

Washington Health Law Manual — Third Edition
Washington State Society of Healthcare Attorneys (WSSHA)

Chapter 8:

Medical Malpractice

Liability

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Reference Date: The author prepared this chapter from reference materials that were available as of January 1, 2011.

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8.1 Applicable Standards.

Washington state’s medical malpractice statutes, RCW 7.70 and RCW 4.24.290, define the primary elements of liability for medical malpractice. Other statutes, including the Consumer Protection Act and the Products Liability Act, have limited applicability in the context of medical care. All medical malpractice claims are subject to applicable statutes of limitations.

8.1.1 Medical Liability Statutes.

RCW 7.70. RCW 7.70 governs any action for damages based on an injury resulting from health care. *E.g., Miller v. Jacoby*, 145 Wn.2d 65, 72, 33 P.3d 68 (2001); *Webb v. Neuroeducation, Inc.*, 121 Wn. App. 336, 346, 88 P.3d 417 (2004); *Wright v. Jeckle*, 104 Wn. App. 478, 481, 16 P.3d 1268 (2001) (RCW 7.70 “sweeps broadly [and] includes causes of action in contract and tort”; RCW 7.70 governs exclusively all causes of action based on health care); *Branom v. State*, 94 Wn. App. 964, 969, 974 P.2d 35 (1999) (“whenever an injury occurs as a result of health care, the action for damages is governed exclusively by RCW 7.70”); *Orwick v. Fox*, 65 Wn. App. 71, 86, 828 P.2d 12 (1992) (“[b]y its terms, RCW 7.70 applies to all action against health care providers, whether based on negligence or intentional tort”). RCW 7.70 provides the substantive and procedural framework for “aspects of all civil actions for damages for injury occurring as a result of health care.” Medical liability may be based on one or more of the three causes of action identified in RCW 7.70.030:

No award shall be made in any action or arbitration for damages for injury occurring as the result of health care which is provided after June 25, 1976, unless the plaintiff establishes one or more of the following propositions:

- (1) That injury resulted from the failure of a health care provider to follow the accepted standard of care;
- (2) That a health care provider promised the patient or his representative that the injury suffered would not occur;
- (3) That injury resulted from health care to which the patient or his representative did not consent.

Unless otherwise provided in this chapter, the plaintiff shall have the burden of proving each fact essential to an award by a preponderance of the evidence.

RCW 7.70.030.

External Resource:
WPI 21.01 (jury instruction re: preponderance of the evidence burden of proof)

RCW 4.24.290. An additional medical liability statute, RCW 4.24.290, establishes an action for professional negligence against a hospital, hospital personnel, or a member of the healing arts, where the plaintiff proves by a preponderance of the evidence that the defendant or defendants “failed to exercise that degree of skill, care, and learning possessed at that time by other persons in the same profession, and that as a proximate result of such failure the plaintiff suffered damages.”

Scope of Application. RCW 7.70 applies to actions involving health care. “Health care” is defined as “the process in which a physician is utilizing the skills which he had been taught in examining, diagnosing, treating or caring for the plaintiff as his patient,” and encompasses the medical advice regarding the diagnosis and recommended course of treatment for the patient. *Young v. Savidge*, 155 Wn. App. 806, 815-16, 230 P.3d 222 (2010); *Reed v. ANM Health Care*, 148 Wn. App. 264, 269, 225

P.3d 1012 (2008) (RCW 7.70 may not govern claim by non-patient for negligent infliction of emotional distress); *Branom v. State*, 94 Wn. App. 964, 969-70, 974 P.2d 335 (1999); *see also* RCW 70.02.010(5) (defining health care for purposes of Uniform Health Care Information Act as “any care, service, or procedure provided by a health care provider: (a) [t]o diagnose, treat, or maintain a patient’s physical or mental condition; or (b) [t]hat affects the structure or any function of the human body”). RCW 7.70 does not govern claims not related to health care. *Young v. Savidge*, 155 Wn. App. 806, 822, 230 P.3d 222 (2010) (RCW 7.70 does not govern common law claim of intentional misrepresentation); *Reed v. ANM Health Care*, 148 Wn. App. 264, 269, 225 P.3d 1012 (2008) (RCW 7.70 may not govern claim by non-patient for negligent infliction of emotional distress); *Sherman v. Kissinger*, 146 Wn. App. 855, 867, 195 P.3d 539 (2008) (RCW 7.70 does not apply to claims of veterinary malpractice); *Bundrick v. Stewart*, 128 Wn. App. 11, 17, 114 P.3d 1204 (2005) (recognizing separate common law cause of action for battery based upon complete failure to obtain consent for surgery); *Estate of Sly v. Linville*, 75 Wn. App. 431, 440, 878 P.2d 1241 (1994) (action for misrepresentation by one physician about another physician does not involve health care). [*See also* §§ 8.1.2-8.1.3, 8.1.6 below.]

RCW 7.70 applies to “health care providers,” which includes physicians, their employees, nurses, hospitals, and many other types of health care providers, including physical therapists, opticians, pharmacists, paramedics, dentists, chiropractors, midwives, and psychologists. RCW 7.70.020; *Miller v. Jacoby*, 145 Wn.2d 65, 72, 33 P.3d 68 (2001); *Eelbode v. Chec Medical Ctrs., Inc.*, 97 Wn. App. 462, 467, 984 P.2d 436 (1999) (physical therapist); *but see Sherman v. Kissinger*, 146 Wn. App. 855, 867, 195 P.3d 539 (2008) (RCW 7.70 does not apply to claims of veterinary malpractice). RCW 4.24.290 applies to actions against a hospital, hospital personnel, or a member of the healing arts, including but not limited to physicians, osteopathic physicians, nurses, dentists, podiatric physicians, chiropractors, and East Asian medicine practitioners.

Washington medical malpractice law applies to physicians located in Washington. *Khung Thi Lam v. Global Med. Sys.*, 127 Wn. App. 657, 668, 111 P.3d 1258 (2005) (“Washington has strong interests in regulating physicians licensed and practicing within its borders, wherever the patient is located”).

8.1.2 Consumer Protection Act.

The Consumer Protection Act (“CPA”), RCW 19.86, which protects consumers from unfair or deceptive practices occurring in trade or commerce, and provides individuals a civil action for damages (RCW 19.86.090), generally does not provide an additional basis for recovery in a medical malpractice action. The CPA applies only to the entrepreneurial aspects of the practice of medicine and other learned professions, and not to claims regarding the actual competence or negligence of the physician, or claims of negligent supervision by a hospital. *E.g.*, *Ambach v. French*, 167 Wn.2d 167, 179, 216 P.2d 405 (2009); *Michael v. Mosquera-Lacy*, 165 Wn.2d 595, 603, 200 P.3d 695 (2009) (use of cow bone instead of human bone for bone graft not an entrepreneurial activity and did not impact the public interest); *Young v. Savidge*, 155 Wn. App. 806, 825-27, 230 P.3d 222 (2010); *Wright v. Jeckle*, 104 Wn. App. 478, 483-85, 16 P.3d 1268 (2001); *Thomas v. Wilfac, Inc.*, 65 Wn. App. 255, 264, 828 P.2d 597 (1992); *Burnet v. Spokane Ambulance*, 54 Wn. App. 162, 166-67, 772 P.2d 1027 (1989) (claim of negligence does not relate to entrepreneurial aspects of physician or hospital practice); *Jaramillo v. Morris*, 50 Wn. App. 822, 827, 750 P.2d 1301 (1988) (reversing application of CPA to claim of hospital negligence; no entrepreneurial aspects of hospital’s business at issue); *Quimby v. Fine*, 45 Wn. App. 175, 181-82, 724 P.2d 403 (1986); *see also Haberman v. WPPSS*, 109 Wn.2d 107, 170, 744 P.2d 1042 (1987) (claims of negligence against professionals not within scope of CPA).

To maintain a CPA claim regarding a physician’s professional services, there must be a showing of lack of informed consent resulting from dishonest and unfair practices motivated by financial gain.

Young v. Savidge, 155 Wn. App. 806, 825-27, 230 P.3d 222 (2010); *Wright v. Jeckle*, 104 Wn. App. 478, 484, 16 P.3d 1268 (2001); *Benoy v. Simons*, 66 Wn. App. 56, 65, 831 P.2d 167 (1992); *Quimby v. Fine*, 45 Wn. App. 175, 181-82, 724 P.2d 403 (1986). Recoverable damages for a CPA claim are limited to injuries to “business or property” and do not include damages for personal injury. *Ambach v. French*, 167 Wn.2d 167, 173, 216 P.2d 405 (2009); *Stevens v. Hyde Athletic Indus.*, 54 Wn. App. 366, 370, 773 P.2d 871 (1989). Proximate cause is required to establish the causation element of a CPA claim. *Indoor Billboard/Wash., Inc. v. Integra Telecom of Wash., Inc.*, 162 Wn.2d 59, 83, 170 P.3d 10 (2007). The statute of limitations for a CPA claim is four years. RCW 19.86.120. The discovery rule applies in appropriate circumstances. *Mayer v. Sto Indus., Inc.* 123 Wn. App. 443, 463, 98 P.3d 116 (2004) (limitations period begins when plaintiffs discovers the construction defect), *rev’d in part on other grounds*, 156 Wn.2d 677, 132 P.3d 115 (2006); *Reeves v. Teuscher*, 881 F.2d 1495, 1501 (9th Cir. 1989) (discovery rule applies in CPA cases where plaintiffs “did not and could not discover the misrepresentation that formed the basis of their CPA claim”).

An insurance company may bring an action against a physician under the Consumer Protection Act for false billings and reports. *State Farm Fire & Cas. Co. v. Huynh*, 92 Wn. App. 454, 459, 962 P.2d 854 (1998).

8.1.3 Products Liability Act.

The state Products Liability Act, RCW 7.72, governs claims in Washington relating to medical devices. A product liability claim imposes strict liability where a product was not reasonably safe as designed or not reasonably safe because adequate warnings or instructions were not provided. RCW 7.72.030(1). The statute of limitations for a products liability claim is three years. RCW 4.16.080(2); *White v. Johns-Manville Corp.*, 103 Wn.2d 344, 348, 693 P.2d 687 (1985). A common law discovery rule extends the limitations period to three years after the plaintiff knew or should have known of the essential elements of the cause of action, but only as to claims “in which the plaintiff could not have immediately known of their injuries due to professional malpractice, occupational diseases, self-reporting or concealment of information by the defendant.” *E.g.*, *Estates of Hibbard, v. Gordon, Thomas*, 118 Wn.2d 737, 749-50, 825 P.2d 690 (1992); *White v. Johns-Manville Corp.*, 103 Wn.2d 344, 348, 693 P.2d 687 (1985); *see also Green v. A.P.C.*, 136 Wn.2d 87, 95, 960 P.2d 912 (1998).

Comment k of the Restatement (Second) of Torts § 402A, however, imposes a negligence standard, rather than strict liability, for claims involving “unavoidably unsafe” products. Comment k has been adopted by Washington courts. *Ruiz-Guzman v. Amvac Chemical Corp.*, 141 Wn.2d 493, 506, 7 P.3d 795 (2000). Washington courts have applied comment k to pharmaceutical drugs, to medical devices that are implanted in the human body, and to human blood products. *Terhune v. A.H. Robins Co.*, 90 Wn.2d 12, 13-14, 577 P.2d 975 (1978) (Dalkon Shield); *Rogers v. Miles Labs.*, 116 Wn.2d 195, 204, 802 P.2d 1346 (1991) (HIV-contaminated blood products); *Young v. Key Pharmaceuticals, Inc.*, 130 Wn.2d 160, 170, 922 P.2d 59 (1996) (prescription drugs). Courts in other jurisdictions have applied comment k to other types of medical devices. *E.g.*, *Adams v. Synthes Spine Co.*, 298 F.3d 1114, 1117 (9th Cir.2002) (spinal device); *Phelps v. Sherwood Med. Indus.*, 836 F.2d 296 (7th Cir.1987) (heart catheter); *Brooks v. Medtronic, Inc.*, 750 F.2d 1227, 1230-31 (4th Cir. 1984) (cardiac pacemaker; applying South Carolina law); *Bowles v. Zimmer Mfg.*, 277 F.2d 868, 875 (7th Cir. 1960) (surgical pin for bone fractures); *Parkinson v. Guidant Corp.*, 315 F. Supp. 2d 741, 747 (W.D. Pa 2004) (cardiac guidewire); *Tatum v. Cordis Corp.*, 758 F. Supp. 457, 462 (M.D. Tenn. 1991) (cardiac pacemaker); *Hufft v. Horowitz*, 5 Cal. Rptr. 2d 377, 380-84, 387 (Cal. Ct. App. 1992) (inflatable penile prosthesis); *Plenger v. Alza Corp.*, 13 Cal. Rptr. 2d 811, 817-18 (Cal. Ct. App. 1992) (IUD); *Breen v. Synthes-Stratec, Inc.*, 108 Conn. App 105, 113, 947 A.2d 383 (2008) (screw plate); *Mele v. Howmedica, Inc.*, 348 Ill. App. 3d 1, 19-21, 283 Ill. Dec. 738, 808 N.E.2d 1026 (2004) (artificial hip); *Perfetti v. McGhan Medical*, 99 N.M. 645, 649, 662 P.2d 646 (Ct. App. 1983) (mammary prosthesis); *Creazzo v. Medtronic, Inc.*, 903 A.2d 24, 31 (Pa. Super. 2006) (implantable neurological electrical

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pulse generator). Under the learned intermediary doctrine, a drug company fulfills its duty to warn by giving warnings regarding prescription drugs to the physician rather than to the patient. *E.g.*, *Physicians Ins. Exch. v. Fisons Corp.*, 122 Wn.2d 299, 313, 858 P.2d 1054 (1993); *Estate of LaMontagne v. Bristol-Myers Squibb*, 127 Wn. App. 335, 345, 111 P.3d 857 (2005); *see also Laisure-Radke v. Par Pharmaceutical, Inc.*, 426 F. Supp. 2d 1163, 1172 (W.D. Wash. 2006). The learned intermediary doctrine also applies in the context of medical devices. *E.g.*, *Brooks v. Medtronic, Inc.*, 750 F.2d 1227, 1230-31 (4th Cir. 1984).

Effect of federal laws re: medical devices and drugs. Federal law regarding medical devices does not preempt the application of state product liability law regarding defective product design against medical devices, even where the device has undergone the premarket approval process for Class III medical devices under the Medical Device Amendments to the Federal Food, Drug and Cosmetic Act, 21 U.S.C. § 360c(a)(1) and § 360e(b). *Wutzke v. Schwaegler*, 86 Wn. App. 898, 909, 940 P.2d 1386 (1997); *but see Berger v. Personal Products*, 115 Wn.2d 267, 275, 797 P.2d 1148 (1990) (federal preemption under 21 U.S.C. § 360k(a) and 21 C.F.R. § 808.1(b) (tampon labeling requirements) for claims of failure to warn). Federal law does not preempt state laws that are of general applicability, such as the state products liability law. *Wutzke*, at 907-09; *see also Physicians Ins. Exch. v. Fisons Corp.*, 122 Wn.2d 299, 329, 858 P.2d 1054 (1993).

Federal laws regarding drug labeling do not preempt a state law product liability claim alleging failure to provide adequate warning of the risks of use of the drug. *Wyeth v. Levine*, 555 U.S. ___, 129 S. Ct. 1187, 1204 (March 4, 2009).

Application to hospitals. Hospitals are not liable under state products liability law as a seller of a product. *McKenna v. Harrison Memorial Hosp.*, 92 Wn. App. 119, 123, 960 P.2d 486 (1998); *see also Howell v. Spokane & Inland Empire Blood Bank*, 114 Wn.2d 42, 51-54, 785 P.2d 815 (1990). Hospitals fall within a state statutory exemption that exempts “provider[s] of professional services” from the liability that would ordinarily apply to sellers of products. *McKenna*, 92 Wn. App. at 123.

Blood Products. Comment k applies to the manufacturers of blood products. *Rogers v. Miles Labs.*, 116 Wn.2d 195, 204, 802 P.2d 1346 (1991) (HIV-contaminated blood products). The product liability laws do not, however, impose liability on a hospital for blood transfusions because the hospital is providing a service rather than a product. *Howell v. Spokane & Inland Empire Blood Bank*, 114 Wn.2d 42, 51-54, 785 P.2d 815 (1990). The blood shield statute, RCW 70.54.120, protects hospitals that have provided blood transfusions from outside sources, provided that the hospital or the facility that provided the blood to the hospital maintains records of donor identification and suitability. *Garvey v. St. Elizabeth Hosp.*, 103 Wn.2d 756, 757-59, 697 P.2d 248 (1985).

Medical diagnostic tests. No Washington decision has determined whether comment k applies to medical diagnostic tests. In other circumstances, Washington courts have concluded that the application of comment k is to be made on a “product-by-product” basis. *Ruiz-Guzman*, 141 Wn.2d at 510-11 (pesticides may fall within comment k if their utility greatly outweighs the risks posed by use); *see also id.* at 506 (“[b]ecause “comment k was not expressly provided for in the WPLA, we must be sparing in its application lest we defeat the letter and policy of the WPLA”).

External Resource: WPI 110.00 – 110.31.02 (jury instructions re: products liability)

8.1.4 Promises to Cure.

RCW 7.70.030 establishes a cause of action where a health care provider “promised the patient or his representative that the injury suffered would not occur.” *See Hansen v. Virginia Mason Med. Ctr.*,

113 Wn. App. 199, 204, 53 P.3d 60 (2002) (doctor’s statement that patient would not die within the year was not a promise). The statute does not create liability for statements that are related to a diagnosis or prognosis and are not related to a specific undertaking or a specific result or cure through a course of treatment or a procedure. *Hansen v. Virginia Mason Med. Ctr.*, 113 Wn. App. 199, 207, 209, 53 P.3d 60 (2002) (finding no evidence of a legally enforceable promise under the statute).

Burden of Proof. The plaintiff has the burden to prove each fact essential to a claim of a breach of promise by a preponderance of the evidence. RCW 7.70.030.

External Resource:

WPI 21.01 (jury instruction re: preponderance of the evidence burden of proof)

8.1.5 Contract Claims.

Washington courts have not recognized common law breach of contract claims when they arise out of health care. *Young v. Savidge*, 155 Wn. App. 806, 819, 230 P.3d 222 (2010) (contract claims arising in health care are analyzed under RCW 7.70).

8.1.6 Intentional Misrepresentation.

A common law claim for intentional misrepresentation does not fall under RCW 7.70. *Young v. Savidge*, 155 Wn. App. 806, 823, 230 P.3d 222 (2010) (claim that dentist misrepresented the type of crown used).

8.2 Commencement of a Medical Malpractice Action.

8.2.1 Statutes of Limitations.

Applicable Statute. The governing limitations statute for medical malpractice is RCW 4.16.350. *Webb v. Neuroeducation, Inc.*, 121 Wn. App. 336, 343, 88 P.3d 417 (2004). RCW 4.16.350 imposes a three-year statute of limitations on medical malpractice actions, including informed consent claims. *Young v. Savidge*, 155 Wn. App. 806, 815, 230 P.3d 222 (2010). The statute of limitations applicable to wrongful death and other non-health care personal injuries, RCW 4.16.080(2), also imposes a three-year statute of limitations. Where the action is for wrongful death, RCW 4.16.080(2) takes precedence over the medical malpractice statute. *Wills v. Kirkpatrick*, 56 Wn. App. 757, 763, 785 P.2d 834 (1990). Violation of a statutory limitations period is an affirmative defense, and the burden of proof to establish a violation is on the party asserting the violation. *Rivas v. Overlake Hosp. Med. Ctr.*, 164 Wn.2d 261, 267, 189 P.3d 753 (2008); *Estate of Sly v. Linville*, 75 Wn. App. 431, 436, 878 P.2d 1241 (1994).

Foreign Objects. A patient has one year from the date of actual knowledge of the presence of a foreign body to commence an action. RCW 4.16.350(3); *Ruth v. Dight*, 75 Wn.2d 660, 667-68, 453 P.2d 631 (1969).

Starting Date for Limitations Period. The starting date for the three-year period is the date of “the act or omission alleged to have caused the injury or condition.” RCW 4.16.350. Because the three-year period begins with the act itself, the period may begin to run, and may even lapse, before the injury itself occurs. *Gunnier v. Yakima Heart Center, Inc., P.S.*, 134 Wn.2d 854, 964, 953 P.2d 1162 (1998). [See discovery rule discussion below.]

Final Saturdays, Sundays, and holidays are excluded in computing statutory limitations periods. RCW 1.12.040; CR 6(a); *Christensen v. Ellsworth*, 162 Wn.2d 365, 376, 173 P.3d 228 (2007); *Sievers v. City of Mountlake Terrace*, 97 Wn. App. 181, 184, 83 P.2d 1127 (1999); *Stikes Woods Neighborhood Ass’n v. City of Lacey*, 124 Wn.2d 459, 466, 880 P.2d 25 (1994).

Tolling by Mediation Request. Under RCW 7.70.110, a party to a medical malpractice claim may toll (suspend) for one year the statute of limitations provided in RCW 4.16.350 by making a written, good faith request for mediation. *Morris v. Swedish Health Servs.*, 148 Wn. App. 771, 776-77, 200 P.3d 261 (2009) (request tolled statute of limitations); *compare Breuer v. Presta*, 148 Wn. App. 470, 475, 200 P.3d 724 (2009) (communications did not constitute a request for mediation).

Tolling by Notice of Intent to Commence Action. Where notice of intent to commence the action is given to the defendant within 90 days of the expiration of the applicable statute of limitations, the time for commencement of the action is extended for 90 days from the date the notice was mailed. RCW 7.70.100. The claimant then has five additional court days to commence the action. *Id.* Although the statutory requirement to provide the notice of intent was found unconstitutional as a violation of the separation of powers doctrine, the courts have not addressed the tolling effect of the notice. *See Waples v. Yi*, 169 Wn.2d 152, 161, 234 P.3d 187 (2010). [See § 8.2.3 below.]

Continuing Course of Treatment. Some injuries may result from a series of interrelated negligent acts—a negligent course of treatment—rather than from a single act of negligence. *Caughell v. Group Health*, 124 Wn.2d 217, 224, 876 P.2d 898 (1994). Where malpractice is claimed throughout a continuous and substantially uninterrupted course of treatment for a particular illness or condition, the statute does not begin to run until the treatment for that particular illness or condition has been terminated. *Caughell v. Group Health*, 124 Wn.2d 217, 225, 876 P.2d 898 (1994) (quoting *Samuelson v. Freeman*, 75 Wn.2d 894, 900-01, 454 P.2d 406 (1969)); *Webb v. Neuroeducation, Inc., P.C.*, 121 Wn. App. 336, 343, 88 P.3d 417 (2004). The entire negligent course of treatment constitutes a single cause of action for the purposes of applying the statute of limitations. *Caughell v. Group Health*, 124 Wn.2d 217, 229, 876 P.2d 898 (1994). A wrongful act cannot occur, however, after the termination of the physician-patient relationship. *Doyle v. Planned Parenthood*, 31 Wn. App. 126, 128, 639 P.2d 240 (1982) (relationship terminated no later than time that patient consulted with another physician). Where the negligent act is followed by non-negligent treatment, however, the statute of limitations runs from the date of the negligent act, not the date of termination of other treatment. *See Caughell v. Group Health*, 124 Wn.2d 217, 229, 876 P.2d 898 (1994) (“claimants must allege that the last negligent act, not simply the end of treatment itself, occurred within” the limitations period); *Bixler v. Bowman*, 94 Wn.2d 146, 150, 614 P.2d 1290 (1980).

Discovery Rule. RCW 4.16.350 also provides a discovery rule that can allow a medical malpractice action to be brought later than the three-year period. *E.g.*, *Winbun v. Moore*, 143 Wn.2d 206, 214, 18 P.3d 576 (2000); *Adcox v. Children’s Orthopedic Hosp. & Med. Ctr.*, 123 Wn.2d 15, 34, 864 P.2d 921 (1993); *Lo v. Honda Motor Co., Ltd.*, 73 Wn. App. 448, 455, 869 P.2d 1114 (1994). The statute allows the action to be brought no later than one year after “the time the patient or his representative discovered or reasonably should have discovered that the injury or condition was caused by said act or omission.” RCW 4.16.350(3). The discovery rule provides that the one-year period begins at the time that the plaintiff has discovered or should have discovered some information about each of the essential elements of a possible cause of action: duty, breach, causation, and damages. *Caughell v. Group Health Coop.*, 124 Wn.2d 217, 237, 876 P.2d 898 (1994); *Ohler v. Tacoma Gen’l Hosp.*, 92 Wn.2d 507, 511, 598 P.2d 1358 (1979); *Cox v. Oasis Physical Therapy, PLLC*, 153 Wn. App. 176, 189, 222 P.3d 119 (2009); *Zaleck v. Everett Clinic*, 60 Wn. App. 107, 110, 802 P.2d 826 (1991); *Olson v. Siverling*, 52 Wn. App. 221, 227, 758 P.2d 991 (1988); *Nevils v. Aberle*, 46 Wn. App. 344, 349, 730 P.2d 729 (1986); *Teeter v. Lawson*, 25 Wn. App. 560, 563, 610 P.2d 925 (1980); *Duffy v. King Chiropractic Clinic*, 17 Wn. App. 693, 700-01, 565 P.2d 435 (1977) (applying 1971 version of RCW 4.16.350); *Yerkes v. Rockwood Clinic*, 11 Wn. App. 936, 941, 527 P.2d 689 (1974). Knowledge of the injury alone is not sufficient. *Winbun v. Moore*, 143 Wn.2d 206, 218, 18 P.3d 576 (2000); *Webb v. Neuroeducation, Inc.*, 121 Wn. App. 336, 343, 88 P.3d 417 (2004) (material facts regarding discovery preclude summary judgment).

The plaintiff need not have discovered that a given act or omission constitutes a violation of her legal rights or that she has a legal cause of action. *Cox v. Oasis Physical Therapy, PLLC*, 153 Wn. App. 176, 189, 222 P.3d 119 (2009); *Nevils v. Aberle*, 46 Wn. App. 344, 349, 730 P.2d 729 (1986); *Green v. A.P.C.*, 136 Wn.2d 87, 95, 960 P.2d 912 (1998) (discovery rule does not require a plaintiff to understand all of the legal consequences of the claim). The key consideration under the discovery rule is the factual, as opposed to the legal, basis of the cause of action. *Adcox v. Children's Orthopedic Hosp. & Med. Ctr.*, 123 Wn.2d 15, 35, 864 P.2d 921 (1993); *Cox v. Oasis Physical Therapy, PLLC*, 153 Wn. App. 176, 190, 222 P.3d 119 (2009). An inquiry by a plaintiff's attorney into grounds for a possible cause of action is not, by itself, sufficient to commence the one-year discovery rule period. *Olson v. Siverling*, 52 Wn. App. 221, 228-29, 758 P.2d 991 (1988).

Where the negligent act was a foreign object left in the body, the one-year statute of limitations begins to run when the plaintiff knew or, in the exercise of reasonable care for her own health and welfare, should have discovered the presence of the foreign body. RCW 4.16.350(3); *Ruth v. Dight*, 75 Wn.2d 660, 667-68, 453 P.2d 631 (1969).

Due diligence to discover. The discovery rule requires a claimant to “use due diligence in discovering the basis for the cause of action.” *Adcox v. Children's Orthopedic Hosp. & Med. Ctr.*, 123 Wn.2d 15, 34, 864 P.2d 921 (1993) (evidence supported conclusion that plaintiffs used due diligence where plaintiffs investigated did not initially learn of negligence); *Cox v. Oasis Physical Therapy, PLLC*, 153 Wn. App. 176, 191, 222 P.3d 119 (2009); *see also Green v. A.P.C.*, 136 Wn.2d 87, 96, 960 P.2d 912 (1998) (“[t]he plaintiff is charged with what a reasonable inquiry would have discovered”); *Estates of Hibbard*, 118 Wn.2d 737, 752, 826 P.2d 690 (1992) (discovery rule tolls the limitations period until “a claimant knows, or in the exercise of due diligence should have known, all the essential elements of the cause of action”); *Burns v. McClinton*, 135 Wn. App. 285, 299, 143 P.3d 630 (2006); *Giraud v. Quincy Farm & Chemical*, 102 Wn. App. 443, 449, 6 P.3d 104 (2000) (“to invoke the discovery rule, the plaintiff must show that he or she *could not* have discovered the relevant facts earlier”). Where a plaintiff has failed to use due diligence, the discovery rule does not extend the limitations period. *E.g.*, *Allen v. State*, 118 Wn.2d at 758-59 (affirming summary judgment dismissal of wrongful death action where plaintiff's “attempts to discover the facts surrounding her husband's death were minimal” and where plaintiff remained ignorant of information known by friends and family members); *Gevaart v. Metco Constr., Inc.*, 111 Wn.2d 499, 502, 760 P.2d 348 (1988) (affirming dismissal of plaintiff's action where plaintiff's knowledge that step sloped required her to use due diligence, by which she could have determined that the step did not conform to building code and was a construction defect); *Reichelt v. Johns-Manville Corp.*, 107 Wn.2d 761, 770-72, 733 P.2d 530 (1987) (affirming summary judgment dismissal of claim where plaintiff reasonably should have known the essential elements of his cause of action based upon his knowledge, plus consultations with an attorney and OSHA training); *Petcu v. State*, 121 Wn. App. 36, 72, 86 P.3d 1234 (2004) (a showing of hardship or understandable delay is insufficient to toll the statute of limitations); *Giraud*, 102 Wn. App. at 455 (affirming summary judgment dismissal of breach of warranty claim where plaintiff observed defendant's representative apply pesticide to potato plants taller than six inches high and plaintiff had access to label warning against spraying pesticide on potato plants more than six inches high); *Zaleck v. Everett Clinic*, 60 Wn. App. 107, 111, 114, 802 P.2d 826 (1991) (affirming summary judgment dismissal of action for failure to exercise due diligence where plaintiff knew of painful injection by physician causing immediate numbness, and physician told plaintiff the same day that he may have hit a nerve).

Discovery of the second element—breach—does not require the plaintiff to know with certainty that the health care provider was negligent. *Zaleck v. Everett Clinic*, 60 Wn. App. 107, 112, 802 P.2d 826 (1991). It is enough that the plaintiff knew or in the exercise of due diligence should have known that

the defendant was possibly negligent. *Id.* (finding plaintiff failed to exercise due diligence to inquire about negligence after learning facts regarding causation and damages).

The discovery rule does not require the plaintiff to have discovered the full extent of the injuries. *Zaleck v. Everett Clinic*, 60 Wn. App. 107, 112, 802 P.2d 826 (1991); *Steele v. Organon, Inc.*, 43 Wn. App. 230, 716 P.2d 920 (1986). It is sufficient that the plaintiff has become aware that some actual and appreciable harm was caused by defendant's wrongful act. *Steele v. Organon, Inc.*, 43 Wn. App. 230, 233-34, 716 P.2d 920 (1986); *see also 1000 Virginia Ltd. P'ship v. Vertecs Corp.*, 158 Wn.2d 566, 581, 146 P.3d 423 (2006); *Green v. A.P.C.*, 136 Wn.2d 87, 96, 960 P.2d 912 (1998); *compare Nevue v. Close*, 123 Wn.2d 253, 258, 867 P.2d 635 (1994) (where plaintiff alleged that she was not aware of a specific injury prior to signing release, there may be a question of fact as to whether settlement was fairly and knowingly made).

Imputation of knowledge in wrongful death action. In applying the discovery rule in a wrongful death action, it is possible that, where applicable, the knowledge of the decedent, and even the beneficiaries, may be imputed to the personal representative. *See Schweitzer v. Estate of Halko*, 751 P.2d 1064, 1066 (Mont. 1988) (“[decedent’s] knowledge concerning the alleged malpractice ... is imputed to his estate”); *DeLozier v. Smith*, 522 P.2d 555, 557 (Ariz. Ct. App. 1974) (imputing to the estate the contributory negligence of the beneficiaries “where the action, though nominally for the benefit of the estate, is in reality in the interests of the beneficiary thereunder”; to do otherwise “would be equivalent to permitting one to profit by his own wrong”).

Intentional Concealment by Defendant. The statutory discovery rule for a medical malpractice action provides that where the defendant has engaged in intentional concealment, the limitations period is one year from actual knowledge of the fraud or concealment. RCW 4.16.350(3); *see Cox v. Oasis Physical Therapy, PLLC*, 153 Wn. App. 176, 187, 222 P.3d 119 (2009); *Webb v. Neuroeducation, Inc.*, 100 Wn. App. 336, 345, 88 P.3d 417 (2004). The operation of the statute is tolled indefinitely where there is intentional concealment. *Webb v. Neuroeducation, Inc.*, 100 Wn. App. 336, 345, 88 P.3d 417 (2004). This exception “is aimed at conduct or omissions intended to prevent the discovery of negligence or of the cause of action.” *Gunnier v. Yakima Heart Ctr., Inc.*, 134 Wn.2d 854, 867, 953 P.3d 1162 (1998) (no intentional concealment where the medical record revealed the relevant information); *see Doe v. Finch*, 133 Wn.2d 96, 98, 942 P.2d 359 (1997) (reversing summary judgment dismissal of malpractice claim where therapist had denied the sexual relationship at issue); *Duke v. Boyd*, 133 Wn.2d 80, 83, 942 P.2d 351 (1997) (reversing summary judgment dismissal of malpractice claim where ophthalmologist misrepresented to plaintiff that she was the only one who did not respond positively to procedure). The plaintiff must prove “that the defendant engaged in some conduct of an affirmative nature designed to prevent the plaintiff from becoming aware of the defect.” *Giraud v. Quincy Farm & Chemical*, 102 Wn. App. 443, 452, 6 P.3d 104 (2000). The affirmative act of concealment requires “actual subjective knowledge by the defendants of the wrong done, *i.e.*, scienter, and some affirmative action on his part in concealing the wrong.” *Id.* (citations omitted). The requirement that the plaintiff have “actual subjective knowledge” may still impose some responsibilities on the plaintiff to exercise due diligence responsibilities. *See, e.g., Estates of Hibbard v. Gordon, Thomas*, 118 Wn.2d 737, 750-51, 826 P.2d 690 (1992) (discovery rule “should have known” standard applies to claims in which the plaintiffs “could not have immediately known of their injuries due to ... concealment of information by the defendant”); *Hamilton v. Arriola Brothers Custom Farming*, 85 Wn. App. 207, 211, 931 P.2d 925 (1997) (applying discovery “should have known” standard to claims “in which the plaintiffs could not have immediately known of their injuries due to ... concealment of information by the defendant”); *Crisman v. Crisman*, 85 Wn. App. 15, 20, 931 P.2d 163 (1997) (applying RCW 4.16.080(4); “[a]pplication of the discovery rule tolls the limitation period until such time as the plaintiff knew or, through the exercise of due diligence, should have known of the fraud”); *Wood v. Gibbons*, 38 Wn. App. 343, 346, 685 P.2d 619 (1984) (physician

not obligated to disclose every piece of information that may be the basis of a lawsuit). Whether intentional concealment occurred is generally a question for the trier of fact. *Duke v. Boyd*, 133 Wn.2d 80, 83, 942 P.2d 351 (1997). But in the absence of allegations of facts supporting the claim, the issue may be resolved as a matter of law. *Gunnier v. Yakima Heart Ctr., Inc.*, 134 Wn.2d 854, 867, 953 P.3d 1162 (1998); *Breuer v. Presta*, 148 Wn. App. 470, 478, 200 P.3d 724 (2009).

Fraud. To toll the limitations period based upon fraud, the plaintiff has the burden to prove each of the nine elements of fraud, or to prove that “the defendant breached an affirmative duty to disclose a material fact.” *Crisman v. Crisman*, 85 Wn. App. 15, 20, 931 P.2d 163 (1997). In addition, a party alleging fraud or intentional concealment must prove it by clear, cogent and convincing evidence. See *Duke v. Boyd*, 133 Wn.2d 80, 83, 942 P.2d 351 (1997). The common law fraud or concealment exception requires plaintiffs to use due diligence to discover relevant information. *Young v. Savidge*, 155 Wn. App. 806, 823, 230 P.3d 222 (2010) (“[m]ere suspicion of wrong is not discovery of the fraud, the discovery contemplated is of evidentiary facts leading to a belief in the fraud and by which the existence of the fraud may be established”); *Giraud v. Quincy Farm & Chemical*, 102 Wn. App. 443, 455, 6 P.3d 104 (2000) (plaintiffs “must do more than merely establish that [the defendant] concealed this information.... [T]hey are required to demonstrate that they were reasonably diligent in their efforts to discover the information that they allege [the defendant] withheld from them”).

Tolling of Statute for Minors and Disabled Persons. The statute of limitations for claims of personal injury resulting from health care is not tolled for minors. RCW 4.16.190(2).

The statute of limitations for bringing a wrongful death action is not tolled by the minority of statutory beneficiaries. *Atchison v. Great Western Malting Co.*, 161 Wn.2d 372, 382, 166 P.3d 662 (2007); *Huntington v. Samaritan Hosp.*, 101 Wn.2d 466, 469, 680 P.2d 58 (1984). The only person entitled to bring a wrongful death action is the personal representative, and the tolling provision of RCW 4.16.190 would only become operative if the personal representative were incompetent or disabled. *Atchison v. Great Western Malting Co.*, 161 Wn.2d 372, 382, 166 P.3d 662 (2007); *Huntington v. Samaritan Hosp.*, 101 Wn.2d 466, 469, 680 P.2d 58 (1984).

The statute of limitations is tolled during a period of incapacity during which the plaintiff “cannot understand the nature of the proceedings.” RCW 4.16.190(1); *Rivas v. Overlake Med. Ctr.*, 164 Wn.2d 261, 264-65, 189 P.3d 753 (2008) (reversing summary judgment dismissal of claim as time-barred where plaintiff was in intensive care unit for four days following the alleged negligence).

The appointment of a guardian ad litem for a disabled person does not alter the tolling of the statute of limitations. *Young v. Key Pharmaceuticals, Inc.*, 112 Wn.2d 216, 221, 770 P.2d 182 (1989). Even the filing of an action by the guardian ad litem does not affect the tolling of the statute of limitations, unless the action proceeds to final judgment. *Young v. Key Pharmaceuticals, Inc.*, 112 Wn.2d 216, 223-24, 770 P.2d 182 (1989). Statutes of Repose. A statute of repose is a statute of limitations that bars the commencement of an action despite the operation of a discovery rule. A statute of repose for tort actions in Washington, RCW 4.16.350, was found unconstitutional under the state constitution. *DeYoung v. Providence Medical Ctr.*, 136 Wn.2d 136, 149, 960 P.2d 919 (1998). A 2006 statute, RCW 4.16.350 re-enacted the statute of repose, and set forth the legislature’s rationale for re-enactment in response to the *DeYoung* decision.

Service on Multiple Defendants. In a case involving multiple defendants, the service of a summons and complaint on one defendant within 90 days of filing the complaint tolls the statute of limitations as to the remaining unserved defendants. *Sidis v. Brodie/Dohrmann, Inc.*, 117 Wn.2d 325, 329-30, 815 P.2d 781 (1991). This rule applies even where separate causes of action are brought against the

different defendants in the same action, where the defendants are joined by a common factual issue. *Wakeman v. Lommers*, 67 Wn. App. 819, 823, 840 P.2d 232 (1992).

