Dr. Snead's theory that Taleia's parents' neglect or abuse on July 19-20 led to her injuries. Larson admitted that (1) he was in a hurry when he dropped Taleia at Tune's apartment; (2) although he believed Taleia should have been hospitalized, he did not call to check on her that night; and (3) his use of drugs had negatively affected his memory of the events. Tune acknowledged that she was using methamphetamine in July 1994 and that she and Stern often ingested methamphetamine on the nights he stayed over.^{FN34} Although Tune testified that she took care of Taleia that night, Taleia's hospital records reflect

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that Stern had cared for Taleia throughout the night. Tune said that she did not give Taleia Tylenol for her fever when she checked her at 4:00 a.m. because Taleia did not feel warm; but the Providence records indicated that Taleia was not given any Tylenol after 9:00 p.m. on July 19 because Tune's supply had run out.

FN34. Stern could not be located and, thus, did not testify at trial.

There were also discrepancies in the history given to the paramedics and the hospital as to how long Taleia's seizure had lasted before 911 was called. Additionally, when Taleia was brought into the hospital the next morning, the nurses noted bruising on the left side of her face and a red area around her neck.

Larson's and Tune's drug use were relevant to their abilities to care properly for Taleia that evening and to remember the evening's events accurately. This evidence also tended to support Dr. Snead's testimony that child abuse and neglect were possible causes. The **trial court** did not err in admitting such evidence.

2. Relevance to Damages

ER 403 does not operate to exclude crucial evidence relative to a party's central contention. *State v. Brown*, 48 Wn. App. 654, 660, 739 P.2d 1199 (1987). At trial, Larson and Tune sought substantial damages for loss of their parent-child relationship with Taleia. Evidence of their extensive drug and alcohol abuse, their tendencies toward violence when using, their repeated failures to complete rehabilitation programs, their criminal convictions and incarceration, and their allegations of child abuse and neglect against each other, were all relevant to their claim for damages for loss of the parent-child relationship, which hinged on the quality of this relationship. This evidence would have been essential for valuation of the parents' damages claims.^{FN35} Thus, the **trial court** did not err in allowing this evidence.

FN35. See n. 27.

C. Expert Witness Testimony

1. Dr. Snead's Opinion

Larson and Tune contend that the **trial court** should have excluded Dr. Snead's testimony because his opinion was based on unreliable and conflicting information. Br. of Appellant at 37. But inadmissible speculation is not the same as a legitimate opinion regarding what 'could be' the truth, so long as that opinion can be stated with the requisite scientific probability....

*10 As long as the scientific methods used to form the opinion are generally accepted within the relevant community, an expert's lack of certainty does not render the evidence inadmissible.

State v. Warness, 77 Wn.App. 636, 643, 893 P.2d 665 (1995).

Dr. Snead was an experienced pediatric neurologist subspecializing in seizures. Central to his causation opinion were (1) the absence of any specific findings supporting other possible causes, (2) the anatomic distribution of the brain injury seen on Taleia's CT scans, (3) the bruises on her face and the redness on her neck, (4) the discrepancies between when the 911 call was placed relative to the length of time of the seizure, and (5) the history of parental substance abuse, which is a risk factor for child abuse or neglect. These facts are of a type reasonably relied on by experts in the field. Moreover, they are the same facts that Taleia's treating physicians and other experts considered and relied on in evaluating and forming their opinions concerning possible causes of Taleia's brain damage. Therefore, Dr. Snead's testimony was admissible under ER 703.^{FN36}

FN36. ER 703 sets forth the appropriate bases of an expert's opinion:

The facts or data in the particular case upon which an expert bases an opinion

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or inference may be those perceived by or made known to the expert at or before the hearing. If of a type reasonably relied upon by experts in a particular field in forming opinions or inferences upon the subject, the facts or data need not be admissible in evidence.

2. Expert Witness, social worker Stuart

Dr. Nelson called social worker Stuart to testify concerning: (1) the services available through government programs to take care of children, like Taleia, with special needs, (2) the risk factors for child abuse and neglect, (3) the presence of such risk factors for the plaintiff parents, and (4) her opinion as to whether, given the risk factors present, it was likely that Taleia would have remained under her parents' care even if she had not sustained brain damage.

