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COURT OF APPEALS, DIVISION II
OF THE STATE OF WASHINGTON

MONIQUE MESSENGER and KEVIN MESSENGER,
wife and husband, individually and on behalf
of their minor children, M.M., G.M., L.M., B.M., and Q.M.,

Appellants,

v.

SHANNON L. WHITEMARSH, as Administrator-Personal
Representative of THE ESTATE OF BRYAN DONALD
WHITEMARSH; and MULTICARE HEALTH
SYSTEM, a Washington nonprofit corporation,

Respondents.

CORRECTED BRIEF OF APPELLANTS

Douglas R. Cloud, WSBA #13456
Law Office of Douglas Cloud
1008 Yakima Avenue #202
Tacoma, WA 98405-4850
(253) 627-1505

Philip A. Talmadge, WSBA #6973
Aaron P. Orheim, WSBA# 47670
Talmadge/Fitzpatrick/Tribe
2775 Harbor Avenue SW
Third Floor, Suite C
Seattle, WA 98126
(206) 574-6661

Attorneys for Appellants
Monique and Kevin Messenger

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A. INTRODUCTION

Whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice, of all mischief and in particular of sexual relations with both female and male persons, be they free or slaves.

-Hippocratic Oath

Dr. Bryan Donald Whitemarsh began a sexual relationship with his patient, Monique Messenger in 2015, while serving as the primary care physician for her, her husband, Kevin Messenger, and their five minor children. When their relationship deteriorated, he threatened to kill her husband and himself. He followed through on the latter threat, ending his own life on June 2, 2016. Monique was not the first patient with whom he had a sexual relationship. As early as 2006, Dr. Whitemarsh was accused of having a sexual relationship with a patient, and, shortly before he ended his own life, he confessed to Monique that he was having inappropriate relationships with multiple other patients as well as a supervisor at the clinic where he worked.

Here, the Court must decide whether a physician breaches the standard of care under RCW 7.70 by engaging in a sexual relationship with his or her patient. The Legislature, courts, and scholars have noted that these relationships are inherently coercive, abusive, and harmful.

Law, logic, and policy demand that physicians be held responsible for the harm they inflict by such actions.

Independent of that question, however, the trial court committed several other errors. Despite material issues of fact, it dismissed the Messengers' independent theory of liability under RCW 7.70 that Dr. Whitemarsh violated the standard of care as a physician providing mental health treatment to Monique by engaging in sexual relations with her. The Messengers presented ample evidence that he treated her for a variety of mental health issues including adjustment disorder with depressed mood and post-partum depression, making summary judgment on that issue inappropriate.

The court also misapplied the so-called dead man's statute, RCW 5.60.030, by precluding any testimony from Monique regarding her impressions of the mental health treatment she received from Dr. Whitemarsh. The statute is inapplicable to her testimony regarding her impressions and feelings about the treatment she received from Dr. Whitemarsh and the relationship she formed with him as a counselor, which he exploited. Furthermore, Dr. Whitemarsh's Estate ("the Estate") affirmatively waived the statute's protections by offering objectively inaccurate evidence of Dr. Whitemarsh and Monique's treatment history while simultaneously arguing that Monique could not rebut it.

The trial court also erred in dismissing the Messengers' claims against Dr. Whitemarsh's employer, MultiCare Health System ("MultiCare"), where they created a material issue of fact as to whether MultiCare negligently hired, retained, supervised, or trained its employees, thus enabling Dr. Whitemarsh's inappropriate relationships with patients and staff.

The Court should reverse these many errors and allow the Messengers their day in court.

B. ASSIGNMENTS OF ERROR

(1) Assignments of Error

1. The trial court erred in entering its April 27, 2018 order granting the Estate's motion for summary judgment. CP 778-81.

2. The trial court erred in entering its April 27, 2018 order granting MultiCare's motion for summary judgment. CP 783-84.

3. The trial court erred in entering its April 6, 2018 order denying the Messengers' motion to continue the hearing on the Estate and MultiCare's summary judgment motions. CP 429-31.

(2) Issues Related to Assignments of Error

1. Did the trial court err in finding that a primary care physician does not breach the standard of care pursuant to RCW 7.70 by engaging in a sexual relationship with a patient as a matter of law? (Assignments of Error Numbers 1 and 2)

2. Did the trial court err in dismissing the Messengers' independent theory of liability under RCW 7.70 that Dr. Whitmarsh breached the standard of care owed as a physician providing mental health treatment when they presented ample evidence to create a question of fact on that issue? (Assignments of Error Numbers 1 and 2)

3. Did the trial court err in its application of the dead man's statute, RCW 5.60.030, where it does not prevent an interested party from testifying regarding her impressions, feelings, and the surrounding circumstances of her interactions with a decedent? (Assignments of Error Numbers 1 and 2)

4. Did the trial court err in failing to find that the Estate waived the protections of the dead man's statute by affirmatively offering evidence – evidence which it knew to be false – to prove the substance of Monique's interactions with the decedent while simultaneously arguing that she should not be allowed to rebut that evidence? (Assignments of Error Numbers 1 and 2)

5. Did the trial court err in dismissing the Messengers' claims against MultiCare where they created a material issue of fact as to whether MultiCare negligently hired, retained, supervised, and trained its employees thus enabling Dr. Whitmarsh's numerous inappropriate relationships with patients and staff? (Assignments of Error Numbers 2)

6. Did the trial court err in denying the Messengers' motion to continue the hearing on the summary judgment motions when the discovery cutoff was still four months away and key depositions were pending including a CR 30(b)(6) deposition of MultiCare?

C. STATEMENT OF THE CASE

Monique Messenger and Kevin Messenger and their three children moved to Puyallup, Washington in 2010. CP 471. In that same year, each

member of the family received medical care at the Good Samaritan South Hill Clinic, which became known as the MultiCare South Hill Clinic in 2011 after MultiCare joined with Good Samaritan. Dr. Bryan Whitemarsh was their primary care physician. CP 475-76. Mr. and Monique had twins in 2014 who also received primary care from Dr. Whitemarsh. CP 462. Later, Dr. Whitemarsh moved to the Frederickson MultiCare clinic and the family began seeing him there.

In addition to routine, primary care matters, Monique received treatment from Dr. Whitemarsh for depression and other mental health issues. In an office visit on November 8, 2012, Dr. Whitemarsh diagnosed Monique with “Adjustment disorder with depressed mood.” CP 350-52. Notes indicated that he followed up on this diagnosis and discussed her depression and mood with her as early as 2012. CP 352. In 2015, Dr. Whitemarsh counseled Monique for post-partum depression after the birth of her twins. CP 466, 487-88. Dr. Whitemarsh also provided her counseling in the aftermath of Monique’s brother’s death in July 2015. CP 480-81. Over many years, they also discussed problems in her marriage, in addition to her mental health issues. CP 350-76, 483. At one point, Dr. Whitemarsh suggested that Monique try a prescription for an antidepressant. CP 466, 488. Monique refused that suggestion but

continued to discuss her depression and other mental health issues with Dr. Whitemarsh. CP 481-82

At some point during his treatment of Monique and her family, Dr. Whitemarsh began to indicate that he was interested in her romantically. He would complement her looks, make flirtatious comments (often in front of her children), and touch or hug her in a flirtatious way. CP 480. Some of Dr. Whitemarsh's flirtatious comments were made in front of his medical assistant, Jill Fisher. CP 499. These included sexual comments he made while inserting an IUD, which Fisher witnessed. CP 373, 466, 499. Fisher told him that he should correct his behavior, but apparently did not report his inappropriate comments to anyone else. *Id.*

In 2015, during an appointment at MultiCare's Frederickson clinic with the Messengers' oldest son, Dr. Whitemarsh suggested that they should go to a shooting range so that the son could learn to shoot a firearm. CP 477-78. He used this invitation to obtain Monique's cell phone number. CP 478. This event marked the start of Monique's and Dr. Whitemarsh's non-professional relationship.

Dr. Whitemarsh began texting Monique, inquiring about her well-being and asking her to meet outside of the clinic. CP 482-83. They did on a few occasions before beginning a sexual relationship that lasted for nearly one year. CP 485-86. During this time, he continued to provide

primary care for her and her family, and he continued to counsel her on her depression. CP 466, 484-88.

The lines between his professional and personal relationship with Monique were completely erased. After their relationship started Whitemarsh continued to treat her family and treated her in regard to the most intimate personal care, including inserting a birth control implant and later an IUD. CP 374. They texted constantly, and many of their conversations regarding her depression took place outside of the clinic and in text messages. CP 466. She also met with him in the clinic, after hours. CP 496-97. At least one time such a rendezvous was witnessed by ARNP Patti Jordan, a MultiCare employee who shared responsibility for the day-to-day management of Frederickson clinic with Dr. Whitemarsh. CP 517-18, 522-25. Jordan did not report to anyone that she saw the two alone together after hours in the office. CP 525.

Eventually, Kevin Messenger became suspicious that his wife and Dr. Whitemarsh were having a sexual relationship. CP 501-02. When Kevin confirmed his suspicions, he contacted the Washington State Department of Health, Health Professionals Quality Assurance Board, and filed a complaint about Dr. Whitemarsh's sexual misconduct with his wife. This occurred in the Spring of 2016. CP 503-07. When Dr. Whitemarsh learned that Kevin had filed a complaint with the Department

concerning the relationship, he made threats to Monique that he would kill Kevin if he did not withdraw his complaint. CP 490-91, 542. Kevin informed the police of this threat.

