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COURT OF APPEALS, DIVISION II  
OF THE STATE OF WASHINGTON

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MATTHEW MENZER as Litigation Guardian ad Litem of KJM, a minor,

Appellant

v.

CATHOLIC HEALTH INITIATIVES, a foreign corporation;

Respondent;

FRANCISCAN HEALTH SYSTEM, a Washington corporation; and  
SAINT JOSEPH MEDICAL CENTER,

Defendants.

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**BRIEF OF RESPONDENT**

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## **I. INTRODUCTION**

Appellant KJM was born in August 2005 at St. Joseph Medical Center in Tacoma, Washington (St. Joseph). A year after his birth, he was diagnosed with a rare genetic disorder, Glutaric Acidemia Type 1 (GA-1). At the time of KJM's birth in 2005, the state-mandated Washington Newborn Screening Program did not include screening for GA-1, and the Department of Health Newborn Screening Laboratory did not screen for it. And in 2005, no acute care hospital licensed by Washington's Department of Health was performing routine newborn screening for GA-1. Thus, if KJM had been born at any other acute care hospital in Washington, such as Tacoma General Hospital (down the road from St. Joseph), or Swedish Medical Center in Seattle (the state's leading childbirth center), or the University of Washington Medical Center (the state's leading academic center), KJM still would not have undergone routine newborn screening for GA-1, and his outcome would have been the same as it is today.

Notwithstanding this fact, KJM claims that St. Joseph and its owner Franciscan Health System (FHS) still should have routinely screened for GA-1 in 2005. Facing the difficult prospect of proving that St. Joseph breached the standard of care by failing to screen for GA-1 when no other acute care hospital in Washington was doing so, KJM decided to sue Catholic Health Initiatives (CHI), the Colorado parent corporation of FHS,

claiming that CHI, which KJM paints as the omniscient corporate member of multi-state health care systems, had a duty to require every hospital in its system to perform the most robust newborn screening possible, regardless of state mandates and over the clinical judgment of individual health care providers.

Although KJM's claims against CHI have many problems, the most basic flaw is that CHI was not a health care provider, and thus had no statutory duty to dictate health care downward to or through its subsidiary corporations. In 2005, CHI did not operate as a hospital or any other health care entity, and it did not see or treat patients. CHI was a separately incorporated parent corporation to a number of health care systems, and its role, contrary to KJM's inaccurate depiction, was not to manage clinical care or direct medical decisions, but to support Catholic hospitals financially and administratively to further the religious ministry of the church. CHI did not employ any health care provider who cared for KJM (or any other patient) at St. Joseph, nor was it involved in KJM's newborn screening. As KJM's action is one claiming damages for injuries occurring as a result of health care, chapter 7.70 RCW governs exclusively. Under that statutory scheme, a non-health care provider like CHI did not owe a duty to KJM.

Contrary to KJM's appeals to policy, public policy disfavors requiring, or even allowing, a non-health care provider corporation from deciding what metabolic, genetic, and other medical screening tests should be performed on newborns, much less to impose those medical decisions downward over the judgment of actual practicing health care providers.

Ultimately, KJM asks this Court to set a precedent never set in Washington or any other state and create a new duty for CHI, a parent corporation that does not provide any health care, to dictate patient care at St. Joseph in the form of newborn screening in excess of what the state mandated and what was being offered by all other acute care hospitals licensed in Washington. Washington law does not support the creation of such a duty either within or beyond the bounds of chapter 7.70 RCW. The trial court properly granted summary judgment dismissing KJM's claims against CHI, and this Court should affirm.

## **II. STATEMENT OF THE ISSUES**

1. Did the trial court properly grant summary judgment dismissing KJM's claims against CHI when CHI, not being a health care provider under RCW 7.70.020, had no statutory duty, and when no authority supports the unprecedented creation of a common law duty?
2. Should this Court reject KJM's belated apparent agency argument because it is irrelevant to the question of CHI's independent duty and is not supported by the record?

### III. COUNTERSTATEMENT OF THE CASE

#### A. Creation and purpose of CHI

Catholic Health Initiatives (CHI) is not a licensed health care provider. *See* CP 97-98, 101-03. It has never been licensed in Washington State as a hospital, clinic, nursing home, or other type of health care facility or institution. *See id.*

In 2005, when KJM was born, CHI was a legally distinct and separately incorporated parent company to its subsidiaries, one of which is Franciscan Health System (FHS). CP 101-41. FHS, not CHI, owned and operated St. Joseph Medical Center in Tacoma, Washington (St. Joseph), where KJM's newborn screening occurred, and FHS, not CHI, employed or contracted with the health care providers at St. Joseph. CP 102-03. CHI did not come into being until decades after St. Joseph saw its first patients in 1891, CP 99, 169-73, and years after FHS's inception in 1981, CP 193-95.

The creation of CHI as a nonprofit parent corporation in 1996, when FHS merged with two other health care systems,<sup>1</sup> was a financial response to mounting pressure from for-profit health systems within the industry. CP 103. As a Public Juridic Person established by the Catholic Church, CHI

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<sup>1</sup> FHS and the two other Catholic health systems that merged to create CHI continued to exist as separate subsidiary corporations. CP 99, 102, 197-202. The sole corporate member of FHS became Catholic Health Initiatives. CP 102, 156-157. By 2005, CHI was the parent corporation of several subsidiary corporations that, like FHS, independently owned and operated hospitals in other states. CP 102.

could share financial resources with other Church entities to strengthen the competitive position of its subsidiary health care systems while ensuring that Catholic ideologies retained a presence. *Id.*, see also CP 109. CHI's stated purpose is "to promote and support, directly or indirectly, by donation, loan, or otherwise, the interests and purposes" of its "sponsored organizations." CP 109-10. CHI's purpose has never been to direct medical care at the hospitals its separately incorporated subsidiaries own or operate. CP 102-03. Instead, CHI's role is a supportive, financial, and religious one. CP 102-03, 109-10, 118-19.

KJM distorts CHI's role by asserting that CHI in 2005 had "complete corporate control over the policies and procedures of its Washington hospitals," *App. Br. at 37*, and that CHI "exercised clinical oversight over hospitals," *App. Br. at 11*. Contrary to KJM's assertions, CHI "did not have any involvement in the clinical decision-making or treatment of patients at St. Joseph Medical Center." CP 102. FHS, not CHI, owned and operated St. Joseph in 2005. CP 97-98, 194. FHS, not CHI, established the operating policies, including all clinical policies and procedures that drove patient care, at St. Joseph, and FHS, not CHI, oversaw all medical operations at that hospital. CP 98-99. As the owner of St. Joseph, FHS directly employed or contracted with physicians, nurses, and other health care providers for its operation. CP 97-98. FHS directly supervised its

medical staff and paid its health care providers. *Id.* FHS maintained an internal peer review process for licensed health care providers. *Id.*

CHI deliberately avoided an organizational structure in which CHI would direct medical and clinical decisions, because that was not its purpose.<sup>2</sup> For example, in 2005, the members of CHI's Board of Stewardship Trustees did not serve on the FHS Board of Directors. CP 102, *see also* CP 141, 163-67. CHI leadership did not dictate decisions regarding hiring or supervision of employees, medical staff privileging, or patient care at any FHS hospital. CP 97-99, 102, *see also* CP 208-35. CHI did not hire, supervise, manage, or evaluate any FHS employee or agent involved in providing health care to patients at St. Joseph. CP 97-99, 102-03. CHI did not direct medical policy, participate in the statutory quality assurance program, maintain the buildings or grounds, or provide supplies or equipment at St. Joseph.<sup>3</sup> *Id.*

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<sup>2</sup> KJM lists numerous items he believes prove CHI's "control" over FHS medical operations, *see App. Br.* 5-6. While these items provide a snapshot of some aspects of the relationship between CHI and FHS, a closer look confirms that, even as cherry-picked by KJM, the relationship between CHI and FHS was primarily administrative (VP of Operations, CEO, accounts payable, IT services, *App. Br.* at 5-6), supportive (facilitating joint commission reviews, long range and strategic plans, approving bylaws, *App. Br.* at 5-6), and financial (transferring assets, insurance, financial support to implement practice bundles, *App. Br.* at 5-6). That CHI could approve and remove members of the FHS Board of Directors does not equate to CHI being able to direct clinical care at FHS, as KJM implies, *see App. Br.* at 6. The FHS Board of Directors was an independent body, bound by its own fiduciary duties, and having its own decision-making authority for the operation of its hospitals, including St. Joseph. *See* CP 216.

