Chapter 7.70 RCW
ACTIONS FOR INJURIES RESULTING FROM HEALTH CARE

Sections

Complaint in personal injury actions not to include statement of damages: RCW 4.28.360.

Evidence of furnishing or offering to pay medical expenses inadmissible to prove liability in personal injury actions for medical negligence: Chapter 5.64 RCW.

Immunity of members of professional review committees, societies, examining, licensing or disciplinary boards from civil suit: RCW 4.24.240.

Malpractice insurance for retired physicians providing health care services: RCW 43.70.460.

Statute of limitations in actions for injuries resulting from health care: RCW 4.16.350.

Verdict or award of future economic damages in personal injury or property damage action may provide for periodic payments: RCW 4.56.260.

RCW 7.70.010 Declaration of modification of actions for damages based upon injuries resulting from health care. The state of Washington, exercising its police and sovereign power, hereby modifies as set forth in this chapter and in RCW 4.16.350, as now or hereafter amended, certain substantive and procedural aspects of all civil actions and causes of action, whether based on tort, contract, or otherwise, for damages for injury occurring as a result of health care which is provided after June 25, 1976. [1975-'76 2nd ex.s. c 56 § 6.]

Severability—1975-'76 2nd ex.s. c 56: See note following RCW 4.16.350.

RCW 7.70.020 Definitions. As used in this chapter "health care provider" means either:

(1) A person licensed by this state to provide health care or related services including, but not limited to, an acupuncturist or acupuncture and Eastern medicine practitioner, a physician, osteopathic physician, dentist, nurse, optometrist, podiatric physician and surgeon, chiropractor, physical therapist, psychologist, pharmacist, optician, physician assistant, midwife, osteopathic physician's assistant, nurse practitioner, or physician's trained mobile intensive care paramedic, including, in the event such person is deceased, his or her estate or personal representative;

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

(3) An entity, whether or not incorporated, facility, or institution employing one or more persons described in part (1) above, including, but not limited to, a hospital, clinic, health maintenance organization, or nursing home; or an officer, director, employee, or agent thereof acting in the course and scope of his or her employment, including in the event such officer, director, employee, or agent is deceased, his or her estate or personal representative. [2019 c 308 § 16; 2010 c 286 § 13; 1995 c 323 § 3; 1985 c 326 § 27; 1981 c 53 § 1; 1975-'76 2nd ex.s. c 56 § 7.]

Findings—2019 c 308: See note following RCW 18.06.010.

Intent—2010 c 286: See RCW 18.06.005.

Effective date—1981 c 53: See note following RCW 18.50.005.

Severability—1975-'76 2nd ex.s. c 56: See note following RCW 4.16.350.

RCW 7.70.030 Propositions required to be established—Burden of proof. No award shall be made in any action or arbitration for damages for injury occurring as the result of health care which is provided after June 25, 1976, unless the plaintiff establishes one or more of the following propositions:

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

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

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

Unless otherwise provided in this chapter, the plaintiff shall have the burden of proving each fact essential to an award by a preponderance of the evidence. [2011 c 336 § 250; 1975-'76 2nd ex.s. c 56 § 8.]

Severability—1975-'76 2nd ex.s. c 56: See note following RCW 4.16.350.

RCW 7.70.040 Necessary elements of proof that injury resulted from failure to follow accepted standard of care—COVID-19 pandemic. (1) The following shall be necessary elements of proof that injury resulted from the failure of the health care provider to follow the accepted standard of care:

(a) The health care provider failed to exercise that degree of care, skill, and learning expected of a reasonably prudent health care provider at that time in the profession or class to which he or she belongs, in the state of Washington, acting in the same or similar circumstances;

(b) Such failure was a proximate cause of the injury complained of.

(2)(a) The following shall be necessary elements of proof that injury resulted from the failure of a health care provider to follow the accepted standard of care in acting or failing to act following the proclamation of a state of emergency in all counties in the state of Washington by the governor in response to the COVID-19 pandemic on February 29, 2020, and until the state of emergency is terminated:

(i) The health care provider failed to exercise that degree of care, skill, and learning expected of a reasonably prudent health care provider at that time in the profession or class to which he or she belongs, in the state of Washington, acting in the same or similar circumstances, taking into account whether the act or omission:

(A) Was in good faith based upon guidance, direction, or recommendations, including in interim or preliminary form, published by the federal government, the state of Washington or departments, divisions, agencies, or agents thereof, or local governments in the state of Washington or departments, divisions, agencies, or agents thereof, in response to the COVID-19 pandemic and applicable to such health care provider; or

(B) Was due to a lack of resources including, but not limited to, available facility capacity, staff, and supplies, directly attributable to the COVID-19 pandemic;

(ii) Such failure was a proximate cause of the injury complained of.

