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COURT OF APPEALS  
DIVISION II

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STATE OF WASHINGTON

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No. 52586-1-II

COURT OF APPEALS OF THE STATE OF WASHINGTON  
DIVISION II

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PHYLLIS COOLEN as Personal Representative of the Estate of  
PATRICK COOLEN, and Individually as Surviving Spouse;

Appellant,

v.

GROUP HEALTH OPTIONS, INC., a for profit Washington Corporation  
doing business in Thurston County; GROUP HEALTH COOPERATIVE,  
a Washington business entity doing business in Thurston County; GROUP  
HEALTH OF WASHINGTON, a Washington business entity doing  
business in Thurston County, JOHN DOES 1-3, providers of health care  
services in Thurston County, jointly and severally;

Respondents.

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APPELLANT'S REPLY BRIEF

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## I. REPLY

### 1. Informed consent:

GH contends that it provided Mr. Coolen with information on prostate cancer screening in 2003, 2006 and 2009.

In the context of the 2003, 2006 and 2009 visits, Dr. Bretan's testimony established that GH **never** documented Mr. Coolen opting out of a PSA test, if he did opt out what the reasons for opting out were, or even that he understood the consequences of opting out. *VRP 118-119.*

Regardless, it was at Mr. Coolen's September 13, **2010** GH visit that Mr. Coolen: (1) presented with complaints of a few months of urinary frequency/urge, some urethral discomfort and an urge to urinate about every hour while awake; (2) was found to have an enlarged prostate, and (3) was diagnosed with benign prostatic hyperplasia ("BPH"). *VRP 132- 133.*

The evidence at trial was overwhelming that at this September, 2010 visit GH failed to discuss with Mr. Coolen the potential for his having cancerous tissue as part of the enlargement of the prostate, anything about a PSA test or even the possibility that it could be cancer, or that there's further workup needed. *VRP 269-270; VRP 273.*

For example, the record from Mr. Coolen's September 13, 2010 GH visit instructs Mr. Coolen to decrease caffeine and alcohol and to drink more

water and follow-up as needed if symptoms worsen or fail to improve. It also advises him that if his urination problem caused by benign prostatic hyperplasia is mild to moderate and does not bother him, home treatment may be all he needs to keep his symptoms from interfering with his daily activities *VRP 271:12-23*.

Medical expert Jonathan Staben, MD testified at trial: "So that person is going to leave that office visit thinking that their urinary problems are caused by alcohol, caffeine, and a benign enlargement of their prostate. And so that's what they're going to go home with. And they're not going to go home with the fact that this could be cancer, because that -- that **was not documented** on that visit **or discussed**."<sup>1</sup> [bold added]. *VRP 272:15-273:5*.

GH appears to believe that facts exist to show that informed consent was provided. But the determination of whether GH obtained informed consent is not the issue on this appeal. That should have been for the jury to decide, but the lower court incorrectly excluded Coolen's<sup>2</sup> informed consent cause of action based on an incorrect conclusion that the *Backlund* rule applied. This case falls directly within the exception set forth in *Backlund v.*

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1

Coolen's opening brief at pages 7 & 15 incorrectly put "September 10, 2013". It should be "September 13, 2010". Also, at p.4 of that brief the word "engorged" was used. It should state "enlarged".

2

The Plaintiff in this Reply is referred to as "Coolen".

*Univ. of Washington*, 137 Wash. 2d 651, 975 P.2d 950 (1999), which derives from *Gates v. Jensen*, 92 Wash. 2d 246, 595 P.2d 919 (1979).

In *Gomez v. Sauerwein*, 180 Wash. 2d 610, 623, 331 P.3d 19, 25 (2014), the Supreme Court held that when a health care provider **rules out** a particular diagnosis based on the circumstances surrounding a patient's condition, including the patient's own reports, there is no duty to inform the patient on treatment options pertaining to a ruled out diagnosis. But in Coolen's case, GH **never ruled out cancer** as a diagnosis. GH simply diagnosed Mr. Coolen with benign prostatic hyperplasia – without informing him of alternative treatment options that could have ruled in or out prostate cancer – i.e. a PSA test followed up with a biopsy.

