Supreme Court No. 101745-6
Court of Appeals, Division III No. 378047
Grant Co. Superior Court Cause 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. l, d/b/a SAMARITAN HEALTHCARE, a Public Hospital; et. al.,

Respondents.

PETITION FOR REVIEW

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IDENTITY OF PETITIONER

This Petition for Review is filed on behalf of Judy Essex, as personal representative of the estate of her deceased daughter, Cindy Essex.

COURT OF APPEALS DECISION

Although the medical negligence statute incorporates general principles of agency law into the definition of a health care provider or institution, RCW 7.70.020(2) & (3), the Court of Appeals below held that "ostensible agency is the *sole* basis for holding a hospital vicariously liable for the negligence of nonemployee physicians." *Essex v. Grant County Public Hosp. Dist.*, — Wn. App. 2d —, 523 P.3d 242, 245 (2023) (emphasis added).[1] This decision conflicts with other Washington decisions and presents an issue of substantial public interest that should be determined by this Court. Review should be granted under RAP 13.4(b)(1)-(2) & (4).

[1] The decision is reproduced in the Appendix.

ISSUES PRESENTED

1. When is a hospital legally responsible for the negligence of nonemployed physicians treating patients who come to the hospital's emergency room? In particular, is the hospital subject to liability for (1) breach of a nondelegable duty, (2) an inherent function of the hospital, and/or (3) agency law principles of delegation? Or, is the hospital's liability limited to ostensible agency?

2. Is there a question of fact regarding Essex's separate claim for direct liability based on corporate negligence?

STATEMENT OF THE CASE

This review involves medical negligence and related claims arising from the failure to timely diagnose and treat necrotizing fasciitis suffered by Cindy Essex, which led to her death. Necrotizing fasciitis—also known as "flesh eating disease"—is an infection that results in the destruction of the body's soft tissues. Judy Essex, the mother of Cindy Essex and personal representative of her estate ("Essex"), filed suit against the health care providers who failed to timely diagnose and treat her daughter: Grant County Public Hospital District No. 1, also known as Samaritan Healthcare ("Samaritan"); emergency room physician Christopher Davis, MD ("Dr. Davis"), whose

employer had contracted with Samaritan to staff the hospital's emergency room; and radiologist Irene Cruite, MD ("Dr. Cruite"), whose employer had contracted with Samaritan to read imaging taken in the hospital's emergency room.

A. Background facts.

Cindy Essex came to the Samaritan emergency room in Moses Lake because she was experiencing intense pain in her left chest and shoulder, rated as "10" on a scale of 1 to 10. CP 509. She appeared "very uncomfortable" to Samaritan nurses and reported that her pain was causing abdominal cramping. CP 507. The nurses took her to a "quiet room" to wait for an evaluation by the emergency room physician. CP 511. While there, she was "yelling out" in pain and writhing around on the bed. CP 512.

Cindy Essex remained in the Samaritan emergency room for more than six hours, and she was eventually transferred to Central Washington Hospital in Wenatchee on a non-emergency basis. During her time in the Samaritan emergency room, she was attended by Dr. Davis and Dr. Cruite, both of whom violated the

standard of care, resulting in misdiagnosis of her condition as gastric outlet obstruction and delaying proper diagnosis and treatment of her necrotizing fasciitis.

By the time Cindy Essex arrived at Central Washington Hospital and was properly diagnosed, it was too late to save her. The "extent and advanced nature" of the necrotizing fasciitis "represented a nonsurvivable condition" and Cindy Essex succumbed to the infection. CP 248-49. If the condition had been timely diagnosed and treated, she would have survived. CP 577 & 579-80.

The standard of care required Dr. Davis to: (1) address Cindy Essex's chief complaint of shoulder and chest pain, CP 1570; (2) evaluate her as soon as possible, given her symptoms, rather than waiting for 77 minutes after her arrival, *id.*; (3) conduct an adequate evaluation and conduct a differential diagnosis that includes all possible causes of her symptoms, CP 1570-71; (4) properly interpret her lab and imaging results, CP 1571-72; (5) order a C-Reactive Protein (CRP) test, given her

symptoms, CP 1572; and (6) monitor and re-evaluate when there were changes in her condition, CP 1576-79; and (7) make a proper "hand-off" to another physician when his shift ended, CP 996-1001.

Dr. Davis violated the standard of care by: (1) ignoring Cindy Essex's chief complaint of shoulder and chest pain, CP 1570-71; (2) delaying her evaluation, CP 1570; (3) improperly diagnosing her with gastric outlet obstruction and failing to consider or rule out necrotizing fasciitis, CP 1570-71; (4) misinterpreting her lab and imaging results, CP 1571-72; (5) failing to order a CRP test, CP 1572; (6) failing to continue monitoring and re-assessing Cindy Essex's condition as it deteriorated, CP 1576-79; and (7) failing to make a proper hand-off to another physician when his shift ended, CP 996-1001.

Dr. Davis's misinterpretation of Cindy Essex's imaging results is explained in part by the failure of the radiologist, Dr. Cruite, to properly interpret the imaging. CP 1578. Nonetheless, Dr. Davis's independent violations of the standard of care

contributed to the misdiagnosis of Cindy Essex's condition, delayed proper diagnosis and treatment, and led directly to her death. CP 351 & 1579.

Dr. Cruite interpreted imaging of Cindy Essex's left chest and abdomen ordered by Dr. Davis. CP 519 & 523-27. She did not report any findings in Cindy Essex's left chest or shoulder, and instead reported that the scan was "suspicious for gastric outlet obstruction although no cause for obstruction is identified." CP 519 & 525.

Dr. Cruite violated the standard of care by "miss[ing] a very critical finding," consisting of "very obvious evidence of inflammation in the left lateral chest wall" in the imaging results of Cindy Essex. CP 356-57 (brackets added). This evidence was "critically important for the treating physician," Dr. Davis. *Id.* "Dr. Cruite's failure to identify the obvious in the available imagery likely changed the course of treatment and reduced [Cindy Essex's] chances of survival …. [b]ecause time is of the essence in cases involving necrotizing fasciitis and sepsis" and

"any delay in diagnosis increases the patient's odds of a bad outcome." CP 357 (brackets & ellipsis added).

B. Procedural history.

On December 10, 2019, Essex moved for partial summary judgment to establish the legal responsibility of Samaritan for the conduct of Drs. Davis and Cruite. CP 479. On March 23, 2020, the court issued a letter ruling explaining its rationale for denying the motion on grounds that hospital liability for nonemployed physicians is limited to ostensible agency. CP 1147-49. On June 5, 2020, the superior court entered a formal written order denying the motion. CP 1342. On June 15, 2020, Essex timely moved for reconsideration of the court's order. CP 1361. On September 11, 2020, the court denied reconsideration. CP 1509. On October 9 and 21, 2020, Essex timely filed a notice of discretionary review. CP 1516 & 2224.[2] On January 6, 2021, the superior court subsequently certified its decisions for discretionary review.

[2] An erratum was filed on October 21, 2020, to correct a clerical error in the prior notice. CP 2224.

CP 2331. The Court of Appeals accepted review of the certified issues and affirmed, and Essex timely seeks review.[3]

[3] Essex does not seek review of the decision of the Court of Appeals reversing the superior court regarding issues of proximate cause. *Essex*, 523 P.3d at 251-55. Nor does she seek review of the issue of concerted action, which was raised by the Court of Appeals sua sponte on review. *Id.* at 251.

However, Essex does seek review of the dismissal of her direct claim against Samaritan for corporate negligence. *Id.* at 252. While this aspect of the decision below involves application of settled law to the facts, and would not independently satisfy the criteria for review, the appellate court nonetheless erred in affirming dismissal of this claim. *See infra* note 9. It is permissible to enlarge the scope of review when the case is otherwise properly before the Court. RAP 1.2(a) ("These rules will be liberally interpreted to promote justice and facilitate the decision of cases on the merits"); *cf. Chadwick Farms Owners Ass'n v. FHC LLC*, 166 Wn.2d 178, 185-86, 207 P.3d 1251, 1255 (2009) ("The Court of Appeals granted discretionary review of the trial court's ruling denying Colonial's motion for summary judgment and, in the interests of judicial economy, also granted review of the summary judgment dismissing the individual members and entities that formed Colonial"). Accordingly, Essex asks the Court to accept review of this issue if review is otherwise granted. *See infra* note 9.

ARGUMENT

A. Hospital liability for the negligence of nonemployed physicians treating patients who come to the hospital's emergency room presents an issue of substantial public interest that should be determined by this Court; and the Court of Appeals decision limiting hospital liability to ostensible agency conflicts with decisions of this Court and the Court of Appeals as well as the medical negligence statute.

In *Adamski v. Tacoma Gen. Hosp.*, 20 Wn. App. 98, 579 P.2d 970 (1978), the Court of Appeals addressed hospital liability for nonemployed physicians who treat patients in the emergency room. A hospital is not subject to vicarious liability based on respondeat superior for the negligence of such physicians precisely because they are not employees. 20 Wn. App. at 104-05. Yet "[t]he experience of the courts has been that application of hornbook rules of agency to the hospital-physician relationship usually leads to unrealistic and unsatisfactory results, at least from the standpoint of the injured patient." *Id.* at 105 (brackets added).

Hospitals have "become more than just a place for physicians to bring their patients for treatment[.]" *Adamski*, 20

Wn. App. at 106 (brackets added). "[T]he hospital itself renders care and treatment through its facilities and employees," as well as contract physicians. *Id.* at 106-08 (brackets added). "[T]he most troublesome situation has been that where the patient, not having contacted his personal physician, presents himself at the hospital for treatment and is there provided with or referred to a physician, usually a specialist, who is neither an intern, resident or other salaried employee of the hospital." *Id*. at 108 (brackets added).

The court in *Adamski* held that hospital liability should not hinge upon the distinction between employed and contract physicians, reasoning as follows:

> When, in fact, the hospital undertakes to provide medical treatment rather than merely serving as a place for a private physician to administer to his patients, the physician employed to deliver that service for the hospital may be looked upon as an integral part of the total "hospital enterprise." ***In such cases, it should make no difference that the physician is compensated on some basis other than salary or that he bills his patient directly. These are artificial distinctions, the efficacy of which has long since disappeared and to the perpetuation of which we do not subscribe***.

20 Wn. App. at 108 (emphasis added; footnote omitted). Accordingly, the court held that a hospital is subject to liability for the negligence of nonemployed physicians on grounds of ostensible agency. *Id.* at 112 (citing Restatement (Second) of Agency § 267 (1958)). The decision below limited Essex to the theory of ostensible agency in attempting to hold Samaritan legally responsible for the conduct of nonemployed physicians like Drs. Davis and Cruite.

In addition to ostensible agency, *Adamski* recognized potential hospital liability for the negligence of nonemployed physicians treating patients in the emergency room based on breach of a nondelegable duty or performance of an inherent function of the hospital. Subsequent case law has not addressed these grounds for liability. Moreover, while *Adamski* recognized that a hospital is subject to liability based on ostensible agency, neither *Adamski* nor subsequent case law has directly addressed other grounds for liability based on other principles of agency law.

Patients injured by negligent treatment in the emergency room should ***not*** be limited to ostensible agency. Ostensible agency is not unique to the hospital liability context, but rather is a general principle of agency law "intended to protect third parties who justifiably rely upon the belief that another is the agent of a principal." *D.L.S. v. Maybin*, 130 Wn. App. 94, 97, 121 P.3d 1210 (2005). Ostensible agency requires proof that:

> [1] the actions of the putative principal must lead a reasonable person to conclude the actors are employees or agents; [2] the plaintiff must believe they are agents; and [3] the plaintiff must, as a result, rely upon their care or skill, to her detriment.

