

73118-1

FILED
Aug 11, 2015
Court of Appeals
Division I
State of Washington

73118-1

No. 73118-1

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

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

Appellants,

vs.

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.

**RESPONDENT SWEDISH HEALTH SERVICES' RESPONSE
BRIEF**

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I. INTRODUCTION

This appeal involves a corporate negligence claim against Respondent Swedish Health Services, which the trial court dismissed on summary judgment. Appellant Christopher M. Warner submitted expert declarations that contained conclusory statements without adequate factual support, and were thus, insufficient to defeat summary judgment. Specifically, the experts failed to *identify* and *apply* the standard of care to (1) hospitals; (2) in Washington; during (3) the relevant time of November 2010.

Mr. Warner moved for reconsideration, based on “newly discovered” evidence that was, in fact, available before the summary judgment hearing. Based on the foregoing, under *de novo* review, the trial court’s order of dismissal should be affirmed.

II. COUNTER-STATEMENT OF ISSUES

(1) Should the Court of Appeals affirm the trial court’s order dismissing the corporate negligence claim against Respondent Swedish Health Services because Mr. Warner’s *experts’ conclusory declarations* did not: (1) identify the applicable standard of care for a Washington hospital in November 2010; (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 Joint Commission on Accreditation of Hospitals—such accreditation establishing that Swedish complies with the standard of care for credentialing physicians; and (3) establish that they were experienced or knowledgeable with Washington’s hospital’s credentialing/privileging process or policies in November 2010.

(2) Should the Court of Appeals affirm the trial court’s order denying Mr. Warner’s motion for reconsideration of Swedish’s dismissal because: (1) Mr. Warner did not present “newly discovered evidence” under CR 59(a)(4) since he could have supplemented his experts’ conclusory opinions with factual statements via supplemental declaration prior to the original summary judgment hearing on 12/19/14; and (2) the experts’ 12/17/14 *deposition testimony*—upon which Mr. Warner relied—still failed to: (1) identify the applicable standard of care for a Washington hospital in November 2010; (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 Joint Commission on Accreditation of Hospitals—such accreditation establishing that Swedish complies with the

standard of care for credentialing physicians; and (3) establish that they were experienced or knowledgeable with Washington's hospital's credentialing and privileging process or policies in November 2010.

III. COUNTER-STATEMENT OF THE CASE

A. Dr. Falicov Was Mr. Warner's Privately Retained Surgeon

Appellant Christopher Warner (b. 1942) had a 25-year history of back pain. CP 18:21. By September 2010, the pain was so unbearable that he would have to stop every 100 yards while walking. CP 18:22. He first sought care from Alexis Falicov, M.D. for crippling low back pain on 09/14/10. CP 18:23.

Respondent Swedish Health Services d/b/a Swedish Medical Center/First Hill and Swedish Orthopedic Institute ("Swedish") did not employ Dr. Falicov, the private surgeon who performed the surgery at issue on Mr. Warner and conducted the surgeon-controlled neuromonitoring at issue during that surgery. CP 18:12-14; CP 45:19-22. It is undisputed that no Swedish employee performed or was associated with any neuromonitoring for this surgery. CP 45:19-22.

Instead, Dr. Falicov is a board-certified orthopedic surgeon employed by now dismissed co-defendant Proliance Surgeons ("Proliance") who

specializes in spine surgery. CP 19:12-13. Dr. Falicov performed neuromonitoring during his residency; read many textbooks on neuromonitoring; and took courses on the subject. CP 19:13-14; CP 42:2-5. He has also performed neuromonitoring with other colleagues. CP 19:14-15. Additionally, he attends the annual meetings of the National Association of Spine Surgeons, wherein neuromonitoring is discussed. CP 19:15-16; CP 42:9-11; CP 42:16-23.

Before the subject surgery, Dr. Falicov examined Mr. Warner and found that he had severe bridging osteophytes at all levels of the spine and minimal motion in the lumbar spine. CP 18:23-19:2. Dr. Falicov diagnosed Mr. Warner with “flat back syndrome” (absence of normal curvature in the lower back), and lumbar spondylosis (arthritis in the lower back). CP 19:3-4.

Correction of flat back syndrome requires a complex and lengthy surgery. CP 19:4-5. Dr. Falicov fully apprised Mr. Warner of the risks associated with this surgery. CP at 19:5-6. Dr. Falicov also told Mr. Warner that while surgery was an option, it would be a complex surgery; if Mr. Warner was able to do his regular activities, *he would advise against surgery.*

CP 19: 6-8. Dr. Falicov also recommended that Mr. Warner obtain a second opinion. CP 19:8-9.

Mr. Warner, a medical recruiter, is, by trade, unusually sophisticated about physicians and their specialties. CP 254 at 23:8-12. Mr. Warner considered having the surgery done by other surgeons, such as Dr. Chapman and Dr. Roh. CP 19:9-10. Ultimately however, out of all of the spine surgeons that his primary care provider and acquaintances recommended, he selected and retained Dr. Falicov. CP 19:10-11. Before the surgery, Dr. Falicov explicitly the neuromonitoring process with Mr. Warner. CP 34:15-16.

B. Dr. Falicov Conducted Intraoperative Neuromonitoring using Medtronic Equipment Neither Leased nor Owned by Swedish.

On 11/03/10, Dr. Falicov performed an anterior L3 to S1 fusion, L2-3 Direct Lateral Interbody Fusion (DLIF), and posterior L2 to S1 instrumentation on Mr. Warner at Swedish. CP 19:17-18. When Dr. Falicov is placing screws into the spine, he likes to use neuromonitoring to check nerve function while the patient is asleep. CP 19:19-20. In this case, it is undisputed that Dr. Falicov elected to use surgeon-controlled neuromonitoring equipment, owned by Medtronic. Dr. Falicov monitored the nerve functions during surgery and his Proliance colleagues, Dr. Esterberg and DR. Garr, performed nerouromonitoring services for Dr. Falicov and Mr. Warner remotely on the sixth floor of the hospital. Swedish's

neuromonitoring team had no involvement, whatsoever, with the surgery. CP 19:20-21.

Dr. Falicov, a private Proliance surgeon (not employed by Swedish) was the primary doctor performing neuromonitoring during the surgery. CP 19:22. Medtronic owns the neuromonitoring machine that Proliance and Dr. Falicov used. CP 19:22-23. Swedish neither owns nor leases the machine. CP 19:23-20:1. Swedish's Contracts Administrative Team member David Gearhard confirmed, under oath, that "Medtronic did not proffer any neuromonitoring machines for acquisition or lease any neuromonitoring machines to Swedish Health Services in or before November 2010." CP 15:14-16. Similarly, "Swedish did not purchase any neuromonitoring or NIM machines from Medtronic." CP 15:18-19.

