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**IN THE COURT OF APPEALS**  
**OF THE STATE OF WASHINGTON**  
**DIVISION II**

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**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,**

Respondent.

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**BRIEF OF APPELLANT**

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## I. INTRODUCTION

KJM was born on August 4, 2005, at St. Joseph Medical Center (St. Joseph) in Tacoma. Every state mandates screening newborns for various treatable, inherited diseases. Washington first mandated newborn screening for a single disorder in 1976. Over time, medical science learned to screen for more diseases, and, starting in the 1990s, to screen for multiple diseases with just a single blood sample. This led providers to test for more than just the diseases that a given state mandated, a practice known as “supplemental newborn screening” (SNS). *See generally* CP 612–13. KJM was born with a disorder known as GA-1. SNS would have detected this, but St. Joseph did not then offer SNS. KJM now has severe brain damage that could have been avoided. The test cost \$25.

St. Joseph is owned by Franciscan Health System (FHS). FHS is a non-profit corporation whose sole corporate member is Catholic Health Initiatives (CHI), a conglomerate operating facilities in 19 states. In the trial court, KJM showed that for years, CHI knew about SNS, offered it at many of its hospitals, *even in some states that did not yet mandate it*, but took no action to offer SNS at St. Joseph in Tacoma. It is undisputed that if KJM had been born at CHI’s St. Joseph Hospital in Reading, Pennsylvania, instead of the one in Tacoma, Washington, KJM would

have received SNS, GA-1 would have been detected, and KJM would have received critical treatment to avoid severe brain damage.

In the trial court, CHI moved for summary judgment. CHI argued that it created a corporate structure through which CHI avoided the definition of “health care provider” in chapter 7.70 RCW, which generally governs actions for injuries “arising out of health care.” Because CHI successfully avoided the statutory definition of “health care provider,” it argued, it had no duty to KJM, regardless of what it knew about SNS, the danger of not offering it at some CHI hospitals, and the foreseeable consequence to babies born at the wrong St. Joseph. The trial court granted CHI’s motion. KJM appeals.

## **II. ASSIGNMENTS OF ERROR**

### *Assignments of Error*

The trial court erred in entering its September 6, 2019 summary-judgment order dismissing claims against CHI and in entering its October 1, 2019 order denying reconsideration.

### *Issues Pertaining to Assignments of Error*

(1) CHI was the corporate parent of FHS and St. Joseph, knew about SNS, and through certain committees undertook responsibility for standardizing care and implementing best practices at CHI facilities. Did CHI owe a duty of care to KJM under Washington negligence law? *Yes.*

(2) Chapter 7.70 RCW generally governs actions for injuries arising out of health care and requires proof of a standard-of-care violation by a health care provider. Where CHI meets Washington standards for tort liability, and there is expert testimony that CHI violated an applicable standard of care, should chapter 7.70 RCW be construed to *either* allow claims against all persons actually providing health care *or* allow parallel claims against non-health care providers whose negligence also proximately causes injury? *Yes*.

(3) Is CHI additionally liable as a principal under the doctrine of apparent authority because FHS and St. Joseph were acting as its apparent agents? *Yes*.

### III. STATEMENT OF THE CASE

Because the Court is reviewing a summary-judgment ruling, the Court considers the evidence and all reasonable inferences from the evidence in the light most favorable to KJM. *Keck v. Collins*, 184 Wn.2d 358, 370, 357 P.3d 1080 (2015). Review is de novo. *Id.*

**A. CHI is a national health-care institution operating in 19 states and is the sole corporate member of FHS, operator of St. Joseph in Tacoma.**

CHI describes itself as a “national health care institution.” CP 50, 103. CHI was formed through the merger of Catholic health systems both because of a decline in Catholic leadership capable of leading health

systems and because of “growing pressure from for-profit health systems and significant consolidation within the industry.” CP 49–50. CHI was established in 1996 in response to “the growing threat to tax-exempt, faith-based hospitals from giant for-profit systems seeking to expand their market share during a wave of consolidation.” CP 103. CHI’s annual report describes it as “one of the nation’s largest non-profit health care systems.” CP 277–78. By 2005, CHI was the sole corporate member, an affiliate, or a partner with “health systems in 19 states,” including FHS and St. Joseph in Tacoma. CP 102.

CHI describes its own mission as providing health care, stating it has “the commitment and ability to go beyond the provision of quality health care to help protect the vulnerable,” among other things. CP 278. This comes from “its mission as a creator and builder of healthy communities.” *Id.* Its bylaws define its vision as “to live out its mission by transforming health care delivery.” CP 118. In CHI’s corporate filings with the Washington Secretary of State, it described its purpose as “[t]o provide, conduct, and administer health care and related services in conformity with the ethical and moral teachings of the Roman Catholic Church.” *E.g.* CP 281 (emphasis added). In the trial court in this case, CHI described itself as being “generally involved in health care.” CP 63.

CHI is the sole corporate member of FHS, the owner and operator of St. Joseph Hospital. CP 102, 152. As sole corporate member of FHS, CHI exercised the following control over FHS:

- CHI held power to approve and remove board members, CP 159;
- CHI held power to appoint and terminate the CEO, CP 160, 387;
- CHI employed FHS's President and CEO, CP 220;
- CHI held power to appoint the Senior VP of Operations to oversee the activities and affairs of FHS, CP 212, 388;
- FHS Board members must be approved by the FHS Senior VP of Operations, then submitted to CHI for appointment or refusal, CP 217;
- CHI held power to unilaterally change FHS's bylaws, CP 215;
- CHI held power to unilaterally transfer FHS assets to CHI, *id.*;
- FHS bylaws state that all activities of the "CHI healthcare system" are overseen and coordinated by CHI, CP 212;
- FHS must obtain CHI board approval for long range and strategic plans, CP 392;
- CHI and FHS share the same captive insurance company, CP 394;

- CHI provides centralized administrative services, accounts payable, IT services, risk management, and insurance for all its hospitals, CP 395;
- CHI's Director of Clinical Performance Improvement facilitated FHS's Joint Commission reviews for hospital accreditation and provided other clinical improvement and quality-assurance support, CP 427;
- CHI provided financial support to implement CHI-directed clinical practice bundles and other clinical practice changes, CP 313.

Through various corporate entities, CHI embraces 64 hospital facilities and 50 long-term care and residential-care facilities in 19 states. CP 435. With certain exceptions not applicable here, CHI's corporate documents state that CHI "controls these organizations through the reservation of certain powers," among them FHS. *Id.* While CHI insists that medical staff at FHS and St. Joseph were responsible for policies and procedures specific to that hospital, CHI concedes that they were "subject to the oversight of the Board of Directors," CP 99, which, in turn, was approved by, and subject to removal by, CHI. CP 159, 217, 386.

**B. By 2005, CHI knew that SNS was necessary to protect newborns from dangerous metabolic disorders and SNS was offered inconsistently within the CHI system.**

As early as 2000, a CHI advisory committee recommended that CHI “[d]evelop educational materials and resources that would assist CHI’s facilities in providing genetic testing education programs for senior leadership, medical staffs, and ethics committees.” CP 348. By 2002, CHI recognized that “[g]enetic screening of newborns for specific genetic diseases is standard practice.” CP 375.