(b) The provisions in (a) of this subsection apply only if relevant to the determination of whether the health care provider followed the standard of care, as determined by the court.

(c) If any health care provider presents evidence described in (a) of this subsection, the injured patient or the patient's representative is permitted to present rebuttal evidence, so long as such evidence is otherwise admissible. [2021 c 241 § 2; 2011 c 336 § 251; 1983 c 149 § 2; 1975-'76 2nd ex.s. c 56 § 9.]

Findings—Intent—2021 c 241: "(1) The legislature finds that the COVID-19 pandemic, a public health crisis, has placed an oversized burden on Washington's health care providers and health care facilities, as they care for communities and families.

(2) The legislature further finds that during the pandemic, the law should accurately reflect the realities of the challenging practice conditions. It is fair and appropriate to give special consideration to the challenges arising during the pandemic, such as evolving and sometimes conflicting direction from health officials regarding treatment for COVID-19 infected patients, supply chain shortages of personal protective equipment and testing supplies, and a proclamation on nonurgent procedures resulting in delayed or missed health screenings and diagnoses.

(3) The legislature intends, during the period of the declared state of emergency due to the COVID-19 pandemic, to amend the current standard of care law governing health care providers to give special consideration to additional relevant factors." [2021 c 241 § 1.]

Effective date—2021 c 241: "This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect immediately [May 10, 2021]." [2021 c 241 § 3.]

Severability—1975-'76 2nd ex.s. c 56: See note following RCW 4.16.350.

RCW 7.70.050 Failure to secure informed consent—Necessary elements of proof—Emergency situations. (1) The following shall be necessary elements of proof that injury resulted from health care in a civil negligence case or arbitration involving the issue of the alleged breach of the duty to secure an informed consent by a patient or his or her representatives against a health care provider:

(a) That the health care provider failed to inform the patient of a material fact or facts relating to the treatment;

(b) That the patient consented to the treatment without being aware of or fully informed of such material fact or facts;

(c) That a reasonably prudent patient under similar circumstances would not have consented to the treatment if informed of such material fact or facts;

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

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

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

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

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

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

(d) The recognized serious possible risks, complications, and anticipated benefits involved in the treatment administered and in the

recognized possible alternative forms of treatment, including nontreatment.

(4) If a recognized health care emergency exists and the patient does not have the capacity to give an informed consent and/or a person legally authorized to consent on behalf of the patient is not readily available, his or her consent to required treatment will be implied. [2021 c 270 § 2; 2011 c 336 § 252; 1975-'76 2nd ex.s. c 56 § 10.]

Effective date—2021 c 270: See note following RCW 7.70.065.

Severability—1975-'76 2nd ex.s. c 56: See note following RCW 4.16.350.

RCW 7.70.060 Consent form—Contents—Prima facie evidence—Shared decision making—Patient decision aid—Failure to use. (1) If a patient who has capacity to make health a care [a health care] decision, or his or her representative if he or she does not have the capacity to make a health care decision, signs a consent form which sets forth the following, the signed consent form shall constitute prima facie evidence that the patient gave his or her informed consent to the treatment administered and the patient has the burden of rebutting this by a preponderance of the evidence:

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

(i) The nature and character of the proposed treatment;

(ii) The anticipated results of the proposed treatment;

(iii) The recognized possible alternative forms of treatment; and

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

(b) Or as an alternative, a statement that the patient elects not to be informed of the elements set forth in (a) of this subsection.

