NO. 100195-9

SUPREME COURT OF THE STATE OF WASHINGTON

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

Petitioner,

v.

CATHOLIC HEALTH INITIATIVES, a foreign corporation;

Respondent,

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

Defendants.

RESPONDENT'S ANSWER TO PETITION FOR REVIEW

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I. IDENTITY OF RESPONDING PARTY

Respondent Catholic Health Initiatives (CHI) submits this answer to Appellant KJM's Petition for Review.

II. COURT OF APPEALS DECISION

In an unpublished opinion, Division II affirmed the trial court's order dismissing KJM's medical malpractice claims against CHI because CHI, as a parent corporation that did not own or operate hospitals, or employ anyone who cared for KJM or was involved in KJM's newborn screening, did not owe a duty as a health care provider under chapter RCW 7.70 to KJM. Slip Op. at 1-2.

When KJM was born in August 2005 at St. Joseph, the state-mandated Washington Newborn Screening Program did not include screening for his later-discovered metabolic disorder, Glutaric Acidemia type 1 (GA-1). KJM claimed that St. Joseph, where his newborn testing occurred, and its owner Franciscan Health System (FHS) still should have screened for GA-1 in 2005, and that CHI, the non-healthcare provider Colorado parent

corporation of FHS, had a separate duty to implement routine supplemental newborn screening (SNS) at all of its subsidiary-owned hospitals, regardless of state mandates and hospitals' decisions.

In affirming the trial court's order dismissing CHI, Division II correctly recognized that, because chapter 7.70 RCW governed KJM's claims as they were for damages for injuries resulting from health care, and CHI was not a health care provider, it owed no duty to KJM as a patient. Slip Op. at 8-12. This decision is consistent with chapter 7.70 RCW's language and intent, decisions of this Court, and published decisions of the Court of Appeals. Division II also correctly determined that public policy disfavored creating a duty for CHI, and that KJM's claim of being left without remedy if not against CHI was inaccurate, as KJM had multiple avenues for seeking recovery. Slip Op. at 12-14. This Court should decline review.

III. COUNTERSTATEMENT OF ISSUES

(1) Did the trial court correctly grant summary judgment dismissing KJM's medical negligence claims against CHI when CHI was not a health care provider under RCW 7.70.020 and thus had no statutory duty?

(2) Did the trial court correctly determine that KJM failed to establish the elements of ostensible agency?

IV. COUNTERSTATEMENT OF THE CASE

Division II's opinion accurately recounts the facts.

A. CHI

CHI is not a 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 health care facility. *See id*.

CHI was created as a nonprofit parent corporation in 1996, "to promote and support, directly or indirectly, by donation, loan, or otherwise, the interests and purposes" of its "sponsored organizations." CP 103, 109-10. CHI's purpose has never been to direct medical care at the hospitals its subsidiaries own or

operate. CP 102-03. CHI's role is supportive, financial, and religious. CP 102-03, 109-10, 118-19.

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 all clinical policies that drove patient care at St. Joseph, and FHS, not CHI, oversaw all medical operations there.[1] CP 98-99. There is no record support for KJM's assertion, *Pet. at 6,* that CHI had the

[1] KJM provides no record support for his assertions, *Pet. at 5-6*, that CHI mandated practice bundles or otherwise directed clinical activity. Although CHI provided some practice bundles through its Clinical Service Group (CSG), they were supportive, not mandatory. CP 311. The CSG encouraged some standard practices and asked permission to implement some changes through practice bundles, but these were never mandatory or directive, and they developed from the bottom up through local hospitals who were interested in implementing specific changes and looked to CHI for support in those endeavors. CP 311-12.

power to mandate medical procedures or require particular courses of testing.[2]

As St. Joseph's owner, FHS employed or contracted with and supervised the physicians, nurses, and other health care providers for St. Joseph's operation. CP 97-98. CHI did not hire or supervise any FHS employee or agent involved in patient care at St. Joseph. CP 97-99, 102-03; CP 208-35. CHI did not employ any person in Washington who provided health care to patients, including KJM. CP 98, 102-03. CHI did not maintain the buildings or grounds, or provide equipment at St. Joseph. *Id.*

B. Newborn Screening

There is no evidence that at the time of KJM's birth any Washington-licensed acute care hospital was routinely screening