GH did not know if Mr. Coolen's condition was "benign" – because it never conducted the appropriate tests to rule in or out prostate cancer.

"Under *Gates*, there may be instances where the duty to inform arises **during the diagnostic process, [. . .]**" [bold added]. *Gomez v. Sauerwein, id.*, at 623. The determining factor is whether the **process of diagnosis** presents an informed decision for the patient to make about his or her care. *id.*

*Backlund v. Univ. of Washington, id.*, does not stand for a blanket abolition of an informed consent action where failure to diagnose is also pursued. Rather, *Backlund* confirms that *Gates v. Jensen, id.*, is an exception

with regard to the overlap between medical negligence and informed consent.

*See Gomez v. Sauerwein, id. at 626.*

GH argues that Coolen failed to raise her informed consent appellate arguments in the trial court. This is incorrect. In its motion in limine on informed consent, GH relied on *Backlund, id. CP 970-971*.

At the hearing on GH's motion in limine, Coolen's counsel stated: "When you have benign prostatic hyperplasia, which you don't know is benign because you haven't tested it, so it can just as easily be cancer, when you have that in conjunction with urethral pain, with urgency and with frequency, you have enough information to tell the patient that this could be cancer. And so **their own caselaw that they're citing** says that the risk to the parent's health is the criteria, not that they didn't diagnose it." [bold added]. *VRP 58:4-12*.

At trial, Coolen's attorney even asked the lower Court to reconsider its decision:

And then the other thing that I wanted to talk about is, I had proposed in Jury Instruction Number 4 and Jury Instruction Number 10, one of them is the shared decision-making and, quote, statute. And the other one is informed consent. [ . . . ]

And so you have, in motion in limine, taken away that informed consent. I'm asking you to give it back. *VRP 830: 7-11 & 14-16*

At trial, Coolen's attorney also took issue with the lower court's

decision on shared decision-making:

So Plaintiff would take exception to the court not using Plaintiff's Amended Proposed Instruction Number 4. This is the one that has the shared decision-making statutory language in it. This is a -- WPI 60.01 allows the use of a jury instruction that recites statutory language. The Group Health Cooperative speaking agent in this trial said, and I'll quote,

"The whole way in which we've constructed our work around prostate cancer is to involve a man in shared decision-making so that they can decide what they'd like to do."

So apparently shared decision-making has to do with the entire way in which they've constructed their work around prostate cancer. And so when that's coming out of the defendant's own mouth on the stand in front of the jury, to not give the statute on shared decision-making, despite the fact that a WPI allows doing that, we take exception to that. It limits our ability to argue the theory of the case." *VRP - 1394:18-1395:12*

Regarding the September 13, 2010 GH visit and GH's failure to do PSA testing on Mr. Coolen, medical expert Jonathan Staben, MD testified:

I don't think that met the standard of care to not do that test at that time **or at least talk to him and say that's part of the workup**. If you have an abnormal finding, you have to, like -- you just can't just let it go and not do anything about it, or at least instruct the patient and say, you know, we think this is benign, but we need to really kind of have this on the radar, and you know, **we need to test for this, even if it's not today, you'd need to come back next month and test for it, you know, because you have an abnormality**. You wouldn't -- you just can't let someone off with a -- with an abnormal growth or a finding and not at least talk about it and offer the testing.

[bold added]. *VRP 255:21-256:5-18.*

Dr. Staben's testimony established that if a practitioner is having a discussion with a patient about cancer screening or prostate screening, and the practitioner is talking about harms, the practitioner also has to talk about PSA as a potential lifesaving diagnostic test. *VRP 266:14-18.*

Q. Did you have any sense, in reviewing the records from 2010 up through 2014, whether there was a fair and balanced presentation of the risks and benefits of cancer screening to Patrick Coolen?

