Supreme Court No. _____

COA No. 32652-7-III

SUPREME COURT
OF THE STATE OF WASHINGTON

ESTATE OF LORRAINE P. HENSLEY, by and through its Personal Representative, JESSICA WILSON and LORRAINE HENSLEY, by and through her Personal Representative,

Petitioner,

v.

COMMUNITY HEALTH ASSOCIATION OF SPOKANE (CHAS); PROVIDENCE HOLY FAMILY HOSPITAL; SPOKANE EAR, NOSE AND THROAT CLINIC, P.S., and MICHAEL CRUZ, M.D.,

Respondents.

PETITION FOR DISCRETIONARY REVIEW

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TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES

CASES: Page

STATUTES:

RULES:

SECONDARY AUTHORITIES:

I. IDENTITY OF THE PETITIONER.

The Petitioner is the Estate of Hensley, and the Appellant in the underlying Division III proceeding.

II. CITATION TO COURT OF APPEALS DECISION.

This is a petition seeking review of a portion of Division III's April 11, 2017 ruling in *Estate of Hensley by & through Wilson v. Cmty. Health Ass'n of Spokane (CHAS)*, 198 Wn. App. 1036 (2017), *reconsideration denied June 6, 2017*. This petition seeks review of Division III's construction of this state's medical informed consent statute, *RCW 7.70.050(1)(a)*. A copy of the decision is in the Appendix at pages Appx. 1-21, with the portion relevant for this appeal at Appx. 7-11.

III. ISSUES PRESENTED FOR REVIEW.

1) Must a serious medical condition that is known to a medical provider be disclosed to their patient as a "material fact," and thus as an obligation attendant to their patient's informed consent right, under RCW 7.70.050(1)(a)?

2) Is an abnormal medical condition a material fact that must be disclosed under RCW 7.70.050(1)(a) even where a plaintiff's medical experts do not or cannot establish both 1) an actual "probability" of the specific medical pathway that caused the

ultimate death to the patient, and 2) that the medical providers subjectively knew of the probability of death?

IV. STATEMENT OF THE CASE.

A. Procedure below—the dismissal of informed consent claims.

The Estate of Lorraine Hensley brought this action against her three "end of life" Respondent medical providers. The Estate alleged that each provider committed, in succession, a failure to provide Lorraine Hensley with the necessary information to enable her to obtain effective treatment before her death from the evolution of her medical condition. The Estate alleged that each provider violated her right to informed consent, and that each committed medical negligence. *RCW 7.70.030(3) and (1), respectively.* At the close of evidence, the trial court dismissed the Estate's informed consent claims.[1] The Estate appealed, and Division III has upheld the dismissal of these informed consent claims in its ruling.

B. All respondent medical providers understood Lorraine Hensley's medical condition and the risk of death from that condition; they disputed only the probability of death from the condition.

Lorraine Hensley ("Lorraine") died on February 9, 2009 at the age of

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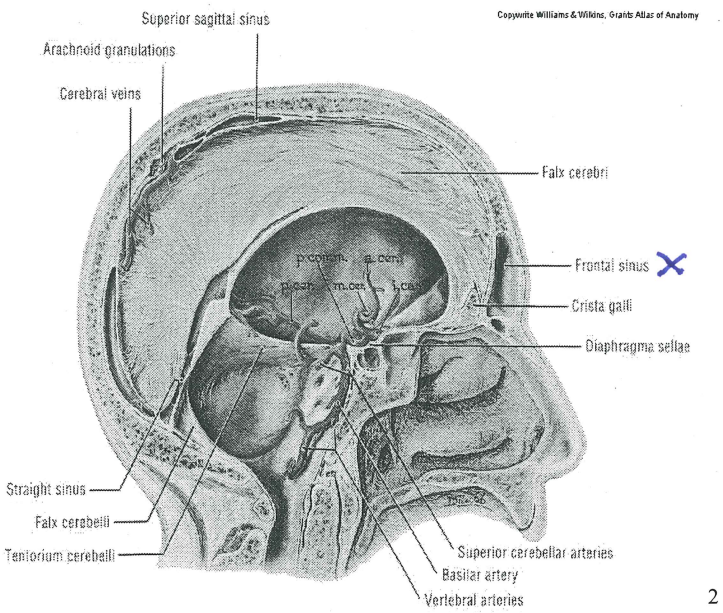
[1] The jury went on to issue different verdicts against the three Defendants on the medical negligence claims, and the negligence claim will necessarily be retried against Respondent Providence Holy Family Hospital.

52 from a "sinus infection" that resulted in brain herniation through cerebral meningitis. *Estate of Hensley, 198 Wn. App. at *1, Appx. at 2.* All of the Respondent medical providers understood that Lorraine was suffering from a progressive medical condition. From January 2, 2009 through February 4, 2009, Lorraine sought medical care from the three successive Respondent medical providers while their treatments with antibiotics failed and her medical condition deteriorated. Lorraine's sinusitis had evolved into an acute condition—a *frontal* sinus infection by unknown bacteria, but bacteria that had demonstrated bone-eroding qualities. *RP 604: 7-12.* This bacteria originated in Lorraine's mouth at a tooth root, but had now eroded through the bone structure in her jaw and ascended upward through her nasal passages to arrive in her frontal sinus, which is positioned on the bone wall protecting the frontal portion of the brain. *Id.* This location can be seen on the upper right side of this diagram in the area marked "frontal sinus:"



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The bone wall between the frontal sinus and the brain is a very thin bone. *RP 697: 3-5.* All three defendant medical providers knew of this medical condition, because CT imaging taken on January 9, 2009 illustrated it. *RP 595: 19-24.*

On the specific issue of knowledge, the Estate presented direct evidence from Respondent Holy Family Hospital's PA-C John Hunter, who acknowledged that on February 1, 2009, he performed CT imaging of Lorraine Hensley's brain. *Hensley at *1, Appx. 2.* PA-C Hunter did this because he was

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[2] Image taken from Atlas and Text-book of Human Anatomy Volume III Vascular System, Lymphatic system, Nervous system and Sense Organs, Dr. Johannes Sobotta, reproduced at *Https://en.wikipedia.org/wiki/Dura_mater#/media/File:Sobo_1909_589.png*

looking for the logical extension of the existing medical condition---this infection may now cross into the brain and be life threatening. *RP 2068:15-16.*[3] The Estate thus established this medical provider's knowledge of both the material fact of the medical condition and the risk of that condition—a life threatening risk. Subsequent respondent medical providers Dr. Michael Cruz and Holy Family hospital physician Dr. Christopher Tullis had PA-C Hunter's CT brain imaging before them in their ensuing medical assessments of Lorraine. The risk fully understood by PA-C Hunter had simply not yet occurred as of February 1, 2009, when the CT was taken.

Throughout her medical deterioration, Lorraine was told only that she had "sinusitis." She died on February 6, 2009 when PA-C Hunter's concern fully manifested. Her death was caused by cerebromeningitis causing a brain herniation "due to purulent sinusitis of the right frontal sinus with *erosion* into the right cranium." *RP 1315: 22 – 1316: 4 (Coroner's Report).* This was the risk PA-Hunter knew existed. A single defense medical expert, Respondent Holy Family Hospital's Dr. Jeffrey Larson, testified for the defense that this infection entered Lorraine's brain through a 4-millimeter hole in the "dura." *Hensley at *1, Appx.2.* But the Coroner's report puts this into

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[3] PA-C Hunter testified"I wanted to rule out any of the possibilities of it becoming life threatening." *RP 2068: 15-16.*

context. This was an erosion of bone. Because of the structure of the brain's coverings, the infection had worked its way, i.e. "eroded" through the bone to reach that porous dura. *RP 1315: 22 – 1316: 4.* The known risk was always one of erosion of bone, which would allow the infection to reach the brain. That risk is exactly what happened.

C. The trial court dismissed the informed consent claims because it held that Plaintiff had not established that death was "probable."