(2) If a patient who has capacity to make a health care decision, or his or her representative if he or she does not have the capacity to make a health care decision, signs an acknowledgment of shared decision making as described in this section, such acknowledgment shall constitute prima facie evidence that the patient gave his or her informed consent to the treatment administered and the patient has the burden of rebutting this by clear and convincing evidence. An acknowledgment of shared decision making shall include:

(a) A statement that the patient, or his or her representative, and the health care provider have engaged in shared decision making as an alternative means of meeting the informed consent requirements set forth by laws, accreditation standards, and other mandates;

(b) A brief description of the services that the patient and provider jointly have agreed will be furnished;

(c) A brief description of the patient decision aid or aids that have been used by the patient and provider to address the needs for (i) high quality, up-to-date information about the condition, including risk and benefits of available options and, if appropriate, a discussion of the limits of scientific knowledge about outcomes; (ii) values clarification to help patients sort out their values and preferences; and (iii) guidance or coaching in deliberation, designed to improve the patient's involvement in the decision process;

(d) A statement that the patient or his or her representative understands: The risk or seriousness of the disease or condition to be prevented or treated; the available treatment alternatives, including nontreatment; and the risks, benefits, and uncertainties of the treatment alternatives, including nontreatment; and

(e) A statement certifying that the patient or his or her representative has had the opportunity to ask the provider questions, and to have any questions answered to the patient's satisfaction, and indicating the patient's intent to receive the identified services.

(3) As used in this section, "shared decision making" means a process in which the physician or other health care practitioner discusses with the patient or his or her representative the information specified in subsection (2) of this section with the use of a patient decision aid and the patient shares with the provider such relevant personal information as might make one treatment or side effect more or less tolerable than others.

(4)(a) As used in this section, "patient decision aid" means a written, audiovisual, or online tool that provides a balanced presentation of the condition and treatment options, benefits, and harms, including, if appropriate, a discussion of the limits of scientific knowledge about outcomes, for any medical condition or procedure, including abortion as defined in RCW 9.02.170 and:

(i)(A) That is certified by one or more national certifying organizations recognized by the medical director of the health care authority; or

(B) That has been evaluated based on the international patient decision aid standards by an organization located in the United States or Canada and has a current overall score satisfactory to the medical director of the health care authority; or

(ii) That, if a current evaluation is not available from an organization located in the United States or Canada, the medical director of the health care authority has independently assessed and certified based on the international patient decision aid standards.

(b) The health care authority may charge a fee to the certification applicant to defray the costs of the assessment and certification under this subsection.

(5) Failure to use a form or to engage in shared decision making, with or without the use of a patient decision aid, shall not be admissible as evidence of failure to obtain informed consent. There shall be no liability, civil or otherwise, resulting from a health care provider choosing either the signed consent form set forth in subsection (1)(a) of this section or the signed acknowledgment of shared decision making as set forth in subsection (2) of this section. [2021 c 270 § 3; 2012 c 101 § 1; 2007 c 259 § 3; 1975-'76 2nd ex.s. c 56 § 11.]

Effective date—2021 c 270: See note following RCW 7.70.065.

Severability—Subheadings not law—2007 c 259: See notes following RCW 41.05.033.

Severability—1975-'76 2nd ex.s. c 56: See note following RCW 4.16.350.

Minors
access to personal records: RCW 42.48.020.

liability of provider: RCW 26.09.310.
mental health treatment: Chapter 71.34 RCW.
sexually transmitted diseases: RCW 70.24.110.

Records, rights: RCW 70.02.130.

RCW 7.70.065 Informed consent—Persons authorized to provide for patients who do not have capacity—Priority—Unaccompanied homeless minors. (1) Informed consent for health care for a patient who does not have the capacity to make a health care decision may be obtained from a person authorized to consent on behalf of such patient. For purposes of this section, a person who is of the age of consent to make a particular health care decision is presumed to have capacity, unless a health care provider reasonably determines the person lacks capacity to make the health care decision due to the person's demonstrated inability to understand and appreciate the nature and consequences of a health condition, the proposed treatment, including the anticipated results, benefits, risks, and alternatives to the proposed treatment, including nontreatment, and reach an informed decision as a result of cognitive impairment; and the health care provider documents the basis for the determination in the medical record.

(a) Persons authorized to provide informed consent to health care on behalf of an adult patient who does not have the capacity to make a health care decision shall be a member of one of the following classes of persons in the following order of priority:

(i) The appointed guardian of the patient, if any;

(ii) The individual, if any, to whom the patient has given a durable power of attorney that encompasses the authority to make health care decisions;

(iii) The patient's spouse or state registered domestic partner;

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

(v) Parents of the patient;

(vi) Adult brothers and sisters of the patient;

(vii) Adult grandchildren of the patient who are familiar with the patient;

(viii) Adult nieces and nephews of the patient who are familiar with the patient;

(ix) Adult aunts and uncles of the patient who are familiar with the patient; and

(x)(A) An adult who:

(I) Has exhibited special care and concern for the patient;

(II) Is familiar with the patient's personal values;

(III) Is reasonably available to make health care decisions;

(IV) Is not any of the following: A physician to the patient or an employee of the physician; the owner, administrator, or employee of a health care facility, nursing home, or long-term care facility where the patient resides or receives care; or a person who receives compensation to provide care to the patient; and

(V) Provides a declaration under (a)(x)(B) of this subsection.

