

No. 78383-7

IN THE SUPREME COURT OF THE STATE OF WASHINGTON

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BY C. J. HERRITT

LIAM STEWART-GRAVES, a minor, and NICHOLE STEWART-
GRAVES, as Guardian ad Litem, and NICHOLE STEWART-GRAVES
and TODD GRAVES, individually,

Plaintiffs/Appellants,

vs.

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

Defendants/Respondents.

BRIEF OF AMICUS CURIAE
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I. IDENTITY AND INTEREST OF AMICUS CURIAE

The Washington State Trial Lawyers Association Foundation (WSTLA Foundation) is a Washington not-for-profit corporation, and a supporting organization of the Washington State Trial Lawyers Association (WSTLA). WSTLA Foundation, which operates the amicus curiae program formerly operated by WSTLA, has an interest in the rights of injured persons seeking legal redress in the civil justice system, including the rights of patients making claims against health care providers for negligence and failure to obtain informed consent.

II. INTRODUCTION AND STATEMENT OF THE CASE

This case involves statutory claims for medical negligence and breach of the duty to obtain informed consent. See generally RCW 7.70.010-.065; RCW 4.24.290 (reproduced in Appendix). The plaintiffs/appellants are minor Liam Stewart-Graves (Liam), represented by his guardian ad litem (and mother) Nichole Stewart-Graves (Nichole), and Nichole Stewart-Graves and Todd Graves (Todd), husband and wife, individually and as parents of Liam (Parents).¹ The defendants/respondents are Katherine F. Vaughn, M.D. (Vaughn), The Vancouver Medical Clinic, Inc. P.S., and Southwest Washington Medical Center.² For purposes of this brief, the facts are principally drawn from the briefing of the parties. See Stewart-Graves Br. at 1-9; Vaughn Br. at

¹ The plaintiffs/appellants filed joint briefing in this case, which will be referred to in this brief as “Stewart-Graves Br.” and “Stewart-Graves Reply Br.”

² Vaughn will be referred to in this brief as if the sole defendant/respondent, and the joint brief of defendants/respondents referred to as “Vaughn Br.”

1-16; Stewart-Graves Reply Br. at 1-8. WSTLA Foundation has also reviewed the superior court “Opinion” (CP 291-94), and the “Affidavit of Carl J. Bodenstein in Support of Plaintiffs’ Opposition to Defendant Vaughn and The Vancouver Clinic’s Motion for Summary Judgment or Alternatively Partial Summary Judgment” (CP 192-210) (Bodenstein Affidavit). The following facts are relevant:

Liam was born without a heartbeat or spontaneous respiration, subsequent to a placental abruption occurring shortly before birth.³ He was delivered by cesarean section and immediately subjected to resuscitation efforts. Vaughn presided over these resuscitation efforts, arriving shortly after the birth. The parties agree that Liam’s “Apgar score” in each of the five categories rated for newborns was zero at the one, five and ten minute benchmarks after delivery. Apgar evaluates five characteristics: color, heart rate, response to stimulation of the sole of the foot, muscle tone, and respiration, with ten being a perfect score. A score below three requires resuscitation. See Stewart-Graves Br. at 1, 5-6 & n.4.

Vaughn continued resuscitation for a total of twenty-four minutes after birth, at which point Liam’s heart began beating. During this interval Nichole was unconscious, and Todd was waiting in the birthing center

³ It is undisputed that Liam was a viable fetus prior to birth, based on gestational age. Liam’s exact status at birth is unclear in the briefing. See Stewart-Graves Br. at 1 (describing Liam at birth as having “no heartbeat and no respiratory function”); Vaughn Br. at 4 (describing Liam at birth as “without a heart rate or spontaneous respiration”), at 7 (indicating Vaughn did not consider Liam dead or a stillbirth), at 34 (describing Liam as a “viable, newly born infant”). Neither party refers to statutory definitions that may bear on Liam’s status at birth. See generally RCW 70.58.150 (defining “fetal death,” and “evidence of death”); cf. 1 U.S.C. §8 (defining “born alive” infant solely for purposes of federal law). WSTLA Foundation will simply refer to Liam by name.

room, and was provided periodic updates by a nurse. He was not consulted by Vaughn during the resuscitation, nor did he participate in any decision-making regarding Liam, although at one point Todd did ask to speak with someone who could give him more information. Though Liam survived, he suffers from permanent and severe disabilities.

Liam and Parents seek damages against Vaughn for negligence in extending resuscitation efforts beyond the time at which the standard of care required them to cease. Liam also seeks damages against Vaughn for lack of informed consent regarding the duration of resuscitation efforts.⁴ Vaughn moved for summary judgment on these claims, arguing that expert testimony is lacking, recovery is not allowed for what is described as “wrongful prolongation of life,” and consent to the treatment here is implied as a matter of law. See Vaughn Br. at 10.

In opposition to summary judgment, Liam and Parents submitted the Bodenstein Affidavit. Bodenstein, a neonatologist, testified that Vaughn was negligent and violated the standard of care by failing to discontinue Liam’s resuscitation when no heart rate was obtained after fifteen minutes. See CP 194-95. He also testified that Vaughn breached her obligation to obtain informed consent by failing after ten minutes of resuscitation to obtain Todd’s consent to continue resuscitation after the time when a reasonably prudent physician would have stopped. Id.