Judd Hunter, a representative from Medtronic, the manufacturer of the neuromonitoring machine, was present and monitored the machine throughout Mr. Warner's surgery. CP 20:4-5. He confirmed that Medtronic owns the machine, and that Swedish did not lease, own, or have any ownership interest in any of the neuromonitoring equipment. CP 49:14-25.

Neither Dr. Falicov nor Dr. Esterberg relied on any Swedish employees to perform or assist with neuromonitoring on Mr. Warner. CP

20:5-6. No alarms sounded during Mr. Warner's surgery and there was no abnormality shown throughout the neuromonitoring. CP 20:6-7.

C. Dr. Esterberg, a Proliance Surgeon, Conducted Backup Remote Monitoring with a Medtronic Representative

At Dr. Falicov's request, fellow Proliance spine surgeon Justin Esterberg, M.D. conducted backup neuromonitoring of Mr. Warner's surgery from an upstairs office that Proliance leases from Swedish. CP 20:2-3. (Proliance "leases the 6th and 7th floors" at Swedish. CP 38:22-23) Likewise, Swedish does not own or operate the computer that Dr. Esterberg used to conduct backup remote neuromonitoring of Mr. Warner in his Proliance office. CP 20:3-4.

D. Throughout the Entire Nine-Hour Surgery, a Doctor Was Always Attentive to the Remote Neuromonitor Screen, Displayed Upstairs while Surgery Occurred Downstairs.

Dr. Esterberg continuously provided backup monitoring during Mr. Warner's surgery from Proliance's office on the sixth floor, using a Proliance-owned laptop computer. CP 65:11; CP 76:3-12. Before starting, he ensured that the laptop "software is communicating properly with the computer and system downstairs, and that's when Dr. Falicov and I would communicate and make sure that it's working and we're seeing a wave, or a baseline electrical output from the muscle groups that we are testing." CP

76:24-77:4. It is Dr. Esterberg's undisputed practice to look at the monitor and to listen to the computer at all times "to hear any actual auditory output."

CP 76:3-4.

Dr. Esterberg remotely neuromonitored Mr. Warner's surgery from the time it started in the morning until 1 p.m.¹ CP 65:7-12.

Q: So is it your testimony in this case that you were continually monitoring Chris Warner's surgery in this monitoring room . . . on the sixth floor from the time the surgery started up until one o'clock in the afternoon?

A: Correct.

CP 65:7-12.

Q: Did you do anything else, for example, in the morning up through one o'clock besides sit there and watch the screen, the monitor screen?

A: I don't believe so.

Q: So you just sat there and watched the screen?

A: Correct?

CP 66:17-22.

From 1-2 p.m., Dr. Esterberg performed a pre-scheduled surgery on a patient. CP 66:2-7. During this one-hour period, it is undisputed that Proliance surgeon, Dr. Garr, stepped in and continuously performed backup

neuromonitoring on Mr. Warner. CP 65:13-25. After Dr. Esterberg finished his short surgery, he talked to Dr. Garr and Dr. Falicov and “continue[d] the monitoring from that point forward.” CP 65:23-66:1. Dr. Garr did not report any problems with Mr. Warner’s neuromonitoring. CP 81:21-23.

Dr. Esterberg testified that he sat in the sixth floor Proliance office and continuously watched the monitor screen during the remainder of Mr. Warner’s surgery. CP 66:21-22. The men’s bathroom was three paces away from the monitor room, so he could easily hear the monitor’s alarm if he stepped into the bathroom. CP 84:17-22. However, he testified that he constantly watched the waveforms and also listened. CP 85:2-6.

Specifically, Dr. Esterberg was watching waveforms and listening to the audible alarm because “the audible alarm is like the waveform. If there is a waveform, there is an audible associated with it.” CP 67:8-10.

Dr. Esterberg testified as follows:

Q: But aside from that brief period of time [when Dr. Garr was neuromonitoring], you’re saying that you constantly saw the waveforms when you were there?

A: **So we’re looking at the waveforms. We’re listening. Correct.**

CP 85:2-6; *see also* CP 66:4-10.

¹Dr. Esterberg also saw an established patient around 11:15 for 5-10 minutes at the sixth floor office, during which time he was listening to the monitor. CP 79:7-19.

Dr. Esterberg has extensive experience conducting “back up” remote monitoring from about 30-40 prior spine surgeries. CP 71:6-10. From all of those surgeries, no patient has ever alleged nerve damage. CP 71:11-13. Dr. Esterberg has also conducted surgeon-controlled neuromonitoring on some of his own patients. CP 72:18-21. He uses the Medtronic machine, which he finds simple to use. CP 72:25-73:5.

Dr. Falicov testified that on November 3, 2010 (the day of the surgery), the neuromonitoring equipment was working fine. “The equipment was working because you could see all the small activities of the muscles, so we know the equipment was working fine, and we know that it was working in terms of triggering, because we were testing all the various nerves.” CP 39:6-10.

Dr. Esterberg testified that he was not “aware of any *requirement* that neuromonitoring be used during the type of procedure that Mr. Warner underwent on November 3, 2010.” CP 82:10-13. He believes that the decision of whether a patient will receive neuromonitoring during a surgery “is up to the individual surgeon.” CP 82:14-19. The patient’s surgeon also decides which “neuromonitoring modalities to use during the patient’s surgery.” CP 83:7-10.

At the end of the nine-hour surgery, Dr. Falicov advised Dr. Esterberg that “we had no abnormalities throughout the entire case [surgery].” CP 38:12-13. A printout of the neuromonitoring was made in the operating room and was a part of Mr. Warner’s medical records. CP 15:9-11. It was a faxed summary report from the neuromonitoring machine, which summarized the neuromonitoring modalities used on Mr. Warner on November 3, 2010, and the results of such monitoring. CP 40:2-10.

Mr. Warner confirmed that the surgery was uneventful. “[T]he operative report of which by Dr. Falicov documented no complications.” CP 88:6. Dr. Esterberg “performed neuromonitoring with continuous recording of EMG activity throughout the operative procedure, the procedure note of which documented no complications.” CP 88:9-10.

E. The Surgery Was Not Completely Successful.

The morning after surgery, Mr. Warner attempted to stand but his left leg gave out. CP 20:9. Since he was demonstrating weakness and numbness with an L3 distribution, Dr. Falicov ordered a CT scan on 11/05/10 which showed a small bone fragment at L 3/4. CP 20:9-10. Dr. Falicov fully discussed this with Mr. Warner. CP 20:10-11. He explained that if the bone fragment was causing Mr. Warner’s symptoms, it would be simple to

surgically remove it. CP 20:11-12. On 11/06/10, after discussing the risks and benefits, Dr. Falicov surgically removed the bone fragment. CP 20:12-13. Unfortunately, this surgery did not make much difference in Mr. Warner's symptoms. CP 20:13-14. On 11/09/10, Mr. Warner was discharged home. CP 6:11. His condition subsequently improved substantially. CP 361:41-42.

