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Division III
State of Washington
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STATE OF WASHINGTON
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No. 100470-2

THE SUPREME COURT OF THE

STATE OF WASHINGTON

ARTIE LEN REINERT and

CONSUELA LEE REINERT,

Petitioners,

v.

ALLEN C. HELLER, M.D. and STEPHANIE HELLER,

husband and wife, and the marital

community composed thereof;

ROCKWOOD CLINIC, P.S.; ROCKWOOD

NEUROSURGERY AND SPINE CENTER;

and DOES 1-10,

Respondents.

PETITIONERS REINERTS' PETITION FOR REVIEW

TABLE OF CONTENTS

I. IDENTITY OF PETITIONER……………….……………………..1

II. COURT OF APPEALS DECISION…….………….…..………1

III. ISSUES PRESENTED FOR REVIEW…………………………..1

A. Objection to Trial Evidence which was Subject …………1
to Final Order

B. Expert Testimony Allowed by Knowledge, Training…….2
And Experience

C. Trial Testimony in Violation of the Court's Order ………3
on Motion in Limine

IV. STATEMENT OF THE CASE..………………………….….…5

A. Introduction - Undisputed Factual Background…………...5

B. The Trial Court Made a Tentative Ruling Re:…………….6
Cumulative Testimony and Final Ruling Re:
"Community" Related Standard of Care Testimony

C. Testimony Re: "Community" Related Standard of Care…9

D. Respondents Concur with Reinerts on this Testimony…..11

E. Respondents' Radiology Expert's Troubled Testimony…12

V. ARGUMENT……………………………………………….15

A. Standard for Acceptance of Review……………………..15

B. Community Standard of Care Testimony is Error……….15

C. The Division III Decision Conflicts With This Court's….16
Decisions

VI. CONCLUSION…….……………………………………….20

VII. APPENDIX……………………………………………………..…...22

A Division III Court of Appeals Opinion Filed September 14, 2021

B Division III Court of Appeals Order Denying Appellants' Motion for Reconsideration filed November 10, 2021

C Hearing Transcript

D RCW 7.70.040

E Dr Barakos Trial Testimony Transcript

TABLE OF AUTHORITIES

CASES

Bengtsson v. Sunnyworld Int'l, Inc., 14 Wash. App. 2d 91, ……………...18
469 P.3d 339 (2020)

Douglas v. Bussabarger, 73 Wash. 2d 476, 489, …………….………..15
438 P.2d 829, 837 (1968)

In Re: Marriage of Katare, 175 Wn.2d 23, 38, 283 P.3d 546 (2012)…...18

Kuhn v. Schnall, 155 Wash. App. 560, 228 P.3d 828 (2010)……………19

Lakey v. Puget Sound Energy, Inc., 176 Wn.2d 909, 918, ……………...17
296 P.3d 860 (2013)at 706 (1989)

Mears v. Bethel Sch. Dist. No. 403, 182 Wash. App. 919, ………… 19, 20
332 P.3d 1077 (2014)

Meeks v. Marx, 15 Wash. App. 571, 575, 550 P.2d 1158, ………………16
1161 (1976)

Pederson v. Dumouchel, 72 Wn.2d 73, 431 P.2d 973, ………………….15
31 A.L.R.3d 1100 (1967)

State v. Allen, 182 Wash.2d 364, 375-76, 341 P.3d 268, 274 (2015)……19

State v. Brooks, 20 Wash. App. 52, 59-60, 579 P.2d 961 (1978)………..18

State v. Brown, 111 Wn.2d 124, 761 P.2d 588 (1988), …………………17
113 Wn.2d 520, 782 P.2d 1013, 787 P.2d 906,
80 A.L.R.4th 989 (1989)

State v. Carlson, 61 Wn. App. 865, 875, 812 P.2d 536 (1991) …………16

State v. Heutink, 12 Wash. App. 2d 336, 355, 458 P.3d 796, …………...17
806 (2020)

State v. Koloske, 100 Wn.2d 889, 895, 676 P.2d 456 (1984) ……….16, 17

State v. Powell, 126 Wash. 2d 244, 256-57, …………………………….16
893 P.2d 615, 623 (1995)

STATUTES

RCW 7.70.040……………………………………………………15, 16

RULES

RAP 13.4(b)……………………………………………………2, 3, 4, 15

ER 402…………………………………………………………….18

ER 403……………………………………………………………18, 19

ER 702…………………………………………………………..3, 17

MISCELLANEOUS

5B K. Tegland, Wash. Prac., Evidence Law and Practice, ……………..17
702.5 at 47 (2016)

I. IDENTITY OF PETITIONERS

Petitioners Reinerts ask this Court to accept review of the Division III Court of Appeal's decisions designated in Part II of this petition.

II. COURT OF APPEAL'S DECISIONS

A copy of the Division III Court of Appeals Opinion filed September 14, 2021, is attached in the Appendix as Appendix A. A copy of the Division III Court of Appeals Order Denying Appellants' Motion for Reconsideration, filed November 10, 2021, is attached in the Appendix as Appendix B.

III. ISSUES PRESENTED FOR REVIEW

A. Objection to trial evidence which was subject to final order.

Premises of the issue:

1) In this surgical medical malpractice case, the trial court committed obvious error in a final ruling denying Reinerts' objections, which ruling allowed one of Respondents' surgical experts to testify on the applicable medical standard of care in terms of Washington's long abandoned "community" (locality) standard of care; and

2) The Division III Court held that Reinerts' attorney failed to preserve the error by failing to object to such testimony at trial, and incorrectly determined, that (a) Respondents' expert did not testify about such standard of care, and (b) that Reinerts' attorney did not move the court

to restrict such testimony.

Was the Division III decision in RAP 13.4(b) in conflict with those Washington decisions which hold that where a judge makes an evidentiary ruling which is final, the losing party has preserved the issue for appeal without being required to make an objection at trial?

B. Expert testimony allowed by knowledge, training, and experience.

Premises of the issue:

1) In addition to the spinal surgeon Respondent (hereinafter Dr. Heller), Respondents were allowed two expert spinal surgeons to provide testimony;

2) Each of these spinal surgeon experts were highly trained, board-certified surgeons and clinicians who routinely clinically diagnosed, determined prognosis, and clinically and/or surgically treated patients for spinal neuropathy, and had intraoperative imaging performed under their control and direction during surgery;

3) Over Reinerts' objections, the trial court allowed a radiologist: (a) who never clinically diagnosed, determined prognosis, nor clinically and/or surgically treated patients with spinal neuropathy; (b) who never participated in or observed the surgery, the type of which was at issue at trial; (c) but who did provide substantial, non-relevant, and often rambling and disjointed testimony at trial which, in several instance contradicted

Respondent's spinal surgeon experts; and (d) who did opine on the diagnosis, prognosis, and treatment of Petitioner Artie Len Reinert (hereinafter "Mr. Reinert"), including intraoperative procedures utilized by Dr. Heller in the surgery subject to this litigation; and

4) The Division III Court held the radiologist qualified to testify.

Was the Division III decision in RAP 13.4(b) in conflict with those Washington decisions which hold that, under ER 702, a trial court must determine that the subject matter of the expert's testimony be: (a) within his or her area of expertise; (b) relevant; (c) would be helpful to and would not tend to confuse the jury; and (d) would not be unfairly prejudicial?

C. Trial testimony in violation of the court's order on motion in limine.

Premises of the issue:

1) During the above referenced radiologist's video deposition preservation testimony, over objection, the radiologist opined that: (a) 50% of the spinal surgeons would mistakenly perform the wrong level spinal surgery; and (b) the surgical technique utilized by the spinal surgeon Respondent was the appropriate standard of care;

2) The trial court granted Reinerts' attorneys objections to this testimony, and Respondents' attorney was to have their professional audio/video contractor (present at trial) remove the offending testimony;

3) The audio/video contractor failed to do so, and Respondents'

attorney failed to confirm edits were made, and thereafter: (a) the tainted testimony was heard by the jury; (b) at trial, Reinerts' attorney did not object to the 50% testimony, but did object to the standard of care testimony; (d) the trial court instructed the jury to disregard the standard of care testimony; and (e) on appeal Reinerts' attorney claimed Respondents' attorney's laxity was misconduct;

4) The Division III Court held that: (a) the violation of the court order was not preserved as to the 50% testimony, where Reinerts' attorney failed to object during trial; (b) where Reinerts' attorney objected during trial to the standard of care testimony, the objection was cured by a contemporaneous court instruction to the jury to disregard it; (c) that the standard of care testimony was harmless, as it was cumulative with respect to other expert testimony; and (d) although Respondent's attorney's laxity was troublesome, there was no apparent intentional misconduct.

Was the Division III decision in RAP 13.4(b) in conflict with Washington decisions which hold that where a party violates an evidentiary ruling, the matter is preserved for appeal? Further, in this Digital Age of ease of audio/video editing and frame location, should Washington attorneys be held to a standard of reviewing third party audio/video edits to assure compliance with court orders, to better assure rights to fair trials?

IV. STATEMENT OF THE CASE

A. Introduction – undisputed factual background.

This is a medical malpractice action in which Artie Len Reinert, Jr., and his spouse, Consuela Lee Reinert, are Petitioners (hereinafter, "the Reinerts"). The Respondents are Allen C. Heller, M.D., a neurosurgeon and, vicariously, his employer, the entity once known as Rockwood Clinic. The Reinerts claim that Dr. Heller, a neurosurgeon, breached the standard of care during an anterior cervical disc fusion (ACDF) procedure performed on Mr. Reinert during October of 2012. During that procedure, Dr. Heller had difficulty in locating the correct C4-5 cervical intervertebral to fuse, due to Mr. Reinert's large, corpulent neck. Immediately post surgery, Dr. Heller ordered imaging to confirm whether he had fused the correct level. Dr. Heller had fused the C5-6 level, not C4-5. This required Mr. Reinert to undergo a second ACDF procedure to fuse C4-5, and make hardware adjustments on the C4-5 C5-6 fusion complex. The second procedure had complications which resulted in a leak of cerebrospinal fluid. Dr. Heller's contemporaneous repair failed, which resulted in Mr. Reinert undergoing a third surgical procedure, with full removal and replacement of fusion hardware, and a catheter like drain inserted through the top of Mr. Reinert's skull, through his brain, to the brain's ventricles (where cerebrospinal fluid is accumulated/stored), to relieve pressure on the leak while it healed.

Mr. Reinert was hospitalized in the intensive care and regular care units for a period of time. Claims were made for general and special damages, including permanent injury and loss of consortium. Respondents denied liability. A trial was held in Spokane County Superior Court in June of 2019, which resulted in a defense verdict.

The Reinerts claimed that the trial court erred and abused its discretion in allowing: cumulative and prejudicial "community standard of care" testimony from one of Respondents' neurosurgery experts, Dr. Larson; and cumulative, prejudicial, impermissible, and irrelevant testimony from Respondents' neuroradiology expert, Dr. Barakos. Further, that Dr. Heller's attorney actively or constructively committed prejudicial misconduct by: a) failing to assure that Dr. Barakos' preservation deposition videotaped testimony was edited to reflect the trial court's order restricting testimony; and b) repeatedly misstating the law on standard of care as a "community," "community hospital," and "community surgeon" standard of care. The Reinerts claimed that each of the trial court's errors, irregularities in the trial proceedings, and attorney misconduct were each independent grounds for a new trial and, collectively, cumulative error.

B. <u>The trial court made a tentative ruling re: cumulative testimony, and a final ruling re: "community" related standard of care testimony</u>.

During trial, the court held a hearing on Reinerts' pre-trial motion in limine regarding objections to the testimony of Dr. Heller's second spine

surgeon expert (Dr. Larson). The motion was based upon the cumulative nature of Dr. Larson's testimony. During the hearing, Respondents' attorney raised a new perspective on Dr. Larson's intended testimony, that of the "community" experience and nature of his practice as a "community" spine surgeon. **The context and nature of Respondents' attorney's statements to the trial court clearly reveal that Dr. Larson's testimony was to address a "community" related standard of care.** The complete, substantive transcript of the hearing is attached hereto, as Appendix C. Less pertinent dialogue has been excised, where indicated. The following begins with discussion on cumulative testimony:

> (Begin, RP p.64 L.1)
>
> "June 25, 2019 - P.M. Session
>
> (JURY NOT PRESENT.)
>
> (Less pertinent dialogue excised.)
>
> MR. RICCELLI: I'm advised that Dr. Jeff Larson, a neurosurgeon, is the next witness for the defense. And I'm -- I'm unsure as to what he has to offer which wouldn't be cumulative. I understand he's going to testify to the standard of care and counting down method and use of AP fluoroscopy.
>
> (Less pertinent dialogue excised.)
>
> THE COURT**: I indicated I would allow, but <u>of course I've got to hear it. If it's cumulative, I -- there's no reason to allow it. I mean, we don't need to plow the same field over and over, do we?</u>**
>
> MR. SESTERO: No, and it's not my intention to plow all of the same field."
>
> (RP p.64 L. 7 –p.65 L.5)

"MR. SESTERO: He -- he will touch upon one of the topics that Dr. Hamilton raised but which Dr. Berven did not, which is there is no formal training program for the surgery on obese and oversized patients, there is nothing in the residency program that is devoted to that. The standard of care questions which I intend to ask are all based upon Dr. Larson as a community hospital surgeon. **<u>The standard of care questions which I intend to ask are all based upon Dr. Larson as a community hospital surgeon</u>. And I have cancelled off virtually any and all questions relating to the dural leak and all topics related to it. I will ask him from a <u>community level</u> with the resources available <u>in the community hospitals</u> whether he can acquire 100 percent certainty in location of surgical level. I will ask him <u>from a community hospital surgical practitioner's standpoint</u> would terminating and referring Mr. Reinert have been required or appropriate?** My examination of him on causation will be exceedingly limited so that I can have Dr. James, who did the CR 35 examination, spend more time on preexisting, postsurgical, and causation elements.

THE COURT: Okay.

MR. RICCELLI: If I may, the standard of care is a national standard of care…

<u>But I don't understand the offer of a community -- a community hospital perspective. I don't think it has any place in this litigation.</u>

THE COURT: All right**. <u>So I'm going to let Dr. Larson testify. I think he brings just a different -- not necessarily a different expertise but a different set of experiences to the table</u>**. But I -- my thought would be is that Dr. Larson's testimony would not be nearly as long as Dr. Berven's, and in fact it should be fairly short."

(RP p.65 L. 21 – p.67 L.15)

"THE COURT: All right. **And, of course, <u>you make objections as we go along, Mr. Riccelli.</u> If something is too cumulative to you, then you're free to object.**

MR. RICCELLI: Well, my question is: Are there going to be issues of standard of care addressed that -- that -- I don't think there was any

testimony that -- from any witness that there should -- there was training in dealing with obese patients or that was required training. In fact, Dr. Hamilton said it was not required training. **So the standard of care issue is one that I'm very concerned about; what -- what issue of standard of care is going to be addressed?**

(Less pertinent dialogue excised.)

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

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

MR. RICCELLI: Okay."

(RP, p.67 L. 21 – p.68 L 19)(Emphasis added)

The trial court's ruling on cumulative testimony was patently tentative. Again, with respect to cumulative testimony from Dr. Larson, the trial court was allowing Dr. Larson to testify, and Reinerts' attorney was required to object to testimony believed to be cumulative, for the court to consider it. Conversely, Dr. Larson's "community" related testimony was to be allowed, regardless of whether there was a contemporaneous objection.

C. Testimony regarding "community" related standard of care.

Following are excerpts of direct examination of Dr. Larson. Again, this was in the context of an immediately prior court ruling which:

a) required Reinerts' attorney to object to cumulative testimony; but b) finally ruled that "community" related standard of care testimony would be allowed, objections permissible, but not required:

> "Q. **In the Community Hospitals that you worked at and were aware of in Spokane and Coeur d'Alene in 2012, what did the standard of care require for localization of the surgical level in a C6-7 ACDF operation on a patient like Mr. Reinert**?
>
> MR. RICCELLI: **Objection. Again, it's cumulative**
>
> THE COURT: **Okay, overruled.**
>
> A. **The standard of care in the Community Hospital in this area in Spokane then in 2012 is the same as it is now in 2019."**
>
> (RP p. 77, L. 19 – p. 78, L. 3) (Emphasis added).
>
> "Q**.** Based on your review of all the materials and your education, skills, and experience, and **given your community practice of neurosurgery, do you have an opinion whether Dr. Heller met or violated the standard of care when he performed the operation on Mr. Reinert on October 2, 2012?**
>
> MR. RICCELLI: **Objection to the form of the question. It's cumulative.**
>
> THE COURT: Okay, **overruled."**
>
> (RP p. 77, L. 21 – p. 78, L. 1) (Emphasis added).
>
> "Q**. Given that Deaconess was a Community Hospital** and given the challenges presented by the imaging on October 2, 2012, **did the standard of care as it applied to Dr. Heller that day require him to refer Mr. Reinert out to an academic center?**
>
> MR. RICCELLI: **Object to the form of the question. The foundation as to Community Hospital is not relevant to standard of care.**

THE COURT: Okay, **overruled**."

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

It must be noted that after a continuing intermingling of the "community" term with the standard of care, Reinerts' attorney did object to the "community" reference, and the court overruled it, as the court said it would.

D. Respondents concur with the Reinerts on the trial court's rulings.

When addressing issues on appeal, and in discussing Reinerts' objections to Respondents' experts' testimony, Respondents clearly expressed the understanding that the court's ruling vis-a-vis "community" standard of care related testimony was final as to trial before the jury. In the Amended Brief of Respondent, Dr. Heller states:

> "Reinert objected to the testimony of Dr. Larson and Dr. Barakos on the ground of cumulativeness**. A component of the objection was that Dr.Larson's offering a standard of care opinion from the perspective of a "community hospital" practitioner was improper. The trial court overruled the objection**.
>
> **The court overruled the objection and, during Dr. Larson's direct examination, defense counsel and Dr. Larson made several references to a "community hospital."** Despite those references, Reinert did not request a curative or special instruction on the standard of care."

Amended Brief of Respondents, p.5 (Emphasis added)

Note that Respondents' comments on Reinerts not requesting a special jury instruction on the standard of care, but not that the objection

was waived for failure to assert it at time of testimony. This waiver theory was imposed by the Division III Court, sua sponte.

E. <u>Dr. Heller's radiology expert's troubled testimony</u>.

A hearing was held prior to presenting the preservation deposition testimony of Respondents' neuroradiology expert, Dr. Barakos (RP p. 393, L. 7 – p. 398 L. 4). It was in part, a continuation of a pretrial Motions in Limine hearing. However, Reinerts' counsel argued much of Dr. Barakos' testimony dealt with: a) his opinion that ACDF surgeons never use a certain a "C-Arm fluoroscope" in AP (Anterior – Posterior) mode to help identify a cervical surgery site, which was something that Dr. Heller previously to the jury he probably did do; and b) the likelihood of the necessity of C5-6 surgery for Mr. Reinert, had it not already been performed by Dr. Heller, testimony which was also by than obviated by Dr. Heller's own testimony, as it was not a readily predictable fact (RP p. 394, L. 3 – p. 396, L. 6).

To better clarify this for this Court on appeal, and lessen the possibility of confusion, the parties have stipulated to a post-trial motion and order which presents a single transcript of Dr. Barakos' preservation deposition testimony in which all testimony except for that shadowed in grey was heard and seen by the jury (CP 221, CP 224-315). The proposed edits or redactions appearing in Reinerts' counsel's submission to the court have been reduced to references to page numbers and line numbers of the

video deposition transcript (CP 218 – 219). The trial court took the matter under advisement and review, but held no independent discussion or hearing with counsel, collectively (RP p. 97, L. 9 – p. 98, L. 4). The trial court decided to allow the entire testimony of Dr. Barakos, with redactions (objections) proposed by Respondents' attorney accepted, and substantively all redactions (objections), but for two proposed by Reinerts' counsel, were denied. The trial court ordered redaction of testimony: a) referencing literature or information that half or 50% of surgeons had performed a wrong level surgery during their career; and b) opinion on standard of care of a surgeon.

When Dr. Barakos' video testimony was played to the jury, **the redactions ordered by the court for the benefit of Reinerts had not been made**. Reinerts' counsel did not interrupt the video testimony when the 50% reference was made, but did object to the standard of care testimony which, by the time the video technician was able to stop the video, had included the most objectionable testimony (RP p. 22, L. 11 – p. 23, L. 19).

Dr. Barakos' testimony also included a review of Mr. Reinert's cervical spine imaging, including the pre-surgery condition of C5-6 (CP p. 250, L. 1 - p. 263, L. 9). This is testimony Reinerts' counsel had objected to (CP p. 218 (left column)). Dr. Barakos, however, admitted during his testimony that he: was not a neurologist nor a clinician who examines

patients (CP p. 306, LL. 15 - 1); does not clinically diagnose neurogenic injuries (CP p. 307, LL. l5 - 16**);** does not operate C-Arm fluoroscopes in the operating room during ACDF surgeries (CP p. 274, LL. 13 - 17); and is not an ACDF surgeon (CP p. 294 L.L. 8-16)**.** However, he does believe he is qualified to and did opine to the jury, in contradiction to Dr. Heller's testimony, yet he speculated that Mr. Reinert would likely have needed the errant C5-6 ACDF procedure performed in the future, but was uncertain about when that might occur (CP p. 288, L. 21 – p. 290, L. 2.). Dr. Barakos' objected to testimony included testimony that on its face suggested issues that were not contested issues at trial. One such instance is where Dr. Barakos engages in a long dissertation about Mr. Reinert's imaging and in showing no damage to his spinal cord as a result of the surgeries performed by Dr. Heller. The Reinerts made no claim in this regard, and the Reinerts' and Respondents' spinal surgery experts all agreed that there was no such injury. (RP P.395, LL. 5-15). Respondents' first ACDF surgical expert, Dr. Berven, testified that he understood Dr. Heller used C-Arm AP views during his ACDF surgery on Mr. Reinert (RP 59, L. 10-19). Dr. Berven also testified regarding Dr. Barakos' statement that ACDF surgeons never used C-Arm fluoroscopes in the AP view during ACDF surgery, that:

> "Again, **Dr. Barakos is a radiologist. He's not a surgeon**. So what actually happens in the operating room, I think I'd be -- I'd be in a

position to testify to."

(RP p. 61, L. 2 – 4) (Emphasis added)

V. ARGUMENT

A. Standard for acceptance of review.

Acceptance of review by this Court is guided by RAP 13.4(b), which states:

> "(b) Considerations Governing Acceptance of Review. A petition for review will be accepted by the Supreme Court only: (1) If the decision of the Court of Appeals is in conflict with a decision of the Supreme Court; or (2) If the decision of the Court of Appeals is in conflict with a published decision of the Court of Appeals; or (3) If a significant question of law under the Constitution of the State of Washington or of the United States is involved; or (4) If the petition involves an issue of substantial public interest that should be determined by the Supreme Court."
> RAP 13.4(b)

Reinerts are confident that, as to each issue discussed herein, one or more criteria of RAP 13.4(b) are found in the facts and circumstances of the issues.

B. Community standard of care testimony is error.

The applicable statute, RCW 7.70.040 (Appendix D) does not suggest any "community" consideration. The term "community" is akin to the term "local" or "locality." Washington once did have a "locality" standard of care rule, but today's provision is two generations removed from it. See *Pederson v. Dumouchel*, 72 Wn.2d 73, 431 P.2d 973, 31 A.L.R.3d

1100 (1967); *Douglas v. Bussabarger*, 73 Wash. 2d 476, 489, 438 P.2d 829, 837 (1968); and *Meeks v. Marx,* 15 Wash. App. 571, 575, 550 P.2d 1158, 1161 (1976). In 1976, the Washington legislature adopted RCW 7.70.040 which established a statewide standard of care with this Court's decisions and Appellate Courts' published decisions.

C. The Division III decision conflicts with this court's decisions.

1) The Trial Court's Final Ruling Against Reinerts on "Community" Standard of Care Testimony Preserved the Issue on Appeal

In Washington, where a judge makes an evidentiary ruling on an objection /motion to limit testimony which is final, the losing party is not required to make objections during trial on that issue, as that party is deemed to have preserved its objections for appeal:

> "This court has explained the difference between final rulings and those that are only tentative or advisory:
>
> **If the trial court has made a definite, final ruling, on the record, the parties should be entitled to rely on that ruling without again raising objections during trial.** When the trial court refuses to rule, or makes only a tentative ruling subject to evidence developed at trial, the parties are under a duty to raise the issue at the appropriate time with proper objections at trial. *Koloske,* at 896. "When a ruling on a motion in limine is tentative, any error in admitting or excluding evidence is waived unless the trial court is given an opportunity to reconsider its ruling." *State v. Carlson,* 61 Wn. App. 865, 875, 812 P.2d 536 (1991)."
>
> *State v. Powell*, 126 Wash. 2d 244, 256-57, 893 P.2d 615, 623 (1995) (Emphasis added)

This Courts holding in *Powell, Id.,* virtually mirrors the facts presented above concerning the trial court's actions in making a tentative ruling on objections to cumulative testimony, and a final ruling on objections to "community" related standard of care testimony. *See, also State v. Koloske,* 100 Wn.2d 889, 896, 676 P.2d 456 (1984), overruled on other grounds by *State v. Brown,* 113 Wn.2d 520, 782 P.2d 1013 (1989). Recently, this holding from *Powell* was replicated in the published Division I case of *State v. Heutink,* 12 Wash. App. 2d 336, 355, 458 P.3d 796, 806 (2020). The Division III decision is contrary to *Powel* and *Koloske, supra,* and *Heutink, Id.*

2) Radiologist Dr. Barakos Lacked Expertise to Testify, and Provided Non – Relevant Contradictory and Confusing Testimony

Under ER 702, a trial court is required to determine if a proposed expert witness has the requisite knowledge, skill, experience, training, or education to provide testimony that will assist the trier of fact. ER 702 has been construed to require that the testimony will assist the trier of fact and that the witness qualifies as an expert. *Lakey v. Puget Sound Energy*, 176 Wn.2d 909, 918, 296 P.3d 860 (2013). The emphasis is on whether the witness could be helpful to the trier of fact rather than on the specific nature of the witness's credentials. 5B K. Tegland, Wash.Prac., Evidence Law and Practice, 702.5 at 47 (2016). The issue the trial court must determine is whether the witness's knowledge of the subject matter is such that his

opinion will most likely assist the trier of fact in arriving at the truth. *Id*. **Whether an expert's testimony is admissible depends upon whether the subject matter is within his or her area of expertise**. See *In re Marriage of Katare*, 175 Wn.2d 23, 38, 283 P. 3d 546 (2012).

