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NO. 69269-1-I

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

SANDRA OLSEN,

Appellant,

v.

DEPARTMENT OF LABOR AND INDUSTRIES OF THE STATE OF
WASHINGTON,

Respondent.

**BRIEF OF RESPONDENT
DEPARTMENT OF LABOR AND INDUSTRIES**

ROBERT W. FERGUSON
Attorney General

Sarah Merkel Reyneveld
Assistant Attorney General
WSBA No. 44856
Office Id. No. 91018
800 Fifth Avenue, Suite 2000
Seattle, WA 98104
(206) 389-2126

ORIGINAL

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I. INTRODUCTION

This is a workers' compensation appeal under RCW Title 51. The Department of Labor & Industries allowed Sandra Olsen's claim but issued an order segregating the condition of neurogenic and/or vascular thoracic outlet syndrome as not related to the claim. The Board of Industrial Insurance Appeals affirmed the Department's order, and a jury affirmed the Board.

The sole issue in this case is whether the trial court abused its discretion when it allowed the Department's witness, Dr. Gary Franklin, to testify about the Department's 2010 Guidelines for Work-Related Neurogenic Thoracic Outlet Syndrome: Diagnosis and Treatment (2010 Guidelines). The trial court properly exercised its discretion for several reasons. First, and most importantly, Olsen opened the door to Dr. Franklin's testimony by asking both of her medical witnesses several questions about the 2010 Guidelines during her case-in-chief in advance of Dr. Franklin's testimony. Second, Dr. Franklin's testimony was relevant to whether Olsen suffered from thoracic outlet syndrome. Finally, even assuming the trial court abused its discretion by admitting this testimony, any error would be harmless because there was ample testimony about the diagnosis and treatment of thoracic outlet syndrome that was consistent with Dr. Franklin's testimony.

II. COUNTERSTATEMENT OF THE ISSUE

1. Olsen asked her expert medical witnesses several questions about the 2010 Guidelines in her case-in-chief. She did not qualify or condition her questions based on the relevancy of the guidelines. Did the trial court properly exercise its discretion in admitting Dr. Franklin's rebuttal testimony regarding the 2010 Guidelines when Olsen opened the door to discussion of the guidelines?

III. COUNTERSTATEMENT OF THE CASE

A. **The Department Allowed Olsen's Claim For Workers' Compensation Benefits For Her Right Wrist But Denied The Conditions Of Neurogenic And/Or Vascular Thoracic Outlet Syndrome Because They Were Not Related To The Occupational Disease Of Her Right Wrist**

Olsen developed pain and weakness in her hands and wrists while performing repetitive data entry at San Mar Corporation. 2 RP at 15-19.¹ She applied for workers' compensation benefits for an occupational disease of her right wrist. BR 3; 2 RP at 17.² The Department allowed Olsen's claim for right carpal tunnel syndrome, right hand tenosynovitis, and left wrist tendonitis. BR 3.

In 2010, Olsen went to vascular surgeons Dr. George Thomas and Dr. Kaj Johansen for evaluations of thoracic outlet syndrome. 2 RP at 34-35, 37-38. Neurogenic thoracic outlet syndrome occurs due to

¹ This testimony was presented at the Board. At superior court, the Board record was read to the jury and a court reporter transcribed the witness testimony.

² The record before the Board is paginated separately from the clerk's papers. Citations to the Board will be to "BR" and either the larger page number in the lower right corner or the witness' last name and page number.

compression of nerves in the brachial plexus. 3 RP at 118. The brachial plexus is a cluster of larger nerves located at the neck and underneath the shoulder that supply the sensory and motor function in the arm. 3 RP at 118-19.

While neurogenic thoracic outlet syndrome is characterized by pain and weakness in the upper extremities, the exact symptoms and diagnostic criteria for this syndrome are contested. 2 RP at 109, 186-87, 209; 3 RP 45-47, 119-20; 4 RP at 17, 25-27. Olsen's experts conclude that an injured worker diagnosed with "non-specific" neurogenic thoracic outlet syndrome will have certain symptoms, physical findings, and normal electrodiagnostic (diagnostic) tests. 2 RP at 109, 186-87. In contrast, the Department's experts conclude that an injured worker diagnosed with neurogenic thoracic outlet syndrome will have appropriate symptoms such as weakness and atrophy in the upper extremities, physical findings, and abnormal diagnostic studies. 3 RP at 45-47, 89; 4 RP at 25-29.

Both Dr. Thomas and Dr. Johansen diagnosed Olsen with the "non-specific" form of neurogenic thoracic outlet syndrome. 2 RP at 137, 214. Dr. Daniel Neuzil, vascular surgeon, and Dr. Robert Price, neurologist, then examined Olsen as part of separate independent medical examinations. 3 RP at 36, 4 RP at 16. Both Dr. Neuzil and Dr. Price

concluded she did not suffer from neurogenic thoracic outlet syndrome. *See* 3 RP at 45; 4 RP at 25.

Subsequently, the Department issued an order denying the conditions of neurogenic and/or vascular thoracic outlet syndrome as not related to Olsen's claim. BR 3. The Department affirmed this order in a January 2011 order, which Olsen appealed to the Board. *See* BR 4, 79-81.

B. The Department Adopted Guidelines In 1995 And 2010 Requiring Abnormal Diagnostic Findings For The Diagnosis and Treatment of Work-Related Neurogenic Thoracic Outlet Syndrome

Under 1995 Guidelines and the 2010 Guidelines, an injured worker must have abnormal diagnostic findings for the Department to accept the diagnosis of neurogenic thoracic outlet syndrome and to authorize surgery for this syndrome. 3 RP at 117, 146-47. There must be objective evidence of an abnormality in the brachial plexus, the nerve group that thoracic outlet surgery addresses. 3 RP at 117.

The 2010 Guidelines were issued by the Industrial Insurance Medical Advisory Committee (IIMAC). 3 RP at 108-115. In 2007, the Legislature established IIMAC to advise the Department on "matters related to the provision of safe, effective, and cost-effective treatments for

injured workers” based on the “best available scientific evidence and expert opinion of the committee members.” RCW 51.36.140.³

The IIMAC and a subcommittee developed the 2010 Guidelines. 3 RP at 110-115. The subcommittee was charged with updating the 1995 guidelines or creating new guidelines for the diagnosis and treatment of neurogenic thoracic outlet syndrome. 3 RP at 110-11. The members of the IIMAC subcommittee were selected by the parent committee because of their expertise and knowledge, and represented the professional societies and the practicing doctors and academic doctors in the state. 3 RP at 111, 115. Before the subcommittee developed the 2010 Guidelines, practitioners in the medical community were invited to present their evidence and opinions regarding the diagnosis and treatment of neurogenic thoracic outlet syndrome to the subcommittee. 3 RP at 112. The subcommittee presented its work to the full IIMAC, and the IIMAC then prepared, finalized and voted on the 2010 Guidelines. 3 RP at 140. The 2010 Guidelines became effective October 1, 2010. 3 RP at 146. Before the 2010 Guidelines, the 1995 Guidelines were in effect. 3 RP at 152.