Although Larson and Tune initially objected to Stuart's testimony concerning the kinds of government services available to children with special needs, they withdrew their objection when Dr. Nelson pointed out that Taleia was receiving those services. Larson and Tune again objected when Stuart was asked to explain the various risk factors for child abuse and neglect. After argument outside the jury's presence, the **trial court** overruled the objection, finding the evidence relevant to the parents' claim for damages for loss of the parent-child relationship.

But Larson and Tune did not contend at trial that Stuart's expert testimony had no relevance to their claim for damages for loss of the parent-child relationship. Nor did they move to bifurcate the trial when the **trial court** ruled that the evidence was relevant to both damages and causation. And they did not request a limiting instruction as to how the jury could consider this evidence. Thus, they effectively waived any objections to evidence of the parents' risk factors for child abuse and neglect. Accordingly, we do not consider this issue raised for the first time on appeal, without citation to authority.^{FN37}

FN37. On appeal, Larson and Tune assert, without citation to authority, that the **trial court** should have stricken Stuart's expert testimony because (1) it lacked a proper foundation required by ER 703 and (2) it was based on innuendoes and references to alleged drug use, alcohol use, child abuse, convictions of crime, etc., tantamount to lay testimony on issues that should have been left to the jury. Br. of Appellant at 30.

II. Jury Instructions

A. Standard of Review

We review challenged jury instructions for claimed errors of law in the context of the instructions as a whole. *State v. Pirtle*, 127 Wn.2d 628, 656, 904 P.2d 245 (1995); *Hue v. Farmboy Spray Co., Inc.*, 127 Wn.2d 67, 92, 896 P.2d 682 (1995). Even when an instruction erroneously states applicable law, it is not reversible error unless it prejudices a party. *McDonald v. Dep't of Labor and Indus.*, 104 Wn.App.617, 17 P.3d 1195, 1198 (2001); *Hue*, 127 Wn.2d at 92. An error is prejudicial if it affects the outcome of the trial. *Stiley v. Block*, 130 Wn.2d 486, 499, 925 P.2d 194 (1996).

*11 The number and specific language of the jury instructions are matters within the **trial court's** discretion. *Havens v. C & D Plastics, Inc.*, 124 Wn.2d 158, 165, 876 P.2d 435 (1994). Jury instructions are sufficient if they allow the parties to argue their theories of the case, are not misleading, and properly inform the jury of the applicable law. *Hue*, 127 Wn.2d at 92; *Havens*, 124 Wn.2d at 165.

B. Instruction No. 6-'Poor Result'

Consistent with 6 Washington Pattern Jury Instructions-Civil, sec. 105.07, at 523-24 (3d 1989) (WPI), Instruction No. 6 provided: 'A poor medical result is not, in itself, evidence of negligence.' Larson and Tune assert that a **trial court** may give this instruction only 'with caution' under certain circumstances and that the instruction was inappropriate here. (Br. of Appellant at 41-42). This argument

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fails.

The 'poor result' instruction states a 'well nigh universally recognized' principle of **medical malpractice** law; it is 'particularly appropriate where the jury has heard evidence or argument from which it might reach an improper conclusion that doctors ... can be found negligent merely because of a bad result.' *Watson v. Hockett*, 107 Wn.2d 158, 163-64, 727 P.2d 669 (1986). Such instruction does not constitute error where, as here, it is used to supplement a proper standard of care instruction. *Christensen v. Munsen*, 123 Wn.2d 234, 248, 867 P.2d 626 (1994). Under these circumstances, the giving of the 'poor result' instruction is discretionary with the **trial court**. *Christensen*, 123 Wn.2d at 248.

Here, a jury might reach an improper conclusion that Dr. Nelson must have been negligent because Taleia suffered a devastating injury. It was within the **trial court's** discretion to give the 'poor result is not evidence' instruction along with the standard of care instruction. Therefore, the **trial court** did not err in giving the 'poor result' instruction.

C. Instruction No. 7: 'Error of Judgment'

Consistent with our Supreme Court Committee on Jury Instructions comment to 6 WPI 105.08, Instruction No. 7 provided:

A physician is not liable for selecting one of two or more alternative courses of treatment even though the treatment is alleged to have resulted in a poor outcome if, in arriving at the judgment to follow the particular course of treatment, the physician exercised reasonable care and skill, within the standard of care the physician was obligated to follow.

