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No. 53248-4-II

COURT OF APPEALS, DIVISION II
OF THE STATE OF WASHINGTON

CHRISTOPHER W. SARTIN and ROSE M. RYKER,
Individually and as a marital community,
Appellants

v.

THE ESTATE OF ALONZO MCPIKE;
PIERCE COUNTY PUBLIC TRANSPORTATION BENEFIT AREA CORPORATION, a/k/a PIERCE TRANSIT, MULTICARE HEALTH SYSTEM, a Washington Corporation d/b/a TACOMA GENERAL HOSPITAL; MULTICARE OCCUPATIONAL MEDICINE; and RICHARD GILBERT, M.D. individually,
Respondents

PETITION FOR REVIEW BY SUPREME COURT

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A. IDENTITY OF PETITIONER

Appellant Christopher Sartin petitions the Court to accept review of the published decision of Division II of the Court of Appeals identified in the following section.

B. COURT OF APPEALS DECISION

In its November 3, 2020 published opinion, attached hereto at Appendix A, Division II of the Court of Appeals denied Mr. Sartin's arguments regarding the summary dismissal of his claims as to all Defendants by the trial court. Mr. Sartin requests review of all portions of this opinion.

C. ISSUE PRESENTED FOR REVIEW

1. Should the Supreme Court reaffirm longstanding precedent in Washington law regarding foreseeability despite Division II's departure from that precedent in this case? YES.

2. Did the Court of Appeals err when it failed to hold each Defendant to standards set forth in the proper FMCSA regulatory scheme? YES.

3. Does the issue of whether members of the public should be able to recover from injuries caused by medically unfit commercial drivers present an issue of substantial public importance? YES.

D. STATEMENT OF THE CASE

I. Federal Regulatory Scheme and Medical Examination

Established under authority set forth in the COMMERCIAL MOTOR VEHICLE SAFETY ACT OF 1986, TITLE XII, P.L. 99-570, the Federal Motor Carrier Safety Administration ("FMCSA") sets forth comprehensive safety regulations for commercial motor carriers. 49 U.S.C. § 31102. FMCSA establishes minimum qualifications for persons

who drive commercial motor vehicles as well as the "minimum duties of motor carriers with respect to the qualifications of their drivers." 49 C.F.R. § 391.1(a). Although states may adopt their own requirements for "intrastate" motor carriers, the Washington state legislature has explicitly adopted these federal standards with the purpose of reducing commercial vehicle injuries through strengthening commercial licensing and testing standards. RCW 46.25.005(1)(c).

Commercial bus drivers must hold a commercial driver's license ("CDL"). CP at 18. In order to obtain a CDL, drivers must undergo periodic physical examinations by a certified medical examiner. 49 C.F.R. § 391.45. These examinations are heavily regulated under the guidelines set forth by FMCSA at 49 C.F.R. § 391.41-43. Certified medical examiners are required by regulation to "[b]e knowledgeable of the physical and mental demands associated with operating a commercial vehicle... and the medical advisory criteria prepared by the FMCSA...." 49 C.F.R. § 391.43(c)(1). The medical examination includes a comprehensive physical evaluation and screening for various health conditions. 49 C.F.R. § 391.41 and *See* Appx. A to Part 391 - Medical Advisory Criteria. In 2014, FMCSA strengthened the requirements of CDL examiners to be specially certified to perform the exams in accordance with FMCSA regulations. CP 336; 49 C.F.R. § 391.43.

The examiner has the authority to grant or deny medical certification and can issue a certificate for anywhere from three months to

two years, depending on the results of the exam. 49 C.F.R. § 391.45(b); *See* Appx. A to Part 391 – Medical Advisory Criteria (F)(4). The focus of the CDL exam is to evaluate whether a driver has medical conditions that can interfere with the drivers' ability to safely operate a vehicle or increase the risk of incapacitation while driving. CP at 1702.

Regarding hypertension and high blood pressure, Appx. A to Part 391 – Medical Advisory Criteria (F)(4) instructs:

> A blood pressure of 160-179 systolic and/or 100-109 diastolic is considered Stage 2 hypertension, and the driver is not necessarily unqualified during evaluation and institution of treatment. The driver is given a one-time certification of three months to reduce his or her blood pressure to less than or equal to 140/90...Provided treatment is well tolerated and the driver demonstrates a blood pressure value of 140/90 or less, he or she may be certified for one year from date of the initial exam.

In addition to concerns about elevated blood pressure, 12 other conditions are closely considered to determine if the conditions will affect the driver's ability to drive safely. *See* 49 C.F.R. § 391.41(b)(1-13). These conditions are important considerations in driver certification because occupational research has shown that these conditions are significant risk factors for preventable crashes. CP at 345-46.

II. Pertinent Factual Background

On May 26, 2015, Defendant Alonzo McPike began his shift as a Pierce Transit public bus driver in Tacoma, Washington. CP at 74. Some time later, Mr. McPike slumped over in the driver's seat, held in by only his seatbelt, and the bus careened ahead and collided with a pickup truck

that was stopped at a red light. CP at 3, 64, 98. Mr. Sartin was a passenger in the truck and was seriously injured in the collision. CP at 3- 4.

Emergency responders arrived at the scene and determined that Mr. McPike's heart had stopped. CP at 121. Mr. McPike remained in a coma and died five weeks after the collision. CP at 121-22. The causes of death listed on his death certificate were anoxic brain injury, cardiac arrest, diabetes and hypertension, and obesity, with untreated obstructive sleep apnea as a contributing factor. CP at 388. At the hospital, Mrs. McPike confirmed her husband's deteriorating health and his refusal to take care of himself, telling a social worker that she had "always feared that his self-inflicted health problems would cause something like this, and it would all land on me. CP at 378.

Indeed, in the months before the collision, Mr. McPike's health had deteriorated. *Infra.* For example, in November 2014, Mr. McPike presented to Dr. Kirk Harmon, a certified CDL medical examiner, to renew his CDL. CP at 277-79. Per controlling CDL regulations, Dr. Harmon denied a full-year renewal of Mr. McPike's CDL because his blood pressure was 150/72 on the date of the exam. CP at 1714-16. Instead, Mr. McPike received a one-time 3-month renewal. *Id.* In a letter dated November 7, 2014, Dr. Harmon warned Mr. McPike that his blood pressure was too high, and regulations required it to be no higher than 140/90 to maintain licensure. CP at 1728, 1105.

On January 30, 2015, Mr. McPike saw Defendant Dr. Gilbert for re-certification. CP at 116-17. Mr. McPike had a disqualifying blood pressure reading of 162/64 on the day of his exam, elevating him to stage 2 hypertension and creating a more dangerous risk of incapacitation.[1] CP at 118. Mr. McPike also exhibited symptoms of 8 of the 13 conditions recognized as risk factors for interfering with safe driving. CP at 345-46. Nonetheless, contrary to FMCSA mandates, Dr. Gilbert re-certified Mr. McPike for a full year. CP at 118.

III. Procedural Background

Plaintiff Christopher Sartin filed a Complaint against Defendants Pierce Transit and the Estate of Alonzo McPike.[2] CP at 1-6. Thereafter, Mr. Sartin filed a Complaint against Defendants Multicare Health System and Richard Gilbert, M.D. (collectively "Dr. Gilbert") for negligence causing injuries arising from the same collision, and the two cases were consolidated. CP at 974, 983.

On January 4, 2019, the trial court granted Pierce Transit's motion for summary judgment, holding that Mr. McPike's loss of consciousness was not foreseeable as a matter of law. CP at 1294. Mr. Sartin filed a motion for reconsideration, which was denied. CP at 1585. Dr. Gilbert

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[1] The FMCSA Medical Examiner Handbook states: BP greater than or equal to 140/90 is deemed high for most... for every 20 mm Hg systolic or 10 mm Hg diastolic increase in BP there is a doubling of mortality from both ischemic heart disease and stroke. The relationship between BP and risk of a [cardiac] event is continuous, consistent, and independent of other risk factors. CP at 1605-06.

[2] Mr. McPike was working in the scope of his employment with Pierce Transit at the time of the collision, so liability is also imputed to Pierce Transit through *respondeat superior* if Mr. McPike is found liable. Plaintiff also maintains separate claims of negligence against Pierce Transit for its failure to properly oversee driver health and safety.

also filed a motion for summary judgment. CP 1382. In ruling on Dr. Gilbert's motion, the court struck the declaration of Dr. Fletcher, Plaintiff's expert, as to his opinions on cardiac issues. CP at 1379, 1837. The court then granted Dr. Gilbert's motion for summary judgment. *Id.*

Mr. Sartin appealed. The Court of Appeals affirmed dismissal as to Mr. McPike holding that Mr. McPike's loss of consciousness was unforeseeable as a matter of law and there was no genuine issue of fact as to whether his loss of consciousness was "sudden." As to Pierce Transit, the Court of Appeals affirmed dismissal, holding that there was no evidence that Pierce Transit's actions were a proximate cause of the collision. Finally, as to Dr. Gilbert, the Court of Appeals affirmed dismissal, holding that without Dr. Fletcher's declaration, there was no evidence that Dr. Gilbert's actions were a proximate cause of the collision.

E. ARGUMENT

Mr. Sartin respectfully requests review by the Supreme Court because: (1) the Court of Appeals diverged from long-standing Washington authority and adopted an incongruent legal standard regarding foreseeability, (2) the Court of Appeals erred in ignoring the applicable regulatory scheme of FMCSA as adopted by the State of Washington, and (3) this case addresses an issue of substantial public importance effecting the safety of the public. As such, this Court should accept review under RAP 13.4(b)(1), (2), and (4).

I. THE COURT OF APPEALS' DECISION IS INCONGRUENT WITH PUBLISHED AUTHORITY FROM THIS COURT, THE COURT OF APPEALS, AND FMCSA

a. The Court of Appeal's analysis misapplies Washington law on foreseeability and conflicts with prior published opinions of this Court and the Court of Appeals.

Summary Judgment is appropriate only when there is no genuine issue as to any material fact and when viewing all facts and inferences in a light most favorable to the non-moving party, the moving party is entitled to judgment as a matter of law. *Strauss v. Premera Blue Cross*, 194 Wn. 2d 296, 300, 449 P.3d 640 (2019). Typically, an expert opinion will be sufficient to create a genuine issue of fact to defeat summary judgment if the opinion is grounded in fact and not merely based on speculation or assumptions. *Id.* at 301. The review on appeal is *de novo*, meaning appellate courts must conduct the same inquiry as the trial court. *Id.* at 300; *Folsom v. Burger King*, 135 Wn.2d 685, 663, 958 P.2d 301 (1998).

It is a long-standing tenet of Washington law that the question of foreseeability is one for the jury. *See e.g., Schooley v. Pinch's Deli Market, Inc.*, 134 Wn.2d 468, 477, 951 P.2d 749 (1998); *Christen v. Lee*, 113 Wn.2d 479, 492, 780 P.2d 1307 (1989). Foreseeability can only be resolved by the court if reasonable minds cannot differ as to whether the defendant's actions foreseeably fall into the scope of their duty to the plaintiff. *Lee v. Willis Enterprises, Inc.*, 194 Wn. App. 394, 401, 377 P.3d 244 (2016). The question for the jury is whether the defendant could have reasonably foreseen the eventual consequences of their actions. *Id.* at 402.

This Court has long stated that foreseeability is established when, "[t]he harm sustained [is] reasonably perceived as being within the general field of danger covered by the specific duty owed by the defendant." *Maltman v. Sauer*, 84 Wn.2d 975, 981, 530 P.2d 254 (1975). It is not a question of whether a particular kind of harm was expectable, but rather whether the harm fell within an anticipated general field of danger. *Rickstad v. Holmberg*, 76 Wn.2d 265, 269, 456 P.2d 355 (1969).

The issue of foreseeability in the context of drivers who lose consciousness has been addressed in two published Washington cases. *Kaiser v. Suburban Transp. System*, 65 Wn.2d 461, 398 P.2d 14 (1965); *Presleigh v. Lewis*, 13 Wn. App. 212, 214, 534 P.2d 606, 607 (1975). In *Kaiser*, the court relieved the driver of liability because the driver was not warned that a medication would cause drowsiness, so it was not foreseeable that he would lose control of his vehicle. 65 Wn.2d at 466-68. Subsequently, in *Presleigh,* the Court of Appeals applied *Kaiser* and squarely laid out the rule applicable in Washington concerning whether the defense of sudden incapacitation is available to a driver:

> One who undertakes to drive his automobile has a duty to drive it in a reasonable manner so as to not injure another... The defendant breached that duty as a matter of law when he undertook to drive his automobile knowing his ability to drive in a reasonable manner might be affected. The fact that he did not know the precise way in which his driving might be affected...does not relieve him from a breach of this duty.

Id. at 214 (emphasis added).

This has remained the rule in Washington for over 40 years. Yet, in its analysis of foreseeability in the present case, the Court of Appeals applied the RESTATEMENT (THIRD) OF TORTS: PHYS. & EMOT. HARM § 11 (2010). This appears to be the first time this Restatement has been applied in Washington law, and Court's application of it represents a significant departure from the rule set forth in *Presleigh*. Restatement § 11(b) states in relevant part:

> The conduct of an actor during a period of sudden incapacitation or loss of consciousness resulting from physical illness is negligent only if the sudden incapacitation or loss of consciousness was reasonably foreseeable to the actor.

