

68267-9

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No. 682679-1

COURT OF APPEALS, DIVISION 1
OF THE STATE OF WASHINGTON

LEWIS and TALENA COLLEY

Plaintiffs/Appellants

v.

PEACEHEALTH d/b/a ST. JOSEPH HOSPITAL

Defendants/Respondents

APPELLANT'S OPENING BRIEF

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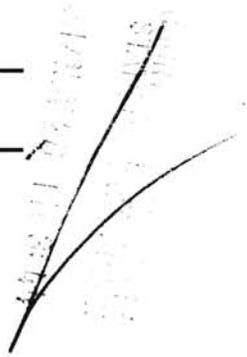
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ORIGINAL

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I. INTRODUCTION

Louis Curtis Colley was brought by his wife to the defendant hospital on My 4, 2006, complaining of severe abdominal pain. Mr. Colley had previously been diagnosed with severe sleep apnea, a condition in which the patient stops breathing for various periods of time while asleep. In an effort to relieve the pain, Mr. Colley was administered a significant amount of narcotics. When the medication failed to relieve the pain, Mr. Colley was admitted to the hospital's observation unit, where he was administered more narcotics. At approximately 5:45 A.M. he suffered respiratory failure, requiring resuscitation and intensive care hospitalization. As a result of the loss of oxygen to his brain Mr. Colley suffered severe and permanent short term memory loss.

Respiratory depression is a well-known side effect of narcotic medications. When combined with a pre-existing sleep apnea, the administration of such medications poses an equally well-known danger of respiratory failure and/or arrest, leading to a decrease of oxygen in the blood and therefore to the brain. Because of this, the standard of care requires continuous monitoring of the oxygen saturation of the blood. This is done by way of a pulse oximeter, a machine that monitors oxygen saturation of the blood, and sounds an alarm when saturation falls below a

set percentage. It is a simple, non-invasive measure, and attaches to the patient with a clip, usually on the finger. Such machines are used in doctor's offices during regular physical check-ups and were available for use in the defendant hospital. It is undisputed that such a device would have called attention to Mr. Colley's falling oxygen saturation before it could drop to harmful levels.

Dr. Jian Sun, the hospitalist attending Mr. Colley testified that she verbally ordered that Mr. Colley's oxygen saturation be monitored in a way that any nurse should have understood the necessity of continuous monitoring by pulse oximetry. Dr. Sun testified that this was the right thing to do in light of the administration of narcotics to a patient with sleep apnea. The observation unit nurse Dawn Hooker recalled no such order, and no such order was recorded in Mr. Colley's chart.

As is usual in such cases, the parties presented opposing expert testimony. Mr. Colley's experts testified that the standard of care required continuous pulse oximetry as ordered by Dr. Sun and that the failure to more closely monitor his oxygen saturation was below the standard of care. The defendant's experts testified that the monitoring was adequate, and that the standard of care did not require continuous pulse oximetry,

despite the fact that the hospital had a sleep apnea protocol which seemed to require it.

However, the defendant was allowed to attack the plaintiff experts by use of their pre-discovery certificates of merit required at the time by RCW 7.70.150. These certificates focused on emergency room personnel, as it was not yet known that Dr. Sun was going to claim she ordered pulse oximetry. The intent was obviously to make the experts look as if they were changing their opinions.

The defendants were also allowed to put on several “causation experts,” who actually had no opinions about causation, in an effort to emphasize that Mr. Colley had many other medical conditions, allowing the jury to speculate about the cause of his memory loss. In a similar attack, the defense was allowed to show that Mr. Colley used to drink a lot, evidence that was solely intended to prejudice the jury against him.

The errors of the trial judge in permitting such evidence denied Mr. Colley a fair trial and require reversal.

II. ASSIGNMENTS OF ERROR

A. Assignments of Error

1. The trial court erred in denying plaintiff's supplemental motion in limine to prohibit use for cross-examination of plaintiffs' expert's certificates of merit filed in accordance with RCW 7.70.150, which had been declared unconstitutional by the Washington Supreme Court.

2. The trial court erred in denying plaintiffs' motion in limine No. 11, permitting entirely speculative and irrelevant expert testimony.

3. The trial court erred in denying plaintiffs' motion in limine No. 16 allowing in evidence of Mr. Colley's past history of alcohol consumption, which was both prejudicial and completely irrelevant.

B. Issues pertaining to Assignments of Error

1. Where the Supreme Court has held that the requirement of the filing of a certificate of merit before any discovery is conducted is unconstitutional as violative of a plaintiff's right to access to the courts, may a defendant nonetheless use the certificate of merit to cross-examine the plaintiffs' experts who signed them? (Assignment of error 1.)

2. Is a plaintiff denied due process by the use of a pre-discovery certificate of merit to cross-examine plaintiffs' experts? (Assignment of error 1)

3. Is use of a pre-discovery certificate of merit required by an unconstitutional statute to impeach plaintiffs' experts prohibited by ER 401 and 403? (Assignment of error 1)

4. Is medical testimony purportedly bearing on causation admissible, which merely identifies potential other causes of harm similar to their experience by plaintiff, without any evidentiary foundation connecting such other causes to the plaintiffs' situation? (Assignment of error 2)

5. In a medical malpractice case in which the evidence shows that the plaintiff suffered an acute onset severe short-term memory loss following respiratory failure in the defendant hospital, can the defendant call medical experts to testify to various conditions that might cause a gradual brain injury but whose only testimony about the plaintiff's actual injury is that they "don't know" if it is related to the respiratory failure? (Assignment of error 2)

6. In a case in which it is undisputed that the administration of a substantial amount of morphine to a patient with severe sleep apnea contributed to the patient suffering respiratory failure, may the defendant call an expert pharmacist to testify generally about the wide variation in dosage of morphine that results in pain relief or in death by overdose,

when neither the level of pain relief nor overdose deaths are at issue?

