

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.

BRIEF OF APPELLANTS

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ASSIGNMENTS OF ERROR

1. The lower court erred in granting Swedish's summary-judgment motion where the plaintiffs submitted expert declarations opining that Swedish fell below the standard of care of a reasonably prudent healthcare provider during Christopher Warner's November 3, 2010 spine surgery using continuous neuromonitoring because it did not have in place any policies or procedures for credentialing of physicians performing neuromonitoring.

2. The lower court abused its discretion in denying plaintiffs' motion to reconsider the December 19, 2014 order granting Swedish's summary-judgment motion where, under CR 59(a)(4), the plaintiffs submitted previously unavailable expert deposition testimony establishing a prima facie case of corporate negligence.

ISSUES RELATED TO ASSIGNMENTS OF ERROR

1. Whether Swedish fell below the standard of care by failing to have a neuromonitoring credentialing process or any policies and procedures for neuromonitoring in place on November 3, 2010?
2. Whether the plaintiffs' expert declarations of Drs. Tarlov and Ney raise a question of fact sufficient to defeat Swedish's summary-judgment motion?
3. Whether the deposition testimony of plaintiffs' experts, Drs. Tarlov and Ney—which only became available after the hearing on Swedish's summary-judgment motion—was newly discovered evidence that raises a question of fact sufficient to defeat Swedish's summary-judgment motion?

SUMMARY OF ARGUMENT

This corporate negligence matter involves plaintiff Christopher Warner's spine surgery that was performed at Swedish Hospital on November 3, 2010 by orthopedic surgeon, Dr. Alexis Falicov. Though no problems were reported, Christopher complained of weakness in his left leg and foot during the post-operative period following surgery. A post surgical lumbar-spine CT revealed a bony encroachment on his neural canal, which Dr. Falicov attempted to remove through a second surgery. The second surgery provided no relief. A subsequent motor and sensory nerve and F-wave study by Dr. William Berg, at Minor & James Medical, was "highly abnormal" and revealed significant nerve damage. Plaintiffs allege that Christopher's injuries are attributable to the corporate negligence of Swedish, as explained below.

Throughout Christopher's surgery, Dr. Falicov utilized surgeon-controlled neuromonitoring with continuous recording of EMG, which involves watching and interpreting a waveform on a screen and listening for an audible alarm for evidence of mounting nerve damage. Another orthopedic surgeon, Dr. Justin Esterberg, performed so-called "back-up" neuromonitoring at a site located two floors above the operating room. Swedish participated with defendant Proliance to hook up this "remote monitoring site" to allow other orthopedic surgeons to perform

neuromonitoring and then bill for that neuromonitoring. Both surgeons testified that they were primarily listening for an alarm rather than watching the waveforms on the screen. Dr. Esterberg testified that, at various points during the surgery, he stepped away from the neuromonitoring station to meet with another patient, eat, or use the bathroom, during which he was only listening for the warning alarm. Dr. Esterberg even left the neuromonitoring station for approximately one hour to perform surgery on another patient. During this time, another orthopedic surgeon, Dr. Garr, was called in to take over the neuromonitoring.

Dr. Esterberg tried to bill Medicare over \$4000 to perform the back-up neuromonitoring. Medicare denied the initial claim and three appeals by Dr. Esterberg and Proliance Physicians. Dr. Esterberg then tried to bill Mr. Warner directly, but when Mr. Warner confronted Dr. Falicov about what appeared to be a phony bill, Dr. Falicov quickly told him he would “take care of it.” Swedish billed Medicare a total of \$168,918.12 for neuromonitoring equipment and supplies and approximately \$27,000 for “disposable” neuromonitoring equipment.

Critical to this appeal is that Swedish has admitted that it did not have any privileging process for neuromonitoring in place at the time of

Christopher's surgery, nor any neuromonitoring policies or procedures to ensure patient safety.

