67350-5 67350-5

NO. 67350-5-1

COURT OF APPEALS FOR DIVISION I
STATE OF WASHINGTON

AOLANI E. GLOVER, a single individual,

Respondent,

v.

THE STATE OF WASHINGTON d/b/a
HARBORVIEW MEDICAL CENTER; AND LULU M. GIZAW, PA-C,

Petitioners

FILED
COURT OF APPEALS DIV I
STATE OF WASHINGTON
2011 OCT 28 PM 1:44

APPELLANTS' OPENING BRIEF

Michael F. Madden, WSBA #8747
Carol Sue Janes, WSBA #16557
Bennett Bigelow & Leedom, P.S.
1700 Seventh Avenue, Suite 1900
Seattle WA 98108
(206) 622-5511

Special Assistant Attorneys General
Attorneys for Appellants

ORIGINAL

TABLE OF CONTENTS

I. INTRODUCTION 1

II. ASSIGNMENT OF ERROR 2

A. Assignment of Error 2

B. Issue Pertaining to Assignment of Error 2

III. STATEMENT OF THE CASE 3

A. Background regarding Ms. Glover's care 3

B. Plaintiff's Negligence Claims 4

C. Facts Relevant to Ruling on Protective Order 5

D. Proceedings Below 9

IV. ARGUMENT 11

A. Summary 11

B. The Superior Court's Extension of *Loudon* Has No Relationship to the Physician-Patient Privilege. 13

C. The Superior Court's Order Interferes with the Attorney-Client Relationship and the Attorney-Client and Work Product Privileges. 21

D. The Superior Court's Order Bars the University from Communicating Confidentially with Its Own Management Personnel. 28

E. The Superior Court's Order Prevents the University's Risk Managers and Counsel from Performing Their Required and Privileged Quality Improvement Functions. 29

F. The Balance of Interests Tips in Favor of the University. 31

G. Courts in Other Jurisdictions Have Refused to Prohibit Communications within an Integrated Health System 33

V. CONCLUSION 34

TABLE OF AUTHORITIES

Cases

Carson v. Fine,
123 Wn. 2d 206, 212, 867 P.2d 610 (1994) 19

Citizens for Health v. Leavitt,
428 F.3d 167, 174 (3d Cir. 2005) 15

DeNeui v. Wellman,
2008 WL 2330953 (D. S. Dakota 2008) 15

Estate of Stephens ex rel. Clark v. Galen Health Care Inc.,
911 So. 2d 277, 282-83 (Fla. 2d Dist. Ct. App. 2005) 33

Hardesty v. Stenchever,
82 Wn. App. 253, 917 P.2d 577 (1996) 6, 26

Holbrook v. Weyerhaeuser Co.,
118 Wn.2d 306, 822 P.2d 271 (1992) 13

Hontz v. State,
105 Wn.2d 302, 310, 714 P.2d 1176 (1986) 1

In re Med. Malpractice Cases Pending in Law Div.,
337 Ill. App. 3d 1016, 787 N.E.2d 237, 245 (Ill. App. Ct. 2003) 34

Kleyer v. Harborview Med. Ctr.,
76 Wn. App. 542, 543 n.1, 887 P.2d 468 (1995) 1

Loudon v. Myhre,
110 Wn.2d 675, 756 P.2d 138 (1988) ..... passim

Manor Care of Dunedin, Inc. v. Keiser,
611 So.2d 1305 (Fla. 2d Dist. Ct. App. 1992) 16

Potashnick v. Port City Const. Co.,
609 F.2d 1101, 1118 (5th Cir. 1980) 32

Rowe v. Vaagen Bros. Lumber, Inc.,
100 Wn. App. 268, 278, 996 P.2d 1103 (2000) 13, 14

Sherman v. State,
128 Wn.2d 164, 190, 904 P.2d 355 (1995) 12, 21, 23, 24

Smith v. Orthopedics Int'l,
170 Wn.2d 659, 244 P.3d 939 (2010) ..... passim

United States v. Philip Morris Inc.,
212 F.R.D. 418, 420 (D.D.C. 2002) 32

Upjohn v. United States,
449 U.S. 383 (1981) ..... passim

Wright v. Group Health,
103 Wn.2d 192, 194, 691 P.2d 564 (1984) 21, 22, 24, 29
Youngs v. PeaceHealth,
No. 67013-1-I; CP 45-47 10

Statutes

45 C.F.R. § 164.506(a) 11, 15
45 CFR 164.514(d)(3)(iii)(C) 11, 15, 16, 17
Health Care Insurance Portability and Accountability Act, P.L.
104-191 15
RCW 28B.20.253 1
RCW 36.62.290 1
RCW 4.92.060 26
RCW 4.92.070 26
RCW 4.92.075 26
RCW 5.60.060(4) 18
RCW 70.41.200 30
RCW 70.41.200(3) 30

Rules

CR 30(b)(6) 29
RPC 1.13 24
RPC 1.13 Comment 1 25
RPC 1.13 Comment 2 25
RPC 1.6 25
RPC 4.2 22

I. INTRODUCTION

This is a medical malpractice action against the State of Washington, Harborview Medical Center, which is for these purposes a part of the University of Washington,[1] and Lulu Gizaw, a physician assistant employed by the University of Washington who was assigned to work in the emergency department at Harborview (collectively hereinafter, "the University"). The question presented is whether *Loudon v. Myhre,* 110 Wn.2d 675, 756 P.2d 138 (1988), and *Smith v. Orthopedics Int'l,* 170 Wn.2d 659, 244 P.3d 939 (2010), prevent counsel for the University from engaging in attorney-client privileged conversations with physicians employed by the University, some of whom are managers whose normal duties would include consultation on matters of this nature, because those physicians subsequently treated the plaintiff or consulted on her care.

---

[1] The state supreme court explained in *Hontz v. State,* 105 Wn.2d 302, 310, 714 P.2d 1176 (1986):

> Harborview is operated and managed by the University of Washington and all of its employees are employees of the University. *See also* RCW 36.62.290. Because the University of Washington is a state agency, Harborview, as operated and managed by the University, is an arm of the State. Its employees are state employees and claims against the University's operation at Harborview are paid from a fund held by the State Treasurer. *See* RCW 28B.20.253.

