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Court of Appeals Case No. 53972-1-II

Case No. 100195-9

SUPREME COURT OF THE STATE OF WASHINGTON

MATTHEW MENZER AS LITIGATION GUARDIAN AD LITEM OF KJM, A MINOR,

Petitioner,

v.

CATHOLIC HEALTH INITIATIVES, A FOREIGN CORPORATION; FRANCISCAN HEALTH SYSTEM, A WASHINGTON CORPORATION; AND SAINT JOSEPH MEDICAL CENTER,

Respondents.

PETITION FOR REVIEW

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A. IDENTITY OF PETITIONER & INTRODUCTION

Petitioner Matthew Menzer as Litigation Guardian Ad Litem for KJM, a minor (KJM) seeks review of the decision identified in Part II.

A 19-state healthcare system, Catholic Health Initiatives (CHI), violated national standards of care for quality improvement and dissemination of lifesaving medical information to its local hospitals. KJM was never given or offered a critical test, which CHI knew about, and developed severe, lifelong brain damage. Despite KJM's expert evidence that CHI breached the standard of care, the lower courts concluded CHI cannot face liability because it is not a defined "health care provider" under Washington's medical negligence statute, chapter 7.70 RCW. But Washington law does not make CHI's responsibility to exercise due care depend on the happenstance of its corporate structure. If it had directly employed the doctors treating KJM at bedside, it would unquestionably be amenable to suit. Its responsibility to use due

care is not eliminated because it operated its Washington hospital as a subsidiary, and so, according to the lower courts, avoided the statutory definition of "health care provider."

Washington has never made the existence of a tort duty of reasonable care depend on narrow technicalities, and the question whether it will do so is one of importance that this Court should review.

B. COURT OF APPEALS DECISION

KJM seeks review of the decision filed on August 10, 2021, by Division II, attached in the Appendix.

C. ISSUES PRESENTED FOR REVIEW

1. Does Washington's medical negligence statute, chapter 7.70 RCW, enacted to limit claims against "health care providers," prohibit negligence claims against *non*-"health care providers" involved in health care delivery?

2. Does Washington law support a tort duty of care by the corporate operator of health care system, which has actual knowledge of lifesaving newborn screening, but (a) fails

to disseminate that information to providers, (b) violates the standard of care, where (c) the result is that a newborn is not offered the critical test and develops catastrophic, lifelong brain damage?

3. Does the doctrine of ostensible agency depend on the totality of the information available to the patient throughout treatment?

D. STATEMENT OF THE CASE

Division II's opinion accurately states much of the record, with several important exceptions.

First, the Court misinterpreted KJM's claim as insisting that CHI had to "adopt specific procedures." App. at 1. KJM's experts testified that supplemental newborn screening (SNS) should have been *offered*, and the standard of care required CHI to *disseminate* lifesaving information it actually knew. CP 616. The experts never testified that CHI had to mandate "specific procedures," App. at 1, but rather share lifesaving information when it knew this information was not known throughout its

system. CP 680. As a result, "CHI breached its duty to FHS/[St. Joseph] and their newborn patients by not providing this vitally important health related service." *Id.*[1]

Second, the Court downplayed CHI's knowledge of SNS. The Court implied CHI's knowledge was limited to the experience of its medical director who came from another system that *did* disseminate knowledge of SNS. But CHI internally recognized that SNS was a "standard practice." CP 375.[2] The Court noted hospitals "in Colorado and Pennsylvania" were already employing SNS, but omitted these were CHI hospitals already using SNS. CP 462-63.

Third, the Court adopted CHI's characterization that it "did not have any involvement in the clinical decision-making

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[1] SNS uses one blood sample already required to be taken to test for a panel of disorders based on a Duke University process to test for multiple disorders with one sample. CP 612.

[2] In May 2005, CHI's genetics advisory committee met to address "the most critical issues" regarding genetic testing, and recommended provider education on "genetic issues and technology available." CP 375-76.

or treatment of patients" at its Washington hospital. App. at 3 (quoting CP 102). But it is undisputed CHI—as "one of the nation's largest nonprofit health systems," App. at 3 (quoting CP 278)—*did* disseminate standard-of-care "practice bundles" for providers. CHI developed "system-wide improvement of safety, quality and efficiency through the roll-out of evidence-based practice bundles to reduce unnecessary variations in care." CP 309. The "practice bundles" were to "help standardize and improve care across the system." CP 311.[3]

The Court of Appeals downplayed the evidence CHI *in fact* influenced frontline care because CHI did not "mandate" its practice bundles App. at 5. CHI disseminated best practices but did not share equivalent information about SNS, despite knowing hospitals were not offering this lifesaving screening. Further, CHI had the power to mandate practice bundles. CHI

[3] Practice bundles explained "all the steps, the evidence, the things you need to do to be able to effectively implement what we – what the research shows is a best practice." CP 310.

had sole power to amend the bylaws of its Washington hospital. CP 215. The bylaws adopted Catholic guidance mandating and forbidding certain medical procedures. CP 213. CHI directly managed its hospitals' compliance with accreditation standards. CP 427, 431. CHI had the power to direct healthcare activity.[4] CHI made the internal decision not to mandate practice bundles, but only because it believed it would be more effective to use a recommendation approach. CP 310.

Division II also accepted CHI's argument that, despite knowing about SNS and having a life-threatening "variability" within the system, CP 542, CHI did not need a pediatrician on its Clinical Services Group because it "provided adult care." App. at 5. The record showed the labor and delivery service was a major portion of CHI's systemwide business. CP 314.

[4] Division II ruled "there is no evidence that CHI could have mandated a particular course of testing or treatment." App. at 16. The record showed precisely that CHI had that power.

Fourth, Division II accepted CHI's argument—made entirely without record support—that "No other acute care hospitals licensed in Washington State offered the test at that time." App. at 4. The record is silent on the practices of other hospitals. Even so, at the time of KJM's birth, Washington's military hospitals provided SNS, CP 615, 675, as well as hospitals in California, Oregon, Idaho, Alaska, Hawai'i, and Guam, CP 615. The court remarked the state Department of Health had not mandated SNS, but the evidence showed the reason for this was a slow budget process. CP 745-46. The Department was trying to update Washington's mandate to include SNS. CP 724-87.[5]

Division II's opinion understated CHI's knowledge of SNS and its influence on bedside care. It described KJM's

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[5] In 2002, the Department circulated information that SNS was available through private laboratories. CP 709, 745. SNS cost "as little as $25," and private laboratories offered it specifically for states whose regulatory processes lagged. CP 674-75.

remedy as pursuing claims "against individual healthcare providers." App. at 14. But *CHI* was aware of a "[k]nowledge deficit" among "physicians & nursing, clinicians" regarding genetic testing. CP 376. KJM's claim, supported by leading experts, is that CHI's responsibility to KJM and to those providers was to disseminate and implement the lifesaving knowledge that it admittedly had.