Plaintiffs' experts, neurosurgeon, Dr. Edward Tarlov, and neurologist and neurophysiologist, Dr. John Ney, have declared and testified that Swedish fell below the standard of care of a reasonably prudent hospital because it failed to have any policies and procedures in place for credentialing of individuals performing neuromonitoring. Specifically, because (1) neuromonitoring is a highly specialized field requiring significant training and must be performed by qualified individuals; and (2) properly done, neuromonitoring requires constant attention to, and interpretation of, the waveform on the screen—not just listening for a warning alarm as was the case here. Drs. Tarlov and Ney opined that Swedish's failure to have any privileging process for neuromonitoring in place, with policies and procedures that would ensure better patient safety, proximately caused Christopher's permanent nerve damage because his neuromonitoring was being performed by untrained or uncredentialed (in neuromonitoring) orthopedic surgeons.

STATEMENT OF THE CASE

A. Christopher Warner undergoes spine surgery during which remote neuromonitoring is performed.

On November 3, 2010, from 10:30 a.m. to 7:30 p.m., Christopher underwent anterior L3 to S1 fusion, L2-3 Direct Lateral Interbody Fusion (DLIF), and posterior L2 to S1 instrumentation performed by Dr. Alexis Falicov at Swedish Medical Center First Hill. CP4. Dr. Falicov's operative report documented no complications. CP4.

Dr. Justin Esterberg testified that throughout *most* of Christopher's 8-hour surgery, he performed remote, backup neuromonitoring¹ with continuous recording of EMG activity via a Medtronic laptop on the 6th floor of the Swedish Orthopedic Institute. CP4-5, 65:7-18, 82:23-83:2, 85:12-14. Dr. Esterberg was, in layman's terms, watching a waveform on a laptop screen and listening for an audible alarm if the waveform exceeded a threshold of 50 milliamps, indicating potential nerve damage. CP67.

Dr. Esterberg testified that he did not watch the waveform continuously throughout Christopher's surgery, such as at around 11:15

¹ Neuromonitoring involves the intraoperative monitoring of electrophysiological methods such as electroencephalography (EEG), electromyography (EMG), and evoked potentials to monitor the functional integrity of certain neural structures (e.g., nerves, spinal cord and parts of the brain) during surgery. Its purpose is to reduce the risk to the patient of iatrogenic damage to the nervous system, and/or to provide functional guidance to the surgeon and anesthesiologist.

See http://en.wikipedia.org/wiki/Intraoperative_neurophysiological_monitoring (Accessed May 18, 2015)

a.m., during a five-to-ten minute meeting with another patient, or while using the men's room. CP78, 86. During those times he relied solely on the computer's audible alarm. CP86. "[I]f an alarm or bell went off, . . . [Dr. Esterberg] would go out and check and confirm and see what is going on and call down to the OR." CP86. In addition, from about 1:00 p.m. to 2:00 p.m., Dr. Esterberg left the neuromonitoring station to perform surgery on another patient. CP78. During that timeframe, Dr. Garr—another spine surgeon and partner of Drs. Falicov and Esterberg—was called by Dr. Esterberg to take over the neuromonitoring. CP65. Upon returning to the neuromonitoring station at 2:00 p.m., Dr. Esterberg consulted with Dr. Garr and no problems were reported. CP88.

B. Post-operative problems.

In the post-operative period following surgery, Christopher complained of left-leg and foot numbness and weakness. CP5. Due to these ongoing problems, on November 5, 2010, he underwent a CT lumbar spine study revealing a "[n]ew L3-L4 bony encroachment on the neural canal with maximum narrowing to 5.9 mm." CP5. To remove the new bony fragment, on November 6, 2010, he underwent an L3 complete laminectomy, L4 superior laminectomy, and left L3-4 facetectomy and foraminotomy by Dr. Falicov. CP5. Unfortunately, the surgery provided

little relief and Christopher continued to feel left-leg weakness, scrotal swelling, and confusion. CP6.

Christopher treated with Dr. Falicov through January 2012 with little improvement. Due to his ongoing complaints of bilateral leg weakness, on January 10, 2012, he underwent a motor and sensory nerve study and F-wave study by Dr. William Berg, at Minor & James Medical.

CP6. Dr. Berg's report revealed, in relevant part, as follows:

Impression.

