

63568-9

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Case No. 63568-9

IN THE COURT OF APPEALS OF
THE STATE OF WASHINGTON
DIVISION ONE

NICHOLE POLETTI,

Appellant,

v.

OVERLAKE HOSPITAL MEDICAL CENTER
and KING COUNTY,

Respondents.

BRIEF OF RESPONDENT OVERLAKE HOSPITAL
MEDICAL CENTER

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A. INTRODUCTION

Shortly after 11:00 p.m. on an overcast winter evening, Sherri Poletti drove on a wet and unlit road in Thurston County. CP 31-33. While rounding a curve, her car drifted off to the shoulder of the roadway. Id. She overcorrected, and unfortunately perished in the resulting car accident. Id.

Both the investigating officer and the coroner determined that Ms. Poletti's death was accidental. CP 31-33, 36, 38. Ms. Poletti's daughter, Plaintiff-Appellant Nichole Poletti¹, has also conceded that the accident may very well have been nothing more than that -- an accident, pure and simple. CP 91:25-92:4. Nevertheless, she sued Overlake Hospital Medical Center ("Overlake") and King County, blaming each of them for Ms Poletti's accident.

Each Defendant moved (separately) for summary judgment. Overlake's motion went first. CP 93, 176. It was based on (1) Plaintiff's lack of qualified and fact-based expert testimony and (2) the lack of proximate cause between any health care that Ms. Poletti received at Overlake and her subsequent car accident. CP 93-103. The trial court took great care in considering the briefing, the evidence, and the argument of counsel. RP 1-33. After doing so, the court correctly recognized the

¹ For purposes of clarity, in this brief, Plaintiff-Appellant Nichole Poletti is referred to as "Plaintiff." Sherri Poletti is referred to as "Ms. Poletti."

multiple fatal deficiencies in Plaintiff's proof, and granted Overlake's motion. CP 173-175. King County's motion followed, and also was granted.² CP 247-249. Plaintiff appeals both rulings. CP 250.

B. ASSIGNMENTS OF ERROR AND ISSUES

Summary judgment serves an important purpose. It expeditiously and economically disposes of cases in which proof is lacking and trial is unnecessary. This was precisely such a case. The trial court properly granted Overlake's motion for summary judgment. It committed no error, and the trial court's ruling should be affirmed.

The issues related to Plaintiff's appeal of Overlake's summary judgment are properly identified as:

1. Is an outpatient psychologist who makes no showing that he is familiar with psychiatric medicine or with the standard of care for inpatient psychiatric nursing qualified to offer expert opinion testimony regarding the medical care provided by an inpatient psychiatric nurse?

[Answer: No]

2. Is a psychiatrist who makes no showing that he is familiar with the standard of care for inpatient psychiatric nursing qualified to offer

² Overlake focuses its briefing on its own motion and on the correctness of the trial court's ruling on that motion. Overlake's lack of direct commentary on King County's motion is not, and should not be construed to be, a comment on the merits of King County's position.

expert opinion testimony regarding the care provided by an inpatient psychiatric nurse? [Answer: No]

3. Are declarations offered in opposition to a motion for summary judgment in a medical practice case sufficient when they do not state (a) what the health care provider's standard of care is or (b) how the standard of care was allegedly violated? [Answer: No]

4. Can a case survive summary judgment where the evidence, viewed in the light most favorable to plaintiff, shows nothing more than a mere possibility that the injury alleged could theoretically have been related to a defendant's conduct? [Answer: No]

C. STATEMENT OF THE CASE

1. The evidence is that Ms. Poletti's car accident was just that: an accident.

The car accident in question occurred at about 11:10 p.m. on December 31, 2006. CP 31. That evening, Ms. Poletti was driving alone in her Honda CR-V westbound on a Highway 8 in Thurston County. CP 31, 32. It was cold (temperature mid- to upper-30s) and overcast. CP 31, 37. The section of roadway Ms. Poletti was on was wet, dark, and without any form of streetlights. CP 31, 32.

At a curve in the road, the CR-V drifted over onto to the right shoulder of the roadway. CP 32, 37. Ms. Poletti attempted to correct the

drift, but unfortunately overcorrected to the left. Id. The CR-V crossed the other westbound lane, hit a rocky embankment, and rolled. CP 31, 32, 37. Without her seatbelt on, Ms. Poletti was ejected from the vehicle. Id. She died at the accident scene. Id.

The investigating officer determined that Ms. Poletti probably fell asleep at the wheel. CP 31 (Item 27), 33. After a thorough scene investigation, interviews with family and law enforcement (during which the coroner learned of Ms. Poletti's bipolar disorder and its manifestations), and an analysis of autopsy and toxicology results, the coroner also determined that Ms. Poletti's death was a simple auto accident. CP 38, 39, 42.

2. Earlier that evening, Ms. Poletti was discharged from Overlake against medical advice, but at her insistence and as required by law.

Ms. Poletti had a history of bipolar disorder dating to several years before her death. CP 119. The day before this accident, December 30, 2006, she had taken herself voluntarily to the emergency room at Swedish Medical Center ("Swedish") and reported that she was having thoughts of suicide. Id. Swedish transferred Ms. Poletti to Overlake for admission to its psychiatric unit. She was admitted voluntarily at about 4:00 a.m. on December 31, 2006. See CP 123.

After sleeping most of the following day and spending time on the unit, at about 6:30 p.m., Ms. Poletti reported to a mental health specialist, Hayward, that she was feeling better and that she wanted to go home. CP 57:11-20. Hayward tried to persuade Ms. Poletti to stay, but was unable to do so. Id. At that point, Hayward advised charge nurse, Elaine Short, of Ms. Poletti's decision to leave Overlake. Id. Nurse Short met with the patient to assess her and try to persuade her to stay. CP 57:21-58:23.

Nurse Short has over thirty years experience as a psychiatric nurse, with duties including crisis intervention and assessing patients. CP 7:3-8:21. She went and introduced herself to Ms. Poletti, told her that she understood Ms. Poletti had requested discharge, and then began asking mental status questions. CP 57:21-58:23. The conversation was purposefully structured to allow Nurse Short to assess Ms. Poletti's current status as to any paranoid delusions or hallucinations she might be having, to assess her potential for self-harm, and to determine whether she was capable of and had a plan to care for herself upon discharge. CP 57:21-58:23; 59:23-60:11.

Additionally, while Nurse Short cannot force a patient to stay in the hospital, during the discussion, Nurse Short attempted to persuade Ms. Poletti to stay and receive further care. CP 57:16-20; 58:17-23. She explained that it was in Ms. Poletti's best interest to stay so that they could

work further with her regarding her medications and could provide her with psychiatric support. CP 58:17-23.

Ms. Poletti stated that she was not responding to auditory hallucinations and that she would not injure herself. CP 58:10-16; 59:25-60:4; 81:13-82:1. She also advised of her plan once she left the hospital, which included taking a cab to get home safely and obtaining follow up psychiatric care. CP 60:5-11.

Nurse Short asked the questions in a manner structured to elicit accurate responses. CP 58:1-23. Ms. Poletti gave clear answers to the questions and did not demonstrate that she was responding to any auditory or visual hallucinations. CP 81:13-82:5; see CP 61:18-62:1; 62:19-25. She did not exhibit nonverbal behavior that suggested that she was disorganized in her thought process or psychotic. Id.

In Nurse Short's experienced professional judgment, based upon Ms. Poletti's current condition at the time she was seeking discharge, Ms. Poletti did not meet criteria for involuntary commitment for forced psychiatric care. CP 56:3-14; 61:18-63:5; 67:13-68:8. Nevertheless, in an abundance of caution, Nurse Short called the County Designated Mental Health Professional (the "CDMHP"). CP 55:21-56:14. Under Washington law (RCW 71.05), only a CDMHP has the power to detain a

person for involuntary commitment proceedings for forced psychiatric care. CP 72:10-16.

Nurse Short described Ms. Poletti's condition to a CDMHP with fourteen years experience on the job, Joseph Militello. CP 71:13-20; 88. As Mr. Militello explained in his deposition, the standard for emergent involuntary commitment is high; a person can be involuntarily detained for psychiatric care if -- and only if -- (1) there is evidence of acute psychiatric impairment, and (2) as a result of that impairment there is evidence of imminent dangerousness to self or others or of grave disability. CP 72:19-73:3. In this context, imminent means likely to happen at any moment or close at hand. CP 72:19-73:7.

This rigorous standard for detention for involuntary commitment proceedings and forced psychiatric care does not allow for detention based upon a patient's history of mental illness. CP 73:23-74:25. It requires that the patient meet criteria "right then and there" at the time of the evaluation. CP 74:13-18.

One example (out of several) other times when Ms. Poletti was probably mentally ill but did not meet criteria for involuntary detention and commitment occurred on December 17, 2006. CP 75:6-78:8. On that day, it was reported that Ms. Poletti had been talking about paranoid themes, that she thought her phone was tapped, and that she told her

daughter “I think I want to kill myself” and hung up the phone. Id. The police were called and essentially broke down the door to check on Ms. Poletti. Id. A CDMHP was consulted. Id.

The CDMHP determined that even with the reporting of the paranoia, delusions, and suicide threat earlier that same day, Ms. Poletti did not meet the criteria for involuntary detention and commitment at the point in time of the evaluation, because the alleged behaviors were not present then. Id. They were in the past. Id. At the time of the evaluation, Ms. Poletti looked clean and groomed. Id. She denied suicidality and denied current symptoms of illness. Id. Her thinking was organized. Id. Based upon her presentation right then and there, without current symptoms of mental disorder that made her an imminent danger to herself or others or made her gravely disabled, Ms. Poletti did not meet statutory criteria. Id. The CDMHPs could not detain her. Id.

