

NO. 78383-7

SUPREME COURT OF THE STATE OF WASHINGTON

LIAM STEWART-GRAVES, a minor, and NICHOLE STEWART-
GRAVES, as Guardian Ad Litem, and NICHOLE STEWART-GRAVES
and TODD GRAVES, Individually,

Appellants,

v.

KATHERINE F. VAUGHN, M.D.; THE VANCOUVER CLINIC, INC.,
P.S.; and SOUTHWEST WASHINGTON MEDICAL CENTER,

Respondents.

JOINT BRIEF OF RESPONDENTS

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I. RESTATEMENT OF ISSUES PRESENTED FOR REVIEW

1. Is a pediatrician's or a hospital's continuation of emergency resuscitation that results in saving the life of a viable newly born infant actionable under Washington law simply because, if the infant's life is saved, the infant may have, or even likely has, brain damage or some other disability?

2. Is the possibility, or even likelihood, that a viable newly born infant has brain damage or some other disability sufficient, without more, to allow the parents (or require a health care provider) to withhold or withdraw life-saving treatment and decide that the child should not be allowed to live?

II. COUNTERSTATEMENT OF THE CASE

A. Nature of the Case.

Liam Stewart-Graves, a minor, his mother Nichole Stewart-Graves, as his guardian ad litem, and both his parents, Nichole Stewart-Graves and Todd Graves, individually, sued Kathleen Vaughn, M.D., her employer The Vancouver Clinic, Inc., P.S., and Southwest Washington Medical Center, seeking damages arising out of Liam's resuscitation following his birth by emergency C-section delivery.¹ See CP 3-15. The

¹ According to plaintiffs' expert, Dr. Carl Bodenstein, "Liam has severe cerebral palsy, mental retardation, a seizure disorder, microcephaly, respiratory distress requiring frequent suctioning and he has to be fed through a feeding tube." CP 200 (¶ 26).

trial court dismissed on partial summary judgment Liam's and his parents' respective claims for failure to obtain informed consent to continued resuscitation efforts, and alleged negligence in continuing resuscitation efforts for more than 10 to 15 minutes after Liam's birth. CP 295-98, 299-302; see CP 291-94. The trial court concluded that the result of the continued resuscitation – "saving Liam's life" – was not actionable and that recognition of a cause of action for wrongful prolongation of life in this case would be inconsistent with existing Washington law that allows the withholding of life-sustaining medical care only in extreme situations. See CP 291-94; see also CP 295-98, 299-302.

The trial court did not dismiss plaintiffs' claim for alleged negligence in the manner in which the resuscitation was performed, as defendants conceded that plaintiffs presented sufficient evidence to proceed on their claim of alleged inadequate resuscitation. See CP 291; see also CP 276-77, 296 (¶ 1), 301. Plaintiffs, however, subsequently voluntarily dismissed all claims not previously adjudicated by the trial court's summary judgment orders, including their claim for alleged inadequate resuscitation, CP 303-04, so that they could appeal the trial court's orders granting partial summary judgment dismissal of their claims concerning the continuation of the resuscitation, see CP 305-17.

B. Factual Background.

On March 2, 2004, Nichole Stewart-Graves, who was then 35 weeks pregnant, presented to Southwest Washington Medical Center (the Hospital) at 2:25 p.m. after having experienced contractions since 9:00 a.m. CP 190. As of 3:00 p.m., Nichole was having frequent mild contractions, her cervix was dilated to 1 cm and there was a reassuring fetal heart rate. Id. After returning from walking around the Hospital for about an hour to assist labor, Nichole's cervix was unchanged but the fetal heart rate was 120-110 with decreasing variability and late decelerations. CP 187, 189, 190. As it was after 5:00 p.m., Dr. Weaver was called and he and Nichole's doctor evaluated the fetal heart rate and decided to administer an IV and initiate continuous monitoring. CP 189, 190-91.

Before the IV was placed, Nichole went to the bathroom. CP 189, 191. When she returned and was placed back on the fetal monitor about 5:22 p.m., the fetal heart rate had dropped to 90. Id. With scalp stimulation, there was a brief increase in the fetal heart rate to the 100s, but then it dropped down into the 60s. Id. Plans were made for emergency C-section. Id. After discussion with Nichole's doctors, she and her husband gave their verbal consent to the emergency C-section. Id.

About 5:30 p.m., Dr. Vaughn, the pediatrician on call for the Hospital's neonatal resuscitation unit, was notified at her office that she

was needed at the hospital because an emergency C-section was going to be performed.² CP 245 (pp. 14-15). Dr. Vaughn immediately left for the hospital after notifying her staff and the office patient she had been seeing when she received the call from the hospital. Id.

Nichole was taken to the operating room at 5:36 p.m. CP 189, 191. Liam was born at 5:48 p.m. without a heart rate or spontaneous respiration. CP 189. Upon delivery, the placenta was consistent in appearance with placental abruption (separation of the placenta from the wall of the uterus and the maternal blood supply). CP 189; see CP 29.

Dr. Vaughn arrived in the operating room within minutes of Liam's birth. CP 244-45 (pp. 13-14). Initial resuscitation steps had already begun and, when Dr. Vaughn arrived, Liam was being oxygenated with bag and mask³ and was being given chest compressions. CP 79, 245 (p. 14), 246 (p. 20). Dr. Vaughn was told that there had most likely been a placental abruption. CP 245 (pp. 15-16).

² Dr. Vaughn specializes in pediatrics and has been licensed to practice medicine in Washington since 1989. CP 77-78. She is board certified by the American Academy of Pediatrics. CP 78. She is also certified in neonatal resuscitation by Neonatal Advanced Life Support (NALS) and in pediatric resuscitation by Pediatric Advanced Life Support (PALS). CP 78. She had last taken a newborn resuscitation class in November of 2003. CP 243 (p. 6).

³ There should be no difference between bag and mask ventilation and bag and endotracheal tube ventilation as far as achieving effective ventilation and oxygenation. CP 254 (p. 53), 257 (p. 62).

Dr. Vaughn took over the resuscitation. CP 78. Liam was intubated,⁴ and an IV was inserted in the umbilical vein. CP 79, 253-54 (pp. 47, 50). Volume (30 cc of normal saline) was given, as were four doses of epinephrine and, at 24 minutes of age, Dr. Vaughn was able to obtain a heart rate for Liam. CP 79. Had the final dose of epinephrine not been effective, Dr. Vaughn would have called the code. CP 246 (pp. 19-20). With the end of volume infusion and after giving the final dose of epinephrine, Dr. Vaughn would have worked through the flow sheet of steps to be taken in a neonatal resuscitation and exhausted all reasonable measures to resuscitate Liam. CP 246 (p. 20). The volume infusion and the final dose of epinephrine, however, worked and, at approximately 24 minutes of life, a heart rate was obtained. CP 79. Sodium bicarbonate was then given and Liam was taken to the special care nursery. CP 79.

Dr. Vaughn then spoke with a neonatologist at Emanuel Hospital and Health Center, and Liam was transported to Emanuel's neonatal intensive care unit. CP 79. There, Liam's parents declined a "Do Not Resuscitate" order. See CP 220, 222 (pp. 96-97, 126-27).

⁴ Liam's intubation was not an easy one. CP 246 (p. 20). Two attempts were made to intubate him, and intubation was accomplished at 5:57 pm. CP 253 (p.47). When asked whether it would have made a difference if Liam had been intubated earlier, Dr. Vaughn stated that effective ventilation can be achieved either through bag and mask or bag and ET tube. CP 254 (p. 53); see CP 257 (p. 62) (bagging a baby is equivalent to intubating in terms of getting oxygen in). Liam continued to be oxygenated during the resuscitation process. CP 249 (p. 32).

The resuscitation of Liam is and was a recognized health care emergency. CP 78, 260-61 (pp. 77-78). It was Dr. Vaughn's job, as part of the neonatal resuscitation team, to try to save Liam's life. CP 78. If the resuscitation had paused or delayed at any point, Liam would not have survived. CP 78.

