SUPREME COURT OF FLORIDA

MILLIE WEYGANT,

Petitioner,

vs.

FORT MYERS LINCOLN MERCURY, INC., d/b/a Fort Myers AMC, Jeep, Renault and CHESTER MEREDITH,

Respondents.

CIRCUIT CASE: 89-761 CA-TSR
APPELLATE CASE: 91-01902
CASE NO: 81,008

ANSWER BRIEF OF RESPONDENTS

AN APPEAL FROM THE SECOND DISTRICT COURT OF APPEAL
LAKELAND, FLORIDA

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CITATIONS OF AUTHORITIES

PREFACE

For purposes of this Answer Brief, all references to the Record on Appeal shall be designated as follows: "R-", followed by the appropriate page number(s) - original Record; "R1-", followed by the appropriate page number(s) - First Supplemental Record; and, "R2-", followed by the appropriate page number(s) - Second Supplemental Record.

Respondents apologize for the length of their STATEMENT OF THE FACTS AND OF THE CASE, but they considered it necessary to fully apprise this Court of the testimony elicited at the underlying trial, upon which the jury based its verdict and the Appellate Court its decision.

STATEMENT OF THE FACTS AND OF THE CASE

Respondents submit the following corrections, additions and clarifications to Petitioner's STATEMENT OF THE FACTS AND OF THE CASE.

Dr. Francis D. Hussey, Jr., a neurologist, first examined Petitioner on February, 1, 1983, as a result of an incident that occurred while Petitioner worked as a security guard. She slipped on a ladder, causing her to complain of headaches, neck pain and shoulder pain. (R1-253, 254, 277) During the subsequent visits to Dr. Hussey, her complaints remained the same. (R1-280, 281) Dr. Hussey's examination revealed bilateral occipital node

tenderness. (R1-278)

Dr. Harry Lowell, a neurosurgeon, first saw Petitioner on February 1, 1984. (R1-632) She complained of long-standing headache and cervical problems which she related to a December, 1980, accident. (R1-632) She was unable to work. (R1-633) She had been on psychotropic medications including Sinequan, prescribed for anxiety and depression. (R1-633, 634) As of February 1, 1984, there was no clinical evidence to support her subjective complaints of pain. He was inclined to believe her symptoms were more as a result of tension and anxiety. (R1-636). Because of her long-standing symptoms, he performed a right C-5,6 laminectomy and foraminotomy on February 28, 1984.

Dr. Lowell thought there was an emotional anxiety component and was suspicious she was over-exaggerating. (R1-639) In June, 1984, the pain recurred and he was suspicious of functional overlay. (R1-641, 642) He gave her a seven percent (7%) permanent partial disability rating. (R1-642) He saw no reason why she could not be gainfully employed in a sedentary capacity. He thought she was "over-exaggerating". (R1-642) In August, 1984, she had headaches that made her unable to sleep. She felt her neck was swelling and complained of neck and right arm pain. (R1-644) He thought there was a functional component.

After the surgery by Dr. Lowell, Petitioner continued to experience the same problems she had prior to surgery. (R1-282, 285) She was becoming increasingly depressed. (R1-282) Her

complaints regarding her sensory loss were vague and inconsistent. (R1-283)

When Dr. Beauregard L. Bercaw, a neurologist, saw Petitioner in October, 1984, she was depressed, very, very distraught and complaining of severe pain. (R1-398-400) Examination revealed some sensory abnormality on the left hand suggestive of cervical radiculopathy. (R1-400) He diagnosed cervical spondylosis and cervical pain secondary to the spondylosis. (R1-400) She had trouble sleeping. She was fatigued, blue, very depressed and separated from her husband. (R1-401)

As of November 13, 1984, she was still complaining of headaches and neck pain on both sides. (R1-284) She was prescribed anti-depressant and mild tranquilizers. (R1-284, 285)

As of January 24, 1985, Petitioner indicated to Dr. Hussey that she had been doing fairly well until she had an incident where she picked up a basket of clothes, turned suddenly, coughed and developed sudden, severe and searing pain in the left side of her neck and shoulder. (R1-285, 286, 368, 401) As of January 24, 1985, she began to complain of numbness and parasthesia in her left hand and some weakness in the extensor of the wrist and triceps, which indicated some nerve root involvement on the left side. (R1-286) Her pain was a "10" on a scale of "1 - 10". (R1-402) She was angry with Dr. Lowell because she thought she had a problem at the C-7 nerve root, which he should have taken care of at surgery. The doctor was surprised she knew the

dermatomal pattern of C-7 and the symptoms and complaints that go with a C-7 radiculopathy. (R1-404)

In January, 1985, she had a series of visits with Dr. Lowell where she described intractable, severe pain - recurrent or recurring exacerbations without any apparent cause. (R1-405) The severity of the pain against the paucity of the findings did not make any sense to him. She told him that she had had a terrible week and couldn't take life anymore. He admitted her to the hospital. In the January, 1985, admission, she told him that she had severe pain in the neck, severe headaches, muscle tenderness, limitation of the motion of her neck and that she had been "gobbling Talwin."