Our Supreme Court has held that this 'error of judgment' instruction should be used with caution and only in cases where there is evidence that (1) the defendant physician was confronted with a choice among competing therapeutic techniques or

competent medical diagnoses, and (2) in arriving at a judgment, the defendant physician exercised reasonable care and skill within the standard of care the physician was obliged to follow. *Watson*, 107 Wn.2d at 165; *Christensen*, 123 Wn.2d at 249.

*12 Larson and Tune argue that 'error of judgment' Instruction No. 7 was improper because 'there was no evidence presented that Dr. Chris Nelson was confronted with a choice of competing therapeutic techniques for which he made one or the other alternative decision {sic}.' (Br. of Appellant at 4243). We disagree.

Here, there was evidence that Dr. Nelson faced a choice among competing therapeutic techniques and medical diagnoses when Taleia presented with an unexplained fever. First, he had to diagnose the cause of the infection based on her physical examination and test results. Once he had reason to believe that Taleia had a urinary tract infection, he had to decide whether to treat her as an outpatient or to hospitalize her, which medications to prescribe, and what follow-up program to establish.

Detailed evidence shows that in arriving at the judgment to treat Taleia as an outpatient, Dr. Nelson complied with the standard of care he was obliged to follow. He examined Taleia. He ordered several laboratory tests to determine the cause of her fever. He prescribed medications to treat infection and reduce fever. He gave Larson a fever instruction sheet and told him to bring Taleia back in one week, or within the next two days if her fever did not improve. Larson and Tune's own expert, Dr. Frasier, conceded that even if Taleia had pyelonephritis, outpatient treatment would be appropriate as long as she did not appear toxic or dehydrated and could take oral medications; Taleia met all these criteria. Therefore, the **trial court** did not err in supplementing the standard of care instruction with the 'error of judgment' instruction.

Larson and Tune further contend that Instructions No. 6 and No. 7 misled the jury and were 'impermissible comment{s} on the evidence.'

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Again, we disagree. An instruction which does no more than accurately state the law pertaining to an issue does not constitute an impermissible comment on the evidence by the trial judge under Const. Art. 4 sec. 16. *Christensen*, 123 Wn.2d at 249. Here, the instructions were correct statements of the law. They were given with a proper standard of care instruction. When read in their entirety and in combination with the standard of care instruction, they could not have misled the jury as to Dr. Nelson's obligations and performance.

Affirmed.

A majority of the panel having determined that this opinion will not be printed in the Washington Appellate Reports, but will be filed for public record pursuant to RCW 2.06.040, it is so ordered.

HOUGHTON, J., and ARMSTRONG, C.J., concur.

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Not Reported in P.3d, 96 Wash.App. 1046, 1999 WL 507857 (Wash.App. Div. 1)
 (Cite as: 1999 WL 507857 (Wash.App. Div. 1))

H
 NOTE: UNPUBLISHED OPINION, SEE RCWA
 2.06.040

Court of Appeals of Washington, Division 1.
 Warren E. DEWEY & Donna L. Dewey, his wife,
 for Respondent(s).

v.

The STATE of Washington and the State of Wash-
 ington Liquor Control Board, Respondents.

No. 42834-9-I.
 July 19, 1999.

Appeal from Superior Court of King County, Docket No. 96-2-29308-3, judgment or order under review, date filed 05/12/1998; George T. Mattson. Clayton E. Longacre, Attorney At Law, Port Orchard, WA, for Appellants.

Susan M. Edison, Assistant Attorney General, Office of the Atty Gen., Seattle, WA, for Respondents.

UNPUBLISHED OPINION

BAKER.

*1 Plaintiff Dewey is a truck driver who was injured in a forklift accident while his truck was being unloaded at a Washington State Liquor Control Board (WSLCB) warehouse. He sued the WSLCB. At trial, the jury found 30 percent comparative negligence. On appeal, Dewey argues that the trial court erred in (1) allowing comparative fault to be argued and instructed to the jury, (2) allowing evidence of his alleged alcoholism, (3) allowing evidence, argument and jury instruction that he failed to mitigate his injuries by submitting to in-patient evaluation of alcoholism, (4) excluding and limiting late disclosed medical expert testimony, and (5) excluding evidence regarding his workers' compensation claim. We find no abuse of discretion in the trial court's various challenged rulings, and affirm.

