

No. 85382-7

SUPREME COURT OF THE STATE OF WASHINGTON

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DOUGLAS FELLOWS as Personal Representative of the Estate of  
JORDAN GALLINAT,  
Petitioner,

v.

DANIEL MOYNIHAN, M.D., KATHLEEN HUTCHINSON, M.D. AND  
SOUTHWEST WASHINGTON MEDICAL CETNER,  
Respondents.

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ANSWER OF RESPONDENT KATHLEEN HUTCHINSON, M.D. TO  
PLAINTIFF'S MOTION FOR DISCRETIONARY REVIEW AND  
JOINDER IN RESPONDENT MOYNIHAN'S ANSWER

---

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## **I. IDENTITY OF RESPONDING PARTY**

Defendant/Respondent Kathleen Hutchinson, M.D. provides this answer to Petitioner's Motion for Discretionary Review.

## **II. SUMMARY OF DR. HUTCHINSON'S ARGUMENT AGAINST GRANTING REVIEW**

Dr. Hutchinson joins in the substantive arguments made by Dr. Moynihan with regard to the lack of any proper basis for review of the prior decisions of the trial court and Court of Appeals. Those Courts upheld the statutory privilege protecting hospital peer review and quality improvement materials from discovery. Dr. Hutchinson adds that the plaintiff's underlying request for her file is improper because her credentials are not at issue. She was not, and has never been, disciplined by any peer review or quality assurance committee. Therefore, any request for her privileged information is a baseless attempt to breach a clearly defined statutory privilege designed to protect this information.

## **III. COUNTERSTATEMENT OF RELEVANT FACTS**

In the interest of judicial economy, Dr. Hutchinson refers to the information offered by defendant Moynihan, as it fairly summarizes the events leading up to plaintiff's Motion for Discretionary Review. *See*, Answer of Respondent Daniel Moynihan, M.D., to Plaintiff's Motion for

Discretionary Review. This defendant adds the following pertinent background information with regard to Dr. Hutchinson's involvement in this case:

Dr. Kathleen Hutchinson is the pediatrician who was called to care for Jordan Gallinat following his birth. She was not present during Jordan's delivery nor did she participate in any respect. The plaintiff has sued Dr. Hutchinson. However, the crux of this case appears to relate to Jordan's delivery under the care of codefendant Daniel Moynihan, M.D.

While the original discovery propounded by the plaintiff broadly requested the credentialing, privileging and personnel files of all physicians involved in Jordan Gallinat's care, the subsequent Motion to Compel addressed to Southwest Washington Medical Center and Dr. Moynihan appeared to argue only for Dr. Moynihan's information. *App. HUT-01*. There is no apparent argument in Plaintiff's Motion or Complaint suggesting that Dr. Hutchinson's qualifications are at issue. *App. HUT-1-HUT-32*. Further, Dr. Hutchinson has been entirely forthcoming with regard to her professional standing. She has responded to discovery as follows:

8. Do you now, or have you ever, had a professional license or certification? If so, please state the nature of the license or certification, the date obtained, the state where it was issued, and if any of your professional licenses or certifications have ever been non-renewed, abandoned, suspended or revoked, state the date these

events occurred, the place where this occurred and the full circumstances surrounding such action.

ANSWER:

See attached curriculum vitae. Dr. Hutchinson's licenses and certifications have never been non-renewed, abandoned, suspended or revoked.

*App. HUT-36.* Given this, Dr. Hutchinson's privileging and credentialing information should not be subject to discovery or review.

**IV. ARGUMENT WHY THE SUPREME COURT SHOULD DENY DISCRETIONARY REVIEW.**

**A. Dr. Hutchinson Has An Interest in Preventing the Production of Her Privileged SWMC Records.**

As noted by Dr. Moynihan, the physicians involved in this case have an interest in protecting their privileged information even though the requested documents are in the possession of SWWMC. Dr. Hutchinson, in particular, objects to the production of her quality improvement and peer review information as it is not only afforded clear statutory protection but is also irrelevant to the issues in this case. Dr. Hutchinson has the right to object to production pursuant to RCW 70.41.200(1) and RCW 4.24.250.

**B. Review Should Be Denied Because Plaintiff Has Failed to Address the RAP 13.5(b) Criteria.**

Dr. Hutchinson adopts and joins all arguments made by defendant Moynihan in paragraph IV (B), with regard to Plaintiff's failure to state a proper basis for review.

C. **The Nature of the Claim in Aid of Which Plaintiff Made His Request for Production of SWWMC Records is Irrelevant.**

Dr. Hutchinson joins in all arguments made by defendant Moynihan in paragraph IV (C).

D. **Neither the Trial Court's Discovery Rulings Nor the Court of Appeals Rulings Denying Review Conflict with Any of the Decisions Plaintiff Contends, or Constitute Obvious or Probable Error.**

Dr. Hutchinson joins in all arguments made by defendant Moynihan in paragraph IV (D).

E. **The "Harm" Prongs of RAP 13.5(b)(1) and (2) Are Not Satisfied.**

Dr. Hutchinson joins in all arguments made by defendant Moynihan in paragraph IV (E).

F. **The Supreme Court Should Decline to Consider Such New Arguments as Plaintiff May Make in Reply.**

Dr. Hutchinson joins in all arguments made by defendant Moynihan in paragraph IV (F).

G. **Dr. Hutchinson's Information is Privileged and Irrelevant.**

While the trial court and Court of Appeals made proper determinations based upon the application of the statutory protections for privileging and credentialing information, a separate basis for the denial of access to and review of Dr. Hutchinson's file exists. There does not appear to be any supportable claim that Dr. Hutchinson was not qualified to

provide care to Jordan Gallinat. In fact, the plaintiff's Complaint and subsequent argument does not even allege that Dr. Hutchinson was improperly credentialed. The Complaint instead argues that "DEFENDANT SOUTHWEST WASHINGTON MEDICAL CENTER is also negligent for failing to employ and supervise competent medical personnel, including obstetricians, perinatologists (obstetricians with specialized training in the care of the fetus and complicated, high-risk pregnancies), and nurses." Dr. Hutchinson is not an obstetrician, perinatologist or a nurse. Therefore, the information in her privileging/credentialing file does not address or pertain to the issue defined above.

Further, as noted above, Dr. Hutchinson has responded to discovery regarding her professional standing. She has clearly indicated that her ability to practice has never been restricted or revoked. In light of this information, it is clear that there is no legitimate issue relating to this physician's qualifications. As a result, the request for her credentialing/privileging information and even for *in camera* review of these materials appears to be nothing more than a fishing expedition. Such an invasion is neither appropriate nor warranted. Discovery of her files should be prohibited and *in camera* review deemed wholly improper. To hold otherwise would not only circumvent the statutory privileges

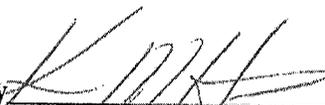
provided in RCW 4.24.250, RCW 70.41.200 and RCW 70.41.230, it would allow broad and sweeping disclosure of information that is irrelevant and has no bearing on the matter before the court. *App. HUT-37-HUT-47*. This is neither what the legislature intended nor does it represent the status of current Washington law.

#### V. CONCLUSION

Dr. Hutchinson's qualifications are not at issue and all privileging/credentialing materials are provided complete protection under applicable statutory provisions. Allowing broad access to privileging information for physicians whose qualifications are not properly at issue would abrogate those privileges in their entirety. Plaintiff's Motion for Discretionary Review should be denied.

**DATED: January 10, 2011, at Seattle, Washington.**

**JOHNSON, GRAFFE,  
KEY, MONIZ & WICK, LLP**

By 

\_\_\_\_\_  
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CERTIFICATE OF SERVICE

I hereby certify under penalty of perjury under the laws of the State of Washington that on January 10, 2011, I caused a true and correct copy of the "Answer of Respondent Kathleen Hutchinson, M.D. to Plaintiff's Motion for Discretionary Review and Joinder in Respondent Moynihan's Answer to be served in the manner indicated below to the following counsel of record:

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DATED this 10th day of January, 2011, at Seattle, Washington.

  
Elizabeth Mitchell

No. 85382-7

SUPREME COURT OF THE STATE OF WASHINGTON

---

DOUGLAS FELLOWS as Personal Representative of the Estate of  
JORDAN GALLINAT,  
Petitioner,

v.

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

---

APPENDIX OF RESPONDENT HUTCHINSON

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**APPENDIX**

1. Plaintiff's Motion to Compel Discovery From Defendants  
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2. Plaintiff's First Amended Complaint For Damages For Personal  
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3. Plaintiff's First Continuing Interrogatories, Requests for  
Production and Request for Update to Defendant Kathleen  
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.....HUT-33
  
4. RCW 4.24.250.....HUT-39
  
5. RCW 70.41.200.....HUT-42
  
6. RCW 70.41.230.....HUT-47

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Honorable Robert Lewis  
Hearing Date: Friday, April 9, 2010  
Time: 9:00 a.m.

IN THE SUPERIOR COURT OF THE STATE OF WASHINGTON  
IN AND FOR THE COUNTY OF CLARK

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

Plaintiff,

v.

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

Defendants.

NO. 09-2-02453-1

**PLAINTIFF'S MOTION TO COMPEL  
DISCOVERY FROM DEFENDANTS  
SOUTHWEST WASHINGTON  
MEDICAL CENTER AND MOYNIHAN**

**I. RELIEF REQUESTED**

Plaintiff Jordan Gallinat respectfully moves the Court to compel defendants Southwest Washington Medical Center ("SWMC") and Daniel Moynihan, M.D. to provide the discovery designated in plaintiff's proposed discovery orders. Plaintiff also requests the Court to impose reasonable terms against defendant SWMC to deter future willful discovery violations and to partially compensate for the costs of bringing this motion.

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1 II. GROUNDS FOR RELIEF

2 This motion should be granted because the information and documents sought are relevant,  
3 non-privileged, and reasonably calculated to lead to the discovery of admissible evidence on the  
4 claims, defenses and issues in this health care liability lawsuit. Plaintiff needs to obtain this  
5 discovery so he can provide it to his expert witnesses, depose the defendants and their experts, and  
6 prepare for trial.

7 III. CR 26(i) CERTIFICATION

8 Plaintiff's counsel John Budlong certifies he has complied with CR 26(I) by sending  
9 discovery letters to and holding discovery conferences with SWMC's and Dr. Moynihan's lawyers.<sup>1</sup>

10 IV. EVIDENCE RELIED ON

11 Declaration of John Budlong with exhibits.

12 V. STATEMENT OF THE CASE

13 A. Jordan Gallinat's Birth Injuries.

14 On September 17, 1996, defendant Moynihan, a family practitioner, made five failed attempts  
15 to deliver Jordan Gallinat with a vacuum extractor. This was the first time Dr. Moynihan had used a  
16 vacuum extractor in private practice.<sup>2</sup> After his attempts failed, Jane Ahearn, M.D., an obstetrician,  
17 was summoned to Southwest Washington Medical Center ("SWMC") to deliver Jordan by  
18 emergency C-section.

