

No. 73118-1-I

IN THE COURT OF APPEALS
FOR THE STATE OF WASHINGTON
DIVISION 1

CHRISTOPHER M. WARNER and PATRICIA ANN MURRAY,
Individually and on behalf of their Marital Community

Appellants,

v.

SWEDISH HEALTH SERVICES d/b/a SWEDISH MEDICAL
CENTER/FIRST HILL and SWEDISH ORTHOPEDIC
INSTITUTE; PROLIANCE SURGEONS, INC., P.S., d/b/a
ORTHOPEDIC PHYSICIAN ASSOCIATES; ALEXIS
FALICOV, M.D., Ph.D.; and JUSTIN L. ESTERBERG, M.D.,

Respondents.

REPLY BRIEF OF APPELLANTS

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REPLY ARGUMENT

- A. The lower court’s decision granting summary judgment to Swedish should be reversed because the declarations of plaintiffs’ experts, Drs. Tarlov and Ney, raise a question of fact as to Swedish’s corporate negligence.**

During oral argument of Swedish’s summary-judgment motion, the lower court made clear that the sole issue it addressed was whether Swedish “fail[ed] to exercise reasonable care to adopt policies and procedures for health care provided within [its] facility,” including “credentialing and privileges” of physicians that perform neuromonitoring. VRP5. In granting Swedish summary judgment, the lower court focused exclusively on the plaintiffs’ expert declarations of Drs. Tarlov and Ney as follows:

THE COURT: . . . But what I don’t have in either of the declarations is a statement about what the standard of care is, what the policy should say. “Other hospitals do this in accordance with this statute and this WAC. Or the AMA has this requirement.” I don’t have that from either of your physicians.

I mean they’re saying the absence of policies is a really bad thing, and I get that, but they’re not telling me what the standard is or that they’re intimately familiar with those standards and that’s what Swedish should have done.

* * *

THE COURT: Is there anywhere in their declarations or other declarations where they say what the policies and procedures should be or what other hospitals do that creates that standard, that the hospital needs to have policies and

procedures with respect to who is allowed to do neuromonitoring, how it's to be conducted?

VRP 21:25-22:10; 23:3-9.

The doctrine of corporate negligence “is based on a nondelegable duty that a hospital owes directly to its patients.” *Douglas v. Freeman*, 117 Wn.2d 242, 248, 814, P.2d 1160 (1991). As relevant to this case, under the doctrine, a hospital owes a duty “. . . (4) to supervise all persons who practice medicine within its walls.” *Id.* citing Comment, *The Hospital-Physician Relationship: Hospital Responsibility for Malpractice of Physicians*, 50 Wash.L.Rev. 385, 412 (1975).

WPI 105.02.02 makes clear that a hospital owes a duty “[to] exercise reasonable care to adopt policies and procedures for health care provided to its patients.” RCW 70.41.030 makes clear that hospitals must “establish and adopt such minimum standards and rules pertaining to the . . . operation of hospitals . . . as are necessary in the public interest, and particularly for the establishment and maintenance of standards of hospitalization required for the safe and adequate care and treatment of patients.”

“The pertinent inquiry [in a corporate negligence action] is whether the hospital exercised reasonable care in the granting, renewal, and delineation of staff privileges.” *Pedroza v. Bryant*, 101 Wn.2d 226,

235, 677 P.2d 166 (1984). In November 2010, Swedish admittedly had no credentialing process in place for neuromonitoring, nor any related policies and procedures for patient safety.

In *Schoening v. Grays Harbor Community Hosp.*, a patient and her husband brought an action against a hospital under, in relevant part, the theory of corporate negligence. 40 Wn. App. 331, 698 P.2d 593 (1985). The hospital was granted summary judgment. *Id.* at 334. Upon reconsideration, the plaintiffs submitted an expert affidavit that the Court of Appeals found raised a question of fact sufficient to defeat summary judgment. *Id.* at 336.

Much like the facts present here, the expert affidavit in *Schoening* simply defined the relevant standard of care as follows: “The minimum standard of care for hospitals required continued monitoring and observation of the patient by the hospital staff, as well as obtaining an additional or independent evaluation of the patient in those instances where the care being provided by the attending physician is questionable and the patient’s condition continues to deteriorate.” *Id.* at 336. The expert’s opinion was “[b]ased upon [his] familiarity with the applicable standards of practice and a review of the records. . .” *Id.* The expert physician in *Schoening* did not cite a JCAH standard, or contend that a

JCAH standard was violated. Nor did he express knowledge of the hospital's bylaws or internal policies and procedures.