Although every state, including Washington, mandates newborn screening for certain genetic diseases, *see* WAC 246-650-020, the states have not uniformly adopted screening requirements for the same disorders at the same time. Washington’s newborn advisory committee recommended in 2001 that the state’s screening be expanded from five disorders to nine, but it took three years, until 2004, to implement that recommendation by final rulemaking. CP 674. It took another four years to expand newborn screening again. *Id.*<sup>1</sup>

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<sup>1</sup> In the trial court, CHI argued, without evidence, that Washington’s regulatory mandate for newborn screening amounted to “what the Washington legislature had determined to be safe and adequate care at the time.” CP 924. This ignores both the history and nature of the screening mandate. Washington hospitals began offering newborn screening in the 1960s before any legal mandate. CP 614. In the 1970s, the legislature empowered the Department of Health to mandate screening for PKU and “other preventable heritable disorders.” Laws of 1977, Ex. Sess., ch. 80 § 40. Newborn screening was revolutionized in the 1990s, when Duke University scientists developed a process to test for multiple disorders using only a single blood sample. CP 612. The ability to test for multiple disorders without needing additional samples led to testing

Even before SNS was mandated, however, the screening was available and inexpensive. As early as 2002, even as the regulatory process was underway, the state Department of Health informed hospitals, including FHS and St. Joseph, that SNS for metabolic disorders was available through laboratories in other states. CP 709, 745. The cost of SNS through private laboratories was “as little as \$25,” and was “specifically designed to help address the situation in states such as Washington where there was significant delay in either offering or mandating broader screening.” CP 674–75. Between 2002 and 2005, several university and private laboratories offered this service to hospitals so that newborns did not lack SNS while the states went through the administrative process to mandate SNS, which is now required in all 50 states. CP 613, 674. By the time KJM was born in 2005, SNS had been adopted regionally, including in California, Oregon, Idaho, Alaska,

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beyond state mandates, i.e., SNS. *Id.* The presence of state mandates in no way prevented providers from performing additional screening necessary to protect patients, and still does not. CP 680, 745. Ironically, the legislature’s delegation to the Department of Health may have slowed Washington’s expansion of the screening mandate. Even when the Department of Health wished to expand screening to match that urged by the *March of Dimes*, it had to “seek necessary funding in the budget development process.” CP 745–46. The slow progress of Washington’s mandate in the 2000s was in no way a product of any governmental determination of what was “safe and adequate” as CHI argues, but rather was rulemaking held hostage to a budget process. This information comes from the Department of Health’s own manual distributed to Washington hospitals to explain that newborn screening had advanced beyond Washington’s existing mandate, which it was working to update. CP 724–87.

Hawai'i, and Guam, CP 615, and was mandatory at Washington's three military hospitals, CP 615, 675.

CHI was aware of SNS during the same period. Recognizing that genetic screening of newborns was already "standard practice," CP 375, in 2002, CHI stated there was "urgency for reflection" on genetic testing and formed a genetics advisory committee, CP 331–32 ("The Healing Ministry in the Age of Genetics"); 344 ("Planning for the Age of Genetics").

In January 2004, CHI's genetics advisory committee held a summit, which included a presentation describing the disparity in state newborn screening. CP 353, 361. CHI noted that the screening then mandated by the states "varies widely." CP 367. The purpose of newborn screening is to "identify disease before damage is done." *Id.* While one state at the time of the CHI summit screened for only three diseases, North Carolina already screened for 36. *Id.*

In January 2004, CHI formed an "interdisciplinary steering committee," comprised of national leaders, board members, and hospital CEOs, in part to review and approve CHI's National Health Care Environmental Assessment. CP 321. Genetic testing was one of nine identified "critically important strategic issues." CP 322.

In 2004, John Anderson, M.D. was appointed CHI's Chief Medical Officer; he had already served for several years on CHI's board. CP 529.

Before this appointment, Dr. Anderson had spent four years at Baylor Healthcare System, as its Vice President and Chief Medical Officer. *Id.* Dr. Anderson knew that Baylor's Institute for Metabolic Disease was a private laboratory offering SNS and that Baylor, as an institution, had ensured, prior to 2004, that all its hospitals offered SNS before any state mandate. CP 530. During Dr. Anderson's time at Baylor, "[i]f your baby [was] born at a Baylor facility, the test [SNS] [was] performed before your newborn leaves the hospital." CP 604.

In addition to its top officials having specific knowledge about the importance of SNS, in May 2005, CHI's genetics advisory committee held a two-day meeting, CP 372, to address "the most critical issues facing CHI regarding genetic testing," CP 375. Among the committee's recommendations was healthcare provider education on "genetic issues and technology available." CP 376. This was because the committee had found that the "critical issues facing CHI" included a "[k]nowledge deficit" among "physicians & nursing, clinicians." *Id.*

Indeed, now three years after CHI had formed the genetics advisory committee, there remained a serious gap in newborn screening within the CHI system. By 2005, CHI was operating hospitals in ten states that had already mandated expanded screening, all of which included screening for GA-1. CP 461–62. These states, and the years in which they

mandated expanded screening, were: Iowa (2001); Minnesota (2002); Oregon (2002); Idaho (2003); Maryland (2003); Nebraska (2003); North Dakota (2004); Ohio (2004); Missouri (2005); and South Dakota (2005). CP 462. Also by 2005, at least two CHI hospitals – Penrose Community Hospital in Colorado and St. Joseph’s Hospital in Pennsylvania – offered expanded newborn screening *even though those states had not yet mandated it. Id.* Despite these state-to-state discrepancies, there is no state-to-state difference in a newborn’s risk of having a detectable genetic disease. CP 463.

**C. CHI exercised clinical oversight over hospitals in its system but took no action in response to the recognized disparity in the use of SNS, violating the standard of care.**

In addition to the formal corporate powers described above, CHI oversaw clinical improvement in its hospitals. CHI provided support during Joint Commission reviews for hospital accreditation, including for St. Joseph. CP 427, 431. CHI’s Clinical Services Group (CSG) was “a multidisciplinary group” that included the CHI chief medical officer, chief nursing officer, certain Vice Presidents of medical affairs, the medical director, and others. CP 311. The “role of the CSG” was to “provide support to the hospitals for a variety of clinical issues.” *Id.* Critically, one such issue was the “quality improvement process.” *Id.* Dr. Anderson, a member of the CSG, CP 325, testified that the CSG “served clinical

information to various parts of the organization.” *Id.* The CSG also included CHI’s Director of Integrative Medicine, Milton Hammerly, M.D. CP 311. In this role, Dr. Hammerly 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. Additionally, the CSG had the responsibility to make sure “that quality improvement processes were in place in all of our local markets.” CP 327.

Dr. Hammerly described CHI’s practice bundles as the system looking at an issue “from a multidisciplinary perspective” to determine “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. The goal of the CSG was to “help standardize and improve care across the system.” CP 311. In some cases, if a CSG initiative would require a substantial time investment or impact on an individual hospital’s budget, CHI would either compensate the hospital or use a budget mechanism to offset the cost. CP 313.

