Court of Appeal Cause No. 49516-3-II

IN THE SUPREME COURT OF THE STATE OF WASHINGTON

LISA BARTON, an individual,

Appellant,

v.

STEVEN SANDIFER, ET AL,

Respondents.

PETITION FOR REVIEW

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IDENTITY OF PETITIONER

The Petitioner herein is Lisa Barton, who was the Plaintiff below and Appellant in the Court of Appeals.

DECISION OF WHICH REVIEW IS SOUGHT

Petitioner seeks review of the attached, unpublished opinion of the Court of Appeals, Division II, No. 49516-3-II, filed July 25th, 2017. There was no Motion for Reconsideration.

ISSUES PRESENTED FOR REVIEW

Issue 1: The Plaintiff suffered a stroke days after the Defendant chiropractor's manipulation of her neck; Is the Defendant's subsequent "profuse" apology to the Plaintiff, in which he "very specifically agreed that his treatment had caused" the Plaintiff's stroke, adding that "this exact situation is why he carries insurance, and that he would contact his insurance company as soon as possible", evidence of an admission by the Defendant that his care was negligent, sufficient to defeat his subsequent motion for summary on that issue?

Issue 2: For purposes of an informed consent case, should "risks" listed in the health care provider's own consent form, which the patient is required to sign as a pre-condition to treatment, be considered "material" as a matter of law?

Issue 3: Is the defendant chiropractor's "very specific agreement" that his treatment caused Plaintiff's stroke evidence of proximate cause, sufficient to defeat summary judgment on that issue on both the negligence and informed consent claims?

STATEMENT OF THE CASE

The Appellant Lisa Barton ("Barton") suffered a serious stroke two days after her second chiropractic manipulation performed by the Respondent Dr. Sandifer ("Dr. Sandifer"). CP 75-79; CP 13-49 (Exhibit 9 to Declaration of Amanda Daylong).

Barton had given a friend a ride to see Dr. Sandifer. CP 75-79. Because Barton herself had been having "minor" neck/back pain, and because her friend "seemed to like" Dr. Sandifer, Barton decided to seek treatment with him. Id.

In her Declaration opposing Summary Judgment, Barton described the "informed consent" process:

> "I have now seen the "informed consent" document included with the Defendant's Motion for Summary Judgment, which I signed that day. I have no memory of having signed the document and nobody went over its contents with me. In fact, if the risks it refers to---including "fractures, disc injuries, stroke, dislocation, sprains/strains, physiotherapy burns"---had been explained to me, I wouldn't have gone through with the treatment".
>
> CP 75-79

The consent form (Ex. 6 to Declaration of Amanda Daylong, CP 13-49) acknowledges "stroke" as an "extremely rare" risk of treatment.

Lisa began treatment July 16th, 2014. CP 75-79. Dr. Sandifer twisted her neck and there was a "pop" and "immediate, severe pain". Id. Barton "screamed and began crying". CP 75-79. Dr. Sandifer "showed no concern whatsoever", and Barton assumed "that the pain [she] felt was part of the 'process' of treatment." Id.

About a week later, Barton returned, and Dr. Sandifer performed the same "twisting" motion on her neck". CP 75-79. Again, Dr. Sandifer expressed no concern, and Barton felt the pain was "a necessary part of the 'process'. Id. Two days later, she suffered a stroke, for which she was hospitalized, and from which she is "still struggling to recover". Id.

Upon her release from the hospital, and again several months later, Barton had conversations with Dr. Sandifer. Due to their importance, her Declaration will be quoted at length (CP 75-79):

> Within days of my release from the hospital, Dr. Sandifer called me at home. He knew of the stroke and was sympathetic, but began asking me questions, obviously trying to identify some cause for it other than his manipulations. He specifically asked if I were on birth control pills, saying that they can occasionally cause strokes. I was not on birth control pills and told him so, but I was not at all comfortable with the conversation and ended the conversation.

> In January of 2015, I had another conversation with Dr. Sandifer. I told him of how drastically the stroke had impacted my life, and he apologized profusely. He told me that he had "not been able to sleep for a month" after my stroke **because he was so upset at having caused it**. He told me that nothing like this had ever happened to him in his career, or to his father in his own chiropractic career.
>
> During this conversation, I very specifically told Dr. Sandifer that I would like some sort of acknowledgment from him that his treatment had cause my stroke. Dr. Sandifer very specifically agreed that his treatment had caused my stroke. He told me that 'this exact situation' is why he carries insurance and that he would contact his insurance company as soon as possible". (all emphasis in original Declaration)

Barton retained counsel and in February, 2016, suit was filed. CP 4-5. The Case Schedule set trial for August 14th, 2017, and the deadline for disclosing expert witnesses was January 17th, 2017. CP 10.