I

Dewey moved in limine to exclude the comparative negligence defense, and unsuccessfully objected to the court's instructions on the issue. He raises two arguments: That there was no evidence to support submitting the issue to the jury; and that submitting the issue to the jury violates case law on assumption of the risk.

The operator of the forklift testified that he could not have inserted the forks if Dewey was in the way, that he saw Dewey move out of the way, and that he said "OK" after inserting the forks to warn Dewey that he would be lifting the packet. That testimony together with Dewey's admission on the way to the hospital that the "accident was his fault" was sufficient to carry the issue to the jury.

Dewey argues at length by analogy to assumption of risk case law. This was not an assumption of risk fact pattern, the case was not so tried, and no assumption of the risk instruction was given or requested. Dewey first argues that his job required him to do what he was doing at the moment of the injury, so he should not be penalized by a finding of comparative negligence. It is true that his job required him to assist forklift operators in unloading his truck. But his job did not require him to be in the exact location he was at the moment of the injury. A trier of fact could find that he was negligent in so locating himself.

Secondly, he argues that even though he was exposed to a general risk because he was required to be in front of the forklift, he had a right to assume that the forklift operator would make certain that he was out of the way before performing the maneuver he did. But that argument goes to the issue of primary negligence on the part of the forklift operator and presents an obvious factual issue as to comparative negligence. Finally, Dewey relies on *Campbell v. ITE Imperial Corp.*,^{FNI} another assumption of risk case, to argue that because he failed to assume the specific risk of the forklift op-

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erator's negligence, he cannot be guilty of assumption of the risk. This argument would only be relevant if assumption of the risk were legally equivalent to comparative negligence, which it is not.

FN1. 107 Wash.2d 807, 820, 733 P.2d 969 (1987).

*2 Dewey vigorously contested any evidence relating to alcoholism. He moved in limine and objected to the evidence which was offered in support of the defense that he failed to mitigate his damages.^{FN2}

FN2. Jury Instruction No. 16 provided:

One who sustains injury for which another is liable is not entitled to recover any damages arising after the original injury which are proximately caused by failure of the injured person to exercise ordinary care to avoid or minimize such new or increased damages.

In determining whether, in the exercise of ordinary care, a person should have secured or submitted to medical treatment, as contended by defendant you may consider the nature of the treatment, the probability of success of such treatment, and all of the surrounding circumstances.

The defendant has the burden to prove plaintiff's failure to exercise ordinary care and the amount of damages, if any, which could have been minimized or avoided. Clerks Papers at 79.

During post-injury evaluation by a panel of doctors in connection with Dewey's workers' compensation claim, Dewey revealed daily use of alcohol in order to be able to sleep at night. Doctor Weinstein decided that a professional evaluation was required in order to determine if there was an alcoholism issue. His reason for doing so was that the nature of the symptoms complained of by

Dewey was easily confused with or masked by symptoms of alcoholism.

Dewey was evaluated by Abbey Smith, a chemical dependency evaluator for the Virginia Mason Clinic's Chemical Dependency Program. Her training and qualifications for the job were established in her testimony. Ms. Smith concluded that Dewey was at least a middle stage alcoholic and that "he met the DSM III criteria for alcohol dependence and moderate." She concluded that Dewey was probably not in need of detoxification, but that inpatient treatment was both reasonable and necessary in order to "evaluate the whole picture, and also to be certain if that person is remaining abstinent[.]" It is significant that no medical practitioner disputed Ms. Smith's conclusions.

Dewey presented substantial lay evidence that he had no alcohol problems. He also presented evidence concerning the absence of any alcohol indicators in a series of "random" urinalyses done through TASC.^{FN3} The defense established that Dewey normally contacted TASC at 6:30 am to see if he needed to be tested that day, but was not tested until after 3:30 in the afternoon. Given alcohol burn-off rates, the testing was not conclusive that Dewey was not using alcohol.

FN3. Treatment Alternative for Street Crime.