See also Kleyer v. Harborview Med. Ctr., 76 Wn. App. 542, 543 n.1, 887 P.2d 468 (1995) ("Employees of Harborview are state employees").

II. ASSIGNMENT OF ERROR

A. Assignment of Error

The University assigns error to the superior court's order prohibiting University lawyers and risk managers from having "*ex parte*" contact with plaintiff's treating physicians who are the University's own employees or agents and who practice at the University of Washington Medical Center ("UWMC"). Clerk's Papers (CP) at 170-71.

B. Issue Pertaining to Assignment of Error

Does *Loudon* or *Smith* prohibit counsel for an integrated health organization, or its risk managers, from communicating with employees of the organization who are not personally accused of negligence regarding a medical malpractice suit against the organization where:

A. the trial court's order effectively requires the organization to waive its attorney-client and work product privileges in order to obtain relevant information from its own employees; and

B. the trial court's order prevents counsel for the organization and its risk managers from consulting with the organization's managing agents regarding defense of the matter?

III. STATEMENT OF THE CASE

A. Background regarding Ms. Glover's care

On or about April 2, 2008, plaintiff Aolani Glover, then 28 years old, suffered a spontaneous dissection of her right coronary artery ("RCA").[2] The dissection was discovered during a diagnostic cardiac catheterization procedure carried out at Harborview on the night of April 2, 2008. Following extensive but futile efforts to repair the dissection by placement of stents, and multiple shocks to restore normal rhythm following a ventricular fibrillation, a temporary pacemaker and an intra-aortic balloon pump were placed in order to maintain heart function and circulation, and she was transferred to the Intensive Care Unit. CP 29-30.

Three days later, before she had regained consciousness, Ms. Glover was transferred from Harborview to UWMC, which is also operated by the University and staffed by physicians and other providers employed by the University. At UWMC, Ms. Glover received further treatment including temporary placement of a ventricular assist device.

---

[2] Coronary arteries are comprised of three layers: the intima, the media, and the adventitia. A coronary artery dissection causes separation of the layers of the arterial wall, creating a false lumen or channel. The separation may be between the intima and the media, or between the media and the adventitia. Hemorrhage into the false lumen can impinge upon the true lumen of the coronary artery, impairing blood flow and causing myocardial ischemia, infarction, or sudden death. Spontaneous dissection is very rare. The cause for spontaneous dissection is unknown in this case, although it most often occurs in young women who are taking oral contraceptives, or during and shortly after pregnancy. *See http://en.wikipedia.org/wiki/Coronary_artery_dissection.*

She was discharged from UWMC to home on April 22, 2008, but returned on May 6, 2008 with complaints of renewed chest pain. On this occasion, she was found to have spontaneously dissected a major branch of her left anterior descending coronary artery and the entirety of her left circumflex coronary artery. The interruption of blood supply resulting from these additional dissections caused extensive damage to the left side of plaintiff's heart. Consequently, she required a heart transplant, which she received on July 27, 2008. CP 30.

Ms. Glover's continuing care at UWMC, as well at University-affiliated clinics, has involved dozens of University physicians and other providers. Some have had extensive involvement. Others have been involved only briefly, sometimes without ever meeting the patient, such as the cardiologists and radiologists who interpreted studies, the members of the transplant committee who reviewed Ms. Glover's status, or the pathologists who examined tissue samples. *Id.*

B. Plaintiff's Negligence Claims

Ms. Glover alleges that the staff at Harborview[3] was too slow to recognize that she was suffering a cardiac event, thereby delaying her transfer to the cardiac catheterization laboratory for diagnosis and treatment. Ms. Glover theorizes that she could have avoided extensive

[3] Ms. Glover's initial medical care at the Harborview ER was provided by defendant Lulu M. Gizaw, PA-C. *See* CP 9.

damage to the right side of her heart if she had undergone catheterization and been successfully stented at an earlier point. She further theorizes that, with less damage to the right ventricle, she would have been a candidate for coronary artery by-pass grafting or some other intervention that would have prevented subsequent dissections and the resultant damage to her left ventricle. CP 30-31.

In addition to the alleged delayed diagnosis, these claims raise a number of other issues, including: (1) Could earlier stenting have succeeded in preventing the dissection, or was Ms. Glover's RCA so weakened that stenting would not have been possible? (2) Assuming an earlier successful intervention, how much damage had already occurred? (3) With respect to the care delivered at UWMC, was there reason to anticipate further dissections such as those discovered on May 8, 2008? (4) If so, would there have been a means to avoid the damage that resulted from those dissections, such as by stenting or by-pass surgery, and thereby to avoid the need for transplantation? CP 31.

C. Facts Relevant to Ruling on Protective Order

The University owns or operates hospitals (including Harborview and UWMC), physician groups, and outpatient clinics. It also employs

physicians and other health care providers to staff those facilities.[4] These facilities and providers are part of a single integrated health care system known as "UW Medicine."[5] Notwithstanding, Ms. Glover asserted below that an identifiable boundary exists between "defendant" health care providers who delivered care at Harborview and other "non-targeted" providers who delivered care at the UWMC, arguing that her care at UWMC should be regarded as if it had been "provided at Swedish Medical Center." CP 61. This assertion is at odds with the record and operational reality of modern health care.

