No. 45834-9-II

COURT OF APPEALS
DIVISION II
STATE OF WASHINGTON

FAIRUZA M. STEVENSON

Plaintiff / Appellant
v.

STATE OF WASHINGTON, DEPARTMENT OF HEALTH,
NURSING CARE QUALITY ASSURANCE COMMISSION,

Defendant / Respondent

OPENING BRIEF FOR APPELLANT STEVENSON

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1. Introduction

This request for Review involves a rather narrow set of facts and only a few issues concerning Assignments of Error.

Appellant is a registered nurse in the State of Washington with a four-year nursing degree and some work towards her Masters. In addition to a significant nursing career in traditional nursing work such as hospitals and clinics, she now operates a specialized Adult Family Home (AFH) dealing with patients/residents who must be cared for on ventilators. She has roughly twenty (20) years in over-all nursing experience in the United States and a significant history of nursing and care in her home country of Romania.

One of her residents was sent to Legacy Hospital because of complaints of abdominal pain and fever. She was hospitalized on November 16, 2007 and discharged on November 24, 2007. When she arrived back at the AFH Appellant noticed there was an additional medication which was not contained in the resident's medical log at the AFH. This addition immediately caught the eye of Appellant in that she had personal knowledge of a bleeding

problem with the patient prior to her admission in November. Appellant knew the resident while on Coumadin had a serious eye bleed, and the new prescription was for an injectable blood thinner known as Enoxaprin, also known as Lovenox, which Appellant knew as a professional nurse, was a much stronger blood thinner than Coumadin. She had an immediate concern that an injection of this drug into the resident could cause bleeding and a significant risk of harm to the resident.

The resident arrived at the AFH on Saturday, November 25, 2007 and the caregivers in the home knew the primary care physician normally was not available on Saturdays and Sundays but as the record will show, attempts were made to contact the primary. Unfortunately attempts during the following week for a few days were also made and the primary frankly did not respond as he should have (later the primary care doctor was changed).

Appellant, by then in a quandary as what to do, started injections on December 3, 2007. Almost immediately Appellant received a fax from the doctor to discontinue the Enoxaprin, which she did.

Both DSHS and the Department of Health (DOH) issued deficiency notices that the delay in giving the new prescription posed a risk to the resident's health and both agencies imposed discipline which now results in the Appellant having a notation on her permanent record of unprofessional conduct which she feels would certainly hinder her nursing career should she choose to return to a hospital or clinic setting.

It should also be mentioned the hospital physician who ordered the new additional drug admitted she had not reviewed the patient's record and was not aware of at least two previous issues concerning bleeding in this patient. One was a chart note from an Ophthalmologist that noted continued bleeding in the resident's eye in September of 2007 and another in chart notes from Legacy during a prior admission of the same resident. As a result of those observations by other professionals Coumadin had been discontinued for this resident.

The Department's only witness argued it was her personal choice and hospital protocol to order a 30-day course of the drug in question whenever she had knowledge a patient was not ambulatory, explaining it was to prevent blood clots. The record will

indicate the resident was not sent to the hospital because of blood clotting, and had no history of clotting, which Appellant was aware of but the Legacy doctor was not. Finally it should be added the resident lived until January of 2009 without the benefit of Coumadin or Enoxaprin and showed no history of blood clotting during the remainder of her life.

II. Assignments of Error

a. It was error for the Superior Court Trial Judge to enter an Order Affirming the Commission's Final Order as there was insufficient evidence submitted to support the Commission's Findings and concluding the Burden of Proof being Proof by a Preponderance of the Evidence was met.

b. DOH should have been precluded from bringing a subsequent action against Appellant based on identical issues of fact and law which Appellant had previously resolved with DSHS under a Stipulation and Settlement Agreement involving identical issues and subject matter

and therefore the DSHS and Appellant's Agreement was Res Judicata and not subject to Collateral attack by DOH with imposition of further sanctions and fines.

c. The formal agreement with DSHS involved an allegation of a Statutory violation by Appellant and the Settlement Agreement entered into between DSHS and Appellant amount to a Stipulation regarding all issues in this case and the subject manner was identical to the DOH charges and therefore was protected as a Binding Stipulation under CR2A.

d. The Findings of Fact and Conclusions and Order were not supported by sufficient evidence.