(Assignment of error 2)

7. May a defendant present evidence of a plaintiff's past alcohol abuse where there is absolutely no evidence presented to connect the alcohol abuse to any issue in the case? (Assignment of error 3)

III. STATEMENT OF THE CASE

A. Procedure

This case is a medical negligence case originally filed against Peace Health d/b/a Saint Joseph Hospital and a number of individuals on July 31, 2008. CP301. Ultimately, the individuals were dismissed and the matter came on for trial before the Honorable Ira J. Uhrig on November 8, through November 23, 2011, with intermittent days off during the trial. CP17.

Plaintiff filed several motions in limine prior to trial. CP252-273, 150-154. Judge Uhrig denied several of these motions allowing the introduction of irrelevant and prejudicial evidence. The erroneous denial of these motions forms the basis of this appeal.

Plaintiff moved in limine to prohibit the defendant from cross-examining plaintiffs' expert hospitalist and nursing expert about the contents of the certificates of merit that they had signed pursuant to RCW 7.70.150. The trial in this matter was subsequent to the Supreme Court opinion in *Putman v. Wenatchee Valley Med. Ctr.*, 166 Wash. 2d 974, 216 P.3d 374 (2009). Plaintiffs' counsel argued that permitting the introduction of evidence on certificates of merit by way of cross-examination of plaintiffs' experts would inject against plaintiffs the very unconstitutional unfairness that led to the Court's holding in *Putman*. RP27. Nonetheless, Judge Uhrig denied this motion. RP67.

Plaintiff also moved in motion in limine 11 to exclude the testimony of three defense expert witnesses. CP259. Defense counsel alleged that these experts were causation witnesses. RP10:19-20. However, none of these witnesses could or did testify that something other than the negligence of the defendant caused plaintiff's claimed injuries. Nor could they testify that the negligence alleged by plaintiff did not cause the plaintiff's injuries. Rather, their testimony was in no way connected with Mr. Colley's condition, but was purely an invitation for the jury to speculate. Judge Uhrig also denied this motion in limine. RP67:9.

Finally, plaintiff moved in limine to exclude evidence of Mr. Colley's history of past alcohol consumption. Defendant introduced evidence to the effect that Mr. Colley at one time was a heavy drinker. However, there was no question that he quit drinking years before the incident in question in this case, and no expert in any way connected his drinking with any symptom relevant to this case. See CP270 to 272. Judge Uhrig also denied this motion. RP67:10. Following the trial of this matter the jury rendered a verdict finding the defendant not negligent CP20, and judgment was entered accordingly, CP16. This appeal followed CP6.

B. Facts Concerning Hospitalization in Question.

On May 4, 2006 Louis Curtis Colley was 45 years old, and had previously been diagnosed by a sleep study as having severe sleep apnea. Ex. 14 On that evening he was suffering severe abdominal pain and was taken by his wife to Saint Joseph's Hospital in Bellingham at about 7:45 p.m. RP 197-8. The plaintiff's factual testimony concerning this hospitalization was presented largely by Mrs. Colley, since Mr. Colley has no memory of the events in the hospital. RP 999. Mr. Colley had been periodically suffering from abdominal pain, and his primary care physician believed that there was a possibility of his developing

pancreatitis and advised the Colleys accordingly. At the hospital Mrs. Colley discussed with the medical personnel the possibility of pancreatitis described by Mr. Colley's primary care physician. RP99.

In the emergency room an abdominal CT scan was done which was basically normal, although it showed some mild markings near the tail of Mr. Colley's pancreas. A later more complete reading of the CT scan was read as showing a distended bladder, and indeed the source of the pain was ultimately determined to be urinary retention. RP 100-1, 1184-1188. In the emergency room he was administered significant amounts of narcotics. From 9:00 p.m. until approximately 1:30 a.m. he received 16 milligrams of morphine as well as 1 milligram of dilaudid. Nonetheless, despite the narcotics, Mr. Colley remained in severe pain. Accordingly, he was admitted to the observation unit with a provisional diagnosis to rule out pancreatitis. RP 109-114.

A temporary order set was written by the emergency room doctor, Dr. Weiche. It included an order for further narcotics, providing two different and alternative narcotics orders. It called for 2 to 4 milligrams of morphine every 2 hours (not to exceed 8 milligrams in any 4-hour period) if the pain scale was from 6 to 10. Alternatively, it called for 1 to 2 milligrams of morphine every hour (not to exceed 8 milligrams in any 4-

hour period) for pain level 3 to 5. Dr. Weiche testified that this order was intended to limit the administration of narcotics to 8 milligrams in any 4-hour period. RP106-114.

However, Dawn Hooker, the nurse on duty on the observation unit interpreted the order to mean that a patient with a pain level from 6 to 10 could get 8 milligrams of morphine in a 4 hour period, and then if the pain was less than 5 given another 2 milligrams every hour, thus doubling the amount of permitted narcotics. RP 470-1. Mr. Colley received 10 milligrams of morphine between his admission to the observation unit at approximately 2:00 a.m. and the last administration at 3:21 a.m. At the time of the last administration of narcotics, Mr. Colley was already noted to be lethargic. RP 457-8.