Through these mechanisms, CHI circulated practice bundles to its hospitals concerning at least: catheter associated urinary infections; central-line assisted blood stream infections; anticoagulation; sepsis; community-acquired pneumonia; heart failure; transfusions; and end-of-life care. CP 539, 542. Each of these CHI initiatives was based on

identifying “best practice” for its hospitals, CP 310, in response to issues on which there was “variability and practices across a system,” CP 542.

CHI even employed a “Director of Clinical Performance Improvement,” Nancy Lima, who served on the CSG and as another quality improvement liaison with CHI hospitals. CP 427–29, 431–32.

CHI admitted that a significant portion of its system-wide business is delivering babies. CP 314. Despite this, CHI never assigned a pediatrician to the CSG. CP 318. CHI could not identify either a practice bundle or any other quality improvement initiative related to pediatrics. CP 314. CHI also did not assign a pediatrician to its genetics advisory committee. CP 318. Even though Dr. Anderson knew that his past employer Baylor had ensured that all its hospitals offered SNS, he conceded that CHI took no steps to address the same disparity within its system. Dr. Anderson testified in regard to SNS: “It simply was not on our radar as a priority.” CP 535–36.

KJM identified highly qualified experts who testified that CHI fell below the standard of care in the management of a health-care system.

Mark Stenius Roberts, M.D., served as Associate Director of quality within the University of Pittsburgh Medical Center Health System. CP 457. Dr. Roberts testified that “[t]he quality improvement and management of patient care throughout a healthcare system requires

oversight by the parent organization.” *Id.* “Operation of a healthcare system providing reasonable health care to its patients requires elimination of inappropriate variation in patient care throughout its healthcare system.” *Id.* Dr. Roberts concluded, “CHI’s system-wide failures with regard to adopting and implementing uniform policies and procedures regarding SNS ... was a clear breach of the standard of care applicable to reasonable, prudent healthcare organizations operating under the same or similar circumstances.” CP 462.

Leslie Selbovitz, M.D. served as Chair, Chief Medical Council, Partners HealthCare System Inc., in Boston, Massachusetts (founded by the Massachusetts General Hospital and the Brigham and Women’s Hospital). CP 673. Dr. Selbovitz testified that “[w]ell before KJM’s birth, every authoritative and relevant national organization ... had concluded that every baby should receive expanded newborn screening for 29 disorders recommended by The American College of Medical Genetics.” CP 675. Dr. Selbovitz concluded, “CHI had superior knowledge about the disparity in state mandated SNS across the states and within its own healthcare system, and the availability of private laboratories offering SNS to hospitals to remedy this disparity.” 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.*

Finally, Bradford L. Therrell, Jr., Ph.D., is considered the leading authority on newborn screening in the United States.<sup>2</sup> Dr. Therrell testified that “[b]y 2005, the standard of care for a reasonable, prudent hospital system in states that lagged behind [in the screening mandate] was to offer SNS for the core 29 conditions to parents of all its newborn patients through a private laboratory. This was a national standard.” CP 615. This screening included screening for GA-1. CP 613. Dr. Therrell testified, “CHI as a healthcare system had a duty to spread its knowledge and information system-wide about the disparity in SNS and the availability of private laboratories to remedy that disparity [in screening], an important health issue impacting newborn patients at all its hospitals across the system.” CP 616.

**D. KJM was not given SNS, and suffered severe, avoidable brain damage as a result.**

KJM’s mother testified that she would have gotten additional screening for KJM if it had been offered. CP 383. Dr. Selbovitz explained: “KJM did have one of the diseases on the SNS panel, and because he was

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<sup>2</sup> Dr. Therrell managed for more than 20 years the Texas newborn screening laboratory, the largest newborn screening laboratory in the world. CP 610. Dr. Therrell has authored or co-authored over 35 books, book chapters or monographs, and over 150 peer reviewed articles on various aspects of newborn screening. CP 611. Dr. Therrell directed the Council on Regional Networks and later the National Newborn Screening and Global Resource Center, the leading national resource center for newborn screening. Dr. Therrell also led the U.S. Health and Human Services Select Technical Assistance Team for Newborn Screening, which audited state newborn screening programs.

not screened, that disease was not identified shortly after birth. Instead, 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 675.

Timely testing and treatment for GA-1 prevents brain damage.

**E. CHI employed a Washington-licensed physician.**

A final matter is the role of CHI employee, Gregory G.

Semerdjian, M.D. Dr. Semerdjian was employed by CHI, maintained his office in Tacoma, and was licensed as a physician in Washington.

CP 317–18, 919–20. Thus, CHI is a “health care provider” under

RCW 7.70.020(1) & (3), which define as a “health care provider” any

“entity . . . employing” a “person licensed by this state to provide health care.”

Although Dr. Semerdjian did not provide bedside patient care, he was CHI’s “Vice President of Medical Operations.” CP 52; *see also* CP 356. He was a member of the Clinical Services Group which distributed practice bundles to CHI hospitals. CP 317. He served on CHI’s Physician Leadership Council. *Id.* He served on CHI’s genetics advisory committee, attended the January 2004 genetics summit, and attended the May 2005 genetics advisory committee meeting on critical issues on genetic testing. CP 318, 356, 379. CHI’s Director of Clinical Performance Improvement testified that if she had recognized the disparity within the

CHI system in hospitals offering SNS, she “probably” would have alerted Dr. Semerdjian, because “that would have been under that purview.” CP 430, 432. Thus, Dr. Semerdjian was directly involved in the CHI omissions that caused injury to KJM.

As discussed below, CHI argues that it was not a “health care provider” despite meeting the statutory definition by employing a Washington-licensed physician. CHI’s argument only highlights the critical point that chapter 7.70 RCW alone does *not* define whether a duty is owed. To the contrary, the Washington Supreme Court holds that the existence of a duty depends upon broader considerations than chapter 7.70 RCW. When the appropriate standards are applied, CHI owed a duty to KJM. Accordingly, KJM asks that this Court reverse summary judgment.

#### **IV. SUMMARY OF ARGUMENT**

Summary judgment should be reversed for the following reasons:

(1) Washington determines the existence of a legal duty based on considerations of logic, common sense, justice, policy, and precedent. Contrary to CHI’s argument in the trial court, Washington courts have applied this analysis in health care settings and have not looked to chapter 7.70 RCW in isolation to determine whether a duty is owed. When the proper standard is applied, CHI owed a tort duty to KJM.

(2) Chapter 7.70 RCW does not immunize CHI from tort liability. The Court should conclude that chapter 7.70 RCW permits CHI to be held accountable for its own conduct in one of two ways: either by embracing claims against all persons actually providing health care – i.e., defining CHI’s conduct as falling *within* the statutory regulation; or by not prohibiting parallel claims against non-health care providers contributing causally to an injury – i.e., by defining CHI’s conduct as falling *outside* the statutory regulation. Chapter 7.70 RCW requires a standard-of-care violation – which KJM’s evidence supports – but nothing suggests it was meant to immunize parties from otherwise proper tort liability.

(3) CHI is additionally liable under the doctrine of apparent authority, under which CHI is liable as a principal because FHS and St. Joseph were its apparent agents.

