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63973-1-I

Case No. 639731-I

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

JENNIFER ROSE ROSS,

Appellant,

v.

PEACEHEALTH d.b.a. ST. JOSEPH HOSPITAL, a Washington Public
Benefit Corporation; and ROBERT JOHNSON and JANE DOE
JOHNSON, husband and wife, and the marital community composed
thereof; JEFFREY RIES and JANE DOE RIES, husband and wife, and the
marital community composed thereof; JOHN DOE I-IV. and JANE DOE
I-IV,

Respondents.

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BRIEF OF RESPONDENTS
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A. INTRODUCTION

In September 2005, Plaintiff-Appellant Jennifer Ross's mother brought her to the emergency room at St. Joseph Hospital in Bellingham, Washington. In deposition, Ms. Ross's mother confirmed that one of the motivating factors for the emergency room visit was serious concern for Ms. Ross's mental health and the potential that Ms. Ross might harm herself. At the visit itself, Ms. Ross indicated that she may be suicidal.

Unfortunately, before she could be fully evaluated to determine the full nature of the threat she posed to her own safety, Ms. Ross attempted to flee the hospital. She was heading to the parking lot without her mother and her young son who were waiting for her in the waiting room when hospital staff prevented her from leaving. The undisputed facts are that this was done out of concern for Ms. Ross's well being, so that her suicide risk could be fully evaluated. It was a reasonable, appropriate, and statutorily authorized thing to do.

Two years later, Ms. Ross filed a lawsuit against the hospital, a nurse, and emergency room physician Jeffrey Ries, MD (and his marital community). The only claim she asserted against this defendant, Dr. Ries, was false imprisonment. Against the other defendants, Ms. Ross's claims included assault, battery, false imprisonment, and malicious prosecution. Plaintiffs' claims were dismissed on summary judgment.

Summary judgment serves an important purpose. It expeditiously and economically disposes of cases in which proof is lacking and trial is unnecessary. This was precisely such a case, and the trial court's ruling was correct for several reasons, each of which is independently sufficient to uphold the dismissal. These include:

- 1) RCW 71.05.120 provides Dr. Ries with immunity for his role in Ms. Ross's detention for mental health evaluation;
- 2) Plaintiff failed to provide the expert support that is mandatory in claims against health care providers; and
- 3) Plaintiff's failed to provide the 90 day notice of intent to commence a lawsuit required by RCW 7.70.100.

Accordingly, Dr. Ries respectfully requests that the Court of Appeals affirm the trial court's dismissal of Plaintiff's claims against Dr. Ries.

B. COUNTERSTATEMENT OF ISSUES

1. Does Dr. Ries have statutory immunity from liability under RCW 71.05.120?
2. Does RCW 7.70, which applies to all claims arising out of the provision of health care, apply to this case about the care provided in the emergency department of St. Joseph's Hospital?

3. Was summary judgment appropriate where Plaintiff failed to offer mandatory expert support for her claims?

4. Were plaintiff's claims properly dismissed on summary judgment for failure to provide the 90 day notice of intent to sue required by RCW 7.70.100, a statute which has been upheld as constitutional by the Court of Appeals?

C. COUNTERSTATEMENT OF THE CASE

1. Ample reasons existed for Ms. Ross's depression on when she presented to the St. Joseph's emergency room on September 18, 2005.

To understand the emergency medical care at issue in this case, it is important to understand the context in which that visit arose. During their depositions, both Ms. Ross and her mother, Stacey Moore, helped to provide that understanding; they spoke at length about the many stressors in Ms. Ross's life during 2005, and before.¹

There was tremendous financial stress. Throughout Ms. Ross's relationship with her husband, she had been the main wage earner for the family. CP 338. But Ms. Ross had quit her job in November or December 2004, and had been unemployed since that time – for approximately nine or ten months immediately prior to her visit to the hospital. CP 271. The

¹ Plaintiff and her mother are close and see each other on a daily basis. CP 270, 309.

reason she quit was because the job was emotionally “very stressful” and “too much” for her. Id. Ms. Ross’s husband’s work had been sporadic, with at least one firing and other abrupt decisions to quit working for months at a time. CP 336-37.

With this extended unemployment, the financial situation had gotten so bad that Ms. Ross had had her car repossessed, and she, her husband, and their five year old son were homeless. CP 272-74, 276-78. They had moved in temporarily with relatives and friends, but each time had worn out their welcomes and were kicked out. CP 276-78, 310, 313, 340.

With no one else’s home to move into, they began moving from cheap hotel to cheap hotel, staying most of the time at the Villa hotel, which Mr. Ross’s mother described as “disgusting.” CP 340. It was very run down, and full of people who reportedly looked like heroin addicts. CP 340-41. Prostitutes worked in the hotel two doors down from Ms. Ross’s room. Id. Ms. Ross’s husband would also go down to a room in the hotel where Ms. Ross suspected he was doing methamphetamine. CP 332-34. Understandably, the finances and the living situation were all very stressful to Plaintiff. CP 339-42.

But these were not the only stressors in Ms. Ross's life. She also had a long history of marital problems. Her marriage has been "on and off" the whole time. CP 335. As Ms. Ross's mother explained:

... she wants him to tow the line and be a good father and not be like her father was, and she won't put up with any of his orneriness or abuse. And – and she'll say, "You have to leave. You have to get out of here. That's it. You have to go." And then he's been -- he's been away for months at a time.

Id. Other times, Ms. Ross's husband would get upset and yell and make nasty remarks and then later give roses and tell Ms. Ross that he loved her and was sorry. CP 310. Ms. Ross agreed that husband was controlling and manipulative, and that he would say degrading things to her, calling her useless and lazy. CP 274-78. He also called her a whore because she had recently aborted another man's baby. CP 276-78.

Other stressors in Ms. Ross's life at the time included the recent death of a grandfather whom she was close to, and a lawsuit she was pursuing against her former landlord for allegedly changing her locks before she was supposed to have moved out and taking all of her things to the dump. CP 273-75.

Perhaps most importantly, Ms. Ross was very worried about the impact that all this was having on her young son. CP 341. Many of the

arguments between the couple and the verbal abuse by Ms. Ross's husband took place in front of their five year old boy. CP 342, 344. The housing situation and the things he was seeing were also bad for him. CP 310. Ms. Ross felt like she was being a bad mother to her son, exposing him to these things. CP 310, 341.

With all of this going on in her life, about a week before the emergency room visit at issue in this case, Ms. Ross told her mother that she was upset and wanted to seek help. CP 314-15. In response, Ms. Ross's mother took her out looking at apartments, hoping that would help Ms. Ross to feel better. Id.

2. On the day of the emergency visit at issue in this case, Ms. Ross came to a harsh realization, which escalated her stress and depression.

On September 18, 2005 Ms. Ross determined that she had "had enough" and that she needed to leave her husband. However, she soon realized that if she did that, she had no where in the world to go. CP 276-77.

That day, Ms. Ross again called her mother for help with her mental health concerns. CP 314-15, 323-24. She told her mother that she needed to see someone, to talk to a counselor. CP 344. This was very significant. Ms. Ross's mother testified:

Q. You said that she talked to you for a while. What kinds of things did she tell you, before you made the phone call to the hospital?

A. Just she said, "Remember last week when I told you, you know, that I was depressed, and then you -- your solution to it was to go out and look at apartments?" She goes, "Well, I think I need to see somebody. I -- I need to talk to somebody, a counselor."

And she's not one to ask for help, to ask to see somebody. So, I know -- I know -- she doesn't feel comfortable discussing her feelings with -- with other people, you know. So for her to ask, now is the time to do it, right now, before she changes her mind and doesn't want to -- and just decides, "I need to be tough and strong," because we come from a long line of strong women, and perhaps we try and act too strong.

Q. So the fact that she was asking for help told you that this was serious?

A. Yes. She wanted help.

CP 345-46. Together they determined that the best initial course of action was to call St. Joseph Hospital to see if they had someone on shift who could evaluate and care for Ms. Ross. CP 314-16.

Ms. Ross made the call herself, asking the hospital staff about coming in to be seen, making sure they had a counselor on duty. Id.; CP 406. Plaintiff's mother's recollection of the call is as follows:

Q. Do you recall anything that Jennifer said while she was on the phone with the person at the hospital?

A. * * *

She said something to the effect of -- you know, like, "I don't know how much, you know, more of this I can take." Because she felt like she was being such a poor mother for Alex, for him being in -- in -- in that situation. And that -- and that she had had thoughts of hurting herself. But nothing like she was going to do something right then. You know, ask for help and -- you know, there was no immediate sense of danger.

CP 406. (emphasis supplied). The hospital told her to come in. Id. So they went to the hospital. Id.

3. Ms. Ross arrived at St. Joseph's seeking treatment for her serious depression and for what multiple health care providers reasonably believed were her suicidal thoughts.

Ms. Ross arrived at the emergency department at 3:42 p.m. on September 18, 2005. CP 350, 363. Her mother was with her when she checked in. CP 317. Ms. Ross advised the clerk that she had called (referencing the telephone call to the hospital where Plaintiff stated that

she had thoughts of hurting herself), and that she wanted to see with someone regarding her depression and regarding a head cold. CP 317.

She was seen by a triage nurse at approximately 4:00 p.m. CP 350, 363. That nurse recorded in the chart that Ms. Ross had “depression x multiple weeks” and that she was “tearful.” CP 363. Ms. Ross waited for some time in the waiting room, and her mother went back up to the desk to see if they could get her in more quickly, again explaining that Ms. Ross needed help with her depression. CP 317-18; CP 325-26.

It was a busy day in the St. Joseph Hospital emergency room, so Ms. Ross was still waiting to see a physician at 6:00 p.m. when her status was formally documented again by a nurse. The nurse wrote that Ms. Ross was “feeling suicidal” and “tearful but cooperative/calm.” CP 370.

About 20 minutes later, Ms. Ross was seen by Dr. Jeffrey Ries, an emergency physician practicing in the emergency department at St. Joseph Hospital. CP 54. Before seeing Ms. Ross, Dr. Ries had the opportunity to review her chart. He learned that she had longstanding depression, was tearful, was reportedly suicidal, and that she was cooperating with hospital personnel. CP 355-56. Dr. Ries next reviewed the computer record of previous contacts, and then met with Mr. Ross. CP 350-51.