[2] KJM's one record citation, CP 213, for this assertion does not state that CHI could mandate medical procedures. It states only that CHI's subsidiary-owned hospitals operate in accordance with Catholic health care's mission and philosophy. That does not create a legal duty for CHI to require its subsidiary-owned hospitals—who developed all of their own policies and procedures—to adopt specific policies and procedures for any and all areas of care, including screening for newborn illnesses.

for GA-1.[3] In 2005, Washington's Newborn Screening Program did not screen for GA-1.[4] CP 240-41. Pertinent authorities agreed that expanded newborn screening needed to occur through legislatively enacted programs because infrastructure, funding, and other resources must first exist. *See* CP 580-81, 586, 589, 591, 599, 659, 661, 664, 669, 727-29.

Unlike CHI, FHS and St. Joseph, being located in Washington, were uniquely aware of Washington's newborn screening status. The Washington Department of Health sent St. Joseph pamphlets on newborn screening in 2002. *See, e.g.*, CP 676, 707-87. St. Joseph knew that SNS existed and could be ordered. *See id.*; CP 745-46 ("Screening for Disorders Not Detected in Washington State"). Nothing, not even KJM's sole citation to CP 376, *Pet. at 8*, supports KJM's contention that FHS and St. Joseph had a "knowledge deficit" about SNS. What KJM

[3] Only three federal military hospitals in Washington routinely screened for GA-1 in 2005. *See* CP 615 (¶55.c), 675 (¶18), 702-03.

[4] Clinicians could test for GA-1 if indicated. *See* CP 240-41.

cites is one bullet point in a CHI Genetics Advisory Committee (GAC) "Business Case Outline" saying: "Knowledge deficit – physician & nursing, clinicians." CP 375-76. It says nothing about whether the deficit pertains to knowledge about SNS as opposed to other genetic testing, to FHS or St. Joseph, or even to a deficit of clinical rather than religious understanding, which was the GAC's focus.

Indeed, KJM overstates CHI's knowledge of and involvement with SNS. Contrary to KJM's assertion, *Pet. at 4,* nothing about the facts that CHI had a GAC, that CHI's CMO was from Baylor, or that CHI subsidiaries' hospitals in two states offered SNS equates to CHI having superior knowledge about the ability to perform SNS than FHS and St. Joseph had. CMO Dr. Anderson was not a pediatrician and was not involved with Baylor's newborn screening. CP 530. While CHI had subsidiaries that owned hospitals in two states with routine SNS, pertinent medical authorities recognize that "compelling reasons for variability in testing between populations exists," CP 599;

e.g., Pennsylvania, one of the two states, has a large Amish population with a high incidence of GA-1, *see* CP 583. The GAC focused on imparting understanding of the Church's religious perspective in the emerging field of genetics in a variety of medical contexts. *See* CP 321-22, 331-42, 949, 961-63. It did not provide clinical recommendations for genetic testing generally, much less directing clinical practice related to newborn screening. *See id.*

C. Procedural History

KJM initially sued FHS and St. Joseph. CP 2. Later, KJM added CHI. *See* CP 8-14, 18-19, 38-45. CHI denied that it employed or credentialed St. Joseph's medical providers, or that it owed an independent duty to KJM. *See* CP 32, 34.

CHI moved for summary judgment dismissal, asserting that it was an improper defendant because it was not a health care provider under RCW 7.70.020, and did not owe KJM duties of a health care provider. CP 46-96. KJM opposed the motion, arguing that CHI was a health care provider under Washington

law, or, alternatively, CHI owed a common law duty to KJM. CP 252-66. The trial court granted CHI's summary judgment motion, CP 1003-05; RP 30-33, and denied KJM's motion for reconsideration, CP 1006-14; 1488-90.

After voluntarily dismissing FHS and St. Joseph without prejudice, KJM appealed. CP 1492-1506.

In his opening brief, KJM contended that CHI had a duty to impose SNS requirements on its subsidiary-owned hospitals due, in part, to KJM's misconception that CHI exercised control over these hospitals:

> Given CHI's control over its facilities, including FHS and SJMC, CHI was in the best position to **ensure** that newborns received the care recommended by national medical standards organizations.

App. Br. at 20 (emphasis added). KJM asserted that CHI "took no action to **implement** SNS uniformly. A reasonable jury could conclude based on KJM's evidence that this was negligence." *App. Br. at 33* (emphasis added)*; see also* CP 18 (CHI had the

"right and ability to require or facilitate appropriate newborn screening tests.").

