

No. 48070-1-II

COURT OF APPEALS,
DIVISION II,
OF THE STATE OF WASHINGTON

KEISHA BAUMGARTNER, as Personal Representative of
the Estate of ANGELA BAUMGARTNER, deceased,

Appellant,

v.

THE VANCOUVER CLINIC, INC., P.S., JASON ANAST, MD,
ERIC KLINE, MD, COLUMBIA ANESTHESIA GROUP, P.S.,
MARK A. MOREHART, MD, LEGACY SALMON CREEK
HOSPITAL, a health care entity, CHRISTOPHER FRALEY, MD,
SPECIALTYCARE, INC., MICHELLE L. HENDRIX, and
DOE ENTITY NO. 1 through NO. 12,

Respondents.

APPELLANT'S REPLY BRIEF

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I. INTRODUCTION

Appellant Keisha Baumgartner, as Personal Representative of the Estate of Angela Baumgartner (“Plaintiff”), submits this Appellant’s Reply Brief.

The trial court erred in granting summary judgment to Respondents Columbia Anesthesia Group, P.S. (“CAG”), and Mark A. Morehart, MD (“Dr. Morehart”) (collectively “Dr. Morehart”). Questions of material fact exist concerning whether Dr. Morehart breached his standard of care in not directing that the cell saver be set up in standby mode so that the cell saver would be immediately available if unexpected heavy bleeding was encountered during the surgery, and concerning whether he then breached his standard of care by not directing that the replacement suction tubing and Yankauer wand be connected to the cell saver for continued cell salvage after conversion to an open procedure. Questions of material fact also exist concerning whether if used throughout the surgery the cell saver could have processed a sufficient amount of Ms. Baumgartner’s blood to prevent her death by anemia following the surgery.

The trial court also erred in denying Plaintiff’s motion for summary judgment and allowing the issues of assumption of risk and

contributory negligence to be raised at trial. Express assumption of the risk does not apply because Ms. Baumgartner did not sign any document releasing defendants from any obligations or liability. *See Shorter v. Drury*, 103 Wn.2d 645, 657, 695 P.2d 116 (1985). Implied primary assumption of risk only applies if the trier of fact concludes that Ms. Baumgartner's death was an inherent risk of the surgery and was not the result of any increased risk caused by Dr. Morehart's negligence. *See Gleason v. Cohen*, 192 Wn. App. 788, 797-98, 368 P.3d 531 (2016). But Plaintiff's claim is that Dr. Morehart's negligence during the surgery increased the risk that Ms. Baumgartner would bleed to death as a result of the surgery. Implied primary assumption of the risk does not apply to this claim. Any instruction on implied assumption of risk would therefore unduly emphasize Dr. Morehart's case and should not be given. *Brown v. Dahl*, 41 Wn.App. 565, 578-79, 705 P.2 781 (1985) Neither the doctrines of implied reasonable or implied unreasonable assumption of risk apply because Ms. Baumgartner did not regain consciousness following the surgery and never had the opportunity to voluntarily chose to encounter the risk created by Dr. Morehart's negligence. *See Gleason*, 192 Wn. App. at 796. Contributory negligence does not apply because Ms. Baumgartner

did not as a matter of law breach her duty of care to herself by agreeing to undergo the surgery in a bloodless surgery program without consenting to blood transfusion but consenting to numerous other medically acceptable alternatives to blood transfusion, including use of a cell saver, used in that program. *See Little v. Countrywood Homes, Inc.*, 132 Wn.App. 777, 780, 133 P.3d 944 (2006).

II. ARGUMENT & AUTHORITIES

A. **The Trial Court Erred in Granting Dr. Morehart's Summary Judgment.**

As set out in Plaintiff's Appellant's Brief, Dr. Morehart's Respondent's Brief, and as further discussed below, there is substantial evidence supporting the following account of the surgery that gives rise to this action:

Jason Anast, MD, ("Dr. Anast") recommended to Angela Baumgartner ("Ms. Baumgartner") that he perform surgery to remove a small tumor on her kidney. Ms. Baumgartner advised Dr. Anast that as a Jehovah's Witness she would not consent to a blood transfusion. Dr. Anast told her that both he and Eric Kline, MD ("Dr. Kline"), who would be assisting him, were comfortable performing the surgery with this restriction. (CP 101 - 103; 119 - 120)