³ Although the Legislature codified IIMAC in 2007, there was an original Industrial Insurance Medical Advisory Committee that was run by the State Medical Society. The 1995 Guidelines were developed by this original committee. *See* 3 RP 146; *see generally* RCW 51.04.020.

As was the case with the 1995 Guidelines, under the 2010 Guidelines an injured worker must have abnormal diagnostic findings for the Department to accept the diagnosis of neurogenic thoracic outlet syndrome and to authorize surgery for this syndrome. See 3 RP at 117, 146-47.

C. In Her Case-In-Chief At The Board, Olsen Asked Dr. Thomas And Dr. Johansen Several Questions About The 2010 Guidelines

Before testimony started at the Board, Olsen raised no relevancy objections regarding potential testimony about the 2010 Guidelines. See BR 61-121; *see also* BR Olsen 2-6. She simply presented her case. See BR Johansen 1-86; BR Olsen 1-94; BR Thomas 1-80. In her case-in-chief, Olsen called Dr. Johansen and Dr. Thomas as her medical witnesses. 2 RP at 103-229; 3 RP at 8-20. She asked both surgeons several questions about the 2010 Guidelines. See BR Johansen 21-25; BR Thomas 49-62. She offered this testimony unconditionally, without subject to an objection to relevancy. See BR Johansen 21-25; BR Thomas 49-61.

During Dr. Johansen's direct examination, Olsen's counsel asked Dr. Johansen to give his opinion of the 2010 Guidelines:

Q: Generally, what is your opinion of these guidelines?

A: Well, they are erroneous in the extreme. Or let me

refine that answer by saying the guidelines are exactly correct for the condition that I had previously outlined called true neurogenic thoracic outlet syndrome, which as you recall -- as you will recall, I said is a condition, a very rare -- an extremely rare one, in which there is direct injury to the brachial plexus penetrating, or blunt trauma. I previously indicated that such individuals routinely have positive electrodiagnostic testing results. And so as a consequence, the Department of Labor and Industries' guidelines are exactly correct for that patient population. For the vastly larger patient population who have what I termed previously nonspecific neurogenic thoracic outlet syndrome, the guidelines are entirely inappropriate because these are not patients who have direct trauma to the brachial plexus.

2 RP at 193-94. Counsel asked Dr. Johansen whether, as a vascular surgeon, he relied upon the 2010 Guidelines. 3 RP at 196. Dr. Johansen replied, "I do not." 3 RP at 196. Counsel then asked Dr. Johansen whether the 2010 Guidelines would apply in the setting of a patient who has been diagnosed with nonspecific thoracic outlet syndrome, to which Dr. Johansen replied, "no." 3 RP at 196.

During Dr. Thomas's direct examination, Olsen's counsel asked Dr. Thomas several questions about the 2010 Guidelines, including whether he was acquainted with the 2010 Guidelines, whether he had an opinion on the 2010 Guidelines, and whether the 2010 Guidelines recognized nonspecific thoracic outlet syndrome:

A: Doctor, are you familiar with the 2010 Department of Labor and Industries guidelines of the diagnosis and treatment of neurogenic thoracic outlet syndrome that were

developed by the Washington State Industrial Insurance Medical Advisory Committee?

A: Yes, I'm acquainted with it.

Q: And in your opinion, based on that study, does the Department of Labor and Industries recognize nonspecific thoracic outlet syndrome?

A: Well, in the provider bulletin that I have in front of me, they do mention nonspecific, or they call it disputed thoracic outlet syndrome. But if I might add an editorial note on that terminology, it's never used in this office -- "disputed".

Q: Why not?

A: Because if you dispute something, you are against something. And we are not against thoracic outlet syndrome. We would like to use the term, and we use the term "nonspecific" if we have to codify the type of thoracic outlet syndrome. I have indicated in my previous statement in this deposition that I use the term "neurogenic thoracic outlet syndrome the common". Now, if you want to define it for authorities such as yourselves, it's nonspecific. It's not disputed.

3 RP at 149-50.

Olsen's counsel then asked Dr. Thomas whether the 2010 Guidelines make any errors, whether he had an opinion on the 2010 Guidelines, and whether the 2010 Guidelines represented the national standard for the diagnosis and treatment of neurogenic thoracic outlet syndrome:

Q: Based on your review of those guidelines, and keeping in mind that the Department is actually going to have Dr.

Franklin testify in this case, in your opinion, based upon your years of experience, do you believe those guidelines make any errors?

A: There are no guidelines for nonspecific thoracic outlet syndrome.

Q: Okay.

A: And also, there's a couple of statements in this guideline that are not true.

Q: What are those statements that are untrue?

A: If you turn to the page that says "surgery for thoracic outlet syndrome" under the medical treatment guidelines, down below in the fine print are two statements that I disagree with. One statement, "most patients with TOS have cervical ribs." Most patients with thoracic outlet syndrome do not have cervical ribs. We always x-ray the patient for the occasional patient who has it. But most do not. Number two, they talk about carpal tunnel syndrome, ulnar neuropathy, cervical radiculopathy. A physician should consider those alternative diagnoses before requesting TOS surgery. It doesn't take much more than a medical student to make those differentiations. So I disagree with that.

Q: Do you have an overall opinion regarding the guidelines that were produced by the Department of Labor and Industries?

A: Well, the committee, first of all, I don't think there's an authority in there that in my mind knew anything about TOS. People are acquainted with it because it's in the literature. But the nuances and issues that I've brought out in this deposition just are not provided by those physicians. Some doctors, I know -- and I know their practice doesn't involve treating TOS. So I'm a little bit disappointed with that committee.

Q: Were you asked to participate on that committee?

A: No.

Q: To the best of your knowledge, was Dr. Johansen asked to participate on that committee?

A: I've heard that he addressed the committee, but I don't think he served as a member.

Q: The guidelines regarding neurogenic thoracic outlet syndrome that were established by the Washington State Department of Labor and Industries -- did those standards represent national standards for the diagnosis and treatment of neurogenic thoracic outlet syndrome?

A: Uh, they are far beyond any acceptance of the doctors that I know and that give lectures about this condition. These are strangely inadequate.