Specifically, the UW Medicine system is organized to provide services and deploy personnel in an integrated manner. To this end, the University maintains a single medical records system whereby all medical records—whether generated at Harborview, UWMC, or elsewhere within the UW Medicine system—were (and are) available to doctors at both facilities through the University's electronic medical record system. *See id.*

Further, certain core services, including cardiology, must be available at both Harborview and UWMC. Accordingly, many University physicians, including both attending physicians and trainees and the key

---

[4] *Hardesty v. Stenchever*, 82 Wn. App. 253, 917 P.2d 577 (1996).
[5] For a further description, *see,* http://uwmedicine.washington.edu/global/about/Pages/default.aspx.

physicians involved in this case, practice at both hospitals. CP 148-49. To illustrate, one of the physicians who cared for Ms. Glover at Harborview on the night of April 2, 2008 was called to Harborview from UWMC, and subsequently cared for her at UWMC after her transfer to that hospital. *Id.*

On the other hand, some specialty services are concentrated at one hospital; *e.g.,* trauma and burn care at Harborview and cardiac surgery and oncology at UWMC. As a result, patients are often transferred between the two facilities. Thus, when Ms. Glover needed a ventricular assist device, a service available at UWMC but not at Harborview, her need was accommodated by transfer to the former facility. CP 149, 168. Rather than being a choice that she independently made following her April 2-5, 2008 care at Harborview, Ms. Glover's treatment providers arranged for Ms. Glover's transfer on her behalf while she remained incapacitated. *Id.;* CP 153-54.

The record further shows that the roster of "non-targeted" treating physicians includes individuals who hold management positions within UW Medicine or who have specialized expertise that the University would ordinarily and necessarily draw upon in evaluating a case of this nature regardless of situs; *e.g.*, Dr. Larry Dean, Director of the UW Regional Heart Center; Dr. Daniel Fishbein, Medical Director of the UW's Heart Failure and Heart Transplant Programs, Dr. Edward Verrier, former chief

of the UW's Division of Cardiothoracic Surgery, and Dr. Charles E. Murry, Director of the University's Center for Cardiovascular Biology. CP 32-33. These four individuals practice at both hospitals and each has responsibilities that cross hospital boundaries. CP 148.

Dr. Dean, who performed two catheterization procedures on Ms. Glover in April and May 2008, is a leading interventional cardiologist and a person uniquely positioned to comment about the ability to successfully stent the dissections experienced by Ms. Glover. Dr. Fishbein, who is currently one of plaintiff's attending cardiologists, is a national expert in the evaluation and treatment of end-stage heart disease and one of the people at the University best-positioned to comment knowledgeably on the cause and probable timing of plaintiff's dissections. Dr. Verrier, who participated as a member of the committee that evaluated Ms. Glover's suitability for transplant, is one of the nation's preeminent cardiac surgeons with special expertise in coronary artery bypass and transplant procedures. Dr. Murry, who examined Ms. Glover's native heart after her transplant operation, is a cardiovascular pathologist who is an expert on the mechanism of myocardial infarction. CP 32-33. By virtue of their positions and expertise, these physicians would normally be expected to consult with defense counsel on matters of this nature. CP 145.

D. Proceedings Below.

At the outset of discovery, Ms. Glover's counsel indicated that her negligence claims were confined to those providers "who had contact with Aolani Glover prior to her transfer to the coronary catheterization laboratory" at Harborview. On this basis, he asserted that *Loudon* and *Smith* preclude defense counsel from contacting any treating physicians (and presumably other health care providers) at Harborview, other than those involved in her care in the Emergency Department, except in a deposition where plaintiff's counsel is present. Subsequently, without expressly indicating that the scope of her claim has expanded, plaintiff's counsel indicated that he did not object to defense counsel's contact with any of the Harborview Emergency or Cardiology staff involved in Ms. Glover's care, so long as those individuals were not shown any records of her subsequent care. CP 31-32, 38-43.

Because the restrictions proposed by plaintiff's counsel are prejudicial and unworkable, the University brought a motion under CR 26 (c), seeking a ruling from the superior court regarding the ability of its counsel to consult with University physicians involved in the case who did not treat Ms. Glover while she was hospitalized at Harborview. CP 16-28. In response, again without explanation for the changed position, plaintiff proposed an order prohibiting defense counsel from contacting any

physicians who cared for her at UWMC, but which does not restrict contact with physicians who saw her at Harborview.

After hearing argument, the superior court denied defendants' motion, and entered Plaintiff's proposed order, directing that

> Defense Counsel and the defendant's risk manager are prohibited from *ex parte* contact, directly or indirectly, with any of Plaintiff Aolani Glover's treating physicians at University of Washington Medical Center.

CP 170-71. The trial court then granted the parties' joint motion for certification of the order for discretionary review to this Court. CP 172-73. The certification order states: "There is no Washington authority addressing the specific issue of whether the rule in *Loudon v. Myhre* prohibiting defense counsel from engaging in *ex parte* contact with a plaintiff's nonparty treating physicians applies to treating physicians employed by the defendants." CP 172.

This Court granted discretionary review (Order dated August 23, 2011), and linked this action with another discretionary review action, reviewing a trial court order that reached the opposite result and allowed privileged communications between counsel and the health system's employed physicians. *See id.; Youngs v. PeaceHealth,* No. 67013-1-I; CP 45-47.[6]

---

[6] To the extent applicable to the facts herein, the University references and adopts the arguments made in the Brief of Respondent in the linked *Youngs* action.

IV. ARGUMENT

A. Summary

The important issue presented here is one of first impression for Washington appellate courts. The superior court's decision to extend the *Loudon* prohibition on *ex parte* communications between defense counsel and non-party treating physicians is unwarranted because none of the policy reasons identified in *Loudon* as cases for prohibiting contact between defense counsel and non-party treating physicians are applicable where the only "disclosure" of the patient's health information would be by a health care provider—acting through its agents—to its own counsel. To the contrary, governing law expressly permits a health care organization like the University to disclose otherwise privileged healthcare information in the possession of its employees to its counsel for the purpose of providing advice or representation relative to a malpractice claim. 45 C.F.R. § 164.506(a); 45 CFR 164.514(d)(3)(iii)(C); RCW 70.02.050(1)(b).

Further, *Loudon* and *Smith* did not consider whether the ban on *ex parte* contacts between defense counsel and non-party treating physicians can limit or override the attorney-client and work product privileges. In this regard, the law is clear that communications between counsel for an

organization and employees of that organization, even those employees who are not managers, are privileged when the purpose of the communications is to allow counsel to obtain relevant knowledge and provide legal advice or representation. *Sherman v. State,* 128 Wn.2d 164, 190, 904 P.2d 355 (1995); *Upjohn v. United States,* 449 U.S. 383 (1981). These interests have led the courts in other jurisdictions that have considered this issue to recognize the existing organizational attorney-client privilege and allow organizational counsel to communicate confidentially with the organization's employees and agents. By preventing such communications unless opposing counsel is present, the superior court's order interferes with the attorney-client relationship and effectively requires the University to waive the attorney-client and work product privileges if it wants to obtain the relevant knowledge and input of its employee-physicians.