1. This is a highly abnormal study.
2. There is denervation in the left leg consistent with an active axonal L5 radiculopathy. There is some suggestion of S1 root irritability.
3. There is denervation in the right leg consistent with axonal L5 and S1 radiculopathies. The lack of proximal denervation suggests ongoing re-innervation.
3. [*sic*] There are scattered sensory and motor abnormalities that appear to be related to the radicular injuries, rather than a separate neuropathy process.

* * *

[Christopher] relates that his surgery was 15 months ago. I have some concern over the degree of denervation on the left and I would question whether there is an ongoing injury.

CP6.

Plaintiffs allege that as a direct and proximate result of the “[n]ew L3-L4 bony encroachment on the neural canal with maximum narrowing to 5.9 mm” that Christopher developed during and/or following Dr.

Falicov's November 3, 2010 surgery, Christopher has suffered significant injury and damages. CP6-7.

C. Swedish moves for summary judgment.

Though Swedish moved for summary judgment on multiple grounds, prior to oral argument, plaintiffs conceded all causes of action except for corporate negligence. VRP4-5. The sole remaining issue addressed by the court 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.

Swedish argued that it was entitled to summary judgment because the plaintiffs lacked expert testimony establishing the requisite standard of care for the hospital, that the standard of care was breached, and that the breach was a proximate cause of Christopher Warner's damages. CP23-24. Specifically, that "plaintiffs . . . produced no expert testimony demonstrating that Swedish supplied Mr. Warner with any defective supplies or equipment" because (1) "the neuromonitoring machine . . . used by Dr. Falicov is owned by Medtronic;" (2) "[t]he machine used by Dr. Esterberg to conduct backup neuromonitoring is not owned by Swedish;" and (3) "there is no evidence that any neuromonitoring equipment malfunctioned." CP24. Swedish also argued that the plaintiffs

did not produce any expert testimony “demonstrating that [it] had any duty to supervise or intervene in the neuromonitoring decisions made by . . . Dr. Falicov.” CP24-25.

In response, plaintiffs argued that Swedish “had a clear duty to provide reasonably prudent medical care to Christopher Warner and to prevent harms caused by negligent provision of medical care.” CP93-94. Namely, by “only allowing properly credentialed physicians to perform the [neuro]monitoring and to establish policies of neuromonitoring for patient safety.” CP94. In support, plaintiffs submitted deposition testimony from Swedish representative Barbara Shaw confirming that Swedish had no credentialing in place for neuromonitoring and also no policies or procedures governing neuromonitoring. CP92, 102-104. Plaintiffs also submitted the expert declarations of neurosurgeon, Dr. Edward Tarlov (CP109-130), and neurologist and neurophysiologist, Dr. John Ney (CP131-143), who each opined that Swedish was required to have policies and procedures for credentialing in place for neuromonitoring.

Dr. Tarlov opined that Swedish fell below the standard of care of a reasonably prudent hospital while treating Christopher Warner when it failed to (1) “require proper qualifications for performing neuromonitoring of Dr. Esterberg, Dr. Garr and Dr. Falicov in its credentialing process,”

and (2) “have any policies and procedures in place for neuromonitoring . . . on November 3, 2010” because, “[p]roperly done, neuromonitoring requires constant attention the screen, not just listening for a warning alarm as apparently was the case here.” CP111, 115. Dr. Tarlov further opined that Swedish’s failure to properly perform neuromonitoring of Christopher Warner “was proximately caused, in part, by the failure of Swedish to have a proper privileging process for neuromonitoring in place, with policies and procedures that would ensure better patient safety.” CP116.

Similarly, Dr. Ney opined as follows:

[Swedish] fell below the standard of care of a reasonably prudent Hospital in regards to Christopher Warner when it failed to require proper qualifications for performing neuromonitoring of Dr. Esterberg, Dr. Garr and Dr. Falicov in its credentialing process. It is important for patient safety that properly trained and qualified individuals be utilized for neuromonitoring. This training allows proper interpretation of the wave forms on the screen instead of just listening for a warning alarm, as was done in this case. Dr. Falicov’s testimony that he was doing the monitoring and the surgery at the same time is not in the interests of patient safety and is not reasonably prudent. There is no evidence that Dr. Falicov, Dr. Esterberg or Dr. Garr had any formalized training in neuromonitoring.

