**D074353**

IN THE COURT OF APPEAL *of the* STATE OF CALIFORNIA

FOURTH APPELLATE DISTRICT, DIVISION ONE

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**STEPHANIE MCCARLEY,**

*Plaintiff & Respondent*,

*v.*

**ANESTHESIA SERVICE MEDICAL GROUP, INC., ET AL.,**

*Defendants & Appellants*.

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Appeal from the Superior Court of San Diego County
No. 37-2014-0018445-CU-MM-CTL
Hon. Eddie C. Sturgeon, Judge

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# Respondent's Brief

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[ ] Continued on attachment 2.

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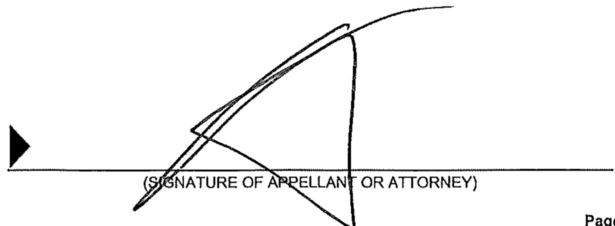

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# INTRODUCTION

This is an appeal from a jury verdict in a medical-malpractice case.

After a six-week trial, a jury found that Defendants Edgar Canada, M.D. ("Canada"), and Anesthesia Service Medical Group ("ASMG"), were negligent in allowing Stephanie McCarley's blood pressure to drop well below the safe threshold for at least 41 minutes during an otherwise routine endoscopy in March 2013. The jury further found that this negligence, by depriving her brain of oxygen, resulted in a significant brain injury to McCarley.

Indeed, witnesses would testify that McCarley was radically different the moment she awoke from the endoscopy and has not been the same since. Among other things, McCarley can no longer drive; struggles to understand oral conversation; struggles with basic tasks like dressing, reading, and talking; lost her acceptance to college; and now depends on family, a service dog, and medication and medical devices to get through the day.

In this appeal, Defendants advance four arguments in an effort to reduce, if not *reverse*, the judgment in favor of McCarley. In each instance, Defendants' argument is belied by the record.

For example, although Defendants claim that reasonable minds can differ regarding the safe threshold for blood pressure under anesthesia, the record actually shows that *everyone*—McCarley's expert anesthesiologist, Canada's expert anesthesiologist, and even Canada *himself*—agrees that Canada violated the standard of care in his handling of McCarley's blood pressure during her March 2013 endoscopy.



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Defendants next argue that the trial court committed reversable error when it precluded Defendants' retained psychiatrist from attributing McCarley's post-endoscopy symptoms to "PCOS," a hormonal disorder. But the record not only shows that the trial court properly excluded such testimony, it also shows Defendants' have in fact waived this issue when they conceded their psychiatrist is "not … eligible to say that any of [McCarley's] specific symptoms are the result of PCOS."

Defendants next argue that the jury's verdict for attendant care should be struck as "speculative," a claim premised on Defendants' assertion that attendant care was awarded solely because McCarley will not be safe alone in an emergency. But the record actually shows that McCarley struggles to perform many fundamental aspects of daily life and therefore needs attendant care simply to get through an ordinary day.

Finally, Defendants argue—for the first time on appeal—that the statutory offer to compromise McCarley sent Canada nearly three years before trial is not valid because, according to Defendants, it was ambiguous regarding whether McCarley intended to settle her entire claim with Canada or only part of it. But even from this imperfect record, it is abundantly clear that McCarley's intent was to settle her entire, "separate and distinct" claim against Canada.

For these reasons, McCarley prays this Court will affirm the judgment below in full.



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## STATEMENT OF THE CASE

### I. Pre-Trial

McCarley filed this lawsuit in June 2014, alleging Defendants failed to maintain her blood pressure at a safe level during her March 2013 endoscopy, depriving her brain of oxygen, resulting in a permanent brain injury. (1 AA 25–30.)[1]

In March 2015, McCarley sent Canada an offer to settle for $1 million under Code of Civil Procedure section 998. (1 AA 38A–D.) Canada never responded. (2 AA 469:5–8)

### II. Trial

Trial commenced in January 2018. Over six weeks, the jury was presented with the following portrait of this case:

### A. McCarley before the March 2013 endoscopy

In March 2013, Stephanie McCarley was a senior at Calvin Christian High School where she was active in several school clubs and student government. (10 RT 1660:2–6.) McCarley testified that she enjoyed school, that English was her favorite subject, and that she liked writing poetry. (10 RT 1660:23–25.) McCarley's English teacher, Emily Wilson, testified that McCarley was a "model student" and one of the highest achieving students in her class. (3 AA 769–770.) Kali Beheneman, McCarley's older sister, testified that McCarley was a good enough writer that she would

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[1] Citations to the "Reporter's Transcript" appear as "**vol. RT p.**" Citations to the "Appellant's Appendix" appear as **"vol. AA p.**"



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often proofread Kali's college papers for her. (4 RT 469:19–24.) McCarley testified that she had planned to attend nursing school at Cal State San Marcos. (10 RT 1666:2–7.)

McCarley's dad, Michael, described his daughter at the time as a "deep thinker." (10 RT 1824:19–24.) He testified that he and McCarley would have long talks about science, politics, and especially theology. (10 RT 1824:25–1825:13.) Indeed, Pastor Chico Goff of Mission Hills Church in San Marcos testified that McCarley was a frequent attendee at their youth church services (9 RT 1522:10–12), and that she would stay behind after youth services to volunteer with "Beyond Limits," a service for adults with special needs. (9 RT 1524:20–1526:3.) McCarley testified that, in March 2013, she was looking forward to upcoming missions with her church group to Guatemala and Senegal to help people with special needs. (10 RT 1667:5–1668:3.)

Kali testified that when her younger sister was not at school or church, she was outside hiking or playing varsity basketball and volleyball at Calvin Christian, where she was a starter on both teams. (4 RT 471:6–18, 472:25–473:7.) McCarley testified that, in addition to sports, she enjoyed riding horses and just generally being outdoors. (10 RT 1659:9–13.) McCarley's dad, Michael, also testified that McCarley enjoyed being outdoors and would often spend hours outside with the animals the family kept on their property. (10 RT 1824:19–21.)



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## B. The March 2013 endoscopy

On March 21, 2013, McCarley came to Rady Children's Hospital for a scheduled endoscopy to explore complaints of acid reflux. (8 RT 1263:27–1264:5.) Although it was nonsurgical, the endoscopy required McCarley to be placed under general anesthesia. (8 RT 1264:6–11.)

Dr. William Wilson—Chief Medical Officer at the University of California Irvine and board-certified in anesthesiology (8 RT 1243:17–21, 1241:28–1242:3)—testified that anesthesia causes a patient's blood pressure to drop. (8 RT 1256:5–19.) Dr. Wilson further testified that if blood pressure gets *too* low, the heart will have a difficult time pumping blood throughout the body, particularly to the small blood vessels in the brain. (8 RT 1256:20–26.) This can result in a "hypoperfusion ischemic brain injury," in which a lack of oxygenated blood causes cells in the brain to effectively suffocate and die, resulting in brain damage. (8 RT 1252:7–1253:3, 1299:12–13.)

Dr. Wilson testified that, to prevent a hypoperfusion ischemic brain injury, the standard of care among anesthesiologists was to ensure that the patient's "mean arterial pressure" or "MAP" remains at 70 mmHg. (8 RT 1259:13–1260:16, 1296:1–3.) Dr. Wilson explained that MAP is calculated using a formula that takes into account the patient's diastolic and systolic blood pressure. (8 RT 1254:20–1255:11.) Dr. Wilson explained that if MAP drops significantly below 70 mmHg, the standard of care among anesthesiologists was to either decrease the amount of inhaled anesthesia or administer a vasoconstricting agent to



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prevent brain damage. (8 RT 1290:15–1291:1; 1292:16–1293:23.) Dr. Wilson testified that, during the endoscopy, McCarley's MAP was *significantly* below 70 mmHg for at least 41 minutes. (E.g., 8 RT 1268:5–6, 1295:14–16; see also AOB, pp. 31–32.)

**C. McCarley after the March 2013 endoscopy**

**1. Witness testimony regarding changes in McCarley**

McCarley's mother, Lori, testified that she knew something was wrong with McCarley immediately after she woke from anesthesia. Lori testified that McCarley was acting "very silly" and not herself. (10 RT 1744:1–5.) McCarley's behavior was so strange that Lori began taking video of McCarley with her phone. (10 RT 1743:26–28.) McCarley would testify that she felt very strange, confused, and "disoriented" after waking up from her endoscopy. (10 RT 1669:21–1670:16.) Kali, McCarley's older sister, testified that the day after the endoscopy, McCarley would vacillate between laughing uncontrollably and crying. (4 RT 468:14–18.)

McCarley attempted to go to school the next day. (10 RT 1671:5–6.) Emily Wilson, McCarley's English teacher, testified that it was "very clear" that "something was very wrong" with McCarley. (3 AA 771.) For example, Wilson testified that McCarley had tried and failed to read aloud to her English class (3 AA 770–771), and reacted in a manner that was "somewhere between laughing and crying." (*Ibid*.)

McCarley would testify that, when she returned to school, she noticed she could no longer process information or read as fast as before. (10 RT 1695:23–25.) McCarley testified that she now



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had difficulty spending a whole day in the classroom. (10 RT 1689:8–13.)

Wilson testified that she saw clear differences in the quality of McCarley's schoolwork after March 2013. In particular, Wilson noticed changes in the coherence of McCarley's thoughts and in her ability to make logical connections. (3 AA 774.) Wilson testified that McCarley needed special accommodations to complete the semester. For example, she gave McCarley extra time for assignments and gave McCarley the benefit of generous grading (3 AA 773, 776.) Wilson testified that the change in McCarley after her March 2013 endoscopy was "the most dramatic change that I've ever seen any of my students in 11 years of teaching." (3 AA 776.) McCarley testified that she had been preliminarily accepted to Cal State San Marcos as planned, but was ultimately unable to enroll there because she could not pass a math course required for admission. (10 RT 1674:9–28.)

Kali offered the jury anecdotes about her younger sister's cognitive lapses. For example, Kali testified that when McCarley tried to help her sell oranges at a local farmer's market, McCarley was struggling to make change out of $20 bills on simple $1 and $5 transactions. (4 RT 482:9–15.)