Id., 130 Wn. App. at 97 (citing *Adamski* inter alia; brackets added).

Although ostensible agency justifies imposition of hospital liability where applicable, it is unduly narrow and ill-suited to the negligence of nonemployee physicians in the emergency room. It is not reasonable to expect emergency patients to prove knowledge or reliance, especially when they are unconscious or in extreme pain when they arrive, as Cindy Essex

was when she arrived at Samaritan. It may not be possible for the estates and family members of patients who do not survive to even obtain admissible evidence of knowledge or reliance by the decedent.

As a result, this Court should accept review to determine whether, upon proper proof at trial, hospitals like Samaritan are subject to liability for the negligence of nonemployed physicians based upon breach of a nondelegable duty, performance of an inherent function of the hospital, and agency principles of delegation in addition to ostensible agency.[4]

1. Hospitals should be subject to liability for nondelegable duties imposed by licensing statutes and regulations.

"When an entity has a nondelegable duty, it cannot escape liability by delegating its duty to another entity." *Afoa v. Port of Seattle*, 191 Wn.2d 110, 123 n.10, 421 P.3d 903 (2018). "An

[4] Hospital liability for the negligence of nonemployed physicians is distinguished from hospital liability for breach of its own duty of care under the doctrine of corporate negligence. 6 Wash. Prac., *supra* WPI 105.02.02 (regarding direct liability for corporate negligence).

entity that delegates its nondelegable duty will be vicariously liable for the negligence of the entity subject to its delegation[.]" 191 Wn.2d at 124 (brackets added); *accord Vargas v. Inland Washington, LLC*, 194 Wn.2d 720, 738-39, 452 P.3d 1205 (2019) (quoting *Afoa* with approval).

Nondelegable duties are typically imposed by statutes or administrative regulations. *Tauscher v. Puget Sound Power & Light Co.*, 96 Wn.2d 274, 285, 635 P.2d 426 (1981) ("administrative rules may impose nondelegable duties as do statutes"; citing Restatement (Second) of Torts § 424 (1965)); *Pedroza v. Bryant*, 101 Wn.2d 226, 234, 677 P.2d 166 (1984) (recognizing hospitals' nondelegable duty for corporate negligence based in part on Department of Health regulations).

In *Adamski*, the court expressly recognized that laws governing hospital licensing may impose a nondelegable duty for care provided in the emergency room:

> Pursuant to RCW Chapter 70.41, the Washington State Board of Health has adopted rules and regulations pertaining inter alia to the establishment and maintenance

> of standards for the care and treatment of patients. The regulations are extensive and comprehensive and, as they apply to emergency services, are contained in WAC 248.18.285. The regulations require a licensed hospital to provide emergency care services in accordance with the community's needs and the hospital's capabilities. Within this general framework, however, the hospital is also required to adopt written policies and procedures specific to emergency care services. One requirement is that there must be a physician responsible for the services, whose functions and responsibilities are subject to the medical direction of the hospital.
>
> ***It could thus be argued that Washington state has imposed upon hospitals a duty to provide emergency care services to the public and that they cannot shift the responsibility by contract***.

20 Wn. App. at 111 n.5 (emphasis added). However, the court did not address nondelegable duty further because the issue was not developed or argued by the parties. *Id.*

The statutes and regulations referenced in *Adamski* as supporting a nondelegable duty "require[d] a licensed hospital to provide emergency care services in accordance with the community's needs and the hospital's capabilities ... adopt written policies and procedures specific to emergency care services," including that "there must be a physician responsible for the

services, whose functions and responsibilities are subject to the medical direction of the hospital." 20 Wn. App. at 111 n.5 (citing Ch. 70.41 RCW and former WAC 248-18-285; brackets & ellipsis added). While these regulations are no longer in effect, the current regulations governing Samaritan impose similar, if not greater, nondelegable duties with respect to care provided in its emergency room.

The Legislature enacted Ch. 70.41 RCW for the "primary purpose" of "promot[ing] safe and adequate care of individuals in hospitals through the development, establishment and enforcement of minimum hospital standards for maintenance and operation." RCW 70.41.010 (brackets added). To accomplish this purpose, the Legislature authorized the Department of Health ("DOH") to establish and enforce rules and regulations for hospitals. RCW 70.41.010(3) & (4); RCW 70.41.030. Hospitals such as Samaritan are required to comply with these regulations. RCW 70.41.020(7) (defining "hospital").

Pursuant to this statutory authorization, DOH regulations require hospital leadership to "[p]rovide all patients access to safe and appropriate care." WAC 246-320-136(5). Hospital leadership must also "[a]dopt and implement policies and procedures which define standards of care for each specialty service" and "[p]rovide practitioner oversight for each specialty service with experience in those specialized services[.]" WAC 246-320-136(3)-(4) (brackets added). The referenced specialty services specifically include "[e]mergency" services. WAC 246-320-136(4) (brackets added). All of these obligations are phrased in terms of what hospital leadership "must" do and are therefore mandatory. *Khandelwal v. Seattle Mun. Court*, 6 Wn. App. 2d 323, 338, 431 P.3d 506 (2018) ("the words 'shall' and 'must' are synonymous under traditional principles of statutory construction and are both words of 'an unmistakably mandatory character'").[5]

[5] WAC 246-320-136 is reproduced in the Appendix.

With respect to emergency services in particular, DOH has also adopted regulations requiring hospitals to "[a]ssure emergency equipment, supplies and services necessary to meet the needs of presenting patients are immediately available." WAC 246-320-281(8). The hospital must also "[m]aintain the capacity to perform emergency triage and medical screening exam twenty-four hours per day," "[d]efine the qualifications and oversight of staff delivering emergency care services," and "[u]se hospital policies and procedures which define standards of care[.]" WAC 246-320-281(2)-(4). Again, these obligations are phrased in terms of what hospitals "must" do and are therefore mandatory. *Khandelwal*, 6 Wn. App. 2d at 338.[6]

These regulations are comparable to those referenced in *Adamski* and give rise to a nondelegable duty on the part of hospitals with respect to the care provided in their emergency rooms. The requirements to "[p]rovide all patients access to safe

[6] WAC 246-320-281 is reproduced in the Appendix.

and appropriate care," WAC 246-320-136(5) and to "[a]ssure emergency equipment, supplies and services necessary to meet the needs of presenting patients are immediately available," WAC 246-320-281(8), actually go well beyond what was required by the regulations referenced in *Adamski*, which merely "require[d] a licensed hospital to provide emergency care services in accordance with the community's needs and the hospital's capabilities," 20 Wn. App. at 111 n.5.[7]

The Court should accept review to determine whether the foregoing statutes and regulations impose a nondelegable duty

[7] Former WAC 248-18-285 cited in *Adamski* is reproduced in the Appendix. The Court of Appeals below incorrectly stated that "the regulations no longer impose the requirement … that there be [a] 'physician responsible for the services, whose functions and responsibilities are subject to the medical direction of the hospital,'" and declined to find a nondelegable duty on this basis. *Essex*, 523 P.3d at 248-49 (quoting *Adamski*'s paraphrase of former WAC 284-18-285(4)). The appellate court was incorrect because the current regulation contains an equivalent requirement to "[p]rovide practitioner oversight for each specialty service with experience in those specialized services," specifically including "[e]mergency" services. WAC 246-320-136(4)(i) (brackets added).

on hospitals for the negligence of nonemployed physicians treating patients who come to the hospital's emergency room for treatment. RAP 13.4(b)(4).

2. Hospitals should be subject to liability for negligent treatment of patients who come to the emergency room because the emergency room is an inherent function of a hospital.

Separate from ostensible agency and nondelegable duty, the court in *Adamski* held that the hospital was subject to liability where the injured plaintiff-patient went directly to the emergency room and did not choose his attending physician because the emergency room is "an inherent function of the hospital":

> Plaintiff went directly to the emergency room of Tacoma General and was there given no choice respecting his physician. In fact, Dr. Tsoi had been chosen for him at the time Tacoma General contracted with TECP for emergency room staffing. It is true … that Dr. Tsoi does not hold a salaried position; rather, except for the guaranty, his group is dependent upon the charges it makes to patients for professional services. ***There is, however, substantial evidence that Dr. Tsoi was performing "an inherent function of the hospital, a function without which the hospital could not properly achieve its purpose," i.e., he was an integral part of the total hospital function or enterprise. 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 arises as to whether that relationship is that of principal and agent.*** It was error to resolve this issue by summary judgment.

20 Wn. App. at 111-12 (ellipsis & emphasis added; citation omitted). The language stating "[i]t was error to resolve this issue by summary judgment" indicates that liability based on an inherent function of the hospital represents a holding. *See id.* at 115-16 (stating separate holding regarding ostensible agency).

This Court subsequently recognized that *Adamski* imposed hospital liability for inherent functions in *Pedroza*, 101 Wn.2d at 230-31:

> Before the emergence of corporate negligence, hospital liability for the negligence of a staff physician was based on the theory of respondeat superior. Plaintiffs found it difficult to recover, however, as courts tended to classify physicians as independent contractors for whose acts the hospital was not liable. ***Some states, Washington among them, have attempted to avoid the somewhat artificial distinctions associated with the independent contractor defense (e.g., classifying an independent private physician with staff privileges who is retained by the patient as an "independent contractor" while a physician whose salary is paid by the hospital is a "servant," even though both are on the same medical staff, performing the same tasks.) They have tried to avoid these distinctions by affixing vicarious liability upon the***

> ***hospital when the individual is performing an "inherent function" of the hospital, or acting as an "ostensible agent." See Adamski v. Tacoma Gen. Hosp., 20 Wn. App. 98, 579 P.2d 970 (1978)***.

(Emphasis added.) Subsequent decisions have confirmed that the emergency room is an "essential" function of a hospital. *Mohr v. Grantham*, 172 Wn.2d 844, 861, 262 P.3d 490 (2011) ("It is also informative that KMC's emergency room is an essential part of its operation"; citing *Adamski*, 20 Wn. App. at 115); *Wilson v. Grant*, 162 Wn. App. 731, 745, 258 P.3d 689, 696 (2011) ("Emergency room care was an essential part of the hospital's operation").

The Court of Appeals below appeared to recognize that *Adamski* adopted "both grounds of agency liability"—i.e., inherent function and ostensible agency—but then inconsistently stated that "inherent function" is merely one factor among others in determining whether there is ostensible agency. *Essex*, 523 P.3d at 250. The appellate court cited the Restatement (Second)

of Agency § 220 (1958), which defines a "servant" but does not address ostensible agency or inherent functions. *Id.*

This Court should grant review to resolve the conflict between the decision below and *Adamski*, as interpreted in *Pedroza, Mohr,* and *Wilson*. RAP 13.4(b)(1) & (2).

3. Hospitals should be subject to liability based on agency law principles of delegation.

As *Adamski* recognized in holding that a hospital is subject to liability for ostensible agency, agency law principles provide a basis for hospital liability even if the grounds for such liability are not limited to agency law. 20 Wn. App. at 105. Such agency-based liability is incorporated into the definition of a "health care provider" under the medical negligence statute, which specifically includes "agent[s]." RCW 7.70.020(2) & (3); *see also Grove v. PeaceHealth St. Joseph Hosp.*, 182 Wn.2d 136, 148, 341 P.3d 261 (2014) (recognizing liability under Ch. 7.70 RCW for "groups of providers" and a "hospital medical team"); *Van Hook v. Anderson*, 64 Wn. App. 353, 364, 824 P.2d 509 (1992) (describing "captain of the ship doctrine" whereby a

surgeon is "vicariously liable for the negligence of a nurse or other assistant, notwithstanding that the nurse or assistant is employed by a different person or entity," i.e., the hospital).