In applying this rule, the Court of Appeals focused on whether the *specific cause* of "sudden incapacitation or loss of consciousness" was foreseeable. This application of the rule completely diverges from long-standing Washington law that only requires that the harm fell within the general field of danger. The Court of Appeals' application does not account for a driver whose ability to safely operate a vehicle will be foreseeably affected in some way due to the risks associated with his multitude of health conditions.

The *Presleigh* rule properly accounts for circumstances in which it is within an actor's *general knowledge* that his ability to drive safely will be affected in some way. Application of this rule to commercial drivers is especially important when considered in the context of regulations that

ensure that only drivers medically fit for duty are certified. The statutory duty is squarely defined in 49 C.F.R. § 392.3, which states:

> No driver shall operate a commercial motor vehicle, and a motor carrier shall not require or permit a driver to operate a commercial motor vehicle, **while the driver's ability or alertness is so impaired, or so likely to become impaired, through fatigue, illness, or any other cause**, as to make it unsafe for him to begin or continue to operate the commercial vehicle. (Emphasis added).

This regulation squares with *Presleigh* and further establishes that the general risk of interference with a driver's ability to drive safely should be the basis of the foreseeability analysis. Under this duty, the general danger to the public was that Mr. McPike's poor health would impair his ability to safely drive – the exact manner in which it were to occur is irrelevant because the outcome remains the same no matter which of his many high-risk ailments ultimately caused the collision.

Here, the lower courts became laser focused on the idea that the specific cause of Mr. McPike's loss of consciousness was due to coronary artery disease ("CAD") which was not foreseeable because he had no prior diagnosis of CAD. However, whether it was foreseeable that Mr. McPike would fall unconscious from CAD was not the proper inquiry under *Presleigh*; the real question was whether it was foreseeable that his overall poor health would affect his ability to safely drive in some way.

The rule set forth in *Presleigh* is also more closely aligned with the rule adopted by the courts in modern analyses of foreseeability. In *Lee,* the court described foreseeability as a "flexible concept, and a defendant

will not be relieved of a responsibility simply because the exact manner in which the injury occurred could not be anticipated." 194 Wn. App. at 402.

Here, the Court of Appeals determined that *Lee* did not apply because it "addresses foreseeability in the context of a legal duty – whether it was foreseeable that the defendant's careless behavior...could cause some injury." In fact, that is exactly the inquiry in this case – whether it was foreseeable to each Defendant that Mr. McPike's known high-risk medical conditions could affect his ability to safely operate a vehicle and cause some injury. Each Defendant's duty is statutorily defined in FMCSA, and the regulations are designed to keep unfit drivers off of the road due to the general risk of danger they pose to the public. Each Defendant here should have known of the risks presented by Mr. McPike by operating a commercial vehicle because FMCSA and occupational health standards specifically warned them of this danger.

It does not matter whether Mr. McPike became incapacitated due to the onset of undiagnosed CAD, or complications with diabetes, or sleep apnea/fatigue issues, or effects of benzodiazepine use, or hypertension. CP 345-46. Each Defendant knew or should have known of the foreseeable risk of allowing Mr. McPike to continue driving because FMCSA provides strict standards that guide whether a driver is medically fit – i.e. reasonably safe – to drive a commercial vehicle. Mr. McPike was undeniably unfit, and his eventual incapacitation was well within the general dangers anticipated by his unfitness under FMCSA guidelines.

Even Dr. Thompson, a defense cardiology expert, signed off on a report stating that Mr. McPike's cardiac arrest was "entirely due to preexisting coronary heart disease caused by hypertension, diabetes, high blood cholesterol, smoking, sleep apnea, and obesity." CP 407. These high-risk factors made Mr. McPike a ticking time bomb for eventual incapacitation.

For the first time in a Washington state case, the Court of Appeals, without explanation, adopted Restatement § 11 and narrowed the rule on foreseeability to whether the *specific cause* of incapacitation was foreseeable. But Washington precedent, like FMCSA, is rightfully concerned with the foreseeable *general risk* that a medically unfit driver poses, not whether the exact manner of eventual incapacitation was predicted. The Court of Appeals' application of foreseeability diverges strongly from long-held tenets of Washington law and creates a conflict among divisions. Accordingly, the Supreme Court must reconcile this conflict and affirm the long-established rule set forth in *Presleigh* et. al in order to protect the public from the foreseeable risks of harm created by medically unfit drivers.

b. Under controlling law, Mr. McPike's incapacitation was foreseeable to Dr. Gilbert based on his examination and mandatory FMCSA standards for CDL licensure.

Certified medical examiners are required by regulation to "[b]e knowledgeable of the physical and mental demands associated with operating a commercial vehicle... and the medical advisory criteria prepared by the FMCSA...." 49 C.F.R. § 391.43(c)(1). It is the

fundamental obligation of the medical examiner to assess whether a driver's physical condition could interfere with his ability to safety operate a commercial vehicle. CP 1702.

Under FMCSA advisory standards, if a driver presents for examination with blood pressure readings over 140/90, an examiner can only issue a ***one- time*** three-month certification. Appx. A to 49 C.F.R. § 391.43(F)(4). If the driver reduces their blood pressure to under 140/90 during those three months, a one-year certification is available. *Id.* However, without an acceptable blood pressure reading following the three-month certification, the driver is disqualified from re-certification, full-stop. *Id.* Despite this requirement, Dr. Gilbert re-certified Mr. McPike for a full year following Dr. Harmon's three-month certification even though his blood pressure reading was a dangerous and disqualifying 162/64 on the day of his re-certification exam. [3]

In addition, Mr. McPike exhibited 8 of 13 conditions known to increase the risk of driver incapacitation – the very peril Dr. Gilbert was charged with assessing; yet, Dr. Gilbert re-certified Mr. McPike without further investigation. FMCSA sets forth clear standards to be followed by certified CDL examiners in order to keep drivers that create a foreseeable risk of harm off the road. Had Dr. Gilbert acted prudently, he would have disqualified Mr. McPike and the collision would have been avoided.

[3] Although the Court of Appeals acknowledged this disqualifying blood pressure reading, it did not examine the significance of Dr. Gilbert's direct violation of the FMCSA mandate that required him to disqualify Mr. McPike from re-certification.

In granting Dr. Gilbert's motion for summary judgment, the trial court and Court of Appeals struck the declaration of Dr. Fletcher, the Plaintiff's expert medical witness, as to causation on cardiac issues because they determined that Dr. Fletcher was not qualified to testify on cardiac issues; yet, the court admitted that Dr. Fletcher was qualified to testify about the appropriate standard of conduct of CDL medical examiners under FMCSA. When considered in the proper context of whether Mr. McPike presented a general risk of foreseeable harm due to his co-morbid conditions, rather than whether CAD was specifically foreseeable, Dr. Fletcher's opinions were not speculative and provided competent evidence regarding occupational health and FMCSA standards.

Reasonable minds could determine only that Dr. Gilbert knew or should have known that Mr. McPike presented a foreseeable risk of harm as established by the certification standards. FMCSA standards alerted Dr. Gilbert that his comorbidities and disqualifying hypertension created a heightened risk of incapacitation; that Mr. McPike would eventually become incapacitated due to his health and cause a collision was the exact danger created by Dr. Gilbert imprudently re-certifying Mr. McPike.

In its adoption of application of foreseeability only to the specific manner of incapacitation, the Court of Appeals significantly narrowed the long-standing rules regarding foreseeability that afford protection against generally foreseeable risks of harm related to a defendant's breach of duty.

In doing so, the Court of Appeals gutted the protections set forth in FMSCA and adopted by the legislature regarding commercial drivers.

c. The Court of Appeals erred when it failed to consider that Mr. McPike could have reasonably foreseen that his ability to drive safely would be affected in some way when he continued to drive despite warnings of his failing health.

The Court of Appeals determined that Mr. McPike had no warning or knowledge that he was not safe to drive, so his incapacitation was unforeseeable. However, the Court of Appeals' analysis did not properly address Mr. McPike's own duty under FMCSA. FMCSA imposes a statutory duty on commercial drivers to refrain from driving when their abilities will so likely become impaired through fatigue, illness, or any other cause, as to make it unsafe for him to operate a commercial vehicle. *Supra*. Here, Mr. McPike had ample warnings that his ability to drive safely would be affected in some way.

The November 7, 2020 letter from Dr. Harmon warned Mr. McPike that his blood pressure was too high to continue driving when it registered 150/72. When Mr. McPike saw Dr. Gilbert three months later and his blood pressure was 162/64 – much higher than in November – he should have known he was not safe to drive. Additionally, Mr. McPike's wife's comments at the hospital indicate that his health was markedly deteriorating in the months prior to the collision, and he was failing to take care of himself. Finally, as cited by Plaintiff at CP 349-51, Mr. McPike made misrepresentations to his health care providers about his health. Viewed in a light most favorable to the Plaintiff, the only logical inference

drawn from Mr. McPike's behavior is that he knew or should have known that he was medically disqualified from driving and it was foreseeable to him that his driving would be affected in some way by his poor health.

Here again, proper application of the FMCSA framework aligns with the rule of foreseeability set forth in *Presleigh* and *Lee* because FMCSA seeks to protect the public from the general dangers created by drivers whose ability to safely drive could foreseeably be affected *in some way*. Thus, in its analysis as to Mr. McPike the Court of Appeals undermined not only the long-standing rule on foreseeability in Washington, but also gutted the regulatory protections of FMCSA.

II. THE COURT OF APPEALS FAILED TO HOLD THE DEFENDANTS TO THE MANDATED STAUTORY REQUIREMENTS OF FMCSA

As discussed at length above, FMCSA provides clear guidance as to what conditions will render a driver disqualified from driving due to the risk of foreseeable harm created by medically unfit drivers. Under *Presleigh*, material issues of fact abound as to whether each Defendant knew or should have known that Mr. McPike's ability to drive would be affected had FMCSA guidance been followed.

As described above, Dr. Gilbert should have refused to re-certify Mr. McPike due to his co-morbid conditions and disqualifying blood pressure under FMCSA, and Mr. McPike should have removed himself from operating a commercial vehicle when he was warned of the dangers of his failing health. As to Pierce Transit, FMCSA imparts a statutory

duty on motor carriers to provide oversight over the health and safety of its drivers, but the Court of Appeals again showed its indifference to FMCSA when it declined to address this issue at all in its opinion.

The Court of Appeals determined that Pierce Transit was not subject to liability because the Plaintiff did not establish that its actions were a proximate cause of Mr. Sartin's injuries since there is no evidence that an employer-ordered follow-up exam as recommended by Dr. Fletcher would have revealed a disqualifying condition such as CAD to Pierce Transit. However, this analysis again ignores that Mr. McPike's overall health presented a foreseeable risk of harm that should have caused Pierce Transit to remove Mr. McPike from the road.

The Court of Appeals ignored a significant part of the Plaintiff's analysis of Pierce Transit's liability when it failed to consider Pierce Transit's oversight and supervision duties under FMCSA. As a motor carrier, Pierce Transit has a distinct duty under FMCSA to ensure that its drivers are medically fit to operate its vehicles. 49 C.F.R. § 392.3 states:

> *A motor carrier shall not require or permit* a driver to operate a commercial motor vehicle, **while the driver's ability or alertness is so impaired, or so likely to become impaired, through fatigue, illness, or any other cause**, as to make it unsafe for him to begin or continue to operate the commercial vehicle. (Emphasis added).

Plaintiff's expert on commercial transportation standards, Lew Grill, opined that Pierce Transit failed to adequately investigate Mr. McPike's medical fitness in violation of industry standards and applicable

regulations. CP at 335-76. As to a motor carrier's duty under FMCSA, Mr. Grill testified:

> That's a motor carrier's call. That's our custom and practice. If it looks like [drivers] are not going to be able to – as a reason of health and waning health to be able to do this...job on a day-by-day basis and become cured from whatever illness they have...it's on us as a motor carrier. CP at 1170.

As part of this duty, Pierce Transit should review records available to it and analyze whether there are red flags that may make that driver a risk to the public. CP at 1155-64, 1180-82. But Pierce Transit's own witness testified that Pierce Transit did not assign anyone to oversee operator health, CP at 332, had never discussed improving operator health, CP at 296, and did not educate operators about medical fitness. CP at 302.

If Pierce Transit had followed required industry and regulatory standards in monitoring driver health, it would have known that Mr. McPike's health presented a foreseeable risk of harm that disqualified him from driving. If it had acted prudently, Pierce Transit would have taken Mr. McPike off the road, preventing the collision. Thus, Pierce Transit's breach of its statutory duty was a proximate cause of this collision.

Despite significant briefing on the subject by the Plaintiff, the Court of Appeals did not consider this issue in its analysis at all. In fact, the Court of Appeals' opinion does not mention expert witness Lew Grill even once. Mr. Sartin presented competent expert testimony on the duties of a motor carrier like Pierce Transit to ensure that they monitor the safety

of their operation by monitoring the health of their drivers, and whether Pierce Transit breached its duties is a question of fact for the jury.[4]

FMCSA imposes a clear and distinct duty on motor carriers to ensure its drivers meet medical fitness requirements. By absolving Pierce Transit of its duty under FMCSA, the Court of Appeals has essentially rendered the statutory mandates of FMCSA "optional" despite the state legislature's clear intent to adopt federal safety standards.

