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STATE OF WASHINGTON
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Court of Appeals
Division I
State of Washington
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No.
101470-8

SUPREME COURT OF
THE STATE OF WASHINGTON

COURT OF APPEALS DIVISION I
STATE OF WASHINGTON No. 83002-3

DR. HUNG DANG, M.D.,

Petitioner,

vs.

FLOYD PFLUEGER & RINGER, P.S., a Washington Professional Services Corporation, and; REBECCA SUE RINGER, an individual,

Respondents.

PETITION FOR REVIEW

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I. Identity of Petitioner

Petitioner Dr. Hung Dang, M.D., plaintiff in the underlying legal malpractice lawsuit and Appellant in Division I, seeks review of the published decision by Division I, as authorized by RAP 13.4(a).

II. Citation to Court of Appeals Decision

Petitioner Dr. Dang seeks review of the Court of Appeals' October 17, 2022 published decision affirming dismissal of his legal malpractice complaint bearing Westlaw citation __Wn. App. 2d __, 518 P.3d 671 (2022). Appx. 001.

III. Issues Presented for Review

A. Proximate Cause

Petitioner seeks review from the fourth in a series of four (4) legal malpractice appeals submitted for decision this year in which Division I has been called upon to decide whether a genuine issue of material fact remains in dispute relative to proximate cause.[1] Here, Division I held that Dr.

1 In addition to this Petition: (1) *Spice v. Lake,* Supreme Court case no.

Dang did not establish that a genuine issue of material fact remained in dispute relative to whether he may have received a lesser (or no) discipline from MQAC but for Ms. Ringer's negligence. (Neither Patient B or C sustained harm as a result of Dr. Dang's alleged conduct).

Division I held that "we do not review in this appeal the propriety of the findings that MQAC made." 518 P.3d at 683. However, this Court has previously held that the victim of legal malpractice is *not* bound by collateral estoppel in the follow-on legal malpractice case when the lawyer's negligence induced the client's loss. *Barr v. Day,* 124 Wn.2d 318, 879 P.2d 912 (1994).

Moreover, the MQAC decisions relative to Patient B and C, based on RCW 18.130.180 [Appx. 25], conflict with both EMTALA and the standards established by this Court's prior

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1012501 (Petition for Review pending); (2) *Cox v. Lasher Holzapfel,* Supreme Court case no. 1014155 (Petition for Review pending) and; (3) *Angelo v. Kindinger,* case no. 82388-4, 2022 WL1008314. Petitioner maintains that Division I reached the correct result in *Angelo v. Kindinger.*

decisions in *Haley v. Medical Disciplinary Board*, 117 Wn.2d 728, 818 P.2d 1062 (1991), *In re Kindschi*, 52 Wn.2d 8, 319 P.2d 824 (1958) (physician's conviction for tax fraud), and *Standow v. Spokane*, 88 Wn.2d 624, 564 P.2d 1145 (1977), and the Court of Appeals in *In re: Farina*, 94 Wn. App. 441, 460, 972 P.2d 531 (1999).

1. Does the Division I refusal to review the propriety of MQAC's findings in the underlying disciplinary proceeding conflict with this Court's prior decision in *Barr v. Day* and thus warrant review pursuant to RAP 13.4(b)(1) and/or (b)(2)?

2. Considering that Division I based its proximate cause decision relative to "Patient B" and "Patient C" on an erroneous interpretation of RCW 18.130.180 and EMTALA that conflicts with prior decisions of this Court and the Court of Appeals, should the Court grant review pursuant to RAP 13.4(b)(1) and/or (b)(2)?

3. Considering that a legal malpractice plaintiff may *not* introduce expert testimony to establish the probable

outcome of the underlying matter and all reasonable inferences must be drawn in his favor, did Petitioner Dang establish that a genuine issue of material fact remains in dispute relative to proximate cause?

B. Attorney Judgment Rule

In addition to the issue of proximate cause, Division I also held that the "attorney judgment rule" is a "component of the standard of care." 518 P.3d at 679. Although this Court has never ruled on the nature of the attorney judgment rule, the Division I decision conflicts with this Court's analogous decision in *Fergen v. Sestero,* 182 Wn.2d 794, 805, 346 P.3d 708 (2015), which arose in the context of medical malpractice and WPI 105.08 (the jury related to judgmental immunity) in which the Court held that judgmental immunity "**does not alter or add any additional elements for a plaintiff to prove.**" (Emphasis added).

Significant confusion exists relative to application of the attorney judgment rule and, unfortunately, the Division I

decision has merely added to that confusion. See, *e.g.* 2 Mallen, *Legal Malpractice* §19.1, pp. 1244 (2022 ed.); 4 Mallen, *supra* at §33:17, pp. 703-722, and 2 Mallen, *supra* at §19.1, pp. 1238-1245 ("In contrast to a true 'immunity' defense which avoids liability for tortious conduct, the 'judgmental immunity' negates only fault").[2]

Here, Dr. Dang's standard of care expert established that a genuine issue of material fact remained in disputed relative to the attorney judgment rule—and yet, Division I deemed that testimony insufficient to defeat summary judgment. CP 1468-1486. How then can a victim of legal malpractice *ever* defeat a defense motion for summary judgment based on the attorney judgment rule?

4. Considering that the Division I opinion in this case conflicts with this Court's decision in *Fergen v. Sestero,* 182 Wn.2d 794, 805, 346 P.3d 708 (2015) and rejects the express

---

[2] The "attorney judgment rule" is also at issue in the *Cox* case referenced in footnote 1, above.

language relative to the nature of the attorney judgment rule enunciated in the Division I and Division II decisions in *Spencer v. Badgley-Mullins Turner, PLLC*, 6 Wn. App. 2d 762, 796, 432 P.3d 821 (2018) and *Clark Cnty Fire Dist. No. 5 v. Bullivant Houser Bailey, P.C.*, 180 Wn. App. 689, 707, 324 P.3d 743 (2014), should the Court grant review pursuant to RAP 13.4(b)(1) and/or RAP 13(b)(2)?

IV. Statement of the Case

A. The Underlying MQAC Proceedings

Dr. Hung Dang is a board-certified otolaryngologist ("ENT") who, at all times relevant to these proceedings (2011-2017), was employed by Group Health Physicians Group ("GHC") and assigned to St. Joseph's Medical Center in Tacoma. CP 413-414 (Ans. to 'Rog. no. 15); CP 525, 549 (¶1.1), 566 (¶1.1). At least as early as 2011, problems arose between CHI Franciscan and the ENT's employed by GHC over Franciscan's community call protocols and procedures as applied to the GHC otolaryngologists. CP 517-

523, 617-633.

When those problems remained unresolved, a new Vice President at Franciscan reported alleged violations by Dr. Dang of the federal Emergency Medical Treatment & Labor Act ("EMTALA") to the Medical Quality Assurance Commission ("MQAC") for allegedly declining to accept patients referred from Franciscan facilities other than St. Joseph's. Dr. Dang's employer (GHC) retained the Defendant law firm of Floyd Pflueger & Ringer, P.S. and Defendant Rebecca Sue Ringer to defend Dr. Dang in the disciplinary proceeding. CP 0007 ¶3.12; CP 0035 ¶1.18; CP 0366-0367(31:20-36:5), CP 369 (49:15-19); CP 421-511.

Early in her representation, and prior to the filing of any disciplinary charges against Dr. Dang, Ms. Ringer knew of the critical and long-standing dispute between Franciscan and the GHC otolaryngologists over "community call." *E.g.,* CP 518-523, 526-527. Thus, in her June 24, 2015 submission to the MQAC staff, Ms. Ringer explained that the EMTALA

allegations against Dr. Dang arose out of "disagreement regarding the scope of community call for admitting providers at FHS hospitals" due to "inconsistent call protocols" followed by Franciscan. CP 526. And, more specifically, Dr. Dang had not committed the alleged EMTALA violations because "Dr. Dang was not on call for St. Clare Hospital."[3] *Id.* Ms. Ringer thus recognized from the outset of her representation the critical importance of proving the nature of the "disagreement regarding the scope of community call" and the "inconsistent" call protocols to the defense of the disciplinary proceeding.

On March 30, 2016, the MQAC issued a Statement of Charges against Dr. Dang. CP 0534. Days later, on April 4, 2016, MQAC issued a Corrected Statement of Charges against Dr. Dang, which included the following allegations [CP 0550-551]:

> A. Dr. Dang violated the community standard of care, Emergency Medical Treatment and Labor Act

[3] St. Clare and St. Francis Hospitals, and *not* St. Joseph's with which Dr. Dang was affiliated, were the sources of the patients.

(EMTALA), and his ethical obligations as a physician when he refused to treat Patient A [1.6]

B. Dr. Dang violated the community standard of care, Emergency Medical Treatment and Labor Act (EMTALA), and his ethical obligations as a physician when he refused to treat Patient B [1.10]

C. Dr. Dang violated the community standard of care, Emergency Medical Treatment and Labor Act (EMTALA), and his ethical obligations as a physician when he refused to treat Patient A [1.16]

MQAC further alleged that Dr. Dang's conduct relative to Patients A, B, and C constituted "unprofessional conduct in violation of RCW 18.130.180(1), (4), and (7) and EMTALA, 42 USC Sec. 13955dd(d)(1)(B) and (C)." CP 551 ¶2.1.

Ms. Ringer's defense of Dr. Dang *always* relied upon and emphasized the dispute between the GHC otolaryngologists and Franciscan. For example, Ms. Ringer's primary argument in her Pre-Hearing Memorandum on behalf of Dr. Dang opened with the following assertion [CP 589]:[4]

[4] CP 1483-1484, 1485 ("when a lawyer has a controlling theory of her case, as evidenced by Ms. Ringer's letter to Ms. De Leon and Mr. Glein, the narrative in her Prehearing Statement, her opening statement and her

> Dr. Dang's exercise of medical judgment not to accept the transfers of Patients A, B, and C did not occur in a vacuum. Instead, this decision was influenced by the political realities surrounding FHS's community call protocols and procedures for patient transfer. . .
>
> For the past several years, there has been disagreement regarding the scope of community call for admitting providers at FHS hospitals. Under the FHS Medical Staff Bylaws and Rules and Regulations, community call is specific to each campus rather than the entire FHS network. Nonetheless, although their [*i.e.*, ENT's employed by GHC] practice is only affiliated with St. Joseph, FHS previously required Dr. Dang and his ENT group to take community call for all FHS campuses against their own written bylaws. In practice, this meant that patients who presented to outlying hospitals in the FHS network were sometimes transferred to St. Joseph for ENT consultations with Dr. Dang and his group.

Ms. Ringer's Opening Statement during the disciplinary hearing similarly opened with and emphasized the "long-standing dispute" between GHC and Franciscan over its community call protocols and procedures for transfer of patients, explaining [CP 670-682]:

> . . .[T]his was an ongoing topic of discussion because the ENT surgeons and probably other specialties—other

closing argument to the MQAC panel, that lawyer has an obligation to her client to marshal all available evidence in support of that controlling theory").

> specialists saw that this wasn't what the bylaws of the hospital say; that they are not actually to be on call to the emergency department at these other hospitals. And the practice continued during these conversations that the groups were having with the administration at St. Joseph Hospital.

Unfortunately, Ms. Ringer had *presumed* that the adverse parties and witnesses would not dispute the existence of the long-standing dispute between the GHC otolaryngologists and Franciscan during the MQAC proceeding. More specifically, the Witness and Exhibit List submitted by Ms. Ringer on behalf of Dr. Dang did *not* include any documentary exhibits designed to establish the existence of that corporate dispute. CP 0575. As a result, the Pre-Hearing Order No. 2 similarly failed to include any such documentation. CP 0608. The significance of Ms. Ringer's omission became apparent in light of the warning set forth in Pre-Hearing Order No. 2 §5 (CP 611, emphasis added):

> Exhibits: **Documentary evidence not offered in the prehearing conference shall not be received into evidence at the adjudicative proceeding absent good cause. WAC 246-11-390(7).** [Emphasis added].

