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No. 53972-1-II

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

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

Appellant,

v.

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

Respondents.

REPLY BRIEF OF APPELLANT

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I. INTRODUCTION

Defendant Catholic Health Initiatives (CHI) seeks a radical new interpretation of chapter 7.70 RCW. That law applies to "health care provider[s]" who provide "health care," and it limits the liability of "health care provider[s]" to three claims enumerated in RCW 7.70.030.[1] The law does not grant even "health care provider[s]" a no-duty immunity from suit, but only fixes the menu of claims for which they are subject to liability when performing "health care." As CHI concedes in its brief, when "health care provider[s]" engage in "non-medical activities," they are *not* protected by chapter 7.70 RCW and are subject to the same general tort claims as everybody else. Resp't Br. at 21 n.14.

Washington courts have adopted a broad definition of "health care." This has always been in the context of a claim against an admitted "health care provider," so that construing "health care" broadly brought claims against a provider into the chapter 7.70 RCW framework and carried out legislative intent that "health care provider[s]" providing "health care" would face liability only for the three enumerated claims. When chapter 7.70 RCW applied in these cases, it did not lead to a conclusion that any defendant owed no duty, but only that a health care

[1] These claims are breach of the standard of care, breach of promise, and failure to obtain informed consent.

provider defendant was subject to suit on only the three enumerated claims.

CHI asks this Court to take chapter 7.70 RCW and do something very different, and completely unprecedented. CHI argues that a defendant who is *not* a "health care provider," and who was *not* engaged in "health care," can adopt chapter 7.70 RCW's protections, and evade *any* liability. This is so, CHI says, because only a health care provider can be liable for the three enumerated claims, and the statute does not provide for any other claims. According to CHI, the legislature enacted a statute intended to protect "health care provider[s]," but in so doing was silently far *more* protective of broad classes of satellite actors in the health care industry. As explained below, this would be an unprecedented result, an incredibly unjust one, and likely unconstitutional. Parties who are not "health care providers" are not supposed to be providing "health care," and cannot invoke chapter 7.70 RCW's protections.

When chapter 7.70 RCW does apply, it allows the three enumerated claims. The plain meaning of chapter 7.70 RCW allows these claims against any defendant within the statutory framework. This includes a "health care provider," as defined in RCW 7.70.020, or any "member of the healing arts" as stated in a related statute, RCW 4.24.290. The effect of this is not to open the courthouse doors to any new liability,

but to limit the liability of a provider to the three enumerated claims, exactly as the legislature intended.

In arguing against this commonsense interpretation of chapter 7.70 RCW, CHI insists that the law cannot possibly apply to just "any 'professional' who has some 'engagement' with or connection to medicine." Resp't Br. at 31. According to CHI, the legislature "never imagined" that the law would apply to "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 resource managers." *Id*. But if the legislature "never imagined" that the law would apply to these non-providers, then it cannot have intended that the law would protect them, either.

A 19-state healthcare conglomerate is no different. CHI is now clear both that it was not a "health care provider" and that its conduct was not "health care."[2] In that case, CHI is not protected by chapter 7.70 RCW, its liability is not limited to the three enumerated claims, and it is subject to liability pursuant to general tort principles.

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[2] In the trial court, CHI was ambiguous on whether its activities were "health care," arguing both that it did not provide "health care," CP 57, but also that it was "generally involved in health care," CP 63. On appeal, CHI has settled on the contention that it "does not provide any health care." Resp't Br. at 3.

The Court should hold: (1) chapter 7.70 RCW applies to claims against "health care provider[s]" for conduct that is "health care;" (2) when chapter 7.70 RCW applies, it allows the three enumerated claims against any covered defendant; and (3) when it does not apply, general tort law determines what claims may be asserted. Remand is required.

