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COURT OF APPEALS, DIVISION III
STATE OF WASHINGTON

CHERYL AND COLTON BEHR, APPELLANTS

v.

CHRISTOPHER ANDERSON, NORTHWEST ORTHOPEDIC
SPECIALISTS, et al., RESPONDENTS

REPLY BRIEF OF APPELLANT
To DEACONESS (3rd of 3)

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I. Reply to Deaconess: Introduction to Reply Brief

Cheryl and Colton Behr begin their Reply Brief by summarizing the structure of the Deaconess Response Brief argument, and then summarize their own reply. The Reply Briefs regarding NWOS, et al, and regarding Dr. Powers, both filed 9/7/20, are incorporated.

A. Structure of the Deaconess Argument

The essence of the Deaconess argument is summarized accurately in their table of contents and statements of the issues on pages 15 and 18: (1) That Dr. Anderson “specifically ruled out” compartment syndrome on 12/11/10, and (2) that causation between the expertly-documented Deaconess violations of the standard of care and the delay in diagnosing Colton Behr’s compartment syndrome cannot be provided by lay common sense or by the causation testimonies of Dr. Cossman and Dr. Collier (and Dr. Powers) that fasciotomy is the only treatment for compartment syndrome.

B. Structure of the Behr Reply

The Behrs’ positions are: (1) That with the Error of Judgment Instruction, by definition Colton’s compartment syndrome was detectable prior to 12/12/10, but that it is excusable for Dr. Anderson to have missed it; (2) That Dr. Anderson -- in reaching for the Error of Judgment Instruction in his new testimony (compared to his declarations) -- created

an informed consent case as Dr. Anderson testified that he decided to “monitor” after his suspicion of compartment syndrome, and by this testimony the Deaconess violations of the standard of care from the afternoon of 12/10/10 to noon on 12/12/10 were critical in Colton’s tissue death and loss of function in his anterior compartment; (3) That if Deaconess had rung its alarm bells appropriately under the standard of care, Colton would have gotten the response he needed to prevent tissue death and loss of function; (4) That given that fasciotomy is the only treatment for compartment syndrome, even a lay person can provide sufficient causal connection between the *Deaconess violations of the standards of care* (and Deaconess concedes the standard of care violations at p. 13 of its Response Brief) and *the failures of the medical team to get Colton a timely diagnosis and fasciotomy*; and (5) Deaconess was part of the “team” treating Colton under the *Grove* and *Hansch* cases.

II. Reply Arguments of Colton and Cheryl Behr

A. Deaconess Duty to “Ring Alarm Bells”

The Behrs’ Nursing Expert’s, Linda Newman’s, trial testimony was summarized in the Opening Brief (at p. 3) as the Duty of Deaconess “*to escalate Colton Behr’s concerns until there was a sufficient orthopedic response.*” The sufficient orthopedic response is only fasciotomy before permanent loss of function, which would have been met if Colton had

received a fasciotomy between noon on Friday 12/10/10 – when the compartment syndrome first appeared -- and the morning of 12/12/10. See, e.g, 12/10/10 at RP 1253, lines 4-14, and RP 1254, lines 1-10.

The multiple Deaconess standards of care that were violated (in Linda Newman’s testimony presented in the Opening Brief) will be summarized herein as “Ringing the alarm bells.”

B. Necessary Logical Implications of the Error of Judgment

Instruction: Two or More Diagnoses Must Have Been Considered

Deaconess seeks to slyly conflate the jury verdict of no violation of the standard of care (Deaconess Resp. at p.3, fn4) under the Error of Judgment instruction with an allegation that Colton had no compartment syndrome at 3:30 p.m. on Saturday, 12/11/20 (Deaconess Resp. at p.3). By definition, the Error of Judgment Instruction only means that *(a) Dr. Anderson missed Colton’s compartment syndrome, but (b) missing the compartment syndrome was an understandable error of judgment.*

It is logically impossible to give the error of judgment (or “exercise of judgment”) instruction and claim a definitive diagnosis at the same time:

And again, the instruction is proper only when there is evidence that the physician made a choice among multiple alternative diagnoses or courses of treatment. Fergen, 182 Wash.2d at 806, 346 P.3d 708.

Needham v. Dreyer, 11 Wash. App. 2d 479, 490, 454 P.3d 136, 143 (reversing an error of judgment instruction and remanding for new trial), *review denied*, 195 Wash. 2d 1017, 461 P.3d 1201 (2020).

