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NO. 93312-0

SUPREME COURT
OF THE STATE OF WASHINGTON

RUDY FRAUSTO, Appellant,

v.

YAKIMA HMA, LLC, et al., Respondent.

BRIEF OF *AMICUS CURIAE*
WASHINGTON DEFENSE TRIAL LAWYERS

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I. IDENTITY AND INTRODUCTION OF *AMICUS CURIAE*

Washington Defense Trial Lawyers (“WDTL”) is a nonprofit organization of attorneys who devote a substantial portion of their practice to representing defendants, companies, or entities in civil litigation. WDTL appears *pro bono* in this and other courts as *amicus curiae* to pursue its mission of fostering justice and balance in the civil courts.

As *amicus curiae* in this case, WDTL will assist the Court by critically analyzing the statutory and policy interests at issue, and providing information regarding the implications of allowing individuals without medical degrees to provide testimony as to medical causation issues.

II. STATEMENT OF THE CASE

WDTL adopts Defendant-Respondent’s (“YRMC”)’s Statement of the Case.

III. ARGUMENT

A. **The scope of practice of nurses does not qualify them to provide medical causation testimony.**

A nurse’s scope of practice is different from that of a physician in respects significant to the issue currently before the Court. While a physician is empowered by his or her education, training and licensure to make medical diagnoses, a registered nurse is empowered by his or her education, training, and licensure to make only nursing diagnoses.

A medical diagnosis is a medical finding made by a physician based on the patient's physiologic **state** or medical condition. The focus is on the patient's illness and the reasons therefore. A nursing diagnosis, on the other hand, is a diagnosis that is based on the **response** of the patient to that illness. A medical diagnosis assists the physician in treating the medical problem, while a nursing diagnosis assists the nurse in caring for the patient. Simply put, a medical diagnosis is **cause**-focused, while a nursing diagnosis is **care**-focused.

For example, a physician may diagnose a particular medical condition, such as myocardial infarction (heart attack). A registered nurse may diagnose only the patient's physiologic or psychologic reaction to that condition, such as acute chest pain or anxiety. While a physician may diagnose pressure ulcers (bed sores), a nurse may diagnose only the patient's physiologic or psychologic reaction to that condition, such as impaired skin integrity or diminished comfort.¹

¹ NANDA (North American Nursing Diagnosis Association) International, the professional organization that develops and disseminates the nomenclature, criteria, and taxonomy of nursing diagnoses, defines the term as follows:

A nursing diagnosis is a **clinical judgment concerning a human response to health conditions/life processes**, or a vulnerability for that response, by an individual, family, group or community. A nursing diagnosis provides the basis for selection of nursing interventions to achieve outcomes for which the nurse has accountability.

<http://www.nanda.org/nanda-international-glossary-of-terms.html>

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The distinction between physician and nursing diagnoses is reflected in those Washington statutes that govern the practice of the two professions.

Chapter 18.71 RCW, governing physicians, provides that a “person is practicing medicine” when he or she:

Offers or undertakes to **diagnose**, cure, advise, or prescribe **for any human disease**, ailment, injury, infirmity, deformity, pain or other condition, physical or mental, real or imaginary, by any means or instrumentality.

RCW 18.71.011 (emphases added). That chapter limits the practice of medicine to those having a valid license to do so. RCW 18.71.021.

Chapter 18.79 RCW, governing nurses, provides that a “registered nursing practice” is one involving, in relevant part:

The observation, assessment, **diagnosis**, care and counsel, and health teaching of individuals with illnesses, injuries, or disability, or in the maintenance of health or prevention of illness of others.

RCW 18.79.040(1)(a) (emphasis added).² Significantly, “diagnosis” within the meaning of the chapter is specifically defined to exclude medical diagnoses:

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(emphasis added).

² An “advanced registered nursing practice” is one involving:

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“Diagnosis,” in the context of nursing practice, means the **identification of**, and discrimination between, **the person’s physical and psychosocial signs and symptoms** that are essential to effective execution and management of the nursing care regimen.

