99947-3

No. 80731-5-I

IN THE COURT OF APPEALS

OF THE STATE OF WASHINGTON

DIVISION 1

KASEY CAHAN, an individual,

Appellant,

v.

FRANCISCAN HEALTH SYSTEM, a Washington public benefit corporation, d/b/a ST. FRANCIS HOSPITAL,

Respondent.

PETITION FOR REVIEW

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I. IDENTITY OF PETITIONER

Petitioner is Appellant Kasey Cahan ("Cahan").

II. COURT OF APPEALS DECISION

Cahan asserted a single cause of action against Respondent Franciscan Health System, a Washington public benefit corporation, doing business as St. Francis Hospital (the "Hospital").

On June 1, 2021, the Court of Appeals, Division One, entered an Unpublished Decision reversing the trial court's finding on summary judgment that a clear mandate of public policy prohibits nurses from administering care to patients without provider orders or patient consents. As this finding on public policy was sufficient for affirming the trial court's decision granting summary judgment, the Court of Appeals did not reach the trial court's ruling that Cahan failed to raise a genuine issue of material fact as to the causation element of her claim, *i.e.*, whether the Hospital's reasons for terminating Cahan were pretextual or her policy-linked conduct was a substantial motivating factor in her termination.

III. ISSUES PRESENTED FOR REVIEW

1. Whether Washington law recognizes a clear mandate of public policy prohibiting nurses from administering care to patients without provider orders?

2. Whether Washington law recognizes a clear mandate of public policy prohibiting nurses from administering care to patients without patient consents?

3. Whether this Court should remand to the Court of Appeals for consideration of the disputed issues of causation and pretext?

IV. STATEMENT OF THE CASE

A. Cahan Worked as Nurse at St. Francis Hospital for 23 Years.

Cahan obtained her bachelor's degree from California State Poly Technic Institute in 1991. (Clerk's Papers ("CP") 596.) In 1995, she earned her nursing license from Highline Community College and the Hospital hired her as a registered nurse. (*Id*.) Cahan worked at the Hospital for 23 years. Not once during those 23 years was Cahan suspended or did she fear being terminated. (*Id*. 1302.) In fact, Cahan's performance evaluations from the prior 10 years all show that she met or exceeded expectations. (*Id*. 1153, 1156-1290.)

For 16 of her 23 years at the Hospital—2002 to 2018—Cahan worked in the perioperative services department. (CP 596.) Perioperative services is comprised of multiple units that manage the different phases of patient care for elective surgeries. (*Id*.) These include the Pre-Admission Clinic where Pre-Admission Testing ("PAT") occurs, the Same-day Admit and Discharge Unit ("SADU"), and the Post-Anesthesia Care Unit ("PACU"). (*Id*.) The nurses in each of these units interact with the patients in both the pre-surgical and post-surgical phases of their care. (*Id*.)

B. Provider Orders, Consents, and Patient Health & Physicals Must be Delivered to Perioperative Services Before Nurses May Administer Non-Exigent Care.

Nurses are not allowed, by law, to administer non-exigent care without orders from a provider; generally, a physician, a nurse practitioner,

or a physician's assistant. The Hospital maintains policies to ensure that provider orders are delivered in a timely manner in order for nurses in perioperative services to prepare for and administer elective procedures. (CP 274.) The Hospital's "Provider Order Policy, 954.25" is intended "[t]o clarify regulatory requirements and assure all provider orders are complete and valid for safe patient care." (*Id*. 292-299.) It states that "[a] provider order is required to admit a patient, place a patient in Observation, discharge a patient, transfer a patient to another physician or facility or unit, and for all tests, services, therapies and procedures."[1] (*Id*.) There are then specific policies to address each necessary step in the pre-operative and post-operative process.

First, a provider must obtain informed consent from a patient or their representative. The Hospital's policy titled "Consent for Treatment, 400.00" requires that providers obtain informed consent prior to any proposed medical treatment or therapy, procedure, surgery, or anesthesia. (CP 304-314.) The policy places the responsibility on the provider to explain the medical treatment and procedures to the patient, and for obtaining the patient's informed consent. (*Id*.) At the same time, the nurse also has an obligation to assure that the physician has obtained the necessary consents. (*Id*.) In her deposition, Bennett, the Manager of the Perioperative Services Unit, described the purpose of the policy as follows:

[1] In certain circumstances, a "standing order" may authorize specific services and treatments, but a standing order is limited in scope and application. (CP 292.)

Q: Is there a reason beyond policy?

A: It's not within the nurse's scope to obtain a consent.

Q: Is it a matter of health and safety for the patient? [objection]

A: I -- the way you're asking the question, I mean, it's -- ultimately, the goal is for the patient to understand what's happening to them, […]. If the patient says I don't understand this or this hasn't been explained to me, then you would go up the chain.

Q: And would you agree that it would be improper to administer surgical care to a patient who does not understand what he is -- what is about to occur?

A: Yes.

(CP 282; emphasis added.) According to Risk Manager Aileen Geerings, if a provider is unwilling or unable to obtain the patient's informed consent, the patient should not proceed to surgery. (CP 290.) This requirement of a hard-stop is necessary "to prevent serious safety harm to the patient." (*Id.*; emphasis added.)

Second, prior to surgery, a nurse must follow the Hospital policy titled "Preoperative Preparation Policy, 960.00." (CP 316-318.) This policy reiterates that a nurse must "[v]erify that pre-operative admitting physician and anesthesia orders have been transcribed and performed as ordered." (*Id.*) The nurse must also have a "Surgical Informed Consent obtained by [the] surgeon performing procedure and witnessed per policy." (*Id.*) The nurse must also have a Health and Physical form ("H&P") completed within 30 days of the scheduled procedures." (*Id.*) Finally, the policy lists the following "reportable concerns" that must be resolved before sending the patient to surgery: Informed consent has not been obtained; no

pre-operative orders from surgeon; and no H&P. (*Id*.) The Hospital's "Surgical Preadmission Assessment and Documentation Guidelines" reiterate that pre-admission nurses must receive timely H&Ps and pre-operative orders in order to process a patient for surgery. (*Id*. 320-325.)

Third, post-operative provider orders are also required. The "Provider Order Policy, 954.25" requires that "[a]ll orders are cancelled upon entry to the surgical suite" and "[n]ew orders must be written after surgery." (CP 292-299.) This means that a nurse may not administer care to a post-surgical patient unless and until the provider enters new orders. Department manager Hannah Bennett testified about the importance of receiving orders for post-surgical care:

> Q: Can you read the first bullet point [of a PowerPoint]?
>
> A: "No Preop orders is an ongoing issue but No Post-procedure orders is a larger safety issue."
>
> Q: How is it a safety issue?
>
> A: In my opinion, when the patients had their procedure and received any type of sedation during a procedure, they're at a higher risk of some sort of a postprocedural complication versus a preop patient who comes in without having had received medications or something invasive that could impact their status.
>
> Q: And so if there's not -- for lack of better words, are the stakes higher in a postprocedural setting if you do not have orders and cannot administer care to that patient? [Objection]
>
> A: If you're comparing the two populations of patients, then I would say yes.

(CP 283; *see also* 301.) The Hospital's Division Director for Accreditation and Licensing also confirmed the effect of the Provider Order Policy:

Q: Is a registered nurse authorized to place a patient in observation without a provider order?

A: No.

Q: Is a registered nurse authorized to discharge a patient without a provider order

A: No.

Q: Is a registered nurse authorized to administer tests to a patient without a provider order?