Dr. Ries recorded that during his initial examination of Ms. Ross, she advised him of the following:

- She had been depressed for a year;
- She had married in February 2005, but her husband treats her poorly. He calls her lazy, useless, and a whore;
- She had had a recent abortion of a baby fathered by someone other than her husband;
- She had been homeless since November 2004, when she lost her job;
- She had been staying with friends and relatives, but kept getting kicked out for various reasons;
- She could not take it anymore and tried to leave her husband that day, but had nowhere to go;
- She had been crying steadily for the last couple of days;
- She was concerned for her safety; and
- She was concerned that she might hurt herself.

CP 365-66. In her deposition, Ms. Ross confirmed that she told Dr. Ries all of this, except she denied that she said she might hurt herself. CP 277-79. However, Ms. Ross did confirm that later that same evening she told a hospital social worker that she had wondered if it would be better if she “just wasn’t here anymore.” She testified:

Q. Okay. “Read suicidal ideation, she states that she had thoughts of suicide today and that is what alarmed her and caused her to seek help.” Did you tell the social worker that?

A. I never said -- those aren't my words.

Q. What were your words?

A. That it would be better if I just --
what if I just wasn't here anymore.

CP 303-04. But it is not the precise words that gave rise to the suicidality concern, it was the message and presentation of the patient.

4. The health care providers took the steps necessary to assess the severity of suicide risk Mr. Ross posed to herself.

If upon initial evaluation a person is determined to possibly be a danger to herself or others, Dr. Ries typically arranges for a mental health evaluation, which would be conducted by a social worker. CP 352-53. In a typical case, the social worker sees the patient; if he or she agrees that the patient might be a danger to herself or others, the social worker and Dr. Ries would determine together whether to call the County Designated Mental Health Professional (the "CDMHP") to assess the patient for involuntary commitment to the hospital. CP 354. This type of mental health evaluation was in process here when Dr. Ries told Ms. Ross that he would have someone come to see her. CP 282.

Ms. Ross understood that it was going to be a social worker who would talk to her about her emotional problems, and about her coping issues, and to see if they could provide her with some assistance. CP 298. At the time, Ms. Ross believed that Dr. Ries was trying to give her the

help she needed. CP 299. Ms. Ross then waited for the next person to come. CP 282-83.

According to Ms. Ross, while she was waiting, she began clicking the heels on her flip flops together, and a nurse abruptly told her to leave. CP 301. Ms. Ross did not tell the nurse that she was waiting because the doctor told her that someone would be coming in to talk to her. CP 284-85. She did not go to the nurses' desk to report what had happened. CP 300. She just "said '[f]ine I am out of here' and got up and walked out." CP 285. She did not even go to get her mother and son, who were still waiting for her in the waiting room; instead she intended to just get out of the building. CP 286-87.

As she was attempting to leave, Dr. Ries saw her and stated that she could not leave and that she needed to stay. CP 357. Dr. Ries believes she responded, "I'm leaving." CP 358. Ms. Ross says that she did not hear anyone talking to her and did not see Dr. Ries on her way out. CP 288. She was just trying to get out the door. Id.

Because she would not voluntarily cooperate and was considered to be at risk for suicide, Dr. Ries notified the nursing staff that Plaintiff should not leave (pending social worker evaluation). CP 359-60. As she was leaving through the doors to the emergency department, nurse Robert Johnson was notified by some other nurses to stop her from leaving, which

he did. There is a dispute over exactly what happened during this time, though it is undisputed that Ms. Ross bit Nurse Johnson and that they fell to the ground. Ms. Ross agrees that Dr. Ries was not involved in this incident. CP 295, 297. Dr. Ries did not even see it happen and did not see Ms. Ross again until after she was restrained. CP 361.

For some time following this incident, Ms. Ross remained in restraints. CP 399-99. A hospital security guard, Craig Mullins, was called to sit with her during a portion of this time. *Id.* Mr. Mullins reported that while he was sitting there, Ms. Ross “kept asking for the restraints to be removed so she could go find [Nurse Johnson] and bite him again.” *Id.* Mr. Mullins reported that Ms. Ross also kept threatening to sue the hospital. *Id.* He asked her to stop talking about that, stating that they were just trying to do their jobs. *Id.* Ms. Ross responded by stating, “I’ll bite any [motherf---er] that comes in her and tries to touch me.” *Id.*

Shortly after that, Plaintiff was evaluated by a social worker, and it was determined that involuntary commitment was not necessary. After evaluation, and scheduling of a future appointment with a physician who could address the patient’s mental health issues, Ms. Ross was discharged from care. *See* CP 367.

4. This litigation ensued, and was properly dismissed.

Two years after her visit to the St. Joseph's emergency department for her depression, Ms. Ross filed suit about the manner in which her mental health care was delivered. CP 429, 432-433. She named the hospital, Nurse Johnson, and Dr. Ries. Id. The specific causes of action she pleaded were assault and battery, false imprisonment, and malicious prosecution. Id. It is understood that only the false imprisonment claim was pleaded against Dr. Ries. See id. Defendants denied Plaintiffs' claims, and Nurse Johnson asserted a counterclaim for assault, battery, and infliction of emotional distress against Ms. Ross. CP 443-47; 449-55.

At hearing on January 14, 2009, (late) Judge James Allendorfer of the Snohomish County Superior Court entered an order granting Dr. Ries' motion for summary judgment and dismissed all claims against Defendants Ries with prejudice. A similar order granting the motion of Defendants Peacehealth and Johnson was entered. CP 9-11. CP 13-15.² It is from these orders (and a companion order denying Plaintiff's motion to strike submissions by St. Joseph's Hospital) that Ms. Ross appeals. It is these orders that should be upheld.

² Dr. Ries mentions the claims between the other parties in his briefing, but focuses primarily on the claims made against him. Despite this focus and for the sake of clarity, Dr. Ries notes that he believes the dismissal of all of Ms. Ross's claims against all Defendants was proper.

D. ARGUMENT

A trial court's order on summary judgment is reviewed de novo based on the record before the trial court at the time of the order. Saluteen-Maschersky v. Countrywide Funding Corp., 105 Wn. App. 846, 850, 22 P.3d 804 (2001). Summary judgment is appropriate if there are no genuine issues of material fact and the moving party is entitled to judgment as a matter of law. Trimble v. Washington State University, 140 Wn.2d 88, 93, 993 P.2d 259 (2000). An appellate court may affirm a trial court's disposition of a summary judgment motion on any basis supported by the record. Redding v. Va. Mason Med. Ctr., 75 Wn. App. 424, 426, 878 P.2d 483 (1994).

1. Dr. Ries was authorized to detain Ms. Ross and is immune from civil liability under RCW ch. 71.05.

Revised Code of Washington chapter 71.05 addresses certain actions that can be taken for persons with mental disorders and the rights of those patients. In part, it is intended to “provide prompt evaluation and timely and appropriate treatment of persons with serious mental disorders.” RCW 71.05.010(2). A “mental disorder” is “any organic, mental, or emotional impairment which has substantial adverse effects on an individual’s cognitive or volitional functions,” a definition which

necessarily includes those who are depressed and suicidal. RCW 71.05.020(26).

Within that context, RCW 71.05.050 provides in pertinent part:

. . . That if the professional staff of any public or private agency or hospital regards a person voluntarily admitted who requests discharge as presenting, as a result of a mental disorder, an imminent³ likelihood of serious harm, or is gravely disabled, they may detain such person for sufficient time to notify the county designated mental health professional of such person's condition to enable the county designated mental health professional to authorize such person being further held in custody or transported to an evaluation and treatment center pursuant to the provisions of this chapter, which shall in ordinary circumstances be no later than the next judicial day: PROVIDED FURTHER, That if a person is brought to the emergency room of a public or private agency or hospital for observation or treatment, the person refuses voluntary admission, and the professional staff of the public or private agency or hospital regard such person as presenting as a result of a mental disorder an imminent likelihood of serious harm, or as presenting an imminent danger because of grave disability, they may detain such person for sufficient time to notify the county designated mental health professional of such person's condition to enable the county designated mental health professional to authorize such person being further held in custody or transported to an evaluation treatment center pursuant to the conditions in this chapter, but which time shall be no more than six hours from the time the professional staff determine that an evaluation by the

³ Appellant's Brief cites a definition of "imminent" in RCW 71.05.020(20) that did not exist at the time of the care in question. App. Brief, p. 38. A definition for "imminent" was not added until 2007. The care at issue occurred in 2005.

county designated mental health professional is necessary.

RCW 71.05.050. This statute authorized Dr. Ries to hold Ms. Ross, a patient who stated it may be better if she weren't there any longer, to determine whether the CDMHP needed to be involved in her care. Id.⁴

The Washington Supreme Court's decision in In re Detention of C.W., 147 Wn.2d 259, 53 P.3d 979 (2002), sheds light on how this statute applies in an emergency room setting. In re C.W. was a consolidated case involving a number of individuals who had been involuntarily detained in emergency rooms pending evaluation by a CDMHP. The plaintiffs argued that they had been held for more than the six hours referenced in the statute, and, therefore, that the petitions to involuntarily commit them for further psychiatric treatment should be dismissed. Id. at 262. In each case, the trial court dismissed the petitions due to alleged statutory time limit violations. Id. The state appealed. Id.

⁴ RCW ch. 71.05 places the ultimate burden of determining whether a person has a mental disorder or creates a likelihood of serious harm sufficient to warrant an involuntary commitment on the CDMHP. Pursuant to RCW 71.05.150, the CDMHP, after receipt of information that an individual, as the result of a mental disorder, presents a likelihood of serious harm or is gravely disabled, is authorized to conduct an independent investigation and evaluation of the person. If the CDMHP, after such investigation and evaluation, finds that the person presents an imminent likelihood of serious harm, he or she may detain that person for not more than seventy-two hours for evaluation. RCW 71.05.150(2). As is implicit in the statute and as experience has taught, not every person who is evaluated under the statute is involuntarily committed, even when the detention or restraint for evaluation is entirely appropriate.

The cases made their way to the Supreme Court, where they were consolidated for consideration. To determine whether the six hour maximum referral time had been exceeded, the Washington Supreme Court reviewed the role of the emergency department in the involuntary restraint or detention of mental health patients who may (or may not) be a danger to themselves or others pursuant to RCW 71.05. The Court acknowledged that the realities of modern medicine mean that professional personnel called upon to act under RCW 71.05 “necessarily includ[e] hospital staff who must triage persons brought into [emergency departments].” Id. at 274.