Following the close of evidence, the trial court dismissed the Estate's informed consent claims. It held that the Estate's medical experts had established the risk of "death" from Lorraine's condition, which is indeed a material risk. *RP 3356: 18-19.* But it held that in order to sustain a viable informed consent claim, the Plaintiffs' experts were also required to establish "how probable" the outcome of death from this condition actually was. *RP 3356: 23.* It held that "[T]here was very little testimony" from the Plaintiffs' experts on the "probability of this occurrence." *RP 3357: 17-23.* Division III sustained the dismissal, holding that "No evidence was presented that any of the defendant providers subjectively knew, given the sinusitis diagnosis and Ms. Hensley's presentation (including the CT scans), that anything approaching a serious risk of intracranial infection and death existed." *Hensley*, 198 Wn. App. 1036 at *7, *Appx. 9.*

But not only did Respondent PA-C Hunter acknowledge his knowledge of this very risk, and perform CT imaging because of it, but the Estate's medical experts testified extensively that this medical condition was a dangerous life-threatening condition which would result in Lorraine's death through bone erosion. Among other evidence, one Estate's medical expert, Dr. Elliot Felman, testified that the medical condition depicted on the earliest January 9th CT scan showed a "high risk, extremely high risk." The material risk of this medical condition was that of the infection going into the brain. *RP 603, 604, 606-07.* Dr. Felman testified that the infection "will" extend into either the lining of her brain, causing meningitis, or it "will" extend into the tissue of the brain itself. *Id.* Dr. Paul Bronston, an Emergency Room physician from Los Angeles, testified that the medical condition depicted on the same January 9, 2009 CT depicted "a very serious, complicated, dangerous, life-threatening infection that could kill her … that was eating away at one of the bones in her face, and starting to destroy the bone." *RP 691.* The risk of that medical condition was the risk of meningitis or brain abscess. *RP 697.* The "risk" was "life-threatening. It can kill a person." *RP 698: 13-16.* Dr. Richard Beck, an otolaryngologist, testified that this medical condition was a "complicated and very dangerous sinus infection." *RP 806: 20-25.* Dr. Beck testified that the end point of the medical condition depicted on both the January 9 and the brain CT taken by PA-C Hunter on February 1st

was "death." *RP 850-51.* The CTs depicted "serious, life-threatening conditions." *RP 851.* Dr. Richard Sokolov, an infectious disease specialist from Los Angeles, California, testified that the infection depicted was "lethal," meaning "it would kill people." *RP 1112.* He confirmed that the end point of the condition depicted in the January 9, 2009 CT could be brain abscess, meningitis, and death. *RP 1112.*

It was undisputed that the Respondent medical providers knew of this medical condition, and of the risk of bone erosion from that condition. Defendant Holy Family's Dr. Jeffrey Larson concurred that the risk of bone erosion and death was indeed possible from this depicted condition; but, he testified, his particular opinion as to the cause of the death—that the infection had passed through the "holes in the dura" —was "very rare." *RP 2005.* His particular causation pathway, he said, was "very, very, very freak, rare." *RP 1849.* But the coroner's report and the plaintiff's experts attested that the death occurred through bone erosion, not through holes in the dura. *Supra.* What was ultimately disputed was not the seriousness of the medical condition or its risk of death; what was disputed was only the probability of death occurring via either means.

By dismissing the Estate's informed consent claims for insufficient evidence, then Division III necessarily construed RCW 7.70.050(1)(a) to

require an evidentiary showing beyond the simple "material fact" mandated by the statute itself.

V. ARGUMENT AS TO WHY REVIEW SHOULD BE ACCEPTED.

This appeal is about whether a *known* serious medical condition is a material fact that must be disclosed to a patient. By law, medical providers must "inform the patient of a material fact or facts relating to the treatment." *RCW § 7.70.050 (1)(a).* This Supreme Court has reiterated time and time again over the years that a known medical condition is a material fact that a medical provider must disclose. *See Section B infra.* Divisions I and II have reiterated the same law—a known medical condition is a material fact, and it must be disclosed. *Id.* Division III has now entered a ruling that conflicts with all courts. In *Estate of Hensley*, Division III holds that a serious medical condition need not be disclosed unless a plaintiff evidences, by medical expert testimony, the percentage probabilities of the specific harm, here, death, occurring from the condition, and the provider's subjective knowledge of the probable risk of that harm, i.e. death, from the defense's offered "medical pathway." *Id. at *7, Appx. 9.* This has never been the law of his state, and it is not the plain language of the statute. The *Hensley* ruling conflicts with longstanding precedent of this Supreme Court, which holds that a known serious medical condition is a material fact that must be

disclosed. *RAP 13.4(b)(1).* It conflicts with published decisions from Division I and II, which follow this Supreme Court's precedent in that holding. *RAP 13.4(b)(2).* It creates an issue of substantial public interest that should be determined by this Court, because Division III has redefined what constitutes a "material fact" for purposes of this state's medical informed consent statute, and it deviates far from the plain meaning of this state's protective statute. *RAP 13.4(b)(4).* While *Hensley* is an unpublished decision, the decision may be cited for use in the trial courts as persuasive authority. *GR 14.1.* Statewide uniformity in this concept is important, and the decision creates the risk of confusion among trial and appellate courts. This is an error of law of such importance to patient rights that it should be corrected.

This court should accept review.

A. <u>This state's medical informed consent statute requires no construction—it requires only a showing that a medical provider failed to disclose a material fact to a patient</u>.

RCW 7.70.050(1)(a) allows a plaintiff to sustain a cause of action for violation of informed consent where it shows that "a material fact" was not disclosed to the patient. A violation of informed consent occurs where a plaintiff shows:

> "(a) That the health care provider failed to inform the patient of a material fact *or* facts relating to the treatment;.."
>
> *RCW § 7.70.050 (1)(a), emphasis added.*

This language is plain and unambiguous. "If (a statute's) meaning is plain on its face, we give effect to that plain meaning as the expression of what was intended." *TracFone Wireless, Inc. v. Dep't of Revenue,* 170 Wn.2d 273, 281 (2010) (citing *Dep't of Ecology v. Campbell & Gwinn, LLC,* 146 Wn.2d 1, 9–10 (2002)). A plaintiff need only establish "a" material fact that was not disclosed to Lorraine Hensley. The Estate established that Lorraine Hensley had a serious medical condition with life threatening risk, and thus established a material fact.

B. Division III's ruling conflicts with statute, with longstanding Supreme Court precedent, and with other divisions of this state's appellate court when it holds that a known serious medical condition is not a material fact which must be disclosed to a patient.

This Supreme Court has long since established that a known serious or dangerous medical condition is a material fact of which a patient must be informed. In *Backlund v. Univ. Washington, 137 Wn.2d 651, 661, 975 P.2d 950 (1999)*, this Supreme Court holds that the obligation of the medical provider is to inform the patient of material facts; thus, if a health care provider

misdiagnoses a patient's condition, the provider cannot inform of the material fact of the medical condition. Similarly, in *Anaya-Gomez v. Sauerwein, 331 P.3d 19 (2014),* this Supreme Court holds that where a health care provider believes that a patient does not have a particular disease, the provider cannot be expected to inform the patient about the unknown disease. *180 Wn.2d 610, 617.* The material fact not being disclosed in these cases is the medical condition that actually existed, and it is only because the condition was not known to the provider that the provider avoids the duty to disclose. Conversely and implicitly, where the particular disease is known, it is therefore a material fact requiring that the patient be informed. In *Keogan v. Holy Family Hosp., 95 Wn.2d 306, 315, 622 P.2d 1246 (1980),* this Supreme Court holds that a material fact is "each item of information which the doctor knows or should know about the patient's physical condition." *Id.,* quoting Division I's ruling in *Miller v. Kennedy, 11 Wn. App. 272, 282, 522 P.2d 852 (1974), aff'd, 85 Wn.2d 151, 530 P.2d 334 (1975).* In *Gates v. Jensen,* 92 Wn.2d 246, 250, 595 P.2d 919, 922 (1979), this Supreme Court again cites to *Miller v. Kennedy*, and reiterates that a physician has a fiduciary duty to inform a patient of abnormalities in his or her body. These rulings are followed in this state's appellate Divisions I and II. Division I established this concept in its 1974 *Miller v. Kennedy* decision, and continued with its decision in *Gustav v. Seattle Urological Associates, 90 Wn. App. 785,*

790-91, 954 P.2d 319 (1998), where it holds, the year before the *Backlund* decision, that the duty to disclose does not arise until the physician becomes aware of the condition by diagnosing it. In other words, as noted above with *Backlund, supra*, the duty *does* arise when the condition is diagnosed. Division II imposes the same result in *Flyte v. Summit View Clinic, 183 Wn. App. 559, 579-80, 333 P.3d 556 (2014),* wherein the evidence showed that providers may well have known of the medical condition, and may have thus failed to inform the patient of that condition.[4]

Here, it was undisputed that this infection's bone eroding qualities, and its ascendance to a position outside Lorraine's brain on the back wall of her frontal sinus were facts that were both known, but not disclosed. This medical condition was described to Lorraine as only "sinusitis," but the plaintiff's experts established a material fact about this disease—this "sinusitis" was abnormal because it was virulent and life threatening. Under *Gates v. Jensen*, "the patient has a right to know the material facts concerning the condition of his or her body, and any risks presented by that condition, so that an informed choice may be made regarding the course which the patient's medical care will take. " *92 Wash. 2d at 250.* The *Gates* court continues, "The existence of an

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[4] In *Flyte*, the question was whether a known diagnosis existed—if it did, it had to be conveyed; evidence was disputed as to whether a medical provider "ruled out" a certain diagnosis of "influenza."

abnormal condition in one's body, the presence of a high risk of disease, and the existence of alternative diagnostic procedures to conclusively determine the presence or absence of that disease…" are all "facts which a patient must know in order to make an informed decision on the course which future medical care will take." *Id.*

The Hensley Estate thus established a material fact for purposes of RCW 7.70.050(1)(a). Lorraine's known medical condition was not just a benign "sinusitis," it was a life threatening infectious condition with bone-eroding qualities, positioned on the bone wall of her brain. PA-C Hunter, as only one provider, recognized that bone-erosion risk in performing brain imaging. The Estate thus met its burden of establishing a material fact, and the providers' knowledge of that fact. It was now for the jury to determine whether these medical providers' informing Lorraine that she had only a "sinusitis" condition was the conveyance of the material facts of either her true medical condition or its risk. A reasonable jury could properly decide that such a benign disclosure by medical providers in the face of this medical condition and its life-threatening qualities did not satisfy the providers' legal obligation.