After CHI pointed out that a non-health care provider parent corporation like CHI does not and should not have a duty to dictate medical decisions concerning newborn screening at hospitals it did not own or operate, *Resp. Br. at 18-45*, KJM shifted focus, claiming that CHI had a duty to "disseminate critical information that it did have on SNS to help its providers," *App. Reply Br. at 14*.

At oral argument, CHI addressed KJM's assertion that CHI's duty was to disseminate critical information to its subsidiaries' hospitals.[5] CHI contended that, if this was indeed the extent of CHI's duty, KJM would be unable to prove causation because there was no evidence that CHI had superior knowledge, or that FHS or St. Joseph had inferior knowledge,

[5] Wash. Court of Appeals, Div. II Oral Argument, *Menzer v. CHI*, No. 53972-1-II (May 20, 2021), at 24 min., 34 sec. through 26 min. (on file with court).

about the availability of and ability to perform SNS. *Id.* Additionally, no evidence supported that FHS or St. Joseph would have done anything differently with respect to KJM had CHI "disseminated" knowledge that the record confirms FHS and St. Joseph already had. *Id.*

Division II affirmed dismissal of KJM's claims against CHI, both because CHI did not owe a duty and because KJM failed to establish an issue of material fact as to apparent agency. Slip Op. 8-14, 16-17. Division II also found insufficient evidence to support causation. Slip Op. 15-16.

KJM petitioned this Court for review.

V. ARGUMENT WHY REVIEW SHOULD BE DENIED

No RAP 13.4(b) consideration warrants this Court's review. Although KJM, *Pet. at 8*, cites RAP 13.4(b)(4) (issue of substantial public interest), and RAP 13.4(b)(1), (2) (conflict with decisions of this Court and the Court of Appeals) because he believes Division II's decision erroneously interprets chapter 7.70 RCW, he is incorrect. Neither this Court nor any other

Washington appellate court has ever held that a non-health care provider parent corporation owed a duty to a patient at a hospital it did not own or operate in the form of requiring or implementing specific policies governing newborn screening. Division II correctly applied chapter 7.70 RCW's plain language to affirm dismissal of CHI, a non-health care provider corporation, from KJM's medical negligence lawsuit. KJM cites no decision of this Court or the Court of Appeals that conflicts with Division II's decision, nor has he articulated an issue of substantial public interest so as to warrant this Court's review.

A. Division II's Decision Is Not in Conflict with Any Decision of This Court or of the Court of Appeals.

1. Division II's decision follows chapter 7.70 RCW.

Division II correctly recognized that, because KJM's action is for damages for injuries occurring as a result of health care, chapter 7.70 RCW creates the source for any duty. That statute exclusively governs "*all* civil actions for damages for injury occurring as a result of health care, regardless of how the

action is characterized." *Branom v. State*, 94 Wn. App. 964, 969, 974 P.2d 335 (1999) (emphasis original), *rev. denied*, 138 Wn.2d 1023 (1999); *see also Reagan v. Newton*, 7 Wn. App. 2d 781, 790, 436 P.3d 411, *rev. denied*, 193 Wn.2d 1030 (2019) (citing *Fast v. Kennewick Pub. Hosp. Dist.*, 187 Wn.2d 27, 34, 384 P.3d 232 (2016) ("[W]henever an injury occurs as a result of health care, the action for damages for that injury is governed exclusively by RCW 7.70")).[6] "This section sweeps broadly." *Branom*, 94 Wn. App. at 969; *see also* RCW 7.70.010.

[6] An exclusive statutory remedy for a specific type of claim is not unique to chapter 7.70 RCW. The appellant in *Wash. State Physicians Ins. Exch. & Ass'n v. Fisons Corp*, 122 Wn.2d 299, 322-23, 858 P.2d 1054 (1993), made an argument similar to KJM's but concerning Washington's Product Liability Act. The plaintiff doctor attempted to recover for his emotional injuries after an unsafe medication harmed his patients, but the PLA did not allow those damages. *Id.* at 318-22. This Court, concluding that the PLA "preempts traditional common law remedies for product-related harms," did not allow the plaintiff to bring a common law negligence claim, even though that meant he could not recover for his claimed emotional injuries. *Id.* at 322-23.

