NO. 40731-1

COURT OF APPEALS, DIVISION II
OF THE STATE OF WASHINGTON

GARY D. HOLLIS, SR.,

Respondent.

v.

DEPARTMENT OF LABOR AND INDUSTRIES FOR THE STATE OF WASHINGTON,

Appellant,

BRIEF OF APPELLANT

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I. INTRODUCTION

This appeal concerns Gary Hollis's request for acceptance of a medical condition under his allowed claim under the Industrial Insurance Act. Mr. Hollis claims that he developed Reiter's syndrome as a result of a needle stick injury that he suffered while at work. Reiter's syndrome is a form of reactive arthritis. It has a genetic basis but can be triggered when certain bacteria enter the body. It is not generally accepted by the medical community that a needle stick can transmit the bacteria that trigger Reiter's syndrome. Also, Dr. Peter Mohai's causation testimony to the contrary is grounded in speculation. Moreover, there is no evidence that the needle that pricked Mr. Hollis contained any bacteria of a kind that can trigger Reiter's syndrome.

For three independent reasons under *Frye v. United States*, 293 F. 1013 (D.C. Cir. 1923), ER 702, and ER 703, the superior court erred when it admitted Dr. Mohai's testimony that the needle stick proximately caused Mr. Hollis to develop Reiter's syndrome. Absent such evidence, the jury's verdict allowing Mr. Hollis's workers' compensation claim is not supported by any evidence of proximate cause. Furthermore, even if Dr. Mohai's causation testimony is admissible, the causation evidence is inadequate to support the jury's verdict that accepted Reiter's syndrome under the needle stick claim. The jury verdict must be vacated.

II. ASSIGNMENTS OF ERROR

A. Assignments

1. **The superior court erred when it overruled the Department's objection and allowed Mr. Hollis to present evidence that his Reiter's syndrome was proximately caused by being stuck with a needle in the course of his employment, because (1) it is not generally accepted in the medical community that Reiter's syndrome can be contracted by a needle stick; (2) Dr. Mohai's testimony that Reiter's syndrome can be contracted by a needle stick is grounded in speculation; and (3) no evidence was presented showing that the needle contained a bacteria of a kind that is known to trigger Reiter's syndrome. CP at 40-41 (superior court ruling denying Department's motion for summary judgment).**

2. **The superior court erred in entering judgment on the jury's verdict because no evidence of proximate cause other than speculation supports the jury's verdict allowing Mr. Hollis's Reiter's syndrome under his workers' compensation claim. CP at 107-09 (superior court judgment on jury verdict).**

B. Issues

1. **Where the undisputed medical testimony established that it is not generally accepted that Reiter's syndrome can, in any circumstance, be proximately caused by a needle stick, was it error as a matter of law under *Frye v. United States* to allow Mr. Hollis to present Dr. Mohai's expert opinion that Mr. Hollis developed Reiter's syndrome as a result of a needle stick at work? (assignments 1, 2)**

2. **Where Dr. Mohai's theory that a needle stick can, in some circumstances, cause Reiter's syndrome is speculative, was it error as a matter of law under Evidence Rule 702 and Evidence Rule 703 to allow**

Mr. Hollis to present Dr. Mohai's expert opinion that Mr. Hollis developed Reiter's syndrome as a result of a needle stick at work? (Assignments 1, 2)

3. **Where Mr. Hollis presented no evidence as to the contents of the needle, was it error under Evidence Rule 702 and Evidence Rule 703 to admit Dr. Mohai's speculative testimony that the needle stick in this case triggered Mr. Hollis's Reiter's syndrome? (assignments 1, 2)**

4. **Where Mr. Hollis presented no evidence other than speculation that he developed Reiter's syndrome as a proximate result of any traumatic incident at work, was it error to enter judgment on the jury's verdict allowing Mr. Reiter's workers' compensation claim? (assignments 1, 2)**

III. STATEMENT OF THE CASE

A. Mr. Hollis's Industrial Injury And Subsequent Workers' Compensation Claim[1]

Mr. Hollis was employed by Peninsula Sanitation Service, Inc. when he pricked his finger on a hypodermic needle while picking up garbage at a dairy farm. CABR at 37. Mr. Hollis applied for benefits under the Industrial Insurance Act, and the Department of Labor and Industries allowed Mr. Hollis's claim. CABR at 36. The Department

[1] "CABR" references the Certified Appeal Board Record. The Clerk's Papers did not renumber the CABR. References to Board pleadings and orders are to the page number stamped by the Board in the lower right corner of the page. Transcripts in the CABR are separately numbered, and references will be to the name of the witness and page number of the transcript. Dr. Ayars's testimony was taken on two dates: January 30, 2009 and February 10, 2009. References to Dr. Ayars's first deposition will be to Ayars I and references to Dr. Ayars's second deposition will be to Ayars II.

ultimately accepted carpal tunnel syndrome as an allowed condition under the claim, and Mr. Hollis underwent a carpal tunnel release surgery. CABR at 35.

Mr. Hollis also contended that he had developed other conditions as a result of the needle stick, including Reiter's syndrome, which is a form of reactive arthritis. CABR at 34. The Department sent Mr. Hollis for two independent medical examinations regarding his request for coverage of Reiter's syndrome under his claim. Peter Mohai, M.D., board certified in internal medicine and rheumatology, Mohai at 5, diagnosed Mr. Hollis with what he described as "incomplete Reiter's syndrome" and concluded that it was more probably than not related to the needle stick. Mohai at 28. Mr. Hollis was examined by Garrison Ayars, M.D., during his second independent medical examination. Dr. Ayars is board certified in internal medicine, infectious diseases, and allergy and clinical immunology. Ayars I at 5. The field of infectious disease involves the diagnosis and treatment of conditions caused by organisms that cause infections, including bacteria. *Id.* Dr. Ayars concluded that, to the extent Mr. Hollis has Reiter's syndrome, it could not have been caused by the needle stick, because the bacteria that trigger Reiter's syndrome do not enter the body via a needle stick. *Id.* at 31.

The Department issued an order that denied responsibility for Reiter's syndrome and other conditions on the grounds that they were not proximately caused by his industrial injury.[2] CABR at 36. Mr. Hollis appealed that Department order to the Board of Industrial Insurance Appeals (Board). CABR at 36. The only relief he requested was acceptance of Reiter's syndrome; Mr. Hollis did not contend that the Department segregated the other medical conditions in error, nor did he present any evidence to the Board that any of those conditions were proximately caused by his industrial injury. Hollis at 3-4; CABR at 34.

During the perpetuation deposition of Dr. Mohai, the Department objected to Dr. Mohai's causation testimony under *Frye*, and based on ER 702 and ER 703. Mohai at 28; 29; 34; 40. The Department renewed its objection at the beginning of the hearing before the Industrial Appeals Judge, and indicated its intention to re-raise and brief the issue of the objection upon the conclusion of the hearing. Hollis at 5. At the conclusion of the hearing, both the Department and Mr. Hollis briefed the issue of whether the Department's *Frye* objection should be sustained.

[2] The other conditions contended by Mr. Hollis but for which the Department denied responsibility included right elbow pain, conjunctivitis, generalized myalgia, fatigue, chronic obstructive pulmonary disease, decreased testosterone level, Hodgkin's disease, depression / panic attacks, and mental health disorder. CABR at 36.

CABR at 92 (Department's motion to strike at 1), CABR at 106 (Claimant's response to motion to strike at 1).

The IAJ issued a Proposed Decision and Order that granted the Department's motion to strike Dr. Mohai's testimony that the needle stick proximately caused Mr. Hollis's Reiter's syndrome. CABR at 34. The IAJ then noted that, in the absence of Dr. Mohai's causation testimony, Mr. Hollis had failed to present any evidence that the industrial injury proximately caused Mr. Hollis's Reiter's syndrome. CABR at 35. The IAJ also noted that, even leaving aside the *Frye* issue, Mr. Hollis had not presented a *prima facie* case that his Reiter's syndrome was proximately caused by his injury, because Mr. Hollis presented no admissible evidence that the needle that pricked him contained any bacteria of a kind that could have caused him to develop Reiter's syndrome. CABR at 35. For those reasons, the IAJ affirmed the Department order segregating Reiter's syndrome from Mr. Hollis's claim. CABR at 37.

Mr. Hollis filed a Petition for Review to the three member Board of Industrial Insurance Appeals and the Board denied review, thereby adopting the Proposed Decision and Order as its own Decision and Order. CABR at 2. Mr. Hollis then appealed that decision to Pacific County Superior Court. CP at 1. During Mr. Hollis's appeal to superior court, the Department moved for summary judgment on the grounds that Dr.

Mohai's testimony was barred by *Frye*, ER 702 and ER 703 and that under the Board record, therefore, he had failed to make a *prima facie* case that Reiter's syndrome was proximately caused by his industrial injury. CP at 3. The superior court denied the Department's motion for summary judgment. CP at 40.

At a pretrial hearing on the objections raised at the Board level, the Department renewed its objection to Dr. Mohai's testimony on the basis that it was barred by *Frye*, ER 702 and ER 703. The superior court overruled the objection. VRP at 122. The case was then presented to a jury. At the conclusion of the trial, the jury found that the Department and Board were incorrect to deny responsibility for Mr. Hollis's Reiter's syndrome, CP at 101, and judgment was entered accordingly. CP at 107. This appeal followed.