In sum, as a matter of this state's law, a known serious medical condition is a material fact which must be conveyed to a patient, and Division III's *Hensley* ruling is in conflict with numerous rulings of this Supreme Court and Division I and II's adherence to that precedent. The trial court's

dismissal of the informed consent claims, and Division III's ruling sustaining that dismissal, is error of law of such importance to patient rights that it should be corrected.

C. Division III fails to differentiate the risk of the medical condition from the medical condition itself, but each is a different material fact that was evidenced.

This Supreme Court's *Gates v Jensen ruling*, in particular, differentiates the material fact of the medical condition itself from the risk of that condition. Both are material facts that must be conveyed. *Gates* holds that "the patient has a right to know the material facts concerning the condition of his or her body, *and* any risks presented by that condition…'" *92 Wn.2d at 250, emphasis added. Gates* notes that the definition of a material fact is wide-ranging. It includes, but is not limited to, "the existence of an abnormal condition in one's body, the presence of a high risk of disease, *and* the existence of alternative diagnostic procedures to conclusively determine the presence or absence of that disease…" *Id. Gates* thus establishes various available definitions of a material fact, and, in some respects, the very least amount of information required to be disclosed to the patient. At the very least, the foregoing "are all facts which a patient must know in order to make an informed decision on the course which future medical care will take." *Id.*

Here, Division III goes far beyond requiring a plaintiff to establish a material fact in holding that a serious medical condition is not material unless the end result of death is supported by percentage probabilities. Division III holds that a plaintiff must present evidence that "the defendant providers subjectively knew, given the sinusitis diagnosis and Ms. Hensley's presentation (including the CT scans), that anything approaching a serious risk of intracranial infection and death existed." *Estate of Hensley at* *7. The trial court held that in order to sustain a viable informed consent claim, the Plaintiffs' experts were also required to establish "how probable" the outcome of death from this condition actually was. *RP 3356.* Nowhere does the statute, nor precedent, require such evidence.

Division III has created a legal threshold to evidencing a material fact that contradicts the plain language of RCW 7.70.050(1)(a), Supreme Court precedent, and the decisions of Division I and II, none of which demand such evidence. Division III seems to be confusing a provider's obligation to disclose a serious medical condition, a material fact in and of itself, with a "probability" definition, applying a sort of *Smith v. Shannon*[5] risk assessment modality which applies to a material risk of <u>treatment</u> of a medical condition. But even under *Smith v Shannon*, evidence of risk is

[5] *Smith v. Shannon, 100 Wn.2d 26, 33, 666 P.2d 351, 356 (1983)*

satisfied where the evidence shows risks "of a serious nature," or, e.g., "high risk," "grave risk," "medically significant risks," and/or "reasonably foreseeable" risks. *Id. at 33.* The trial court recognized that the Hensley Estate evidenced this level of risk when it held that the Estate's medical experts established the risk of "death" from Lorraine's condition, which is indeed a material risk. *RP 3356: 18-19.* The Estate's medical experts' testimony established that the risk from this condition was "life threatening," "high," and, e.g., "extremely high." *See, e.g., RP 606-07.*

By applying its new "probability" requirement, Division III deviates far from the plain language of the informed consent statute, and from even *Smith v. Shannon's* "probability" assessment, and from this Supreme Court's and other Appellate Divisions' precedent. Courts are "'required to assume the Legislature meant exactly what it said and apply the statute as written.' ... " *HomeStreet, Inc. v. State, Dep't of Revenue, 166 Wn.2d 444, 453, 210 P.3d. 297 (2009).* Division III's new threshold to materiality contradicts the plain meaning of RCW 7.70.050(1)(a), and conflicts with the decisions of this Supreme Court, and the decisions of Divisions I and II, all of which hold that a known serious medical condition is a material fact that must be disclosed. Petitioner respectfully ask that this decision be reviewed under RAP 13.4(b)(1),(2) and(4).

VI. CONCLUSION.

The only evidentiary dispute in this case was over the probability of death from this known serious infections condition. The trial court's dismissal of informed consent claims under these facts is error of law, it conflicts with longstanding Supreme Court precedent, and with precedent from other appellate divisions. Petitioner respectfully requests review.

DATED this 6th day of **July, 2017**.

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CERTIFICATE OF SERVICE

The undersigned hereby certifies that on the **6th** day of **July, 2017**, the foregoing document was delivered to the following persons in the manner indicated below:

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APPENDIX

198 Wash.App. 1036

NOTE: UNPUBLISHED OPINION, SEE WA R GEN GR 14.1

Court of Appeals of Washington, Division 3.

ESTATE OF Lorraine P. HENSLEY, BY AND THROUGH its Personal Representative, Jessica WILSON and Lorraine Hensley, by and through her Personal Representative, Appellants,

v.

COMMUNITY HEALTH ASSOCIATION OF SPOKANE (CHAS); Providence Holy Family Hospital; Spokane Ear, Nose and Throat Clinic P.S., and Michael Cruz, M.D., Respondents.

No. 32652–7–III

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APRIL 11, 2017

Appeal from Spokane Superior Court, No. 12–2–00325–9, Honorable Kathleen M. O'Connor, Judge

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UNPUBLISHED OPINION

Siddoway, J.

*1 The estate of Lorraine Hensley appeals several adverse rulings before, during and following a four-week medical malpractice trial that ended with defense verdicts in favor of three of the defendants and a hung jury as to the fourth. Three defendants cross appeal trial court rulings.

We affirm all of the challenged rulings and remand for trial of the as yet unresolved claim.

FACTUAL AND PROCEDURAL OVERVIEW

Beginning on January 2, 2009, Lorraine Hensley, then 52 years old, sought medical care from Community Health Association of Spokane (CHAS) for a recurrence of sinus infection and dental problems CHAS had treated over a couple of years. She was diagnosed this time with sinusitis—sinus inflammation—likely related to an abscessed molar. The CHAS providers' initial recommendation was to use a steroid spray to decrease swelling and use nasal rinses. On January 9, after Ms. Hensley complained of increasing pain, an odorous discharge, and swelling in the area of her right eye, Ms. Hensley was prescribed oral antibiotics, prednisone to reduce inflammation, and was referred for a CT [1] scan.

1 Computerized axial tomography.

The CT scan revealed that the root of the abscessed molar was impinging into Ms. Hensley's lower maxillary sinus. Since the tooth was the source of the infection, CHAS providers gave Ms. Hensley a copy of the CT scan and told to see her dentist. In the weeks that followed, CHAS providers prescribed a different antibiotic and pain medication.

Ms. Hensley saw her dentist on January 27, her dentist agreed that the molar needed to be removed, and an appointment was made to have it pulled on February 3.

On February 1, Ms. Hensley went to the emergency room of Providence Holy Family Hospital (Holy Family) complaining of continuing sinus pain, swelling and a headache. She was seen by John Hunter, a certified physician assistant, who reviewed the January 9 CT scan; obtained and reviewed another CT scan of her brain; prescribed a different antibiotic and some pain medication; and referred her to see an ear, nose and throat specialist the next day.

On February 2, Ms. Hensley was examined at the Spokane Ear, Nose, and Throat Clinic (the ENT clinic) by Michael Cruz, M.D. She told him her abscessed molar was scheduled to be removed the next day. Dr. Cruz performed an endoscopic exam, took a culture for testing, prescribed prednisone for inflammation, a painkiller, and recommended a decongestant.

On the late evening of February 3, 2009, Ms. Hensley returned to the Holy Family emergency room, complaining of worsening pain, and was seen by Dr. Christopher Tullis, an emergency room physician. She told him about her tooth removal earlier in the day. After taking her history and performing a physical examination, he administered intravenous antibiotics and pain medication (Dilaudid) before discharging her in the early morning hours of February 4.

On February 6, 2009, Ms. Hensley died. The cause of death, identified at autopsy, was brain herniation resulting from cerebral meningitis. A small hole was found in the back wall of Ms. Hensley's frontal sinus bone that was too small for the medical examiner to measure and an abnormal 4–millimeter hole was found in her dura (one of the meninges, the membranes that surround the brain). The two holes proved to be the pathway through which infection had reached the brain, causing Ms. Hensley's death.