III. Issues Pertaining to Assignments of Error

a. Regarding the issue of whether DOH met its standard of its burden of proof, the primary issues from which this court should find there was a failure of proof are that the Department presented no evidence via lay testimony or expert opinion that Appellant's conduct under any

circumstances fell below any standard of care for a registered nurse in the State of Washington. They relied on certain statutory and WAC sections to try and raise the inference that withholding medication under the facts of the case raised the inference there was a risk the patient may be harmed and Appellant willfully or repeatedly failed to administer medications and / or treatments in accordance with nursing standards and this was a violation of nursing conduct or practice. When the court considers the full extent of the sections relied on by the Department, it should be clear that Appellants conduct under the circumstances did not constitute unacceptable nursing conduct, practice or unprofessional conduct. More importantly, the Department failed to present any testimonial evidence that Appellant's conduct fell below any standard of care, instead arguing they need not abide by common law standards such as proof by preponderance of the evidence but rather contended the Board itself can set the standard of proof.

b. On the issues of Res Judicata and Collateral Estoppel, Appellant's issues are that the Settlement Agreement entered into with DSHS about 2 years before the DOH action was a full and comprehensive settlement of all claims the State had from the conduct in question. The conduct alleged by DSHS was the failure to give the injectable medication and claimed this put the resident at high risk for medical complications. These were identical to the allegations made by DOH. The DOH argument on this point was an analogy they drew to proceedings such as DUI prosecutions where the accused in the misdemeanor DUI case can also be subject to license revocation under the Department of Licensing procedures. Appellant's response is there is a specific regulation in DUI cases where the driver consents to the rules and procedures as a condition of the right to receive a driver's license. There is no such regulation offered by the Department for the type of duel disciplinary proceedings brought here.

c. The third issue raised is that the Settlement Agreement reached in the DSHS case was in itself a CR2A Stipulation that would be binding on both State Agencies so long as the facts and issues and the subject matter were identical. Appellant asserts that they are and the Court should find the initial Settlement Agreement concluded the State's right to exact any further punishment out of Appellant.

IV. Statement of the Case

Appellant's troubles began when DSHS issued what is usually referred to as Statement of Deficiencies (SOD) on December 6, 2007 (ROP 213-216). The SOD was a 4-page document laying out the alleged deficiencies by Appellant and the WACs violated. Although the SOD deals with two matters, one being a fire safety issue, apparently that charge was resolved informally as there seems to be no mention of it in the Settlement resolved documents.

On page two however, DSHS focuses on the same facts used in the DOH disciplinary proceeding, particularly where they allege the action arose out of an admission of the resident on 11/16/07 and that resident's discharge on 11/24/07 admitting the admission was for abdominal pain and fever not a blood coagulation problem. It goes on to say that after discharge, there were two additional medication orders being Enoxaprin (Lovanox) 40 milligrams subcutaneous daily (an injectable medication) and Seroquel which was never an issue since the Appellant continued to administer that drug until told to stop by the primary doctor. The last page of the SOD shows the medication was ordered by the home promptly and received on 11/26/2007 but was not given until 12/3/2007. Paragraph 1 on page 3 of the SOD correctly states events between 11/24 and 12/3 except it omits any references as to whether or not Appellant told the investigator she was fearful to give the drug for reasons of prior knowledge of bleeding. Paragraph 2 of the SOD on page 3 is contrary to what Appellant said she did and is not born by the record in that exhibits were produced in support of the Superior Court hearing indicating communications back and forth between AFH staff and the primary care physician

and the primary care physician belatedly advised not to give the drug in question (ROP 183-184).

The DSHS made a verbal Offer of Settlement to Appellant which was confirmed by letter and accepted as part of the record (ROP 153). In a letter from Appellant's counsel it was stated she was doing so not as an admission of liability but to avoid the high costs of a contested proceeding and the unpredictability of the outcome. Appellant paid the requested fine to DSHS and wrote a Plan of Correction required by the Settlement Agreement. Those obligations were completed on or about November 10, 2008 (ROP 152).

On April 2, 2010 almost 2 ½ years later the Department of Health, Nursing Quality Assurance Commission filed a Statement of Charges against Appellant. Other than background information laid out in paragraphs 1.1, 1.2, 1.3 and 1.5, the facts stated in 1.4 were the same allegations on page 2 of 4 being paragraph 2, alleged violations (ROP 003) as raised by DSHS.

The DOH alleged only two code violations. One was a violation of RCW 18.130.180(4),(7),(12), and WAC 246-840-710(2)(d). Of those alleged violations only subparagraph (4) could

actually apply to Appellant as evidence submitted by the State shows they centered their entire case on the fact the injectable blood thinner was not given, essentially saying that failure to do so created an unreasonable risk that a patient may be harmed.

Also DOH focused on WAC 246-840-710 arguing that a violation of that WAC subjects a nurse to a previously cited statute, RCW 18.130. They relied on two things, first they stated failure to adhere to standards of WAC 246-840-700 and second the Appellant willfully or repeatedly failed to administer medications under treatments in accordance with nursing standards and thereafter concluded this provided grounds for imposing sanctions under RCW 18.130.160.

The facts giving rise to the DSHS allegations and those of DOH are straightforward. They allege the resident as admitted to Legacy Hospital in Salmon Creek, Washington on 11/16/07 for abdominal pain and fever and was discharged on 11/24/07 with medication orders that were not included in the medication log at the AFH. The prescription of consequence in the proceedings was that of Enoxaprin (Lovanox) 40 milligrams subcutaneous daily.