<sup>3</sup> Although KJM asserts that CHI exercised "clinical oversight" by having a Clinical Services Group and developing practice bundles, *App. Br.* at 11-13, those aspects of CHI's relationship with FHS in actuality reinforce the supportive, rather than directive, nature of

Notably, in 2005, CHI did not employ any person in Washington who provided health care to patients, including KJM.<sup>4</sup> CP 102-03. No CHI employee had privileges to practice as a member of the medical staff at St. Joseph in 2005. CP 98. Only one CHI employee, Dr. Gregory Semerdjian, held a Washington license in 2005, CP 103, but he did not care for patients in Washington, did not practice or have privileges at St. Joseph, and did not participate in any way in KJM's care or newborn screening. CP 945, 952-53. He was a remote administrator for several facilities in other states. *Id.*

**B. Newborn screening in 2005**

KJM likewise creates the erroneous impression that all hospitals had a commonplace duty to conduct expanded newborn screening at the time of his birth in 2005. But as KJM nowhere disputes, *see App. Br. at 8-9*, at the time of his birth, no acute care hospital licensed in Washington was testing

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CHI's function. The role of the Clinical Services Group "was to provide support to the hospitals for a variety of issues...dealing with crises such as disruptive physician behaviors...contract negotiation breakdowns." CP 311. The Clinical Services Group would also visit subsidiary systems to help support clinicians by asking: "Who feels strongly about this? Who are the subject matter experts across the system?...Who ...feels passionate about this...We'd basically have to ask permission...then over the process of probably somewhere between 6 to 12 months because all of this takes time, we would then have a toolkit...But it wasn't coming from the national office. It was coming from this multidisciplinary group." CP 310. Responding to the articulated needs of the clinicians, the Clinical Services Group helped develop practice bundles. *See id.* Rather than directing medical care, the Clinical Services Group and the practice bundles that emerged from them were supportive, not dictatorial.

<sup>4</sup> Of the approximately 46 CHI employees working in Washington in 2005, the majority performed information technology or billing services. CP 102-03.

for the genetic disorder GA-1.<sup>5</sup> KJM also does not dispute that, in 2005, Washington’s mandated Newborn Screening Program did not include screening for GA-1,<sup>6</sup> or that the Department of Health Newborn Screening Laboratory did not test for it.<sup>7</sup> *See* WAC 246-650-020 (2005); CP 240-41.

Further, although KJM claims that every major pediatric society advocated for expanded newborn screening in 2005, *see App. Br. at 8*, implying that CHI should have imposed such expanded screening on its subsidiaries and their hospitals regardless of state legislative or regulatory requirements, in reality, those societies sought expanded newborn screening in the setting of *legislatively* enacted programs. *See, e.g.,* CP 659 (“Newborn screening should continue as a mandated state public health process, with ultimate responsibility for a successful program resting with the state public health department”),<sup>8</sup> 661 (“March of Dimes state chapters and their partners work closely with governors, state legislators, and health

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<sup>5</sup> Only the three U.S. military hospitals in Washington conducted routine newborn screening for GA-1 in 2005. *See* CP 615 (¶55.c), 675 (¶18), 702-03 (Thompson Dep. at 58-59); *App. Br. at 9*.

<sup>6</sup> Pediatricians and other clinicians could order a test for GA-1 if indicated for a specific patient. *See* CP 240-41. KJM’s pediatrician did not do so and KJM did not sue his pediatrician for failing to order a GA-1 test.

<sup>7</sup> The Washington Department of Health did not add GA-1 to the screening program until 2008, three years after KJM’s birth. *See* WAC 246-650-020 (2008).

<sup>8</sup> “Statement On Newborn Screening And Treatment Of Individuals With Inborn Errors Of Metabolism Detected By Newborn Screening.” *The Society for Inherited Metabolic Disorders*, 7 June 2004 (cited by KJM’s expert Dr. Therrell, CP 613 (¶30)).

departments to improve state newborn screening programs”).<sup>9</sup> Infrastructure, funding, and other resources must be in place to manage newborn screening before it can be effective. CP 664,<sup>10</sup> 669.<sup>11</sup> Similarly, despite KJM’s suggestion that CHI should have implemented across its whole system the supplemental screening two discrete hospitals in Colorado and Pennsylvania offered, *see App. Br. at 11*, the medical publications that KJM’s experts cite state that “there are sometimes compelling reasons for variability in testing between populations.” CP 658. KJM points to nothing in the record explaining why these Colorado and Pennsylvania facilities demonstrated variability in testing, but the medical literature he highlights confirms that this variability had legitimate reasons.

Thus, in accordance with the statutes and administrative rules applicable in Washington in 2005, St. Joseph personnel collected a blood

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<sup>9</sup> “March of Dimes Statement on Newborn Screening Report.” *March of Dimes*. 22 Sept. 2004 (cited by KJM’s expert Dr. Therrell, CP 613 (¶34)).

<sup>10</sup> “[T]he NSGC [National Society of Genetic Counselors] respectfully requests that in its recommendations this Committee also address the need for careful evaluation of each state’s resources to support the ACMG suggestions. Existent state systems which have already incorporated expanded newborn screening have experienced increased demands for clinical follow-up services on already limited resources.” *National Society of Genetic Counselors*, Public Statement: September 23, 2004 (cited by KJM’s expert Dr. Therrell, CP 613 (¶35)).

<sup>11</sup> “In its endorsement of the [Newborn Screening Report from the American College of Medical Genetics], the AAP [American Academy of Pediatrics] Board of Directors commented, ‘While we endorse the concept of expanded newborn screening, we strongly maintain that an explicit follow-up system must be established to support its effects on pediatric practices...We don’t want a child to be identified, and then not receive the necessary care or follow up.’” “AAP Endorses Newborn Screening Report from the American College of Medical Genetics.” *American Academy of Pediatrics*, May 12, 2005 (cited by KJM’s expert Dr. Therrell, CP 614 (¶38)).

sample from KJM for the Washington State Newborn Screening program and sent it to the Department of Health Newborn Screening Laboratory to test for nine genetic disorders. *See* chapter 70.83 RCW (2005); WAC 246-650-020 (2005); CP 240-41. A Washington State Department of Health pamphlet entitled “Newborn Screening Tests & Your Baby,” routinely provided to parents of newborns, listed the disorders identified by the test, and advised parents to consult their health care provider for information on screening for other conditions. *See* CP 240-41, 775. GA-1, KJM’s genetic condition, was not listed among the disorders identified by the test. *See id.*

**C. CHI’s lack of involvement with newborn screening**

Despite the fact that no Washington acute care hospital was testing for GA-1 in 2005, KJM asserts, *App. Br. at 8-10*, that CHI had a duty to require St. Joseph to do so in his case because CHI had a Genetics Advisory Committee and CHI’s Chief Medical Officer was from Baylor, where supplemental newborn screening was common.<sup>12</sup> KJM overstates CHI’s engagement with newborn screening, misconstrues the purpose and focus of CHI’s committees, and ignores CHI’s lack of involvement in directing clinical policies at its subsidiaries.

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<sup>12</sup> Although CHI’s Chief Medical Officer in 2005, Dr. Anderson, was from Baylor, he was a vascular surgeon, not a pediatrician, OB or neonatologist, and therefore not even involved with newborn screening at Baylor: “I was generally aware of the topic but not with any specificity...just from my own experience with my own children.” CP 530.