III. THIS DECISION INVOLVES A MATTER OF SUBSTANTIAL PUBLIC IMPORTANCE BECAUSE IT HAS LONG-REACHING EFFECTS ON THE PUBLIC'S ABILITY TO RECOVER FOR INJURIES CAUSED BY MEDICALLY UNFIT DRIVERS

The rulings by the lower courts in this case have essentially overruled the statutory guidelines set forth in FMCSA and rendered them purposeless in Washington. To allow CDL examiners and motor carriers to put medically unfit drivers on the public roads undermines the federal regulatory scheme that was specifically adopted by the Washington State legislature with the purpose of protecting the public from the exact peril that was created by Mr. McPike's driving.

The Court of Appeals' improper application of foreseeability renders each Defendant in this case free from any duty to the travelling public, despite their ability to protect the public by ensuring drivers are medically fit and removing them from operation when they are not. It is squarely within the purview and control of these entities to ensure that the

[4] Under the *de novo* review standard, Mr. Grill's witness testimony as to Pierce Transit's failures creates a material issue of fact and dismissal of these claims was improper.

general public is safe from unfit drivers having the opportunity to get behind the wheel of a dangerous vehicle like a bus.

Pierce Transit, Dr. Gilbert, and Mr. McPike are gatekeepers to ensuring the public's safety in relation to commercial vehicles. Yet, the lower courts absolved each Defendant of liability despite their failures to follow the statutory mandates of FMSCA. To allow each of these entities to be free from liability as suggested by the Court of Appeals has the effect of rendering federal commercial vehicle regulations inapplicable in Washington, despite the legislature's adoption of these standards. To affirm the Court of Appeals' decision would be in complete defiance of the scope and purpose of applicable regulations and will disregard the intent of the Washington state legislature. *See* RCW 46.25.005.

F. CONCLUSION

The Court of Appeals erred in its application of Restatement § 11 in conflict with long-standing Washington precedent regarding foreseeability. Additionally, the Court of Appeals disregarded the federal mandates of FMCSA, rendering the statutory scheme futile in Washington despite the legislature's adoption of federal standards. Finally, this case presents an issue of substantial public importance that must be resolved by due to the long reaching affects this decision will have on the ability of injured plaintiffs to recover from commercial drivers. For these reasons, review of this decision by the Supreme Court is proper under RAP 13.4(b)(1),(2),(4).

RESPECTFULLY SUBMITTED this 1st day of December 2020.

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CERTIFICATE OF SERVICE

The undersigned certifies under penalty of perjury under the laws of the State of Washington that I am an employee of Davies Pearson, P.C., over the age of 18 years, and competent to be a witness herein.

On this date, I caused to be served via the Washington State Court of Appeals, Division II, e-filing system, the foregoing Petition for Review and this Certificate of Service on:

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The undersigned further certifies that on this date I electronically filed the foregoing documents with the Washington State Court of Appeals, Division II, via the Washington State Appellate Court's Portal upload (https://ac.courts.wa.gov/).

/s/ Linda Khampradith
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Paralegal to Sok-Khieng K. Lim

APPENDIX A

Filed
Washington State
Court of Appeals
Division Two

November 3, 2020

IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON

DIVISION II

CHRISTOPHER W. SARTIN and ROSE M. RYKER, individually and as a marital community; and JILL SACKSTEDER and CHARLES SACKSTEDER, individually and as a marital community, Appellants, v. THE ESTATE OF ALONZO McPIKE; PIERCE COUNTY PUBLIC TRANSPORATION BENEFIT AREA CORPORATION, a/k/a/ PIERCE TRANSIT; and MULTICARE HEALTH SYSTEM, a Washington corporation d/b/a TACOMA GENERAL HOSPITAL and MULTICARE OCCUPATIONAL MEDICINE; and RICHARD GILBERT, MD, individually, Respondents.	No. 53248-4-II PUBLISHED OPINION

MAXA, J. – Christopher Sartin appeals the trial court's dismissal on summary judgment of a personal injury lawsuit he filed against the Estate of Alonzo McPike and his employer Pierce Transit, and against Dr. Richard Gilbert and his employer MultiCare Health System (collectively, Dr. Gilbert). The lawsuit arose from an incident in which McPike lost consciousness due to cardiac arrest while driving a Pierce Transit bus, and the bus collided with a vehicle Sartin was occupying. A few months earlier, Dr. Gilbert had conducted a medical examination on McPike as required for renewal of McPike's commercial driver's license (CDL) and had determined that McPike qualified for a CDL medical certificate.

Sartin asserted that (1) although the general rule is that a vehicle driver who suddenly loses consciousness is not negligent unless the loss of consciousness was reasonably foreseeable to the driver, McPike was negligent because his numerous health problems made his loss of consciousness foreseeable; (2) Pierce Transit was negligent for failing to monitor McPike's medical conditions and order fitness for duty evaluations; and (3) Dr. Gilbert was negligent for issuing McPike a CDL medical certificate despite his health problems.

We conclude that (1) as matter of law, it was not reasonably foreseeable to McPike that he would lose consciousness even though he had several preexisting health problems; (2) there is no genuine issue of fact regarding Pierce Transit's independent liability for failure to monitor McPike's medical conditions because there is no evidence that fit for duty examinations would have disqualified McPike from driving a bus; and (3) without deciding Dr. Gilbert owed or breached a duty to Sartin, the trial court did not err in striking Sartin's expert's testimony about cardiac issues and causation, and therefore there is no genuine issue of fact regarding causation.

Accordingly, we affirm the trial court's grant of summary judgment in favor of McPike's estate, Pierce Transit, Dr. Gilbert and MultiCare.

FACTS

McPike was 58 years old at the time of the accident. He had worked for Pierce Transit as a bus operator for approximately 18 years. He had never experienced cardiac arrest or a sudden loss of consciousness while driving a bus.

Regulatory Background

Pierce Transit bus drivers must maintain a CDL. Federal and state statutes establish Washington's requirements for issuing CDLs. Obtaining a valid CDL requires a driver to undergo an annual medical examination with a medical examiner registered on the National

Registry of Certified Medical Examiners list to ensure that he or she is physically qualified to operate a commercial vehicle. Washington also has created a waiver program for intrastate drivers who otherwise would be disqualified for having insulin-dependent diabetes.

At the CDL medical examination, the driver is advised about the limited scope of the exam for employment purposes only. The driver fills out a form called the Department of Transportation (DOT) long form before the physical examination. The medical examiner reviews the driver's medical history and conducts a complete physical examination. The examiner has the authority to grant or deny a one year medical certificate. The examiner also may issue only a three-month "short card" certificate if the driver has a medical condition that must be treated or resolved.

McPike's Medical History

Dr. Mark Brooks was McPike's primary care physician for over 20 years. He monitored McPike and coordinated care with various specialists. Dr. Brooks acknowledged that McPike had multiple health problems, including diabetes mellitus, hypertension, high cholesterol and obesity, that increased his risk of developing a heart condition at some time in the future. However, Dr. Brooks stated that McPike never reported precursor signs or symptoms of sudden cardiac arrest. McPike also had no history of coronary heart disease or any other serious heart conditions.

In 2012, Dr. Brooks referred McPike to Dr. Zhiyu Wang to treat McPike's diabetes. Dr. Wang monitored McPike's condition until shortly before the accident.

In November 2012, Dr. Timothy Larson conducted a cardiac workup on McPike. Dr. Larson subjected McPike to a number of tests, including an electrocardiogram (ECG) and a cardiac echocardiogram (ECHO). Testing revealed two types of irregular rhythms: premature

atrial contractions (PACs) and premature ventricular contractions (PVCs). Dr. Larson considered the findings benign. The ECHO also showed normal heart function and no sign of any coronary artery disease. Dr. Larson did not recommend a follow up.

In January 2014, McPike took two separate leaves of absence that totaled up to two weeks to manage his diabetes. Pierce Transit did not order a fitness for duty examination upon his return.

In November 2014, Dr. Kirk Harmon performed McPike's annual CDL medical examination. He recorded McPike's blood pressure as 150/72, which was too high for a one year qualification but sufficient for a three month short card. Dr. Harmon informed McPike that he needed to see his primary care physician to get his blood pressure under control. He also recommended that McPike undergo a screening sleep study for sleep apnea.

Dr. Harmon sent Dr. Brooks a note requesting three blood pressure readings under 140/90. Dr. Brooks saw McPike several times in the next few months and personally took McPike's blood pressure. He recorded readings of 134/70 on November 28, 138/68 on December 16, and 132/70 on January 14, 2015. Dr. Brooks also certified that McPike's blood pressure was under adequate control and that he could drive a commercial vehicle.

In December 2014, McPike underwent a sleep study and was diagnosed with severe sleep apnea. He began using a continuous positive airway pressure (CPAP) machine to control his sleep apnea.

In January 2015, McPike met with Dr. Gilbert for another CDL medical examination. Dr. Gilbert reviewed McPike's medical history and conditions and noted that he was taking insulin for his diabetes. He also reviewed an intrastate waiver application signed by Dr. Wang certifying that McPike's diabetes was not likely to interfere with his ability to drive safely. Dr.

Gilbert also reviewed McPike's sleep apnea diagnosis and noted that he was using a CPAP machine to control it.

Dr. Gilbert reviewed McPike's diagnosis of hypertension and reviewed the compliance letter that Dr. Harmon issued in November 2014. He noted Dr. Brooks' recent blood pressure results and certification that McPike's hypertension was under control and that his blood pressure did not prevent him from driving a commercial vehicle. However, Dr. Gilbert measured McPike's blood pressure at 162/64.

Finally, Dr. Gilbert identified an irregular cardiac rhythm, likely PACs. McPike informed him that he had a cardiac workup done within the last year or so and that the results were normal. However, Dr. Gilbert could not locate those records. Dr. Gilbert did not think that McPike's cardiac rhythm likely would interfere with his ability to safely operate a commercial motor vehicle. Dr. Gilbert issued McPike a one year CDL medical certificate.

On March 3, 2015, McPike had a follow up visit with Dr. Wang. Dr. Wang noted that McPike's control of his diabetes had declined somewhat due to an irregular diet and uncontrolled eating because of his work schedule. Dr. Wang recommended that McPike monitor his blood gas levels. At that time, McPike's weight was 305 pounds and his blood pressure was 140/78. His cardiovascular exam was normal.

On March 27, McPike had a follow up visit with Dr. Brooks regarding his hypertension. Dr. Brooks noted that McPike's blood pressure was under control and that he had no cardiac symptoms. McPike did not complain of any cardiac issues and there were no abnormalities found on cardiopulmonary exam. Dr. Brooks saw no evidence that McPike had coronary artery disease or that he needed a cardiac referral. The assessment was stable hypertension.

May 2015 Accident

On May 26, 2015, McPike reported for work at Pierce Transit and began his usual bus route around 4:30 AM. Around 8:30 AM, passengers noticed that McPike was slumped in his seat while the bus was in motion. McPike lost control of the bus, which collided with the back of another vehicle. Sartin was a passenger in that vehicle.

Doctors later determined that McPike had suffered a cardiac arrest. Sudden cardiac arrest occurs when the electrical system to the heart malfunctions, often causing immediate loss of consciousness.

When emergency responders arrived at the scene of the collision, they found McPike unconscious with no heartbeat. They were able to restore the heartbeat, and McPike was hospitalized in a coma. Doctors conducted a cardiac work-up while McPike in the hospital. The reviewing doctor did not detect any cardiac abnormalities other than the electrical malfunction. The reviewing doctor's findings were not consistent with coronary artery disease. McPike ultimately died four weeks later without regaining consciousness.

Pierce Transit buses are equipped with video cameras and footage from the cameras is available for preservation for 30 days. Pierce Transit preserved only eight minutes of footage from the day of the collision, and only approximately two minutes were immediately preceding the accident.

Complaint and Summary Judgment

Sartin filed a complaint for personal injuries against McPike's estate and Pierce Transit. Sartin later filed a separate lawsuit against Dr. Gilbert and MultiCare. These two lawsuits eventually were consolidated.

In December 2017, McPike's estate and Pierce Transit filed a summary judgment motion on liability, arguing a lack of evidence that McPike's loss of consciousness was foreseeable. The motion was supported by the declaration of Dr. Robert Thompson, a cardiologist and internal medicine specialist. Dr. Thompson gave an opinion that based on McPike's medical history and records, his sudden cardiac arrest was not reasonably foreseeable. McPike's estate and Pierce Transit also submitted the declarations of Dr. Brooks, Dr. Wang and Dr. Gilbert, who opined that McPike's medical conditions did not make him unfit to drive a bus.

In opposition, Sartin submitted the declaration of Dr. David Fletcher, an occupational and environmental medicine specialist and an expert in the medical certification of commercial drivers. Dr. Fletcher gave the opinion that McPike's sudden cardiac arrest and loss of consciousness was reasonably foreseeable because of his preexisting medical problems. Sartin also submitted declarations from two passengers on the bus at the time of the accident who said that McPike had failed to stop at several regular stops on the morning of the accident. One also stated that McPike was demonstrating erratic behavior.