A: No. […]

Q: Is a registered nurse allowed to administer an IV, an intravenous drip to a patient without provider orders? [Objection.]

A: A nurse would need an order to start an IV.

(CP 274; emphasis added.)

This is not just a matter of Hospital policy. Washington law precludes nurses from providing care absent provider orders. "Registered nursing practice" includes "[t]he executing of medical regimen as prescribed by a licensed physician and surgeon[.]" RCW 18.79.040(e); emphasis added. Thus, registered nurses operate in an interdependent capacity when providing medical care, treatment and service to patients. *See* WAC 246-840-705. RCW 18.79.260 states that a registered nurse may only administer medications, treatments, tests, and inoculations at or under the general direction of a licensed physician or surgeon. *See also* WAC 246-840-700(3). Nursing care that exceeds the direction of a licensed physician or surgeon is subject to discipline under the Uniform Disciplinary Act. *See* RCW 18.79.120. In other words, violation of these laws places a nurse's license in jeopardy.

C. The Hospital's Pre-Admission Protocol Requires that Providers Deliver Records Two Days In Advance of a Procedure.

Providers are not only required to enter orders per Hospital policy (and state law), but they must also do so within a specific timeframe. The Hospital's Pre-Admission Protocol states that providers must submit the following documentation two days before a patient may be admitted: (1) pre-operative risk screen form and surgery confirmation; (2) surgeon orders (signed within 90 days); (3) surgery consent (signed within 90 days); and (4) office notes or "history and physical" (H&P) prepared within 180 days. (CP 327.) The Pre-Admission Protocol is a health and safety protocol. The Hospital's Risk Manager testified on this point at her deposition:

> Q: Does the hospital have an expectation how far in advance a provider will provide that type of documentation before a patient may be admitted to perioperative services? [Objection to form.]
>
> A: So an expectation, yes. They do have an expectation so that we have before taking the patient to surgery, and if that is -- if you don't have all the proper documentation, then the patient shouldn't proceed. You shouldn't proceed to -- for the surgery because you need to have all that. It's part of your universal protocol as well and your time-out, and those are -- those are safety measures that are put in to prevent serious safety harm to the patient. One of them is being that you have a consent signed. […]. So these are the safety measures that are in place. And typically, the nurse -- the nurses are really good in identifying those safety concerns.
>
> Q: So having the appropriate documentation before commencing a procedure is a health and safety issue?
>
> A: Yes, yes.

(CP 290.) The Hospital's Chief Nursing Officer, Johnson, reiterated that the Pre-Admission protocol is a patient health and safety policy:

Q: Is it important for you as a chief nursing officer to ensure that doctors are getting in their preadmit orders in a timely fashion?

A: Yes.

Q: Would you agree that it's a health and safety issue?

A: I think it could be, but I wouldn't agree blanket. I wouldn't say yes definitively.

Q: A failure to deliver timely orders could lead to giving improper care to a patient; correct?

A: I suppose that circumstance could exist.

(CP 335.)

D. From June 2015 - December 2017, the Hospital Routinely Violated the Provider Order Policy, the Consent Policy, and the Pre-Admission Protocol.

From June 2015 until December 2017, the Hospital tracked surgeons who failed to deliver mandatory documentation (including pre-surgical orders, risk screens, H&Ps, and consents) as of the day before surgery. (CP 337-474.) During this 31-month period, there were approximately **4,345** times that a surgeon was deemed non-compliant with the Pre-Admission Protocol, or an average of about 140 times per month. (*Id*.)

From January 2018 through July 31, 2018, the Hospital tracked an additional 1,000+ instances of non-compliance with the orders and consent policies, but the Hospital loosened the criteria to "final sign off by RN 3 days before surgery." (CP 476-510.) During this period, Bennett directed the nurses to also submit "IRIS" reports when non-compliance occurred. (*Id* 512.) In a seven-month period, the nurses reported an additional 59 times when the physicians failed to deliver orders, consents, risk screens, or

H&Ps. (*Id*.) Finally, a hard-copy spreadsheet tacked to the back of a door in the SADU tracked another 96 instances of non-compliance during the same period. (*Id*. 514-529.)

During this same period, the Hospital assigned Tammy Dobson, the Regional Project Manager for Perioperative Services, to address the seemingly obvious task of ensuring that surgeries did not occur in the absence of critical, albeit readily available, information. (CP 279.) Ms. Dobson "identif[ied] those providers (employed and community) that are currently not complying with [the Hospital's] CHI FH Standard Preadmit Process and associated documentation requirements." (*Id*. 938.) On June 7, 2017, Ms. Dobson sent a non-compliance report to Bennett identifying 35 surgeons who routinely ignored the patient record policies. (*Id*. 938-939.) With the tracking data and the list of non-compliant providers, there was nothing preventing the Hospital from addressing this problem, yet nothing changed.

E. Cahan Reported that the Hospital Was Failing its Patients and Nurses By Allowing the Chronic Non-Compliance with its Policies.

On December 12, 2017—after discussing the issues with her colleagues and getting no help from management on her unit—Cahan reported to the Hospital's Risk Manager and Clinical Nurse Specialist that nurses were being pressured and allowed to admit patients and administer care, treatment, and services before receiving orders, consents, or H&Ps. (CP 949-954; 08.19.2019 Cahan Declaration ¶ 11.) To the Risk Manager, Aileen Geerings, Cahan wrote:

> There are several patients that come to us for surgery that do not have orders from their doctors pre admission. […] We do try to call the doctors but many of our patients arrive at 0500 and reaching the doctor is not possible at that hour. (The doctor on call doesn't want to write orders for another doctor's non emergent surgical patients). This has been an ongoing issue and there have been too many incidents where we are being told to bring the patients back to begin their admissions BEFORE we get actual orders on an H and P or a consent.

(*Id*. 956.) Cahan forwarded the same message to the Clinical Nurse Specialist, Christopher Peredney. (*Id*. 949-954, 956.) In response, Ms. Geerings responded that "[y]ou should have orders to execute prior to the patient arriving to SADU. At the very least you should have an order for the procedure being performed." (*Id*.) Similarly, Mr. Peredney responded by referencing the Provider Order Policy and the Surgical Preadmission Assessment and Documentation Guidelines, which require that orders be delivered two days before surgery. (*Id*.)

Cahan provided Ms. Geerings' and Mr. Peredney's responses to Bennet and the interim department director, Amanda Brandon. (CP 599; 08.19.2019 Cahan Declaration ¶ 13.) On December 13, 2017, Bennett responded to Cahan as follows: "It would be helpful to have specific incidents to refer to hold providers accountable. It is difficult to make effective changes with blanket statements, unfortunately we need specifics." (*Id*. 949-954.) This was stunningly disingenuous. Bennett had more than 30 months of data at her fingertips, including a provider non-compliance report. Bennett deflected Cahan's concerns because it was her responsibility to address the problem, and she had failed.

On December 13, 2017, Cahan informed Bennett she would no longer admit patients for whom a doctor had not provided the required documentation. (CP 599; 08.19.2019 Cahan Declaration ¶ 15.) She wrote:

> Chris [Peredney] indicated that we should not take patients at all without orders so now I am genuinely confused. Do we take them and wait 15 minutes or do we not take them to preserve our licensure until we get orders? The procedure patients do not fall under anesthesia protocol so while we have them in our care without orders, that makes us liable. If that's the case, and I am referencing Chris Peredney here, I personally don't feel comfortable in taking these patients anymore."