8.2.2 Claim Filing Requirements against Public Entities.

Where defendants are public entities or employees, Washington tort claim statutes generally require the plaintiff to comply with tort claim filing requirements prior to filing a complaint. RCW 4.92.110 (requiring plaintiff bringing claim against state or state agency to present and file a tort claim with the Division of Risk Management, and then allow sixty days to elapse after the claim was filed before commencing a lawsuit); *see also* RCW 4.92.100; .210(1); .006; RCW 4.96.020 (requiring plaintiff bringing claim against county or other local government agencies to file a tort claim with the local government entity); *Troxell v. Rainier Public School Dist., No. 307*, 154 Wn.2d 345, 360, 111 P.3d 1173 (2005); *Renner v. City of Marysville*, 145 Wn. App. 443, 447, 187 P.3d 283 (2008). However, medical malpractice actions under RCW 7.70 are exempt from these tort claim filing requirements. RCW 4.92.110; RCW 4.96.020.

8.2.3 Notice of Intent to File.

Where notice of the intent to file a medical malpractice action is served within 90 days of the expiration of the applicable statute of limitations, the time for commencement of the action is extended 90 days from the date the notice is mailed, plus an additional five days to allow the claimant to timely file suit. RCW 7.70.100; *Jackson v. Sacred Heart Med. Ctr.*, 153 Wn. App. 498, 501, 225 P.3d 1016 (2009). Although the statutory requirement to provide the notice of intent was found unconstitutional as a violation of the separation of powers doctrine, the courts have not addressed the tolling effect of the notice. *See Waples v. Yi*, 169 Wn.2d 152, 161, 234 P.3d 187 (2010) (notice of intent requirement unconstitutional). [See § 8.2.1 above.]

8.2.4 Certificates of Merit.

A statute that had required the plaintiff to file a certificate of merit, executed by a health care provider qualified to be an expert, stating that there is a reasonable probability that the defendant's conduct did not follow the accepted standard of care required to be exercised by the defendant, was found unconstitutional as an undue burden on the right of access to courts and a violation of the separation of powers. RCW 7.70.150; *Putman v. Wenatchee Valley Med. Ctr.*, 166 Wn.2d 974, 977, 216 P.3d 374 (2009).

8.2.5 Attorney Certification of Non-Frivolousness.

By statute, any attorney that has drafted or assisted in drafting an action, claim, counter-claim, cross-claim, third-party claim, or a defense to a claim, for a medical malpractice action must certify upon signature and filing that to the best of the party's or attorney's knowledge, information, and belief, formed after reasonable inquiry it is not frivolous, and is well grounded in fact and is warranted by existing law or a good faith argument for the extension, modification, or reversal of existing law, and that it is not interposed for any improper purpose, such as to harass or to cause frivolous litigation. RCW 7.70.160.

8.2.6 Declaration re: Arbitration.

In any case in which a party does not agree to voluntary arbitration, that party must file a declaration at the time of filing its initial pleading stating that the attorney representing the party provided the party with a copy of the provisions of RCW 7.70A before filing the initial pleading and that the party elected not to submit the dispute to arbitration under the voluntary arbitration chapter. RCW 7.70A020.

8.3 Standard of Care

8.3.1 General Rule.

Reasonably Prudent Practitioner. The standard of care established under RCW 7.70 and RCW 4.24.290 “is that of a reasonably prudent practitioner possessing the degree of skill, care, and learning possessed by other members of same profession in the State of Washington.” *Harris v. Robert C. Groth, M.D., Inc., P.S.*, 99 Wn.2d 438, 451, 663 P.2d 113 (1983); *see also, e.g., Davies v. Holy Family Hosp.*, 144 Wn. App. 483, 492, 183 P.3d 283 (2008); *Eng v. Klein*, 127 Wn. App. 171, 176, 110 P.3d 844 (2005) (a plaintiff must show that the defendant health care provider “failed to exercise that degree of care, skill, and learning expected of a reasonably prudent health care provider in the profession or class to which he belongs, in the State of Washington, acting in the same or similar circumstances”).

Reasonably Prudent Practitioner Standard v. Actual Standard of Practice. The standard of care for the reasonably prudent practitioner, *see* RCW 7.70.040, is not unilaterally defined by or equivalent to the standard actually practiced by the medical profession. *Harris v. Robert C. Groth, M.D., Inc., P.S.*, 99 Wn.2d 438, 445, 451, 663 P.2d 113 (1983) (“[i]t is society and their patients to whom physicians are responsible, not solely their fellow practitioners”); *Watson v. Hockett*, 107 Wn.2d 158, 166, 727 P.2d 669 (1986) (reasonably prudent practitioner standard is the standard “expected by society” rather than “expected by the medical profession”); *Keogan v. Holy Family Hosp.*, 95 Wn.2d 306, 318, 622 P.2d 1246 (1980); *Adair v. Weinberg*, 79 Wn. App. 197, 203, 901 P.2d 340 (1995) (“both the medical profession and society play a role in establishing what is expected of a medical provider”) (emphasis in original); *Richards v. Overlake Hosp.*, 59 Wn. App. 266, 277, 796 P.2d 737 (1990) (“although the standard of care is not restricted to what is actually practiced, it must be determined by reference to expert testimony as to what is reasonably prudent”); *Brown v. Dahl*, 41 Wn. App. 565, 581, 705 P.2d 781 (1985) (reasonable prudence standard is higher than “average” or “reasonable” or “ordinary” standard). The standard actually practiced is evidence of what is reasonably prudent, but not always dispositive. *Harris v. Robert C. Groth, M.D., Inc., P.S.*, 99 Wn.2d 438, 448, 451, 663 P.2d 113 (1983); *Bauer v. White*, 95 Wn. App. 663, 668, 976 P.2d 664 (1999); *Adair v. Weinberg*, 79 Wn. App. 197, 203-04, 901 P.2d 340 (1995) (“both the medical profession and society play a role in establishing what is expected of a medical provider”) (emphasis in original); *see also* WPI 105.02. The necessary standard of care imposed by the courts may be higher than that actually practiced by those in the profession. RCW 4.24.290 (requiring proof of failure to exercise the “skill, care and learning possessed at that time by others in the profession”); *see also, e.g., Gates v. Jensen*, 92 Wn.2d 246, 252, 595 P.2d 919 (1979) (error not to instruct the jury that reasonable prudence may require a higher standard of care than that followed by practicing specialists); *Helling v. Carey*, 83 Wn.2d 514, 519, 519 P.2d 981 (1974) (reasonable prudence may require a higher standard of care than that followed by practicing specialists). The standard of care is also not defined by what course of treatment another physician may follow, or that physician’s personal opinion. *Versteeg v. Mowery*, 72 Wn.2d 754, 759, 435 P.2d 540 (1967); *Skodje v. Hardy*, 47 Wn.2d 557, 560, 288 P.2d 471 (1955).

“Standard of Care” v. “Standard of Practice.” The term “standard of care” is contained in RCW 7.70.030 and used in many Washington decisions in reference to the required standard. *E.g., Seybold v. Neu*, 105 Wn. App. 666, 675-76, 678-79, 19 P.3d 1068 (2001); *Hall v. Sacred Heart Med. Ctr.*, 100 Wn. App. 53, 58-60, 995 P.2d 621 (2000). The term “standard of practice” is not used in any statute, and is generally not used to describe the required standard. *See Harris v. Robert C. Groth, M.D., Inc., P.S.*, 99 Wn.2d 438, 448 n.5, 451, 663 P.2d 113 (1983) (omitting “standard of practice” language); WPI 105.01 comment; *but see Miller v. Peterson*, 42 Wn. App. 822, 829, 831-32, 714 P.2d 695 (1986) (finding no error in instruction using “standard of practice” language).

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No guarantee. The standard of care does not require a physician to guarantee the results of diagnosis and treatment, unless the doctor so contracts. *Christensen v. Munsen*, 123 Wn.2d 234, 247-48, 867 P.2d 626 (1994) (affirming use of jury instruction re: no guarantee); *Watson v. Hockett*, 107 Wn.2d 158, 163-64, 727 P.2d 669 (1986) (“[a] doctor does not guarantee a good medical result”); *Miller v. Kennedy*, 91 Wn.2d 155, 158-59, 588 P.2d 734 (1978); *Estate of Lapping v. Group Health Coop.*, 77 Wn. App. 612, 628, 892 P.2d 1116 (1995) (affirming use of jury instruction as to no guarantee). A doctor is not an insurer that health will return to the patient. *Miller v. Kennedy*, 11 Wn. App. 272, 279, 522 P.2d 852 (1974) (“[t]he law does not hold a physician to a standard of infallibility”), *aff’d and adopted*, 85 Wn.2d 151 (1975).

External Resource:

WPI 105.07 (jury instruction re: no guarantee) [See § 8.9.2 below.]

Expectations of Society. The standard of care is not solely defined by the expectations of society. *Adair v. Weinberg*, 79 Wn. App. 197, 203, 901 P.2d 340 (1995) ; *Richards v. Overlake Hosp. Med. Ctr.*, 59 Wn. App. 266, 277, 796 P.2d 737 (1990) (“the law does not permit a jury to base a standard of care on what it believes to be a prudent expectation of society or patients”). This would suggest that a doctor must guarantee a result if society expects it. *Adair*, 79 Wn. App. at 203. Rather, “both the medical profession and society play a role in establishing what is expected of a medical provider.” *Id.* at 203 (emphasis in original).

Statewide standard. [See § 8.4.2 below.]

Time of Applicable Standard: After-Acquired Knowledge. The question of whether or not a health care provider exercised reasonable care and skill is to be determined by reference to what was known in relation to the case at the time of the patient’s care and determined by reference to the pertinent facts then in existence, which the health care provider either knew or should have known, and is not determined in the light of any after-acquired knowledge. *Gjerde v. Fritzche*, 55 Wn. App. 387, 391-92, 777 P.2d 1072 (1989); *Vasquez v. Markin*, 46 Wn. App. 480, 487-89, 731 P.2d 510 (1986). [See § 8.9.2 below.]

Regulatory/Organizational Standards. The hospital’s standard of care ordinarily must be established by expert testimony. *Douglas v. Freeman*, 117 Wn.2d 242, 249, 814 P.2d 1160 (1991); *Ripley v. Lanzer*, 152 Wn. App. 296, 324, 215 P.3d 1020 (2009). The standard of care to which a hospital should be held may be defined by JCAHO accreditation standards, the hospital’s own bylaws, and/or applicable statutes. *Douglas v. Freeman*, 117 Wn.2d 242, 248-49, 814 P.2d 1160 (1991); *Pedroza v. Bryant*, 101 Wn.2d 226, 233-34, 677 P.2d 166 (1984). *Adcox v. Children’s Orthopedic Hosp. & Med. Ctr.*, 123 Wn.2d 15, 38, 864 P.2d 921 (1993) (affirming use of jury instruction stating that a hospital’s nursing staff is obligated to follow hospital rules and policies, and that violation of rules or policies may be considered in determining negligence); *Ripley v. Lanzer*, 152 Wn. App. 296, 324-25, 215 P.3d 1020 (2009) (affirming dismissal of corporate negligence claim for lack of expert evidence of failure to meet JCAHO standards).

While a specific JCAHO standard may be evidence of negligence on the part of a hospital, it is not relevant to a negligence claim against a physician. *Bays v. St. Luke’s Hosp.*, 63 Wn. App. 876, 885-86, 825 P.2d 319 (1992).

Specialist Standards. [See § 8.4.2 below.]

Treatment of the Disabled. The standard of care does not require a health care provider to withhold treatment of a newborn infant based on the likelihood that the infant will be severely disabled, if it survives. *Stewart-Graves v. Vaughn*, 162 Wn.2d 115, 134, 170 P.3d 1151 (2007).

8.3.2 Duty to Patients and Non-Patients.

An action for medical malpractice does not require a physician-patient relationship. *Petersen v. State*, 100 Wn.2d 421, 428, 671 P.2d 230 (1983) (malpractice claim possible where plaintiff was injured by patient of psychiatrist); *Kaiser v. Suburban Transp. Sys.*, 65 Wn.2d 461, 469, 398 P.2d 14 (1965) (malpractice claim possible where plaintiffs were injured while on bus driven by patient of defendant physician and hospital); *Webb v. Neuroeducation, Inc., P.C.*, 121 Wn. App. 336, 346, 88 P.3d 417 (2004) (parent injured by psychologist placement of false memories of sexual abuse in son; “the plaintiff need not be the patient”); *Branom v. State*, 94 Wn. App. 964, 970, 974 P.2d 335 (1999) (parent alleged injury from medical negligence in treatment of child; “a parent who is injured as the result of the negligent treatment of his child has a cause of action” for medical malpractice); *Eelbode v. Chec Medical Ctrs., Inc.*, 97 Wn. App. 462, 467, 984 P.2d 436 (1999) (malpractice during pre-employment physical examination); *Daly v. United States*, 946 P.2d 1467, 1469 (9th Cir. 1991) (malpractice during pre-employment physical); *see also McKee v. American Home Products Corp.*, 113 Wn.2d 701, 715, 782 P.2d 1045 (1989) (pharmacist duty to warn of known or obvious errors in prescription); *Harbeson v. Parke-Davis, Inc.*, 98 Wn.2d 460, 478-81, 656 P.2d 483 (1983) (duty to unconceived child despite lack of physician-patient relationship); *but see Tyner v. DSHS*, 92 Wn. App. 504, 522, 963 P.2d 215 (1988) (no duty by therapist to third-party parent). Where a physician is employed by the patient’s employer, the physician is immune from liability under the worker’s compensation immunity for the employer. RCW 51.24.030(1); *Daniels v. Seattle Seahawks*, 92 Wn. App. 576, 584-85, 968 P.2d 883 (1998); *Kerr v. Olson*, 59 Wn. App. 470, 477, 798 P.2d 819 (1990) (physician found to be employee of patient’s employer).

A physician-patient relationship, and a duty of care, may arise even though the only contact was via telephone. *Khung Thi Lam v. Global Med. Sys.*, 127 Wn. App. 657, 664-65, 111 P.3d 1258 (2005) (physician contracted with vessel owner to provide medical consultation services to vessels).

8.3.3 Good Samaritan.

Physicians or others who voluntarily render services at the scene of an emergency are protected from liability. RCW 4.24.300-.310. The purpose of the statute is to encourage persons to render emergency care to those in need by releasing rescuers from liability should injuries result from negligent acts committed in the course of rendering emergency care or transportation. *Gardner v. Loomis Armored, Inc.*, 128 Wn.2d 931, 939, 913 P.2d 377 (1996); *State v. Hillman*, 66 Wn. App. 770, 776, 832 P.2d 1369 (1992) (“[i]t has long been the policy of our law to protect the ‘Good Samaritan’”).

These “Good Samaritan” laws protect physicians who provide such care without compensation. RCW 4.24.300(2); *Hansen v. Horn Rapids R.O.V. Park*, 85 Wn. App. 424, 932 P.2d 724 (1997) (referencing lower court decision that volunteer EMTs were immune under the statute). The laws do not apply where the physician renders emergency care in the course of regular employment and expects to receive compensation for such care. RCW 4.24.300(2)-(3).

The protection of the statute does not apply where the physician engaged in conduct that constituted gross negligence or willful or wanton misconduct. RCW 4.24.300(1); *Youngblood v. Schireman*, 53 Wn. App. 95, 108, 765 P.2d 1312 (1988). Gross negligence is negligence substantially and appreciably greater than ordinary negligence, and willful or wanton misconduct is intentional activity taken in reckless disregard of the consequences under circumstances such that a reasonable person would know, or have reason to know, that substantial harm to another is highly likely to result.

Youngblood v. Schireman, 53 Wn. App. 95, 109, 765 P.2d 1312 (1988) (finding no gross negligence or willful or wanton misconduct where no evidence that parties who provided transportation to emergency room following tooth loss would have reason to know that half-hour delay would significantly affect reimplantation success).

The statute also does not apply to limit the liability for the operation of a motor vehicle, with the exception of liability, for negligence, to the injured person or persons being transported for further medical treatment or care. RCW 4.24.310(3); *Maynard v. Ferno-Washington, Inc.*, 22 F. Supp.2d 1171, 1174 (E.D. Wash. 1998) (EMT and employer may be liable to fellow EMT for injuries caused while caring for a third party).

8.3.4 EMTALA

The standard of care is also defined in part by a federal law, the Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd, requiring certain screening and emergency care.

Screening. The statute requires a hospital to provide a screening for any patient that comes to the emergency room and requests care. 42 U.S.C. § 1395dd. The hospital must provide an examination within the capability of the hospital's emergency department in order to determine whether an emergency medical condition exists. *Id.* An "emergency medical condition" is a condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical treatment could reasonably be expected to result in placing the health of the individual or an unborn child in jeopardy, serious impairment of bodily functions, or serious dysfunction of any bodily organ or part. 42 U.S.C. § 1395dd(e). With respect to a pregnant woman who is having contractions, an emergency medical condition means that there is inadequate time to effect a safe transfer before delivery, or the transfer may pose a threat to the health or safety of the woman or the unborn child. 42 U.S.C. § 1395dd(e)(1)(b). A hospital cannot delay a medical screening examination, further medical examination, or treatment to inquire about the individual's method of payment or insurance status. 42 U.S.C. 1395dd(h). The requirements of EMTALA apply to all patients, not only indigent patients. *E.g.*, *Correa v. Hospital San Francisco*, 69 F.3d 1184, 1194 (1st Cir. 1995), *cert. denied*, 517 U.S. 1136 (1996). The goal of these requirements is to address the problem of disparate treatment of insured and uninsured patients with emergency medical conditions. *Brooks v. Maryland Gen'l Hosp.*, 996 F.2d 708, 710-11 (4th Cir. 1993); *Gatewood v. Washington Healthcare Corp.*, 933 F.2d 1037, 1040 (D.C. Cir. 1991). A refusal to follow regular screening procedures in a particular instance contravenes the EMTALA screening requirement, but faulty screening, as opposed to disparate screening or refusing to screen at all, does not contravene the statute. *Cruz-Queipo v. Hospital Espanol Auxilio Mutuo de Puerto Rico*, 417 F.3d 67, 71 (1st Cir. 2005) (EMTALA does not create a cause of action for medical malpractice). EMTALA does not require any particular documentation of the screening examination; deviance from the documentation required in a hospital's screening policy does not, by itself, give rise to a cause of action under EMTALA. *Guzman v. Mem. Hermann Hosp. Sys.*, 637 F. Supp. 2d 464, 499 (S.D. Tenn. 2009).

Stabilizing. A hospital may not transfer a patient to another facility prior to stabilization unless the patient requests a transfer in writing after being informed of the risks, or a qualified medical person, after consultation with a physician, certifies in writing that the benefits of transfer outweigh the risks. 42 C.F.R. § 489.24(d). "Stabilized" means that no material deterioration is likely to occur during a transfer or, in the case of a pregnant woman, that the woman has delivered the baby and placenta. 42 U.S.C. § 1395dd(e). The EMTALA duty to stabilize does not impose a standard of care prescribing how physicians must treat a critical patient's condition while he remains in the hospital, but merely prescribes a precondition the hospital must satisfy before it may undertake to transfer the patient; a hospital cannot violate the duty to stabilize unless it transfers a patient. *Alvarez-Torres v. Ryder*

Mem. Hosp., 582 F.3d 47, 51-52 (1st Cir. 2009); *Harry v. Marchant*, 291 F.3d 767, 771 (11th Cir. 2002).

Transfer. The transfer must be appropriate. 42 U.S.C. § 1395dd(c). The transferring hospital must provide medical treatment within its capacity that minimizes risks from transfer. 42 U.S.C. § 1395dd(c)(2)(A). The transfer must be to a facility that has available space and qualified personnel and has agreed to accept the transfer and provide appropriate medical treatment. The transferring hospital must send all medical records, including the consent for transfer, to the receiving facility. 42 U.S.C. § 1395dd(c)(2)(C). The transfer must be performed by qualified personnel with the use of any necessary transportation equipment and medically appropriate life support measures. 42 U.S.C. § 1395dd(c)(2)(D).

Enforcement. A patient has a cause of action against a hospital that does not comply with the requirements regarding treatment of emergency medical conditions. 42 U.S.C. § 1395dd(d)(2). There is no private cause of action against individual physicians. *Baker v. Hospital Corp. of Am.*, 977 F.2d 872, 878 (4th Cir. 1992). A physician who negligently violates the EMTALA requirements may, however, be subject to civil fines. 42 U.S.C. § 195dd(d)(1).

External Resource:

American Health Lawyers Association, *Fundamentals of Health Law*, § 2.1.2.1(4th ed. 2009).

8.3.5 Violation of Other Statutes.

Violation of a statutory requirement is evidence of negligence, but not negligence per se. RCW 5.40.050; *Morinaga v. Vue*, 85 Wn. App. 822, 832, 935 P.2d 637 (1997).

External Resource:

WPI 60.03 (jury instruction re: statutory violations)

8.3.6 Specific Health Professions and Practices

8.3.6.1 Psychiatry

In addition to other duties owed by a physician, a psychiatrist has a duty to take reasonable precautions to protect any person who might foreseeably be endangered by his patient's mental problems. *Petersen v. State*, 100 Wn.2d 421, 428, 671 P.2d 230 (1983).

8.3.6.2 Use of Restraints.

The decision whether to use restraints for a patient in an in-patient setting is a matter of clinical judgment. *Adams v. State*, 71 Wn.2d 414, 423, 429 P.2d 109 (1967) (court will not interfere with exercise of judgment whether to use restraints); *Teig v. St. John's Hosp.*, 63 Wn.2d 369, 374, 387 P.2d 527 (1963); *Gerard v. Sacred Heart Med. Ctr.*, 86 Wn. App. 387, 389-90, 937 P.2d 1104 (1997).

8.3.6.3 Paramedic and Emergency Medical Personnel.

RCW 18.71.210 provides a qualified immunity from liability for emergency medical personnel for simple negligence while rendering emergency services as long as they act in good faith. *Marthaller v. King County Hosp.*, 94 Wn. App. 911, 916, 973 P.2d 1098 (1999) (claim against paramedic dismissed on summary judgment).

8.3.6.4 Nursing.

A nurse does not have a legal duty to warn a patient of potential risks associated with taking a drug prescribed by a physician, to review with the patient the instructions for taking the drug

if there is no indication that the written warnings provided with the drug will not effectively advise the patient, or to consult with the prescribing physician if the prescription does not contain a clear error or mistake. *Silves v. King*, 93 Wn. App. 873, 881-83, 970 P.2d 790 (1999).

8.3.6.5 Pharmaceutical.

Physician Prescriptions. A patient has a cause of action against a physician for prescribing a drug to which the patient becomes addicted. *E.g., Caughell v. Group Health Coop. of Puget Sound*, 124 Wn.2d 217, 234, 876 P.2d 898 (1994) (prescribing Valium).

Pharmacist Duties. A pharmacist has a duty to fill the prescription correctly. *McKee v. American Home Products, Inc.*, 113 Wn.2d 701, 707-08, 720, 82 P.2d 1045 (1989); *Attwood v. Albertson's Food Ctrs.*, 92 Wn. App. 326, 333, 966 P.2d 351 (1998).

A pharmacist does not have a duty to warn of possible hazards, interactions or contraindications associated with a prescription drug. *Silves v. King*, 93 Wn. App. 873, 879, 970 P.2d 790 (1999); *McKee v. American Home Products*, 113 Wn.2d 701, 712, 782 P.2d 1045 (1989). The duty to warn is best left to the physician who is in the best position to determine the proper drug therapy and to determine how and when to inform a patient of its risks and benefits. *Silves v. King*, 93 Wn. App. 873, 879, 970 P.2d 790 (1999); *McKee v. American Home Products*, 113 Wn.2d 701, 712, 782 P.2d 1045 (1989). A pharmacist has no duty to provide to the consumer a copy of the package insert, which is directed to the physician. *McKee v. American Home Products, Inc.*, 113 Wn.2d 701, 718-20, 782 P.2d 1045 (1989). The pharmacist has no duty to consult with or question the judgment of the doctor. *Silves v. King*, 93 Wn. App. 873, 880, 970 P.2d 790 (1999); *McKee v. American Home Products*, 113 Wn.2d 701, 720, 782 P.2d 1045 (1989).

8.3.7 Duty of Confidentiality.

The disclosure of confidential health information may be an act of medical malpractice under RCW 7.70. *Berger v. Sonneland*, 144 Wn.2d 91, 114, 26 P.3d 257 (2001); *cf. Wynn v. Earin*, 163 Wn.2d 361, 380, 181 P.3d 806 (2008) (malpractice claim arising from appearance and testimony at court hearing barred by witness immunity rule). An action for unauthorized disclosure of health care information may also be brought under the Uniform Health Care Information Act, RCW 70.02.170, but a party is not limited to bringing such a claim only under the Uniform Health Care Information Act. *Berger*, 144 Wn.2d at 103-04, 114; *cf. Wynn*, 163 Wn.2d at 385 (witness immunity rule does not bar claim for violation of Uniform Health Care Information Act, RCW 70.02). [See also WSSHA Health Law Manual Chapter 1 (Healthcare Information, Confidentiality).] A physician's unauthorized disclosure of confidential information occurs as a result of "health care" when the breach occurs while the physician is utilizing the skills the physician had been taught in examining, diagnosing, treating or caring for the patient. *Berger*, 144 Wn.2d at 114 (recognizing possible medical malpractice cause of action where physician disclosed confidential information about a patient's use of narcotic pain medication to patient's former husband, who was a physician).

8.3.8 Informed Consent.

[See also Chapter 2 regarding Consent to Healthcare.]

General Rule. As a general rule, a health care provider must obtain the informed consent of a patient prior to treatment. A physician has a fiduciary duty to the patient to obtain consent. *Stewart-Graves v. Vaughn*, 162 Wn.2d 115, 122, 170 P.3d 1151 (2007); *Miller v. Kennedy*, 11 Wn. App. 272, 286, 522 P.2d 852 (1974), *aff'd and adopted*, 85 Wn.2d 151 (1975). The patient has a right to know and to "chart his own destiny." *Miller v. Kennedy*, 11 Wn. App. 272, 282, 522 P.2d 852 (1974), *aff'd and*

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adopted, 85 Wn.2d 151 (1975); *see also Stewart-Graves v. Vaughn*, 162 Wn.2d 115, 123, 170 P.3d 1151 (2007); *Smith v. Shannon*, 100 Wn.2d 26, 29, 666 P.2d 351 (1983) (recognizing a individual’s “right to determine what shall be done with his own body”); *Young v. Group Health Coop.*, 85 Wn.2d 332, 336, 534 P.2d 1349 (1975); *Housel v. James*, 141 Wn. App. 748, 756, 172 P.3d 712 (2007); *Shellenbarger v. Brigman*, 101 Wn. App. 339, 349, 3 P.3d 211 (2000); *Morinaga v. Vue*, 85 Wn. App. 822, 829, 935 P.2d 637 (1997) (“adults of sound mind have a right to make decisions about their own medical treatment”); *Estate of Lapping v. Group Health*, 77 Wn. App. 612, 623, 892 P.2d 1116 (1995); *LeBeuf v. Atkins*, 28 Wn. App. 50, 56, 621 P.2d 787 (1980); *Archer v. Galbraith*, 18 Wn. App. 369, 377, 567 P.2d 1155 (1977) (informed consent “is based upon the patient’s right to know”); *Watkins v. Parpala*, 2 Wn. App. 484, 490, 492, 469 P.2d 974 (1970) (the “normal and serious risks” of procedure must be communicated to patient; provider should disclose those risks the provider should know about and which the patient does not know). The purpose of informed consent is so that the patient’s choice will be an intelligent one, based upon sufficient knowledge to enable the patient to balance probable risks and probable benefits. *ZeBarth v. Swedish Hosp. Med. Ctr.*, 81 Wn.2d 12, 23, 499 P.2d 1 (1972).

To establish a claim for lack of informed consent, a plaintiff must prove by a preponderance of the evidence:

- (a) That the health care provider failed to inform the patient of a material fact or facts relating to the treatment;
- (b) That the patient consented to the treatment without being fully aware or fully informed of such material fact or facts;
- (c) That a reasonable prudent patient under similar circumstances would not have consented to the treatment if informed of such material fact or facts;
- (d) That the treatment in question proximately caused injury to the patient.

RCW 7.70.050(1); *see also* 7.70.030(3); *see, e.g., Housel v. James*, 141 Wn. App. 748, 756, 172 P.3d 712 (2007); *Seybold v. Neu*, 105 Wn. App. 666, 681, 19 P.3d 1068 (2001); *Bertsch v. Brewer*, 97 Wn.2d 83, 90, 640 P.2d 711 (1982); *Bays v. St. Luke’s Hosp.*, 63 Wn. App. 876, 880-81, 825 P.2d 319 (1992); *Alexander v. Gonser*, 42 Wn. App. 234, 239, 711 P.2d 347 (1985); *Archer v. Galbraith*, 18 Wn. App. 369, 376, 567 P.2d 1155 (1977). Washington’s other medical liability statute, RCW 4.24.290, does not apply to an action for lack of informed consent.

External Resource:

WPI 105.04-.05 (jury instructions re: informed consent)

WPI 21.01 (jury instruction re: preponderance of the evidence burden of proof)

A claim for lack of informed consent is an alternative means of imposing liability on health care providers, independent of or in addition to medical negligence. *Stewart-Graves v. Vaughn*, 162 Wn.2d 115, 123, 170 P.3d 1151 (2007) (“A health care provider may be liable to an injured patient for breaching this duty even if the treatment otherwise meets the standard of care”); *Backlund v. University of Washington*, 137 Wn.2d 651, 659, 975 P.2d 950 (1999); *Housel v. James*, 141 Wn. App. 748, 756, 172 P.3d 712 (2007); *Degel v. Buty*, 108 Wn. App. 126, 129 n.4, 29 P.3d 768 (2001); *Shellenbarger v. Brigman*, 101 Wn. App. 339, 348, 3 P.3d 211 (2000); *Gustav v. Seattle Urological Assocs.*, 90 Wn. App. 785, 789, 954 P.2d 319 (1998); *Holt v. Nelson*, 11 Wn. App. 230, 237, 523 P.2d 211 (1974).

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Physician-Patient Relationship. The duty to disclose is a duty to the patient, not to others. A claim for lack of informed consent requires a physician-patient relationship. RCW 7.70.050(1)(d); *Webb v. Neuroeducation, Inc.*, 121 Wn. App. 336, 346, 88 P.3d 417 (2004) (no independent informed consent duty to father of minor counseling patient); *Branom v. State*, 94 Wn. App. 964, 973, 974 P.2d 35 (1999). In the case of a child, the duty is owed to the child, through the parent, but there is no direct duty to the parent. *Crawford v. Wojnas*, 51 Wn. App. 781, 783-84, 754 P.2d 1302 (1988) (no duty to disclose to parent the risks of the parent contracting polio from the child's polio vaccination).

Materiality. The guide for disclosure of a possible risk is materiality. *Christensen v. Munsen*, 123 Wn.2d 234, 245, 867 P.2d 626 (1994); *Smith v. Shannon*, 100 Wn.2d 26, 31, 666 P.2d 351 (1983); *Seybold v. Neu*, 105 Wn. App. 666, 681, 19 P.3d 1068 (2001); *Villanueva v. Harrington*, 80 Wn. App. 36, 39-41, 906 P.2d 374 (1995) (reversing summary judgment dismissal of informed consent claim where plaintiff presented evidence to support materiality of omitted information); *Miller v. Kennedy*, 11 Wn. App. 272, 287, 522 P.2d 852 (1974), *aff'd and adopted*, 85 Wn.2d 151, 152, 530 P.2d 334 (1975). For the purposes of informed consent, a fact is material if a reasonable person in plaintiff's position would attach significance to it in deciding whether or not to submit to the proposed treatment. RCW 7.70.050(2); *Christensen v. Munsen*, 123 Wn.2d 234, 245, 867 P.2d 626 (1994); *Smith v. Shannon*, 100 Wn.2d 26, 31, 666 P.2d 351 (1983); *Archer v. Galbraith*, 18 Wn. App. 369, 377, 567 P.2d 1155 (1977); *Villanueva v. Harrington*, 80 Wn. App. 36, 38, 906 P.2d 374 (1995); *Estate of Lapping v. Group Health*, 77 Wn. App. 612, 625, 892 P.2d 1116 (1995) (reversing directed verdict where patient presented evidence that a reasonable patient would have attached significance to the omitted information); *Adams v. Richland Clinic, Inc.*, 37 Wn. App. 650, 656, 681 P.2d 1305 (1984).

The determination of materiality is a two-step process. First, the scientific nature of the risk must be ascertained, *i.e.*, the nature of the harm and its probability of occurrence. Second, the fact-finder must then decide whether the probability of that type of harm is a risk which a reasonable patient would consider in deciding on treatment. *Smith v. Shannon*, 100 Wn.2d 26, 33-34, 666 P.2d 351 (1983); *Seybold v. Neu*, 105 Wn. App. 666, 681, 19 P.3d 1068 (2001); *Villanueva v. Harrington*, 80 Wn. App. 36, 39, 906 P.2d 374 (1995); *Ruffer v. St. Frances Cabrini Hosp.*, 56 Wn. App. 625, 631, 784 P.2d 1288 (1990). The first step requires expert testimony, but the second step does not. *Smith v. Shannon*, 100 Wn.2d 26, 33-34, 666 P.2d 351 (1983); *Seybold v. Neu*, 105 Wn. App. 666, 681, 19 P.3d 1068 (2001).

Material facts include, for example, the existence of an abnormal condition in one's body, the presence of a high risk of disease, and the existence of alternative diagnostic procedures. *Gates v. Jensen*, 92 Wn.2d 246, 251, 595 P.2d 919 (1979) (duty by eye physician to inform patient of simple test for glaucoma); *LeBeuf v. Atkins*, 28 Wn. App. 50, 57, 621 P.2d 787 (1980) (duty to inform patient of simple test that might have prevented his stroke and death).

Actual Practices re: Disclosure. Customary practice regarding disclosure may sometimes be considered as evidence, but is not dispositive. *Smith v. Shannon*, 100 Wn.2d 26, 32, 666 P.2d 351 (1983); *Klink v. G.D. Searle & Co.*, 26 Wn. App. 951, 956-57, 614 P.2d 701 (1980); *Archer v. Galbraith*, 18 Wn. App. 369, 378, 567 P.2d 1155 (1977). A patient need not prove what other doctors might tell their patients, or the community standard for disclosure. *Miller v. Kennedy*, 11 Wn. App. 272, 284, 288, 522 P.2d 852 (1974), *aff'd and adopted*, 85 Wn.2d 151 (1975); *Hunter v. Brown*, 4 Wn. App. 899, 906, 484 P.2d 1162 (1971) (a physician's duty to disclose is not governed by the standard practice of physician's community, but is a duty imposed by law).

Objective Standard. It is not sufficient for a plaintiff to testify that he would have chosen a different course of treatment. *Backlund v. University of Wash.*, 137 Wn.2d 651, 665-66, 975 P.2d 950 (1999).

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The test for an informed consent claim is whether a reasonably prudent patient in plaintiff's position would have chosen a different course if fully informed. *Backlund v. University of Wash.*, 137 Wn.2d 651, 665-66, 975 P.2d 950 (1999); *Degel v. Buty*, 108 Wn. App. 126, 132, 29 P.3d 768 (2001); *Brown v. Dahl*, 41 Wn. App. 565, 574, 705 P.2d 781 (1985). The use of an objective standard for causation, rather than a subjective one, is constitutional, and does not alter a patient's right to determine his or her own treatment. *Degel v. Buty*, 108 Wn. App. 126, 132, 29 P.3d 768 (2001).

Burden of Proof. The plaintiff has the burden to prove each fact essential to a claim of lack of informed consent by a preponderance of the evidence. RCW 7.70.030, .050; *see also, e.g., Archer v. Galbraith*, 18 Wn. App. 369, 377, 567 P.2d 1155 (1977). Once the plaintiff has established all of the elements of an informed consent claim, the burden shifts to the defendant to prove a defense justifying failure to impart that material information. *Ruffer v. St. Cabrini Hosp.*, 56 Wn. App. 625, 630, 784 P.2d 1288 (1990); *Miller v. Kennedy*, 11 Wn. App. 272, 284, 522 P.2d 852 (1974), *aff'd and adopted*, 85 Wn.2d 151 (1975).

External Resource:

WPI 105.05 (jury instruction re: burden of proof for informed consent claim)

WPI 21.01 (jury instruction re: preponderance of the evidence burden of proof)

Informed Consent by a Specialist. A specialist has a duty to inform the patient of matters which a reasonably specialist in his field should know. *Morrison v. McKillop*, 17 Wn. App. 396, 400, 563 P.2d 220 (1977).

Alternatives. RCW 7.70.050(3) provides that the health care provider need only disclose "the recognized possible alternative forms of treatment." The alternatives as to which a patient must be informed include the alternative of nontreatment. *Miller v. Kennedy*, 11 Wn. App. 272, 282, 522 P.2d 852 (1974), *aff'd and adopted*, 85 Wn.2d 151 (1975); *Housel v. James*, 141 Wn. App. 748, 757, 172 P.3d 712 (2007);. The patient must also be informed of the risks of the alternative forms of treatment. *Archer v. Galbraith*, 18 Wn. App. 369, 376, 567 P.2d 1155 (1977); *Miller v. Kennedy*, 11 Wn. App. 272, 282, 522 P.2d 852 (1974), *aff'd and adopted*, 85 Wn.2d 151 (1975); *Holt v. Nelson*, 11 Wn. App. 230, 237, 523 P.2d 211 (1974). Whether an alternative treatment is feasible under the patient's physical condition is a question of fact. *Thornton v. Anest*, 19 Wn. App. 174, 180, 574 P.2d 1199 (1978); *Archer v. Galbraith*, 18 Wn. App. 369, 379, 567 P.2d 1155 (1977); *see also Housel v. James*, 141 Wn. App. 748, 756, 172 P.3d 712 (2007) (whether defendant informed patient of alternatives, including nontreatment, is a question of fact). The plaintiff is required to present expert testimony regarding the recognized possible alternative forms of treatment, and the risks of the alternatives. RCW 7.70.050(3).

Written Consent. A written consent form constitutes prima facie evidence of consent. RCW 7.70.060; *Housel v. James*, 141 Wn. App. 748, 756, 172 P.3d 712 (2007); *Morinaga v. Vue*, 85 Wn. App. 822, 830, 935 P.2d 637 (1997); *Vasquez v. Markin*, 46 Wn. App. 480, 485-86, 731 P.2d 510 (1986). Failure to use a form shall not be admissible as evidence of failure to obtain consent. RCW 7.70.060. Where a written consent form satisfies the requirements of RCW 7.70.060, the burden shifts to the plaintiff to rebut the presumption that informed consent was obtained. *Vasquez v. Markin*, 46 Wn. App. 480, 486-87, 731 P.2d 510 (1986); *Brown v. Dahl*, 41 Wn. App. 565, 569, 705 P.2d 781 (1985). The evidence of consent arising from a written consent form may be rebutted under a preponderance of evidence standard. *Morinaga v. Vue*, 85 Wn. App. 822, 830, 935 P.2d 637 (1997) (sufficient evidence presented to rebut presumption). Consent to treatment may be contained in a validly executed mental health care directive. RCW 7.70.068.