The Court explained that, to carry out these duties, hospital staff must be allowed sufficient time to screen, evaluate and make a determination of whether they believe the patient meets criteria for involuntary detention. Id. at 272-273. If so, at that point, the CDMHP should be called to make a formal determination regarding detention. Id. In contrast, if after full evaluation it is determined that the patient does not meet criteria, at that point she is free to leave. Id. The Court also noted that, with mental health patients, during this screening and evaluation phase, patients are often physically secured to a bed or placed in a locked section of the hospital before they can be fully evaluated. Id. at 273. The Court offered no criticisms of any of these practices. Instead, it explained

these realities matter-of-factly, impliedly acknowledging that these practices are what appropriate treatment of an involuntary mental health patient can demand. See id. at 272-273.

Ultimately, the Court ruled that the six hour timeframe of RCW 71.05.050 does not begin to run until after a determination is made that the CDMHP must be called in to evaluate the patient. Id. at 262. The petitioners had argued that such a rule would allow for a period of time that constituted pre-detention restraint, where the patient was not detained but also was not free to leave the emergency department. Id. at 275. The Court agreed that this was precisely the situation contemplated, explaining:

...RCW 71.05.050 does allow for such a period of restraining, if necessary, to evaluate the person to determine whether he or she meets the statutory requirements for notifying the CDMHP.

Id. at 276. This permissible, statutorily authorized restraint is what happened in this case.

2. Summary judgment was appropriate because RCW 71.05.120 granted Dr. Ries broad immunity that stood as an insuperable bar to Ms. Ross's claims.

Recognizing the peril physicians can face in applying the provisions of RCW 71.05, the Legislature passed a broad grant of immunity for actions taken in connection with the treatment of involuntary

mental health patients, which was codified at RCW 71.05.120. Ms. Ross does not appear to contend that this statute does not apply to the actions taken by her health care providers on September 18, 2005. Instead, she asserts that the trial court improperly applied the statute on summary judgment. Review of the statute and its judicial interpretation shows that the trial court was correct in its application.

Revised Code of Washington 71.05.120 provides in pertinent part:

(1) No officer of a public or private agency, nor the superintendent, professional person in charge,⁵ his or her professional designee, or attending staff of any such agency, nor any public official performing functions necessary to the administration of this chapter, nor peace officer responsible for detaining a person pursuant to this chapter, nor any county designated mental health professional, nor the state, a unit of local government, or an evaluation and treatment facility shall be civilly or criminally liable for performing duties pursuant to this chapter with regard to the decision of whether to admit, discharge, release, administer antipsychotic medications, or detain a person for evaluation and treatment: PROVIDED, That such duties were performed in good faith and without gross negligence.

RCW 71.05.120(1). The Legislature did not require that the patient ultimately be detained, or even that the physician be free from ordinary negligence in making determinations regarding the patient care. Instead,

⁵ “Professional person” includes physicians. RCW 71.05.020(31); see *In re C.W.*, 147 Wn.2d at 274.

the only limitation to the broad grant of immunity is if the physician acts either in bad faith or with gross negligence.

Spencer v. King County, 39 Wn. App. 201, 692 P.2d 874 (1984), rev. denied, 103 Wn.2d 1035 (1985)⁶ explains the very limited nature of these two exceptions. The case arose out of an involuntary detention of Mr. Spencer; he had exhibited emotional problems and his daughter thought he was intending to harm certain individuals. Id. at 202-203. The CDMHP went to Mr. Spencer's home to determine if mental health treatment was necessary. Id. at 202. Following a difficult meeting and an altercation, Mr. Spencer was taken by ambulance for a 72 hour psychiatric evaluation pursuant to RCW 71.05. Id. at 203-204. He was released at the end of the 72 hours. Id. at 204. Mr. Spencer sued over the detention, alleging among others, three of the same claims that Plaintiff here alleges: assault, battery, and false imprisonment. Id. at 204.

The defendants asserted RCW 71.05.120 immunity from suit, and the claims were dismissed. Id. at 204. Mr. Spencer appealed. Based upon the plain language of the statute, the Court of Appeals agreed that immunity for actions taken in connection with RCW 71.05 was lost only upon a showing of bad faith or gross negligence. Id. at 205. The Court of

⁶ This decision was overruled in part by Frost v. City of Walla Walla, 106 Wn.2d 669, 673-674, 724 P.2d 1017 (1986); however, the applicable portion of the decision, which is discussed in this motion, is good law.

Appeals then explained that bad faith was typically construed to mean acting with tainted or fraudulent motives, with dishonest purpose, or with moral obliquity. Id. at 208-209. It stated also that:

[Bad faith] implies conscious doing of wrong. It means a breach of a known duty through some motive of interest or ill will. It partakes of the nature of fraud.

Id. at 208 (emphasis in original).⁷ With no evidence in the record that the defendants acted with ill will or fraudulent intent, the bad faith exception did not apply to Mr. Spencer's claims. Id.

The Spencer Court also explained what it means for there to be gross negligence defeating immunity:

gross or great negligence, that is, negligence substantially and appreciably greater than ordinary negligence. It's correlative, failure to exercise slight care, means not the total absence of care but care substantially or appreciably less than the quantum of care inherent in ordinary negligence.

Id. at 206 (quoting Nist v. Tudor, 67 Wn.2d 322, 331, 407 P.2d 798 (1965) (emphasis in original)). With no evidence that the defendants acted

⁷ This Court has defined bad faith similarly in other contexts. For example, in State v. Sizemore, 48 Wn. App. 835, 741 P.2d 573 (1987), when analyzing allegations of prosecutorial bad faith, the Court of Appeals observed:

Bad faith is defined as 'actual or constructive fraud' or a 'neglect or refusal to fulfill some duty. . . not prompted by an honest mistake as to one's rights or duties, but by some interested or sinister motive.'

Id. at 837 (citing BLACK'S LAW DICTIONARY 127 (5th ed. 1979) (ellipses in original)).

without even slight care, Mr. Spencer's claim of gross negligence also failed as a matter of law. Id. at 208.

Just like the plaintiff in Spencer, Ms. Ross did not offer any evidence to show that Dr. Ries acted with ill will or lack of even slight care in the actions that he took. This was because there was no such evidence. The type of evidence Ms. Ross needed in order continue to pursue her claim was lacking entirely, and the record before the trial court was replete with evidence of Ms. Ross's depression and potential for self harm.

The evidence showed that even with a dispute over whether Ms. Ross used the word "suicide," Dr. Ries had a reasonable concern that Ms. Ross may have been at serious risk for self harm. See CP 406-410. In making that determination, Dr. Ries was entitled to "consider hospital professional staff to be reliable and credible sources of information." See In re C.W., 147 Wn.2d 259, 275 (2002) (discussing the ability of the CDMHP to rely upon hospital staff's reporting). Here, Dr. Ries's request to keep the patient in the emergency department to be evaluated for risk of self harm was completely appropriate based on the information he had been provided at the time, and he was not even involved in the subsequent incident with Nurse Johnson.

Reviewing the evidence before the trial court on summary judgment, reasonable minds could not differ in their determination that the detention of Ms. Ross was not professionally negligent, much less grossly negligent or in bad faith.⁸ As such, because Dr. Ries was statutorily entitled to hold Ms. Ross under RCW 71.05.050, and because he had statutory immunity under RCW 71.05.120, summary judgment dismissing all claims against defendants Ries was properly granted by the trial court. The dismissal can, and should, be affirmed for this reason alone.

3. Summary judgment was separately and independently appropriate given Ms. Ross's failure to comply with the expert testimony and prefiling notice of intent to sue requirements of RCW ch. 7.70.

In ruling on the motion for summary judgment, the trial court also expressly found that summary judgment was appropriate because Ms. Ross failed to provide expert testimony in support of this medical practice claim, and failed to provide a 90 day notice of intent to sue pursuant to RCW 7.70.100. RP 46:22 to 47:12. These rulings were correct and serve as independent grounds to uphold the summary judgment order.

⁸ Ms. Ross's reliance upon Petersen v. State, 100 Wn.2d 421, 671 P.2d 230 (1983), is misplaced. Petersen was not a summary judgment, but an appeal after a jury trial. With respect to RCW 71.05.120, Petersen held only that it was appropriate for the trial court to have included the words "good faith" in a jury instruction. Id. at 441. Petersen sheds no light on the issues raised in this appeal.

- a. **Because Ms. Ross's claims arise out of the delivery of (mental) health care, they are subject to RCW ch. 7.70.**

In 1975, it was widely understood that the entire nation's health care delivery system was under serious threat due to a medical malpractice insurance crisis. DeYoung v. Providence Medical Ctr., 136 Wn.2d 136, 148, 960 P.2d 919 (1998). In preparing to confront Washington's difficulties as best it could at the time, the Legislature took evidence from many sources. Id.

The evidence showed that, in recent years, medical malpractice loss payments for at least one insurer had skyrocketed, and medical malpractice insurance premiums for specified classes of physicians had doubled and tripled. Id. Washington's Supreme Court has acknowledged that, based upon this and other evidence before the Legislature at the time, the rational conclusion was that a medical malpractice insurance crisis either was upon Washington or was likely. Id.

In response to the urgent situation, the Legislature adopted the laws that became RCW 7.70. Sherman v. Kissinger, 146 Wn. App. 855, 866, 195 P.3d 539 (2008) (citing 1975-1976 Final Legislative Report, 44th Wash. Leg., 2d Ex. Sess., at 22). The primary goal of RCW ch. 7.70 was to stem the crisis and the corresponding increase in consumer health care costs. Id.

Enacted as part of the 1975 legislation, RCW 7.70.010 declares the Legislature's intent to modify 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."

Interpreting this section, the Court of Appeals has explained:

This section sweeps broadly. It clearly states that RCW 7.70 modifies procedural and substantive aspects of all civil actions for damages for injury occurring as a result of health care, regardless of how the action is characterized.

Branom v. State, 94 Wn. App. 964, 969, 974 P.2d 335, rev. denied, 138 Wn.2d 1023, 989 P.2d 1136 (1999) (emphasis in the original). Similar holdings have been reached in a variety of cases. E.g., Miller v. Jacoby, 145 Wn.2d 65, 72, 33 P.3d 68 (2001); Webb v. Neuroeducation, Inc., 121 Wn. App. 336, 346, 88 P.3d 417 (2004); Thomas v. Wilfac, Inc., 65 Wn. App. 255, 264, 828 P.2d 597 (1992).