* * *

[Swedish] fell below the standard of care of a reasonably prudent Hospital in regards to Christopher Warner when it failed to have any policies and procedures in place for neuromonitoring. . . If proper polices and procedures had

been in place, there would have been a dedicated and properly trained individual monitoring the wave forms on the screen, and been in constant contact with the surgeon to alert the surgeon to any irregularities in the wave forms which might not cause an alarm to sound but might be detrimental to the patient.

CP135-136.

Dr. Ney also opined that Swedish's failure to perform proper neuromonitoring of Christopher Warner . . .

was proximately caused, in part, by the failure of Swedish to have a proper privileging process for neuromonitoring in place, with policies and procedures that would ensure better patient safety. . . By failing to require evidence of such training, Swedish Hospital fell below the standard of care in permitting these surgeries to be carried out in its operating rooms with the neuromonitoring being carried out as it was in this case.

CP136.

In reply, Swedish argued that plaintiffs' experts were not qualified to offer opinions on the standard of care for credentialing/privileging, policies and procedures because they did not mention in their declarations how they were familiar with the standard of care for a hospital in Washington. CP182-183. Swedish also argued that the plaintiffs' expert declarations did not establish what the standard of care was for a hospital in Washington with regard to neuromonitoring privileges, credentialing, and policies and procedures, or whether a Washington hospital was even required to have such privileges, credentialing, and policies and

procedures in place. CP184. Despite Swedish acknowledging that it did not have any policies and procedures in place for credentialing for neuromonitoring, Swedish contended that whatever “credentialing and privileging procedures [it had] . . . must [have been] . . . sufficient” because Swedish is accredited by the Joint Commission on Accreditation of Hospitals. CP183. Finally, Swedish reiterated that it did not lease or own any of the neuromonitoring equipment used during Christopher’s surgery; or that the equipment was otherwise defective. CP184-185.

D. Upon oral argument, Swedish is granted summary judgment.

Swedish’s summary-judgment motion was heard on December 19, 2014 and oral argument focused on whether the plaintiffs’ expert declarations raised material issues of fact.

Swedish contended that the plaintiffs’ experts did not offer (1) how they were familiar with the standards and laws applying to Washington hospitals (VRP12); (2) what the neuromonitoring standards for credentialing in Washington were on November 3, 2010 (VRP13); (3) what the policies and procedures for neuromonitoring should have been at that time (VRP14); and (4) that the declarations were otherwise conclusory (VRP14).

In response, plaintiffs initially pointed to defense counsel’s representations that confirmed Swedish did not have any policies or

procedures regarding credentialing for neuromonitoring at the time of Christopher's surgery. VRP17. Plaintiffs also demonstrated that their experts were not unfamiliar with Washington standards and laws regarding neuromonitoring. Dr. Ney's declaration attested that he (1) is familiar with the standard of care for neuromonitoring of spinal surgery with continuous EMG; (2) has performed the procedure in Washington; (3) is licensed in Washington; (4) operates a neuromonitoring business; and (5) was the chief of clinical neurophysiology at Madigan Army Medical Center in Tacoma, Washington. VRP18-19. Likewise, Dr. Tarlov attested that he is familiar with the standard of care for neuromonitoring in Washington because it is the same standard as in Massachusetts where he formerly practiced. CP110. Further, plaintiffs made clear that Swedish was wrong to suggest that neuromonitoring privileges are a part of basic orthopedic privileges. VRP20. Both Drs. Tarlov and Ney opined that neuromonitoring is specialized care that requires trained and qualified individuals to continuously watch the waveforms, not just listen for an alarm. VRP20, CP111, 136. Finally, to refute Swedish's contention that it did not own or lease the backup neuromonitoring equipment, plaintiffs pointed to the testimony of Medtronic sale representative, Judd Hunter, which established that the remote monitoring system was a joint venture

or joint procedure between Medtronic and Swedish and that Swedish had their hand in setting up the system. VRP17.