Under agency law principles, a hospital cannot discharge its obligations to a patient who comes to its emergency room simply by delegating those obligations to nonemployed physicians. A hospital enters into an implied contract with a patient who comes to its emergency room for treatment. *See Fugitt v. Myers*, 9 Wn. App. 523, 525, 513 P.2d 297, 299 (1973), *rev. denied*, 83 Wn.2d 1003 (1983) (noting a contract arises from the provision of medical services); 61 Am. Jur. 2d *Physicians, Surgeons, Etc.* § 349 (Feb. 2023 update) ("Even in the absence of an express contract, the rendering of medical services creates an implied contract between the provider and the person being given the medical care").

The hospital is subject to liability for nonperformance of the agreement to treat a patient by nonemployed physicians. *Lonsdale v. Chesterfield*, 99 Wn.2d 353, 359, 662 P.2d 385

(1983) ("When a party contracts to perform a specified obligation, he cannot escape liability for nonperformance by delegating his duty to perform; he remains secondarily liable (as a surety) for performance of the duty promised"; citing Restatement (Second) of Contracts § 318(3) (1981)); Restatement (Second) of Contracts § 318(3) ("Unless the obligee agrees otherwise, neither delegation of performance nor a contract to assume the duty made with the obligor by the person delegated discharges any duty or liability of the delegating obligor").

The hospital is also subject to liability for negligent performance of the agreement to treat patients by the nonemployed physicians. Restatement (Third) of Agency § 7.06 (2006) ("A principal required by contract … to protect another cannot avoid liability by delegating performance of the duty, whether or not the delegate is an agent"; brackets & ellipsis added). As explained by the Restatement (Third) of Agency:

> Delegating performance of a duty does not in itself discharge the duty unless the person to whom the duty is owed so agrees. See Restatement Second, Contracts § 318(3). ***This basic principle has the effect of expanding the range of circumstances in which an actor's tortious conduct subjects a principal to liability to a third party*** because it is not limited by whether the actor has a relationship of agency with the principal, whether the principal has chosen the actor with reasonable care, or, if the actor is an employee, by whether the employee's tortious conduct occurs within the scope of employment under § 7.07(2)

Id. § 7.06 cmt. *b* (emphasis added). This is another type of nondelegable duty, albeit one assumed by contract rather than imposed by statute or regulation.[8]

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[8] While the Restatement (Third) of Agency § 7.06 has not been expressly adopted in Washington, it is consistent with Washington law. *Lonsdale*, 99 Wn.2d at 359. It relies on the Restatement (Second) of Contracts § 318(3), and it corresponds to the Restatement (Second) of Agency § 214 (1958), both of which have been adopted and cited with approval by Washington courts in different contexts. Restatement (Third) of Agency § 7.06 Reporter's Notes *a* (noting section corresponds to Restatement (Second) § 214); *Niece v. Elmview Grp. Home*, 131 Wn.2d 39, 55, 929 P.2d 420 (1997) ("Under § 214, certain voluntary relationships create a duty to see that due care is actually used by servants or agents to protect another party," but finding inapplicable to intentional or criminal conduct); *Knutson v. Macy's W. Stores, Inc.*, 1 Wn. App. 2d 543, 547, 406 P.3d 683, 685 (2017) ("In *Niece* … the court favorably quoted *Restatement*

The Court of Appeals below completely ignored Samaritan's liability based on agency principles of delegation. This Court should grant review to determine whether a hospital's delegation of treatment of patients who come to its emergency room to nonemployed physicians relieves the hospital of responsibility for negligent treatment by those physicians. RAP 13.4(b)(4).[9]

(Second) of Agency § 214 (1958), which states the vicarious liability that may arise when a principal delegates the performance of its duty of care to an agent" and applying to common carrier).

[9] The Court of Appeals affirmed dismissal of Essex's direct claim against Samaritan for corporate negligence on grounds that one expert (Thomas Cumbo, MD) allegedly did not link any failure in Samaritan's policies, training, or oversight of its nurses to the misdiagnosis of Cindy Essex. 523 P.3d at 252. However, the court ignored Dr. Cumbo's testimony that failure of hospital oversight was a proximate cause of Cindy Essex's death. CP 905-06, 908-09, 914, 921-22, 964-65, 967, 969, 972, 978, & 980-81. Among other things, the nurses did not fully communicate how Essex was responding to pain management, CP 970-71 & 980-81, nor did they communicate her elevated serum lactate, CP 1641-43. The appellate court also overlooked the testimony of a nursing expert (Amy Curley, DNP), CP 330-34 & 932-33, and neurosurgeon (Robert Sawyer, MD), CP 577 & 579, both of whom attested to the causal relationship between Samaritan's corporate negligence and Cindy Essex's death. The appellate

CONCLUSION

This Court should accept review and hold that hospitals are subject to liability for nondelegable duties, inherent functions, and agency law principles of delegation upon proper proof at trial.

RAP 18.17 CERTIFICATE

This document contains 4,999 words, excluding the parts of the document exempted from the word count by RAP 18.17.

Respectfully submitted this 22nd day of February, 2023.

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court held there were questions of fact whether the nurses negligently caused Cindy Essex's misdiagnosis and it is inconsistent for the court to find Samaritan's lack of training and supervision of those same nurses was not a proximate cause. The Court should therefore include the issue of corporate negligence in its grant of review. *See supra* note 3.

CERTIFICATE OF SERVICE

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 electronically filed the foregoing 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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Signed at Spokane, Washington on February 22, 2023.

s/George M. Ahrend
George M. Ahrend, WSBA #25160

APPENDIX

523 P.3d 242
Court of Appeals of Washington, Division 3.

The ESTATE OF Cindy ESSEX, BY AND THROUGH Judy ESSEX, as Personal Representative of the Estate of Cindy Essex, Petitioners,
v.
GRANT COUNTY PUBLIC HOSPITAL DISTRICT NO. 1, d/b/a Samaritan Healthcare, a Public Hospital; and Dr. Irene W. Cruite, M.D., and John Doe Cruite, husband and wife, and the marital community composed thereof, Respondents,
Confluence Health, a Washington Corporation; Wenatchee Emergency Physicians, PC, a Washington Corporation; DR. Christopher Davis, M.D., and Jane Doe Davis, husband and wife, and the marital community composed thereof; and John and Jane Does 1-10, Defendants.

No. 37804-7-III (consolidated with No. 37994-9-III)
|
Filed January 24, 2023

Synopsis

Background: Estate of patient who died at hospital operated by public hospital district brought medical-malpractice action in which it asserted negligence claims against district, physician who cared for patient at hospital but who was not an employee of district's hospital, radiologist who cared for patient at hospital but who was not a employee of district's hospital, and nurses at hospital. The Superior Court, Grant County, John D. Knodell, J., entered partial-summary-judgment orders and then certified them to the Court of Appeals, which granted interlocutory review.

Holdings: The Court of Appeals, Lawrence-Berrey, A.C.J., held that:

[1] public hospital district could not be held vicariously liable for the actions of nonemployee physician and nonemployee radiologist;

[2] alleged failures by hospital in regard to its triage policies, training, and oversight could not establish that such failure proximately caused failure of nonemployee physician to diagnose necrotizing fasciitis;

[3] genuine issue of material fact as to whether nonemployee physician would have considered a diagnosis of necrotizing fasciitis if radiologist had reported inflammation in patient's chest wall precluded summary judgment as to claim against radiologist; and

[4] genuine issue of material fact as to whether nonemployee physician knew all the information that nurses had concerning patient while patient was awaiting transfer precluded summary judgment as to whether failure of nurses to inform physician that patient's pain had returned while she was awaiting transfer was proximate cause of failure to diagnose necrotizing fasciitis.

Affirmed in part and reversed in part.

West Headnotes (21)

[1] **Judgment** Absence of issue of fact

A "material fact" for summary-judgment purposes is one on which the outcome of the litigation depends. Wash. Super. Ct. Civ. R. 56(c).

[2] **Appeal and Error** Review using standard applied below

An appellate court reviews an order on summary judgment de novo, engaging in the same inquiry as the trial court based on the evidence and issues before it. Wash. R. App. P. 9.12.

[3] **Appeal and Error** Evidence or Other Material Not Considered Below

When reviewing partial-summary-judgment orders that the trial court had certified for interlocutory review in medical-malpractice action, the Court of Appeals would consider the entire trial court record rather than only the evidence called to the attention of the trial court; the case was before the Court on interlocutory review at a point in the litigation where the trial court could revise its rulings. Wash. R. App. P. 9.12.

[4] **Appeal and Error** Negligence in general

As is relevant to a negligence claim, the existence of a duty is a question of law which an appellate court reviews de novo.

[5] **Health** Duty to provide emergency care or admit; penalties

While regulations require a hospital to assure that emergency equipment, supplies, and services necessary to meet the needs of patients are immediately available, regulations do not require that a physician provide medical care in an emergency department; instead a hospital need only assure that there is at least one registered nurse skilled and trained in emergency care services on duty and in the hospital at all times. Wash. Admin. Code 246-320-281(5), 246-330-225(4).

[6] **Health** Hospitals or Clinics

Public hospital district could not be held vicariously liable for the actions of nonemployee physician and nonemployee radiologist who cared for emergency-department patient; current statutes and regulations, unlike prior ones, did not create a duty to have a physician provide medical care in an emergency department, let alone one subject to the control of the hospital. Wash. Admin. Code 246-320-281(5), 246-330-225(4).

[7] **Health** Hospitals or Clinics

That physician and radiologist were performing an alleged inherent function of public hospital district's hospital when they, as nonemployees, provided care for hospital's emergency-department patient could not be a basis for finding that hospital could be vicariously liable for alleged medical-malpractice-based negligence of physician and radiologist.

[8] **Health** Hospitals or Clinics

That physician and radiologist who, despite being nonemployees of public hospital district's hospital, were the "functional equivalent" of hospital employees when they provided care to hospital's emergency-department patient could not be a basis to find that hospital could be vicariously liable for alleged medical-malpractice-based negligence of physician and radiologist. Wash. Rev. Code Ann. § 7.70.020(3).

[9] **Health** Hospitals or Clinics

Absent evidence that physician and radiologist who, despite being nonemployees of public hospital district's hospital, intended to act in an unlawful manner when they provided care to hospital's emergency-department patient, hospital could not be vicariously liable for purported medical-malpractice-based negligence of physician and radiologist pursuant to a common-law theory of concerted action. Wash. Rev. Code Ann. § 4.22.070(1)(a).

[10] **Torts** Concerted action in general

Concerted action under common law derives from vicarious liability and requires that plaintiff show tacit agreement among defendants to perform tortious act.

[11] **Judgment** Existence or non-existence of fact issue

On summary judgment, a defendant may demonstrate there is no genuine issue of material fact for trial by showing that the plaintiff has

failed to prove an essential element of their claim.

[12] **Judgment** Existence or non-existence of fact issue

If the party that did not move for summary judgment fails to make a showing sufficient to establish the existence of an element that is essential to that party's case and on which that party will bear the burden of proof at trial, then the trial court should grant the motion.