In April and May of 1985, Petitioner was still experiencing left side radicular complaints, sensory loss and weakness. (R1-287, 288) As of June, 1985, she was still having significant cervical and neck problems and did not feel well except when her head was on a pillow. (R1-289) On the June 25, 1985, hospital admission, Dr. Lowell felt that the major problem was anxiety and depression.

As of July, 1985, she was on Limbitrol, Clinoril, Sinequan and Tagamet. On January 31, 1986, she had been down to Miami and had been robbed. She had marked cervical tenderness, muscle spasms and limited range of motion of her neck. (R1-370, 416) She could not do secretarial work because it hurt her neck too much. (R1-416, 417)

Dr. Lloyd Richard Miller is a psychiatrist practicing out of Miami. (R1-490) He saw Petitioner on October 25, 1985. She was complaining of a headache that had lasted for three (3) weeks, and the doctor stated there is no such thing as a physical three-week headache. (R1-492) The doctors had thought there might be some psychological factors (depression) that might be manifesting in complaints of physical pain and discomfort. (R1-492) He prescribed Limbitrol. (R1-492) She had been on Limbitrol, Flexoril, Talwin and Demerol. (R1-493) She had seen a psychologist for biofeedback and self-hypnosis when she was nineteen years old. (R1-495) She had been married a couple of times. The second husband, whom she had divorced twice, was an alcoholic. She had been abused by the first husband. (R1-496) Dr. Miller's diagnosis was psychogenic pain disorder. It was his opinion, within a reasonable degree of psychiatric probability, that she suffered a permanent psychiatric impairment or disability as a result of the 1980 accident. (R1-499)

On March 16, 1986, Dr. Hussey took her off job search for six to eight weeks because she was still having all of her complaints and symptoms. (R1-291, 292)

The automobile accident upon which this lawsuit was based occurred on April 30, 1986. In May, 1986, Dr. Bercaw began to wonder if he was becoming a "demon" because she would be fine while he was talking to her in her hospital room and then would develop what appeared to be a very severe headache, as if

something had happened to her while he was just talking. (R1-418) Dr. Bercaw felt her problem was conversion reaction, somatization or some other significant psychiatric illness, and cervical disc disease; all of which he thought originated with her Workers' Compensation injury. (R1-418, 419, 421) Somatization, conversion reaction, or psychiatric mechanism of pain are all different ways of saying a person takes an anxiety or depression and turns it into a physical symptomatology. It is also called psychogenic pain disorder. (R1-418, 419)

Dr. Hussey first saw Petitioner, after the April, 1986, accident, on July 3, 1986. (R1-292) She informed him that she had gone back to work and was functioning and thought she was doing reasonably well until she became involved in the auto accident. (R1-292) She was complaining of a left-handed tremor which he related to the medicine for anxiety. (R1-293, 294)

When she came in on July 3, 1986, her complaints were essentially the same as the ones she had on March 18, 1986, with some minimal differences. (R1-294) He related her difficulty with anxiety and depression to pre-existing chronic pain situation. (R1-294, 295) He rendered an opinion that she had an eleven percent (11%) impairment rating; eight percent (8%) from the original injury in 1980 and four percent (4%) from the auto accident. It was his best attempt to straighten out the two injuries which were very much intertwined. (R1-301, 302) He wanted her seen by a psychiatrist because of the psychogenic

factors at play. (R1-382) She was distraught with depression, anxiety and varying neurological symptomatologies since basically the 1980 slip and fall, ladder accident. (R1-302, 303)

Dr. Michael Lusk, a neurosurgeon, first examined Petitioner on August 7, 1986. (R1-156) She told him that she had had a previous injury in 1980 which required surgery by Dr. Lowell. She had slowly gotten better and was doing relatively well until April 30, 1986. (R1-159) However, she also told him that the surgery performed by Dr. Lowell had not done her any good and, in fact, had made her condition worse. (R1-192) Dr. Lusk agreed it was a bit confusing. (R1-192) He performed surgery on August 18, 1986, an anterior cervical microdiscectomy at C-5,6. (R1-161) The operation he performed is generally quoted as being anywhere from eighty-five percent to ninety percent (85% - 90%) successful for stopping pain. (R1-167) As of February 4, 1987, he indicated she could resume employment on a part-time basis. (R1-182)