*2 In 2012, Ms. Hensley's estate brought this action against CHAS, Holy Family, the ENT clinic and Dr. Cruz, alleging medical negligence and lack of informed consent. The estate contended that the January 9 CT scan revealed Ms. Hensley was at high risk for intracranial complications. It asserted that the standard of care required admitting Ms. Hensley to a hospital for continuous intravenous antibiotics, surgical intervention, and further testing. The estate also asserted lack of informed consent to the less aggressive treatment provided by the defendants.

Pretrial summary judgment motions and counter motions were all denied. The matter proceeded to trial in May 2014. During trial, the court denied several motions for judgment as a matter of law, including defense motions to dismiss the medical negligence claims for failure to establish a breach of the standard of care to the required degree of medical certainty, and for failing to establish that the independent contractors who treated Ms. Hensley in Holy Family's emergency room were the hospital's agents. In arriving at final jury instructions, the trial court agreed with the defense that there was insufficient evidence to submit the estate's lack of informed consent claim to the jury.

Defense verdicts were returned in favor of CHAS, the ENT clinic, and Dr. Cruz. Although the jury found that providers at CHAS violated the standard of care, it found that the violation was not the proximate cause of Ms. Hensley's death. The jury found no violation of the standard of care by Dr. Cruz or the ENT clinic.

The jury was unable to reach a verdict on the estate's claim against Holy Family, and the court declared a mistrial as to the hospital.

In June 2014, the estate filed a motion for a new trial based on the court's refusal to instruct the jury on informed consent and on alleged juror misconduct. It supported its allegation of juror misconduct with the declaration of one of the jurors, who asserted that two other jurors "shut [ ] down" jurors who spoke in favor of the estate, exhibited bias in favor of medical providers, made pejorative statements about the estate's attorney, discounted the court's instructions on causation, and offered evidence of their own experiences with medical treatment. Clerk's Papers (CP) at 937. The trial court denied the motion and entered judgment on the jury verdicts.

The estate appeals and three of the defendants cross appeal, presenting a total of six issues. A more detailed procedural history is provided in analyzing the respective issues.

ANALYSIS

The following errors are assigned:

By the estate:

- ☐ The trial court erred in denying the estate's motions for summary judgment against Holy Family and CHAS on the elements of medical negligence liability and causation;

- ☐ The trial court erred in refusing to instruct the jury on the estate's informed consent claims; and

- ☐ The trial court erred in refusing to grant a new trial on the basis of jury misconduct.

By Holy Family:

- ☐ The trial court erred in denying Holy Family's motions for judgment as a matter of law that the estate failed to

present evidence creating a jury issue of agency; and

☐ The trial court erred in denying defense motions for judgment as a matter of law that the estate failed to present evidence creating a jury issue of a violation of the applicable standard of care.

By the ENT clinic and Dr. Cruz:

☐ Both join Holy Family in contending the trial court erred in denying defense motions for judgment as a matter of law that the estate failed to present evidence sufficient to create a jury issue of a violation of the applicable standard of care.

*3 We address the issues in the order stated.

I. APPEAL

A. We will not consider the estate's assignment of error to the trial court's order denying its motions for summary judgment because following trial, the challenge to the sufficiency of evidence must be to the trial evidence

Within a few months after the estate's complaint was filed, the defendants moved for summary judgment on the basis that the estate had not demonstrated a prima facie case. The estate responded with a counter motion for summary judgment, an accompanying declaration of Dr. Steven Kmucha alleging violations of the standard of care and lack of informed consent on the part of all defendants, and argument that a right to point to deficiencies in the other side's evidence "works both ways." CP at 28.

The defendants challenged the sufficiency of Dr. Kmucha's declaration to raise a genuine issue of material fact, arguing that as an otolaryngologist,[2] he could not testify to the standard of care of the emergency medical care providers contracted by Holy Family or the family practitioners at CHAS, and that he failed to provide evidence as to the standard of care in the State of Washington.[3]

2 An otolaryngologist is "[a] physician who specializes in" the "diseases of the ear, pharynx, and larynx, including the upper respiratory tract and diseases of the head and neck, tracheobronchial tree, and esophagus." STEDMAN'S MEDICAL DICTIONARY 1395 (28th ed. 2006) (combining the definitions of otolaryngologist and otolaryngology).

3 RCW 7.70.040(1) provides that one of the elements a plaintiff must establish for a claim of medical negligence is that the defendant health care provider "failed to exercise that degree of care, skill, and learning expected of a reasonably prudent health care provider at that time in the profession or class to which he or she belongs, in the state of Washington, acting in the same or similar circumstances."

CHAS responded with only a conclusory declaration from its family practitioner denying that he violated the standard of care. Holy Family, reporting difficulty obtaining declarations from Mr. Hunter and Dr. Tullis, submitted only declarations from their attorney, who claimed to have been told by both clients that they denied having violated the standard of care. According to CHAS and Holy Family, the asserted deficiencies in Dr. Kmucha's declaration reduced their concern about the estate's counter motion.

The ENT clinic and Dr. Cruz, whose standard of care Dr. Kmucha was more clearly qualified to address, submitted a detailed opposition declaration from Dr. Cruz. The estate does not contend it was entitled to summary judgment against them.

On June 22, the trial court heard argument of both sides' motions. It orally denied the estate's counter motion on two grounds. As to CHAS and Holy Family, it found a question of fact whether Dr. Kmucha, as an otolaryngologist, could testify to the standard of care of the family practice and emergency medical care providers. As to all defendants, it found Dr. Kmucha's declaration to be statutorily deficient because he asserted that the standard of care in Washington was the national standard but without explaining his basis for that assertion. Denial of the estate's counter motion was reduced to a written order. [4]

4 Rather than grant defense motions to dismiss the complaint on the basis of Dr. Kmucha's failure to provide a foundation for his knowledge of the Washington standard of care, the court gave the estate a deadline for obtaining a supplemental declaration from Dr. Kmucha that would cure that deficiency. The estate complied.

After providing Dr. Kmucha's supplemental declaration, the estate asked the court to allow the supplemental declaration to relate back, in effect, as a basis for reconsidering the court's denial of its counter motion for summary judgment. The court refused, stating in its order, "It was never my intention to grant Plaintiffs' countermotion for summary judgment." CP at 301.

*4 The estate's first assignment of error is to this denial of its motion for summary judgment against CHAS and Holy Family. It argues that evidence offered in opposition to its motion was conclusory in the case of CHAS and inadmissible hearsay in the case of Holy Family.

It is well settled that "[w]hen a trial court denies summary judgment due to factual disputes ... and a trial is subsequently held on the issue, the losing party must appeal from the sufficiency of the evidence presented at trial, not from the denial of summary judgment." *Adcox v. Children's Orthopedic Hosp. & Med. Ctr.*, 123 Wn.2d 15, 35 n.9, 864 P.2d 921 (1993) (citing *Johnson v. Rothstein,* 52 Wn. App. 303, 759 P.2d 471 (1988)). The rule is supported by policy (we favor the decision that is based on the best record) and by the purpose of summary judgment (the objective of avoiding useless trials is no longer served once trial takes place). *Johnson,* 52 Wn. App. at 306–07.

The estate argues that a summary judgment denial is subject to review if the facts are not disputed and the decision turned solely on a substantive issue of law, citing *Kaplan v. Northwestern Mutual Life Insurance Co.*, 115 Wn. App. 791, 799–800, 65 P.3d 16 (2003). In *Kaplan,* the issue of law decided incorrectly at summary judgment was whether an ambiguous disability insurance policy was required to be construed against the insurer. On facts that were sufficient and undisputed, the correct legal answer was yes, but the court said no and allowed the meaning of the policy to be determined by the jury. The decision on that pure legal issue was held appealable.

In this case, one basis for the trial court's denial of the estate's motion as it related

to CHAS and Holy Family was that a question of fact existed as to whether Dr. Kmucha could testify to the standard of care of their family practice and emergency medical care providers. While Dr. Kmucha's declaration stated he was "well familiar with the national standards of care of medical professional treatment for processes such as acute sinusitis" and expressed his opinion that providers at CHAS and Holy Family provided medical care below the standard "in the profession or class to which that provider belongs," he offered no explanation as to how he was familiar with the standard of care of family practitioners and emergency medical care providers. CP at 42.

CR 56(e) provides that a supporting affidavit such as that provided by Dr. Kmucha "shall show affirmatively that the affiant is competent to testify to the matters stated therein." Under the rule, declarations that contain conclusory statements unsupported by facts are insufficient for purposes of summary judgment. *Davies v. Holy Family Hosp.*, 144 Wn. App. 483, 495–96, 183 P.3d 283 (2008) (citing *Guile v. Ballard Cmty. Hosp.*, 70 Wn. App. 18, 25, 851 P.2d 689 (1993)).

