

No. 85382-7

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FILED
APR 23 2012
CLERK OF THE SUPREME COURT
STATE OF WASHINGTON

DOUGLAS FELLOWS, as Personal Representative of the ESTATE OF
JORDAN GALLINAT,

Plaintiff/Petitioner,

vs.

DANIEL MOYNIHAN, M.D., KATHLEEN HUTCHINSON, M.D. and
SOUTHWEST WASHINGTON MEDICAL CENTER,

Defendants/Respondents.

BRIEF OF AMICUS CURIAE
WASHINGTON STATE ASSOCIATION FOR JUSTICE FOUNDATION

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ORIGINAL

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I. IDENTITY AND INTEREST OF AMICUS CURIAE

The Washington State Association for Justice Foundation (WSAJ Foundation) is a not-for-profit corporation organized under Washington law, and a supporting organization to Washington State Association for Justice (WSAJ). WSAJ Foundation is the new name of Washington State Trial Lawyers Association Foundation (WSTLA Foundation), a supporting organization to Washington State Trial Lawyers Association (WSTLA), now renamed WSAJ. WSAJ Foundation, which operates the amicus curiae program formerly operated by WSTLA, has an interest in the rights of plaintiffs under the civil justice system, including an interest in the proper interpretation and application of the privileges provided to health care providers under RCW 4.24.250, 70.41.200 and related statutes.

II. INTRODUCTION AND STATEMENT OF THE CASE

This review provides the Court with the opportunity to clarify the interpretation and application of RCW 4.24.250 and 70.41.200, involving privileges available to hospital peer review and quality improvement committees. This action was commenced by Douglas Fellows, as Personal Representative of the Estate of Jordan Gallinat, a minor (Fellows), against physicians Daniel Moynihan (Moynihan), Kathleen Hutchinson (Hutchinson) and Southwest Washington Medical Center (SWMC or Hospital). Fellows alleges negligence claims against these health care

providers based upon injuries sustained by Jordan Gallinat at the time of his birth and subsequent resuscitation, including a corporate negligence claim against SWMC.

The case is before the Court on interlocutory review stemming from a series of discovery orders entered by the superior court, which hinge upon proper interpretation and application of RCW 4.24.250 and 70.41.200. The underlying facts are set forth in the ruling denying discretionary review issued by the Commissioner of the Court of Appeals, Division II, and the briefing of the parties. See Ruling Denying Discretionary Review, Commissioner Eric B. Schmidt, Aug. 30, 2010¹; Fellows Mot. for Disc. Rev. at 1-5²; Moynihan Ans. to Mot. for Disc. Rev. at 1-8; Hutchinson Ans. to Mot. for Disc. Rev. at 1-3; SWMC Ans. to Mot. for Disc. Rev. at 1-3; Fellows Reply on Mot. for Disc. Rev. at 3-4; Fellows Br. at 1-8; Joint SWMC et al. Br. at 1-8; Fellows Reply Br. at 2-4.

For purposes of this amicus curiae brief, the following facts are relevant: The series of superior court orders regarding discovery requests by Fellows involve interpretation and application of the statutory privileges set forth in RCW 70.41.200 and, to a lesser extent,

¹ The Commissioner's ruling is reproduced in the Appendix to this brief for the convenience of the Court.

² This motion was denominated "Petition for Review by the Supreme Court." See Fellows Reply on Mot. for Disc. Rev. at 1 n.1.

RCW 4.24.250.³ The briefing before this Court indicates that, as a result of these orders, Fellows' discovery requests for the following information or documentation were denied based on claims of statutory privilege: 1) Hospital credentialing records relating to the initial grant of staff privileges to Moynihan, Hutchinson and another physician, and any additional credentialing records post-dating the initial grant of staff privileges; and 2) documentation maintained in the Hospital quality improvement committee files regarding the reasons for restrictions on Moynihan's staff privileges following Jordan Gallinat's birth.

Fellows sought discretionary review of the superior court's discovery orders in the Court of Appeals, Division II, which was denied by the Commissioner. A panel of the court denied Fellows' motion to modify the Commissioner's ruling. Fellows then sought discretionary review, framing the issue before this Court as:

Did the Court of Appeals err in ruling that in a medical negligence and corporate negligence lawsuit, the quality improvement privilege in RCW 70.41.200(3) shields from discovery all of a hospital's credentialing, privileging and personnel records that relate to whether or not the plaintiff's treating physicians were professionally competent to perform the medical procedures that resulted in the plaintiff's injuries?

Id. The Court granted review "limited to the issues raised in the motion for discretionary review." See Order, July 19, 2011.

³ The current versions of RCW 4.24.250 and 70.41.200 are reproduced in the Appendix.

III. ISSUES PRESENTED

(1) Whether RCW 70.41.200 and RCW 4.24.250 apply to personnel and credentialing records regarding physicians at the time they are first granted staff privileges by a hospital, and at any time thereafter?

(2) To what extent does RCW 70.41.200(1), requiring hospitals to maintain a quality improvement program that oversees quality improvement and medical malpractice prevention, "both retrospectively and prospectively," render hospital records in a "physician's personnel or credential file maintained by the hospital" subject to the quality improvement committee privilege set forth in subsection (3) of the statute?

(3) Whether the exception to the privilege provided in RCW 70.41.200(3)(d), allowing disclosure of the fact that a physician's staff privileges have been restricted and the reasons for any restrictions, allows discovery of the *documentation* in the quality improvement committee files bearing on this information?

IV. SUMMARY OF ARGUMENT

This review principally involves interpretation and application of RCW 70.41.200. This statute, which provides hospitals with a privilege from discovery of certain information and documents created specifically for, and collected and maintained by, their quality improvement committees, is in derogation of the common law and inconsistent with the general policies of the *Civil Rules* favoring broad discovery. As such, it must be strictly construed and limited to the purposes for which it is intended, just as the Court has strictly construed RCW 4.24.250, which provides similar protections for information and documents of a regularly constituted hospital peer review committee. In turn, exceptions to the

privilege provided in RCW 70.41.200 must receive a correspondingly liberal construction. As the parties claiming the privilege, the burden of proof is on the health care providers to establish the applicability of the privilege provided by RCW 70.41.200 (and RCW 4.24.250) and the inapplicability of any exceptions.

Properly construed, RCW 70.41.200's privilege cannot be invoked by hospitals defending against corporate negligence claims to prevent discovery of: 1) relevant personnel and credentialing information and documents regarding a physician generated or received by an original source in the hospital *other than* its quality improvement committee; 2) relevant personnel and credentialing information and documents bearing on a hospital's initial grant of staff privileges to a physician; and 3) at the very least, the statutorily required written documentation in a hospital's quality improvement committee records memorializing the reasons for restrictions on a physician's staff privileges, if not the underlying documentation from which the written reasons were derived. Nothing in RCW 4.24.250 requires a different result.

V. ARGUMENT

The focus of the briefing of the parties is on the proper interpretation and application of RCW 70.41.200, although there is also some discussion of RCW 4.24.250, which predates RCW 70.41.200. This

brief focuses on the interpretation and application of RCW 70.41.200 in the abstract, while referring to the facts and circumstances of this case when necessary to provide context. It also comments on RCW 4.24.250, and whether the analysis under this statute is any different than the analysis under RCW 70.41.200.