(B) An adult who meets the requirements of (a)(x)(A) of this subsection shall provide a declaration, which is effective for up to six months from the date of the declaration, signed and dated under penalty of perjury pursuant to chapter 5.50 RCW, that recites facts

and circumstances demonstrating that he or she is familiar with the patient and that he or she:

(I) Meets the requirements of (a)(x)(A) of this subsection;

(II) Is a close friend of the patient;

(III) Is willing and able to become involved in the patient's health care;

(IV) Has maintained such regular contact with the patient as to be familiar with the patient's activities, health, personal values, and morals; and

(V) Is not aware of a person in a higher priority class willing and able to provide informed consent to health care on behalf of the patient.

(C) A health care provider may, but is not required to, rely on a declaration provided under (a)(x)(B) of this subsection. The health care provider or health care facility where services are rendered is immune from suit in any action, civil or criminal, or from professional or other disciplinary action when such reliance is based on a declaration provided in compliance with (a)(x)(B) of this subsection.

(b) If the health care provider seeking informed consent for proposed health care of the patient who does not have the capacity to make a particular health care decision, other than a person who is under the age of consent for the particular health care decision, makes reasonable efforts to locate and secure authorization from a competent person in the first or succeeding class and finds no such person available, authorization may be given by any person in the next class in the order of descending priority. However, no person under this section may provide informed consent to health care:

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

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

(c) Before any person authorized to provide informed consent on behalf of a patient who does not have the capacity to make a health care decision exercises that authority, the person must first determine in good faith that that patient, if he or she had the capacity to make the health care decision, would consent to the proposed health care. If such a determination cannot be made, the decision to consent to the proposed health care may be made only after determining that the proposed health care is in the patient's best interests. This subsection (1)(c) does not apply to informed consent provided on behalf of a patient who has not reached the age of consent required to make a particular health care decision.

(d) No rights under Washington's death with dignity act, chapter 70.245 RCW, may be exercised through a person authorized to provide informed consent to health care on behalf of a patient who does not have the capacity to make a health care decision.

(2) Informed consent for health care, including mental health care, for a patient who is under the age of majority and who is not otherwise authorized to provide informed consent, may be obtained from a person authorized to consent on behalf of such a patient.

(a) Persons authorized to provide informed consent to health care, including mental health care, on behalf of a patient who is under the age of majority and who is not otherwise authorized to provide informed consent, shall be a member of one of the following classes of persons in the following order of priority:

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

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

(iii) Parents of the minor patient;

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

(v) A competent adult representing himself or herself to be a relative responsible for the health care of such minor patient or a competent adult who has signed and dated a declaration under penalty of perjury pursuant to chapter 5.50 RCW stating that the adult person is a relative responsible for the health care of the minor patient. Such declaration shall be effective for up to six months from the date of the declaration.

(b)(i) Informed consent for health care on behalf of a patient who is under the age of majority and who is not otherwise authorized to provide informed consent may be obtained from a school nurse, school counselor, or homeless student liaison when:

(A) Consent is necessary for nonemergency, outpatient, primary care services, including physical examinations, vision examinations and eyeglasses, dental examinations, hearing examinations and hearing aids, immunizations, treatments for illnesses and conditions, and routine follow-up care customarily provided by a health care provider in an outpatient setting, excluding elective surgeries;

(B) The minor patient meets the definition of a "homeless child or youth" under the federal McKinney-Vento homeless education assistance improvements act of 2001, P.L. 107-110, January 8, 2002, 115 Stat. 2005; and

(C) The minor patient is not under the supervision or control of a parent, custodian, or legal guardian, and is not in the care and custody of the department of social and health services.

(ii) A person authorized to consent to care under this subsection (2)(b) and the person's employing school or school district are not subject to administrative sanctions or civil damages resulting from the consent or nonconsent for care, any care, or payment for any care, rendered pursuant to this section. Nothing in this section prevents a health care facility or a health care provider from seeking reimbursement from other sources for care provided to a minor patient under this subsection (2)(b).