In accordance with *Schoening* and Washington law, Drs. Tarlov and Ney opined that a reasonably prudent hospital in Washington in November 2010 should have policies and procedures in place for patient safety when neuromonitoring is utilized. CP111, 136. The experts further opined that such policies would require that neuromonitoring must be performed “by qualified technical persons and neurologists with special training” to allow “for proper interpretation of the wave forms on the screen instead of just listening for a warning alarm.” *Id.* This is the standard of care. Thus it was Drs. Tarlov and Ney's opinion, within a reasonable degree of medical certainty, that Swedish fell below the standard of care by failing to have (1) properly trained and credentialed neurologists or technical persons performing the neuromonitoring on Christopher Warner and (2) any neuromonitoring policies and procedures in place.

Beginning on page 22 of its responding brief, Swedish lists nine straw-man arguments purportedly demonstrating the deficiencies in the declarations of Drs. Tarlov and Ney. Namely, that the experts' opinions were conclusory. Swedish's arguments are refuted in order as follows:

1. Contrary to Swedish's contention—and analogous to the expert declaration in *Schoening*—Drs. Tarlov and Ney stated that they were familiar with the standard of care for neuromonitoring in Washington and identified that the standard of care requires that neuromonitoring be performed only by properly trained and credentialed neurologists or technical persons, with policies and procedures in place to ensure patient safety; CP109-10, 111, 115-16, 131-32, 133, 135-36.
2. Drs. Tarlov and Ney could not review Swedish's policies and procedures because Swedish admittedly did not have any credentialing requirements or policies and procedures in place for neuromonitoring; CP102-03.
3. Drs. Tarlov and Ney were not required to review or demonstrate knowledge of (1) Swedish's accreditation status with the JCAH, (2) JCAH standards, or (3) Swedish's credentialing and privileging procedures during November 2010. Regarding points 1 and 2, there is no case law holding that a plaintiff must demonstrate a violation of a JCAH standard to make out a case. Nor has Swedish presented any expert testimony opining the same. JCAH standards were never once mentioned during the depositions of Drs. Tarlov or Ney and Swedish improperly raised the issue for the first time in its reply papers in support of summary judgment. Regarding point 3, as previously stated,

Drs. Tarlov and Ney were not required to review Swedish's credentialing and privileging procedures in effect during November 2010 because Swedish, admittedly, had no credentialing and privileging procedures in place for neuromonitoring at that time; *Id.*

4. Drs. Tarlov and Ney were not required to review or demonstrate knowledge of Swedish's bylaws as they relate to credentials or privileges for orthopedic surgeons because the issue is whether there were any credentials or privileges in place for neuromonitoring in November 2010—not for orthopedic surgeons—and Swedish admittedly did not have not any;
5. Drs. Tarlov and Ney were not required to state that Swedish's bylaws were below the standard of care or contravened JCAH standards because Swedish admittedly did not have any bylaws related to neuromonitoring; *Id.*
6. Drs. Tarlov and Ney were not required to explicitly state that they were familiar with credentialing/privileging decisions or policy approval at any specific hospital or a specific Washington hospital because they stated familiarity with the requisite standard of care of a hospital in Washington and Swedish admittedly did not have any credentialing or privileging decisions, or policy approval, with regard

to neuromonitoring; CP102-03, 109-10, 111, 115-16, 131-32, 133, 135-36.

7. Drs. Tarlov and Ney both opined that Swedish was required to have policies and procedures pertaining to neuromonitoring during spine surgery in place in November 2010. The experts were not required to opine about what other hospitals did in November 2010 (though the experts would certainly opine that other hospitals should meet the same standard they articulated with regard to Swedish, i.e., requiring a credentialing process to ensure that qualified and trained individuals perform neuromonitoring and having policies and procedures in place for patient safety); *Id.*
8. Drs. Tarlov and Ney were not required to opine that Swedish negligently granted Drs. Falicov and Esterberg credentials for staff membership and/or privileges to perform orthopedic surgery. The issue is that Swedish negligently allowed the doctors to perform neuromonitoring without any neuromonitoring credentialing requirements or policies and procedures in place for the safety of Christopher Warner; (CP102-03) and
9. Drs. Tarlov and Ney were not required to provide proof as to what other Washington hospitals were doing with regard to a specific privilege for neuromonitoring in November 2010. The experts were

only required to express opinions raising a question of fact that Swedish should have had a credentialing process, and policies and procedures in place, for neuromonitoring in November 2010, with all reasonable inferences from their opinions flowing in plaintiffs' favor.