## V. ARGUMENT

In Washington, “[t]he essential elements of actionable negligence are: (1) the existence of a duty owed to the complaining party; (2) a breach thereof; (3) a resulting injury; and (4) a proximate cause between the claimed breach and resulting injury.” *Pedroza v. Bryant*, 101 Wn.2d 226, 228, 677 P.2d 166 (1984) (discussing a claim of negligence against a hospital). CHI challenges only one element: whether CHI owed a duty to KJM. Applying Washington standards for when a duty exists, it did.

**A. Under Washington tort law, CHI owed a duty to KJM.**

CHI's conduct meets the standards under Washington tort law to impose a duty of care. This Court should find that CHI, as a corporate health system with superior knowledge, resources, and control over the local hospital that treated KJM, owed him a duty to act reasonably and in accordance with the standard of care for a health system.

**1. Based on logic, common sense, justice, policy, and precedent, CHI owed KJM a duty to act reasonably.**

“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) (quoting *Snyder v. Med. Serv. Corp. of E. Wash.*, 145 Wn.2d 233, 243, 35 P.3d 1158 (2001)) (internal quotations omitted). Courts will 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 *Taylor v. Stevens County*, 111 Wn.2d 159, 168, 759 P.2d 447 (1988) (quoting W. Page Keeton, et al., *Prosser and Keeton on Torts* § 53, at 357 (5th ed. 1984))). To determine whether the plaintiff should be protected from defendants’ conduct, courts use their judgment to balance the interests at stake. *Id.* The interest in protecting people,

including children like KJM, from physical injury is particularly weighty.  
*See id.* at 452.

This standard is met here. First, large corporate health systems such as CHI occupy positions of control over the care provided by the hospitals they manage. Given CHI's control over its facilities, including FHS and St. Joseph, CHI was in the best position to ensure that newborns received the care recommended by national medical standards organizations and required by the majority of states. Second, tort liability would require corporate health systems to bear the costs of their unreasonable conduct, making them more likely to take due care. Third, corporate health systems have the knowledge and resources to develop best practices for the hospitals under their control. If the decision below stands, CHI would be immune from liability for unreasonable conduct – no matter how egregious its behavior or how seriously injured babies are at its hospitals. This would place the cost of this unreasonable conduct on patients and their families – and often public assistance programs such as Medicaid – rather than the large health-care systems in a position to affect the outcome. As in *LTK*, “[b]y deterring unreasonable behavior before it occurs and placing responsibility in the hands of the persons who can best

mitigate the risks, a duty of reasonable care could reduce the overall social costs.” 170 Wn.2d at 453.<sup>3</sup>

**2. Washington’s statutory regulation of health care liability complements the analysis of whether a duty exists.**

In the trial court, CHI never challenged the substantive application of the test set forth in *LTK* (among other cases). Rather, the centerpiece of CHI’s argument was that there was no need to consider any factors other than chapter 7.70 RCW and the contention that “CHI’s proper use of its corporate form entitles it to the protection of the general rule of non-liability for alleged torts committed by its corporate subsidiary.” CP 928. In truth, however, Washington courts have always looked to considerations beyond chapter 7.70 RCW when determining whether a tort duty exists in a health care setting.

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<sup>3</sup> Finding a duty by CHI is consistent with broader tort principles placing a duty upon those best-positioned to avert serious harm. See *Folsom v. Burger King*, 135 Wn.2d 658, 676, 958 P.2d 301 (1998) (“we recognize that liability can arise from the negligent performance of a voluntarily undertaken duty”) (discussing Restatement (Second) of Torts § 324A (1965)). It is well settled that “[o]ne who undertakes, albeit gratuitously, to render aid to or warn a person in danger is required by our law to exercise reasonable care in his efforts, however commendable.” *Brown v. MacPherson’s, Inc.*, 86 Wn.2d 293, 299, 545 P.2d 13 (1975) (citing *Jay v. Walla Walla College*, 53 Wn.2d 590, 595, 335 P.2d 458 (1959)). *Brown* held, “the State would be liable for its agents’ failure to warn [claimants] of their danger if they had assumed a duty to do so within the scope of their employment.” *Id.* at 302. CHI was formed precisely to ensure that its member hospitals such as FHS and St. Joseph had the benefits of industry consolidation, CP 103, and CHI in fact undertook to improve practice within its system in areas of discrepancy across the system, CP 310–11.

The history and purpose of Washington’s statutory regulation of health care liability is explained in *Harbeson v. Parke-Davis, Inc.*, 98 Wn.2d 460, 471, 656 P.2d 483 (1983). In an earlier case, *Helling v. Carey*, 83 Wn.2d 514, 519 P.2d 981 (1974), the Court had held that as a matter of law reasonable prudence required testing all patients for glaucoma, irrespective of the ophthalmology profession’s disregard of the test for those deemed to be at lower risk. The immediate impetus behind laws on health care liability enacted in 1975 and 1976, including chapter 7.70 RCW, was to reestablish the pre-*Helling* requirement that health care providers be judged against the medical standard of care. *Harbeson*, 98 Wn.2d at 468.

But even from the first days of statutory regulation, the courts continued to determine the existence of a *duty* “against the traditional concepts of duty, breach, injury, and proximate cause.” *Id.* at 471. This embraces broader considerations than merely chapter 7.70 RCW. It also comports with the Supreme Court’s observation that health-care liability in Washington is based on both “evolving common law” and applicable statutes. *Paetsch v. Spokane Dermatology Clinic, P.S.*, 182 Wn.2d 842, 849, 348 P.3d 389 (2015) (“[W]e recognize an evolving common law doctrine of the duties owed by physicians and have a robust statutory

scheme that carefully controls the practice of medicine by health care providers, . . . and defines liability for medical malpractice.”<sup>4</sup>

**3. Washington courts apply general tort standards to determine duty, including in health-care settings.**

In *Harbeson*, the issue was whether the Court would recognize a claim for wrongful birth, where providers had failed to warn expecting parents about the risk of possible birth defects. 98 Wn.2d at 464. The court began by recounting the 1970s legislation. When the court turned to duty, the court looked not to statutory criteria, but rather 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 the 1975–76 statutes, general tort law determines whether a duty is owed.* The 1975–76 statutes guide whether – once duty is established – 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).

A year after *Harbeson*, the Supreme Court engaged in a similar analysis in *Pedroza*. The court found that hospitals owe a duty, directly to the patient, to carefully select staff physicians and review their competency. 101 Wn.2d at 229. This was decided against the backdrop of chapter 7.70 RCW, but the court did not determine the existence of a duty

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<sup>4</sup> *Paetsch* did not reach the issue of duty based on a jury verdict finding no negligence. 182 Wn.2d at 850.

by reference to the statute. Rather, the court looked first to decisions predating chapter 7.70 RCW, 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.” *Pedroza*, 101 Wn.2d at 232.<sup>5</sup> The *Pedroza* court reviewed the nature of the modern hospital in 1984, finding that the doctrine of corporate negligence should be adopted 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 (quoting Southwick, *The Hospital as an Institution—Expanding Responsibilities Change Its Relationship with the Staff Physician*, 9 Cal. W. L. Rev. 429 (1973)).