B. Reiter's Syndrome

Reiter's syndrome is a form of reactive arthritis.[3] Mohai at 23. Dr. Mohai testified that the bacteria that trigger Reiter's syndrome can live

[3] A review of the medical literature suggests there may be some debate as to whether Reiter's syndrome is synonymous with reactive arthritis, or merely a form of reactive arthritis. Both Dr. Mohai and Dr. Ayars indicate that it is a subset of reactive arthritis. Ayars II at 35-36, Mohai at 71. The term Reiter's syndrome seems to have become disfavored in recent years as it has emerged that Dr. Reiter committed crimes against humanity as a member of the Nazi Party during World War II. At least one article suggests that the recommended term for Reiter's syndrome is now reactive arthritis. Danielle Lauren Petersell, M.D., et al., *Reactive Arthritis*, 19 INFECT. DIS. CLIN. N. AM. 863, 866 (2005). Because Dr. Ayars and Dr. Mohai consistently use the term Reiter's syndrome, and because it remains uncertain whether Reiter's syndrome is

either in the genitourinary tract or in the gastrointestinal tract. Mohai at 29. Dr. Mohai testified that these bacteria include *Chlamydia*, *Salmonella*, *Shigella*, and *Yersinia*. Mohai at 42. Dr. Ayars testified that *Campylobacter* is also a well known Reiter's-causing bacteria. Ayars I at 16. *Chlamydia* travels through the genitourinary tract while the other four bacteria travel through the gastrointestinal tract. Mohai at 42-43.

Certain individuals, most commonly males, have a genetic predisposition to Reiter's syndrome, and that predisposition can be triggered when the individual is exposed to certain specific bacteria, or pathogens. Mohai at 29. The genetic predisposition to Reiter's syndrome occurs when an individual has a certain gene, known as HLA-B27 – or Human Leukocyte Antigen B27. Mohai at 23. Mr. Hollis has the HLA-B27 gene. Mohai at 23.

Reiter's syndrome has three main manifestations: arthritis, urarthritis, and either iritis or conjunctivitis.[4] Mohai at 29. These conditions are symptoms of Reiter's syndrome, but they are not causes of

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synonymous with reactive arthritis or a subset of reactive arthritis, this brief will continue to use the term Reiter's syndrome with respect to the testimony by Dr. Mohai and Dr. Ayars.

[4] It may be an open question as to whether one of the Reiter's syndrome manifestations is iritis, conjunctivitis, or both. Dr. Mohai testified first that it is iritis, not conjunctivitis, which is associated with Reiter's syndrome. Mohai at 29-30. He later testified that conjunctivitis can be a part of the Reiter's triad. Mohai at 30. Dr. Ayars testified that, along with urarthritis and arthritis, the third manifestation of Reiter's syndrome is conjunctivitis. Ayars I at 13.

that condition. Ayars II at 13 (noting that the three conditions are symptoms of Reiter's syndrome), Mohai at 29 (noting that Reiter's syndrome is triggered by certain bacteria, which then manifests in the symptoms of arthritis, urarthritis, and iritis).

Where an individual does not have the complete triad of manifestations, Dr. Mohai testified that the condition is referred to as "incomplete Reiter's syndrome". Mohai at 29. Dr. Ayars testified that Reiter's syndrome consists of a triad of three conditions: arthritis, urarthritis, and conjunctivitis. Ayars I at 13-14. He did not address whether "incomplete Reiter's syndrome" is a diagnosable condition. Because Mr. Hollis did not have urarthritis, Dr. Mohai diagnosed him with incomplete Reiter's syndrome. Mohai at 33 and 69.

C. Expert Testimony On The Causes Of Reiter's Syndrome

Dr. Ayars testified that it is not generally accepted among medical experts that a needle stick can cause Reiter's syndrome. Ayars I at 18; Ayars II at 42. Dr. Ayars testified that the medical community's lack of acceptance of this form of transmission holds true even assuming for argument's sake that the needle contained one of the Reiter's-triggering bacteria. Ayars I at 19-20. Dr. Ayars acknowledged that there had been isolated reports associating certain vaccinations with reactive arthritis, *id.* at 23-24, but he testified that it was not generally accepted within the

medical community that needle sticks can trigger Reiter's syndrome, even where the needle had once contained vaccinations. *Id.* at 19-20, 36. Dr. Ayars testified that he had never even heard of a needle stick causing Reiter's syndrome. Ayars II at 42.

Dr. Mohai was asked on multiple occasions whether his theory that a needle stick can cause Reiter's syndrome was generally accepted in the medical community. The following exchange is representative of his responses:

> Q: Would you agree that the theory that a person can develop Reiter's syndrome based on having genetic factor for HLA-B27 and getting a needle stick would be controversial among experts in the field?
>
> A: I'm not sure what you mean by controversial.
>
> Q: Would there be experts in the field who would disagree that that is a – the theory that Reiter's syndrome could be caused by those factors?
>
> A: I would say, again – based on a reasonable clinical conclusion, it's based on the scientific information that's known and, as I said, my own experience."

Mohai at 49.[5]

Dr. Ayars testified that the medical literature does not support the theory that a needle stick can cause Reiter's syndrome. Ayars I at 18; Ayars II at 42. In response to the suggestion that Mr. Hollis contracted

[5] Appendix A to this brief contains an index to Dr. Mohai's testimony addressing the questions of (1) whether Dr. Mohai's needle stick causation theory is controversial or accepted, and (2) whether there is anything in the medical literature that supports Dr. Mohai's theory that a needle stick can cause Reiter's syndrome. Appendix A also includes a copy of the portions of the original deposition transcript in which these questions and answers appeared.

Reiter's syndrome via the needle stick, Dr. Ayars testified that "it was alleged by some observers that maybe he got an infection from the needle stick and that would lead to the [Reiter's] syndrome. And actually, if you go over the world's literature you can't find anything to support that. Plus, as a matter of fact, infectious diseases of the skin, cutaneous infections of the fingers, have never been proven to be associated with Reiter's syndrome." Ayars II at 33-34. Dr. Ayars testified there is not one documented case of a needle stick causing Reiter's syndrome. Ayars I at 30. Because there are millions of needle sticks and Reiter's syndrome is a distinctive condition, Dr. Ayars testified that a correlation between the two would be obvious if it existed in the literature. *Id.*

Dr. Mohai was provided multiple opportunities to establish that the medical literature supports his theory that a needle stick can cause Reiter's syndrome. Although he mentioned that he had heard of case reports linking Reiter's syndrome with a hepatitis B vaccination, Mohai at 52, and a vaccination for Measles, Mumps, and Rubella, *id.*, the exchange below is representative of the circularity and speculation in his responses:

> Q: My question was, were there any medical studies in your search of the medical research that supported the conclusion?
>
> A: Well, again, the supporting medical literature that would support it is that he's HLA-B-27 positive and that he was exposed to a pathogen.

Mohai at 45.

D. The Medical Literature Regarding Reiter's Syndrome[6]

Although there is a general consensus regarding the causes and manifestations of Reiter's syndrome, there is no single set of criteria for diagnosing reactive arthritis. John M. Townes, M.D., *Reactive Arthritis after Enteric Infections in the United States: The Problem of Definition*, 50 CLIN. INFECT. DIS. 247 (2010). Instead, reactive arthritis is a general term used since 1969 to describe arthritis that follows a bacterial infection at another body site, but where no micro-organisms from the infecting agent can be recovered from the arthritic joint. Mohammad-Bagher Owlia, et al., *Is the role of Chlamydia trachomatis underestimated in patients with suspected reactive arthritis?* 13 INT'L J. RHEUM. DIS. 27, 28 (2010).

The development of reactive arthritis involves both genetic factors and infectious factors. After an initial infection by one of the bacteria capable of triggering Reiter's syndrome, the body will produce a body-wide immune response to the bacteria and this immune response will then cause an acute peripheral aseptic synovitis. Danielle Lauren Petersell, M.D., et al., *Reactive Arthritis*, 19 INFECT. DIS. CLIN. N. AM. 863, 869-70

[6] In considering the admissibility of evidence under the *Frye* standard, the appellate court "may consider other evidence not in the record, including scientific and law review articles . . . ." to determine whether the scientific theory is generally accepted by the scientific community and supported by reliable data. *Ruff v. Dep't of Labor & Indus.*, 107 Wn. App. 289, 300, 28 P.3d 1 (2001).

(2005). This immune response is strongly associated with the presence of the Human Leukocyte Antigen - B27 gene. *Id.* at 874. It is generally believed that reactive arthritis is not caused by an actual infection at the arthritic site – rather, an infection in the genitourinary or gastrointestinal tract triggers an immune system response that manifests itself in certain joints. *Id.* at 873.

One study conducted a Medline search for all studies from 1966 to 2006 that investigated the epidemiology of bacteria-associated reactive arthritis. Janet E. Pope, M.D., et al., Campylobacter *Reactive Arthritis: A Systematic Overview*, 37 SEMIN. ARTH. RHEUM. 48, 51 (2007) ("Pope study"). The Pope study reported three types of infectious agents. The first two categories of agents were the bacteria that live in the gastrointestinal tract and the bacteria that live in the genitourinary tract. These included five principal bacteria: *Yersinia*, *Salmonella*, *Shigella*, and *Campylobacter*, which all live in the gastrointestinal tract, Pope study at 48, and *Chlamydia*, which lives in the genitourinary tract. Pope study at 51. Also included in these two categories were a handful of other bacteria such as *Giardia* and, possibly, *E. coli*. Pope study at 49. The correlation between reactive arthritis and these two categories of infections is sufficiently established that the American College of Rheumatology diagnostic criteria for reactive arthritis requires a documented

gastrointestinal or genitourinary infection. Hervé C. Gérard, Ph.D, et al., *Molecular Biology of Infectious Agents in Chronic Arthritis*, 35 RHEUM. DIS. CLIN. N. AM. 1, 2 (2009).

The Pope study indicated a third category of bacteria that travel through the respiratory system. This category included two bacteria: *Campylobacter pneumoniae* and, on an unconfirmed, but hypothesized basis, hemolytic *Streptococcus*. Pope study at 49. The report, which drew on 40 years of studies in the medical field to review the literature on the epidemiology of *Campylobacter* and other bacteria-associated reactive arthritis, did not report any bacteria or types of bacteria that travel via needle sticks or the bloodstream.