However, when Ms. Ringer cross-examined Franciscan's "associated chief medical officer and vice-president of quality for CHS Franciscan Network," Dr. Kim Moore,[5] the following exchange occurred [CP 790-791 (156:15-157:20)]:

> Q [by Ms. Ringer]: Good afternoon, Dr. Moore. I'm Rebecca Ringer and I represent Dr. Dang in this matter. Now, before this phone call on this day back in 2014,[6] you were already familiar with the fact that there was ongoing discussion between the ENT specialists and the Franciscans about the issue of community call, correct?
> A [Dr. Moore]: No, I was not aware.
> Q: Did you take over for Tony Haftel?
> A: I did.
> Q: He didn't alert you to the fact that this has been a brewing issue, there is ongoing conversation and this needs to be addressed?
> A: No.
> Q: Were—you were never made award of that in any regard?
> A: No.
> Q: How about until right now?
> A: Yes, before today I knew that it was an issue, but not back in 2012.
> Q: And I'm talking about 2014?
> A: 2014.
> Q: So you were unaware that there was this issue between the ENT surgeons and the hospital about call?

[5] Dr. Moore is an emergency medicine physician and *not* an ENT.

[6] "This phone call back in 2014" refers to events related to "Patient C."

A: No. I knew that the call structure was complicated, but I didn't know that there were issues.

Q: Okay. Who was the head of the—of the St. Joseph ENT department at the time you took over your job?

A: I believe it was Dr. Souliere.

Q: And did you ever read any—or talk to him about this whole issue about community call and the specialist coverage?

A: No.

Whether due to forgetfulness or malice, Dr. Moore testified in error that she had no knowledge of the ongoing problems relating to patient transfers within the CHI Franciscan Health System that had festered since 2011 and remained unresolved at the time Patients A, B and C had presented to Dr. Dang. CP 617-633. To make matters worse, the MQAC panel expressly found Dr. Moore credible. CP 1337 ¶1.20.

Unprepared to properly cross-examine Dr. Moore with documentary evidence or testimony by Dr. Haftel, Ms. Ringer instead attempted to mitigate the effects of Dr. Moore's surprise testimony by offering email chains into evidence to establish that the dispute over the community call protocols and

procedures had existed and continued without resolution since 2011—and that Dr. Moore had actual knowledge of that dispute. **CP 613-617.** As Ms. Ringer explained to the MQAC panel [CP 1326]:

> [T[he documents were relevant, **would speak to Dr. Moore's credibility** and only became necessary after Dr. Moore's testimony. [Emphasis added].

However, the MQAC panel excluded the email chains from evidence based on Ms. Ringer's failure to identify and offer them at the pre-hearing conference, commenting [CP 1302-1304 and nn. 1-2; CP 1326-1328 and nn. 3-5]:

> Dr. Moore was identified at the prehearing conference as a witness. **<u>The Respondent knew or should have known that any documents containing prior statements by Dr. Moore could become relevant.</u>** This is especially true given that the documents have been in the Respondent's sole possession since 2011 and 2014 respectively. Thus, these documents should have been disclosed if the Respondent desired to have them become part of the record. **Moreover, any uncertainties pertaining to Dr. Moore's testimony could have been resolved by deposing her. However, the Respondent's failure to do either has resulted in prejudice to the Department at this stage of the proceeding.** Consequently, the Respondent has failed to demonstrate the necessary good cause for failing to produce evidence

at the prehearing conference. [Emphasis added].

Ms. Ringer's closing argument also opened with and emphasized the inconsistency and uncertainty surrounding Franciscan's community call protocols and procedures for transfer of patients to St. Joe's [CP 1277-1278 (641:2-642:6)]:

> This story really is a case of David and Goliath. There is a large healthcare system flexing its muscles. That's what this case is about. . . . There is an ongoing, for many years at this point, discussion, disputes, problem with coverage—call coverage in the Franciscan Health System system and part of it is because the system is growing and yet the—and the expectation is not being changed. . .

Following the administrative hearing, the MQAC determined that: (1) Dr. Dang had not violated RCW 18.130. 180 or EMTALA relative to Patient A; (2) Dr. Dang had not violated EMTALA but had violated RCW 18.130.180 relative to Patient B, and; (3) violated EMTALA and RCW 18.130.180 relative to Patient C. CP 1301, 1324. As punishment, the MQAC ordered two years of oversight of Dr. Dang's medical practice, monitoring requirements, and a $5,000 fine. *Id.* Shortly thereafter, GHC terminated Dr. Dang's employment

and he has been unable to find employment in his specialty of otolaryngology since then. CP 0414 (Ans. to 'Rog. no. 16).

Ms. Ringer thereafter prepared and filed a Petition for Review of the MQAC decision on behalf of Dr. Dang. CP 380-381 (101:1-103:14), 1348. Soon thereafter, Ms. Ringer and Floyd Pflueger & Ringer withdrew from representing Dr. Dang, who nevertheless continued to pursue the Petition for Review and appeal *pro se*, albeit unsuccessfully, through **Division I, which held** in pertinent part that "Dr. Dang did not show good cause because he [*i.e.*, Ms. Ringer] did not produce the documentary evidence at the prehearing conference." *Dang v. Wash. DOH (MQAC),* 10 Wn. App.2d 650, 670-672, 450 P.3d 1189 (2019).[7]

B. Proceedings in the Trial Court

Dr. Dang filed his Complaint alleging legal malpractice

[7] *Dang v. Washington DOH,* 195 Wn.2d 1004, 458 P.3d 781 (2020), *review den'd,* U.S. __, 141 S. Ct. 371, 208 L. Ed. 2d 94 (2020).

on November 23, 2020. CP 1. The defendants answered the complaint and alleged a counterclaim for $2,408.44 in fees and expenses allegedly owed by Dr. Dang. CP 033, 039 ¶3.5.

The parties each moved for summary judgment on multiple issues. CP 045-046, 0314-0315. Dr. Dang's summary judgment opposition included the declaration of expert standard of care witness Kenneth S. Kagan. CP 1468. Mr. Kagan is a former WSBA Disciplinary Counsel and a litigator with extensive experience in the representation of health care providers in professional disciplinary proceedings. CP 1469 ¶¶3-6. Based on his review, Mr. Kagan opined that Ms. Ringer's representation of Dr. Dang in the MQAC proceeding fell below the standard of care in multiple respects. CP 1481-485. He also directly addressed the Defendants' attorney judgment rule defense, commenting [CP 1485]:

> It is not my position that ***no*** reasonable lawyer would have made those choices, but it is my position that those judgment were not ***informed* decisions.** Because those decisions were not made in the exercise of reasonable care, but were made on the basis of

> uninformed speculation on Ms. Ringer's part, it is my opinion that she should not benefit from the so-called "attorney judgment rule." [Emphases in original].

On June 7, 2021, the trial court denied Dr. Dang's CR 56(f) motion, granted the defendants' motion for summary judgment and denied Dr. Dang's motion for partial summary judgment. CP 1508, 1510. Dr. Dang timely appealed

C. Proceedings in Division I

The Court of Appeals affirmed dismissal of Dr. Dang's legal malpractice case, holding relative to proximate cause that "we do not review in this appeal the propriety of the findings that MQAC made." 518 P.3d at 683. Based on that limitation, Division I held that no reasonable juror could have concluded that he would have suffered a lesser discipline regardless of Ms. Ringer's breaches of the standard of care.

Division I further held that the attorney judgment rule is not an affirmative defense but, instead, a "component of the standard of care." 518 P.3d 679.

V. ARGUMENT WHY THE COURT SHOULD GRANT REVIEW

A. Division I Erred When It Refused to Correct the MQAC's Error in Its Interpretation of RCW 18.130.180, Contrary to *Barr v. Day*.

Application of collateral estoppel in legal malpractice claims poses a unique problem if the defendant/attorney in the legal malpractice case also represented the plaintiff/client in the underlying matter, as here. The seminal treatise, *Legal Malpractice*, thus explains that collateral estoppel does *not* apply "if the client's prior position was induced by the negligence of the attorney, and the attorney's conduct was not adjudicated." 3 Mallen, *supra* §22.61, p. 298.

These principles led to this Court's seminal decision in addressing application of collateral estoppel to the client's legal malpractice claim arising out of the conduct of the client's former attorney in an underlying matter, *i.e., Barr v. Day,* 124 Wn.2d 318, 879 P.2d 912 (1994), in which the Court explained [124 Wn.2d at 326]:

> As to the unfairness prong, we note a simple principle. . [I]f she [*i.e.,* Mrs. Barr] agreed to the settlement and urged its approval based on attorney misfeasance or nonfeasance, it is not unjust to permit her to rectify her error.

Accord, *Schibel v. Eymann,* 189 Wn.2d 93, 100, 399 P.3d 1129 (2017); *Primiani v. Schneider, supra* at *4-5; *Ryan v. Ford*, 16 S.W.3d 644, 649 (Mo. App. 2000); *Channel v. Loyacono,* 954 So.2d 415, 426 (Miss. 2007); *Smith v. Hastie,* 367 S.C. 410, 626 S.E.2d 13, 18-19 (S.C. App. 2005); see further, *Restatement (Second) of Judgments* §29 (1982).

Thus, if Ms. Ringer's negligence "induced" errors in the interpretation and application of RCW 18.130.180 and/or EMTALA, then Division I erred when it refused to review the MQAC findings based on those erroneous interpretations.

B. Genuine Issues of Material Fact Existed Relative to Proximate Cause.

Here, the MQAC Board concluded that Dr. Dang violated RCW 18.130.180 relative to Patients B and C, and violated the Emergency Medical Treatment and Labor Act

("EMTALA") relative to Patient C.

The question, therefore, is whether the defense established that no genuine issue of material fact remained as to whether the disciplinary panel may have reached a different conclusion, relative to either Patient B or Patient C (or both), *if* Ms. Ringer had met the standard of care.

RCW 18.30.180

RCW 18.130.180 establishes standards of "unprofessional conduct" applicable to Washington health professionals (including Dr. Dang). RCW 18.130.180 describes unprofessional conduct, pertinent here, as:

> (1) The commission of any act of moral turpitude, dishonesty or corruption. . . . . .
>
> (4) Incompetence, negligence, or malpractice which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed. . . .
>
> (7) Violation of any state or federal statute or administrative rule regulating the profession in question, including any statute or rule defining or establishing standards of patient care or professional conduct or practice.

Relative to Patient B, the MQAC panel determined that Dr. Dang violated RCW 18.130.180(1) and (4), but not EMTALA, because his "refusal to consult with the emergency room doctor . . .lowered the standing of the profession in the eyes of the public . . .[and] created an unreasonable risk of harm to the patient." CP 1335 ¶1.13, CP 1338-1339 ¶¶2.4-2.5.

Relative to Patient C, the MQAC panel concluded that Dr. Dang violated EMTALA when he failed "to appear and treat Patient C once he [*i.e.*, Patient C] was transferred to SJMC" and he violated RCW 18.130.180(1) and (7) because his "refusal to treat Patient C created an unreasonable risk of harm to Patient C and lowered the standing of the profession in the eyes of the public." CP 1336-1337 ¶¶1.19, CP 1338-1339 ¶2.4, 2.7-2.8.

However, the MQAC panel's reference to lowering the standing of the profession in the eyes of the public, as establishing "moral turpitude," critical to its findings of RCW

18.130.180(1)violations, relied on *Haley v. Medical Disciplinary Board*, 117 Wn.2d 728, 818 P.2d 1062 (1991) in which the "moral turpitude" applied to a 66-year-old physician who established a sexual relationship with his 16-year old patient. *Haley*, in turn, relied upon *In re Kindschi,* 52 Wn.2d 8, 319 P.2d 824 (1958) (physician's conviction for tax fraud); *Standow v. Spokane,* 88 Wn.2d 624, 564 P.2d 1145 (1977) (denial of taxi license based on prior convictions for larceny and burglary),

However, "[t]he **definition of moral turpitude** does not encompass merely technical and unwitting violations. It **is an act of 'baseness, vileness, or the depravity in private and social duties which man owes to his fellow man[.]'"** *In re: Farina,* 94 Wn. App. 441, 460, 972 P.2d 531 (1999)[emphasis added].[8] *Farina* further explains [*id.* 94 Wn. App. at 460-461]:

The decisions reserve "moral turpitude" for such

[8] In the underlying appeal of the MQAC decision, Division I rejected *Farina* as "inapposite," but did *not* conduct an analysis of "moral turpitude" as applicable to the facts and case law as set forth here. *Dang, supra,* 10 Wn. App.2d at 666.