The surgery was performed at Legacy Salmon Creek Hospital (“LSCH”) under its bloodless surgery program, a program developed specifically for surgeries on patients, including Jehovah’s Witnesses, without blood transfusion. (CP 110 - 114) Prior to the surgery, Ms. Baumgartner met with a representative of LSCH and discussed alternatives to blood transfusion used in the bloodless surgery program, including a cell saver machine. (CP 159 - 162; 169) She also signed a power of attorney and a consent form, confirming her refusal of blood transfusion but consent to cell salvage if necessary during the surgery. (CP 133; 135 - 136) She also met with Dr. Morehart, the anesthesiologist selected by LSCH for the surgery, to discuss her wishes regarding blood products and salvage. (CP 107 - 108)

LSCH provided the cell saver and technician to operate it, Michelle L. Hendrix (“Technician Hendrix”) during the surgery. The surgery was a laparoscopic robotically assisted surgery, performed through small holes or ports with instruments of small diameter designed to fit through these ports. (CP 1296)

Technician Hendrix believed that Jehovah’s Witness beliefs required that the cell saver be set up with a continuous circuit from the suction wand on the front end of the machine through to the reinfusion bag

attached to an IV to the patient at the back end of the machine, and that both ends, the suction wand on the front end and the reinfusion bag on the back end, had to remain in contact with the patient's body throughout the surgery from before the first cut was made. (CP 561 - 562; 566) She announced this to the surgical team, including Dr. Morehart, and set up the cell saver in this manner, handing off the suction tubing to be used with the cell saver to a nurse in the sterile field of the surgery. (CP 983 - 985) Dr. Morehart did not express any disagreement with Technician Hendrix's pronouncement or otherwise direct her to set up the cell saver for standby as usually done in a surgery with minimal expected bleeding.

Because the surgery was to be conducted laparoscopically, a suction/irrigator wand was attached to the suction tubing from the cell saver, with a small enough bore to fit through one of the holes or ports used in a laparoscopic surgery. This wand only provides suction when its trigger is pressed. (CP 1638)

Technician Hendrix left at some point during the surgery, leaving the cell machine on. While she was gone, the surgeons encountered heavier than expected bleeding on excising the tumor from the kidney. The suction/irrigator wand did not permit the surgeons to clear enough blood from the surgical field to determine its source or stop it

laparoscopically, so they determined to undock the robot and convert to an open procedure. In the process of doing so, the suction tubing attached to the drapes on the patient fell below the surgical sterile field. (CP 537; 539; 117; 543; 545) The surgical staff observed this and opened new, sterile replacement tubing to attach to the cell saver machine. (CP 574) Doing so would have taken about two minutes, about the same amount of time as required to convert to an open procedure. (CP 633 - 634; 556)

When Technician Hendrix returned to the operating room, she also noticed that the suction tubing had dropped below the sterile field. The surgeons requested that she replace the suction line to the cell saver. She could have complied by simply handing the operating room nurse new suction tubing. But Technician Hendrix refused to do so, announcing her understanding that the circuit required of Jehovah's Witness beliefs had been broken and the cell saver had been contaminated and no longer could be used. (CP 565; 574; 567 - 568) There was a discussion involving Technician Hendrix and Dr. Morehart among others concerning continued use of the cell saver, in which one of the surgical staff heard Dr. Morehart state he would not reinfuse any blood collected by the machine. (CP 1573 - 1574) Dr. Morehart "agrees that he did engage in a conversation about the Cell Saver device" (Respondent's Brief, pg. 12) and does not dispute

that he agreed during the surgery that the cell saver could no longer be used consistent with Jehovah's Witness beliefs. He only disputes the timing of when this statement was made. (*Id.*)

Technician Hendrix believed she was discharged from the surgery and so removed the disposable components of the machine, stowed it, and went to another part of the hospital to do her paperwork. (CP 583 - 584) Dr. Anast believed that during this time Technician Hendrix was replacing all of the disposable components of the machine. (CP 545 - 546) This process would have taken about 12 minutes. (CP 632 - 633) Since the cell saver machine was not available to provide suction after they had finished converting to an open procedure, they used a Yankauer wand and tubing attached directly to wall suction to clear the surgical field. (CP 546) All suctioned blood was then discarded.