(iii) Upon request by a health care facility or a health care provider, a person authorized to consent to care under this subsection (2)(b) must provide to the person rendering care a declaration signed and dated under penalty of perjury pursuant to chapter 5.50 RCW stating that the person is a school nurse, school counselor, or homeless student liaison and that the minor patient meets the elements under (b)(i) of this subsection. The declaration must also include written notice of the exemption from liability under (b)(ii) of this subsection.

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

responsible for the health care of the minor patient, or person claiming to be authorized to consent to the health care of the minor patient.

(d) A health care facility or a health care provider may, in its discretion, require documentation of a person's claimed status as being a relative responsible for the health care of the minor patient, or a person claiming to be authorized to consent to the health care of the minor patient under (b) of this subsection. However, there is no obligation to require such documentation.

(e) The health care provider or health care facility where services are rendered shall be immune from suit in any action, civil or criminal, or from professional or other disciplinary action when such reliance is based on a declaration signed under penalty of perjury pursuant to chapter 5.50 RCW stating that the adult person is a relative responsible for the health care of the minor patient under (a)(v) of this subsection, or a person claiming to be authorized to consent to the health care of the minor patient under (b) of this subsection.

(3) An unaccompanied homeless youth who is under the age of majority, who is not otherwise authorized to provide informed consent, and is unable to obtain informed consent under subsection (2)(b)(i) of this section is authorized to provide informed consent for nonemergency, outpatient, primary care services, including physical examinations, vision examinations and eyeglasses, dental examinations, hearing examinations and hearing aids, immunizations, treatments for illnesses and conditions, and routine follow-up care customarily provided by a health care provider in an outpatient setting, excluding elective surgeries.

(a) For purposes of this subsection:

(i) "Unaccompanied" means a youth experiencing homelessness while not in the physical custody of a parent or guardian.

(ii) "Homeless" means without a fixed, regular, and adequate nighttime residence as set forth in the federal McKinney-Vento homeless education assistance improvements act of 2001, P.L. 107-110, January 8, 2002, 115 Stat. 2005.

(b) A health care facility or a health care provider may, in its discretion, require documentation that the minor patient under this subsection (3) is an unaccompanied homeless youth. However, there is no obligation to require such documentation. Acceptable documentation that a minor patient is an unaccompanied homeless youth includes a written or electronic statement signed under penalty of perjury pursuant to chapter 5.50 RCW by:

(i) Staff at a governmental or nonprofit human services agency or homeless services agency;

(ii) An attorney representing the minor patient; or

(iii) An adult relative of the minor patient or other adult with knowledge of the minor patient and the minor patient's housing situation.

(c) A health care provider may, but is not required to, rely on the representations or declaration stating that the patient is an unaccompanied homeless youth, if the health care provider does not have actual notice of the falsity of any of the statements made by the person claiming to be authorized to consent to the health care of the minor patient.

(d) The health care provider or health care facility where services are rendered is immune from suit in any action, civil or criminal, and from professional or other disciplinary action when such

reliance is based on a declaration signed under penalty of perjury pursuant to chapter 5.50 RCW stating that the patient is an unaccompanied homeless youth under (b) of this subsection, or is based on the statement of a minor patient regarding the minor patient's housing situation.

(e) A person who provides a statement for documentation that the minor patient is an unaccompanied homeless youth is not subject to administrative sanctions or civil liability for providing documentation in good faith based upon the person's knowledge of the minor patient and the minor patient's housing situation.

(f) During a visit with an unaccompanied homeless youth who provides informed consent authorized under this subsection (3), a primary care provider as defined under RCW 74.09.010 shall use existing best practices that align with any guidelines developed by the office of crime victims advocacy established in RCW 43.280.080 and the commercially sexually exploited children statewide coordinating committee established under RCW 7.68.801 designed to identify:

(i) Whether the unaccompanied homeless youth may be a victim of human trafficking; and

(ii) Potential referral to additional services, the department of children, youth, and families, or law enforcement.

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

(5) A person who knowingly provides a false declaration under this section shall be subject to criminal penalties under chapter 9A.72 RCW. [2022 c 291 § 1; 2021 c 270 § 1; 2020 c 312 § 705. Prior: 2019 c 232 § 8; 2019 c 209 § 1; 2017 c 275 § 1; 2007 c 156 § 11; 2006 c 93 § 1; 2005 c 440 § 2; 2003 c 283 § 29; 1987 c 162 § 1.]