E. ARGUMENT WHY REVIEW SHOULD BE GRANTED

This Court should review Division II's opinion under RAP 13.4(b)(4), because it conflicts with decisions of this Court and the Court of Appeals, because it adopts a new, erroneous interpretation of chapter 7.70 RCW, and because relieving anyone involved in health care from being responsible to exercise reasonable care if they do not meet the statutory definition of "health care provider" is a question of substantial importance.

CHI is far from unique. Commentators have noted, "Healthcare in the United States is changing. Recent years have brought a significant increase in healthcare mergers, and provisions in the Patient Protection and Affordable Care Act ('Affordable Care Act') encourage integration and coordination of healthcare services." Jacob Snow, Ronnie Solomon, Kyle Quackenbush, The Efficiencies Defenestration: Are Regulators Throwing Valid Healthcare Efficiencies Out the Window?, 27 Competition: J. Anti., UCL & Privacy Sec. Cal. L. Assoc. 73 (2018). CHI admitted that it was formed to meet the demands of modern medicine. This is not limited to CHI: "Over the past several years, faced with rising costs, pressures to improve quality, changes to insurance reimbursements, and other regulatory developments, the healthcare field has witnessed increasing consolidation." Lisl Dunlop, Certificates of Public Advantage: Bypassing the FTC in Healthcare Mergers?, 27 Competition: J. Anti., UCL & Privacy Sec. Cal. L. Assoc. 11 (2018). This Court should review Division II's holding that

chapter 7.70 RCW puts such entities beyond the reach of Washington tort law.

1. This Court looks to broad considerations of policy—not merely narrow statutory definitions—to determine whether a duty of care is owed.

Contrary to Division II's analysis, this Court has never used chapter 7.70 RCW in isolation to determine whether a duty of reasonable care is owed.

"To decide if the law imposes a duty of care, and to determine the duty's measure and scope, courts weigh considerations of logic, common sense, justice, policy, and precedent." *Affiliated FM Ins. Co. v. LTK Consulting Servs., Inc.*, 170 Wn.2d 442, 449–50, 243 P.3d 521 (2010) (quotation omitted). Courts find a duty when "considerations of public policy . . . lead the law to conclude that a 'plaintiff's interests are entitled to legal protection against the defendant's conduct.'" *Id.* (quoting W. Page Keeton, et al., Prosser and Keeton on Torts § 53, at 357 (5th ed. 1984)).

a. Case law relies on the general tort standard to determine duty.

Even after the enactment of chapter 7.70 RCW, this Court has looked to this standard to determine the existence of a tort duty of reasonable care in cases involving health care. In *Harbeson v. Parke-Davis, Inc.*, 98 Wn.2d 460, 464, 656 P.2d 483 (1983), providers failed to warn expecting parents about the risk of possible birth defects. The court began with chapter 7.70 RCW; but on duty, the court looked not to statutory criteria, but improvements in the medical field "to predict the occurrence and recurrence of defects attributable to genetic disorders." *Id*. at 472. *Harbeson* shows that, *even after chapter 7.70 RCW, general tort law determines whether a duty is owed.* The statutes guide whether there has been a "failure to conform to the appropriate standard of skill, care, or learning." *Id*. at 473 (citing RCW 4.24.290; RCW 7.70.040).

This Court engaged in a similar analysis in *Pedroza v. Bryant*, 101 Wn.2d 226, 677 P.2d 166 (1984). The Court looked

to case law in which Washington had "recognized and adopted the fundamental principle of the theory, namely, that a hospital owes an independent duty of care to its patients directly." *Id.* at 232. *Pedroza* reviewed the nature of the modern hospital, finding a duty because "[t]he community hospital has evolved into a corporate institution, assuming 'the role of a comprehensive health center ultimately responsible for arranging and coordinating total health care.'" *Id.* at 231 (quotation omitted). *Accord Volk v. DeMeerleer*, 187 Wn.2d 241, 274, 386 P.3d 254 (2016) (finding a duty based on "fairly [balancing] the needs of protecting the public, allowing recovery for victims of psychiatric patients' crimes, and providing the necessary protection for mental health professionals to perform their jobs.").

In *Lam v. Glob. Med. Sys., Inc., P.S.*, 127 Wn. App. 657, 663, 111 P.3d 1258 (2005), survivors of a deceased seaman sued two physicians for giving negligent advice to the crew of the fishing boat on which he was employed. *Id*. at 660-61. On

duty, the court did not look to chapter 7.70 RCW but the physicians' contractual agreement to "render consultation and provide advice." *Id.* at 665. Cases from Texas, New York, and Ohio supported a duty of care. *Id.* at 664 n.17 & 18. Like *Harbeson*, *Pedroza*, and *Volk*, the *Lam* court found a duty without reference to chapter 7.70 RCW, because the physicians' "*activity*" was "amply sufficient to create a duty of care." *Id.* at 665 (emphasis added).[6]

Division II's opinion conflicts with *Harbeson*, *Pedroza*, *Volk*, *Lam*, *Judy*, and *Alexander*, because it failed to apply this Court's test for when a duty of care exists.

Pedroza is instructive, because it concerned care governed by chapter 7.70 RCW but sill focused on the role of

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[6] Likewise, decisions that *declined* to find a duty also turned on considerations outside of chapter 7.70 RCW. See *Judy v. Hanford Envtl. Health Found.*, 106 Wn. App. 26, 38, 22 P.3d 810 (2001) (no duty by physician conducting pre-employment screening); *Alexander v. Gonser*, 42 Wn. App. 234, 239, 711 P.2d 347 (1985) (no duty by hospital to inform patient of physician-ordered test results).

the hospital in modern medicine. The role of the multi-state health system four decades later demands a similar analysis. Because multi-state health systems influence practice and have their own standards of care, review by this Court to clarify the intent of chapter 7.70 RCW is particularly relevant.

b. Chapter 7.70 RCW provides the exclusive claims for a "health care provider" providing "health care," but this exclusivity does not determine the existence of a duty by CHI.

Division II misinterpreted the significance of the exclusive scope of chapter 7.70 RCW for claims arising from health care.

Division II relied on the rule that "[W]henever an injury occurs as a result of health care, the action for damages for that injury is governed exclusively by RCW 7.70." *Fast v. Kennewick Pub. Hosp. Dist.*, 187 Wn.2d 27, 34, 384 P.3d 232 (2016) (quoting *Branom v. State*, 94 Wn. App. 964, 969, 974 P.2d 335 (1999)). The claims allowed under chapter 7.70 RCW make a "health care provider" liable. Putting these two concepts

together for the first time, Division II ruled that chapter 7.70 RCW means that if an injury arises from "health care," then only a "health care provider" can be liable for the injury, and anyone who is not a "health care provider" cannot be liable.

But neither *Fast* nor *Branom* held this. In *Fast*, the issue was tolling for wrongful death claims. 187 Wn.2d at 29. In *Branom*, the issue was whether the informed-consent duty ran to a minor's parents in their own right. 94 Wn. App. at 966. The exclusivity of chapter 7.70 RCW meant that a "health care provider" providing "health care" could only be liable pursuant to that law. Neither court considered whether others, not defined as "health care providers," could owe a parallel duty for the same injury, or whether "health care providers" acting outside the capacity of providing "health care" could owe a parallel duty.