19  
20  
21  
22 <sup>1</sup>Exhibit 1--October, 30, 2009 CR 26(I) discovery conference letter to SWMC's lawyer. Exhibit  
23 2--October, 30, 2009 CR 26(I) discovery conference letter to defendant Moynihan's lawyer.

24 <sup>2</sup>Exhibit 3--Defendant Moynihan's answer to interrogatory 7 says that "During his residency [Dr.  
25 Moynihan] delivered approximately 200 babies and estimates that over 25 of those deliveries included  
26 use of a vacuum." At the October 14, 2009 discovery conference, Dr. Moynihan's lawyer Dana Schele confirmed that this answer meant that Dr. Moynihan had not previously used a vacuum extractor in his private practice.

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1 In the last 15 minutes before Jordan was delivered, his heart rate dropped into the bradycardia  
2 danger zone of 90 bpm. Jordan was born limp, pale and gasping with Apgar scores of 2, 3 and 4 (out  
3 of 10) and a cyanotic arterial blood gas of 6.86 from acute birth asphyxia.

4 To resuscitate Jordan from his cardiac arrest, Dr. Moynihan or a hospital nurse intubated,  
5 extubated, and re-intubated him. They left the endotracheal tube in his right bronchus. Jordan  
6 developed a pneumothorax, a collapsed lung and pulmonary hemorrhage.

7 Later that morning, Dr. Sue Ann Smith, a neonatologist at Oregon Health Sciences  
8 University, was summoned to SWMC to care for Jordan. Dr. Smith reported that about a third of  
9 Jordan's blood volume had hemorrhaged into a subgaleal hematoma on top of his head where the  
10 vacuum extractor had been applied.

11 Jordan was transferred to OHSU on a ventilator. By now, he had irreversible bilateral renal  
12 cortical necrosis, liver and renal failure, and anoxic hepatitis. Doctors attributed his condition to  
13 hypovolemic shock and hypoxia caused by the large blood loss from the subgaleal hemorrhage.<sup>3</sup>

14 Plaintiff Jordan Gallinat was a term baby from a low risk pregnancy with no prenatal  
15 complications. Today Jordan is 13. He takes special education classes. He has hypertension and  
16 proteinuria, both indicative of advancing renal disease. A leading medical expert says Jordan is  
17 likely to develop end stage chronic renal failure within the next two decades. This will require  
18 chronic dialysis or a kidney transplant with high risks of graft failure or high mortality rates  
19 associated with long-term dialysis.<sup>4</sup>

20 **B. Defendant Moynihan's Disciplinary History at SWMC.**

21 On September 17, 1997, SWMC filed an Adverse Action Report against defendant Moynihan  
22 with the Washington State Department of Health which led to charges that he acted with  
23 "incompetence, negligence or malpractice which result[ed] in injury to a patient" and "violation of

---

24 <sup>3</sup>Exhibit 4—October 26, 2009 report from Barry M. Brenner, M.D.

25 <sup>4</sup>*Id.*

26  
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1 health agency rules" in Jordan's case and a previous obstetrical case.<sup>5</sup> SWMC's Executive  
2 Committee also "initiated a corrective action resulting in exclusion of [Dr. Moynihan's] operative  
3 vaginal delivery privileges."<sup>6</sup> On May 12, 1998, Dr. Moynihan sent a letter in response either to  
4 SWMC's Adverse Action Report or the DOH charges, then stipulated to give up his in-hospital  
5 obstetrics and postpartum privileges to avoid further disciplinary proceedings.<sup>7</sup> The charges  
6 stemmed from medical errors Dr. Moynihan committed in two obstetrical cases at SWMC:

7 **Case One**

8 The DOH reported that in February 1996, eight months before Jordan was born, Dr.  
9 Moynihan admitted a 35 year old woman to SWMC for an at-term delivery. Dr. Moynihan was  
10 unable to interpret and evaluate the fetal heart monitor tracing. He left the hospital. The hospital  
11 nurses called Dr. Moynihan several times saying they were concerned about the heart monitor  
12 tracings and the baby's fetal distress. Dr. Moynihan did not return to the hospital. The nurses had to  
13 call in another physician, who called an obstetrician to deliver the baby with vacuum extraction.

14 **Case Two: Jordan Gallinat**

15 In the second case, the DOH reported that on September 17, 1996, Dr. Moynihan admitted a  
16 28 year old woman (Jordan's mother Angela Huston) to SWMC for an at-term delivery. After Dr.  
17 Moynihan made several failed attempts to deliver Jordan by vacuum extraction, an obstetrician was  
18 called in to perform an emergency C-section.<sup>8</sup>

19 The DOH concluded the foregoing evidence, if established at a disciplinary hearing, would  
20 prove that defendant Moynihan breached the medical standard of care in treating both patients and  
21 violated RCW 11.43.880(4) and (11), which define unprofessional conduct as:

22 \_\_\_\_\_  
23 <sup>5</sup>Exhibit 5-February 12, 1999 DOH Statement of Allegations.

24 <sup>6</sup>*Id.*

25 <sup>7</sup>*Id.* and Exhibit 6-April 15, 1999 Stipulation to Informal Disposition.

26 <sup>8</sup>*Id.*

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- 1 (4) Incompetence, negligence or malpractice which results in injury to a patient or which  
2 creates an unreasonable risk that a patient may be harmed; and  
3 (11) Violation of rules established by any health agency.

4 SWMC terminated Dr. Moynihan's operative delivery privileges (and may have terminated  
5 his obstetrical and postpartum treatment privileges as well) based on its Adverse Action Report and  
6 Dr. Moynihan's stipulation to the DOH's Statement of Charges. Neither SWMC nor Dr. Moynihan  
7 has produced the Adverse Action Report or Dr. Moynihan's response letter.

8 **C. Physicians Insurance's Control over the Defendants' Discovery Responses and**  
9 **Coordination of Their Defenses.**

10 Physicians Insurance insures all three defendants in this lawsuit. It manages their litigation  
11 through its Defense Counsel Guidelines, which set forth its "express understanding of our  
12 expectations of defense counsel."<sup>9</sup> Under the Defense Counsel Guidelines, Physicians controls the  
13 timing and responsiveness of its insureds' discovery responses. According to the Defense Counsel  
14 Guidelines, defense counsel pay any sanctions for inadvertent failure to meet discovery deadlines,  
15 while Physicians evidently pays the sanctions for willful discovery violations:

16 **DISCOVERY**

17 **B. Extensions**

18 We expect that all discovery deadlines will be met. .... Sanctions imposed due to  
19 inadvertent failure to meet deadlines will not be considered billable expenses.<sup>10</sup>

20 Physicians Insurance also controls the disclosure of insurance coverage information by  
21 deciding whether or not it will produce 1) the actual policies that were in effect when the claims  
22 against its insureds were first made (rather than "Specimen Policies" that may have been in effect in a  
23 different year); 2) the group, clinic and hospital policies (such as its policy on Dr. Moynihan's  
24 practice group Family Physicians Group or SWMC's policies) that may provide additional coverage

25 <sup>9</sup>Exhibit 7-Physicians Insurance Defense Counsel Guidelines, p. 1.

26 <sup>10</sup>*Id.* at p. 15

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1 for physicians or ostensible agents while they are working in the hospital; or 3) excess or umbrella  
2 policies that may provide additional coverage for the hospital or the doctor defendants. The Defense  
3 Counsel Guidelines say:

4 H. Interrogatories and Request for Production Regarding Insured's Coverage.

5 The current law requires production of the actual policy providing coverage to the  
6 insured. When served with an interrogatory requesting production of the policy, you  
7 should contact the claims representative handling the case. He or she will secure the  
8 appropriate policy and send a copy to you.<sup>11</sup>

9 Physicians' Defense Counsel Guidelines instruct defense counsel not to assert cross-claims  
10 against co-defendants or attempt to reduce or eliminate their own client's liability by apportioning  
11 fault to other defendants without its "specific authorization":

12 K. Cross-Complaints

13 Physicians Insurance wants to ensue a proper atmosphere for a coordinated defense.  
14 Our experience has shown that when co-defendants are critical of one another, the  
15 prospects for a successful defense are diminished. Therefore, we generally discourage  
16 filing of cross-complaints against other physicians or hospitals and require specific  
17 authorization from Physicians Insurance before filing a cross-complaint.<sup>12</sup>

18 Physicians Insurance also prevents fault apportionment among co-defendants by having its  
19 claim representatives "play an active role in litigation involving our insureds" and "attend, as often as  
20 possible, meetings with experts and consultants..." whose standard of care and medical causation  
21 testimony furnishes an evidentiary basis for the jury's fault apportionment determinations.<sup>13</sup>

22 Physicians also decides whether or not it will ask for or obtain its insured's consent to settle.  
23 The Defense Counsel Guidelines say that Physicians policies require the insured's consent to settle  
24 and that Physicians' claims representatives are responsible for obtaining consent, if it is desired:

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25 <sup>11</sup>*Id.* at p. 18.

26 <sup>12</sup>*Id.* at p. 20.

<sup>13</sup>*Id.* at p. 2.

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1 SETTLEMENT

2 B. Insured's Consent to Settle

3 Physicians policies require the insured's written consent to settle. Generally,  
4 obtaining this consent is the responsibility of the claims representative.<sup>14</sup>

5 VI. THE DISCOVERY AT ISSUE ON THIS MOTION

6 A. Defendant Moynihan's Discovery Responses.

7 On September 29, 2009, defendant Moynihan served his responses to plaintiff's first  
8 discovery requests.<sup>15</sup> In a November 20, 2009 letter, Dr. Moynihan's lawyer supplemented his  
9 discovery responses.<sup>16</sup> The November 20, 2009 letter is not signed by defendant Moynihan under  
10 oath and does not comply with CR 33(a), which says:

11 Each interrogatory shall be answered separately and fully in writing under oath, unless it is  
12 objected to, in which event the reasons for objection shall be stated in lieu of an answer. The  
13 answers are to be signed by the person making them, and the objections signed by the attorney  
14 making them.

15 Defendant Moynihan refused to produce or objected to producing the following discovery:

16 **Interrogatories/Requests for Production**

- 17 RFP 1 All credentialing files regarding Dr. Moynihan's former and current privileges  
18 at defendant SWMC and at other health care entities.
- 19 RFP 6 Defendant Moynihan's own records of proceedings to suspend, modify or  
20 revoke his license to practice medicine in any state.<sup>17</sup>
- 21 13/7 Identification of all hearings to suspend, diminish, revoke or not renew Dr.  
22 Moynihan's privileges at any hospital or other healthcare facility, including  
23 SWMC, and all related non-privileged documents discoverable under RCW  
24 70.41.200(3).