The Genetics Advisory Committee and its meetings focused on imparting a basic understanding of the Catholic Church's ethical and religious perspective in the emerging field of genetic testing, not only in newborn screening, but in a variety of medical contexts, including oncology, cardiology, prenatal testing, and forensics. *See* CP 331-42, 961-62. Mr. Middleton, the committee chair, was not even a physician, but instead the Vice President of Theology and Ethics for CHI. CP 341. As a Catholic entity, Catholic law binds CHI. CP 958. Catholic teachings do not restrict genetic testing if its purpose is within the rules the Church provided. CP 959-60. Thus, CHI formed several committees, including the Genetics Advisory Committee, to address the ethical issues and educate CHI's affiliates about the religious implications of genetic testing. CP 321-22, 331-42, 949, 961-63. CHI committees did not endeavor to provide clinical recommendations for any particular genetic testing, much less attempt to direct clinical practice related to newborns screening. *See id.*

**D. Procedural history**

**1. KJM's lawsuit**

When KJM filed this lawsuit in March 2017, he sued only Franciscan Health System d/b/a St. Joseph Medical Center, asserting that St. Joseph was the location where the alleged negligence had occurred in 2005, and that FHS owned and operated St. Joseph. CP 2. Later, KJM

brought Catholic Health Initiatives into the case, asserting that CHI owed independent duties to KJM. *See* CP 8-14, 18-19, 38-45. CHI denied that it employed or credentialed medical providers at St. Joseph, or that it owed an independent duty to KJM. *See* CP 32, 34.

## **2. CHI's summary judgment motion**

CHI moved for summary judgment dismissal of KJM's claims against it. CP 46-96. CHI did not seek dismissal of KJM's claims against FHS or St. Joseph, nor did it seek any relief that would affect KJM's ability to proceed against either of those defendants. CP 46-47. Instead, CHI asserted that it alone was an improper defendant in KJM's action, *id.*, because it was not a "health care provider" under RCW 7.70.020, and because chapter 7.70 RCW provided the exclusive remedy in actions for damages for injuries occurring as a result of health care such as KJM's. Thus, because CHI did not owe KJM the duties of a "health care provider" under chapter RCW 7.70, CHI argued that it could not be liable in this action. CP 55-59.

KJM opposed the motion, arguing that CHI was a health care provider under Washington law because it employed Dr. Semerdjian. CP 252-59. KJM went on to argue that, even if CHI was not a health care provider under chapter 7.70 RCW, the court should still find that CHI owed a common law duty to KJM because he believed that CHI should have

improved clinical practice at St. Joseph by requiring more robust newborn screening than required by Washington's Newborn Screening Program. CP 260-66. Finally, KJM asserted that CHI voluntarily assumed a duty. CP 266-69.

In reply, CHI re-emphasized that Dr. Semerdjian's license alone did not make CHI a health care provider when Dr. Semerdjian did not practice medicine in Washington and was not even tangentially related to the care at issue, nor did the Genetics Advisory Committee's focus on the religious and ethical implications of genetic testing mean that CHI assumed a duty to assure that all of its subsidiaries' hospitals provided enhanced newborn screening that included a GA-1 test. CP 919-31.

Although not permitted by the court rules, KJM filed a "sur-reply" the day before the summary judgment hearing, asserting for the first time that the court should hold CHI vicariously liable for the acts of FHS and St. Joseph based on apparent agency. CP 964-1002. At the summary judgment hearing, CHI objected to KJM's late-filed sur-reply brief, noting that it had no opportunity to reply. RP 11:5-9.

After hearing argument, the trial court granted CHI's motion for summary judgment and dismissed KJM's claims against CHI with prejudice, finding that CHI did not owe a duty to KJM, as CHI was not a

health care provider and KJM did not allege that any CHI employees were negligent. CP 1003-05; RP 30-33.

### **3. KJM's motion for reconsideration and appeal**

On September 16, 2019, KJM moved for reconsideration of the trial court's decision, asserting that he could pursue a common law negligence claim against CHI among various other legal theories. CP 1006-14. The trial court denied the motion for reconsideration, CP 1488-90, and entered final judgment dismissing CHI, CP 1491. KJM then voluntarily dismissed the remaining defendants, FHS and St. Joseph, CP 1492, and filed his notice of appeal, CP 1493-1506.

## **IV. SUMMARY OF ARGUMENT**

The trial court properly dismissed KJM's claims against CHI because CHI did not owe a duty to dictate—over legislative mandate and the medical judgment of actual health care providers—what newborn screening tests its subsidiaries or their hospitals generally, or FHS or St. Joseph in particular, were required to perform on pediatric patients in 2005. Because CHI did not provide care to KJM and had no employment relationship with any of the licensed individuals who did, CHI was not KJM's "health care provider" and did not owe him a duty under chapter 7.70 RCW.

First, KJM's claims against CHI unquestionably arise from health care, and Washington has a comprehensive statutory scheme governing all actions for damages for injuries occurring as a result of health care. Chapter 7.70 RCW provides the exclusive remedy from which KJM can recover. That statutory scheme does not extend a duty to non-health care providers.

Second, CHI is not a health care provider. It does not fall under any of the categories enumerated in RCW 7.70.020 that define "health care provider." It is not a hospital, clinic, or other licensed health care facility. It did not employ any physicians or individuals who cared for KJM or who were involved in determining what newborn screening KJM received. In 2005, CHI employed only one person with a Washington medical license, Dr. Semerdjian. But Dr. Semerdjian's license alone did not make CHI a health care provider under chapter 7.70 RCW because Dr. Semerdjian was not involved in the care at issue, has not practiced clinical medicine since 1991, and never did so in Washington or at St. Joseph.

Because CHI does not fit within the RCW 7.70.020's definition of a "health care provider," KJM asks this Court to expand that definition to include "all persons engaged in the healing arts." The plain language of the statute, legislative intent, and case law, however, do not support KJM's proposed definition, and that proposed definition is too broad and vague to be practicable. This Court should reject the definition that KJM has

invented. Because CHI is not a health care provider, it has no duty under chapter 7.70 RCW, and liability cannot extend to it in this action for damages for injuries occurring as a result of health care.

Third, because chapter 7.70 RCW provides the exclusive remedy in this case, the Court should reject KJM's invitation to create some new common law duty for CHI. Neither precedent, logic, common sense, justice nor policy support creating a new common law duty in this case. KJM asks this Court to expand potential liability under Washington's medical malpractice statute far beyond what the legislature intended and what courts have held.

Finally, KJM's afterthought argument that, even if CHI had no independent duty, it should still be vicariously liable based on apparent agency is without merit. Whether CHI may be liable for the actions of its subsidiary based on apparent agency has nothing to do with the actual issue on appeal, which is whether CHI owed KJM an independent duty. Further, KJM's evidence on apparent agency is legally insufficient, as he has failed to establish the basic elements of apparent agency.

## **V. STANDARD OF REVIEW**

"The existence of a duty is a question of law." *Branom v. State*, 94 Wn. App. 964, 968, 974 P.2d 335 (1999), *rev. denied*, 138 Wn.2d 1023 (1999). An action for negligence does not lie unless the defendant owes a

duty of care to the plaintiff. *Silves v. King*, 93 Wn. App. 873, 882, 970 P.2d 790 (1999) (citing *McCluskey v. Handorff-Sherman*, 125 Wn.2d 1, 6, 882 P.2d 157 (1994)). The meaning of a statute is also a matter of law. *Beggs v. Dep't of Soc. & Health Servs.*, 171 Wn.2d 69, 75, 247 P.3d 421 (2011). Questions of law are reviewed de novo. *Branom*, 94 Wn. App. at 968 (citing *Mains Farm Homeowners Ass'n v. Worthington*, 121 Wn.2d 810, 813, 854 P.2d 1072 (1993)).

Orders granting summary judgment are also reviewed de novo, with the appellate court engaging in the same inquiry as the trial court. *Gunnier v. Yakima Heart Ctr., Inc.*, 134 Wn.2d 854, 858, 953 P.2d 1162 (1998). “Summary judgment is proper if there is no genuine issue as to any material fact and the moving party is entitled to judgment as a matter of law.” *Id.* (citing CR 56(c)). The appellate court may affirm a trial court’s grant of summary judgment on any basis supported by the record. *LaMon v. Butler*, 112 Wn.2d 193, 200-01, 770 P.2d 1027 (1989), *cert. denied*, 493 U.S. 814 (1989); *Davies v. Holy Family Hosp.*, 144 Wn. App. 483, 491, 183 P.3d 283 (2008).