Further, admission of evidence is first tested by its relevancy relevant evidence, that which has a tendency to make consequential fact determinations more probable is admissible, **but evidence that is not relevant is not admissible**. ER 402. **Further, relevant evidence may be excluded if it could be unduly prejudicial, confusing, misleading, wastes time, and/or is cumulative. ER 403.** These issues are in a published decision. See *Bengtsson v. Sunnyworld Int'l, Inc.,* 14 Wash. App. 2d 91, 469 P.3d 339 (2020). Unfortunately, the only practical way to obtain a sense of how irrelevant and confusing the trial testimony of Dr. Barakos was, is to parse through the entire stipulated transcript of his testimony (CP 216-315).

The Division III Court's decision allowing such testimony from Dr. Barakos constitutes a fundamental derogation of Reinerts' rights to a fair trial, and contrary to the recent published *Bengtsson* matter, *Id.* The trial court and the Division III Court's decision to allow Dr. Barakos' testimony (especially when Respondents had two other qualified expert spine surgeons) contradicts this court's prior opinions regarding qualification of experts.

3) Misconduct / Violation of Order in Limine / Misstatement of Law

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

> "The Court of Appeals diminished **the prejudicial effect of misstating the law** because the State produced sufficient circumstantial evidence to allow the jury to find actual knowledge. However, deciding whether a prosecuting attorney commits prejudicial misconduct "is not a matter of whether there is sufficient evidence to justify upholding the verdicts." "Rather, the question is whether there is a substantial likelihood that the instances of misconduct affected the jury's verdict." The Court of Appeals' reliance on the sufficiency of the evidence is misplaced. Second, the misstatement of law was repeated multiple times. **Repetitive misconduct can have a "'cumulative effect**.'"
>
> *State v. Allen*, 182 Wash. 2d 364, 375-76, 341 P.3d 268, 274 (2015) (internal citations and paragraph break omitted.) (Emphasis added.)

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

(2014). Respondents' long experienced medical malpractice defense attorney: a) repeatedly misstated the law by weaving "community" as a foundational term into the standard of care dialogue at trial; and b) apparently failed to make any attempt to assure that the selected redactions were made to Dr. Barakos' testimony. Although there was probably no intent on the part of Dr. Heller's attorney to violate the Court's order, there was obviously some intentional lack of thoroughness, which this Court should consider expounding on, possibly in the nature of constructive intent. This, to avoid the potential of possibly less honorable attorneys excluding what may be a court created loophole to work around an unfavorable order in limine in today's Digital Age.

VI. CONCLUSION

In conclusion, the Washington Supreme Court is requested to accept review and thoroughly consider and rule on the issues raised herein.

RESPECTFULLY SUBMITTED this 10th day of December, 2021.

MICHAEL J RICCELLI PS

By:______________________________
Michael J. Riccelli, WSBA #7492
Attorney for Petitioners

DECLARATION OF SERVICE

I caused to be served a true and correct copy of the foregoing by E-Mail to the following

Christopher J. Kerley – ckerley@ecl-law.com
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Of Evans, Craven & Lackie, P.S.

I declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.

December 10, 2021

Date   Signed

Appendix A

FILED
SEPTEMBER 14, 2021
In the Office of the Clerk of Court
WA State Court of Appeals Division III

IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON
DIVISION THREE

ARTIE LEN REINERT, JR AND CONSUELA LEE REINERT, Appellant, v. ALLEN C. HELLER, M.D. and STEPHANIE A. HELLER, husband and wife, and the martial community composed thereof; ROCKWOOD CLINIC, P.S.; ROCKWOOD NEUROSURGERY AND SPINE CENTER; DEACONESS HOSPITAL; and SPOKANE WASHINGTON HOSPITAL COMPANY, LLC, and DOES 1-10, Respondents.	)	No. 37081-0-III UNPUBLISHED OPINION

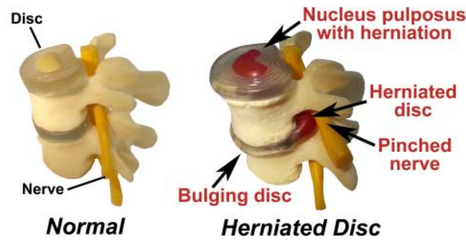
FEARING, J. — Neurosurgeon Allen Heller performed a discectomy on Artie Reinert's C5-6 cervical spine level when Reinert and Heller intended for Dr. Heller to perform the procedure at the C6-7 level. After discovering the mistake, Dr. Heller returned Reinert to the operating room two days later and performed the surgery at the

C6-7 level. Plaintiff Artie Reinert appeals from an adverse verdict in a medical malpractice lawsuit against Allen Heller. Reinert assigns error to numerous evidentiary rulings of the trial court. Because the trial court did not abuse its discretion in any of its rulings, we affirm the judgment entered in favor of defendant Dr. Heller.

FACTS

Artie and Consuela Reinert sued Allen Heller, M.D., and Dr. Heller's employer, Rockwood Clinic, for an alleged breach of a physician's standard of care during an anterior cervical discectomy fusion (ACDF) that Heller performed on Artie Reinert in October 2012. We refer to the plaintiffs collectively as Artie Reinert, and we refer to the defendants collectively as Dr. Allen Heller or Heller. A discectomy removes the damaged portion of a herniated disc in the spine. The anterior nature of Artie Reinert's surgery looms important in this dispute. The patient lies prone on his back. For an anterior cervical discectomy, the surgeon performs an incision through the throat, rather than through the back of the neck.

Artie Reinert suffered a disc herniation at level C6-7 of his cervical spine. A herniation occurs when the soft, central portion of the intervertebral disc bulges beyond the torn, hard outer ring of the disc. Reinert's herniated disc pressed on a nearby nerve. Reinert also experienced a disc bulge and bone spur at the C5-6 disc level.



Artie Reinert consulted with Dr. Allen Heller, a neurological surgeon, and, during initial conversations, the two discussed surgery at the C6-7 level and the C5-6 level of the spine. The physician and patient decided, however, to treat only level C6-7. Dr. Heller advised that surgery on the C6-7 level presented an urgent medical necessity due to the resulting compression on a spinal cord nerve. The large disc herniation at C6-7, if left untreated, would worsen and possibly result in paralysis. Dr. Heller did not then consider surgery on level C5-6 a medical necessity. Heller scheduled an ACDF, a common procedure, at the C6-7 level.

When performing a discectomy, the surgeon must locate the targeted disc. The cervical spine consists of seven vertebrae. Most of these vertebrae consist of square blocks stacked on one another. The first cervical vertebrae, the C1, bears the unique shape of a ring sitting on top of the C2 vertebrae. C2 also has a unique appearance. The C2 vertebrae is a square block but with a thumb-like appendage. When locating a lower level of the cervical spine during a discectomy, surgeons will often first locate levels C1 and C2, due to their unique structures, and then count down to the level sought. The C6-7 level is located toward the bottom of the cervical spine.

Neurosurgeons also employ a portable x-ray machine called a C-arm fluoroscopy machine (C-Arm) to locate the ruptured disc for a discectomy. Fluoroscopy shows a continuous X-ray image on a monitor, much like an X-ray movie. A radiology technician takes images of the cervical spine for review by the surgeon. The C-Arm rotates in an arc in order to x-ray the spine from various angles.

C-Arm fluoroscopy machine

On October 2, 2012, Dr. Allen Heller proceeded with an ACDF on Artie Reinert's C6-7 level. Dr. Heller positioned Reinert on his back on the operating table. He extended Reinert's neck so that his chin pointed toward the ceiling. Heller then endeavored to locate the targeted level.

During Artie Reinert's surgery, Dr. Allen Heller used the C-Arm to obtain a lateral fluoroscope view. To obtain that view, the radiology technician positions the C-Arm to shoot beams from left to right. A lateral x-ray permits a surgeon to view isolated levels of the vertebrae and disc space. According to Dr. Heller, on October 2, he also sought a

different view, called an anterior posterior (AP) view, or straight up and down view. He did not save images from this view, however. The AP view often provides unreliable and distorted images causing difficulty in distinguishing various vertebral bodies. During trial, Dr. Heller opined that a lateral fluoroscopic image with the use of a metallic marker affords the most reliable view for locating a disc level.

The position of the patient's shoulders can complicate locating level C6-7 with use of the C-Arm fluoroscopy machine. The patient may raise his shoulders or one shoulder may be higher than the other, both of which occurrences cause a darkened area on the x-ray, preventing a physician from clearly identifying the various spinal discs.

During Artie Reinert's ACDF, Reinert's shoulders rode high. Dr. Allen Heller employed different techniques in order to find, with the C-Arm, the lower levels of Reinert's spine. Dr. Heller first taped, with robust cloth tape, Reinert's shoulders to the operating table. Despite the taping, the x-ray showed the cervical spine only to the C3-4 level. Below this level, the image appeared black. Dr. Heller then shot still images at various angles and different planes with the C-Arm machine. The still images did not lead to a clearer view of the lower cervical spine. Heller next attempted to trick the C-Arm. He taped bags of saline fluid to the side of Reinert's neck in order to equal the density of the shoulders. This technique did not improve the image of Reinert's lower cervical spine.

Dr. Allen Heller tried a fourth technique by placing a metallic object on Artie Reinert's throat where he estimated he would cut his incision for level C6-7. Dr. Heller incised the spot and dissected down to the spinal column. He inserted a spinal needle into the immediate disc. He did not know the level at which he placed the needle because the C-Arm revealed only blackness. Heller then began internal counting. He took a "peanut," a blunt-tipped long metallic clamp and ran the peanut up the spinal column as far as he could. Another C-arm still shot revealed that the tip of the peanut sat at level C3-4. Heller then palpated down the front of the spine and counted the cervical vertebrae to the spot he concluded was level C6-7.

A normal healthy spine, without degenerative wear-and-tear, yields predictable contour when the neurosurgeon counts cervical spine levels. The bones feel like valleys and the intervertebral discs feel like peaks. When Dr. Allen Heller counted down Artie Reinert's spine, Heller felt one peak, then a valley, followed by another peak. He determined each peak to be a new bone or cervical level.

Dr. Allen Heller performed the ACDF at the level he counted to be C6-7. According to his trial testimony, he possessed 99 percent certainty that he had reached the correct disc level.

After Artie Reinert's surgery, Dr. Allen Heller ordered a CT scan to confirm that he performed the surgery at the correct location. The scan revealed that Dr. Heller had performed the ACDF on level C5-6. Heller had misinterpreted multiple peaks during his

palpation. At trial, Heller attributed the miscounting to bone spurs and other disc bulges in Reinert's cervical spine. Dr. Heller informed Reinert, while Reinert lay in recovery, of the mistake. Reinert responded that they had discussed conducting the procedure on the C5-6 level anyway.

Two days later, on October 4, 2012, Dr. Allen Heller performed the ACDF procedure on level C6-7. He easily found the correct spine level because of the implant at the C5-6 level remaining from the earlier surgery.

During the second operation, Dr. Allen Heller noticed a portion of the large disc herniation at level C6-7 pressing on the spinal cord protective membrane, known as the dura mater (dura). A piece of the disc herniation adhered to the dura. In removing the displaced piece of disc, Dr. Heller tore a hole in the dura, which caused spinal fluid to leak. A dural tear during surgery is rare. When the surgeon performs the discectomy in the anterior position, the surgeon cannot sew the dura shut, because no needle is small enough to permit a suture. Therefore, Dr. Heller attached patch material, either some of Artie Reinert's own muscle or an artificial substance, to patch the hole. He deposited the material and used glue to seal the tear. After patching the dural leak, Heller completed the surgery. Reinert went home the next day, which is common following an ACDF, even with a patched dural tear.

On October 9, 2012, Artie Reinert returned to the hospital emergency room. Imaging showed a bulge under the location of the C6-7 incision cite. The seal on the

dura had failed to hold. Dr. Allen Heller admitted Reinert to the hospital on October 9 and, on October 11, Heller performed a third surgery on Reinert to repair the tear. In order to monitor the October 11 repair, Reinert stayed in the hospital until October 18, five of which days he recuperated in the intensive care unit.

PROCEDURE

Artie Reinert filed suit against Dr. Allen Heller and his employer for negligently performing the first ACDF on the wrong spinal level on October 2, 2012. Reinert claimed that Dr. Allen Heller failed to follow the accepted standard of care when attempting to locate the C6-7 disc level during the October 2, 2012 operation and Heller's violation of the standard of care led to a second surgery two days later.

Dr. Allen Heller listed as defense medical experts: neurosurgeon Jeffrey Larson, orthopedic surgeon Sigurd Berven, and neuroradiologist Jerome Barakos. Artie Reinert thereafter and before trial filed a motion in limine to limit the number of experts testifying on behalf of Dr. Heller because of the cumulative nature of the testimony. He sought exclusion of either Dr. Jeffrey Larson or Dr. Sigurd Berven as a trial witness. Reinert emphasized that Larson and Berven would testify identically that Heller did not breach the duty of care and that any breach caused no harm.

In addition to moving to limit the number of expert witnesses, Artie Reinert moved to exclude portions of neuroradiologist Jerome Barakos' preservation deposition testimony. He objected to Dr. Barakos' comments on the use of the C-Arm fluoroscopy

machine and his testimony regarding the applicable standard of care. Reinert argued that the introduction of Barakos' testimony was cumulative of the testimony of the other experts. Reinert also contended that Barakos lacked the qualifications to render opinions on the standard of care in the use of intraoperative C-Arm fluoroscopy since Barakos acknowledged that the surgeon, not a radiologist, decides the angles of the fluoroscopy.

In response to Artie Reinert's motions in limine, Dr. Allen Heller emphasized that the testimony of the orthopedic surgeon Dr. Sigurd Berven and the neurosurgeon Dr. Jeffrey Larson would not overlap because Dr. Berven would render opinions from an academic background and Dr. Larson would testify from a local practice background. Dr. Berven would provide the jury an opinion about the standard of care, in a teaching hospital, for locating spinal levels. Dr. Jeffrey Larson would opine about the standard of care for locating spine levels when performing surgery in a local community hospital. Dr. Heller mentioned that Reinert's expert, Dr. Hamilton, like Dr. Berven, only provided an expert opinion for an academic background. In response, Artie Reinert commented that a state standard of care equivalent to a national standard of care applied such that a community hospital perspective was immaterial.

Dr. Allen Heller underscored that neuroradiologist Jerome Barakos would explain the nature of the imaging employed by Dr. Heller when performing surgery on Artie Reinert. Heller asserted that Barakos possessed extensive knowledge regarding the type of imaging used at thirty-two hospitals where surgeons perform ACDF surgery. Dr.

Barakos also possessed opinions as to causation of injury based on his review of the radiology records from Artie Reinert's care. Dr. Heller represented that Barakos would not offer standard of care testimony relevant to the performance of an ACDF procedure. After a pretrial hearing, the trial court reserved a ruling on Artie Reinert's motions in limine.

During trial, Artie Reinert called defendant Allen Heller as an adverse witness and as his first witness. Reinert's counsel asked Dr. Heller about the steps he undertook to locate the C6-7 level during the October 2, 2012 ACDF. Counsel questioned Heller regarding the availability of different technology and the use of various techniques when locating a cervical spine level during surgery. According to counsel's leading questions, the technology and methods included C-Arm views, intraoperative MRI and CT scanning, brain mapping, and 3-D imaging such as stereotactic imaging, which involves the assigning of x, y and z coordinates to an area of the body to assist in localization efforts. Reinert's counsel inquired as whether Dr. Heller considered use of any of these other technologies and techniques. Counsel asked Heller if he contemplated stopping Reinert's surgery in order to refer Reinert to another facility.

Dr. Allen Heller answered that he was not aware of stereotactic imaging in October 2012. Heller responded that he never considered terminating the discectomy because of the possibility that he located the wrong cervical level. Artie Reinert, through counsel, asserted in a leading question that Dr. Heller was:

> really not aware of what, if any, status there was as to their use and application of—stereotactic or 3D technology in cervical surgeries, whether it be ACDF or other types of cervical surgeries . . . . you weren't aware—weren't aware of what was going on with it, were you?

Report of Proceedings (RP) at 206. Dr. Heller responded that he used the C-Arm machine and employed various angles and techniques to view the various vertebrae levels. Heller further testified that he obtained all views needed to perform the operation of Artie Reinert through use of the C-Arm. He averred that Deaconess Medical Center lacked an intraoperative CT scan in 2012 or at the time of trial.

Days later, Dr. Allen Heller testified in his own case. Heller's counsel asked Dr. Heller if he documented each angle shot by the C-Arm during a surgery. Heller responded that he did not. Nevertheless, according to Heller, he probably looked at an anterior-posterior view during Reinert's surgery, despite lacking any of the imaging thereafter.

Artie Reinert's counsel then cross-examined Dr. Allen Heller regarding AP views with the C-Arm. Counsel asked if Dr. Heller had any independent recollection of using views other than lateral fluoroscopic views. Heller responded that he lacked an independent recollection of every view taken of Reinert's cervical spine on October 2. Counsel for Reinert then asked,

> Do you recall using an AP view in any ACDF surgery previously?

RP at 358. Dr. Heller's attorney objected and Reinert's attorney rephrased the question:

> As you sit here today, can you recall ever using—do you have independent recollection of ever using or attempting to use an AP view, either in the direct AP mode, AP caudal, or AP coronal, in attempting to locate cervical discs during an ACDF procedure?

RP at 358-59. Dr. Heller responded:

> A. Not in attempting to locate a disc. But it's not uncommon to use AP fluoroscopy to identify the midline. So I have taken AP images before during ACDF surgery, but it's more valuable in locating midline.
>
> Q. And so your answer's you don't recall independently of ever using an AP view, either AP direct, caudal, or coronal, to identify a surgical site in the cervical spine?
>
> A. That's correct. I generally find it very unreliable and don't specifically recall an instance of using it.

RP at 359. Dr. Heller later averred that he believed he tried every possible angle or view during Reinert's surgery, though he did not have a specific recollection of every image.

During other testimony, Dr. Allen Heller declared that, as the surgeon, he bears the responsibility for garnering the images needed during surgery. Heller acknowledged that the radiologist would not make decisions or recommendations on surgery. The radiologist limits his or her role to interpreting images.

Neurosurgeon Allan Hamilton testified as Artie Reinert's expert witness. Dr. Hamilton joined the faculty at the University of Arizona in 1990 and has devoted his career to academic medicine. He last performed surgery in 2004, although he teaches students how to perform an ACDF.

Dr. Allan Hamilton testified to the applicable standard of care. In Dr. Hamilton's opinion, Dr. Allen Heller violated the standard of care twice. First, Heller should have

anticipated problems in locating the targeted spine level. Second, once in the operating room, Dr. Heller needed to be certain he located the correct level before proceeding with the discectomy. According to Hamilton, Dr. Heller violated the standard of care when he was not certain he had located the C6-7 level, but operated anyway.

Dr. Allan Hamilton listed methods that Dr. Allen Heller could have employed to isolate the C6-7 level. Before surgery, Dr. Heller could have taken a "frameless stereotactic MRI" or CT-scan. RP (June 19, 2019) at 34-35. During surgery, Heller could have shot different views with the C-Arm, including an AP view.

Regarding a stereotactic MRI, Artie Reinert's counsel questioned:

> Q. And how—could that have been—do you know whether or not that could have been achieved at the Deaconess center in 2012?
> A. Yes.
> Q. You think so?
> A. The technology exists. Yeah.

RP (June 19, 2019) at 35.

Dr. Allan Hamilton also opined that Dr. Heller had the option to abandon the procedure when he could not be certain he had identified the C6-7 level.

> So we abort procedures. It's unusual but we abort procedures, particularly if we have either technical difficulties we had not anticipated or something else is going on with the patient's physiology that's making the surgery more dangerous than we thought. But we always have the option of backing out and telling the patient I wasn't happy with the conditions and I'm going to regroup.
>
> I may use a different technology. I may go to a different hospital. Some hospitals have intraoperative CTs. You can actually do a CT scan in

> the operating room to be sure where you're at. So you could book it in a room where you have operative CT.

RP (June 19, 2019) at 36. Dr. Hamilton declared that Swedish Medical Center and the University of Washington Medical Center performed CT scans in the operating room. Dr. Hamilton explained that a physician should not use post-operative imaging to confirm that he or she correctly completed surgery at the correct location.

During his trial testimony, Dr. Allan Hamilton acknowledged that, had a single level fusion been conducted on level C6-7 at the time of surgery, additional forces would have been placed on level C5-6. As a result, a higher likelihood of degenerative progression would have existed at level C5-6. Hamilton, however, would not opine on a more probable than not basis whether Artie Reinert would have needed future surgery on level C5-6. On cross-examination, Dr. Heller's counsel asked Dr. Allan Hamilton whether he intended to testify that Artie Reinert had a diagnosable neurological injury as a result of the surgeries performed by Dr. Heller, to which Hamilton responded, no.

Before Dr. Jerome Barakos testified in Dr. Allen Heller's case, the trial court entertained further oral argument on Artie Reinert's pretrial motion to exclude portions of Dr. Barakos' preservation deposition. Reinert argued that Dr. Barakos' lack of qualifications as a neurosurgeon and his cumulative testimony demanded redactions. Reinert emphasized that Dr. Barakos did not enter operating rooms, but instead received images taken by a surgeon during surgery. Reinert mentioned that Dr. Barakos testified

that surgeons do not use the AP view during ACDF surgeries, which testimony conflicted with Dr. Allen Heller's testimony that he may have used an AP view. Reinert contended that experts Dr. Allan Hamilton and Dr. Allen Heller already agreed that level C5-6 had degenerative disease and, therefore, Dr. Barakos' similar testimony was unnecessary. Finally, according to Reinert, Dr. Barakos' testimony regarding the absence of neurological damage resulting from the surgeries on Artie Reinert as shown by imaging repeated the opinions of Dr. Hamilton and Heller.

In its ruling, the trial court ordered the redaction of Dr. Jerome Barakos' testimony that literature reflected that fifty percent of all surgeons had performed surgery on an incorrect vertebrae level. The parties also agreed that Dr. Barakos' testimony regarding the appropriate standard of care should not be admitted. Therefore, Dr. Allen Heller agreed to redact the following testimony:

> A: Let's see. So a wrong-level surgery is not seen as a breach of the standard of care. Why? Because the methods employed to identify the appropriate level of surgery are well defined and well accepted. And just as in this case, the standard is one of counting, numerically counting.

Clerk's Papers (CP) at 273

The jury thereafter saw and heard Dr. Jerome Barakos' videotaped testimony. Through the preserved deposition, Dr. Barakos testified that he is a board-certified neuroradiologist and currently the director of neuroimaging for the Sutter Hospital system in California, a position which he has held since 1992. Barakos explained the role

of a radiologist as a physician who interprets imaging studies to assist the primary physician engaged in a task. He is not a radiologist technician, nor a surgeon, and he does not generate images. He is not present in the operating room. A neuroradiologist interprets images including x-rays, MRIs, and fluoroscopy. He does not use the images to evaluate a procedure. Dr. Barakos acknowledged that he reviews only images that the surgeon decides to archive, and the surgeon does not archive every image taken during a procedure. Barakos testified that only a radiologist, because of training and certification, holds the privilege to issue a final report on imaging studies.

Dr. Jerome Barakos testified to the characteristics and uses of fluoroscopy. "[I]ntraoperative lateral fluoroscopy" is performed in conjunction with ACDF surgeries. CP at 235. According to Barakos, the surgeon only employs the lateral view with an anterior cervical discectomy fusion on the cervical spine, which limits imaging of the upper levels of the cervical vertebrae. Barakos averred that he recalled no time when the surgeon shot an anterior-posterior view during an ACDF. He elaborated:

> And basically, it has to do with the fact that if you obtain a radiograph in that direction, the head and the skull and the facial structures, a lot of bone overlies the proximal cervical spine. So the proximal cervical spine, the C1-C2, is best visualized from a lateral perspective because there's less tissue, and certainly less bone . . . from a frontal AP view, it's very hard, if not impossible, to see the C1-2 levels. You can certainly see lower down well, but upper areas are obscured by the skull. So as a result, you're not accomplishing your objective of visualizing the cervical spine.

CP at 236-37. Dr. Barakos further explained that an AP view would result in a "parallax effect" that distorted the area that needs to be counted during a cervical discectomy.

On cross-examination, Dr. Jerome Barakos opined:

> an AP caudal view would not show us with any clarity the proximal portion of the spine. . . .
>
> So in summary, an AP view would not provide additional localization information which is why, as I've outlined, I can't recall one being used in any of our facilities for as long as I've been there.

CP at 287-88. Dr. Barakos avowed that neurosurgeons never employ other technologies, such as Stealth Station, Brainlab, stereotactic, or 3-D navigation, during an ACDF.

Dr. Jerome Barakos testified that he examined the preoperative, intraoperative, and postoperative imaging taken of Artie Reinert. He averred that the images showed no injury caused by the surgeries conducted by Dr. Allen Heller. Barakos added that an MRI done on August 14, 2012 before Reinert's first surgery showed a "moderate spinal canal stenosis" at level C5-6 and a "severe spinal canal stenosis" at level C6-7. CP at 249. "Stenosis" is the narrowing of a blood vessel or valve that restricts blood flow. Dr. Jerome Barakos admitted that rarely does the surgeon order a CT scan immediately after surgery to ensure surgery on the correct location. He knows of only two instances, during his twenty-five year career, when a neurosurgeon ordered a postsurgery scan.

