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

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LINDA J. ACOSTA,

Appellant,

v.

STATE OF WASHINGTON, DEPARTMENT OF CORRECTIONS,

Respondent.

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**RESPONDENT'S BRIEF**

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## I. INTRODUCTION

The trial court properly dismissed Plaintiff Linda J. Acosta's medical malpractice suit against the State of Washington Department of Corrections (the Department) when she failed to present any expert testimony to support her claims at summary judgment. Acosta, who has been incarcerated at the Washington Corrections Center for Women (WCCW) since 2012, had a history of lower back, hip, knee, and lower extremity pain. After she fell on her buttocks and back in October 2014, WCCW medical staff conservatively treated her subsequent pain complaints. Over time, medical staff obtained multiple imaging studies and specialist consults, culminating in back surgery in June 2016. Meanwhile, they simultaneously treated Acosta's other intervening medical conditions.

Acosta sued the Department alleging malpractice related to the treatment of her 2014 back injury. Expert testimony is required to prove both the alleged negligence and causation. Acosta came forward with none. Further, the doctrine of *res ipsa loquitur* does not apply in this case where the record shows the Department's treatment was not of a kind that ordinarily does not happen absent negligence, the Department did not exclusively control Acosta's treatment, and Acosta participated in the process of arranging her treatment. Summary judgment should be affirmed.

## **II. COUNTERSTATEMENT OF THE ISSUE ON APPEAL**

Did the trial court properly grant the Department summary judgment on Acosta's medical malpractice claims because she failed to present expert testimony to create a genuine issue of material fact as to negligence or causation, and because the doctrine of *res ipsa loquitur* does not apply?

## **III. COUNTERSTATEMENT OF THE CASE**

### **A. Acosta Arrives at WCCW in 2012 and Has a History of Lower Back, Hip, Knee, and Lower Extremity Pain**

Acosta has been in the Department's custody since March 2012. CP 95. Upon arrival at WCCW at age 63, Acosta reported hip and back pain. CP 95-96, 106-11. Her medical history included a total right hip replacement, and diagnoses of osteoarthritis and multilevel degenerative disc disease. CP 58, 69. Between July 2012 and September 2014, Acosta sought treatment at the WCCW medical clinic for back, hip, knee, and lower extremity pain and stress incontinence. CP 179-86, 214, 288. She presented with a limp and, later, an antalgic gait, which patients assume when they have back pain. CP 96, 180, 184. Medical staff prescribed medications, evaluated her for a walker, ordered X-rays of her right hip, and referred her to a specialist for surgery to suspend her prolapsed bladder (cystocele). CP 96, 179-86, 214, 216, 288. The hip X-rays found no fracture or dislocation, but were suspicious for bone loss. CP 96-97, 213.

**B. Acosta Falls in October 2014 and WCCW Staff Begin Conservatively Treating Her Fracture and Pain**

On or about October 31, 2014, Acosta tripped on a floor mat and fell on her buttocks and back. CP 178, 353. A week later, she presented to the clinic complaining of increasing lumbar pain and denied any bowel or bladder dysfunction. CP 97, 177-78. Acosta had old bruising on her back, tenderness to palpation in the lumbar region, and could ambulate short distances. CP 177-78. ARNP Pamelyn Saari requested X-rays, prescribed pain medication and a muscle relaxant, and ordered a wheelchair. CP 97, 176-77, 212. The X-rays showed an age indeterminate compression fracture of the L1 vertebra with over 50 percent loss of vertebral height, multilevel degenerative disc disease, osteoarthritis, and atherosclerosis. CP 97, 211.

After reviewing the X-rays, ARNP Saari requested a sit-down walker for Acosta, allowed continued use of the wheelchair until its arrival, and referred Acosta for physical therapy. CP 97, 175. Later that November, Acosta requested to be seen by an orthopedic surgeon. CP 358. ARNP Saari responded that they were conservatively treating her fracture and that an orthopedist would not do anything different. CP 358. She also prescribed medication for Acosta's osteoporosis. CP 97, 174, 358.

In mid-December, Acosta returned to the clinic in a sit-down walker; she had not been to physical therapy. CP 173. ARNP Saari

encouraged Acosta to walk as much as possible. CP 173. About two weeks later, Acosta sought treatment for lower right back pain. CP 97, 170-71. She reported that her right upper posterior hip area hurt and was now at 10/10 pain radiating to her groin when she attempted to bear weight. CP 97-98, 170. She further advised that she had begun having aching pain with activity in her right lateral hip and thigh, which was “different.” CP 98, 170. Acosta also reported that she was “regaining mobility” after her fall in October, was using a walker, and her back pain had resolved. CP 98, 170. On exam, Dr. Lisa Anderson found Acosta’s hip very painful and questioned whether the pain was localized from the sacroiliac joint versus the hip joint. CP 98, 170. She ordered X-rays and prescribed pain medication. CP 98, 170.

**C. WCCW Staff Obtain Additional X-Rays and an Orthopedic Consult, and Respond to Acosta’s Parotid Gland Infection and Discovery of Her Thyroid Nodule**

X-rays taken of Acosta’s hips and pelvis in January 2015 indicated mild sacroiliac joint osteoarthritis. CP 98, 210. Acosta soon returned to the clinic complaining of right hip pain radiating from her front right groin area to her upper right buttock, as well as constipation from medication. CP 98, 167-68. ARNP Saari admitted Acosta to the inpatient unit (IPU) for pain control and bowel regulation. CP 98, 167-68. Dr. Mary Colter, WCCW’s Facility Medical Director and an internal medicine physician, followed up with Acosta and referred her to physical therapy. CP 95, 98, 167, 264.

Acosta next returned to the clinic with right face swelling. CP 165-66. Dr. Colter assessed her with suppurative parotitis (infection of the parotid gland), started IV antibiotics, and admitted her to the IPU. CP 165-66. The next day, WCCW sent Acosta to St. Anthony Hospital. CP 268-69. Imaging confirmed Acosta's acute parotitis and revealed a left thyroid nodule needing further evaluation. CP 269, 271, 273-74. Acosta was admitted, treated with IV antibiotics, and improved in 48 hours. CP 269.

After returning to WCCW, Acosta reported pain in her right back flank and buttocks; she denied numbness or tingling in her right leg. CP 98, 163. Acosta reported that slow mobility to the toilet due to pain was leading to incontinence. CP 162-63. ARNP Saari was unclear if Acosta's lower back pain was due to the compression fracture or a new muscle strain. CP 162. She prescribed medications and encouraged self-care. CP 98-99, 162.