This is true even in cases like the one at issue here, where the Plaintiff has claimed an intentional tort. On this point, Orwick v. Fox, 65 Wn. App. 71, 86, 828 P.2d 12 (1992), rev. denied, 120 Wn.2d 1014, 844 P.2d 435 (1992), is particularly instructive. In Orwick, the plaintiff had been brought into the Harborview Medical Center emergency room by the police. Id. at 75. Harborview employees restrained him, took his blood

pressure, and drew blood while providing care to him. Id. at 85. He later sued, alleging assault. Id. The trial court dismissed the claim. Id. The Court of Appeals upheld the dismissal, holding:

By its terms, RCW ch. 7.70 applies to all actions against health care providers, whether based on negligence or intentional tort.

Id. at 86.

Ms. Ross admits she went to the hospital in order to receive health care, and her claim is undeniably asserted against her health care providers. See, e.g., Appellant's Br. p. 5; CP 149. The undisputed evidence on summary judgment also showed that when Dr. Ries stated that Ms. Ross should not leave the hospital, he did that in an effort to complete the mental health evaluation that was in process, and to determine whether the CDMHP would need to be called for involuntary commitment evaluation. The case undeniably arises out of the delivery of health care regardless of the names or legal causes of action Ms. Ross chooses to assign her claims. As such, just as the Legislature intended, and just as is mandated by Branom, Miller, Webb, Thomas, and Orwick, in order to pursue her claims, Ms. Ross's was obligated to comply with RCW ch. 7.70. This obligation was not created by the defenses in this

case as Ms. Ross contends, but rather was created by the nature of the claims themselves.⁹

b. Expert support for Ms. Ross's claims was mandatory to allow them to survive summary judgment, but was entirely absent.

Revised Code of Washington chapter 7.70 creates specific requirements for health care claims, including the need to have expert testimony in support of almost all claims. Orwick is instructive on this point as well. After the Court held that RCW ch. 7.70 applies to all actions against health care providers, it explained that RCW 7.70.030 set out the only potential bases for Mr. Orwick's claim. Id. at 85-86. They included demonstrating a breach of the standard of care by a treating health care provider. Id. However, Mr. Orwick did not have expert support for his claims. Id.

The Court held that without competent expert testimony, Mr. Orwick could not establish a breach of the standard of care as a matter of law, and had not otherwise satisfied RCW 7.70.030's requirements for health care claims. Id.¹⁰ Mr. Orwick had failed to offer the evidence

⁹ Nothing about the Texas unpublished opinion cited in Ms. Ross's brief at page 11 changes this. Not only does established Washington law govern this Washington claim, but under Texas Rules of Form 4.1.2(c), an unpublished Texas opinion has no precedential value even in Texas.

¹⁰ Other options under RCW 7.70.030 are a claim for lack of informed consent, and a claim for breach of a medical promise. But see Bundrick v. Stewart, 128 Wn.

necessary to effectively resist the summary judgment, and the dismissal was proper. Id. at 86.

The Orwick dismissal is consistent with the well-established rule in Washington that, absent extreme circumstances, expert testimony is required to prove a health care provider's breach of the standard of care. E.g., Douglas v. Freeman, 117 Wn.2d 242, 249, 814 P.2d 1160 (1991) (citations omitted); Harris v. Groth, 99 Wn.2d 438, 451, 663 P.2d 113 (1983) (standard of care for medical personnel is generally beyond the knowledge of lay persons). In medical malpractice cases, "a doctor is entitled to summary judgment once he establishes the plaintiff lacks competent expert testimony." Morinaga v. Vue, 85 Wn. App. 822, 831, 935 P.2d 637, rev. denied, 133 Wn.2d 1012 (1997).

In opposition to Dr. Ries's motion for summary judgment, Ms. Ross failed to provide any expert testimony in support of her claim that Dr. Ries's actions violated the standard of care or were otherwise inappropriate for an emergency room physician effectuating the mental health evaluation. See CP 92-174. The trial court correctly determined that this lack of expert support was fatal to Ms. Ross's claims; the determination should not be disturbed on appeal.

App. 11, 17, 114 P.3d 1204 (2005) (recognizing claim for medical battery when complete failure to obtain any consent at all).

- c. **Similarly, RCW 7.70.100 required Ms. Ross to serve a notice of intent to sue, but she failed to do so.**

Unfortunately, the crisis that prompted the adoption of RCW ch. 7.70 was not stemmed in the 1970's. By 2001, because of heavy medical malpractice losses and concerns about the future of these claims, the St. Paul Companies announced that they would leave the medical malpractice insurance business. Milt Freudenheim, St. Paul Cos. Exit Medical Malpractice Insurance, N.Y. Times, December 13, 2001. This ended coverage for 750 hospitals, 42,000 physicians, and 73,000 other health care workers nationwide, including a fair number in Washington. Id. In 2003, the Office of the Insurance Commissioner placed an insolvent Washington Casualty Co. into receivership, at a time when it reportedly insured 46 Washington hospitals, 20 Washington community health clinics, and other Washington entities and physicians. See Thurston County Superior Court Cause No. 03-2-00401-1. These are only two of many examples of the continuing crisis.

In the fall of 2005, competing Initiatives 336 and 330 were introduced by those interested in the important civil liability issues related to the delivery of health care. That fall, the initiatives were at the forefront of the news, and on the minds of every engaged voter. The battle over the

initiatives was lengthy. It was expensive. And it was ugly. In the end, Washington's voters rejected both initiatives.

The furor associated with the initiatives passed with the November 2005 general election, but reform was still needed; the status quo was not acceptable. The Legislature dove in on issues that had been percolating for approximately four years, and put together a set of important changes to laws related to health care through House Bill 2292. The bill's prime sponsor, Representative Pat Lanz explained in a February 20, 2006 hearing before the Senate Committee on Health and Long Term Care (the "Senate Committee"):

After the initiative election this fall, it was so very clear that what the people were saying was that there are some issues that are just way too complex for us to deal with at the ballot box. And we elected you to take on these hard issues.¹¹

In also speaking before the Senate Committee that day, Governor Gregoire thanked those who had assisted with the negotiations on the bill's provisions, including: three members of the Washington State Trial Lawyers Association, two members of the Washington State Hospital Association, three members of the Washington State Medical Association,

¹¹ The audio of this hearing can be found at <http://www.tvw.org/search/siteSearch.cfm?EvntType=C&keywords=Senate%20Health%20&date=2006&bhcp=1>. An unofficial transcription of key portions of the hearing is also included in the appendix to this brief; Senate Committee Hearing transcription at 3.

general counsel for Physicians Insurance, two members of the Washington State Bar Association leadership, members of the Governor's office, and those from the Department of Health and the Office of the Insurance Commissioner. Governor Gregoire then expressed her support for the bill, with a proposed striker amendment that added the notice of intent provision.¹²

The Washington State Trial Lawyers Association (now known as the Washington State Association for Justice) added:

John Budlong on behalf of the Washington State Trial Lawyers.¹³ We also would encourage this body to enact bill 2292 as written with the striker amendments. We also would like to thank our colleagues in the health care professions who have spent five sessions of three hours each discussing all aspects of 2292, particularly the liability provisions in great detail. These were candid, open, I think very friendly discussions, and I think the voters perhaps would want to know that after this last campaign. I think that we made a lot of progress in here in enacting comprehensive reform in patient safety, insurance reform, civil justice reform issues. We also would like to thank Representative Pat Lanz who

¹² Senate Committee Hearing transcription at 1-2. The "striker" Governor Gregoire referenced in her comments was the final "striker amendment" to (by then) 2SHB 2292. Among other revisions to the bill, this amendment added the notice of intent provision that is at issue in this case. See Senate Bill Report 2SHB 2292 at 7 (under heading "Amended Bill Compared to Second Substitute Bill"), a copy of which is included in the appendix to this brief.

¹³ Mr. Budlong was then a member of its Board of Governors, and is now a past President.

has put this bill out as the vehicle, for the last, I believe it started four years ago, and finally, of course, for Governor Gregoire, I fully agree with Dr. Dunbar. I think without her gift for bringing opposing parties together that we would not be here today unanimously in favor of this bill as written. Thank you.

Senate Committee Hearing transcription at 5. S. Brooke Taylor also explained:

I have practiced law in Port Angeles, Washington for 37 years, and I have to tell you I never thought I'd see this day. I am here today in my capacity as President of the Washington State Bar Association.

* * *

After the bitter initiative campaigns, I was searching for answers. And it seemed to me that the voters were telling all of us, among other things, that they wanted significant balanced reforms in how we resolved these disputes.

* * *

Then Governor Gregoire, with her superb leadership, made it all happen. Doctors and lawyers sitting at the same table face to face, discussing these issues, which have for decades divided our professions, which have so much in common in every other respect.

I can tell you that the Washington State Bar Association endorses this bill as it is currently written, and we would urge this body to enact it. I can also tell you that Dr.

Dunbar as president of his association and I as president of mine, have agreed to continue this dialogue, this engagement into the future, recognizing that there is still work to be done and this is only a start. But it is a very, very good start. Thank you.

Id. at 6-7. As the speakers quoted above and others at the hearing made clear, the notice of intent provision at issue in this case came about as part of a truly historic and progressive compromise of 2006. The notice of intent provision was part of the reforms that were wanted and needed by Washington's citizens, by Washington's government, by Washington's physicians and patients, and by Washington's lawyers.

The Legislature's official findings adopted in connection with the 2006 reforms to RCW ch. 7.70 are:

The legislature finds that access to safe, affordable health care is one of the most important issues facing the citizens of Washington state. The legislature further finds that the rising cost of medical malpractice insurance has caused some physicians, particularly those in high-risk specialties such as obstetrics and emergency room practice, to be unavailable when and where the citizens need them the most. The answers to these problems are varied and complex, requiring comprehensive solutions that encourage patient safety practices, increase oversight of medical malpractice insurance, and making the civil justice system more understandable, fair, and efficient for all the participants.

Laws of 2006, ch. 8, § 1 (cited in Waples v. Yi, 146 Wn. App. 54, 61 n. 3, 189 P.3d 813 (2008), rev. granted, 165 Wn.2d 1031, 203 P.3d 382 (2009)).

It is also the legislature's intent to provide incentives to settle cases before resorting to court, and to provide the option of a more fair, efficient, and streamlined alternative to trials for those for whom settlement negotiations do not work.

Laws of 2006, ch. 8, § 1.