When the resident returned to the AFH the hospital did not supply the new prescriptions but the AFH ordered them nevertheless and they were available by 11/26/07 (ROP 160 & 161).

The facts from this point are fairly straight forward. The resident was at Legacy between 11/16/07 and 11/24/07 (ROP 169-171). She was discharged on 11/24/07 with discharge orders that included two new prescriptions not contained in the AFH medication log prior to the resident's admission to the hospital (ROP 160 & 161).

The Appellant quickly recognized the drug, Enoxaprin, was an injectable, powerful, blood thinner, and in fact more powerful than Coumadin, which the resident had been on sometime prior to her November admission to the hospital and had been taken off of the Coumadin in August of 2007 because of bleeding (ROP 164).

Upon return of the resident to the AFH Appellant balked at giving the injections because she had concrete evidence that the resident had suffered a significant eye bleed during a prior hospital admission and was still being diagnosed in September of 2007 by her Ophthalmologist with blood in her eye. By November of 2007

there were no blood thinning prescriptions on the resident's AFH medication log (ROP 160 & 161). Appellant made strenuous efforts to contact the primary care physician as evidenced by a call log (ROP 174, 175, 176) and faxes back and forth to the doctor's office. Finally on December 3, 2007 Appellant started the injections mostly out of frustration on lack of response from the primary care doctor's office, Appellant finally received a fax dated November 29, 2007 stating the Enoxaprin should not be given but Appellant did not receive that fax until after she started the injections (ROP 128)

The Department admits there was no harm as a result of the gap in giving the blood thinning medications SOC (ROP 003) and the assigned physician at Legacy, Dr. Hu, admitted in her testimony that she had not reviewed the resident's chart and was unaware of the bleeding problem when she prescribed the blood thinning medication (ROP 338). In any event the resident then lived until her death in January of 2009 without Coumadin, Enoxaprin or any other blood thinning prescription and there was no evidence to support any theory she ever experienced a bleeding problem again, Dr. Hu also admitted that when she later saw the August chart there was a major blood problem (ROP 348). There is also no credibility to the

argument that discharging with Lovanox was the hospitals or all doctor's protocol because the resident was discharged from her August 2007 admission without Coumadin or Lovanox (ROP 350).

As mentioned, the DOH obviously had full knowledge of the DSHS proceeding about withholding the injections but still filed its Statement of Charges approximately two years plus subsequent to the SOD and Settlement with DSHS.

The factual testimony concerning the need or lack of need for any kind of blood thinning prescription especially the Enoxaprin are mixed. The Department presented one witness, Dr. Hu, who apparently was the resident's in-hospital doctor for the approximately 8 days she was hospitalized. The Appellant offered her own testimony, and that of the resident's new primary care physician who took over after the poor communication episode with the other primary care physician, Dr. Grudzien and the testimony of a caregiver, Judy Tichrob, about efforts to contact the primary.

The Board itself was comprised of two LPNs and there was only one RN who had credentials similar to that of the Appellant.

DOH refused or neglected to present testimony from a nursing specialist about whether the conduct of the Appellant was

or was not below the standard of care or caused a reasonable risk of harm to the resident. Dr. Hu, the primary physician during the hospitalization, was not asked to express an opinion about whether or not Appellant's conduct fell below the standard of care for a nurse given the over-all circumstances.

Both professional witnesses for Appellant testified that not only did her conduct not fall below the standard of care for a nurse under the facts as presented (ROP 374) Dr. Patton and the resident's MD, Dr. Herroun, expressed an opinion that giving the injectable medication imposed a high risk of harm to the resident (ROP 460).

The hearing officer concluded that Appellant's conduct did fall below the standards set forth in the WACs cited and the DOH imposed a monetary fine and what might be called an education plan which Appellant complied with.

V. Summary of Argument

In Summary, Appellant argues she was somewhat of an innocent victim in a battle between MD's. One being Dr. Hu from Legacy who apparently had her protocol for releasing non-

ambulatory patients from her facility with the Enoxaprin. The rational for that was expressed by Dr. Hu's statement that she prescribed the drug to prevent strokes, yet there was no history of stroke in this resident's chart, had the doctor taken time to look. Furthermore, Dr. Hu admitted she did not review the resident's chart for prior bleeding before prescribing blood thinners but rather justified that as being her protocol (ROP 353).

Appellant also argues DOH has the same burden of proof as one would in any civil common law proceeding and that was to prove their case by the preponderance of the evidence. This is the type of case where lay testimony would not normally be acceptable to establish medical negligence. Therefore opinions from individuals qualified to know when, if at all, a nurse should withhold medications until she receives further instructions, was only presented by the Appellant. The State however, when confronted with the argument they had a failure of proof, argued to Judge Gregerson of the Clark County Superior Court that even though there was no expert testimony on their behalf concerning the Standard of Care of Appellant, the Standard of Care could be set

by the Board, regardless of whether it reached the level of preponderance of the evidence.