On January 20, Acosta requested an MRI. CP 359. ARNP Saari set an appointment for Acosta to follow up with Dr. Colter. CP 99, 157, 359. Acosta described her pain to Dr. Colter as located in the right lower back, just above the right superior iliac crest and radiating around her lateral hip and down into her posterior knee. CP 157. Dr. Colter assessed Acosta with severe low back pain without any "red flags." CP 156. Acosta had normal strength and straight leg raises bilaterally, full range of motion of hips and knees, no spinal or paraspinal tenderness of the low back, and only some

tenderness to palpation of the right lower back over the iliac crest. CP 156. Dr. Colter continued Acosta's prescriptions, ordered lumbar X-rays, requested a consult by the Department's orthopedic surgeon, Dr. Kenneth Sawyer, and consulted with the Department's Chief Medical Officer, Dr. G. Steven Hammond, about Acosta's thyroid nodule. CP 99, 156, 158, 266.

Dr. Sawyer reviewed Acosta's X-rays and noted that, in the absence of any red flags or neurologic deficit, he would assume she had mechanical low back pain; he recommended additional imaging. CP 99, 154-55. New X-rays were taken, which Dr. Sawyer described as showing a further interval collapse of the L1 vertebral body, from about 50 percent to 60-70 percent. CP 99, 151, 208. He explained that, if Acosta was neurologically intact, WCCW could continue observation. CP 151. It was unclear to Dr. Sawyer if her pain was due to pathology at L1 or a lower level, and he suggested checking for point tenderness in the midline. CP 99, 151. Meanwhile, medical staff ordered a check of a hormone related to Acosta's thyroid nodule, as well as a biopsy of it. CP 152, 159, 263.

**D. WCCW Staff Continue Conservatively Treating Acosta's Pain, Order an MRI, Further Evaluate Her Thyroid Nodule, and Respond to Her Gastrointestinal Bleed**

On February 2, 2015, Acosta presented to Dr. Colter to follow-up on her lower back pain and thyroid nodule. CP 99, 150. Acosta denied any pain or tenderness to palpation over the L1 fracture site and stated her

bilateral hip pain was much better, but that her right lower back pain was no better and she had tenderness to palpation over the right posterior superior iliac crest. CP 99, 150. Acosta was neurologically intact and denied any numbness or tingling. CP 150. Dr. Colter reviewed Dr. Sawyer's recommendations with Acosta, continued her medications, ordered physical therapy, and planned for the thyroid nodule biopsy. CP 99, 150. Acosta asked for an extension of her request for meals in until she underwent an MRI. CP 287, 360. ARNP Saari denied the request because she did not see an indication that Acosta was being sent for an MRI. CP 287, 360.

In mid-February, Acosta began physical therapy. CP 261. She had postural and gait impairments, and tenderness to palpation in the low back. CP 261. Her physical therapist believed Acosta would benefit from postural exercises and issued her a home exercise program. CP 261. Acosta followed up in therapy in March, May, and August 2015. CP 259-60, 262.

In late February 2015, Acosta requested a new wheelchair and underwent a biopsy of her thyroid nodule, which was non-diagnostic. CP 206-07, 258, 362. Dr. Colter told Acosta that she should be out of the wheelchair and moving as much as possible. CP 362. In March 2015, Acosta followed up about her back and hip pain. CP 100, 146. ARNP Saari contacted Drs. Sawyer and Hammond about injecting Acosta's iliac crest. CP 100, 146. She also noted Acosta's desire for an MRI and that she had

called TRA Medical Imaging with Acosta's request. CP 146. Acosta would decide if she would get the imaging after learning its cost.<sup>1</sup> CP 146.

During March 2015, Acosta asked about her thyroid biopsy and her request for a self-paid MRI. CP 283-86, 363-67. Dr. Colter wanted more diagnostic imaging of Acosta's thyroid nodule. CP 146. As for the MRI, ARNP Saari had told TRA about the areas to be imaged, but had not heard back; she instructed Acosta to contact Health Services Manager Jeff Perry. CP 284-86, 363-65. On March 30, Dr. Colter saw Acosta and discussed her thyroid and recent symptoms of an upper respiratory infection; Acosta was in a wheelchair but walked and got up on the exam table without difficulty. CP 145. The next day, Acosta had an ultrasound of her thyroid. CP 204-05.

In April 2015, Acosta presented to the clinic complaining of difficulty swallowing, shortness of breath, weakness, decreased appetite, bowel issues, and an episode of chest pain. CP 141-44. WCCW sent Acosta to St. Anthony Hospital, where she was admitted for a gastrointestinal (GI) bleed. CP 140-41. She returned to WCCW two days later. CP 140.

Also in April, Acosta asked ARNP Saari and Perry about her MRI. CP 282, 368-70. Perry responded that he had not received her cost estimate,

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<sup>1</sup> The Department has a policy, DOC 600.020, Offender-Paid Health Care, that outlines the necessary process for approval of self-paid medical services. CP 346-52.

which he needed to know so he could do the work; ARNP Saari instructed Acosta to contact TRA about the cost and then contact Perry when she was ready to make payment. CP 282, 368-70. In May 2015, ARNP Saari provided Acosta with the initial MRI cost estimates. CP 281, 371. She later provided additional MRI cost estimates. CP 280, 373.

Meanwhile, Acosta followed up with Dr. Colter for her GI bleed. CP 191. She reported walking around her unit and only using a wheelchair for long distances. CP 191. Dr. Colter noted that Acosta was off her osteoporosis medication; she also asked Acosta to take Tylenol for her back pain. CP 191. Acosta later presented to the clinic complaining of shortness of breath, chest tightness, and vomiting. CP 139. Staff administered an EKG and observed Acosta, releasing her after her symptoms improved. CP 139.

In August 2015, Acosta presented to ARNP Saari complaining of left knee pain, and ARNP Saari spoke with Acosta and Perry about the plan for the self-paid MRI. CP 138. In September 2015, Dr. Colter requested further diagnostic imaging of Acosta's thyroid nodule, which showed no significant change. CP 197, 255. On September 22, Acosta signed a medical records disclosure for her self-paid MRI and completed her portion of the paperwork. CP 289, 292. In October 2015, Acosta's MRI paperwork was completed, and ARNP Saari sent the MRI request to TRA. CP 100, 137, 256, 291-92. Acosta was then scheduled for the MRI. CP 376-77.