Most recently in *Volk v. DeMeerleer*, 187 Wn.2d 241, 274, 386 P.3d 254 (2016), the court recognized in a health-care setting a duty of care by mental health providers “to act consistent with the standards of the

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<sup>5</sup> Even though *Pedroza* concerned care which occurred after 1976 and was governed by chapter 7.70 RCW, the court looked to pre-7.70 case law to decide whether to recognize a duty of care. In *Pederson v. Dumouchel*, 72 Wn.2d 73, 431 P.2d 973 (1967), the court held that a hospital violated the duty of care it owed to its patients. The court explained: “we conclude that it is negligence as a matter of law for a hospital to permit a surgical operation upon a patient under general anesthetic without the presence and supervision of a medical doctor in the operating room, in the absence of extraordinary and emergent circumstances.” *Id.* at 80. Similarly, in *Osborn v. Public Hosp. Dist. 1*, 80 Wn.2d 201, 205, 492 P.2d 1025 (1972), the court held that a hospital owed a duty of care to patients, independent of the duty owed by the physician, to establish policies to keep patients safe. *Id.* (citing former WAC 248-18-200(7)).

mental health profession and to protect the foreseeable victims of his or her patient.” Again, the court’s analysis of whether to recognize a duty did not turn on chapter 7.70 RCW, but rather 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.” *Id.* There can be no doubt, however, that in adopting as the standard of care “the standards of the mental health profession,” the court required proof of a standard-of-care violation as established in chapter 7.70 RCW.

The Court of Appeals applied an identical analysis distinguishing duty from standard of care in *Lam v. Glob. Med. Sys., Inc., P.S.*, 127 Wn. App. 657, 663, 111 P.3d 1258 (2005).<sup>6</sup> In *Lam*, survivors of a deceased seaman brought an action against two Washington physicians and their employer for allegedly giving negligent advice about the seaman’s condition to the crew of the fishing boat on which he was employed. *Id.* at 660–61. On the issue of duty, the court did not look to the 1975–76 statutes but relied on the physicians’ contractual agreement to “render consultation and provide advice.” *Id.* at 665. The court found support for the existence of a duty in holdings by courts in Texas, New York, and

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<sup>6</sup> *Lam* was a maritime action brought under the federal Death on the High Seas Act, 46 U.S.C.A. app. § 761(a) (2000), which incorporated Washington tort law as the law of decision. 127 Wn. App. at 663.

Ohio. *Id.* at 664 n.17 & 18. Like the Supreme Court in *Harbeson*, *Pedroza*, and *Volk*, the *Lam* court found a duty without any reference to chapter 7.70 RCW, but rather concluded that the physicians’ “activity” was “amply sufficient to create a duty of care.” *Id.* at 665 (emphasis added). Only after finding a duty existed, the court turned to the standard of care and held, on this issue, “Washington’s medical malpractice statute, chapter 7.70 RCW, should govern.” *Id.*

The court used a similar analysis, though one that incorporated chapter 7.70 RCW, in *Webb v. Neuroeducation Inc., P.C.*, 121 Wn. App. 336, 346, 88 P.3d 417 (2004). In *Webb*, a parent alleged a psychologist engendered false allegations of abuse in a child. 121 Wn. App. at 341–42. While recognizing that the statute defined the elements of a claim for injury arising out of health care, the court looked to broader considerations than the statute to determine that the psychologist owed a duty, including: whether a parent is among the class “foreseeably harmed by negligent investigation into allegations of child abuse,” the “bond between parent and child,” and decisions by “other jurisdictions” to “balance the interests of society in protecting children and the burden on therapists of imposing liability.” *Id.* at 349.<sup>7</sup>

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<sup>7</sup> Like *Harbeson*, *Pedroza*, *Volk*, *Lam*, and *Webb*, decisions that *declined* to find a duty also turned on considerations outside of chapter 7.70 RCW. In *Judy v. Hanford Envtl. Health Found.*, 106 Wn. App. 26, 22 P.3d 810 (2001), the court considered whether a

The consistent teaching of Washington decisions is that whether a duty is owed turns on fundamental principles of Washington tort law as established by the Supreme Court. In contrast, the work of the 1975–76 legislation is to define the standard of care, and what must be proved to establish breach. *Pedroza* is highly persuasive: CHI was established as a national health-care organization as part of a “wave of consolidation.” CP 103. Just as in *Pedroza*, the Court should recognize a duty that is consistent with the actual practice of medicine in the 21<sup>st</sup> century.<sup>8</sup>

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physician conducting pre-employment screening owed a duty to the employee. Finding no duty under the circumstances, the court noted that a duty by the screening physician did exist in some circumstances, but “this duty is not coextensive with that of the person’s own doctor, where the purpose of the examination is therapeutic” – a distinction absent from chapter 7.70 RCW, which only demands a standard of care violation once a duty is found. *Id.* at 38. Likewise, in *Alexander v. Gonser*, 42 Wn. App. 234, 239, 711 P.2d 347 (1985), the court held that a hospital had no duty to inform a patient of test results ordered by a physician, despite the hospital’s status as a provider subject to the requirements of chapter 7.70 RCW.

<sup>8</sup> Washington precedent establishes that the Court should recognize a duty by CHI. Non-Washington authority also supports a duty of care in these circumstances. For example, several courts have recognized liability claims premised on inadequate or incomplete research. *Lucarelli v. DVA Renal Healthcare, Inc.*, 2009 WL 262431, at \*5 (S.D. Ohio Feb. 3, 2009) (“The second amended complaint sufficiently alleges a claim for failing to exercise reasonable care in remedying known or suspected hazards with its equipment, once defendant voluntarily chose to study whether the equipment was in fact, safe.”); *Mut. Ins. Co. v. Bobst Group, Inc.*, 319 F. Supp. 2d 880, 883 (N.D. Ill. 2004) (duty to complete and report research on dangerous fumes emitted by printing machines); *Wright v. Brooke Group Ltd.*, 114 F. Supp. 2d 797, 831 (N.D. Iowa 2000) (duty to report research data on effects of smoking); *Silicone Gel Breast Implants Prod. Liability Litigation*, 887 F. Supp. 1455, 1461 (N.D. Ala. 1997) (claim for negligent research and testing on effects of silicone). CHI pointed to only one case dealing specifically with the liability of a health system, *Seagle v. Cross*, 2009 WL 2137420, noted at 680 S.E.2d 901 (N.C. Ct. App. 2009) (unpublished). While *Seagle* did affirm summary judgment for a health system based on the entity’s not acting as a health care provider under North Carolina law, this was only because the plaintiff had adduced no evidence that the entity or its personnel “were involved in the conduct upon which Plaintiff predicates his claim.” 2009 WL 2137420 at \*8.

Considerations of “logic, common sense, justice, policy, and precedent,” *LTK*, 170 Wn.2d at 449–50 (quotation omitted), all point to a conclusion that CHI owed KJM a duty of care.

**B. Finding a duty by CHI is consistent with legislative regulation of health-care liability.**

Ignoring Washington’s long history of decisions, including *Pederson*, *Osborn*, and *Pedroza* holding that health-care institutions – in addition to individual providers – owe a duty of care to patients in their system, CHI argues that its particular corporate structure places it beyond the reach of RCW 7.70.020’s definition of “health care provider,” and therefore beyond the reach of liability. This is wrong.