These privilege issues mainly arise in connection with Fellows' corporate negligence claim. Under the doctrine of corporate negligence, direct liability may be imposed on a hospital when it fails to exercise reasonable care in the granting or renewal of staff privileges, or in monitoring and reviewing the competency of health care providers practicing at the hospital. See Pedroza v. Bryant, 101 Wn.2d 226, 229-33, 677 P.2d 166 (1984) (expressly adopting doctrine in staff privileges context); see also WPI 105.02.02 (stating elements of corporate negligence claim).⁴ Given the nature of a corporate negligence claim against a hospital, the discovery of evidence bearing on staff credentials and the grant or renewal of staff privileges is vitally important to plaintiffs pursuing such claims. See Anderson v. Breda, 103 Wn.2d 901, 903-05, 700 P.2d 737 (1985).

A. Overview Of The Immunities From Discovery Provided To Hospitals Under RCW 4.24.250 And 70.41.200, And The Rules Of Construction Governing These Statutes.

⁴ The current version of WPI 105.02.02 and comments are reproduced in the Appendix.

RCW 4.24.250 was first enacted in 1971 to encourage hospitals to engage in careful self-assessment. See Laws of 1971, ch. 144 § 1; Coburn v. Seda, 101 Wn.2d 270, 274-75, 677 P.2d 173 (1984) (summarizing rationale). Subsection (1) of the current version of the statute provides:

The proceedings, reports, and written records of [a regularly constituted review committee or board of a professional society or hospital whose duty it is to evaluate the competency and qualifications of members of the profession, including limiting the extent of practice of such person in a hospital or similar institution, or before a regularly constituted committee or board of a hospital whose duty it is to review and evaluate the quality of patient care], or of a member, employee, staff person, or investigator of such a committee or board, are not subject to review or disclosure, or subpoena or discovery proceedings in any civil action, except actions arising out of the recommendations of such committees or boards involving the restriction or revocation of the clinical or staff privileges of a health care provider as defined in RCW 7.70.020(1) and (2).

The statute confers immunity from discovery on certain records and proceedings of regularly constituted hospital quality review committees, for hospitals having such committees. See Coburn, 101 Wn.2d at 273-75.⁵

RCW 4.24.250 represents a legislative choice between competing public concerns:

The Legislature recognized that external access to committee investigations stifles candor and inhibits constructive criticism thought necessary to effective quality review. The immunity from discovery of committee review embraces this goal of medical staff candor in apprising their peers to improve the quality of in-hospital medical practice at the

⁵ In Coburn, interpreting a prior version of RCW 4.24.250, the Court distinguished an immunity from discovery, such as attorney work product, and an evidentiary privilege, such as the attorney-client privilege, and stated "it is not clear that the statute grants a full evidentiary privilege." 101 Wn.2d at 275.

costs of impairing malpractice plaintiffs access to evidence revealing the competency of a hospital's staff.

Anderson, 103 Wn.2d at 905. However, because the immunity from discovery afforded by RCW 4.24.250 was nonexistent at common law, and because it is in sharp contrast to the general policy favoring broad discovery, the statute is strictly construed and limited to its purposes. See Coburn at 276 & 278; Anderson at 905; Adcox v. Children's Orthopedic Hosp. & Med. Ctr., 123 Wn.2d 15, 31, 864 P.2d 921 (1993).

The burden of establishing immunity from discovery under RCW 4.24.250 rests upon the party resisting disclosure. See Anderson at 905; Adcox, 123 Wn.2d at 31. The immunity is limited to hospital review committees "whose duty it is to evaluate the competency and qualifications of members of the profession ... or ... to review and evaluate the quality of patient care." RCW 4.24.250(1). The immunity does not apply in the absence of proof that the hospital review committee in question is "regularly constituted." RCW 4.24.250(1); see also Coburn at 277 (remanding for factual determination); Adcox at 31-32 (finding statute inapplicable based on failure of proof). The immunity also does not apply to files of hospital administration. See Anderson at 906-08. Given the proper strict construction, the statute cannot be used as a shield to prevent discovery of material generated outside of review committees, so

as to immunize information otherwise available from original sources. See Coburn at 277 & n.3; Anderson at 906-07.

While the hospital review committee contemplated by RCW 4.24.250 is optional, with the adoption of RCW 70.41.200 in 1986 the Legislature required each hospital to maintain a quality improvement and medical malpractice prevention program, including the establishment of a quality improvement committee (or QIC). See Laws of 1986, ch. 300 § 4; see also Adcox at 29-30 (noting adoption and prospective operation of RCW 70.41.200). Among other things, the program involves periodic review of the privileges, credentials, physical and mental capacity, and competence of physicians associated with the hospital. See RCW 70.41.200(1)(b)-(c). A QIC oversees and coordinates the program. See RCW 70.41.200(1)(a).⁶

RCW 70.41.200(3) also contains a provision conferring immunity from discovery in civil cases for “[i]nformation and documents, including complaints and incident reports, created specifically for, and collected and maintained by, a quality improvement committee[.]” This immunity

⁶ RCW 4.24.250 uses the phrase “review committee,” which Anderson at 907 describes as a “peer review committee,” whereas RCW 70.41.200 uses the phrase “quality improvement committee,” abbreviated herein as “QIC.” While these phrases are not the same because, for example, RCW 4.24.250 would include review committees of a professional society, in the hospital context they appear to be essentially similar, and they are viewed as interchangeable for purposes of this brief. It is evident from the briefing that the parties deem the Hospital’s quality improvement committee under RCW 70.41.200 to be a review committee under RCW 4.24.250.

provision is subject to five enumerated exceptions, including: “in any civil action, disclosure of the fact that staff privileges were terminated or restricted, including the specific restrictions imposed, if any[,] and the reasons for the restrictions[.]” RCW 70.41.200(3)(d).⁷

RCW 70.41.200 has not been addressed by this Court to date. However, the discovery immunity in subsection (3) is no less in derogation of the common law and contrary to the policy favoring broad discovery than RCW 4.24.250. Accordingly, RCW 70.41.200(3) should be subject to the same rule of strict construction. See Lowy v. Peacehealth, 159 Wn.App. 715, 720-21, 247 P.3d 7 (applying strict construction to RCW 70.41.200(3), describing RCW 4.24.250 as “a similar statute,” and relying on Coburn, supra), *review granted*, 171 Wn.2d 1027 (2011).

The enumerated exceptions, including subsection (3)(d), should receive a correspondingly broad and liberal construction. See State v. Kane, 101 Wn. App. 607, 612, 5 P.3d 741 (2000) (stating, where statute is strictly construed as being in derogation of the common law, exception to statute is interpreted broadly). This approach is not only consistent with the Court’s jurisprudence regarding RCW 4.24.250, it is also consistent with the strict construction of privileges in general. See generally 5A Karl

⁷ The same immunity and exceptions are codified at RCW 70.41.230(5). The full text of the current version of RCW 70.41.230 is reproduced in the Appendix to this brief.