[13] **Health** Elements of malpractice or negligence in general

In a medical-malpractice action, a plaintiff must prove duty, breach, injury, and proximate cause. Wash. Rev. Code Ann. § 7.70.040.

[14] **Health** Proximate Cause

Proximate cause, as required to support a medical-malpractice claim, generally requires a showing that the breach of duty was a cause in fact of the injury and a showing that liability should attach as a matter of law. Wash. Rev. Code Ann. § 7.70.040.

[15] **Health** Emergency room care in general

Any failures by hospital in regard to its triage policies, training, and oversight could not establish that such failure proximately caused failure of nonemployee physician to diagnose necrotizing fasciitis in emergency-department patient, and thus such alleged failures by hospital, which was operated by public hospital district, could not result in hospital being liable for corporate negligence; despite contention that nursing staff should have brought patient's symptoms to physician's attention sooner, physician had all the relevant information when he evaluated patient.

[16] **Health** Emergency room care in general

Absent evidence that alleged failure of hospital nurses to notify nonemployee physician that emergency-department patient's pain had returned was linked to hospital's alleged failure in regard to its triage policies, training, and oversight, testimony that nurses' alleged failure fell below the standard of care could not establish that hospital was liable for corporate negligence arising from the physician's failure to correctly diagnose necrotizing fasciitis insofar as the alleged corporate negligence stemmed from theory that hospital failed in regard to its triage policies, training, and oversight—assuming that Washington law recognized such a theory.

[17] **Health** Questions of Law or Fact and Directed Verdicts

Judgment Tort cases in general

Genuine issue of material fact as to whether physician who cared for patient in hospital's emergency department would have considered a diagnosis of necrotizing fasciitis if radiologist had reported inflammation in patient's chest wall precluded summary judgment as to proximate-cause element of medical-malpractice-based negligence claim against radiologist.

[18] **Products Liability** Learned intermediary

Products Liability Drugs in general

The "learned intermediary" doctrine defines a drug manufacturer's duty to warn, limiting it to the prescribing doctor rather than the end user.

[19] **Evidence** Professional negligence; malpractice

As long as the trier of fact understood that expert testimony as to whether physician who cared for patient in hospital's emergency department would have considered a diagnosis of necrotizing fasciitis if radiologist had reported inflammation in patient's chest wall was being admitted for the limited purpose of showing what physician would have done, such evidence would be relevant and admissible as to medical-malpractice-based negligence claim against

radiologist, subject to an analysis under rule on exclusion of relevant evidence on grounds of prejudice, confusion, or waste of time. Wash. R. Evid. 403.

[20] **Judgment** Torts

On summary-judgment motion regarding medical-malpractice-based negligence claim stemming from theory that radiologist's failure to report that emergency-department patient had inflammation in chest wall led to physician's failure to consider diagnosing necrotizing fasciitis, testimony that a surgical consult would likely have been available between 30 and 60 minutes and could have happened at hospital was sufficient to establish a prima facie case that a surgeon was likely available to timely operate on patient, as would support finding that patient's estate established a prima facie case of proximate cause.

[21] **Health** Questions of Law or Fact and Directed Verdicts

Judgment Tort cases in general

Genuine issue of material fact as to whether physician knew all the information that nurses had concerning emergency-department patient who was awaiting transfer precluded summary judgment as to whether failure of nurses to inform physician that patient's pain had returned while she was awaiting transfer was proximate cause of failure to diagnose necrotizing fasciitis and thus precluded summary judgment on medical-malpractice-based negligence claim.

***245** Appeal from Grant Superior Court, Docket No: 18-2-00746-8, Honorable John D. Knodell, Judge

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PUBLISHED OPINION

Lawrence-Berrey, A.C.J.

¶1 The trial court certified multiple partial summary judgment orders in this medical malpractice case and we accepted review. We conclude: (1) ostensible agency is the sole ***246** basis for holding a hospital vicariously liable for the negligence of nonemployee physicians, (2) summary judgment was properly granted with respect to petitioners' corporate negligence claim against the hospital, and (3) summary judgment was improperly granted with respect to petitioners' negligence claims against the hospital's nurses and the radiologist. We affirm in part and reverse in part.

FACTS

¶2 On June 24, 2015, Cindy Essex visited Samaritan Healthcare's[1] emergency department in Moses Lake complaining of left shoulder pain. When Ms. Essex arrived at the emergency department, she was experiencing 10 out of 10 pain and abdominal cramping. She arrived at 2:13 p.m. and was triaged at 2:31 p.m. She was in too much pain to complete paperwork, so her mother completed it instead. At 2:36 p.m., she was taken to a quiet room to wait for the doctor to evaluate her. While waiting, the nurse applied ice to Ms. Essex's left shoulder, which Ms. Essex said helped the pain.

1 Grant County Hospital District No. 1 doing business as Samaritan Healthcare.

¶3 Dr. Christopher Davis arrived at 3:47 p.m. to assess Ms. Essex. She reported bloody diarrhea, vomiting, general abdominal pain, and said she had some blood in her stool. She also reported increased aching left shoulder pain that was worse with movement and palpation. She said her children all had a fever and she thought she picked up a virus from them.

¶4 Dr. Davis ordered two milligrams of intramuscular hydromorphone for pain, which was administered to Ms. Essex at 3:56 p.m. When reassessed at 4:40 p.m., her pain had gone down to a 7 out of 10. Because her symptoms extended from her shoulder to her abdomen, Dr. Davis ordered x-rays of Ms. Essex's chest and abdomen to keep his "diagnostic net fairly wide." Clerk's Papers (CP) at 987. The x-rays, as read by radiologist Dr. Irene Cruite at 5:19 p.m., showed a "[n]onspecific paucity of gas in the bowel loops with a large gastric air bubble." CP at 523.

¶5 Based on the air bubble in Ms. Essex's stomach and the lack of air in her intestines, Dr. Davis suspected Ms. Essex had a gastric outlet obstruction and ordered a computed tomography (CT) scan of her abdomen and pelvis. Around 5:30 p.m., Ms. Essex's pain was 7 out of 10, and she received one milligram of intravenous hydromorphone. The report of her CT scan was completed at 6:20 p.m. As interpreted by Dr. Cruite, it showed a "[m]arkedly distended stomach with[ ] fluid, suspicious for gastric outlet obstruction although no cause for obstruction is identified. Placement of a nasogastric tube for decompression ... is recommended." CP at 526. At 6:56 p.m., a nasogastric tube was inserted into Ms. Essex's stomach and 1.6 to 1.8 liters of clear green fluid was removed.

¶6 Because the CT scan did not identify a cause of Ms. Essex's gastric outlet obstruction, Dr. Davis consulted with a gastroenterologist, who recommended Ms. Essex be transferred for endoscopy. Dr. Davis spoke with Dr. Stephen Wiest at Central Washington Hospital in Wenatchee, who accepted Ms. Essex as a transfer. Dr. Davis ordered nonemergency ambulance transport and that Ms. Essex be given intravenous medication en route.

¶7 Shift change at Samaritan was at 7:00 p.m., and incoming nurse Zachary Hontz noted there was bruising on Ms. Essex's upper arms that was "small in nature." CP at 236. He noted Ms. Essex was sweating, her abdomen was distended, and she was complaining of lower back pain. He noted her temperature had not previously been charted, but measured it at 98.1 degrees.

¶8 Dr. Davis remained after his shift ended at 7:00 p.m. to complete paperwork. The last care he gave to her was at 7:25 p.m. Dr. Jonathan Kim came on shift at 7:00 p.m. but did not provide any care to Ms. Essex.

¶9 At 8:25 p.m., while waiting for transfer, Ms. Essex reported that her lower back pain was again a 10 out of 10. Nursing staff administered 0.5 milligrams of hydromorphone based on Dr. Davis's standing order to administer as needed.

¶10 At 8:35 p.m., the ambulance arrived to take Ms. Essex from Samaritan in Moses Lake to Central Washington Hospital in ***247** Wenatchee. Ms. Essex arrived at Central Washington Hospital at 10:10 p.m. She was very lethargic and had a high heart rate and low blood pressure. A nurse noted redness in Ms. Essex's left inner arm, breast, and chest area. She was given fluids and Dr. Wiest came to see her as soon as possible. The skin redness had darkened and there were new raised areas, which concerned Dr. Wiest as possibly indicating necrotizing fasciitis, a rapidly progressing soft-tissue infection. He ordered additional laboratory tests, which showed "severe elevations in her inflammatory markers." CP at 240. A CT scan at 1:11 a.m. revealed "[e]xtensive contusion or edema in the body wall ... on the left." CP at 251. Dr. Wiest compared the CT scan to that taken at Samaritan and saw areas of inflammation in Ms. Essex's chest wall that were not noted in the CT report.

¶11 Dr. Wiest consulted with a surgeon, who agreed immediate debridement as a lifesaving measure was appropriate. In the 30 to 40 minutes it took the surgeon to arrive, Ms. Essex's skin redness had "rapidly" spread down to her groin. CP at 240-41. The surgery revealed extensive areas of nonviable muscle, beyond anything the surgeon had seen. The extent of necessary debridement was "not consistent with the survivable condition." CP at 249. After surgery, Ms. Essex was moved to comfort care, and she died later that morning.

PROCEDURE

Essex's complaint

¶12 Ms. Essex's estate (Essex) sued multiple entities for negligence, including Samaritan Healthcare, Dr. Davis, and Dr. Cruite. The parties conducted extensive discovery and brought a series of motions for partial summary judgment.

The trial court considered extensive briefing and arguments and made a number of rulings, which we summarize below:

- A genuine issue of material fact precludes granting Essex's motion to hold Samaritan vicariously liable for the purported negligence of its nonemployee doctors, Dr. Davis and Dr. Cruite;
- Vicarious liability can be established based only upon ostensible authority; Washington has yet to recognize the theories of nondelegable duty or inherent authority;
- Lack of proximate cause precludes holding (1) Samaritan liable under a theory of corporate negligence, (2) Samaritan liable for the purported negligence of its nurses, and (3) Dr. Cruite liable for her purported negligence for not reporting inflammation in the chest area, visible on the CT scan.

¶13 The superior court certified its orders to this court under RAP 2.3(b)(4). We granted review on (1) whether a nondelegable duty exists for emergency room care in Washington, and (2) whether, in the context of concurrent tortfeasors, expert testimony can create a genuine issue of material fact as to what a subsequent tortfeasor would have done had the prior tortfeasor not been negligent. Comm'r's Ruling, *Estate of Essex v. Grant County Pub. Dist. No. 1*, No. 37804-7-III (Wash. Ct. App. Aug. 19, 2021).

¶14 We later requested supplemental briefing on two issues that appeared to be raised in one of the summary judgment motions: (1) whether Dr. Davis was an agent of Samaritan for respondeat superior liability, and (2) whether Dr. Davis and Dr. Cruite were jointly liable under the common law concerted action theory.

ANALYSIS

A. Summary judgment and record on review

[1] **[2]** ¶15 A party moving for summary judgment must show there is no genuine issue of material fact and that they are entitled to judgment as a matter of law. CR 56(c). A material fact is one on which the outcome of the litigation depends. *Clements v. Travelers Indem. Co.*, 121 Wash.2d 243, 249, 850 P.2d 1298 (1993). In deciding a motion for summary judgment, the trial court views all facts and reasonable inferences therefrom in the light most favorable to the nonmoving party. *Id.* We review an order on summary judgment de novo, engaging in the same inquiry as the trial court ***248** based on the evidence and issues before it. *See McLaughlin v. Travelers Com. Ins. Co.*, 196 Wash.2d 631, 637, 476 P.3d 1032 (2020); RAP 9.12.