25 <sup>14</sup>*Id.* at p. 22.

26 <sup>15</sup>Exhibit 3-Defendant Moynihan's discovery responses.

<sup>16</sup>Exhibit 8-November 20, 2009 letter from defendant Moynihan's lawyer Dana Scheele.

<sup>17</sup>Ms. Scheele's November 20, 2009 letter admits the DOH has conducted proceedings to suspend, modify or revoke Dr. Moynihan's license to practice medicine in Washington. But Dr. Moynihan has refused to produce any documents of these proceedings "which are in [his] possession, custody or control" as required by CR 34(a).

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1 All of these discovery requests seek information and documents that are relevant, non-  
2 privileged, reasonably calculated to lead to admissible evidence, and obviously discoverable:

3 The persons who made SWMC's discovery responses [Rog 1];

4 The hospital's legal status [Rog 2];

5 Service of process compliance [Rogs 4-6];

6 SWMC's billing records for Jordan and his mother [RFP 3];

7 SWMC's diagnostic and treatment records for Jordan and his mother [RFP 7];

8 The defendants' business, professional and contractual relationships [Rog 7, 36/RFPs 5, 30];

9 Persons with knowledge of Jordan's injury [Rog 11];

10 Alterations or redactions of hospital records or medical records [Rog 15/RFP 9];

11 Undisclosed documents and records [Rog 16/RFP 10];

12 Photographs and videos [RFP 15];

13 Jordan's diagnoses [Rog 22/RFP 16];

14 Information about the incident and opinions about Jordan's outcome [Rogs 23, 24];

15 Product information about the vacuum extractor that injured Jordan [Rog 25];

16 SWMC's infant resuscitation protocols [Rog 29/RFP 23];

17 SWMC's privileging rules for neonatal resuscitation and the use of vacuum extractors and  
18 forceps [Rogs 31, 32/RFPs 19, 25, 26];

19 The grounds for SWMC's affirmative defenses and contentions as to relative fault [Rogs 48-  
20 50/RFPs 41-43];

21 SWMC's insurance policies and coverage information [Rogs 56, 57/RFP 47];

22 SWMC's managing and speaking agents in this lawsuit [Rog 60].

23 In October 2009, SWMC agreed to supplement its answers to the following interrogatories  
24 and requests for production, but it has not done so.<sup>20</sup>

25 \_\_\_\_\_  
26 <sup>20</sup>Exhibit 1.

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T. J. D. M.

**Interrogatories/Requests for Production:**

- 1
- 2 Rogs 8, 9 Identification of the health care providers who treated Angela Huston and  
3 Jordan Gallinat or have information about their medical conditions before,  
4 during and after Jordan's birth.
- 5 Rog 10 Identification of physicians who were present on SWMC's premises and had  
6 privileges to perform C-sections when Angela was admitted to SWMC for  
7 Jordan's birth.
- 8 Rog12 Identification of eyewitnesses and persons who have knowledge about  
9 Angela's labor and delivery, Jordan's resuscitation, the cause of the incident,  
10 and the extent of Jordan's injuries.
- 11 14/8 All written records and notes concerning Angela or Jordan.
- 12 21/15 All photos and videos of Jordan, his delivery, resuscitation and injuries,  
13 including all investigation and surveillance photos and videos.
- 14 26/20 All SWMC and Joint Commission on Accreditation of Hospital Organizations  
15 (JCAHO) policies, rules, regulations, standards, procedures, instructions,  
16 protocols or bylaws that were in effect at SWMC in 1996.
- 17 27/21 All rules, regulations, policies, standards, protocols or procedures which  
18 addressed the standard of care for SWMC's obstetrical nursing staff in 1996.
- 19 28/22 All rules, regulations, policies, standards, protocols or procedures which  
20 addressed the standard of care for making entries in patient charts or medical  
21 records at SWMC in 1996.
- 22 Defendant SWMC has asserted privilege objections as to the following items of discovery.<sup>21</sup>
- 23 RFP 1 The complete credentialing files for Dr. Moynihan, Dr. Hutchinson and Dr.  
24 Ahearn.
- 25 RFP 2 SWMC's policies and procedures for privileging and background checks for  
26 physicians, nurses or other medical providers working at the hospital in 1996.
- RFP 6 All personnel, employment and job description records (except for salary  
information which may be redacted) concerning the duties and responsibilities  
of each employee, independent contractor or other person or entity who treated  
or consulted about Angela or Jordan.
- RFP 10 All papers, writings, documents or things relating to the subject incident and to  
plaintiff's medical treatment and injuries.

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<sup>21</sup>Plaintiff's proposed discovery orders do not require defendants Moynihan or SWMC to produce any privileged information or documents that were "created specifically for, and collected and maintained by, a 'regularly constituted' quality improvement committee."

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- 1 17/11 All incident or investigative reports and other documents relating to the  
investigation of the incident.
- 2 18/12 All information and documents concerning this incident, including SWMC's  
3 Adverse Action Report and Dr. Moynihan's response letter, that were not  
4 "created specifically for, and collected and maintained by, a 'regularly  
constituted' quality improvement committee."
- 5 19/13 All information and documents relating to the termination or restrictions of  
6 privileges of any health care provider who treated Angela's or Jordan,  
7 including whether staff privileges were terminated or restricted, the specific  
restrictions imposed, and the reasons for the restrictions per RCW  
70.41.200(3)(d).
- 8 20/14 All signed and unsigned statements obtained from any persons regarding this  
9 incident that were not "created specifically for, and collected and maintained  
by, a 'regularly constituted' quality improvement committee."
- 10 24/17 SWMC's opinions why Jordan had the outcome that occurred in this case and  
11 the basis of its opinions.
- 12 25/18 Information about the vacuum extractor used in Jordan's delivery, including  
13 each time it was used, the reasons for using it, identification of each person  
present each time it was used to attempt to deliver Jordan, and all product  
14 literature, instructions, and warnings for the vacuum extractor.
- 15 RFP 19 All SWMC rules, protocols, guidelines and standards relating to the use of  
16 vacuum extractors that were in effect from 1996 to the present.
- 17 30/24 All SWMC rules, regulations, policies or procedures relating to the granting of  
18 privileges to perform C-sections at the hospital.
- 19 33/27 All post-incident changes to any policies, rules, regulations, procedures,  
20 instructions or bylaws regarding the kind of medical treatment provided to  
Angela and Jordan.
- 21 34/28 All policies, procedures, and documents, including SWMC's bylaws and  
22 procedures and JCAHO policies in effect in 1996, that pertained to granting or  
denying staff privileges to physicians at SWMC.
- 23 35/29 All policies, procedures, documents and correspondence, including SWMC's  
24 policies and the JCAHO policies in effect in 1996, which pertained to  
monitoring and supervising the physicians and nurses who treated Angela and  
Jordan at SWMC.
- 25 37/31 All contracts, agreements, rules, regulations, policies and procedures,  
26 including SWMC's policies and procedures and the JCAHO standards in  
effect in 1996, which addressed the standards of care that SWMC, Dr.  
Moynihan, Dr. Hutchinson and Dr. Ahearn were expected to follow at SWMC.

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PLAINTIFF'S MOTION TO COMPEL DISCOVERY FROM  
DEFENDANTS SWMC AND MOYNIHAN- 11

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- 1           38/32           All written or oral assurances or promises by Dr. Moynihan, Dr. Hutchinson or
- 2                           Dr. Ahearn that they would comply with SWMC's contracts, agreements,
- 3                           rules, regulations, policies or procedures that addressed the standard of care
- 4                           they were expected to follow.
- 5           39/33           All information and documents which relate to whether or not Dr. Moynihan,
- 6                           Dr. Hutchinson or Dr. Ahearn complied with SWMC's contracts, agreements,
- 7                           rules, regulations, policies or procedures, including those involving the use of
- 8                           vacuum extractors.
- 9           51 and 52/44   Information, complaints, claims, documents or records of other professional
- 10                          malpractice lawsuits or claims against SWMC involving labor, delivery or
- 11                          infant resuscitation.
- 12           53/45           Information, complaints, claim forms documents or records of other
- 13                          professional malpractice lawsuits or claims against Dr. Moynihan or Dr.
- 14                          Hutchinson in SWMC's possession or control.
- 15           54 and 55/46   Information, complaints, claim forms, documents or records of other
- 16                          disciplinary proceedings or criminal actions against Dr. Moynihan or Dr.
- 17                          Hutchinson.
- 18           59/50           All information and documents concerning understandings of any nature
- 19                          between any defendant and any insurance company relating to providing
- 20                          financial protection, insurance coverage, indemnity or reimbursement for any
- 21                          judgment in this case.

**VII. ARGUMENT**

**A. The Law Requires Full Disclosure of Relevant Evidence.**

Under *Physicians Ins. Exch. v. Fisons Corp.*, parties must fully answer all discovery requests or file a motion for a protective order:

The rules are clear that a party must *fully* answer all interrogatories and requests for production, unless a specific and clear objection is made. If the [defendant] did not agree with the scope of production or did not want to respond, then it was required to move for a protective order. [If] the documents requested were relevant...the [defendant] did not have the option of determining what it would produce or answer, once discovery requests were made.

[A] defendant may not unilaterally determine what is relevant to a plaintiff's claim or to a particular case, defendant's remedy, if any, was to seek a protective order pursuant to CR 26©, not to withhold discoverable material.<sup>22</sup>

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<sup>22</sup>122 Wn.2d 299 at 341, 354-355, 354, n.89, 858 P.2d 1054 (1993).

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1 In *Magana v. Hyundai*, the Supreme Court recently held:

2 Broad discovery is permitted under CR 26. "It is not ground for objection that the  
3 information sought will be inadmissible at the trial if the information sought appears to be  
4 reasonably calculated to lead to the discovery of admissible evidence." CR 26(b)(1). If a  
5 party objects to an interrogatory or a request for production, then the party must seek a  
6 protective order under CR 26©. CR 37(d). If the party does not seek a protective order, then  
7 the party must respond to the discovery request. The party cannot simply ignore or fail to  
8 respond to the request. "[A]n evasive or misleading answer is to be treated as a failure to  
9 answer." CR 37(d).

10 Trial courts need not tolerate deliberate and willful discovery abuse.<sup>23</sup>

11 **B. Discovery Relevant to the Standard of Care, Medical Causation and Medical**  
12 **Injury.**

13 The elements of health care malpractice are set forth in RCW 7.70.040:

14 (1) The health care provider failed to exercise that degree of care, skill, and learning expected  
15 of a reasonably prudent health care provider at that time in the profession or class to which he  
16 belongs, in the state of Washington, acting in the same or similar circumstances;

17 (2) Such failure was the proximate cause of the injury complained of.