The trial court denied McPike's estate's and Pierce Transit's summary judgment motion. The court later stated that it denied the motion because the declarations submitted raised questions of fact.

In November 2018, McPike's estate and Pierce Transit filed a renewed motion for summary judgment. The basis of the motion was that Dr. Fletcher now had been deposed, and his deposition testimony removed any questions of fact created by the opinions stated in his declaration. The trial court granted the renewed summary judgment motion. The court found that McPike's loss of consciousness was not foreseeable as a matter of law.

Dr. Gilbert subsequently filed a summary judgment motion, arguing that he owed no duty to Sartin because Sartin was not his patient and that there was no evidence that McPike's sudden loss of consciousness was foreseeable or preventable. Dr. Gilbert submitted the declarations of Dr. Peter Kudenchuk and Dr. Andrew Epstein, two cardiac specialists. Both Dr. Kudenchuk and Dr. Epstein gave an opinion that McPike had no evidence of coronary artery disease or any other heart condition either before or after the accident, and that his cardiac arrest was unexpected and unpreventable. Sartin again relied on Dr. Fletcher's declaration. Dr. Gilbert argued that Dr. Fletcher was not qualified to render opinions regarding cardiology issues and causation.

The trial court granted Dr. Gilbert's summary judgment motion. In the summary judgment order, the court stated that it had struck Dr. Fletcher's testimony as to cardiac issues and causation.

Sartin appeals the trial court's summary judgment orders.

ANALYSIS

A. SUMMARY JUDGMENT STANDARD

Summary judgment orders are reviewed de novo. *Mackey v. Home Depot USA, Inc.*, 12 Wn. App. 2d 557, 569, 459 P.3d 371, *review denied*, 195 Wn.2d 1031 (2020). We review all evidence and reasonable inferences in the light most favorable to the nonmoving party. *Id.* But if there are genuine issues of material fact, then the order granting summary judgment must be overturned. CR 56(c); *Mackey*, 12 Wn. App. 2d at 569. There is a genuine issue of material fact when reasonable minds could disagree on the facts controlling the outcome of the litigation. *Mackey*, 12 Wn. App. 2d at 569.

The party moving for summary judgment bears the initial burden to show there is no genuine issue of material fact. *Id.* A moving defendant can meet this burden by demonstrating

the plaintiff cannot support his claim with any evidence. *Id.* After the defendant has made such a showing, the burden shifts to the plaintiff to present specific facts that reveal a genuine issue of material fact. *Id.* Summary judgment is appropriate if a plaintiff fails to show sufficient evidence that creates a question of fact about an essential element on which he or she will have the burden of proof at trial. *Id.*

An expert opinion generally is sufficient to create a question of fact and defeat summary judgment. *Strauss v. Premera Blue Cross*, 194 Wn.2d 296, 301, 449 P.3d 640 (2019). But an expert's opinion must be grounded in fact, and statements based solely on speculation or assumptions will not preclude summary judgment. *Id.*

B. MCPIKE'S LIABILITY – FORESEEABILITY OF LOSS OF CONSCIOUSNESS

Sartin argues that the trial court erred in granting summary judgment in favor of McPike's estate because there are genuine issues of material fact as to whether McPike's loss of consciousness was reasonably foreseeable. We disagree.

1. Legal Principles

The general rule is that "[a] driver who becomes suddenly stricken by an unforeseen loss of consciousness, and is unable to control the vehicle, is not chargeable with negligence." *Kaiser v. Suburban Transp. Sys.*, 65 Wn.2d 461, 466, 398 P.2d 14, 401 P.2d 350 (1965). The *Restatement (Third) of Torts* states the rule as follows: "The conduct of an actor during a period of sudden incapacitation or loss of consciousness resulting from physical illness is negligent only if the sudden incapacitation or loss of consciousness was reasonably foreseeable to the actor." RESTATEMENT (THIRD) OF TORTS: LIABILITY FOR PHYS. & EMOT. HARM § 11(b) (AM. LAW INST. 2010).

Whether a loss of consciousness is foreseeable to the actor "depends on what information was available to the actor indicating that at some uncertain point in the future the actor might suffer an instance of incapacitation while engaging in a potentially dangerous activity such as driving." *Id.*, cmt. d. Evidence bearing on this issue includes: (1) "the number and frequency of episodes of incapacitation in the past"; (2) "the circumstances of those episodes, insofar as those circumstances bear on the likelihood of a reoccurrence"; (3) "the extent to which medical treatment the actor is receiving can be expected to control the underlying medical problem"; and (4) "whatever advice the actor's physician has provided." *Id.* Foreseeability of loss of consciousness generally is a question of fact for the jury. *Id.*

Only two published Washington cases have addressed a sudden loss of consciousness of a driver, and both involved a driver taking medication. In *Kaiser*, a bus driver lost consciousness and caused an accident because of the side effects of a drug his doctor prescribed. 65 Wn.2d at 462-63. The driver claimed that the doctor gave no warning about possible side effects. *Id.* at 463. However, the driver began feeling groggy and drowsy a few miles before the accident. *Id.*

The court held that the driver could not be found negligent as a matter of law if he was not warned about the drug's side effects. *Id.* at 466-68. "We do not think that one who innocently takes a pill, which is prescribed by a doctor, can be . . . negligent per se unless he has knowledge of the pill's harmful qualities. To hold otherwise would be to punish one who is not culpable." *Id.* at 466. The court further stated, "Knowledge and conscious appreciation of the significance of facts constituting premonitory warning of sleep or incapacity to the driver is essential to sustain the bus driver's liability." *Id.* at 468. Conversely, the driver would be liable if he was warned about the drug's side effects. *Id.* at 469.

The court left open the possibility that a jury could find the driver liable even if he was not warned about the drug's side effects, apparently based on his continuing to drive after he became groggy and drowsy. *See id.*

In *Presleigh v. Lewis*, a driver blacked out and caused an accident after a doctor gave him an anti-nausea injection and warned him that the shot could affect his driving. 13 Wn. App. 212, 212-13, 534 P.2d 606 (1975). The doctor told the driver it was ok to drive home, just not on the freeway or someplace where he would be in traffic. *Id.* at 213. The court stated,

> One who undertakes to drive his automobile has a duty to drive it in a reasonable manner so as to not injure another in his person or property. The defendant breached that duty as a matter of law when he undertook to drive his automobile knowing his ability to drive in a reasonable manner might be affected. The fact that he did not know the precise way in which his driving might be affected and he did not in fact become drowsy before he blacked out or went to sleep does not relieve him from a breach of this duty. Thus, defendant was negligent as a matter of law for driving after he was warned that his driving could be affected by the injection and must be held liable for the damages resulting therefrom.

Id. at 214-15.

2. Foreseeability Analysis

a. McPike Estate's Evidence

McPike's estate and Pierce Transit presented substantial evidence that McPike's loss of consciousness was unforeseeable. Dr. Thompson explained the cause of McPike's loss of consciousness:

> [S]udden cardiac arrest, as suffered by Mr. McPike, occurs when the electrical system to the heart malfunctions and suddenly becomes very irregular (*i.e.*, arrhythmia) . . . . Cardiac arrest symptoms often are immediate and drastic. Cardiac arrest symptoms can include immediate collapse, loss of pulse, loss of breathing, and loss of consciousness . . . . Cardiac arrest and immediate loss of consciousness often occurs without any prior symptoms or warnings, leaving the person completely incapacitated with no time to react.

Clerk's Papers (CP) at 122.

Dr. Thompson stated that sudden cardiac arrest typically occurs in a person with a pre-existing heart condition like coronary artery disease. But McPike's medical records did not show any diagnosis or treatment for any heart condition, including coronary artery disease. Dr. Thompson stated, "Although Mr. McPike had comorbidities known to increase the risk of developing coronary artery disease, Mr. McPike's hypertension, blood pressure, and diabetes had been well-controlled." CP at 123. Dr. Thompson also noted that McPike's medical records did not contain any warnings against driving due to the risk of cardiac arrest or because of his medical conditions.

Dr. Thompson concluded, "Based on his medical history, diagnoses, and treatment, Mr. McPike's sudden cardiac arrest and loss of consciousness in the seconds preceding the collision with the pickup were not reasonably foreseeable." CP at 123. He emphasized that the sudden cardiac arrest was not foreseeable to McPike's treating physicians or his CDL medical examiner. He stated, "[I]f these medical professionals could not reasonably foresee Mr. McPike's cardiac arrest . . ., then, certainly, the cardiac arrest was not reasonably foreseeable to Mr. McPike or to Pierce Transit." CP at 124.

Dr. Brooks confirmed that during the 20 years he treated McPike, "he never gave a history of precursor signs or symptoms of sudden cardiac arrest." CP at 101. Nor did McPike have a history of coronary artery disease or any other heart condition. Dr. Brooks stated, "Although Mr. McPike's comorbidities increased the risk of developing a heart condition at some unknown point in the future, there is no way to know or to predict one's risk of sudden cardiac arrest." CP at 101. Finally, Dr. Brooks concluded that McPike's medical conditions did not prevent him from safely driving a bus.

Dr. Wang stated that he saw no indication that McPike's diabetes or any other medical condition affected his fitness to drive a bus. Dr. Wang concluded,

> In my opinion, although Mr. McPike's diabetes mellitus and other comorbidities put him at increased risk for heart disease, the medical evidence available to me while Mr. McPike was under my care did not, at any point, demonstrate that Mr. McPike had actually developed a heart condition. Accordingly, Mr. McPike's sudden cardiac arrest . . . was not foreseeable to me, and I do not believe it would have been reasonably foreseeable to other physicians based on Mr. McPike's medical history and presentation of symptoms (or lack thereof).

CP at 131.

Finally, Dr. Gilbert stated that McPike's diabetes, hypertension, sleep apnea, and irregular cardiac rhythm did not interfere with his ability to operate a commercial motor vehicle. And Dr. Gilbert concluded that McPike qualified for a CDL medical certificate less than four months before the accident.

b. Sartin's Evidence

Substantial evidence supporting the moving party's position, standing alone, is not sufficient to allow the grant of summary judgment because conflicting evidence must be viewed in the light most favorable to the nonmoving party. *Mackey*, 12 Wn. App. 2d at 569. However, the presentation of such evidence shifts the burden to the nonmoving party to come forward with specific evidence that creates a genuine issue of material fact. *Id.*

First, Sartin claims that the proper inquiry is not whether McPike's cardiac arrest or loss of consciousness was unforeseeable, but whether the accident fell within a general field of danger that was foreseeable. He relies on *Lee v. Willis Enterprises, Inc.*, where this court stated that "the test of foreseeability is whether the result of the act is within the general field of danger which should have been anticipated." 194 Wn. App. 394, 402, 377 P.3d 244 (2016). Based on this position, Sartin asserts that it must have been foreseeable only that McPike's driving would

be affected *in some way*. He argues that McPike's various medical problems should have prevented him from driving a bus, and therefore it was reasonably foreseeable that those problems might affect his ability to drive *in some way*.

However, Sartin's claim is inconsistent with well-settled law regarding sudden loss of consciousness. Both *Kaiser* and the *Restatement* are clear that there is no negligence unless the *loss of consciousness* is foreseeable to the defendant. *See Kaiser*, 65 Wn.2d at 466; RESTATEMENT § 11(b). *Lee* addresses foreseeability in the context of the scope of a legal duty – whether it was foreseeable that the defendant's careless behavior while working around high voltage equipment could cause some injury. 194 Wn. App. at 401-03. Conversely, this case involves the foreseeability of a very specific event – McPike's loss of consciousness.

Second, Sartin offers Dr. Fletcher's declaration as evidence that McPike's loss of consciousness was foreseeable. Dr. Fletcher stated an opinion that McPike's sudden cardiac arrest and loss of consciousness were foreseeable. He stated, "Mr. McPike had several medical conditions, when unmanaged, individually and collectively contributed to his sudden incapacitation that was foreseeable." CP at 343. He further stated that McPike "was at a substantial risk for sudden death due to cardiac disease, based on his cardiac risk profile of the late middle age male, a former smoker/tobacco user who had allegedly quit in 2012, and had a history of hypertension, hyperlipidemia [high cholesterol], diabetes, obstructive sleep apnea along with his morbid obesity." CP at 344. Finally, Dr. Fletcher stated, "This event was hardly unforeseen, as it was predictable based on McPike's medical history, cardiac history, examination findings, and comorbidities." CP at 346.

Dr. Fletcher also relied on research that found having three concomitant medical conditions from a list of 13 conditions was a statistically significant risk factor for vehicle

accidents. He noted that McPike had eight of those conditions, showing that his risk of accident was significantly elevated. Dr. Fletcher concluded that because of McPike's combined medical conditions, he was not medically fit to operate a commercial motor vehicle.

c. Analysis

Sartin emphasizes that Dr. Fletcher's opinion that it was foreseeable that McPike would suffer incapacitation because of his multiple medical conditions is sufficient to preclude summary judgment on the issue of foreseeability, which generally is an issue of fact.