Liam's mother, Nichole, had been placed under general anesthesia for the emergency C-section and was thus unconscious during the course of Liam's resuscitation. CP 78. At the time of the resuscitation, Dr. Vaughn did not know where Liam's father, Todd Graves, was because her attention was focused on the resuscitation.⁵ Id. Had Mr. Graves been brought into the operating room, Dr. Vaughn probably would have introduced herself and indicated that she was in the middle of an intense

⁵ Mr. Graves was waiting in a birthing center room. CP 226 (p.27). As the resuscitation continued, a nurse periodically came in and reported to Mr. Graves, and each time told him the amount of time that they had been working on Liam. CP 227 (p. 30). At eight minutes, the nurse told him that his son had been delivered, that they were continuing to work on resuscitating him, but that the resuscitation attempts had been unsuccessful to that point in time. CP 226 (pp. 28-29). The same nurse returned at 13 minutes, 17 minutes, and 22 minutes during the resuscitation efforts. CP 227 (p. 30). At the 17-minute point, she brought a chaplain. Id. According to Mr. Graves, the "whole event at Southwest was pretty overwhelming and shocking, and during the course of the nurse coming into our room, I said very little to her, if anything at all." CP 226 (pp. 28-29). At one point, however, he told the nurse that he wanted to talk to someone to give him more information and she responded that everyone was busy and she would try to find someone as soon as possible. CP 228 (p. 34). Shortly after the 22-minute report, the nurse came back to say that the team had gotten a heartbeat. CP 227 (p. 30). Mr. Graves cannot recall what he felt when he learned that Liam had a heart rate as there were so many emotions and he was in such a state of shock. CP 270-71. Once Liam was born and Mr. Graves was able to hold him and spend time with him, Mr. Graves was thankful for Liam's life and hopeful for his eventual outcome. CP 229 (p. 49).

situation. CP 250 (pp. 36-37). She would have spoken to him, but would not have been able to speak at length. Id. (p. 37). She “would have been focused on what [she] needed to do to try to save Liam’s life.” Id. She would not have had the time or any facts or figures at hand to present to Mr. Graves to enable him to give an appropriate and informed consent.⁶ CP 251 (p.38). As Dr. Vaughn explained, she did not know the statistics, and the resuscitation is “not something like you can take a five-minute break from and really discuss the issue.” CP 251 (p. 38).

Dr. Vaughn believes that Liam’s resuscitation is probably the only resuscitation she has done where an infant had Apgars of zero at one, five and ten minutes. CP 245 (p. 17). Dr. Vaughn has read of a child surviving with Apgars of zero at one, five and ten minutes, and may actually have had such a child in her practice. CP 247 (p. 22). In the case she was thinking of, the child did well and was able to go to regular classes in mainstream school, but may have had some learning issues. CP 247 (p. 23). At no time after Liam was born did Dr. Vaughn consider him dead or think that she was trying to resuscitate a still birth. CP 246-47 (pp. 21-22), 249 (p. 32), 258 (p. 66).

⁶ According to Mr. Graves, what he would have liked to have happen is “to have been informed thoroughly, extensively, what was going on, what the possible outcomes were, what does the research say that, you know, have results of cases like this.” CP 228 (pp 36-37). He also acknowledged, however, that the whole event was overwhelming and shocking, and that he was in a state of shock. CP 226 (pp. 28-29), 228 (p.34).

The steps Dr. Vaughn took during resuscitation followed the neonatal advanced life support (NALS) protocol for neonatal resuscitation. CP 79; see CP 242-43 (pp. 5-7). According to Dr. Vaughn, the standard of care required her to follow the flow chart for newborn resuscitation that contains appropriate steps for such resuscitation. CP 243 (p. 7), 245-46 (pp. 17-18). Every resuscitation is unique and not amenable to definition by a certain number of minutes. CP 248 (p. 26), 258 (p. 68).

Dr. Vaughn is aware of statements in the NRP book (concerning newborn resuscitation) that, after 10 minutes of asystole (no heart beat), a child is unlikely to survive or to survive without severe disability, CP 247 (p. 24), and that, after 15 minutes, discontinuation of resuscitative efforts may be appropriate. CP 248 (p. 26). Asked why the book would indicate that it may be appropriate to go 15 minutes if, after 10 minutes it's unlikely the infant will survive, or survive without severe disability, Dr. Vaughn replied that every resuscitation is unique and the physician is thinking of whether everything has been done for the patient. Id. As to the 10-minute or 15-minute guidelines, she has been taught that the physician has to look at each case individually, try to assess what is going on, and treat accordingly. CP 248 (p. 27). She believes that the NPR book also indicates that it is better to continue to resuscitate if the physician feels that the physician has not done everything that can be done

for the patient. CP 248 (p. 28). After 10 minutes of asystole, although there is a chance that the outcome might not be good, the doctor cannot say that for sure, and the doctor is in the midst of the resuscitation. CP 247 (p. 24).

According to Dr. Vaughn the standard of care for when to stop resuscitation is when one exhausts all reasonable methods. CP 249 (p. 31). She feels she would have violated the standard of care if she had stopped at 15 minutes without having done everything that could have been done for the baby.⁷ CP 258 (pp. 66-67). Dr. Vaughn is of the opinion that Liam's brain injury was caused by hypoxia/anoxia due to the placental abruption.⁸ CP 246 (p. 19).

C. Procedural Background.

Liam's parents, individually, and his mother, as his guardian ad litem, sued Dr. Vaughn, The Vancouver Clinic, and Southwest Washington Medical Center, alleging not only negligence in the course of Liam's resuscitation, but also negligence in, and lack of informed consent

⁷ When asked whether she would have followed the father's wishes if, hypothetically, Liam's father had known that there was a risk of death or severe damage after 10 minutes of asystole, and had told Dr. Vaughn after 15 minutes that he wanted her to stop the resuscitation, Dr. Vaughn indicated that she probably would have. CP 259 (p. 72). But, as Dr. Vaughn also indicated, in a case where you are involved in a resuscitation, there is typically neither the time nor the needed information to make such a "personal decision." See CP 260 (p. 76), 263 (pp. 86-88).

⁸ Dr. Vaughn formed that opinion after the event, when there was more time to reflect on the history and the lab work was available. CP 246 (p. 19).

to, Liam's continued resuscitation after 10 minutes. CP 1-15.

Defendants moved for summary judgment on grounds that plaintiffs lacked the requisite expert testimony for their negligence and informed consent claims. CP 28-39, 40-81. The Hospital also moved on the ground that it had no duty of informed consent, CP 33-35, and Dr. Vaughn and the Clinic, joined by the Hospital, moved on the ground that the circumstances of the resuscitation presented an emergency under which the patient's consent to treatment is implied, CP 45-48, citing *inter alia* RCW 7.70.050(4), which provides:

If a recognized health care emergency exists and the patient is not legally competent to give an informed consent and/or a person legally authorized to consent on behalf of the patient is not readily available, his consent to required treatment will be implied.

Dr. Vaughn and the Clinic also moved to dismiss plaintiffs' informed consent and negligence claims with respect to continued resuscitation on grounds that Washington does not and should not recognize a cause of action for alleged wrongful prolongation of life. CP 48-52.

Dr. Vaughn submitted an affidavit in support of her motion for summary judgment, CP 77-81, establishing her qualifications to testify in the field of pediatrics, including testifying as to the standard of care required of a pediatrician in the resuscitation of a newborn. CP 78. Among other things, she noted that the resuscitation of Liam was a

recognized health care emergency, that her job was to attempt to save Liam's life, and that if resuscitation had been paused or delayed at any point, Liam would not have survived. CP 78-79.

Plaintiffs responded, *inter alia*, with the declaration of Carl Bodenstein, M.D., CP 192-205, in which he opined, among other things, that the defendants violated the standard of care in the manner in which Liam was resuscitated, and that their failure to adequately resuscitate him caused brain damage to him. CP 194-95 (¶¶ 7-8), 198-200 (¶¶ 19-24). Dr. Bodenstein also opined that defendants violated the standard of care by failing to obtain Todd Graves' informed consent to continued resuscitation after 10 minutes,⁹ and by continuing to resuscitate Liam when no heart beat had been obtained within 15 minutes.¹⁰ CP 194-95 (¶ 7), 202-05 (¶¶ 33-42). According to Dr. Bodenstein, "the emergent circumstances of the resuscitation ceased after 10 minutes of resuscitative efforts with continued asystole."¹¹ CP 203 (¶ 36). In Dr. Bodenstein's

⁹ According to Dr. Bodenstein "the standard of care required Dr. Vaughn to involve Mr. Graves in the decision whether or not to continue resuscitative efforts inasmuch as he and his wife would be responsible to care for their severely brain damaged child assuming Liam survived as he did in this case." CP 202 (¶ 33).

