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COURT OF APPEALS,  
DIVISION III  
OF THE STATE OF WASHINGTON

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COA No. 364691-III

VICTOR BORST,

*Appellant,*

vs.

PATRICK S. LYNCH, JR., M.D. and NORTHWEST ORTHOPAEDIC  
SPECIALISTS, P.S., a Washington Corporation,

*Respondents*

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**RESPONDENTS' BRIEF**

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EVANS, CRAVEN & LACKIE, P.S.  
James B. King, WSBA #8723  
Sean M. King, WSBA #52104  
818 W. Riverside, Suite 250  
Spokane, WA 99201-0910  
(509) 455-5200  
ATTORNEYS FOR RESPONDENTS  
PATRICK S. LYNCH, JR., M.D.; and  
NORTHWEST ORTHOPAEDIC  
SPECIALISTS

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## I. INTRODUCTION

This appeal arises from a trial in a medical negligence case involving a total right knee replacement for Borst by Dr. Lynch on September 19, 2011. Borst alleges Dr. Lynch injured his Achilles tendon during surgery and that postsurgical care was substandard which caused the alleged Achilles injury to be exacerbated.

Borst's assignments of error focus on two jury instructions given by the trial court: the "no guarantee/bad result instruction" and the RCW 7.70.040 elements instruction regarding the "applicable standard of care." Both instructions were approved by the Washington State Supreme Court Committee on Jury Instructions in 2009. The "no guarantee/bad result instruction" was a correct statement of the law and was supported by the evidence. The trial court did not abuse its discretion in giving it. The RCW 7.70.040 elements instruction was likewise a correct statement of the law, allowed both parties to argue their theories of the case, and did not confuse or mislead the jury in any way. Moreover, even if it was error to give either or both instructions, the "error" was harmless.

Borst's contentions regarding the jury instructions strain credulity and are semantic quibbles. Borst's argument ignores the fundamental standard that instructions must be read as a whole and not in isolation. Borst's appeal should be denied and this Court should uphold the defense verdict at trial.

**II. RESTATEMENT OF ISSUES PERTAINING TO ASSIGNMENTS OF ERROR**

1. Was the trial court's RCW 7.70.040 elements instruction appropriate in that it was a correct statement of the law, allowed the parties to argue their theories of the case, was not misleading, and when read as a whole properly informed the trier of fact of the applicable law?
2. Was the trial court's "no guarantee/bad result" instruction appropriate in that it was a correct statement of the law, allowed the parties to argue their theories of the case, was not misleading, and when read as a whole properly informed the trier of fact of the applicable law?
3. If it was error by the trial court to give either the RCW 7.70.040 elements instruction or the "no guarantee/bad result" instruction, was the error harmless?

**III. RESTATEMENT OF THE CASE**

**A. Procedural History**

Borst filed suit against Dr. Lynch and NWOS on September 9, 2015 alleging Dr. Lynch was negligent in the performance of a total right knee replacement on September 19, 2011 allegedly causing injuries to Borst's Achilles tendon. CP 1-11. Because Borst's appeal is based on the giving of

two jury instructions at trial, much of the procedural history prior to the commencement of trial is irrelevant. An in depth discussion and analysis of the jury instructions at issue appears *infra*.

Trial commenced on June 11, 2018. RP Vol. 1 (June 11-13 2018), pg. 7:2-10. Motions in limine were decided that same day and a jury was empaneled on June 12, 2018. Trial concluded on June 20, 2018. The jury returned a unanimous verdict on June 21, 2018 finding that Dr. Lynch and NWOS were not negligent in the care and treatment of Borst. CP 174-175.

Borst moved for a new trial based on alleged jury misconduct and instructional error (the giving of a “no guarantee/bad result” instruction and the wording of the court’s instruction No. 13 regarding the duty owed by an orthopedic surgeon). CP 176-251. That motion was denied. CP 252-253. A notice of appeal followed. CP 254-260. Borst’s appeal abandoned the juror misconduct claim and the orthopedic surgeon instruction claim in favor of challenging the “no guarantee/bad result” instruction and the RCW 7.70.040 elements instruction.

**B. Underlying Medical Care and Surgery at Issue.**

Victor Borst was a long time patient of Patrick S. Lynch, Jr., M.D., a board certified orthopedic surgeon employed by NWOS in Spokane. RP Vol. 1 (June 11-13, 2018), pgs. 143:24-25; 144:1-23. Dr. Lynch began treating Borst in 1998 after Borst was injured at work. *Id.* at 144:15-25;

145:1-6. Dr. Lynch performed arthroscopic knee surgery on Borst's right knee in 1998. *Id.* at 146:21-23. After this surgery, Borst had ongoing issues with the knee. *Id.* at 149:4-16. Dr. Lynch ultimately performed four additional arthroscopic procedures on the right knee between 1998 and 2011. *Id.*; 153:21-23.

On March 17, 2011, Borst came to see Dr. Lynch with a continuation of knee symptoms. *Id.* at 154:14-19. Dr. Lynch recommended a total knee replacement, and Borst was taken to surgery by Dr. Lynch on September 19, 2011. *See* Exhibit D101. During the surgery, Borst's right foot was initially placed in a neutral position meaning 90 degrees dorsiflexion at the ankle. RP Vol. 1 (June 11-13, 2018), pg. 173:2-8. The right foot was generally kept in the same position through the use of a bolster during surgery except for necessary changes dictated by the operative sequence. *Id.* at 173:9-14; RP Vol. 1 (June 18, 2018), pgs. 165:17-25; 166:1-4; *See also* Exhibit D101. The surgery was performed without incident. The patient was taken to the recovery room in stable condition. *See* Exhibit D101. Borst remained in the hospital until discharge on September 23, 2011. In the hospital postoperatively, he was seen by a variety of providers, including physical therapists, nurses, and also by Dr.

Lynch. *See* Exhibit D107 at pg. 6.<sup>1</sup> Borst's ankle strength was tested at 4+/5 in the hospital and there were no complaints of pain reported to the physical therapist who did the testing. RP Vol. 4, pg. 740:7-14; *See* Exhibit D107 at pg. 18. 4+/5 strength after surgery is excellent and stands just below the top strength finding of 5/5. RP Vol. 4, pgs. 740:21-25; 741:1-7.

Borst had no problems with Achilles pain or discomfort in the immediate postoperative period. *See* Exhibit D107 at pg. 6. Of the various nurses who rounded on Borst at Sacred Heart postoperatively, none documented complaints of pain or problems with the right Achilles tendon. *Id.* at 58-67.

Borst improved with physical therapy. *Id.* at pg. 6. During a postoperative physical therapy session on September 20, 2011, Borst offered no complaints of pain or mentioned an issue with his Achilles tendon. *Id.* at pg. 19. Borst's pain complaints were restricted to the surgically repaired right knee; he was able to ambulate 60 feet with a front-wheeled walker. *Id.* at pg. 59-60.