Q: Do those guidelines represent the standard of diagnosis and treatment for this condition in the State of Washington?

A: Not in my opinion.

3 RP at 149-52. Counsel did not ask any of these questions conditioned on a relevancy objection about the 2010 Guidelines. *See* BR Johansen 21-25; BR Thomas 49-62.

D. In Response To Dr. Johansen's And Dr. Thomas's Testimony About The 2010 Guidelines, The Department Asked Its Medical Witnesses About The 2010 Guidelines And The Criteria For The Diagnosis And Treatment Of Thoracic Outlet Syndrome

In response to Olsen's case-in-chief, the Department called three medical witnesses: Dr. Neuzil, Dr. Price, and Department Medical Director Dr. Gary Franklin. Dr. Neuzil and Dr. Price concluded that Olsen

did not suffer from neurogenic thoracic outlet syndrome in part because she lacked objective findings, including abnormal diagnostic studies. 3 RP at 45-47; 4 RP at 25-27.

Both Dr. Neuzil and Dr. Price testified about the significance of objective medical findings, including the need for abnormal diagnostic studies, in the diagnosis and treatment of neurogenic thoracic outlet syndrome without reference to the 2010 Guidelines. 3 RP at 58; 4 RP at 29. Dr. Neuzil testified that a “neurological study showing abnormal nerve conductive studies” is required to properly diagnose thoracic outlet syndrome. 3 RP at 58. Dr. Price agreed that the role of abnormal diagnostic studies in the diagnosis of neurogenic thoracic outlet syndrome is “very significant.” 4 RP at 29. However, Dr. Price testified that he did not rely on the 2010 Guidelines to reach this conclusion, but instead relied on the standards in the literature, and other professional organization meetings, American Academy of Neurology, and American Board of Electrodiagnostic Medicine. 4 RP at 37-38. When asked to opine on the 2010 Guidelines in cross-examination, Dr. Price stated that he had not “really investigated” the guidelines and did not depend on them when he evaluated injured workers. 4 RP at 38.

Dr. Neuzil also opined on the distinction between “classical” thoracic outlet syndrome and “non-specific” or “disputed” neurogenic

thoracic outlet syndrome without referencing the 2010 Guidelines. 3 RP at 35, 52-53. Dr. Neuzil relied on studies, scientific literature, and recent articles on the diagnosis and treatment of thoracic outlet syndrome in forming his conclusions regarding “non-specific” or “disputed” neurogenic thoracic outlet syndrome. 3 RP at 52-53. Dr. Neuzil summarized his findings as follows:

Well, the neurogenic thoracic outlet in the literature requires a nerve conduction abnormality. And the disputed or nonspecific neurogenic outlet, in the multiple papers out there, that's the conundrum. There's nothing that can make that diagnosis. It's sort of a clinical constellation of symptoms and complaints because there is no abnormalities on the studies.

3 RP at 47.

When asked to clarify on cross-examination whether “disputed” thoracic outlet syndrome implies something negative, Dr. Neuzil stated:

No. It just means that there are no ways to actually diagnose or put a diagnoses on a lot of folks that have a constellation of symptoms that some people want to call it thoracic outlet, and a lot of us don't. So it's disputed in the literature about what to do with it or how to diagnose it.

3 RP at 61-62.

Dr. Neuzil also testified that he reviewed the 2010 Guidelines and agreed with the criteria for the diagnosis of thoracic outlet syndrome. 3 RP at 86-87. Olsen's counsel did not object to this testimony. BR Neuzil 22, 27, 28. Counsel then asked Dr. Neuzil several questions regarding the

2010 Guidelines on re-cross examination. 3 RP at 90-94. Counsel did not ask any of these questions conditioned on a relevancy objection to the guidelines. BR Neuzil 59-60.

Dr. Franklin testified about his 125 original journal articles, studies, the 2010 and 1995 Guidelines, and the distinction between classic and non-specific/disputed neurogenic thoracic outlet syndromes. 3 RP at 107-118. Dr. Franklin thought the guidelines were important because they represented the expert consensus opinion of the committee and were evidence based. 3 RP at 116, 142. According to Dr. Franklin, the guidelines are used for diagnosis and treatment. 3 RP at 116. They are also used to determine whether treatment will be authorized by the Department. 3 RP at 116.

Dr. Franklin testified that under the 2010 Guidelines for the Department to accept the diagnosis of neurogenic thoracic outlet syndrome and allow surgical treatment the injured worker must have “signs, symptoms and an abnormal diagnostic test.” 3 RP at 117. Dr. Franklin explained that the requirement of an abnormal diagnostic test to diagnose and surgically neurogenic treat thoracic outlet syndrome was the same under the 1995 Guidelines. 3 RP at 146-47. Dr. Franklin testified that an abnormal diagnostic test is required for the diagnosis and surgical treatment of thoracic outlet syndrome because the test shows a “clear-cut

abnormality in the brachial plexus, which is the nerve group that the surgery is supposed to help.” 3 RP at 117. Olsen’s counsel did not object or move to strike Dr. Franklin’s testimony regarding the directive of the guidelines to require “abnormal diagnostic studies” to diagnose neurogenic thoracic outlet syndrome. BR Franklin 31-32; 3 RP 118.

Dr. Franklin also clarified the distinction between what he termed “classic” neurogenic thoracic outlet syndrome and “non-specific” or “disputed” thoracic outlet syndrome without specific reference to the 2010 or 1995 Guidelines. 3 RP at 119-21. When asked on direct examination whether he was familiar with the term “disputed” thoracic outlet syndrome, he stated that the diagnosis of “disputed” thoracic outlet syndrome is the same as “non-specific” because the “hard, objective signs of the sensory loss and their motor weakness, and the muscle deterioration, and the electromyographic findings are not there in these cases.” 3 RP at 119-20. Olsen’s counsel did not object or move to strike this testimony regarding “true” and “non-specific” thoracic outlet syndrome. BR Franklin 32-35; 3 RP 119-21.

Olsen’s counsel objected and moved to strike some of Dr. Franklin’s testimony regarding the guidelines on the basis of relevance. BR Franklin 18, 20, 22, 25, 26, 28, 30, 31, 37, 40, 45. Olsen objected and moved to strike additional testimony regarding the guidelines on the basis

of prejudice and hearsay. BR Franklin 22, 25, 30, 39, 45. When the Department completed the direct examination of Dr. Franklin, Olsen's counsel moved to strike the entirety of Dr. Franklin's testimony on the basis of relevance and prejudice. BR Franklin 45.