KJM agrees that a necessary element in a claim against an entity such as CHI should include evidence that the organization breached an applicable standard of care. KJM has presented leading national experts opining that CHI did breach the standard of care. As a matter of policy, then, KJM’s claim is fully consistent with chapter 7.70 RCW. What is important in this appeal is that, to the extent CHI’s negligent clinical oversight was health care, KJM’s claim can go forward because chapter 7.70 RCW should be construed to cover all persons actually providing health care, or, as CHI describes itself, those “generally involved in health care.” CP 63. But even if CHI’s negligent clinical oversight was not health

care, then CHI is nevertheless subject to liability parallel to any other parties, including the direct providers, if CHI also proximately caused injury to KJM. In either case, there is no legislative intent to immunize a party for negligence when the standards for tort liability are met.

**1. The Court should construe chapter 7.70 RCW to govern all persons engaged in the healing arts.**

CHI ignores Washington's principles of statutory construction, in which the court does 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). Examination of RCW 7.70.020 in context shows that it was never intended to supplant the traditional duty analysis – as indeed it never has – but was intended to impose a standard-of-care requirement for persons engaged in the healing arts. KJM's claim complies with chapter 7.70 RCW because KJM agrees he must present, and did present, expert testimony that CHI violated the standard of care for a health-care system.

The immediate impetus for legislative action on health-care liability in the 1970s was the *Helling* decision departing from the traditional rule that the medical community sets the standard of care. *Harbeson*, 98 Wn.2d at 468. This led to several statutory enactments.

First, in 1975, the legislature enacted RCW 4.24.290 to re-establish the pre-*Helling* standard. Under this statute, in any action “based on professional negligence against a hospital . . . , or 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).

Second, this was followed in 1976 by Laws of 1975–76, 2d Ex. Sess., ch. 56, codified as chapter 7.70 RCW. This covered all actions “for injury occurring as a result of health care.” RCW 7.70.010. The chapter limited claims to three categories: negligence, breach of promise, and informed consent. *Harbeson*, 98 Wn.2d at 468–69 (citing RCW 7.70.030). It reiterated the pre-*Helling* standard of RCW 4.24.290. *Id.* at 469 (citing RCW 7.70.040). It did not define “health care,” but defined a “health care provider” generally as either a person licensed to provide health care, a person employed by a licensed provider, or an entity, including a hospital, employing a licensed provider. RCW 7.70.020(1)–(3). Courts later held the legislature intended a “broad definition of ‘health care provider.’” *Grove v. PeaceHealth St. Joseph Hosp.*, 182 Wn.2d 136, 150, 341 P.3d 261 (2014); *cf. Reagan v. Newton*, 7 Wn. App. 2d 781, 798, 436 P.3d 411, *review denied*, 193 Wn.2d 1030 (2019) (L&I examination was “health care” for purposes of expert testimony requirement of chapter 7.70 RCW).

Last, the legislature amended chapter 7.70 RCW in 2006, incorporating, for purposes of informed consent, the definition of “health care” in RCW 70.02.010. *See* Laws of 2006, Reg. Sess., ch. 93. This definition limits “health care” to care “by a health care provider,” and therefore makes anything done by a non-health care provider *not* “health care.” *See* RCW 7.70.065(3) & 70.02.010(15); *see also* *Sherman v. Kissinger*, 146 Wn. App. 855, 867, 195 P.3d 539 (2008) (using RCW 70.02.010 to define the scope of chapter 7.70 RCW).<sup>9</sup> RCW 70.02.010’s definition of health care is consistent with the definition of health care adopted in *Reagan*: “the process in which the physician was utilizing the skills in which he had been taught in examining, diagnosing, treating, or caring for the plaintiff as [their] patient.” 7 Wn. App. 2d at 791–92 (quoting *Beggs v. Dep’t Social & Health Servs.*, 171 Wn.2d 69, 79, 247 P.3d 421 (2011) (discussing the test used by the Court of Appeals)).

Together, these statutes show the legislature intended to establish the standard of care for all professionals engaged in the “healing arts.” RCW 4.24.290. If CHI was providing health care, then it should be held to

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<sup>9</sup> Even before this legislative incorporation, the Supreme Court used RCW 70.020.010’s definition of “health care” in defining “health care” under RCW 7.70.020. *Berger v. Sonneland*, 144 Wn.2d 91, 109, 26 P.3d 257 (2001).

the standard of care of a health care provider and should be held liable in tort for any breach of that standard.<sup>10</sup>

**a. Construing the statute to govern all persons engaged in the healing arts best serves public policy.**

Holding CHI to the standard of care of a health care provider would be consistent with public policy and avoid aberrant results.

CHI's position would require a court to hold that persons providing health care can avoid liability for their negligence so long as they are not licensed by the state. This would make unlicensed medical professionals immune from tort liability. An unlicensed doctor is not a health care provider under RCW 7.70.020 (defining a health care provider as, relevantly, "[a] person licensed by this state to provide health care"). If an unlicensed doctor, or even a doctor licensed in Oregon but not in Washington, were to negligently injure a patient while performing surgery in Tacoma, CHI's position would require this Court to hold that the patient had no remedy. The unlicensed doctor would not qualify as a health care provider, and so, according to CHI, could not be sued under

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<sup>10</sup> Chapter 7.70 RCW defines officers or directors of an entity as healthcare providers. RCW 7.70.020(3). They certainly do not engage in direct clinical practice taking care of patients, but their role greatly impacts healthcare services provided to patients. Health care is not just bedside care, i.e., a doctor's history and physical, differential diagnosis, and treatment plan. Health care also includes implementing policies and procedures to assure quality care. WPI 105.02.02 ("A hospital owes an independent duty of care to its patients. This includes the duty to . . . exercise reasonable care to adopt policies and procedures for healthcare provided to its patients.").

RCW 7.70.020. But under CHI's position, the patient could not maintain a general negligence claim against the doctor because the injury "occur[ed] as the result of health care."

CHI argued below that it is not a "health care provider" as strictly defined in RCW 7.70.020 and should not be held to any standard of care because it did not directly employ any of the licensed physicians who participated in KJM's health care. Even if this were true, which KJM disputes, CHI's argument leads to untenable results. As noted above, the definition of "health care" adopted in 2006 limits that term to care provided "by a health care provider." RCW 7.70.065(3) & 70.02.010(15). Accordingly, if CHI was not acting as a "health care provider," – as it insists, CP 46, 56, 921 – then by definition its activity was not "health care." This would require remand, as it would mean it was error to apply chapter 7.70 RCW. Yet, this would set up a conflict with RCW 4.24.290, if CHI was nevertheless acting in the "healing arts."