Technician Hendrix did later return to the operating room and set up the cell saver with new components, but the cell saver was not available for use for 25 minutes after the suction tubing dropped below the sterile field, and by the time it was available the bleeding had been gotten under control. (CP 584; 131 - 132) No blood was processed by the cell saver. Ms. Baumgartner died from blood loss a few hours after the surgery. (CP 131 - 132)

1. Questions of Fact Exist Concerning Whether Dr. Morehart Was Negligent in Not Directing That the Cell Saver Be Set Up in Standby Mode.

Relying primarily on *Kirby v. City of Tacoma*, 124 Wn.App. 454, 98 P.3d 827 (2004), Dr. Morehart contends the trial court correctly directed summary judgment dismissing Plaintiff's claim that Dr. Morehart was negligent in not directing that the cell saver be set up in standby mode, asserting this as a new theory of recovery Plaintiff had not previously identified or alleged. (Respondent's Brief, pg. 17.) *Kirby* involved new allegations of discrimination and violation of First Amendment rights, and the Court ruled that even under the broad requirements of notice pleading neither the plaintiff's complaint nor his notice of claim provided notice to the defendant City of these claims, because they did not even contain any reference to "free speech" or "first amendment." *Id.*, at 470-71.

In the present case, Plaintiff alleged in her complaint that Dr. Morehart breached his standard of care in connection with the operation of the cell saver during the surgery. (CP 54 - 55) Plaintiff's specific assertion that Dr. Morehart was negligent by failing to direct that the cell saver machine be used in standby mode is just one of the ways in which Plaintiff asserts Dr. Morehart was negligent in connection with the operation of the cell saver during the surgery. This is not a new theory of recovery, any

more than an allegation that the operator of a car was negligent in driving at an excessive speed would be a new theory of recovery in a lawsuit started under a complaint generally alleging he was negligent in the operation of the car.

Citing to *Marthaller v. King Cnty. Hosp. Dist. No. 2*, 94 Wn.App. 911, 973 P.2d 1098 (1999), and *Klontz v. Puget Sound Power & Light Co.*, 90 Wn.App. 186, 951 P.2d 280,283 (1998), Dr. Morehart also contends that Dr. Spiess somehow offered conflicting testimony between his deposition and declarations, because Dr. Spiess did not in response to Dr. Morehart's counsel's question during his deposition specifically list Dr. Morehart's failure to direct that the cell saver be used in standby mode as one of the ways in which he felt Dr. Morehart's care fell below his standard of care. (Dr. Morehart's Brief, pgs. 18 - 19) In *Marthaller*, a coroner specifically testified in his deposition that he would not offer opinions on the standard of care applicable to paramedics or that a tube ended up in the esophagus as a result of the paramedics failing to meet the appropriate standard of care. *Marthaller*, 94 Wn.App. at 918. When the expert then did so testify in declarations submitted in opposition to the defendant's motion for summary judgment, the Court found this specific contradiction could not be used to create a question of fact to defeat

summary judgment. *Id.*, at 919. *Klontz* was a breach of implied employment contract case. In opposition to the defendant's motion for summary judgment he submitted a declaration that he did rely on policy guide provisions concerning termination of his employment, when he had specifically testified in his deposition that he did not actually read the guide's provisions until after his employment was terminated. The Court held that this declaration contradicted his deposition testimony and could not be used to create a question of fact. *Klontz*, 90 Wn.App. at 191-92.

A complete copy of the 178 page transcript of Dr. Spiess's April 20, 2015, deposition (CP 1738 - 1914) was attached to and incorporated into Dr. Spiess's declaration submitted in opposition to Dr. Morehart's motion, partly to refute this contention by Dr. Morehart that he had contradicted his deposition testimony in his declarations. Dr. Spiess explained in his deposition that whether the suction wand is in or out of the sterile field has no bearing on whether the circuit complies with Jehovah's Witness beliefs, because the suction wand always starts outside of the sterile field when the cell saver is being set up, so it can be set up at any time during the surgery. (CP 1778, Ins. 3-13) Dr. Spiess then in his deposition specifically addressed the issue of using a cell saver in standby mode, testifying that there would be no reason to have a cell saver

connected at the start of a laparoscopic case such as Ms. Baumgartner's, in which a small bore suction irrigator is used through the tiny holes used for laparoscopic insertions, not appropriate for use of a Yankauer suction wand used where significant blood loss is encountered. (CP 1782:3-17) He explains that a Yankauer suction wand has a much larger bore than a suction irrigator and is used for sucking up large quantities of fluids. (CP 1783:5-12)