RCW 18.79.020(4) (emphasis added).

A nurse’s statutory authority to make nursing diagnoses regarding a patient’s symptoms does not extend so far as to allow him or her to make a physician’s medical diagnosis as to the etiology of the patient’s medical condition.

In keeping with physicians’ distinct statutory qualifications, this Court has previously recognized the unique role of physicians as to their competence to provide expert testimony in a medical malpractice cases.

As the Court has held, expert medical testimony will “generally be necessary to establish the standard of care ... and most aspects of causation” in medical malpractice cases. *Harris v. Groth*, 99 Wn.2d 438, 450, 663 P.2d 113 (1983). *See also Berger v. Sonneland*, 144 Wn.2d 91, 110-11, 26 P.3d 257 (2001) (“medical testimony on proximate cause is

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Performance of **the acts of a registered nurse** and the performance of an expanded role in providing health care services as recognized by the medical and nursing professions, the scope of which his defined by rule by the commission. Upon approval by the commission, an advanced registered nurse practitioner may prescribe legend drugs and controlled substances...

RCW 18.79.050 (emphasis added)

required in medical malpractice cases.”); *Reese v. Stroh*, 128 Wn.2d 300, 308, 907 P.2d 282 (1995) (same).

In *Harris*, this Court declined to pronounce that nonphysicians are “per se” disqualified from testifying as medical experts in medical malpractice actions. *Harris*, 99 Wn.2d at 450-51. However, the Court cautioned as follows:

Our rejection of the rule that nonphysicians are per se disqualified from testimony as experts in medical malpractice actions **should not be read as requiring that they always or even usually be allowed to testify**. Trial courts retain broad discretion in determining whether an expert is qualified and will be reversed only for manifest abuse. . . **Moreover, whether or not the expert is licensed to practice medicine is certainly an important factor to be taken into account in making this determination.** . . . We hold simply that it may not be considered dispositive.

Id. (emphases added; internal citations omitted).

Despite the Court’s reluctance to place a “per se” limitation on nonphysician expert testimony in *Harris*, more recently this Court held that a pharmacist was not competent to testify as to whether physicians breached the standard of care. *Young v. Key Pharmaceuticals, Inc.*, 112 Wn.2d 216, 230-31, 770 P.2d 182 (1989). In so holding, the Court reasoned as follows:

It is true that this court has rejected the rule that nonphysicians are per se disqualified from testifying as experts in medical malpractice actions. *Harris v. Groth*, 99 Wn.2d 438, 450, 663 P.2d 113 (1983). This court has

never accepted however, a rule that would allow a nonphysician to testify as an expert regarding the proper standard of care for a physician practicing a medical specialty. Such a rule would severely degrade administration of justice in medical malpractice actions.

Id. at 227. As the Court further noted:

To allow a pharmacist's testimony on a physician's standard of care runs counter to public policy in the administration of justice in medical malpractice trials. With all due respect to the pharmaceutical profession, pharmacists are not doctors and are not licensed to prescribe medication because **they lack the physician's rigorous training in diagnosis and treatment.**

Id. at 230 (emphasis added).

In dictum, the Court noted that that a medical degree itself will not always qualify a witness to testify as an expert in a medical malpractice case, a statement that Division III subsequently interpreted as "suggesting a medical degree is a preliminary requirement." *Colwell v. Family Hosp.*, 105 Wn. App. 606, 612, 15 P.3d 210 (2001); *See also White v. Kent Med. Ctr. Inc.*, 61 Wn. App. 163, 173, 810 P.2d 4 (1991) ("[s]o long as a physician *with a medical degree* has sufficient expertise to demonstrate familiarity with the procedure or medical problem at issue, '[ordinarily [he or she] will be considered qualified to express an opinion on any sort of medical question.']) (quoting 5A Karl B. Tegland, Wash. Prac. Evidence §290[2], at 386 (3d ed. 1989).