In her conversation with Mr. Militello on December 31, 2006, Nurse Short explained Ms. Poletti’s history of having presented to Swedish the evening before with suicidal thoughts, paranoia, and auditory hallucinations. CP 80:5-81:6; 88. She also explained that Ms. Poletti had slept while at Overlake, that she currently denied being suicidal, and that she evidenced no overt signs or symptoms of paranoia, delusions or hallucinations. CP 81:13-82:1. Additionally, Nurse Short explained that

Ms. Poletti had a plan to take a cab home from Overlake and that she had further psychiatric care scheduled. CP 82:6-10. That was significant to Mr. Militello because it evidenced Ms. Poletti's intention to continue with mental health treatment, and also showed that she was thinking about and planning for the future, which suggests that suicide is not imminent. CP 82:17-83:11.

As Mr. Militello explained, though Ms. Poletti was refusing anti-psychotic medications when she was seeking discharge, that does not equate with the patient being gravely disabled or committable. CP 84:5-22. People have the right to refuse medication. Id.

In the end, after receiving the information about Ms. Poletti from Nurse Short, and collaborating on the case with Nurse Short for approximately 20 minutes, Mr. Militello concluded:

... if patient, as [Nurse Short] expects she will, presents to MHPs as she is currently presenting, we would not have evidence to detain due to lack of evidence of imminent dangerousness or [grave disability].

CP 80:5-9, 84:24-85:9. To this day, Mr. Militello agrees with that determination. CP 85:10-86:20. He explained again during his deposition:

...in that limited scope, she's denying being suicidal, she's denying psychotic symptoms, she's presenting as being absent of signs of psychotic

symptom, which is how we corroborate a patient's reports with an external observation of their behaviors, she's future oriented, has a plan to follow up with her doctor, has a reasonable plan for getting herself home, that scenario by and large is not a commitment scenario.

CP 86:12-20. As Nurse Short also explained in her deposition:

... [Mr. Militello] clearly said she will not -- if I come see her, she will not be detained.

CP 64:11-12.

With Ms. Poletti unwilling to stay voluntarily and not meeting criteria for involuntary detention and commitment, Ms. Poletti was discharged at her insistence and against medical advice. CP 131. Stringent criteria prevent the state from arbitrarily declaring someone “crazy” and locking them up. See CP 72:19-73:7; 73:23-74:25. In the end, perhaps Nurse Short explained it best when she testified:

You know, we have good intentions that we want to help people, but that doesn't mean that we have the legal right to force people to do -- we have no legal right to force them unless they're detained by the court of law, which is the mental health court.

So it's not against the law to have hallucinations. It's not against the law to have a mental disorder, which can last your whole life, which for most people does last their whole lifetime. So it's variable how unstable you are during that period of time. So unless you meet criteria at that moment in time that you're gravely disabled, a danger to yourself or a danger to others, we cannot take away your freedoms.

CP 67:13-68:1. Nurse Short continued on regarding Ms. Poletti:

At that time we did not see her at that situation that we could take away her freedoms. Neither myself and when talking to -- I called the mental health professionals saying there are concerns. These are what we're seeing, and the comment back is we do not have enough criteria to detain her. We will not detain her. So that's where we stopped.

CP 68:2-8. At that point, Overlake had to let Ms. Poletti, a legally competent adult, make her own determinations about what health care she would, or would not, receive. Ms. Poletti chose not to receive any more health care that evening and left Overlake. See CP 131. This was done against medical advice, but it was well within her right to do so. Id.

3. Overlake moved for summary judgment, and put Plaintiff on express notice of what she needed to show to defeat the motion. Plaintiff failed to meet her burden.

Ms. Poletti's fate was not related to, and was not a result of, the care she received at Overlake. Because Overlake believes its care was appropriate and was not the cause of this unfortunate auto accident, it moved for summary judgment. RP 20; CP 93-103. It explained that Plaintiff had not offered the mandatory expert testimony in support of her claim and that there was a lack of proximate cause between Overlake's care and Ms. Poletti's car accident. CP 100-103.

In opposition to the motion, Plaintiff first offered a declaration from Bruce A. Olson, Ph.D., a psychologist. CP 104-114. A psychologist is a professional who is trained in the science of human (and sometimes animal) behavior and related mental and physiological processes. STEDMAN'S MEDICAL DICTIONARY 1458 (26th ed. 1995). CP 260; App. A-3. A psychologist is not a medical doctor, is not trained in psychiatry (a medical specialty), is not authorized to prescribe psychiatric medicine, and does not supervise psychiatric charge nurses. *Id.* Psychology is a different field than medicine, including the medicine of psychiatry.³ CP 260; App. A-2, A-3.

A psychologist's qualifications and duties are not only far different from a psychiatrist's, they are far different than a psychiatric charge nurse's. CP 260; App. A-2, A-3, A-4, A-5. A psychiatric charge nurse like Nurse Short is a nurse who is concerned with the scientific application of principles of care related to prevention of illness and care during illness. STEDMAN'S MEDICAL DICTIONARY 1231-32 (26th ed. 1995). CP 260; App. A-4, A-5. He/she practices under the supervision of a qualified

³ Psychiatry is the medical specialty concerned with the diagnosis and treatment of mental disorders. Psychiatrists are medical doctors with specialized training. STEDMAN'S MEDICAL DICTIONARY 1456 (26th ed. 1995). CP 260; App. A-2. Copies of the cited pages of STEDMAN'S were attached to the bench and service copies of the motion, and are included in the appendix to this brief.

psychiatrist. See RCW 18.79.260 (listing who may supervise a registered nurse; psychologist is not one of the options).

In his declaration, Dr. Olson did not make any showing that he was qualified to offer an opinion about the standard of care to be practiced by a psychiatric charge nurse like Nurse Short. See CP 104-114. This fundamental foundational issue was not even addressed in the declaration. Id.

Despite utterly lacking the foundation to offer any opinion at all regarding the care Nurse Short provided, Dr. Olson did offer some criticisms of Nurse Short. CP 105-106. However, as is discussed in more detail below, the law required more than mere criticism or complaint. It required more even than a simple allegation of error. The law required a statement of what the standard of care was for Nurse Short and of how she is alleged to have breached the standard of care. Dr. Olsen testified to neither in his declaration. Id.

Based on these and other deficiencies, Overlake moved to strike Dr. Olson's declaration. CP 258-263. After the motion to strike was filed, and after the due date for Plaintiff's opposition to the motion for summary judgment had come and gone, Plaintiff offered the declaration of a second witness, Christian G. Harris, M.D., a psychiatrist. CP 264-266.

Dr. Harris's declaration suffered from the same fatal flaws -- flaws that had been spotlighted for Plaintiff by Overlake's motion to strike -- as Dr. Olson's declaration. Id. In the motion to strike, Overlake had expressly advised Plaintiff of the deficiencies in the Olson declaration, and even of how to remedy them. CP 259-262. For example, Overlake's motion cited Plaintiff to a recent Court of Appeals case on the very topic of how to qualify a physician to testify to a nurse's standard of care, Davies v. Holy Family Hosp., 144 Wn. App. 483, 183 P.3d 283 (2008). CP 261. However, Plaintiff still did not produce a witness who would provide that testimony. CP 264-266.

Dr. Harris's declaration provided no information showing that he had a sufficient knowledge or experience base to qualify him to testify on the standard of care for an inpatient psychiatric charge nurse. Id. Dr. Harris also failed to set forth what he thought that standard of care for Nurse Short might be. Id. Nor did Dr. Harris explain how he claimed that the standard of care was breached. Id. Even with Plaintiff's late addition of Dr. Harris's declaration, there still was not qualified, fact-based expert testimony in support of Plaintiff's claim. CP 104-106, 264-266.

As for proximate cause, Overlake offered a two pronged analysis of the defects in Plaintiff's claim. RP 5:13-9:8; CP 101-103, 151-153,

154. The first prong, Overlake explained, was that Plaintiff could not show that the car accident in question was related to the care that Ms. Poletti received at Overlake. RP 8:22-9:5; CP 101-103.

Though Plaintiff has not conceded that it was a simple car accident, she has conceded that she does not know that it was not a simple car accident. Plaintiff testified in her deposition that she could only “guess” at the cause of the accident. Specifically, she stated:

My two guesses, my best guesses is either she was so tired and she fell asleep and woke up and overcorrected and hit right into the rock culvert, or she purposefully hit the rock culvert because she wanted to kill herself.

CP 91:25-92:4. Plaintiff’s lawyer conceded this point during oral argument as well. She argued:

We will never know if this individual intended to go off the road, fell asleep at the wheel, or had hallucinations that prevented her from seeing where she was driving.

RP 12:24-13:2 (emphasis supplied).⁴ With no proof that this was anything more than an accident, and no proof that the accident was caused by the health care provided at Overlake, Overlake explained that there was no

⁴ While Plaintiff’s attorney was willing to make this argument to this Court, there is no evidence in the record that Ms. Poletti was having visual hallucinations at any point in time during her contact with Overlake or that visual hallucinations prevented Ms. Poletti from seeing anything. There also is no evidence in the record that she was suicidal at the time of discharge or thereafter.

proximate cause and that Plaintiff's claim fails as a matter of law. RP 8:22-9:5; CP 101-103.