¹⁰ Dr. Bodenstein's opinions concerning the continuation of resuscitation were apparently based on his view that the medical literature (for which he cited one 1991 study published in Pediatrics) indicates that resuscitation of newly born infant after 10 minutes of asystole is highly unlikely to result in survival or survival without severe physical and mental disabilities. CP 201 (¶ 28).

¹¹ Dr. Vaughn, however, testified in her deposition, which plaintiffs submitted in opposition to the summary judgment motion, that each resuscitation is unique and that

opinion, the failure to obtain Mr. Graves' informed consent to continued resuscitation after 10 minutes or to stop the resuscitation after 15 minutes "doomed Liam and his parents to a lifetime of severe disability requiring extensive medical, nursing and rehabilitative care over the course of Liam's lifetime" CP 195 (¶ 9). Dr. Bodenstein did not assert that the continued resuscitation after 10 or 15 minutes caused Liam's brain damage;¹² rather he opined that had defendants discontinued resuscitative efforts, "more likely than not, Liam would not have survived and his catastrophic injuries and extraordinary medical expenses would have been avoided." CP 195 (¶ 10).

Although plaintiffs conceded that "no one would assert that Defendants needed to obtain an informed consent before beginning resuscitation when Liam Stewart-Graves was delivered from the womb lifeless,"¹³ CP 169, they claimed that, after 10 minutes of resuscitation

she cannot imagine putting a minute time limit on it. CP 248 (p. 26); CP 258 (p. 68). There are no absolute times for when to call a code and the physician exercises judgment as he or she works mentally through the flow sheet of things to be done in a resuscitation. CP 246 (p. 21).

¹² His testimony was that "when Apgar scores are zero at one, five and 10 minutes of life, [Liam] had effectively no chance of avoiding certain severe brain damage and other devastating injuries if their efforts at resuscitation ultimately were successful" CP 202 (¶ 34).

¹³ As plaintiffs' counsel stated at the summary judgment hearing, RP 13:

There is no question that there was an emergency when that baby was born, there was a need to go in and attempt a resuscitation, because you don't know what the outcome is going to be at that point, you have no idea what the outcome is going to be.

efforts, there was no longer any emergency, CP 159, 169-70, and that Dr. Vaughn should have called Mr. Graves to the operating room where she was attempting to resuscitate Liam and obtain Mr. Graves' informed consent to continuing the resuscitation. CP 169-70. They asserted that Dr. Vaughn could have continued with resuscitation efforts while obtaining Mr. Graves' informed consent to continue or stop resuscitation, CP 167, and that Dr. Vaughn "had a duty under the standard of care to call the code at 15 minutes unless the family said to go forward."¹⁴ RP 26, see RP 36.

Plaintiffs also submitted the declaration of Mr. Graves, in which he stated that, if he had been told that, despite 10 minutes of resuscitative efforts, Liam had no heartbeat and that resuscitation of newborns after 10 minutes was unlikely to result in survival or survival without severe disability, he would have directed the code team to cease resuscitative efforts. CP 231-32. Mrs. Graves, in turn, stated in her declaration that she would have wanted her husband to do so.¹⁵ CP 234.

Plaintiffs also claimed in opposition to summary judgment that

¹⁴ Although plaintiffs' counsel asserted at the summary judgment hearing that the resuscitation handbook says to call the code at 15 minutes, see RP 27, the handbook does not say that a doctor must stop resuscitation at 15 minutes; rather it says resuscitation *may* be stopped at 15 minutes, see RP 37-38; CP 248 (p.26).

¹⁵ When asked in deposition whether she would have wanted resuscitation if her baby was going to have severe cerebral palsy, cognitive delays and attendant problems because

their claim was not a “wrongful prolongation of life” claim, but rather that both Liam and his parents were entitled to damages under the “wrongful life, wrongful birth” analysis in Harbeson v. Parke-Davis, Inc., 98 Wn.2d 460, 656 P.2d 483 (1983). CP 173-82.

In reply, Dr. Vaughn and the Hospital acknowledged that Dr. Bodenstein’s declaration raised an issue of fact as to alleged negligence in the steps taken in the course of resuscitation, but argued that the informed consent claims and the claim that Liam’s life was wrongfully prolonged by continued resuscitation should still be dismissed as a matter of law. CP 276-85, 286-90.

D. The Trial Court’s Decision.

The trial court, the Honorable John F. Nichols, issued a written opinion. CP 291-94. The trial court noted that plaintiffs had asserted three bases for the action: (1) alleged negligence in the resuscitation procedure, (2) failure of the doctor and Hospital to obtain informed consent to continue resuscitation, and (3) continuation of resuscitation beyond the “normal” period of time, which the court characterized as an issue concerning “the existence of a cause of action for ‘wrongful prolongation of life.’” CP 291.

of oxygen deprivation from the abruption, Mrs. Graves replied that she would want them to try five, maybe ten minutes at most. CP 222 (p. 128).

As to the first basis, defendants had acknowledged that Dr. Bodenstein's declaration was sufficient to create a genuine issue of material fact as to the claim of alleged negligence in the resuscitation procedure, and the trial court so ruled. CP 291. As for the remaining two bases for plaintiffs' action, concerning informed consent and the existence of a cause of action for "wrongful prolongation of life," the trial court found them intertwined. Id. The trial court determined that there was no obligation on the part of the Hospital to obtain informed consent. CP 292. The court also determined that plaintiffs were seeking to establish a wrongful prolongation of life cause of action, not recognized in Washington, and that to find that parents could decide not to continue efforts to resuscitate a newborn would be inconsistent with Washington law and statutes that allow the withholding of medical care only in extreme situations. CP 293-94

The trial court then entered orders denying defendants' motions on Count 1 (alleging negligence in the manner in which the resuscitation was performed), but granting defendants' motions on Counts 2 and 3 of the Complaint (alleging, on behalf of the parents and Liam, respectively, informed consent and negligence with respect to continuing the resuscitation). CP 295-98, 299-302; see CP 9-14 (Complaint). Plaintiffs thereafter dismissed without prejudice all unadjudicated claims, including

their claims of inadequate resuscitation, or negligence in the manner in which the resuscitation was performed, CP 303-04, and brought this appeal, CP 305-17.

III. STANDARD OF REVIEW

An order granting summary judgment is reviewed *de novo* and the appellate court engages in the same inquiry as the trial court, considering the facts in the light most favorable to the nonmoving party. Christensen v. Grant County Hosp. Dist. No. 1, 152 Wn.2d 299, 305, 96 P.3d 957 (2004) (citation omitted). Summary judgment is properly granted where there is no genuine issue of material fact and the moving party is entitled to judgment as a matter of law. Id. Questions of law presented on summary judgment are reviewed *de novo*. Coppernoll v. Reed, 155 Wn.2d 290, 296, 119 P.3d 318 (2005). An order granting summary judgment may be affirmed on any basis supported by the record. Id.

IV. ARGUMENT

The dismissal of plaintiffs' claims that defendants negligently failed to adequately resuscitate Liam, thereby causing him to sustain brain damage, is not at issue on this appeal. The trial court did not dismiss those claims on summary judgment. Instead, plaintiffs voluntarily dismissed them.

All that is at issue on this appeal is whether the trial court properly dismissed plaintiffs' claims that Dr. Vaughn, while performing Liam's emergency resuscitation, should have consulted Liam's father and allowed him to decide whether life-saving, or life-sustaining, resuscitative efforts should be stopped after 10 minutes, and that Dr. Vaughn and/or the Hospital were required to cease those life-saving and life-sustaining resuscitative efforts after 15 minutes (with or without parental consent), because it was possible, or even likely, that Liam had severe brain damage. The trial court properly viewed those claims as intertwined, requiring it to recognize a cause of action for alleged wrongful prolongation of life, a cause of action not previously recognized in Washington and inconsistent with Washington law allowing the withholding of life-sustaining treatment only in extreme situations.

A. Contrary to Plaintiffs' Assertions, Plaintiffs Have Not Stated a Cause of Action Under *Harbeson* for Wrongful Birth or Wrongful Life.