Mrs. Colley stayed with Mr. Colley throughout the time in the emergency room and stayed in his room as well on the observation unit. In the early morning hours, it appeared to her that Mr. Colley was having trouble breathing in the same way he had before he had been diagnosed with sleep apnea and had received his CPAP machine. She reported this to the nurse, and the "house manager" the overnight head nurse, advised Ms. Colley to go home and get Mr. Colley's CPAP machine. Ms. Colley

was reluctant to leave but was told someone would be with Mr. Colley while she was gone. RP 461-2, 210-212.

When she got back to the hospital at approximately 5:45 a.m., she went into Mr. Colley's room and noticed that he was not breathing. She yelled for the nurse and tried to put on his CPAP unit. When the nurse finally arrived, she called for the hospitalist on duty, Dr. Sun and the respiratory therapist. RP 210-212. An emergency room doctor was called to intubate Mr. Colley. He was taken to the ICU unconscious and extubated himself when he arrived there. Re-intubating him was very difficult, requiring three attempts, during which Mr. Colley vomited. RP 181-2

The hospitalization was very difficult. Mr. Colley extubated himself on more than one occasion. When he regained consciousness he was delusional and combative and had to be restrained. His thrashing around while restrained injured his shoulder, an injury that persists to this day. RP 185-8, 216-7.

More significantly, as Mr. Colley began getting back to normal, it became apparent that he was cognitively very different. Both Ms. Colley and the hospitalist in charge of him noted difficulties with his short-term memory. RP 217.

Mrs. Colley and numerous family and friends as well as his primary care practitioner testified that following his hospitalization, Mr. Colley was a completely different person. A cheerful, friendly and talkative individual to one who would repeat himself constantly, ask questions over and over, and could not even read the Bible, one of his true passions, as he immediately forgot what he had read. RP 218-223, 349-353, 354-57, 369-373, 379-384, 641-650.

C. Evidence Related to Negligence

Mr. Colley was sent by a neurologist at the defendant hospital to a neuropsychologist Dr. Ted Judd. Dr. Judd testified that his testing showed that Mr. Colley had a severe and almost "pure" short-term memory deficit. RP 409. (By this he meant that Mr. Colley's other cognitive functions were largely intact). He testified that it was the kind of memory loss that was routinely associated with deprivation of oxygen. RP 394-6. Sleep apnea is a condition in which a person has periods during sleep when he stops breathing for a period of time. This results in a decrease in the oxygen saturation of the person's blood, and can lead to respiratory failure and respiratory arrest. RP 287-293. In order to avoid this situation, patients are prescribed CPAP machines, which produce pressure into the airway and thus prevent periods of apnea. Narcotics have the tendency to depress

respiration. Thus, the administration of narcotics to a person with sleep apnea significantly increases the risk of respiratory failure. RP 287-93. Mr. Colley had been diagnosed with a severe sleep apnea RP 940, Ex. 14.

Plaintiffs presented evidence of negligence through Dr. Steven Pantilat a professor of medicine at the University of California San Francisco and a board certified hospital medicine specialist. Dr. Pantilat testified that because of the increased risk created by administering narcotics to a person with sleep apnea, the standard of care at the time of Mr. Colley's treatment required monitoring the oxygen saturation of such a patient by use of a pulse oximeter. RP 287-93. A pulse oximeter is a machine attached to the patient usually by a clip on the finger. The machine provides a constant reading of oxygen saturation, and can be set to sound an alarm when the oxygen saturation falls below a set level. In Mr. Colley's case the application of a pulse oximeter would have notified the nurse if his oxygen saturation fell to unacceptable levels, before he experienced respiratory failure. RP 288-298.

Dr. Pantilat also testified that the defendant hospital had a sleep apnea protocol in force at the time of this incident that required continuous pulse oximetry for a patient such as Mr. Colley. RP 289-290, Ex. 5. Indeed the hospital had an order set for sleep apnea a year prior to this

incident that required continuous pulse oximetry for patients with sleep apnea who are administered narcotics. Ex.25. Ms. Hooker confirmed that Ex. 5 was the type of sleep apnea protocol applicable to the observation unit.

Dr. Jian Y. Sun, the hospitalist who assumed care of Mr. Colley when he was transferred from the emergency room to the observation unit virtually agreed with Dr. Pantilat. She testified that when she became aware that Mr. Colley had sleep apnea she gave a verbal order to the nurse on the unit to monitor Mr. Colley's oxygen saturation. RP 1028 She testified that it was her intention that this be done by continuous pulse oxymetry, by the use of a bedside pulse oximeter which was available at all times from the respiratory therapy unit. RP 1030. Although she said that she may not have used the term pulse oximeter, she believed that her order was such that it should have been clearly understood by any reasonably prudent nurse. RP 1064-5. Dr. Sun testified that she ordered the pulse oximetry because it was the "right thing to do" in light of the administration of narcotics with Mr. Colley's diagnosed sleep Apnea. RP 1037:4-13

The nurse on the unit Dawn Hooker, on the other hand, testified that she did not recall getting any such order from Dr. Sun, and if she had

she would have written it down. No such order was written in the hospital record. RP 483. Defendant's nursing expert based her opinion that Ms. Hooker complied with the appropriate standard of care on her belief that Dr. Sun never gave such an order. However, she conceded that if Dr. Sun had given this order, and Ms. Hooker did not carry it out, then Ms. Hooker's conduct was below the standard of care. RP 878.