McCarley testified that conversation is now difficult. (10 RT 1678:19–21.) She has a hard time finding the right words and is slow to process what people are saying to her. (*Ibid.*) McCarley has particular difficulty tracking a conversation with more than one other person. (10 RT 1685:27–1686:14.) McCarley also emphasized that she struggles with short-term memory. (10 RT 1678:21–24.)



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McCarley's father testified that, after March 2013, he and his daughter no longer have their long talks about science, politics, or their faith. (10 RT 1828:10–11.) Pastor Goff testified that, after March 2013, McCarley was a rare addition to church services and no longer participated in their volunteer efforts. (9 RT 1527:5–1528:21.) McCarley also missed her church's missions to Guatemala and Senegal. (10 RT 1668:4–5.)

McCarley testified that she no longer plays basketball because it is "disorienting" and "stressful." (10 RT 1683:13–23.) McCarley also cannot play volleyball because her hand-eye coordination and reaction speed are much worse after March 2013. (10 RT 1683:24–1684:3.) And McCarley testified that she can no longer safely ride horses. (10 RT 1683:8–16.)

McCarley also testified that she is often crippled by overwhelming fatigue. For example, McCarley testified that she cannot manage to take more than two classes at Palomar College, and that even that would consume all her energy. (10 RT 1694:2–11.) McCarley testified she is unable to do anything the day after classes. (10 RT 1694:16–19.) Kali, McCarley's older sister, testified that McCarley's "exhaustion is the hardest thing to watch" (4 RT 483:26), and that when her fatigue strikes, McCarley "could lay there for a day or two" and will be so exhausted she will not even bother to "eat or drink anything," which Kali has seen happen "hundreds of times." (4 RT 485:9–20.) Kali described how McCarley was so fatigued on the day of Kali's baby shower that she stayed inside a bedroom the entire time. (4 RT 483:26–484:6.)



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McCarley's dad, Michael, testified that McCarley is now extremely heat intolerant and cannot spend time outside in warm weather without overheating. (10 RT 1828:8–10.) McCarley testified that she now mostly spends most of her day inside either from fatigue or to avoid the heat. (10 RT 1695:7–22.)

McCarley's mother, Lori, testified that McCarley now relies on others to drive her to school or to see friends. (10 RT 1768:16–18, 1769:1–2.) Lori also testified that, after some initial improvement, McCarley has remained unchanged for nearly four years. (10 RT 1761:7–21.) Lori does not believe McCarley can ever live on her own. (10 RT 1772:3–13.) McCarley's dad, Michael, told the jury he doubts his daughter will ever find a husband, since anyone who marries McCarley would become a caretaker. (10 RT 1833:13–18.) McCarley herself testified that she no longer sees children in her future because she does not believe she will have the energy to raise them. (10 RT 1698:15–23.)

### 2. Expert testimony regarding the damage to McCarley

Numerous medical experts helped the jury understand what was behind the obvious changes in McCarley after her March 2013 endoscopy.

Dr. William Wilson, McCarley's retained anesthesiologist, explained that because McCarley's "mean arterial blood pressure" or "MAP" was allowed to remain significantly below 70 mmHg for over 40 minutes, she most likely suffered a "hypoperfusion ischemic brain injury" (i.e., brain damage from inadequate blood flow to the brain). (8 RT 1298–1299.)



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Dr. Daniel Silverman—Professor of Nuclear Medicine at UCLA and the inventor of the most widely used software program in the United States for interpreting brain PET scans (9 RT 1552:15–17, 1558:12–17)—was able to confirm that McCarley has brain damage. Silverman testified that McCarley's brain PET scans showed evidence of metabolic changes in the frontal and occipital lobes of her brain, which is the hallmark of brain damage. (9 RT 1564:3–23; 1580:25–1581:23.)

Dr. Michael Lobatz, McCarley's treating neurologist—contextualized this damage for the jury. Dr. Lobatz testified that he had been treating McCarley for nearly four years, which included supervising McCarley in a four-month brain-injury rehabilitation program. (5 RT 748.) Dr. Lobatz testified that, as a result of her brain injury, McCarley suffers, among other things:

- "Cognitive impairment," manifesting as a reduction in her ability to complete otherwise simple tasks independently (5 RT 733:12–740:4; 771:19–772:5; 6 RT 970:11–19);

- Impaired "executive function," which affects McCarley's ability to plan and execute complex tasks (5 RT 771:23–28; 7 RT 1074:22–26);

- "Central auditory processing disorder," a disorder in which McCarley's brain has difficulty processing what people are saying (5 RT 754:8–759:10, 777:25–778:12, 795:9–12; 6 RT 1001:12–27, 1003:2–17, 1022:2–15);

- "Dysautonomia," a disorder in which McCarley's brain struggles to perform background tasks such as maintaining a proper heart rate, blood



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pressure, and internal temperature regulation (5 RT 756:14–757:28);

- Debilitating fatigue (5 RT 717:19–720:2, 736:6–738:1, 750:5–15, 752:2–14; 6 RT 970:13–971:15); *and*

- Impaired memory (5 RT 771:23–28).

Dr. Lobatz testified that McCarley struggled with the driver-safety portion of the brain-injury rehabilitation program and is no longer safe to drive. (5 RT 751–752.) Dr. Lobatz also testified that McCarley's cognitive impairment significantly limits "her ability to do basic things like bathing, dressing, grooming" and other "activities of daily living." (5 RT 739:7–740:4.) Dr. Lobatz testified that McCarley's cognitive impairments justify assistance from a care provider on a daily basis. (*Ibid.*)

Other witnesses further contextualized McCarley's brain damage:

Dr. Calvin Colarusso, a psychiatrist, testified that McCarley now has "lapses in judgment"—such as "leav[ing] the stoves on"—"that require the presence of another adult who can see that she gets through the day without serious difficulty." (7 RT 1077:2–5.) Dr. Colarusso explained that McCarley's brain injury impacts her ability to "multitask" or perform "complex tasks," because she "has difficulty with attention" and "cannot focus on more than one thing" at a time. (7 RT 1074:17–26.) Dr. Colarusso testified that McCarley now suffers from slower "processing speed." (7 RT 1074:17–21.) He emphasized that her impaired "executive function"—which limits "planning and being able to follow through



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with daily activities"—is where she is most dependent on help from others. (7 RT 1074:26–1075:1.) For these reasons, Dr. Colarusso agreed McCarley "will never be able to function as an independent adult" and needs regular supervision. (7 RT 1076:19–24.)

Dr. Nancy Markel—a neuropsychologist who spends approximately 70% of her practice evaluating patients with brain injuries (6 RT 841, 847)—testified that, in addition to cognitive impairment, McCarley's severe fatigue and headaches contribute to a "restricted life." (6 RT 898:15–23.) Dr. Markel testified that neuropsychological testing showed that McCarley's cognitive impairments were largely unchanged in the five years since her endoscopy and will likely be permanent. (6 RT 899:6–13.) Markel also testified that McCarley will never be gainfully employed. (6 RT 899:19–900:4, 971:1–15.) Dr. Markel also opined that McCarley needs attendant care. (6 RT 901:6–14.)

McCarley testified that she now wears hearing aids to help her understand what others are saying. (10 RT 1696:14–18.) The jury heard that, as a result of her dysautonomia, McCarley must use a medical device known as a "cool vest" to keep her from overheating on hot days. (6 RT 898:21–899:1.) McCarley testified that a cardiologist prescribed medication to control her heart rate. (10 RT 1696:4–8.) McCarley also testified that she now depends on a support dog, which she described as "one of the best things in my life." (10 RT 1702:15–27.)



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### 3. Expert testimony regarding the monetary harm to McCarley

Carol Hyland, a certified life-care planner and disability-management specialist, testified that McCarley's vocational assessment showed that McCarley was now unemployable. (4 AA 1024.) Hyland also provided a life-care plan reflecting 24/7 attendant care for McCarley, in light of testimony from Drs. Lobatz, Colarusso, and Markel, as well as Hyland's own conversations with McCarley and her parents. (8 RT 1381:4–1382:12.)

Robert Johnson, a forensic economist, valued Hyland's life-care plan at between $8,810,544 and $11,305,020, depending on whether the attendant care is provided by a private hire or through an agency, respectively. (9 RT 1485:9–20.) Johnson also testified that the present cash value of McCarley's lost earnings was $4,227,840. (*Ibid.*)



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## III. Verdict & Judgment

The jury found that Defendants were negligent and that their negligence was a substantial factor in McCarley's injuries. (1 AA 282–283.) The jury awarded $83,395 for past medical care, $5,582,973 for future medical care, $2,500,000 for lost earning capacity, and $5,000,000 for noneconomic losses. (*Ibid.*)

After reducing the noneconomic damages from $5,000,000 to $250,000 under Civil Code section 3333.2, the court entered judgment for $8,416,368, plus approximately $2.5 million in prejudgment interest based on McCarley's Code of Civil Procedure section 998 offer. (1 AA 286–287; 1 AA 38A–D.) The trial court also awarded McCarley $332,675 in costs, which included approximately $249,000 in expert fees. (2 AA 302; 2 AA 551.)



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## ARGUMENT

### I. There was ample evidence—including concessions by Canada and Defendants' own expert—that Canada was negligent.

Defendants first argue the verdict must be reversed because, in their view, the evidence at trial insufficient to justify a finding that Canada was negligent in failing to maintain McCarley's blood pressure during her March 2013 endoscopy. Here, Defendants contend that the standard of care among anesthesiologists regarding safe blood pressure was subject to a robust reasonable-minds-can-differ "debate" in the profession.

But it is well settled that an appellate court's review of a jury verdict "begins and ends with the determination as to whether, on the entire record, there is substantial evidence, *contradicted or uncontradicted*, which will support the [jury's] factual determinations." (*Ermoian v. Desert Hospital* (2007) 152 Cal.App.4th 475, 501, italics added.)

Moreover, as discussed below, far from a "debate" regarding the proper standard of care for safe blood pressure during an endoscopy, the substantial evidence in this record shows that all three doctors who opined regarding the standard of care—McCarley's expert, Canada's expert, and even Canada *himself*—agree that Canada breached the standard of care in a fundamental way.



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### A. The verdict was supported by direct testimony that Canada violated the standard of care.