"To testify that the defendant has breached the applicable standard of care, 'a physician must demonstrate that he or she has sufficient expertise in the relevant specialty.' " *Id.* at 494 (quoting *Young v. Key Pharm., Inc.*, 112 Wn.2d. 216, 229, 770 P.2d 182 (1989)). In *Davies,* a plaintiff submitted declarations of a Washington physician who was board certified in radiology, offering his opinion as to a breach of the standard of care by members of Holy Family's medical staff. This court held that because the expert's declarations failed to establish that he had sufficient expertise or familiarity with the standard of care applicable to nurses and other health care providers, he "[could not] be deemed competent to establish the standard of care or to testify regarding a breach of that standard." *Id.* at 496. The expert conclusorily claimed familiarity with the appropriate measures that should have been taken by hospital staff in treating the plaintiff, but this court held that his declarations did not affirmatively show that he "had sufficient expertise to be considered qualified to express an opinion regarding the standard of care applicable to nurses and other health care providers. In fact, [his] declarations fail to reference any education, medical training, or supervisory experience that could demonstrate his familiarity with the standard of care in other health care fields." *Id.* at 495.

***5** A party responding to summary judgment can show that genuine issues of material fact require trial in two ways: (1) with conflicting evidence, or (2) by argument alone, if the moving party's evidence is insufficient. "If the moving party fails to sustain [its initial burden of production], it is unnecessary for the nonmoving party to submit affidavits or other materials." *Hash v. Children's Orthopedic Hosp. & Med. Ctr.*, 49 Wn. App. 130, 132, 741 P.2d 584, (1987), *aff'd*, 110 Wn.2d 912 (1988). In opposing the estate's early counter motion for summary judgment, CHAS and Holy

Family persuaded the court that the estate's evidence was insufficient.

The trial court did not deny summary judgment based on an issue of substantive law; it denied summary judgment because the estate presented too little evidence that Dr. Kmucha was qualified to express an opinion regarding the standard of care applicable to family practitioners or emergency medicine providers. The usual rule barring post-trial appeal of summary judgment denial applies.

B. The trial court properly refused to instruct the jury on informed consent

The estate next assigns error to the trial court's refusal to instruct the jury on its lack of informed consent claim. The court never limited the estate's effort to present evidence in support of that claim. The court reserved ruling on a defense motion in limine to exclude evidence and argument in support of the claim, and later denied a defense motion for a directed verdict dismissing the claim at the end of the estate's case. Ultimately, the court refused to instruct on the claim, however, stating "this, fundamentally, is not an informed consent case, this is a medical negligence case." Report of Proceedings (RP)[5] at 3355. It reiterated that primary reasoning in denying the estate's new trial motion, stating, "[M]y view is that this is a standard of care issue, a negligence issue." RP (July 11, 2015) at 56. On both occasions, the court also observed that the estate had not presented expert testimony on the likelihood of the risk that a patient diagnosed with sinusitis and exhibiting the condition reflected on the CT scans would suffer an intracranial infection and death.

5 Unless otherwise indicated by a parenthetical date, "RP" refers to the 3603 page report of proceedings that begins with proceedings on May 2, 2014, continues through trial proceedings up until the conclusion of closing arguments, and includes, at 3554–3603, hearings taking place on June 22 and July 20, 2012.

Judgment as a matter of law is appropriate only when, after construing all facts and reasonable inferences in favor of the nonmoving party, the court determines no competent and substantial evidence exists to support a verdict. *Paetsch v. Spokane Dermatology Clinic, P.S.,* 182 Wn.2d 842, 848, 348 P.3d 389 (2015). "Substantial evidence" is evidence sufficient "to persuade a rational, fair-minded person that the finding is true." *Cantu v. Dep't of Labor & Indus.,* 168 Wn. App. 14, 21, 277 P.3d 685 (2012). Review is de novo. *Paetsch,* 182 Wn.2d at 848.

The Washington Supreme Court first recognized the doctrine of informed consent in *ZeBarth v. Swedish Hospital Medical Center,* 81 Wn.2d 12, 499 P.2d 1 (1972). Three years later, the legislature adopted RCW 7.70.050 with the intent to codify the common law doctrine as set forth in *Miller v. Kennedy,* 11 Wn. App. 272, 522 P.2d 852 (1974), *aff'd per curiam,* 85 Wn.2d 151, 152, 530 P.2d 334 (1975); *Anaya Gomez v. Sauerwein,* 180 Wn.2d 610, 617, 331 P.3d 19 (2014). *Miller* explained that the duty to warn and advise of alternatives exists if " '(1) the risk of injury inherent in the treatment is material; (2) there are feasible alternative courses available; and (3) the plaintiff can be

advised of the risks and alternatives without detriment to his well-being.' " *Miller,* 11 Wn. App. at 286–87 (quoting *Getchell v. Mansfield,* 260 Ore. 174, 182, 489 P.2d 953 (1971)).[6] The informed consent doctrine affirms an "individual's right to ultimately control what happens to [her] body." *Keogan v. Holy Family Hosp.,* 95 Wn.2d 306, 313–14, 622 P.2d 1246 (1980).

6 The statute requires proof of the following four elements:
(a) That the health care provider failed to inform the patient of a material fact or facts relating to the treatment;
(b) That the patient consented to the treatment without being aware of or fully informed of such material fact or facts;
(c) That a reasonably prudent patient under similar circumstances would not have consented to the treatment if informed of such material fact or facts;
(d) That the treatment in question proximately caused injury to the patient.
RCW 7.70.050(1)(a)–(d).

***6** In this case, the view of the estate's medical experts was not that this was a case in which (1) there were "feasible alternative courses available" one being the course of treatment followed by the defendant providers, (2) that each met the standard of care, and (3) the patient had a right to know about each and its attendant risks. They opined, instead, that the course of treatment followed by the defendant providers fell far short of the standard of care. Arguably that alone demonstrates that this was a medical negligence case, not an informed case. Since RCW 7.70.050(1) does not clearly recognize that distinction, however, we examine the parties' positions further.

The defendant providers rely on well settled Washington law that a health care provider who misdiagnoses a patient's condition is not subject to an action based on failure to secure informed consent with respect to treatments for the undiagnosed condition. *See, e.g., Backlund v. Univ. of Wash.,* 137 Wn.2d 651, 661, 975 P.2d 950 (1999). This is because "a health care provider who believes the patient does not have a particular disease cannot be expected to inform the patient about the unknown disease or possible treatments for it." *Anaya Gomez,* 180 Wn.2d at 618. In such circumstances, it is a medical negligence claim that compensates the patient for the provider's misdiagnosis and resulting failure to provide appropriate treatment. *See id.*

The estate argues that this well settled law does not apply because this is not a misdiagnosis case. According to the estate,

> The condition that Ms. Hensley had (i.e., bony erosion and the frontal sinusitis), was not undiagnosed. It was present in living color on CT imaging. These providers didn't fail to diagnose the condition, they simply minimized the risk of the known condition. They chose not to tell Mrs. Hensley about her condition, or alternative treatments.

Appellant's Reply Br. at 26–27 (footnote omitted). The estate's experts agreed with the sinusitis diagnosis and the presence of

the bony erosion in the maxillary sinus. The estate contends that Ms. Hensley acquiesced in the defendant providers' nonaggressive treatment plan without being informed of the risk of intracranial complications and death, whose materiality it argues was supported by its experts' testimony and should have been a question for the jury.

This case illustrates that it is a mistake to place too much emphasis on "diagnosis" when a patient's experts are prepared to agree with a diagnosis but espouse a completely divergent view of facts material to treatment and management given the patient's presentation.[7] Washington cases hold that the doctrine of implied consent requires only that health care providers disclose material facts and risk relating to treatment of which they are subjectively aware. As the seminal decision in *Miller*[8] recognizes, the doctrine of informed consent is a "negligence doctrine." 11 Wn. App. at 282, 289.

7 Defendants dispute whether the plaintiff's experts actually did agree with the diagnosis, pointing to testimony by a defense expert that in substance, the plaintiff's experts were relying on a diagnosis of "complicated acute frontal sinusitis," which is different. *See* RP (July 11, 2015) at 39; RP at 2835 (stating "it's a bit of semantics").

8 *See Smith v. Shannon,* 100 Wn.2d 26, 30, 666 P.2d 351 (1983) (citations omitted) ("The seminal case on informed consent in this case is *Miller v. Kennedy* .... This Court of Appeals opinion bears the strong stamp of approval by this court, which unanimously and unequivocally approved it.").

In *Burnet v. Spokane Ambulance*, for example, there was evidence that the treating physician was unaware of the risk to his patient of brain herniation and subsequent injury. As the court observed, "[i]t is undisputed Mr. Graham was unaware of Tristen's condition which implicated risk to her, so he had no duty to disclose." 54 Wn. App. 162, 169, 772 P.2d 1027 (1989) (*Burnet* I). In *Gustav v. Seattle Urological Associates,* 90 Wn. App. 785, 790–91, 954 P.2d 319 (1998), the court held that a lack of informed consent claim could not be based on a condition that had not been diagnosed but also could not be based on the treating physician's lack of understanding of different assays used in testing and failure to inform his patient of material facts on that score. Whether he should have understood the difference in the assays "raised the question of negligence ..., not informed consent." *Id.* at 791.