As far as being able to relate any of her injury to the automobile accident, that would be based solely on the history given to him by Petitioner. He has to depend on the truthfulness and veracity of the patient. (R1-189, 190) He accepted her word that, following the surgery in 1984, she had done relatively well until the accident of April 30, 1986. (R1-190, 191)

Petitioner told Dr. Lusk that she did not have any pain immediately following the accident, but it developed a little later in the day. (R1-191) She told him that before the accident

she did not experience any left-sided pain or complaints and that the left-sided shoulder and arm pain was new. (R1-193) He had no knowledge of the severe left-sided neck, shoulder and arm pain she experienced one and one-half months before her automobile accident. (R1-193)

In his examination, Dr. Lusk found tenseness, no evidence of atrophy, and some radicular findings or decreased sensation, both to the right and left, in a C-5,6 dermatomal pattern. (R1-193, 194) He agreed that someone who is knowledgeable about anatomy, such as a nurse, could fake the dermatomal pattern. (R1-195, 196) He also stated that the muscle spasm he found could be caused by trauma, tension, or stress. (R1-195, 196) He agreed that, in general, with any kind of severe nerve root damage, you would begin to see some atrophy in the extremities. He found none in Petitioner's case. (R1-195 - 197) She was already on Limbitrol, Esgic and Talwin. (R1-197) He would have expected those medications to be prescribed after the accident of April 30, 1986, based on what she told him. (R1-197, 198)

Bony spurs and disc problems such as disc bulging are known as degenerative changes. (R1-199) Dr. Lusk made it clear that bulging and herniated discs can be caused without trauma and just as a result of normal wear and tear of living. (R1-200, 201) Dr. Lusk conceded that the C-5 disc upon which he operated in August, 1986, could have pre-dated the automobile accident of April 30, 1986. He can relate it to that particular accident only by the

patient's history. (R1-207, 208, 231, 232)

X-rays, in September, 1986, revealed the degenerative changes in Petitioner's cervical spine, including the bone spur formation at C-5,6. (R1-208 - 210) She had fallen in the bathtub one week prior to September 4, 1986, and indicated she felt worse than she did before the surgery. (R1-210)

At some point in his treatment, Dr. Lusk became very sure that Petitioner may have been seeking drugs or narcotics. (R1-211, 212) On September 4, Petitioner was at Naples Community Hospital complaining of severe neck pains. He examined her, found no evidence of acute significant injury other than neck strain, but admitted her for pain control. She indicated her pain was not controlled even by the Dilaudid, a stronger and more addictive narcotic than Talwin. (R1-210 - 213)

In October, she complained of severe neck pain and bilateral shoulder pain; however, she had a normal neurological exam. (R1-214) He felt that she needed medication in order to cope with life. She had family problems and did not tolerate life well. (R1-214, 215) He could not find any further reason, over the period of several years, to explain any of her continued complaints. That particular aspect of her personality was not caused by the motor vehicle accident of April 30, 1986. (R1-215, 216)

Petitioner continued to complain of severe pain, both left-sided and right-sided. Dr. Lusk could find no clinical

evidence or abnormalities to support the subjective complaints of severe pain. (R1-216, 217, 219, 223, 224, 225, 226, 228, 229, 233) He admitted her to the hospital on several occasions for pain control. He felt she definitely had a mental drug dependency, rather than a physical drug dependency. (R1-219, 220, 223) Because of her drug seeking behavior, he referred her to a psychiatrist. (R1-223, 224) He was unaware of her having had psychiatric care or treatment, or need for such, prior to the accident of April 30, 1986. (R1-218)

He felt that litigation in and of itself played some significant role in her continued complaints of pain. (R1-221) Secondary gain often plays a very significant role in how quickly or slowly a patient recovers. (R1-221, 222) Every time some important event would occur in litigation, she would begin to have more severe symptoms and would have to go back into the hospital for narcotic treatment. (R1-227) He also felt that her inter-spousal problem with an alcoholic husband was adversely affecting her perceived symptomatology of pain. (R1-228, 229)

Dr. Lusk indicated it was difficult to determine which of the two injuries (1980 Workers' Compensation injury or 1986 automobile accident) was the worse of the two. (R1-231) Based on what he knew about the case, he felt the automobile accident was probably a major factor causing the bulging disc. (R1-231) He gave her a total disability rating of five percent (5%) to ten percent (10%). (R1-231) He agreed that there appeared to be

quite a bit about her prior history of which he had no knowledge at the time he treated her and of which he still had no knowledge. (R1-232)

Dr. Lusk's last examination of Petitioner was on January 20, 1988, and again, there were no clinical objective findings to support her complaints. (R1-233) The surgery had given her absolutely no relief. The symptomatology was exactly the same in January, 1988, when he last saw her, as it had been the first day he saw her in 1986. (R1-233) Petitioner had never gotten better from the first surgery (1984 by Dr. Lowell) years previously, and he suspected she will always have pain because of the nature of her personality. (R1-233, 234)