F. An EMG Conducted in 2012 Purportedly Showed Abnormalities that Mr. Warner Asserted Defendants Failed to See or Correct During the 2010 Neuromonitoring.

Despite improvement, Mr. Warner continued to experience weakness in his left leg. CP 20:15. Dr. Falicov saw Mr. Warner from September 2010 through January 2012. CP 20:15-16. The January 2012 EMG report, prepared *two years after the subject surgery*, purportedly showed abnormalities in both lower extremities. CP 20:16-17. Dr. Falicov did not think the report matched the patient's symptoms since Mr. Warner's major problem was weakness in the *thigh muscles*. CP 20:17. The EMG report showed problems with the *ankle muscles*, for the most part, rather than the thigh muscles. CP 20:17-18.

Nevertheless, Mr. Warner believed that the January 2012 EMG Report revealed abnormalities that Drs. Falicov or Esterberg would have noticed and corrected if they had been adequately conducting

neuromonitoring during the 11/3/10 surgery.

G. Mr. Warner Sued Drs. Falicov and Esterberg, Proliance, and Swedish for General Negligence and Medical Malpractice in September 2013.

On September 17, 2013—almost three years after the November 2010 surgery—Mr. Warner filed a medical malpractice lawsuit² against Drs. Falicov and Esterberg, Proliance, and Swedish, alleging that he suffered an injury as a direct and proximate cause of developments “during and/or following Dr. Falicov’s 11/3/10 surgery.” CP 6:25-26. Specifically, Mr. Warner alleged that the defendants, (collectively, including Swedish) breached duties to “properly, adequately or timely monitor, manage, diagnose, refer, consult, inform and treat Christopher M. Warner’s operative and post-operative courses; failing to inform him of the material risks to his approach to treatment; failing to properly obtain his informed consent to treatment, and otherwise failing to render the necessary care Christopher M. Warner required.” CP 7:21-27.

Mr. Warner did not plead a cause of action against Swedish for corporate negligence. He did not allege that Swedish had negligent hospital policies and procedures or negligent hospital credentialing, nor did he ever

²Mr. Warner also alleged “ordinary negligence” even though “ordinary negligence” is not a cause of action in medical malpractice claims brought pursuant to RCW 7.70 *et seq.* CP 7:7.

amend his complaint to allege corporate negligence.

H. Mr. Warner Settled with Drs. Falicov and Esterberg, and Proliance on August 29, 2014.

On August 29, 2014, Drs. Falicov and Esterberg and their employer, Proliance, settled with Mr. Warner, but vigorously denied and continued to deny any negligence. CP 362:1-3. The Stipulation and Order of Dismissal was entered October 2, 2014. CP 357.

Despite their dismissal from the case, Mr. Warner continued to seek discovery and depositions from them with respect to Proliance's billing records. Drs. Falicov and Esterberg had been previously deposed. CP 361:7-16. Despite their dismissal from the case, Mr. Warner sought to retroactively assert a Medicare fraud claim against them, alleging that Dr. Falicov's willingness to write off the neuromonitoring bill "smacks of Medicare fraud."³ CP 91:15-20. The dismissed defendants moved to quash the subpoenas and for a protective order. CP 360-70.

I. Mr. Warner then Alleged that Swedish Was Purportedly Participating in an Undefined "Medicare Scheme."

Mr. Warner's complaint does not allege any cause of action related to Medicare or any party's billing practices, nor did Mr. Warner allege any

³ Swedish vehemently denies any allegation of Medicare fraud and resents any implication of same. This allegation is solely based on speculation, *i.e.*, "Swedish was involved in

causal connection between his alleged injury from the November 3, 2010 surgery and billing for the neuromonitoring. Nevertheless he tried to subpoena billing records from Proliance and Drs. Falicov and Esterberg to establish a billing “scheme” involving Medicare, even though his claims against those defendants were settled on August 29, 2014.

Drs. Falicov and Esterberg, and Proliance moved to quash the subpoena and moved for a protective order. CP 147-58. Finally, Mr. Warner agreed to accept Proliance’s billing records with Medicare in exchange for not pursuing any more discovery from Proliance, which had been dismissed. CP 187:8-11. Thwarted in establishing “fraud” against Proliance and Drs. Falicov and Esterberg, Mr. Warner turned his attention to Swedish.

There is no evidence that Swedish billed Mr. Warner for neuromonitoring services or that *such alleged billing caused Mr. Warner’s injuries*. The sole bill for those services was prepared and sent by Proliance under Dr. Esterberg’s name. CP 67:21-68:25. Swedish does not prepare bills for services provided by Proliance, Dr. Falicov or Dr. Esterberg. Swedish did not receive the bill, and did not even see it until this litigation ensued. Second, Mr. Warner erroneously *assumed* that because Medicare rejected Dr. Esterberg’s bill for neuromonitoring services, the bill was “fraudulent.” Mr.

providing the hookup for the remote monitoring system so it obviously knew what was going

Warner further *assumed* that Swedish was complicit in this “fraud” because it allegedly assisted Proliance to set up a “network connection” for the Proliance-owned laptop that Dr. Esterberg used for remote neuromonitoring. This “fraudulent billing” claim is not a corporate negligence claim and it has nothing to do with health care. As such, it is not a proper claim against Swedish. Moreover, Mr. Warner never paid for neuromonitoring services because Dr. Falicov, as explained below, asked Proliance to waive the bill.

Despite all of the foregoing, Mr. Warner continues to drag this issue into the appeal against Swedish, while ignoring the incontrovertible testimony of Drs. Falicov and Esterberg. With respect to billing and Medicare, Dr. Falicov testified as follows:

Q: Do you remember there was a conversation between you and Chris Warner where Chris wondered who Dr. Esterberg was and what did he do, and you said you would take care of the bill?

A: He had asked me about the neuromonitoring bill, and again, I don't get involved with billing, and when I heard that I told him that I would just take care of it.

Q: What does that mean, that you paid it yourself?

A: I just waived the charges.

Q: Is it customary for someone like Dr. Esterberg to be up there watching this during the surgery and then billing for it?

A: It's customary, unfortunately, in the U.S. system, any time you do something, you bill for it.

Q: Now, there was some reference, and I forget exactly where it was but maybe it was an **e-mail where you made reference to the fact that Medicare doesn't allow someone in the operating room, that they won't pay for that.**

A: **Yeah, that's why I didn't submit a bill for neuromonitoring.**

CP 196:2-25.

Q: Do you know why Medicare refused to pay [Dr. Esterberg's neuromonitoring] bill?

A: You're asking me how I know how Medicare works. I have not one clue, sorry.

CP197:2-4.

Q: I'm wondering how it is that if Dr. Esterberg was sending the bill for \$4,000 plus dollars, how is it that you are able to just waive that?

A: We have a lot of leeway in how we bill, and we were just documenting what we did. I did the surgery, I did the monitoring, he [Dr. Esterberg] did the monitoring, we just submitted the codes for what we did.