E. The Board Affirmed The Department's Order And Denied Olsen's Motions To Strike Dr. Franklin's Testimony About The 2010 Guidelines And To Strike Dr. Franklin's Testimony In Its Entirety

After considering the evidence, the industrial appeals judge issued a proposed decision and order affirming the Department's order segregating the condition of neurogenic and/or vascular thoracic outlet syndrome as not related to the claim. BR 61-74. In the proposed decision and order, the industrial appeals judge overruled Olsen's objections and motions to strike the testimony of Dr. Franklin in its entirety and to strike specific portions of his testimony about the 2010 Guidelines. BR 62.

Olsen petitioned the three-member Board for review. BR 16-60. The Board affirmed the evidentiary rulings and affirmed the proposed decision and order in a final decision and order. BR 2-5. Olsen appealed to King County Superior Court. BR 1.

F. The Superior Court Permitted The Jury To Hear Dr. Franklin's Testimony About The 2010 Guidelines Because Olsen Had Opened The Door To This Testimony

Before jury selection, Olsen renewed her motion to strike the testimony of Dr. Franklin in its entirety based on relevance. 1 RP at 11-12. She did not renew her objections based on prejudice or hearsay. 1 RP at 11-12. Olsen stated that Dr. Franklin's testimony was not relevant because he described "insurance company guidelines—Department of Labor and Industries' guidelines that were not effective until October 2010 when the issue in this case is whether or not . . . Sandra Olsen developed a condition in 2007." 1 RP at 11. On the first day of trial, the court ruled that Dr. Franklin could testify about guidelines used by the Department at the time the "decision was made" by the Department. 1 RP at 14-15. The parties then proceeded with voir dire and made opening statements. 1 RP at 23-169.

The following day, the court clarified that although Dr. Franklin could testify about the prior guidelines, he could not testify about the 2010 Guidelines that went into effect after the incident occurred. 2 RP at 5. The Department then asked the trial court to reconsider its ruling to exclude Dr. Franklin's testimony about the 2010 Guidelines because Olsen had opened the door to testimony about the guidelines in her case-in-chief.

2 RP at 5-6. After the Department's motion, the court asked Olsen's counsel for a response:

MR. ENDRES: . . . [M]y response is only that the department called Dr. Franklin to testify and he was admitted as a witness by the judge. And knowing he's gonna testify on guidelines from 1995 and 2010 and his one journal article. The way these cases are put together, it was reasonable for me to ask some of these questions to give an opinion on the guidelines. I'd be happy to strike out those questions that I asked as well. That's the only response I have.

....

THE COURT: I wasn't aware of this yesterday when I ruled. So I need to -- I do need to reconsider the ruling. Um, the difficulty at this point is that -- well, first let me ask a question of you, Mr. Endres. In the course of the hearing, did you call your witnesses before Dr. Franklin was called?

MR. ENDRES: Yes. Well before.

THE COURT: So you did open the door then. Um, if you had called them in reply, uh, subject to your objection to strike Dr. Franklin's testimony, that might be a different issue. But I understand your -- your tactical reasons for doing that.

However, now we have a jury who is supposed to be deciding whether the Board -- what the Board considered amounted to a -- amounted to something that they can sustain or something that they need to reject. And given the fact that you did raise the issue in your case, whether that was for you know, strategic reasons or because that was something that you felt the Board should consider at this point. I -- I really don't think that I have a choice but to permit the -- the State from -- from providing a response. Otherwise, what we're doing is we're dissecting what the

Board considered and then asking the jury to – to match up their decision with something that’s different from what they heard. So...I am gonna reverse my ruling on that and let it all in

2 RP at 7-8.

Olsen’s counsel explained that he was “trying to respond in advance . . . to address [Dr. Franklin’s] testimony based on what my witnesses think of those guidelines.” 2 RP at 10. The trial court responded:

I understand your decision making process. And it’s not my - - it’s not my position to advise you on how to handle your case. That’s a perfectly legitimate way to handle your case. But as far as I’m concerned, uh, I’m in charge of deciding how it should be presented to this jury. And given the fact that the order of events at the hearing was that you opened the door, I can only - - I think I am - - it necessitates my permitting the - - all of that testimony in.

2 RP at 11.

After hearing the evidence, the jury found that the Board was correct in finding that Olsen did not suffer from neurogenic thoracic outlet syndrome proximately caused by the distinct conditions of her employment. CP 212. Olsen appeals.

IV. STANDARD OF REVIEW

In a workers’ compensation case, the superior court reviews the decision of the Board of Industrial Insurance Appeals de novo on the certified appeal board record. RCW 51.52.115; *Raum v. City of Bellevue*,

171 Wn. App. 124, 139, 286 P.3d 695 (2013), *review denied*, 176 Wn.2d 1024 (2013). The superior court may rule independently on evidentiary questions. *Sepich v. Dept. of Labor & Indus.*, 75 Wn.2d 312, 316, 450 P.2d 940 (1969). But, as an appellate tribunal, it can only pass upon those matters that have first been presented to the Board and preserved in the Board's record for review. *Sepich*, 75 Wn.2d at 316; *see* RCW 51.52.115; *see also* RCW 51.52.104.

This Court reviews a trial court's motion to strike testimony for abuse of discretion. *Holbrook v. Weyerhaeuser Co.*, 118 Wn.2d 306, 314-15, 822 P.2d 271 (1992). A trial court abuses its discretion when its exercise of discretion is manifestly unreasonable or based upon untenable grounds or reasons. *Holbrook*, 118 Wn.2d at 315.

Additionally, this Court reviews a trial court's determination that a party has opened the door for abuse of discretion. *See State v. Ortega*, 134 Wn. App. 617, 626, 142 P.3d 175 (2006); *State v. Bennett*, 42 Wn. App. 125, 127, 708 P.2d 1232 (1985). A trial court has the discretion to admit evidence that might otherwise be inadmissible if a party opens the door to the evidence. *State v. Warren*, 134 Wn.App. 44, 65, 138 P.3d 1081 (2006) *aff'd* 165 Wn.2d 17, 195 P.3d 940 (2008). "The trial court has considerable discretion in administering this open-door rule." *Ang v.*

Martin, 118 Wn. App. 553, 562, 76 P.3d 787 (2003), *aff'd* 154 Wn.2d 477 (2007).

V. ARGUMENT

A. **The Trial Court Properly Exercised Its Discretion In Denying Olsen's Motion To Strike Dr. Franklin's Testimony Because Olsen Opened The Door To That Testimony When She Asked Her Medical Witnesses About The 2010 Guidelines**

1. **A party may open the door to testimony**

Olsen argues that the trial court abused its discretion when it allowed the jury to hear Dr. Franklin's testimony about the 2010 Guidelines. App. Br. 1. But because Olsen asked her experts several questions about the 2010 Guidelines during her case-in-chief, she opened the door to testimony about these guidelines. *See* 2 RP at 149-52, 192-96. Accordingly, the trial court properly exercised its discretion to allow Dr. Franklin's testimony about the guidelines.