In his article on the causes and treatment of reactive arthritis, John D. Carter, M.D., divided cases of reactive arthritis into two categories: those arising from infections of the gastrointestinal tract and those arising from infections of the genitourinary tract. John D. Carter, M.D., *Reactive Arthritis: Defined Etiologies, Emerging Pathophysiology, and Unresolved Treatment*, 20 INFECT. DIS. CLIN. N. AM. 827, 828 (2006). Dr. Carter noted the distinction between reactive arthritis – also known as Reiter's syndrome – and certain diseases that are caused by bacterial infections and whose symptoms include some form of inflammatory arthritis, such as Lyme disease. Carter at 834. Because of the difference

in features between these diseases and reactive arthritis, Dr. Carter cautioned that they should be considered separate conditions. *Id.*

Dr. Carter's article included a list of the bacteria and microbes capable of triggering reactive arthritis, grouped into definite causes, probable causes, possible causes, and other types of inflammatory arthritis in which bacteria may play a causative role. *Id.* The list of definite causes includes only bacteria that cause infections in either the gastrointestinal tract or the genitourinary tract. *Id.* Of the three probable causes, one – *Chlamydophila pneumoniae* – is associated with an infection of the lungs and the other two are associated with infections of the genitourinary tract. *Id.* Although some of the possible causes are associated with pathways other than the gastrointestinal tract or genitourinary tract, *id.*, Dr. Carter noted that most of these cases exist only in the form of case reports. *Id.* at 834.

Several of the studies refer to the case reports referenced by Dr. Mohai in his testimony. Dr. Townes described the report referred to by Dr. Mohai involving the outbreak of reactive arthritis aboard a United States Navy ship. Townes at 248. Dr. Townes confirmed that the outbreak occurred after the sailors had contracted dysentery caused by the bacteria *Shigella*. *Id.*

Another article documented incidents of rheumatic complaints following a hepatitis B vaccination, but the study was unable to conclude that there was any causal connection between the hepatitis B vaccinations and the subsequent rheumatic conditions. J.F. Maillefert, et al., *Rheumatic Disorders Developed after Hepatitis B Vaccination*, 38 RHEUMATOLOGY 978 (1999). Furthermore, the study did not limit its scope to reactive arthritis, but rather looked at all rheumatic complaints following a Hepatitis B vaccination. *Id.* at 979.

Another case report described an individual who had developed reactive arthritis after a tetanus vaccination. Nilay Sahin, et al., *Reactive Arthritis Following Tetanus Vaccination: A Case Report*, 19 MOD. RHEUMATOLOGY 209 (2008). Although the authors acknowledged that the subject experienced symptoms of reactive arthritis after a tetanus vaccination, they concluded that no causal relationship between vaccination and the establishment of arthritis has yet been established. *Id.* at 211.

E. The Needle

For unknown reasons, the needle that pricked Mr. Hollis was never tested, so no direct evidence as to what was actually in or on the needle was ever presented. Mohai at 48. Mr. Hollis testified that he believed it had been used to vaccinate cattle. Hollis at 9. Dr. Mohai testified that

Mr. Hollis had also told him that the needle had been used to vaccinate cattle. Mohai at 9. Emergency room records reviewed by Dr. Mohai suggested, without stating the source of the information, that the needle had been used for vaccinations. Mohai at 15. A chart note, again without stating the source of the information, reviewed by Dr. Mohai indicated that the needle had been used to vaccinate cattle against pinkeye. Mohai at 18. Dr. Mohai did not testify that bacteria capable of triggering Reiter's syndrome would be expected to be in any such vaccination. Dr. Ayars testified that the medical records he reviewed indicated, again without stating the source of the information, that the vaccine appeared to be for cow-related conjunctivitis, along with some steroids, vitamins, and hormones. Ayars I at 9. No evidence was presented that the needle contained any of the bacteria capable of causing Reiter's syndrome.

IV. STANDARD OF REVIEW

Review of superior court decisions in the appellate courts in workers' compensation cases is controlled by RCW 51.52.140, which provides for review "as in other civil cases." The appellate court reviews the trial court's decision to admit or exclude evidence subject to the *Frye* standard on a de novo basis. *State v. Cauthron*, 120 Wn.2d 879, 887, 846 P.2d 502 (1993), *overruled on other grounds by State v. Buckner*, 133 Wn.2d 63, 66, 941 P.2d 667 (1997). In such a review, the appellate court

"may consider other evidence not in the record, including scientific and law review articles . . ." to determine whether the scientific theory is generally accepted by the scientific community and supported by reliable data. *Ruff v. Dep't of Labor & Indus.*, 107 Wn. App. 289, 300, 28 P.3d 1 (2001).

The appellate court reviews the trial court's other rulings on the admissibility of evidence – here, the rulings under ER 702 and ER 703 – for an abuse of discretion. *State v. Powell*, 126 Wn.2d 244, 258, 893 P.2d 615 (1995).

The appellate court reviews a superior court's legal conclusions de novo. *Adams v. Great Am. Ins. Co.*, 87 Wn. App. 883, 887, 942 P.2d 1087 (1997). Sufficiency of the evidence to support a jury verdict is a question of law for the appellate court to decide. *See, e.g., State v. J-R Distributors, Inc.*, 82 Wn.2d 584, 590, 512 P.2d 1049 (1973). But when an administrative agency is charged with application of a statute, the agency's interpretation of an ambiguous statute is accorded great weight. *City of Pasco v. Public Employment Relations Com'n*, 119 Wn.2d 504, 507-08, 833 P.2d 381 (1992). Interpretations of the Industrial Insurance Act by both the Department and Board are entitled to such deference. *Ackley-Bell v. Seattle School Dist.*, 87 Wn. App. 158, 165, 940 P.2d 685 (1997).

A jury's verdict in a workers' compensation case must be set aside if a probable causal connection between an industrial injury and a medical condition is not supported by admissible medical testimony. *Stampas v. Dep't of Labor & Indus.*, 38 Wn.2d 48, 50, 227 P.2d 739 (1951). Medical testimony grounded in speculation will not support a finding of causation. *Chalmers v. Dep't of Labor & Indus.*, 72 Wn.2d 595, 601, 434 P.2d 720 (1967).

V. SUMMARY OF ARGUMENT

The Department challenges the superior court judgment on jury verdict on the grounds that the only causation evidence supporting Mr. Hollis's case was inadmissible on three independent bases. First, Dr. Mohai's causation testimony should have been excluded under *Frye* because his theory that a needle stick can, under some circumstances, cause Reiter's syndrome is not generally accepted in the relevant medical community. Second, Dr. Mohai's theory that a needle stick can, under some circumstances, cause Reiter's syndrome was also inadmissible under both ER 702 and ER 703 because the theory is grounded in speculation. Third, even assuming without conceding the validity under *Frye*, ER 702 and ER 703 of Dr. Mohai's theory that a needle stick can, under some circumstances, cause Reiter's syndrome, his assumption that the needle contained a substance that can cause Reiter's syndrome is not supported in

the record, is based upon speculation, and is therefore inadmissible under ER 702 and ER 703.

Thus, Mr. Hollis failed to present any competent medical evidence establishing that his Reiter's syndrome was proximately caused by his industrial injury. Because of Mr. Hollis's failure to establish the critical causation element of his case, there is no support for the jury verdict allowing Mr. Hollis's workers' compensation claim.

Finally, the Department challenges the jury verdict on grounds that, even assuming Dr. Mohai's testimony is admissible, his testimony is grounded in speculation and therefore not sufficient to support the jury's finding of causation. *See Chalmers*, 72 Wn.2d at 601.

VI. ARGUMENT

A. Because Dr. Mohai's Opinion That Mr. Hollis Developed Reiter's Syndrome As A Proximate Result Of The Needle Stick Should Have Been Excluded, And Because Dr. Mohai's Opinion Is Fundamentally Grounded In Speculation, There Is No Support For The Jury Verdict

The Industrial Insurance Act requires claimants to establish via medical opinion that the claimant's condition was proximately caused by the industrial injury on a more probable than not basis. *See generally Stampas*, 38 Wn.2d at 50. In *Dennis v. Dep't of Labor and Indus.*, 109 Wn.2d 467, 477, 745 P.2d 1295 (1987), the Supreme Court stated: "The causal connection between a claimant's physical condition and his or her

employment must be established by competent medical testimony which shows that the disease is probably, as opposed to possibly, caused by the employment."

Here, Mr. Hollis presented only one medical witness – Dr. Peter Mohai – to attempt to establish that he developed Reiter's syndrome as a proximate result of his industrial injury. As noted below in Parts VI.B and VI.C, Dr. Mohai's testimony should have been stricken because it was inadmissible under *Frye,* ER 702, and ER 703. In the absence of Dr. Mohai's testimony, Mr. Hollis presented no competent evidence establishing that he developed Reiter's syndrome as a proximate result of his industrial injury. The Department is entitled to judgment as a matter of law.

Furthermore, as explained in Part VI.D below, Dr. Mohai's causation theory is grounded in speculation and does not support the jury's verdict. Because Dr. Mohai failed to identify any Reiter's-triggering pathogen to which Mr. Hollis was exposed, the Department is entitled to judgment as a matter of law even if Dr. Mohai's causation testimony is admissible.

B. Dr. Mohai's Causation Testimony Is Inadmissible Because It Violated The Standard For The Admissibility Of Expert Testimony As Established In *Frye v. United States*; Therefore, There Is No Admissible Evidence To Support The Jury's Verdict

Washington law requires that when an expert's opinion invokes a novel scientific theory or method, the court must consider whether an opinion based on the novel theory is admissible under *Frye v. United States*. *See, e.g.*, *Ruff*, 107 Wn. App. at 301. Under *Frye*, expert testimony as to causation based on a novel scientific theory is admissible only where the theory's proponent establishes that the theory is generally accepted in the relevant scientific community and that it is supported by reliable and reproducible data. *See Ruff*, 107 Wn. App. at 299-300.