## VI. ARGUMENT

A. **In all civil actions for damages for injuries occurring as a result of health care, including KJM’s, chapter 7.70 RCW provides the exclusive remedy.**

KJM asks this Court to reverse CHI’s summary judgment dismissal, based on his claim that CHI owed him an independent duty.<sup>13</sup> As his action is one for damages for injury occurring as a result of health care, any such duty must flow from the chapter 7.70 RCW statutory scheme. That statutory scheme exclusively governs “all civil actions for damages for injury occurring as a result of health care, regardless of how the action is characterized.” *Branom*, 94 Wn. App. at 969 (emphasis in original); *see also Fast v. Kennewick Pub. Hosp. Dist.*, 187 Wn.2d 27, 34, 384 P.3d 232 (2016) (“[W]henver an injury occurs as a result of health care, the action for damages for that injury is governed exclusively by RCW 7.70”). KJM’s action is no exception. This is consistent with legislative intent, as articulated in the policy statement set forth in RCW 7.70.010:

The state of Washington, exercising its police and sovereign power, hereby modifies as set forth in this chapter and in RCW 4.16.350 ... certain substantive and procedural aspects of all civil actions and causes of action, whether based on tort, contract, or otherwise, for damages for injury occurring as a result of health care...

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<sup>13</sup> As previously noted, both the existence of a duty and the meaning of statute are questions of law. *Branom*, 94 Wn. App. at 968 (existence of a duty); *Beggs*, 171 Wn.2d at 75 (meaning of a statute).

“This section sweeps broadly.” *Branom*, 94 Wn. App. at 969.

Despite this well-established law, KJM nevertheless asserts, *App. Br. at 38-39*, that, if this Court determines that CHI is not a health care provider, it must also conclude that KJM’s claims against CHI did not arise from health care. That is incorrect. The determination of whether chapter 7.70 RCW applies is whether the claims arose from health care, not whether CHI was KJM’s “health care provider.” KJM’s claims clearly arose from health care, and his action is indisputably one for damages for injury occurring as a result of health care exclusively governed by chapter RCW 7.70.

For purposes of ascertaining when chapter 7.70 RCW applies, Washington courts look to the following definition of “health care”:

[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), *rev. denied*, 193 Wn.2d 1030 (2019) (internal citation omitted) (citing *Beggs*, 171 Wn.2d at 79; *Berger v. Sonneland*, 144 Wn.2d 91, 109, 26 P.3d 257 (2001); *Branom*, 94 Wn. App. at 969-70). This is consistent with the dictionary definition of “health care” as “[t]he prevention, treatment, management of illness and the preservation of mental and physical wellbeing through the services offered by the medical and allied health

professions.” *Id.* at 791-92 (internal citations omitted). It encompasses not only the traditional sense of bedside patient care, but also other situations involving the practice of medicine. *Id.* at 792.

*Branom v. State* is illuminating because the *Branom* plaintiffs’ claimed injuries did not arise from health care provided to them, but the Court of Appeals nevertheless concluded that their claims arose from health care such that chapter 7.70 RCW governed exclusively. *See Branom*, 94 Wn. App. at 970-71. *Branom* involved the parents’ claim for their emotional distress injuries due to the failure of their infant’s physician to inform them of his medical condition. *See id.* The parents contended that their injury did not result from “health care” because their infant’s physician did not treat them. *Id.* at 970. The Court of Appeals disagreed, finding that the “situation falls squarely within the statutory framework of RCW 7.70,” because the physician, although not providing care to the parents, was still “examining, diagnosing, treating or caring for” the infant, and it was from these actions that the parents’ own claims arose. *Id.* at 970-71.

Here, KJM’s claims arose from health care regardless of whether CHI was his “health care provider.” His complaint asserts damages for injuries resulting from the defendants’ alleged failure to include supplemental newborn screening for specific metabolic and genetic disorders, including GA-1, in the newborn tests offered to pediatric patients

like KJM at St. Joseph, and the alleged failure to consider other “best medical practices.” CP 10-11, 21, 42-43. This clearly constitutes the “prevention, treatment, management of illness and the preservation of mental and physical wellbeing through the services offered by the medical and allied health professions.” *Reagan*, 7 Wn. App. 2d at 791-92. Clinical policies and procedures regarding medical tests for diagnosing metabolic and genetic conditions, and the appropriate medical practices to implement newborn screening, fall squarely under “[t]he prevention, treatment, management of illness.” *Id.* As KJM’s claims arise from such “health care,” chapter 7.70 RCW provides the exclusive remedy.<sup>14</sup>

**B. Because CHI is not a health care provider, it did not owe a duty to KJM under chapter 7.70 RCW.**

Under RCW 7.70.030, a plaintiff may recover damages for injuries occurring as a result of health care only if the plaintiff proves one of three propositions:

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<sup>14</sup> KJM, *App. Br.* at 38-39, cites two nursing home cases, *Harris v. Extendicare Homes, Inc.*, 829 F. Supp. 2d 1023 (W.D. Wash. 2011), and *Conrad v. Alderwood Manor*, 119 Wn. App. 275 (2003), for the proposition 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. As those cases make clear, however, although the plaintiffs could pursue general negligence claims against the nursing homes arising from non-medical activities such as providing food and water, any claims pertaining to medical issues, such as deficiencies in physician-approved care plans, arose from health care and had to be brought under chapter 7.70 RCW. These cases reinforce that it is the nature of the action as arising from health care, rather than the status of the defendant as a health care provider, that determines whether chapter 7.70 RCW applies. Here, if KJM had claims against CHI that did not arise from health care, which he does not, he could pursue those. For example, if an IT specialist employed by CHI negligently installed a computer, causing an electrical fire that injured KJM, he could bring a general negligence claim.

- (1) That injury resulted from the failure of a health care provider to follow the accepted standard of care;
- (2) That a health care provider promised the patient or his or her representative that the injury suffered would not occur;
- (3) That injury resulted from health care to which the patient or his or her representative did not consent.

All three propositions are predicated on an act or omission of a *health care provider*, either for failing to follow the accepted standard of care, or for promising that the injury suffered would not occur, or for failing to obtain the patient's informed consent. *See* RCW 7.70.030, 7.70.040, and 7.70.050.

As KJM's action is one for damages for injury occurring as a result of health care, whether CHI owed KJM a duty turns on the statutory definition of a "health care provider" in RCW 7.70.020. The legislature has articulated who owes a duty under chapter 7.70 RCW, and it is "health care providers." Because CHI did not provide care to KJM and did not employ any of the licensed individuals who did provide care to him or who were even remotely involved in newborn screening at St. Joseph, CHI was not KJM's "health care provider" and therefore did not owe him a duty under chapter 7.70 RCW.

**1. CHI does not fall within the definition of "health care provider" in RCW 7.70.020.**

The legislature chose to define "health care provider" in RCW 7.70.020 as:

- (1) A person licensed by this state to provide health care or related services ...;
- (2) An employee or agent of a person described in part (1) above, acting in the course and scope of his [or her] employment ...; 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 ....

CHI is not a person licensed to practice health care in Washington under RCW 7.70.020(1). CHI is not an employee or an agent of a person licensed to practice health care in Washington under RCW 7.70.020(2). CHI is not a hospital, clinic, health maintenance organization, or nursing home, and it is not an officer, director, employee or agent of those entities under RCW 7.70.020(3). KJM does not dispute this. Instead, KJM says that CHI is a “health care provider” because it employed one Washington-licensed physician who had nothing to do with KJM’s care, did not have privileges at St. Joseph, and did not even practice medicine in Washington. *App. Br.* 35-36. This is insufficient to bring CHI within the definition of a “health care provider” for purposes of chapter 7.70 RCW.

**2. Employing Dr. Semerdjian does not mean that CHI acted as a “health care provider” to KJM.**

KJM claims, *App. Br. at 35-36*, that, because CHI employed one physician, Dr. Semerdjian, who happened to have a Washington license,

CHI is a health care provider under RCW 7.70.020. Yet, KJM presents no evidence that Dr. Semerdjian provided care to KJM or anyone else in Washington. Nor was he involved in KJM's genetic screening or any other aspect of the health care giving rise to KJM's claimed injuries.

Dr. Semerdjian is a CHI employee, but he does not provide health care as a physician, and he has not since 1991. CP 941. In 2005, CHI employed Dr. Semerdjian as a remote Vice President of Medical Operations to work with rural hospitals in North Dakota, Minnesota, Kansas, and Kentucky, not in Washington State. CP 944-45. While he resided in Tacoma, his work encompassed traveling to the out-of-state facilities assigned to him. CP 945-46. In 2005, Dr. Semerdjian had a cubicle in an office space owned by FHS, but he did not work with any FHS facilities, including St. Joseph, and had no role whatsoever in FHS. *Id.*; CP 954-55. He has never cared for patients in Washington State, and he did not have privileges to practice medicine or see patients at St. Joseph. CP 952-53.