In June 2016, Monique decided to reconcile with her husband and terminate her relationship with Dr. Whitemarsh. CP 492-93. In response, Whitemarsh repeatedly threatened to kill himself if she ended the relationship. CP 490-91. At their last meeting on June 2, 2016, he disclosed that he had been seeing other patients in addition to Monique. CP 495. Monique then went to his house and disclosed their affair to his wife and informed her of Dr. Whitemarsh's suicidal ideations. CP 492-95. His wife later confirmed that he admitted to multiple affairs with patients. CP 616-17.

According to police records, Dr. Whitemarsh returned home after meeting with Monique on June 2, had a discussion with his wife, and then fatally shot himself in the family's front yard. CP 532-45. Police went to the Messengers' house to do a welfare check on Kevin, due to Dr. Whitemarsh's prior threats to kill him. CP 541-42. They informed the Messengers of Dr. Whitemarsh's death. *Id.*

Unsurprisingly, through a public records request, the Messengers learned that Dr. Whitemarsh had been the subject of a prior complaint by a female patient in 2006 which alleged sexual misconduct by Dr.

Whitemarsh while he worked for Good Samaritan which was subsequently acquired by MultiCare. CP 465, 651. MultiCare retained Dr. Whitemarsh as an employee after MultiCare's subsequent acquisition of Good Samaritan's South Hill Clinic. Monique testified that she wished that she had known about this history prior to engaging in treatment with Dr. Whitemarsh. CP 465.

Patti Jordan, the ARNP who witnessed Monique alone with Dr. Whitemarsh in the clinic after hours, had never been warned by MultiCare that there had been a prior reported incident involving alleged sexual misconduct by Dr. Whitemarsh with a patient. CP 514. Without that warning, she explained, she did not report the incident because "there wasn't a red flag there for me." *Id.*

The Messengers also presented evidence that Jordan's failure to report Dr. Whitemarsh was likely also due to her own less-than-professional relationship with him. Jordan admits that she and Dr. Whitemarsh were more than colleagues, attended events together without their respective spouses, talked every night, and that he would even tell her he loved her before bed every night. CP 256. They also prescribed medications for one another, off the record, including an antidepressant she wrote for him shortly before his death. CP 274-75, 526-27. Jordan also indicated that she would protect Dr. Whitemarsh if an allegation of

impropriety arose. For example, in a Facebook message, after Monique said that Dr. Whitemarsh likely did not tell Jordan about their relationship because “he was afraid of losing his job,” Jordan wrote back, “Shit. Like I would do that. He knew better.” CP 257, 530.

The Messengers presented other evidence that MultiCare failed to adequately train and supervise its employees regarding sexual advances from doctors. In addition to Jordan’s failures, Fisher failed to report inappropriate comments made by Dr. Whitemarsh when inserting her IUD. CP 499. And despite her role as one of the day-to-day supervisors at the clinic, Jordan was unaware of MultiCare’s training policies and measures in place to prevent sexual relationships with patients. CP 599-602. When asked if MultiCare provided any training on the issue, she could only point to a yearly, computerized refresher covering general topics like patient abuse and neglect. CP 600. In sum, the Messengers presented evidence that the culture at MultiCare allowed Dr. Whitemarsh the freedom to carry on his many affairs without supervision or restriction.

The Messengers sued MultiCare and the Estate in Pierce County Superior Court, arguing that Dr. Whitemarsh breached the standard of care owed as a physician pursuant to RCW 7.70 and that MultiCare negligently hired and supervised its employees causing the Messenger family

damages. CP 2-6. The Estate and MultiCare brought summary judgment motions to dismiss the Messengers' claims. CP 46-76.

Monique testified that the sexual relationship with Dr. Whitemarsh developed in the MultiCare Frederickson clinic. CP 483. She testified that the trust she developed for Dr. Whitemarsh in her patient-physician relationship occurred in the setting of MultiCare's clinic. *Id.* The confidential information she discussed with Dr. Whitemarsh as her primary care physician, including her depression, marital struggles, her brother's death, etc., enhanced his power and influence over her. *Id.* He also knew intimate details about her family through his treatment of them and used their appointments to proposition and exploit her. *Id.* She testified that she should have been informed of his history with patients. *Id.* She and Kevin also testified that they feared for their family's safety when Dr. Whitemarsh made threats against them. *See, e.g.*, CP 490-91, 542.

The Messengers submitted the testimony of Dr. Howard B. Miller, a primary care physician who has owned, operated and provided and managed clinics providing primary care in Washington for 41 years. CP 454-59. Dr. Miller testified Dr. Whitemarsh breached the standard of care by engaging in sexual relationship with his patient. CP 456. Dr. Miller testified Dr. Whitemarsh further breached the standard of care by

engaging in sexual relations with his patient when he had been counseling her regarding symptoms of depression. *Id.* Dr. Miller also testified that both Dr. Whitemarsh and MultiCare failed to warn and/or protect Monique from Dr. Whitemarsh's sexual interest in his patients and that this failure was a breach of the standard of care and fiduciary duties owed to Monique by MultiCare. CP 457-58. Dr. Miller testified that MultiCare should have done better to protect female patients after receiving the prior complaint in 2006. CP 457. Dr. Miller testified that both Dr. Whitemarsh and MultiCare breached their fiduciary duties owed to each member of the Messenger family. CP 456-59. The Estate and MultiCare presented no expert testimony to rebut Dr. Miller.

Although armed with ample evidence to support their claims, the Messengers sought to discover additional evidence and brought a motion to continue the hearing on the summary judgment motions. The discovery cutoff was still four months away, and the Messengers sought to take depositions from potentially key witnesses, including nurses and staff at MultiCare, including Dr. Whitemarsh's supervisor. CP 212-21. They also sought to take a CR 30(b)(6) deposition of MultiCare to discover key information regarding the company's practices in hiring, retaining, training, and supervising employees. CP 219. Despite four months remaining before the discovery cutoff, the trial court denied this motion.

CP 429-31. The court noted that the matter “should be decided on the legal arguments.” RP (4/6/18) at 17.

After a hearing, the trial court, the Honorable Edmund Murphy, granted summary judgment on all claims to the Estate and MultiCare finding that a sexual relationship with a patient did not violate the standard of care pursuant to RCW 7.70. CP 778-79. It refused to consider any testimony of depression treatment provided by Dr. Whitmarsh, wrongfully applying the dead man’s statute, RCW 5.60.030. *Id.* And it granted MultiCare’s motion finding that MultiCare adequately supervised its employees as a matter of law. CP 783-84. The Messengers timely appealed. CP 774-79.

D. SUMMARY OF ARGUMENT

A primary care physician breaches the standard of care pursuant to RCW 7.70 by engaging in sexual relations with a patient. The law in Washington, logic behind the many rules barring such relations, and policy considerations fundamental to protecting a patient’s health mandate that result. The Court should also hold that the Messengers created material issues of fact regarding whether Dr. Whitmarsh breached the standard of care pursuant to the transference phenomenon, an independent theory for liability under RCW 7.70. Ample evidence showed that Dr.

Whitemarsh provided mental health treatment to Monique, thus creating a therapist like relationship that is fundamentally harmful when sexualized.

The trial court misapplied the dead man's statute in excluding testimony regarding Dr. Whitemarsh's treatment of Monique where the Estate affirmatively waived its protections, and it did not prevent Monique's testimony regarding her impressions regarding her mental health treatment with Dr. Whitemarsh.

The Court should also reverse summary judgment as to MultiCare where there was a material issue of fact as to whether MultiCare negligently hired, retained, supervised, or trained its employees enabling Dr. Whitemarsh's inappropriate relationships with multiple patients and staff causing great harm to the Messenger family. Reversal is warranted.

E. ARGUMENT¹

- (1) The Trial Court Erred in Dismissing the Messengers' Claims Against the Estate for Breaching the Standard of Care Owed Under Chapter 7.70 RCW
 - (a) Dr. Whitemarsh Owed a Duty to Monique Not to Have Sex with Her as His Primary Care Patient

¹ This Court reviews the trial court's decision to dismiss the Messengers' case on summary judgment *de novo*. *Dowler v. Clover Park Sch. Dist. No. 400*, 172 Wn.2d 471, 484, 258 P.3d 676 (2011). The trial court was obligated to view the facts, and reasonable inferences therefrom, in light most favorable to the Messengers as the non-moving party. *Id.* Here the facts did not support dismissal of the Messengers' claims against the Estate or against MultiCare.

There is no question that sexual relations, even when ostensibly consensual, are never appropriate between a physician and patient. It is considered improper by the American Medical Association, warned against in medical school, and prohibited by Washington law. *See* CP 456; RCW 18.130.180(24) (prohibiting sexual contact between a physician and patient). According to WAC 246-16-100(1), “A health care provider shall not engage, or attempt to engage, in sexual misconduct with a current patient, client, or key party, inside or outside the health care setting. Sexual misconduct shall constitute grounds for disciplinary action.” Sexual misconduct includes soliciting dates, flirting, hugging, kissing, sexual intercourse, and any other romantic or sexual contact. *Id.* Commencing sexual relations, even with a former patient, is also an “abuse of the trust inherent in the physician’s role” and is prohibited under RCW 18.130.180(1) as an act of “moral turpitude, dishonesty, or corruption relating to the practice of [a doctor’s] profession.” *Haley v. Med. Disciplinary Bd.*, 117 Wn.2d 720, 743, 818 P.2d 1062 (1991).