Conclusion: Under the error of judgment instruction, the jury verdict simply cannot offer Deaconess (or NWOS) the definitive exoneration it proposes. The logic of the instruction, as explained in *Fergen* and *Needham*, precludes that result.

As the Behrs presented on p. 60 of their Opening Brief:

Judge McKay allowed the error of judgment instruction based upon Dr. Anderson's suddenly-appearing *informed consent testimony*, that *Dr. Anderson presented at trial for the first time in the history of the case* (emphasis added):

THE COURT: Based upon my review of the instruction, and again on my review of the testimony by all parties, both the plaintiff and the defense, there were possibly two diagnoses that were put on the record by Mr. King, so I will be giving this instruction.

RP 1751, lines 4-8.

To reiterate: Logically, the jury's verdict cannot necessarily imply the jury's rejection of a diagnosable compartment syndrome at 3:30p.m. on Saturday, 12/11/10, when the instruction allows (a) for diagnosable compartment syndrome to exist, and (b) for Dr. Anderson to "understandably" miss it.

How loudly Deaconess staff should have run the alarm bells surely would have impacted Dr. Anderson's attention (or that of any other

contacted physician) and, more likely than not, the responding physician would have avoided the “error of judgment.”

C. Dr. Anderson’s Informed Consent Testimony

Dr. Anderson’s testimony was that he made a choice between treatment and non-treatment in contemplation of compartment syndrome:

Q. And in connection with that conclusion, Doctor, did you do what this jury has heard about called compartment pressures, sticking a needle in the various compartments and getting a pressure reading?

A. I did not, no.

Q. Please explain to the jury your thinking or your thought process related to compartment pressure testing on Saturday, December 11th?

A. Well, compartment pressure monitoring in and of itself is not exact science. And if the history and the physical do not reach the level where you would say "I think this patient has a compartment syndrome," the pressure isn't -- it can be off by several millimeters of mercury, just the machine. The usage of the machine can be inaccurate. And so you don't make a decision to do fascial releases or compartment surgery based on that number if your clinical exam didn't support it.

RP 1402 (Dr. Anderson’s Trial Testimony).

The development of informed consent testimony continued under direct examination:

Q. Have you, in your training or your experience, ever taught or learned that it's okay to do a fasciotomy on mere suspicion even if the patient doesn't go on to develop a compartment syndrome?

A. You would need appropriate level of clinical certainty to go ahead.

Q. And is that notion of clinical certainty to prevent an unnecessary surgery and the complications you've just described?

A. Not sure I'm following.

Q. Is the necessity for appropriate clinical certainty to prevent an unindicated or unnecessary surgery and the complications that can arise from it?

A. So you're saying don't do surgery the patient doesn't need because a lot of bad things could happen? Is that what you're asking me?

Q. That's better than what I asked.

A. Okay. Yes, you should not do that.

RP 1435-36 (Dr. Anderson's Trial Testimony).

As indicated in prior briefing, Dr. Anderson, at this point, went beyond simply "exercising judgment," and moved into an informed consent realm under *Flyte v. Summit View Clinic* (below).

In the Opening Brief, the Behrs showed that a patient must have all material facts about possible diagnoses -- even if no diagnosis is yet made -- as long as the doctor considered the diagnosis, then the case is not solely a medical negligence claim. See, e.g., *Flyte v. Summit View Clinic*, 183 Wash. App. 559, 565, 333 P.3d 566, 569–70 (2014) (patient must have all material facts about possible diagnoses, even if no diagnosis is yet made -- as long as the doctor considered the diagnosis, then the case is not solely a medical negligence claim).

While the informed consent element of this case has been presenting in the Opening Brief and in the Reply to NWOS, once Dr. Anderson began to consider and monitor for compartment syndrome, then the volume and frequency of Deaconess "ringing the alarm bells" became

causally crucial. Deaconess failed in this duty to raise the alarm about Colton's symptoms, causing Colton permanent harm.

D. Nursing Expert Linda Newman on the Duty to Get a Surgical Response

Nursing Expert, Linda Newman's, trial testimony is found at RP 832-970. Repeatedly and consistently, Linda Newman was clear that if Deaconess staff had rung its alarm bells appropriately under the standard of care, Colton would have gotten the response he needed to prevent tissue death and loss of function. For one of many examples (emphasis added):

BY MR. MASON: Q. What is the significance of this note in a patient's medical record?