Dr. Sandifer moved for Summary Judgment on August 5th, 2016, more than a year from trial, and about five months before the deadline for disclosing expert witnesses. CP 50-64. There was no Declaration from Dr. Sandifer or any other witnesses submitted with the Motion. CP 50-64. The motion quoted from unauthenticated medical records, but no expert testimony actually interpreted them for the Court. Id. The Motion was based upon the "lack of competent testimony" supporting Barton's claims of negligence and failure to obtain informed consent. Id.

Barton opposed the Motion with her declaration, laying out Dr. Sandifer's admissions to her as set forth above, and by pointing out that the deadline for identifying experts was still months away. CP 75-79, CP 80-90.

The Motion was heard, and granted, September 30th, 2016. CP 101, 102. Timely appeal followed and the Court of Appeals affirmed.

ARGUMENT

1. The evidentiary and legal significance of a health care provider's "apology" is a significant question of Washington law, especially since the enactment of the "apology statute", RCW 5.64.010

No one would seriously argue that, generally, a defendant's acknowledgment of fault would be admissible evidence. ER 801 (d)(2) ("admission by party opponent"). Further, though RCW 5.66.010 excludes evidence of "benevolent gestures expressing sympathy" from civil cases, that statute specifically provides that "a statement of fault, however, which is part of, or in addition to" such expressions of sympathy "shall not be made inadmissible" by the rule.

Of course, RCW 7.70.040 requires more specialized proof in medical negligence cases:

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

(1) The health care provider failed to exercise that degree of care, skill, and learning expected of a reasonably prudent health care provider at that time in the profession or class to which he or she belongs, in the state of Washington, acting in the same or similar circumstances;

(2) Such failure was a proximate cause of the injury complained of."

It does not appear that this Court has ever analyzed the significance of a health care provider's "apology", containing an acknowledgment of "fault", vis a vis Plaintiff's statutory burden of proof in a medical case.

Notably, in 2008, the Legislature excluded "early" apologies in medical negligence cases, specifically those <u>including</u> expressions of fault. RCW 5.64.010 (2)(b)(i). The statute states:

* * * *

(2)(a) In a civil action against a health care provider for personal injuries that is based upon alleged professional negligence, or in any arbitration or mediation proceeding related to such civil action, a statement, affirmation, gesture, or conduct identified in (b) of this subsection is not admissible as evidence if:

(i) It was conveyed by a health care provider to the injured person, or to a person specified in RCW 7.70.065 (1)(a) or (2)(a) <u>within thirty days of the act or omission that is the basis for the allegation of professional negligence</u> or within thirty days of the time the health care provider discovered the act or omission that is the basis for the allegation of

professional negligence, whichever period expires later; and

(ii) It relates to the discomfort, pain, suffering, injury, or death of the injured person as the result of the alleged professional negligence.

(b) (a) of this subsection applies to:

(i) Any statement, affirmation, gesture, or conduct expressing apology, fault, sympathy, commiseration, condolence, compassion, or a general sense of benevolence; or

(ii) Any statement or affirmation regarding remedial actions that may be taken to address the act or omission that is the basis for the allegation of negligence.
(emphasis added)

In fact, by conventional definition, an "apology" is an expression of "fault". For example, Merriam-Webster's online definition of "apology" is:

" an admission of error or discourtesy accompanied by an expression of regret" (emphasis added)

Acknowledging that there is abundant room for ambiguity on a case-by-case basis, in this case there can be no legitimate doubt---at least for purposes of summary judgment----that Dr. Sandifer openly admitted that the stroke was his "fault". According to Barton, he:

"Very specifically agreed that his treatment had caused [Barton's] stroke";

"Apologized profusely";

Told Barton that he'd "not been able to sleep for a month" because he was "so upset at having caused" her stroke;

> Told her that "this exact situation is why he carries insurance"; and
>
> Told her that he would "contact his insurance company as soon as possible".