Swedish's straw-man counterarguments improperly address issues not contained in the record that were raised for the first time in their reply papers in support of summary judgment. Put simply, Drs. Tarlov and Ney opined in non-conclusory fashion that Swedish negligently failed to have any credentialing process or policies and procedures in place to ensure that anyone performing neuromonitoring knew what they were doing, i.e., was both trained and credentialed. Accordingly, the lower court's decision granting Swedish summary judgment should be reversed.

B. The lower court's decision denying plaintiffs' motion for reconsideration should be reversed because the deposition testimony of plaintiffs' experts was properly and timely submitted in the motion for reconsideration and the deposition testimony of Drs. Tarlov and Ney raises issues of fact as to Swedish's corporate negligence.

In asking the trial court to reconsider its ruling, the litigant must "identify the specific reasons in fact and law as to each ground on which the motion is based." **CR 59(b)**. "Under **CR 59(a)(4)**, reconsideration is warranted if the moving party presents new and material evidence that it could not have discovered and produced at trial." *Wagner Dev., Inc. v.*

Fid. & Deposit Co., 95 Wn. App. 896, 906, 977 P.2d 639 (1999). If the evidence was available but not offered until after the opportunity passed, the party is not entitled to submit the evidence. *Id.* at 907. This is not the case here.

The deposition testimony of Drs. Tarlov and Ney was not available to submit with the plaintiffs' response because the depositions took place in Boston on December 17, 2014, two days before oral argument, and the transcripts were not yet available. It was an impossibility for plaintiffs to supplement the previously submitted expert declarations in the less-than 24-hour period between when the depositions concluded in Boston and when Swedish's summary-judgment motion was heard in Seattle. Suffice it to say, the deposition testimony was newly available evidence that plaintiffs properly offered upon reconsideration to raise a question of fact sufficient to defeat summary judgment.

The testimony of Drs. Tarlov and Ney properly spells out the standard of care and how Swedish violated it. As Dr. Ney testified:

Q. So let me hear you define standard of care.

A. So the standard of care for a hospital is again to provide optimum safety within share[d] operating rooms and to act as advocates for the patient in that regard.

Q. Okay. So your view is your form of neuromonitoring is superior to the surgeon directed form of neuromonitoring; correct?

A. That is my view.

Q. Is it your view that any hospital that doesn't mandate your form of neuromonitoring but allows surgeon controlled neuromonitoring is below the standard of care?

A. It is my opinion that if they are allowing the surgeon directed monitoring and they're allowing the surgeons to choose whether they receive the kind of monitoring that I provide, which includes EMG, motor evoke potentials, somatosensory evoke potentials, and a host of other modalities, as opposed to a machine that beeps every time you have a signal that goes above 50 milliamps, then, yes, they are violating a standard of care at that point.

Q. I want to make sure that I'm clear on this point. Swedish and any other hospitals that allow a spine surgeon that select to use the Medtronic equipment with the surgeon controlled neuromonitoring is below the standard of care for a hospital?

A. I would say—

Q. Is that true?

A. I would say that assuming—because we had talked about the times where the standard of care would not be met and that would be when there is not a neurophysiologist available, when there aren't techs available when that is not the case.

Certainly, Swedish has, as far as I understand, an in-house program where they have neuromonitoring techs; they also have a Johns Hopkins trained clinical neurophysiologist, neurologist; and that the hospital at that point is providing two different standards . . .

* * *

Q. We have to go back to my question; I want a direct answer to it, and then you can offer any information you want the jury to hear.

Is it your opinion that any hospital that permits a spine surgeon to utilize the Medtronic equipment and the surgeon controlled neuromonitoring is acting below the standard of care?

A. It is my opinion that if they do so in lieu of having a qualified technician and a qualified oversight physician, then, yes, they are potentially causing harm to the patient and violating the standard of care.

Q. And violating the standard of care?

A. Yes.

Q. So any hospital that doesn't have the type of neuromonitoring that you offer in use is violating the standard of care; correct?

A. That's not what I said.

Q. I think it is.

A. No. I said that if they are using a dynamic threshold EMG in lieu of a qualified technician and a qualified oversight physician, then they are potentially violating the standard of care.

CP267-68 at 76:23-80:19.

And as Dr. Tarlov testified:

Q. Will you be testifying at trial that Swedish's written policies fail to comply with the standard that you believe is in place?

A. In this case no qualified neuromonitoring expert was close at hand where he could, he or she could give feedback to the surgeon when it would be relevant, and I don't see that they have a procedure at Swedish Hospital for identifying or certifying the qualifications of anyone to do that.

Q. Are you going to testify at trial, Dr. Tarlov, that Swedish's written policies were deficient?

A. Yes.

Q. Okay. So what written policy do you believe should have existed that did not?

A. Well, I think some certification of the doctors who were doing this function, which they're billing large amounts of money for and where are not actually being carried out, I think they're deficient from the patient's viewpoint in that area.