Even though there is no claim in this case that the Hospital or Dr. Vaughn, the pediatrician called to handle Liam's resuscitation following his emergency C-section delivery, owed or breached any duty to Liam's parents to do or refrain from doing anything that would have enabled them to prevent Liam's conception or his birth, plaintiffs go to great lengths, App. Br. at 10-11, 23-33, to try to bring their claims for allegedly

wrongful continued resuscitation within the rubric of causes of action for “wrongful birth” and “wrongful life” recognized in Harbeson v. Parke-Davis, Inc., 98 Wn.2d 460, 656 P.2d 483 (1983). In so doing, plaintiffs misperceive the nature of the duty found to exist in Harbeson, and ignore the very precise descriptions and carefully circumscribed scope of the “wrongful birth” and “wrongful life” causes of action recognized in Harbeson.

As described by the Harbeson court for purposes of its analysis, wrongful birth “refer[s] to an action based on an alleged breach of the duty of a health care provider to impart information or perform medical procedures with due care, where the breach is a proximate cause of the birth of a defective child.” Harbeson, 98 Wn.2d at 467. Recognizing the recent ability of medical science to predict the occurrence and recurrence of genetic defects, and the ability of diagnostic techniques such as amniocentesis to reveal defects in the unborn fetus, the Harbeson court phrased the issue it had to decide as “whether these developments confer upon potential parents the right to prevent, either before or after conception, the birth of a defective child.” Harbeson, 98 Wn.2d at 471-72. The court held that parents had such a right, giving rise to a duty on the part of health care providers correlative to that right “to impart to their patients material information as to the likelihood of future children’s being

born defective, to enable the potential parents to decide whether to avoid the conception or birth of such children,” and to perform with due care any medical procedures undertaken to avoid the conception or birth of defective children. Id. at 472.

The Harbeson court also recognized a cause of action for “wrongful life,” which it described as “the child’s equivalent” of the parents’ wrongful birth cause of action.¹⁶ Id. at 478-79. As the Harbeson court explained, in a “wrongful life” claim:

[t]he child does not allege that the physician’s negligence caused the child’s deformity. Rather, the claim is that the physician’s negligence--his failure to adequately inform the parents of the risk--has caused the *birth* of the deformed child. The child argues that *but for* the inadequate advice, it would not have been born to experience the pain and suffering attributable to the deformity. [Emphasis by court.]

Comment, “*Wrongful Life*”: *The Right Not To Be Born*, 54 Tul. L. Rev. 480, 485 (1980).

Harbeson, 98 Wn.2d at 478. The court added that “the physician’s negligence need not be limited to failure to adequately inform the parents of the risk,” but also included the “negligent performance of a procedure intended to prevent the birth of a defective child,” such as sterilization or

abortion. Id.

In analyzing the duty question presented in determining whether to adopt a “wrongful life” cause of action, the court recognized that, with a wrongful life action, “in every case the alleged negligent act will occur before the birth of the child, and in many cases . . . before the child is conceived.” Harbeson, 98 Wn.2d at 480. The court concluded, however, that the duty the parents’ health care providers owed to them, as patients, to adequately inform them of the risks of a future child being born defective and to perform with due care any procedures undertaken to avoid the conception or birth of a defective child, extended as well to the unborn or unconceived child.¹⁷ Id. at 480-81, 483. The court phrased the causation issue presented in a “wrongful life” action as “whether ‘[b]ut for the physician’s negligence, the parents would have avoided conception, or aborted the pregnancy, and the child would not have existed.’” Id. at 482-83 (citation omitted).

Thus, both the wrongful life and the wrongful birth causes of

¹⁶ Washington is one of very few jurisdictions to have adopted a “wrongful life” cause of action. See Willis v. Wu, 362 S.C. 146, 607 S.E.2d 63, 68-69 and n.3 (2004), and cases cited therein.

¹⁷ Contrary to plaintiffs’ assertions, App. Br. at 24, the Harbeson court did not premise the “wrongful life” cause of action on any “recognized right of the child not to be born into a life of suffering from mental and physical disabilities.” The only right found by the Harbeson court was the right of the parents, as patients, to prevent the birth of a defective child, which gave rise to a correlative duty on the part of the parents’ health

action adopted in Harbeson are based on (1) the right of parents to prevent, before or after conception, the birth of a defective child; (2) the existence of a duty on the part of health care providers correlative to that right to adequately inform their patients (the parents) of the risks of having defective children and to perform with due care any procedure undertaken to avoid the conception or birth of defective children, and (3) the fact that, but for the parents' health care provider's alleged negligence in failing to adequately inform or failing to exercise due care in the performance of any sterilization or abortion procedure, the parents would have avoided conception or aborted the pregnancy, and the child would not have been born. That is not what is at issue on this appeal.

Here, there is no claim that Dr. Vaughn or the Hospital did or failed to do anything that prevented the Stewart-Graves from exercising any right they had to prevent the conception or birth of a defective child. Indeed, Dr. Vaughn was neither parent's physician and had no involvement in the prenatal or labor and delivery care. Liam was her patient. That parents, as patients, have a right under Harbeson to prevent, before or after conception, the birth of defective child does not mean that, once a viable child is born, the parents, who are not the patients, have an

care providers to adequately inform them concerning the risks of birth defects and to perform with due care any procedure undertaken to avoid conception or birth.

unfettered right to allow the child to die by withholding or terminating life-saving or life-sustaining treatment. Nothing in Harbeson stands for the proposition that, once their child is born, parents have an unfettered right (or the child's health care providers have a correlative duty) to withhold or withdraw life-saving or life-sustaining treatment from the child, and thereby allow the child to die, simply because the child may, or even likely will, have brain damage or be defective in some other respect.

Plaintiffs' attempt to extend Harbeson well beyond its carefully circumscribed limits is not warranted. The claims they make in this case do not fall within either the "wrongful birth" or "wrongful life" causes of action recognized in Harbeson. Rather, their claims are claims for "wrongful prolongation (or wrongful saving) of life" – claims which the trial court properly concluded were not recognized in Washington and were inconsistent with Washington law allowing the withholding of life-sustaining treatment only in extreme situations.

B. Washington Courts Have Not and Should Not Recognize a Cause of Action for Alleged Wrongful Prolongation of a Viable Newly Born Infant's Life.

The essence of plaintiffs' claims is that, after Liam was born and had undergone 10 to 15 minutes of undisputedly necessary emergency resuscitative efforts, defendants should have stopped, or Dr. Vaughn should have consulted Liam's father and allowed him to decide whether to

stop, life-saving resuscitative measures and allow Liam to die, based on the potential, or even the likelihood, that Liam had severe brain damage. That is the equivalent of a “wrongful prolongation of life” claim, which has not been, and for sound public policy reasons should not be, recognized in Washington.

1. The court in *Benoy* has already refused to recognize a claim for wrongful prolongation of life by analogy to *Harbeson*.

The only Washington court that has been asked to recognize a claim for wrongful prolongation of life has refused to do so. *Benoy v. Simons*, 66 Wn. App. 56, 831 P.2d 167, rev. denied, 120 Wn.2d 1014 (1992). In *Benoy*, a 16-year-old girl gave birth by emergency C-section at Kadlec Medical Center to a premature baby, Dustin, who suffered from severe respiratory distress syndrome. Id. at 59. While in intensive care, Dustin developed a pneumothorax and an intracranial hemorrhage with intracerebral hemorrhage which required surgical intervention. Id. He was kept on a ventilator at Kadlec, but his condition worsened. Id. at 60. He was then transferred to Children’s Orthopedic Hospital in Seattle where he was removed from the ventilator and died at approximately six weeks of age. Id. The Benoy’s, the parents of the 16-year-old mother, individually, as the mother’s guardian, and as the personal representative of Dustin’s estate, sued Kadlec and Dr. Simon, the neonatologist at

Kadlec, *inter alia* for medical negligence, lack of informed consent, outrage and intentional infliction of emotional distress. Id.

The Benoy's urged the court to recognize a new cause of action for wrongful prolongation of life under the theory of medical negligence or lack of informed consent because Dustin had been placed on a ventilator without their informed consent. Id. at 62. In much the same way that plaintiffs here attempt to base their claims by analogy to Harbeson, see App. Br. at 23-33, so the Benoy's argued that the court's reasoning in Harbeson should by analogy allow for a wrongful prolongation of life cause of action. Id.

The Benoy court, however, found the analogy to Harbeson unsound, reasoning:

The analogy is unsound because Harbeson, [98 Wn.2d] at 473, is based on recognition that parents have a right to prevent the birth of a defective child and health care providers have a duty to the parents correlative to that right.