On September 21, 2011, two days postoperatively, Borst reported the pain in his right knee had improved. *Id.* at pg. 61. He performed heel cord stretches with no complaints of Achilles pain. *Id.* Borst ambulated 140

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<sup>1</sup> Referenced page number refers to the Bates stamp page number that appears in the lower right hand corner of each individual record.

feet with a front-wheeled walker and made no complaints of any issue with the right Achilles. *Id.* Later that same day, during another physical therapy session, Borst ambulated another 50 feet with a front-wheeled walker and there were no complaints of right Achilles pain. *Id.* at pg. 62.

During a physical therapy session on September 22, 2011 in the early afternoon, Borst reported he had been able to get up and go to the bathroom multiple times without any problems. *Id.* at pg. 64. The physical therapist observed that Borst ambulated “with ease” and exhibited good heel strike with the right foot. *Id.* Later that same day, during another physical therapy session, Borst ambulated about 100 feet with the aid of a front-wheeled walker and was able to weight bear as tolerated with his right leg. *Id.* at pg. 65. Further, Borst was able to ambulate up and down four stairs without using the railing. *Id.* Again, Borst made no mention of any complaints concerning the right Achilles.

On the morning of September 23, 2011 prior to discharge from Sacred Heart and during his last physical therapy session, Borst complained of pain around his distal thigh where the tourniquet was placed during surgery. *Id.* Borst also complained of moderate to severe knee pain, but no mention was made of pain in the right Achilles. *Id.*

After discharge, Borst received home health care from Nancy Mack (formerly Rohauer), a physical therapist. RP Vol. 4, pgs. 669:4-25; 671:2-

9. She conducted an initial assessment of Borst on September 24, 2011. *Id.* at 671:23-25; 672:1-20. During the initial assessment, Borst made no mention or complaints of pain in his Achilles tendon, foot, or ankle. *Id.* at 673:18-22; 674:15-25; 675:1-8. Ms. Mack would have documented such a mention or complaint if made by Borst because of the impact on his mobility. *Id.* at 675:9-25; 676:1-7. Ms. Mack also instructed Borst on certain physical therapy exercises that he performed under her observation on September 24, 2011. *Id.* at 677:7-27; 678:1-2. One such exercise was ankle pumps in which Borst flexed and extended his ankle to promote circulation. *Id.* at 678:3-18. Ms. Mack also instructed Borst in walking with a front wheel walker. *Id.* at 678:19-22. In the course of performing those exercises, Borst made no mention or complaint of Achilles tendon or heel or foot pain. *Id.* at 678:23-25; 679:1-3. It would have been Ms. Mack's routine, custom, and practice to document such mentions or complaints of pain from Borst if he had made them. *Id.* at 679:4-10.

Borst was next seen by Anne Dessert, a physical therapy assistant, on September 29, 2011 at his home. RP Vol. 3, pgs. 623:10-25; 624:1-7. Ms. Dessert and Borst worked on patient safety, some therapeutic exercises, range of motion, transfer training, gait training, walking, and pain management at that visit. *Id.* at 623:14-19. Ms. Dessert documented that Borst appeared better at this visit, and Borst also reported the same. *Id.*

at 626:16-19. Borst made no mention or complaint of any pain or discomfort in his ankle, foot, or Achilles tendon. *Id.* at 628:3-7. If Borst had mentioned or complained of Achilles pain or foot pain during the course of the home visit, Ms. Dessert would have documented it and instructed Borst to call his physician. *Id.* at 628:15-25; 629:1-2.

Ms. Dessert next saw Borst for another at home visit on October 5, 2011. *Id.* at 629:9-20. Borst continued with standard protocol for total knee exercises in bed and Ms. Dessert added mini squats to help facilitate knee flexion. *Id.* at 629:21-25. When a patient does mini squats, they keep their feet flat on the floor and use the quadriceps to increase flexion of the knee. *Id.* at 630:14-21. When keeping feet flat on the floor doing a mini squat, the Achilles tendon is extended both to the left and the right. *Id.* at 630:22-25. Borst performed mini squats while being observed by Ms. Dessert, and he did not mention or complain of pain in the foot, heel, or Achilles tendon. *Id.* at 631:1-14; 632:2-6. Ms. Dessert would have documented such a complaint if Borst had made it. *Id.* at 632:7-12. Ms. Dessert also had Borst perform gait training at this same appointment, and Borst did not complain of any heel or Achilles tendon pain at all. *Id.* at 632:13-15; 633:3-7.

Ms. Dessert next saw Borst on October 7, 2011 at another home visit. *Id.* at 633:8-11. Borst told Ms. Dessert he had been performing mini squats since their last appointment and they were of great benefit. *Id.* at

633:15-23; 634:1-8. Borst did not indicate that the mini squats had caused any issues with his foot, ankle, or Achilles tendon. *Id.* at 634:9-12. Ms. Dessert would have documented such a report if Borst had made it. *Id.* at 634:13-16. Borst also performed gait training and did not indicate any problems with his heel, Achilles tendon, or ankle. *Id.* at 634:17-25; 635:1-11. If Borst had indicated pain in his heel, Achilles tendon, or ankle, Ms. Dessert would have documented it. *Id.* at 635:12-13.

On October 11, 2011, Borst was in to see Dr. Lynch and was noted to be doing well with no specific musculoskeletal complaints. *See* Exhibit D100 at 00016.

Ms. Dessert next provided physical therapy services to Borst on October 14, 2011. RP Vol. 3, pg. 636:3-7. Borst again performed mini squats and did not complain of pain in his Achilles tendon. *Id.* at 636:11-17. Borst was also undergoing continuous passive motion (CPM) at this time for about two hours two to three times per day, which involves a machine bending the knee up and down at a slow rate. *Id.* at 636:18-21; 637:11-25; 638:1-9. Borst made no mention of CPM causing problems with his foot, ankle, or Achilles tendon. *Id.* at 638:16-20.

On October 18, 2011, Borst returned to NWOS and saw PA-C Buescher. *See* Exhibit D100 at 00017. Borst reported he was happy with

the results from surgery and was in no distress. *Id.* There were no reports of Achilles pain or discomfort. *Id.*

On October 25, 2011, Borst saw John McKinnon, a physical therapist at Four Seasons Physical Therapy, for the first time. RP Vol. 3, pg. 572:5-23; *See* Exhibit D106, pgs. 1-5. Borst complained of pain in the hip area, the thigh, the knee, and the shin. *Id.* at 575:2-10. Borst did not complain of any pain in the dorsum of the foot or the ankle, in the calf, or in the Achilles tendon area. *Id.* at 575:11-15; 576:8-14. If Borst had made such complaints, Mr. McKinnon would have made note of it as a part of his regular routine. *Id.* at 575:16-20; 576:13-16. Mr. McKinnon would have been particularly alert for any complaints of calf pain or Achilles pain because of the concern for deep vein thrombosis (DVT) in a post knee replacement patient like Borst. *Id.* at 576:17-24. In the course of taking Borst's history at the October 25, 2011 appointment, Mr. McKinnon did not make note of Borst ever mentioning that he had Achilles pain, or pain in the calf. *Id.* at 577:24-25; 578:1-3. Mr. McKinnon had Borst perform passive range of motion exercises, leg presses, assisted bend exercises, and ankle pumps and no complaints were made regarding pain in the foot, ankle, or Achilles tendon. *Id.* at 579:11-16; 582:1-5; 586:4-7; 587:4-17; 588:2-4; 590:5-20.