18 In *Berger v. Sonneland*, the Supreme Court held that "Expert testimony will generally be  
19 necessary to establish the standard of care and most elements of causation."<sup>24</sup>

20 SWMC's unanswered discovery is relevant and necessary to provide an evidentiary  
21 foundation for expert testimony on the standard of care, medical causation and medical injury. It  
22 includes the identity of Jordan's and Angela's health care providers; witnesses to the labor and  
23 delivery; records, documents, photos, videos, and statements pertaining to Jordan, Angela, and the  
24 subject incident; SWMC's opinions as to the reasons for Jordan's outcome; information and product  
25 literature about the vacuum extractor; any other similar malpractice complaints and lawsuits against  
26 the defendants; and the defendants' compliance or non-compliance with (a) SWMC's contracts,  
policies and procedures, (b) JCAHO procedures, and © other rules and regulations which define the  
standard of care.

<sup>23</sup>167 Wn.2d 570, 576, 584, 220 P.3d 191 (2009).

<sup>24</sup>144 Wn.2d 91, 110-11, 26 P.3d 257 (2001).

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1           **C.     Discovery Relevant to Hospital Corporate Negligence.**

2           Plaintiff's amended complaint alleges SWMC is directly liable for corporate negligence and  
3 vicariously liable for the incompetence or negligence of its employees and ostensible agents. In  
4 *Douglas v. Freeman*, the Supreme Court defined corporate negligence:

5           "[D]uties owed by a hospital under the doctrine of corporate negligence [include]: ... (2) to  
6 furnish the patient supplies and equipment free of defects; (3) to select its employees with  
7 reasonable care; and (4) to supervise all persons who practice medicine within its walls." ...

8           "This court has held that the standards of care to which a hospital should be held may be  
9 defined by the accreditation standards of the Joint Commission on Accreditation of Hospitals  
10 [JCAHO] and the hospital's own bylaws.<sup>25</sup> Other decisions have found the standard of care  
11 for hospitals defined by statute.

12           In *Pedroza v. Bryant*, the Washington Supreme Court said:

13           Forcing hospitals to assume responsibility for their corporate negligence may also provide  
14 those hospitals a financial incentive to insure the competency of their medical staffs. The  
15 most effective way to cut liability insurance costs is to avoid corporate negligence.<sup>26</sup>

16           **1.     Hospital Credentialing and Personnel Records and JCAHO Standards.**

17           Washington hospitals are required by state law and federal JCAHO standards to credential  
18 physicians for staff membership and clinical privileges independently of any "peer review" or  
19 "quality improvement" committees. RCW 70.43.010 requires hospitals to "set standards and  
20 procedures to be applied by the hospital and its medical staff in considering and acting upon  
21 applications for staff membership or professional privileges."

22           In *Pedroza v. Bryant*, the Supreme Court said JCAHO standards for the medical staff  
23 appointment/reappointment process, delineation of clinical privileges, and periodic appraisals of each  
24 physician on the medical staff are vital to patient safety and define the standard of care for hospitals:

25           Perhaps the most important of the national standards voluntarily adopted by hospitals are  
26 those promulgated by the [JCAH]. The JCAH standards clearly establish the institution's

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27           <sup>25</sup>117 Wn.2d 242, 248-49, 814 P.2d 1160 (1991).

28           <sup>26</sup>101 Wn.2d 226, 233-34, 677 P.2d 166 (1984), *quoting from* Koehn, "Hospital Corporate  
29 Liability: An Effective Solution to Controlling Private Physician Incompetence?", 32 Rutgers L.Rev.  
30 342, 376-77 (1979).

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1 governing board as ultimately responsible for the overall quality of patient care provided in  
2 the hospital. The medical staff, in turn, is responsible to the governing board for the  
3 professional competence of all physicians and dentists who are members of the hospital's  
4 medical staff. The standards place particular emphasis on the appointment/reappointment  
5 process, delineation of clinical privileges, and periodic appraisals of each physician staff  
6 member. In addition, the hospital is required to institute reliable and valid measures that  
7 continuously evaluate the quality of care rendered all patients. JCAH accreditation means  
8 that a hospital has sufficiently complied with standards aimed at providing a comprehensive,  
9 ongoing system of review capable of identifying any incompetent members of the medical  
10 staff. The standards could be valuable as a measure against which the hospital's conduct is  
11 judged to determine if the institution is meeting its duty of care to patients.<sup>27</sup>

12 In *Burnet v. Spokane Ambulance*, the Supreme Court held that the trial court abused its  
13 discretion in not ordering a hospital to produce its credentialing files for physicians who allegedly  
14 negligently injured a child in the hospital:

15 More importantly, though, we agree with the Burnets that their negligent credentialing claim  
16 against Sacred Heart, and discovery relating to it, should not have been excluded absent a trial  
17 court's finding that the Burnets willfully violated a discovery order. ...

18 In any case, we are satisfied that it was an abuse of discretion for the trial court to impose the  
19 severe sanction of limiting discovery and excluding expert witness testimony on the  
20 credentialing issue....<sup>28</sup>

21 Under *Douglas, Pedroza* and *Burnet*, SWMC's personnel files, credentialing files for Drs.  
22 Moynihan, Hutchinson and Ahearn, and its JCAHO standards in effect in 1996 are relevant, non-  
23 privileged and discoverable on plaintiff's corporate negligence and standard of care claims.

## 24 **2. Hospital Bylaws, Rules, Procedures and Regulations.**

25 The Supreme Court in *Pedroza* also emphasized the role of hospital bylaws in setting the  
26 standard of care for corporate negligence:

Also relevant to a hospital's standard of care are the hospital's own bylaws. *See, e.g., Purcell v. Zimelman*, 18 Ariz. App. 75, 81, 500 P.2d 335 (1972). Hospitals are required by statute and regulation to adopt bylaws with respect to medical staff activities. RCW 70.41.010, .030; WAC 248-18-030. It is "recommended" that the organization and functions of the medical staff under the bylaws be in accord with the JCAH standards. WAC 248-18-030(2). Bylaws

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27 101 Wn.2d 226, 233-34, 677 P.2d 166 (1984), *quoting from* Koehn, "Hospital Corporate Liability: An Effective Solution to Controlling Private Physician Incompetence?", 32 Rutgers L.Rev. 342, 376-77 (1979).

28 131 Wn.2d 484, 497, 933 P.2d 1036 (1997).

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1 are therefore based on national standards, and their use in defining a standard of care for  
2 hospitals is appropriate.<sup>29</sup>

3 Under *Douglas, Pedroza, Morinaga* and WAC 246-320-365(7), SWMC's bylaws, rules and  
4 procedures pertaining to the privileging, retention and supervision of medical staff and hospital staff,  
5 hospital equipment, fetal heart monitoring, C-section capability, labor and delivery, vacuum  
6 extraction, and other obstetrical subjects are relevant and discoverable on the issues of medical  
7 causation, medical injury, standard of care, corporate negligence, and fault apportionment.

8 In *Morinaga v. Vue*, the Court of Appeals held that health care regulations establish the  
9 standard of care.<sup>30</sup> Health care regulation WAC 246-320-365(7), for example, provides that  
10 "Hospitals will:... If providing obstetrical services: (a) Have the capability to perform cesarean  
11 sections twenty-four hours per day..."

12 Hospital rules and procedures and DOH C-section capability regulations are relevant for  
13 example on whether SWMC had or lacked C-section capability when Jordan needed a C-section, or  
14 whether or not SWMC negligently failed to identify and remedy Dr. Moynihan's inexperience after  
15 the first incident, or negligently allowed him to use its vacuum extractor without proper training or  
16 supervision, or failed to intervene or invoke the chain of command to prevent him from using  
17 unfamiliar or unauthorized obstetrical procedures.

18 **D. Discovery of Investigative, Disciplinary, and Licensing Records.**

19 Dr. Moynihan's investigative, disciplinary and licensing records for the two obstetrical cases  
20 at SWMC obviously are relevant and reasonably calculated to lead to discovery of admissible  
21 evidence. Neither SWMC nor Dr. Moynihan has demonstrated that any of these records are  
22 privileged under the "peer review" statute, RCW 4.24.250(1) or the "quality improvement" statute,  
23 RCW 70.41.200(3). RCW 4.24.250(1) provides:

24 \_\_\_\_\_  
25 <sup>29</sup>*Id.* at 234.

26 <sup>30</sup>85 Wn. App. 822, 833, 935 P.2d 637 (1997).

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1 The proceedings, reports, and written records of ... [a] regularly constituted committee or  
2 board of a hospital whose duty it is to review and evaluate the quality of patient care ... are  
3 not subject to review or disclosure, or subpoena or discovery proceedings in any civil  
4 action....

RCW 70.41.200 contains the following discovery limitations and exceptions:

(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; ...

(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.

In *Coburn v. Seda*, the Supreme Court said "peer review" statutes are to be strictly construed, limited to their purpose, and may not be used to shield discovery of information generated outside review committee meetings:

As a statute in derogation of both the common law and the general policy favoring discovery, RCW 4.24.250 is to be strictly construed and limited to its purposes."

The statute may not be used as a shield to obstruct proper discovery of information generated outside review committee meetings. The statute does not grant an immunity to information otherwise available from original sources. For example, any information from original sources would not be shielded merely by its introduction at a review committee meeting.<sup>31</sup>

<sup>31</sup>101 Wn.2d 270, 276-77, 677 P.2d 173 (1984).

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1 In *Anderson v. Breda*, the Supreme Court held that “the burden of establishing entitlement to  
2 nondisclosure rests with the party resisting discovery.”<sup>32</sup> It further held that the peer review/quality  
3 assurance discovery exemptions only apply when the following “two components are present”:

4 First, RCW 4.24.250 is only applicable if the information sought has been generated in a  
5 regularly constituted committee or board of the hospital whose duty it is to review and  
6 evaluate the quality of patient care or the competency and qualifications of members of the  
7 profession. In determining whether a hospital activity is properly classified as a regularly  
8 constituted quality review committee, the organization and function of the committee may be  
9 examined in light of the guidelines and standards of accreditation bodies and the  
10 organizational precepts of the hospital itself. Whether the activity is concerned with  
11 retrospective review or current care is an additional consideration.

12 The second component is that only the proceedings, reports and written records of such  
13 regularly constituted committees are immune from discovery. ... At most, [plaintiffs] are  
14 deprived only of the opportunity to examine the record of testimony which was given at the  
15 committee proceedings and the findings of the committee. ... [T]he discovery immunity does  
16 not embrace the files of the hospital administration. ... These administrative records are  
17 discoverable to the extent they do not contain the record of immune proceedings.<sup>33</sup>

18 In *Adcox v. Childrens Orthopedic Hosp.*, the Supreme Court held that the peer review  
19 privilege does not apply to a hospital investigation outside a regularly constituted review committee:

20 The Hospital instead argued the informal review reflected in the internal investigation  
21 documents is sufficient to meet the requirements of RCW 4.24.250, especially when one of  
22 the participants in this review was designated a quality assurance coordinator.