The second prong of the proximate cause analysis had to do with the CDMHP's determinations and testimony. RP 5:13-8:21; CP 103, 151-153, 154. Specifically, Overlake stated that even if it was assumed for the sake of argument that there was a breach of the standard of care by Nurse Short, any breach made no difference, because only a CDMHP can make a determination whether to detain someone for involuntary forced psychiatric treatment. Id.

Plaintiff conceded that the determination was the CDMHP's and the CDMHP's alone during the hearing on the motion:

THE COURT: Ms. Young, is that what [an Overlake psychiatrist] said, or did he say, If she stays off her meds -- if she refuses to take meds, then we will send her to the CDMHP and see whether she is committable?

MS. YOUNG: Well, he said: I believe she meets the criteria. He said --

THE COURT: But he can't make that determination. The CDMHP has to make that determination, correct?

MS. YOUNG: Right. . . .

RP 26:1-9.

The experienced CDMHP involved here testified that given all that he knew at the time, and even all that he knows now about Ms. Poletti and her presentation on the evening in question, she did not meet criteria for involuntary detention. CP 84:24-86:20. If he had come out to Overlake and evaluated Ms. Poletti in person, she would not have been detained. Id.; CP 64:11-12.

Overlake explained in its motion that not only was the CDMHP correct that Ms. Poletti was not detainable, but the fact that he had formulated that opinion -- when he was the only one who could make the decision that evening to detain Ms. Poletti for involuntary commitment proceedings -- is dispositive. CP 95-99, 103, 151-153. Under those circumstances, even if Plaintiff were correct (though she is not) that Nurse Short made an error, or even multiple errors, on the evening in question, the end result would not have changed in any way. Id. Ultimately, the CDMHP would not have detained Ms. Poletti, and Ms. Poletti would have been discharged from the hospital just as she was. Id.

The trial court thoroughly reviewed the motion papers, patiently listened to the attorneys for both sides, and took the matter under advisement. See RP 30:1-3. The next court day, the trial court issued its decision. CP 173-175.

4. In a well-reasoned memorandum order, the trial court properly granted Overlake's motion for summary judgment.

The trial court held that Bruce Olson, Ph.D.'s declaration was insufficient to defeat Overlake's motion because:

- a. Dr. Olson's curriculum vitae did not show psychiatric nursing experience or experience supervising psychiatric nurses. CP 174:18-19;
- b. Dr. Olson failed to identify any qualification he may have to testify to the psychiatric nursing standard of care. CP 174:19-20; and
- c. Dr. Olson failed to identify what he claimed the psychiatric nursing standard of care was. CP 174:20-21.

The trial court held that Dr. G. Christian Harris's declaration was "similarly deficient." CP 174:21-22. In connection with this holding, the trial court found that neither Dr. Harris nor Dr. Olson had shown in their declarations that they knew what the standard of care was for Nurse Short, that neither had identified what the standard of care was for Nurse Short, and that neither had identified how Nurse Short was alleged to have violated the standard of care.⁵ CP 174:22-24.

⁵ The order is somewhat ambiguous regarding Dr. Harris's qualification to offer expert testimony regarding Nurse Short's standard of care. See CP 174: 21-24. Regardless of whether the trial court found that Dr. Harris failed in his declaration to establish the requisite qualification to testify to the nursing

The trial court also found that Plaintiff had an independent failure of proof on proximate cause. CP 175:8-11. As the trial court explained in the memorandum order: It was undisputed that Ms. Poletti was at Overlake voluntarily, that Ms. Poletti decided to leave Overlake against medical advice, that Ms. Poletti refused to take medications, that Nurse Short tried to persuade Ms. Poletti to stay at Overlake, that Nurse Short called the CDMHP and described how Ms. Poletti was presenting and was told that Ms. Poletti was not involuntarily detainable. It was also undisputed that Ms. Poletti took a taxi home from the hospital. CP 175:1-8. The court properly found that there was no evidence that showed proximate cause between Overlake's actions and Plaintiff's car accident. CP 175:8-11.

On these three bases, the trial court correctly dismissed Plaintiff's claims against Overlake.

D. ARGUMENT

A trial court's order on summary judgment is reviewed de novo based on the record before the trial court at the time of the order. Saluteen-Maschersky v. Countrywide Funding Corp., 105 Wn. App. 846, 850, 22 P.3d 804 (2001). Summary judgment was appropriate if there

standard of care, this is another basis to reject his testimony at the appellate level. The trial court's order on summary judgment may be affirmed on any correct ground within the record, regardless of the basis for the trial court's decision. Nast v. Michels, 107 Wn.2d 300, 308, 730 P.2d 54 (1986).

were no genuine issue of material fact and the moving party was entitled to judgment as a matter of law. Trimble v. Washington State University, 140 Wn.2d 88, 93, 993 P.2d 259 (2000).

1. Qualified, fact-based expert testimony is mandatory for medical malpractice claims like the one Plaintiff made here.

To prevail on a medical malpractice claim, a plaintiff must prove that the defendant health care provider “failed to exercise that degree of skill, care, and learning expected of a reasonably prudent health care provider in the profession or the class to which he belongs, in the state of Washington, acting in the same or similar circumstances” (i.e. a deviation from the standard of care) and proximately caused harm. RCW 7.70.040. This is a particularized expression of the four traditional elements of negligence: duty, breach, cause and harm. Caughell v. Group Health Coop., 124 Wn.2d 217, 233, 876 P.2d 898 (1994).

Put another way, in a medical malpractice case, the health care provider has a duty to comply with the standard of care. A plaintiff makes a prima facie case of medical malpractice if, and only if, she shows that the duty (i.e., the standard of care) was breached, and that the breach of the standard of care proximately caused harm to the plaintiff. See Putnam v. Wenatchee Valley Med. Ctr., PS, ____ Wn.2d ____, 2009 Wash. LEXIS 754, at *9 (Sept. 17 2009) (medical malpractice claims are

fundamentally negligence claims); Caughell, 124 Wn.2d at 233. If a plaintiff has failure of proof on any of one of these elements, on duty, on breach, on cause, or on harm, the claim is subject to summary judgment dismissal. West Coast, Inc. v. Snohomish County, 112 Wn. App. 200, 205, 48 P.3d 997 (2002) (failure of proof on even one element of a claim renders all other elements become immaterial, and the claim fails on summary judgment).

In medical malpractice cases, absent extreme circumstances not present here, competent expert testimony is required to prove the applicable standard of care and a health care provider's deviation from the standard of care. E.g., Douglas v. Freeman, 117 Wn.2d 242, 249, 814 P.2d 1160 (1991) (citations omitted); Harris v. Groth, 99 Wn.2d 438, 451, 663 P.2d 113 (1983) (standard of care for medical personnel is generally beyond the knowledge of lay persons); Davies v. Holy Family Hosp., 144 Wn. App. 483, 492, 183 P.3d 283 (2008). Without such expert testimony, the claim fails. See, e.g., Harris, 99 Wn.2d at 451 (citations omitted).⁶

⁶ The very unusual medical case that does not require expert testimony is the case where medical facts and implications are readily observable and understood by lay persons; for example, when a foreign object is left in a patient during a surgery. E.g., Bauer v. White, 95 Wn. App. 663, 677, 976 P.2d 664 (1999). In the overwhelming majority of medical cases, and in this case:

[J]urors and courts generally do not possess sufficient knowledge and training to determine where a physician

Not just any “expert” testimony will do. It is long established in Washington that, when the court rules on a motion for summary judgment, the court may consider only admissible evidence. Dunlap v. Wayne, 105 Wn.2d 529, 535-36, 716 P.2d 842 (1986); Charbonneau v. Wilber Ellis Co., 9 Wn. App. 474, 512 P.2d 1126 (1973). It is equally well-recognized that no expert opinion is admissible over objection unless the witness has first been qualified by a showing that he or she has sufficient expertise to state a helpful and meaningful opinion. See, e.g., ER 702, 703; Sehlin v. Chicago, Milwaukee, St. Paul and Pacific R. Co., 38 Wn. App. 125, 133, 686 P.2d 492 (1984).

2. Neither of Plaintiff’s witnesses was appropriately qualified to testify to the psychiatric nursing standard of care.

To establish sufficient foundation in a medical malpractice case like this one, the expert witness must be shown to practice in the same field as the health care provider whose care is at issue. Morton v. McFall, 128 Wn. App. 245, 253, 115 P.3d 1023 (2005) (citing McKee v. Am. Home Prods. Corp., 113 Wn.2d 701, 706, 782 P.2d 1045 (1989)).

or surgeon’s actions actually caused Plaintiffs’ injury.
The medical field is foreign to common experience.

Reese v. Stroh, 128 Wn.2d 300, 308, 907 P.2d 282 (1995) (quoting a law review article regarding the necessity of medical expert testimony in medical malpractice cases).

McKee is instructive in this case, because it too involved a health care provider attempting to testify outside the scope of his expertise. McKee involved a plaintiff who was addicted to prescription drugs. 113 Wn.2d. at 703. She filed suit against a physician, a drug manufacturer, and two pharmacists, blaming them for her addiction. Id. The pharmacists moved for summary judgment. Id. at 706.

In opposition, plaintiff offered a physician's declaration purporting to testify about the pharmacists' standard of care. Id. The Washington Supreme Court rejected such testimony, explaining by way of example:

The duty of physicians must be set forth by a physician, the duty of structural engineers by a structural engineer and that of any expert must be proven by one practicing in the same field – by one's peer.