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Who Must Obtain Consent. It is the physician's duty to obtain informed consent. A hospital does not have an independent duty under state law to obtain informed consent from the patient, absent specific knowledge of extraordinary circumstances concerning the patient's condition. *Howell v. Blood Bank*, 114 Wn.2d 42, 54-55, 785 P.2d 815 (1990); *Silves v. King*, 93 Wn. App. 873, 970 P.2d 790 (1999); *Burnet v. Spokane Ambulance*, 54 Wn. App. 162, 169-70, 772 P.2d 1027 (1989); *Alexander v. Gonser*, 42 Wn. App. 234, 239-41, 711 P.2d 347 (1985). [See § 8.6.6 below.]

Competency to Give Consent; Other Persons Authorized to Consent. A competent adult may give consent. Informed consent for a person who is not competent may be obtained from other individuals. RCW 7.70.060. The individuals who are authorized to give consent for another person are identified in RCW 7.70.065. [See also WSSHA Health Law Manual Chapter 2 (Consent to Healthcare).] An individual does not need to be declared legally incompetent to be incompetent to make health care decisions. RCW 11.88.010(1)(e); *Morinaga v. Vue*, 85 Wn. App. 822, 830, 935 P.2d 637 (1997) (developmentally disabled woman may not be competent to give consent to sterilization). The presumption of competency may be rebutted by clear, cogent and convincing evidence. *Morinaga v. Vue*, 85 Wn. App. 822, 830, 935 P.2d 637 (1997). A parent may consent on behalf of a minor patient. RCW 7.70.065(2)(a)(iii); *Stewart-Graves v. Vaughn*, 162 Wn.2d 115, 127, 170 P.3d 1151 (2007).

Timing for Obtaining Consent. The physician's duty to disclose arises whenever the physician becomes aware of an abnormality which may indicate risk or danger. *Keogan v. Holy Family Hosp.*, 95 Wn.2d 306, 314, 622 P.2d 1246 (1980). The duty can arise before an actual diagnosis is completed. *Gates v. Jensen*, 92 Wn.2d 246, 250-51, 595 P.2d 919 (1979).

Limitations to Duty to Disclosure. There are numerous limitations recognized from the disclosure requirements relevant to informed consent. See generally *Stewart-Graves v. Vaughn*, 162 Wn.2d 115, 125, 170 P.2d 1151 (2007); *Smith v. Shannon*, 100 Wn.2d 26, 30, 666 P.2d 351 (1983); *Holt v. Nelson*, 11 Wn. App. 230, 241, 523 P.2d 211 (1974). These include:

- Risks of which the patient is already aware. *Holt v. Nelson*, 11 Wn. App. 230, 241, 523 P.2d 211 (1974).
- Dangers that are commonly known, where it can be assumed that the patient is already aware. *Holt v. Nelson*, 11 Wn. App. 230, 241, 523 P.2d 211 (1974).
- Conditions posing a risk of which the physician is unaware. *Gustav v. Seattle Urological Assocs.*, 90 Wn. App. 785, 789, 954 P.2d 319 (1998); *Bays v. St. Luke's Hosp.*, 63 Wn. App. 876, 881-82, 825 P.2d 319 (1992); *Burnet v. Spokane Ambulance*, 54 Wn. App. 162, 169, 772 P.2d 1027 (1989).
- Risks that are not reasonably foreseeable. *Backlund v. University of Washington*, 137 Wn.2d 651, 668-69, 975 P.2d 950 (1999) (no duty to disclose 1 in 10,000 chance of injury); *Ruffer v. St. Cabrini Hosp.*, 56 Wn. App. 625, 632, 784 P.2d 1288 (1990) (as a matter of law, risks that are 1 in 20,000 or 1 in 50,000 are not material, serious, or foreseeable); *Meeks v. Marx*, 15 Wn. App. 571, 578, 550 P.2d 1158 (1976) (no duty to disclose risks that "lay in the realm of mere possibilities founded on speculation and conjecture"); *Holt v. Nelson*, 11 Wn. App. 230, 240, 523 P.2d 211 (1974); *Mason v. Ellsworth*, 3 Wn. App. 298, 313-14, 474 P.2d 909 (1970) (a 0.75% risk of esophageal puncture is not a material risk).
- Risks of improper performance of the procedure. *Holt v. Nelson*, 11 Wn. App. 230, 241, 523 P.2d 211 (1974).

Chapter 8: Medical Malpractice Liability

(prepared from reference materials available as of January 1, 2011)

- A provider's lack of experience with a proposed treatment. *Housel v. James*, 141 Wn. App. 748, 756, 172 P.3d 712 (2007); *Whiteside v. Lukson*, 89 Wn. App. 109, 112, 947 P.2d 1263 (1997).
- A provider's qualifications. *Thomas v. Wilfac, Inc.*, 65 Wn. App. 255, 261, 828 P.2d 597 (1992).
- Risks that are not material or serious. *Ruffer v. St. Cabrini Hosp.*, 56 Wn. App. 625, 630, 784 P.2d 1288 (1990); *Adams v. Richland Clinic, Inc.*, 37 Wn. App. 650, 656, 681 P.2d 1305 (1984); *Smith v. Shannon*, 100 Wn.2d 26, 31, 666 P.2d 351 (1983); *Holt v. Nelson*, 11 Wn. App. 230, 241, 523 P.2d 211 (1974).
- Emergencies. The doctrine of informed consent does not apply in emergency situations. RCW 7.70.050(4) provides that consent is implied where "a recognized health care emergency exists and the patient is not legally competent to give an informed consent and/or a person legally authorized to consent on behalf of the patient is not readily available." *Stewart-Graves v. Vaughan*, 162 Wn.2d 115, 123, 170 P.3d 1151 (2007) (affirming dismissal of claim for lack of informed consent for emergency resuscitation of newborn); *Orwick v. Fox*, 65 Wn. App. 71, 86, 828 P.2d 12 (1992) (dismissing claim for lack of informed consent for emergency room care). The emergency exception is based on the impracticality of having an adequate informed consent discussion in the midst of a medical emergency, and the importance of allowing a physician to maintain focus on providing lifesaving treatment to the patient. *Stewart-Graves v. Vaughan*, 162 Wn.2d 115, 123-24, 170 P.3d 1151 (2007). The presumption is that the harm from failure to treat outweighs any harm threatened by the proposed treatment. *Id.* at 124. "Readily available" means that there is sufficient time and opportunity for discussion and deliberation; mere physical proximity is not enough. *Id.* at 123 (parents were not "readily available during emergency resuscitation of newborn). A physician has no duty to disclose alternative diagnostic procedures before providing immediate emergency treatment. *Keogan v. Holy Family Hosp.*, 95 Wn.2d 306, 316, 622 P.2d 1246 (1980); *Holt v. Nelson*, 11 Wn. App. 230, 241, 523 P.2d 211 (1974).
- Where full disclosure would not be in the patient's best interests. *Holt v. Nelson*, 11 Wn. App. 230, 240, 523 P.2d 211 (1974).
- Where the patient insists on not being informed. *Holt v. Nelson*, 11 Wn. App. 230, 241, 523 P.2d 211 (1974).

Failure to Diagnose v. Informed Consent. A claim for failure to diagnose is a claim for medical negligence, not a claim for lack of informed consent. *E.g.*, *Backlund v. University of Washington*, 137 Wn.2d 651, 659, 975 P.2d 950 (1999); *Shellenbarger v. Brigman*, 101 Wn. App. 339, 350 n.5, 3 P.3d 211 (2000); *Gustav v. Seattle Urological Assocs.*, 90 Wn. App. 785, 789, 954 P.2d 319 (1998); *Thomas v. Wilfac, Inc.*, 65 Wn. App. 255, 261, 828 P.2d 597 (1992). *Bays v. St. Luke's Hosp.*, 63 Wn. App. 876, 881, 825 P.2d 319 (1992); *Burnet v. Spokane Ambulance*, 54 Wn. App. 162, 169, 772 P.2d 1027 (1989).

Proximate causation required. A plaintiff claiming lack of informed consent must show that the treatment proximately caused injury to the plaintiff. RCW 7.70.050(1); *Branom v. State*, 94 Wn. App. 964, 974, 974 P.2d 335 (1999); *Benoy v. Simons*, 66 Wn. App. 56, 61, 831 P.2d 167 (1992) (no informed consent claim for alleged injuries to a third party). A reasonably prudent patient may choose to consent in spite of the risk. *See Barth v. Rock*, 36 Wn. App. 400, 405, 674 P.2d 1265 (1984). There is no violation of the duty to obtain informed consent where the physician can establish that the patient would have proceeded whether or not the patient was told of the risks. *Holt v. Nelson*, 11 Wn. App. 230, 241, 523 P.2d 211 (1974).

Expert testimony required. Expert testimony is required in order to establish the existence, nature, and likelihood of occurrence of the risk at issue. RCW 7.70.050(3); *Smith v. Shannon*, 100 Wn.2d 26, 33-34, 666 P.2d 351 (1983); *Seybold v. Neu*, 105 Wn. App. 666, 681, 19 P.3d 1068 (2001); *Archer v. Galbraith*, 18 Wn. App. 369, 378, 567 P.2d 1155 (1977); *Bays v. St. Luke's Hosp.*, 63 Wn. App. 876, 881, 825 P.2d 319 (1992); *Ruffer v. St. Cabrini Hosp.*, 56 Wn. App. 625, 631, 784 P.2d 1288 (1990); *Adams v. Richland Clinic, Inc.*, 37 Wn. App. 650, 659-60, 681 P.2d 1305 (1984). Expert testimony must also establish what the complications and benefits are from the treatment administered and the recognized alternative forms of treatment, including nontreatment. RCW 7.70.050(3); *Seybold v. Neu*, 105 Wn. App. 666, 682, 19 P.3d 1068 (2001); *Ruffer v. St. Cabrini Hosp.*, 56 Wn. App. 625, 631, 784 P.2d 1288 (1990); *Adams v. Richland Clinic, Inc.*, 37 Wn. App. 650, 657, 681 P.2d 1305 (1984). It is permissible for the expert testimony to reflect personal opinion. *Adams v. Richland Clinic, Inc.*, 37 Wn. App. 650, 661, 681 P.2d 1305 (1984).

Whether the probability of harm is a risk which a reasonable patient would consider in deciding about treatment is strictly for the trier of fact. *Adams v. Richland Clinic, Inc.*, 37 Wn. App. 650, 658, 681 P.2d 1305 (1984).

Expert testimony in an informed consent claim need not rise to the level of evidence needed to prove a standard of care claim. *Adams v. Richland Clinic, Inc.*, 37 Wn. App. 650, 659, 681 P.2d 1305 (1984). Only those elements of the informed consent claim which are the province of the medical profession, such as risks and alternatives, need be proven by expert testimony. *Miller v. Kennedy*, 11 Wn. App. 272, 284, 522 P.2d 852 (1974), *aff'd and adopted*, 85 Wn.2d 151 (1975). It is not necessary to present testimony that the risks of the treatment were greater than the risks of the available alternatives. *Brown v. Dahl*, 41 Wn. App. 565, 574-75, 705 P.2d 781 (1985).

Battery. Where there is a complete lack of consent for medical treatment, a common law claim for battery arises as an alternative to a claim for lack of informed consent. *Young v. Savidge*, 155 Wn. App. 806, 822, 230 P.3d 222 (2010); *Bundrick v. Stewart*, 128 Wn. App. 11, 17, 114 P.3d 1204 (2005) ([a]n action for total lack of consent sounds in battery, while a claim for lack of informed consent is a medical malpractice action sounding in negligence"); *see also Keogan v. Holy Family Hosp.*, 95 Wn.2d 306, 313-14, 622 P.2d 1246 (1980); *Miller v. Kennedy*, 11 Wn. App. 272, 281-82, 522 P.2d 852 (1974), *aff'd and adopted*, 85 Wn.2d 151, 152, 530 P.2d 334 (1975); *but see Branom v. State*, 94 Wn. App. 964, 969, 974 P.2d 35 (1999) ("whenever an injury occurs as a result of health care, the action for damages for that injury is governed exclusively by RCW 7.70"); *Orwick v. Fox*, 65 Wn. App. 71, 86, 828 P.2d 12 (1992) ("[b]y its terms, RCW 7.70 applies to all action against health care providers, whether based on negligence or intentional tort").

8.3.9 Assumption of Risk/Release.

A release by a patient who expressly assumes a specific risk is valid if he has knowledge of the specific risk, appreciates it and understands its nature, and voluntarily chooses to incur it. *Shorter v. Drury*, 103 Wn.2d 645, 652, 695 P.2d 116, *cert. denied*, 474 U.S. 827 (1985) (reducing liability due to release signed by Jehovah's Witness patient who signed release due to her refusal to accept blood transfusion).

A patient release of liability for negligence for a health care provider is not valid because it is against public policy. *Eelbode v. Chec Med. Ctrs., Inc.*, 97 Wn. App. 462, 471-72, 984 P.2d 436 (1999) (release signed prior to pre-employment physical); *Vodopest v. MacGregor*, 128 Wn.2d 840, 861-62, 913 P.2d 779 (1996) (release signed prior to non-therapeutic health study).

External Resource:

WPI 13.00-13.04 (jury instructions re: assumption of risk)

WPI 21.11-.13 (jury instructions re: burden of proof for assumption of risk claims)

8.4 Breach of Standard of Care.

8.4.1 General Rule.

As a general rule, there is no liability to a patient for medical negligence unless there is a breach of the standard of care. To establish liability for a breach of the standard of care, RCW 7.70.040 provides:

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

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

RCW 7.70.040. *E.g., Ripley v. Lanzer*, 152 Wn. App. 296, 306, 215 P.3d 1020 (2009); *Housel v. James*, 141 Wn. App. 748, 758, 172 P.3d 712 (2007); *Seybold v. Neu*, 105 Wn. App. 666, 676-77, 19 P.3d 1068 (2001); *Shellenbarger v. Brigman*, 101 Wn. App. 339, 347, 3 P.3d 211 (2000); *Morinaga v. Vue*, 85 Wn. App. 822, 831, 935 P.2d 637 (1997).

Poor Result Not Evidence of Negligence. A poor result is not, in itself, negligence. *Watson v. Hockett*, 107 Wn.2d 158, 163-64, 727 P.2d 669 (1986); *Miller v. Kennedy*, 91 Wn.2d 155, 158-59, 588 P.2d 734 (1978); *Guile v. Ballard Community Hosp.*, 70 Wn. App. 18, 27, 851 P.2d 689 (1993); *Miller v. Kennedy*, 11 Wn. App. 272, 279, 522 P.2d 852 (1974), *aff'd and adopted*, 85 Wn.2d 151 (1975); *see also Christensen v. Munsen*, 123 Wn.2d 234, 247-48, 867 P.2d 626 (1994) (affirming use of jury instruction re: poor result); *Estate of Lapping v. Group Health Coop.*, 77 Wn. App. 612, 628, 892 P.2d 1116 (1995) (affirming use of jury instruction). Liability is not imposed upon a doctor for an unfavorable, unforeseeable outcome that was not the result of negligence. *Miller v. Kennedy*, 11 Wn. App. 272, 280, 522 P.2d 852 (1974) (“[t]he law does not hold a physician to a standard of infallibility”), *aff'd and adopted*, 85 Wn.2d 151 (1975).

External Resource:

WPI 105.07 (jury instruction re: poor result) [See § 8.9.2 below.]

Exercise of Judgment (Error of Judgment). A physician is not liable for an error in judgment if the physician was confronted with a choice among competing therapeutic techniques or among medical diagnoses and, in arriving at that judgment, the physician exercised reasonable care and skill within the accepted standard of care that the physician was obliged to follow. *Christensen v. Munsen*, 123 Wn.2d 234, 249, 867 P.2d 626 (1994); *Housel v. James*, 141 Wn. App. 748, 760, 172 P.3d 712 (2007); *Ezell v. Hutson*, 105 Wn. App. 485, 489-90, 20 P.3d 975 (2001). If they complied with the standard of care of his peers, the efforts of a physician may be in error without being negligent. *See Watson v. Hockett*, 107 Wn.2d 158, 164, 727 P.2d 669 (1986); *Miller v. Kennedy*, 91 Wn.2d 155, 160-61, 588 P.2d 734 (1978); *Gerard v. Sacred Heart Med. Ctr.*, 86 Wn. App. 387, 388, 937 P.2d 1104 (1997); *Thomas v. Wilfac, Inc.*, 65 Wn. App. 255, 263, 828 P.2d 597 (1992) (“[a] physician is not liable for an error of judgment if, in arriving at that judgment, the physician exercised reasonable care and skill within the standard of care which that physician is obliged to follow”).

External Resource:

WPI 105.08 (jury instruction re: exercise of judgment). [See § 8.9.2 below.]

Wrong Diagnosis. A wrong diagnosis is not in itself negligence. *Keogan v. Holy Family Hosp.*, 95 Wn.2d 306, 327, 622 P.2d 1246 (1980).

Failure to Refer. At least one Washington decision has held that a chiropractor may be considered negligent for a failure to refer a patient to a medical doctor. *Mostrom v. Pettibon*, 25 Wn. App. 158, 163, 167, 607 P.2d 864 (1980). In *Estate of Stalkup v. Vancouver Clinic, Inc., P.S.*, 145 Wn. App. 572, 581-82, 187 P.3d 291 (2008), the failure of the defendant physician to refer to a cardiologist was one of the plaintiff's two theories of negligence (as well as negligent failure to perform an adequate workup). The jury found the physician negligent, but the negligence was not the proximate cause of the patient's death. *Id.*

Burden of Proof. The burden of proof for each fact essential to a claim of medical malpractice is a preponderance of the evidence. RCW 4.24.290; 7.70.030.

External Resource:

WPI 105.03 (jury instruction re: burden of proof for medical negligence claim)

WPI 21.01 (jury instruction re: preponderance of the evidence burden of proof)

A breach of the standard of care may be determined as a matter of law. *Keogan v. Holy Family Hosp.*, 95 Wn.2d 306, 324, 622 P.2d 1246 (1980); *Byerly v. Madsen*, 41 Wn. App. 495, 503, 704 P.2d 1236 (1985).

8.4.2 Expert Testimony.

Generally, the standard of care in a medical malpractice action, and the breach of the standard of care, must be established by expert medical testimony. *Putman v. Wenatchee Valley Med. Ctr.*, 166 Wn.2d 974, 988, 216 P.3d 374 (2009); *Miller v. Jacoby*, 145 Wn.2d 65, 72, 33 P.3d 68 (2001); *Berger v. Sonneland*, 144 Wn.2d 91, 111-12, 26 P.3d 257 (2001); *Douglas v. Freeman*, 117 Wn.2d 242, 248-49, 814 P.2d 1160 (1991); *McLaughlin v. Cooke*, 112 Wn.2d 829, 836, 774 P.2d 1171 (1989); *Young v. Key Pharmaceuticals, Inc.*, 112 Wn.2d 216, 228, 770 P.2d 182 (1989) (“we have found no cases in which a nonphysician is found competent to testify on a physician’s technical medical standard of care in a medical malpractice case”); *Harris v. Robert C. Groth, M.D., Inc., P.S.*, 99 Wn.2d 438, 449, 451, 663 P.2d 113 (1983); *Huttner v. Mackay*, 48 Wn.2d 378, 386, 273 P.2d 766 (1956); *Skodje v. Hardy*, 47 Wn.2d 557, 559, 288 P.2d 471 (1955); *Eakins v. Huber*, 154 Wn. App. 592, 598, 225 P.3d 1041 (2010); *Ripley v. Lanzer*, 152 Wn. App. 296, 315, 215 P.3d 1020 (2009); *Davies v. Holy Family Hosp.*, 144 Wn. App. 483, 492, 183 P.3d 283 (2008); *Hill v. Sacred Heart Med. Ctr.*, 143 Wn. App. 438, 446, 177 P.3d 1152 (2008); *Housel v. James*, 141 Wn. App. 748, 759, 172 P.3d 712 (2007); *Eng v. Klein*, 127 Wn. App. 171, 176, 110 P.3d 844 (2005); *Seybold v. Neu*, 105 Wn. App. 666, 676, 682, 19 P.3d 1068 (2001); *Shellenbarger v. Brigman*, 101 Wn. App. 339, 347, 3 P.3d 211 (2000); *Hall v. Sacred Heart Med. Ctr.*, 100 Wn. App. 53, 59, 995 P.2d 621 (2000); *Bauer v. White*, 95 Wn. App. 663, 667, 976 P.2d 664 (1999); *Morinaga v. Vue*, 85 Wn. App. 822, 831, 935 P.2d 637 (1997); *Guile v. Ballard Community Hosp.*, 70 Wn. App. 18, 25-26, 851 P.2d 689 (1993); *White v. Kent Medical Ctr., Inc., P.S.*, 61 Wn. App. 163, 171, 810 P.2d 4 (1991); *Noel v. King County*, 48 Wn. App. 227, 231, 738 P.2d 692 (1987); *Swanson v. Brigham*, 18 Wn. App. 647, 651, 571 P.2d 217 (1977); *Shoberg v. Kelly*, 1 Wn. App. 673, 677, 467 P.2d 280 (1979). The requirement for expert testimony applies to claims against hospitals as well as individual practitioners. *Douglas v. Freeman*, 117 Wn.2d 242, 249, 814 P.2d 1160 (1991) [See § 8.6.6 below.]

Where a plaintiff fails to present competent expert testimony in a medical negligence case, the defendant is entitled to summary judgment dismissal. *McKee v. American Home Prods. Corp.*, 113 Wn.2d 701, 706-07, 782 P.2d 1045 (1989); *Young v. Key Pharmaceuticals, Inc.*, 112 Wn.2d 216, 226-27, 770 P.2d 182 (1989); *Eakins v. Huber*, 154 Wn. App. 592, 598, 225 P.3d 1041 (2010); *Smith v. Sacred Heart Med. Ctr.*, 144 Wn. App. 537, 542, 184 P.3d 646 (2008); *Seybold v. Neu*, 105 Wn. App. 666, 676, 19 P.3d 1068 (2001); *Morinaga v. Vue*, 85 Wn. App. 822, 829, 935 P.2d 637 (1997); *Guile v. Ballard Community Hosp.*, 70 Wn. App. 18, 26, 851 P.2d 689 (1993).

Level of Certainty. A plaintiff's expert evidence must rise to the level of a "reasonable medical certainty." *Rounds v. Nellcor Puritan Bennett, Inc.*, 147 Wn. App. 155, 163, 194 P.3d 274 (2008); *Davies v. Holy Family Hosp.*, 144 Wn. App. 483, 492, 183 P.3d 283 (2008); *Hill v. Sacred Heart Med. Ctr.*, 143 Wn. App. 438, 448, 177 P.3d 1152 (2008); *Pelton v. Tri-State Mem. Hosp., Inc.*, 66 Wn. App. 350, 355, 831 P.2d 1147 (1992). The expert may not merely state a personal opinion that the expert would have chosen a different course than the defendant. *White v. Kent Med. Ctr.*, 61 Wn. App. 163, 172, 810 P.2d 4 (1991); *Adams v. Richland Clinic, Inc.*, 37 Wn. App. 650, 655, 681 P.2d 1305 (1984); *Versteeg v. Mowery*, 72 Wn.2d 754, 759, 435 P.2d 540 (1967); *Richison v. Nunn*, 57 Wn.2d 1, 16, 340 P.2d 793 (1959), *cert. denied*, 364 U.S. 816 (1960); *but see Ketchum v. Overlake Hosp.*, 60 Wn. App. 406, 413, 804 P.2d 1283 (1991) (disapproving the use of a jury instruction that testimony of other experts stating that they would have followed a different course of treatment is not enough to establish negligence).

It has not been established whether the testimony of a defense expert must necessarily rise to the level or "reasonable certainty" in order to be admissible. For example, could a defense expert testify simply to rebut a plaintiff's expert, or to testify that certainty is impossible? Defendants are entitled to present relevant evidence that "make[s] the existence of any fact ... more probable *or less probable*." ER 401 (emphasis added). As stated in 5 Teglund, Washington Practice: Evidence Law & Practice § 401.3 at 216 (4th ed. 1999):

[T]he test for relevance should not be confused with the burden of proof...To be relevant, it is only necessary that the evidence have "any tendency" to make "any fact that is of consequence" more or less probable—a test that is far less rigorous than proving all necessary elements of a claim by a preponderance of the evidence.

See also, e.g., Kappelman v. Lutz, 167 Wn.2d 1, 9, 217 P.3d 286 (2009) (even minimally relevant evidence is admissible); *Lamborn v. Phillips Pacific Chemical Co.*, 89 Wn.2d 701, 706, 575 P.2d 215 (1978) (facts "tending to ... disprove the testimony of an adversary are relevant").

Speculation and Assumptions Not Sufficient. The expert testimony may not be based on speculation or conjecture. *Rounds v. Nellcor Puritan Bennett, Inc.*, 147 Wn. App. 155, 163, 194 P.3d 274 (2008); *Winkler v. Giddings*, 146 Wn. App. 387, 393, 190 P.3d 117 (2008); *Davies v. Holy Family Hosp.*, 144 Wn. App. 483, 493, 183 P.3d 283 (2008); *Hill v. Sacred Heart Med. Ctr.*, 143 Wn. App. 438, 448, 177 P.3d 1152 (2008); *Seybold v. Neu*, 105 Wn. App. 666, 677, 19 P.3d 1068 (2001). An expert opinion may not be based on assumptions that do not have some kind of a factual basis. *Riccobono v. Pierce County*, 92 Wn. App. 254, 268, 966 P.2d 327 (1998).

Expert Testimony Not Always Necessary or Conclusive. [See § 8.3 above, § 8.4.3 below.] In limited circumstances, the general rule requiring expert testimony is not applied. *Miller v. Jacoby*, 145 Wn.2d 65, 7273, 33 P.3d 68 (2001) (expert testimony not required when medical facts are observable by a layperson's senses and describable without medical training); *McLaughlin v. Cooke*, 112 Wn.2d 829, 838, 774 P.2d 1171 (1989) (expert testimony regarding the standard of care and its breach is not needed where the conduct at issue "is such a gross deviation from ordinary care that a lay person

could easily recognize it”); *Petersen v. State*, 100 Wn.2d 421, 438, 671 P.2d 230 (1983) (same); *Harris v. Robert C. Groth, M.D., Inc., P.S.*, 99 Wn.2d 438, 449, 663 P.2d 113 (1983) (expert testimony may not be required where the “evidence is observable by lay persons and describable without medical training”); *Hill v. Parker*, 12 Wn.2d 517, 529, 122 P.2d 476 (1942) (“[a] malpractice case may be proved without the aid of expert testimony by a chain of circumstances from which an ordinary layman may reasonably and naturally infer the ultimate fact required to be established”); *Ripley v. Lanzer*, 152 Wn. App. 296, 306-07, 215 P.3d 1020 (2009) (relying on *Harris*); *Shellenbarger v. Brigman*, 101 Wn. App. 339, 347, 3 P.3d 211 (2000) (relying on *Hill v. Parker*); *Bauer v. White*, 95 Wn. App. 663, 668, 976 P.2d 664 (1999) (foreign object left in surgical patient); *Morinaga v. Vue*, 85 Wn. App. 822, 829, 832, 935 P.2d 637 (1997) (expert testimony not required in “exceptional circumstances”); *Van Hook v. Anderson*, 64 Wn. App. 353, 359-60, 824 P.2d 509 (1992) (foreign object left in patient). Whether expert testimony is required is a question of law. *Bauer v. White*, 95 Wn. App. 663, 666, 976 P.2d 664 (1999).

The expert testimony may also not be conclusive where the court imposes a higher standard of care than that identified by experts. Where the standard of care of practitioners is itself not reasonably prudent, negligence may be established even where there is expert testimony that the defendant met the standard of care of practitioners. *Helling v. Carey*, 83 Wn.2d 514, 517-19, 519 P.2d 981 (1974) (failure to give simple, harmless, and inexpensive glaucoma pressure test outside the standard of care, even though failure to do so was within the standard of care of his profession); *see also Keogan v. Holy Family Hosp.*, 95 Wn.2d 306, 326, 622 P.2d 1246 (1980) (negligence as a matter of law not to do EKG to rule out heart attack on middle aged man with chest pains brought to the hospital by ambulance in the middle of the night); *Gates v. Jensen*, 92 Wn.2d 246, 252, 595 P.2d 919 (1979) (RCW 4.24.290 did not abrogate *Helling v. Carey* standard). This doctrine applies to both health care providers and hospitals. *Miller v. Jacoby*, 145 Wn.2d 65, 72, 33 P.3d 68 (2001); *Ripley v. Lanzer*, 152 Wn. App. 296, 306-07, 215 P.3d 1020 (2009).

Qualified Experts. To qualify as an expert, the expert testimony must be from a medical expert. RCW 7.70.040(1) (conduct must be measured by that expected of provider “in the profession or class” to which the provider belongs); *Morton v McFall*, 128 Wn. App. 245, 253, 115 P.3d 1023 (2005); *Hall v. Sacred Heart Med. Ctr.*, 100 Wn. App. 53, 59, 995 P.2d 621 (2000) (“an expert medical opinion is required to establish the standard of care”); *White v. Kent Med. Ctr.*, 61 Wn. App. 163, 173, 810 P.2d 4 (1991). The expert witness generally must practice in the relevant profession. *McKee v. American Home Prods. Corp.*, 113 Wn.2d 701, 706, 782 P.2d 1045 (1989) (physician may not testify against a pharmacist); *Young v. Key Pharmaceuticals, Inc.*, 112 Wn.2d 216, 229, 770 P.2d 182 (1989) (pharmacist may not testify against a physician); *Harris v. Robert C. Groth, M.D., Inc., P.S.*, 99 Wn.2d 438, 448, 451, 663 P.2d 113 (1983); *Miller v. Peterson*, 42 Wn. App. 822, 831, 714 P.2d 695 (1986); *Swanson v. Brigham*, 18 Wn. App. 647, 651, 571 P.2d 217 (1977) (same); *Miller v. Kennedy*, 11 Wn. App. 272, 284, 522 P.2d 852 (1974), *aff’d and adopted*, 85 Wn.2d 151 (1975) (expert must be professional equal of the defendant); *see also Huttner v. Mackay*, 48 Wn.2d 378, 386, 273 P.2d 766 (1956) (same).

Specialists: Field of Expertise. The relevant standard of care is derived from the profession or class to which the provider belongs. RCW 7.70.040(1) (health care provider must “exercise that degree of care, skill, and learning expected of a reasonably prudent health care provider at that time *in the profession or class to which he belongs*, in the state of Washington, acting in the same or similar circumstances”) (emphasis added). The proponent of expert testimony bears the burden of establishing testimonial competency. CR 56(e); *Doherty v. Municipality of Metro. Seattle*, 83 Wn. App. 464, 469, 921 P.2d 1098 (1996); *Safeco Ins. Co. v. McGrath*, 63 Wn. App. 170, 817 P.2d 861 (1991). A specialist is held to the standard of care possessed by other members of that specialty. *Dinner v. Thorp*, 54 Wn.2d 90, 97, 33 P.2d 137 (1959); *Atkins v. Clein*, 3 Wn.2d 168, 171, 100 P.2d 1

(1940). The general rule is that “a practitioner of one school of medicine is incompetent to testify as an expert in a malpractice action against a practitioner of another school.” *Eng v. Klein*, 127 Wn. App. 171, 176, 110 P.3d 844 (2005). Several well-established exceptions exist to this rule, which include circumstances where: “(1) the methods of treatment in the defendant’s school and the school of the witness are the same; (2) the method of treatment in the defendant’s school and the school of the witness should be the same; or (3) the testimony of a witness is based on knowledge of the defendant’s own school.” *Miller v. Peterson*, 42 Wn. App. 822, 830-31, 714 P.2d 695 (1986); see also *Hill v. Sacred Heart Med. Ctr.*, 143 Wn. App. 438, 448, 177 P.3d 1152 (2008). “It is the scope of the witness’ knowledge and not the artificial classification by title that should govern the question of admissibility of expert medical testimony in a malpractice case.” *White v. Kent Med. Ctr.*, 61 Wn. App. 163, 174, 810 P.2d 4 (1991). See *Davies v. Holy Family Hosp.*, 144 Wn. App. 483, 494, 183 P.3d 283 (2008) (physician allowed to testify about any medical question “so long as the physician has sufficient expertise to demonstrate familiarity with the medical procedure or problem at issue in the action”; radiologist did not have expertise to testify to standard of care for nursing, physical therapy, or respiratory therapy); *Hill v. Sacred Heart Med. Ctr.*, 143 Wn. App. 438, 448, 451, 455, 177 P.3d 1152 (2008) (physicians [internist and hematologist] may testify to standard of care applicable to gastroenterologist practice general internal medicine and applicable to residents; no lower standard for residents; nurse allowed to testify to nursing standard of care); *Elber v. Larson*, 142 Wn. App. 243, 248-49, 173 P.3d 990 (2007); *Morton v McFall*, 128 Wn. App. 245, 253, 115 P.3d 1023 (2005) (internist qualified to testify against pulmonologist as to standard of care; “[t]here is no general rule that prohibits ... a specialist in one area from testifying about another area”); *Eng v. Klein*, 127 Wn. App. 171, 172, 110 P.3d 844 (2005) (infectious disease expert qualified to testify against neurosurgeon regarding diagnosis of meningitis; diagnostic methods the same; “[i]t is the scope of a witness’s knowledge and not artificial classification by professional title that governs the threshold question of admissibility of expert medical testimony in a malpractice case”); *Seybold v. Neu*, 105 Wn. App. 666, 677-80, 19 P.3d 1068 (2001) (plastic surgeon qualified to testify against orthopedic surgeon regarding cutaneous malignancies and bone grafting, where plastic surgeon also trained and experienced with the disease and treatment); *White v. Kent Med. Ctr.*, 61 Wn. App. 163, 173-74, 810 P.2d 4 (1991) (physician is qualified as an expert where familiarity demonstrated with the procedure or medical problem at issue, even if not a specialist with respect to same; ENT physician qualified to testify as to standard of care for general practitioner); *Miller v. Peterson*, 42 Wn. App. 822, 830, 714 P.2d 695 (1986) (orthopedic surgeon qualified to testify about podiatrist’s standard of care so long as both used the same methods of treatment).

Whether a practitioner is a specialist may be an issue of fact. See *Richards v. Overlake Hosp. Med. Ctr.*, 59 Wn. App. 266, 276, 796 P.2d 737 (1990).

A non-physician is not necessarily precluded from testifying as to the standard of care of a physician or other aspects of medical negligence. *Young v. Key Pharmaceuticals, Inc.*, 112 Wn.2d 216, 227, 770 P.2d 182 (1989); *Harris v. Robert C. Groth, M.D., Inc., P.S.*, 99 Wn.2d 438, 449-50, 663 P.2d 113 (1983) (“the line between chemistry, biology, and medicine is too indefinite to admit of a practicable separation of topics and witnesses”) (citations omitted); *Douglas v. Bussabarger*, 73 Wn.2d 476, 482, 428 P.2d 829 (1968) (“[t]estimony of doctors is not the only type of evidence which may be considered by juries when deciding whether or not physicians are guilty of malpractice”); *Swanson v. Hood*, 99 Wash. 506, 514-15, 170 P. 135 (1918) (osteopath may testify against allopath); *Housel v. James*, 141 Wn. App. 748, 760, 172 P.3d 712 (2007); *White v. Kent Med. Ctr.*, 61 Wn. App. 163, 173, 810 P.2d 4 (1991) (osteopath may testify against allopath); *Breit v. St. Luke’s Hosp.*, 49 Wn. App. 461, 465, 743 P.2d 1254 (1987) (pharmacologist allowed to testify as to adverse effects of injection when given in upright position; “the modern trend in the law is not to impose per se limitations on the testimony of otherwise qualified nonphysicians, i.e., less reliance on formal titles

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and degrees ... whether an expert is licensed to practice medicine is an important, but not dispositive, factor to be considered ... as to whether an expert is qualified”).

A specialist may testify as to the standard of care of a general practitioner, although the general practitioner is not normally held to the standard of care of the specialist. *Morton v McFall*, 128 Wn. App. 245, 253, 115 P.3d 1023 (2005) (“[t]here is no general rule that prohibits a specialist from testifying regarding the standard of care applicable to a general practitioner”); *Eng v. Klein*, 127 Wn. App. 171, 177 n.10, 110 P.3d 844 (2005); *White v. Kent Med. Ctr.*, 61 Wn. App. 163, 173, 810 P.2d 4 (1991). The test is whether the physician has sufficient expertise to demonstrate familiarity with the medical problem at issue. *White v. Kent Med. Ctr.*, 61 Wn. App. at 173, The witness must measure the defendant’s treatment by the criteria of the defendant’s own school of medicine. *Id.*

A physician is competent to present expert testimony on the standard of care of nurses if the physician has expertise regarding the standard of care. *Eng v. Klein*, 127 Wn. App. 171, 177 n.10, 110 P.3d 844 (2005); *Hall v. Sacred Heart Med. Ctr.*, 100 Wn. App. 53, 60, 995 P.2d 621 (2000); *cf. Davies v. Holy Family Hosp.*, 144 Wn. App. 483, 495-96, 183 P.3d 283 (2008) (radiologist lacked expertise in relevant standards of care for nurses, physical therapists, dietitians, and other nonphysician employees).

The plaintiff may obtain from the defendant, testifying as an adverse witness, the required expert testimony to establish the standard of care. *Douglas v. Freeman*, 117 Wn.2d 242, 250, 814 P.2d 1160 (1991).

Generally Accepted Scientific Theory. ER 702 requires that an expert’s opinion must be based on a theory generally accepted in the scientific community. *E.g., State v. Copeland*, 130 Wn.2d 244, 255-60, 922 P.2d 1304 (1996); *Reese v. Stroh*, 128 Wn.2d 300, 907 P.2d 282 (1995); *Eakins v. Huber*, 154 Wn. App. 592, 598, 225 P.3d 1041 (2010); *Ruff v. Dept. of Labor & Indus.*, 107 Wn. App. 289, 299-300, 28 P.3d 1 (2001); *State v. Black*, 46 Wn. App. 259, 262, 730 P.2d 698 (1986).

A party may not obtain admission of testimony based on scientific experimental procedures that are not generally accepted in the relevant scientific community. *Eakins v. Huber*, 154 Wn. App. 592, 598-99, 225 P.3d 1041 (2010); *Burkett v. Northern*, 43 Wn. App. 143, 144, 715 P.2d 1159 (1986). The test is whether the scientific principles from which the deductions are made are sufficiently established to have general acceptance in the relevant scientific community as being reliable and accurate. *Burkett v. Northern*, 43 Wn. App. 143, 144, 715 P.2d 1159 (1986) (excluding evidence of injury based on thermographic photography).