Dr. Sandifer submitted no evidence disputing Barton's Declaration to the above effect, and submitted no evidence purporting to explain "his side" of the conversation. For purposes of the summary judgment motion, Barton's version of the conversation was undisputed (and her version would control on the Summary Judgment calendar anyway).

A reasonable jury could infer from the above that Dr. Sandifer purposefully and forthrightly "expressed" his "fault" for Barton's stroke. Coming well outside the time period protected by the "apology" statute, the question is: Why shouldn't this admission be satisfactory evidence on each element of Barton's statutory burden of proof?

Relying on Keck v. Collins, 184 Wn.2d 358, 370, 357 P.3d 1080 (2015), the Court of Appeals held that this evidence failed "in substance" (Opinion, p. 7). The Court correctly pointed out that Dr. Sandifer "did not identify how he might have been negligent or what he did wrong. He did not state what a reasonable chiropractor would have done or how Sandifer failed to meet such a standard". (Opinion, p.6).

But, respectfully, it is one thing to require such detail of a retained expert, whose opinions are necessarily, based upon his/her review of medical records, deposition, etc. [1] It should be another to apply such a standard to a party opponent's own "profuse apology" for having admittedly caused the Plaintiff's harm, where, as here, the Defendant has personal knowledge of his care and treatment.

Imagine an intersection collision case, where the plaintiff sustained a concussion and didn't remember the accident, but brought suit because, months after the accident, the other driver had visited the Plaintiff and:

> "Very specifically agreed that his driving had caused Plaintiff's injuries"";
>
> "Apologized profusely";
>
> "Told Plaintiff that he'd not been able to sleep for a month after the accident because he was so upset at having caused it";
>
> "Told Plaintiff that this exact situation is why he carries insurance"; and
>
> "Told Plaintiff that he would contact his insurance company as soon as possible".

Surely these "expressions" would support a jury verdict against the Defendant, though at no point did he say "what he'd done wrong", or

[1] ER 705 specifically allows the Court to require a testifying expert to disclose the "underlying facts or data" supporting his/her opinion.

what "a reasonable driver would have done", or "what he failed to do". Why should a medical case be different?

Indeed, and again respectfully, on this undisputed record, there's little doubt that Dr. Sandifer knows that he triggered Barton's stroke, and that in doing so he "failed to exercise that degree of care, skill and learning expected of a reasonably prudent health care provider at that time in the profession or class to which he belongs, in the State of Washington, acting in the same or similar circumstances". RCW 7.70.040. Any true expression of "fault" by a health care provider in a medical case admits that the Defendant is aware of the applicable standard of care, and believes that he/she breached that standard.

No case holds that any expert's testimony on medical negligence must come in the form of "magic words", or some "script". On the contrary, in White v Kent Medical Center, 61 Wn. App. 163, 172, 810 P.2d (1991), the Court of Appeals held that "To require experts to testify in a particular format would elevate form over substance."

True ER 801 "admissions" are historically justified on ours being an adversarial system of justice. See generally Tribe, "Triangulating Hearsay", 87, Har v L. Rev. 957, 961-63 (1974). The party opponent will

presumably be at trial and is free to dispute, or explain his/her "admission". Certainly Dr. Sandifer is free to do that, though for all we know he'll confirm Barton's version of their conversations.

Barton asks this Court to hold that, as here, where a health care provider offers the Plaintiff an apology that includes an "expression" of fault, the apology standing alone is sufficient evidence as an admission by a party opponent that the provider is (1) aware of the applicable standard of care, and (2) that he/she violated that standard, (3) proximately causing Plaintiff's injury. Since Barton presented abundant evidence to that effect, summary judgment should be reversed.

Plaintiff respectfully submits that this question presents a significant issue of Washington Law.

2. A "risk" listed in the health care provider's own consent form should be "material" as a matter of law.

RCW 7.70.050 describes the elements of an informed consent claim:

> (1) The following shall be necessary elements of proof that injury resulted from health care in a civil negligence case or arbitration involving the issue of the alleged breach of the duty to secure an informed consent by a patient or his or her representatives against a health care provider:
>
> (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.

Dr. Sandifer argued and the Court of Appeals agreed that Plaintiff had "no expert testimony" that the risk of stroke was "material". But before she received care, Barton signed a consent form provided and required by Sandifer himself. This document is obviously a statement of which Dr. Sandifer "manifested an adoption or belief in its truth" and, therefore, is an admission under ER 801(2). The form specifically describes "stroke" as a risk of his care.