Dr. Jerome Barakos acknowledged Dr. Allen Heller's opinion that, on October 2, Artie Reinert needed surgery only at the C6-7 level. In response to a question from Artie Reinert's counsel regarding whether Dr. Barakos could predict, on a more probable than

not basis, whether further degeneration on the C5-6 disc would have caused later symptoms, Barakos responded:

> A. Yes, sir. I would state with reasonable medical probability, doing this for over 25 years in a high-volume spinal center, that if someone only did the more pronounced 6-7 level, we know by definition and the literature supports the concept of adjacent segment degenerative disease, which means that if this 6-7 level is a solid fused block which is the intended goal of surgery, there will be additional dynamic forces and pressure being applied to the contiguous levels.
>
> *Since at this point in time the C5-6 level already shows significant degeneration with impingement on the spinal cord, I would state with reasonable medical probability sometime down the road Mr. Reinert is going to need additional level surgery*.
>
> Now, I can't say whether it's going to be months later or years later. I would defer to a surgical expert. But I'm certainly in a position with my experience and training to know that that is a real and expected condition, namely, after a single-level surgery given the degree of disease Mr. Reinert already displays at the C5-6 level, that it's going to be pretty much an inevitable outcome that this spinal canal stenosis and continued again—and remember, the gentleman's relatively young at this point, He's only 49—that in the years to come, we would expect advanced degenerative changes at the C5-6 level.

CP at 280-81 (emphasis added).

During the playing of Dr. Jerome Barakos's video testimony, the disk played portions of testimony that the trial court ordered redacted. The video first played the portions of testimony referencing the number of surgeons who had performed wrong level surgeries. Artie Reinert did not then object. The video then played Dr. Barakos' answer regarding the standard of care, though it did not include the question asked. Artie Reinert objected to the testimony and the following colloquy ensued:

MR. RICELLI [counsel for Artie Reinert]: Your Honor?

THE COURT: Is there an issue?

(Video Deposition Paused.)

MR. SESTERO [counsel for Dr. Allen Heller]: That should have been omitted from line 22 before . . .

THE COURT: I'm sorry?

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

MR. RICCELLI: Subject to the motion in limine.

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

THE COURT: Page 53, line 22?

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

THE COURT: Okay.

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

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

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

MR. RICCELLI: Yes.

THE COURT: You agree. So I'll—

MR. RICELLI: Yes.

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

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

MR. RICELLI: The answer about the national standard of care—

THE COURT: Okay.

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

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

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

MR. SESTERO: May we, for technical reasons—

THE COURT: Yeah.

MR. SESTERO:—take an afternoon break, and then we'll—

THE COURT: Let's do that.

MR SESTERO:—wrap up?

THE COURT: Let's do it. Let's take a short recess.

> (JURY LEFT COURTROOM.)
> THE COURT: Okay. Are you going to go through the rest of this to make sure that it's accurate?
> MR. SESTERO: Yes.
> THE COURT: I'll step down, then.

RP at 22-24 (emphasis added).

The defense called Dr. Sigurd Berven, a spine surgeon and the chief of spine services at the University of California in San Francisco, to testify. Dr. Berven opined that Artie Reinert suffered degenerative spinal disease on multiple levels of his cervical spine, including levels C4-5, C5-6, and C6-7 and mild signs of the disease below C6-7. He averred that Dr. Allen Heller met the standard of care. He explained that the surgical outcome does not define whether a surgeon provided reasonable care, stating in part:

> I think really the process is what the surgeon is accountable for, as is the appropriate process; and a process is consistent with the standard of care.

RP at 37.

According to Dr. Sigurd Berven, Dr. Allen Heller complied with the standard of care when he employed lateral intraoperative fluoroscopy with the C-Arm and the counting method to localize the C6-7 level. The method to be employed is a judgment call for the neurosurgeon. Dr. Berven further opined that Allen Heller need not have used stereotactic navigation or an AP view to meet the standard of care.

During his testimony, Dr. Sigurd Berven stated that he understood from Dr. Heller's testimony that Heller used AP views to assist in finding a level or midline during

an ACDF surgery. Dr. Berven testified that he had shot AP views to assist during an ACDF surgery, but he and other surgeons mostly rely on lateral views. An AP image can be inaccurate. Counsel for Artie Reinert asked:

> Q. *Dr. Barakos testified yesterday by video deposition that he's never seen an ACDF surgeon ever use an A—an AP view on any of his cases.*
> A. *Well, Dr. Barakos isn't a surgeon.* But it's my clear testimony that the most reliable images are going to be the lateral projections, and I rely on those most. There can be a lot of reasons that the AP image is off; specifically, you can't actually see the most identifiable landmark (indicating), which is the odontoid process, because the mandible's in the way. So you can't see the top of the spine to count from the top, and trying to count from the bottom can be really difficult. There's all sorts of bones between the first rib and the clavicle that can really make it difficult to count from the bottom. So therefore the lateral is the x-ray that I rely upon most.
> Q. Okay. *But my question was about Dr. Barakos, who stated yesterday he doesn't think AP surgeons ever use the AP view. Is he incorrect in that statement as far as your practice is concerned?*
> A. *Again, Dr. Barakos is a radiologist. He's not a surgeon*. So what actually happens in the operating room, I think I'd be—I'd be in a position to testify to.

RP at 60-61 (emphasis added).

On cross-examination, Dr. Sigurd Berven testified that he would terminate a surgery if he could later return to the surgery under more optimal circumstances. Nevertheless, if a good x-ray showed the peanut on the C3-4 level, as in the surgery of Artie Reinert, he would have counted down from the well-defined level. Dr. Berven disagreed with Dr. Allan Hamilton's testimony that, even assuming the availability of an intraoperative CT scan, the scan might not provide reliable results in the operating room.

Berven explained that, with a small incision used in an ACDF procedure, the surgeon lacks sufficient room to directly place a marker on the bone. He characterized the use of an intraoperative CT to locate the C6-7 level as misguided. Berven declared that his operating theaters in 2012 did not employ fiducial or stereotactic navigation.

Dr. Sigurd Berven opined that Dr. Allen Heller acted reasonably when he proceeded with surgery when he believed he had a 99 percent certainty of the location of the C6-7 level and then ordered a postoperative image due to the one percent doubt. Dr. Berven also rebutted the possibility of referring Reinert to another facility:

> Then the notion of possibly sending the patient to a tertiary care center, to Seattle for example, that—that's something that I think would involve significant risk in terms of transportation of somebody who has such severe stenosis. But also reoperating could introduce other risks, infection and other complications.

RP at 45-46. According to Dr. Berven, Dr. Heller met the standard of care when he proceeded with surgery based on the evidence and his judgment.

Dr. Sigurd Berven also testified about the dural tear that occurred on October 4, 2012 during the second surgery conducted by Dr. Heller on Artie Reinert. Dr. Berven opined that the tear healed by the time of Reinert's discharge on October 18, 2012. Berven testified that a dural tear can occur despite a surgeon using reasonable care. He also averred that, had Heller performed, on October 2, the ACDF on level C6-7 as intended, a tear was equally likely to occur as on October 4.

Dr. Sigurd Berven concluded that no injury resulted to Artie Reinert from Dr. Allen Heller's care. Dr. Berven opined that any continuing neck pain suffered by Reinert likely resulted from the preexisting levels of degeneration at multiple levels of the cervical spine. According to Berven, Heller's operation on the C5-6 level on October 2 caused no harm because Reinert likely would have needed the surgery at a later time.

Allen Heller's defense also called Dr. Jeffrey Larson to testify during trial. Before the testimony, Artie Reinert again objected to Larson's testimony as cumulative since his testimony focused on the standard of care, the counting down method of locating a cervical spine level, and use of AP fluoroscopy. Other witnesses had already addressed these subjects. Dr. Allen Heller responded that Dr. Larson knew the resources at Deaconess Medical Center and those resources available at a community hospital, whereas the defense's other expert, Dr. Sigurd Berven, practiced in academia and at a major medical center in a large metropolitan area. Heller stated that his counsel would pose Larson questions regarding the standard of care based on the neurosurgeon's role at a community hospital and based on his knowledge of resources available at a community hospital. Counsel disclosed the intent to ask Larson, from a surgical practitioner's standpoint, whether terminating the surgery and referring Reinert would have been required or appropriate. Artie Reinert replied that he did not contend that Deaconess lacked any needed resource. Instead, he argued that Dr. Heller should have sent Reinert

to another facility. Finally, Reinert objected to the use of a community hospital standard as contrary to law.

The trial court allowed the testimony of Dr. Jeffrey Larson because of his encountering different experiences from Dr. Allan Hamilton and Dr. Sigurd Berven. The court, nonetheless, directed Artie Reinert's counsel to object if, at some point, the testimony became exceptionally cumulative.

Dr. Jeffrey Larson testified that, from 1997 to 2003, he practiced in Spokane at Sacred Heart Medical Center and Deaconess Medical Center. In 2003, he moved to Coeur d'Alene and established a private clinic, and he conducts surgeries at Kootenai Medical Center. Larson distinguished between a community hospital, where one treats the community, and an academic center, where one teaches and trains young physicians.

During direct examination, Dr. Allen Heller's attorney inquired as to whether Dr. Jeffrey Larson believed that Dr. Heller violated the standard of care "*given your community practice of neurosurgery*." RP at 77 (emphasis added). Artie Reinert's lawyer objected to the question as cumulative. The court overruled the objection, and Larson opined that Heller did not violate the standard of care.

Defense counsel next asked Dr. Jeffrey Larson:

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

RP at 77 (emphasis added). Reinert again objected on the basis of cumulative testimony, and the court overruled the objection. Dr. Larson responded:

> A. The standard of care in the community hospital in this area in Spokane then in 2012 is the same as it is now in 2019. And it is lateral localization of the C spine level, whether it be seeing it directly or by seeing the lowest level that you can see and then counting from that level.

RP at 78. Dr. Larson added that a neurosurgeon does not necessarily breach the standard of care when performing an operation at the wrong cervical level. The surgeon did not need 100 percent certainty of the correct location to comply with the standard of care.

Later, in questioning Dr. Jeffrey Larson, Dr. Allen Heller, through counsel, made another community reference:

> Q. Sir, *as a community spinal surgeon*, did the standard of care under the circumstances that existed on October 2, 2012 require Dr. Heller to refer Mr. Reinert out of the community hospital to a different level of care?
> A. Can you ask the front part of that question again? It's—
> Q. It was poorly worded. I'll try it again.
> A. Okay.
> Q. *Given that Deaconess was a community hospital* and given the challenges presented by the imaging on October 2, 2012, did the standard of care as it applied to Dr. Heller that day require him to refer Mr. Reinert out to an academic center?
> MR. RICCELLI: Object to the form of the question. The foundation as to community hospital is not relevant to standard of care.
> THE COURT: Okay, overruled.
> A. I have to ask you to ask that one more time, sorry. I'm—it got lost in the. . . .
> Q. I'm going to tighten it up as best I can.
> A. Okay.

> Q. Did Dr. Heller need to refer Mr. Reinert out to an academic center like Harborview or University of Washington under the circumstances that existed on October 2, 2012?
> A. No, he did not.

RP at 80 (emphasis added). Despite being an expert on community, not teaching, hospitals, Larson explained that the Seattle teaching hospitals had no equipment that Deaconess lacked.

On cross-examination, Dr. Jeffrey Larson repeated that he testified to the standard of care "in this community." RP at 83. He elaborated that he believed the standard of care in Washington State equaled that of the national standard. He added that the standard of care at Deaconess Medical Center and Harborview Medical Center echoed the other.

The jury entered a verdict in favor of Dr. Allen Heller and his employer.

LAW AND ANALYSIS

On appeal, Artie Reinert asserts the same evidentiary objections he forwarded during trial. He also contends that defense trial counsel engaged in misconduct when playing portions of Dr. Jerome Barakos' videotape deposition that the trial court earlier excluded.

Community Standard of Care

On appeal, Artie Reinert contends that Dr. Jeffrey Larson referenced a community hospital standard of care, which misstated applicable Washington law. Dr. Allen Heller

responds that Reinert failed to preserve this argument on appeal. Allen Heller argues, on the merits, that any reference to the community or a community hospital was appropriate for three reasons. First, neither Dr. Heller nor Dr. Jeffrey Larson ever defined the standard of care as limited to a community hospital or another healthcare provider in Dr. Heller's community. Second, the standard of care in Washington State as outlined in RCW 7.70.040 permits consideration of the circumstances in which a healthcare provider acted. Third, the other experts in the case, Dr. Allan Hamilton and Dr. Sigurd Berven, practiced in large academic centers, whereas Dr. Larson provided testimony from his personal experience in the community hospitals of Deaconess Medical Center and Kootenai Health. Finally, Allen Heller argues that any alleged error is harmless. Reinert replies that Dr. Heller did not need to submit testimony from Dr. Larson regarding the resources, specifically advanced imaging techniques, available at Deaconess Medical Center because Reinert's expert, Dr. Allan Hamilton, never attributed the failure to use such resources as a basis for Dr. Heller's breach of the standard of care.

Issue 1: Whether Artie Reinert preserved a challenge to Dr. Jeffrey Larson's testimony that referenced a community hospital, community practice, or community standard of care?

Answer 1: No.

To determine whether Artie Reinert preserved error, we must outline instances during which Dr. Allen Heller's counsel mentioned a community hospital standard of care when posing questions to Dr. Jeffrey Larson. Heller's counsel asked Larson:

> Based on your review of all the materials and your education, skills, and experience, and *given your community practice of neurosurgery*, do you have an opinion whether Dr. Heller met or violated the standard of care when he performed the operation on Mr. Reinert on October 2, 2012?
> MR. RICCELLI: Objection to the form of the question. It's cumulative.
> THE COURT: Okay, overruled.
> A. Yes, I do.
> Q. What is your opinion, sir?
> A. He did not violate the standard of care.

RP at 77 (emphasis added). We henceforth refer to this question as the first question.

> *In the community hospitals that you worked at* and were aware of in Spokane and Coeur d'Alene in 2012, what did the standard of care require for localization of the surgical level in a C6-7 ACDF operation on a patient like Mr. Reinert?
> MR. RICCELLI: Objection. Again, it's cumulative.
> THE COURT: Okay, overruled.
> A. The standard of care in the community hospital in this area in Spokane then in 2012 is the same as it is now in 2019. And it is lateral localization of the C spine level, whether it be seeing it directly or by seeing the lowest level that you can see and then counting from that level.

RP at 77-78 (emphasis added). We hereafter refer to this question as the second question.

Artie Reinert's attorney objected to the first and second questions on the basis that the questions were cumulative. Reinert did not object on the ground that the questions wrongly assumed a community practice or hospital standard of care applied. The court

overruled objections to both questions solely on the grounds that Reinert raised the objection of cumulative evidence.

Artie Reinert's counsel next objected after Dr. Allen Heller's counsel asked Dr. Jeffrey Larson:

> Q. Sir, as a *community spinal surgeon*, did the standard of care under the circumstances that existed on October 2, 2012 require Dr. Heller to refer Mr. Reinert out of the *community hospital* to a different level of care?
> A. Can you ask the front part of that question again? It's—
> Q. It was poorly worded. I'll try it again.
> A. Okay.

RP at 80 (emphasis added). We refer to this question as the third question. Defense counsel rephrased the question:

> Q. Given that Deaconess was a *community hospital* and given the challenges presented by the imaging on October 2, 2012, did the standard of care as it applied to Dr. Heller that day require him to refer Mr. Reinert out to an academic center?
> MR. RICCELLI: Object to the form of the question. The foundation as to community hospital is not relevant to standard of care.
> THE COURT: Okay, overruled.

RP at 80 (emphasis added). We refer to this reshaped question as the fourth question. Dr. Larson asked counsel to rephrase the question once more. In a third attempt to please Dr. Larson, Heller's counsel removed the word "community" and asked:

> Did Dr. Heller need to refer Mr. Reinert out to an academic center like Harborview or University of Washington under the circumstances that existed on October 2, 2012?

RP at 80. We refer to this question as the fifth question. Dr. Larson answered, "No, he did not." RP at 80.

An appellant may challenge evidentiary error only on a specific ground forwarded before the trial court. *State v. Kirkman*, 159 Wn.2d 918, 926, 155 P.3d 125 (2007). This rule permits the trial court to have the first opportunity to prevent or cure an alleged error. *State v. Kirkman*, 159 Wn.2d 918, 926 (2007). A trial court may then exclude or strike the challenged testimony. *State v. Kirkman*, 159 Wn.2d at 926.

To repeat, Artie Reinert objected to the first two questions on the sole basis of cumulative testimony. He now raises an alternative basis for reversal, arguing that questions one and two assumed an improper standard of care. Based on *State v. Kirkman*, we agree with Allen Heller that Reinert may not now challenge the testimony on new grounds.

Artie Reinert may be asking this court to ignore his lack of an objection to the first two questions based on the wrong legal standard by arguing that the trial court indicated that the court would overrule any objection based on a community hospital standard of care and that Reinert earlier made a "clear record" of his objection. Amended Br. of Appellants at 30. We disagree. The trial court earlier overruled an objection to Dr. Jeffrey Larson's testimony on the sole basis of cumulativeness. Artie Reinert had not objected before to the testimony of Dr. Larson being based on an irrelevant or erroneous legal standard. Although the two objections may possess some relationship in this unique

setting, the two objections are distinct. In response to Dr. Heller's counsel's first two references to a community hospital when questioning Dr. Larson, Reinert did not afford the trial court any opportunity to determine whether mention of a community hospital or practice was irrelevant on the ground that no community hospital standard of care exists in Washington State.

Artie Reinert may also be arguing that, during the pretrial arguments on his motions in limine, he commented that Dr. Allen Heller's reference to a community hospital perspective was irrelevant to the state standard of care that controlled the malpractice claim. If Reinert in fact forwards this argument, we disagree. Reinert never brought a motion to exclude references to a community hospital or local standard of care.

When Allen Heller's counsel asked the fourth question, Artie Reinert finally objected on the basis that the suggestion of a community hospital standard lacked relevance because it assumed a mistaken standard of care. Dr. Jeffrey Larson, however, did not respond to the fourth question. So Larson presented no testimony based on a community or local standard of care. When Heller's counsel rephrased the question one more time, counsel omitted any mention of a community hospital, a community practice, or a community standard. Reinert's attorney did not object to this fifth question.

Issue 2: Whether testimony of a community or local standard of care conflicted with Washington State's state standard of care?

Answer 2: We do not address this question because Dr. Jeffrey Larson did not testify to a community standard of care.

Artie Reinert complains that Dr. Jeffrey Larson mentioned a community standard of care. In turn, Reinert objects that mention of this standard of care lowers the standard to which Dr. Allen Heller needed to comply. Reinert emphasizes that RCW 7.70.040(2) requires the health care provider to exercise the degree of care expected in the state of Washington. In response, Dr. Heller contends that any mention by Dr. Larson of practicing in the community coincides with the statute's notion that the health care provider must exercise that degree of care expected of a practitioner in the state of Washington "acting in the same or similar circumstances."

We do not address this assignment of error. Dr. Jeffrey Larson declined to answer any question that assumed a local or community practice standard of care. Dr. Larson and other defense experts mentioned the presence of different technology at Deaconess Hospital from teaching hospitals in Seattle, and those witnesses mentioned using the available technology. Nevertheless, no witness testified to a different standard of care in Spokane from Seattle or forwarded an opinion based on a lower standard of care for community practitioners.

Issue 3: Whether testimony about a community standard of care constituted harmless error?

Answer 3: We do not address this question because we find no error.

Cumulative Testimony of Berven and Larson

Issue 4: Did the trial court abuse its discretion by permitting cumulative testimony from Dr. Jeffrey Larson and Dr. Sigurd Berven?

Answer 4: No.

Artie Reinert next argues that the trial court erred by permitting Dr. Jeffrey Larson to provide testimony cumulative to that of Dr. Sigurd Berven. He argues that Dr. Larson's testimony, when read in its entirety, provide no unique perspective or experience when compared with the other experts. Dr. Heller responds that, although Dr. Berven and Dr. Larson presented overlapping testimony, the trial court properly admitted both witnesses' testimony because both held qualifications to testify, the two possessed distinct experiences, and both provided helpful testimony to the jury.

The admissibility of cumulative evidence lies within the trial court's discretion. *Christensen v. Munsen*, 123 Wn.2d 234, 241, 867 P.2d 626 (1994). The trial court generally does not abuse its discretion when excluding cumulative testimony or when allowing cumulative testimony. *Larson v. City of Bellevue*, 188 Wn. App. 857, 883, 355 P.3d 331 (2015), *aff'd sub nom. Spivey v. City of Bellevue*, 187 Wn.2d 716, 389 P.3d 504 (2017), *overruled on other grounds by Clark County v. McManus*, 185 Wn.2d 466, 372 P.3d 764 (2016); *Saldivar v. Momah*, 145 Wn. App. 365, 396, 186 P.3d 1117 (2008). *Carson v. Fine*, 67 Wn. App. 457, 462-63, 836 P.2d 223 (1992), *aff'd in part, rev'd in part*, 123 Wn.2d 206, 867 P.2d 610 (1994). The admission of evidence which is merely

cumulative is not prejudicial error. *State v. Todd*, 78 Wn.2d 362, 372, 474 P.2d 542 (1970); *Carson v. Fine*, 67 Wn. App. 457, 463 (1992).

Dr. Heller relies on *Christensen v. Munsen*, 123 Wn.2d 234 (1994). Plaintiff Maren Christensen argued that the defense violated the trial court's order that only one expert per side could testify as to causation or the standard of care. The trial court had ordered that each party would be limited to "one expert per specialty area, not to exceed two experts per specialty." 123 Wn.2d at 240. Of course the ruling was confusing, because the order first allowed only one expert and then allowed two experts. The court listed the five specialty areas as pars planitis, glaucoma, pharmacology, economics, and rehabilitation. Perhaps the trial court deemed "specialty areas" to mean narrow subject matters and "specialty" to be physician practice specialties.

In *Christensen v. Munsen*, our high court reviewed the context of the trial court's order and determined that the trial court intended to permit one expert to testify to each of five specialty areas in the case. The high court held that multiple experts testifying regarding causation and the standard of care did not violate the court's order, provided they came from the different areas of each specialty. Still the opinion suggests that more than one ophthalmologist testified on behalf of the defense. The Supreme Court noted that sometimes overlapping testimony of experts was inevitable. If *Christensen v. Munsen* helps any party, that party is defendant Allen Heller.

Dr. Jeffrey Larson and Dr. Sigurd Berven testified for Allen Heller on the standard of care of a neurosurgeon. The trial court allowed both to testify because the two physicians brought different experiences to court. The testimony of both overlapped extensively. Nevertheless, the trial court may admit cumulative testimony in its discretion. Any admission did not prejudice Artie Reinert.

Artie Reinert concludes by arguing that Dr. Jerome Barakos also commented on the standard of care adding to the cumulative testimony by Dr. Allen Heller's experts. Before Dr. Barakos' testimony, the trial court ordered his standard of care testimony redacted from his deposition testimony. The testimony inadvertently played at trial. Because Reinert develops his argument related to Dr. Barakos' testimony in subsequent assignments of error, we address whether admission of the standard of care testimony from Barakos prejudiced Reinert within subsequent analysis.

Admissibility of Jerome Barakos Testimony

Artie Reinert challenges the entire testimony of Dr. Jerome Barakos on numerous grounds: that he testified on a subject matter for which he lacked the requisite knowledge, skill, experience, training, education, and foundation; that the testimony was irrelevant; that the testimony was cumulative; that the testimony was more prejudicial than probative; that the testimony could not be reasonably expected to assist the trier of fact to understand the evidence or to determine a fact in issue; that the testimony likely caused

the jury to speculate about an issue not before the jury. We catalogue the challenges into four categories: lack of expertise, relevance, cumulativeness, and ER 403.

Issue 5: Whether Dr. Jerome Barakos held the necessary expertise to provide the opinions he supplied the jury?

Answer 5: Yes.

Artie Reinert argues that the trial court abused its discretion by refusing to exclude all testimony from Dr. Jerome Barakos. Reinert argues that Dr. Barakos, as a neuroradiologist, lacked a surgeon's knowledge or experience of using a C-Arm during an ACDF surgery. Reinert underscores alleged inconsistencies between Dr. Barakos' testimony and that of other experts on appeal. Reinert also contends that Dr. Barakos did not conduct clinical assessments of patients' symptoms and, therefore, he improperly opined on the need for future surgery on the C5-6 level should surgery have been performed on the C6-7 level on October 2. Dr. Allen Heller responds that Dr. Barakos specialized in spinal imaging such that he possessed the qualifications to testify to liability and causation of which spinal imaging played a central role.

A physician with a medical degree will ordinarily be considered qualified to express an opinion with respect to any medical question, including questions in areas in which the physician is not a specialist, so long as the physician has sufficient expertise to demonstrate familiarity with the medical procedure or problem at issue in the action. *Davies v. Holy Family Hospital*, 144 Wn. App. 483, 494, 183 P.3d 283 (2008), *abrogated*

on other grounds by Frausto v. Yakima HMA, LLC, 188 Wn.2d 227, 393 P.3d 776 (2017). The scope of the witness' knowledge rather than his or her professional title governs the threshold question of admissibility of expert medical testimony in a malpractice case. *Hill v. Sacred Heart Medical Center*, 143 Wn. App. 438, 447, 177 P.3d 1152 (2008).

We conclude that Artie Reinert's observations of Dr. Jerome Barakos' practice limitations did not disqualify Dr. Barakos from testifying to those opinions he rendered. Dr. Barakos did not testify that a neurosurgeon violates the standard of care by failing to perform an anterior posterior view of the cervical spine with the C-Arm machine. Instead he testified that, in his experience as a radiologist reviewing the imaging, no neurosurgeon had ordered the AP view. He explained that, because of the lay of the skull over the cervical spine, the imaging from an AP view would result in the cervical region appearing black. Dr. Barakos further explained that an AP view would result in a "parallax effect" that distorted the area that needs to be counted during a cervical discectomy. CP at 237. Finally, Dr. Barakos avowed that neurosurgeons never employed other technologies, such as StealthStation, Brainlab, stereotaxis, and 3-D navigation, during an ACDF. Barakos' experience and training as a radiologist reading images would qualify him to provide testimony as to the types of imaging technologies employed by neurosurgeons.

Artie Reinert contends that Dr. Jerome Barakos' testimony conflicted with that of other experts as Barakos denied that ACDF surgeons ever use AP views in localization efforts. Regarding the use of the AP view during an ACDF surgery, Dr. Barakos testified that, in his experience, he could not "recall a single case in which a front-to back referred to anterior-posterior view was employed." RP at 236.