"[T]he specific question of whether the injury is actionable is governed by RCW 7.70.030." *Branom*, 94 Wn. App. at 969. A plaintiff may recover only by proving either:

> (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; [or]
>
> (3) That injury resulted from health care to which the patient or his or her representative did not consent.

RCW 7.70.030. All three propositions are predicated on an act or omission of a health care provider. *See* RCW 7.70.030, 7.70.040, 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 whether CHI comes within the statutory definition of a "health care provider." It does not. The legislature unambiguously defined "health care provider" 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 ….

RCW 7.70.020. KJM essentially concedes, *see Pet. at 17-21,* that CHI does not satisfy these definitions. In a straightforward interpretation, consistent with the statute's unambiguous language, Division II correctly applied chapter 7.70 RCW to affirm dismissal of CHI.

KJM claims, *Pet. at 20-21,* that Division II should have adopted an expanded definition of "health care provider" that no court in this state has recognized to include "all persons engaged in the healing arts." This Court should, as Division II did, decline KJM's invitation to rewrite the statutory definition. *See 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.").

2. Division II's decision does not conflict with any decision of this Court or the Court of Appeals.

Unsurprisingly given the statute's plain language, no decisions of this Court or of the Court of Appeals that KJM cites actually conflict with Division II's decision.

KJM asserts, *Pet. at 10*, that even in the setting of a health care liability lawsuit such as his own, "this Court has never used chapter 7.70 RCW in isolation to determine whether a duty of reasonable care is owed." 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. Each case that KJM cites involved a health care provider defendant that, unlike CHI here, fit exactly within RCW 7.70.020's statutory definition.

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 *Judy v. Hanford Envtl. Health Found*., 106 Wn. App. 26, 22 P.3d 810 (2001), the issue was whether a *physician* in a physical capacity to work evaluation owed a duty to the employee. The courts in all of these cases that KJM cites as "conflicting" do not conflict at all: they assessed whether a health care provider owed a specific duty under a specific claim for damages for injury occurring as a result of health care, not whether a *non-health care provider entity* owed a duty at all under a chapter 7.70 RCW claim for damages for injury occurring as a result of health care.

Similarly, *Pedroza v. Bryant*, 101 Wn.2d 226, 677 P.2d 166 (1984), and *Alexander v. Gonser*, 42 Wn. App. 234, 711 P.2d 347 (1985), addressed duties of a hospital, that again, unlike CHI,

is a "health care provider" under RCW 7.70.020. While St. Joseph, as a hospital, has a set number of duties, CHI is not a hospital and sees no patients. Because it is not a hospital and did not own or operate St. Joseph, CHI had no role in any of the duties that Washington courts recognize as the basis for corporate liability: maintaining grounds, providing equipment, employing licensed staff, granting practice privileges, supervising employees, or reviewing the quality of care provided at St. Joseph. *Douglas v. Freeman*, 117 Wn.2d 242, 248, 814 P.2d 1160 (1991); CP 97-99. FHS alone fulfilled those duties. *Id.*, 101-03.

Even if CHI were a "health care provider," which it is not, *Douglas* establishes four duties that a hospital owes directly to patients, and does not include duties to require specific screening tests, adopt certain clinical policies, or disseminate medical information. *See* 117 Wn.2d at 248 (duties "(1) to use reasonable care in the maintenance of buildings and grounds for the protection of the [institution's] invitees; (2) to furnish the patient

supplies and equipment free of defects; (3) to select its employees with reasonable care; and (4) to supervise all persons who practice medicine within its walls"); *Alexander v. Gonser*, 42 Wn. App. 234, 235, 711 P.2d 347 (1985) (affirming dismissal of hospital because hospital had no "independent duty to inform a patient of test results administered at the request of the treating physician"). Division II's decision, which declined to impose a duty on a non-hospital corporation to require SNS or disseminate information about it, is not in conflict with corporate negligence jurisprudence.

KJM, *Pet. at 16-17*, also cites cases for the proposition that chapter 7.70 RCW does not preclude general negligence claims, even against doctors or hospitals. That is true only if the claim does not seek damages for injuries resulting from health care. In *Estate of Sly v. Linville*, 75 Wn. App. 431, 433-34, 878 P.2d 1241 (1994), the plaintiff brought a negligent misrepresentation claim against his surgeon for informing him that another surgeon's care was adequate when, in fact, the surgeon believed the other

surgeon's techniques were lacking. As a result, the patient failed to timely sue the first surgeon. *Id.* at 434. In concluding that the medical malpractice statute of limitations did not apply to bar the plaintiff's suit against the second surgeon, the Court reasoned that the claim did not result from health care—even though the defendant and plaintiff had a physician-patient relationship—because the claim arose from discussions about the other surgeon rather than the provision of health care. *Id.* at 437-40.