On the other hand, Defense hospitalist Dr. Danielson conceded that he had formed the opinion that Dr. Sun had complied with the standard of care based on the understanding that she had in fact ordered continuous pulse oximetry, and that at his deposition he had stated that such an order was "appropriate". RP 1151. However, he indicated that continuous pulse oximetry was not necessary to meet the standard of care, as long as the patient was closely monitored, and that Dr. Sun's order sufficiently complied with this standard of care RP 1178. (Of course Ms. Hooker did not recall ever hearing anything about monitoring the patient's oxygen saturation. RP 481-3) The hospital record itself reveals only three notations recording Mr. Colley's oxygen saturation. On intake in the observation unit at approximately 2:00 A.M. it was 97 percent. At 4:00 in the morning it was 92 percent. A notation by Ms. Hooker indicated it was "in the 80s" at 5:45 A.M., but this notation was made after Mr. Colley had

already been administered oxygen in an attempt to resuscitate him. RP 288-300.

It was conceded by all witnesses that there is no way of knowing what Mr. Colley's oxygen saturation between 4:00 and 5:45 . Dr. Pantilat testified that once it starts to fall, oxygen saturation can drop very rapidly. Ms. Colley testified that when she returned to the hospital with Mr. Colley's CPAP machine, he was "not breathing". RP 298-9.

Ms. Hooker testified that she probably checked Mr. Colley's oxygen saturation more frequently than is recorded, but she also testified that if she had taken a reading, she would have written it down. RP 483. Plaintiff's nursing expert Sarah Covington testified that Ms. Hooker's conduct fell below the standard of care in that she administered more morphine than was permitted by Dr. Weiche's order, and that she failed to adequately monitor a patient to whom she was administering narcotics, and who she knew suffered from severe sleep apnea. Ms. Covington testified that Nurse Hooker should have been checking oxygen saturations frequently and recording the data. Ms. Hooker testified that when using a pulse oximeter, she usually set the alarm to go off if oxygen saturation fell below 90 or 92 percent, and thus she would have been notified of Mr. Colley's progressive desaturation before Ms. Colley's return with the

CPAP machine. When the oximeter reading fell below that range she would call the doctor or respiratory therapy . RP 507-9.

D. Evidence Relating to Causation

Plaintiffs called as their expert on causation Dr. Arthur Ginsberg a Board-certified neurologist. Dr. Ginsberg testified that the diagnosis of the extent and cause of brain damage is precisely within the specialty of neurology. RP 697:2 9. Dr. Ginsberg was surprised that the defendants did not have a neurology expert in the case, since the question of the cause of Mr. Colley's memory loss is a question of neurology. RP 697:16-698:1. Dr. Ginsberg testified that on a more probable than not basis Mr. Colley's severe short-term memory loss was caused by brain damage resulting from the loss of oxygen associated with his respiratory failure. RP 698:10 699:13. He testified that brain imaging, such as CT scans or MRIs are not necessary helpful in diagnosing this kind of injury, as one can have an injury to the brain causing a severe short-term memory loss which is not visible by imaging. RP 710:1 7. He further testified that there is no other good explanation for the short-term memory loss. RP 715:12 15.

It is not likely associated with Mr. Colley's sleep apnea, because sleep apnea, if untreated can lead to brain injury as a result of reduced oxygen, but it happens by a slow progression and not acutely as was true

in Mr. Colley's case. RP 722:14 15. This was confirmed by Dr. Pascualy. RP 964-5. Furthermore, his sleep apnea and other medical conditions made him more vulnerable for the kind of brain damage resulting in this matter. RP 727:15 16.

As was noted by Dr. Ginsberg, the defense presented no neurologist on the issue of causation. Rather they presented two doctors and a pharmacist alleging in response to plaintiffs' motion in limine that they were "causation witnesses." The first of these Dr. Stimac is a neuroradiologist. He testified about his reading of an MRI taken of plaintiff after the hospitalization in question and a CT scan that had been taken previously when Mr. Colley was complaining of headaches.

Dr. Stimac was allowed to show the jury other MRIs completely unrelated to the facts of this case. For example, he compared Mr. Colley's MRI with MRIs showing what brain damage appears like after a severe insult such as a stroke or a significant period of complete deprivation of oxygen. RP 801-802. Dr. Stimac testified that Mr. Colley showed the diffuse loss of brain tissue, such as occurs in normal degeneration, but more advanced than one would expect from a person of his age. However, he noted that nothing about Mr. Colley's scans "demand symptoms or predict symptoms." RP 821:18 22. In other words, you could have another person with an identical scan to Mr. Colley's, and one could have

symptoms and the other one might not. RP 821:23 822:1. He explicitly testified that he had no opinion on what was causing Mr. Colley's memory loss. RP 821:11 14. He further testified that a person could have a hypoxic insult to the brain which would cause memory loss which would not be perceptible by any scanning technique. RP 824:20 24. He concluded by saying that radiology does not answer the question of causation, RP 827:24 828:3, and that memory loss is a failure of function which is not generally visualized on scans as specific abnormalities. RP 833:23.

The defense also presented over objection the testimony of Dr. Alan Ellsworth, a pharmacist. He likewise gave no testimony relevant to any issue in the case. He testified that it is hard to talk about the therapeutic blood levels when discussing morphine, because it is virtually unknown and widely variable between individuals. RP 921:25 922:7. He also testified that even with respect to acute overdoses there are wide ranges of blood levels of morphine which can lead to death. The amounts vary from person to person on the order of fifty times. RP 924. He frankly conceded that none of the studies he referred to had anything to do with morphine's tendency to suppress the respiratory drive. RP 929:25 930:4.