(*Id*. 960; emphasis added.) The following day, on December 14, 2017, Bennett reported Cahan's decision to her interim director, Brandon, and the Chief Nursing Officer, Johnson:

> One SADU nurse Kasey has stated she will no longer accept patients from IR or Cath lab until orders are placed in Epic due to the consistent issue with delays in receiving orders, sometimes up to 90 minutes. I understand the nurses feel liable for the patients and cannot provide quality care without orders from the providers.

(CP 959.) In the same message, Bennett informed Johnson that "Cardiology and Radiology providers are also on the 'naughty list' for lack of pre-procedure orders as well as post-procedure orders." (*Id*.; emphasis added.)

On December 27, 2017, Cahan refused to admit a patient without report or orders because the doctor had yet to provide the required documentation. (CP 599; 08.19.2019 Cahan Declaration ¶ 16.) The day after Cahan refused to admit the patient without the necessary documentation, on December 28, 2017, the Hospital suspended Cahan for the first time in 23 years of employment. Cahan was fired less than six

months later following a string of faux-disciplinary charges by the same Hospital administrators who were responsible for pressuring nurses, including Cahan, to administer care without provider orders or patient consents.

V. ARGUMENT WHY REVIEW SHOULD BE ACCEPTED

The Court of Appeals erred by ruling that (1) a clear mandate of public policy does not exist prohibiting nurses from administering care to patients without provider orders; and (2) a clear mandate of public policy does not exist prohibiting nurses from administering care to patients without patient consents. The ruling has wide ranging implications for exposing nurses to liability for exceeding the scope of their licenses, and exposing patients to care that should only be administered according to provider orders and with informed consent. The Court of Appeals also erred by not reaching whether Cahan's protected activity was a substantial factor motivating the Hospital to terminate her employment; and whether the Hospital's justification for Cahan's termination was pretextual.

Cahan asserts a single claim for wrongful termination in violation of public policy. In *Thompson v. St. Regis Paper Co*., the Washington Supreme Court held that to prevail on the cause of action, a plaintiff employee must demonstrate that his or her "discharge may have been motivated by reasons that contravene a clear mandate of public policy." *Id*., 102 Wn. 2d 219, 232, 685 P.2d 1081 (1984). Then, "the burden shifts to the employer to prove that the dismissal was for reasons other than those alleged by the employee." *Id*. at 232-33, 685 P.2d 1081. The tort has

generally been limited to four scenarios: "(1) where employees are fired for refusing to commit an illegal act; (2) where employees are fired for performing a public duty or obligation, such as serving jury duty; (3) where employees are fired for exercising a legal right or privilege, such as filing workers' compensation claims; and (4) where employees are fired in retaliation for reporting employer misconduct, *i.e.*, whistle-blowing." *Gardner v. Loomis Armored, Inc.*, 128 Wn.2d 931, 936, 913 P.2d 377 (1996) (citing *Dicomes v. State*, 113 Wn.2d 612, 618, 782 P.2d 1002 (1989)).

Cahan's wrongful termination falls within the traditional four scenarios as her claim arises from her reporting of the Hospital's misconduct and her refusal to commit an unlawful act; namely, providing care and treatment to a patient for whom no consent and no orders had been written. Accordingly, this Court should apply the standard enunciated in *Thompson*. *See Becker v. Cmty. Health Sys., Inc.*, 184 Wn.2d 252, 258-59, 359 P.3d 746 (2015); *Rose v. Anderson Hay & Grain Co.*, 184 Wn.2d 268, 277-78, 287, 358 P.3d 1139 (2015). Under the applicable jury instructions, Cahan prevails by "proving that a substantial factor motivating the employer to terminate her employment was her refusing to commit an unlawful act, performing a public duty, exercising a legal right or privilege, or reporting what she reasonably believed to be employer misconduct." *See* WPI 330.50.

A. A Clear Mandate of Public Policy Prohibits Nurses From Providing Patient Care Without Provider Orders or Patient Consents.

The trial court correctly concluded Cahan asserted sufficiently specific and clear public policies to satisfy this element of her claim. The Court of Appeals erred by reversing this finding.

It is a question of law "whether ... a clear mandate of public policy exists" for purposes of claiming wrongful discharge in violation of public policy. *Sedlacek v. Hillis*, 145 Wn.2d 379, 388, 36 P.3d 1014 (2001). The plaintiff's burden is to "establish a clear statement of public policy, not that … that the public policy was [actually] violated." *Hubbard v. Spokane Cty.*, 146 Wn. 2d 699, 708, 50 P.3d 602 (2002), overruled by *Rose*, 184 Wn. 2d 268 on other grounds. To state her cause of action, Cahan must have been seeking to "further the public good, and not merely private or proprietary interests." *Farnam v. CRISTA Ministries*, 116 Wn. 2d 659, 671–72, 807 P.2d 830 (1991) (citing *Dicomes*, at 620). At the trial court, the evidence was indisputable that Cahan reported Hospital practices that negatively affect the public good by jeopardizing patient safety and care. Based on these facts and the following legal authority, the Court of Appeals should affirm that Cahan has satisfied the "public policy" element of her wrongful termination claim.

1. Permitting nurses to administer care to pre- and post-surgical patients without orders contravenes public policy.

"Registered nursing practice" includes "[t]he executing of medical regimen as prescribed by a licensed physician and surgeon[.]"

RCW 18.79.040(e); emphasis added. In this respect, registered nurses operate in an interdependent capacity when providing medical care, treatment and service to patients. *See* WAC 246-840-705 ("the registered nurse functions in an interdependent role when executing a medical regimen under the direction of" a physician or surgeon.) The nurse is an indispensable member of the care team, but she does not act independently when dictating the care, treatment, and services to be dispensed. RCW 18.79.260 states that a registered nurse may only administer medications, treatments, tests, and inoculations at or under the general direction of a licensed physician or surgeon. *See also* WAC 246-840-700(3). Nursing care that exceeds the direction of a licensed physician or surgeon is subject to discipline under the Uniform Disciplinary Act. *See* RCW 18.79.120.

The Hospital's "Provider Orders Policy" is premised on and is fully consistent with RCW 18.79.040(e) and 18.79.260. It states that "a provider order is required to admit a patient, place a patient in Observation, discharge a patient, transfer a patient to another physician or facility or unit, and for all tests, services therapies and procedures." This requirement is reiterated and confirmed in the "Preoperative Preparation Policy, 960.00" and the "Surgical Preadmission Assessment and Documentation Guidelines." Based on these authorities and the Hospital's several policies, the Hospital's practice of permitting nurses to administer care to pre-surgical and post-surgical patients without provider orders contravenes public policy.

2. Permitting nurses to administer care before the patient provides informed consent contravenes public policy.

Under the doctrine of informed consent, a health care provider has a fiduciary duty to disclose relevant facts about the patient's condition and the proposed course of treatment so that the patient may exercise the right to make an informed health care decision. *Stewart-Graves v. Vaughn*, 162 Wn. 2d 115, 122–23, 170 P.3d 1151 (2007) (citing *Miller v. Kennedy*, 11 Wn. App. 272, 282, 522 P.2d 852 (1974), aff'd, 123 85 Wn.2d 151, 530 P.2d 334 (1975). A health care provider may be liable to an injured patient for breaching this duty even if the treatment otherwise meets the standard of care.[2] *See* RCW 7.70.050; *Keogan v. Holy Family Hosp.*, 95 Wn. 2d 306, 313, 622 P.2d 1246 (1980). The doctrine of informed consent is based on "the individual's right to ultimately control what happens to his body." *Id*. at 313–14, 622 P.2d 1246. According to the Department of Health (DOH), the "failure to ensure the complete process of informed consent impedes the patient's ability to make informed consent decisions regarding his or her care and participate in the care planning process."