A summary of Appellant's argument on the Res Judicata and Collateral Estoppel issues is that DOH's argument they can impose a second and additional punishment for the same act by a nurse because one branch of the same State oversees licensing and another branch is in charge of monitoring medical care is the equivalent of double jeopardy in a criminal case. DOH argued DSHS is primarily concerned with licensing and DOH with care provided by health care providers. While that argument could be true in many cases, it was not so here. DSHS dealt solely with the medical nursing issue to impose their fine just as DOH did and not with the many other day to day functions in an AFH that DSHS often inspects and cites for. DOH relied on exactly the same alleged mistake by Appellant based upon identical facts and the same subject matter and therefore should have been precluded from bringing the second action, and Appellant's Motion to Dismiss on Res Judicata and Collateral Estoppel should have been granted.

Finally, Appellant argued she entered into a Stipulated Settlement with the DSHS being the allegation she should have

given the blood thinning prescription regardless of her prior knowledge of its danger and regardless of her training and instincts in this area. She accepted the Settlement Offer from DSHS, paid the fine, wrote a correction plan as directed and that should have ended the matter. The sanctions imposed the second time around by DOH were identical except more onerous. The fine was greater ($2,000) and additional education completed by Appellant was imposed on her at considerable expense. Furthermore, the action by the DOH carries with it a notation in her registry of either unprofessional conduct or a finding of negligence that could have placed a patient at risk of injury or death. She believes that is not justified by the facts or the law in this case. And further, her Agreement with DSHS should be treated as a CR2A Stipulation ending the matter as a settlement.

VI. Argument

a. Argument on State's Burden of Proof

In the event the court should decline to accept what Appellant considers a conclusive argument on Res Judicada and

Collateral Estoppel there remains a significant failure of proof in the Department's presentation.

The burden of proving one's case is most succinctly set forth in an old and well enunciated case *Palmer v. Houston, 67 Wa 210, 121 P 452 (1912)*. There the court defines the sometimes elusive term "burden of proof by preponderance of the evidence" as being simply more than just the tipping or balance of the scales, the court said

> " it is the excess over the amount of testimony necessary to balance the scales and when we say the burden of the proof is upon the party, we mean simply that he must furnish that excess before he is entitled to a verdict"

also citing *McKenzie v. Oregon Imp. Co. 5 Wa 409, 31 P 748*.

A much more recent case testing the burden of proof is *Welch Foods, Inc. v. Benton County, 136 Wn App 314, 321-22, 148 P 3d 1092 (2006)*. There the court defined the burden of proof by dividing it into two elements. It said the burden of proof can be divided into two tasks- "a burden of production and a burden of persuasion". It went on to say that "a burden of persuasion defines

the degree of certainty with which the fact finder must decide the issues".

While finding the burden of proof had been met in the Welch case, they went on to define what the burden of persuasion actually is. It defined that as substantial evidence and substantial evidence as being more than a mere scintilla of evidence.

In another approach in defining burden of proof, *Emerick v. Bush, 36 Wa 2d 759, 220 P. (2d) 340 (1950)*, the court says at *763* that "lack of affirmative proof of a vital fact may not be cured by the opposing litigant's failure to prove the negative thereof".

In order to carefully weigh the argument about the burden of proof the court needs some additional facts.

The resident was admitted to Legacy Hospital Salmon Creek on November 16, 2007 because of a diagnosis of abdominal pain and fever. She was discharged on November 24, 2007 and her discharge summary included a prescription for an injectable medication, Enoxaprin, also known as Lovenox.

The Appellant argued at hearing that she did not immediately start the injectable medication because she was aware of a previous severe bleeding problem that had the resident in Legacy in August of 2007 (ROP 629) due to significant bleeding in the eye to the extent the resident was unable to see out of the eye. Appellant, from her experience with the patient was also aware that an ophthalmologist had on September 21, 2007 observed continued bleeding in the resident's eye, see Dr. Rasky's note (ROP 645).

Appellant, a trained RN with a four-year degree and advanced nursing classes felt giving the drug, because of her training, indicated an injectable drug such as that contained in the discharge summary presented a high degree of risk for bleeding. She was particularly concerned because there had been bleeding from Coumadin which Appellant knew was of a lesser strength than the injectable drug.

The important chronology is that beginning with the resident's return to the Adult Family Home on November 24, Appellant continuously and more than one time a day, contacted

the primary care physician's office seeking guidance as to whether to give the drug or not (ROP 611, 639, 639 & 640). She withheld the injections until December 3, 2007 but started the injections on her own for fear the confusion would be held against her as it eventually was (see medication logs ROP 624 & 625) and attorney's letter (ROP 621 and 622), also see Appellant's chronology as to the situation (ROP 637, 638, 639, 640, 642 & 643).

