SUPREME COURT NO. 1017456
Court of Appeals, Division III No. 378047
Grant Co. Superior Court No. 18-2-00746-13

SUPREME COURT OF WASHINGTON STATE

THE ESTATE OF CINDY ESSEX, by and through JUDY ESSEX, as Personal Representative of the ESTATE OF CINDY ESSEX,

Petitioners,

vs.

GRANT COUNTY PUBLIC HOSPITAL DISTRICT NO. 1, d/b/a SAMARITAN HEALTHCARE, a Public Hospital; et al.

Respondents.

GRANT COUNTY PUBLIC HOSPITAL DISTRICT NO. 1 d/b/a SAMARITAN HEALTHCARE'S ANSWER TO PETITION

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I. IDENTITY OF ANSWERING RESPONDENT

The answering Respondent in this case is Grant County Public Hospital District No. 1 dba Samaritan Healthcare, a Public Hospital. It is not believed that any other defendant or party in this action will be filing an answer.

II. COURT OF APPEALS DECISION

The unanimous correct decision by Division III of the Washington Court of Appeals adhering to long-standing Washington law filed on January 24, 2023 in Essex v. Grant County Public Hospital District No. 1, ____ Wn. App. ____ 2d ____, 523 P.3d 242 (2023).

III. ISSUES PRESENTED FOR REVIEW

1. Should this Court accept discretionary review when the Court of Appeals' decision is consistent with decisions from this Court as well as other Court of Appeals and does not involve an issue of substantial public interest.

2. Should this Court accept discretionary review when the Petitioner admits that an issue does not satisfy the criteria for discretionary review?

IV. COUNTER STATEMENT OF THE CASE

A. INTRODUCTION

In this well-established area of Washington law, the Plaintiff requests this Court to replace calm with chaos. The Plaintiff wants to replace a rule of law in the state of Washington that has been in existence since 1978. It is a rule that has been reviewed and adopted by this Court. It has been a rule that has been reviewed and previously adopted by the Washington Court of Appeals. The decision by Division III in this case does not conflict with any Washington appellate decisions.

Moreover, it is a rule of law that has worked well for both Plaintiff and Defendants. There is no demonstration that it has caused any injustice or proved unworkable.

Conversely, overturning the well-established precedent would be disastrous. It would add unnecessary complexity to

cases and could lead to increased healthcare expenses at a time when such expenses are already increasing exponentially.

B. PERTINENT SUBSTANTIVE FACTUAL BACKGROUND

1. Preface

We will not burden this Court by discussing facts that are not pertinent to the issue. We will limit the discussion of facts to what we submit are relevant to the ostensible/apparent agency issue. By doing so, this should not be construed as tacit admission that the alleged facts set forth by the Plaintiff are complete and accurate.

2. General factual background

It is unclear in this case whether Ms. Essex decided to seek care at Samaritan Hospital. The evidence is that her mother brought her to Samaritan. (CP 501, 502, 678).

As part of the admission process, Samaritan informed Ms. Essex's mother that some of the physicians providing care may be independent contractors. (CP 502, 678-79). Ms. Essex

had been provided and signed this document at a previous admission to Samaritan. (CP 681).

At the trial court level, Samaritan introduced substantial evidence demonstrating that a hospital has no right to control the actions of physicians that have staff privileges. The evidence demonstrated that the physicians act independently and make independent clinical judgments on how to treat a patient. There is no one from the hospital administration supervising physicians at all times and checking every action that physician makes. (CP 683-701, 706-720, 724-30, 738-41, 751, 759-64, 778). The Plaintiff produced no evidence that a hospital has a right to control the actions of physicians with staff privileges at the hospital.

3. Facts demonstrating that Samaritan did not control the clinical judgment of Dr. Davis

There is no dispute that Dr. Davis was not an employee of Samaritan. Dr. Davis was an employee of the Defendant Wenatchee Emergency Physicians. (CP 691, 739, 759).

Moreover, the agreements with the parties demonstrate that it was intended that Dr. Davis be an independent contractor.

At the time of the care provided to Ms. Essex, Samaritan did not assign emergency room physicians to shifts or to see patients. That task was performed by Washington Emergency Physicians, Dr. Davis' employer. (CP 778).

Dr. Davis, as an emergency room physician, acted independently. He exercised independent judgment in deciding how to treat his patients. He was ethically required to do so. His actions were not controlled by the hospital administration or by hospital administration oversight. (CP 696-97, 739-40).

4. <u>Facts demonstrating that Samaritan did not control the clinical judgment of Dr. Cruite</u>

During Ms. Essex' stay at Samaritan for the time in question, Ms. Essex did not see Dr. Cruite nor did anybody in Ms. Essex's family see Dr. Cruite. Moreover, there were no communications between any of them. (CP 677). Dr. Cruite was

not even at the hospital at the time and had never been at the hospital. (CP 663).

Dr. Cruite was not an employee of Samaritan. (CP 739). Dr. Cruite as a radiologist exercised her own independent judgment and was not subject to the control of hospital administration. She was ethically bound to do so. (CP 725-26).

V. ARGUMENT WHY REVIEW SHOULD BE DENIED

A. DIVISION III'S DECISION IN THIS CASE IS NOT IN CONFLICT WITH ANY OTHER APPELLATE COURT DECISION

This Court has already established the rule to apply in determining whether an independent contractor physician may be the ostensible or apparent agent of a hospital. The issue presented itself to this Court in Mohr v. Grantham, 172 Wn.2d 844, 262 P.3d 490 (2011).

In Mohr, this Court cited with approval and adopted the holding of the 1978 decision Adamski v. Tacoma General Hospital, 20 Wn. App. 98, 579 P.2d 970 (1978). The Adamski decision primarily adopted the theory of ostensible/apparent

agency. This theory has been relied upon by numerous trial courts. See, 6 Washington Practice, Washington Pattern Jury Instruction, Civil WPI 105.02.03 (7th Ed.).

Relying on Adamski and noting that there are several factors involved, this Court in Mohr determined that there was a factual issue whether non-employed physicians could be determined to be the apparent agents of the hospital. "As in Adamski, we find that a hospital may be, depending on the facts found by a jury, liable for the negligence of its contractor doctors, who are held out to be agents of the hospital." Id., at 861-67.

Adamski v. Tacoma General Hospital, 20 Wn. App. 98, 579 P.2d 970 (1978) is the ground-breaking case in the state of Washington adopting the legal theory to apply to determine if a physician with staff privileges can be the apparent/ostensible agent of a hospital. The Adamski decision is the seminal case in Washington on that issue.

Division II of the Washington Court of Appeals in Adamski concluded a hospital may be vicariously liable for the

acts of an independent physician under a theory of "holding out" or "ostensible agent." Id. at 112. Other courts have referred to this as an apparent agency theory, e.g., Mohr v. Grantham, 172 Wn.2d 844, 262 P.3d 490 (2011).

The Court in Adamski determined that under an ostensible or apparent agency theory it is generally a jury decision whether an independent contractor physician is the ostensible/apparent agent of a hospital. In arriving at that decision, the Adamski court relied upon Restatement (2nd) of Agency, Section 267 (1958). It provides:

> One who represents that another is his servant or other agent and thereby causes a third person justifiably to rely upon the care or skill of such apparent agent is subject to liability to the third person for harm caused by the lack of care or skill of the one appearing to be a servant or other agent as if he were such.

Id. at 112.

The Washington Pattern Jury Instructions have adopted Adamski in producing the instruction on the issue of a non-employed physician being the apparent agent of a hospital.

6 Washington Practice, Washington Pattern Jury Instruction, Civil WPI 105.02.03 (7th Ed.). The comment section to this instruction relies almost exclusively on the Adamski decision as the Washington authority on the issue of a non-employee physician being the apparent agent of a hospital. See also, WPI 105.02.01.

Prior to the ruling in this case, Division III also filed a previous opinion that is consistent with its position here. In Wilson v. Grant, 162 Wn. App. 731, 258 P.3d 689 (2011), Division III addressed this issue and adopted the Adamski rule. In doing so, the Wilson court also cited with approval Restatement (2nd) of Agency, Section 267 (1958). Id. at 744.

The Wilson court clearly and succinctly set forth the well-recognized rule in Washington to determine whether a non-employed physician can be the ostensible/apparent agent of a hospital.