In an attempt to force his case against CHI into the legal framework of chapter 7.70 RCW where it clearly does not fit, KJM contends, *App. Br. at 36*, that there is still a "nexus" between Dr. Semerdjian's activities and KJM's claimed injuries. Although KJM claims that Dr. Semerdjian "was directly involved in the CHI conduct that caused injury to KJM," *id.*, that is not true. Dr. Semerdjian did not see KJM, was not involved in his care, and

had nothing to do with the newborn screening he received. *See* CP 940-55. He also did not direct, manage, or have any involvement implementing policies and procedures on any topic, let alone newborn screening, at St. Joseph or FHS. CP 945, 955. In 2005, Dr. Semerdjian's role as Vice President of Medical Operations was exclusively with the rural hospitals in North Dakota, Minnesota, Kansas, and Kentucky. *Id.* He had no role in any capacity at St. Joseph or FHS. *Id.*

Washington law, which has consistently focused on the delivery of the medical care at issue as the touchstone for liability, does not support KJM's assertion that, by employing Dr. Semerdjian who had nothing to do with patient care at St. Joseph or FHS generally, or KJM's care or the newborn screening he underwent specifically, CHI became KJM's health care provider. By its plain language, the statutory definition of "health care provider" constitutes persons "licensed by this state *to provide health care or related services,*" and their employers. RCW 7.70.020(1), (3) (emphasis added). Simply employing someone who holds a Washington license does not bring an entity within the definition of "health care provider" if that individual did not provide the care at issue, or did not even generally provide any health care in the state. *See, e.g. Grove v. PeaceHealth St. Joseph Hosp.*, 182 Wn.2d 136, 144-150, 341 P.3d 261 (2014) (even with a "broad definition of 'health care provider,'" the question of duty remained

focused on the physicians employed by the hospital comprising the “medical team” who collaborated in the plaintiff’s care at issue).

No Washington court has ever extended the definition of “health care provider” to a company simply by virtue of having employed *any* licensed health care provider, especially one who was not present, had no role whatsoever in the care at issue, and did not direct clinical care. RCW 7.70.020 does not support such an untenable interpretation. It would create a health care provider-patient relationship and corresponding duty for non-health care entities, including, for example, law firms who employ legal nurse consultants and insurance companies who employ doctors to review claims. This Court should reject KJM’s invitation to define CHI as KJM’s “health care provider” simply because it employed Dr. Semerdjian.

**3. KJM’s argument that the Court should change RCW 7.70.020’s definition of “health care provider” to “all persons engaged in the healing arts” is untenable.**

KJM alternatively asks this Court, *App. Br. at 29-34*, to ignore the legislatively enacted definition in RCW 7.70.020 and adopt an expanded definition of “health care provider” never before recognized in this state that would include “all persons engaged in the healing arts.” This Court should decline KJM’s invitation to rewrite the statutory definition for several reasons, including that it contravenes RCW 7.70.020’s plain statutory

language, it is contrary to legislative intent, it lacks any precedential support, and its application would yield all-encompassing results.

**a. *Unambiguous statutory language does not support KJM's proposed definition.***

Defining a “health care provider” as “all persons engaged in the healing arts” is not what RCW 7.70.020 or RCW 4.24.290, which KJM cites in support of his argument, *App. Br. at 30-33*, says. KJM’s proposed definition is contrary to the unambiguous language of both statutes. When “a statute is not ambiguous, only a plain language analysis of a statute is appropriate.” *Cerrillo v. Esparza*, 158 Wn.2d 194, 201, 142 P.3d 155 (2006) (“Courts may not read into a statute matters that are not in it and may not create legislation under the guise of interpreting a statute.”) (quoting *Kilian v. Atkinson*, 147 Wn.2d 16, 21, 50 P.3d 638 (2002) (citing *Progressive Animal Welfare Soc’y v. Univ. of Wash.*, 114 Wn.2d 677, 688, 790 P.2d 604 (1990), and *Associated Gen. Contractors of Wash. v. King County*, 124 Wn.2d 855, 865, 881 P.2d 996 (1994)). Here, neither RCW 7.70.020 nor RCW 4.24.290 is ambiguous, and the plain language of neither statute supports KJM’s invented definition.

RCW 7.70.020 sets forth three categories of persons or entities that qualify as a “health care provider,” and none of them contain the phrase “engaged in the healing arts.” *See* RCW 7.70.020. As discussed above, CHI

does not fit in any of RCW 7.70.020's categories, and, apart from KJM's contentions about Dr. Semerdjian, KJM agrees. In terms of KJM's latching onto RCW 4.24.290 to argue for a new definition of "health care provider," that statute is much narrower than KJM suggests. KJM argues, *App. Br. at 31*, that RCW 4.24.290 supports a definition of "health care provider" that is "all professionals engaged in the 'healing arts.'" What RCW 4.24.290 actually refers to is "member of the healing arts," when it provides:

In any civil action for damages based on professional negligence against a hospital which is licensed by the state of Washington or against the personnel of any such hospital, or against a member of the healing arts, including, but not limited to, an acupuncturist or acupuncture and Eastern medicine practitioner licensed under chapter 18.06 RCW, a physician licensed under chapter 18.71 RCW, an osteopathic physician licensed under chapter 18.57 RCW, a chiropractor licensed under chapter 18.25 RCW, a dentist licensed under chapter 18.32 RCW, a podiatric physician and surgeon licensed under chapter 18.22 RCW, or a nurse licensed under chapter 18.79 RCW, the plaintiff in order to prevail shall be required to prove by a preponderance of the evidence that the defendant or defendants failed to exercise that degree of skill, care, and learning possessed at that time by other persons in the same profession, and that as a proximate result of such failure the plaintiff suffered damages, but in no event shall the provisions of this section apply to an action based on the failure to obtain the informed consent of a patient.

Except for mentioning "a member of the healing arts" instead of "person" before beginning the list of health care providers, RCW 4.24.290 sets forth

essentially the same definition as RCW 7.70.020.<sup>15</sup> RCW 4.24.290 is not incongruent with RCW 7.70.020 but largely the same, and neither statute's plain language defines a "health care provider" as "all professionals engaged in the 'healing arts.'"

**b. *KJM's proposed definition is contrary to legislative intent and not endorsed by case law.***

KJM cites no precedent approving a definition of health care provider so conflicting with statute and contrary to legislative intent. As KJM points out, *App. Br. at 30*, the legislature enacted chapter 7.70 RCW in 1976, a year after the legislature enacted RCW 4.24.290 in 1975. If the legislature wanted to consistently use the phrase "member of the healing arts" in RCW 7.70.020, or expand that definition to include "*all professionals engaged in the healing arts*" (emphasis added) as KJM suggests, it could have done so. Instead, it omitted any reference to "member of the healing arts" in RCW 7.70.020.

KJM incorrectly asserts, *App. Br. at 31*, that RCW 7.70.020 and RCW 4.24.290 "show the legislature intended to establish the standard of care for all professionals engaged in the 'healing arts.'" The legislature enacted chapter 7.70 RCW to limit, not enlarge, the reach of medical

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<sup>15</sup> RCW 7.70.020 is broader than RCW 4.24.290, with regard to the types of entities it includes, as RCW 4.24.290 is limited to licensed hospitals, whereas RCW 7.70.020(3) also includes certain non-hospital entities such as clinics, health maintenance organizations, and nursing homes.

malpractice actions. In the mid-1970s, a medical malpractice insurance crisis was upon the nation, posing a threat to the nation's health care systems by the corresponding rise in health care costs. *See, e.g., DeYoung v. Providence Med. Ctr.*, 136 Wn.2d 136, 147-48, 960 P.2d 919 (1998) (citing LAWS OF 1975-76, 2nd Ex. Sess., ch. 56); *Sherman v. Kissinger*, 146 Wn. App. 855, 866, 195 P.3d 539 (2008). In an effort to decrease the costs of health care, the legislature enacted chapter 7.70 RCW "to limit civil causes of action against a health care provider." *Sherman*, 146 Wn. App. at 866 (citing 1976 Final Legislative Report, 44th Wash. Leg., 2d Ex. Sess., at 22).