And this is precisely what RCW 7.70.100's notice of intent provision does; it promotes quick and early settlement, and conserves resources for all involved (the parties, insurers, and the courts). Bennett v. Seattle Mental Health, 150 Wn. App. 455, 462, 208 P.3d 578 (2009), petition for rev. pending, 2009 Wash. LEXIS 1024 (2009) ("Reading the plain language of RCW 7.70.100(1) as a whole, it is clear that the legislative intent is to require a mandatory 90 day waiting period to allow the parties the opportunity resolve medical malpractice claims against the health care provider."); Breuer v. Presta, 148 Wn. App. 470, 477, 200 P.3d 724 (2009) (purpose of notice of intent is to help achieve the Legislature's policy goal of settling cases pre-filing); Waples, 146 Wn. App. at 61 (same); see also Medina v. Pub. Utility Dist. No. 1 of Benton County, 147 Wn.2d 303, 53 P. 3d 993 (2002) (it is generally accepted that a purpose of the governmental claim-filing provisions of RCW 4.96.020 is to allow

government entities time to investigate, evaluate, and settle claims).¹⁴ To effectual these real and substantial goals, RCW 7.70.100 (and other health care reforms) took effect on June 7, 2006. Ms. Ross filed her lawsuit over a year later, on September 14, 2007. CP 427.

d. Ms. Ross failed to comply with RCW 7.70.100's notice of intent to sue requirement.

Revised Code of Washington 7.70.100 provides in pertinent part:

(1) No action based upon a health care provider's professional negligence may be commenced unless the defendant has been given at least ninety days' notice of the intention to commence the action. The notice required by this section shall be given by regular mail, registered mail, or certified mail with return receipt requested, by depositing the notice, with postage prepaid, in the post office addressed to the defendant....

In her briefing on this issue, Ms. Ross did not deny that she had failed to submit a notice of intent to Dr. Ries. See CP 163-170. Nor did she deny that the Court of Appeals has already determined that the presuit notice is a condition precedent to maintaining a lawsuit regarding medical care, and that failure to comply mandates dismissal. Bennett v. Seattle Mental

¹⁴ For many years, RCW 4.96.020 pre-suit notice requirements applied to public hospitals to facilitate settlement. See id.; Hardesty v. Stenchever, 83 WN. App. 253, 257, 917 P.2d 577 (1997) (RCW 4.96.020 applies to public hospital districts). However, the Legislature recently amended RCW 4.96.020 to make clear that RCW 7.70's notice (and other) provisions exclusively govern claims against the public hospitals now.

Health, 150 Wn. App. 455, 456, 465, 208 P.3d 578 (2009), petition for rev. pending, 2009 Wash. LEXIS 1024 (2009). Id.

Instead, at the trial court, Ms. Ross made vague assertions that RCW 7.70.100 was unconstitutional. See CP 160; 163-170. The trial court rejected Ms. Ross's assertions, and determined that Ms. Ross's failure to serve the notice of intent was an alternative basis for dismissing her claims. RP 47. On appeal, Ms. Ross largely focuses her RCW 7.70.100 argument on a challenge to the constitutionality of the statute.

However, given the other bases for upholding the trial court discussed above, the constitutional issue should not be reached. Gersema v. Allstate Ins. Co., 127 Wn. App. 687, 697, 112 P.3d 552 (2005) (reviewing court should not decide a constitutional issue unless it is absolutely necessary to the determination of the case) (citing State v. Hall, 95 Wn.2d 536, 539, 627 P.2d 101 (1981)). If this issue is reached, Ms. Ross's arguments must be rejected, and the trial court upheld.¹⁵

¹⁵ At the trial court, the parties also briefed and argued the constitutionality of the certificate of merit statute, RCW 7.70.150. However, the trial court did not dismiss Ms. Ross's claims based upon her failure to file a certificate of merit in compliance with RCW 7.70.150. See RP 47. Thus, not only would there be no proper assignment of error on this topic by Ms. Ross since the issue did not go against her, but RCW 7.70.150 and its unconstitutionality (Putman v. Wenatchee Valley Med. Ctr., P.S., 166 Wn.2d 194, 216 P.3d 374 (2009)) are at issue in this case.

- e. **RCW 7.70.100 does not conflict with court rules, and therefore there is no separation of powers problem.**

None of Ms. Ross's arguments regarding the constitutionality of RCW 7.70.100 was fleshed out at the trial court level. On appeal, Ms. Ross asserts that RCW 7.70.100 violates the separation of powers by conflicting with CR 3, which instructs that a lawsuit is commenced by filing or serving the pleadings. She has not articulated what the purported conflict is. On this basis alone, the Court may decline to consider the assertion. Health Ins. Pool v. Health Care Authority, 129 Wn.2d 504, 511-12, 919 P.2d 62 (1996) (court may decline to address constitutional issues inadequately briefed or argued).

The argument may be that the statute seeks to tamper with CR 3's instruction on how to commence a lawsuit. If that is the case, the problem Ms. Ross faces is that RCW 7.70.100 is plain on its face, and therefore its terms must be taken at face value as an expression of legislative intent. In re Forfeiture of One 1970 Chevrolet Chevelle, 166 Wn.2d 834, 838, 215 P.3d 166 (2009). By RCW 7.70.100's terms, the presuit notice is intended to be, and in fact is, something entirely different than instruction on how to commence a lawsuit.

This is evident from the fact that presuit notice is (1) required to be provided before the commencement takes place, and (2) required to notify

the recipient of the sender's "intention to commence the action." RCW 7.70.100(1). It does not notify that commencement has already occurred or it in process. It speaks about the act of commencement that will take place some time in the future.

Comparing the statute and the rule it is, clear that RCW 7.70.100 does not address how to commence a lawsuit, and Civil Rule 3 does not address anything but that topic. The statute and the rule do not overlap and are not in conflict. Both before and after the adoption of RCW 7.70.100, commencement of the action occurs pursuant to CR 3's rules about serving or filing the pleadings (depending on which option is selected). RCW 7.70.100 did not change the actual commencement of an action in any way.

But even if the court determined that there were some conflict, that would not necessarily mean that there is a separation of powers problem. While citing liberally to Putman v. Wenatchee Valley Med. Ctr., P.S., 166 Wn.2d 974, 216 P.2d 374 (2009) in this section of her brief, Ms. Ross fails to acknowledge Putman's clear instruction that if there appears to be a conflict between a statute and a court rule, the Court must first attempt to harmonize the statute and the rule, and give effect to them both. Id. at 984 (citing Fircrest v. Jensen, 158 Wn.2d 384, 394, 143 P.3d 776 (2006), cert. denied, 549 U.S. 1254 (2007)). Moreover, statutes are presumed

constitutional; the presumption is overcome only if the challenging party can prove beyond a reasonable doubt that the statute is unconstitutional. E.g., Island County v. State, 135 Wn.2d 141, 146-47, 955 P.2d 377 (1998). Ms. Ross had not sustained this burden here.¹⁶ The statute should not be invalidated as a separation of powers violation.

f. RCW 7.70.100 does not create unconstitutional delay or burden.

All RCW 7.70.100(1) requires is that a plaintiff mail a letter and wait 90 days before commencing litigation in a medical practice case. It is a much less technical statute than the governmental claims statutes that have been upheld by Washington courts in numerous decisions. See, e.g., Daggs v. City of Seattle, 110 Wn.2d 49, 750 P.2d 626 (1988) (sixty day presuit notice for claims against Seattle did not violate equal protection); Hall by Hall v. Niemer, 97 Wn.2d 574, 649 P.2d 98 (1982) (upholding constitutionality of former RCW 36.45.040 presuit notice requirement); Coulter v. State, 93 Wn.2d 205, 608 P.2d 261 (1980) (upholding RCW 4.92.100's presuit notice requirement).

¹⁶ Ms. Ross cites to Curtis Lumber Co. v. Sortor, 83 Wn.2d 764, 522 P.2d 822 (1974) in the separation of powers section of her brief. It does not support her claims. Curtis involved a scenario where the provisions of a statute and a rule were potentially directly conflicting (about whether service was mandatory to commence a case after the adoption of CR 3). Id. at 766-768. Even in Curtis, where the statute had previously been interpreted to deal with the same subject matter as the rule (unlike in this case), the Court revisited the interpretation of the statute and harmonized it with the rule (interpreting it as a statute of limitations) rather than invalidating the statute. Id. at 768.

Article I, § 10 does not require any different outcome in this case. It states only that “Justice in all cases shall be administered openly, and without unnecessary delay.” In recently discussing Article I, Section 10, our Supreme Court commented:

We have previously held that the state constitution does not contain any guaranty that there shall be a remedy through the courts for every legal injury suffered by a plaintiff. See Shea v. Olson, 185 Wash. 143, 160-61, 53 P.2d 615 (1936). However, the Shea court did not directly address article I, section 10 of the state constitution when it made this conclusion. See *id.* Nevertheless, we decline at this time to determine whether a right to a remedy is contained in article I, section 10 of the state constitution.

We adopt the view of the Supreme Court of Oregon that “[i]t has always been considered a proper function of legislatures to limit the availability of causes of action by the use of statutes of limitation so long as it is done for the purpose of protecting a recognized public interest.” Josephs v. Burns, 260 Ore. 493, 503, 491 P.2d 203 (1971), abrogated on other grounds by Smothers v. Gresham Transfer, Inc., 332 Ore. 83, 23 P.3d 333 (2001). Similarly, the Supreme Court of Missouri has concluded that its open courts provision does not require “that a plaintiff can always go to court and obtain a judgment on the claim asserted.” Blaske, 821 S.W.2d at 832. Because we recognize that the legislature has broad police power to pass laws tending to promote the public welfare, we decline at this time to determine

whether article I, section 10 of the state constitution guarantees a right to a remedy.

1519-1525 Lakeview Boulevard Condominium Ass'n v. Apartment Sales Corp., 144 Wn.2d 570, 581-82, 29 P.3d 1249 (2001).

The notice of intent requirement of RCW 7.70.100(1) is an exercise of the police power for the compelling state interests outlined in Sections 3(a) and (c) above. In fact, it creates a lesser burden than some types of restrictions that routinely pass constitutional muster, such as statutes of limitation and other presuit notices of intent.¹⁷ It is also one of the simplest and least expensive things that is done in connection with any litigation.

Ms. Ross's contention that RCW 7.70.100(1) is ineffective and that makes it unconstitutional must also be rejected. The Court's role is not to second guess or critique the Legislature. See Sofie v. Fibreboard Corp., 112 Wn.2d 636, 642, 771 P.2d 711 (1989). Nor is it to pass judgment on the wisdom of the statute. Id. The Court's only role is to determine whether the legislation at issue passes constitutional muster. Id.

And, when the constitutionality an act of the legislature is drawn in question, the court will not declare it void unless its invalidity is so apparent as to leave no reasonable doubt on the subject. . . .