> To recover under the theory of apparent agency, the state must show: (1) conduct by the hospital that would cause a reasonable person to believe that

> Dr. Grant was an agent of the hospital, and (2) reliance on the apparent agency relationship by the decedent.

Id.

Consequently, there are three previous Washington reported appellate decisions that have addressed the exact issue presented here. The rule of law was set forth in Washington in 1978 under the Adamski decision and has been consistently followed for the 45 years since then. Any contention by the Plaintiffs that Division III's ruling in this case conflicts with decisions of the Washington appellate courts is erroneous.

B. THE APPELLATE COURT'S DECISION FOLLOWED THE OVERWHELMING LAW FROM OTHER JURISDICTIONS

Although not binding on this Court, this Court considers the relevant opinions from other jurisdictions addressing a particular issue as persuasive. See, Boeing Co. v. Aetna Casualty & Surety Co., 113 Wn.2d 869, 878, 784 P.2d 507 (1990). There is an abundance of case law addressing this specific issue from other jurisdictions.

Other jurisdictions have almost universally adopted the holding of Division III here, and by the Washington appellate courts in the Mohr, Adamski, and Wilson cases. That rule being that courts from other jurisdictions adopt the rationale of the Restatement (2nd) of Agency, Section 267 (1958) or similar rule of law in determining whether a factfinder can conclude a non-employed physician is the agent of a hospital. See, e.g., James v. Ingalls Memorial Hospital, 791 N.E.2d 627 (Ill. App. 1998); Brown v. St. Vincent's Hospital, 899 So.2d 227 (Ala. 2004); Jones v. Healthsouth Treasure Valley Hospital, 206 P.3d 473 (2009); Simmons v. Tuomey Regional Medical Center, 533 S.E.2d 312 (S.C. 2000); Markel v. William Beaumont Hospital, 982 N.W.2d 151 (Mich. 2022).

Moreover, the majority of jurisdictions that have specifically addressed the non-delegable duty argument raised by Plaintiff have rejected it. See, e.g., Estates of Milliron v. Francke, 793 P.2d 824 (Mont. 1990); Pamperin v. Trinity Memorial Hospital, 423 N.W.2d 848 (Wisc. 1988); Baptist

Hospital System v. Sampson, 969 S.W.2d 945 (Tex. 1998); Kelly v. St. Luke's Hospital of Kansas City, 826 S.W.2d 391 (Mo. App. 1992); Bain v. Colbert County NW Alabama Health Care Authority, 233 So.3d 945 (Ala. 2017); Tiplady v. Maryles, 120 A.3d 528 (Conn. App. 2015), appealed denied, 125 A.3d 527 (Conn. App. 2017); Renown Health, Inc. v. Vanderford, 235 P.3d 614 (Nev. 2010).

C. BASIS FOR VICARIOUS LIABILITY IS NOT APPLICABLE HERE

The principle foundation of the theory that a principal can be vicariously liable for the acts of others is the right to control. "The doctrine of respondeat superior, which is the basis of vicarious tort liability in this jurisdiction whether an agent or an employee is involved, requires that the one charged with imputed liability have control of or the right to control the physical actions of the negligent actor." McLean v. St. Regis Paper Co., 6 Wn. App. 727, 732, 460 P.2d 571 (1972). See also, Hollingberry v. Dunn, 68 Wn.2d 75, 411 P.2d 431 (1966).

There is fairness to a rule that a principal can be liable for the acts of the other if the principal has the right to control the conduct and activities of the other. That concept of fairness evaporates when the principal has no ability to control the actions of another.

The undisputed facts demonstrated to the trial court are that Samaritan had absolutely no right to control the actions of Dr. Davis or Dr. Cruite. These specialist physicians are ethically required to exercise their independent judgment and hospitals do not control those independent judgment decisions.

This factor should weigh heavily against a decision to expand hospital's vicarious liabilities for a non-employed physician that merely has staff privileges at the hospital. Staff privileges at a hospital do not impose vicarious liability. Burnett v. Spokane Ambulance, 54 Wn. App. 162, 169, 772 P.2d 1027, rev. denied, 113 Wn.2d 1005 (1989).

D. PUBLIC INTEREST WOULD BE HARMED BY ADOPTING THE RULE ADVOCATED BY PLAINTIFF

1. <u>It would be a hardship for Washington hospitals to absorb the increased costs</u>

A discussion of the policy reasons of imposing vicarious lability in a case decided over 50 years ago is equally applicable now and persuasive.

> . . . They contend that St. Regis, rather than the innocent injured plaintiff, should bear the loss as part of its cost of doing business; and that St. Regis is better able to absorb the loss and distribute it through prices to the community at large.
>
> This contention might possess arguable merit if we could limit consideration of the question of vicarious tort liability to the large, well-to-do commercial establishment with the strength and financial ability to absorb or pass along to the public the risk which such extension of the doctrine would generate. This type of liability, however, must attach uniformly to all regardless of size and resources. The 'deep pockets' referred to by some of the legal writers as the rationale for the doctrine of vicarious tort liability, may indeed be a shallow pocket; and the serious effect of the extension of imputed liability to the individual or the small business in the manner suggested is a significant policy consideration which cannot lightly be ignored.

McLean v. St. Regis Paper Co., 6 Wn. App. 727, 733-34, 466 P.2d 251 (1972).

This Court should not lightly ignore the risk which such an extension of the doctrine Plaintiff proposes would generate. Samaritan is a small rural hospital. More significantly, Washington hospitals in general are facing difficult financial issues. A recent newspaper article indicates that hospitals in the state of Washington lost in excess of two billion dollars in 2022.[1]

It is apparent that hospitals in the state of Washington are not "well-to-do commercial establishments." They are facing financial crises for a number of reasons. Public policy would be harmed by placing the burden on them of having even more persons for whom they are vicariously liable. Moreover, it does not serve the public interest for hospitals to distribute the risk through higher prices to the community at large. Raising the cost of health care is not in the public interest.

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1 Yakima Herald-Republic, March 22, 2023 at 1.

2. The change proposed should be left to the legislature

An excellent persuasive analysis of this issue is contained in a case by the Supreme Court of Nevada, Renown Health v. Vanderford, 126 Nev. 221, 235 P.3d 614 (2010). The court in Vanderford cited and relied upon this Court's decision in Niece v. Elmview Group Home, 131 Wn.2d 39, 929 P.2d 420 (1997) in deciding that the decision to impose a non-delegable in this situation should be left to the legislature. The Vanderford court first correctly noted that the rule proposed by the plaintiff here is essentially a strict liability concept. Id. at 224.

The Vanderford court in discussing the public policy concept ruled:

> Third, we decline to impose an absolute non-delegable duty on hospitals based upon public policy. This court may refuse to decide an issue if it involves policy questions better left to the legislature. . . .; See also, Niece v. Elmview Group Home, 131 Wn.2d 39, 929 P.2d 420, 428 (1997) (noting that the policy decision to expand the scope of an employer's liability for an employee's intentional acts against a person to whom the employer owes a duty of care "should be left to the

> legislature."). The legislature has heavily regulated hospitals and would have codified a non-delegable duty to emergency room patients if the legislature had intended such a duty to be imposed on hospitals.

Id. at 225.

As in Niece, this Court should leave this issue to the Washington legislature. Washington state has significant regulations related to hospitals and if the legislature wanted to codify a non-delegable duty to be imposed on hospitals, it would have done so.

3. The new rule advocated by the Plaintiff is over encompassing

Careful attention should be made to the choice of wording by Plaintiff in the Petition filed in this matter as to what they are requesting. Plaintiff is not only requesting that emergency room physicians, and apparently radiologists, that provide care in an emergency room as a matter of law be deemed the agents of the hospital. Plaintiff requests that all non-employed physicians treating patients in the emergency department are the hospital's agent. (*See, e.g., Petition for Review at i, 2, 9, 13*).

Frequently a patient's primary care physician, specialists that have treated a patient, or other specialists are called in to the emergency department to provide care. Under Plaintiff's proposed unjustified expansion of potential liability, all of these various physicians would as a matter of law be deemed the hospital's agents for whom the hospital is vicariously liable.