The true focus should be on the activity in which CHI did engage, which included assessing, evaluating, and improving medical care at its facilities. In its efforts to standardize care at its facilities, it recognized the importance of genetic testing, but took no action to implement SNS uniformly. A reasonable jury could conclude based on KJM's evidence that this was negligence and proximately caused KJM to unnecessarily

suffer from GA-1. This is consistent with established Washington law recognizing that anyone performing a regulated professional task will be held to the standard of care of that profession. Any person engaging in the practice of law is held to the standard of care of that profession even if not licensed in order “to safeguard the public interest.” *Jones v. Allstate Ins. Co.*, 146 Wn.2d 291, 305, 45 P.3d 1068 (2002) (insurance adjuster); *see also Perkins v. CTX Mortgage Co.*, 137 Wn.2d 93, 104–06, 969 P.2d 93 (1999) (mortgage broker); *Cultum v. Heritage House Realtors, Inc.*, 103 Wn.2d 623, 631, 694 P.2d 630 (1985) (realtors). Similarly, if CHI was providing health care to KJM, it should be held to the standard of care of a health care provider, regardless of its corporate form.<sup>11</sup>

Nothing suggests the legislature intended chapter 7.70 RCW to serve as a shield from the duty analysis. Holding entities that provide health care to the standard of care of a health care provider avoids creating unintended immunity for tortfeasors. If the legislature had intended either RCW 4.24.290, chapter 7.70 RCW, or RCW 70.02.010 to put any parties

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<sup>11</sup> At minimum, whether CHI provided health care and therefore should be held to the standard of care of a health care provider is a fact question on which summary judgment was inappropriate. KJM has produced evidence that from 2000 through 2005, when registering with the State of Washington, CHI stated its business was to “provide, conduct, and administer health care and related services.” CP 281. Similarly, KJM produced evidence of CHI’s knowledge of SNS, genetic testing initiatives, and omission to implement SNS on a system-wide basis. *E.g.* CP 367.

beyond the reach of Washington tort law no matter their influence on Washington health care, it would have said so explicitly.

**b. CHI also qualifies as a health care provider under RCW 7.70.020 because it employs a physician licensed in Washington.**

The strange thing about CHI's insistence that it did not "act as a 'health care provider,'" CP 56, is that it does meet the definition. CHI employed Dr. Semerdjian, a Washington-licensed physician.

Under RCW 7.70.020(3), a "health care provider" includes "an entity, whether or not incorporated, facility, or institution employing one or more persons described in part (1) above." Part (1) includes "a person licensed by this state to provide health care." RCW 7.70.020(1). CHI admits that in 2005, "one CHI employee, Dr. Gregory Semerdjian actually held a Washington license." CP 52. Despite this, CHI argues that it still does not owe a duty, because Dr. Semerdjian "did not actually provide 'bedside care'" to KJM. CP 922. But this argument fails for at least four reasons.

First, the statute does not require a finding that a particular doctor employed by the defendant failed to follow the accepted standard of care. Instead, KJM "need prove only that his injury 'resulted from the failure of a *health care provider* to follow the accepted standard of care.'" *Grove*, 182 Wn.2d at 150 n.15 (citing RCW 7.70.030(1)) (emphasis in original).

CHI is a health care provider under the statute because it employed “a person licensed by this state to provide health care.” RCW 7.70.020, and KJM presented expert testimony that CHI breached the standard of care.

Second, CHI’s argument undercuts Washington’s broad definition of health care. *See Grove*, 182 Wn.2d at 150. CHI’s argument assumes that “health care” can refer only to the particular professional expertise deployed by the physicians who met with KJM’s parents and provided his immediate bedside care. KJM’s evidence shows otherwise: institutional decisions about whether to go beyond state-mandated screening on an institutional basis – as Baylor did – had obvious and profound impacts on KJM’s health outcome.

Third, CHI’s argument ignores the role that Dr. Semerdjian did have within the CHI system. To the extent some nexus is required between Dr. Semerdjian’s activities and KJM’s outcome – even though none is required under the statute – a jury could find that nexus here. KJM presented evidence that Dr. Semerdjian was directly involved in the CHI conduct that caused injury to KJM.

Fourth, CHI’s argument requires the Court to adopt both a narrow, literal reading of the statute, and at the same time a broad, purpose-based reading of the statute – a contradictory analysis tailored to suit CHI’s interests. On the one hand, CHI insists that the Court must strictly construe

the text of chapter 7.70 RCW for purposes of determining whether CHI may be subject to any liability. But, on the other hand, CHI insists that the Court must create some nexus requirement, which is totally absent from the statute, to justify holding that CHI is not a “health care provider” despite the fact it did employ a Washington-licensed physician. This is not fair to KJM.

CHI’s argument is inconsistent with Washington law. CHI argues that it can exercise complete corporate control over the policies and procedures of its Washington hospitals, yet do so from within a corporate structure that puts it beyond the reach of any tort liability to patients. The Court should recognize that any holding endorsing this arrangement is likely to trigger immediate restructuring of health systems operating in Washington to take advantage of this unjust loophole. Given that health care in the United States now operates in a post-consolidation environment, CP 103, this poses genuine danger to Washington patients.<sup>12</sup>

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<sup>12</sup> It is obvious that if CHI’s cynical legal strategy is successful, its insurer and lawyers – who represent both CHI and FHS/St. Joseph – next would move in limine to exclude all evidence of what CHI knew or did outside Washington to give the jury the gross misimpression that St. Joseph (1) is just a small community hospital without expertise in SNS, (2) was generally unaware of SNS, and (3) reasonably relied on and awaited direction from experts at the Washington Department of Health by way of a mandate, despite being part of a 19-state conglomerate that in fact knew its failure to implement SNS put newborn patients at grave risk.

**2. Alternatively, to the extent CHI acted outside of chapter 7.70 RCW, the Court should recognize a duty by CHI parallel to the statute.**

Despite CHI's insistence it was not a health care provider, CHI also is profoundly wrong about the legal ramifications if the Court were to accept its argument. If CHI was not acting as a health care provider, this would establish only that CHI operated outside chapter 7.70 RCW. This in no way immunizes it from liability.

By its terms, RCW 7.70.030 creates requirements for damage claims for injuries "occurring as a result of health care." CHI argued below that its conduct is not covered by chapter 7.70 RCW because it did not provide health care to KJM and because it was not a health care provider under the statute, due to its corporate form. CP 46, 57 ("CHI was not a 'health care provider' . . . . CHI did not provide healthcare to Plaintiff KJM."). But if CHI acted outside the statute, this Court should recognize that CHI had a duty to KJM under general principals of negligence law.

Courts have recognized that chapter 7.70 RCW does not preclude general negligence claims, even those that involve doctors or hospitals, if the claim is not based on an injury that occurred as a result of health care. For example, in *Harris v. Extendicare Homes, Inc.*, the court allowed a negligence claim under Washington law against a nursing home outside of

chapter 7.70 RCW. 829 F.Supp.2d 1023, 1028–29 (W.D. Wash. 2011). The court explained that while the development of a physician-approved care plan for the plaintiff was health care and any claims relating to deficiencies in the plan must be brought under chapter 7.70 RCW, other allegations of negligence, such as failure to give the plaintiff sufficient water and negligent hiring, retention, training, and supervision, “constitute claims of ordinary, common law negligence.” *Id.* (quotation omitted); *see also Conrad v. Alderwood Manor*, 119 Wn. App. 275, 78 P.3d 177 (2003) (affirming a negligence claim in the nursing home context).