Q: Tell me, mechanically, how was it that you waived the bill. What did you do?

A: I called our billing office and said, hey, can you waive this bill please.

CP 197:5-11; CP 197:17-20.

Swedish answered Mr. Warner's interrogatory about what involvement, if any, Swedish had with regard to Dr. Esterberg's bill that was sent to Medicare; rejected; and then sent to Mr. Warner for the neuromonitoring services:

Swedish was not involved in sending a bill for neuromonitoring services in this case to Medicare, to any insurer or to any individual. Swedish does not prepare bills for any services provided by Dr. Esterberg or Dr. Falicov and Swedish does not receive those bills.

CP 201:9-15 (emphasis added). Additionally, Swedish answered that "*No Swedish Medical Center representative participated in billing Medicare for neuromonitoring services performed during Chris Warner's 11/3/10 surgery.*"

CP 202:13-17 (emphasis added).

J. Swedish Moved For Summary Judgment Dismissal.

After the key defendants were dismissed, Mr. Warner began and engaged in significant discovery with Swedish in September and October 2014. CP 17:23. It is undisputed that Swedish supplied comprehensive responses to plaintiffs' discovery requests, produced a 30(b)(6) representative to testify regarding credentialing, and provided plaintiffs with proof that it does not own or lease the neuromonitoring machine at issue. CP 187:1-3. Swedish moved to dismiss Mr. Warner's medical malpractice claims against

it on December 19, 2014—two months before the rescheduled February 9, 2015 trial date. CP 12-13. Given Mr. Warner’s broad and non-specific allegations against the hospital, Swedish moved for dismissal on six separate grounds: (1) if plaintiffs alleged that Swedish was an ostensible agent of the dismissed principals/parties, then Swedish must be dismissed because the principals were dismissed; (2) if plaintiffs alleged corporate negligence (though it was never pled), then that claim must be dismissed for failure to offer required expert support; (3) if plaintiffs alleged lack of informed consent, then that claim must be dismissed as a matter of law because informed consent rests with the patient’s physician, not the hospital; (4) if plaintiffs alleged that Swedish failed to save the neuromonitoring records, then that claim should be dismissed because plaintiffs cannot demonstrate that the alleged negligence caused any of their injuries; (5) all health care actions arise from RCW 7.70 *et seq.*, so plaintiffs’ claim of “ordinary negligence” must be dismissed CP 7:7 (alleging “ordinary negligence”); and (6) if plaintiffs alleged that the subject neuromonitoring equipment was defective or malfunctioned, then that claim should be dismissed because Swedish did not own or lease the subject equipment. CP 18:1-10; CP 23:2-3; CP 24:17-20; and CP 75:3-8.

In sum, Swedish argued that it was merely the locus of the subject surgery, nothing more. CP 18:20. Conversely, Swedish's neuromonitoring team was not used for the surgery, CP 19:20-12; Swedish neither owned nor leased the Medtronic machine used by Proliance, CP 19:23-20:1; no Swedish employee assisted with the neuromonitoring, CP 20:5-6; and Swedish did not bill Mr. Warner for neuromonitoring services or participate in preparing or sending bills for that service, CP 20:22-23.

In response, Mr. Warner only addressed the *unpled* corporate negligence claim, alleging for the first time that Swedish was engaged in corporate negligence for (1) not ensuring that doctors (*i.e.*, Drs. Falicov and Esterberg) were appropriately "credentialed" to neuromonitor the subject surgery; and (2) not ensuring that the hospital had policies and procedures governing neuromonitoring. CP 91:23-92:4. Once again, Mr. Warner relied on "ordinary negligence," which does not apply to health care. CP 93:11-22.

First, Mr. Warner relied on the deposition testimony of Barbara Shaw, Swedish's 30(b)(6) representative regarding hospital policies and procedures, and the credentialing and privileging of Drs. Falicov and Esterberg. CP 102:8-19. Ms. Shaw confirmed that Swedish does not have hospital policies and procedures for how surgeons use or don't use neuromonitoring during

spine surgery. CP 102:20-103:3. Ms. Shaw also confirmed that “neuromonitoring” is not on the privilege form for orthopedic surgery. CP 104:18-19.

Mr. Warner attached to his declaration what purports to be a bill with Swedish’s name at the top, (CP 107), however, this bill was never authenticated or otherwise admissible under CR 56(e). The only information gleaned from the highlighted section on CP 107 is that it totals \$168,918.12. This neither supports nor refutes an issue of material fact.

K. Mr. Warner’s Experts’ Conclusory Declarations Were Factually Unsupported Opinions in Derogation of CR 56(e).

Mr. Warner submitted virtually identical declarations from two Massachusetts experts in support of his unpled corporate negligent claim, namely Edward Tarlov, M.D., a retired neurosurgeon, and John Ney, M.D., a neurophysiologist. Both experts heavily criticized Drs. Esterberg and Falicov for various acts and omissions, even though these defendants were already dismissed from the lawsuit. The most consistent criticism *lodged against the Proliance surgeons* was that they were not properly trained to perform neuromonitoring services, and that a doctor must *watch* the wave forms on the screen, rather than *listen* to audible sounds or alarms. CP 111:16-17; CP 136:1-2.

Their criticisms of Swedish, as drafted in their declaration admittedly prepared by plaintiffs' counsel, were that Swedish (1) "failed to require proper qualifications for performing neuromonitoring" in its credentialing process, CP 115:18-21; (2) failed to have any policies and procedures in place for neuromonitoring on November 3, 2010, CP 115:24-25; and (3) that these alleged "failures" proximately caused Mr. Warner's injuries, CP 116:2-8.

They also opined that "Swedish was complicit in promoting a billing scheme for neuromonitoring that did not provide direct patient benefit and resulted in charges that were never rendered."⁴ CP 116:10-12. Their opinions ignored Dr. Falicov's testimony that: (1) "Medicare doesn't allow someone in the operating room" to charge for neuromonitoring, CP 196:2-15; and (2) Dr. Falicov waived Dr. Esterberg's fees for neuromonitoring, CP 197:2-11; CP 197:17-20.