Under well-established case law, a party who raises a subject while examining a witness in her case-in-chief "opens the door" to admission of evidence on that same subject by the opposing party. *See State v. Gefeller*, 76 Wn.2d 449, 455, 458 P.2d 17 (1969). As the Supreme Court explained:

It would be a curious rule of evidence which allowed one party to bring up a subject, drop it at a point where it might appear advantageous to him, and then bar the other party from all further inquiries about it. Rules of evidence are designed to aid in establishing the truth. To close the door after receiving only a part of the evidence not only leaves

the matter suspended in air at a point markedly advantageous to the party who opened the door, but might well limit the proof to half-truths.

Gefeller, 76 Wn.2d at 455.

Otherwise irrelevant testimony may become admissible if the opposing party offers the testimony.⁴ *Woodruff v. Spence*, 88 Wn. App. 565, 570, 945 P.2d 745 (1997); *see also Johnson v. Weyerhaeuser Co.*, 134 Wn.2d 795, 804, 953 P.2d 800 (1998) (in a workers' compensation appeal, a party may open the door regarding evidence of collateral benefits). Thus, in a dispute over validity of service of process, a defendant testified that he "always" reacted to service of process. *Woodruff*, 88 Wn. App. at 569. The trial court allowed the plaintiff to introduce evidence that the defendant had had at least six other default judgments entered against him in recent years. *Id.* The court affirmed because the defendant opened the door to otherwise irrelevant evidence. *Id.* at 570. "Though the 'other cases' evidence might otherwise have been irrelevant, Mr. Spence opened the door" *Woodruff*, 88 Wn. App. at 570; *see Warren*, 134 Wn. App. 65 ("The trial court has discretion to admit evidence that might otherwise be inadmissible if the defendant opens the door to the evidence.").

Similarly in *Ang*, where a plaintiff's witness testified that jurors made statements suggesting that they would acquit in a previous criminal

⁴ As discussed below in Part V.B, the Department does not concede that Dr. Franklin's testimony about the 2010 Guidelines was irrelevant.

trial, the trial court allowed the defense to call a witness to testify that several of the jurors told him that the defendants were guilty, even though this would normally be inadmissible hearsay. 118 Wn. App. at 557, 560-61. The *Ang* Court held that because the plaintiffs “opened up the subject of the possible verdict, the trial court did not abuse its considerable discretion in permitting further questioning on that topic, even if it necessitated admitting hearsay.” *Ang*, 118 Wn. App. at 563.

Once a party raises a material issue, the opposing party will be permitted to explain, clarify, or contradict the evidence. *State v. Berg*, 147 Wn. App. 923, 939, 198 P.3d 529 (2008), *overruled on other grounds by State v. Mutch*, 171 Wn.2d 646, 254 P.3d 803 (2011); *see also In re Disciplinary Proceeding Against Burtch*, 162 Wn.2d 873, 891, 175 P.3d 1070 (2008); *Ang*, 118 Wn. App. at 563. For example, in *Gefeller*, the defendant asked questions regarding lie detectors, because he did so the prosecution could then inquire about the matter. 76 Wn.2d at 454-55. The defendant could not subsequently argue it was error to admit this testimony given that he had opened the door to the subject. *Id.*

The reason for the open the door rule is when a party chooses to introduce a subject, the party cannot then object to the complete story being told about the subject. *See Gefeller*, 76 Wn.2d at 455. A fair playing field would necessitate the introduction of evidence on the same

subject by the other side. *Ang*, 118 Wn. App. at 563. Without the rule, only a “half-truth” is told. *Gefeller*, 76 Wn.2d at 455. Not only would this give an unfair advantage to the party who opened the door, but it would prevent the jury from exercising its role as fact-finder because it would not have complete information before it.

2. The trial court correctly applied the opening the door doctrine when it allowed Dr. Franklin to testify about the 2010 Guidelines in response to Dr. Johansen’s and Dr. Thomas’s extensive testimony about these guidelines

Here, although Olsen suggests that Dr. Franklin’s testimony might otherwise have been irrelevant, Olsen opened the door to this testimony. *See* App. Br. at 12. She questioned both of her medical experts, Dr. Thomas and Dr. Johansen, extensively about the 2010 Guidelines. *See* 2 RP at 149-52, 193-96. She even questioned the Department’s witnesses, Dr. Neuzil and Dr. Price about the guidelines during cross and re-cross examination. 3 RP at 90-94; 4 RP at 38. Each of Olsen’s witnesses made sweeping assertions about the guidelines. *See Woodruff*, 88 Wn. App. at 570 (defendant made “sweeping assertions” that opened the door to testimony). For example, Dr. Johansen called them “erroneous in the extreme” and “entirely inappropriate” for patients like Olsen, and Dr. Thomas asserted that some statements in the guidelines were untrue. 2 RP at 150, 193-194.

This testimony opened the door to rebuttal testimony from the Department with regard to the 2010 Guidelines. *See Burtch*, 162 Wn.2d at 891; *Gefeller*, 76 Wn.2d at 455; *Berg*, 147 Wn. App. at 939; *Ortega*, 134 Wn. App. at 626; *Warren*, 134 Wn. App. 65; *Ang*, 118 Wn. App. at 563; *Woodruff*, 88 Wn. App. at 570; *Bennett*, 42 Wn. App. at 127. Thus, in response to Dr. Thomas's assertion that there was not an authority on the subcommittee who "knew anything about TOS," Dr. Franklin explained that the subcommittee consisted of representatives from professional societies. 2 RP at 151; 3 RP at 115. In response to Dr. Thomas's assertion that the guidelines were "strangely inadequate," Dr. Franklin clarified that the guidelines reflect the standard of medical care for injured workers in Washington. 2 RP at 152; 3 RP at 122. Additionally, Dr. Franklin contradicted Dr. Thomas's characterization of the term "disputed" when he testified that "disputed" thoracic outlet syndrome is the same as "non-specific" because the "hard, objections objective signs of the sensory loss and their motor weakness, and the muscle deterioration, and the electromyographic findings" are not present. RP 3 at 120.

The trial court correctly recognized that the Department should have had the opportunity to present testimony on the 2010 Guidelines because Olsen questioned her witnesses extensively about these guidelines. *See* 2 RP at 7-8. By doing so, the trial court allowed the

complete story to be told about the 2010 Guidelines and correctly applied the well-established principles about the opening the door rule.