Dr. Allen Heller testified that he believed he used the AP view during the discectomy performed on Artie Reinert. Nevertheless, he no longer had an independent recollection of every view that he or the radiologist technician procured during surgery. Dr. Heller explained that he would not use the AP view "in attempting to locate a disc. But it's not uncommon to use AP fluoroscopy to identify the midline. So I have taken AP images before during ACDF surgery, but it's more valuable in locating midline." RP at 359. He stated, "I'm certain in that particular case we tried every method possible." RP at 359. He testified that he finds the AP "very unreliable." RP at 359.

Dr. Sigurd Berven stated that he understood from Dr. Allen Heller's testimony that he used AP views. Dr. Berven testified that he had used AP views during ACDF surgeries either to find the midline or a cervical level. Counsel for Artie Reinert inquired as to Dr. Jerome Barakos's testimony, asking:

> Q. *Dr. Barakos testified yesterday by video deposition that he's never seen an ACDF surgeon ever use an A—an AP view on any of his cases.*
> A. *Well, Dr. Barakos isn't a surgeon*. But it's my clear testimony that the most reliable images are going to be the lateral projections, and I

> rely on those most. There can be a lot of reasons that the AP image is off; specifically, you can't actually see the most identifiable landmark (indicating), which is the odontoid process, because the mandible's in the way. So you can't see the top of the spine to count from the top, and trying to count from the bottom can be really difficult. There's all sorts of bones between the first rib and the clavicle that can really make it difficult to count from the bottom. So therefore the lateral is the x-ray that I rely upon most.
>
> Q. Okay. *But my question was about Dr. Barakos, who stated yesterday he doesn't think AP surgeons ever use the AP view. Is he incorrect in that statement as far as your practice is concerned?*
>
> A. *Again, Dr. Barakos is a radiologist. He's not a surgeon*. So what actually happens in the operating room, I think I'd be—I'd be in a position to testify to.

RP at 60-61 (emphasis added).

We disagree that any inconsistencies demonstrate that Dr. Jerome Barakos lacks qualifications to opine on imaging taken during an ACDF procedure. Dr. Barakos particularly possesses the training and experience in reading imaging so he would be an expert on what views allow the best look at the cervical spine. Any denigration of Barakos' expertise by Dr. Sigurd Berven goes to the weight of Barakos' testimony, not its admissibility. Contrary to Reinert's contention, Dr. Barakos did not assert that neurosurgeons never order an AP view. Dr. Barakos testified that he had never noticed an AP view ordered.

Artie Reinert particularly challenges Dr. Jerome Barakos' qualification to testify to the damage to Reinert's spine at the C5-6 level, to speak about any injury caused by surgeries performed by Dr. Allen Heller, and to opine whether Reinert would need

surgery at this level in the future. Nevertheless, Dr. Barakos based his opinion on twenty-five years of experience in reviewing imaging studies and the impact of degenerative changes in the spine. As a radiologist, he works in the only specialty authorized to interpret anatomical images. Barakos reviewed the images of Reinert's spine. He should be able to determine whether damage to a cervical level can increase with additional degeneration.

Issue 6: Whether Dr. Jerome Barakos presented irrelevant testimony?

Answer 6: No.

Artie Reinert characterizes Dr. Jerome Barakos' testimony as irrelevant medical gobbledygook. When parsing the argument, we isolate two instances that Reinert specifically contends Barakos presented irrelevant testimony. First, Barakos testified: "But when you're in the operating room, you don't have this information [degenerative diseases that can be seen on an MRI, but not a fluoroscopy]." CP at 184. Second, Barakos testified that Dr. Allen Heller's surgeries left no physical injury to Artie Reinert's spinal cord.

We deem both snippets of testimony relevant. Dr. Heller defended the suit in part on the difficulty to determine, in the operating room, the targeted level by the use of C-Arm fluoroscopy. Dr. Jerome Barakos' testimony directly related to this defense. Artie Reinert complained about a dura tear caused by Dr. Heller during the second surgery.

Barakos' testimony about his review of the imaging and whether the imaging showed permanent injury responded to Reinert's complaint.

ER 402 declares:

> All relevant evidence is admissible, except as limited by constitutional requirements or as otherwise provided by statute, by these rules, or by other rules or regulations applicable in the courts of this state. Evidence which is not relevant is not admissible.

In turn, ER 401 defines "relevant evidence:"

> "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.

To be relevant evidence must (1) tend to prove or disprove the existence of a fact, and (2) that fact must be of consequence to the outcome of the case. *Davidson v. Municipality of Metropolitan Seattle*, 43 Wn. App. 569, 573, 719 P.2d 569 (1986).

The threshold to admit relevant evidence is low; even minimally relevant evidence is admissible. *Kappelman v. Lutz*, 167 Wn.2d 1, 9, 217 P.3d 286 (2009); *Mutual of Enumclaw Insurance Co. v. Gregg Roofing, Inc.*, 178 Wn. App. 702, 729, 315 P.3d 1143 (2013). Evidence tending to establish a party's theory, or to qualify or disprove the testimony of an adversary, is relevant evidence. *Lamborn v. Phillips Pac. Chemical Co.*, 89 Wn.2d 701, 706, 575 P.2d 215 (1978); *Hayes v. Wieber Enterprises, Inc.*, 105 Wn. App. 611, 617, 20 P.3d 496 (2001). Relevant evidence embraces even facts which offer only circumstantial evidence of any element of a claim or defense. *Davidson v.*

Municipality of Metropolitan Seattle, 43 Wn. App. 569, 573 (1986); 5 KARL B. TEGLAND, WASHINGTON PRACTICE: EVIDENCE LAW AND PRACTICE § 83 (2d ed. 1982).

Issue 7: Whether Dr. Jerome Barakos presented cumulative testimony?

Answer 7: Probably, but the trial court did not err in allowing the testimony.

Dr. Jerome Barakos testified that imaging showed no neurological damage to Artie Reinert's cervical spine after Dr. Allen Heller's three surgeries on Reinert. Artie Reinert complains that this testimony repeated opinions of Dr. Allan Hamilton and Dr. Allen Heller. We agree that Dr. Barakos' testimony repeated testimony of Allan Hamilton and Allen Heller, but we note that Barakos' testimony provided more insight into the conclusion of no harm. Barakos, the only testifying neuroradiologist, stated, unlike other witnesses, that the imaging confirmed an absence of damage. This variance alone leads us to conclude the trial court did not abuse its discretion when permitting the testimony of Jerome Barakos.

Issue 8: Whether the trial court should have excluded testimony of Dr. Jerome Barakos under ER 403?

Answer 8: No. The trial court did not abuse its discretion in allowing admissibility of Dr. Barakos' testimony.

Finally, Artie Reinert raises the catch-all evidence rule, ER 403, to assert that the trial court erred in allowing testimony from Dr. Jerome Barakos. ER 403 reads:

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

ER 403 allows relevant evidence to be excluded when the danger of unfair prejudice substantially outweighs its probative value. *State v. Barry*, 184 Wn. App. 790, 801, 339 P.3d 200 (2014). Trial courts have considerable discretion to consider the relevancy of evidence and to balance the probative value of the evidence against its possible prejudicial impact. *State v. Rice*, 48 Wn. App. 7, 11, 737 P.2d 726 (1987). A decision to admit or exclude evidence is reviewed for an abuse of discretion. *City of Kennewick v. Day*, 142 Wn.2d 1, 5, 11 P.3d 304 (2000). Because of the trial court's considerable discretion in administering ER 403, reversible error is found only in the exceptional circumstance of a manifest abuse of discretion. *State v. Gould*, 58 Wn. App. 175, 180, 791 P.2d 569 (1990). For the same reasons that we conclude that the testimony of Dr. Jerome Barakas did not violate any other evidence rule, we rule that the trial court did not abuse its discretion when denying Artie Reinert's motion to exclude testimony under ER 403.

Attorney Misconduct

Artie Reinert next complains of misconduct by Dr. Allen Heller's counsel when counsel failed to assure the redaction of prejudicial testimony subject to the trial court's orders in limine from Dr. Jerome Barakos' preservation deposition video prior to being

presented to the jury. The trial court ordered the redaction of testimony of Dr. Barakos that literature showed that fifty percent of surgeons have conducted a wrong level surgery and that Dr. Heller complied with the standard of care. Contrary to the court's order in limine, Dr. Heller played those portions of Dr. Barakos' deposition to the jury. Artie Reinert also contends that defense counsel, when questioning witnesses, repeatedly misstated the law on the physician standard of care by reference to a community or community hospital standard of care. In addressing these assignments of error, we must first determine if Reinert properly preserved an appellate challenge.

Issue 9: Whether this court should review Artie Reinert's assignment of error with regard to the failure to redact testimony that fifty percent of surgeons have conducted a wrong level surgery when Reinert did not object at the time of the playing of the deposition?

Answer 9: No, at least because Reinert did not object within a reasonable time or seek a remedy due to the violation.

Dr. Allen Heller contends that Artie Reinert failed to preserve error as to the playing of testimony about other neurosurgeons performing surgery at the wrong spinal level. At the time of the playing of this testimony, Reinert did not object or mention that the testimony violated the order in limine. Reinert responds that he did not need to object to preserve his challenge to evidence offered in violation of an order in limine.

Artie Reinert advances *State v. Brooks*, 20 Wn. App. 52, 59-60, 579 P.2d 961 (1978) for the rule that erroneous evidence offered in violation of an order in limine does not require an objection to preserve the issue on appeal. He further argues that, had objections and a request for curative orders been made, the objections would have further highlighted the erroneous testimony before the jury. *State v. Smith*, 189 Wash. 422, 65 P.2d 1075 (1937), in addition to *State v. Brooks*, supports this rule.

The Washington Supreme Court also addressed this question in *Fenimore v. Donald M. Drake Consruction Co.*, 87 Wn.2d 85, 549 P.2d 483 (1976). The plaintiff assigned error to the admission of the evidence that he had sought to exclude during a pretrial motion in limine. The trial court denied the pretrial motion on the basis that it needed to hear some of the evidence before making a ruling, but the court advised the plaintiff to object as the evidence was offered, at which time the court would be in a proper position to rule upon its admissibility. Later when the defense offered the evidence, plaintiff did not object. On appeal, the plaintiff argued he need not have objected at the time of the admission of the evidence to raise the issue on appeal because of his pretrial motion in limine. The Supreme Court disagreed because the trial court had directed plaintiff to object again during trial. In dicta, the court noted that, had the trial court granted the pretrial motion, the plaintiff need not have objected at the time of the admission of the evidence because, under the rule of *State v. Smith*, 189 Wash. 422

(1937), no objection was needed to preserve the right to claim error if the evidence was nevertheless admitted.

Since *Fenimore v. Donald M. Drake Consruction Co.*, this court has twice ruled contrary to *State v. Smith*. *A.C. ex rel. Cooper v. Bellingham School District*, 125 Wn. App. 511, 105 P.3d 400 (2004); *State v. Sullivan*, 69 Wn. App. 167, 847 P.2d 953 (1993). The court, in *A.C. ex rel. Cooper v. Bellingham School District*, merely followed the ruling and reasoning in *State v. Sullivan* without deep analysis.

In *State v. Sullivan*, James Sullivan argued on appeal that the prosecutor elicited evidence placing him in a high risk category of sexual offenders in violation of an order in limine. This court ruled that, even if the prosecuting attorney violated the order in limine, Sullivan had failed to preserve the violation for appeal. The court noted the general rule that a litigant cannot remain silent as to a claimed error during trial and later urge error on appeal. Nevertheless, when the litigant advanced the issue below, giving the trial court an opportunity to rule on relevant authority, and the court so rules, the litigant may not need to object at the time of admission of the claimed erroneous evidence in order to preserve the issue for appeal. A motion in limine presents an opportunity for the trial to rule on admissibility of evidence. If the trial court denies the motion in limine, the party losing the motion has a standing objection. After reviewing Washington case law, the court concluded that only the party who lost the motion to exclude evidence merits the standing objection. Sullivan received a favorable ruling and

the State arguably violated it. Unlike when the trial court denies the motion in limine, the issue is not whether the order in limine was proper in the first instance. The issue becomes whether the State violated the order in limine, and if so, what remedy to impose. The trial court deserves the opportunity to determine if the opposing party violated the order, if any violation caused prejudice, and the steps to take to rectify the harm. Otherwise, the complaining party could simply do nothing, gamble on the verdict, and then seek a new trial on appeal. Since James Sullivan failed to notify the trial court of any claimed violation, he failed to preserve error for appeal.

This court, in *State v. Sullivan,* noted the Supreme Court's pronouncement, in *Fenimore v. Donald M. Drake Construction Co.*, 87 Wn.2d 85, 92 (1976), that, when the trial court grants the appellant's motion to exclude evidence, no objection is necessary to preserve the right to claim error if the evidence was nevertheless admitted. The *Sullivan* court also observed that the *Fenimore* court cited *State v. Smith*, 189 Wash. 422 (1937), for its pronouncement. Nevertheless, the court, in *State v. Sullivan*, wrote that the *Fenimore* pronouncement was dictum, since the trial court did not grant but denied the motion in limine and advised the appellant to object as the evidence was offered.

This court, in *State v. Sullivan*, also discussed *State v. Smith*. In *Smith*, the defendant, a former deserter from the United States Marine Corps, was charged with two counts of assault that allegedly occurred while he was employed by management as a private guard during a tense labor-management dispute. The trial court, in response to

the defendant's pretrial motion to exclude any reference to the desertion, ordered that the State first seek the trial court's permission before injecting, on cross-examination, the manner in which the defendant left the Marine Corps. The State ignored the court ruling, and the defense failed to object to the evidence. The trial court denied the defendant's motion for a new trial because no objection was made to the evidence when offered. The Supreme Court reversed the trial court. The Supreme Court ruled that the absence of an objection did not control, because an objection, even if sustained, would cause more damage than almost any answer. In view of the State's deliberate disregard of the court's ruling, the Supreme Court ruled that prejudice must be presumed and a new trial should have been given.

This court, in *State v. Sullivan*, distinguished *State v. Smith*. James Sullivan failed to demonstrate that the State deliberately disregarded the trial court's ruling or that an objection by itself would be so damaging as to be immune from any admonition or curative instruction by the trial court. This court held that, in the absence of any unusual circumstance that makes it impossible to avoid the prejudicial impact of evidence that had previously been ruled inadmissible, the complaining party at the time must make a proper objection in order to preserve the issue for appeal.

We agree with this court's reasoning, in *State v. Sullivan*, that a party who wins a motion in limine should immediately notify the trial court of a claimed violation of an order in limine. Nevertheless, we question whether the *Sullivan* court possessed the

prerogative to ignore the ruling in *State v. Smith* despite the circumstances in each decision being disparate. *State v. Gore*, 101 Wn.2d 481, 681 P.2d 227 (1984). Regardless, we conclude that the party claiming the violation of an order in limine must within a reasonable time, during trial, notify the trial court of the alleged breach and seek a remedy before asking for a new trial for the first time on appeal. The complaining party must also show some prejudice. As to the testimony about other neurosurgeons performing surgery at the wrong spinal level, Reinert never sought a remedy or claimed prejudice during the trial court proceedings.

Issue 10: Whether this court should grant Artie Reinert a new trial because of defense counsel's failure to redact Dr. Jerome Barakos' testimony on the standard of care?

Answer 10: No.

Artie Reinert timely objected to Dr. Jerome Barakos' deposition testimony as to the standard of care. The trial court then stopped the video and issued an instruction to the jury to disregard the question and answer.

Artie Reinert argues on appeal that, although not an intentional act, this court should determine that the playing of the testimony amounted to constructive misconduct. Reinert contends that, in this current digital age, trial attorneys should be held accountable for making redactions required by the trial court before playing video testimony before a jury.

A new trial may be granted based on the prejudicial misconduct of counsel if the movant establishes that the conduct complained of constitutes misconduct and not mere aggressive advocacy and that the misconduct is prejudicial in the context of the entire record. *Aluminum Co. of America v. Aetna Casualty & Surety Co.*, 140 Wn.2d 517, 537, 998 P.2d 856 (2000). The movant must have properly objected to the misconduct, and the misconduct must not have been cured by court instructions. *Aluminum Co. of America v. Aetna Casualty & Surety Co.*, 140 Wn.2d 517, 539 (2000). A jury is presumed to follow the court's instructions. *State v. Hepton*, 113 Wn. App. 673, 685, 54 P.3d 233 (2002). A mistrial should be granted only when nothing the trial court could have said or done would have remedied the harm done to the defendant. *Aluminum Co. of America v. Aetna Casualty & Surety Co.*, 140 Wn.2d at 539. Attorney misconduct includes an attorney's attempts to violate the rules of evidence by placing inadmissible or irrelevant evidence before the jury. *Teter v. Deck*, 174 Wn.2d 207, 223-24, 274 P.3d 336 (2012).

Artie Reinert acknowledges that the alleged misconduct was unintentional. Reinert provides no citation to legal authority that this court should determine that the conduct of counsel amounts to "constructive misconduct."

Dr. Allen Heller argues that, rather than attorney misconduct, the issue before this court is an unintended trial irregularity. *See e.g.*, *State v. Young*, 129 Wn. App. 468, 472-73, 119 P.3d 870 (2005). Under this standard, this court examines the following:

> (1) the seriousness of the irregularity; (2) whether it involved cumulative evidence; and (3) whether the trial court properly instructed the jury to disregard it.

State v. Young, 129 Wn. App. at 473. Absent an objection to counsel's remarks, the issue of misconduct cannot be raised for the first time in a motion for a new trial unless the misconduct is so flagrant that no instruction could have cured the prejudicial effect. *A.C. ex rel. Cooper v. Bellingham School District*, 125 Wn. App. 511, 524 n.37, 105 P.3d 400 (2004).

Dr. Allen Heller cites to *State v. Jones*, 144 Wn. App. 284, 183 P.3d 307 (2008), in which this court held that the inadvertent playing of a body wire recording did not constitute prosecutorial misconduct. This court reasoned that the prosecutor did not commit the conduct in flagrant disregard of the trial court's ruling. We follow the ruling in *State v. Jones*. We also emphasize that Artie Reinert waited until the appeal to seek a new trial.

We deem the violation by counsel serious, but note that the offending testimony was cumulative. Dr. Jeffrey Larson testified that a wrong level surgery did not constitute a violation of the standard of care. Dr. Sigurd Berven also opined that a complication during surgery does not constitute a violation of the standard of care as one could not guarantee a surgical outcome.

Artie Reinert complains about the strength and sternness of the trial court's curative instruction. Nevertheless, he posed no alternative instruction during trial. Regardless, the trial court instructed the jury to ignore the testimony.

Despite our ruling, we express dismay at the playing of videotape testimony ruled inadmissible by the trial court. The trial court ordered only a few excerpts redacted. We know of no excuse for the videotape company to have failed to properly follow the trial court's direction. We know of no excuse as to why defense counsel should not have reviewed the videotape to confirm that the ordered excisions occurred.

Issue 11: Whether this court should grant Artie Reinert a new trial because defense counsel referenced a community hospital standard during questioning of witnesses?

Answer 11: No.

Next Artie Reinert argues that Dr. Allen Heller's counsel knew that a "community hospital" standard of care conflicts with the standard of care outlined in RCW 7.70.040. Reinert argues that counsel repeatedly misstated the law by referencing this standard and such references should also be considered constructive misconduct.

Artie Reinert objected once to Dr. Allen Heller's counsel's reference to the community on the basis that a community hospital was not relevant to the standard of care. The trial court overruled the objection. Dr. Jeffrey Larson then requested that counsel rephrase. The final question ultimately posed removed all reference to a

community hospital. Thus we reject Reinert's contention that counsel's reference to community in this instance amounted to prejudicial misconduct.

Cumulative Error

Issue 12: Whether this court should grant Artie Reinert a new trial because of cumulative error?

Answer 12: No.

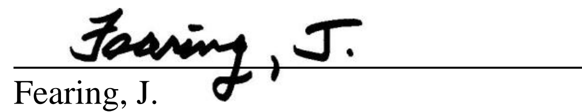
Artie Reinert contends that the cumulative effect of his asserted grounds for reversal warrant the granting of a new trial. The cumulative error doctrine applies when a combination of trial errors denies the accused a fair trial, even when any one of the errors, taken individually, would be harmless. *In re Personal Restraint of Cross*, 180 Wn.2d 664, 690, 327 P.3d 660 (2014)*, abrogated on other grounds by State v. Gregory*, 192 Wn.2d 1, 427 P.3d 621 (2018). The doctrine does not apply when the errors are few and have little or no effect on the outcome of the trial. *State v. Weber*, 159 Wn.2d 252, 279, 149 P.3d 646 (2006). In *Rookstool v. Eaton*, 12 Wn. App. 2d 301, 311, 457 P.3d 1144 (2020), this court held that civil litigants should be ensured a fair trial and, therefore, the cumulative error doctrine applies to civil cases as well as criminal cases.

The playing of Dr. Barakos' testimony on the standard of care was error. Nevertheless, this error, as discussed above, did not impact the outcome on the jury's verdict. Artie Reinert's other alleged errors do not constitute grounds for reversal.

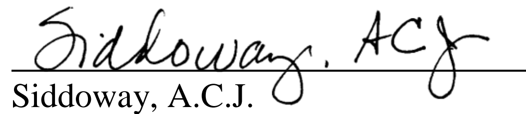
CONCLUSION

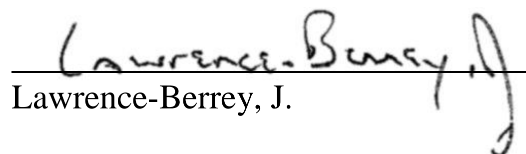
We affirm the jury's verdict and the trial court's judgment in favor of the defense.

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


Fearing, J.

WE CONCUR:


Siddoway, A.C.J.


Lawrence-Berrey, J.

FILED
NOVEMBER 10, 2021
In the Office of the Clerk of Court
WA State Court of Appeals Division III

IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON
DIVISION THREE

ARTIE LEN REINERT, JR AND CONSUELA LEE REINERT, Appellant, v. ALLEN C. HELLER, M.D. and STEPHANIE A. HELLER, husband and wife, and the martial community composed thereof; ROCKWOOD CLINIC, P.S.; ROCKWOOD NEUROSURGERY AND SPINE CENTER; DEACONESS HOSPITAL; and SPOKANE WASHINGTON HOSPITAL COMPANY, LLC, and DOES 1-10, Respondents.	No. 37081-0-III ORDER DENYING APPELLANTS AMENDED MOTION FOR RECONSIDERATION

THE COURT has considered appellant's amended motion for reconsideration, and is of the opinion the amended motion should be denied. Therefore,

IT IS ORDERED the amended motion for reconsideration of this court's opinion of September 14, 2021, is denied.

PANEL: Judges Fearing, Siddoway, Lawrence-Berrey

FOR THE COURT:

REBECCA L. PENNELL
Chief Judge

Appendix C

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SUPERIOR COURT OF WASHINGTON FOR SPOKANE COUNTY

7 ARTIE LEN REINERT, JR AND CONSUELA LEE REINERT, Plaintiffs/Appellants, vs. ALLEN C. HELLER, M.D. and STEPHANIE A. HELLER, husband and wife, and the martial community composed thereof; ROCKWOOD CLINIC, P.S.; ROCKWOOD NEUROSURGERY AND SPINE CENTER; and DOES 1 - 10, Defendants/Respondents.	No. 16203847-1 Division III Appeal No. 370810 STIPULATION, MOTION, AND ORDER TO SUPPLEMENT TRIAL RECORD

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17 **STIPULATION**

18 The parties, by and through the undersigned attorneys, hereby agree and stipulate as
19 follows regarding the video preservation testimony of Jerome Barakos, M.D., which was heard by
20 the jury at trial.

21 A. Plaintiffs Reinert (Reinert) objected to the entirety of the presentation of testimony
22 by Dr. Barakos at trial, pursuant to plaintiffs' Motions in Limine, paragraph K, filed June 5, 2019.

23 B. On June 13, 2019, the trial court heard argument on the parties' motions in limine,
24 made rulings thereon, but reserved the issue of Dr. Barakos' testimony at trial, to be considered in

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the context of the presentation of Plaintiffs' case.

C. On June 17, 2019, Defense Attorney Sestero filed "Defendants Designation of Testimony by Jerome Barakos, M.D." In this filing, the defendants listed the redactions proposed to be made to the video preservation testimony of Dr. Barakos by referencing the transcription of that testimony, by page and line number. The transcript of Dr. Barakos' complete video preservation deposition is attached as Exhibit A.

D. On June 20, 2019, outside the presence of the jury, the court and the parties revisited the issue of Dr. Barakos' testimony. Plaintiffs' Attorney Riccelli provided a marked (highlighted) copy of Dr. Barakos' preservation testimony transcript to defense attorney Sestero and the court. Without waiver of objection to Dr. Barakos' entire testimony, attorney Riccelli had: marked in light orange highlighting that testimony of Dr. Barakos which Plaintiffs objected to; and marked in blue highlighting that testimony of Dr. Barakos which he understood defendants proposed to redact or were amenable to redaction of. Included in the blue highlighting was standard of care testimony attorney Riccelli understood attorney Sestero was amenable to redaction of. The transcript of this June 20, 2019 colloquy is attached hereto as Exhibit B.

E. Although the highlighted transcript version provided the trial court and attorney Sestero by attorney Riccelli was apparently not filed in this matter, Exhibit B clearly demonstrates that it was substantively discussed and was subject to consideration by the court and attorney Sestero prior to any ruling on submission of testimony of Dr. Barakos to the jury.