In keeping with the reasoning set forth in *Young*, the Division III *Colwell* decision concluded that, though a nurse may be qualified to testify as to the standard of care of nurses, a nurse is nevertheless not qualified to provide causation testimony. *Colwell*, 105 Wn. App. at 611-13. This rule was re-affirmed in *Davies v. Holy Family Hospital*, 144 Wn. App. 483, 183 P.3d 283 (2008), which held that the declaration of a nursing expert was insufficient to defeat a summary judgment motion because the nurse was “not competent to testify as to the patient’s cause of death.” *Id.* at 500-01.

While the question of whether a nurse may provide causation testimony in a medical malpractice action has not yet been decided by this Court, the reasoning employed by the appellate court in *Colwell* and *Davies* is sound. With due respect to nurses and to the vital role they play in medical care, nurses lack the rigorous training of physicians in the etiology and diagnosis of disease. Their scope of practice is limited, in their education and training, in their practice, and by operation of statute, to the diagnosis and care of a patient’s symptoms. They are not similarly educated, trained or qualified to make medical diagnoses or attest to the cause of a medical condition.

The appellant here has suggested that a nurse is qualified to make the causative link between immobility and bed sores, asserting that the

latter is a commonly-observed result of the former. But, just as a poor result is not, in and of itself, evidence of negligence, *Watson v. Hocket*, 107 Wn.2d 158, 166-67, 727 P.2d 669 (1986), a causation opinion based on observations of that poor result is not sufficient to carry the plaintiff's burden to prove that the result was proximately caused by the negligence alleged.

Rather, an expert must be qualified to make a causal link between the alleged **negligence** itself, and the damages asserted. See RCW 7.70.040(a) (necessary elements of proof in medical malpractice action include that the failure to "exercise that degree of care, skill, and learning of a reasonably prudent health care provider...was a proximate cause of the injury complained of."). This requirement is in accord with the fact that in all personal injury actions, a plaintiff must prove the causal relationship between the acts of the defendant and the injuries for which relief is sought. *Moyer v. Clark*, 75 Wn.2d 800, 804, 454 P.2d 374 (1969).

Without a physician's training in the diagnosis and etiology of disease, a nurse is not qualified to differentiate the causative effect of negligence from that of the patient's other physiologic conditions with sufficient certainty to opine, on a more probable than not basis, that the illness was proximately caused by the negligence rather than any alternative cause or condition. In the present case, a nurse is not qualified

to opine that the development of pressure sores would not have occurred if the standard of care had been met, despite the patient's individual circumstances such as his pre-existing medical conditions (including paraplegia) and the illness that brought him to the hospital.

If the Court were to here hold that nurses were qualified to offer medical causation testimony in medical malpractice cases, that holding would inappropriately extend the legislatively-defined role of nurses, and would fail to give value to the more rigorous education, training and experience of physicians in the diagnosis and etiology of disease.

Based on the above, this *amicus* respectfully requests that the Court hold that nurses are not qualified to offer causation testimony in medical malpractice actions such as this one.

B. The trial court appropriately excluded the testimony of the nursing expert.

Even if the Court is not inclined to issue a "bright-line" rule that nurses are unqualified to opine as to medical causation in medical malpractice cases, neither should the Court pronounce that nurses are so qualified in every case. Any holding that might allow expert causation testimony from nonphysicians should be strictly limited.

The appellant has argued that, under WAC 246-840-300 (ARNP Scope of Practice), Advanced Registered Nurse Practitioners have additional qualifications, above and beyond those of Registered Nurses,

that render them competent to provide medical causation testimony.³ Even assuming, however, that ARNPs may be differently-positioned from RNs such that they may provide medical causation testimony under some circumstances, the ARNP must still be shown to have the requisite “knowledge, skill, experience, training, or education,” to testify as to causation in the particular case at bar. ER 702. At a minimum, such a showing should include evidence that the ARNP is educated, trained and experienced (akin to a physician) as to the diagnosis and etiology of the particular condition about which the ARNP purports to offer causation testimony. WAC 246-840-300 does not qualify an ARNP to offer such testimony as to particular conditions in every case.