This case presents a question of first impression in Washington – whether a primary care physician breaches the standard of care owed under RCW 7.70 by having a sexual relationship with his or her patient. Put another way, does a physician owe a duty to a patient he or she is treating to refrain from sexual contact? The answer must be yes.

The relevant portion of RCW 7.70.030 states: “No award shall be made in any action or arbitration for damages for injury occurring as the result of health care which is provided after June 25, 1976, unless the plaintiff establishes...that injury resulted from the failure of a health care provider to follow the accepted standard of care.”

Logic dictates that primary care physician who has sex with a patient fails to follow the accepted standard of care. In Washington, “[t]he relationship of patient and physician is a fiduciary one of the highest degree. It involves every element of trust, confidence and good faith.” *Lockett v. Goodill*, 71 Wn.2d 654, 656, 430 P.2d 589 (1967); *see also*, *Loudon v. Mhyre*, 110 Wn.2d 675, 679, 756 P.2d 138 (1988) (noting that physician-patient relationship is a fiduciary relationship). Such a relationship is inherently unequal, as the fiduciary could abuse the trust and confidence of the patient, and therefore sexual relations between a physician and patient are never appropriate.² CP 454-59.

² The imbalance in the relationship is also why the Rules of Professional Conduct for lawyers also prohibit sexual relationships between a lawyer and client:

The relationship between lawyer and client is a fiduciary one in which the lawyer occupies the highest position of trust and confidence. The relationship is almost always unequal; thus, a sexual relationship between lawyer and client can involve unfair exploitation of the lawyer’s fiduciary role, in violation of the lawyer’s basic ethical obligation not to use the trust of the client to the client’s disadvantage. In addition, such a relationship presents a significant danger that, because of the lawyer’s emotional involvement, the lawyer will be unable to represent the client without impairment of the exercise of

Courts have recognized that the statutory prohibition on sexual relations between a physician and patient is a “bright line rule.” *In re Disciplinary Proceeding Against Halverson*, 140 Wn.2d 475, 492, 998 P.2d 833 (2000), *abrogated on other grounds by In re Disciplinary Proceeding Against Anshell*, 149 Wn.2d 484, 69 P.3d 844 (2003). In *Halverson*, our Supreme Court increased the sanction imposed on an attorney who had a consensual sexual relationship with his client, finding that he knowingly violated several RPCs in doing so, to the client’s detriment. The Court recognized that the case would be even more egregious had the attorney violated a bright line, statutory rule, like Dr. Whitemarsh did as a physician. *Id.* at 491-92 (citing RCW 18.130.180). Dr. Whitemarsh knew his conduct was immoral, unprofessional, and violated his duty of care to his patient.

independent professional judgment. Moreover, a blurred line between the professional and personal relationships may make it difficult to predict to what extent client confidences will be protected by the attorney-client evidentiary privilege, since client confidences are protected by privilege only when they are imparted in the context of the client-lawyer relationship. Because of the significant danger of harm to client interests and because the client’s own emotional involvement renders it unlikely that the client could give adequate informed consent, this Rule prohibits the lawyer from having sexual relations with a client regardless of whether the relationship is consensual and regardless of the absence of prejudice to the client.

RPC 1.8 cmt. 17. Similar concerns are present for a physician/patient relationship, though a doctor is privy to intimate details about a patient’s body, sexual and family history, and mental health which makes a sexual relationship between a doctor and patient even more exploitative. This is especially true for a primary care physician like Dr. Whitemarsh, who treated a vulnerable patient and her entire family over many years.

The Messengers presented un rebutted expert testimony that Dr. Whitemarsh's failure to abide by the bright line rule prohibiting sexual contact with a patient fell below the standard of care. CP 454-59. Their expert, Dr. Howard Miller, has provided, and managed physicians providing, primary care in Washington for over 41 years. CP 454. He testified regarding the inherent imbalance of power in the physician/patient relationship, especially as it exists in the field of primary care. CP 456. He knew details about her personal life, her family, and her vulnerabilities including her marital struggles and depression, all of which he would not have known absent his treatment of Monique as her primary care physician. CP 456. Dr. Miller testified regarding the trust necessary in a physician/patient relationship and breaching that trust by engaging in a sexual affair harmed her and her family's health. CP 457-58.

Dr. Miller's testimony falls in line with academic literature throughout the medical world. For example, commentators have recognized that "[t]here is no such thing as a consensual sexual relationship between a doctor and a patient...[t]here is a power imbalance that makes it impossible for a patient to actually be consenting to having that relationship." Roger Collier, *When The Doctor-Patient Relationship Turns Sexual*, 188(4) Canadian Medical Association Journal 247 (2016) (quoting Dr. Carol Leet, former president of the College of Physicians and

Surgeons of Ontario) (Appendix). Research also shows that these relationships are not innocent trysts, rather “[f]or the patient the overwhelming evidence is that sexual contact with the doctor is seriously harmful.” Thomas Fahy & Nigel Fisher, *Sexual Contact Between Doctors and Patients: Almost Always Harmful*, 304 *BMJ* (formerly *British Medical Journal*) 1519 (1992) (Appendix).

There are multiple policy reasons to hold that a doctor owes a duty to refrain from sexual contact with a patient. As discussed above, it is an exploitative relationship, inherently imbalanced by the doctor patient dynamic and forbidden by law.³ Doctors are trusted confidantes, held in high esteem in society, and they are privy to intimate details of a patient’s life. CP 456. Patients should be encouraged to share such details with their primary care physician, without fear that they will be subject to sexual advances. Especially when there are mental health issues at play, as here with Monique’s depression history, even a relationship that seems consensual from the outside or at first, may in fact devolve into one of power and control. For example, a jilted partner’s threats to harm patient’s family if the other partner ends the relationship – threats which

³ The need to prevent the abuse of power in imbalanced relationships is as salient today as ever. The crimes and scandals exposed by the Me Too and Time’s Up movements share a common thread – they involve a person (almost universally a man) in a position of power exploiting that power over others for their own sexual gratification. Such violations must stop, whether in a movie producer’s, a politician’s, or a doctor’s office. Liability under RCW 7.70 will further this goal.

Dr. Whitemarsh made – are even more concerning coming from a physician who knows intimate details about that patient’s life and family.

Doctor-patient sexual relations can also distort a doctor’s objectivity in terms of treatment. CP 456. A doctor may wish to please their sexual partner by prescribing unnecessary medications when asked, such as pain medications.⁴ A physician may also become overly protective of a patient in such a relationship, making the doctor less likely to send the patient out to specialists or for second opinions. The impropriety and harm created by a sexual relationship with a patient has been recognized for millennia, as evidenced by the Hippocratic Oath quoted at the opening of this brief.

In sum, law, logic, and policy should compel this Court to hold that a primary care physician owes a duty to refrain from sexual contact with a patient. Summary judgment on this issue should be reversed.

(b) Contrary to the Estate’s Arguments Below, the Supreme Court Has Held Dr. Whitemarsh’s Misconduct Relates to the Practice of Medicine

Despite the overwhelming law, logic, and policy dictating that a doctor owes a duty under RCW 7.70 to refrain from sexual contact with a patient, the Estate argued below that Dr. Whitemarsh’s conduct was not

⁴ As evidenced by Jordan’s testimony, Dr. Whitemarsh was prescribing medications for at least one of his romantic partners. CP 274-75, 526-27.

malpractice because it was not related to “examining, diagnosing, treating, or caring for the plaintiff as his patient.” CP 61 (quoting *Branom v. State*, 94 Wn. App. 964, 969-70, 974 P.2d 335 (1999)). The Supreme Court has held otherwise.

In *Haley*, the Supreme Court discussed at length the impropriety of a surgeon who started a sexual relationship with his former patient. 117 Wn.2d 720. Though that case was a discipline matter and not a malpractice action, the Court expressly “reject[ed]” the doctor’s argument that his conduct was “not related to his practice of medicine because it was not performed during the course of his medical diagnosis, care, or treatment of patients.” *Id.* at 737-38. Rather, he abused the “trust and confidence he established, as a surgeon” when he engaged in a sexual relationship that harmed both the patient and her family. *Id.* His immoral abuse of the trust he had established as the patient’s doctor “relat[ed] to the practice of his profession.” *Id.* at 737 (citing RCW 18.130.180(1)).

The Estate failed to distinguish *Haley*’s clear holding in any way. There is simply no reason not to apply it here, especially where Dr. Whitmarsh abused the trust and confidence he built, not just as the one-time surgeon for an acute injury or condition like the doctor in *Haley*, but *as the primary care physician for Monique and her entire family for years.*

Other jurisdictions agree. For example, in *Pons v. Ohio State Med. Bd.*, 614 N.E.2d 748 (Ohio 1993), the Ohio Supreme Court was asked whether a consensual sexual relationship with a patient, represented “[a] departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances.” *Id.* at 751. In holding that it did, the court noted that “the care a doctor renders to a patient includes more than just procedures performed or medications prescribed. The overall care consists of the entire treatment relationship between the physician and patient.” *Id.* As in the Messengers’ case, the physician in *Pons* provided years of primary care including counseling on contraception, knew about the patient’s history of depression, and knew that the patient was having marital difficulties. *Id.* The doctor “knew, or should have known, that [the patient] placed a great deal of trust in him.” *Id.* He “exploit[ed]” that trust by entering into a sexual relationship with her, acting against her best interest. *Id.* at 751-52.