⁴ Liam and Parents separately asserted negligence claims based on Vaughn’s resuscitation methods, which are not involved in this appeal. See Stewart-Graves Br. at 9; Vaughn Br. at 2.

Bodenstein testified that after ten minutes of resuscitation efforts with no heart rate, it was highly unlikely Liam would survive, or survive without severe physical and mental disability. See CP 201. Liam's father Todd also testified by declaration that had he been told that without a heartbeat at the ten-minute benchmark it was not likely Liam would survive or, if he did survive, it would be with severe disabilities, he would have directed resuscitation efforts cease. See Stewart-Graves Br. at 16; Vaughn Br. at 13.⁵ Bodenstein testified that in his opinion, Todd's testimony is consistent with what other reasonable persons would do in such circumstances. See CP 205.

Regarding the consequences of the violation of the standard of care and failure to obtain informed consent, Bodenstein testified:

9. (...) [T]he failure to stop the resuscitation after 15 minutes of no heart rate and failure to obtain Mr. Graves' consent to continue the resuscitation, doomed Liam and his parents to a lifetime of severe disability requiring extensive medical, nursing and rehabilitative care over the course of Liam's lifetime projected to cost millions of dollars.

10. It is my opinion to a reasonable degree of medical probability, that had the Defendants adhered to the standard of care and discontinued resuscitative efforts, more likely than not, Liam would not have survived and his catastrophic injuries and extraordinary medical expenses would have been avoided.

CP 195.

On the other hand, Vaughn testified that there is no absolute time to cease resuscitation efforts, and the determination is based upon the unique circumstances of each case and the exercise of the physician's

⁵ Nichole testified by declaration that she would have wanted her husband to make such a decision under the circumstances. Vaughn Br. at 13.

judgment according to recognized protocols. See Vaughn Br. at 4 & n.2, 8, 11-12 & n.11, 13 & n.13. Vaughn further testified that under the circumstances there was no time to consult with Todd during the course of the resuscitation efforts, see id. at 6-7, disagreeing with Bodenstein that, if handled correctly, Todd's informed consent could have been obtained, see CP 203-05. Vaughn did acknowledge that had Liam's father known of the risks after ten minutes without a heartbeat and asked Vaughn to cease resuscitation at the fifteen-minute benchmark, she would probably have done so. See Vaughn Br. at 9, n.7.

The superior court dismissed Liam and Parents' negligence claims, and also dismissed Liam's informed consent claim. The court found these claims to be "intertwined." See CP 291, 294. It concluded the claims essentially were for "wrongful prolongation of life," a cause of action not recognized in Washington, and refused to recognize claims for relief based upon Liam's non-survival where he was not suffering from an incurable condition such as is contemplated in the Natural Death Act (NDA), Ch. 70.122 RCW. See CP 293-94. Both Liam and Parents appealed, and this Court granted direct review.

III. ISSUES PRESENTED

The particular legal issues before the Court are:

- 1.) Under RCW 7.70.030-.040, did Liam and Parents demonstrate a genuine issue of material fact on whether Vaughn violated the applicable standard of care in continuing resuscitation of Liam when he showed no response fifteen minutes after birth?

- 2.) Under RCW 7.70.050, did Liam demonstrate a genuine issue of material fact on whether, if properly consulted, a reasonably prudent surrogate decision-maker in the father's position would not have consented to continued resuscitation of Liam due to the likelihood of severe physical and mental disability?
- 3.) Under RCW 7.70.050(4), did Vaughn demonstrate as a matter of law that a "health care emergency" existed at all times relevant to the attempted resuscitation of Liam, thereby establishing Liam's implied consent to such resuscitation efforts?

IV. SUMMARY OF ARGUMENT

This Court should be wary of being drawn into providing general answers to broad medical and ethical questions when the statutes governing medical negligence and informed consent tort claims provide the framework for resolving Liam and Parents' claims. If genuine issues of material fact exist, a jury should resolve these claims.

Re: Medical Negligence Claims

Liam and Parents' negligence claims, based upon resuscitation conducted in violation of the standard of care, are free-standing claims under RCW 7.70.030-.040. Because the medical experts propose different standards of care, resolution of these claims is a matter for the jury, particularly where Vaughn merely disputes the validity of the opposing expert's opinions. Under this Court's unanimous opinion in Harbeson v. Parke-Davis, Inc., 98 Wn.2d 460, 656 P.2d 483 (1983), recognizing tort claims for wrongful life and wrongful birth, it is not fatal to Liam and Parents' negligence claims that they presuppose that, had the standard of care been met, Liam would not have survived. Harbeson rejected the policy-based argument that no recovery should be allowed because it is

not possible to measure an impaired life as compared to non-existence, choosing instead to fulfill the compensatory function of tort law and provide a comprehensive and consistent deterrent to malpractice. While this case involves sophisticated medical and ethical questions, it nonetheless fits comfortably within the statutory framework of Ch. 7.70 RCW for resolving medical negligence claims.