*7 No evidence was presented that any of the defendant providers subjectively knew, given the sinusitis diagnosis and Ms. Hensley's presentation (including the CT scans), that anything approaching a serious risk of intracranial infection and death existed. The estate contends that they should have recognized the risk and responded differently but that was the basis of the medical negligence claims. The estate presented those claims to the jury.

The estate implies on appeal that the defendant providers did subjectively know of the risk and "simply minimized [it]" and "chose not to tell Mrs. Hensley." Appellant's Reply Br. at 27. It likens the estate's claim to the facts in *Flyte v. Summit View Clinic,* 183 Wn. App. 559, 579–80, 333 P.3d 566 (2014), in which a lack of informed consent claim was remanded for trial because the evidence

raised a jury question about the defendant physician's subjective knowledge.

The defendant physician in *Flyte* testified at trial that he had ruled out a diagnosis of influenza, which was ultimately the cause of his patient's death. Having ruled it out, he argued that he had no obligation to inform the patient of facts material to treatment for that diagnosis. *Id.* at 579. But his chart notes did not support his trial testimony that he had ruled out influenza. The patient's father, who accompanied her into the exam room, testified that the physician *said* she had influenza. *Id.* Where evidence supporting a health care provider's subjective knowledge of a material fact is presented but disputed, the court should instruct the jury on informed consent—including the limitation of informed consent to matters known by the health care provider. The jury can then decide what the health care provider knew. Matters that "should have been" known can be addressed by the patient's medical negligence claim.

In this case, construing all facts and reasonable inferences in favor of the estate, no competent and substantial evidence at trial supported a claim that the defendant providers knew that Ms. Hensley was at a material risk of intracranial infection and death but minimized that risk or chose not to disclose it to her. Here, unlike in *Flyte,* there are no contradictory chart notes. There were no witnesses to damning admissions. The expert testimony as a whole demonstrated that the estate's medical experts did not speak for the entire profession. And the estate offered no evidence of any reason or motive for the defendant providers to withhold subjective knowledge of material facts.

The estate's evidence was, instead, that the defendant providers failed to recognize and act on the asserted risk: its medical negligence claim. Like the trial court in *Anaya Gomez,* the trial court below allowed the estate to present evidence but then reasonably refused to instruct on the lack of informed consent claim.[9] Because we may affirm the trial court on this basis, we need not reach the estate's challenge to the court's secondary basis for its ruling: that the estate presented insufficient evidence of the likelihood of intracranial infection and death.

9 In the trial court, the estate also argued that the facts of its case were similar to those in *Gates v. Jensen*, 92 Wn.2d 246, 595 P.2d 919 (1979), which our Supreme Court identified in *Anaya Gomez* as presenting the limited circumstance in which a misdiagnosis case can also present an issue of informed consent: "The determining factor is whether *the process* of diagnosis presents an informed decision for the patient to make about his or her care." 180 Wn.2d at 623 (emphasis added). In *Gates*, an ophthalmologist failed to diagnose a patient's glaucoma. The ophthalmologist had treated the patient for over two years, had seen consistently high eye pressure readings that pointed to her higher risk for glaucoma, had available two additional diagnostic tests that were simple, inexpensive and risk free, and yet not only did not employ the tests but did not tell the patient they were an option. *Id.* at 621. *Anaya Gomez* limits *Gates* to its "unique set of facts" "aris[ing] during the diagnostic process." *Id.* at 623. It observes that "*Gates* is the exception and not the rule with regard to the overlap between medical negligence and informed consent" and "[g]iven the unique factual situation in *Gates,* it is unlikely we will ever see such a case again." *Id.* at 626.

The *Gates* exception would apply if Ms. Hensley had shown consistent signs of being at high risk of having a pathway for the infection from her abscess to reach the brain; there were simple, inexpensive,

and risk free diagnostic tests for determining whether such a pathway existed; and her treating providers failed to inform her of the option of having those tests performed. There was no such evidence here.

C. The trial court did not abuse its discretion in denying the motion for a new trial on the basis of juror bias or misconduct

***8** The estate finally argues that juror bias or misconduct required a new trial.

Juror bias

We first address the distinct situation where a juror's bias is evidenced by dishonesty in voir dire, thereby depriving a party of the opportunity to challenge the prospective juror for cause. This type of juror misconduct has been said to deprive a party of a constitutional trial. *E.g., Allison v. Dep't of Labor & Indus.*, 66 Wn.2d 263, 265, 401 P.2d 982 (1965). *Robinson v. Safeway Stores, Inc.*, 113 Wn.2d 154, 776 P.2d 676 (1989), on which the estate relies, is such a case.[10]

10 As observed in *State v. Cho*, 108 Wn. App. 315, 323, 30 P.3d 496 (2001), *Robinson* applied a standard for challenging a verdict that was more lenient than current Washington law.

As the United States Supreme Court has observed:

> Demonstrated bias in the responses to questions on voir dire may result in a juror's being excused for cause; hints of bias not sufficient to warrant challenge for cause may assist parties in exercising their peremptory challenges. The necessity of truthful answers by prospective jurors if this process is to serve its purpose is obvious.

McDonough Power Equip., Inc. v. Greenwood, 464 U.S. 548, 554, 104 S. Ct. 845, 78 L.Ed. 2d 663 (1984).

Whether a party is entitled to a new trial for juror bias is subject to its own test, recognized in *McDonough* and later adopted in Washington. In *McDonough*, the Supreme Court held that "to obtain a new trial in such a situation, a party must first demonstrate that a juror failed to answer honestly a material question on voir dire, and then further show that a correct response would have provided a valid basis for a challenge for cause." *Id.* at 556. It added that "[t]he motives for concealing information may vary, but only those reasons that affect a juror's impartiality can truly be said to affect the fairness of a trial." *Id.*

The *McDonough* standard was adopted in Washington in a capital case, in which our Supreme Court held that a prospective juror's incorrect responses to two questions asking if he had been the victim of a crime or of a sexual offense did not warrant a new trial. *In re Elmore*, 162 Wn.2d 236, 267–68, 172 P.3d 335 (2007) (citing the observation in *In re Det. of Broten*, 130 Wn. App. 326, 336, 122 P.3d 942 (2005) that Washington cases

are in accord with the *McDonough* standard for granting a new trial for juror bias)).

In this case, the estate contends that bias on the part of the presiding juror and another male juror identified as "Jay" deprived it of a fair trial. Its opening brief summarily identifies the portions of voir dire on which it relies. Br. of Appellant at 38–40. We have set out in full, in an appendix, the lawyers' statements and questions that the estate identifies. The estate relies for the most part on the lawyers' general admonitions about the purpose of voir dire and the need for honest answers, but without identifying any question it contends was answered dishonestly by the presiding juror or Jay. The estate also relies on Holy Family's questions about jurors' emergency room experiences, but here again, it identifies no question that the presiding juror or Jay answered dishonestly.

***9** Since there is no dishonestly answered question that, if answered honestly, would have been a basis for excluding the juror for cause, the trial court had no basis for ordering a new trial. [11]

11 In a statement of additional authority, the estate directs our attention to the recent United States Supreme Court decision in *Pena–Rodriguez v. Colorado*, — U.S. —, 137 S. Ct. 855, 197 L.Ed. 2d 107, 125 (2017), which recognizes an exception to the federal no-impeachment rule for a juror's "clear statement that indicates he or she relied on racial stereotypes or animus to convict a criminal defendant." The decision was based on "unique historical, constitutional, and institutional concerns" implicated by racial bias. *Id.* at 124. It has no application to this case.

Other misconduct

The estate's remaining charges of misconduct rely on its juror affiant's allegations that the presiding juror and Jay advocated for the defense and " 'shut[ ] down' " jurors who disagreed with them. CP at 937. The estate's affiant also claims the presiding juror and Jay made the following statements during deliberations:

- That doctors should not be sued for trying to do their job; or if they only see a patient once; or if, like CHAS's providers, they deal with a lot of poor people and are not properly paid;
- Statements about Ms. Hensley's health condition delivered "in a pejorative fashion";
- That it was well known the estate's lawyer only took "big money cases"; the jurors knew she could "twist things around"; and that her argument that the "more probable than not" instruction applied to causation as well as to the standard of care was "spin"; and
- That Jay's mother had been administered Dilaudid at the emergency room and was discharged with slurring speech (like Ms. Hensley) but his mother was fine.

CP at 938–39. The defendants responded with a declaration of the presiding juror, who denied personally making the improper statements alleged by the estate's affiant, denied or claimed not to recall other jurors

making the improper statements, asserted that no juror was shut down, and claimed that jurors were encouraged to, and did, follow instructions.