The superior court's order also prohibits the University's counsel from communicating with certain of its senior management personnel, solely on the basis that they happen to also be "non-targeted" treatment providers in this particular case. These individuals not only possess relevant knowledge about the facts of this case, but also are critical institutional resources who are expected to work with counsel and risk management staff to evaluate the liability and causation issues in the case,

regardless of their involvement in the treatment. Nothing in *Loudon* or *Smith* justifies placing these key institutional resources off-limits.

The superior court also erred by prohibiting the University's risk managers from communicating with its treating physicians, an outcome inconsistent with the risk managers' statutory duties on behalf of the quality improvement committee to investigate, evaluate, and prevent medical malpractice issues.

B. The Superior Court's Extension of *Loudon* Has No Relationship to the Physician-Patient Privilege.

Loudon identified four specific concerns that led to its protection for the physician-patient privilege. *See Holbrook v. Weyerhaeuser Co.*, 118 Wn.2d 306, 822 P.2d 271 (1992) (discussing bases for *Loudon*). The first and primary concern was that the waiver of privilege resulting from commencement of a personal injury suit extends only to information that is relevant and discoverable under CR 26 and that, without the presence of plaintiff's counsel, a nonparty treating physician might disclose irrelevant and, therefore, privileged information. *Loudon,* 110 Wn.2d at 677-78; *see also Rowe v. Vaagen Bros. Lumber, Inc.,* 100 Wn. App. 268, 278, 996 P.2d 1103 (2000) ("The primary concern is potentially prejudicial but irrelevant disclosures").

Second, *Loudon* reflected a concern that non-party physicians may not understand the appropriate boundaries of the privilege waiver in personal injury cases, and cannot rely on defense counsel to advise them on that subject. *Loudon,* at 677-78. Third, the court noted that, "for some," there could be a chilling effect on the patient-physician relationship if direct contact with their doctors was permitted. *Id.* at 679; *see also Rowe* at 278 ("the threat that a doctor might talk with a legal adversary outside the presence of plaintiff's counsel could have a chilling effect on the injured person's willingness to continue with treatment and be forthright with the physician"). In the same vein, *Smith* indicated that the "risk that a nonparty treating physician testifying as a fact witness might assume the role of a nonretained expert for the defense ... may result in chilling communications between patients and their physicians about privileged medical information." *Smith,* 170 Wn.2d at 669. Finally, *Loudon* indicated that pre-trial interviews might lead to situations where defense counsel was compelled to testify as impeachment witnesses concerning their communications with non-party physicians. 110 Wn.2d. at 680.

Here, by contrast, the public policy concerns relating to the patient-physician privilege are not impacted. First, healthcare providers have always been free to disclose privileged healthcare information to their

lawyers for the purpose of obtaining legal advice. *See, e.g., DeNeui v. Wellman,* 2008 WL 2330953 (D. S. Dakota 2008) (non-party treating physician entitled to disclose privileged information to counsel who was appointed by same insurer that provided coverage for the defendant). Both state and federal statutes permit healthcare providers and their employees or agents to disclose confidential healthcare information to their lawyers. The Washington Uniform Health Care Information Act,[7] and the Health Care Insurance Portability and Accountability Act ("HIPAA"),[8] allow disclosure of confidential health care information

---

[7] RCW Ch. 70.02 (Uniform Health Care Information Act). RCW 70.02.050(1)(b) provides:

> 1) A health care provider or health care facility may disclose health care information about a patient without the patient's authorization to the extent a recipient needs to know the information, if the disclosure is:
>
> ...
>
> (b) To any other person who requires health care information for ... administrative, legal, financial, actuarial services to, or other health care operations for or on behalf of the health care provider or health care facility.

[8] P.L. 104-191 (HIPAA). HIPAA permits the use and disclosure of protected health information without a patient's consent for "treatment, payment and health care operations." 45 C.F.R. § 164.506(a). This so-called "routine use" exception refers to a wide range of management functions for covered entities, including quality assessment, practitioner evaluation, and auditing services. *See Citizens for Health v. Leavitt*, 428 F.3d 167, 174 (3d Cir. 2005). The federal Department of Health and Human Services has issued official guidance expressly permitting disclosures to legal counsel. *See* U.S. Dept. of Health & Hum. Services, Health Information Privacy, Frequently Asked Questions (the covered entity will share protected health information for litigation purposes with its lawyer, who is either a workforce member or a business associate). In these cases, the Privacy Rule permits a covered entity to reasonably rely on the representations of a lawyer who is a business associate or workforce member that the information requested is the minimum necessary for the stated purpose. *See* 45 CFR 164.514(d)(3)(iii)(C).) available at http://www.hhs.gov/ocr/privacy//faq/permitted/judicial/705.html.

without the patient's authorization to any person who requires that information to provide legal services to a health care provider or facility.

These laws preclude any finding that patients could have a legitimate expectation that they can limit the use of relevant information that is within the possession and control of the entity they have sued. Accordingly, there is no privilege preventing employees of a health care organization from disclosing confidential information to the organization's lawyers for the purpose of allowing the lawyers to advise the organization. *See, e.g., Manor Care of Dunedin, Inc. v. Keiser,* 611 So.2d 1305 (Fla. 2d Dist. Ct. App. 1992) (statutory exception to privacy protections for healthcare information, allowing defendants to access such information, also permitted *ex parte* interviews of employees and former employees).