In *State v. Copeland,* 130 Wn.2d 244, 255, 922 P.2d 1304 (1996), the Washington State Supreme Court explained that Washington courts follow the *Frye* rule because it allows them to perform their traditional function as gatekeepers, in keeping with the rationale that "expert testimony should be presented to the trier of fact *only* when the scientific community has accepted the reliability of the underlying principles." (emphasis added). By applying the *Frye* inquiry to disputed scientific evidence, the court "shield[s] juries from any tendency to treat novel scientific evidence as infallible." *Id.* at 256. The *Frye* inquiry "recognizes both the need for admissibility of novel scientific evidence where it is

sufficiently accepted, and the need to protect against novel scientific evidence which has not even gained general acceptance in the relevant field." *Id.* at 259. Because Dr. Mohai's causation theory is neither generally accepted in the medical community nor supported by reliable data, it should be excluded under *Frye*.

1. Dr. Mohai's Scientific Theory Is Novel

The Department anticipates that Mr. Hollis will argue, as he did to the superior court, that Dr. Mohai's testimony is not subject to the *Frye* inquiry. CP at 23 (Plaintiff's response to Department's motion for summary judgment). There, Mr. Hollis argued that this case does not involve any novel theory, and hence there is no need for him to satisfy the elements of the *Frye* standard.

When an objection is made to expert testimony on the grounds that the expert is expressing an opinion that is based on a novel theory that is not generally accepted within the medical community, the *Frye* rule has been implicated. *Ruff*, 107 Wn. App. at 301. The court must then determine 1) whether the novel theory has been generally accepted by the medical community, and 2) whether the novel theory is supported by any technique, experiment, or study that is capable of producing verifiable results. *State v. Riker,* 123 Wn.2d 351, 359, 869 P.2d 43 (1994). If the court concludes that the testimony is based on a novel theory, then the

evidence may not be admitted unless it is both generally accepted by the scientific community and it is supported by verifiable data in the form of a scientifically reliable technique, experiment or study.

Mr. Hollis's argument fails because Dr. Mohai's opinion in this matter *is* based on a novel theory. Although *Frye* does not require that an expert's *conclusion* in a given case be generally accepted by the relevant scientific community (*see Ruff,* 107 Wn. App. at 300), *Frye* does require that any novel theory underlying an expert's conclusion be both generally accepted by the medical community and supported by reliable and reproducible tests, experiments, or studies. *Id.; see also Grant v. Boccia,* 133 Wn. App. 176, 179, 137 P.3d 20 (2006) and *Eakins v. Huber*, 154 Wn. App. 592, 599-600, 225 P.3d 1041 (2010).

In *Grant*, the Court of Appeals held that an expert's *opinion* that a plaintiff developed fibromyalgia as a result of a traumatic accident was inadmissible because the *theory* that traumatic accidents can be a proximate cause of fibromyalgia was a novel one that was not generally accepted by the medical community. *Grant*, 133 Wn. App. at 183. Similarly, in *Ruff*, the Court of Appeals held that an expert's opinion that the claimant developed porphyria as a result of exposure to low levels of volatile organic compounds was properly excluded under *Frye* because that opinion was based on the novel – and not generally accepted –

scientific theory that exposure to such compounds can cause porphyria. *Ruff*, 107 Wn. App. at 305.

Likewise, in *Eakins*, the Court of Appeals rejected the argument that a scientific opinion on causation was not based on a novel theory. *Eakins*, 154 Wn. App. at 600-01. The challenged expert in *Eakins* opined that hardware installed in surgery caused an allergic reaction. *Id.* at 596. The proponent of the evidence asserted that the causation theory was not novel because the theory (1) was supported by principles that supported FDA and manufacturer's warnings and scientific studies, and (2) was based on the doctor's own extensive professional experience. *Id.* at 600.

The *Eakins* Court rejected the argument that the opinion did not involve a novel theory. *Id.* at 601. First, the causation theory was not based solely on experience, but was instead ultimately based on the drawing of a "hypothetical link" between the hardware and the medical condition. *Id.* Second, the causation theory called upon the expert's "specialized background knowledge" in a particular area of medicine. *Id.* Third, other expert testimony in the case attacked the causation theory as being speculative and not supported by studies. *Id.* Fourth, the causation theory posed an admissibility question that was one of first impression in Washington and elsewhere. *Id.*

All of the *Eakins* novelty indicators apply equally here. Dr. Mohai went beyond his own experience to hypothesize a causal link. His opinion calls upon his specialized background knowledge in a particular area of medicine. Conflicting expert opinion attacks his theory as being both speculative and not supported by a consensus in the relevant medical field. And Dr. Mohai's particular causation theory poses an admissibility question of first impression in Washington and elsewhere.

The Department objected to Dr. Mohai's testimony because that testimony was based on the novel *theory* that Reiter's syndrome can be triggered via a needle stick. The testimony of Dr. Ayars supports the Department's argument that Dr. Mohai's theory is a novel one, and Dr. Mohai's testimony does not squarely address whether his theory is novel or not. This Court should hold that Dr. Mohai's causation theory is subject to *Frye*.

2. Under *Frye*, Evidence Based On A Novel Theory Is Inadmissible Unless The Theory Is Both Generally Accepted And Scientifically Reliable

Under *Frye*, scientific evidence based on a novel theory is admissible only if the party offering it demonstrates both that the underlying theory is generally accepted and that there are techniques, experiments, or studies that are capable of producing reliable results and that support the novel theory. *Riker,* 123 Wn.2d at 359. It is not enough

that an expert's theory satisfy one of the two tests but not the other. *Id.* at 360. For example, a theory popular within the relevant scientific community that had not been verified with generally accepted techniques, experiments, or studies would be inadmissible under *Frye* despite its popularity. *Id.* On the other hand, where the plaintiff contends that her medical expert's theory is supported by studies but the theory is not generally accepted by the relevant medical community, the theory would remain inadmissible under *Frye*. *Eakins*, 154 Wn. App. at 602.

a. Dr. Mohai's Theory That A Needle Stick Can Trigger Reiter's Syndrome Is Not Admissible Under *Frye* Because The Theory Is Not Generally Accepted

When deciding whether evidence is generally accepted within the relevant scientific community, the court's inquiry seeks to determine "whether a consensus of scientific opinion has been achieved." *Eakins*, 154 Wn. App. at 599. Where there is no consensus of opinion as to a particular theory, the *Frye* standard precludes the admission of the disputed theory. *Grant*, 133 Wn. App. at 183 (noting that the existence of a consensus in the medical community as to the cause of a condition is necessary for admission of a novel theory of causation). Therefore, even if many experts within a given field subscribe to a novel theory, evidence regarding that theory is inadmissible if the evidence shows that there is "a

significant dispute between qualified experts as to the validity of scientific evidence." *Copeland*, 130 Wn.2d at 255 (emphasis added); *accord Grant* at 179.

Dr. Ayars testified that it is not generally accepted among medical experts that a needle stick can cause Reiter's syndrome. Ayars I at 18; Ayars II at 42. Dr. Ayars further testified that the medical community's lack of acceptance of this form of transmission would hold true even assuming (despite the lack of supporting evidence – *see* Part VI.C *infra*) that the needle contained one of the Reiter's-triggering bacteria or a vaccination. Ayars I at 19-20.

Despite multiple invitations to address whether the needle stick causation theory is generally accepted or controversial in the medical field, Dr. Mohai consistently deflected the question toward his general medical experience and the self-characterized reasonableness of his conclusion. *See* discussion *supra* Part III.C and *see* Appendix A to this brief. But Dr. Mohai's personal experience and personal reasoning does not assist the court in determining the central *Frye* issue of whether the theory that Reiter's syndrome can be triggered by a needle stick is generally accepted by the medical community. Nor does Dr. Mohai's characterization of his own conclusion as reasonable satisfy, or even address, the *Frye* inquiry. *See Grant*, 133 Wn. App. at 180 (the simple

assertion that a methodology or principle is well-accepted does not take the expert's opinion outside the ambit of *Frye*). Because courts are often ill-equipped to gauge the validity of scientific theories, *Frye* requires that those theories have gained a general acceptance within the relevant scientific community before they may be presented to a jury by an expert. Where, as here, the expert will not discuss the degree to which his theory has been accepted by the relevant scientific community, he frustrates the court's ability to engage in the *Frye* inquiry, and the theory must be rejected.

b. Dr. Mohai's Theory That A Needle Stick Can Trigger Reiter's Syndrome Is Not Admissible Under *Frye* Because Medical Studies Do Not Show That The Theory Is Reliable

Even assuming that Dr. Mohai's needle stick causation theory is generally accepted (a conclusion not supported by any of the evidence in this case), his opinion would still be inadmissible because he has not shown that there are studies that can produce reliable results when applied to his theory. As *Riker* explains, "the gatekeeping function of *Frye* requires both an accepted theory and a reliable method of applying that theory to the facts of the case." *Riker*, 123 Wn.2d at 363. Whether such a method exists can be established by the expert's reference to experiments, techniques, or studies in the relevant literature.

This is not to suggest that an expert's conclusions in a particular case must always be supported by studies – as the Court of Appeals observed in *Bruns v. PACCAR*, 77 Wn. App. 201, 215, 890 P.2d 469 (1995), the *Frye* inquiry addresses only novel scientific theories and methodology, not medical conclusions based on established scientific techniques. But there must be studies or other reliable data that support an expert's novel theory. Without studies documenting the reliability of the expert's *theory*, "the expert's opinion amounts to no more than an unsupported guess." *Riker* at 364.

In this case, the evidence shows without any reasonable basis for dispute that there are no studies, experiments, or other verifiable data that support Dr. Mohai's novel theory that Reiter's syndrome can be triggered via a needle stick. Dr. Ayars testified that the medical literature does not support the theory that a needle stick can cause Reiter's syndrome. Ayars I at 18; Ayars II at 42. Dr. Mohai never testified that the medical literature supports his theory that a needle stick can trigger Reiter's syndrome. On the few occasions when Dr. Mohai referred to the literature, he made only generalized references to unidentified articles. *See, e.g.*, Mohai at 52 ("there's a suspicion that the MMR vaccine" can trigger Reiter's syndrome). The Department has found nothing in the medical literature to

support Dr. Mohai's needle stick causation theory, nor has Mr. Hollis yet identified any such support.