3. The trial court's discretionary ruling to allow Dr. Franklin to rebut the testimony of Olsen's medical witnesses regarding the 2010 Guidelines was not made on an unreasonable or untenable basis

The trial court did not abuse its discretion in admitting the testimony of Dr. Franklin because it is not unreasonable or untenable to allow testimony to which a party has opened the door. Olsen's arguments that the trial court abused its discretion are without merit.

Olsen asserts that, knowing the nature of Dr. Franklin's expected testimony, she asked Dr. Thomas and Dr. Johansen to testify about the 2010 Guidelines as a form of rebuttal testimony in advance of Dr. Franklin's testimony. *See* App. Br. at 7. She specifically says "[d]uring the Board hearing, Olsen had objected to Dr. Franklin, and that objection was denied, so Dr. Franklin was allowed to testify regarding the guidelines. Ms. Olsen's counsel acknowledged that, having been advised on the Board's ruling allowing Dr. Franklin's (sic) to testify and knowing the nature of Dr. Franklin's testimony, he solicited rebuttal testimony from Dr. Thomas in advance of Dr. Franklin's testimony." App. Br. at 7. Olsen said at trial:

The department called Dr. Franklin to testify and he was admitted as a witness by the judge. And knowing that he's

gonna testify on guidelines from 1995 and 2010 and his one journal article. The way these cases are put together, it was reasonable for me to ask some of these questions to get my experts to give an opinion on the guidelines.

2 RP at 6. First, to the extent that Olsen implies that there was a ruling about Dr. Franklin's testimony before she presented her witnesses' testimony, this is not correct. *See* BR 61-121; *see also* BR Olsen 2-6. She did not move to exclude Dr. Franklin or his testimony about the 2010 Guidelines before the hearing took place at the Board or before her witnesses testified. *See* BR 61-121; *see also* BR Olsen 2-6. The industrial appeals judge made no ruling in advance about Dr. Franklin; the Department simply named Dr. Franklin as a witness. BR 61-121; *see also* BR Olsen 2-6. Second, Olsen offered the testimony of Dr. Johansen and Dr. Thomas unconditionally. For example, she did not say, "Without waiving an objection to relevance . . ." before offering the testimony. Rather she made a strategic decision to take the sting out of Dr. Franklin's testimony by unconditionally questioning all the doctors, including her own, about the guidelines. *See* BR Johansen 21-25; BR Thomas 49-62; BR Neuzil 63-68; BR Price 31; BR Franklin 55-61, 64-72.

Olsen suggests that it "would have been an excellent compromise" to strike her own witnesses' testimony about the guidelines. App. Br. at 14; *see also* App. Br. at 7. But Olsen's offer at trial to strike the testimony

of her own witnesses was too late as she would have to have done this at the Board. *See Sepich*, 75 Wn.2d at 316. As Olsen did not object to the admission of testimony regarding the guidelines from her own witnesses she cannot raise this objection for the first time at trial. *Omeitt v. Dep't of Labor & Indus.*, 21 Wn.2d 684, 689-90, 152 P.2d 973 (1944). Under RCW 51.52.115, the record developed at the Board is presented to the jury. *See Lewis v. Simpson Timber Co.*, 145 Wn. App. 302, 316, 189 P.3d 178, *published with some modifications* at 144 Wn. App. 1028 (2008). She provides no authority for the novel proposition that the record could be reformed at superior court. An appellate court does not consider argument unsupported by citation to the authority. *See* RAP 10.3(a)(6); *Cowiche Canyon Conservancy v. Bosley*, 118 Wn.2d 801, 809, 828 P.2d 549 (1992); *Joy v. Dep't of Labor & Indus.*, 170 Wn. App. 614, 629, 285 P.3d 187 (2012), *review denied*, 176 Wn.2d 1021 (2013). This Court should not consider her unsupported theory.

Olsen appears to argue that the trial court confused the standard of review under which it should consider the Board's evidentiary rulings. *See* App. Br. at 13, 15. She points to the judge's statement to the effect that granting the motion would mean the jury would consider something different than the Board. App. Br. at 13 (quoting 2 RP at 8). The trial court was appropriately concerned that the jury consider the evidence

developed at the Board as RCW 51.52.115 provides that the fact-finder considers the Board record. *See Sepich*, 75 Wn.2d at 316; *Raum*, 171 Wn. App. at 139; *Lewis*, 145 Wn. App. at 316. RCW 51.52.115 allows a trial court to rule on evidentiary objection raised at the Board on a de novo basis. *See Johnson*, 134 Wn.2d at 800, n.4. The record demonstrates that the trial court plainly understood that a de novo review was allowed of the evidentiary rulings. *E.g.*, 1 RP at 14; 2 RP 222; 3 RP at 55-57, 99, 108, 111-12.

Here, when Olsen moved to exclude Dr. Franklin's testimony, she did not inform the trial court that both her expert witnesses had opined at length on the guidelines before the Department called Dr. Franklin to testify in its case-in-chief. 1 RP at 11. With the benefit of complete information regarding this testimony, the trial court properly exercised its discretion in reversing its ruling and allowing Dr. Franklin's entire testimony regarding the 2010 Guidelines as Olsen opened the door to such testimony. *See* 1 RP at 14-15.

If the trial court had granted Olsen's motion to the strike, this would have given Olsen an unfair advantage and limited the proof to "half-truths." *See Gefeller*, 76 Wn.2d at 455. Thus, the trial court's ruling allowing Dr. Franklin's testimony regarding the 2010 Guidelines was not made on an unreasonable or untenable basis.

B. Dr. Franklin's Testimony About The 2010 Guidelines Is Independently Admissible Because It Is Relevant To The Material Issue Of Whether Olsen Suffered From Thoracic Outlet Syndrome

In the alternative, the trial court did not abuse its discretion in admitting Dr. Franklin's testimony about the 2010 Guidelines because such testimony was relevant to a material issue at trial. This Court may affirm a superior court's decision on any legal ground supported by the record. *State v. Costich*, 152 Wn.2d 463, 477, 98 P.3d 795 (2004); *State v. Michielli*, 132 Wn.2d 229, 242, 937 P.2d 587 (1997). The testimony about the 2010 Guidelines had probative value as to whether Olsen suffered from neurogenic thoracic outlet syndrome.

To be relevant, evidence must meet two requirements: (1) the evidence must have a tendency to prove or disprove a fact (probative value), and (2) that fact must be of consequence in the context of the other facts and the applicable substantive law (materiality). ER 401; *State v. We*, 138 Wn. App. 716, 724, 158 P.3d 1238 (2007); *State v. Rice*, 48 Wn. App. 7, 12, 737 P.2d 726 (1987). Under ER 401, "[m]inimal logical relevancy" establishes probative value. *Davidson v. Municipality of Metro. Seattle*, 43 Wn. App. 569, 573, 719 P.2d 569 (1986). "[A]ny fact that is of consequence to the determination of the action" has material value. *Id.* at 573.