B. Tegland, Wash. Prac., Evidence Law & Practice § 501.3 (5th ed. 2011) (noting general rule and collecting cases).

The burden of proving that material is immune from discovery under RCW 70.41.200(3) and that no exceptions apply should also be placed on the party resisting discovery. This is consistent with the placement of the burden of proof under RCW 4.24.250. See Anderson at 905; Adcox at 31. It is also consistent with the placement of the burden of proof regarding other types of privileges, and for establishing good cause for a protective order limiting discovery.⁸

The proper interpretation and application of RCW 70.41.200 goes to the heart of this case, and the parties' disagreements regarding its meaning and effect are addressed below.

B. Original Source-Type Documents Regarding Health Care Provider Credentials And Staff Privileges Are Not Immune From Discovery Under RCW 70.41.200 (or RCW 4.24.250).

There seems to be a dispute between the parties regarding whether all of the records requested in discovery in this case are collected and maintained by the QIC. However this essentially factual dispute is

⁸ See e.g. Soter v. Cowles Pub. Co., 162 Wn. 2d 716, 745, 174 P.3d 60 (2007) (stating “[t]he party asserting attorney-client privilege has the burden of showing the attorney-client relationship existed and that relevant materials contain privileged communications”); Dreiling v. Jain, 151 Wn. 2d 900, 916, 93 P.3d 861 (2004) (adopting Ninth Circuit precedent that “a party asserting good cause bears the burden, for each particular document it seeks to protect, of showing that specific prejudice or harm will result if no protective order is granted”).

resolved, the holdings of Coburn and Anderson that original source-type documents are not immune from discovery under RCW 4.24.250 should carry forward and apply with equal, if not greater, force under RCW 70.41.200. The language of RCW 70.41.200(3), referring to “[i]nformation and documents ... *created specifically for, and collected and maintained by, a quality improvement committee[.]*” emphasizes that information and documents collected and maintained outside of the QIC are subject to disclosure. (Emphasis added) It further emphasizes that, even when collected and maintained by the QIC, information and documents not created specifically for the QIC are subject to disclosure. In this way, RCW 70.41.200(3) is in harmony with the holdings of Coburn and Anderson that information generated by or available from original sources within the hospital is not shielded from discovery. The burden should be on the health care providers to demonstrate that all records withheld from discovery are collected and maintained by, and created specifically for, the QIC.

C. Under RCW 70.41.200 (And RCW 4.24.250), Information And Documents Related To The Initial Grant Of Privileges Are Not Immune From Discovery.

The Hospital and physicians argue that *all* credentialing records are privileged, including those surrounding the initial grant of staff privileges to a physician. See Joint SWMC et al. Br. at 15-17. On the

other hand, Fellows contends that information and documents surrounding the initial award of staff privileges cannot be privileged under the statute. See id. at 14-15. Based on the language and purpose of RCW 70.41.200 (and RCW 4.24.250), records relating to the initial grant of privileges are not immune from discovery.

Pursuant to RCW 70.41.200(1)(c), a QIC conducts “*periodic review* of the credentials, physical and mental capacity, and competence in delivering health care services of all persons who are employed or associated with the hospital.” (Emphasis added); accord RCW 70.41.200(1)(b) (providing for “[a] medical staff sanctions procedure through which the credentials, physical and mental capacity, and competence in delivering health care services are *periodically reviewed* as part of an evaluation of staff privileges”; emphasis added). Strictly construed, the phrase “periodic review” contemplates an existing and ongoing relationship between a hospital and the health care provider.⁹

A hospital’s assessment of a health care provider when staff privileges are initially granted falls outside of periodic review. It occurs before the relationship is entered and formalized. Nor can it be argued, even if the hospital has specifically empowered its QIC to make the initial

⁹ See Merriam-Webster Online, s.v. “periodic” (defining word as “occurring or recurring at regular intervals” and “occurring repeatedly from time to time”; available at www.m-w.com).

decision to grant privileges, that this decision-making process is privileged because the QIC's responsibility is "to review the *services rendered* in the hospital, both retrospectively and prospectively, in order to improve the quality of medical care and to prevent medical malpractice." RCW 70.41.200(1)(a) (emphasis added). When privileges are first granted, no services have been rendered by the particular health care provider.

The language of RCW 70.41.200(1)(a) referring to retrospective and prospective review does not bring the initial grant of privileges within the periodic review of such privileges by the QIC. The "retrospectively and prospectively" language distinguishes RCW 70.41.200 from RCW 4.24.250. Given the complaint-driven focus of RCW 4.24.250, this Court held in Coburn and reiterated in Anderson that the discovery immunity conferred by that statute does not apply to materials relating at least in part to current patient care—i.e., prospective review—as opposed to retrospective review of a health care provider's conduct in a particular case.¹⁰ The initial grant of privileges to a health care provider does not seem to fit within either of the retrospective or prospective categories as delineated by the Court in Coburn and Anderson. Nonetheless, because the

¹⁰ See Coburn at 278 (citing Davidson v. Light, 79 F.R.D. 137 (D. Colo. 1978), which compelled production of "Infection Control Report" related in part to current patient care, distinguishing retrospective review of the effectiveness of certain medical procedures); accord Anderson at 906 (stating "[w]hether the activity is concerned with retrospective review or current care is an additional consideration").

initial grant of privileges does not involve the response to a complaint of incompetence or misconduct, it would not be encompassed within RCW 4.24.250(1) any more than a review of current patient care.

Under RCW 70.41.200(1), the focus is both retrospective and prospective, and the health care providers argue that the initial grant of privileges is encompassed within the prospective review of services rendered. See Joint SWMC et al. Br. at 15-17. However, the purpose of RCW 70.41.200(3) would not be served by conferring immunity on records regarding the initial grant of privileges. As noted above, the scope of immunity should be limited by the purpose of the statute. See supra § A; cf. Coburn at 276 & 278 (applying this rule of construction to RCW 4.24.250(1)); Anderson at 905 (same). Like RCW 4.24.250(1), the evident purpose of RCW 70.41.200(3) is to encourage hospitals to engage in careful self-assessment. Disclosure of QIC materials regarding periodic review of a health care provider's privileges would potentially discourage candor by participants in the assessment process, because of concern about the existing relationship with a health care provider or the potential for tort liability. However, with respect to the initial grant of privileges, there is no relationship and every reason for candor to avoid the tort liability that flows from granting privileges to an incompetent physician. Confining the

discovery immunity under RCW 70.41.200(3) to its purpose, records regarding the initial grant of privileges should be discoverable.¹¹

D. The Exception In RCW 70.41.200(3)(d), Allowing Discovery Of The Fact That A Physician's Staff Privileges Were Restricted And The Reasons For The Restrictions, Should At Least Include Discovery Of Statutorily Required "Written Records Of Decisions To Restrict ... Privileges," If Not The Underlying Records From Which The Reasons For The Restrictions Were Derived.

The Hospital and health care providers argue that disclosure of the reasons for restrictions on a health care provider's hospital privileges under RCW 70.41.200(3)(d) is limited to answers to deposition questions or interrogatory answers, and does not extend to the records documenting the QIC's reasons for terminating or restricting staff privileges. See Joint SWMC et al. Br. at 2-3 & 19-21. Fellows counters that disclosure of such reasons should entail disclosure of all records related to the reasons.