Before this case, Washington courts permitted parallel duties. In *Lam*, the court rejected the argument that the existence of the shipowner's duty negated the physicians' duty.

127 Wn. App. at 663. The physicians owed a duty governed by chapter 7.70 RCW, and the shipowner owed a parallel duty to provide seaworthy conditions. Here too, the mere fact frontline providers owed a duty to follow the standard of care is "irrelevant" to whether CHI owed a duty because of its standing relative to KJM. *Lam*, 127 Wn. App. at 663.

Likewise, defined "health care providers" are subject to general tort claims for activities occurring parallel to "health care." *Estate of Sly v. Linville*, 75 Wn. App. 431, 439, 878 P.2d 1241 (1994), held that torts outside of the provision of health care are not governed by chapter 7.70 RCW but are governed by general negligence principles. *Harris v. Extendicare Homes, Inc.*, 829 F.Supp.2d 1023, 1028–29 (W.D. Wash. 2011), allowed a negligence claim under against a nursing home outside of chapter 7.70 RCW for injury-causing conduct other than establishing care plans. *See also Conrad v. Alderwood Manor*, 119 Wn. App. 275, 78 P.3d 177 (2003) (same).

In *Lam*, *Estate of Sly*, *Harris*, and *Conrad*, the claimed injury occurred in the context of health care, but non-providers and providers acting in a capacity other than health care could be liable under general tort law. Division II's opinion forecloses this possibility by making chapter 7.70 RCW the sole arbiter of whether any duty can be owed in a health care setting. The opinion therefore conflicts with these decisions as well.

2. Chapter 7.70 RCW was never intended to preclude claims against persons who are not health care providers, and interpreting it do so is inconsistent with this Court's decisions on statutory interpretation.

The effect of Division II's opinion is that CHI cannot owe a duty to KJM *not* because of Court's case law on the existence of a tort duty, but simply because it was not a "health care provider" and under chapter 7.70 RCW only a "health care provider" can be liable. This reading transforms chapter 7.70 RCW into a broad grant of immunity that the Legislature neither intended nor could have foreseen. The purpose of the law was to limit claims against "health care providers" when

providing "health care" to solely the three claims allowed under the statute. The law was never concerned with, and never addressed, the liability of persons who do not fall into the definition of "health care provider." The result of Division II's opinion is that parties who are *not* providers are absolutely protected by chapter 7.70 RCW from owing a tort duty if the injury occurred in a health care setting. The Legislature never said anything about the liability of *non*-health care providers, yet, according to Division II, was far more protective of them than it was of "health care providers" themselves.

Division II arrived at this erroneous conclusion by failing to apply this Court's decisions on statutory interpretation. It cited, but failed to apply, the rule that courts do not consider a statute in isolation, but in the full context of "all that the Legislature has said in the statute and related statutes which disclose legislative intent about the provision in question." *State, Dep't of Ecology v. Campbell & Gwinn, L.L.C.*, 146 Wn.2d 1, 11, 43 P.3d 4 (2002).

The Legislature's enactments on health care liability show that the Legislature intended that all persons may be liable for violation of the standard of care applicable to their activity. KJM presented precisely this evidence as to CHI. CP 462, 616, 680. Equally important, the Legislature *never* stated, in chapter 7.70 RCW or elsewhere, that *anyone* is relieved of a tort duty by virtue of any statutory enactment.[7]

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[7] If the Legislature attempted to eliminate common law tort liability explicitly, as Division II has held it did by implication, such a law would be subject to constitutional requirements that Division II never evaluated. First, the constitution demands that "[w]hen the Legislature abolishes a cause of action, it does so explicitly." *Sofie v. Fibreboard Corp.*, 112 Wn.2d 636, 665, 771 P.2d 711 (1989) (damages cap unconstitutional). Second, when the legislature creates an immunity from common law liability, this must have a "reasonable ground" under Washington's Privileges and Immunities clause. *Schroeder v. Weighall*, 179 Wn.2d 566, 571, 316 P.3d 482 (2014) (eliminating tolling of minor claims unconstitutional). Finally, legislation eliminating common law liability is more likely to be upheld when it creates a substitute remedy. *State v. Clausen*, 65 Wash. 156, 210, 117 P. 1101 (1911) (workers' compensation). This is only more evidence that Division II mistook the Legislature's intent.

The Legislature's enactments show intent to allow all parties to be held liable for standard of care violations. First, before chapter 7.70 RCW, in RCW 4.24.290, the Legislature established that in any action "based on professional negligence . . . against *a member of the healing arts*," the plaintiff must show that "the defendant . . . failed to exercise that degree of skill, care, and learning possessed at that time by other persons in the same profession." RCW 4.24.290 (emphasis added). This statute contemplates that there may be persons involved in health care delivery beyond those defined as "health care providers" in chapter 7.70 RCW, and who owe a duty to follow the standard of care.[8]

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[8] The impetus for RCW 4.24.290 and later chapter 7.70 RCW was *Helling v. Carey*, 83 Wn.2d 514, 519 P.2d 981 (1974), which deemed a test to be the standard of care as a matter of law despite the fact the medical profession did not follow that standard. The legislation restored the standard of care as set by the medical community: *nothing* supports the proposition the Legislature intended to statutorily preclude claims against parties where there is evidence they did not follow the standard of care of the medical community, as there is here.

Second, chapter 7.70 RCW includes in the definition of "health care provider" non-medical personnel including "an officer, director, employee, or agent" of a health care entity. RCW 7.70.020(3). This contemplates that non-medical personnel may influence health outcomes and therefore owe a tort duty of reasonable care.[9]

Third, chapter 7.70 RCW incorporates a limitation on the definition of "health care." RCW 7.70.040 incorporates the definition of "health care" of RCW 70.02.010, which limits the scope of "health care" to care that is provided by a "health care provider." *See* RCW 7.70.065(3) & 70.02.010(15).[10] The effect of this limitation is that, by definition, any activity by a party who is *not a health care provider* is therefore *not health care*.

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[9] Implementing policies and procedures to assure quality care is an integral part of safe health care delivery. *E.g*. WPI 105.02.02 (hospital's duty to adopt policies and procedures).

[10] Even before this statutory cross reference, this Court looked to RCW 70.02.010 to determine the scope of the term "health care." *Berger v. Sonneland*, 144 Wn.2d 91, 109, 26 P.3d 257 (2001).