When Dr. Bercaw saw Petitioner on March 29, 1987, she had multiple numb spots that he was not sure were caused by nerve impingement or psychological problems. (R1-380, 381) It became apparent to him over the course of time that Petitioner's problems were not the arthritis or nerve root irritation, but a psychological problem with the way she was and the way she reacted to pain. (R1-383, 384) She had a lot of depression, severe anxiety and was a somatizer, meaning she would somatize her anxiety into physical symptoms. (R1-383, 384) He stated that the psychiatric reaction probably started after her initial problem in 1980. (R1-386)

On September 2, 1987, she was in the hospital complaining of back pain, primarily on the right. (R1-303, 304) She appeared to

be under a lot of stress. The stress factors included financial problems, ongoing depression, anxiety, ongoing pain and regular day-to-day stresses of family problems. (R1-305, 306) She was having severe pain in the back of her head and around her right ear. (R1-307) Dr. Bercaw was unable to say within a reasonable degree of medical probability when the herniated disc first appeared. (R1-307, 309)

Petitioner was hospitalized at Naples Community Hospital in March and April, 1987, for severe complaints of neck pain and right shoulder pain. (R1-313, 314) She described intractable and unbearable pain in the right side of her shoulders, arms and neck. (R1-314)

On March 20, 1989, when Dr. Lowell saw Petitioner again, she was complaining of neck and right shoulder pain for five months. In March, 1989, he felt there was marked functional overlay. She turned down Darvocet and Tylenol and wanted something stronger. (R1-647) The cervical x-rays showed progression of her degenerative disease. (R1-647, 648) She told him that, since the surgery in August, 1986, she had done quite well with intermittent episodes of alternating bilateral cervical and upper extremity pain. (R1-649)

In March, 1989, Dr. Lowell diagnosed C-5,6 cervical spondylitic disease complicated by functional overlay. Her primary complaint was neck and right shoulder pain and right arm pain, more than the left. (R1-649) The examination was

unreliable in that there was manifested weakness that he did not think was real. (R1-650) She denied any left-sided cervical pain at that time. (R1-651)

It is difficult for Dr. Lowell to state whether she sustained a permanent injury as a result of the April 30, 1986, accident, as it appears her problem is at the same level as her work related injury in 1980. (R1-651) The MRI results do not necessarily mean that the degenerative changes are painful. (R1-653) Degenerative changes can cause bulging discs. It is a common result of just getting old and natural degenerative disease. (R1-654, 655)

In September, 1989, Dr. Bercaw's impressions were conversion reaction, depression, with her major problem being psychiatric in nature, rather than physiological. She had the same type of complaints that had been ongoing from the first time he saw her back in October, 1984. (R1-425) She had intoxicating levels of Elavil in her blood in September, 1989. (R1-425, 426)

Ninety-nine percent (99%) of her problem was somatization or psychological. (R1-427) Dr. Bercaw wondered if things at home would push her into the stress situations. (R1-427) The only way he can causally relate the aggravation of her injury to the April, 1986, accident would be based on the history related by Petitioner. (R1-429) Because of her severe psychiatric problems, he did not know if she would be accepted at a pain clinic. (R1-430)

It is Dr. Bercaw's opinion, within a reasonable degree of medical probability, that, with or without the April 30, 1986, accident, she would have continued to have complaints of pain and most of her pain would have been due to the hysterical conversion reaction. As to whether she worsened after the accident, Petitioner is the only one who can tell us of her pain. (R1-431)

Dr. Eduardo R. Huergo, a psychiatrist, first saw Petitioner on August 29, 1989. The Talwin medication had been stopped because of abscesses on her buttocks from too many injections. She gave him a history as to how her complaints of pain started, indicating she had suffered an accident at work several years ago and injured her cervical spine. She did not tell him about any other accident (including the April, 1986, accident). (R1-452, 453) There was some indication there was something wrong at home but she did not want to talk about the "real problem." (R1-454, 455) She was a woman who craved pain medication. (R1-466) Her family history was positive for depression - her mother having been chronically depressed. (R1-467, 468)

As Dr. Huergo agreed, pain is subjective; you have to rely on the patient to tell you whether they are, in fact, experiencing pain. There are individuals who profess to be in pain but actually are not. (R1-484) He filed a Petition for Order for involuntary treatment for drug dependency, as she adamantly denied she abused any drugs. (R1-470, 471)