Here Dr. Whitmarsh exploited the Messengers’ trust by entering into a sexual relationship with Monique. He used his position of trust and confidence to take advantage of her. He only knew of her marital difficulty and depression through his medical treatment as her primary care physician. He knew she was vulnerable to his advances by virtue of this privileged information, shared in confidence during her treatment with

him as her primary care physician. *See, e.g.*, CP 350-76. He also exploited his position as primary care physician to her children, using their appointments as opportunities to flirt with and proposition their mother. And after their sexual relationship started, he continued to treat and counsel Monique regarding her most intimate health care needs despite his own obvious personal interest. For example, he treated her when she sought a new birth control method, first inserting an implant, which caused complications, before removing it and inserting an IUD. CP 373-74.

These facts were supported by medical records submitted by the Estate and testimony from numerous witnesses. The Messengers also presented Dr. Miller, an expert with years of primary care experience, who testified that this conduct fell below the standard of care. The Estate presented no expert testimony in rebuttal. In its ruling, the trial court said that it “gave no weight” the declaration of Dr. Miller, wrongfully determining that the “legal question” of whether a duty is owed under RCW 7.70 controlled the outcome. RP (4/27/18) at 45-46; *see also*, CP 779 (striking his declaration). But for the reasons stated above, Dr. Miller correctly articulated the bright line rule that a primary care physician has a duty under RCW 7.70 to refrain from having sexual contact with a patient. He his testimony articulated the reasoning behind that rule and how Dr.

Whitemarsh clearly breached his duty of care to his patient. Dr. Miller's un rebutted testimony is relevant, admissible, and supports the Messengers claim against the Estate.⁵

In sum, the Messengers met their evidentiary burden to sustain a claim under RCW 7.70 and summary judgment should be reversed.

(c) Fact Issues Were Present Here as to Dr. Whitemarsh's Violation of the Standard of Care as a Physician Providing Mental Health Care

Summary judgment was also inappropriate where the plaintiffs alleged violations of the "transference phenomenon." Under this independent theory of liability, it is commonly regarded as breach of the standard of care when a doctor providing mental health treatment engages in sexual relations with a patient. *Simmons v. United States*, 805 F.2d 1363, 1365 (9th Cir. 1986) (cited favorably by *Am. Home Assur. Co. v. Cohen*, 124 Wn.2d 865, 872 n.8, 881 P.2d 1001 (1994)). Transference is a term recognized by mental health treatment professionals to describe a kind of child/parent surrogate relationship that develops between a patient and a doctor providing mental health counseling. *Id.* "When the therapist

⁵ This court applies a *de novo* standard "when reviewing all trial court rulings made in conjunction with a summary judgment motion" including the relevancy and admissibility of expert testimony for summary judgment purposes. *Folsom v. Burger King*, 135 Wn.2d 658, 663, 958 P.2d 301 (1998). Dr. Miller's testimony was relevant to the claims against the Estate and as to MultiCare's failures to supervise employees as discussed *infra* and should have been viewed in the light most favorably to the Messengers. The trial court erred in striking it.

mishandles transference and becomes sexually involved with a patient, medical authorities are nearly unanimous in considering such conduct to be malpractice.” *Id.*

Below, the Estate recognized that the transference phenomenon can support a medical negligence claim in Washington. CP 413-15. The only dispute is whether Dr. Whitmarsh provided Monique counseling or treatment for her mental health, thus creating a therapist-patient like relationship. CP 415. The Estate argued “for evidentiary reasons” that there was no therapeutic relationship between the Monique and Dr. Whitmarsh. CP 415. In its motion for summary judgment, the Estate presented deposition testimony and Monique’s medical records proffering to show that he did not provide her counseling or mental health treatment. CP 415-17.

The Estate’s argument necessarily fails because “evidentiary” disputes are questions of fact, unsuitable for summary judgment. Monique testified that Dr. Whitmarsh provided her counseling over the entire course of her relationship with him as her primary care provider. The Estate’s own evidence supports this fact, as her medical records dating back to 2012 show that he diagnosed her with “Adjustment disorder with depressed mood” and that they discussed her depression and marital issues when she first began seeing Dr. Whitmarsh as a patient. CP 350-52. The

records show that she continued to confide in Dr. Whitemarsh regarding her struggles in her relationship with her husband and her mood. CP 356; 361. And Monique herself, testified that he counseled her on depression many times, but failed to document it in his notes. CP 465. This included post-partum depression she experienced after giving birth to twins. CP 466.⁶

The Messengers more than met their burden to create a question of fact as to whether Dr. Whitemarsh provided her counseling or mental health treatment. This “evidentiary” dispute was for the jury to determine, and summary judgment should be reversed.

(d) The Trial Court Erred in Applying the Dead Man’s Statute

The Estate also argued that Monique was precluded from offering any evidence regarding her mental health treatment with Dr. Whitemarsh, arguing that the dead man’s statute, RCW 5.60.030, barred such testimony.⁷ Despite the inapplicability of the statute, the fact that the

⁶ It is also worth noting that many of these discussions took place outside of scheduled medical visits, both in person and via text message while their affair played out. CP 466. Dr. Whitemarsh blurred the lines as to whether his discussions with Monique were as a counselor, a doctor, a friend, or something else. This blurring of the lines caused great stress and psychological harm. *See* RPC 1.8 cmt. 17, *supra* (noting that the blurred personal/professional lines is a harmful aspect of an attorney/client relationship that turns sexual). It is another reason why a sexual relationship with a patient is never appropriate and why this Court should hold that a sexual relationship with a patient breaches the standard of care.

⁷ RCW 5.60.030 is reprinted in the Appendix to this brief.

Estate waived its protection, and the fact that the Estate offered objectively falsified evidence from Dr. Whitemarsh to support its position, the trial court determined that the statute applied and excluded any evidence from Monique that she received counseling and treatment from Dr. Whitemarsh for depression or other mental health issues. CP 778-79. That was error.

(i) The Dead Man's Statute Does Not Apply

The dead man's statute does not apply to Monique's testimony regarding her impressions of her relationship with Dr. Whitemarsh. "The purpose of the statute is to prevent interested parties from giving self-serving testimony regarding conversations and transactions with the deceased because the dead cannot respond to unfavorable testimony." *Kellar v. Estate of Kellar*, 172 Wn. App. 562, 574, 291 P.3d 906 (2012), review denied, 178 Wn.2d 1025 (2013). "That is not to say that an interested party cannot testify at all." *Id.* An interested party can testify regarding his or her own acts, feelings, and impressions, "so long as they do not concern a specific transaction or reveal a statement made by a decedent." *Id.* at 575 (citing *Jacobs v. Brock*, 73 Wn.2d 234, 237-38, 437 P.2d 920 (1968)). For example, in *Jacobs*, our Supreme Court held that a plaintiff may testify regarding a deceased defendant, "I was always given the impression we were getting the lake property for looking after him." 73 Wn.2d at 237-38.

It is no surprise that most cases dealing with the dead man's statute involve a contract, probate, property, or tort claim tied to one "principal event or occurrence," like the conveyance of property or execution of a contract. *See, e.g.,* Karl Tegland, 5A *Wash. Prac., Evidence Law and Practice* § 601.20 (6th ed.) (citing *Vogt v. Hovander*, 27 Wn. App. 168, 172, 616 P.2d 660 (1979)). As Professor Tegland noted, while the statute may bar testimony regarding the "principal event or occurrence" an "interested party may still testify about the surrounding circumstances" regarding their interactions with a decedent. *Id.*

The statute simply does not apply here where Monique only seeks to show her impressions, feelings, and the surrounding circumstances regarding her relationship with Dr. Whitemarsh. She was under the impression that she received counseling and treatment for depression from Dr. Whitemarsh over the course of many years during which he treated her as her primary care physician. This occurred at various times, for various reasons, and is documented at several points in her medical records. Importantly, Monique does not attempt to show that she entered into some specific transaction or conducted some specific business with Dr. Whitemarsh, as contemplated by RCW 5.60.030. Rather, she should have been allowed to testify regarding her own feelings, her own acts (*i.e.* what information she confided in Dr. Whitemarsh for counseling purposes), and

her own impressions as to whether she saw Dr. Whitemarsh as a mental health treatment provider and/or counselor. This is consistent with *Kellar*, *Jacobs*, *Vogt*, and the other authorities cited above.

Allowing such testimony is also consistent with the fundamental reasons for imposing liability pursuant to the transference phenomenon itself. Courts have recognized that liability under this theory focuses not on a specific interaction or treatment, but rather on how the patient views the physician and whether the “relationship grows so that the client comes to experience the therapist as a powerful, benevolent parent figure.” *Simmons*, 805 F.2d at 1365. The dead man’s statute simply does not apply to Monique’s testimony regarding how the relationship grew, the surrounding circumstances of his treatment of her over many years, and how she came to view Dr. Whitemarsh and a counselor figure and/or mental health therapist. Liability focuses on her “feelings and impressions” and how they developed over the course of many years while seeing her primary care physician who provided her mental health treatment.

This is not the case of a surgeon or specialist propositioning a patient after seeing the patient one time. Dr. Whitemarsh was the primary care physician for Monique *and her entire family*. In primary care, relationship-building and trust are key to successful treatment. *See*

generally, CP 454-59. Dr. Whitemarsh should have known that by mixing his personal and professional relationship, he was bound to exploit, confuse, and harm his patient, a patient whom he treated for mental health issues. Application of the statute and summary judgment on this issue were inappropriate.

(ii) The Estate Waived the Dead Man’s Statute’s Protections

Not only is the statute inapplicable, but the Estate waived its protection by affirmatively offering evidence in the form of deposition testimony and medical records to show that counseling for depression did not occur.⁸ The trial court erred when it determined otherwise.