The language of RCW 70.41.200(3)(d)—providing for “disclosure of the fact that staff privileges were terminated or restricted, including the

¹¹ The fact that the QIC discovery immunity and its exceptions are also restated in RCW 70.41.230(5) does not change the analysis. RCW 70.41.230(1) describes the steps “a hospital or facility” must take “[p]rior to granting or renewing” staff privileges, and subsection (2) describes additional steps the “hospital or facility” must take “[p]rior to granting privileges[.]” While a QIC has statutory authority to oversee and coordinate the “periodic review” of staff privileges, it does not have similar statutory authority over the initial grant of privileges. See RCW 70.41.200(1)(a)-(c) & (f). In this sense, information and documents related to the initial grant of privileges is not “created specifically for” a QIC, as required for discovery immunity under RCW 70.41.200(3) or .230(5). While the hospital could conceivably delegate to a QIC the responsibility to make decisions regarding the initial grant of privileges, RCW 70.41.230, and in particular subsection (5), do not expand upon QIC authority or the discovery immunity.

specific restrictions imposed, if any[,] and the reasons for the restrictions”—seems to be drawn from the analysis of RCW 4.24.250 in Anderson, where the Court stated:

Although the extent of a physician’s hospital privileges may be determined by what occurs within a quality review committee, the fact that a physician’s privileges were restricted, suspended or revoked is not properly subject to the protections of the statute. The goal and fundamental purpose of the statute is open discussion during committee investigations. *Open discussion is not inhibited by permitting discovery of the effect of the committee proceedings.* The purpose of this statute is to keep peer review studies, discussions, and deliberations confidential. A facial examination of the statute reveals that it is not designed to obstruct discovery as to whether a physician’s privileges had been revoked or suspended.

103 Wn.2d at 907 (emphasis added).

RCW 70.41.200(3)(d) goes farther than Anderson did in interpreting RCW 4.24.250, in also stating that the “reasons for the restrictions” fall outside of the privilege. This language appears to have been added to RCW 70.41.200(3)(d) in recognition of the fact that the QIC is simultaneously charged with responsibility of overseeing and coordinating the collection and maintenance of records, as well as conducting sanction proceedings resulting in termination or restriction of health care provider privileges. See RCW 70.41.200(1)(a), (b) & (f). In light of the QIC’s dual functions, the Legislature is unwilling to allow the reasons for the adverse action to be placed beyond the reach of the discovery rules. Instead, the Legislature requires a QIC to share the

reasons for its actions, reflecting a careful balance between preserving the confidentiality of discussions and deliberations of the QIC, and disclosure under the civil discovery rules of the reasons for its actions to a patient alleging tortious conduct by the hospital or health care provider.

Under a proper liberal construction, the statutory language referring to “reasons for the restrictions” should be deemed to include, at a minimum, the records memorializing the QIC’s reasons. It would not make sense to acknowledge that a QIC must disclose the reasons for restrictions on a health care provider’s hospital privileges, while simultaneously designating the records relating to the reasons for the restrictions as immune from discovery. See Yakima First Baptist Homes, Inc. v. Gray, 82 Wn.2d 295, 303, 510 P.2d 243, 248 (1973) (stating “[w]here a common-sense construction of the statute is at hand, it is not the function of this court to reach an extreme and unrealistic conclusion in statutory interpretation”).

A hospital is required by statute to “keep written records of decisions to restrict or terminate privileges of practitioners,” which must be reported to the appropriate authority. See RCW 70.41.220¹²; accord RCW 70.41.230(4) (requiring hospital to provide “the reasons for suspension, termination or curtailment of employment or privileges” to

¹² The current version of RCW 70.41.220 is reproduced in the Appendix.

other hospitals or facilities requesting it). These written records would presumably emanate from the QIC when it decides to restrict privileges. Answers to deposition questions or interrogatories about the reasons embodied in these records are not the best evidence of the reasons for restrictions on a health care provider's hospital privileges. See CR 26(b)(1) (providing for discovery of information that is reasonably calculated to lead to the discovery of admissible evidence); ER 1102 (requiring original writing to prove the contents thereof). If the written records of the decision were immune from discovery, then a hospital would become the sole arbiter of how the reasons for the restrictions are characterized.

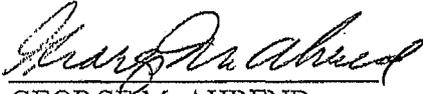
Furthermore, the Court should also permit discovery of the documentation from which the written records of the decision are derived. The text of RCW 70.41.200(3)(d) is not limited to *written* reasons. Under a proper liberal construction, it should be deemed to include *all* documentation supporting the restrictions imposed.

Disclosure of the reasons for restrictions on staff privileges should include the written records of the decision and the underlying documentation.

VI. CONCLUSION

This Court should adopt the arguments advanced in this brief in resolving the issues on review accordingly.

DATED this 16th day of April, 2012.


GEORGE M. AHREND


BRYAN P. HARNETIAUX,
WITH AUTHORITY

On behalf of WSAJ Foundation

Appendix

Gallinat was born at SWMC on September 17, 1996. A vaginal delivery was first attempted by Daniel Moynihan, M.D., a family practitioner. After Dr. Moynihan made a number of attempts to deliver Gallinat using a vacuum extractor, Jane Ahearn, M.D., was summoned to SWMC to deliver Gallinat by emergency Caesarian section. Kathleen Hutchinson, M.D., a pediatrician, cared for Gallinat after his delivery. Gallinat suffers from kidney damage which his doctors attribute to hemorrhage and apoxia that Gallinat suffered during and following his delivery.

SWMC had granted Dr. Moynihan staff privileges as a family medicine practitioner in 1993. In 1997, as a result of the Gallinat case and of another obstetrics case, the Executive Committee of SWMC withdrew Dr. Moynihan's vaginal delivery privileges pending his taking additional training and pending having his deliveries proctored by another physician. Dr. Moynihan elected not to seek renewal of his delivery privileges.

In 2009, Gallinat sued Dr. Moynihan, Dr. Hutchinson and SWMC, alleging medical negligence. He also alleged that SWMC was negligent in its selection and supervision of medical personnel. As part of discovery, Gallinat requested from SWMC "the complete credentialing files" for Drs. Moynihan, Hutchinson and Ahearn. Mot. for Disc. Rev., Appendix at 45. SWMC objected, stating that "the documents sought are protected by the peer review privilege afforded under RCW 4.24.250 and RCW 70.41.200." Mot. for Disc. Rev., Appendix at 45. Gallinat then moved to compel disclosure of the files, challenging whether the

files fell within the protection of RCW 4.24.250 or RCW 70.41.200. The trial court concluded that the files "are privileged as described in RCW 70.41.200 and RCW 70.41.230." Mot. for Disc. Rev., Appendix at 2. It denied the motion to compel and ordered SWMC to "file a certification that all of the credentialing and privileging materials sought are covered by the privilege, or by the attorney-client privilege or work-product doctrine." Mot. for Disc. Rev., Appendix at 2. SWMC's counsel then filed a declaration stating:

I received the credentialing files for [Drs. Moynihan, Hutchinson and Ahearn] from Southwest Washington Medical Center and these files have been reviewed and analyzed. . . . I certify that the information and documents contained in the credentialing files are protected by the quality assurance and quality improvement statutes and the work-product doctrine.