Finally, defendant produced the testimony of Dr. Ralph Pascualy. Dr. Pascualy is a psychiatrist and a widely-recognized expert in sleep

medicine. He testified that Mr. Colley had a severe sleep apnea. RP 940. He testified that Mr. Colley had lots of conditions which could cause memory loss. RP 941:14 15. However he could not say whether the respiratory failure in the hospital caused more memory trouble or it didn't. RP 941:16 18. He testified that he could not say whether the event in the hospital was significant enough to cause a severe memory loss because the evidence by way of pulse oximetry did not exist for the period of time between 4:00 a.m. and 5:45, since Mr. Colley had not been monitored. RP 942:1 5.

Dr. Pascualy testified that he discounted the imaging that Dr. Stimac had discussed because it didn't answer the question of causation. It didn't say that the memory loss was or wasn't related to the respiratory failure and that therefore he thought that made the imaging "irrelevant". RP 950:7 10.

He testified that memory complaints previous to the incident in the hospital would make sense in somebody with a multi-factorial memory loss RP 951:3 8. Finally he agreed with Dr. Ginsberg that sleep apnea does not cause memory loss on an acute basis. RP 964:15 18, 965:16 20. The defense continuously insisted that Mr. Colley had had memory complaints previous to this incident in the hospital. As indicated above, none of the lay witnesses who testified had ever noticed any kind of

memory issues with Mr. Colley. Indeed, out of the hundreds of pages of medical records that were introduced, the only mention of memory loss is in the report of the sleep study by which Mr. Colley was diagnosed with sleep apnea. However, the only mention in that exhibit is in connection with the question of whether Mr. Colley finds himself drowsy during the daytime. He indicated that he did, and that when he was drowsy he sometimes had trouble with his memory. Ex.14.

IV. ARGUMENT

A. The requirement of a Certificate of Merit was unconstitutional. Use of the Certificate of Merit to discredit Plaintiffs' witnesses compounds the deprivation of due process.

Former RCW 7.70.150 required the filing of a Certificate of Merit prior to the filing of a lawsuit alleging health care negligence. Defense counsel inquired of Plaintiffs' Sarah Covington, R.N., M.S.N., about the contents of the certificate she signed. In Ms. Covington's certificate, she opined about the negligence of two emergency room nurses, whom later discovery found not to be negligent. RP 163-168, Ex.7. Defense counsel compounded this error by asking Ms. Colley about allegations in the certificate of merit concerning the negligence of emergency room personnel. RP 254-6. For the same reasons that the Supreme Court held in

Putman v. Wenatchee Valley Med. Ctr., 166 Wash.2d 974, 216 P.3d 374

(2009) that RCW 7.70.150 was unconstitutional, this was error.

The Supreme Court held that the requirement of certificates of merit violates due process, because it unduly burdens access to the courts.

The people have a right of access to courts; indeed, it is “the bedrock foundation upon which rest all the people's rights and obligations.” *John Doe v. Puget Sound Blood Ctr.*, 117 Wash.2d 772, 780, 819 P.2d 370 (1991). This right of access to courts “includes the right of discovery authorized by the civil rules.” *Id.* As we have said before, “[i]t is common legal knowledge that extensive discovery is necessary to effectively pursue either a plaintiff's claim or a defendant's defense.” *Id.* at 782, 819 P.2d 370.

Requiring medical malpractice plaintiffs to submit a certificate prior to discovery hinders their right of access to courts. Through the discovery process, plaintiffs uncover the evidence necessary to pursue their claims. *Id.* Obtaining the evidence necessary to obtain a certificate of merit may not be possible prior to discovery, when health care workers can be interviewed and procedural manuals reviewed. Requiring plaintiffs to submit evidence supporting their claims prior to the discovery process violates the plaintiffs' right of access to courts. It is the duty of the courts to administer justice by protecting the legal rights and enforcing the legal obligations of the people. *Id.* at 780, 819 P.2d 370. Accordingly, we must strike down this law.

Id. at 979.

The evil inherent in the requirement of certificates of merit was nonetheless be visited on plaintiffs here when Defense counsel was

permitted to question witnesses about their certificates. Before discovery is conducted, as the Court stated, it may be difficult, if not impossible to know exactly which health care provider is responsible for what decision. Having been forced to file certificates by an unconstitutional statute, Plaintiffs should not further be punished by having their witnesses questioned about opinions given at a time when the evidence provided by discovery was not available.

Indeed, allowing the Certificates of Merit to be discussed in front of the jury is worse than requiring them in the first place. As the Supreme Court stated, it may well be impossible to tell who is at fault until after discovery. Explaining this to the jury would require significant inquiry into completely tangential matters about the course of litigation.

Such evidence is not “relevant” as defined by ER 401, and must be excluded pursuant to ER 402. Even if arguably relevant, its probative value, consisting of expert opinions given at a time when all of the evidence was not available, is substantially outweighed by the danger of unfair prejudice and confusion of the issues, as well as by considerations of undue delay and waste of time. This line of questioning should have been prohibited.

Evidence of negligence was at least close in this case. As direct assault on the credibility of Plaintiff's experts, by use of unconstitutional Certificates of Merit unfairly impaired Plaintiff's case.

B. The Court should have excluded the purely speculative defense expert testimony

Under Washington law, defense counsel may not ask medical experts questions regarding other possible causes of the plaintiff's injuries for which there is no foundation. In *Supanchick v. Pfaff*, 51 Wn. App. 861 (1988), the Court of Appeals held that the trial court committed prejudicial error when it allowed defense counsel to ask medical experts questions concerning other possible causes for the plaintiff's back condition. The court cited *Washington Irrig. & Dev. Co. v. Sherman*, 106 Wn.2d 685 (1986), which held that speculative questions concerning possible causes of injury to an industrial insurance claimant, without any showing that the subsequent accidents had any effect on the claimant's disability, were improper. The *Supanchick* court held that, should the issue arise on retrial, the defense must demonstrate a good faith basis for questions concerning possible causes of the plaintiff's injuries other than speculation. The issue is whether or not a medical expert is saying on a more probable than not basis that the injuries sustained by the plaintiff were caused by X.