However, the question here is whether the loss of consciousness was reasonably foreseeable *to McPike*. RESTATEMENT § 11(b) (stating that the loss of consciousness must be "reasonably foreseeable *to the actor*") (emphasis added). Whether loss of consciousness was reasonably foreseeable to Dr. Fletcher upon review of McPike's medical records is not necessarily determinative. Dr. Fletcher never opines that McPike knew or should have known that sudden loss of consciousness while driving was foreseeable.

In addition, Dr. Fletcher's deposition testimony undermined the relevance of his declaration opinions because he acknowledged that McPike had no notice that he allegedly was unfit to drive. Dr. Fletcher admitted that no medical provider advised McPike that he was not fit to drive a bus. Similarly, Dr. Fletcher admitted that no medical provider told McPike that he could not drive because of his high blood pressure, diabetes, or sleep apnea, or because of his irregular heartbeat.

Further, Dr. Fletcher testified in his deposition that "20 percent of the time the first manifestation of coronary heart disease is sudden death due to cardiac arrhythmia. *And that's what I believe happened here*." CP at 1047-48 (emphasis added). In other words, Dr. Fletcher

admitted that McPike had no notice of the heart condition that Dr. Fletcher believed caused his cardiac arrest.

Applying the *Restatement* factors, McPike showed that he never had experienced a loss of consciousness, he had no history of any heart problems that would cause sudden cardiac arrest and his other medical conditions were under control, and none of his doctors believed that it was unsafe for him to drive a bus. *See* RESTATEMENT § 11 cmt. d. Application of these factors supports the conclusion that McPike's loss of consciousness was not foreseeable to McPike as a matter of law. Dr. Fletcher's opinions regarding foreseeability simply do not address this issue.

We hold that there is no genuine issue of fact as to whether the sudden loss of consciousness was foreseeable to McPike.[1]

3. Notice of Impending Loss of Consciousness

Sartin also argues that a questions of fact exists as to whether Sartin's loss of consciousness was sudden. He relies on the declarations of two passengers who were on the bus at the time of the accident. Both stated that McPike had failed to stop at several regular stops. One also stated that McPike was behaving erratically. Sartin claims that this evidence supports a finding that McPike was experiencing symptoms before the accident that should have alerted him to stop driving, which under *Kaiser* and *Presleigh* subjects him to liability.

However, there was no direct evidence that McPike was experiencing symptoms before the accident. Regarding circumstantial evidence, it is not reasonable to infer that McPike was

[1] Sartin suggests in an argument subheading that McPike withheld his dangerous medical history from his medical providers and Pierce Transit. He also claims that McPike made misrepresentations to his medical providers to get re-certified. Dr. Fletcher made the same allegation. However, Sartin provides no argument regarding this allegation. Specifically, he does not explain why withholding medical information would affect the foreseeability of McPike's loss of consciousness. Therefore, we do not consider this issue. *See Billings v. Town of Steilacoom*, 2 Wn. App. 2d 1, 33, 408 P.3d 1123 (2017).

experiencing symptoms of a cardiac arrest or had notice that he might lose consciousness simply because he missed stops or was behaving erratically. There are many other reasons why McPike might have acted that way besides experiencing symptoms. Further, Dr. Thompson stated that "[c]ardiac arrest symptoms often are immediate and drastic" and that "[c]ardiac arrest and immediate loss of consciousness often occurs without any prior symptoms or warnings, leaving the person completely incapacitated with no time to react." CP at 122. In light of this unchallenged testimony, it is not reasonable to infer that McPike had symptoms of cardiac arrest for some period of time before he lost consciousness.

Sartin claims that because Pierce Transit destroyed all bus video footage before the accident except for two minutes, under spoliation of evidence principles it must be inferred that the destroyed video would have been detrimental to McPike. But as McPike points out, Sartin did not present this issue to the trial court for resolution. In his opposition to McPike's estate's first summary judgment motion, Sartin stated that he was "not intending for the Court to rule on the spoliation issue as part of this briefing." CP at 155. And Sartin did not raise spoliation in his opposition to the renewed summary judgment motion. We decline to consider an argument not presented to the trial court. RAP 2.5(a).

We conclude that there are no genuine issues of fact as to whether McPike's loss of consciousness was sudden.

4. Summary

We hold that the trial court did not err in granting summary judgment in favor of McPike's estate and Pierce Transit on the issue of whether McPike was negligent in colliding with the vehicle in which Sartin was riding.

C. PIERCE TRANSIT'S LIABILITY – FAILURE TO MONITOR MCPIKE'S MEDICAL CONDITIONS

Sartin argues that Pierce Transit is subject to liability independent of McPike's liability. He claims that Pierce Transit had a duty to ensure McPike was physically able to drive a bus safely, and that it breached this duty by failing to monitor McPike's multiple health conditions. Sartin asserts that Pierce Transit should have ordered McPike to undergo fitness for duty evaluations, which would have revealed that McPike was physically unqualified to drive. Pierce Transit argues that there is no genuine issue of fact regarding proximate cause because Sartin presented no evidence that a fitness for duty evaluation would have revealed a disqualifying condition. We agree with Pierce Transit.[2]

Proximate cause is an essential element of negligence liability. *Ehrhart v. King County*, 195 Wn.2d 388, 396, 460 P.3d 612 (2020). The two aspects of proximate cause are cause in fact and legal cause. *Collins v. Juergens Chiropractic, PLLC*, 13 Wn. App. 2d 782, 794, 467 P.3d 126, 133 (2020). "Cause in fact refers to the physical connection between an act and an injury—whether, but for the act, the injury would not have occurred." *Id.* Legal cause refers to a " 'policy determination[ ] as to how far the consequences of a defendant's acts should extend.' " *Id.* (quoting *N.L. v. Bethel Sch. Dist.*, 186 Wn.2d 422, 437, 378 P.3d 162 (2016)).

Dr. Fletcher stated an opinion that Pierce Transit should have ordered a fitness for duty evaluation in January 2014 when McPike took time off to manage his diabetes. But Dr. Fletcher

[2] Pierce Transit also argues that (1) it did not have access to McPike's CDL examination forms or other medical records, (2) there is no evidence that the need for a fitness for duty evaluation was triggered in 2015, and (3) Dr. Fletcher's opinion that a more thorough workup would have revealed coronary artery disease is unsupported. Because we find no genuine issue of material fact regarding proximate cause, we do not address these arguments. *See Mackey*, 12 Wn. App. 2d at 569 ("Summary judgment is appropriate if a plaintiff fails to show sufficient evidence to establish a question of fact as to the existence of an element on which he or she will have the burden of proof at trial.").

admitted that he had no evidence that McPike would not have passed the evaluation, saying that whether he would have passed would involve speculation.

Dr. Fletcher also opined that Pierce Transit should have ordered a fitness for duty evaluation in 2015. He believed that a cardiac workup in the spring of 2015 would have revealed that McPike had coronary artery disease. However, Dr. Fletcher stated that whether coronary artery disease would be a disqualifying factor depends upon the severity of the condition and the treatment. And he admitted that he had no idea the extent of the coronary artery disease that he believed McPike had.

Sartin did not present any evidence that but for Pierce Transit's failure to monitor McPike's medical condition, the accident would not have occurred. Therefore, there is no genuine issue of fact as to whether any negligence by Pierce Transit was a proximate cause of McPike's accident. We hold that the trial court did not err in granting summary judgment in favor of Pierce Transit.

D. DR. GILBERT'S LIABILITY – MEDICAL NEGLIGENCE

Sartin argues that the trial court erred in granting summary judgment in favor of Dr. Gilbert because Dr. Gilbert is subject to liability for negligently issuing a CDL medical certificate to McPike. Sartin claims that although he was not Dr. Gilbert's patient, Dr. Gilbert owed a duty to members of the public like Sartin to exercise care in issuing CDL medical certificates because of his relationship with McPike. Sartin also argues that the trial court erred in striking Dr. Fletcher's declaration regarding cardiac issues and causation.

We hold that the trial court did not err in striking Dr. Fletcher's declaration regarding cardiac issues and causation, and as a result there are no genuine issues of fact as to whether any

alleged negligence was the proximate cause of Sartin's injury. Therefore, we need not decide whether Dr. Gilbert owed a duty to Sartin and whether Dr. Gilbert breached that duty.

Sartin's theory of liability against Dr. Gilbert apparently is that because of McPike's multiple medical conditions, Dr. Gilbert should have done a more thorough evaluation, including a full cardiovascular workup, before issuing him a CDL medical certification. Sartin claims, based on the testimony of Dr. Fletcher, that such an evaluation would have revealed that McPike had coronary heart disease and would have precluded Dr. Gilbert from issuing the certification. Dr. Gilbert's asserts that there is no admissible evidence that his alleged negligence was a proximate cause of McPike's accident.

1. Admissibility of Dr. Fletcher Testimony

The threshold issue is the admissibility of Dr. Fletcher's testimony on cardiac issues and causation. Sartin argues that Dr. Fletcher is qualified to provide opinion testimony on the issue of causation based on his experience as a certified medical review officer and a preventative medicine specialist. Dr. Gilbert disagrees and argues that the issue of proximate cause is based on cardiac issues and Dr. Fletcher is not a cardiac specialist.

In a medical negligence case, the injured party is generally required to provide expert medical testimony to establish causation. *Reyes v. Yakima Health Dist.*, 191 Wn.2d 79, 86, 419 P.3d 819 (2018). The expert must have sufficient knowledge and expertise in the relevant specialty to testify on the issue of causation. *Frausto v. Yakima HMA, LLC*, 188 Wn.2d 227, 232, 393 P.3d 776 (2017). The expert must show that the failure to comply with the applicable standard of care proximately caused the harm incurred. *Keck v. Collins*, 184 Wn.2d 358, 371, 357 P.3d 1080 (2015).

Significantly. "[t]he expert's opinion must be based on fact and cannot simply be a conclusion or based on an assumption if it is to survive summary judgment." *Volk v. DeMeerleer*, 187 Wn.2d 241, 277, 386 P.3d 254 (2016). "When an expert fails to ground his or her opinions on facts in the record, courts have consistently found that the testimony is overly speculative and inadmissible." *Id.*

We review de novo the trial court's decision to exclude expert testimony in conjunction with a summary judgment motion. *Folsom v. Burger King*, 135 Wn.2d 658, 663, 958 P.2d 301 (1998). When reviewing the admissibility of expert testimony, we generally look at three elements: whether " '(1) the expert is qualified, (2) the expert relies on generally accepted theories in the scientific community, and (3) the testimony would help the trier of fact.' " *Gilmore v. Jefferson County Pub. Transp. Benefit Area*, 190 Wn.2d 483, 495, 415 P.3d 212 (2018) (quoting *Johnston-Forbes v. Matsunaga*, 181 Wn.2d 346, 352, 333 P.3d 388 (2014)). The expert's testimony cannot be speculative and must be based on the facts in the case. *See Reyes*, 191 Wn.2d at 89.

As a national registry certified medical examiner for CDL medical examinations, Dr. Fletcher was qualified to testify about the appropriate standard of conduct for CDL medical examiners and examinations. However, Dr. Fletcher admitted that he was not a cardiac expert. And he conceded that he would defer to the opinions of cardiac specialists regarding cardiac issues.

Dr. Fletcher's opinions relevant to Dr. Gilbert's liability all involved cardiac issues. He testified that he was certain that McPike had significant coronary artery disease that caused the arrhythmia that resulted in his cardiac arrest. Similarly, he testified that a cardiovascular workup would have revealed coronary artery disease. But he never explained the basis for these opinions

in light of the fact that he was not a cardiac expert. And Dr. Epstein, who *was* a cardiac specialist, did not see any clinical basis for Dr. Fletcher's opinions and stated that these opinions were contrary to the objective evidence.

In addition, Dr. Fletcher's opinion that a cardiovascular workup would have precluded McPike from driving was based on speculation. He stated that whether coronary artery disease would be a disqualifying factor depends upon the severity of the condition and the treatment. But he admitted that he had no idea the extent of the coronary artery disease that he believed McPike had.

We hold that the trial court did not err in striking Dr. Fletcher's testimony on cardiac issues and causation.

2. No Evidence Regarding Causation

Dr. Gilbert argues that in the absence of Dr. Fletcher's testimony regarding cardiac issues and causation, Sartin cannot create a genuine issue of fact whether Dr. Gilbert's failure to order a more thorough workup was a proximate cause of McPike's accident. We agree.

Without Dr. Fletcher's testimony, Sartin has no evidence that a more thorough workup would have discovered coronary artery disease or made any difference. As the nonmoving party, Sartin had an obligation to come forward with affirmative evidence that created a question of fact regarding causation. *See Mackey*, 12 Wn. App. 2d at 569. He failed to do so. And Dr. Gilbert presented contrary evidence. Dr. Epstein, a cardiac specialist, stated that "even if further workup had been performed, it is impossible to say what would have been found or that it would have changed his outcome." CP at 1509.

We conclude that there is no genuine issue of fact as to whether Dr. Gilbert's alleged negligence was the proximate cause of McPike's accident. Accordingly, we hold that the trial court did not err in granting summary judgment in favor of Dr. Gilbert.