Mot. for Disc. Rev., Appendix at 100-01.

Gallinat's subsequent motion for reconsideration was denied. Gallinat then moved to have the trial court engage in an *in camera* review of the files to determine whether they fell within the protection of RCW 70.41.200. The trial court denied that motion, ruling that "SWMC's counsel will file within two weeks a certification that the files were reviewed and that any documents under the exceptions of RCW 70.41.200(3) and (5) were produced or do not exist." Mot. for Disc. Rev., Appendix at 6. The court also ruled that it:

accept[ed] SWMC's counsel's representation that SWMC had a regularly constituted review committee in 1996 or 1997 when OB Cases 1 and 2 were reviewed, but records or evidence which show the formation and existence of the committee are not privileged and should be produced.

Mot. for Disc. Rev., Appendix at 9-10.

Gallinat seeks discretionary review of the trial court's orders. This court grants discretionary review only when:

- (1) The superior court has committed an obvious error which would render further proceedings useless;
- (2) The superior court has committed probable error and the decision of the superior court substantially alters the status quo or substantially limits the freedom of a party to act;
- (3) The superior court has so far departed from the accepted and usual course of judicial proceedings, or so far sanctioned such a departure by an inferior court or administrative agency, as to call for review by the appellate court; or
- (4) The superior court has certified, or that all parties to the litigation have stipulated, that the order involves a controlling question of law as to which there is substantial ground for a difference of opinion and that immediate review of the order may materially advance the ultimate termination of the litigation.

RAP 2.3(b).

First, Gallinat argues that the trial court committed obvious error, or so far departed from the accepted and usual course of judicial proceedings as to call for review by this court, when it ruled that the credentialing files fell within the privilege contained in RCW 70.41.200(3) based on SWMC's counsel's certification that the files fell within the privilege. It contends that the trial court had a duty, under ER 104(a)¹ to determine for itself whether the files fell within the privilege.

¹"Preliminary questions concerning the qualification of a person to be a witness, the existence of a privilege, or the admissibility of evidence shall be determined by the court" ER 104(a).

As a hospital licensed in Washington, RCW 70.41.200(1)(a) requires SWMC to have a "quality improvement committee." RCW 70.41.200(3) provides in pertinent part that:

Information and documents, including complaints and incident reports, created specifically for, and collected and maintained by, a quality improvement committee are not subject to review or disclosure, except as provided in this section, or discovery or introduction into evidence in any civil action, and no person who was in attendance at a meeting of such committee or who participated in the creation, collection, or maintenance of information or documents specifically for the committee shall be permitted or required to testify in any civil action as to the content of such proceedings or the documents and information prepared specifically for the committee.²

Statutes that create privileges such as that contained in RCW 70.41.200(3) are in derogation of the common law and the policy favoring discovery and so must be construed strictly. *Adcox v. Children's Orthopedic Hosp.*, 123 Wn.2d 15, 81, 864 P.2d 921 (1991); *Anderson v. Breda*, 103 Wn.2d 901, 905, 700 P.2d 737 (1985); *Goburn v. Seda*, 101 Wn.2d 270, 276, 677 P.2d 173 (1984) (all interpreting RCW 4.24.250, which creates a similar privilege against discovery of hospital peer review committees). Each of these decisions discussed what a hospital needed to present in order to gain the protection of the privilege. In remanding to the trial court to determine whether Kadlec Hospital had "a regularly constituted committee . . . whose duty it is to review and evaluate the quality of patient care," as required to fall within the privilege granted in RCW 4.24.250, the *Goburn* court stated:

² RCW 70.41.230(5) contains the same privilege against discovery.

the trial court may wish to consider, in addition to other relevant evidence, the guidelines and standards of the Joint Commission on Accreditation of Hospitals and the bylaws and internal regulations of Kadlec Hospital. These materials may aid the trial court in ascertaining the organization and function of the committee as well as whether it is "regularly constituted."

101 Wn.2d at 278. See also *Anderson*, 103 Wn.2d at 905-06. And in holding that Children's Hospital had not shown that RCW 4.24.250 privileged the records sought by the plaintiffs, the *Adcox* court noted that "[t]he Hospital never presented any of its bylaws or internal regulations; never referred to the standards and guidelines of relevant accreditation bodies; and never even identified the committee members or the procedures involved in reviewing hospital care in 1984." *Adcox*, 123 Wn.2d at 31-32.

In this case, the trial court concluded that the files sought by Gallinat fell within the privilege provided by RCW 70.41.200(3). In order for that privilege to apply, SWMC must demonstrate that those files had been created for a "quality improvement committee," RCW 70.41.200(3). In determining that SWMC had such a committee, the trial court "accept[ed] SWMC's counsel's representation that SWMC had a regularly constituted review committee in 1996 or 1997 when OB Cases 1 and 2 were reviewed." Mot. for Disc. Rev., Appendix at 9-10. While this court has no reason to disbelieve SWMC's counsel's representation, that representation does not appear to meet the evidentiary standard set forth in *Coburn*, *Anderson* and *Adcox*, because she had no personal knowledge about whether SWMC had a quality improvement committee in 1996 or 1997. As such,

the trial court appears to have committed obvious error in accepting that representation in reaching its conclusion that RCW 70.41.200(3) applied.

However, that conclusion does not end this court's inquiry. Gallinat must also show that further proceedings are useless. And further proceedings, namely Gallinat's Motion to Enforce Court Orders and for CR 37 Evidentiary Hearing, have resulted in SWMC submitting evidence, in the form of a Declaration of Cindy Eling, that SWMC had a quality improvement committee in 1996 and 1997. Thus, SWMC now seems to have met the evidentiary standard set forth in *Coburn, Anderson and Adcox*, such that the trial court's ruling no longer rests solely on SWMC's counsel's representation. Gallinat has not shown that discretionary review is appropriate under RAP 2.3(b)(1). Nor has he shown that the trial court's ruling is the result of a departure from the accepted and usual course of judicial proceedings as to call for review by this court, so he has not shown that discretionary review is appropriate under RAP 2.3(b)(3).