DOH contends it would have been simpler to call the ER rather than a primary care physician. This theory is not supported by any evidence in the record that this is a preferred practice. As part of the chronology the court will see the primary care physician did agree with Appellant's assessment of the situation (ROP 648) and on (ROP 647) there is an exchange between the primary care physician's office's staff and Appellant which is obviously misdated. It shows subject requested information date February 13, 2008. Under the comment section however it shows the dates of inquiry as 11/26 and 28/ 2007. It should also be noted that when Dr. Grudzien discontinued the new medications suggested by the

Legacy Staff he put the resident back on medications being used prior to hospitalization (ROP 648). That correspondence is dated November 29, 2007. According to Ms. Stevensen's testimony (ROP 497) she did not actually receive it until after she started injections on her own on December 3, 2007.

b. The States' Statement of Charges does not Establish Unprofessional Conduct or Violation of Nursing Standards

The State's burden of proof is to prove failure to comply with the statute being RCW 18.130.180 and WAC 246.840.710.

The Statement of Charges (ROP 163) admits at 1.5 the patient suffered no apparent harm from the missing medication. Page 2 selects three sections of RCW 18.130.180 being subsections 4, 7 and 12 as violations.

The State presents only one witness, Dr. Hu to testify that her policy and the hospital's policy was to give this type of patient Enoxaprin and therefore DOH concluded Appellant's decision of not giving the injectable medication once the resident was returned to her home violated one or more of those three sections.

Looking at subsection 4 of the SOC (ROP 003), it first requires proof of incompetence, negligence, or malpractice, which results in an injury. It goes on to say that it would be a violation if the nurse's conduct creates an unreasonable risk that the patient may be harmed. Nothing in Dr. Hu's testimony indicates there was an unreasonable risk that this patient would be harmed by failure to the give the potent blood thinning injectable medication Enoxaprin. Rather the doctor testified that her experience was that patients who were not ambulatory had a risk of embolism which was high. The hospital records however indicated this patient had not been ambulatory for months prior to admission on November 16, 2007 and was not receiving Enoxaprin (ROP 603 & 604). This raises the strong inference that Dr. Hu was merely following protocol rather than carefully analyzing the individual patient's history of bleeding. In fact she admitted (ROP 338) that she was not aware of prior admissions for bleeding in the eye nor was she aware of the ophthalmologist's finding of bleeding in September of 2007, just shortly before admission on November 16, 2007 (ROP 347). This by itself should lead to the conclusion that Dr. Hu did not have even

a hint of this patient's history of bleeding when the Enoxaprin was prescribed.

The State goes on to argue that subsection 7 of RCW 18.130.180 was violated and the violation of any State or Federal Statute or Administrative Rule regulating the profession in question and under subsection 12 that there was practice beyond the scope of practice as defined by Law or Rule.

When one however looks at the sections on violations of standards of nursing conduct or practice, WAC 246.840.710. It refers one back to WAC 246.840.700.

There is no mention that the kind of conduct charged to the Appellant violates any of the sections and subsections of that WAC. The only possible violation would fall under subsection 2 of WAC 246.840.700. When one reads WAC 246.840.700 they will see it is divided into two sections, one for registered nurses on the left side and one for licensed practical nurses on the right side. Again reading down through the sub-criteria there is nothing that includes the conduct alleged by DOH to be unprofessional. In fact when one

reads WAC 246.840.700 carefully, and looks at subsection (d) on the left side for nurses, there appears to be a duty of a nurse to implement a plan of care by *initiating nursing interventions* (emphasis added) through giving direct care and supervising other members of the care team.

In this case, Appellant, based on the more accurate information about the patient's condition than the hospital reviewed, had sound reason to believe that bleeding with this patient posed a greater risk than an embolism because by history the patient had been non-ambulatory for months, possibly even longer, and her prior prescriptions had never included Enoxaprin, the drug prescribed by Dr. Hu nor was there any history of stroke or embolism.

The court needs to look at the testimony offered on behalf of Appellant who went to the time, care and expense to bring competent witnesses who testified as to the standard of care in this case, which Dr. Hu did not.

Appellant offered the testimony of Jody Tichrob who was a caregiver in Appellant's home. She was called primarily to clear up the issue as to whether or not a sincere effort was made to contact Dr. Grudzien's office and what availability existed to Dr. Grudzien when the resident was discharged from Legacy.

Ms. Tichrob noted that the patient was discharged back to the family home on Saturday which was the 24th of November 2007 with Sunday obviously being the 25th. She also noted that apparently from her experience that Dr. Grudzien's office was closed on the weekend and his regular hours were Monday through Friday. She also went on to testify she made substantial and "repeated" efforts both in writing and verbally to get an authorization to discontinue the drug. She testified the receptionist repeatedly told her the doctor was busy and would get back to her; Tichrob (ROP 431 & 432). The entries at (ROP 429 & 430) explain there was obviously a mistake made in using the year 2008.