WAC 246-320-166 furthers the importance of obtaining the patient's informed consent by requiring all hospitals to "[c]reate medical records that…[h]ave signed consent documents." Based on this requirement, the Hospital maintains a "Consent for Treatment" policy that

[2] An action for total lack of consent sounds in battery, while a claim for lack of informed consent is a medical malpractice action sounding in negligence. *Bundrick v. Stewart*, 128 Wn. App. 11, 17, 114 P.3d 1204, 1208 (2005). "The performance of an operation without first obtaining any consent thereto may fall within the concepts of assault and battery as an intentional tort, but the failure to tell the patient about the perils he faces is the breach of a duty and is appropriately considered under negligence concepts." *Miller*, 11 Wn. App. at 281–82.

states: "It is the policy of CHI Franciscan Health (CHI FH) to take reasonable steps to assure that the physician, other authorized provider, or allied health provider has obtained informed consent and any necessary consents have been obtained and documented prior to any proposed medical treatment or therapy, procedure, surgery, or anesthesia." Based on these authorities, the Hospital's practice of permitting nurses to admit and administer care to patients without first obtaining informed consents contravenes public policy.

VI. CONCLUSION

A clear mandate of public policy prohibits nurses from administering care without provider orders or patient consent. Hospital practices that require nurses to provide care without provider orders or patient care contravenes public policy. The trial court was correct in finding that Cahan established a clear mandate of public policy, and the Court of Appeals erred by reversing this finding. For these reasons, this Court should reverse Division One's decision and remand this case for review on the disputed issues of causation and pretext.

RESPECTFULLY SUBMITTED this 1st day of July, 2021.

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CERTIFICATE OF SERVICE

I hereby certify under penalty of perjury under the laws of the State of Washington that on July 1, 2021, I caused to be served a copy of the foregoing on the following person(s) in the manner indicated below at the following address(es):

Jessica M. Andrade, WSBA No. 39297 Adam B. Merrill (*pro hac vice*) Karen K. Cain (*pro hac vice*) Donald L. Samuels (*pro hac vice*) Polsinelli PC 1000 2nd Ave, Suite 3500 Seattle, WA 98104 Phone: (206) 393-5400 Jessica.andrade@polsinelli.com ABMerrill@polsinelli.com KCain@polsinelli.com DSamuels@polsinelli.com	☑ by E-Service ☐ by Electronic Mail ☐ by First Class Mail ☐ by Hand Delivery ☐ by Overnight Delivery

DATED this 1st day of July, 2021.

Danna Hutchings
Legal Assistant

APPENDIX

A. Unpublished Opinion, *Cahan v. Franciscan Health System, et al.*, Court of Appeals, Division 1, No. 80731-5-I, dated June 1, 2021

FILED
6/1/2021
Court of Appeals
Division I
State of Washington

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Respondent/Cross-Appellant.

No. 80731-5-I

DIVISION ONE

UNPUBLISHED OPINION

COBURN, J. — After she was terminated by St. Francis Hospital, registered nurse (RN) Kasey Cahan sued Franciscan Health System for wrongful termination in violation of public policy.[1] The trial court summarily dismissed Cahan's claim. It concluded that Cahan's termination implicated public policy but Cahan failed to raise a genuine issue of material fact as to the causation element of her claim, i.e., whether the hospital's reasons for terminating Cahan were pretextual or her allegedly public-policy-linked conduct was nonetheless a substantial motivating factor in her termination.

[1] In its answer to Cahan's complaint, Franciscan admitted Cahan's allegation that Franciscan "is a health care organization and a Washington public benefit corporation . . . , doing business as St. Francis Hospital." On appeal, Franciscan avers that it "is not doing business as St. Francis Hospital," and instead, the hospital "is a separate entity operating under the corporate umbrella of Franciscan Health System dba CHI Franciscan Health." Franciscan does not argue that the nature of its relationship to the Hospital is relevant to any issues on appeal and, thus, we need not resolve it.

We hold that Cahan fails as a matter of law to establish that her termination may have been motivated by reasons that contravene a clear mandate of public policy. Accordingly, we affirm on that basis and need not reach the issue of causation.

BACKGROUND

Facts

Before her termination in July 2018, Cahan had been employed by the hospital for 23 years—the last 15 as an RN in the perioperative services unit. According to Cahan's later declaration, perioperative services "is comprised of multiple units that manage the different phases of patient care for elective surgeries." "These include the Pre-Admission Clinic where Pre-Admission Testing ('PAT') occurs, the Same-day Admit and Discharge Unit ('SADU'), and the Post-Anesthesia Care Unit ('PACU')." "The nurses in these units interact with the patients in both the pre-surgical and post-surgical phases of their care." From mid-2014 until her termination, Cahan's supervisor in the perioperative services unit was Hannah Bennett. Bennett's supervisor throughout 2017 until the end of May 2018 was Amanda Brandon, who was later replaced by Lorie Khorsand.

It is undisputed that at all times relevant herein, hospital policy required doctors to transmit certain documentation to the perioperative services unit before their patients arrived there. It also is undisputed that some doctors were not timely transmitting that documentation, which included doctors' orders, consent forms, and history and physical (H&P) documentation. And, it is

undisputed that the job of tracking down missing documentation, including calling doctors, fell on nurses, and that nurses in the perioperative services unit, including Cahan, experienced frustration when patients would arrive without their documentation being available yet in the hospital's database. In her later deposition, Bennett described the situation as follows:

> I would say we had been struggling with some inefficiencies and staff frustration around having the required documentation to feel efficient at their work, and it had been an ongoing issue actually for a number of years that staff had raised concerns about the issue of inefficiency and having to stop during admission and call the doctor and kind of work stoppage-type issues.

On December 12, 2017, Cahan emailed Aileen Geerings, the hospital's Risk Manager, regarding patients arriving without doctors' orders:

> The question has come up multiple times regarding the nurse's liability for a surgical admission that comes to the SADU without orders. There are several patients that come to us for surgery that do not have orders from their doctors pre admission. Can we bring the patient back to a room if they do not have orders? Can we do vitals and have them disrobe and use surgical wipes? Is there an added level of liability if we DO check vitals, for example a blood pressure, and it is high? Who do we call at that point if we do not have orders to treat the patient? We have been calling anesthesia if we can't get a hold of the surgeon but are they the right choice? Procedure patients that are only receiving sedation do not have an anesthesiologist. Also, the CHG[2] wipes are considered a standard doctor's order. Can the patient use them without official orders? Many patients have sensitive skin and have reacted to the wipes. If the patient uses them as standard protocol and has a reaction to the CHG wipes is the admit nurse liable for the reaction if there were no written doctor's order? Can we do an IV[3] under the Anesthesia standard orders? What about the procedure patients? Again, they do not have anesthesia but often come without orders pre procedure.

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[2] "CHG" is not defined in the record but presumably stands for "Chlorhexidine Gluconate."

[3] Intravenous drip.

> We DO try to call the doctors but many of our patients arrive at 0500 and reaching the doctor is not possible at that hour. (The doctor on call doesn't want to write orders for another doctor's non emergent surgical patients).
>
> This has been an ongoing issue and there have been too many incidents where we are being told to bring the patients back to begin their admissions BEFORE we get actual orders or an H and P or a consent.
>
> If you could provide some clarity to this issue it would be greatly appreciate[d]. There is confusion as to what we, the nurses, are allowed to do with our licensure without over stepping our bounds and would really appreciate your input.