CONCLUSION

We affirm the trial court's orders granting summary judgment in favor of McPike's estate, Pierce Transit, and Dr. Gilbert and MultiCare.

Maxa, J.
MAXA, J.

We concur:

, C.J.
LEE, C.J.

Glasgow, J
GLASGOW, J.

APPENDIX B

Restatement (Third) of Torts: Phys. & Emot. Harm § 11 (2010)
Restatement of the Law - Torts
|
October 2020 Update
Restatement (Third) of Torts: Liability for Physical and Emotional Harm
Chapter 3. The Negligence Doctrine and
Negligence Liability

§ 11 Disability
Comment:
Reporters' Note
Case Citations - by Jurisdiction

(a) The conduct of an actor with a physical disability is negligent only if the conduct does not conform to that of a reasonably careful person with the same disability.

(b) The conduct of an actor during a period of sudden incapacitation or loss of consciousness resulting from physical illness is negligent only if the sudden incapacitation or loss of consciousness was reasonably foreseeable to the actor.

(c) An actor's mental or emotional disability is not considered in determining whether conduct is negligent, unless the actor is a child.

...

d. Sudden incapacitation. Sudden incapacitation can be caused by a heart attack, a stroke, an epileptic seizure, diabetes, or other medical conditions. A typical case is sudden incapacitation that causes a driver to lose control of the car. This is distinctly dangerous and substandard driving which, absent the incapacitation, would easily merit a finding of negligence. Even so, when the incapacitation is itself unforeseeable, it follows that no reasonable precautions were available to the driver that could have avoided the risk of harm. The denial of negligence in these cases is hence consistent with § 3.

Sudden incapacitation is a defense against a claim of negligence in the sense that the burden of production rests on the party claiming incapacitation. The burden is so assigned largely because the facts relating to sudden incapacitation are, in general, peculiarly available to the afflicted party. For the same reason, the burden of production on the issue of the absence of reasonable foreseeability also rests on that party. If an actor has information indicating that an incident of incapacitation may be imminent or is likely to occur in the immediate future, the actor will obviously be unable to show unforeseeability and hence can be found negligent for the subsequent incident of substandard conduct. For that matter, if such an incident is foreseeable in the immediate future, the actor can be found negligent for proceeding to engage at all in a dangerous activity such as driving. For example, if an actor with a diabetic condition feels a hypoglycemic episode approaching, the actor is guilty of negligence in driving a car—or at least in failing to take medication to prevent the episode.

In many cases, however, it is clear that the immediate incident was one that the actor had no ability to foresee. Whether the reasonable-foreseeability standard is satisfied in such a case depends on what information was available to the actor indicating that at some uncertain point in the future the actor might suffer an instance of incapacitation while engaging in a potentially dangerous activity such as driving. Evidence bearing on reasonable foreseeability includes: the number and frequency of episodes of incapacitation in the past; the circumstances of those

episodes, insofar as those circumstances bear on the likelihood of a recurrence; the extent to which medical treatment the actor is receiving can be expected to control the underlying medical problem; and whatever advice the actor's physician has provided. Whether the information is significant enough to render the instance of incapacitation reasonably foreseeable is commonly a question to be decided by the jury. In the assessment of reasonable foreseeability, a principal issue to be considered by the jury is whether the prospect of incapacitation is sufficiently foreseeable as to render the actor negligent for choosing to engage in a potentially dangerous activity such as driving.

APPENDIX C

Appendix A to Part 391—Medical Advisory Criteria

I. Introduction

This appendix contains the Agency's guidelines in the form of Medical Advisory Criteria to help medical examiners assess a driver's physical qualification. These guidelines are strictly advisory and were established after consultation with physicians, States, and industry representatives, and, in some areas, after consideration of recommendations from the Federal Motor Carrier Safety Administration's Medical Review Board and Medical Expert Panels.

II. Interpretation of Medical Standards

Since the issuance of the regulations for physical qualifications of commercial motor vehicle drivers, the Federal Motor Carrier Safety Administration has published recommendations called Advisory Criteria to help medical examiners in determining whether a driver meets the physical qualifications for commercial driving. These recommendations have been condensed to provide information to medical examiners that is directly relevant to the physical examination and is not already included in the Medical Examination Report Form.

A. Loss of Limb: §391.41(b)(1)

A person is physically qualified to drive a commercial motor vehicle if that person: Has no loss of a foot, leg, hand or an arm, or has been granted a Skills Performance Evaluation certificate pursuant to §391.49.

B. Limb Impairment: §391.41(b)(2)

1. A person is physically qualified to drive a commercial motor vehicle if that person: Has no impairment of:

(i) A hand or finger which interferes with prehension or power grasping; or

(ii) An arm, foot, or leg which interferes with the ability to perform normal tasks associated with operating a commercial motor vehicle; or

(iii) Any other significant limb defect or limitation which interferes with the ability to perform normal tasks associated with operating a commercial motor vehicle; or

(iv) Has been granted a Skills Performance Evaluation certificate pursuant to §391.49.

2. A person who suffers loss of a foot, leg, hand or arm or whose limb impairment in any way interferes with the safe performance of normal tasks associated with operating a commercial motor vehicle is subject to the Skills Performance Evaluation Certificate Program pursuant to §391.49, assuming the person is otherwise qualified.

3. With the advancement of technology, medical aids and equipment modifications have been developed to compensate for certain disabilities. The Skills Performance Evaluation Certificate Program (formerly the Limb Waiver Program) was designed to allow persons with the loss of a foot or limb or with functional impairment to qualify under the Federal Motor Carrier Safety Regulations by use of prosthetic devices or equipment modifications which enable them to safely operate a

commercial motor vehicle. Since there are no medical aids equivalent to the original body or limb, certain risks are still present, and thus restrictions may be included on individual Skills Performance Evaluation certificates when a State Director for the Federal Motor Carrier Safety Administration determines they are necessary to be consistent with safety and public interest.

4. If the driver is found otherwise medically qualified (§391.41(b)(3) through (13)), the medical examiner must check on the Medical Examiner's Certificate that the driver is qualified only if accompanied by a Skills Performance Evaluation certificate. The driver and the employing motor carrier are subject to appropriate penalty if the driver operates a motor vehicle in interstate or foreign commerce without a current Skill Performance Evaluation certificate for his/her physical disability.

C. [Reserved]

D. Cardiovascular Condition: §391.41(b)(4)

1. A person is physically qualified to drive a commercial motor vehicle if that person: Has no current clinical diagnosis of myocardial infarction, angina pectoris, coronary insufficiency, thrombosis or any other cardiovascular disease of a variety known to be accompanied by syncope, dyspnea, collapse or congestive cardiac failure.

2. The term "has no current clinical diagnosis of" is specifically designed to encompass: "a clinical diagnosis of" a current cardiovascular condition, or a cardiovascular condition which has not fully stabilized regardless of the time limit. The term "known to be accompanied by" is designed to include a clinical diagnosis of a cardiovascular disease which is accompanied by symptoms of syncope, dyspnea, collapse or congestive cardiac failure; and/or which is s likely to cause syncope, dyspnea, collapse or congestive cardiac failure.

3. It is the intent of the Federal Motor Carrier Safety Regulations to render unqualified, a driver who has a current cardiovascular disease which is accompanied by and/or likely to cause symptoms of syncope, dyspnea, collapse, or congestive cardiac failure. However, the subjective decision of whether the nature and severity of an individual's condition will likely cause symptoms of cardiovascular insufficiency is on an individual basis and qualification rests with the medical examiner and the motor carrier. In those cases where there is an occurrence of cardiovascular insufficiency (myocardial infarction, thrombosis, etc.), it is suggested before a driver is certified that he or she have a normal resting and stress electrocardiogram, no residual complications and no physical limitations, and is taking no medication likely to interfere with safe driving.

4. Coronary artery bypass surgery and pacemaker implantation are remedial procedures and thus, not medically disqualifying. Implantable cardioverter defibrillators are disqualifying due to risk of syncope. Coumadin is a medical treatment which can improve the health and safety of the driver and should not, by its use, medically disqualify the commercial motor vehicle driver. The emphasis should be on the underlying medical condition(s) which require treatment and the general health of the driver. The Federal Motor Carrier Safety Administration should be contacted at (202) 366-4001 for additional recommendations regarding the physical qualification of drivers on coumadin.

E. Respiratory Dysfunction: §391.41(b)(5)

1. A person is physically qualified to drive a commercial motor vehicle if that person: Has no established medical history or clinical diagnosis of a respiratory dysfunction likely to interfere with ability to control and drive a commercial motor vehicle safely.

2. Since a driver must be alert at all times, any change in his or her mental state is in direct conflict with highway safety. Even the slightest impairment in respiratory function under emergency conditions (when greater oxygen supply is necessary for performance) may be detrimental to safe driving.

3. There are many conditions that interfere with oxygen exchange and may result in incapacitation, including emphysema, chronic asthma, carcinoma, tuberculosis, chronic bronchitis and sleep apnea. If the medical examiner detects a respiratory dysfunction, that in any way is likely to interfere with the driver's ability to safely control and drive a commercial motor vehicle, the driver must be referred to a specialist for further evaluation and therapy. Anticoagulation therapy for deep vein thrombosis and/or pulmonary thromboembolism is not medically disqualifying once optimum dose is achieved, provided lower extremity venous examinations remain normal and the treating physician gives a favorable recommendation.

F. Hypertension: §391.41(b)(6)

1. A person is physically qualified to drive a commercial motor vehicle if that person: Has no current clinical diagnosis of high blood pressure likely to interfere with ability to operate a commercial motor vehicle safely.

2. Hypertension alone is unlikely to cause sudden collapse; however, the likelihood increases when target organ damage, particularly cerebral vascular disease, is present. This regulatory criteria is based on the Federal Motor Carrier Safety Administration's Cardiovascular Advisory Guidelines for the Examination of commercial motor vehicle Drivers, which used the Sixth Report of the Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure (1997).

3. Stage 1 hypertension corresponds to a systolic blood pressure of 140-159 mmHg and/or a diastolic blood pressure of 90-99 mmHg. The driver with a blood pressure in this range is at low risk for hypertension-related acute incapacitation and may be medically certified to drive for a one-year period. Certification examinations should be done annually thereafter and should be at or less than 140/90. If less than 160/100, certification may be extended one time for 3 months.

4. A blood pressure of 160-179 systolic and/or 100-109 diastolic is considered Stage 2 hypertension, and the driver is not necessarily unqualified during evaluation and institution of treatment. The driver is given a one-time certification of three months to reduce his or her blood pressure to less than or equal to 140/90. A blood pressure in this range is an absolute indication for anti-hypertensive drug therapy. Provided treatment is well tolerated and the driver demonstrates a blood pressure value of 140/90 or less, he or she may be certified for one year from date of the initial exam. The driver is certified annually thereafter.

5. A blood pressure at or greater than 180 (systolic) and 110 (diastolic) is considered Stage 3, high risk for an acute blood pressure-related event. The driver may not be qualified, even temporarily, until reduced to 140/90 or less and treatment is well tolerated. The driver may be certified for 6 months and biannually (every 6 months) thereafter if at recheck blood pressure is 140/90 or less.

6. Annual recertification is recommended if the medical examiner does not know the severity of hypertension prior to treatment. An elevated blood pressure finding should be confirmed by at least two subsequent measurements on different days.

7. Treatment includes nonpharmacologic and pharmacologic modalities as well as counseling to reduce other risk factors. Most antihypertensive medications also have side effects, the

importance of which must be judged on an individual basis. Individuals must be alerted to the hazards of these medications while driving. Side effects of somnolence or syncope are particularly undesirable in commercial motor vehicle drivers.

8. Secondary hypertension is based on the above stages. Evaluation is warranted if patient is persistently hypertensive on maximal or near-maximal doses of 2-3 pharmacologic agents. Some causes of secondary hypertension may be amenable to surgical intervention or specific pharmacologic disease.

G. Rheumatic, Arthritic, Orthopedic, Muscular, Neuromuscular or Vascular Disease: §391.41(b)(7)

1. A person is physically qualified to drive a commercial motor vehicle if that person: Has no established medical history or clinical diagnosis of rheumatic, arthritic, orthopedic, muscular, neuromuscular or vascular disease which interferes with the ability to control and operate a commercial motor vehicle safely.

2. Certain diseases are known to have acute episodes of transient muscle weakness, poor muscular coordination (ataxia), abnormal sensations (paresthesia), decreased muscular tone (hypotonia), visual disturbances and pain which may be suddenly incapacitating. With each recurring episode, these symptoms may become more pronounced and remain for longer periods of time. Other diseases have more insidious onsets and display symptoms of muscle wasting (atrophy), swelling and paresthesia which may not suddenly incapacitate a person but may restrict his/her movements and eventually interfere with the ability to safely operate a motor vehicle. In many instances these diseases are degenerative in nature or may result in deterioration of the involved area.

3. Once the individual has been diagnosed as having a rheumatic, arthritic, orthopedic, muscular, neuromuscular or vascular disease, then he/she has an established history of that disease. The physician, when examining an individual, should consider the following: The nature and severity of the individual's condition (such as sensory loss or loss of strength); the degree of limitation present (such as range of motion); the likelihood of progressive limitation (not always present initially but may manifest itself over time); and the likelihood of sudden incapacitation. If severe functional impairment exists, the driver does not qualify. In cases where more frequent monitoring is required, a certificate for a shorter period of time may be issued.

