IN THE COURT OF APPEALS OF THE
STATE OF OREGON

Kazuko Arai GARDNER,
Personal Representative of
the Estate of Jacqueline S. Mahoney,
Plaintiff-Appellant,

v.

OREGON HEALTH SCIENCES UNIVERSITY,
a public corporation;
Marvin D. Fickle, M.D., an individual;
and Jennifer Shay, an individual,
Defendants-Respondents.

Multnomah County Circuit Court
15CV02134; A165903

Judith H. Matarazzo, Judge.

Argued and submitted March 15, 2019.

Gregory Kafoury argued the cause for appellant. Also on the briefs were Mark McDougal and Kafoury & McDougal.

Janet M. Schroer argued the cause for respondents Oregon Health Sciences University and Marvin D. Fickle, M.D. Also on the brief was Hart Wagner, LLP.

Jay W. Beattie argued the cause for respondent Jennifer Shay. Also on the brief were Thomas McDermott, Katie Eichner, and Lindsay Hart, LLP.

Before Lagesen, Presiding Judge, and DeVore, Judge, and Sercombe, Senior Judge.

DeVORE, J.

Affirmed.

DeVORE, J.

After the decedent's suicide, plaintiff, the personal representative of the estate, brought this wrongful death action against the decedent's mental-health providers. Plaintiff now appeals a general judgment of dismissal and award of costs, assigning error to the trial court's decision to deny a motion *in limine* and to allow consideration of the decedent's comparative fault. Plaintiff also assigns error to the denial of a motion for a new trial. With respect to the first assignment of error, we conclude that Oregon has no *per se* rule against comparative fault in cases involving outpatient suicide. Plaintiff's second assignment of error presents no reversible error. Accordingly, we affirm.

The relevant facts are not disputed. The decedent was receiving mental-health treatment from defendants, a psychiatrist and a licensed clinical social worker, at Oregon Health & Science University (OHSU). After the decedent took her life by firearm, her estate brought this wrongful death action, asserting that defendants knew she had purchased a gun and had expressed the intent to commit suicide, but negligently failed to take a number of preventative steps. Specifically, the complaint alleged that defendants failed to adequately obtain and consider the decedent's history, ensure removal of the gun from her possession, hospitalize her, or develop and implement a safety plan.

Defendants raised the affirmative defense of comparative fault, arguing that the decedent's death resulted from her own actions, including: denying and withholding the true nature and extent of her suicidality and suicide plans; declining voluntary commitment to a mental treatment facility or intensive outpatient therapeutic unit; denying that she would use the gun to commit suicide; refusing to notify her mother about the gun or consent to notification; and failing to return the gun or give it to her mother. In a motion *in limine*, plaintiff moved to exclude any reference to that defense, arguing that, as a matter of law, "contributory negligence does not apply in suicide cases," and asserting that similar reasoning applied to comparative fault. The court denied that motion.

At trial, plaintiff called an expert witness who testified to OHSU's negligence. In closing argument, defense counsel made disparaging comments about that plaintiff's witness:

> "[DEFENSE COUNSEL]: The law is very clear in this state. I don't care what [plaintiff's witness] says, you can't just go be a cowboy. One of the reasons he probably isn't at OHSU anymore.
>
> "[PLAINTIFF'S COUNSEL]: Objection, Your Honor.
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> "THE COURT: Sustained.
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> "[DEFENSE COUNSEL]: The law in this state is very clear. ***
>
> "And the criteria is defined by the Oregon Health Division to mean imminently dangerous. *** That doesn't mean you get to hold them against their will indefinitely, any time you want to act like a cowboy and put them in an institution. Doctors don't get to do that to us because we have legal rights."

Plaintiff raised no further objection, but later responded to defense counsel's statements during rebuttal:

> "[PLAINTIFF'S COUNSEL]: So what's the attack on [plaintiff's witness]? That's why he was doing this, he's a cowboy. That's probably why he's not at OHSU. You represent OHSU. If you have any evidence of why he's not there or you've got dirt against him, you've been a lawyer for a long, long time. You know how—
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> "[DEFENSE COUNSEL]: Your Honor, I could have brought the evidence in.
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> "THE COURT: [Plaintiff's counsel], move on."