That same day, Cahan sent the same email to Christopher Peredney, the hospital's clinical nurse specialist. Peredney responded less than an hour later:

> Thanks for the email bringing up the issues. There are a lot of questions to address so it may take me until the end of the week. I have meetings today from 1300 to 1600, so I will not be able to start working on it until tomorrow, but I will work on it and get you some answers. Here are a few excerpts from relevant policies. And once you see the policy language you will see that the practice you describe is not in line with policy.
> I am also attaching the document for community providers and the case request process for FMG[4] docs. Both require orders to schedule a case, thus should really be there prior to the patient coming in.
> More to come.

Appended to Peredney's response were excerpts from relevant hospital policies, including an excerpt that Peredney indicated meant "per policy they are supposed to have orders in 2 days before surgery."

Peredney followed up with another email the next morning writing:

> I spoke with [Bennett] and she gave me some perspective and let me know that she is aware of the issue of "Missing Orders" and is looking into it.

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[4] "FMG" is not defined in the record but presumably stands for "Franciscan Medical Group."

> As far as truly invasive interventions such as IV starts and port access I think we are all on the same page that we need to ensure that there is an order before proceeding. The anesthesia preop order set is actually embedded in the preop surgical orders. So if there are not surgical orders there are probably not anesthesia preop orders. If it is a surgical patient then there probably is a[n] anesthesia provider who could give at least a verbal order to start IV, pending the full order set. But my understanding is that this is not occurring with surgical patients but more with procedural areas.
>
> For vitals, getting the patient changed, and even CHG wipes we are working off a protocol that would cover the nurse from "liability". It seems like a lot of the "orders not present" may be occurring with DI/IR[5] patients and I do not believe the CHG is used for them.
>
> To address the CHG in more detail. I had initially thought that an order would be required. But after speaking with inpatient leadership a[s] well as regulator compliance and risk, we determined that operating by an established protocol/policy would be sufficient to cover the nurses from any "liability" of use. Of course we want to ask the patient if they have any known sensitivities to CHG we would not want to use it. And if they have very sensitive skin a test application may be warranted. But I would think that the number of surgical patients that do not have an order is small because having orders is part of the case scheduling process in the policies I sent yesterday.
>
> [Bennett] let me know she is working on this issue and would appreciate notification anytime this occurs so that she can address it in real time.
>
> Let me know if this answers your questions and please don't hesitate to let me know what I can do to help.

Geerings also responded to Cahan on December 13, 2017:

> Thank you for your questions below. You should have orders to execute prior to the patient arriving to SADU. At the very least you should have an order for the procedure being performed. I strongly recommend bringing these concerns to your unit manager or if you would like you can also complete an IRIS[6] anonymously and it would go directly to [Bennett] for review. Behavioral issues with

[5] "DI/IR" is not defined in the record but presumably stands for "Diagnostic Imaging/Interventional Radiology."

[6] "IRIS" refers to an internal system used to record policy concerns.

> medical staff providers such as providers not writing orders would go to me for additional review. Behavioral issues are forwarded to the medical director and vice president of medical affairs for review. We also look to see if there is a particular provider who consistently does not follow the standard. We look for trends and address them appropriately.
>
> Is there a way to ensure that patient[s] have orders prior to coming to surgery for admission[?] What is your current practice? Do you have staff responsible for checking the documents necessary to proceed prior to the day of surgery? My recommendation is to ensure that you have orders prior to proceeding to reduce your risk for liability. Another important info that I wanted to relay is that after the admission assessment, it's the nurse responsibility to communicate . . . any abnormal findings to the surgeon. If you are not able to get a hold of the provider, please escalate the concern to your charge nurse. We do have a chain of command (communication) policy which you can follow to help resolve patient safety issues.
>
> Let me know if you have any further questions. I will be happy to assist.

On December 13, 2017, Cahan forwarded Peredney's initial response to Bennett and Brandon. Bennett responded as follows the same day:

> Thank you for bringing your concerns forward. I know we've had discussion about these concerns recently and I'm sorry if some of your questions weren't resolved.
>
> It sounds like there are a few separate concerns you are referring to:
>
> - Pre-surgical patients without orders on DOS.[7]
> - Pre-procedural patients without orders on DOS.
> - Post-procedural patients being transferred to SADU without orders.
>
> Did I capture that correctly?
>
> Regarding pre-surgical patients not having orders on the day of surgery: would it be possible to track these for me? We are tracking compliance up to the day before surgery, but our current process is to include a call to me if documentation isn't obtained by 1300 day

[7] "DOS" is not defined in the record but presumably stands for "day of surgery."

> before surgery. We can use anesthesia protocol for some basic orders and if the patient is having anesthesia, they are the right provider to call regarding abnormal vital signs. CHG wipes fall under the policy and don't require an order. They are non-invasive and can be purchased over the counter.
>
> For pre-procedural patients, I need to know which providers do not have pre-procedural orders in. I have spoken with Jim Shreve within the past month regarding this concern and he is happy to follow up with specific providers.
>
> For post-procedural patients, I agree the orders should be in when the patient comes to us. I will continue to work with Peggy Coltrin and Jim Shreve on this concern. I had asked staff to please IRIS patients who don't have orders in within 15 minutes of transfer to SADU or PACU. I haven't seen any IRIS's regarding this yet. I know IRIS takes extra time, but it is helpful to track issues, especially related to providers. I would be happy to receive an email as well.
>
> An example email or IRIS would say:
> "I received a liver BX patient of Dr. Chen's today from IR at 1230. There were no post-procedure orders in Epic. I called him to ask that orders be placed. The orders were not in Epic until 1300. This delayed my ability to provide care for the patient."
>
> I understand the frustration and anxiety this causes and I want to resolve it. It would be helpful to have specific incidents to refer to hold providers accountable. It is difficult to make effective changes with blanket statements, unfortunately we need specifics. If you can help me with that part, I would be grateful.

In a subsequent response to Bennett, Cahan wrote that "[Peredney] indicated that we should not take patients at all without orders so now I am genuinely confused." She also wrote, "I personally don't feel comfortable in taking these patients any more."

On December 27, 2017, Cahan refused to admit a patient from the Interventional Radiology (IR) lab without orders. That same day, Brandon emailed Peggy Coltrin, the clinical manager of the laboratory that sent the patient, writing:

> Mike in the cath lab just sent us a patient without MD orders and without report. . . .
>
> When Mike called to tell SADU the patient was coming, Kasey Cahan, SADU RN told Mike that the patient must have post op orders to come to SADU. Mike then called for a transporter to deliver the patient to SADU without report and without orders. This patient has multiple illnesses. This is a patient safety issue. When [Cahan] called Mike, he told her that "it was not my patient."
>
> Peggy, the OR[8] no longer sends patients to PACU without orders. We have managed to get this under control. We are reaching the critical point very quickly that we will no longer accept patients when they have no MD orders. Please make sure the doctors know that this is not going to continue to occur. We are also feeling a fair amount of flippancy from the Cath Lab RN's when this is occurring which also needs to stop.

About six months later, the hospital terminated Cahan. According to a discharge letter dated July 11, 2018, the hospital terminated Cahan for refusing to meet to discuss a performance improvement plan (PIP) that was issued to assist Cahan in correcting identified performance issues.

Procedure

In September 2018, Cahan sued Franciscan for wrongful termination in violation of public policy. She alleged that the hospital had retaliated against her for reporting noncompliance with the hospital's policies regarding pre-operative orders and for refusing the IR patient who had arrived without orders.