The protections of the statute may be waived when a protected party offers “testimony favorable to the estate about transactions or communications with the decedent.” *Kellar*, 172 Wn. App. at 577. “Protection of the deadman’s statute may be waived by the protected party when the evidence is submitted concerning a transaction with the deceased in connection with a summary judgment motion as well as at trial.” *Hill v. Cox*, 110 Wn. App. 394, 406, 41 P.3d 495, *review denied*, 147 Wn.2d 1024 (2002) (estate presented a deposition of decedent taken prior to his

⁸ As discussed above, the medical records belied the Estate’s argument in many instances because they showed that they did discuss Monique’s depression, marital issues, and mood in several instances. And as discussed below, they were objectively falsified in other instances which should have opened the door to rebuttal testimony from Monique.

death as evidence of the underlying transaction). “Engaging in pretrial discovery, including taking depositions or propounding interrogatories, does not waive the deadman’s statute unless a representative of the estate introduces the deposition or interrogatories into evidence.” *Estate of Lennon v. Lennon*, 108 Wn. App. 167, 175, 29 P.3d 1258 (2001). This makes sense, because it would be “palpably unjust to permit the representative of a deceased person to use the adverse party to the extent that it might aid him in defeating a claim...and then claim the benefit of the statute when the adverse party sought to qualify or explain his testimony.” *Id.* (citing *Robertson v. O’Neill*, 67 Wash. 121, 124, 120 P. 884 (1912)).

Here the Estate introduced testimony in the form of depositions and Monique’s medical records purporting to show that Dr. Whitemarsh did not treat Monique for depression. *See, e.g.*, CP 340-96. Pursuant to *Lennon*, it used this information gathered from the adverse party to aid it in defeating a claim. This opened the door to allowing Monique the opportunity to “qualify or explain” her testimony, and to elaborate on the treatment she felt she received from Dr. Whitemarsh over many years. The Estate affirmatively offered this evidence in its own summary judgment motion, thus waiving the protection of the statute. *Id.* Pursuant

to *Kellar, Cox, Lennon, supra*, the trial court erred in failing to recognize that a waiver occurred.

(iii) The Estate Misled the Tribunal by Offering Objectively Falsified Evidence to Support Its Argument

The statute is also inapplicable because the Estate offered objectively false evidence to support the applicability of the statute while simultaneously arguing that Monique must not be allowed to contradict that evidence in any way. The trial court erred in refusing to waive the dead man statute to allow Monique to rebut objectively false testimony against her.

Portions of the medical records were objectively false. When Dr. Whitemarsh saw Monique in February 2016 to remove a birth control implant and insert an IUD, he noted in her medical records her sexual history writing, “Single current partner for past 7 months/years.” CP 374. Dr. Whitemarsh knew that to be false, as he had been carrying on a sexual relationship with Monique since August of the prior year.

Importantly, the Estate knew this evidence was false, having admitted that Dr. Whitemarsh began a sexual relationship with Monique in August 2015. CP 403. Yet the Estate submitted her medical records to defeat her claims on summary judgment while simultaneously arguing that Monique should not be allowed to rebut them in any way. That was an

abuse of the evidence rules, ethical rules, and the adversarial system itself; it should not have been permitted by the trial court. *See* RPC 3.3 cmt. 10 (noting that by offering false evidence to the court, a party “subvert[s] the truth finding process which the adversary system is designed to implement.”); ER 102 (rules of evidence are “construed to secure fairness” and to promote that “the truth may be ascertained and proceedings justly determined.”). After all, the dead man’s statute is merely designed to “prevent frauds upon the estates of those who are no longer present to defend themselves.” *Lennon*, 108 Wn. App. 167 at 177. It is not a vehicle to allow an Estate to commit a fraud on the court. ER 102, *supra*.

By offering this objectively false evidence to the court, the Estate opened the door to allow Monique the opportunity to rebut its veracity with her own testimony. Monique offered such testimony to show that the medical records did not accurately reflect her treatment with Dr. Whitmarsh. He omitted his counseling regarding her post-partum depression, the fact that he counseled her about having an abortion (which she did not go through with), and the fact that they discussed her depression in and out of the office during their relationship. CP 462-66. She testified that he also strangely (or perhaps jealously) invented entries regarding her seeing other men. *Id.* And the records’ inaccuracy is

independently verified by the fact that he entered his many of his notes weeks after treating her. *Id.*

Through these medical records – which the Estate knew were fabricated in key areas – he crafted an objectively false narrative regarding his treatment and relationship with Monique. Monique’s testimony should have been admitted to promote a fair hearing on her claims.

Properly admitted, Monique’s testimony created a material issue of fact as to whether Dr. Whitemarsh’s mental health treatment could independently support liability under chapter 7.70 RCW. Summary judgment was inappropriate.

(2) The Trial Court Erred in Dismissing the Negligent Hiring, Retention, Supervision, and Training Claims Against MultiCare

The trial court also erred in dismissing claims against MultiCare. MultiCare owed certain non-delegable duties to the Messengers pursuant to the doctrine of “corporate negligence.” *Pedroza v. Bryant*, 101 Wn.2d 226, 677 P.2d 166 (1984). Among those duties was the duty to select and retain its employees with reasonable care and to supervise and train all persons who practice medicine within its facilities. *Douglas v. Freeman*, 117 Wn.2d 242, 248, 814 P.2d 1160 (1991). An employer may be liable for torts committed by their employees, even with acting outside the scope of their employment, if the employer fails to exercise ordinary care in

hiring, retaining, supervising or training its employees. *Evans v. Tacoma Sch. Dist. No. 10*, 195 Wn. App. 25, 49, 380 P.3d 553, *review denied*, 186 Wn.2d 1028 (2016) (citing *Niece v. Elmview Grp. Home*, 131 Wn.2d 39, 48, 929 P.2d 420 (1997)). Liability arises when the employer knows or has reason to know that the employee presented a risk of danger to others. *Id.* Even when employees act outside the scope of employment, an employer owes a duty to foreseeable victims “to prevent the tasks, premises, or instrumentalities entrusted to an employee from endangering others.” *Rucshner v. ADT, Sec. Sys., Inc.*, 149 Wn. App. 665, 680, 204 P.3d 271, *review denied*, 166 Wn.2d 1030 (2009) (quoting *Niece*, 131 Wn.2d at 48).

Importantly, this Court has noted that “employers can be liable for an employee’s misconduct when the job duties ‘facilitate or enable’ the offense.” *Rucshner* 149 Wn. App. at 684 (citing *Betty Y. v. Al-Hellou*, 98 Wn. App. 146, 150, 988 P.2d 1031 (1999), *review denied*, 140 Wn.2d 1022 (2000)). In *Rucshner*, this Court considered the example of a teacher, hired to work with young students on school premises, who later molested a student. 149 Wn. App. at 685-87. The Court reasoned that the employer owed a greater duty to properly hire, train, and supervise such a teacher, because the teacher’s job duties made contact with potential victims “inevitable.” *Id.* The Court applied the same principles to a

salesman for a security company who raped a child he met while on a door-to-door sales call. *Id.* The Court determined that such home visits, which necessarily involve personal contact in a potential victim's home, imposed a greater duty on the company to ensure its workers were properly hired, trained, and supervised. *Id.* The Court found that a material issue of fact existed as to whether the security company acted appropriately to prevent the "tasks, premises, or instrumentalities entrusted" to its employees from injuring the victim. *Id.* at 686.

Like the examples discussed in *Rucshner*, MultiCare owed a duty to prevent sexual misconduct with patients because a primary care physician's duties "facilitate and enable" such offenses. Contact with potential victims is "inevitable," especially here where Dr. Whitemarsh treated not only Monique but her entire family. The relationship between a primary care physician and a patient is necessarily one that must be treated with extra care because a primary care physician is a trusted confidante with an intimate relationship that develops over many visits. Perhaps more than any other employee, MultiCare had a duty to properly vet, train, and supervise primary care physicians like Dr. Whitemarsh.

Here, viewed in the light most favorable to the Messengers, the Messengers created a material fact as to whether MultiCare breached its duty to adequately hire, retain, supervise, and train its employees.

MultiCare knew or should have known as early as 2006 that Dr. Whitemarsh had been accused of sexual contact with a patient. This was a publicly available complaint made to the Board of Health. It failed to discover this history or take any precautions to protect his future female patients, and he began sexual relationships with several of them. It also failed to discover and disclose this information to other staff including Jordan – who saw Monique alone with Dr. Whitemarsh after hours – and Fisher – who heard him make sexual comments while inserting Monique’s IUD. Jordan testified that she did not know about his prior complaint. If she had known or been properly trained to identify warning signs, perhaps Monique’s presence in his office after hours would have “raised a red flag,” causing Jordan to report the incident.⁹ CP 514. Had Fisher known or been properly trained by MultiCare, she might have properly reported his inappropriate and unethical conduct.

The Messengers presented evidence to show that MultiCare failed to exercise ordinary care to prevent a culture of impropriety which enabled Dr. Whitemarsh’s actions at the Frederickson clinic. This is no better evidenced than in the relationship of Dr. Whitemarsh and Jordan, who expressed romantic love for one another, wrote undocumented

⁹ Of course, we now know that due to their own less-than-professional relationship, Jordan would have protected Dr. Whitemarsh regardless. The fact that these two top supervisors in the office had such a relationship further illustrates MultiCare’s failings to staff its clinic with appropriate supervisors.

prescriptions for one another, and engaged in an emotional relationship which otherwise clouded both of their judgments. Shortly after Dr. Whitemarsh's suicide, Jordan even told Monique that she would not have reported him for having a sexual relationship with a patient. CP 257, 530. These are two day-to-day supervisors at MultiCare's neighborhood Frederickson clinic, who received improper supervision and training from MultiCare. Such intimate clinics, with only a handful of treatment providers, further "facilitate or enable" the abuse of patients and must be monitored closely. *Rucshner, supra*. MultiCare had a duty to prevent the mismanagement in its Fredrickson facility to protect foreseeable victims like Monique from harm.