Gallinat also argues that the trial court committed obvious error, or so far departed from the accepted and usual course of judicial proceedings as to call for review by this court, when it denied his motion to compel without having first reviewed SWMC's credentialing files *in camera*. He contends that because RCW 70.41.200(3) only privileges "[i]nformation and documents, including complaints and incident reports, created specifically for, and collected and maintained by, a quality improvement committee," the only way a trial court can determine whether documents fall within that definition is to review them *in camera*. *Barry v. USAA*,

98 Wn. App. 199, 208, 989 P.2d 1172 (1999) (citing *Limstrom v. Ladenburg*, 136 Wn.2d 595, 615, 963 P.2d 869 (1998)).³

Neither *Barry* nor *Limstrom* creates the right to *in camera* review that Gallinat contends they do. Both involve claims that particular documents, within an otherwise discoverable file, should be privileged from discovery because they contain attorney work product. Because the files requested potentially contained both privileged and non-privileged documents, the appellate court remanded to the trial court for an *in camera* review to determine which documents were privileged and which were not. In this case, the SWMC credentialing files could contain exclusively "[i]nformation and documents, including complaints and incident reports, created specifically for, and collected and maintained by, a quality improvement committee," such that RCW 70.41.200(3) would privilege the entire file and *in camera* review would not be required. Under Gallinat's theory, the trial court would be obliged to conduct an *in camera* review in every case where a facility or provider invoked a peer review or quality improvement privilege against disclosure. Washington case law does not support such a blanket obligation. Gallinat has not established that the trial court's denial of his motion for *in camera* review was either obvious error or a departure from the

³ Gallinat's reliance on *Burnet v. Spokane Ambulance*, 131 Wn.2d 484, 497-98, 933 P.2d 1036 (1997), is misplaced because it addressed limitations on discovery of credentialing records imposed as a sanction for violation of a discovery order, not imposed by RCW 70.41.200(3) or other similar privileging statutes.

accepted and usual course of judicial proceedings and so does not show that discretionary review is appropriate under RAP 2.3(b)(1) or (3).

Gallinat has not shown that discretionary review is appropriate. Accordingly, it is hereby

ORDERED that Gallinat's motion for discretionary review is denied.

DATED this 30th day of August, 2010.

Eric B. Schmidt
Eric B. Schmidt
Court Commissioner

cc: John Budlong
Donald L. Webbrock
John C. Gräffe, Jr.
Dana Shenker-Scheele
Mary H. Spillane
Amy T. Forbis
Blair Russ
Hon. Robert Lewis

RCW 4.24.250. Health care provider filing charges or presenting evidence--Immunity--Information sharing

(1) Any health care provider as defined in RCW 7.70.020(1) and (2) who, in good faith, files charges or presents evidence against another member of their profession based on the claimed incompetency or gross misconduct of such person before a regularly constituted review committee or board of a professional society or hospital whose duty it is to evaluate the competency and qualifications of members of the profession, including limiting the extent of practice of such person in a hospital or similar institution, or before a regularly constituted committee or board of a hospital whose duty it is to review and evaluate the quality of patient care and any person or entity who, in good faith, shares any information or documents with one or more other committees, boards, or programs under subsection (2) of this section, shall be immune from civil action for damages arising out of such activities. For the purposes of this section, sharing information is presumed to be in good faith. However, the presumption may be rebutted upon a showing of clear, cogent, and convincing evidence that the information shared was knowingly false or deliberately misleading. The proceedings, reports, and written records of such committees or boards, or of a member, employee, staff person, or investigator of such a committee or board, are not subject to review or disclosure, or subpoena or discovery proceedings in any civil action, except actions arising out of the recommendations of such committees or boards involving the restriction or revocation of the clinical or staff privileges of a health care provider as defined in RCW 7.70.020(1) and (2).

(2) A coordinated quality improvement program maintained in accordance with RCW 43.70.510 or 70.41.200, a quality assurance committee maintained in accordance with RCW 18.20.390 or 74.42.640, or any committee or board under subsection (1) of this section may share information and documents, including complaints and incident reports, created specifically for, and collected and maintained by, a coordinated quality improvement committee or committees or boards under subsection (1) of this section, with one or more other coordinated quality improvement programs or committees or boards under subsection (1) of this section for the improvement of the quality of health care services rendered to patients and the identification and prevention of medical malpractice. The privacy protections of chapter 70.02 RCW and the federal health insurance portability and accountability act of 1996 and its implementing regulations apply to the sharing of individually identifiable

patient information held by a coordinated quality improvement program. Any rules necessary to implement this section shall meet the requirements of applicable federal and state privacy laws. Information and documents disclosed by one coordinated quality improvement program or committee or board under subsection (1) of this section to another coordinated quality improvement program or committee or board under subsection (1) of this section and any information and documents created or maintained as a result of the sharing of information and documents shall not be subject to the discovery process and confidentiality shall be respected as required by subsection (1) of this section and by RCW 43.70.510(4), 70.41.200(3), 18.20.390(6) and (8), and 74.42.640(7) and (9).

[2005 c 291 § 1, eff. July 24, 2005; 2005 c 33 § 5, eff. July 24, 2005; 2004 c 145 § 1, eff. June 10, 2004; 1981 c 181 § 1; 1979 c 17 § 1; 1977 c 68 § 1; 1975 1st ex.s. c 114 § 2; 1971 ex.s. c 144 § 1.]

RCW 70.41.200. Quality improvement and medical malpractice prevention program--Quality improvement committee--Sanction and grievance procedures--Information collection, reporting, and sharing

(1) Every hospital shall maintain a coordinated quality improvement program for the improvement of the quality of health care services rendered to patients and the identification and prevention of medical malpractice. The program shall include at least the following:

(a) The establishment of a quality improvement committee with the responsibility to review the services rendered in the hospital, both retrospectively and prospectively, in order to improve the quality of medical care of patients and to prevent medical malpractice. The committee shall oversee and coordinate the quality improvement and medical malpractice prevention program and shall ensure that information gathered pursuant to the program is used to review and to revise hospital policies and procedures;

(b) A medical staff privileges sanction procedure through which credentials, physical and mental capacity, and competence in delivering health care services are periodically reviewed as part of an evaluation of staff privileges;

(c) The periodic review of the credentials, physical and mental capacity, and competence in delivering health care services of all persons who are employed or associated with the hospital;

(d) A procedure for the prompt resolution of grievances by patients or their representatives related to accidents, injuries, treatment, and other events that may result in claims of medical malpractice;

(e) The maintenance and continuous collection of information concerning the hospital's experience with negative health care outcomes and incidents injurious to patients including health care-associated infections as defined in RCW 43.70.056, patient grievances, professional liability premiums, settlements, awards, costs incurred by the hospital for patient injury prevention, and safety improvement activities;

(f) The maintenance of relevant and appropriate information gathered pursuant to (a) through (e) of this subsection concerning individual physicians within the physician's personnel or credential file maintained by the hospital;

(g) Education programs dealing with quality improvement, patient safety, medication errors, injury prevention, infection control, staff responsibility to report professional misconduct, the legal aspects of patient care, improved communication with patients, and causes of malpractice claims for staff personnel engaged in patient care activities; and

(h) Policies to ensure compliance with the reporting requirements of this section.

(2) Any person who, in substantial good faith, provides information to further the purposes of the quality improvement and medical malpractice prevention program or who, in substantial good faith, participates on the quality improvement committee shall not be subject to an action for civil damages or other relief as a result of such activity. Any person or entity participating in a coordinated quality improvement program that, in substantial good faith, shares information or documents with one or more other programs, committees, or boards under subsection (8) of this section is not subject to an action for civil damages or other relief as a result of the activity. For the purposes of this section, sharing information is presumed to be in substantial good faith. However, the presumption may be rebutted upon a showing of clear, cogent, and convincing evidence that the information shared was knowingly false or deliberately misleading.