**E. After MRI and CT Imaging and Consults with Two Outside Surgeons, Acosta Has Surgery in June 2016**

On November 24, 2015, Acosta underwent an MRI of her right hip and lumbar spine. CP 100, 194-96. Dr. Colter then approved a request for an outside surgical consult, which noted the MRI findings and that Acosta had continued but improved low back pain from one year prior. CP 100, 231. The Department's Care Review Committee (CRC) also approved the surgical consult. CP 294. Dr. Colter also approved payment of the MRI by the Department. CP 446, 449.

In December 2015, Acosta saw Dr. Marc Goldman, an outside neurosurgeon. CP 100, 249-54. Dr. Goldman noted that the MRI showed a greater than 90 percent height loss burst fracture of L1 with severe canal stenosis due to retropulsed bone fragments. CP 250. Acosta reported weakness, numbness, and paresthesia in her right greater than left leg, but that she had no perineal numbness and no bowel or bladder complaints. CP 250. Dr. Goldman believed "there [was] no urgency in treatment" and ordered a CT scan. CP 253. He noted that, while it "may" be beneficial to perform a decompression and fusion surgery, he was "not entirely certain this will help her back pain." CP 253. Rather, he noted that, because she had severe canal compromise, it should be decompressed. CP 253.

In January 2016, Acosta underwent the CT scan and, in February 2016, she followed up with Dr. Goldman. CP 100, 192-93, 246-47. He noted he was “not entirely sure that a lumbar decompression and fusion across the thoracolumbar junction . . . would be beneficial to her in the long run.” CP 247. He also noted that “it might be best just to treat her pain symptomatically and consider intrathecal pain pump.” CP 247. Dr. Goldman wanted a second opinion from Dr. Michael Martin, an outside orthopedic surgeon. CP 247.

Thereafter, Acosta asked if the wedge recommended by her surgeon had been ordered and if she had been scheduled to see Dr. Martin. CP 385-89. ARNP Saari responded she was awaiting approval for the wedge and that Acosta was scheduled to see Dr. Martin. CP 385-89. In late February, the CRC approved the wedge. CP 136. In March 2016, ARNP Saari told Acosta that she had ordered the wedge and renewed Acosta’s walker and wheelchair. CP 390-91. ARNP Saari also reported that Dr. Martin’s office had put Acosta’s paperwork in the wrong doctor’s box for a time, they were waiting for his office to answer, and she would be scheduled soon. CP 392.

In mid-March 2016, Acosta presented to Dr. Martin and Nicholas Harrison, PA-C, for a second surgical opinion. CP 101, 244-45. Dr. Martin recommended a laminectomy at T12-L3 and a fusion at T11-L3. CP 245.

Thereafter, ARNP Saari contacted Dr. Martin's office to schedule Acosta's surgery; she also ordered wheelchair use without limitations. CP 101, 135.

In April 2016, Acosta asked if she had been scheduled for surgery. CP 393-99. WCCW staff initially responded that she had been scheduled and would be sent for another MRI, then clarified that they were awaiting a return call from Dr. Martin's office. CP 393-96. Staff worked on expediting Acosta's surgery date and continued contacting Dr. Martin's office. CP 132, 397. Meanwhile, Acosta also presented to the medical clinic with complaints of mid and lower back pain, a left sciatic pain that started in the left lower back and radiated down through the buttock into the left leg, and a burning sensation. CP 101, 130-34. Acosta's bilateral lower extremities had range of motion within normal limits, equal strength, and strong pulses. CP 130. Medical staff noted Acosta was due to have surgery soon, and prescribed her pain medications and a muscle relaxant. CP 101, 130-34.

In May 2016, Perry reported that the clinic had made contact with Dr. Martin's scheduler, and Acosta underwent a pre-operative assessment. CP 102, 215-16, 415. The day after her pre-op assessment, Dr. Colter saw Acosta to tie up loose ends and discuss any possible heart disease. CP 102, 128-29. A month later, Acosta underwent a bone densitometry (DEXA) scan, which confirmed a diagnosis of osteoporosis. CP 102, 295-97. On June 7, 2016, Drs. Martin and Goldman performed a T12-L2 laminectomy

and foraminotomy surgery on Acosta with fusion at T11-L3. CP 228-30. She returned to WCCW 17 days later. CP 102, 233-37.

**F. WCCW Staff Treat Acosta's Continued Pain After Surgery**

In mid-July 2016, Acosta followed up with PA-C Harrison about her surgery. CP 225-27. She indicated significant improvement in her thoracolumbar pain, but noted some right posterior thigh pain. CP 226. In September 2016, Acosta complained of bilateral posterior thigh and calf pain. CP 222-24. Dr. Martin ordered an EMG of her bilateral lower extremities to evaluate for lumbar radiculopathy. CP 187-90, 223.

In October 2016, Acosta underwent the EMG testing, which was abnormal with evidence of left acute S1 radiculopathy with active denervation and left chronic L5 radiculopathy without active denervation. CP 102, 187-90. In November 2016, Acosta complained of nerve pain radiating from her right buttock into her right thigh. CP 125. Dr. Colter prescribed medications for pain and osteoporosis. CP 125.

In February 2017, Acosta saw Dr. Martin, reported her symptoms had improved, but she complained of pain in the left buttock and right posterior thigh. CP 102, 113-15. She had no tenderness in the lumbar spine, but was still using a walker. CP 102, 114. Dr. Martin went over the results from the EMG. CP 114. He recommended she stay active and exercise daily, and indicated she could stop using a walker when ready. CP 102, 114.

In June and July 2017, Acosta and Dr. Colter discussed Acosta's use of a walker. CP 311. Acosta also reported she had twisted her back, causing mild back pain. CP 311. In October 2017, Acosta presented to the medical clinic and discussed her need for a walker due to leg numbness and weakness. CP 308-09. She reported that Dr. Martin had said she could use the walker for up to two years post-surgery. CP 308. In November 2017, Acosta followed up with Dr. Martin and reported that her back was fine, but that her legs were giving her problems with weakness and pain and that she was having incontinence. CP 323-25. Acosta also complained of right posterior thigh and calf pain. CP 324. Dr. Martin believed most of her symptoms came from her hip and a leg length discrepancy. CP 325. He noted that she should have her hip evaluated by a specialist. CP 325.

In January and February 2018, Acosta underwent diagnostic testing because of her left lower extremity pain complaints. CP 313-17. Testing revealed an acute non-occlusive thrombosis within her left popliteal vein, and acute to subacute occlusive thrombosis within the left distal femoral vein, left popliteal vein, and left posterior tibial vein. CP 313-15.