23 Nevertheless, as we clearly stated in both *Coburn* and *Anderson*, this showing of an informal  
24 investigation is not sufficient under RCW 4.24.250. Rather, we recognized the statute  
25 requires a “regularly constituted review committee.”<sup>34</sup>

26 Neither SWMC nor Dr. Moynihan has proven that any “quality review committee” existed in  
1996 or 1997 when the hospital’s executive committee reviewed Dr. Moynihan’s two cases and filed  
its Adverse Action Report with the DOH. Nor have they shown that the information and documents  
sought in plaintiff’s discovery requests were “generated in a regularly constituted committee or board

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<sup>32</sup>103 Wn.2d 901, 905, 700 P.2d 737 (1985).

<sup>33</sup>*Id.* at 906-07.

<sup>34</sup>123 Wn.2d 15, 864 P.2d 921 (1993).

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1 of the hospital whose duty it is to review and evaluate the quality of patient care or the competency  
2 and qualifications of members of the profession.”

3 SWMC initiated its corrective action on September 17, 1997, a year after Jordan was born.  
4 There almost certainly was a separate, informal hospital investigation soon after Jordan’s birth into  
5 the cause of his injury and the responsibility for his unexpected outcome. All informal, departmental  
6 investigative proceedings and findings are relevant, non-privileged and discoverable under *Coburn*,  
7 *Anderson* and *Adcox*.

8 SWMC’s restriction of Dr. Moynihan’s staff privileges, the specific restrictions imposed, and  
9 the reasons for the restrictions are expressly discoverable under RCW 70.41.200(3)(d). The  
10 SWMC’s Executive Committee’s Adverse Action Report and Dr. Moynihan’s response letter also are  
11 relevant, non-privileged, and discoverable under RCW 70.41.200(3)(d) and because they were  
12 provided to the DOH for licensing proceedings, and were not “created specifically for, and collected  
13 and maintained by, a quality improvement committee.”

14 JCAHO standards HR.4.2, PI.4.3 and RI.2.2 require hospitals to investigate, intensively  
15 analyze, and report “sentinel events” in cases like Jordan’s where a patient unexpectedly is seriously  
16 injured in a hospital and there are major discrepancies between pre-operative diagnoses (*i.e.* low risk,  
17 term pregnancy without complications) and post-operative diagnoses (*i.e.* cardiac arrest, birth  
18 asphyxia, brain hemorrhage and renal failure).<sup>35</sup>

19 **JCAHO Standard HR.4.2**

20 **2. Sentinel Event.** An unexpected occurrence involving death or serious physical or  
21 psychological injury or the risk thereof. Serious injury specifically includes loss of limb or  
22 function.

23  
24 <sup>35</sup>Exhibit 10-2001 JCAHO standards, HR.4.2. (p. 17), PI.4.3 (pp. 8-9), RI.2.2 (p. 15). These  
25 JCAHO sentinel event investigation, root cause analysis and reporting standards were in effect in  
26 hospitals in 2001. Plaintiff doesn’t know if these sentinel event standards were in effect in 1996 and  
accordingly has asked SWMC to produce its 1996 JCAHO standards.

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**JCAHO Standard PI.4.3.**

[S]entinel events are intensively analyzed... The organization initiates *intense analysis* ...when a sentinel event has occurred. A *root cause analysis* is performed when a sentinel event occurs. An intense analysis is also performed for the following:

- Major discrepancies, or patterns of discrepancies, between preoperative and postoperative (including pathologic) diagnoses....

**JCAHO Standard RI.2.2.**

Patients and, when appropriate, their *families are informed about the outcomes of care, including unanticipated outcomes.*

The responsible licensed independent practitioner or his or her designee *clearly explains the outcome of any treatments or procedures to the patient and, when appropriate, the family, whenever those outcomes differ significantly from the anticipated outcomes.*

Under RCW 70.43.010, SWMC was required to prepare and comply with its own bylaws and procedures and JCAHO standards. The JCAHO requirements exist independently of any "peer review" or "quality assurance" committee activities. Moreover, if an investigation and root cause analysis of Jordan's sentinel event was required by "guidelines and standards of accreditation bodies (*i.e.* JCAHO) [or by] the organizational precepts of the hospital itself" (*i.e.* SWMC's bylaws, rules and administrative procedures), it would not appear to be privileged, even if the hospital delegated its administrative investigation to a "regularly constituted peer review committee." *See Anderson v. Breda, supra.* ("the discovery immunity does not embrace the files of the hospital administration. ... These administrative records are discoverable... They do not contain the record of immune proceedings.")

Under these legal authorities, defendants SWMC and Moynihan should be ordered to produce *all* investigative, disciplinary, and licensing records that they are withholding, unless they first prove four things: 1) that SWMC had a "regularly constituted quality review committee" in 1996 when the two cases involving Dr. Moynihan occurred; 2) the date the committee was originally constituted, the composition of any such committee, and the inclusive dates of the committee's proceedings in these two cases; 3) that any information and documents that defendants are withholding from discovery

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1 were "created specifically for, and collected and maintained by" the review committee; and 4) were  
2 not independently required by or conducted under SWMC's bylaws or administrative procedures or  
3 the standards of the Joint Commission on Accreditation of Hospital Organizations.

4 Even if defendants SWMC and Moynihan submit this proof, they still should be ordered to  
5 produce SWMC's Adverse Action Report and Dr. Moynihan's response letter to the DOH; all  
6 SWMC documents indicating that Dr. Moynihan's staff privileges were restricted, including the  
7 specific restrictions imposed, and the reasons for the restrictions per RCW 70.41.200(3)(d); all  
8 communications with the DOH relating to the DOH's Statement of Charges and Dr. Moynihan's  
9 Stipulation to Informal Discipline; all of SWMC's and Moynihan's investigation documents,  
10 findings, minutes, analyses and reports concerning the two medical incidents that were not "created  
11 specifically for, and collected and maintained by, a regularly constituted quality improvement  
12 committee" (with patient identification information only redacted as to patient one).

13 E. Discovery of Defendants' Fault Apportionment, Expert Witness, Verdict Sharing  
14 and Litigation Recommendations and Agreements.

15 Plaintiffs interrogatories and requests for production seek discovery of all understandings,  
16 agreements, recommendations or requirements of any nature as to whether the defendants will or will  
17 not (a) allege that another party or entity was at fault in causing Jordan's injuries; or (b) coordinate  
18 the hiring of expert witnesses or the subject matter and use of their testimony in deposition and at  
19 trial; or © share in any verdict or judgment. This discovery is relevant on the issues of fault  
20 apportionment under RCW 4.22.070 and is necessary to aid the jury in considering the evidence and  
21 judging the credibility of the defendants and their expert witnesses.

22 Washington's fault apportionment statute, RCW 4.22.070, requires the jury to determine and  
23 apportion the relative fault of every party and entity whose fault caused the claimant's harm:

24 In all actions involving fault of more than one entity, the trier of fact shall determine the  
25 percentage of the total fault which is attributable to every entity which caused the claimant's  
26 damages....

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1 RCW 4.22.015 provides that "fault" includes both negligence and causation:

2 "Fault" includes acts or omissions, including misuse of a product, that are in any measure  
3 negligent or reckless toward the person or property of the actor or others, or that subject a  
4 person to strict tort liability or liability on a product liability claim. The term also includes  
5 breach of warranty, unreasonable assumption of risk, and unreasonable failure to avoid an  
6 injury or to mitigate damages. Legal requirements of causal relation apply both to fault as the  
7 basis for liability and to contributory fault.

8 A comparison of fault for any purpose under RCW 4.22.005 through 4.22.060 shall involve  
9 consideration of both the nature of the conduct of the parties to the action and the extent of  
10 the causal relation between such conduct and the damages.

11 Under RCW 4.22.015 and .070, the jury will need to compare "the nature of the defendants'  
12 conduct and the extent of the causal relation between such conduct and the [plaintiff's] damages" in  
13 order to "determine the percentage of the total fault which is attributable to every entity which caused  
14 the claimant's damages...."

15 WPI 1.02 allows the jury to consider the following factors in determining the credibility of lay  
16 and expert witnesses:

17 You are the sole judges of the credibility of the witnesses and of what weight is to be given  
18 the testimony of each. In considering the testimony of any witness, you may take into account  
19 the opportunity and ability of the witness to observe, the witness's memory and manner while  
20 testifying, any interest, bias, or prejudice the witness may have, the reasonableness of the  
21 testimony of the witness considered in light of all the evidence, and any other factors that bear  
22 on believability and weight.

23 WPI 2.10 allows the jury to consider the following additional factors in determining the  
24 credibility of expert witnesses:

25 You may also consider the reasons given for the opinion and the sources of his or her  
26 information, as well as considering the factors already given to you for evaluating the  
27 testimony of any other witness.

28 Whether the defendants or Physicians Insurance have recommended, required or agreed to  
29 coordinate their fault apportionment defenses is relevant and discoverable because the jury needs this  
30 information to judge the credibility of the parties and their medical expert witnesses and the  
31 reasonableness of their testimony. The Washington Pattern Jury Instructions and case law require  
32 that the jury be informed about any interest, bias, or prejudice the witness may have and other factors

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1 that bear on believability and weight. In *Faust v. Albertson*, the Supreme Court recently reaffirmed  
2 that the juries in Washington state are given wide latitude to determine the credibility of witnesses  
3 based on such factors as inconsistency, self-interest, and bias stemming from fraternal ties.<sup>36</sup>

4 For example, assume there is evidence that the defendants' insurer, lawyers and expert  
5 witnesses are coordinating their defenses by agreeing not to apportion fault to co-defendants, but  
6 instead to attribute Jordan's injuries to non-medical causes. If that happened, a reasonable jury could  
7 conclude that the credibility of the defense experts and the reasonableness of their testimony was  
8 tainted by "interest, bias, or prejudice the witness may have" from being required to follow the  
9 Defense Counsel Guidelines directives or similar recommendations. The jury also could conclude  
10 that the true "reasons given for the [expert] opinion and the sources of his or her information"  
11 stemmed from Physicians' requirements or the defendants' verdict sharing arrangements, rather than  
12 from a legitimate medical evaluation of the "degree of care, skill, and learning expected of a  
13 reasonably prudent health care provider" and whether or not it "was the proximate cause of the injury  
14 complained of."

15 **F. Discovery of Insurance Policies and Agreements Affecting Coverage.**

16 CR 26(b)(2) authorizes discovery of insurance agreements and any documents affecting a  
17 defendant's insurance coverage:

18 **(2) Insurance Agreements.** A party may obtain discovery and production of: (i) the  
19 existence and contents of any insurance agreement under which any person carrying on an  
20 insurance business may be liable to satisfy part or all of a judgment which may be entered in  
21 the action or to indemnify or reimburse for payments made to satisfy the judgment; and (ii)  
22 any documents affecting coverage (such as denying coverage, extending coverage, or  
23 reserving rights) from or on behalf of such person to the covered person or the covered  
24 person's representative.