Moreover, any other physician that merely has staff privileges at the hospital that provides a service related to the patient while the patient is in the emergency department would be the hospital's agent under Plaintiff's theory. This would include potentially pathologists, anesthesiologists, hematologists, any specialist physician that an emergency physician contacted to consult regarding the patient, and many other specialist physicians. Essentially, Plaintiff's proposal has no bounds. This is a disservice to the public because it potentially exposes Washington hospitals to exponentially greater liability.

4. There is no demonstration that the current law has negatively impacted the public interest

In the Petition filed in this case, Plaintiff has submitted no evidence that the rule adopted in Adamski has resulted in any injustice or unfairness to any medical malpractice plaintiff in the state of Washington. The Plaintiff has not even presented any anecdotal evidence. Samaritan is not aware of any such evidence.

To the contrary, there is strong evidence that the Adamski rule is a workable rule that has provided justice to malpractice plaintiffs. This evidences the fact that it has been in existence for over 44 years.

5. Making such medical malpractice cases more complicated is not in the public interest

The Plaintiff represented at the trial court level that its reason for advocating this change in Washington law is so that plaintiffs would only have to sue hospitals and not individual physicians. (CP 12, 13-14). However, adoption of the rule advocated by the Plaintiff most likely would not produce such a

result. Instead, it would just add complexity to a medical malpractice case involving alleged negligence by a non-employed physician.

The emergency room physician as well as the radiologist involved in this case had separate medical malpractice liability insurance. (CP 609-10, 782). If Plaintiff did not independently name them as defendants in this case, the hospital most likely would have filed a contribution claim under RCW 4.22.040. This would cause confusion to the jury and leave the jury wondering why the hospital is suing a physician that practices at the hospital. Such a situation would also be prejudicial to the defendant hospital to bring a claim against non-employed physicians on its hospital staff.

Furthermore, such a rule would be detrimental to the non-employed physicians. Under the scenario where the plaintiff is only naming the hospital and claiming the hospital is vicariously liable for acts of non-employed physicians, the physicians would most likely be named in the body of the complaint. Obviously,

if there was a verdict against the hospital it would be based upon these physician's act. Such a result would require reporting of the physician to the National Practitioner's Data Bank. (See 45 CFR, Part 60).

Reporting to the NPDB is damaging to a physician. It impacts that physician's ability to obtain privileges at hospitals, obtain liability insurance, and the physician's ability to be an approved provider by health insurance providers.

There is an inherent conflict of interest in these medical malpractice cases where a plaintiff is alleging the non-employed physician is negligent but also that the hospital's nurses may have been negligent in not providing sufficient information to the non-employed physician. A physician needs independent counsel under such a scenario to protect his or her interests. This is achieved under the current rule which typically necessitates that the Plaintiff specifically name the non-employed physicians as defendants.

6. Radical change in the law is unnecessary

Anyone that has some fundamental knowledge of a health care system or is up on current affairs knows that independent contractor physicians are becoming the exception rather than the rule. Hospital systems are expanding and taking over additional hospitals. The majority of physicians now are employees of hospitals, large clinic or hospital systems.

The point being that under the current state of affairs, there is no justification in addressing vicarious liability of hospitals for non-employed physicians. This is because more and more physicians are becoming employees of the hospital. Thus, they are clearly agents of the hospital and vicarious liability is not an issue. Public policy is not served by changing a 44-year rule of law when the issue is on the verge of becoming moot. (See the materials attached hereto in the Appendix that were also attached to Samaritan's Response Brief filed with Division III).

E. PLAINTIFF OVEREMPHASIZES THE ADAMSKI DISCUSSION OF NON-DELEGABLE DUTY

The Adamski court's fleeting reference to the non-delegable duty doctrine as it applies in this situation is contained in a mere footnote. Adamski v. Tacoma General Hospital, 20 Wn. App. 98, 111 n.5, 579 P.2d 970 (1978). That discussion is Adamski is obviously dicta. Johnson v. Liquor & Cannabis Board, 197 Wn.2d 605, 618, 486 P.3d 125 (2021). Dicta is not binding on this Court and need not be followed. Id.

Perhaps more significantly, the statutes the Adamski court referred to in the mere footnote have been substantially modified since the 1978 decision. With the substantial amendments to RCW Chapter 70.41 the quality of medical care is not the focus of this licensing scheme. Plaintiff contends that the new language in the WAC is "equivalent." (*Answer to Petition 19, n. 7*). This is a gross misstatement.

The court in Adamski in interpreting the regulations relied on found that the regulations provided that there would be a

physician responsible for services in the emergency department "whose functions and responsibilities are subject to medical direction of the hospital." Id. There is no current regulation where the hospital directs the functions and responsibilities of a physician responsible for emergency department services.

Amendments to the Washington statutes and regulations since Adamski prohibit such regulatory provisions. The legislature amended RCW 70.41.180 in 1985. The amendments to that statute prevent the Department of Health from establishing standards for physicians. Plaintiff's argument that current Washington statutes and regulations establish the standard for physicians that emergency room physicians are agents of the hospital is in violation of this statute.

F. WASHINGTON APPELLATE DECISIONS HAVE NOT RECOGNIZED INHERENT FUNCTION AS AN INDEPENDENT BASIS FOR VICARIOUS LIABILITY

Plaintiff in its Petition to this Court suggests that the inherent function basis standing alone is recognized in

Washington as a separate independent basis for establishing vicarious liability in this situation. Such an argument is untenable. The court in Adamski did not establish the inherent function analysis as an independent ground for vicarious liability. No subsequent Washington appellate case has done so.

The court in Adamski v. Tacoma General Hospital, 20 Wn. App. 98, 579 P.2d 970 (1978) discussed inherent function as one of many elements to consider whether an independent contractor emergency physician could be the agent of a hospital. In discussing the inherent function analysis, the court cited Beeck v. Tucson General Hospital, 18 Ariz. App. 165, 500 P.2d 1153 (1972), that apparently coined the term inherent function. However, the Beeck court looked at over nine separate elements in determining whether an agency relationship exists, and not solely at inherent function. Id. at 169-71. (A subsequent Arizona appellate decision states that Beeck merely established ostensible agency principles. Barrett v. Samaritan Health Services, Inc., 153 Ariz. 138, 735 P.2d 460 (1987)).

Similarly, the other cases cited by Plaintiff and that Plaintiff seems to suggest adopt the independent inherent function analysis as a basis for establishing vicarious liability, Pedroza, Mohr, and Wilson, do not support such an argument. (*Petition for Review at 23*).

The issue in Pedroza v. Bryant, 101 Wn.2d 226, 677 P.2d 166 (1984) was not vicarious liability. The discussion in Pedroza regarding Adamski is dicta. As Plaintiff correctly points out in the Petition, the theory of corporate negligence is distinct and separate from the theory of vicarious liability. (*Petition for Review at 13, n. 4*).

Moreover, Mohr v. Grantham, 172 Wn.2d 844, 262 P.3d 490 (2011) and Wilson v. Grant, 162 Wn. App. 731, 258 P.3d 689 (2011) do not adopt the inherent function analysis as an independent basis for establishing vicarious liability. In Wilson the court simply made a comment that the emergency room was an essential part of a hospital's operation. In the court's discussion of apparent agency, it was just one of numerous

elements that the court looked at to determine there was a factual question whether apparent agency applied. Id. at 744-45.

This Court's analysis of inherent function or essential part of function of operations in Mohr v. Grantham, 178 Wn.2d 844, 262 P.3d 490 (2011) does not contain any suggestion that inherent function is an independent basis for vicarious liability. This Court's discussion of it occurred while discussing apparent agency and a number of elements that a jury could consider in making the factual determination of whether apparent agency existed. Id. at 860-61.

Finally, the Washington Pattern Civil Jury Instructions correctly demonstrate how the inherent function analysis applies in the determination of vicarious liability in these situations. It is just one of many elements a jury should consider in making the factual determination of whether the ostensible/apparent agency relationship exists. 6 Washington Practice, Washington Pattern Jury Instruction, Civil WPI 105.02.03 (7th Ed.).

The Adamski court holding where it discusses the inherent function element is contained at page 112 of that decision. The Adamski court determined there were a number of factors that must be applied to determine whether a physician in this situation is the hospital's agent. "Clearly, when one considers all the facts and circumstances of the relationship between Tacoma General and its emergency room physicians, a substantial and genuine issue of fact arises as to whether the relationship is that of principal and agent." Id. at 112. To suggest that Adamski found that the inherent function analysis alone can establish a principal/agent relationship is inappropriate and not supported.