Second, even if there is some potentially irrelevant privileged information within the possession of non-targeted University providers, the authority to disclose that information to counsel does not mean that counsel are free to use protected information for unauthorized purposes. To the contrary, the institution, its staff, and its outside counsel are all obligated under federal law to maintain appropriate confidentiality.[9] And,

---

[9] *See* 45 CFR 164.514(d)(3)(iii)(C) and HIPAA FAQ ("the lawyer who is a workforce member of the covered entity must make reasonable efforts to limit the protected health information disclosed to the minimum necessary for the purpose of the disclosure. Similarly, a lawyer who is a business associate [outside counsel] must apply the minimum necessary standard to its disclosures, as the business associate contract may not

unlike the situation in *Loudon* where defense counsel owed no obligation to the non-party physicians, counsel for a health care organization have an obligation to appropriately advise its providers regarding the appropriate protection of privileged information.[10]

The third reason for the *Loudon* rule is the concern that allowing *ex parte* contact between non-party treating physicians and defense counsel might induce a non-party treating physician, out of sympathy for a colleague or a desire to tamp down malpractice suits, to shade her testimony in favor of the defendant-physician. To the extent that there is validity to the notion that contact with defense counsel produces these effects, the logical weight of that notion largely vanishes in the present circumstances. All of the providers—whether "targeted" or not—are employees of the University and colleagues in UW Medicine and, in addition to duties to patients, each of them owes a duty of loyalty to the University, which would include a duty to cooperate in the defense of this case. This situation is far different from the circumstance where counsel may try to enlist an independent physician as a partisan for defense.

---

authorize the business associate to further use or disclose protected health information in a manner that would violate the HIPAA Privacy Rule if done by the covered entity").

[10] *See* 45 CFR 164.514(d)(3)(iii)(C) and HIPAA FAQ ("the Privacy Rule permits a covered entity to reasonably rely on the representations of a lawyer who is a business associate or workforce member that the information requested is the minimum necessary for the stated purpose").

Further, because of the limitations on patient-physician privilege and privacy of medical records previously discussed, a patient who has sued a health care organization has no legitimate expectation that the organization will not access information within its possession that is necessary to assess its liability. *See Burger v. Lutheran General Hosp.*, 198 Ill. 2d 21, 52, 759 N.E. 2d 533 (2001) (where patient seeks care in an integrated health care system, any legitimate expectation of privacy is limited to the institution, rather than any individual provider).

With respect to the concern that treating physicians may become defense experts, the calculus is different when the treating physician's role within the defendant-organization already includes consultation with the organization's lawyers or risk managers. In these circumstances, there is no risk that contact with the organization's lawyers will change the physician's role.

Finally, there is also no legitimate prospect that defense counsel's contact with the client's employees will require counsel to testify, since all of those communications are privileged.

Because the *Loudon* rule is intended to preserve and foster the patient-physician privilege, its application must be tethered to the scope and purposes of the privilege. In Washington, the privilege exists solely by virtue of RCW 5.60.060(4), which prohibits a physician from testifying

in a civil action as to information acquired in attending a patient without his or her consent. *Carson v. Fine*, 123 Wn. 2d 206, 212, 867 P.2d 610 (1994). As a statute in derogation of common law, RCW 5.60.060(4) is strictly construed and its application is limited by the statutory purposes of facilitating full disclosure by the patient and protecting against embarrassment which may result from disclosure of medical information. *Id.* Regardless of how these purposes apply to limit interactions between independent treating physicians and defense counsel, there is no question that the privilege does not prevent physicians from disclosing confidential information to their lawyers, or to the lawyers for their employers.

Ms. Glover may, nevertheless point to the portion of Justice Fairhurst's concurring opinion in *Smith,* where she dissented from the majority, as confirmation that the lead opinion's prohibition on direct contact with non-party treating physicians extends to contacts between defense counsel and employees and agents of the client. A review of the circumstances in *Smith* refutes this suggestion. In that case, a group headed by the Washington State Hospital Association ("WSHA") filed an *amicus* brief, urging the Supreme Court to (a) affirm the Court of Appeals; and (b) avoid any unnecessary pronouncements about the application of *Loudon* to contacts between defense counsel and agents of a defendant health care organization. The lead opinion in *Smith,* written by Justice

Alexander and joined by six other justices with respect to application of *Loudon* to the facts, confirmed that "the fundamental purpose of the *Loudon* rule is to protect the physician-patient privilege."[11] 170 Wn.2d at 667. Nothing in the lead opinion, or Justice C. Johnson's concurrence/dissent,[12] signals that the court intended to apply *Loudon* to facts such as those presented here. To the contrary, reading the two opinions joined by seven justices who found a *Loudon* violation, it appears that court heeded WSHA's request to avoid making a pronouncement on an issue that was not presented by the record in *Smith.*

In Justice Fairhurst's opinion, however, she argued that the lead opinion goes beyond the scope of the patient-physician privilege and contravenes the provisions of the Uniform Health Care Information Act allowing disclosure of privileged information to lawyers. *Id.* at 677. This statement is not a part of the majority holding, of course, and given the close divisions among the justices and the careful phrasing of the holding

---

[11] Justices Owens and J. M. Johnson joined Justice Alexander in holding that there was a *Loudon* violation, but found no resulting prejudice. Justices C. Johnson, Sanders, Chambers and Stephens agreed with the lead opinion on the application of *Loudon,* but would have applied a *per se* prejudice rule and reversed the judgment. Justice Fairhurst, joined by Chief Justice Madsen, found no *Loudon* violation and hence no prejudice, thus making a 5-4 majority for affirmance.

[12] Justice Johnson's concurrence/dissent begins, "The lead opinion correctly concludes that *Loudon* prohibits the type of *ex parte* contact that took place in this case." (emphasis supplied).

so as to avoid comment on an issue not presented, it would be improperly presumptuous to expand *Smith* beyond its facts and specific holding.

C. The Superior Court's Order Interferes with the Attorney-Client Relationship and the Attorney-Client and Work Product Privileges.

The trial court's extension of *Loudon* invades the attorney-client relationship between the University and its counsel. The order forbids defense counsel (and the University's risk management personnel) from obtaining relevant information on a privileged basis from the University's own employees. The superior court's order ignores the consistent authority that applies the organizational attorney-client privilege to allow an organization's counsel to communicate on a confidential basis in order to obtain information from all of its employees with relevant knowledge of a matter, regardless of whether those employees are managing agents of the organization or would be considered "clients."