CHI makes several misrepresentations of the record in attempting to argue that it was not negligent. However, the Court must construe the record in the light most favorable to KJM. *Keck v. Collins*, 184 Wn.2d 358, 370, 357 P.3d 1080 (2015). Under this standard, the Court must accept the following facts as true:

1. KJM was born with GA-1, a treatable inherited disorder;

2. Supplemental Newborn Screening (SNS) was available when KJM was born, cost $25, and presented no risk to the baby;

3. SNS would have detected GA-1 in time to treat it;

4. Every state surrounding Washington had mandated SNS prior to KJM's birth;

5. Every military hospital in Washington had mandated SNS prior to KJM's birth;

6. Every relevant professional medical society had endorsed SNS for all babies prior to KJM's birth;

7. The Washington Department of Health recommended SNS while it completed the regulatory process to mandate it; and

8. At the time of KJM's birth, CHI was aware of SNS; it owned many hospitals around the country in other states that offered SNS to babies, either voluntarily or due to state mandates.

These circumstances support the conclusion that CHI did owe a duty, and that a jury should determine KJM's claim.

II. ARGUMENT IN REPLY

A. Chapter 7.70 RCW operates only to limit the liability of a "health care provider" providing "health care," and does not extinguish the liability of any party.

1. By statute, the reach of chapter 7.70 RCW is limited to conduct "by a health care provider."

CHI completely ignores the statutory definition of "health care" in RCW 70.02.010(15). *See* App. Br. at 31, 33-34. The definition of "health care" in RCW 70.02.010(15) is expressly incorporated into chapter 7.70 RCW's informed consent standards. *See* RCW 7.70.065(3). To determine the "plain meaning" of a statute, the court must consider "all that the Legislature has said in the statute *and related statutes which disclose legislative intent*." *State, Dep't of Ecology v. Campbell & Gwinn, L.L.C.*, 146 Wn.2d 1, 11, 43 P.3d 4 (2002) (emphasis added).[3]

[3] Washington courts have reiterated this principle many times. *E.g. State v. J.P.*, 149 Wn.2d 444, 450, 69 P.3d 318 (2003) ("The plain meaning of a statute may be discerned

In the statutory definition of "health care" set forth in RCW 70.02.010(15), the legislature limited "health care" to "any care, service, or procedure *provided by a health care provider*." (Emphasis added). Accordingly, any care, service, or procedure – or any other conduct – by a non-provider is not "health care." If CHI was not a health care provider, then its conduct, by definition, was not health care.

That non-providers can owe duties of care alongside providers was settled in *Lam v. Glob. Med. Sys., Inc., P.S.*, 127 Wn. App. 657, 663–64, 111 P.3d 1258 (2005). *See* App. Br. at 40–41.[4] In *Lam*, the court rejected the argument that a shipowner's owing a duty of care to a seaman precluded the conclusion that consulting physicians also owed a duty subject to chapter 7.70 RCW. *Id*. ("The fact that the ship owner has a nondelegable duty does not mean no other independent duty can arise.").

Other cases demonstrate that a claimant can have a claim arising out of "health care" against a provider under chapter 7.70 RCW and at the same time have other claims against non-providers. Although the decision addressed a different issue, in *Rufer v. Abbott Labs.*, 154 Wn.2d 530, 536,

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from all that the Legislature has said in the statute and related statutes.") (quotation omitted); *City of Seattle v. Allison*, 148 Wn.2d 75, 81, 59 P.3d 85 (2002) ("Under the 'plain meaning' rule, examination of the statute in which the provision at issue is found, as well as related statutes."); *State v. Wilcox*, 196 Wn. App. 206, 210, 383 P.3d 549 (2016) ("To ascertain the plain language, we examine the statute's language, other provisions of the same act, and related statutes.").

[4] CHI cites *Lam*, but offers no argument rebutting this analysis. *See* Resp't. Br. at 34.