G. THE CONTRACT DELEGATION THEORY DOES NOT APPLY IN TORT CASES

No Washington appellate court has ruled or implied that the delegation theory which is based on contract law, not tort law, applies under these circumstances. Even an extremely strained interpretation of the case primarily relied upon the Plaintiff in

making this argument, Fugitt v. Meyers, 9 Wn. App. 523, 513 P.2d 297 (1993) does not support Plaintiff's position.

The primary issue in Fugitt was the interpretation and impact of RCW 11.76.110 regarding the payment of administrative debts. In passing, the court stated that there is a general rule a patient is liable under an implied contract for the payment of medical services rendered to her or him. Id. at 525. That is just based upon long-standing contract law such as unjust enrichment. That holding has nothing to do with the issues in this case.

H. PLAINTIFF HAS NOT ESTABLISHED ANY JUSTIFICATION FOR ACCEPTING ANY OTHER ISSUE FOR DISCRETIONARY REVIEW

In mere footnotes Plaintiff suggests this Court should accept review of other issues in addition to the agency issue. *(Petition for Review at 8, note 3 and 27, note 9)*. However, Plaintiff rightfully admits Plaintiff cannot satisfy the necessary criteria under RAP 13.4(b) as to any other issue. This Court

should, based upon that admission alone, not accept review of any additional issues.

Moreover, Plaintiff's truncated arguments as to why this Court should accept review of these issues is not persuasive. Division III's opinion on the lack of proximate cause for the corporate negligence claim against Samaritan was supported by the law and undisputed substantial facts in the record established by Plaintiff's expert. (CP 969, 970, 971, 972, 976, 978, 979, 980, 982, 983).

VI. CONCLUSION

Division III's opinion in this matter is consistent with the three primary Washington appellate cases dealing with this issue, Adamski, Mohr, and Wilson. It follows the rule adopted in Adamski over 44 years ago. It is also consistent with the majority of jurisdictions in the United States.

Moreover, public policy would be adversely impacted if this Court were to adopt the Plaintiff's argument. Hospitals in

the state of Washington are in crisis. Adopting the Plaintiff's position would exponentiate that crisis.

There is no basis under RAP 12.4(b) for this Court to accept discretionary review in this matter. The Plaintiff's Petition should be denied.

Certificate of Compliance: I hereby certify there are **4842** words contained in this Answer, excluding the parts of the document exempted from the word count by RAP 18.17.

DATED this 24th day of March, 2023

/s/ Jerome R. Aiken .
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Meyer, Fluegge & Tenney, P.S.
Attorneys for Respondent
Samaritan Healthcare

CERTIFICATE OF TRANSMITTAL

The undersigned does hereby declare the same under oath and penalty of perjury of the laws of the State of Washington:

On the date set forth below, I caused the foregoing to be electronically filed with the Washington State Appellate Court's Secure Portal system, which will send notification and a copy of this document to all counsel of record:

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Dated this 24th day of March, 2023 at Yakima, Washington.

_/s/ Sheryl A. Jones_____.
SHERYL A. JONES, Legal Assistant to
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APPENDIX

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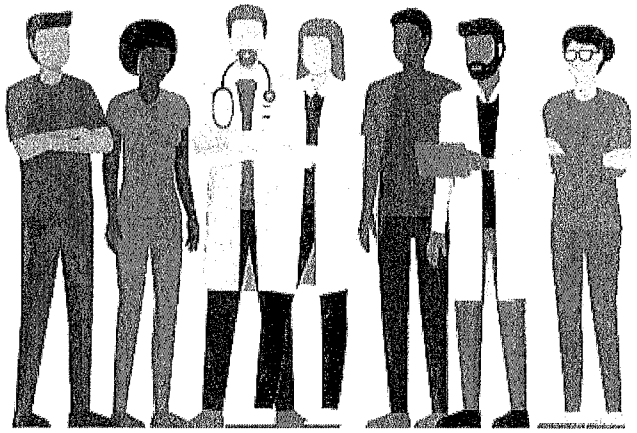
King County Medical Society

Analysis: Who and where are Washington physicians?



By Thomas A. Lerner

The Washington Medical Commission conducted a census of Washington licensed physicians over a 2 year period, and published its results this spring. While no survey yields a 100% response rate, the Commission timed their inquiry with license renewals and then followed up approximately 3-4 weeks afterwards with those who had not responded. About 40% of those who received the follow up inquiry submitted responses. The comments below summarize some of the highlights from the census.

Almost 15,400 licensed physicians are actively practicing in Washington. 88% of Washington physicians are Board certified. The largest cohort among currently active practitioners is in the "echo generation" which followed the baby boomers. 44% of that generation of physicians are women, while 54% of the physicians born after 1983 are women. This is a sharp acceleration of a trend that has been increasing over prior generations.

If you have the sense that independent practices are on the decline, the survey supports that impression. Only 8% of physicians report being solo practitioners. 45% of active physicians are employed by a hospital, a clinic or the state or federal government. 26% practice in single specialty groups and 23% practice in multi-specialty groups. The multi-specialty groups tend to be quite large. Only about 20% sponsor Physician Assistants. The data suggests that there is an opportunity for physicians—particularly those working the hardest—to make more use of physicians assistants.

40% of active physicians practice in more than one location. 62% work more than 100 hours per month, and 16% work more than 200 hours per month. For context, a 40 hour work week averages 180 hours per month. 55% report spending about 30 hours or less per week on administrative tasks, and only 3% report spending more time than that.

About three quarters of Washington physicians practice general medicine, with internal medicine representing over one-third of that number, followed by family medicine and pediatrics. Surgeons represent the next largest category.

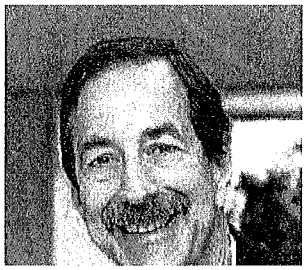
Most physicians accept Medicare and Medicaid patients, but about a quarter didn't know the answer to that question. (One assumes that they are not the ones burdened with the heaviest administrative load). The State Insurance Commissioner has identified about 40 direct health care practices, almost all of which are west of the Cascades. A "direct health care" practice, sometimes referred to as "concierge practices", charge a monthly fee and in return provides unlimited access to doctors for primary-care services. Direct health care practices are required to be registered with the Insurance Commissioner.

About half of Washington's physicians are in King County, although only about 30% of the State's population live here. This is consistent with the concentration of physicians in counties with Washington's largest population centers. The Commission sorted its data into four regions across the state, and it is easy to see the impact of the urban concentration of physicians in cities.

In the dozen counties in Eastern Washington, there are about 500 people per physician. If you exclude Spokane County, there is one physician for every 700 people in the rest of Eastern Washington. In Central Washington, the disparity is less. In these 8 counties, there are 610 people per physician. If you exclude the population centers of Yakima and Benton counties, the number rises to 660 people per doctor. Western and Southwestern Washington (excluding the Puget Sound counties north of Thurston County) are well served with 380 people per physician. But if you drop Thurston and Clark County from the calculation, each doctor has 605 potential patients. The 7 counties that make up the Puget Sound region and north average 396 people per doctor. King County (not surprisingly) has the densest concentration of physicians with 303 people per physician. If you exclude King County from the analysis, from the Snohomish County line to the Canadian border is home to 580 people per physician. If you are feeling oppressed by competition, housing costs or traffic, the answer is clear—get out of town! The rest of the state needs you.

Skamania and Wahkiakum Counties, along the Columbia River in southwest Washington each have 3 physicians, or about 1500 people for each doctor. But let's tip our caps to the one physician—yes, one—in all of Garfield County (in southeastern Washington), taking care of 2200 people. Perhaps not surprisingly, that physician practices emergency medicine.

The experience of Washington physicians in the past twenty years suggests that all of this data are points on a trend line. Consolidation of health care has been the big story for physicians, as larger institutions roll up formerly free standing ones, like The Everett Clinic, Northwest Hospital and The Polyclinic. That has implications for employment and the prospect for maintaining independence in your practices. But the data is also revealing of opportunities for those ready to shift directions away from the trends of concentration and urbanization. One doesn't need to go far to find under served communities in need of more providers.