> egregious conduct as sexual misconduct with patients or clients. [Citations omitted]. Even violation of a criminal statute does not necessarily involve moral turpitude, and the **statute must be examined for inherent immorality.**" [Emphasis added].

Consistent with *Farina* and *Haley,* a social worker engaged in an act of moral turpitude by commencing a sexual relationship with a patient the day after the formal therapist-patient relationship concluded. *Heinmiller v. DOH,* 127 Wn.2d 595, 903 P.2d 433 (1995).

Unfortunately, Ms. Ringer failed to brief the limitations of moral turpitude before the MQAC panel. CP 0588-0605. Had she done so, or *if* Division I would have examined MQAC's erroneous statutory interpretation, discipline based on the circumstances related to Patient B would not have constituted a violation of RCW 18.130.180(1).

Second, as Division I correctly concluded, EMTALA does *not* establish a standard of care, thus recognizing that the purported violation of EMTALA relative to Patient C did *not* occur and could not have warranted discipline by MQAC.

518 P.d at 683. Again, however, Ms. Ringer did *not* point out that EMTALA does *not* establish a standard of care, the breach of which would have violated RCW 18.130.180.

Moreover, the only other possible violation would have to have occurred under RCW 18.130.180(7), *i.e.,* [v]iolation of any state or federal statute or administrative rule regulating the profession in question, including any statute or rule defining or establishing standards of patient care or professional conduct or practice" which regulates hospitals and does not establish a standard for patient care.

Genuine issues of material fact thus remained in dispute as to whether Ms. Ringer's breaches of the standard of care may have proximately caused the discipline (or the extent of the discipline) of Dr. Dang.

C. Division I Erred When It Held that the Attorney Judgment Rule Is a "Component" of the Standard of Care.

The attorney judgment rule insulates an attorney from liability for making an erroneous decision involving honest,

good faith judgment **if** (1) that decision was within the range of reasonable alternatives from the perspective of a reasonable, careful, and prudent attorney in Washington; **and** (2) in making that judgment decision the attorney exercised reasonable care. *Clark Cnty. Fire Dist. No. 5 v. Bullivant Houser Bailey P.C.*, 180 Wn. App. 689, 701-704, 324 P.3d 743 (2014). Both *Clark Cnty Fire Dist.* and *Spencer v. Badgley Mullins Turner, PLLC,* 6 Wn. App. 2d 762, 796, 432 P.3d 821 (2018) refer to the attorney judgment rule as an affirmative defense. More significantly, *Fergen v. Sestero,* 182 Wn.2d 794, 805, 346 P.3d 708 (2015) previously held that judgmental immunity "**does not alter or add any additional elements for a plaintiff to prove**" in the analogous context of medical malpractice. (Emphasis added).

Division I nevertheless resiled from the language of *Clark Cnty* and *Spencer*, holding instead that the attorney judgment rule is some sort of "component" of the standard of care. What does that mean in the context of legal malpractice

summary judgment and trial? Must the defense raise the attorney judgment rule in its opening summary judgment motion or may it raise it for the first time in reply? Must the plaintiff anticipate that argument in its summary judgment opposition or case in chief, regardless of whether the defense initially raises the issue? Division I does not say.

The Court should therefore grant review of the attorney judgment rule issue pursuant to RAP 13.4(b)(1) and/or (b)(2).

VI. Conclusion

For these reasons, the Court should grant Dr. Dang's Petition and, upon review, reverse the decisions of the Court of Appeals and the trial court, and remand this case for trial.

VII. RAP 18.17 Certificate of Compliance

This brief complies with the type-volume limitation of RAP 18.17 because this brief contains 4857 words, which is less than the 5,000-word limitation.

DATED: November 16, 2022.

WAID LAW OFFICE, PLLC

BY: /s/ Brian J. Waid
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CERTIFICATE OF SERVICE

This document was filed via CM/ECF and will be automatically served on all registered participants. Additional copies served by mail: None, unless requested.

DATED: November 16, 2022.

WAID LAW OFFICE, PLLC

BY: /s/ Brian J. Waid
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Attorney for Petitioner

518 P.3d 671
Court of Appeals of Washington, Division 1.

Dr. Hung DANG, M.D., a single person, Appellant,
v.
FLOYD, PFLUEGER & RINGER, PS, a Washington professional services corporation; and Rebecca Sue Ringer, an individual, Respondents.

No. 83002-3-I
|
Filed October 17, 2022

Synopsis
Background: Client brought legal negligence claim against attorney and law firm, arising from representation during hearing before Medical Quality Assurance Commission (MQAC). The Superior Court, King County, Judith Ramseyer, J., 2021 WL 3174496, granted summary judgment in favor of attorney and firm, and denied client's motion to continue summary judgment hearing. Client appealed.

Holdings: The Court of Appeals, Birk, J., held that:

[1] client was not required to present expert testimony;

[2] client failed to establish that trier of fact could reasonably have reached more favorable outcome in hearing had omitted evidence been admitted; and

[3] continuance of summary judgment hearing was not warranted.

Affirmed.

West Headnotes (27)

[1] **Judgment** ⇐ Presumptions and burden of proof

Initial burden, of party seeking summary judgment, to show absence of genuine issue of material fact can be met by showing absence of evidence to support nonmoving party's burden of proof at trial.

[2] **Attorneys and Legal Services** ⇐ Malpractice or negligence in general; nature and elements

To establish legal negligence claim, plaintiff must prove (1) existence of attorney-client relationship which gives rise to duty of care on part of attorney to client, (2) act or omission by attorney in breach of duty of care, (3) damage to client, and (4) proximate causation between attorney's breach of duty and damage incurred.

[3] **Attorneys and Legal Services** ⇐ Mistakes or errors in judgment; attorney judgment rule

Attorneys and Legal Services ⇐ Defenses, Excuses, and Justifications

Attorneys and Legal Services ⇐ Pleadings

In context of legal negligence claim, attorney judgment rule is not affirmative defense which defendant must plead in answer; rather, rule is aspect of attorney standard of care. Wash. Super. Ct. Civ. R. 8.

[4] **Attorneys and Legal Services** ⇐ Mistakes or errors in judgment; attorney judgment rule

In matters of professional judgment, plaintiff may establish legal negligence, pursuant to attorney judgment rule, by showing that no reasonable Washington attorney would have made same decision as defendant attorney- in other words, by showing that decision itself violated standard of care because it was not within range of reasonable alternatives from perspective of reasonable, careful, and prudent attorney in Washington.

[5] **Attorneys and Legal Services** ⇐ Mistakes or errors in judgment; attorney judgment rule

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Plaintiff may establish legal negligence, pursuant to attorney judgment rule, by showing that attorney's decision was arrived at in manner that violated standard of care, such as because it was uninformed decision.

[6] **Attorneys and Legal Services** ⇐ Mistakes or errors in judgment; attorney judgment rule

In context of legal negligence claim, attorney judgment rule does not protect decision that is not within standard of care for particular situation, that was arrived at through means violating standard of care, or that was not made in good faith.

[7] **Attorneys and Legal Services** ⇐ Mistakes or errors in judgment; attorney judgment rule

In general, error in professional judgment or in trial tactics, without more, does not subject attorney to liability for legal negligence, pursuant to attorney judgment rule, merely because professional judgment or tactic led to disadvantageous outcome.

[8] **Attorneys and Legal Services** ⇐ Mistakes or errors in judgment; attorney judgment rule

Attorney judgment rule is dependent on attorney arriving at professional judgment or trial tactic while exercising standard of care consisting of degree of care, skill, diligence, and knowledge commonly possessed and exercised by reasonable, careful, and prudent lawyer in practice of law in Washington.

[9] **Attorneys and Legal Services** ⇐ Mistakes or errors in judgment; attorney judgment rule

Attorney judgment rule reflects that range of strategic approaches may be reasonable and within standard of care in given representation, notwithstanding that reasonable strategy based on appropriate evaluation may not lead to desired outcome.

[10] **Attorneys and Legal Services** ⇐ Mistakes or errors in judgment; attorney judgment rule

When professional judgment or trial tactic falls into attorney judgment rule because it was reasonable decision, appropriately arrived at, within standard of care, and made in good faith, it does not amount to legal negligence.

[11] **Attorneys and Legal Services** ⇐ Merits of claim or defense; "case within a case"

To show proximate cause in legal negligence claim arising out of litigation matter, client must show that client would have fared better but for asserted mishandling of representation by attorney.

[12] **Attorneys and Legal Services** ⇐ Merits of claim or defense; "case within a case"

Manner in which plaintiff in legal negligence action must go about showing that better result would have been achieved but for attorney's negligent handling of litigation matter, as necessary to show proximate cause, involves unique characteristics compared to other types of tort cases.

[13] **Attorneys and Legal Services** ⇐ Merits of claim or defense; "case within a case"

Determining cause in fact in legal negligence case arising out of litigation matter requires trial within trial, and plaintiff re-presents underlying matter to trier of fact, that time presenting matter free of deficiencies of original presentation alleged to be negligent; trier of fact may then replicate judgment that would have been obtained without negligence, and difference in trier of fact's conclusion, if any, shows what reasonable jury or fact finder in initial cause of action would have done, and therefore shows any disparity in outcome that is but for consequence of original lawyer's allegedly deficient performance.

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[14] **Attorneys and Legal Services** ⇐ Questions of law or fact

Proximate cause, for purposes of legal negligence claim, is generally determined by trier of fact, but court can determine proximate cause as matter of law if reasonable minds can reach only one conclusion.

[15] **Judgment** ⇐ Attorneys

To avoid summary judgment in legal negligence case, for purposes of proximate causation element, plaintiff must produce evidence that error in judgment did in fact affect outcome.

[16] **Attorneys and Legal Services** ⇐ Necessity of expert evidence

Client was not required to present expert testimony establishing that, but for attorney's alleged negligence, he would have fared better in hearing before Medical Quality Assurance Commission (MQAC) in order to demonstrate proximate causation, as necessary to prevail on legal negligence claim brought against attorney and law firm, arising from representation during hearing; inquiry into whether reasonable trier of fact could reach conclusion more favorable to client if record included evidence omitted by attorney could be made without expert testimony, by comparing reasonable inferences trier of fact could make from original record, as supplemented with evidence client asserted was lacking, with conclusions MQAC panel in fact reached.

[17] **Attorneys and Legal Services** ⇐ Necessity of expert evidence

Nature of cause in fact inquiry in legal negligence cases arising out of litigation matters demonstrates that plaintiff is not necessarily required to come forward with expert testimony specifically establishing that but for attorney's alleged negligence plaintiff would have fared better.

[18] **Attorneys and Legal Services** ⇐ Merits of claim or defense; "case within a case"

Focus of re-presentation of case to trier-of-fact, in legal negligence case, for purpose of determining proximate cause is not on what particular trier-of-fact would have done, but rather on what reasonable trier of fact would have done, i.e., what result would have been without negligence.

[19] **Attorneys and Legal Services** ⇐ Necessity of expert evidence

When cause in fact is to be established by trier of fact's assessment of re-presented case, for purpose of proximate causation element of legal negligence claim, plaintiff is not necessarily required to present expert testimony on causation, because trier of fact will assess merits of matter as re-presented.

[20] **Evidence** ⇐ Causation

Purported expert testimony, in determining proximate causation in legal negligence case, to effect that trier of fact would have responded more favorably in original matter may be subject to exclusion as inherently speculative.

[21] **Evidence** ⇐ Causation

Expert opinion may be relevant in legal negligence proceeding, in determining proximate cause, to demonstrate evidence that should have been presented in original proceeding.

[22] **Attorneys and Legal Services** ⇐ Merits of claim or defense; "case within a case"

Evidence in legal negligence matter must be sufficient to allow trier of fact to reach conclusion that is more favorable than one that was reached based on original presentation in order to establish proximate causation; that evidence may take form of additional evidence that was not in original presentation.