Harbeson recognized two different logical grounds for wrongful birth actions. The first is an action based upon informed consent: breach of a duty to impart material information to the parents of the likelihood of future children being born defective, to enable the potential parents to decide whether to avoid conception or birth of such children. The second is an action based upon the standard of care: breach of the duty to perform with due care medical procedures on the parents, undertaken to prevent the conception or birth of defective children. Harbeson, [98 Wn.2d] at 472. Neither is applicable here. Dustin was the patient.

Id. Moreover, as the Benoy court noted in rejecting the Benoy's informed consent claim, "[t]he Benoy's did not establish that Dustin, the patient, was injured as result of the placement on the ventilator." Benoy, 66 Wn. App. at 61. And, as the Benoy court noted in rejecting the Benoy's claims for failure to terminate life support based on outrage and intentional infliction of emotional distress theories, "the Benoy's failed to show Dr. Simon acted other than in conformance with his professional obligation to preserve the life of his patient." Id. at 64.

Plaintiffs attempt to distinguish Benoy by suggesting that the Benoy court somehow "ignored Harbeson's adoption of a wrongful life cause of action, which belongs to the infant, and focused solely on wrongful birth action, which belongs to the parents." App. Br. at 33. That attempt is misguided at best.

The wrongful life cause of action recognized in Harbeson is merely "the child's equivalent" of the parent's wrongful birth cause of action. Harbeson, 98 Wn.2d at 478. Both causes of action arise out of breaches of duty owed to the parents, as patients – either breach of a duty to impart material information to enable the parents to avoid the conception or birth of a defective child or breach of a duty to perform with due care procedures on the parents that are undertaken to avoid the conception or birth of a defective child. Id. at 472.

Thus, where as here, Dr. Vaughn and the Hospital owed no duty to the parents to do or refrain from doing anything that would have enabled the parents to prevent Liam's conception or birth, and Liam, not either of his parents, was Dr. Vaughn's and the Hospital's patient for purposes of the life-saving resuscitative treatment they provided to Liam, neither the parents' wrongful birth nor the child's equivalent wrongful life cause of action recognized in Harbeson applies. There is no showing that Dr. Vaughn or the Hospital acted other than in conformance with their professional obligation to preserve the life of their patient, Liam, or that the continuation of their efforts to successfully resuscitate him caused his brain damage. The Benoy court's reasoning is sound. Neither directly nor by analogy, does Harbeson provide support for recognizing an action for alleged wrongful prolongation of life.

2. Adoption of a wrongful prolongation of life cause of action in this case would be inconsistent with Washington law allowing the withholding or withdrawal of life-sustaining treatment only in extreme circumstances.

Under Washington law, life-sustaining treatment may be withheld or withdrawn only in certain limited circumstances. For example, under Washington's Natural Death Act, RCW Ch. 70.122, a competent adult person may execute a directive directing the withholding or withdrawal of life-sustaining treatment in the event that the adult person is diagnosed to

be in a terminal condition¹⁸ by the attending physician, or in a permanent unconscious condition¹⁹ by two physicians. RCW 70.122.030(1) provides in pertinent part:

Any adult person may execute a directive directing the withholding or withdrawal of life-sustaining treatment in a terminal condition or permanent unconscious condition.

...

RCW 70.122.030(2) provides, in turn, that:

Prior to withholding or withdrawing life-sustaining treatment, the diagnosis of a terminal condition by the attending physician or the diagnosis of a permanent unconscious state by two physicians shall be entered in writing and made a permanent part of the patient's medical records.

Even with such an executed directive, however, a health care provider cannot be required by law to participate in the withholding or withdrawal of life-sustaining treatment if the health care provider objects to doing so.

RCW 70.122.060(4) provides:

No nurse, physician, or other health care practitioner may be required by law or contract in any circumstances to participate in the withholding or withdrawal of life-sustaining treatment if the person objects to so doing. No person may be discriminated against in employment or

¹⁸ “‘Terminal condition’ means an incurable and irreversible condition caused by injury, disease, or illness, that, within reasonable medical judgment, will cause death within a reasonable period of time in accordance with accepted medical standards, and where the application of life-sustaining treatment serves only to prolong the process of dying.” RCW 70.122.020(9).

¹⁹ “‘Permanent unconscious condition’ means an incurable and irreversible condition in which the patient is medically assessed within reasonable medical judgment as having no reasonable probability of recovery from and irreversible coma or a persistent vegetative state.” RCW 70.122.020(6).

professional privileges because of the person's participation or refusal to participate in the withholding or withdrawal of life-sustaining treatment.

The Natural Death Act does not provide the exclusive method for withholding or withdrawing life-sustaining treatment. In re Guardianship of Hamlin, 102 Wn.2d 810, 816, 689 P.2d 1372 (1984). By its terms, it is limited to persons of sound mind and, thus, does not apply to incompetent persons. Id. "An incompetent person does not lose his right to consent to termination of life supporting care by virtue of his incompetency." Id.

Thus, in In re Welfare of Colyer, 99 Wn.2d 114, 660 P.2d 738 (1983), the Washington Supreme Court affirmed a trial court's grant of a husband's petition to have life support removed from his 69-year-old wife who was in a persistent vegetative state and unable to breathe on her own. As noted in In re Guardianship of Ingram, 102 Wn.2d 827, 689 P.2d 1363 (1984), the Colyer court, in its post-order decision, distinguished between proposed treatment that may cure or prolong the life of the patient, and proposed treatment that would merely prolong the dying process, and further "made clear that it was not deciding the proper procedure for cases involving life prolonging or curative treatments." Ingram, 102 Wn.2d at 835 (citing Colyer, 99 Wn.2d at 127-28).

In Hamlin, the patient, blind and severely retarded since birth, suffered a heart attack at the age of 42, was resuscitated, but was thereafter

in a vegetative state with no evidence of neurological activity above the brainstem. Hamlin, 102 Wn.2d at 813. After his guardian refused to authorize withdrawal of the mechanical ventilator without a court order, the hospital petitioned for an order so authorizing. Id. The trial court appointed a guardian ad litem and later authorized the withdrawal of the ventilator with the parties all stipulating that such should not occur until after appeal. Id. at 813-14. The court noted that among the guardian's statutory duties was the duty "to care for and maintain the incompetent or disabled person, assert his or her rights and best interests, and provide timely, informed consent to necessary medical procedures." Id. at 814 (quoting RCW 11.92.040(3)).

Thus, the guardian has the duty and, therefore, the power to act in the best interests of the ward, to assert the ward's rights, and participate in medical decisions. Just as medical intervention is, in the majority of cases, clearly in the best interests of the ward, nonintervention in some cases may be appropriate and, therefore, in the ward's best interest. We emphasize that these decisions must be made on a case-by-case basis with *particularized consideration of the best interests and rights of the specific individual*. We also stress the distinction between treatment which is expected to result in some measure of recovery and that which merely postpones death. See, e.g., Superintendent of Belchertown State Sch. v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977); In re Storar, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266 (1981). [Emphasis by the court.]

Hamlin, 102 Wn.2d at 815. In allowing the guardian to consent to termination of life support, the court discussed extensively the procedural safeguards that must be followed in making such a momentous decision for an incompetent. Id. at 816-20. The court noted that, before such a decision could be made, the attending physicians must first make a medical diagnosis, which the prognosis committee must then unanimously approve, that the incompetent patient is in a persistent vegetative state with no reasonable chance to recover and that the patient's life is being maintained by life support systems. Id. at 819. While not requiring court intervention in most cases, the court required the unanimous agreement of the immediate family, the treating physicians, and the prognosis committee. Disagreement among family members as to the incompetent's wishes or among the physicians as to prognosis, or certain other circumstances would require court intervention. Id. at 819-21.

The court, in In re Guardianship of Grant, 109 Wn.2d 545, 747 P.2d 445 (1987), allowed a parent to consent to withhold life sustaining treatment, including nutrition and hydration,²⁰ from her daughter who had been institutionalized since the age of 14 due to deterioration from Batten's disease – a genetic, neurological, degenerative condition of the

²⁰ As later revised, In re Guardianship of Grant, 757 P.2d 534 (1988), only four justices agreed to the withdrawal of nutrition and hydration. See Grant, 109 Wn.2d at 546, 574.

central nervous system from which most victims die in their teens or early twenties. See id. at 547. The daughter continued to deteriorate and, when the daughter was approximately age 21 or 22, her mother moved to have her life support removed. The Grant court reversed the trial court, who had found the motion premature because the daughter was not yet in a coma or persistent vegetative state. The Grant court held that:

[I]n the absence of countervailing state interests, a person has the right to have life sustaining treatment withheld where he or she (1) is in an advanced stage of a terminal and incurable illness, and (2) is suffering severe and permanent mental and physical deterioration. We have previously indicated four state interests which might militate against allowing the exercise of this right in any particular case. Those interests are: (1) the preservation of life; (2) the protection of interests of innocent third parties; (3) the prevention of suicide; and (4) the maintenance of the ethical integrity of the medical profession. In re Colyer, 99 Wn.2d 114, 122, 660 P.2d 738 (1983). None of these interests are present here.