25 Physicians Insurance has redacted the declarations pages of defendants Moynihan's and  
26 Hutchinson's policies and has produced only a "specimen policy", rather than their actual policies,

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<sup>36</sup>166 Wn.2d 653, 663, 211 P.3d 400 (2009).

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1 for the year 1996 only.<sup>37</sup> Physicians and SWMC have refused to produce SWMC's primary and  
2 excess professional liability policies. Nor has Physicians or Dr. Moynihan produced the 1996-98  
3 professional liability policies for his practice group, Family Physicians Group, which may provide  
4 him with additional coverage.<sup>38</sup> CR 26(b)(2) specifically requires production of these actual,  
5 unredacted policies for all potentially applicable coverage years.

6 CR 26(b)(2) also authorizes discovery of information and documents affecting a defendant's  
7 insurance coverage. Documents affecting a defendant's insurance coverage include things like  
8 reservations of rights letters, consents to settle, and verdict or judgment sharing agreements, which  
9 reflect denials or extensions of coverage.

10 According to Physician Insurance's Defense Counsel Guidelines, Dr. Moynihan's and Dr.  
11 Hutchinson's indemnification coverage depends on their written consent to settle, which depends in  
12 turn on whether or not Physicians claims representatives have asked for their consent to settle.  
13 Further, any information or documents for verdict or judgment sharing, or any agreement or refusal to  
14 settle this case jointly or individually, any conditions to settlement, or any understandings or  
15 agreements which relate to providing financial protection, insurance coverage, indemnity or  
16 reimbursement affect the defendants' respective indemnification coverage and therefore are relevant  
17 and discoverable.

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22 <sup>37</sup>Exhibit 11-Declarations pages of Moynihan and Hutchinson policies. Dr. Moynihan claims  
23 plaintiff's claims were first made in 1996. See Scheele letter, Exhibit 8, p. 2. Plaintiff believed his claim  
was first made in 1998 and therefore is requesting the Court to compel defendants to produce all policies  
and declarations pages for all three defendants for the years 1996-1998.

24 <sup>38</sup>Plaintiff is seeking the defendants' and Family Physicians Group's professional liability policies  
25 for the years 1996 through 1998 because the undersigned believes Physicians Insurance provided an  
26 additional layer of coverage to some of its insured physicians and their practice groups, perhaps including  
Dr. Moynihan and/or Family Physicians Group, through their group policies until approximately 2003.

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1           G.     **The Court Should Impose the Least Severe Discovery Sanctions against**  
2                     **Defendant SWMC.**

3           In *Burnet v. Spokane Ambulance*, the Supreme Court held that a trial court should impose the  
4     least severe sanction that will be adequate to deter future discovery violations, compensate the  
5     opposing party, and make sure the party withholding discovery does not profit from its wrong:

6           [T]he court should impose the least severe sanction that will be adequate to serve the purpose  
7     of the particular sanction, but not be so minimal that it undermines the purpose of discovery;  
8     the purpose of sanctions generally are to deter, to punish, to compensate, to educate, and to  
9     ensure that the wrongdoer does not profit from the wrong.<sup>39</sup>

10          Defendant SWMC has not answered 27 of plaintiff's interrogatories and 18 of plaintiff's  
11     requests for production listed on pages 8 and 9 of this motion, notwithstanding the parties' CR 26(I)  
12     discovery conference in October 2009. This represents a total, willful failure of discovery. SWMC  
13     has refused to supplement its responses to the 9 interrogatories and 5 requests for production listed  
14     on pages 10 and 11 of this motion. It objects to answering the 19 interrogatories and requests for  
15     production listed on pages 12 and 13 without having proven that any "quality improvement  
16     committee" existed, let alone that the information and documents it is withholding were "created  
17     specifically for, and collected and maintained by, a quality improvement committee."

18          Under *Burnet* and *Fisons*, the Court should impose the least severe sanction against  
19     SWMC—*i.e.* reasonable monetary sanctions in an amount not so minimal as to undermine the purpose  
20     of discovery by encouraging SWMC or its co-defendants to continue to resist full disclosure and  
21     production of all of the requested discovery. The sanctions should be sufficient to educate and deter  
22     the defense lawyers from using unfounded objections to interfere at future depositions in the areas of  
23     discovery that the Court orders SWMC and Moynihan to produce. The sanctions should be in an  
24     amount sufficient to ensure that the defendants and their insurer do not profit from their wrong.  
25     Plaintiff according requests the Court to order SWMC to pay sanctions in an amount the Court deems

26                     

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                   <sup>39</sup>131 Wn.2d 484, 495-96, 933 P.2d 1036 (1997), *citing Physicians Insurance Exch. v. Fisons*,  
                   122 Wn.2d at 355-56, 858 P.2d 1054.

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1 reasonable under the *Burnet* criteria to the Law Offices of Lawrence Wobbrock within 20 days of the  
2 discovery order. The undersigned can provide the Court with documentation for the time spent in  
3 preparing and arguing this motion, if that would assist the Court in making its determination.

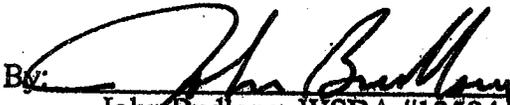
4 **VIII. CONCLUSION**

5 Based on the foregoing legal authorities, plaintiffs respectfully request the Court to order  
6 defendants SWMC and Moynihan to produce all of the discovery designated in the attached proposed  
7 orders, which clearly separate the discoverable information and documents from any potentially  
8 privileged information or documents.

9  
10 RESPECTFULLY OFFERED this 25<sup>th</sup> day of March, 2010.

11 LAW OFFICES OF JOHN BUDLONG

LAWRENCE WOB BROCK

12  
13 By: 

By: 

14 John Budlong, WSBA #12594  
Eaye J. Wong, WSBA #30172

Lawrence Wobbrock, WSBA #11412

15 Attorneys for Plaintiff Jordan Gallinat  
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IN THE CLARK COUNTY SUPERIOR COURT  
STATE OF WASHINGTON

DOUG FELLOWS, as Conservator for JORDAN  
GALLINAT,  
  
v.  
  
DANIEL J. MOYNIHAN, M.D; KATHLEEN  
HUTCHINSON, M.D.; and SOUTHWEST  
WASHINGTON MEDICAL CENTER, Defendants.)  

---

Case No.: 09-2-02453-1  
  
**FIRST AMENDED COMPLAINT FOR  
DAMAGES FOR PERSONAL INJURY**

COMES NOW, Plaintiff, DOUG FELLOWS PLAINTIFF as Conservator for JORDAN  
GALLINAT, and for cause of action to recover damages suffered and incurred by Plaintiff  
against Defendants, DANIEL J. MOYNIHAN, M.D.; KATHLEEN HUTCHINSON, M.D.; and  
SOUTHWEST WASHINGTON MEDICAL CENTER, a Washington Corporation, alleges as  
follows:

LAWRENCE WOBROCK  
Trial Lawyer, P.C.  
10<sup>th</sup> Floor  
Jackson Tower  
806 SW Broadway  
Portland, Oregon 97205  
Telephone: (503) 228-6600

I. PARTIES

1.1 Plaintiff: DOUGLAS FELLOWS is the duly appointed Conservator/legal guardian ad litem for JORDAN GALLINAT, a minor child.

1.2 Defendant: DANIEL J. MOYNIHAN, M.D., at all times material hereto, has been a physician, and a healthcare provider licensed to practice in the State of Washington. At the times and incidents alleged herein, DANIEL J. MOYNIHAN, M.D. was providing medical services to his patients, including patient JORDAN GALLINAT, at and for the benefit of DEFENDANT SOUTHWEST WASHINGTON MEDICAL CENTER in Clark County, Washington.

1.3 Defendant: KATHLEEN HUTCHINSON, M.D., at all times material hereto, has been a physician, and a healthcare provider licensed to practice in the State of Washington. At the times and incidents alleged herein, KATHLEEN HUTCHINSON, M.D., was providing medical services to her patients, including patient JORDAN GALLINAT, at and for the benefit of DEFENDANT SOUTHWEST WASHINGTON MEDICAL CENTER in Clark County, Washington.

1.4 Defendant: SOUTHWEST WASHINGTON MEDICAL CENTER, at all times material hereto, has been a corporation organized under the laws of the State of Washington holding itself out as providing medical and surgical care in the evaluation and treatment of, among other things, labor and delivery of infants. In that capacity, DEFENDANT SOUTHWEST WASHINGTON MEDICAL CENTER employed as agents or ostensible agents, DEFENDANTS DANIEL J. MOYNIHAN, M.D., and KATHLEEN HUTCHINSON, M.D., to treat patients in the City of Vancouver, County of Clark, State of Washington, including JORDAN GALLINAT. At the times and incidents alleged herein, DEFENDANTS DANIEL J. MOYNIHAN, M.D., and

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1 KATHLEEN HUTCHINSON, M.D., were providing medical services to their patients, including  
2 patient JORDAN GALLINAT, at and for the benefit of DEFENDANT SOUTHWEST  
3 WASHINGTON MEDICAL CENTER, located in Clark County, Washington.  
4

## 5 II. JURISDICTION AND VENUE

- 6 2.1 The negligent acts alleged herein occurred in Clark County, Washington.  
7 2.2 Personal and subject matter jurisdiction are proper in Clark County Superior Court.  
8 2.3 Venue is proper in Clark County, Washington, pursuant to RCW 4.12.025.

## 9 III. FACTS

- 10 3.1 On September 17, 1996, Angela Huston aka Angela Gallinat was admitted to  
11 DEFENDANT SOUTHWEST WASHINGTON MEDICAL CENTER in labor with her son,  
12 JORDAN GALLINAT.  
13  
14 3.2 On September 18, 1996 DEFENDANTS MOYNIHAN and SOUTHWEST  
15 WASHINGTON MEDICAL CENTER provided medical care to JORDAN GALLINAT and his  
16 mother Angela Huston during the delivery of JORDAN GALLINAT and DEFENDANT  
17 HUTCHINSON provided medical care to JORDAN GALLINAT after he was delivered.  
18  
19 3.3 As a result of DEFENDANTS' negligence in the medical care provided to Angela Huston  
20 aka Angela Gallinat and Jordan Gallinat, JORDAN GALLINAT suffered severe permanent  
21 injury and will require future medical and surgical care, treatment and rehabilitation.