114 P.3d 1182 (2005), a patient who had undergone a hysterectomy she did not need based on an erroneous test successfully sued both the University of Washington Medical Center, a provider, for malpractice, and Abbot Laboratories, a non-provider, for product liability. In *Washington State Physicians Ins. Exch. & Ass'n v. Fisons Corp.*, 122 Wn.2d 299, 317, 858 P.2d 1054 (1993), the court allowed a physician who had been sued for malpractice to cross-claim against a drug company, a non-provider, for providing false information about a drug.

In fact, *even health care providers* otherwise protected by chapter 7.70 RCW are subject to claims under general tort law for conduct that is not "health care." CHI acknowledges that plaintiffs can pursue "general negligence claims" against providers "arising from non-medical activities," even alongside claims "pertaining to medical issues" that "had to be brought under chapter 7.70 RCW." Resp't. Br. at 21 n.14 (citing *Harris v. Extendicare Homes, Inc.*, 829 F.Supp.2d 1023, 1028–29 (W.D. Wash. 2011) (allowing general negligence claims separate from health care claims subject to chapter 7.70 RCW); *Conrad v. Alderwood Manor*, 119 Wn. App. 275, 78 P.3d 177 (2003) (same)).

As a result, as CHI explains in its own words, "**if KJM had claims against CHI that did not arise from health care . . . he could pursue those**," giving the example of an IT error leading to an electrical fire.

Resp't. Br. at 21 n.14 (emphasis added). Apart from conceding that a general tort duty **<u>does</u>** exist, CHI shows that general tort law governs any claims that are not based on "health care." Since "health care" must be limited to "any care, service, or procedure *provided by a health care provider*," RCW 70.02.010(15) (emphasis added), if CHI was *not* a health care provider, as it argues, then it was *not* providing "health care" and is subject to general tort liability.

The limitation of "health care" to conduct "by a health care provider" is consistent with case law adopting a broad definition of "health care," applied most recently in *Reagan v. Newton*, 7 Wn. App. 2d 781, 791, 436 P.3d 411, *review denied*, 193 Wn.2d 1030 (2019) (citing *Beggs v. Dept. of Soc. & Health Servs.*, 171 Wn.2d 69, 79, 247 P.3d 421 (2011); *Estate of Sly v. Linville*, 75 Wn. App. 431, 439, 878 P.2d 1241 (1994); *Berger v. Sonneland*, 144 Wn.2d 91, 109, 26 P.3d 257 (2001); *Branom v. State*, 94 Wn. App. 964, 969–70, 974 P.2d 335 (1999)). In *Reagan*, *Berger*, and *Branom*, the rationale for adopting a broad definition of "health care" was to comprehensively embrace the activities of a defendant who was undisputedly a "health care provider," so as to fulfill legislative intent that claims against a health care provider would be limited to the three enumerated claims of RCW 7.70.030. In contrast, in *Beggs* and *Estate of Sly*, the providers were not engaged in health care and

so were subject to general tort law claims, for an implied cause of action for violation of a child abuse reporting statute, *Beggs*, 171 Wn.2d at 80, and fraudulent misrepresentation, *Estate of Sly*, 75 Wn. App. at 440.

None of these authorities suggest that even a broad definition of "health care" reaches the conduct of a party that is *not* a "health care provider." CHI's expansion of the term "health care" to include parties who are *not* providers – and then immunize them from suit – leads to the incongruous result that providers face greater liability than non-providers. Because chapter 7.70 RCW does not apply to non-providers who are not providing health care, it does not exempt them from claims proper under general tort standards. As a result, summary judgment should be reversed.