State of Washington standard. The standard of care is defined by the state as a whole, not by testimony as to local practices. *Pederson v. Dumouchel*, 72 Wn.2d 73, 79, 431 P.2d 973 (1967) (rejecting “locality rule”); *Adams v. Richland Clinic, Inc.*, 37 Wn. App. 650, 654-56, 681 P.2d 1305 (1984) (testimony as to local standard of care improper).

An expert must be prepared to testify as to the standard of care of a practitioner practicing in the state of Washington. *See McKee v. American Home Prods. Corp.*, 113 Wn.2d 701, 707, 782 P.2d 1045 (1989) (Arizona physician may not testify to standard of care of Washington pharmacist).

Where the evidence shows that the standard of care differs depending on the area of the country, and the health care provider’s preference and training, the expert must be familiar with the standard of care in Washington. *Winkler v. Giddings*, 146 Wn. App. 387, 393, 190 P.3d 117 (2008). Expert testimony that the standard of care is a national standard and the same in Washington may be sufficient. *Elber v. Larson*, 142 Wn. App. 243, 249, 173 P.3d 990 (2007) (expert testified that

standard was a national standard); *Eng v. Klein*, 127 Wn. App. 171, 178-80, 110 P.3d 844 (2005). A physician is not held to a national standard of care where there is no evidence of a national standard. *Versteeg v. Mowery*, 72 Wn.2d 754, 757, 435 P.2d 540 (1967); compare *Meeks v. Marx*, 15 Wn. App. 571, 550 P.2d 1158 (1976) (“[w]e ... decline the invitation to define the area in geographical terms, be they broad or narrow”).

Treating Physicians as Experts. The plaintiff may obtain from the defendant, testifying as an adverse witness, the required expert testimony to establish the standard of care. *Douglas v. Freeman*, 117 Wn.2d 242, 250, 814 P.2d 1160 (1991). A defendant may call a patient’s treating physician as an expert witness for the defense, where the testimony is relevant and not unduly prejudicial under ER 403. *Carson v. Fine*, 123 Wn.2d 206, 219, 867 P.2d 626 (1994). A treating physician, whose knowledge and opinions were not derived in anticipation of litigation, is not a consulting expert under CR 26. *Paiya v. Durham Constr. Co.*, 69 Wn. App. 578, 579, 849 P.2d 660 (1993); *Peters v. Ballard*, 58 Wn. App. 921, 930, 795 P.2d 1158 (1990).

The opinion of a physician who developed the opinion for purposes of an industrial insurance claim and not for purposes of litigation or trial may be admitted as nonexpert testimony. *Kimball v. Otis Elevator Co.*, 89 Wn. App. 169, 175-76, 947 P.2d 1275 (1997).

The testimony of a physician who performed an independent medical examination on behalf of the insurer is protected by the work product doctrine and may not be admitted by the opposing party in a personal injury action. See *Harris v. Drake*, 152 Wn.2d 480, 489, 99 P.3d 872 (2004).

Number of Experts. The number of experts permitted to testify for each party is an issue of cumulativeness addressed to the sound discretion of the trial court. *Bays v. St. Luke’s Hosp.*, 63 Wn. App. 876, 884, 825 P.2d 319 (1992).

Consulting Experts. A party may choose to retain some experts as consultants but not call them as witnesses at trial; in such circumstances, the opinions of those experts may not be discoverable. [See § 8.7.7.1 below.]

External Resource:

ER 702-705 (evidence rules re: experts)

WPI 2.10 (jury instruction re: expert testimony)

8.4.3 Res Ipsa Loquitor: Inference of Negligence.

Certain circumstances allow the finder of fact to make an inference of negligence even in the absence of expert testimony or other evidence of negligence. E.g., *Curtis v. Lien*, ___ Wn.2d ___, 239 P.2d 1078 (2010); *Pacheco v. Ames*, 149 Wn.2d 431, 436, 69 P.3d 324 (2003); *Miller v. Jacoby*, 145 Wn.2d 65, 74, 33 P.3d 68 (2001); *Douglas v. Bussabarger*, 73 Wn.2d 476, 482, 428 P.2d 829 (1968); *Ripley v. Lanzer*, 152 Wn. App. 296, 315, 215 P.3d 1020 (2009) (plaintiff not required to present expert testimony where elements of res ipsa are met). This rule of res ipsa loquitor (“the thing speaks for itself”), “is to be used sparingly because it, in effect, spares the plaintiff the necessity of establishing a complete prima facie case against the defendant.” *Kimball v. Otis Elevator Co.*, 89 Wn. App. 169, 177, 947 P.2d 1275 (1997); see also *Ripley v. Lanzer*, 152 Wn. App. 296, 308, 215 P.3d 1020 (2009) (res ipsa “is ordinarily sparingly applied ‘in peculiar and exceptional cases, and only where the facts and the demands of justice make its application essential’”); *Tinder v. Nordstrom, Inc.*, 84 Wn. App. 787, 790, 929 P.2d 1209 (1997) (same); *Nelson v. Murphy*, 42 Wn.2d 737, 740, 258 P.2d 472 (1953) (medical malpractice case; “a mere bad result will not invoke the doctrine of res ipsa loquitor”). The res ipsa loquitor doctrine allows the jury to infer negligence where three elements are met: (1) the accident or occurrence producing the injury is of a kind that ordinarily does not occur

absent someone's negligence; (2) the injuries were caused by an agency or instrumentality within the exclusive control of the defendant; and (3) the injury-causing accident or occurrence was not due to any voluntary action or contribution on the part of the plaintiff. *Curtis v. Lien*, ___ Wn.2d ___, 239 P.2d 1078 (2010); *Pacheco v. Ames*, 149 Wn.2d 431, 436, 69 P.3d 324 (2003); *Miller v. Jacoby*, 145 Wn.2d 65, 74, 33 P.3d 68 (2001); *Horner v. Northern Pac. Beneficial Ass'n Hosps., Inc.*, 62 Wn.2d 351, 359, 382 P.2d 518 (1963); *Ripley v. Lanzer*, 152 Wn. App. 296, 307, 215 P.3d 1020 (2009); *Kimball v. Otis Elevator Co.*, 89 Wn. App. 169, 177, 947 P.2d 1275 (1997); *Andrews v. Burke*, 55 Wn. App. 622, 627, 779 P.2d 740 (1989); *Swanson v. Brigham*, 18 Wn. App. 647, 649, 571 P.2d 217 (1977). The res ipsa doctrine uses circumstantial evidence to prove a breach of duty. E.g., *Miller v. Jacoby*, 145 Wn.2d 65, 74, 33 P.3d 68 (2001); *Pederson v. Dumouchel*, 72 Wn.2d 73, 81, 431 P.2d 973 (1967) (“[a] case in which the doctrine of res ipsa loquitor applies is a circumstantial-evidence case”); *Ripley v. Lanzer*, 152 Wn. App. 296, 307, 215 P.3d 1020 (2009).. The res ipsa doctrine does not apply unless there is a reasonable probability that the alleged injury-producing event did in fact occur. *Marshall v. Western Air Lines*, 62 Wn. App. 251, 259-60, 813 P.2d 1269 (1991). The doctrine “has no applicability when there is evidence that the accident could occur without negligence on the defendant's part.” *Kimball v. Otis Elevator Co.*, 89 Wn. App. 169, 177, 947 P.2d 1275 (1997). A plaintiff presenting a res ipsa theory “retains the ultimate burden of persuading the court” that negligence has occurred. *Robison v. Cascade Hardwoods, Inc.*, 117 Wn. App. 552, 563-64, 72 P.3d 244 (2003).

Whether the res ipsa doctrine applies to a specific circumstance is an issue of law. *Pacheco v. Ames*, 149 Wn.2d 431, 436, 69 P.3d 324 (2003); *Zukowsky v. Brown*, 79 Wn.2d 586, 596, 488 P.2d 269 (1971); *Nelson v. Murphy*, 42 Wn.2d 737, 739, 258 P.2d 472 (1953); *Ripley v. Lanzer*, 152 Wn. App. 296, 308, 215 P.3d 1020 (2009); *DeHaven v. Gant*, 42 Wn. App. 666, 673, 713 P.2d 149 (1986).

Satisfaction of the first element does not require the plaintiff to eliminate with certainty all other possible causes of the injury other than negligence. *Curtis v. Lien*, ___ Wn.2d ___, 239 P.2d 1078, 1083 (2010). To satisfy the first element requires that one of several factors be met: (1) the act causing the injury is so palpably negligent that it may be inferred as a matter of law; (2) the general experience and observation of mankind teaches that the result would not be expected without negligence; or (3) proof by experts in an esoteric field creates an inference that negligence caused the injury. *ZeBarth v. Swedish Hosp. Med. Ctr.*, 81 Wn.2d 12, 19, 499 P.2d 1 (1972); *Zukowsky v. Brown*, 79 Wn.2d 586, 595, 488 P.2d 269 (1971); *Horner v. Northern Pac. Beneficial Ass'n Hosps., Inc.*, 62 Wn.2d 351, 360, 382 P.2d 518 (1963); *Ripley v. Lanzer*, 152 Wn. App. 296, 312, 215 P.3d 1020 (2009); *Tate v. Perry*, 52 Wn. App. 257, 263, 758 P.2d 999 (1988); *Swanson v. Brigham*, 18 Wn. App. 647, 650, 571 P.2d 217 (1977). To satisfy the first element, it is not sufficient to demonstrate that the injury rarely occurs. *Andrews v. Burke*, 55 Wn. App. 622, 627, 779 P.2d 740 (1989) (no error in refusing to instruct on res ipsa; the event was “not so unusual or extraordinary as to infer that it was caused by negligence”); *Swanson v. Brigham*, 18 Wn. App. 647, 650, 571 P.2d 217 (1977) (a “bad result” by itself is not enough to warrant the application of the doctrine). Where an accident may have occurred as the result of one of two causes, the reason for the res ipsa rule fails and it cannot be invoked. *Adams v. Western Host, Inc.*, 55 Wn. App. 601, 606, 779 P.2d 281 (1989); *but see Douglas v. Bussabarger*, 73 Wn.2d 476, 485-86, 438 P.2d 829 (1968) (where only possible alternate cause is indefinite abnormality or unexplainable reaction, res ipsa can still be applied).

The second element prevents the use of the res ipsa doctrine where the defendant does not have exclusive control over the injury-producing event. *Pacheco v. Ames*, 149 Wn.2d 431, 437, 69 P.3d 324 (2003); *Howell v. Spokane & Inland Empire Blood Bank*, 114 Wn.2d 42, 58, 785 P.2d 815 (1990) (doctrine does not apply to claim against hospital for injury from HIV-contaminated infusion because hospital did not have exclusive control over the transfused blood); *Zukowsky v. Brown*, 79 Wn.2d 586, 595, 488 P.2d 269 (1971) (“[t]o satisfy this requirement, the degree of control must be exclusive

to the extent that it is a legitimate inference that defendant's control extended to the instrumentality causing injury or damage"); *Ripley v. Lanzer*, 152 Wn. App. 296, 313, 215 P.3d 1020 (2009); *DeHaven v. Gant*, 42 Wn. App. 666, 675, 713 P.2d 149 (1986) (doctrine does not apply to claim against anesthesiologist for nerve damage to arm where there was no showing that the anesthesiologist had control over plaintiff's arm during the surgery). There must also be a corresponding lack of control by the injured party to take action to avoid the injury. *ZeBarth v. Swedish Hosp. Med. Ctr.*, 81 Wn.2d 12, 19, 499 P.2d 1 (1972); *Ripley v. Lanzer*, 152 Wn. App. 296, 306-07, 215 P.3d 1020 (2009). Because the purpose of the res ipsa doctrine is to require the defendant to produce evidence explaining the cause of an injury that the plaintiff cannot explain, exclusive control by the defendant of the injury-producing event is an essential element of liability. *Pacheco v. Ames*, 149 Wn.2d 431, 437, 69 P.3d 324 (2003).

The third element of the test "has little relevance and is generally merged into the second element" due to "the advent of comparative fault." *Kimball v. Otis Elevator Co*, 89 Wn. App. 169, 177, 947 P.2d 1275 (1997). [See § 8.5.5 below.]

Where all three elements are satisfied, it is appropriate to give the res ipsa instruction. *ZeBarth v. Swedish Hosp. Med. Ctr.*, 81 Wn.2d 12, 22, 499 P.2d 1 (1972); *Brown v. Dahl*, 41 Wn. App. 565, 582-83, 705 P.2d 781 (1985); WPI 22.01; *but see Zukowsky v. Brown*, 79 Wn.2d 586, 602, 488 P.2d 269 (1971) (res ipsa instruction not necessary because the circumstantial evidence instruction adequately covered the theory). The plaintiff may be entitled to rely on the res ipsa doctrine even if the defendant's testimony would explain how the event causing the injury to the plaintiff occurred. *Pacheco v. Ames*, 149 Wn.2d 431, 440, 69 P.3d 324 (2003). The defendant may still offer reasons other than negligence for the occurrence. *Curtis v. Lien*, __ Wn.2d __, 239 P.2d 1078, 1083 (2010).

The res ipsa doctrine is applicable in the appropriate circumstances to claims against doctors and hospitals. *Miller v. Jacoby*, 145 Wn.2d 65, 74, 33 P.3d 68 (2001) ("[u]nder circumstances proper to its application, res ipsa loquitor can apply to physicians and hospitals"); *see also Pacheco v. Ames*, 149 Wn.2d 431, 437, 69 P.3d 324 (2003) (doctrine applicable where dentist drilled on wrong side of mouth); *ZeBarth v. Swedish Hosp. Med. Ctr.*, 81 Wn.2d 12, 20-21, 499 P.2d 1 (1972) (res ipsa instruction proper in case of paraplegia following radiation therapy for Hodgkin's disease; no dispute that radiation therapy caused the injury); *Pederson v. Dumouchel*, 72 Wn.2d 73, 81-82, 431 P.2d 973 (1967) (res ipsa loquitor doctrine applies where patient did not awaken from general anesthesia for a month and then awoke with brain damage); *Leach v. Ellensburg Hosp. Ass'n*, 65 Wn.2d 925, 400 P.2d 611 (1965) (reversing directed verdict for hospital; issue of fact whether the hospital had exclusive control); *Horner v. Northern Pac. Beneficial Ass'n Hosps., Inc.*, 62 Wn.2d 351, 359-60, 382 P.2d 518 (1963) (inference of negligence appropriate where patient awoke after hysterectomy surgery with paralyzed arm); *Ripley v. Lanzer*, 152 Wn. App. 296, 308, 215 P.3d 1020 (2009) (applying res ipsa to claims against doctor and hospital for scalpel blade left following surgery); *Brown v. Dahl*, 41 Wn. App. 565, 582-83, 705 P.2d 781 (1985) (error not to give instruction where airway was blocked during anesthesia, resulting in cardiac arrest and physical and mental impairments); *Miller v. Kennedy*, 11 Wn. App. 272, 279, 522 P.2d 852 (1974), *aff'd and adopted*, 85 Wn.2d 151 (1975) (error not to instruct on res ipsa where biopsy needle was inserted into a calyceal area of the kidney); *Stone v. Sisters of Charity*, 2 Wn. App. 607, 612, 469 P.2d 229 (1970) ("[t]here is no doubt that the doctrine of res ipsa loquitor is applicable to a physician, a hospital and nurse"). In many circumstances, however, the res ipsa doctrine is not applicable in the context of medical malpractice claims. *E.g.*, *Andrews v. Burke*, 55 Wn. App. 622, 628, 779 P.2d 740 (1989) (no application of doctrine to claim of negligence in resuscitation efforts); *Tate v. Perry*, 52 Wn. App. 257, 264, 758 P.2d 999 (1988) (no application of doctrine to claim of encephalopathy following CT scan in the absence of expert testimony as to causation of injury, or that the injury does not occur in the absence of negligence); *Mason v. Ellsworth*, 3 Wn. App. 298, 305, 474 P.2d 909 (1970) (no

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application of doctrine to claim of perforation of esophagus during esophagoscopy; expert testimony did not support inference that perforation does not occur in the absence of negligence); *Stone v. Sisters of Charity*, 2 Wn. App. 607, 612, 469 P.2d 229 (1970) (no application to plaintiff's claim of negligence resulting in post-surgery infection); *Shoberg v. Kelly*, 1 Wn. App. 673, 677-78, 463 P.2d 280 (1969) (no application of doctrine to claim of vesicovaginal fistula following hysterectomy; expert testimony required).

Foreign Objects Left in Patient's Body. The res ipsa doctrine has been used where a foreign object is left in a patient's body. A surgeon may be held negligent as a matter of law for leaving a surgical instrument or other foreign object in the patient's body. *E.g.*, *McCormick v. Jones*, 152 Wn.2d 508, 510-11, 278 P. 181 (1929) (foreign substance); *Conrad v. Lakewood Gen'l Hosp.*, 67 Wn.2d 934, 937, 410 P.2d 785 (1966) (surgical instrument); *Ripley v. Lanzer*, 152 Wn. App. 296, 311, 215 P.3d 1020 (2009) (scalpel blade); *Bauer v. White*, 95 Wn. App. 663, 668, 976 P.2d 664 (1999) (metal positioning pin; "[s]imply put, it is not reasonable prudence to unintentionally leave a foreign substance in a surgical patient").

The inference of negligence with regard to foreign objects may be dispelled, however. *Miller v. Jacoby*, 145 Wn.2d 65, 73, 33 P.3d 68 (2001) (Penrose drain intentionally left in patient; portion remained when removed; "proper use, purpose, and insertion of a Penrose drain are not within the common understanding or experience of a layperson"). Where a surgical sponge was left in the patient, the evidence raised an inference of negligence by the responsible surgeon; however, the inference was dispelled by additional evidence that the nurses were responsible for sponge counts, that they told the surgeon that the count was correct, that the surgeon complied with the standard of care by relying on the nurses, and that the surgeon in fact relied on the nurses' count. *Van Hook v. Anderson*, 64 Wn. App. 353, 362-63, 824 P.2d 509 (1992) (only possible remaining basis for liability was if the surgeon was vicariously liable for the nurses' conduct).

External Resource:

WPI 22.01 (jury instruction re: res ipsa loquitor)

8.5 Causation and Damages.

8.5.1 Elements of Causation.

A medical malpractice plaintiff has the burden to prove that the breach of the standard of care, or the lack of informed consent, was a proximate cause of the injury complained of. RCW 7.70.040(2); 7.70.050(1)(d). A jury verdict that a health care provider was negligent but did not cause the plaintiff's injury is not internally inconsistent. *Estate of Stalkup v. Vancouver Clinic, Inc., P.S.*, 145 Wn. App. 572, 585-86, 187 P.3d 291 (2008).

External Resource:

WPI 15.01 – 15.02 (jury instructions re: proximate cause)

The question of proximate causation may still be an issue of fact even though negligence has been established as a matter of law. *See Keogan v. Holy Family Hosp.*, 95 Wn.2d 306, 328, 622 P.2d 1246 (1980); *Byerly v. Madsen*, 41 Wn. App. 495, 503, 704 P.2d 1236 (1985).

Causation in Informed Consent Claim. Where lack of informed consent is claimed, the plaintiff must also prove that "a reasonably prudent patient under similar circumstances would not have consented to the treatment if informed of such material fact or facts." RCW 7.70.050(1)(c). The reasonably prudent patient standard requires proof that a reasonably prudent person in plaintiff's position would have chosen a different course, and is not satisfied by testimony that the plaintiff herself would have

chosen a different course of treatment. *Keogan v. Holy Family Hosp.*, 95 Wn.2d 306, 323, 622 P.2d 1246 (1980); *Miller v. Kennedy*, 11 Wn. App. 272, 290 n.11, 522 P.2d 852 (1974), *aff'd and adopted*, 85 Wn.2d 151 (1975); *ZeBarth v. Swedish Hosp. Med. Ctr.*, 81 Wn.2d 12, 31, 499 P.2d 1 (1972). A plaintiff can prove proximate causation for purposes of an informed consent claim by establishing an uninterrupted chain of circumstances ending in her injury. *Adams v. Richland Clinic, Inc.*, 37 Wn. App. 650, 661, 681 P.2d 1305 (1984).

8.5.2 Expert Testimony re: Causation and Damages.

As a general rule, expert medical testimony on the issue of proximate cause is required in a medical malpractice action, in addition to the expert testimony as to the standard of care and its breach. *Berger v. Sonneland*, 144 Wn.2d 91, 111-12, 26 P.3d 257 (2001) (requiring expert medical evidence as to causation where causation is not observable by lay persons); *Reese v. Stroh*, 128 Wn.2d 300, 308, 907 P.2d 282 (1995) (“the general rule in Washington is that expert testimony on the issue of proximate cause is required in medical malpractice cases”); *Douglas v. Freeman*, 117 Wn.2d 242, 249, 814 P.2d 1160 (1991); *Young v. Key Pharmaceuticals, Inc.*, 112 Wn.2d 216, 228, 770 P.2d 182 (1989); *McLaughlin v. Cooke*, 112 Wn.2d 829, 837, 774 P.2d 1171 (1989) (“[a]s a general rule, expert medical testimony on the issue of proximate cause is also required in medical malpractice cases”); *Harris v. Robert C. Groth, M.D., Inc., P.S.*, 99 Wn.2d 438, 449, 451, 663 P.2d 113 (1983) (expert testimony will “usually be necessary to prove causation”); *Reese v. Stroh*, 128 Wn.2d 300, 308, 907 P.2d 282 (1995) (“the general rule in Washington is that expert medical testimony on the issue of proximate cause is required in medical malpractice cases”); *O’Donoghue v. Riggs*, 73 Wn.2d 814, 824, 440 P.2d 823 (1968); *Seybold v. Neu*, 105 Wn. App. 666, 676, 19 P.3d 1068 (2001); *Eakins v. Huber*, 154 Wn. App. 592, 598, 225 P.3d 1041 (2010); *Ripley v. Lanzer*, 152 Wn. App. 296, 306-07, 215 P.3d 1020 (2009); *Rounds v. Nellcor Puritan Bennett, Inc.*, 147 Wn. App. 155, 162-63, 194 P.3d 274 (2008); *Davies v. Holy Family Hosp.*, 144 Wn. App. 483, 492, 183 P.3d 283 (2008); *Hill v. Sacred Heart Med. Ctr.*, 143 Wn. App. 438, 448, 177 P.3d 1152 (2008); *Morinaga v. Vue*, 85 Wn. App. 822, 833, 935 P.2d 637 (1997) (“[u]nder *Harris*, causation also requires expert testimony”); *Coggle v. Snow*, 56 Wn. App. 499, 510, 784 P.2d 554 (1990) (“[t]he plaintiff generally must offer proof [of the elements of a medical negligence action] through the testimony of expert medical witnesses”); Where a plaintiff fails to present expert medical testimony as to causation, the defendant is entitled to summary judgment dismissal of the plaintiff’s claim. *E.g.*, *McKee v. American Home Prods. Corp.*, 113 Wn.2d 701, 70607, 782 P.2d 1045 (1989); *Rounds v. Nellcor Puritan Bennett, Inc.*, 147 Wn. App. 155, 165, 194 P.3d 274 (2008); *Fabrique v. Choice Hotels Intern., Inc.*, 144 Wn. App. 675, 685, 183 P.3d 1118 (2008); *Davies v. Holy Family Hosp.*, 144 Wn. App. 483, 492-93, 183 P.3d 283 (2008); *Morinaga v. Vue*, 85 Wn. App. 822, 832, 935 P.2d 637 (1997); *Noel v. King County*, 48 Wn. App. 227, 233, 738 P.2d 692 (1987) (affirming summary judgment dismissal of medical negligence claim where plaintiff “failed to show by expert medical testimony that there is any issue of material fact as to the breach of any applicable standard of care”); *see also Seybold v. Neu*, 105 Wn. App. 666, 676, 19 P.3d 1068 (2001). Summary judgment is not appropriate in a medical malpractice action, however, where a reasonable person could infer, from the facts, circumstances, and medical testimony, that a causal connection exists. *Shellenbarger v. Brigman*, 101 Wn. App. 339, 348, 3 P.3d 211 (2000) (reversing summary judgment); *Attwood v. Albertson’s Food Ctrs., Inc.*, 92 Wn. App. 326, 330, 966 P.2d 351 (1998) (reversing summary judgment).

Level of Certainty. The medical testimony must establish that the event at issue probably or more likely than not caused the claimed injury, and must reasonably exclude as a probability every hypothesis other than the one relied on. *O’Donoghue v. Riggs*, 73 Wn.2d 814, 824, 440 P.2d 823 (1968); *Rounds v. Nellcor Puritan Bennett, Inc.*, 147 Wn. App. 155, 163, 194 P.3d 274 (2008); *Davies v. Holy Family Hosp.*, 144 Wn. App. 483, 493, 183 P.3d 283 (2008); *Fabrique v. Choice Hotels Intern., Inc.*, 144 Wn. App. 675, 688, 183 P.3d 1118 (2008) (affirming dismissal of action for

lack of sufficient causation testimony; testimony must demonstrate that the injury “probably” or “more likely than not” caused the subsequent condition, rather than that the injury “might have,” “could have,” or “possibly did” cause the subsequent condition); *Hill v. Sacred Heart Med. Ctr.*, 143 Wn. App. 438, 448, 177 P.3d 1152 (2008); *Shellenbarger v. Brigman*, 101 Wn. App. 339, 348, 3 P.3d 211 (2000); *Attwood v. Albertson’s Food Ctrs., Inc.*, 92 Wn. App. 326, 331, 966 P.2d 351 (1998); *Richards v. Overlake Hosp. Med. Ctr.*, 59 Wn. App. 266, 278 n.3, 796 P.2d 737 (1990); *Merriman v. Toothaker*, 9 Wn. App. 810, 814, 515 P.2d 509 (1973).

Speculation Not Sufficient. The degree of proof of causation must be sufficient to avoid speculation or conjecture. *Reese v. Stroh*, 128 Wn.2d 300, 309, 907 P.2d 282 (1995); *McLaughlin v. Cooke*, 112 Wn.2d 829, 837, 774 P.2d 1171 (1989); *O’Donoghue v. Riggs*, 73 Wn.2d 814, 824, 440 P.2d 823 (1968); *Attwood v. Albertson’s Food Ctrs., Inc.*, 92 Wn. App. 326, 331, 966 P.2d 351 (1998). Testimony based on speculation or conjecture includes testimony that the injury “might have” or “possibly did” result from the hypothesized cause. *O’Donoghue v. Riggs*, 73 Wn.2d 814, 824, 440 P.2d 823 (1968); *Rounds v. Nellcor Puritan Bennett, Inc.*, 147 Wn. App. 155, 163, 194 P.3d 274 (2008); *Attwood v. Albertson’s Food Ctrs., Inc.*, 92 Wn. App. 326, 331, 966 P.2d 351 (1998).

Where experts differed as to what the cause of the injury was, the court may give a special instruction on proximate cause to inform the jury that the causal relationship must be established by evidence that rises above “speculation, conjecture, or mere possibility.” *McLaughlin v. Cooke*, 112 Wn.2d 829, 837, 774 P.2d 1171 (1989) (evidence is insufficient where “the jury must resort to speculation or conjecture in determining the causal relationship”); *Young v. Group Health*, 85 Wn.2d 332, 340, 534 P.2d 1349 (1975) (approving jury instruction stating rule where proximate cause is central issue in the case); *O’Donoghue v. Riggs*, 73 Wn.2d 814, 824, 440 P.2d 823 (1968); *Vanderhoff v. Fitzgerald*, 72 Wn.2d 103, 108, 431 P.2d 969 (1967) (approving jury instruction stating rule); *Seybold v. Neu*, 105 Wn. App. 666, 677, 19 P.3d 1068 (2001); *Shellenbarger v. Brigman*, 101 Wn. App. 339, 348, 3 P.3d 211 (2000); *Attwood v. Albertson’s Food Ctrs., Inc.*, 92 Wn. App. 326, 331, 966 P.2d 351 (1998) (“that the defendant’s actions ‘might have,’ ‘could have,’ or ‘possibly did’ cause the subsequent condition is insufficient”); *Richards v. Overlake Hosp. Med. Ctr.*, 59 Wn. App. 266, 278 n.3, 796 P.2d 737 (1990). WPI 105.03, 21.01.

Proximity Not Sufficient. Causation cannot be inferred from a proximity of events. *See, e.g., Anica v. Wall-Mart Stores, Inc.*, 120 Wn. App. 481, 489, 84 P.3d 1231 (2004) (“coincidence is not proof of causation”; rejecting party’s causation argument because it “relies on a logical fallacy-post hoc, ergo propter hoc or ‘after this, therefore because of this’”); *Guile v. Ballard Community Hosp.*, 70 Wn. App. 18, 27, 851 P.2d 689 (1993) (“negligence cannot be inferred from the mere fact that [the plaintiff] suffered from complications following her surgery”); *see also Anton v. Chicago*, 92 Wash. 305, 308, 159 P. 115 (1916) (affirming dismissal and rejecting speculative testimony of medical expert; “The law demands that verdicts rest upon testimony and not upon conjecture and speculation. There must be some proofs connecting the consequence with the cause relied upon”); *see also Jennings v. Palomar Pomerado Health Systems, Inc.*, 114 Cal. App. 4th 1108, 1120 n.12, 8 Cal. Rptr. 3d 363 (2004) (upholding exclusion of medical expert testimony; expert testimony must be to a reasonable medical probability that the negligent act was a cause-in-fact of the plaintiff’s injury, and must illuminate why the facts have convinced the expert; expert “must provide some articulation of how the jury, if it possessed his or her training and knowledge and employed it to examine the known facts, would reach the same conclusion as the expert”); *but see Teig v. St. John’s Hosp.*, 63 Wn.2d 369, 381, 387 P.2d 527 (1963) (plaintiff need only show a chain of circumstances from which the ultimate fact required to be established is naturally and reasonably inferable; expert testimony did show causation).

Expert Testimony Not Always Necessary. Expert testimony is not required to prove every element of causation. *Douglas v. Freeman*, 117 Wn.2d 242, 252, 814 P.2d 1160 (1991) (“[i]t 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”); *McLaughlin v. Cooke*, 112 Wn.2d 829, 837, 774 P.2d 1171 (1989) (“expert medical testimony [as to causation] is not necessary if the questioned practice of the profession is such a gross deviation from ordinary care that a lay person could easily recognize it”); *Ripley v. Lanzer*, 152 Wn. App. 296, 324, 215 P.3d 1020 (2009).

Qualification of Experts. Causation expert testimony must generally be provided by a medical doctor. *Colwell v. Holy Family Hosp.*, 104 Wn. App. 606, 613, 15 P.3d 210 (2001); *Hall v. Sacred Heart Med. Ctr.*, 100 Wn. App. 53, 59, 995 P.2d 621 (2000) (“an expert medical opinion is required to establish the standard of care and most aspects of causation in medical negligence cases”); *Dobbins v. Commonwealth Aluminum Co.*, 54 Wn. App. 788, 791-92, 776 P.2d 139 (1989) (no abuse of discretion in refusing to consider chiropractor testimony as to medical causation); *but see Harris v. Robert C. Groth, M.D., Inc., P.S.*, 99 Wn.2d 438, 449-50, 663 P.2d 113 (1983) (causation expert testimony “may be provided by nonphysicians” where “the trial court finds them qualified”; “the line between chemistry, biology, and medicine is too indefinite to admit of a practicable separation of topics and witnesses”) (citations omitted). A nurse may be qualified to provide expert testimony as to causation in a nursing negligence case. *Hill v. Sacred Heart Med. Ctr.*, 143 Wn. App. 438, 446, 177 P.3d 1152 (2008) (overruling *Colwell v. Holy Family Hosp.*, 104 Wn. App. 606, 613, 15 P.3d 210 (2001)). . [See also § 8.4.2 above; § 8.9.1 below.]

8.5.3 Measure of Damages; Evidence of Damages.

Determination of the amount of an award of damages is uniquely within the province of the jury. *Bingaman v. Grays Harbor Comm. Hosp.*, 103 Wn.2d 831, 835, 699 P.2d 1230 (1985). A damages award will not be disturbed unless it is outside the range of substantial evidence, shocks the conscience, or was reached as the unmistakable result of passion or prejudice. *Adcox v. Children’s Orthopedic Hosp. & Med. Ctr.*, 123 Wn.2d 15, 32, 864 P.2d 921 (1993); *Bingaman*, 103 Wn.2d at 835. The evidence need not fix the amount of damages with mathematical certainty. *Omer v. Edgren*, 38 Wn. App. 376, 382, 685 P.2d 635 (1984).

A statutory cap on noneconomic damages is unconstitutional as it violates the state constitutional right to a jury trial. *Sofie v. Fibreboard Corp.*, 112 Wn.2d 636, 656, 771 P.2d 711, 780 P.2d 260 (1989). Damages determinations are a constitutionally consigned jury function. *Id.*

Elements Considered. An award of damages may properly include as a factor the loss of enjoyment of life, independent of recovery for pain and suffering. *Kirk v. Washington State Univ.*, 109 Wn.2d 448, 460-62, 746 P.2d 285 (1987). A damages award may include consideration of the decedent’s mental anguish resulting from the realization of impending death. *Bingaman v. Grays Harbor Comm. Hosp.*, 103 Wn.2d 831, 837-38, 699 P.2d 1230 (1985).

External Resource: WPI 30.00-30.18.01 (jury instructions re: damages)
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Medical Expenses. A plaintiff is permitted to recover the reasonable value of the medical services they receive not the total of all bills paid. *Hayes v. Wieber*, 105 Wn. App. 611, 616, 20 P.3d 496 (2001). The amount actually billed or paid is not itself determinative. *Hayes v. Wieber*, 105 Wn. App. 611, 20 P.3d 496 (2001) (no abuse of discretion in refusing to admit evidence that plaintiff’s physician accepted amount paid by insurance company as payment in full). The question is whether

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the sums requested for medical services are reasonable. *Hayes v. Wieber*, 105 Wn. App. 611, 616, 20 P.3d 496 (2001).

The burden of proving the reasonableness and necessity of medical expenses rests with the plaintiff. *Patterson v. Horton*, 84 Wn. App. 531, 543, 929 P.2d 1125 (1997). Medical expenses must be both reasonable and necessary to be recovered as damages. See, e.g., *Palmer v. Jensen*, 132 Wn.2d 193, 199, 937 P.2d 597 (1997). To be reasonable and necessary, medical expenses must be attributable to the defendant's negligence, not to any other event, and not due to any exaggerated injuries. *Kadmiri v. Claassen*, 103 Wn. App. 146, 151, 10 P.3d 1076 (2000); *Hawkins v. Marshall*, 92 Wn. App. 38, 45-46, 962 P.2d 834 (1998).

External Resource: WPI 30.07.01-30.07.02 (jury instructions re: medical expenses)
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Lost Wages and Lost Earning Capacity. A plaintiff is entitled to recover the reasonable value of lost wages and lost earning capacity. RCW 4.56.250; see also, e.g., *Sherman v. City of Seattle*, 57 Wn.2d 233, 246, 356 P.2d 316 (1960) (lost earning capacity for three year-old); *Riddel v. Lyon*, 124 Wash. 146, 150-51, 213 P.2d 487 (1923) (lost earning capacity for unemployed 71 year-old).

External Resource: WPI 30.08.01 (jury instruction re: lost wages and lost earning capacity)
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Relevant Evidence re: Damages. Although the causation of damages must be established by expert medical testimony, the testimony of other health care witnesses may be relevant as to the measure of damages. E.g., *Saldivar v. Momah*, 145 Wn. App. 365, 398, 186 P.3d 1117 (2008) (social worker may testify to existence of PTSD and its effects). Trial courts retain broad discretion in determining whether an expert is qualified to testify on health-related matters and will be reversed only for manifest abuse. *Goodman v. Boeing Co.*, 75 Wn. App. 60, 79, 877 P.2d 703 (1994) (allowing testimony from a registered nurse regarding future care needs).

Life Expectancy. The award for damages should be calculated based upon the life expectancy of the plaintiff. *Ramirez v. Diamond*, 70 Wn. App. 729, 732-34, 855 P.2d 338 (1993); *Lofgren v. Western Wash. Corps. of Seventh Day Adventists*, 65 Wn.2d 144, 147-48, 396 P.2d 139 (1964); *Bradshaw v. City of Seattle*, 43 Wn.2d 766, 784, 264 P.2d 265 (1953).

External Resource: WPI 34.04 (jury instruction re: mortality tables used for calculation of life expectancy)

Need for Future Care. A registered nurse with relevant experience is competent to testify as to a patient's future need for care. *Goodman v. Boeing Co.*, 75 Wn. App. 60, 79-81, 877 P.2d 703 (1994).

Present Value of Damages. An award of future economic damages must be for the present cash value of those damages. *Kellerher v. Porter*, 29 Wn.2d 650, 673-76, 189 P.2d 223 (1948); see also *Bartlett v. Hantover*, 84 Wn.2d 426, 432-33, 526 P.2d 1217 (1974) (present value must be explained to the jury); *Hinzman v. Palmanteer*, 81 Wn.2d 327, 335-36, 501 P.2d 1228 (1972) (jury must be given guidelines about interest rate to apply). Expert testimony as to the cost of an annuity is admissible on the issue of the present cash value of future losses. *Cornejo v. State*, 57 Wn. App. 314, 325-29, 788 P.2d 554 (1990).

External Resource:

WPI 34.02 (jury instruction re: present cash value of future economic damages)

Periodic Payments. Where a verdict includes an award of more than \$100,000 in future economic damages, the court shall allow for periodic payment of that portion of the award. RCW 4.56.260. Adequate security must be posted. *Id.* The award may be adjusted downward upon the death of the claimant. *Id.*

Pre-Existing Injuries or Conditions. An award of damages must isolate and ignore any damages that would result from a pre-existing condition. *See* WPI 30.17 (providing limiting instruction for damages resulting from pre-existing bodily condition that was causing pain or disability prior to alleged act of negligence); WPI 30.18 (providing same for pre-existing bodily condition that was not causing pain or disability prior to alleged act of negligence); *Hoskins v. Reich*, 142 Wn. App. 557, 570, 174 P.3d 1250 (2008) (only evidence of the natural progression of a pre-existing condition is relevant to damages; periodic use of chiropractic services before and after injury, without more, does not affect damages); *Torno v. Hayek*, 133 Wn. App. 244, 252-53, 135 P.3d 536 (2006) (affirming use of jury instruction to exclude recovery for injuries that would have resulted from natural progression of the pre-existing condition). Where evidence is in dispute about whether a pre-existing condition was causing pain prior to the alleged act of negligence, it is proper to give a jury instruction based upon both WPI 30.17 and WPI 30.18. *See, e.g., Thogerson v. Heiner*, 66 Wn. App. 466, 474, 832 P.2d 508 (1992) (“whenever the evidence is in dispute as to the existence of a preexisting condition or disability, it is appropriate to use instructions based on both WPI 30.17 and 30.18 as were the instructions in this case”); *Wagner v. Monteilh*, 43 Wn. App. 908, 911, 720 P.2d 847 (1986) (where the plaintiff had a preexisting injury, the plaintiff must show evidence as to which injuries were probably attributable to the plaintiff’s initial injury and which were probably attributable to the physician’s negligence); *Bowman v. Whitelock*, 43 Wn. App. 353, 359, 717 P.2d 303 (1986) (upholding jury instruction combining WPI 30.17 and WPI 30.18 where parties disputed whether plaintiff’s preexisting degenerative spinal condition was causing pain at time plaintiff was injured in seaplane accident). The rule requiring isolation of pre-existing injuries applies to pre-existing mental conditions as well as preexisting physical conditions. *Xieng v. Peoples National Bank*, 63 Wn. App. 572, 582-83, 821 P.2d 520 (1991).