Borst's next appointment with Mr. McKinnon was scheduled for November 1, 2011, but Borst cancelled the appointment despite reporting his Achilles tendon was very tender. *Id.* at 591:17-23; *See* Exhibit D106 at pg. 7.

Borst did return to Four Seasons for an appointment on November 3, 2011 that was handled by Jodi Katz, a physical therapist's assistant. *Id.* at 592:2-4; *See* Exhibit D106 at pg. 8. Borst told Ms. Katz the pain in the Achilles tendon had lessened compared to earlier in the week and said that the pain had been present since just after surgery and that he had a contusion on the shin after surgery. *Id.* at 592:5-12.

Borst then saw Mr. McKinnon on November 8, 2011 reporting that the Achilles tendon pain was still present, but slightly better. *Id.* at 592:19-25; 593:1-7; *See* Exhibit D106 at pgs. 9-10. Mr. McKinnon indicated he was able to get Borst to be fully weight bearing in that Borst was able to put all of his weight, with a step, on the right foot and leg. *Id.* at 593:12-15. Borst complained of Achilles tendon pain with that effort. *Id.* at 593:8-11. At the next appointment on November 10, 2011, Borst reported that the Achilles tendon pain had increased after getting up and down more while at home. *Id.* at 593:16-21; *See* Exhibit D106 at pg. 11. Over the prior two weeks, Borst had progressed to full weight-bearing with therapy. *Id.* at 593:25; 594:1-2. Per Mr. McKinnon, and as a result of the progress made

resulting in greater movement, Borst's Achilles tendon pain increased due to the increased degree of motion. *Id.* at 594:8-14.

At his next appointment on November 14, 2011, Borst reported to Mr. McKinnon that he had been hunting and had developed more soreness in his knee and Achilles tendon. *Id.* at 594:18-22; *See* Exhibit D106 at pg. 12. Because Borst had been exerting more effort with weight-bearing exercises and movement in general, his complaints of pain in the knee and Achilles tendon were consistent with increased movement. *Id.* at 594:23-25; 595:1.

During an appointment on November 23, 2011 with Mr. McKinnon, Borst reported he was walking better with less pain in the Achilles tendon and the right hip. *Id.* at 595:19-25; 596:13-16; *See* Exhibit D106 at pg. 15. Borst made a similar report during an appointment on November 28, 2011 in which he stated he was doing better with minimal Achilles tendon pain and moderate hip pain. *Id.* at 596:17-25; 597:1-12; *See* Exhibit D106 at pg. 16.

After the November 28, 2011 appointment, Mr. McKinnon prepared a report detailing Borst's treatment over the past month and what the treatment had yielded. *Id.* at 597:13-24; *See* Exhibit D106 at pg. 17. The report provided that Borst was progressing with his physical therapy, but pain in the hip and Achilles tendon had limited weight-bearing

activities. *Id.* at 598:5-7. According to Mr. McKinnon, the pain in the Achilles tendon and hip was due to Borst's long-term knee flexion contracture in existence prior to the total arthroplasty performed by Dr. Lynch on September 19, 2011. *Id.* at 598:7-9. Mr. McKinnon's conclusions after a month of physical therapy were as follows: (1) Borst's new right knee had changed his ability to flex and extend to some extent, (2) the increased ability to flex and extend was superimposed on a long-standing flexion contracture associated with his prior knee injury and surgeries, and (3) the resulting alteration in gait mechanics resulting from the new knee caused hip and Achilles tendon pain as part of the rehabilitation process. *Id.* at 598:15-25; 599:1.

On December 1, 2011, Borst complained to Dr. Lynch for the first time that he had Achilles tendon pain pointing to the back of his heel as the source of pain and stated the pain had been going on since the arthroplasty surgery in September. *See* Exhibit D100 at 00018. Dr. Lynch examined the Achilles tendon and found it to be well aligned with no defect but noted insertional pain, pain with dorsiflexion, and minimal swelling. *Id.* Dr. Lynch wrote that since the foot was dorsiflexed in a 90° or neutral position during arthroplasty surgery, the position might be associated with insertional tearing of the Achilles and/or Achilles tendonitis. *Id.* This lawsuit is largely based on this note of Dr. Lynch's which Borst contends

is an admission that the manner in which Borst's knee was positioned during surgery caused the injury to the Achilles tendon. Dr. Lynch ordered a MRI to evaluate the Achilles. *Id.* The MRI showed Achilles tendinosis with a small distal linear intrasubstance tear. *See* Exhibit D102.

Dr. Lynch did not assume that the linear tear of Borst's Achilles tendon was related to the total knee replacement. RP Vol. 1 (June 11-13, 2018), pg. 247:17-21. Instead, Dr. Lynch simply documented what Borst told him about what Borst thought had caused the Achilles pain. *Id.* Borst likely had damage to that Achilles tendon for quite some time, even a period of years. *Id.* at 248:5-7. Dr. Lynch has no recollection and was not aware of a call Borst placed to NWOS on September 28, 2011 requesting medication for pain in his right ankle and Achilles tendon. *Id.* at 250:8-20.

**C. Borst Trial Testimony**

During the 37-year period between 1979 and 2016, Borst spent more than a third of his time on time loss with L&I. RP Vol. 2, pgs. 456:19-25; 457:1-8.

Borst claimed that he developed pain in his heel, foot, and Achilles tendon at Sacred Heart immediately subsequent to the total knee replacement on September 19, 2011. The pain, he claimed, was a 9 on a scale of 1 to 10. *Id.* at 462:21-25; 463:1. That pain was worse than the pain he felt in his surgically repaired knee. *Id.* at 463:2-7.

Borst underwent outpatient physical therapy with Four Seasons Physical Therapy a few weeks after the knee replacement surgery. *Id.* at 470:15-20. If Borst was having significant heel or Achilles pain during his initial presentation with Four Seasons, he would have told the physical therapist as such. *Id.* at 470:21-25; 471:1-12.

**D. Dr. Barrow Expert Testimony**

Dr. Craig Barrow was one of the Respondents' expert witnesses. Dr. Barrow is a board certified orthopedic surgeon, fellowship trained in foot and ankle surgery, who practices at Providence Healthcare in Spokane. RP Vol. 4, pgs. 706:21-23; 707:2-3; 709:2-6; 710:2-6. Dr. Barrow specializes in injuries to the leg, the ankle, the tendons around the foot and ankle, the Achilles tendon, the mid-foot, arthritis of the ankle and foot, hammer toes, bunions, and severe injuries to the foot from accidents. *Id.* at 710:14-24. In his regular practice, Dr. Barrow does not perform knee replacement surgeries, but he was trained to conduct such surgeries and often sees patients who have undergone a knee replacement procedure. *Id.* at 711:11-25; 712:1-6.