¹⁷ For instance, since 2007, RCW 7.70.100(1) has extended the time to file suit: "the claimant shall have an additional five court days to commence the action."

Id. Ms. Ross has failed in her burden to prove unconstitutionality beyond a reasonable doubt here.

g. The Court of Appeals has already determined that RCW 7.70.100 does not violate equal protection.

Ms. Ross's combined and indistinguishable equal protection and due process argument is not briefed or argued with sufficient clarity or application to the facts to allow for detailed analysis. As with Ms. Ross's other constitutional challenges, this challenge could be rejected on that basis alone. Health Ins. Pool, 129 Wn.2d at 511-12 (court may decline to address constitutional issues inadequately briefed or argued).

To the extent it overlaps or restates arguments Ms. Ross stated elsewhere in her briefing, it should be rejected for the same reasons discussed in connection with those arguments. It also must be noted that in Waples, the plaintiff had contended that RCW 7.70.100's notice of intent requirement violated the right to equal protection, but this claim was unequivocally rejected by the Court of Appeals. The Court held:

Former RCW 7.70.100 rationally furthered a legitimate state purpose. In passing RCW 7.70.100, the legislature intended "to provide incentives to settle [medical malpractice] cases before resorting to court." Laws of 2006, ch. 8, § 1; *see also* § 314. Seeking to provide an incentive to settle before filing a medical negligence claim provides a legitimate state purpose and

limiting the notice requirement to medical negligence claimants is not an arbitrary classification in furtherance of that legitimate goal. The classification helps to achieve the policy's aims of facilitating settlement between a claimant and a medical professional in such claims. Accordingly, former RCW 7.70.100 did not violate equal protection.

Waples, 146 Wn. App. at 61 (footnotes omitted).

The Waples Court further noted that the statute had no effect on the statute of limitations because it allowed for tolling of the statute; thus, it treats all medical negligence claimants the same. Id. at 60. In the context of other presuit notice requirements, the Supreme Court has found this acceptable, and confirmed that no constitutional violation problem exists. See, e.g., Medina v. Pub. Utility Dist. No. 1 of Benton County, 147 Wn.2d 303, 53 P. 3d 993 (2002) (it is generally accepted that a purpose of the governmental claim-filing provisions of RCW 4.96.020 is to allow government entities time to investigate, evaluate, and settle claims; equal protection challenge and claim of creation of different classes rejected). As Justice Chambers explained in dissent in Medina:

In Daggs, we concluded that where the statute of limitations was not affected, the short 60-day buffer period between filing a claim and suit is reasonably related to achieving negotiated settlement. In other words, a short 60-day waiting period is a fair and reasonable means to accomplish the

limited and rational purpose of giving the government an opportunity to negotiate and settle claims.

Medina, 147 Wn.2d at 327 (internal citations omitted). The rationale of Medina and related cases, including their rejection of constitutional challenge to a presuit notice requirement, is equally applicable to this case.

Although Waples is currently on review by the Washington Supreme Court, it remains good law and it is consistent with other Washington cases. No significance should be attached to the decision to accept review, “since the decision whether or not to review a particular case derives from considerations other than [the Supreme Court’s] opinion of the merits.” Chrobuck v. Snohomish County, 78 Wn.2d 858, 886 n.5, 480 P.2d 489 (1971). Ms. Ross’s equal protection/due process argument should be rejected.

h. The Court of Appeals has already determined that RCW 7.70.100 does not violate the privileges and immunities clause.

In Breuer v. Presta, 148 Wn. App. 470, 476-77, 200 P.3d 724, petition for rev. pending, 2009 Wash. LEXIS 776 (2009),¹⁸ the Court of Appeals was asked to consider a challenge to RCW 7.70.100(1) based on Article I, Section 12 of the Washington constitution (i.e., a privileges and immunities challenge). The Court explained that “a legislative

¹⁸ The Supreme Court has deferred ruling on the petition for review in Breuer, pending the outcome of Waples.

classification will be invalidated under article I, section 12 of the Washington Constitution if the relationship between the classification and the legislative goal is so attenuated as to render the distinction arbitrary and irrational.” Id. (citing DeYoung v. Providence Med. Ctr., 136 Wn.2d 136, 149, 960 P.2d 919 (1998)). The Court then rejected the privileges and immunities challenge to RCW 7.70.100(1) because the statute “creates no arbitrary or irrational classification here because the time period helps achieve the policy’s aim ‘to settle [medical malpractice] cases before resorting to court.’” Breuer, 148 Wn. App. at 477 (citation omitted). As is explained above, this law also was passed as part of a collaborative effort to help to stem the decades long health care crisis in Washington and to benefit all of the citizens of the state. The Breuer Court was correct; there is no constitutional violation.

E. CONCLUSION

For the foregoing reasons, which include (1) Dr. Ries’s immunity from suit under RCW 71.05.120; (2) Ms. Ross’s failure to provide expert support for her claim; and (3) Ms. Ross’s failure to serve a presuit notice of intent as required by RCW 7.70.100(1), and those in the Co-Defendants/Respondents brief (which are incorporated by reference as if set out herein), Dr. and Mrs. Ries respectfully request that the order granting their motion for summary judgment be affirmed.

DATED this 28th day of December, 2009.

FAIN ANDERSON VANDERHOEF, PLLC



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Erin H. Hammond, WSBA #28777
Attorneys for Respondents Dr. and Mr. Ries

**WASHINGTON STATE SENATE
HEALTH & LONG TERM CARE
COMMITTEE HEARING
FEBRUARY 20, 2006**

**WASHINGTON STATE SENATE HEALTH &
LONG TERM CARE COMMITTEE HEARING**

February 20, 2006

Unofficial Transcription of the Audio Recording of Select Testimony¹

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¹ This unofficial transcription is provided for the Court's ease of reference, and is believed to be a true and accurate transcription. The emphasis in the transcription reflects an effort to capture the emphasis in the speakers' voices. A complete audio recording of the hearing is available at no charge at: <http://www.tvw.org/search/siteSearch.cfm?ByntType=C&keywords=Senate%20Health%20&date=2006&bhcp=1>

Senate Bill Report 2SHB 2292 dated February 22, 2006 is also included in this Appendix. On page 7, it lists all witnesses who testified at the hearing and the nature of the testimony.

Washington Governor Christine Gregoire:

Thank you Senator and members of the committee. I thought I would first do justice to those who come together over the last several weeks and describe briefly who they were for you, some of whom are here to testify before you today. From the Washington State Trial Lawyers Association, we had Larry Shannon, John Budlong, and Reed Schifferman. From the Washington State Hospital Association, Randy Revelle and Barbara Schickish. From the Washington State Medical Association, Dr. Peter Dunbar who is the current president, Len Eninger, and Dr. Ken Issacks who is the immediate past president. From Physicians Insurance Gary Morse. From the Washington State Bar Association Brooke Taylor and Gail Stone. And then from my office, Lucy Asaki and Marty Brown.

We divided the negotiations up, with regard to the three aspects of the bill. Patient safety and civil justice reform, I worked on with these folks as well as Secretary of Health Mary Selecki. And then, with respect to the insurance reform, that was separate. Those negotiations were separate with the insurance commissioner, Mike Kreidler. These folks that I just described to you, with me alone, put in at least five sessions of three hours. And then with me, five sessions of two hours each. And that doesn't include some pre-meetings.

They came to the table with much trepidation, as you might well imagine, but the negotiations were always very professional and always in good faith. And I will tell you what I think you will hear later, that what you have now is a bill that is better. It is complete. It is not everything that anyone at the table wanted. So there is more work to be done. And I will say for myself, I did not get everything I wanted, let alone did everyone else at the table get everything what they wanted.

But to put this all in perspective, we have looked around the country, at what is going on around the country, and most states are grappling with this issue. And to be perfectly honest with you, failing. So I think the fact that these people were able to come to the table, and negotiate with the paramount responsibility in mind that they had to be true to their patients and to the public at large is an example of why we were able to reach agreement today. I come on their behalf. We stand arm in arm. We are united in support of the striker to 2292.

We think that it is collectively a good bill in all three fronts that we had to deal with, but we do also believe there's more work to be done in the future. But with that, to be brief, I would urge your immediate consideration and passage of the striker of 2292. Thank you madam Chair.

Chair:

Thank you Governor very much, and I really do want to complement you on the effort you put forward to resolve this longstanding dispute and to put everyone at the same table and make everyone work on the level playing field there, so. Senator Deccio has a comment?

Senator Deccio: Governor I was going to say somewhat the same thing. I think the fact that you got everyone together makes you eligible for the medal of valor next year.

Laughter.

[Additional questions and comments omitted.]

Washington Representative Pat Lanz (prime sponsor of HB 2292):

Thank you Chair Kaiser, and to all the members of the committee. You know in your lifetime there aren't very many moments like this one. And I think I have kind of a silly grin on my face that won't erase. It started this morning.

2292 is a number that is etched in my brain. I have been here for ten years, and I *don't* remember bill numbers, but I will *always* remember this bill number. We laid a very good foundation when we started this process four years ago in the House, and then last year actually had the bill that kept that foundation of the three legged stool. We knew it was so important to have all three parts of this bill balanced. We need patient safety being front and center, but that leg of civil liability reform as well as insurance reform was equally important in order to keep the stool level.

After the initiative election this fall, it was so very clear that what the people were saying was that there are some issues that are just *way* too complex for us to deal with at the ballot box. And we elected you to take on these hard issues. So, that two or three days after the election, that was many telephone calls about how we should proceed. I never hesitated for a moment. I knew I had a responsibility to move forward. So that is why, that first week of session, if you will recall, we made some minor corrections in the bill that we had brought back from Rules, and sent it off the floor. We were hoping that what happened, would happen, that it took a detour to the Governor's office. And in there, with the very very capable hands of the Governor, we had *all* of those competing interests come together around the table and deal with, what I guess we could say the rough edges of the foundation and the walls of the structure. Or, I have a stool, of the legs of the stool that we had constructed.

So you will hear from them about how they were able to negotiate, how they were able to come to a compromise on some issues and in some instances just decide that they had to agree to disagree. But in any event, what we have here, is a product that meets standards of a legislative product in the *very* finest sense of the word. We *do* the work of compromise. That's what is our skill. That's our talent. And we *hope* that on occasion it reaches an art form. It is the art of compromise that we have seen here, and I am so very very pleased to bring you this striker amendment so that we can do what the people of the state of Washington asked us to do, which is legislate deliberately and thoughtfully in order to improve the lot of all of the citizens of Washington state.