[3] ¶16 RAP 9.12 instructs that we consider only the evidence called to the attention of the trial court on review of a motion for summary judgment. But this is not the typical review of a summary judgment order. Here, the case is before us on interlocutory review at a point in the litigation where the trial court could revise its rulings. *See Hubbard v. Scroggin*, 68 Wash. App. 883, 887, 846 P.2d 580 (1993). We therefore consider the entire trial court record in our review of each and all of the certified orders.[2]

2 During oral argument, we discussed the unusual procedural posture of these orders and questioned the parties whether we should review the entire record for each and all of the certified orders. They agreed we should. Wash. Court of Appeals oral argument, *Estate of Essex v. Grant County Pub. Hosp. Dist. No. 1*, No. 37804-7-III (Dec. 7, 2022), at 18 min., 19 sec. through 26 min., 51 sec., *video recording by* TVW, Washington State's Public Affairs Network, https://tvw.org/video/division-3-court-of-appeals-2022121161/?eventID=2022121161.

B. Samaritan's potential vicarious liability

¶17 Essex contends the trial court erred by limiting Samaritan's potential vicarious liability for the acts of Dr. Davis and Dr. Cruite to the theory of ostensible agency. We discuss the other theories posited by Essex below.

Nondelegable duty

¶18 Essex contends Samaritan has a nondelegable duty to provide emergency care that subjects it to vicarious liability for the actions of Dr. Davis and Dr. Cruite. We disagree.

[4] ¶19 The existence of a duty is a question of law we review de novo. *Pedroza v. Bryant*, 101 Wash.2d 226, 228, 677 P.2d 166 (1984). In *Adamski v. Tacoma General Hospital*, 20 Wash. App. 98, 111 n.5, 579 P.2d 970 (1978), we suggested that Washington regulations arguably imposed on hospitals a nondelegable duty to provide emergency care services to the public. We discussed the relevant regulations in place at the time:

> The regulations require a licensed hospital to provide emergency care services in accordance with the community's needs and the hospital's capabilities. Within

> this general framework, however, the hospital is also required to adopt written policies and procedures specific to emergency care services. One requirement is that there must be a physician responsible for the services, whose functions and responsibilities are subject to the medical direction of the hospital.

Id. (emphasis omitted). While these regulations are no longer in place, Essex argues current regulations impose such a duty.

¶20 The Department of Health has authority to promulgate regulations to "establish and adopt such minimum standards and rules pertaining to the construction, maintenance, and operation of hospitals ... particularly for the establishment and maintenance of standards of hospitalization required for the safe and adequate care and treatment of patients." RCW 70.41.030. Pursuant to this authority, the Department of Health has adopted regulations requiring "hospital leaders" to "[p]rovide all patients access to safe and appropriate care." WAC 246-320-136(5). Leaders must "[a]dopt and implement policies and procedures which define standards of care for each specialty service" and "[p]rovide practitioner oversight for each specialty service" including emergency services. WAC 246-320-136(3), (4). Hospitals need not provide emergency services, but if they do, they must "[m]aintain the capacity to perform emergency triage and medical screening exam twenty-four hours per day; ... [d]efine the qualifications and oversight of staff delivering emergency care services; ... [and u]se hospital policies and procedures which define standards of care." WAC 246-320-281(2)-(4).

¶21 While a hospital must "[a]ssure emergency equipment, supplies and services necessary to meet the needs of patients are immediately available,"[3] the regulations no longer impose the requirement, identified in *Adamski*, that there be "physician responsible ***249** for the services, whose functions and responsibilities are subject to the medical direction of the hospital." 20 Wash. App. at 111 n.5, 579 P.2d 970. Instead, a hospital need only assure there is "at least one registered nurse skilled and trained in emergency care services on duty and in the hospital at all times, who is: (a) [i]mmediately available to provide care; and (b) [t]rained and current in advanced cardiac life support." WAC 246-320-281(5).

3 WAC 246-330-225(4).

[5] **[6]** ¶22 Unlike in *Adamski*, the current statutes and regulations do not create a duty to have a physician provide medical care in an emergency department, let alone one subject to the control of the hospital. We see no basis to hold Samaritan vicariously liable for the actions of Dr. Davis and Dr. Cruite based on the duties identified in the statutes and regulations.

Inherent function

[7] ¶23 Essex argues the court erred in denying its motion for summary judgment on the basis that Dr. Davis and Dr. Cruite were performing an inherent function of the hospital. We disagree.

¶24 Essex asserts that the *Adamski* court recognized that when a physician is performing an inherent function of a hospital, the hospital is subject to vicarious liability for the physician's actions. Samaritan disputes the court recognized such a duty. We thus discuss the case in more detail.

¶25 In *Adamski*, a patient injured his finger while playing basketball and sought treatment in the defendant's emergency room. 20 Wash. App. at 100, 579 P.2d 970. He experienced complications with the wound and brought an action for damages against the emergency room physician, Dr. Tsoi, the group of physicians to which Dr. Tsoi belonged and that contracted with the hospital for its emergency department staffing and the hospital. *Id.* at 102, 579 P.2d 970. The patient alleged that the hospital was liable in part because Dr. Tsoi was acting as its agent. *Id.* The trial court granted summary judgment in favor of the hospital, concluding Dr. Tsoi was an independent contractor rather than an employee of the hospital. *Id.* at 103, 579 P.2d 970.

¶26 On appeal, the court extensively discussed principles of agency in the context of a hospital's relationship with its nonemployee doctors. We noted that applying the traditional right to control test to this relationship "usually leads to unrealistic and unsatisfactory results, at least from the standpoint of the injured patient." *Id.* at 105, 579 P.2d 970. We proceeded to discuss various approaches to hospital liability that other courts had developed. In rejecting its prior theory of hospital immunity, the New York Court of Appeals had reasoned:

> "The conception that the hospital does not undertake to treat the patient, does not undertake to act through its doctors and nurses, but undertakes instead simply to procure them to act upon their own responsibility, no longer reflects the fact. Present-day hospitals, as their manner of operation plainly demonstrates, do far more than furnish facilities for treatment. They regularly employ on a salary

> basis a large staff of physicians, nurses and internes, as well as administrative and manual workers, and they charge patients for medical care and treatment, collecting for such services, if necessary, by legal action. Certainly, the person who avails himself of 'hospital facilities' expects that the hospital will attempt to cure him, not that its nurses or other employees will act on their own responsibility."

Id. at 106, 579 P.2d 970 (emphasis omitted) (quoting *Bing v. Thunig*, 2 N.Y.2d 656, 666, 143 N.E.2d 3, 163 N.Y.S.2d 3 (1957)).

¶27 The *Adamski* court discussed how California had developed the *Brown* test, which applied if the patient sought treatment primarily from the hospital (rather than the doctor) and if the hospital paid the doctor a salary (rather than the doctor billing the patient). *Id.* at 107, 579 P.2d 970 (citing *Brown v. La Societe Francaise de Bienfaisance Mutuelle*, 138 Cal. 475, 71 P. 516 (1903)). We noted that other courts moved to a "significant relationship" approach, looking at whether, in light of all the facts and circumstances, the relationship between the physician and the hospital was significant ***250** enough that the rule of respondeat superior should apply. *Id.* at 108, 579 P.2d 970. Under that approach, when a hospital chooses to "provide medical treatment rather than merely serving as a place for a private physician to administer to his patients, the physician employed to deliver that service for the hospital may be looked upon as an integral part of the total 'hospital enterprise.' " *Id.* We viewed this as a "more enlightened approach" to determining respondeat superior liability. *Id.*

¶28 In analyzing Dr. Tsoi's agency for the purpose of the hospital's respondeat superior liability, the *Adamski* court first applied the *Brown* test, finding the first prong satisfied because the patient went directly to the emergency room and did not choose his doctor. *Id.* at 111-12, 579 P.2d 970. The second prong, however, failed because Dr. Tsoi's physician group billed patients for its professional services rather than receiving a salary from the hospital. *Id.* at 112, 579 P.2d 970.

¶29 The *Adamski* court then applied the "significant relationship" approach and noted there was substantial evidence that Dr. Tsoi was performing an inherent function of the hospital, "*i.e.*, he was an integral part of the total hospital function or enterprise." *Id*. It concluded that "when one considers all the facts and circumstances of the relationship" between the hospital and Dr. Tsoi, "a substantial and genuine issue arises as to whether that relationship is that of principal and agent." *Id.* It thus concluded that the trial court erred in granting summary judgment for the hospital on the issue of Dr. Tsoi's agency. *Id.*

¶30 The *Adamski* court then proceeded to discuss ostensible agency as an alternate basis of liability, concluding that there was a genuine issue of material fact as to whether the hospital "held out" Dr. Tsoi as providing emergency care on behalf of the hospital. *Id*. at 115-16, 579 P.2d 970. It remanded for further proceedings on both grounds of agency liability. *Id.* at 117, 579 P.2d 970.

¶31 Based on our review of *Adamski*, we disagree that the court adopted a new "inherent function" test for vicarious liability. Rather, the court discussed inherent function as a factor, among others, in determining whether the parties had a significant relationship such that respondeat superior liability should apply. *See* Restatement (Second) of Agency § 220 (Am. Law Inst. 1958). We find no support for inherent function as an independent theory for establishing vicarious liability. We conclude the trial court did not err in rejecting such a theory.

Functional equivalent

[8] ¶32 In a statement of additional authorities, Essex noted that our Supreme Court recently recognized that nonemployee physicians are the "functional equivalent" of the hospital's employees for purposes of permitting the hospital's attorney to have ex parte communication with them. *Hermanson v. MultiCare Health Sys., Inc.*, 196 Wash.2d 578, 589-90, 475 P.3d 484 (2020). There, the divided court noted, "Whether there is vicarious liability between two defendants is separate from whether such parties may have ex parte communications with one another under evidentiary privilege." *Id.* at 590, 475 P.3d 484. To its credit, Essex noted this distinction, but urges us to adopt a rule based on what we think our Supreme Court would do should this issue come before it.

¶33 We think our Supreme Court would reject imposing vicarious liability based on the notion of functional equivalency. First, three dissenting justices wanted to preserve the distinction between the nonemployee physician and the hospital. *Hermanson*, 196 Wash.2d at 594, 475 P.3d 484 (Stephens, C.J, concurring in part, dissenting in part). And of the six justices in the majority, the inclusion of the quoted language shows that some wanted to preserve the distinction for purposes of imposing vicarious liability.

¶34 Also, policy is best affected by the legislature. *In re Guardianship of Hamlin*, 102 Wash.2d 810, 821-22, 689 P.2d 1372 (1984). This is especially true in areas such as health care and medical negligence where the legislature has set policy through statutes and regulations promulgated by legislative authority. *See*, *e.g.*, Title 70 RCW, chapter 7.70 RCW, Title 246 WAC. It appears our legislature has chosen to limit a hospital's vicarious liability to its officers, directors, ***251** employees, and agents. *See* RCW 7.70.020(3) (for injuries resulting from health care, defining "health care provider" as a nonexclusive list of entities, including a hospital, together with their "officer[s], director[s], employee[s], or agent[s]" acting within their scope of employment). We see nothing in the statutes or regulations that support imposing vicarious liability against a hospital for nonemployee doctors.