In this case, the experts disagreed significantly about the diagnostic criteria for neurogenic thoracic outlet syndrome. Olsen's experts concluded that Olsen suffers from "non-specific" thoracic outlet syndrome, a condition diagnosed with signs and symptoms, but in which objective diagnostic testing is uniformly negative or normal. 2 RP at 109, 186. In contrast, the Department's experts concluded that Olsen does not suffer from thoracic outlet syndrome in part because she does not have objective findings as measured by abnormal diagnostic studies. 3 RP at 45-47; 4 RP at 25-27.

Here, Dr. Franklin's testimony regarding the 2010 Guidelines is relevant because it provides the fact-finder with knowledge of the standard of medical care for the treatment and diagnosis of thoracic outlet syndrome and substantiates the diagnostic criteria used by the Department's witnesses. *See* 3 RP at 122. Specifically, the 2010 Guidelines, consistent with the 1995 Guidelines, require an "an abnormal diagnostic test" to diagnose neurogenic thoracic outlet syndrome and warrant surgical treatment. 3 RP at 117, 146-47. The 2010 Guidelines provide valuable context for how the state's practicing and academic doctors diagnose and treat thoracic outlet syndrome in injured workers such as Olsen. *See* 3 RP at 115, 122.

Without citation to the record, Olsen asserts that the 2010 Guidelines do not address the disease she has: “non-specific thoracic outlet syndrome of a vascular nature.” App. Br. at 12. First, Olsen appears to be mistaken as to the nature of her alleged syndrome as both her own experts testify that she suffers from *neurogenic* thoracic outlet syndrome, not thoracic outlet syndrome of a *vascular* nature. See 2 RP at 137, 214. Second, Olsen mischaracterizes the applicability of the 2010 Guidelines to her alleged condition. App. Br. at 12. Dr. Franklin testified that the 2010 Guidelines specifically address both “true” and “non-specific” or “disputed” thoracic outlet syndrome. See 3 RP at 147. Accordingly, Dr. Franklin clarified that the guidelines are largely about “non-specific” thoracic outlet syndrome as doctors such as Dr. Johansen diagnose and treat a condition that is not “classic” thoracic outlet syndrome. See 3 RP at 147.

Olsen also argues that the 2010 Guidelines are irrelevant because, she asserts, they are “essentially insurance utilization review tools, not in any way diagnostic tools.” App. Br. at 3; *see also* App. Br. at 12. This is incorrect. Dr. Franklin testified that the 2010 Guidelines are to be used for both diagnosis and treatment of thoracic outlet syndrome in injured workers. 3 RP at 116-17. They aid doctors and the Department’s utilization review firm in making “evidence-based” decisions regarding

the diagnosis and treatment of thoracic outlet syndrome. 3 RP at 116. They do not simply relate to “business practices” but instead also relate to diagnosis and treatment. *Contra* App. Br. at 11.

Finally, Olsen argues that the 2010 Guidelines are irrelevant to the issue of whether Olsen suffered from thoracic outlet syndrome because they “were released three years after the injury.” App. Br. at 12. This argument lacks merit. It is undisputed that the 2010 Guidelines were in effect when the Department issued its final order segregating the condition of thoracic outlet syndrome as not related to the claim on January 3, 2011. *See* BR 81; *see also* 3 RP at 146. The 2010 Guidelines were relevant to the question of whether the Department should allow the condition as of the time of the Department order on appeal. *Cf. Lenk v. Dep’t of Labor & Indus.*, 3 Wn. App. 977, 982, 478 P.2d 761 (1970) (scope of review is that of matters considered by the Department). Thus, there is no basis to exclude the 2010 Guidelines as they were relevant to the Department’s medical decision to reject the condition of thoracic outlet syndrome as not related to Olsen’s claim. Further, Olsen cites no authority for the proposition that the medical guidelines that are in effect at the time the Department makes a medical decision should not be considered. *See* App. Br. at 12. This Court should reject this unsupported argument. *See*

Cowiche Canyon Conservancy, 118 Wn.2d at 809; *Joy*, 170 Wn. App. at 629.

In any event, as Dr. Franklin explained, the criteria for the diagnosis and surgical treatment for thoracic outlet syndrome was the same when the original “committee met 15 years ago.” 3 RP at 146. Most significantly, the guidelines in existence since 1995 were the same in requiring abnormal diagnostic studies to diagnose and surgically treat thoracic outlet syndrome. 3 RP at 146-47.

In summary, the 2010 Guidelines are relevant to the issue of whether Olsen suffered from thoracic outlet syndrome and whether the Department was responsible for Olsen’s condition when it made its decision to segregate the condition, and is properly admitted on this basis.

C. Olsen Did Not Properly Raise An ER 403 Argument At Superior Court, Even If She Did, This Argument Fails

Olsen argues that the trial court abused its discretion in allowing Dr. Franklin’s objection over her ER 403 objection. App. Br. at 1. She argues that Dr. Franklin’s testimony about the 2010 Guidelines was prejudicial and confusing to the jury. App. Br. 10. She further argues that there is “prejudicial language buried in Dr. Franklin’s testimony regarding the specific type of thoracic outlet syndrome Olsen claims” and she

references the distinction between “disputed” and “non-specific” thoracic outlet syndrome. App. Br. at 14-15.

Contrary to her assertion, Olsen did not preserve an ER 403 objection when she objected to Dr. Franklin’s testimony about the guidelines at the superior court. See App. Br. at 3; 1 RP at 11-12. She objected to his testimony solely on the basis of relevance under ER 401, not ER 403. See 1 RP at 11-12. To preserve an alleged error for appellate review, the opposing party must timely and specifically object at trial. *E.g., State v. Gray*, 134 Wn. App. 547, 557, 138 P.3d 1123 (2006); see also ER 103(a)(1). Further, the appellate court does not consider an objection on a different basis than the one raised at trial. *State v. Ferguson*, 100 Wn.2d 131, 138, 667 P.2d 68 (1983). In any case, her argument fails.

Under ER 403, otherwise relevant evidence can be excluded if the danger of unfair prejudice, confusion of the issues, or misleading the jury substantially outweighs the evidence’s probative value. ER 403. The ER 403 balancing test should be administered “in an evenhanded manner.” *Carson v. Fine*, 123 Wn.2d 206, 225, 867 P.2d 610 (1994). Thus, if evidence has been admitted on behalf of one party, similar evidence offered by the opposing party should not be excluded under ER 403. *Carson*, 123 Wn.2d at 225-26 (where plaintiff in medical malpractice

action called one of her physicians to testify, the defense was then properly allowed to call another of plaintiff's physicians as a witness).