CHI argued below that chapter 7.70 RCW provides the exclusive remedy in this case because, while it denies that it provided health care to KJM, it argues that his injury nevertheless occurred as a result of health care. But while one cause of KJM’s injury was the negligent health care by FHS and St. Joseph, KJM produced evidence that his injury was also caused by CHI’s negligent failure to advise its hospitals of or set policies about SNS, despite its knowledge of the testing and its control over CHI hospitals. CHI, like FHS and St. Joseph, was a proximate cause of KJM’s injury. If CHI acted outside the bounds of chapter 7.70 RCW, then this court should recognize that, as to CHI, KJM can pursue a general negligence claim.

There can be more than one proximate cause of the same injury. *N.L. v. Bethel Sch. Dist.*, 186 Wn.2d 422, 437, 378 P.3d 162 (2016) (“There may, of course, be more than one proximate cause of an injury.” (quoting *Smith v. Acme Paving Co.*, 16 Wn. App. 389, 396, 558 P.2d 811 (1976))); *Douglas v. Freeman*, 117 Wn.2d 242, 252, 814 P.2d 1160 (1991) (Injured plaintiff “charged Dr. Freeman with negligence in extracting her teeth and the clinic with negligence in supervising him. These are different theories of liability based on different standards of care” and are not inconsistent). If CHI was not providing health care, then chapter 7.70 RCW cannot bar its being liable for proximately causing injury to KJM, even if regulated health care providers may also have caused injury. *Estate of Sly v. Linville*, 75 Wn. App. 431, 439, 878 P.2d 1241 (1994) (holding that torts outside of the provision of health care are not governed by chapter 7.70 RCW but are instead governed by general negligence principles).

The court allowed claims on parallel duties in *Lam*. There, survivors of a deceased seaman brought claims based both on a shipowner’s nondelegable duty to care for seamen and on a duty by physicians consulting on injuries at sea to meet the chapter 7.70 RCW standard of care. The court rejected the argument that the existence of the shipowner’s duty negated the physicians’ duty. 127 Wn. App. at 663. Here

too, the mere fact that FHS or St. Joseph owed a duty to adhere to the chapter 7.70 RCW standard of care is “irrelevant” to the question whether CHI owed a duty because of its standing relative to KJM. *Id.*<sup>13</sup>

Nothing in chapter 7.70 RCW indicates that the legislature intended to eliminate negligence claims against entities who fall outside of the statute, let alone deliberately bring entities into the statute only to immunize them from liability.

**3. Precluding KJM’s claim entirely would be against public policy.**

CHI asks this Court to insulate it from any judicial review of its conduct – despite operating its hospitals as a health-care system – solely because it separately incorporated its individual facilities. Immunizing CHI from liability would violate the public policy of this state. The Washington Supreme Court has recognized that safeguarding “the safety of persons and property from physical injury” is “an interest that the law of torts protects vigorously.” *LTK*, 170 Wn.2d at 452 (citing *DAN B. DOBBS, THE LAW OF TORTS*, § 3 (“Legal rules give the greatest protection to physical security of persons and property.”)). If CHI is not subject to any negligence claim, there would be no way for the law of torts to

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<sup>13</sup> Chapter 7.70 RCW does not supersede all tort claims. For example, in *Bundrick v. Stewart*, 128 Wn. App. 11, 16–17, 114 P.3d 1204 (2005), the court recognized that the legislature, when enacting chapter 7.70 RCW, did not eliminate the claim of medical battery.

encourage CHI to act reasonably or to hold it responsible when it unreasonably injures babies like KJM.

KJM has produced abundant evidence establishing that by 2005: CHI knew about SNS and the disparities in offering it at CHI's hospitals; SNS was known to be inexpensive, risk free, and life-saving to one in every few thousand babies;<sup>14</sup> the majority of states already mandated it (and the rest planned to); all relevant professional standards organizations recommended it; and the standard of care required healthcare systems to offer it. Despite this and CHI's clear power to establish uniform practices throughout its system, CHI chose not to require or even suggest that the hospitals it operated in Washington offer SNS to parents. As a result, KJM was severely injured by a condition that should have been prevented. Nothing in chapter 7.70 RCW was intended to put conglomerates such as CHI beyond the reach of Washington tort law.

KJM's evidence showed a national standard of care for health care systems. CP 615. It would be tragic for patients if large health systems could avoid accountability for breaching an applicable standard simply by separately incorporating their many individual hospitals.

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<sup>14</sup> In 2004 and 2005 combined, there were 9,617 births at the three FHS hospitals, including 7,016 births at St. Joseph. CP 676.

**C. CHI held out itself and its reputation, thereby creating apparent authority in FHS and St. Joseph to act on its behalf.**

KJM's mother's hospital admission form, the discharge instructions, the order for newborn screening, KJM's own admission record, and almost all the medical records all bear the name "Catholic Health Initiatives." CP 455–56, 992–94, 1385–90. It is inconsistent with Washington law for CHI to brand FHS and St. Joseph as CHI facilities, to portray to the public that it is a large institution having the expertise of – and designed to compete as, CP 103 – a sophisticated healthcare conglomerate, and yet at the same time disclaim any responsibility for the care occurring at its facilities. In Washington:

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, 262 P.3d 490 (2011) (quotation omitted) (reversing summary judgment for hospital where there was fact question about whether physicians were held out as agents of hospital).

*Accord Adamski v. Tacoma Gen. Hosp.*, 20 Wn. App. 98, 112, 579 P.2d 970 (1978) (holding that whether doctor is apparent agent of hospital is fact question based in part on discharge instructions bearing name "Tacoma General Hospital") (quotation omitted).

The rule is the same even among multiple corporate entities. *Greene v. Rothschild*, 60 Wn.2d 508, 514, 374 P.2d 566 (1962), *overruled on other grounds in later appeal*, 68 Wn.2d 1, 402 P.2d 356 (1965) (“Conceding that the partnership had no control over the cab driver and was not a principal, it is still responsible for the driver’s negligence if, in reliance upon the representation of agency, the plaintiff sought the service of the Yellow Cab”); *Hansen v. Horn Rapids O.R.V. Park of the City of Richland*, 85 Wn. App. 424, 431, 932 P.2d 724 (1997) (“there is at least a genuine factual question whether Mr. Hansen reasonably believed Squisher Racing was Sunnyside Honda’s agent”).

Besides CHI’s actual efforts to promote system-wide standardization and best practices discussed above, CHI’s public representation is that its patients will secure the benefits of CHI’s consolidation as a health system. Thus, in addition to CHI’s owing KJM a duty based on its own actions, CHI additionally should be held liable because FHS and St. Joseph were its apparent agents.

CHI is hoping to set up a trial in which it disingenuously portrays St. Joseph as a simple community hospital that could not be expected to match the sophistication of institutions such as Baylor University, when in reality, CHI as a system was designed and able to offer state-of-the-art care. CHI actually had the knowledge and the means to protect KJM from

severe disability. Under the evidence KJM adduced, CHI is appropriately held liable for care performed in its name.

## VI. CONCLUSION

KJM respectfully asks that the Court reverse summary judgment and remand to superior court for further proceedings.

DATED this \_\_\_ day of April, 2020.

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