A. For me, I would like to preface this with physical therapy is a very important part of the team. They spend a lot of time with the patient, much more time in a very concentrated focus than, oftentimes, the nursing or the physician that's on call for that day. This note would have raised a lot of alarm for compromise vascularly for this patient.

Q. What does vascular compromise mean?

A. The fact that there is a definite change with the sensation and the definite change regarding weakness, decreasing movement and edema, would be -- definitely I would be following through with the physician, myself, to ensure that he was aware of this.

MR. RAMSDEN: I'm going to object and move to strike. What she would do is not relevant. MR. HAZEL: Join. [No ruling.]

BY MR. MASON: Q. What should the nurse have done?

A. The nurse should have followed the chain of command, which is a basic standard of care, and made sure that this message got to him. And certainly have discussed it with her charge nurse that this was a definite neurological change and needed attention.

Q. Are you experienced with patients with compartment syndrome?

A. Yes, I am. I've seen it in the ICU multiple times. I've seen it post-operatively in our patients in PACU, usually with a cast, which is an external pressure on a compartment. Different than Colton Behr, who had internal issues with edema and swelling. But it does happen. It is always an emergency. It usually involves a patient going right back to the operating room.

RP: 867-68 (Trial Testimony of Nursing Expert, Linda Newman).

Deaconess was dismissed on the causation issue, not on the violations of the standard of care (which Deaconess concedes in its Response Brief). But Deaconess evades the implications of Nurse Newman's un-rebutted testimony that Deaconess did not ring the alarm bells until an orthopedic surgeon sufficiently responded to ease Colton's symptoms. These symptoms that have only one treatment, a fasciotomy.

In short: Colton's symptoms required a competent nursing and PT staff (and the rest of the Deaconess "team") to keep ringing the alarm bells until Colton got relief. It is unanimous among defense experts, as well as plaintiff experts, that the one and only relief for compartment syndrome is a fasciotomy. By the standard of care articulated by Dr. Cossman and Dr. Collier (but which Judge McKay did not allow to the jury) requires diagnosis and treatment before permanent loss of function occurs.

The unchallenged nursing standard of care is that the alarm bells must be wrung until Colton got relief. This comports with the Cossman and Collier testimony that was not allowed to get to the jury instructions.

E. Causation is Established by Fasciotomy as the Only Treatment

Given that fasciotomy is the only treatment for compartment syndrome, even a lay person can provide sufficient causal connection between the Deaconess violations of the standards of care and the failures of the medical team to get Colton a timely diagnosis and fasciotomy. See, for example, *McLaughlin v. Cooke*:

It is not always necessary to prove every element of causation by medical testimony. 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. *Bennett v. Department of Labor & Indus.*, 95 Wash.2d 531, 533, 627 P.2d 104 (1981). Further, expert medical testimony is not necessary if the questioned practice of the professional is such a gross deviation from ordinary care that a lay person could easily recognize it. *Petersen v. State*, 100 Wash.2d 421, 437, 671 P.2d 230 (1983); *Breit v. St. Luke's Mem. Hosp.*, 49 Wash.App. 461, 464, 743 P.2d 1254 (1987).

McLaughlin v. Cooke, 112 Wash. 2d 829, 837–38, 774 P.2d 1171, 1175–76 (1989).

Application of *McLaughlin v. Cooke*: It is clear in this case not only should a laymen be allowed to determine (a) the “gross deviation” from the standard of care, but also the jury can infer causation, here, under the doctrine (b) that “from the facts and circumstances” and from “the medical testimony given” that “a reasonable person can infer that the causal connection exists.”

Reinforcing this view is *Bauer v. White*:

Expert testimony is necessary only if the medical facts are not observable to the lay person. *Harris*, 99 Wash.2d at 449, 663 P.2d 113 (quoting *Bennett v. Department of Labor & Indus.*, 95 Wash.2d 531, 533, 627 P.2d 104 (1981)). Here, the medical facts are observable to a lay person.

Bauer v. White, 95 Wash. App. 663, 667, 976 P.2d 664, 667 (1999).

Finally, see also *St. v. Weyerhaeuser Co.*:

In other words, it is sufficient if “a reasonable person can infer” from the medical testimony, in conjunction with lay testimony, “that the causal connection exists.” *Id.* at 637, 600 P.2d 1015. This suggests there are no “magic words” for proving the issue of medical causation.

St. v. Weyerhaeuser Co., 189 Wash. 2d 187, 196–97, 399 P.3d 1156, 1162 (2017).