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Physician Demographic Census Aggregate Report

I - PHYSICIAN INFORMATION

Census start date	1/1/2017
Census end date	12/31/2018
Created on	2/20/2019
Total Returns	21,626

Sex	Active		Retired	
Male	12,363	57%	1,395	6%
Female	7,406	34%	462	2%
	19,769	91%	1,857	9%

Age group and breakdown by sex

Date of Birth	Total	Percentage	Male	Male %	Female	Female %
1900 - 1945	1,235	6%	1,123	5%	112	1%
1946 - 1964	8,490	39%	6,149	28%	2,341	11%
1965 - 1982	10,020	46%	5,628	26%	4,392	20%
1983+	1,881	9%	858	4%	1,023	5%
Total	21,626	100%	13,758	64%	7,868	36%

Practitioners by sex and year of birth:

6. How would you classify your race/ethnicity?*

	Active		Retired	
White	13,310	67%	1,549	83%
Black/African American	422	2%	20	1%
American Indian/Alaskan Native	147	1%	15	1%
Asian	3,795	19%	139	7%
Native Hawaiian/other Pacific Islander	80	0%	4	0%
Hispanic	608	3%	26	1%
Other	494	2%	24	1%
Prefer not to answer	1,447	7%	112	6%

7. Do You have a DEA number?

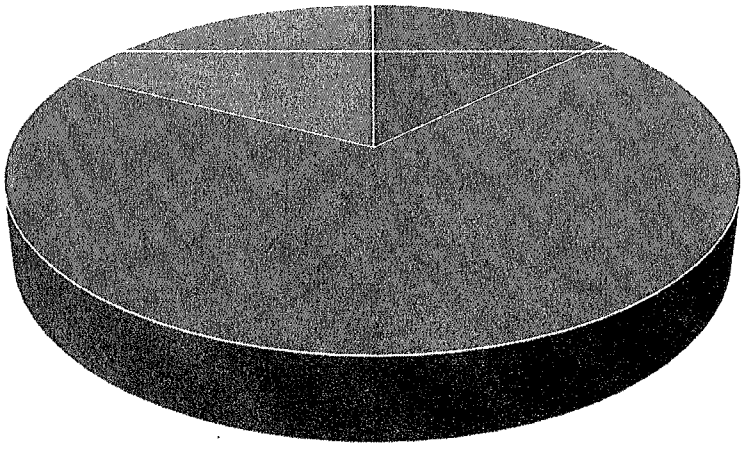
	Active		Retired	
Yes	19,011	96%	1,273	69%
No	758	4%	584	31%

8. Do you currently reside in Washington State?

	Active		Retired	
Yes	14,370	73%	1,517	82%
No	5,399	27%	340	18%

13. Where did you obtain your Medical Degree?

Washington State	2,760	13%
Other US State/Territory	15,079	70%
Foreign Country	3,773	17%
Unknown	14	0%



**Physicians may select multiple options*

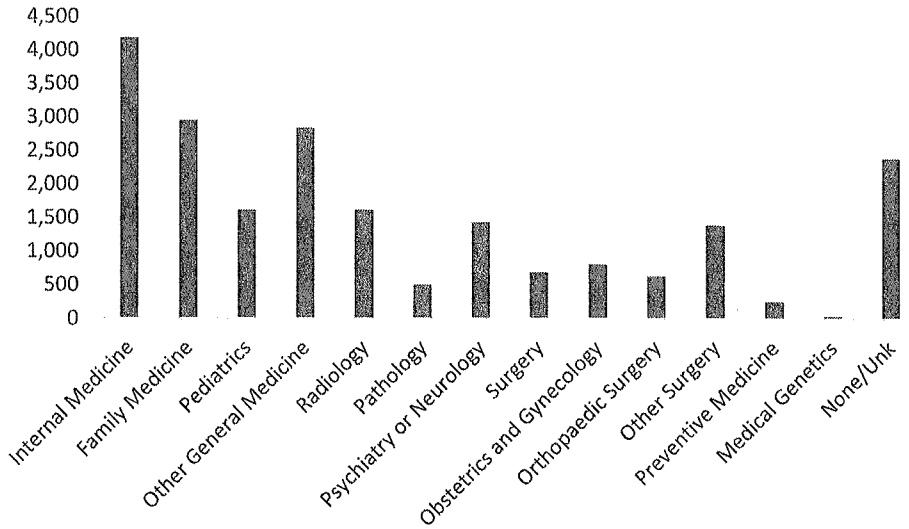
14. Are you ABMS Board Certified?

	Active		Retired	
No	2,383	12%	350	19%
Yes	17,386	88%	1,507	81%

What are your ABMS Board Certifications*

General Medicine	
Allergy and Immunology	96
Anesthesiology	1,206
Dermatology	293
Emergency Medicine	988
Family Medicine	2,951
Internal Medicine	4,183
Pediatrics	1,615
Physical Medicine and Rehab.	254
Radiology	
Diagnostic Radiology	1,336
Interventional Radiology	34
Medical Physics	0
Nuclear Medicine	92
Radiation Oncology	156
Neurology and Psychiatry	
Neurology	400
Neurology/Child Neurology	41
Psychiatry	988
Pathology	
Pathology - Anatomic	71
Pathology - Clinical	33
Pathology-Anatomic/Clinical	394
Surgical	
Colon and Rectal Surgery	34
Neurological Surgery	139
Obstetrics and Gynecology	808
Ophthalmology	388
Orthopaedic Surgery	629
Otolaryngology	248
Plastic Surgery	136
Surgery	689
Thoracic and Cardiac Surgery	117
Urology	217
Vascular Surgery	112

Preventive Medicine	
Aerospace Medicine	20
Occupational Medicine	109
Public Health & Gen. Prev. Med.	123
Medical Genetics	
Clinical Biochemical Genetics	5
Clinical Cytogenetics	2
Clinical Genetics	34
Clinical Molecular Genetics	1
Total Board Certifications	18,942
General Medicine	11,586
Radiology	1,618
Neurology & Psychiatry	1,429
Pathology	498
Surgical	3,517
Preventive Medicine	252
Medical Genetics	42



**Physicians may select multiple options*

15. Have you retired from clinical practice?

No	19,769	91%
Yes	1,857	9%

DOB	No	Yes
1900-1945	51%	49%
1946-1964	86%	14%
1965-1982	99%	1%
1983+	100%	0%

Questions 16 - 31 are only answered by physicians who have not retired

16. Do you plan on retiring from clinical practice in the next 12 months?

No	19,119	97%
Yes	650	3%

17. Upon retirement from clinical practice, will you convert your license to "retired active"

No	255	39%
Yes	395	61%

II - PRACTICE INFORMATION

18. Do you currently practice in Washington?

Yes	15,377	78%
No	4,392	22%

19. At how many locations do you provide patient care?

0 or unknown	1,377	7%
1	11,600	59%
2	4,069	21%
3 or more	2,723	14%

20. Approximately, how much time do you spend at each site in a given month?

	Site 1	Site 2	Site 3
Over 250 hours	4%	0%	0%
200 - 250 hours	12%	1%	0%
100 - 200 hours	46%	8%	4%
Under 100 hours	38%	91%	96%
Total	100%	100%	100%