Id. (citing Young v. Key Pharmaceuticals, Inc., 112 Wn.2d 216, 770 P.2d 182 (1989)). The Court went on to hold that only a pharmacist who knew the practice and standard of care in Washington could establish the pharmacists' standard of care. Id. at 707. The physician was unqualified, and his declaration was inadequate as a matter of law. Id.

Under these principles, and in much the same way that a physician is not qualified as a matter of law to testify to a pharmacist's standard of care, a psychologist is not qualified to testify to the standard of care of a psychiatric (i.e., a medical) nurse. Even if there are times when a

psychologist and a psychiatric nurse may interact, just as there are times when a physician and a pharmacist may interact, they are two different professional fields. As a matter of law, psychologist Dr. Olsen is not qualified to and cannot testify to the standard of care for a psychiatric nurse like Nurse Short. See id.

Davies v. Holy Family Hosp., 144 Wn. App. 483, 183 P.2d 283 (2008), is also consistent with these rules regarding expert witness qualification and is directly on point regarding physician Dr. Harris's declaration in this case. Davies involved a claim that during a radiology-guided kidney biopsy, the kidney capsule detached (a known risk of the procedure). Id. at 488. Plaintiff alleged that the biopsy had been negligently undertaken and that capsule damage led to bleeding that was not properly diagnosed or treated. Id. at 488-89.

In opposition to defendant's motion for summary judgment, Plaintiff offered the declaration testimony of a medical doctor, Dr. Randall Patten, whose specialty is radiology. Id. at 490. Dr. Patten testified that the hospital and its nursing staff had breached the standard of care. Id. at 490. The hospital replied, arguing that the radiologist was not qualified to offer expert opinion on the nursing standard of care. Id. The hospital's motion was granted. Id.

Plaintiff appealed. The Court of Appeals considered whether Dr. Patten was qualified to offer opinion testimony regarding the standard of care for nurses and other non-physician hospital employees. Id. at 494. The court turned to the long standing rule that the standard of care required of a professional practitioner can only be established by the testimony of an expert who practices in the same field. Id. (citing McKee, 113 Wn.2d at 706). The court explained that, in order to be competent to testify, and before offering an opinion, a physician must first demonstrate that he or she has sufficient expertise in the relevant specialty. Id. (citing Young v. Key Pharmaceuticals, Inc., 112 Wn.2d at 229).

The Davies court explicitly recognized that there are instances when a medical doctor is qualified to testify to the nursing standard of care. For example, the Davies court discussed Hall v. Sacred Heart Medical Ctr., 100 Wn. App. 52, 60, 995 P.2d 621 (2000). Davies, 144 Wn. App. at 495. In Hall, a medical doctor was determined to be qualified to testify to the nursing standard of care based upon his medical training and his nursing supervisory experience. Id. (citing Hall, 100 Wn. App. at 60). There, a proper foundation for the physician's opinions had been offered. Id. As the Davies court pointed out, this was in stark contrast to the scenario in the appeal before it.

In Davies, Dr. Patten's declarations stated that he was "familiar" with appropriate measures to be taken by "hospital staff, including nursing staff" in response to internal bleeding.⁷ 144 Wn. App. at 495. The fatal flaw in this foundational testimony was not what Dr. Patten did say; it was what he did not say. Dr. Patten did not testify that he had knowledge of the standard of care for the nurses or other hospital staff he was seeking to offer opinion testimony about. Id. Dr. Patten did not reference any education, medical training, or other supervisory experience that would demonstrate his familiarity with the standard of care of the nurses or others. Id. Nor did Dr. Patten provide any basis for his claimed "familiarity" with the appropriate measures to be taken. Id.

The Davies court concluded that because Dr. Patten did not affirmatively establish that he had familiarity and expertise in the standard of care applicable to the nurses and the others, as a matter of law, Dr. Patten was incompetent to offer the required medical opinion testimony on standard of care and breach of the standard of care. Id. at 495-96 (citing CR 56(e); Guile v. Ballard Community Hosp., 70 Wn. App. 18, 25, 851 P.2d 689 (1993)). The declarations Plaintiff offered in opposition to Overlake's motion for summary in this case were inadequate in much the same way.

⁷ Dr. Patten submitted two declarations on behalf of Plaintiff. Each was deficient. Davies, 144 Wn. App. at 495.

Neither Dr. Olson nor Dr. Harris testified that he had knowledge of the standard of care for psychiatric nurses.⁸ CP 104-114, 264-266. And neither referenced any education, medical training, or other supervisory experience that would demonstrate familiarity with the nursing standard of care. Id. The requisite foundation was not laid to allow either of these witnesses to offer an opinion. Id. The inquiry should end there.

If the Court were to consider the opinions offered by Plaintiff's witnesses, the opinions themselves were deficient as well. Neither witness offered any testimony on what he believed the standard of care was, or on how he believed the standard of care was breached. Id. As set forth above, this type of testimony is required by Douglas, Harris, Young, Morton, Guile and related cases, for a fundamental prima facie case of medical malpractice.

In her appeal, for the first time, Plaintiff argues that Morton v. McFall, 128 Wn. App. 245, 115 P.3d 1023 (2005), saves these declarations from their own deficiencies. She is incorrect. Morton

⁸ In Plaintiff's appellate brief, Plaintiff cites to Dr. Harris's certificate of merit filed at the outset of this action. Plaintiff's Br. at 17. This is one of several improper attempts Plaintiff makes to augment the record on appeal. The attempt should be rejected. The record on appeal is limited to those documents the parties submitted to the trial court for its consideration on the motion. RAP 9.12; see, e.g., State v. Emerson, 43 Wn.2d 5, 14, 259 P.2d 406 (1953) ("An appeal must stand or fall on the record made in the trial court."). Moreover, if the certificate were considered over Overlake's objection, the certificate does not save Plaintiff's claim because Dr. Harris does not set forth any foundation for offering opinions on the nursing standard of care in his certificate of merit either.

involved the unnecessary surgical removal of the upper lobe of a patient's lung. Id. at 249. In opposition to a motion for summary judgment, Ms. Morton's expert physician testified that the defendant physicians had violated the standard of care, and then specified how that was done. Id. at 250. Specifically, Ms. Morton's expert physician testified that the breach occurred when the defendant physicians failed to obtain the results of a test that would have told them that the lobectomy surgery was unnecessary before they performed the lobectomy surgery. Id. It was clear from the Morton expert's testimony that the Morton expert believed the standard of care required the doctors to obtain the test results pre-surgically. Id. There was no such clarity in Plaintiff's witnesses' testimony in this case.

In their declarations, Plaintiff's witnesses recited a slanted version of the facts and offered criticism having nothing to do with the matters at hand. For example, they criticize the record keeping about observation of the patient hours before the actual discharge. CP 105:23-25; 265:17-19. The record keeping is irrelevant. There is nothing in either of Plaintiff's witnesses' declarations that allows the finder of fact to ascertain what the witness is saying (1) the standard of care required or (2) how the standard of care was breached in relation to the decision to discharge the patient.

The trial court correctly concluded that the declarations in this case were impermissibly conclusory and insufficient to stave off summary

judgment under Guile and related case law. The requirement that Plaintiff affirmatively show what she says the standard of care was and how she claims it was violated serves an important purpose. Not only is it fundamental to a prima facie case of medical malpractice, but in the medical malpractice context a mere criticism does not suffice to allow a case to go forward.

The law in Washington is that a health care provider may make an error in judgment without violating the standard of care and without giving rise to liability. See, e.g., Christensen v. Munsen, 123 Wn.2d 234, 248-249, 867 P.2d 626 (1994). Thus, a simple criticism offered that does not rise to the level of a violation of the standard of care serves only to confuse the issues. It does not save the case from summary judgment. Caughell, 124 Wn.2d at 233 (plaintiff must show duty (i.e., standard of care), breach of duty, causation, and harm); West Coast, Inc., 112 Wn. App. at 205 (failure of proof on even one element requires entry of summary judgment). In short, the trial court correctly applied Washington law and correctly concluded that the declarations of Dr. Olson and Dr. Harris were deficient as a matter of law.

Plaintiff on appeal has added another new argument, which is also without merit. She has attempted to side step her experts' lack of qualification by arguing that that Nurse Short fell within RCW

71.05.020's statutory definitions of "mental health professional" or "professional person," and that there is no specific definition for "psychiatric nurse" offered in RCW 71.05.020. Plaintiff then takes this to mean that Nurse Short should be held to a vague standard of care of a "mental health professional" or "professional person," rather than to the standard of a psychiatric charge nurse on duty in an inpatient psychiatric ward of a hospital who was performing psychiatric nursing duties. Plaintiff makes this argument without citation to any authority; the Court must presume this is because there is no authority to support the position. Mercer Place Condominium Ass'n v. State Farm Fire and Casualty Co., 104 Wn. App. 597, 606, 17 P.3d 626 (2000) ("Where no authorities are cited, the court may assume that counsel, after diligent search, has found none.").

It is with good reason that no authority supports Plaintiff's new argument. Plaintiff does not call out in her briefing the key definition that explains that it is the CDMHPs who have the duties under Chapter RCW 71.05. RCW 71.05.020(11) states:

"Designated mental health professional" means a mental health professional designated by the county or other authority authorized in rule to perform the duties specified in this chapter.

It is a CDMHP, and only a CDMHP, who carries out the responsibilities for involuntary detention under RCW Chapter 71.05. See RCW 71.05.040; RCW 71.05.153. CDMHPs, like Plaintiff's witness Dr. Olson, are an entirely different category of provider than psychiatric nurses like Nurse Short. See RCW 71.05.020.