KJM fails to cite any authority that endorses defining a health care provider as "all professionals engaged in the healing arts" for purposes of chapter 7.70 RCW. Even *Grove v. PeaceHealth*, a case that KJM touts as supporting a broad definition of health care provider, does not go beyond the plain language of the RCW 7.70.020, as the defendant in that case was a hospital included in RCW 7.70.020(3), and Washington licensed physicians, physician assistants, nurses, and other medical staff provided the care at issue. *See Grove*, 182 Wn.2d at 140. And, even in *Reagan v. Newton*, the other case KJM relies upon to support his new definition of "health care provider," the defendant was a physician, fitting squarely within RCW 7.70.020(1)'s definition of "health care provider." *See 7 Wn. App. 2d 781.*

**c. *KJM's proposed definition is too broad and vague to be practicable.***

Beyond lacking statutory or case law support, the definition that KJM proposes is too vague and encompassing to be practicable.<sup>16</sup> If this Court defines “health care provider” as “all professionals engaged in the ‘healing arts,’” the reach of chapter 7.70 RCW would go from the appropriately finite that the legislature intended, to boundless. KJM’s definition would expand chapter RCW 7.70 to include claims against any “professional” who has some “engagement” with or connection to medicine, however remote or isolated. The list of “health care providers” under KJM’s definition would include ones the legislature never imagined chapter 7.70 RCW should reach, including health care insurers, medical malpractice defense attorneys, in-house hospital counsel, medical sales people, pharmaceutical representatives, receptionists, transcriptionists, medical coders, IT professionals, administrative assistants, and human resources managers.

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<sup>16</sup> KJM suggests, *App. Br. at 32-33*, that his all-inclusive definition of “health care provider” is necessary to ensure that negligent people engaged in medicine are not immune from liability, for example, unlicensed physicians who injure a patient. This is a hollow argument. Washington’s legislature has provided means to address injuries resulting from unlicensed practice of medicine. *See, e.g.*, RCW 18.130.190 (providing penalties and liability for practicing medicine without a license). There are also civil remedies in the form of intentional torts like battery, assault, and fraud that would be available in KJM’s hypothetical.

This Court should “not subject an unambiguous statute to statutory construction” as KJM requests, and should decline KJM’s invitation “to add language to an unambiguous statute” by re-defining health care provider with limitless language and meaning absent from both RCW 7.70.020 and RCW 4.24.290. *See Cerrillo*, 158 Wn.2d at 201.

**C. KJM’s policy arguments do not support creating a new duty.**

Although chapter 7.70 RCW provides the exclusive remedies in actions for damages for injuries occurring as a result of health care, KJM asks the Court to create a new duty for CHI, even if it is not a “health care provider” under the statutory scheme, claiming that public policy demands it. This Court should not contravene the exclusive remedies and limitations imposed by chapter 7.70 RCW, including the limitations imposed by RCW 7.70.020’s definition of “health care provider.” Because the legislature has already determined that it is “health care provider[s]” as defined in RCW 7.70.020 that owe duties in actions for damages for injuries occurring as a result of health care and CHI is not such an entity, this Court should reject KJM’s common law duty arguments.

Even if this Court were to evaluate the factors for a common law duty, despite the fact that chapter 7.70 RCW provides the exclusive remedies for KJM’s action, evaluation of those factors only confirms that the Court should not create a duty here. A duty of care is “an obligation, to

which the law will give recognition and effect, to conform to a particular standard of conduct toward another.” *Affiliated FM Ins. Co. v. LTK Consulting Servs., Inc.*, 170 Wn.2d 442, 449, 243 P.3d 521 (2010) (internal citations omitted). In evaluating whether to impose a duty, courts consider “logic, common sense, justice, policy, and precedent, as applied to the facts of the case.” *Centurion Props. III, LLC v. Chi. Title Ins. Co.*, 186 Wn.2d 58, 64-65, 375 P.3d 651 (2016) (citing *LTK*, 170 Wn.2d at 449). None of these factors justifies creating an unprecedented duty for CHI that requires a non-hospital corporation with no role in employing, credentialing, or supervising the licensed providers who actually treated KJM to impose on its affiliates medical decisions like newborn screening.

**1. Precedent weighs against creating a duty for CHI.**

Precedent does not support creating the duty that KJM seeks to invent for CHI. None of the cases that KJM cites is analogous to the situation here, and other precedent opposes recognizing this novel duty.

**a. *The cases that KJM cites are not analogous.***

The cases that KJM says establish Washington precedent for the duty he seeks to create do not do so. KJM asserts, *App. Br. at 21*, that even in the setting of a health care liability lawsuit such as his own, “Washington courts have always looked to considerations beyond chapter 7.70 RCW when determining whether a tort duty exists.” Although Washington courts

may have done so in the context of articulating specific duties owed by *health care providers*, none has done so in the setting of a non-health care provider corporation like CHI.

Unlike here, each medical liability case that KJM cites, *App. Br. at 22-27*, involved a health care provider defendant who fit exactly within the statutory framework of RCW 7.70.020. In *Helling v. Carey*, 83 Wn.2d 514, 519 P.2d 981 (1974), the court evaluated whether a *physician* had a duty to perform a specific test for glaucoma. In *Harbeson v. Parke-Davis, Inc.*, 98 Wn.2d 460, 656 P.2d 483 (1983), the issue was whether *physicians* had a duty to protect parents' right to prevent the birth of children with defects. In *Volk v. DeMeerler*, 187 Wn.2d 241, 386 P.3d 254 (2016), the issue was whether a *psychiatrist* had a duty to protect reasonably foreseeable victims of his patient's violence. In *Khung Thi Lam v. Global Med. Sys.*, 127 Wn. App. 657, 111 P.3d 1258 (2005), the issue was whether *physicians* who provided telephone medical advice pursuant to a contract owed a duty to patients on board a ship. In *Webb v. Neuroeduc. Inc., P.C.*, 121 Wn. App. 336, 88 P.3d 417 (2004), the issue was whether a *psychologist* owed a duty to protect parents harmed by child abuse allegations. In *Judy v. Hanford Envtl. Health Found.*, 106 Wn. App. 26, 22 P.3d 810 (2001), the issue was whether a *physician* in physical capacity to work evaluation owed a duty to the employee. The courts in those cases assessed whether a health care

provider owed a specific duty under a specific set of facts, not whether a non-health care provider entity owed a duty at the outset under chapter 7.70 RCW.

Similarly, *Pedroza v. Bryant*, 101 Wn.2d 226, 677 P.2d 166 (1984), *Pederson v. Dumouchel*, 72 Wn.2d 73, 431 P.2d 973 (1967), *Alexander v. Gonser*, 42 Wn. App. 234, 711 P.2d 347 (1985), and *Osborn v. Public Hosp. Dist. 1*, 80 Wn.2d 201, 492 P.2d 1025 (1972), cited by KJM, *App. Br. at 23-27*, addressed the duties owed by a hospital, which is a “health care provider” under RCW 7.70.020. While St. Joseph, as a hospital, may be subject to corporate negligence under chapter 7.70 RCW, CHI is not a hospital and sees no patients. At no time relevant to this case did CHI undertake, perform, or participate in any of the duties that Washington courts recognize as the basis for corporate liability, such as maintenance of buildings and grounds, provision of supplies and equipment free of defects, selection of employees with reasonable care, and supervision of “all persons who practice medicine within its walls.” See *Douglas v. Freeman*, 117 Wn.2d 242, 248, 814 P.2d 1160 (1991). CHI had no role in maintaining grounds, providing equipment, employing licensed staff, granting practice privileges, supervising employees, or reviewing the quality of care provided at St. Joseph. CP 97-99. FHS fulfilled those duties independently. *Id.*, 101-03.

KJM's reliance on *Affiliated FM Ins. Co. v. LTK Consulting Servs., Inc.*, 170 Wn.2d 442, 243 P.3d 521 (2010), *App. Br. at 20-21*, is similarly misplaced. *LTK* merely affirmed that engineers have a common law duty to exercise reasonable skill and judgment in performing engineering services, rejecting the claim that the engineers had no duty independent of their contract. *See id.* at 461. Consistent with what Washington courts had already held for years, that decision ratified prior precedent. *See id.* at 454. Here, by contrast, KJM asks this Court to adopt an entirely novel duty that no court in the state has recognized. *LTK* is unhelpful in this regard.