In considering the parties' arguments, the court acknowledged that having neuromonitoring policies and procedures in place "would have been the better situation." VRP21. The court also acknowledged that the "absence of [neuromonitoring] policies is a really bad thing," but it found that the plaintiffs' expert declarations did not establish what the standard of care for neuromonitoring should be, what a neuromonitoring policy or procedure should say, or what standards other hospitals follow. VRP21-22.

The plaintiffs countered by pointing out that the law does not require them to present evidence establishing what the policies and procedures should have been. VRP22. Instead, the issue is that Swedish fell below the standard of care because it had no neuromonitoring policies or procedures in place. VRP22. "[W]hat other health care providers do in the same or similar circumstances is not controlling, it is just some evidence." VRP24. Both Drs. Tarlov and Ney attested that Swedish was required to have policies and procedures for credentialing of neuromonitoring in place and it should "be up to the jury to weigh the testimony." VRP25.

In rebuttal, Swedish argued that a hospital should not be permitted to tell a doctor how to perform neuromonitoring and that the procedure should be left entirely to a physician's judgment. VRP28.

The court reserved judgment but ultimately entered an order granting Swedish summary judgment. CP207-208.

E. Plaintiffs move for reconsideration and offer the newly obtained deposition testimony of their experts, Drs. Tarlov and Ney.

The plaintiffs argued that Swedish's summary-judgment motion was granted in the face of valid, contravening declarations by two competent physicians, each of which established duty, breach, causation, and damages. CP213. Nevertheless, because the depositions of plaintiffs' experts were taken in Boston on Wednesday, December 17, 2014—two days before the court granted Swedish summary judgment—the transcripts were not available to submit with the plaintiffs' response. Thus the plaintiffs were required to submit the transcripts in a supplemental declaration to their CR 59(a)(4) motion to reconsider. CP239-247.

Dr. Tarlov's deposition testimony established that Swedish fell below the standard of care by failing to have (1) a qualified neuromonitoring expert perform backup monitoring of the surgeon-controlled neuromonitoring; and (2) policies and procedures in place for credentialing a neuromonitoring expert. CP241-242, 317. His testimony

also established that Swedish's above failures proximately caused Christopher's damages because a properly credentialed neuromonitoring expert would have seen waveforms evidencing significant nerve damage as it was occurring, as confirmed by Christopher's later EMG. CP242, 323.

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 which 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. . . .

CP241-242, 317.

* * *

Q. No, I'm asking you what do you believe would have been shown on the monitor screen that was not conveyed via the audible alarm?

Mr. Otorowski: Object to the form of the question.

A. Well, there would be evidence of damage to the nerves as there was when an EMG, an electromyogram, a similar sort of monitoring, was carried out at a later time. It showed nothing subtle. It showed extensive damage to the nerves. So I think that the screen might have—had the equipment been connected and had, had the doctors been looking at it and they would have seen evidence of nerve damage.

CP242, 323.

Similarly, Dr. Ney's testimony established that Swedish fell below the standard of care by failing to have a qualified and trained neuromonitoring technician and a credentialed oversight physician to perform backup monitoring of the surgeon-controlled neuromonitoring by Dr. Falicov. CP268. Further, Dr. Ney testified that Swedish's above failures proximately caused Christopher's damage because the waveform

evidence of nerve damage, i.e., the “diminution of signals” that was visible on the subsequent EMG by Dr. Berg, was not detected and therefore could not be reversed. CP263.

Q. . . . 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 standard of care.

Q. And violating the standard of care?

A. Yes.

CP268.

Q. Do you have criticism that Swedish was below the standard of care in this case in any regarding relating to credentialing?

A. I believe that having a credentialed oversight physician for the neuromonitoring would have been helpful, number one, and, two, that Swedish did not meet the standard of care in having Dr. Esterberg as the oversight physician for the neuromonitoring.

Q. When you say properly credentialed oversight physician, you mean somebody with your level of training, either a neurologist or neurophysiologist; correct?

A. This is correct.

Q. So you believe that for Swedish to allow Dr.—

A. Esterberg?

Q. —actually any of them; Dr. Falicov, Dr. Esterberg, and Dr. Garr, to oversee surgeon directed neuromonitoring was below the standard of care because they weren't trained as neurologist or neurophysiologists; correct?