Re: Informed Consent Claim

Liam’s informed consent claim, for extending resuscitation beyond certain limits without consent of his father as surrogate decision-maker, is fully capable of being resolved under the informed consent statutes, RCW 7.70.050 & .065, aided by this Court’s analysis in Harbeson. This issue is not about any “unfettered discretion” on the part of Liam’s father to end Liam’s life. Under this statutory claim, Liam must prove that *a reasonably prudent surrogate decision-maker*, acting on behalf of Liam, would not have consented to the treatment. This standard is an objective one. There is no question here that Liam’s father was a proper surrogate decision-maker, and that Liam presented evidence that a reasonably prudent surrogate decision-maker would not have consented to continuation of resuscitation efforts after a certain point in time, even if it meant Liam would not have survived. The issue is for the jury.

Vaughn’s invocation of the “health care emergency” exception under RCW 7.70.050(4), as grounds for resolving the informed consent claim as a matter of law, should be rejected. There appear to be material

questions of fact on Liam's father's availability, and whether the necessary information could have been imparted in a timely manner while Liam's resuscitation was ongoing.

V. ARGUMENT

A.) **Overview Of Washington Law Regarding Tort Claims Against Health Care Providers For Negligence And Breach Of Duty To Obtain Informed Consent.**

Since 1975 tort claims against health care providers for negligence and failure to obtain informed consent have been governed by statute in Washington. See RCW 7.70.010-.065 & RCW 4.24.290 (reproduced in Appendix); see also Berger v. Sonneland, 144 Wn.2d 91, 109, 26 P.3d 257 (2001).⁶ Negligence and informed consent claims are distinct grounds for imposing liability on a health care provider. Thus, a provider may act in a non-negligent manner as to the standard of care, yet be liable for failure to obtain informed consent. See generally Backlund v. University of Wash., 137 Wn.2d 651, 659, 975 P.2d 950 (1999). Each of these theories is discussed briefly below.⁷

Negligence claims against health care providers are principally governed by RCW 7.70.030-.040. A plaintiff establishes negligence by proving a violation of the standard of care. See RCW 7.70.030(1).

⁶ For a useful history of the common law regarding negligence and informed consent, see Harbeson, 98 Wn.2d at 467-70.

⁷ By all accounts, state law governs this case. While 1 U.S.C. §8 provides a definition of a "born alive" infant for purposes of any applicable act of Congress, neither party has referenced this definition or argued that federal acts affected by it, such as the Emergency Medical Treatment and Labor Act (EMTALA), 42 U.S.C. §1395dd, or the Child Abuse Protection and Treatment Act (CAPTA), 42 U.S.C. §5101, apply in this case. See Vaughn Br. at 37 n.23. WSTLA Foundation has not discovered any authority to the contrary.

Evidence must show that the health care provider failed to exercise that degree of skill, care and learning possessed at the time in the profession or class to which the provider belongs, in the state of Washington, acting in the same or similar circumstances. RCW 7.70.040; see also RCW 4.24.290 (imposing similar requirement). In most instances, expert testimony is required to support the claim. See Harbeson, 98 Wn.2d at 468-69. Notably, Ch. 7.70 RCW does not specify the types of negligence claims that may be asserted against health care providers.

Claims for breach of the duty of informed consent are governed by RCW 7.70.050. This statute essentially codifies preexisting common law. See generally ZeBarth v. Swedish Hosp. Med. Center, 81 Wn.2d 12, 499 P.2d 1 (1972); Miller v. Kennedy, 11 Wn.App. 272, 522 P.2d 852 (1974), *aff'd per curiam*, 85 Wn.2d 151 (1975). RCW 7.70.050 sets forth in detail the elements of proof necessary for establishing an informed consent claim.⁸ Of particular interest here is RCW 7.70.050(1)(c), which requires a plaintiff to prove as part of the informed consent claim:

That *a reasonably prudent patient* under similar circumstances would not have consented to the treatment if informed of such material fact or facts.

(Emphasis added). Recently, this Court confirmed that this is an objective standard, not a subjective one. Backlund, 137 Wn.2d at 665-69. It has its

⁸ RCW 7.70.050(1)(a) requires that a patient prove he was not provided all “material” facts. Whether a particular fact is material must be demonstrated by expert testimony. However, expert testimony is not required to show that the failure to provide material facts was below any standard of care, or out of keeping with the practice of other health care providers. See Miller, 11 Wn.App. at 284-86.

origins in Washington common law. See Miller, 11 Wn.App. at 289; see also ZeBarth, 81 Wn.2d at 31-32. Thus, while the individual plaintiff's testimony as to what he or she might have done if properly informed of all material facts may be relevant and admissible, it is not determinative. See ZeBarth at 31; Backlund at 665 & n.4.⁹

RCW 7.70.065 addresses what persons may make decisions on behalf of an incapacitated person, for informed consent purposes. With respect to minors, parents of the minor patient make the decision in the absence of an appointed guardian or a legal custodian authorized pursuant to Title 26 RCW, or a court authorized surrogate for children subject to an out-of-home placement. See RCW 7.70.065(2)(a)(i)-(iii). Read together with RCW 7.70.050(1)(c), the surrogate decision-maker for the minor is subject to the "reasonably prudent patient" standard. See also RCW 7.70.030(2),(3) (referencing "patient or his representative"); RCW 7.70.050(2) (same).