In April 2018, Acosta followed up with Dr. Colter about her back surgery. CP 304-05. She reported doing well, but still used a walker because of low back pain and lower extremity weakness. CP 304. Dr. Colter advised Acosta that, if she did not increase her lower extremity strength, then she

would probably have to use the walker for the rest of her life. CP 304. In May 2018, Acosta returned to the clinic complaining of left hip and groin pain. CP 303. X-rays of Acosta's left hip showed mild hip joint space narrowing and small osteophyte formation. CP 312. In June 2018, Acosta returned to the clinic for left hip pain. CP 302.

In July 2018, Acosta followed up with Dr. Martin for the last time. CP 318-22. She complained of pain in her legs and was using a walker. CP 318. X-rays of her thoracolumbar spine showed no appreciable change. CP 321. Dr. Martin assessed Acosta with pain symptoms classic for neurogenic claudication associated with the normal course of aging. CP 321. He indicated that she required no further follow-ups. CP 321. In August 2018, Acosta saw Dr. Colter, who noted that Acosta had neurogenic claudication and needed a walker indefinitely. CP 300.

#### **G. Procedural History**

Acosta filed suit against the Department alleging medical malpractice claims related to the treatment of her October 2014 back injury. CP 1-7. The Department moved for summary judgment arguing Acosta could not establish its medical staff violated the applicable standard of care or that their treatment caused her injury. CP 16. The Department argued Acosta needed expert testimony on negligence and causation, which she did not have. CP 17, 35-39, 416-23. Meanwhile, the Department submitted

testimony of Drs. Colter and W. Brandt Bede, an orthopedic surgeon, in support of its motion. CP 57-63, 95-103, 444-47.

Dr. Colter testified that she and her medical staff at WCCW treated Acosta's compression fracture and pain complaints conservatively, as is the normal medical standard, and consulted with surgical specialists as time progressed. CP 102. She opined that all medical treatment Acosta obtained at WCCW met the standards of care for all practitioners who provided care. CP 103. Dr. Colter also testified that, according to Acosta's nerve conduction and EMG testing, the cause of her lower back, hip, and lower extremity pain appears related to an S1 nerve root issue. CP 103.

Dr. Bede opined that ARNP Saari's treatment of Acosta during the injury's acute phase met the standard of care for treatment of a compression fracture. CP 59. He also opined that the treatment plan followed by Drs. Colter and Sawyer met the standard of care and that the Department's medical personnel followed standard medical procedures for diagnosis and treatment of an L1 compression fracture, later diagnosed as an L1 burst fracture. CP 60, 62. Dr. Bede opined that the timing of Acosta's lumbar surgery did not cause or worsen her lumbar condition, that her bilateral lower extremity radiculopathy stems from her S1 nerve root, and that the significant arthritic and degenerative condition of her lumbar spine was not caused or worsened by any conduct of Department personnel. CP 62-63.

Acosta opposed the Department's motion for summary judgment. CP 326-415. She did not submit any expert testimony on violation of the standard of care or causation, and instead argued the doctrine of *res ipsa loquitur* applied. CP 327, 331-38. The Department contended the doctrine was inapplicable and submitted additional testimony of Dr. Colter that (1) the process of setting up an offender-paid health care procedure requires the offender to complete certain steps; (2) the Department cannot control the length of time it takes to hear back from an outside provider related to an offender-paid health care procedure; and (3) the Department cannot control if there is a delay in scheduling an appointment with an outside provider because the provider's schedule is full for weeks or months. CP 420, 445-46. Dr. Colter also explained that the time between Acosta's appointments with Drs. Goldman and Martin were subject to the availability of those doctors' schedules, additional tests, and surgical calendars. CP 446.

The trial court agreed with the Department that *res ipsa loquitur* did not apply. VRP 13-15. Because Acosta did not have expert testimony to support her claims, the trial court granted the Department's motion. CP 452-53, VRP 15. Acosta appeals. CP 454-58.

#### **IV. ARGUMENT**

Summary judgment in favor of the Department should be affirmed in this medical malpractice case. To survive summary judgment, Acosta

needed to present expert testimony on negligence and causation. *See, e.g., Keck v. Collins*, 184 Wn.2d 358, 370, 357 P.3d 1080 (2015). She did not do so. In addition, as the trial court correctly concluded, the doctrine of *res ipsa loquitur* does not apply in this case. *See, e.g., Conner v. Meadows*, No. 78494-3-I, 2019 WL 3554750 (Wash Ct. App. Aug. 5, 2019) (unpublished).<sup>2</sup> Here, the record demonstrates that the Department’s treatment was not of a kind that ordinarily does not happen absent negligence, the Department did not exclusively control Acosta’s treatment, and Acosta participated in the process of arranging for her treatment. Summary judgment was appropriate.

**A. The Order Granting Summary Judgment Is Reviewed De Novo**

Summary judgment is appropriate when “there is no genuine issue as to any material fact” and “the moving party is entitled to judgment as a matter of law.” *Walston v. Boeing Co.*, 181 Wn.2d 391, 395, 334 P.3d 519 (2014); CR 56(c). The purpose of summary judgment is to avoid unnecessary trials where insufficient evidence exists. *Pelton v. Tri-State Memorial Hosp., Inc.*, 66 Wn. App. 350, 355, 831 P.2d 1147 (1992) (citing *Young v. Key Pharm., Inc.*, 112 Wn.2d 216, 226, 770 P.2d 182 (1989)). On

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<sup>2</sup> *See* GR 14.1(a). The decision has no precedential value, is not binding on any court, and is cited only for such persuasive value as the Court deems appropriate.

appeal, “[t]he appellate court engages in the same inquiry as the trial court, with questions of law reviewed de novo and the facts and all reasonable inferences from the facts viewed in the light most favorable to the nonmoving party.” *Christensen v. Grant Cty. Hosp. Dist. 1*, 152 Wn.2d 299, 305, 96 P.3d 957 (2004). This Court may affirm for any reason supported by the record. RAP 2.5(a).

In medical malpractice cases, a defendant may move for summary judgment by either setting forth its version of facts and alleging that there is no genuine issue as to those facts, or showing an absence of competent evidence to support the plaintiff’s case. *Guile v. Ballard Cmty. Hosp.*, 70 Wn. App. 18, 21-23, 851 P.2d 689 (1993); *see also Young*, 112 Wn.2d at 226 (“A defendant may move for summary judgment on the ground the plaintiff lacks competent medical evidence to make out a prima facie case of medical malpractice.”). Under the second method, the defendant is not required to support its motion with affidavits or other materials disproving the plaintiff’s case. *Guile*, 70 Wn. App. at 22. The defendant need only “identify those portions of the record, together with the affidavits, if any, which he or she believes demonstrate the absence of a genuine issue of material fact.” *Id.* The burden then shifts to the nonmoving party to rebut the moving party’s proof. *Young*, 112 Wn.2d at 226.