Application of *Bauer v. White* and *St. v. Weyerhaeuser Co.*: There was sufficient medical testimony that along with Linda Newman’s testimony, that the Deaconess failure to “ring the alarm bells” until Colton got his one and only possible relief – a fasciotomy – should have gone to the jury.

Additionally, the trial court did not follow *Driggs v. Howlett*, by which Linda Newman could rely upon Dr. Cossman and Dr. Collier for causation vis-à-vis Deaconess, as was raised in the Opening Brief:

One expert may rely on the opinions of another expert when formulating opinions.

Driggs v. Howlett, 193 Wash. App. 875, 900, 371 P.3d 61, 73 (2016), citing *State v. Russell*, 125 Wash.2d 24, 69, 882 P.2d 747 (1994). See also

Volk v. Demeerleer, 184 Wash.App. at 430–31, 337 P.3d 372 (2014);
Deep Water Brewing, LLC v. Fairway Res. Ltd., 152 Wash. App. 229,
271, 215 P.3d 990 (2009).

In sum, the court committed legal error in dismissing Deaconess as a matter of law on the causation issue.

F. Deaconess as Part of the “Team” Caring for Colton Behr

The Replies to NWOS and to Dr. Powers are incorporated. Under *Grove v. PeaceHealth St. Joseph Hosp.*, 182 Wash. 2d 136, 341 P.3d 261 (2014) (citing and reinvigorating *Hansch v. Hackett*, 190 Wash. 97, 66 P.2d 1129 (1937)), Deaconess was part of the team caring for Colton Behr.

Deaconess should be liable as part of the team for its breaches of care identified by Linda Newman and under *res ipsa loquitur* as no one should suffer undiagnosed compartment syndrome from the known complication of a tibial repair to the point of the diagnosis being delayed until permanent loss of function occurs (let alone the tissue death and debridement suffered by Colton).

Vascular Surgical Expert, Dr. David Cossman, presented the standard of care testimony that ***no patient under direct care should suffer permanent injury from compartment syndrome when it is a known complication*** -- as it was in Colton Behr’s tibial plateau repair.

Dr. Cossman's Trial Testimony at RP 1257-58 read as follows

(objection discussions are omitted from the following quote):

Q. What is the standard of care regarding performing fasciotomies in a clinical condition in which compartment syndrome is known to be a complication? ...

THE WITNESS: Standard of care requires that fasciotomies be done when they are needed to be done to avoid any permanent damage, and that they be done correctly and completely. Because you can do a fasciotomy that's incomplete, where you don't open up all the fascial compartments. So you have to do it in a timely manner and you have to do it correctly.

BY MR. MASON: Q. And what is the standard of care for diagnosing when a fasciotomy is to be done? ...

THE WITNESS: It's really the same answer in that the standard of care requires that the diagnosis be made before you have any permanent damage so that when you do the fasciotomy, you don't wind up with any permanent loss of function or tissue.

Dr. Cossman Trial Testimony at RP 1257-58 (emphasis added).

Dr. Cossman articulated this standard with reasonable medical certainty (emphasis added):

Q. Regarding the standard of care statement that you are obliged under the standard of care in clinical settings where compartment syndrome is a known complication to perform fasciotomies before there's permanent tissue damage or death, have you made that statement on a more probable than not basis with reasonable medical certainty?

A. Yes.

Q. Regarding your statement that the standard of care requires compartment pressure checks if you can't rule out compartment syndrome, have you made that statement on a more probable than not basis with reasonable medical certainty?

A. Yes.

Dr. Cossman Trial Testimony at RP 1259. The Behrs should have been allowed to present their instructions, including the res ipsa loquitur instruction, based upon their substantial evidence admitted at trial, implicating Deaconess in liability. See *Pacheco v. Ames*, 149 Wash. 2d 431, 440–41, 69 P.3d 324, 329 (2003); *Curtis v. Lein*, Wn.2d, 239 P.3d 1078, 1081 (2010); *Brown v. Dahl*, 41 Wash.App. 565, 582, 705 P.2d 781 (1985); *Siegler v. Kuhlman*, 81 Wash.2d 448, 451–53, 502 P.2d 1181 (1972). See also, as unpublished authority for such weight as the court gives it under GR 14.1, *Soucy v. Gilbertson*, No. 79927-4-I, 2020 WL 4753839, at *2 (Wash. Ct. App. Aug. 17, 2020).