As instructed, plaintiff proceeded to make other arguments.

The case was submitted to the jury, including the issue of comparative fault. The jury returned a verdict assigning 42 percent of the responsibility to defendants and 58 percent to the decedent. As a result, the court entered a general judgment of dismissal and award of costs in favor of defendants.

Subsequently, plaintiff moved for a new trial. Plaintiff based the motion, in relevant part, upon "the misconduct of the defense counsel," who, plaintiff argued, "poisoned the proceedings" by suggesting that plaintiff's witness "was forced out of his position" due to "disreputable" conduct. The trial court entered an order denying that motion. Plaintiff appealed the general judgment of dismissal and the order denying a new trial.

On appeal, plaintiff first assigns error to the trial court's decision permitting defendants to assert comparative fault. As a matter of law, plaintiff argues, mental-health providers cannot assert that defense when the decedent commits suicide, the very thing those defendants have a duty to prevent. Plaintiff contends that the decedent's failure to seek help or follow professional advice was "precisely the behavior to be expected from people with [her] condition," and that suicide "was the ultimate symptom of her underlying mental illnesses." Plaintiff claims, "It makes little sense to argue, as defendants do, that [the decedent] bears fault for acting in conformity with her illnesses."

Defendants argue that Oregon has no *per se* rule regarding the availability of comparative fault defenses in cases involving suicide or outpatient treatment, and that the proper approach, adopted by the majority of jurisdictions, looks to the "uniquely tragic facts" of the case to determine whether such a defense is appropriate. Defendants conclude that cases involving suicide are "simply a variety of malpractice cases *** subject to the same rules as other malpractices cases," and, therefore, the defenses available, including under ORS 31.600, depend on the facts and evidence of the particular case. Defendants argue that they properly invoked the defense here, where the decedent failed to "be candid" or to "cooperate with" defendants during treatment.

The question before us, then, is whether the trial court erred in allowing defendants to plead and prove comparative fault.[1] We approach this question in two steps. First,

[1] Plaintiff only objected to the defense pretrial, at the pleading phase. The parties agree that this case presents no question as to whether the record supported a jury instruction or a jury verdict on the issue. As plaintiff acknowledges, "The availability of the defense of comparative fault is the sole legal question at issue in plaintiff's first assignment of error."

we must determine whether, as a matter of law, Oregon's comparative fault statute provides a special exception for actions against mental-health providers arising from an outpatient's suicide. That presents a question of statutory construction, requiring us to examine the statute's text in context, including related case law. *State v. Gaines*, 346 Or 160, 171-73, 206 P3d 1042 (2009) (outlining the methodology). Second, if the statute provides no special exception, we will assess whether the defense was appropriate in this particular case. In this analysis, we review the trial court's decision for legal error. In doing so, we assume the truth of the facts alleged and draw inferences in favor of the nonmoving party. *Son v. Ashland Community Healthcare Services*, 239 Or App 495, 508, 244 P3d 835 (2010), *rev den*, 350 Or 297 (2011) (citing *Doyle v. Oregon Bank*, 94 Or App 230, 232, 764 P2d 1379 (1988), *rev den*, 307 Or 571 (1989)) (reviewing the trial court's motion to strike for failure to state a defense).

We first consider whether the legislature intended to provide an exception in ORS 31.600 for comparative fault involving suicide. We conclude that it did not. To determine the legislature's intent, we begin with the statute. *Gaines*, 346 Or at 171-73. Oregon's statute on contributory and comparative negligence allows the factfinder to compare a plaintiff's fault with that of the tortfeasor and to award damages accordingly. ORS 31.600. The law provides, in relevant part,

> "(2) The trier of fact shall compare the fault of the claimant with the fault of any party against whom recovery is sought, the fault of third party defendants who are liable in tort to the claimant, and the fault of any person with whom the claimant has settled. *** Except for persons who have settled with the claimant, there shall be no comparison of fault with any person:
>
> "(a) Who is immune from liability to the claimant;
>
> "(b) Who is not subject to the jurisdiction of the court; or
>
> "(c) Who is not subject to action because the claim is barred by a statute of limitation or statute of ultimate repose."