A. I don't think there's any discussion of that during those visits.

*Dr. Staben direct examination, at VRP 267:1-6.* Dr. Staben testified that “The patient gets to decide” regarding whether to go forward with prostate cancer screening **once that shared decision-making process has commenced.** *VRP 267:22-268:1.* This involves a discussion about the risks and benefits of prostate cancer screening. *See Staben cross, VRP 268:4-10.*

Dr. Staben testified that “[. . .] so the standard of care for working up this problem would be to do a PSA. So the -- and now if you had -- if you had a discussion here on this visit that said “I recommend a PSA” and the patient declined, then that's one acceptable way to comply with the standard of care. But that -- that wasn't done here. No. There was no discussion documented that a PSA was ordered or even discussed with the patient.” *VRP*

269:21-270. Dr. Staben further testified: “[. . .] I would expect that when you have something that would be a -- something that would potentially lead to a diagnosis of cancer, that that, in fact, actually would be important to document. And that -- that's part of the complying with the standard of care.”  
*VRP 270:17-22.*

In Dr. Staben's experience, he has **never** had a male patient over sixty decline a PSA test after a digital rectal exam. *VRP 264:3-7.* He even testified, "But I've never, in 15 years, had someone say I want the rectal exam and not the blood test." *VRP 264:14-16.*

In this case, it was the **process** for diagnosing prostate cancer that – had Mr. Coolen been informed of and offered a PSA test – should have presented him with a decision pertaining to his care.

Medical expert Peter Bretan, MD, the standing president of the California Urological Association and the healthcare policy representative for the American Urological Association, testified at trial: “I think this is something that should have been done, could have been done, low toxicity, and it would have ended up with Mr. Coolen still alive today.” *VRP 225:8-11.*

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## 2. Corporate Negligence:

### Theory 1: Failure to Adopt Policies & Procedures:

*Osborn v. Pub. Hosp. Dist. I, Grant Cty.*, 80 Wash. 2d 201, 492 P.2d 1025 (1972) and RCW 7.70.030 are not mutually exclusive. The fact that *Osborn* was decided before enactment of ch. 7.70 RCW is inconsequential because the two corporate negligence theories in Coolen's case both apply to RCW 7.70.030(1) – i.e. that injury resulted from the failure of GH to follow the accepted standard of care.

The question becomes, what is the accepted standard of care? As a necessary element to prove the proposition of RCW 7.70.030(1) the Plaintiff is required to prove:

- (1) The health care provider failed to exercise that degree of care, skill, and learning expected of a reasonably prudent health care provider at that time in the profession or class to which he or she belongs, in the state of Washington, acting in the same or similar circumstances;
- (2) Such failure was a proximate cause of the injury complained of.

*RCW 7.70.040.*

At a **minimum**, the standard of care expected would be to comply with pertinent patient care statutes in ch. 70.41 RCW and regulations promulgated thereunder. We know this, because RCW 70.41.030 mandates that the Department of Health establish and adopt such **minimum standards**

and rules pertaining to the operation of hospitals, as are necessary in the public interest, and particularly for the establishment and maintenance of standards of hospitalization required for the **safe and adequate care and treatment of patients.**

In *Douglas v. Freeman*, 117 Wash. 2d 242, 249, 814 P.2d 1160 (1991), the Supreme Court stated: “Other decisions have found the standard of care for hospitals defined by statute”, and cited: “*Byerly v. Madsen*, 41 Wash.App. 495, 503, 704 P.2d 1236, *review denied*, 104 Wash.2d 1021 (1985); *Schoening v. Grays Harbor Comm'ty Hosp.*, 40 Wash.App. 331, 335, 698 P.2d 593, *review denied*, 104 Wash.2d 1008 (1985); *see also RCW 7.70.040(1).*” [bold added].

GH characterizes ch. 70.41 RCW as merely a “licensing statute.” That is a self-serving mischaracterization, and it does not accurately reflect the true purpose of the chapter. The purpose of ch. 70.41 RCW is set forth in RCW 70.41.010 and in pertinent part is to promote **safe and adequate care of individuals** in hospitals. *See RCW 70.41.010.*

One minimum standard established and adopted by the Department as directed in RCW 70.41.030 is that the hospital must **adopt and implement patient care policies and procedures** designed to guide staff that address (1) care and handling of patients whose condition require special

medical or medical-legal consideration and (2) use of preestablished patient care guidelines and protocols. *See WAC 246-320-226(3)(h) & (g).*

The evidence (and common sense) show that prostate cancer is a disease that involves special medical consideration. For example, Dr.