In *Douglas v. Bussabarger*, the trial court was reversed and a new trial was ordered after the failure to give the res ipsa loquitur instruction; and the appellate court denied that it was harmless error:

Defendant-Bussabarger contends, however, that, even if it was error for the trial judge to give instruction No. 11 [the res ipsa loquitur instruction], it was harmless error since the evidence discussed above is insufficient to establish his negligence as the cause of plaintiff's injuries. We find no merit in this contention. The doctrine of res ipsa loquitur was available to plaintiff to get her case to the jury.

In the recent case of *Pederson v. Dumouchel*, 72 Wash.Dec.2d 73, 81, 431 P.2d 973, 979 (1967), we described cases in which res ipsa loquitur is available as follows:

A case in which the doctrine of res ipsa loquitur applies is a circumstantial evidence case. In it, the jury is permitted to infer negligence from a result which ordinarily would not have been reached unless someone

was negligent. The jury may make the inference of negligence or it may refuse to do so.

We believe the instant case falls within this rule. Plaintiff submitted to surgery for the purpose of having a stomach ulcer repaired. After surgery she was paralyzed from the waist down. It is clear to us that this typifies those cases in which res ipsa loquitur applies because mankind's general experience and observation teaches that the harmful result probably would not occur in the absence of someone's negligence. See *Horner v. Northern Pac. Beneficial Ass'n Hosps., Inc.*, 62 Wash.2d 351, 382 P.2d 518 (1963).

In *Pederson v. Dumouchel*, supra, at 81, 431 P.2d at 979, we made the following statement:

Not to awaken from a general anesthetic for almost a month, and then with apparent brain damage is so extraordinary an occurrence within the general observations of mankind as to raise an inference of negligence.

In our judgment, paralysis after an operation to repair a stomach ulcer raises the same inference.

Assuming that plaintiff's disability does not fall clearly and unmistakably within the category of those res ipsa cases described above, nevertheless we believe the medical testimony in the instant case, under what we regard as the unique circumstances of medical malpractice cases, was enough in this case to create an inference of negligence and justify application of the principles of res ipsa loquitur.

Douglas v. Bussabarger, 73 Wash. 2d 476, 482–83, 438 P.2d 829, 833–34 (1968).

Application of the Case Law: From the cases cited, above, Deaconess should have been included as part of the team whose failures to Colton were subject to a res ipsa loquitur instruction.

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III. Other Reply Details and Topics

The remainder of this Reply Brief will address mis-constructions of the issues by Deaconess. The Behrs presume that tactics of conflation and false distinction that work on harried trial judges are likely to be less successful in the more studied environment of the appellate court.

A. Page 3 Issues of the Deaconess Response

As was noted above, Judge McKay found two diagnoses by Dr. Anderson on 12/11/10, which is why she allowed the Error of Judgment instruction (and which is why Colton Behr moved to amend his complaint for an informed consent claim). Additionally, as was noted above, Linda Newman testified that nurses had an obligation to escalate concerns until Colton Behrs' needs were met. Colton continued in severe pain, as his tissues agonizingly died from lack of oxygen, and proper escalation of his concerns would have led to either (a) proper diagnosis and immediate fasciotomy under the standard of care articulated by Dr. Cossman, Dr. Collier and Dr. Powers Powers (negligence claim) or (b) a response from a doctor who would have given Colton the option of a fasciotomy upon suspicions of compartment syndrome, instead of denying Colton that treatment option, without informed consent, and, as Dr. Anderson did, unilaterally choosing monitoring upon that suspicion without telling Colton of the potential diagnosis and treatment option.

Next, Deaconess says that Colton's "muscle damage had already occurred." The point is not that muscle damage occurred, but that Colton suffered muscle damage to the point of loss of function. And Colton's harm from medical malpractice went beyond loss of function to the death of the compartment and its removal from his leg.

What Dr. Cossman actually said at trial was this:

Q. Yes. What would have been the long-run condition or outcome for Mr. Behr if anterior compartment -- the fasciotomy had been done on December 10th, 2010?

A. He'd have two fasciotomy incisions and a normally-functioning leg.

Q. And can you say that on a more probable than not basis with reasonable medical certainty?

A. Sure.

Q. And what would have been the condition of his anterior compartment if there had been a fasciotomy done on December 11th, 2010? ...[objection and ruling omitted]..