This shows that *if*, as it maintains, CP 46, CHI was *not a health care provider*, then any claims against it for its conduct—such as failing to disseminate and implement its actual knowledge of SNS in violation of the standard of care—are not claims arising out of "health care" governed by chapter 7.70 RCW.[11]

These enactments contemplate that all persons may be liable if they violate the standard of care. They further contemplate that parties beyond just defined "health care provider[s]" covered by chapter 7.70 RCW *may* influence health care outcomes and have a responsibility to use

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[11] Every time Washington courts have adopted a broad definition of "health care," it has been in the context of broadly defining the activities of a *health care provider* to be *health care*, so that chapter 7.70 RCW governed the claims. *See Reagan v. Newton*, 7 Wn. App. 2d 781, 791, 436 P.3d 411, *review denied*, 193 Wn.2d 1030 (2019); *Beggs v. Dept. of Soc. & Health Servs.*, 171 Wn.2d 69, 79, 247 P.3d 421 (2011); *Estate of Sly v. Linville*, 75 Wn. App. 431, 439, 878 P.2d 1241 (1994); *Berger v. Sonneland*, 144 Wn.2d 91, 109, 26 P.3d 257 (2001); *Branom v. State*, 94 Wn. App. 964, 969–70, 974 P.2d 335 (1999). Courts have never used a broad definition of "health care" to *apply* the statute to a party who was *not* a health care provider, and then hold the party cannot be sued.

reasonable care. Chapter 7.70 RCW never states that *non*-providers—who are not even mentioned—are insulated from the general rule for the existence of a duty of reasonable care. Division II misinterpreted the statute, and failed to follow this Court's case law on legislative intent, when it held otherwise.

3. This Court's corporate practice of medicine doctrine does not address the issue of a duty of reasonable care by CHI.

Division II included a one-page analysis of the corporate practice of medicine doctrine, reasoning that the better public policy is to limit KJM to claims against the frontline providers. The corporate practice of medicine, to the contrary, only would support liability when corporate policies affect patient care.

The purpose of the corporate practice of medicine doctrine is that "the commercialization of professions would destroy professional standards and that the duties of professionals to their clients are incompatible with the commercial interests of business entities." *Columbia Physical Therapy, Inc., P.S. v. Benton Franklin Orthopedic Associates,*

P.L.L.C., 168 Wn.2d 421, 431, 228 P.3d 1260 (2010). "At bottom, the doctrine exists to protect the relationship between the professional and the client." *Id*.

KJM's claim that CHI had a duty to disseminate life-saving information it knew about SNS in no way threatens the relationship between KJM and frontline, individual providers. There is no evidence any provider thought the blood sample should *not* be tested. Rather, the evidence shows there was a "knowledge deficit" among providers that CHI was well aware of, but never addressed, CP 376, and Washington's testing mandate lagged because of a slow budget process, CP 745-46.[12]

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[12] CHI's argument the KJM should sue the frontline providers seeks to take advantage of the knowledge deficit it knew about but did not address. If CHI's legal strategy is successful, its lawyers—who represent all defendants—would move in limine to exclude evidence of what CHI knew to give the jury the misimpression that frontline providers (1) practiced at a community hospital without expertise in SNS, (2) were unaware of SNS, and (3) reasonably awaited direction from the state Department of Health, all despite being part of a 19-state conglomerate that knew its failure to implement SNS put newborn patients at grave risk.

Under Division II's analysis, no duty would exist even if CHI *had* threatened the relationship between patient and provider, because it interpreted RCW 7.70 to shield CHI from liability relating to health care. The corporate practice of medicine does not speak to this issue, but certainly cannot mean that corporations cannot be sued when they actually influence health outcomes at hospitals they own.

4. The Court of Appeals misapplied, and inappropriately narrowed, the law of ostensible agency.

Division II's analysis of ostensible agency is also inconsistent with this Court's decisions. In addition to supporting direct negligence claims against CHI discussed above, KJM's evidence supports holding CHI liable for the acts of local providers based on ostensible agency. Division II rejected KJM's evidence on this fact question for two reasons. First, the Court held a patient must show "reliance" on the representation of the ostensible principal's responsibility, as opposed to simply perceive and reasonably believe it. Second,

applying the erroneous reliance requirement, Division II rejected KJM's claim on the ground that her mother had "already selected St. Joseph" before going there and so would not have relied on CHI being its principal. App. at 17.

This analysis contradicts Washington law on ostensible agency. Washington has never required reliance in a health care case. The Restatement (Third) of Agency, which the court followed in *Udall v. T.D. Escrow Servs., Inc.*, 159 Wn.2d 903, 913, 154 P.3d 882 (2007), states: "*Reliance*. To establish that an agent acted with apparent authority, it is not necessary for the plaintiff to establish that the principal's manifestation induced the plaintiff to make a detrimental change in position." Restatement (Third) of Agency § 2.03 (2006), cmt. e. Ostensible agency turns on reasonable *belief* when "objective manifestations of the principal cause the one claiming apparent authority to actually, or subjectively, believe that the agent has authority to act for the principal and such belief is objectively

reasonable." *Mohr v. Grantham*, 172 Wn.2d 844, 860, 262 P.3d 490 (2011) (quotation omitted).

Thus, courts allow post-service representations to support ostensible agency, after the selection of the provider. *Adamski v. Tacoma Gen. Hosp.*, 20 Wn. App. 98, 115, 579 P.2d 970 (1978) (citing *Howard v. Park*, 195 N.W.2d 39, 41 (Mich. Ct. App. 1972)). The importance attached to the principal's role is at best only a single factor bearing on the existence of ostensible agency; it well settled that no one factor is controlling. *Mohr*, 172 Wn.2d at 861-62 (quotations omitted).

Under this Court's case law, KJM's mother needed only to "reasonably believe" that the local providers "were employees or agents" of CHI. *Mohr*, 172 Wn.2d at 861. KJM's mother placed importance on being cared for in "part of a larger health system," CP 990, and the representations available to her made no distinction between CHI and its local providers. This Court did not explicitly discuss the Restatement (Third) of Agency in following a consistent rule in *Mohr*. Division II's

erroneous reliance requirement presents an opportunity to reaffirm *Mohr* and clarify that reliance is not Washington's test.

5. The Court of Appeals should not have *sua sponte* raised and decided proximate cause.

Finally, Division II departed from this Court's practice when it *sua sponte* raised proximate cause and decided this fact question against KJM. Noting an appellate court may affirm on any basis supported by the record, Division II ruled that KJM's trial court evidence did not support proximate cause.

But CHI never sought summary judgment on proximate cause. CHI argued solely that it did not owe a duty of care. KJM was never put on notice to submit evidence or briefing on proximate cause, and neither party did. As this Court has explained: "when the alternative ground for affirming the trial court's order of summary judgment has not been argued and briefed by the parties either before the trial court or the appellate court, caution must be exercised so as not to deny the appellant the right to dispute the facts material to the new

theory." *Bernal v. Am. Honda Motor Co., Inc.*, 87 Wn.2d 406, 414, 553 P.2d 107 (1976).

This was the case here. A jury could find proximate cause by concluding, factually, that if CHI had disseminated or implemented its knowledge about SNS, then CHI's providers would have offered the testing.

Division II ignored this view of proximate cause—because it was never briefed—and analyzed the issue based on whether the Washington-licensed physician that CHI employed was involved in KJM's care. But KJM never argued that he was. CHI's own standard-of-care violation—not disseminating and implementing its actual knowledge of SNS—proximately caused KJM's injury. Division II should not have *sua sponte* raised and decided proximate cause.