Garnick testified at trial:

And there was -- there were so many complexities surrounding the issue of prostate cancer, screening and diagnosis and outcomes and treatment, that I felt that I wanted to memorialize many of the discussions that I was having with my individual patients in my -- in my clinic and my office to a broader audience. So I went to the Harvard Medical School publishing arm, which is called Harvard Health Publications, and I suggested that we put together a report -- or actually a pamphlet, and it's actually a book now, that deals with the complexities of understanding prostate cancer, what the results of studies have been, how patients who are contemplating a diagnosis of prostate cancer or how patients who have been diagnosed with prostate cancer, who's at risk of developing prostate cancer, would have a completely unbiased view of what the specific issues are.

*VRP 625:18 - 626:10.* Referring to prostate cancer screening, GH's speaking agent testified at trial: "But it's a **complicated topic**, and most people need some time to think it through, because it's a little counterintuitive." *VRP 553:7-9.* GH's speaking agent also testified: "[. . .] we think that a man should not be screened until they have a full understanding of **the complexity of the issue.**" *VRP 533:22-25.*

Dr. Bretan testified at trial: "Because when you're talking about the

cancer that killed Mr. Coolen, you need to document that, because essentially, it is a life or death decision.” *VRP 118-119*.

Yet according to GH’s testimony at trial, GH did not have a single men’s health policy for prostate cancer:

Q. Doctor, does Group Health have any men's health policies for prostate cancer?

A. We do not. *VRP: 577:17-19*.

GH failed to meet even the minimum standard established under WAC 246-320-226(3)(h) & (g) and RCW 70.41.040.

GH points out that the WAC referenced in *Osborn* (248-18-200) no longer exists. That is immaterial. That WAC was promulgated under ch. 70.41 RCW and required establishment of safety policies and procedures for patient care. The pertinent WAC in the present case was also promulgated under ch. 70.41 RCW (which is still the law), also pertains to patient care, and similarly requires the hospital to adopt certain patient care policies and procedures. *See WAC 246-320-226(3)(h) & (g)*.

GH argues that sections of ch. 70.41 RCW “indicate that no private right of action exists for a violation of the statute [ . . . ]” – an argument that fails to have significance to the present case because it requires an improper conflating of “right of action” with “standard of care”. Coolen has a private “right of action” under RCW 7.70.030(1) based on corporate negligence. This

is because he sustained injury resulting from GH's failure to follow the accepted standard of care.

Chapter 70.41 RCW and WAC 246-320-226(3)(h)&(g) promulgated thereunder provide the minimum "standard" by which GH must operate, that is, to adopt and implement patient care policies and procedures designed to guide staff that address: (1) care and handling of patients whose condition require special medical or medical-legal consideration, and (2) use of preestablished patient care guidelines and protocols.

*WAC 246-320-226(3)(h) & (g)* is evidence of an **accepted standard of care**. If legislatures proscribe certain conduct by statute, that establishes the duty, i.e., the standard of care. *Callan v. O'Neil*, 20 Wash. App. 32, 37, 578 P.2d 890 (1978). A breach of a duty imposed by statute, ordinance, or administrative rule may be considered by the trier of fact as evidence of negligence. *See RCW 5.40.050*.

In *Pedroza v. Bryant*, 101 Wash. 2d 226, 677 P.2d 166 (1984), the Supreme Court related RCW 70.41.010 to a **hospital's duty of care**:

RCW 70.41, which controls the licensing and regulation of hospitals, supports the limitation of a hospital's duty of care to those who are patients in the hospital. RCW 70.41.010 provides in pertinent part: "The primary purpose of this chapter is to promote safe and adequate care of individuals in hospitals ..."

*Pedroza, id.*, at 236–37. Ch. 70.41 RCW was part of the *Pedroza* court's

discussion on duty of care because it had bearing on duty of care. The *Pedroza* court relied on ch. 70.41 RCW to conclude that a hospital's **duty of care** under the doctrine of corporate negligence extends only to those who are patients within the hospital. *Id.*, at 236-237.