It is not sufficient for the defendants to claim that cross-examination of Plaintiffs' experts can alter or rebut causation testimony. Cross-examination of an expert must be based upon a provable or established premise and cannot invite the jury to speculate, particularly about matters outside of the knowledge of lay witnesses. *Washington Irrigation and Development Co. v. Sherman*, 106 Wn.2d 685, 724 P.2d 997 (1986), for example, involved the appeal of an administrative decision in a worker compensation case. The worker, Sherman, contended that he suffered an industrial injury to his lower back. Sherman was involved in two rear-end collisions after his industrial injury, and the Department sought to attribute Sherman's medical problems to the auto accidents rather than the industrial injury, despite the fact that the Department had no evidence to support such a claim. The Court of Appeals held that the trial court erred when it permitted the Department's attorney to ask Sherman's medical witnesses questions about the effects of rear-end collisions on persons with preexisting low back problems. The Court stated that the questions were misleading because no showing was made that Sherman's subsequent auto accidents had any effect on his disability. The Court noted that "[s]uch questions improperly suggested to the jury that there may have been a superseding cause of Sherman's condition although no proof of such a cause is in the record." *Id.* at 691. The Court

held that it was error to allow the misleading cross-examination by the Department's attorney because the questions had no basis in fact and simply invited speculation by the jury:

[B]ecause the respondents presented no evidence showing that Sherman's low back condition was aggravated by his automobile accidents, it was improper for respondents' counsel to ask broad questions about the effects of rear-end accidents on persons with low back injury. A jury could only speculate as to the amount of aggravation, if any, Sherman may have suffered as a result of his automobile accidents because no affirmative evidence on the issue surfaced during trial. * * * On remand, such questions should not be allowed unless the respondents are able to support by evidence that the subsequent accidents affected Sherman's low back condition.

Id. at 692; *see also Queen City Farms v. Central National Ins.*, 126 Wn.2d 50, 100, 882 P.2d 703 (1994) ("A verdict cannot be founded on mere speculation."); *Lamphiear v. Skagit Corp.*, 6 Wn. App. 350, 356, 493 P.2d 1018 (1972) ("It is the rule that a verdict cannot be founded on mere theory, speculation or conjecture.")

The admission of medical expert testimony is governed by *ER 702*.

That rule provides:

If scientific, technical, or other specialized knowledge *will assist the trier of fact to understand the evidence or to determine a fact in issue*, a witness qualified as an expert by knowledge, skill, experience, training, or education, may testify thereto in the form of an opinion or otherwise. *ER 702* (emphasis added).

In order to satisfy *ER 702*, it is a well-established rule that medical expert testimony must be based upon an adequate foundation and stated upon a reasonable degree of medical certainty. *Reese v. Stroh*, 128 Wn. 2d 300, 907 P. 2d 283, 286 (1995). As our court had earlier explained in *Miller v. Staton*, 58 Wn. 2d 879, 886, 365 P. 2d 333 (1961),

The causal relationship of an accident or injury to a resulting physical condition must be established by medical testimony **beyond speculation and conjecture**. The evidence must be more than the accident “might have,” “may have,” “could have,” or “possibly did,” cause the physical condition. It must rise to the degree of proof that the resulting condition was probably caused by the accident, or that the resulting condition more likely than not resulted from the accident, to establish a causal relation. (Emphasis added)

The medical expert in *Miller*, *supra*, whose testimony the *Miller* court agreed should have been excluded, answered opinion questions by stating “It is possible...” *Id* at 885-86 (emphasis added).

The *Miller* decision has been followed by and is consistent with numerous subsequent Washington decisions. In *O'Donoghue v. Riggs*, 73 Wn. 2d 814, 824, 440 P. 2d 823 (1968) the court stated:

In many recent decisions of this court we have held that such determination is deemed based on speculation and conjecture if the medical testimony does not go beyond the expression of an opinion that the physical disability “might have” or “possibly did” result from the hypothesized cause.

See also *Orcutt v. Spokane County*, 58 Wn. 2d 846, 853, 364 P. 2d 1102 (1961); *Carlos v. Cain*, 4 Wn. App. 475, 477, 481 P. 2d 945 (1971) (directly quoting *Miller*, supra). *Miller's* lesson is very clear – the admission of expert medical opinions that do not rise above the level of speculation and conjecture constitutes reversible error. The rule is consistent with *ER 401*, *402*, and *403*, which, when read together, require that before evidence be deemed admissible it must make a fact in issue more or less *probable*.

Defendants frequently ask treating medical experts questions expressed in terms of “possibility.” Defendants argue that since they do not have the burden of proof on causation, the rules requiring that opinions be expressed in terms of “reasonable medical probability” do not apply to them. The cases and rules cited above do not distinguish between plaintiffs and defendants, nor do they distinguish treating physicians from purely forensic medical expert witnesses.

Opinions expressed in terms of “possibility” and not “probability” simply invites the jury to speculate. Just about anything is “possible.” An opinion expressed in such terms is meaningless, and of no use to the trier of fact in determining the “facts in issue.” See *Supanchick v. Pfaff*, 51 Wn.App. 861, 756 P.2d 146 (1988); *Washington Irrigation and*

Development Co. V. Sherman, 106 Wn.2d 685, 724 P.2d 997 (1986).

Whatever slight or remote probative effect such speculative opinions may have is far outweighed by the likely or probable prejudicial effect such speculation will have on the jury.