The scope of the attorney-client privilege within an organizational setting has been defined by two Washington decisions: *Wright v. Group Health,* 103 Wn.2d 192, 194, 691 P.2d 564 (1984), and *Sherman v. State,* 128 Wn.2d 164, 190, 904 P.2d 355 (1995), and a third, *Upjohn v. United States,* 449 U.S. 383 (1981), a United States Supreme Court decision with conclusions specifically adopted in both *Wright* and *Sherman.* These decisions all confirm that under an organization's attorney-client privilege,

communications between an organization's counsel and the organization's employees for the purpose of gathering information or assisting in the representation of the organization, are confidential, regardless of whether those employees are also "speaking agents" for the organization.

Wright. *Wright* addressed the limited issue of the scope of communications that opposing counsel may have with a corporation's employees without invoking the prohibitions of CPR DR7-104(A) (now RPC 4.2) on communicating with a party represented by counsel. *Wright* adopted a "flexible interpretation," which depends on the position and authority of the speaker and the nature of the particular statement. 103 Wn.2d. at 200-01. The court cited in its analysis a series of cases applying ER 801(d)(2) (or earlier law) pertaining to the admissibility of admissions of a party-opponent, which went both ways on the question. Among the cited cases was *Young v. Group Health*, 85 Wn.2d 332, 534 P.2d 1349 (1975), which *Wright* parenthetically noted stood for the proposition that a "doctor had 'speaking authority' for [a] hospital" and therefore could not be contacted by opposing counsel. *Id.* at 201.

The *Wright* decision does not support any conclusion that the boundaries for permissible *ex parte* communications between an opposing counsel and an organization's employees are the same boundaries defining the scope of confidential communications between the organization's own

counsel and the organization's employees. To the contrary, *Wright's* only focus was defining the conduct from which opposing counsel was prohibited. As to the boundaries of the privilege protecting communications between organizational counsel and employees, the *Wright* court specifically acknowledged that *Upjohn* controlled. *Id.* at 195 (noting that, despite its holding, the "the attorney-client privilege may in certain instances extend to lower level employees" to "protect communications"). The *Wright* court observed that "the *Upjohn* court was expanding the definition of 'clients' so the laudable goals of the attorney-client privilege would be applicable to a greater number of corporate employees"). *Id.* at 201.

Sherman. The court in *Sherman v. State,* 128 Wn.2d 164, 190, 905 P.2d 355 (1995), held that privileged communications between a University attorney and a medical resident concerning a malpractice claim did not make the resident a client of the attorney, such that the resident could demand that the attorney be disqualified from a later lawsuit between the resident and the University. In addition to noting the absence of an attorney-client relationship that extended to the employee individually, the court specifically concluded that communication "between an attorney for a corporate entity and that entity's employees is subject to the attorney-client privilege of the corporate entity." *Id.*

Upjohn. Both *Wright* and *Sherman* specifically adopted and relied upon *Upjohn,* which rejected the proposition that the attorney-client privilege applies only to communications between counsel and those in the "control group" of the corporation, stating: "In a corporation, it may be necessary to glean information relevant to a legal problem from middle management or non-management personnel as well as from top executives." *Id.* at 391-92 (citations omitted). Under *Upjohn*, an organization's attorney-client privilege protects as confidential communications that extend beyond the "control group" and includes communications between counsel and lower level employees, for the purpose of gathering information necessary for counsel to advise the client regarding its potential liabilities. To hold otherwise, *Upjohn* noted, would "frustrate[] the very purpose of the privilege by discouraging the communication of relevant information by employees of the [organization] to attorneys seeking to render legal advice to the client [organization]." *Id.* at 392. The reliance of both *Wright* and *Sherman* on the *Upjohn* decision makes clear that Washington courts recognize the need for confidentiality of communications between an organization's counsel and its employees.

Consistent with *Upjohn*, RPC 1.13 provides that organizational counsel "represents the organization acting through its duly organized

constituents." The comments to that rule state that the "constituents of the corporate organizational client" include its "employees" and that "[w]hen one of the constituents of an organizational client communicates with the organization's lawyer in that person's organizational capacity, the communication is protected by [RPC] Rule 1.6" (prohibiting a lawyer from revealing "information relating to the representation of a client"). RPC 1.13 Comments 1 and 2.

The superior court's order ignored these authorities, as well as the specific authority that the University's counsel has here to represent the University and its employees, and the University's statutory obligation to provide that defense. The University's counsel in this action have been appointed as special assistant attorneys general to "advise and represent the University, including its health care providers, employees, and/or indemnitees involved in this matter." CP 29, 36. The purpose for this scope of engagement is to allow counsel to advise both the providers and the University regarding their potential liability which, as the shifting scope of the claims in this case illustrates, may change as the case progresses. The University and its physicians may also need advice regarding their obligations in responding to discovery in the matter. Counsel's engagement anticipates that need.

In addition, the University must provide a defense to all of its employees and agents, whether located at Harborview or at UWMC. Under RCW 4.92.060,.070 and .075, a claim against an individual state officer or employee is a claim against the state and the state's resources. Subject to conditions, every University employee is therefore statutorily entitled to defense by the state attorney general.[13] Under *Upjohn,* the attorney-client privilege for the University extends not just to targeted physicians or to the University's management physicians, but to all of the University's health care providers/agents and employees, even those who are not part of management. The University is permitted to confidentially provide all of its relevant information to counsel, so that counsel can provide the most informed advice and defense.

---

[13] The court explained in *Hardesty,* 82 Wn. App. at 260:

> Under Chapter 4.92, the State is required to defend a state employee sued for damages for acts arising from the performance of his or her official duties and to satisfy any judgment resulting from such an action. Under RCW 4.92.060, any "state officer, including state elected officials, employee, volunteer, or foster parent" sued for damages arising from acts or omissions "while performing, or in good faith purporting to perform, official duties" may ask the state attorney general to authorize the defense of the action at State expense. Under RCW 4.92.070, if the attorney general finds that the employee's acts or omissions were, or were purported to be, in good faith and performed within the scope of that person's official duties, he must grant the request. Under RCW 4.92.075, when the attorney general has represented a state officer or employee and a court has entered a judgment, the judgment creditor must seek satisfaction only from the State, and the judgment cannot become a lien on the individual's property. RCW 4.92.075.