Mrs. Stevenson testified on her own behalf. She has a four-year degree as an RN. In addition she had started work towards

her Masters completing two semesters with about a year to go (ROP 487, 488 & 489).

Unlike many RN's however, Mrs. Stevenson had previous training in her home country which is not identified in the record but is believed to be Romania. She testified to having had five years in hospital work, another seven in a clinical setting and the balance of her career in an Adult Family Home where she specializes in ventilator patients, (ROP 490 & 491).

While her testimony was lengthy a few things stand out. It is clear the resident in August 2007 had a serious eye bleed resulting from an underlying condition (ROP 495). She goes on to explain the difficulties with Dr. Grudzien became frustrating and at the bottom of (ROP 496) she tells us she went ahead and started the injections out of frustration primarily. She goes on through (ROP 497) to say she got hold of him on December 3, 2007 and he gave her a verbal order to discontinue the drug. She also mentioned she got an authorization to discontinue dated the 29th and even though the fax was dated that date she did not receive it until sometime in December.

Mrs. Stevenson adds another interesting fact to the discussion over the chart notes. Unfortunately they were incomplete until the time of hearing when Mrs. Stevenson was then able to review them. The Discharge Summary, as she testifies to at (ROP 503 & 504) makes no mention of clotting and the resident's diagnosis on discharge was fever, abdominal pain and constipation. Also at (ROP 504) she testifies she did give the shot on December 3rd and there were no complications which the State admits to in their Statement of Charges.

It should be noted the patient's had no Coumadin and no Enoxaprin between her discharge in November of 2007 and her death in January 2009 raising the reasonable inference that withholding the Enoxaprin was a medically sound choice (ROP 504). Mrs. Stevenson testifies at (ROP 500) to clear up the issue of whether she made an immediate effort to contact Dr. Grudzien and testifies at line 10 that she did call on November 24th in hopes he had somebody on call. Unfortunately as other witnesses have testified Dr. Grudzien did not return her calls or confirm discontinuance until December 3rd.

As noted, DOH only called one witness, Dr. Hu, to attempt to substantiate their charges.

Dr. Hu did not form or express an opinion on the Standard of Care concerning Mrs. Stevenson's conduct. She simply stated that she personally and the hospital apparently had a firm policy about using Enoxaprin in the event they were treating a patient who had a history of being non-ambulatory which she opinioned put a patient at risk for stroke.

There was significant testimony controverting Dr. Hu's theory by two far more experienced professionals who expressed opinions that Mrs. Stevenson's conduct did not fall below the standard of care and in fact was acceptable under the circumstances.

Appellant called Dr. Lee Paton, PhD as one of her witnesses.

Dr. Paton's credentials were that she had a four-year undergraduate nursing degree, a Masters in nursing from Seattle University, and a Doctorate from Oregon Health Sciences University (OHSU) (ROP 367). She obtained her Doctorate in 1999

and testified she has worked in clinics, hospitals, a visiting nurse, and as a consultant to Adult Foster Homes (ROP 368).

Her nursing experience ended in 2006 when she became a professor at Concordia School of Nursing in Portland, Oregon, teaching surgical nursing, ethics, and health policy, (ROP 368).

Dr. Paton testified she had reviewed the August hospitalization of the resident and Dr. Rasky's report concerning bleeding, the November admission to Legacy, and Orders and Discharge Summary, (ROP 658). At line (ROP 369) she was asked if she had an opinion about whether Mrs. Stevenson had a duty to question the prescription of Enoxaprin. Dr. Paton stated in her opinion, she did.

At (ROP 370) the doctor was asked about whether an anticoagulant was contraindicated. She opined there were two reasons there was. It increased the risk of small bleeds in the brain, leading to greater exacerbation of dementia (this resident was 94

years old) and it led to an "incredibly high risk" of hemorrhagic stroke (ROP 370).

At (ROP 374) the doctor was asked about the choice to withhold this injection. She was asked in layman's terms if she believed the conduct of Mrs. Stevenson fell below the standard of care, her answer was "she did not fall below the standard of care". The question came up later upon cross-examination about Dr. Hu's statement that Mrs. Stevenson should have called her back and at (ROP 377) her testimony was "I was very surprised to hear Dr. Hu say she gets frequent calls from patients after discharge". Just prior to that she testified at (ROP 377) that when a question comes up about a medication they almost always refer back to the primary care physician.

Previously she had testified at (ROP 373) about the role of a doctor such as Dr. Hu in a hospital setting. She stated that the purpose of a hospital is to do acute care and to work with an acute hospitalization problem. On lines 15 through 18 of that page Dr. Paton explains the acute care hospital is looking at what do we need to do to treat this person and get them ready for discharge.

This undoubtedly explains why Dr. Hu did not go back to the resident's prior hospital charts from the August hospitalization.