This issue directly applies to three of Defendant's witnesses, Ralph Pascualy, M.D., Gary K. Stimac, M.D., and Allan Joseph Ellsworth, Pharm.D., PA-C. All of these witnesses offer purely speculative testimony, that in no way served the purpose of assisting the trier of fact in determining causation or any other issue.

Dr. Pascualy is a well qualified sleep medicine doctor, and a recognized expert on sleep apnea. However, his testimony in this case was limited to his testimony that sleep apnea can cause (usually reversible) cognitive impairment, including memory problems. He could not say that the respiratory arrest suffered by Mr. Colley was not the cause of his memory loss, nor does he have sufficient foundation to say that sleep apnea was. He has no information about Mr. Colley's functioning before the hospitalization in question. His testimony is precisely the kind that serves no purpose except to lead the jury to speculate.

The same must be said about Dr. Stimac. Dr. Stimac is a neuroradiologist who spends 75% of his time on medical legal matters.

He reviewed two studies of Mr. Colley's brain, a CT scan taken before the hospital stay in question and an MRI taken after. The information he obtained from this review is that the natural degeneration of brain tissue was greater than he would expect from a 45-year-old man. Further, he did not see the signs one would expect from a massive global deprivation of oxygen. However, he cannot say that the degeneration is something that would be associated with any symptoms, nor can he say from the scans that Mr. Colley did not suffer sufficient focal damage to his brain to cause the memory loss he has suffered. In short, there is no connection at all between his findings and any issue in this case. Neuroradiology is not a field in which the average juror could be expected to extrapolate information to a given fact situation. Dr. Stimac's testimony is a pure invitation to the jury to make leaps of logic that he as an expert is unwilling to make. It says essentially nothing that could aid the jurors in answering any question material to this case. His testimony should be excluded.

Finally, the testimony of Dr. Ellsworth is even more useless as a means of assisting the jury to understand the evidence. Using data he apparently obtained from some online studies he mathematically extrapolates to make two points. The first calculates using data from

surgical patients, the amount of morphine necessary to achieve analgesia (pain relief). This data is from patients given an infusion of morphine in an IV solution, while Mr. Colley received his in a direct injection. Using this apples and oranges comparison, it appears that he was trying to make the point that the amount of morphine given to Mr. Colley is within the (admittedly wide) parameters of the amount necessary to achieve analgesia in patients having surgery without anesthetics. This of course says nothing about any issue in this case.

Next, he takes data from a single experiment with a man much smaller than Mr. Colley to show that much of the morphine would have been cleared by the time there was “any respiratory problems”. However, the time used is 5:45 A.M., at which time Mr. Colley was unable to breathe on his own and had to be intubated. Dr. Ellsworth recognizes that by 4:00 A.M. Mr. Colley’s blood oxygen had dropped from the high 90s to 92% (the level at which a pulse oximetry alarm usually goes off), and that no one knows what his oxygenation level was at anytime between 4:00 A.M. This of course makes this calculation; to the degree it has any validity¹, entirely irrelevant to any issue in this case. Furthermore, it is

¹ It is hard to imagine that use of values taken from one experiment with a person unlike Mr. Colley meets the *Frye* standard [*Frye v. United States*, 54 App. D.C. 46, 293 F. 1013 (1923)] of a theory and/or methodology generally accepted in the relevant scientific

undisputed by the medical evidence in this case that the depression of Mr. Colley's respiration due to the administration of morphine was a cause of his respiratory arrest. Dr. Ellsworth could not say to the contrary, as such causation opinions can only be given by medical doctors

Finally, Dr Ellsworth will opine that under certain definitions, the morphine administered was not an "overdose". Two of those definitions are based on morphine levels that cause death. The other is from a population of patients without sleep apnea who were administered morphine by infusion (as Mr. Colley was not) and needed respiratory ventilation. Such testimony begs the question. In the first instance the doctors of the Defendant persistently refer in their records to this administration as an overdose. More important, there is no question that the morphine led to Mr. Colley's respiratory arrest. Whatever it is called, it did the job. More important, there is no claim in the case that the administration of the morphine was an overdose. Rather plaintiff claims (1) that the nurse administered more morphine than the doctor ordered and (2) it was negligent to administer morphine to a patient with severe sleep apnea without continuous pulse oximetry. In this context Dr. Ellsworth's testimony is completely irrelevant and again can only lead to speculation.

community. See *Anderson v. Akzo Nobel Coatings, Inc.*, ___ Wash.2d. ___, 260 P.3d 857 (2011).

Plaintiffs are well aware of the time-honored defense tactic of throwing stuff against the wall in the hope that something will stick. However, before such tactic may be employed, it is necessary that that the “stuff in question” be admissible. This expert testimony simply is not.

This court’s recent decision in *Stedman v. Cooper*, ____ Wash.App. ____; 282 P. 3d 1168 (2012) is directly on point in Appellant’s favor. There this court upheld the trial court’s exclusion of the testimony of Allan Tencer a biomechanical engineer. Dr. Tencer intended to testify that the forces involved in the collision in question were small, and not likely enough to cause injury. This Court cited with approval from a trial Court’s order excluding Tencer’s testimony.

Dr. Tencer is very careful to state that he is not testifying to what specific injuries the accident caused to this plaintiff. But that is exactly the inference that the defense wants the jury to draw from his testimony: that because, on average, the forces in such an accident would not injure a vehicle occupant, the plaintiff in this case must not have been injured by this accident. If the jury does not draw this inference, Dr. Tencer’s testimony, while interesting, is irrelevant to the proceeding before the court.