## 22 IV. NEGLIGENCE

- 23 4.1 Plaintiff realleges the contents of paragraph I, II, and III, and by this reference  
24 incorporates them herein.  
25  
26

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1 4.2 DEFENDANT SOUTHWEST WASHINGTON MEDICAL CENTER and its employees,  
2 managers, and/or healthcare providers, and DEFENDANT DANIEL J. MOYNIHAN, M.D.,  
3 breached the standard of care of a reasonable and prudent healthcare provider and were negligent  
4 in the care and treatment of Angela Huston aka Angela Gallinat and JORDAN GALLINAT and  
5 caused him permanent injury.  
6

7 4.3 DEFENDANT KATHLEEN HUTCHINSON, M.D., breached the standard of care of a  
8 reasonable and prudent healthcare provider and was negligent in the care and treatment of  
9 JORDAN GALLINAT and caused him permanent injury.

10 4.4 DEFENDANT SOUTHWEST WASHINGTON MEDICAL CENTER is also negligent  
11 for failing to employ and supervise competent medical personnel, including obstetricians,  
12 perinatologists, and nurses. The liability of DEFENDANT SOUTHWEST WASHINGTON  
13 MEDICAL CENTER is based on theories of respondeat superior, agency, and its own corporate  
14 negligence. As a corporation, DEFENDANT SOUTHWEST WASHINGTON MEDICAL  
15 CENTER is vicariously liable for any negligent or wrongful acts of misconduct committed by  
16 any of its directors, officers, shareholders, managers, members, agents or employees while they  
17 are engaged on its behalf in the rendering of professional services.  
18  
19

20 **V. PHYSICIAN PATIENT PRIVILEGE**

21 5.1 The Plaintiff asserts the physician-patient privilege for 89 days following the filing of this  
22 complaint. On the 90<sup>th</sup> day following the filing of this complaint, Plaintiff waives the physician  
23 patient privilege pursuant to RCW 5.60.060(4)(b). The waiver is conditioned and limited as  
24 follows: (1) the Plaintiff does not waive his constitutional right of privacy; (2) Plaintiff does not  
25 authorize contact with his healthcare providers of any kind except by judicial proceedings  
26

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1 authorized by the Rules of Civil Procedure; and (3) defendants' representatives are specifically  
2 instructed not to attempt ex parte contacts with any of Plaintiff's health care providers.

3  
4 **VI. DAMAGES**

5 6.1 As a direct and proximate result of defendants' negligence, Plaintiff suffered damages in  
6 an amount to be proven at trial.

7 6.2 JORDAN GALLINAT sustained the following damages:

- 8 A. Medical and surgical expenses, past and future;  
9 B. Pain and suffering damages;  
10 C. Impairment of earning capacity;  
11 D. Need for habilitation and rehabilitation; and  
12 E. All other rights and remedies existing.

13  
14 **VII. COMPLIANCE WITH RCW 7.70.100 REQUIRING PRE-SUIT NOTICE**

15 7.1 In compliance with RCW 7.70.100, DEFENDANT DANIEL J. MOYNIHAN, M.D.,  
16 DEFENDANT KATHLEEN HUTCHINSON, M.D., and SOUTHWEST WASHINGTON  
17 MEDICAL CENTER were served with a letter titled "Ninety (90) Day Notice of Intent to  
18 Commence Professional Negligence Action," advising Defendants of JORDAN GALLINAT'S  
19 intent to commence a professional negligence action through his Conservator.  
20

21 7.2 This Complaint for Professional Negligence was not filed or served until after the  
22 expiration of ninety (90) days notice to defendant of plaintiff's intent to bring this action.

23 **VIII. CERTIFICATE OF MERIT**

24 8.1 Along with the Summons and Complaint, Plaintiffs have filed Certificates of Merit,  
25 signed by Dr. Lonnie Lee Smucker; Dr. Kathleen Lagana, and Dr. Maureen Sims, declaring that  
26

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1 each believes that there is a reasonable probability that DEFENDANTS' conduct did not follow  
2 the accepted standard of care required of a reasonable and prudent health care provider licensed  
3 to practice in the State of Washington.

4 **IX. ELECTION NOT TO SUBMIT TO ARBITRATION**

5  
6 9.1 Pursuant to RCW 7.70A.020, the provisions for Arbitration have been presented to the  
7 claimant and an Arbitration Declaration has been filed indicating that Plaintiff does not elect to  
8 submit this dispute to arbitration under RW 7.70A.020.

9 **PRAYER FOR RELIEF**

10 WHEREFORE, Plaintiff prays for judgment against defendants, jointly and severally on each and  
11 every cause of action alleged herein; that in the alternative, plaintiff prays for judgment against  
12 all other parties and non-parties against whom defendants may prevail; that further, the plaintiff  
13 be awarded reasonable attorney fees and costs of suit under RCW 4.84, et. seq. and as otherwise  
14 provided for by law; and that plaintiff be awarded pre- and post-judgment interest; and that  
15 plaintiff have such other just and equitable relief as the court deems appropriate under the  
16 circumstances, including, but not limited to, the right reserved hereby to amend the pleadings.  
17

18 DATED this \_\_\_\_\_ day of September, 2009.

19  
20 **LAWRENCE WOBROCK TRIAL LAWYER, P.C.**

21 BY:

22 LAWRENCE WOBROCK, WSBA #31412  
23 806 SW Broadway, 10<sup>th</sup> Floor  
24 Portland, OR 97205  
25 Ph: 503-228-6600  
26 Fax: 503-222-4787  
Email: lwobbrock@wobbrock.com  
Of Attorneys for Plaintiff

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Honorable Robert Lewis  
Individual Calendar

IN THE SUPERIOR COURT OF THE STATE OF WASHINGTON  
IN AND FOR THE COUNTY OF CLARK

DOUG FELLOWS, as Conservator for  
JORDAN GALLINAT,

Plaintiff,

v.

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

Defendants.

NO. 09-2-02453-1

**PLAINTIFF'S FIRST CONTINUING  
INTERROGATORIES, REQUESTS  
FOR PRODUCTION AND REQUEST  
FOR UPDATE TO DEFENDANT  
KATHLEEN HUTCHINSON, M.D.**

AND ANSWERS THERETO

**TO: DEFENDANT KATHLEEN HUTCHINSON, M.D.;**  
**AND TO: John C. Graffe and JOHNSON, GRAFFE, KEAY, MONIZ & WICK, LLP, her  
attorneys.**

These interrogatories and requests for production are continuing in nature and seek all responsive information, documents and tangible things that the defendant has or controls. Answers are to be changed promptly upon receipt of new or different information. These interrogatories are directed to all knowledge and all sources of knowledge with respect to the subject matter indicated, including all knowledge of the defendant, her agents, employees, attorneys, representatives, underwriters, insurers and investigators. The words "you" or "your" as used in each interrogatory include all of the foregoing sources.

In accordance with Rules of Civil Procedure 26 and 33, you will please answer, in writing, the following interrogatories, separately and fully, under oath, and serve the original and one copy of your answers upon the undersigned attorneys within thirty (30) days of the date of service of these interrogatories upon you.

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John Rudland

EDMONDS, WASHINGTON 98020  
TEL

1 You are further requested to produce pursuant to Rules of Civil Procedure 26 and 34 on the  
 2 thirtieth (30th) day after service of these requests for production, or if that day should not be a normal  
 3 business day, then the first business day thereafter, each of the items referenced below at the offices  
 4 of plaintiffs' counsel, Law Offices of John Budlong, 100 Second Avenue South, Suite 200, Edmonds,  
 5 Washington 98020. Production may be accomplished by mailing copies of the requested items to  
 6 the above office.

7 In addition, you are requested to update and supplement your answers to these interrogatories  
 8 and requests for production fully and completely not later than sixty (60) days before any trial date  
 9 scheduled herein.

10 The term "document" or "documents" as used herein is defined to include any and all manner  
 11 of written, typed, printed, reproduced, filmed or recorded material, including computer data, and all  
 12 photographs, pictures, plans or other representations of any kind of anything pertaining, describing,  
 13 referring or relating, directly or indirectly, in whole or in part, to the subject matter of each  
 14 interrogatory, and the term includes, without limitation:

- 15 1. Papers, books, journals, ledgers, statements, memoranda, reports, invoices, work  
 16 sheets, work papers, notes, transcriptions of notes, letters, correspondence, abstracts, checks,  
 17 diagrams, plans, blue prints, specifications, pictures, drawings, films, photographs, graphic  
 18 representations, diaries, calendars, desk calendars, pocket calculators, calculators of any type, lists,  
 19 logs, purchase orders, messages, resumes, summaries, agreements, contracts, telegrams, telexes,  
 20 cables, recordings, audio tapes, magnetic tapes, visual tapes, transcriptions of tapes or records, or any  
 21 other writings or other tangible things on which any handwriting, typing, printing, photostatic, or  
 22 other forms of communications are recorded or reproduced, as well as all notations on the foregoing;
- 23 2. Originals and all other copies not absolutely identical; and
- 24 3. All drafts and notes, whether typed, handwritten or otherwise, made or prepared in  
 25 connection with such document, whether used or not.

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**OBJECTION**

Defendant objects to the forgoing statement, and any further statement, by the plaintiff to the extent it attempts to change, modify or add to the requirements for answering discovery found in the Civil Rules.

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**VI. LICENSURE, PRIVILEGES AND DISCIPLINARY ACTIONS**

8. Do you now, or have you ever, had a professional license or certification? If so, please state the nature of the license or certification, the date obtained, the state where it was issued, and if any of your professional licenses or certifications have ever been non-renewed, abandoned, suspended or revoked, state the date these events occurred, the place where this occurred and the full circumstances surrounding such action.

**ANSWER:**

See attached curriculum vitae. Dr. Hutchinson's licenses and certifications have never been non-renewed, abandoned, suspended or revoked.

9. Please list all hospitals, clinics or any other healthcare facilities in which you have been granted privileges to provide medical services and provide the following information:

- a. the nature and extent of your privileges to provide medical services;
- b. the duration of your privileges at each hospital, clinic or healthcare facility;
- and
- c. whether each hospital, clinic or healthcare facility has administrative rules, protocols, guidelines or standards governing your privileges to provide medical services.

**ANSWER:**

Based on defendant's current knowledge and belief:

- a. Dr. Hutchinson holds active staff pediatric privileges at SWWMC.
- Dr. Hutchinson holds active staff pediatric privileges at Legacy Salmon Creek.
- Dr. Hutchinson holds volunteer staff privileges at Oregon Health and Sciences University -Department of Pediatrics.
- b. See attached curriculum vitae. Dr. Hutchinson believes she has held her volunteer privileges at OHSU since 1990.
- c. Dr. Hutchinson believes each facility has rules relating to her privileges.

10. Have you ever been involved in any proceedings involving a question of whether your license to practice medicine should be suspended, modified or revoked? If so, please state the date of each proceeding, the place of each proceeding and the result of each proceeding.

**ANSWER:**

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John Budlong

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No.

11. Has there ever been a hearing to suspend, diminish, revoke or not renew your privileges at any hospital or other healthcare facility? If so, state the name of such hospital or healthcare facility and the date and result of the hearing.