Acting in concert

[9] ¶35 In its motion for summary judgment, Essex argued that Samaritan was liable for the negligence of Dr. Davis and Dr. Cruite because they were acting in concert under RCW 4.22.070(1)(a). In our de novo review of the record, we requested supplemental briefing on whether the common law theory of concerted action was applicable to Dr. Davis and Dr. Cruite. We conclude it is not.

[10] ¶36 Concerted action under the common law derives from vicarious liability and requires that a plaintiff show "a tacit agreement among defendants to perform a tortious act." *Martin v. Abbott Lab'ys*, 102 Wash.2d 581, 596, 689 P.2d 368 (1984). A defendant can be liable for harm resulting from another person's tortious act if he " 'gives substantial assistance to the other in accomplishing a tortious result and his own conduct, separately considered, constitutes a breach of duty to the third person.' " *Id.* (quoting Restatement (Second) of Torts § 876(c), at 315 (Am. Law Inst. 1977)). Under this theory, a defendant need not know that his act or the other's is tortious. *Id.* at cmt. e.

¶37 RCW 4.22.070(1)(a) provides an exception to Washington's default proportionate liability, making a party "responsible for the fault of another person or for payment of the proportionate share of another party where both were acting in concert ...." The provision was enacted as part of the "Tort Reform Act of 1986." *See* Laws of 1986, ch. 305, § 401. We previously discussed the impact of the Tort Reform Act on the common law theory of concerted action, concluding it intended to restore a " 'strict and narrow understanding of concerted action.' " *Gilbert H. Moen Co. v. Island Steel Erectors, Inc.*, 75 Wash. App. 480, 486, 878 P.2d 1246 (1994), *rev'd on other grounds*, 128 Wash.2d 745, 912 P.2d 472 (1996) (quoting Gregory C. Sisk, *Interpretation of the Statutory Modification of Joint and Several Liability: Resisting the Deconstruction of Tort Reform*, 16 U. Puget Sound L. Rev. 1, at 105 (1992)).

¶38 Under this narrow interpretation:

> "Cooperation in a lawful enterprise, which results in harm to a third person through negligence, does not rise to the high level of concerted activity. Participation in a legitimate commercial relationship does not constitute acting in concert, even if a third person is harmed by the actions of one of the parties[.]"

Id. (emphasis omitted) (alteration in original) (quoting Sisk, *supra* at 107). Our Supreme Court later adopted the *Moen* court's analysis and its definition of acting in concert for the purpose of RCW 4.22.070(1)(a) as " 'consciously act[ing] together in an unlawful manner.' " *Kottler v. State*, 136 Wash.2d 437, 448, 963 P.2d 834 (1998) (quoting *Moen*, 75 Wash. App. at 487, 878 P.2d 1246).

¶39 Here, there is no evidence that Dr. Davis, Dr. Cruite, and Samaritan intended to act in an unlawful manner. The trial court correctly denied Essex's motion to hold Samaritan vicariously liable under RCW 4.22.070(1)(a) for the purported negligence of Dr. Davis and Dr. Cruite.

C. Proximate cause

¶40 Essex contends the trial court erred by dismissing various negligence claims for lack of proximate cause. We agree in part.

[11] **[12]** ¶41 On summary judgment, a defendant may demonstrate there is no genuine issue of material fact for trial by showing that the plaintiff has failed to prove an essential element of their claim. *Young v. Key Pharms., Inc.*, 112 Wash.2d 216, 225, 770 P.2d 182 (1989). If the nonmoving party " 'fails to make a showing sufficient to establish the existence of an element essential to that party's case, and on which that party will bear the burden of proof at trial', then the trial court should grant the motion." *Id.* (quoting ***252** *Celotex Corp. v. Catrett*, 477 U.S. 317, 322, 106 S. Ct. 2548, 91 L. Ed. 2d 265 (1986)).

[13] **[14]** ¶42 In a medical malpractice action, a plaintiff must prove "duty, breach, injury, and proximate cause." *Mohr v. Grantham*, 172 Wash.2d 844, 850, 262 P.3d 490 (2011)

(citing RCW 7.70.040). Proximate cause generally requires a showing that the breach of duty was a cause in fact of the injury and a showing that liability should attach as a matter of law. *Id.* We now examine the three negligence claims dismissed by the trial court following its conclusion that Essex could not establish proximate cause.

Corporate negligence claim

[15] ¶43 Essex contends the trial court erred in dismissing its claim that Samaritan could be liable for corporate negligence. We disagree.

¶44 Essex's theory of corporate negligence was that Samaritan was required to have policies in place with respect to recognizing infectious disease, to adequately train its nurses in those policies, and to have adequate oversight of its nurses engaged in triage.

¶45 Dr. Amy Curley identified deficiencies in Samaritan's policies regarding ongoing training and identification of infectious diseases and its oversight, opining that nursing staff should have brought Ms. Essex's symptoms to Dr. Davis's attention sooner. However, Dr. Thomas Cumbo acknowledged that when Dr. Davis evaluated Ms. Essex, he had all the relevant information. Even with that relevant information, Dr. Davis diagnosed gastric outlet obstruction, not necrotizing fasciitis.[4] Any failure by Samaritan in regard to its triage policies, training, and oversight did not proximately cause Dr. Davis's failure to diagnose necrotizing fasciitis.

4 Indeed, given that Ms. Essex's symptoms became more severe over time, it seems likely that if Dr. Davis had examined her earlier, he would have been even less likely to diagnose necrotizing fasciitis.

[16] ¶46 Dr. Cumbo also identified the nurses' failure to notify Dr. Davis that Ms. Essex's pain had returned as falling below the standard of care.[5] However, he did not link that failure to any failure in Samaritan's policies, training, or oversight. To the contrary, he stated he was sure the nurses had training in what abnormal vital signs were. While this testimony may establish that the nurses breached their standard of care, it does not support Essex's claim of corporate negligence. We conclude the trial court did not err when it dismissed Essex's corporate negligence claim.[6]

5 Samaritan argued below and argues on appeal that Dr. Davis was aware of how Ms. Essex was responding to pain because he noted she felt better after her first intravenous dose of hydromorphone and the removal of almost two liters of liquid from her stomach. This does not address whether Dr. Davis knew that Ms. Essex's pain returned to and stayed at a 10 out of 10 while awaiting transport to Wenatchee, despite a second intravenous dose of hydromorphone.
Samaritan argued below that Dr. Davis ordered the administration of intravenous hydromorphone because he realized the initial intramuscular hydromorphone did not relieve her pain. This is contradicted by the record. Dr. Davis testified he ordered the administration of an initial intramuscular dose only because an intravenous line had not yet been placed.

6 Samaritan urges us to hold that Washington does not recognize Essex's theory of corporate negligence. Because we have resolved Essex's claim on other grounds, we elect not to decide whether Washington recognizes such a theory.

Dr. Cruite's negligence

[17] ¶47 Essex contends the trial court erred in dismissing its negligence claim against Dr. Cruite for lack of proximate cause. We agree.

¶48 Before we discuss the law, we set forth the relevant evidentiary facts. The parties disputed whether Dr. Cruite's failure to identify the abnormality in the left chest wall altered the course of Dr. Davis's treatment. They focused on deposition testimony from Dr. Davis.

> Q.[7] ... If the radiologist had said, "Yeah, we've got some stuff going on up here in the chest wall, too," would that have changed your position with regard to how you handled this patient?
>
> ***253** ....
>
> [Dr. Davis]. Hypothetically, I could say that it probably would have. It would not have changed my diagnosis of gastric outlet obstruction because that was still independently and clinically present, but it would have alerted me that there were additional findings that were not consistent with that single diagnosis explaining her entire complaint and it would have prompted me to do other things.

CP at 1053-54. He further testified that he reviewed the CT scan the following morning after Ms. Essex had been

transferred to Central Washington Hospital and diagnosed with necrotizing fasciitis, and "[i]n hindsight" there was "obvious" inflammation in Ms. Essex's chest wall. CP at 2048-49. "That inflammation was also nonspecific, but it was there." CP at 2049. He had previously considered necrotizing fasciitis in his differential diagnosis, but ruled it out in part because all of Ms. Essex's symptoms were explained by a gastric outlet obstruction.

7 The speaker is not identified in the excerpt, but from context appears to be Essex's attorney, William Gilbert.

¶49 Dr. Kevin Hanson testified that emergency department physicians rely on radiologists to read CT scans, although they may pull up the scan based on interest. Dr. Charles Pilcher opined that the standard of care would require an emergency room doctor to explore abnormalities reported in imaging studies. Had Dr. Cruite reported the soft tissue abnormalities in Ms. Essex's chest wall, Ms. Essex's "course of care would have been altered" and the necrotizing fasciitis would have been discovered through a surgical consult. CP at 1748.

¶50 Dr. Cumbo testified that the standard of care for a surgical consult for necrotizing fasciitis is 30 to 60 minutes and debridement should happen as soon as possible and could have happened at Samaritan.

¶51 The parties' arguments below and on discretionary review have centered on two Washington cases. We begin by discussing those cases.

¶52 In *Douglas v. Bussabarger*, 73 Wash.2d 476, 477, 438 P.2d 829 (1968), a patient was harmed by the anesthetic used during surgery and sued the surgeon and the drug manufacturer. After a jury returned a verdict in favor of the defendants, the patient appealed, and our Supreme Court affirmed as to the drug company. *Id.* at 491, 438 P.2d 829. It noted that the patient's only issue was whether the drug company should have warned of possible dangers of the drug on its label, but the surgeon testified at trial "that he relied on his own knowledge of anesthetics and, in fact, did not read the labeling which was on the container." *Id.* at 478, 438 P.2d 829. The court concluded that even if the drug company was negligent for failing to warn of dangers on the drug's label, "this negligence was not a proximate cause of plaintiff's disability." *Id.*

¶53 We followed *Douglas* in *Sherman v. Pfizer, Inc.*, 8 Wash. App. 2d 686, 698-99, 440 P.3d 1016 (2019), another case involving a drug manufacturer's failure to warn. There, a patient developed a movement disorder after taking medication produced by the defendant drug companies. *Id.* at 691-92. She brought a products liability claim against the drug companies, alleging they should have updated their package insert to warn against extended use of the medication. *Id.* at 689. The prescribing doctor, however, testified that he did not read package inserts and had never read a package insert for the medication. *Id.* at 693. The court reasoned that the patient had introduced no evidence to create a genuine issue of material fact regarding whether the doctor had read the package inserts and thus, as a matter of law, the failure to update the inserts could not have proximately caused the patient's harm. *Id.* at 699.

[18] ¶54 The principle identified in *Douglas* and *Sherman* relates to the basic and longstanding "but for" test of cause in fact. The patients were required to prove that they would not have been harmed by the medication but for the failure to warn. They could not do so because the doctors would have used the medications regardless of inadequate warnings. The "but for" test is applicable in most cases, including most medical malpractice cases.[8] ***254** *Dunnington v. Virginia Mason Med. Ctr.*, 187 Wash.2d 629, 636, 389 P.3d 498 (2017). Thus, had Dr. Davis testified he would not have considered necrotizing fasciitis even had Dr. Cruite reported inflammation in Ms. Essex's chest wall, this would break the causal chain between Dr. Cruite's failure to report the existing inflammation and Ms. Essex's harm.