Quoted in *Stedman*, supra, at 1171-2.

The same is obviously true here. Dr. Pascualy testifies that Mr. Colley has several other conditions that can cause memory loss; Dr Stimac

testifies that Mr. Colley's MRI shows brain degeneration which might or might not be related to symptoms. Neither can say that Mr. Colley's respiratory failure was not the result of his injury; neither says something else was. They are merely inviting the jury to speculate and reach the conclusion that they are unwilling to state directly. Such testimony is not in any way helpful to the jury under ER 702. Dr. Ellsworth's testimony is not remotely related to any issue in the case.

Defendants were apparently unable to come up with a competent neurologist to support their position. As a substitute, they brought in "experts" who did not have actual opinions about causation, but merely invited the jury to make those conclusions they could not. Especially in light of the unconstitutional attack on Plaintiffs' experts, the testimony of these experts should have been excluded.

C. Evidence of Mr. Colley's history of alcohol consumption.

Mr. Colley's medical records contain notations about his having an alcohol problem in his past. Dr. Pascualy related that Mr. Colley stated he used to drink like a fish. RP 948. The evidence of his prior drinking was also elicited in Dr. Judd's evaluation. However, the evidence is uncontested that Mr. Colley quit drinking years before the incident in question here, and at the time of the hospitalization in question was

completely abstinent. Significantly, there has been no testimony from any medical or vocational professional that Mr. Colley's use of alcohol affected his life expectancy or his employment or was in any way connected to liability issues. There is no testimony that his drinking caused his memory loss. The mere possibility that either "might" have been affected is insufficient to warrant its admissibility.

This case is thus stronger for the plaintiff than *Kramer v. J.I. Case Mfg. Co.*, 62 Wash. App. 544, 815 P.2d 798 (1991), which is controlling. In that case the court held that plaintiff's alcoholism was inadmissible absent expert testimony indicating a relationship between the alcoholism and loss of earning capacity, or reduced life expectancy. There is likewise no such evidence here. The court in *Kramer* cited with approval case from other jurisdictions that had similar holdings:

Other courts, however, have limited admissibility of such evidence. For example, the Ohio court has ruled that in an action to recover damages for personal injuries, evidence as to plaintiff's *intemperate habits prior* to the occasion when such injuries were sustained is admissible as tending to show a mitigation of damages for claimed impairment of ability to work, *only* after it is established that plaintiff's ability to work actually was impaired prior to such occasion, and that such impairment was the result of such intemperate habits.

(Emphasis added.) *Shellock v. Klempay Bros.*, 167 Ohio St. 279, 289-90, 148 N.E.2d 57, 75 A.L.R.2d 900 (1958). *Kramer, supra*, at 558.

Notwithstanding the broad discretion of the trial court regarding the admissibility of evidence, the Supreme Court held that admission of the alcoholism evidence was an abuse of that discretion and further held that before such prejudicial evidence may be admitted the proponent of the evidence must make an offer of proof as to its relevance. *Id.* at 559.

There is no such relevance her. ER 401 defines relevant evidence as:

... evidence having any tendency to make the existence of any fact that is of consequence to the determination of the action more probable or less probable than it would be without the evidence.

ER 402 provides that “[e]vidence which is not relevant is not admissible.” Lewis Colley’s drinking is not at issue. Neither does it have any tendency to make the existence of any fact of consequence to the determination of the action more or less probable. Therefore, such evidence should be excluded as irrelevant under ER 402. Even if there were some marginal relevance to past alcohol consumption, it should nevertheless be excluded under ER 403 and 404(b).

ER 403 provides:

Although relevant, evidence may be excluded if its probative value is substantially outweighed by the danger of unfair prejudice, confusion of the issues, or misleading

the jury, or by considerations of undue delay, waste of time, or needless presentation of cumulative evidence.

There is no doubt that evidence of excessive drinking is prejudicial. There is no probative evidence that outweighs this prejudice in this case. Under ER 404(b), evidence of other crimes, wrongs or acts is “presumptively inadmissible to prove character and show action in conformity therewith.” *State v. Powell*, 126 Wash. 2d 244, 258 (1995). The rule applies to evidence of prior crimes, regardless of whether they resulted in convictions, as well as “acts that are merely unpopular or disgraceful.” See generally 5 K. Tegland, WASHINGTON PRACTICE: EVIDENCE § 404.11 at 670 (2004 ed.). The rule bars evidence of prior crimes or acts of misconduct even if it comes in the form of a defendant’s own admission or confession. *Id.*, § 404

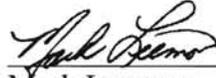
Introduction of the issue of excessive drinking is undeniably prejudicial to the plaintiff, and it has no probative value whatsoever. This evidence should have been excluded.

V. CONCLUSION

For the foregoing reasons the judgment herein should be reversed and remanded to the trial court for a new trial.

Dated this 28th day of November, 2012.

LEEMON + ROYER

A handwritten signature in cursive script, appearing to read "Mark Leemon".

Mark Leemon

Attorney for Plaintiffs/Appellants

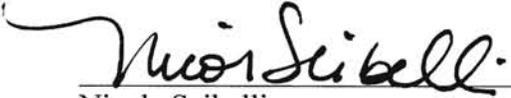
CERTIFICATE OF SERVICE

The undersigned hereby certifies that I am an employee of LEEMON + ROYER PLLC, and am a person of such age and discretion as to be competent to serve papers, and that on today's date, I caused a true and correct copy of Plaintiffs/Appellants Opening Appeals Brief to be served via legal messenger and via electronic mail to the following:

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Dated this 28th day of November, 2012.



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