A. Right, right, because they—

Q. And any hospital that allowed that would simply be below the standard of care in your opinion; correct?

A. I believe that to be the case yes.

CP270.

Q. Are you able to point though to any particular data that's published somewhere that demonstrates that the kind of nerve injury Mr. Warner, in your opinion, sustained during the surgery is reduced with intraoperative neuromonitoring?

A. Right. So what I can say is that intraoperative neuromonitoring allows you to see deficits as they evolve. You know, there's a very limited window. We like to say that time is brain, but time is also nerves. If you're able to go in early enough and remove whatever the offending either instrument or device or, as Dr. Falicov was saying, that this was a, probably a very slow compressive process, if you're able to remove that, then you're also able to limit extent of the injury and possible make it reversible.

So to that extent, I would say that there—I would be leaning toward, you know, causation; that if there was neuromonitoring in this case that was beyond a dynamic threshold EMG machine that very likely the deficits that were depicted on the EMG by Dr. Berg would not have been seen and the patient would have done quite well, because we would have had very early detection and been able

to reverse any diminution of signals.

CP263.

Q. . . . You believe that the Medtronic system of intraoperative neuromonitoring is inadequate?

A. Right.

CP266-267.

Despite this testimony, on January 13, 2015, the lower court entered an order denying plaintiffs' motion to reconsider. CP341-342.

Plaintiffs timely noticed appeal of the December 19, 2014 order granting Swedish summary judgment and the January 13, 2015 order denying plaintiffs' motion to reconsider. CP343-244.

LEGAL ARGUMENT

A. Standards of Review

Summary judgment rulings are reviewed de novo. *See Seybold v. Neu*, 105 Wn. App. 666, 675, 19 P.3d 1068 (2001). When reviewing an order granting summary judgment, the appellate court engages in the same inquiry as the trial court, considering all facts and reasonable inferences in the light most favorable to the nonmoving party. *See Kahn v. Salerno*, 90 Wn. App. 110, 117, 951 P.2d 321 (1998). Summary judgment is appropriate if the record before the court shows that there is no genuine issue as to any material fact and the moving party is entitled to judgment as a matter of law. *See CR 56(c)*.

“Motions for reconsideration are addressed to the sound discretion of the trial court and a reviewing court will not reverse a trial court’s ruling absent a showing of manifest abuse of discretion.” *Wilcox v. Lexington Eye Inst.*, 130 Wn. App. 234, 241, 122 P.3d 729 (2005). An abuse of discretion exists only if no reasonable person would have taken the view the trial court adopted, the trial court applied the wrong legal standard, or it relied on unsupported facts. *See Salas v. Hi-Tech Erectors*, 168 Wn. 2d 664, 668–69, 230 P.3d 583 (2010).

B. Competent expert testimony opining that Swedish fell below the standard of care by failing to have a credentialing process or any policies and procedures for neuromonitoring raises a question of fact sufficient to defeat summary judgment.

To prove actionable negligence, a plaintiff must establish (1) the existence of a duty owed to the complaining party; (2) a breach of that duty; (3) injury; and (4) that the breach was a proximate cause of the resulting injury. *Sheikh v. Choe*, 156 Wn.2d 441, 447-48, 128 P.3d 574 (2006). The existence of a duty—the threshold question in any negligence action—is a question of law. *Id.* Once a duty is established, issues of fact regarding its breach and whether the breach was a proximate cause of injury are normally for the fact finder. *See Johnson v. State*, 77 Wn. App. 934, 937, 894 P.2d 1366 (1995).

Summary judgment is only proper when reasonable minds could reach but one conclusion regarding the material facts. *See Tran v. State Farm Fire and Casualty Co.*, 136 Wn. 2d 214, 233, 961 P.2d 358 (1998). Swedish, as the moving party, had the initial burden of showing the absence of any issue of material fact as to its negligence. *See Young v. Key Pharmaceuticals*, 112 Wn. 2d 216, 225, 770 P.2d 182 (1989). The court must view all facts and reasonable inferences from those facts in the light most favorable to the plaintiffs, the nonmoving party. *See*

Mountain Park Homeowners Ass'n v. Tydings, 125 Wn. 2d 337, 341, 883 P.2d 1383 (1994).