H. Epilepsy: §391.41(b)(8)

1. A person is physically qualified to drive a commercial motor vehicle if that person: Has no established medical history or clinical diagnosis of epilepsy or any other condition which is likely to cause loss of consciousness or any loss of ability to control a motor vehicle.

2. Epilepsy is a chronic functional disease characterized by seizures or episodes that occur without warning, resulting in loss of voluntary control which may lead to loss of consciousness and/or seizures. Therefore, the following drivers cannot be qualified:

(i) A driver who has a medical history of epilepsy;

(ii) A driver who has a current clinical diagnosis of epilepsy; or

(ii) A driver who is taking antiseizure medication.

3. If an individual has had a sudden episode of a nonepileptic seizure or loss of consciousness of unknown cause which did not require antiseizure medication, the decision as to whether that person's condition will likely cause loss of consciousness or loss of ability to control a motor vehicle is made on an individual basis by the medical examiner in consultation with the treating physician. Before certification is considered, it is suggested that a 6 month waiting period elapse from the time of the episode. Following the waiting period, it is suggested that the individual have a complete neurological examination. If the results of the examination are negative and antiseizure medication is not required, then the driver may be qualified.

4. In those individual cases where a driver has a seizure or an episode of loss of consciousness that resulted from a known medical condition (*e.g.,* drug reaction, high temperature, acute infectious disease, dehydration or acute metabolic disturbance), certification should be deferred until the driver has fully recovered from that condition and has no existing residual complications, and not taking antiseizure medication.

5. Drivers with a history of epilepsy/seizures off antiseizure medication and seizure-free for 10 years may be qualified to drive a commercial motor vehicle in interstate commerce. Interstate drivers with a history of a single unprovoked seizure may be qualified to drive a commercial motor vehicle in interstate commerce if seizure-free and off antiseizure medication for a 5-year period or more.

I. Mental Disorders: §391.41(b)(9)

1. A person is physically qualified to drive a commercial motor vehicle if that person: Has no mental, nervous, organic or functional disease or psychiatric disorder likely to interfere with ability to drive a motor vehicle safely.

2. Emotional or adjustment problems contribute directly to an individual's level of memory, reasoning, attention, and judgment. These problems often underlie physical disorders. A variety of functional disorders can cause drowsiness, dizziness, confusion, weakness or paralysis that may lead to incoordination, inattention, loss of functional control and susceptibility to accidents while driving. Physical fatigue, headache, impaired coordination, recurring physical ailments and chronic "nagging" pain may be present to such a degree that certification for commercial driving is inadvisable. Somatic and psychosomatic complaints should be thoroughly examined when determining an individual's overall fitness to drive. Disorders of a periodically incapacitating nature, even in the early stages of development, may warrant disqualification.

3. Many bus and truck drivers have documented that "nervous trouble" related to neurotic, personality, or emotional or adjustment problems is responsible for a significant fraction of their preventable accidents. The degree to which an individual is able to appreciate, evaluate and adequately respond to environmental strain and emotional stress is critical when assessing an individual's mental alertness and flexibility to cope with the stresses of commercial motor vehicle driving.

4. When examining the driver, it should be kept in mind that individuals who live under chronic emotional upsets may have deeply ingrained maladaptive or erratic behavior patterns. Excessively antagonistic, instinctive, impulsive, openly aggressive, paranoid or severely depressed behavior greatly interfere with the driver's ability to drive safely. Those individuals who are highly susceptible to frequent states of emotional instability (schizophrenia, affective psychoses, paranoia, anxiety or depressive neuroses) may warrant disqualification. Careful consideration should be given to the side effects and interactions of medications in the overall qualification determination.

J. Vision: §391.41(b)(10)

1. A person is physically qualified to drive a commercial motor vehicle if that person: Has distant visual acuity of at least 20/40 (Snellen) in each eye with or without corrective lenses or visual acuity separately corrected to 20/40 (Snellen) or better with corrective lenses, distant binocular acuity of at least 20/40 (Snellen) in both eyes with or without corrective lenses, field of vision of at least 70 degrees in the horizontal meridian in each eye, and the ability to recognize the colors of traffic signals and devices showing standard red, green, and amber.

2. The term "ability to recognize the colors of" is interpreted to mean if a person can recognize and distinguish among traffic control signals and devices showing standard red, green and amber, he or she meets the minimum standard, even though he or she may have some type of color perception deficiency. If certain color perception tests are administered, (such as Ishihara, Pseudoisochromatic, Yarn) and doubtful findings are discovered, a controlled test using signal red, green and amber may be employed to determine the driver's ability to recognize these colors.

3. Contact lenses are permissible if there is sufficient evidence to indicate that the driver has good tolerance and is well adapted to their use. Use of a contact lens in one eye for distance visual acuity and another lens in the other eye for near vision is not acceptable, nor telescopic lenses acceptable for the driving of commercial motor vehicles.

4. If an individual meets the criteria by the use of glasses or contact lenses, the following statement shall appear on the Medical Examiner's Certificate: "Qualified only if wearing corrective lenses." commercial motor vehicle drivers who do not meet the Federal vision standard may call (202) 366-4001 for an application for a vision exemption.

K. Hearing: §391.41(b)(11)

1. A person is physically qualified to drive a commercial motor vehicle if that person: First perceives a forced whispered voice in the better ear at not less than 5 feet with or without the use of a hearing aid, or, if tested by use of an audiometric device, does not have an average hearing loss in the better ear greater than 40 decibels at 500 Hz, 1,000 Hz, and 2,000 Hz with or without a hearing aid when the audiometric device is calibrated to American National Standard (formerly ADA Standard) Z24.5-1951.

2. Since the prescribed standard under the Federal Motor Carrier Safety Regulations is from the American National Standards Institute, formerly the American Standards Association, it may be necessary to convert the audiometric results from the International Organization for Standardization standard to the American National Standards Institute standard. Instructions are included on the Medical Examination Report Form.

3. If an individual meets the criteria by using a hearing aid, the driver must wear that hearing aid and have it in operation at all times while driving. Also, the driver must be in possession of a spare power source for the hearing aid.

4. For the whispered voice test, the individual should be stationed at least 5 feet from the medical examiner with the ear being tested turned toward the medical examiner. The other ear is covered. Using the breath which remains after a normal expiration, the medical examiner whispers words or random numbers such as 66, 18, 3, etc. The medical examiner should not use only sibilants (s sounding materials). The opposite ear should be tested in the same manner.

5. If the individual fails the whispered voice test, the audiometric test should be administered. If an individual meets the criteria by the use of a hearing aid, the following statement must appear on the Medical Examiner's Certificate "Qualified only when wearing a hearing aid."

L. Drug Use: §391.41(b)(12)

1. A person is physically qualified to drive a commercial motor vehicle if that person does not use any drug or substance identified in 21 CFR 1308.11, an amphetamine, a narcotic, or other habit-forming drug. A driver may use a non-Schedule I drug or substance that is identified in the other Schedules in 21 CFR part 1308 if the substance or drug is prescribed by a licensed medical practitioner who:

(i) Is familiar with the driver's medical history, and assigned duties; and

(ii) Has advised the driver that the prescribed substance or drug will not adversely affect the driver's ability to safely operate a commercial motor vehicle.

2. This exception does not apply to methadone. The intent of the medical certification process is to medically evaluate a driver to ensure that the driver has no medical condition which interferes with the safe performance of driving tasks on a public road. If a driver uses an amphetamine, a narcotic or any other habit-forming drug, it may be cause for the driver to be found medically unqualified. If a driver uses a Schedule I drug or substance, it will be cause for the driver to be found medically unqualified. Motor carriers are encouraged to obtain a practitioner's written statement about the effects on transportation safety of the use of a particular drug.

3. A test for controlled substances is not required as part of this biennial certification process. The Federal Motor Carrier Safety Administration or the driver's employer should be contacted directly for information on controlled substances and alcohol testing under Part 382 of the FMCSRs.

4. The term "uses" is designed to encompass instances of prohibited drug use determined by a physician through established medical means. This may or may not involve body fluid testing. If body fluid testing takes place, positive test results should be confirmed by a second test of greater specificity. The term "habit-forming" is intended to include any drug or medication generally recognized as capable of becoming habitual, and which may impair the user's ability to operate a commercial motor vehicle safely.

5. The driver is medically unqualified for the duration of the prohibited drug(s) use and until a second examination shows the driver is free from the prohibited drug(s) use. Recertification may involve a substance abuse evaluation, the successful completion of a drug rehabilitation program, and a negative drug test result. Additionally, given that the certification period is normally two years, the medical examiner has the option to certify for a period of less than 2 years if this medical examiner determines more frequent monitoring is required.

M. Alcoholism: §391.41(b)(13)

1. A person is physically qualified to drive a commercial motor vehicle if that person: Has no current clinical diagnosis of alcoholism.

2. The term "current clinical diagnosis of" is specifically designed to encompass a current alcoholic illness or those instances where the individual's physical condition has not fully stabilized, regardless of the time element. If an individual shows signs of having an alcohol-use problem, he or she should be referred to a specialist. After counseling and/or treatment, he or she may be considered for certification.

[80 FR 22822, Apr. 23, 2015, as amended at 83 FR 47521, Sept. 19, 2018]

Appendix A to Part 391—Medical Advisory Criteria

I. Introduction

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B. Limb Impairment: §391.41(b)(2)

1. A person is physically qualified to drive a commercial motor vehicle if that person: Has no impairment of:

(i) A hand or finger which interferes with prehension or power grasping; or

(ii) An arm, foot, or leg which interferes with the ability to perform normal tasks associated with operating a commercial motor vehicle; or

(iii) Any other significant limb defect or limitation which interferes with the ability to perform normal tasks associated with operating a commercial motor vehicle; or

(iv) Has been granted a Skills Performance Evaluation certificate pursuant to §391.49.

2. A person who suffers loss of a foot, leg, hand or arm or whose limb impairment in any way interferes with the safe performance of normal tasks associated with operating a commercial motor vehicle is subject to the Skills Performance Evaluation Certificate Program pursuant to §391.49, assuming the person is otherwise qualified.

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commercial motor vehicle. Since there are no medical aids equivalent to the original body or limb, certain risks are still present, and thus restrictions may be included on individual Skills Performance Evaluation certificates when a State Director for the Federal Motor Carrier Safety Administration determines they are necessary to be consistent with safety and public interest.

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2. The term "has no current clinical diagnosis of" is specifically designed to encompass: "a clinical diagnosis of" a current cardiovascular condition, or a cardiovascular condition which has not fully stabilized regardless of the time limit. The term "known to be accompanied by" is designed to include a clinical diagnosis of a cardiovascular disease which is accompanied by symptoms of syncope, dyspnea, collapse or congestive cardiac failure; and/or which is s likely to cause syncope, dyspnea, collapse or congestive cardiac failure.

3. It is the intent of the Federal Motor Carrier Safety Regulations to render unqualified, a driver who has a current cardiovascular disease which is accompanied by and/or likely to cause symptoms of syncope, dyspnea, collapse, or congestive cardiac failure. However, the subjective decision of whether the nature and severity of an individual's condition will likely cause symptoms of cardiovascular insufficiency is on an individual basis and qualification rests with the medical examiner and the motor carrier. In those cases where there is an occurrence of cardiovascular insufficiency (myocardial infarction, thrombosis, etc.), it is suggested before a driver is certified that he or she have a normal resting and stress electrocardiogram, no residual complications and no physical limitations, and is taking no medication likely to interfere with safe driving.

4. Coronary artery bypass surgery and pacemaker implantation are remedial procedures and thus, not medically disqualifying. Implantable cardioverter defibrillators are disqualifying due to risk of syncope. Coumadin is a medical treatment which can improve the health and safety of the driver and should not, by its use, medically disqualify the commercial motor vehicle driver. The emphasis should be on the underlying medical condition(s) which require treatment and the general health of the driver. The Federal Motor Carrier Safety Administration should be contacted at (202) 366-4001 for additional recommendations regarding the physical qualification of drivers on coumadin.

E. Respiratory Dysfunction: §391.41(b)(5)

1. A person is physically qualified to drive a commercial motor vehicle if that person: Has no established medical history or clinical diagnosis of a respiratory dysfunction likely to interfere with ability to control and drive a commercial motor vehicle safely.

2. Since a driver must be alert at all times, any change in his or her mental state is in direct conflict with highway safety. Even the slightest impairment in respiratory function under emergency conditions (when greater oxygen supply is necessary for performance) may be detrimental to safe driving.

3. There are many conditions that interfere with oxygen exchange and may result in incapacitation, including emphysema, chronic asthma, carcinoma, tuberculosis, chronic bronchitis and sleep apnea. If the medical examiner detects a respiratory dysfunction, that in any way is likely to interfere with the driver's ability to safely control and drive a commercial motor vehicle, the driver must be referred to a specialist for further evaluation and therapy. Anticoagulation therapy for deep vein thrombosis and/or pulmonary thromboembolism is not medically disqualifying once optimum dose is achieved, provided lower extremity venous examinations remain normal and the treating physician gives a favorable recommendation.