ORS 31.600. Examining the statute's plain text, we see that it expressly allows for consideration of a claimant's relative fault. It specifies certain exceptions, none of which involve circumstances related to mental-health treatment or suicide. Given what is written, the text itself offers no support for the special exception that plaintiff puts forth, and we are not at liberty to insert such language ourselves. ORS 174.010 ("In the construction of a statute, the office of a judge is simply to ascertain and declare what is, in terms or in substance, contained therein, not to insert what has been omitted or to omit what has been inserted[.]").

Nothing in the larger context of the statute suggests a legislative intent to exempt suicidal patients from comparative fault. The legislature would have been aware that existing law generally allowed medical professionals to assert patient fault as a defense. *See Montara Owners Assn. v. La Noue Development, LLC*, 357 Or 333, 341, 353 P3d 563 (2015) (citing *Blachana, LLC v. Bureau of Labor and Industries*, 354 Or 676, 691, 318 P3d 735 (2014)) ("The context for interpreting a statute's text includes the pre-existing common law, and we presume that the legislature was aware of that existing law."); *Wemmett v. Mount*, 134 Or 305, 316, 292 P 93 (1930) (a patient's contributory negligence could affect recovery in the medical malpractice claim against her physician); *Beadle v. Paine*, 46 Or 424, 431, 80 P 903 (1905) ("It is a good defense in an action for malpractice *** that the patient was negligent at the time[.]"). We also recognized liability for mentally ill individuals. *See Schumann v. Crofoot*, 43 Or App 53, 55, 602 P2d 298 (1979) (adopting the rule from the *Restatement (Second) of Torts* section 283B (1965) that, "[u]nless the actor is a child, his insanity or other mental deficiency does not relieve the actor from liability for conduct which does not conform to the standard of a reasonable man under like circumstances"). Our limited case law suggests that, to the extent that the legislature contemplated liability for patients or individuals with mental-health issues, it did so with approval.

Plaintiff provides little support for the proposed categorical rule. The main case upon which plaintiff relies is unhelpful, as it was predicated on a legal theory regarding

duty that is inapplicable. That case, *Cole v. Multnomah County*, involved a negligence claim against jail officials. We concluded that the inmate could not be contributorily negligent for his attempted suicide because the "acts which [the inmate's] mental illness allegedly caused him to commit were the very acts which defendants had a duty to prevent." 39 Or App 211, 214, 592 P2d 221, *rev den*, 286 Or 449 (1979) (citing *Vistica v. Presbyterian Hosp. & Med. Ctr. of San Francisco, Inc.*, 67 Cal 2d 465, 432 P2d 193 (1967); *Hunt v. King Cty.*, 4 Wash App 14, 481 P2d 593, *rev den*, 79 Wash 2d 1001 (1971)). Although we elaborated little in *Cole*, the cases upon which we relied, *Hunt* and *Vistica*, show that our reasoning was based on a common-law understanding of duty that, in a jail or similar setting, custodians assume the duty of self-care for individuals under their exclusive control. An inmate cannot be liable for breaching a duty of which he was absolved.[2] This understanding is prevalent.[3]

Assuming *Cole* was good law at the time of the statute's enactment, it nevertheless provides little support for the proposition that the legislature intended to preclude consideration of comparative fault in cases of outpatient

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[2] As the Washington Court of Appeals explained in *Hunt*,

> "the hospital's duty to safeguard its patient under its exclusive control in a closed psychiatric ward, against the reasonably foreseeable risk of self-inflicted injuries *** contemplates the reasonably foreseeable occurrence of self-inflicted injury whether or not the occurrence is the product of the injured person's volitional or negligent act. In principle, as between the actor and the injured party, the necessary effect of such a duty undertaken or imposed during its operative period may be said to absolve the injured party from the performance of his otherwise existing duty to take reasonable care to avoid self-injury. He is not called upon to perform the duty of the actor. The injured party being absolved from the duty of self-care, the question of the injured party's conduct, whether or not volitional or whether or not otherwise constituting contributory negligence, does not arise. In the absence of a duty breached, the question of whether the injured party's conduct is a proximate cause becomes irrelevant."