Contrary to *Frye's* mandate, Dr. Mohai did not testify to what the articles said, where or when they appeared, whether the articles were peer-reviewed, or whether they were studies or simply anecdotal case reports. *See Eakins*, 154 Wn. App. at 608 (mere anecdotal reports are insufficient to substantiate a disputed medical causation theory). Such vagueness does not permit the court to engage in the inquiry necessary to determine whether the offered theory finds any support in the relevant scientific literature. *See Eakins* at 602 (where the plaintiff cited and discussed five different articles and studies to support her position, the Court held that they were insufficient to establish that a consensus existed regarding plaintiff's medical expert's theory).

The *Frye* standard requires Dr. Mohai to have established that the theory on which he based his causation conclusion is generally accepted within the medical community and that there are techniques, experiments or studies using that theory that are capable of producing reliable results. *See, e.g.*, *Grant*, 133 Wn. App. at 179 (the *Frye* analysis requires both an accepted theory and a valid technique to implement that theory). Dr. Mohai failed to establish either element. Dr. Mohai did not testify that it is generally accepted within the medical community that a needle stick

can trigger Reiter's syndrome, and he did not testify that there are studies in the medical literature that support his theory that a needle stick can trigger Reiter's syndrome.

Even assuming that it can be inferred from Dr. Mohai's testimony that Dr. Mohai believes his theory is supported in the medical literature or generally accepted by the medical community – although he never so stated – this would show at most that it is *disputed* as to whether or not this theory is valid. Under *Frye*, when there is a significant dispute between qualified experts as to the validity of a scientific theory, evidence based on that theory must be rejected. *State v. Greene*, 139 Wn.2d 64, 70, 984 P.2d 1024 (1999); *accord Grant*, 133 Wn. App. at 183 (holding that the existence of a consensus is necessary for the admissibility of expert opinion testimony).

C. Dr. Mohai's Causation Testimony Is Also Inadmissible Under Evidence Rule 702 And Evidence Rule 703 Because It Is Based On Speculation; Therefore, There Is No Admissible Evidence To Support The Jury's Verdict

Evidence Rule 702 permits an expert witness to provide opinion testimony if such testimony will "assist the trier of fact to understand the evidence or to determine a fact in issue." ER 702.[7] Under ER 703, an

[7] ER 702 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."

expert may testify based on facts or data perceived by or made known to the expert at or before the hearing. ER 703.[8] But both rules exclude expert testimony where the testimony is based on speculation. Because Dr. Mohai's testimony is based solely on the double speculation that a needle stick is capable of triggering Reiter's syndrome and that Mr. Hollis was actually exposed to a Reiter's-triggering pathogen by way of the needle stick, it should be excluded under both ER 702 and ER 703.

a. Speculative Expert Testimony Is Not Helpful To The Trier Of Fact And Must Be Excluded Under Evidence Rule 702

As discussed above, Dr. Mohai's causation theory is inadmissible because it is not based upon a generally accepted scientific theory. But even assuming that *Frye* does not apply, Dr. Mohai's opinion that Mr. Hollis developed Reiter's syndrome as a result of a needle stick still must be excluded under ER 702 because it was speculation based on speculation – that is, the speculative theory that a needle stick is capable of triggering Reiter's syndrome based on the speculative assumption that a bacteria capable of triggering Reiter's syndrome was on the needle.

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[8] ER 703 provides: "The facts or data in the particular case upon which an expert bases an opinion or inference may be those perceived by or made known to the expert at or before the hearing. If of a type reasonably relied upon by experts in the particular field in forming opinions or inferences upon the subject, the facts or data need not be admissible in evidence."

It is well settled that expert testimony is inadmissible under ER 702 if it is speculative. *See State v. Lewis*, 141 Wn. App. 367, 389, 166 P.3d 786 (2007). In *Lewis*, the Court of Appeals held that the trial court properly excluded expert testimony where it found that the testimony was speculative and therefore not helpful to the jury. *Id.* There, the defense's medical expert would have testified about the effects that methamphetamine could have on various individuals, including the victim. *Id.* But because the medical expert had never actually observed the victim, with or without methamphetamines in his system, the Court held that such testimony was speculative and therefore properly excluded. *Id.* In excluding the expert's testimony, the Court noted that "speculative testimony is not rendered less speculative or of more consequence to the jury's determination simply because it comes from an expert." *Id.*

(1) Dr. Mohai's Speculative Theory That A Needle Stick Can Trigger Reiter's Syndrome Is Not Helpful To The Trier Of Fact And Must Be Excluded Under Evidence Rule 702

Even where a theory has satisfied *Frye*, the proponent's theory must still establish, under the two-part test of ER 702, that the witness qualifies as an expert and that the testimony would be helpful to the trier of fact. *Copeland*, 130 Wn.2d at 256. The Department does not dispute

Dr. Mohai's expert qualifications, but Dr. Mohai's theory must be excluded because it is not helpful to the trier of fact.

The Supreme Court has said that under the second part of the ER 702 test, the trial court must determine whether the theory is sufficiently reliable to be helpful to the trier of fact. *Cauthron*, 120 Wn.2d at 890. In *State v. Swan*, 114 Wn.2d 613, 656, 790 P.2d 610 (1990) the Supreme Court held that where a proposed expert's testimony regarding the memory capacity of children was not reliable, the testimony was properly excluded under ER 702.

Here, the testimony from Dr. Mohai and Dr. Ayars indicates that the medical literature does not establish the reliability of Dr. Mohai's needle stick causation theory. The few references Dr. Mohai made to the medical literature were to case reports that indicated a possible association between Reiter's syndrome and certain vaccinations. *See, e.g.*, Mohai at 42. But Dr. Ayars testified that such anecdotal reports are insufficient to establish a causal relationship. Ayars I at 21. Perhaps more importantly, Dr. Ayars testified that the medical literature does not support the reliability of Dr. Mohai's theory. Ayars I at 18. Where the medical literature does not support the reliability of Dr. Mohai's theory, it is unhelpful to offer such a theory to the trier of fact and it must be excluded under ER 702.

(2) Dr. Mohai's Speculative Assumption That The Needle Contained A Bacteria Capable Of Triggering Reiter's Syndrome Is Not Helpful To The Trier Of Fact And Must Be Excluded Under Evidence Rule 702

Dr. Mohai's testimony was based on the speculation that the needle that stuck Mr. Hollis contained a pathogen that can trigger Reiter's syndrome. But there is no evidence that the needle that pricked Mr. Hollis contained a pathogen that could trigger Reiter's syndrome. In fact, Dr. Mohai admitted on multiple occasions and without exception that he had no idea what was on the needle. At one point, Dr. Mohai testified that Mr. Hollis had a "finger stick with who knows what was on it . . . ." Mohai at 45. Later, Dr. Mohai testified that "no one probably really knows what was on [the needle]." Mohai at 76.

The closest Dr. Mohai came to actually testifying that Mr. Hollis was exposed to a pathogen came when he was justifying his conclusion that Mr. Hollis had developed Reiter's syndrome from the needle stick. Dr. Mohai's rationale was that "he's HLA-B27 positive and that he was exposed to a pathogen." Mohai at 45.

But this is quintessentially circular reasoning: Dr. Mohai concluded that Mr. Hollis developed Reiter's syndrome from the needle stick because Mr. Hollis had the HLA-B27 gene and was exposed to a

pathogen, but the sole basis of the conclusion that Mr. Hollis was exposed to a pathogen is that Mr. Hollis had the HLA-B27 gene and developed Reiter's syndrome. Because Dr. Mohai's causation testimony was based on speculation and circular logic, Dr. Mohai's causation conclusion is inadmissible under ER 702. *Lewis*, 141 Wn. App. at 389; *see also Chalmers*, 72 Wn.2d at 601 (pre-ER 702 case holding that doctor's opinion assuming facts not proven may not be considered).

b. It Is Not Reasonable For Experts To Rely On Speculation And Any Testimony Based On Such Speculation Must Be Excluded Under Evidence Rule 703

The fact that Dr. Mohai's causation conclusion is based on speculation also renders his opinion inadmissible under ER 703. Expert testimony is inadmissible under ER 703 if it is based on speculation rather than actual facts or data perceived by or made known to the expert. *See Miller v. Likins*, 109 Wn. App. 140, 148-50, 34 P.3d 835 (2001) (holding that the trial court properly excluded as speculative an expert's testimony regarding the location of an accident when the expert admitted he had no way of actually determining where the point of impact in the accident occurred); *accord Holmes v. Wallace*, 84 Wn. App. 156, 165, 926 P.2d 339 (1996) (holding that experts' opinions were properly excluded as speculative when they were based only on the experts' casual

observations, not specific data). The material underlying the expert's testimony must be of the type reasonably relied upon by experts in the field. *State v. Nation*, 110 Wn. App. 651, 662-63, 41 P. 3d 1204 (2002) (citing *State v. Ecklund*, 30 Wn. App. 313, 317-18, 633 P. 2d 933 (1981)). Put another way, the expert must show not only that he relies upon such material in forming his conclusions, but that others in his field rely on such material, as well. *Id.* at 663. Where the expert can do no more than show that he relies upon such material, the testimony should be excluded under ER 703. *Id.*

(1) Dr. Mohai's Speculative Theory That A Needle Stick Is Capable Of Triggering Reiter's Syndrome Is Not The Type Of Material That Experts Reasonably Rely Upon And So Must Be Excluded Under ER 703

Here, Dr. Mohai based his conclusion on the theory that a needle stick is capable of triggering Reiter's syndrome. But through his failure to testify that such a theory is generally accepted in the medical field or that such a theory is supported in the medical literature, Dr. Mohai did no more than establish that his is a theory that *he* relied upon in forming his conclusion in this case. And the testimony of Dr. Ayars that Dr. Mohai's theory is neither generally accepted in the medical field nor supported in the medical literature further erodes any assertion that Dr. Mohai's theory

is reasonably relied upon by medical experts. Because Dr. Mohai's needle stick causation theory is not reasonably relied upon by medical experts, it should be excluded under ER 703.