[23] Attorneys and Legal Services — Merits of claim or defense; "case within a case"

Client, a doctor, failed to show trier of fact could reasonably have reached more favorable outcome in hearing before Medical Quality Assurance Commission (MQAC), alleging violations of Emergency Medical Treatment and Labor Act (EMTALA) and standard of care, had omitted evidence been admitted, as necessary to demonstrate proximate cause required to prevail on legal negligence claim brought against attorney and law firm; MQAC did not find violation regarding one patient, emails about community call would have had no effect on MQAC's determination that client's refusal to consult regarding another patient lowered public standing and created risk of harm, and depositions and emails would not have effected determination that client violated EMTALA with respect to third patient, given MQAC decided client was obligated to treat patient regardless of whether he was properly transferred. Social Security Act § 1867, 42 U.S.C.A. § 1395dd; Wash. Rev. Code Ann. §§ 18.130.180, 18.130.180(4), 18.130.180(7).

[24] Judgment — Hearing and determination

Continuance of summary judgment hearing was not warranted in legal negligence action brought by client against attorney and law firm, even though client argued trial court condoned defense gamesmanship of delaying deposition of former law firm associate when court proceeded with hearing and that he was unable to depose associate, whose work constituted majority of services on client's case; although client indicated that, had he been allowed to depose associate, he would have expected to further investigate attorney's decision-making process when she decided to omit individual and emails from witness and exhibit list, attorney testified that she approved list, and even if attorney had good reason for delay in obtaining associate's deposition, evidence client sought was at most speculative. Wash. Super. Ct. Civ. R. 56(f).

[25] Judgment — Hearing and determination

When party opposing summary judgment motion shows reasons why party cannot present facts justifying its opposition, trial court has duty to give that party reasonable opportunity to complete record before ruling on case. Wash. Super. Ct. Civ. R. 56(f).

[26] Judgment — Hearing and determination

Trial court may deny motion to continue summary judgment hearing when (1) requesting party does not have good reason for delay in obtaining evidence; (2) requesting party does not indicate what evidence would be established by further discovery; or (3) new evidence would not raise genuine issue of material fact. Wash. Super. Ct. Civ. R. 56(f).

[27] Appeal and Error — Continuance and stay

Trial court's decision on request to continue summary judgment hearing is reviewed for abuse of discretion; court abuses discretion if it bases decision on untenable or unreasonable grounds. Wash. Super. Ct. Civ. R. 56(f).

*674 Honorable Judith Ramseyer, Judge

Attorneys and Law Firms

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PUBLISHED OPINION

Birk, J.

¶1 Hung Dang, MD, brought a legal negligence claim against Floyd, Pflueger & Ringer PS and Rebecca Ringer (together FPR). Ringer represented Dr. Dang in a hearing before the Washington Medical Quality Assurance Commission (MQAC).[1] Dr. Dang asserts that decisions to not call certain witnesses, not offer certain exhibits, and not depose two witnesses, amounted to a breach of the standard of care and proximately caused damage to Dr. Dang. We conclude there is not a reasonable inference that had the omitted evidence been admitted Dr. Dang would have received a more favorable outcome. As a result, the trial court correctly granted summary judgment to FPR. We also conclude the trial court properly denied Dr. Dang's CR 56(f) motion to continue the summary judgment hearing. We affirm.

1 MQAC has since been renamed to Washington Medical Commission, but for consistency with our previous opinion affirming the MQAC findings in Dr. Dang's matter, we continue to refer to the commission as MQAC. See RCW 18.71.015, amended by Laws of 2019, Ch. 55, § 3(1).

I

A

¶2 The underlying facts are set forth in further detail in our opinion in Hung Dang v. Department of Health, in which we upheld the discipline that MQAC imposed on Dr. Dang. 10 Wash. App. 2d 650, 450 P.3d 1189 (2019), review denied, 195 Wash.2d 1004, 458 P.3d 781, cert. denied, — U.S. —, 141 S. Ct. 371, 208 L. Ed. 2d 94 (2020). We summarize the facts here.

¶3 Dr. Dang is an otolaryngologist, specializing in the treatment of the ear, nose, and throat (ENT). Dr. Dang worked at Group Health Cooperative. As a condition of his employment with Group Health, Dr. Dang maintained staff privileges and worked as an on call emergency ENT specialist at St. Joseph Medical Center in Tacoma for all Group Health patients. St. Joseph is one of several hospitals in the Franciscan Health System and is a level II trauma center.

¶4 Dr. Dang and his fellow Group Health ENT specialist colleagues (together "Group Health ENT specialists") took "community call" for St. Joseph patients, covering the general St. Joseph population including those not covered by Group Health. "Community call" means that if a patient presents to an emergency department (ED) and specialty services are needed, a request can be made on behalf of the patient for a specialty physician to come in to evaluate and care for that patient. Active medical staff members are generally expected to take community call.

¶5 The Group Health ENT specialists taking community call at St. Joseph also received consultation calls from EDs at Franciscan's other affiliated hospitals, such as St. Francis Hospital in Federal Way and St. Clare Hospital in Lakewood. ED physicians at the other affiliated hospitals were provided a call schedule for on call specialists who consulted on Group Health patients, and another call schedule for on call specialists who consulted for Franciscan patients. The Group Health ENT specialists received calls because the ED physicians at the affiliated Franciscan hospitals possessed the ENT specialist rotation call schedule published by Franciscan based on the specialists holding privileges at St. Joseph. This led to the Group Health ENT specialists receiving consultation requests not only for Group Health covered patients, but also for Franciscan's other patient population.

¶6 Burdened with the additional caseload, the Group Health ENT specialists objected to accepting consultation calls from Franciscan-affiliated hospitals other than St. Joseph, *675 reasoning that the Franciscan medical staff bylaws did not require them to take such calls. ED physicians from the Franciscan-affiliated hospitals argued Dr. Dang and his colleagues were responsible for the consultation calls and failing to comply might be considered a violation of the Emergency Medical Treatment and Labor Act (EMTALA), 42 U.S.C. § 1395dd.

¶7 EMTALA requires hospitals to treat patients who need emergency medical care, regardless of their ability to pay. 42 U.S.C. § 1395dd; Jackson v. E. Bay Hosp., 246 F.3d 1248, 1254 (9th Cir. 2001). EMTALA was based in part on a concern by Congress that hospitals were "dumping" patients who were unable to pay for care, either by refusing to provide emergency treatment to these patients, or by transferring the patients to other hospitals before the patients were stabilized.

Jackson, 246 F.3d at 1254. Under EMTALA, a hospital must provide appropriate emergency medical care to stabilize the patient's medical condition or transfer the patient to another medical facility provided certain requirements are satisfied. 42 U.S.C. § 1395dd(b), (c).

¶8 Tony Haftel, MD, the former Franciscan vice president of quality and associate chief medical officer, became involved in trying to resolve the community call issue. Kim Moore, MD, succeeded Dr. Haftel and also sought to resolve the issue. On October 5, 2011, Dr. Haftel e-mailed Dr. Dang and Dr. Moore to inform them that Franciscan made it clear to their ED physicians that the Group Health ENT specialists on community call were responsible for St. Joseph as the schedule stated. In an e-mail dated April 30, 2014, Dr. Moore acknowledged meeting with Craig Iriye, MD MHA, the medical center chief for Group Health's Tacoma Medical Center, to discuss the Group Health ENT specialists' concerns. Dr. Moore also suggested a screening checklist for the patient transfer center to use when getting a request to contact a Group Health ENT for a patient consultation.

¶9 The Group Health administration told the Group Health ENT specialists that they must comply with Franciscan's request that the Group Health ENT specialists manage the patients from the entire Franciscan system. Group Health reasoned that doing otherwise might be seen as an EMTALA violation, and Group Health wanted to maintain its partnership and cooperation with Franciscan.

B

¶10 On March 30, 2016, the Washington State Department of Health (DOH) filed a statement of charges against Dr. Dang, alleging violation of EMTALA and the Uniform Disciplinary Act (UDA), chapter 18.130 RCW. The UDA governs licensing and discipline of physicians. RCW 18.130.180 regulates unprofessional conduct. Among other things, it is unprofessional conduct for a licensed health professional to commit an act involving moral turpitude relating to the practice of the person's profession, or commit negligence, malpractice, or incompetence which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed. RCW 18.130.180(1), (4). Additionally, it is unprofessional conduct for a licensed health professional to violate any state or federal statute or administrative rule regulating the profession in question, including any statute or rule defining or establishing standards of patient care or professional conduct or practice. RCW 18.130.180(7).

¶11 The DOH statement of charges against Dr. Dang alleged violations of EMTALA and RCW 18.130.180(1), (4), and (7) with respect to patients "A," "B," and "C." According to the charges, generally, Dr. Dang violated EMTALA and the UDA by refusing to consult on three patients on the grounds that he was not on call for the Franciscan hospitals to which the patients first presented.

¶12 Dr. Dang retained attorney Rebecca Ringer and filed an answer to the statements of charges. MQAC proposed a settlement agreement which would have consisted of stipulated findings of fact, conclusions of law, and an agreed order, and which would have avoided a hearing on the charges. Dr. Dang rejected the settlement offer. Ringer did not depose Dr. Moore in advance of the MQAC hearing. In the prehearing filings, Ringer did not list Dr. Haftel as a witness or identify as *676 exhibits any of the e-mails in which Dr. Moore had acknowledged the existence of the Group Health ENT specialists' concerns about receiving consultation requests from Franciscan hospitals other than St. Joseph.

¶13 Ringer later testified that she did not call Dr. Haftel because she did not think he could provide any information needed for the time frame relevant to Dr. Dang's case. Ringer opted against deposing Dr. Moore because she viewed Dr. Moore's involvement as evident in the record and did not want deposition questioning to allow an adverse witness to become better prepared. Ringer preferred to avoid depositions because doing so would make it less likely the DOH would depose Dr. Dang, and therefore less likely that it would discover the e-mails concerning community call. Ringer did not offer the community call e-mails because she believed using them as evidence would lead the DOH to other evidence that she thought would do "more harm than good" and be "risky" and "dangerous" for Dr. Dang at the hearing. Ringer believed relying on the e-mails would have led the DOH to seek discovery of all related e-mails, beyond just those Dr. Dang believed supported the existence of the community call dispute.

C

¶14 The three day MQAC hearing began on January 30, 2017. On September 29, 2017, MQAC issued its 22 page findings of fact, conclusions of law, and final order. On December 20, 2017, MQAC issued amended findings of fact, conclusions of

law, and final order. This court upheld the MQAC's amended findings of fact, conclusions of law, and final order. Hung Dang, 10 Wash. App. 2d at 675, 450 P.3d 1189.

¶15 MQAC entered findings in regard to the three patients it had charged Dr. Dang with refusing to transfer or see.

1

¶16 MQAC found patient A was seen at St. Clare for facial swelling, an enlarged tongue with airway obstruction, and difficulty breathing and swallowing. It found, based on patient A's medical history and current condition, the ED physician was concerned that patient A's condition could worsen and a specialist who could render a higher level of care was needed. It found St. Clare did not have an ENT specialist on call. And it found Dr. Dang was contacted to care for patient A, but he refused to accept patient A's transfer to St. Joseph.

¶17 Dr. Dang testified that in the handling of the call with the ED physician for patient A, Dr. Dang complied with EMTALA and the applicable standard of care. Dr. Dang reasoned that based on the information he received from the St. Clare ED physician, patient A was not suffering from serious airway issues, and the ED physician should go through the transfer center to process patient A's transfer out of St. Clare.

¶18 MQAC found that Dr. Dang's conduct regarding patient A did not violate the standard of care or EMTALA. It found that patient A was not transferred to St. Joseph and that Dr. Dang was not on call at St. Clare, so Dr. Dang had no duty to treat or accept the transfer of patient A.

2

¶19 MQAC found that patient B was seen at the St. Francis ED for a sore throat, difficulties with swallowing and breathing, and fluid collection consistent with tonsillar abscess. It found, based on patient B's physical examination and the computerized tomography scan results, the ED physician determined that it was necessary to transfer patient B to St. Joseph for further treatment and to consult with an ENT specialist. MQAC also found that Dr. Dang refused to discuss the case with the ED physician, admit patient B, or agree to a transfer.

¶20 Dr. Dang testified that he did not refuse to consult with the ED physician about patient B, but instead told the ED physician that he was driving so he would call back. Dr. Dang stated he wanted to use his computer to look at patient B's medical records and test results to determine whether transferring patient B to St. Joseph would be appropriate. Dr. Dang said when he returned the ED physician's call, patient B's abscess had been successfully drained.