External Resource:

WPI 30.17 – 30.18 (jury instructions re: pre-existing injuries).

Subsequent Injury. Where a physician has caused injury, the physician is also liable for any aggravation of that injury by the subsequent negligence of another physician in treating that injury. *Lindquist v. Dengel*, 92 Wn.2d 257, 262, 595 P.2d 934 (1979); *Peters v. Ballard*, 58 Wn. App. 921, 931, 795 P.2d 1158 (1990).

Unreasonable Failure to Mitigate. A plaintiff may not recover damages proximately caused by that person’s unreasonable failure to mitigate by securing treatment. *Fox v. Evans*, 127 Wn.2d 300, 301, 111 P.3d 267 (2005) (plaintiff refused diagnosis of depression and would have improved if treatment obtained); *Cox v. Keg Restaurants, Inc.*, 86 Wn. App. 239, 233, 935 P.2d 1377 (1997) (evidence must be sufficient to support submission of issue to jury; expert testimony may be required where causation involves “obscure medical factors”).

External Resource:

WPI 33.01-33.03 (jury instructions re: mitigation of damages)

Community Property Considerations. Recovery for injury to a married spouse is the separate property of the injured spouse. *Brown v. Brown*, 100 Wn.2d 729, 739, 675 P.2d 1207 (1984). Recovery for income or expenses is community property. *Id.* A special verdict form should be used to allow for separate awards of the community and separate property items.

Damages for Outrage/NIED Claims. Specific evidence of damages is required for certain claims, such as claims for outrage or negligent infliction of emotional distress. [See § 8.6.4 below.]

Punitive Damages. No recovery is allowed for punitive or exemplary damages, unless specifically authorized by statute. *Dailey v. North Coast Life Ins. Co.*, 129 Wn.2d 572, 574-75, 919 P.2d 589 (1996); *see generally* WPI 35.01.

8.5.4 Loss of Chance.

A plaintiff may be entitled to damages for loss of chance of survival based upon a defendant's failure to timely diagnose, even where the plaintiff already had a less than 50% chance of survival based on the existing injury. *Herskovits v. Group Health*, 99 Wn.2d 609, 619, 664 P.2d 474 (1983). An instruction on loss of chance of survival is permitted only if the evidence shows: (1) a substantial reduction in chance of survival, and (2) that the defendant's negligence caused the reduction. *Zueger v. Public Hosp. Dist. No. 2*, 57 Wn. App. 584, 591, 789 P.2d 326 (1990). The plaintiff may recover only the amount representing the value of the chance destroyed by a defendant's negligent conduct. *Herskovits v. Group Health*, 99 Wn.2d 609, 619, 664 P.2d 474 (1983); *Shellenbarger v. Brigman*, 101 Wn. App. 339, 349, 3 P.3d 211 (2000) (recognizing claim for loss 20 percent chance of slowing disease and increasing life expectancy); *Zueger v. Public Hosp. Dist. No. 2*, 57 Wash. App. 584, 589, 789 P.2d 326 (1990).

Where the patient has not developed cancer, evidence of an increased risk of developing cancer is not admissible to establish damages for that increased risk, but may be admissible as a damage factor for plaintiff's current reasonable fear of contracting cancer. *Sorenson v. Raymark Indus.*, 51 Wn. App. 954, 956-58, 756 P.2d 740 (1988); *see also Koker v. Armstrong Cork, Inc.*, 60 Wn. App. 466, 482-83, 804 P.2d 659 (1991).

External Resource:

WPI 105.09 (jury instruction re: loss of chance)

8.5.5 Joint and Several Liability/Contribution/Apportionment.

Apportionment. Under the principles of proportionate liability adopted in the 1986 Tort Reform Act, as modified, a negligent party is generally liable for its own proportionate share of fault and no more. RCW 4.22.070; *Kottler v. State*, 136 Wn.2d 437, 443, 445, 963 P.2d 834 (1998); *Washburn v. Beatt Equipment Co.*, 120 Wn.2d 246, 294, 840 P.2d 860 (1992). The sum of the percentages of the total fault attributed to at-fault entities must equal one hundred percent. RCW 4.22.070(1). All entities, including the plaintiff, defendants, third-party defendants, and defendants released through settlement agreements, are included in the determination. *Id.* The court then enters judgment against each defendant, in an amount representing that party's proportionate share of the plaintiff's total damages, with the exception that, as to those to whom fault has been apportioned, but who have been released through settlement prior to trial or are otherwise not defendants, no judgment is entered.¹ *Id.*

¹ Apportionment includes the assignment of fault to immune entities, such as employers who are immune from liability under industrial insurance statutes. RCW 51.24.060(1)(f); *Clark v. PacifiCorp.*, 118 Wn.2d 167, 822 P.2d 162 (1991).

A non-settling defendant in a proceeding can assert that another entity, including a settling defendant, is at fault; that party must present sufficient evidence of the other entity's fault in order for fault to be apportioned to that entity. *Adcox v. Children's Orthopedic Hosp. & Med. Ctr.*, 123 Wn.2d 15, 25-26, 864 P.2d 921 (1993); *see also* CR 12(i) (requiring defendants to assert non-party entity fault as an affirmative defense). Only the plaintiff, however, can assert that another person is liable to the plaintiff. *Mailloux v. State Farm*, 76 Wn. App. 507, 511, 887 P.2d 449 (1995). If a defendant proves that an entity other than another defendant is at fault, that entity is not liable to the plaintiff (because the plaintiff has made no claim against that entity), but that entity's fault operates to reduce the proportionate share of damages that the plaintiff can recover from those against whom the plaintiff has made a claim. *Id.* at 512.

Joint and Several Liability. While proportionate liability is the general rule, *Washburn v. Beatt Equip. Co.*, 120 Wn.2d 246, 294, 840 P.2d 860 (1992), joint and several liability remains in two distinct situations. RCW 4.22.070(1)(a)-(b); *Mazon v. Krafchick*, 158 Wn.2d 440, 451, 144 P.3d 1168 (2006).²

- (a) *Acting in concert.* Under the first scenario, each defendant is jointly and severally liable where they were *acting in concert* or where a person was acting as an agent or servant of a party. RCW 4.22.070(1)(a). Joint and several liability under this scenario, however, extends only to the proportionate shares of the defendants who were acting in concert. *Id.* In order to be found to be "acting in concert" for the purposes of this provision, the parties must be found to be "consciously act[ing] together in an unlawful manner." *Kottler*, 136 Wn.2d at 449.
- (b) *Non-fault plaintiff.* Under the second scenario, each defendant is jointly and severally liable where the *plaintiff is not at fault*. RCW 4.22.070(1)(b). Where the plaintiff is not at fault, each defendant is jointly and severally liable only for the combined proportionate shares of all those defendants *against whom judgment is entered*. *Id.* (emphasis added). Therefore, *settling parties*, released parties, and immune parties are not parties against whom judgment is entered, and will not be jointly and severally liable under this second statutory exception. *Id.*; *Mazon v. Krafchick*, 158 Wn.2d 440, 452, 144 P.3d 1168 (2006); *Kottler v. State*, 136 Wn.2d at 446-47; *Washburn*, 120 Wn.2d at 294; *Allstate Ins. Co. v. Batacan*, 139 Wn.2d 443, 451, 986 P.2d 823 (1999). The non-settling defendants are not jointly and severally liable for the fault of settling defendants. *c Washburn*, 120 Wn.2d at 294-95. As the court explained in *Kottler v. State*, 136 Wn.2d at 446-47:

This modified joint and several liability differs from traditional joint and several liability in three respects. First, it arises only if plaintiff is fault-free. Second, parties held jointly and severally liable will be jointly and severally liable only for the sum of their proportionate liability. Third, the only parties that will be jointly and severally liable are "the defendants against whom judgment is entered." RCW 4.22.0170(1)(b). Settling parties, released parties, and immune parties are not parties against whom judgment is entered and will not be jointly and severally liable under RCW 4.22.070(1)(b). *Washburn*, 120 Wn.2d at 294; *Anderson*, 123 Wn.2d at 852 (a released party "cannot under any reasonable interpretation of RCW 4.22.070(1)(b) be a defendant against whom judgment is entered."). Likewise, parties not named in the underlying suit are not "defendants against whom judgment is entered."

² A third situation involves hazardous waste, tortious interference with business, and unmarked fungible goods such as asbestos. RCW 4.22.070(3)(a)-(c).

Only in the limited circumstances where parties are jointly and severally liable may one of such parties then seek contribution from another jointly and severally liable defendant. *Mazon*, 158 Wn.2d at 451; *Kottler*, 136 Wn.2d at 448 (“[c]ontribution still has vitality, but only when joint and several liability exists—now an infrequent occurrence”) (quoting Stewart A. Estes, *The Short Happy Life of Litigation Between Tortfeasors: Contribution, Indemnification and Subrogation After Washington’s Tort Reform Acts*, 21 Seattle U.L. Rev. 69, 70 (1997)); *Washburn*, 120 Wn.2d at 295; RCW 4.22.070(2); RCW 4.22.060(2). As one commentator noted:

[U]nder the 1986 Act, the percentage share of fault of released parties has already been deducted from the amount of the plaintiff’s judgment, thus eliminating the need for a separate credit. Thus, in most cases where the plaintiff is found to be at fault, the amount of settlement credit will become irrelevant, since the plaintiff will only be able to obtain a judgment against the remaining defendants in the amount of that defendant’s proportionate share. The burden is upon the defendant who seeks to limit his liability to a percentage share to introduce evidence upon which the jury could base an allocation of fault as between the defendant and some other entity. On the other hand, where a plaintiff is free from fault, judgment will be entered against the non-settling defendants for the sum of their respective percentage shares. Unless a settlement takes place after judgment is entered, there is no place for a settlement credit.

DeWolf & Allen, *Washington Practice Vol. 16, Tort Law and Practice*, § 12.52, p. 279 (West 2000).

Contribution. Under RCW 4.22.070, contribution may be obtained only from other defendants “against whom judgment has been entered.” Contribution may also be obtained where an independent basis for contribution exists. *E.g.*, *Kirk v. Moe*, 114 Wn.2d 550, 556, 789 P.2d 84 (1990) (negligent employee released by settlement still liable for contributions to settling employer). Where an entity cannot be one against whom judgment could be entered, then there can be no claim for contribution against that entity. *Gerrard v. Craig*, 122 Wn.2d 288, 298-99, 857 P.2d 1033 (1993) (no contribution against a party as to whom the plaintiff’s statute of limitations had run). The statute of limitations for a contribution action is one year from the date the judgment is final. RCW 4.22.050(3).

8.5.6 Award of Damages; Periodic Payments.

Where a verdict or award in a personal injury action is made for an amount of at least \$100,000, a party may request the court to enter a judgment that provides for periodic payments of the future economic damages. RCW 4.56.260; *Dutra v. United States*, 478 F.3d 1090, 1090 (9th Cir. 2007).

8.6 Special Damage and Liability Considerations.

8.6.1 Wrongful Death/Survival Actions.

8.6.1.1 Wrongful Death Action.

Where the patient has died, the estate has a claim for wrongful death under RCW 4.20.010. Wrongful death actions are not recognized under common law, and so are defined entirely by the terms of the statute. *Tait v. Wahl*, 97 Wn. App. 765, 771-72, 987 P.2d 127 (1999). A wrongful death action may only be brought by the personal representative, not by any family member or beneficiary. *E.g.*, *Rose v. Fritz*, 104 Wn. App. 116, 119, 15 P.3d 1062 (2001); *Benoy v. Simons*, 66 Wn. App. 56, 59, 831 P.2d 167 (1992). Even though the wrongful death action may only be brought by the personal representative, the action may not be settled

without the consent of the beneficiary. *Ebsary v. Pioneer Human Servs.*, 59 Wn. App. 218, 226-27, 796 P.2d 769 (1990).

Beneficiaries of Wrongful Death Action. The statute identifies who may benefit from the estate's wrongful death action, specifically, the spouse, state registered domestic partner, and children, including stepchildren. RCW 4.20.020. If there is no spouse, state registered domestic partner, or such child or children, then the action may benefit the parents or siblings who may be dependent upon the deceased person for support, and who are resident in the United States at the time of the death. RCW 4.20.020. There is no recovery for a spouse that has been separated from the decedent with no intention to reconcile. *Parrish v. Jones*, 44 Wn. App. 449, 457-58, 722 P.2d 878 (1986). Where there is no beneficiary in existence from the list of statutory beneficiaries, there is no cause of action. *Schumacher v. Williams*, 107 Wn. App. 793, 804-05, 28 P.3d 792 (2001); *Benoy v. Simons*, 66 Wn. App. 56, 59, 831 P.2d 167 (1992) (no cause of action for grandparents); *Masunaga v. Gapasin*, 57 Wn. App. 624, 628, 790 P.2d 171 (1990) (no cause of action for parties not identified in statute); *Long v. Dugan*, 57 Wn. App. 309, 312, 788 P.2d 1 (1990) (no cause of action for minor siblings of deceased); *Roe v. Ludtke Trucking, Inc.*, 46 Wn. App. 816, 821, 732 P.2d 1021 (1987) (no cause of action for unmarried partner of deceased).

The jury instruction usually names each beneficiary on the verdict form. *Cornejo v. State*, 57 Wn. App. 314, 332, 788 P.2d 554 (1990).

Statute of Limitations. A three-year statute of limitations applies to wrongful death actions based upon medical malpractice. See RCW 4.16.080(2); *Wills v. Kirkpatrick*, 56 Wn. App. 757, 763, 785 P.2d 834 (1990). The limitation period for a wrongful death action is not tolled by the minority of a beneficiary. *Atchison v. Great Western Malting Co.*, 161 Wn.2d 372, 382, 166 P.3d 662 (2007); *Huntington v. Samaritan Hosp.*, 101 Wn.2d 466, 470, 680 P.2d 58 (1984). The "discovery rule" applies to wrongful death actions, and provides that a cause of action accrues at the time the personal representative, discovered or reasonably should have discovered all of the facts establishing the essential elements of his or her cause of action, *i.e.*, duty, breach, causation, and damages. *White v. Johns-Manville Corp.*, 103 Wn.2d 344, 353, 693 P.2d 687 (1985); *Allen v. State*, 60 Wn. App. 273, 275, 803 P.2d 54 (1991). [See § 8.2.1 above.] Where there is no proof of death, the statute of limitation for a wrongful death action (RCW 4.16.080) does not begin to run until the plaintiff can present evidence of death by way of legal presumption. *Nelson v. Schubert*, 98 Wn. App. 754, 762, 994 P.2d 225 (2000).

Recoverable Damages. Recoverable damages in a wrongful death action are for the injuries to the pecuniary interests of the statutory beneficiaries including, in addition to monetary contributions, compensation for the loss of other services such as the "love, affection, care, companionship, society, and consortium" of the deceased spouse. *Bowers v. Fiberboard Corp.*, 66 Wn. App. 454, 461, 832 P.2d 523 (1992); see also *Hatch v. Tacoma Police Dept.*, 107 Wn. App. 586, 587-89, 27 P.3d 1223 (2001).

A claim for loss of consortium is an element of the recoverable damages in a wrongful death action, but it is not an independent cause of action. *Hatch v. Tacoma Police Dept.*, 107 Wn. App. 586, 589, 27 P.3d 1223 (2001); *Long v. Dugan*, 57 Wn. App. 309, 313, 788 P.2d 1 (1990). It may only be brought by the personal representative. *Hatch v. Tacoma Police Dept.*, 107 Wn. App. 586, 589, 27 P.3d 1223 (2001).

Noneconomic damages are distributed to the statutory beneficiaries based upon the standards for intestate succession. *Parrish v. Jones*, 44 Wn. App. 449, 457, 722 P.2d 878 (1986).

In an action brought for wrongful death, the contributory fault of the decedent is imputed to the claimant in the wrongful death action. RCW 4.22.020. *Ginocchio v. Hesston Corp.*, 46 Wn. App. 843, 846, 733 P.2d 551 (1987).

8.6.1.2 Survival Action.

Where the patient has died, the personal injury claim survives under two separate statutes, RCW 4.20.046 and .060. Survival actions preserve the causes of action that the decedent could have brought had he or she survived. *Otani ex rel. Shigaki v. Broudy*, 151 Wn.2d 750, 755, 92 P.3d 192 (2004). Survival statutes “govern predeath damages.” *Id.* Neither statute creates a new cause of action, but preserves actions that a decedent could have brought had he or she survived. *Id.* at 762. “The purpose of awarding damages under the survival statutes is to remedy the common law anomaly which allowed tort victims to sue if they survived but barred their claims if they died.” *Id.* at 755. A survival action may be brought on behalf of, among others, a viable unborn child. *Cavazos v. Franklin*, 73 Wn. App. 116, 120, 867 P.2d 674 (1994).

Statute of Limitations. A three-year statute of limitations applies to survival actions based upon personal injury. See RCW 4.16.080(2); *Wills v. Kirkpatrick*, 56 Wn. App. 757, 763, 785 P.2d 834 (1990). The “discovery rule” applies to survival actions, and provides that the cause of action accrues “at the earliest time at which the decedent or his personal representative knew, or should have known, the causal relationship between” the alleged tort and the injury. *White v. Johns-Manville Corp.*, 103 Wn.2d 344, 359-60, 693 P.2d 687 (1985) (“Since the decedent would have benefited from the discovery rule had he not died, his representatives should likewise benefit from it: what survives to the personal representatives are not only the decedent’s ripe causes of action but include their potential causes of action which may not have accrued at the time of death”); *Allen v. State*, 60 Wn. App. 273, 275, 803 P.2d 54 (1991). [See § 8.2.1 above.]

General Survival Action (RCW 4.20.046). RCW 4.20.046 is referred to as the general survival statute, which preserves all causes of action, “whether such actions arise on contract or otherwise,” that a decedent could have brought if he or she survived. *Otani ex rel. Shigaki v. Broudy*, 151 Wn.2d 750, 755-56, 92 P.3d 192 (2004). The cause of action survives to the decedent’s personal representative. RCW 4.20.046. Recovery under RCW 4.20.046 is for the benefit of, and passes through, the estate. *Otani ex rel. Shigaki v. Broudy*, 151 Wn.2d 750, 756, 92 P.3d 192 (2004); *Tait v. Wahl*, 97 Wn. App. 765, 772, 987 P.2d 127 (1999).

Recoverable Damages: General Survival Action. Recoverable damages in a survival action are the damages to which the decedent would have been entitled had he or she survived. *Otani ex rel. Shigaki v. Broudy*, 151 Wn.2d 750, 755, 756 n.3, 92 P.3d 192 (2004) (damages include medical expenses and assets of decedent’s estate, which includes any cause of action). Recoverable damages consist of the economic loss to the estate from the decedent’s net lost income that the estate would have acquired if the decedent had survived to the expected life time. *Federated Services v. Estate of Norberg*, 101 Wn. App. 119, 126, 4 P.3d 844 (2000). The amount of the lost income is reduced to a net value by the deduction of all probable expenditures of the decedent, and is reduced to present value. *Wagner v. Flightcraft, Inc.*, 31 Wn. App. 558, 569, 643 P.2d 906 (1982). The recovery is the net accumulations which the estate would have acquired if the decedent had survived to the expected life time. *Federated Services v. Estate of Norberg*, 101 Wn. App. 119, 126, 4 P.3d 844 (2000); *Warner v. McCaughan*, 77 Wn.2d 178, 181, 460 P.2d 272 (1969). Recoverable damages also include the funeral expenses for the deceased. *Federated Services v. Estate of Norberg*, 101 Wn. App. 119, 127 n.1, 4 P.3d 844 (2000).

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(prepared from reference materials available as of January 1, 2011)

The personal representative “shall only be entitled to recover damages for pain and suffering, anxiety, emotional distress, or humiliation personal to and suffered by the deceased on behalf of those beneficiaries enumerated in RCW 4.20.020.” RCW 4.20.046. Recoverable damages under RCW 4.20.046 do not include postdeath damages for loss of enjoyment of life. *Otani ex rel. Shigaki v. Broudy*, 151 Wn.2d 750, 761, 92 P.3d 192 (2004).

Special Survival Action (RCW 4.20.060). RCW 4.20.060 is referred to as the special survival statute, which addresses specifically the survival of the claim for personal injury that results in death. *Otani ex rel. Shigaki v. Broudy*, 151 Wn.2d 750, 756, 92 P.3d 192 (2004). Recovery under RCW 4.20.060 is for the benefit of, and is distributed directly to, the statutory beneficiaries. *Id.*

Beneficiaries. Valid statutory beneficiaries in a special survival action include the surviving spouse, state registered domestic partner, and living children or stepchildren. RCW 4.20.060. If there is no spouse, state registered domestic partner, or such child or children, then the action may benefit the parents or siblings who may be dependent upon the deceased person for support, and who are resident in the United States at the time of the death. RCW 4.20.060. There is no recovery for a spouse that has been separated from the decedent with no intention to reconcile. *Parrish v. Jones*, 44 Wn. App. 449, 457-58, 722 P.2d 878 (1986). A child, state registered domestic partner, or spouse does not need to show dependency to obtain damages in a survival action. *Higbee v. Shorewood Osteopathic Hosp.*, 105 Wn.2d 33, 39, 711 P.2d 306 (1985). No other parties may benefit from a special survival action. *Tait v. Wahl*, 97 Wn. App. 765, 771, 987 P.2d 127 (1999). Where there is no beneficiary in existence from the list of statutory beneficiaries, there is no cause of action under RCW 4.20.060. *Schumacher v. Williams*, 107 Wn. App. 793, 804-05, 28 P.3d 792 (2001). A parent also has a separate cause of action for the death of a child if the decedent was a minor or if the parent was financially dependent on the decedent child. RCW 4.24.010. [See § 8.6.1.3 below.]

Recoverable Damages: Special Survival Action. Recoverable damages in a survival action under RCW 4.20.060 may include damages for pain and suffering and other noneconomic damages, including loss of enjoyment of life, but the damages must be consciously experienced by the decedent prior to death, and do not include any recovery for the death itself. RCW 4.20.060; *Otani ex rel. Shigaki v. Broudy*, 151 Wn.2d 750, 758-62, 92 P.3d 192 (2004); *Bowers v. Fiberboard Corp.*, 66 Wn. App. 454, 461, 832 P.2d 523 (1992). Noneconomic damages are distributed to the statutory beneficiaries based upon the standards for intestate succession. *Parrish v. Jones*, 44 Wn. App. 449, 457, 722 P.2d 878 (1986).

A claim for loss of consortium may be brought for damages suffered by the surviving spouse before the decedent’s death. *Hatch v. Tacoma Police Dept.*, 107 Wn. App. 586, 590, 27 P.3d 1223 (2001).

External Resource:

WPI 31.00-31.07.01 (jury instructions re: damages in wrongful death and survival actions)

WPI 32.01-32.06.01 (jury instructions re: injury to spouse, parent, or child)

8.6.1.3 Death of a Child.

A parent who has regularly contributed to the support of his or her minor child may also recover under a special statute for the injury or death of the minor child. RCW 4.24.010; *e.g.*, *Postema v. Postema Enterprises, Inc.*, 118 Wn. App. 185, 196-97, 72 P.3d 1122 (2003); *Cavazos v. Franklin*, 73 Wn. App. 116, 117, 867 P.2d 674 (1994) (RCW 4.24.010 provides

an remedy additional to 4.20.010 and RCW 4.20.046 for the death of a child); *Benoy v. Simons*, 66 Wn. App. 56, 59, 831 P.2d 167 (1992) (no cause of action for grandparents). The statute provides a remedy that is an alternative to the wrongful death statute. *Cavazos v. Franklin*, 73 Wn. App. 116, 121, 867 P.2d 674 (1994); *Masunaga v. Gapasin*, 57 Wn. App. 624, 627-28, 790 P.2d 171 (1990); *Machek v. Seattle*, 118 Wash. 42, 45, 203 P. 25 (1921).

The statute allows for recovery for the death of a viable fetus, but not for the death of a nonviable unborn fetus. *Moen v. Hanson*, 85 Wn.2d 597, 601, 537 P.2d 266 (1975 (viable fetus)); *Baum v. Barrington*, 119 Wn. App. 36, 42-43, 79 P.3d 456 (2003) (nonviable fetus).

The parent may also recover for the injury or death of a child on whom the parent was dependent for support. RCW 4.24.010; e.g., *Armantrout v. Carlson*, 166 Wn.2d 931, 941, 214 P.2d 914 (2009) (trier of fact may consider services when assessing dependency); *Masunaga v. Gapasin*, 57 Wn. App. 624, 628, 790 P.2d 171 (1990) (financial dependence must be substantial). A parent may not recover for the loss of consortium with an adult child upon whom the parent was not dependent for support. *Philippides v. Bernard*, 151 Wn.2d 376, 388, 88 P.3d 939 (2004); *Shoemaker v. St. Joseph Hosp.*, 56 Wn. App. 575, 578-79, 784 P.2d 562 (1990). [See § 8.6.3 below.]

The statute allows for recovery of damages for the pain and suffering experienced by the parents. RCW 4.24.010; *Cavazos v. Franklin*, 73 Wn. App. 116, 122, 867 P.2d 674 (1994). The statute also allows for recovery of medical expenses, and loss of services and support, loss of love and companionship of the child; and injury to or destruction of the parent-child relationship. RCW 4.24.010; *Balmer v. Dilley*, 81 Wn.2d 367, 371-72, 502 P.2d 456 (1972) (loss of companionship damages not limited to period of decedent's minority); *Skeels v. Davidson*, 18 Wn.2d 358, 369, 139 P.2d 301 (1943) (losses for services and support of minor child limited to period of child's minority); *Mieske v. Public Utility Dist. No. 1*, 42 Wn.2d 871, 873-74, 259 P.2d 647 (1953) (same); *Lockhart v. Besel*, 71 Wn.2d 112, 115, 426 P.2d 625 (1967) (same); see also *Wilson v. Lund*, 80 Wn.2d 91, 96 491 P.2d 1287 (1971) (construing the language 'loss of love ... and ... injury to or destruction of the parent-child relationship' to provide recovery for parental grief, mental anguish, and suffering"). "Loss of love and companionship" and "injury to the parent-child relationship" are separate and distinct items of compensable damage and recovery may be found for each. *Hinzman v. Palmanteer*, 81 Wn.2d 327, 501 P.2d 1228 (1972). Recovery for loss of services and support of a minor child requires proof of services that would have been performed, and must be proven by substantial evidence. *Clark v. Icicle Irrigation Dist.*, 72 Wn.2d 201, 210, 432 P.2d 541 (1967); *Lofgren v. Western Wash. Corp. of Seventh Day Adventists*, 65 Wn.2d 144, 149, 396 P.2d 139 (1964). Recoverable damages are not limited to the period of the child's minority. See generally *Balmer v. Dilley*, 81 Wn.2d 327, 501 P.2d 1228 (1972).

External Resource:

WPI 31.00-31.07.01 (jury instructions re: damages in wrongful death and survival actions)
WPI 32.01-32.06.01 (jury instructions re: damages for injury to spouse, parent, or child)

8.6.2 Wrongful Birth/Wrongful Life.

Wrongful Birth. A parent may maintain an action for the wrongful birth of a child born with congenital defects. *Harbeson v. Parke-Davis, Inc.*, 98 Wn.2d 460, 472, 656 P.2d 483 (1983); *Quimby v. Fine*, 45 Wn. App. 175, 177, 724 P.2d 403 (1986); cf. *Stewart-Graves v. Vaughn*, 162 Wn.2d 115, 130, 170 P.3d 1151 (2007) (no claim for wrongful birth/wrongful life where negligence occurs after birth); *Benoy v. Simons*, 66 Wn. App. 56, 831 P.2d 167 (1992) (same). The proximate cause element of an action for wrongful birth requires proof of cause in fact—i.e., that the injury would not have

occurred but for the health care provider's breach of duty—and proof that the parents would have avoided conception or aborted the fetus if the health care provider had not been negligent. *Harbeson v. Parke-Davis, Inc.*, 98 Wn.2d 460, 475-77, 656 P.2d 483 (1983). Recoverable damages include the extraordinary expenses for medical care and special training resulting from the defect. *Id.* at 477.

A claim for wrongful birth accrues from the date of birth, not from the date of a wrongful conception. *Quimby v. Fine*, 45 Wn. App. 175, 177, 724 P.2d 403 (1986).

Wrongful Conception. The parents of a healthy child may not maintain a cause of action for wrongful conception of a healthy child following an unsuccessful sterilization procedure. *McKernan v. Aasheim*, 102 Wn.2d 411, 420-21, 687 P.2d 850 (1984). Compare *Quimby v. Fine*, 45 Wn. App. 175, 177-78, 724 P.2d 403 (1986) (allowing wrongful birth claim for birth of child with birth defects following an unsuccessful sterilization procedure).

Wrongful Life. A child may also maintain an action for wrongful life for a congenital defect. *Stewart-Graves v. Vaughn*, 162 Wn.2d 115, 122, 133, 170 P.3d 1151 (2007). *Harbeson v. Parke-Davis, Inc.*, 98 Wn.2d 460, 478-83, 656 P.2d 483 (1983). The wrongful life action is the child's equivalent of the parent's wrongful birth action. *Stewart-Graves*, 162 Wn.2d at 122, 133; *Harbeson*, 98 Wn.2d at 478-83. Recoverable damages include the extraordinary expenses resulting from the congenital defect. *Harbeson*, at 482.

Wrongful Prolongation of Life. There is no cause of action for wrongful prolongation of life. *Benoy v. Simons*, 66 Wn. App. 56, 831 P.2d 167 (1992) (action by mother, grandparents, and estate of deceased child).

External Resource:

WPI 31.00-31.07.01 (jury instructions re: damages in wrongful death and survival actions)

WPI 32.01-32.06.01 (jury instructions re: damages for injury to spouse, parent, or child)

8.6.3 Loss of Consortium.

Injury to Spouse. In relation to claims for personal injury, a spouse may make a claim for loss of consortium resulting from the injury of the other spouse. *Oltman v. Holland Am. Line USA, Inc.*, 163 Wn.2d 236, 250, 178 P.3d 981 (2008); *Green v. A.P.C.*, 136 Wash.2d 87, 101, 960 P.2d 912 (1998); *Reichelt v. Johns-Manville Corp.*, 107 Wn.2d 761, 773, 733 P.2d 530 (1987); *Christie v. Maxwell*, 40 Wn. App. 40, 47-48, 696 P.2d 1256 (1985); *Lundgren v. Whitney's, Inc.*, 94 Wn.2d 91, 96, 614 P.2d 1272 (1980). The claim for loss of consortium is a separate cause of action, which may accrue a different time than the claim of the injured party. *Oltman.*, 163 Wn.2d at 250; *Reichelt v. Johns-Manville Corp.*, 107 Wn.2d 761, 776, 733 P.2d 530 (1987); *Christie v. Maxwell*, 40 Wn. App. 40, 44, 696 P.2d 1256 (1985). The spouse's claim for loss of consortium may be pursued separately from the injured spouse's claim. *Oltman.*, 163 Wn.2d at 250; *Lund v. Caple*, 100 Wn.2d 739, 743-44, 675 P.2d 226 (1984). A release signed by the injured spouse, however, may bar a separate consortium action by the non-injured spouse. *Conradt v. Four Star Promotions, Inc.*, 45 Wn. App. 847, 852-53, 728 P.2d 617 (1986); but see *Oltman.*, 163 Wn.2d at 249-50 (spouse allowed to recover for loss of consortium where injured spouse had signed a cruise contract waiving injured spouse's liability claim). In an action governed by industrial insurance, there is no separate cause of action by the worker's spouse against the employer for loss of consortium. *Provost v. Puget Sound Power & Light Co.*, 103 Wn.2d 750, 756, 696 P.2d 1238 (1985); *Ash v. S.S. Mullen, Inc.*, 43 Wn.2d 345, 347, 261 P.2d 118 (1953).

In Relation to a Wrongful Death. A claim for loss of consortium in a wrongful death action under RCW 4.20.010 and .020 is not an independent cause of action, but rather is an element of damages.

The wrongful death statute precludes a separate common law right of action. *Long v. Dugan*, 57 Wn. App. 309, 313, 788 P.2d 1 (1990); *Ginocchio v. Hesston Corp.*, 46 Wn. App. 843, 848, 733 P.2d 551 (1987).

Minor Child's Claim for Injury or Death of Parents. A minor child has a separate cause of action for the loss of consortium with a parent injured by a third party. *Ueland v. Pengo Hydra-Pull Corp.*, 103 Wn.2d 131, 131-32, 691 P.2d 190 (1984); *Kelley v. Centennial Contractors Enters., Inc.*, 169 Wn.2d 381, 383, 236 P.3d 197 (2010); *Cunningham v. Lockard*, 48 Wn. App. 38, 42, 736 P.2d 305 (1987);. A claim for loss of consortium resulting from the loss of a parent allows for recovery of damages for the loss of the parent's love, care, companionship, and guidance. *Ueland v. Pengo Hydra-Pull Corp.*, 103 Wn.2d 131, 132 n.1, 691 P.2d 190 (1984). The loss of love and companionship is a separate element of damages from the destruction of the parent-child relationship. *Hinzman v. Palmanteer*, 81 Wn.2d 327, 329, 501 P.2d 1228 (1972) (action for wrongful death of child). Damages for loss of companionship and destruction of the parent-child relationship are not limited to the period of the child's minority. *Balmer v. Dilley*, 81 Wn.2d 367, 372, 502 P.2d 456 (1972). The child's action should be joined with the parent's action unless it is shown why joinder is not feasible. *Ueland v. Pengo Hydra-Pull Corp.*, 103 Wn.2d 131, 141, 691 P.2d 190 (1984); *see also Kelley v. Centennial Contractors Enters., Inc.*, 169 Wn.2d 381, 390, 236 P.3d 197 (2010) (fact issues about whether joinder was feasible preclude summary judgment dismissal of a later filed action by minor children).

Parents' Claim for Injury or Death of Child. A parent may recover under a special statute, RCW 4.24.010, for the injury or death of a minor child, or for a child on whom the parent was dependent for support. A parent may not recover for the loss of consortium with an adult child upon whom the parent was not dependent for support. *Philippides v. Bernard*, 151 Wn.2d 376, 388, 88 P.3d 939 (2004); *Shoemaker v. St. Joseph Hosp.*, 56 Wn. App. 575, 578-79, 784 P.2d 562 (1990).

External Resource:

WPI 31.00-31.07.01 (jury instructions re: damages in wrongful death and survival actions)
WPI 32.01-32.06.01 (jury instructions re: injury to spouse, parent, or child)

8.6.4 Outrage/Negligent Infliction of Emotional Distress (NIED).

8.6.4.1 Outrage.

Washington law recognizes a cause of action for the tort of intentional infliction of emotional distress, also known as the tort of outrage. *Robel v. Roundup Corp.*, 148 Wn.2d 35, 51 n.7, 59 P.3d 611 (2002); *Grimsby v. Samson*, 85 Wn.2d 52, 59, 530 P.2d 291 (1975) (adopting Restatement (Second) of Torts § 46(2)). To establish a claim for the tort of outrage, plaintiffs must demonstrate: (1) the conduct of defendant complained of was outrageous and extreme; (2) the emotional distress was inflicted intentionally or recklessly, not negligently; (3) severe emotional distress suffered by the plaintiff; and (4) the plaintiff was personally either the object of defendant's conduct or present at the time of such conduct. *Reid v. Pierce Co.*, 136 Wn.2d 195, 202, 204, 961 P.2d 333 (1998); *Benoy v. Simons*, 66 Wn. App. 56, 63, 831 P.2d 167 (1992); *Cunningham v. Lockard*, 48 Wn. App. 38, 44, 736 P.2d 305 (1987); *Lewis v. Bell*, 45 Wn. App. 192, 194, 724 P.2d 425 (1986); *see also Dicomes v. State*, 113 Wn.2d 612, 630, 782 P.2d 1002 (1989); *Corey v. Pierce County*, 154 Wn. App. 752, 763, 225 P.3d 367 (2010).

Outrageous Conduct. The first element requires proof that the conduct was "so outrageous in character, and so extreme in degree, as to go beyond all possible bounds of decency, and to be regarded as atrocious, and utterly intolerable in a civilized community." *Robel*, 148 Wn.2d at 51 (quoting *Grimsby v. Samson*, 85 Wn.2d 52, 59, 530 P.2d 291 (1975)); *see also*

Chapter 8: Medical Malpractice Liability

(prepared from reference materials available as of January 1, 2011)

Robel, 148 Wn.2d at 51 (“the standard for an outrage claim is admittedly very high (by which we mean that the conduct supporting the claim must be appallingly low)”); *Reid v. Pierce Co.*, 136 Wn.2d 195, 202, 204, 961 P.2d 333 (1998); *Birkliid v. Boeing Co.*, 127 Wn.2d 853, 857, 867, 873, 904 P.2d 278 (1995); *Corey v. Pierce County*, 154 Wn. App. 752, 764, 225 P.3d 367 (2010) *Strong v. Terrell*, 147 Wn. App. 376, 385, 195 P.3d 977 (2008); *Saldivar v. Momah*, 145 Wn. App. 365, 389, 186 P.3d 1117 (2008). The court must initially determine there is sufficient evidence of outrageous conduct that reasonable minds “could differ on whether the conduct was sufficiently extreme to result in liability.” *Robel*, 148 Wn.2d at 51 (quoting *Grimsby*, 85 Wn.2d at 59). In determining whether conduct is sufficiently outrageous, the court must consider the following factors:

- (1) the position occupied by the defendant;
- (2) whether the plaintiff was particularly susceptible to emotional distress, and if the defendant knew this fact;
- (3) whether the defendant's conduct may have been privileged under the circumstances;
- (4) whether the degree of emotional distress caused by a party was severe as opposed to mere annoyance, inconvenience, or normal embarrassment; and
- (5) whether the defendant was aware that there was a high probability that his or her conduct would cause severe emotional distress and proceeded in a conscious disregard of it.

Spurrell v. Block, 40 Wn. App. 854, 862-63, 701 P.2d 529 (1985); see also *Reid v. Pierce Co.*, 136 Wn.2d 195, 203, 204, 961 P.2d 333 (1998); *Birkliid v. Boeing Co.*, 127 Wn.2d 853, 867, 867-68, 873, 904 P.2d 278 (1995); *Grimsby v. Samson*, 85 Wn.2d 52, 59, 530 P.2d 291 (1975); *Phillips v. Hardwick*, 29 Wn. App. 382, 388, 628 P.2d 506 (1981) (affirming finding of outrage); *Jackson v. Peoples Fed. Credit Union*, 25 Wn. App. 81, 86-87, 604 P.2d 1025 (1979) (reversing denial of motion to dismiss outrage claim); Restatement (Second) of Torts § 46 and comments (1965).