That is not to say there is no role in the statutory scheme for psychiatric nursing providers like Nurse Short, who have contact with, and participate in, the involuntary commitment process. There certainly is such a role. That distinct, medical role is recognized in part in the definitions Plaintiff cites. It is also recognized, for example, in RCW 71.05.120, which provides statutory immunity for professional persons for the decisions they make in connection with possible involuntary treatment when there is no gross negligence or bad faith. But nothing about these statutory definitions changes Nurse Short's provision of care into anything other than what it is – the provision of psychiatric nursing care.

Plaintiff's own certificate of merit for this case also implicitly recognizes this. In her certificate of merit filed at the outset of the case, Plaintiff had Dr. Harris differentiate between the standard of care for psychiatric care provided in a hospital and the standard of care for a CDMHP acting under RCW 71.05. CP 13.

Both definitions cited by Plaintiff group together physicians with other health care providers, including nurses.⁹ RCW 7.70.020 has a similar definition. It says that for purposes of RCW 7.70 (which governs all medical malpractice lawsuits, see, e.g., Orwick v. Fox, 65 Wn. App. 71, 86, 828 P.2d 12 (1992)) the term “health care provider” includes physicians, pharmacists, nurses, hospitals, physical therapists, opticians, and others.

The fact that different health care providers are lumped together in one definition for use in a statutory scheme does not mean that all of these categories of “health care providers” are held to a single standard of care or are competent to testify to each other’s standard of care. To the contrary, the case law has specifically ruled out that type of cross testimony unless and until a proper foundation is laid. E.g., Davies, 144 Wn. App. at 494; McKee, 113 Wn.2d at 706. Here, no such foundation was laid. Both witnesses’ testimony was properly rejected by the trial court as lacking the requisite foundation.

⁹ RCW 71.05.020 provides:

- (25) “Mental health professional” means a psychiatrist, psychologist, psychiatric nurse, or social worker, and such other mental health professional as maybe defined by rules adopted by the secretary. . . .
- (28) “Professional person” means a mental health professional and shall also mean a physician, psychiatrist advanced registered nurse practitioner, registered nurse, and such others as my be defined by rules. . . .

3. **Even if the declarations of Plaintiff's witnesses were acceptable, the trial court still properly concluded that Plaintiff had a failure of proof on proximate cause.**

RCW 7.70.040(2) mandates that, like other all other negligence claims, causation is a necessary element of a medical malpractice claim. If a medical malpractice plaintiff cannot show that a breach of the standard of care proximately caused the injury complained of, the claim fails a matter of law. Pelton v. Tri-State Memorial Hosp., 66 Wn. App. 350, 355, 831 P.2d 1147 (1992); West Coast, Inc., 112 Wn. App. at 205 (failure of proof on even one element of a claim renders all other elements become immaterial, and the claim fails on summary judgment).

Though it typically requires expert medical testimony, in other ways, proximate cause in a medical malpractice case is like proximate cause in any other lawsuit. Caughell, 124 Wn.2d at 233 (medical malpractice proof requirements encompass the four traditional elements of negligence: duty, breach, proximate cause, and harm); Hill v. Sacred Heart Med. Ctr., 143 Wn. App. 438, 448, 177 P.3d 1152 (2008). It refers to a cause that, in direct sequence unbroken by any new independent cause, produces the injury complained of, and without which such injury would not have happened. Hill, 143 Wn. App. at 448 (citing Hertog v. City of Seattle, 138 Wn.2d 265, 282-283, 979 P.2d 400 (1999)).

Without such “but for” causation, the claim cannot go to the jury.

As the Washington Supreme Court has mandated:

If there is nothing more tangible to proceed upon than two or more equally reasonable inferences from a set of facts, and under only one of the inferences would the defendant be liable, a jury will not be allowed to resort to conjecture to determine the facts.

Grobe v. Valley Garbage Service, Inc., 87 Wn.2d 217, 226, 551 P.2d 748 (1976) (quoting Schmidt v. Pioneer United Dairies, 60 Wn.2d 271, 276, 373 P.2d 764 (1962)). In this case, there is not even sufficient evidence from which the Plaintiff could accurately argue that there were two equal inferences to be drawn from the facts, and that one of them would make Overlake liable.

Instead, in this case, Plaintiff admitted in her deposition that she does not know what caused Ms. Poletti’s car accident. CP 91:24-92:4. She expressly and affirmatively acknowledged that she was only “guessing.” Id. Plaintiff’s attorney likewise conceded at oral argument that “we will never know” what caused the car accident. RP 12:24.

It is well established Washington law that speculation or mere argument that an act “might have,” “could have,” or “possibly did” cause injury is insufficient to take a claim to the jury. Rounds v. Nellcor Puritan Bennett, Inc., 147 Wn. App. 155, 163, 194 P.3d 274 (2008), rev. denied,

165 Wn.2d 1047, 208 P.3d 554 (2009); Fabrique v. Choice Hotels Int'l, Inc., 144 Wn. App. 675, 686-687, 183 P.3d 1118 (2008) (citing Ugolini v. States Marine Lines, 71 Wn.2d 404, 407, 429 P.2d 213 (1967); Orcutt v. Spokane County, 58 Wn.2d 846, 853, 364 P.2d 1102 (1961)) (dismissal for failure of proof on causation proper where plaintiff's expert testified that plaintiff's painful condition may have been caused by wrongful act or it may have had a different cause). "Might have" is the best Plaintiff can state in this case. As Plaintiff's counsel conceded at oral argument, "we will never know" if mental health factored into Ms. Poletti's car accident. RP 12:24. As a matter of law, Plaintiff's proof on causation was lacking.

On appeal, Plaintiff cites for the first time to Petersen v. State, 100 Wn.2d 421, 671 P.2d 330 (1983), in support of her effort to take this case out of the realm of speculation. However, Petersen is factually different, and of no assistance to Plaintiffs in this case. Peterson involved a state patient who was believed to have suffered from a schizophrenic type reaction to angel dust. Id. at 424. He was involuntarily hospitalized in a state hospital after he amputated his own testicle while on angel dust. Id. at 423. He was subsequently discharged from the hospital, and was then involved in a car accident while on angel dust. Id. at 424. In Petersen -- unlike in this case -- there was direct evidence (not just speculation) that

the mental health condition that Plaintiff had been treated for was involved in the car accident in question. Id.

The primary question before the Petersen court was whether the state should be liable to third-parties for harm inflicted upon them when a state mental hospital (allegedly) wrongfully releases a dangerous patient too early. Id. at 426-432. It was a question of whether the state had a duty to the third-party. Id. That is not the issue here. Collateral questions decided by the Court included, for example, whether the state had sovereign immunity from the third-party's claim. Id. at 433. Proximate cause was mentioned in the opinion, but the Court dispatched the question with little discussion. Id. It found that Petersen had submitted sufficient evidence to allow the claim in that case to reach the jury. Id. at 437. Petersen sheds no light on the proper outcome of the case before this Court.

In contrast to Petersen, this case is one where Plaintiff has admitted in her testimony, and Plaintiff's counsel has admitted in her argument, that there is nothing more than speculation to tie this car accident to Nurse Short's treatment. This case is just like Rounds and Fabrique -- cases that were properly dismissed on summary judgment where Plaintiff's causation theory is no stronger than a claim that an alleged breach of duty "might have," "could have," or "possibly did" cause the claimed injury.

Plaintiff's citation to Conrad v. Alderwood Manor, 119 Wn. App. 275, 78 P.3d 177 (2003), does nothing to change this. Plaintiff quoted the case for the proposition that circumstantial evidence may be used to establish proximate cause, but she omitted the key part of the rule. The Conrad court explained:

But evidence establishing proximate cause must rise above speculation, conjecture, or mere possibility. Reese v. Stroh, 128 Wn.2d 300, 309, 907 P.2d 282 (1995). A jury is not permitted to speculate on how an accident or injury occurred when causation is based solely on circumstantial evidence and there is nothing more substantial to proceed on than competing theories with the defendant liable one but not the other. [Additional citations omitted.]

Id. at 282. The full rule of Conrad and of the more recent cases discussed above support the trial court's conclusion in this case that Plaintiff had a fatal failure of proof on proximate cause.

Separate and apart from the speculative nature of the cause of the accident, there is a second, independent interruption in any alleged causal chain. Mr. Militello is the CDMHP who would have evaluated Ms. Poletti on the evening in question. He would have been the person making the determination of whether she would be involuntarily detained or not. As Mr. Militello testified, he stands by his statement that Ms. Poletti was not involuntarily detainable or committable when she wanted to leave Overlake. CP 85:22-86:4. As such, even if Overlake had required the

CDMHP to evaluate Ms. Poletti in person, there would have been absolutely no difference in her outcome. Ms. Poletti would not have been detained for forced psychiatric treatment. Even with an in person evaluation, Ms. Poletti still would have been discharged to leave Overlake.

Plaintiff attempts to save her claim by focusing heavily on an earlier assessment that was performed by Overlake physician Dr. Kelan Koenig. Plaintiff emphasizes her claim that Dr. Koenig felt that Ms. Poletti “currently” met criteria for involuntary commitment. This emphasis ignores the fact, which Plaintiff’s counsel admitted at oral argument, that while Dr. Koenig may have an opinion about whether Plaintiff met criteria, he could not legally make that determination. See RCW 71.05.050; RCW 71.05.153. It also fails to acknowledge that Dr. Koenig’s assessment took place at 1:00 p.m. -- over six hours before Ms. Poletti’s discharge. CP 125. For involuntary commitment purposes, there was nothing “current” about the assessment at the time that Ms. Poletti requested discharge.