4 Wash App at 22, 481 P2d at 598 (citations omitted).

[3] That understanding is common in custodial settings. *See, e.g.*, *P.W. v. Children's Hosp. Colorado*, 364 P3d 891, 896 (Colo 2016) (hospital assumed an affirmative duty of care, which subsumed the patient's own duty of self-care, when it admitted patient into its psychiatric ward, and therefore that patient could not be found comparatively negligent for his suicide attempt); *Sandborg v. Blue Earth Cty.*, 615 NW2d 61, 64 (Minn 2000) (in the "exceptional circumstance" of the jailer-detainee relationship, duty to protect against a known possibility of self-inflicted harm transfers entirely to the jailer, and so it is inappropriate to compare the fault of the detainee).

suicide.[4] *Cole* applied to the specific context of a custodial setting and where the act of comparative negligence was the suicide itself. Significantly, in those situations, the individual is under the exclusive control of the custodian and relinquishes the power—and responsibility—to manage self-care. An outpatient who is negligent in facilitating treatment is in a fundamentally different situation. Even if the legislature contemplated *Cole*, the case provides no support for a statutory exception that would extend to the facts at hand.

In sum, nothing in the text or context of ORS 31.600 suggests a legislative intention to except cases involving outpatient suicide from comparative fault. The statute's text explicitly permits consideration of a claimant's relative fault, and it contains no exception like that which plaintiff proposes. Nothing in our case law suggests that the legislature would have intended to eliminate the defense, and plaintiff offers no relevant authority for that proposition. Accordingly, we conclude that there is no *per se* rule against comparative fault in cases involving outpatient suicide.

Having concluded that ORS 31.600 generally permits consideration of comparative fault in cases involving suicide, the question remains as to whether it was proper in this case specifically. Because defendants alleged that the decedent engaged in conduct that undermined the treatment at issue in plaintiff's malpractice claim, we conclude that defendants asserted a viable comparative fault defense.

We have said that, to assess a plaintiff's comparative fault, "general common-law negligence principles apply." *Son*, 239 Or App at 507. The negligence standard is whether the plaintiff "took some action or failed to take some action which a reasonable person could have foreseen would

[4] Oregon significantly changed how it conceptualized negligence in the time that elapsed between *Cole* and the comparative fault statute's enactment. *See* Or Laws 1995, ch 696, § 3 (amending *former* ORS 18.470 (1971), *renumbered as* ORS 31.600 (2003)). Notably, the Oregon Supreme Court "abandoned the traditional notion of 'proximate cause,' as well as the concept of common-law duty in the absence of a special relationship." *Son*, 239 Or App at 506 (citing *Fazzolari v. Portland School Dist. No. 1J*, 303 Or 1, 17, 734 P2d 1326 (1987)); *see also Towe v. Sacagawea, Inc.*, 357 Or 74, 86-87, 347 P3d 766 (2015) (discussing *Fazzolari*). For the present purposes, we need not reexamine *Cole*. Even based on the case's reasoning, it provides no support for plaintiff's proposed *per se* rule.

increase the risk of harm to the plaintiff, and that the plaintiff did indeed suffer harm of the type which could have been foreseen." *Id.* (quoting *Dahl v. BMW*, 304 Or 558, 563, 748 P2d 77 (1987)).

For a medical malpractice claim, "findings of comparative fault can be based on the plaintiff's failure to take reasonable measures which might have prevented or reduced the injury caused by the defendant's negligence." *Id.* at 509 (quoting *Becker v. Port Dock Four, Inc.*, 90 Or App 384, 390, 752 P2d 1235 (1988)) (emphasis omitted). The jury is concerned with the degree to which the patient's negligence accounts for harm otherwise attributed to the medical professional. Thus, a plaintiff's negligent conduct can form the basis of such a defense when it relates and contributes to the negligent treatment at issue in the malpractice claim. *Id.* at 509. "[T]he focus is therefore on the injury caused by the malpractice (*i.e.*, the harm caused by the doctor's failure to meet the standard of care used in the reasonable practice of the profession in the community), not the original injury that necessitated treatment." *Id.*