The non-moving party may not rely on allegations in its pleadings to oppose a motion for summary judgment. CR 56(e). Further, summary judgment cannot be defeated with speculation, conjecture, or mere possibility. *Chamberlain v. Dep't of Transp.*, 79 Wn. App. 212, 215, 901 P.2d 344 (1995). The nonmoving party must present evidence demonstrating a genuine issue of material fact. *See Youker v. Douglas Cty.*, 178 Wn. App. 793, 796, 327 P.3d 1243 (2014) (“A genuine issue is one upon which reasonable people may disagree; a material fact is one controlling the litigation’s outcome.”). Summary judgment is appropriate if the nonmoving party fails to do so. *Walston*, 181 Wn.2d at 395-96.

**B. Summary Judgment Was Appropriate Because Acosta Lacks Expert Support on Negligence and Causation**

In this medical malpractice case, Acosta bears the burden of proving both negligence and causation. RCW 7.70.040, which governs her claims for injury allegedly resulting from health care, identifies the required elements of proof:

The following shall be necessary elements of proof that injury resulted from the failure of the health care provider to follow the accepted standard of care:

- (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.

Generally, jurors lack the knowledge and experience to determine violation of the standard of care and causation. Expert testimony is required when an essential element in a case is best established by an opinion beyond the expertise of a layperson. *Harris v. Robert C. Groth, M.D., Inc.*, 99 Wn.2d 438, 449, 663 P.2d 113 (1983) (citing 5A *Karl B. Tegland, Washington Practice: Evidence* § 300 (1982)). “Medical facts in particular must be proven by expert testimony unless they are ‘observable by [a layperson’s] senses and describable without medical training.’” *Id.* (quoting *Bennett v. Dep’t of Labor & Indus.*, 95 Wn.2d 531, 533, 627 P.2d 104 (1981)). For example, technical medical expertise is not required in cases where a physician amputates the wrong limb or pokes a patient in the eye while stitching a wound on the face. *Berger v. Sonneland*, 144 Wn.2d 91, 111, 26 P.3d 257 (2001). Most plaintiffs, however, must prove violation of the standard of care and proximate cause by expert testimony. *Keck*, 184 Wn.2d at 370; *see also Seybold v. Neu*, 105 Wn. App. 666, 676, 19 P.3d 1068 (2001) (“[T]o defeat summary judgment in almost all medical negligence cases, the plaintiffs must produce competent medical expert testimony establishing that the injury was proximately caused by a failure to comply with the applicable standard of care.”). This case is no different.

**1. Acosta failed to present any competent expert testimony showing a violation of the standard of care**

When establishing negligence in a medical malpractice case, the plaintiff must establish the standard of care in Washington and breach of that standard through the testimony of a professional equal to the defendant. *McKee v. American Home Products, Corp.*, 113 Wn.2d 701, 706, 782 P.2d 1045 (1989); *Young*, 112 Wn.2d at 227-28. A health care provider's conduct is to be measured against the standard of care of a reasonably prudent practitioner possessing the degree of skill, care, and learning possessed by other members of the same area of specialty in the State of Washington. *Harris*, 99 Wn.2d 438 (construing RCW 7.70.040). For example, in *McKee*, the testimony of an Arizona physician did not set forth the standard of care applicable to a Washington pharmacist. 113 Wn.2d at 706-07. And in *Young*, the testimony of a pharmacist did not rebut the testimony of the defendant physicians. 112 Wn.2d at 227. Expert testimony also must be based on facts and not speculation. *Seybold*, 105 Wn. App. at 677.

In this case, Acosta claims that the Department delayed and negligently treated her back injury after her fall in October 2014. Appellant's Brief (App. Br.) at 1; CP 1-5. Given Acosta's complicated medical history and presentation, as well as her other contemporaneous medical conditions, a lay jury should not be left to decide for itself the

acceptable standard of medical care for the Department's medical providers in treating Acosta's pain and compression fracture. *See Harris*, 99 Wn.2d at 449. Whether and when a medical provider should order particular imaging, obtain specialist consults, and proceed with surgery are among the very issues for which expert testimony is required in this case.

Here, X-rays taken a week after Acosta's fall showed an age indeterminate compression fracture of her L1 vertebra. CP 97, 211. Between November 2014 and October 2015, Acosta, who had a history that included pre-existing lower back, hip, knee, and lower extremity pain, a total right hip replacement, osteoarthritis, and multilevel degenerative disc disease, complained of various pains. *See supra* Part III.A-D.

For example, a week after the fall, Acosta reported increasing lumbar pain and tenderness to palpation to her lumbar region. CP 177-78. About two months later, she reported "regaining mobility" and that her back pain had resolved, but she was now having aching pain in right upper posterior hip that radiated to her groin. CP 170-71. In January 2015, Acosta reported severe low back pain, just above the iliac crest and radiating around her lateral hip and into her posterior knee. CP 157. The next month, she denied any pain or tenderness over the fracture site, reported her hip pain was much better, but complained of right lower back pain and tenderness over the right posterior iliac crest. CP 150. In April 2015, she reported

walking in her unit and only using a wheelchair for long distances. CP 191.

In August 2015, Acosta reported left knee pain and mild swelling. CP 138.

During this same time, Acosta did not have any “red flags.” CP 156. She initially denied bowel and bladder dysfunction, and later attributed constipation to pain medication and episodes of incontinence to her slow mobility. CP 162-63, 167-68, 178. She remained neurologically intact, denied numbness or tingling, had normal strength and straight leg raises bilaterally, and full range of motion in her hips and knees. CP 150, 156, 163.

The Department began treating Acosta conservatively and, over time, prescribed pain and bone strengthening medications, muscle relaxants, therapy, and assistive devices, obtained imaging studies and consults with specialists both internal to and outside of the Department, and ultimately arranged for back surgery in June 2016. *See supra* Part III.B-E. Meanwhile, during the same period, the Department also treated a number of Acosta’s other health conditions. *See supra* Part III.C-D. These included an infection of her parotid gland, the discovery of her thyroid nodule, and a GI bleed. CP 140-44, 165-66, 273-74. Both the infection and the GI bleed required outside hospitalization. CP 140-41, 268-69.