The superior court's order prohibits counsel from contacting University physicians, despite the undisputed fact that they have relevant knowledge that is likely to assist counsel in advising their client. Some of them have specialized knowledge relevant to issues in the case, which is not readily available from other sources. The superior court's order has placed in the hands of plaintiff's counsel the power to determine—by his choice of "targeted" providers—the scope of the confidentiality of the communications between counsel and the organization's employees. As the proceedings have reflected, plaintiff's counsel's choices regarding who is "targeted" can and do change, leaving the organization's ability to communicate internally and to defend itself to be determined unilaterally by plaintiff's counsel, and leaving the protections of privilege as illusory.

Contrary to Ms. Glover's assertion below, depositions are not a substitute for confidential communications between an organization's counsel and its employees. Providers and other employees cannot be expected to be fully candid in the presence of opposing counsel. And, requiring counsel to conduct their internal investigation of the case, including exploration of liability or causation theories, in the presence of opposing counsel necessarily invades the work-product privilege. The superior court erred in limiting the extent to which an organization's

counsel can perform its essential functions of representation of the organization and its constituents.

D. The Superior Court's Order Bars the University from Communicating Confidentially with Its Own Management Personnel.

Even if *Loudon* had some application in this setting, the trial court's blanket order unjustifiably prohibits communications between counsel and the University's management personnel. This key factor further distinguishes this case from *Loudon* and *Smith* and alters the balance of interests between the parties. In this case, the roster of physicians that defense counsel are prohibited from contacting includes several who hold key management positions within UW Medicine and who normally would be expected to consult with counsel and risk management and contribute their knowledge, expertise and judgment in formulating the University's position in this highly unusual case. These include interventional cardiologist Dr. Larry Dean, cardiologist Dr. Daniel Fishbein, cardiac surgeon Dr. Edward Verrier, and cardiovascular pathologist, Dr. Charles E. Murry, each of whom holds or did hold at the time in question a director or chief level administrative appointment to manage significant programs within the University's School of Medicine, has nationally-recognized expertise in his field, and also provided some type of treatment for Ms. Glover. These physicians likely are, by virtue of

their management roles, speaking agents for the University under *Wright*, 103 Wn.2d at 201, which even Ms. Glover's counsel acknowledged. If the University were required to produce CR 30(b)(6) witnesses on its cardiac programs, these individuals would be the likely witnesses. Under the trial court's order, however, these physicians, despite the minimal involvement some of them had in Ms. Glover's care, cannot carry out their normal roles relative to liability claims against the University.

These individuals are critical institutional resources, and would be expected to assist counsel and the University with their candid evaluation of the very complicated and unusual liability and causation issues that this action presents, regardless of whether they were involved in the questioned care. Counsel cannot perform their functions on behalf of its client organization without communicating with these individuals.

E. The Superior Court's Order Prevents the University's Risk Managers and Counsel from Performing Their Required and Privileged Quality Improvement Functions.

The superior court order extended *Loudon* not only to impose communication barriers between the University's counsel and its employees, but also to impose communication barriers between the University's "risk manager" and University employees. Neither Ms. Glover nor the superior court cited authority supporting this prohibition, and it is not apparent that courts have jurisdiction to regulate the manner

by which the University manages its internal affairs. Further, the order ignored the reality that risk management activities encompass both quality improvement and claims handling services, which are not necessarily connected to the activities of counsel, and that the confidentiality of information provided to risk management personnel is specified by statute.

RCW 70.41.200 requires all hospitals to maintain a quality improvement program "for the improvement of the quality of health care services" and "the identification and prevention of medical malpractice." The hospital must establish a quality improvement committee with the responsibility to "ensure that information gathered pursuant to the program is used to review and revise hospital policies and procedures." *Id.* The program has responsibility for, among other things, "[t]he maintenance and continuous collection of information concerning the hospital's experience with negative health care outcomes" and "[e]ducation programs dealing with ... the legal aspects of patient care." *Id.* The statute also imposes confidentiality on "[i]nformation and documents... collected and maintained by" the quality improvement committee. RCW 70.41.200(3). The University, like other hospitals, has performed its quality improvement responsibilities under this statute utilizing the functions of, among other personnel, its risk managers and its counsel, both before and after a negligence claim might be filed. The

committee, or counsel or risk managers collecting information on its behalf, communicates with treating providers and others with information relevant to the committee's work. These communications are protected by a statutory privilege, a result inconsistent with the superior court's choice to negate the confidentiality of these communications solely when they occur within the framework of a civil medical malpractice action.

F. The Balance of Interests Tips in Favor of the University.

When courts make policy, they necessarily proceed based on the particular circumstances and interests before them, rather than a review of all of the conceivable circumstances that may bear on the question. The *Loudon* rule was developed "as a matter of public policy," in order "to protect the physician-patient privilege," based on the court's perception of the relative balance of interests presented by the case-specific facts. *Loudon*, 110 Wn. 2d at 677; *Smith,* 170 Wn. 2d at 667. Neither *Loudon* nor *Smith* involved circumstances or interests similar to those presented here. In both *Loudon* and *Smith*, the issues raised concerned only communications between defense counsel and treating physicians who were completely independent of both the defendants and their defense counsel.

When the *Loudon* court said it was "unconvinced that any hardship caused the defendants by having to use formal discovery procedures

outweighs the potential risk involved with *ex parte* interviews" (*Loudon,* at 680), it did not have occasion to consider a circumstance where application of its rule would prevent defense counsel and its client organization from obtaining relevant information—evidentiary and otherwise—from employees and agents of the client organization, except by waiving the attorney-client privilege. Nor did the *Loudon* or *Smith* court have occasion to weigh a defendant's interest in having its counsel consult—on a privileged basis—with its own senior leadership and other knowledgeable employees and to receive their input relative to a matter, or the negative consequences to the organization and its functions in preventing them from doing so.