Dr. Spiess then explains in his declaration submitted in opposition to Dr. Morehart's motion that factual materials developed since his deposition included confirmation that a suction irrigator was attached to the cell saver machine when it was initially set up during the surgery (CP 1638:15 - 1639:1), as well as the deposition of David R. Rosencrantz, MD, the founder and co-Director of the Legacy Bloodless Surgery Program, in which Dr. Rosencrantz had confirmed that in a surgery such as Ms. Baumgartner's where minimal blood loss was expected the cell saver would be employed in standby mode and would not be hooked up to the patient unless and until excessive bleeding occurred, and that this was acceptable to Jehovah's Witnesses who accept cell salvage (CP 1639:2-16). In light of this additional information, Dr. Spiess then opines in his declaration that Dr. Morehart breached his standard of care by not

directing that the cell saver be set up in standby mode, given that if unexpected heavy bleeding occurred during the surgery requiring conversion to an open procedure, effective cell salvage would necessarily involve use of a larger bore Yankauer suction wand, not the small bore suction irrigator inserted in the tiny port holes used during laparoscopic surgery. (CP 1641:9 - 1642:14)

Dr. Spiess did not testify in his deposition that setting up a cell saver in standby mode would be inconsistent with Jehovah's beliefs, or that he would not be testifying as to the standard of care required of an anesthesiologist. Dr. Spiess states in his declaration the standard of care requires that an anesthesiologist in a surgery such as Ms. Baumgartner's has a shared duty with the surgeons to direct the operator of the cell saver machine to act as appropriate and permitted by Jehovah's Witness beliefs. (CP 1640:9-20) His deposition testimony and declaration testimony are not inconsistent.

2. Questions of Fact Also Exist Concerning Whether Dr. Morehart Was Negligent in Not Directing that the Suction Tubing Be Replaced.

Dr. Morehart contends that Plaintiff's assertion he breached his standard of care in not directing that Technician Hendrix hook up the replacement suction tubing already opened when she re-entered the

operating room, discovered that the suction tubing had dropped below the surgical field, and announced that it could not be replaced pursuant to Jehovah's Witness protocol, ignores "the fact that the suction line being outside of the sterile field also contaminated (infected) the Cell Saver device." (Respondent's Brief, pg. 24) Plaintiff does not ignore this, because this is not a fact.

In his first July declaration submitted in opposition to SpecialtyCare's motion for summary judgment, incorporated into his declaration in opposition to Dr. Morehart's motion (CP 1637:4-8), Dr. Spiess specifically addressed and refuted this contention. He explains that the only possible justification for replacing all of the disposable components of the machine would be if the *interiors* of those components had been contaminated by materials sucked up by the suction wand. In fact, the exteriors of these components are already outside the sterile field. But despite Technician Hendrix's claims to the contrary, this did not happen because the button or trigger on the suction/irrigator wand that was attached to the cell saver must be manually pressed to enable suction. (CP 1658:22 - 1659:13) There could be no suction of contaminants through the suction/irrigator wand hanging outside of the sterile field, because the trigger was not being depressed. Regardless of whether Dr. Morehart was

in a physical position to see if the suction wand itself had dropped to the floor, he should have known this.

“A physician with a medical degree is qualified to express an opinion on any sort of medical question, including questions in areas in which the physician is not a specialist, so long as the physician has sufficient expertise to demonstrate familiarity with the procedure or medical problem at issue in the medical malpractice action.” *Hill v. Sacred Heart Medical Center*, 143 Wn.App. 438, 447, 177 P.3d 1152 (2008). In his deposition, Dr. Spiess confirmed that he is an expert in the treatment of Jehovah’s Witness patients, based on writing, research, speaking, and experience.

For 11 years he was a director of his hospital’s Blood Utilization Committee, which ran a Practicing Excellence in Transfusion program. During his tenure, they tried to make the hospital an expert center for Jehovah’s Witnesses. (CP 1761 - 1762) He has written articles and an editorial on the treatment of Jehovah’s Witnesses, and there is a chapter in a book he edited on the subject. (CP 1762 - 1763) Although he does not recall specifically discussing the setup of cell saver under a Jehovah’s Witness circuit, he has spoken all over the world on blood transfusion, including the treatment of Jehovah’s Witnesses. (CP 1764 - 1765).