A medical malpractice plaintiff can defeat a summary-judgment motion by presenting expert testimony that raises a material issue of fact about the defendant's compliance with the standard of care and causation. See *Coggle v. Snow*, 56 Wn. App. 499, 510-11, 784 P.2d 554 (1990). A medical expert must base his or her testimony on a reasonable degree of medical certainty. See *McLaughlin v. Cooke*, 112 Wn. 2d 829, 836, 774 P.2d 1171 (1989). It is not always necessary to prove every element of causation by medical testimony. If, from the facts and circumstances and the medical testimony given, a reasonable person can infer that the causal connection exists, the evidence is sufficient. See *Bennett v. Department of Labor & Indus.*, 95 Wn. 2d 531, 533, 627 P.2d 104 (1981). Further, expert medical testimony is not necessary if the questioned practice of the professional is such a gross deviation from ordinary care that a lay person could easily recognize it. *Petersen v. State*, 100 Wn. 2d 421, 437, 671 P.2d 230 (1983).

To be considered an expert witness in a medical malpractice case, the witness must (1) be qualified and (2) offer useful testimony. *Reese v. Stroh*, 128 Wn. 2d 300, 303, 907 P.2d 282 (1995). A standard-of-care expert must also be reasonably familiar with the practices of a reasonably

prudent practitioner. Expert testimony may not be based on speculation or conjecture; an expert must testify to his or her conclusions to a “reasonable degree of medical certainty.” *McLaughlin*, *supra* at 836.

A hospital’s corporate responsibility for the quality of care is reflected in **WPI 105.02.02** and was established by *Pedroza v. Bryant*, 101 Wn.2d 226, 233-34, 677 P.2d 166 (1984) and *Douglas v. Freeman*, 117 Wn.2d 242, 814 P.2d 1160 (1991). Under this doctrine, hospitals owe an independent and non-delegable duty directly to its patients to exercise reasonable care. **WPI 105.02.02** acknowledges, among other things, a hospital’s obligation to “exercise reasonable care to:” (1) “grant and renew staff privileges so as to permit only competent physicians and surgeons to use its facilities;” and (2) “to adopt policies and procedures for health care provided to its patients.” These duties are based upon **RCW 70.41.030**, which requires the establishment and enforcement of standards, rules and regulations for safe patient care in the operation of hospitals. These standards are to be consistent with the standards of the Joint Commission on Accreditation of Hospitals (“JCAH”). The *Pedroza* court held that the standards of the JCAH and a hospital’s by-laws and policies are relevant in determining the standard of care owed by a hospital and its employee health care providers. *See Pedroza* at 233-34. **WAC 246-320-111** requires that hospitals conform to

the requirements of **RCW 70.41.010** et. seq. by “adopt[ing] bylaws with respect to medical staff activities.” *Id.* at 234.

C. Swedish fell below the standard of care by failing to have neuromonitoring policies and procedures for credentialing in place on November 3, 2010.

To defeat Swedish’s summary-judgment motion, the plaintiffs were required to raise an issue of fact by submitting competent expert testimony, based upon a reasonable degree of medical probability, demonstrating that Swedish fell below the standard of care in failing to adopt policies and procedures for credentialing of physicians that would perform neuromonitoring. The expert declarations of Drs. Tarlov and Ney met this burden because both doctors stated that they are familiar with the standard of care for neuromonitoring with continuous EMG in Washington, and with what constitutes reasonably prudent policies and procedures within a hospital for the credentialing and neuromonitoring of spine surgeries.