As part of his orthopedic training, Dr. Barrow learned about positioning of patients who are undergoing knee replacement surgery. *Id.* at 715:22-25. Based on reasonable medical probability, at no time during a knee replacement surgery is the Achilles tendon at risk because it is

relaxed during such a surgery. *Id.* at 716:20-25; 717:1-4. During knee replacement surgery, the entire positioning system and protocol is protective of the Achilles tendon. *Id.* at 717:5-18.

The December 13, 2011 MRI of Borst's foot and ankle showed a chronic, long-standing tear in the Achilles tendon. *Id.* at 720:11-20; 722:15-18; 724:17-25; 725:1-8. The tear occurred in the center of the tendon, which is common in a patient with a chronic, long-standing Achilles tendinosis. *Id.* at 722:20-25. Tendinosis is a long-standing injury to the Achilles tendon that has been present for months or years. *Id.* at 726:10-25; 727:1-3. This type of tear is usually caused by irritation from the bone (tibia) that is directly next to the area of the tendon where the tear is located. *Id.* at 722:25; 723:1-2.

The MRI of the Achilles also showed a Haglund's deformity, otherwise known as a bone spur, located in close proximity to the area of the Achilles tendon injury. *Id.* at 723:3-7; 724:4-9; 725:9-23. This deformity had been present for years. *Id.* A bone spur can exist with no symptoms at all. *Id.* at 812:17-19. The MRI showed "classic" signs of a chronic injury to the Achilles tendon that had been ongoing for years, namely calcification in the tendon. *Id.* at 723:8-15; 724:10-16; 727:4-7. Every aspect of the MRI points to a chronic tear of the Achilles tendon, most likely caused by the bone spur located adjacent to the tendon. *Id.* at

723:22-25. A bone spur can cause tendinosis or a longitudinal tear in the Achilles tendon through the constant pressing of the bone spur on the tendon with each step. *Id.* at 728:4-11.

The tear and tendinosis shown in the December 2011 MRI was not the result of a dorsiflexion injury during the knee arthroplasty on September 19, 2011. *Id.* at 729:20-25; 730:1-7. In a dorsiflexion injury, an MRI would show the tendon fibers separated by several centimeters from the bone. *Id.* at 730:6-12. This differs from what appeared in Borst's MRI in that the Achilles tendon fibers were still attached to the bone. *Id.*

Based on reasonable medical probability, the Achilles linear tear/tendinosis and Haglund's deformity were in existence for years prior to Borst's knee replacement surgery on September 19, 2011. *Id.* at 730:21-25; 731:1-5. Even if an MRI had been obtained on August 1, 2011 before the knee replacement surgery, the same findings would have been present because it takes a very long time (two to five years) for the tendons to form a calcific area *Id.* at 731:6-19. It is not unusual for a patient like Borst with asymptomatic tendinosis, a longitudinal tear, or a Haglund's deformity to become symptomatic after the anatomic defects have been present for a number of years. *Id.* at 732:7-23. Often, a patient like Borst will change activities or routines and that change will cause the longstanding asymptomatic abnormalities to flare up and become symptomatic even

though the defects themselves had been present for years. *Id.* Dr. Barrow sees these types of patients on a weekly basis. *Id.* at 732:24-25; 733:1-4.

There was nothing done during the knee replacement surgery that caused the tendinosis. *Id.* at 734:25; 735:1-8. The tendinosis was a chronic, long-standing anatomic condition as evidenced by the December 13, 2011 MRI. *Id.* at 735:7-9; *See* Exhibit D102. The MRI did not show any evidence of an injury that happened with any necessary dorsiflexion during the surgery. *Id.* at 735:9-11. There was no stress on the Achilles tendon during the entire surgery due to positioning. *Id.* at 735:11-13. These opinions of Dr. Barrow were stated to the degree of reasonable medical probability. *Id.* at 736:6-8.

Similarly, the linear tear referred to in the MRI report is not related to the knee replacement surgery because a chronic linear tear such as Borst's is not caused by a dorsiflexion injury. *Id.* at 735:14-25; 736:1. The linear tear was caused by a chronic, long-standing wear to the Achilles tendon from the bone spur located directly next to the tear. *Id.* at 736:1-4.

If Borst's Achilles tendon was injured during surgery or if he had an inflamed Achilles immediately after surgery, Dr. Barrow would have expected him to complain of extreme pain and barely be able to move his ankle. *Id.* at 741:8-19. Borst's ankle strength was measured at 4+/5 after the surgery. *Id.* at 740:10-11. If a patient had a symptomatic linear tear in

the Achilles tendon after total knee replacement surgery, postoperative ankle strength testing would disclose extreme pain with ankle strength at 1 or 2/5 according to Dr. Barrow. *Id.* at 741:8-19. Based on the results of Borst's postoperative ankle strength testing at Sacred Heart Medical Center, Borst did not have symptomatic tendinosis in the immediate post-operative time period. *Id.* at 813:10-14.

Two days after the knee replacement surgery, September 21, 2011, Borst underwent a number of physical therapy exercises. *Id.* at 742:8-23. One such activity was completing Achilles tendon stretching. *Id.* If Borst had symptomatic tendinosis or a symptomatic intrasubstance linear tear in his Achilles tendon at that time, Dr. Barrow would have expected Borst to be in extreme pain with Achilles stretching exercises and would likely have been unable to tolerate any stretching of an injured, symptomatic, and inflamed chronic tear of the Achilles tendon. *Id.* at 743:2-9. There was no evidence in the record of such pain or behavior.

During the October 27, 2011 physical therapy appointment with Ms. Katz, Borst reported he flared up his Achilles tendon while doing sheet stretching exercises. *Id.* at 744:1-12. By performing those types of stretching exercises with a sheet when the Achilles tendon has had a chronic, longstanding tear, that can cause pain when the tendon rubs against the bone spur. *Id.* at 744:13-24. Something as benign as stretching

the Achilles tendon with a bending exercise using a sheet can cause an asymptomatic Achilles tendon with chronic changes “light up” and become symptomatic. *Id.* at 745:4-8.

According to Dr. Barrow, after Borst’s total knee replacement, he became more active and the mechanics of his walking changed due to being able to more completely flex the knee and because of the knee being in a better position as he walked. *Id.* at 749:8-16. Borst did not have the full use of his leg for years prior to the knee replacement surgery, but with increased range of motion, the preexisting Achilles tendon injury flared up with increased use of the leg. *Id.* at 749:8-24. This is consistent with Borst’s October 18, 2011 appointment at NWOS in which he reported he was happy with the postoperative knee extension he could achieve. *Id.* at 750:1-21; *See also* Exhibit D100 at 00017. There was no mention by Borst during this appointment of any issues or problems having to do with his Achilles tendon, foot, or heel. *Id.* at 752:13-17. It is very common for chronic tears or tendinosis to wax and wane in terms of physical pain to the patient. *Id.* at 753:15-19.