#### 1. Dr. Wilson's testimony was sufficient to support the jury's verdict that Canada was negligent.

Regarding the standard of care for anesthesiologists, McCarley called Dr. William Wilson—a board-certified anesthesiologist who had practiced anesthesiology for more than 25 years. (8 RT 1241:28–1242:3) Dr. Wilson is the Chief Medical Officer at UCI. (8 RT 1243:17–21.) Prior to becoming the Chief Medical Officer at UCI, Dr. Wilson was Vice-Chair of Anesthesiology at UCSD Medical Center. (8 RT 1242:15–1243:21.)

Dr. Wilson explained that anesthesia causes a patient's blood pressure to drop (8 RT 1256:5–19), and that if it gets too low, the heart will struggle to pump blood throughout the body, particularly throughout the brain. (8 RT 1256:20–26.) This can result in a "hypoperfusion ischemic brain injury," in which a lack of oxygenated blood causes cells in the brain to effectively suffocate and die, resulting in brain damage. (8 RT 1252:7–1253:3, 1299:12–13.)

Dr. Wilson explained that, to a point, the brain can compensate for a drop in blood pressure by adjusting the size of blood vessels in a process known as "autoregulation." (8 RT 1257:2–27.) But the brain's ability to maintain adequate blood pressure through autoregulation is not unlimited; if the blood pressure drops past a certain threshold—known as the "lower limit of autoregulation" or "LLA"—the brain can no longer compensate and the risk of ischemic injury skyrockets. (8 RT 1259:13–26.)



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Dr. Wilson testified that the lower limit of autoregulation is typically expressed in terms of the patient's "mean arterial pressure" or "MAP," which is calculated using a formula based on the patient's diastolic and systolic blood pressures. (8 RT 1254:20–1255:11.) Dr. Wilson testified that the lower level of autoregulation—that is, the threshold below which the risk of ischemic brain injury increases—is a MAP of 65 to 70 mmHg. (E.g., 8 RT 1259:13–1260:16, 1296:1–3.)

In citing a MAP of 65 to 70 as the lower level of autoregulation, Dr. Wilson enjoyed the support of *both* leading textbooks on anesthesiology.

For example, *Miller's Anesthesia*—which Dr. Wilson described as "the most authoritative and widely read textbook in anesthesiology" (8 RT 1261)—states: "In normal *human* subjects, the best available data ... are consistent with the limits of autoregulation occurring at MAP values of approximately 70 and 150 mmHg." (6 AA 1722, italics in original.)

Similarly, Cottrell and Patel's *Neuroanesthesia*—which Canada described as a reliable authority on the subject (13 RT 2511, 2512:16–18)—states that "most available evidence suggests that, based on MAP, the lower limit of autoregulation in humans is substantially higher on average than 50 mmHg (at least 70mmHg)." (6 AA 1727.)

Because there is no dispute that McCarley's MAP averaged just 55 mmHg for 41 minutes during the endoscopy (4 AA 1043; 13 RT 2519:10–17), Dr. Wilson's opinion that the standard of care called for him to maintain a MAP above 65 to 70 mmHg confirms



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that Canada breached the standard of care. This was itself sufficient to support the verdict. (*Chodos v. Insurance Co. of North America* (1982) 126 Cal.App.3d 86, 97 ["the testimony of a single witness … may be sufficient" to create "substantial evidence"].)

### 2. Reasonable minds do *not* disagree regarding the safe lower limit of autoregulation in 2013.

In an attempt to avoid the effect of Dr. Wilson's testimony, Canada claims that, in March 2013, the safe lower limit of autoregulation was still subject to a robust "debate" among anesthesiologists regarding whether the lower limit of autoregulation was 50 mmHg or 70 mmHg. Canada's obvious intent is to suggest that reasonable minds could differ on the subject and therefore that he was not negligent in choosing the lower limit. (AOB, p. 41.)

As a threshold matter, it is questionable whether the existence of a "debate" regarding the standard of care would, in fact, disturb a negligence verdict. Indeed, a debate regarding the standard of care will be inherent in *every* medical-malpractice case that goes to trial.

In any event, it is simply untrue that, by March 2013, the lower limit of autoregulation was still subject to a genuine debate.

In arguing otherwise, Canada selectively quotes from the textbooks at issue. For example, Canada emphasizes that *Miller's Anesthesiology* states that "[t]he lower limit of autoregulation (LLA) has been widely quoted as a MAP of 50 mmHg." (6 AA 1722.) Similarly, Canada emphasizes that Cottrell and Patel's *Neuroanesthesia* states, "Traditionally, many textbooks report



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that CBF [cerebral blood flow] is maintained relevantly constant within the range of mean arterial blood pressure (MAP), from approximately 50 to 150 mmHg." (6 AA 1727.)

But these texts make clear that the "traditional" and "widely quoted" 50 mmHg figure is for *animals*, not *humans*. Indeed, the very next sentence after the reference to 50 mmHg in *Miller's Anesthesiology* states: "Although this number [i.e., 50 mmHg] may be correct *for some animal species*, the data available argue that the LLA is considerably higher *in humans*." (*Ibid.*, emphasis added.) Similarly, after discussing the "traditional" assumptions about 50 mmHg, Cottrell and Patel's *Neuroanesthesia* states that "most available evidence suggests that, based on MAP, the lower limit of autoregulation *in humans* is substantially higher on average than 50 mmHg (at least 70 mmHg)." (6 AA 1727, italics added.)

Second, in both *Miller's Anesthesiology* and Cottrell and Patel's *Neuroanesthesia*, 50 mmHg is clearly presented as an outdated paradigm about which the texts urge caution. This is for good reason: Evidence at trial showed that the belief that a MAP of 50 was the lower level of autoregulation was rooted in "meager" data from the 1950s. (12 RT 2221:27–2222:14, 2224:14–18.)

These texts thus make abundantly clear that modern data—and, indeed, the *preponderance of the evidence*—supports a MAP of 70 mmHg as the lower limit of autoregulation. (E.g., 6 AA 1727 ["[M]ost available evidence suggests that, based on MAP, the lower



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limit of autoregulation in humans is substantially higher on average than 50 mmHg (at least 70 mmHg).”].)[2]

Nor can anything helpful to Canada be inferred from the 1997 letter by Dr. John Drummond titled, “The Lower Limit of Autoregulation: Time to Revise Our Thinking?” There, Dr. Drummond asserted that anesthesiologists to use a MAP of 70 mmHg for the lower limit of autoregulation. At most, this letter stands for the proposition that this issue was subject to debate *22 years ago*. But the mere fact that the lower level of autoregulation was subject to debate in the mid-1990s is *not* evidence that it was *still* subject to debate in 2013. If anything, it implies the opposite, particularly in light of the aforementioned textbooks.

### B. Canada conceded he violated the standard of care.

#### 1. Canada conceded he allowed McCarley’s blood pressure to drop more than 20% from baseline during the endoscopy.

During his video deposition—which was played at trial (4 RT 553:2–8)—Canada stated that he operated on the assumption that McCarley could safely tolerate a 15% to 20% reduction in her blood pressure. (3 AA 671.) When asked what the concern would be “about allowing the blood pressure to decrease more than 15 to 20 percent for a patient such as Stephanie McCarley,” Canada replied that the concern would be “about blood flow to vital organs.” (*Ibid;* 4 RT 553:2–8.)

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[2] The pertinent aspects of *Neuroanesthesia* and *Miller’s Anesthesia* were both published in 2010. (6 AA 1720; 13 RT 2510:17–19; see also 13 RT 2509–2518.)



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And yet, at trial, Canada agreed that "throughout the time that [McCarley] was in the operating room under your care that her mean arterial pressures as reported were all more than 20 percent below baseline." (4 RT 552:7–18.) In fact, Canada agreed that McCarley's blood pressure was actually *more than 30% below* her baseline on average during the endoscopy. (4 RT 552:20–553:1; 4 AA 1046 [Ex. 206].)

The juxtaposition between (1) Canada's concession that anything below a 20% drop in blood pressure exposed McCarley to the risk of inadequate "blood flow to vital organs" (3 AA 671), and (2) his concession that McCarley's blood pressure was, on average, **over 30%** below baseline for a 41-minute span, was itself sufficient evidence for the jury to conclude that Canada breached the standard of care.

**2. Canada conceded he allowed McCarley's "Cerebral Perfusion Pressure" to drop below 50 during the endoscopy.**

Canada actually *twice* conceded that he violated the standard of care: The second concession occurred at the end of trial during a discussion of "Cerebral Perfusion Pressure" or "CPP."

Whereas MAP (or "mean arterial pressure") is a general measurement of blood pressure in the body, CPP is a measurement of blood flow to the brain. As with MAP, a CPP value below the threshold for "autoregulation" exposes the brain to inadequate blood flow, and thus, the risk of brain damage from oxygen deprivation. (13 RT 2518:16–28; see also 11 RT 2007:26–2008:2.)



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Canada agreed that, for CPP, the threshold for autoregulation was 50 mmHg. Indeed, Canada was asked whether, at a CPP below 50, "there's no longer autoregulation, correct?" (13 RT 2518:27–28.) Canada replied, "Correct." (13 RT 2519:1.)

Canada also acknowledged that a patient's CPP is generally 10 to 15 mmHg less than MAP, and therefore that a MAP of 60 to 65 corresponds to a CPP of 50:

> Q: And you would agree that a lower limit of autoregulation of 50, expressed as CPP or cerebral perfusion pressure, is equivalent to a lower limit of autoregulation of 60 to 65, expressed as mean arterial pressure, correct?
>
> A: Yes.

(11 RT 2013:6–11.) Indeed, this is standard knowledge. (See 6 AA 1722 [noting that "an LLA of 70 expressed as MAP corresponds to an LLA of 55 to 60 mm Hg expressed as CPP"].)

With the relationship between MAP and CPP established, Canada was then asked: "If Stephanie McCarley's average mean arterial pressure [MAP] during the endoscopy was 55 … that would mean that her cerebral perfusion pressure [CPP] was somewhere between 40 and 45 for at least 41 minutes, correct?" (13 RT 2519:10–17.) Canada replied: "Correct." (13 RT 2519:18.) Canada was then asked, "And that's lower than the lower limit of autoregulation, correct?" (13 RT 2519:19–20.) Again, Canada replied: "Correct." (13 RT 2519:21.)

This exchange—which occurred just before the close of evidence—was nothing short of an express concession by Canada that he breached the standard of care.



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### C. Dr. Hammer's testimony does not justify reversal.

#### 1. The jury was entitled to disregard Dr. Hammer's testimony.

Canada relies on testimony by his retained anesthesiologist, Dr. Gregory Hammer, to establish a "debate" among anesthesiologists regarding the safe threshold for MAP.