2. To the extent any party is covered by chapter 7.70 RCW, it allows the three enumerated claims.

Chapter 7.70 RCW nowhere states that *any* party does *not* owe a duty of care. Rather, it limits the claims that can be made against a "health care provider" arising out of "health care" to the three claims enumerated in RCW 7.70.030. In order to effectuate the legislature's intent that these three claims *may* be brought, the Court should hold that they may be brought against any party whose conduct is regulated by chapter 7.70 RCW. Because any "member of the healing arts" must be held to "that degree of skill, care, and learning possessed at that time by other persons

in the same profession," RCW 4.24.290, the three enumerated claims of RCW 7.70.030 need to be available to enforce that standard.[5]

CHI never denies that it could qualify as a "member of the healing arts" under RCW 4.24.290. CHI argues that looking to the related statute would violate "plain language analysis." Resp't. Br. at 27. But this analysis is precisely why the Court *must* give effect to RCW 4.24.290's extension of the standard of care to any "member of the healing arts." Under "plain language analysis," the court *must* consider "related statutes which disclose legislative intent." *Campbell & Gwinn*, 146 Wn.2d at 11.

For the standard of care to be meaningful under RCW 4.24.290, any "member of the healing arts" must be subject to suit for violations of the standard of care. Thus, to the extent CHI was providing "health care" and is subject to chapter 7.70 RCW (which it denies), it should be held liable for its own standard of care violations. RCW 7.70.040(1).[6]

3. CHI urges an unconstitutional interpretation of chapter 7.70 RCW.

In arguing that chapter 7.70 RCW reaches out to embrace claims against CHI, but exempts it from owing a legal duty because it is not a

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[5] Contrary to CHI's argument, its position would shield an unlicensed provider as well. It references RCW 18.130.190, but that statute provides for no civil liability for an unlicensed provider.

[6] Further, as shown in KJM's opening brief, CHI met the definition of "health care provider" because it employed a Washington-licensed physician. App. Br. at 35.

"health care provider," CHI asks the Court to create a class never mentioned in chapter 7.70 RCW, but that would nonetheless enjoy sweeping immunity. CHI says it would be too broad to include in chapter 7.70 RCW any "member of the healing arts" because this would subject to chapter 7.70 RCW at least eleven classes of parties that it says the legislature "never imagined" the law should reach. Resp't. Br. at 31. These are professionals CHI claims have "some 'engagement' with or connection to medicine," *id.*, but are not "health care provider[s]" under RCW 7.70.020.

But CHI is the party insisting that chapter 7.70 RCW *does* regulate claims against these non-providers to begin with, to set up its argument that "whether CHI owed KJM a duty turns on the statutory definition of a 'health care provider.'" Resp't. Br. at 22.

CHI interprets chapter 7.70 RCW as creating an *implied* immunity for itself and the eleven other classes it mentions, who contribute in some way to modern health care delivery but are not "health care providers" as defined in RCW 7.70.020. This heads towards a thicket of constitutional problems. First, constitutional considerations demand that "[w]hen the Legislature abolishes a cause of action, it does so explicitly." *Sofie v. Fibreboard Corp.*, 112 Wn.2d 636, 665, 771 P.2d 711 (1989) (damages cap unconstitutional). Second, when the legislature creates an immunity

from common law liability, this must have a "reasonable ground" under Washington's Privileges and Immunities clause. *Schroeder v. Weighall*, 179 Wn.2d 566, 571, 316 P.3d 482 (2014) (statute eliminating tolling of minor claims unconstitutional); *accord DeYoung v. Providence Med. Ctr.*, 136 Wn.2d 136, 147, 960 P.2d 919 (1998) (8-year statute of repose for medical negligence unconstitutional). Finally, legislation eliminating common law liabilities is more likely to be upheld when it creates a substitute remedy. *State v. Clausen*, 65 Wash. 156, 210, 117 P. 1101 (1911) (workers' compensation).

If chapter 7.70 RCW's limitation of claims against "health care providers" arising out of "health care" also eliminated any duty by whole categories of non-providers, the statute could not survive "reasonable ground analysis," because the statute provides no ground at all for such sweeping immunity. There is, however, an obvious, constitutional interpretation of chapter 7.70 RCW, which is that it does not apply *at all* to claims against parties who are not "health care provider[s]," and that it allows claims for violation of the standard of care when it does apply. Either way, CHI is subject to suit because there is evidence that KJM was injured because of CHI's failure to follow the applicable standard of care.