Professor Tegland has summarized the well settled two-step process by which a trial court decides a challenge to a verdict based on jury misconduct:

> First, the court determines whether the alleged misconduct is the sort of juror misconduct that can be considered on a motion for new trial. Conduct that inheres in the verdict, or inheres in the jurors' thought processes, cannot be considered, and the inquiry is at an end. If the alleged misconduct *is* the sort [of] misconduct that can be considered, then, as the second step, the court determines whether the misconduct was sufficiently prejudicial to warrant a new trial. On this second step, the outcome is always fact-specific, and the trial court has considerable discretion.

14A KARL B. TEGLAND, WASHINGTON PRACTICE: CIVIL PROCEDURE § 32:29, at 377 (2d ed. 2009).

Assuming for present purposes that the estate's affiant's allegations are true, most inhere in the verdict. Most deal with the affiant's or other jurors' thought processes.

> The mental processes by which individual jurors reached their respective conclusions, their motives in arriving at their verdicts, the effect the evidence may have had upon the jurors or the weight particular jurors may have given to particular evidence, or the jurors' intentions and beliefs, are all factors inhering in the jury's processes in arriving at its verdict, and, therefore, inhere in the verdict itself, and averments concerning them are inadmissible to impeach the verdict. ...
>
> ***10** A different rule, one permitting jurors to impugn the verdicts which they have returned by asserting matters derogatory to the mental processes, motivations and purposes of other jurors or purporting to explain how and why a juror voted as he did in arriving at his verdict, would inevitably open nearly all verdicts to attack by the losing party and thwart the courts in achieving a long held and cherished ambition, the rendering of final and definitive judgments.

Cox v. Charles Wright Acad., Inc., 70 Wn.2d 173, 179–80, 422 P.2d 515 (1967) (citations omitted).

A failure to understand or follow the jury instructions also inheres in the verdict. *E.g., State v. McKenzie,* 56 Wn.2d 897, 900, 355 P.2d 834 (1960) (juror argued law was contrary to instruction); *Ralton v. Sherwood Logging Co.,* 54 Wash. 254, 256, 103 P. 28 (1909) (ignored court's instructions).

Whether jurors feel threatened or pressured inheres in the verdict. *State v. Standifer,* 48 Wn. App. 121, 127–28, 737 P.2d 1308 (1987) (juror sensed peer pressure to decide the case in a particular way); *State v. Aker,* 54 Wash. 342, 346, 103 P. 420 (1909) (juror's acquiescence after other jurors threatened to report the juror's connection to a party).

What the estate characterizes as improper extrinsic evidence—Jay's mother's response to Dilaudid—falls within well settled law allowing jurors to use personal life experiences to evaluate the evidence presented at trial. *Breckenridge v. Valley Gen. Hosp.,* 150 Wn.2d 197, 204, 75 P.3d 944 (2003).

The estate's evidence of juror misconduct fails at the first step of the verdict challenge analysis, because the misconduct alleged is not the sort that can be considered on a motion for a new trial.

The trial court also considered prejudice, observing that the estate's "closest" case for a comment that could have some impact on a jury verdict was that "you shouldn't sue a doctor if they only see a patient once"—but the court then stated it was "really, really unclear" that the statement had any impact here. RP (July 11, 2015) at 63. Given the trial court's opportunity to observe the witnesses and its familiarity with the evidence, we give great deference to its determination that the complained of conduct, if it occurred, did not affect the verdict. *See McCoy v. Kent Nursery, Inc.,* 163 Wn, App. 744, 759, 260 P.3d 967 (2011).

II. CROSS APPEALS

A. The trial court did not err in denying Holy Family's motions for a directed verdict on the basis of a failure to present evidence of agency

Mr. Hunter and Dr. Tullis, who provided Ms. Hensley's care at Holy Family, are not employees of the hospital. The estate alleged that they were agents, for whose negligence Holy Family was vicariously liable. "Under apparent authority, an agent (e.g., a doctor) binds a principal (e.g., a hospital) if objective manifestations of the principal 'cause the one claiming apparent authority to actually, or subjectively, believe that the agent has authority to act for the principal' and such belief is objectively reasonable." *Mohr v. Grantham,* 172 Wn.2d 844, 860, 262 P.3d 490 (2011) (quoting *King v. Riveland,* 125 Wn.2d 500, 507, 886 P.2d 160 (1994)). "A finding of apparent agency can subject a hospital to vicarious liability for the negligence of contractor physicians or staff working at the hospital." *Id.* at 860–61.

Holy Family moved for a directed verdict at the close of the estate's case, arguing that the estate had presented no evidence of Mr. Hunter's and Dr. Tullis's ostensible agency for the hospital. The estate responded that agency "was not a disputed issue coming into this trial" and was not identified as such on the joint trial report. RP at 1863. The court also expressed surprise that agency was an issue and stated it was "going to deny the motion at this point." RP at 1869.

*11 Holy Family renewed its motion at the end of the evidence, arguing that the record still contained no evidence of agency. The trial court not only denied the motion but instructed the jury that Mr. Turner and Dr. Tullis were Holy Family's agents and it was vicariously liable for their conduct.

At issue is whether Holy Family's conduct leading up to the trial amounted to a judicial admission of agency on which the estate and trial court were entitled to rely. "Judicial admissions are not evidence ..... Rather, they are formal concessions in the pleadings in the case or stipulations by a party or counsel that have the effect of withdrawing a fact from issue and dispensing wholly with the need for proof of the fact. Thus, a judicial admission, unless allowed by the court to be withdrawn, is conclusive in the case." 2 KENNETH BROUN, MCCORMICK ON EVIDENCE § 254, 181 (6th ed. 2006) (footnote omitted). Factual stipulations are formal concessions that have the effect of withdrawing a fact from issue and dispensing wholly with the need for proof of the fact. *Christian Legal Soc'y Chapter of Univ. of Cal., Hastings Coll. of Law v. Martinez,* 561 U.S. 661, 677–78, 130 S. Ct. 2971, 177 L.Ed. 2d 838 (2010); *Cf.* CR 2A (stipulations will be recognized if made and assented to in open court or in writing and signed by the attorney disputing the stipulation).

During the hearing on the parties' summary judgment motion on June 22, 2012, Holy Family's counsel stated:

> [COUNSEL FOR HOLY FAMILY]: ... There's four causes of action here, your Honor; corporate negligence, informed consent, res ipsa loquitur,... and the vicarious liability, which would be the activities of Dr. Tullis and Mr. Hunter, represented by Bill Etter.
>
> [THE COURT]: Are they Holy Family staff?
>
> [COUNSEL FOR HOLY FAMILY]: They are. *They would be, your Honor, at a minimum, ostensible agents.* They are not employees, they are independent contractors. *But I think under* Adamski, *they are ostensible agents. I am responsible for—it's odd. I am responsible for their conduct but I don't represent them so it is a unique situation. Obviously the burden is on plaintiffs today to establish a prima facie case.*

RP at 3572 (emphasis added). We agree with the estate that the underlined language appears to be an admission. The italicized language that is not underlined creates ambiguity, however.

At the conclusion of the hearing, the court orally announced its ruling, in which it stated:

> Everybody acknowledges that Holy Family ... would have vicarious liability for the actions of the medical providers involved who are not presently before the court so that is not an issue before me on summary judgment.

RP at 3589. Holy Family did not object to or correct this statement.

The parties filed a trial management joint report in April 2014. The form indicates that it is filed pursuant to Spokane County LCR 16. That rule requires parties to cases governed by a civil case schedule order to jointly prepare "a Trial Management Joint Report (form CI–06.0150)." LCR 16(a). The first page of the court form states, among other matters,

> Failure to fully disclose all items required on this report may result in exclusion or restriction on use of evidence at trial. This is a joint report, requiring counsel to meet, confer, and attempt to resolve differences in the matter [sic] addressed in this report.

***12** CP at 1255.

Section E of the court form reads:

> E. **LIST EACH ISSUE THAT IS DISPUTED** (Issues not identified here may not be raised at trial without leave of court):

CP at 1256.

The parties completed section E by listing the following as "each issue that is disputed":

1. Standard of Care;
2. Informed Consent;
3. Res Ipsa Loquitor;
4. Wrongful Death;
5. Medical Causation;
6. Nature and extent of any damages;
7. Comparative fault.

Id. The report was signed or electronically approved by lawyers for all parties.

On the same day the trial management joint report was filed, Holy Family filed its trial brief. A section was devoted to argument that evidence would show that Mr. Hunter and Dr. Tullis did not violate the standard of care. There was no discussion of agency.