Their declarations lacked a factual basis for their conclusory opinion that Swedish somehow allegedly fell below the standard of care in credentialing its physicians or in its hospital's policies and procedures. Significantly both experts failed to meet the criteria of CR 56(e) because:

- Neither Drs. Tarlov nor Ney identified the applicable standard

⁴ Plaintiff's expert, Dr. Tarlov, also opined that Swedish knew it was "paying huge amounts for orthopedic hardware and then rebilling Medicare for disposable neuromonitoring

of care for: (a) Washington (b) hospitals, or stated their familiarity with those standards;⁵

- Neither Drs. Tarlov nor Ney reviewed Swedish's policies and procedures, or the credentialing files of Drs. Falicov and Esterberg;
- Neither Drs. Tarlov nor Ney reviewed or demonstrated knowledge of Swedish's accreditation status with the Joint Commission on Accreditation of Hospitals (JCAH), including JCAH's standards, as well as the credentialing and privileging procedures at Swedish during the relevant time period of November 2010;
- Neither Drs. Tarlov nor Ney reviewed or demonstrated knowledge of Swedish's bylaws, as they relate to credentials or privileges for orthopedic surgeons;
- Neither Drs. Tarlov nor Ney stated that Swedish's bylaws were below the standard of care or that they contravene JCAH standards;
- Neither Drs. Tarlov nor Ney stated that they have ever been

equipment," for \$190,000. CP 116:14-17. This assertion is wholly unsubstantiated and Swedish has repeatedly refuted it.

involved with or are familiar with credentialing/privileging decisions or policy approval at any hospital, much less a Washington hospital;

- Neither Drs. Tarlov nor Ney opine that in November 2010, a Washington hospital *was required to have policies and procedures pertaining to neuromonitoring during spine surgery*;
- Neither Drs. Tarlov nor Ney opined that Swedish negligently granted Drs. Falicov and Esterberg credentials for staff membership and/or privileges to perform orthopedic surgery; and
- Neither Drs. Tarlov nor Ney provided proof that *any hospital in Washington* was offering a specific privilege for neuromonitoring during orthopedic surgery in November 2010.

In sum, Swedish argued that plaintiffs' experts' theory that Swedish permitted unqualified orthopedic surgeons to perform neuromonitoring during the subject spine surgery was simply a criticism of how Drs. Falicov and Esterberg elected to exercise their privileges as Mr. Warner's private

⁵ They both simply stated, without further elaboration or explanation that "[t]he standard of

surgeons, and not corporate negligence.

L. The Trial Court Granted Swedish Summary Judgment.

At oral argument on December 19, 2014, before the Honorable Theresa B. Doyle, Swedish argued that neuromonitoring is not required for the complex spinal surgery performed on Mr. Warner. Verbatim Report of Proceedings (“VRP”) at 7:9-15. If used, the type of neuromonitoring, “is left completely up to the discretion and judgment of the operating surgeon, as it should be. This is certainly nothing that a patient or a surgeon would want some hospital administrator stepping in and making a treatment decision about. This is something totally within the realm of the operating surgeon.” VRP 7:16-22.

This is consistent with Dr. Esterberg’s opinion that the decision of whether a patient will receive neuromonitoring during a surgery “is up to the individual surgeon.” CP 82:14-19. The patient’s surgeon also decides which “neuromonitoring modalities to use during the patient’s surgery.” CP 83:7-10.

Swedish confirmed that it did not own the laptop computer used for backup neuromonitoring, or the neuromonitoring machine in the surgery room, and that Dr. Falicov utilized supplies, hardware, and parts from Metronic. VRP 7:23-8:13. The trial court asked Swedish about the allegation

care in Washington is the same as it is in Massachusetts.” CP 115:12; CP 135:18.

of its alleged failure to provide reasonable care in credentialing and privileging procedures. VRP 10:17-20.

Swedish argued that Dr. Tarlov's declaration was conclusory and that he had demonstrated no experience or knowledge in working in the field of hospital credentialing or hospital policies and procedures. VRP 12:2-11. Also, Dr. Tarlov "doesn't say that he has any familiarity with the standards or more particularly even the laws applying to hospitals in the state of Washington." VRP 12:12-16. In fact, "[u]nlike medical practice, where the residency programs are national the board certification is national; you know, hospitals are very much governed by the specific statutes in each and every state and they differ considerably." VRP 12:16-20.

Swedish underscored that neither Dr. Tarlov nor Dr. Ney state that "they've ever served on any type of committee or had any role to play in credentialing of physicians and what constitutes adequate credentialing for an orthopedic spine surgeon." VRP 12:23-13:2. Additionally, "[t]hey don't establish a basis, a factual basis for their conclusory allegation that Swedish somehow fell below some standard of care in credentialing or in policies and procedures." VRP 13:16-19. Swedish also explained that neither Dr. Tarlov nor Dr. Ney tell you what the standard is, such as "[h]ere's the standard of

reasonably prudent medical practice for credentialing an orthopedic surgeon to conduct surgeon-directed neuromonitoring. And they have to do that. They have to tell us this is what the standard is.” VRP 13:21-25. In sum, they “just put out there, in a few short sentences, that somehow Swedish fell below this. And I don’t think that’s sufficient.” VRP 14:2-4.

Swedish also argued the expert declarations were insufficient because they made conclusory statements that Swedish’s conduct “was a proximate cause of the injury to the patient.” VRP 14:12-14.

Swedish concluded that “there is a lot of verbiage, inflammatory type verbiage, you know; conniving, a billing scheme, things—words to that effect.” VRP 14:17-19. “What was undisputed is that Swedish had no connection whatsoever to that [Dr. Esterberg’s] bill. VRP 14:23-24. Swedish noted that the “billing issue is gone. That was a Falicov/Proliance/Esterberg billing issue; that was not a Swedish billing issue.” VRP 15:2-5. “Swedish doesn’t have anything to do with the bill that was sent by Proliance” and “there is no evidence of any bill coming from Swedish to Mr. Warner” and “there has been no allegation of anything that was an impropriety in any way.” VRP 15:8-13. Additionally, “[h]aving settled with Proliance and the other defendants, any sort of billing issue is out.” VRP 15:17-18. Finally,

“Mr. Warner is claiming that he had some nerve injury occurring during surgery, so that can’t causally be connected to a bill that was sent to his insurance company after the fact.” VRP 15:21-24.

Mr. Warner explained that Swedish did not have policies regarding neuromonitoring, to which the trial court responded: *“what I don’t have before me is any expert saying that that’s [not having a neuromonitoring policy] a violation of the standard of care, what’s the standard of care for hospitals with respect to having policies regarding the remote neuromonitoring.”* VRP17:13-19; VRP 17:25-18:4. The trial court also noted while the expert declarations concluded “that the failure to have proper policies in this area was the proximate cause in his belief of the injuries, but doesn’t really say what those procedures should be.” VRP 18:16-19.

Mr. Warner ultimately faulted Dr. Esterberg (not Swedish) for conducting a short surgery and seeing one patient during Mr. Warner’s surgery—therefore not performing backup neuromonitoring “continuously.” VRP 19:8-14. However, Mr. Warner failed to explain to the trial court that Dr. Garr stepped in and continuously monitored Mr. Warner’s surgery while Dr. Esterberg was briefly away. CP 65:13-25. And that when Dr. Esterberg returned, Dr. Garr reported no problems with the neuromonitoring. CP 81:21-

23.

Mr. Warner also faulted Dr. Esterberg for not being sufficiently “trained” and “credentialed” to observe waveforms on the monitor. However, neither he nor his experts explained how Dr. Esterberg, an orthopedic surgeon with extensive experience performing neuromonitoring, was unqualified or how Swedish allegedly violated the standard of care. VRP 20:2-21:1.