In some instances RCW 7.70.065 sets forth the criteria to be used by the surrogate decision-maker in acting on behalf of an incapacitated person. See e.g. RCW 7.70.065(1)(b) (requiring, where incapacity not based on minority, preliminary good faith determination as to what the patient, if competent, would do and, if such determination cannot be made,

⁹ In Degel v. Buty, 108 Wn.App. 126, 29 P.3d 768 (2001), *review denied*, 145 Wn.2d 1031 (2002), the Court of Appeals upheld the reasonably prudent patient standard as constitutional, and not violative of the patient's right to determine his or her own treatment. In so doing, it concluded: "[i]ndeed, the standard for recovering damages in a lawsuit against a doctor has no bearing on the patient's freedom to choose medical procedures." 108 Wn.App. at 132.

a decision based upon the “patient’s best interests”). On the other hand, RCW 7.70.065(2)(a)(iii), designating parents as decision-makers for minor patients, does not specify the criteria to be employed in making such decisions.

B.) Background Regarding *Harbeson v. Parke-Davis, Inc.* Recognition Of Wrongful Birth/Wrongful Life Tort Claims, And The Rationale Supporting These Claims.

This Court’s landmark decision in Harbeson v. Parke-Davis, Inc. is referenced extensively by the parties in this case, and considered relevant to the disposition here. Consequently, it may be helpful to review the nature of the holdings in Harbeson, and the basis for them.

In Harbeson, a unanimous Court upheld tort claims based upon “wrongful birth” and “wrongful life.” The Court first upheld the parents’ claim for “wrongful birth,” under both negligence and informed consent theories of recovery. The parents contended two children were born with defects because of negligence and lack of informed consent in failing to advise the parents of this potentiality, at a time when they could have chosen not to have any more children. In recognizing the claim for wrongful birth, the Court applied a traditional tort analysis, and allowed pecuniary damages for extraordinary medical, educational and similar expenses attributable to the defects, along with any mental anguish and emotional distress suffered by the parents during each child’s life, offset by corresponding emotional benefits. Harbeson, 98 Wn.2d at 465-78. Wrongful birth was defined as:

[A]n action based on an alleged breach of the duty of a health care provider to impart information or perform medical procedures with due care, where the breach is a proximate cause of the birth of a defective child.

Id. at 467.

The Court also recognized a corresponding claim for the Harbeson children, under both negligence and informed consent, for “wrongful life.” See id. at 478-83. Under this theory, the child is allowed recovery for the enhanced costs of living with the particular impairment throughout his or her lifetime (with no double recovery for damages awarded the parents on this basis). Id. at 482. However, unlike these pecuniary damages which the Court found calculable, it denied recovery for general damages because of the impossibility of valuing an impaired life *viz a viz* non-existence. Id.

Significantly, notwithstanding the limitation on general damages for wrongful life, this Court otherwise upheld the claims for wrongful birth and wrongful life even though each presupposed that, in the absence of negligence or breach of the duty of informed consent, the children would not have been born. Id. at 476-77 & 480-83. In rejecting policy arguments to the contrary, the Court found the compensatory and deterrent functions of tort law prevailed. Id. at 473-75, 479-81.¹⁰

¹⁰ Subsequently, in McKernan v. Aasheim, 102 Wn.2d 411, 687 P.2d 850 (1984), a case arising after enactment of Ch. 7.70 RCW and RCW 4.24.290, this Court recognized that a claim for wrongful conception of a healthy child was cognizable in Washington, but declined to permit recovery by the parents for the costs of rearing a healthy child. The Court found that allowing such a recovery would violate public policy, because portraying the birth of a healthy child as a “damage” would carry with it the possibility of emotional harm to the child. Id., 102 Wn.2d at 421. However, in so holding the Court

C.) Liam And Parents Have Demonstrated A Genuine Issue Of Material Fact Regarding Their Free-Standing Negligence Claims, Based Upon Vaughn's Continued Resuscitation Beyond The Fifteen-Minute Benchmark.

Liam and Parents offered evidence on summary judgment that Vaughn was negligent and violated the applicable standard of care in continuing resuscitation after the fifteen-minute benchmark. Based on this evidence they seek recovery for the expenses associated with Liam's severe disabilities throughout his lifetime. Their claims are supported by the expert testimony of Bodenstein, which, although disputed by Vaughn, is not challenged as inadmissible for any reason. These are straightforward negligence claims that meet the requirements of proof under RCW 7.70.030-.040 and RCW 4.24.290. They are free-standing and not inextricably tied to Liam's informed consent claim, addressed in §D.

Moreover, Liam and Parents' negligence claims are consistent with this Court's analysis in Harbeson. It is true that these negligence claims do not fall within the definitions of "wrongful birth" or "wrongful life" set out in Harbeson. See 98 Wn.2d at 466-67, 478. Nonetheless, Harbeson is relevant because it permits recovery under traditional tort analysis and Washington public policy for damages for the extraordinary expenses associated with a child's lifelong impairment, notwithstanding that the alternative is the nonexistence of the child. See id. at 480-83. The sensibilities and policy analysis at the heart of Harbeson apply equally

rejected policy arguments based upon avoiding placing an unreasonable burden on health

here. Thus, as in Harbeson, Liam and Parents may recover damages for negligence regardless of the fact that their claim is not predicated directly on injury to the child. See id. at 474-75; cf. RCW 4.24.010. Similarly, they may recover for negligence, although recovery presupposes that, had Vaughn acted properly, Liam would not have survived.¹¹

Liam and Parents are entitled to trial on their negligence claims. These claims are cognizable under Washington law, and fully capable of resolution within the framework of Ch. 7.70 RCW. Vaughn’s characterization of the claims as for “wrongful prolongation of life” merely introduces a new phrase that sheds more heat than light. See Vaughn Br. at 21-23, 48-49.