Counties	Site 1	Avg Hrs/Mo	Site 2	Avg Hrs/Mo	Site 3	Avg Hrs/Mo	Total MDs in County
Northwest Washington							
Island	59	125	13	39	3	18	66
King	6,729	126	2,448	40	896	27	7,258
Pierce	1,562	132	572	43	235	33	1,769
San Juan	23	105	10	26	4	9	39
Skagit	222	121	103	45	28	33	287
Snohomish	882	123	333	38	137	29	1,132
Whatcom	326	126	113	44	50	23	367
Total	9,803	127	3,592	41	1,353	28	10,918
Southwest Washington							
Clallam	138	123	40	47	9	45	157
Clark	973	90	308	40	132	26	1,086
Cowlitz	161	112	58	31	12	27	224
Grays Harbor	59	133	36	45	11	32	98
Jefferson	48	113	17	31	2	40	59
Kitsap	369	124	140	45	60	27	434
Lewis	86	123	53	50	23	23	143
Mason	30	125	10	48	12	25	51
Pacific	19	84	6	32	1	100	27
Skamania	1	64	2	42	0	0	3
Thurston	506	121	217	44	73	27	636
Wahkiakum	1	30	1	8	1	16	3
Total	2,391	109	888	42	336	27	2,921
Central Washington							
Benton	319	139	114	44	35	32	387
Chelan	182	138	72	56	15	13	209
Douglas	11	103	2	44	2	5	15
Grant	57	144	44	30	13	22	105
Kittitas	34	124	13	36	8	13	54
Klickitat	34	79	8	45	3	23	42
Okanogan	46	115	25	27	11	22	66
Yakima	330	123	122	39	42	28	389
Total	1,013	130	400	42	129	25	1,267
Eastern Washington							
Adams	13	96	5	44	3	7	17
Asotin	38	124	12	38	5	100	49
Columbia	2	180	5	57	2	32	10
Ferry	6	127	3	45	0	0	7
Franklin	55	127	16	35	8	17	74
Garfield	1	120	0	0	0	0	1
Lincoln	3	54	4	87	1	10	6
Pend Oreille	13	125	8	18	3	20	23
Spokane	1,133	128	375	42	140	31	1,200
Stevens	28	136	12	39	3	20	39
Walla Walla	146	125	42	48	9	9	161
Whitman	52	107	22	24	9	20	73
Total	1,490	127	504	41	183	30	1,660
Grand Total	**14,697**	**124**	**5,384**	**41**	**2,001**	**28**	**16,766**

21. Please indicate your current area of practice and area of residency accredited by ACGME you have received*

Area of Practice	Principal Practice	Principal Percentage	Secondary Practice	Secondary Percentage	ACGME Residency	ACGME Percentage
Adolescent Medicine	43	0%	72	0%	37	0%
Allergy and Immunology	83	0%	37	0%	78	0%
Anesthesiology	1,195	6%	145	1%	1,181	5%
Cardiology	479	2%	73	0%	452	2%
Child Psychiatry	130	1%	92	0%	204	1%
Colon and Rectal Surgery	33	0%	19	0%	34	0%
Critical Care Medicine	233	1%	240	1%	400	2%
Dermatology	288	1%	43	0%	275	1%
Emergency Medicine	1,116	6%	209	1%	929	4%
Endocrinology	142	1%	39	0%	131	1%
Family Medicine	2,861	14%	455	2%	2,836	13%
Gastroenterology	323	2%	60	0%	317	1%
Geriatric Medicine	99	0%	219	1%	156	1%
Gynecology Only	86	0%	36	0%	51	0%
Infectious Diseases	178	1%	70	0%	225	1%
Internal Medicine	2,654	13%	1,517	8%	4,090	19%
Nephrology	187	1%	38	0%	225	1%
Neurological Surgery	163	1%	32	0%	156	1%
Neurology	418	2%	79	0%	424	2%
Obstetrics and Gynecology	679	3%	233	1%	783	4%
Occupational Medicine	136	1%	55	0%	83	0%
Ophthalmology	384	2%	57	0%	384	2%
Orthopaedic Surgery	667	3%	125	1%	644	3%
Other Surgical Specialties	62	0%	70	0%	102	0%
Otolaryngology	222	1%	28	0%	219	1%
Pathology	468	2%	106	1%	481	2%
Pediatrics	1,109	5%	439	2%	1,534	7%
Pediatrics Subspecialties	498	2%	259	1%	620	3%
Physical Medicine and Rehab.	257	1%	34	0%	248	1%
Plastic Surgery	146	1%	42	0%	153	1%
Preventive Medicine/Public Health	78	0%	123	1%	116	1%
Psychiatry	1,010	5%	188	1%	1,041	5%
Pulmonology	219	1%	108	1%	277	1%
Radiation Oncology	168	1%	30	0%	157	1%
Radiology	1,395	7%	390	2%	1,335	6%
Rheumatology	101	1%	20	0%	99	0%
Surgery	540	3%	172	1%	676	3%
Thoracic and Cardiac Surgery	115	1%	29	0%	113	1%
Urology	218	1%	47	0%	209	1%
Vascular Surgery	112	1%	41	0%	119	1%
Other (e.g. Hospitalist)	735	4%	972	5%	76	0%
None	144	1%	12,940	65%	1,296	6%
Total	**20,174**		**19,983**		**22,966**	

**Some Physicians selected multiple fields*

22. For patient related activities, indicate your practice arrangement and size of group*

Single Specialty Group	5,213	26%
Multi-Specialty Group	4,602	23%
Solo Practitioner	1,538	8%
Employee of a Hospital or Clinic	6,980	35%
State or Federal Employer	2,004	10%
Other	1,593	8%

Group size	Single	Single %	Multi	Multi %
501 +	26	0%	1,000	22%
101 - 500	236	5%	1,294	28%
51 - 100	505	10%	545	12%
21 - 50	1,092	21%	443	10%
1 - 20	3,133	60%	769	17%
Unknown	226	4%	555	12%
Total	5,218	100%	4,606	100%

23. Is your primary clinical practice:

Office based	10,211	52%
Hospital based	7,850	40%
Neither	1,708	9%

24. How many Physician Assistants do you sponsor?

0	15,704	79%
1	2,032	10%
2	858	4%
3 or more	1,175	6%

25. Do you have hospital clinical privileges in Washington State?

All active licensees

Yes	12,161	62%
No	7,608	38%
Total	19,769	100%

Practices in Washington

Yes	11,647	76%
No	3,730	24%
Total	15,377	100%

Doesn't practice in Washington

Yes	514	12%
No	3,878	88%
Total	4,392	100%

**Physicians may select multiple options*

26. Are interpretation services offered at your practice?

No	3,818	19%
Yes	15,951	81%

If yes, what languages are offered for interpretation?

English	9,601	60%
Korean	9,520	60%
French	9,190	58%
Spanish	11,810	74%
Russian	10,012	63%
Mandarin Chinese	9,635	60%
Other	2,089	13%
Do not know	3,518	22%

27. Do you speak any languages other than English well enough to communicate with your patients?

Korean	217	1%
French	707	4%
Spanish	3,079	16%
Russian	213	1%
Mandarin Chinese	652	3%
Other	2,857	14%

28-30. Are you currently accepting patients covered by Medicare, Medicaid, Tricare?
Percentage of your patient population that currently uses this insurance

	Medicare				Medicaid				Tricare			
	Yes	No	Don't know	Total	Yes	No	Don't know	Total	Yes	No	Don't know	Total
Accepting	*60%*	*16%*	*25%*	*100%*	*55%*	*18%*	*27%*	*100%*	*46%*	*16%*	*38%*	*100%*
% of pts.												
67 - 100%	5%	1%	1%	3%	4%	1%	1%	2%	2%	0%	0%	1%
34 - 66%	17%	5%	4%	12%	10%	1%	2%	6%	1%	0%	0%	0%
1 - 33%	26%	9%	6%	19%	34%	14%	9%	24%	43%	9%	7%	24%
0 or unk	52%	84%	89%	66%	52%	84%	89%	68%	54%	91%	93%	75%
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

All questions past this point are answered by all licensees

31. In the past 12 months, how many weeks did you work or volunteer in a clinical setting?

	Active		Retired	
48 - 52 weeks	9,024	46%	91	5%
40 - 47 weeks	4,976	25%	89	5%
31 - 39 weeks	435	2%	23	1%
1 - 30 weeks	2,079	11%	456	25%
0 or unknown	3,255	16%	1,198	65%

32. In a typical work week, indicate the average number of hours dedicated to the following professional activities

	Clinical		Research		Admin		Education		Volunteer		Other	
	Act	Ret	Act	Ret	Act	Ret	Act	Ret	Act	Ret	Act	Ret
>40 hrs	30%	2%	1%	1%	1%	3%	0%	0%	0%	1%	0%	2%
31-40 hrs	34%	2%	1%	1%	2%	3%	0%	0%	0%	1%	1%	2%
30 or less	29%	5%	18%	9%	55%	18%	37%	16%	5%	11%	4%	18%
0 or unk	7%	92%	80%	89%	43%	77%	62%	83%	94%	88%	94%	78%
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

33. Do you provide telehealth/telemedicine services?

	Active		Retired	
No	16,870	85%	1,815	98%
Yes	2,899	15%	42	2%

If yes, how many hours per week do you practice telehealth/telemedicine?