A medical malpractice claim looks to the harm arising from the negligent medical treatment, and, as a consequence, the underlying health issue precipitating that treatment cannot serve as a predicate for liability of the medical professional or, comparatively, the patient. Accordingly, Oregon law is consistent with the majority of other jurisdictions in that "a physician simply may not avoid liability for negligent treatment by asserting that the patient's injuries were originally caused by the patient's own negligence." *Id.* at 510 (citing *Fritts v. McKinne*, 934 P2d 371, 374 (Okla Civ App 1996)). "[A]s a matter of law, conduct that merely creates the need for medical treatment cannot cause the type of harm at issue in medical malpractice cases—the injury resulting from the malpractice." *Id.*

We explained this distinction in *Son*. In that case, the decedent, who ingested an unknown quantity of pills, died hours after arriving to the emergency room. *Id.* at 498-99. The decedent's estate filed a wrongful death action against the hospital and attending physicians, alleging that they failed to (1) perform an adequate assessment, (2) make

or follow an appropriate treatment plan, or (3) transfer the decedent to another hospital. *Id.* at 499. The defendants raised the affirmative defense of comparative fault, alleging, in relevant part, that the decedent caused or contributed to her death by consuming the substances. *Id.* The trial court granted a motion by the plaintiff to strike that defense, and the jury returned a verdict for the plaintiff. *Id.* at 500-01.

On appeal, the defendants argued that the court improperly struck their defense that the decedent was comparatively at fault for consuming the substances that caused her medical condition and death. *Id.* at 502. We disagreed that the "type of conduct alleged" could "support a comparative fault defense," reasoning,

> "[G]iven that the focus in medical malpractice claims is on the negligent acts or omissions of the medical provider, it is inappropriate to use the patient's negligence that led to the condition that required medical attention to excuse the defendants' failure to meet the accepted standard of care. A patient who negligently injures himself is nevertheless entitled to subsequent nonnegligent medical treatment, and, if it is not provided, the patient is entitled to recover damages for the consequences of that negligence."

Id. at 508-09 (citation omitted). The defendants could not invoke the decedent's consumption of substances as a defense for their malpractice, because that was the event that created the need for her medical care in the first instance. *Id.* at 512.[5]

Conversely, we noted that a plaintiff's negligent conduct can form the basis of a comparative-fault defense when it relates and contributes to the negligent treatment at issue in the malpractice claim. *Id.* We recognized examples of such conduct, including (1) failing to follow medical instructions, (2) refusing or neglecting prescribed treatment,

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[5] The defendants in *Son* successfully raised the affirmative defense of comparative fault with respect to the decedent having failed to accurately tell her family, the nurses, or the physicians what substances she had consumed, how much, or when. *Id.* at 499. The plaintiff moved for directed verdict on that defense, and the trial court denied that motion. *Id.* at 501. On appeal, the plaintiff asserted evidentiary arguments, but did not challenge the defense as a matter of law. *Id.* at 501-02, 502 n 2. As a result, our inquiry focused on the extent to which the record supported that defense.

or (3) intentionally giving erroneous, incomplete, or misleading information which is the basis for medical care or treatment. *Id.* at 511.[6]

In the case at hand, defendants allege facts that can constitute a legally viable comparative-fault defense. Notably, they predicate the defense on the decedent's conduct relating and contributing to the injury associated with the *malpractice*, citing acts or omissions that undermined the treatment itself. Defendants assert that the decedent provided incomplete or inaccurate information by denying and withholding the true nature and extent of her suicidality and her suicidal plans. Defendants also allege that the decedent failed to follow their advice and prescribed treatment in declining voluntary commitment to an inpatient mental treatment facility or intensive outpatient therapeutic unit, refusing to permit the psychiatrist to notify her mother about the gun, and failing to return the gun or give it to her mother.

Unlike in *Son*, defendants here do not base their comparative-fault defense on the decedent's conduct that created the initial need for treatment. They do not, as plaintiff suggests, blame the decedent's underlying depression or its symptom, suicide.[7] Rather, their complaint focuses on