The Washington Constitution provides judges of the superior courts with authority to adopt "uniform rules for the government of the superior courts." CONST. ART. IV, § 24. The superior courts also have the authority to adopt rules of procedure that are supplementary and do not conflict with statewide rules adopted by the Washington Supreme Court. RCW 2.04.210; RCW 2.08.230. The Washington Supreme Court has adopted a rule that authorizes each superior court to "make and amend local rules governing its practice not inconsistent with these rules." CR 83(a). "Court rules are inconsistent under CR 83(a) only when they are 'so antithetical that it is impossible as a matter of law that they can both be effective.' " *Sorenson v. Dahlen,* 136 Wn. App. 844, 853, 149 P.3d 394 (2006) (quoting *Heaney v.*

Seattle Mun. Ct., 35 Wn. App. 150, 155, 665 P.2d 918 (1983)).

We address the validity and application of a court rule de novo. *Id.* at 850. If a court rule is valid and applies, we review a trial court's exercise of discretion recognized by the rule for abuse of discretion.

Spokane County's LCR 16 is not inconsistent with the civil rules. A principal purpose of the parallel civil rule, CR 16, which provides for pretrial conferences participated in by the court, is to "compel the parties to disclose their claims and defenses." *Burnet v. Spokane Ambulance,* 131 Wn.2d 484, 503, 933 P.2d 1036 (1997) (*Burnet* II). Spokane County's LCR 16 simply extends this valuable pretrial exercise to cases where court time does not permit, or the issues do not require, court participation. Under both the civil rule and the local rule, the identification of disputed issues is by agreement.

A trial management report should not be construed as including an admission where surrounding circumstances suggest that it was merely drafted unartfully or is incomplete. Here however, there had been other indications that agency was not in dispute. The trial court did not err in treating the identification of disputed issues in the April 2014 trial management joint report as a judicial admission for purposes of the May 2014 trial. It therefore did not err in instructing the jury that Mr. Hunter and Dr. Tullis were Holy Family's agents and that Holy Family was vicariously liable for their conduct.

B. The trial court did not err in denying Holy Family's and the ENT clinic's motion to dismiss the estate's medical negligence claim for a lack of adequate expert testimony

***13** Finally, Holy Family and the ENT clinic argue that the court erred in denying their motions for judgment as a matter of law on the basis that the estate's medical experts did not testify to opinions based on a reasonable degree of medical certainty. "Expert testimony is necessary to prove whether a particular practice is reasonably prudent under the applicable standard of care." *McLaughlin v. Cooke,* 112 Wn.2d 829, 836, 774 P.2d 1171 (1989). This expert testimony must be based on a reasonable degree of medical certainty. *Id.* [12]

12 The *Restatement (Third) of Torts* observes that "[t]o an expert witness, virtually any proposition may be 'possible,' but the law demands proof by a preponderance of the evidence in civil cases," so "[i]n an effort to screen expert opinions that are speculative, some courts have employed a requirement that an expert testify that an opinion is held to a 'reasonable degree of medical [or scientific] certainty' for it to be admissible." RESTATEMENT (THIRD) OF TORTS: LIABILITY FOR PHYSICAL & EMOTIONAL HARM § 28 cmt. e (AM. LAW INST. 2010). Nonetheless, "the vast majority of those courts state that the standard is equivalent to the usual preponderance requirement" when providing a definition or defining the phrase. *Id.*

The trial court denied the motion because it was confident from its trial notes that the estate's lawyer had posed opinion questions to experts in the required form. [13]

13 We can affirm the trial court's ruling on any basis supported by the record. *LaMon v. Butler,* 112 Wn.2d 193, 200–1, 770 P.2d 1027 (1989).

With the benefit of the transcript, we can see that while the estate's lawyer sometimes asked a preliminary question as to whether an expert's opinion was based on a reasonable degree of medical certainty, the "reasonable degree of medical certainty" mantra was not repeated every time a question about the expert's opinion was asked. We can also see, however, that the defense attorneys never objected to such questions for lack of foundation nor did they move to exclude the witnesses. The failure to raise a timely foundation objection precludes a party from moving for a new trial on the basis of an inadequate foundation. *Estate of Stalkup v. Vancouver Clinic, Inc., P.S.,* 145 Wn. App. 572, 584, 187 P.3d 291 (2008) (failure to object that physician did not testify to a reasonable medical certainty waived the foundation challenge). Not having objected to the foundation for the plaintiffs' experts' opinions, Holy Family and the ENT clinic were not entitled to judgment as a matter of law.

Affirmed.

A majority of the panel has determined this opinion will not be printed in the Washington Appellate Reports, but it will be filed for public record pursuant to RCW 2.06.040.

WE CONCUR:

Lawrence–Berrey, A.C.J.

Pennell, J.

APPENDIX

The estate identifies the following statements made or questions posed during voir dire as relevant to its claim that the presiding juror and Jay were biased:

The estate's voir dire:

> [T]he purpose of this process at this point is to allow me to talk with you a little bit about some of the things that we learn through life and through experience that become prejudices, that become biases, that become the way that we think about things, sometimes without even knowing that we think about things that way. So what I want to do is, I want to talk with you a little bit about some of the things that may come up in this trial, some of the beliefs you may have, about things that may come up in this trial that might interfere with your ability to listen fairly to both sides of the equation. In order for us to do that I'm going to hope that you'll share with me freely, as best as you can in a group, some of the

> [sic] your beliefs on some of these issues.

*14 RP at 125.

CHAS's voir dire:

> You all realize that that rule, is all we want to know, is can the panel that sits here, can they be impartial to both sides, truly, to both sides. I think that's the goal of this process, the jury selection process, is that we want an impartial panel who will listen to the evidence and then listen to the law as the judge instructs you on it, and then come to your decision based upon that law.

RP at 146–47.

Holy Family's voir dire (questions about experiences in the emergency room) questions only:

> ... [J]uror number 15. I wrote down that you had treatment at the Holy Family emergency room, is that right?
>
> ... Okay. Can you tell me a little bit about, first of all, when this was?
>
> ... Okay. And if you're comfortable, what brought you to the emergency room?
>
> ... All right. Were you admitted to the hospital or just treated in the emergency room?
>
> ... Did you feel that you were listened to and cared for properly in the emergency room?
>
> ... And would anything about your previous emergency room experience at Holy Family impact your ability to listen to all the evidence in this case?
>
> ... [T]hank you. Mr. [ ], I think you said that your children had been treated, if I wrote this down wrong correct me, maybe once at Holy Family and once at Sacred Heart in the emergency room department.
>
> ... And hospital admission or just treated in the emergency department?
>
> ... Did you feel that your family's concerns were properly listened to and addressed by the emergency physicians or nurses?
>
> ... Anything about your previous experience with the emergency departments, understanding it wasn't Holy Family, that would impact your ability to listen to the evidence in this case?
>
> ....
>
> ... Juror number 30, I wrote down that Holy Family and then three question marks so maybe you can fill it in.
>
> ... Thanks. Tell me about Holy Family.
>
> ... When was that?
>
> ... All right. Were any of your children admitted after being treated in the emergency room?

... Did you think that your concerns were listened to and you were treated fairly by the emergency room staff?

... What do you mean by slow?

... Did you have any experience where you thought you were in the waiting room longer than you needed to be?

... Pretty fair point there, yeah. I got it. My daughter's crying, it becomes an emergency situation. And anything about your experiences at the emergency room that would cause to you [sic] have trouble listening to go [sic] all the evidence in this case?

... Thank you. And then lastly number 48, can you stand for me? I don't want to hazard a guess at your name is so I'll just go with 48. I think you said you had kids in the ER twice within the last six months, is that right?

... And was that at Holy Family?

... And what was the nature of the ER visits?

... Bones or scrapes or bruises, that type of thing?

... Were either of your children admitted to the hospital?

... Did you think you were treated fairly and equitably and people listen to your concerns at the emergency room?

... So someone close to you that you're familiar with had passed away based upon an infection they acquired at Holy Family, is that right.

*15 ... How did that impact you?

... Sure. And how long ago did this church member pass away?

... And you still have feelings about what happened to that person?

... You think that they probably shouldn't have caught an infection at the hospital and passed away, right?

... And you still have those feelings about what happened at Holy Family. And based upon the experience you had, or those close to you you've had, would it impact your ability to listen to the record regarding Holy Family, in particular the emergency department?

... Based upon the experience that you've had and those close to you.

... Those feelings aren't likely to change in the next three to four weeks as I [sic] you sit here, correct?

... Absolutely. Thank you, I appreciate your candor. And I'll finish up real quick by way of show of hands. I'm gonna ask some general questions and try to follow up in the time that I have left. So if you can keep your hands up in the air long enough for me to count them. Anybody here, separate and apart from what the judge asked you, a bad medical experience, I want to know, in particular, if anyone's had a bad experience, you or a loved one, in the emergency room.

... Anywhere. You're number 13, is that right?

... Number 49, okay.

RP at 149–57.

ENT clinic voir dire:

... Do you have any problems setting aside sympathy that anyone would have for someone that's lost a loved one, and to be objective as you listen to the facts in this case?

PROSPECTIVE JUROR NO. 12: No. I think with any court case you should be objective.

RP at 164–65.

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