B. CHI fails to credibly argue that it does not owe a duty under general tort law.

In the trial court, CHI argued exclusively that chapter 7.70 RCW granted it immunity from KJM's claims. CHI never argued that it otherwise would not face liability under Washington's general standards for tort liability. Clearly it would. Under Washington law, a corporate health care institution having the knowledge and means to protect patients in its system is properly accountable for its own negligence.

1. Construing the record in KJM's favor shows that CHI had the information necessary to protect KJM from brain injury but chose not to disseminate it.

CHI opens by misrepresenting the record in violation of RAP 10.3(a)(5). To lessen the significance of its own institutional knowledge of SNS, CHI argues that "in 2005, no acute care hospital licensed by Washington's Department of Health was performing routine newborn screening for GA-1." Resp't. Br. at 1, 7-8. The record is silent on what other Washington hospitals did in 2005, except that Washington's military hospitals *were* using SNS. CP 615, 675.

CHI also misrepresents KJM's argument, stating that KJM asserts CHI had a duty to "require every hospital in its system to perform the most robust newborn screening possible . . . over the clinical judgment of individual health care providers." Resp't. Br. at 2.

First, the *legal* question before the Court is whether CHI owed a duty to exercise *reasonable care*. KJM's experts never opine that a health care system should impose arbitrary mandates "over the clinical judgment of individual health care providers." Resp't. Br. at 2. They say that reasonable care required CHI to disseminate critical information that it did have on SNS to help its providers – whose knowledge may have lagged behind – deliver better care. CP 416, 462, 680.[7]

Second, KJM's specific claim in this case does not seek a corporate countermanding of bedside clinical judgment. There is no evidence that there was *any* "clinical judgment" in determining to test KJM's newborn blood sample only for disorders then in Washington's screening mandate, and not spend the additional $25 to test the same blood sample for the full range of disorders, which would have detected GA-1. Glenn Jordan, Chief of Neonatology at KJM's birth hospital testified that pediatricians at St. Joseph's Hospital should have had a meeting about SNS but did not. CP 449. There is no evidence that clinicians within CHI's system had any objection to SNS.

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[7] Moreover, corporate health care entities already have the duty to intervene "over the clinical judgment of individual health care providers," Resp't. Br. at 2, when they learn that those providers are committing "obvious negligence," *Schoening v. Grays Harbor Cmty. Hosp.*, 40 Wn. App. 331, 335, 698 P.2d 593 (1985).

Third, CHI ignores that Washington's screening mandate in 2005 was not the product of any "clinical judgment." The Department of Health was urging hospitals to spend the extra $25 for SNS because – in contrast to surrounding states – Washington's mandate had not been updated due to delays in "necessary funding in the budget development process." CP 745–46.

Finally, CHI spends much of its brief arguing the nature of its relationship to its local hospitals. CHI emphasizes its role in allowing its local hospitals to share "financial resources," Resp't. Br. at 5, but ignores that the point of doing so includes the development of standard of care practices at lower cost. CHI prefers to describe its role as "supportive," *id*., but ignores that its support included disseminating "best practices" on many clinical issues, including catheter associated urinary infections; central-line assisted blood stream infections; anticoagulation; sepsis; community-acquired pneumonia; heart failure; transfusions; and end-of-life care. CP 310, 539, 542. CHI's brief completely ignores the knowledge it did have about SNS but chose not to disseminate.

2. Logic, common sense, justice, policy, and precedent support a duty.

These circumstances show that "considerations of logic, common sense, justice, policy, and precedent" support the existence of a duty of

care. *Affiliated FM Ins. Co. v. LTK Consulting Servs., Inc.*, 170 Wn.2d 442, 449–50, 243 P.3d 521 (2010) (quotation omitted).