The trial court properly exercised its discretion in this case because Dr. Franklin's testimony was not confusing to the jury or unfairly prejudicial to Olsen. Dr. Franklin's testimony regarding the guidelines was not confusing to the jury or "unfair" to Olsen because it was offered to explain and clarify testimony from Olsen's own expert medical witnesses. An evenhanded administration of the ER 403 balancing test should allow the jury to hear the Department's similar evidence on the 2010 Guidelines. *See Carson*, 123 Wn.2d at 225-26.

Further, Olsen did not timely object to some of Dr. Franklin's testimony regarding "non-specific" or "disputed" thoracic outlet syndrome at the Board or at superior court. BR 32-35; 3 RP at 119-21. Because Olsen did not timely object to this testimony at the Board she cannot raise the issue now. *See Sepich*, 75 Wn.2d at 316; *see also State v. Quigg*, 72 Wn. App. 828, 837, 866 P.2d 655 (1994) (alleged errors in admitting evidence must be raised at trial to preserve the issue for appeal).

Finally, Dr. Franklin's testimony regarding "non-specific" or "disputed" thoracic outlet syndrome is not confusing to the jury or unfairly prejudicial as it is similar in nature to the testimony of Dr. Thomas, Dr. Johansen, and Dr. Neuzil. 2 RP at 149-52, 196; 3 RP at 47, 52-53, 61-62.

Each of these medical experts testified before Dr. Franklin and opined extensively on the definition of “disputed” thoracic outlet syndrome. Thus, there is no prejudice to Olsen to allow similar testimony from Dr. Franklin.

Because Olsen failed to show that Dr. Franklin’s testimony regarding the 2010 Guidelines was prejudicial, the trial court did not abuse its discretion in allowing testimony regarding the guidelines.

D. Assuming Any Error, It Was Harmless Because It Was Consistent With Other Testimony

Even assuming that the trial court abused its discretion in allowing Dr. Franklin’s testimony regarding the 2010 Guidelines, any error was harmless.

An erroneous evidentiary ruling is not reversible error unless the court determines that, “within reasonable probabilities, had the error not occurred, the outcome of the trial would have been materially affected.” *Cobb v. Snohomish Cnty.*, 86 Wn. App. 223, 236, 935 P.2d 1384 (1997). Improper admission of evidence constitutes harmless error if the evidence is cumulative or of only minor significance in reference to the evidence as a whole. *Hoskins v. Reich*, 142 Wn. App. 557, 570, 174 P.3d 1250 (2008).

Here, the alleged error of allowing Dr. Franklin’s testimony regarding the guidelines would be of minor significance because the

Department's expert witnesses, Dr. Neuzil and Dr. Price, both testified at length about the diagnostic criteria for thoracic outlet syndrome independent of the Guidelines. *See* 3 RP at 35, 52-53; 4 RP at 29-30. Both medical experts opined on the significance of objective medical findings in the diagnosis and treatment of thoracic outlet syndrome. 3 RP at 58; 4 RP at 29. Both medical experts concluded that Olsen did not suffer from thoracic outlet syndrome in part due to a lack of objective findings, including abnormal diagnostic studies. 3 RP at 45-47; 4 RP at 25-27. Neither expert relied on the 2010 Guidelines in reaching these conclusions. Therefore, even if the testimony of Dr. Franklin were excluded, the fact-finder would still have knowledge of the facts, namely the use of diagnostic studies for diagnostic purposes, that Olsen is alleging are prejudicial to her case. A reasonable jury could still have concluded that Olsen did not suffer from thoracic outlet syndrome. *See Hoskins*, 142 Wn. App. at 570. Hence, the outcome of the trial would not have been materially affected.

Olsen argues that Dr. Franklin's testimony regarding "disputed" thoracic outlet syndrome is particularly prejudicial to her. App. Br. at 15-16. Contrary to Olsen's characterization on appeal, the use of the term "disputed" is widely used in scientific studies and literature, and is not unique to the 2010 Guidelines. *See* App. Br. at 15-16; 3 RP at 52-53. Dr.

Neuzil, not Dr. Franklin, was the first Department witness to opine at length about “disputed” thoracic outlet syndrome. *See* 3 RP at 47, 52-53. He testified that “disputed” or “nonspecific” thoracic outlet in the multiple papers out there is a “conundrum” because there is a “clinical constellation of symptoms and complaints because there is no abnormalities on the studies.” 3 RP at 47. In reaching his conclusions regarding “disputed” thoracic outlet syndrome, Dr. Neuzil relied on studies, scientific literature, and recent articles, but not the 2010 Guidelines. 3 RP at 52-53. Dr. Franklin similarly opined on “disputed” thoracic outlet syndrome generally, without referencing the 2010 Guidelines. 3 RP at 120.

Finally, Dr. Neuzil testified about the 2010 Guidelines. 3 RP at 86-87. He testified he reviewed and agreed with the 2010 Guidelines. 3 RP at 86-87. This was done without objection. 3 RP at 86-87.

For the first time on appeal, Olsen objects to similar testimony about the guidelines presented by Dr. Neuzil and Dr. Price. App. Br. at 11. (“Some similar testimony was presented by Dr. Neuzil and Dr. Price, to which Olsen also objects”). However, because Olsen did not timely object to this testimony at the Board, she cannot raise the issue now. *See Sepich*, 75 Wn.2d at 316; *see also Quigg*, 72 Wn. App. at 837.

Consequently, even if Dr. Franklin’s testimony regarding the guidelines were excluded, the fact-finder would still have knowledge of

the facts regarding the 2010 Guidelines that Olsen is alleging are prejudicial to her case. There has been no prejudicial error in allowing Dr. Franklin's testimony regarding the 2010 Guidelines as the outcome of the trial has not been materially affected.

This Court should affirm the trial court because it was not error to allow the testimony about the 2010 Guidelines and, assuming any error it was not prejudicial.

VI. CONCLUSION

For the foregoing reasons, the Department requests that this Court affirm the superior court's judgment.

RESPECTFULLY SUBMITTED this 3rd day of October, 2013.

ROBERT W. FERGUSON
Attorney General



Sarah Merkel Reyneveld
Assistant Attorney General
WSBA No. 44856
Office Id. No. 91018
800 Fifth Avenue, Suite 2000
Seattle, WA 98104
(206) 389-2126