According to Dr. Bede, an orthopedic surgeon, and Dr. Colter, an internal medicine physician, Acosta’s treatment at WCCW met the standard of care. CP 59-63, 102-03. Acosta does not have any expert testimony to

suggest, let alone prove, otherwise. Because a jury of non-healthcare providers lacks the expertise needed to evaluate the medical facts in this case, Acosta's failure to present expert testimony to establish that the Department violated the applicable standard of care requires that her claims be dismissed. *See Keck*, 184 Wn.2d at 370; *Harris*, 99 Wn.2d at 449.

**2. Acosta failed to present any competent expert testimony showing the Department proximately caused her injury**

In addition, Acosta needed to have expert testimony to prove causation – that the Department's alleged negligence and delay caused an extension of her pain and disability. *See App. Br.* at 1, 7-8, 11. “[T]he general rule in Washington is that expert medical testimony on the issue of proximate cause is required in medical malpractice cases.” *Reese v. Stroh*, 128 Wn.2d 300, 308, 907 P.2d 282 (1995). Generally, such expert medical testimony on proximate cause must come from a physician. *See Colwell v. Holy Family Hosp.*, 104 Wn. App. 606, 613, 15 P.3d 210 (2001) (“In sum, while [an expert registered nurse] possesses the education and skill to testify to the standard of care of the decedent's treating nurses, a medical doctor must still generally connect [the decedent's] death to the alleged nursing deficiencies.”), *abrogated in part by Frausto v. Yakima HMA, LLC*, 188 Wn.2d 227, 234, 393 P.3d 776 (2017) (“If an ARNP is qualified to independently diagnose a particular medical condition, it follows that the

ARNP may have the requisite expertise under ER 702 to discuss medical causation of that condition.”).

Evidence will be sufficient to establish proximate cause only if it supports a reasonable inference of all the essential elements. *Pelton*, 66 Wn. App. at 354. “[A] ‘reasonable inference’ is founded on expert medical testimony rising to the level of reasonable medical certainty.” *Id.* at 354-55. When faced with a technical causation issue, it would be unreasonable to rely on a lay opinion. *Id.* at 355. Moreover, a motion for summary judgment cannot be defeated based on mere speculation or possibility. *Id.* “To remove the issue from the realm of speculation, the medical testimony must at least be sufficiently definite to establish that the act complained of ‘probably’ or ‘more likely than not’ caused the subsequent disability.” *O’Donoghue v. Riggs*, 73 Wn.2d 814, 824, 440 P.2d 823 (1968).

For example, in *Berger v. Sonneland*, the Court held that because of the plaintiff’s “extensive and unusual medical history,” the cause of her insomnia, stress, and gastrointestinal problems required medical evidence and could not be determined by observation of laypersons. 144 Wn.2d 91 at 111. The Court further explained that causation of the plaintiff’s injuries was not readily observable because she had the same symptoms years before the defendant’s allegedly negligent health care and those preexisting medical problems were the reason she consulted the defendant. *Id.*

The same reasoning from *Berger* applies here. Again, Acosta claims the Department's alleged negligence and delay caused an extension of her pain and disability. App. Br. at 1, 7-8, 11. Acosta needed expert medical testimony to prove that claim because a lay jury could not readily observe and determine the cause of her pain given her extensive and complicated medical history, pre-existing lower back, hip, and knee pain, and continued pain complaints after surgery. *See supra* Part III.A-F.

To illustrate, prior to her fall, Acosta had complained of lower back, hip, knee, and lower extremity pain, had undergone a total right hip replacement, and had been diagnosed with osteoarthritis and multilevel degenerative disc disease. CP 58, 69, 96, 106-11, 179-86. Her L1 compression fracture, when discovered, was of an indeterminate age. CP 211. About two months after her fall, Acosta reported her back pain had resolved, but her right upper posterior hip area had begun to hurt. CP 170-71. That pain reportedly radiated from her front right groin to her upper right buttock. CP 167-68. Later, Acosta reported her pain was located in the right lower back, just above the superior iliac crest, radiating around her lateral hip and into her posterior knee. CP 157. Still later, she denied any pain or tenderness to palpation over the fracture site but was tender over her right posterior superior iliac crest. CP 150.

Prior to surgery, several of Acosta's treating providers, including one of her surgeons, noted their uncertainty as to the cause of her pain or the benefit of surgery. CP 151, 162, 170, 247, 253. And after her surgery, she continued to complain of right posterior thigh and calf pain, pain radiating from her right buttock into her right thigh, and leg pain, weakness, and numbness. CP 222-26, 308-09, 324. By the spring of 2018, Acosta reported still using a walker because of low back pain and lower extremity weakness; she also complained of left hip and groin pain. CP 303-04. To sort through the import of those extensive and complicated medical facts on the issue of causation, expert testimony is required.

Acosta, however, appears to argue that, because her back pain improved after surgery, the Department's alleged delay in arranging imaging and surgery caused her prolonged pain. *See* App. Br. 7-8, 13, 15. Putting aside that she has not proved any alleged delay violated the standard of care, discussed *supra* in Part IV.B.1, Acosta's apparent assumption that a sequence of events alone can establish causation is an example of the logical fallacy of post hoc, ergo propter hoc – i.e., after this, therefore because of this. “Post hoc ergo prop[t]er hoc is neither good logic nor good law.” *Volentine & Littleton v. United States*, 169 F. Supp. 263, 265 (Ct. Cl. 1959). As “coincidence is not proof of causation,” Acosta must do more than rely on a logical fallacy to meet her burden of proof. *See Anica v.*

*Wal-Mart Stores, Inc.*, 120 Wn. App. 481, 489, 84 P.3d 1231 (2004). This is especially true in light of the totality of the record and evidence that her back pain waxed and waned over time.

Moreover, the Department submitted Dr. Bede's testimony that the timing of Acosta's surgery did not cause or worsen her lumbar condition, that her lower extremity radiculopathy stemmed from her S1 nerve root, and that no action or inaction by the Department caused or worsened her pre-existing arthritic and degenerative lumbar spine condition. CP 62-63. Dr. Colter also testified that, according to Acosta's nerve conduction and EMG testing, the cause of her lower back, hip, and lower extremity pain appears related to an S1 nerve root issue. CP 103. Because Acosta presented no expert testimony on causation, the trial court properly dismissed her claims. *See Keck*, 184 Wn.2d at 370; *Harris*, 99 Wn.2d at 449.

**C. Summary Judgment Was Appropriate Because the Doctrine of Res Ipsa Loquitur Does Not Apply**

This Court should reject Acosta's attempt to rely on the doctrine of res ipsa loquitur to avoid the general rule that expert testimony is required to prove violation of the standard of care and causation. *See App. Br.* at 9-12. Res ipsa loquitur means "the thing speaks for itself." W. Page Keeton et al., *Prosser and Keeton on the Law of Torts* § 39, at 243 (5th ed. 1984). This is not such an unusual case where negligence by the Department, or

causation, can be inferred merely from Acosta's pain complaints or the timing of her treatment.