The policy-based arguments advanced by Vaughn for not imposing tort liability on health care providers appear to relate primarily to Liam’s claim based upon lack of informed consent. Vaughn contends that recognition of such a claim impermissibly undermines the value of life in a less than perfect state. See e.g. Vaughn Br. at 38. These and related policy arguments do not provide a basis for rejecting a negligence claim, and are answered in §D., infra, regarding Liam’s informed consent claim.

care providers or subjecting them to tort judgments. Id. at 418.

¹¹ The trial court relied upon Benoy v. Simons, 66 Wn.App. 56, 831 P.2d 167, *review denied*, 120 Wn.2d 1014 (1992), in concluding Harbeson does not apply here. See CP 292; see also Vaughn Br. at 25 (relying upon Benoy and stating that children’s wrongful life claims recognized in Harbeson arose “out of breaches of duty owed to the parents as patients”). The cursory analysis of the Court of Appeals in Benoy misreads Harbeson as only recognizing a cause of action when the parent, not the child, is the patient. In fact, Harbeson recognized that a child, independent of the parents, has a claim for wrongful life based on a duty running to the child. See 98 Wn.2d at 480-83. This duty appears even stronger when, as here, the child is also the patient. Benoy should be disapproved to the extent it misapprehends application of Harbeson in this context.

As to the negligence claim, Vaughn’s argument appears to be that Bodenstein’s characterization of the applicable standard of care is wrong, while Vaughn’s is correct. See Vaughn Br. at 34-35, 41. Vaughn contends in her testimony that resuscitation may continue beyond the fifteen-minute benchmark, until all reasonable methods have been exhausted, apparently up to the point of medical futility. See Vaughn Br. at 8, 9, 35, 48. This reflects a mere disagreement between medical experts, a question typically resolved by a jury. Vaughn has not argued that Bodenstein’s opinion is inadmissible for any reason. Instead, Vaughn has sought to discredit Liam and Parents’ negligence claims by casting them as “intertwined” with Liam’s informed consent claim, and thus subject to the “unfettered parental discretion” / “sanctity of life” policy arguments primarily aimed at the informed consent claim. See e.g. Vaughn Br. at 17, 41.

The negligence claims are free-standing, and involve a familiar battle of experts over the governing standard of care. The Court should reject consideration of Vaughn’s policy-based arguments with respect to the negligence claims¹²

¹² To the extent Vaughn contends that as a matter of policy a physician in these circumstances should be relieved from having to endure a challenge to his or her decision-making, where the expert testimony as to the underlying standard of care is sharply divided, this argument should be rejected. See Vaughn Br. at 41-42. Both Ch. 7.70 RCW and RCW 4.24.290 contemplate such challenges in a broad spectrum of contexts, including troubling, emotionally-charged situations such as this one. The fact that expert opinion is divided presents a case for trial, not grounds for insulating health care providers from liability.

D.) Liam Has Demonstrated A Genuine Issue Of Material Fact Under The “Reasonably Prudent Patient” Standard, Regarding Failure To Obtain Informed Consent Under The Circumstances From Liam’s Father As Surrogate Decision-Maker.

RCW 7.70.050 provides a framework for resolving all informed consent claims arising out of treatment by health care providers. The statute sets forth elaborate proof requirements that must be met and supported by expert testimony in some respects. The standard by which the consent issue is evaluated is objective: whether the *reasonably prudent patient* would have consented to the treatment if informed of all material facts. RCW 7.70.065(2)(a) designates parents as surrogate decision-makers for a minor child, in the absence of an appointed representative. In reading the two statutes together, the question is whether a reasonably prudent surrogate decision-maker in Liam’s father’s position would have consented to continuing resuscitation if informed of all material facts. Liam presented lay and expert testimony creating a genuine issue of fact on this question. See supra at 3-5. It should have been submitted to the jury.

As in the case of Liam and Parents’ negligence claims, the principles established in Harbeson support Liam’s informed consent claim, notwithstanding that it presupposes he would not have survived if consent had been withheld regarding continued resuscitation. See 98 Wn.2d at 481-82 (rejecting notion that all recovery for wrongful life should be disallowed because it is not possible to measure an impaired life

as compared to non-existence, instead choosing to provide “a comprehensive and consistent deterrent to malpractice”).

Vaughn ignores the statutory scheme for resolving informed consent claims in Washington, and also fails to appreciate the teachings of Harbeson. Vaughn seeks to draw this Court into resolving broad medical and ethical issues more appropriately addressed by the Legislature, and which, at the very least, need not be decided by the Court at this time. The case and controversy at hand is further blurred by emotionally-charged rhetoric that poses the alternatives before the Court as either upholding the “sanctity of life” or delivering a “death sentence.” See Vaughn Br. at 49.