Effective date—2021 c 270: "This act takes effect January 1, 2022." [2021 c 270 § 6.]

Effective dates—2020 c 312: See note following RCW 11.130.915.

Intent—2005 c 440: "(1) It is the intent of the legislature to assist children in the care of kin to access appropriate medical services. Children being raised by kin have faced barriers to medical care because their kinship caregivers have not been able to verify that they are the identified primary caregivers of these children. Such barriers pose an especially significant challenge to kinship caregivers in dealing with health professionals when children are left in their care.

(2) It is the intent of the legislature to assist kinship caregivers in accessing appropriate medical care to meet the needs of a child in their care by permitting such responsible adults who are providing care to a child to give informed consent to medical care." [2005 c 440 § 1.]

RCW 7.70.068 Informed consent—May be contained in mental health advance directive. Consent to treatment or admission contained in a validly executed mental health advance directive constitutes informed consent for purposes of this chapter. [2003 c 283 § 30.]

RCW 7.70.070 Attorneys' fees. The court shall, in any action under this chapter, determine the reasonableness of each party's attorneys fees. The court shall take into consideration the following:

(1) The time and labor required, the novelty and difficulty of the questions involved, and the skill requisite to perform the legal service properly;

(2) The likelihood, if apparent to the client, that the acceptance of the particular employment will preclude other employment by the lawyer;

(3) The fee customarily charged in the locality for similar legal services;

(4) The amount involved and the results obtained;

(5) The time limitations imposed by the client or by the circumstances;

(6) The nature and length of the professional relationship with the client;

(7) The experience, reputation, and ability of the lawyer or lawyers performing the services;

(8) Whether the fee is fixed or contingent. [1975-'76 2nd ex.s. c 56 § 12.]

Severability—1975-'76 2nd ex.s. c 56: See note following RCW 4.16.350.

Attorneys' fees: Chapter 4.84 RCW.

RCW 7.70.080 Evidence of compensation from other source. Any party may present evidence to the trier of fact that the plaintiff has already been compensated for the injury complained of from any source except the assets of the plaintiff, the plaintiff's representative, or the plaintiff's immediate family. In the event such evidence is admitted, the plaintiff may present evidence of an obligation to repay such compensation and evidence of any amount paid by the plaintiff, or his or her representative or immediate family, to secure the right to the compensation. Compensation as used in this section shall mean payment of money or other property to or on behalf of the plaintiff, rendering of services to the plaintiff free of charge to the plaintiff, or indemnification of expenses incurred by or on behalf of the plaintiff. Notwithstanding this section, evidence of compensation by a defendant health care provider may be offered only by that provider. [2006 c 8 § 315; 1975-'76 2nd ex.s. c 56 § 13.]

Findings—Intent—Part headings and subheadings not law—Severability—2006 c 8: See notes following RCW 5.64.010.

Severability—1975-'76 2nd ex.s. c 56: See note following RCW 4.16.350.

RCW 7.70.090 Hospital governing bodies—Liability—Limitations. Members of the board of directors or other governing body of a public or private hospital are not individually liable for personal injuries or death resulting from health care administered by a health care provider granted privileges to provide health care at the hospital unless the decision to grant the privilege to provide health care at

the hospital constitutes gross negligence. [1987 c 212 § 1201; 1986 c 305 § 905.]

Preamble—Report to legislature—Applicability—Severability—1986 c 305: See notes following RCW 4.16.160.

RCW 7.70.100 Mandatory mediation of health care claims—Procedures. (1) Before a superior court trial, all causes of action, whether based in tort, contract, or otherwise, for damages arising from injury occurring as a result of health care provided after July 1, 1993, shall be subject to mandatory mediation prior to trial except as provided in subsection (4) of this section.