As Mr. Militello testified, and as RCW Ch. 71.05 requires, a person cannot be emergently involuntarily detained unless there is evidence of imminent dangerousness to self or others or of grave disability. CP 72:19-73:7; RCW 71.05.050. In this context, imminent means likely to happen at any moment or close at hand. CP 73:4-7; RCW

E. CONCLUSION

Plaintiff failed to create an issue of fact in response to Overlake's motion for summary judgment. Plaintiff's case failed both in that it lacked the necessary expert testimony and it lacked sufficient proof on proximate cause. For all the foregoing reasons, Overlake Hospital Medical Center respectfully requests that the Court of Appeals reject appellant's contentions and affirm the trial court's dismissal of all claims against it.

DATED this 8th day of October, 2009.

Respectfully submitted,

Fain Sheldon Anderson & VanDerhoef, PLLC



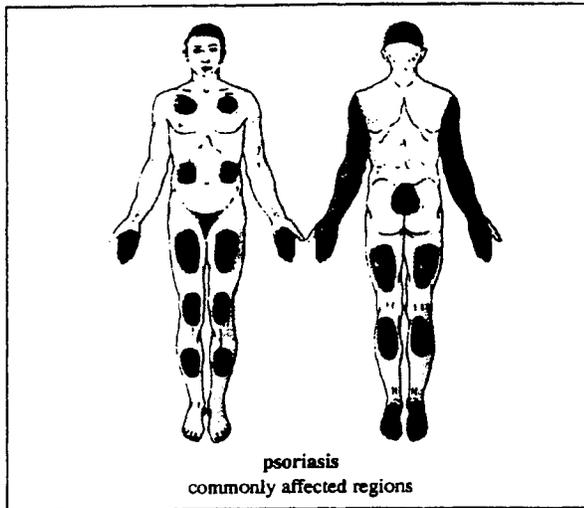
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APPENDIX

STEDMAN'S

26th Edition

ILLUSTRATED IN COLOUR



p. circina'ta, p. in which healing is taking place at the center of the lesion while the process continues at the periphery, producing a ring-shaped or annular lesion. SYN p. annularis, p. annulata, p. orbicularis.

p. diffu'sa, **diffused p.**, a form of p. with extensive coalescence of the lesions.

p. discoi'dea, p. in which the lesions are discrete and disklike. SYN p. nummularis.

generalized pustular p. of Zambusch, SYN pustular p. (1).

p. geograph'ica, p. gyrata in which the lesions suggest the coast outline on a map.

p. gutta'ta, p. occurring abruptly in round patches of small size; seen in young persons following streptococcal infections.

p. gyra'ta, p. circinata in which there is a coalescence of the rings giving rise to figures of various outlines.

p. invetera'ta, p. in which the lesions are confluent, the affected skin being thickened, indurated, and scaly.

p. nummula'ris, SYN p. discoidea.

p. orbicula'ris, SYN p. circinata.

p. ostrea'cea, p. with concentric tiers of scales which give the appearance of the layering of an oyster shell. SYN p. rupioides.

p. puncta'ta, p. in which the individual lesions are papules, each red in color, and tipped with a single white scale.

pustular p., (1) an extensive exacerbation of p., with pustule formation in the normal and psoriatic skin, fever, and granulocytosis; sometimes precipitated by oral steroids; SYN generalized pustular p. of Zambusch. (2) a local pustular eruption of the palms and soles, occurring most commonly in a patient with p.; difficult to distinguish from acrodermatitis continua.

p. rupioi'des, SYN p. ostreacea.

p. spondylit'ica, p. associated with an ankylosing spondylitis.

p. universa'lis, a generalized p.

psori-at-ic (sō-rē-at'ik). Relating to psoriasis. SYN psoriatic.

psori-c (sō'rik). Relating to scabies. SYN psorous.

psoro-oid (sō'royd). Resembling scabies. [G. *psōra*, itch (scabies), + *eidos*, resemblance]

Psorop-tes (sō-rop'tēz). A genus of itch or mange mites (family Cheyletidae), including the species *P. cuniculi* (the scab mite of rabbits), *P. equi* (the mange or body mite of horses), and *P. ovis* (the common scab mite of sheep and cattle). [G. *psōra*, itch]

psoro-us (sō'rūs). SYN psoric.

PSP Abbreviation for phenolsulfonphthalein.

△ **psych-**. SEE psycho-

psy-cha-go-gy (sī'kā-go-jē). Rarely used term for psychotherapeutic reeducation stressing social adjustment of the individual. [psych- + G. *agōgia*, a tutor's office]

psy-chal-ga-lla (sī-kal-gā'lē-ā). SYN psychalgia (1).

psy-chal-gia (sī-kal'jē-ā). 1. Distress attending a mental effort, noted especially in melancholia. SYN algopsychalia, mind pain, phrenalgia (1), psychalgalia, soul pain. 2. SYN psychogenic pain. [psych- + G. *algos*, pain]

psy-cha-lia (sī-kā'lē-ā). An emotional condition characterized by auditory and visual hallucinations.

psy-cha-nop-sia (sī'kā-nop'sē-ā). SYN mind blindness. [psych- + G. *an-* priv., + *opsis*, vision]

psy-cha-tax-ia (sī-kā-tak'sē-ā). Mental confusion; inability to fix one's attention or to make any continued mental effort. [psych- + G. *ataxia*, confusion]

psy-che (sī'kē). Term for the subjective aspects of the mind, self, soul; the psychological or spiritual as distinct from the bodily nature of persons. [G. mind, soul]

△ **psyche-**. SEE psycho-

psy-che-del-ic (sī-kē-del'ik). 1. Pertaining to a rather imprecise category of drugs with mainly central nervous system action, and with effects said to be the expansion or heightening of consciousness, e.g., LSD, hashish, mescaline. 2. A hallucinogenic substance, visual display, music, or other sensory stimulus having such action. [psyche- + G. *dēloō*, to manifest]

psy-chen-to-nia (sī-ken-tō'nē-ā). Rarely used term for mental tension. [psych- + G. *en*, in, + *tonos*, tension]

psy-chi-at-ric (sī-kē-at'rik). Relating to psychiatry.

psy-chi-at-rics (sī-kē-at'riks). SYN psychiatry.

psy-chi-at-ric trend. Benign or morbid emotional interests, urges, and tendencies as revealed by postures, gestures, actions, or speech.

psy-chi-a-trist (sī-kī'ā-trist). A physician who specializes in psychiatry.

psy-chi-a-try (sī-kī'ā-trē). 1. The medical specialty concerned with the diagnosis and treatment of mental disorders. 2. The diagnosis and treatment of mental disorders. For some types of p. not listed below, see also subentries under therapy, psychotherapy, psychoanalysis. SYN psychiatrics. [psych- + G. *iatria*, medical treatment]

analytic p., SYN psychoanalytic p.

biological p., a branch of p. that emphasizes molecular, genetic, and pharmacologic approaches in the diagnosis and treatment of mental disorders.

community p., p. focusing on the detection, prevention, early treatment, and rehabilitation of individuals with emotional disorders and social deviance as they develop in the community rather than as encountered one-on-one, in private practice, or at larger centralized psychiatric facilities; particular emphasis is placed on the social-interpersonal-environmental factors that contribute to mental illness.

contractual p., psychiatric intervention voluntarily assumed by the patient, who is prompted by his personal difficulties or suffering and who retains control over his participation with the psychiatrist.

cross-cultural p., a field of p. with interest in the study of psychological and psychiatric phenomena as differentially expressed in the cultures of different countries.

descriptive p., that aspect of the practice of psychiatry that deals with the diagnosis of mental disorders.

dynamic p., SYN psychoanalytic p.

existential p., SYN existential *psychotherapy*.

forensic p., **legal p.**, the application of p. in courts of law, e.g., in determinations for commitment, competency, fitness to stand trial, responsibility for crime.

industrial p., the application of the principles of p. to problems in business and industry.

orthomolecular p., an approach to p. that focuses on the use of megavitamins and nutrition in the treatment of such mental illnesses as the schizophrenic disorders.

psychoanalytic p., psychiatric theory and practice emphasizing the principles of psychoanalysis. SYN analytic p., dynamic p.

social p., an approach to psychiatric theory and practice emphasizing the cultural and sociological aspects of mental disorder and treatment; the application of p. to social problems. SEE ALSO community p.