The Messengers presented expert testimony from Dr. Miller, who has over 41 years of experience in small primary care facilities, including as a manager. He testified that MultiCare failed to exercise ordinary care in supervising Dr. Whitemarsh and in training its employees to recognize the danger he imposed. CP 457. MultiCare presented no expert testimony to rebut this opinion.

Indeed, MultiCare offered no evidence of the training it provided staff at the Frederickson clinic to support summary judgment. *See* CP 187-96, 640-48 (MultiCare pleadings). Jordan could think of no training MultiCare offered in regard to sexual relationships with patients (or

among staff), other than a yearly “computer thing” which spoke about patient abuse and neglect generally. CP 600. The Messengers created an issue of fact as to whether MultiCare should have better trained and supervised its staff to prevent Dr. Whitemarsh’s abuses, especially given past allegations from patients, the intimate nature of the clinic itself, and the ongoing mismanagement in the facility.

There is no telling how many of his patients Dr. Whitemarsh had a sexual relationship with at the Frederickson clinic. But there is no denying that his exploits seriously harmed the Messenger family. The Messengers created a material issue of fact as to whether MultiCare failed to exercise ordinary care in hiring, retaining, and supervising its employees. Summary judgment on this claim should be reversed.

(3) To the Extent There Was Any Lack of Evidence, the Trial Court Erred in Denying the Messengers’ Motion to Continue

The Messengers presented sufficient evidence to create a material issue of fact despite being seriously hindered by the trial court’s refusal to grant a continuance to depose key witnesses. For example, they sought depositions of MultiCare doctors and nurses who worked with Dr. Whitemarsh, including his supervisor and friend, Dr. Doug Smathers, and a CR 30(b)(6) deposition of the company itself. CP 216-20. Despite the discovery cutoff being four months away, the Court denied this modest

continuance request. To the extent that there is any question regarding the sufficiency of the evidence presented by the Messengers, denying them the opportunity to conduct full discovery was error.

The right to discovery is fundamental and relates to a plaintiff's "right of access to the courts." *Doe v. Puget Sound Blood Ctr.*, 117 Wn.2d 772, 780, 819 P.2d 370 (1991). CR 56(f) allows for a hearing on summary judgment to be continued "to permit affidavits to be obtained or depositions to be taken or discovery to be had." "Where a party knows of the existence of a material witness and shows good reason why the witness' affidavit cannot be obtained in time for the summary judgment proceeding, the court has a duty to give the party a reasonable opportunity to complete the record before ruling on the case." *Coggle v. Snow*, 56 Wn. App. 499, 507, 784 P.2d 554 (1990) (trial court abused its discretion in failing to grant a CR 56(f) continuance when new counsel associated late in the case). "Absent prejudice to the moving party, the trial court should grant a motion for continuance." *Keck v. Collins*, 181 Wn. App. 67, 88, 325 P.3d 306 (2014), *aff'd*, 184 Wn.2d 358, 357 P.3d 1080 (2015).

Keck is instructive. In that case, Division III determined that a trial court abused its discretion in failing to grant a modest continuance to obtain expert testimony where "the dispositive motions deadline [was] still three months away." *Id.* at 89. The court determined that in light of this

remaining time, the respondents would “suffer no prejudice” by allowing for full discovery to take place. *Id.* at 89.¹⁰ Here too, there was no delay or prejudice as the dispositive motion deadline was months away.

While a decision on a continuance motion under CR 56(f) is normally reviewed for an abuse of discretion, courts typically will only deny such a motion if: “(1) the moving party does not offer a good reason for the delay in obtaining the evidence; (2) the moving party does not state what evidence would be established through the additional discovery; or (3) the evidence sought will not raise a genuine issue of fact.” *West v. Seattle Port Comm’n*, 194 Wn. App. 821, 833-34, 380 P.3d 82 (2016). None of these factors is present here.

The Messengers did not delay in obtaining discovery. They dutifully pursued their claim, exchanging multiple sets of interrogatories and requests for production, conducting depositions of several witnesses, and discovering public documents. CP 219-20. They requested depositions of key witnesses, including members of Dr. Whitewash’s family and Dr. Smathers, before the Estate and MultiCare even filed their summary judgment motions. CP 297-308. MultiCare dragged its heels, responding that Dr. Smathers was not available until May, before filing its

¹⁰ The Supreme Court affirmed the Court of Appeals for a different reason, but did not criticize the court’s interpretation of CR 56(f) and reiterated the lack of prejudice to the non-moving party because trial “was several months away.” *Keck v. Collins*, 184 Wn.2d 358, 369, 357 P.3d 1080 (2015).

summary judgment motion to be heard in April. *Id.* In light of this good reason why a material witness's testimony could not be obtained before the hearing, the trial court failed in its "duty to give the party a reasonable opportunity to complete the record before ruling on the case." *Coggle, supra.* And there was plenty of time before the discovery cutoff, *which was four months away*, to conduct these depositions. There was no delay.

The Messengers identified the evidence they hoped to obtain, most notably as related to their claims of corporate negligence. As a MultiCare employee directly supervising Dr. Whitemarsh, Dr. Smathers' testimony would be relevant to the negligent supervision claim. Moreover, as a friend of Dr. Whitemarsh, it is likely he would have knowledge of Dr. Whitemarsh's personal relationships. This is especially likely considering the testimony of Patti Jordan, another supervising employee at the Clinic who disclosed further evidence of Dr. Whitemarsh's misconduct during her deposition. Additionally, a CR 30(b)(6) deposition is a vital discovery tool, and courts have recognized their importance. For example, in *Flower v. T.R.A. Indus., Inc.*, 127 Wn. App. 13, 38-41, 111 P.3d 1192 (2005), *review denied*, 156 Wn.2d 1030 (2006), Division III held that a trial court abused its discretion in issuing a protective order preventing a 30(b)(6) deposition from taking place. The court noted that a corporation may not object to such a deposition on the grounds that they are "wasteful or

duplicitous” nor are interrogatories an adequate “substitute” for a 30(b)(6) deposition. *Id.* at 40-41. Rather, the 30(b)(6) deposition was squarely relevant to the Messengers’ corporate negligence claims. Denying the modest continuance was improper where the Messengers identified what evidence they sought.

Finally, the court abused its discretion in failing to recognize the genuine issues of fact raised by the Messengers. In fact, the trial court directly contradicted itself regarding whether the dispute was legal or factual in nature. When denying the motion to continue, the trial court stated that the matter “should be decided on the legal arguments.” RP (4/6/18) at 17. But later, when granting summary judgment to MultiCare, the trial court based its ruling on the facts, stating that “there was no indication that anyone had any knowledge of” Dr. Whitemarsh’s sexual misconduct with Monique and “I don't think that there’s any basis to make a finding that there was a failure to supervise or that there’s corporate negligence.” RP (4/27/18) at 46-47. Not only did the Messengers present ample evidence to create a question of fact regarding MultiCare’s negligence, but they likely would have bolstered their claims after deposing key witnesses like Dr. Whitemarsh’s supervisor and MultiCare’s corporate representative. Again, MultiCare offered no evidence regarding the training and supervision of its employees, and Patti Jordan could think

of no training or supervision related to sexual relationships with patients and coworkers. Additional discovery would have highlighted these deficiencies on the part of MultiCare.

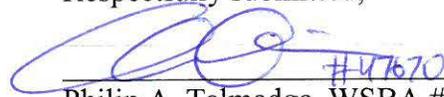
To the extent that there is any doubt about the sufficiency of the evidence presented by the Messengers to defeat summary judgment, the trial court erred in refusing to grant a modest continuance pursuant to CR 56(f). Reversal is warranted on this issue if the Court does not reverse on the merits for the reasons articulated earlier in this brief.

F. CONCLUSION

A primary care physician breaches the standards of care by entering into a sexual relationship with a patient. The Court should also hold that the Messengers material issues of fact regarding whether Dr. Whitmarsh breached the standard of care pursuant to the transference phenomenon, an independent theory for liability under RCW 7.70. Furthermore, the Court should correct the trial court's errors applying the dead man's statute, which does not apply in this case and was affirmatively waived by the Estate. And the Court should reverse summary judgment in favor of MultiCare where the Messengers created material issues of fact regarding its negligence, even where discovery was wrongfully truncated. Costs on appeal should be awarded to the Messengers.

DATED this 24th day of November, 2018.