Dr. Michael Woulas is a psychotherapist. (R1-514) She told

him that her father was an alcoholic and "king of the castle" and her mother was lazy and selfish and enjoyed attention from others. (R1-538, 539) She married at the age of sixteen, but it was a dysfunctional marriage with physical abuse. She married the second time, which was also dysfunctional, with an alcoholic husband. (R1-539) The MMPI revealed the profile of someone with a personality where psychological stresses are often converted into physical complaints of problems. (R1-554) He felt it was important to look into conversion reaction and secondary gain. (R1-546, 547) Her profile suggested hypochondriacal traits, histrionic traits, impulsiveness, and probability of functional physical complaints. (R1-547)

It was Dr. Woulas' opinion that Petitioner's impairment rating was aggravated as a result of the 1986 accident, based on the history that she gave him. (R1-529, 548) He did not know that some of the psychiatrists, in 1986, had already assessed her with a permanent psychological impairment, nor did he know that she had any significant problems from a psychiatric or emotional standpoint prior to April 30, 1986. It is his understanding she had been able to function and cope well until that accident. (R1-548, 549) A fall could cause the neurological injury which led to her psychological problem. (R1-551)

Dr. Miller stated that the mere fact that she had an injury in this same area (cervical) and more surgery is not enough to conclude that there was or was not any aggravation of a

pre-existing injury. (R1-509)

The EMT Report from the April 30, 1986, automobile accident indicates that Petitioner was sitting in the front seat of the ambulance as a visitor. (R1-629) Within a few minutes, Petitioner contradicted herself several times regarding the issue of whether she had complained of being injured at the scene and whether she was treated at the scene by the EMS personnel, or whether she did not complain of any discomfort or pain until she arrived at the hospital, and rode as a passenger in the ambulance as opposed to a patient. (R1-99 - -102)

At trial, Petitioner testified that, prior to the April 30, 1986, accident she never had any problems with pain on the left side of her neck, and no problems with pain or discomfort in the left arm. (R1-110-113) She did not recall being treated by several doctors for left-sided complaints before the accident of April 30, 1986. She did not recall, on January 21, 1985, lifting up a clothes basket, coughing and turning and having searing, sudden pain in the left side of her neck and down her left arm. She did not recall the pain being so severe that she could not straighten up, and had to go see Drs. Bercaw and Hussey. (R1-112-114)

She testified that she was taking some medication, but not very much, once or twice a day. (R1-114) She did not recall, in the hospitalizations of June, 1985 and July, 1985, telling Dr. Bercaw that she was "gobbling Talwin" because of all the pain. (R1-114, 115)

She had testified, in her February, 1987 Workers' Compensation deposition, that she had to take pills twenty-four hours a day for her right-sided problems and that the left-sided problems, caused by the auto accident, were not incapacitating her. (R1-115, 116)

At trial, she stated she was admitted to Naples Community Hospital some twenty-five or twenty-six times since the 1986 accident for severe and chronic pain going down the left shoulder and left arm. (R1-107, 108)

At the time of trial, she claimed that she still had the severe pain down the left arm and had had it ever since the accident of April 30, 1986. (R1-108) She was confronted with the evidence that, at the time of her deposition on May 21, 1990, in the Workers' Compensation case, she testified that she had more of a right-sided neck, shoulder and arm pain; that Dr. Lusk's surgery in 1986 had stopped the left arm pain; and, that she was not having any pain down her left arm or hand; thereby, placing emphasis on her Workers' Compensation injury. (R1-108, 109)

When asked, at trial, whether or not she testified (in her February, 1987 Workers' Comp deposition) that the disability she had as of that time was due to the Workers' Compensation injury and not the automobile accident, which had occurred some ten or eleven months prior to the deposition, she indicated she did not recall what she had said. When that portion of her deposition was read to her in front of the jury, she agreed that it was

correct - that her disability was as a result of the Workers' Compensation injury and not the automobile injury of April 30, 1986. (R1-117, 118)

At the time of trial, she agreed that, at her Workers' Compensation deposition on March 16, 1990, she had stated that prior to April 30, 1986, she did not have any difficulty with depression. (R1-118) At trial, she first stated that she did not recall being depressed, but then stated that she did recall being depressed before the April 30, 1986 accident because she could not go back to work. (R1-119) The Naples Community Hospital admission of February 22, 1984, reveals Petitioner being depressed because of her inability to perform her usual activities. (R1-718)

She stated that, since the accident of April 30, 1986, she had fallen in the bathtub at home, but did not injure herself. (R1-120, 121) She also denied hurting her neck as a result of slipping while coming out of the shower on May 16, 1986, while in the Naples Community Hospital. (R1-124) However, the Naples Community Hospital records for the admission which began on May 6, 1986, reveal that, on May 16, 1986, Petitioner stated, "As I was coming out of the shower, I slipped and fell and jarred my neck something terrible." (R1-718) Note that the MRI that showed the posterior disc protrusion at C-5,6 on the left was not performed until July 18, 1986, two (2) months after the fall of May 16, 1986.