In August 2019, Franciscan moved for summary judgment, and Cahan moved for partial summary judgment. In her motion, Cahan argued that the court should determine as a matter of law that "Cahan has satisfied the public policy element of her wrongful termination claim," thus leaving only "matters of

[8] Operating Room.

causation and damages" for trial. In its motion, Franciscan argued that as a matter of law, Cahan's termination did not implicate a "clear mandate of public policy," and even if it did, Cahan could not "prove that her alleged public-policy-linked conduct was a 'significant factor' in her discharge." Instead, Franciscan asserted Cahan was fired for her refusal to meet with managers about a PIP after being warned about her " 'bullying and confrontational' " behavior.

In support of its motion, Franciscan submitted an affidavit from Bennett in which she attested, that between April and November 2017, she spoke with Cahan to discuss at least six instances in which Bennett concluded Cahan had engaged in inappropriate behavior toward Bennett or another employee. Bennett supported her affidavit with records memorializing her discussions. An April 24, 2017 counseling record described an incident where Cahan told a colleague, " 'You are just like a rat, trying to jump off the ship.' " According to the counseling record, the colleague perceived the comment as rude and offensive, and Cahan was counseled to refrain from making rude statements to colleagues. An April 26, 2017 a counseling record described an incident where Cahan was telling other staff members that a former colleague had been fired when in fact she had been laid off. In a June 20, 2017 "Written Warning," Bennett wrote to Cahan, "[T]here have been a number of incidents where your behavior did not meet behavioral standards . . . You were counseled about these incidents at the time; however, you appear to have established a pattern of continuing unacceptable behavior." The written warning described a September 2015 staff meeting in which Cahan had become "defensive, argumentative . . . and personal with

others in the room" and a June 2017 staff meeting in which Cahan disregarded Bennett's directive to stop after Cahan "brought up a personal issue about a co-worker who was not present, related to an HR issue." The written warning also stated, "Please be advised that continued unacceptable behavior issues, especially issues similar to those described above, will result in additional corrective action which may include your discharge from employment."

An October 25, 2017 counseling record described an incident in which Cahan had given "forceful feedback" to Bennett that a staffing issue had not been managed well. According to the counseling record, Cahan's comments were not founded, and Bennett later coached Cahan that it was unprofessional to have given the feedback to Bennett in front of the SADU team. Bennett wrote that Cahan's response was, " 'I don't operate in shadow, and I say what I think,' " and that Cahan indicated that she "didn't really care to hear [Bennett's] feedback." A November 20, 2017 counseling record described an incident where Cahan left a patient in SADU without giving a proper handoff to the evening shift staff. And another counseling record, also dated November 20, 2017, stated that during a recent staff meeting, Cahan "made undermining comments regarding not receiving education" prior to starting a new program. According to the counseling record, Bennett explained to Cahan during the meeting that she had been working to set up the relevant education but that it had not been arranged yet due to scheduling conflicts. Bennett indicated that Cahan continued to push the issue in the meeting in a confrontational tone, which Bennett described as disrespectful, abrasive, and confrontational.

According to Bennett's affidavit, on December 28, 2017 (i.e., the day after Cahan had refused to admit the patient who had arrived from the IR lab without orders) Bennett learned of an interaction between Cahan and a colleague, Marva Johnson, that left Johnson visibly upset. In an excerpt from Bennett's later deposition that was also submitted in support of Franciscan's summary judgment motion, Bennett recalled that she had been instructed by HR to investigate and to put Cahan on leave pending the investigation. Bennett testified she met with employees who had witnessed the exchange between Cahan and Johnson, and "as they were explaining what happened, [Bennett] was typing up what they said." Bennett testified she then had them review the statement to confirm it was accurate and then sign it. One employee witness's statement described Cahan's tone as "elevated and aggressive"; another described her demeanor as "rude and aggressive toward [Johnson]"; and a third described Cahan's tone as "elevated and rude." Two witness statements indicated that the interaction occurred in the presence of patients and visitors who were in the lobby at the time.

Franciscan presented evidence that after investigating, Bennett concluded that Cahan's behavior was inappropriate and issued Cahan a "Final Warning in Lieu of Suspension." In it she wrote to Cahan that the purpose of the final warning was "to convey to you the urgent need for you to correct the behavior issues referenced above" and that "further behavior issues may result in further corrective action, which would result in your discharge from employment."

Franciscan also presented evidence of two additional incidents involving

Cahan that occurred after Bennett issued the final warning in January 2018. The first occurred in May 2018. Bennett testified, that on May 18, 2018, it was brought to her attention by the charge nurse that "there had been some switching of assignment[s] happening, which then led to a delay in lunch relief starting." According to a counseling record that Bennett prepared following the incident, Cahan had switched assignments with another nurse without notifying or getting permission from the nurse in charge. Bennett testified that when she tried to ask Cahan about it, Cahan "immediately got defensive," would not allow Bennett to finish speaking, and walked away from Bennett when Bennett tried to explain why she was asking questions.

The second incident occurred on June 7, 2018. According to Bennett, she had received a call that morning that the Department of Health was in the hospital and that staff should be " 'on [their] toes.' " Bennett testified that when she explained to Cahan and another nurse some of the things they should do to prepare, Cahan "didn't respond at all." According to a report Bennett prepared that day, Cahan "never looked up to acknowledge what [Bennett] said, and continued working on the computer and looking at her phone[and] . . . blatantly ignored what [Bennett] was saying."

Bennett declared that after the June 7, 2018 incident, she believed the next disciplinary step would be termination given that she had issued a final warning to Cahan in January 2018. Bennett emailed regional human resources (HR) director Mason Hudson indicating that she "would like to investigate and move to termination." Bennett declared that Hudson instructed her to set up a

meeting with HR and Cahan, and that on June 8, 2018, she and Cahan met with HR manager Les Soltis. Bennett declared that she learned later that HR had decided to issue a suspension and PIP to Cahan rather than terminate her.

According to an excerpt from Cahan's deposition, which Franciscan also submitted in support of its motion, on June 19, 2018, Cahan met with Hudson, Bennett, and Khorsand. At the meeting, Cahan was issued a written suspension, which confirmed that Cahan would "be issued a [PIP] designed to assist you in meeting our expectations." Cahan testified that at the June 19 meeting, Hudson told her that she would have to meet with Bennett regarding the PIP, Cahan told Hudson she would not meet without a witness, and Hudson told her that she could not have a witness. According to Bennett's deposition, several days later, after the PIP had been approved by HR, she and Stephanie Tomlin, another manager, attempted to meet with Cahan to discuss the PIP. Bennett testified that Cahan again indicated that she would not meet without a witness, and that after conferring with HR, Bennett told Cahan, " 'I just want to make sure you understand failure to meet will—could result in your discharge from employment.' " Bennett testified that Cahan responded, " 'I know that. [Soltis] already told me that,' " and then took her badge off and handed it to Bennett. Cahan testified that was her last day at the hospital, and she later received a letter from the hospital, dated July 11, 2018, indicating that it was "processing [her] discharge from employment effective immediately."

The trial court granted summary judgment in favor of Franciscan. In so doing, the court concluded that there existed clear public policies mandating that

"RNs must have provider orders and informed consent before they begin admin[i]stering care to patients as part of a surgery or procedure to be compliant with their licenses and fiduciary obligations." It also concluded that Cahan had raised a genuine issue of material fact as to whether her December 2017 conduct constituted whistleblowing with regard to these stated policies.