Respectfully submitted,



Philip A. Talmadge, WSBA #6973
Aaron P. Orheim, WSBA #47670
Talmadge/Fitzpatrick/Tribe
2775 Harbor Avenue SW
Third Floor, Suite C
Seattle, WA 98126
(206) 574-6661

Douglas R. Cloud, WSBA #13456
Law Office of Douglas Cloud
1008 Yakima Avenue #202
Tacoma, WA 98405-4850
(253) 627-1505

Attorneys for Appellants
Monique and Kevin Messenger

APPENDIX

RCW 5.60.030

No person offered as a witness shall be excluded from giving evidence by reason of his or her interest in the event of the action, as a party thereto or otherwise, but such interest may be shown to affect his or her credibility: PROVIDED, HOWEVER, That in an action or proceeding where the adverse party sues or defends as executor, administrator or legal representative of any deceased person, or as deriving right or title by, through or from any deceased person, or as the guardian or limited guardian of the estate or person of any incompetent or disabled person, or of any minor under the age of fourteen years, then a party in interest or to the record, shall not be admitted to testify in his or her own behalf as to any transaction had by him or her with, or any statement made to him or her, or in his or her presence, by any such deceased, incompetent or disabled person, or by any such minor under the age of fourteen years: PROVIDED FURTHER, That this exclusion shall not apply to parties of record who sue or defend in a representative or fiduciary capacity, and have no other or further interest in the action.

When the doctor–patient relationship turns sexual

Simon asked her to lunch because he needed a shoulder to cry on. His girlfriend, who was diagnosed with a brain tumour some time ago, had recently died. During lunch, she told Simon that she had just ended a relationship and joined a dating service. Quit the dating agency, Simon told her, and go out with me instead. She was taken aback — gobsmacked, really. Here she was, expecting to console someone in grief, and was instead faced with an ill-timed romantic proposal.

Still, she was interested. Just two days earlier, she had been crying into her cappuccino with her girlfriends, worried that she would never again find a loving relationship. So, despite her reservations, she accepted Simon's offer. Their relationship blossomed, and the couple wed two years later.

But in 2013, after 13 years of marriage, they decided it was time to end the relationship, which they felt had deteriorated beyond repair. By then, in fact, Simon had already begun seeing someone else, a businesswoman named Ellen. A mere six months after the divorce, in February of 2014, Simon married Ellen, and they remain together today.

There are, however, a few complicating factors about this story, beyond the regular emotional turmoil that so often accompanies failed romantic endeavors. Simon's full name is Simon Holmes, and he is a 59-year-old family doctor in the United Kingdom. He got to know his first wife, identified in court hearings as Patient A, while treating her for depression. And he got to know his second wife, identified in court hearings as Patient B, while counselling her over relationship troubles with her former husband. After these details eventually came to light, a medical disciplinary panel suspended Holmes from practising for three months for failing to maintain professional boundaries.

This case, of course, is a rather exceptional one. British newspapers had a field day with it, more than one going all caps in their headlines to note Holmes had



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There is no such thing as a consensual sexual relationship between a doctor and a patient, but sometimes, in certain contexts, considering certain factors, things aren't so black and white.

married not one but TWO of his patients. Though instances of doctors and patients entering romantic relationships are indeed rare, it does sometimes happen. Physicians sometimes have sexual relationships with patients, or with former patients. Sometimes the initiator is the physician, and sometimes it is the patient. Often times these are clear-cut cases of unethical behaviour on the part of doctors — perhaps even criminal behaviour. But sometimes, in certain contexts, considering certain factors, these affairs of the heart are a little more complicated.

Black and white rules

In Canada, if a doctor engages in sexual activity with a current patient, and doesn't terminate the professional relationship, it is considered sexual misconduct by provincial medical regulatory colleges. And it doesn't matter if the relationship is consensual.

“There is no such thing as a consensual sexual relationship between a doctor and a patient,” says Dr. Carol Leet, former president of the College of Physicians and Surgeons of Ontario. “There is a power imbalance that makes it impossible for a patient to actually be consenting to having that relationship.”

According to the college's policy on maintaining appropriate boundaries with patients, “any form of sexual relations between physicians and patients is considered sexual abuse” under the Ontario Regulated Health Professions Act. This includes not only sexual contact, but also behaviour or remarks of a sexual nature. There are typically two types of doctors who commit sexual abuse of patients, says Leet. Some are sexual predators — “There are criminals in all walks of life,” she notes — and some are going through personal problems that have compromised their judgment.

“One of the things about sexual abuse by physicians is that it isn’t necessarily a very common thing but it’s certainly a very serious thing,” says Leet. “That’s why the college devotes a fair bit of energy and resources to try to not only prevent it but to deal with it when it happens and to support the victims.”

In any given year, the proportion of licensed physicians disciplined by provincial regulatory colleges ranges from 0.06% to 0.11%. According to a 2011 paper in *Open Medicine*, among those physicians disciplined, sexual misconduct is the most common offence, accounting for 20% of cases between 2000 and 2009.

“It is concerning that a large proportion of violations by Canadian physicians involved sexual misconduct,” states the paper, also noting that “despite a lack of consensus regarding how to educate medical trainees and physicians with regard to sexual boundaries, this finding may identify a need for greater attention to this critical topic within the medical education curricula.”

Dr. Chaim Bell, a coauthor of the paper and an associate professor at the University of Toronto says because it’s not common there isn’t a lot of information, making it difficult to develop targeted interventions. “Instead you are using fairly diffuse interventions that may not be pertinent or relevant.”

Sexual misconduct does appear to be a bigger issue, however, in some medical disciplines more than others. A 1998 study of physicians disciplined for sex-related offenses in the United States, found that they were more likely to be in psychiatry, family medicine, and obstetrics and gynecology. One theory is that the nature and length of doctor–patient relationships in these disciplines increases the chances of boundary violations.

In psychiatry “the nature of our contact with patients is more intimate,” says Dr. Mona Gupta, an assistant professor of psychiatry at the Université de Montréal and a member of the bioethics committee of the Royal College of Physicians and Surgeons. “The very things you are addressing in these encounters makes patients extra vulnerable, because you are talking about their most private fears or sources of distress.”

There are, however, characteristics

about the practice of medicine in general that may make a physician susceptible to violating a boundary with a patient. Historically, notes Gupta, doctors have been expected to deal with all stress that occurs in the context of their work and not show they need help. That can increase vulnerability, compromise judgment and lead doctors to engage in behaviour that, in retrospect, they recognize as inappropriate.

From the patient’s perspective, the empathy of a caring physician can sometimes be confusing. A patient who is vulnerable may mistake a doctor’s kind words or gestures for romantic interest. This could lead to a patient seeking more from a doctor than health care.

Psychiatrists are trained to understand that this behaviour is a reflection of what the patient may be going through, says Gupta. “The fact that something is initiated by a patient doesn’t in any way change your responsibilities in terms of keeping boundaries or in terms of helping that person.”

Real-life grey zone

When a patient becomes a former patient, things become less clear. You can’t violate the doctor–patient relationship, after all, if it no longer exists. Well, that may be true, but these situations can still be tricky. The discussion moves, however, from the realm of sexual abuse into the world of ethics.

The College of Physicians and Surgeons of Ontario, for example, doesn’t consider sexual contact with former patients to be abuse, but does warn in its boundaries policy that “the physician may still be found to have committed professional misconduct.” The American Psychiatric Association, in its Principles of Medical Ethics, states that “sexual activity with a current or former patient is unethical.”

In the United Kingdom, the General Medical Council once discouraged physicians from having romantic relationships with any former patient. That changed in 2013, however, though the council did update its guidelines to include factors a doctor should consider before going down that path. These include the nature of the professional relationship, how long ago it ended and

whether the physician is caring for other members of the former patient’s family.

The problem with rules by regulatory bodies, is that they tend to be broad easy-to-communicate norms that leave little room for nuance. In the real world, each relationship is unique and complex and such rules, however well intentioned, may not apply to all cases.

“I totally support the norms that one should avoid at all costs entering into a romantic or sexual relationship with a patient because there is a high probability that it could undermine the doctor–patient relationship with potential risk to the patient,” says Dr. Eugene Bereza, director of the Centre for Applied Ethics at the McGill University Health Centre. “Having said that, in real life, there may be the rare — and I stress the word rare — justifiable exception where vulnerability is virtually zero, the risk to the patient is zero, there is a way to manage it by transferring care and you invoke a third party if necessary to adjudicate.”

One scenario often mentioned in discussions of possible exceptions is the dilemma of the rural doctor. What if, for instance, you are the only doctor in a remote community? Should you forgo romantic relationships and marriage and a family? It is generally less frowned upon when a rural doctor falls in love with a patient, though ethicists still suggest that the professional relationship be terminated and, barring an emergency, that care be transferred to a doctor in a different community.

The rule of thumb, however, is generally agreed upon in the medical profession. Romantic relationships between doctors and patients are fraught with hazards and best avoided. The doctor–patient relationship is fiduciary, and the physician’s responsibility is to put the patient’s health needs first, not their own wants or desires. But doctors are people, too. And people sometimes find love even if they aren’t looking for it.

“I do know of rare, rare cases where a physician has unintentionally and unwittingly, over time, fallen in love with somebody,” says Bereza. “It was mutual, consensual and they went on to get married and have a family and be a pillar of the community.” — Roger Collier, *CMAJ*

CMAJ 2016, DOI:10.1503/cmaj.109-5230

Sexual contact between doctors and patients

Almost always harmful

All codes of medical practice, ancient and modern, explicitly forbid a doctor to have sex with a patient. The General Medical Council forbids "improper relationships" or "indecent behaviour," while the American Medical Association states that "sexual activity with a patient is unethical." The American Psychiatric Association extends this sanction to include "ex-patients," believing that relationships with former patients are likely to exploit emotions deriving from treatment.