F. Hypertension: §391.41(b)(6)

1. A person is physically qualified to drive a commercial motor vehicle if that person: Has no current clinical diagnosis of high blood pressure likely to interfere with ability to operate a commercial motor vehicle safely.

2. Hypertension alone is unlikely to cause sudden collapse; however, the likelihood increases when target organ damage, particularly cerebral vascular disease, is present. This regulatory criteria is based on the Federal Motor Carrier Safety Administration's Cardiovascular Advisory Guidelines for the Examination of commercial motor vehicle Drivers, which used the Sixth Report of the Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure (1997).

3. Stage 1 hypertension corresponds to a systolic blood pressure of 140-159 mmHg and/or a diastolic blood pressure of 90-99 mmHg. The driver with a blood pressure in this range is at low risk for hypertension-related acute incapacitation and may be medically certified to drive for a one-year period. Certification examinations should be done annually thereafter and should be at or less than 140/90. If less than 160/100, certification may be extended one time for 3 months.

4. A blood pressure of 160-179 systolic and/or 100-109 diastolic is considered Stage 2 hypertension, and the driver is not necessarily unqualified during evaluation and institution of treatment. The driver is given a one-time certification of three months to reduce his or her blood pressure to less than or equal to 140/90. A blood pressure in this range is an absolute indication for anti-hypertensive drug therapy. Provided treatment is well tolerated and the driver demonstrates a blood pressure value of 140/90 or less, he or she may be certified for one year from date of the initial exam. The driver is certified annually thereafter.

5. A blood pressure at or greater than 180 (systolic) and 110 (diastolic) is considered Stage 3, high risk for an acute blood pressure-related event. The driver may not be qualified, even temporarily, until reduced to 140/90 or less and treatment is well tolerated. The driver may be certified for 6 months and biannually (every 6 months) thereafter if at recheck blood pressure is 140/90 or less.

6. Annual recertification is recommended if the medical examiner does not know the severity of hypertension prior to treatment. An elevated blood pressure finding should be confirmed by at least two subsequent measurements on different days.

7. Treatment includes nonpharmacologic and pharmacologic modalities as well as counseling to reduce other risk factors. Most antihypertensive medications also have side effects, the

importance of which must be judged on an individual basis. Individuals must be alerted to the hazards of these medications while driving. Side effects of somnolence or syncope are particularly undesirable in commercial motor vehicle drivers.

8. Secondary hypertension is based on the above stages. Evaluation is warranted if patient is persistently hypertensive on maximal or near-maximal doses of 2-3 pharmacologic agents. Some causes of secondary hypertension may be amenable to surgical intervention or specific pharmacologic disease.

G. Rheumatic, Arthritic, Orthopedic, Muscular, Neuromuscular or Vascular Disease: §391.41(b)(7)

1. A person is physically qualified to drive a commercial motor vehicle if that person: Has no established medical history or clinical diagnosis of rheumatic, arthritic, orthopedic, muscular, neuromuscular or vascular disease which interferes with the ability to control and operate a commercial motor vehicle safely.

2. Certain diseases are known to have acute episodes of transient muscle weakness, poor muscular coordination (ataxia), abnormal sensations (paresthesia), decreased muscular tone (hypotonia), visual disturbances and pain which may be suddenly incapacitating. With each recurring episode, these symptoms may become more pronounced and remain for longer periods of time. Other diseases have more insidious onsets and display symptoms of muscle wasting (atrophy), swelling and paresthesia which may not suddenly incapacitate a person but may restrict his/her movements and eventually interfere with the ability to safely operate a motor vehicle. In many instances these diseases are degenerative in nature or may result in deterioration of the involved area.

3. Once the individual has been diagnosed as having a rheumatic, arthritic, orthopedic, muscular, neuromuscular or vascular disease, then he/she has an established history of that disease. The physician, when examining an individual, should consider the following: The nature and severity of the individual's condition (such as sensory loss or loss of strength); the degree of limitation present (such as range of motion); the likelihood of progressive limitation (not always present initially but may manifest itself over time); and the likelihood of sudden incapacitation. If severe functional impairment exists, the driver does not qualify. In cases where more frequent monitoring is required, a certificate for a shorter period of time may be issued.

H. Epilepsy: §391.41(b)(8)

1. A person is physically qualified to drive a commercial motor vehicle if that person: Has no established medical history or clinical diagnosis of epilepsy or any other condition which is likely to cause loss of consciousness or any loss of ability to control a motor vehicle.

2. Epilepsy is a chronic functional disease characterized by seizures or episodes that occur without warning, resulting in loss of voluntary control which may lead to loss of consciousness and/or seizures. Therefore, the following drivers cannot be qualified:

(i) A driver who has a medical history of epilepsy;

(ii) A driver who has a current clinical diagnosis of epilepsy; or

(ii) A driver who is taking antiseizure medication.

3. If an individual has had a sudden episode of a nonepileptic seizure or loss of consciousness of unknown cause which did not require antiseizure medication, the decision as to whether that person's condition will likely cause loss of consciousness or loss of ability to control a motor vehicle is made on an individual basis by the medical examiner in consultation with the treating physician. Before certification is considered, it is suggested that a 6 month waiting period elapse from the time of the episode. Following the waiting period, it is suggested that the individual have a complete neurological examination. If the results of the examination are negative and antiseizure medication is not required, then the driver may be qualified.

4. In those individual cases where a driver has a seizure or an episode of loss of consciousness that resulted from a known medical condition (*e.g.,* drug reaction, high temperature, acute infectious disease, dehydration or acute metabolic disturbance), certification should be deferred until the driver has fully recovered from that condition and has no existing residual complications, and not taking antiseizure medication.

5. Drivers with a history of epilepsy/seizures off antiseizure medication and seizure-free for 10 years may be qualified to drive a commercial motor vehicle in interstate commerce. Interstate drivers with a history of a single unprovoked seizure may be qualified to drive a commercial motor vehicle in interstate commerce if seizure-free and off antiseizure medication for a 5-year period or more.

I. Mental Disorders: §391.41(b)(9)

1. A person is physically qualified to drive a commercial motor vehicle if that person: Has no mental, nervous, organic or functional disease or psychiatric disorder likely to interfere with ability to drive a motor vehicle safely.

2. Emotional or adjustment problems contribute directly to an individual's level of memory, reasoning, attention, and judgment. These problems often underlie physical disorders. A variety of functional disorders can cause drowsiness, dizziness, confusion, weakness or paralysis that may lead to incoordination, inattention, loss of functional control and susceptibility to accidents while driving. Physical fatigue, headache, impaired coordination, recurring physical ailments and chronic "nagging" pain may be present to such a degree that certification for commercial driving is inadvisable. Somatic and psychosomatic complaints should be thoroughly examined when determining an individual's overall fitness to drive. Disorders of a periodically incapacitating nature, even in the early stages of development, may warrant disqualification.

3. Many bus and truck drivers have documented that "nervous trouble" related to neurotic, personality, or emotional or adjustment problems is responsible for a significant fraction of their preventable accidents. The degree to which an individual is able to appreciate, evaluate and adequately respond to environmental strain and emotional stress is critical when assessing an individual's mental alertness and flexibility to cope with the stresses of commercial motor vehicle driving.

4. When examining the driver, it should be kept in mind that individuals who live under chronic emotional upsets may have deeply ingrained maladaptive or erratic behavior patterns. Excessively antagonistic, instinctive, impulsive, openly aggressive, paranoid or severely depressed behavior greatly interfere with the driver's ability to drive safely. Those individuals who are highly susceptible to frequent states of emotional instability (schizophrenia, affective psychoses, paranoia, anxiety or depressive neuroses) may warrant disqualification. Careful consideration should be given to the side effects and interactions of medications in the overall qualification determination.

J. Vision: §391.41(b)(10)

1. A person is physically qualified to drive a commercial motor vehicle if that person: Has distant visual acuity of at least 20/40 (Snellen) in each eye with or without corrective lenses or visual acuity separately corrected to 20/40 (Snellen) or better with corrective lenses, distant binocular acuity of at least 20/40 (Snellen) in both eyes with or without corrective lenses, field of vision of at least 70 degrees in the horizontal meridian in each eye, and the ability to recognize the colors of traffic signals and devices showing standard red, green, and amber.

2. The term "ability to recognize the colors of" is interpreted to mean if a person can recognize and distinguish among traffic control signals and devices showing standard red, green and amber, he or she meets the minimum standard, even though he or she may have some type of color perception deficiency. If certain color perception tests are administered, (such as Ishihara, Pseudoisochromatic, Yarn) and doubtful findings are discovered, a controlled test using signal red, green and amber may be employed to determine the driver's ability to recognize these colors.

3. Contact lenses are permissible if there is sufficient evidence to indicate that the driver has good tolerance and is well adapted to their use. Use of a contact lens in one eye for distance visual acuity and another lens in the other eye for near vision is not acceptable, nor telescopic lenses acceptable for the driving of commercial motor vehicles.

4. If an individual meets the criteria by the use of glasses or contact lenses, the following statement shall appear on the Medical Examiner's Certificate: "Qualified only if wearing corrective lenses." commercial motor vehicle drivers who do not meet the Federal vision standard may call (202) 366-4001 for an application for a vision exemption.

K. Hearing: §391.41(b)(11)

1. A person is physically qualified to drive a commercial motor vehicle if that person: First perceives a forced whispered voice in the better ear at not less than 5 feet with or without the use of a hearing aid, or, if tested by use of an audiometric device, does not have an average hearing loss in the better ear greater than 40 decibels at 500 Hz, 1,000 Hz, and 2,000 Hz with or without a hearing aid when the audiometric device is calibrated to American National Standard (formerly ADA Standard) Z24.5-1951.

2. Since the prescribed standard under the Federal Motor Carrier Safety Regulations is from the American National Standards Institute, formerly the American Standards Association, it may be necessary to convert the audiometric results from the International Organization for Standardization standard to the American National Standards Institute standard. Instructions are included on the Medical Examination Report Form.

3. If an individual meets the criteria by using a hearing aid, the driver must wear that hearing aid and have it in operation at all times while driving. Also, the driver must be in possession of a spare power source for the hearing aid.

4. For the whispered voice test, the individual should be stationed at least 5 feet from the medical examiner with the ear being tested turned toward the medical examiner. The other ear is covered. Using the breath which remains after a normal expiration, the medical examiner whispers words or random numbers such as 66, 18, 3, etc. The medical examiner should not use only sibilants (s sounding materials). The opposite ear should be tested in the same manner.

5. If the individual fails the whispered voice test, the audiometric test should be administered. If an individual meets the criteria by the use of a hearing aid, the following statement must appear on the Medical Examiner's Certificate "Qualified only when wearing a hearing aid."

L. Drug Use: §391.41(b)(12)

1. A person is physically qualified to drive a commercial motor vehicle if that person does not use any drug or substance identified in 21 CFR 1308.11, an amphetamine, a narcotic, or other habit-forming drug. A driver may use a non-Schedule I drug or substance that is identified in the other Schedules in 21 CFR part 1308 if the substance or drug is prescribed by a licensed medical practitioner who:

(i) Is familiar with the driver's medical history, and assigned duties; and

(ii) Has advised the driver that the prescribed substance or drug will not adversely affect the driver's ability to safely operate a commercial motor vehicle.

2. This exception does not apply to methadone. The intent of the medical certification process is to medically evaluate a driver to ensure that the driver has no medical condition which interferes with the safe performance of driving tasks on a public road. If a driver uses an amphetamine, a narcotic or any other habit-forming drug, it may be cause for the driver to be found medically unqualified. If a driver uses a Schedule I drug or substance, it will be cause for the driver to be found medically unqualified. Motor carriers are encouraged to obtain a practitioner's written statement about the effects on transportation safety of the use of a particular drug.

3. A test for controlled substances is not required as part of this biennial certification process. The Federal Motor Carrier Safety Administration or the driver's employer should be contacted directly for information on controlled substances and alcohol testing under Part 382 of the FMCSRs.

4. The term "uses" is designed to encompass instances of prohibited drug use determined by a physician through established medical means. This may or may not involve body fluid testing. If body fluid testing takes place, positive test results should be confirmed by a second test of greater specificity. The term "habit-forming" is intended to include any drug or medication generally recognized as capable of becoming habitual, and which may impair the user's ability to operate a commercial motor vehicle safely.

5. The driver is medically unqualified for the duration of the prohibited drug(s) use and until a second examination shows the driver is free from the prohibited drug(s) use. Recertification may involve a substance abuse evaluation, the successful completion of a drug rehabilitation program, and a negative drug test result. Additionally, given that the certification period is normally two years, the medical examiner has the option to certify for a period of less than 2 years if this medical examiner determines more frequent monitoring is required.

M. Alcoholism: §391.41(b)(13)

1. A person is physically qualified to drive a commercial motor vehicle if that person: Has no current clinical diagnosis of alcoholism.

2. The term "current clinical diagnosis of" is specifically designed to encompass a current alcoholic illness or those instances where the individual's physical condition has not fully stabilized, regardless of the time element. If an individual shows signs of having an alcohol-use problem, he or she should be referred to a specialist. After counseling and/or treatment, he or she may be considered for certification.

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