(2) Dr. Mohai's Speculative Assumption That The Needle Contained Bacteria Capable Of Triggering Reiter's Syndrome Is Not The Type Of Material That Experts Reasonably Rely Upon And So Must Be Excluded Under ER 703

In this case, for the reasons noted above, Dr. Mohai's testimony was based on the speculative assumption – unsupported by evidence of any kind – that the needle contained a bacteria of a kind that can trigger Reiter's syndrome. Dr. Mohai provided no testimony that others in the medical field reasonably rely upon such speculation in forming their opinions. Because his opinion is based on speculation, his reliance is not reasonable, and his opinion is inadmissible under ER 703.

D. Even Assuming That Dr. Mohai's Testimony Is Admissible, Mr. Hollis Did Not Adequately Support Dr. Mohai's Causation Theory Because He Presented Only Speculative Medical Evidence That He Was Exposed To Any Agent That Could Have Caused Him To Develop Reiter's Syndrome; Therefore, The Evidence Was Insufficient To Support The Jury's Verdict

Even if this Court determines that the superior court did not err when it admitted Dr. Mohai's causation testimony, this Court should still rule that the Department is entitled to judgment as a matter of law, because

the evidence is inadequate as a matter of law to establish that Mr. Hollis's Reiter's syndrome was proximately caused by his needle stick injury. Mr. Hollis failed to carry his burden of proof because he did not present any evidence other than speculation that he was exposed to any bacteria in the course of that injury that could have caused him to develop Reiter's syndrome.

Intalco Aluminum v. Department of Labor & Industries, 66 Wn. App. 644, 658, 833 P.2d 390 (1992), discussed the evidentiary standard a worker must meet when he alleges that he has been injured by a toxin or group of toxins, but is unable to identify the precise toxin that injured him. *Intalco* held that a group of injured workers did not need to identify the *precise* chemical they were exposed to in order to establish that their condition was proximately caused by the exposure. *Id.* It was sufficient that the workers proved they were exposed to a group of chemicals that were all known to be associated with and capable of causing their conditions. *Id.* Implicit in the Court's ruling was a recognition that while the worker need not identify the particular chemical that caused the condition, the worker must prove that he or she was exposed to *at least one chemical* that is known to produce the condition complained of.

In *Intalco*, three workers filed claims for occupational diseases that they alleged they contracted in the course of their employment at Intalco's

Ferndale aluminum plant. *Intalco* at 647. Expert testimony indicated that a number of known toxins would be present in the pot room where the workers worked. *Id.* at 649. Medical testimony concluded that the workers' illnesses were more probably than not caused by the workers' workplace exposure to toxins. *Id.* at 652-53. The workers' medical witnesses could not identify the precise toxin that had caused the workers' illnesses, nor could they identify the precise mechanism by which the toxins had caused the illnesses. *Id.* at 655.

After the Board and superior court found that the claims should be allowed, Intalco appealed to the Court of Appeals. Intalco argued, among other things, that the workers' medical experts had failed to identify the precise toxin that caused the workers' illnesses. *Id.* at 655. The Court of Appeals affirmed the jury's verdict, reasoning that, where experts had specifically identified several of the neurotoxins in the room and it was undisputed that some of the known neurotoxins were associated with neurologic disease, "the workers' compensation statute does not require the claimant to identify the precise chemical in the work place that caused his or her disease." *Id.* at 658. But implicit in this holding, as the opinion demonstrates and subsequent Washington cases have confirmed, is the requirement that the claimant identify at least *a* chemical in the workplace that caused his condition.

The *Intalco* Court indicated that the ruling was dependent on factors particular to the case, and not a general statement that claimants need not identify *any* chemical that caused their condition. First, the Court noted that the claimants had established they were exposed to multiple causal agents while working at Intalco, including fluoride, aluminum, and coal tar pitch. *Id.* at 653. Second, the Court noted that the causal mechanism had been established where one of the neurotoxins – aluminum – could cause symptoms similar to those exhibited by the claimants. *Id.* at 656. Although the claimants had not identified the *precise* toxin that caused their disease, the Court reasoned that the chain of proximate causation had been established by way of testimony as to the causal agent.

The *Intalco* Court relied on two cases outside Washington to support its conclusion that a claimant need not identify the precise toxin that caused his condition. A review of both cases reveals that they are factually similar to *Intalco* – and factually dissimilar from the present case – in that the plaintiffs had identified a suite of toxins to which the plaintiffs had been exposed but the plaintiffs' medical witnesses were unable to identify precisely which toxin had caused the plaintiff's conditions.

In *Earl v. Cryovac*, 115 Idaho 1087, 772 P.2d 725 (1989), the plaintiff sued the manufacturer of a plastic meat-wrap for damages the plaintiff suffered while working as a meat-cutter. The *Intalco* Court explained, "the Court of Appeals of Idaho reversed a summary judgment in favor of the manufacturer, holding that the plaintiff presented sufficient evidence to allow a jury to conclude that his lungs were injured as a result of exposure to vapors emitted from a plastic film used in the meat-packing room where he worked." *Intalco* at 657.

But the *Earl* Court so held only because the plaintiff had established that he was exposed to specific chemicals emanating from the meat-wrap, including polyvinyls, plasticizers, and stabilizers. *Earl*, 772 P.2d at 730. Against this factual background, the *Earl* Court held that "the question of legal liability does not turn upon the isolation of the offending substance(s) *where each suspected substance emanates from the defendant's product*." *Id.* at 733 (emphasis added).

In *Robinson v. SAIF Corporation*, 78 Or. App. 581, 717 P.2d 1202 (1986), the plaintiff sought workers' compensation benefits for damages she sustained after inhaling toxic chemicals in a furniture store. The worker established that she had been exposed to formaldehyde, phenols, and hydrocarbons at work, *Robinson* at 1203, and medical testimony

established that the major contributing cause of her condition was her workplace exposure to chemicals. *Robinson* at 1206.

On those facts, the Oregon Court of Appeals found in favor of Robinson. *Id.* The Court reasoned that "[t]o recover, a claimant must prove that the conditions at work were the major contributing cause of the disability. Although the specific chemical cause of claimant's sensitivity is not conclusively established, she has shown by a preponderance of the evidence that the major contributing cause was her work environment at Struthers, *which exposed her to concentrations of chemicals much greater than she was ordinarily exposed to outside the course of employment.*" *Id.* (emphasis added).

The medical condition at issue in this case is triggered by exposure to certain bacteria rather than by exposure to toxic chemicals. But *Intalco's* reasoning is nonetheless squarely on point. Like the workers in *Intalco*, *Robinson*, and *Earl*, Mr. Hollis alleges that his workplace exposure to an unknown agent caused him to develop his condition. But unlike the workers in those cases, he failed not only to identify the *specific* bacteria that triggered his condition, he also failed to prove that he was exposed to *any* bacteria that is known to be capable of triggering Reiter's syndrome. Because he failed to present any evidence that he was exposed to any bacteria capable of causing Reiter's syndrome, he failed, as a matter

of law, to present evidence that could persuade a reasonable person that his Reiter's syndrome was proximately caused by his industrial injury.

The cases decided after *Intalco* bolster the conclusion that although a worker alleging that he or she developed a disease as a result of exposure to a harmful agent need not identify the precise agent that caused the disease, the worker must prove there was exposure to at least one agent known to be capable of causing that disease. In *Bruns v. PACCAR*, 77 Wn. App. at 204, a number of PACCAR drivers sued PACCAR under a products liability theory, alleging that they had been injured by toxic fumes emanating from the cabs of PACCAR's Kenworth trucks. Like *Intalco*, the *Bruns* plaintiffs established that they were exposed to a suite of airborne chemicals in the workplace, several of which could have caused the injuries that the plaintiffs suffered, but their medical witnesses were unable to identify the precise toxin that caused the plaintiffs' conditions. *Id.* at 205-06.

The *Bruns* Court, like the *Intalco* Court, ruled in favor of the plaintiffs. *Id.* at 213. But the *Bruns* Court specifically noted its conclusion was based on the fact that the plaintiffs had established that they were exposed to a suite of chemicals capable of causing their conditions: "Here, the Drivers point to a 'chemical soup' as the defect. They provide a list of chemicals found in the truck cabs and the

concentrations at which they were found. Therefore, we find that the Drivers offered sufficient evidence to allow a reasonable person to find the trucks not reasonably safe." *Id.*

It is apparent from *Bruns* that the Court's holding turned on the fact that the plaintiffs proved they were exposed to at least one chemical in the course of their use of the defective product that could have caused the conditions that they developed. Conversely, in the present case, Mr. Hollis failed to produce this critical evidence.

The next Washington case to apply the *Intalco* rule was *Ruff*. The injured worker, Ruff, claimed that she had acquired porphyria by virtue of her workplace exposure to chemicals during the course of a building remodel. *Ruff*, 107 Wn. App. at 294. Ruff and her medical experts failed to identify any chemicals to which she was exposed during the remodel. *Ruff* at 306. When her case was before the Court of Appeals, *Ruff* apparently attempted to rely on *Intalco* on the basis that she, like the *Intalco* plaintiffs, was unable to identify the precise chemical that caused her condition. *Ruff* at 306.

The Court of Appeals distinguished *Intalco* from Ruff's appeal, reasoning that "[the *Intalco*] court declined to require proof of the precise chemical that caused the claimants' disease *because several known neurotoxins were identified in the pot room*, it was undisputed that the

neurotoxins cause symptoms similar to that exhibited by the claimants, and their symptoms did not fit any diagnostic criteria of any known disease." *Id.* (emphasis added). In contrast to the established suite of toxins in *Intalco*, the *Ruff* Court noted that "no one knows what chemicals Ruff was exposed to during the week-long building remodel." *Ruff* at 306. The Court's rejection of Ruff's argument demonstrates that just as *Intalco* stands for the proposition that a claimant need not establish the *precise* chemical to which he was exposed, it stands just as surely for the proposition that a claimant must establish at least *a* chemical to which he was exposed.