Whether *res ipsa loquitur* applies in this case is a question of law. See *Curtis v. Lein*, 169 Wn.2d 884, 889, 239 P.3d 1078 (2010) (citing *Pacheco v. Ames*, 149 Wn.2d 431, 436, 69 P.3d 324 (2003)). The doctrine of *res ipsa loquitur* frees the plaintiff from proving specific acts of negligence in cases where a plaintiff asserts that he or she suffered injury, the cause of which cannot be fully explained, and the injury is of a type that would not ordinarily result if the defendant were not negligent. *Pacheco*, 149 Wn.2d at 436 (citations omitted). "Generally, it 'provides nothing more than a permissive inference' of negligence." *Id.* (quoting *Zukowsky v. Brown*, 79 Wn.2d 586, 600, 488 P.2d 269 (1971)). It can also support an inference of causation. *Ripley v. Lanzer*, 152 Wn. App. 296, 307, 215 P.3d 1020 (2009). The doctrine is "ordinarily sparingly applied, in peculiar and exceptional cases, and only where the facts and the demands of justice make its application essential." *Curtis*, 169 Wn.2d at 889-90 (internal citations and quotation marks omitted).

Under proper circumstances, *res ipsa loquitur* can be applied to physicians and hospitals. *ZeBarth v. Swedish Hospital Medical Center*, 81 Wn.2d 12, 18, 499 P.2d 1 (1972). "[T]he tests for *res ipsa loquitur* have remained substantially the same as when the doctrine was first explicitly

described in *Byrne v. Boadle*, 159 Eng. Rep. 299, 2 H. & C. 722 (1863), the case where a barrel for no provable reasons rolled out of an upstairs window onto the plaintiff below, injuring him.” *Id.* at 19. In order to apply *res ipsa loquitur*, the following criteria must be met:

(1) the accident or occurrence producing the injury is of a kind which ordinarily does not happen in the absence of someone’s negligence, (2) the injuries are caused by an agency or instrumentality within the exclusive control of the defendant, and (3) the injury-causing accident or occurrence is not due to any voluntary action or contribution on the part of the plaintiff.

*Reyes v. Yakima Health Dist.*, 191 Wn.2d 79, 89-90, 419 P.3d 819 (2018) (internal citation and quotation marks omitted); *see also Brugh v. Fun-Tastic Rides Co.*, 8 Wn. App. 2d 176, 180, 437 P.3d 751 (2019). As will be explained below, because none of those three criteria are met here, *res ipsa loquitur* is inapplicable.

**1. The Department’s treatment was not of a kind that ordinarily does not happen absent negligence**

The first criterion – that the occurrence producing the injury is of a kind which ordinarily does not happen in the absence of negligence – may be satisfied in one of three ways:

(1) [w]hen the act causing the injury is so palpably negligent that it may be inferred as a matter of law, i.e., leaving foreign objects, sponges, scissors, etc., in the body, or amputation of a wrong member; (2) when the general experience and observation of mankind teaches that the result would not be expected without negligence; and (3) when proof by experts

in an esoteric field creates an inference that negligence caused the injuries.

*Reyes*, 191 Wn.2d at 90 (internal citation and quotation marks omitted).

In *Reyes*, the Court concluded that prescribing the decedent isoniazid, which sometimes can lead to fatal liver toxicity, was not so “palpably negligent” as leaving foreign objects in a body or amputating the wrong limb. 191 Wn.2d at 90. Nor could a layperson’s “general experience and observation” show that it was negligent. Thus, *res ipsa loquitur* was inapplicable and could not be substituted for expert testimony. *Id.* Similarly, in *Miller v. Jacoby*, the Court concluded that, “[w]ithout knowing the professional standard of care for a health care provider placing a Penrose drain during surgery, a layperson would not be able to determine that [the plaintiff’s] injury would not have occurred absent negligence by [the defendant surgeon].” 145 Wn.2d 65, 75, 33 P.3d 68 (2001).

Most recently, in *Conner v. Meadows*, No. 78494-3-I, 2019 WL 3554750 at \*4 (Wash. Ct. App. Aug. 5, 2019) (unpublished),<sup>3</sup> the court held that the plaintiff failed to establish that her shoulder pain could only have resulted from the chiropractor’s negligence. The court concluded that a chiropractic procedure followed by shoulder pain was not so palpably

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<sup>3</sup> See GR 14.1(a). The decision has no precedential value, is not binding on any court, and is cited only for such persuasive value as the Court deems appropriate.

negligent that it may be inferred as a matter of law. Nor could a layperson's general experience and observation show that it was negligent. Thus, the doctrine of *res ipsa loquitur* did not relieve the plaintiff of her burden to present expert testimony. *Id.*

By contrast, in *Pacheco*, 149 Wn.2d at 439, the Court noted that the surgeon's act of drilling on the wrong side of the patient's mouth was akin to a surgeon's amputation of the wrong limb and concluded that "it is within the general experience of mankind that the act of drilling on the wrong side of a patient's jaw would not ordinarily take place without negligence." Similarly, in *Ripley*, the court noted that the defendant "does not and could not argue that a surgeon who leaves a scalpel blade in a patient without noticing the blade is there and closes the surgical portals is doing something that ordinarily happens in the absence of negligence." 152 Wn. App. at 313.

This case is analogous to *Reyes*, *Miller*, and *Conner*. Here, conservatively treating Acosta's pain and obtaining additional imaging, specialist consults, and eventually surgery as time progressed was not so "palpably negligent" that it can be compared to leaving foreign objects in a body or amputating the wrong limb. *See Reyes*, 191 Wn.2d at 90. And without knowing the professional standard of care for health care providers treating an age indeterminate vertebral compression fracture and lower back, hip, knee, and lower extremity pain in a patient with pre-existing pain

complaints, osteoarthritis, and degenerative disc disease, “a layperson would not be able to determine that [Acosta’s] injury would not have occurred absent negligence by [the Department].” *See Miller*, 145 Wn.2d at 75. Further, just as in *Conner*, where the plaintiff failed to establish that her shoulder pain could only have resulted from the chiropractor’s negligence, so too has Acosta failed to establish that her continued pain could only have resulted from the Department’s negligence. *See* 2019 WL 3554750 at \*4.<sup>4</sup>

The Department submitted evidence establishing it met the standard of care, CP 59-63, 102-03; that Acosta’s own treatment providers were unsure of the cause of her pain or the benefit of surgery, CP 151, 162, 170, 247, 253; that the timing of her surgery did not cause or worsen her lumbar condition, CP 62-63; and that her continued pain appears to stem from an S1 nerve root issue, rather than her lumbar spine. CP 62-63, 103.