Despite such unambiguous ethical and legal declarations several sources suggest that violations are not uncommon. In a survey of 1442 north American psychiatrists, 7% of male and 3% of female respondents acknowledged having had sexual contact with their own patients.¹ Similar figures have been reported for psychologists² and psychotherapists.³ The problem, however, is not confined to those working in mental health. Kardener and colleagues reported that 18% of obstetricians, 13% of general practitioners, and 12% of internists confessed to or condoned sexual contact with their patients.⁴ A survey of Dutch gynaecologists and ear, nose, and throat specialists published in this issue found that 4% of respondents in each group reported a history of sexual contact with a patient (p 1531),⁵ suggesting that this is not only a north American phenomenon.

To be attracted to a patient is a common experience, acknowledged by 86% of male and 52% of female trainee psychiatrists in the United States¹ and 84% of male and 27% of female gynaecologists in the Dutch study.⁵ It may not always be clear why some doctors are unable or unwilling to maintain the boundaries dictated by the established ethical, professional, and clinical codes of practice, but several risk factors can be identified.

In some cases it may be a conscious predatory desire to take advantage of their powerful position that leads doctors deliberately to exploit vulnerable patients. In other cases, boundary violations by clinicians may be an early symptom of psychiatric disorders, such as hypomania. Certain specialties may also be a greater risk, including psychiatry and gynaecology, which necessitate the most extreme invasions of the patient's physical or emotional privacy. Anecdotal accounts also suggest that the isolated middle aged practitioner who has experienced a mid-life crisis such as bereavement or separation may also be at risk of forming inappropriate relationships with patients.⁶

Certain patients also seem to be at increased risk of fostering a sexual relationship with their doctor, including

those with dependent or submissive personalities, and people with more profound personality disturbances who have difficulty defining or accepting psychological and social boundaries.⁷ The victims of sexual abuse or neglect in childhood may continue to sexualise future relationships with important figures including the doctor. In these cases it may not be the individual doctor who is attractive but what the doctor represents in the patient's internal world. Similar psychological vulnerabilities on the doctor's part may lead him or her to initiate or respond to inappropriate erotic overtures.

For the patient the overwhelming evidence is that sexual contact with the doctor is seriously harmful.^{3,8} In one survey 65% of American psychiatrists had treated patients who had been sexually involved with previous therapists; this was considered to be harmful to the patient in 87% of cases.⁹ This is in keeping with doctors' own reports of sexual contact with their own psychotherapists, which is nearly always described as being damaging.¹⁰ In addition, the long term consequences of sexual assault in children and adults are being increasingly recognised.^{11,12} Despite these results there is a marked tendency for offenders to rationalise their behaviour and minimise the potential harm to the patient.¹³ The effects for the doctor may also be serious, including suspension of medical registration, criminal proceedings, and public humiliation.

The management of dysfunctional patient-doctor relationships must first address the immediate needs of the victim, but this may be hampered by the reluctance of victims to come forward to therapeutic agencies at the time of abuse. This may be because patients do not necessarily view the sexual aspect of the relationship as a problem or because of feelings of shame or fear. For obvious reasons the offending doctor is often reluctant to come forward. More important is the reluctance of third party doctors to report cases that have come to their attention,⁹ probably reflecting uncertainty about the value of reporting, concern to protect the patient's confidentiality,¹³ and a failure to trust patients' accounts of their experiences.

Some American states have taken this dilemma out of doctors' hands by passing legislation which obliges therapists to report cases where they suspect previous sexual involvement. Statutes also exist making sexual contact with patients a crime and which make it easier to sue offending therapists, and consequently encourage reporting by patients.¹⁴ This in part reflects a lack of confidence in the internal disciplinary

procedure of the profession. More positively, this offers help to patients who may be abused by practitioners, including unlicensed psychotherapists and practitioners of alternative medicine, who may not be bound by codes of practice or internal disciplinary procedures.

Once cases do come to light there should be help and compensation for the victim. Patients should be treated outside the setting in which the original abuse occurred. Victims should be allowed to ventilate feelings about their experience, which will include a complex mixture of anger, guilt, and sadness. The therapist should not attempt to shield professional colleagues from normal disciplinary procedures. In this context it is important for doctors, both individually and as a profession, publicly to take a clear stance on this matter so that patients can be sure that their complaints are taken seriously and dealt with effectively.

Management of the offender should combine a compassionate regard for their special needs, including counselling or psychiatric treatment, with implementation of the appropriate disciplinary measures. Deliberate misconduct demands strict censure and supervision of future clinical practice. This should reinforce public confidence, act as a deterrent to the exploitive offender, and encourage the sick to seek help.

The cornerstone of prevention of sexual contact between doctors and patients is education. Discussion of the subject could be appropriately included in undergraduate psychiatry and medical ethics courses. Doctors should also be able to discuss these issues with their supervisors or peers without fear of ridicule or persecution.

Clinicians can take steps to make it less likely that they will be drawn into an erotic relationship.⁶ Such steps will also reduce the risk of false accusations, which can be extremely damaging. Those working in hospital can most readily protect themselves by using chaperones when seeing patients and minimising social contact with patients. Setting limits on patient contact such as seeing patients only in the clinic, at appointed times, and with chaperones are impractical for

those who have to offer emergency treatment at the patient's request. Furthermore, the recommendation that all social contact with patients should be avoided as it could be a precursor to frankly unethical activity is unrealistic for some practitioners. In such situations it is important to have a close working relationship with other health professionals. If a doctor becomes aware of professional boundaries being eroded then this should be discussed with colleagues, and possibly the care of the patient transferred to another clinician.

THOMAS FAHY

Lecturer in Psychological Medicine

King's College Hospital and
Institute of Psychiatry,
London SE5

NIGEL FISHER

Senior Registrar in Psychiatry

Maudsley Hospital,
London SE5

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Living bone grafts

Cell culture may overcome the limitations of allografts

Bone grafting is widely used in orthopaedics and maxillofacial surgery.¹ Currently the ideal graft material is autologous cancellous bone, usually taken from the iliac crest, which provides living osteoblasts and may provide mechanical support. Its use, however, is hindered by morbidity at the donor site, which includes postoperative pain, infection, wound scarring, neuralgia paraesthesia, subluxation of the hip, and prolongation of the hospital stay.²⁻⁴ Furthermore, the volume required often exceeds what is available, especially in children.

To overcome these difficulties alternative forms of graft material have been sought. These fall into two broad groups: bone preparations—both human and animal, mineralised and demineralised—and bioceramics, which are mainly composed of a combination of tricalcium phosphate and hydroxyapatite. Bioceramics include marine coral, which is currently being investigated.⁵

Human allografts provide mechanical strength but do not contain living osteoblasts; their use carries the risk of infection, although sterilisation should largely eliminate this. Fresh allografts provoke a vigorous inflammatory response

and often rejection of the graft,¹ although immunogenicity can be reduced by demineralising and freezing "treatments" of the material. Re-establishment of the blood flow, which is a vital step in incorporating a graft, is thought to be impaired in allogeneic grafts, and this inhibits the rate of formation of new bone and resorption of the graft.⁶

Demineralising allograft bone, as well as reducing immunogenicity, may expose a group of matrix growth factors known as the bone morphogenetic proteins. These cause the formation of bone in soft tissues by stimulating primitive mesenchymal cells to differentiate into osteoblasts—a process known as osteoinduction.⁷ Demineralised bone is therefore superior to untreated allograft because it has intrinsic bone forming ability, although it may have reduced mechanical strength.⁸

Recently, recombinant bone morphogenetic protein-2 has been shown to heal large segmental bone defects in dogs, but more extensive work, including studies in humans, is required.⁹ Using bone marrow aspirates to enhance both bioceramics and bone allografts has been another approach,¹⁰ which has so far met with only limited success. Bioceramics

DECLARATION OF SERVICE

On said day below, I electronically served a true and accurate copy of the *Corrected Brief of Appellants* in Court of Appeals Cause No. 51893-7-II to the following parties:

Douglas R. Cloud
Law Office of Douglas Cloud
1008 Yakima Avenue #202
Tacoma, WA 98405-4850

Elizabeth A. Leedom, WSBA #14335
Rhianna M. Fronapfel, WSBA #38636
Bennett Bigelow & Leedom, P.S.
601 Union Street, Suite 1500
Seattle, WA 98101-1363

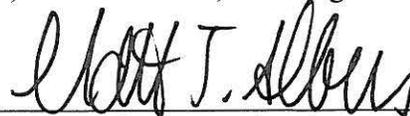
Daniel F. Mullin, WSBA #12768
Tracy A. Duany, WSBA #32287
Mullin, Allen & Steiner, PLLC
101 Yesler Way, Suite 400
Seattle, WA 98104

Howard M. Goodfriend, WSBA #14355
Catherine W. Smith, WSBA #9542
Smith Goodfriend, P.S.
1619 8th Avenue North
Seattle, WA 98109

Original E-filed with:
Court of Appeals, Division II
Clerk's Office

I declare under penalty of perjury under the laws of the State of Washington and the United States that the foregoing is true and correct.

DATED: November 29, 2018 at Seattle, Washington.



Matt J. Albers, Paralegal
Talmadge/Fitzpatrick/Tribe

TALMADGE/FITZPATRICK/TRIBE

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- phil@tal-fitzlaw.com
- rfronapfel@bblaw.com
- tduany@masattorneys.com

Comments:

Corrected Brief of Appellants

Sender Name: Matt Albers - Email: matt@tal-fitzlaw.com

Filing on Behalf of: Aaron Paul Orheim - Email: Aaron@tal-fitzlaw.com (Alternate Email: matt@tal-fitzlaw.com)

Address:

2775 Harbor Avenue SW

Third Floor Ste C

Seattle, WA, 98126

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