8 Essex argues these cases are not applicable outside the drug manufacturer failure to warn context, contending that the *Sherman* court "expressly based its discussion of proximate cause on the learned intermediary doctrine." Pet'rs' Reply Br. at 33. This is incorrect. The *Sherman* court based its discussion of duty on the learned intermediary doctrine. 8 Wash. App. 2d at 695, 440 P.3d 1016. The learned intermediary doctrine defines a drug manufacturer's duty to warn, limiting it to the prescribing doctor rather than the end user. *Dearinger v. Eli Lilly & Co.*, 199 Wash.2d 569, 574, 510 P.3d 326 (2022). It does not alter the rules of causation; rather, it "has bearing only on who a manufacturer must warn." *Id.* at 585, 510 P.3d 326 (emphasis omitted).

[19] ¶55 As identified by the *Sherman* court, Essex had to establish that Dr. Davis, himself, would have considered necrotizing fasciitis had Dr. Cruite reported the existing inflammation.[9] Dr. Davis testified that had the CT results disclosed the existing inflammation in the

chest wall, he would have investigated further because his diagnosis of gastric outlet obstruction would not explain the inflammation.[10] He did not testify he would have correctly diagnosed necrotizing fasciitis had Dr. Cruite reported inflammation, but this is not fatal to Essex's claim. But Dr. Pilcher testified that Dr. Davis more likely than not would have diagnosed necrotizing fasciitis had Dr. Cruite reported the existing inflammation. This testimony achieves the same purpose.

9 The parties disagree on whether expert testimony on this subject is relevant. Because this issue is likely to arise at trial, we offer the following comments.
One may presume that Dr. Davis, a trained emergency room doctor, would act in a reasonably prudent manner. As long as the trier of fact understands that expert testimony on this subject is being admitted for the limited purpose of showing what Dr. Davis would have done, it is relevant and admissible, subject to an ER 403 analysis by the trial court.

10 Dr. Cruite argues at length that Dr. Davis unequivocally testified he would not have changed his diagnosis. The relevant inquiry is not whether Dr. Davis would have changed his diagnosis of gastric outlet obstruction, but rather whether he would have *additionally* diagnosed necrotizing fasciitis.

[20] ¶56 Still, Essex must establish more to present a triable issue that Dr. Cruite's negligence proximately caused harm. In addition to evidence that Dr. Davis likely would have diagnosed necrotizing fasciitis, Essex also must establish that a surgeon was likely available to timely operate on Ms. Essex. Essex satisfied this burden. Dr. Cumbo testified that a surgical consult would likely have been available between 30 and 60 minutes and could have happened at Samaritan. This is sufficient to establish a prima facie case of proximate cause.

¶57 The crucial distinction between this case and *Douglas* and *Sherman* is that there, the doctors' testimony cut off the chain of causation and so the drug companies' failure to warn was not a cause in fact of the patients' injuries. Here, viewing the facts in the light most favorable to Essex, Dr. Davis would have continued investigating Ms. Essex's symptoms, diagnosed necrotizing fasciitis, and initiated successful surgery but for Dr. Cruite's alleged failure to identify inflammation in the CT scan. We conclude the trial court erred in dismissing Essex's negligence claim against Dr. Cruite.

Samaritan's liability for its nurses

[21] ¶58 Essex contends the trial court erred in dismissing its negligence claim against Samaritan's nurses for lack of proximate cause. We agree.

¶59 As discussed above, in relation to corporate negligence, Essex could not prove that any breach of the standard of care on the part of the nurses *before* Dr. Davis's diagnosis of gastric outlet obstruction proximately caused Ms. Essex's death. However, Dr. Cumbo also identified as a breach of the standard of care the nurses' failure to inform Dr. Davis that Ms. Essex's pain returned while she waited for transfer. Dr. Pilcher stated that based on Ms. Essex's changes after 7:00 p.m., the standard of care required a doctor to reassess her and that a physical exam and reassessment after 7:00 p.m. would have identified necrotizing fasciitis. Dr. Davis ***255** himself testified he would have continued trying to diagnose Ms. Essex's condition if he was aware she had symptoms not entirely explained by gastric outlet obstruction.

¶60 Samaritan argued at summary judgment that it was unrefuted that Dr. Davis had all the information the nurses had. This is not so. As noted above, Dr. Davis was aware that Ms. Essex's pain was not immediately relieved by painkillers and that she improved after additional medication and stomach decompression. But this does not answer whether he knew her pain returned to 10 out of 10 while awaiting transport. Although the nurses charted Ms. Essex's vital signs and symptoms, there is no evidence that Dr. Davis referred to her chart contemporaneously such that he was aware of her deteriorating condition while awaiting transport. This creates a genuine issue of material fact as to whether Dr. Davis had all the information the nurses had. Had Dr. Davis known of the existing inflammation *and* the return of Ms. Essex's horrendous pain following decompression, this would have presented another opportunity for the doctor "to do other things." CP at 1054. We conclude the trial court erred in dismissing Essex's negligence claim against Samaritan's nurses.

¶61 Affirmed in part, reversed in part.

WE CONCUR:

Pennell, J.

Staab, J.

All Citations

523 P.3d 242

End of Document

Washington Administrative Code
Title 246. Health, Department of
Facility Standards and Licensing
Chapter 246-320. Hospital Licensing Regulations (Refs & Annos)
Licensing

WAC 246-320-136

246-320-136. Leadership.

Currentness

This section describes leadership's role in assuring care is provided consistently throughout the hospital and according to patient and community needs.

The hospital leaders must:

(1) Appoint or assign a nurse at the executive level to:

(a) Direct the nursing services; and

(b) Approve patient care policies, nursing practices and procedures;

(2) Establish hospital-wide patient care services appropriate for the patients served and available resources which includes:

(a) Approving department specific scope of services;

(b) Integrating and coordinating patient care services;

(c) Standardizing the uniform performance of patient care processes;

(d) Establishing a hospital-approved procedure for double checking certain drugs, biologicals, and agents by appropriately licensed personnel; and

(e) Ensuring immediate access and appropriate dosages for emergency drugs;

(3) Adopt and implement policies and procedures which define standards of care for each specialty service;

(4) Provide practitioner oversight for each specialty service with experience in those specialized services. Specialized services include, but are not limited to:

(a) Surgery;

(b) Anesthesia;

(c) Obstetrics;

(d) Neonatal;

(e) Pediatrics;

(f) Critical or intensive care;

(g) Alcohol or substance abuse;

(h) Psychiatric;

(i) Emergency; and

(j) Dialysis;

(5) Provide all patients access to safe and appropriate care;

(6) Adopt and implement policies and procedures addressing patient care and nursing practices;

(7) Require that individuals conducting business in the hospital comply with hospital policies and procedures;

(8) Establish and implement processes for:

(a) Gathering, assessing and acting on information regarding patient and family satisfaction with the services provided;

(b) Posting the complaint hotline notice according to RCW 70.41.330; and

(c) Providing patients written billing statements according to RCW 70.41.400;

(9) Plan, promote, and conduct organization-wide performance-improvement activities according to WAC 246-320-171;

(10) Adopt and implement policies and procedures concerning abandoned newborn babies and hospitals as a safe haven according to RCW 13.34.360;

(11) Adopt and implement policies and procedures to require that suspected abuse, assault, sexual assault or other possible crime is reported within forty-eight hours to local police or the appropriate law enforcement agency according to RCW 26.44.030.

Credits

Statutory Authority: Chapter 70.41 RCW and RCW 43.70.040. WSR 09-07-050, S 246-320-136, filed 3/11/09, effective 4/11/09.

Current with amendments adopted through the 22-24 Washington State Register, dated December 23, 2022. Some sections may be more current. Please consult the credit on each document for more information.

WAC 246-320-136, WA ADC 246-320-136

End of Document

Washington Administrative Code
Title 246. Health, Department of
Facility Standards and Licensing
Chapter 246-320. Hospital Licensing Regulations (Refs & Annos)
Patient Care

WAC 246-320-281

246-320-281. Emergency services.

Currentness

The purpose of this section is to guide the management and care of patients receiving emergency services. Hospitals are not required to provide these services in order to be licensed.

If providing emergency services, hospitals must:

(1) Adopt and implement policies and procedures, consistent with RCW 70.170.060, for every patient presenting to the emergency department with an emergency medical condition to include:

Transfer of a patient with an emergency medical condition or who is in active labor based on:

(a) Patient request;

(b) Inability to treat the patient due to facility capability;

(c) Staff availability or bed availability; and

(d) The ability of the receiving hospital to accept and care for the patient;

(2) Maintain the capacity to perform emergency triage and medical screening exam twenty-four hours per day;

(3) Define the qualifications and oversight of staff delivering emergency care services;

(4) Use hospital policies and procedures which define standards of care;

(5) Assure at least one registered nurse skilled and trained in emergency care services on duty and in the hospital at all times, who is:

(a) Immediately available to provide care; and

(b) Trained and current in advanced cardiac life support;

(6) Post names and telephone numbers of medical and other staff on call;

(7) Assure communication with agencies and health care providers as indicated by patient condition; and

(8) Assure emergency equipment, supplies and services necessary to meet the needs of presenting patients are immediately available.

Credits

Statutory Authority: Chapter 70.41 RCW and RCW 43.70.040. WSR 09-07-050, S 246-320-281, filed 3/11/09, effective 4/11/09.

Current with amendments adopted through the 22-24 Washington State Register, dated December 23, 2022. Some sections may be more current. Please consult the credit on each document for more information.

WAC 246-320-281, WA ADC 246-320-281

End of Document

(4) The hospital shall adopt a recognized method of checking sterilizer performance.

(5) Clean and sterilized supplies and equipment shall be kept separate from soiled and contaminated supplies and equipment. [Order 119, § 248-18-260, filed 5/23/75; Regulation 18.260, effective 3/11/60.]

WAC 248-18-270 Use of medical gases, combustible anesthetics. In rooms where combustible anesthetic (cyclopropane, divinyl ether, ethyl chloride, ethyl ether, and ethylene) agents are used, the installation, maintenance, and use of equipment and other precautions observed by personnel shall be in accordance with the current issue of the National Fire Protection Association, No. 56, (Safe practices for hospital operating rooms). [Order 119, § 248-18-270, filed 5/23/75; Regulation 18.270, effective 3/11/60.]

WAC 248-18-280 Oxygen. (1) Oxygen gauges and manometers shall be tested for accuracy periodically and be conspicuously labeled "Oxygen, use no oil".

(2) "No Smoking" signs shall be posted where oxygen is being administered.

(3) Oxygen tent canopies shall be fabricated of slow burning or noncombustible material.

(4) Electric equipment used in connection with oxygen tents shall be properly designed for use with oxygen. [Order 119, § 248-18-280, filed 5/23/75; Regulation 18.280, effective 3/11/60.]

WAC 248-18-285 Emergency care services. The hospital shall have a well defined system for providing emergency care services. The nature and scope of the hospital's emergency care services should be in accord with the community's needs and the hospital's capabilities.

(1) The hospital shall provide the following basic, outpatient emergency care services.

(a) Assessment of a person's condition to determine the nature, acuity, and severity of the person's immediate medical need.

The condition of each person, who comes or is brought to the hospital for emergency medical care, shall, upon arrival, be assessed by a registered nurse, physician, or physician's assistant for the purpose of determining the nature and urgency of the person's medical need and the timing and place of the person's care and treatment.

(b) Immediate diagnosis and treatment of any life threatening cardiac arrythmia, respiratory insufficiency or shock.