Likewise, *Harris v. Extendicare Homes, Inc.*, 829 F. Supp. 2d 1023 (W.D. Wash. 2011), and *Conrad v. Alderwood Manor*, 119 Wn. App. 275 (2003), allowed general negligence claims arising from non-medical activities such as providing food and water, whereas chapter 7.70 RCW governed claims resulting from health care, such as deficiencies in physician-approved care plans.

These consistent decisions confirm that Division II was correct. While plaintiffs can pursue general negligence claims against health care providers arising from non-medical activities,

any claims for damages for injuries resulting from health care must be brought under chapter 7.70 RCW. The nature of the action as arising from health care, rather than the status of the defendant as a health care provider, determines whether chapter 7.70 RCW applies. KJM does not dispute that his claims are for damages for injuries allegedly resulting from health care, *i.e.*, what metabolic and genetic screening newborns should undergo. Chapter 7.70 RCW thus governed exclusively.

3. Division II's decision is consistent with other Court of Appeals' decisions.

Two Court of Appeals' decisions in particular illustrate Division II's consistency with Washington authority. In one sentence, KJM attempts to distinguish *Branom, Pet. at 15*, and he ignores *Coolen v. Group Health*, 2020 Wash. App. LEXIS 2331, *rev. denied*, 196 Wn.2d 1039 (2021).[7]

First, in *Branom*, 94 Wn. App. at 970-71, the Court of Appeals concluded that the plaintiff parents' claims were for

[7] Unpublished opinion per GR 14.1.

damages for injuries resulting from health care such that chapter 7.70 RCW governed, although they had no provider-patient relationship with any health care provider. The parents asserted emotional distress injuries due to the failure of their infant's physician to inform them of the child's 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.

Second, in *Coolen*, 2020 Wash. App. LEXIS 2331, *2, the Court of Appeals held that even a hospital "did not have a duty to adopt specific policies and procedures for particular methods of screening illnesses." The *Coolen* plaintiff's husband died from prostate cancer that she alleged would have been diagnosed

sooner had Group Health adopted policies standardizing prostate cancer screening. *Id.* at *1-2, 9, 12. Group Health did not have a policy on uniform prostate cancer screening because it allowed providers to engage in decision-making with patients about screening on an individual basis. *Id.* at *8. In affirming the trial court's decision not to instruct the jury on corporate negligence, the Court of Appeals reasoned that *Douglas* "did not include under corporate negligence a duty to adopt particular policies and procedures governing patient care." *Id.* at *12.

Coolen applies most forcibly here. CHI, which is not a hospital, had no duty to require its subsidiary-owned hospitals to adopt policies mandating routine newborn screening for genetic disorders. Attempting to distinguish *Coolen* through semantics, KJM asserts, *Pet. at 3*, that Division II misinterpreted KJM's claims as a duty to "require" its subsidiaries' hospitals to provide SNS, when all CHI needed to do was "offer" SNS. CP 615. It is difficult to conceive how CHI had a duty to offer SNS to all newborns, but not a duty to require its subsidiaries to perform

SNS on all newborns. They are two sides of the same coin. Without requiring its subsidiaries' hospitals to perform SNS, CHI cannot "offer" SNS to all newborns.

B. KJM's Petition Does Not Involve an Issue of Substantial Public Interest.

KJM suggests, *Pet. at 17-19,* that, by declining review, this Court will allow CHI to "immunize" itself.[8] His premise is incorrect for multiple reasons.

First, this Court has established 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. *See 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

[8] KJM incorrectly contends that Division II erred in not considering common law duty. CHI extensively briefed why Division II should not create a duty, and Division II agreed.

principle of corporate law deeply ingrained in our economic and legal systems that a parent corporation [] is not liable for the acts of its subsidiaries"). If KJM had evidence suggesting that CHI misused its corporate form to violate or evade a duty, he could attempt to pierce the corporate veil. *See Truckweld Equip. Co. v. Olson*, 26 Wn. App. 638, 643-44, 618 P.2d 1017 (1980). KJM offered no such evidence, nor has he challenged the legitimate reasons CHI has for maintaining a separate corporate identity.