Borst saw Dr. Lynch for a follow up appointment on December 1, 2011. *Id.* at 757:18-21; *See* Exhibit D100 at 00018. Borst complained of Achilles tendon pain and Dr. Lynch noted that “Achilles tendinitis

probably related to the positioning during knee replacement.” *See* Exhibit D100 at 00018.

In Dr. Barrow’s opinion, there was no dorsiflexion injury to the Achilles tendon as a result of the positioning during the total knee replacement. RP Vol. 4, pg. 759:12-13. In fact, the positioning utilized by Dr. Lynch during the surgery is used worldwide by orthopedic surgeons. *Id.* at 814:24-25; 815:1-2. It is also the positioning protocol that Dr. Barrow was trained in and observed during his residency. *Id.* at 815:3-5. It is impossible to stretch the Achilles tendon when the knee is flexed, and when the knee is straight and the foot is plantar flexed, there is no stress at all on the Achilles tendon. *Id.* at 759:15-18. The Achilles tendinosis was not caused by the surgery; rather, it was a long standing, chronic asymptomatic preexisting condition as evidenced by the December 2011 MRI. *Id.* at 759:18-21.

**E. Dr. Lovell Expert Testimony**

Dr. Timothy Lovell was another of Respondents’ expert witnesses. Dr. Lovell is board certified in orthopedic surgery and practices at Providence Orthopedics in Spokane. RP Vol. 1 (June 18, 2018), pgs. 142:15-18; 143:5-8. For over 20 years, Dr. Lovell’s practice focus has been on conducting hip and knee replacements. *Id.* at 144:21-25. During that timeframe, Dr. Lovell has performed thousands of knee replacements. *Id.*

at 145:2-9. Dr. Lovell has taught hundreds of fellowship-trained orthopedic surgeons from around the world regarding processes and techniques for knee and hip replacements. *Id.* at 147:17-25; 148:1-25; 149:1-2. He has also given hundreds of presentations at meetings of orthopedic surgeons over the years. *Id.* at 149:3-19. Dr. Lovell is familiar with the standard of care imposed upon a reasonably prudent orthopedic surgeon in the State of Washington in 2011 in the performance of a total knee replacement surgery under the circumstances Dr. Lynch was in when Dr. Lynch operated on Borst on September 19, 2011. Dr. Lovell knows that standard due to his daily practice as an orthopedic surgeon, his teaching of other orthopedic surgeons in the State of Washington and around the United States, and being a referral for other orthopedic surgeons in Washington and around the country when those other surgeons have questions or concerns regarding their patients. *Id.* at 152:19-25; 153:1-21.

Borst had his knee replaced in September 2011 to address knee arthritis. *Id.* at 159:1-4. It had been significantly affecting Borst for quite some time even as far back as 2003 when Borst began requesting a knee replacement. *Id.* at 159:5-12. Dr. Lynch complied with the standard of care in ultimately recommending Borst receive a total knee replacement. *Id.* at 161:15-24. The surgery itself was appropriately indicated under the standard of care in 2011 because Borst was “bone-on-bone” meaning the

cartilage had worn away to a point that Borst had one bone rubbing on the other bone. *Id.* at 161:25; 162:1-14. Once any patient is “bone-on-bone”, the only thing that will rectify the problem is a joint replacement. *Id.* at 162:18-20. Dr. Lynch’s operative report appropriately described the surgery in compliance with the standard of care he was obliged to follow in the State of Washington in 2011. *Id.* at 199:8-16.

There is a standard method of positioning a patient during a knee replacement surgery that is utilized around the United States. *Id.* at 162:23-25; 163:1-8. The patient lies on their back (supine position) on the operating room table and at roughly the midcalf or upper midcalf, a bolster or “bump” is placed that the sole of the foot rests on when the surgeon flexes the patient’s knee. *Id.* at 163:3-18. Dr. Lovell utilizes this same approach in his practice. *Id.* at 165:12-16. Achieving this positioning through the use of a bolster or “bump” complies with the standard of care. *Id.* at 169:24-25; 170:1-2. A specifically designed bolster like the one used by Dr. Lynch is appropriate under the standard of care. *Id.* at 166:25; 167:1-20. When the foot is in position against the bolster, there is no further need to dorsiflex the foot during surgery. *Id.* at 168:12-16.

Total knee replacement surgery is a dynamic process and the leg being operated on is never in one position for very long because the surgeon moves it to check different things such as obtaining a different

view of the knee when it is straight out compared to when the knee is flexed. *Id.* at 165:17-25; 166:1-4. A tourniquet is placed on the thigh right before the first incision is made to minimize bleeding. *Id.* at 166:5-17.

Based on a reasonable degree of medical probability, there is no risk of injury to the Achilles tendon or the foot whatsoever during the course of performing a total knee replacement when the patient is positioned as described *supra*. *Id.* at 170:9-21. There has never been a reported case in the medical literature of an Achilles tendon injury during a total knee replacement.<sup>2</sup> *Id.* at 170:22-25. Dr. Lovell attempted to find such an instance, but was unable to do so. *Id.* at 170:25; 171:1. Dr. Lovell has never been taught or told of an injury occurring to the Achilles tendon during a total knee replacement. *Id.* at 171:1-4. There is no pressure on the Achilles tendon at all based on the patient's positioning during a total knee replacement. *Id.* at 171:5-9. When the knee is flexed, it relaxes the Achilles tendon. *Id.* at 171:17-23. When the leg is extended and the bolster hits the calf, there is no pressure on the Achilles tendon. *Id.* at 171:24-25; 172:1-4.

Dr. Lovell would not conduct an examination of the Achilles tendon preoperatively before conducting a total knee replacement because he has never heard of or been made aware of an issue with the Achilles

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<sup>2</sup> Borst's expert, Dr. Roback, testified to the same during his trial testimony. RP Vol. 1 (June 18, 2018), pg. 82:12-23.

tendon during a knee replacement surgery. *Id.* at 172:5-16. The standard of care in Washington does not require such an examination. *Id.* at 172:17-19. Postoperatively, the standard of care does not require the orthopedic surgeon to examine the knee replacement patient's Achilles tendon to determine whether an injury occurred to it during the course of the surgery. *Id.* at 172:20-25; 173:1. An examination would only be required if the patient made a complaint postoperatively about the Achilles tendon, but again, there has never been a reported case of an injury to the Achilles tendon during a knee replacement operation. *Id.* at 173:2-12. Borst made no complaints of pain with his Achilles tendon, foot, heel, or ankle at Sacred Heart postoperatively. *Id.* at 173:13-22.

Two days after the surgery, September 21, 2011, Borst did heel cord stretches and made no complaints of pain whatsoever. *Id.* at 176:4-13; *See* Exhibit D107 at pg. 61. This is significant because the heel cord is another name for the Achilles tendon, so Dr. Lovell would expect Borst to complain of Achilles pain while doing heel cord stretches if the Achilles had been injured some way during the surgery. *Id.*

Borst's ankle strength findings the day after surgery are also significant because they were both measured at 4+/5, meaning both ankles were nearly at full strength. *Id.* at 177:6-11; *See* Exhibit D107 at pg. 18. It is not possible that there could have been an injury to the right Achilles

tendon in surgery considering the exact same strength was measured in both ankles immediately after surgery because an actual injury to the right Achilles tendon would have made the right ankle weaker than the left ankle. *Id.* at 177:25; 178:1-9.