The rescuer liability cases that KJM footnotes to suggest CHI assumed a duty, *see App. Br. at 21, n.3*, are likewise off-topic. The "rescuer" doctrine establishes liability for assuming a duty "if (1) the actor voluntarily promises to aid or warn the person in need and (2) the person in need reasonably relies on the promise or a third person who reasonably relies on the promise." *Shizuko Mita v. Guardsmark, LLC*, 182 Wn. App. 76, 85, 328 P.3d 962 (2014); *Brown v. MacPherson's, Inc.*, 86 Wn.2d 293, 298-301, 545 P.2d 13 (1975). A party may be liable for attempting a voluntary rescue and making the situation worse by: "(1) increasing the danger; (2) misleading the plaintiff into believing the danger had been removed; or (3) depriving the plaintiff of the possibility of help from other sources." *Folsom v. Burger King*, 135 Wn.2d 658, 676, 958 P.2d 301 (1998).

KJM claims, *App. Br. at 9-12*, that CHI voluntarily undertook a duty to guide FHS and St. Joseph's clinical practice regarding newborn screening by having a Genetics Advisory Committee and developing practice bundles on other medical topics. KJM not only mischaracterizes the purpose and substance of CHI's activities regarding genetic testing in 2005, which were primarily religious, as well as the practice bundles, which were supportive, but he also fails to offer evidence establishing the elements of rescuer liability. KJM does not allege that CHI voluntarily attempted to set system-wide medical policies on newborn screening, but did so negligently. There is no evidence that CHI promised to aid or warn KJM that Washington hospitals screened for different conditions than hospitals in other states. There is also no evidence, and KJM does not allege, that CHI increased KJM's risk of having a condition not included in screening, or misled KJM's parents into believing that Washington hospitals provided screening for all possible conditions or that all CHI affiliates provided such screening, or deprived KJM of help from other sources. The voluntary rescue assumption of duty doctrine does not apply under these facts.

**b. *This Court should consider out-of-state persuasive authority that is analogous.***

Although Washington courts have not addressed the duties of a corporation with no role in providing medical care at a hospital owned and

operated by another entity, a North Carolina court has evaluated a similar situation. In *Seagle v. Cross*, 2009 N.C. App. LEXIS 1119, \*1, \*11-18 (2009) (unpub.), *rev. denied*, 363 N.C. 807 (2010), the appellate court affirmed summary judgment dismissal of a patient's claims against a defendant "health system" corporation because the hospital where the patient received care was owned and operated by a separate corporate entity. The evidence established that: (1) Mission Hospitals, not the defendant health system, owned and operated the hospital where the patient was treated; (2) Mission Hospitals and defendant health system "were separate and distinct corporate and legal entities"; and (3) Mission Hospitals, not the defendant health system, credentialed the physicians practicing at the hospital. *Id.* at \*5, \*12-13. Even though the defendant health system was Mission Hospitals' sole member and managed it, those facts alone did not "tend to show the existence of a health care provider to patient relationship...of the type necessary to support a medical negligence action." *Id.* at \*15-16. The court concluded that defendant health system was not a "health care provider." *Id.* at \*12-13.

The *Seagle* case is persuasive authority. The *Seagle* court recognized that, in addition to eclipsing the statutory definition of "health

care provider,”<sup>17</sup> it did not make sense to extend the specialized duty of care owed by a hospital to its patients to a corporation not involved in hiring, credentialing, or supervising the licensed medical professionals who provided the care at issue. *Id.* at \*24-25. In other words, a corporation that was not “functioning as a health care provider in connection with the treatment that [plaintiff] received” should not be liable for the acts or omissions of licensed medical professionals over which it had no authority or influence. *Id.* at \*12. Here, it is undisputed that no CHI employee provided the care at issue or was involved in the decision surrounding what newborn screening KJM should have received. The result in *Seagle* should apply here as well.<sup>18</sup>

**c. *The corporate practice of medicine doctrine is precedent that disfavors creating a duty for CHI.***

The corporate practice of medicine doctrine militates against imposing a duty on CHI to dictate what treatments or tests its subsidiaries’

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<sup>17</sup> The North Carolina statute provides a definition of “health care provider” that includes hospitals, like that of RCW 7.70.020(3). *See Alexander*, 42 Wn. App. at 239, 242 n.4. The North Carolina statute refers to licensed persons and persons “acting at the direction or under the supervision” of hospitals. *See Seagle*, 2009 N.C. App. LEXIS 1119 at \*11-12. Like the Washington Legislature, the North Carolina Legislature chose to impose a specialized duty of care upon those who employ licensed medical professionals to provide patient care. The North Carolina court’s interpretation of its statute defining “health care provider” affords persuasive insight into the Washington Legislature’s similar choices.

<sup>18</sup> “Since Plaintiff has to show that agents, servants, or employees of Defendant were involved in the provision of health care services to Seagle in order for Plaintiff to obtain a recovery from Defendant, evidence that Defendant may have operated a hospital facility and provided such services to other persons through its agents, servants and employees simply does not suffice to rebut Defendant’s forecast of evidence that it was not involved in the provision of health care services to Seagle.” *Id.* at \*26.

hospital health care providers should or must provide. Under the corporate practice of medicine doctrine, a tenet of Washington law for nearly 80 years:

“While a corporation is in some sense a person and for many purposes is so considered, yet, as regards the learned professions which can only be practiced by persons who have received a license to do so after an examination as to their knowledge of the subject, it is recognized that a corporation cannot be licensed to practice such a profession. ...”

“A corporation cannot be licensed to carry on the practice of medicine. Nor, as a general rule, can it engage in the practice of medicine, surgery, or dentistry through licensed employees. ...”

*State ex rel. Std. Optical Co. v. Superior Court for Chelan County*, 17 Wn.2d 323, 328, 135 P.2d 839 (1943) (citation omitted). “The corporate practice of medicine doctrine provides that, absent legislative authorization, a business entity may not employ medical professionals to practice their licensed professions.” *Columbia Physical Therapy, Inc. v. Benton Franklin Orthopedic Assocs., PLLC*, 168 Wn.2d 421, 430, 228 P.3d 1260 (2010) (citing *Morelli v. Ehsan*, 110 Wn.2d 555, 558, 756 P.2d 129 (1988)). Our Supreme Court has recognized that “[a]t bottom, the doctrine exists to protect the relationship between the professional and the client,” cognizant of the potential danger 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.” *Id.* at 431 (internal citations omitted). For example, running more medical

tests equates to more medical bills, leading to increased profits for a corporation, but that is not necessarily in a patient's best interest, which is why the corporate practice of medicine doctrine leaves these types of decisions in the hands of health care providers, not non-health care provider corporations.

Here, KJM seeks to impose a duty on CHI that does exactly what the corporate practice of medicine doctrine guards against – the corporate invasion into the clinical practice and medical decisions of actual health care providers. CHI has never intended to, nor has it ever, encroached on the medical judgment of the licensed medical providers at its subsidiaries' hospitals across the country. Maintaining the medical autonomy of its subsidiaries' hospitals, CHI did not engage in "clinical oversight" of St. Joseph, nor did it exercise "complete corporate control over the policies and procedures of its Washington hospitals," as KJM erroneously asserts, *App. Br. at 11, 37*. CHI's structure instead allowed clinical and medical decisions to remain in the hands of medical providers at its subsidiaries' hospitals. *See supra* Sections III (A) and (C). In this vein, CHI chose not to dictate downward to health care providers what newborn genetic screening tests were appropriate.<sup>19</sup> *Id.*

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<sup>19</sup> Providing its subsidiaries with resources from which to engage in discussions about the ethics of genetic testing is not the same as CHI unilaterally determining what specific newborn screening tests were appropriate and requiring all of its corporate subsidiaries

Washington State, through the corporate practice of medicine doctrine, has expressly recognized that the practice of medicine is a profession. *See, e.g., Columbia Physical Therapy, Inc.*, 168 Wn.2d at 430; *Morelli*, 110 Wn.2d at 559. Our legislature has determined and nearly a century of judicial precedent has confirmed that only professionals licensed and trained in medicine should be making medical decisions. What tests are medically appropriate to screen particular newborn patients for specific genetic disorders is no exception. The corporate practice of medicine doctrine is strong precedent opposing the creation of the duty KJM seeks, which would require CHI, a non-health care provider, to interfere with and dictate clinical medicine.