(3) Information and documents, including complaints and incident reports, created specifically for, and collected and maintained by, a quality improvement committee are not subject to review or disclosure, except as provided in this section, or discovery or introduction into evidence in any civil action, and no person who was in attendance at a meeting of such committee or who participated in the creation, collection, or maintenance of information or documents specifically for the committee shall be permitted or required to testify in any civil action as to the content of such proceedings or the documents and information prepared specifically for the committee. This subsection does not preclude: (a) In any civil action, the discovery of the identity of persons involved in the medical care that is the basis of the civil action whose involvement was independent of any quality improvement activity; (b) in any civil action, the testimony of any person concerning the facts which form the basis for the institution of such proceedings of which the person had personal knowledge acquired independently of such proceedings; (c) in any civil action by a health care provider regarding the restriction or revocation of that individual's clinical or staff privileges, introduction into evidence information collected and maintained by quality improvement committees regarding such health care

provider; (d) in any civil action, disclosure of the fact that staff privileges were terminated or restricted, including the specific restrictions imposed, if any and the reasons for the restrictions; or (e) in any civil action, discovery and introduction into evidence of the patient's medical records required by regulation of the department of health to be made regarding the care and treatment received.

(4) Each quality improvement committee shall, on at least a semiannual basis, report to the governing board of the hospital in which the committee is located. The report shall review the quality improvement activities conducted by the committee, and any actions taken as a result of those activities.

(5) The department of health shall adopt such rules as are deemed appropriate to effectuate the purposes of this section.

(6) The medical quality assurance commission or the board of osteopathic medicine and surgery, as appropriate, may review and audit the records of committee decisions in which a physician's privileges are terminated or restricted. Each hospital shall produce and make accessible to the commission or board the appropriate records and otherwise facilitate the review and audit. Information so gained shall not be subject to the discovery process and confidentiality shall be respected as required by subsection (3) of this section. Failure of a hospital to comply with this subsection is punishable by a civil penalty not to exceed two hundred fifty dollars.

(7) The department, the joint commission on accreditation of health care organizations, and any other accrediting organization may review and audit the records of a quality improvement committee or peer review committee in connection with their inspection and review of hospitals. Information so obtained shall not be subject to the discovery process, and confidentiality shall be respected as required by subsection (3) of this section. Each hospital shall produce and make accessible to the department the appropriate records and otherwise facilitate the review and audit.

(8) A coordinated quality improvement program may share information and documents, including complaints and incident reports, created specifically for, and collected and maintained by, a quality improvement committee or a peer review committee under RCW 4.24.250 with one or more other coordinated quality improvement programs maintained in

accordance with this section or RCW 43.70.510, a coordinated quality improvement committee maintained by an ambulatory surgical facility under RCW 70.230.070, a quality assurance committee maintained in accordance with RCW 18.20.390 or 74.42.640, or a peer review committee under RCW 4.24.250, for the improvement of the quality of health care services rendered to patients and the identification and prevention of medical malpractice. The privacy protections of chapter 70.02 RCW and the federal health insurance portability and accountability act of 1996 and its implementing regulations apply to the sharing of individually identifiable patient information held by a coordinated quality improvement program. Any rules necessary to implement this section shall meet the requirements of applicable federal and state privacy laws. Information and documents disclosed by one coordinated quality improvement program to another coordinated quality improvement program or a peer review committee under RCW 4.24.250 and any information and documents created or maintained as a result of the sharing of information and documents shall not be subject to the discovery process and confidentiality shall be respected as required by subsection (3) of this section, RCW 18.20.390 (6) and (8), 74.42.640 (7) and (9), and 4.24.250.

(9) A hospital that operates a nursing home as defined in RCW 18.51.010 may conduct quality improvement activities for both the hospital and the nursing home through a quality improvement committee under this section, and such activities shall be subject to the provisions of subsections (2) through (8) of this section.

(10) Violation of this section shall not be considered negligence per se.

[2007 c 273 § 22, eff. July 1, 2009; 2007 c 261 § 3, eff. July 22, 2007. Prior: 2005 c 291 § 3, eff. July 24, 2005; 2005 c 33 § 7, eff. July 24, 2005; 2004 c 145 § 3, eff. June 10, 2004; 2000 c 6 § 3; 1994 sp.s. c 9 § 742; 1993 c 492 § 415; 1991 c 3 § 336; 1987 c 269 § 5; 1986 c 300 § 4.]

RCW 70.41.220. Duty to keep records of restrictions on practitioners' privileges--Penalty

Each hospital shall keep written records of decisions to restrict or terminate privileges of practitioners. Copies of such records shall be made available to the board within thirty days of a request and all information so gained shall remain confidential in accordance with RCW 70.41.200 and 70.41.230 and shall be protected from the discovery process. Failure of a hospital to comply with this section is punishable by [a] civil penalty not to exceed two hundred fifty dollars.

[1986 c 300 § 8.]

RCW 70.41.230. Duty of hospital to request information on physicians granted privileges

(1) Prior to granting or renewing clinical privileges or association of any physician or hiring a physician, a hospital or facility approved pursuant to this chapter shall request from the physician and the physician shall provide the following information:

(a) The name of any hospital or facility with or at which the physician had or has any association, employment, privileges, or practice;

(b) If such association, employment, privilege, or practice was discontinued, the reasons for its discontinuation;

(c) Any pending professional medical misconduct proceedings or any pending medical malpractice actions in this state or another state, the substance of the allegations in the proceedings or actions, and any additional information concerning the proceedings or actions as the physician deems appropriate;

(d) The substance of the findings in the actions or proceedings and any additional information concerning the actions or proceedings as the physician deems appropriate;

(e) A waiver by the physician of any confidentiality provisions concerning the information required to be provided to hospitals pursuant to this subsection; and

(f) A verification by the physician that the information provided by the physician is accurate and complete.

(2) Prior to granting privileges or association to any physician or hiring a physician, a hospital or facility approved pursuant to this chapter shall request from any hospital with or at which the physician had or has privileges, was associated, or was employed, the following information concerning the physician:

(a) Any pending professional medical misconduct proceedings or any pending medical malpractice actions, in this state or another state;

(b) Any judgment or settlement of a medical malpractice action and any finding of professional misconduct in this state or another state by a licensing or disciplinary board; and

(c) Any information required to be reported by hospitals pursuant to RCW 18.71.0195.

(3) The medical quality assurance commission shall be advised within thirty days of the name of any physician denied staff privileges, association, or employment on the basis of adverse findings under subsection (1) of this section.

(4) A hospital or facility that receives a request for information from another hospital or facility pursuant to subsections (1) and (2) of this section shall provide such information concerning the physician in question to the extent such information is known to the hospital or facility receiving such a request, including the reasons for suspension, termination, or curtailment of employment or privileges at the hospital or facility. A hospital, facility, or other person providing such information in good faith is not liable in any civil action for the release of such information.