It was made clear at trial that, at the time of her deposition in the automobile case on March 16, 1990, she stated that she had not attempted to go back to work since April 30, 1986. (R1-125, 126) However, in her Workers' Compensation deposition of February 23, 1987, she stated that she had been looking for work, at least doing a job search, since December, 1986 or January, 1987. (R1-126, 127) The only reason she was going through the procedure of applying for a new job was to comply the Workers' Comp job search requirements. (R1-127, 128)

Prior to the automobile accident on April 30, 1986, Petitioner last worked in 1984. (R1-93, 95 and 96) She did not work from 1984 to 1986 because of all her physical problems (headaches, neck pain, shoulder pain and arm pains). (R1-93) Subsequent to her Workers' Compensation injury in 1980, her jobs consisted of very short term positions. From September to November, 1981, she worked at Red Lobster as a waitress. (R1-86) She left Red Lobster because she was having too much pain and difficulty with her arm and neck to be able to perform her job. (R1-86) She did not work again until she went to work for Imperial River Landscaping from May - October, 1982. (R1-86) She left the Imperial River job because of stress and severe headaches. (R1-88) Her next job was in 1984, working for her brother at Plantation Landscaping. (R1-89, 93) She worked there a little less than two months and was taking therapy three times per week. She was not able to do the job on a full-time basis.

She was having severe headaches and needing to go to the doctor. (R1-90) On March 18, 1986, one and one-half months before the April, 1986, accident, because of her severe complaints of neck pain, shoulder pain and arm pain, she was taken off the job search by Dr. Hussey. (R1-96-98)

At trial, the jury was properly instructed. These instructions included the Florida Standard Jury Instructions on expert witnesses and, contrary to Petitioner's Initial Brief, aggravation of pre-existing conditions. (R1-688, 691, 692)

ISSUES ON APPEAL

Petitioner states the Issues on Appeal as follows:

I. THE MOREY LINE OF CASES SHOULD BE APPROVED BY THIS COURT, AND THE DECISION OF THE SECOND DISTRICT COURT OF APPEAL SHOULD BE REVERSED.

II. THE TRIAL COURT COMMITTED REVERSIBLE ERROR IN ALLOWING REPEATED REFERENCES TO BE MADE TO THE PETITIONER'S PENDING WORKERS' COMPENSATION CLAIM AND LITIGATION.

Respondents prefer to restate the Issues as follows:

I. THE SECOND DISTRICT COURT OF APPEAL WAS EMINENTLY CORRECT IN REJECTING THE RATIONALE OF MOREY V. HARPER AND IN REFUSING TO INAPPROPRIATELY REMOVE THE ISSUE OF PERMANENT INJURY FROM THE PROVINCE OF THE JURY.

II. THE SUPREME COURT HAS NO JURISDICTION TO ADDRESS THE ISSUE OF THE TRIAL COURT'S DENIAL OF PETITIONER'S MOTION FOR NEW TRIAL REGARDING THE REFERENCE TO PETITIONER'S WORKERS' COMPENSATION CLAIM FOR AN INJURY OCCURRING ON DECEMBER 28, 1980.

SUMMARY OF ARGUMENT

The Second District Court of Appeal correctly determined that the issue of permanency at trial was an issue for the jury. The jury was fully advised of the basis for the experts' opinions and, as instructed, was given the right to accept or reject said opinions. Florida Standard Jury Instructions, 2.2(b)

The record is full of evidence showing that the basis for the experts' opinions was false. The evidence against Petitioner's claim in the case at bar was so convincing that the jury did not even reach the issue of permanency, as it found Petitioner sustained no injury.

This Supreme Court has ruled in Respondents' favor on this very issue in the case of Easkold v. Rhodes, 18 F.L.W. 134 (Fla. Mar. 4, 1993). This Court determined that the jury has a right to look at the basis of medical expert opinions and decide if it will reject or accept said opinions. Id. Easkold resolved the issues raised by Petitioner in this Appellate Proceeding and would seem to mandate a Per Curiam affirmance of the District Court's opinion.

Respondents know of no basis for the Supreme Court extending its jurisdiction to address the issue of the trial Court's denial of Petitioner's motion for new trial regarding the reference to Petitioner's Workers' Compensation claim for an injury occurring on December 28, 1990. Assuming, arguendo, the Court finds jurisdiction, Respondents would state that the reference to

Workers' Compensation was not admitted as a collateral source. In all of the relevant medical records and depositions, the reference to the 1980 Workers' Compensation incident was intertwined with references to the 1986 automobile accident. The Petitioner's testimony in the Workers' Compensation case was relevant and clearly impeached her, undermining her credibility.