Chair:

Thank you Representative Lanz. Appreciate your passion on this issue.

[Additional questions and comments omitted.]

John Budlong, Washington State Trial Lawyers Association Board Member:

Thank you madam chair. John Budlong on behalf of the Washington State Trial Lawyers. We also would *encourage* this body to enact Bill 2292 as written with the striker amendments. We also would like to thank our colleagues in the health care professions who have spent five sessions of three hours each discussing all aspects of 2292, particularly the liability provisions in *great* detail. These were candid, open, I think very friendly discussions, and I think the voters perhaps would want to know that after this last campaign. I think that we made a lot of progress in here in enacting *comprehensive* reform in patient safety, insurance reform, civil justice reform issues. We also would like to thank Representative Pat Lanz who has put this bill out as the vehicle, for the last, I believe it started four years ago, and finally, of course, for Governor Gregoire, I fully agree with Dr. Dunbar. I think without her gift for bringing opposing parties together that we would not be here today unanimously in favor of this bill as written. Thank you.

S. Brooke Taylor, Washington State Bar Association President:

Thank you madam chairman, members of the committee. My name is Brooke Taylor. I have practiced law in Port Angeles, Washington for 37 years, and I have to tell you I never thought I'd see this day.

I am here today in my capacity as President of the Washington State Bar Association. And I think it's important to distinguish that group from the other professional associations that are here at the table. The Washington State Bar Association is a mandatory organization. All 29,800 lawyers licensed to practice in this state belong to this association.

I have not been here to testify before and it is unlikely that I will be here again. The reason for that is because we have very severe constraints on taking positions on issues that have any significant political content at all. And this one certainly has over the years. However, it's also important to understand that very few of our members have anything to do with medical malpractice litigation. That having been said, all of our members -- all of the lawyers involved in this litigation do belong to our association, whether they represent physicians or patients. So, our positions have to be rather circumspect.

After the bitter initiative campaigns, I was searching for answers. And it seemed to me that the voters were telling all of us, among other things, that they wanted significant balanced reforms in how we resolved these disputes. And they were not at all interested in extremes or special interest legislation.

So, I wrote an article. It was called, "An Open Letter to Physicians: We Need to Talk." It was really a shot in the dark. The *very first* response I got was from the executive director of the Washington State Medical Association, within 24 hours, who said, "Yes. We need to talk. We're ready to talk."

Then Governor Gregoire, with her superb leadership, made it all happen. Doctors and lawyers sitting at the same table face to face, discussing these issues, which have for decades divided our professions, which have so much in common in every other respect.

I can tell you that the Washington State Bar Association endorses this bill as it is currently written, and we would urge this body to enact it. I can also tell you that Dr. Dunbar as president of his association and I as president of mine, have agreed to continue this dialogue, this engagement into the future, recognizing that there is still work to be done and this is *only* a start. But it is a *very, very* good start. Thank you.

Chair:

Thank you Mr. Taylor. And I am really pleased to hear that you are going to continue your conversations and your relationships that have been built.

SENATE BILL REPORT

2SHB 2292

FEBRUARY 22, 2006

SENATE BILL REPORT

2SHB 2292

As Reported By Senate Committee On:
Health & Long-Term Care, February 22, 2006

Title: An act relating to improving health care by increasing patient safety, reducing medical errors, reforming medical malpractice insurance, and resolving medical malpractice claims fairly without imposing mandatory limits on damage awards or fees.

Brief Description: Addressing health care liability reform.

Sponsors: House Committee on Judiciary (originally sponsored by Representatives Lantz, Cody, Campbell, Kirby, Flannigan, Williams, Linville, Springer, Clibborn, Wood, Fromhold, Morrell, Hunt, Moeller, Green, Kilmer, Conway, O'Brien, Sells, Kenney, Kessler, Chase, Upthegrove, Ormsby, Lovick, McCoy and Santos).

Brief History: Passed House: 1/23/06, 54-43.

Committee Activity: Health & Long-Term Care: 2/20/06, 2/22/06 [DPA].

SENATE COMMITTEE ON HEALTH & LONG-TERM CARE

Majority Report: Do pass as amended.

Signed by Senators Keiser, Chair; Thibaudeau, Vice Chair; Deccio, Ranking Minority Member; Benson, Brandland, Johnson, Kastama, Kline, Parlette and Poulsen.

Staff: Edith Rice (786-7444)

Background: Patient Safety

Statements of Apology: Under both a statute and a court rule, evidence of furnishing or offering to pay medical expenses needed as the result of an injury is not admissible in a civil action to prove liability for the injury. In addition, a court rule provides that evidence of offers of compromise are not admissible to prove liability for a claim. Evidence of conduct or statements made in compromise negotiations are likewise not admissible.

In 2002, the Legislature passed legislation that makes expressions of sympathy relating to the pain, suffering, or death of an injured person inadmissible in a civil trial. A statement of fault, however, is not made inadmissible under this provision.

Reports of Unprofessional Conduct: A provision of law gives immunity specifically to physicians, dentists, and pharmacists who in good faith file charges or present evidence of incompetency or gross misconduct against another member of their profession before the Medical Quality Assurance Commission, the Dental Quality Assurance Commission, or the Board of Pharmacy.

Medical Quality Assurance Commission Membership (MQAC): The MQAC is responsible for the regulation of physicians and physician assistants. This constitutes approximately 23,000

credentialed health care professionals. The MQAC currently has 19 members consisting of 13 licensed physicians, two physician assistants, and four members of the public.

Health Care Provider Discipline: The Uniform Disciplinary Act (UDA) governs disciplinary actions for all 57 categories of credentialed health care providers. The UDA defines acts of unprofessional conduct, establishes sanctions for such acts, and provides general procedures for addressing complaints and taking disciplinary actions against a credentialed health care provider. Responsibilities in the disciplinary process are divided between the Secretary of Health (Secretary) and the 16 health profession boards and commissions according to the profession that the health care provider is a member of and the relevant step in the disciplinary process.

Upon a finding of an act of unprofessional conduct, the Secretary or the board or commission decides which sanctions should be ordered. These sanctions include: revocation of a license, suspension of a license, restriction of the practice, mandatory remedial education or treatment, monitoring of the practice, censure or reprimand, conditions of probation, payment of a fine, and surrender of the license. In the selection of a sanction the first consideration is what is necessary to protect or compensate the public, and the second consideration is what may rehabilitate the license holder or applicant.

Disclosure of Adverse Events: A hospital is required to inform the Department of Health when certain events occur in its facility. These events include: unanticipated deaths or major permanent losses of function; patient suicides; infant abductions or discharges to the wrong family; sexual assault or rape; transfusions with major blood incompatibilities; surgery performed on the wrong patient or site; major facility system malfunctions; or fires affecting patient care or treatment. Hospitals must report this information within two business days of the hospital leaders learning of the event.

Coordinated Quality Improvement Programs: Hospitals maintain quality improvement committees to improve the quality of health care services and prevent medical malpractice. Quality improvement proceedings review medical staff privileges and employee competency, collect information related to negative health care outcomes, and conduct safety improvement activities. Provider groups and medical facilities other than hospitals are encouraged to conduct similar activities.

Insurance Industry Reform

Medical Malpractice Closed Claim Reporting: The Insurance Commissioner (Commissioner) is responsible for the licensing and regulation of insurance companies doing business in this state. This includes insurers offering coverage for medical malpractice. There is no statutory requirement for insurers to report to the Commissioner information about medical malpractice claims, judgments, or settlements.

Cancellation or Non-Renewal of Liability Insurance Policies: With certain exceptions, state insurance law requires insurance policies to be renewable. An insurer is exempt from this requirement if the insurer provides the insured with a cancellation notice that is delivered or mailed to the insured no fewer than 45 days before the effective date of the cancellation. Shorter notice periods apply for cancellation based on nonpayment of premiums (10 days) and for cancellation of fire insurance policies under certain circumstances (five days). The written notice must state the actual reason for cancellation of the insurance policy.

Prior Approval of Medical Malpractice Insurance Rates: The forms and rates of medical malpractice policies are "use and file." After issuing any policy, an insurer must file the forms and rates with the Commissioner within 30 days. Rates and forms are subject to public disclosure when the filing becomes effective. Actuarial formulas, statistics, and assumptions submitted in support of the filing are not subject to public disclosure.

Health Care Liability Reform

Statutes of Limitations and Repose: A medical malpractice action must be brought within time limits specified in statute, called the statute of limitations. Generally, a medical malpractice action must be brought within three years of the act or omission or within one year of when the claimant discovered or reasonably should have discovered that the injury was caused by the act or omission, whichever period is longer.

The statute of limitations is tolled during minority. This means that the three-year period does not begin to run until the minor reaches the age of 18. An injured minor will therefore always have until at least the age of 21 to bring a medical malpractice action.

The statute also provides that a medical malpractice action may never be commenced more than eight years after the act or omission. This eight-year outside time limit for bringing an action is called a "statute of repose." In the 1998 Washington Supreme Court decision *DeYoung v. Providence Medical Center*, the eight-year statute of repose was held unconstitutional on equal protection grounds.

Certificate of Merit: A lawsuit is commenced either by filing a complaint or service of summons and a copy of the complaint on the defendant. The complaint is the plaintiff's statement of his or her claim against the defendant. The plaintiff is generally not required to plead detailed facts in the complaint; rather, the complaint may contain a short and plain statement that sets forth the basic nature of the claim and shows that the plaintiff is entitled to relief.

There is no requirement that a plaintiff instituting a civil action file an affidavit or other document stating that the action has merit. However, a court rule requires that the pleadings in a case be made in good faith (Civil Rule 11). An attorney or party signing the pleading certifies that he or she has objectively reasonable grounds for asserting the facts and law. The court may assess attorneys' fees and costs against a party if the court finds that the pleading was made in bad faith, or to harass or cause unnecessary delay or needless expense.

Voluntary Arbitration: Parties to a dispute may voluntarily agree in writing to enter into binding arbitration to resolve the dispute. A procedural framework for conducting the arbitration proceeding is provided in statute, including provisions relating to appointment of an arbitrator, attorney representation, witnesses, depositions, and awards. The arbitrator's decision is final and binding on the parties and there is no right of appeal. A court's review of an arbitration decision is limited to correction of an award or vacation of an award under limited circumstances.

Collateral Sources: In the context of tort actions, "collateral sources" are sources of payments or benefits available to the injured person that are totally independent of the tortfeasor. Examples of collateral sources are health insurance coverage, disability insurance, or sick

leave. Under the common law "collateral source rule," a defendant is barred from introducing evidence that the plaintiff has received collateral source compensation for the injury.