Plaintiff asks this Court to hold that any risk described in a consent form provided by a defendant/party opponent health care provider prior to the treatment in question is "material" as a matter of law.

RCW 7.70.060 creates a rebuttable presumption that the patient gave informed consent, where the patient has signed a consent form identifying the risk at issue. The presumption is rebuttable, by a preponderance of the evidence. Here, a jury could find the presumption rebutted, based on Barton's testimony that no one went over the form with

her, and that if she had been made aware of the risks described in the form, she would not have gone through with the treatment.

3. Dr. Sandifer's "very specific" admission that his treatment had caused Barton's stroke is sufficient evidence of causation

The Court of Appeals felt it unnecessary to address the issue, raised by Dr. Sandifer below, that there was insufficient evidence of causation, for lack of "expert testimony" that his treatment caused her stroke. But again: Dr. Sandifer is (presumably) an expert, and has personal knowledge of his treatment. His "very specific" acknowledgment that his treatment had cause the stroke is an admission under ER 802 (d)(2). Admissions in the form of opinions are admissible. Young v. Group Health Co-Op of Puget Sound, 85 Wn.2d 332, 337, 534 P.2d 1349 (1975).

CONCLUSION

Barton requests Review of the issues set forth above.

Respectfully submitted on this 17 Day of August, 2017.

David A. Williams, WSBA #12010
Attorney for Appellant

PROOF OF SERVICE

The undersigned declares under penalty of perjury, under the laws of the State of Washington, that the following is true and correct: That on this_____day of August, 2017, I arranged for service VIA U.S. MAIL and EMAIL a copy of the foregoing **Petition for Review** to the parties to this action as follows:

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ATTACHMENT

Filed
Washington State
Court of Appeals
Division Two

July 25, 2017

IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON

DIVISION II

LISA BARTON, an individual, Appellant, v. DR. STEVEN SANDIFER, D.C. and JANE DOE SANDIFER, individually and their marital community, and CHAMPION CHIROPRACTIC CENTER, INC., a Washington corporation, Respondent.	No. 49516-3-II UNPUBLISHED OPINION

JOHANSON, J. — Lisa Barton appeals the superior court's order granting summary judgment and dismissing her claims against Dr. Steven Sandifer and Champion Chiropractic Center, Inc., with prejudice. On appeal, Barton argues that the superior court erred when it dismissed her medical malpractice claim and her lack of informed consent claim. Because Barton failed to produce competent expert testimony to support essential elements of her claims, we affirm the superior court's summary judgment order.

FACTS

I. BACKGROUND

In July 2014, Barton met with Sandifer, a chiropractor, and complained of back and neck pain and headaches.[1] After Barton signed an informed consent form, Sandifer performed adjustments on two separate days. Two days after the second adjustment, Barton suffered strokes and went to the hospital. Barton claimed that in January 2015, Sandifer called her, apologized, and agreed that his treatment had caused her stroke.

In February 2016, Barton sued Sandifer and Champion (collectively, "Defendants") and claimed that the second, July 22, 2014, "manipulation was performed negligently and without [Barton's] informed consent," resulting in Barton's strokes. Clerk's Papers (CP) at 4. The superior court's case scheduling order set the deadline for disclosure of Barton's expert witnesses in February 2017 and required dispositive motions to be heard by June.

II. SUMMARY JUDGMENT

A. DEFENDANTS' SUMMARY JUDGMENT MOTION AND EVIDENCE

In August 2016, Defendants moved for summary judgment because Barton had failed to provide competent expert testimony that (1) Sandifer had breached the standard of care, (2) Sandifer had caused Barton's strokes, or (3) explained the nature and probability of the risk of stroke from chiropractic manipulation.

In support of their summary judgment motion, Defendants submitted records of Barton's visits to Champion, including the informed consent form signed by Barton on July 14, 2014. As

[1] Barton had been involved in a car accident in 1982 and a slip and fall accident in 2000.

relevant here, the informed consent form stated that Sandifer had been informed that chiropractic treatment posed risks, including "stroke," that were "extremely rare occurrences" and that Barton nevertheless agreed to undergo chiropractic care. CP at 32. By the form's terms, Barton agreed that she had "read[] or . . . [someone] had read to [her]" the informed consent form. CP at 32. According to Champion's records, on July 16 and 22, Barton underwent chiropractic treatment.