F. The orange highlighting made to a copy of Exhibit A by attorney Riccelli was that testimony of Dr. Barakos which Plaintiffs objected to, and which was presented to the trial court and attorney Sestero on June 20, 2019, is represented by the following references to Exhibit A:

///

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PAGE	LINES	PAGE	LINES	PAGE	LINES
7	7-15	37	1-25	63	19-25
16	19-25	38	1-20	64	1-25
17	1-25	39	4-25	65	1-24
18	1-2	40	1-10	66	2-7
20	20-25	40	16-25	66	17-22
21	1-7	41	1-25	67	2-20
21	22-25	42	1-24	67	21*
22	1-6	43	19-25	68	7-25
23	11-25	44	1-4	69	1-25
24	1-25	47	19-25	70	1-25
26	1-25	48	1-19	71	1-25
27	1-25	48	24-25	73	5-25
28	1-25	49	1-14	74	1-25
29	1-25	50	18-21	75	1-25
30	1-25	51	5-19	76	1-21
31	1-9	51	25**	76	24-25
31	15-25	52	21-23	77	1-25
32	1-24	56	12-25	78	1-22
32	25*	57	1-24	79	4
33	1-25	59	18-25	79	9-16
34	1-3*	60	1-25	79	21-23
34	3-23	61	1-25	85	7-25
35	15-25	62	1-20	86	1-4
36	1-25				

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* Indicates included lines or line portions of un-highlighted sentence fragments, etc., that are presumed intended to have been highlighted due to contiguous highlighting.

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** Indicates included lines or line portions of highlighted sentence fragments, etc., that are presumed intended to have been un-highlighted due to contiguous lack of highlighting.

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G. The blue highlighting made to a copy of Exhibit A by attorney Riccelli, which was

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that testimony of Dr. Barakos which he understood defendants proposed to redact or were amenable to redaction of, and which was presented to the trial court and attorney Sestero on June 20, 2019 is represented by the following references to Exhibit A:

PAGE	LINES	PAGE	LINES	PAGE	LINES
6	10-17	52	24-25	67	22-25
16	10-14	53	1-3	68	1-6
18	22-25	53	22-25	72	1-25
19	1-13	54	1-25	73	1-4
31	10-14	55	1-3	76	22-23
38	21-25	56	4-11	78	23-25
39	1-3	57	25	79	1-3
40	11-15	58	1-4	79	5-8
42	25	58	8-9	79	24-25
43	1-6	62	21-25	80	1
48	20-23	63	1-18	81	12-23
50	22-25	65	25	82	1-4
51	1-4	66	1	86	5-25
51	20-24	66	23-25	88	12-25
52	6	67	1		

H. Subsequent to the above referenced colloquy, the trial court ruled to allow the proposed redactions of the defense's June 17, 2019 filing, subject to any specific additional redactions (audio/video edits) ordered by the court.

I. At trial, the defense utilized a professional audio/video/technology consulting service to present evidence allowed by the court to be seen and heard by the jury by way of the court's large screen video monitor. Defense attorney Sestero tasked this service to edit (redact) the video preservation testimony of Dr. Barakos purportedly consistent with the trial court's

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rulings thereon.

J. Dr. Barakos' edited video preservation deposition testimony was heard by the jury on June 24, 2019. The actual testimony played to the jury is represented by the entirety of the testimony found in Exhibit A, with redactions/edits made to the video as represented by the Gray highlighting on that Exhibit A, and the corresponding following references to Exhibit A:

PAGE	LINES	PAGE	LINES	PAGE	LINES
5	4-25	52	24-25	67	22-25
6	1-7	53	1-3	68	1-7
18	22-25	53	22-25	72	1-25
19	1-13	54	1-3	73	1-4
31	10-14	54	10-25*	76	22-23
38	21-25	55	1-19	78	23-25
39	1-3	56	4-11	79	1-3
40	11-15	57	25	79	5-8
42	25	58	1-5	79	24-25
43	1-25	58	8-9	80	1
44	1-6	62	21-25	81	12-23
48	20-23	63	1-18	82	1-4
50	22-25	65	25	86	5-25
51	1-4	66	1	88	12-25
51	20-24	66	23-25		
52	6	67	1		

*Not redacted/edited - video stopped at approximately Line 10. Video resumed at Page 55, line20.

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J. The purpose of this stipulation is to supplement the court's file in this matter in order to document: (a) the highlighted transcript discussed above in court on June 20, 2019; and (b) the video preservation deposition testimony of Dr. Barakos actually heard by the jury at trial on June 24, 2019. This stipulation does not serve as any waiver of any party's rights or remedies.

MOTION

WHEREFORE, the parties, by and through the undersigned counsel, hereby move the court to order that: 1) the above-referenced redactions described in paragraphs "F" and "G" above accurately represent the orange and blue highlighting of the marked transcript presented and utilized in the June 20, 2019 hearing; the video preservation deposition testimony of Dr. Barakos seen and heard by the jury on June 24, 2019, is the complete testimony found in Exhibit A, less the redactions/edits as highlighted in gray thereon, and as correspondingly described in paragraph "J" above; and that this stipulation and order and its exhibits shall be subject to designation as a part of the clerks papers/ trial record on review by either party.

DATED June 10, 2020, at Spokane, Washington.

MICHAEL J. RICCELLI, P.S.

By: [signature]
Michael J. Riccelli, WSBA #7492
Attorney for Plaintiffs/Appellants

EVANS, CRAVEN & LACKIE, P.S.

By: [signature]
Christopher J. Kerley, WSBA # 16489
Attorney for Defendants/Respondents

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1 **ORDER**

2 This matter came before the above-entitled court on stipulation of the parties. Upon review
3 of the court's trial notes and the records and files herein, and in consideration of the foregoing
4 stipulation and motion, the Court ORDERS AS FOLLOWS:

5 1. The above-referenced redactions described in paragraphs "F" and "G" contained in
6 the stipulation above accurately represent the orange and blue highlighting of the marked transcript
7 of Dr. Barakos' video preservation deposition upon which his video trial testimony was based, and
8 which was presented and utilized in the June 20, 2019 hearing;

9 2. The video preservation deposition testimony of Dr. Barakos actually heard by the
10 jury at trial on June 24, 2019, is the complete testimony found in Exhibit A, less the redactions/edits
11 as highlighted in gray thereon, and as correspondingly described in paragraph "J" above; and

12 3. This stipulation and order and its exhibits shall be subject to designation as a part
13 of the clerk's papers/trial record on review by either party.

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15 Dated June ______, 2020

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17 ______________________________
JUDGE MARYANN C. MORENO

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19 Presented by:

20 MICHAEL J. RICCELLI PS

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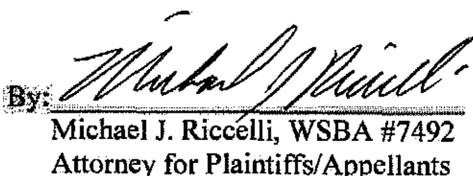
22 
By: ______________________________

23 Michael J. Riccelli, WSBA #7492
Attorney for Plaintiffs/Appellants

Notice of Presentment Waived:

EVANS, CRAVEN & LACKIE

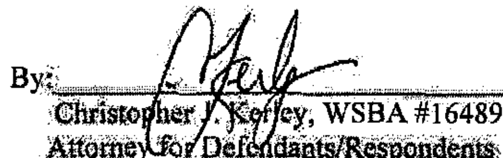

By: ______________________________
Christopher J. Kerley, WSBA #16489
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EXHIBIT A

VIDEO DEPOSITION TRIAL TESTIMONY OF JEROME BARAKOS, M.D.

(Testimony Highlighted in Gray was Not Heard by the Jury)

1 SAN FRANCISCO, CALIFORNIA
2 WEDNESDAY, JUNE 5, 2019, 5:56 P.M.
3
4 PROCEEDINGS
5 THE VIDEOGRAPHER: Good evening. We are on the
6 record. This is the recorded preservation trial
7 testimony of Jerome Barakos M.D., in the matter of Artie
8 Len Reinert, Jr., et al, versus Allen Heller, M.D., et
9 al, in the Superior Court of the State of Washington in
10 and for the County of Spokane. The case number is
11 16-2-03847-1, taken on behalf of defendant. We are
12 located at U.S. Legal Support, 44 Montgomery Street,
13 Suite 550, San Francisco, California, on June 5th, 2019.
14 The time is 5:56.
15 My name is Dan DeFrank. I'm the videographer
16 with U.S. Legal Support located at 44 Montgomery Street,
17 Suite 550, San Francisco, California.
18 Video and audio recording will be taking place
19 unless all counsel have agreed to go off the record.
20 Would all present please introduce themselves,
21 beginning with the questioning attorney.
22 MR. SESTERO: Rob Sestero on behalf of the
23 defendants.
24 MR. RICCELLI: Michael Riccelli on behalf of
25 plaintiffs.

1 THE VIDEOGRAPHER: The certified court reporter
2 today is Mark Banta. Would you please wear in the
3 Doctor.
4 JEROME BARAKOS, M.D.
5 Having stated that he would testify the truth,
6 the whole truth, and nothing but the truth, testified as
7 follows:
8 EXAMINATION
9 BY MR. SESTERO:
10 Q. Doctor, for our record, would you please state
11 your full name and spell your last name.
12 A. Yes, sir. My name is Jerome Barakos, spelled B
13 as in boy, A-R-A-K-O-S.
14 Q. What is an address that we can associate with
15 you?
16 A. Yes. 1101 Van Ness Avenue, here in
17 San Francisco.
18 Q. What is your occupation, sir?
19 A. I'm a physician.
20 Q. Do you specialize in any field of medicine?
21 A. Yes, sir, I do.
22 Q. What is that area of medicine?
23 A. I'm specialized in the field of radiology.
24 Q. And we'll get into your education, training and
25 experience in just a moment.

1 In this matter, were you retained by my law firm
2 to serve as an expert witness?
3 A. Yes, sir.
4 Q. Do you charge for your time spent in review of
5 materials and testimony?
6 A. Yes, sir. I charge for time spent.
7 Q. In terms of the issues in this case, can you
8 generally explain what issues you were asked to address?
9 A. Yes, sir. Very similar to what I'm performing,
10 the function I'm performing on a daily basis in my
11 office. Basically review imaging studies and ascertain
12 what they demonstrate in regards to the clinical context
13 in which they're obtained. So basically I'm doing the
14 same thing I would perform in the office, but I'm doing
15 it here on a forensic matter.
16 Q. Would you please tell the ladies and gentlemen
17 of the jury your educational background, starting with
18 where you attended your undergraduate studies.
19 A. Yes, sir. So I completed my undergraduate
20 studies at the University of California, San Diego. That
21 was completed in 1982. At that point I then attended
22 medical school, University of Southern California, and
23 completed that with an M.D. degree in 1986.
24 Following earning the M.D. degree, I did one
25 year of medical internship at the University of

1 California, San Francisco, and that was from '86 to '87.
2 At that point you take some tests and you're a
3 licensed physician and surgeon of the State of
4 California, but you haven't specialized. And in the
5 U.S., we have 24 different subspecialties of medicine. I
6 selected the field of radiology and then performed a
7 four-year radiology residency which I completed in 1990.
8 At that point you take some tests and you're a
9 certified radiologist. However, even in the field of
10 radiology, we have 14 subspecialties, and so I selected
11 the subspecialty of neuroradiology, and thus performed an
12 additional two-year neuroradiology fellowship at the
13 University of California, San Francisco, completing that
14 training in 1992.
15 Q. Thank you. Now, the ladies and gentlemen of the
16 jury may have already heard what a residency is, but if
17 they have not by this point, can you explain what's
18 involved in a radiology residency?
19 A. Yes, sir. The residency is the training
20 performed after the internship. So you go through
21 medical school, get your M.D. degree, then you do an
22 internship, either a medical or surgical internship.
23 At that point you select which of those 20
24 field -- 24 fields of medicine you're going into. And
25 the residency is the training for one of those 24 fields.

1 So it may be neurology, it may be some form of surgery or
2 pediatrics. So it is the specific time during which a
3 physician trains for a subspecialty in the field of
4 medicine.
5 Q. Can you explain what neuroradiology is?
6 A. So as most people know, radiology consists of
7 the physician who interprets the medical imaging. So in
8 other words, when the clinician caring for us is unable
9 to make a diagnosis, they're able to order an imaging
10 study that allows us to look inside the body to help them
11 make a diagnosis. So the radiologist is the physician
12 who interprets those imaging studies to work with the
13 clinician to try and figure out what is going on with the
14 patient.
15 So the field of radiology is the physician who
16 interprets imaging studies from anywhere throughout the
17 body. It could be the abdomen, an ultrasound for the
18 gallbladder, an obstetrical sonogram, many tests that we
19 may have had, a chest X-ray. Whereas the field of
20 neuroradiology is specifically designated to evaluate
21 disorders and imaging of the brain and spine. So a
22 neuroradiologist is the physician who interprets the
23 medical imaging referable to any sorts of disorders of
24 the brain and spine.
25 Q. Now, the ladies and gentlemen of the jury have

1 heard about board certification. Have you obtained board
2 certification in any medical field?
3 A. Yes, sir, I have.
4 Q. In what area are you board certified?
5 A. So I'm board certified in my specialty, the
6 field of radiology.
7 Q. In terms of your attendance in trial on
8 videotape, why is it that you're not in Spokane?
9 A. Yes, sir. Unfortunately, I have a long-planned
10 family vacation which I will be away during the time of
11 trial.
12 Q. In terms of your medical practice, after the
13 conclusion of the fellowship in 1992, can you give us a
14 brief outline of where you have practiced as a
15 neuroradiologist and when?
16 A. Yes, sir. So once completing my training, time
17 to find a job. That was back in 1992. That so happened
18 that the Sutter hospital system of Northern California
19 was looking for a director of neuroimaging, and I was
20 fortunate to obtain that position and have held that
21 position ever since 1992.
22 Q. Now, can you explain to the ladies and gentlemen
23 in Spokane kind of the size and scope of the Sutter
24 system?
25 A. Yes, sir. So the Sutter system of Northern

1 California is a complex of 32 hospitals in the California
2 and Bay region that comprises one of the largest teaching
3 private medical centers anywhere in the country.
4 Out of the 32 hospitals, I'm tasked with
5 directing the neuroradiology imaging services for a
6 central subgroup of five hospitals which is a tertiary
7 and quaternary referral center. We have more than 5,000
8 physicians in the entire enterprise, and in our direct
9 group we have over 80 surgeons and orthopedists. And so
10 my role as the director of neuroimaging is to ensure that
11 we are providing high-quality neuroimaging services for
12 all our physicians and patients in the local as well as
13 the outlying hospitals.
14 Q. You just used a few terms I'd like you to
15 define. Tertiary and quatenary?
16 A. Quaternary. Yes, that refers to a lot of
17 complex cases, so a lot of the more complex cases that
18 will be referred from our outlying hospitals will come to
19 these major medical centers in the immediate Bay Area.
20 So although we do a wide variety of just routine
21 orthopedic and spinal work, we also perform many of the
22 more complex procedures as well.
23 Q. From 1992 up until the time of Mr. Reinert's
24 surgery in October of 2012, how frequently were you
25 called upon to interpret cervical MRI studies?

1 A. Essentially on a daily basis. So in other
2 words, on a routine basis would evaluate anywhere from,
3 let's say, maybe five or more of those exams every single
4 day.
5 Q. Similar question: Between 1992 and October of
6 2012, with what frequency did you interpret cervical
7 plain film X-rays?
8 A. With the same frequency. Probably anywhere
9 between five or ten a day. So over a career spanning
10 more than 25 years, literally thousands of MRIs of the
11 cervical spine and even more than that, probably tens of
12 thousands of radiographs of the cervical spine.
13 Q. Now, the jury's already heard the word
14 "fluoroscopy," but from a neuroradiology standpoint, can
15 you define the term?
16 A. Yes, sir. In brief, fluoroscopy is the use of
17 X-rays to obtain almost a movie-like picture in realtime.
18 So in other words, we're familiar with X-rays that are
19 taken where the body part, let's say the hand or the
20 cervical spine, stands still, you expose the radiation
21 through the patient and you get an image on the film. So
22 that would be using radiation to generate an X-ray.
23 Fluoroscopy is using that same radiation but a
24 much lower level so you can get a realtime view of the
25 physical anatomy.

1 So in summary, again, an X-ray, you take one
2 exposure so it's a picture where you get one picture of
3 the anatomy where the radiation is transmitted through.
4 Where with a fluoroscopy, you are actually doing really a
5 movie where you're running the radiation continuously,
6 and so in realtime you can see the anatomy.
7 So fluoroscopy is used for purposes of
8 localization. So if we want to see something in realtime
9 where our surgical instrument may be relative to anatomy,
10 you could run this continuous fluoroscopy so you can see
11 in realtime where your instrument is located.
12 Q. Between 1992 and October 2012, what was the
13 nature of your exposure and experience with
14 intraoperative fluoroscopy studies?
15 A. Yes, sir. So in that regard, the department of
16 radiology is charged with providing and ensuring that
17 surgeons who would be using fluoroscopy have that service
18 available to them. So in other words, since it's a
19 radiology tool, our department serves to provide that
20 service to anybody who may need it in the operating room.
21 So in summary, our department under my guidance is
22 providing these services of fluoroscopy for any surgeon
23 who may want to use that service intraoperatively.
24 Additionally, you have to realize that as a
25 radiologist, we're interpreting films. We actually don't

1 generate the images ourselves. There are radiology
2 technologists who actually generate those images, whether
3 it's an X-ray, an MRI, or fluoroscopy. So our department
4 is also tasked with providing the technologists who go
5 into the operating room to provide those services for the
6 surgeon. So we're responsible for training and
7 accrediting those technologists to ensure that those
8 services are available to the surgeons.
9 Once the surgeons use those services and obtain
10 imaging, well, then the radiologist is the individual
11 that actually interprets that imaging in terms of a final
12 form. In other words, in terms of hospital privileges,
13 only the radiologist has the privileges to actually issue
14 a final report on imaging studies because we are the
15 specific individuals with the training and expertise to
16 interpret the studies and who are board certified to do
17 so.
18 So in brief, the role of the radiologist and the
19 radiology department in regards to the operative
20 fluoroscopy is we provide the service in terms of the
21 actual radiography equipment, we provide the
22 technologists who run that equipment and obtain the
23 images and develop the images, and then at the end of the
24 day we're the ones who also interpret those images,
25 generating a final report that becomes part of the

1 patient's permanent medical record.
2 Q. Thank you. This case is about an anterior
3 cervical discectomy and fusion. Would it be all right
4 with you if I abbreviate and refer to that procedure as
5 an ACDF?
6 A. Yes, sir. That's the term we commonly use.
7 Q. Now, in the circumstances of an ACDF, between
8 1992 and 2012, did you have experience in both the setup
9 of the imaging technology and the interpretation of the
10 intraoperative imaging?
11 A. Yes, sir. Given that the medical center in
12 which I'm directing the neuroradiology services is one of
13 the largest spine centers on the West Coast with 80-some
14 surgeons, that's a big part of what we're doing on a
15 daily basis. So in other words, in addition to the
16 interpretation of a significant number of cervical MRIs,
17 cervical X-rays, cervical fluoroscopy related to ACDF
18 surgery would be something that I would encounter
19 probably several times every day, so anywhere between
20 three to maybe six or seven times per day. So literally,
21 thousands of cases over that period of time.
22 Q. Over that period of time, meaning over the
23 course of your career from '92 to 2012?
24 A. Yes, sir.
25 Q. And I don't mean to cut off your career at 2012.

1 Do you continue to serve as the director of neuroimaging?
2 A. Yes, sir. Currently.
3 Q. And has your practice remained about the same
4 from 2012 up through today?
5 A. It has.
6 Q. In terms of your experience with imaging
7 intraoperatively in an ACDF, can you tell me, based on
8 all of your experience, in 2012 what type of imaging was
9 performed in conjunction with ACDF surgeries?
10 A. Yes, sir.
11 MR. RICCELLI: Object. Object to the form of
12 the question. It's vague.
13 BY MR. SESTERO:
14 Q. You can answer, Doctor.
15 A. Yes, sir. So quite straightforward, it's the
16 same technique that's been employed literally for decades
17 since 1992, consisting of intraoperative lateral
18 fluoroscopy.
19 Q. Now, I know with imaging there are different
20 views that can be obtained. In your experience between
21 1992 and 2012, in the context of ACDF surgeries, what
22 views were obtained in intraoperative fluoroscopy?
23 A. Yes, sir. The view is a lateral view of the
24 proximal cervical spine. And the reason for that has to
25 do with the objective of what are we trying to do. So to

1 successfully complete the goal of what we're trying to
2 do, the key imaging technique is what's called a lateral
3 view, so we're looking from the side, and we're looking
4 to identify the proximal or the top portion of the
5 cervical spine (indicating).
6 Q. In your experience with the 80 spine surgeons
7 and orthopedists and your experience with ACDF, in 2012
8 were anterior-posterior or AP views of intraoperative
9 fluoroscopy utilized?
10 A. No. I really can't recall a single case in
11 which a front-to back referred to anterior-posterior view
12 was employed. And basically, it has to do with the fact
13 that if you obtain a radiograph in that direction, the
14 head and the skull and the facial structures, a lot of
15 bone overlies the proximal cervical spine. So the
16 proximal cervical spine, the C1-C2, is best visualized
17 from a lateral perspective because there's less tissue,
18 and certainly less bone. So if you go from side to side
19 you can directly image the spine without overlying bone,
20 affording the surgeon the ability to start the counting
21 at the top of the cervical spine and allowing them to
22 then have a reference landmark. Whereas from a frontal
23 AP view, it's very hard, if not impossible, to see the
24 C1-2 levels. You can certainly see lower down well, but
25 upper areas are obscured by the skull. So as a result,

1 you're not accomplishing your objective of visualizing
2 the cervical spine.
3 Q. In your field, is there a term called
4 "parallax"?
5 A. Yes. Parallax is a term that has to do with the
6 concept of distortion occurring at the periphery of the
7 X-ray field. So in other words, the X-rays are traveling
8 in a perpendicular but parallel fashion, so perpendicular
9 to the structure we're going to image, but parallel to
10 one another.
11 So at the edges of where we're imaging, there's
12 going to be inherent anatomic distortion. And the idea
13 is if you're imaging an AP view and you're looking
14 further down to try and localize where you are in
15 surgery, you will have this parallax effect that's
16 distorting the area where you need to be counting. So
17 that would be the proximal cervical spine.
18 So parallax is one of the technical artifacts
19 that are inherent when obtaining a plane radiograph which
20 further compounds and limits the utility of an AP or
21 front-to-back view.
22 Q. In your experience up to October 2, 2012, can
23 you give us a sense for how frequently the mid and lower
24 cervical spine levels were either difficult or impossible
25 to visualize on lateral intraoperative fluoroscopy

1 imaging?
2 MR. RICCELLI: Object to the form of the
3 question. He lacks foundation, as he has previously
4 admitted in his deposition, that he has never been inside
5 the operating room during one of these procedures.
6 MR. SESTERO: And that's why I asked about the
7 image. So I'll restate the question to make sure we're
8 clear.
9 MR. RICCELLI: Well, before you -- before you
10 restate the question, my objection is based on the fact
11 that he presumes that he knows what images were taken and
12 what images the doctors had difficulty with.
13 BY MR. SESTERO:
14 Q. Doctor, I'm going to ask this question about
15 your review of intraoperative fluoroscopy in the case of
16 ACDFs. And if I understood your earlier testimony,
17 you've reviewed literally thousands of those kinds of
18 studies; is that correct?
19 A. Yes, sir.
20 Q. And in your review of perhaps a thousand or more
21 of those studies, have you ever looked at intraoperative
22 fluoroscopy images where you cannot see or interpret the
23 mid and lower cervical thoracic spine levels?
24 A. Yes, sir.
25 Q. And with what frequency in the context of ACDF

1 surgeries do you find that it is difficult, if not
2 impossible, to visualize mid and lower cervical spine
3 levels?
4 A. So in fact, the majority of cases. And it
5 simply is related to our anatomy. So in other words,
6 when obtaining these lateral views, we use the
7 side-to-side-view because we can identify the proximal
8 cervical spine relatively easily.
9 But as soon as you get down to the mid and lower
10 cervical spine, your shoulders are in the way. So by
11 definition, as soon as you start imaging the mid and
12 lower cervical spine, there's too much soft tissue as you
13 try and expose the radiation from one side of the patient
14 all the way through the right shoulder, then the neck,
15 and then the left shoulder. That all gets summated and
16 added together, so there's a lot of density. And as
17 we'll see in Mr. Reinert as well, it's what we expect.
18 The majority of the time we're unable, using fluoroscopy,
19 to visualize mid and lower cervical vertebra.
20 Q. Doctor, I'm going to change topics slightly but
21 stay within the realm of your practice with imaging.
22 In 2012 were you familiar with something called
23 stealth station imaging technology?
24 A. Yes, sir.
25 Q. In your experience, up to 2012, was stealth

1 station imaging technology utilized in the performance of
2 ACDF operations as you reviewed the imaging from those
3 operations?
4 A. No, sir. So throughout our 32 hospital complex,
5 and literally with hundreds of surgeons performing on
6 cervical surgery, it had never been used and still to
7 this date is not used for cervical ACDF surgery.
8 Q. Were you familiar in 2012 with something called
9 stereotactic imaging?
10 A. Yes, sir.
11 Q. Was stereotactic imaging utilized up to 2012
12 over any of the facilities where you provided imaging
13 evaluations in the context of ACDF surgeries?
14 A. No, sir. So again, for all the hospitals and
15 all the surgeries, I do not know of a single case in
16 which that technology was used for performing ACDF. And
17 that's true today. And here as we sit down in 2019, it's
18 no different than 2012. Those tools -- they're useful
19 tools, but they're designed for a very different task.
20 And as a result, they have not been used, and even today
21 are not used for ACDF localization purposes.
22 Q. Are you familiar with imaging technology
23 referred to as Brainlab?
24 A. Yes, sir.
25 Q. Was Brainlab imaging technology utilized for

1 ACDF operations in 2012 or before?
2 A. No, sir. So same with other 3-D localization
3 surgeries. Throughout the hospital complex, literally
4 several hundred surgeons, has never been utilized for
5 ACDF surgery up until 2012 and even as I sit here today
6 in 2019.
7 Q. Is 3-D navigation a term you're familiar with?
8 A. Yes, sir. And it's something that we use on a
9 daily basis in our operating suites.
10 Q. What type of operations result in imaging with
11 3-D navigation that you interpret?
12 A. Yes. The majority of it relates to complex
13 brain surgery where the surgeon needs to know with high
14 precision in a complex environment exactly where they're
15 located. But the important thing is you have to have
16 robust fiducials which means you have to have a solid
17 knowledge of where the patient's body is in space which
18 is acquired using very specific landmarks. So in other
19 words, you have to have non-movable landmarks such as the
20 skull, a very well-defined structure that can be
21 co-registered with the system so the machine knows
22 exactly where the body is in space. And the patients are
23 actually in what we refer to as a halo in many cases
24 which is holding the head in a very specific location.
25 So the key to any of this 3-did technology --

1 and there are many different types -- is you can't have
2 any mobility. Because as soon as you have movement of a
3 structure such as occurs with skin, if you had a marker
4 that's localizing skin, or anterior neck muscles or
5 tissue that may move, that throws off your localization
6 dramatically. You have to have high degree of precision
7 in terms of structures that don't move, and we'll see
8 that's why these tools are not applicable when doing
9 anterior neck surgery as part of an ACDF surgical
10 approach.
11 Q. Doctor, I'm going to change gears and ask you
12 about materials that you've reviewed in your capacity as
13 an expert witness in this case. And to move things
14 along, I'm just going to spit out some of the things and
15 you can confirm or deny having seen and reviewed it.
16 Did you receive and review a copy of
17 Mr. Reinert's legal complaint?
18 A. Yes, sir.
19 Q. Did you receive and review records on
20 Mr. Reinert from the Rockwood Clinic and Dr. Heller's
21 practice?
22 A. I did.
23 Q. Did you receive records from B & B Physical
24 Therapy?
25 A. I did.