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synopsis of three great psychological theories			
	psychoanalysis (depth psychology)	behaviorism	cognitive psychology
central area of research	unconscious drives and content of the unconscious	external behavior (reactions, reflexes)	consciousness
determining factors of behavior	(unconscious) complexes, fixations	environmental conditions (stimulus, reinforcement)	structures of consciousness
image of the human being	human being is a prisoner of drives	freedom and reason are pre-scientific concepts; human behavior is completely determined by the environment and its stimuli	humans possess insight, foresight and thereby have responsibility and freedom of choice
preferred method of research	search for symbolic contents of the unconscious in speech and nonverbal expression	assessment of stimuli and reactions	open questioning
preferred method of treatment	enlightenment about traumas, complexes, and suppressions	behavior modification through planning of stimuli and reinforcement	counsel, assistance toward self-reflection and self-control

psy-cho-lag-ny (sī-kō-lag'nē). Rarely used term for sexual excitement and satisfaction from mental imagery. [psycho- + G. *lagneia*, lust]

psy-cho-lep-sy (sī'kō-lep-sē). Rarely used term for sudden mood changes accompanied by feelings of hopelessness and inertia. [psycho- + G. *lēpsis*, seizure]

psy-cho-ling-uistics (sī'kō-ling-gwi'stiks). Study of a host of psychological factors associated with speech, including voice, attitudes, emotions, and grammatical rules, that affect communication and understanding of language. [psycho- + L. *lingua*, tongue]

psy-cho-log-ic, psy-cho-log-i-cal (sī-kō-loj'ik, -loj'i-kāl). 1. Relating to psychology. 2. Relating to the mind and its processes. SEE psychology.

psy-cho-l-o-gist (sī-kol'ō-jist). A specialist in psychology licensed to practice professional psychology (e.g., clinical p.), or qualified to teach psychology as a scholarly discipline (academic p.), or whose scientific specialty is a subfield of psychology (research p.).

psy-cho-l-o-gy (Ψ) (sī-kol'ō-jē). The profession (e.g., clinical p.), scholarly discipline (academic p.), and science (research p.) concerned with the behavior of humans and animals, and related mental and physiological processes. [psycho- + G. *logos*, study]

adlerian p., SYN individual p.

analytical p., SYN jungian *psychoanalysis*.

animal p., a branch of p. concerned with the study of the behavior and physiological responses of animal organisms as a means of understanding human behavior; some synonyms include comparative psychology, experimental psychology, and physiological psychology.

atomistic p., any psychologic system based on the doctrine that mental processes are built up through the combination of simple elements; e.g., psychoanalysis, behaviorism.

behavioral p., SYN behaviorism.

behavioristic p., a branch of psychology that uses behavioral approaches such as desensitization and flooding in contrast to counseling and other psychodynamic approaches to the treatment of psychological disorders. SEE ALSO behavior *therapy*.

child p., a branch of p. the theories and applications of which focus on the cognitive and intellectual development of the child in contrast to the adult; subspecialties include developmental psychology, child clinical psychology, pediatric psychology, and pediatric neuropsychology.

clinical p., a branch of p. that specializes in both discovering new knowledge and in applying the art and science of p. to persons with emotional or behavioral disorders; subspecialties include clinical child p. and pediatric p.

cognitive p., a branch of p. that attempts to integrate into a

whole the disparate knowledge from the subfields of perception, learning, memory, intelligence, and thinking.

community p., the application of p. to community programs e.g., in the schools, correctional and welfare systems, and community mental health centers.

comparative p., a branch of p. concerned with the study and comparison of the behavior of organisms at different levels of phylogenic development to discover developmental trends.

constitutional p., the p. of the individual as related to body habitus.

counseling p., p. with emphasis on facilitating the normal development and growth of the individual in coping with important problems of everyday living, as initially contrasted with clinical p.

criminal p., the study of the mind and its workings in relation to crime. SEE forensic p.

depth p., the p. of the unconscious, especially in contrast with older (19th century) academic p. dealing only with consciousness; sometimes used synonymously with psychoanalysis.

developmental p., the study of the psychological, physiological, and behavioral changes in an organism that occur from birth to old age.

dynamic p., a psychologic approach that concerns itself with the causes of behavior.

educational p., the application of p. to education, especially to problems of teaching and learning.

environmental p., the study and application by behavioral scientists and architects of how changes in physical space and related physical stimuli impact upon the behavior of individuals. SEE ALSO personal *space*.

existential p., a theory of p., based on the philosophies of phenomenology and existentialism, which holds that the primary study of p. is an individual's experience of the sequence, spatiality, and organization of his or her existence in the world.

experimental p., (1) a subdiscipline within the science of p. that is concerned with the study of conditioning, learning, perception, motivation, emotion, language, and thinking; (2) also used in relation to subject-matter areas in which experimental, in contrast to correlational or socio-experiential, methods are emphasized.

forensic p., the application of p. to legal matters in a court of law.

genetic p., a science dealing with the evolution of behavior and the relation to each other of the different types of mental activities.

gestalt p., SEE gestaltism.

health p., the aggregate of the specific educational, scientific, and professional contributions of the discipline of p. to the promotion and maintenance of health, the prevention and treatment

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identifiers; invented by and named for Lancelot Hogben. The mathematician; Hogben n.'s are the basis for identification n.'s in many primary care facilities and are used in many record linkage systems.

Hounsfield n., SYN CT n.

hydrogen n., the quantity of hydrogen that 1 g of fat will absorb; it is a measurement of the amount of unsaturated fatty acids in the fat. SEE ALSO iodine n.

iodine n., an indication of the quantity of unsaturated fatty acids present in a fat; it represents the number of grams of iodine absorbed by each 100 g of fat. SEE ALSO hydrogen n. SYN iodine value.

Kestenbaum's n., the difference between the two pupil diameters when each eye is measured in bright light with the other eye tightly covered; an indicator of the relative afferent pupillary defect in patients with two normally innervated irises.

Knoop hardness n. (KHN), a n. obtained by dividing the load in kg applied to a pyramid-shaped diamond of specific size divided by the projected area of the impression: $KHN = L/A$, where A = the projected area of the impression in mm^2 and L = the load in kg; used for measurements of hardness of any materials, especially very hard and brittle substances such as tooth dentin and enamel.

Koettstorfer n., SYN saponification n.

linking n. (L), a property of a long biopolymer (such as duplex DNA) equal to the number of twists (related to the frequency of turns around the central axis of the helix) plus the writhing n.

Loschmidt's n. (n_0), the n. of molecules in 1 cm^3 of ideal gas at 0°C and 1 atmosphere of pressure; Avogadro's n. divided by 22,414 (i.e., $2.6868 \times 10^{19}\text{ cm}^{-3}$).

Mach n., a n. representing the ratio between the speed of an object moving through a fluid medium, such as air, and the speed of sound in the same medium.

mass n., the mass of the atom of a particular isotope relative to hydrogen-1 (or to $1/12$ the mass of carbon-12), generally very close to the whole number represented by the sum of the protons and neutrons in the atomic nucleus of the isotope (indicated in the name or symbol of the isotope; e.g., oxygen-16, ^{16}O); not to be confused with the atomic weight of an element, which may include a number of isotopes in natural proportion.

MIM n., the catalog assignment for a mendelian trait in the MIM system. If the initial digit is 1, the trait is deemed autosomal dominant; if 2, autosomal recessive; if 3, then X-linked. Whenever a trait defined in this dictionary has a MIM n. the n. from the tenth edition of MIM is given in square brackets with or without an asterisk as appropriate e.g., Pelizaeus-Merzbacher disease [MIM*169500] is a well-established, autosomal, dominant, mendelian disorder.

Polenské n., the n. of milliliters of 0.1 N KOH required to neutralize the nonvolatile fatty acids obtained from 5 g of a saponified fat or oil.

Reichert-Meissl n., an index of the volatile acid content of a fat; the n. of milliliters of 0.1 N KOH required to neutralize the soluble volatile fatty acids in 5 g of fat that has been saponified, acidified to liberate the fatty acids, and then steam-distilled. SYN volatile fatty acid n.

Reynolds n., a dimensionless n. that describes the tendency for a flowing fluid, such as blood, to change from laminar flow to turbulent flow or vice versa.

saponification n., the n. of milligrams of KOH required to saponify 1 g of fat; an approximate measure of the average molecular weight of a fat, with which it varies inversely. SYN Koettstorfer n.

stoichiometric n. (v), the n. associated with a reactant or product participating in a defined chemical reaction; usually an integer.

thiocyanogen n., the n. of grams of thiocyanogen taken up by 100 g of fat; analogous to the iodine n., except that thiocyanogen will not add to all the double bonds in polyunsaturated fatty acids as will iodine. SYN thiocyanogen value.

transport n., the fraction of the total current carried through a solution by a particular type of ion present in that solution.

turnover n. (k_{cat}), the number of substrate molecules converted

into product in an enzyme-catalyzed reaction under saturating conditions per unit time per unit quantity of enzyme; e.g., $k_{cat} = V_{max}/[E_{total}]$.

volatile fatty acid n., SYN Reichert-Meissl n.

wave n., the n. of waves (of any wave form such as light or sound) per unit length.

writhing n., the n. of times a DNA duplex axis crosses over itself in space.

numb-ness (nūm'nes). Indefinite term for abnormal sensation, including absent or reduced sensory perception as well as paresthesias.

num-mi-form (nūm'i-fōrm). SYN nummular.

num-mu-lar (nūm'yū-ler). 1. Discoid or coin-shaped; denoting the thick mucous or mucopurulent sputum in certain respiratory diseases, so called because of the disc shape assumed when it is flattened on the bottom of a sputum mug containing water or transparent disinfectant. 2. Arranged like stacks of coins, denoting the lining up of the red blood cells into rouleaux formation. SYN nummiform. [L. *nummulus*, small coin, dim. of *nummus*, coin]

num-mu-la-tion (nūm-yū-lā'shūn). Formation of nummular masses.

nun-na-tion (nū-nā'shūn). A form of stammering in which the *n* sound is given to other consonants. [Ar. *nūn*, the letter *n*.]