A claim of outrage can be maintained against a physician or hospital where facts support all of the elements of an outrage claim. *Grimsby v. Samson*, 85 Wn.2d 52, 60, 530 P.2d 291 (1975). Several Washington cases, including at least one related to medical treatment, have found conduct sufficiently outrageous and extreme to raise a factual issue supporting the first element of the outrage claim. *E.g.*, *Kloepfel v. Bokor*, 149 Wn.2d at 194 (outrageous conduct where defendant's actions resulted in misdemeanor and felony convictions for harassment, stalking, and violation of no contact orders, including 640 phone calls to plaintiff's home, 100 phone calls to plaintiff's workplace, surveillance of plaintiff's house at all hours of the day and night, and threats to kill plaintiff and a friend whom plaintiff was dating); *Birkliid v. Boeing Co.*, 127 Wn.2d 853, 857, 867-68, 873, 904 P.2d 278 (1995) (plaintiff employees alleged deliberate intention to injure by supervisors through oppressive behavior, intentional human experimentation with a substance the employer knew to be toxic, prevention of workers from transferring even after the workers had been given medical restrictions from working with the substance, removal of labels on the substance and denial of access to Material Safety Data Sheets, harassment of employees who requested protective equipment or availed themselves of medical treatment, alteration of workplace conditions during government safety tests to manipulate test results and disguise the harm of the chemicals, and experimental exposure of workers to toxic chemicals without their informed consent, all resulting in medical symptoms); *Grimsby*, 85 Wn.2d at 53-54 (claim by a husband against a hospital and doctors treating his wife alleging breach of the physician/patient relationship by abandoning her and failing to provide medical care, causing suffering and resulting in her death before his eyes).

Relationship of the Parties. The relationship between the parties may be a factor in determining whether the conduct was outrageous. *Robel v. Roundup Corp.*, 148 Wn.2d at 52 (finding factual issues supporting outrage claim where plaintiff alleged repeated harassment by coworkers; "[t]he relationship between the parties is a significant factor in determining whether liability should be imposed"; added impetus" is given to an outrage claim "[w]hen one in a position of authority, actual or apparent, over another has allegedly made racial slurs and jokes and comments") (internal citations omitted); *see also Contreras v. Crown Zellerbach Corp.*, 88 Wn.2d 735, 741, 565 P.2d 1173 (1977); *Jackson v. Peoples Fed. Credit Union*, 25 Wn. App. 81, 87, 604 P.2d 1025 (1979); *compare Washington v. Boeing Co.*, 105 Wn. App. 1, 17, 19 P.3d 1041 (2000) (upholding summary judgment for defendant where plaintiff's claim of harassment by coworkers failed to demonstrate "how the conduct complained of is deemed extreme or outrageous or that she suffered extreme emotional distress").

Negligence Not Sufficient. An allegation of negligence will generally not support a claim of outrage. *Shoemaker v. St. Joseph Hosp.*, 56 Wn. App. 575, 581, 784 P.2d 562 (1990) (physician); *see also Spurrell v. Block*, 40 Wn. App. 854, 863, 701 P.2d 529 (1985) (state employees and agencies).

Potential liability for intentional infliction of emotional distress cannot be inferred from any potential liability on the part of the defendants for breach of informed consent. *Nguyen v. Sacred Heart Med. Ctr.*, 97 Wn. App. 728, 732, 736, 987 P.2d 634 (1999) ("[w]e reject a rule that would always subsume an outrage claim within a claim of informed consent"; "[c]learly these two causes of action comprise different elements" and "[w]e cannot say that one encompasses the other directly or implicitly").

Severe Emotional Distress. The third element requires allegation and proof of "severe" emotional distress, which is more than "highly unpleasant mental reactions" like "fright, horror, grief, shame, humiliation, embarrassment, anger, chagrin, disappointment, worry, and nausea." *Kloepfel v. Bokor*, 149 Wn.2d 192, 203, 66 P.3d 630 (2003); *Woodward v. Steele*, 32 Wn. App. 152, 154-55, 646 P.2d 167 (1982). Severe emotional distress is not transient and trivial, but distress such that no reasonable man could be expected to endure it. *Kloepfel v. Bokor*, 149 Wn.2d 192, 203, 66 P.3d 630 (2003). Unlike a claim for negligent infliction of emotion distress [*see* § 8.6.4.2 below], objective symptomatology is not required for a showing of severe emotional distress sufficient to satisfy the third element of a claim for intentional infliction of emotional distress. *Kloepfel v. Bokor*, 149 Wn.2d at 203; *Reid v. Pierce Co.*, 136 Wn.2d 195, 202, 961 P.2d 333 (1998); *Brower v. Ackerley*, 88 Wn. App. 87, 99, 943 P.2d 1141 (1997).

A plaintiff seeking to establish liability for other intentional wrongdoing may not need to establish the severity of the emotional distress that is necessary for the tort of outrage. *Nord v. Shoreline Sav. Ass'n*, 116 Wn.2d 477, 483-84, 805 P.2d 800 (1991).

Presence of Plaintiff. Under the fourth element, the "presence" requirement, the allegedly outrageous conduct must occur in the presence of the plaintiff, and the plaintiff must suffer the emotional distress at the time of the conduct at issue. *See, e.g., Reid*, 136 Wn.2d at 204 (holding that because plaintiffs "were not present when the conduct occurred, they may not maintain tort of outrage actions" and explaining that there is no support for overlooking "the presence element ... in either the Restatement (Second) of Torts, the comments thereto, as we adopted in *Grimsby*, or our previous cases"); *Lund v. Caple*, 100 Wn.2d 739, 742, 675 P.2d 226 (1984) ("[t]he fatal flaw in appellant's outrage theory is that he was not present when the

alleged outrageous conduct occurred, and did not even learn of the conduct until several months later”); *Grimbsby*, 85 Wn.2d at 60 (plaintiff “must be present at the time of [the alleged] conduct”) (internal citation omitted); see Restatement (2d) of Torts § 46 Cmt. 1 (1965) (in order to prevent “virtually unlimited” liability, the tort of intentional infliction of emotional distress is “limited ... to plaintiffs who were present at the time, as distinguished from those who discover later what has occurred”).

The plaintiff’s alleged emotional distress must also be suffered in the presence of the outrageous conduct, rather than later, after the fact. See, e.g., *Reid v. Pierce Co.*, 136 Wn.2d at 203-04 (no recovery where defendants allegedly pilfered autopsy photographs and displayed them publicly, because plaintiffs were not present when photographs were taken and did not learn of conduct until later); *Marzolf v. Stone*, 136 Wn.2d 122, 127, 960 P.2d 424 (1998) (presence requirement provides reasonable limit on liability; otherwise “defendants would be subject to potentially unlimited liability to virtually anyone who suffers mental distress caused by the despair anyone suffers upon hearing of the death or injury of a loved one”; “It would surely be an unreasonable burden on all human activity if a defendant who has endangered one person were to be compelled to pay for the lacerated feelings of every other person disturbed by reason of it”) (citing *Gain*, 114 Wn.2d at 260 (quoting *Budavari v. Barry*, 176 Cal. App. 3d 849, 855, 222 Cal. Rptr. 446 (1986)); *Gain v. Carroll Mill Co.*, 114 Wn.2d 254, 260, 787 P.2d 553 (1990) (no recovery for negligent infliction of emotional distress where plaintiffs saw film of alleged outrageous conduct on television); see also *Heinrich v. Sweet*, 49 F. Supp.2d 27, 40-41 (D. Mass. 1999) (dismissing outrage claim due to lack of contemporaneous link where plaintiffs claimed that their decedents had allegedly been subjected to experimentation without their consent three decades earlier; plaintiffs became aware of the experimentation following issuance of a governmental report); *Justus v. Atchison*, 565 P.2d 122, 135-36 (Cal. 1977) (denying recovery to father who was present for delivery of stillborn child, because he did not learn that child was stillborn until later, and “the impact derived not from what he saw and heard during the attempted delivery, but from what he was told after the fact”), *overruled on other grounds*, *Ochoa v. Superior Court*, 703 P.2d 1 (1985); *Nancy P. v. D’Amato*, 517 N.E.2d 824, 828 (Mass. 1988) (intentional infliction claim requires “substantially contemporaneous knowledge of the outrageous conduct”); *Quinn v. Walsh*, 732 N.E.2d 330, 333 (Mass. Ct. App. 2000) (“the manifestation of intentionally inflicted emotional injury must be substantially contemporaneous with the outrageous conduct.”); Speiser, Krause & Gans, 4 American Law of Torts § 16:28 (“[t]he test is whether the shock resulted from a direct emotional impact upon the plaintiff from the sensory and contemporaneous observance of the accident as contrasted with learning of the accident from others after its occurrence”).

Qualified Plaintiffs. The person against whom the outrageous conduct was directed may bring an outrage claim. *Contreras v. Crown Zellerbach Corp.*, 88 Wn.2d 735, 738, 565 P.2d 1173 (1977). Other than that individual, only immediate family members who satisfy the elements of the outrage claim may bring an outrage claim. *Contreras v. Crown Zellerbach Corp.*, 88 Wn.2d 735, 738, 565 P.2d 1173 (1977); *Grimbsby*, 85 Wn.2d at 60 (“the plaintiff must be an immediate family member of the person who is the object of the defendant’s actions”) (internal citation omitted); *Shoemaker v. St. Joseph Hosp.*, 56 Wn. App. 575, 579, 784 P.2d 562 (1990); *Strickland v. Deaconess Hosp.*, 47 Wn. App. 262, 268-69, 735 P.2d 74 (1987). The family member must be present at the time of such conduct. *Reid v. Pierce County*, 136 Wn.2d 195, 20204, 961 P.2d 333 (1998); *Lund v. Caple*, 100 Wn.2d 739, 742, 675 P.2d 226 (1984); *Lewis v. Bell*, 45 Wn. App. 192, 195, 724 P.2d 425 (1986). “Immediate family member” is defined by the class of relative enumerated in RCW 4.24.020. *Shoemaker*, 56 Wn. App. at 579-80; *Strickland v. Deaconess Hosp.*, 47 Wn. App. at 268-69.

External Resource:
WPI 14.03-14.03.04 (jury instructions re: outrage)

8.6.4.2 NIED.

Presence of Plaintiff Required. An NIED (negligent infliction of emotional distress) claim may only be brought by those who were present at the scene of the injury or arrived shortly thereafter, before there is a material change in the attendant circumstances. *Colbert v. Moomba Sports, Inc.*, 163 Wn.2d 43, 54-55, 176 P.3d 497 (2008); *Hegel v. McMahon*, 136 Wn.2d 122, 132, 960 P.2d 424 (1998); *Gain v. Carroll Mill Co.*, 114 Wn.2d 254, 261, 787 P.2d 553 (1990); *Chavez v. Estate of Chavez*, 148 Wn. App. 580, 583, 201 P.3d 340 (2009).

Objective Symptomatology Required. Unlike an outrage claim, a claim of negligent infliction of emotional distress must be supported by objective symptomatology. *Colbert v. Moomba Sports, Inc.*, 163 Wn.2d 43, 50, 176 P.3d 497 (2008); *Nord v. Shoreline Sav. Ass'n*, 116 Wn.2d 477, 485, 805 P.2d 800 (1991); *Strong v. Terrell*, 147 Wn. App. 376, 387, 195 P.3d 977 (2008); *Spurrell v. Block*, 40 Wn. App. 854, 863, 701 P.2d 529 (1985). The evidence goes to proof of liability, not merely damages. *Nord v. Shoreline Sav. Ass'n*, 116 Wn.2d 477, 485, 805 P.2d 800 (1991). The objective symptomatology must include “physical symptoms evidencing and resulting from the emotional distress.” *Shoemaker v. St. Joseph Hosp.*, 56 Wn. App. 575, 581, 784 P.2d 562 (1990). The mental distress must be the reaction of a normally constituted reasonable person absent the defendant’s knowledge of some peculiar characteristic or condition of plaintiff. *Hunsley v. Giard*, 87 Wn.2d 424, 436, 553 P.2d 1096 (1976).

Qualified Plaintiffs. Only an immediate family member may bring an NIED claim in addition to the person against whom the conduct was directed. *Shoemaker v. St. Joseph Hosp.*, 56 Wn. App. 575, 580, 784 P.2d 562 (1990). “Immediate family member” is defined by the class of relative enumerated in RCW 4.24.020 but without regard to their economic status of dependency. *Shoemaker*, 56 Wn. App. at 580.

An NIED claim may be pursued separately from a medical malpractice claim under RCW 7.70 where the health care provider’s action were motivated by something other than medical judgment. *Reed v. ANM Health Care*, 148 Wn. App. 265, 271, 225 P.3d 1012 (2008) (plaintiff alleged that nurse improperly barred her from ICU where life partner was a patient).

8.6.5 Physician Liability for Other Practitioners.

As a general rule, physicians independently employed or acting independently of each other in regard to the conduct in question are not vicariously liable. *E.g., Peters v. Ballard*, 58 Wn. App. 921, 933, 95 P.2d 1158 (1990) (physician not agent as a matter of law of fellow shareholder). Each defendant generally has proportionate liability only for the conduct of that defendant. [See § 8.5.5 above.]

Acting in Concert. Where, however, two physicians are “acting in concert”, then they may be held jointly liable for each other’s conduct. RCW 4.22.070(1)(a); *Gilbert H. Moen Co. v. Island Steel Erectors*, 75 Wn. App. 480, 486, 878 P.2d 1246 (1994), *rev'd on other grounds*, 128 Wn.2d 745, 912 P.2d 472 (1996). Under RCW 4.22.070(1)(a), for the “acting in concert” exception to the general rule of proportionate liability to apply, two or more persons must “consciously act together in an unlawful manner.” *Gilbert H. Moen Co.*, 75 Wn. App. at 487; *see also Kottler v. State*, 136 Wn.2d 437, 448, 963 P.2d 834 (1998).

Supervision of Another Physician. Where a physician observed, or, in the exercise of ordinary care, should have observed, the wrongful act of the other, there may be liability for the other’s conduct.

Conrad v. Lakewood General Hospital, 67 Wn.2d 934, 937-38, 410 P.2d 785 (1966) (evidence did not prove whether surgeon or the assisting general practitioner was the negligent actor in leaving instrument in patient; directed verdict against surgeon was proper where it was surgeon's responsibility to ascertain that the operative field was clear of foreign objects).

The "acting in concert" exception does not apply where two or more health care providers merely each played a role in the treatment accorded the same patient. *Moen*, 75 Wn. App. at 486-87 ("[c]ooperation" or "[p]articipation" do not "rise to the high level of concerted activity" or "constitute acting in concert").

Physician Liability for Nursing Negligence. An independent physician providing treatment at the hospital can be held liable, under the "captain of the ship" doctrine, for the negligence of a hospital employee nurse acting at his direction. *Van Hook v. Anderson*, 64 Wn. App. 353, 363-64, 824 P.2d 509 (1992); *Stone v. Sisters of Charity*, 2 Wn. App. 607, 610, 469 P.2d 229 (1970). The *Van Hook* court, however, decided that the physician was not negligent under the circumstances of that case, because the physician had fulfilled his duty, and the undisputed evidence was that the negligence was the sole responsibility of the nurse, who was an employee of the hospital. *Van Hook*, 64 Wn. App. at 363-64. The physician did not have control over the particular act of negligence of the nurse, and therefore the evidence did not support the application of the "captain of the ship" doctrine. *Id.* at 365; *but see Bauer v. White*, 95 Wn. App. 663, 668, 976 P.2d 664 (1999) (physician liable for surgical pin left in patient; two surgical technicians also handled the pins).

8.6.6 Institutional Negligence/Vicarious Liability.

Hospitals and other health care facilities can be liable to a patient for breach of the hospital's independent duties of care, and under certain circumstances may also be liable for the conduct of health care practitioners practicing at the hospital.

External Resource:

WPI 105.02.01-105.02.03 (jury instructions re: hospital liability)

8.6.6.1 Independent Duties of a Hospital.

A hospital has an independent duty to exercise reasonable care under the standards set forth in the medical malpractice statutes, RCW 4.24.290, RCW 7.70.030 and .040 (requiring health care provider to "exercise that degree of care, skill, and learning expected of a reasonably prudent health care provider at that time in the profession or class to which he belongs, in the state of Washington, acting in the same or similar circumstances"); *see also* RCW 7.70.020(3) (including hospitals in definition of health care provider); *see generally Pedroza v. Bryant*, 101 Wn.2d 226, 231, 677 P.2d 166 (1984); *Osborn v. Public Hosp. Dist. No. 1*, 80 Wn.2d 201, 205-06, 492 P.2d 1025 (1972); *Pederson v. Dumouchel*, 72 Wn.2d 73, 80, 431 P.2d 973 (1967); *Byerly v. Madsen*, 41 Wn. App. 495, 503, 704 P.2d 1236 (1985). A hospital owes four non-delegable duties directly to its patients, independent of any duty owed by the physician, or any direction given by the physician:

- (1) to use reasonable care in the maintenance of buildings and grounds for the protection of the hospital's invitees;
- (2) to furnish the patient supplies and equipment free of defects;
- (3) to select its employees with reasonable care;
- (4) to supervise all persons who practice medicine within its walls.

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Douglas v. Freeman, 117 Wn.2d 242, 247, 814 P.2d 1160 (1991).

See also *Ripley v. Lanzer*, 152 Wn. App. 296, 324, 215 P.3d 1020 (2009) (citing duty to furnish supplies free of defects). A hospital's liability is not necessarily limited to injuries that occur on the premises of the hospital. *Wilson v. Overlake Hosp. Medical Ctr.*, 77 Wn. App. 909, 915, 895 P.2d 16 (1995).

Physical Safety. In addition to the duties of a hospital identified in *Douglas*, a hospital also has an independent duty to attend to the patient's physical safety. *Osborn v. Public Hosp. Dist. No. 1*, 80 Wn.2d 201, 205-06, 492 P.2d 1025 (1972) ("there was a responsibility of the hospital attendants to administer to the physical safety of this patient as their reasonable observation of [the patient's] state of mind and physical condition at that time would reveal, independent of the implied direction from the attending physician as of the day before"). The duty is independent of any duty owed by the physician, or any direction given by the physician. *Id.* The hospital is not, however, the insurer of the patient's safety. *Roth v. Havens, Inc.*, 56 Wn.2d 393, 396, 353 P.2d 159 (1960) (reversing verdict and dismissing claim against hospital where patient fell without negligence). The hospital owes the patient a duty of such reasonable care as the mental and physical condition of the patient reasonably requires. *Id.*; *Teig v. St. John's Hosp.*, 63 Wn.2d 369, 373, 387 P.2d 527 (1963); *Cochran v. Harrison Mem. Hosp.*, 42 Wn.2d 264, 270, 254 P.2d 752 (1953).

Duties to Non-Patients. A hospital, like other premises, owes a duty of ordinary care to invitees to maintain the premises in a reasonably safe condition, and discover any dangerous conditions. *Zenkina v. Sisters of Providence in Wash., Inc.*, 83 Wn. App. 556, 561, 922 P.2d 171 (1996). A hospital does not owe a duty of care to a nonpatient invitee who is watching a medical procedure of a family member to prevent the invitee from fainting or to warn the invitee of the possibility of fainting while watching a medical procedure. *Zenkina v. Sisters of Providence in Wash., Inc.*, 83 Wn. App. 556, 561-62, 922 P.2d 171 (1996).

Informed Consent. Under Washington law, a hospital has no independent duty to obtain the informed consent of the patient. The hospital does not have a duty to obtain informed consent from the patient, absent specific knowledge of extraordinary circumstances concerning the patient's condition. *Howell v. Blood Bank*, 114 Wn.2d 42, 54-55, 785 P.2d 815 (1990); *Silves v. King*, 93 Wn. App. 873, 882 n.2, 970 P.2d 790 (1999); *Burnet v. Spokane Ambulance*, 54 Wn. App. 162, 169-70, 772 P.2d 1027 (1989); *Alexander v. Gonser*, 42 Wn. App. 234, 239-41, 711 P.2d 347 (1985). The hospital has no duty to inform the patient of test results ordered by a doctor; the hospital has only a duty to inform the doctor. *Alexander v. Gonser*, 42 Wn. App. 234, 239-41, 711 P.2d 347 (1985). [See § 8.3.7 above.]

Test Results. Further, the hospital has an independent duty to make lab results or x-rays accessible to the physician in the patient's chart. *Byerly v. Madsen*, 41 Wn. App. 495, 503-04, 704 P.2d 1236 (1985) (directing verdict against hospital where hospital failed to place EKG test results in patient's chart prior to scheduled surgery). A hospital does not have an independent duty to directly advise a patient of test results ordered by a doctor; the hospital has only a duty to inform the doctor. *Alexander v. Gonser*, 42 Wn. App. 234, 239-41, 711 P.2d 347 (1985).

Intentional/Unauthorized Conduct. An institution is generally not liable for the unauthorized conduct of its agents. *E.g.*, *Thompson v. Everett Clinic*, 71 Wn. App. 548, 551, 554, 860 P.2d 1054 (1993). The *Thompson* court held that the clinic was not liable because the physician's sexual contact with a patient was not in furtherance of the employer's business.

Id. at 553. The court held that a claim of negligent supervision can arise for acts outside the scope of employment where the employer has prior knowledge of such tendencies by the employee, but the plaintiff failed to produce any evidence of such prior knowledge. *Id. at 555-56.*

Applicable Standards. One source for determining the hospital's standard of care is the accreditation standards of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). *Douglas v. Freeman*, 117 Wn.2d 242, 248, 814 P.2d 1160 (1991); *Pedroza*, 101 Wn.2d at 233-234; *Ripley v. Lanzer*, 152 Wn. App. 296, 324, 215 P.3d 1020 (2009). The JCAHO standards are published in manuals that are specific to the type of facility. *E.g.*, Joint Comm'n on Accreditation of Healthcare Orgs. (JCAHO), *2006 Comprehensive Accreditation Manual for Hospitals*. The JCAHO establishes standards for reviewing hospital policies and practices in such areas as credentialing, scope of privileges for patient care, and performance improvement. *See id.* A hospital's violation of standard established by JCAHO or by hospital bylaws does not, however, establish negligence per se. *Andrews v. Burke*, 55 Wn. App. 622, 626, 779 P.2d 740 (1989) (“[s]tandards adopted by private parties or trade associations are admissible on the issue of negligence where shown to be reliable and relevant, but do not have the legal force of a statute, ordinance, or statutorily authorized administrative regulation”).

Another source of the standard of care for hospitals is the hospital's own bylaws. *Douglas*, 117 Wn.2d at 248; *Pedroza*, 101 Wn.2d at 233-234; *Osborn v. Public Hosp. Dist. No. 1*, 80 Wn.2d 201, 204-05, 492 P.2d 1025 (1972); *Ripley v. Lanzer*, 152 Wn. App. 296, 324, 215 P.3d 1020 (2009). A hospital is obligated to exercise reasonable care to adopt policies and procedures. *Osborn v. Public Hosp. Dist. No. 1*, 80 Wn.2d 201, 204-05, 492 P.2d 1025 (1972); *Ripley*, 152 Wn. App. at 324 (standard of care is that of an “average, competent health care facility”); RCW 70.41.010; WAC 246320-125.

Statutes and regulatory provisions are, of course, also relevant to identifying the standard of care for hospitals. *Douglas v. Freeman*, 117 Wn.2d 242, 248-49, 814 P.2d 1160 (1991). Such statutes include:

- (1) Federal Regulations. The Medicare Conditions of Participation for hospitals, 42 CFR § 482.22, include requirements for credentialing and assessment, governance, definition of privileges.
- (2) Washington state statutes. The Washington state statutes for hospital licensing, RCW 70.41, include requirements for a hospital quality improvement and medical malpractice prevention program (RCW 70.41.200), and for credentialing (RCW 70.41.230).
- (3) Washington state regulations. The Washington hospital licensing regulations, WAC 246-320, include various requirements for hospital governance (WAC 246-320-125); medical staff credentialing and assessment (WAC 246-320-185); management of information (WAC 246-320-205); improving organizational performance (WAC 240-320-225); and inpatient care services (WAC 246-320-345).

Expert Testimony Required. A hospital's standard of care must usually be established with expert testimony. *Douglas v. Freeman*, 117 Wn.2d 242, 247, 814 P.2d 1160 (1991); ; *but see Ripley v. Lanzer*, 152 Wn. App. 296, 324-25, 215 P.3d 1020 (2009) (no expert testimony requirements where res ipsa requirements are met; elements not met). It may also be established by reference to JCAHO accreditation standards, the hospital's own bylaws, or

applicable statutes. *Douglas v. Freeman*, 117 Wn.2d at 247; ; *Pedroza v. Bryant*, 101 Wn.2d 226, 234, 677 P.2d 166 (1984). A violation of a hospital bylaw does not amount to negligent per se. *Andrews v. Burke*, 55 Wn. App. 622, 626, 779 P.2d 740 (1989).

8.6.6.2 Liability for Conduct of Health Care Practitioners.

A health care facility can, under various circumstances, also be liable for the medical malpractice of a health care practitioner. The liability of the facility depends upon the relationship between the practitioner and the institution. Where the practitioner is an employee of the institution, then liability flows automatically under the doctrine of respondeat superior or vicarious liability. Where the practitioner is not an employee of the institution, there is no liability under respondeat superior/vicarious liability, but liability may be imposed under the corporate negligence doctrine. The corporate negligence doctrine does not impose liability automatically, but rather liability is based upon whether the institution has complied with its independent duties to the patient.

8.6.6.2.1 Vicarious Liability.

Where a hospital's liability arises from vicarious liability, a release of the physician from liability also releases the hospital. *Perkins v. Children's Orthopedic Hosp.*, 72 Wn. App. 149, 162-63, 864 P.2d 398 (1993).

8.6.6.2.2 Negligent Hiring.

Where a health care provider who is a hospital employee is found liable, the liability flows automatically to the hospital itself through the doctrine of vicarious liability or respondeat superior.

Physician Employees. Certain Washington hospitals may have an employment relationship with their physicians. In such circumstances, the employment relationship creates liability under the doctrine of respondeat superior for care provided by those employees. E.g., *Keogan v. Holy Family Hosp.*, 95 Wn.2d 306, 309 n.1, 622 P.2d 1246 (1980) (“[u]nder the doctrine of respondeat superior, [the] Hospital is liable for damages if its employee [physician] is found liable”; imposing liability on hospital for malpractice of employee emergency room physician). In these circumstances, respondeat superior liability eliminates the traditional barriers to hospital liability for any negligent care provided by independent contractor physicians. For example, the University of Washington has a statutory relationship with its physicians that imposes liability upon the University for its physicians acting within the scope of their employment. *Hardesty v. Stenchever*, 82 Wn. App. 253, 260, 917 P.2d 577 (1996) (“Under Chapter 4.92, the State is required to defend a state employee sued for damages for acts arising from the performance of his or her official duties and to satisfy any judgment resulting from such an action.... [T]he judgment creditor must seek satisfaction only from the State”).

Nurses. Like the rule for employee physicians, institutions are liable under respondeat superior for the malpractice of their employee nurses. See, e.g., *Van Hook v. Anderson*, 64 Wn. App. 353, 357, 824 P.2d 509 (1992) (neither party disputed the hospital's liability for the negligence of its employee nurse); *Stone v. Sisters of Charity*, 2 Wn. App. 607, 610, 469 P.2d 229 (1970) (respondeat superior applies to nurses); see also *Adamski v. Tacoma Gen. Hosp.*, 20 Wn. App. 98, 116, 579 P.2d 970 (1978) (implying respondeat superior liability for nursing negligence). This follows the rule that applies to physician employees of hospitals.

Hospitals are also vicariously liable for the conduct of nonemployee nurses such as student nurses. *Adcox v. Children's Orthopedic Hosp.*, 123 Wn.2d 15, 36-37, 864 P.2d 921 (1993) (“whether student nurse Menefee was termed an employee or an agent, the Hospital was responsible for her acts and omissions”).

8.6.6.2.3 Negligent supervision.

Is the hospital liable where the health care provider is not an employee of the institution? At hospitals, unlike other corporate entities, those who perform service within the walls of the corporate facility have traditionally not been employees of the corporation. At many hospitals, physicians have an independent contractor relationship with the institution. The independent status of the physicians had therefore resulted in the immunity of the hospital itself from liability because the traditional doctrine of respondeat superior/vicarious liability did not apply. *E.g.*, *Burnet v. Spokane Ambulance*, 54 Wn. App. 162, 170, 772 P.2d 1027 (1989) (fact of staff privileges given to a physician does not render a hospital vicariously liable for the physician's treatment of a patient). The hospital corporate negligence doctrine arose to overcome the traditional barrier that had immunized hospitals from liability for the care and treatment provided at the hospital. As the court explained in *Pedroza v. Bryant*, 101 Wn.2d 226, 230, 677 P.2d 166 (1984):

Before the emergence of corporate negligence, hospital liability for the negligence of a staff physician was based on the theory of respondeat superior. Plaintiffs found it difficult to recover, however, as courts tended to classify physicians as independent contractors for whose acts the hospital was not liable.

See also Comment, *Corporate Negligence Actions Against Hospitals—Can the Plaintiff Prove A Case?*, 59 Wash. L. Rev. 913, 916 (1984) (noting that in most circumstances the respondeat superior doctrine “does not closely fit the physician-hospital relationship”). The hospital corporate negligence doctrine recognizes that hospitals have an independent duty to patients to perform supervisory functions related to the care provided at its facility. The underlying policy of the corporate negligence doctrine is to establish an incentive for the hospital to take responsibility for the competency of the health care providers within its walls:

Forcing hospitals to assume responsibility for their corporate negligence may also provide those hospitals a financial incentive to insure the competency of their medical staffs. The most effective way to cut liability insurance costs is to avoid corporate negligence.

Pedroza, 101 Wn.2d at 232.

Scope of Duty. The hospital's duty to supervise does not impose a duty to intervene in the relationship between the patient and a non-employee physician, unless there is “obvious negligence” by the attending physician. *Alexander*, 42 Wn. App. at 241; *Schoening v. Grays Harbor Comm. Hosp.*, 40 Wn. App. 331, 335, 698 P.2d 593 (1985) (finding an issue of fact as to whether hospital had met its duty).

Intentional/Unauthorized Conduct. An institution is generally not liable for the unauthorized conduct of its agents. *E.g.*, *Thompson v. Everett Clinic*, 71 Wn. App.

548, 551, 554, 860 P.2d 1054 (1993). The *Thompson* court held that the clinic was not liable because the physician's sexual contact with a patient was not in furtherance of the employer's business. *Id.* at 553. The court held that a claim of negligent supervision can arise for acts outside the scope of employment where the employer has prior knowledge of such tendencies by the employee, but the plaintiff failed to produce any evidence of such prior knowledge. *Id.* at 555-56.

Foreseeable Victims. Hospitals have a duty to prevent their employees from harming foreseeable victims, but foreseeability requires that the alleged harm fall within the general field of danger covered by the employer's duty. *Smith v. Sacred Heart Med. Ctr.*, 144 Wn. App. 537, 544, 184 P.3d 646 (2008); *Schooley v. Pinch's Deli Market, Inc.*, 80 Wn. App. 862, 869, 912 P.2d 1044 (1996) (“[F]oreseeability means foreseeability from the point of view of a reasonable person who knows what the defendant's conduct will be, but who does not know the specific sequence of events that ultimately will ensue therefrom.”).

Special Relationship. Generally, there is no duty to prevent a third party from intentionally harming another unless “a special relationship exists between the defendant and either the third party or the foreseeable victim of the third party's conduct.” *Smith v. Sacred Heart Med. Ctr.*, 144 Wn. App. 537, 545, 184 P.3d 646 (2008) (citing *Petersen v. State*, 100 Wn.2d 421, 426, 671 P.2d 230 (1983)). The relationship between a hospital and its vulnerable patients “is a recognized special relationship.” *Smith v. Sacred Heart Med. Ctr.*, 144 Wn. App. 537, 545, 184 P.3d 646 (2008) (citing *Niece v. Elmview Group Home*, 131 Wn.2d 39, 46 n.2, 929 P.2d 420 (1997)). This special relationship imposes a duty on the hospital to protect patients from intentional harm by third parties. *Niece v. Elmview Group Home*, 131 Wn.2d 39, 46 n.2, 929 P.2d 420 (1997); *Smith v. Sacred Heart Med. Ctr.*, 144 Wn. App. 537, 545, 184 P.3d 646 (2008). This duty arises because the hospital is entrusted with the patient's well-being. *Niece v. Elmview Group Home*, 131 Wn.2d 39, 42, 50, 51, 929 P.2d 420 (1997) (group home had a duty to protect resident who had cerebral palsy and profound developmental disabilities); *Smith v. Sacred Heart Med. Ctr.*, 144 Wn. App. 537, 545, 184 P.3d 646 (2008) (hospital did not have duty to protect discharged psychiatric patients from employee who abandoned his employment); *Shepard v. Mielke*, 75 Wn. App. 201, 205, 877 P.2d 220 (1994) (convalescent center had a duty to protect resident who suffered brain damage and could not lock her door, screen visitors, or protect herself); *Hunt v. King County*, 4 Wn. App. 14, 20-21, 481 P.2d 593 (1971) (hospital had a special relationship with a disturbed and suicidal patient).

Liability of Individual Board Members. Members of hospital's governing body are not individually liable for harm resulting from health care by a practitioner with privileges at the hospital “unless the decision to grant the privilege to provide health care at the hospital constitutes gross negligence.” RCW 7.70.090.

Non-hospital practice. A hospital is not liable for the acts of privileged practitioners that take place outside the hospital. *Pedroza v. Bryant*, 101 Wn.2d 226, 236, 677 P.2d 166 (1984) (“[t]he hospital does *not* hold itself out as an inspector or insurer of the private office practices of its staff members”) (emphasis in original).

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(prepared from reference materials available as of January 1, 2011)

No liability for acts of former employees. A hospital is not liable under theories of vicarious liability or negligent supervision for the acts of former employees. *Smith v. Sacred Heart Med. Ctr.*, 144 Wn. App. 537, 184 P.3d 646 (2008) (no liability for damages alleged resulting from personal relationship between former nursing assistant and patients he met while he was an employee).

Liability independent of physician negligence. Because of the hospital's independent duties, a hospital may be held liable for negligent supervision "in the absence of any negligence on the part of the treating physician." *Douglas v. Freeman*, 117 Wn.2d 242, 814 P.2d 1160 (1991);. A hospital is liable as a matter of law for allowing a surgical operation to take place in the absence of a physician. *Pederson v. Dumouchel*, 72 Wn.2d 73, 80, 431 P.2d 973 (1967).

Proximate Causation Required. To hold a hospital liable for negligent supervision, the plaintiff must prove that the injury was proximately caused by the negligent supervision. RCW 7.70.040(2); *Alexander v. Gonser*, 42 Wn. App. 234, 241-42, 711 P.2d 347 (1985) (finding insufficient evidence that hospital's alleged failure to adequately monitor physician was the proximate cause of injury to patient); see also *Andrews v. Burke*, 55 Wn. App. 622, 629, 779 P.2d 740 (1989) (insufficient evidence to support corporate negligence instruction where no evidence of incompetence by physician that should have led to hospital's removal of privileges).

Expert Testimony Required. A claimant alleging hospital corporate negligence must also still establish through expert testimony what the standard of care for the hospital is, that it was breached, and that the breach was a proximate cause of the alleged injury. E.g., *Douglas v. Freeman*, 117 Wn.2d 242, 249, 814 P.2d 1160 (1991); ("[u]sually, the standard of care must be established by expert testimony"; noting that "several expert witnesses testified regarding the clinic's duty to supervise").

Agency and Other Theories of Liability. Other Washington decisions have imposed hospital liability for physician malpractice in the absence of an employment relationship where the practitioner was: (1) performing an "inherent function" of the hospital, or (2) an "ostensible agent" of the hospital. See *Adamski v. Tacoma Gen. Hosp.*, 20 Wn. App. 98, 112, 579 P.2d 970 (1978) (reversing summary judgment in favor of hospital where patient had presented to the emergency room of a hospital and received care from the doctor "on duty" and from the hospital's employee nurses); see also *Adcox v. Children's Orthopedic Hosp.*, 123 Wn.2d 15, 36-37, 864 P.2d 921 (1993) (relying on *Adamski*). Under the "inherent function" doctrine, a hospital is liable for the conduct of physicians that are performing inherent functions of the hospital, including such services as emergency room care and radiology. *Adamski*, at 108-12. Under the doctrine of ostensible agency, a hospital may be held liable for the malpractice of a physician where the hospital "holds out" a physician as an agent of the hospital, regardless of the physician's actual status with the hospital, and the patient reasonably relies on this information in forming a belief that the hospital was the provider of the medical care. *Adamski*, at 112-16.

Respondeat superior and corporate negligence. Claims against a hospital under respondeat superior and the corporate negligence doctrine appear to be mutually

exclusive claims. See WPI 105.02.02 comment (corporate negligence instruction “should not be used for issues involving direct negligence of a hospital employee in the performance of medical care”). Decisions that impose liability under hospital corporate negligence all involve physicians that had independent contractor relationships with the hospital, in contrast to the employment relationships that exist at other hospitals. *Douglas v. Freeman*, 117 Wn.2d 242, 245, 814 P.2d 1160 (1991) (visiting resident); *Pedroza v. Bryant*, 101 Wn.2d 226, 229, 677 P.2d 166 (1984) (independent contractor); *Schoening v. Grays Harbor Comm’y Hosp.*, 40 Wn. App. 331, 334 n.2, 698 P.2d 593 (1985) (independent contractor).

Where plaintiffs in non-hospital contexts have tried to assert liability against an institution based upon both the respondeat superior and upon negligent supervision, Washington courts have specifically excluded the negligent supervision claim where an employment relationship exists. The court in *Gilliam v. Department of Social & Health Serv.*, 89 Wn. App. 569, 585, 950 P.2d 20 (1998) (reversing dismissal of vicarious liability action against state agency for alleged conduct of state caseworker, but affirming dismissal of negligent supervision claim), concluded that the negligent supervision claim was properly dismissed as “redundant” because the state was already subject to liability under vicarious liability. The court in *Francom v. Costco Wholesale Corp.*, 98 Wn. App. 845, 866, 991 P.2d 1182 (2000) (reversing dismissal of discrimination claim but affirming dismissal of negligent supervision claim), affirmed the dismissal of the negligent supervision claim as “duplicative.” And the court in *Rodriguez v. Perez*, 99 Wn. App. 439, 450, 994 P.2d 874 (2000) (reversing dismissal of negligent investigation claim but affirming dismissal of negligent supervision claim), affirmed the dismissal of the negligent supervision claim as not “necessary.”

External Resource: RCW 70.41 Hospital licensing WAC 246-320 Hospital regulations WPI 105.02.01-105.02.03 (jury instructions re: hospital liability)
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8.6.7 HMO Liability.