A. THE WITNESS: Yeah. I mean, the 11th is 24 hours long. And the way the compartment syndrome works is what happens to the muscle's a function of the amount of pressure over the amount of time. So the 11th is kind of a critical day. If it was done early on the 11th, the result would probably be very similar to the 10th. He'd be whole. If it was done one minute before the stroke of midnight before the 12th, he'd probably be better off than when it was done 12 hours later, but he might have lost some muscle.

RP 1253, lines 4-14, and RP 1254, lines 1-10.

Deaconess implies that Colton had "already" suffered his damages at 3:30 p.m. when Dr. Anderson either missed it (his pre-trial declarations) or thought about compartment syndrome and decided to monitor it (his

trial testimony). Deaconess arguing about a “marginally” better outcome is a damages issue, not a liability issue. As Dr. Cossman testified, above, the “damage” would have been only cosmetic as of 12/10/10.

Dr. Powers was the assigned physician, but he had gone out of town skiing. (See Reply to Dr. Powers, incorporated). Dr. Powers clearly would have performed a fasciotomy, per his trial testimony, upon suspicion of compartment syndrome. RP 577-639.

The withholding in discovery of the NWOS electronic message of 12/10/10 -- that was withheld by NWOS agents Dr. Anderson, Dr. Lynch, and Dr. Powers -- led not only to the erroneous dismissal of Dr. Powers and Dr. Lynch, but the trial consequence of that withholding led the court to allow no testimony at all about 12/10/10. As a reminder from page 25 of the Opening Brief:

In the 3/3/14 Declaration of Dr. Lynch, CP 413-15, Dr. Lynch stated that the PT Ruth Benage message “did not come to my [his] attention.” However, the 12/10/10 *NWOS e-message* discovered in early 2018, as explained by NWOS agents, Marcie Loshbaugh (CP 3925-52) and Deneen Tate (CP 4025-49) show that Dr. Lynch forwarded the 12/10/10 *NWOS e-message* to Dr. Powers on that same day. Related facts at CP 3973-4025, 3904-12, 3685-3808.

The nurses and staff had a medical duty to “keep ringing the alarm bells,” on 12/10/10 after there was no response to their noon message – in the face of Colton’s escalating symptoms of compartment syndrome. The

jury is the finder of fact to determine whether greater nursing pushes for a 12/10/10 response from NWOS would have led to a timely-fasciotomy. In short, whether the Deaconess alarm bells had been rung with an insistence that met the standard of care, and would have saved Colton's leg, was a jury question.

Dr. Powers certainly implied that Dr. Anderson (who had much less experience) lacked the experience to detect compartment syndrome.

The following is from Dr. Powers' trial testimony:

Q. And when you say be aware of the clinical situation, what would that mean in Colton Behr's instance? Instance of a 39-year-old athletic person?

A. Well, I think in his situation, almost everybody taking care of him is aware that he's had a plateau fracture that was surgically repaired, and they may or may not be aware of the severity of that fracture. But I think those two things, the fact that he had a plateau fracture and that it was surgically repaired, would automatically put you a little bit on alert that something potentially bad could happen.

Q. And is that -- so that's what you mean by awareness of the clinical situation?

A. Certainly. You wouldn't be clinically suspicious of a compartment syndrome in someone who hadn't had an injury or some other reason to have one.

Q. The second of three things you said is then kind of a comparative analysis relative to other patients?

A. That's -- people like to ask the question about pain out of proportion. What does that mean? You have to have something to relate that to.

Q. And I guess I was wondering if that was actually a concept you use or just people on this side of the room.

A. If you look in textbooks under "compartment syndrome," one of the signs or symptoms potentially would be, might be, pain out of proportion with what you would expect to see.

Q. I guess, how would you know what to expect?

A. Well, that's why we do five years of residency and a year of fellowship, and they don't let you just go out of medical school and into practice. Because you need to experience some things.

Q. And are patient pain number selections very helpful?

A. They can be. They can be, if they understand the scale.

Q. And then finally, what did you mean by "understand the diagnosis and think of it"?

A. If you don't think about compartment syndrome, you're not going to make the diagnosis of it.

Q. And what helps you think of it, I guess?

A. Well, I think that training is one, experience is another. Those are big parts of it. There are a number of documented areas in the notes where people describe having thought about compartment syndrome. So it's a discussed topic.

RP: 629-631 (Dr. Powers' Trial testimony, emphasis added).

Had the Deaconess nurses, on 12/10/10, "rung the alarm bells" as they needed, to meet the nursing standard of care, Colton Behr would have timely had the one-and-only treatment for his compartment syndrome (fasciotomy), and would have had no loss of function and/or tissue death.