The trial court responded to Mr. Warner’s arguments as follows:

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 really a 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.

VRP 21:25-22:10.

Mr. Warner responded that he did not “believe the law requires that policies be based upon a WAC or a statute.” VRP 22:11-13. The trial court replied, “*But it has to be based on something.*” VRP 22:14-15.

During rebuttal, Swedish stated that “things within the purview of the physician training, judgment, discretion, knowledge base cannot be legislated

by a hospital in written policies.” VRP 28:12-15. Dr. Ney may have a different style or process than Drs. Falicov or Esterberg, “but in neither event can the hospital tell a doctor, ‘here’s how you do neuromonitoring,’ any more than they could tell a surgeon, ‘hey, here’s how you do a surgery.’ A hospital isn’t licensed to do that.” VRP 28:18-23. Swedish clarified that the JCAH policies and standards are certainly required for hospitals as it relates to nonphysician judgment. However, hospitals do not practice medicine. VRP 28:25-29:4.

Swedish also stated that it “was asked for and produced hundreds of pages from the credentialing files of Drs. Esterberg and Falicov,” but that plaintiffs’ expert declarations notably did not list the credentialing files among the files that they reviewed in forming their conclusory opinions. VRP 27:9-15; *see also* CP 110 (no reference to credentialing files in documents listed in Dr. Tarlov’s declaration); and CP 132 (same re Dr. Ney’s declaration).

Swedish argued that the experts’ conclusion that Swedish “doesn’t have policies for credentialing is without a factual basis.” VRP 27:18. “Of course Swedish has policies in place for credentialing competent, well-trained physicians.” VRP 27:19-20. Taking Dr. Falicov as an example, he was an

“undergrad at Berkeley, medical school at Harvard, Ph.D. at MIT. I mean, Swedish looks at, evaluates, does all the necessary steps to credential competent, in fact highly competent, very well qualified physicians.” VRP 27:21-25.

Swedish concluded that “if the plaintiffs’ attorneys aren’t even going to give these experts the credentialing materials that have been produced, how can they have an adequate factual basis on which to opine about Swedish’s policies on credentialing?” VRP 28:2-6.

The trial court granted Swedish summary judgment dismissal on December 19, 2014. CP 207-08.

M. Mr. Warner Moved for Reconsideration, Which Was Denied.

Mr. Warner moved for reconsideration on December 29, 2014. CP 210. He first re-argued his contention that his experts’ declarations “established a prima facie case of duty, breach, causation and damages.” CP 211:21. Second, he argued that he needed more time under CR 56(f), but this related to “obtaining certain discovery [regarding Medicare billing] which had been resisted with three motions to quash properly set depositions of corporate personnel of dismissed party Proliance.” CP 211:25-26. This had nothing to do with Swedish or Mr. Warner’s unpled corporate negligence

claim.

Finally, Mr. Warner stated that the depositions of his two experts had been taken on December 17, two days before the summary judgment hearing on December 19, and he did not have enough time to obtain the transcripts. CP 212:1-3. However, Swedish filed its reply in support of summary judgment on December 15, outlining all of the deficiencies in his experts' declarations. CP 182. Mr. Warner could have supplemented his experts' declarations with factual support and mitigated the conclusory statements anytime between December 15 and December 19, the date of the hearing. In fact, he was in Boston with both experts on December 17 and could have supplemented their declarations before the December 19 hearing. He did not do so, and instead blamed Swedish for cancelling its transcript order *after Swedish had been dismissed on summary judgment*. CP 212:2-3. Accordingly, none of these bases met the criteria of CR 59(a)(4), (7)-(9). CP 211:2-12.

In a January 8, 2015, supplemental declaration, Mr. Warner highlighted the relevant deposition testimony of Drs. Tarlov and Ney that he believed warranted reconsideration. CP 241:10-242:19; CP 244:7-245:22.

Specifically, Mr. Warner submitted and relied upon Dr. Tarlov's

deposition testimony that Swedish should have had a written policy about “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.” CP 241:129-22. He clarified that “they’re not deficient in looking after their own interests.” CP 241:24. Dr. Tarlov criticized the billing practices, then opined that “if the equipment had been connected and had, had the doctors been looking at it and they would have seen evidence of nerve damage.” CP 242:18-19. These were erroneous assumptions because Dr. Tarlov did not rely on any admissible evidence that the equipment was, in fact, disconnected, or unwatched by either Dr. Falicov or Dr. Esterberg. Additionally, this expert testimony does not explain if or how Swedish failed to exercise reasonable care in adopting its policies and procedures, and credentialing process.

Dr. Ney testified that he believed that the entire “Medtronic system of intraoperative neuromonitoring is inadequate.” CP 245: 20-21. He also testified that Dr. Esterberg was not competent to perform the neuromonitoring because—in his opinion—it should be done by a neurologist or neurophysiologist. CP 244:22-24. Again, the expert deposition

testimony— upon which Mr. Warner expressly relied in his motion for reconsideration—was not directed at Swedish and did not establish the experts’ familiarity with the standard of care for hospitals in Washington during the relevant time of November 2010. They did not explain how Drs. Falicov and Esterberg were insufficiently credentialed by Swedish to perform neuromonitoring. They did not establish experience with or knowledge of hospital policies or credentialing. In sum, the motion for reconsideration relied on conclusory opinions. The trial court denied the motion for reconsideration. CP 341-42.

Mr. Warner timely appealed the trial court’s order dismissing Swedish, and denying his motion for reconsideration. CP 343-50.

IV. ARGUMENT

A. The De Novo Standard of Review Applies to Summary Judgment.

Mr. Warner contends that summary judgment orders are reviewed for abuse of discretion. *See* Appellants’ Opening Brief at 28. This is incorrect; the Court of Appeals reviews summary judgment orders de novo. *Hadley v. Maxwell*, 144 Wn.2d 306, 310-11, 27 P.3d 600 (2001). Summary judgment is appropriate only when there are no genuine issues of material fact and the moving party is entitled to judgment as a matter of law. CR 56(c); *Peterson v.*

Groves, 111 Wn. App. 306, 310, 44 P.3d 894 (2002). The Court considers the evidence and reasonable inferences therefrom in the light most favorable to the nonmoving party. *Schaaf v. Highfield*, 127 Wn.2d 17, 21, 896 P.2d 665 (1995).

CR 56(b) enables a defendant to move for summary judgment dismissing an action or any part thereof. The summary judgment procedure dispenses with the time and cost of litigating meritless actions through trial. *W.G. Platts, Inc. v. Platts*, 73 Wn.2d 434, 442-43, 438 P.2d 867 (1968); *Padron v. Goodyear Tire*, 34 Wn. App. 473, 475, 662 P.2d 67 (1983).