But as noted above, Defendants are fundamentally misguided in their belief that the existence of a "debate" among experts is sufficient to overturn a jury's negligence verdict.

In any event, Defendants' emphasis on Dr. Hammer's testimony is wasted breath: The jury "was entitled to give [Dr. Hammer's] opinion such credit as it felt it was entitled to receive; and the jury was not bound to accept such opinion and might even totally disregard it in favor of its own opinion." (*Wells Truckways v. Cebrian* (1954) 122 Cal.App.3d 666, 678.) Here, the jury had good reason to disregard Dr. Hammer's testimony:

First, Dr. Hammer could not cite *any* modern medical textbooks that supported a MAP of 50 as the lower limit of auto-regulation.

Second, Dr. Hammer's opinion that a MAP of 50 was "reasonable" was based on a two articles Dr. Hammer himself authored, both of which are inapplicable to this case.

The first article— "Evaluation of Sodium Nitroprusside for Controlled Hypotension in Children During Surgery" (12 RT 2231:17–18)—sought to explore safe blood pressure during surgeries that entail significant blood loss. (12 RT 2209:7–18.) As Dr. Hammer conceded, in procedures where blood loss is a risk,



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very low blood pressure is actually a *virtue* since it reduces blood loss. (12 RT 2210:3–9.) As a result, anesthesiologists in so-called "controlled hypotension" surgeries will intentionally suppress blood pressure as low as possible to mitigate a risk of blood loss.

But Dr. Hammer agreed that "[t]he context of doing anesthesia for an operation where … we anticipate a lot of blood loss is *completely different* than this context." (12 RT 2248:20–24, italics added.) This is because endoscopy does *not* involve any risk of bleeding, and therefore there is no reason to push the envelope regarding the lowest blood pressure the patient can tolerate. (12 RT 2232:18–26.) Accordingly, this study was, when applied to an *endoscopy*, comparing apples to oranges.

Dr. Hammer's other study—"Hemodynamic Model to Guide Blood Pressure Control During Deliberate Hypotension with Sodium Nitroprusside in Children" (12 RT 2234:21–24)—was also distinguishable: As Dr. Hammer conceded, the absolute oldest patient in Dr. Hammer's study was 14.8 years old, almost four years younger than McCarley at the time of her endoscopy. (12 RT 2236:10–14.) This difference is significant because younger patients can tolerate lower blood pressure before losing adequate blood flow to vital tissues. (8 RT 1320:16–1321:16.)

Moreover, even though that study involved very young patients, the target MAP for the "model patient" in Dr. Hammer's study was *still* **67 to 68 mmHg** (12 RT 2236:15–17), *exactly* in line with Dr. Wilson's testimony. (8 RT 1292:16–1293:23 [describing standard of care as a MAP of 65 to 70].)



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### 2. Dr. Hammer conceded that Canada breached the standard of care.

Dr. Hammer also conceded that Canada breached the standard of care. This occurred when Dr. Hammer was asked if he agreed with the premise that "if the blood pressure got to less than 15 to 20 percent below baseline" one "would be concerned about blood flow to vital organs." (12 RT 2238:10–21.) Dr. Hammer replied, "Sure. Yes." (12 RT 2238:22.)

Of course, as discussed earlier, Canada conceded that "throughout the time that [McCarley] was in the operating room under [his] care that her mean arterial pressures as reported were all more than 20 percent below baseline." (4 RT 552:7–18.) Again, McCarley's blood pressure was actually more than **30%** below her baseline on average during the endoscopy. (4 RT 552:20–553:1.)

Accordingly, by agreeing that a drop in blood pressure more than 15% to 20% from baseline risks "blood flow to vital organs" (12 RT 2238:10–22), Dr. Hammer effectively conceded that Canada violated the standard of care and exposed her to a risk of harm as a result.



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## II. Dr. Max's "expert" opinion regarding PCOS was properly excluded and does not warrant reversal.

Defendants next argue that the trial court abused its discretion when it prevented their retained psychiatrist, Dr. Jeffrey Max, from offering certain opinions at trial. According to Defendants' brief, Dr. Max would have testified that McCarley's post-endoscopy symptoms were due to a preexisting hormonal disorder called "polycystic ovarian syndrome" or "PCOS."

What qualified Dr. Max to offer such an opinion? It was not any experience with PCOS in general; indeed, Dr. Max freely admitted he's "not the expert on PCOS." (3 AA 851:14).

Nor was it any familiarity with McCarley's medical history in particular; indeed, Dr. Max was unaware that McCarley had been living with PCOS—symptom free—for "about three years" before her fateful endoscopy. (AOB, p. 51, 5 RT 784; 6 RT 1019.)

Nor was Dr. Max's opinion fueled by an inconsistency between an anoxic brain injury and McCarley's symptoms; indeed, Dr. Max agreed that an anoxic brain injury could cause McCarley's post-endoscopy symptoms (3 AA 856:13–20), and further agreed that there's "no question" McCarley "was functioning at a much higher level before the [endoscopy] than after." (3 AA 846:17–19.)

Rather, Dr. Max's opinion that McCarley's symptoms were due to a PCOS was based solely on several articles he found on Google linking PCOS to many of McCarley's post-endoscopy symptoms. (E.g., 3 AA 834.) On that basis, Dr. Max was prepared to opine that McCarley's retained experts and treating physicians—a half-dozen highly respected physicians across



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multiple disciplines—all “became so focused on brain damage as the explanation for her condition that they failed to even consider her preexisting PCOS.” (AOB, p. 44.)

Defendants cannot show the trial court committed reversable error when it excluded that opinion.

First, Defendants will have to explain why this issue was not waived when, during trial, Defendants’ counsel conceded Dr. Max was “not … eligible to say that any of [McCarley’s] specific symptoms are the result of PCOS” (10 RT 1839:18–20), and therefore that Defendants’ counsel had no “intent to call him to offer medical causation opinion regarding PCOS.” (10 RT 1839:10–13.)

Second, even if Defendants did not waive this argument, they must show that the trial court “abused its discretion” when it excluded Dr. Max’s PCOS-related opinions. (*Shaw v. County of Santa Cruz* (2008) 170 Cal.App.4th 229, 281.) To do so, Defendants will have to establish that the trial court “exceed[ed] the bounds of reason.” (*Denham v. Superior Court* (1970) 2 Cal.3d 557, 566.)

Third, even if Defendants could show that trial court “exceeded the bound of reason” by excluding Dr. Max’s PCOS-related testimony, Defendants will have to show that it was “probable” the jury would have reached “a different result” if it heard Dr. Max’s PCOS testimony. (*Zhou v. Unisource Worldwide* (2007) 157 Cal.App.4th 1471, 1476, citing Evid. Code, § 354, Code Civ. Proc., § 475.)

As discussed below, Defendants cannot make any *one* of these showings, let alone all three.



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### A. Defendants waived the right to challenge the exclusion of Dr. Max's PCOS opinions.

On appeal, Defendants argue that the trial court erred when it precluded Dr. Max from offering "testimony that McCarley suffers from a depressive disorder *caused by* PCOS." (AOB, p. 50, italics added.) But Defendants expressly abandoned any attempt to offer Dr. Max for that purpose when their trial counsel said, in open court, that "it's not my intent to call him to offer medical causation opinion regarding PCOS." (10 RT 1839:10–13.)

This admission occurred during a hearing regarding McCarley's motion to exclude Dr. Max's PCOS-related testimony. There, Defendants' counsel stated *unequivocally* that Dr. Max would not offer *any* causation opinions regarding PCOS: "Your Honor, I don't believe it's Dr. Max's intent, or it's not my intent to call him to offer medical causation opinion regarding PCOS." (10 RT 1839:10–13.) Counsel confirmed this a moment later when he represented to the court that Dr. Max is "not going to say that he's diagnosed her or that he's eligible to say that any of her specific symptoms are the result of PCOS." (10 RT 1839:18–20.)

Those statements were admissions that bind Defendants in this appeal. (See *Fassberg Construction Co. v. Housing Authority of City of Los Angeles* (2007) 152 Cal.App.4th 720, 752.) Thus, Defendants have waived their claim that the trial court erred when it excluded Dr. Max's testimony "that McCarley suffers from a depressive disorder *caused by* PCOS." (AOB, p. 50.)



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**B. The trial court did not abuse its discretion when it excluded Dr. Max's testimony regarding PCOS.**

**1. Dr. Max conceded he is not an expert on PCOS.**

To offer an opinion that is "'beyond common experience,'" the person offering that opinion must first "qualify as an expert" on that subject. (E.g., *Jennings v. Palomar Pomerado Health Systems, Inc.* (2003) 114 Cal.App.4th 1108, 1116–1117 (quoting Evid. Code, § 801, subd. (a).)

The most obvious problem with Defendants' attempt to portray Dr. Max as an expert on PCOS is that Dr. Max conceded he is *not*. At Dr. Max's deposition—which Defendants characterize as the "offer of proof" for his testimony (AOB, p. 43, n. 12)—Dr. Max was pointedly asked, "Are you an expert in polycystic ovarian syndrome?" Dr. Max replied, "No." (3 AA 838:15–17.) Later, Dr. Max volunteered that "I'm not the expert on PCOS." (3 AA 851:14.)

The fact that Dr. Max would not hold himself out as an expert on PCOS is no surprise given that he has virtually no clinical experience with it. Indeed, Dr. Max conceded that he could not think of a single patient in his career who came to him seeking treatment because of PCOS. (3 AA 840:1–3.)

In fact, although Dr. Max believed it was "obvious" that McCarley's psychiatric symptoms were due to PCOS (3 AA 843:20), Dr. Max did not know if any of his psychiatric patients actually had PCOS. (3 AA 840:4–18.) The most could say was that some of his patients exhibited physical symptoms *consistent with* PCOS. (3 AA 840:4–18.) Even then, Dr. Max conceded that such patients—who may or may not have PCOS—are "not a major proportion of



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my practice." (3 AA 840:17–18.) Ultimately, Dr. Max's only clinical familiarity with PCOS *at all* was his awareness that two medications he uses in his psychiatry practice can increase the risk of developing PCOS. (3 AA 838:21–839:4.)

Rather than any actual experience with PCOS, the sole basis for Dr. Max's opinions were articles he found by typing "PCOS" and words like "depression" and "bipolar disorder" (i.e., McCarley's post-endoscopy symptoms) into Google. (E.g., 3 AA 834.) Of course, it perhaps suffices to say that it would turn the concept of expert medical testimony on its head if a doctor who lacks any first-hand experience with a subject could become an "expert" on that subject merely by reading articles he found online.