B. Deaconess' Restatement of the Issues from pp. 4-5 of the

Response: Judgments as a Matter of Law are Reviewed De Novo

Deaconess repeats the causation issues, already addressed, above, as its "A" and "B" on pages 4-5 of its "Restatement of the Issues," and then a new issue is raised as the Deaconess Point "C." Deaconess says that a Plaintiff cannot appeal a pre-trial summary judgment motion after trial. However, that is not true when the issues are entirely matters of law.

Summary judgment shall be granted if the pleadings, depositions, answers to interrogatories and admissions on file, together with the affidavits, show that there is no genuine issue of material fact and that the moving party is entitled to judgment as a matter of law. An appellate court reviews *de novo* a grant or denial of summary judgment. Such an order is subject to review “if the parties dispute no issues of fact and the decision on summary judgment turned solely on a substantive issue of law.”

Washburn v. City of Fed. Way, 169 Wash. App. 588, 609, 283 P.3d 567, 578 (2012), *aff'd on other grounds*, 178 Wash. 2d 732, 310 P.3d 1275 (2013) (footnotes omitted), and citing *Univ. Vill. Ltd. Partners v. King Cty.*, 106 Wash. App. 321, 324, 23 P.3d 1090, 1092 (2001).

The *Washburn* court goes on to say that normally questions of duty implicate facts to be found by the jury; however, legal causation issues are clearly subject to *de novo* review.

No facts on behalf of Deaconess were put to the jury; therefore, review of all summary judgment motions regarding Deaconess, including the 2014 motion to which Deaconess did not reply on liability, are before the reviewing court, especially on a causation as a matter of law:

Although we ordinarily do not review an order denying summary judgment after a trial on the merits, we will review such an order if the parties dispute no issues of fact and the decision on summary judgment turned solely on a substantive issue of law. Because the parties in this case agree as to all material facts and the summary judgment was based on a legal conclusion, we will review the trial court's order.

Univ. Vill. Ltd. Partners v. King Cty., 106 Wash. App. 321, 324, 23 P.3d 1090, 1092 (2001) (footnotes omitted).

C. The Nurse's Duty and Standard of Care

Nursing Expert Linda Newman testified to the nurse's duty to escalate concerns until Colton got relief, and not merely to "report" symptoms. Deaconess says (at p. 6 of its Response): "The nurses' role was limited to observing and reporting signs and symptoms to Mr. Behr's orthopedist." Linda Newman's standards of care are more protective of patients than the standard that Deaconess proposes (despite elsewhere conceding Linda Newman's standards of care in its Response Brief).

As a side note: Had Deaconess responded to the summary judgment motion of 2014, the causation issue could have been raised earlier and addressed more comprehensively.

D. Dr. Anderson's Trial Testimony

Contrary to the Deaconess Response at p. 9, as has been repeatedly noted, Dr. Anderson modified his testimony from not seeing the compartment syndrome on 12/11/10, to making a unilateral decision to monitor, despite his suspicions of compartment syndrome, rather than let Colton make an informed-consent choice to have a fasciotomy. Judge McKay allowed the Error of Judgment jury instruction because of Dr.

Anderson's "two diagnoses," and therefore the nurses failures to ring the alarm bells are casually material.

E. Deaconess Acknowledges the Dismissal Was on Causation; and Deaconess Concedes that It Breached the Standards of Care as a Matter of Law on This Appeal

On page 13, Deaconess acknowledges that its dismissal was on causation, and not because Nurse Newman failed to identify breaches in the standard of care by Deaconess.

Deaconess concedes, also on page 13:

For purposes of this appeal, Deaconess does not dispute that Mr. Behr presented expert testimony asserting that Deaconess nurses failed to comply with the standard of care.

When Deaconess turns to "but for" causation on page 14, Nurse Newman's standard of care includes the duty to escalate up the chain of command until the patient gets relief. Common sense can supplement the experts – Dr. Collier, Dr. Cossman, and Nurse Newman – with the facts that Colton was seen as a "problem patient" (due to his textbook symptoms), and was not seen by Deaconess staff as someone for whom louder alarm bells must be rung.

F. Dr. Anderson's Missing (or Failing to Inform) Raised Again

This "exoneration by jury verdict" argument by Deaconess has already been addressed, and has also been addressed in the Behrs' Reply

to NWOS. Dr. Anderson's jury verdict is ambiguous as to its meaning, because the Error of Judgment Instruction means, "You are okay to miss the diagnosis because you had another diagnosis." And Linda Newman's testimony is that the nurses had to ring alarm bells until Colton's pain was understood and his problem fixed. To reiterate, the expert testimony of all parties is that only a fasciotomy would treat the literal "fire" (of oxygen-deprived tissues) in Colton's leg – Colton's compartment syndrome.