B. BARTON'S RESPONSE AND EVIDENCE

In response to the summary judgment motion, Barton argued that Sandifer's January 2015 apology was an admission of causation and breach of the standard of care admissible as a party-opponent's statement under ER 801. Barton also argued that the consent form's statement that a stroke was an "extremely rare" potential complication of chiropractic manipulation was evidence of materiality. CP at 32.

Barton relied upon the evidence submitted in support of the summary judgment motion as well as her own declaration. In her declaration, Barton stated that she had signed the informed consent form but that she had "no memory of having signed the [form] and nobody went over its contents with me." CP at 76 (emphasis omitted). Had someone explained the risk of chiropractic treatment, Barton claimed that she would not have undergone treatment.

Barton further claimed that during both treatments, she had felt a "'pop' and immediate, severe pain" when Sandifer twisted her neck. CP at 76. Barton acknowledged that Sandifer had called her "[w]ithin days of [her] release from the hospital," and Barton claimed that they had spoken again in January 2015. CP at 76. During this January conversation, according to Barton, Sandifer "apologized profusely," said that he had "'not been able to sleep for a month' after my stroke because he was so upset at having caused it," and "agreed that his treatment had caused my

stroke." CP at 77 (emphasis omitted). Sandifer had stated that "'this exact situation' is why he carries insurance, and that he would contact his insurance company as soon as possible." CP at 77.

C. Summary Judgment Hearing and Order

At the summary judgment hearing, which was continued for one month on the parties' stipulation, Barton stated that she was "not asking for a continuance," although Barton claimed that the motion was "premature." Report of Proceedings (RP) at 10. The superior court granted Defendants' summary judgment motion. Barton appeals.

ANALYSIS

I. Summary Judgment Standard of Review

We review summary judgment orders de novo and consider the evidence in the light most favorable to the nonmoving party. *Keck v. Collins*, 184 Wn.2d 358, 370, 357 P.3d 1080 (2015). "The 'purpose [of summary judgment] is not to cut litigants off from their right of trial by jury if they really have evidence which they will offer on a trial[;] it is to carefully test this out, in advance of trial by inquiring and determining whether such evidence exists.'" *Keck*, 184 Wn.2d at 369 (alteration in original, emphasis omitted, internal quotation marks omitted) (quoting *Preston v. Duncan*, 55 Wn.2d 678, 683, 349 P.2d 605 (1960)).

Summary judgment is appropriate only when "there is no genuine issue as to any material fact" and "the moving party is entitled to judgment as a matter of law." CR 56(c). A moving defendant may meet his burden to show no genuine issue of material fact by showing an absence of evidence to support the plaintiff's case. *Lee v. Metro Parks Tacoma*, 183 Wn. App. 961, 964, 335 P.3d 1014 (2014). "The burden then shifts to the plaintiff to come forward with sufficient

evidence to establish the existence of each essential element of the plaintiff's case." *Lee*, 183 Wn. App. at 964. "A complete failure of proof concerning an essential element of the nonmoving party's case necessarily renders all other facts immaterial." *Repin v. State*, 198 Wn. App. 243, 262, 392 P.3d 1174 (2017).

II. MEDICAL MALPRACTICE CLAIM

A. LEGAL PRINCIPLES

To establish medical malpractice, the plaintiff must prove two elements—failure to meet the standard of care and proximate cause:

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

RCW 7.70.040; *see Keck*, 184 Wn.2d at 370. Generally, the plaintiff must prove both elements through medical expert testimony. *Keck*, 184 Wn.2d at 370.

B. NO EVIDENCE OF BREACH

Barton argues that the superior court erred when it granted Defendants' summary judgment motion regarding Barton's medical malpractice claim because there are genuine issues of material fact related to negligence and causation. We disagree.

The standard of care is "that degree of care, skill, and learning expected of a reasonably prudent health care provider at that time in the profession or class to which [he] belongs, in the state of Washington, acting in the same or similar circumstances." RCW 7.70.040(1). Failure to

meet the standard of care must generally[2] be established through expert testimony. *Keck*, 184 Wn.2d at 370. The plaintiff must have an expert testify regarding "what a reasonable doctor would or would not have done, that the [d]octor[] failed to act in that manner, and that this failure caused her injuries." *Keck*, 184 Wn.2d at 371.