(c) Appropriate transfer or referral of a patient who needs medical care services not provided by the hospital. Prior to transfer of an emergency patient to another health care facility, the hospital shall:

(i) Perform the emergency procedures needed to minimize aggravation of the patient's condition during transport to the other health care facility; and

(ii) Ascertain that the means by which the patient is to be transported to the other health care facility are suitable for the patient.

(2) A hospital shall not be required to comply with WAC 248-18-285(3)(h), WAC 248-18-285(4)(a) and (d), WAC 248-18-285(5)(a) and WAC 248-18-285(6)(a) if the hospital does not offer outpatient emergency care services regularly and only provides the outpatient emergency services required under WAC 248-18-285(1) to the occasional emergency patient who comes or is brought to the hospital by chance.

(3) The hospital shall have, in effect, written policies and procedures which supplement and are coordinated with the hospital's basic policies and are specific to emergency care services. These policies and procedures shall be: reviewed and revised as necessary to keep them current and, in any case, at least annually; dated and approved in writing by appropriate representatives of the hospital's administrative, medical, and nursing staffs; and made known and readily available to physicians, nurses, and other persons having a responsibility for emergency care services. Policies and procedures pertaining to emergency care services shall include the following.

(a) Policies on the scope and extent of the emergency care services to be provided.

(i) The hospital shall establish the conditions under which treatment is to be provided in the emergency care area, the types of procedures that are to be performed in another area of the hospital (e.g., surgery) rather than the emergency area, the conditions under which a patient is to be admitted as an inpatient, the conditions under which a patient is to be transferred to another health care facility, the conditions under which a patient is to be referred to a private physician or another health care facility, and the conditions under which arrangements should be made for a patient to return to the hospital for treatment.

(ii) A patient shall not be transferred to another health care facility until the other health care facility has been contacted and has consented to accept the patient.

(iii) A record containing the following data shall be sent with an emergency patient who is transferred to another health care facility: patient identification data, identification of the patient's illness or injury, treatment given to the patient, and an appraisal of the patient's condition upon transfer.

(b) Policies and procedures which prescribe the course of action to be taken when the number of emergency patients, who have arrived or are expected, constitute an overload for the emergency service facilities and staff on hand.

The hospital shall establish who is to be notified when an overload of emergency patients occurs, the conditions under which arrangements are to be made for care of some emergency patients at other hospitals, the conditions under which additional physicians, nurses, and other persons are to be summoned, the methods by which necessary, additional supplies and equipment are to be obtained, and the conditions under which rooms and areas outside the emergency service area of the hospital are to be used for emergency care and treatment.

(c) Medical policies, standing emergency medical orders, and written medical procedures to guide the action of nurses and other personnel when a person presents a medical emergency and a physician is not present.

(i) Medical policies shall delineate the circumstances under which particular medical policies are to be followed, provide for a physician to be called as rapidly as possible, and establish the minimum qualifications or training of persons who may execute particular emergency medical orders.

(ii) There shall be written procedures, approved in writing by a representative of the medical staff, for any use of defibrillators, respirators or other special medical equipment and for the performance of the special, emergency medical procedures listed in WAC 248–18–285(4)(c).

(iii) A standing medical order for administration of a drug or other treatment during a medical emergency shall include: a description of the treatment which includes the name of any drug or other agent; the dosage, concentration or intensity of any drug or other agent; the route or method of administration; where pertinent, the time interval, frequency, or duration of administration; and the signature of a representative of the medical staff.

(d) Policies which delineate medical staff responsibilities for emergency care services as related to assigned clinical privileges, physician coverage of emergency care services, and physician participation in the training of personnel.

(e) Policies regarding the notification of an emergency patient's next of kin or legal guardian.

(f) Policies relevant to obtaining consent for treatment from an emergency patient or other person who may legally give consent for treatment of the patient.

These shall include instructions regarding action to be taken when the condition of an emergency patient and the absence of another person legally able to act on behalf of the patient make it impossible to gain an informed consent for critically needed treatment or consent for critically needed treatment is refused.

(g) Policies and procedures pertaining to the care and handling of persons whose conditions require special medical or medico–legal consideration.

(i) Policies and procedures shall prescribe the course of action to be followed in the care of persons who manifest severe emotional disturbances, are under the influence of alcohol or other drugs, are victims of suspected child abuse, are victims of other suspected criminal acts, have a contagious disease, have been contaminated by radioactive material, are diagnosed dead on arrival, or present other conditions requiring special directions regarding action to be taken.

(ii) Definite provision shall be made for communications, as indicated, with health authorities, police or coroner relative to a person whose condition or its cause are reportable.

(h) Policies governing special diagnostic and therapeutic services (e.g., clinical laboratory, x–ray, pharmacy, surgery) to emergency patients.

These shall be designed to ensure prompt availability of necessary diagnostic and therapeutic services and establish the types, scope, and extent of the special diagnostic and therapeutic services to be provided for the care of emergency patients.

(i) Policies regarding notification of an emergency outpatient's personal physician and procedures for transfer of relevant reports to the personal physician.

(j) Policies regarding disclosure of information about an emergency patient.

(4) Organization and staffing for emergency care services shall be in accord with the anticipated patient load and the services provided by the hospital.

(a) There shall be a physician responsible for the medical direction of the hospital's emergency care services. This physician shall be a representative of the medical staff or a physician whose services the hospital has arranged on a regular basis. The functions and responsibilities of the physician responsible for medical direction of the emergency care services shall be delineated in writing and made known to members of the medical and nursing staffs.

(b) At all times, there shall be a physician on duty or call for emergency care services. A current schedule of the names of on–call physicians and the telephone numbers of these physicians or the call service(s) through which they can be contacted rapidly shall be posted in the emergency care area.

(c) At all times, there shall be on duty within the hospital at least one registered nurse who is immediately available and responsible for emergency care services and who is qualified to perform the following: administration of intravenous fluids, electrocardiography and defibrillation of life threatening arrythmias, cardio–pulmonary resuscitation, control of hemorrhage, gastric lavage, and basic neurological evaluation. It is recommended that such a nurse also be qualified to perform endotracheal intubation and arterial puncture.

(d) There shall be additional nursing staff and other personnel for emergency care services as are necessary to provide the types and amount of care required by patients.

(i) Staffing for emergency care services shall be adequate to ensure that each applicant for emergency medical care is seen within a period of time commensurate with the nature, acuity and severity of his or her immediate medical need.

(ii) Each hospital employee engaged in the provision of emergency care shall have had the education and training necessary to perform the emergency medical procedures and other functions and duties for which he or she may be responsible.

(5) The physical plant facilities, equipment, and supplies for emergency care services shall be commensurate with the scope, types and volume of the services provided by the hospital.

(a) A hospital which regularly offers emergency care services shall maintain a distinct emergency service area.

(i) The emergency service area shall be in close proximity to an emergency entrance and separate from the surgery and delivery suites and inpatient nursing units.

(ii) The emergency service area shall provide adequate space for reception and screening of patients and have examination, treatment, and observation rooms in such numbers, sizes, and arrangements as are necessary to assure safe and effective treatment of patients.

(iii) There shall be some means of providing visual privacy to patients in all rooms or areas in which patients are examined or treated.

(iv) At the emergency entrance there shall be an outside night call bell which, when activated, sounds in an area of the hospital in which nursing personnel are always on duty.

(b) A hospital which limits its emergency care services to care of the occasional emergency patient shall not be required to maintain a distinct emergency service area, but shall designate the area(s) to be used for emergency care and provide the equipment, pharmaceuticals and other supplies essential to providing basic emergency care services required under WAC 248-18-285(1). Emergency equipment and supplies shall be maintained in such a location and manner (e.g., on a "crash" cart) that they may be brought into use immediately upon arrival of a person who presents a medical emergency.

(c) The equipment, pharmaceuticals and other supplies necessary to provide emergency care services shall be readily available at all times.

(i) There shall be specific, designated locations for storage of drugs, parenteral solutions, other supplies, instruments and special equipment so personnel can obtain them rapidly.

(ii) There shall be a system for regular inventory and replenishment of the stock of emergency supplies and equipment to ensure an adequate supply at all times.

(iii) There should be regular inspection and maintenance servicing of medical equipment to keep it in a safe and operable condition.

(d) Current references on toxicology, antidote information and the telephone number of the Regional Poison Control Center shall be readily available in the emergency care area.

(e) Telephone numbers of the pharmacist, the blood bank, the ambulance service, the Washington State Patrol, Military Assistance Safety and Traffic (MAST), the fire department, the police department, local health authorities, the coroner and other persons or organizations emergency service personnel may need to contact rapidly shall be posted in the emergency service area.

(f) Hospital to ambulance radio communication compatible with the state-wide emergency communication system is recommended for any hospital which regularly provides emergency care services.

(6) The hospital shall maintain an emergency service register and a medical record for each person who has received emergency care service.

(a) There shall be a permanent, current register for all emergency patients.

(i) The register shall contain at least the following data for each person who comes or is brought to the hospital for immediate medical care services: full name, age, date and time of arrival, the identifying number, the disposition of the patient and the time of the patient's departure from the emergency service area.

(ii) Data on patients shall be entered in the register in chronological order according to the dates and times of arrivals.

(iii) Identification data on a person who is dead on arrival shall be entered in the register.

(b) The hospital shall maintain a medical record for each person who receives emergency care services. Each medical record shall contain the following data.

(i) Patient identification data.

(ii) The date and time of arrival, the means by which the patient came to the hospital and by whom the patient was transported or accompanied.

(iii) Pertinent history of the patient's injury or illness which may include information on first aid or emergency care given the patient prior to his or her arrival.

(iv) Description of significant clinical findings derived from an assessment or examination of the patient.

(v) Any clinical laboratory or roentgenologic findings.

(vi) Diagnosis (tentative or definitive).

(vii) Treatment given.

(viii) Orders for administration of drugs or other treatments which are received by telephone, radio, or verbally from a physician or other person legally authorized to prescribe and acting within the scope of his or her license.

Such a telephone or verbal order shall be received, entered in the patient's medical record and signed by a registered nurse. The counter-signature of the physician or other legally authorized practitioner who gave the order shall be obtained as soon as possible thereafter. This shall not be interpreted to include verbal orders which are received from a physician or other legally authorized practitioner to whom one is providing direct assistance in care of the patient or to include standing emergency medical orders which have been established in accordance with WAC 248-18-285(3)(c)(iii).

(ix) Appraisal of the patient upon transfer or departure.

(x) Disposition of the patient, which shall include a resume of any instruction given to the patient or his family regarding necessary follow-up care.

Entries of data listed as (iv) (vi) (vii) (ix) and (x) above shall be authenticated by the signature of the person who rendered the service. [Order 142, § 248-18-285, filed 2/8/77; Order 119, § 248-18-285, filed 5/23/75; Order 110, § 248-18-285, filed 3/14/75; Order 106, § 248-18-285, filed 1/13/75.]

WAC 248-18-290 Diagnostic and treatment facilities, outpatient services. If the hospital has an organized unit as an outpatient department or clinic, adequate waiting area, examining and treatment rooms, toilets and special rooms necessary for the services to be rendered, shall be provided. [Order 119, § 248-18-290, filed 5/23/75; Order 106, § 248-18-290, filed 1/13/75; Regulation 18.290, effective 3/11/60.]

WAC 248-18-300 Laboratory. (1) Laboratory services shall be sufficient to provide adequate care of all patients.

(2) The hospital shall make satisfactory provision for the typing and cross matching of blood for transfusions.

(3) Bacteriological cultures that are contaminated shall be disposed of in a safe manner.

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