F. CONCLUSION

For the foregoing reasons, KJM respectfully asks that the Court grant review of Division II's opinion.

I hereby certify that this document contains 4,979 words in accordance with RAP 18.17.

RESPECTFULLY SUBMITTED this 9th day of September, 2021.

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Appendix

Filed
Washington State
Court of Appeals
Division Two

August 10, 2021

IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON

DIVISION II

MATTHEW MENZER, as Litigation Guardian Ad Litem of KJM, a minor, Appellant, v. CATHOLIC HEALTH INITIATIVES, a foreign corporation; FRANCISCAN HEALTH SYSTEM, a Washington corporation; and SAINT JOSEPH MEDICAL CENTER, Respondents.	No. 53972-1-II UNPUBLISHED OPINION

SUTTON, J. — Matthew Menzer, as litigation guardian ad litem for KJM, a minor, sued Catholic Health Initiatives (CHI), Franciscan Health System (FHS), and Saint Joseph Medical Center (St. Joseph). CHI is the parent corporation of FHS and FHS owns St. Joseph. KJM alleged that CHI failed to adopt specific procedures requiring FHS and St. Joseph to screen newborns for a rare genetic disorder that KJM was later diagnosed with after his birth at St. Joseph. At the time of his birth, the Department of Health did not mandate this newborn screening test in acute care hospitals in Washington State although other states did.

KJM claims that CHI, a corporate entity, owed him a duty because it directed health care decisions regarding his care and it directed health care decisions to its subsidiaries in other states' hospitals throughout the United States. KJM argues that CHI meets the definition of a Washington "health care provider" because it employed one licensed doctor in Washington. KJM argues that

CHI can be sued for damages for injuries to KJM occurring as a result of health care under chapter 7.70 RCW. Alternatively, if CHI is not a health care provider, KJM argues that we should expand RCW 7.70.020's definition of health care provider to include "persons engaged in the healing arts," which would then include CHI. KJM also argues that CHI, as a principal, is vicariously liable for FHS's and St. Joseph's actions based on their apparent authority to act for CHI. Thus, KJM argues that the superior court erred by granting summary judgment dismissal to CHI.

We hold that because CHI is not a health care provider under RCW 7.70.020, CHI does not owe a duty to KJM and even assuming a duty is owed, KJM fails to prove causation as a matter of law, and no duty exists under common law. We decline to expand the definition of health care provider and we hold that CHI is not vicariously liable for FHS or St. Joseph. We also decline KJM's invitation to apply Washington's definition of health care provider in a way that assumes CHI directed health care decisions in this matter as KJM provided no evidence that was the case. We affirm.

FACTS

I. BACKGROUND

A. CHI, FHS, AND ST. JOSEPH

CHI is a nonprofit parent corporation formed in 1996 and incorporated in Colorado. CHI's purpose is to "promote and support, directly or indirectly, by donation, loan, or otherwise, the interests and purposes" of its "sponsored organizations." Clerk's Papers (CP) at 109-10. By 2005, CHI was the parent corporation of several subsidiary corporations that independently owned and operated hospitals in other states.

CHI describes itself as a "national health care institution." CP at 50. CHI's mission, "[a]s one of the nation's largest nonprofit health care systems," is to "go beyond the provision of quality health care to help protect the vulnerable; to encourage participation in the political process; and to safeguard the environment." CP at 278. CHI has 64 hospital facilities and 50 long-term care and residential-care facilities in 19 states.

FHS was formed in 1981. CHI was created when FHS and two other Catholic health care systems merged, but they continued to exist as separate subsidiary corporations. FHS owns and operates St. Joseph. The FHS Board of Directors was the governing body for St. Joseph. FHS was responsible for appointing medical staff, approving clinical privileges for medical staff, ensuring St. Joseph and its staff carried out peer review activities and other quality assurance activities in accordance with RCW 70.41.200, approving contracts with physicians to perform specific activities, and providing general oversight and supervision of the hospital.

In August 2005, when KJM was born, no person employed by CHI had been granted privileges as a member of St. Joseph's medical staff. In August 2005, the corporate operations of CHI and FHS were separate and distinct. Both St. Joseph and FHS were subject to oversight by the CHI Board of Directors, including subject to the approval of or removal by CHI.

CHI "did not have any involvement in the clinical decision-making or treatment of patients at St. Joseph." CP at 102. When KJM was born at St. Joseph in August 2005, CHI employed 46 people who "[had] an office, workspace, or were otherwise associated with working in Washington State." CP at 103.

Of the CHI employees who were associated with working in Washington State, Dr. Gregory Semerdjian was the only one who was "a licensed health care provider." CP at 103. Dr.

Semerdjian was CHI's Vice President of Medical Operations, a member of the Clinical Services Group, and a member of CHI's Physician Leadership Council. He attended the 2004 Genetics Advisory Summit and the 2005 meeting of the Genetics Advisory Committee. Dr. Semerdjian did not provide health care services to KJM. Dr. Semerdjian has not practiced clinical medicine since 1991. Dr. Semerdjian was employed as a remote Vice President of Medical Operations to work with rural hospitals in North Dakota, Minnesota, Kansas, and Kentucky, not in Washington State. He did reside in Tacoma, Washington, but his work required him to travel out of state to the facilities CHI assigned him. He had a cubicle in an office space owned by FHS, but he did not work with any FHS facilities, or work at St. Joseph, and had no role related to making health care decisions about KJM.

B. SUPPLEMENTAL NEWBORN SCREENING AND KJM'S BIRTH

In August 2005, KJM was born at St. Joseph in Tacoma. At that time, St. Joseph did not include a newborn screening test for Glutaric Acidemia type 1 (GA-1) in its supplemental newborn screening (SNS) panel. The pediatrician who attended to KJM at St. Joseph was not named in the lawsuit, but could have ordered individual genetic testing if necessary. No other acute care hospitals licensed in Washington State offered the test at that time. The Department of Health required acute care hospitals in the state to conduct newborn screening for nine genetic disorders in August 2005, but did not mandate newborn screening for metabolic disorders such as GA-1.

KJM was diagnosed with GA-1 when he was 11 months old. By the time he was diagnosed, KJM had developed brain damage due to GA-1. KJM's mother said she would have gotten the additional screening test at St. Joseph if it had been offered.

Prior to KJM's birth, other states[1] had mandated testing for GA-1 in the SNS panel. In 2005, hospitals in Colorado and Pennsylvania voluntarily included the GA-1 test in their SNS panel despite it not being mandatory in those states.

KJM's mother noticed the CHI logo on the admission paperwork she filled out upon arriving at St. Joseph to give birth, which was "important" to her.