Dr. Spiess specifically confirmed that it is not a requirement for Jehovah's Witnesses that the suction wand be in the surgical field from the beginning of the surgery. (CP 1773:19-23) He bases this on "talking to many Jehovah's Witnesses and doing cases with Jehovah's Witnesses all the time." (CP 1773:24 - 1774:3) While he could not point to any writings stating what is or is not a Jehovah's Witness circuit, he stated it "absolutely wrong" to say the circuit is broken because the suction wand is not in the surgical field. (CP 1774:9-14) His opinions in this regard are supported by the deposition testimony of the founding director of LSCH's bloodless surgery program, Dr. Rosencrantz, and Jonathan Waters, MD, the expert retained by Technician Hendrix's employer, SpecialtyCare, Inc., who both agree that the continuous circuit required by Jehovah's Witness beliefs was not broken when the suction tubing fell below the sterile field, because the cell saver can be used in standby mode, in which the suction wand is not even used unless the cell saver is needed for unexpected bleeding. (Dr. Rosencrantz: CP 1021:23 - 1022:5 and 1023:22 - 1024:4; Dr. Waters: CP 594:20 - 595:15)

The issue is not whether Jehovah's Witness beliefs with regard to blood leaving their body are rational. The issue is whether Dr. Morehart, who was participating in LSCH's bloodless surgery program, specifically

touted as compliant with Jehovah's Witness beliefs, correctly understood those beliefs. Plaintiff submitted substantial, competent evidence that he did not.

3. Plaintiff Submitted an Expert Declaration Sufficient to Sustain a Verdict for Plaintiff on Causation.

Dr. Morehart points to the operative report's notation by Dr. Anast that they were limited in their ability to suck due to the lower suction required on the cell saver as evidence it did not have the functional capacity to handle the bleeding. But this notation concerned the bleeding that occurred during the laparoscopic part of the surgery, when a suction irrigator wand small enough to insert through the ports was attached to the cell saver. This does not establish what the functional capacity of the cell saver was when the larger bore Yankauer suction wand designed for sucking blood during an open procedure would have been attached.

Dr. Waters, SpecialtyCare's own expert, testified that the suction can be dialed up. (CP 589:14-18) Dr. Waters testified and Dr. Spiess agreed that the cell saver with a Yankauer could have been used to suction the shed blood as effectively as the wall suction the surgeons employed to do so. (CP 1656:20-25) The cell saver has a reservoir into which blood is suctioned, so it would not need to process any heavy bleeding as it

occurred. (CP 1643:25 - 1644:7) With regard to his statement that no suction can keep up with the bleeding from a vascular disconnect at the aorta, Dr. Spiess explained that this aortic bleeding was noted after they had opened up the body and removed the kidney. The surgeons then used lap sponges to compress and control this bleeding, not to clear the surgical field after converting to an open procedure, which they did with wall suction and could have done equally well with the cell saver. (CP 1643:1-10)

Dr. Morehart's argument that the cell saver would not have been available for a period of up to 12 minutes ignores the fact that only the suction tubing and wand had to be replaced because the remaining components of the cell saver were not contaminated, and this entire process would have taken only two minutes, about the same time it would have taken to convert to an open procedure. (CP 633:18 - 634:5; 556:7-21) As Dr. Spiess notes the OR nurse had already started this process by opening spare suction tubing to replace the contaminated tubing so that they could resume suction from the open surgical site. (CP 1654:23 - 1655:6) It was at this point there was a discussion involving Dr. Morehart concerning whether they could continue to use the cell saver for suction. (CP 1655:4-7) During this discussion, one of the nurses heard Dr.

Morehart specifically state that he would not give back any more blood collected during the surgery due to the fact it was no longer a continuous circuit. (CP 1573:16-24) She specifically recalls Dr. Morehart saying that there was no longer a circuit, so any blood collected would not be given. (CP 1574:2-3)

Had Dr. Morehart - the anesthesiologist who had met with Ms. Baumgartner prior to the surgery and who was responsible for the reinfusion of salvaged blood - directed Technician Hendrix to simply replace the tubing she would have done so. Instead, he supported Technician Hendrix's refusal, preventing salvage of blood available in the patient's body. There is substantial evidence and Dr. Spiess so opines that had she done so, the cell saver could have then suctioned and processed enough of her shed blood to have made her survival following the surgery more medically probable than not. (CP 1643:13 - 1645:23)

B. The Trial Court Erred in Denying Plaintiff's Motion For Partial Summary Judgment.

In light of Plaintiff's settlements with all the defendants except Dr. Morehart and his employer, CAG, the issue of joint and several liability is moot. Therefore, this brief will only address the issues of the applicability of the doctrines of assumption of the risk and contributory negligence, as

unless this Court orders otherwise these issues will still be before the trial court if the case is remanded.