*677 ¶21 For patient B, MQAC found no EMTALA violation, but found Dr. Dang's refusal to consult with the ED physician concerning the care of patient B was an act of moral turpitude that lowered the standing of the profession in the eyes of the public, in violation of RCW 18.130.180(1). Additionally, MQAC found Dr. Dang's refusal to consult with a fellow physician acting in good faith to help a patient created an unreasonable risk of harm to patient B. See RCW 18.130.180(4).

3

¶22 MQAC found that patient C was seen at the St. Clare ED for ear pain, a sore throat, and trouble swallowing. It found the treating staff suspected a retropharyngeal abscess, which is described in the record as a "deep neck space infection[ ] that can pose an immediate life-threatening emergency with the potential for airway compromise." MQAC found the St. Clare ED physician spoke with Dr. Dang, who was the on call specialist at St. Joseph. It found Dr. Dang refused to consult on or accept a transfer of patient C, since he was not on call for St. Clare. And, MQAC found the St. Clare ED physician contacted Harborview Medical Center in Seattle, which did not have capacity to accept patient C, and then the St. Clare ED physician contacted Dr. Moore.

¶23 Dr. Moore testified that she approved the transfer of patient C from St. Clare's ED to St. Joseph's ED. Dr. Moore said Dr. Dang "refused to come in and see the patient." Dr. Moore called Dr. Dang and "asked him to go in and see the patient." According to Dr. Moore, Dr. Dang told her he "would not go in to see the patient because the patient had come from St. Clare." Dr. Moore testified that Dr. Dang did not give "any other reason why he would not or could not come in and see the patient."

¶24 Dr. Dang testified that he did not consult on patient C. Dr. Dang testified that he told Dr. Moore that he was

"not physically capable" of treating patient C because of his recently having taken pain medication. Dr. Dang testified that in late February or early March 2014, he had had ankle surgery. Dr. Dang said that he fell and injured his heel and took a "hydrocodone and acetaminophen combination ... pill" for the pain. Other than his testimony at the MQAC hearing, there is no evidence that Dr. Dang indicated his physical incapacity to see patient C contemporaneous with his conversation with Dr. Moore and refusal to see the patient. Rather, the first evidence of Dr. Dang asserting that he was physically compromised was his testimony at the MQAC hearing, many months after patient C sought treatment. The MQAC hearing panel stated it was not persuaded by Dr. Dang's "after-the-fact justification."

¶25 For patient C, MQAC found that Dr. Dang violated EMTALA and RCW 18.130.180. MQAC noted that patient C was experiencing an emergency medical condition that had not been stabilized, and his transfer to St. Joseph was appropriate. Furthermore, even if the transfer was improper, MQAC concluded that Dr. Dang was "nonetheless obligated under EMTALA to appear and treat patient C once he was transferred to [St. Joseph]."

¶26 As a result of its findings on patients A, B, and C, MQAC ordered oversight of Dr. Dang's medical license for two years, monitoring requirements, and a $5,000 fine.

4

¶27 Ringer does not dispute that the existence of the community call dispute was important to providing an explanation for Dr. Dang's conduct with patients A, B, and C. When Ringer cross-examined Dr. Moore regarding the community call issue, Dr. Moore denied knowledge of the issue:

> Q [Y]ou were already familiar with the fact that there was ongoing discussion between the [Group Health] ENT specialists and the Franciscans about the issue of community call; correct?
>
> A No, I was not aware.
>
> Q Did you take over for Tony Haftel?
>
> A I did.
>
> Q He didn't alert you to the fact that this has been a brewing issue, there is ongoing conversation and this needs to be addressed?
>
> A No.
>
> *678 Q Were - you were never made aware of that in any regard?
>
> A No.
>
> Q How about until right now?
>
> A Yes, before today I knew that it was an issue, but not back in 2012.
>
> Q And I'm talking about 2014?
>
> A 2014.
>
> Q So you were unaware that there was this issue between the ENT surgeons and the hospital about call?
>
> A No. I knew that the call structure was complicated, but I didn't know that there were issues.

¶28 After Dr. Moore denied knowledge of the community call issue, Ringer attempted to introduce the e-mails that Dr. Moore was copied on and replied to from October 6, 2011 and April 30, 2014, but the health law judge excluded them because they had not been disclosed earlier. Ringer testified that her original concerns about relying on the community call e-mails no longer existed, because by that point there would not be additional discovery. Ringer nevertheless did not believe the community call e-mails would strongly impeach Dr. Moore about her ability to recall discussions about the community call issue, and therefore did not see those e-mails as important evidence.

D

¶29 On November 23, 2020, Dr. Dang filed suit against FPR, alleging legal negligence. On January 11, 2021, FPR filed an answer, including affirmative defenses and a counterclaim for unpaid legal fees. Dr. Dang deposed Ringer on April 14, 2021. On May 4, 2021, FPR filed a motion for summary judgment. Dr. Dang sought a continuance of that motion under CR 56(f) so that he could complete the deposition of Ringer's former associate. Dr. Dang filed a motion for partial summary judgment on May 10, 2021, asking the trial court

to determine that Dr. Dang may recover emotional distress damages in his legal negligence case and to reject several of FPR's affirmative defenses.

¶30 The trial court denied Dr. Dang's request for a CR 56(f) continuance and granted FPR's motion for summary judgment. The trial court declined to address Dr. Dang's motion for partial summary judgment as moot. FPR voluntarily dismissed its counterclaim for unpaid fees.

¶31 Dr. Dang appeals.

II

A

[1] ¶32 A party seeking summary judgment bears the initial burden to show the absence of a genuine issue of material fact. Young v. Key Pharms., Inc., 112 Wash.2d 216, 225, 770 P.2d 182 (1989). This burden may be met by showing an absence of evidence to support the nonmoving party's burden of proof at trial. Id. at 225, 770 P.2d 182 n.1. Then, the burden shifts to the nonmoving party to show the existence of a genuine issue of material fact. Id. at 225, 770 P.2d 182. We review an order granting summary judgment de novo. Id. at 226, 770 P.2d 182. We view the evidence and all reasonable inferences therefrom in the light most favorable to the nonmoving party. Id.

[2] ¶33 To establish a legal negligence claim, a plaintiff must prove (1) the existence of an attorney-client relationship which gives rise to a duty of care on the part of the attorney to the client, (2) an act or omission by the attorney in breach of the duty of care, (3) damage to the client, and (4) proximate causation between the attorney's breach of the duty and the damage incurred. Hizey v. Carpenter, 119 Wash.2d 251, 260-61, 830 P.2d 646 (1992).

B

¶34 Dr. Dang's assertions of negligence concern Ringer's exercise of professional judgment about the manner in which to handle the defense to the DOH's charges. As a result, Dr. Dang's assertions of negligence must be analyzed under Washington's attorney judgment rule. Dr. Dang argues that the attorney judgment rule is an affirmative defense, and that because FPR did not state it in its answer, FPR therefore waived it.

[3] [4] [5] [6] ¶35 In the context of a legal negligence claim, the attorney judgment rule is *679 not an affirmative defense which a defendant must plead. Rather, the attorney judgment rule is an aspect of the attorney standard of care. As explained in Clark County Fire District No. 5 v. Bullivant Houser Bailey P.C., in matters of professional judgment, a plaintiff may establish legal negligence by showing that "no reasonable Washington attorney would have made the same decision as the defendant attorney"—in other words, by showing that the decision itself violated the standard of care because it was not within the range of reasonable alternatives from the perspective of a reasonable, careful, and prudent attorney in Washington. 180 Wash. App. 689, 706, 324 P.3d 743 (2014). Alternatively, the plaintiff may establish legal negligence by showing that the decision was arrived at in a manner that violated the standard of care, such as because it was an uninformed decision. Id. The attorney judgment rule does not protect a decision that is not within the standard of care for a particular situation, that was arrived at through means violating the standard of care, or that was not made in good faith. See Cook, Flanagan & Berst v. Clausing, 73 Wash.2d 393, 396, 438 P.2d 865 (1968) (generally approving a jury instruction stating an attorney is not liable for malpractice where the method employed to solve a legal problem is one recognized and approved by reasonably skilled attorneys practicing in the community as a proper method in the particular case); Clark County Fire Dist., 180 Wash. App. at 704-05, 324 P.3d 743 (attorney not liable for making an allegedly erroneous decision involving honest, good faith judgment if (1) that decision was within the range of reasonable alternatives from the perspective of a reasonable, careful, and prudent attorney in Washington, and (2) in making that judgment decision the attorney exercised reasonable care).

[7] [8] [9] ¶36 In general, an error in professional judgment or in trial tactics, without more, does not subject an attorney to liability for legal negligence merely because the professional judgment or tactic led to a disadvantageous outcome. Halvorsen v. Ferguson, 46 Wash. App. 708, 717, 735 P.2d 675 (1986). The attorney judgment rule is dependent on the attorney arriving at a professional judgment or trial

tactic while exercising the standard of care consisting of "the degree of care, skill, diligence, and knowledge commonly possessed and exercised by a reasonable, careful, and prudent lawyer in the practice of law in this jurisdiction." Hizey, 119 Wash.2d at 261, 830 P.2d 646. The attorney judgment rule reflects that a range of strategic approaches may be reasonable and within the standard of care in a given representation, notwithstanding that a reasonable strategy based on an appropriate evaluation may not lead to the desired outcome.

[10] ¶37 This principle is not an affirmative defense that must be pleaded in a defendant's answer under CR 8, but rather reflects the definition of the standard of care. By definition, when a professional judgment or a trial tactic falls into the attorney judgment rule because it was a reasonable decision, appropriately arrived at, within the standard of care, and made in good faith, it does not amount to negligence. In Halvorsen, the plaintiff asserted legal negligence based on an attorney's handling of the apportionment of the value of two businesses owned by divorcing spouses. 46 Wash. App. at 710-11, 735 P.2d 675. The issue of apportionment was then "an uncertain and unsettled legal area" in Washington law, and the record showed that the attorney in his trial brief both appropriately presented the available Washington authorities and made the available arguments based on "informed judgment." Id. at 718-19, 735 P.2d 675. This court concluded that the plaintiff's evidence failed to show a breach of the standard of care, where the plaintiff's experts testified only that they would have handled the issue differently, but conspicuously not that the attorney's handling of the issue was a breach of the standard of care. See id. at 718, 735 P.2d 675. Halvorsen applied the attorney judgment rule by analyzing the adequacy of the plaintiff's evidence to show a breach of the standard of care, not by requiring the attorney defendant to meet an affirmative burden of proof.

¶38 We are not persuaded that this court previously held that the attorney judgment rule is an affirmative defense, as opposed to a component of the standard of care, despite *680 language suggesting otherwise in Clark County Fire District, 180 Wash. App. at 707, 324 P.3d 743, and in Spencer v. Badgley Mullins Turner PLLC, 6 Wash. App. 2d 762, 796, 432 P.3d 821 (2018).

¶39 Although Spencer described the attorney judgment rule as an affirmative defense to a legal negligence claim, it said so while evaluating a breach of fiduciary duty claim based on alleged violations of the Rules of Professional Conduct (RPCs). 6 Wash. App. 2d at 793-96, 432 P.3d 821. That context matters. In Spencer, the jury concluded that an attorney committed legal negligence by failing to submit available evidence, within an extremely short time frame, that the plaintiffs would have been able to buy out co-owners of investment real estate, so as to avoid sale to a third party. Id. at 770, 772, 776, 432 P.3d 821. But the trial court concluded the attorney did not violate the RPCs and did not breach any fiduciary duty. Id. at 800-01, 432 P.3d 821. In context, this court's comment about the attorney judgment rule concerned whether an attorney's good faith exercise of judgment may be asserted as a defense to a claim that the attorney has violated the RPCs. Id. at 796, 432 P.3d 821. Thus, the court was not directly commenting on the elements of legal negligence, but rather identifying the issue raised by the parties of whether good faith, in some circumstances, may be a defense to certain alleged RPC violations. Additionally, the court in Spencer ultimately did not reach whether the attorney judgment rule would provide a defense to alleged RPC violations, because the court upheld the trial court's rulings that the attorney did not violate the RPCs. Id. at 796, 432 P.3d 821.