A defendant may move for summary judgment without supporting affidavits on the grounds that the plaintiff lacks competent evidence to support an essential element of her case. *Guile v. Ballard Cmty. Hosp.*, 70 Wn. App. 18, 23-24, 851 P.2d 689 (1993) (citations omitted). In a medical malpractice case, expert testimony is usually required to establish standard of care and causation. *Harris v. Groth*, 99 Wn.2d 438, 451, 663 P.2d 113 (1983); *Shoberg v. Kelly*, 1 Wn. App. 673, 677, 463 P.2d 280 (1969). Once the defendant demonstrates that the plaintiff lacks competent expert testimony, “the burden shifts to the plaintiff to produce an affidavit from a qualified expert witness that alleges specific facts establishing a cause of

action. *Affidavits containing conclusory statements without adequate factual support are insufficient to avoid summary judgment.*” *Guile*, 70 Wn. App. at 25 (emphasis added).

B. The “Abuse of Discretion” Standard Applies to a Motion for Reconsideration.

The Court of Appeals will “review a trial court’s denial of a motion for reconsideration for abuse of discretion.” *Kleyer v. Harborview Med. Ctr. of Univ. of Wash.*, 76 Wn. App. 542, 545, 887 P.2d 468 (1995). “The proper standard is whether discretion is exercised on untenable grounds or for untenable reasons, considering the purposes of the trial court’s discretion.” *Coggle v. Snow*, 56 Wn. App. 499, 784 P.2d 554 (1990).

The experts’ 12/17/14 *deposition testimony*—upon which Mr. Warner relied—still failed to: (1) identify the applicable standard of care for a Washington hospital in November 2010; (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 Joint Commission on Accreditation of Hospitals—such accreditation establishing that Swedish complies with the standard of care for credentialing physicians; and (3) establish that they were experienced or knowledgeable with Washington’s hospital’s

credentialing/privileging process or policies in November 2010. The trial court did not abuse its discretion in denying Mr. Warner's motion for reconsideration—particularly since he could have submitted supplemental declarations before the 12/19/14 hearing.

C. This Appeal Is Governed by RCW 7.70 *et seq.* Not Ordinary Negligence.

Inexplicably, Mr. Warner relies upon and cites a cause of action for “negligence.” *See* Appellant’s Opening Brief at 23. However, his claim of corporate negligence against Swedish is governed exclusively by RCW 7.70 *et seq.* in Washington for all civil actions based on tort, contract, or otherwise, for damages arising from health care. “RCW 7.70 modifies procedural and substantive aspects of *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).

In addition, “the legislature expressly limit[s] medical malpractice actions for injuries against health care providers to claims based on the failure to follow the accepted standard of care, the breach of an express promise by a health care provider, and the lack of consent.” *Sherman v. Kissinger*, 146 Wn. App. 855, 866, 195 P.3d 539 (2008) (citing RCW 7.70.030); *Orwick v.*

Fox, 65 Wn. App. 71, 86, 828 P.2d 12 (1992) (“RCW 7.70 applies to all actions against health care providers, whether based on negligence or intentional tort.”).

D. A Hospital Has an Independent Duty to Exercise Reasonable Care.

Due to Mr. Warner’s failure to plead “corporate negligence” against Swedish, it only learned two months before trial that this was his theory. He contends that Swedish breached an independent duty owed to him. *Douglas v. Freeman*, 117 Wn.2d 242, 248, 814 P.2d 1160 (1991) (a claim of corporate negligence is based on a nondelegable duty that a hospital owes directly to its patients.)

WPI 105.02.02 identifies a hospital’s responsibilities as follows:

A hospital owes an independent duty of care to its patients. This includes the duty to:

[exercise reasonable care to grant and renew staff privileges so as to permit only competent physicians and surgeons to use its facilities.]

[exercise reasonable care to periodically monitor and review the competency of all health care providers who practice medicine at the hospital.]

[exercise reasonable care to intervene in the treatment of a patient at the hospital under the care of an independent physician if one of its officers, employees, or agents becomes aware of obvious negligence.]

[exercise reasonable care to adopt policies and procedures for health care provided to its patients.]

“Reasonable care” in this instruction means that degree of skill, care, and learning expected of a reasonably prudent

hospital in the State of Washington acting in the same or similar circumstances and at the same time of the care or treatment in question. Failure to exercise such skill, care, and learning is negligence.

The degree of care actually practiced by hospitals is evidence of what is reasonably prudent. However, this evidence alone is not conclusive on the issue and should be considered by you along with any other evidence bearing on the question.

WPI 105.02.02 (emphasis added). Here, Mr. Warner focuses on Swedish's duty to: (1) exercise reasonable care to grant and renew staff privileges so as to permit only competent physicians and surgeons to use its facilities; and (2) exercise reasonable care to adopt policies and procedures for health care provided to its patients.

As with any other claim of medical negligence, Mr. Warner must establish through expert testimony the standard of care for the hospital; that the standard of care was breached; and that the breach proximately caused the alleged injuries. *Freeman*, 117 Wn.2d at 249. In *Douglas* for example, the Court noted that "several expert witnesses testified regarding the clinic's duty to supervise." *Id.*

In *Ripley v. Lanzer*, 152 Wn. App. 296, 215 P.3d 1020 (2009), the plaintiffs alleged corporate negligence against Evergreen Medical Center Hospital for failure to furnish supplies and equipment free of defects. *Id.* at 304. The Court affirmed summary dismissal of the corporate negligence claim because the plaintiffs failed to produce the required expert medical

evidence to establish the standard of care. *Id.* at 302. In this case, since Mr. Warner failed to supply sufficient expert testimony in support of a claim of corporate negligence against Swedish, the claim, if any, was correctly dismissed.

In *Douglas*, the Supreme Court noted that the “standard of care is based on proof of the customary and usual practices within the profession.” *Id.* (citations omitted). “[T]he standards of care to which a hospital should be held may be defined by the accreditation standards of the Joint Commission on Accreditation of Hospitals and the hospital’s own bylaws.” *Id.* (relying on *Pedroza v. Bryant*, 101 Wn.2d 226, 677 P.2d 166 (1984)). The *Pedroza* Court was persuaded that the hospital’s accreditation standards suggested a method of defining the standard of care to which hospitals would be held. *Id.* at 233.

The Joint Commission on Accreditation of Hospitals (JCAH) has been characterized by commentators as “the most important of national standards voluntarily adopted by hospitals.” *Id.* The Washington Supreme Court adopted a commentator’s cogent analysis of the JCAH standards, wherein those “standards clearly establish the institution’s governing board as ultimately responsible for the overall quality of patient care provided in the hospital. The medical staff, in turn, is responsible to the governing board for the professional competence of all physicians and dentists who are members

of the hospital's medical staff.” *Id.* at 234 (citing Koehn, *Hospital Corporate Liability: An Effective Solution to Controlling Private Physician Incompetence?*, 32 Rutgers L. Rev. 342, 369-70 (1979)).