C. CHI'S KNOWLEDGE OF SNS

Dr. John Anderson, CHI's Chief Medical Officer from 2004 to 2008, explained that CHI's Clinical Services Group did not have a pediatrician because CHI did not include a children's hospital; the hospitals in its subsidiaries provided adult care. CHI provided best practice resources in the form of "practice bundles" to its subsidiaries. "Practice bundles" include all of the resources that would be necessary to implement a practice change, but they do not mandate a particular course of testing or treatment.[2] Dr. Anderson explained that SNS was not a priority at that time. CHI did not provide a practice bundle to its subsidiaries relating to SNS. Baylor University's Institute for Metabolic Disease, the institution Anderson previously worked at, ensured that all of its hospitals offered SNS before any state mandate.

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[1] These states include: Iowa, Minnesota, Oregon, Idaho, Maryland, Nebraska, North Dakota, Ohio, Missouri, and South Dakota.

[2] Wash. Court of Appeals, Div. II oral argument, *Matthew Menzer as Litigation Guardian ad Litem of KJM v. Catholic Health Initiatives*, No. 53972-1-II (May 20, 2021), at 12 min., 41 sec. through 14 min., 44 sec. (on file with court). KJM has not pointed to any evidence in this record that contradicts this explanation of practice bundles, nor has KJM provided evidence in this record to contradict the assertion that a practice bundle does not mandate particular testing or treatment.

II. Procedure

In March 2017, KJM filed a negligence suit against FHS d/b/a/ St. Joseph for alleged negligence in August 2005, and it alleged that FHS owned and operated St. Joseph. Later, KJM amended his complaint to allege that CHI owed an independent duty to KJM for its failure to conduct SNS tests that he alleged would have detected GA-1 and for its failure to inform KJM's parents of the material facts relating to KJM's care and treatment. CHI denied that it employed or credentialed medical providers at St. Joseph and denied it owed a duty to KJM.

CHI moved for summary judgment dismissal of KJM's claims against it because it did not employ or credential any licensed health care provider at St. Joseph—who allegedly caused damages to KJM. CHI argued that (1) CHI was not a health care provider as defined in RCW 7.70.020, nor was any employee of CHI involved in KJM's care and treatment, (2) no common law duty exists, and (3) CHI was not vicariously liable for FHS or St. Joseph under the corporate medical negligence doctrine.

KJM argued in response that CHI is a health care provider under Washington law that owes a duty to the participants in its system because CHI was "registered to do business in Washington as a corporation whose purpose was to 'provide, conduct, and administer health care and related services,' in Washington." CP at 251 (boldface type omitted). KJM also argued that CHI had a common-law duty to patients of its health care system and CHI had voluntarily assumed a duty owed to KJM. In opposition to CHI's motion for summary judgment KJM filed the declaration of its expert, Dr. Leslie Selbovitz. She was the Chief Medical Officer and Senior Vice President for Medical Affairs at Milford Regional Medical Center in Milford, Massachusetts. She stated that

"KJM was not diagnosed until after he was approximately 11[ ]months old which was too late, as by then he had suffered brain damage." CP at 675.

The superior court ruled that CHI did not owe KJM a duty under RCW 7.70.030 because CHI was not a health care provider as defined in RCW 7.70.020. KJM filed a motion for reconsideration which the superior court denied. In its order denying KJM's motion for reconsideration, the superior court reiterated its ruling on summary judgment regarding CHI:

> It is not enough to allege CHI was negligent. It is fundamental that an action for negligence does not lie unless the defendant owes a duty . . . to [the] plaintiff. *McCluskey v. Handorff-Sherman*, 125 Wn.2d 1, 6, 882 P.2d 157 [] (1994). [KJM] has failed to articulate why CHI had a duty to [KJM] here.

CP at 1490.

KJM appeals the superior court's orders granting summary judgment and denying reconsideration, the final judgment of dismissal of CHI with prejudice, the order dismissing the remaining defendants,[3] and the order striking the trial date.

ANALYSIS

I. SUMMARY JUDGMENT STANDARD

"The standard of review of a summary judgment dismissal is de novo." *Collins v. Juergens Chiropractic, PLLC*, 13 Wn. App. 2d 782, 792, 467 P.3d 126 (2020). "We review all evidence and reasonable inferences in the light most favorable to the nonmoving party." *Collins*, 13 Wn. App. 2d at 792. "We may affirm an order granting summary judgment if there are no genuine issues of material fact and the moving party is entitled to judgment as a matter of law." CR 56(c);

[3] KJM voluntarily dismissed his claims without prejudice against FHS and St. Joseph pursuant to CR 41(a)(1)(A).

Collins, 13 Wn. App. 2d at 792. "A genuine issue of material fact exists where reasonable minds could differ on the facts controlling the outcome of the litigation." *Collins*, 13 Wn. App. 2d at 792.

"The party moving for summary judgment has the initial burden to show there is no genuine issue of material fact." *Collins*, 13 Wn. App. 2d at 792. "A moving defendant can meet this burden by showing that there is an absence of evidence to support the plaintiff's claim." *Collins*, 13 Wn. App. 2d at 792. "Once the defendant has made such a showing, the burden shifts to the plaintiff . . . to present specific facts that show a genuine issue of material fact." *Collins*, 13 Wn. App. 2d at 792. "Summary judgment is appropriate if a plaintiff fails to show sufficient evidence to create a question of fact regarding an essential element on which he or she will have the burden of proof at trial." *Collins*, 13 Wn. App. 2d at 792.

II. No Duty Owed To KJM

KJM argues that CHI qualifies as a health care provider under RCW 7.70.020 because it employs Dr. Semerdjian, a physician licensed in Washington. KJM argues that CHI, as a health care provider, owed him a duty to act reasonably because it is a corporate health system with superior knowledge, resources, and control over the local hospital, St. Joseph, where KJM received care. We disagree. We hold that CHI is not a health care provider as defined in RCW 7.70.020. We further hold that CHI had no employment relationships with any licensed health care providers who did make health care decisions regarding KJM at St. Joseph, particularly related to what screening tests for newborns were required to be given in August 2005, and thus, CHI did not owe KJM a duty.

A. LEGAL PRINCIPLES

1. Statutory Interpretation

We review questions of statutory interpretation de novo. *Jametsky v. Olsen*, 179 Wn.2d 756, 761, 317 P.3d 1003 (2014). Our goal when interpreting a statute is to "ascertain and carry out the legislature's intent." *Jametsky*, 179 Wn.2d at 762. We give effect to the plain meaning of the statute as "derived from the context of the entire act as well as any 'related statutes which disclose legislative intent about the provision in question.'" *Jametsky*, 179 Wn.2d at 762 (quoting *Dep't of Ecology v. Campbell & Gwinn, LLC*, 146 Wn.2d 1, 11, 43 P.3d 4 (2002)). If a statute's meaning is plain on its face, we give effect to that meaning as an expression of legislative intent. *Blomstrom v. Tripp*, 189 Wn.2d 379, 390, 402 P.3d 831 (2017).

2. Duty under Chapter 7.70 RCW

To prevail in a negligence claim, a plaintiff must establish "duty, breach, and resultant injury; and the breach of duty must also be shown to be the proximate cause of the injury." *Hartley v. State*, 103 Wn.2d 768, 777, 698 P.2d 77 (1985). To prove proximate cause, a plaintiff must prove cause in fact and legal causation. *Hartley*, 103 Wn.2d at 777.