¶40 Similarly, in Clark County Fire, despite the court's reference to the attorney judgment rule as an affirmative defense, like earlier Washington cases, it analyzed the rule in the context of evaluating the sufficiency of the plaintiff's evidence. 180 Wash. App. at 701, 705, 324 P.3d 743. The court held that the plaintiff's expert testimony that the defendant attorney's decisions breached the standard of care supported the inference that the decisions were not within the range of reasonable alternatives from the perspective of a reasonable, careful and prudent attorney in Washington. 180 Wash. App. at 702, 709, 711, 324 P.3d 743. Despite referring to the attorney judgment rule as being an affirmative defense, neither Spencer nor Clark County Fire applied the rule as a defense depending on a defendant making an affirmative showing.

¶41 Accordingly, we hold that the attorney judgment rule is not an affirmative defense that a defendant must plead in an answer under CR 8.

C

[11] [12] ¶42 To show proximate cause in a legal negligence claim arising out of a litigation matter, the client must show that the client would have fared better "but for" the asserted mishandling of the representation by the attorney. Daugert v. Pappas, 104 Wash.2d 254, 257, 704 P.2d 600 (1985). Washington courts have often remarked that the general principles of causation are usually no different in a legal negligence action than in an ordinary negligence case. Ward v. Arnold, 52 Wash.2d 581, 584, 328 P.2d 164 (1958); Sherry v. Diercks, 29 Wash. App. 433, 437, 628 P.2d 1336 (1981); Boguch v. Landover Corp., 153 Wash. App. 595, 611, 224 P.3d 795 (2009). This is true insofar as the plaintiff must show that the plaintiff would have achieved a better result had the attorney performed the representation without negligence. Daugert, 104 Wash.2d at 257, 704 P.2d 600; VersusLaw, Inc. v. Stoel Rives, LLP, 127 Wash. App. 309, 328, 111 P.3d 866 (2005). But the manner in which the plaintiff must go about showing that a better result would have been achieved but for an attorney's negligent handling of a litigation matter involves "unique characteristics" compared to other types of tort cases. Brust v. Newton, 70 Wash. App. 286, 290, 852 P.2d 1092 (1993).

1

[13] ¶43 At issue is the cause in fact component of proximate cause. See Ang v. Martin, 154 Wash.2d 477, 482, 114 P.3d 637 (2005). Determining cause in fact in a legal negligence case arising out of a litigation matter requires a "trial within a trial." Id. The plaintiff re-presents the underlying matter *681 to a trier of fact, this time presenting the matter free of the deficiencies of the original presentation alleged to be negligent. Daugert, 104 Wash.2d at 257, 704 P.2d 600; Aubin v. Barton, 123 Wash. App. 592, 608-09, 98 P.3d 126 (2004). The trier of fact assessing the matter without the original asserted deficiencies may then "replicate" the judgment that would have been obtained without negligence. Brust, 70 Wash. App. at 293, 852 P.2d 1092. The difference in the trier of fact's conclusion in the legal negligence case, if any, shows "what a reasonable jury or fact finder in the initial cause of action would have done," and therefore shows any disparity in outcome that is the "but for" consequence of the original lawyer's allegedly deficient performance. See Shepard Ambulance, Inc. v. Helsell, Fetterman, Martin, Todd & Hokanson, 95 Wash. App. 231, 235-36, 244-45, 974 P.2d 1275 (1999).

[14] [15] ¶44 Proximate cause is generally determined by the trier of fact, but the court can determine proximate cause as a matter of law if reasonable minds can reach only one conclusion. Smith v. Preston Gates Ellis, LLP, 135 Wash. App. 859, 864, 147 P.3d 600 (2006). To avoid summary judgment, "the plaintiff must produce evidence that the error in judgment did in fact affect the outcome." Clark County Fire Dist., 180 Wash. App. at 707, 324 P.3d 743.

[16] [17] [18] [19] ¶45 Dr. Dang did not present expert testimony specifically on cause in fact, but this is not dispositive. The nature of the cause in fact inquiry in legal negligence cases arising out of litigation matters demonstrates that a plaintiff is not necessarily required to come forward with expert testimony specifically establishing that but for the attorney's alleged negligence the plaintiff would have fared better. The focus of the re-presentation of the case is not on what a particular trier of fact would have done, but rather on what a reasonable trier of fact would have done, i.e., what the result would have been without negligence. Brust, 70 Wash. App. at 293, 852 P.2d 1092. Therefore, when cause in fact is to be established by a trier of fact's assessment of the re-presented case, a plaintiff is not necessarily required to present expert testimony on causation, because the trier of fact will assess the merits of the matter as re-presented in the legal negligence case. Slack v. Luke, 192 Wash. App. 909, 918, 370 P.3d 49 (2016).

[20] [21] [22] ¶46 Purported expert testimony to the effect that a trier of fact would have responded more favorably in the original matter may be subject to exclusion as inherently speculative. See Halvorsen, 46 Wash. App. at 721-22, 735 P.2d 675. Some decisions of this court have at times pointed to a lack of expert testimony on cause in fact as supportive of summary judgment for lack of proof in legal negligence cases. Estep v. Hamilton, 148 Wash. App. 246, 257, 201 P.3d 331 (2008) ("Estep provides no evidence she would have prevailed. Her expert ... did not opine on the subject."); Geer v. Tonnon, 137 Wash. App. 838, 851, 155 P.3d 163 (2007) ("Geer failed to provide expert testimony or other

evidence to demonstrate that such a breach of Tonnon's duty of care was the cause in fact of Geer's claimed damages."). Expert opinion may be relevant to demonstrate the evidence that should have been presented in the original proceeding. Aubin, 123 Wash. App. at 609-10, 98 P.3d 126. The key, however, is that the evidence in the legal negligence matter must be sufficient to allow the trier of fact to reach a conclusion that is more favorable than the one that was reached based on the original presentation. This evidence may take the form of additional evidence that was not in the original presentation. As a result, expert testimony on causation is not necessarily required to show cause in fact in a legal negligence matter.

¶47 Dr. Dang argues that for purposes of summary judgment he needed to establish only that his position would have been materially strengthened but for Ringer's alleged negligence. But Dr. Dang's burden of proof on cause in fact was to show that with the representation he asserts was called for, a trier of fact could reasonably reach a better outcome. Daugert, 104 Wash.2d at 257, 704 P.2d 600; Versuslaw, 127 Wash. App. at 328, 111 P.3d 866; cf. 6 Washington Practice: Washington Pattern Jury Instructions: Civil 107.07, at 654 (7th ed. 2019). Properly framed, the issue for the trial court on summary judgment was whether, *682 with the original MQAC record strengthened by the evidence which was allegedly negligently omitted and by the foreknowledge from depositions Dr. Dang says was lacking, a reasonable trier of fact in the legal negligence case could reach a conclusion that was more favorable than the conclusion the MQAC panel reached. Cf. Spencer, 6 Wash. App. 2d at 779, 432 P.3d 821. Upon such a showing, the question of cause in fact on Dr. Dang's legal negligence claim would be one for the trier of fact to resolve through a trial within a trial, and summary judgment would be properly denied.

[23] ¶48 This inquiry can be made without expert testimony, by comparing the reasonable inferences that a trier of fact in the legal negligence case may make from the original MQAC record as supplemented with the evidence Dr. Dang asserts was lacking, with the conclusions the MQAC panel in fact reached. Speculation about what the original MQAC panel would have done is not relevant. Brust, 70 Wash. App. at 293, 852 P.2d 1092. We do not need to assess the precise boundaries of expert opinion evidence potentially relevant to cause in fact in legal negligence cases, and we do not hold as a general matter that such evidence is necessarily improper. But Dr. Dang's claim does not fail merely because his standard of care expert appropriately declined to speculate about what the original MQAC panel would have decided if it had had the record Dr. Dang claims should have been presented. Rather, we assess in the light most favorable to Dr. Dang how a trier of fact might reasonably view the MQAC record as he says it should have been developed.

2

¶49 For patient A, MQAC stated that there was insufficient evidence to find that Dr. Dang violated the standard of care or violated EMTALA. Dr. Dang could not have received a more favorable outcome on these MQAC findings. It is significant that, for patient A, MQAC accepted that Dr. Dang did not have an obligation to provide treatment or accept a transfer because Dr. Dang was not on call at St. Clare, where patient A first presented. As discussed below, when MQAC found violations for patient B and patient C, it did so based on actions by Dr. Dang that were independent of the fact those patients first presented at hospitals other than St. Joseph where Dr. Dang was on call. This further demonstrates why additional evidence concerning Dr. Dang's basis for disputing call responsibilities towards patients originating at Franciscan hospitals other than St. Joseph does not support a trier of fact in the legal negligence case in reaching a more favorable conclusion on the MQAC charges.

¶50 For patient B, MQAC stated that there was insufficient evidence to find that Dr. Dang violated EMTALA. However, it found that Dr. Dang's refusal to consult with the St. Francis ED physician concerning patient B's care lowered the standing of the profession in the eyes of the public in violation of RCW 18.130.180, and his refusal to consult with the ED physician, who acted in good faith on behalf of patient B, created an unreasonable risk of harm to patient B.

¶51 The omitted evidence forming the basis for Dr. Dang's legal negligence claim would have had no effect on these findings. Dr. Dang's rationale for declining to consult with the ED physician about patient B based on call disputes between Group Health and Franciscan, whether appropriate or not, does not change the fact that Dr. Dang, in fact, declined to consult. Based on the MQAC findings, this put patient B, who experienced difficulties swallowing and breathing, at an unreasonable risk of harm and delayed treatment. Both findings by MQAC make clear that Dr. Dang's violations concerned the relationships between the patients and public with the medical profession, not the relationships between

providers and provider institutions. Dr. Dang presents no evidence about possible testimony by Dr. Haftel or Dr. Moore, and there is no inference from the omitted e-mails, that would support a trier of fact in the legal negligence case in reaching a different conclusion than the MQAC panel reached.

¶52 For patient C, the MQAC panel found that Dr. Dang violated EMTALA when he failed to treat patient C, while he was on call for St. Joseph. The amended MQAC order expressly states, "[F]ailure to utilize a Patient *683 Placement Center does not relieve a practitioner from his/her obligations under [EMTALA]." Even if the transfer was improper or the call structure unsatisfactory, the MQAC panel found that Dr. Dang was nonetheless obligated to treat patient C once he was transferred to St. Joseph.

¶53 Dr. Dang and Kenneth Kagan, Dr. Dang's standard of care expert, take issue with Ringer's failure to depose Dr. Moore, failure to depose Dr. Haftel or list him as a witness, and failure to introduce Dr. Dang's e-mails with Dr. Moore and others concerning the ongoing community call issue. All of this evidence concerns the community call issue the Group Health ENT specialists faced. Dr. Dang called one of his Group Health ENT specialist colleagues, Alex Moreano, MD, who testified extensively on the community call issue. Dr. Moreano and his colleagues believed that they were not obligated to care for patients seen outside of St. Joseph based on the bylaws. Dr. Moreano described the "pushback" he and his colleagues received from the Franciscan ED physicians, who believed the Group Health ENT specialists could be committing an EMTALA violation by refusing to take calls from the other Franciscan-affiliated hospitals. Group Health and the Franciscan administrations sought to address the issue, but ultimately Group Health informed Dr. Dang and Dr. Moreano that they must comply with Franciscan's request to manage patients from their entire system.

¶54 Even based on an MQAC hearing record supplemented with the e-mails and the depositions of Dr. Moore and Dr. Haftel, Dr. Dang does not demonstrate that the evidence would support a trier of fact in the legal negligence case in reaching a more favorable conclusion with regard to the specific circumstances of the violations found as to patient C. Although Kagan saw the disputes between Franciscan and the Group Health ENT specialists as critical to the case, the record is clear that MQAC did not. Whether patient C was properly or justifiably transferred to St. Joseph under the applicable procedures was irrelevant, and MQAC expressly found that Dr. Dang was obligated to treat patient C at St. Joseph. Moreover, the evidence Dr. Dang asserts was negligently omitted concerning the community call dispute would not have had any bearing on Dr. Dang's assertion at the hearing that he did not see patient C because he was under the influence of medication, nor the MQAC panel's rejection of that assertion. Because it was undisputed that Dr. Dang was on call at St. Joseph and refused to treat or consult patient C after transfer to St. Joseph, while patient C was facing a potentially life-threatening condition, additional evidence that there had been a dispute about call requirements would not support a trier of fact in the legal negligence case in arriving at a more favorable outcome for Dr. Dang.