[6] For further illustrations of such conduct, see *Restatement (Third) of Torts* § 7 comment m (2000) (noting courts will take into account a patient's negligence in failing to cooperate with treatment); *Jensen v. Archbishop Bergan Mercy Hosp.*, 236 Neb 1, 10, 459 NW2d 178, 184 (1990) (discussing examples of bases for a patient's relative negligence articulated above); *Martineau v. Nelson*, 311 Minn 92, 102, 247 NW2d 409, 415 (1976) (same); *Brown v. Dibbell*, 227 Wis 2d 28, 49, 595 NW2d 358, 369 (1999) (incomplete and inaccurate information provided to doctors); *Carreker v. Harper*, 196 Ga App 658, 659, 396 SE2d 587, 588 (1990), *cert den* (1991) (failure to disclose relevant medical information and to seek additional medical care when condition worsened); *Fall v. White*, 449 NE2d 628, 633-34 (Ind App 1983) (failure to follow the physician's instructions and to provide medical information); *Jamas v. Krpan*, 116 Ariz 216, 218, 568 P2d 1114, 1116, *reh'g den* (1977) (failure to follow advice and to reveal medical history to physicians); *Rochester v. Katalan*, 320 A2d 704, 707-08 (Del 1974) (considering patient's misrepresentations, omissions, and requests to hospital staff); *Mackey v. Greenview Hosp., Inc.*, 587 SW2d 249, 255 (Ky Ct App 1979) (failure to provide truthful medical history).

[7] In earlier versions of defendants' answers to plaintiff's amended complaint, they did cite the decedent's decision to "unexpectedly commit suicide" or "take her own life" as negligent acts. In deciding plaintiff's motion *in limine*, the trial court determined that defendants could not allege those acts in the affirmative defense. Thus, the amended answers omitted reference to plaintiff's suicide itself.

the ways in which the decedent engaged with mental-health professionals and treatment, and her failure to take reasonable measures—providing accurate information, agreeing to recommended interventions, disposing of the gun, consenting to family notification—that may have prevented or reduced the likelihood that the negligent care would result in death.

Plaintiff argues that assigning fault to the decedent's conduct here is effectively the same as blaming the decedent for her mental illness, the condition necessitating treatment, because the alleged conduct and the mental illness are inseparable. As noted, our case law is not so categorical and, instead, permits consideration of negligent interference with treatment as a matter of comparative fault.[8] The ultimate determination is a question of fact for the jury, depending on the evidence in any given case.

Further, most jurisdictions permit mental-health providers to allege comparative fault in cases involving outpatient suicide. *See, e.g.*, *Mulhern v. Catholic Health Initiatives*, 799 NW2d 104, 117 (Iowa 2011) (concluding that mental-health professionals in a medical malpractice action could raise a comparative fault defense based on a noncustodial patient's act of suicide); *Sheron v. Lutheran Med. Ctr.*, 18 P3d 796, 801 (Colo App 2000), *cert dismissed* (2001) ("[W]e hold that a patient who is treated by health care providers for suicidal ideations, and who later commits suicide, may be found comparatively negligent or at fault[.]"); *Brandvain v. Ridgeview Institute, Inc.*, 188 Ga App 106, 372 SE2d 265, 275, 118 (1988), *aff'd*, 259 Ga 376, 382 SE2d 597 (1989) (holding comparative fault of suicidal patient was a question for the jury); *Hobart v. Shin*, 185 Ill 2d 283, 290, 705 NE2d 907, 911 (1998), *reh'g den* (1999) (finding "the better-reasoned approach" is to allow the defense of contributory negligence when mental incapacity is unchallenged or

[8] Insofar as plaintiff suggests that *Son* stood for that proposition, we disagree. As discussed, *Son* addressed what conduct can form the basis of a comparative-fault defense in medical malpractice cases. We concluded that the defendants could not predicate their defense on the decedent's ingestion of pills, as that was the very issue that created the need for medical treatment in the first place. We did not base our conclusion on some inference that the decedent may have been attempting suicide.

a question of fact); *Maunz v. Perales*, 276 Kan 313, 326-27, 76 P3d 1027, 1035 (2003) (holding trial court correctly submitted the comparative negligence to the jury in a malpractice action arising from the patient's suicide several days after discharge from the hospital); *Champagne v. United States*, 513 NW2d 75, 79 (ND 1994) ("Comparison of fault between a suicide victim and a defendant, who has a duty of medical care toward that victim, is generally for the trier of fact.").