Precedent. Washington has a long history of holding that health care institutions should be liable for their own negligence. In *Pedroza v. Bryant*, 101 Wn.2d 226, 231, 677 P.2d 166 (1984), the court held a hospital owed a duty of care because, by 1984, it had become "a multifaceted health care facility responsible for the quality of medical care and treatment rendered." Considerations supporting a duty included:

- "[I]t is the responsibility of the institution to create a workable system whereby the medical staff of the hospital continually reviews and evaluates the quality of care," *id*. (quoting *Moore v. Bd. of Trustees of Carson-Tahoe Hosp.*, 495 P.2d 605, 608 (Nev. 1972));
- "[T]he hospital is in a position superior to that of state licensing boards, professional organizations, and the PSRO [Professional Standards Review Organizations] program to monitor and control physicians' medical performance," *id*. at 232 (quoting Koehn, *Hospital Corporate Liability: An Effective Solution to Controlling Private Physician Incompetence?*, 32 Rutgers L. Rev. 342, 376–77 (1979)); and

- "Forcing hospitals to assume responsibility for their corporate negligence may also provide those hospitals a financial incentive to insure the competency of their medical staffs," *id*. at 232.

The Court's review of these considerations in *Pedroza* built on earlier Washington precedents extending similar liability to hospitals. This included imposing liability based on the hospital's ability to keep up-to-date observations on the patient: "[I]t would appear unreasonable to say the hospital attendants who had the opportunity to observe the mental condition of [the patient], could blindly follow the implied direction of the doctor . . . , and be relieved of any responsibility." *Osborn v. Pub. Hosp. Dist. I, Grant Cty.*, 80 Wn.2d 201, 205, 492 P.2d 1025 (1972). Washington had also allowed claims against hospitals because "[t]hey, too, are members of national organizations and subject to accreditation." *Pederson v. Dumouchel*, 72 Wn.2d 73, 80, 431 P.2d 973 (1967).

These same considerations apply to a 21st century multi-state health care conglomerate. CHI was formed to help its facilities compete at lower cost. It developed and disseminated "best practices" to improve and presumably lower the cost of clinical care. It had actual knowledge of SNS and knew that many of its institutions employed it. Moreover, as KJM's experts emphasize, many aspects of health care now are handled at the

level of the *hospital system*. CP 457. *Pedroza* teaches that the law must keep up with real-world developments.

CHI never addresses the rationales of these precedents. Instead, it first attacks these and other cases by arguing that they apply only to institutions defined as "health care provider[s]" RCW 7.70.020. But as shown above, the term "health care provider" in chapter 7.70 RCW was never intended, and cannot be interpreted, to imply that other entities owe no duty. Second, none of these cases suggest that other entities would be subject to any different analysis for whether a tort duty is justified in a particular case.

CHI next tries to distinguish these cases by arguing that CHI is not a hospital. What CHI ignores is that the law attaches liability based on the role, knowledge, and superiority that CHI did have, not based on any particular label. CHI argues that it factually never "participate[d]" in the duties already recognized of Washington hospitals and had "no role" in such things as "reviewing the quality of care." Resp't. Br. at 35. But CHI's effort at carefully parsing what it did *not* do ignores that it *did* evaluate practices on a system-wide basis, disseminate clinical "best practices," and develop knowledge about SNS. Indeed it had to, if its institutions were going to compete in the 21st century as a multi-state health system. The

same reasons that supported duties in *Pedroza*, *Pederson*, and *Osborn* are present here, even though the corporate structure is new since 1984.

Instead of looking to the rationales of these decisions of the Washington Supreme Court, CHI relies on an unpublished decision of the North Carolina Court of Appeals, *Seagle v. Cross*, 2009 WL 2137420, noted at 680 S.E.2d 901 (N.C. Ct. App. 2009) (unpublished). But *Seagle* did not address a claim that the hospital system itself was negligent. *Seagle* held only that the system's status as corporate parent "*alone*" did not justify liability. Resp't. Br. at 38 (emphasis added). There was no evidence that the entity or its personnel "were involved in the conduct upon which Plaintiff predicates his claim." 2009 WL 2137420 at *8.