Of course, Defendants disagree, and offer numerous cases which they believe stand for the proposition that merely reviewing medical literature is sufficient to charge a doctor with sufficient knowledge to testify as an expert on that subject. (AOB, pp. 47–48.) But that effort fails for two reasons:

First, despite the articles, Defendants conceded Dr. Max was still "not ... eligible to say that any of [McCarley's] specific symptoms are the result of PCOS." (10 RT 1839:18–20.) Thus, whether reviewing medical literature might be a sufficient basis to offer expert opinions in another case, it was clearly insufficient here.

Second, none of Defendants' cases actually stands for the premise that medical literature itself is sufficient to render a doctor an "expert" on a particular subject. If anything, Defendants' cited cases appear to stand for the opposite proposition.



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For example, rather than permit an expert to testify solely on the basis of "the contents or statements of the medical books," *Healy v. Visalia & T.R. Co.* (1894) 101 Cal. 585, emphasized that a physician who offers expert opinions must do so based "upon empirical knowledge which he gained through his own practice." (*Id.* at p. 591.)

*Forrest v. Fink* (1925) 71 Cal.App. 34, merely established the unremarkable idea—not in dispute here—that a medical expert can testify regarding "what statistics showed concerning the result of injuries" at issue. (*Id.* at p. 39.)

In *People v. Catlin* (2001) 26 Cal.4th 81, the decision to allow a pathologist to testify about paraquat poisoning was *not* based solely on the fact that he "had studied the medical and scientific literature regarding paraquat toxicology." (*Catlin*, *supra*, 26 Cal.4th at p. 133.) Rather, it was also the fact that, as a pathologist, he had extensive "experience in interpreting both the clinical evidence of disease or tissue damage and laboratory results showing the presence of disease agents or toxic materials in human tissue." (*Id.* at pp. 132–133.) Moreover, unlike Dr. Max (who never met McCarley), the pathologist in *Catlin* had performed *the actual autopsy* on the murder victim in the case. (*Id.* at p. 133.)

In *People v. Chavez* (1985) 39 Cal.3d 823, it was not merely a pathologist's review of "medical literature on alcohol and its effects" that justified his testimony regarding the effects of alcohol. (*Id.* at p. 829.) Rather, the *Chavez* court emphasized that the pathologist had also "analyzed the results of between 500 and 600 post-mortem blood alcohol tests and related those results to the



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circumstances surrounding death." (*Id.* at p. 828.) And even then, the *Chavez* court was "not entirely free of doubt" that the pathologist's testimony should have been admitted. (*Id.* at p. 829.)

*People v. Bui* (2001) 86 Cal.App.4th 1187, also does not stand for the proposition that reviewing "scientific literature, statistical data, and epidemiological data" is sufficient to allow a doctor to render expert opinions on a topic with which he is otherwise unfamiliar. (AOB, p. 48.) In fact, in *Bui* the studies on which the doctor relied regarding the effects of methamphetamines were "epidemiological studies *he conducted*." (*Id.* at p. 1195, italics added.) Obviously, this would be a very different case if Dr. Max conducted epidemiological studies and "two published papers that were subjected to peer review" regarding PCOS and its causal role in other symptoms. (*Ibid.*) But that is not this case.

Finally, in *Miller v. Silver* (1986) 181 Cal.App.3d 652, the court permitted a psychiatrist to offer opinions regarding "the role prophylactic antibiotics play in implant patients." (*Id.* at p. 661.) But in so holding, the *Miller* court was careful to note that it viewed that particular subject as one "within the knowledge and observation of *every physician*," and *not* "'a special course of treatment to be tested by the teachings and doctrines of a particular school.'" (*Ibid.*, italics added, quoting *Mirich v. Balsinger* (1942) 53 Cal.App.2d 103, 117–118.)

Defendants have not established that the causal relationship between PCOS and a specific patient's conditions is "within the knowledge and observation of every physician." To the contrary, Defendants' recurring theme at trial was that



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*endocrinologists* are uniquely suited to assess PCOS and its effects:

For example, in his opening statement to the jury, Defendants' counsel indicated that "endocrinologists" are the "experts who deal with PCOS" and that "Dr. Sherry Franklin"—McCarley's treating endocrinologist—"will fall into that category." (3 RT 423:15–17.) Thus, Defendants' counsel told the jury "I'm confident" that "Dr. Sherry Franklin … will allow that had she thought about polycystic ovarian syndrome as a component of this young lady's medical history, she would have acknowledged that … it was associated prominently with fatigue." (3 AA 422:23–423:17.)

Later, when cross-examining Dr. Lobatz, McCarley's treating neurologist, Defendants' counsel asked whether, in determining if there is a causal connection between McCarley's symptoms and PCOS, Dr. Lobatz "would defer to someone with expertise, presumably an endocrinologist?" (6 RT 1009:24–25.)

Similarly, when cross-examining McCarley's treating cardiologist, Dr. Todd Hitchcock, regarding whether PCOS bore a causal connection to some of McCarley's post-endoscopy symptoms, Defendants' counsel asked: "And you would defer, I take it, to probably an endocrinologist in that regard?" (7 RT 1187:10–1188:4.)

In short, rather than show that a doctor can become an "expert" on an otherwise unfamiliar topic simply by reviewing literature, Defendants' cases show that a doctor must have some underlying expertise with a subject to offer expert opinions on it.



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## 2. Dr. Max's anticipated opinions were inadmissible.

As discussed above, Defendants' counsel expressly disclaimed any intent to call Dr. Max to offer causation opinions regarding PCOS. (10 RT 1839:10–13 ["Your Honor, I don't believe it's Dr. Max's intent, or it's not my intent to call him to offer medical causation opinion regarding PCOS."]; 10 RT 1839:18–20 ["[H]e's not going to say that he's diagnosed her or that he's eligible to say that any of [McCarley's] specific symptoms are the result of PCOS."].)

Rather, according to Defendants' trial counsel, Dr. Max's testimony would have consisted of the following:

> He will, I anticipate, say that he's aware that PCOS is part of her medical history and that he's aware that PCOS had been implicated with certain symptoms that are exhibited by some individuals who sufficient from PCOS, including things like fatigue, depression, and the cognitive issues.

(11 RT 1839:12–17.)

But if that was the extent of Dr. Max's anticipated testimony, it was obviously inadmissible. Indeed, such testimony would serve no purpose except to raise the *possibility* that PCOS was the cause of McCarley's symptoms.

But "[i]n a personal injury action, causation must be proven within a reasonable medical probability based on expert testimony; *a mere possibility is insufficient*." (See *Jones v. Ortho Pharmaceutical Corp.* (1985) 163 Cal.App.3d 396, 402, italics added.) Thus, a defendant cannot simply invite a jury to speculate that a plaintiff's injuries *might* be due to an alternative cause (such



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as a preexisting condition) merely by raising *possibilities*. Instead, a defendant must offer *proof* (i.e., testimony from a competent medical expert) that the alternative cause is, more likely than not, a substantial factor. (E.g., *Chakalis v. Elevator Solutions, Inc.* (2012) 205 Cal.App.4th 1557, 1573.)

Nor, as Defendants urge in their brief, would it have been admissible for Dr. Max to opine that McCarley's treating physicians and retained experts "became so focused on brain damage as the explanation for her condition that they failed to even consider her preexisting PCOS." (AOB, p. 44.) Putting aside the audacity of that effort, testimony regarding another's state of mind is inherently speculative and inadmissible. (E.g., *Gherman v. Colburn* (1977) 72 Cal.App.3d 544, 582.) Accordingly, the trial court was right to preclude Dr. Max from opining that McCarley's physicians all suffered from "tunnel vision."

### C. Dr. Max's PCOS opinions would not have changed the outcome at trial.

#### 1. The jury had ample reason to give little weight to Dr. Max's PCOS opinions.

Even if the jury had heard Dr. Max's PCOS-related opinions they would have had numerous reasons to distrust them.

Chief among the reasons to distrust Dr. Max's theory that PCOS was the cause behind McCarley's symptoms is that it is fundamentally at odds with the timeline in this case.

As summarized in McCarley's "Statement of the Case," the jury was presented with overwhelming evidence not only that the



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endoscopy exposed McCarley to an anoxic brain injury, but that McCarley changed dramatically *immediately* after the endoscopy.

Notably, Dr. Max himself conceded (1) that an anoxic brain injury could cause McCarley's post-endoscopy symptoms (3 AA 856:13–20), and (2) that there's "no question" McCarley "was functioning at a much higher level before the [endoscopy] than after." (3 AA 846:17–19.)

By contrast, McCarley was diagnosed with PCOS "about three years before" the endoscopy that gave rise to this case. (AOB, p. 51; see also 5 RT 783:19–25.) And yet, there was no evidence McCarley exhibited *any* of the symptoms Dr. Max hoped to pin on PCOS in the roughly three years before the endoscopy at issue.

For example, Dr. Lobatz, McCarley's treating neurologist, confirmed there was nothing in her medical history regarding fatigue or depression before the March 2013 endoscopy. (E.g., 5 RT 784; 6 RT 1019.) Dr. Colarusso, McCarley's retained psychiatrist, also confirmed there was no evidence of fatigue in McCarley's medical history before her endoscopy. (7 RT 1083.)

Indeed, even Dr. Max conceded that McCarley's psychiatric symptoms did not appear until *after* the March 2013 endoscopy at issue in this case. (3 AA 841:20–24.) The effect of that concession was apparently lost on Dr. Max because he did not actually know when McCarley was diagnosed with PCOS and therefore *did not know* that she had been living with it for three years without symptoms. (3 AA 840:20–841:2.)

Ultimately, to a reasonable juror, the fact that McCarley's symptoms did not appear in the three years following her PCOS



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diagnosis—and only surfaced after the endoscopy—would have obviously undercut the suggestion that PCOS was behind those symptoms.

But the jury would have had many other reasons to place little weight on Dr. Max's PCOS-related testimony apart from the overwhelming evidence pointing to the endoscopy as the cause of McCarley's post-endoscopy symptoms.

**First**, Dr. Max's conceded that he's not an expert on PCOS and has no real clinical experience with it (3 AA 851:14; 3 AA 838:15–17.)