¶55 In reaching this holding, we do not rely on finding that EMTALA imposes a standard of care or directly applies to Dr. Dang.[2] Courts have broadly recognized that EMTALA was not enacted to establish a federal medical negligence cause of action nor to establish a national standard of care. Bryant v. Adventist Health Sys./W., 289 F.3d 1162, 1166 (9th Cir. 2002); Nartey v. Franciscan Health Hosp., 2 F.4th 1020, 1025 (7th Cir. 2021) (joining seven other circuit courts that concluded EMTALA cannot be used to challenge the quality of medical care), cert. denied, — U.S. —, 142 S. Ct. 2770, — L.Ed.2d — (2022). Instead, we rely on the Washington statutory provisions that govern the standard of care and unprofessional conduct of health professionals under RCW 18.130.180. The statute contemplates that a physician may violate a statute independently of whether the physician has violated the standard of care towards a patient. See RCW 18.130.180(4), (7). Regardless, we do not review in this appeal the propriety of the findings that MQAC made. Rather, we review whether Dr. Dang's evidence, as supplemented by the omitted e-mails concerning community call, would support a trier of fact in the legal negligence case in reaching a more *684 favorable conclusion. We do not need to determine whether MQAC was correct in concluding Dr. Dang violated EMTALA when he failed to treat patient C, because the community call e-mails do not support a conclusion other than that he failed to treat the patient. Because the omitted community call e-mails would not alter MQAC's factual findings, they likewise would not alter the panel's conclusion about the significance of those findings.

2 The additional authority which Dr. Dang referenced at oral argument nevertheless leaves open the possibility that EMTALA may apply directly to "an on-call physician who 'fails or refuses to appear within a

> reasonable period of time.' " Martindale v. Indiana Univ. Health Bloomington, Inc., 39 F.4th 416, 423 (7th Cir. 2022) (quoting 42 U.S.C. § 1395dd(d)(1)(C)).

¶56 We conclude that, considered in the light most favorable to Dr. Dang, the omitted depositions and e-mails, together with the reasonable inferences therefrom, would not support a trier of fact in the legal negligence case in reaching a conclusion more favorable to Dr. Dang on the MQAC charges. Nor does Dr. Dang make any argument or offer any evidentiary basis for concluding that any of the omitted evidence would support a trier of fact in imposing lesser discipline than was imposed. Dr. Dang fails to present a material issue of fact on cause in fact, and his claim necessarily fails.

III

[24] ¶57 Finally, we conclude the trial court did not err by denying Dr. Dang's request to continue the summary judgment hearing under CR 56(f). Erica Roberts was a former associate at Floyd, Pflueger & Ringer who assisted Ringer with Dr. Dang's case. Dr. Dang contends the trial court "condoned the defense gamesmanship" of delaying Roberts's deposition when the court proceeded with the summary judgment hearing. Dr. Dang argues that he was unable to depose Roberts and her work constituted the majority of services on Dr. Dang's case before the MQAC hearing. Kagan took issue with some of those services that he deemed critical to the issue of whether Ringer's judgments were informed. FPR responded by arguing that Dr. Dang waited to seek Roberts's deposition until seven weeks before both parties filed their motions for summary judgment and Roberts's testimony would not create a genuine fact dispute regarding breach and concerning causation.

[25] [26] ¶58 A trial court may continue a summary judgment hearing if the nonmoving party shows a need for additional time to obtain additional affidavits, take depositions, or conduct discovery. CR 56(f). When the party opposing a summary judgment motion shows reasons why the party cannot present facts justifying its opposition, the trial court has a duty to give that party a reasonable opportunity to complete the record before ruling on the case. Mannington Carpets, Inc. v. Hazelrigg, 94 Wash. App. 899, 902-03, 973 P.2d 1103 (1999). However, the trial court may deny a motion to continue when (1) the requesting party does not have a good reason for the delay in obtaining the evidence, (2) the requesting party does not indicate what evidence would be established by further discovery, or (3) the new evidence would not raise a genuine issue of material fact. Tellevik v. 31641 W. Rutherford St., 120 Wash.2d 68, 90, 838 P.2d 111 (1992).

[27] ¶59 A trial court's decision on a request to continue a summary judgment hearing under CR 56(f) is reviewed for abuse of discretion. Bldg. Indus. Ass'n of Wash. v. McCarthy, 152 Wash. App. 720, 743, 218 P.3d 196 (2009). A trial court abuses its discretion if it bases its decision on untenable or unreasonable grounds. Id.

¶60 At the summary judgment hearing, the trial court rejected Dr. Dang's argument that Roberts may have had information to contradict Ringer's testimony that Ringer made the decisions at issue. Further, the trial court deemed any argument to the contrary as merely speculative.

¶61 Dr. Dang claims that had he been allowed to depose Roberts, he would have expected to further investigate the decision-making process used by Ringer when she decided to omit Dr. Haftel and the community call e-mails from Dr. Dang's witness and exhibit list. Ringer testified that she and Roberts discussed what to include, Roberts made the preliminary selections, and Ringer finalized the list and approved it.

¶62 Even if we were to find that Dr. Dang had a good reason for any delay in obtaining Roberts's deposition, the evidence Dr. Dang sought was at most speculative, and its discovery would not raise a genuine issue of material fact. Dr. Dang cannot point specifically *685 to what about Ringer's decision-making process he would learn from Roberts's deposition. Further, Dr. Dang cannot point to any additional evidence relevant to proximate cause that would be learned at Roberts's deposition. Dr. Dang does not show how testimony by Roberts would support inferences justifying a more favorable outcome on the MQAC charges. Although the community call issue became the main thrust of Dr. Dang's defense at the hearing, MQAC did not give that argument the weight that Dr. Dang attributes to it. MQAC did not reference the community call issue in the conclusions of law section of its decision as to both EMTALA and RCW 18.130.180 violations. Roberts's deposition would not give rise to a genuine issue of material fact supporting cause in fact, and the trial court did not abuse its discretion when it denied Dr. Dang's CR 56(f) motion.

¶63 Because Dr. Dang's claim fails due to lack of evidence of cause in fact, the emotional distress damages issue is moot, and we need not address it.

¶64 Affirmed.

WE CONCUR:

Chun, J.

Hazelrigg, J.

All Citations

518 P.3d 671

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APPENDIX A: EMTALA
42 USCA §1395dd

United States Code Annotated
Title 42. The Public Health and Welfare
Chapter 7. Social Security (Refs & Annos)
Subchapter XVIII. Health Insurance for Aged and Disabled (Refs & Annos)
Part E. Miscellaneous Provisions (Refs & Annos)

42 U.S.C.A. § 1395dd

§ 1395dd. Examination and treatment for emergency medical conditions and women in labor

Effective: December 27, 2020
Currentness

(a) Medical screening requirement

In the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits under this subchapter) comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition (within the meaning of subsection (e)(1)) exists.

(b) Necessary stabilizing treatment for emergency medical conditions and labor

(1) In general

If any individual (whether or not eligible for benefits under this subchapter) comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either--

(A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition, or

(B) for transfer of the individual to another medical facility in accordance with subsection (c).

(2) Refusal to consent to treatment

A hospital is deemed to meet the requirement of paragraph (1)(A) with respect to an individual if the hospital offers the individual the further medical examination and treatment described in that paragraph and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such examination and treatment, but the individual (or a person acting on the individual's behalf) refuses to consent to the examination and treatment. The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such examination and treatment.

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(3) Refusal to consent to transfer

A hospital is deemed to meet the requirement of paragraph (1) with respect to an individual if the hospital offers to transfer the individual to another medical facility in accordance with subsection (c) and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such transfer, but the individual (or a person acting on the individual's behalf) refuses to consent to the transfer. The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such transfer.

(c) Restricting transfers until individual stabilized

(1) Rule

If an individual at a hospital has an emergency medical condition which has not been stabilized (within the meaning of subsection (e)(3)(B)), the hospital may not transfer the individual unless--

(A)(i) the individual (or a legally responsible person acting on the individual's behalf) after being informed of the hospital's obligations under this section and of the risk of transfer, in writing requests transfer to another medical facility,

(ii) a physician (within the meaning of section 1395x(r)(1) of this title) has signed a certification that[1] based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual and, in the case of labor, to the unborn child from effecting the transfer, or

(iii) if a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person (as defined by the Secretary in regulations) has signed a certification described in clause (ii) after a physician (as defined in section 1395x(r)(1) of this title), in consultation with the person, has made the determination described in such clause, and subsequently countersigns the certification; and

(B) the transfer is an appropriate transfer (within the meaning of paragraph (2)) to that facility.

A certification described in clause (ii) or (iii) of subparagraph (A) shall include a summary of the risks and benefits upon which the certification is based.

(2) Appropriate transfer

An appropriate transfer to a medical facility is a transfer--

(A) in which the transferring hospital provides the medical treatment within its capacity which minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child;

(B) in which the receiving facility--

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(i) has available space and qualified personnel for the treatment of the individual, and

(ii) has agreed to accept transfer of the individual and to provide appropriate medical treatment;

(C) in which the transferring hospital sends to the receiving facility all medical records (or copies thereof), related to the emergency condition for which the individual has presented, available at the time of the transfer, including records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) provided under paragraph (1)(A), and the name and address of any on-call physician (described in subsection (d)(1)(C)) who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment;

(D) in which the transfer is effected through qualified personnel and transportation equipment, as required including the use of necessary and medically appropriate life support measures during the transfer; and

(E) which meets such other requirements as the Secretary may find necessary in the interest of the health and safety of individuals transferred.

(d) Enforcement

(1) Civil money penalties

(A) A participating hospital that negligently violates a requirement of this section is subject to a civil money penalty of not more than $50,000 (or not more than $25,000 in the case of a hospital with less than 100 beds) for each such violation. The provisions of section 1320a-7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply with respect to a penalty or proceeding under section 1320a-7a(a) of this title.

(B) Subject to subparagraph (C), any physician who is responsible for the examination, treatment, or transfer of an individual in a participating hospital, including a physician on-call for the care of such an individual, and who negligently violates a requirement of this section, including a physician who--

(i) signs a certification under subsection (c)(1)(A) that the medical benefits reasonably to be expected from a transfer to another facility outweigh the risks associated with the transfer, if the physician knew or should have known that the benefits did not outweigh the risks, or

(ii) misrepresents an individual's condition or other information, including a hospital's obligations under this section,

is subject to a civil money penalty of not more than $50,000 for each such violation and, if the violation is gross and flagrant or is repeated, to exclusion from participation in this subchapter and State health care programs. The provisions of section 1320a-7a of this title (other than the first and second sentences of subsection (a) and subsection (b)) shall apply

to a civil money penalty and exclusion under this subparagraph in the same manner as such provisions apply with respect to a penalty, exclusion, or proceeding under section 1320a-7a(a) of this title.

(C) If, after an initial examination, a physician determines that the individual requires the services of a physician listed by the hospital on its list of on-call physicians (required to be maintained under section 1395cc(a)(1)(I) of this title) and notifies the on-call physician and the on-call physician fails or refuses to appear within a reasonable period of time, and the physician orders the transfer of the individual because the physician determines that without the services of the on-call physician the benefits of transfer outweigh the risks of transfer, the physician authorizing the transfer shall not be subject to a penalty under subparagraph (B). However, the previous sentence shall not apply to the hospital or to the on-call physician who failed or refused to appear.

(2) Civil enforcement

(A) Personal harm

Any individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for personal injury under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

(B) Financial loss to other medical facility

Any medical facility that suffers a financial loss as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for financial loss, under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

(C) Limitations on actions

No action may be brought under this paragraph more than two years after the date of the violation with respect to which the action is brought.