	Active		Retired	
Over 40 hrs	93	3%	1	2%
31 - 40 hrs	419	14%	4	10%
10 - 30 hrs	403	14%	8	19%
Under 10 hrs	1,497	52%	15	36%
0 or unknown	487	17%	14	33%

What percentage of your telehealth/telemedicine population is provided to patients in Washington?

	Active		Retired	
67 - 100%	766	26%	16	38%
34 - 66%	118	4%	2	5%
1 - 33%	737	25%	5	12%
0 or unknown	1,278	44%	19	45%

34. Do you prescribe opioids for patients with chronic noncancer pain?

	Active		Retired	
No	14,212	72%	1,780	96%
Yes	5,557	28%	77	4%

If yes, Please estimate the number of opioid patients in the last month

	Active		Retired	
Over 100	410	7%	1	1%
11 - 100	1,562	28%	11	14%
1 -10	3,042	55%	35	45%
0 or Unk	543	10%	30	39%

35. Are you a certified pain management specialist?

	Active		Retired	
No	19,411	98%	1,840	99%
Yes	358	2%	17	1%

Under what section of WAC 246-919-945 are you qualified as a pain management specialist*

	Active		Retired	
A	261	73%	9	53%
B	52	15%	2	12%
D	67	19%	3	18%
I do not Qualify	38	11%	3	18%

36. Do you have colleague(s) to whom you can refer pain patients?

	Active		Retired	
No, I can treat w/o referrals	967	5%	106	6%
No colleagues to refer	6,344	32%	889	48%
Yes	12,004	61%	504	27%
No answer	454	2%	358	19%

If yes, How many colleagues are available?

	Active		Retired	
Unknown	2,838	24%	81	16%
1	1,919	16%	100	20%
2	2,466	21%	129	26%
3	1,452	12%	62	12%
4+	3,329	28%	132	26%

37. Do you treat patients through nontraditional therapies?

	Active		Retired	
No	18,607	94%	1,821	98%
Yes	1,162	6%	36	2%

Have you completed this census on behalf of another person?

	Active		Retired	
Yes	942	5%	18	1%
No	18,827	95%	1,839	99%

**Physician may select more than one option, WAC was modified and renumbered effective 1/1/19*

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Physician principal area of practice and counties with practice sites - Northwest Washington

	Island	King	Pierce	San Juan	Skagit	Snohomish	Whatcom	Total
Adolescent Medicine		23	5	1		1		**30**
Allergy and Immunology		40	8		1	8		**57**
Anesthesiology	1	429	131	1	36	60	35	**693**
Cardiology		181	34		11	29	6	**261**
Child Psychiatry		61	19	2	1	6	3	**92**
Colon and Rectal Surgery		16	3			4		**23**
Critical Care Medicine		101	21	1	5	9	3	**140**
Dermatology	1	112	23		3	18	7	**164**
Emergency Medicine	7	325	124	10	13	80	23	**582**
Endocrinology		70	13		1	7	2	**93**
Family Medicine/General Practice	12	864	238	13	45	213	75	**1460**
Gastroenterology		128	31		3	19	10	**191**
Geriatric Medicine		48	5			4	5	**62**
Gynecology Only		36	11			6	2	**55**
Infectious Diseases		104	5		2	10	3	**124**
Internal Medicine (General)	10	966	245	2	31	157	32	**1443**
Nephrology		60	18		3	9	3	**93**
Neurological Surgery		66	7			4	3	**80**
Neurology	1	173	36		2	21	6	**239**
Obstetrics and Gynecology	6	228	52	1	7	33	13	**340**
Occupational Medicine		35	9		4	10	2	**60**
Ophthalmology	3	133	32	1	12	28	11	**220**
Orthopaedic Surgery	4	208	60		9	28	10	**319**
Other Surgical Specialties		20	2			3		**25**
Otolaryngology		84	22		8	18	6	**138**
Pathology	1	167	25		1	19	11	**224**
Pediatrics (General)	3	419	113	2	19	79	16	**651**
Pediatrics Subspecialties	1	294	62			16		**373**
Physical Med. & Rehabilitation		115	26		1	18	1	**161**
Plastic Surgery		80	13		1	11	4	**109**
Preventive Med/Public Health		13	5	1		3	1	**23**
Psychiatry	3	445	75	1	11	30	16	**581**
Pulmonology		99	22		4	7	4	**136**
Radiation Oncology		47	15		4	9	4	**79**
Radiology	5	358	107		12	60	13	**555**
Rheumatology	1	49	4			6	3	**63**
Surgery (General)	5	161	55	1	11	32	9	**274**
Thoracic and Cardiac Surgery		34	13			6	2	**55**
Urology		91	20		6	8	5	**130**
Vascular Surgery		38	11			7	3	**59**
Other (e.g. Hospitalist, Admin.)	2	309	42	2	15	32	14	**416**
None or Unknown		28	7		5	4		**44**
Total	**66**	**7258**	**1769**	**39**	**287**	**1132**	**366**	**10917**

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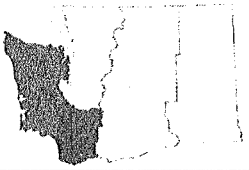
Physician principal area of practice and counties with practice sites - Southwest Washington



	Clallam	Clark	Cowlitz	Grays Harbor	Jefferson	Kitsap	Lewis	Mason	Pacific	Skamania	Thurston	Wahkiakum	Total
Adolescent Medicine		3	4			2			1		1		**11**
Allergy and Immunology		7	2			4	1				3		**17**
Anesthesiology	6	53	7	4		22	4				35		**131**
Cardiology	4	27	5	4	1	12	3	2			14		**72**
Child Psychiatry		4	2	2		2	2				3	1	**16**
Colon and Rectal Surgery		3	1	1	1								**6**
Critical Care Medicine	1	14	2	1		8	1				8		**35**
Dermatology	4	17	2	1	1	6					13		**44**
Emergency Medicine	13	51	13	23	7	24	15	9	11		29		**195**
Endocrinology		3				5					5		**13**
Family Medicine/General Practice	40	142	39	13	14	83	25	10	8	2	115		**491**
Gastroenterology	1	20	2			6	2				12		**43**
Geriatric Medicine	1	5	1			2	1				3		**13**
Gynecology Only		5									5		**10**
Infectious Diseases		9				2	1				3		**15**
Internal Medicine (General)	24	146	26	16	13	54	24	10	2		87	1	**403**
Nephrology	1	18	2		1	5					8		**35**
Neurological Surgery		10				4					8		**22**
Neurology	1	25	1	1		4	1		1		10		**44**
Obstetrics and Gynecology	3	70	3	1		18	4	1			26		**126**
Occupational Medicine		5	3	1		9					5		**23**
Ophthalmology	3	30	5	1	3	16	7	1			15		**81**
Orthopaedic Surgery	6	35	5	2	1	12	4	2			25		**92**
Other Surgical Specialties	1	2				4							**7**
Otolaryngology	2	18	2			7					7		**36**
Pathology	1	21	4			7	6		1		7		**47**
Pediatrics (General)	6	87	18	5		22	11	4			34		**187**
Pediatrics Subspecialties	1	37	4			2	1				14		**59**
Physical Med. & Rehabilitation		8	2		1	3	2				4		**20**
Plastic Surgery		5				1	1				4		**11**
Preventive Med/Public Health	2	5	1		2	2	1	1			2	1	**17**
Psychiatry	4	32	12	3	6	14	5	3	1	1	24		**105**
Pulmonology	2	22	3			9					6		**42**
Radiation Oncology	3	8	1	5	1	4	5				13		**40**
Radiology	8	43	21	4		24	7	4	1		31		**143**
Rheumatology		4	1			2					1		**8**
Surgery (General)	7	30	8	3	3	9	6	1	1		15		**83**
Thoracic and Cardiac Surgery		6	1			4					2		**13**
Urology	3	17	6	1	1	4					8		**40**
Vascular Surgery	1	4	1			4					6		**16**
Other (e.g. Hospitalist, Admin.)	8	35	12	6	3	10	3	3			21		**101**
None or Unknown			2			2					4		**8**
Total	**157**	**1086**	**224**	**98**	**59**	**434**	**143**	**51**	**27**	**3**	**636**	**3**	**2921**

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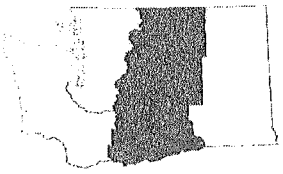
Physician principal area of practice and counties with practice sites - Central Washington