Our supreme court has held, "'[W]henever an injury occurs as a result of health care, the action for damages for that injury is governed exclusively by RCW 7.70.'" *Fast v. Kennewick Pub. Hosp. Dist.*, 187 Wn.2d 27, 34, 384 P.3d 232 (2016) (alteration in original) (quoting *Branom v. State*, 94 Wn. App. 964, 969, 974 P.2d 335 (1999)).

Under RCW 7.70.030(1), a plaintiff can only recover damages from a health care related injury if he or she can prove that the "injury resulted from the failure of a health care provider to follow the accepted standard of care." Actions under chapter 7.70 RCW are all predicated on an

act or omission of a health care provider. Thus, under *Fast*, chapter RCW 7.70 is KJM's exclusive remedy for alleged damages regarding his birth at St. Joseph and the alleged failure to provide genetic testing in August 2005. 187 Wn.2d at 34. There is no remedy at common law for KJM's injuries.

To determine when chapter 7.70 applies, Washington courts look to the definition of "health care provider" under RCW 7.70.020 which is defined as 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.

(Emphasis added.)

"Health care" is defined as:

> "[T]he process in which [the physician] was utilizing the skills which he had been taught in examining, diagnosing, treating or caring for the plaintiff as his patient."

Reagan v Newton, 7 Wn. App. 2d 781, 791, 436 P.3d 411 (2019), *review denied*, 193 Wn.2d 1030 (2019) (alterations in original) (internal quotation marks omitted) (quoting *Beggs v. Dep't of Soc. & Health Servs.*, 171 Wn.2d 69, 79, 247 P.3d 421 (2011)).

The question of who is a health care provider under RCW 7.70.020 determines whether a person or entity owes a duty to a patient under chapter 7.70 RCW. The statutory definition of "health care provider" includes persons "licensed by this state to provide health care or related services" and their employers. RCW 7.70.020(1), (3).

B. CHI DOES NOT MEET THE DEFINITION OF "HEALTH CARE PROVIDER" UNDER RCW 7.70.020

KJM argues that CHI should be considered a "health care provider" under RCW 7.70.020(3) because it employs one physician licensed in Washington, Dr. Semerdjian. KJM also argues that there was a "nexus" between Dr. Semerdjian's activities and KJM's alleged injuries and Dr. Semerdjian "was directly involved in the CHI conduct that caused injury to KJM." Br. of Appellant at 36-37. The record in this case does not support this assertion. We hold that under the plain language of RCW 7.70.020, CHI does not meet the definition of a health care provider as correctly determined by the superior court.

Under a plain language analysis, "health care provider" is defined as persons "licensed by this state to provide health care or related services," and their employers. RCW 7.70.020(1), (3). Employing a person who is licensed in Washington State, does not bring that entity, here CHI, under the definition of health care provider where the employee is not actively engaged in providing health care or related services in Washington State. To the extent that the plain language of the definition reaches Dr. Semerdjian under the plain language of the statute, CHI's corresponding duty is limited to its role as an employer. He was not providing health care to any

patients in Washington, he had not provided direct care to patients in Washington since 1991, and CHI employed no person who was providing healthcare to patients in Washington when KJM was injured in 2005. Thus, for purposes of this case, CHI was not acting as a health care provider under the statute.

There is no evidence in the record that Dr. Semerdjian has provided health care in Washington as a physician since 1991. Dr. Semerdjian was not employed or credentialed at St. Joseph or at any FHS facilities in August 2005. Further, CHI does not employ any physicians who are actively engaged in the provision of health care services in Washington. Under the plain language of RCW 7.70.020, CHI is not a health care provider because CHI does not employ anyone actively engaged in providing health care or related services in Washington State.

C. EXPANDED DEFINITION OF "HEALTH CARE PROVIDER" UNDER RCW 7.70.020

KJM alternatively asserts that we should expand the definition of health care provider to "construe chapter 7.70 RCW to govern all persons engaged in the healing arts," arguing that to do so would serve public policy. Br. of Appellant at 29. KJM fails to cite authority to support this argument and we decline to expand the definition of health care provider in RCW 7.70.020 contrary to the plain language of the statute and legislative intent.

1. Legal Principles

Preliminarily, RAP 10.3(a)(6) requires a party to cite supporting authority for its argument. We note that KJM fails to cite authority for its proposed expansion of the definition of health care provider. But we exercise our discretion under RAP 1.2(a) to address this issue.

Our goal in interpreting a statute is to "ascertain and carry out the legislature's intent." *Jametsky*, 179 Wn.2d at 762. We give effect to the plain meaning of the statute as "derived from

the context of the entire act as well as any 'related statutes which disclose legislative intent about the provision in question.'" *Jametsky*, 179 Wn.2d at 762 (quoting *Campbell*, 146 Wn.2d at 11). If a statute's meaning is plain on its face, we give effect to that meaning as an expression of legislative intent. *Blomstrom*, 189 Wn.2d at 390. We avoid construing a statute to lead to absurd results. *Jespersen v. Clark County*, 199 Wn. App. 568, 578, 399 P.3d 1209 (2017). We do not add words to a statute that are not there. *Jespersen*, 199 Wn. App. at 578.

KJM asks us to expand the definition of a "health care provider" to include everyone "engaged in the healing arts" as does the language in RCW 4.24.290. We decline to do so. If the legislature had intended to include "all persons engaged in the healing arts" along with "person[s] licensed by this state to provide health care or related services," then presumably it would have done so. RCW 7.70.020(1).[4] However, it did not. KJM's proposed definition is not consistent with the plain language of the statute or legislative intent. We decline KJM's invitation to expand the definition.

2. Public Policy Does Not Support KJM's Claim

KJM next claims that "[i]f CHI is not subject to any negligence claim, there would be no way for the law of torts to encourage CHI to act reasonably or to hold it responsible when it unreasonably injures babies like KJM." Br. of Appellant at 41-42. But this argument wrongly assumes that CHI owed KJM a duty and subsequently breached that duty. We held earlier that CHI did not owe KJM a duty.

[4] The Legislature most recently amended this statute in 2019 and did not expand the definition at that time.

KJM also claims that without this expanded definition of health care provider to include CHI, he is left without any tort remedy here. But that is not accurate. Nothing in our analysis prevents a cause of action against individual health care providers, St. Joseph, or FHS.

Further, we agree with CHI that the corporate practice of medicine doctrine disfavors creating a duty for CHI in this case. Our supreme court has held that "[t]he corporate practice of medicine doctrine provides that, absent legislative authorization, a business entity may not employ medical professionals to practice their licensed profession." *Columbia Physical Therapy, Inc. v. Benton Franklin Orthopedic Assocs.*, *PLLC*, 168 Wn.2d 421, 430, 228 P.3d 1260 (2010). KJM's argument, that CHI exercised "complete corporate control over the policies and procedures of its Washington hospitals," is at odds with the corporate structure of CHI, which left the health care decisions regarding KJM's care and genetic testing to the licensed health care providers who provided KJM care and treatment at St. Joseph. Br. of Appellant at 37.