ARGUMENT

I. THE SECOND DISTRICT COURT OF APPEAL WAS EMINENTLY CORRECT IN REJECTING THE RATIONALE OF MOREY V. HARPER AND IN REFUSING TO INAPPROPRIATELY REMOVE THE ISSUE OF PERMANENT INJURY FROM THE PROVINCE OF THE JURY.

The Second District Court of Appeal correctly determined that to follow Morey v. Harper, 541 So.2d 1285 (Fla. 1st DCA 1989), Rev. den. 551 So.2d 461 (Fla. 1989) would invade the province of the jury to properly weigh evidence and determine the credibility of witnesses. Easkold v. Rhodes, 18 F.L.W. 134 (Fla. Mar. 4, 1993); Shaw v. Poleo, 159 So.2d 641 (Fla. 1964).

At the conclusion of the trial, the jury was instructed on the law. Two of the jury instructions given were as follows:

> BELIEVABILITY OF WITNESSES
>
> General Considerations
>
> In determining the believability of any witness and the weight to be given the testimony of any witness, you may properly consider the demeanor of the witness while testifying; the frankness or lack of frankness of the witnesses; the intelligence of the witness; any interest the witness may have in the outcome of the case; the means and opportunity the witness had to know the facts about which the witness testified; the ability of the witness to remember the matters about which the witness testified; and the reasonableness of the testimony of the witness, considered in the light of all the evidence in the case and in light of your own experience and common sense.

Florida Standard Jury Instructions, 2.2(a).

> Expert witnesses
>
> You have heard opinion testimony from persons referred to as expert witnesses. You may accept such opinion testimony, reject it, or give it the weight you think it deserves, considering the knowledge, skill, experience, training, or education of the witness, the reasons given by the witness for the opinion expressed, and all the other evidence in the case.
>
> Florida Standard Jury Instructions 2.2(b). (emphasis added)

Petitioner would have this Court find that these instructions are not meant to apply to any case where a threshold issue is involved. Petitioner now seeks to have this Court retroactively restrict the expert opinion instruction, (2.2(b)), so that it applies to all experts except medical doctors rendering an opinion regarding permanency. Petitioner would have this Court negate the effect of these instructions; which is to put the issues into the hands of the jury.

The record is full of conflicting evidence and reasonable inferences on the issue of permanent injury from which the jury could have properly concluded that Petitioner did not sustain a permanent injury as a result of the accident in question; and therefore, the trial Court correctly denied Petitioner's motion for directed verdict. Powell v. Napolitano, 578 So.2d 747, 748 (Fla. 2nd DCA 1991); Easkold v. Rhodes, 18 F.L.W. 134 (Fla. Mar. 4, 1993) Respondents will not repeat all of the conflicting testimony, but would refer to their STATEMENT OF THE FACTS AND OF

THE CASE, which outlines some of the conflicting testimony heard by the jury.

Additionally, Petitioner would have this Court ignore the overwhelming evidence that all of the doctors' opinions, down to the decisions to perform surgery, both in 1984 and in 1986, were based upon Petitioner's complaints of pain and when those complaints started. What became abundantly clear at trial, both through the treating psychologists and physicians and Petitioner's own testimony, was that Petitioner had no credibility when it came to her complaints of pain or any other aspect of her case.

If this Court were to accept Petitioner's argument that a jury has no option but to blindly accept expert opinions (in direct conflict with Florida Standard Jury Instruction 2.2(b)) regardless of the overwhelming evidence of the falsity of the data or facts upon which such opinions are based, then the jury system would become virtually meaningless. While this would considerably shorten jury trials, it would do so at the expense of common sense, truth and justice!!

Even if the jury believed that Petitioner was having pain as a result of a herniated disc, what was the cause of the herniation? Was it the result of: (1) degeneration; (2) prior injury (1980) at the same level; (3) the January, 1985, incident when Petitioner felt searing pain on the left; (4) the April 30, 1986, automobile accident; (5) the May 16, 1986, slip in the

shower, or some other incident??

With such overwhelming evidence at trial, the jury did not even reach the issue of whether Petitioner had sustained a permanent injury within a reasonable degree of medical probability. The jury found that Petitioner sustained no injury as a result of the April 30, 1986, automobile accident. (R1-708, 709)

This Court, in the case of Easkold v. Rhodes, 18 F.L.W. 134 (Fla. Mar. 4, 1993), has decided the very issue in this Appellate Proceeding. In Rhodes v. Easkold, 588 So.2d 267, (Fla. 1st DCA, 1991), the First District Court of Appeal, relying on its poorly reasoned decision in Morey v. Harper, 541 So.2d 1285 (Fla. 1st DCA 1989, Rev. den. 551 So.2d 461 (Fla. 1989), reversed the lower Court's denial of a Motion for New Trial. Rhodes v. Easkold, 588 So. 2d at 268 The First District determined that the medical testimony regarding the Petitioner sustaining permanent injury as a result of the automobile accident was uncontroverted because no medical testimony was presented to the contrary and neither doctor testified that additional medical history would have changed his opinion. Id.