nurse (ners). 1. To breast feed. 2. To provide care of the sick. 3. One who is educated in the scientific basis of nursing under defined standards of education and is concerned with the diagnosis and treatment of human responses to actual or potential health problems. [O. Fr. *nourice*, fr. L. *nutrix*, wet-nurse, nurse, fr. *nutrio*, to suckle, to tend]

certified registered n. anesthetist (C.R.N.A.), a registered professional nurse with additional education in the administration of anesthetics. Certification achieved through a program of study recognized by the American Association of Nurse Anesthetists.

charge n., a n. administratively responsible for a designated hospital unit on an 8 hour basis. SYN head n. (2).

clinical n. specialist, a registered n. with at least a master's degree who has advanced education in a particular area of clinical practice such as oncology, psychiatry. Usually employed in a hands-on clinical setting such as a hospital.

community n., SYN public health n.

community health n., SYN public health n.

dry n., a woman who cares for newborn infants without breast feeding them, as opposed to a wet n.

n. epidemiologist, a registered n. with additional education in the monitoring and prevention of nosocomial infections in the client population in an agency. SYN infection control n.

flight n., a n. who cares for clients during transport in any type of aircraft.

general duty n., n. who accepts assignment to any unit of a hospital other than an intensive care unit.

graduate n., a n. who has received a degree, most often a bachelor's degree, from a school or college of nursing.

head n., (1) a n. administratively responsible for a designated hospital unit on a 24 hour basis; (2) SYN charge n.

home health n., a n. who is responsible for a group of clients in the home setting. Visits clients on a routine basis to assist client and family with care as needed and to teach family the care needed so that the client may remain in his/her home. SYN visiting n.

hospital n., a registered n. working in a hospital.

infection control n., SYN n. epidemiologist.

licensed practical n. (L.P.N.), a n. who has graduated from an accredited school of practical (vocational) nursing, passed the state examination for licensure and been licensed to practice by a state authority. Program is generally one year in length. SYN licensed vocational n.

licensed vocational n. (L.V.N.), SYN licensed practical n.

practical n., a graduate of a specific educational program that

prepares the individual for a career in nursing with less responsibility than a graduate or registered n.

private n., SYN private duty n.

private duty n., (1) a n. who is not a member of a hospital staff, but is hired by the client or his/her family on a fee-for-service basis to care for the client; (2) a n. who specializes in the care of patients with diseases of a particular class, e.g., surgical cases, tuberculosis, children's diseases. SYN private n.

public health n., a n. who provides care to individuals or groups in a community outside of institutions. Usually works through the auspices of a state or city health department. SYN community health n., community n.

registered n. (R.N.), a n. who has graduated from an accredited nursing program, has passed the state exam for licensure, and been registered and licensed to practice by a state authority.

school n., a n., usually an RN, working in a school or similar institution.

scrub n., a n. who has scrubbed arms and hands, donned sterile gloves and, usually, a sterile gown, and assists an operating surgeon, primarily by passing instruments.

special n., a n., who might be a registered nurse or a practical nurse, assigned to limited, specialized functions; usually synonymous with private duty nurse.

student n., a student in a program leading to certification in a form of nursing; usually applied to students in an RN or practical n. program.

visiting n., SYN home health n.

wet n., a woman who breast-feeds a child not her own.

nurse prac-ti-tion-er (ners prak-tish'ü-ner). A registered nurse with at least a master's degree in nursing and advanced education in the primary care of particular groups of clients. Capable of independent practice in a variety of settings.

Nurse practitioners have been recognized in the U.S. since 1955, and currently are seen as a possible means of reducing health care costs. They are able to carry out 60-90% of the tasks required of a primary health care provider, including taking medical histories, performing physical exams and laboratory tests, and treating common illnesses and injuries. In this way they free physicians to address more acute illnesses, or, especially in rural regions without a local primary care physician, allow patients to receive treatment for most medical problems without having to travel long distances. Generally, nurse practitioners emphasize preventive health care and close management of chronic disorders.

nurs-ing (ner'sing). 1. Feeding an infant at the breast; tending and caring for a child. 2. The scientific application of principles of care related to prevention of illness and care during illness.

n. assignment, the method(s) by which the patient care load is distributed among the n. personnel available to provide care.

n. audit, a defined procedure used to evaluate the quality of n. care provided within an agency to its clients.

n. model, a set of abstract and general statements about the concepts that serve to provide a framework for organizing ideas about clients, their environment, health and nursing.

n. plan of care, the written framework that provides direction for the delivery of n. care.

n. process, a five-part systematic decision-making method focusing on identifying and treating responses of individuals or groups to actual or potential alterations in health. Includes assessment, n. diagnosis, planning, implementation, and evaluation. The first phase of the n. process is assessment, which consists of data collection by such means as interviewing, physical examination, and observation. It requires collection of both objective and subjective data. The second phase is n. diagnosis, a clinical judgment about individual, family or community n. responses to actual or potential health problems/life processes. Provides the basis for selection of n. intervention to achieve outcomes for which the nurse is accountable (NANDA, 1990). The third phase is planning, which requires establishment of outcome criteria for the client's care. The fourth phase is imple-

mentation (intervention). This phase involves demonstrating those activities that will be provided to and with the client to allow achievement of the expected outcomes of care. Evaluation is the fifth and final phase of the n. process. It requires comparison of client's current state to the stated expected outcomes and results in revision of the plan of care to enhance progress toward the stated outcomes.

nurs-ing home. A convalescent home or private facility for the care of individuals who do not require hospitalization and who cannot be cared for at home.

Nussbaum, Johann von, German surgeon, 1829-1890. *see* **braceler**.

Nussbaum, Moritz, German histologist, 1850-1915. *see* **experiment**.

nu-ta-tion (nū-tā'shūn). The act of nodding, especially involuntary nodding. [L. *annuo*, to nod]

nut-gall (nū'tgahl). An excrescence on the oak, *Quercus fectoria* (family Fagaceae) and other species of *Quercus*, caused by the deposit of the ova of a fly, *Cynips gallae tinctorum*, an astringent and styptic, by virtue of the tannin it contains. SYN (3), galla, oak apple.

nut-meg (nū'tmeg). The dried ripe seed of *Myristica fragrans* (family Myristicaceae), deprived of its seed coat and aril; an aromatic stimulant, carminative, condiment, and source of oil and expressed nutmeg oils; it is consumed for its central nervous system effects. *SEE ALSO* myristicin. SYN nutmeg.

nut-meg oil. The volatile oil distilled from the dried kernels of the ripe seeds of *Myristica fragrans*; used as a flavoring and a carminative; in large quantities, it may produce nausea and delirium; the fixed oil expressed from *M. fragrans* is not a rubefacient. SYN myristica oil.

nu-tri-ent (nū'trē-ent). A constituent of food necessary for normal physiologic function. [L. *nutriens*, fr. *nutrio*, to nourish] **essential n.'s**, nutritional substances required for optimal health. They must be in the diet since they are not formed metabolically within the body.

trace n., SYN micronutrients.

nu-tri-lites (nū'tri-līts). Essential nutritional factors. [L. *lactare*, to suckle, nourish]

nu-trit-ion (nū-trish'ūn). 1. A function of living plants and animals, consisting in the taking in and metabolism of material whereby tissue is built up and energy liberated. 2. The study of the food and liquid requirements of human beings or animals for normal physiologic functions, including energy, need, maintenance, growth, activity, reproduction, and lactation. [L. *nutritio*, fr. *nutrio*, to nourish]

total parenteral n. (TPN), n. maintained entirely by intravenous injection or other nongastrointestinal route.

nu-tri-tive (nū'tri-tiv). 1. Pertaining to nutrition. 2. Capable of nourishing. SYN alible.

nu-tri-ture (nū'tri-chūr). State or condition of the nutrition of the body; state of the body with regard to nourishment. [L. *nutrire*, a nursing, fr. *nutrio*, to nourish]

Nuttall, G. H. F., U.S. biologist, 1862-1937. *see* **Nuttallia**.

Nut-tal-lia (nū-tal'ē-ā). Former name for *Babesia*. **nux vom-i-ca** (nūks vom'i-kā). Poison nut or Quaker butternut seed of *Strychnos nux-vomica* (family Loganiaceae), a tree of tropical Asia; it contains two alkaloids, strychnine and brucine, has been used as a bitter tonic and central nervous system stimulant. [Mod. L. emetic nut, fr. L. *nux*, nut, + *vomo*, to vomit]

Nva Abbreviation for norvaline.

△ **nyct-**. *see* nycto-

nyc-tal-gia (nik-tal'jē-ā). Denoting especially the eye pain of syphilis occurring at night. SYN night pain. [nyct-, *algos*, pain]

nyc-ta-lo-pla (nik-tā-lō'pē-ā). Decreased ability to see at night due to reduced illumination. Seen in patients with impaired rod function, often associated with a deficiency of vitamin A. SYN dark night blindness, nocturnal amblyopia, nyctanopia. [nyct-, *alao*, obscure, + *ops*, eye]

n. with congenital myopia [MIM*310500], an abnormality

X-linked inheritance, or nyctalopia

nyc-ta-no-pi- priv. + *opsis*

nyc-ter-ine (*nykterinos*)

nyc-ter-o-hem- [G. *nykteros*, dark]

nycto-, nyct-

nyc-to-hem- (*nykteroheme*)

nyc-to-phil- (*nykterophil*)

nyc-to-pho- (*nykteroph*)

nycto-the- (*nykteroth*)

nyct- (*nykter*)

CERTIFICATE OF SERVICE

I hereby certify that I caused a copy of the **Brief of Respondent Overlake Hospital Medical Center** to be delivered to the following on the 8th of October, 2009:

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