Several courts in other jurisdictions have concluded that a health maintenance organization (HMO) may be held liable for the acts of its participating physicians where the patient relies upon the HMO to provide health care services, and does not rely upon a specific physician. *E.g. Petrovich v. Share Health Plan of Illinois, Inc.*, 719 N.E.2d 756, 766 (Ill. 1999) (liability may be imposed even though physician contracts and patient handbook stated that physicians were independent contractors; evidence demonstrated that HMO exercised control over physician, HMO materials referred to physicians as “our staff,” and patient looked to HMO for care rather than individual physician); see also *Ramos v. Preferred Med. Plan, Inc.*, 842 So. 2d 1006, 1007-08 (Fla. Ct. App. 2003) (relying on *Petrovich*).

A Washington statute, the Health Care Patient Bill of Rights, RCW 48.43.500-.550, adopted in 2000, requires an HMO operating in the State of Washington to “adhere to the accepted standard of care for health care providers under chapter 7.70 RCW when arranging for the provision of medically necessary health care services to its enrollees.” RCW 48.43.545(1)(a). The HMO is also liable for harm “proximately caused by health care treatment decisions that result from a failure to follow the accepted standard of care.” RCW 48.43.545(1)(b).

Disclosures. The Patient Bill of Rights also requires the HMO to disclose its list of benefits, including drug benefits; exclusions; its definition of medical necessity; its confidentiality policy; cost of premiums; and grievance process. RCW 48.43.510(1).

Non-covered services. The Patient Bill of Rights also provides that the HMO may not “preclude or discourage its providers from informing an enrollee of the care he or she requires, including various treatment options, and whether in the providers’ view such care is consistent with the plan’s health coverage criteria.” RCW 48.43.510(6).

8.6.8 Insurance Coverage Issues.

Scope of Coverage. Medical malpractice insurance coverage generally does not provide coverage for sexual acts or other intentional misconduct. *E.g.*, *Standard Fire Ins. Co. v. Blakeslee*, 54 Wn. App. 1, 8-11, 771 P.2d 1172 (1989); *Washington Ins. Guar. Ass’n v. Hicks*, 49 Wn. App. 623, 627-28, 744 P.2d 625 (1987); *but see Woo v. Fireman’s Fund Ins. Co.*, 161 Wn.2d 43, 57, 64-65, 164 P.3d 454 (2007) (liability arising from practical joke during dental procedure falls within scope of professional liability and general liability coverage). It also does not generally provide coverage for a CPA claim that involves injury to “business or property.” *Podiatry Ins. Co. v. Isham*, 65 Wn. App. 266, 270, 828 P.2d 59 (1992).

Reservation of Rights. In circumstances where an insurer disputes whether the insurance provides coverage for a particular claim, the insurer may choose to provide defense coverage under a reservation of rights. *E.g.*, *Mutual of Enumclaw Ins. Co. v. Dan Paulson Const., Inc.*, 161 Wn.2d 903, 914-15, 169 P.3d 1 (2007). Where an insurer defends a claim under a reservation of rights, it is not obligated to pay the cost of any independent counsel retained by the insured for protection of the insured’s interests beyond policy limits. *Johnson v. Continental Cas. Co.*, 57 Wn. App. 359, 363, 788 P.2d 598 (1990). The insurer may be liable for the costs of such counsel, and other damages, where the insurer breaches its enhanced obligations of fairness in the reservation of rights context. *Id.*

Duty of Good Faith to Insured. An insurer owes a duty of good faith and fair dealing to its insured. *Van Noy v. State Farm Mut. Auto. Ins. Co.*, 142 Wn.2d 784, 792, 16 P.3d 574 (2000); *see also Truck Ins. Exch. v. VanPort Homes, Inc.*, 147 Wn.2d 751, 764-66, 58 P.3d 276 (2001) (bad faith refusal to defend estopped insurer from denying coverage). A defendant’s insurer has the following duties to the defendant in order to meet its duty of good faith to defendant: (1) to thoroughly investigate the cause of the insured’s accident and the nature and extent of plaintiff’s injuries; (2) to retain competent counsel for the insured, with the understanding of both defense counsel and the insurer that the insured is the only client; (3) to fully inform the insured not only of any reservation of rights defense, but also of all developments relevant to policy coverage and the progress of the lawsuit, including all settlement offers made by the insurer; and (4) to refrain from engaging in any activity that would demonstrate greater concern for the insurer’s monetary interest than for the insured’s financial risk. *Mutual of Enumclaw Ins. Co. v. Dan Paulson Const., Inc.*, 161 Wn.2d 903, 915, 169 P.3d 1 (2007); *Tank v. State Farm Fire & Cas. Co.*, 105 Wn.2d 381, 388, 715 P.2d 1133 (1986). Denial of coverage without a good faith investigation constitutes bad faith. *Industrial Indem. Co. v. Kallevig*, 114 Wn.2d 907, 917-19, 792 P.2d 520 (1990).

An insurer may also be liable for the insured’s attorney fees where the insurer denies coverage, requiring the insured to sue to obtain a determination that the policy covers the claim, or in such other circumstances where the insured incurs attorney fees in order to obtain the full benefit of its insurance contract. *Colorado Structures, Inc. v. Insurance Co. of the West*, 161 Wn.2d 577, 607, 167 P.3d 1125 (2007); *Olympic Steamship v. Centennial Ins. Co.*, 117 Wn.2d 37, 52-53, 811 P.2d 673 (1991).

Settlement and Offers of Settlement. Because of the potential conflict between the interests of the insurer and the insured in a settlement, the insurer must give equal consideration to the interests of the insured. *Hamilton v. State Farm Ins. Co.*, 83 Wn.2d 787, 791, 523 P.2d 193 (1974); *Tyler v. Grange Ins. Ass'n*, 3 Wn. App. 167, 178, 473 P.2d 193 (1970). The insurer should investigate and communicate with the insured about the risk of recovery in excess of the policy limits. *Tyler v. Grange Ins. Ass'n*, 3 Wn. App. 167, 174, 473 P.2d 193 (1970).

Defense Counsel Duties in Insurance Context. Defense counsel retained by the insurer also has a duty under RPC 1.4 and RPC 5.4(c) to the insured to provide ongoing and full disclosure, including any potential conflicts of interest, and to resolve any conflicts between the insurer and the insured in favor of the insured. All information relevant to the defense must be communicated to the insured, including all offers of settlement. See RPC 1.4; RPC 5.4(c).

8.6.9 Liens Subrogation.

An important consideration in any payment for medical malpractice liability is whether there is any subrogated interest in the payment to the plaintiff. Numerous entities may have a subrogated interest in the amount received by the plaintiff. These entities include:

- Department of Labor and Industries. Where a plaintiff has received payment from the Department of Labor and Industries (L&I) for workers compensation, and then seeks recovery from a third party for the same injury, the Department is entitled to reimbursement of benefits paid if the third party recovery exceeds the benefits paid, and has a lien against any such recovery obtained by plaintiff. RCW 51.24.060; e.g., *Gersema v. Allstate Ins. Co.*, 127 Wn. App. 687, 696, 112 P.3d 552 (2005); see also *Flanigan v. Department of Labor & Indus.*, 123 Wn.2d 418, 424, 869 P.2d 14 (1994); *Clark v. Pacificorp.*, 118 Wn.2d 167, 174-75, 822 P.2d 162 (1991); *Hadley v. Department of Labor & Indus.*, 116 Wn.2d 897, 900, 810 P.2d 500, amended, 814 P.2d 666 (1991); *Tobin v. Department of Labor & Indus.*, 145 Wn. App. 607, 614-15, 187 P.3d 780 (2008); *Estate of Kinsman*, 44 Wn. App. 174, 721 P.2d 981 (1986); *Estate of Boettcher*, 35 Wn. App. 178, 181, 665 P.2d 1378 (1983). L&I may not obtain reimbursement from that portion of the third-party recovery that compensates for pain and suffering. *Tobin v. Department of Labor & Indus.*, 145 Wn. App. 607, 614-15, 187 P.3d 780 (2008).
- Department of Social and Health Services. Where a plaintiff has received payment of Medicaid benefits, and then obtains recovery from a third party for the injury, the Department of Social and Health Services is entitled to obtain reimbursement of the paid Medicaid benefits. RCW 43.20B.060; RCW 74.09.180; *Patterson v. Horton*, 84 Wn. App. 531, 538-39, 929 P.2d 1125 (1997). The state may not assert and enforce a lien in excess of an amount designated as payment for medical expenses. *Arkansas Dep't of Health & Human Servs. v. Ahlborn*, 547 U.S. 268, 283 (2006); *Paopao v. DSHS*, 145 Wn. App. 40, 47, 185 P.3d 640 (2008).
- Medicare and other federal programs. Medicare and other programs, such as the Veterans Administration and the federal workers compensation program, have similar bases for recovery against awards and settlements obtained from a third party. E.g., 42 U.S.C. § 1395y; 52 C.F.R. part 411 (Medicare). Insurers are responsible to report to the Secretary of Health and Human Services that a third party claim has been paid on behalf of a Medicare beneficiary. 42 USC § 1395y(b)(8)(A). The Secretary is empowered to issue a civil penalty in the amount of \$1,000 per day for non-compliance. 42 USC § 1395y(b)(8)(E)(1).

- Private insurers. Where the plaintiff's insurer has made payments to the plaintiff, and then the plaintiff obtains an award or settlement from the defendant, the plaintiff's insurer may seek subrogation from the defendant or its insurer. *E.g., Skiles v. Farmers Ins. Co.*, 61 Wn. App. 943, 946-47, 814 P.2d 666 (1991). However, the plaintiff's insurer may not recover any sums from the plaintiff until it has been established that the plaintiff has been made whole; the insurer can then only recover from the excess that the insured has received from the tortfeasor. *Id.* (citing *Thiringer v. American Motors Ins. Co.*, 91 Wn.2d 215, 219, 588 P.2d 191 (1978)). However, a release between an insured and a tortfeasor does not extinguish the insurer's subrogation rights if: (1) the tortfeasor knows of the insurer's payment and right of subrogation; (2) the insurer does not consent to the settlement; and (3) the settlement does not exhaust the tortfeasor's assets. *Leader Nat'l Ins. Co. v. Torres*, 113 Wn.2d 366, 373-74, 779 P.2d 722 (1989).
- Other private parties. Other parties may have an interest in collecting on debts owed by plaintiff. A primary example is unpaid health care costs that were not insured. Washington law provides for a statutory lien by hospitals. RCW 60.44; *United States v. Deaconess Med. Ctr.*, 140 Wn.2d 104, 108, 994 P.2d 830 (2000). The lien is registered with the county auditor. RCW 60.44. The enforcement of the lien does not require the entry of a judgment against the tortfeasor. *Id.*, *United States v. Deaconess Med. Ctr.*, 140 Wn.2d 104, 108, 994 P.2d 830 (2000).

8.6.10 Settlement/Release/Reasonableness Hearings.

8.6.10.1 Elements of a Settlement Agreement.

Settlement agreements often contain or give consideration to the following elements:

- Authority to execute. All signing parties should warrant their capacities to enter into the agreement.
- Release of all defendants and their insurers. The release should include not only the released defendants but also their insurers and any related parties.
- Hold Harmless. A settlement agreement should include a waiver of liability of the settling defendant(s), and agreement to hold harmless, for any liens or subrogation claims. But see Washington State Bar Association, Informal Op. 1355 (1990); 1263 (1989).
- Release of all known and unknown claims. The settlement agreement should include a release of all claims by relatives or others for loss of consortium or emotional or other damages. It should preclude all future claims arising out of or in any way connected with the incidents, injuries, or damages. The agreement should release all known and unknown claims, and provide that the plaintiff assumes the risk that the claimed injuries or damages may worsen in the future and that new, as yet unknown, injuries or damages may develop. *See Bennett v. Shinoda Floral, Inc.*, 108 Wn.2d 386, 395-96, 739 P.2d 648 (1987); *see also Nevue v. Close*, 123 Wn.2d 253, 258, 867 P.2d 635 (1994) (question of fact as to whether settlement was fairly and knowingly made where plaintiff alleged that she was not aware of back injury prior to signing release; "only if the trier of fact determines that the parties specifically contemplated and bargained for the assumption of risk of future unknown injuries can the release be held to have been fairly and knowingly made as to those injuries").
- Confidentiality provisions. Almost all settlement agreements include a provision for the confidentiality of the agreement and the terms of settlement. The agreement provides

that the confidentiality provision applies to attorneys, family members (“agents, assignees, successors”). The confidentiality applies to the facts, the amount of settlement, and to any other conditions or terms of settlement. It also applies to any direct or indirect communications with the media.

Some confidentiality provisions also include a liquidated damages clause for violation of the confidentiality clause, equal to total amount of consideration under the release, plus equitable relief and actual damages.

Some common exceptions to the confidentiality requirement will allow the parties to reveal information for limited purposes, such as:

- declaring income to the IRS (declaration of income), or as otherwise required by law
- informing others that the issues have been resolved
- enforcing or defending the terms of the settlement
- The agreement may also provide that defendants can agree to other disclosure in writing. The agreement may also allow some exception to the confidentiality in order for the plaintiff to disclose information to immediate family members or, to the extent reasonably necessary, to persons providing legal, financial, or counseling services, provided that such person “is instructed and agrees not to publish or further disclose the information.”
- Tax Identification number of all plaintiffs.
- No future activity in relation to defendant. Some settlement agreements include a provision that the plaintiff agrees not to contact or harass any defendant. It may also include a provision that the plaintiff agrees not to voluntarily appear at future court or governmental proceedings involving any defendant.
- Governing law. The agreement specifies that Washington law applies to the construction and interpretation of the settlement agreement.
- Dismissal with Prejudice. The settlement agreement includes a grant of authority to enter a Dismissal with Prejudice.
- No admission of liability. The settlement agreement should specify that the agreement is not an admission of liability.
- Signature for plaintiff’s attorney. The agreement also includes a provision that the plaintiff’s attorney is bound by terms of the release. The agreement also includes a signature block for the attorney.

8.6.10.2 Minors as Settling Parties.

If a settling plaintiff is a minor, the settlement must undergo court hearing and approval. RCW 11.88.090; SPR 98.16W. A settlement and release of a wrongful death action, for example, on behalf of a minor beneficiary entered into by the decedent’s personal representative does not bind the minor beneficiary unless there has been court approval following appointment of a guardian. *Wood v. Dunlop*, 83 Wn.2d 719, 725, 521 P.2d 1177

(1974). Court approval requires the appointment of a settlement guardian ad litem to review the settlement and provide a detailed report to the court. SPR 98.16W(c)-(e). The hearing results in an Order Approving Settlement and Disbursement of Funds that approves the proposed settlement, authorizes the guardian ad litem to execute releases, determines that the costs, the attorney fees, and the settlement guardian ad litem's fee are reasonable, and discharges the settlement guardian ad litem. *Id.*

8.6.10.3 Multiple Party Settlements.

Where a settlement document does not resolve the claims of all plaintiffs and all defendants, including all spouses and other family members, and all other associated entities, parties will need to consider the impact of a settlement on any remaining parties to the lawsuit or other potential claimants or tortfeasors that are not parties to the settlement.

Reasonableness hearing. When one of multiple defendants settles out of the case, that defendant must give notice of the proposed settlement to all other parties and to the court. RCW 4.22.060. The notice must contain a copy of the proposed agreement. *Id.* The court then conducts a reasonableness hearing as to the amount of the proposed settlement, with all parties afforded an opportunity to present evidence. *Id.* The burden of proof of reasonableness is on the party seeking the settlement. *Id.* The court must determine that the amount of settlement is reasonable. *Id.* Factors that a court considers in determining reasonableness include: (1) the releasing person's damages; (2) the merits of the releasing person's liability theory; (3) the merits of the released person's defense; (4) the released person's relative fault; (5) the risks and expenses of continued litigation; (6) the released person's ability to pay; (7) any evidence of bad faith, collusion, or fraud; (8) the extent of the releasing person's investigation and preparation of the case; and (9) the interests of the parties not being released. *Hogan v. Sacred Heart Medical Ctr.*, 101 Wn. App. 43, 50-51, 2 P.3d 968 (2000); *see also Mutual of Enumclaw Ins. Co. v. Dan Paulson Constr., Inc.*, 161 Wn.2d 903, 925 n.21, 169 P.3d 1 (2007); *Glover v. Tacoma Gen'l Hosp.*, 98 Wn.2d 708, 717-18, 658 P.2d 1230 (1983); *see also Meadow Valley Owners Ass'n v. St. Paul Fire & Marine Ins. Co.*, 137 Wn. App. 810, 820, 156 P.3d 240 (2009) (affirming trial court adjustment of settlement amount following reasonableness hearing)

Where one defendant has settled prior to trial, the trier of fact may still apportion a percentage of fault to that entity. [See § 8.5.5 above.]

8.6.10.4 Structured Settlements; Annuities.

A structured settlement is one where the payments to plaintiff are made over time. A structured settlement may be in the form of a single payment by the defendant, or periodic payments by the defendant.

Periodic Payments by Defendant. Where a verdict includes an award of more than \$100,000 in future economic damages, the court shall allow for periodic payment of that portion of the award. RCW 4.56.260. Adequate security must be posted. *Id.* The award may be adjusted downward upon the death of the claimant. *Id.*

Single Payment by Defendant. The defendant in a structured settlement generally makes a single payment; that payment is then used to purchase an annuity that makes the payments to the plaintiff over time. An annuity provides a stream of income with periodic payments for the life of the annuitant. The annuity may include such items as:

- fixed payments for the life of the plaintiff, with scheduled rates of increase,

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- minimum number of payments guaranteed, which protects parties if the plaintiff should pass away in shorter than expected time span,
- increased payments upon reaching majority or other future target dates,
- lump sum payments at certain years, for anticipated future expenses, and
- creation of special needs trust for oversight of future payments and expenses.

Settlement Considerations for Plaintiff. A structured settlement in the form of the purchase of an annuity provides numerous benefits to the plaintiff over the alternative of periodic payments directly from the defendant:

- it provides for professional fund management at no additional cost;
- it reduces the potential of a lump sum payment for squandering or mismanaging the money or falling into unscrupulous or unqualified investment advisors;
- the payments are guaranteed for life;
- the annuity provider takes the risk that the plaintiff will outlive his/her life expectancy;
- it protects the plaintiff from any future insolvency of the defendant, *see, e.g., Brewer v. Fibreboard Corp.*, 127 Wn.2d 512, 518-19, 901 P.2d 297 (1995) (defendant that agreed to structured settlement became insolvent);
- it allows the parties to share the parties to place the risk of future contingencies on the annuity provider.

Some plaintiff's counsel also arrange for a structured, annuity payment of their fees in order to avoid the tax consequences of a lump sum payment of the fees.

Settlement Considerations for Defendant. A single payment resolves and settles the matter with no future obligations or involvement. The defendant benefits by obtaining the value of a reduced overall payment based on the present value of the amounts to be paid. The defendant does not, however, obtain any benefit available under RCW 4.56.260 if the plaintiff should not live to his or her life expectancy.

8.6.10.5 Evidence of Settlements.

Evidence of settlements is inadmissible. *Vasquez v. Markin*, 46 Wn. App. 480, 484, 731 P.2d 510 (1986); *see also* ER 408; CR 2A.

8.6.10.6 Effect of Settlement and Release.

An agreement settling a matter and releasing a defendant or potential defendant from liability is valid and enforceable. *E.g., Bennett v. Shinoda Floral, Inc.*, 108 Wn.2d 386, 392, 739 P.2d 648 (1987); *Jensen v. Beaird*, 40 Wn. App. 1, 696 P.2d 612 (1985). Where the plaintiff was not aware of a specific injury at the time of the settlement, there may be a question of fact as to whether the settlement and release was fairly and knowingly made. *See Del Rosario v. Del Rosario*, 152 Wn.2d 375, 377, 97 P.3d 11 (2004) (doctrine applies only to unknown or latent injuries); *Nevue v. Close*, 123 Wn.2d 253, 258, 867 P.2d 635 (1994); *Finch v. Carlton*, 84 Wn.2d 140, 145-46; 524 P.2d 898 (1974).

A settlement does not alter the liability of other entities. *Kirk v. Moe*, 114 Wn.2d 550, 556, 789 P.2d 84 (1990) (negligent employee released by settlement still liable for contributions to settling employer); *Cooper v. Viking Ventures*, 53 Wn. App. 739, 744, 770 P.2d 659 (1989) (under RCW 4.22.060, tendering a defense to a party who then settles does not terminate liability of the tendering party). Compare *Glover v. Tacoma Gen'l Hosp.*, 98 Wn.2d 708, 709, 718-19, 658 P.2d 1230 (1983) (settlement by physicians results in dismissal of vicarious liability claims against hospital, but not independent claim for hospital negligence). If a “proportionately liable party settles, he settles for his share alone, and he may neither seek nor be liable for contribution.” *Kottler v. State*, 136 Wn.2d 437, 445-46, 963 P.2d 834 (1998).

Effect of Settlement/Release with Physician on Hospital Liability. Where a hospital’s liability arises from vicarious liability or respondeat superior, a release of the physician from liability also releases the hospital. *Perkins v. Children’s Orthopedic Hosp.*, 72 Wn. App. 149, 162-63, 864 P.2d 398 (1993); *Schoening v. Grays Harbor Hosp.*, 40 Wn. App. 331, 334, 698 P.2d 593 (1985); see also *Hogan v. Sacred Heart Med. Ctr.*, 101 Wn. App. 43, 49-50, 2 P.3d 968 (2000) (release of physician extinguishes vicarious liability claim against hospital, but only where the physician/agent is deemed “solvent”; otherwise, the principal is entitled only to an offset of the settlement amount against any judgment it incurs).

A settlement does not necessarily extinguish the subrogation rights of an insurer or other third-party lien holder. [See § 8.6.9 above.]

Information Technology Resource:

American Bar Association Section of Litigation, *Ethical Guidelines for Settlement Negotiations* (August 2002) (available at <http://www.abanet.org/litigation/ethics/settlementnegotiations.pdf>).

8.7 Discovery

8.7.1 Health Care Records; Waiver of Patient Privilege.

The statutory physician-patient privilege, protects against the disclosure of patient information by the physician. RCW 5.60.060; see also RCW 5.62.020 (nurse-patient privilege); RCW 18.83.110 (psychologist-patient privilege); RCW 18.19.180 (counselor-patient privilege); RCW 18.52.200 (optometrist-patient privilege). The statutory privilege is strictly construed and limited to its purposes. *E.g.*, *State v. Ross*, 89 Wn. App. 302, 307, 947 P.2d 1290 (1997).

There are also numerous other statutory protections against the disclosure of individually identifiable health information. *E.g.*, RCW 70.02.020 (Uniform Health Care Information Act); RCW 70.41.200(8) (patient information protected from disclosure by quality improvement committee); RCW 4.24.250(2) (same); RCW 43.70.510(4) (same); 42 U.S.C. § 1320d-5 (HIPAA); but see *State v. Ross*, 89 Wn. App. 302, 307, 947 P.2d 1290 (1997) (no paramedic-patient privilege). [See WSSHA Health Law Manual Chapter 1 (Health Care Information; Confidentiality)]

After a plaintiff has started a lawsuit alleging personal injury, however, the statutory physician-patient privilege is waived. RCW 5.50.060(4)(b); *Christensen v. Munsen*, 123 Wn.2d 234, 239, 867 P.2d 626 (1994); *Carson v. Fine*, 123 Wn.2d 206, 213, 867 P.2d 610 (1994); *Loudon v. Mhyre*, 110 Wn.2d 675, 679, 756 P.2d 138 (1988); *Randa v. Bear*, 50 Wn.2d 415, 421, 312 P.2d 640 (1957); *Mayer v. Huesner*, 126 Wn. App. 114, 121, 107 P.3d 152 (2005) (privilege waived by industrial insurance claim; “[o]nce [plaintiff] raised her medical condition, she effectively waived her confidentiality concerns”). The waiver applies to the physician’s opinions as well as to facts observed by the

physician. *Carson v. Fine*, 123 Wn.2d 206, 214, 867 P.2d 610 (1994); *Christensen v. Munsen*, 123 Wn.2d 234, 239, 867 P.2d 626 (1994). The physician-patient privilege is also waived where the patient introduces the testimony of his physician into a proceeding. *E.g.*, *State v. Rochelle*, 11 Wn. App. 887, 893, 527 P.2d 87 (1974). Failure to assert the privilege also results in waiver. *Wynn v. Earin*, 163 Wn.2d 361, 381, 181 P.3d 806 (2008).

The waiver of privilege applies to autopsy reports and related pathology reports. *Zueger v. Public Hosp. Dist. No. 2*, 57 Wn. App. 584, 587-88, 789 P.2d 326 (1990) (discussing RCW 68.50.105).

Medical examinations conducted not for the purpose of providing treatment but for forensic purposes are not protected by the physician-patient privilege. *State v. Cross*, 156 Wn.2d 580, 613, 132 P.3d 80 (2006).

Privacy Interest. Some have asserted that there may still be some privacy rights that the patient retains even in the context of the waiver of the health care privilege. *See, e.g.*, *Bering v. Share*, 106 Wn.2d 212, 227, 721 P.2d 918 (1986) (noting federal constitutional right of privacy; “[t]he right of privacy dictates protection of the private relationship between a woman and her physician” in the context of abortion); *In re Rosier*, 105 Wn.2d 606, 612, 717 P.2d 1353 (1986) (privacy interest in personal information contained in state records); *In re Colyer*, 99 Wn.2d 114, 120, 660 P.2d 738 (1983) (in context of decision to withhold life sustaining treatment, recognizing state constitutional right of privacy and common law right to be free from bodily invasion); *Hearst Corp. v. Hoppe*, 90 Wn.2d 123, 135-36, 580 P.2d 246 (1978) (recognizing tort for invasion of privacy); *State v. Koome*, 84 Wn.2d 901, 904, 530 P.2d 260 (1975) (right to privacy extends to minors in context of abortion). It is doubtful whether this privacy interest, however, would limit access to health care records where a patient has brought their physical condition into issue. *See, e.g.*, *State v. Rochelle*, 11 Wn. App. 887, 893, 527 P.2d 87 (1974) (recognizing waiver of privilege without application of statutory waiver); *see also, e.g.*, *State v. Ross*, 89 Wn. App. 302, 307, 947 P.2d 1290 (1997) (the statutory privilege is in derogation of common law and is therefore strictly construed and limited to its purposes).

8.7.2 Spoliation of Evidence.

In the narrow circumstance where a party is unable to provide a satisfactory explanation for the loss of information under its control, a “spoliation instruction” is appropriate. *Pier 67, Inc. v. King County*, 89 Wn.2d 379, 573 P.2d 2 (1977). In deciding whether to give the spoliation instruction, the court must take into consideration “(1) the potential importance or relevance of the missing evidence; and (2) the culpability or fault of the adverse party.” *Henderson v. Tyrrell*, 80 Wn. App. 592, 607, 910 P.2d 522 (1996). A party may be responsible for spoliation without acting in bad faith. *Homeworks Const., Inc. v. Wells*, 133 Wn. App. 892, 900, 138 P.3d 654 (2006).

8.7.3 Communications with Treatment Providers; Ex Parte Contact.

The statutory waiver of privilege does not allow the defense to have ex parte contact with plaintiff’s treating physicians. *Loudon v. Mhyre*, 110 Wn.2d 675, 677, 756 P.2d 138 (1988). This applies to any type of communication between the treater and defense attorney, even if the communication is through the treater’s counsel or the information transmitted is public record. *Smith v. Orthopedics Int’l, Ltd.*, ___ Wn.2d ___, ___ P.2d ___, 2010 WL 5129020 (slip op. Dec. 16, 2010). The defendant must use formal discovery procedures to communicate with treating physicians. *Loudon v. Mhyre*, 110 Wn.2d 675, 677, 756 P.2d 138 (1988). A treating physician may, however, provide expert testimony for the defense. *Carson v. Fine*, 123 Wn.2d 206, 219, 867 P.2d 610 (1994). [See § 8.4.2, § 8.5.2 above.] The prohibition on ex parte contact applies even where the defense will be calling the treating physician as a witness at trial. *Ford v. Chaplin*, 61 Wn. App. 896, 898, 812 P.2d 532 (1991). *See also* § 8.7.7.2 *infra*.

8.7.4 Depositions.

Taking of Depositions. Washington court rules allow for the taking of depositions of fact or expert witnesses who have information that is or may be relevant to the action. *See* CR 30, CR 26(b).

Corrections to Deposition Transcripts. The individual deposed has the opportunity to review the transcript of the deposition and make corrections, providing reasons for the changes. CR 30(e).

The uncorrected version of the deposition testimony is admissible as evidence. *Seattle-First National Bank v. Rankin*, 59 Wn.2d 288, 293, 367 P.2d 835 (1962) (rejecting argument that “a deposition is not the final testimony of the witness until he is given an opportunity to make changes or corrections, and when an answer is changed or corrected, the answer, as originally given, is not admissible in court as substantive evidence”); *see also id.* at 294 (“it is important that the original testimony appear in the deposition as well as the changed testimony, so that if the deposition is used at the trial, a true picture will be presented.” CR 30 permits changes to be made, “but both the original and the changed testimony will appear in the deposition along with a statement of the reasons given by the deponent for making the changes. *Id.*

Reasons for Change to Transcript. Changes to deposition testimony are not considered unless a reason is given for the changes. *Young v. Group Health*, 85 Wn.2d 332, 338, 534 P.2d 1349 (1975) (“since the deponent failed to state a reason for the addition he made to his original statement, that portion which was added subsequent to the taking of the deposition cannot be considered”).

8.7.5 Protective Orders.

Protection from Discovery. Some types of information are not discoverable. [*See* § 8.7.4, § 8.7.7.1 below.]

Protection of Confidentiality of Produced Information. Some discovery may take place under a protective order that preserves the confidentiality of documents and information produced by a party. A protective order is available, for good cause shown, for documents produced to another party in discovery and not otherwise made a part of the court record. CR 26(c); *Rufer v. Abbott Laboratories, Inc.*, 154 Wn.2d 530, 541, 114 P.3d 1182 (2005); *McCallum v. Allstate Property & Cas. Ins. Co.*, 149 Wn. App. 412, 420, 204 P.3d 944 (2009). To establish good cause, the party should show specific prejudice or harm will result if no protective order is issued. *Dreiling v. Jain*, 151 Wn.2d 900, 916-17, 93 P.3d 861 (2004); *McCallum*, 149 Wn. App. at 423. Once a document becomes part of the court record, however, there is a presumption of openness, with the exception of published, unused depositions, and may not be kept from public view without some compelling interest that overrides the public’s right to the open administration of justice. *Rufer v. Abbott Laboratories, Inc.*, 154 Wn.2d 530, 549, 114 P.3d 1182 (2005); *Building Indus. Ass’n of Wash. v. McCarthy*, 152 Wn. App. 412, 420, 204 P.3d 944 (2009).

8.7.6 Attorney-Client Privilege/Work Product.

8.7.6.1 Attorney-Client Privilege.

RCW 5.50.060(2) is the statutory statement of the attorney-client privilege. It protects the communications between an attorney and client from admission or discovery. *E.g.*, *Morgan v. City of Federal Way*, 166 Wn.2d 747, 755, 213 P.3d 598 (2009) (no protection where no attorney-client relationship); *Harris v. Pierce County*, 84 Wn. App. 222, 235, 928 P.2d 111 (1996) (attorney-client privileged unavailable under pretrial discovery rules and therefore exempt from public disclosure).

Ex-Parte Communication with Employees of a Institutional Party. It remains unclear whether the physician-patient privilege prevents defense counsel for the hospital from communicating ex parte with non-party treating physicians even where they are employed by the hospital. *Smith v. Orthopedics Int'l, Ltd.*, __ Wn.2d __, __ P.2d __, 2010 WL 5129020 (slip op. Dec. 16, 2010) (affirming ruling that ex parte communication with non-employee treating physician violated the physician-patient privilege); *compare* (Fairhurst, J., concurring), at *9 (commenting on “[t]he lead opinion’s creation of a bright line rule prohibiting all ex parte contact”).

The attorney-client privilege does not prohibit plaintiff’s attorneys from interviewing hospital employees ex parte. *Wright v. Group Health Hosp.*, 103 Wn.2d 192, 201-03, 691 P.2d 564 (1984). Plaintiff’s counsel may not have ex parte contact with current employees who have a right to speak for and bind the hospital. *Id.* The hospital may not prohibit or instruct non-speaking agent employees from meeting with plaintiff’s counsel. *Id.* Employed doctors are speaking agents of the employer hospital. *Young v. Group Health Coop.*, 85 Wn.2d 332, 338, 534 P.2d 1349 (1975).

8.7.6.2 Attorney Work Product.

CR 26(b)(4) provides that an exemption from discovery for materials that are “prepared in anticipation of litigation or for trial.” The exception does not protect documents that were prepared by a third party not in anticipation of litigation. *E.g., In re Williams*, 147 Wn.2d 476, 494, 55 P.3d 597 (2002). The doctrine generally protects: (1) legal research and opinions, mental impressions, theories, and conclusions prepared or formed by an attorney or other representative engaged on behalf of a client, unless the attorney’s or representative’s mental impressions are directly at issue; (2) notes or memoranda prepared by an attorney from oral communications, unless the attorney’s mental impressions are directly at issue; and (3) factual written statements and other tangible items gathered by an attorney or other representative engaged on behalf of a client in preparation for or in anticipation of litigation. *Limstrom v. Ladenburg*, 136 Wn.2d 595, 611, 963 P.2d 869 (1998). In determining whether a document was prepared in anticipation of litigation, the court considers the expectations of the parties involved. *Barry v. USAA*, 98 Wn. App. 199, 208, 989 P.2d 1172 (1999).

A statement made by insured to an insurer regarding an incident is protected as work product. *Heidebrink v. Moriwaki*, 104 Wn.2d 392, 399, 706 P.2d 212 (1985); *Kim v. Allstate Ins. Co., Inc.*, 153 Wn. App. 339, 365, n.9 223 P.3d 1180 (2009). It is not discoverable except upon a showing of substantial need and inability without undue hardship to obtain the substantial equivalent by other means. *Id.* A statement made by an insured to the physician performing an independent medical examination on behalf of the insurer is also protected as work product. *Harris v. Drake*, 152 Wn.2d 480, 489, 99 P.3d 872 (2004).

The protection afforded by the work product doctrine does not cease after the litigation for which the documents were prepared has terminated. *Pappas v. Holloway*, 114 Wn.2d 198, 210, 787 P.2d 30 (1990). The protection afforded by the work product doctrine extends to documents prepared in anticipation of any litigation, regardless of whether the party from which the documents are requested is a party in the present litigation. *Dever v. Fowler*, 63 Wn. App. 35, 49, 816 P.2d 1237 (1991).

8.7.7 Peer Review and QA Materials.

Several Washington statutes protect from discovery the documents relating to quality assurance review committees. The first, RCW 4.24.250(1), protects from disclosure reports, records, and proceedings of regularly constituted hospital quality review committees or boards. The statute also

protects the records of committee members and agents. *Anderson v. Breda*, 103 Wn.2d 901, 905, 700 P.2d 737 (1985).

The second, RCW 70.41.200(3), protects from disclosure information and documents collected and maintained by a hospital quality assurance committee. Similar protections are provided in RCW 43.70.510(4). RCW 42.17.310(hh) also exempts from public disclosure information related to the peer review/quality improvement process.

The burden of establishing the privilege rests on the party resisting disclosure. *Anderson v. Breda*, 103 Wn.2d 901, 905, 700 P.2d 737 (1985). The party resisting discovery must establish that the documents to be protected were from a “regularly constituted” committee rather than an ad hoc investigation. *Adcox v. Children’s Orthopedic Hosp.*, 123 Wn.2d 15, 31, 864 P.2d 921 (1993). The statute, like other statutory privileges, is to be strictly construed and limited to its purposes. *Anderson v. Breda*, 103 Wn.2d 901, 905, 700 P.2d 737 (1985); *Coburn v. Seda*, 101 Wn.2d 270, 276, 677 P.2d 173 (1984).

The privilege does not protect information from original sources merely due to its introduction at a review committee meeting. *Coburn v. Seda*, 101 Wn.2d 270, 277, 677 P.2d 173 (1984). It also does not shield from disclosure the identity and knowledge of the individuals with personal knowledge of the underlying event, even if those persons presented evidence to the hospital review committee. *Anderson v. Breda*, 103 Wn.2d 901, 906, 700 P.2d 737 (1985); *Coburn v. Seda*, 101 Wn.2d 270, 277, 677 P.2d 173 (1984).

The privilege does not apply to protect from disclosure the fact of any restriction on the physician’s privilege. *Anderson v. Breda*, 103 Wn.2d 901, 907, 700 P.2d 737 (1985).

8.7.8 Fact Witnesses. [Patient, Family, Treating Physicians]

Discovery of Information Regarding Fact Witnesses. A party is entitled to discover what information is known by fact witnesses. Interrogatories may be propounded to any witness who is also a party, and depositions may be taken of witness who is not a party. CR 33, CR 30.

Disclosure of Information Regarding Fact Witnesses. In some Washington courts, local rules require the court to set a date by which the parties must disclose a list of fact witnesses and a description of their testimony. *E.g.*, King County LR 4(e).

Ex Parte Contact. A party or its counsel may have ex parte contact with individuals who have or may have knowledge related to the case, unless those individuals are parties to the action, or are known to be represented by counsel. CR 26, CR 30; RPC 4.2.

8.7.9 Expert Witnesses.

8.7.9.1 Disclosure and Discovery of Experts and Opinions.

[See § 8.4.2, § 8.5.2 above.] A party may retain an expert for consultation but decide not to call the individual as an expert at trial. In that case, the opposing party may not obtain the opinions of that expert or present those opinions at trial, absent exceptional circumstances. CR 26(b)(5); *Crenna v. Ford Motor Co.*, 12 Wn. App. 824, 828, 532 P.2d 290 (1975) (CR 26(b)(5), a discovery rule, also applies at trial). This rule applies even where the consulted expert has conducted an independent medical examination and the report has been provided to opposing party. *Mothershead v. Adams*, 32 Wn. App. 325, 331-32, 647 P.2d 525 (1982).

A treating physician is not a consulting expert whose opinions may be protected from disclosure by CR 26. *Peters v. Ballard*, 58 Wn. App. 921, 930, 795 P.2d 1158 (1990).

Payment of Expert Fees. Generally a party pays for the services of an expert for consultation and testimony. Where an expert witness for an opposing party is deposed, the deposing party generally pays the reasonable fee of the expert for the time of the deposition. CR 26(b)(5)(C); *Paiya v. Durham Constr. Co.*, 69 Wn. App. 578, 580 n.1, 849 P.2d 660 (1993).

A physician who was involved as an actor in the transaction, such as a treating physician who is also an expert, is treated a fact witness who is entitled to only the statutory witness fee, and not entitled to an expert witness fee under CR 26(b)(4). RCW 2.40.010, RCW 2.36.150; *Paiya v. Durham Constr. Co.*, 69 Wn. App. 578, 580 n.1, 849 P.2d 660 (1993); *see also, e.g., Baird v. Larson*, 59 Wn. App. 715, 719-20, 801 P.2d 247 (1990) (accountant not entitled to expert fee when he testified as fact witness; “an expert person is not necessarily an expert witness as defined in CR 26(b)(4)”).