Grant, 109 Wn.2d at 556. In particular, the court noted, id. at 556:

The State's interest in preserving life may require *lifesaving* treatment for patients who have not consented to it being withheld. This interest weakens considerably, however, if treatment will merely postpone death for a person with a terminal and incurable condition. [Emphasis by the court.]

The Grant court set forth several procedural safeguards or criteria that had to be met before a decision, without prior court authorization, to withhold an incompetent's life-sustaining treatment could be carried out. Id. at 565-68. In particular, as the court explained:

We hold that prior court authorization to withhold life sustaining treatment shall not be required where all the following circumstances are present:

1. The incompetent patient's attending physician, together with two other physicians qualified to assess the patient's condition, determine with reasonable medical judgment that the patient is in an advanced stage of a terminal and incurable illness and is suffering severe and permanent mental and physical deterioration.
2. The incompetent patient's legal guardian, if one has been appointed determines [or, if no guardian has been appointed, the patient's immediate family members agree] that either (a) the patient, if competent, would choose to refuse life sustaining treatment; or (b) if such a determination cannot be made, the guardian determines [or the immediate family members agree] that the withholding of life sustaining treatment would be in the best interests of the patient;
3. No members of the incompetent patient's immediate family object to the decision to withhold such treatment; and
4. Neither the patient's physicians nor the health care facility responsible for the care of the patient object to the decision to withhold such treatment.

Id. at 566-67 (footnotes omitted). The court further reiterated what the

Natural Death Act also provides, see RCW 70.122.060(4), that:

No health care provider should be required to participate in the withholding or withdrawing of life sustaining treatment if such an action or actions would be contrary to the dictates of their conscience or belief. . . .

Grant, 109 Wn.2d at 567 n. 6.

In each of these cases, the decision to allow withdrawal of life support was deliberate and considered, and involved procedures designed to ensure that the best decision would be made.²¹ Contrary to plaintiffs' suggestion, App. Br. at 13, cases like Hamlin and Grant do not support plaintiffs' claim that Dr. Vaughn and the Hospital should be held liable for saving Liam's life, especially under the circumstances.

Plaintiffs have conceded, App. Br. at 13-14, 36; CP 169; RP 13, that emergency resuscitation was necessary and proper, and that the continuation of such emergency resuscitation measures remained necessary and proper for at least the first 10 minutes without any need to obtain parental consent.²² None of the procedural safeguards delineated in the Natural Death Act, or in the cases allowing for the withholding or withdrawal of life-sustaining treatment, were present here either at the outset or after 10 or 15 minutes of resuscitative efforts. Neither Dr.

²¹ In re Guardianship of Ingram, 102 Wn.2d 827, 689 P.2d 1363 (1984), did not involve a choice between life or death. There, because the guardian did not feel he could make such a decision, the court considered whether an incompetent, due to mental illness, could choose to have radiation for her laryngeal cancer, instead of surgery that would deprive her of her vocal cords but would be more effective in treating the cancer. Although suffering from delusions, the incompetent was alert, had fluent speech, and was generally goal-directed. The trial court had ordered the surgery, but the Supreme Court reversed, finding that the patient could choose between two curative treatments even though one was likely to be more effective than the other. Ingram, 102 Wn.2d at 843.

²² According to Dr. Bodenstein, defendants violated the standard of care when they failed to obtain Todd Grave's informed consent to continued resuscitation after 10 minutes, and continued to resuscitate Liam after 15 minutes of asystole. CP 194-95 (¶ 7), 202-05 (¶¶ 33-42).

Vaughn nor any other physician had made a medical judgment that Liam was in persistent vegetative state, or in an advanced stage of terminal and incurable illness and was suffering severe and permanent mental and physical deterioration as a result. Whether Liam in fact had brain damage or the extent to which his brain damage, if any, would impair him was not known at the time that Dr. Vaughn was performing emergency resuscitation in an effort to save Liam's life.

Neither the Natural Death Act, nor the cases allowing for the withholding or withdrawal of an incompetent person's life-sustaining treatment under carefully circumscribed conditions, authorize the withholding, stoppage, or withdrawal of life-saving treatment, simply because a newly born viable infant may have, or even likely has, brain damage or some other defective condition. Nor do the Natural Death Act, or the cases allowing the withholding or withdrawal of an incompetent person's life-sustaining treatment, impose some correlative duty on a physician or Hospital attending a viable, newly born infant following an emergency C-section to participate in the withholding or withdrawal of life-saving or life-sustaining treatment especially when they do not believe, as Dr. Vaughn did not believe in this case, that she had exhausted all reasonable methods to save Liam's life. The continued resuscitative

efforts in this case were by no means medically futile. In fact, they saved Liam's life.

The circumstances presented here are fundamentally different from the circumstances presented in the guardianship cases, where a thoughtful and considered decision can and should be made. Washington is one of only a few jurisdictions that has gone so far as to characterize life as an injury when a defective infant's parents were deprived of their right, as patients, to prevent the conception or birth of a defective child. This Court should go no further and should not presuppose that allowing a viable newly born infant to die is a legally viable alternative on the mere expectation, or even likelihood, that the infant will, in some as yet unquantifiable way, be a defective person.

3. Allowing a cause of action for the alleged wrongful prolongation of a viable newly born infant's life is bad public policy.

Holding health care providers liable for saving or prolonging the life of viable newly born infant is not only inconsistent with Washington law prescribing the circumstances under which life-saving or life-sustaining treatment may be withheld or withdrawn, but also is contrary to sound public policy. As the court noted in Grace Plaza v. Elbaum, 588 N.Y.S.2d 853, 183 A.D.2d 10 (N.Y. App. Div. 2d Dep't 1992), aff'd, 82

N.Y.2d 10, 623 N.E.2d 513 (1993), “scant support” for such a result exists even in those states that allow for surrogate decision-making.

Even in these States, in which the right to die is broader than in New York, “the law will not require the medical profession to yield to private demands of surrogate decision makers” (Westhart v Mule, 213 Cal App 3d 542, 261 Cal Rptr 640, 646 [Crosby, Acting P. J., concurring] [depublished]). It has also been held, in these other jurisdictions, that no medical professional may be compelled to violate his own medical ethics by being forced to remove a feeding tube from an incompetent patient, unless the patient’s conservator proves the total unavailability of any physician willing to do so (see, Brophy v New England Sinai Hosp., *supra* [, 398 Mass 417, 497 NE2d 626]; Conservatorship of Morrison, 206 Cal App 3d 304, 307, 253 Cal Rptr 530). In some of these States, it has been held that no cause of action for battery may be maintained against a medical professional who continues to provide treatment to a patient over the objections of the patient’s family (see, McVey v Englewood Hosp. Assn., 216 NJ Super 502, 524 A2d 450; see also, Benoy v Simons, 66 Wash App 56, 831 P2d 167; Bartling v Glendale Adventist Med. Ctr., 184 Cal App 3d 961, 229 Cal Rptr 360; cf., Estate of Leach v Shapiro, 13 Ohio App 3d 393, 469 NE2d 1047; Young v Oakland Gen. Hosp., 175 Mich App 132, 437 NW2d 321).

Grace Plaza, 183 A.D.2d at 16-17.

The Wisconsin Court of Appeals, in Montalvo v. Borkovec, 256 Wis. 2d 472, 647 N.W.2d 413, *rev. denied*, 653 N.W.2d 890 (Wis. App. 2002), *cert. denied*, 538 U.S. 907 (2003), has perhaps best articulated the public policy considerations that militate against recognizing causes of action against health care providers for an alleged wrongful resuscitation

of a viable newly born infant. In Montalvo, Emanuel, a premature infant of a little over 23 weeks of gestation, was delivered by emergency C-section and a neonatologist successfully performed life-saving resuscitation. Montalvo, 647 N.W.2d at 415-16. Emanuel's parents and guardian ad litem sued, among others, the neonatologist, claiming that he failed to properly obtain informed consent relating to the resuscitation efforts. Id. at 417. The trial court ruled that that claim was not legally cognizable and the Wisconsin Court of Appeals affirmed. Id. at 417, 421.