(5) Information and documents, including complaints and incident reports, created specifically for, and collected, and maintained by a quality improvement committee are not subject to discovery or introduction into evidence in any civil action, and no person who was in attendance at a meeting of such committee or who participated in the creation, collection, or maintenance of information or documents specifically for the committee shall be permitted or required to testify in any civil action as to the content of such proceedings or the documents and information prepared specifically for the committee. This subsection does not preclude: (a) In any civil action, the discovery of the identity of persons involved in the medical care that is the basis of the civil action whose involvement was independent of any quality improvement activity; (b) in any civil action, the testimony of any person concerning the facts which form the basis for the institution of such proceedings of which the person had personal knowledge acquired independently of such proceedings; (c) in any civil action by a health care provider regarding the restriction or revocation of that individual's clinical or staff privileges, introduction into evidence information collected and maintained by quality improvement committees regarding such health care provider; (d) in any civil action, disclosure of the fact that staff privileges were terminated or restricted, including the specific restrictions imposed, if any and the reasons for the restrictions; or (e) in any civil action, discovery and introduction into evidence of the patient's medical records required by regulation of the department of health to be made regarding the care and treatment received.

(6) Hospitals shall be granted access to information held by the medical quality assurance commission and the board of osteopathic medicine and surgery pertinent to decisions of the hospital regarding credentialing and recredentialing of practitioners.

(7) Violation of this section shall not be considered negligence per se.

[1994 sp.s. c 9 § 744; 1993 c 492 § 416; 1991 c 3 § 337; 1987 c 269 § 6; 1986 c 300 § 11.]

WPI 105.02.02 Hospital Responsibility—Corporate Negligence

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.

NOTE ON USE

Use this instruction when there is an issue of hospital corporate negligence. The instruction sets forth four examples of independent duties that a hospital owes to its patients. Use one or all of the bracketed clauses as applicable depending on the facts of each case. See the Comment below.

It is important to distinguish between the three theories on which liability against a hospital may be based: corporate negligence, vicarious liability for a non-employee physician (“ostensible” or “apparent” agency), and vicarious liability for the negligence of a hospital's officers, employees, or agents. One or all of these theories may be advanced against a hospital in

any one case. This instruction should not be used for issues of vicarious negligence of non-hospital employees. Instead use WPI 105.02.03. This instruction should also not be used for issues involving direct negligence of a hospital employee in the performance of medical care. Instead, use WPI 105.02.01.

COMMENT

This instruction is based on *Pedroza v. Bryant*, 101 Wn.2d 226, 677 P.2d 166 (1984), and *Douglas v. Freeman*, 117 Wn.2d 242, 814 P.2d 1160 (1991). The doctrine of corporate negligence was expressly adopted and applied to hospitals by the Supreme Court in *Pedroza*. Under this doctrine, hospitals owe independent and non-delegable duties directly to their patients to exercise reasonable care.

The court in *Pedroza* held that the accreditation standards of the Joint Commission on Accreditation of Hospitals and the hospital's own by-laws are relevant to determining the standard of care owed by a hospital. 101 Wn.2d at 233-34. However, a violation of a hospital regulation adopted by its governing body does not amount to negligence per se. *Andrews v. Burke*, 55 Wn.App. 622, 626, 779 P.2d 740. The second paragraph of the instruction defines the duty of reasonable care using the language of RCW 7.70.040.

The opinion in *Douglas v. Freeman*, supra, contains extensive discussion of corporate negligence. The *Douglas* court identified four specific duties a hospital owes to its patients under the doctrine of corporate negligence: (1) to use reasonable care in the maintenance of buildings and grounds for the protection of the hospital's invitees; (2) to furnish and select patient supplies and equipment free of defects; (3) to select its employees with reasonable care; and (4) to supervise all persons who practice medicine within its walls.

Two of these four duties discussed in *Douglas* are found in the bracketed language in the instruction. The duty regarding maintenance of grounds and buildings, and the duty regarding patient supplies, are not included because claims of negligence for violation of those duties are not claims for damages for injury as a result of health care. Thus, such claims are not made pursuant to RCW 7.70.010 and the committee believes that they do not belong in this instruction.

The third bracketed clause instructs the jury as to the hospital's duty to intervene in the treatment of its patients if there is obvious negligence. This duty is discussed in *Schoening v. Grays Harbor Community Hosp.*, 40 Wn.App. 331, 698 P.2d 593 (1985), and *Alexander v. Gonser*, 42 Wn.App. 234, 711 P.2d 347 (1985). The committee has made no attempt to define the word "obvious" for the jury. In the absence of a definition by the appellate courts, the committee believes the word should be given its common and ordinary meaning.

The fourth bracketed clause instructs the jury regarding the hospital's duty to exercise reasonable care to adopt policies and procedures. This duty is discussed in *Osborn v. Public Hospital Dist. I, Grant County*, 80 Wn.2d 201, 492 P.2d 1025 (1972), and is based on RCW 70.41.010 and WAC 246-318-190.

The instruction's paragraph on evidence of reasonably prudent practices was new to the fourth edition of this volume. The committee added this paragraph to make the instruction more consistent with the related instructions WPI 105.01 and 105.02, each of which has a similar concluding paragraph. Although no court has specifically applied these principles to hospitals, the committee could think of no reason why they would not be applied to hospitals. For a discussion of these principles generally, see the Comment to WPI 105.01.

The doctrine of corporate negligence does not encompass a claim for lack of informed consent. *Howell v. Spokane & Inland Empire Blood Bank*, 114 Wn.2d 42, 785 P.2d 815 (1990).

In *Andrews v. Burke*, 55 Wn.App. 622, 779 P.2d 740 (1989), the court held that the trial court's failure to give a corporate negligence instruction was not error in the absence of evidence to support such an instruction. In *Douglas v. Freeman*, supra, the court found that there was sufficient evidence to support the trial court's corporate negligence instruction. The court also held that the trial court properly instructed the jury that in order to find for the plaintiff on a corporate negligence theory it had to find a duty of care owed to the plaintiff by the defendant clinic, a breach of that duty, and proximate cause between the breach and the plaintiff's injury.

RCW 7.70.090, enacted as part of the 1986 Tort Reform Act, limits the liability of members of a hospital's board of directors or other governing body. It provides the members "are not individually liable for personal injuries or death resulting from health care administered by a health care

provider granted privileges to provide health care at a hospital unless the decision to grant the privilege to provide health care at the hospital constitutes gross negligence.”

[Current as of June 2009.]

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Subject: RE: Fellows v. Moynihan, et al. (S.C. #85382-7)

Rec. 4-16-12

Please note that any pleading filed as an attachment to e-mail will be treated as the original. Therefore, if a filing is by e-mail attachment, it is not necessary to mail to the court the original of the document.

-----Original Message-----

From: George Ahrend [<mailto:gahrend@ahrendlaw.com>]
Sent: Monday, April 16, 2012 4:55 PM
To: OFFICE RECEPTIONIST, CLERK
Cc: amicuswsajf@wsajf.org; john@budlonglawfirm.com; mspillane@williamskastner.com; aforbis@bblaw.com; jcrisera@bblaw.com; pandrews@bblaw.com; holmesk@jgkmw.com; Stewart A. Estes
Subject: Re: Fellows v. Moynihan, et al. (S.C. #85382-7)

Dear Mr. Carpenter:

On behalf of the Washington State Association for Justice Foundation, a proposed amicus curiae brief is attached to this email for filing in the above referenced case. A letter request to appear as amicus curiae was previously submitted on April 13, 2012. The parties are being served simultaneously by copy of this email, in accordance with a prior agreement among counsel.

Respectfully submitted,

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