However, the trial court concluded further that Franciscan articulated "a legitimate nonpretextual nonretaliatory reason" for Cahan's termination, and Cahan "failed to meet her burden to present evidence that the firing was pretextual, or that her conduct in December 2017 was a substantial motivating factor in her termination." Accordingly, the court summarily dismissed Cahan's wrongful termination claim. Cahan moved for reconsideration, which the trial court denied. Cahan appeals. Franciscan cross-appeals arguing that the trial court "erred when it concluded that Cahan identified clear mandates of public policy applicable to her claims."

DISCUSSION

Standard of Review

"[S]ummary judgment is appropriate where there is 'no genuine issue as to any material fact and . . . the moving party is entitled to a judgment as a matter of law.' " Elcon Constr., Inc. v. E. Wash. Univ., 174 Wn.2d 157, 164, 273 P.3d 965 (2012) (second alteration in original) (quoting CR 56(c)). We review summary judgment orders de novo, viewing all evidence and reasonable inferences in the light most favorable to the nonmoving party. Keck v. Collins, 184 Wn.2d 358, 370, 357 P.3d 1080 (2015). And, we may affirm on any basis supported by the

record.[9] Bavand v. OneWest Bank, 196 Wn. App. 813, 825, 385 P.3d 233 (2016). We review questions of law, including whether Washington has established a clear mandate of public policy, de novo. Danny v. Laidlaw Transit Servs., Inc., 165 Wn.2d 200, 207, 193 P.3d 128 (2008) (plurality opinion).

Termination in Violation of Public Policy

Absent a contract to the contrary, employees are generally terminable "at will," i.e. for any reason. Id. In Thompson v. St. Regis Paper Co., our Supreme Court adopted an exception to this general rule by recognizing "a cause of action in tort for wrongful discharge if the discharge of the employee contravenes a clear mandate of public policy." 102 Wn.2d 219, 232, 685 P.2d 1081 (1984).

We construe the public policy exception narrowly to guard against frivolous lawsuits. Gardner v. Loomis Armored Inc., 128 Wn.2d 931, 936, 913 P.2d 377 (1996). Accordingly, claims of termination in violation of public policy have generally been limited to four scenarios:

> "(1) where employees are fired for refusing to commit an illegal act; (2) where employees are fired for performing a public duty or obligation, such as serving jury duty; (3) where employees are fired for exercising a legal right or privilege, such as filing workers' compensation claims; and (4) where employees are fired in retaliation for reporting employer misconduct, i.e., whistleblowing."

Becker v. Cmty. Health Sys., Inc., 184 Wn.2d 252, 258-59, 359 P.3d 746 (2015) (quoting Gardner, 128 Wn.2d at 936).[10] Here, both parties treat Cahan's

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[9] For this reason, a cross-appeal was not necessary for Franciscan to raise its argument that Cahan's termination did not implicate public policy because this argument merely presents an alternative basis for affirming the trial court's summary dismissal of Cahan's claim.

[10] When the plaintiff's case "does not fit neatly within one of these scenarios," courts apply the four-factor "Perritt analysis" for guidance. Becker,

December 2017 conduct as whistleblowing for purposes of this appeal.[11]

A plaintiff alleging termination in violation of public policy bears the initial burden to show that his or her discharge " 'may have been motivated by reasons that contravene a clear mandate of public policy.' " Martin v. Gonzaga Univ., 191 Wn.2d 712, 725, 425 P.3d 837 (2018). The plaintiff must also produce evidence "that the public-policy-linked conduct was a cause of the firing, and may do so by circumstantial evidence." Id. "If the plaintiff succeeds in presenting a prima facie case, the burden then shifts to the employer to 'articulate a legitimate nonpretextual nonretaliatory reason for the discharge.' " Id. at 725-26 (quoting Wilmot v. Kaiser Aluminum & Chem. Corp., 118 Wn.2d 46, 70, 821 P.2d 18 (1991)). "If the employer articulates such a reason, the burden shifts back to the plaintiff either to show 'that the reason is pretextual, or by showing that although the employer's stated reason is legitimate, the [public-policy-linked conduct] was

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184 Wn.2d at 259. To satisfy his or her burden under the Perritt analysis, the plaintiff must prove (1) "the existence of a clear public policy (the *clarity* element)"; (2) "that discouraging the conduct in which they engaged would jeopardize the public policy (the *jeopardy* element)"; (3) "that the public-policy-linked conduct caused the dismissal (the *causation* element)"; and (4) that the employer cannot "offer an overriding justification for the dismissal (the *absence of justification* element)." Gardner, 128 Wn.2d at 941.

[11] Therefore, the Perritt analysis does not apply. See Martin v. Gonzaga Univ., 191 Wn.2d 712, 724, 524 P.3d 837 (2018) (holding that the Court of Appeals erred by applying the Perritt test to a whistleblowing claim). Cahan asserts that her refusal to admit the IR patient also falls within the first scenario, i.e., refusal to commit an illegal act. But Cahan does not point to any evidence that admitting or caring for that patient would have constituted an illegal act. In any case, as discussed below, Cahan does not establish that her conduct, however characterized, implicated public policy. Accordingly, whether Cahan's conduct also constituted refusal to commit an illegal act does not affect the outcome of this appeal, and thus, we need not make a determination in that regard.

nevertheless a substantial factor motivating the employer to discharge the worker.' " Id. at 726 (quoting Wilmot, 118 Wn.2d at 73).

Here, and as further discussed below, Cahan fails to meet her initial burden to establish that her termination may have been motivated by reasons that contravene a clear mandate of public policy and, thus, the trial court did not err by summarily dismissing her claim.

To determine whether a clear public policy exists, the court asks "whether the policy is demonstrated in 'a constitutional, statutory, or regulatory provision or scheme.' " Danny, 165 Wn.2d at 207-08 (internal quotation marks omitted) (quoting Thompson, 102 Wn.2d at 232). "Although judicial decisions may establish public policy, 'courts should proceed cautiously if called upon to declare public policy absent some prior legislative or judicial expression on the subject.' " Id. at 208 (internal quotation marks omitted) (quoting Thompson, 102 Wn.2d at 232).

"To qualify as a public policy for purposes of the wrongful discharge tort, a policy must be 'truly public' and sufficiently clear." Id. (quoting Sedlacek v. Hillis, 145 Wn.2d 379, 389, 36 P.3d 1014 (2001)); see also Dicomes, 113 Wn.2d at 618 (" '[P]ublic policy concerns what is right and just and what affects the citizens of the State collectively.' " (quoting Palmateer v. Int'l Harvester Co., 85 Ill. 2d 124, 130, 421 N.E.2d 876 (1981))). This is because "the tort of wrongful discharge is not designed to protect an employee's purely *private interest* in his or her continued employment; rather, the tort operates to vindicate the *public interest* in prohibiting employers from acting in a manner contrary to fundamental public

policy." Smith v. Bates Tech. Coll., 139 Wn.2d 793, 801, 991 P.2d 1135 (2000).

Cahan does not clearly articulate in her briefs on appeal what she believes the relevant public policy mandates are. But she asserts that "the Hospital's practice of permitting nurses to administer care to pre-surgical and post-surgical patients without provider orders contravenes public policy." She also asserts that "the Hospital's practice of permitting nurses to admit and administer care to patients without first obtaining informed consents contravenes public policy." Accordingly, we interpret her argument to be that her termination contravened clear public policies (1) prohibiting nurses from administering care to pre-surgical and post-surgical patients without provider orders, and (2) prohibiting nurses from admitting and administering care to patients without first obtaining informed consents.[12] For the following reasons, we disagree.