GH claims that Coolen presented no evidence of breach, relying on Dr. Bretan's testimony that the GH policy complied with national standards with which he is familiar. *Respondent's Brief at 16*. But for this argument to have any merit, GH's policy must be - - "a policy". But at trial, GH made a tactical choice to claim that its policies are not policies, but are guidelines that need not be followed (even though in discovery GH called them policies). *e.g. VRP 455:2-10.; VRP 456:20-25. VRP 577:17-25. 578:6-7.*

GH took this position at trial because if they were policies, then violation of these policies would be detrimental to its defense against Coolen's malpractice claim. By admitting that it has no men's health policies on prostate cancer, GH is admitting that it failed to even meet the minimum standards to adopt policies as required by law.

GH must also have procedures - not *just* policies. Even if GH had requisite policies, they are useless if there are no procedures in place to accomplish the policy.

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**A. Causation:**

In *Douglas v. Freeman, id.*, the Plaintiff sued Dr. Freeman and the clinic for damages arising from injury to her lingual nerve. *id.*, at 246. The Plaintiff charged the clinic with negligence in supervising Dr. Freeman - i.e. corporate negligence. *id.*, at 253. At the time of the Plaintiff's wisdom teeth extractions, Dr. Freeman, who performed the extractions, was not licensed to practice dentistry in Washington. *id.*, at 245. The jury returned a verdict for Dr. Freeman on the negligence claim, but against the clinic on the corporate negligence claim. *id.*, at 246.

After the jury trial, the clinic filed a motion for judgment notwithstanding the verdict or, in the alternative, for a new trial. *id.* The trial court denied the motion on the basis that there was evidence from which the jury could have concluded that the clinic's failure to have a dental assistant present during the extractions rendered it liable for corporate negligence. *id.*

The clinic appealed and the Court of Appeals reversed, finding insufficient evidence to support the jury's corporate negligence verdict. *id.* Plaintiff then petitioned the Supreme Court for review. *id.*

On the corporate negligence claim, the clinic argued that there was insufficient evidence of causation. *id.*, at 252.

Dr. Freeman stated several times that wisdom tooth extractions

require an assistant, and he repeatedly referred to the assistant's role as he explained the extraction procedure. *id.*, at 253-254. He described the assistant as suctioning blood and holding the tissue aside after the incision had been made so that he could see and reach the tooth. *id.*, at 254. He testified that it would be virtually impossible to do perform an extraction trying to hold instruments at different times to get to a tooth, and that it is essential that someone is there to do that, and that “You can't keep all tissue out of the way to do what you have to do without assistance.” *id.*

Two expert witnesses testified that the lingual nerve **could** be damaged at stages where Dr. Freeman stated he required an assistant. One expert testified that the lingual nerve **could** be damaged during injection of the anesthetic, incision of the soft tissues, removal of the bone around or over the tooth, removal of the tooth, and during the stitching of the incision. *id.*, at 254. Another expert testified that damage to plaintiff's lingual nerve was probably caused by either a scalpel, an elevator in retracting the tissue, or probably, most likely the drill, during the removal of Plaintiff's wisdom tooth. *id.* This expert had testified earlier that the drill is used to remove the bone surrounding the tooth. *id.* The Supreme Court noted that here again, tissue would have been cut and blood suctioned before and during drilling, thus, according to Dr. Freeman, necessitating the presence of an assistant. *id.*

The Supreme Court also noted that Dr. Freeman never stated directly

that a dental assistant was necessary to prevent lingual nerve damage. *id.*

The Supreme Court held that although Dr. Freeman **never stated directly** that a dental assistant was necessary to prevent lingual nerve damage, a jury could **reasonably infer from the evidence** that the assistant's absence caused him to perform the extractions in a manner that injured plaintiff. *id.*

The Supreme Court stated: "If, from the facts and circumstances and the medical testimony given, a reasonable person can infer that the causal connection exists, the evidence is sufficient." *Id.*, at 252.

"As a general proposition, expert testimony is not required to establish a standard of care in an action for negligence." *Petersen v. State*, 100 Wash. 2d 421, 437, 671 P.2d 230 (1983).