Deaconess concedes that the nurses did not sufficiently ring the alarm bells to meet the standard of care, and there is sufficient expert testimony for the jury to supply lay intelligence to determine that a sufficient ringing of the alarm bells would have brought Colton timely relief. The issue should have gone to the jury under *Bauer v. White*, 95 Wash. App. 663, 667, 976 P.2d 664, 667 (1999), and *St. v. Weyerhaeuser Co.*, 189 Wash. 2d 187, 196–97, 399 P.3d 1156, 1162 (2017), cited above.

The "causal" question was a question of fact, not of law. The matter should go to the jury with a new trial on causation and damages issues. As to liability, Deaconess should be found liable as a matter of law.

G. Patient Escalating Symptoms versus "Diagnosis"

Deaconess competently summarizes parts of Colton's argument on pp. 18 to 19 of its Response. Then Deaconess erroneously claims that the Behrs are asserting that nurses should know that Colton has been

“misdiagnosed.” The distinction missed is that the nurses should know that Colton’s problem has not been resolved and that his symptoms are escalating. Colton was given narcotics to the point that his ability to breathe was arresting, and yet his pain and symptoms kept escalating.

Deaconess said it conceded Nurse Newman’s standards of care, and thus Deaconess cannot “take it back” on page 19 what it conceded on page 13.

It is for this court (Division III) to decide if connecting the testimony of Nurse Newman to that of Dr. Collier and Dr. Cossman requires only practical wisdom (Colton Behr) or would be speculation (Deaconess on p. 20).

The Behrs addressed the *Frausto* case in their Opening Brief, and only add in Reply that experience remains a touchstone for expert opinion:

ER 702 requires that an expert providing opinion testimony be qualified. An expert can be qualified “ ‘by virtue of knowledge, skill, experience, training, *or* education.’ ” Thus, an expert’s “practical experience” or “[t]raining in a related field or academic background alone may also be sufficient.”

We review for abuse of discretion a trial court’s decision **whether** to qualify an expert.

Washington courts have long applied this rule to permit **otherwise** qualified nonphysicians to testify as to “causation, reasonable prudence, or underlying facts tending to prove [those] ultimate facts” in medical malpractice actions. This reflects a recognition that “ ‘the line between chemistry, biology, ... medicine[,]’ ” and other related fields “ ‘is too indefinite to admit of a practicable separation of topics and witnesses.’ ”

L.M. by & through Dussault v. Hamilton, 200 Wash. App. 535, 556–57, 402 P.3d 870, 881 (2017), *aff'd*, 193 Wash. 2d 113, 436 P.3d 803 (2019) (footnotes omitted).

Here, there is more than a reasonable probability that the outcome of the trial was materially affected by these errors, and a new trial should be ordered. *In re Welfare of X.T.*, 174 Wash. App. 733, 739, 300 P.3d 824, 828 (2013).

IV. Conclusion

Deaconess concedes the breaches of the standards of care, and defends its dismissal as a matter of law on the causation question.

Division III is asked to find Deaconess liable as a matter of law, and the court is asked to return the matter to trial on damages on the terms of their jury-apportioned causation between the respondents whose lax care caused Colton and Cheryl Behr lasting harm.

Respectfully submitted on 9/14/20,



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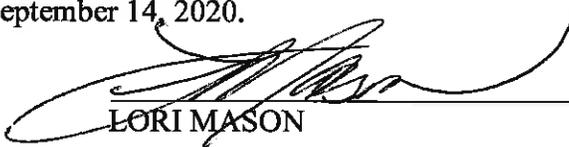
COURT OF APPEALS, DIVISION III, STATE OF WASHINGTON

Colton and Cheryl Behr)	
)	
Appellants,)	
)	CERTIFICATE OF SERVICE
v.)	re: Reply Brief of Appellant
)	to Deaconess
Christopher G. Anderson, et al,)	
)	
Respondents.)	

I certify, under penalty of perjury under the laws of the State of Washington, that on the 14th day of September, 2020, I caused a true and correct copy of Appellants' Reply Brief to Deaconess to be served upon the following, via the eFiling Portal for the Washington State Appellate Courts:

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