Division II also recognized that the corporate practice of medicine doctrine, precedent for 80 years, militates against imposing a duty on a corporation that does not even own or operate hospitals to dictate what screening its subsidiaries' hospitals must provide. This 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." *See, e.g., Columbia Physical Therapy, Inc. v. Benton Franklin Orthopedic Assocs., PLLC*, 168 Wn.2d 421, 430-31, 228 P.3d 1260 (2010). CHI has never intended to, nor has it, encroached on the medical judgment of medical providers or hospitals across the country. Maintaining the medical autonomy of its subsidiaries' hospitals, CHI's structure allowed medical decisions to remain in providers' hands. Public policy disfavors penalizing CHI for doing so.

Finally, Division II recognized that there are multiple proper health care provider defendants from whom KJM could attempt to recover for his alleged injuries occurring as a result of health care. FHS and St. Joseph are health care providers, and KJM initially sued them. CP 1-5. St. Joseph is the hospital where KJM underwent the newborn screening that he says negligently omitted GA-1 testing, and FHS is the owner and operator of St. Joseph, employing the medical staff whose care is at issue. KJM's pediatrician could also have ordered genetic testing, including for GA-1, if she believed it was necessary. *See*

CP 240-41. CHI is not a health care provider, actively avoided practicing medicine or invading the province of health care providers, and was not, therefore, a proper defendant with a duty as a health care provider to a patient in a medical negligence lawsuit such as KJM's.

C. KJM's Proximate Cause Arguments Do Not Warrant Review.

KJM incorrectly contends, *Pet. at 28-29*, that Division II erred in *sua sponte* affirming CHI's dismissal based on lack of causation.

Division II's decision was well within its bounds, particularly because CHI addressed at oral argument KJM's newly watered-down assertion that CHI's duty encompassed disseminating information to its subsidiaries' hospitals. CHI contended that if this was the duty, KJM would be unable to prove causation because there was no evidence that CHI had superior knowledge, or that FHS or St. Joseph had inferior knowledge, about the availability of and ability to perform SNS,

or that FHS or St. Joseph would have done anything differently in KJM's case because it already knew about SNS.[9] Unlike CHI, FHS and St. Joseph, being located in Washington, were uniquely aware of Washington's mandates with respect to newborn screening, and Washington's DOH actually sent St. Joseph pamphlets on supplemental newborn screening in 2002. CP 676. KJM failed to provide any evidence at oral argument to raise an issue of fact on causation.

D. KJM's Apparent Agency Arguments Do Not Warrant Review.

Division II's determination that KJM failed to present sufficient evidence of apparent agency is not in conflict with any decision of this Court or the Court of Appeals.

The acts or omissions of an ostensible agent can bind a principal, "if objective manifestations of the principal cause the one claiming apparent authority to actually, or subjectively,

[9] Wash. Court of Appeals, Div. II Oral Argument, *Menzer v. CHI*, No. 53972-1-II (May 20, 2021), at 24 min., 34 sec. through 26 min. (on file with court).

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). In the hospital setting, 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 Adamski v. Tacoma Gen. Hosp.*, 20 Wn. App. 98, 112, 579 P.2d 970 (1978); *Wilson v. Grant*, 162 Wn. App. 731, 745, 258 P.3d 689 (2011) (plaintiffs sought care from principal hospitals, not agent physicians).

KJM failed to present sufficient evidence to establish apparent agency. At most, 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. 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. Even when viewed in the light most favorable to KJM, Division II correctly

determined this evidence was insufficient to support apparent agency.

VI. CONCLUSION

This Court should deny KJM's petition for review.

I certify that the foregoing document contains 4,993 words.

RESPECTFULLY SUBMITTED this 11th day of October, 2021.

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CERTIFICATE OF SERVICE

I hereby certify under penalty of perjury under the laws of the State of Washington that on the date hereof I caused a true and correct copy of the foregoing document to be delivered in the manner indicated below to the following counsel of record:

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DATED this 11th day of October, 2021, at Tacoma, Washington.

s/ *Deidre M. Turnbull*
Deidre M. Turnbull, Legal Assistant

FAVROS LAW

October 11, 2021 - 10:20 AM

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