In support of the first stated policy, Cahan points to RCW 18.79.040(1)(e), which defines "registered nursing practice" to *include* "[t]he executing of medical regimen as prescribed by a licensed physician and surgeon." (Emphasis added.) She also points to WAC 246-840-705(3), which states that RNs function in "an interdependent role *when* executing a medical regimen under the direction of a . . . licensed physician and/or surgeon." (Emphasis added.) And she points to

[12] This interpretation is consistent with her counsel's formulation at oral argument, i.e., that the relevant public policies prohibit "administering care by nurses to patients without receiving or before receiving . . . orders from the physicians and without obtaining the informed consent of the patients." Wash. Court of Appeals oral argument, *Cahan v. Franciscan Health System*, No. 80731-5-I (Feb. 26, 2021), at 7 min., 0 sec. through 7 min., 15 sec., *video recording by* TVW, Washington State's Public Affairs Network, https://www.tvw.org/watch/?eventID=2021021333.

RCW 18.79.260(2), which states that an RN "may, at or under the general direction of a licensed physician and surgeon . . . , administer medications, treatments, tests, and inoculations." Finally, she points out that under RCW 18.79.120, unlicensed care is subject to discipline under the Uniform Disciplinary Act, chapter 18.130 RCW.

But none of these statutes or regulations express a clear mandate prohibiting nurses from administering care in the absence of provider orders. They do suggest that provider orders are required for nurses to administer certain types of care, including when functioning interdependently to execute a "medical regimen" under the direction of a physician or surgeon, or when administering medications, treatments, tests, and inoculations. But they also contemplate that nurses will provide other types of care independently by employing their "specialized knowledge, judgment, and skill." RCW 18.79.040(1); see also WAC 246-840-705(3) ("The [RN] functions in an *independent* role when utilizing the nursing process . . . to meet the complex needs of the client." (emphasis added)); RCW 18.79.040(1)(a) (including, in the definition of "registered nursing practice," "observation, assessment, diagnosis, care or counsel, and health teaching"). Cahan points out that the hospital's policy states, " 'a provider order is required to admit a patient, place a patient in Observation, discharge a patient, transfer a patient to another physician or facility or unit, and for all tests, services, therapies, and procedures.' " But she cites no authority for the proposition that an internal hospital policy can establish a clear mandate of *public* policy. For the foregoing reasons, we decline Cahan's

invitation to declare a public policy prohibiting nurses from administering care to patients without provider orders.[13] Cf. Sedlacek, 145 Wn.2d at 389 (to balance interests of employer and employee and ensure judicial restraint, "we cannot conclude that a clear mandate of public policy exists merely because the plaintiff can point to a potential source of public policy that addresses the relevant issue").

Turning to Cahan's second assertion of public policy, i.e., a policy prohibiting nurses from administering care to patients without first obtaining informed consents, Cahan relies primarily on the informed consent doctrine. See Stewart-Graves v. Vaughn, 162 Wn.2d 115, 122, 170 P.3d 1151 (2007) (providing that under the informed consent doctrine, "a health care provider has a fiduciary duty to disclose relevant facts about the patient's condition and the proposed course of treatment so that the patient may exercise the right to make an informed health care decision"). But the only reasonable conclusion from Cahan's December 12, 2017 email, and her later refusal to admit a patient, is that she was protesting the fact that consent documents were not being timely *transmitted* by providers before admission in accordance with hospital policy. She points to no evidence that she was concerned about informed consents not

[13] Rather, the apparent purpose of the nurse licensing statutes and regulations on which Cahan relies is to protect patients from incompetent care. See RCW 18.79.010 ("It is the purpose of the nursing care quality assurance commission to regulate the competency and quality of professional health care providers under its jurisdiction."); cf. In re Flynn, 52 Wn.2d 589, 594, 328 P.2d 150 (1958) (observing that the purpose of licensing dentists is to protect the public from incompetent and untrustworthy dentists). And Cahan points to no evidence that she raised a concern that patients were receiving incompetent care.

being *obtained* for the relevant procedures. Indeed, even Cahan testified that sending patients back to the operating room without documentation was "kind of a hard stop that they had to have orders prior to the actual hands-on, touching surgery." In short, assuming without deciding that the doctrine of informed consent rises to the level of a clear public policy,[14] Cahan fails to point to facts from which a reasonable factfinder could conclude that her termination—even if linked to her December 2017 conduct—contravened any such policy.

Furthermore, as Cahan herself acknowledges in the retaliation context, the employee "must have been seeking to 'further the public good' " in engaging in her allegedly public-policy-linked conduct. Farnam v. CRISTA Ministries, 116 Wn.2d 659, 671, 807 P.2d 830 (1991) (quoting Dicomes, 113 Wn.2d at 620). Yet Cahan points to no evidence that she was seeking to further the public good when she reached out to Geerings and Peredney in December 2017 and later when she refused to admit the IR patient. Rather, the only reasonable conclusion from the record is that Cahan's December 2017 conduct was motivated by private or proprietary interests, namely, her frustration with doctors' failure to comply with *internal* policies regarding timely transmittal of documentation—and management's decision not to do more to correct this noncompliance. This frustration was understandable, as it is undisputed that it

[14] We observe that although there exists a cause of action for failure to secure informed consent, the failure to obtain informed consent is not alone sufficient to establish that cause of action: The plaintiff must also establish that "a reasonably prudent patient under similar circumstances would not have consented to the treatment if informed of [the] material fact or facts"; and that "the treatment in question proximately caused injury to the patient." RCW 7.70.050(1)(c), (d).

fell on Cahan and her colleagues to follow up with doctors for the required documentation. Nonetheless, the frustration arose out of an internal workflow matter.

Cahan disagrees and asserts that the hospital's practice of not enforcing its internal policy negatively affected the public good "by jeopardizing patient safety and care." But she fails to support this assertion with reference to relevant parts of the record. See RAP 10.3(a)(6) (requiring argument to include "references to relevant parts of the record"); cf. In re Estate of Lint, 135 Wn.2d 518, 532, 957 P.2d 755 (1998) (court will not assume obligation to "comb the record" for evidence to support counsel's arguments). Furthermore, even assuming the hospital's practice of not enforcing its internal policies affected patient safety, the fact that a practice *affected* the public good is not the same as establishing that Cahan was *seeking to further* the public good through her conduct. See Farnam, 116 Wn.2d at 671-72 ("Conduct that may be praiseworthy from a subjective standpoint or may remotely benefit the public will not support a claim for wrongful discharge." (citations omitted)).

In short, we are not persuaded by Cahan's assertion that there exists a clear mandate of public policy prohibiting nurses from administering care to patients without provider orders. And even assuming there exists a public policy prohibiting nurses from administering care without obtaining informed consent, Cahan fails to establish that her termination may have been motivated by reasons that contravened that policy. For these reasons, Cahan fails to establish a prima facie case of wrongful termination in violation of public policy. We affirm

the trial court's summary dismissal of Cahan's claim on this basis and need not reach the issue of causation.[15]

Fees on Appeal

As a final matter, Cahan requests fees on appeal pursuant to RCW 49.48.030, which authorizes an award of fees "[i]n any action in which any person is successful in recovering judgment for wages or salary owed to him or her." Because the trial court did not err by summarily dismissing Cahan's claims, Cahan was not "successful" under that statute. Accordingly, we deny Cahan's request for fees on appeal.

Colum, J.

WE CONCUR:

Mann, C.J.

Dwyer, J.

[15] We also need not reach the issue of whether the trial court erred by denying Cahan's motion for reconsideration, which was addressed only to the causation element of her claim.

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