Barton argues that Sandifer's January apology was sufficient to create a genuine issue of material fact that Sandifer had been negligent. Sandifer told Barton that "he had 'not been able to sleep for a month' after [Barton's] stroke because he was so upset at having caused it." CP at 77 (emphasis omitted). Sandifer also told Barton, "[N]othing like this had ever happened to him in his career," he "very specifically agreed that his treatment had caused [Barton's] stroke," and he said that "'this exact situation' is why he carries insurance, and that he would contact his insurance company as soon as possible." CP at 77 (emphasis omitted).

In considering Barton's argument, we treat the January apology as a party-opponent's admission.[3] And even if we assume, without deciding, that Barton's apology amounted to expert testimony, Sandifer's apology does not establish the standard of care or that Sandifer failed to meet that standard. *See Keck*, 184 Wn.2d at 371. Sandifer did not identify how he might have been negligent or what he did wrong. He did not state what a reasonable chiropractor would have done or how Sandifer failed to meet such a standard.

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[2] The rare exception is where "medical facts are observable to," *Bauer v. White*, 95 Wn. App. 663, 667, 976 P.2d 664 (1999), and within "the expertise of a layperson." *Seybold v. Neu*, 105 Wn. App. 666, 676, 19 P.3d 1068 (2001). Barton does not argue that this rare exception applies.

[3] "[A statement is not hearsay if] [t]he statement is offered against a party and is . . . the party's own statement." ER 801(d)(2)(i).

Barton cites to *White v. Kent Medical Center, Inc.*, for the proposition that experts need not use specific "standard of care" terminology. 61 Wn. App. 163, 172, 810 P.2d 4 (1991). But our holding is consistent with the rule from *White*: here, Sandifer's apology is insufficient not because Sandifer failed to utter the phrase "standard of care" but because the *substance* of Sandifer's apology was deficient.

Viewing the evidence in the light most favorable to Barton and drawing all reasonable inferences therefrom, Barton produced no expert testimony that Sandifer breached the applicable standard of care. *See Keck*, 184 Wn.2d at 370. Barton's "complete failure of proof" concerning an essential element of her medical malpractice case "necessarily renders all other facts immaterial." *Repin*, 198 Wn. App. at 262. Accordingly, we hold that the superior court properly granted Defendants' summary judgment motion and dismissed Barton's medical malpractice claim.[4]

III. LACK OF INFORMED CONSENT CLAIM

Barton argues that the superior court erred when it granted Sandifer's summary judgment motion regarding her lack of informed consent claim because there are genuine issues of material fact. Barton specifically argues that because the informed consent form listed "stroke" as an "extremely rare" risk of treatment, Barton has shown that stroke was a "material" risk of treatment

[4] Because Barton's evidence fails to establish breach of the standard of care, an essential element of her medical malpractice claim, her claim that the superior court wrongly granted summary judgment necessarily fails. *See Repin*, 198 Wn. App. at 262. Thus, we do not reach Barton's argument that a genuine issue of material fact exists related to whether Sandifer's alleged negligence proximately caused Barton's injury.

and that she can rebut the presumption of informed consent created by her signature on the informed consent form. Again, we disagree.

A. LEGAL PRINCIPLES

Negligence and lack of informed consent are alternative methods of imposing liability; lack of informed consent, unlike negligence, allows recovery even where treatment was not negligent. *Backlund v. Univ. of Wash.*, 137 Wn.2d 651, 659, 975 P.2d 950 (1999). To make a prima facie case of lack of informed consent, the plaintiff must show

> (a) [t]hat 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); *Backlund*, 137 Wn.2d at 664. Washington takes an "objective approach" to lack of informed consent, so that the relevant inquiry is what a reasonably prudent patient under similar circumstances would have done. *Backlund*, 137 Wn.2d at 666 (citing RCW 7.70.050(1)(c)).

Materiality, referenced in RCW 7.70.050(1)(a) through (c), is defined by RCW 7.70.050(2): "a fact is . . . a material fact, if a reasonably prudent person in the position of the patient . . . would attach significance to it [in] deciding whether or not to submit to the proposed treatment." RCW 7.70.050(3) explains which material facts "must" be established by expert testimony:

> (a) The nature and character of the treatment proposed and administered;
> (b) The anticipated results of the treatment proposed and administered;
> (c) The recognized possible alternative forms of treatment; or

> (d) The recognized serious possible risks, complications, and anticipated benefits involved in the treatment administered and in the recognized possible alternative forms of treatment, including nontreatment.