1 Q. From Occupational Medicine Associates?
2 A. Yes, sir.
3 Q. From Deaconess Medical Center, both the
4 admission of October 2 and October 9?
5 A. Yes, sir.
6 Q. Did you receive a disc containing imaging on
7 Mr. Reinert?
8 A. I did.
9 Q. Did the discs include imaging from Rockwood
10 Clinic?
11 A. Yes, sir.
12 Q. Deaconess Medical Center?
13 A. Yes.
14 Q. And Inland Imaging?
15 A. Yes, sir.
16 Q. Have you received and reviewed depositions,
17 including that of the plaintiff's expert, Alan Hamilton,
18 M.D.?
19 A. Yes, sir.
20 Q. Did you review and receive or vice versa to
21 that, Allen Heller, M.D.'s, deposition?
22 A. Yes, sir.
23 Q. Did you review and -- the deposition of Artie
24 Reinert?
25 A. I did.

1 Q. Did you evaluate Mr. Reinert's pre-operative
2 imaging?
3 A. Yes, sir.
4 Q. Did you review the intraoperative imaging on
5 Mr. Reinert from October 2, 2012?
6 A. Yes, sir.
7 Q. Did you review the post-operative CT scan of
8 October 3, 2012?
9 A. Yes, sir.
10 Q. Did you review any of the imaging after the
11 operations on Mr. Reinert from October 2012 concerning
12 his cervical spine?
13 A. I did.
14 Q. And we'll go through those in a moment.
15 I'd like to start off in a chronological order
16 with the MRI that was conducted on April -- or excuse me,
17 August 14, 2012.
18 For purposes of our record, there is a disc that
19 is marked as Exhibit 149, and does that contain the MRI
20 study?
21 A. Yes, sir, it does.
22 Q. In addition, there is a single image that was
23 marked as Defendant's Exhibit 103, and does Exhibit 103
24 reflect the MRI?
25 A. Yes, sir, it does.

1 Q. Now, we talked about views. What is the view
2 that is established on Defendant's Exhibit 103?
3 A. Yes, sir. As we have on the monitor currently,
4 this is Image 6 of Series 3, and this happens to be one
5 of many different images of Mr. Reinert obtained on
6 August 14, 2012.
7 This is what we call a mid-line sagittal view.
8 What that means is the patient is facing off to
9 this direction, off to our left (indicating). You can
10 see the base of the patient's tongue here. This black is
11 the airway. This is the front of the patient.
12 On the other side towards the back we have the
13 posterior portion or the back of the patient.
14 Now, this is if you were to slice me let's say
15 right down the middle and look at that mid-line slice.
16 We can see the base of the brain at this level
17 (indicating), and then we can see the spinal cord as this
18 dark structure coming down within the spinal canal
19 (indicating). The spinal fluid itself is this bright
20 signal (indicating).
21 Q. And I'm sorry to interrupt. Is that white in
22 comparison to the cord itself?
23 A. Precisely. So the spinal cord is this darker
24 signal structure, whereas the bright fluid surrounding it
25 represents the cerebrospinal fluid in which the spinal

1 cord is bathed.
2 Q. Doctor, on this image, do you find any evidence
3 of spinal cord abnormality? And if so, can you explain
4 it?
5 A. So you're asking specifically is there an
6 abnormality of the spinal cord itself. Well, it turns
7 out there's no damage or injury to the spinal cord, in
8 other words, we don't see a stroke or a scarring within
9 the spinal cord. However, we can see that at two levels
10 within the lower cervical spine there is impingement on
11 the spinal cord.
12 So if we actually take a closer look at that,
13 what you can see is above in the region of the proximal
14 cervical spine, we can see fluid or bright cerebrospinal
15 fluid in front and in back of the spinal cord.
16 And as you follow that down, you come to this
17 level where you almost have an hourglass appearance.
18 There is loss of the cerebrospinal fluid both in front
19 and in back of the spinal cord, and that's even more so
20 at the level below where the spinal cord is actually
21 somewhat squeezed.
22 But if we continue down, after these two levels
23 of cord -- spinal cord impingement or squeezing, things
24 then back -- then open up back again, and we can see the
25 normal cerebrospinal fluid both in front of and in back

1 of the spinal cord.
2 So you can see how Mr. Reinert has this area of
3 relative narrowing and spinal cord impingement at two
4 levels, one greater than the other, which constitutes a
5 pathologic condition. And we can talk a little bit about
6 what level that is occurring at and how we know that.
7 Q. And which of those two levels, which is the
8 upper level?
9 A. Correct. So what we do is looking at the
10 anatomy, as we have heard, the C2 vertebral body has a
11 very characteristic appearance. It has this elongated
12 configuration. So as a result, we can use that unique
13 morphology as our ability to start the counting. We know
14 by definition and with certainty that this is C2
15 (indicating). The C1 is actually a small ring as you
16 know. It affords us the ability to rotate our heads, so
17 the C1, the first cervical vertebra, is a ring that
18 rotates on the axis which is this process that is
19 pointing up from C2 called the odontoid process or the
20 dens.
21 So long story short, this structure as we come
22 to the mid-line is the C2 vertebra (indicating). And
23 then we can then say this is C3, C4, C5, C6 and C7.
24 So as a result, we can tell that the arrow --
25 area of narrowing is at two levels. The upper level is

1 what's called C5 and C6. That's the space between those
2 two vertebral bodies. And then C6 and C7 is the second
3 level where we have even greater spinal canal narrowing.
4 Q. You mentioned that this constitutes a
5 physiologic or pathologic condition. What is the
6 condition that this represents?
7 A. Well, we all know and can imagine how vital the
8 spinal cord is. It turns out that the spinal cord is
9 sitting in this bony confines, the spinal canal, where
10 there is bone in front and bone in back. So it's almost
11 like a vault. So that protects the spinal cord. But
12 with disc degenerative disease, as things encroach such
13 as disc disease, as it encroaches on the spinal cord, the
14 spinal cord is trapped within this bony space.
15 So the concern is, number one, that encroachment
16 can squeeze the spinal cord leading to neurologic
17 disability. But of even greater concern is if a patient
18 were to fall and have a significant flexion or extension
19 injury, that mobility of the cervical spine could impinge
20 the spinal cord, leading to a permanent cord injury and
21 frank paralysis.
22 So in summary, Mr. Reinert clearly has
23 significant two-level disc pathology with spinal cord
24 impingement which would constitute a risk.
25 Q. When you interpret a study like this, do you

1 quantify the nature or extent of the disc abnormality?
2 A. So that's an important point. In radiology we
3 frequently do not measure things. If there's a need to,
4 certainly, like a size of a tumor and following up the
5 size of a tumor, it's important to quantify as much as
6 possible.
7 In general, for disc pathology and spinal canal
8 pathology, we are qualitative in our description, not
9 quantitative.
10 So for example, I would describe the C5-6 level
11 as moderate spinal canal stenosis, and then the level
12 below, the 6-7, as severe spinal canal stenosis and, in
13 fact, to the point where we actually have some degree of
14 compression of the spinal cord itself.
15 Q. Doctor, do you have opportunity to follow the
16 imaging on patients with this kind of pathology before,
17 intraoperatively with fluoroscopy imaging, and
18 afterwards?
19 A. Precisely. So most of our patients -- some
20 travel from out of town or from different parts of the
21 country. Many of them will have follow-up imaging at
22 their local venue which is then transferred to us for
23 follow up. But the majority of our patients are going to
24 be having all their follow-up imaging in our facility.
25 So yes, as the imager, I typically get to review the

1 pre-operative, the intraoperative, as well as the
2 post-operative imaging, because, as you know, when a
3 patient has surgery, oftentimes they will have follow-up
4 imaging to ensure that the hardware is appropriately
5 placed and remains in good -- in a good condition.
6 Q. Based on your education, your training, and your
7 experience following these films, do you have an opinion
8 whether degenerative disc disease is a progressive
9 condition or not?
10 A. Yes.
11 MR. RICCELLI: Object to the form of the
12 question. I think that calls for a neurologist's
13 conclusion. I think he lacks foundation.
14 Go ahead.
15 THE WITNESS: So the answer is yes. By
16 definition, degenerative disease is a progressive
17 condition, meaning that -- and of course, it's a very
18 intimate topic that we as imagers are familiar with. We
19 are the ones who make the diagnosis, we are the ones who
20 evaluate the imaging to characterize the magnitude and
21 extent of those degenerative changes.
22 And in brief, shortly after puberty, our body
23 starts to undergo expected wear and tear, especially the
24 spine. That wear and tear is the result of activities of
25 daily living. And basically, things wear down slowly

1 over time. And for example, none of our spines look like
2 they did 10, 20 years ago. There's a normal process of
3 wear which is referred to as degenerative arthritic-type
4 changes that are, by definition, progressive. It would
5 be great if they could be reversible, but they are a fact
6 of life that they are invariably progressive and, by
7 definition, they're not going to reverse. And the role
8 of surgery in certain cases is to try to simply stem or
9 mitigate the progression of this inexorable process.
10 BY MR. SESTERO:
11 Q. Doctor, I'm going to change studies now. I'm
12 going to ask you to pull up the Defendant's Exhibit 106
13 which is the intraoperative fluoroscopy image of
14 October 2, 2012, which I think we've referred to as a
15 spinal needle image.
16 A. Yes, sir. So here we are looking at that study
17 dated 10-2-2012 at 4:04 p.m.
18 Q. All right. Now, with the use of the image on
19 the monitor, can you just identify what you see, but
20 let's start off with what view is this relative to an
21 intraoperative fluoroscopy study?
22 A. Yes, sir. This is the lateral view we were
23 describing. So this is -- these two lines represent the
24 back of the patient's jaw or their mandible (indicating).
25 The skull base is coming right down to about this level

1 (indicating).
2 So we are looking right at the base of the neck,
3 at the base of the head, and you can see these large dark
4 structures coming across the image. Those are the
5 patient's shoulders. So we are looking right at the base
6 of the skull at this point here (indicating), this little
7 dark structure, we then have a bit of gap, and then we
8 hit the patient's shoulders, and that constitutes all
9 this big bulk of dark material.
10 Q. Where is the spinal needle?
11 A. The spinal needle is down at this level
12 (indicating). So this line, dark line coming across, is
13 the actual spinal needle.
14 Q. Now, based on your experience in reviewing
15 similar films in the context of an ACDF, are you able to
16 determine the location in the cervical spine where that
17 cervical needle is pointed or located?
18 A. Not from this film. We can identify this
19 elongated structure which is the beginning of our
20 counting. So this would be our C2 level. But we lose
21 the definition of the vertebra due to the thick density
22 of the shoulders.
23 Q. Would you turn to Defendant's Exhibit 107, this
24 is the second intraoperative fluoroscopy image which
25 we've referred to as the peanut. Tell me when you have

1 that ready.
2 A. Yes, sir.
3 Q. Now, first of all, what is the peanut?
4 A. The peanut refers to a surgical device,
5 basically a form of forceps, which consists of this
6 dark -- actually, it's very dense, so it's a white
7 structure on the X-rays, on this particular X-ray.
8 Q. Does that image provide sufficient clarity to
9 define where the peanut is located relative to the
10 cervical vertebrae?
11 A. Yes, sir. We can see on this image we again
12 have the anatomy referable to the patient's skull base
13 (indicating).
14 These lines here are the back of the mandible
15 (indicating).
16 And this elongated structure is our second
17 cervical vertebra (indicating). So this little one here
18 is C1, this is C2. We can then identify C3 as this
19 vertebral body. And so by definition, we are at the C3
20 to C4 level.
21 So yes. Using the surgical instrument being
22 referred to as the peanut affords us the ability to
23 definitively identify the surgical level at this point.
24 Q. Doctor, it may be suggested in this case that
25 Dr. Heller should have called a radiologist to the

1 operating room to aid in localization of the disc level.
2 Do you have an opinion whether a radiologist
3 would have been helpful or added any useful data in
4 localization of the surgical spine level?
5 A. No, sir. I would state that as radiologists, we
6 have no special superpower or anything different than the
7 surgeon themselves, and as I've pointed out on these
8 films, this is the same information that the surgeon
9 would have.
10 This film clearly affords us the ability to
11 identify the level in question. The other film simply
12 didn't. But in summary, there's nothing additional that
13 we as radiologists can bring to the picture in this
14 setting.
15 Q. Dr. Barakos, I'm going to have you move to the
16 Exhibit 112, that's the still image. Exhibit 150 is the
17 disc containing the CT scan of October 3, 2012. So this
18 is one day after the initial surgery.
19 A. Yes, sir. So here we have the representative
20 images relating to the CT of 10-3-2012.
21 Again, these are the sagittal views, meaning
22 that these are slices going down the center of the
23 patient. We can again see the base of the patient's
24 tongue as the patient is facing to our left as we look at
25 this picture. And then the back of the neck is seen here

1 towards our right.
2 Now, each of these bony structures, these
3 protuberances, are what we call the spinous processes.
4 And these are the little bumps you can feel when you push
5 on the back of your neck.
6 So in summary, this is the post-operative exam
7 that shows that the patient has undergone an ACDF with
8 appropriately-positioned surgical hardware.
9 Q. Now, what level is fused?
10 A. Yes. So we simply make a count. Here is the
11 elongated vertebral body we discussed earlier, so this is
12 C2. C3, C4, C5. So we see that the level fused is in
13 fact the C5-6 level.
14 Q. Doctor, is Defendant's Exhibit 112 a still image
15 of the sagittal view of the CT scan?
16 A. Yes, sir. That corresponds to the image we are
17 looking at now, Image 34 of Series 201.
18 Q. In addition to the MRI and our discussion about
19 the condition of Mr. Reinert's discs, does the CT scan
20 reveal any other evidence of a degenerative process in
21 the cervical spine from a radiologic standpoint?
22 A. Yes, sir, it does.
23 Q. What other degenerative changes can you identify
24 from this image?
25 A. What we can see is if we look at the normal

1 contours of a vertebral body -- so this square structure
2 is the vertebral body, and then the space between them is
3 the disc which will be the cushioning material between
4 the vertebral bodies -- what we can see is Mr. Reinert's
5 vertebra show these bony spurs and spikes. These are
6 called osteophytes. So these are bony projections that
7 are a reflection of degenerative arthritis.
8   So the body's response to excessive wear and
9 tear over time is that the body actually builds and forms
10 new bone as a response to that repetitive force being
11 applied.
12   So what we can see is the fact that there are
13 numerous areas of bony spurring involving the cervical
14 vertebra which are protruding into the anterior soft
15 tissues of the neck. And some of these are quite large.
16 We can see, especially at the level of 4-5, these are
17 many millimeters in diameter extending anteriorly into
18 the soft tissues of the neck.
19   Q.   Thank you, Doctor. I'm going to move past the
20 time of the surgeries in October 2012 and ask you to look
21 at Defendant's Exhibit 151. This is the disc containing
22 a thoracic spine MRI study dated January 14, 2013.
23   A.   Yes, sir. This is the image of the thoracic MRI
24 dated 2-14 of 2013. Again, this is a mid-line sagittal
25 view where we can see the front of the patient to the

1 left, and then again, the back of the patient to our
2 right.
3 Q. Doctor, Exhibit 114 of the exhibits, is that a
4 similar view sagittally from the thoracic spine MRI
5 study?
6 A. Yes, sir, it is, representing Image 8 of this
7 Series 4 of this exam.
8 Q. What do you see that is of relevance in the
9 cervical spine on this study?
10 A. Yes, sir. We can see the hardware artifact due
11 to the ACDF surgery. So in other words, as we know, MRI
12 images are generated using a powerful magnetic field.
13 And as a result, any metal that may be affected by the
14 magnetic field will distort the magnetic field and the
15 images.
16 So as a result, the normal hardware, screws and
17 plates that are part of the ACDF surgery, generate
18 significant artifact. And what we can see at these
19 levels of C5, 6 and 7, is a distortion of the image
20 field. And that's what we expect.
21 THE VIDEOGRAPHER: Take a break?
22 MR. SESTERO: Yes.
23 THE VIDEOGRAPHER: Going off the record. The
24 time is 6:46.
25 (Recess taken from 6:46 to 6:47 p.m.)

1 THE VIDEOGRAPHER: Okay. We are back on the
2 record. The time is 6:47.
3 BY MR. SESTERO:
4 Q. Dr. Barakos, picking up with this thoracic MRI,
5 I want to ask about your knowledge based on your review.
6 Based on your review of the records and imaging,
7 are you aware that Mr. Reinert ended up having a
8 two-level fusion covering C5-6 and C6-7 in October of
9 2012?
10 A. Yes, sir.
11 Q. And are you familiar, based on your review of
12 the records, that there was a dural leak associated with
13 the October 4, 2012, surgery?
14 A. Yes, sir.
15 Q. And are you familiar, then, with a subsequent
16 revision of the fusion and further repair of the dural
17 leak following the readmission of October 9, 2012?
18 A. Yes, sir.
19 Q. Now, based on this image, do you have an opinion
20 as to whether there is any objective evidence of injury
21 to any neurological structure of the cervical spine in
22 Mr. Reinert as of January 2013?
23 A. I do have an opinion. And this imaging study
24 confirms that there is no injury to any neurologic
25 structures -- certainly, the spinal cord, no evidence of

1 injury. And what we see are basically the expected
2 post-surgical changes that we would encounter in a
3 patient who's had a two-level ACD surgery.
4 Q. Do you hold that opinion on a
5 more-probable-than-not basis?
6 A. I do.
7 Q. Doctor, I'm going to turn your attention to
8 Defendant Exhibit 152. This is the cervical MRI of
9 June 22, 2013. Please let me know when you have that
10 image up.
11 MR. RICCELLI: What was that number again?
12 MR. SESTERO: It's Exhibit 152.
13 MR. RICCELLI: Okay.
14 THE WITNESS: Yes, sir.
15 BY MR. SESTERO:
16 Q. Sir, is this a film that you reviewed as part of
17 your evaluation of this matter?
18 A. Yes, sir.
19 Q. What, if anything, is significant of the
20 cervical spine based on this MRI study in June of 2013?
21 A. Yes. The finding of significance is you'll
22 recall one of the first -- actually, the pre-operative
23 MRI study showed that there was disc disease at two
24 levels which effaced or obliterated the cerebrospinal
25 fluid surrounding the spinal cord.

1 After the two-level surgery, we see -- we can
2 now identify the cerebrospinal fluid as this thin white
3 line both in front of and in back of the spinal cord
4 which previously wasn't evident.
5 So by definition, this patient has undergone a
6 successful decompression of the cervical spine at the two
7 levels at which the patient had significant spinal canal
8 stenosis and cord impingement.
9 At the same time, this study -- and there are
10 several hundred images going through the spine in many
11 different directions and using different techniques --
12 shows no evidence of injury whatsoever to the spinal cord
13 or any other neurologic structure.
14 Q. As to that last point, the absence of evidence
15 of neurologic injury or damage to other structure, do you
16 hold that opinion on a more-probable-than-not basis?
17 A. Yes, sir.
18 Q. Is there any evidence, either on the thoracic
19 imaging MRI or this cervical MRI, of any damage relative
20 to a dural tear in October of 2012?
21 A. No, sir. So no evidence of an injury referable
22 or related to a dural tail -- tear identified on either
23 study.
24 Q. And I'm not going to have you pull it up, but
25 you had mentioned that in an MRI there's many, many

1 different views or images acquired. Is that correct?
2 A. Yes, sir. For example, in this particular study
3 we're reviewing, there's over -- there are approximately
4 130. And for the thoracic spine, 175. So there are many
5 images.
6 The images I'm showing here today are the same
7 ones I would be showing my orthopedists and neurosurgeons
8 in our daily and weekly conferences. So many of the
9 images may not be showing the pertinent anatomy and may
10 be out of the field of interest, so we localize, looking
11 for the areas that show findings of significance and of
12 import.
13 Q. Based on your review of Mr. Reinert's imaging,
14 can you identify any objective evidence of harm suffered
15 to any neurologic structure in the cervical spine as a
16 result of any operation in October of 2012?
17 A. And the answer is no. The imaging confirms that
18 there is no evidence of any form of injury to any
19 identifiable structure of relevance. So in other words,
20 no evidence of any damage to the spinal cord, its
21 surrounding structures, as well as the nerve roots that
22 are going to be exiting at each neural level.
23 MR. SESTERO: Doctor, I don't have any other
24 questions, and I will pass the baton to Mr. Riccelli.
25 THE VIDEOGRAPHER: Going off the record, the

1 time is 6:53.
2 (Recess taken from 6:53 to 6:58 p.m.)
3 THE VIDEOGRAPHER: Okay. We're back on the
4 record. The time is 6:58.
5 EXAMINATION
6 BY MR. RICCELLI:
7 Q. Good afternoon, Dr. Barakos. I'm Michael
8 Riccelli with the plaintiffs here.
9 And as I understand it, you've testified before
10 in matters?
11 A. Yes, sir, I have.
12 Q. How many times have you been engaged by a party
13 to testify for forensic purposes?
14 A. I would say probably in the order of anywhere
15 between five to eight times a year, and I've been doing
16 this for over 25 years.
17 Q. In the hundreds?
18 A. Yes, sir.
19 Q. And how much of the percentage of your income is
20 derived from forensic testimony?
21 A. Yes, sir. It's comparable to my percent of
22 time. So about 5 percent of my time is spent doing this
23 sort of forensic analysis, and it represents about
24 5 percent of my income.
25 Q. Does that mean you get paid by the hour as a

1 physician?
2 A. Yes, sir. So and my hourly rate is comparable
3 to what I'm earning at work, so basically that's why it's
4 comparable.
5 Q. And what is the hourly rate that you're charging
6 in this matter?
7 A. I charge for review and consultation $450 an
8 hour.
9 Q. And testimony?
10 A. Testimony, since it's after hours or taking a
11 block of time, I charge $450 an hour. Oh, I'm sorry, I
12 misspoke. For the testimony after hours, 750 an hour.
13 Q. Now, as a neuroradiologist, you state that you
14 review C arm fluoroscopy on a regular basis?
15 A. Yes, sir.
16 Q. And what is the purpose of that review?
17 A. The purpose of that review is to document the
18 imaging that was obtained and what that imaging shows.
19 So at the end of the day, it represents a formal
20 recording of what procedure was done in terms of
21 identifiable by the images, and is a formal report of
22 what those images show.
23 Q. Is that based upon your status as a department
24 director for imaging?
25 A. No, sir. It would be based on the status of

1 being a radiologist. So my partners are also reviewing
2 many of these images as well. So the status is the
3 radiologist is the one that provides the final
4 interpretation of those intraoperative X-rays and
5 fluoroscopy.
6 Q. I understand that. But you're not actually
7 doing it for the purposes of evaluating the surgical
8 procedure, are you?
9 A. No, sir. That is being done in realtime by the
10 surgeon themselves.
11 Q. And so whatever you see is what the surgeon
12 records as imaging; correct?
13 A. Yes, sir. That's correct.
14 Q. And not every imaging that' taken -- all of the
15 imaging that is taken during a procedure is recorded, is
16 it?
17 A. That's correct, sir. It is not.
18 Q. So you only see what the surgeon decides to make
19 an archive of; is that correct?
20 A. Precisely, sir. So whatever pictures the doctor
21 takes is the only recording of that information. So
22 you're right, that's what we're reviewing.
23 Q. And do you receive a report from the
24 technologist as to what procedures were actually taken or
25 that the surgeon ordered?