1. Assumption of Risk.

a. Express Assumption of the Risk Does Not Apply.

The facts of *Shorter, supra*, are not only significantly different than those of the present case, those differences illustrate why express assumption of the risk does not apply in the present case. In *Shorter*, both the decedent wife and her husband were required to sign a release of the hospital and her physicians. *Shorter*, 103 Wn.2d at 648-49. The Court held that the language of this document, under which the Shorters released the defendants from “*any responsibility whatever* for unfavorable reactions or *any untoward results* due to my refusal to permit the use of blood or its derivatives,” was broad enough to include the risk of bleeding to death caused by the defendant doctor’s negligence. *Id.*, at 651 (emphasis in the original). However, in the present case, Ms. Baumgartner did not sign a release in connection with the surgery, and neither the durable power of attorney or the informed consent form Ms. Baumgartner did sign contained any language releasing defendants from any responsibility or liability.

b. Implied Primary Assumption of Risk Does Not Apply.

There is also a significant difference between the facts of *Shorter* and the facts of the subject case with regard to the application of implied primary assumption of the risk. *Shorter* only involved the refusal of blood transfusion, there was no discussion concerning acceptable alternatives to blood transfusion. So when unexpected bleeding occurred during Mrs. Shorter's surgery, the only remedy available to the surgeon was blood transfusion, to which the Shorters refused to consent. However, in the present case, there was an alternative to blood transfusion to which Ms. Baumgartner did consent, the cell saver machine.

In *Gleason, supra*, this Court recently addressed the issue of implied primary assumption of the risk in the context of an individual who was injured by a falling tree while helping a landowner cut down trees on his property. The trial court granted the landowner's motion for summary judgment, ruling that the plaintiff's claim was barred by implied primary assumption of risk, because he was aware of the risk that the particular tree he was cutting down could fall on him. On appeal, this Court explained that this doctrine only applies where a plaintiff is injured by a risk inherent in and necessary to a particular activity. *Gleason*, 192 Wn. App. at 797

(citing to *Scott By and Through Scott v. Pac. W. Mountain Resort*, 119 Wn.2d 484, 500-01, 834 P.2d 6 (1992)). This Court noted that implied primary assumption of risk would apply to the dangers inherent in cutting down trees. *Id.*, 192 Wn.App. at 800. But the Court went on to note that Gleason claimed that Cohen engaged in additional conduct that increased the risk of his being injured while cutting down trees, and “Washington law is clear that implied primary assumption of risk does not apply to this additional negligence.” *Id.*

In the context of major surgeries, a patient consenting to blood transfusion still impliedly assumes the risk that he might bleed to death even if the surgery is properly performed and blood transfusion is given, because that is an inherent risk of any major surgery. But a patient who consents to blood transfusion does not assume the risk that he might bleed to death following the surgery if due to the negligence of his doctors blood transfusion is not given. Similarly, a patient who declines blood transfusion but consents to use of a cell saver impliedly assumes the risk that he might bleed to death following a properly performed surgery during which blood transfusion is not given but a cell saver is used, because that is an inherent risk of such a surgery. But a patient who consents to use of a cell saver during a surgery does not impliedly assume the risk that he

might bleed to death following a surgery during which the cell saver was *not* used due to the negligence of his doctors, because that is not an inherent risk of the surgery.

Plaintiff's claim is that Dr. Morehart's negligence during the surgery - in not directing before the surgery started that the cell saver be set up in standby mode to facilitate its immediate use if unexpected heavy bleeding occurred and in not directing during the surgery that the suction tubing be replaced and the cell saver be used after the suction tubing dropped below the sterile field - increased the risk that Ms. Baumgartner would bleed to death as a result of the surgery. Implied primary assumption of the risk does not apply to this claim.

c. Implied Reasonable and Implied Unreasonable Assumption of Risk Do Not Apply.