In so doing, the Wisconsin Court of Appeals rejected the notion that informed consent was an option under the circumstances, stating:

First, requiring the informed consent process here presumes that a right to decide not to resuscitate the newly born child or to withhold life-sustaining medical care actually existed. This premise is faulty. . . .

Id. at 418. The court noted that there was no evidence that the infant was in a persistent vegetative state and that, under Wisconsin common law, “in the absence of a persistent vegetative state, the right of a parent to withhold life-sustaining treatment from a child does not exist.”²³ Id. at

²³ In addition to relying on Wisconsin common law governing the withholding or withdrawing of life-sustaining treatment, the Montalvo court also cited the existence of the United States Child Abuse Protection and Treatment Act (CAPTA) of 1984, 42 U.S.C. § 5101 et. seq., in concluding that “[t]he implied choice of withholding treatment, proposed by plaintiffs, is exactly what CAPTA prohibits.” Montalvo, 647 N.W.2d at 419. Contrary to plaintiffs’ suggestion, App. Br. at 35, the mere fact that CAPTA is not at issue in this case, does not render the Montalvo court’s public policy reasoning inapposite or unsound.

419. Because the infant's parents did not have the right to withhold or withdraw immediate post-natal life-saving care from him, the court concluded that "no viable alternative health treatment existed to trigger the informed consent process." *Id.* The court quoted from Iafelice v. Zarafu, 221 N.J. Super. 278, 534 A.2d 417, 418 (App. Div. 1987), noting that the New Jersey Appellate Division had "examined the exact same issue . . . and exclaimed:"

The mistaken premise of this appeal is that allowing the child to die untreated was a legally viable alternative . . . we find no support for the belief that a newborn child may be put to death through [allowing a natural delivery with no resuscitation efforts upon birth] on the mere expectation that she will, in some unquantified way, be a defective person. As the Supreme Court wrote in Berman v. Allan, 80 N.J. 421, 430, 404 A.2d 8 (1979), "It is life itself, that is jealously safeguarded, not life in a perfect state."

Montalvo, 647 N.W.2d at 419 n.4.

The trial court in Montalvo had recognized that the resuscitation of the newborn infant was "a life or death or situation," that the child was not breathing, and that "any amount of loss of oxygen could be devastating to the child," and that "[w]hat the doctors did was save this child's life." *Id.* at 420. On public policy grounds, the trial court concluded:

Protection of children is something that the community has an interest in, and a parent does not have the right to withhold necessary emergency treatment, and I agree entirely that had the doctors acted in any other way they would face not only . . . civil cases against them but

possibly criminal cases. We simply can't say that the possibility that this child could be disabled or even the probability if it is that strong is sufficient to withhold life-saving measures and decide this child does not deserve to live.

Id. The Wisconsin Court of Appeals agreed, noting that, in appropriate circumstances: "Wisconsin courts have not hesitated to dismiss complaints on public policy grounds, particularly where allowing recovery would place an unreasonable burden on physicians or where allowing recovery would provoke an exercise that has no sensible or just terminal point." Id. at 421. The Montalvo court reasoned that:

The physicians involved in the resuscitation measures could be faced with a "damned if you do, damned if you don't" dilemma. . . . If treating physicians can be sued for failing to resuscitate a baby they feel is not viable, and for resuscitating a viable baby such as Emanuel, they are placed in a continuing "damned" status. The public policy of Wisconsin does not tolerate such a "lose-lose" enigma.

If the parents' claim is allowed to proceed, courts will be required to decide which potential imperfections or disabilities are . . . "worse than death." They will have to determine which disability entitles a child to live and which disability allows a third-party surrogate to withhold or withdraw life-sustaining treatment with the intent to allow a disabled person to die. This determination could vary greatly based on the parents' beliefs. One set of parents may view a particular disability as "worse than death," while another set of parents would not. Such a process, not unreasonably, has kaleidoscopic, unending implications. The trial court did not err in reaching its conclusion based upon public reasons.

Id. (citations omitted).

The public policies elucidated by the Montalvo court are equally applicable here and plaintiffs' efforts to try to distinguish Montalvo away are unavailing. Indeed, plaintiffs' asserted distinctions are nothing more than distinctions without a difference.

Contrary to plaintiffs' assertions, App. Br. at 35, the fact that Wisconsin law limits the right to refuse life-sustaining treatment to persons in a persistent vegetative state, while Washington also confers that right on persons in a permanent unconscious condition and persons suffering a terminal condition, does not render the Montalvo court's reasoning inapposite or unsound. Here, there is no evidence that, at the time of the resuscitation, Liam was in any of the conditions that the legislature or the courts have indicated might allow for withholding or withdrawal of life-saving or life-sustaining treatment. As previously noted at page 33, none of the procedural safeguards set forth in the Natural Death Act, or in the cases allowing for the withholding or withdrawal of life-sustaining treatment from incompetent persons, were present in this case at the time that Dr. Vaughn successfully resuscitated Liam.

Nor, see App. Br. at 36, does the fact that plaintiffs, unlike the plaintiffs in Montalvo, are not contending that emergency resuscitation measures should not have been initiated immediately upon Liam's delivery without their consent, but are contending only that they should

not have been continued without their consent after ten minutes, render the Montalvo court's reasoning inapposite or unsound. Whether it was immediately after the delivery, or ten minutes later, the fact remains that Liam was in a life or death situation. He was not breathing. Under Washington law, his parents did not have the right to withhold or withdraw life-saving or life-sustaining treatment from him. In the words of the Montalvo court, 647 N.W.2d at 420: "Failure to treat was tantamount to a death sentence."

Attaching liability to a physician's decision to continue (or to stop) resuscitation when one set of parents might view the possible (or even likely) risk that a newborn may have some, as yet unquantifiable, amount of brain damage as a fate "worse than death," while another set of parents would not, or when one expert might say that resuscitation should always be stopped after 15 minutes, while another expert would say that resuscitation should continue until all reasonable measures have been exhausted and it is clear that further steps will be medically futile, would place the physician in an unwarranted and untenable "damned if you, damned if you don't" position. Sound public policy dictates against countenancing such a "lose-lose" situation.

Making physicians liable for saving lives is bad public policy, and puts physicians in an untenable position. Suppose that resuscitation were

stopped after 10 or 15 minutes, as Mr. Graves testified he would have requested. What if the mother, who was then under anesthesia, later disagreed? What is the likelihood of a suit for a failure to complete all accepted protocols, which Dr. Vaughn was attempting to do, but had not yet completed within the 10-15 minutes plaintiffs would like to have a jury impose as an outside limit for continued resuscitation in this case?

The trial court's dismissal of plaintiffs' wrongful prolongation of life claims, whether premised on allegations of negligence or failure to obtain informed consent, was proper under existing law and sound public policy principles. The trial court's dismissal of plaintiffs' claims concerning the alleged wrongful continuation of resuscitation should be affirmed.

C. Plaintiffs' Claim Against Dr. Vaughn and The Vancouver Clinic Based on Dr. Vaughn's Allegedly Negligent Failure to Obtain Informed Consent to Liam's Continued Resuscitation Was Properly Dismissed for at Least Two Additional Reasons.

Plaintiffs assert, App. Br. at 12, that they stated a cause of action against Dr. Vaughn and The Vancouver Clinic based on Dr. Vaughn's failure to obtain their informed consent to the continuation of resuscitation efforts beyond 10 minutes.²⁴ In addition to the reasons discussed above

²⁴ Plaintiffs have not assigned error to the trial court's dismissal of their informed consent claim against the Hospital, nor have they presented any argument concerning it in their opening brief. Plaintiffs have therefore waived any issue on appeal with respect to the dismissal of that claim. E.g., Cowiche Canyon Conservancy v. Bosley, 118 Wn.2d 801,

(including the fact that such a claim erroneously presupposes that, under existing law, the parents had the right to dictate the withholding or withdrawal of life-saving or life-sustaining treatment from Liam after 10 minutes of resuscitative efforts, which they did not), there are at least two other reasons why plaintiffs' informed consent claim was properly dismissed.