Even assuming that ARNPs may be qualified to offer causation testimony in other cases, the trial court appropriately determined that plaintiff’s ARNP expert was not qualified to testify as to the medical causation issues in this case.

ER 702 requires that a witness must have the “knowledge, skill, experience, training, or education,” to testify as an expert and, as this

³ WAC 246-840-300 provides, in relevant part:

(5) Performing within the scope of the ARNP’s knowledge, experience, and practice, the licensed ARNP may perform the following:

(a) Examine patients and establish diagnoses by patient history, physical examination, and other methods of assessment.

Court has held, ordinarily “[t]he qualifications of an expert are to be judged by the trial court, and its determination will not be set aside in the absence of a showing of abuse of discretion.” *McKee v. American Home Products, Inc.* 113 Wn.2d 701, 706, 782 P.2d 1045 (1989), citing *Bernal v. American Honda Motor Co.*, 87 Wn.2d 406, 413, 553 P.2d 107 (1976), quoting *Nordstrom v. White Metal Rolling & Stamping Corp.*, 75 Wn.2d 629, 642, 453 P.2d 619 (1969).⁴

Of particular significance here, while plaintiff’s expert Ms. Wilkinson testified that her “**nursing experience** includes extensive experience **caring** for adult quadriplegic patients and the bedding, equipment, and skin assessment required for this patient population,” CP 127 (emphasis added), that experience appears to be that of a registered nurse: caring for a patient with a medical condition. In addition, the texts that Ms. Wilkinson has relied upon in forming the opinion that Mr. Frausto’s pressure ulcers were “caused by the failure to meet the standard of care,” CP 133, appear to be nursing texts related to care provided by registered nurses, rather than diagnoses made by physicians or duly-qualified ARNPs. CP 133-34.

⁴ A trial court’s evidentiary rulings made at the time of summary judgment are reviewed de novo. See *Seybold v. Neu*, 105 Wn. App. 666, 678, 19 P.3d 1068 (2001).

Ms. Wilkinson did not testify that she has education, training and experience regarding the physiologic cause and diagnosis of pressure ulcers. Without that testimony, there has been no showing that she is qualified to render an opinion that the ulcers here were more probably than not caused by the alleged negligence of the hospital staff, rather than simply the patient's underlying medical conditions.

It is also notable that Mr. Wilkinson's ARNP board certification, and the vast majority of her experience, is in pediatric nursing. CP 11-12. That certification and experience does not qualify her provide medical causation testimony with respect to pressure ulcers in adults. *See Miller v. Peterson*, 42 Wn. App. 822, 832, 71 P.2d 695 (1986) (the general rule "is that a practitioner of one school of medicine is not competent to testify as an expert in a malpractice action against a practitioner of another school of medicine.").

Under these circumstances, the trial court acted appropriately in determining that Ms. Wilkinson was not qualified to testify as to medical causation in this case.

Ms. Wilkinson's lack of qualification to provide causation testimony here also cautions against binding trial courts in their ability to appropriately exclude nonphysician experts in future medical malpractice cases. Should the Court hold that ARNPs are not "per se" disqualified

from offering causation testimony, the Court should nevertheless hold that the qualification to provide such testimony does not extend to individuals, such as registered nurses or other nonphysicians, who are not educated, trained, experienced, or licensed to make medical diagnoses or attest to the cause of a medical condition.

IV. CONCLUSION

For the policy, legal, and practical reasons discussed above, WDTL respectfully requests that this Court affirm the trial court's order granting summary judgment dismissal, and hold that nurses are not qualified to offer causation testimony in medical malpractice actions such as this one.

Respectfully submitted this 6th day of January, 2017.

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