When Dr. Paton said she was quite surprised at Dr. Hu's statement that nurses frequently call in to question prescriptions it brings to mind a common sense question of what difference would it have made in this case. Dr. Hu had testified she had insisted on the prescription and use of this drug for at least 30 days out of protocol. Had Appellant called back without reaching Dr. Grudzien which we know became the problem, any intelligent person such as Appellant would have assumed Dr. Hu was not going to reverse a prescription until she heard from the primary care physician.

Mrs. Stevenson also called Mr. Douglas Herroun, MD on her behalf.

Dr. Herroun testified he had a medical degree since 1997, had done a residency at the University of Texas and was Board Certified in internal medicine (ROP 450, 451 & 485) as to Board Certification.

Dr. Herroun had twenty years experience in traditional internal medicine, he described as being primarily hospital work and ten years working in Geriatrics primarily Adult Family Homes, which is the sole of his practice at that time (ROP 451). He also testified he treated the resident in question off and on since approximately 2006 (ROP 452).

Starting at (ROP 456) Dr. Herroun was asked about the use of Lovenox. Continuing onto (ROP 457) about why the Lovenox was prescribed and was told for deep vein thrombosis from previous testimony by Dr. Hu. When asked about his opinion as to whether or not Dr. Hu should have made that prescription, at line 12 he expressed an opinion saying "I've got a pretty strong opinion against that". When questioned "what's your opinion", answered "that should not have been done", questioned "why", answer " well, number one, nobody does it, that's a pretty good indication you just don't see people coming out of the hospital on Lovenox for a month. I mean it's not routine by any means". Then at (ROP 457 & 458) he was asked about whether there was increased risk to this patient being given a prescription of Lovenox, his answer was

"yes". Further down on (ROP 458 L 19) he expresses an opinion that Lovenox is not used to prevent clots, it is used primarily for people that have been diagnosed with clotting and there is nothing in the records presented by the State to indicate this resident had a clotting problem. At (ROP 460) there is a discussion about the *risk to this patient/benefit to the patient* and the doctor said at line 9 that "once that lady had the first retinal, bleed, the risk was overwhelming, for very, very little benefit, I mean, *the risk / benefit was entirely against using anticoagulants*" (emphasis added).

At (ROP 461) the standard of care is approached. The doctor was asked, "do you believe it was appropriate for her to question that Order" (referring to Appellant). He answered, "I think it was appropriate for her to not give the drug, I think it showed excellent judgment". Further down at line 18 the doctor was asked did Mrs. Stevenson's conduct "fall below the standard of care, in his opinion for a nurse". At (ROP 461 L 23) he said "I trust the opinion that I think she did what she could with what she had, I think she succeeded in protecting the patient from further harm". Continuing on to (ROP 462) starting at the bottom he said "I think if she was

given Lovenox, and continued to give that Lovenox without question, the patient could have been harmed." Later at in cross-examination, (ROP 468 L 13) "assuming those factors, was it reasonable to start her on Lovenox?" Answer, "I don't think so, at all".

c. Argument regarding Res Judicata and Collateral Estoppel

The Department should be barred from proceeding with this action under the doctrine of Res Judicata.

Generally there are two doctrines that come into play when an enforcement agency attempts to re-litigate an issue that has already been fully litigated or could have been fully litigated.

Collateral Estoppel applies to cases that were fully litigated and bars re-litigation of such issues when actually litigated in a former proceeding. *Hirata V. Evergreen State Ltd. P'ship No. 5, 124 Wn App 631 @ 642 (2004).*

Res Judicata on the other hand bars a party from not only re-litigating "claims" that had previously been litigated involving the same parties and issues but also bars re-litigation in a second proceeding of claims that could have been litigated but were not, *Northwest Seafarms v. US 931 Fed Sup 1515*. Also see *Hirata Supra @ 642*.

Under our facts both sides had an opportunity to fully litigate whether or not there was any actual deficiency concerning whether Respondent's conduct fell below the standard of care for a nurse under the facts alleged. DSHS did not litigate that issue and could have. Respondent withdrew her appeal and did not litigate that issue but could have.

Generally speaking these issues were resolved by settlement because Respondent felt she could not afford or did not wish to become involved in protracted and expensive litigation.

One does not know the Department's motives but apparently they did not see the issue of litigation as essential to overall patient

care for those under the Respondent's care and therefore agreed to a non-litigation resolution.

Both parties had their opportunity to fully litigate that issue and chose not to.

d. The Sound Policy of Upholding Settlements

The case was fully settled concerning the allegation of proper or improper dispensing of medications by Respondent.

Washington has long favored the conclusiveness of settlement agreements. *OR. MUT. INS. CO. v. Barton, 109 Wn. App. 405, and Lehrer v. DSHS 101 Wn App 509 (2001).*

Respondent gave up her right to fully litigate the issue alleged and the Department chose not to proceed as well.