In the present case, medical expert Peter Bretan, MD, was asked at trial why GH's doctor's are not complying with the GH documentation policy with respect to prostate guidelines. Dr. Bretan testified in part: "[. . .] sometimes guidelines, recommendations, you know, they're voluntary to some extent. **Unless you really tell people that you need to do this** and you're monitored and it's monitored in the EMR, **you're probably not going to get much compliance.**" *VRP 221:23-222:12.*

Dr. Bretan chided the practice of using a final prostate cancer screening for the death of the patient or to make a diagnosis that the patient

has metastatic disease – and opined that such a practice is going to be repeated over and over “unless you have a policy in place that says you need to do this, because lives are lost and we’re going to track this.” *VRP 222:13-20*. Dr. Bretan added: “[. . .] for a simple blood test, if you [i.e. GH] tell them [i.e. GH providers], you know, just order the darned test or send them to the urologist who will order it for you, I think you’ll save lives.” *VRP 222:3-6*.

Dr. Bretan further testified: “Well, again, if you’re ordering it, a PSA test, once you suspect a patient has metastatic disease already, that’s a dire situation. And you had the opportunity to do it five years earlier, maybe ten years earlier. That is - - that should not happen. That should not happen.” *VRP 223:18-23*.

But GH had merely a discretionary guideline – not a policy – that a PSA test to screen for prostate cancer must be offered to patients and that if the patient declines, the GH practitioner must document that. Having no men’s health policy (i.e. mandate) in place for prostate cancer, GH failed to offer Coolen a PSA test to screen for prostate cancer. Dr. Bretan testified: “It doesn’t appear that any of those things [offering a PSA test and documenting decline] happened at a time when the disease was confined to the prostate and the patient had no symptoms, thus a very curable state if it was found at that time.” *VRP 118*.

Dr. Bretan opined that in 2010, if Patrick Coolen had a prostate

cancer, which Dr. Bretan believes more likely than not he did, it would have been contained to the prostate. *VRP184*. Dr. Bretan was asked if the prostate cancer had been caught because of an elevated PSA in 2009 or in 2010, what would he expect the survival to be for Patrick Coolen, and he answered in pertinent part: “The data shows, as well as my personal data, that high-grade cancers, when picked up early, confined to the prostate is very curable.” *VRP 139-140*

Dr. Bretan also opined: “The earliest that you could estimate that he could have still been saved would possibly be early 2013, late 2012.” *VRP 142-143*.

GH’s claims of deficiency on the informed consent issue are unfounded.

**Theory 2: Failure to Monitor (supervise) the competency of all healthcare providers practicing medicine at GH:**

According to WPI 0.10, the pattern instructions restate otherwise existing law. The second bracketed duty in the corporate negligence WPI (105.02.02) is “exercise reasonable care to periodically monitor and review the competency of all health care providers who practice medicine at the hospital.” *See WPI 105.02.02*. This is taken from the Supreme Court’s opinion in *Douglas v. Freeman*, 117 Wash. 2d 242, 814 P.2d 1160 (1991). *See Comment to WPI 105.02.02 Hospital Responsibility—Corporate*

*Negligence, (6th ed.):*

The Douglas court identified four specific duties a hospital owes to its patients under the doctrine of corporate negligence: [. . .](4) to supervise all persons who practice medicine within its walls.

*See also Douglas, id.* at 248. **GH does not challenge** or even address the lower court's obvious error of determining that this duty applies only in the instances when the hospital is aware of obvious negligence. *VRP 1364*. No such limitation exists within the duty to supervise/monitor.

Instead, GH claims that there was a lack of evidence as to causation and as to what the standard of care is, pertaining to the "failure to monitor" corporate negligence theory. This claim is unfounded.

**A. Standard of Care:**

"Hospitals are also in a superior position to monitor and control physician performance." *Pedroza v. Bryant, id.*, at 231.

The Supreme Court held that an appropriate standard of care in cases involving hospital corporate negligence was enunciated by the court in *Pederson v. Dumouchel*, 72 Wash. 2d 73, 431 P.2d 973 (1967), which was "that of an average, competent practitioner acting in the same or similar circumstances." *Pedroza v. Bryant, id.*, at 226, quoting *Pederson v. Dumouchel, id.*, at 79. This standard is essentially restated in WPI 105.02.02 and identified as "reasonable care":

“Reasonable care” in this instruction means that degree of skill, care, and learning expected of a reasonably prudent hospital in the State of Washington acting in the same or similar circumstances and at the same time of the care or treatment in question. Failure to exercise such skill, care, and learning is negligence.