In sum, we agree with defendants and other jurisdictions that "[e]ach case turns on its uniquely tragic facts," *Mulhern*, 799 NW2d at 107, and that the comparative fault of a mentally ill or suicidal outpatient is a question of fact for the jury. This approach corresponds with statute and case law, and it allows for consideration of the distinctive mental-health issues, symptoms, and conduct in a given case. Here, defendants raised an appropriate comparative-fault defense for a medical malpractice action, predicated on conduct that contributed to the injury and hampered the treatment itself, and they did not fault decedent for the underlying illness. For those reasons, we conclude that the trial court did not err in allowing the jury to consider the defense by denying plaintiff's motion *in limine*.

In a second assignment of error, plaintiff challenges the trial court's denial of the motion for a new trial. Plaintiff argues that defense counsel's disparaging remarks, and his assertion that he had evidence to prove them, were "extremely inappropriate, deliberate, and constituted misconduct extremely prejudicial to plaintiff."

As we have previously stated,

> "It is well established that, when an irregularity occurs during trial and is known to a party but the party fails to call it to the trial court's attention, the party thereby waives any objection, and the denial of a later motion for a new trial on that ground generally is not reviewable."

State v. Carrasco-Montiel, 279 Or App 64, 79, 379 P3d 529, *rev den*, 360 Or 568 (2016) (citing *State v. Sundberg*, 233 Or App 77, 87, 225 P3d 89 (2009), *rev'd on other grounds*, 349 Or 608, 247 P3d 1213 (2011)) (internal quotation marks and brackets omitted). Our precedents have made clear that "the

law does not permit defendant to wait and gamble on the outcome of the case and then raise the question if the results were adverse." *Id.* at 82 (quoting *Transamerica Title Ins. v. Millar*, 258 Or 258, 263, 482 P2d 163 (1971)). Rather, "it is incumbent on a party to make a proper objection during trial and to assign error to the ruling on that objection." *Sansone v. Garvey, Schubert & Barer*, 188 Or App 206, 227, 71 P3d 124, *rev den*, 336 Or 16 (2003). "[T]he defining criterion for reviewability has been whether the basis for the motion was known to the appellant before the verdict was rendered." *Carrasco-Montiel*, 279 Or App at 81-82.

Here, plaintiff takes issue with multiple statements by defense counsel, only one of which provides grounds for review; two are not reviewable. First, defense counsel insinuated that plaintiff's witness no longer worked with OHSU because he was "be[ing] a cowboy." Second, defense counsel referenced that earlier statement, saying that a doctor cannot legally "act like a cowboy," holding individuals "against their will indefinitely." Third, when plaintiff's counsel later alluded to those remarks, defense counsel responded that he "could have brought the evidence in" as support.

With respect to the first statement, the trial court *sustained* plaintiff's objection, defense counsel complied with that ruling, and no further remedy was requested. Although the issue was preserved, there is no error to be corrected on appeal. As for the other statements, plaintiff failed to raise any objection or otherwise bring the purported issues to the trial court's attention. Plaintiff was aware of the ostensible irregularity before the verdict was rendered, and the lack of objection distinguishes this case from the one upon which plaintiff relies.[9] For those reasons, plaintiff's second assignment of error presents no reversible error.

[9] In *Cler v. Providence Health System-Oregon*, neither the Supreme Court nor the Court of Appeals reviewed the trial court's denial of a motion for a new trial. Rather, both appellate courts considered arguments around the trial court's ruling on the plaintiffs' earlier objections during trial. *See* 349 Or 481, 485 n 4, 487, 245 P3d 642 (2010) (noting that the plaintiffs assigned error to the trial court's rulings on their objections, and that those objections adequately preserved the argument on appeal); 222 Or App 183, 189, 192 P3d 838 (2008), *rev'd on other grounds*, 349 Or 481, 245 P3d 642 (2010) (noting that the "denial of a motion for a new trial based on the trial court's earlier rulings is not reviewable on appeal" and confining review to the trial court's rulings on the plaintiffs' objections).

In conclusion, we hold that Oregon has no *per se* rule against comparative fault in cases involving outpatient suicide. Rather, that defense turns on the unique facts of the case and the findings of the jury. The trial court did not err in denying plaintiff's motion *in limine*, and plaintiff's second assignment of error is nonreviewable.

Affirmed.