1 A. Yes, sir. That would be part of the order.
2 There's an order that's generated that the surgeon is
3 requesting intraoperative fluoro. Then we have a record
4 of the type of pictures the surgeon is obtaining and we
5 have a record of that, yes.
6 Q. Now, during your testimony previously today, it
7 wasn't mentioned, the fact that the basis of this case is
8 a wrong-level fusion, a discectomy and fusion by
9 Dr. Heller removing the C5-6 disc and fusing the C5-6
10 level as opposed to the planned operation at the C6-7
11 level; is that correct?
12 A. Yes, sir. I understand that.
13 Q. And in that regard, I think you previously
14 stated that the radiologists such as yourself don't
15 actually operate the C arm fluoroscope in the operating
16 room. It's a technologist; correct?
17 A. Yes, sir, that's correct.
18 Q. Do you have any indication as to how often, say,
19 an AP view is used for various purposes in the surgical
20 suite, regardless of whether it's an AA -- ACDF surgery
21 or some other form of surgery?
22 A. Excuse me. Yes, in other forms of surgery an AP
23 view is used. A typical example would be if the surgeons
24 are working on the abdomen. So by definition, in that
25 scenario, the lateral view has very little utility, and

1 it's pretty much more often than not an AP view.
2 So again, the views the surgeons will be using
3 and obtaining is going to be a reflection of the
4 different body parts they're working on or the different
5 anatomy that's being evaluated.
6 Q. And to your knowledge, then, the surgeon
7 performing the procedure, whether it's an ACDF or any
8 other form of procedure, is the one that directs the type
9 of image to be obtained by the technologist; correct?
10 A. Yes, sir. That's true.
11 Q. And it's the surgeon who is responsible to
12 determine whether or not the image that's obtained is
13 useful or appropriate for the intended purpose?
14 A. Yes, sir.
15 Q. And to some degree, that then requires basically
16 the surgeon to be his or her own expert when it comes to
17 surgical C arm fluoroscopy; correct?
18 A. Yes.
19 Q. And you're not one of those experts, are you?
20 You don't actually perform surgeries with a C arm
21 fluoroscope?
22 A. Well, so a mixed answer. As the radiologist, we
23 are the imaging experts. So we -- no one better than the
24 radiologist understands the role of imaging and how the
25 body is best imaging. That's our -- our job. So if a

1 clinician has a specific question of, "Hey, Jerry, how --
2 we have a patient who has a certain condition, what is
3 the most appropriate imaging?" There's no one better
4 than the radiologist. That's our job.
5   Your question asking in the operating room when
6 the surgeon is in need of guidance in terms of
7 fluoroscopic guidance to help localize where they are,
8 yes, they are the ones in charge of determining what
9 techniques to be used. But, of course, we're always
10 available to consult with them if the question arises.
11 And I must admit, invariably it doesn't since they know
12 their anatomy, they know what they're looking for, and
13 they know what tools to use to obtain that localization
14 information.
15   Q.   Okay. So your testimony today previously about
16 the use of C arm fluoroscopy was hypothetical. It didn't
17 actually relate to this specific procedure because you
18 weren't in the operating room and you didn't see this
19 patient being imaged at the time of the surgery, did you?
20   MR. SESTERO: Object to the form of the
21 question. That is a mischaracterization of the direct
22 testimony.
23   You can answer again.
24   THE WITNESS: So, no, sir, I respectfully
25 disagree. There is no assumptions or hypotheticals

1 involved.
2 Having done this for over 25 years and seen
3 literally thousands of these images, and also being
4 tasked with ensuring that the appropriate services are
5 available to the surgeon, I know what services they need,
6 I know what imaging is performed, how and why, because
7 it's an essential part of providing that service to them.
8 And also, it's an essential part of interpreting the
9 images. I see what images are obtained by the surgeons.
10 So in this particular case, I know exactly what
11 images have been obtained, I know how they were obtained,
12 and I'm intimately familiar with that. So no
13 hypothetical or no assumptions being made in this
14 particular case.
15 BY MR. RICCELLI:
16 Q. So is it your testimony with absolute certainty,
17 then, that had you been on the staff at Deaconess
18 Hospital when Dr. Heller performed the October 2, 2012,
19 surgery, that had he called you to the surgical suite and
20 said, "Jerry, I'm not sure, I'm not getting the imaging
21 that gives me my level of confidence that I'm at the
22 right level, can you give me any ideas? Can you give me
23 suggestions?" You wouldn't have done that?
24 A. So the hypothetical, what would we have done or
25 what would I have done? Absolutely, I would provide the

1 additional information needed. But it would be no
2 different than what the doctor's already obtained.
3 There's no different imaging. There's no tricks.
4 Basically, what we have here are the images that would
5 have been obtained even under my direct guidance, and
6 that's the information from which the surgeon is going to
7 work.
8 So my answer is, yes, it would be no different
9 than what has transpired. I'd go into the operating
10 room. I'm seeing exactly what the surgeon is seeing.
11 The imaging is limited by the patient's anatomy, and we
12 have the information. And the surgeon is going to work
13 with that information to their level of comfort.
14 Q. How often do you see a surgeon doing an ACDF
15 procedure have a patient imaged immediately or close to
16 immediately after the surgery to see if the level that
17 was operated on was the correct level?
18 A. I would say that's less common. I mean we do
19 know that the literature shows that about half of all
20 surgeons have operated at the wrong level at some time in
21 their career --
22 MR. RICCELLI: Let me object to the form. I'm
23 going to object to the answer and move that it be
24 stricken. That is not responsive to the question.
25 And I'll ask you to try to maintain a response

1 to the question.
2 MR. SESTERO: For our record, go ahead and
3 complete your answer, because you don't get to interrupt
4 him.
5 THE WITNESS: I'm sorry. So the question
6 basically was how often do I see a surgeon obtain a film
7 immediately following surgery specifically for a question
8 you asked, how often do they obtain it when they think
9 they may have been at the wrong level?
10 And I was saying I'm thinking, I know that at
11 our institution, again, directly responsive to your
12 question, that our rate of wrong levels reflects what the
13 literature, what the medical literature shows, that
14 it's -- it's less than 1 percent. And that's a
15 reflection of the fact that the literature shows about
16 50 percent of all surgeons at one point or another in
17 their career have been off a level or more.
18 So my answer is it's infrequent, but I have seen
19 it several times over my 25-plus year career.
20 MR. RICCELLI: I'm going to move that your
21 answer be stricken as nonresponsive and prejudicial.
22 Now, to that part which was not -- excuse me, more
23 responsive and less prejudicial, I'm going to ask a
24 simple question.
25 Q. Doctor, how many times have you, in your

1 recollection, actually -- how many times do you recall an
2 instance where a surgeon performing an ACDF procedure
3 sent a patient in for imaging after the surgery to
4 determine whether the appropriate level was the site
5 which was operated on?
6 MR. SESTERO: Objection. Asked and answered.
7 THE WITNESS: As I have outlined, several times
8 every few years. It's relatively infrequent. More often
9 than not the purpose is to identify the positioning of
10 the hardware. But as I outlined, probably once every few
11 years.
12 BY MR. RICCELLI:
13 Q. So how long have you been practicing?
14 A. A bit over 25 years.
15 Q. Once every few years means maybe four or five
16 times?
17 A. Right. In that span of time.
18 Q. Now, are you aware of every wrong-level cervical
19 surgery that's actually performed at one of the
20 institutions that you're associated with?
21 A. No, sir. And that was a point I was going to
22 make on the last question. It obviously can be quite a
23 bit higher because --
24 MR. RICCELLI: I'm asking you a simple question.
25 MR. SESTERO: Please let him finish his answer.

1 It is inappropriate to interrupt the witness.
2 BY MR. RICCELLI:
3 Q. Go ahead. Go and respond.
4 A. So yes, sir. So the answer to your question,
5 no, I'm not aware of every inaccurate level of surgery
6 because oftentimes the request for imaging may not
7 specifically state that's the purpose of the imaging.
8 And also, I don't personally review all the imaging since
9 there's an entire team of neuroradiologists, so as a
10 result, the number of wrong-level surgeries at our
11 institution again reflects the national average as
12 documented in the medical literature.
13 Q. And in that regard, are you a member of the
14 quality control committee at your institutions?
15 A. Yes, sir, I am.
16 Q. Do you review -- generically, do you review all
17 the cases of wrong-level surgery that are brought to your
18 quality control committee?
19 A. No, sir, I don't. That would be the subject of
20 review by the neurosurgery and the orthopedic department,
21 not the radiology department.
22 Q. And so you don't have any personal experience
23 with determining whether or not a wrong-level surgery was
24 due to either a breach of the standard of care or just
25 inadequate imaging, do you?

1 MR. SESTERO: Let me just object in that that
2 calls for a legal conclusion.
3 You can answer.
4 THE WITNESS: Let's see. So a wrong-level
5 surgery is not seen as a breach of the standard of care.
6 Why? Because the methods employed to identify the
7 appropriate level of surgery are well defined and well
8 accepted. And just as in this case, the standard is one
9 of counting, numerically counting. And so the surgeon
10 identifies the beginning of the cervical spine and counts
11 down. That is not 100 percent, but it's a reasonably
12 reliable and reproducible technique. As such, it remains
13 the standard of practice throughout the country at all
14 medical institutions, and that's the way it's done
15 because it has a high degree of reliability and
16 reproducibility compared to other techniques.
17 MR. RICCELLI: Would you read back the question
18 to the witness, please?
19 (Question read as follows:
20 "Q. And so you don't have any personal
21 experience with [personally] determining whether
22 or not a wrong-level surgery was due to either a
23 breach of the standard of care or just
24 inadequate imaging, do you?")
25 MR. SESTERO: Asked and answered, if you're

1 posing the same question.
2 MR. RICCELLI: No, I need to strike his answer
3 as being nonresponsive and prejudicial.
4 Q. It was my impression, based on your prior
5 testimony, you would not be commenting on the standard of
6 care, the actual -- the actual standard of care itself.
7 A. Correct. I'm not a neurosurgeon or -- or an
8 orthopedist.
9 Q. So you're in no position to determine whether
10 there was a breach of the standard of care in this case
11 or in any other case, are you?
12 A. I'm simply in a position to describe -- and
13 that's what I'm here for and what I do on a daily
14 basis -- what does the imaging show and how does that
15 relate to the procedure being performed.
16 As to whether something in and of itself is a
17 breach of the standard of care, of course, that's beyond
18 my scope, but I can certainly comment on how and why
19 these issues come up.
20 Q. Why don't we go through the various images that
21 you have displayed previously.
22 A. Yes, sir.
23 Q. Let's start with the first one which -- that
24 exhibit was -- which image is that?
25 A. Yes, sir. This is the August 14, 2012,

1 pre-operative MRI.
2 Q. And that was the defendant's exhibit which?
3 A. I believe 104.
4 MR. SESTERO: Are you asking what the disc
5 number is?
6 MR. RICCELLI: Actually, the exhibit number
7 you're using.
8 MR. SESTERO: Well, there's the plain image
9 which has Exhibit 103, and then the disc with the full
10 imaging is Exhibit 149.
11 BY MR. RICCELLI:
12 Q. Okay. First, can you scroll slowly through the
13 image?
14 A. Yes, sir. So this is the 103 Exhibit. And then
15 we can show the additional views from side to side going
16 from left to right.
17 Q. Slow down. Slow down.
18 A. Yes.
19 Q. Okay. Now go back one. Doesn't that image show
20 a substantial amount of cerebrospinal fluid around the
21 C5-6 level?
22 A. Yes, sir, it does. But that's the point. It's
23 showing it at the side, but at the center -- on both
24 sides it should. But the point is on the center is where
25 the spinal cord is being squeezed. So in other words,

1 it's as if you have this rounded canal and you've got the
2 spinal cord in the middle. The spinal cord is getting
3 squeezed in the center where it typically is, but the
4 spinal cord just sits in the center of the canal. So by
5 definition, you're going to have cerebrospinal fluid on
6 the sides.
7 So yes, as the spinal cord is going to be
8 significantly squeezed, it's still going to have
9 cerebrospinal fluid at its side.
10 Q. And isn't one of the issues of concern as to
11 whether what large -- how large the imprint of that
12 pressure may be?
13 A. Absolutely.
14 Q. And can you tell me in this instance how large
15 the imprint is from the C5-6?
16 A. Yes, sir. The answer would be that imprint is
17 big enough. In other words, again, we don't have a
18 quantitative sense, but since the cord is effaced from
19 front to back, that's a significant degree of spinal
20 canal narrowing.
21 So to answer your question, we don't kind of
22 present a quantitative response other than, yeah, it's
23 tight and there is squeezing of the spinal cord or
24 effacement of the spinal cord at that level.
25 MR. RICCELLI: Would you read back the question,

1 please?
2 (Question read as follows:
3 "Q. And can you tell me in this instance
4 how large the imprint is from the C5-6?")
5 MR. RICCELLI: I'll rephrase the question.
6 Q. Can you tell me definitively the measurement of
7 the imprint on the spinal cord?
8 MR. SESTERO: Object. Objection. Asked and
9 answered.
10 THE WITNESS: No, sir. As I outlined earlier,
11 the standard evaluation for the MRI is a qualitative. As
12 I outlined, routinely we're describing this as the extent
13 or magnitude of the narrowing, and this would be
14 described as moderate. But no, I don't have an actual
15 measurement.
16 BY MR. RICCELLI:
17 Q. And isn't -- aren't decisions about treatment of
18 a patient based on clinical presentation, including
19 symptoms?
20 A. Yes, sir.
21 Q. And can you state -- can you bring that back,
22 please?
23 A. Yes.
24 Q. Can you state to whether symptoms are being
25 produced by the C5-6 level?

1 A. I can't state specifically other than what I've
2 already outlined. With this degree of spinal canal
3 stenosis and encroachment on the spinal cord, this is
4 consistent with a cause of the patient's symptomatology.
5 But again, at the end of the day, we don't treat the
6 films, we treat the patient, and it's up to the surgeon
7 to correlate what the patient's symptoms are with these
8 imaging findings.
9 Q. So in this instance, Dr. Heller, the surgeon,
10 stated he was not going to proceed with the -- there's no
11 indication he was intending to proceed with a two-level
12 fusion, a discectomy fusion, is there?
13 A. That's my understanding. Correct.
14 Q. So it was his clinical decision that it was only
15 a C6-7 level that needed to be attended to at the time
16 the surgery took place; correct?
17 A. Correct. At the time of surgery, yes.
18 Q. And can you describe this phenomena of disc
19 dehydration?
20 A. Yes, sir. Disc dehydration, we can get a sense
21 of it has to do with the disc between the vertebral
22 bodies is a cushion-type material, and it has some fluid
23 within it. As the disc ages and degenerates, it really
24 starts to dry out. And so the gel -- it's kind of like
25 if you have a mouse pad that's drying out. You get

1 cracks and fissuring in the margin and the disc starts to
2 lose its height and its water content, so that's
3 dehydration, and it starts to bulge, and we can see that
4 occurring primarily at these two levels.
5 Q. And are there instances where the actual disc
6 bulges and then recedes due to dehydration?
7 A. Well, typically it's part and parcel of a
8 degenerative process which is progressive and typically
9 accentuated after fusion.
10 So it's not uncommon that areas that are damaged
11 to begin with such as this sixth -- C5-6 level, when you
12 fuse a level next to it will undergo altered
13 biomechanical forces, so that's altered biomechanical
14 forces because there's less flexibility at the adjacent
15 level, meaning that this level is going to degenerate at
16 a faster rate.
17 So no, you don't expect that over time that
18 these discs are going to magically disappear. As I
19 described earlier, by definition, this is a progressive
20 degenerative process.
21 Q. My question again is can you -- I'll rephrase
22 the question.
23 Can you predict whether in Mr. Reinert's case
24 with any degree of medical certainty as to whether the
25 C5-6 disc would more probably than not degenerate to the

1 extent that it would cause later symptoms?
2 A. Yes, sir. I would state with reasonable medical
3 probability, doing this for over 25 years in a
4 high-volume spinal center, that if someone only did the
5 more pronounced 6-7 level, we know by definition and the
6 literature supports the concept of adjacent segment
7 degenerative disease, which means that if this 6-7 level
8 is a solid fused block which is the intended goal of
9 surgery, there will be additional dynamic forces and
10 pressure being applied to the contiguous levels.
11 Since at this point in time the C5-6 level
12 already shows significant degeneration with impingement
13 on the spinal cord, I would state with reasonable medical
14 probability sometime down the road Mr. Reinert is going
15 to need additional level surgery.
16 Now, I can't say whether it's going to be months
17 later or years later. I would defer to a surgical
18 expert. But I'm certainly in a position with my
19 experience and training to know that that is a real and
20 expected condition, namely, after a single-level surgery,
21 given the degree of disease Mr. Reinert already displays
22 at the C5-6 level, that it's going to be pretty much an
23 inevitable outcome that this spinal canal stenosis and
24 continued aging -- and remember, the gentleman's
25 relatively young at this point, he's only 49 -- that in

1 the years to come, we would expect advanced degenerative
2 changes at that C5-6 level.
3 Q. And you've never seen cases where the disc
4 dehydrates prior than to causing symptoms to the point
5 where it actually collapses in?
6 A. No, sir. Part and parcel of the degenerative
7 process is the bony spur formation which we saw in
8 Mr. Reinert is quite pronounced, and that's the type of
9 thing in addition to the disc degeneration is something
10 that progresses over time.
11 In brief, so what's happening with those bony
12 spurs is there's something called the Sharpey fibers that
13 insert to the margin of the disc at the end plate, and
14 with these degenerative changes, it's drawing out that
15 bone formation that we saw in Mr. Reinert's X-rays, and
16 the disc is continually coming out with it. It's being
17 drawn out as part of that dehydration and compressive
18 process.
19 So continued spinal canal stenosis is part and
20 parcel of this aging condition.
21 Q. So then you're stating that Dr. Heller should
22 have at least advised Mr. Reinert of that possibility? I
23 don't understand your discussion to date stating that it
24 was inevitable for this to occur but then you leave it up
25 to the surgeon.

1 MR. SESTERO: I object insofar as this is well
2 beyond the scope of direct. It's also outside the scope
3 of any pled cause of action.
4 MR. RICCELLI: No. I'm asking --
5 Q. Clearly, you brought up this impingement. And
6 now you're suggesting that Dr. Heller should have started
7 out with the idea of a two-level fusion; is that correct?
8 MR. SESTERO: Objection. That mischaracterizes
9 the testimony. It's also beyond the scope of direct.
10 THE WITNESS: No, sir. I'm making two points,
11 trying to make them clear. Namely, number one,
12 Dr. Heller was clearly being conservative and
13 addressing -- wanting to address the most significant
14 level. No two ways about that.
15 The decision as to whether to do two levels as
16 opposed to one, that's purely a surgical decision to
17 which I defer to the surgeons.
18 BY MR. RICCELLI:
19 Q. Okay. So the purpose in presenting this image
20 from your standpoint, then, how does that relate to the
21 issue of whether the two-level fusion occurred or
22 misoccurred due to imaging?
23 A. Yes, sir. A good point. And the point is
24 although using the MRI we can clearly see that the
25 primary disc pathology is at C6-7, when you're in the

1 operating room, you do not have this information. In
2 other words, you do not have this ability to localize.
3 Remember, the fluoroscopy being used
4 intraoperatively just shows you these faint outlines of
5 the vertebra. It doesn't show you the disc, the soft
6 tissues, the degenerative disease, or the spinal canal
7 stenosis.
8 So the reality, the purpose of this image is to
9 show, yes, this MRI is a very powerful tool that can show
10 us where the pathology is. But when you're in the
11 operating room, you don't have this information. All you
12 see are some faint outlines in the vertebra, and to get
13 this level you need to do what the standard procedure
14 consists of, namely, counting vertebra from the C2 down.
15 So I think that's the important point to understand.
16 It's not as if intra-operatively the surgeon can see
17 exactly where this disc is. They have to rely on the
18 vertebral localization.
19 Q. So my question, again, is what is the relevance,
20 then, of this image as to whether or not Dr. Heller
21 breached the standard of care or did not due to
22 fluoroscopic imaging as opposed to MRI imaging -- MRI
23 imaging? What is the relevance of this particular MRI
24 scan to be shown to the jury?
25 A. Yes, sir. It has great relevance. Namely, it

1 shows the indication for why the patient needed the
2 surgery and also lays the foundation for the anatomy
3 which is the entire basis of the information that the
4 surgeon is going to be using intraoperatively to help
5 them identify and localize the disease.
6 So this is the essence of why the surgery is
7 being done and gives us the factual foundation of
8 understanding how the surgeon is going to use this
9 information to localize the area of surgery.
10 Q. Isn't that the same information Dr. Heller gave
11 to Mr. Reinert to cause Mr. Reinert to select the
12 surgery?
13 A. I'm sorry, sir, I didn't understand the
14 question.
15 Q. Isn't that -- didn't Dr. Heller, to your
16 knowledge, use image like this to describe to Mr. Reinert
17 the need for surgery?
18 A. I don't know specifically, but, yes, I would
19 expect that's a common occurrence. When our surgeons
20 interface with the patients, oftentimes they'll show them
21 the anatomy to outline the significance and why surgery
22 would be indicated, as it clearly is in this case.
23 Q. And so Dr. Heller would probably state the same
24 thing that you're stating today; correct?
25 MR. SESTERO: Objection. Speculation.

1 Conjecture.
2 THE WITNESS: So, sir, I wouldn't want to even
3 start to try and read somebody else's mind or assume what
4 someone else is going to say. I'm here today to outline
5 my opinions with reasonable medical probability and
6 certainty, and I can't speak for others.
7 BY MR. RICCELLI:
8 Q. And so you're not speaking for operating room
9 surgeons, are you? You're not speaking for operating
10 room technicians, are you, as to what occurs during any
11 single surgery?
12 A. So I guess I don't understand the question.
13 As I've outlined, I don't do the surgery nor do
14 I obtain the imaging. But, of course, I play an integral
15 role in the obtaining of that information and its
16 interpretation.
17 Q. And it's likely that Dr. Heller did use some
18 image of his MRI to explain to Mr. Reinert as to the need
19 of surgery, and my question again is what is the
20 relevance of your presentation beyond that of what
21 Dr. Reinert may have done in the actual instance of
22 describing this to Mr. Reinert?
23 MR. SESTERO: Objection. Speculation as to the
24 conversation he was not privy to. Speculation as to what
25 you believe is relevant in the case.

1 You can answer if you understand the question.
2 THE WITNESS: I'm not sure I do. I think I've
3 already outlined why, as an imager, this image, this
4 study is important and how it plays an important role in
5 this entire situation, namely, a patient undergoing
6 surgery because of abnormalities on a film. Then we
7 obtain intra- and post-operative imaging, and I play an
8 intimate role in outlining why those images are obtained
9 and what they show and what their significance is.
10 BY MR. RICCELLI:
11 Q. Let's go to the next image that you had
12 displayed. I believe it was -- well, first, no, go back
13 to that image. And can you read the -- read the report
14 on that?
15 A. I don't have that available to me as I sit here.
16 Q. Isn't the report contained in the database?
17 A. Not this one.
18 Q. What's the date of that?
19 A. This is the 8-14-2012 MRI, cervical spine.
20 Q. And at Rockwood Clinic?
21 A. Yes, sir.
22 MR. RICCELLI: Do you have that report in hard
23 copy, Counsel?
24 MR. SESTERO: No.
25 MR. RICCELLI: Okay. I can bring it up here.

1 Can we go off the record a moment.
2 THE VIDEOGRAPHER: Going off the record. The
3 time is 7:33.
4 (Recess taken from 7:33 to 7:36 p.m.)
5 THE VIDEOGRAPHER: Okay. We are back on the
6 record. The time is 7:36.
7 BY MR. RICCELLI:
8 Q. The next image that you discussed?
9 A. Yes, sir. Would be the intraoperative views
10 obtained on 10-2-2012.
11 Q. How does that view comport with the possibility
12 of what might have been revealed on, let's say, an AP
13 caudal -- or cauded? And I've heard that both ways.
14 Which is the correct. Caudal or cauded?
15 A. Caudal.
16 Q. Caudal. An AP caudal view?
17 A. Yes, sir. So an AP caudal view would not show
18 us with any clarity the proximal portion of the spine.
19 So typically, due to the overlying jaw, you
20 would obscure visualization of your primary counting
21 vertebra, the C2, and you would see a needle overlying
22 bony structures such as the sternum and the spine. And
23 as a result, you wouldn't have purposes of localization
24 to figure out your space in terms of location because
25 it's basically as if you have a ruler that has no

1 numbering. So if you get your AP view and you're
2 somewhere in the middle of the ruler and you can't see
3 the edge, then you still don't know where you are.
4 So in summary, an AP view would not provide
5 additional localization information which is why, as I've
6 outlined, I can't recall one being used in any of our
7 facilities for as long as I've been there.
8 Q. What about surgical suite CT scanning? Would
9 that assist -- assist Dr. Heller in a case like this, or
10 any surgeon in an AP case -- excuse me, an ACDF case
11 where there's a difficulty in obtaining a proper level?
12 A. Now, again, I am not familiar with a CT being
13 used for that purpose, as I've outlined.
14 Q. What is a CT scan used for surgically in an
15 operating suite?
16 A. It's used, again, for the 3-D localization. So
17 it's used in cases where you have a fixed structure that
18 you can evaluate, very similar to the 3-D technology. So
19 from a posterior approach where you have a fixed
20 structure such as the spinous process, it may have some
21 relevance. But in an anterocervical approach where you
22 have mobile tissues and you don't have a fixed landmark,
23 it's not going to provide a useful tool for localization.
24 Otherwise, it would be something that would be used with
25 some frequency, and it certainly is not.

1 Q. What about the use of it to help align hardware
2 and screws, pedicle screws?
3 A. Again, that wouldn't be something used in an
4 anterior approach. In theory, it may be used from a
5 posterior approach, again, that's what pedicle screws are
6 making reference to.
7 Q. Um-hmm.
8 A. But again, as I've outlined, I've not seen that
9 tool used for that express purpose.
10 Q. But wouldn't a CT scan give you some good
11 imaging of levels? Isn't that what's done sometimes in a
12 fixed CT scan pre- or post-operatively for certain
13 conditions?
14 A. Hypothetically, yes, you certainly can. But not
15 in the operating room setting.
16 Typically, the CT used in the operating room
17 setting is a very different type of CT that is typically
18 very limited in the space it's going to cover. And
19 again, if you were to scan through your operative field,
20 you simply don't know where you are in space. That's the
21 whole issue with surgical localization. If you do a CT,
22 it's not going to be the type of dedicated CT that you
23 obtain routinely where you can scan the patient from one
24 end to another and get localization counting from the
25 top.

1 You're going to be confined to a limited area
2 and you won't have the ability to do that counting.
3 So yes, it's a good tool to look at a very
4 specific area, and that's why it's used for complex brain
5 surgery, complex spinal anatomy where you're in a fixed
6 location, but it's not going to give you that
7 localization information of seeing the end of the spine
8 such that you can count down.
9 Q. Now, Plaintiff's Exhibit No. -- or Defense
10 Exhibit No. 112, would you turn to that. Image 34 of
11 Series 201.
12 A. Yes, sir.
13 Q. And what does that depict?
14 A. This is the dedicated cervical spine MRI -- I'm
15 sorry, I misspoke. The dedicated cervical CAT scan
16 obtained on October 3 of 2012.
17 Q. And why was that done? Do you know?
18 A. As I sit here, I don't know the specific
19 clinical indication.
20 Q. That was the day after surgery; correct?
21 A. Yes, sir.
22 Q. Did you read Dr. Heller's deposition?
23 A. I do. I did.
24 Q. Do you recall what he stated about that?
25 A. I don't specifically.