To show materiality, the plaintiff must have expert testimony regarding "'the existence of a risk, its likelihood of occurrence, and the type of harm in question.'" *Seybold v. Neu*, 105 Wn. App. 666, 682, 19 P.3d 1068 (2001) (quoting *Smith v. Shannon*, 100 Wn.2d 26, 34, 666 P.2d 351 (1983)).

B. No Prima Facie Case

The first three elements of a prima facie case of lack of informed consent require that Barton show that there was a "material fact"—here, the risk of stroke—of which she was not informed or otherwise aware. RCW 7.70.050(1)(a)-(c). Materiality, specifically the "'existence of a risk, its likelihood of occurrence, and the type of harm in question,'" *must* be established by expert testimony. *Seybold*, 105 Wn. App. at 681-82 (emphasis added) (quoting *Smith*, 100 Wn.2d at 34).

Barton acknowledges that she must provide expert testimony, yet she relies solely upon the informed consent form's statement that there were risks to treatment including "stroke" and other complications and that the complications were "extremely rare." CP at 32. Barton's reliance on the informed consent form is misplaced: the informed consent form is not the requisite expert testimony. *See Seybold*, 105 Wn. App. at 682. After Defendants moved for summary judgment, it was Barton's burden to come forward with or point to expert testimony. *See Seybold*, 105 Wn. App. at 682; *Lee*, 183 Wn. App. at 964; CR 56(e). Such expert testimony is required in order to show the existence of the risk of stroke, its likelihood of occurrence, and the type of harm in question. *See Seybold*, 105 Wn. App. at 682. But Barton failed to come forward with or point to

any expert testimony as required to show the first three elements of lack of informed consent, and accordingly her complete failure of proof concerning essential elements of her claim of lack of informed consent necessarily renders all other facts immaterial. *See Repin*, 198 Wn. App. at 262.

A second reason that Barton fails to show all the elements of a prima facie case is that the first element requires Barton to show "[t]hat the health care provider failed to inform the patient of a material fact . . . relating to the treatment." RCW 7.70.050(1)(a). Barton admits that she signed the informed consent form, which set forth the risk of "stroke." *See* CP at 76 ("I have now seen the 'informed consent' document[,] . . . which I signed that day."). Barton's sole argument related to this factor, which is her argument that she has shown that the risk of stroke was "material," does not create a factual dispute related to whether Barton was actually informed regarding the risk of stroke as a result of the treatment.

A plaintiff must establish all the elements of a prima facie case of lack of informed consent. *See* RCW 7.70.050(1). But when viewing the evidence in the light most favorable to Barton, she fails to produce any evidence to support the elements in subsections (a) through (c) of RCW 7.70.050(1). *See Repin*, 198 Wn. App. at 262. Accordingly, we hold that the superior court properly granted Defendants' summary judgment motion and dismissed Barton's lack of informed consent claim.[5]

[5] Because Barton fails to establish essential elements of her lack of informed consent prima facie case, her argument that the superior court wrongly granted Defendants' request for summary judgment of her lack of informed consent claim fails. *See Repin*, 198 Wn. App. at 262. Thus, we do not address Barton's argument that a genuine issue of material fact exists as to whether she could rebut the presumption of informed consent. We also reject Barton's claim underlying her appellate arguments that it was unfair for the superior court to grant the summary judgment motion on the basis of lack of expert testimony when the motion was brought well before the deadline to designate experts. This claim is not well-taken because Barton did not seek a continuance under CR 56(f) and in fact represented to the superior court that she did not want a continuance. Thus,

We affirm.

A majority of the panel having determined that this opinion will not be printed in the Washington Appellate Reports, but will be filed for public record in accordance with RCW 2.06.040, it is so ordered.

Johanson, J.
JOHANSON, J.

We concur:

Maxa, A.C.J.
MAXA, A.C.J.

J.
LEE, J.

Barton may not argue on appeal that summary judgment was wrongly granted because the matter should have been continued.

LAW OFFICE OF DAVID A. WILLIAMS

August 17, 2017 - 11:30 AM

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