A major thrust of Vaughn’s argument is that allowing an informed consent claim here would vest parents generally with an “unfettered right” to dictate withholding or withdrawal of life-sustaining treatment. See e.g. Vaughn Br. at 21-22, 48. This is not so. The Legislature has ordained that patients seeking recovery for lack of informed consent must show that the “reasonably prudent patient” would not have consented to the particular treatment, and allows surrogate decision-making by parents on their minor child’s behalf. See RCW 7.70.050 & .065.¹³ The trier of fact in an informed consent case asks, *post hoc*, what would the reasonably prudent decision-maker have decided for the minor under the circumstances. There is no evaluation based upon the unfettered, subjective decision of a particular parent. In this case, the jury must decide whether, if presented

¹³ Vaughn does not cite the statute on surrogate decision-making, RCW 7.70.065. Liam references it once. See Stewart-Graves Reply Br. at 22.

with the opportunity, a reasonably prudent decision-maker would have directed resuscitative efforts to cease, on Liam's behalf.¹⁴

Vaughn also argues that under the NDA and related case law such as In re Hamlin, supra, there is no basis for allowing a parent, without court intervention or procedural safeguards, to provide the informed consent contemplated in this case. By its terms, the NDA does not apply, as it is confined to adult persons and those facing a terminal illness or permanent unconscious condition. See generally RCW 70.122.010. Moreover, the Legislature has made clear the act is not exclusive as to decision-making regarding health care treatment. See RCW 70.122.910 (reproduced in Appendix). In this case, Ch. 7.70 RCW, not the NDA, guides the Court's decision. The Legislature has devised a means for resolving informed consent tort cases, which includes an objective standard against which to evaluate liability.

¹⁴ RCW 7.70.065(2) does not purport to establish the factors or criteria to be used by the parent as surrogate decision-maker. Compare RCW 7.70.065(1)(c) (providing criteria for decision-making when incapacity is due to reasons other than minority). Consequently, at trial the parties may present expert testimony, or perhaps propose jury instructions, on what factors should be considered by the reasonably prudent decision-maker.

The parties have not addressed this issue, though the literature in this area is extensive. See e.g. Norman L. Cantor, The Bane of Surrogate Decision-Making: Defining the Best Interests of Never-Competent Persons, 26 J. of Legal Medicine 155 (2005); Sadath A. Sayeed, The Marginally Viable Newborn: Legal Challenges, Conceptual Inadequacies, and Reasonableness, 34 J. L. Med. & Ethics 600 (2006). The Court should allow this question to be fully vetted at trial, and not attempt to resolve it now. However, if the Court is inclined to provide guidance to the litigants and others, it should at least call for supplemental briefing under RAP 12.1(b). This approach is not without difficulty, as it may draw the Court into offering an advisory opinion. Cf. In re Hamlin, 102 Wn.2d 810, 818-21, 689 P.2d 1372 (1984) (replacing dicta in prior decision regarding aspects of the NDA with new dicta); In re Rosebush, 491 N.W.2d 633, 641-42 (Mich.App. 1992) (Sawyer J., concurring in part, dissenting in part; criticizing majority for suggesting criteria for guiding parental decision-making in "best interests" of the child, as not necessary to resolution of the case before the court).

Lastly, relying on cases from other jurisdictions, Vaughn contends that upholding the informed consent claim here is a disavowal of the “sanctity of life” and amounts to imposing a “death sentence.” See Vaughn Br. at 49. A similar argument was expressly rejected in Harbeson, and its teachings should control here. See 98 Wn.2d at 472, 482. Undoubtedly, this is a difficult case, with complex and layered medical and ethical issues, but this does not mean the plaintiffs’ tort claims cannot be resolved by a jury that carefully considers lay testimony and expert opinion, and is properly instructed on the law.¹⁵

E.) Vaughn Has Not Demonstrated A “Health Care Emergency” Under RCW 7.70.050(4) As A Matter Of Law, As A Basis For Finding Liam’s Implied Consent To Such Treatment.

RCW 7.70.050(4) sets forth an exception under which consent is “implied” when a patient is not competent to give informed consent and an authorized surrogate is “not readily available.” Vaughn argues that this exception applies as a matter of law as a basis for dismissing Liam’s informed consent claim. See Vaughn Br. at 44-47. Because the emergency exception is in the nature of a defense, the burden should be on Vaughn to prove it applies as a matter of law. Cf. Miller, 11 Wn.App. at 283-84, 288 (noting in common law informed consent case that when failure to inform is established the health care provider has the burden of

¹⁵ Vaughn contends that Liam’s informed consent claim fails for the additional reason that he has not demonstrated injury to the patient, as required by RCW 7.70.050(1)(d). See Vaughn Br. at 43-44. This is yet another variation on Vaughn’s argument that there can be no action sounding in tort for saving Liam’s life. The policy reasons forwarded in Harbeson for allowing a similar recovery answer this argument. Cf. 98 Wn.2d at 483 (recognizing ordinary expenses for medical care and special training are calculable, and qualify as injuries).

proving a defense or excuse, including an emergency). However, the briefing reflects Liam presented evidence that his father was nearby at times pertinent to the resuscitation, as well as expert testimony suggesting informed consent could have been obtained under the circumstances involved. See CP 203-05; see also Vaughn Br. at 6-7, 9 & n.7. Accordingly, application of the emergency exception should not be determined as a matter of law.

VI. CONCLUSION

This Court should adopt the arguments advanced in this brief with respect to the negligence and informed consent claims, and resolve each claim accordingly.

DATED this 22nd day of December, 2006.
FILED AS ATTACHMENT
TO E-MAIL

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BRYAN P. HARNETIAUX

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DEBRA L. STEPHENS

On Behalf of WSTLA Foundation

*Brief transmitted for filing by e-mail; signed original retained by counsel.