1 Q. Well, I'll refresh your recollection.
2 Dr. Heller stated he wasn't sure that he got the right
3 level. He wasn't -- he was uncertain that he operated on
4 the right level, so wanted to see if he did.
5 MR. SESTERO: Excuse me. Object to the question
6 as it mischaracterizes testimony.
7 Can you answer, Doctor.
8 THE WITNESS: Okay. Understood.
9 BY MR. RICCELLI:
10 Q. We'll just read the -- I'll go to the deposition
11 here and read it. Read it to the -- to the witness.
12 MR. SESTERO: It's still going to be an
13 objectionable question as you're asking one witness to
14 comment on the other witness' testimony.
15 MR. RICCELLI: No. I'm asking if he knows what
16 Dr. Heller stated about it because he read his
17 deposition. You asked him if he read his deposition, and
18 he said he did.
19 MR. SESTERO: And you're asking him to comment
20 on another witness' testimony which I think is
21 inappropriate.
22 MR. RICCELLI: No, I'm asking if he knew why
23 Dr. Heller stated he did that.
24 MR. SESTERO: And he's answered that question.
25 Now you're asking him to comment on the testimony of

1 another witness.
2 MR. RICCELLI: I'm going to ask him if he
3 recalls the statement. So there we go. I'm having a
4 hard time, too, so we'll go away on that.
5 Q. Let's go to Exhibit No. -- Defense Exhibit 114.
6 A. Yes, sir.
7 Q. Okay. This is the post-operative condition? Is
8 that correct?
9 A. Yes, sir. Post-operative MRI of the thoracic
10 spine dated February 14 of 2013.
11 Q. That's the thoracic spine? Okay. But you're
12 seeing at the top the hardware?
13 A. Yes, sir.
14 Q. Okay. Let me... I have a question about that.
15 Let's see if these batteries...
16 So at the top, are those -- there seems to be --
17 can you magnify that a little bit, at the top, the
18 hardware?
19 A. Yes, sir.
20 Q. Okay. At the top there seems to be some
21 impingement there. What is that from?
22 A. So as I outlined, hardware, the screws interact
23 with the main magnetic field and result in image
24 distortion such that the anatomy is significantly altered
25 and affected in the area of the hardware.

1 In other words, these black areas and, for
2 example, these black areas, are where the signal, due to
3 the metal from the screws and hardware, is being
4 mismapped and warped (indicating).
5 So the normal signal that would be seen in this
6 area is warping out, making this white arc. And that's
7 an interaction of metal with the high field strength MRI
8 machine.
9 So in other words, there's no metal or structure
10 that's impinging on the patient's airway or soft tissues.
11 This is an image artifact, and we call that magnetic
12 susceptibility artifact. And the same thing is occurring
13 posteriorly.
14 So what we see here is in the areas of the
15 screws there's mismapping and warping of tissue, and this
16 is not an accurate reflection of what is taking place
17 here.
18 Along the same vein, the high signal identified
19 within the spinal cord is a classic artifact seen in this
20 setting called a Gibbs artifact, G-I-B-B-S.
21 So in summary, if we want to get accurate
22 visualization of what's taking place here, we need an MRI
23 or CT specifically designed to evaluate this anatomy, and
24 that consists of the studies that we showed subsequently,
25 namely, the MRI of the cervical spine on follow up that

1 demonstrates there is, in fact, no evidence of any spinal
2 cord injury. And this type of MRI is done in a specific
3 manner to minimize those artifacts we saw on the previous
4 study.
5 So that thoracic spine study is not an accurate
6 rendition since it has a fair amount of artifact given
7 how it was performed. Still, allowing for that artifact,
8 there's no evidence of a spinal injury of any sort. And
9 that's confirmed on this follow-up MRI as well as other
10 follow-up imaging.
11 Q. There's no impingement of the spinal fluid there
12 at all?
13 A. There still is, but what we would consider a
14 more nominal level or degree.
15 So in other words, I think we spent a fair
16 amount of time showing how, on the previous imaging, this
17 cerebrospinal spinal fluid was effaced both in front and
18 in back at both the C5-6 and the C6-7 level, or actually,
19 this the C5-6 and C6-7 level, so it was clearly improved,
20 and that was the goal of surgery. This would be deemed
21 an ideal surgical result, and that's what I would expect
22 to see in my institution.
23 And you ask is there still, Jerry, some
24 impingement on the thecal sac? That means is that CSF
25 still somewhat impinged? Yes, it's always going to be

1 impinged no matter the nature of your surgery.
2 Their goal, the surgeon's goal, is to take off
3 that compressive effect, and the fact that we now see
4 cerebrospinal fluid in front and in back of the spinal
5 cord confirms that this was ideally performed, and this
6 was the goal and the intended purpose of this surgical
7 intervention.
8 Q. So you're speaking about what was in the mind of
9 Dr. Heller at the time he recommended and performed the
10 surgery?
11 A. No, sir. So at no point do I mean to be
12 speaking for another physician or to assume the thoughts
13 of a physician. I simply stated the facts from an
14 imaging point of view what this imaging shows and how it
15 relates to Mr. Reinert's clinical symptoms.
16 Very pure and simple. We saw significant spinal
17 canal stenosis. The patient was clearly a surgical
18 candidate given their clinical symptomatology and their
19 imaging findings. The surgeon does their job, and I'm
20 here to comment on what these imaging studies show and
21 how it relates to the surgical procedure.
22 MR. RICCELLI: And I'll move to strike your
23 testimony about what the goal of the surgery was.
24 Q. As I understand it, you did not correlate
25 Mr. Reinert's clinical symptoms with either the C5-6 or

1 C6-7 potential impingement, did you?
2 A. Now obviously, I've reviewed medical records,
3 I'm aware of the patient's symptomatology including
4 bilateral paresthesias and numbness extending into their
5 arms. As you know, that includes distribution of C5, C6,
6 C7. So without a doubt, that symptomatology with which
7 the patient presented would be a reflection of potential
8 impingement certainly along these levels, the C5, the C6,
9 the C7 levels.
10 So yes, I have correlated and I'm in a position
11 to state that Mr. Reinert's initial presentation of the
12 multi-level canal narrowing would correspond to the
13 patient's neurologic symptoms.
14 Q. And there's no potential play of the brachial
15 plexus?
16 A. So you're asking was there a role of potential
17 pathology in the brachial plexus? The answer would be
18 given the bilateral nature of his symptoms, it would be
19 unusual to have -- it would be like lightning striking
20 twice in the same spot. You would have to assume a
21 pathologic process of one brachial plexus, which is
22 unusual, and then another unusual process for the other
23 brachial plexus. As you know, the brachial plexus are
24 all the nerves that are coming down into the arm.
25 So given these imaging findings that we saw

1 pre-operatively of high-grade spinal canal stenosis and a
2 patient presenting with bilateral arm weakness, by
3 definition, their problem is due to that spinal canal
4 stenosis unless someone has reason to suspect otherwise.
5 Q. So are you qualified to provide a diagnosis as a
6 neurologist would?
7 A. I provide maybe to a different extent. Now,
8 remember, again that as a neuro-imager, my role is to be
9 at the crossroads of how the body responds to various
10 physiologic conditions and how that manifests clinically.
11 So in other words, no one better than the imager, the
12 radiologist, is sitting there looking at the body and
13 looking at pathology in the body and knowing how it
14 manifests.
15 So I don't perform the exam on the patient, I'm
16 not a neurologist. But I am certainly qualified to do as
17 I do in my daily practice on a daily basis of
18 interpreting what the imaging shows, how that correlates
19 with the manifestation of symptoms, and, as I've stated,
20 Mr. Reinert's spinal canal stenosis would certainly
21 account for his presentation of the bilateral arm
22 numbness and paresthesias.
23 MR. RICCELLI: So would you read back my last
24 question again?
25 (Question read as follows:

1 "Q. So are you qualified to provide a
2 diagnosis as a neurologist would?")
3 BY MR. RICCELLI:
4 Q. So can you give me a yes or no answer on that?
5 MR. SESTERO: Objection. There's no obligation
6 to provide a yes or no. You are asking the same question
7 again hoping for a different answer, so it has been asked
8 and answered.
9 THE WITNESS: So the answer is yes, in
10 certain -- certain circumstances. I'm using imaging. I
11 can give the exact same diagnosis that a neurologist
12 would provide.
13 In other circumstances where the diagnosis is
14 more based on clinical exam, since I'm not examining the
15 patient, I would have to defer to the neurologist.
16 BY MR. RICCELLI:
17 Q. And you referenced a dura leak. Do you have any
18 opinion associated with the actual dura leak itself as to
19 the causation?
20 A. No, sir, I don't.
21 Q. As a neuroradiologist, what's your understanding
22 of the causation of a dura leak?
23 A. I can --
24 MR. SESTERO: Let me just object. It's both
25 beyond the scope of direct, it's also irrelevant, given

1 the prior answer of the witness.
2 THE WITNESS: So to answer your question,
3 surgeons routinely purposefully go through the dura. So
4 again, every single day across the country thousands of
5 times surgeons are purposely going -- opening the dura to
6 access the contents of the thecal sac and then close it
7 on their way out. So that's a routine occurrence.
8 In the case of an ACDF when that occurs, that is
9 characteristically the result of the adhesion of the dura
10 to those bony spurs we were describing in Mr. Reinert.
11 In other words, when you get disc degenerative disease
12 which impinges on the spinal canal, it causes chronic
13 long-standing inflammatory changes that result in
14 scarring. As a result, it's not uncommon that when the
15 surgeon's doing their work in removing that disc, that
16 it's adherent to the dura which is the sac, the spinal
17 canal sac, and as part of doing their job, it's not
18 uncommon that you can actually damage the dura due to its
19 adherence to that inflammatory bony spur.
20 So when you ask -- when you ask about the nature
21 of dural leak, yes, I understand, in a case like this
22 where you have severe spinal canal stenosis, it would be
23 understood that you would expect inflammation and
24 adherence of the dura that then can lead to its
25 compromise during the surgical intervention.

1 BY MR. RICCELLI:
2 Q. And how do you come to that conclusion? Do you
3 actually see that in radiology?
4 A. Well, yes, sir. And not only do we see the bony
5 spurring, the adhesion or the proximity to the dura, but
6 it's a well-understood pathophysiologic process that as
7 imagers we are aware of when we analyze and evaluate this
8 anatomy.
9 Q. And you're aware of that through your practice
10 of radiology with reviewing imaging in ACDF procedures?
11 A. Yes, sir.
12 MR. RICCELLI: So Bob, do you want us to open up
13 the original here or do you want to just give him a copy
14 of his deposition?
15 MR. SESTERO: I don't care.
16 MR. RICCELLI: Well, this is U.S. Legal, so I
17 guess they know what they're doing. Would you -- give
18 this to the court reporter to have him identify it and
19 mark it as an exhibit -- not as an exhibit, but...
20 (Discussion with Reporter off stenographic
21 record.)
22 THE REPORTER: This looks like the cover letter
23 to -- oh, I see. All right.
24 This is the Videotaped Conference Deposition of
25 Expert Jerome Barakos taken on May 2, 2019.

1 MR. RICCELLI: Would you turn to page 29 for me.
2 THE REPORTER: Hold on just a second. Let me
3 get back on the record here.
4 BY MR. RICCELLI:
5 Q. And beginning on page 10, can you read the
6 question and answer slowly. Excuse me. Line 10 of page
7 29.
8 A. Yes, sir.
9 "Do you have any opinion associated with
10 the actual dural -- the dura leak itself as to
11 causation?"
12 Q. And answer?
13 A. "No, sir, other than we -- I guess there's
14 two ideas: There's obviously a neuro injury I'm
15 well aware when the doctors go through the dura.
16 Obviously, probably on a weekly or daily basis
17 they're purposefully going through the dura when
18 they need to work on the spinal cord itself, but
19 they maybe accidentally go through the dura when
20 performing surgical decompression of the spine,
21 and that's an expected and not uncommon
22 complication."
23 Q. And may I ask you, do you recall giving your
24 deposition?
25 A. Yes, sir. And this is the exact answer I just

1 gave moments ago when you asked me the same question.
2 Q. And then continue on with the question again,
3 the next question.
4 A. "Are there any other causes of dural
5 leaks that you're aware of?" -- question. "I
6 mean during the surgical -- spinal surgery,
7 whatever causes the dura leaks that you're aware
8 of?"
9 Q. Answer?
10 A. "Answer: No. They would typically be
11 related to the surgical work itself. Sometimes
12 you may have a Tarlov cyst or other anatomic
13 variant where the dura may be excessively thin,
14 and that can lead to a much more easy leak
15 through the dura."
16 Q. Okay. Is there a reason you didn't discuss the
17 anatomic variations you discussed today in regarding the
18 adhesions?
19 A. No, sir, since they're not relevant.
20 Q. What do you mean, they're not relevant?
21 A. So when you asked me the causes of dural leaks,
22 I gave you the most common causes. A, either the doctor
23 needs to go through the dura, which they routinely do, or
24 B, it's related to the surgery that they're doing,
25 specifically if there's an adhesion.

1 And then you asked me to come up with other
2 considerations. And so I'm thinking of very rare
3 circumstances --
4 Q. Now, my question is --
5 MR. SESTERO: You're interrupting him.
6 MR. RICCELLI: Well --
7 THE WITNESS: And so when you asked me the
8 second question, then I've moved on to very rare
9 conditions such as the Tarlov cyst and anatomic variants
10 which are not relevant to Mr. Reinert's matter. And so
11 that's why I wouldn't bring them up because we don't see
12 any evidence of those.
13 BY MR. RICCELLI:
14 Q. Where in that response did you use the word
15 "adhesion"?
16 A. I don't use the specific word, but when I say
17 "when performing surgical decompression," and that means
18 when there's compressive forces on the spinal canal as we
19 have in Mr. Reinert, that's where you typically get those
20 adhesive changes because of the reasons I've already
21 outlined.
22 Q. Okay. So you gave an incomplete answer on the
23 2nd of May?
24 A. No, sir. I clearly outlined, gave a very
25 similar answer. It's simply I can go into greater detail

1 and keep talking about these things, but the general
2 principle has been pointed out.
3 MR. RICCELLI: Okay. Thank you. I have no
4 further questions. Thank you.
5 EXAMINATION
6 BY MR. SESTERO:
7 Q. Dr. Barakos, very briefly, you were asked
8 questions about your review of the August 12 MRI image,
9 and so I'm going to ask you some questions about your
10 role as a radiologist.
11 When you are looking at radiology on a patient,
12 is it commonplace to review other films for comparison
13 purposes on that patient?
14 A. The answer is yes. Whenever we review an
15 imaging study, we have access to invariably all preceding
16 imaging studies because comparison is a very important
17 concept to see what the patient's anatomy looked like
18 before, how it may have changed subsequently. So the
19 answer is yes, we certainly and obviously have access to
20 all previous medical imaging.
21 Q. And I do not want to get into the causation
22 opinions you've already voiced in this case, but my
23 question as a foundation is: Is the August 2012 MRI of
24 the cervical spine part of the composite of films you
25 analyzed and considered in reaching your causation

1 opinions in this case?
2 A. The answer is yes. Absolutely.
3 MR. SESTERO: I don't have anything else. Thank
4 you.
5 THE VIDEOGRAPHER: All done?
6 MR. RICCELLI: No. No.
7 EXAMINATION
8 BY MR. RICCELLI:
9 Q. Doctor, so is it your testimony -- are you
10 testifying as to radiology or causation of a surgical --
11 a surgical result?
12 MR. SESTERO: Objection. That's a false
13 dichotomy.
14 BY MR. RICCELLI:
15 Q. Well, my question is are you testifying as to
16 actual causation of the -- the wrong-level cervical
17 discectomy and fusion, or are you simply limiting your
18 testimony to the difficulty of imaging in obtaining the
19 level?
20 MR. SESTERO: Objection. That's also a false
21 dichotomy. You are defining his testimony in two boxes
22 and that is inappropriate because it is a false
23 representation.
24 MR. RICCELLI: Let's ask him what his
25 representation is.

1 Q. Are you stating with reasonable medical
2 certainty based on your actual education, training,
3 background and experience as to the actual causation of
4 the wrong-level fusion, cervical discectomy and fusion,
5 on October 2, 2012?
6 A. Well, I came here today to -- as I would in my
7 own practice, to describe the imaging findings, what they
8 mean, how they were obtained, and how they relate to the
9 patient's anatomy and symptoms. And I think you've given
10 me the opportunity to answer your questions in regards to
11 the factual information. And so I don't understand the
12 specific nature of your question. I mean I've outlined
13 my opinions, what the imaging shows, what it means. I'm
14 not here to talk about on a specific standard of prac --
15 standard of -- standard of practice for a neurosurgeon.
16 I'm not a neurosurgeon.
17 Q. And you don't know what was going on in the mind
18 of Dr. Heller during that surgery, do you?
19 A. Again, as I've outlined, no. I'm not in a
20 position to speak for someone else or come up with their
21 own thoughts. I simply have to base all my testimony
22 which I've provided here today with reasonable medical
23 probability based on the medical facts we have that are
24 clearly established that allow me to say everything I've
25 said here today as being factual and based on reasonable

1 medical probability and certainty. I've made no
2 assumptions. I'm not guessing. Nothing is hypothetical.
3 Everything I've stated is with reasonable medical
4 certainty and probability.
5 Q. And so you don't know whether there was proper
6 indexing of the level that Dr. -- Dr. Heller started
7 counting from or whether Dr. Heller may have miscounted
8 as he was counting down?
9 A. Right. I'm not offering an opinion in that
10 regard.
11 MR. RICCELLI: No further questions. Thank you.
12 MR. SESTERO: I believe we're all done.
13 THE VIDEOGRAPHER: Okay. Going off the record,
14 the time is 8:12.
15 THE REPORTER: Copies, Counsel?
16 MR. SESTERO: Yes, so I need to order and get
17 the original, then a PDF e-tran for my use. And then I
18 will order the film to be sent to the geniuses in Seattle
19 who know how to do all that.
20 THE VIDEOGRAPHER: We've got that.
21 THE REPORTER: Mr. Riccelli?
22 MR. RICCELLI: Yes, I need a copy.
23 (The deposition concluded at 8:12 p.m.)
24 (Declaration under penalty of perjury on the
25 following page hereof.)

EXHIBIT B

June 20, 2019 Courtroom Discussion/Hearing Re: Barakos Trial Testimony

1 **June 20, 2019 - A.M. Session**

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3 THE FOLLOWING IS AN EXCERPT OF JURY TRIAL. THE PORTION OF THE JUNE 20, 2019 A.M. SESSION THAT PRECEDED THE FOLLOWING COLLOQUY

4 WAS NOT REQUESTED TO BE INCLUDED IN THIS TRANSCRIPT.)

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6 (JURY NOT PRESENT.)

7 THE COURT: What else do you have?

8 MR. RICCELLI: I'd left the marked up deposition, the

9 preservation deposition of Dr. Barakos. And it's substantially

10 marked up. And the issue there is --

11 THE COURT: You left it where? Because I don't have

12 it.

13 THE CLERK: It's right here.

14 THE COURT: Oh, I have it now. Okay.

15 MR. RICCELLI: And I'm advised that we have to email

16 you the electronic file because you can't download off of a zip

17 drive. So we -- I can do that, have that done fairly quickly

18 but...

19 THE COURT: What do the colors mean?

20 MR. RICCELLI: The blue is the defender's, the

21 defendant's, that's theirs, their redactions; and the orange is

22 ours. They -- the orange redactions depend upon what the Court

23 will rule as far as whether Dr. Barakos is appropriate to

24 provide any testimony. And then the orange redactions are

25 based upon either cumulative evidence or foundation. And --

1 THE COURT: Your objection originally was that his
2 testimony would be cumulative, correct?
3 MR. RICCELLI: And foundation, because he's -- he
4 doesn't go into the operating rooms. He -- he only receives
5 whatever the -- and we established that the physicians don't
6 send all of the -- all of the images or -- whether they're
7 motion images or still images, they don't send them all. In
8 this case, only two images were sent. And in every case,
9 Dr. Barakos agrees that all the images that are taken aren't
10 sent and that the -- I think everybody -- all the testimony of
11 all the experts, defense or plaintiff's, state that the surgeon
12 is the expert who's running the -- who's -- who's basically in
13 command of the imaging and that the technician works at the
14 direction of the surgeon.
15 And so Dr. Barakos's testimony is -- is outside the --
16 the actual facts of this case. And -- and his -- the primary
17 thing they're trying to place with this whole testimony is that
18 he reviews these things and he just doesn't see ACDF surgeries,
19 ACDF -- excuse me, ACDF anterior/posterior views. And that
20 testimony alone will confuse the jury, because Doctor -- well,
21 his testimony is that never happens, that -- that surgeons
22 doing ACDF surgery don't use AP views. But yesterday
23 Dr. Heller testified he may have. So if you put that testimony
24 in, it's only going to confuse the jury.
25 THE COURT: So what do you -- I don't understand. The

1 blue is what you want out?
2 MR. RICCELLI: That's what defense is -- they wanted to
3 excise, and the orange is what I believe is either cumulative
4 or lacks foundation.
5 THE COURT: So the orange is what you want out?
6 MR. RICCELLI: Yeah. And -- and basically Dr. Barakos
7 testified as to the sagittal view of the spine and pointing out
8 the two levels of disc, you know, the 5-6, 6-7, the same
9 testimony that Dr. Hamilton and Dr. Heller agreed there was
10 degenerative disease there. He testified that there may be a
11 likelihood of more degeneration over time, which both
12 Dr. Hamilton and Dr. Heller agree to, and that basically
13 it's -- it goes through the laundry list of no -- based on the
14 imaging, there's no definable neurological injury, which
15 Dr. Hamilton and Dr. Heller agree to.
16 Now, saying that there's no definable neurological
17 injury on imaging doesn't mean that there's some pain or
18 suffering resulting from the surgery. And that's what the -- I
19 think that the cumulative nature of this is they want to say
20 over and over and over C5-6 was bad. But there's -- nobody's
21 offering testimony as to, if it's bad, when it might be bad
22 enough to have surgery. But they want to keep repeating that
23 through the various witnesses, and they want to keep repeating
24 the fact that there's no discernible resulting neurological
25 injury on the imaging, which has already been testified to by

1 Dr. Heller and Dr. Hamilton, and that the -- the main issue is
2 confusing and would be difficult for the jury to deal with is
3 that Dr. Barakos testifies that ACDF surgeries and surgeons
4 don't use AP views, period. And Dr. Heller's testifying that
5 he may have used an AP view. And if those two sentiments are
6 in the same case, then the jury's going to be confused.
7 THE COURT: Well -- well, it's just -- it's a matter of
8 one expert saying one -- giving one opinion and another expert
9 giving another opinion.
10 MR. RICCELLI: Well, the one giving the other opinion's
11 the plaintiff. And if you want to allow that, then -- then a
12 lot of the redactions that are there would then be revised.
13 THE COURT: All right. Well, I haven't read it yet. I
14 was just -- it was just handed to --
15 MR. RICCELLI: No, again, I'm --
16 THE COURT: -- me.
17 MR. RICCELLI: -- I'm saying that's -- those are the
18 arguments.
19 THE COURT: So let me take a look at it.
20 Mr. Sestero, did you need to weigh in on this right
21 now?
22 MR. SESTERO: I -- I'd like to, but I can't do it in an
23 informed fashion, because I received these redactions at 9:15
24 this morning.
25 THE COURT: You got them way before I did.

1 MR. SESTERO: Apparently so.
2 THE COURT: All right. So let me -- I'll take a look
3 at them. And I don't know if -- how you want to go through
4 them. I mean, I -- I think I understand the objections, and
5 we've already talked about -- so let me just make sure that I
6 understand. The blue is what you would like out?
7 MR. SESTERO: Correct. It's colloquy and other things
8 that are not substantive.
9 THE COURT: Okay. All right. And the orange is what
10 the plaintiff wants out. So let me read it. If I have
11 questions, I will let you know. And then I'll figure out how
12 to respond to this as soon as I can.
13 MR. SESTERO: All right, thank you.
14 THE COURT: All right?
15 MR. RICCELLI: If I may, your Honor, the -- from our
16 perspective, if you view it from the issue of whether it's
17 cumulative evidence or confusing to the jury and you determine
18 that -- that some of it can be allowed and some of it can't be
19 allowed, so based on what you would allow would -- may -- may
20 change what I want to have redacted, so... Because there's --
21 there's -- Dr. Barakos is very verbose and he says a lot of
22 things in answering one question and integrates a lot of
23 answers beyond the question that's asked. So part of that has
24 to deal with if you're going to allow certain testimony about
25 certain issues, whether or not we want to redact some areas, or

1 to clarify them, remove some of the redactions. So...

2 THE COURT: All right. I'll start with what I have,

3 okay?

4 MR. RICCELLI: Mm-hm, yes.

5 (THIS CONCLUDES THE EXCERPT FROM JUNE 20TH, 2019 REGARDING VIDEO DEPOSITION REDACTIONS. THE REMAINDER OF THE 6/20/2019

6 PROCEEDINGS WERE NOT REQUESTED TO BE INCLUDED IN THIS TRANSCRIPT.)

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Appendix D

RCW 7.70.040 *

The following shall be necessary elements of proof that injury resulted from the failure of the health care provider to follow the accepted standard of care:

(1) The health care provider failed to exercise that degree of care, skill, and learning expected of a reasonably prudent health care provider at that time in the profession or class to which he or she belongs, in the state of Washington, acting in the same or similar circumstances;

(2) Such failure was a proximate cause of the injury complained of.

* As existed prior to the 2021 amendment for Covid -19, and as applicable to this matter.

MICHAEL J RICCELLI PS

December 10, 2021 - 4:51 PM

Transmittal Information

Filed with Court:	Court of Appeals Division III
Appellate Court Case Number:	37081-0
Appellate Court Case Title:	Artie Len Reinert, et al v. Allen C. Heller MD, et al
Superior Court Case Number:	16-2-03847-1

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