(3) Consultation with quality improvement organizations

In considering allegations of violations of the requirements of this section in imposing sanctions under paragraph (1) or in terminating a hospital's participation under this subchapter, the Secretary shall request the appropriate quality improvement organization (with a contract under part B of subchapter XI) to assess whether the individual involved had an emergency medical condition which had not been stabilized, and provide a report on its findings. Except in the case in which a delay would jeopardize the health or safety of individuals, the Secretary shall request such a review before effecting a sanction under paragraph (1) and shall provide a period of at least 60 days for such review. Except in the case in which a delay would jeopardize the health or safety of individuals, the Secretary shall also request such a review before making a compliance determination as part of the process of terminating a hospital's participation under this subchapter for violations related to the appropriateness of a medical screening examination, stabilizing treatment, or an appropriate transfer as required by this section, and shall provide a period of 5 days for such review. The Secretary shall provide a copy of the organization's report to the hospital or physician consistent with confidentiality requirements imposed on the organization under such part B.

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(4) Notice upon closing an investigation

The Secretary shall establish a procedure to notify hospitals and physicians when an investigation under this section is closed.

(e) Definitions

In this section:

(1) The term "emergency medical condition" means--

(A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in--

(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

(ii) serious impairment to bodily functions, or

(iii) serious dysfunction of any bodily organ or part; or

(B) with respect to a pregnant woman who is having contractions--

(i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or

(ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.

(2) The term "participating hospital" means a hospital that has entered into a provider agreement under section 1395cc of this title.

(3)(A) The term "to stabilize" means, with respect to an emergency medical condition described in paragraph (1)(A), to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), to deliver (including the placenta).

(B) The term "stabilized" means, with respect to an emergency medical condition described in paragraph (1)(A), that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), that the woman has delivered (including the placenta).

(4) The term "transfer" means the movement (including the discharge) of an individual outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of an individual who (A) has been declared dead, or (B) leaves the facility without the permission of any such person.

(5) The term "hospital" includes a critical access hospital (as defined in section 1395x(mm)(1) of this title) and a rural emergency hospital (as defined in section 1395x(kkk)(2) of this title).

(f) Preemption

The provisions of this section do not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of this section.

(g) Nondiscrimination

A participating hospital that has specialized capabilities or facilities (such as burn units, shock-trauma units, neonatal intensive care units, or (with respect to rural areas) regional referral centers as identified by the Secretary in regulation) shall not refuse to accept an appropriate transfer of an individual who requires such specialized capabilities or facilities if the hospital has the capacity to treat the individual.

(h) No delay in examination or treatment

A participating hospital may not delay provision of an appropriate medical screening examination required under subsection (a) or further medical examination and treatment required under subsection (b) in order to inquire about the individual's method of payment or insurance status.

(i) Whistleblower protections

A participating hospital may not penalize or take adverse action against a qualified medical person described in subsection (c)(1)(A)(iii) or a physician because the person or physician refuses to authorize the transfer of an individual with an emergency medical condition that has not been stabilized or against any hospital employee because the employee reports a violation of a requirement of this section.

CREDIT(S)

(Aug. 14, 1935, c. 531, Title XVIII, § 1867, as added Pub.L. 99-272, Title IX, § 9121(b), Apr. 7, 1986, 100 Stat. 164; amended Pub.L. 99-509, Title IX, § 9307(c)(4), Oct. 21, 1986, 100 Stat. 1996; Pub.L. 99-514, Title XVIII, § 1895(b)(4), Oct. 22, 1986, 100 Stat. 2933; Pub.L. 100-203, Title IV, § 4009(a)(1), formerly § 4009(a)(1), (2), Dec. 22, 1987, 101 Stat. 1330-56, 1330-57; renumbered and amended Pub.L. 100-360, Title IV, § 411(b)(8)(A)(i), July 1, 1988, 102 Stat. 772; Pub.L. 100-485, Title VI, § 608(d)(18)(E), Oct. 13, 1988, 102 Stat. 2419; Pub.L. 101-239, Title VI, §§ 6003(g)(3)(D)(xiv), 6211(a) to (h), Dec. 19, 1989, 103 Stat. 2154, 2245; Pub.L. 101-508, Title IV, §§ 4008(b)(1) to (3)(A), 4207(a)(1)(A), (2), (3), (k)(3), formerly 4027(a)(1)(A), (2), (3), (k)(3), Nov. 5, 1990, 104 Stat. 1388-44, 1388-117, 1388-124; renumbered and amended Pub.L. 103-432, Title I, § 160(d)(4), (5)(A), Oct. 31, 1994, 108 Stat. 4444; Pub.L. 105-33, Title IV, § 4201(c)(1), Aug. 5, 1997, 111 Stat. 373; Pub.L.

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108-173, Title VII, § 736(a)(14), Title IX, § 944(b), (c)(1), Dec. 8, 2003, 117 Stat. 2355, 2423; Pub.L. 112-40, Title II, § 261(a)(3)(A), (E), Oct. 21, 2011, 125 Stat. 423; Pub.L. 116-260, Div. CC, Title I, § 125(b)(2)(B), Dec. 27, 2020, 134 Stat. 2966.)

Footnotes

1 So in original. Probably should be followed by a comma.

42 U.S.C.A. § 1395dd, 42 USCA § 1395dd

Current through P.L. 117-52.

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APPENDIX B: RCW 18.130.180

KeyCite Yellow Flag - Negative Treatment
Proposed Legislation

West's Revised Code of Washington Annotated
Title 18. Businesses and Professions (Refs & Annos)
Chapter 18.130. Regulation of Health Professions--Uniform Disciplinary Act (Refs & Annos)

West's RCWA 18.130.180

18.130.180. Unprofessional conduct

Effective: July 25, 2021
Currentness

The following conduct, acts, or conditions constitute unprofessional conduct for any license holder under the jurisdiction of this chapter:

(1) The commission of any act involving moral turpitude, dishonesty, or corruption relating to the practice of the person's profession, whether the act constitutes a crime or not. If the act constitutes a crime, conviction in a criminal proceeding is not a condition precedent to disciplinary action. Upon such a conviction, however, the judgment and sentence is conclusive evidence at the ensuing disciplinary hearing of the guilt of the license holder of the crime described in the indictment or information, and of the person's violation of the statute on which it is based. For the purposes of this section, conviction includes all instances in which a plea of guilty or nolo contendere is the basis for the conviction and all proceedings in which the sentence has been deferred or suspended. Nothing in this section abrogates rights guaranteed under chapter 9.96A RCW;

(2) Misrepresentation or concealment of a material fact in obtaining a license or in reinstatement thereof;

(3) All advertising which is false, fraudulent, or misleading;

(4) Incompetence, negligence, or malpractice which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed. The use of a nontraditional treatment by itself shall not constitute unprofessional conduct, provided that it does not result in injury to a patient or create an unreasonable risk that a patient may be harmed;

(5) Suspension, revocation, or restriction of the individual's license to practice any health care profession by competent authority in any state, federal, or foreign jurisdiction, a certified copy of the order, stipulation, or agreement being conclusive evidence of the revocation, suspension, or restriction;

(6) Except when authorized by *RCW 18.130.345, the possession, use, prescription for use, or distribution of controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diversion of controlled substances or legend drugs, the violation of any drug law, or prescribing controlled substances for oneself;

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(7) Violation of any state or federal statute or administrative rule regulating the profession in question, including any statute or rule defining or establishing standards of patient care or professional conduct or practice;

(8) Failure to cooperate with the disciplining authority by:

(a) Not furnishing any papers, documents, records, or other items;

(b) Not furnishing in writing a full and complete explanation covering the matter contained in the complaint filed with the disciplining authority;

(c) Not responding to subpoenas issued by the disciplining authority, whether or not the recipient of the subpoena is the accused in the proceeding; or

(d) Not providing reasonable and timely access for authorized representatives of the disciplining authority seeking to perform practice reviews at facilities utilized by the license holder;

(9) Failure to comply with an order issued by the disciplining authority or a stipulation for informal disposition entered into with the disciplining authority;

(10) Aiding or abetting an unlicensed person to practice when a license is required;

(11) Violations of rules established by any health agency;

(12) Practice beyond the scope of practice as defined by law or rule;

(13) Misrepresentation or fraud in any aspect of the conduct of the business or profession;

(14) Failure to adequately supervise auxiliary staff to the extent that the consumer's health or safety is at risk;

(15) Engaging in a profession involving contact with the public while suffering from a contagious or infectious disease involving serious risk to public health;

(16) Promotion for personal gain of any unnecessary or inefficacious drug, device, treatment, procedure, or service;

(17) Conviction of any gross misdemeanor or felony relating to the practice of the person's profession. For the purposes of this subsection, conviction includes all instances in which a plea of guilty or nolo contendere is the basis for conviction and all proceedings in which the sentence has been deferred or suspended. Nothing in this section abrogates rights guaranteed under chapter 9.96A RCW;

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(18) The procuring, or aiding or abetting in procuring, a criminal abortion;

(19) The offering, undertaking, or agreeing to cure or treat disease by a secret method, procedure, treatment, or medicine, or the treating, operating, or prescribing for any health condition by a method, means, or procedure which the licensee refuses to divulge upon demand of the disciplining authority;

(20) The willful betrayal of a practitioner-patient privilege as recognized by law;

(21) Violation of chapter 19.68 RCW or a pattern of violations of RCW 41.05.700(8), 48.43.735(8), 48.49.020, 48.49.030, 71.24.335(8), or 74.09.325(8);

(22) Interference with an investigation or disciplinary proceeding by willful misrepresentation of facts before the disciplining authority or its authorized representative, or by the use of threats or harassment against any patient or witness to prevent them from providing evidence in a disciplinary proceeding or any other legal action, or by the use of financial inducements to any patient or witness to prevent or attempt to prevent him or her from providing evidence in a disciplinary proceeding;

(23) Current misuse of:

(a) Alcohol;

(b) Controlled substances; or

(c) Legend drugs;

(24) Abuse of a client or patient or sexual contact with a client or patient;

(25) Acceptance of more than a nominal gratuity, hospitality, or subsidy offered by a representative or vendor of medical or health-related products or services intended for patients, in contemplation of a sale or for use in research publishable in professional journals, where a conflict of interest is presented, as defined by rules of the disciplining authority, in consultation with the department, based on recognized professional ethical standards;

(26) Violation of RCW 18.130.420;

(27) Performing conversion therapy on a patient under age eighteen;

(28) Violation of RCW 18.130.430.

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Credits

[2021 c 157 § 7, eff. July 25, 2021; 2020 c 187 § 2, eff. June 11, 2020; 2019 c 427 § 17, eff. Jan. 1, 2020. Prior: 2018 c 300 § 4, eff. June 7, 2018; 2018 c 216 § 2, eff. June 7, 2018; 2010 c 9 § 5, eff. June 10, 2010; 2008 c 134 § 25, eff. June 12, 2008; 1995 c 336 § 9; 1993 c 367 § 22; prior: 1991 c 332 § 34; 1991 c 215 § 3; 1989 c 270 § 33; 1986 c 259 § 10; 1984 c 279 § 18.]

OFFICIAL NOTES

***Reviser's note:** RCW 18.130.345 was repealed by 2015 c 205 § 5.

Conflict with federal requirements--2021 c 157: See note following RCW 74.09.327.

Findings--Intent--Effective date--2019 c 427: See RCW 48.49.003 and 48.49.900.

Intent--Finding--2018 c 300: "(1) The legislature intends to regulate the professional conduct of licensed health care providers with respect to performing conversion therapy on patients under age eighteen.

(2) The legislature finds and declares that Washington has a compelling interest in protecting the physical and psychological well-being of minors, including lesbian, gay, bisexual, and transgender youth, and in protecting its minors against exposure to serious harms caused by conversion therapy." [2018 c 300 § 1.]

Construction--2018 c 300: "This act may not be construed to apply to:

(1) Speech that does not constitute performing conversion therapy by licensed health care providers on patients under age eighteen;

(2) Religious practices or counseling under the auspices of a religious denomination, church, or organization that do not constitute performing conversion therapy by licensed health care providers on patients under age eighteen; and

(3) Nonlicensed counselors acting under the auspices of a religious denomination, church, or organization." [2018 c 300 § 2.]

Intent--2010 c 9: See note following RCW 69.50.315.

Finding--Intent--Severability--2008 c 134: See notes following RCW 18.130.020.

Application to scope of practice--Captions not law--1991 c 332: See notes following RCW 18.130.010.

Severability--1986 c 259: See note following RCW 18.130.010.

West's RCWA 18.130.180, WA ST 18.130.180
Current with all effective legislation of the 2021 Regular Session of the Washington Legislature.

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