Acosta nonetheless argues that the time between January 2015, when she complained of severe back pain and requested a self-paid MRI, and November 2015, when she underwent the MRI, and June 2016, when she underwent surgery, establishes negligence by the Department. App. Br. at 11-12. She contends that, had she not been incarcerated, there would have

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<sup>4</sup> *See* GR 14.1(a). The decision has no precedential value, is not binding on any court, and is cited only for such persuasive value as the Court deems appropriate.

been no delay and that she alone has the ability to decide whether to undergo surgery. *Id.* Acosta is wrong.

It is the judgment of medical professionals to decide when diagnostic imaging is appropriate and when a patient is a candidate for surgery. Here, there is *no* evidence in the record of what an MRI likely would have shown had it been taken months earlier, let alone that it would have revealed findings supporting surgical consultation as were present in November 2015. There is also *no* evidence of whether Acosta's surgeons would have determined that she was a candidate for surgery had she consulted with them sooner. Rather, the record indicates that her surgery, when it occurred, was not considered urgent. CP 446. Nothing about the timing of Acosta's MRI or surgery was so palpably negligent that negligence may be inferred as a matter of law. Thus, *res ipsa loquitur* did not relieve Acosta of her burden to present expert testimony in this case.

## **2. The Department did not exclusively control Acosta's treatment**

Acosta also cannot establish that her alleged injury was caused by an agency or instrumentality within the exclusive control of the Department.

*See Reyes*, 191 Wn.2d at 89-90. As was explained in *Pacheco*,

The reason for the prerequisite of exclusive control of the offending instrumentality is that the purpose of the rule is to require the defendant to produce evidence explanatory of the physical cause of an injury which cannot be explained by the

plaintiff. If the defendant does not have exclusive control of the instrumentality producing the injury, he cannot offer a complete explanation, and it would work an injustice upon him to presume negligence on his part and thus in practice demand of him an explanation when the facts indicate such is beyond his ability.

149 Wn.2d at 437 (quoting *Morner v. Union Pac. R.R. Co.*, 31 Wn.2d 282, 296, 196 P.2d 744 (1948)).

In *Miller*, the surgeon did not have exclusive control of the Penrose drain following surgery. 145 Wn.2d at 75. The Court noted that the drain appeared to be functioning properly while in place, and the surgeon was not present when a nurse and urologist removed the drain several days later. Thus, the doctrine of *res ipsa loquitur* was not available to impose liability on the surgeon. *Id.*

By comparison, when a surgeon had exclusive control of a scalpel or drill, and when a radiation device was operated under the exclusive control of a hospital and its agents, courts have held that the second element supporting the doctrine of *res ipsa loquitur* was met. *See Pacheco*, 149 Wn.2d at 438 (drill); *ZeBarth*, 81 Wn.2d at 20 (radiation device); *Ripley*, 152 Wn. App. at 314 (scalpel).

In this case, Acosta's treatment was not in the exclusive control of the Department. Akin to *Miller*, her treatment also depended on the actions of other medical providers outside the Department—TRA Medical Imaging

and Drs. Goldman and Martin. The Department worked to coordinate with those providers. CP 132, 135, 146, 194-96, 228-30, 244-56, 281, 284-86, 392, 396-97, 415. The Department, however, cannot control the length of time it takes to hear back from an outside provider related to an offender-paid health care procedure, and the Department cannot control if there is a delay in scheduling an appointment with an outside provider because the provider's schedule is full for weeks or months. CP 445-46. In addition, the time that elapsed between Acosta's appointments with Drs. Goldman and Martin were subject to the availability of those doctors' schedules, additional tests required, and surgical calendars. CP 446. Applying the doctrine of *res ipsa loquitur* in these circumstances, where the Department did not have exclusive control of the timing of Acosta's treatment, would work an injustice by demanding of it an explanation for the delay of others.

**3. Acosta participated in the process of arranging for her treatment**

Finally, *res ipsa loquitur* does not apply in this case because Acosta participated in the process of arranging her treatment. The doctrine requires that "the injury-causing accident or occurrence is not due to any voluntary action or contribution on the part of the plaintiff." *Reyes*, 191 Wn.2d at 90. Thus, in *Ripley*, where there was no evidence that the injury-causing accident or occurrence was due to any voluntary action or contribution on

the plaintiff's part while she was anesthetized during surgery, the third criterion was met. 152 Wn. App. at 311.

Here, however, there is evidence that Acosta participated in arranging for the MRI. The process of setting up an offender-paid health care procedure requires the offender to complete certain steps, including locating a medical provider in the community willing to see the offender, filling out a request that the Department have the procedure or appointment, paying a processing fee, obtaining a cost estimate for the procedure or appointment, and submitting money needed to cover the cost of the procedure or appointment. CP 445.

Because Acosta participated in the process of arranging for the MRI, the third element of the doctrine of *res ipsa loquitur* is not met in this case. As Acosta cannot establish that the doctrine relieved her of her duty to present expert testimony on negligence and causation, and because she submitted no such testimony, dismissal of her claims was appropriate.

## **V. CONCLUSION**

This Court should affirm summary judgment in favor of the Department in this medical malpractice case. Acosta does not have any expert testimony to support her allegations that Department medical staff negligently treated her back injury and caused a prolongation of her pain. Expert testimony is required because determining whether the Department

violated the standard of care and, if so, whether any such alleged violation proximately caused her injury is beyond the knowledge of a lay jury. Further, the doctrine of res ipsa loquitur is inapplicable based on the evidence in the record. The trial court properly dismissed Acosta's claims.

RESPECTFULLY SUBMITTED this 20<sup>th</sup> day of September, 2019.

*s/ Sara A. Cassidey*

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## DECLARATION OF SERVICE

I declare under penalty of perjury, pursuant to the laws of the State of Washington, that on the date below, the preceding “RESPONDENT’S BRIEF” was electronically filed in the Washington State Court of Appeals, Division II, and electronically served on the following parties, according to the Court’s protocols for electronic filing and service.

Brett A Purtzer  
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DATED this 20<sup>th</sup> day of September, 2019, at Tumwater, Washington.

*s/ Tina M. Sroor*  
\_\_\_\_\_  
TINA M. SROOR, Legal Assistant

**ATTORNEY GENERAL OF WASHINGTON**

**September 20, 2019 - 1:36 PM**

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