**2. Logic and common sense disfavor creating the duty KJM asks this Court to impose.**

Logic and common sense also do not support imposing the duty KJM seeks to impose on CHI. KJM asks this Court to find that CHI, a non-health care provider corporation, owed him a duty to decide what newborn screening tests were medically appropriate for all pediatric patients in every state, and dictate that decision downward, regardless of a patient's clinical needs as determined by his health care providers or a state's legislative

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across the country to adopt them over the clinical decisions of their own health care providers or applicable state mandates. Similarly, CHI providing practice bundles on specific aspects of patient care at the request of its subsidiaries was not a substitute for the clinical judgment of health care providers. *See supra* Sections III (A) and (C).

mandate. As the cases above demonstrate, society disfavors the idea of a corporation—one whose financial interests may compete with individual patient needs—making medical decisions. That is because, logically, society wants those who have received years of education as physicians with professional ethics binding them, and those hospitals undergoing rigorous licensing, to use their clinical judgment in the practice of medicine. It is these health care providers, not corporations like CHI, who should decide what newborn tests should be offered to patients.

Taken to its logical conclusion, KJM's argument would impose direct responsibility on every parent corporation of a hospital's sole corporate member to improve all aspects of patient care by anticipating emerging trends, making medical decisions, and then imposing those decisions on health care providers in different states notwithstanding the input of their legislatures and licensed health care providers. Washington courts have never imposed such a duty on hospitals, much less on a parent corporation, like CHI, of a separate entity that owns or operates a hospital. This Court should decline to do so here.

**3. Justice and policy do not support creating a duty.**

In his appeals to justice and policy, KJM repeatedly suggests, *see e.g., App. Br. at 20*, that if this Court does not create a new legal duty, then CHI will be allowed to “immunize” itself from all liability regardless of

how egregious its acts, leaving KJM and other injured children without access to justice. This plea to emotion paints an inaccurate legal and factual picture for several reasons.

First, our Supreme Court has clearly stated that using the corporate form to limit liability is a legitimate purpose of a corporation that is not misconduct or some illegal loophole to “immunize” itself. *Meisel v. M & N Modern Hydraulic Press Co.*, 97 Wn.2d 403, 410-11, 645 P.2d 689 (1982). CHI and FHS are separate corporate entities. By definition, that does not expose CHI to liability for torts attributed to FHS. *Minton v. Ralston Purina Co.*, 146 Wn.2d 385, 397-99, 47 P.3d 556 (2002) (“It is a general principle of corporate law deeply ingrained in our economic and legal systems that a parent corporation (so-called because of control through ownership of another corporation’s stock) is not liable for the acts of its subsidiaries”) (internal quotations and citations omitted). Piercing the corporate veil “is an equitable remedy imposed” only in “exceptional circumstances” “to rectify an abuse of the corporate privilege.” *Truckweld Equip. Co. v. Olson*, 26 Wn. App. 638, 643-44, 618 P.2d 1017 (1980). The doctrine includes two factors: (1) “the corporate form must be intentionally used to violate or evade a duty,” and (2) “disregard must be necessary and required to prevent unjustified loss to the injured party.” *Meisel*, 97 Wn.2d at 410 (internal quotations omitted). If KJM had evidence suggesting that CHI misused its

corporate form to violate or evade a duty, he could pierce the corporate veil and pursue CHI. *See id.* KJM has offered no such evidence, nor has he challenged the legitimate reasons CHI has for maintaining a separate corporate identity distinct from FHS.

Second, KJM's emotional appeals to justice citing the importance of protecting newborn babies does not mean that he and other babies cannot still pursue "justice" from the correct defendants. There are multiple proper defendants from which KJM could attempt, and some of which KJM has attempted, to recover for his alleged injuries. FHS and St. Joseph are health care providers. St. Joseph is the location where KJM underwent the newborn screening that he says negligently omitted testing for GA-1, and FHS is the owner and operator of St. Joseph, employing the physicians, nurses, and other medical staff whose care is at issue. *Supra* Sections III (A), (B), and (C). Although KJM voluntarily dismissed without prejudice FHS and St. Joseph to pursue this appeal against CHI, CP 1491-92, and while these former defendants are prepared to defend their actions, KJM can still attempt to recover from them in the future should he choose. Additionally, there is no dispute that KJM's pediatrician could have ordered individual genetic testing, including for GA-1, if she believed it was necessary. *See* CP 240-41. While KJM elected not to sue his pediatrician, this would have been another avenue for potential recovery. In short, to

suggest that precluding his lawsuit against CHI will completely foreclose KJM and all babies' access to justice is an empty emotional plea entirely devoid of fact.

**D. KJM's argument that CHI is vicariously liable for FHS and St. Joseph based upon apparent agency is irrelevant to independent duty and legally insufficient.**

**1. Apparent agency is not determinative of this appeal.**

The issue on appeal is whether CHI owed KJM an independent duty. As demonstrated above, the law does not support KJM's position in that regard. KJM muddies the waters by asserting that, regardless of CHI's independent duty, it must remain in this lawsuit as vicariously liable for St. Joseph and FHS, who KJM says are CHI's apparent agents, *App. Br. at 43-44*. The issue of apparent agency is not determinative of this appeal. The Court should not use it as a ground to reverse the trial court's dismissal of CHI, where, as here, there is no evidence to support apparent agency.

**2. KJM's apparent agency argument is legally insufficient.**

Even if apparent agency were relevant to this appeal, which it is not, KJM has not presented sufficient evidence to establish its elements. Under apparent agency, the acts or omissions of an agent can bind 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) (internal quotations omitted) (citing *King v. Riveland*, 125 Wn.2d 500, 507, 886 P.2d 160 (1994)).<sup>20</sup> To establish apparent agency, the plaintiff must prove three basic elements:

the actions of the putative principal must lead a reasonable person to conclude the actors are employees or agents; the plaintiff must believe they are agents; and the plaintiff must, as a result, rely upon their care or skill, to her detriment.

*D.L.S. v. Maybin*, 130 Wn. App. 94, 98-99, 121 P.3d 1210 (2005) (citing *Riveland*, 125 Wn.2d 500, 886 P.2d 160 (1994); *Adamski*, 20 Wn. App. at 112). Applied in the hospital setting, a finding of apparent agency is predicated on the plaintiff seeking care from the alleged principal (CHI), not the apparent agent (St. Joseph), and believing that the apparent agent was an employee of the principal. *See, e.g., Adamski*, 20 Wn. App. at 112; *Wilson v. Grant*, 162 Wn. App. 731, 745, 258 P.3d 689 (2011) (plaintiffs sought care from principal hospitals by going to the ERs at the hospitals; they did not seek out the apparent agent physicians).

Here, KJM failed to present sufficient evidence to establish apparent agency. KJM's mother, in her declaration, says she noticed CHI's logo next to FHS's logo on her medical records *after* she had already chosen St.

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<sup>20</sup> "A finding of apparent agency can subject a hospital to vicarious liability for the negligence of contractor physicians or staff working at the hospital." *Mohr*, 172 Wn.2d at 860-61 (citing *Adamski v. Tacoma Gen. Hosp.*, 20 Wn. App. 98, 107-08, 579 P.2d 970 (1978)).

Joseph for prenatal care and KJM's birth. *See* CP 989-90. Thus, she did not choose to go to CHI; she chose to go to St. Joseph. Further, KJM's mother says that she thought FHS and St. Joseph were "part of a larger health system," and that this was "important" to her. CP 990. But she says nothing about believing that St. Joseph or FHS had authority to act for CHI, or that she believed they were agents of CHI, or that she relied on St. Joseph or FHS because she thought that they were agents of CHI. Even when viewed in the light most favorable to KJM, there is insufficient evidence to support his apparent agency claim.

## VII. CONCLUSION

The trial court properly granted summary judgment dismissing KJM's claims against CHI. The trial court properly concluded that CHI was not a "health care provider" subject to liability under chapter 7.70 RCW, and that there were no grounds supporting an unprecedented creation of duty beyond the statute. This Court should affirm.

RESPECTFULLY SUBMITTED this 12th day of June, 2020.

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