*WPI 105.02.02 - Hospital Responsibility - Corporate Negligence (6<sup>th</sup> Ed).*

The degree of care actually practiced by hospitals is evidence of what is reasonably prudent. *Id.* To that end, Coolen presented medical expert testimony of Kaiser’s practice regarding monitoring – which was to screen and implement an **electronic medical record tracking of their physicians.**

*VRP 222.* The evidence at trial also established that GH failed to even come close to meeting this standard of care:

1. GH does not audit the charts or track the use of PSA testing at a population level; *VRP 535:12-13*;

2. GH did not put in place any system that would audit whether their physicians are actually giving information to their patients on prostate cancer or on the use of PSA testing at a population level; *VRP 535:23-536:3.*

3. GH did not put in place any control that would audit whether their physicians are actually giving information to their patients on prostate cancer or on the use of PSA testing at a population level; *VRP 535:23-536:3.*

4. GH did not put in place any audit that would audit whether their physicians are actually giving information to their patients on prostate cancer

or on the use of PSA testing at a population level; *VRP 535:23-536:3*.

5. GH does not audit the records, period. *VRP 560*. This means that GH does not audit the records to monitor what their providers are saying to patients about prostate cancer screening -or whether they are saying anything at all. This also means that GH does not audit the records to ensure that the training GH gives to its clinicians on discussing prostate cancer screening with the patient is actually being implemented by the clinicians.

**B. Causation:**

At trial, there was ample evidence to be drawn from the testimony presented in Mr. Coolen's case-in-chief that GH's lack of oversight of its clinicians via auditing their records to monitor their competency in the giving of information to patients on prostate cancer and prostate cancer screening – including the use of PSA testing – was a cause of GH's failure to diagnose and therefore his untimely death.

The proposition that the absence of proper supervision by a healthcare provider contributed to the Plaintiff's injury may be proven through circumstantial evidence drawn from the testimony of medical experts. *See Douglas v. Freeman, id at 255*.

Referring to Mr. Coolen's urinary symptoms at the September 13, 2010 GH visit, medical expert Jonathan Staben, MD, testified at trial: "I

would -- you know, based on his symptoms, I would also do a PSA or talk to him about that, a prostate cancer screening test. [. . .]" *VRP 254:14-25*.

Dr. Staben proceeded: "Just because you have -- you have an abnormal finding, so you have an enlarged prostate, and you can't just by an exam just assume that it's a benign -- what we call benign, noncancerous. So you can't just say, well, it's enlarged so it has to be benign and we don't need to do any more testing. You wouldn't do that with other kinds of abnormal findings in other parts of the body." *VRP 254:25-255:8*.

At that visit, GH diagnosed Mr. Coolen with benign prostatic hyperplasia (BPH). Dr. Staben testified that if the PSA is elevated, going up over time, that is going to trigger the provider to take action beyond watchful waiting. *VRP 261:25-262:5*. But no GH provider ever put BPH on Mr. Coolen's problem list in his records. *VRP 252:23-253:3*. Dr. Staben testified at trial that the problem list is part of the physician's records, so the patient is not going to have access to that. *VRP 262:14-17*. He also testified that the problem list could work as a flag for the provider regarding a patient who has BPH. *VRP 252:10-18*.

Q. Did you have any sense, in reviewing the records from 2010 up through 2014, whether there was a fair and balanced presentation of the risks and benefits of cancer screening to Patrick Coolen?

A. I don't think there's any discussion of that during those

visits.

*Dr. Staben testimony VRP 267:1-6.* Dr. Staben testified: “That discussion of the possibility of it could be cancer or that there's further workup needed wasn't done.” *VRP 273.*

Dr. Bretan opined at trial that if GH had given Mr. Coolen PSA testing in 2010, that would have “absolutely” provided a basis for further evaluation between 2010 and 2014. *VRP 121.*

GH admitted at trial that “The decision of the patient should be documented.” *VRP 452.* GH's speaking agent admitted that during his residency training, GH taught in its residency: if it isn't documented, it wasn't done. *VRP 451.* Yet GH failed to audit its clinician's records pertaining to prostate cancer or prostate cancer screening – and therefore did not adequately supervise its clinician's competency as to whether and how PSA tests to screen for prostate cancer were being offered or even discussed with the patient.