**Second**, had Dr. Max opined that McCarley's psychiatric symptoms were "obviously" attributable to PCOS, McCarley would have countered by pointing out that Dr. Max did not know if any of his patients had actually ever been diagnosed with PCOS. (3 AA 840:4–18.) Dr. Max's apparent total apathy towards PCOS *in his psychiatry practice* is, of course, at odds with his opinion that PCOS is the "obvious" explanation behind McCarley's psychiatric symptoms here.

**Third**, the suspicion that PCOS was simply a contrived theory by Defendants' "hired-gun" expert was amplified by the fact that it appears Dr. Max apparently did not explore an association between PCOS and psychiatric symptoms until just before his deposition in this case. (3 AA 847:24—848:13 [articles regarding PCOS absent from Dr. Max's file produced prior to deposition].)

**Fourth**, had Dr. Max attempted to pin McCarley's symptoms on PCOS, the jury would have considered the fact that Dr. Max never met with McCarley. (3 AA 855:14–18.) But when



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asked if he would ever "render a psychiatric diagnosis without personally examining the patient" in his clinical practice, Dr. Max conceded "I wouldn't." (3 AA 856:8–12.) Thus, in concluding that McCarley's psychiatric symptoms are due to PCOS, Dr. Max deviated from his own custom and practice in perhaps the most fundamental way possible.

For these reasons, a reasonable jury would have put little, if any weight, on Dr. Max's attempt to pin McCarley's post-endoscopy symptoms on PCOS.

**2. The jury ruled in McCarley's favor despite testimony regarding possible associations between PCOS and McCarley's symptoms.**

Perhaps the biggest reason to doubt that the jury would have reached a different verdict if Dr. Max had been able to offer PCOS-related testimony is the fact the jury found in McCarley's favor despite testimony from multiple experts that PCOS can be associated with McCarley's symptoms.

For example, Dr. Lobatz, McCarley's treating neurologist, agreed that many of McCarley's symptoms—including "fatigue," "heat intolerance," and "insomnia"—"may be associated with PCOS." (6 RT 1009:1–12.)

Similarly, Dr. Markel, McCarley's retained neuropsychologist, agreed that PCOS can be associated with "mood disturbances." (6 RT 930:3–19)

Likewise, Dr. Colarusso, McCarley's retained psychiatrist, agreed that "[d]epression" can be a feature of PCOS. (7 RT 1109:15–25.) In fact, Dr. Colarusso actually related Dr. Max's



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opinion to the jury when, on direct exam, Dr. Colarusso noted that Dr. Max "raises a question of polycystic ovarian syndrome," and specifically noted that Dr. Max "says that this diagnosis is often accompanied by depression and other kinds of symptoms." (7 RT 1080:8–12.)

Finally, the defense actually accomplished most, if not all, of what it sought to with Dr. Max by way of Dr. Harry Chugani, Defendants' retained neurologist. On his direct exam, Dr. Chugani told the jury that PCOS "can be associated with—with neuropsychiatric syndrome." (12 RT 2119:23–26.) Dr. Chugani also told the jury that he's "seen PCOS giving [patients] mental symptoms." (12 RT 2120:5–6.) Later, Dr. Chugani was asked whether "there's a possibility that some of the complaints Stephanie McCarley is exhibiting now could be related to PCOS," to which Dr. Chugani responded, "I think I'm entertaining that possibility." (12 RT 2151:7–11.)

To be sure, each time Dr. Chugani suggested a connection between PCOS and McCarley's symptoms, he would note that he's "not an expert" on PCOS and therefore stopped short of attributing McCarley's symptoms to PCOS. (E.g., 12 RT 2119:26–2120:20; 2151:11–13.)

But again, Dr. Max's would have also admitted he's "not the expert on PCOS." (3 AA 851:14; 3 AA 838:15–17.) And Dr. Max also would have stopped short of opining that PCOS was, more likely than not, the cause of McCarley's symptoms. (10 RT 1839:10–13 ["Your Honor, I don't believe it's Dr. Max's intent, or it's not my intent to call him to offer medical causation opinion



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regarding PCOS."]; 10 RT 1839:18–20 ["[H]e's not going to say that … he's eligible to say that any of her specific symptoms are the result of PCOS."].) Thus, Dr. Chugani was, for all intents and purposes, a proxy for Dr. Max.

In short, Defendants' interest in raising PCOS—with Dr. Max or anyone else—was to make the jury aware that "these symptoms [are] known to be connected to PCOS." (6 RT 1027:16–22.) If that was their objective, Defendants accomplished it: Numerous doctors—including Drs. Lobatz, Markel, Colarusso, and Chugani—testified that PCOS is known to be associated with several of McCarley's symptoms.

And yet, despite that testimony, the jury found that McCarley's symptoms were, more likely than not, attributable to damage she sustained from the March 2013 endoscopy. Thus, this Court need not wonder whether Dr. Max's PCOS-testimony might have changed the outcome at trial; it is clear it would not have.

**3. Defendants have themselves to blame for any vacuum in the absence of Dr. Max's testimony.**

Nor is there merit to Defendants' argument that they were prejudiced by the trial court's decision to exclude Dr. Max's testimony because "the references to PCOS" Defendants' counsel made during trial were "left hanging." As Defendants put it, this damaged "[c]ounsel's, and thus defendant's, credibility." (AOB, p. 54.)

First, it is hardly true that counsel's statements regarding PCOS as a potential factor in McCarley's symptoms were "left hanging." As just discussed, even without Dr. Max, the jury in fact



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heard *a lot* of testimony from doctors regarding the association between PCOS and McCarley's symptoms.

Second, Defendants have only themselves to blame if juror expectations were dashed by Dr. Max's exclusion. Indeed, not only was Defendants' counsel the first person to bring PCOS up with the jury (1 RT 194:12–16 [voir dire questions regarding PCOS]), but he did so shortly after the trial court warned Defendants' counsel that Dr. Max's testimony was most likely not coming in.

Indeed, during the initial hearing on motions in limine, the trial court, emphasizing that Dr. Max "[s]aid he's not an expert" on PCOS, did not mince words: "I will say for the defense, that is a great concern for the Court." (1 RT 66:20–26.) Although the court was clearly leaning toward exclusion—"If I had to make a ruling now I would tell you it would be very easy to make"—as a courtesy to Defendants, the court deferred a final ruling to "see how the evidence flows in first." (1 AA 66:11–14.)

Thus, by referencing PCOS in voir dire and beyond, Defendants willingly assumed the risk that those references might be "left hanging," if, as the trial court warned, Dr. Max's PCOS-related opinions were ultimately excluded.

Nor were Defendants unduly prejudiced by references McCarley's counsel made to PCOS during trial.

In his opening statement, McCarley's counsel did nothing more than what Defendants' counsel had already done in voir dire: He provided the jury with a standard medical definition for PCOS and noted that it "may come up" during trial. (3 RT 383:21–26.)



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By contrast, in his opening statement, Defendants' counsel repeatedly referenced PCOS with pointed causation assertions. (E.g., 3 RT 430:4–6 ["[McCarley's] depression … may be attributable to the polycystic ovarian syndrome as one of the underlying components"]; see also 3 RT 408:22–409:21, 421:12–424:15, 429:20–430:11.)

At that point, it was clear to McCarley that Defendants were determined to make PCOS an issue in the case. Thus, in presenting testimony from her witnesses, McCarley had no choice but to proactively rebut the idea that PCOS was behind her symptoms.

In short, even if the many references to PCOS in the trial *were* "left hanging" when the trial court stopped Dr. Max from offering inadmissible opinions regarding PCOS, the fault for that lies squarely with Defendants themselves. Of course, parties cannot seek reversal based on "errors" they invited. (E.g., *Norgart v. Upjohn Co.* (1999) 21 Cal.4th 383, 403.)



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## III. The verdict for attendant care reflects substantial evidence McCarley's is unable to care for herself in numerous fundamental ways.

Defendants next argue that the jury's verdict for future "attendant care" should be struck.

Here, Defendants refer to money the jury awarded in response to testimony from at least three doctors—including McCarley's treating neurologist—that McCarley will need significant attendant care for the rest of her life. Ultimately, based on an 82-year life expectancy, the jury awarded $4,459,312 in future attendant care, which amounts to roughly 10-14 hours a day of attendant care, depending on the agency. (AOB, pp. 58–59.)

In their brief, Defendants disingenuously assert that the sole basis for McCarley's attentive care was the fact that she can no longer react to emergencies effectively. Because no one can predict if an emergency will occur, Defendants claim that the entire award for attentive care was inherently speculative. As discussed below, there are two problems with Defendants' argument.

### A. McCarley's brain injury has had a widespread impact on her ability to care for herself.

The biggest flaw with Defendants' argument is that the award for attentive care was *not* based solely—or even predominantly—on McCarley's inability to react to emergencies. Rather, there was substantial evidence that McCarley needs attendant care because she is unable to accomplish simple, everyday tasks.



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For example, Dr. Lobatz explained that McCarley's cognitive impairment significantly limits "her ability to do basic things like bathing, dressing, grooming" and other "activities of daily living." (5 RT 739:7–740:4.) Dr. Lobatz explained that McCarley's ability to handle those tasks independently has been reduced purely from a cognitive perspective. (*Ibid.*)

Thus, while Dr. Lobatz testified that McCarley's *neurological* impairments (i.e., dysautonomia) do not necessarily warrant 24/7 attendant care, he testified that her *cognitive* impairments—and the resulting effects on her ability to execute basic activities of daily living—justify attendant care. (6 RT 974:1–13.) Ultimately, Dr. Lobatz deferred to Dr. Calvin Colarusso and Dr. Nancy Markel on the need for attendant care. (*Ibid.*)

And, indeed, Drs. Colarusso and Markel further underscored McCarley's need for attendant care:

For example, Dr. Colarusso, a psychiatrist, not only mentioned that McCarley would struggle to deal with an emergency (7 RT 1076:26–1077:1), he also noted "other things" that limit McCarley's independence. For example, Dr. Colarusso noted that McCarley has "lapses in judgment"—such as "leav[ing] the stoves on"—"that require the presence of another adult who can see that she gets through the day without serious difficulty." (7 RT 1077:2–5.) Dr. Colarusso further explained that McCarley cannot "multitask anymore" because she "has difficulty with attention" and "cannot focus on more than one thing," which inhibits her ability to perform "complex tasks." (7 RT 1074:17–26.)