This Court found such reasoning to be flawed and contrary to Florida Standard Jury Instruction 2.2(b) which instructs the jury as to the believability of expert witnesses. Florida Standard Jury Instruction 2.2(b) is based upon Shaw v Poleo, 159 So.2d 641 (Fla. 1964) wherein this Court recognized the jury's right to

accept or reject testimony of medical experts just as it may that of any other expert. Id. at 664. Although there are many other valid arguments that could be presented against the "rationale" of the First District Court of Appeal in Morey, 541 So.2d 1285 (Fla. 1st DCA 1989), Rev. den. 551 So.2d 461 (Fla. 1989), such as the Court's apparent confusion over which party has the burden of proof regarding permanency threshold issues, this Court's decision in Easkold, 18 F.L.W. 134 (Fla. Mar. 4, 1993), renders any such argument unnecessary.

II. THE SUPREME COURT HAS NO JURISDICTION TO ADDRESS THE ISSUE OF THE TRIAL COURT'S DENIAL OF PETITIONER'S MOTION FOR NEW TRIAL REGARDING THE REFERENCE TO PETITIONER'S WORKERS' COMPENSATION CLAIM FOR AN INJURY OCCURRING ON DECEMBER 28, 1980.

Petitioner attempts to raise the issue of the trial Court's denial of Petitioner's Motion for New Trial regarding the reference to Petitioner's Workers' Compensation claim for an injury occurring on December 28, 1980. However, Respondents know of no basis for this Court to extend jurisdiction to address this issue and merely ask that the Court deny jurisdiction on this issue.

Assuming, arguendo, the Court determines that they have jurisdiction, Petitioners would offer the following analysis. The trial Court correctly denied Petitioner's Motion for New Trial on this issue. The collateral source doctrine, which prohibits the mention of collateral sources at trial, and

the causes cited to by Petitioner in her Initial Brief, do not apply in this case. The applicable Florida Statute that pertains to automobile accident cases allows, and in fact requires, that the amount of collateral sources be admitted into trial. Florida Statute Sec.627.7372 (1985). In fact, since the 1986 Tort Reform Act, collateral sources are now admissible in non-automotive cases. Florida Statute Sec.768.79 (1987)

Be that as it may, Respondents agree that Workers' Compensation is not a collateral source and never contended otherwise. Workers' Compensation is prohibited from being mentioned in a trial where the benefits are being paid for the incident upon which the case is based. The Workers' Compensation injury mentioned in the case at bar was in 1980; whereas, the accident being sued upon occurred in 1986. Respondents know of no cases addressing the issue of the admissibility of Workers' Compensation reference under these facts.

The fact that Petitioner had been involved in a Workers' Compensation case, and was still so involved at the time of trial, was not brought before the jury as a potential collateral source, nor as an attempt to show Petitioner as being litigious. In the deposition testimony and medical records, the Workers' Compensation case, described as such in said records, and the 1986 automobile accident, were so intertwined so as to make it an unreasonable burden to remove all references to the prior injury being a Workers' Compensation case.

Additionally, as the record so vividly shows, the reference to the Workers' Compensation case was necessary to show the jury all of contradictory and damning testimony that obliterated Petitioner's credibility. To cite just one example - Petitioner agreed, at trial, that the following testimony elicited from Petitioner on February 23, 1987, in her Workers' Compensation case, was true:

> Question: So let me make sure I understand your testimony to date. If it be necessary for you to testify in circuit Court as a result of your automobile accident case, your testimony would be that your disability today is as a result of your worker's compensation injury and not your auto injury?
> Answer: Yeah, I would say that...

CONCLUSION

For the reasons set forth above, and in line with this Court's decision in Easkold, 18 F.L.W. 134 (Fla. Mar. 4, 1993), the undersigned attorney for Respondents would respectfully request a Per Curiam affirmance.

Respectfully submitted this 12th day of March, A.D., 1993.

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CERTIFICATE OF SERVICE

I DO HEREBY CERTIFY that a true copy of the foregoing has been furnished to MARK A. NEUMAIER, ESQUIRE, Attorney for Petitioner, Post Office Box 8623, Tampa, Florida 33674, 33963, and MARK YESLOW, Esquire, Co-Counsel for Respondents CHESTER MEREDITH, P. O. Box 9226, Ft. Myers, Florida 33902, by U.S. Mail, this 12th day of March, A.D., 1993.

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