Dewey relies heavily on *Kramer v. J.I. Case Mfg. Co.*^{FN4} in support of his argument that defense alcoholism evidence did not meet the criteria for admission into evidence. Dewey asserts such evidence requires proof of impact on earning capacity and work-life expectancy before admission at trial. Kramer does not stand for this proposition. In Kramer, evidence of alcohol abuse and past marijuana abuse was allowed at trial based upon the defense assertion that it would be shown to be relevant regarding the issue of earning capacity and work-life expectancy.^{FN5} However, no evidence connecting up the alcohol and marijuana use was ever offered.^{FN6} We held that the trial court ab-

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used its discretion in allowing the testimony when no evidence connecting it to the proffered reasons for the testimony was provided.^{FN7} Kramer did not involve a defense argument that the symptoms claimed to result from the injury were or might be alcohol symptoms, nor did Kramer involve a defense of failure to mitigate. It is true that alcohol evidence is obviously prejudicial, and trial courts should be careful to require evidence regarding the legitimacy of the diagnosis and its relevancy before admitting the evidence. Here Ms. Smith provided such evidence.

FN4. 62 Wash.App. 544, 559-60, 815 P. 2d 798 (1991).

FN5. 62 Wash.App. at 556-57, 815 P. 2d 798.

FN6. *Kramer*, 62 Wash.App. at 559, 815 P. 2d 798.

FN7. *Kramer*, 62 Wash.App. at 559, 815 P. 2d 798.

*3 Dewey argues that the defendant was not entitled to have the jury instructed on a failure to mitigate defense, because the evidence failed to establish conclusively that the head injury program would benefit Dewey, let alone return him to his former truck driver occupation. He relies on *Cox v. Keg Restaurants U.S., Inc.*^{FN8} He further argues that this defense hinged on what he asserts was the unsupported alcoholism diagnosis.

FN8. 86 Wash.App. 239, 935 P.2d 1377, review denied, 133 Wash.2d 1012, 946 P.2d 402 (1997).

In *Cox* this court reversed a trial court's submission of a failure to mitigate defense.^{FN9} The defense was based upon a brain-injured plaintiff's refusal to have a shunt which had been surgically installed to drain excess fluid from his brain, removed or restructured as recommended by his psychiatrist.^{FN10} But the psychiatrist only testified that the procedure might have been useful, and

could not testify that it was necessary or that it would alleviate plaintiff's headaches.^{FN11} The plaintiff's neurosurgeon testified that it was reasonable to decline the suggested revision, and that the revision would aggravate the plaintiff's condition.^{FN12} Here, inpatient evaluation would benefit the plaintiff to a reasonable degree of medical certainty. *Cox* therefore does not control the issue in this case. Dewey is correct that there was evidence that the head injury program might not benefit him, or necessarily return him to his former occupation. However, there was other evidence in the case that the plaintiff's refusal to undergo in-patient alcohol evaluation prevented a reliable diagnosis of his claimed injuries. There was also evidence that a substantial majority of patients in the head injury program were benefited by the treatment and most returned to gainful employment. The trial court did not abuse its discretion in allowing the evidence to go to the jury.

FN9. 86 Wash.App. at 241, 935 P.2d 1377.

FN10. *Cox*, 86 Wash.App. at 244, 935 P.2d 1377.

FN11. *Cox*, 86 Wash.App. at 244-45, 935 P.2d 1377.

FN12. *Cox*, 86 Wash.App. at 245, 935 P.2d 1377.

Dewey failed to make an offer of proof concerning that testimony Dr. Chalstrom would give. His attorney's very general description to the trial court does not meet the criteria of a meaningful offer of proof.^{FN13} Thus the issue has not been preserved for appellate review.

FN13. ER 103(a)(2), *Sturgeon v. Celotex Corp.*, 52 Wash.App. 609, 617-18, 762, 762 P.2d 1156 (1988).

Dewey has also failed to preserve with a proper offer of proof the exclusion or limitation of testimony by the physician assistant, Heriford. In any event, the trial court's ruling was justified because

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the broad range of opinions Dewey suggested Heriford would testify to were well beyond the qualifications of a non-medical doctor witness. In addition, Heriford began treating Dewey only five days before the discovery cut-off and despite the fact that he was deposed during that five day period, he had expressed no such opinions during his deposition because he had not yet reviewed Dewey's file.

Dewey argues that the trial court abused its discretion by refusing to allow him "to waive the protection of the collateral source rule." Dewey's argument on this issue is very confusing. Review is not aided by the fact that, once again, Dewey failed to make any offer of proof. Because meaningful appellate review is not possible on this record, we decline to address the issue on its merits.

***4 AFFIRMED.**

GROSSE and BECKER, concur.

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