* * *

Q. What do you believe the qualifications, the minimum qualifications are that Swedish had to require in order to comply with the standard you expect?

A. I think there would be a statement that the doctor is recognized by the hospital as being competent to do not only orthopedic surgery, but neurological monitoring during orthopedic surgery if he's going to bill for the same. . . .

CP317 at 82:23-84:13.

Swedish's arguments ignore this straightforward testimony regarding the standard of care and how Swedish negligently breached it.

Swedish offers three reasons for why it believes the testimony of Drs. Tarlov and Ney was deficient.

Swedish first claims that plaintiffs' expert testimony does not "(1) identify the applicable standard of care for a Washington hospital in November 2010." Respondents' Brief at 36. To the contrary, plaintiffs' experts testified that Swedish should have had a neuromonitoring credentialing process to ensure that individuals performing neuromonitoring were properly trained and qualified, with policies and procedures in place for the safety of patients.

Next, Swedish claims that the experts' testimony failed to "(2) explain how Swedish failed to exercise reasonable care in (a) adopting hospital policies and procedures, and (b) properly credentialing physicians in November 2010, when Swedish, in fact, enjoys full accreditation through the [JCAH]." *Id.* As previously mentioned, both experts opined that Swedish failed to exercise reasonable care by failing to adopt any hospital policies and procedures, or credentialing any physicians, with regard to neuromonitoring, as admitted by Swedish. Swedish's accreditation with the JCAH is not relevant and carries no weight in the analysis. No case law requires plaintiffs to demonstrate a violation of a specific JCAH standard to make out a case to defeat summary judgment.

Moreover, the JCAH issue was improperly raised by Swedish for the first time in its reply papers in support of summary judgment.

Finally, Swedish argues that the experts' testimony did not "(3) establish that they were experienced or knowledgeable with Washington's hospital's credentialing/privileging process or policies in November 2010." *Id.* at 36-37. This argument ignores the fact that Swedish admittedly did not have any credentialing process or policies in place for neuromonitoring. Drs. Tarlov and Ney did not need to explain how Drs. Falicov and Esterberg were insufficiently credentialed because Swedish's admission makes clear that they had no credentialing for neuromonitoring and their testimony makes clear that they were mostly listening for a warning sound rather than paying close attention to the monitor—a violation of the standard of care. Thematically, Drs. Tarlov and Ney also did not need to express knowledge of, or experience with, specific hospital policies or credentialing because Swedish had none related to neuromonitoring. Drs. Tarlov and Ney merely opined that Swedish was required to have (1) a credentialing process in place to ensure that properly trained individuals perform neuromonitoring, and (2) specific neuromonitoring policies and procedures in place for patient safety. Swedish's violation of this basic standard resulted in neuromonitoring being performed on Christopher Warner in wild-west fashion without any

regulation or oversight, which proximately caused his extensive and permanent nerve damage.

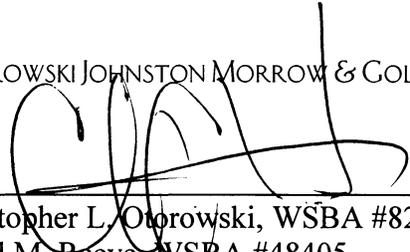
Accordingly, plaintiffs' experts, through their testimony, have raised a question of fact sufficient to defeat summary judgment. The lower court's order granting Swedish summary judgment should therefore be reversed.

CONCLUSION

For the reasons stated, it is respectfully requested that the lower court's decision granting the defendants' summary-judgment motion and the lower court's decision denying plaintiffs' motion for reconsideration be reversed.

RESPECTFULLY SUBMITTED this 4th day of September, 2015.

OTOROWSKI JOHNSTON MORROW & GOLDEN, PLLC



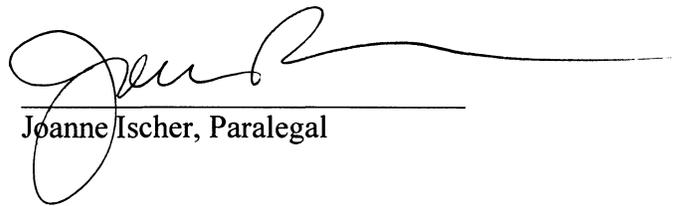
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CERTIFICATE OF SERVICE

THIS IS TO CERTIFY that on the 8th day of September, 2015, I
caused to be served a true and correct copy of the foregoing REPLY of Appellants
via email and messenger and addressed to the following:

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