Drs. Tarlov and Ney both found that Swedish fell below the standard of care in treating Christopher Warner because (1) there were no policies and procedures in place for neuromonitoring; and (2) Drs. Falicov, Esterberg, and Garr were not properly trained and credentialed to perform neuromonitoring. Dr. Tarlov opined that neuromonitoring must be performed “by qualified technical persons and neurologists with special

training in neuromonitoring,” not by orthopedic surgeons who lack such special training like Drs. Falicov, Esterberg, and Garr. CP111. Dr. Ney opined that “[i]t is important for patient safety that properly trained and qualified individuals be utilized for neuromonitoring” to allow for “proper interpretation of the wave forms on the screen instead of just listening for a warning alarm.” CP136. This requires a “dedicated and properly trained individual monitoring the wave forms on the screen, and be[ing] in constant contact with the surgeon to alert the surgeon to any irregularities in the wave forms which might not cause an alarm to sound but might be detrimental to the patient.” CP136. Dr. Tarlov opined similarly and also noted that Dr. Esterberg “even took time out to see a patient and do a surgery himself.” CP111.

These opinions alone raise a question of fact sufficient to defeat summary judgment because they establish that the standard of care for neuromonitoring requires qualified individuals with special training who continuously monitor the waveforms—not orthopedic surgeons who merely listen for an alarm. Swedish’s admitted lack of any policies and procedures for neuromonitoring confirms the breach of its duties under **WPI 105.0202**, as established by *Pedroza* and *Douglas*, and **RCW 70.41.030**. Swedish’s arguments that plaintiffs’ experts declarations were insufficient because they did not express knowledge of JCAH standards or

of Swedish's by-laws are red herrings because those standards are only relevant—not dispositive—in determining the standard of care. *See Pedroza* at 233-34.

Accordingly, the lower court's decision granting Swedish summary judgment was an abuse of discretion because the court improperly weighed the evidence rather than view it in a light most favorable to the plaintiffs, as was required.

D. Upon reconsideration, the deposition testimony of Drs. Tarlov and Ney raises a question of fact as to whether Swedish fell below the standard of care by failing to establish policies and procedures for neuromonitoring, or have a neuromonitoring credentialing process.

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.

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 Swedish was granted

summary judgment, and the transcripts were not yet available. Defense counsel ordered the deposition transcripts but the order was cancelled on December 23, 2014. Plaintiffs obtained the transcripts on or around January 7, 2014 and submitted them in a supplemental declaration to their motion to reconsider.

Dr. Tarlov testified that Swedish should have had a credentialing process and policies and procedures in place for neuromonitoring. Specifically, “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 . . .” CP317. Dr. Ney also testified that Swedish should have had “a credentialed oversight physician for the neuromonitoring . . .” CP270. That is, either a neurologist or neurophysiologist. CP270. Thus each physician’s testimony satisfies the issues addressed by the lower court during oral argument of Swedish’s summary-judgment motion. Namely, what the standard of care for neuromonitoring should have been and what a neuromonitoring policy or procedure should include. VRP21-22. Though their testimony does not address what neuromonitoring standards other hospitals follow, such testimony is irrelevant in deciding a summary-judgment motion. *See Klink v. G.D. Searle & Co.*, 26 Wn. App 951, 956, 614 P.2d 701 (1980) (In a malpractice case, the trial court properly refused to admit a poll of

physicians that was meant to disclose what the standard of care was with respect to disclosure when prescribing birth control pills, where the poll merely provided evidence of what other doctors had told their patients.).

Swedish's contention that the plaintiffs' experts failed to supply proof that hospitals in Washington were required to offer specific privileges or have policies and procedures for neuromonitoring during spine surgery is without merit because the law required Swedish "to adopt policies and procedures for health care provided to its patients." **WPI 105.02.02**. Swedish admittedly did not have any such privileges, policies, or procedures for neuromonitoring in place on the date of Christopher's surgery and the plaintiffs' experts found this to be below the standard of care.

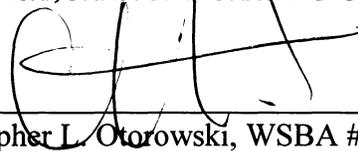
Accordingly, plaintiffs' experts have raised a question of fact as to whether Swedish was required to have such neuromonitoring credentialing policies and procedures in place and, further, that the failure to have such policies proximately caused injury to Mr. Warner. Therefore the lower court's order granting Swedish summary judgment should 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 22nd day of June, 2015.

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