Borst made no mention of ankle or Achilles tendon pain and PA-C Buescher did not note any bruising near the Achilles tendon during an October 18, 2011 appointment. *Id.* at 182:4-14; *See* Exhibit D100 at 00017. Borst was very happy with his progress since surgery. *Id.* at 182:15-18.

Borst's second postoperative clinic visit with Dr. Lynch occurred on December 1, 2011. *Id.* at 186:25; 187:1-3; *See* Exhibit D100 at 00018. Borst complained of ankle and Achilles tendon pain that had been ongoing since the surgery<sup>3</sup>, but Dr. Lynch's examination found the Achilles to be well-healed with no defect and minimal swelling. *Id.* at 187:5-25; 188:1-4. Dr. Lynch also noted in his impression, "Achilles tendinitis probably related to positioning during knee replacement." *Id.* at 188:8-11. This note does not reflect Dr. Lynch saying he injured the Achilles tendon during the surgery. *Id.* at 189:23-25. Dr. Lynch was simply noting about how an injury to the Achilles might happen as a result of the knee replacement surgery. *Id.* at 188:12-17; 190:1-6. Under the standard of care, Dr. Lynch was not

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<sup>3</sup> The numerous postoperative records from various providers unequivocally establish that Borst was not experiencing ankle, heel, or Achilles pain since the date of surgery.

required to go back through all of Borst's relevant records to determine whether or not the patient is giving an accurate history. *Id.* at 188:18-22. The standard of care is to write down what the patient conveys to the physician under the circumstances and the physician is taught to listen and not contest what the patient expresses. *Id.* at 188:23-25; 189:1-3.

In making the December 1, 2011 note, Dr. Lynch complied with the standard of care he was obligated to follow. *Id.* at 189:19-22.

Dr. Lynch ordered an MRI during the December 1, 2011 appointment, which went above and beyond the standard of care considering this was the first occasion Dr. Lynch was made aware of an issue with Borst's Achilles. *Id.* at 190:24-25; 191:1-14. The standard of care did not dictate that Dr. Lynch refer Borst to a foot and ankle specialist at that time because it is not proper to refer a patient to a specialist simply because they report pain. *Id.* at 191:15-23.

Based on reasonable medical probability, Dr. Lynch's (1) positioning of Borst during the surgery and (2) the surgery itself did not cause an injury to the Achilles tendon. *Id.* at 194:15-25; 195:1-16. Regarding the positioning during surgery, it is not possible to have direct pressure on the Achilles at any time during a knee replacement. *Id.* at 195:17-25; 196:1-14. If the foot is dorsiflexed past 90 degrees or neutral, that complies with the standard of care and the surgeon is not risking an

Achilles injury because the flexion of the knee has relaxed the tendon at the same time. *Id.* at 197:3-10.

After the December 2011 MRI diagnosed an intrasubstance tear, Dr. Lynch referred Borst to Dr. Shirzad, a foot and ankle specialist at NWOS. *Id.* at 197:11-14. Dr. Lynch also referred Borst for physical therapy associated with the MRI findings. *Id.* at 197:15-17. The timeliness of Dr. Lynch's referrals complied with the standard of care he was obliged to follow. *Id.* at 197:

**F. Trial Court Procedure Re: Jury Instructions At Issue.**

Borst claims it was error for the trial court to give jury instructions No. 10 (based on WPI 105.03) and No. 13 (based on WPI 105.07).

In relation to WPI 105.03, Borst orally objected to the giving of the instruction at trial on June 20, 2018. RP Vol. 4, pgs. 884:4-25; 885:1-13. WPI 105.03 (Instruction No. 10 given by the trial court) provides, in pertinent part:

In connection with the Plaintiff's claims of injury resulting from negligence, the Plaintiff has the burden of proving each of the following propositions:

First, that the Defendant failed to follow the applicable standard of care and was therefore negligent...

CP 164.

Borst claimed WPI 105.03 should not have been given because the term “applicable” is not defined in the jury instructions and it was error by the trial court to neglect to define the word. RP Vol. 4, pgs. 884:5-12; 885:3-5. Borst never proposed or submitted a definition for “applicable.” Respondents asserted that WPI 105.03 is a pattern instruction approved by the committee, and that “applicable” had to be read in conjunction with the standard of care as defined in the preceding Instruction No. 9. *Id.* at 885:14-21. Instruction No. 9 provides:

A health care professional owes to the patient a duty to comply with the standard of care for one of the profession or class to which he or she belongs.

A physician who holds himself out as a specialist in orthopedic surgery has a duty to exercise the degree of skill, care, and learning expected of a reasonably prudent orthopedic surgeon in the State of Washington acting in the same or similar circumstances at the time of the care or treatment in question. Failure to exercise such skill, care, and learning constitutes a breach of the standard of care and is negligence.

The degree of care actually practiced by members of the medical profession is evidence of what is reasonably prudent. However, this evidence is not conclusive on the issue and should be considered by you along with any other evidence bearing on the question.

CP 163.

Thus, the applicable standard of care is that standard exercised by a reasonably prudent orthopedic surgeon in the State of Washington acting in the same or similar circumstances at the time of the care or treatment in question.

The trial court gave the instruction as approved by the committee. RP Vol. 4, pg. 885:22-24.

Borst also objected to the giving of WPI 105.07 in Instruction No. 13 on June 20, 2018. CP 148; RP Vol. 4, pg. 890:18.

WPI 105.07 provides:

An orthopedic surgeon does not guarantee the results of his care and treatment. A poor medical result is not, by itself, evidence of negligence.

CP 167.

Borst asserted WPI 105.07 was misleading under the facts of the case and a comment on the evidence. CP 148-150; RP Vol. 4, pgs. 890:18-25; 891:1-25. Respondents countered that WPI 105.07 is a well-accepted pattern instruction supported by decades of appellate opinions from both the Court of Appeals and Supreme Court. RP Vol. 4, pgs. 892:1-25; 893:1. The instruction is appropriate in a medical negligence action because it is imperative for the jury to understand that a physician or surgeon does not guarantee there will be no adverse consequences from a surgery and that a

poor medical result, by itself, is not evidence of negligence. *Id.* The trial court decided evidence justified the giving of the instruction. *Id.*

#### IV. ARGUMENT

##### A. Standard Of Review

Jury instructions are sufficient when they allow counsel to argue their theory of the case, are not misleading, and when read as a whole properly inform the trier of fact of the applicable law. *Anfinson v. FedEx Ground Package System, Inc.*, 174 Wn.2d 851, 860, 281 P.3d 289 (2012); *Fergen v. Sestero*, 182 Wn.2d 794, 803, 346 P.3d 708 (2015).