This Court most recently considered the *Intalco* rule in *Lewis v. Simpson Timber Company*, 145 Wn. App. 302, 189 P.3d 178 (2008). This Court noted that although a worker need not identify the precise toxin that caused her injury, she must establish the presence of at least *a* toxin that more probably than not caused her condition. *Lewis* at 323.

In the *Lewis* case, the claimant established that she had been exposed at work to a fungicide known as Mycostat-P20. *Lewis* at 308. Expert testimony established that Mycostat-P20 contained the chemical propiconazole and several unidentified solvents. *Lewis* at 323. Expert testimony further established that these solvents likely – although not certainly – included "a mixture of mineral oil, petroleum (Stoddard)

solvents, toluene, xylene, glycol ethers, and alcohols . . . ." *Lewis* at 324. Medical testimony established that Lewis's workplace exposure to toxins more probably than not caused her symptoms. *Lewis* at 326. The *Lewis* Court cited to *Intalco* for the proposition that "although the precise chemical need not be identified, *testimony must establish that the presence of a toxin or combination of toxins in [the] work environment more probably than not caused [the worker's] medical condition.*" *Lewis* at 323 (emphasis added).

Put another way, a worker may proceed to make his case on causation only after he has established the existence of *some* causal agent to which he was exposed. Once the worker has established that he was exposed to at least *a* causal agent capable of causing his condition, the role of the trier of fact is to determine whether the causal agent to which the worker was exposed proximately caused the condition complained of. Where the claimant has established at least one causal agent to which he was exposed, the worker cannot be faulted for failing to identify the precise agent that caused the condition.

But *Lewis* does not stand for the proposition that the worker may ask the trier of fact to simply assume that the existence of the causal agent has been established before proceeding to consider whether the putative causal agent proximately caused the worker's condition. If there is no

evidence of at least *a* causal agent, as here, it is incorrect as a matter of law to infer a causal connection, regardless of whether a doctor is willing to testify on a more probable than not basis that the work somehow caused the condition.

The jury's verdict here thus cannot stand because there is insufficient evidence to support a finding of causal connection.

VII. CONCLUSION

For the reasons discussed above, the Department respectfully requests that this Court reverse the superior court's decision and rule that the Department is entitled to judgment as a matter of law.

RESPECTFULLY SUBMITTED this 27th day of October, 2010.

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APPENDIX A

A. Dr. Mohai's Testimony Regarding Whether It Is Generally Accepted In The Medical Community That A Needle Stick Can Trigger Reiter's Syndrome

1. Page 47, Line 23 - Page 48, Line 8: question and response regarding acceptance of theory

2. Page 48, Line 12 – Page 48, Line 19: question and response regarding acceptance of theory

3. Page 48, Line 20 – Page 49, Line 2: question and response regarding acceptance of theory

4. Page 49, Line 5 – Page 49, Line 21: question and response regarding whether theory is controversial

5. Page 50, Line 9 – Page 51, Line 16: question and response regarding acceptance of theory

B. Dr. Mohai's Testimony Regarding Whether There Is Any Support In The Medical Literature For The Theory That A Needle Stick Can Trigger Reiter's Syndrome

1. Page 41, Line 25 – Page 42, Line 8: response noting references in medical literature to association between certain vaccines and arthritic conditions

2. Page 44, Line 12 – Page 44, Line 18: question and response regarding support in the medical literature for theory

3. Page 44, Line 24 – Page 45, Line 15: question and response regarding support in the medical literature for theory

4. Page 45, Line 18 – Page 45, Line 24: question and response regarding support in the medical literature for theory

5. Page 46, Line 3 – Page 47, Line 7: question and response regarding support in the medical literature for theory

6. Page 47, Line 8 – Page 47, Line 21: questions and responses regarding citation for article linking Reiter's syndrome and dysentery

7. Page 51, Line 22 – Page 52, Line 1: question and response regarding support in the medical literature for theory

8. Page 52, Line 2 – Page 52, Line 7: question and response regarding support in the medical literature for theory

9. Page 52, Line 8 – Page 52, Line 21: question and response regarding citation for article linking Reiter's syndrome with certain vaccinations

10. Page 52, Line 22 – Page 53, Line 5: question and response regarding citation for article linking Reiter's syndrome with certain vaccinations

11. Page 53, Line 6 – Page 53, Line 13: question and response regarding support in the medical literature for theory

12. Page 53, Line 14 – Page 54, Line 7: question and response regarding support in the medical literature for theory

13. Page 54, Line 18 – Page 55, Line 1: question and response regarding support in the medical literature for theory

14. Page 69, Line 16 – Page 70, Line 8: questions and responses regarding whether vaccination articles were peer-reviewed

factors to look at for whether or not a person has Reiter's syndrome?

A. Yes.

Q. I mean, there are many people who have that same genetic factor who do not have Reiter's syndrome; is that correct?

A. Well, like I say, if you tested the general population, there are 15 -- about, maybe, 15 percent who'd have it. But if you take people who have Reiter's or things of that nature, it's about 95 percent plus.

Q. But most people who have that factor do not develop Reiter's; is that correct?

A. So -- yeah, if the question is how many people don't have Reiter's out of that group, I actually don't know.

Q. Now, in diagnosing Reiter's syndrome, there's not one specific test that you can specifically say, okay, this person has Reiter's syndrome; is that correct?

A. Right. That's the reason it's called a syndrome, because there isn't any one test that says, aha, this is it. It's -- you have to have various components. And when you have a sufficient number of components, that's usually the basis of the diagnosis.

Q. Now, is the condition of Reiter's syndrome caused by bacterial infection?

A. The classic descriptions were of urinary-tract

infections from bacteria and also from infections in the GI tract. But there's -- those were the classic initial ones. But there's been syndrome -- there've been people who've gotten arthritis conditions from other things, such as vaccines; hepatitis B vaccine, for example. There's specific literature of people who get an -- who get arthritis conditions after a vaccine. There's also high suspicion of the MMR.

Q. Now, you testified regarding there are certain situations where there's a known association with development of Reiter's syndrome; is that correct?

A. Correct.

Q. And you mentioned that one of them relates to the chlamydia; is that correct?

A. Correct.

Q. And that bacteria is known to pass from one person to another through sexual contact.

A. Correct.

Q. And is that referred to as urogenital --

A. Correct.

Q. And you also mentioned the bacteria associated with salmonella and Shigella and Yersinia; is that correct?

A. Correct.

Q. And those are known to be associated -- or related to a person's gastrointestinal system; is that right?

A. Correct.
Q. And that is because as a diagnostician, a doctor wants to make sure that there's medical evidence supporting a medical opinion; isn't that right?
A. Correct.
Q. Now, have you done a medical-literature search regarding the causes of Reiter's syndrome?
A. In the past, yeah.
Q. So you have not done one -- well, strike that.
When is the last time you did one?
A. Oh, maybe a few weeks ago.
Q. Now, again, without waiving any prior objections, would it be correct that in your search of the medical literature, you have not found medical literature supporting the theory that the circumstances in -- that you testified present in this case caused Reiter's syndrome?
A. Let me have you repeat the question.
Q. Sure. I'll slightly adjust the question.
In your search of medical literature, have you found any medical literature that supports the theory or your opinion -- strike that. That's -- let me start it again.
In your search of the medical literature, did you find any medical literature that supports the theory

that the kind of -- that the circumstances that you testified here concerning Mr. Hollis has resulted in a person developing Reiter's syndrome?

A. I would say on the basis of what events and facts are known, the answer is yes. And again, it's -- and it is a, you know, more-probable-than-not conclusion since, again, he is HLA-B27 positive, he did have this finger stick with who knows what was in it on it, and then you had the temporal relationship to that with the onset of this conjunctivitis and then the arthritis, and then also in a male --

Q. And what -- I'm sorry; go ahead. Were you finished?

A. And I would say those components in my mind make it a more-probable-than-not conclusion that there is a relationship.

MR. BECKER: Okay, I'm going to ask the answer be stricken as nonresponsive.

Q. (by Mr. Becker) My question is -- was, were there any medical studies in your search of the medical research that supported that conclusion?

MR. COSTELLO: Object as asked and answered.

A. Well, again, the supporting medical literature that would support it is that he's HLA-B27 positive and that he was exposed to a pathogen.

MR. BECKER: I'm going to object to the last part

as lack of foundation and hearsay, and I'm also going to object as, again, it's nonresponsive.

Q. (by Mr. Becker) What studies specifically can you cite to that support the opinion that those circumstances --

A. I can give you a very -- actually, it's a very interesting one, because many years ago, it was recognized that young men would get this syndrome with certain infections. And that knowledge came, really, before the HLA-B27 connection.

And there was actually a very famous one that was written up, I think, around -- I believe either World War II or maybe even the Korean War, where a Navy ship was going to come in to dock and the men were all going to get leave and they were going to have a party and so forth. And the cook -- one of the cooks had dysentery, and he failed to report this because his leave was in jeopardy.

And as a consequence, a significant number of the men -- actually, I think all of the men got dysentery. And about 10, 15 percent of those men came down with Reiter's, which mean iritis, arthritis, and urarthritis. And that was the -- that was actually the first literature that I'm aware of that made the link between GI pathogens.

And then what was interesting was that years

later, when the HLA-B27 connection was made, somebody actually tracked down a whole bunch of these sailors from that report and tested them HLA-B27. The interesting result was that the men who didn't get the Reiter's were all negative and the ones that had the Reiter's were positive. So that's one of the compelling literature.

Q. And where is that -- what is the citation for that literature?

A. I'll have to get it for you. This is something I read years ago.

Q. So you don't know what journal it was in?

A. I can look it up.

Q. But as of now, you don't know what --

A. No.

Q. -- journal it was in?

A. No.

Q. And you don't know what year it was?

A. No.

Q. And do you know who conducted the study?

A. No.

Q. Now, is the theory that -- well, strike that.

Would you agree that a theory that, because a person has HLA-B27 and is then stuck -- gets a needle stick, that that would, therefore, be a cause for

developing Reiter's syndrome, would you agree that that theory is not generally accepted among experts in the field?