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Notably, rather than the mere threat of emergencies, Dr. Colarusso emphasized that McCarley's impaired "executive function"—which limits her "planning and being able to follow through with daily activities"—is where she is most dependent on help from others. (7 RT 1074:26–1075:1.) Dr. Colarusso agreed that McCarley "will never be able to function as an independent adult" and needs regular supervision. (7 RT 1076:19–24.)

Dr. Markel—a neuropsychologist who spends approximately 70% of her practice evaluating patients with brain injuries (6 RT 841, 847)—noted that, in addition to her cognitive impairment, McCarley's severe fatigue and headaches are factors that contribute to McCarley's "restricted life." (6 RT 898:15–23.) Dr. Markel also emphasized that McCarley's dysautonomia—by inhibiting her body's ability to sweat—impairs her ability to function on hot days. (6 RT 898:21–899:1.) As a result, Dr. Markel opined that McCarley will need 24/7 attendant care. (6 RT 901:6–14.)

McCarley's mother, Lori, testified that, in the five years between endoscopy and trial, McCarley had been left alone no more than a handful of times and for no more than four hours at a time. (10 RT 1811:11–28.) In addition to McCarley's near-total dependency on others during her bouts of fatigue, Lori also emphasized that McCarley needs constant reminders to do simple—but fundamental—things like drinking water and taking her medication. (10 RT 1765–1767.) Finally, McCarley herself testified that she simply does not feel safe alone given all her impairments. (10 RT 1700–1701.)



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Thus, contrary to Defendants' claim that the jury's award for attendant care was predicated solely on testimony that McCarley would not be safe in an emergency, the jury was, in fact, presented with substantial evidence that, among other things, McCarley (1) lacks the cognitive functioning to engage in basic activities of daily living without assistance, (2) cannot drive, (3) has difficulty processing speech, (4) has lapses in judgment, (5) is frequently debilitated by fatigue, headaches, and a nervous system disorder.

Ultimately, a jury verdict will be upheld were it is supported by substantial evidence. (*Zagami, Inc. v. James A Crone, Inc.* (2008) 160 Cal.App.4th 1083, 1096.) And in reviewing for substantial evidence, this Court must view the evidence in a light most favorable to the verdict, resolving all doubts in its favor. (*Osborn v. Irwin Memorial Blood Bank* (1992) 5 Cal.App.4th 234, 258–259.)

When viewed in light most favorable to McCarley, there is substantial evidence in this record to support the jury's finding that McCarley needs 10-14 hours of attendant care per day for the remainder of her life.

**B. Where an injury has been established, doubt regarding the extent to which consequences of that injury will manifest does not render a jury's verdict inherently speculative.**

Although the foregoing is sufficient to sustain the verdict for attendant care, Defendants are also wrong to the extent they believe that the irregularity or unpredictability of the conditions giving rise to McCarley's dependency makes the verdict for attentive care impermissibly speculative.



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Thus, while it may be true that no one can predict "when … these really fatigued times come up" (10 RT 1767:8–10), when a debilitating headache will strike, when a lapse in judgment will occur, or when an emergency might arise, this does not justify striking the award for attentive care.

First, as just discussed, McCarley's need for attentive care was based on persistent cognitive impairments in her ability to engage in fundamental daily activities such as driving, dressing, grooming, and other tasks.

Second, where a plaintiff has shown that she suffered an underlying injury, uncertainty as to the extent that "future evil consequences would result from the injury," (*Oliveria v. Warren* (1938) 24 Cal.App.2d 712, 715–716), does *not* render a resulting damages verdict impermissibly speculative. (See, e.g., *Ostertag v. Bethlehem Etc. Corp.* (1944) 65 Cal.App.2d 795, 805–806 [damages not speculative where physician believed the plaintiff "is going to have trouble with [his injuries] in the future," but could not say "how much" or "what the course of that trouble will be"]; *Oliveria, supra*, 24 Cal.App.2d at p. 715–716 [damages are not speculative where doctors expressed "the[] opinion that a brain injury sustained by the plaintiff *might* produce convulsions and paralysis, and that there was *a danger of* mental deterioration," italics added, citing *Cordiner v. Los Angeles Traction Co.* (1907) 5 Cal.App. 400]; *Riggs v. Gasser Motors* (1937) 22 Cal.App.2d 636, 640 [damages not speculative even where damages witnesses "only gave their opinions as to what might and might not occur" regarding the injury the plaintiff sustained].)



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Rather, a plaintiff need only establish proof of adequate compensation "'with as much certainty as the nature of the tort and the circumstances permit.'" (*Clemente v. State of California* (1985) 40 Cal.3d 202, 219, citing Rest.2d Torts, § 912, p. 478; see also (*Ostertag*, *supra*, 65 Cal.App.2d at p. 807 ["The rule to be drawn from the foregoing cases is that … it is for the jury to determine whether future detriment is reasonably certain to occur in the particular case."].)

## IV. McCarley's 998 offer was valid.

Defendants next argue that the trial court erred when it awarded McCarley expert costs and prejudgment interest based on her offer to compromise under Code of Civil Procedure section 998. The pertinent part of that offer reads as follows:

> Pursuant to California Code of Civil Procedure section 998 …, Plaintiff STEPHANIE McCARLEY … hereby offers to compromise the above-entitled action in the amount of One Million Dollars ($ 1,000,000) for your several liability only and not for a discharge of any other Defendant's liability.

(1 AA 38A.)

By awarding McCarley expert costs and prejudgment interest, the trial court clearly read McCarley's 998 offer as she intended: as an offer to settle her entire claim with Canada *only* and not with any of his codefendants.

Defendants now argue—for the first time—that "for your several liability only" could instead be read as an offer to settle only Canada's liability for *noneconomic damages*, thus leaving his liability for *economic* damages intact. (AOB, p. 62.) Accordingly,



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Defendants argue that McCarley's 998 offer was ambiguous if not invalid. (AOB, pp. 62–63.) As discussed below, Defendants' argument fails even if it has not been waived.

### A. McCarley's 998 offer was unambiguous in its intent to settle her entire claim against Canada.

Section 998 offers are generally interpreted according to the principles of contractual interpretation. (*Timed Out LLC v. 13359 Corp.* (2018) 21 Cal.App.5th 933, 942.) As such, the terms of 998 offers must not only be understood according to "the usual and ordinary meaning of the language used" in the offer (*Chinn v. KMR Property Management* (2008) 166 Cal.App.4th 174, 183–184), they must also "be construed in the context of that instrument as a whole, and in the circumstances of that case." (*Producers Dairy Delivery Co. v. Sentry Ins. Co.* (1986) 41 Cal.3d 903, 916, fn. 7.)

As discussed below, when understood in light of (1) the "usual and ordinary" meaning of the term "several liability," (2) the offer as a whole, and (3) the circumstances of the case, it is abundantly clear that McCarley's 998 offer operated as an offer to settle her *entire claim* with Canada, and not merely an offer to resolve his exposure for noneconomic damages.

#### 1. "Several liability" refers to a tortfeasor's independent liability to the plaintiff.

As noted above, McCarley included the phrase "several liability only" in her 998 offer merely to confirm that she was offering to settle with Canada separately, and was not offering to "discharge [] any other Defendant's liability." (1 AA 38A.) Not



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surprisingly, McCarley's use of "several liability" for that purpose is entirely consistent with the "usual and ordinary meaning" of that phrase. (*Chinn*, *supra*, 166 Cal.App.4th at pp. 183–184.)

"When attempting to ascertain the ordinary, usual meaning of a word, courts appropriately refer to the dictionary definition of that word." (*Wasatch Property Management v. Degrate* (2005) 35 Cal.4th 1111, 1121–1122.) Black's Law Dictionary defines "several liability" broadly as "[l]iability that is separate and distinct from another's liability, so that the plaintiff may bring a separate action against one defendant without joining the other liable parties." (Black's Law Dict. (8th Ed. 2004) p. 933, col. 2.)

The scope of Canada's "separate and distinct" liability to McCarley was defined by the fact that Canada was alleged to be independently responsible for McCarley's injuries. (E.g., 1 AA 28 [¶ 14] ["As a result of the conduct of Defendants, *and each of them* …," italics added]; 1 AA 29 [¶ 15] [same].) Accordingly, as a matter of bedrock California law, Canada was potentially "separately and distinctly" liable to McCarley for the entirety of her damages. (See Civ. Code, § 1714, subd. (a) ["Everyone is responsible … for an injury occasioned to another by his or her want of ordinary care or skill …."]; see also *American Motorcycle Association v. Superior Court* (1978) 20 Cal.3d 578, 589 ["As we have already explained, a concurrent tortfeasor is liable for the whole of an indivisible injury whenever his negligence is a proximate cause of that injury."].)

Notably, the mere fact Canada was one of several defendants in the case did *not* alter the potential scope of his "separate and distinct" liability to McCarley.



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For example, although McCarley sued other alleged tortfeasors along with Canada, she did not have to: "When independent negligent actions of a number of tortfeasors are each a proximate cause of a single injury, each tortfeasor is thus personally liable for the damage sustained, *and the injured person may sue one or all of the tortfeasors to obtain a recovery for h*[*er*] *injuries*." (*American Motorcycle*, *supra*, 20 Cal.3d at 587, italics added.) Thus, consistent with the very definition of "several liability," McCarley could have brought "a separate action against [Canada] without joining the other liable parties." (Black's Law Dict. (8th Ed. 2004) p. 933, col. 2.)

The prospect that a jury might ultimately apportion fault among several defendants also did not alter the scope of Canada's "separate and distinct" liability to McCarley.

For one, the fact that a jury might have ultimately apportioned only some fault to Canada would not have changed the fact that Canada's negligence was, itself, a "separate and distinct" proximate cause of McCarley's indivisible injuries. (*American Motorcycle*, *supra*, 20 Cal.3d at p. 589 ["[T]he mere fact that it may be possible to assign some percentage figure to the relative culpability of one negligent defendant as compared to another does not in any way suggest that *each defendant's negligence is not a proximate cause of the entire indivisible injury*." italics added].)

By that same token, the fact that Canada might have been made to pay noneconomic damages in excess of his proportional share of fault does *not* mean that those damages reflected anything



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beyond Canada's "separate and distinct" liability to McCarley. Indeed, even in the context of joint-and-several liability, "[l]iability attaches to a concurrent tortfeasor … not because he is responsible for the acts of other independent tortfeasors who may also have caused the injury, *but because he is responsible for all damage of which is own negligence was a proximate cause*." (*American Motorcycle*, *supra*, 20 Cal.3d at p. 587, italics added.)