In this regard, it should be considered that some restrictions on communications between civil counsel and client may be unconstitutional.[14] In addition, *Smith* and *Loudon* did not consider the fact that the statutory patient-physician privilege does not apply when a physician discloses privileged or protected information to a lawyer, when that disclosure is for the purpose of allowing the lawyer to render advice

[14] *See Potashnick v. Port City Const. Co.*, 609 F.2d 1101, 1118 (5th Cir. 1980) (order prohibiting counsel for corporation from consulting with president of corporation during breaks and recesses in trial infringed on due process rights); *United States v. Philip Morris Inc.,* 212 F.R.D. 418, 420 (D.D.C. 2002) ("there are clearly constitutional overtones and concerns about any interference with or limitation on the ability of counsel to confer with her witnesses (whether client or not), to strategize about the case (if the witness is the client), and to provide day-to-day commercial advice (if, for example, the witness is a commercial client).").

to the physician or the physician's employer. When these factors are considered, extension of *Loudon* and *Smith* would be unprecedented and unwarranted, requiring the University to waive the attorney-client privilege in order to obtain relevant information that is within the knowledge of its own employees and agents.

G. Courts in Other Jurisdictions Have Refused to Prohibit Communications within an Integrated Health System

Ms. Glover has identified no decision from other jurisdictions, and the University is aware of none, that supports the superior court's extension of rule prohibiting defense counsel communications with treating physicians to also prohibit communications with treating physicians who are associated with a defendant health care organization. To the contrary, the courts that have addressed the issue have ruled that a prohibition on *ex parte* communications does not extend to this circumstance. *See, e.g., Estate of Stephens ex rel. Clark v. Galen Health Care Inc.,* 911 So. 2d 277, 282-83 (Fla. 2d Dist. Ct. App. 2005) (patient-physician privilege applies to communications between counsel for hospital and employed non-party physicians; such communications do not violate patient privacy rights; "a doctor is not disclosing [privileged patient] information in violation of a doctor/patient privilege by discussing the patient information with the hospital's risk manager, for example");

Burger v. Lutheran General Hosp., 198 Ill. 2d 21, 41-42, 759 N.E. 2d 533 (2001) ("any information known by any hospital caregiver with respect to a patient's care at that hospital is hospital information"); *In re Med. Malpractice Cases Pending in Law Div.*, 337 Ill. App. 3d 1016, 787 N.E.2d 237, 245 (Ill. App. Ct. 2003) (the law "does permit intrahospital communications relating to the care and treatment rendered to a patient between employees and agents of a hospital, including members of its medical staff, and both the hospital's legal counsel and those parties responsible for risk management"). The superior court's order stands alone in its failure to recognize the interests that should allow for confidential communications between a health care organization's counsel and its employed treating physicians.

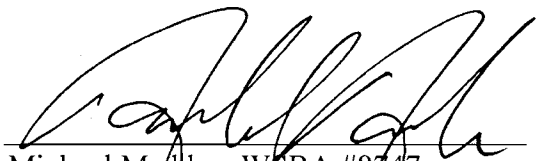
V. CONCLUSION

The superior court's order does not preserve the patient-physician privilege, but it does materially interfere with the ability of the University's counsel to investigate and obtain the candid views of University physicians on the matter. It also limits the ability of counsel to consult with the University's management and, ultimately, to provide an appropriate level of service to their clients. For these reasons, the Court should reverse the trial court's order prohibiting the University's counsel

from engaging in attorney-client privileged communications with its employed physicians.

Respectfully submitted this 27 day of October, 2011

BENNETT BIGELOW & LEEDOM, P.S.



By: _____
Michael Madden, WSBA #8747
Carol Sue James, WSBA #16557
Special Assistant Attorney General
Attorneys for Appellants

CERTIFICATE OF SERVICE

I certify under penalty under the laws of the State of Washington that on October 27 2011, I caused a true and correct copy of the foregoing APPELLANTS' OPENING BRIEF to be delivered as follows:

Thomas R. Golden	☐	Hand Delivered
Otorowski Johnston Morrow &	☐	Facsimile
Golden, PLLC	☒	Email
298 Winslow Way West	☒	1st Class Mail
Bainbridge Island,WA 98110	☐	Priority Mail
Fax: (206) 842-0797	☐	Federal Express, Next Day
email: **trg@medilaw.com**		

Participants for Linked Case # 67350-5-I

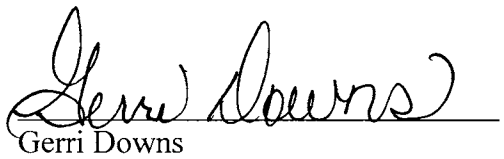
Joel D. Cunningham	☐	Hand Delivered
J. Andrew Hoyal, II	☐	Facsimile
Luvera Law Firm	☐	Email
701 5th Ave, Ste 6700	☒	1st Class Mail
Seattle, WA 98104-7016	☐	Priority Mail
joel@luveralawfirm.com	☐	Federal Express, Next Day
andy@luveralawfirm.com		

James L. Holman	☐	Hand Delivered
Attorney at Law	☐	Facsimile
4041 Ruston Way, Ste 101	☐	Email
P.O. Box 1338	☒	1st Class Mail
Tacoma, WA 98401-1338	☐	Priority Mail
jlholman@jameslholman.com	☐	Federal Express, Next Day

John C. Graffe, Jr.	☐	Hand Delivered
Heath S. Fox	☐	Facsimile
Johnson Graffe Keay Moniz & Wick,	☐	Email
LLP	☒	1st Class Mail
925 4th Ave, Ste 2300	☐	Priority Mail
Seattle, WA 98104-1145	☐	Federal Express, Next Day

johng@jgkmw.com
heath@jgkmw.com

Mary Spillane Daniel W. Ferm Williams, Kasnter & Gibbs, PLLC Two Union Square 601 Union St, Ste 4100 Seattle, WA 98101 mspillane@williamskastner.com dferm@williamskastner.com	☐ ☐ ☐ ☒ ☐ ☐	Hand Delivered Facsimile Email 1st Class Mail Priority Mail Federal Express, Next Day



Gerri Downs

{1408.00092/M0444245.DOCX; 4}