APPENDIX

RCW 4.24.290 Action for damages based on professional negligence of hospitals or members of healing arts—Standard of proof—Evidence—Exception

In any civil action for damages based on professional negligence against a hospital which is licensed by the state of Washington or against the personnel of any such hospital, or against a member of the healing arts including, but not limited to, an acupuncturist licensed under chapter 18.06 RCW, a physician licensed under chapter 18.71 RCW, an osteopathic physician licensed under chapter 18.57 RCW, a chiropractor licensed under chapter 18.25 RCW, a dentist licensed under chapter 18.32 RCW, a podiatric physician and surgeon licensed under chapter 18.22 RCW, or a nurse licensed under chapter 18.79 RCW, the plaintiff in order to prevail shall be required to prove by a preponderance of the evidence that the defendant or defendants failed to exercise that degree of skill, care, and learning possessed at that time by other persons in the same profession, and that as a proximate result of such failure the plaintiff suffered damages, but in no event shall the provisions of this section apply to an action based on the failure to obtain the informed consent of a patient.

CREDIT(S)

[1995 c 323 § 2; 1994 sp.s. c 9 § 702; 1985 c 326 § 26; 1983 c 149 § 1; 1975 1st ex.s. c 35 § 1.]

RCW 7.70.010 Declaration of modification of actions for damages based upon injuries resulting from health care

The state of Washington, exercising its police and sovereign power, hereby modifies as set forth in this chapter and in RCW 4.16.350, as now or hereafter amended, certain substantive and procedural aspects of all civil actions and causes of action, whether based on tort, contract, or otherwise, for damages for injury occurring as a result of health care which is provided after June 25, 1976.

CREDIT(S)

[1975-'76 2nd ex.s. c 56 § 6.]

RCW 7.70.020 Definitions

As used in this chapter "health care provider" means either:

(1) A person licensed by this state to provide health care or related services, including, but not limited to, a licensed acupuncturist, a

physician, osteopathic physician, dentist, nurse, optometrist, podiatric physician and surgeon, chiropractor, physical therapist, psychologist, pharmacist, optician, physician's assistant, midwife, osteopathic physician's assistant, nurse practitioner, or physician's trained mobile intensive care paramedic, including, in the event such person is deceased, his or her estate or personal representative;

(2) An employee or agent of a person described in part (1) above, acting in the course and scope of his employment, including, in the event such employee or agent is deceased, his or her estate or personal representative; or

(3) An entity, whether or not incorporated, facility, or institution employing one or more persons described in part (1) above, including, but not limited to, a hospital, clinic, health maintenance organization, or nursing home; or an officer, director, employee, or agent thereof acting in the course and scope of his or her employment, including in the event such officer, director, employee, or agent is deceased, his or her estate or personal representative.

CREDIT(S)

[1995 c 323 § 3; 1985 c 326 § 27; 1981 c 53 § 1; 1975-'76 2nd ex.s. c 56 § 7.]

RCW 7.70.030 Propositions required to be established—Burden of proof

No award shall be made in any action or arbitration for damages for injury occurring as the result of health care which is provided after June 25, 1976, unless the plaintiff establishes one or more of the following propositions:

(1) That injury resulted from the failure of a health care provider to follow the accepted standard of care;

(2) That a health care provider promised the patient or his representative that the injury suffered would not occur;

(3) That injury resulted from health care to which the patient or his representative did not consent.

Unless otherwise provided in this chapter, the plaintiff shall have the burden of proving each fact essential to an award by a preponderance of the evidence.

CREDIT(S)

[1975-'76 2nd ex.s. c 56 § 8.]

RCW 7.70.040 Necessary elements of proof that injury resulted from failure to follow accepted standard of care

The following shall be necessary elements of proof that injury resulted from the failure of the health care provider to follow the accepted standard of care:

- (1) The health care provider failed to exercise that degree of care, skill, and learning expected of a reasonably prudent health care provider at that time in the profession or class to which he belongs, in the state of Washington, acting in the same or similar circumstances;
- (2) Such failure was a proximate cause of the injury complained of.

CREDIT(S)

[1983 c 149 § 2; 1975-'76 2nd ex.s. c 56 § 9.]

RCW 7.70.050 Failure to secure informed consent—Necessary elements of proof—Emergency situations

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

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

(d) That the treatment in question proximately caused injury to the patient.

(2) Under the provisions of this section a fact is defined as or considered to be a material fact, if a reasonably prudent person in the position of the patient or his representative would attach significance to it deciding whether or not to submit to the proposed treatment.

(3) Material facts under the provisions of this section which must be established by expert testimony shall be either:

(a) The nature and character of the treatment proposed and administered;

(b) The anticipated results of the treatment proposed and administered;

(c) The recognized possible alternative forms of treatment; or

(d) The recognized serious possible risks, complications, and anticipated benefits involved in the treatment administered and in the recognized possible alternative forms of treatment, including nontreatment.

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

CREDIT(S)

[1975-'76 2nd ex.s. c 56 § 10.]