KJM does not argue that CHI is liable merely because it is the parent corporation. KJM claims that as a multi-state health system, CHI violated the standard of care for such a system by not disseminating its knowledge about SNS, and harmed KJM as a result. *Seagle* never addressed this claim, which is proper under Washington law.[8]

[8] For the same reason, CHI's reliance on cases about piercing the corporate veil and the corporate practice of medicine are off point. KJM does not seek to hold CHI liable merely as corporate parent of the local entities, nor does KJM question the legality of the corporate structure. KJM argues only, and unremarkably, that CHI must face liability for its own negligence and deviation from the standard of care for a health care system.

Logic, common sense, justice, and policy. Finally, CHI relies on a "parade of horribles" to explain why it should not have to face liability for its own negligence. None are persuasive.

First, CHI tries to paint a picture of a corporate bureaucracy countermanding "a patient's best interest," forced to "encroach[] on the medical judgment of the licensed medical providers" and threatening the "medical autonomy of its [] hospitals." Resp't. Br. at 41. All of these arguments would apply equally against holding hospitals liable for failing to intervene in cases of patient crisis or obvious negligence, but they have been rejected there and should be rejected here. Moreover, ultimate liability requires a proven standard of care and a violation of that standard. KJM's experts opine that CHI needed to disseminate its knowledge for the benefit of both its patients and its frontline providers. No one has suggested that CHI should have imposed arbitrary diagnoses against its frontline physicians' judgment, and no rational person would.

Second, CHI claims that there should not be a duty by the parent corporation to "decide what screening tests were medically appropriate for all pediatric patients" and "dictate that decision downward, regardless of a patient's clinical needs." Resp't. Br. at 42. This again grossly mischaracterizes KJM's claim, which is that CHI should be held to a standard of reasonable care for a health care system; not that it needed to

arbitrarily decide in Denver what a baby needed in Tacoma. The other problem with this argument is that CHI did exactly this, when it did disseminate "best practices" on a variety of clinical subjects. CP 310, 539, 542. The fact that some situations call for uniform best practices *when medically justified* does not mean that the corporate office has suddenly eliminated individual clinical judgment.

Finally, although CHI complains that it should not have to "dictate downward" even lifesaving best practices that it knows about, it has no problem passing the buck downward to avoid accountability. CHI argues that there are "multiple proper defendants" that KJM should sue, including the local hospital, its frontline staff, and even "KJM's pediatrician," who "could have ordered individual genetic testing." Resp't. Br. at 45. But the key point is this: *The evidence is that CHI had much more extensive knowledge of SNS than these frontline providers, including the great disparity between what was offered to patients in Tacoma versus patients in Colorado or Pennsylvania.* CHI had access to national experts. It had far greater resources. It had the power to – and did – sponsor working groups and national meetings on genetic testing.

This goes to the heart of why CHI hopes to get itself out of this lawsuit and leave only the relatively less well-informed frontline providers. CHI hopes the jury will never learn that this care occurred in a

19-state health system whose corporate leaders were actually aware of SNS. If CHI's dismissal is upheld, the defendants' next step is to move *in limine* to exclude everything CHI knew, as not relevant to what its frontline providers knew – because CHI kept them in the dark.

Washington's fundamental policy is to lay responsibility for each party's fault with that party. RCW 4.22.070. There can be more than one cause of an injury. WPI 15.01. As shown above, Washington has permitted non-providers to be held accountable for their own conduct, even while claimants also pursued recovery for the same injuries against providers on claims arising out of health care. *Lam*, 127 Wn. App. at 663–64 (shipowner); *Rufer*, 154 Wn.2d at 536 (laboratory), *Fisons*, 122 Wn.2d at 317 (drug manufacturer).