	Benton	Chelan	Douglas	Grant	Kittitas	Klickitat	Okanogan	Yakima	Total
Adolescent Medicine					1		1	2	4
Allergy and Immunology	2	1		2			1	2	8
Anesthesiology	24	12						16	52
Cardiology	12	4		5		2	1	14	38
Child Psychiatry		1						3	4
Colon and Rectal Surgery									
Critical Care Medicine	9	1		1	1			2	14
Dermatology	3	6		1			1	5	16
Emergency Medicine	23	28	1	22	4	6	15	33	132
Endocrinology	3			1			1	1	6
Family Medicine/General Practice	35	30	11	23	15	14	17	60	205
Gastroenterology	8	2				1	1	6	18
Geriatric Medicine	1	1						2	4
Gynecology Only	1	1					1	1	4
Infectious Diseases	5	1		1				2	9
Internal Medicine (General)	55	32		8	4	3	3	57	162
Nephrology	5			1				7	13
Neurological Surgery	2	1		1	1			4	9
Neurology	9	4		1		1		4	19
Obstetrics and Gynecology	17	5		4	2		2	21	51
Occupational Medicine	6	2	1		1	1		5	16
Ophthalmology	11	6	1	1	4		3	7	33
Orthopaedic Surgery	18	10		2	5	1	3	11	50
Other Surgical Specialties	2	2		1					5
Otolaryngology	3	6				1	2	4	16
Pathology	4	2						3	9
Pediatrics (General)	27	12	1	8	3			29	80
Pediatrics Subspecialties	16	4		3				6	29
Physical Med. & Rehabilitation	4	2		1	1			3	11
Plastic Surgery	2	2						1	5
Preventive Med/Public Health								2	2
Psychiatry	8	5			1	2	1	11	28
Pulmonology	5	1		1	1			3	11
Radiation Oncology	9	2		1				5	17
Radiology	24	6		4	3	8	7	11	63
Rheumatology	3	2		1			1	3	10
Surgery (General)	10	7		4	4	2	2	9	38
Thoracic and Cardiac Surgery	2	1					1	3	7
Urology	3	1		1			1	6	12
Vascular Surgery	3	1		1			1	5	11
Other (e.g. Hospitalist, Admin.)	11	5		2	3			16	37
None or Unknown	2			2				3	7
Total	**387**	**209**	**15**	**104**	**54**	**42**	**66**	**388**	**1265**

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Physician principal area of practice and counties with practice sites - Eastern Washington

	Adams	Asotin	Columbia	Ferry	Franklin	Garfield	Lincoln	Pend Oreille	Spokane	Stevens	Walla Walla	Whitman	Total
Adolescent Medicine					1				2				**3**
Allergy and Immunology					2				3				**5**
Anesthesiology		2			4				64		8		**78**
Cardiology		2					1	2	42	2	4	3	**56**
Child Psychiatry			1						5			1	**7**
Colon and Rectal Surgery									3				**3**
Critical Care Medicine					1				16		2	1	**20**
Dermatology		1							17		4	1	**23**
Emergency Medicine	3	3	4	1	4	1	1	5	66	11	16	9	**124**
Endocrinology							1		9		1		**11**
Family Medicine/General Practice	10	9	3	6	15		2	8	160	14	23	21	**271**
Gastroenterology		2			2				24		3	1	**32**
Geriatric Medicine	1				1				3				**5**
Gynecology Only									6				**6**
Infectious Diseases		1							4				**5**
Internal Medicine (General)		8			8			1	164	5	31	11	**228**
Nephrology		2			2				17	1	2	1	**25**
Neurological Surgery									13		2	1	**16**
Neurology					1				31		4		**36**
Obstetrics and Gynecology	1	3			4				33		3	3	**47**
Occupational Medicine					3				9		1		**13**
Ophthalmology		1			1				31	1	4	2	**40**
Orthopaedic Surgery		2			1		1	2	48	1	4	7	**66**
Other Surgical Specialties		1							7				**8**
Otolaryngology					2				17		2		**21**
Pathology		3							17				**20**
Pediatrics (General)	1				3				59		4	5	**72**
Pediatrics Subspecialties									40		1		**41**
Physical Med. & Rehabilitation					1				20		5		**26**
Plastic Surgery		1							10				**11**
Preventive Med/Public Health									1				**1**
Psychiatry			1		4			1	68	2	6	1	**83**
Pulmonology					1				8		3		**12**
Radiation Oncology									13		1		**14**
Radiology		2	1		7				61		9	2	**82**
Rheumatology					1				9				**10**
Surgery (General)	1	3			2			4	22	2	6		**40**
Thoracic and Cardiac Surgery									14				**14**
Urology		1			3				7		3	1	**15**
Vascular Surgery									6				**6**
Other (e.g. Hospitalist, Admin.)		2							43		8	2	**55**
None or Unknown									8		1		**9**
Total	**17**	**49**	**10**	**7**	**74**	**1**	**6**	**23**	**1200**	**39**	**161**	**73**	**1660**

III - SECONDARY CONTACTS

MDs who did not return a census form were emailed with a PDF copy of the census attached. Those without a valid email address were sent a hard copy. The secondary contact was made approximately three to four weeks after license renewal. The three most recent months are shown.

Secondary contact returns as of 1-1-2019

Month	Contacts	Returns to Date	Returned
October	758	319	42%
November	366	124	34%
December	317	130	41%

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WMC.wa.gov

PHYSICIANS ADVOCACY INSTITUTE

PAI-Avalere Report on Physician Employment Trends and Practice Acquisitions in 2019-21: Key Research Findings

National Physician Employment Trends

Over the three-year study period ending in 2021, 108,700 additional physicians left independent practice and became employees of hospitals or other corporate entities, and 83,000 (76%) of that growth occurred *after* the onset of Covid-19.

- 58,200 additional physicians became *hospital* employees between 2019-21
  - 51,000 of that growth occurred *after* the onset of Covid-19
- 50,500 additional physicians became employees of *corporate entities* between 2019-21
  - 32,000 of that growth occurred *after* the onset of Covid-19

By the end of 2021, nearly three of four (74%) of physicians were employed by hospitals, health systems or corporate entities such as private equity firms or health insurers.

- 52.1% of physicians were employed by hospitals and health systems
- 21.8% of physicians were employed by other types of corporate entities

National Medical Practice Acquisitions and Ownership Trends

Hospitals and other corporate entities acquired 36,200 additional physician practices over the three-year period (a 36% increase).

- *Hospitals* acquired 4,800 additional physician practices over the three-year period, resulting in an 8% increase in hospital-owned practices.
- *Corporate entities* acquired 31,300 additional physician practices over the three-year period, an 84% increase in corporate-owned practices. Most of that growth (22,900) occurred following the onset of COVID-19.

By January 2022, hospitals and corporate entities owned more than half (53.6%) of physician practices in the U.S.

- Ownership is almost evenly split between hospitals/health systems (26.4%) and other types of corporate entities (27.2%)

Regional Physician Employment and Practice Acquisitions Trends

All regions of the country experienced continued growth in physician employment and practice acquisitions throughout the three-year study period that accelerated in the last half of 2020 and throughout 2021, showing the significant impact of pandemic country wide.

- The percentage of hospital *or* corporate-owned practices increased between 28.3% (Midwest) and 43.9% (South).
- The percentage of hospital *or* corporate-employed physicians grew between 13.3% (Midwest) and 23.8% (South).

- Practice acquisitions by *corporate entities* grew between 71.3% (Midwest) and 94% (South).
- *Corporate* employment of physicians increased between 30.2% (Northeast) and 53.1% (South).
- The *Midwest* leads other regions in *hospital* employment at 63.5%.
- The *South* has the highest percentage of corporate-employed physicians at more than 25% and experienced the biggest increase in corporate-employment over the three-year period with more than 53.1% growth, spurred by a 94% increase in the percentage of corporate-owned medical practices.

MEYER, FLUEGGE & TENNEY

March 24, 2023 - 3:33 PM

Transmittal Information

Filed with Court:	Supreme Court
Appellate Court Case Number:	101,745-6
Appellate Court Case Title:	Estate of Cindy Essex, et al. v. Grant County Public Hospital District, et al.
Superior Court Case Number:	18-2-00746-8

The following documents have been uploaded:

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