MR. COSTELLO: Object; it assumes facts not in evidence, it's argumentative, it's hearsay.

A. Again, it's on the basis of a more-probable-than-not conclusion. And so it's -- to my knowledge, I don't think anything was cultured from the alleged needle, so --

Q. (by Mr. Becker) But my question -- and let me repeat the question -- or maybe ask it a little differently.

The theory that a person can get Reiter's syndrome because they are HLA-B25 (sic) -- because they have that genetic factor and because they get a needle stick, is that theory generally accepted among experts in the field?

MR. COSTELLO: Same objection.

A. It's a reasonable clinical conclusion based on what is known in the literature.

Q. (by Mr. Becker) Would you agree that the theory that a person could get -- develop Reiter's syndrome from the circumstances you described would be controversial among experts in the field?

MR. COSTELLO: Object; asked and answered.

Q. (by Mr. Becker) You can answer.

A. It's my conclusion from my knowledge of the literature and my own clinical experience.
Q. But my question is, if you listen to the -- let me strike that. Let me just repeat the question.
Would you agree that the theory that a person can develop Reiter's syndrome based on having genetic factor for HLA-B27 and getting a needle stick would be controversial among experts in the field?
MR. COSTELLO: Same objection. He's asked it four times now. Asked and answered.
MR. BECKER: And I have not got an answer to the question.
A. I'm not sure what you mean by controversial.
Q. (by Mr. Becker) Would there be experts in the field who would disagree that that is a -- the theory that Reiter's syndrome could be caused by those factors?
A. I would say, again --
MR. COSTELLO: Object; it's irrelevant.
A. -- based on a reasonable clinical conclusion, it's based on the scientific information that's known and, as I said, my own experience.
Q. (by Mr. Becker) You testified that medical literature supports the Reiter's syndrome developing through sexual contact; is that correct?
MR. COSTELLO: Asked and answered.

MR. BECKER: It's a foundational question for a further, later question.

Q. (by Mr. Becker) Is that correct?

A. That is one of the --

MR. COSTELLO: Asked and answered.

Q. (by Mr. Becker) That understanding is widely accepted in the field; is that correct?

A. Correct.

Q. Is it widely accepted in the field that a person can develop Reiter's syndrome through a needle stick if the person has HLA -- has a genetic factor for HLA-B27?

MR. COSTELLO: And I object. By my count, this is the fifth time the question's been asked. The doctor's answered it. This would be much more appropriately answered by the allergist that the Department's calling. Department's not paying attention to their own IME physician that they set up this appointment with. The doctor's clearly testified that this is a condition that's caused by an effect -- an infection together with the HLA-B27 -- antigen?

THE WITNESS: Correct.

MR. COSTELLO: And whether the infection's caused by a needle stick or some other contact -- I don't know why he keeps bringing up sexual contact, but -- I think the doctor's answered as best he could. We don't need

to spend the next half an hour repeating the question. It's been asked five times now.

Q. (by Mr. Becker) You can still answer.

A. Okay. Well, same answer.

Q. And what is that answer? So you -- strike that.

Okay, so you're not -- I'm going to say you are not able to testify -- I'm not asking for what your opinion was under these circumstances. But you are not able to testify, is my understanding, whether or not it's widely accepted in the community that a person can develop Reiter's syndrome under these circumstances.

MR. COSTELLO: Asked and answered sixth time now.

Q. (by Mr. Becker) You can answer.

A. It is widely accepted that people, males in particular, that are HLA-B27 positive, when they're exposed to a pathogen, they can get Reiter's syndrome.

Q. It requires them being exposed to a pathogen; is that correct?

A. (Witness nodded head.)

Q. Is that yes?

A. Correct.

Q. Now, you mentioned a study earlier that you testified to. Any other specific studies that you can reference that would support that opinion -- your opinions?

A. Well, I can give you a bibliography, but I don't have

one now.
Q. So at this moment, you don't have any other specific studies that you would testify that you would rely on in providing this testimony; is that correct?
A. Well, it's over 30, 40 years of reading and -- but after a while, I can't quote you an article I read 15 years ago or 20 years ago.
Q. Now, you -- okay, now, you testified specifically as to needle sticks that you're aware of a study or you're aware of a case where someone developed Reiter's syndrome or -- based on receiving hepatitis B vaccine; is that correct?
A. Correct.
Q. And do you know the name of that study or what journal it was published in?
A. I don't remember.
Q. And that study or -- that you're referring to is related -- was limited to hepatitis B vaccine; is that correct?
A. Correct. But I think I mentioned too that there's a suspicion that the MMR vaccine can do a similar thing.
Q. I was going to get to that in a moment.

So regarding the MMR vaccine, your testimony was that there's a high suspicion that it may be related to developing Reiter's syndrome?

A. Well, I've seen a number of cases. And when I've checked the literature early on, I really couldn't find reports, and now more recently I am finding reports.
Q. And do you know any specific studies regarding that?
A. My memory's not that good.
Q. Aside from what you've testified to regarding hepatitis B vaccine and MMRI (sic) vaccine, are you aware of any other studies that show that a needle stick can cause Reiter's syndrome?
MR. COSTELLO: Object; asked and answered.
A. Well, as I said, if a person is HLA-B27 positive and they're a male and they're exposed to a pathogen, they can get Reiter's.
Q. (by Mr. Becker) I'm just going to try a very specific question: Are you aware of any other studies in the medical literature that a needle stick has caused Reiter's syndrome other than the ones you've mentioned already regarding hepatitis B vaccine and MMRI (sic) vaccine?
MR. COSTELLO: Objection; asked and answered. I think this is the seventh time or eighth time.
Q. (by Mr. Becker) Can you answer the question?
MR. COSTELLO: I mean, it's clear it's the pathogen that's the issue, not whether he got the pathogen from a needle stick. Why don't we just move

on?

MR. BECKER: I'm entitled to answer -- ask a question until I get a specific question and answer.

MR. COSTELLO: He's answered it for you seven times.

A. Well, same answer: He's HLA-B27 and he was exposed to a pathogen.

MR. BECKER: Can we go off the record for a minute.

[Off the record - discussion]

Q. (by Mr. Becker) I'm going to try this question one last time --

MR. COSTELLO: I'm going to object for the ninth time now.

Q. (by Mr. Becker) Are you aware --

MR. BECKER: And I'm going to say for the record this question has not been answered yet.

Q. (by Mr. Becker) Are you aware of anything in the medical literature that says that a needle stick has caused Reiter's syndrome other than the study you -- other than the medical literature you described before regarding hepatitis B vaccinations and MMRI (sic) vaccinations?

MR. COSTELLO: Objection; asked and answered.

A. And again, HLA-B27, has been exposed to a pathogen; on

a more-probable-than-not basis, he has Reiter's.

Q. (by Mr. Becker) Now, you testified that you wrote a report related to your evaluation of Mr. Hollis; is that correct?

A. Correct.

Q. And in that report, you were asked to provide your opinions on a number of medical matters related to Mr. Hollis.

A. Correct.

Q. And you were asked -- one of those was, you were asked to provide an opinion as to whether the needle stick caused Mr. Hollis's Reiter's syndrome; is that right?

A. Correct.

Q. And I'll -- I would assume that when you write these, you're careful in the language you use, because the language you use in these reports is important. Would you agree with that?

A. You know, I try. To be honest, when I do these things through a panel, they have their own kind of -- what do you call it -- quality control and formats. And I think this report kind of is an example of where it looks to me like the conclusions were kind of reformatted. Consequently, there is certain parts of it that I think is confusing.

Q. Again, without waiving prior objections, in that report

Q. (by Mr. Becker) By the way, earlier you testified that it was, in your opinion, incomplete Reiter's syndrome --
A. Yeah.
Q. -- is that correct?
A. Yes.
Q. And that's because he did not have the full triad of symptoms?
A. Correct.
Q. Which symptoms -- which aspect of the triad of symptoms did he not have?
A. Iritis and urarthritis.
Q. So actually, two out of the three he did not have; is that correct?
A. Correct.
Q. And just -- that study that you testified to regarding hepatitis B vaccine, do you recall that?
A. Yes.
Q. Was that a peer-reviewed study, do you know?
A. I believe so.
Q. I'm sorry?
A. I believe so.
Q. But you're not certain?
A. It's been a while since I've read that literature.
Q. So you're not certain?

A. No.
Q. And was -- the literature you read regarding MMR vaccination, was that peer-reviewed literature?
A. Probably.
Q. Sorry?
A. Probably.
Q. You're not certain?
A. No.

MR. BECKER: And finally, I have no further questions. I'm going to repeat for the record that I am moving to strike the opinion testimony provided today for lack of foundation pursuant to Frye, ER 702, and ER 703.

I have no further questions.

REDIRECT EXAMINATION

BY MR. COSTELLO:

Q. Doctor, if I understand it right, the mechanism of injury in Mr. Hollis's case, in your opinion, is that he got a pathogen through a needle stick, which caused an infection, developing the arthritic symptoms, which correlate with the HLA-B27 antigen, and that's how you arrive at the diagnosis --
A. Correct.
Q. -- and your --

No. 40731-1

COURT OF APPEALS FOR DIVISION II
STATE OF WASHINGTON

DEPARTMENT OF LABOR AND INDUSTRIES FOR THE STATE OF WASHINGTON, Appellant, v. GARY D. HOLLIS, SR., Respondent.	DECLARATION OF MAILING

DATED at Tumwater, Washington:

The undersigned, under penalty of perjury pursuant to the laws of the State of Washington, declares that on the below date, I mailed the Department's Brief of Appellant to counsel for all parties on the record by depositing a postage prepaid envelope in the U.S. mail addressed as follows:

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DATED this 22nd day of October, 2010.

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