Dr. Bretan opined that in 2010, if Patrick Coolen had a prostate cancer, which Dr. Bretan believes more likely than not he did, it would have been contained to the prostate. *VRP184.* Dr. Bretan opined that if Mr. Coolen had received a PSA test in 2009 or 2010 or even 2011, “you would have a biopsy and we would make that diagnosis and we would offer him

surgery, radiation, or both. [ . . . ]” *VRP 143*.

The GH guidelines ask that the PSA test to screen for prostate cancer be offered to patients and ask that, if the patient declines, the GH practitioner document it. *VRP 118*. Dr. Bretan testified at trial that: “It doesn’t appear that any of those things happened at a time when the disease was confined to the prostate and the patient had no symptoms, **thus a very curable state if it was found at that time.**” [bold added]. *VRP 118*.

But GH had no system or control in place to audit its clinicians’ records, and in fact did not audit its clinicians’ records, to monitor their competency in what common sense informs us is one of the, if not *the*, most important roles of a medical practitioner: The giving of information to patients on prostate cancer and prostate cancer screening – including the use of PSA testing at a population level.

Dr. Bretan was asked his opinion on why the GH doctors were not complying with the GH documentation policy with respect to prostate guidelines. His opinion pointed directly to a lack of monitoring:

[ . . . ] my opinion, having worked with Kaiser in California, is that once Kaiser decided to screen [i.e. monitor] and **implement an electronic medical record tracking of their physicians** if they didn’t screen [i.e. screen for prostate cancer], that’s where the teeth came in. [ . . . ]

Unless you really tell people that you need to do this and **you’re monitored and it’s monitored** in the EMR, you’re

probably not going to get much compliance.

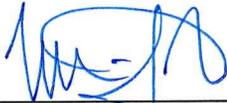
[bold added]. *VRP 221:23-222:7*. The lower court committed reversible error when it removed Mr. Coolen's corporate negligence cause of action and failed to instruct the jury on corporate negligence.

## II. CONCLUSION

As a whole, GH's response brief is more befitting a closing argument on the evidence to the jury. All Plaintiff seeks is the opportunity to let Plaintiff and GH present Coolen's informed consent, shared decision making and corporate negligence causes to the jury. But the lower court prevented Coolen from doing so - based on misapplication of law and other error as set forth herein and in Coolen's opening brief. Coolen respectfully requests that this Court reverse those decisions and order a new trial.

DATED: June 19, 2019.

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STATE OF WASHINGTON

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DEPUTY

No. 52586-1-II

WASHINGTON STATE COURT OF APPEALS  
DIVISION II

PHYLLIS COOLEN as Personal Representative of  
the Estate of PATRICK COOLEN, and  
Individually as Surviving Spouse;  
Appellant,

v.

GROUP HEALTH OPTIONS, INC., a for profit  
Washington Corporation doing business in  
Thurston County; GROUP HEALTH  
COOPERATIVE, a Washington business entity  
doing business in Thurston County; GROUP  
HEALTH OF WASHINGTON, a Washington  
business entity doing business in Thurston County,  
JOHN and/or JANE DOES 1-3, providers of  
health care services in Thurston County; and  
BUSINESS ENTITIES 1-3, providers of health  
care services in Thurston County, jointly and  
severally;

Respondents.

DECLARATION OF SERVICE OF  
APPELLANT'S REPLY BRIEF

I declare under penalty of perjury under the laws of the State of Washington that on the date stated below I caused the documents referenced below to be served in the manners indicated below on the following:

DOCUMENTS:      1.      Appellant's Reply Brief, and  
                         2.      This Declaration of Service.

ORIGINALS TO:

David C. Ponzoha, Court Clerk  
Washington State Court of Appeals Division II

Via Hand Delivery

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DATED this 19<sup>th</sup> day of June, 2019, at Olympia, Washington.

  
Mindy Leach, Litigation Paralegal