(2) The supreme court shall by rule adopt procedures to implement mandatory mediation of actions under this chapter. The implementation contemplates the adoption of rules by the supreme court which will require mandatory mediation without exception unless subsection (4) of this section applies. The rules on mandatory mediation shall address, at a minimum:

(a) Procedures for the appointment of, and qualifications of, mediators. A mediator shall have experience or expertise related to actions arising from injury occurring as a result of health care, and be a member of the state bar association who has been admitted to the bar for a minimum of five years or who is a retired judge. The parties may stipulate to a nonlawyer mediator. The court may prescribe additional qualifications of mediators;

(b) Appropriate limits on the amount or manner of compensation of mediators;

(c) The number of days following the filing of a claim under this chapter within which a mediator must be selected;

(d) The method by which a mediator is selected. The rule shall provide for designation of a mediator by the superior court if the parties are unable to agree upon a mediator;

(e) The number of days following the selection of a mediator within which a mediation conference must be held;

(f) A means by which mediation of an action under this chapter may be waived by a mediator who has determined that the claim is not appropriate for mediation; and

(g) Any other matters deemed necessary by the court.

(3) Mediators shall not impose discovery schedules upon the parties.

(4) The mandatory mediation requirement of subsection (2) of this section does not apply to an action subject to mandatory arbitration under chapter 7.06 RCW or to an action in which the parties have agreed, subsequent to the arisal of the claim, to submit the claim to arbitration under chapter 7.04A or 7.70A RCW.

(5) The implementation also contemplates the adoption of a rule by the supreme court for procedures for the parties to certify to the court the manner of mediation used by the parties to comply with this section. [2013 c 82 § 1; 2007 c 119 § 1; 2006 c 8 § 314; 1993 c 492 § 419.]

Findings—Intent—Part headings and subheadings not law—Severability—2006 c 8: See notes following RCW 5.64.010.

Medical malpractice review—1993 c 492: "(1) The administrator for the courts shall coordinate a collaborative effort to develop a voluntary system for review of medical malpractice claims by health services experts prior to the filing of a cause of action under chapter 7.70 RCW.

(2) The system shall have at least the following components:

(a) Review would be initiated, by agreement of the injured claimant and the health care provider, at the point at which a medical malpractice claim is submitted to a malpractice insurer or a self-insured health care provider.

(b) By agreement of the parties, an expert would be chosen from a pool of health services experts who have agreed to review claims on a voluntary basis.

(c) The mutually agreed upon expert would conduct an impartial review of the claim and provide his or her opinion to the parties.

(d) A pool of available experts would be established and maintained for each category of health care practitioner by the corresponding practitioner association, such as the Washington state medical association and the Washington state nurses association.

(3) The administrator for the courts shall seek to involve at least the following organizations in a collaborative effort to develop the informal review system described in subsection (2) of this section:

(a) The Washington defense trial lawyers association;

(b) The Washington state trial lawyers association;

(c) The Washington state medical association;

(d) The Washington state nurses association and other employee organizations representing nurses;

(e) The Washington state hospital association;

(f) The Washington state physicians insurance exchange and association;

(g) The Washington casualty company;

(h) The doctor's agency;

(i) Group health cooperative of Puget Sound;

(j) The University of Washington;

(k) Washington osteopathic medical association;

(l) Washington state chiropractic association;

(m) Washington association of naturopathic physicians; and

(n) The department of health.

(4) On or before January 1, 1994, the administrator for the courts shall provide a report on the status of the development of the system described in this section to the governor and the appropriate committees of the senate and the house of representatives." [1993 c 492 § 418.]

Findings—Intent—1993 c 492: See notes following RCW 43.20.050.

Short title—Savings—Reservation of legislative power—Effective dates—1993 c 492: See RCW 43.72.910 through 43.72.915.

RCW 7.70.110 Mandatory mediation of health care claims—Tolling statute of limitations. The making of a written, good faith request for mediation of a dispute related to damages for injury occurring as a result of health care prior to filing a cause of action under this

chapter shall toll the statute of limitations provided in RCW 4.16.350 for one year. [1996 c 270 § 1; 1993 c 492 § 420.]

Findings—Intent—1993 c 492: See notes following RCW 43.20.050.

Short title—Savings—Reservation of legislative power—Effective dates—1993 c 492: See RCW 43.72.910 through 43.72.915.

RCW 7.70.120 Mandatory mediation of health care claims—Right to trial not abridged. RCW 7.70.100 may not be construed to abridge the right to trial by jury following an unsuccessful attempt at mediation. [1993 c 492 § 421.]

Findings—Intent—1993 c 492: See notes following RCW 43.20.050.

Short title—Savings—Reservation of legislative power—Effective dates—1993 c 492: See RCW 43.72.910 through 43.72.915.