While the trial court must define technical words and expressions used in jury instructions, it need not define words and expressions that are of ordinary understanding or self-explanatory. *State v. Stacey*, 181 Wn. App. 553, 572, 326 P.3d 136 (2014).

Jury instructions must be read as a whole, and the challenged portions considered in context. *State v. Pirtle*, 127 Wn.2d 628, 656-57, 904 P.2d 245 (1995).

Legal errors in jury instructions are reviewed *de novo*. *Fergen*, at 803, *citing Anfinson*, 174 Wn.2d at 860, 281 P.3d 289. An erroneous instruction is reversible error only if it is prejudicial to a party. *Id.* “If the instruction contains a clear misstatement of law, prejudice is presumed and is grounds for reversal unless it can be shown that the error was harmless.”

*Fergen*, at 803 *citing Anfinson*, 174 Wn.2d at 860, 281 P.3d 289. The party challenging the instruction bears the burden of establishing prejudice. *Fergen*, at 803, *citing Griffin v. W.R.S, Inc.*, 143 Wn2d. 81, 91, 18 P.3d 558 (2001).

An erroneous jury instruction is harmless if the error is “trivial, or formal, or merely academic, and was not prejudicial to the substantial rights of the party assigning the error, and in no way affected the final outcome of the case. *State v. Townsend*, 142 Wn2d 838, 848, 15 P.2d 145 (2001).

In deciding whether instructional error contributed to the verdict or whether it was harmless the court must “thoroughly examine the record and may consider how the case [was] argued to the jury.” *State v. Stacey*, at 573, *citing State v. Johnson*, 116 Wn. App. 851, 857, 68 P.3d 290 (2003).

An erroneous jury instruction is harmless if it is not prejudicial to the substantial rights of the parties and in no way affected the final outcome of the case. *Blaney v. International Association of Machinists and Aerospace Workers, Dist. No. 110*, 151 Wn.2d 203. 211, 87 P.3d 757 (2004).

Whether to give a “no guarantee/bad result” instruction is a matter of trial court discretion. *Christensen v. Munsen*, 123 Wn.2d 234, 248, 867 P.2d 626 (1994).

**B. The Trial Court’s WPI-Based Elements Instruction (Instruction No. 10 – CP 164) Was A Correct Statement Of The Law.**

The court’s RCW 7.70.040 elements instruction, (Instruction No. 10 – CP 164) read:

In connection with the Plaintiff’s claims of injury resulting from negligence, the Plaintiff has the burden of proving each of the following propositions:

First, that the defendant failed to follow the applicable standard of care and was therefore negligent;

Second, that the plaintiff was injured;

Third, that the negligence of the defendant was a proximate cause of the injury to the plaintiff.

If you find from your consideration of all of the evidence that each of these propositions has been proved, your verdict should be for the plaintiff. On the other hand, if any of these propositions has not been proved, your verdict should be for the defendants.

This instruction followed WPI 105.03 verbatim (burden of proof – negligence – healthcare provider)<sup>4</sup>.

Borst makes the novel argument that this instruction was an incorrect statement of law because of its reference to “the applicable

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<sup>4</sup> Washington Pattern Jury Instructions are not the law. However, that a challenged instruction is a WPI is “persuasive authority” of its legal correctness. *State v. Hayward*, 152 Wn. App. 632, 645, 217 P.3d 352 (2009).

standard of care.” But that is simply an acknowledgment that different healthcare providers have different standards of care (see RCW 7.70.020 for list of different healthcare providers covered by the medical malpractice statute) and that the standard of care for any individual defendant healthcare provider is a “duty to comply with the standard of care for one of the professional class to which he or she belongs.” See RCW 7.70.040(1). Instruction No. 9 (CP 163) informed the jury that a healthcare professional “owes to the patient a duty to comply with the standard for one of the profession or class to which he belongs” and then defined the standard of care for a “physician who holds himself out as a specialist in orthopedic surgery.” Accordingly, the reference in the court’s burden of proof instruction to the “applicable standard of care”, particularly when read in light of RCW 7.70.040(1) and Instruction No. 9, was legally correct.

**C. Even If The Trial Court’s Elements Instruction Could Somehow Be Construed As An Incorrect Statement Of The Law, It Did Not Result In Any Prejudice To Borst.**

Here, even if the court’s RCW 7.70.040 elements instruction could somehow be construed as a misstatement of the law, (which it was not), the error was harmless. During the questioning of expert witnesses, counsel for Borst and Dr. Lynch couched their standard of care questions in terms of the “standard of care” for a “reasonably prudent orthopedic

surgeon”. See e.g. RP Vol. 1 (June 18, 2018), pgs. 20, 25, 153-54; RP Vol. 4, pgs. 842-43. In addition, Borst’s counsel<sup>5</sup> spent considerable time during closing argument explaining the standard of care<sup>6</sup> applicable to Dr. Lynch and the meaning of the court’s jury instructions. RP Vol. 4, pgs. 956-59, 970-71. In short, there is simply no possibility the jury was in any way confused as to the standard of care that applied to Dr. Lynch.

**D. The Trial Court Did Not Abuse Its Discretion In Giving The “No Guarantee/Bad Result” Instruction.**

The “no guarantee” and “bad result” instructions “state well-nigh universally recognized principles of medical malpractice law.” *Watson v. Hockett*, 107 Wn.2d 158, 163, 727 P.2d 669 (1986). These instructions “supplement” and “clarify” the standard of care, *Id.* at 166, and “provide useful watch words to remind judge and jury that medicine is an inexact science, where the desired result cannot be guaranteed, and where professional judgment may reasonably differ as to what constitutes proper treatment.” *Id.* at 166 – 67, quoting *J. Perdue Texas Medical Malpractice*, Chapter 2, “Standard of Care”, 22 Hous. L. Rev., 47, 60 (1985). “... [I]n

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<sup>5</sup> Dr. Lynch’s counsel also described Instruction No. 9 as the “standard of care that Dr. Lynch is to be judged by in this case, and that’s the standard of a reasonably prudent orthopedic surgeon in the State of Washington acting under the same or similar circumstances.” RP 979-80.

<sup>6</sup> In evaluating whether error was harmless or prejudicial, the Court can consider a party’s closing argument(s). *Driggs v. Howlett*, 193 Wn. App. 875, 904-05, 371 P.3d 61 (2016).

most cases, this instruction will be given.” *Watson* at 164, quoting *New Mexico Supreme Court, Uniform Jury Instructions – Civil* 11.12, at 219 (1980 Repl.). The instruction is appropriate, and supported by the evidence, where the main issue at trial was whether the plaintiff’s condition was the result of the defendant’s treatment or some other cause. See e.g. *Christensen v. Munsen*, 123 Wn.2d 234, 248, 867 P.2d 626 (1994).

Here, the giving of the “no guarantee” and “bad result” instruction was a proper exercise of trial court discretion. The instruction followed an appropriate instruction on the standard of care. And, like in *Christensen v. Munsen*, the evidence supported giving the instruction because the main issue at trial was whether Borst’s Achilles problems were the result of Dr. Lynch’s treatment, or, rather, pre-existing pathology that became symptomatic after the surgery for reasons unrelated to any standard of care violation on the part of Dr. Lynch.