In short, as an independent tortfeasor whose "separate and distinct" negligence was alleged to be the proximate cause of McCarley's entire indivisible injuries, the potential scope of Canada's "separate and distinct" liability to McCarley was likewise coterminous with her entire damages.

Accordingly, when McCarley offered to settle Canada's "several liability only" she was *not* offering to resolve Canada's liability for her noneconomic damages. Rather, McCarley was offering to resolve her *entire* "separate and distinct" claim against Canada, but "only" as to *him*, thus leaving her claims against his co-defendants intact. (See 1 AA 38A [offering to accept $1 million from Canada "for your several liability only *and not for a discharge of any other Defendant's liability*," italics added].)

**2. When viewed "as a whole," McCarley's 998 offer was clearly an offer to settle her entire claim with Canada.**

In addition to the "usual and ordinary" meaning of its terms, the language in a 998 offer "must be construed in the context of that instrument as a whole." (*Producers Dairy*, *supra*, 41 Cal.3d at p. 916, fn. 7.) And, indeed, when McCarley's 998 offer is read *as a whole* instead of excerpted in a vacuum, it becomes even more



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obvious that her 998 offer sought to settle her entire claim Canada, and was not intended to settle only her claim against him for noneconomic damages.

First, the very language in McCarley's offer confirms that the reference to "several liability only" was meant to clarify that the offer did not apply to any of Canada's codefendants. Indeed, this is evident from the balance of the sentence where that language appears, in which McCarley told Canada she would accept $1 million for "your several liability only *and not for a discharge of any other Defendant's liability*." (1 AA 38A.)

Later in the offer, McCarley re-emphasizes this same theme, noting that "[a]cceptance of this offer constitutes agreement that the sum shall afford only a deduction from any other Defendant's liability *and not a discharge of such Defendant*." (1 AA 38B, italics added.) In so stating, McCarley was simply being mindful of Code of Civil Procedure section 877, subdivision (a), which provides that a settlement between a plaintiff and a defendant will also serve to discharge co-defendants' liability if "its terms so provide."

Other language in the 998 offer further confirms that it was intended to resolve McCarley's entire claim against Canada and not merely a part of it.

For example, the offer referenced Code of Civil Procedure section 998, a section that clearly "contemplates that an offer to compromise which is accepted will result in the final disposition of the underlying lawsuit." (*Goodstein v. Bank of San Pedro* (1994) 27 Cal.App.4th 899, 906.) Indeed, a 998 offer that is accepted is recorded as a "judgment." (See Code Civ. Proc., § 998, subd. (b)(1).)



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Of course, a "judgment" is defined as "the final determination of the rights of the parties in an action or proceeding." (*Id.*, § 577.)

Consistent with this theme, McCarley's offer also expressly stated a desire to "compromise the above-entitled action." (1 AA 38A.) Of course, "an action … 'refers to the entire judicial proceeding at least through judgment and is generally considered synonymous with suit.'" (*Salawy v. Ocean Towers Housing Corp.* (2004) 121 Cal.App.4th 664, 672, quoting *Nassif v. Municipal Court* (1989) 214 Cal.App.3d 1294, 1298.)

Finally, McCarley's offer used the word "settlement." (1 AA 38B.) Of course, the common understanding of a "settlement" is that it "conclude[s] all matters put in issue by the pleadings—that is, questions that otherwise would have been resolved at trial." (*Folsom v. Butte County Assn. of Governments* (1982) 32 Cal.3d 668, 677.)

In short, when McCarley's 998 offer is viewed "as a whole," it is clear that it sought to resolve her entire claim against Canada, not merely the noneconomic component of it.

### 3. When viewed in light of the "circumstances of the case," it is evident that McCarley's offered to settle her entire claim with Canada.

The conclusion that McCarley's 998 offer purported to settle her entire claim against Canada—and not merely the noneconomic aspect of it—becomes even more obvious when the offer is viewed in light of "the circumstances of th[e] case." (*Producers Dairy*, *supra*, 41 Cal.3d at p. 916, fn. 7; see also AOB, p. 61 [agreeing that a 998 offer must be understood in light of '"the circumstances



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under which it was made,'" quoting *Chinn*, *supra*, 166 Cal.App.4th at pp. 183–184.)

Most notable here is the $1 million value of the offer itself. Under MICRA, McCarley was limited to a maximum of **$250,000** in noneconomic damages from all defendants *combined*. (E.g., *Gilman v. Beverly California Corp.* (1991) 231 Cal.App.3d 121, 129 ["[A] plaintiff cannot recover more than $250,000 in noneconomic damages from all health care providers for one injury."].) With that in mind, it would have been entirely *unreasonable* for Canada to view McCarley's $1 million offer as an offer to resolve only his noneconomic liability. (See *Rashidi v. Moser* (2014) 60 Cal.4th 718, 727 ["The prospect of a fixed award of noneconomic damages … restrains the size of settlements. Settlement negotiations are based on liability estimates that are necessarily affected by the cap."].)

It is also worth noting that the 998 offer to Canada was accompanied by a letter to Defendants' counsel in which McCarley made clear that she would dismiss Canada's practice group and co-defendant, ASMG, for a waiver of costs if Canada accepted McCarley's 998 offer. (See 2 AA 468:3–7.) This letter has two implications here:

First, it further supports the inference that McCarley's 998 offer was intended to settle the entire litigation between McCarley and Canada. After all, why would McCarley offer to dismiss ASMG contingent on a settlement that resolved only *part* of her claim against Canada?



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Second, that letter—or, more accurately, its *absence*—very likely compels the conclusion that Defendants have waived their challenge to McCarley's 998 offer in this appeal.

Indeed, the reason McCarley cannot show this Court that letter is because it was never lodged with the trial court. (See Cal. Rules of Court, rule 8. 155 (a)(1)(A).) And that letter was not lodged with the trial court because Defendants waited until now to quarrel with the "several liability only" language in McCarley's 998 offer. Indeed, in his motion to tax costs in the trial court, Defendants only argued that McCarley's 998 offer was "unreasonable." (2 AA 366–367.)

Of course, "the general rule is that failure to raise an issue below will waive that claim on appeal." (*People v. Clark* (1993) 5 Cal.4th 950, 988, fn. 13.) Notably, this rule "is based on the rationale that the opposing party should not be required to defend for the first time on appeal against a new theory that 'contemplates a factual situation the consequences of which are open to controversy and were not put in issue or presented at the trial.'" (*Ward v. Taggert* (1959) 51 Cal.2d 736, 742, quoting *Panopulos v. Maderis* (1956) 47 Cal.2d 337, 341.)

That is precisely the situation here: Had Defendants disputed the "several liability only" language in the trial court, McCarley would have offered her letter to Defendants into evidence. Defendants' decision to raise this argument for the first time on appeal has thus deprived McCarley of the evidence to rebut it. Defendants have therefore waived this latest challenge to the 998 offer.



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### B. To the extent Canada was uncertain about the scope of McCarley's 998 offer, he should have sought clarity.

The foregoing sections show that the "several liability only" language in McCarley's 998 offer was *not* ambiguous. Indeed, a document is "ambiguous" only if it "is susceptible of more than one *reasonable* interpretation." (*Fremont Indemnity Co v. Fremont General Corp.* (2007) 148 Cal.App.4th 97, 114, italics added.) But given the meaning of "several liability," the language of the offer as a whole, and the circumstances of the case, it would have been *unreasonable* to view McCarley's 998 offer as anything but an offer to resolve her entire claim with Canada.

Nonetheless, even if there was room to doubt the scope of McCarley's 998 offer, this would not automatically void it. Indeed, a well-recognized exception to the general rule that 998 offers should be treated like contractual instruments is where such rules would "conflict with []or defeat the statute's purpose of encouraging the settlement of lawsuits prior to trial." (*Elite Show Services, Inc. v. Staffpro, Inc.* (2004) 119 Cal.App.4th 263, 268.)

With this in mind, numerous courts have indicated that a party who perceives ambiguity in an otherwise acceptable 998 offer should attempt to clarify it. (E.g., *Prince v. Invensure Ins. Brokers, Inc.* (2018) 23 Cal.App.5th 614, 622–623 ["[W]here two sophisticated parties are represented by counsel, allowing an offer to compromise to be clarified in writing after the offer was made serves the purposes of section 998. Such clarification encourages reasonable settlement offers to be accepted."]; *Peterson v. John Crane, Inc.* (2007) 154 Cal.App.4th 498, 506, fn. 8 ["We do observe,



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however, that it would be consistent with the settlement purposes of section 998 for an offeree to clarify any perceived ambiguity of an offer with the offeror.”]; *Berg v. Darden* (2004) 120 Cal.App.4th 721, 730–731 [“If the offeree is uncertain about some aspect of the offer ... he is free to explore those matters with the offeror ….”]; *Hartline v. Kaiser Foundation Hospitals* (2005) 132 Cal.App.4th 458, 472 [party who is uncertain about the scope of a 998 offer should “communicate his concern to [the offeror]”].)

Thus, if Canada’s only concern with McCarley’s 998 offer was the “several liability only” language, the “reasonable course of action” would have been “to communicate his concern to [McCarley] and to make a counteroffer” that excluded that language. (*Hartline*, *supra*, 132 Cal.App.4th at p. 472.) The fact Canada did not do so is reason to reject his post-hoc attempt to evade the consequences of his unreasonable failure to accept McCarley’s 998 offer.



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## CONCLUSION

For the foregoing reasons, McCarley prays this Court will **affirm** the judgment below in full.

September 4, 2019 By: */s/ Benjamin I. Siminou*
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## CERTIFICATE OF COMPLIANCE

As required by California Rules of Court, rule 8.204, subdivision (b)(1), I certify that, according to the word-count feature in the word processor used to generate it, this brief contains **13,916** words, including footnotes, but excluding the tables, this certificate, and any attachments permitted under California Rules of Court, rule 8.204, subdivision (d).

September 4, 2019 By: */s/ Benjamin I. Siminou*
Benjamin I. Siminou



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## PROOF OF SERVICE

I am employed in the County of San Diego, State of California. I am over the age of 18 and not a party to this action. My business address is 2305 Historic Decatur Rd., Ste. 100, San Diego, CA 92106.

On the date set forth below, I served the document(s) described as follows: "**Respondent's Brief.**"

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I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct and that this declaration was executed on **September 4, 2019**, in San Diego, California.

Benjamin I. Siminou



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