CHI did not mandate what newborn genetic screening tests KJM's doctors or St. Joseph had to do in August 2005, and there is no evidence in the record that it did so. Providing specific practice bundles on patient care at the request of its subsidiaries did not result in CHI substituting its judgment for the clinical judgment of the licensed and credentialed health care providers working at the hospitals in its subsidiaries. The legislature has determined that licensed health care providers should make health care decisions with their patients and the provider owes a duty to the patient under chapter 7.70 RCW. Thus, for these reasons, public policy does not support imposing a duty on CHI in this case.

D. NO FACTUAL OR LEGAL CAUSATION

Even assuming there is a duty owed by CHI to KJM, KJM fails to establish cause in fact or legal causation as a matter of law. KJM sued for damages for injuries resulting from CHI's alleged failure to include SNS testing for specific metabolic and genetic disorders, including GA-1, in the newborn tests offered to pediatric patients like KJM at St. Joseph. KJM also alleged that the defendants failed to consider other "best medical practices." CP at 42.

Cause in fact, or "but for" causation, refers to the "physical connection between an act and an injury." *Hartley*, 103 Wn.2d at 778. KJM argues that a jury could find a nexus between Dr. Semerdjian's activities and KJM's injury because of the role that Dr. Semerdjian had within the CHI system. But KJM fails to establish any cause in fact linking Dr. Semerdjian's activities to the health care decisions made by the licensed health care providers at St. Joseph which allegedly caused KJM's damages. Further, as a matter of law, KJM also fails to establish legal causation. Dr. Semerdjian did not treat KJM in August 2005 at St. Joseph, nor was he involved in making any health care decisions related to KJM, including newborn genetic screening for KJM at St. Joseph. The record also shows that CHI did not make any health care decisions or direct the health care of the licensed health care providers who did treat KJM at St. Joseph and who made decisions related to the genetic screening of KJM at St. Joseph.

KJM argues that CHI should have gone beyond the mandated screening on an institutional basis instead of a hospital-by-hospital basis because Baylor's Institute for Metabolic Disease, the institution CHI's Chief Medical Officer previously worked at, had ensured that all of its hospitals offered SNS before any state mandate. KJM does not cite anything that demonstrates that CHI had an obligation to adopt a similar SNS testing policy to that of Baylor's; rather, he simply asserts

that CHI *should* have adopted a similar policy. This argument is cursory at best and does not establish a causal connection between the treatment KJM received and his injury, especially where there is no evidence that CHI could have mandated a particular course of testing or treatment under the established relationship between CHI and KJM's health care providers. RAP 10.3(a)(6).

Because KJM fails to establish causation, and we can affirm on any grounds supported by the record, this additional basis supports summary judgment dismissal of KJM's claims against CHI. *See Port of Anacortes v. Frontier Indus., Inc*., 9 Wn. App. 2d 885, 892, 447 P.3d 215 (2019), *review denied*, 195 Wn.2d 1005 (2020).

E. CONCLUSION

KJM's argument that CHI owes him a duty under chapter 7.70 RCW is contrary to the plain language of the statute and legislative intent. We hold that the superior court correctly ruled that CHI did not owe a duty to KJM under chapter 7.70 RCW, and thus, it properly granted summary judgment dismissal on this basis.

III. VICARIOUS LIABILITY – APPARENT AUTHORITY

Finally, although not determinative of this appeal, KJM argues that CHI was vicariously liable for FHS and St. Joseph because they acted with apparent authority for CHI. Citing his mother's declaration, KJM states that CHI's name was printed on almost all of the medical records at St. Joseph's related to KJM's birth and newborn care. There is no evidence of apparent authority of FHS or St. Joseph sufficient to create a genuine issue of material fact even viewing the evidence in the light most favorable to KJM. Thus, we hold that CHI is not vicariously liable for FHS or St. Joseph.

"Under apparent authority, an agent . . . binds a principal . . . if objective manifestations of the principal 'cause the one claiming apparent authority to actually, or subjectively, believe that the agent has authority to act for the principal' and such belief is objectively reasonable.'" *Mohr v. Grantham*, 172 Wn.2d 844, 860-61, 262 P.3d 490 (2011) (quoting *King v. Riveland*, 125 Wn.2d 500, 507, 886 P.2d 160 (1994)). To recover under a theory of apparent agency, a plaintiff must show (1) conduct by the principal that would cause a reasonable person to believe that the agent was in fact an agent of the principal, and (2) reliance on that apparent agency relationship by the plaintiff. *Wilson v. Grant*, 162 Wn. App. 731, 744, 258 P.3d 689 (2011).

Here, KJM's mother stated in her declaration that the CHI logo was on the admission paperwork she filled out at St. Joseph when she arrived at the hospital to give birth to KJM. She stated this logo appeared on other "medical records and other documents relating to KJM's pediatric care after discharge." CP at 990. Based on this evidence in the record, KJM's mother had already selected St. Joseph as the hospital she intended to give birth at and only noted the CHI logo on the paperwork upon arrival and following discharge. KJM's mother did not select St. Joseph because she thought that specific hospital was acting at CHI's agent. KJM has not set forth any additional evidence that shows that FHS or St. Joseph had authority to act for CHI regarding the health care decisions of the licensed health care providers at St. Joseph who provided care and treatment to KJM, or that KJM's mother thought FHS or St. Joseph were apparent agents of CHI.

Thus, we hold that CHI is not vicariously liable for FHS or St. Joseph under a theory of apparent authority, and KJM fails to present sufficient evidence to support this claim.

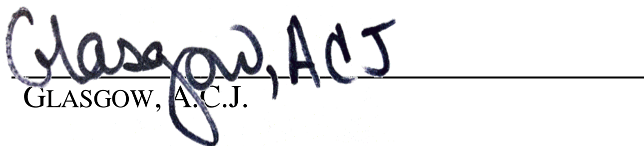
CONCLUSION

We hold that because CHI is not a health care provider under RCW 7.70.020, CHI does not owe a duty to KJM and even assuming a duty is owed, KJM fails to prove causation as a matter of law, and no duty exists under common law. We decline to expand the definition of health care provider and we hold that CHI is not vicariously liable for FHS or St. Joseph. We also decline KJM's invitation to apply Washington's definition of health care provider in a way that assumes CHI directed health care decisions in this matter as KJM provided no evidence that was the case. We affirm.

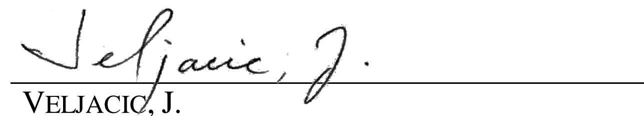
A majority of the panel having determined that this opinion will not be printed in the Washington Appellate Reports, but will be filed for public record in accordance with RCW 2.06.040, it is so ordered.

SUTTON, J.

We concur:



GLASGOW, A.C.J.



VELJACIC, J.

KELLER ROHRBACK L.L.P.

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