8.7.9.2 Ex Parte Contact.

A party and its counsel are not entitled to have ex parte communications with an expert for an opposing party. CR 26(b)(5).

8.7.9.3 Expert’s Financial Records.

Washington courts have not yet decided whether to allow discovery of an expert’s financial records, such as tax returns and related materials, in order to determine the percentage of income derived from expert fees, but have indicated disfavor for such discovery. *Scott v. Grader*, 105 Wn. App. 136, 140, 18 P.3d 1150 (2001) (discovery of expert’s financial records “could have a chilling effect on the ability to obtain doctors willing to testify and could cause future trials to consist of many days of questioning on the collateral issue of expert bias rather than on the true issues of liability and damages”).

8.7.10 Independent Medical Examinations.

A defendant may arrange for an independent medical examination of a plaintiff in a medical malpractice action, because the plaintiff’s medical condition is at issue. *See* CR 35(a) (allowing for physical examination where the mental or physical condition of a party is in controversy); *see generally Schlagenhauf v. Holder*, 379 U.S. 104 (1964).

An independent medical examination conducted by the insurer is protected by the work product doctrine. *Harris v. Drake*, 152 Wn.2d 480, 489, 99 P.3d 872 (2004); *Kim v. Allstate Ins. Co., Inc.*, 153 Wn. App. 339, 365, n.9 223 P.3d 1180 (2009). [*See* § 8.7.4.2 above.]

8.7.11 Misconduct During Discovery; Discovery Sanctions.

CR 37(b) authorizes a court to impose sanctions ranging from exclusion of evidence to default judgment. *Magana v. Hyundai Motor America*, 167 Wn.2d 570, 583, 220 P.3d 191 (2009). Discovery sanctions are reviewed for abuse of discretion. *Magana v. Hyundai Motor America*, 167 Wn.2d 570, 583, 220 P.3d 191 (2009); *Physicians Ins. Exch. v. Fisons Corp.*, 122 Wn.2d 299, 338, 858 P.2d 1054 (1993); *Blair v. TA-Seattle East #176*, 150 Wn. App. 904, 909, 210 P.3d 326 (2009) (excluding some late-disclosed witnesses); *Lancaster v. Perry*, 127 Wn. App. 826, 833, 113 P.3d 1 (2005) (affirming exclusion of late disclosed witnesses). Where the trial court imposes a harsher remedy for discovery violations, then the record must clearly show (1) one party willfully or deliberately violated the discovery rules and orders, (2) the opposing party was substantially prejudiced in its ability to prepare for trial, and (3) the trial court explicitly considered whether a

lesser sanction would have sufficed. *Magana v. Hyundai Motor America*, 167 Wn.2d 570, 584, 220 P.3d 191 (2009); *Burnet v. Spokane Ambulance*, 131 Wn.2d 484, 494, 933 P.2d 1036 (1997).

8.8 Motions and Pretrial Procedures.

8.8.1 Discovery Motions.

Motion to Compel. A party who has been unable to obtain discovery from an opposing party may move to compel discovery. CR 26(i) requires the parties to confer prior to the filing of a discovery motion, and certify to the court that the conference requirement has been met. *See also, e.g.*, King County LR 37(e).

Motion to Quash/for Protective Order. A party seeking to protect certain information from discovery may move for a protective order to protect the information from disclosure.

8.8.2 Summary Judgment Motions.

Summary judgment motions allow for a judgment prior to trial where there is no genuine issue of material fact and the moving party is entitled to judgment as a matter of law. CR 56(c).

Burden on Moving Party. To support a motion for summary judgment the moving party is required to at least set out its version of the facts and allege that there is no genuine issue as to the facts as set out. *Guile v. Ballard Community Hosp.*, 70 Wn. App. 18, 21, 851 P.2d 689 (1993); *Hash v. Children's Orthopedic Hosp.*, 110 Wn.2d 912, 916, 757 P.2d 507 (1988).

A defendant in a medical liability case can move for summary judgment in one of two ways. First, it can meet its initial burden by showing that the plaintiff lacks sufficient evidence, including competent expert medical testimony. *Berger v. Sonneland*, 144 Wn.2d 91, 111-12, 26 P.3d 257 (2001); *Young v. Key Pharmaceuticals, Inc.*, 112 Wn.2d 216, 225 n.1, 770 P.2d 182 (1989); *Eakins v. Huber*, 154 Wn. App. 592, 598, 225 P.3d 1041 (2010); *Rounds v. Nellcor Puritan Bennett, Inc.*, 147 Wn. App. 155, 162-63, 194 P.3d 274 (2008); *Davies v. Holy Family Hosp.*, 144 Wn. App. 483, 492, 183 P.3d 283 (2008); *Hill v. Sacred Heart Med. Ctr.*, 143 Wn. App. 438, 445, 177 P.3d 1152 (2008); *Seybold v. Neu*, 105 Wn. App. 666, 677, 19 P.3d 1068 (2001); *Morinaga v. Vue*, 85 Wn. App. 822, 833, 935 P.2d 637 (1997); *Guile v. Ballard Community Hosp.*, 70 Wn. App. 18, 22, 851 P.2d 689 (1993); *White v. Kent Med. Ctr.*, 61 Wn. App. 163, 170, 810 P.2d 4 (1991). The defendant in this circumstance does not need to support its summary judgment motion with declarations, or identification of specific facts. *Young v. Key Pharmaceuticals, Inc.*, 112 Wn.2d 216, 225, 770 P.2d 182 (1989) (“a complete failure of proof concerning an essential element of the non-moving party’s case necessarily renders all other facts immaterial”); *Seybold v. Neu*, 105 Wn. App. 666, 676-77, 19 P.3d 1068 (2001); *White v. Kent Med. Ctr.*, 61 Wn. App. 163, 170, 810 P.2d 4 (1991). The defendant must identify those portions of the record, together with declarations, if any, which he or she believes demonstrate the absence of a genuine issue of material fact. *Baldwin v. Sisters of Providence in Wash., Inc.*, 112 Wn.2d 127, 132, 769 P.2d 298 (1989); *Seybold v. Neu*, 105 Wn. App. 666, 677, 19 P.3d 1068 (2001); *White v. Kent Med. Ctr.*, 61 Wn. App. 163, 170, 810 P.2d 4 (1991).

Second, a defendant may also move for summary judgment by affirmatively establishing that no genuine issue of material fact exists. *Hash v. Children's Orthopedic Hosp. & Med. Ctr.*, 110 Wn.2d 912, 916, 757 P.2d 507 (1988); *Davies v. Holy Family Hosp.*, 144 Wn. App. 483, 492, 183 P.3d 283 (2008); *Seybold v. Neu*, 105 Wn. App. 666, 677, 19 P.3d 1068 (2001); *Guile v. Ballard Community Hosp.*, 70 Wn. App. 18, 27, 851 P.2d 689 (1993); *Turner v. Kohler*, 54 Wn. App. 688, 692, 775 P.2d 474 (1989) (defendant’s expert affidavit established that defendant met the standard of care); *Nicholson v. Deal*, 52 Wn. App. 814, 820-21, 764 P.2d 1007 (1988) (defendant failed to show absence of material fact).

Burden on Non-Moving Party. Where a defendant in a medical liability case has met its initial burden in moving for summary judgment, the burden then shifts to the plaintiff to produce an affidavit from a qualified expert witness that sets forth specific facts establishing a cause of action. *Young v. Key Pharmaceuticals, Inc.*, 112 Wn.2d 216, 226-27, 770 P.2d 182 (1989); *Rounds v. Nellcor Puritan Bennett, Inc.*, 147 Wn. App. 155, 162-63, 194 P.3d 274 (2008); *Davies v. Holy Family Hosp.*, 144 Wn. App. 483, 492, 183 P.3d 283 (2008); *Seybold v. Neu*, 105 Wn. App. 666, 678, 19 P.3d 1068 (2001); *Guile v. Ballard Community Hosp.*, 70 Wn. App. 18, 26-27, 851 P.2d 689 (1993) *White v. Kent Med. Ctr.*, 61 Wn. App. 163, 171, 810 P.2d 4 (1991); *see also Berger v. Sonneland*, 144 Wn.2d 91, 112, 26 P.3d 257 (2001) (plaintiff failed to present any evidence to rebut defendant's initial showing of no material fact).

Affidavits containing conclusory statements without adequate factual support are insufficient to defeat a motion for summary judgment. *Davies v. Holy Family Hosp.*, 144 Wn. App. 483, 492, 183 P.3d 283 (2008); *Guile v. Ballard Community Hosp.*, 70 Wn. App. 18, 26, 851 P.2d 689 (1993) (expert's declaration in opposition to summary judgment motion ineffective because it was "merely a summarization of the [the [patient's] postsurgical complications, coupled with the unsupported conclusion that the complications were caused by [the doctor's] faulty technique; the declaration "does little more than reiterate the claims made in [the patient's] complaint"); *Ruffer v. St. Frances Cabrini Hosp.*, 56 Wn. App. 625, 628, 784 P.2d 1288 (1990); *Vant Leven v. Kretzler*, 56 Wn. App. 349, 356, 783 P.2d 611 (1989); *compare Morton v. McFall*, 128 Wn. App. 245, 255, 115 P.3d 1023 (2005) (expert opinion was not conclusory because it "clearly identify[d] the facts supporting her opinion"). The evidence and inferences therefrom presented by the nonmoving party must be examined in the light most favorable to that party. *Young v. Key Pharmaceuticals, Inc.*, 112 Wn.2d 216, 226, 770 P.2d 182 (1989); *Herskovits v. Group Health Coop.*, 99 Wn.2d 609, 613, 664 P.2d 474 (1983); *Eakins v. Huber*, 154 Wn. App. 592, 598, 225 P.3d 1041 (2010); *Rounds v. Nellcor Puritan Bennett, Inc.*, 147 Wn. App. 155, 162, 194 P.3d 274 (2008); *Davies v. Holy Family Hosp.*, 144 Wn. App. 483, 491, 183 P.3d 283 (2008); *Hill v. Sacred Heart Med. Ctr.*, 143 Wn. App. 438, 445, 177 P.3d 1152 (2008); *Branom v. State*, 94 Wn. App. 964, 972, 974 P.2d 35 (1999), *White v. Kent Med. Ctr.*, 61 Wn. App. 163, 171, 810 P.2d 4 (1991); *Omer v. Edgren*, 38 Wn. App. 376, 377, 685 P.2d 635 (1984).

Declarations that Contradict Prior Deposition Testimony. A declaration submitted in relation to a summary judgment motion cannot negate the existence of an issue of material fact where the party has previously given answers in a deposition that "negate the existence of any genuine issue of material fact." *Marthaller v. King County Hosp.*, 94 Wn. App. 911, 918, 973 P.2d 1098 (1999); *see also Ramos v. Arnold*, 141 Wn. App. 11, 19, 169 P.3d 482 (2007) (party cannot create an issue with an affidavit that merely contradicts, without explanation, previously given clear testimony); *McCormick v. Lake Wash. School Dist.*, 99 Wn. App. 107, 111, 992 P.2d 511 (1999) (self-serving affidavits contradicting prior sworn deposition testimony cannot be used to create a material issue of fact); *Klontz v. Puget Sound Power & Light*, 90 Wn. App. 186, 192, 951 P.2d 280 (1998); *Marshall v. AC&S, Inc.*, 56 Wn. App. 181, 185, 782 P.2d 1107 (1989) (an affidavit that contradicts, without explanation, answers to unambiguous deposition questions cannot be used to create a material issue of fact); *compare Beers v. Ross*, 137 Wn. App. 566, 571-72, 154 P.3d 277 (2007) (declaration did not flatly contradict deposition testimony); *State Farm Mut. Auto Ins. Co. v. Treciak*, 117 Wn. App. 402, 409, 71 P.3d 703 (2003) (equivocal deposition responses, and later explanations of the responses by declaration, may be considered in evaluating existence of material fact).

8.8.3 Motions in Limine.

A common pretrial procedure is for both parties to make motions in limine seeking to exclude certain evidence from trial. CR 16; *see also, e.g., Gammon v. Clark Equip.*, 38 Wn. App. 274, 288, 686 P.2d 1102 (1984). A motion in limine should be granted if: (1) it describes the evidence objected to with

sufficient specificity to enable the trial court to determine that it is clearly inadmissible; (2) the evidence is so prejudicial that the movant should be spared the necessity of calling attention to it by objecting when it is offered; and (3) the trial court is given a memorandum of authorities showing that the evidence is inadmissible. *Gammon*, 38 Wn. App. at 288. The granting or denial of a motion in limine is within the discretion of the trial court. *Id.*

8.8.4 Mediation.

Mediation of medical malpractice claims is required under RCW 7.70.100. Where the mediation is unsuccessful, the parties preserve their right to a jury trial. RCW 7.70.120. CR 53.4 governs for the procedure for mandatory mediation of medical malpractice claims. .

8.8.5 Arbitration.

A 2006 statute provides that in any case in which a party does not agree to voluntary arbitration, that party must file a declaration at the time of filing its initial pleading that the attorney representing the party presented the party with a copy of the provisions of this chapter before filing the initial pleading and that the party elected not to submit the dispute to arbitration under the voluntary arbitration chapter. RCW 7.70A.020. Where the parties do agree to arbitration, the statute provides a schedule of events leading to arbitration, and states the policy that the arbitration be commenced no later than 12 months after the election for arbitration. *Id.* Arbitration awards are limited to a total of one million dollars. *Id.* The fees of the arbitrator are to be paid by the nonprevailing party. *Id.* There is no right to trial de novo from the arbitration, and the bases for appeal are limited to those provided in the Uniform Arbitration Act, RCW 7.04A.230(1)-.240. *Id.*

8.9 Trial.

8.9.1 Admissible Evidence.

The general rule is that relevant evidence is admissible. ER 402. Relevant evidence is evidence “having any tendency to make the existence of any fact that is of consequence to the determination of the action more probable or less probable than it would be without the evidence.” ER 401. Evidence may be excluded, even if relevant, “if its probative value is substantially outweighed by the danger of unfair prejudice, confusion of the issues, or misleading the jury, or by consideration of undue delay, waste of time, or needless presentation of cumulative evidence.” ER 403; *Kappelman v. Lutz*, 167 Wn.2d 1, 9, 217 P.3d 286 (2009); *Riggins v. Bechtel Power Corp.*, 44 Wn. App. 244, 253, 722 P.2d 819 (1986) (ER 403 provides the court with “discretion to control distracting ‘side issues’”); *State v. Israel*, 91 Wn. App. 846, 856, 963 P.2d 897 (1998) (excluding testimony that would “produce a ‘trial within a trial’ on a collateral matter”).

Medical Records. Medical records are generally relevant and admissible in a medical malpractice trial. *See, e.g., Bell v. State*, 147 Wn.2d 166, 181, 52 P.3d 502 (2002) (“[e]vidence is relevant [and admissible] if it has a tendency to make the existence of any fact of consequence more probable or less probable than it would be without the evidence”). Reports of lab test results contained in the physician's medical files are admissible as business records under RCW 5.45.020. *State v. Ziegler*, 114 Wn.2d 533, 539, 789 P.2d 79 (1990) (non-medical case) (“[a] practicing physician’s records, made in the regular course of business, properly identified and otherwise relevant, constitute competent evidence of a condition therein recorded”).

Generally, out of court statements made for purposes of medical diagnosis are admissible as an exception to the general rule excluding hearsay. ER 803(a)(4). Where the statements may contain medical information but are not made for purposes of diagnosis, they are not admissible under the exception to the hearsay rule. *State v. Alvarez-Abrego*, 154 Wn. App. 351, 366-69, 225 P.3d 396 (2010) (statement by four year-old reported by mother to physician about cause of infant’s injury not

made by four year-old for purpose of treatment; admission was harmless error; “[t]o be admissible, the declarant's apparent motive must be consistent with receiving treatment, and the statements must be information on which the medical provider reasonably relies to make a diagnosis.”); *Silves v. King*, 93 Wn. App. 873, 884, 970 P.2d 790 (1999) (statements made to plant physician evaluating whether employee capable of returning to work are not made for purposes of diagnosis or treatment).

Novel Scientific Evidence; Frye Rule. The determination whether to admit novel scientific evidence involves two related inquiries: (1) whether the scientific principle or theory from which the testimony is derived is generally accepted in the relevant scientific community under the *Frye* standard [*Frye v. United States*, 293 F. 1013 (D.C. Cir. 1923)]; and (2) whether there are techniques, experiments, or studies utilizing that theory which are capable of producing reliable results and are generally accepted in the scientific community. *State v. Riker*, 123 Wn.2d 351, 359, 869 P.2d 43 (1994); *State v. Copeland*, 130 Wn.2d 244, 261, 922 P.2d 1304 (1996) (affirming Washington’s adherence to *Frye* rule; *Grant v. Boccia*, 133 Wn. App. 176, 178, 137 P.3d 20 (2006). If there is significant dispute in the relevant scientific community about the validity of the scientific theory, it may not be admitted. *Grant v. Boccia*, 133 Wn. App. at 179. Several Washington decisions have upheld the exclusion of evidence for failure to meet the Frye standard. *E.g.*, *Eakins v. Huber*, 154 Wn. App. 592, 608, 225 P.3d 1041 (2010) (affirming exclusion of testimony that metal stent caused allergic reaction); *Grant v. Boccia*, 133 Wn. App. at 185-86 (affirming exclusion of testimony that fibromyalgia was caused by auto accident); *Ruff v. Department of Labor & Indus.*, 107 Wn. App. 289, 301, 28 P.3d 1 (2001) (excluding testimony that exposure to chemicals caused porphyria).

Use of Expert Depositions at Trial. Where the expert witness is located in the State of Washington but out of the county and more than 20 miles from the place of trial, or where the parties have stipulated that the deposition may be used for all purposes allowed by the civil rules, a party may offer the deposition at trial in lieu of live testimony. CR 32(a)(3)(B), 32(a)(5)(A); *Pimentel v. Roundup Co.*, 32 Wn. App. 647, 656, 649 P.2d 135 (1982), *aff’d*, 100 Wn.2d 39 (1983).

8.9.2 Excluded Evidence.

8.9.2.1 Apology or Expression of Sympathy.

In any action against a health care provider alleging professional negligence for personal injuries, or a related mediation or arbitration, a 2006 Washington statute, provides that a statement “expressing apology, fault, sympathy, commiseration, condolence, compassion, or a general sense of benevolence” relating to the injury or suffering as the result of the alleged negligence, or a statement regarding remedial actions to address the act of negligence, is not admissible if the statement is made within 30 days of the act or omission that is the basis for the allegation of professional negligence, or 30 days from the health care provider’s discovery of the act or omission, whichever is later. RCW 5.64.010 [2006 Wash. Laws. Ch. 8, sec. 101] (effective date: June 7, 2006).

A 2002 Washington statute limits the admission of some expressions of sympathy. RCW 5.66.010. The statute provides that “benevolent gestures expressing sympathy or a general sense of benevolence” are not admissible. RCW 5.66.010(1). The statute defines “benevolent gestures” to mean “actions that convey a sense of compassion or commiseration emanating from humane impulses.” RCW 5.66.010(2)(b). The statement must relate to “the pain, suffering, or death of a person involved in an accident.” RCW 5.66.010(1). The statute apparently encompasses injuries from medical malpractice: “accident” is broadly defined as “an occurrence resulting in injury or death to one or more persons that is not the result of willful action by a party.” RCW 5.66.010(2)(a). The application of the statute is limited to benevolent gestures that are expressed to family members, as identified in the statute. RCW

5.66.010(2)(c). The statute does not limit the admission of a statement of fault. RCW 5.66.010(1).

8.9.2.2 Unreasonable or Unrelated Medical Expenses.

A jury may award past economic damages including “[t]he reasonable value of necessary medical care, treatment and services.” See WPI 30.07.01, 30.01.01. The test for determining damages is whether the sums requested for medical services are reasonable. *Hayes v. Wieber*, 105 Wn. App. 611, 616, 20 P.3d 496 (2001).

A plaintiff may admit evidence of the reasonable value of the medical services they receive not the total of all bills paid. *Hayes v. Wieber*, 105 Wn. App. 611, 616, 20 P.3d 496 (2001). A court may exclude evidence that plaintiff’s physician accepted an amount paid by insurance company as payment in full, rather than the full amount billed. *Hayes v. Wieber*, 105 Wn. App. 611, 616, 20 P.3d 496 (2001).

Medicaid patients. Medicaid patients are not obligated to pay for the value of their care in excess of the amount paid by Medicaid. Under the Medicaid statute, 42 U.S.C. § 1396a(a)(25)(C), the treatment provider for a Medicaid beneficiary has an obligation to collect from the Medicaid beneficiary no more than the amount of the Medicaid payment.³ See, e.g., *Olszewski*, 69 P.3d at 945 (citing numerous cases).

A defendant in a medical malpractice action may present evidence regarding alternative causes for plaintiff’s condition. E.g., *Schlagenhauf v. Holder*, 379 U.S. 104, 119 (1964) (“A plaintiff in a negligence action who asserts mental or physical injury ... places that mental or physical injury clearly in controversy and provides the defendant with good cause ... to determine the existence and extent of such asserted injury”); see also RCW 5.60.060(4)(b) (personal injury action waives physician-patient privilege “as to all physicians or conditions”).

8.9.2.3 Collateral Source: Evidence of Other Payments to Plaintiff.

In a medical malpractice action, unlike many other types of civil actions, the jury is allowed to learn of evidence of other sources of funding for plaintiff’s injuries. RCW 7.70.080 provides:

Any party may present evidence to the trier of fact that the plaintiff has already been compensated for the injury complained of from any source except the assets of the plaintiff, the plaintiff’s representative, or the plaintiff’s immediate family. In the event such evidence is admitted, the plaintiff may present evidence of an obligation to repay such compensation and evidence of any amount paid by the plaintiff, or his or her representative or immediate family, to secure the right to the compensation. Compensation as used in this section shall mean payment of money or other property to or on behalf of the plaintiff, rendering of services to the plaintiff free of charge to the plaintiff, or indemnification of expenses incurred by or on behalf of the plaintiff.

³ The statute provides that a state Medicaid plan must provide:

that in the case of an individual who is entitled to medical assistance under the State plan with respect to a service for which a third party is liable for payment, the person furnishing the service may not seek to collect from the individual (or any financially responsible relative or representative of that individual) payment of an amount for that service.

42 U.S.C. § 1396a(a)(25)(C).

Notwithstanding this section, evidence of compensation by a defendant health care provider may be offered only by that provider.

“For medical malpractice cases, RCW 7.70.080 replaces the common law’s collateral source rule.” *Adcox v. Children’s Orthopedic Hosp.*, 123 Wn.2d 15, 40, 864 P.2d 921 (1993) (finding error in trial court’s failure to admit evidence of collateral sources in medical malpractice action) (citing *Lange v. Raef*, 34 Wn. App. 701, 704, 664 P.2d 1274 (1983), as stating the common law collateral source rule); *see also Mahler v. Szucs*, 135 Wn.2d 398, 412 n.4, 957 P.2d 632, 966 P.2d 305 (1998) (“[t]he Legislature has abolished the collateral source rule in the specific case of injuries occurring as a result of health care”). The *Adcox* court explained the difference between the common law rule and RCW 7.70.080:

The collateral source rule, still in effect for many types of cases, provides that “a tortfeasor may not reduce damages, otherwise recoverable, to reflect payments received by a plaintiff from a collateral source, that is, a source independent of the tortfeasor.” *Lange v. Raef*, 34 Wn. App. 701, 704, 664 P.2d 1274 (1983). The primary motivation in doing away with the collateral source rule [in medical malpractice actions] is the [common law] rule allows plaintiffs to recover more than their total damages. Under the collateral source rule, a plaintiff could recover 100 percent of the damages from a liable defendant, even if the plaintiff had already recovered a portion of the damages from another source, such as insurance. Because the rule overcompensated plaintiffs, it came to be viewed as imposing unnecessary costs on society and causing higher insurance premiums. *See* Daena Goldsmith, Comment, *A Survey of the Collateral Source Rule: The Effects of Tort Reform and Impact on Multistate Litigation*, 53 J. Air L. & Com. 799, 802-03, 827-29 (1987-1988).

Adcox, at 40; *see also id.* at 41 (“[t]he primary goal in eliminating the collateral source rule has been to prevent overcompensating plaintiffs in light of the resulting costs to society”). The statute reserves for the jury the “task of examining the extent to which the plaintiff has already been compensated by third parties for the injuries incurred by the defendant and the additional task of offsetting these recoveries from the damages being assessed against the defendant.” *Id.*

External Resource: WPI 2.13 (jury instruction re: insurance)

8.9.2.4 Insurance for Defendant.

Insurance for Defendant. The fact that a defendant may be insured is not admissible. ER 411.

External Resource: WPI 2.13 (jury instruction re: insurance)

8.9.2.5 Character Evidence.

ER 404(b) prohibits the admission of evidence of prior acts at trial to “prove the character of a person to show action in conformity therewith.” Prior acts by the defendant are generally irrelevant in a civil case. *E.g.*, *Tyler v. Pierce County*, 188 Wash. 229, 234, 62 P.2d 32 (1936); *Corum v. Blomquist*, 116 Wash. 196, 198, 198 P. 727 (1921); *Houck v. University of Wash.*, 60 Wn. App. 189, 201-02, 812 P.2d 103 (1991); *Dickerson v. Chadwell, Inc.*, 62 Wn. App. 426, 432-33, 814 P.2d 687 (1991).

8.9.2.6 Opinions on the Law.

A party may not obtain admission of a legal opinion or legal conclusion. *E.g., State v. Clausing*, 147 Wn.2d 620, 628, 56 P.3d 550 (2002) (“[f]or an expert to testify to the jury on the law usurps the role of the trial judge”).

8.9.2.7 Licensure Status.

The exclusion of evidence of unlicensed status is not an abuse of discretion. *Kappelman v. Lutz*, 167 Wn.2d 1, 8, 217 P.3d 286 (2009) (excluding evidence of lack of motorcycle permit in action for injury from motorcycle accident).

8.9.3 Jury Instructions.

General Principles. Jury instructions should not be misleading, should allow the parties to argue their theories of the case, and when read as a whole properly inform the trier of fact of the applicable law. *Richards v. Overlake Hosp. Med. Ctr.*, 59 Wn. App. 266, 275, 796 P.2d 737 (1990); *State v. Clausing*, 147 Wn.2d 626, 628, 56 P.3d 550 (2002). Jury instructions should present the law in a neutral format, and not engage in advocacy or argument for either party. *Watson v. Hockett*, 107 Wn.2d 158, 163, 727 P.2d 669 (1986) (jury instructions state only the law; “[c]urrent practice is to avoid slanted or argumentative instructions”); *Ford v. Chaplin*, 61 Wn. App. 896, 900, 812 P.2d 532 (1991); *Brown v. Dahl*, 41 Wn. App. 565, 583, 705 P.2d 781 (1985) (overemphasis of one party’s case in the jury instructions deprives the other of a fair trial).

A jury instruction may not comment on the evidence. *Ketchum v. Overlake Hosp.*, 60 Wn. App. 406, 413, 804 P.2d 1283 (1991) (disapproving as a comment on the evidence the use of a jury instruction that testimony of other experts stating that they would have followed a different course of treatment is not enough to establish negligence). An instruction commenting on the evidence is presumed prejudicial. *State v. Boss*, 167 Wn.2d 710, 721, 223 P.3d 506 (2009).

Identification of Claims (WPI 20.01). The identification of the claims should not be argumentative. *See Naranen v. Harders*, 1 Wn. App. 1014, 1021-22, 466 P.2d 521 (1970).

Medical Malpractice Actions. Accepted pattern jury instructions are available for certain aspects of medical malpractice cases. WPI 105.01-.09. The number and specific language of the instructions are matters left to the trial court’s discretion. *Petersen v. State*, 100 Wn.2d 421, 440, 671 P.2d 230 (1983).

- Negligence – General Health Care Provider (WPI 105.01). [See § 8.4 above.]
- Negligence – Health Care Provider – Specialist (WPI 105.02). [See § 8.3 above.]
- Negligence – Hospital (WPI 105.02.01-105.02.03). [See § 8.6.6 above.]
- Hospital Responsibility – Corporate Negligence (WPI 105.02.02). [See § 8.6.6 above.]
- Negligence – Hospital – Apparent Agency (WPI 105.02.03). [See § 8.6.6 above.]
- Burden of Proof – Negligence – Health Care Provider (WPI 105.03). [See § 8.4 above.]
- Informed Consent – Health Care Provider (WPI 105.04). A jury instruction based on the verbatim language of RCW 7.70.060 is appropriate. *Vasquez v. Markin*, 46 Wn. App. 480, 485-86, 731 P.2d 510 (1986). [See § 8.3.7 above.]

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- Burden of Proof – Informed Consent – Health Care Provider (WPI 105.05). [See § 8.3.7 above.]
- Theories of Recovery (WPI 105.06). This instruction summarizes the three theories of medical liability identified in RCW 7.70. [See § 8.1 above.]
- No Guarantee/Poor Result (WPI 105.07). The jury may be instructed that the physician does not guarantee the results of treatment. *Vasquez v. Markin*, 46 Wn. App. 480, 488, 731 P.2d 510 (1986). This supplements the standard of care instruction. *Christensen v. Munsen*, 123 Wn.2d 234, 247-48, 867 P.2d 626 (1994) (affirming the use of jury instruction re: poor result); *Watson v. Hockett*, 107 Wn.2d 158, 166-67, 727 P.2d 669 (1986); *Miller v. Kennedy*, 91 Wn.2d 155, 159, 588 P.2d 734 (1978). Whether to give this instruction is the trial court’s discretion. *Christensen v. Munsen*, 123 Wn.2d 234, 248, 867 P.2d 626 (1994). This instruction is particularly appropriate where the jury has heard evidence or argument from which it might reach an improper conclusion that doctors guarantee good results. *Watson*, 107 Wn.2d at 164. In most medical malpractice cases, the instruction should and will be given. *Id.* This instruction is not appropriate, however, where there is a claim that a physician promised a particular result. *Watson v. Hockett*, 107 Wn.2d 158, 164, 727 P.2d 669 (1986).
- The jury may also be instructed that a poor result is not evidence of negligence. *Vasquez v. Markin*, 46 Wn. App. 480, 488, 731 P.2d 510 (1986). This supplements the standard of care instruction. *Christensen v. Munsen*, 123 Wn.2d 234, 247-48, 867 P.2d 626 (1994); *Watson v. Hockett*, 107 Wn.2d 158, 166-67, 727 P.2d 669 (1986); *Miller v. Kennedy*, 91 Wn.2d 155, 159, 588 P.2d 734 (1978). Whether to give this instruction is the trial court’s discretion. *Christensen v. Munsen*, 123 Wn.2d 234, 248, 867 P.2d 626 (1994). This instruction is particularly appropriate where the jury has heard evidence or argument from which it might reach an improper conclusion that doctors can be found negligent merely because of a bad result. *Watson*, 107 Wn.2d at 164. In most medical malpractice cases, the instruction should and will be given. *Id.* [See § 8.4.1 above.]
- Exercise of Judgment (Error of Judgment) (WPI 105.08). The jury may be instructed regarding the exercise of judgment, also known as the “error of judgment” instruction, where “(1) in arriving at a judgment, the physician exercised reasonable care and skill within the standard of care that the physician was obliged to follow, and (2) the physician was confronted with a choice among competing therapeutic techniques or among medical diagnoses.” *Christensen v. Munsen*, 123 Wn.2d 234, 249, 867 P.2d 626 (1994) (affirming use of “error of judgment” instruction); *Watson v. Hockett*, 107 Wn.2d 158, 164-65, 727 P.2d 669 (1986) (affirming use of “error in judgment” instruction; instruction is to be given with great caution); *Miller v. Kennedy*, 91 Wn.2d 155, 160, 588 P.2d 734 (1978); *Housel v. James*, 141 Wn. App. 748, 760, 172 P.3d 712 (2007) (affirming use of instruction where defendant was presented with treatment choices); *Ezell v. Hutson*, 105 Wn. App. 485, 488, 20 P.3d 975 (2001); *Gerard v. Sacred Heart Med. Ctr.*, 86 Wn. App. 387, 388-89, 937 P.2d 1104 (1997) (affirming use of “error of judgment” instruction in context of nursing); *Thomas v. Wilfac, Inc.*, 65 Wn. App. 255, 263-64, 828 P.2d 597 (1992) (affirming use of “error of judgment” instruction); *Vasquez v. Markin*, 46 Wn. App. 480, 488-89, 731 P.2d 510 (1986). This supplements the standard of care instruction. [See § 8.4.1 above.]
- Loss of Chance of Survival (WPI 105.09). [See § 8.5.4. above.]

After-acquired knowledge. The jury may be instructed that the physician is to be judged based on what he or she knew or should have known at the time of the diagnosis and treatment, and not in the light of after-acquired knowledge. *Gjerde v. Fritzsche*, 55 Wn. App. 387, 391-92, 777 P.2d 1072

(1989); *Vasquez v. Markin*, 46 Wn. App. 480, 487-89, 731 P.2d 510 (1986); *Meeks v. Marx*, 15 Wn. App. 571, 579, 550 P.2d 1158 (1976).

Causation (WPI 15.01-15.02). [See § 8.5.2. above] Where experts differed as to what the cause of the injury was, the court may give a special instruction on proximate cause to inform the jury that the causal relationship must be established by evidence that rises above “speculation, conjecture, or mere possibility.” *McLaughlin v. Cooke*, 112 Wn.2d 829, 837, 774 P.2d 1171 (1989) (evidence is insufficient where “the jury must resort to speculation or conjecture in determining the causal relationship”); *Young v. Group Health*, 85 Wn.2d 332, 340, 534 P.2d 1349 (1975) (approving jury instruction stating rule where proximate cause is central issue in the case); *O’Donoghue v. Riggs*, 73 Wn.2d 814, 824, 440 P.2d 823 (1968); *Vanderhoff v. Fitzgerald*, 72 Wn.2d 103, 108, 431 P.2d 969 (1967) (approving jury instruction stating rule).

Damages. The jury may be instructed regarding the elements to be considered in determining an award of damages. WPI 30.00-30.09.02. Economic damages include medical expenses (WPI 30.07.01-30.07.02), and lost wages and lost earning capacity (WPI 30.08.01). The jury is instructed that future economic damages are reduced to their present cash value. WPI 34.02. The jury is instructed that the award of damages excludes any pre-existing injuries. WPI 30.17-30.18. The jury instructed regarding the plaintiff’s responsibility to mitigate damages. WPI 33.01-33.03. The jury may be instructed regarding the life expectancy, based upon a calculation using the standard mortality table. WPI 34.04. Where loss of chance damages are at issue, the jury should be instructed regarding how loss of chance damages are calculated. *See* WPI 105.09. Separate jury instructions also exist regarding damages for wrongful death and survival actions (WPI 31.00-31.07.01), and for damages for injuries to a spouse, parent, or child (WPI 32.01-32.06.01).

8.9.4 Closing Arguments – “Golden Rule” Limitations.

The biblical golden rule states a standard of conduct for individuals: Do unto others as you would have them do unto you. *E.g.*, *Adkins v. Aluminum Co. of Am.*, 110 Wn.2d 128, 139, 750 P.2d 1257, 756 P.2d 142 (1988) (citing Luke 6:31). Generally, references by counsel to the golden rule per se, or allusions to the rule, such arguments that ask the jurors to place themselves in the position of one of the parties to the litigation, or to grant a party a recovery they would wish themselves if they were in the same position, are improper golden rule arguments. *Adkins*, 110 Wn.2d at 139.

8.9.5 Jury Deliberation and Verdict.

Jury discussion of personal life experiences involving medical issues during deliberation of a medical malpractice action does not constitute extrinsic evidence, but inheres in the verdict. *Breckenridge v. Valley Gen. Hosp.*, 150 Wn.2d 197, 204, 75 P.3d 944 (2003).

A jury verdict finding that a defendant is negligent but that the negligence was not a proximate cause of the plaintiff’s injuries is not inconsistent if there is evidence to support a finding of negligence but also evidence to support a finding that the resulting injury would have occurred regardless of the defendant’s actions. *Estate of Stalkup v. Vancouver Clinic, Inc., P.S.*, 145 Wn. App. 572, 586, 187 P.3d 291 (2008).

8.10 Post-Trial Considerations.

8.10.1 Attorney Fees.

An attorney who has represented a plaintiff in a medical malpractice action is entitled to recovery for substantial performance under a contingency fee agreement. *Goncharuk v. Barrong*, 132 Wn. App. 745, 749, 133 P.3d 510 (2006).

8.10.2 Appeals.

Where Appeals Are Heard. Most medical malpractice actions are tried in state court. Appeals are generally heard at the Washington State Court of Appeals.

Effect of Pendency of Appeal. A trial court decision may be enforced pending appeal or review unless stayed. RAP 8.1(b). A stay pending appeal generally requires the posting of a supersedeas bond to provide security for the amount of the judgment. *Id.* Even where a bond has been posted, interest continues to accrue on any judgment while an appeal is pending. RCW 4.56.110(3) (judgments generally); RCW 4.56.115 (judgments against the State of Washington); RCW 19.52.020 (setting general interest rate of 12% or market rate, whichever is higher). Interest accrues, as a general rule, beginning from the date of entry of judgment until the judgment is satisfied. RCW 4.56.110(4).

8.10.3 Mandatory Reporting.

Federal. Any entity that makes a payment under a policy of insurance, self-insurance, or otherwise in settlement, partial settlement, or satisfaction of a judgment in a medical malpractice action or claim on behalf of a physician must report the payment to the National Practitioner Data Bank, and the MQAC. 42 U.S.C. § 11131, 45 CFR 60.5, 60.7.

State. An insurer is obliged to report to the State Department of Health any payment for malpractice in excess of \$20,000, as well as any time that there are three or more payments within five years, regardless of amount. RCW 18.71.350(1).

In 2006, a new statute requires, beginning in January 1, 2008, the reporting, by the insurer or a self-insuring health care provider or facility, of any closed medical malpractice claim to state insurance commissioner, regardless of whether payment has been made or not. RCW 48.140.020. The reported information is protected from public disclosure. RCW 48.140.040.

8.10.4 Revocation/Restriction of Privileges.

Medical malpractice liability could result in adverse consequences to a health care practitioner's privileges. *See generally* WSSHA Health Law Manual Chapter 16 Peer Review and Quality Assurance Requirements).

8.10.5 Return/Destruction of Health Care Records.

State law does not have any specific provision requiring the return of health care records following their use in litigation. *See* RCW 70.02. The physician-patient privilege is waived in most medical malpractice cases, and there is no provision for its restoration at the conclusion of the litigation. *See* RCW 5.60.060(4)(b). HIPAA regulations, however, require that disclosures for the purpose of litigation be limited to "the minimum necessary to accomplish the intended purpose." *See* 45 CFR 164.502(b), 164.514(d). [*See also* WSSHA Health Law Manual Chapter 1 (Healthcare Information, Confidentiality).] Reasonable efforts should be made to protect the privacy of the information following the conclusion of the litigation.

External Resources:

<http://www.hhs.gov/ocr/privacy>