First, under RCW 7.70.050(1)(d),²⁵ a necessary element of proof of a claim based on failure to obtain informed consent is “[t]hat the treatment in question proximately caused injury *to the patient*.” (Emphasis added.)

809, 828 P.2d 549 (1992). Even if they had raised the issue on appeal, Washington law is clear that hospitals do not have a duty to obtain informed consent from their patients absent extraordinary circumstances. Howell v. Spokane & Inland Empire Blood Bank, 114 Wn.2d 42, 56, 785 P.2d 815 (1990); Burnet v. Spokane Ambulance, 54 Wn. App. 162, 170, 772 P.2d 1027, rev. denied, 113 Wn.2d 1005 (1989); Alexander v. Gonser, 42 Wn. App. 234, 239, 711 P.2d 347 (1985), rev. denied, 105 Wn.2d 1017 (1986).

²⁵ RCW 7.70.050(1) provides:

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

- (a) That the health care provider failed to inform the patient of a material fact or facts relating to the treatment;
- (b) That the patient consented to the treatment without being aware of or fully informed of such material fact or facts;
- (c) That a reasonably prudent patient under similar circumstances would not have consented to the treatment if informed of such material fact or facts;
- (d) That the treatment in question proximately caused injury to the patient.

Here, plaintiffs presented no evidence that the treatment in question – continuation of resuscitation efforts beyond 10 minutes – caused Liam’s brain damage or any other injury. To the contrary, it saved his life. Even Dr. Bodenstein did not assert that the continued resuscitation beyond 10 minutes caused Liam’s brain damage. His testimony was that “when Apgar scores are zero at one, five and 10 minutes of life, [Liam] had effectively no chance of avoiding certain severe brain damage and other devastating injuries if their efforts at resuscitation ultimately were successful” CP 202 (¶ 34). Thus, according to Dr. Bodenstein, Liam’s brain damage was likely present at the 10-minute mark, and the failure to obtain Mr. Graves’ informed consent to continued resuscitation after 10 minutes “doomed Liam and his parents to a lifetime of severe disability” CP 195 (9). The only alternative, however, was Liam’s death. Saving Liam’s life – which is what the treatment in question “proximately caused” – does not constitute an injury.

Second, to the extent that any duty to obtain informed consent may exist in a case like this, where the “[f]ailure to treat was tantamount to a death sentence,” Montalvo, 647 N.W.2d at 420, RCW 7.70.050(4) sets forth an exception to the duty to obtain informed consent where the patient is incompetent and a recognized health care emergency exists. RCW 7.70.050(4) provides:

If a recognized health care emergency exists and the patient is not legally competent to give informed consent, and/or a person legally authorized to consent on behalf of the patient is not readily available, his consent to required treatment will be implied.”

Here, plaintiffs do not dispute that a recognized health care emergency existed necessitating the initiation of resuscitative efforts. They conceded that an emergency existed and that no informed consent was needed “before beginning resuscitation when Liam was delivered from the womb lifeless.” CP 169; see also RP 13; App. Br. at 14. Instead, plaintiffs and their expert asserted that, even though the circumstances had not changed (Liam still had no spontaneous heart rate) and the failure to treat remained tantamount to a death sentence, any emergency ceased to exist after 10 minutes. That conclusory, illogical, and nonsensical assertion is not enough to create any genuine issue of material fact, especially when Liam would have died had resuscitative efforts been paused or delayed.

Plaintiffs also assert, App. Br. at 14, that even if Liam’s health care emergency continued to exist throughout the duration of the resuscitation efforts, the emergency exception does not apply because Todd Graves was waiting in a birthing room at the hospital and thus “readily available.” But, “readily available” has to mean more than physically in the vicinity, and should be considered in light of the practicalities of the existing health

care emergency and the ability of the physician to impart the information needed for the parent to provide a truly informed consent. Here, Mr. Graves testified that the whole event was “overwhelming and shocking” and that he was in a state of shock. CP 226 (pp. 28-29). Dr. Vaughn testified that, even if Mr. Graves had been brought into the operating room, she would not have had the time or any facts or figures at hand to present to Mr. Graves to enable him to give an informed consent. CP 251 (p. 38). She was focused on what she needed to do to try to save Liam’s life. CP 250 (p. 37). Common sense and basic logic dictate that under such circumstances, with an overwhelmed and shocked parent and a physician who is trying to do what needs to be done in an emergency effort to save a baby’s life, there is no ready availability for obtaining a truly informed consent.

The court in Miller v. HCA, Inc., 118 S.W.3d 758, 767-78 (Tex. 2003), under similar circumstances, held that “a physician who is confronted with emergent circumstances and provides life-sustaining treatment to a minor child, is not liable for not first obtaining consent from the parents.” In that case, like this one, the plaintiffs attempted to argue that no emergency existed that would excuse providing life-sustaining treatment to a newly born infant without parental consent. In Miller, the health care providers were aware prior to the birth that the infant would be

delivered prematurely at 23 weeks gestation. Id. at 761. The health care providers thus actually had time prior to the birth to discuss with the parents their desires concerning resuscitation. Id. at 761-62. Despite that pre-birth knowledge and discussion, the Texas Supreme Court concluded that the time to evaluate the infant was after the infant was born, that the doctor had to make a split second decision regarding providing life-sustaining treatment, and that there was simply no time to obtain the parents' informed consent. Id. at 769. The Miller court noted that:

[T]he emergent circumstances exception acknowledges that the harm from failing to treat outweighs any harm threatened by the proposed treatment, because the harm from failing to provide life-sustaining treatment under emergent circumstances is death.

Id. at 768. The Miller court further noted that “it is impossible for the courts to calculate the relative benefits of an impaired life versus no life at all.” Id.

Although plaintiffs attempt to distinguish Miller, App. Br. at 20, their distinctions again make no difference. The relative likelihood that the baby in Miller, and Liam, would be defective makes no difference. That the baby in Miller was not necessarily going to have problems later was not a basis for the Miller court's ultimate decision. Moreover, just as the neonatologist in Miller did not know with certainty that the baby would or would not have problems, so Dr. Vaughn here did not know with

certainty that Liam would, as she was aware of another infant with Apgars like Liam's who did well. CP 247 (pp. 22-24). Nor does the fact that the baby in Miller was born breathing and with a heartbeat, while Liam was delivered with no heartbeat or spontaneous respiration, make a material difference. If anything, the absence of any heartbeat or spontaneous respiration, which persisted even at 10 minutes, made the need to provide resuscitation all the more the emergent in Liam's case.

Plaintiffs, App. Br. at 21, chastise the trial court for failing to address the emergency exception to the informed consent doctrine. Yet, although the emergency exception provides an additional basis for concluding that plaintiffs' informed consent claim was properly dismissed, it was not essential to the court's holding.

Ultimately, this is not an informed consent case. To say that it is presupposes that Liam's parents had right to dictate the withholding or withdrawal of life-sustaining treatment to him, and that Dr. Vaughn had some corresponding duty to yield to their dictate. That is simply not the case as the Natural Death Act and the cases dealing with the withholding or withdrawal of life support make clear. Moreover, to say that this is an informed consent case presupposes that there was some reasonable and viable alternative to ceasing resuscitative efforts that were not yet medically futile. There was not, for the cessation of resuscitative efforts

was tantamount to a death sentence. Finally, to say that this is an informed consent case presupposes that the outcome of the resuscitative efforts – the saving of Liam’s life – was an injury. But, to do so would truly disavow the sanctity of life. “It is life itself, that is jealously safeguarded, not life in a perfect state.” Montalvo, 647 N.W.2d at 419 n.4 (quoting Iafelice, 534 A.2d at 418, and Berman v. Allan, 80 N.J. 421, 430, 404 A.2d 8 (1979)).

V. CONCLUSION

For the reasons set forth above, the trial court’s grant of summary judgment dismissing plaintiffs’ negligence and informed consent claims premised on the alleged wrongful saving or wrongful prolongation of Liam’s life by continued resuscitation should be affirmed.

RESPECTFULLY SUBMITTED this 7th day of August, 2006.

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CERTIFICATE OF SERVICE

I hereby certify under penalty of perjury that under the laws of the State of Washington that on the 7th day of August, 2006 I caused a true and correct copy of the foregoing document, "Joint Brief of Respondents," to be delivered via U.S. Mail to the following counsel of record:

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