Furthermore CR2A also may well apply because the stipulation to pay a civil fine results from an allegation under RCW 70.128.160 of wrong doing on the part of Appellant and therefore there should be no reason the Superior Court Rules should not apply including CR2A. In addition to other cases cited the Court

may wish to consider *Norris v. Norris, 95 Wn 2d 124, 622 P 2d 816 (1980)* on the issue of collateral attack.

e. Miscellaneous Matter

Although of minor concern but out of an abundance of caution it should be noted that while the Department relied partially on WAC 246.840.700 under their theory of unprofessional conduct and violations of nursing standards, two of the panel members were LPNs and only one was an RN.

There is no reason an LPN would necessarily be concerned with the criteria set forth in the left hand column of WAC 246.840.700(2) which seems to give an RN much more latitude in implementing care plans and initiating nursing interventions than an LPN. That language does not appear under (d) in the right hand column of the WAC pertaining to LPNs.

VII. Conclusion

This court should conclude there has been a complete failure of proof by DOH and they have not met their duty to prove their case by a preponderance of the evidence.

An analogy which may well apply to the situation in this case might be counsel for the Appellant wandering into trial court in a medical mal-practice case and simply offering his client's testimony that the doctor that treated the client must have been negligent because the medical result was unsatisfactory. Obviously this type of testimony without an expert opinion that the doctor's conduct fell below the standard of care and a further opinion that the doctor was negligent and the performance of a doctor's care would quickly result in a dismissal of Plaintiff's case. Essentially that is what we have before us in this matter.

Appellant sincerely believes the issue of Res Judicata and Collaterally Estoppel does apply here and the analogy used by DOH might apply in some settings but are not appropriate under the facts of this case.

The court should reverse the fines paid by Appellant returned, an award of costs for the extra educational courses she

was required to incur which essentially were duplications of the courses she had already taken and instruct DOH to remove any negative comments from any registry that resulted from these proceedings.

Respectfully submitted this 24th day of June, 2014 by:

Robert D. Mitchelson, WSBA#4595
Attorney for Appellant

ORIGINAL

COURT OF APPEALS FOR THE STATE OF WASHINGTON
DIVISION II

FAIRUZA M. STEVENSON, Plaintiff/Appellant, vs. STATE OF WASHINGTON, DEPARTMENT OF HEALTH, NURSING CARE QUALITY ASSURANCE COMMISSION, Defendant/ Respondent.	**APPEALS CASE NO. 45834-9-II** **PROOF OF SERVICE**

STATE OF WASHINGTON)
ss.
COUNTY OF CLARK)

I state under penalty of perjury under the laws of the State of Washington that I personally hand delivered an Original and one true copy of the Appellant's Brief to the Washington State Court of Appeals Division II at

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950 Broadway, #300 Tacoma, WA 98402-4454 and placed a true copy in the US Postal Service to Daniel R. Baker 1125 Washington St. S.E. Po Box 40100 Olympia, WA 98504-0100 on June 24, 2014.

Robert D. Mitchelson WSBA#4595
Attorney for Appellant

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Wednesday,
June 25, 2014

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June 25, 2014

Washington State Court of Appeals
Division II
950 Broadway, #300
Tacoma, WA 98402-4454
Attn: Case Manager Kim

Re: Fairuza Stevenson, Appellant v. State of WA, Dept of Health, et al., Respondents
Case no. 45834-9-II

Dear Mr. Ponzoha:

This is to clarify references to the record in the above matter.

Since this was an Appeal from an Administrative Proceeding that went to the Superior Court, there is no prescribed RAP on how to the format the ROP for delivering appropriate information to the Court of Appeals for review, briefing and later argument.

What happened was the Department hired their own Court Reporter to prepare a transcript, which the Appellant paid for. They also assembled exhibits that had been admitted into evidence and certain pleadings. We also paid to have the Superior Court Judge's Opinion transcribed.

The Dept of Health then Bates stamped those documents starting with 001 consecutively through the end of entire stack of documents and did not differentiate between Pleadings, Exhibits, Clerk's Papers and the Transcripts, as we normally do in a Court of Appeals proceeding.

Therefore references in Appellant's Brief as (ROP) are to the Bates number stamped at the bottom right hand of each document in the Administrative Record from 001 through 676 with the result being that items such as exhibits are comingled with pleadings and the transcript of the proceedings.

This presented a significant difficulty in preparing the Brief from our end and I hope this letter will act to make it easier for staff at the court to understand why the Clark County Superior Clerk simply sent up the same set of documents given to her by the Dept. of Health.

We designated certain pleadings, and exhibits out of the Administrative Record to be sent up by the Superior Court Clerk, but the Clerk for some reason treated the entire package of the Administrative Record provided by the Dept. of Health as Clerk Paper's no. 39 which really seems to have no significance as far as the proceedings in the Administrative Hearing and the Superior Court were concerned.

If this causes any further confusion feel free to contact me.

Thank you for your time and consideration.

Sincerely,

/s/
Robert D. Mitchelson
Attorney at Law

RDM/st

C: Daniel Baker ATG