**E. The “No Guarantee/Bad Result” Instruction Was Not An Impermissible Comment On The Evidence.**

Without directly saying so, Borst argues that the “no guarantee/bad result” instruction, in light of the expert testimony given, overly emphasized Dr. Lynch’s theory of the case, and served to negate or undercut the testimony of Borst’s medical expert. In order to obtain reversal on the ground that an instruction or the instructions overly

emphasized the opponent's theory of the case, the instructions on a particular point must be "so repetitious as to generate an 'extreme emphasis' that 'grossly' favors one party over the other." *Adcox v. Children's Orthopedic Hospital and Medical Center*, 123 Wn.2d 15, 38, 864 P.2d 921 (1993) quoting *Samuelson v. Freeman*, 75 Wn.2d 894, 897, 454 P.2d 406 (1969).

Here, the "no guarantee/bad result" instruction did not constitute an "extreme emphasis" that "grossly" favored Dr. Lynch over Borst.

Borst isolates the word "result" in the instruction, and argues the word could have been construed by the jury to mean the position of Borst's foot during surgery, rather than the overall outcome of Dr. Lynch's medical care/treatment. This strained argument should be rejected for several reasons. While a trial court must define technical words and expressions used in jury instructions, the court need not define words and expressions that are of ordinary understanding or self-explanatory. *State v. Stacy*, 181 Wn. App. 553, 572, 326 P.3d 136 (2014). Here, the ordinary meaning of the word "result" as used in the instruction is the outcome of medical care/treatment, not some physical act that takes place during the course of treatment. This ordinary meaning is particularly evident given the court's issue/claims instruction, Instruction No. 8 (CP 162), which informed the jury that Borst was claiming that Dr. Lynch was "negligent in the

performance of a knee surgery on plaintiff's right knee on September 19, 2011, as well as post-operative management both in the hospital and after discharge from the hospital." Also, the word "result" in the challenged instruction is immediately preceded by the word "medical" as well as by the sentence stating that an orthopedic surgeon does not guarantee the "results of his care and treatment."

The giving of the no guarantee/poor result instruction by the trial court was appropriate because Borst did experience a poor medical result subsequent to the surgery. However, the poor result was not due to Dr. Lynch improperly performing a total knee arthroplasty. Borst's poor medical result was due to the lighting up of a previously asymptomatic preexisting condition, including a Haglund's deformity, a linear tear associated with the Haglund's deformity and tendinosis, calcification in the Achilles, and from a change in gait mechanics due to the acquired ability from the arthroplasty to flex and extend the right knee. As a consequence of the procedure, although unintended by Dr. Lynch and unexpected by Borst, Borst was left with a less than optimal result, alleged permanent pain, reduced ability to ambulate, inability to engage in employment activities other than on a sedentary basis and inability to engage in certain outdoor activities. Accordingly, the "no guarantee/bad result" instruction was indicated.

In his effort to portray the “no guarantee/bad result” instruction as a comment on the evidence, Borst grossly distorts the medical testimony. For example, he claims that “all the physicians testifying on the standard of care in essence testified that but for the incorrect positioning of the foot the Achilles would not have been torn.” Appellant’s Opening Brief, pg. 35. That is patently false. While Borst’s expert, Dr. Roback, testified that, in his opinion, the tear shown on the December 12, 2011 MRI was caused by Dr. Lynch incorrectly positioning the foot during the surgery, (RP Vol. 1, June 18, 2018, pgs. 32, 53), Dr. Lynch’s causation expert, Dr. Barrow, testified that the longitudinal tear revealed by the MRI was long-standing, chronic pathology that pre-dated the surgery. RP Vol. 4, pgs. 719, 723, 726, 730-31; *See also* RP Vol. 3, pgs. 598:7-9; 15-25; 599:1.

Dr. Barrow and Dr. Lovell also testified that positioning of the lower extremity during surgery did not cause the longitudinal Achilles tendon tear or any other Achilles tendon pathology, because the leg positioning that takes place during the surgery does not stress the Achilles tendon in any way. RP Vol. 4, pgs. 716-17; 756-57 (Dr. Barrow); RP Vol. 1 (June 18, 2018), pgs. 170-71 (Dr. Lovell). Dr. Lynch, Dr. Lovell, and Dr. Roback all testified that, despite their vast experience in performing knee replacement surgeries and their familiarity with the literature, they had never seen, heard about, or read about a patient sustaining an Achilles

tendon injury during a knee replacement surgery. RP Vol. 1 (June 18, 2018), pgs. 170-71 (Dr. Lovell); RP Vol. 4, pg. 829 (Dr. Lynch); RP Vol. 1 (June 18, 2018), pgs. 81-82 (Dr. Roback).

Borst makes the equally specious claim that Dr. Barrow's testimony on the origins of the pathology shown on the December 12, 2011 MRI was "speculative", and that the trial court's instruction "perpetuated the speculation". Appellant's Opening Brief, pg. 35. But Borst labeling Dr. Barrow's testimony as "speculation" does not make it so, and Dr. Barrow's detailed explanations of the MRI findings and their genesis demonstrate his testimony was anything but. See RP Vol. 4, pgs. 719-736; 756-57.

**F. Even If Giving The "No Guarantee/Bad Result" Instruction Could Be Considered An Abuse Of Discretion, The "Error" Was Harmless.**

Considering the jury instructions as a whole, the parties' claims, the parties' respective expert testimony, and the manner in which the case was argued to the jury, the giving of the "no guarantee/bad result" instruction, even if error, in no way affected the outcome of the trial. Accordingly, the "error" was harmless.

**V. CONCLUSION**

For the reasons set forth above, Dr. Lynch and NWOS respectfully request the Court (1) find it was not an error of law for the trial court to

give Jury Instructions Nos. 10 and 13 and (2) affirm the verdict and judgment rendered at trial in favor of Dr. Lynch and NWOS.

DATED this 2nd day of September, 2020

EVANS, CRAVEN & LACKIE, P.S.

By   
JAMES B. KING, WSBA #8723  
SEAN M. KING, #52104  
Attorneys for Respondents

**CERTIFICATE OF SERVICE**

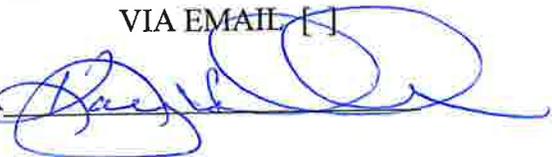
Pursuant to RCW 9A.72.085, the undersigned hereby certifies under penalty of perjury under the laws of the State of Washington, that on the 2<sup>nd</sup> day of September, 2020, the foregoing was delivered to the following persons in the manner indicated:

Victor F. Borst  
P.O. Box 152  
Valley, WA 99181

VIA REGULAR MAIL   
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Address:  
818 W. Riverside  
Suite 250  
Spokane, WA, 99201  
Phone: (509) 455-5200

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