**RCW 7.70.060 Consent form—Contents—Prima facie evidence—
Failure to use**

If a patient while legally competent, or his representative if he is not competent, signs a consent form which sets forth the following, the signed consent form shall constitute prima facie evidence that the patient gave his informed consent to the treatment administered and the patient has the burden of rebutting this by a preponderance of the evidence:

(1) A description, in language the patient could reasonably be expected to understand, of:

- (a) The nature and character of the proposed treatment;
 - (b) The anticipated results of the proposed treatment;
 - (c) The recognized possible alternative forms of treatment; and
 - (d) The recognized serious possible risks, complications, and anticipated benefits involved in the treatment and in the recognized possible alternative forms of treatment, including nontreatment;
- (2) Or as an alternative, a statement that the patient elects not to be informed of the elements set forth in subsection (1) of this section.

Failure to use a form shall not be admissible as evidence of failure to obtain informed consent.

CREDIT(S)

[1975-'76 2nd ex.s. c 56 § 11.]

RCW 7.70.065 Informed consent—Persons authorized to provide for patients who are not competent—Priority

(1) Informed consent for health care for a patient who is not competent, as defined in RCW 11.88.010(1)(e), to consent may be obtained from a person authorized to consent on behalf of such patient.

(a) Persons authorized to provide informed consent to health care on behalf of a patient who is not competent to consent, based upon a reason other than incapacity as defined in RCW 11.88.010(1)(d), shall be a member of one of the following classes of persons in the following order of priority:

- (i) The appointed guardian of the patient, if any;
- (ii) The individual, if any, to whom the patient has given a durable power of attorney that encompasses the authority to make health care decisions;
- (iii) The patient's spouse;

(iv) Children of the patient who are at least eighteen years of age;

(v) Parents of the patient; and

(vi) Adult brothers and sisters of the patient.

(b) If the health care provider seeking informed consent for proposed health care of the patient who is not competent to consent under RCW 11.88.010(1)(e), other than a person determined to be incapacitated because he or she is under the age of majority and who is not otherwise authorized to provide informed consent, makes reasonable efforts to locate and secure authorization from a competent person in the first or succeeding class and finds no such person available, authorization may be given by any person in the next class in the order of descending priority. However, no person under this section may provide informed consent to health care:

(i) If a person of higher priority under this section has refused to give such authorization; or

(ii) If there are two or more individuals in the same class and the decision is not unanimous among all available members of that class.

(c) Before any person authorized to provide informed consent on behalf of a patient not competent to consent under RCW 11.88.010(1)(e), other than a person determined to be incapacitated because he or she is under the age of majority and who is not otherwise authorized to provide informed consent, exercises that authority, the person must first determine in good faith that that patient, if competent, would consent to the proposed health care. If such a determination cannot be made, the decision to consent to the proposed health care may be made only after determining that the proposed health care is in the patient's best interests.

(2) Informed consent for health care, including mental health care, for a patient who is not competent, as defined in RCW 11.88.010(1)(e), because he or she is under the age of majority and who is not otherwise authorized to provide informed consent, may be obtained from a person authorized to consent on behalf of such a patient.

(a) Persons authorized to provide informed consent to health care, including mental health care, on behalf of a patient who is incapacitated, as defined in RCW 11.88.010(1)(e), because he or she is under the age of majority and who is not otherwise authorized to provide informed consent, shall be a member of one of the following classes of persons in the following order of priority:

(i) The appointed guardian, or legal custodian authorized pursuant to Title 26 RCW, of the minor patient, if any;

(ii) A person authorized by the court to consent to medical care for a child in out-of-home placement pursuant to chapter 13.32A or 13.34 RCW, if any;

(iii) Parents of the minor patient;

(iv) The individual, if any, to whom the minor's parent has given a signed authorization to make health care decisions for the minor patient; and

(v) A competent adult representing himself or herself to be a relative responsible for the health care of such minor patient or a competent adult who has signed and dated a declaration under penalty of perjury pursuant to RCW 9A.72.085 stating that the adult person is a relative responsible for the health care of the minor patient. Such declaration shall be effective for up to six months from the date of the declaration.

(b) A health care provider may, but is not required to, rely on the representations or declaration of a person claiming to be a relative responsible for the care of the minor patient, under (a)(v) of this subsection, if the health care provider does not have actual notice of the falsity of any of the statements made by the person claiming to be a relative responsible for the health care of the minor patient.

(c) A health care facility or a health care provider may, in its discretion, require documentation of a person's claimed status as being a relative responsible for the health care of the minor patient. However, there is no obligation to require such documentation.

(d) The health care provider or health care facility where services are rendered shall be immune from suit in any action, civil or criminal, or from professional or other disciplinary action when such reliance is based on a declaration signed under penalty of perjury pursuant to RCW 9A.72.085 stating that the adult person is a relative responsible for the health care of the minor patient under (a)(v) of this subsection.

(3) For the purposes of this section, "health care," "health care provider," and "health care facility" shall be defined as established in RCW 70.02.010.

CREDIT(S)

[2006 c 93 § 1, eff. June 7, 2006; 2005 c 440 § 2, eff. July 24, 2005; 2003 c 283 § 29, eff. July 27, 2003; 1987 c 162 § 1.]

RCW 70.122.910 Construction [Natural Death Act]

This chapter shall not be construed as providing the exclusive means by which individuals may make decisions regarding their health treatment, including but not limited to, the withholding or withdrawal of life-sustaining treatment, nor limiting the means provided by case law more expansive than chapter 98, Laws of 1992.

CREDIT(S)

[1992 c 98 § 11.]