This Court's reasoning in *Gleason* also establishes why implied reasonable and implied unreasonable assumption of risk also do not apply in the present case. As noted in that decision, implied reasonable and unreasonable assumption of risk only apply "where a plaintiff is aware of a risk that has *already been created* by the negligence of the defendant, yet chooses to voluntarily encounter it." *Gleason*, 192 Wn.App. at 796 (quoting *Scott*, 119 Wn.2d at 499, in turn quoting with approval

Leyendecker v. Cousins, 53 Wn.App. 769, 774, 770 P.2d 675 (1989); emphasis supplied).

In the present case, unlike the plaintiff wife in *Shorter*, Ms. Baumgartner never regained consciousness following the surgery. Unlike Mrs. Shorter, Ms. Baumgartner never had the opportunity to make a decision concerning whether she would agree to encounter the risk of bleeding to death without blood transfusion created by Dr. Morehart's negligence in connection with use of the cell saver during the surgery.

2. Contributory Negligence.

The doctrine of contributory negligence requires proof of the elements of negligence. *Webley v. Adams Tractor Co.*, 1 Wn.App. 948, 949, 465 P.2d 429 (1970). The elements of both negligence and contributory negligence are "duty, breach of duty, and proximate causation." *Papac v. Mayr Bros. Logging Co.*, 1 Wn.App. 33, 36, 459 P.2d 57 (1969). "It is well settled that an essential element in any negligence action is the existence of a legal duty * * *." *Petersen v. State*, 100 Wn.2d 421, 425-26, 671 P.2d 230 (1983); *see also Christensen v. Royal School Dist. No. 160*, 156 Wn.2d 62, 64-65, 124 P.3d 283 (2005). Whether a party owed a duty of care is a question of law for the Court. *Little*, 132 Wn.App. at 780.

Dr. Morehart argues that “a patient using ordinary care would allow her physicians to provide any reasonable medically accepted treatment, when such treatment is needed during the surgery to save the patient’s life.” (Respondent’s Brief, pg. 47) As Ms. Baumgartner did not regain consciousness following the surgery, any contributory negligence by her could only have arisen as a result of her decision before the surgery to undergo it with the condition that it be performed without blood transfusion, as she consented to the use of a cell saver and numerous other medically acceptable alternatives to blood transfusion. Therefore, under Dr. Morehart’s argument Ms. Baumgartner was negligent as a matter of law simply as a result of her decision to undergo the surgery without blood transfusion, despite her acceptance of numerous other medically acceptable alternatives to it. Not only that, but by the same reasoning everyone who participated in the surgery with the knowledge that Ms. Baumgartner did not consent to blood transfusion was negligent as a matter of law, despite the fact that the surgery was performed in Legacy’s bloodless surgery program. Indeed, anyone participating in Legacy’s bloodless surgery program with knowledge that a patient did not consent to blood transfusion would be negligent as a matter of law.

III. CONCLUSION

Dr. Morehart moved for summary judgment solely on the basis that Plaintiff could not prove a prima facie case that he was negligent or that any negligence by him was a proximate cause of Ms. Baumgartner's death. Dr. Morehart did not support his motion with any declaration from his own expert supporting these contentions, he only attacked the declaration testimony of Plaintiff's expert already submitted in opposition to SpecialtyCare's motion. In response, Plaintiff submitted an additional declaration from her expert specifically addressing Dr. Morehart's allegations.

Plaintiff has submitted substantial evidence in support of her prima facie case. Plaintiff therefore requests that this case be remanded for trial against Dr. Morehart and CAG. Plaintiff further requests that on remand this Court instruct the trial court that the jury is not to be given any instructions concerning assumption of risk or contributory negligence.

Respectfully submitted this 10th day of June, 2016.

s/ Laurence R. Wagner

William F. Nelson, WSBA #1013
Laurence R. Wagner, WSBA #17605

DECLARATION OF SERVICE

I, Tori K. Ring, declare under penalty of perjury under the laws of the State of Washington that the following is true and correct:

1. On this 10th day of June, 2016, I personally deposited in the mails of the U.S., a properly stamped and addressed envelope directed to the attorney of record of Defendants containing a true copy of the document (Appellant's Reply Brief) to which this declaration is affixed.

DATED this 10th day of June, 2016, at Vancouver, Washington.

s/ Tori K. Ring

TORI K. RING

BAUMGARTNER NELSON & WAGNER

June 10, 2016 - 3:31 PM

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