These cases emphasize that modern health care delivery depends on many participants – health care providers and non-providers alike – to properly fulfill their roles to support patient care. What would be truly dangerous in an era of consolidation is to hold that corporate actors cannot be held accountable for their own conduct. Suppose that CHI's anticoagulation "best practice" turned out to be erroneous, but its providers relied on it just as the physician did in *Fisons*: under CHI's argument, even then it could not be held accountable, and it would place

the burden on the frontline providers to second-guess its own directives. The Court should reject this argument, and reverse summary judgment.

C. Apparent agency is an additional basis on which CHI may be found liable to KJM.

CHI does not dispute that all providers were part of the CHI system and designated as such to patients generally. This supports liability under Washington's law of apparent authority in health care.

First, as a factual matter, CHI implies that representations that CHI was the system providing care occurred only after services were provided to KJM and his mother. But this is inaccurate. Pre-admission forms disclosed CHI as the system providing care. CP 992. Post-service representations also occurred, and these also support a conclusion of apparent authority. *Adamski v. Tacoma Gen. Hosp.*, 20 Wn. App. 98, 115, 579 P.2d 970 (1978) (citing *Howard v. Park*, 195 N.W.2d 39, 41 (Mich. Ct. App. 1972)). As a result, the record discloses representations supporting apparent authority.

Second, CHI misstates KJM's burden to establish apparent authority. CHI argues that KJM needed to "rely . . . to [his] detriment" on the local providers' care or skill. Resp't. Br. at 47 (quoting *D.L.S. v. Maybin*, 130 Wn. App. 94, 97, 121 P.3d 1210 (2005)).[9] But Washington

[9] *D.L.S.* held that a franchise was not an apparent agent of the franchisor where a former employee of the franchise had actual knowledge that the two entities were distinct.

has never required detrimental reliance in a health care case. The Restatement (Third) of Agency, which the court followed in discussing apparent authority in *Udall v. T.D. Escrow Servs., Inc.*, 159 Wn.2d 903, 913, 154 P.3d 882 (2007), states explicitly: "*Reliance*. To establish that an agent acted with apparent authority, it is not necessary for the plaintiff to establish that the principal's manifestation induced the plaintiff to make a detrimental change in position." Restatement (Third) Of Agency § 2.03 (2006), cmt. e. CHI also argues that apparent authority requires that KJM sought care from the principal and "not the apparent agent." But apparent agency may be found when a patient seeks care only "*primarily*" from the principal and "*not just*" from an individual provider. *Wilson v. Grant*, 162 Wn. App. 731, 744, 258 P.3d 689 (2011) (emphasis added).

Apparent authority depends on "several factors," as well as "all of the facts and circumstances" of the relationship among defendants, and "no one of the factors is controlling." *Mohr v. Grantham*, 172 Wn.2d 844, 861–62, 262 P.3d 490 (2011) (quotations omitted). Apparent agency is a fact question. *Id*. at 862 (reversing summary judgment). Even when facts are undisputed, summary judgment is inappropriate if they are susceptible to competing inferences. *Southside Tabernacle v. Pentecostal Church of God, Pac. Nw. Dist., Inc.*, 32 Wn. App. 814, 824, 650 P.2d 231 (1982).

Admission papers carried CHI's name, CP 992, and records prepared after services were rendered showed that the local providers were part of the CHI organization, Resp't. Br. at 47–48. This is evidence that the local providers were apparent agents of CHI. KJM's mother did not need to have a reasonable belief particularly about the local providers' "authority to act for CHI." Resp't. Br. at 48. She needed only to "reasonably believe" that the local providers "were employees or agents" of CHI. *Mohr*, 172 Wn.2d at 861. KJM's mother placed importance on being cared for in "part of a larger health system," CP 990, and the representations available to her at any time made no distinction between CHI and its local providers. Accordingly, apparent authority is a jury question and is another basis on which CHI may be liable to KJM.

III. CONCLUSION

KJM respectfully asks that the Court reverse the summary judgment ruling and remand KJM's claims against CHI.

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RESPECTFULLY SUBMITTED this 13th day of July, 2020.

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