The JCAH standards “place particular emphasis on the appointment/reappointment process, delineation of clinical privileges, and periodic appraisals of each physician staff member. In addition, the hospital is required to institute reliable and valid measures that continuously evaluate the quality of care rendered all patients.” *Id.*

In sum, the *Pedroza* Court noted that “JCAH accreditation means that a hospital has sufficiently complied with standards aimed at providing a comprehensive, ongoing system of review capable of identifying any incompetent members of the medical staff. The standards could be valuable as a measure against which the hospital’s conduct is judged to determine if the institution is meeting its duty of care to patients.” *Id.* The *Pedroza* Court also determined that a hospital’s bylaws may be relevant to establish the standard of care. *Id.* Usually, the standard of care must be established by expert testimony.

E. Mr. Warner’s Experts Failed to Articulate the Threshold Standard.

A “*plaintiff in a medical malpractice action must, by expert testimony, establish the applicable standard of care, skill, and diligence and show that the defendant had in some way departed therefrom.*” *Hill v. Parker*, 12 Wn.2d 517, 529, 122 P.2d 476 (1942) (emphasis added).

Mr. Warner’s experts failed to establish, as a threshold matter, that any hospital in Washington was offering a specific privilege for neuromonitoring during spine surgery in November 2010, or that any hospital in Washington was required to do so. Nor did Mr. Warner’s experts demonstrate that Swedish negligently granted Drs. Falicov and Esterberg credentials for staff membership and/or privileges to perform orthopedic surgery. Moreover, Mr. Warner’s experts’ theory that Swedish permitted unqualified orthopedic surgeons to perform neuromonitoring during the subject spine surgery is actually just a criticism of how Drs. Falicov and Esterberg elected to exercise their privileges as Mr. Warner’s private surgeons, *not corporate negligence*. Finally, neither expert demonstrates that in November 2010, a hospital in Washington was required to have policies and procedures pertaining to neuromonitoring during spine surgery. Instead, the experts offer conclusory opinions premised on assumptions and presumptions. However, “[p]resumptions may not be pyramided upon

presumptions, nor inference upon inference.” *Prentice Packing & Storage Co. v. United Pac. Ins. Co.*, 5 Wn.2d 144, 164, 106 P.2d 314 (1940).

F. Mr. Warner’s Experts’ Declarations Fail Because They Were Conclusory.

“The opinion of an expert which is only a conclusion or which is based on assumptions is not evidence which satisfies the summary judgment standards because it is not evidence which will take a case to the jury.” *Doe v. Puget Sound Blood Ctr.*, 117 Wn.2d 772, 787, 819 P.2d 370 (1991); *see also Guile*, 70 Wn. App. at 25 (“Affidavits containing conclusory statements without adequate factual support are insufficient to defeat a motion for summary judgment.”); *Van Leven v. Kretzler*, 56 Wn. App. 349, 355-56, 783 P.2d 611 (1989) (an affidavit was insufficient to raise a material factual issue because the physician failed to identify any facts supporting his conclusion).

Here, neither Dr. Ney nor Dr. Tarlov explain the standard of care for a (1) hospital in (2) Washington, (3) during November 2010. They also fail to explain how Swedish failed to exercise reasonable care in establishing its policies and procedures—particularly if it allows surgeons to exercise their discretion regarding when and how they utilize neuromonitoring. Dr. Esterberg testified that he continuously performed backup neuromonitoring. Accordingly, how did Swedish fail to exercise reasonable care?

Neither expert articulates or demonstrates any knowledge of the JCAH standards or of Swedish's JCAH accreditation status. Swedish's First Hill campus is JCAH accredited; accordingly the credentialing and privileging procedures at that campus must therefore be sufficient. Neither expert expresses knowledge of Swedish's bylaws. As a result, neither expert can state that Swedish's bylaws – as they relate to credentials or privileges for orthopedic surgeons – are below the standard of care; that any of those bylaws were violated in this case; or that the hospital's policies, procedures and credentialing for orthopedic surgeons contravene JCAH standards.

Neither Dr. Ney nor Dr. Tarlov established that they have ever been involved with credentialing/privileging decisions or policy approval *at any hospital*. Instead, they *assume* that the absence of specific policy regarding how neuromonitoring must be done is, in itself, below the standard of an unspoken standard of care. The experts then *assume* that the absence of a specific policy caused Mr. Warner's injuries. Neither expert reviewed Swedish's policies; neither expert reviewed the credentialing files of Drs. Falicov and Esterberg; neither expert provided testimony that any hospital in Washington was offering a specific privilege for neuromonitoring in November 2010; neither expert considered the discretion and judgment that

Washington allows its credentialed and licensed surgeons to exercise during surgery.

G. The Claim That Swedish Was Complicit in Fraudulent Billing to Medicare for Neuromonitoring Services Was Properly Dismissed.

There is no evidence that Swedish billed for neuromonitoring services. The sole bill for those services was prepared and sent by Proliance under Dr. Esterberg's name. Swedish does not prepare bills for services provided by Proliance Dr. Falicov or Dr. Esterberg. Swedish did not receive the bill, and did not even see it until this litigation. Also, Mr. Warner erroneously assumes that because Medicare rejected Dr. Esterberg's bill for neuromonitoring services, the bill was "fraudulent."

Mr. Warner further assume that Swedish was complicit in this "fraud" because it allegedly assisted Proliance to set up a "network connection" for the Proliance-owned laptop Dr. Esterberg used for remote neuromonitoring. This "fraudulent billing" claim is not a corporate negligence claim and it has nothing to do with health care. As such, it was not a proper claim against Swedish. Finally, Mr. Warner did not pay the bill for neuromonitoring services because Dr. Falicov asked Proliance to waive it.

V. CONCLUSION

The Court of Appeals should affirm the trial court's order dismissing

Mr. Warner's corporate negligence claim against Swedish, and affirm the trial court's order denying reconsideration. CR 56(e) states that an affidavit "must set forth facts showing there is a genuine issue for trial." Mr. Warner's experts did not set forth specific facts. "Affidavits containing conclusory statements without adequate factual support are insufficient to defeat a motion for summary judgment." *Guile v. Ballard Comty. Hosp.*, 70 Wn. App. 18, 25, 851 P.2d 689 (1993). Based on the foregoing, the trial court's orders should be affirmed.

Dated this 11 day of August, 2015.

Respectfully submitted,

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CERTIFICATE OF SERVICE

THIS IS TO CERTIFY that on the 11th day of August, 2015, I caused
to be served a true and correct copy of the foregoing via email and messenger,
and addressed to the following:

Christopher L. Otorowski / Susan C. Eggers	<input type="checkbox"/> Facsimile
Otorowski Johnston Morrow & Golden, PLLC	<input type="checkbox"/> Messenger
298 Winslow Way West	<input checked="" type="checkbox"/> U.S. Mail
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Sopheary Sanh, Legal Assistant