The traditional collateral source rule has been modified in medical malpractice actions. In a medical malpractice action, any party may introduce evidence that the plaintiff has received compensation for the injury from collateral sources, except those purchased with the plaintiff's assets (e.g., insurance plan payments). The plaintiff may present evidence of an obligation to repay the collateral source compensation.

Summary of Amended Bill: The Legislature finds that addressing the issues of consumer access to health care and the increasing costs of medical malpractice insurance requires comprehensive solutions that encourage patient safety, increase oversight of medical malpractice insurance, and making the civil justice system more understandable, fair, and efficient. The Legislature intends to prioritize patient safety and the prevention of medical errors, to provide incentives to settle cases prior to going to court, and to provide the insurance commissioner with tools and information necessary to regulate medical malpractice insurance rates and policies so they are fair to insurers and the insured.

Part I

PATIENT SAFETY

Statements of Apology: In a medical negligence action, a statement of fault, apology, or sympathy, or a statement of remedial actions that may be taken, is not admissible as evidence if the statement was conveyed by a health care provider to the injured person or certain family members within 30 days of the act or within 30 days of the time the health care provider discovered the act, whichever is longer.

Reports of Unprofessional Conduct: A health care professional who makes a good faith report, files charges, or presents evidence to a disciplining authority against another member of a health profession relating to unprofessional conduct or inability to practice safely due to a physical or mental condition is immune in a civil action for damages resulting from such good faith activities. A health care professional who prevails in a civil action on the good faith defense is entitled to recover expenses and reasonable attorneys' fees incurred in establishing the defense.

Medical Quality Assurance Commission (MQAC): The public membership component of the MQAC is increased from four to six members, and at least two of the public members must not be from the health care industry.

Health Care Provider Discipline: When imposing a sanction, a health profession disciplining authority may consider prior findings of unprofessional conduct, stipulations to informal disposition, and the actions of other Washington or out-of-state disciplining authorities.

Adverse health event : "Adverse event" is defined as the list of serious reportable events adopted by the national quality forum in 2002. "Incident" is defined as a situation involving patient care which results in an unanticipated injury not part of the patient's illness, or a situation which could result in injury or require additional health care services but did not. Other definitions are provided.

Adverse Event Notification: Medical facilities must notify the Department of Health (DOH) within 48 hours of confirmation that an adverse event has occurred. A report must be submitted to the DOH within 45 days after confirmation that an adverse event has occurred. If DOH determines that an adverse event has not been reported or investigated, DOH will direct the facility to report or investigate it.

Independent entity to receive notification of adverse events and incidents: DOH will contract with an independent entity to develop an internet based system for reporting adverse events by facilities immediately available to DOH. The system will protect confidentiality, and the independent entity will develop recommendations for changes in health care practices for the purpose of reducing the number and severity of adverse events.

Whistleblower protection: An adverse event or incidents are specifically mentioned as information for which whistleblowers are protected if reported to DOH in good faith.

Confidentiality: Notification or reports of adverse events or are subject to the confidentiality provisions in current law and are exempt from public disclosure.

Prescription Legibility: Prescriptions for legend drugs must either be hand-printed, typewritten, or generated electronically.

Part II

INSURANCE INDUSTRY REFORM

Medical Malpractice Closed Claim Reporting: Self-insurers and insuring entities that write medical malpractice insurance are required to report any closed claim to the Office of the Insurance Commissioner (OIC). OIC may fine those who violate this requirement, up to \$250 per day. The reports must contain specified data that is (to the extent possible) consistent with the format for data reported to the national practitioner data bank.

The Office of the Commissioner is required to prepare aggregate statistical summaries of closed claims based on the data submitted, while protecting the confidentiality of the underlying data.

OIC must prepare an annual report starting in 2010 which should include an analysis of closed claim information and any information the Commissioner finds is relevant to trends in medical malpractice. OIC will monitor losses and claim development patterns in the Washington state medical malpractice insurance market.

If the National Association of Insurance Commissioners adopts revised model statistical reporting standards for medical malpractice insurance, the OIC must analyze them and report any changes and recommendations to the Legislature by December 1, the year after they are adopted.

Written notice of a medical malpractice policy non-renewal must be delivered or mailed to the named insured at least 90 days before policy expiration and must include the actual reason for refusing to renew.

Medical malpractice policy forms or application forms are subject to the requirements under current law which must be filed with and approved by the OIC unless exempted from doing so by rule.

Part III

HEALTH CARE LIABILITY REFORM

Statutes of Limitations and Repose:

The eight-year statute of repose is re-established. Legislative intent and findings regarding the justification for a statute of repose are provided in response to the Washington Supreme Court's decision overturning the statute of repose in *DeYoung v. Providence Medical Center*. This means that a civil action for injury from health care must be commenced within three years of the act causing injury or within one year of the time that the patient discovered the injury or should have discovered the injury, whichever is later. However, this cannot be more than eight years after the original act causing the injury.

There are exceptions for fraud or intentional concealment until the date the patient has actual knowledge of the act of fraud or concealment, then they have one year from knowledge of the fraud or concealment. Knowledge of a custodial parent or guardian is imputed to a minor (person under 18 years of age). This means that tolling of the statute of limitations during minority is eliminated. Any actions not meeting these requirements are barred.

Certificate of Merit: In medical negligence actions involving a claim of a breach of the standard of care, the plaintiff must file a certificate of merit at the time of commencing the action (or no later than 45 days after filing the action if the action is filed 45 days prior to the running of the statute of limitations). If there is more than one defendant, a certificate of merit must be filed for each defendant. The person executing the certificate of merit must state that there is reasonable probability that the defendant's conduct did not follow the accepted standard of care required.

Failure to file a certificate of merit that complies with these requirements results in dismissal of the case. If a case is dismissed for failure to comply with the certificate of merit requirements, the filing of the claim may not be used against the health care provider in liability insurance rate settings, personal credit history, or professional licensing or credentialing.

Voluntary Arbitration: A voluntary arbitration system is established for disputes involving alleged professional negligence in the provision of health care. The voluntary arbitration system may be used only where all parties have agreed to submit the dispute to voluntary arbitration once the suit is filed, either through the initial complaint and answer, or after the commencement of the suit upon stipulation by all parties.

Arbitration award: The maximum award an arbitrator can make is limited to \$1 million for both economic and non-economic damages. In addition, the arbitrator may not make an award of damages based on the "ostensible agency" theory of vicarious liability (an agency created by operation of law - a principle's actions would reasonably lead a third party to conclude that an agency relationship existed). Fees and expenses shall be paid by the non-prevailing party.

Appeal: There is no right to a trial de novo on an appeal of the arbitrator's decision. An appeal is limited to the bases for appeal provided under the current arbitration statute for vacation of an award under circumstances where there was corruption or misconduct, or for modification or correction of an award to correct evident mistakes.

Notice: Ninety days notice of intent to file a lawsuit is required if the lawsuit is based on a health care provider's professional negligence. Mandatory mediation does not apply to parties who have agreed to arbitration.

Collateral Sources: The collateral source payment statute is amended to remove the restriction on presenting evidence of collateral source payments that come from insurance purchased by the plaintiff. The plaintiff, however, may introduce evidence of amounts paid to secure the right to the collateral source payments (e.g., premiums).

Frivolous Lawsuits: When signing and filing a claim, counterclaim, cross claim, or defense, an attorney must certify that the claim or defense is not frivolous. An attorney who signs a filing in violation of this section is subject to sanctions, including an order to pay reasonable expenses and reasonable attorneys' fees incurred by the other party.

Amended Bill Compared to Second Substitute Bill: The amended bill provides that statements of fault or apology are not admissible if conveyed within 30 days of the act, no longer contains a reference to mandatory revocation of a health care professional license. Adverse events are defined and reporting requirements for adverse events are described. The amended bill removes the reference to burden of proof for license suspension or revocation, and deletes the reference to business and occupation tax credits for physicians treating the uninsured. Reference to filing underwriting standards is removed, the limitation on number of expert witnesses is deleted, as is the reference to offers of settlement. A 90 day notice of intent to file a medical malpractice lawsuit is required.

Appropriation: None.

Fiscal Note: Available.

Committee/Commission/Task Force Created: No.

Effective Date: Ninety days after adjournment of session in which bill is passed.

Testimony For: This bill is an improvement, but not necessarily everything everyone wanted. There is more work to be done in the future, but this is a good start. This bill has appropriate trade-offs. This bill will allow us to be better prepared for future changes. Real data will allow us to make meaningful changes in the future. This is an important first step. We fully support the striking amendment. This is an important step towards comprehensive reform. We have agreed to continue the dialogue started with this striking amendment. We have concerns about the additional data required. This will add cost, and we have concerns about the penalties in this bill.

Testimony Against: None.

Who Testified: PRO: Governor Christine Gregoire; Insurance Commissioner Mike Kreidler; Representative Pat Lantz, Prime sponsor; Randy Revelle, Washington State Hospital Association; Peter Dunbar, MD, Washington State Medical Association; John Budlong, Washington State Trail Lawyers Association; Mary Selecky, Secretary, Department of Health; Gary Morse, Physicians Insurance; S. Brooke Taylor, Washington State Bar Association; Tom Parker, Surplus Lines; Mike Kapplohn, Farmers Insurance.

COURT OF APPEALS
OF THE STATE OF WASHINGTON
DIVISION ONE

JENNIFER ROSE ROSS, an
individual,,

Plaintiff,

v.

PEACEHEALTH d.b.a. ST.
JOSEPH HOSPITAL, a Washington
Public Benefit Corporation; and
ROBERT JOHNSON and JANE
DOE JOHNSON, husband and wife,
and the marital community
composed thereof; JEFFREY RIES
and JANE DOE RIES, husband and
wife, and the marital community
composed thereof;

Defendants.

No. 63973-1-1

Trial Court No. 07-2-02163-5

DECLARATION OF MAILING

2009 DEC 30 PM 4: 54

FILED
COURT OF APPEALS DIV. #1
STATE OF WASHINGTON

I, DANA EMERSON, hereby certify that on the 30th day of December,
2009, I served a copy of the following document:

➤ Brief of Respondents Jeffrey Ries, M.D. and Jane Doe Ries
upon counsel by having a true and correct copy of the same, with this
Declaration, delivered to the business offices of said attorneys below:

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Counsel for Appellants.

DATED this 30th day of December, 2009.

By: 
Dana Emerson