RCW 7.70.130 Mandatory mediation of health care claims—Exempt from arbitration mandate. A cause of action that has been mediated as provided in RCW 7.70.100 shall be exempt from any superior court civil rules mandating arbitration of civil actions or participation in settlement conferences prior to trial. [1993 c 492 § 423.]

Findings—Intent—1993 c 492: See notes following RCW 43.20.050.

Short title—Savings—Reservation of legislative power—Effective dates—1993 c 492: See RCW 43.72.910 through 43.72.915.

RCW 7.70.140 Medical malpractice closed claim reporting requirements. (1) As used in this section:

(a) "Claim" has the same meaning as in RCW 48.140.010(1).

(b) "Claimant" has the same meaning as in RCW 48.140.010(2).

(c) "Commissioner" has the same meaning as in RCW 48.140.010(4).

(d) "Medical malpractice" has the same meaning as in RCW 48.140.010(9).

(2)(a) For claims settled or otherwise disposed of on or after January 1, 2008, the claimant or his or her attorney must report data to the commissioner if any action filed under this chapter results in a final:

(i) Judgment in any amount;

(ii) Settlement or payment in any amount; or

(iii) Disposition resulting in no indemnity payment.

(b) As used in this subsection, "data" means:

(i) The date of the incident of medical malpractice that was the principal cause of the action;

(ii) The principal county in which the incident of medical malpractice occurred;

(iii) The date of suit, if filed;

(iv) The injured person's sex and age on the incident date; and

(v) Specific information about the disposition, judgment, or settlement, including:

(A) The date and amount of any judgment or settlement;

(B) Court costs;
(C) Attorneys' fees; and
(D) Costs of expert witnesses. [2006 c 8 § 209.]

Findings—Intent—Part headings and subheadings not law—Severability—2006 c 8: See notes following RCW 5.64.010.

RCW 7.70.150 Actions alleging violation of accepted standard of care—Certificate of merit required. (1) In an action against an individual health care provider under this chapter for personal injury or wrongful death in which the injury is alleged to have been caused by an act or omission that violates the accepted standard of care, the plaintiff must file a certificate of merit at the time of commencing the action. If the action is commenced within forty-five days prior to the expiration of the applicable statute of limitations, the plaintiff must file the certificate of merit no later than forty-five days after commencing the action.

(2) The certificate of merit must be executed by a health care provider who meets the qualifications of an expert in the action. If there is more than one defendant in the action, the person commencing the action must file a certificate of merit for each defendant.

(3) The certificate of merit must contain a statement that the person executing the certificate of merit believes, based on the information known at the time of executing the certificate of merit, that there is a reasonable probability that the defendant's conduct did not follow the accepted standard of care required to be exercised by the defendant.

(4) Upon motion of the plaintiff, the court may grant an additional period of time to file the certificate of merit, not to exceed ninety days, if the court finds there is good cause for the extension.

(5)(a) Failure to file a certificate of merit that complies with the requirements of this section is grounds for dismissal of the case.

(b) If a case is dismissed for failure to file a certificate of merit that complies with the requirements of this section, the filing of the claim against the health care provider shall not be used against the health care provider in professional liability insurance rate setting, personal credit history, or professional licensing and credentialing. [2006 c 8 § 304.]

Findings—Intent—Part headings and subheadings not law—Severability—2006 c 8: See notes following RCW 5.64.010.

RCW 7.70.160 Frivolous claims. In any action under this section [chapter], an attorney that has drafted, or assisted in drafting and filing an action, counterclaim, cross-claim, third-party claim, or a defense to a claim, upon signature and filing, certifies that to the best of the party's or attorney's knowledge, information, and belief, formed after reasonable inquiry it is not frivolous, and is well-grounded in fact and is warranted by existing law or a good faith argument for the extension, modification, or reversal of existing law, and that it is not interposed for any improper purpose, such as to harass or to cause frivolous litigation. If an action is signed and filed in violation of this rule, the court, upon motion or upon its

own initiative, may impose upon the person who signed it, a represented party, or both, an appropriate sanction, which may include an order to pay to the other party or parties the amount of the reasonable expenses incurred because of the filing of the action, counterclaim, cross-claim, third-party claim, or a defense to a claim, including a reasonable attorney fee. The procedures governing the enforcement of RCW 4.84.185 shall apply to this section. [2006 c 8 § 316.]

Findings—Intent—Part headings and subheadings not law—Severability—2006 c 8: See notes following RCW 5.64.010.