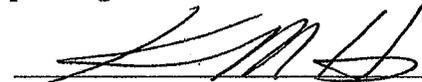
**ANSWER:**

No.

12. Was there any hearing, inquiry, investigation, or professional meeting, of any nature, concerning the occurrence that is the subject of this lawsuit? If so, please state the date of the proceeding, the name of the administrative entity or body that held it, names of persons conducting it and the outcome of such proceeding.

**ANSWER:**

Objection. This Interrogatory seeks information which would fall under the quality assurance and peer review privileges.

  
\_\_\_\_\_  
Kim M. Holmes, WSBA #36136

Subject to the foregoing objections, Dr. Hutchinson is not aware of any such hearing, inquiry, investigation or professional meeting relating to her care.

**VII. PLAINTIFF'S HEALTH CARE PROVIDERS**

13. Please provide the name, address, employer, inclusive dates of employment, job title of each physician, nurse, health care provider, or other person or entity who provided health care, consultation, advice or treatment of any kind to Angela Huston (formerly Gallinat) and plaintiff Jordan Gallinat, or who conducted or analyzed any diagnostic studies, or who made any entry in their records, while they were your patients, and describe your understanding of the care, treatment or consultation each person rendered and the dates it was rendered. (This question also is intended to include all persons and entities who have made entries in Angela Huston's and Jordan Gallinat's medical records and all persons who were the employees, agents, or representatives of SWWMC, or who were independent contractors or consultants, or were involved in any other way in Angela's and Jordan's care, whether their name and/or initials appear in the hospital records or not).

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See attached.

36. All documents, memoranda, correspondence, reports or any other records relating to your giving or withholding consent to settle this lawsuit as referenced in Interrogatory No. 52.

**RESPONSE:**

See objection and response to Interrogatory No. 36.

37. All documents, memoranda, correspondence, reports or any other records relating to any understanding between any defendant and any insurance company as referenced in Interrogatory No. 53.

**RESPONSE:**

See objection and response to Interrogatory No. 53.

STATE OF WASHINGTON )  
COUNTY OF Clark ) ss.

Kathleen M. Hutchinson, being first duly sworn upon oath, deposes and states as follows: that I am a defendant in the above-entitled action, and I have read the foregoing answers to interrogatories and responses to requests for production, know their contents, and believe them to be true and correct.

RESPONSES AND OBJECTIONS to discovery requests dated this 19<sup>th</sup> day of November, 2009.

Kathleen M. Hutchinson, M.D.  
KATHLEEN HUTCHINSON, M.D.

LAW OFFICES OF  
**John Budlong**  
100 SECOND AVENUE SOUTH, SUITE 200  
EDMONDS, WASHINGTON 98020

West's Revised Code of Washington Annotated Currentness

Title 4. Civil Procedure (Refs & Annos)

Chapter 4.24. Special Rights of Action and Special Immunities (Refs & Annos)

**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).

CREDIT(S)

[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.]

#### HISTORICAL AND STATUTORY NOTES

**Reviser's note:** This section was amended by 2005 c 33 § 5 and by 2005 c 291 § 1, each without reference to the other. Both amendments are incorporated in the publication of this section under RCW 1.12.025(2). For rule of construction, see RCW 1.12.025(1).

**Findings--2005 c 33:** See note following RCW 18.20.390.

Laws 1975, 1st Ex.Sess., ch. 114, § 2, inserted language relating to pharmacists.

Laws 1977, ch. 68, § 1, in the first sentence, substituted "Any health care practitioner as defined in RCW 7.70.020(1) and (2) as now existing or hereafter amended" for "Physicians licensed under chapter 18.71 RCW or chapter 18.57 RCW, dentists licensed under chapter 18.32 RCW, and pharmacists licensed under chapter 18.64 RCW"; substituted "board of a professional society" for "board of a medical, dental, or pharmaceutical society"; and made nonsubstantive changes in verb forms.

Laws 1979, ch. 17, § 1, in the second sentence, following "records of such committees or boards" inserted ", or of a member, employee, staff person, or investigator of such a committee or board,"; and, following "recommendations of such committees" added "or boards".

Laws 1981, ch. 181, § 1, at the beginning of the first sentence, substituted "Any health care provider" for "Any health care practitioner" and following "in a hospital or similar institution," inserted "or before a regularly constituted committee or board of a hospital whose duty it is to review and evaluate the quality of patient care,"; at the beginning of the second sentence, substituted "The proceedings, reports, and written records" for "The written records"; and, at the end of the sentence, added the language beginning "involving the restriction or revocation".

Laws 2004, ch. 145, § 1 rewrote the section, which formerly read:

"Any health care provider as defined in RCW 7.70.020(1) and (2) as now existing or hereafter amended 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, shall be immune from civil action for damages arising out of such activities. 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, shall not be subject to 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 above."

2005 Legislation

Laws 2005, ch. 33, § 5, in subsec. (2), near the beginning, inserted the reference to a quality assurance committee; and, at the end of subsec. (2), updated the statutory references.

Laws 2005, ch. 291, § 1, in subsec. (1), in the first sentence, following the statutory reference, deleted "as now existing or hereafter amended"; in the last sentence, made nonsubstantive changes and inserted "review or disclosure, or".

West's Revised Code of Washington Annotated Currentness

Title 70. Public Health and Safety (Refs & Annos)

Chapter 70.41. Hospital Licensing and Regulation (Refs & Annos)

**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.

#### CREDIT(S)

[2007 c 273 § 22, eff. July 1, 2009; 2007 c 261 § 3, eff. July 22, 2007; 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.]

#### HISTORICAL AND STATUTORY NOTES

**Reviser's note:** This section was amended by 2007 c 261 § 3 and by 2007 c 273 § 22, each without reference to the other. Both amendments are incorporated in the publication of this section under RCW 1.12.025(2). For rule of construction, see RCW 1.12.025(1).

**Effective date--Implementation--2007 c 273:** See RCW 70.230.900 and 70.230.901.

**Finding--2007 c 261:** See note following RCW 43.70.056.

**Findings 2005 c 33:** See note following RCW 18.20.390.

**Severability Headings and captions not law Effective date 1994 sp.s. c 9:** See RCW 18.79.900 through 18.79.902.

**Findings Intent 1993 c 492:** See notes following RCW 43.20.050.

**Short title Severability Savings Captions not law Reservation of legislative power Effective dates 1993 c 492:** See RCW 43.72.910 through 43.72.915.

**Legislative findings Severability 1986 c 300:** See notes following RCW 18.57.174.

Laws 1987, ch. 269, § 5, in subsec. (3), in the first sentence, substituted "under review or have been evaluated" for "subject to evaluation"; and, in the last sentence, added subd. (d).

Laws 1991, ch. 3, § 336, near the end of subsec. (3) and in subsec. (4), substituted "department of health" for "department of social and health services".

Laws 1993, ch. 492, § 415, in subsec. (1), in the introductory paragraph, substituted "quality improvement program for the improvement of the quality of health care services rendered to patients and the" for "program for the"; in subsec. (1)(a), in the first sentence, substituted "improvement" for "assurance", and inserted ", both retrospectively and prospectively,"; in the second sentence, inserted "quality improvement and"; deleted a former last sentence; in subsec. (1)(g), inserted "quality improvement"; in subsec. (2), inserted "quality improvement and", and substituted "improvement" for "assurance"; rewrote subsec. (3); inserted subsec. (4); and renumbered former subsecs. (4) to (6) as (5) to (7).

Laws 1994, 1st Sp.Sess., ch. 9, § 742, in subsec. (6), in the first sentence, substituted "quality assurance commission" for "disciplinary board"; in the second sentence, inserted "commission or".

Laws 2000, ch. 6, § 3, inserted a new subsec. (7); and redesignated former subsec. (7) as (8).

#### 2004 Legislation

Laws 2004, ch. 145, § 3, in subsec. (1)(g), inserted "medication errors"; in subsec. (2), added the second sentence; inserted subsec. (8); and redesignated former subsec. (8) as subsec. (9).

#### 2005 Legislation

Laws 2005, ch. 33, § 7, in subsec. (8), in the first sentence, inserted the reference to a quality assurance committee; updated the statutory references at the end of subsec. (8); inserted subsec. (9); and redesignated former subsec. (9) as subsec. (10).

Laws 2005, ch. 291, § 3, in subsec. (3), in the first sentence, inserted "review or disclosure, except as provided in this section, or".

#### 2007 Legislation

Laws 2007, ch. 261, § 3 rewrote subsecs. (1)(e) and (1)(g), which formerly read:

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

"(g) Education programs dealing with quality improvement, patient safety, medication errors, injury prevention, 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"

Laws 2007, ch. 273, § 22, in subsec. (8), in the first sentence, inserted "a coordinated quality improvement committee maintained by an ambulatory surgical facility under section 8 of this act,".

West's RCWA 70.41.230

West's Revised Code of Washington Annotated Currentness

Title 70. Public Health and Safety (Refs & Annos)

Chapter 70.41. Hospital Licensing and Regulation (Refs & Annos)

**➔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.

CREDIT(S)

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

HISTORICAL AND STATUTORY NOTES

**Severability--Headings and captions not law--Effective date--1994 sp.s. c 9:** See RCW 18.79.900 through 18.79.902.

**Findings--Intent--1993 c 492:** See notes following RCW 43.20.050.

**Short title--Severability--Savings--Captions not law--Reservation of legislative power--Effective dates--1993 c 492:** See RCW 43.72.910 through 43.72.915.

**Legislative findings--Severability--1986 c 300:** See notes following RCW 18.57.245.

Laws 1987, ch. 269, § 6, in subsec. (5), in the first sentence, substituted "under review or have been evaluated" for "subject to evaluation"; and, in the last sentence, added subd. (d).

Laws 1991, ch. 3, § 337, near the end of subsec. (5), substituted "department of health" for "department of social and health services".

Laws 1993, ch. 492, § 416, in subsec. (5), in the introductory material, inserted "specifically for, and"; following "and maintained" deleted "about health care providers arising out of the matters that are under review or have been evaluated"; substituted "quality improvement committee" for "review committee conducting quality assurance reviews"; substituted "who participated in the creation, collection, or maintenance of information or documents specifically for the committee" for "board"; inserted "or the documents and information prepared specifically for the committee"; also in subsec. (5), inserted subd. (a); redesignated former subds. (a) to (d) as subds. (b) to (e); then, in subd. (c), substituted "improvement" for "assurance"; and, in subd. (d), inserted "and the reasons for the restrictions".

Laws 1994, 1st Sp.Sess., ch. 9, § 744, in subsec. (2)(c), inserted "(as recodified by this act)"; in subsec. (3), substituted "quality assurance commission" for "disciplinary board"; in subsec. (6), substituted "quality assurance commission" for "disciplinary board".